



# **Medicaid Reform: Quality and Health Information Exchange**

*A Perspective from the States*

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# Agenda

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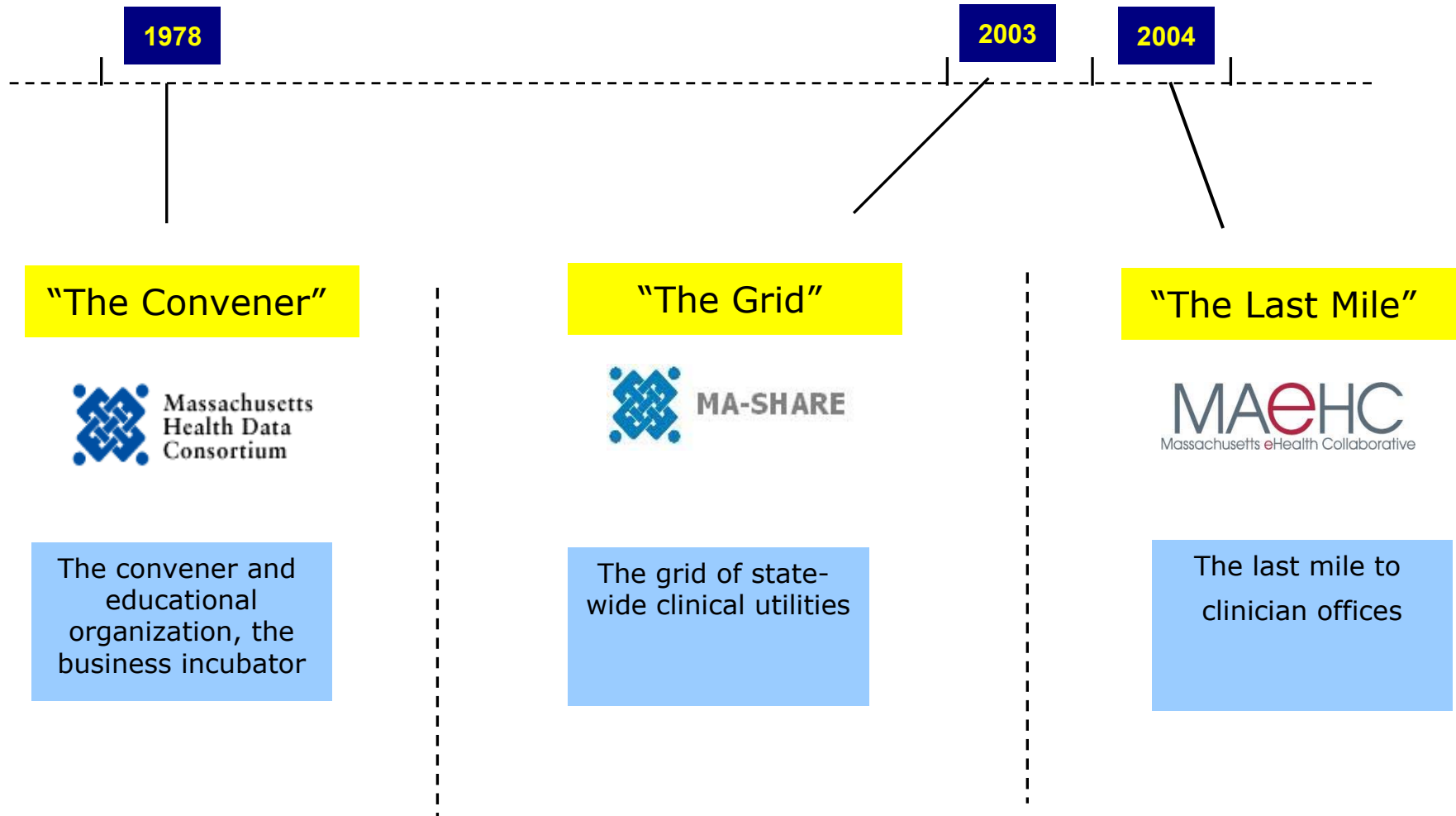
- Overview of HIT and HIE in Massachusetts
- Medicaid's Role to Date
- Health Care Reform and New Opportunities
- Challenges and Potential Roles for Medicaid

# Massachusetts is an active participant in HII and quality initiatives

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- Massachusetts Health Data Consortium (1978)
  - Health information collection, analysis, storage and dissemination
  - HIT education
- Massachusetts Health Quality Partnership (1995)
  - All payer database; quality comparisons at physician level
- MA-SHARE (2003)
  - Statewide infrastructure support for networks and gateways
  - “Google” for records
- Massachusetts e-Health Collaborative (2004)
  - Community “e-health connectivity” pilots (2006-2008) providing practice management systems (EHR and CPOE) to physicians
- Governor Romney’s Health Care Reform Proposal (2005)
  - Transparency of cost and quality information
- EOHHS Health Care Quality and Cost Information Website (2005)
  - Comparative quality and cost information

# Massachusetts community of e-health organizations



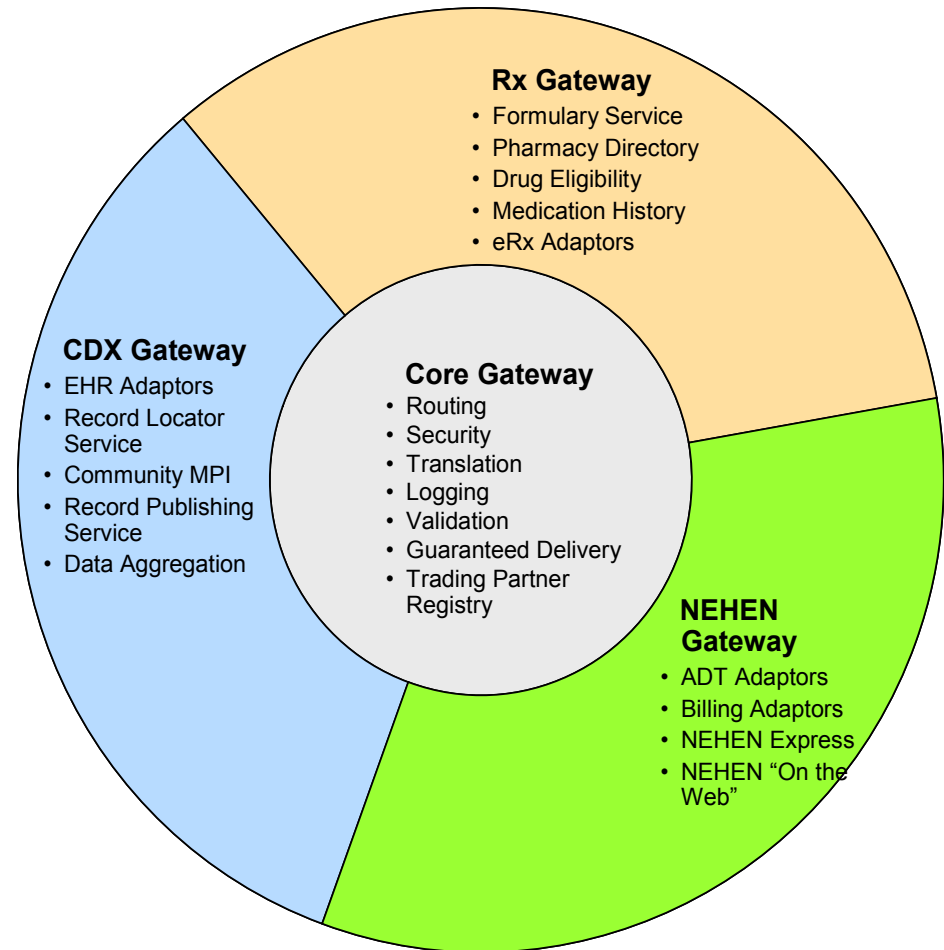
# MA-SHARE health care exchange offerings

## Common

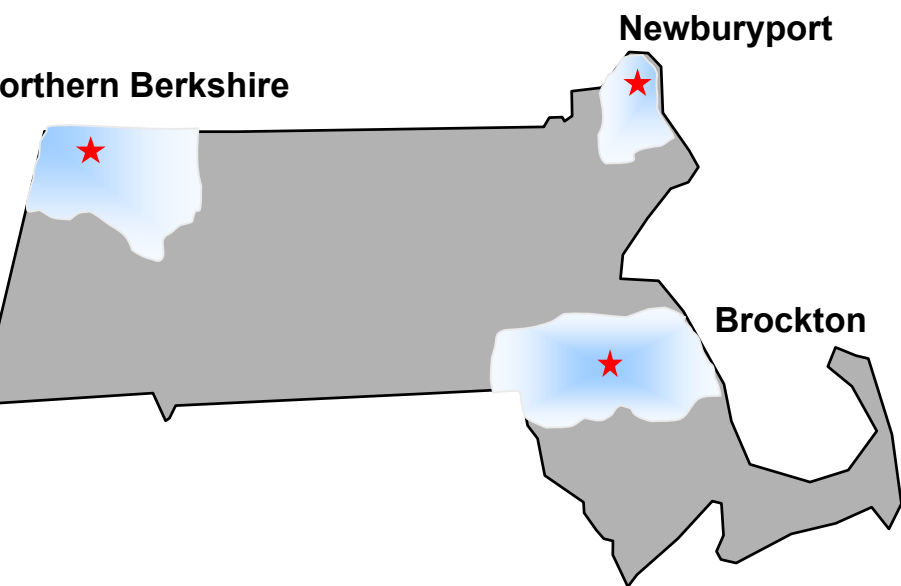
- Routing
- Security
- Translation
- Logging
- Validation
- Guaranteed delivery
- Trading partner registry

## Unique

- Business services
  - eRx: formulary lookup, pharmacy directories, drug eligibility, etc.
  - CDX: record location service, record publishing service, community MPI
  - NEHEN: NEHEN Express, NEHEN "On-the-web"
- System adaptors
  - eRx: clinical systems, stand-alone eRx systems
  - CDX: EHR, EMR systems
  - NEHEN: ADT and billing systems



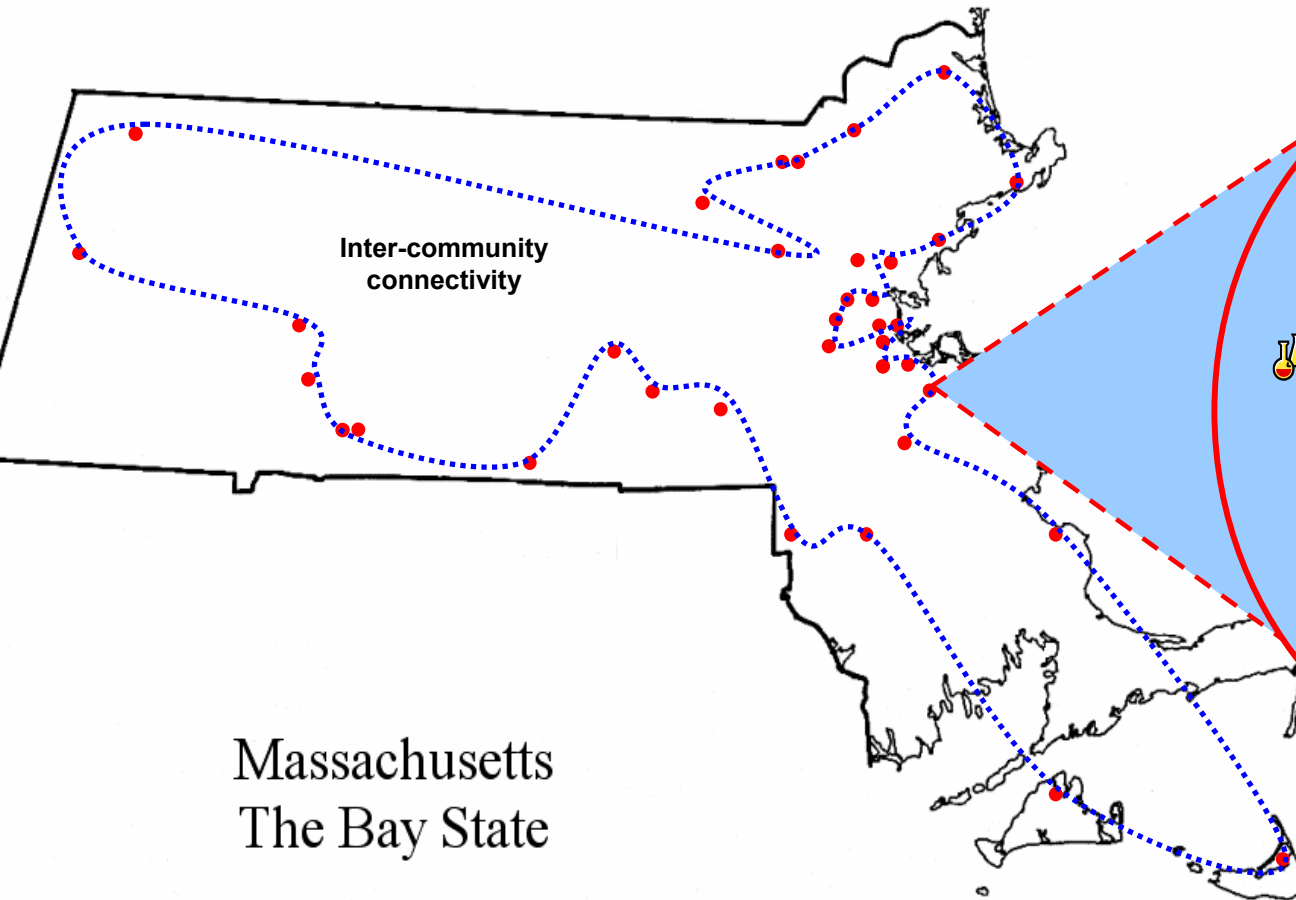
# Massachusetts e-Health Collaborative: three pilot communities strong individually and collectively



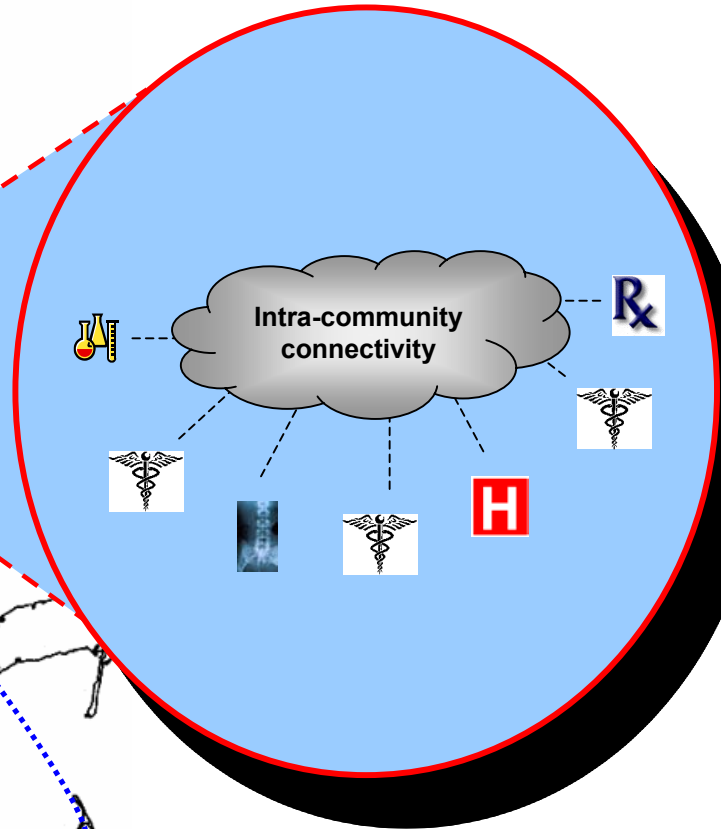
## Pilot Characteristics

- High capture of medical encounters
- Breadth and depth of community cohesion
  - Wide array of ancillary providers
  - Broad & deep physician commitment
  - Strong, dedicated leadership
- Demonstrated commitment to using IT to transform health care delivery
- Represent a diversity of patients, practices, locations, and size
- Platforms for conducting all dimensions of evaluation
- Models to enable state-wide expansion

# The grid and the last mile

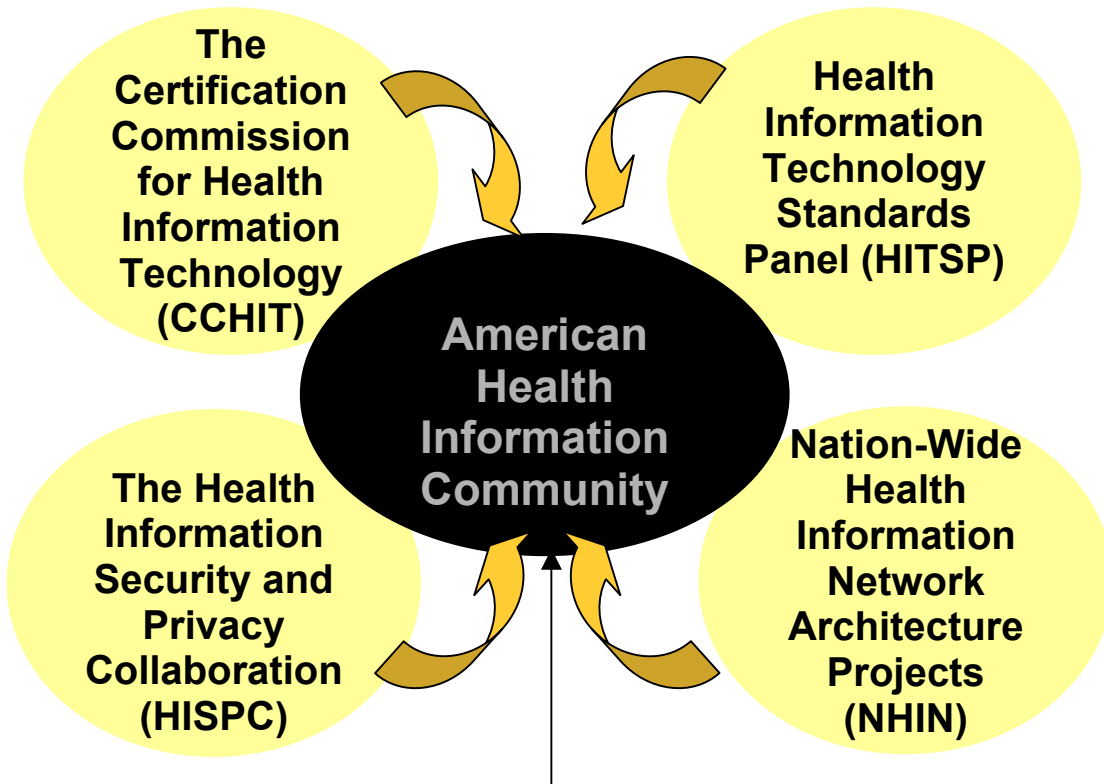


Massachusetts  
The Bay State



# Massachusetts participates in national HIT initiatives

## Overcoming the Barriers



- Chaired by HHS Secretary Leavitt
- Seven federal agency representatives
- Six health industry members
- One IT industry member (Intel)
- One employer (Pepsi)
- One state health department member (IN)

- The AHIC Community serves as hub for identifying breakthrough opportunities
- HISPC is a partnership focused on addressing variations in business policy and state law that affect privacy and security
- NHIN focuses on interoperability pilots starting in 2006
- HITSP bringing together all relevant stakeholders to identify appropriate IT standard
- CCHIT focuses on developing a mechanism for certification of health care IT products



# Medicaid is a relatively new, but important participant

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- Medicaid as a source of patient data
  - Small limited pharmacy pilot with EDs (MedsInfo-ED)
  - Integrated data sets for useful provider level data
- Medicaid as a source of information for consumers
  - HEDIS, CAHPS, quality improvement via contracting
- Senior Care Options (SCO)
  - Automated centralized enrollee records
- Virtual Gateway
  - On-line screening and application for various public programs
- Medicaid is a large payer and can drive reform in the system

# New Opportunities Created by Health Care Reform

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- Chapter 58 of the *Acts of 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care*
  - Health Care Quality and Cost Council
  - Medicaid rate increases tied to Pay-for-Performance
  - \$5M in funding for CPOE
  - Promotion of value driven tiered provider networks, high deductible low cost plans tied to HSAs, coinsurance flexibility
- HIT is necessary to drive consumers to lower cost but equally effective care (similar to px brand to generic push)
- HIT is necessary to address the limited information available to consumers and businesses that would allow for informed quality and cost decisions

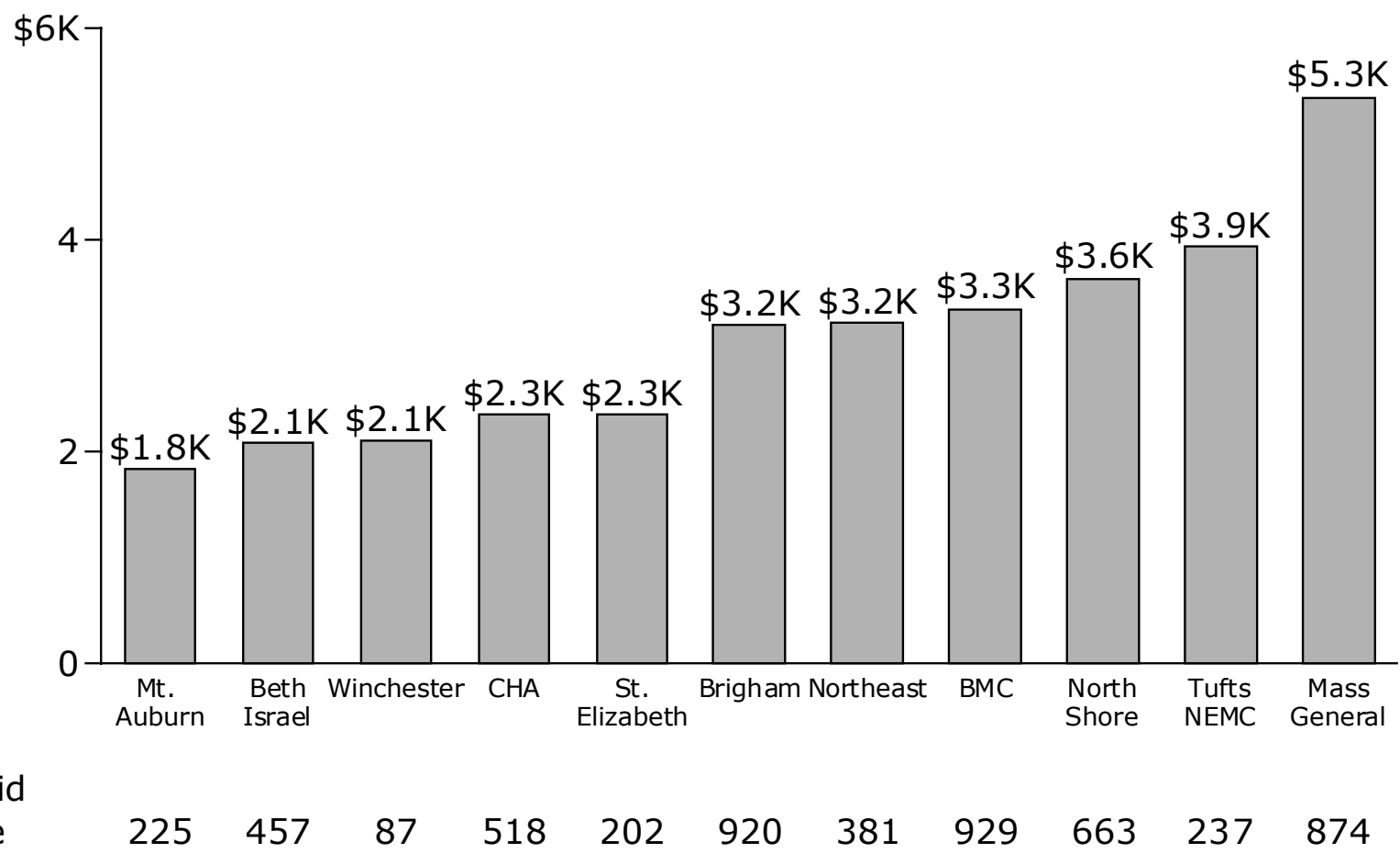
# Health Care Quality and Cost Council

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- **Mission: To set quality improvement and cost containment goals for the Commonwealth**
  - New power to collect cost, price and quality data from health care providers, pharmacies, payers, and insurers
  - More integrated and standardized approach to measure and monitor quality
  - Maintain website for consumers and purchasers
  - Greater transparency and accountability to inform better decision-making by businesses and consumers
- Necessary path to creating the data necessary for real consumer engagement and consumer-directed care
- Council will leverage the recently launched EOHHS Quality and Cost Information Website
  - Nine discharges with cost and quality measures (hip fracture, hip replacement; stroke; gastrointestinal hemorrhage; heart attack, congestive heart failure, coronary artery bypass graft, percutaneous coronary intervention, pneumonia)
  - Obstetric and maternity utilization statistics by hospitals
  - Surgical volume statistics by hospitals in five areas (Bone, Joint and Muscle; Digestive; Gastroenterology; Heart and Circulatory System; Male reproductive System)

# Costs vary by provider - Is the state an efficient buyer of medical services?

## Cost and volume of Maternity - DRG 620 - Slightly Low-Weight Newborn



# “Patient right to know” – CABG example

## Massachusetts Health Care Quality and Cost Information, by Hospital Coronary Artery Bypass Graft Surgery (CABG) Mortality

### Legend

- ★ Mortality significantly higher than state average
- ★★ Mortality as expected
- ★★★ Mortality significantly lower than state average

- \$ Hospitals with lowest 25% of costs
- \$\$ Hospitals in middle 50% of costs
- \$\$\$ Hospitals with highest 25% of costs

Hospital Name	Quality	Cost	Total Cases	Days in Hospital
			4,604	
Hospital A	★★	\$\$	454	7
Hospital B	★★	\$\$	381	8
Hospital C	★★	\$\$\$	623	9
Hospital D	★★	\$\$	296	7
Hospital E	★★	\$	393	7
Hospital F	★★	\$\$	718	9
Hospital G	★★	\$\$	149	10
Hospital H	★★	\$\$	365	7
Hospital I	★★	\$\$\$	191	8
Hospital J	★★	\$\$\$	419	8
Hospital K	★★	\$\$	26	8
Hospital L	★★	\$	80	7
Hospital M	★★	\$	508	9

### Notes:

Cost and Days data from FY02; Quality, Cases, from CY02 Mass-DAC, MDPH

Sources: DHCFP Hospital Discharge Data, DHCFP 403 Hospital Cost Report, Mass-DAC CABG report

For CABG methodology, refer to Mass-DAC report, October, 2004

# Medicaid Pay-for-Performance (P4P)

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- Mandates P4P for the Medicaid program based on newly collected data
  - Quality standards and performance benchmarks developed by Medicaid in consultation with Health Care Quality and Cost Council
  - But...coordination with private payers to ensure rational approach
  - Advance common national framework for quality measurement and reporting
  - Utilization of electronic medical record as a prescribed variable

# Medicaid faces unique challenges...

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- Unique technical, organizational, business, clinical and legal issues
- Medicaid is a different animal
  - Taxpayer dollars
  - Multiple diverse stakeholders (many small providers and “safety net” providers)
  - Medically vulnerable population
  - Complex data
  - Antiquated systems
  - Title XIX limits tools for using data to drive utilization
- Medicaid investment in HIT is difficult to prioritize in good and bad economic times
  - Resources spent on services
- Federal and state rules around data sharing

# ...but can and should play a critical role!

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- Marketplace influence: ability to drive reform in the system
  - One of largest payers in system
    - Significant data source
    - Needs to be involved in policy making and clinical standards setting
  - Significant portion of state budget
  - Primary payer for long term care providers (institutional and HCBS)
  - Can lend credibility and neutrality
  - Can serve as convener of and facilitator for diverse stakeholders
  - Can contract and use incentives creatively
- Use of HIT and HIE data would be beneficial to Medicaid
  - Costs by provider vary considerably
  - Volume is often concentrated in higher cost facilities
  - Ability to coordinate and integrate behavioral health and primary care is important
  - Can benefit substantially from even small administrative and programmatic efficiencies (patient safety, quality, cost reduction)
  - Can use the tools it does have to inform consumers and direct care



# Questions?

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