Quality and Information Technology in Medicaid

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Preview of Presentation

- Quality initiatives in Medicaid
- Selected challenges in non-IT quality "transformation" efforts
- Health information technology
- Preview of some key questions for the July 2006 session

Quality Initiatives in Medicaid

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Very little attention is paid to health care quality "management" in fee-for-service . . .

- Medicaid fee-for-service (FFS) was built on other metrics:
  - Eligibility determination processing time
  - Number of enrolled providers
  - Speed of processing claims
  - Units of various services provided to a population

. . . and Medicaid computer systems grew accordingly.

- Assigning provider ID numbers
- Checking claims against various edits. E.g., :
  - Person eligible at time of service?
  - Provider eligible at time of service?
  - Does third-party coverage exist for service?
- Reporting aggregate data to HCFA/CMS on services and expenditures by eligibility group, and service
- Little to no tracking of quality:
  - At an individual level
  - Against clinical guidelines
  - Based on diagnoses
  - On a case-mix adjusted basis to evaluate providers

The introduction of managed care in Medicaid brought commercial tools to measure quality and population health

- HEDIS®
  - "Health Plan Employer Data and Information Set"
- CAHPS®
  - "Consumer Assessment of Healthcare Providers and Systems"
- NCQA Accreditation
  - "National Committee for Quality Assurance"

Many states rely on HEDIS® measures . . .

- Performance measures
- Rigorous development and auditing process
- Used by commercial, Medicare, and Medicaid programs
- Nationally recognized and generally accepted

. . . and these are commonly-used HEDIS® measures.

- Childhood immunization rates
- Cervical cancer screening rates
- Breast cancer screening rates
- Follow-up care post-hospitalization

Other standardized national measures include CAHPS®...

- This is a survey of member satisfaction
- Evaluates members' experience with their managed care organization (MCO)
- Used by commercial, Medicare, and Medicaid programs

...and NCQA Accreditation

- Evaluates MCO operations on a number of determinants of quality:
  - Structural measures
  - Process measures
  - Outcomes measures
- Used by commercial, Medicare, and Medicaid programs

States encourage performance improvement through financial incentives . . .

- Financial bonuses are paid to MCOs that perform above target levels on a set of standard measures

Also called “Pay for Performance”

. . . and non-financial incentives.

- Public reporting (“Report Cards”)
- Preference for auto-assigned enrollees (who are usually lower cost enrollees)

Medicaid agencies tend to focus on MCO performance, rather than individual providers

- Easier to work with 6-10 MCOs than hundreds or thousands of providers
- “Delegate” responsibility for managing provider quality to the MCOs
- Require MCOs, or sometimes specialty companies, to pursue disease management for covered populations

MCOs use many of the same tools and incentives with their network providers

- If providers score well, the MCO will as well
- MCOs may offer additional incentives for good performance
  - Gift cards or movie tickets to motivate members to attend smoking cessation or weight management programs
  - Opportunity to providers to bill the MCO for member education

MCO performances against care standards may be measured . . .

Table 2. HEDIS Effectiveness of Care Measures
Select Medicaid Averages, 2000 - 2004

Measure	2000	2001	2002	2003	2004
Beta-Blocker Treatment After a Heart Attack	82.9	87.9	90.1	83.5	**84.8**
Breast Cancer Screening	54.9	55.1	55.8	55.9	**54.1**
Childhood Immunization Status - Combo 1	56.4	58.9	57.7	62.0	**65.4**
Cholesterol Management - Control (LDL < 130)	28.2	34.5	36.7	39.0	**40.7**
Comprehensive Diabetes Care - Poor HbA1c Control*	54.9	48.3	48.2	48.6	**48.6**
Controlling High Blood Pressure	45.4	53.0	53.4	58.6	**61.4**

Source: The State of Health Care Quality 2005, NCQA

. . . and improved performance is known to save lives . . .

Table 4. Lives Saved Due to Improvements Among Publicly Reporting Plans: Commercial and Medicare

MEASURE	LIVES SAVED
Beta-Blocker Treatment After a Heart Attack	3,757 - 4,739
Cholesterol Management After a Heart Attack	3,352 - 5,658
Controlling High Blood Pressure	31,817 - 55,233
Poor HbA1c Control*	1,269 - 2,172
TOTAL	**40,195 - 67,802**

** **Note:** Lower rates of poor control indicate improvement for this measure. Calculation reflects improvement of plans from a measure's first year of public reporting through 2004.*

Source: The State of Health Care Quality, 2005, NCQA

. . . and reduce unnecessary utilization, therefore saving health care costs.

Table 6. Avoidable Death and Medical Costs Due to Unexplained Variations in Care: Selected Measures and Conditions, U.S. Population

MEASURE	AVOIDABLE DEATHS	AVOIDABLE MEDICAL COSTS
Beta-Blocker Treatment	800 - 1,200	$9.7 million - $23.9 million
Breast Cancer Screening	150 - 600	$41.6 million - $78.3 million
Controlling High Blood Pressure	12,000 - 32,000	$382 million - $1 billion
Cervical Cancer Screening	650 - 850	N/A
Cholesterol Management (Control)	3,400 - 7,200	$70 million - $88 million
Diabetes Care - HbA1c Control	5,300 - 11,700	$693 million - $1.2 billion
Smoking Cessation	8,300 - 13,200	$859 million - $1 billion
Prenatal Care	1,000 - 1,750	$519 million - $524 million
Colorectal Cancer Screening	4,100 - 6,200	$188 million - $194 million
Flu Shots (65+)	3,500 - 7,500	N/A
Osteoporosis Management	N/A	$8.3 million - $8.7 million
Total	**39,200 - 83,600**	**$2.8 billion - $4.2 billion**

Source: The State of Health Care Quality, 2005, NCQA

Public reporting makes a difference

APPENDIX 8
HEDIS Effectiveness of Care Measures: Publicly vs. Non-Publicly Reporting Plans (Medicaid, 2004)

MEASURE	PUBLIC REPORTERS	NON-PUBLIC REPORTERS	DIFFERENCE
Adolescent Immunization Status (Combo 1)	61.5	47.2	14.3
Adolescent Immunization Status (Combo 2)	41.3	30.5	10.8
Adolescent Immunization Status (Hepatitis B)	65.4	51	14.4
Adolescent Immunization Status (MMR)	74.8	63.7	11.1
Adolescent Immunization Status (VZV)	50.1	39	11.1
Antidepressant Medication Management (Acute Phase)	47.3	42.9	4.4
Antidepressant Medication Management (Continuation Phase)	30.8	29.1	1.7
Antidepressant Medication Management (Contacts)	19.5	18.8	0.7
Appropriate Testing for Children with Pharyngitis	55.7	50.6	5.1
Appropriate Treatment for Children with URI	79.2	81.8	-2.7
Asthma Medication Use (age 10 to 17)	64.8	58.9	6.0
Asthma Medication Use (age 18 to 56)	67.2	60.6	6.6
Asthma Medication Use (age 5 to 9)	66.4	58.7	7.7
Beta-Blocker Treatment After a Heart Attack	87.4	73.9	13.5
Breast Cancer Screening	54.8	52.7	2.1
Cervical Cancer Screening	66.0	62.7	3.3
Childhood Immunization Status (Combo 1)	66.8	63.0	3.8

Source: The State of Health Care Quality 2005, NCQA

In pursuing quality initiatives, providers and MCOs should be included in designing incentive programs

- These stakeholders must understand what is being measured and how it is being measured

- They must be motivated by the incentive(s)

Performance measurement targets can be challenging, but must be within reach

- If the bar is too high, the cost of achieving the target may exceed the potential benefit to the provider or MCO, so they may choose to skip it
- If the bar is too low, quality improvement is minimal

Selected Challenges in Non-IT Quality "Transformation"

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The first challenge is engaging beneficiaries . . .

- Medicaid agencies and MCOs have challenges engaging beneficiaries that are *not* unique to Medicaid:
  - Lifestyle issues
  - Seeking preventive care
- And some that are unique to Medicaid:
  - More transient population
  - More challenges in cultural competence
  - More challenges with mental illness, substance abuse and other factors that affect compliance

. . . the next is engaging providers . . .

- Establishing rewards *within* current budgets involves difficulties with financial withholds from already-low fees
- Establishing rewards *outside* current budgets might be a budget-buster
- Changing provider behavior is as difficult in Medicaid as it is anywhere else.

. . . the next is preparing for potential skirmishes with MCOs . . .

- Compare MCOs on a case-mix adjusted basis?
- Establishing rewards *within* current budgets involves difficulties with financial withholds from already-low capitation payments
  - Can a state withhold enough for the reward to be meaningful, without “underpaying” for services?
- Establishing rewards *outside* current budgets might be a budget-buster

. . . and a major one is keeping our eye on the ball.

- True transformation involves tackling medical errors:
  - Which involves practice patterns, issues of reporting/liability, and IT
- And tackling better interoperability of electronic information to reduce administrative costs.
- And evaluating when and whether the “latest and greatest” expensive intervention or medication should be approved for routine use.

Health Information Technology

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The role of information technology

- Data collection and analysis
- Clinical reminder systems in electronic health records (EHRs)
- Electronic prescribing and dispensing of drugs
- Identifying contraindications
- Reduction of medical errors

National effort to advance health information technology (HIT)

- President Bush signed an Executive Order establishing a National Coordinator for HIT on April 27, 2004
- This Coordinator's role is to lead a process toward widespread adoption of HIT:
  - Including developing strategies on how the federal government can use its purchasing power
  - And strategies on how to engage and move the private sector
- HIT developments at the VA and DoD have shown great success

Transforming HIT is expected to be both expensive . . .

- Current estimates are the health care organizations spend between $17 billion and $42 billion per year on health information technology.

In Medicaid, the federal government pays:
- 90% of new IT developmental costs
- 75% of ongoing IT operational costs

. . . and cost-effective.

- Studies in ambulatory care settings estimate that EHRs would save $112 billion/year
- Better HIT should reduce the number of avoidable medical errors, which lead to 44,000-98,000 deaths per year (Institute of Medicine estimate)
- Better HIT should reduce the number of office visits caused by adverse drug effects, which now number over 5 million per year
- Better HIT should *increase* from 55% the percent of people who receive recommended care.
- Better HIT should *decrease* from 30% the percent of health care expenditures spent on non-efficacious care.

Preview of Some Key Questions for the July 2006 Session

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Key recommendations in "quality and information technology" from the Commission will include:

- How can quality initiatives be encouraged?
- Should new quality "requirements" be required in Medicaid programs?
- What policies should be deployed to engage beneficiaries and providers?
- What is Medicaid's role in systems-level quality issues (medical errors, practice standards, etc.)?
- What is the federal government's role in financing new HIT systems in Medicaid?

Questions

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