Medicaid Quality Strategy

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Objectives of Presentation

- Introduce the recently created CMS Medicaid and SCHIP Division of Quality, Evaluations and Health Outcomes
- Answer questions from the last meeting related to DRA
- Introduce the Medicaid Neonatal Outcomes Improvement Project

Driving Forces

- Documented concerns related to health care quality in the US.
- Increasing share of both Federal and State budgets directed toward the financing of Medicaid.
- Exploring options in benefit design and eligible populations alone will not ensure that payors are receiving value for the dollars spent on health care.
- States have an expectation that CMS will help provide leadership in support of Medicaid as national efforts and Alliances are becoming increasingly active and challenges to implementing improvement activities continue to exist .
- Providers and employer groups continually request that CMS join national efforts to reduce duplication in effort and administrative burden.
- Consumers are expected to participate in health care through vehicles such as consumer-directed plans, health savings accounts, and other mechanisms that will require information on cost and quality to make informed decisions.

Price and Quality Transparency.

" The President seeks the commitment of medical providers, insurance companies, and business leaders to help consumers obtain better information on health care prices and quality. The Administration will leverage Federal resources and work with the private sector to develop meaningful measures for health care quality and to emphasize the importance of all-inclusive price information."

Budget of the United States, FY07

Driving Forces

- **Secretary Leavitt's 500 Day Plan/250 Day Update**

Vision

  - Wellness and prevention are sought as rigorously as treatment.
  - Information about the quality and price of health care is widely available and Americans have a sense of ownership about choices for health care and their health.
  - Inequalities in health care are eliminated.
  - Medicare and Medicaid are modernized to provide high-quality health care in a financially sustainable way.
  - Medicare and Medicaid beneficiaries are cost-conscious consumers.
  - Medicare and Medicaid are leaders in the use of advanced technologies and performance measures.

Medicaid Modernization

- DRA provides states with flexibility in establishing benefit plans.
  - Exempt from the benchmark plans unless they choose to opt in.
    - Pregnant women that receive mandatory benefits
    - Blind or disabled individuals
    - Dual eligible individuals
    - Terminally ill hospice patients
    - Children in foster care receiving child welfare services and children receiving foster care or adoption services.

EPSDT and DRA

- Any child under 19 years of age who is covered under the State plan must be provided early and periodic screening, diagnostic, and treatment services either through the plan itself or through wrap around benefits.

Current DRA Activity

- 4 States have filed DRA amendments
  - Kentucky
  - West Virginia
  - Idaho
  - Kansas

- All DRA amendments to date are reviewed by the CMS Central Office and the Regional Office prior to approval.

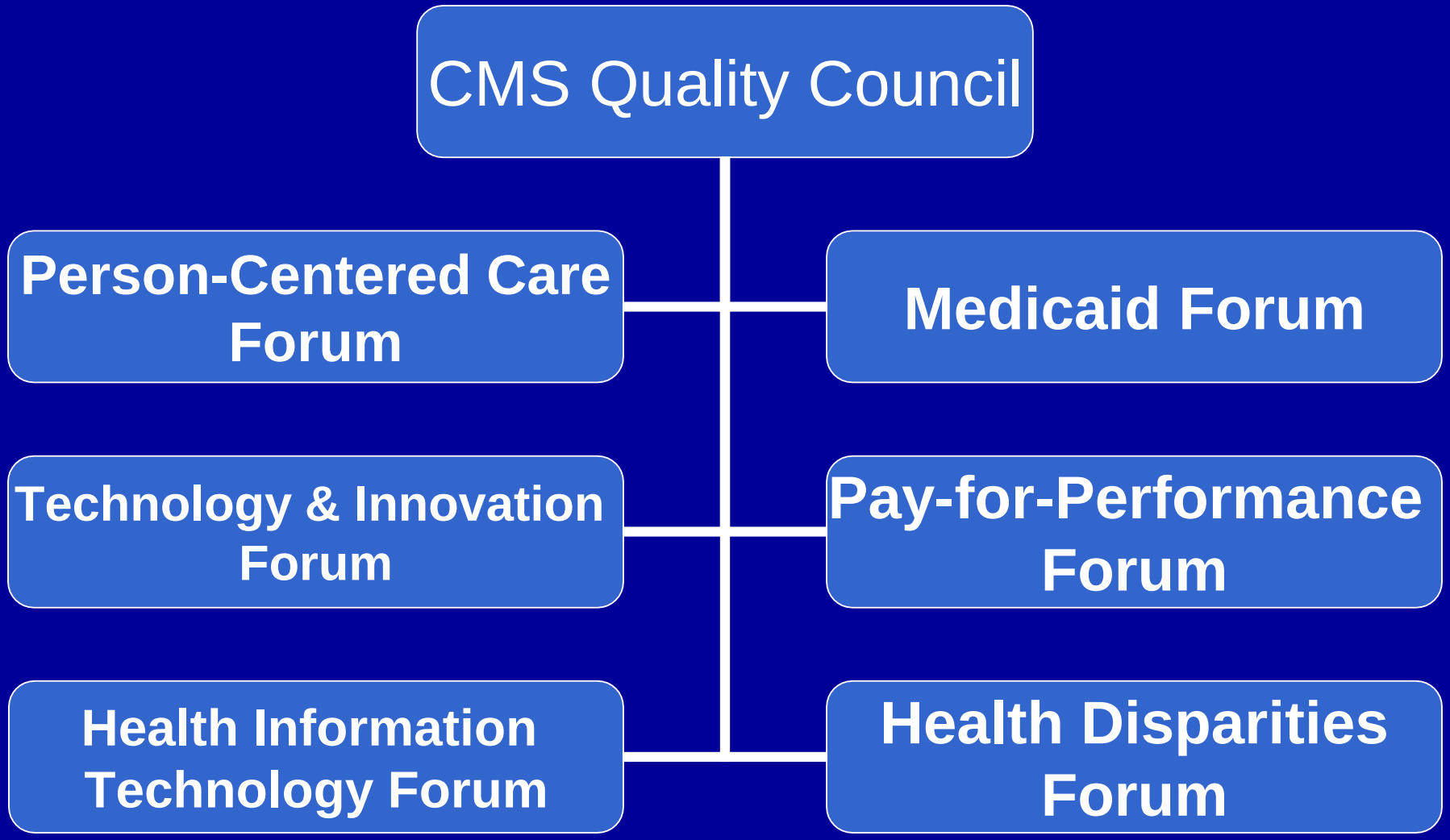
CMS Quality Improvement Roadmap

Released in August 2005

- **Vision: The right care for every person every time**

Aims: Make care safe, effective, efficient, patient-centered, timely; and equitable

CMS Quality Council Forums



Medicaid/SCHIP Quality Strategy

- Created the Division of Quality, Evaluation and Health Outcomes in Spring 2005
- Developed the Medicaid/SCHIP Quality Strategy in August 2005 and revised it in July 2006
- Strategy builds upon the CMS Quality Roadmap and is structured to recognize the unique relationship between the Federal Government and States.
- The pillars of the Medicaid/SCHIP framework are:
  - Evidenced-Based Care and Quality Measurement
  - Supporting Value Based Payment methodologies
  - Health Information Technology
  - Partnerships
  - Information Dissemination and Technical Assistance

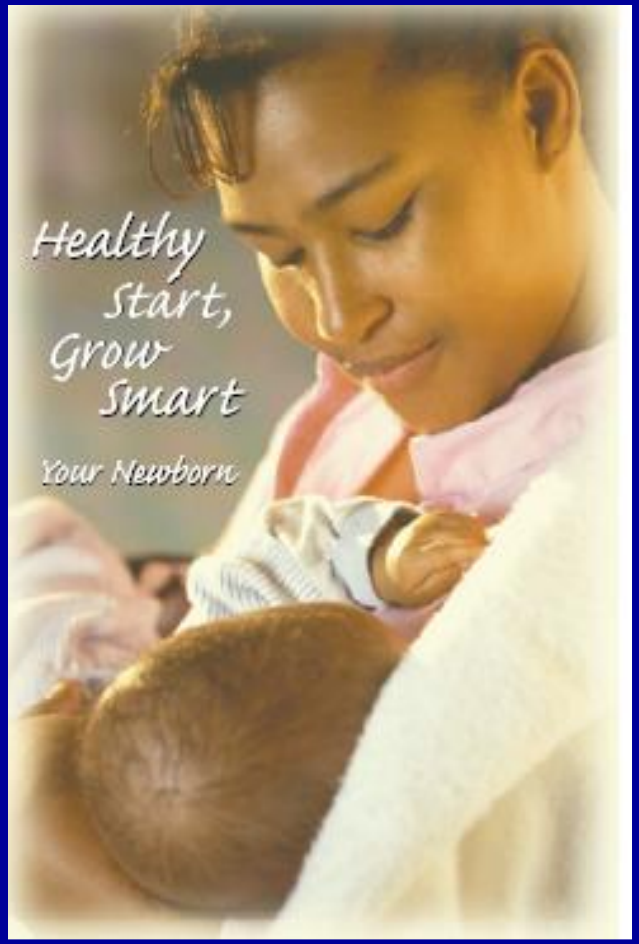
Neonatal Outcomes Improvement Project

- We envision a future in which low birth weight infants survive with high quality of life.
- We wish to join efforts to reduce the disease burden as well as death rate associated with a low birth weight and prematurity.

Prevention First

- Of course it is better to prevent low birth weight deliveries than to intervene once it is imminent.
- Question is where can Medicaid be most effective in the short term.
- These efforts will compliment and provide entrée into other efforts for which CMS is involved that span the life cycle including:
  - Healthy Start Grow Smart Prenatal Brochure
  - Childhood Obesity Steering Committee
  - Smoking Cessation Guidance to States
  - Flexible Benefit Plans designed to address healthy behaviors
  - Health Care disparities efforts such as the NCQA CLAS awards and the CHCS Health Care Disparities Summit

Healthy Start Grow Smart



Coming Soon Health Start, Grow Smart: Prenatal Care

THE PRESENT SITUATION

- Medicaid finances about 40% of annual births in the USA.
- The USA ranks 36th in the world in Infant Mortality. Its rate is about three times that of the nation with the lowest rate.
- Infant Mortality is a disparity of care issue- the rate for African-Americans is about twice the national rate.

Preterm Births

- Preterm Births are the leading cause of Infant Mortality in the USA. According to a new study published in Pediatrics, about 34% of annual infant mortality is due to prematurity.
- This amounts to about 9,000 deaths a year.

Costs of Preterm Births

- In addition to these deaths, prematurity is associated with significant morbidity in the preterm infants who survive.
- According to a recent study published by the Institute of Medicine, the annual cost to the United States of premature births is about 26.2 billion dollars a year. Of that, 16.9 billion dollars are attributable to additional medical costs.

Medicaid Response

- Medicaid pays a significant proportion of these medical costs because it covers the low-income women who are at greatest risk of preterm birth
- Consequently, improving the quality of perinatal care to Medicaid mothers has the potential to not only reduce infant mortality and morbidity, but also to reduce Medicaid costs in the process.

Neonatal Outcomes Improvement Project

- A significant amount of the mortality and morbidity associated with prematurity can be averted by the use of known and proven medical interventions.
- CMS has selected, with the help of national experts on neonatal care, seven interventions that, if used, would significantly reduce the burden of mortality and morbidity associated with premature birth.
- All are already widely accepted as standard medical practice; however, there is variation in implementation.

Neonatal Outcomes Improvement Project

- Preliminary study reveals that interventions have the potential of greatly reducing the risk of death and respiratory distress.
- Cost savings estimates from both AHRQ and CMS indicate the potential for millions of dollars in savings between both State and Federal share.
- A commitment is required to achieve a significant breakthrough in the care of premature infants through implementation of these interventions in appropriate situations.
- Project will move forward as a public and private partnership.

Interventions

The seven interventions are:

- Early identification of mothers at high-risk for prematurity and prenatal transfer of these expectant mothers to facilities with tertiary care NICUs (Neonatal Intensive Care Units).
- Use of antenatal steroids in pregnant women at risk of preterm delivery.
- For those seriously ill premature babies born at facilities without tertiary care NICUs, optimal resuscitation and stabilization of the baby before transfer to the appropriate facility.
- Prophylactic or early administration of the first dose of surfactant to premature infants at risk for Respiratory Distress Syndrome.
- Vitamin A prophylaxis in infants with a birth weight less than 1000 grams to prevent chronic lung disease.
- Proper Infection Control Practices in the NICU and hospital to prevent infection.
- Optimizing NICU discharge planning and follow-up.

Prenatal Transfer

- **Practice timely identification and transfer of pregnant women likely to deliver high-risk newborns, to hospitals with appropriate level neonatal intensive care units (if delivery is not immediately impending).**
- Supporting evidence**:** Several studies have shown that in-utero transfer of babies to tertiary centers with Level III NICU's (i.e., maternal transfer when high risk delivery is anticipated) is associated with lower neonatal morbidity than ex-utero transfer. This recommendation is also endorsed in the Guidelines for Perinatal Care published by the American Academy of Pediatrics and The American College of Obstetricians and Gynecologists.

Antenatal Steroids

- **Practice-** Use of antenatal betamethasone in pregnant women at risk of preterm
- **Outcomes targeted-** Mortality, respiratory distress syndrome, intraventricular hemorrhage in preterm infants.
- **Anticipated effect size on outcome-**Significant reduction in mortality (odds ratio 0.47), respiratory distress syndrome (odds ratio 0.57) and intraventricular hemorrhage (odds ratio 0.27).
- **Comments-**Betamethasone therapy is preferred over dexamethasone.

Stabilization Before Transfer

- **Practice-**Optimal resuscitation and stabilization of high-risk newborns who are born in community hospitals or in other hospitals without Level III neonatal intensive care.
- **Endorsed-** the American Heart Association, the American Academy of Pediatrics and the Guidelines for Perinatal Care.
- **Outcome targeted-**Mortality, neurodevelopmental outcomes.
- **Comments-**Currently approximately 10 – 15% of infants less than 1500 grams are born outside Level III centers and transferred there after birth. Such infants have a higher morbidity and mortality. Inadequate resuscitation and stabilization prior to the arrival of the transport team contributes to worse outcomes.

Early Administration of Surfactant

- **Practice-**early administration of the first dose of surfactant in preterm infants at risk for, or with signs of respiratory distress syndrome.
- **Outcome targeted-**Mortality, pneumothorax, pulmonary interstitial emphysema and the composite outcome of bronchopulmonary dysplasia or death.
- **Anticipated effect size-** Significant reductions in all of the targeted outcomes

Vitamin A Prophylaxis

- **Practice-** Vitamin A prophylaxis in infants with a birth weight less than 1000 grams to prevent chronic lung disease.

- **Outcome targeted-**Chronic lung disease

- **Anticipated effect size on outcome-** Supplementation with vitamin A reduces death or oxygen requirement at one month of age and oxygen requirement at 36 weeks.

Infection Control Practices

- **Practice-**Infection control practices to prevent catheter-related bloodstream infections and other nosocomial infections. Use of CDC Guidelines
- **Outcome targeted-**Nosocomial infection, mainly catheter-related bloodstream infection
- **Anticipated effect size on outcome-**

  33 % - 100% decrease in the rate of nosocomial infections

Optimizing NICU Discharge Planning

- **Practice-**Optimizing NICU discharge planning and post-discharge comprehensive follow-up of high-risk NICU graduates, with home nursing visits after discharge, easy access to clinic visits for acute illness, 24 hour availability of providers for acute complaints, provision of transport to the emergency room for acute illness, liaison with ER staff by primary care providers, and telephone support following ER visit.

- **Outcome targeted-**Life-threatening illnesses (ie, causing death or hospital admission for pediatric intensive care) occurring between nursery discharge and age 1 year; and hospital costs

- .**Anticipated effect size on outcome-**Comprehensive care resulted in 48% fewer life-threatening illnesses, 57% fewer intensive care admissions, and 42% fewer intensive care days.

Status of Project

- CMS is launching a pilot project which will involve the National Initiative for Children's Healthcare Quality (NICHQ) and four State Medicaid Agencies in a voluntary effort to improve outcomes of neonatal care of premature infants over the next few years.

- Currently, about fifteen states have expressed preliminary interest in partnering with us on this project. Participating states would agree to encourage use of one or more of the seven interventions in their Medicaid Programs.

- We anticipate sending out invitations in January to a national stakeholders/experts meeting sometime before March 31, 2007. Selected states will receive professional and some financial help in implementing the Project.

Vision

- Our vision is that low birth weight infants will survive with high quality of life. We wish to reduce the disease burden (e.g. chronic lung disease, intraventricular hemorrhage, retinopathy, infections and other complications) as well as the death rate associated with low birth weight.
- These goals can be accomplished by formation and successful implementation of statewide quality collaboratives dedicated to increasing the use of evidence based approaches.

The Right Care for Every Person Every Time