

## Medicaid Practice Benchmark Report

### Overview

In 2015, the Maine Health Management Coalition (MHMC) distributed its first Medicaid Practice Benchmark Report to over 300 pediatric and adult practices, capturing quality metrics and medical costs for almost 60 percent of Maine's adult Medicaid population.

Practice Benchmark Reports include key quality metrics and the Total Cost of Care (TCOC) indices developed by HealthPartners and endorsed by the National Quality Forum. The focus of this paper is on TCOC, a method of measuring health care affordability.

The analysis, which to date has been released only to providers, allows doctors and healthcare systems to compare their risk adjusted expenditures and utilization to peer statewide benchmarks. These reports provide valuable information supporting providers in working towards the Institute for Healthcare Improvement's Triple Aim: improving health, enhancing patient experience, and making health care more affordable.

### About MHMC and Maine

MHMC ([www.mehmc.org](http://www.mehmc.org)) a regional healthcare improvement collaborative, has played a leading role in health care quality measurement and public reporting ([www.getbettermaine.org](http://www.getbettermaine.org)) since 1993; bringing together consumers, providers and employers, working collaboratively, to improve the quality and affordability of health care in Maine.

The state of Maine has been a pioneer in using claims data to improve the quality and cost of care for more than a decade. It was the first in the nation to establish an all payer claims database in 2003, and it currently collects claims from commercial insurance carriers licensed

in Maine, inpatient and outpatient services provided by 39 non-governmental hospitals, third-party administrators, pharmacy benefit managers, MaineCare (Maine's Medicaid program), and Medicare. (Source: Maine Health Data Organization, 2015).

Every state designs and administers its Medicaid programs and determines the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to cover "optional benefits" through the Medicaid program. In 2014, about 260,000 Mainers, 20 percent of the population, received MaineCare benefits, a similar rate to the national average. Maine is not participating in Medicaid expansion under the Affordable Care Act.

In 2012, Maine was awarded a State Innovation Model (SIM) award, and a portion of the funds went to expand the state's ability to collect and analyze MaineCare claims data. MaineCare claims information includes administrative claims data from every healthcare entity the patient interacts with during the designated period; primary care, hospitalizations, emergency department visits, pharmacy costs, and outpatient facilities.

## How MHMC crafted the Maine Medicaid Practice Benchmark Report

Since 2012, MHMC has sent its commercially-insured Practice Benchmark Reports to more than 600 physicians and group practice administrators around the state. The reports help practices benchmark their cost and quality against their peers. For example, the report tells a provider what percentage of their patients have asthma, what their asthma patients incur in annual medical costs on average, and how those figures compare to their peers — the benchmark. By comparing risk-adjusted, per patient costs against the benchmark, the report helps identify opportunities to reduce costs and improve care. Similar reports were developed for the MaineCare population, building on the commercial reports, but with modifications to reflect the Medicaid program enrollment and use of services.

## Attribution

Members are attributed to practices based on the following criteria:

1. Fully eligible members in a medical and pharmacy coverage program, age 18-64
2. Six months contiguous or 9 months total enrollment with a designated MaineCare Health Home
3. Six months contiguous or 9 months total enrollment to a practice with a plurality of primary care services

MHMC produced separate reports for children and adults and included disabled and dual eligible patients to align with MaineCare's Accountable Community (AC) initiative. MHMC will revisit post SIM as patient spend varies considerably between groups.

## Services Included

Deciding what healthcare services to measure for a Medicaid population is a challenge for any state, and users must first identify what they want to know and how the report is to be used before identifying what services to include.

From the beginning, MHMC wanted the MaineCare report methodology to be similar to the commercial report to allow an exploration about a provider's quality of care and costs for both patient groups. With similar design, format and content, MHMC hoped doctors and practice administrators could easily compare the reports to assess quality of care, costs and determine differences in illness burden and treatment patterns. Of interest were common chronic conditions that afflict both patient populations, including diabetes, depression, asthma, and hypertension.

MHMC compared its commercial report to MaineCare medical services in hopes of achieving similarity in services between populations. It was challenging, as some MaineCare patients required services that varied from the commercially-insured

patients, also covered services differed, i.e. MaineCare pays for transportation to medical appointments. MHMC hoped to exclude any exceptions that would deter providers from making valid healthcare cost and quality comparisons between populations.

MHMC relied on MaineCare’s Accountable Community (AC) initiative, which was being expanded through the SIM program, for assistance, particularly how they defined “core” and “optional” services. That gave MHMC an external source to define what essential medical services to include. Using the AC core service definitions, MHMC excluded home care for elderly, dental services, personal care and other services and instead focused on core services.

Differences still exist and additional research is required to better understand these differences before comparisons can be made at an overall level between the two populations. Currently the Medicaid and commercial populations are reported separately, provider results are benchmarked against peer averages for the respective populations.

## **Medical services reported in the MaineCare Practice Benchmark Report**

**MHMC used “core services” defined by MaineCare’s “Accountable Communities.”**

- *General Acute*
  - *Inpatient*
  - *Outpatient*
- *Psychiatric*
  - *Inpatient*
  - *Outpatient*
- *Physician — Primary Care*
  - *Physician, Physician Assistant, Nurse Practitioner, Nurse Midwife, Federally Qualified Health Centers, Rural Health Centers, Indian Health Services*
- *Physician — Specialty*
  - *Physician, Physician Assistant*
- *Mental Health*
  - *School Health Centers, Behavioral Health Services, Rehabilitative and Community Support Services*
- *Laboratory/Radiology*
  - *Lab and Imaging Services*
- *Long Term Care*
  - *Hospice, Home Health*
- *Durable Medical*
  - *Durable Medical Equipment*
- *Other*
  - *School Health Centers, Ambulance, Dialysis, Early Intervention, Family Planning, Occupational and Physical and Speech Therapy (including services provided in schools and at Nursing Facilities), Chiropractic Services, Optometry, Audiology, Podiatry*
- *Pharmacy*

## Risk Adjustment

Claims data for both the Medicaid and commercial populations are risk adjusted using Optum Symmetry Episode Risk Groups® to mitigate differences in illness burden between providers. Both actual and risk adjusted figures are provided in the reports. Again, although a similar risk adjustment methodology was applied to both commercial and Medicaid populations, it was done independently due to population differences. Further research is necessary before making the leap of combining these populations into one report.

## Report Content

Practice results are benchmarked against state peer averages. With the addition of risk adjustment to account for differences in illness burden and TCOC methodology to differentiate resource utilization and pricing, valuable cost (Per Member Per Month (PMPM), Total Cost Index) and utilization (per 1000 rates, Resource Use Index) comparisons were produced in the following areas:

- Demographics—population age/gender, condition prevalence
- Annual adjusted PMPM trend
- Major service category trends
- Inpatient/Emergency Department utilization by admission type, days, readmits (all/avoidable) and top diagnoses
- Outpatient and professional by service category and top diagnoses
- Primary and Specialty care
- Pharmacy—Generic/Brand, top medications

- Chronic condition summary
- High cost patient summary
- Quality metrics compliance

## Current Use

Currently, MHMC releases the reports to practices with an initial goal of “starting a conversation” about practice patterns, how they compare to their peers, and how their treatment decisions impact their patients’ healthcare costs. To date, no statewide policy changes have resulted from the reports, and they are not shared publicly. Providers currently receive multiple reports on different patient populations which is time consuming and difficult to absorb. Reports are segregated by insurer; Commercial, MaineCare and soon to be Medicare as well as between pediatric and adult patients. Providing a summary level report identifying key areas of focus will be an important endeavor in the future, but for now much can be learned from producing these reports independently.

## Lessons Learned in Maine

MHMC’s MaineCare Practice Benchmark report demonstrates that HealthPartners’ TCOC and Resource Use measures, which have been effectively applied to commercial populations, can also be applied to a Medicaid population within a region or state. Tailoring it for a Medicaid population may require refinements in methodology like population selection and services covered as discussed above.

Understanding state policy changes and how they impact trends is ongoing. Fortunately, MHMC benefits from a close relationship with the state due to the AC initiative in Maine. A lot of effort is spent researching and understanding the impact of policy changes from year to year.

MaineCare population shifts are compounded by income, employment and policy changes. Defining acceptable inclusion criteria most likely will be different for each state. A careful look at services incurred and payment coverage also adds complexity and varies by state.

These reports contain valuable information, but without collaboration and additional support/resources required to make these reports actionable, impact will be minimal.

Each state Medicaid program is unique and understanding that is a necessary first step. The Oregon Health Care Quality Corporation (Q Corp) is also interested in reporting TCOC for the Medicaid population. In order to understand the system better, Q Corp held two listening sessions with stakeholders who work closely with Medicaid every day. Q Corp developed a series of focused questions to guide attendees through the key topics associated with Medicaid TCOC reporting.

## **Oregon Listening Session**

*Because Oregon expanded Medicaid access under the Accountable Care Act (ACA) and created Coordinated Care Organizations (CCOs), which are fully responsible for their assigned Medicaid patients' care, some aspects of the Medicaid system in Oregon are more complex than in other states. The CCOs are paid a Per Member Per Month fee from the State which they then funnel to providers through a variety of payment structures including bundles and capitation.*

*The listening sessions explored these payment complexities, as well as the need to include mental health services in any TCOC report for Medicaid in Oregon due to the high cost and utilization of those services. Overall, the listening sessions provided Q Corp with valuable information that otherwise would have been difficult to collect about the Medicaid payment and benefit structure system in Oregon. As every state Medicaid program is unique, the structured questions may prove valuable to others interested in reporting Medicaid TCOC as well. A sample [Stakeholder Discussion Guide](#) can be found on [page 9](#).*

## Future use for Medicaid Practice Benchmark Reports

MHMC is currently assessing provider interest in the Practice Benchmark report. Initial conversations have been positive, the report has been well received, but alternative funding will be key to continuing this report with the SIM Grant ending.

In Maine, the conversation about healthcare delivery for commercially-insured and MaineCare patients has been enhanced by the data presented in the Practice Benchmark reports. These reports capture a lot of information and it will be important to identify and target areas for improvement and provide additional detailed analysis as necessary. Now the challenge is for providers and other stakeholders to use the information to help improve the cost and quality of care.

## Resources

For more information about the HealthPartners' Total Cost of Care framework visit their website at <https://www.healthpartners.com/hp/about/tcoc/index.html>.

For more information about MaineCare's Health Homes and Accountable Community initiatives visit their website at <http://www.maine.gov/dhhs/oms/vbp/>.

For more information about the NRHI Getting to Affordability initiative on Total Cost of Care, visit their website at <http://www.nrhi.org/work/multiregion-innovation-pilots/tcoc/> or contact them at [gettingtoaffordability@nrhi.org](mailto:gettingtoaffordability@nrhi.org).

## Sample Stakeholder Discussion Guide

Based on Q Corp's listening session experience, the following questions stimulated meaningful discussion to inform next steps and could be modified and used in other markets.

- What risk adjustment methods are currently being used for payment with the Medicaid population? What is your assessment of these methods?
- What types of cost and quality reporting are physicians currently getting on their Medicaid patients?
- What types of reporting would be most beneficial to primary care clinics? To CCOs? What level of aggregation would be useful for different stakeholders (clinic, CCO, region)?
- The total cost of care methodology that Q Corp uses requires 9 months of continuous enrollment. Does this present bigger challenges for the Medicaid population?
- Payment & Benefit Structure
  - Medicaid pays for many services not covered by Medicare or commercial plans. Can we focus on core medical costs obtained from claims data?
  - Should the dual-Eligible population be included?
  - Which services are paid for outside of claims data? (example, mental health prescriptions)
- Patients under age one are a target population in Medicaid, they can also skew the data. Thoughts on incorporation of this population in standard reports?
- Concerns?

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### ABOUT THE NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT (NRHI)

The Network for Regional Healthcare Improvement is a national organization representing over 35 regional multi-stakeholder groups working toward achieving the Triple Aim of better health, better care, and reduced cost through continuous improvement. NRHI and all of its members are non-profit organizations, separate from state government, working directly with physicians, hospitals, health plans, purchasers, and patients using data to improve healthcare. For more information about NRHI, visit [www.nrhi.org](http://www.nrhi.org).

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