

The Business Case for Quality in Medicaid – Still Searching for the “Slam Dunk”

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The *Business Case for Quality: Phase II (BCQ II)*, an initiative that ran from 2008-2011, represented the second in a two-part series of efforts by the Center for Health Care Strategies (CHCS) to assess whether interventions targeting Medicaid populations could demonstrate both improved quality and cost-savings. These initiatives were launched at a time when the promise of the Triple Aim was not as widely accepted as being within reach as it is today; at a time when cost and quality were commonly perceived as countervailing forces in our health care system.

With the launch of the first BCQ initiative in 2004, through the completion of Phase II in 2011, CHCS sought to demonstrate if, where, and how quality improvement and cost savings could be simultaneously achieved in Medicaid. The hope was that by rigorously demonstrating that quality improvement made good business sense for payors, we could encourage the spread of effective interventions, thereby improving health outcomes and controlling expenditure growth in public programs. And, if we could identify misalignments between where investments to improve quality needed to be made and where savings were likely to be captured, we could create opportunities to better align payment models with desired outcomes. While these efforts began almost a decade ago, their goals are highly aligned with current efforts to reform care delivery and payment systems in our post ACA-world.

Program Origins

The impetus for the original BCQ demonstration came from a 2003 *Health Affairs* article by Sheila Leatherman, Don Berwick, and colleagues, that questioned the existence of a business case for improving health care quality.¹ Noting the absence of Medicaid among the case studies in the article, CHCS recognized that Medicaid managed care offered significant opportunities for testing the business case for quality, based on the high prevalence of chronic illness among eligible populations and the powerful financial incentives provided by capitation arrangements.² In response, CHCS partnered with researchers at the University of North Carolina at Chapel Hill to conduct the

IN BRIEF

The *Business Case for Quality* was a two-part initiative designed by the Center for Health Care Strategies to evaluate the potential for chronic care management interventions to improve quality and reduce costs for high-need Medicaid populations. The rigorous demonstration and evaluation, made possible by the Robert Wood Johnson Foundation and The Commonwealth Fund, was conducted to shed light on whether investments in quality are financially sustainable across all levels of the health care system. The study design sought to measure who wins and who loses financially from these investments and pave the way for reforms that remove disincentives to quality from current payment systems. Although Phase II results did not demonstrate a positive return on investment, there are key lessons worth considering for Medicaid stakeholders in designing care management programs and other payment and delivery system reforms. This brief summarizes key findings; the evaluation conducted by Mathematica Policy Research is available at www.chcs.org.

BCQ demonstration and evaluation, with funding support provided by the Robert Wood Johnson Foundation and The Commonwealth Fund.

Among 10 projects included in the original demonstration, four demonstrated positive returns on investment (ROI). Based on these results, the following two interrelated factors were identified as critical to achieving cost-savings: (1) interventions must focus on populations expected to be high-cost in the future; and (2) target populations should have chronic conditions associated with high rates of avoidable acute care expenditure.

Goals for Phase II

CHCS' interest in building upon these original findings and addressing a number of limitations of the original demonstration led us to launch *BCQ II* in 2008. Specifically, *BCQ II* was designed to deliver “slam dunk” results through its: (1) focus on high-risk childhood asthma, for which prior research indicated high rates of avoidable acute care utilization; (2) rigorous approach to measuring cost-savings, to control for factors such as regression to the

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mean; (3) measurement of clinical quality as well as cost, to ensure that quality was indeed improving; and (4) business case analyses for multiple-stakeholders, to identify potential financing misalignments that impede investments in quality.

Three grantees were competitively chosen to participate in this four-year initiative, including: Alameda Alliance for Health (Oakland, CA); Cincinnati Children’s Hospital Medical Center; and Monroe Plan for Medical Care (Rochester, NY).

Phase II Findings

So, what did we learn? As detailed in an independent evaluation by Mathematica Policy Research, we learned a great deal – although not necessarily what we expected. Of the three projects included in BCQ II, none achieved the sought-after “slam dunk” results indicating a positive ROI – although all demonstrated improvements in quality of care. This was despite the fact that the project incorporated the key lessons from the original demonstration, and allowed a relatively long timeframe for achieving results. However, important lessons can still be drawn from the results, as summarized below:

1. **Engagement of front-line providers is critical, and takes time.** With BCQ II, we devoted a year of the project timeline to planning and ramp-up activities, followed by a (relatively long) three-year intervention period. Even still, as detailed in the accompanying evaluation reports, it took longer than expected to build clinician buy-in for these projects. As we know, the rubber meets the road at the point of care, and these days, there are many competing priorities for providers’ time – even for those with a commitment to continuous quality improvement. With coverage expansion looming, the demands on our generally under-resourced Medicaid providers will

only grow – and our expectations of all they will be able to deliver in this context may benefit from some greater modesty. We might think more, for example, about the provider supports (and associated funding) that would facilitate efforts like those pursued under this project.

2. **Engagement of patients is equally critical, and can take even more time.** Our aspirations for improved management of chronic conditions, and resulting improvements in quality and cost outcomes, rely on the willingness of individual patients and their families to engage with providers in new ways. By nature of their Medicaid eligibility, these individuals tend to have many complex and competing needs – only some of which pertain to health care – which can make engagement particularly challenging. Although there is great work being done across the country to improve approaches to consumer engagement, including the use of motivational interviewing and other promising techniques, a key area for continued research is improved ability to identify the subset of individuals who would be most amenable to, and most likely to have positive outcomes through intervention. Otherwise, we risk overestimating the number of individuals who will benefit from the improved models of care delivery that we are so actively pursuing.
3. **We still have much to learn about the interventions themselves.** When providers and patients are engaged, we have real opportunity for impacting quality and cost – assuming the interventions employed are effective. BCQ II aimed to implement evidence-based interventions across its three project sites; however, the results came up short. For example, in New York, the Monroe Plan for Medical Care

successfully engaged primary care providers to improve adherence to treatment guidelines for managing pediatric asthma. As a result, adherence to guidelines increased significantly across an array of treatment recommendations. However, this did not translate to reductions in emergency department visits or hospital admissions for the children seen by these providers. So, the question must be asked – are we using the right guidelines? Is there a sufficient link between the processes of care that we increasingly hold providers of care accountable for delivering and the quality and cost outcomes we seek?

4. **Methodology matters, particularly when there is money on the line.** Not all cost-savings estimates are created equal. A number of our *BCQ II* project partners conducted internal analyses that paralleled our rigorous independent evaluation, and frequently came up with results suggesting greater impacts than those identified in the independent evaluation. In some cases the difference can be explained by the absence of comparison groups among the internal analyses, which can lead to attributing as an impact what is actually regression to the mean or some other external trend. Alternatively, the use of flawed comparison groups could lead to similarly imperfect conclusions, and in unpredictable directions. As shared savings models proliferate through accountable care organizations and other payment reform initiatives, we need to be mindful of the constraints of the methodologies employed. When cost-savings estimates translate into

financial transactions, the stakes become much greater for all involved.

Looking Ahead

Surely, there were things that could have been done in planning and implementing *BCQ II* that may have increased the likelihood of delivering more robust impacts on both cost and quality. And, with equal certainty, many Medicaid beneficiaries and their families received better care as a result of this initiative. In fact, two of the three *BCQ II* grantees have opted to continue their initiatives despite the evaluation findings, given their commitment to providing high-quality care, and their belief that that these models can be financially sustained.

To be sure, we are still believers in the explicit linkage between quality and cost that is intrinsic to the Triple Aim, and are actively working with states across the country on a broad range of reforms that share this common goal. However, the experience of *BCQ II* is an important reminder of the magnitude of the challenges that we are trying to tackle, and the complexity of the systems are that we are trying to change. These lessons are humbling but important – particularly if we are going to expect greater successes in current and future iterations of these and related efforts to improve quality and control costs.

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For More Information

Visit www.chcs.org for more information about BCQ II, including the final evaluation report by Mathematica Policy Research and case studies for each of the participating programs.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

Endnotes

¹ S. Leatherman, D. Berwick, et al. "The Business Case for Quality: Case Studies and an Analysis." *Health Affairs*, 2003, 22(2):17-30.

² See Letter to the Editor from Stephen A. Somers in *Health Affairs*, 2003, 22(4):260.