Quality and Information Technology in Medicaid

October 26-27th, 2005

Charles Milligan, JD, MPH

Medicaid Commission Meeting
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
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

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

Source: The State of Health Care Quality 2005, NCQA
and improved performance is known to save lives.

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

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

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

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)

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

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”
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
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
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
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

Charles Milligan
Executive Director, UMBC/CHPDM
410.455.6274
cmilligan@chpdm.umbc.edu
www.chpdm.org