Access and Value: Issues for Medicaid and CHIP as Purchasers

This introduction describes the role of Medicaid and the State Children's Health Insurance Program (CHIP) as purchasers and highlights the importance of access measures as a tool for monitoring and improving program performance. Medicaid is among the nation's largest purchasers of health care, spending $432 billion in fiscal year 2011 on health care and long-term services and supports (LTSS) for 70 million enrollees. In the same year, CHIP made expenditures of nearly $12 billion on behalf of 8 million children. Medicaid accounted for roughly 16 percent of the nation's health care spending in 2010, making the program an important purchaser and positioning Medicaid to be an important contributor to ongoing efforts to improve the quality of health care service delivery, access to care and outcomes of care, and approaches to paying for health care. The opportunities for Medicaid are perhaps greatest where the program is a major purchaser, including, for example, LTSS, behavioral health care, and pediatric and obstetric care.

Medicaid enrollees are an especially diverse group—including low-income children and adults, pregnant women, persons with life-long disabilities, and seniors—some who are relatively healthy and others who have a high need for acute care and LTSS. Medicaid plays a critical role for its enrollees, helping to assure access to health care for millions of people who would otherwise remain uninsured or underinsured. It also plays a significant role in the health care system, improving population health and shoring up providers and other payers by covering some of the nation's highest-need and highest-cost individuals.

As large purchasers—accountable for the efficient use of public resources and facing resource constraints—Medicaid and CHIP should seek to improve program performance in order to achieve better care and better outcomes, while at the same time promoting economy and efficiency. Like all purchasers, Medicaid and CHIP seek to determine whether the basic requirement of providing access to necessary, efficient, and effective services is being met, and work to ensure that enrollees are receiving appropriate services at the right time and in the right setting. Meeting these goals for Medicaid may help improve quality, lower costs, and achieve better value—the objective of any purchasing strategy.

The sections that follow this introduction present information on data for monitoring access (Section A), and report findings on access to care for adults in Medicaid (Section B). These sections begin to identify data sources and monitoring approaches that can be used to examine the implications of changes in health care delivery and in

the market for health care services on Medicaid and CHIP—a core part of the Commission's statutory charge.

Medicaid and CHIP as Purchasers

Medicaid is a major purchaser of health services, and may be an especially important payer in given markets—notably pediatric services, obstetric services, behavioral health care, and LTSS. In 2011, for example, Medicaid and CHIP provided coverage, at some time during the year, to 40 million children—roughly half of the U.S. child population (MACPAC 2012). In 2009, Medicaid financed 48 percent of the nation's spending on LTSS (MACPAC 2011). Medicaid's role as a key health care purchaser will be enhanced over the coming years as current law provisions take effect.

Many state Medicaid and CHIP programs have joined other purchasers in working toward a health care system that delivers higher-value health care. This may include creating more integrated delivery systems and payments aligned with value so that purchasers use their leverage in the market to acquire timely, effective, appropriate, and high-quality services that result in the best outcomes possible.

Innovations in Purchasing

State Medicaid and CHIP agencies, other purchasers, and providers are working to design service delivery and payment innovations that support the goals of purchasing cost-effective, quality care (Wilensky 2011). To achieve their goals, payers are increasingly assigning accountability for outcomes to defined parties and seeking ways to reward those parties for efficiency and quality.

Payment approaches that seek to reward quality are one tool that Medicaid agencies use in their purchasing strategies. States have a long history of undertaking efforts to improve service delivery systems to achieve better access to care, better quality of care, better outcomes of care for people enrolled in Medicaid, and better public health. Some of these efforts are also designed to lower program spending or slow the rate of growth of program spending. States have sought to reorient service delivery to focus on improved coordination of services, more timely access to primary and preventive care, and better home- and community-based supports for people with disabilities and the frail elderly.

States have considerable flexibility within Medicaid to pursue these goals, including flexibility in payment approaches and benefit design. In addition, states have some other unique tools at their disposal, such as scope-of-practice laws and certificate-of-need programs.

Purchasers and providers are also reorganizing primary care and chronic disease care with an emphasis on coordination and outcomes. Their hope is to achieve patient-centered care that integrates the full range of acute and supportive services while also lowering costs. In some cases, state Medicaid and CHIP programs have been at the forefront of such innovations, including:

- **comprehensive, risk-based managed care** that seeks to improve access and quality while moderating costs;
- **patient-centered medical homes** that seek to redesign care delivery with a focus on continuity of care, prompt access, and care delivered and coordinated by teams;
- **primary care case management programs** that actively promote the coordination of services over time and across settings;
- **innovative payment approaches** that reward providers who reduce costs while meeting quality standards;

- **bundled payments for episodes of care** that seek to reduce cost shifting and improve the integration and coordination of care; and
- **global payments to accountable care organizations** to increase care coordination and program availability (Bacharach 2010a, 2010b).

All of these approaches share the common objective of paying for access, efficiency, quality, and outcomes. These innovations are paired with efforts to collect better information—on the characteristics of patients and on the quality, cost, and outcomes of their care—to better evaluate how care teams, delivery systems, and payment incentives are working to improve care and lower costs.

States have opportunities to develop innovative payment and delivery models, especially where Medicaid is an important payer. In other areas, where program payments account for a smaller share of total expenditures, such as inpatient hospital services, Medicaid may need to be aligned with other private and public payers to test approaches that may improve quality and lower costs. New models are testing the feasibility of implementing these cross-payer initiatives (Cavanaugh 2012).

Improving Program Performance and Accountability

In Medicaid, determining whether access to care needs to be improved—and how much, for which populations, for what services, in what delivery systems, and under what payment approaches—will help shape performance improvement. To monitor and improve the performance of Medicaid, however, access must be considered in the context of cost, quality, and value.

Access

As purchasers, state Medicaid programs are fundamentally concerned with access to care—and, more precisely, with assuring that the supply of high-quality providers is sufficient for enrollees to receive needed services in a timely fashion. The goal of any purchasing strategy, however, is not to facilitate any and all access, but rather to provide efficient and effective access that assures that patients get the right care at the right time in the right setting.

The Commission has developed a framework for assessing access to care that defines access in terms of enrollee characteristics, provider availability, service utilization, the appropriateness and efficiency of care, and ultimately the outcomes of health care service use (MACPAC 2011). The framework acknowledges that access to care for Medicaid enrollees depends on many factors, including both policy choices in Medicaid (such as payment policies, provider enrollment practices, and education and outreach strategies) and factors that may not be easily influenced by Medicaid alone (such as provider supply and the structure of local health care delivery systems).

Data Sources for Monitoring Access to Care in Medicaid and CHIP. Section A of this Report explores some of the data and information that can be used to monitor access. The Commission has defined a number of principles for developing an effective and efficient access monitoring system that, for example, allows for timely proactive and reactive monitoring and provides a meaningful mechanism for beneficiary feedback and information sharing. An access monitoring system should reliably detect emerging issues in the short term and over a longer time horizon. It should draw on a wide variety of data sources and approaches and should inform program improvement on an ongoing basis.

States have developed data-collection and monitoring efforts to detect access problems as part of their performance-monitoring and improvement efforts. A recent proposed federal rule provides additional guidance and options for states to improve access-monitoring approaches, including beneficiary feedback mechanisms (CMS 2011). These state and federal initiatives are based on an understanding that complete and timely assessments of enrollees' access to appropriate care—across types of services, delivery models, and geographic areas, and for distinct enrollee populations—are needed to evaluate the impact of service and payment innovations and, ultimately, to judge the success of Medicaid's purchasing strategies.

Approaches to evaluating access to care in Medicaid need to consider the health needs and characteristics of the people served by the program, the service delivery models within which they receive care (fee-for-service, risk-based managed care, or other models), and the characteristics of local health care markets, among other factors. Health care service utilization and access can be expected to vary, for example, by age, health status, number and severity of chronic conditions, race and ethnicity, the presence of functional limitations, and other beneficiary characteristics.

The Commission's work to date has examined access for children (MACPAC 2012) and non-elderly adults in Medicaid (this Report). In addition, the Commission's March 2012 Report to the Congress highlighted the critical role that Medicaid plays for 9.1 million non-elderly persons with disabilities—the fastest growing eligibility group in Medicaid over the past three decades. This same Report recommended the development of innovative service delivery models, such as efforts to improve the coordination of Medicaid-financed services, that may improve the quality and lower the cost of care for persons with disabilities who have Medicaid as their only source of coverage. The Commission also noted the challenges of measuring the quality of care provided to persons with disabilities and described evolving approaches to quality measurement. The Commission made recommendations for more specific, robust, and relevant measures for this population.

Future MACPAC analyses will examine access to care and quality of care for people with disabilities and other important high-need, high-cost subpopulations such as: people who need LTSS, including older, frail adults and younger persons with physical or cognitive disabilities; women with high-risk pregnancies and births; and premature or otherwise at-risk infants and children with special needs.

Access to Care for Non-elderly Adults. Section B of this Report examines access to care for non-elderly adults in Medicaid. The analyses in Section B show that, on average across the nation, access to care for non-elderly adults in Medicaid—measured by certain key indicators such as having a usual source of care or having had a primary or specialist office visit in the past year—is comparable to that of adults with employer-sponsored insurance (ESI) and far better than that of uninsured adults.

Similarly, although non-elderly adults in Medicaid are, on average, more likely than adults with ESI to be in poor health and to have one or more chronic health conditions—factors that are likely to increase their use of health care services—our analyses show that when these health and demographic differences are taken into account adults in Medicaid use services at rates that are comparable to adults with ESI.

Other Measures of Performance: Quality, Cost, and Value

Any meaningful effort to assess access in today's environment needs to take into account concerns about cost and value. It is possible for Medicaid to assure access to care, but at costs that may be too high and with outcomes that may be too low. A complete evaluation of Medicaid's performance may take all of these factors—access, quality, cost, and value—into consideration.

There are growing opportunities for Medicaid to pursue innovations that improve access and quality and have the potential to lower program expenditures. For relatively low-cost populations in Medicaid, there is an opportunity to demonstrate that delivering high-value services—like timely access to preventive services or services delivered at an earlier stage of illness—can improve outcomes and satisfaction with care.

For high-need, high-cost groups, it may be possible to achieve better outcomes at lower total cost by increasing spending on certain services—for example, by providing more supportive services for people with functional limitations and serious chronic conditions to offset the use and costs of acute care services. There are meaningful opportunities for Medicaid to undertake innovations to improve care for people with disabilities who are covered by Medicaid only, for example, and to improve care and lower costs for people who are dually eligible for Medicare and Medicaid.

For LTSS, states have significant opportunities to improve service delivery to achieve better outcomes and reduce costs. Indeed, many states have made progress toward reorienting delivery systems to provide a broader range of home- and community-based services.

For all of Medicaid's populations and across the range of services Medicaid provides—LTSS, acute care, behavioral health care, and primary and preventive care—program administrators and policymakers will need much better measures to assess whether Medicaid is purchasing higher-value care. Better measures of the outcomes of care (that is, the impact of the full range of services provided to a patient over time on a patient's health and function) and the total costs of care for patients over time will be needed (Porter 2010). This kind of comprehensive outcome and cost measurement is not yet in place, but may be useful to support changes in delivery and payment, to achieve higher-value care for Medicaid, and to strengthen program accountability and integrity. The Commission's March 2012 Report to the Congress made recommendations that would enhance Medicaid program integrity by promoting those efforts that are most effective and eliminating programs that are redundant, outdated or not cost-effective.

Looking Forward

One of the key tests of the effectiveness of a health coverage program is whether it provides appropriate and timely access to services, and whether those services lead to the best outcomes for patients—improvement in health, maintenance of function, and, for patients who are in declining health, appropriate and effective care and supportive services that improve quality of life.

Medicaid and CHIP can contribute to improving delivery systems in order to provide better primary and preventive care, more effective supportive services, and better service coordination to improve outcomes and lower costs. Using payment policies as a lever for promoting high-quality care, Medicaid can seek to increase accountability among plans and providers and align financial incentives with desired quality and cost outcomes.

Evaluating access to care in Medicaid and CHIP, and monitoring and improving the programs' performance, requires answers to key questions, including:

- Can bundled payments and new service delivery models lower costs while improving access to services and treatments that benefit patients?
- What features of new delivery and payment models result in more effective service delivery, improved access, lower costs, and better outcomes of care?
- How do service delivery models, payment approaches, and monitoring efforts need to be tailored to meet the needs of diverse Medicaid populations?
- What Medicaid program features (such as optional simplified eligibility redetermination processes or 12-month continuous eligibility provisions, which some states have adopted for children in Medicaid) may be needed to improve the continuity and quality of care, and increase value?
- What data and monitoring approaches are needed to evaluate the success of purchasing strategies and assure program accountability?

These are some of the key questions that underlie purchasing strategies in Medicaid and CHIP and that will help guide MACPAC's future analyses.

The analysis and information presented in the sections that follow begin to: (A) describe the data and information available to answer questions about access, and (B) assess access to care for adults in Medicaid using key indicators. These sections begin to deepen the analysis of access monitoring as a tool for both evaluating and improving Medicaid and CHIP's performance and program accountability and understanding the implications of changes in health care delivery for these programs.

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