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# Importance of the Medicaid Medical Directors' Multi-State Collaborative for Improving Care in Medicaid

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## **Abstract**

**Introduction:** There are many benefits of multistate collaboratives or networks to states, but at the center is that they allow for the opportunity to learn from other states and experts about the practices and policies states have implemented without the significant time lag of published research. This commentary examines these benefits and illustrates the importance of quality improvement collaborations to decision-making in state Medicaid programs.

**Background:** In 2007, the Medicaid Medical Directors Learning Network (MMDLN) began conducting quality improvement studies using their own state-level administrative data to better understand the major clinical issues facing the Medicaid populations and to work together on policies to improve outcomes.

**Rationale and Results:** The three issues selected by MMDs for quality improvement monitoring to date involved an important national problem – including both morbidity and cost – and were amenable to policy solutions. The studies examined the use of antipsychotic medication in children, hospital admissions and readmissions, and early elective deliveries (i.e., elective deliveries occurring before 39 weeks).

**Importance and Utility:** The multistate clinical quality projects conducted offer a key mechanism for achieving the goal of helping the Medicaid program deliver value-driven, high-quality, cost-effective health care in an efficient manner. These projects also provide the participating states with data to inform policies internally.

**Conclusions:** In order for the quality of health care to improve, the system needs to be structured as a learning health care system; one that is always accessing evidence, implementing a variation of it (i.e., with new data sources or tools such as electronic clinical data), assessing effectiveness, and sharing results for others to repeat the cycle.

## **Acknowledgements**

We acknowledge the leadership of the MMDLN in launching collaborative studies for the benefit of Medicaid beneficiaries. We especially acknowledge those interviewed for this analysis, as well as the states that participated in the MMDLN multistate collaborative projects. In addition, we thank Marjorie Shofer, the MMDLN Project Officer at AHRQ for her support of the projects and the staff of the EDM Forum for recognizing the importance of sharing this information. The opinions expressed in this document are those of the authors and do not reflect the official position of AHRQ or the U.S. Department of Health and Human Services.

## **Keywords**

quality improvement, Learning Health System, Research Networks

## **Disciplines**

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# Importance of the Medicaid Medical Directors' Multistate Collaborative for Improving Care in Medicaid

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## Abstract

**Introduction:** There are many benefits of multistate collaboratives or networks to states, but at the center is that they allow for the opportunity to learn from other states and experts about the practices and policies states have implemented without the significant time lag of published research. This commentary examines these benefits and illustrates the importance of quality improvement collaborations to decision-making in state Medicaid programs.

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## Introduction

Within the last few years, multistate collaboratives or networks have become a more prevalent mode for implementing health care quality improvement initiatives. There are many benefits to states for participating in such collaboratives, but at the center is that they give states the opportunity to learn from each other, as well as from experts, about successful practices and policies. Further, the sharing of information can take place rapidly and without the significant time lag needed for published research to become available. Our experience from participating in the Medicaid Medical Directors Learning Network (MMDLN) whose motto is to “steal shamelessly and share senselessly,” has borne out the importance of such collaboratives. As the Colorado Medicaid Medical Director (JZ), MMDLN manager (KG), and Medicaid Medical Director (MMD)-led study principle investigators (GF, TT), our leadership roles have given us a unique perspective on the benefits and importance of such collaboratives to states and the field at large. In this paper, we share our experiences and lessons about the value of participating in this learning network.

The MMDLN is focused on the development and use of evidence-based medicine, measurement, and improvement of health care quality; and on the redesign of health care delivery systems through expert presentations and peer-to-peer learning. The MMDLN is one of several state-level collaboratives or networks, all of which share the ultimate goal of improving health care quality. While these collaboratives may have slightly different purposes or populations of focus, they have in common the ultimate purpose of providing actionable evidence to aid in states' decision-making. For example, the Health Resources and Services Administration's (HRSA) Collaborative Improvement & Innovation Network (CoIIN) is facilitating learning and adoption of common, proven quality improvement practices across all 50 states to reduce infant mortality and improve birth outcomes,<sup>1</sup> the Centers Medicare & Medicaid Services funded National Improvement Partnership Network (NIPN) is a network of over 20 states developed to advance quality and transform health care for children and their families,<sup>2</sup> and the Medicaid Evidence-based Decisions (MED) Project was established as a self-governing, state-funded collaboration of state

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Medicaid agencies to provide policymakers with the tools and resources they need to make evidence-based decisions including producing independent and objective evaluations of clinical evidence and convening states around clinical topics of interest.<sup>3</sup>

A major value of collaboratives like the MMDLN and these others is that they allow for rapid learning among state members. Evidence provided to the states through these collaboratives comes in varying forms including data analysis results, literature reviews, expert presentations, and even anecdotal references from peers. For the MMDs, evidence to date has also come from administrative claims data from participating states, aggregated and assembled to show patterns at the national level. A companion paper describes methods for using this distributed claims data resource.<sup>4</sup>

Along with the value of rapid learning in these collaboratives is the fact that knowledge builds on prior experiences as practices are shared. For example, when a new quality improvement practice is implemented by one state based on information shared through collaboratives, it is often picked up and further improved upon by other states. Thus, states, and ultimately their constituents, benefit in a timely manner from the continuous cycle of sharing, implementation, assessment, refinement, and more sharing. However, there are also challenges associated with participating in claims-based data aggregation projects and maintaining a learning network that are also discussed in the companion paper.

Despite these challenges, these collaborations are of benefit to states. This commentary examines these benefits and illustrates the importance of quality improvement collaborations to decision-making in state Medicaid programs.

## Background

The MMDLN was created by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) in 2005 under contract to AcademyHealth. While that contract ended in 2013, the work of the network is continuing under the National Association of Medicaid Directors as a clinical arm of the national association of state Medicaid programs. The network, as an integrated national resource, seeks to advance the health of Medicaid patients in the states and across the nation while best stewarding available resources. Network participation is open to MMDs and those in similar clinical leadership positions who advise the Medicaid director for one or more components of a Medicaid program administered by a state, territory, or the District of Columbia.

For the last eight years, network activities have focused on regular in-person and virtual learning sessions addressing topics of high relevance and importance for the Medicaid population. In addition, we have a regularly maintained website and use a Web forum to share documents and pose questions to other members of the network. These activities have allowed MMDs the opportunity to interact with our peers and learn from each other's experiences.

In 2007, through the MMDLN, MMDs also began conducting quality improvement studies using their own state-level administrative data to better understand the major clinical issues facing the Medicaid populations and to work together on policies to improve outcomes. MMDs saw an opportunity as clinical leaders in the states to assess clinical outcomes, to better understand an issue, and to make quality improvement decisions.

The first project dealt with antipsychotic medication use in children and adolescents;<sup>5</sup> the second examined hospital admissions and readmissions, while the third focused on early elective deliveries. The companion paper describes in detail the methods used to conduct them; the present commentary focuses on the benefits of such studies and their importance to quality improvement in Medicaid. Findings in this commentary, as well as the companion paper, are based on review of documents; personal experiences; and discussions with MMDs leaders, researchers involved in these studies, and state analysts.

## Rationale and Results of Medicaid Medical Directors Collaborative Studies

All problems selected by MMDs for quality improvement monitoring involved an important national problem – one that involved both morbidity and cost for the Medicaid population – and were amenable to policy solutions. The importance of understanding and improving care and cost in Medicaid can hardly be overstated. With 74 million beneficiaries,<sup>6</sup> cost from excess utilization can be enormous, and conversely, even small improvements can result in cost savings. In the selected areas, a benchmark or goal rate for Medicaid programs to compare themselves against did not exist.

### Antipsychotic Medication Use in Children and Adolescents

The first study examined the use of antipsychotic medication in children, and was selected in response to the high level of concern among the MMDs about this issue. The results of this multistate study – that antipsychotic medication use was prevalent, even among young children and especially among children in foster care – highlighted a problem that had previously received little attention nationally and galvanized action to address it. States also shared policy tools to address antipsychotic medication use in children and the evidence that these policies worked.

Subsequently, it has been consistently referenced by the U.S. Department of Health & Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) in letters to Medicaid Directors when discussing the seriousness of the issue, and was the topic of a Summit in the fall of 2012 sponsored by the HHS Administration for Children, Youth, and Families. Further, in recognition of the importance of this issue, there has been subsequent funding to states to improve monitoring of prescribing in foster care children. This first study made clear the need for such efforts in Medicaid and the benefit to states.

## Hospital Admission and Readmission

The second multistate study examined hospital admissions and readmissions. The MMDs selected this topic as the second area of focus due to the prevalence, expense and presumed preventability of hospital use (at least for some diagnoses).<sup>7-8</sup> National data showed that about 1 in 12 adults discharged from a hospital was readmitted within 30 days, adding an additional \$16 billion to health care costs in the United States.<sup>9</sup> Additionally, the MMDs took note of the fact that Medicare had targeted hospital readmissions as an important area for both cost savings and care improvement and crafted nonpayment policies for some readmissions.<sup>10-11</sup> Many state officials expected that similar policies might be applied to the Medicaid population. It was thus deemed critically important to understand the extent and nature of hospital readmissions in Medicaid, which had not been studied, in order to create effective state-level policies.

This study found that readmissions were costly for the states and were more prevalent in those with certain diagnoses such as mental health. Further, readmission rates varied considerably among the 19 participating states, which allowed states with higher rates to learn from those with lower rates.<sup>12</sup>

## Early Elective Deliveries

The third multistate study, which is currently under way, is examining early elective deliveries (i.e., labor induction or Cesarean deliveries occurring before 39 weeks). This topic was important to the MMDs for several reasons. First, there was a large body of evidence showing that these early deliveries led to poorer neonatal outcomes and long-term problems, as well as excess cost.<sup>13-18</sup> Second, there was a clear policy statement from the American College of Obstetricians and Gynecologists (ACOG) calling for the restriction of these early elective deliveries.<sup>19-20</sup> Third, an MMD-led effort in partnership with public health colleagues, could exert a multiplier effect by building on and complementing other efforts including the HRSA CoIIN and CMS Strong Start for Mothers and Newborns Initiative to reduce preterm births and improve birth outcomes.<sup>21</sup> Finally, since Medicaid pays for up to 48 percent of the births nationally (1.8 million births),<sup>22-23</sup> the program has a clear vested interest in developing policies to reduce complications and costs associated with these early elective deliveries.

This study initially found that, of the Medicaid singleton deliveries in 22 states, early elective deliveries are prevalent and that states can improve their reported rates by implementing policies to reduce them and improving the reporting on the birth certificates of medical indications for an early labor induction or Cesarean delivery.

## Importance and Utility of Multistate Collaborative Projects

There are a number of reasons why these studies are important and useful to state policy making and practices for the Medicaid program.

## Learning about Medicaid to Improve Population Health

One of the most important reasons is that these studies respond to crucially important national health and policy concerns for the Medicaid population. Medicaid is currently at the vortex of policy making for the nation's lowest-income, most vulnerable, and sickest residents, and as Medicaid expands under the Affordable Care Act (ACA) the size and importance of this vulnerable population will increase. This will bring new demands to the program and heighten the need for these collaborative, rapid learning projects on areas of concern to multiple states. The multistate clinical quality projects conducted by the MMDs offer a key mechanism (possibly the best mechanism) to help Medicaid monitor program outcomes across the country and continuously measure efforts to deliver value-driven, high-quality, cost-effective health care in an efficient manner. These projects also provide states an important opportunity to share successes and failures.

## Quality Improvement Projects Can Spur Action

Quality improvement studies often start discussions about improvement goals and drive action in the states. For example, the studies can lead to important state-level actions to implement effective policies that then are built upon by other states' reassessment.

Working together has also spurred sharing and policy conversations across states. As one MMD said, "instead of 'this is our strategy and that is yours' now it will be, 'what can we do together to get there faster?' That is a very exciting conversation to have." Some MMDs believe that these multistate studies also enable states to share and implement policies and practices used by others. Another MMD said that "the outcomes were not just [about] the data, but several states picked up on other states' practices and implemented them..." Similar to the effect of sharing and understanding data on reducing practice variation, work must be done between states to accelerate policy changes.

## Benefits to State-Level Quality Improvement Projects

The MMD's quality improvement projects provide participating states with data to inform policies internally. Such data is important because state legislatures and policymakers are often more persuaded by local state data than by studies from another state or at the national level. Only aggregated data from all states are shared publicly, but each state receives information on its own progress. Specifically, individual states receive information comparing its outcomes with the average across all states and to the range of outcomes. This information allows the Medicaid agency to highlight specific areas for policy or payment change. These studies are especially important in that there is a relative dearth of published research relying on Medicaid administrative data.

Even though the reports are not the first to examine given issues, they are important because state policymakers often need to see their own data in comparison to the aggregate multistate results to make a strong case for improvements. And indeed, states have used the findings from the reports in a variety of ways, including

the following: to identify and correct problems such as disparities, to set policies, to plan within the state, and to continue to monitor the data on their own.

**Identifying and correcting problems.** An example of identifying and correcting problems includes some MMDs taking the data on readmissions to hospitals and nursing homes that were “in the top for readmissions.” As an example, one children’s hospital did not believe that they had a problem with readmissions, but the results convinced them otherwise, and convinced them to take action by implementing an internal quality improvement program.

**Using results to set policy.** Many states have used the results of the studies to set policy, for example, one state used the antipsychotic medications study learnings to require prior review and authorization for use. One MMD stated the report on antipsychotic drug use, “has been really impactful in that it has pushed the...policy conversation that...is taking place especially in the kids in foster care. You see antipsychotics in those kids and what we do around that and it really pushes the physical and behavioral health integration issues. So, that has really pushed up policy questions really well.” Other states incorporated readmissions into pay-for-performance hospital policies and used the readmissions results to inform decisions on incentive payments to hospitals.

**Using data for planning and continued monitoring.** In addition, one state used the antipsychotic medication data for planning purposes, as a basis for a grant to further address the problem of inappropriate use. Finally other states use the project materials, such as the data dictionaries, to continue to monitor the issue. One state is continuing to track antipsychotic use (using the code developed in this project), and another state mentioned that tracking readmissions and the readmission report “pushed the discussions” of the problems and solutions in the state.

### Lessons Can Be Used for Future Studies with New Data Sources

In addition, lessons learned from these studies will be valuable in the future as the sources of data to support new evidence changes. For MMDs, evidence to date has primarily come from administrative claims since few studies are done on the Medicaid population. These administrative claims have sometimes been linked to other state data sources, such as birth certificates, but to date the distributed claims databases in various states have formed the backbone of the available evidence. In the future, the MMDs hope to use clinical data from electronic health records, as interoperability methods for extracting, storing, and analyzing these centrally become more robust. Including additional clinical data will permit monitoring of clinical outcomes across the states, in addition to utilization and cost information from claims. It will create a more complete picture of the issue, for example, more specific diagnoses contributing to readmissions.

## Conclusions

The MMDLN is an important vehicle for improving quality and reducing costs in the Medicaid program. In order for the quality of health care to improve, the system needs to be structured as a learning health care system: one that is always accessing evidence, implementing a variation of it (i.e., with new data sources or tools such as electronic clinical data), assessing effectiveness, and sharing results for others to repeat the cycle. Its ability to function as a learning health care system will grow as electronic health data become more available and are linked to information from claims. This will give the MMDs information on both quality outcomes for the population as well as cost. The importance of a learning network in Medicaid will grow rapidly as Medicaid expands under the ACA to take on more of the nation’s most vulnerable and costly individuals.

## Acknowledgements

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