

UTILIZING DATA A Link To Quality Improvement

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Introduction

Consumers, providers, and purchasers are increasingly dismayed as access to healthcare remains limited, quality of care fluctuates and medical errors become more evident. Lack of access to services, disparities in care, and medical errors increase patient risk and the overall cost of healthcare.

Recent reports have focused on problems of quality within the current healthcare system. The need to identify “flaws” and restructure is growing. By focusing on systemic approaches to evaluate and improve the system of care, purchasers can use their resources more effectively to advance the quality of care for consumers.

Within state sponsored programs, such as Medicaid that utilize state and federal funds, it is even more critical to understand how health plans and providers are caring for those who are most vulnerable: low-income and underserved children and families. States must ensure that public monies are purchasing quality services. Over the years, states and the public have increasingly used healthcare performance data to stay informed about the quality of care provided by health plans serving Medicaid consumers enrolled in managed care. One valuable tool for sharing performance data has been consumer report cards. They not only hold plans accountable by publicly rating and comparing a plan’s performance to its competitors, but also help consumers choose a plan that best meets their needs. However, report cards are only one avenue for increasing health plan accountability. To truly address quality of care issues, state agencies must take more direct actions. Quality improvement systems must encompass a broad spectrum of activities that address shortfalls and improve quality. Many states have developed systems that enable them to analyze performance, identify deficiencies, and work collaboratively with plans to improve the overall quality of care within Medicaid programs.

This Policy Brief is the second in a series focusing on quality improvement systems within Medicaid managed care programs. The Brief will explore how California and other states utilize data to identify problems and help plans improve the care they provide to consumers. It will serve as a guide to California on how the State’s current system compares to others. It will explore areas for improvement to strengthen the system and better ensure that quality care is provided to Medicaid managed care consumers.

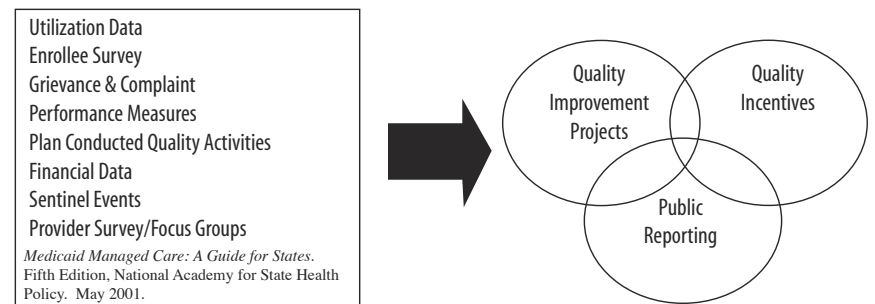
Ensuring Quality

State Medicaid agencies began transitioning many consumers into managed care in the early 1990s. Driving this move was the belief that consumers would receive better preventive services, and improved care and care coordination, while program costs could be more contained. States established internal quality improvement systems that drew upon existing elements of national standards. They used QISMC guidelines (Quality Improvement System for Managed Care), JCAHO (Joint Commission on Accreditation of HealthCare Organizations) and NCQA (National Committee for Quality Assurance) to guide the development of their standards for Medicaid managed care programs.

States also engage in other quality activities such as establishing enrollee hotlines, monitoring enrollment/ disenrollment, requiring accreditation by an outside agency (i.e. NCQA), and/or setting up a state ombudsman program. In addition to the state activities, Federal Medicaid regulations require that states complete an annual External Quality Review of health plans. This regulation instructs states to contract with an independent organization to conduct activities like random medical record reviews, focus studies, performance measure validations, surveys of patient experience of care, and/or audits.

By implementing some or all of the above strategies, states are able to collect and analyze various types of data that can be used for public reporting, quality improvement projects, and incentives.

Diagram A
Types of Data Collected and Potential Use of Data



As Diagram A demonstrates, the data that states collect can be utilized in a number of ways. For example, using performance data for public reporting is one mechanism increasingly used by states to hold plans accountable. As noted in issue brief I¹, public reports for consumers can drive competition among plans, promote choice, and improve services. In this issue, our efforts will focus on exploring the use of data for quality improvement projects and incentives.

Quality Improvement Projects that provide opportunities to maximize performance, identify poor performance, assess provider adherence to accepted practice guidelines and performance measures, problem solve, and explore innovative programs can be one important strategy in a state’s quality assurance system. Quality improvement efforts are often formed based upon performance data. Analyses of the data may spur a number of activities including studies to target specific problem areas, interventions to address plan-specific deficiencies, or system-wide interventions to improve overall performance.

Quality Incentives are increasingly being used by states to tie quality performance and improvements to the business aspects of plans and providers. Financial and other incentives are important tools for rewarding good performance, incenting quality improvements, and/or holding plans accountable for poor performance. Methods might include determining enrollment auto-assignments by assigning default enrollees to higher performing plans, linking performance incentives to capitation rates, and including performance incentives in plan contracts. Linking plan performance to financial rewards and possible sanctions helps states purchase higher quality healthcare and compels plans to invest in the delivery of quality healthcare.

State Quality Improvement Systems

States have taken many approaches to using performance data and financial incentives to highlight performance and drive quality improvements. Below are examples from four states that are leaders given their experience and investing in quality improvement systems.

Massachusetts

Quality Improvement Goals: Massachusetts annually negotiates quality improvement goals with plans utilizing HEDIS results and the plans' own data. Typically all plans focus on 3 universal goals and 2 individually selected by each plan. The State has established a collaborative and evaluative relationship with the plans. The plans are required to report semi-annually on their progress and are scored individually on whether they meet expectations. If plans are not performing, Massachusetts provides continuous feedback and assistance to develop effective interventions.

Rhode Island

Performance-Based Contracting: For the past three years, Rhode Island has utilized a performance contracting system. This incentive program incorporates three types of performance goals: administrative (encounter and on-site review), access (wait time for appointments, etc.), and clinical measures (immunizations, lead screen, etc.). The State uses a "percent of standard" approach to recognize improvement. Plans are evaluated annually and scored against the standard set for that measure. Rhode Island sets aside \$1.25 per patient (approximately \$1 million per year), which is then calculated against the plan's score. Depending upon its score, a plan could be awarded up to \$800,000 for the year. The money that is set aside for this incentive is separate from the plan's capitation rates, which average \$127 per month per member.

Michigan²

Performance Monitoring Standards & Expectations: Michigan has established performance-monitoring standards for plans and sets performance expectations in their contracts. Utilizing encounter and HEDIS measures that primarily focus on women and children, Michigan evaluates whether plans have met the standard at the end of the year. For those not performing as expected, the State institutes corrective action plans with set parameters. If plans are unable to improve performance within the timeframe established in the corrective action plan, the State can freeze enrollment, impose monetary sanctions, or cancel the contract.

Health plans are required to have quality improvement and assurance plans in place and to utilize all the data the State generates to assess areas for improvement. Plans are also expected to generate their own data to identify areas of particular concern to their population.

Financial Incentive: To incorporate financial incentives, Michigan annually sets aside a percentage of plans' capitation rates in a "pool" (average capitation rate is \$151). The State uses the money in two ways: to reward plans on a benchmark bonus activity and to focus on one clinical initiative. For the benchmarking program, plans are scored and rated on accreditation (NCQA, JCAHO) and selected HEDIS/CAHPS measures based upon NCQA percentiles. The top 5 plans are then awarded the cash bonus. The focus initiative rewards plans for efforts and improvements on a specific measure selected at the beginning of the year. The plans identify the barriers and interventions they will incorporate in order to address performance. The State then rewards those plans that demonstrate improvements and meet the standards set by the State.

Assignment of Default Enrollees: Michigan also uses clinical and administrative performance data to assign consumers who do not choose a plan at enrollment to plans with a higher level of performance on selected measures.

New York³

Quality Evaluation: New York has developed the Quality Performance Matrix. The Matrix evaluates a plan's performance over time and compares it to the statewide average utilizing data submitted as part of the quality assurance reporting requirements. The matrix has been used for the past 4 years with Medicaid, commercial, and SCHIP plans. The State ranks each plan's performance in the matrix for all payor mixes, shares the results with the plan, and requires plans to conduct root cause analyses for measures identified as needing improvement. Plans must develop state-approved multifaceted action plans to address deficiencies. The State feels the Quality Matrix pushes plans to target identified needs. The Matrix provides plans with a picture of how they are doing over time. The State sees this as a collaborative relationship rather than a punitive one.

Focus Studies: New York also enlists their EQRO to conduct focus studies at the State level. Plans are required by their contracts to conduct one focus study, which is usually in an area that has been identified as needing improvement. The State also provides training, workshop, and conference opportunities so that plans can share how they are addressing various issues and strategies to improve quality.

Quality Incentive: The State recently instituted a quality incentive to their capitation rates (statewide average capitation rate is \$163). Looking at two years of data, plans are given points on ten HEDIS and five satisfaction measures. The plan's score determines the bonus it receives. The maximum add on is one percent and depending on the plan's score, it can get either 100%, 75%, 50%, 25% or 0% of that amount. The financial bonus is for plans that perform well. New York does not penalize plans by withholding money.

Assignment of Default Enrollees: New York's auto-assignment methodology includes a component that evaluates quality of care when assigning consumers who do not choose a plan at the time of enrollment.

As these strategies indicate, quality improvement projects often encompass a continuous dialogue and flow of information among health plans and the state. Some activities can be ongoing and expand over several years to allow states and plans to implement intervention strategies, assess progress and evaluate the impact of interventions. Using data to feed quality improvement projects gives states and plans the opportunity to work collaboratively on developing interventions, sharing information, and learning from each other best practices to meet quality standards. A strong working relationship between the state and the health plans is advantageous to improving the delivery of quality services. Some may argue that by only focusing on what is measured, plans may become lax in other areas that impact quality of care. It is important to ensure that focusing on quality improvement activities does not distract from using other measures and resources as tools to identify and ameliorate problems. By continually evaluating and communicating information among states and plans, quality improvement efforts can be an effective long-term means to advance quality of care.

Many have found that utilizing incentives as a component of their quality improvement system significantly impacts plan performance. Financial incentives can create competition and add pressure points for plans to be accountable for delivering quality care. Incentives are a way to influence plans to focus on quality improvement and accountability as states reward higher performing plans. Penalties or sanctions can sometimes hinder relationships and lead plans to withdraw from Medicaid altogether. For states to move in the direction of tying incentives to performance, they must have adequate financing to invest in rewarding plans and a competitive marketplace to leverage and encourage competition.

¹*Informing Consumers: A Link to Quality Improvement, Issue Brief 1, Summer 2002, Community Health Councils, Inc.*

²Michigan also produces an annual Consumer Guide, which allows consumers to select health plans based on performance. See *Informing Consumers: A Link to Quality Improvement, Issue Brief 1, Summer 2002, Community Health Councils, Inc.* for more information.

³New York also produces an annual Consumer Guide, which allows consumers to select health plans based on performance. See *Informing Consumers: A Link to Quality Improvement, Issue Brief 1, Summer 2002, Community Health Councils, Inc.* for more information.

⁴*Confronting Health Care Purchasing Challenges within a New Framework, CHCS Brief, August 2001.*

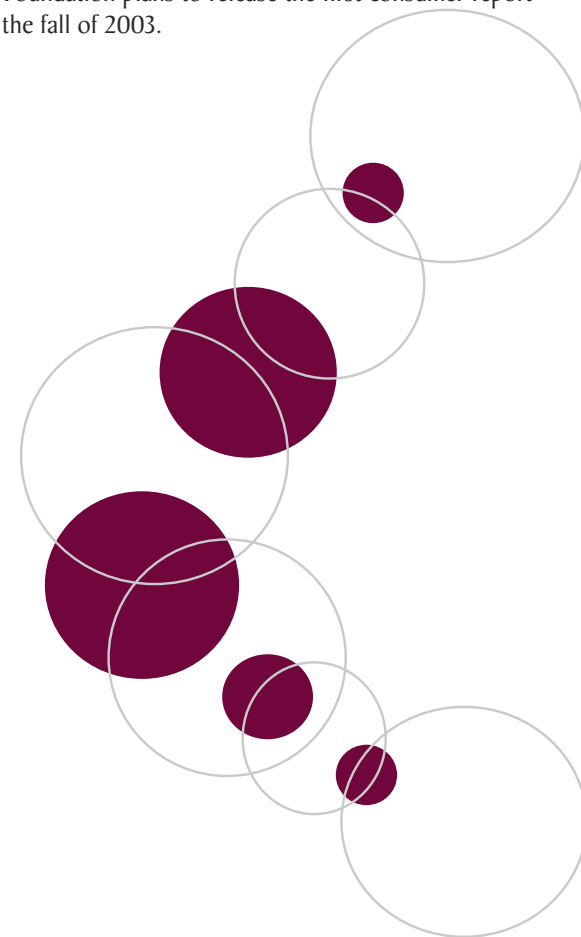
⁵*Trends and Indicators in the Changing Health Care Marketplace 2002 Chartbook, Kaiser Family Foundation.*

California's Quality Improvement Strategies

As indicated, states are incorporating various strategies to use data to drive the delivery of the highest quality of care to Medicaid consumers. The State Department of Health Services Medi-Cal Managed Care Division (MMCD) is responsible for the monitoring and oversight of the care provided to Medi-Cal consumers enrolled in managed care contracted plans. California has implemented quality improvement strategies similar to those discussed, and as in other states, the MMCD primarily uses performance data to compel quality improvement in plans.

California recently shifted to a more collaborative approach to support a cooperative environment among the plans and the MMCD. This approach better allows the plans and the MMCD to share expertise, resources, learning experiences, and technical assistance. The plans are required to participate in statewide collaboratives initiated by the MMCD, as well as three self-identified areas for improvement, one of which must be a collaborative with other plans. Currently, Medi-Cal managed care's small group collaboratives focus on asthma, diabetes and childhood immunizations. A statewide collaborative on improving chlamydia screening in young women is in the evaluation phase, and a new statewide collaborative on adolescent healthcare is in the planning phase. Through this approach, the State is able to help plans with problem solving, resources, and technical assistance. California has also instituted a quality improvement policy. This policy requires plans that do not meet the minimum performance levels on selected quality measures to submit a strategy to address the deficiency, monitor the progress of the intervention, and assess its impact on improving performance.

In addition to the quality improvement projects mentioned, the State also releases performance data reports, publicly recognizes plans for high quality care, and in collaboration with the California HealthCare Foundation plans to release the first consumer report card for Medi-Cal managed care in the fall of 2003.



Steps to Strengthen Quality Assurance in California

Thus far, the State has used data to inform plans and publish annual reports on Medi-Cal managed care plan performance. Plans and the MMCD have used the information to initiate quality improvement activities. While recognizing that the State has instituted a meaningful system to monitor and push plans to focus on quality improvement, there is still a need for further enhancements to ensure quality care and efficient use of funds. As noted by the Center for Health Care Strategies, an organization that promotes high quality healthcare services for low-income populations and people with chronic illnesses and disabilities:

Improving quality rests on the ability of state agencies to gather, analyze, and use performance information to continuously reward and improve the quality of health care services. Best practices in this area include collecting/using quality and performance data; linking performance to financial and non-financial incentives; developing quality improvement strategies; and disseminating data to key stakeholders.⁴

The MMCD is currently pursuing other areas to link quality performance with incentives, one of which would include moving to an auto-enrollment assignment system for default enrollees based on plan performance. While the State would like to use more fiscal influences and financially reward plans for high performance, current financial constraints will hamper any action in the immediate future. California already has one of the poorest payment rates in the country, an average of \$82.75. This compares to the national median Medicaid managed care payment rate of \$124.96 per month⁵. The State's fiscal limitations have not hindered health plans from incorporating financial incentives for providers and members in their quality improvement activities. Plans have found the incentives an effective method for improving performance, collecting data, and encouraging members to seek preventative services.

Unfortunately this year, due to unanticipated delays in securing a contract with an external quality review organization, the MMCD is not requiring plans to submit HEDIS performance data in 2003. The State will continue to collect the CAHPS survey data of consumers in 2003. It is critical that MMCD ensure that HEDIS performance measures are collected annually in the future. California must begin to use data for multiple purposes in order to inform itself as a purchaser, to foster improvements, and to ensure the delivery of quality care.

Recommendations for Improving California's Quality Assurance System

The following recommendations have been developed to strengthen California's quality assurance system for Medi-Cal managed care.

Short-term:

- ◆ Establish a culture within DHS and the MMCD that values quality care. Reinforce the Department's commitment to quality by incorporating quality measurements and principles into all major policy, budgeting, and strategic planning decisions.
- ◆ Move forward with current plans to incorporate the auto-assignment of enrollees to health plans based on levels of performance.
- ◆ Evaluate usefulness of current performance data collected, identify gaps in data collection, explore other sources of data, and examine expanding data collected.
- ◆ Explore utilizing other patient experience surveys to gather a more thorough understanding of patient experiences of care and consumer satisfaction. Establish a clear structure and timelines for plans to address poor performance and enforce consequences for continuously poor performance, such as freezing enrollment or canceling/ non-renewal of contracts.
- ◆ Institutionalize the release of a consumer report card on an annual basis.
- ◆ Strengthen the use of data for assessing quality by committing resources to work collaboratively with plans to improve the completeness and validity of data submitted.
- ◆ Establish a system that routinely allows the State to review data collected (i.e. every 3 years) in order to ensure that the State's informational needs are adequate for measuring and monitoring quality of care.

Long-term:

- ◆ Create an annual budget allocation to demonstrate the Department's investment in staff resources and systems to support the implementation, oversight, and monitoring of quality improvement strategies.
- ◆ Develop an action plan for incorporating financial incentives and/or performance-based contracting to reward plans for high performance and spur quality improvement efforts.
- ◆ Develop a plan for increasing provider payment rates, at a minimum to the national average of \$124.96 per month.
- ◆ Encourage and assist plans with seeking accreditation from organizations such as NCQA and JCAHO to raise standards and expectations across the board.

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State Interviews

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LINDA RUDOLPH, MD, Chief Medical Director, Medi-Cal Managed Care Division, California Department of Health Services.

KATE WILLRICH-NORDAL, Director, MCO Program, MassHealth, Division of Medical Assistance, Commonwealth of Massachusetts.

BILL WHITE, Director, ACS/Center for Child and Family Health, Rite Care Program, Rhode Island Department of Human Services.

Additional Information and Resources Used in the Development of this Report

WEBSITES

Agency for Healthcare Research and Quality: www.ahrq.gov
American Public Human Services Association: <http://medicaid.aphsa.org>
California HealthCare Foundation: www.chcf.org
California Institute for Health System Performance: www.cihsp.org
Center for HealthCare Strategies: www.chcs.org
Center for Health Services Research & Policy: www.gwu.edu/~chsrp
Center for Medicare & Medicaid Services: <http://cms.hhs.gov>
Commonwealth Fund: www.cmwf.org
Council of State Governments: www.csg.org
Institute for Healthcare Improvement: <http://ihi.org>
Institute of Medicine: www.iom.edu
Joint Commission on Accreditation of HealthCare Organizations: www.jcaho.org
Journal of Urban Health: <http://jurban.oupjournals.org>
Mathematica Policy Research, Inc.: www.mathematica-mpr.com
National Academy for State Health Policy: www.nashp.org
National Committee for Quality Assurance: www.ncqa.org
Rand Health: www.rand.org/health

STATE WEBSITES

California: www.dhs.ca.gov
New York: www.health.state.ny.us
Michigan: www.michigan.gov/mdch
Massachusetts: www.state.ma.us/dma
Rhode Island: www.state.ri.us/index.htm

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ABOUT COMMUNITY HEALTH COUNCILS, INC.

We are a non-profit health advocacy, policy and education organization working to improve health and human conditions for people throughout California. The Medi-Cal Managed Care Quality Initiative Project increases public accountability and consumer involvement in Medi-Cal Managed Care programs. The Project works to increase consumers' awareness and enhance consumer and patient organizations' involvement in healthcare quality issues. This brief is the second in a series that highlights quality of care and consumer education issues as part of CHC's commitment to improving California's Medi-Cal Managed Care quality assurance systems.

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