Medicaid 2.0
Issue Brief: Access & Quality

Background

The ACA related Medicaid expansion increased demand for services compounding existing difficulties in accessing care, particularly specialist care. While access to primary care has improved, access to specialists, dentists and behavioral health providers continues to present a challenge. Wait times for appointments for some services like behavioral health outpatient services can be two months or longer. More generally, MCO provider network directories are often out of date as they rely on the credentialing process for updates.

As required under the ACA and with 100% Federal funding, in 2013 Medicaid increased its primary care rates to the same level as Medicare. However once the federal government withdrew the added funding, the rates reverted to their pre-ACA level. In 2016, New Jersey Medicaid added $90M in new funding to its MCO contracts to improve access to primary and preventive physician services as well as postpartum physician services. The State also increased rates for behavioral health services by $127M. To broaden coverage, in 2014, Medicaid expanded coverage for telehealth for behavioral health services. During the previous decade, the State increased reimbursement rates for dental services and while dental access has improved, many patients, particularly the developmentally disabled, continue to struggle to find a suitable provider.

Technology presents many opportunities to improve access. In addition to telehealth, our research indicates that states are experimenting with e-consults to improve access to specialty care and developing applications that use GPS technology to rapidly connect patients with services. However, while there are significant opportunities to improve access with technology, payers remain cautious and want to avoid policies that would create parity between in-person and tele-visits. At this point, NJ remains one of the few states that does not have a comprehensive strategy for how to expand its use on a much larger scale.

Other opportunities to improve access may come from an overhaul of current practice limitations. Many states have or are in the process of refining their scope of practice statutes and regulations to expand access. Greater use of Advanced Practice Nurses (APNs), Nurse Practitioners (NPs), Physician Assistants (Pas) and licensed clinical social workers in New Jersey could significantly improve access for Medicaid beneficiaries.

Limited access often means lower quality as Medicaid beneficiaries are forced to receive services from providers willing to accept reimbursement rates which have historically been significantly less than that of Medicare and commercial insurance. The growing use of Medicare and Medicaid ACOs and Patient Centered Medical Homes (PCMH) is contributing to an improvement in quality, but for a large segment of beneficiaries the quality of care has not kept pace. For example, NJ rates of C-sections, pre-term and/or low birthweight babies remain well above national quality metrics. Medicaid accounts for 1/3 of all deliveries in NJ. In addition, only three of the five MCOs have achieved Excellent or Commendable

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ratings from the National Committee for Quality Assurance (NCQA). And while hardly a perfect measure, recent Medicare hospital compare rankings indicated that safety net hospitals as a group are below average.

There are practice improvement demonstrations in progress that are showing positive improvements in quality scores but they remain limited as demonstration programs. For example, the Strong Start model for prenatal care has shown 7% reduction in pre term birth rate here in the NJ demonstration. A South Carolina Strong Start pilot reported that participation in the program reduced premature birth risk by 36%, low birth weight by 44% and 28% lower risk of being admitted to a NICU. Additionally, State Medicaid Directors were recently provided with options to facilitate reimbursement for Long-Acting Reversible Contraception (LARC) which can reduce unintended pregnancies and help prevent poor birth spacing, thereby reducing the risk of low-weight and/or premature birth. The expanded use of LARC in Colorado resulted in significant drops in the birth rate among teens and young adult women. The abortion rate among women between 15 and 19 years old dropped by more than a third; high-risk pregnancies by a fourth and there was a 35% drop in abortions between 2009 and 2013.

Lastly, some states are experimenting with ways to encourage Medicaid beneficiaries to select higher quality providers. While patient rewards programs and health savings accounts are the most common approaches, one state -- Massachusetts -- has proposed to offer a limited benefit package for patients that do not participate in one of their ACO models.

Problem Statement

- Lack of access causes patients to defer care which ultimately drives patients to higher cost venues like emergency rooms
- MCO network directories do not reflect the current provider participation
- Opportunities with telehealth and other technologies have not been expanded
- The State has not embraced expanded scope of practice opportunities
- Quality improvements have been slow to roll out across the state and practice improvements have not been replicated statewide
- Dental services, particularly for the developmentally disabled, remain one of the most difficult services for patients to access

Goal(s)

- Expand access to specialty services through the use of new innovations and technology
- Improve network directory accuracy
- Identify and recommend proven quality models to expand immediately
- Identify and recommend strategies to encourage Medicaid beneficiaries to select the highest quality providers
- Develop a strategy to increase the number of dentists participating in Medicaid and a comprehensive statewide strategy for the dental services for the developmentally disabled

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Strategy Options (informed by other states)

Access

- Expand scope of practice to allow Advanced Practice Nurses, Nurse Practitioners, Physician Assistants and Licensed Clinical Social workers to perform services currently limited to Physicians and Psychologists
- Modify the credentialing process to include a field that identifies where the practitioner actually sees patients
- Use DSRIP funding to pay for specialists, palliative care and housing
- Expand the use of telehealth to include services directly to homes (and nursing homes) and allow additional provider types to offer telehealth like Emergency Departments
- Reimburse specialty providers for E-consults with PCPs
- Increase access to Long Acting Reversible Contraceptives (LARCs) by restructuring reimbursement
- Expand Medical Marijuana Diagnoses – expanding the range of diagnoses to include pain management may reduce Medicaid pharmacy costs

Quality

- Require Hospitals to adopt Strong Start prenatal program
- Expand Smoking Cessation programs for Pregnant women
- Require and reimbursement home visits after delivery
- Increase use of rewards or restrict optional benefits for beneficiaries that remain in unmanaged settings
- Adopt non-invasive respiratory management models of care – see Appendix 1
- Increase direct state/dental provider engagement
- In conjunction with the medical schools develop a statewide network of dental providers for the developmentally disabled
- Require Medicaid to cover Doulas
- Pay hospitals more for vaginal births than for C-sections

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* The NJHCQI website is being updated. Documents saved on the NJHCQI website may have different links once the new site launches

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Appendix 1
Respiratory Treatment for Patients with Neuromuscular Weakness
Clinical Protocol Demonstration
September 18, 2016

Background

Patients with neuromuscular disease or other chronic debilitating disorders can experience muscle weakening that can result in the need for intubation and (unless treated in the manner we propose) eventually a tracheotomy. The use of invasive, tracheostomy mechanical ventilation (TMV) mandates ongoing around-the-clock nursing care, often initially in a long-term care acute hospital facility (LTAC), but ultimately in skilled care nursing facilities or at home with 16-24 hours per day of nursing care. New Jersey's University Hospital Department of Physical Medicine and Rehabilitation uses a cost effective clinical protocol that provides an alternative, extubation to continuous noninvasive ventilatory support (CNVS) and long-term noninvasive management that eliminates the need for surgical tracheotomies and in most cases, need for long-term nursing care.

Many individuals with these diseases are not initially eligible for NJ Medicaid and receive services through commercial insurers. However, once there is need for institutional care, in most cases, the individuals will qualify for Medicaid. Therefore, the broader statewide use of this protocol has the potential to very significantly lower costs for NJ Medicaid.

Proposal

As part of a 3-year demonstration project, the state will require the MCOs under contract with Medicaid to conduct an e-consult with University Hospital Department of Physical Medicine and Rehabilitation to determine if CNVS is a viable alternative for patients with neuromuscular weakness who are intubated and cannot be weaned from respiratory support to be successfully extubated without resort to tracheotomy and TMV.

Initially, the program will be limited to disorders that do not require need for in-person evaluation for candidature for the program. All cognitively intact OR patients with sufficient cognition to follow directions and with adequate family support for home management with the following disorders are eligible:

- All muscular dystrophies including congenital and Duchenne muscular dystrophies
- All spinal muscular atrophies (SMAs) including SMA type 1
- All congenital myopathies
- Neuromuscular conditions without severe central nervous system or upper motor neuron pathology in acute crises such as of myasthenia gravis and Guillain-Barre' syndrome
- Ventilator "unweanable" patients with critical care neuromyopathies without multi-organ failure

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Benefits – Quality and Costs

The quality of life benefits resulting from the use of this protocol are hard to overstate. Patients fortunate enough to take advantage of this option return directly home from critical care and avoid the trauma of a tracheotomy, invasive mechanical ventilation, and potentially avoid a lifetime of institutionalization/nursing care.

On the cost side, per patient savings from adopting CNVS instead of a TMV via tracheostomy tubes are substantial (American Journal of Physical Medicine and Rehabilitation Vol 94, No 6, June 2015). Based on the research done at University Hospital, on average, Medicaid would experience an immediate cost savings by avoiding the costs of surgical tracheotomies and institutionalization in ventilator units (from $280,000 for skilled care units to over $300,000 for home nursing) per year per case. While the number of cases may be relatively small initially at approximately 150, annual savings to Medicaid would approximate $15M (75 x $200,000), assuming only 50% of the cases were able to avoid tracheotomy and subsequent invasive mechanical ventilation even though our success rates for over 250 cases is over 98% (Bach JR, Gonçalves MR, Hamdani I, Winck JC. Extubation of unweanable patients with neuromuscular weakness: a new management paradigm. Chest 2010;137(5):1033-1039; Bach JR, Sinquee D, Saporito LR, Botticello AL. Efficacy of mechanical insufflation-exsufflation in extubating unweanable subjects with restrictive pulmonary disorders. Respir Care 2015;60(4):477–483).

Implementation

The NJ Medicaid MCO contract will include the requirement that the HMOs, upon notice of admission for selected DRGs, will require the treating physician to first obtain an e-consult with the Rutgers Department of Physical Medicine and Rehabilitation for intubated patients with the noted diagnoses before requesting consent for a tracheotomy. The Rutgers Department of Physical Medicine and Rehabilitation will either attempt to talk the patient's intensivists through extubation to CNVS (since a primary goal is to disseminate the knowledge of how to accomplish this) or facilitate transferring the patient to University Hospital ICUs for extubation to CNVS. Initial consultation by telephone is available 24/7 by cell phone 1-973-7143662.

Research Component and Proof of Efficacy

The following data will be gathered on the percentage of patients who avoid tracheotomy in every diagnostic category:

- Diagnosis and demographics (age, gender),
- Pulmonary function (including vital capacity, cough peak flows, CO2, and ambient air oxyhemoglobin saturation upon arrival at University Hospital),
- Co-morbidities,
- To where the patient was projected to have been discharged had they not benefitted from the noninvasive protocol (from the referring hospital's social worker) and the anticipated costs,
- Perspective cost-savings as a result of discharge to the community including annual respiratory equipment rentals will be determined.

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Potential Program Expansion

After the first year, with the accord of Medicaid, candidature for noninvasive management will be expanded to patients with chronic obstructive pulmonary disease and more broadly to ventilator “unweanable” patients with critical care neuromyopathies (deconditioning) who will require on-site evaluation for candidature for transfer to University Hospital by Dr. Bach or his appointee. This may greatly increase the population requiring transfer and would require the establishment of a separate ventilator management unit.

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