IMPROVING THE QUALITY OF CARE IN SOUTH CAROLINA’S MEDICAID PROGRAM

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Today

- Who is NCQA?
- Why measure quality?
- What is the state of health care in the U.S.?
- What is the state of health care in South Carolina?
- How can we improve the quality of care in South Carolina and the nation?
NCQA: A BRIEF INTRODUCTION

• Private, independent non-profit health care quality oversight organization founded in 1990

• Committed to measurement, transparency and accountability

• Unites diverse groups around common goal: improving health care quality
WHO DOES NCQA MEASURE?

- **Health Plans**
  - 2/3 of HMOs in U.S. are NCQA Accredited
    - Covering 75% of HMO lives
  - Only Accreditation program that scores programs on quality of care

- **Physicians/physician groups**
  - NCQA Physician Recognition programs (diabetes, heart/stroke, back pain, use of practice systems, medical home)
    - Nearly 12,000 physicians are recognized!
WHAT DOES NCQA MEASURE?

- **HEDIS®**
  - Cancer screening, diabetes, cardiac care
  - Measures of effective, appropriate care
  - HEDIS measure criteria: valid, relevant, feasible
  - Specifications vetted by committee of health care stakeholders, thought leaders
  - Results are rigorously audited

- **CAHPS®**
  - Access, timeliness, satisfaction
WHO REPORTS HEDIS?

- 845 health plan submissions in 2008
  - An all-time high
- 605 HMOs/POS plans
  - Includes 177 Medicaid plans
- 240 PPOs
- Covering 106 million American lives
  - 29% increase from 2007
  - 1 in 3 Americans are covered by HEDIS reporting
  - 2/3 remain outside an accountable health care system
WHAT MAKES A DESIRABLE MEASURE?

• **Scientific Soundness**
  - Strong clinical evidence
  - Reproducible, valid, accurate results
  - Comparable available data sources

• **Feasibility**
  - Possible to produce precise specifications
  - Reasonable cost burden of measurement
  - Logistically possible to collect

• **Relevance**
  - Physicians and/or plans can cause a difference
  - Holds potential for improvement
  - Important to health, finance
  - Measure represents a cost-effective change
SELECT HEDIS MEASURES OF EFFECTIVENESS OF CARE

- Annual Monitoring for Patients on Persistent Medications
- Antidepressant Medication Management
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with an Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status
- Chlamydia Screening
- Cholesterol Management for Patients with Cardiovascular Conditions
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Flu Shots for Adults
- Follow-up After Hospitalization for Mental Illness
- Follow-up Care for Children Prescribed ADHD Medication
- Imaging Studies for Low Back Pain
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Medical Assistance with Smoking Cessation
- Medication Management in the Elderly
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Prenatal and Postpartum Care
- Use of Appropriate Medications for People with Asthma
- Use of Spirometry in the Assessment and Diagnosis of COPD
BEFORE WE MEASURE...

- Quality is assumed to be high and uniform
- Government and private sector make purchasing decisions based on price alone
- We have no way to plan for improvements in patient and population health
- Measurement is thought of as a luxury we can’t afford
AFTER WE MEASURE...

- We know that quality is highly variable
- We can identify where things are going well
- We can pinpoint where things are going poorly
- We can improve the health of patients and communities
- We can demand value for the money we are spending for coverage
THE STATE OF HEALTH CARE QUALITY: 2008
TOP LINE RESULTS

• The Good News
  – Overall, the care for those patients improved in 2008 - the ninth consecutive year of improvement!
  – Strong gains in commercial market despite slowing economy

• Areas for Concern
  – Very little improvement in public sector programs - Medicare and Medicaid
  – Significant variations in quality exist throughout the system
  – Significant gaps in measurement and reporting block further progress
Controlling Hypertension Saves Lives


% controlled (<140/90)

Measure specification change

76% improvement

4% improvement

90th Percentile
Mean
10th Percentile

NCQA
Measuring quality, improving health care.

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13
Use of Beta-Blockers Prevents Heart Attacks

23% improvement

90th Percentile Mean 10th Percentile

2004 2005 2006 2007

% on beta blockers 6 months

0 10 20 30 40 50 60 70 80 90 100
Immunizations Prevent Disease, Save Money
Childhood Immunizations, Combination 3: Medicaid Plans, 2005-2007

Combination 3: Diphtheria/tetanus, polio, MMR, Hib, hepatitis B, chicken pox, pneumococcal conjugate

90th Percentile
Mean
10th Percentile

56% improvement
**THESE IMPROVEMENTS SAVE LIVES!**

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>LIVES SAVED*</th>
<th>SINCE</th>
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<tbody>
<tr>
<td>Beta Blocker Treatment</td>
<td>24,000 – 30,000</td>
<td>1996</td>
</tr>
<tr>
<td>Cholesterol Management</td>
<td>23,000 – 39,000</td>
<td>2000</td>
</tr>
<tr>
<td>Blood Pressure Control</td>
<td>76,000 – 132,000</td>
<td>2000</td>
</tr>
<tr>
<td>Diabetes - HbA1c Control</td>
<td>2,000 – 3,500</td>
<td>1999</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>125,000 – 205,000</strong></td>
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VARIATIONS IN QUALITY PLAGUE THE NATION
QUALITY IS ALL OVER THE MAP

• Quality varies by:
  – who pays for your care
  – what region of the country you live in
  – the type of health plan you join
IMPROVEMENTS VARIED BY SOURCE OF COVERAGE

- Commercial plans improved on 44 of 54 measures
  - 16 statistically significant gains
- Medicare plans improved on 24 of 45 measures
  - Only 6 statistically significant gains
- Medicaid plans improved on 26 of 52 measures
  - Almost all gains were miniscule
  - Marked declines:
    - Persistence of beta-blocker treatment
    - Avoidance of antibiotics in adults with acute bronchitis
Some Areas of the Country Deliver Better Care

Regional Performance Relative to National Average: Commercial Plans, 2008

- Pacific: -0.2
- Mountain: -1.7
- New England: +4.7
- Middle Atlantic: +1.3
- East North Central: +0.7
- West North Central: +0.1
- South Central: -4.0
- South Atlantic: -1.0
- New England: +4.7
- Middle Atlantic: +1.3
- East North Central: +0.7
- West North Central: +0.1
- South Central: -4.0
- South Atlantic: -1.0
Medicare Performance Also Varies by Region

Regional Performance Relative to National Average: Medicare Plans, 2008
Regional Performance Relative to National Average: Medicaid Plans, 2008

- East North Central: +1.2
- Middle Atlantic: +1.1
- East: +6.0
- New England: +6.0
- Pacific: -0.1
- Mountain: -0.5
- South Central: -3.9
- South Atlantic: -3.0

Colors:
- +2.5% or more
- +1.0% to 2.5%
- Within 1.0% of mean
- -1.0% to 2.5%
- -2.5% or more
REPORTING ALSO VARIES BY REGION
We Don’t Know Enough About Care in Broad Swaths of the Country

State Variation in HEDIS Reporting
Percentage of population in accountable systems, 2008

50% or more
40 - 49%
30 - 39%
20 - 29%
10 - 19%
Less than 10%
HOW MANY PEOPLE IN SOUTH CAROLINA ARE IN ACCOUNTABLE PLANS?

- Total population: 4.4 million
- In accountable plans: 716,000 (16%)
- 693,000 in commercial plans
- 21,500 in Medicare plans
- 1,500 in Medicaid plans (most are in plans based in neighboring states)
HEALTH CARE REFORM IS NEEDED
IN 19 DAYS, WE ELECT A NEW PRESIDENT
BOTH CANDIDATES HAVE PROMISED TO REFORM HEALTH CARE
82% of Americans Say the Health Care System Needs Fundamental Change

- Rebuild completely: 32%
- Only minor changes: 16%
- Fundamental changes: 50%

Source: Commonwealth Fund Survey of Public Views of the U.S. Health System, 2008
REFORMS THE NATION MUST TAKE

ACCESS

COSTS

QUALITY

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RECOMMENDATIONS FOR REFORM
1. MEASURE, MEASURE, MEASURE!

• Make measurement and reporting a condition of providing coverage to employers, Medicare, Medicaid and S-CHIP

• Demand more consistent measurement and reporting by Medicaid and S-CHIP

• Identify ways to compare the performance of traditional Medicare to Medicare Advantage
2. REDUCE, THEN ELIMINATE VARIATIONS IN CARE & COSTS

- Establish benchmarks to identify low-quality states and regions
  - Set quality targets for each region and tie payments to achieving those goals
- Create a public-private entity to support comparative effectiveness research and dissemination
3. REFORM PAYMENT SYSTEMS TO REWARD QUALITY

• Replace outdated fee-for-service payment models with a combination of payments based on episodes of care, capitation
• Expand use of pay-for-performance to reward high performing plans and physicians; create incentives for improvement
• Support creation of Patient-Centered Medical Homes to coordinate care and increase use of primary care
DISCUSSION

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