



Medicaid and SCHIP Quality

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Medicaid/SCHIP Quality Strategy

- **Vision: The right care for every person every time**
- **Aims: Make care safe, effective, efficient, person-centered, timely; and equitable**
- The pillars of the Medicaid/SCHIP framework are:
 - Evidenced-Based Guidelines and Performance Metrics
 - Supporting Value Based Payment methodologies
 - Health Information Technology
 - Reduction of Health Care Disparities
 - Partnerships
 - Information Dissemination and Technical Assistance

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Evidenced Based Guidelines and Performance Metrics

- A number of efforts are underway related to performance measurement strategies for child health, disparities, efficiency etc.
- The Quality Alliance Steering Committee has released a draft Road Map for a Performance-Based System
- CMS is promoting the use of NQF endorsed measures when possible

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Quality Measures
Compendium

Vol. 2.0, October 2007

Medicaid and SCHIP
Quality Improvement

Compiled by the
Division of Quality, Evaluation
and Health Outcomes

Family and Children's Health Programs Group

Other organizations are interested in partnering to support efforts to increase the availability of performance measures for underrepresented domains and populations. Specifically organizations are interested in partnering with CMS to establish a national agenda for the development of pediatric measures. The National Association of Children's Hospitals and Related Institutions (NACHRI), the National Initiative for Children's Healthcare Quality (NICHQ) and the American Academy of Pediatrics (AAP) have approached CMS to expand the selection of measures relevant for pediatric populations.

AHRQ - Agency of Healthcare Research and Quality

The Agency of Healthcare Research and Quality (AHRQ) developed the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, originally a tool to assess and report satisfaction of enrollees with health plans, it has evolved into a suite of satisfaction tools across care settings. In addition to the health plan survey, satisfaction tools are available for the hospital, behavioral health care services, in-center hemodialysis, and nursing home settings. A nursing home satisfaction tool is currently under development to determine and report patient satisfaction with nursing home quality. The Quality Indicators (QIs) were also developed by AHRQ, these measures use readily available administrative data for measurement of various aspects of quality—prevention, inpatient care, pediatric inpatient care and patient safety.

AMA - American Medical Association

The Physician Consortium for Performance Improvement (PCPI) is a workgroup of interdisciplinary specialists of the American Medical Association involved in performance measure development. The group supports and advances measure sets that facilitate clinical performance improvement among physicians for a number of select conditions. Measures are available for conditions such as bone conditions, diabetes, hypertension and mental health.

AQA Alliance

Collaborative organizations perform an important role in consensus building across multiple stakeholder organizations. Such organizations bring together stakeholders on particular domains of health care. For example, the AQA alliance (formerly the Ambulatory Quality Care Alliance) convenes a national coalition of more than 125 organizations to improve health care quality through a process in which stakeholders agree on a performance measurement strategy for physician-level reporting. Through this effort a starter set of 25 measures relevant to the ambulatory care setting were endorsed meeting the group's criteria for clinical importance, physician accountability, feasibility and consumer and purchaser relevance.

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The Guide to Quality Measures: A Compendium Version 1.0									
Category	Measure	Description	Measure Setting	Population	Source	Type	Data Source	Endorsement	QII/A
Preventive	Discussion of Smoking Cessation Medication	% of patients whose practitioner recommended or discussed smoking cessation medications	Ambulatory	adult	NCOA	process	administrative		A
Preventive	Influenza Vaccination	% of patients who received an influenza vaccine	Ambulatory	adult	CMS, NCOA, AQA	process	administrative	Pending	A
Preventive	Pneumonia Vaccination	% of patients who was received a pneumococcal vaccine; (ages 65 years)	Ambulatory	adult	NCOA, CMS	process	administrative	Y	A
Preventive	Childhood Immunization	% of patients who turned 2 years old during the measurement year who had four DTaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B and one chicken pox vaccine (VZV) by the time period specified and by the child's second birthday	ambulatory	pediatric	NCOA	process	administrative		A
Preventive	Well Child Visits	% of members who received zero, one, two, three, four, five, and six or more well child visits with a primary care practitioner during their first 15 months of life	ambulatory	pediatric	NCOA	process	administrative		A
Preventive	Well Child Visits in 3rd, 4th, 5th and 6th Year	% of members age 3 to 6 years old who received one or more well-child visits with a primary care practitioner during the measurement year	ambulatory	pediatric	NCOA	process	administrative		A
Preventive	Adolescent Well Care Visit	% of members age 12 through 21 years who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.	ambulatory	pediatric	NCOA	process	administrative		A

Benchmark Report

- CMS is in the process of awarding a contract to provide technical assistance to Medicaid Plans in the collection of HEDIS data
- The Contractor will develop a benchmark report useful for CMS, States, EQRO and Medicaid Health Plans
- The Contractor will establish an advisory committee to advise on project specifics

Value Based Purchasing

- State Medicaid Programs are leaders in value-based purchasing with at least 30 states that have purchasing initiatives in place (primarily in managed care); other programs are set to begin soon
- There are many models for financial and non-financial incentives used in pay-for-performance strategies.
- Should be viewed as only one component of a broader strategy of promoting health care quality.
- Many States are implementing policies related to measures on “Never Events” and “Present on Admission” to align payment incentives with desired outcomes and decrease payment for preventable errors.

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Never Events

- Prompted in part by the 1999 report by the Institute of Medicine titled “To Err is Human: Building a Safer Health System,” the National Quality Forum has created a list of 28 “never events”
- Starting in October, Medicare will no longer pay for several of these events.
- Several States are planning related to their liability to pay for dual eligibles when Medicare does not pay
- A select number of States have expressed an interest in implementing a program similar to the Medicare Program for all Medicaid Beneficiaries and in fact, the State of Pennsylvania launched a program in January 2008
- CMS held a national teleconference with the State Medicaid Programs on April 23, 2008 to provide a general overview and to begin a dialogue on issues facing the States related to this policy
- CMSO is currently discussing several policy options to address the implications of the serious reportable events policy as it relates to Medicaid

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Physician Level Pay-for-Performance

- CMS notes increased interest of States to direct incentives directly to providers as they seek to improve access, efficiency and outcomes
- States are eager to apply lessons learned from value-based purchasing initiatives in other arenas such as the Medicare Physician Quality Reporting Initiative (PQRI)

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Physician Level Pay-for-Performance

- Contractual relationships exist between the State and MCOs in risk based arrangements
- States under risk-based arrangements are prohibited from making payments to entities outside of the terms of the agreement for that particular arrangement except as required by law
- Therefore, regulations restrict States' ability to offer direct incentives from the State to physician level providers

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Physician Level Pay-for-Performance

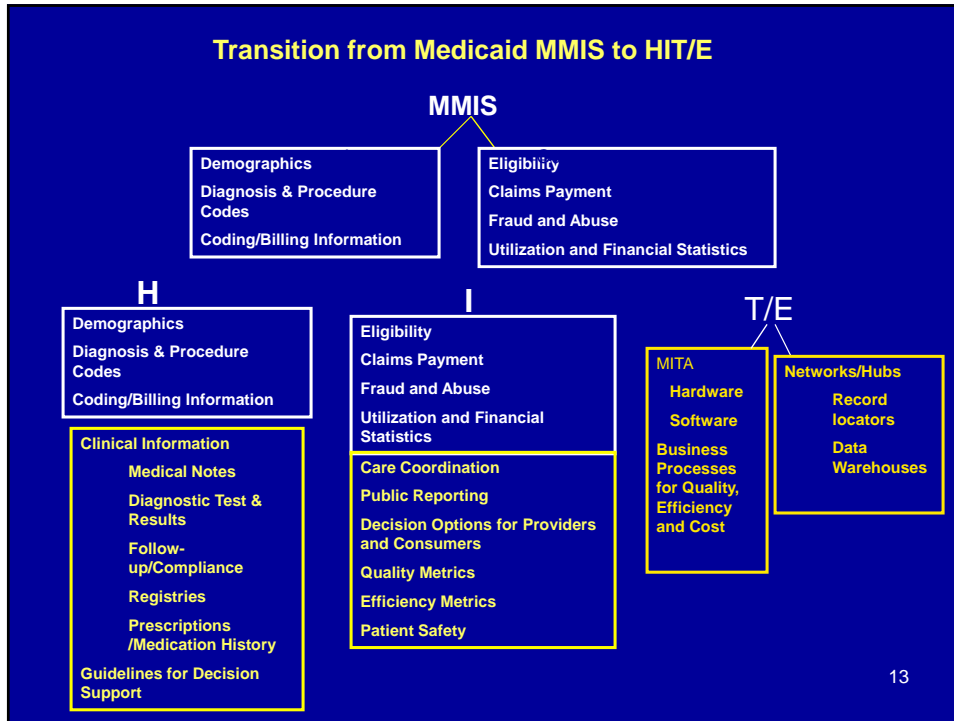
- Under current regulation, States' roles in provider incentive programs include:
 - Specifying pass through incentive payments to physicians in managed care contracts, if desired
 - Adjusting plan capitation to account for incentives
 - Making any incentive payments to the managed care entity
 - Adhering to CMS actuarial soundness criteria

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Health Information Technology

- Medicaid Information Technology Architecture
- Medicaid Transformation Grants
- Chartered Value Exchanges

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Medicaid Transformation Grants

- Section 6081 of the DRA of 2005 authorizes the Medicaid Transformation Grants program. This legislation authorizes new grant funds to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid.
- The program spans a 2-year period and appropriates a total of \$150,000,000.

Exchange of Dual-Data

- States have made several requests of CMS to access data for dual-eligible beneficiaries for purposes other than coordination of payment
- CMS has developed a process for States to use Medicare duals claims data for both internal quality improvement activities as well as for re-release to requesting provider groups as permissible under HIPAA and other applicable laws and regulations
- These data will be useful in evaluating performance, assessing and improving the quality of care for individual beneficiaries, improving care coordination and treatment, and reducing treatment errors and duplication of services
- CMS will use the Coordination of Benefits Agreement (COBA) as the vehicle to enable States to use the Medicare duals claims data

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Chartered Value Exchanges

- A “Value Exchange” is a multi-stakeholder organization that has taken clear action in its community to convene industry stakeholders and advance the four cornerstones of Value-Driven Health Care.
- Chartered Value Exchanges are identified and selected by HHS. They must meet the following:
 - Recognized by HHS as a Community Leader;
 - Active engagement with critical stakeholders in the community;
 - Having non-profit organization status, with staff or consultant expertise;
 - Demonstrated financial sustainability;
 - Facilitating the collection of provider-level measurements across the six Institute Of Medicine performance domains (safe, timely, effective, efficient, equitable, patient-centered care);
 - Using (or promoting the use of) performance measures for:
 - Public reporting of costs and consumer assessments
 - Rewarding and fostering better performance
 - Improvement by providers
 - Use of interoperable health information technologies
 - Fostering collaboration across multiple stakeholders and serving as a hub for sharing information and dialogue;
 - Supporting knowledge transfer and sharing lessons learned
 - Conducting ongoing evaluation and improvement of efforts.
 - Using national provider performance measures effectively.

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Reduction of Health Care Disparities

- **Medicaid and SCHIP supports the reduction of Health Care Disparities through**
 - Funding of National and State Initiatives
 - Enforcement of Regulations
 - Collaborations

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Information Dissemination

The screenshot shows a Microsoft Internet Explorer browser window. The address bar displays the URL: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/10_Promising%20PracticesConceptNominationProcess.asp. The browser's menu bar includes File, Edit, View, Favorites, Tools, and Help. The page content is titled "Promising Practices: Concept/Nomination Process" and includes a navigation menu on the left with items like "Overview", "What's New in Quality", "Evidence-based Care/Performance Measurement", "Pay for Performance", "Health Disparities", "Tools, Tips, and Protocols", "Promising Practices: Concept/Nomination Process", "Evaluation of Medicaid Programs and Demonstrations", and "SCHIP Promising". The main content area has an "Overview" section that states: "CMS seeks to stimulate the consideration of alternative approaches for improving the quality of health care and life for Medicaid beneficiaries and State Child Health Insurance Program enrollees. This role is endorsed in the CMS Quality Roadmap, 'A Quality Improvement Plan for CMS' and the Medicaid/State Child Health Insurance Program (SCHIP) strategic plan. (See the links below for these documents.)" It also defines a "promising practice" and lists two requirements: "Be related to the improvement of quality of care and/or life for Medicaid and/or SCHIP beneficiaries" and "Address a significant problem in health status or functioning based on trends in...". The browser's status bar at the bottom shows the time as 12:05 PM.

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Partnerships

...collaborative efforts to improve quality of health care in areas of mutual interest

Examples of external partners with whom CMSO has met to discuss areas of potential collaboration:

- Agency for Health Research and Quality
- HHS Office of Disabilities
- Health Resources and Services Administration
- National Association of Children's Hospitals
- Center for Health Care Strategies
- Association for Community Affiliated Plans (ACAP)
- Child and Adolescent Health Care Initiative (CAHMI)
- National Initiative for Children's Healthcare Quality (NICHQ)
- Commonwealth Fund
- Centers for Disease Control
- Medicaid Medical Directors (AHRQ Learning Network)
- National Association of State Medicaid Directors
- National Committee for Quality Assurance
- Child and Adolescent Health Measurement Initiative

FY07 and Beyond in Medicaid Quality:

White House Releases Medicaid PART Information on ExpectMore.Gov. Quality Goal is highlighted

PROGRAM ASSESSMENT

Medicaid

Medicaid is a means tested, Federal State funded entitlement program that provides medical assistance, including acute and long term care, to families with dependent children as well as aged, blind, or disabled individuals. The Centers for Medicare and Medicaid Services (CMS) provides Federal oversight of this program.

RATING
What This Rating Means

PERFORMING
Advisable

- Medicaid provides health insurance to millions of targeted individuals. In 2005, the number of Medicaid enrollees was 41.3 million. Nearly one in every four children in America relies on Medicaid for health coverage. Two-thirds of all Medicaid enrollees are in low-wage working families. Medicaid also pays for no out of every ten beds in nursing homes.
- New performance measures assess program effectiveness. Center for Medicare and Medicaid Services (CMS) created new performance measures that assess health quality and focus on improving program management. More work needs to be done. CMS is working on a national strategy to improve the quality of care across State Medicaid programs and to developing a national payment error rate for Medicaid.

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- Medicaid is an open-ended Federal-State partnership and opportunities exist for States to draw down Federal matching funds inappropriately. The Federal government currently all-allocates State dollars spent on Medicaid, regardless of the amount or quality of services. The funding structure creates Medicaid "shortfalls" and has enabled States to shift costs to Medicaid that may not be appropriate.

IMPROVEMENT PLAN
About Improvement Plans

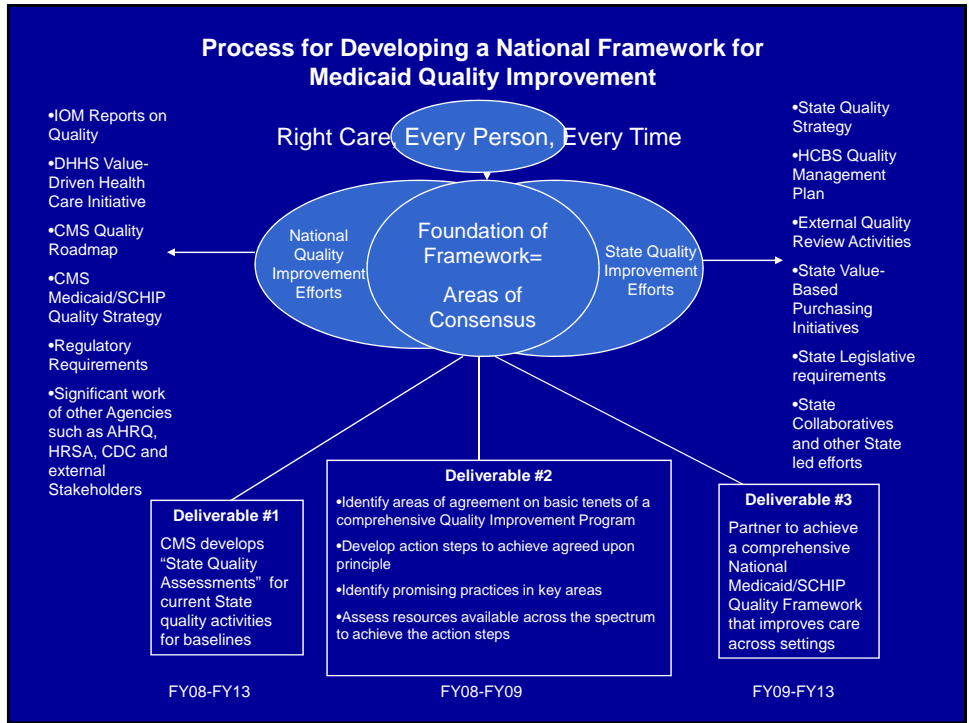
We are taking the following actions to improve the performance of the program:

- Working with the States to measure, track, and improve quality of care in Medicaid and moving toward a national framework for Medicaid quality.
- Reducing fraud, waste, and abuse in the Medicaid program, and improving overall program integrity.
- Working with States to establish baseline data for the newly developed Medicaid performance measures.

LEARN MORE

- View Similar Programs.
- View all the programs are assessed.
- Learn more about Medicaid.

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The Right Care for Every Person Every Time

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