Session 44 L, Medicaid Quality: A Key Driver of Payer Financial Viability

Moderator/Presenter:

Presenters:
Richard Lieberman
David Anthony Neiman, FSA, MAAA
TODAY’S AGENDA
• Actively involved in the development of risk adjustment systems for 25 years
  • Johns Hopkins ACG Development Team, 1991-2005
  • Implemented the risk-adjusted payment system for Maryland Medicaid
  • Designed the clinical model for the first-to-market revenue management “suspecting” engine

• Developer of integrated decision-support platforms coalescing quality measurement, risk adjustment, and population health metrics

• Disseminator of risk adjustment and quality measurement technology and intellectual property to health plans, services vendors, and consultants
AND YOU MAY ASK YOURSELF: HOW DID WE GET HERE?

• Section 1932(c) of the Social Security Act, added by section 4705 of the Balanced Budget Act of 1997 (BBA), describes how quality measurement and performance improvement methods should be applied to Medicaid managed care programs through two specific approaches:
  
  • External quality review of their MCOs
  
  • Develop and implement a quality assessment and improvement strategy
It took 5-6 years to codify the statutory language of BBA-97 into regulations. In 2002, CMS promulgated:

- Standards for access to care;
- Examination of other aspects of care and services related to improving quality;
- Monitoring procedures for regular and periodic review of the strategy.

The EQRO standards were established in 2003.
EXTERNAL QUALITY REVIEW

• Since March 2003, States have been required to arrange for External Quality Review (EQR) of their Medicaid MCOs

• Federal regulations at 42 CFR Part 438, subpart E (External Quality Review) set forth the parameters that states must follow when conducting an external quality review (EQR) of its contracted managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs)
• Although quality measurement didn’t begin with Medicare–Advantage, the Stars initiative began the integration of quality improvement and financial performance for government–regulated health plans.

• I see the 5 percent Stars bonuses as the government’s investment for plans to build out a performance improvement program.

• Many Medicaid states have taken quality improvement into a variety of different dimensions.
• Stars was a one-time gift!
• Medicaid states rarely use positive financial incentives to motivate MCOs.
• Unlike risk adjustment, which in Medicaid is typically “baked” into the capitation rate, quality improvement is front-and-center.
  • It is a key driver of profitability in many Medicaid states
STATES USE A VARIETY OF PAY-FOR-PERFORMANCE METHODS

• Medicaid states have some of the most aggressive pay-for-performance programs in place

• There are at least six types of incentive schemes in use:
  • Bonuses
  • Differential reimbursement for rates or fees
  • Penalties
  • Auto-assignment of beneficiaries to a plan or provider
  • Withholds
  • Grants
Almost all states require reporting of the HEDIS measure set to NCQA
  - NCQA accreditation is required as well

But..... The measure sets that are used for sanctions may not be all HEDIS measures or they may include some non-HEDIS measures

There is also CAHPS survey data as well

Incentive payments or withhold returns are often often tied to achieving quality improvement thresholds for a group of HEDIS measures
  - The spend for performance improvement is considered a claim cost for MLR reconciliation

BUT IT’S JUST HEDIS RIGHT?
WELL, NOT QUITE!

• States love to create their own measures!
• They also like to use different measurement schemes and/or penalty schemes within the same measure set
  • Some states compare MCO’s performance to national benchmarks
  • Other states compare MCO’s to other MCO’s in the same state
• Then there are the really “cool” sanctions, as in Florida:
  Failure to comply with the preventive dental services rate requirement of at least twenty-eight percent (28%), described in the Contract.
  $50,000 per occurrence in addition to $10,000 for each percentage point less than the target.
WILL STATES DITCH QUALITY IMPROVEMENT IF THEY GET THE OPPORTUNITY?

HEALTH CARE

Md. Praised for Medicaid Changes Since Death

By Mary Otto
Washington Post Staff Writer
Friday, February 15, 2008

In the year since a Prince George's County boy died of a dental infection, lawmakers say Maryland has begun addressing the structural problems and funding shortages that are blamed for breakdowns in the state's Medicaid system.

At a congressional hearing yesterday, Maryland officials won praise for initiating changes in the troubled program, which in recent years provided dental services to fewer than one-third of the 500,000 poor children statewide entitled to care.

"The new administration . . . under Governor Martin O'Malley had laudably taken the initiative," said Rep. Dennis J. Kucinich (D-Ohio), chairman of a subcommittee that has investigated the failings of the system nationwide since the death of 12-year-old Deamonte Driver last February.

"Maryland's Medicaid administration has taken a number of significant actions," said Kucinich, who called for more pressure by federal officials to push for reforms in other states.
FLORIDA HAS A RATHER COMPLICATED SYSTEM

The Agency shall assign performance measures a point value that correlates to the National Committee for Quality Assurance HEDIS National Means and Percentiles for Medicaid plans. The scores will be assigned according to the table below. Individual performance measures will be grouped and the scores averaged within each group.

<table>
<thead>
<tr>
<th>PM Ranking</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;= 90th percentile</td>
<td>6</td>
</tr>
<tr>
<td>75th – 89th percentile</td>
<td>5</td>
</tr>
<tr>
<td>60th – 74th percentile</td>
<td>4</td>
</tr>
<tr>
<td>50th – 59th percentile</td>
<td>3</td>
</tr>
<tr>
<td>25th-49th percentile</td>
<td>2</td>
</tr>
<tr>
<td>10th – 24th percentile</td>
<td>1</td>
</tr>
<tr>
<td>&lt; 10th percentile</td>
<td>0</td>
</tr>
</tbody>
</table>

The Agency may require the Managed Care Plan to complete a Performance Measure Action Plan (PMAP) after the first year of poor performance.

The Managed Care Plan may receive a monetary sanction of up to $10,000 for each performance measure group where the group score is below three (3). Performance measure groups are as follows:
## WHAT IS NEW YORK UP TO?

<table>
<thead>
<tr>
<th>Component</th>
<th>Measures</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality – QARR (HEDIS® and NYS-specific)</td>
<td>26</td>
<td>100 points</td>
</tr>
<tr>
<td>Satisfaction – CAHPS® Health Plan Survey</td>
<td>3</td>
<td>30 points</td>
</tr>
<tr>
<td>Prevention Quality Indicators</td>
<td>2</td>
<td>20 points</td>
</tr>
<tr>
<td>Total points</td>
<td></td>
<td>150 points</td>
</tr>
<tr>
<td>Compliance (Subtracted from Total)</td>
<td>5</td>
<td>Up to 20 points</td>
</tr>
<tr>
<td>Final Score</td>
<td>Final points/150</td>
<td></td>
</tr>
</tbody>
</table>

* The number of measures in components has varied from year to year.
HEDIS® Measures

- Adolescent Well-Care Visits
- Annual Dental Visit (Ages 2 – 20 years)
- Comprehensive Diabetes Care: HbA1c Poor Control
- Controlling High Blood Pressure
- Frequency of Ongoing Prenatal Care: ≥81 Percent of Expected Number of Prenatal Care Visits
- Prenatal Care in the First Trimester
- Postpartum Care
- Well-Child Visits in the First 15 Months of Life, 6 or more

One Pennsylvania Performance Measure: Reducing Potentially Preventable Readmissions
HEDIS is the annual process of retrospectively measuring how the plan performed on quality LAST YEAR

- But it isn’t possible to change the past
- The craziness of the annual HEDIS data collection only addresses a handful of measures
- Many of the measures that states use in their quality improvement programs are “administrative” measures.

The administrative measures have to be addressed concurrently during the year. There is nothing the HEDIS team can do to “juice” these measures during “HEDIS season”
HEDIS AND QUALITY IMPROVEMENT ARE TWO DIFFERENT THINGS!

• HEDIS is quality measurement, retrospective quality measurement

• Quality improvement is an ongoing, concurrent process that has to be part of the MCO’s culture.
  • Quality measures impact every department in a health plan

• Most Medicaid states publish quality performance statistics monthly or quarterly
ADMINISTRATIVE VS. HYBRID MEASURES

- Hybrid measures
  - Sample of the population reviewed after the measurement year is complete
    - Typical sample size is 411 eligible members
  - Utilizes medical record review
- Administrative Measures
  - Compliance rates are tabulated from machine-readable data (claims, lab results, Rx claims, etc.)
  - No medical record reviews!
SO LET’S TAKE ANOTHER LOOK AT PENNSYLVANIA’S MEASURE SET

- Adolescent Well-Care Visits
- Annual Dental Visit (Ages 2 – 20 years)
- Frequency of Ongoing Prenatal Care: ≥81 Percent of Expected Number of Prenatal Care Visits
- Prenatal Care in the First Trimester
- Postpartum Care
- Well-Child Visits in the First 15 Months of Life, 6 or more
- Comprehensive Diabetes Care: HbA1c Poor Control
- Controlling High Blood Pressure
- Reducing Potentially Preventable Readmissions
Historically states have struggled to collect complete and accurate encounter data from managed care plans and to manage that data in legacy systems designed for FFS.

The most important change is that federal payment for Medicaid managed care is tied to the submission of accurate, complete, and timely encounter data to CMS in a CMS-specified format, likely TMSIS.

Accurate and comprehensive coding is required on all encounters.

- States are increasingly assessing money penalties for inaccurate encounter data.
EXAMPLE FROM WASHINGTON STATE MCO CONTRACT

- “The Contractor’s encounter data submitted and accepted…will be validated against submitted and accepted data captured…and must be within one percent (1%) of what HCA captured”
- The Withhold Factor is intended to hold back one percent (1%) of the capitation payments excluding any SNAF, PAP, or Trauma funding…The amount withheld from the monthly premium payment will be released upon successful reconciliation of the Contractor’s encounter data per subsection 5.11.6 of this Contract.
Need to know more about encounter data?

- Please join me and several actuaries tomorrow (Tuesday) at Session 65
- “Medicaid Risk Adjustment: Role of Encounter Data and Understanding Model Specific Nuances”
- 9:00 – 10:30 a.m.

Be there or be square!

“I know it’s the truth, but on this promo for our site, do you think we should use promo code ‘desperation?’”
MISSOURI ALSO HAS ELABORATE ENCOUNTER DATA REQUIREMENTS AND POTENTIAL SANCTIONS

<table>
<thead>
<tr>
<th>Encounter Data Completeness/Accuracy Specific Performance Metrics</th>
<th>Frequency of Metric Evaluation</th>
<th>Statewide vs Regional Application</th>
<th>Original Contract Period Withhold Amount</th>
<th>Metrics Applicable during the Following Contract Periods:</th>
<th>1st Year</th>
<th>Renewal Period</th>
<th>2nd Renewal Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Monthly encounter submissions must meet a ninety-eight percent (98%) acceptance rate. If the health plan is new to the MO HealthNet Managed Care Program, the health plan must transmit their first encounter data submission to the state agency by October 31, 2015 and meet a submission acceptance rate of at least eighty percent (80%) for claims incurred from July 1, 2015 to September 30, 2015. Beginning January 1, 2016, if the health plan is new to the MO HealthNet Managed Care Program, the health plan must transmit monthly encounter data submissions and meet the ninety-eight percent (98%) acceptance rate consistent with the measures for all other health plans.</td>
<td>Quarterly</td>
<td>Regional</td>
<td>0.50% (computed by region) for the Original Contract Period and 0.17% for the 1st and 2nd Renewal Periods</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2. Monthly health plan encounter volumes must be within a certain percentage of historical average volumes or regional averages if the health plan is new to the MO HealthNet Managed Care Program.</td>
<td>TBD</td>
<td>Regional</td>
<td>0.17%</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
The MCO must submit Encounter Data transmissions at least monthly, and include all Encounter Data and Encounter Data adjustments processed by the MCO. In addition, Pharmacy Encounter Data must be submitted no later than 25 calendar days after the date of adjudication and include all Encounter Data and Encounter Data adjustments processed by the MCO.
Unlike Medicare-Advantage, most Medicaid states regularly publish quality scores.

- Often these are published monthly or quarterly

**Maintaining quality is the key to ensuring MCO profitability!**

- Many states already limit MCO surpluses to 3 percent
- Quality measurement withholds can range from 0.5% to as high as 5%
WHAT SHOULD MCOs DO FOR QUALITY MEASUREMENT

- Quality improvement is, “where it’s at” in Medicaid
  - Risk adjustment is important, but the value-proposition for quality improvement is easier to explain
- MCOs that operate in multiple states are going to have to navigate many different quality measurement paradigms
- The mega-reg requires states to implement a star-rating system not unlike MA stars
  - Except there are not likely to be bonuses, only penalties
LEARN ABOUT OUR QUALITY IMPROVEMENT TOOL: QISim

Meeting and exceeding CMS quality standards has never been more important for providers and plans alike. Since the institution of the Medicare Advantage Star Rating system, scores have been steadily rising as players across the healthcare ecosystem recognize the impact of these ratings on both consumer choice and profitability. Now, with QISim, our innovative quality improvement simulation application, quality improvement teams have a powerful tool to develop effective strategies and measure performance trends.
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