Promoting Quality in Medicaid: What does the research tell us?

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October 21, 2010

2010 South Carolina Medicaid Managed Care Policy, Practice, and Research Conference
Topics

• History of quality improvement
• Quality improvement in the Medicaid Program
  • Over time
  • States’ current activities
• Evidence about improving quality
• New opportunities
Access vs. Quality

• Plenty of evidence that Medicaid improves access – which is one type of quality
  • Percent of enrollees with a visit in a year (particularly relevant for children)
  • Percent of adults and children who receive preventive services
  • Percent of women starting prenatal care in the first trimester
  • Percent of beneficiaries with a chronic illness receiving appropriate monitoring and follow-up care

• Question for today: Do strategies (beyond coverage) improve quality of care?
Quality Improvement – a new and (slowly) growing field

1. Typologies – Structure, process, and outcomes
2. Demonstrating problems exist
   • Small area variation, disparities, quantifying waste and inefficiency
3. Professional development of clinical standards, focus on evidence-based medicine
4. Credentialing of plans and providers
5. Public reporting
6. Consumer empowerment
7. Improvement science
8. Comparative effectiveness research
Federal Medicaid quality requirements

- Focus on quality within managed care plans
- States (or external reviewers, or both) must review MCO against standards
  - Assure availability of an adequate provider network
  - Monitor enrollee satisfaction and grievances
  - Plans must consider special needs of Medicaid patients (e.g., language, transportation, culture)
  - ID patients with special health care needs
  - Treatment plans for complex patients
State Medicaid Quality Improvement Activities

- Measurement and reporting
- Structuring the delivery system
  - Primary Care Case Management
  - Medical Home
- Linking payment to quality
  - Risk-based managed care plans
  - Incentives
- Auditing/credentialing
States with Selected Medicaid Quality Initiatives FY 2010

Number of States

- HEDIS® or Similar for MCOs, PCCM or FFS: 47
- CAHPS® or Similar for MCOs, PCCM or FFS: 43
- Public Reporting of Health Plan Performance: 41
- P4P for MCOs and other Providers*: 34
- MCO Accreditation*: 18

NOTE: Data for two measures from 2009 survey. MCO Accreditation includes states that require or reward accreditation.

Health plan quality initiatives for Medicaid patients

- QI Initiatives
  - Managing care for people with chronic illness
  - Screening: cancer, depression
  - Children: Immunizations, Well-child or EPSDT visits
  - Managing high risk pregnancies
- Some plans report improving outcomes with QI initiatives
  - Self-reported by plans, unaudited, unpublished
  - Best for immunization rates
  - Incomplete data a major barrier (less than 50% report)
- Feeding back data to providers done by about 1/3 of plans
- Financial incentives to providers to submit data (particularly the data needed for HEDIS)

How much has quality improved?
Hospital Core Measures Have Improved

Graph 5: Overall accountability composite greater than 90 percent

Mortality Amenable to Health Care by State
Deaths* per 100,000 Population

2004–05

Quartile (range)
- Top (63.9–76.8) Best: MN
- Second (77.2–89.9)
- Third (90.7–107.5)
- Bottom (108.0–158.3) Worst: DC

2001–02  2004–05

Best state
- Top 5 states average
- All states median
- Bottom 5 states average
- Worst state**

DATA: Analysis of 2001–02 and 2004–05 CDC Multiple Cause-of-Death data files using Nolte and McKee methodology, BMJ 2003
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

*Age-standardized deaths before age 75 from select causes; includes ischemic heart disease.

**Excludes District of Columbia.
"I think you should be more explicit here in step two."

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We don’t know enough about the pathway to quality

Strength of the clinical evidence → Physician/hospital practice → Patient characteristics and behavior

Process redesign, QI methods → Data and measurement → Availability of services in community

Payment, benefits policies → Quality
Little valid research on the improvement method

- Bad data, incomplete data, inconsistent data
- Inconsistency in the intervention
- Voluntary participation in research – noncomparability
- Lack of comparisons
- Lack of control for other concurrent changes
Do we have to be so picky about the research?

• Yes! Differences in populations, intervention sites, and “treatment strength” all affect our ability to generalize to a new location
• Missing data -- don’t represent the true experience

• Example: Do Disease Management Programs improve outcomes and lower costs?
• Use of services increased, with trivial effects on quality
  • How sick were the enrollees?
  • How unmanaged were the enrollees?
  • How did the care manager interact with the enrollee?
  • How were the savings shared between state/DM company?
  • Was the clinical evidence about best practices strong and credible to the providers?
Pay-for-performance: design decisions

- Conditions – high cost, big health impact, or readily changed
- Reporting
- Locus of control
- Size of incentives ($, enrollment)
- Timing of payments
- Physician engagement strategy
- Supporting tools
State Medicaid P4P Projects

- 12 states in 2006
- 34 states in 2009
- Measures vary, though often HEDIS
- Some using an incentive to submit data, rather than an incentive to improve care
- Incentives vary
  - Enrollees versus dollars
  - Reward improvement or high performance
  - Withholds vs. bonuses
Example: Illinois’ Bonus Payments

- Fifth year of program, second year of paying bonuses
- $25 per member per incentivized service
- 5 services selected – diversity of ages, conditions
- In first year (2008 claims), paid 4,126 PCP’s a total of $2.8m
- In second year (2009 claims), paid 4,248 PCP’s $3.3m
- Largest increase in quality is for appropriate developmental screening for children. Involved physician training and support with appointment scheduling

Essential elements:
- partnership with providers in designing and implementing;
- giving the providers tools for knowing which patients were not up to date, according to state data

Biggest challenge: keeping patient contact information current
NYC PCP’s seeing Medicaid and uninsured patients eligible to receive EHR and technical assistance to improve health of all their patients.

Customized EHR includes 10 public health priority measures.

Rates have already risen before incentives started.

Evaluation of relative impact of incentives versus EHR and technical assistance is just beginning.

Believes it will be small impact – gap between promise and payment has been long, but will shorten next round.

Doctors participating because tools are perceived as valuable for managing patients.
P4P in Medicaid Behavioral Health

- A 2008 study reviewed the impact of all 24 known P4P demonstrations related to behavioral health
- Depression most common condition targeted
- Limitations: financial incentives were small; struggle to obtain accurate and valid data on process or outcomes of care; little public reporting.
- Conclusions: P4P is not a magic bullet. More intensive efforts focused on strengthening the quality infrastructure in behavioral health will be required
Research Question

- Will paying health plans, doctors, or hospitals a bonus (or assessing them a penalty) improve quality?

- Is money the reason for lack of quality now?
How has P4P affected quality so far?

- Ability and willingness to report data has improved, but still a work in progress
- Some processes improved, but no evidence on outcomes
- Insufficient information to know if it’s the incentive that made the difference, or just improved awareness
- States are struggling with fiscal realities
- P4P is not the full story – just one step in a process.
  - Is it a necessary step??
"Paying for performance may have the unintended effect of diverting medical resources away from the communities that need these resources the most. If you don't watch where the money goes, pay-for-performance programs have the potential to make disparities worse."

- Dr. Mark Friedberg, Rand Corporation, 2010
What about the Research on Medical Homes?

“To date, the ability of the PCMH to achieve the anticipated improved efficiency and cost reductions remains unproven. As pilots multiply it will be increasingly important to articulate and standardize an explicit set of performance benchmarks that will enable payers and providers to evaluate and compare the cost effectiveness of the varied PCMH models in progress. Without the establishment and assessment of such benchmarks for impacts on efficiency and costs, the PCMH experiment, like so many previous health policy initiatives, risks being undone by a failure to live up to unrealistic expectations.”
Non-payment for “never events”

• Growing list of states using this strategy, as well as CMS
• Science not very strong on how to prevent them
• No evidence yet that they lower events. In fact, what is happening first is that hospital reporting is improving, so the numbers are rising.
## Help Wanted – Expertise in...

<table>
<thead>
<tr>
<th>Initiative</th>
<th>% Total (n=53)</th>
<th>% Medicaid (n=42)</th>
<th>% CHIP (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National benchmarking database for QI</td>
<td>75</td>
<td>62</td>
<td>74</td>
</tr>
<tr>
<td>Information on what other states are doing</td>
<td>62</td>
<td>62</td>
<td>64</td>
</tr>
<tr>
<td>Disparities benchmarking database</td>
<td>51</td>
<td>50</td>
<td>55</td>
</tr>
<tr>
<td>Training in applying and presenting quality measures</td>
<td>47</td>
<td>45</td>
<td>55</td>
</tr>
<tr>
<td>Support of HIT capacity and training for providers</td>
<td>47</td>
<td>57</td>
<td>9</td>
</tr>
<tr>
<td>Information or training on how to use existing measures</td>
<td>43</td>
<td>40</td>
<td>55</td>
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HMA, 2008 Survey of Medicaid and CHIP directors about children’s quality.
So what is a state to do?

- Identify the key problems
- Identify all the resources that could be available
- Set priorities
- Identify solutions
- Think comprehensively, no magic bullet
- Be ready to take advantage of emerging research and new funding opportunities
South Carolina

Dashboard on Health Care Quality Compared to All States

Overall Health Care Quality

Performance Meter: All Measures

- = Most Recent Data Year
- - - - = Baseline Year

(Baseline year may vary across measures)
AHRQ State Quality Report

Care by Clinical Area

- Cancer Measures
- Diabetes Measures
- Heart Disease Measures
- Maternal and Child Health Measures
- Respiratory Diseases Measures
State Ranking on Potentially Avoidable Use of Hospitals and Costs of Care Dimension

State Rank
- Top Quartile
- Second Quartile
- Third Quartile
- Bottom Quartile

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009
<table>
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<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Adults</td>
<td>366,446 more adults (ages 18–64) would be covered by health insurance (public or private), and therefore would be more likely to receive health care when needed.</td>
</tr>
<tr>
<td>Insured Children</td>
<td>110,321 more children (ages 0–17) would be covered by health insurance (public or private), and therefore would be more likely to receive health care when needed.</td>
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<tr>
<td>Adult Preventive Care</td>
<td>131,282 more adults (age 50 and older) would receive recommended preventive care, such as colon cancer screenings, mammograms, pap smears, and flu shots at appropriate ages.</td>
</tr>
<tr>
<td>Diabetes Care</td>
<td>86,908 more adults (age 18 and older) with diabetes would receive three recommended services (eye exam, foot exam, and hemoglobin A1c test) to help prevent or delay disease complications.</td>
</tr>
<tr>
<td>Childhood Vaccinations</td>
<td>10,030 more children (ages 19–35 months) would be up-to-date on all recommended doses of five key vaccines.</td>
</tr>
<tr>
<td>Adults with a Usual Source of Care</td>
<td>233,151 more adults (age 18 and older) would have a usual source of care to help ensure that care is coordinated and accessible when needed.</td>
</tr>
<tr>
<td>Children with a Medical Home</td>
<td>111,097 more children (ages 0–17) would have a medical home to help ensure that care is coordinated and accessible when needed.</td>
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<tr>
<td>Preventable Hospital Admissions</td>
<td>12,388 fewer hospitalizations for ambulatory care sensitive conditions would occur among Medicare beneficiaries (age 65 and older) and $78,305,484 dollars would be saved from the reduction in hospitalizations.</td>
</tr>
<tr>
<td>Hospital Readmissions</td>
<td>2,567 fewer hospital readmissions would occur among Medicare beneficiaries (age 65 and older) and $32,533,530 dollars would be saved from the reduction in readmissions.</td>
</tr>
<tr>
<td>Hospitalization of Nursing Home Residents</td>
<td>1,537 fewer long-stay nursing home residents would be hospitalized and $10,711,145 dollars would be saved from the reduction in hospitalizations.</td>
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<tr>
<td>Mortality Amenable to Health Care</td>
<td>2,095 fewer premature deaths (before age 75) would occur from causes that are potentially treatable or preventable with timely and appropriate health care.</td>
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States Working on Quality in Groups, with Research Partners

- Commonwealth Fund/AcademyHealth State Quality Improvement Institute – 2 years of planning and implementation support to work on delivery systems, care coordination, or information systems, in CO, KS, MA, MN, NM, OH, OR, VT, and WA

Opportunities

- CHIPRA Quality Demonstration Grants
- Medicaid Quality Demonstration Grants
- HIT/HIE development, implementation, and use
- Delivery system/financing demonstrations
  - ACOs, Medical homes, and new funding from the CMS Demonstration Center
- AHRQ
  - New research, including comparative effectiveness
- National Quality Forum
- MACPAC
- Requirements for plans participating in exchanges
National Quality Strategy

*Principles*

- Person-centeredness and family engagement will guide all strategies, goals, and improvement efforts.
- The strategy and goals will address all ages, populations, service locations, and sources of coverage.
- Eliminating disparities in care – including but not limited to those based on race, ethnicity, gender, age, disability, socioeconomic status and geography – will be integral to all strategies and goals.
- The design and implementation of the strategy will consistently seek to align the efforts of public and private sectors.

Conclusions

• States have a lot of competing priorities, little money, and staff constraints

• It may be prudent to wait to implement a large scale quality improvement effort until more evidence is available to help design and fund it
  • Knowledge on quality measurement and improvement is about to expand exponentially

• In the short term, improved data collection and analysis may be worthwhile investment

• Partnerships formed now can help take advantage of future funding opportunities

• Heed the evidence, not the hype