HMA

Value of Medicaid Managed Care in Quality Improvement

Presentation by Health Management Associates (HMA)

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FEBRUARY 15, 2022

THE VALUE OF MEDICAID MANAGED CARE IN QUALITY IMPROVEMENT

A comparison of quality outcomes across state Medicaid program delivery models

NOVEMBER 2021

David Wedemeyer, Anthony Davis, Sharon Silow-Carroll and Joe Moser

View Report

CMS 2019 MEDICAID ADULT AND CHILD CORE DATASET

METHODOLOGY

DATA FROM CMS MEDICAID CORE ADULT AND CHILD DATASETS

59 MEASURES

- HYBRID
- ADMINISTRATIVE

50 STATES

IDENTIFY DELIVERY SYSTEM MODEL(S) BY STATE AND ASSIGN RELATIVE WEIGHTS

WEIGHT - ADJUST PERFORMANCE ON EACH MEASURE BY MODEL

49 MEASURES

NOT ENOUGH DATA REPORTED

10 MEASURES

- **WOMEN'S HEALTH** 14
- **DISEASE MANAGEMENT** 11
- **BEHAVIORAL HEALTH** 15
- **PREVENTIVE HEALTH** 9

PREVENTIVE HEALTH

WCC-BMI	AWC	DEV
CIS	W34	W15
IMA-HPV	IMA-Tdap	ABA

PREVENTIVE HEALTH SUMMARY RESULTS

OBJECTIVES

To better understand how different care delivery and payment models in State Medicaid programs perform, HMA conducted an analysis of performance quality measures comparing the three existing models:

- **Managed Care through Managed Care Organizations (MCOs):** Representing managed care health plans contracted with the State for Medicaid and CHIP services.
- **Direct Fee-for-Service (FFS):** Representing members enrolled directly in the State Medicaid program with benefits paid on a fee-for-service basis.
- **Primary Care Case Management (PCCM):** Representing a model of health care delivery that generally requires a Medicaid enrollee to choose a primary care provider (PCP) who is responsible for coordinating the enrollee's care and is paid a monthly fee for doing so, on top of fee-for-service payments for providing medical services.

MEASURE FOCUS AREAS

We focused on 2019 **Child and Adult Core Set Measures** maintained and required by the CMS. These measure sets utilize several Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance (NCQA) and CMS-required specific measures that are publicly reported. The CMS 2019 Child Core Set consists of 26 total measures of which we were able to draw comparisons across the different delivery models for 21, and the Adult Core Set consists of 33 total measures of which we were able to draw comparisons across the different delivery models for 28 (see Appendix A for list of measures and results). We also analyzed the measure sets to compare performance in four domains:

- ***Preventive Health:*** Measures linked to the prevention of a disease such as cancer screening, child well care visits and immunizations
- ***Women's Health:*** Measures related to care for women such as breast cancer screening and prenatal/postpartum care
- ***Disease Management:*** Measures related to managing disease and chronic conditions such as cardiovascular disease and diabetic care
- ***Behavioral Health (BH):*** Measures related to the utilization of mental health and substance use disorder services, such as follow-up after hospitalization for mental illness and BH medication adherence

DATA SOURCES

For our analysis, we used publicly available quality measures from a **Mathematica analysis of MACPro and Form CMS-416** reports for the federal fiscal year (FFY) 2019 reporting cycle. We also used a 2019 analysis from the Kaiser Family Foundation Survey of Medicaid Officials in 50 States that detailed the distribution of Medicaid members attributed to each delivery model in each State. (See Appendix B for table of model distribution by State and additional details of methodology). The FFY 2019 Core Set was the most recent reporting year data available at the time of this analysis. State Core Set reporting for FFY 2019 generally covers care furnished to children and adults in Medicaid and CHIP in calendar year 2018. This data precedes any effects that may have been observed from the COVID-19 pandemic.

https://data.medicaid.gov/browse?category=Quality&limitTo=datasets&sortBy=newest&tags=performance+rates
https://www.medicaid.gov/state-overviews/state-profiles/index.html
Sources: Kaiser Family Foundation Survey of Medicaid Officials in 50 states and DC (https://www.kff.org/medicaid/report/a-view-from-the-states-key-medicaid-policy-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2019-and-2020/) conducted by Health Management Associates, October 2019.
https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2019-core-set-reporting.pdf

METHODS AND CHALLENGES TO DATA NORMALIZATION

- **Mix of models by State:** Virtually all States use some combination of MCOs, FFS, and PCCM, and each State combined the performance rates across models for individual measures. We addressed this by applying relative weights to performance rates based on the portion of Medicaid members enrolled in each model (see Appendix B State Normalization for weights used).
- **Uneven reporting:** Some States excluded specific populations for some measures, so we adjusted the relative weighting to ensure the excluded populations were not counted for those identified measures or States (e.g., a specific State might have 90% MCO and 10% FFS, but FFS was excluded for that measure, so the measure was weighted 100% for MCO).
- **Mix of data reporting/collection methods:** States used either administrative data (primarily claims and encounter data) or a hybrid of administrative data and sample medical record review; these methods varied within States for different performance measures. Because the hybrid approach and administrative approach result in vastly different results (hybrid tends to result in much higher rates), we only compared results coming from the same collection method. Ensuring we had a sufficient sample within each model to draw comparisons, this resulted in most of our measures being compared based on the administrative reporting method.
- **BH carve-outs:** We excluded BH measures in States that carve out BH outpatient services from MCO coverage (including measures abbreviated as ADD, APP, AMM, SSD, FUM and SAA). In analyzing measures for MCOs, we excluded the follow-up after hospitalization (FUH) measures in States that carved out either outpatient or inpatient BH services. We also excluded measures for high dosage opioid use (OHD) and emergency department visits for alcohol and substance abuse with follow-up (ED) in States that carved out outpatient SUD services. See Table B.2 in the Appendix B for further details.

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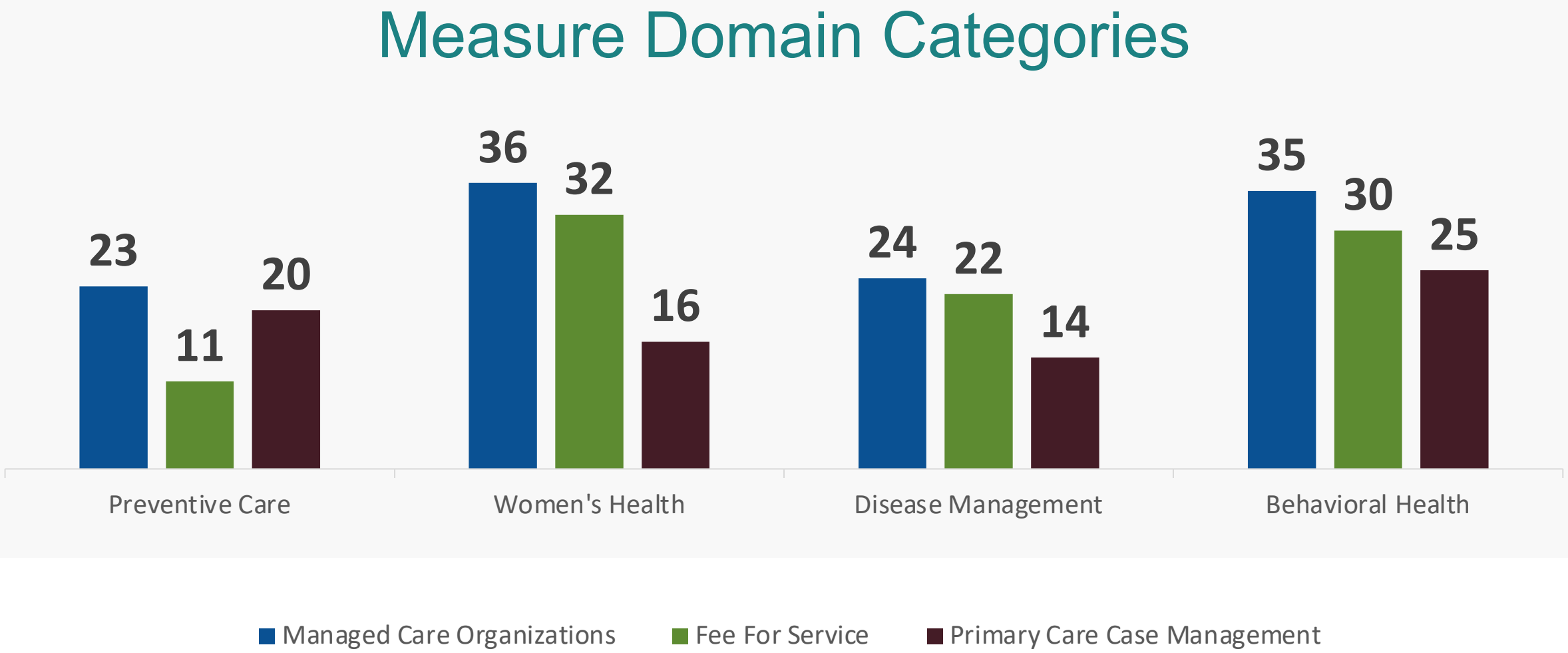
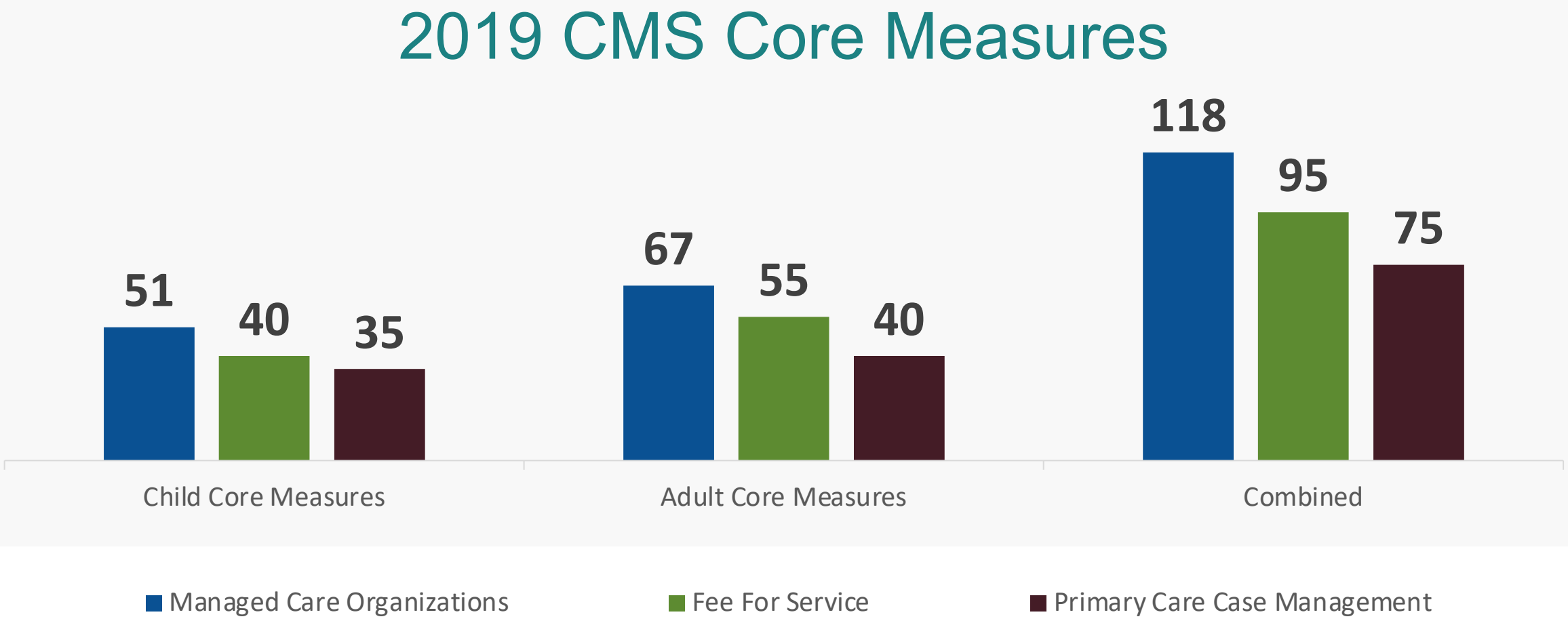
PREVENTIVE HEALTH SUMMARY RESULTS

RESULTS: MCO OUTPERFORMED FFS AND PCCM MODELS IN ALL MEASURE CATEGORIES



RESULTS: MCO OUTPERFORMED FFS AND PCCM MODELS IN BOTH ADULT AND CHILD CORE SET MEASURES



KEY FINDINGS

Medicaid managed care programs with MCOs delivered higher performance on quality indicators when compared to FFS and PCCM in the 2019 Core Dataset

MCOs are incentivized to make significant investments in infrastructure, clinical data capture techniques, value-based contracting arrangements, member and provider incentive programs, population health stratifications and proactive member engagement

Achieving higher quality requires strong alignment and collaboration between state regulators, MCO partners, and providers