

# Managing Medicaid quality and cost

*States seek ways to ensure that managed care organizations do not undermine the quality of care provided to Medicaid recipients while trying to control health care costs. The lack of national standards makes comparisons among states difficult.*

BY TRUDI MATTHEWS

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**A**rizona, while last to develop a Medicaid program, in 1981 received the first comprehensive statewide waiver from the federal government to develop a Medicaid managed care program.

The first few years of Arizona's experiment were a disaster. Some providers and plans lost money and pulled out of the program, while others took advantage of administrative disarray and fraudulently lined their pockets. There were disruptions to care as well as questionable quality of care. Congress held hearings in 1984 on Arizona's management of its Medicaid program.

Since that early experiment, Arizona has come a long way. Its pioneering efforts in ensuring lower costs and better quality serve as models for the all but two states that have embraced Medicaid managed care. Arizona has managed to build a relatively stable pool of plans and providers and has a comprehensive quality management system in place.

"We have been able to successfully mainstream our members into Arizona's health care system," said Nan



Jeannero, manager of Health Plan Operations for Arizona's Health Care Cost Containment System. "Eighty percent of physicians in Arizona participate in our program, and various reports on our system have found that we provide equal if not better care than fee-for-service."

In recent years, 48 states and the District of Columbia have adopted Medicaid managed care programs. Managed care covered less than 10 percent of the Medicaid population before 1992 and now covers more than 54 percent, according to the Health Care Financing Administration. The switch came as states received more flexibility from the federal government, sought to contain skyrocketing health care costs for Medicaid and provide better care coordination for enrollees.



## Ensuring quality

Yet, some people fear that the emphasis on cost savings has hurt the quality of care provided by public and private managed care plans. Critics say that managed care, with its use of fixed payments, contains an inherent incentive to deny care and underserve patients. States, which spend a lot of money on Medicaid and know the special needs of many covered by Medicaid, have enhanced oversight procedures and data collection requirements for Medicaid managed care programs, according to a new report by The Council of State Governments.

These state quality assurance or quality improvement efforts seek to ensure that Medicaid recipients receive adequate quality of care and are pro-

tected from managed care plan abuses. The report, *Measuring the Quality of Medicaid Managed Care: An Introduction to State Efforts*, looks at state quality assurance programs.

The report found that, while there have been disruptions to care and problems with the quality of care, especially during early phases of implementation, state Medicaid managed care programs have made big strides toward improving quality assurance programs and monitoring plan performance. According to CSC's report:

- Every state with a managed care program collects performance measures/quality indicators for some portion of its Medicaid population. Most states use measures from the National Committee for Quality Assurance's Health Plan Employer Data and Information Set, or HEDIS, to monitor quality.
- Every state with a Medicaid managed care program performs satisfaction surveys of Medicaid recipients.

Surveys are performed either by the managed care plans, by external quality review organizations or by the responsible state agency. This is a significant increase from the 27 states that did so in 1996, according to the National Academy for State Health Policy. Most states used the Consumer Assessment of Health Plan Satisfaction survey instrument to assess Medicaid recipient satisfaction.

## State successes

Other states have reported successes similar to Arizona's.

"In Wisconsin, one of the ways we measure quality is through data reported by HMOs on important health outcomes for the population in managed care," said Angela Dombrowicki, director of the Managed Care Section in Wisconsin's Bureau for Health Care Financing, which oversees Wisconsin's Medicaid program. "HMOs have consistently reported better outcomes

## Ways to measure quality

In the early 1990s, organizations and the federal government developed models for state agencies and managed care plans to use in assessing quality and fulfilling reporting requirements. Below is a list of initiatives and tools developed to measure quality that are relevant to Medicaid managed care.

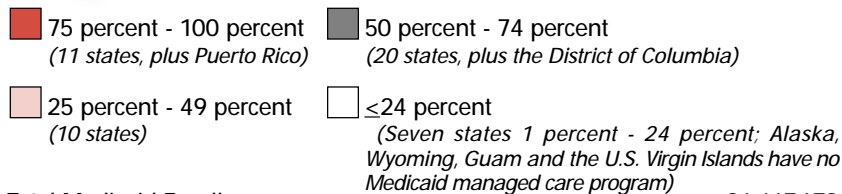
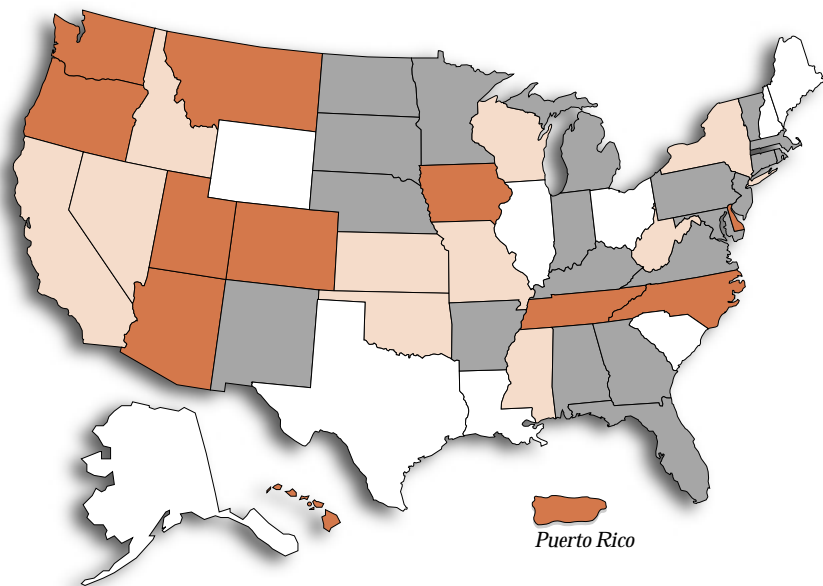
**Quality Assurance Reform Initiative** — Developed by the Health Care Financing Administration, this initiative is a tool for states to use in assessing the quality of care in Medicaid managed care programs.

**Quality Improvement System in Managed Care** — This system was developed to provide a comprehensive, coordinated oversight and quality improvement system for Medicare's managed care programs. It also is intended for voluntary use by states for Medicaid. Still in implementation, this system takes the Quality Assurance Reform Initiative guidelines a step further by requiring plans to demonstrate that they are improving quality. More information is at [www.hcfa.gov/quality/3a.htm](http://www.hcfa.gov/quality/3a.htm).

**National Committee for Quality Assurance Health Employer Data and Information Set** — This organization is responsible for the most comprehensive and widely accepted set of quality indicators for both private and public health plans. The committee in 1996 established several quality measures specific to the Medicaid population. More information is at [www.ncqa.org](http://www.ncqa.org).

**Consumer Assessment of Health Plans Survey** — This is a tool for assessing consumer satisfaction with care provided. Respondents can give ratings on a number of variables, including access to and availability of care, interpersonal skills of providers, wellness advice, and patient involvement in decision-making. More information is at [www.ahcpr.gov/qual/cahpfact.htm](http://www.ahcpr.gov/qual/cahpfact.htm).

## Medicaid managed care enrollment, by state, 1998



Total Medicaid Enrollees .....	31,117,679
Total Enrolled in Medicaid Managed Care .....	16,834,390
Percent of Medicaid Enrollees in Managed Care .....	54%

Note: State Medicaid enrollment includes individuals enrolled in state health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

Source: Health Care Financing Administration

on most measures.”

Dennis Whalen, executive deputy commissioner for the New York Department of Health, agreed.

“All the measures that we have been reviewing — increased access to primary and specialty care, increased receipt of preventative services, better management of chronic diseases, maintaining or improving recipient satisfaction — point to an overall improvement in services,” Whalen said.

Whalen cited the prevalence of lead screenings, which is especially important for children living in poor housing conditions with peeling lead-based

paint. In New York, which requires Medicaid managed care plans to report lead screening rates, 70 percent of Medicaid recipients were tested, compared to 19 percent for Medicaid programs nationwide.

### A lack of uniform standards

In spite of some states’ Medicaid managed care accomplishments, there is still much for states to do to ensure quality care. According to CSG’s report, one of the biggest obstacles to assessing the quality of care provided by managed care plans and providers is

the absence of nationally recognized quality assurance standards and data collection methods. Although HEDIS data is recognized widely and used by governments and businesses, there is still no single set of standards acceptable to all Medicaid programs.

In addition, states use a variety of practices in quality assurance programs for Medicaid managed care. These include monitoring the clinical aspects of care and requiring plans to report data on certain quality indicators, reviewing plan administrative procedures and functions, monitoring consumer satisfaction and member informational materials, and using ombudsmen and hotlines to receive and handle problems or complaints. While all of these assist state officials in monitoring quality and protecting recipients’ rights, the complexity and variation of requirements across states make quality comparisons between states difficult. Without nationally accepted benchmarks, it is difficult to say how well or how poorly Medicaid managed care plans are performing.

Other challenges for Medicaid managed care programs include ensuring the quality of care for recipients with chronic illnesses and special needs, such as those with diabetes and the disabled, and dealing with the growing number of recipients who need long-term care. Such populations may not be as suited to managed care arrangements and states are experimenting with ways to handle special populations. ★

### CSG resources

For more information about quality assurance efforts in Medicaid managed care programs, contact Trudi Matthews, CSG health policy analyst, at (606) 244-8157. To order the report, *Measuring the Quality of Medicaid Managed Care: An Introduction to State Efforts*, (order # C193980) call CSG’s publications department at (800) 800-1910 or visit CSG’s online store, [www.csg.org](http://www.csg.org).