IMPLEMENTING HEALTH REFORM

Medicaid Adult Quality Measures

Two years from now, millions of previously uninsured Americans will gain health coverage through the Medicaid program. With that in mind, section 2701 of the Affordable Care Act instructs officials in the Health and Human Services Department to design a voluntary quality measurement program focused on the care of new adults coming into the program. On Jan. 4, the HHS published the initial core set of health care quality measures for Medicaid-eligible adults. It includes 26 quality indicators (see box) that cover adult health, maternal/reproductive health, complex health care needs, and mental health and substance use. Measures were selected based on recommendations from the Agency for Healthcare Research and Quality, which convened a committee of state Medicaid representatives and health care quality experts to pare down a list of about 1,000 possible measures.

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MR. SALO

Matt Salo, executive director of the National Association of Medicaid Directors, shared thoughts on how the HHS did in assembling the list of core measures and how the quality program could affect the success of the Medicaid expansion.

CLINICAL ENDOCRINOLOGY NEWS: Participation in the program is voluntary. Does that make it less effective?

Mr. Salo: It's voluntary largely for political reasons. When you're trying to push adoption of any kind of change, whether that's changing state Medicaid programs or the behavior of physicians, making that change voluntary is a lot more politically palatable. I don't think it makes it less effective. We've learned that quality measures are constantly evolving. The concept of measuring quality is by no means a new one. But what we measure, who we measure it on, and how we measure it is constantly changing. As a result, it's actually very difficult for anyone to say, 'yes, we know what the absolute answer is and we're going to carve it into stone and everyone has to do it now.' The voluntary nature of this is kind of a testament to that. You will see people adopting it and maybe tweaking it slightly, but they will get there.

CEN: Will this program help states to prepare for the 2014 Medicaid expansion?

Mr. Salo: Yes, in part. This is a very small slice of what states are going to need to do to prepare for 2014. But it is relevant because the bulk of people who will be coming into the Medicaid program in 2014 will be adults, in contrast to the bulk of people who are on Medicaid today: pregnant women and children.

CEN: How do Medicaid programs currently evaluate quality of care?

Mr. Salo: Every state measures quality today; it's just that they do it in different ways. They measure different things. They measure different populations. They measure them in different time periods and in different quantities. This program helps because it starts to give quality measurement a little bit more structure. The HHS looked at thousands of quality measures from numerous sources and were able to sift through to find the ones that really make a difference and are accurate and effective and narrow that down to a fairly small number. By doing that, it gives states a road map to try to narrow down the diversity of approaches they are taking and start to provide more commonality across states and across programs and providers.

CEN: Would you add or delete anything from the core list of measures?

Mr. Salo: I wouldn't change anything from that list. It's a really solid first effort. Once put into practice, we may start to see that there's something that was missed or a measure that isn't really useful. But I think at this stage of the game they've done a really good job.

CEN: Physicians are being asked to measure their performance by many payers already. Will this create an additional burden for them?

Mr. Salo: Medicaid directors are frequently inundated with new requirements from Congress or the HHS, so this is something that we grapple with too. We are very sensitive to the potential for overburdening physicians. This is actually going to go in the opposite direction. There really aren't, or at least there shouldn't be, any physicians out there who aren't participating in some kind of quality measurement. This effort should help focus and streamline the future of quality reporting for physicians. It's going to provide some really useful tools that the states will use, that insurance plans will use, but that physicians can use too. Obviously physicians care very deeply about how they are performing compared to the practice down the street or across the state. This is going to start creating a lot more apples-to-apples comparisons that physicians are going to be able to use to find out more. I think that's a good thing no matter how you slice it. ■

Medicaid's Initial Set of Adult Quality Measures

Prevention and Health Promotion	• Adult asthma admission rate • Adult BMI assessment • Breast cancer screening • Cervical cancer screening • Chlamydia screening for women aged 21-24 • Chronic obstructive pulmonary disease admission rate • Clinical depression screening and follow-up • Diabetes short-term complications admission rate • Flu shots for adults aged 50-64 years • Heart failure admission rate • Medical assistance with smoking cessation • Plan for all-cause readmission
Management of Acute Conditions	• Elective delivery • Follow-up after hospitalization for mental illness • Prenatal steroids
Management of Chronic Conditions	• Adherence to antipsychotics for individuals with schizophrenia • Annual HIV-AIDS medical visit • Annual monitoring for patients on persistent medications • Antidepressant medication management • Comprehensive diabetes care: hemoglobin A_{1c} testing • Comprehensive diabetes care: LDL cholesterol screening • Controlling high blood pressure
Family Experiences of Care	• Consumer Assessment of Healthcare Providers & Systems (CAHPS) Health Plan Survey, version 4.0 – Adult Questionnaire With CAHPS Health Plan Survey, version 4.0H – NCQA Supplemental
Care Coordination	• Care transition – transition record transmitted to health care professional
Availability	• Initiation and engagement of alcohol and other drug dependence treatment • Prenatal and postpartum care: postpartum care rate

Source: Department of Health and Human Services

IMNG MEDICAL MEDIA

Medicare Demonstration Projects Fall Short on Savings

BY MARY ELLEN SCHNEIDER

Over the last 2 decades, policy makers have proposed several ways to change how health care is delivered in the Medicare program, but a new analysis from the nonpartisan Congressional Budget Office shows that those efforts have failed to yield significant savings.

The CBO analyzed 10 major Medicare demonstrations involving disease management and care coordination or some type of value-based payments and found that most of the projects didn't save money.

The analysis has implications for health policy. Under the Affordable Care Act, Congress required the Centers for Medicare and Medicaid Services to pursue new payment and care delivery models including accountable care organizations and bundled payments. Congress also created the Innovation Center within the CMS to test other models of care. The idea behind the center is that Medicare officials can expand successful projects without having to return to Congress for approval.

Dr. Glen R. Stream, president of the American Academy of Family Physicians, said the Innovation Center may yield better results because its projects focus on broader care delivery concepts, such as the patient-centered medical home, rather than only certain conditions.

Looking at the six disease management and care coordination projects that Medicare had already undertaken, CBO analysts found that on average there was little to no effect on hospital admissions or regular Medicare spending. The demonstrations were more likely to reduce costs if they used care managers who had significant, direct contact with physicians and patients, but those programs didn't save enough money to cover the cost of the extra services provided. For example, in programs with significant in-person or telephone interaction between care management and patients there was an average 7% drop in hospital admissions and a 3% reduction in regular Medicare spending. But to offset the cost of the care management fees, the programs would have had to reduce regular Medicare expenditures by 13%.

In the four demonstrations that focused on changing the financial incentives for health care providers, only one project produced significant savings. A project that offered bundled payments to physicians and hospitals for heart bypass surgery reduced Medicare expenditures related to heart bypass by about 10% without an adverse impact on patient outcomes. ■