Coordinated Care Improvement Group Meeting Minutes
October 13, 2011

Present:

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Francis Middleton
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DHHS Director Tony Keck welcomed the group, and introductions were made. Mr. Keck spoke about the purpose of the group, saying that as the coordinated care environment in South Carolina matures, we must ask if the system is producing the results we want. Have we defined where we want to be, and how do we get there?

Two reports required by budget proviso provide a good starting point in answering these questions. These two reports, required by Proviso 21.33 of the SFY 2012 Appropriations Act, are the USC HEDIS report and the Milliman Cost Effectiveness report. This group will be looking at the issues brought up in these reports – and other issues related to coordinated care – and developing recommendations for South Carolina. This will be an open, public series of meetings, in an effort to get all questions on the table.

Rob Damler of Milliman then presented the Cost Effectiveness Analysis, leading the group through the actuary's findings regarding South Carolina coordinated care. This analysis examined the cost effectiveness of the different coordinated care programs versus fee-for-service from April 2010 through March 2011. Mr. Damler described the various assumptions and methodologies applied to the analysis, to ensure a normalized, actuarially sound report.

Milliman found that for the TANF children, TANF adults, and SSI populations, in sum, Medicaid managed care organizations save 7% versus fee-for-service, while medical home networks save 6%. Fee-for-service carries the highest risk in the SSI and TANF children populations, while MHNs carry the highest risk in the TANF adult population.

The group discussed Milliman's methodology and assumptions, discussing the capture and calculation of various cost components related to the report. Items discussed include MHN shared savings, hospital cost settlements, and pharmacy management by the plans. The group offered some issues for follow up, including the drivers of the differences in cost among plans and what role providers, claim issues, utilization and unit cost play in these measurements.

Following Mr. Damler's presentation, Mr. Keck noted there is statistically no difference among plan types in the total cost. Some data shows that the capitated arrangement manages medical cost more, yet with a higher administrative rate while the MHN model may not manage medical costs as much but has a lower administrative cost. A question to consider then is which medical cost number is desired.

Mr. Damler noted that during the enrollment choice period people with higher morbidity are choosing the MHNs, thus making MHNs the avenue for coordinated care for this population. The reason for this is not understood. South Carolina is one of a few states operating a dual coordinated care system, and most states have gone to a full risk-based model, he said.

Mr. Keck said that this group and these issues being discussed represent the effort for continuous quality improvement. Answering these questions will help South Carolina dig down to find the "hidden costs" in the system, which is important.

Dr. Ana Lopez-DeFede spoke next, presenting the Medicaid Health Care Performance Report compiled by the USC Institute for Families in Society. She first described the process, assumptions, limitations, data sources, and methodology of this report, indicating that the key to measuring quality is creating an "apples to apples" environment. The Medicaid Health Care Performance Report measured HEDIS measurements across six domains: pediatric care, women's care, living with illness, behavioral health, access to care, and consumer experience with care. Dr. Lopez-DeFede noted that going forward, USC will be applying case mix adjustments to the HEDIS measures being tracked for Medicaid.

In summary, the Medicaid Health Care Performance Report found that managed care plans performed well overall compared to fee-for-service in quality measurements. These results will be measured against other state Medicaid plans. Among 43 HEDIS rates, in South Carolina 20 of them fell below the 25th percentile vs. national NCQA Medicaid benchmarks. These 20 fell below the lowest value in the benchmark range. Only two rates scored above the 90th percentile. This data was compiled for fee-for-service, MCOs, and MHNs.

Moving on to plan report cards, Dr. Lopez-DeFede led the group through the findings regarding the six domains that were measured. She described how each domain was identified, and how elements comprising the domain were measured, including the geographical variances found within South Carolina. For most of the domains, the variation among plans was noted, as was the progress being made and the room to improve.

The group discussed the areas of strength, the areas appearing to require attention, the possible reasons for specific results or disparity between plans, and considerations related to the capture and reporting of certain data in this report. The group also examined the state aggregate findings for all the measures across the domains. It was noted that coordinated efforts among stakeholders to address a particular health outcome or care delivery issue produce results. A CHIPRA pediatric coordinated care effort currently underway at DHHS was offered as an example of this dynamic.

Closing her presentation, Dr. Lopez-DeFede said there is variance across the plans, and across the health system. She also said that health care quality can be measured and can be improved. Measuring quality is an evolving science that must engage the public and providers to strengthen the reporting capacity required. Data on the patient experience is also essential.

Mr. Keck again told Coordinated Care Improvement Group that their work will be received from the process improvement perspective. The array of questions to consider can be as specific as an operational issue to broad queries like, "how many plans does South Carolina need?" Mr. Keck encouraged the group to submit issues or questions they would like explored or answered, and DHHS will coordinate responses. He challenged the group to help South Carolina rise above average in terms of quality. He cited Commonwealth Fund and AHRQ data showing that the state has an effective health care system. South Carolina can produce, he said, when we focus on issues. Quality should be such an issue.

In considering the probable Medicaid expansion under any Affordable Care Act eventuality, the state needs to consider how it can build the system to produce quality, as Medicaid experiences 50% growth to nearly 1.5 million South Carolinians. The state must determine what results it values, and build a sustainable system to produce those results. Fortunately, South Carolina has rich data resources, he said.

Discussion followed about how the state does indeed perform when stakeholders collaborate. Engaging and rewarding front-line providers will be a key requirement, as will be holding them accountable. The group also discussed the various health needs the adults will bring who become newly enrolled under health care reform, and how the state needs to prepare for that. The group may need to also consider issues beyond Medicaid – issues related to the regulatory and legislative environments in the state that affect the health care system.

Closing comments included discussion about how coordinated care clearly seems to provide cost savings to the state; however the quality variance among plans is something to study more. Discussion followed about how the state does indeed perform when stakeholders collaborate. In other areas, collaboration has brought results for South Carolina, and that this effort for coordinated care – bringing the stakeholders together - could do the same. Other comments were made about engaging and rewarding front-line providers and holding them accountable – since they are the key to change. The group also discussed the various health needs the adults will bring who become newly enrolled under health care reform, and how the state needs to prepare for that. There was talk about the role of hospitals in pursuing cost reduction, and the fact that clinicians are best suited to lead that effort. Setting goals and incentives to lead clinicians toward desired outcomes is a strategy to consider. Some said the group may need to also consider issues beyond Medicaid – issues related to the regulatory and legislative environments in the state that affect the health care system.

The group was encouraged to take all the information from this meeting back to stakeholders, and begin thinking of other issues and questions to address going forward.

21.33. (DHHS: Medicaid Cost and Quality Effectiveness) The Department of Health and Human Services shall establish a procedure to assess the various forms of managed care (Health Maintenance Organizations and Medical Home Networks, and any other forms authorized by the department) to measure cost effectiveness and quality. These measures must be compiled on an annual basis. The Healthcare Effectiveness Data and Information Set (HEDIS) shall be utilized for quality measurement and must be performed by an independent third party according to HEDIS guidelines. Cost effectiveness shall be determined in an actuarially sound manner and data must be aggregated in a manner to be determined by a third party in order to adequately compare cost effectiveness of the different managed care programs versus Medicaid fee-for-service. The methodology must use appropriate case-mix and actuarial adjustments that allow cost comparison of managed care organizations, medical home networks, and fee-for-service. The department shall issue annual healthcare report cards for each participating Medicaid managed care plan and Medical Home Network operating in South Carolina and the Medicaid fee-for-service program. The report card measures shall be developed by the department and the report card shall be formatted in a clear, concise manner in order to be easily understood by Medicaid beneficiaries. The results of the cost effectiveness calculations, quality measures and the report cards shall be made public on the department's website no later than ninety days after the end of each fiscal year.