

Salient Research in Medicaid (Operations)



Stephen A. Somers, PhD
President, CHCS

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CHCS in a Nutshell

- **Mission:** Improve Quality for Medicaid beneficiaries
- **Modus Operandi:** Training/TA/grants
- **Key Partners:** States, health plans, consumer organizations
- **Key Funders:** RWJF, Casey, California HealthCare, Commonwealth, Packard
- **Total Support:** \$70 M since 1995

Today's Presentation in a Nutshell

- The Medicaid context.
- A study of managed care for PWD/SSI.
- CHCS QI efforts and the Business Case for Quality.

Embattlement Days for Medicaid

- \$70-80 B state deficits
- + Almost all states are cutting Medicaid pops/services
- + Millions of beneficiaries are losing coverage
- + Bush Reform scheme
- = “all hell breaks loose”
- vs.
- = opportunity to sustain the gains for 45 million

“Sustain the Gains” in Medicaid Managed Care

- ❖ Budgetary predictability
- ❖ Access to medical home
- ❖ Incentives for prevention/coordination
- ❖ Levers for QA/QI

Embattlement Fever Symptom: “Let’s Return to the Good Ol’ Days of FFS”?!

- ❖ The conceptual appeal to state legislators and budget officials = stop frontloading capitation \$\$ upon Medicaid enrollment.

Embattlement Fever Symptom: “Let’s Return to the Good Ol’ Days of FFS” *(cont)*

- ❖ Unanticipated (?) consequences:
 - Managed care costs 3-5 % < FFS.
 - Decimated State infrastructure for managing FFS, securing discounts, and controlling inappropriate utilization.
 - Transition/loss of PCP = more ER visits.

Embattlement Fever Symptom: “Let’s Return to the Good Ol’ Days of FFS” *(cont)*

- Providers (PCP and specialty) paid more by MCO may exit FFS creating new access problems.
- Politics of taking something away (e.g. medical home) from vulnerable pops.
- Broken promises: MCOs will wipe Medicaid off their radar screens forever.

Embattlement Fever Symptom: “Let’s Return to the Good Ol’ Days of FFS” *(cont)*

- ❖ Middle ground—Disease Management and Administrative Services Only organizations with enough revenue and risk/responsibility to maintain incentives for robust clinical management?

Study: Enrolling PWD/SSI in MMC

- ❖ Should CA do it?
- ❖ Studied 4 states (MA, NJ, OR, PA) and several SNP's.
- ❖ Other states thinking about it because, per Willie Sutton, “that’s where the money is.”

Findings: Enrolling PWD/SSI in MMC

- ❖ Know your allies (e.g. MCOs) and adversaries (e.g. advocates, providers).
- ❖ Go comprehensive (full cap, no carve-outs):
 - scale, leverage, rate predictability, integration.
- ❖ But, at the least, get care managed: (PCCM, DM, ASO), because clinical management infrastructure works (= the secret of “pure play MMCOs”).

Findings: Enrolling PWD/SSI in MMC *(cont)*

- ❖ Forget about saving \$ soon!
- ❖ “Tolerance for deferred gratification.”
- ❖ Flexible networks: “there is no board certification for disability care.”
- ❖ Real consumer involvement.

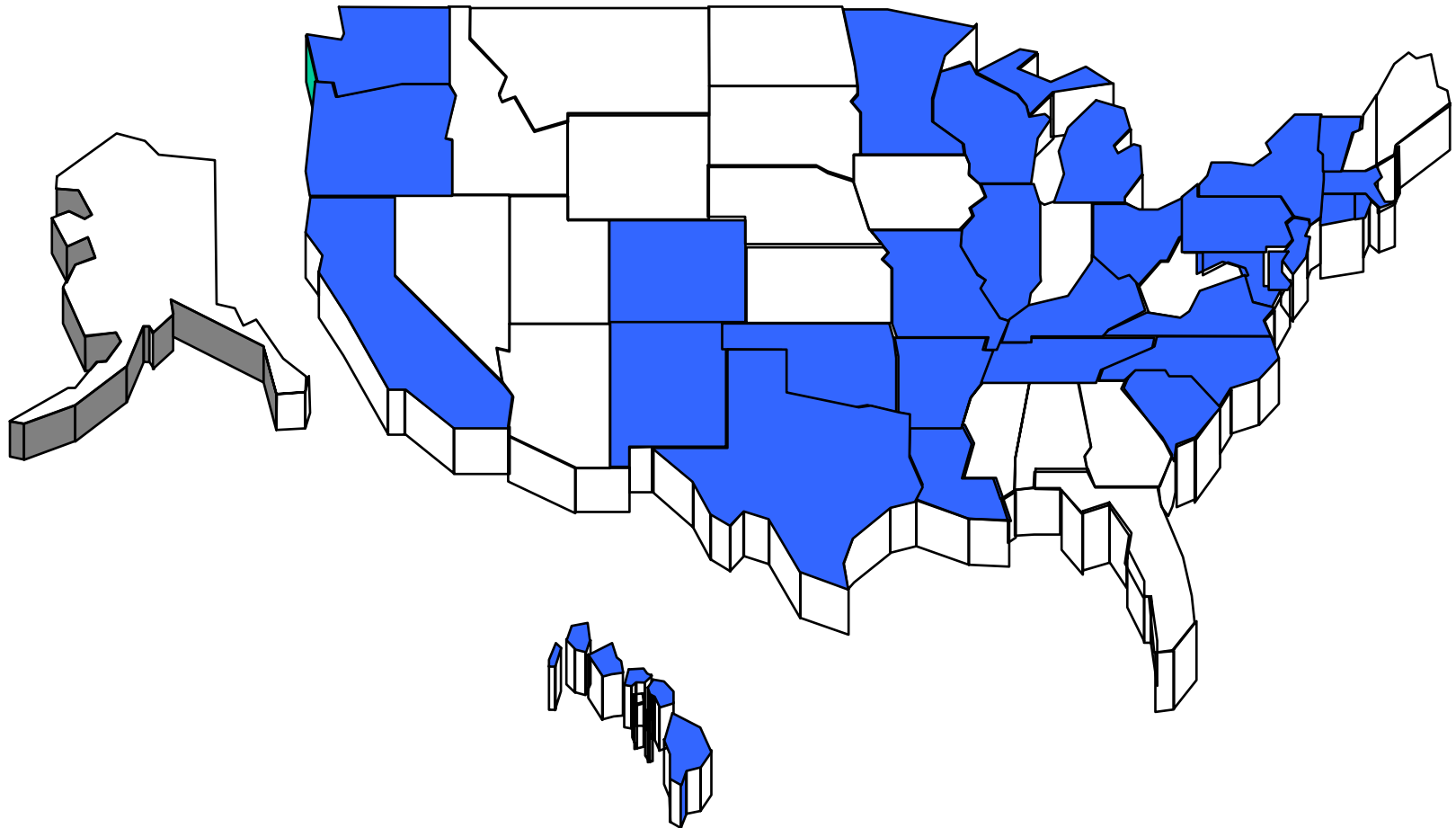
Findings: Enrolling PWD/SSI in MMC

- ❖ Carve outs = untold mischief
- ❖ Further work needed:
 - behavioral health
 - Rx
 - LTC
- ❖ Build on your strengths (- 2 Plan Model in CA) and “be careful out there.”

CHCS: Quality Improvement Efforts

- ❖ BCAP
- ❖ Purchasing Institute
- ❖ CFQ on Asthma
- ❖ HRSA/CHCS collaborative on Racial Disparities
- ❖ Clinical Pharmacy Management Initiative

BCAP Participation: All Workgroup Health Plans (April 2000-March 2003)

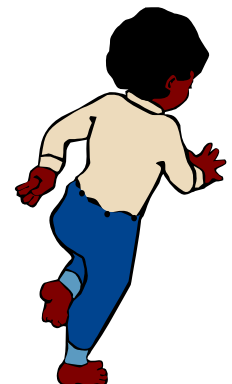
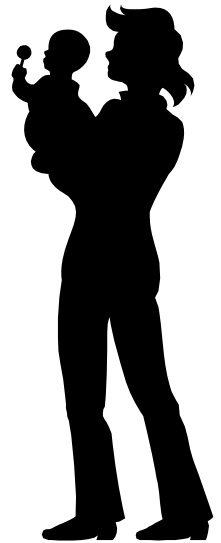


Total Number of Medicaid/SCHIP Lives = 8,023,872
57 Health Plans Across 30 States

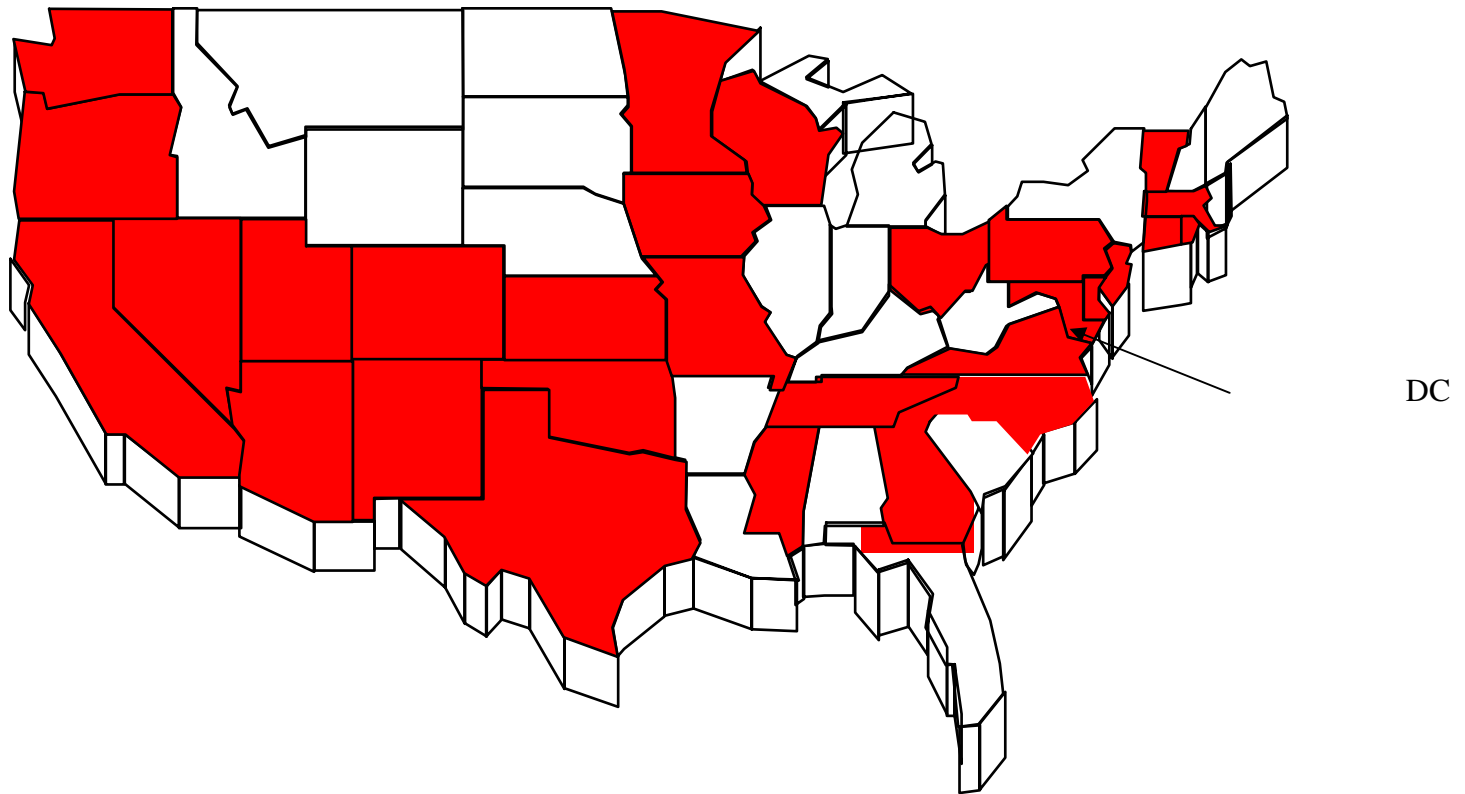
BCAP: Selected Successes

❖ Harmony Health Plan of IL-increased percent of women identified by the health plan within the first trimester of pregnancy from 3% to 76%.

❖ Heartland Health Plan of Oklahoma-implemented a pilot project in one clinic and accomplished the following: to (1) increased # of members who take control meds from 23% to 93.5% (2) increased percent of members using peak flow meters at home from 13% to 94%; (3) increase percent of members with a written action plan from 4% to 100%.



State Purchasing: Institute and Technical Assistance Participation



Total Number of States = 30 (60% of total # of states)
Total Number of Medicaid and SCHIP Lives = 24 million

State Purchasing: Selected Activities and Successes

- ❖ *Rewarding Managed Care Performance* Technical Assistance Series (9 states)
 - New Mexico implemented non-financial incentive program focused on six performance measures
 - Georgia expanded its physician profiling efforts to include additional performance measures
 - Maryland implemented a financial incentive program initially focused on eight performance measures – state to pay out \$1M in first year of program
- ❖ States trying to provide recognition and other support in lieu of unavailable or limited rate increases

State Purchasing: Clinical Pharmacy Management Initiative (CPMI)

Clinical Pharmacy Management programs are efforts that improve quality of care while achieving overall cost savings (beyond prescription drugs). Current Medicaid examples include:

Pharmacy Case Management
(e.g., AZ, MS, UT)

Physician and Patient Profiling
(e.g., FL, TX, WA)

Improved coordination and communication among caregivers and patients

Improved compliance with proven “best practices”

Improved information to providers and consumers

Improved disease monitoring and timeliness of interventions

Measurable improvements in outcomes and costs

CHCS Quality Improvement Typology

Clinical and Administrative Goal	Measurable goals established by purchaser/plan/consumer organization.
Identification	Beneficiaries with targeted condition (e.g., pregnancy, asthma, diabetes) identified.
Stratification	Target group is stratified into low, medium, high risk levels.
Outreach	Culturally effective approaches for reaching target population are put in place.
Intervention	Innovative practice for improving quality for target group is piloted.
Monitoring/Evaluation	Pilot is assessed in terms of process, outcomes, costs.
Diffusion	Model is spread within organization, adapted for other conditions, disseminated externally.

The Business Case for Quality (*Health Affairs*)

**PRIVATE PURCHASERS, MEDICARE,
Medicaid, PROVIDERS, CONSUMERS,
managed care.**

The Business Case for Quality (*Health Affairs*)

business case = ROI for purchaser/payer/MCO in terms of profit, reduction in loss, avoided admin costs, etc.

economic case = future avoided costs for health services not captured by purchaser/payer/MCO.

social case = benefit to individuals or society of healthier consumers with improved productivity and quality of life.

CHCS: The Business Case for Quality

MEDICAID, MANAGED CARE = best opportunity to demonstrate business, economic, social case for quality

- *Capitated MCO* – e.g. ROI for using BCAP typology on asthma.
- *Medicaid* – avoided health care costs for churning beneficiaries in new MCO or PCCM.
- *State/federal government* – avoided costs and more productive citizens.

Summary of (Salable) Research Issues in Medicaid/SCHIP Operations (\neq Policy)

- Purchasing
 - Value added of managed care (e.g. TANF, PWD, LTC).
 - Viable options to full-risk capitation that sustain the gains.
 - Can HIFA-like flexibility improve outcomes?
- Managed Care Best Practices
 - Cost effectiveness of quality improvements (the business case/ROI/quality pays).
 - Evidence-based approaches without the evidence-base (e.g. disability, LTC).
- Consumer Action
 - Consumer self-direction in acute physical? behavioral? LTC?
 - Culturally effective care to reduce racial/ethnic disparities.

Study: Enrolling PWD/SSI in MMC

It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new system. For the initiator has the enmity of all who would profit by the preservation of the old institutions and merely lukewarm defenders in those who would gain by the new ones. The hesitation of the latter arises in part from the fear of their adversaries, who have the laws on their side, and in part from the general skepticism of man-kind which does not really believe in an innovation until experience proves its value.

Niccolo Machiavelli