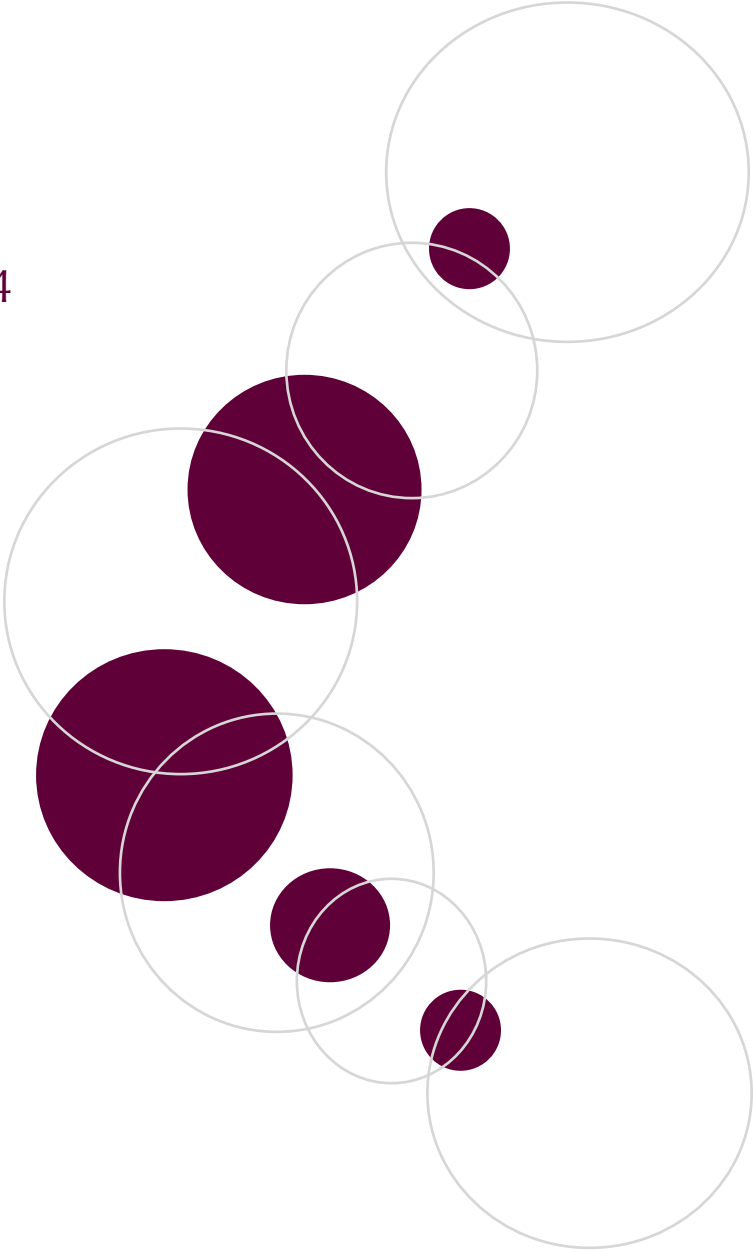


ALIGNMENT AND COORDINATION A Link To Quality Improvement

issue brief 4
fall 2004



Introduction

Consumers, purchasers and regulators across the nation have been demanding greater accountability for the quality of healthcare. It is generally agreed that the introduction of managed care or health maintenance organizations (HMOs) provided an opportunity to increase accountability in healthcare quality.¹ However, many have found that widespread and persistent, systemic shortcomings in quality exist throughout our nation's healthcare system.² The Institute of Medicine (IOM) launched a study in 2001, *Crossing the Quality Chasm: A New Health System for the 21st Century*, defining a vision for improving the quality of our nation's healthcare. The Chasm report distilled the principles of change into six guiding goals: healthcare should be safe, effective, efficient, patient-centered, timely and equitable.³ Since this report, the IOM has focused on translating these goals into reality. And while these efforts are not solely focused on the delivery of care through managed care systems, they indicate the need to evaluate this delivery system given the nation's investment and promise to control costs while improving patient care.

For healthcare consumers in California, managed care is the primary delivery system. Managed care covers more than 17 million California residents,⁴ the largest managed care enrollment level in the country.⁵ Of these, over 7 million are low-income and working-poor families and children who are covered by one of three public healthcare programs: Medi-Cal, Healthy Families, or through a local Children's Health Initiative.⁶ For low-income uninsured children and their families, healthcare coverage has expanded through a series of incremental steps. The effort began with the introduction of the Medicaid or Medi-Cal program in California in 1965. The program has evolved over time to extend coverage to 3.3 million children statewide. As the number of uninsured children continued to grow, significant federal and state expansion efforts have built upon the Medi-Cal program.⁷ Today, an additional 673,000 children⁸ are enrolled in the Healthy Families Program through the State Children's Health Insurance Program (SCHIP). With support of Proposition 10 funding and other funding sources, more than 44,000 children⁹ ineligible for either the Medi-Cal or Healthy Families programs are enrolled in nine county-sponsored Children's Health Initiatives (CHI). All three programs utilize a managed care model in which care is provided through 27 health plans statewide. Combined, these programs represent the healthcare delivery system for the most vulnerable population.

The growth of managed care in California has resulted in an increased number of regulatory and oversight agencies and quality assurance systems. These systems developed over time through a series of parallel, yet often disjointed, efforts by government regulatory and oversight agencies at the federal, state, and local levels. In California, the role of regulator and administrator for publicly-sponsored programs is the responsibility of the following agencies: Centers for Medicare and Medicaid Services (CMS); California Department of Managed Health Care (DMHC); California Department of Health Services (CDHS); Managed Risk Medical Insurance Board (MRMIB); and the advisory boards of the local Children's Health Initiative (CHI).

Each agency represents one or more coverage programs, with an independent administrative structure, funding stream and quality assurance system. Within this network, we find separate standards of accountability and reporting based on who finances the program and irrespective of the program services or population served. For consumers enrolled in one of California's public health coverage programs, discrepancies exist in accountability, quality information, and ultimately in the quality of care received. As California moves forward to expand coverage through county and/or privately-sponsored health coverage programs and ultimately moves to create a seamless system of care for children, it is increasingly important that the programs are bolstered by an infrastructure and systems of quality assurance and accountability that are aligned, efficient, and effective.

Having regulatory agencies work together not only reduces state costs and increases administrative efficiencies, but also improves quality performance.¹⁰ Both The Commonwealth Fund and the Institute for Healthcare Improvement have recommended that agencies and departments adopt common quality improvement efforts to advance quality healthcare.¹¹ To bridge differences and decrease replication, California has sought to reduce duplication in oversight. However, these efforts have been largely directed towards managed care organizations participating in the state Medicaid program. In the absence of broader efforts by regulatory and oversight agencies to better align and coordinate systems, consumers must rely on isolated quality assurance systems, and managed care organizations must meet a wide range of incongruent state, federal and local requirements.

This policy brief is the fourth in a series focusing on quality improvement strategies for Medi-Cal managed care and other public health coverage programs. The brief will go beyond the Medi-Cal program and review quality assurance systems for all children's health coverage programs to identify opportunities to improve monitoring, oversight, and the quality of care California offers its children.

Overseeing Quality for California's Children

As a consequence of expanding managed care in California's publicly-sponsored healthcare programs, multiple regulatory and oversight activities emerged to ensure quality care for low-income children and their families. Many of these activities and systems reflect funding streams, state legislation, regulatory policies, and industry standards at the time of implementation rather than efforts to meet clear long-term policy goals. The regulatory and oversight agencies for publicly-sponsored programs include the Centers for Medicare and Medicaid Services (CMS); California Department of Managed Health Care (DMHC); California Department of Health Services (CDHS); Managed Risk Medical Insurance Board (MRMIB); and the advisory boards of the local Children's Health Initiative (CHI) health program.

Trends at the national level towards industry standardization influenced the elements these agencies included in their quality assurance policies. For example, the National Committee for Quality Assurance (NCQA) evaluates health plans for patient safety, confidentiality, consumer protection, access, service and continuous improvement.¹² NCQA also accredits managed care health plans, at the health plans' request, to provide standardized, objective information about the quality of managed care organizations.¹³ The CMS, National Academy for State Health Policy (NASHP), and the Agency for Healthcare Research and Quality (AHRQ) have also developed tools, frameworks, and guidelines for states to follow in establishing a comprehensive quality assurance system that not only monitors but also encourages quality improvement efforts. As a result of these efforts and others, it is increasingly evident that a quality assurance system should examine and inform on the following: Financial Stability; Access and Capacity; Utilization; Delivery of Care/Services; Consumer Experiences; and Evaluation. To assess how California's regulatory and oversight agencies examine the quality of public health coverage programs, their role and quality assurance systems must be investigated.

Federal Regulator

CENTERS FOR MEDICARE AND MEDICAID SERVICES

CMS, formerly the Health Care Financing Administration (HCFA), is the federal agency with oversight responsibility for Medicare, Medicaid, and SCHIP. CMS also implements various provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While CMS does not directly oversee the delivery of healthcare, the agency sets forth guidelines, standards, and requirements for state administrators of the Medicaid and SCHIP programs to utilize when structuring their quality assurance systems, as these programs represent a significant federal and state partnership. CMS's efforts focus on:

- Protecting and improving beneficiary health and satisfaction
- Providing leadership in the broader healthcare marketplace to improve health.¹⁴

State Regulator

DEPARTMENT OF MANAGED HEALTH CARE

DMHC operates as the "control tower over the industry" working for "aggressive prevention, high quality healthcare, improved consumer education and empowerment, HMO and medical group solvency and accountability."¹⁵ Thus, with a few minor exceptions,¹⁶ DMHC has responsibility for executing the laws that regulate all HMOs within the state, totaling over 100¹⁷ health plans that encompass vision, dental, and general health services. The Knox-Keene Act of 1975, including subsequent amendments and regulations, are the laws by which DMHC is authorized to oversee managed care plans. To support and improve a better managed healthcare system in California, DMHC efforts focus on:

- Ensuring HMO accountability by enforcing prevention and quality of care laws
- Developing and launching public education and awareness efforts
- Providing an annual report card on quality of care of the state's HMOs
- Ensuring fiscal accountability for consumer premium dollars and co-payments throughout the HMO system
- Working to bring managed healthcare back to its roots of better preventative care that saves lives and preserves precious health dollars for those who become ill.¹⁸

State Administrators

CALIFORNIA DEPARTMENT OF HEALTH SERVICES

CDHS administers a broad range of public and clinical health programs for Californians, including Medi-Cal. In 1993, California submitted a Medicaid waiver under Section 1115 of the Social Security Act to capitalize on the promises of managed care. The waiver sought authorization to enroll all Medi-Cal eligible families with dependent children in a mandatory managed care system. The approval of the waiver led to the development of the Division of Medi-Cal Managed Care under CDHS, which oversees 23 Medi-Cal managed care health plans.¹⁹ To ensure quality within the Medi-Cal program, the Department's efforts focus on:

- Its partners and collaborative relationships to improve the health of all Californians
- Ensuring that all Californians have access to high quality healthcare, experience low levels of preventable diseases and disabilities, and enjoy optimal levels of health and well-being
- A valued and expert work force committed to continually improving the quality of services the CDHS provides
- Being a steward dedicated to improved public access, fiscal integrity, and accountability of programs and services.²⁰

MANAGED RISK MEDICAL INSURANCE BOARD

MRMIB was created in 1990 with a broad mandate to advise the Governor and the Legislature on strategies for reducing the number of uninsured persons in the state. The Board is made up of volunteers appointed by the Governor and Legislature who provide general oversight and instruction to the MRMIB executive director and staff. As a result of federal efforts to expand healthcare coverage to uninsured children, the federal government established and provided funding for the State Children’s Health Insurance Program (SCHIP). In turn, the state established the Healthy Families program in 1997 to provide low-cost healthcare coverage to children under 19. Currently, MRMIB has administrative responsibility for Healthy Families, Access for Infants and Mothers (AIM), and the Major Risk Medical Insurance Program (MRMIP). MRMIB is responsible for the administrative oversight of the 24 health plans²¹ providing care to children throughout the state under the Healthy Families program. To ensure quality within Healthy Families, MRMIB’s focus is on:

- Improving the health of Californians by increasing access to affordable, comprehensive and quality healthcare coverage.²²

CMS, DMHC, CDHS, and MRMIB provide a federal and state regulatory and administrative system to govern the quality of care given to consumers in managed care, including in the Medi-Cal and Healthy Families programs. The establishment of Children’s Health Initiatives (CHI) added quality oversight at the county level.

County Administrator

COUNTY-SPONSORED CHILDREN’S HEALTH INITIATIVES

There are currently 9 county-sponsored CHI programs with 8 health plan administrators. Each CHI represents the children’s health insurance program known as Healthy Kids²³ in 8 of 9 counties. The health programs exist in Alameda, Santa Clara, San Francisco, Riverside, San Mateo, Los Angeles, San Bernardino, San Joaquin, and Santa Cruz counties. Other counties—including Kern, San Luis Obispo, Tulare, Fresno, Sonoma and Del Norte—are well on their way to implementing similar types of coverage expansions. Funding for the health programs comes from various sources including state and/or county First 5 Commissions with Proposition 10 funding supporting services specifically for young children (birth to 5 years of age); the city or county; the health plans that deliver the health services; and various foundations and hospitals. Currently, the health plans administering the CHI programs are the local initiative²⁴ health plans operating under the I15 waiver within the Medi-Cal program or through the established County Organized Health System (Table I). However, commercial health plans could eventually administer the program.

Table I: Children’s Health Initiatives

County	Year Established	Funding	Health Plan
Alameda (AL)	2000	Tobacco Settlement Funds Alameda Alliance for Health Foundations	Alameda Alliance for Health
Santa Clara (SC)	2001	First 5 Santa Clara County Board of Supervisors City of San Jose Santa Clara Family Health Foundations & Hospitals	Santa Clara Family Health Plan
San Francisco (SF)	2002	First 5 San Francisco City and County of San Francisco General Revenue	San Francisco Health Plan
Riverside (RI)	2002	First 5 Riverside Riverside County Inland Empire Health Plan Foundations	Inland Empire Health Plan
San Mateo (SM)	2003	First 5 San Mateo County Board of Supervisors Peninsula Health Care District Foundations & Hospitals	Health Plan of San Mateo
Los Angeles (LA)	2003	First 5 Los Angeles UniHealth eApp LA Care Health Plan Foundations	LA Care Health Plan
San Bernardino (SB)	2003	First 5 San Bernardino Inland Empire Health Plan	Inland Empire Health Plan
San Joaquin (SJ)	2003	First 5 San Joaquin Health Plan of San Joaquin	Health Plan of San Joaquin
Santa Cruz (SCZ)	2004	First 5 Santa Cruz County Board of Supervisors Foundations & Hospitals	Central Coast Alliance for Health

These initiatives were developed to expand coverage to children ineligible for state- and federally-funded programs. Consequently, the CHI programs fall outside federal mandates for Medi-Cal or Healthy Families. CHI programs are largely subject only to DMHC's regulations because they are generally offered through a Knox-Keene licensed health plan. Thus, the CHI's role, capacity, and efforts to ensure quality are solely dependent on the local entity's commitment to quality assurance and DMHC requirements. To ensure some quality oversight authority, the CHIs, through their contracts and/or Memorandums of Understanding (MOU) with the health plans, have outlined additional recommendations for program management, structure, and quality improvement beyond what is currently required under the Knox-Keene Act.

The older CHI programs, such as Alameda's and Santa Clara's, have more developed quality assurance systems than programs established within the last year. Some CHIs have gone a step further by hiring an independent evaluator, the Urban Institute, to assess their administrative data, their capacity to facilitate care, and consumer experiences.²⁵ However, the current administrative model essentially eliminates one level of accountability and independent oversight seen in the Medi-Cal and Healthy Families programs through the state administering agencies. Efforts are underway by California's First 5 Children and Families Commission to further enhance the quality assurance efforts undertaken by the CHI health insurance programs, including working with DMHC to avoid duplicating any regulatory requirements.

With this understanding of the roles of the regulatory and administrative agencies, we can review the activities each agency conducts to oversee and monitor quality care. Many of the agencies apply similar activities, tools, measures, and improvement efforts. Table II indicates the quality monitoring and oversight activities of each regulatory and administrative agency. CMS's requirements and standards are reflected in CDHS and MRMIB activities.

Table II: Monitoring and Oversight Activities in California

Activities	DMHC			CDHS	MRMIB	County CHI									
	MC	HF	CHI	MC	HF	AL	SC	SF	RI	SM	LA	SB	SJ	SCZ	
Capacity to Facilitate Care															
Facility reviews (e.g. health and safety, qualified staff, evaluate health plan/contractor relationship)	√a	√	√	√a	√	√	√	√	√	√	√	√	√	√	√
Utilization management reviews and data collection (e.g. encounter, demographics)	√a	√	√	√a	√	√	√	√	√	√	√	√	√	√	√
Access and availability (e.g. cultural/linguistic, emergency services) reviews and data collection	√a	√	√	√a	√	√	√	√	√	√	√	√	√	√	√
Administrative organization capacity reviews	√a	√	√	√a	√	√	√	√	√	√	√	√	√	√	√
Financial audits (includes interviews and collection of data)	√a	√b	√	√a	√b	√	√	√	√	√	√	√	√	√	√
Quality management reviews	√a	√	√	√a	√	√	√	√	√	√	√	√	√	√	√
Level of Care Provided															
Plan performance based on clinical measurement collection (e.g. HEDIS and non-HEDIS)				√	√	√	√	√	√						
Plan performance based on consumer experiences (e.g. CAHPS)				√	√			√c							
Grievance and complaint reviews and data collection	√a	√	√	√a	√	√	√	√	√						
Plan performance measurement comparison/benchmarks				√	√	√	√	√	√						
Improvement Efforts															
Data (can include demographics & enrollment) collection results are shared internally	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Data (can include demographics & enrollment) collection results are made available to public	√	√	√	√	√										
Public reporting for consumers				√d	√										
Quality studies on health status & improvements				√	√	√	√	√							
Quality improvement projects	√	√	√	√		√	√	√							

Notes: a—These audits are conducted jointly between DMHC and CDHS to prevent duplication.

b—Financial audits are coordinated between DMHC and MRMIB to prevent duplication.

c—SFHP has developed its own survey to measure its Healthy Kids consumer experiences and satisfaction.

d—CDHS is currently working on a consumer's guide/report card as a form of public reporting on Medi-Cal managed care health plans.

While the regulations and guidelines established in the Knox-Keene Act provide a baseline, Medi-Cal has been the model for California's quality assurance systems for its children's coverage programs. The quality assurance system adopted by MRMIB for the Healthy Families expansion is almost identical to Medi-Cal's. Similarly, many of the CHIs modeled their quality assurance activities around MRMIB's Healthy Families program. A review of California's regulatory and oversight agencies' roles and activities indicates that many agencies are conducting and sharing similar processes and goals. Therefore, state and local agencies should examine opportunities for alignment and coordination to improve quality oversight, monitoring, and delivery, while still recognizing the need for some independence to reflect the variety of populations served.

One effort to better coordinate among the agencies currently takes place with CDHS and DMHC. Their joint monitoring activity includes reviews of facilities, utilization management, access and availability of care, administration structure, financial stability, grievances and complaints, and quality management of care. This joint monitoring occurs every 3 years. CDHS collects this information for years not jointly monitored. DMHC utilizes the jointly-gathered information to determine licensing approval for managed care plans.

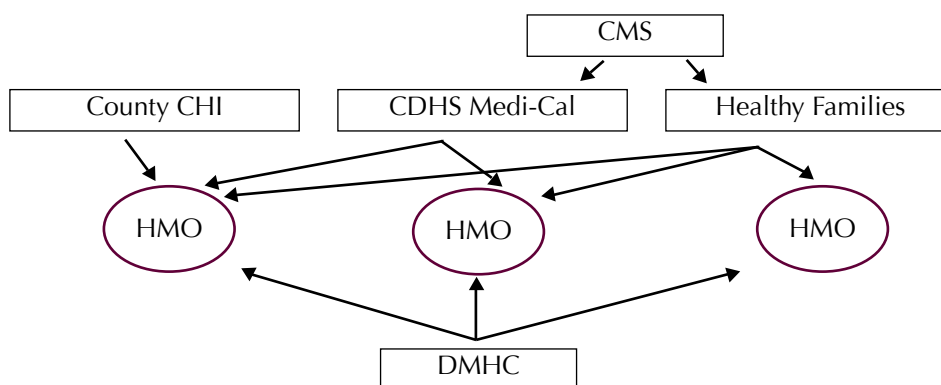
As the oversight entity for Medi-Cal managed care, CDHS goes a step further. It independently collects and analyzes clinical and consumer data to evaluate the plans' quality performance. CDHS utilizes these data to develop quality studies and identify areas for improvement, and then often addresses these areas through collaboratives among the health plans.

MRMIB's activities are conducted independently of both DMHC and CDHS. However, MRMIB relies on DMHC auditing, especially its financial audits. MRMIB and DMHC develop joint timelines for reviews so that both agencies are timely in their approval of plan regulatory filings. MRMIB separately reviews facilities, utilization management, access and availability of care, administration structure, grievances and complaints, and quality care management. These activities occur every year. It also independently collects and analyzes clinical and consumer data to evaluate the plans' quality performance. MRMIB utilizes these data to develop quality studies and identify areas for improvements.

As demonstrated by Table II, each county and program conducts activities for the CHIs that are independent of other CHI programs and of DMHC, CDHS, and MRMIB. This failure to coordinate creates a system that relies on self-regulation by the CHI and/or health plan for the delivery of quality care with the exception of DMHC regulation of the health plan.

As a result of the activities listed in Table II, information about the "level of care" provided is reported to three separate entities every year. Reviews and audits of "capacity to facilitate care" are also conducted by three separate entities, with the addition of one conducted jointly with DMHC every three years. All entities, except for DMHC, analyze their findings and share this information within their department to evaluate how well a health plan is performing every year. DMHC generally issues "medical survey" reports every 3 years, but does conduct "non-routine" or focused reviews at other times, when the need arises. Diagram A further illustrates the contractual relationships among the health plans, regulators, and administrators and the crossover in oversight.

Diagram A : Quality Oversight & Reporting Relationships



One opportunity to coordinate efforts centers on monitoring health plans' "capacity to facilitate care." Others exist in aligning how agencies and health plans assess the level of care provided and in improving the collection of clinical measures and consumer experience data. While Medi-Cal has a broader scope of quality assurance activities in this area because it also serves adults, all three programs could focus alignment efforts around their child populations.

Measuring Quality of Care for Children

In the managed care industry, the primary data used to determine delivery of services are clinical and consumer experience measures. CDHS, MRMIB, and a few CHIs incorporate these measures in their quality assurance systems. Health Employer Data Information System (HEDIS) and Consumer Assessment Health Plan Survey (CAHPS) are the principal tools used to collect performance data. These tools were developed by NCQA to transform healthcare quality through measurement, transparency, and accountability.²⁶

HEDIS is the most widely accepted measurement of performance both in public and commercial markets. Currently, there are 56 HEDIS quality measurements. Of the 56 measures, the Medi-Cal program collects nine measures, five of which target children. As the Healthy Families program serves children, not adults, MRMIB collects six HEDIS measurements that target only children. Before enrollment began for the Healthy Families program, there was an extensive process of involving consumers, advocates and health plans in developing a set of measures for quality. The number of clinical measures collected by the CHI programs varies from four to five. The CAHPS surveys are currently used in the Medi-Cal and Healthy Families program. These surveys are given to each program's specific population to measure consumer experiences and satisfaction. The CHI health programs are considering using these surveys.

The Medi-Cal program also collects three non-HEDIS measures, while the Healthy Families program collects one non-HEDIS measure. All of the child-based measures for the three programs are outlined in Table III.

Table III: Child-Based Quality Assurance Measures by Program

HEDIS Measures	MC	HF	County CHI ²⁷			
			Alameda	Santa Clara	San Francisco	Riverside
Use of appropriate medications for people with asthma	√	√			√a	
Childhood immunization status	√	√	√	√	√a	√a
Child and adolescent access to primary care practitioners (PCP)		√	√	√	√	√
Well-child visits (Year 3, 4, 5, 6)	√	√	√	√	√	√
Adolescent well-care visits	√	√	√	√	√	√
Well-baby visits (First 15 months of life)	√		√			
Follow-up after hospitalization for mental illness		√				
Treatment for children with upper respiratory infection			√			
CAHPS	√	√				
Non-HEDIS Measures						
Children's initial health assessment	√	√		√		
Asthma rescue medicine			√			
Blood lead screening	√					

Note: a—These measures will be collected for the upcoming year.

As seen in Table III, there are several key HEDIS childhood measures that are collected by both the Medi-Cal and Healthy Families programs and the CHI health programs. Only four of the nine county CHI health programs have been in operation for more than two years, the minimum time needed to collect HEDIS measures. Therefore, data on clinical quality performance are in the developmental stages. Data on the well-child visits and adolescent well-care visits are collected by all programs. By next year, the childhood immunization measure will also be collected by all programs. Information on access to a PCP is collected by all programs with the exception of Medi-Cal.

Only the Medi-Cal and Healthy Families programs have adopted the CAHPS survey to assess consumers' experience satisfaction with care. As with any patient satisfaction survey, CAHPS can be expensive to administer and requires a significant sample size to provide meaningful data. The fact that several CHIs have operated for less than three years may contribute to their hesitation in this area. Furthermore, there is little agreement or consistency in the collection of other child health indicators beyond a few basic HEDIS measures.

In addition to the variance in measurements collected by programs, there is no consistency or agreement on how the measures are analyzed and viewed comparatively. The tendency is to compare health plan performance within the specific programs and within the region in which the plan operates. Medi-Cal and Healthy Families also compare to national performance standards. The CHI contracted health plans currently evaluate themselves against the other programs they administer and the other health plans that deliver the CHI health program. All three program administrators review the results of these findings to see how well their health plans are performing. However, there is no cross comparison among the three children's programs because of their different program requirements. The type of reports generated and who reviews them also vary across all programs.

The Role of the Health Plan

In addition to understanding the various regulatory and administrative activities that occur at the state and local levels, one must also consider how these roles and quality assurance systems impact the health plans directly responsible for delivering care to consumers. Of the 27 health plans facilitating healthcare through their medical networks and providers for California's low-income children, 20 health plans²⁸ contract with at least two of the children's coverage programs (Table IV).

Table IV: Participation of Managed Care Health Plans in Children's Coverage Programs

HMO	Medi-Cal	Healthy Families	County CHI
Alameda Alliance for Health	√	√	√
Central Coast Alliance for Health Plan	√	√	√
Health Plan of San Joaquin	√	√	√
Health Plan of San Mateo	√	√	√
Inland Empire Health Plan*	√	√	√
LA Care Health Plan	√	√	√
Santa Clara Family Health Plan	√	√	√
San Francisco Health Plan	√	√	√
Blue Cross*	√	√	
Cal Optima	√	√	
Community Health Group*	√	√	
Contra Costa Health Plan	√	√	
Health Net	√	√	
Kaiser Permanente	√	√	
Kern Family Health Care	√	√	
Molina*	√	√	
Santa Barbara Regional Health Authority	√	√	
Sharp Health Plan	√	√	
UHP Healthcare	√	√	
Universal Care	√	√	
Partnership Health Plan	√		
UCSD Health Plan	√		
Western Health Advantage	√		
Blue Shield		√	
Care First Health Plan		√	
Community Health Plan		√	
Ventura County Health Care Plan		√	

Note: * These health plans are NCQA accredited.

The 20 health plans are responsible for establishing quality assurance structures in accordance with DMHC, CDHS, and MRMIB's regulatory and oversight requirements and activities. As seen in Diagram A, a health plan that delivers three programs would respond to four regulatory and/or administrative entities. Even health plans delivering one program are subject to two oversight systems. Exceptions are Medi-Cal contracted health plans that are relieved of collecting and reporting duplicative information to two agencies because of joint efforts by CDHS/DMHC. COHS health plans also have a lesser burden because most COHS health plans are exempt from DMHC regulation.

“The next step is to align and coordinate quality assurance policies, measures, and reporting systems across all children’s health coverage programs to improve the health of our children.”

In lieu of better aligned and coordinated quality assurance systems at the state and or local level, health plans administering more than one program have sought to internally align and coordinate their quality activities. To limit duplication, health plans delivering all three programs conduct quality assurance activities, including improvement projects, simultaneously to cover all three programs and populations that share facilities and providers. For example, a physician incentive quality improvement project conducted by a health plan will benefit all health programs within the plan because the plan shares the same facilities and physicians throughout all programs. Health plans have found that it is advantageous to have one department oversee quality activities for all public coverage programs.

In addition to these efforts, the health plans are also identifying and implementing procedures to share information, coordinate, and collaborate among themselves. The health plans operating as Local Health Initiatives in Two-Plan model counties under Medi-Cal managed care meet regularly to learn from each other and share best practices. Because many of these health plans also contract with the local CHI program, these talks are beginning to include the CHI program. The same health plans are currently working on a quality improvement collaborative based on incentives. The Local Initiatives Rewarding Results project is a collaboration between CDHS, MRMIB, the Center for Health Care Strategies (CHCS) and the local health initiative plans.

While the relationships outlined above and the systems and activities taking place demonstrate overlaps within our systems, they also present an opportunity to improve California's quality oversight. However, before seeking to implement strategies and/or re-organize California's current structure, other states' systems and recommendations should be reviewed.

Lessons Learned From Other States

NASHP's *Medicaid Managed Care: A Guide for States* reports that other state Medicaid agencies have made efforts to align and coordinate with their respective oversight state agencies. These efforts include:

1. A formal interagency agreement where another agency and the Medicaid agency will work or collaborate with each other on various projects. Projects may include measurement; quality improvement; enrollment; and working together to address other agencies' issues and concerns.
2. Joint Medicaid and SCHIP health plan contracts for plans that work with both programs. Set performance expectations for both programs could then be created.
3. Shared administration that collapses both programs under one department, although this recommendation has been cited as efficient for smaller states with fewer enrollees.
4. Shared health plan monitoring, where all health plans that administer the Medicaid and SCHIP programs are held at the same level of expectation because all are monitored by one entity.
5. Sharing information and data among the state agencies to learn from each other and address the needs of their populations without undertaking this effort on their own.
6. Forming a joint advisory group between Medicaid and SCHIP where program and policy decisions that affect both programs are combined.
7. Holding joint meetings among state agencies that would benefit from each other's experience.

NASHP also cites the importance of having agencies share financial and other administrative information to reduce the administrative load on plans and agencies.²⁹

There are 16 states with separate Medicaid and SCHIP programs. Nineteen states have an expanded Medicaid program with a separate SCHIP program. One of these states is California.³⁰ As of 2000, among these 35 states, 16 state Medicaid agencies were coordinating efforts. Of these efforts, 11 state Medicaid agencies were holding joint meetings with their SCHIP program, 8 shared data and other information, and 6 shared the same administration.³¹

The following section further describes how two states have aligned and coordinated efforts. These states have both programs under the authority of one agency and are similar to California in their program structure and the large enrollee populations served.

New York

New York's efforts focus on the collection and evaluation of quality measures. The state collects HEDIS and non-HEDIS measures for New York's commercial, Medicaid, and SCHIP programs and analyzes results across all programs. New York developed and adapted Quality Assurance Reporting Requirements (QARR) to hold all the state's managed care health plans to the same standard of care, to improve the validity of the data collected, and to improve their overall evaluation of health plans.

The QARR is a series of measures designed to examine managed care plan performance in several key areas. The measures are largely adopted from the NCQA HEDIS with additional New York state-specific measures added to address public health issues, such as lead testing of two-year olds. New York also uses CAHPS. Whenever possible, these plans are compared to national averages and goals. New York believes that as a result of their efforts, all health plans are evaluated with the same expectations for both public programs and the commercial industry, operations are more efficient, and overall health quality is improved.

Michigan

Michigan's alignment efforts have centered on their Medicaid and SCHIP programs as well as a third, new public health coverage program for underinsured adults without children. These three programs share the same contract manager under the Managed Care Plan Division. This step was taken in response to findings that the three programs were held to varying standards and evaluated differently. As a result, the Division recently rewrote the contracts for all three programs. They now parallel each other with clear expectations that the structure of their quality assurance programs will operate at the same level for all programs. Once Michigan has evaluated the effectiveness of redrafting these components, the state hopes to identify other opportunities. Alignment and coordination are their means for improving cost, quality, and administration of the health plans, the programs, and state staff.

As demonstrated with the states above and the NASHP, various alignment and coordination efforts are currently being implemented across the nation that have proven efficient and successful. Based on these findings, California should explore ways to better align, collaborate, and coordinate their quality assurance systems.

Steps Towards Alignment and Coordination

There is increasing movement towards alignment and coordination at the national, state and local levels. CMS developed a collaborative effort—the Quality Assurance Reform Initiative (QARI)—between states, the managed care industry, consumer advocates and others to design practical approaches to monitoring and improving the quality of Medicaid managed care services. An early recommendation was to coordinate efforts among all state agencies with quality oversight responsibility.³² CMS also introduced the Quality Improvement System for Managed Care (QISMC) initiative, which developed a coordinated Medicare and Medicaid quality oversight system that would reduce duplication or conflicting efforts and send a uniform message on quality to states and consumers.

In 2001, the Medi-Cal Policy Institute and NCQA produced the *Medi-Cal Audit Crosswalk*.³³ The report outlined the regulatory oversight requirements for managed care health plans for Medi-Cal—including those by CMS, CDHS, and DMHC—and compared them to the NCQA accreditation standards. The report found that most broad standards are highly consistent, meaning the intent of the standards are similar if not identical among all agencies. The report served as California's first steps to identifying cross-over and coordinating efforts among regulators and administrators.

California has begun to coordinate the regulatory and administrative agencies with oversight responsibility for a given children's health coverage program. The successful joint monitoring activities conducted by DMHC and CDHS are a result of state legislation, passed in 1998, requiring the two state agencies charged with licensing and/or monitoring the delivery of healthcare through managed care to reduce duplication in their medical audit programs.³⁴ Thus, audits of health plans that deliver the Medi-Cal product line have been reduced. However, further coordinated effort is still required to completely eliminate unnecessary duplications.

Informally, DMHC, CDHS, and MRMIB have met periodically to review quality assurance indicators. The CHIs, with assistance from the Institute for Health Policy Solutions, have established an unofficial network. Budding CHI programs will outreach to the more experienced CHIs for guidance in their process, including the implementation of a quality assurance system.

As mentioned earlier, other alignment and coordination efforts among agencies include CDHS and MRMIB conducting CAHPS surveys to evaluate consumer satisfaction; the collection of some common child-based measures, although not yet a formalized process; and the alignment of programs at the health plan level to coordinate all of the plans' quality activities.

However, the landscape continues to change with the expansion of low-income health coverage programs for children, resulting in more duplication of efforts and a dilution of resources. The range of resources in each county makes every CHI an independent and autonomous health insurance product rather than a statewide program. Consequently, California now offers essentially eleven publicly-supported low-income healthcare coverage programs for children. We can no longer simply turn to the Medi-Cal program to determine how well California's children are faring or to ascertain how we can continue to improve the care they receive. With the introduction of the Healthy Families and now CHI programs, we need mechanisms to learn from the best each program has to offer and ensure that California's children receive the best possible care.

Therefore, the next step is to align and coordinate quality assurance policies, measurements, and reporting systems across all children's health coverage programs to improve the health of our children. The following recommendations are designed to help California take the next step and strengthen the quality of healthcare for all children.

Alignment

- Establish an expanded standardized set of initial plan performance measures and quality improvement system across all children's coverage programs
- Assist all plans providing care to children to receive NCQA accreditation by 2010 as contractual conditions
- Develop boilerplate language for Medi-Cal, Healthy Families and CHI contracts on quality assurance system requirements, including the review of audit and reporting requirements, protocols to reduce the burden on health plans and administrators, and quality improvement incentives

Coordination

- Establish a joint quality assurance committee with representation from all children's healthcare coverage to develop a standardized set of quality assurance measurements, monitor performance trends, and determine statewide quality improvement efforts
- Develop cooperative agreements between DMHC, MRMIB and the CHI to reduce duplication and conduct joint audits similar to that of DMHC and CDHS
- Develop policy and contractual conditions that provide access to data and information by state regulatory and administrative agencies performing quality assurance oversight

Centralization

- Establish oversight authority for all CHI quality assurance through an independent state level agency such as CDHS, MRMIB or First 5 Commission
- Provide authorization and establish a centralized system for developing a comparative analysis and annual report on plan performance for all children's health coverage programs through DMHC

[ENDNOTES]

¹ For the purposes of this report, the term managed care is used interchangeably with the term HMO.

² Institute of Medicine, *Shaping the Future*, Vol. 1, Number 1, Winter 2002.

³ Institute of Medicine, *Crossing the Quality Chasm*, Project Scope, www4.nationalacademies.org.

⁴ Kominski, Gerald, PhD et al, *Profile of California's HMO Enrollees: Findings from the 2001 California Health Interview Survey*, UCLA Center for Health Policy Research for the California Office of the Patient Advocate, January 2003.

⁵ California Association of Health Plans, www.calhealthplans.com.

⁶ *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*, California HealthCare Foundation, January 2004. *The Healthy Families Program: An Overview*, California HealthCare Foundation, January 2004. Child and Family Coverage Technical Assistance Center, www.cfctac.org.

⁷ *Medi-Cal Facts and Figures*.

⁸ *Healthy Families Program*.

⁹ Child and Family Coverage Technical Assistance Center.

¹⁰ The Commonwealth Fund, *Time for Change: The Hidden Cost of a Fragmented Health Insurance System*, Invited Testimony before the Senate Committee on Health, Education, Labor, and Pensions, 2004.

¹¹ Institute for Healthcare Improvement, *Improvement Tip: "Quality" Is Not a Department*, www.ihl.org/IHI/Topics/Improvement/. Beal, Anne, MD, *Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care*, The Commonwealth Fund, New York, NY, September 2004.

¹² National Committee on Quality Assurance, www.ncqa.org.

¹³ Ibid.

¹⁴ Centers for Medicare & Medicaid Services, http://cms.hhs.gov.

¹⁵ Department of Managed Health Care, "About the DMHC," www.dmhc.ca.gov.

¹⁶ County Organized Health Care Delivery systems (COHS) are not considered health plans under state law. The COHS health plans operate with a federal waiver and under the authority of the state's Welfare and Institutions Code and County Ordinances. As a result, most of the COHS are exempt from being regulated as a typical health plan. However, Health Plan of San Mateo is a Knox-Keene licensed health plan and is regulated by the state accordingly.

¹⁷ Department of Managed Health Care.

¹⁸ Ibid.

¹⁹ State of California, California State Department of Health Services, *Medi-Cal Managed Care Plans, Results of the HEDIS 2002 Performance Measures for Medi-Cal Managed Care Members*, February 2003.

²⁰ California State Department of Health Services, www.dhs.ca.gov.

²¹ State of California, *Healthy Families Program Handbook*, June 2002.

²² Managed Risk Medical Insurance Board, www.mrmib.ca.gov.

²³ In Alameda County, the health program is referred to as Alliance Family Care and covers children and families.

²⁴ Local Initiative Health Plans are local non-profit plans established under the Two-Plan Delivery Model for mandatory managed care.

²⁵ Santa Clara, San Mateo, and Los Angeles CHIs are all contracting with the Urban Institute to conduct these evaluations.

²⁶ National Committee for Quality Assurance.

²⁷ Clinical performance measures require a plan to have at least two years of enrollment status. Therefore, only four CHIs—Alameda, Santa Clara, San Francisco and Riverside—are currently conducting activities that are centered on the collection and evaluation of HEDIS or other clinical measures.

²⁸ United States General Accounting Office, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*, September 2001.

²⁹ Kaye, Neva, *Medicaid Managed Care: A Guide for States*, Fifth Edition, National Academy for State Health Policy, May 2001.

³⁰ Kaiser Family Foundation, *State Facts*, www.kff.org.

³¹ Kaye, Neva.

³² Riley, Trish and Booth, Maureen, "HCFA Quality Assurance Reform Initiative," *Public Welfare*, Vol. 53, Issue 2, Spring 1995.

³³ Thurston, Kristine et al, *Medi-Cal Audit Crosswalk*, Medi-Cal Policy Institute, National Committee on Quality Assurance, January 2001.

³⁴ California Assembly Bill 162 and Assembly Bill 1959.

Additional Information and Resources Used

State Websites

California:

Department of Managed Health Care: www.dmhc.ca.gov

Department of Health Services: www.dhs.ca.gov

Managed Risk Medical Insurance Board: www.mrmib.ca.gov

New York: www.health.state.ny.us

Michigan: www.michigan.gov/mdch

Additional Websites

Agency for Healthcare Research and Quality: www.ahrq.gov

California Association of Health Plans: www.calhealthplans.com

Centers for Medicare & Medicaid Services: <http://cms.hhs.gov>

Child and Family Coverage Technical Assistance Center: www.cfctac.org

Institute for Health Policy Solutions: www.ihps.org

Institute of Medicine of the National Academies: www.iom.edu

Kaiser Family Foundation: www.kff.org

National Academy for State Health Policy: www.nashp.org

National Committee on Quality Assurance: www.ncqa.org

ABOUT COMMUNITY HEALTH COUNCILS, INC.

Community Health Councils is a non-profit, community-based health promotion, advocacy and policy organization. Established in 1992, CHC's mission is to improve health and increase access to quality healthcare for uninsured, economically-disadvantaged, and underserved populations. 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 fourth and final in a series that highlights quality of care and coordination efforts as part of CHC's commitment to improve California's quality assurance systems.

Community Health Councils, Inc.

3761 Stocker Street, Suite 201

Los Angeles, CA 90008

TEL: 323/295-9372 FAX 323/295-9467

www.chc-inc.org

Interviews

JIM BANKS, Quality Director, and Scott Crawford, Healthy Kids Program Manager, LA Care Health Plan

JACQUELINE BUTCH, Director, Quality Measurement, and Beverly H. Pasley, Manager, Quality Improvement Bureau of Quality Management and Outcomes Research, New York State Department of Health Services

JACOB DIEKMANN, Quality Improvement and Research Manager, Inland Empire Health Plan

ELLEN DUNN-MALHOTRA, Director of Planning and Evaluation Services, Health Plan of San Mateo

SHEILA EMBRY, Manager, and Joyce Hight, Senior Analyst, Quality Improvement and Program Development Section, Comprehensive Health Plan Division, Medical Services Administration, Michigan Department of Community Health

CHERIE FIELDS, Chief Executive Officer, Local Health Plans of California

CHRISTINE GERBO, Quality Director, Santa Clara Family Health Plan

STEVE GOBY, Senior Counsel, and Robin Fried, Assistant Chief Counsel, California Department of Managed Health Care

MAUREEN HANLON, Former Quality Director, Alameda Alliance for Health

DORI LANGE, Quality Director, San Francisco Health Plan

VALLITA LEWIS, Program Operations Manager, and Carolyn Tagupa, Research Program Specialist, Benefits and Quality Monitoring Division, California Managed Risk Medical Insurance Board

BARBARA MARQUEZ, Health Program Specialist, First 5 California

RACHAEL NAVA, Healthy Kids Program Manager, and Barbara Palla, MD, Medical Director, Central Coast Alliance for Health

WILLIAM NICHOLS, Research Analyst, First 5 Los Angeles

ROBIN ROCHE, Board Member, Santa Clara Family Health Foundation

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

SHARON STEELY, Quality Director, Health Plan of San Joaquin

Credits

Issue Brief Prepared by: Sandra Diaz, MSSW, Policy Analyst; Caroline Rivas, MSW, Project Director; and Lark Galloway-Gilliam, Executive Director, Community Health Councils, Inc.

Edited by: JANICE TAYLOR, Communications Director, Community Health Councils, Inc.

Special thanks to Sara Bholat for research assistance and to Merry Wood for her continued support and expertise in the production of the four briefs in this series.