Medicaid Managed Care Quality Improvement Efforts: Past, Present, Future

Quality Indicators for Quality Improvement in Medicaid Managed Care

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HEALTH MANAGEMENT ASSOCIATES
Medicaid Managed Care Quality

• Why Quality Improvement is Important in Medicaid now and in the future
  • Medicaid’s current role, scope and impact
  • Medicaid spending and enrollment trends
• Current state strategies to improve quality
  • Targeted approaches
  • Comprehensive reform
• Outlook for the future
Medicaid Is the Largest Health Program in America:
63 Million Enrolled in 2008

- 30 million children
  - 26% of all children; 51% of low-income children; 41% of U.S. births
- 17 million adults in families
  - 20% of low-income adults
- 10 million persons with disabilities
  - 20% of Americans with severe disabilities; 44% of persons with HIV/AIDS; 60% of persons in nursing homes
- 6 million elderly age 65 and older
  - Low-income Medicare beneficiaries also on Medicaid as “Dual eligibles”

Medicaid Faces a Bigger Challenge, But Costs Less than Private Health Insurance

- Medicaid enrollees are sicker, compared to low-income adults with private health insurance
  - Over twice as likely to be in fair or poor physical or mental health, and more likely to have chronic health conditions
  - “By every measure, adult Medicaid recipients had much higher medical needs, even when those with severe disabilities were excluded.”

- Medicaid per capita costs are lower (adjusted for health status)
  - ¼ less for adults; 1/3 less for children
  - “…after health and demographic characteristics were controlled for, Medicaid/SCHIP coverage was associated with significantly lower per person medical spending.”

- Medicaid per capita cost growth has been lower
  - 23% less than for persons with private health insurance

Medicaid Coverage Makes a Difference: Medicaid Access to Medical Care for Children Is Close to Private Insurance

*Note: Physician or any health professional, including hospital. All data age-adjusted.
Medicaid is $360 Billion of “Financial Glue” Holding Together Local Health Care Safety Nets

- **Mental health, public health and schools**
  - Over half of publicly financed mental health care

- **Community Health Centers**
  - Medicaid averages 40% of Health Center revenues

- **Hospitals that serve the uninsured**
  - $16 billion in Medicaid “DSH” payments

- **Medicare**
  - Medicaid-paid premiums, copays, deductibles, long-term care and other benefits for over 7 million low-income “duals” account for about 40% of Medicaid spending

- Altogether, Medicaid is 1/6 of all U.S. health spending and 2.5% of U.S. GDP
Total Medicaid Spending Growth, 1996-2009

**Economic Downturn, Enrollment & Cost Growth, 2000-2003**


**Strong Economy, Welfare Reform, Enrollment Declines, Managed Care 1995-1998**

- Economic Downturn & Program Enhancements 2008-2009

**Rx Spending for Duals Moved From Medicaid to Part D & Low Enrollment Growth 2006-2007**

- 4.1% 1.3%
- 3.4% 2.0%
- 4.7% 6.8%
- 6.4% 7.7%
- 8.5% 8.7%
- 10.4% 12.7%

**NOTE:** Estimates in State Fiscal Year FY 2009 Adopted does not include California.

**SOURCE:** KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates FY 2007, 2008 and 2009 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008.
Key Factors Behind U.S Medicaid Spending Trends in 2008 and 2009

• Provider rates
  – Legislatively-approved catch up increases
• Utilization of services
  – Growth in inpatient, mental health, other services
• Enrollment growth
  – Due to economic downturn and some expansions of coverage
• At the same time, state cost control actions have constrained growth

U.S. Medicaid Enrollment
Annual Growth  FY 1992 - FY 2009

Note: 1992-1997 based on CMS data for federal fiscal years. 1998-2009 data are June to June fiscal years.

NOTE: Enrollment percentage changes from June to June of each year. 2009 U.S. calculation excludes California due to late adoption of state budget, and unavailability of caseload projections for FY 2009.


U.S. Medicaid Spending Growth

Medicaid Enrollment Growth

NOTE: Enrollment percentage changes June to June of each year. Spending growth changes in state fiscal year.
Health Insurance Premiums and Worker Contributions
Average Cost for Family Coverage 1999-2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Employers</th>
<th>Workers</th>
<th>Total Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>$4,247</td>
<td>$1,543</td>
<td>$5,791</td>
</tr>
<tr>
<td>2008</td>
<td>$9,325</td>
<td>$3,354</td>
<td>$12,680</td>
</tr>
</tbody>
</table>

119% Increase

Note: The average worker contribution and the average employer contribution do not add to the average total premium due to rounding.

Latest Forecasts Say Health Costs Will Grow Substantially in 2009

- Employer health costs predicted to increase by 9.6%
  - PriceWaterhouse Coopers, 2008 Annual Survey

- Premium growth is projected to exceed 10% in 2009 across all plans, including HMOs, PPOs, POS plans, high deductible plans and FFS.
  - 2009 Segal Health Plan Cost Trend Survey

- Worker premiums are projected to climb 9% in 2009, including 10.1% in out-of-pocket health costs and 8% in premiums. Employer share of health insurance premiums to rise 6.4%.
For States, Medicaid Is Expected to Grow as Share of State Budgets: 1985 – 2015 Projected

Total Medicaid Spending as % of State Budgets

Source: National Association of State Budget Officers, State Expenditure Reports, December 2007 and earlier years; Percentages for 2010 and 2015 projected by HMA, 2008.
Obtaining Value for State Dollars is More Important Now as State Budgets Worsen

State finance officials “are concerned at the prospect of even slower growth, or even outright declines, over the next 18 months.” “...it is so bleak.”

– Scott Pattison, Executive Director, National Association of State Budget Officers

Lawmakers are facing “a bleak fiscal landscape.”

– Jim Eads, Executive Director, Federation of Tax Administrators

Since the April-June quarter, “things have gotten worse, and are going to get a lot worse still.”

– Don Boyd, Rockefeller Institute of Government, October 2008

“State budget problems generally lag economic slowdowns, so this is going to be a three-or-four year struggle for states.”

– Ray Scheppach, Executive Director, National Governors Association, in Newsweek.

From 2003 – 2007, Fiscal Pressures Forced Every State to Restrict Medicaid Spending

For FY 2008 and FY 2009, Most States Made Positive Changes in Medicaid

- Rate, benefit and eligibility restorations and increases
- Quality initiatives, care management and value-based purchasing
- Continued “balancing” long-term care

Most Medicaid Programs Now Use Care Management for Chronic and High-Cost Care

- 35 states had care management or disease management programs in FY 2008
- Programs are in place for:
  - Asthma, diabetes, COPD, CHF, hypertension, obesity, high-risk prenatal care, ESRD, mental health, children with complex needs
  - Half of Medicaid spending is for 4% of enrollees
- Initiatives increasingly use predictive modeling, community-based nurses and tele-health

State’s Adopted Primarily Positive Policy Actions in FY 2008 and FY 2009

<table>
<thead>
<tr>
<th>States with Expansions / Enhancements</th>
<th>Implemented FY 2008</th>
<th>Adopted FY 2009</th>
</tr>
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<tbody>
<tr>
<td>Provider Payments</td>
<td>50</td>
<td>47</td>
</tr>
<tr>
<td>Eligibility</td>
<td>33</td>
<td>34</td>
</tr>
<tr>
<td>Benefits</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>42</td>
<td>41</td>
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</table>

States with Program Restrictions

<table>
<thead>
<tr>
<th>Provider Payments</th>
<th>Eligibility</th>
<th>Benefits</th>
<th>Long Term Care</th>
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<tbody>
<tr>
<td>21</td>
<td>7</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>22</td>
<td>5</td>
<td>7</td>
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</tr>
</tbody>
</table>

NOTE: Not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals. Eligibility includes eligibility and application expansions/restrictions.

**Medicaid Rate Cuts for Major Provider Groups: Inpatient Hospitals, Physicians, Nursing Facilities or Managed Care Organizations**

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<thead>
<tr>
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<tbody>
<tr>
<td><strong>Number of States</strong></td>
<td>14</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>5</td>
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</table>

**Adopted FY 2009:**

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<tbody>
<tr>
<td><strong>Number of States</strong></td>
<td>5</td>
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Medicaid Rate Changes for MCOs
FY 2006 – FY 2009 Adopted

States with Rate Increases

- Actual FY 2006: 29
- Actual FY 2007: 29
- Actual FY 2008: 31
- Adopted FY 2009: 29

2006: 2
2007: 0
2008: 1
2009*: 3

States with Rate Restrictions

*2009 as adopted; adopted actions are not always implemented.

Medicaid Has Increasingly Relied on Organized Delivery Systems

Note: HMO share continued to increase, but drop in other forms of managed care caused first ever drop in % in 2007

Note: “Managed Care” includes HMOs, PIHPs, HIOs and state-administered Primary Care Case Management Plans (PCCMs). Enrollment dropped in 2007 in PCCM and Partial Capitation Models

Source: CMS, Medicaid Managed Care Reports, 1994-2008.
U.S. Health Insurance Market Continues to Change:
Employees, by Type of Health Plan: 1988-2007

Percent of all covered employees in each type of plan

In 2008 Medicaid Further Strengthened the Role of Managed Care

- Shifts to mandatory enrollment
- Extensions to additional geographic areas, usually rural
- Expansions to additional populations, usually the disabled and dual eligibles
- Focus on quality improvement, payment incentives, chronic care management

State Officials Say Access Problems in Medicaid Fee-for-Service Are Addressed in Managed Care

Number of States in 2008, by How They Described Access
- Significant/Some Problems
- Very Few Problems
- Good/Excellent Access

<table>
<thead>
<tr>
<th>Service</th>
<th>Significant/Some Problems</th>
<th>Very Few Problems</th>
<th>Good/Excellent Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>17</td>
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<tr>
<td>Specialty Care</td>
<td>36</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Dental Care</td>
<td>39</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

States Are Responding to Evidence That U.S. Health Care Quality Needs to Improve

• “American adults received just 55% of recommended care for the leading causes of death and disability, 54% of recommended care for acute health problems, and 56% of care that doctors agree is necessary for people with chronic conditions.”

  – Examples: % getting recommended treatment
    • Congestive heart failure…64%
    • Depression …………………58%
    • Asthma ……………………54%
    • Diabetes ……………………45%

States Are Especially Well Positioned to Improve Health Care Quality for Children

- “Insured children received only 47% of recommended care overall.”
- States can address quality improvement for adults and children through
  - Medicaid performance standards for HMOs, hospitals, EPSDT providers
  - Data collection, measurement, reporting
  - Improvements in interoperable, interconnected health information technology
  - Systems for coordination of care
  - Reimbursement systems that reward quality

Building Blocks for Quality: Examples of State Initiatives in Medicaid

1. Evidence-based Practices
   NY: standardized asthma guidelines

2. Measures/Outcomes
   CA: “Dashboard” reports

3. Information Technology
   IN: electronic patient data registry for chronic disease management

4. Continuous Quality Improvement
   WI: collaboration with MCOs to plan, track CQI projects

5. Pay for Performance
   MI: Bonus payments and auto enrollment based on quality performance

6. Care Management
   NC: RN managers assist chronically ill

7. Integrated Care
   MA: comprehensive specialized plan for care coordination of dual eligibles

8. Consumer Direction
   NJ: cash and counseling demo, patients manage own care

# Selected State Medicaid Quality Initiatives

**FY 2008 and Adopted for FY 2009**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Total States in 2008</th>
<th>Total States in 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDIS® or Similar</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>CAHPS® or Similar</td>
<td>43</td>
<td>44</td>
</tr>
<tr>
<td>Published Health Plan Performance</td>
<td>34</td>
<td>40</td>
</tr>
<tr>
<td>MCO Pay-for-Performance</td>
<td>31</td>
<td>37</td>
</tr>
<tr>
<td>MCO Accreditation*</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Electronic Medical / Health Records</td>
<td>12</td>
<td>21</td>
</tr>
</tbody>
</table>

*Note: MCO Accreditation includes states that require or reward accreditation.

Medicaid Pay-for-Performance Goals

- Recognize and reward high quality of care
- Reduce variation in patterns of care
- Improve state’s performance on particular measures of importance
- Support broader quality strategies, such as value based purchasing
- Facilitate achievement of specific goals, such as access to care, immunization

States Increasingly Use Pay-for-Performance Incentives in Medicaid: 1991 to 2009

Number of States


CT, IN, NH, NJ, VT
AL, DE, DC, HI, LA, MO, WY
CO, KS
CA, GA, NV, PA, TN
AR, FL, IL, SC, TX
AZ, WA, OH
MI
MD
CA, GA, NV, PA, TN
AZ, WA, OH
ME, MN, NM, NY
OK, RI, IA
UT
WI, MA

HEDIS® Measures States Use in Medicaid Pay-for-Performance Initiatives, 2006

*Examples: For children, immunizations, well-child visits; for chronic conditions, care for people with asthma, diabetes; for women, prenatal care, cancer screenings; for behavioral health, follow up after hospitalization for mental illness, anti-depression med. management.

Additional Measures States Use for Medicaid Pay-for-Performance Incentives

– Clinical
  • EPSDT screening, lead testing, hospital admits for ambulatory care sensitive conditions

– Administrative
  • Data reporting, use of generic drugs

– Accreditation
  • e.g., NCQA

– Access to care,
  • network capacity, participation with safety net providers

– Targeted health initiatives
  • teen pregnancy, disease management programs

What Is Coming in Medicaid Pay-for-Performance?

- Financial incentives that are larger
- Rate increases, contract renewal tied to performance
- Greater focus on health outcomes, reducing disparities, coordination with public health
- Direct incentives for hospitals, physicians, LTC and other providers
- Incentives for developing and using electronic medical records, e-prescribing
- Incentives for patients / enrollees
Latest NCQA Report: Medicaid Managed Care Is Under-Performing on Quality Improvement

- **Commercial health plans:**
  - improvements on 44 of 54 measures of health care quality
  - significant gains in 16 areas such as blood pressure control and postpartum care for women and their newborns.

- **Medicaid health plans:**
  - “…little improvement in the quality of care provided to Medicaid beneficiaries.”
  - “Only 26 of 52 measures showed any increase and most of those were very small.”
  - One exception: improvement in delivery of childhood immunizations.

Some States Now Strive to Improve Quality through Comprehensive Health Reform

Strategies seek to improve quality, efficiency and access in a “whole-system approach” that includes:

- Coverage expansions
- Affordable health insurance coverage
- Lower administrative costs
- Incentives for higher quality and more efficient care
- Widespread use of health information technology, information exchange,
- Specific goals and benchmarks, with a system to monitor and evaluate performance

New England States Have Led The Way on Comprehensive Health Reform: All Incorporate Strong Quality Components

Maine “Dirigo Health Plan” – 2003
- Goal to achieve near-universal coverage through
  - Market reform, affordable insurance
- Maine Quality Forum for information on best health practices

Massachusetts Health Plan – 2006
- Goal to achieve near-universal coverage through
  - Subsidized health insurance for low income individuals, individual and employer mandates and Medicaid expansion to 300% of FPL
  - “Connector” to affordable health insurance options
- Quality improvement and plan performance indicators

Vermont – Catamount Health Plan - 2006
- Goal to achieve near-universal insurance coverage through
  - Employer mandate except for small employers
  - Premium assistance for employer plans up to 300% of FPL
- “Blueprint for Health,” a prevention and quality improvement initiative with a focus on chronic conditions
2008 Scorecard on U.S. Health System Performance Shows Need to Improve

- “The U.S. health system continues to fall short of what is attainable, especially given the resources invested.”
- “The U.S. spends twice per capita what other major industrialized countries spend on health care, and costs continue to rise faster than income. We should expect better return on this investment.”
- “The U.S. fell to last place among 19 industrialized nations on ‘mortality amenable to health care’ – deaths that might have been prevented with timely and effective care.”

Federal Officials Increasingly Convey a Sense of Urgency about the Federal Budget

“...under any plausible scenario, the federal budget is on an unsustainable path.... rising costs for health care ...will cause federal spending to grow rapidly.

“Future growth in spending per beneficiary for Medicare and Medicaid will be the most important determinant of long-term trends in federal spending. Changing those programs in ways that reduce the growth in costs ... is ultimately the nation’s central long-term challenge in setting federal fiscal policy.”

# Bending the Curve: Policy Options and 10-Year Savings to National Health Expenditures

## (in billions)

## Selected options to illustrate potential / relative impact:

<table>
<thead>
<tr>
<th>Producing and Using Better Information</th>
<th>Reduction in NHE ($billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Promote Health Information Technology</td>
<td>$88</td>
</tr>
<tr>
<td>2. Promote Medical Effectiveness and Decision-Making</td>
<td>$368</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aligning Incentives with Quality and Efficiency</th>
<th>Reduction in NHE ($billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Hospital Pay-for-Performance</td>
<td>$34</td>
</tr>
<tr>
<td>4. Episode-of-Care Payment</td>
<td>$229</td>
</tr>
<tr>
<td>5. Strengthening Primary Care and Care Coordination</td>
<td>$194</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Promoting Health and Disease Prevention</th>
<th>Reduction in NHE ($billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Public Health: Reducing Tobacco Use</td>
<td>$191</td>
</tr>
<tr>
<td>7. Public Health: Reducing Obesity</td>
<td>$283</td>
</tr>
<tr>
<td>8. Positive Incentives for Health</td>
<td>$19</td>
</tr>
</tbody>
</table>

Conclusion

• States increasingly strive to improve quality and value through Medicaid and SCHIP

• Medicaid managed care is primary vehicle for improving quality because health plans can
  – Assure access through an organized delivery system
  – Assure a “medical home”
  – Provide a mechanism to monitor and improve performance
  – Be held accountable for performance
  – Help states achieve goals for improved health and better health care outcomes

• Every state is able to structure its Medicaid managed care system to fit its issues, objectives, priorities, strengths and limits

• State and federal budget pressures will be an even more powerful force in the future to obtain better value in Medicaid