Access and Quality in Managed Care

Contracting with managed care plans creates the potential for some states to improve access to appropriate services, better coordinate care for Medicaid enrollees, and measure performance with regard to quality. Medicaid managed care links enrollees with a primary care provider (PCP) or case manager and, in doing so, offers opportunities for improved continuity and care coordination. Capitated payment and other managed care features can also be designed to emphasize prevention and early detection of health conditions. However, poorly designed or implemented Medicaid managed care programs can also create issues for states that may lead to poor enrollee health outcomes. In addition, there may be considerations for managed care in addressing the needs of certain populations or geographic areas.

Standards, reporting, and enforcement of Medicaid managed care contract requirements vary considerably across states. This variation among states creates challenges for comparing and assessing access and quality. The ability to synthesize research across states is also constrained because individual studies typically provide national estimates or focus only on one or a few states and vary considerably in the measures used, their comprehensiveness, and their research quality; many studies in this area are also dated. Current national surveys have limitations, such as the absence of sufficient state-level sample sizes, the time lag in gathering and reporting survey data, the lack of information on whether or not individuals are enrolled in managed care, and the limited range of access measures that can be self-reported.

This section:

- reviews how comprehensive risk-based Medicaid managed care relates to each dimension of access defined in the Commission's March 2011 Report to the Congress (MACPAC 2011);
- describes quality measurement and improvement activities most commonly used by states; and

- identifies the importance of data and updated analyses to assess access and quality in Medicaid managed care.

Monitoring Access in Comprehensive Risk-based Managed Care

The Commission's initial access framework was developed in order to guide our future work on access to care and services for Medicaid and CHIP enrollees. Drawing upon over 30 years of research on defining and measuring access to care, the framework provides an approach that considers the complex characteristics and health needs of the Medicaid and CHIP populations, as well as program variability across states. We expect our access framework to evolve to address new health care practice patterns, changing program needs, and new areas of focus.

The Commission's initial framework for monitoring access to care focuses on three main elements: enrollees and their unique characteristics, provider availability, and appropriate utilization:

- **Enrollees.** Medicaid and CHIP enrollees have unique characteristics to be accounted for in monitoring access to care.
- **Availability.** Provider availability for Medicaid and CHIP enrollees affects access and is influenced by provider supply and provider participation.
- **Utilization.** An assessment of access to care should focus on whether appropriate and available services are used, the affordability of services, the enrollee's ability to navigate the health care system, and the enrollee's experiences with the health care system.

These three components will serve as the basis for the Commission to evaluate access, including the appropriateness of services and settings, efficiency, economy, and quality of care, and impact on health outcomes.

Enrollees

Medicaid enrollees have unique health care needs and characteristics to be accounted for in monitoring access to care, including demographic characteristics and the ways in which they qualify for coverage. Section B of this Report discusses the characteristics of the various eligibility groups and potential challenges related to their enrollment in managed care. Issues particularly salient to access to care for Medicaid enrollees include:

- frequent turnover in eligibility;
- complex, chronic medical needs that may benefit from care coordination, care management, and continuity of care;
- provider networks that include adequate numbers of PCPs and specialists who treat health issues such as behavioral health needs that are more common in the Medicaid population; and
- coordination with Medicare on care and benefits for those dually eligible for Medicaid and Medicare.

These issues may have implications for how Medicaid enrollees experience access to care in managed care settings.

Frequent turnover in eligibility may mean that enrollees have intermittent access to the same providers during the year. If individuals re-enroll, there is a chance they could be enrolled in different plans with different provider networks and face challenges in maintaining continuity of care (March 2011 MACStats Table 1).

Complex medical needs lead many Medicaid enrollees to require more provider visits during the year than are typically used by individuals not enrolled in Medicaid (MACStats Tables 3C, 4C, 5C). Thus, Medicaid managed care provider networks may need to include a larger and more specialized set of providers to facilitate adequate access. This may be particularly true as states increasingly move to enroll children with special health care needs and adults with disabilities into managed care plans.

Specialty care needs may also differ for the Medicaid population compared to the privately insured population. For example, child and adult Medicaid/CHIP enrollees are more likely than the privately insured to have certain health conditions that may require specialty care (MACStats Tables 3B, 4B).

Dual eligibility for Medicare and Medicaid can create particular challenges for Medicaid managed care enrollees. Dual eligibles may have access to a very different set of providers for their Medicare-covered benefits compared to the benefits covered by their Medicaid managed care plan. Nearly all providers participate in fee-for-service (FFS) Medicare; if a dual eligible is instead enrolled in a Medicare Advantage (MA) plan, that plan may have a network of providers that is different from the enrollee's Medicaid managed care network of providers. States are currently exploring ways to improve coordination of the two programs, as described in Section B of this Report.

Availability of Providers

For all Medicaid enrollees, provider availability is influenced by provider supply in their geographic area and the share of those providers that agree to participate in Medicaid. Concerns about both provider supply and provider participation affect both traditional FFS Medicaid and Medicaid managed care programs. Provider participation may vary because health providers voluntarily choose whether or not to participate in these programs.[1] Managed care offers states additional mechanisms for assessing and influencing the adequacy of provider participation in Medicaid. Through their contracts with participating managed care plans, states can require compliance with standards for network adequacy.

One of the most detailed studies of provider networks in Medicaid and CHIP health plans comes from a 2001 survey of health plans in 11 states with the largest plan enrollment (Gold et al. 2003). At that time, most plans said that they experienced few problems developing and maintaining their provider networks, but reported more problems with specialist contracting than with PCPs, with particular issues in certain specialties (e.g., pediatric subspecialties).

As a preliminary step to understanding the current landscape of monitoring access across states and examining access to care in Medicaid, the Commission requested information from state Medicaid directors in the 50 states and the District of Columbia from November 2010 through April 2011. The questionnaire was designed to compile timely information on how states monitor and identify potential provider supply problems. Findings from the questionnaire are presented in the Annex to this Section.

[1] While state legislatures could require health professionals to participate in Medicaid or CHIP as a condition of licensure or gaining other valued commodities, opposition to such policies makes enactment difficult (Gold and Aizer 2000).

Appropriate Utilization

Because Medicaid coverage does not guarantee access to services and may not ensure appropriate use of services, an analysis of utilization for the purpose of assessing access to care needs to focus on:

- whether or not appropriate, available services are obtained;
- the affordability of services;
- the enrollee's ability to navigate the health care system; and
- the enrollee's experiences with the health care system.

In an effort to improve outcomes and reduce costs, managed care programs aim to better manage the use of health care services. In FFS Medicaid, enrollees may seek care from any participating provider. Comprehensive risk-based plans often have specific rules regarding appropriate use of services. In both comprehensive risk-based plans and primary care case management (PCCM) programs, enrollees may be required to select a PCP or obtain prior authorization or approval to receive certain tests or visits to specialists unless an emergency situation exists.[2]

Methods for coordinating care and assuring receipt of appropriate services may be clearly delineated in comprehensive risk-based managed care. State contracts may emphasize the need for plans to place a greater focus on enrollees and their health needs, giving plans responsibility for arranging, providing, and overseeing the care of their members consistent with the specified benefit package and medical necessity. Building on the FFS structure, PCCM programs incorporate managed care features such as care management, often using PCPs to perform these activities on behalf of the enrollees.

States require participating comprehensive risk-based plans to ensure that each enrollee has a PCP and that PCP assignments, when necessary, are based on factors such as proximity to an enrollee's home, primary language spoken, and prior PCP relationship. Plans may be required to provide a designated case manager for some individuals with chronic or complex medical conditions who require additional assistance obtaining services. Plans may also be required to establish disease management programs to provide education and clinical guidance to enrollees with specific medical conditions such as asthma or diabetes. Contracts may also specify staffing requirements (e.g., clinically relevant experience, staffing ratios) for individuals coordinating care and providing case management and disease management services.

Monitoring Quality of Care in Comprehensive Risk-based Managed Care

Quality measurement, monitoring, and improvement have received increasing attention in Medicaid. Such interest has been facilitated by increasingly sophisticated and prevalent information technology tools for data collection and analysis, as well as the development of a range of measures for almost all aspects of health care delivery and outcomes (Smith et al. 2010). Payers have exhibited a marked interest in using these population-based measures to gauge the value and quality of the services they purchase (Rosenbaum et al. 2003).

Medicaid programs are using information from managed care plans to set standards, structure payment, measure performance, and provide comparison reports to consumers. To help Medicaid enrollees choose a managed care plan,

[2] States may also use utilization management tools such as prior authorization in their FFS programs.

BOX E-1. Updated Analyses Would Support Program Evaluation

Available evidence on the overall impact of comprehensive risk-based managed care on utilization, receipt of appropriate services, and quality of care in Medicaid is mixed, reflecting differences across states, markets, services, and metrics used for comparison. The studies and data used are generally dated, making it difficult to draw comparisons to state Medicaid managed care programs today. Many study findings may not be applicable to experience today, particularly as states have gained experience with managed care and have become more adept at using the managed care contract as a tool for achieving certain program outcomes. Overall, there is a significant gap in research that does not allow for comparisons of performance among state Medicaid managed care programs in order to determine which techniques are effective (or ineffective) for monitoring the quality, economy, and costs of care. We present examples of available studies for context, but recognize more work is needed in this area.[3]

states are also increasingly publishing information on managed care plan performance on websites, in reports, or in the form of report cards. In FY 2010, 41 states indicated that they publicly report health plan performance information (Smith et al. 2010).

States must meet certain requirements established by the Balanced Budget Act of 1997 (P.L. 105-33) and subsequent regulations for monitoring quality of care, but have a fair amount of flexibility in what they report to the federal government (CMS 2002). For example, under 42 CFR 438.240(b), comprehensive risk-based plans must have an ongoing quality assessment and performance improvement program. These requirements are discussed in more detail in Section F of this Report.

States make plans accountable for providing quality care by incorporating quality requirements in their Medicaid managed care contracts. Commonly used tools for monitoring quality in Medicaid managed care include:

- External quality review organizations (EQROs);
- Healthcare Effectiveness Data and Information Set (HEDIS);[4]
- Consumer Assessment of Healthcare Providers and Systems (CAHPS);[5]
- accreditation; and
- pay for performance.

EQROs

States must provide for an external, independent review of their managed care plans conducted by an EQRO. States must contract with an independent entity, an EQRO, to conduct the review. Comprehensive risk-based plans must have an external quality review (EQR) performed on the quality, timeliness, and access to services they provide (42 CFR 438.310). The external review

[3] While some of these studies have been published recently, they are generally based on data as old as the mid-1990s. Examples of available research on access include: Sparer 2008, Bella et al. 2006, CHCF 2004, Chang et al. 2003, Brown et al. 2001, Long and Coughlin 2001, Mitchell et al. 2001, Gold 1999, Lillie-Blanton and Lyons 1998, and McCall and Winter 1997. Examples of research on quality include: GAO 2009, Bollinger et al. 2007, Landon and Epstein 1999, Fontanella et al. 2006, and Aizer et al. 2007.

[4] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[5] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality, which oversees the survey.

must include an assessment of the plan's strengths and weaknesses with respect to quality, timeliness, and access to services; recommendations for improving quality of services; and an assessment of how well the plan addressed recommendations from the previous review (42 CFR 438.364). Because federal requirements give states flexibility on what types of services should be reviewed, results are difficult to compare across states. For example, one state might focus on quality of oral health services provided and another on behavioral health services. Results can, however, be used to address performance improvements with managed care plans.

HEDIS

The National Committee for Quality Assurance (NCQA) has created a set of state-level quality, access, and effectiveness-of-care measures for selected conditions known as HEDIS. Many states require their participating plans to collect and report data on these HEDIS measures. Table E-1 includes a sample of select measures from NCQA's *The State of Health Care Quality 2010 Report*, which compares national averages for enrollees in Medicaid managed plans, individuals with commercial coverage enrolled in a health maintenance organization (HMO), and enrollees in MA HMOs. Scores on all of these measures are lower for Medicaid managed care enrollees than for individuals in other types of plans. For example, the rate of high blood pressure control for Medicaid enrollees is lower than the rates for MA enrollees and for individuals with commercial insurance (55 percent compared to 60 and 64 percent, respectively). However, important differences between the commercial, Medicare, and Medicaid populations such as health status and income may affect the results. In addition, data are only reported for individuals who are continuously enrolled for 12 months, so they may not be representative of the entire Medicaid managed care population. Therefore, comparisons among the populations need to be viewed with caution.

CAHPS

CAHPS is a set of beneficiary surveys designed for children and adults that covers a range of topics, including access to care and use of services, wait times, appointment scheduling, access to specialty care, and satisfaction with providers. For Medicaid programs, CAHPS is an important quality

TABLE E-1. Select HEDIS Effectiveness of Care Measures (National HMO Means, 2009)

Measure	Commercial	Medicare	Medicaid
Use of appropriate medications for people with asthma	92.7%	N/A	88.6%
Prenatal and postpartum care: Timeliness of prenatal care	93.1	N/A	83.4
Controlling high blood pressure	64.1	59.8%	55.3
Weight assessment and counseling for nutrition and physical activity in children and adolescents: Counseling for physical activity	36.5	N/A	32.5

Note: Comparisons among the populations need to be viewed with caution because important differences between the commercial, Medicare, and Medicaid populations may affect the results (i.e., health status, income, and benefit designs of the different programs).

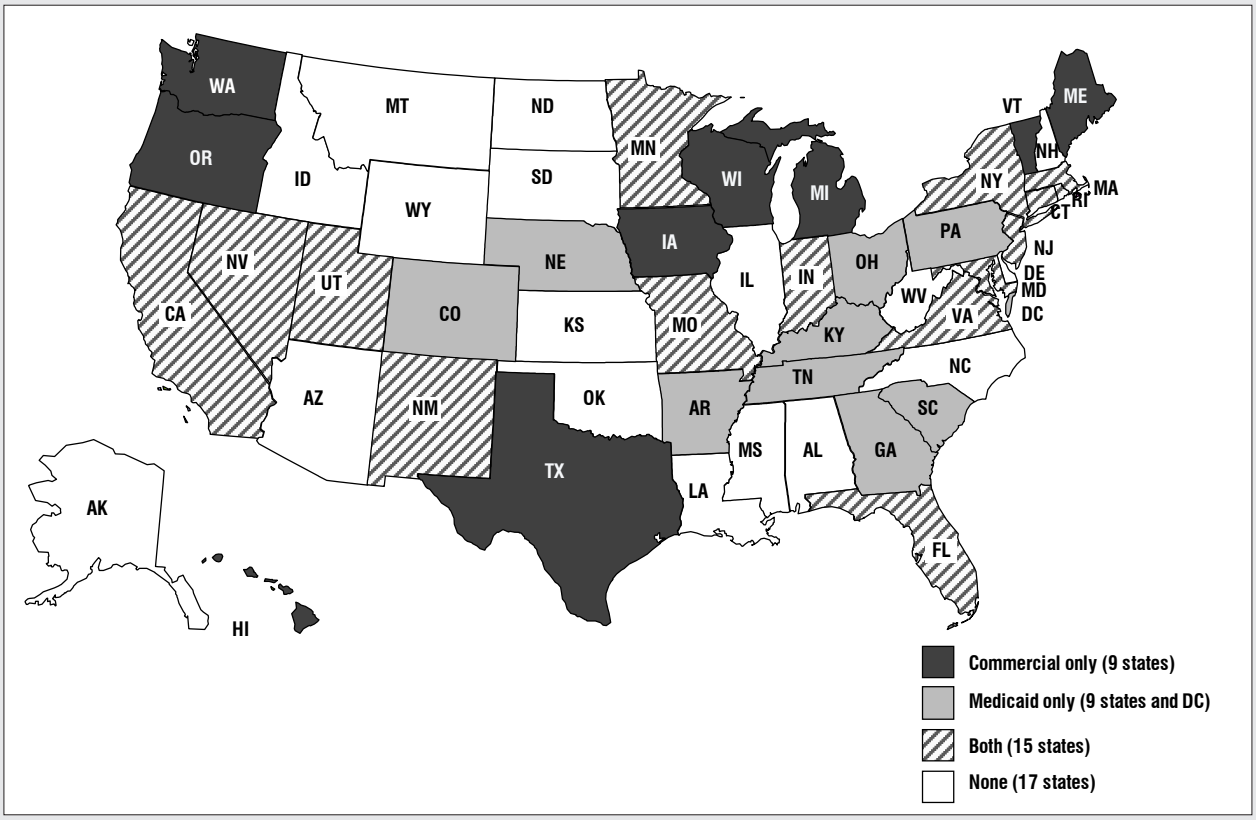
Source: NCQA 2010a

improvement tool used by states and managed care plans to measure performance, determine where to focus improvement efforts, and track improvements over time. Some state Medicaid agencies use CAHPS and similar measures to gauge member satisfaction with Medicaid managed care arrangements. Data from the 2010 CAHPS survey show that enrollees in Medicaid managed care plans gave their health plan a higher overall rating compared to privately insured or Medicare patients (NCQA 2010a). Figure E-1 shows which states require HEDIS and CAHPS measures for Medicaid and for other lines of business.

Accreditation

States may require that managed care plans receive accreditation from an approved accrediting body as a condition of participation in Medicaid. To receive accreditation, plans must meet a set of standards that align with federal requirements for Medicaid managed care. There are several accreditation organizations that states may use in their accreditation processes. For example, NCQA is an accreditation organization that evaluates plans by product line or product (e.g., Medicaid, Medicare, commercial), and plans can receive an accreditation status of Excellent, Commendable, Accredited, Provisional, or Denied. According to NCQA, 25

FIGURE E-1. Required HEDIS and CAHPS Measures by State, 2010



Source: NCQA 2010b[6]

[6] Some states may only collect HEDIS and CAHPS data for commercial purposes only, particularly if the state has no risk-based managed care.

states recognize or require NCQA accreditation for their Medicaid managed care plans. States requiring NCQA accreditation may use this process to scale back their own state quality monitoring activities (NCQA 2010b). Another accreditation organization, URAC (formerly known as the Utilization Review Accreditation Commission), is also recognized and used by several states for monitoring quality in their Medicaid managed care plans (URAC 2009).

Pay for Performance Incentives

As an increasing number of Medicaid enrollees are in some form of managed care, states have looked for ways to incent plans to provide high quality, accessible, and cost-effective services. In 2010, 34 states reported having "pay for performance" policies and performance-based payment methodologies for plans, including financial incentives (e.g., bonus payments for exceeding performance benchmarks) and nonfinancial incentives (e.g., auto-assignment of Medicaid members into higher performing plans) (Smith et al. 2010).

Plans often routinely report data that states can incorporate into a pay for performance system; most plans have more staff capacity to participate in such a system than individual providers do (Kuhmerker and Hartman 2007). However, there has been little research on the extent to which these pay for performance strategies are associated with improved quality outcomes at the plan level.

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Section E Annex

Preliminary Review of State Activities for Monitoring Access to Care

As a preliminary step in examining access to care in Medicaid, the Commission asked state Medicaid Directors to complete an informal questionnaire about state efforts for assessing access in Medicaid. From November 2010 through April 2011, Medicaid Directors in 47 states and the District of Columbia provided information about current activities for monitoring and identifying potential problems with access to care and provider capacity in their Medicaid programs.[1]

Examples of Access Monitoring by States

States indicated that they used many approaches to monitor access.

Monitoring enrollee feedback and conducting community outreach

- Monitor complaints through the use of enrollee or provider telephone hotlines
- Communicate regularly with a network of health care system stakeholders (i.e., beneficiary representatives, providers, local social service agencies, county case workers, public officials such as legislators or the Governor's office)
- Conduct community outreach with providers and beneficiary representatives
- Work with professional associations to encourage provider participation

Reviewing available data

- Review utilization data from the Medicaid Management Information System (MMIS) or a utilization dashboard to identify unusual patterns in claims and encounter data (i.e., use of emergency departments)
- Include requirements in managed care plan contracts for plans to measure and monitor access standards and report outcomes to the state on a prescribed schedule
- Require managed care plans to administer HEDIS and CAHPS data to monitor health plan performance on access as well as quality issues
- Analyze reports from transportation brokers to identify information on sudden changes in frequency or distance of transports

[1] All states and DC responded to the Commission's request for information; three states indicated that they were unable to complete the questionnaire at that time.

Leveraging other resources

- Work with academic institutions or other organizations in the state to monitor access-related issues
- Require managed care plans to sponsor initiatives to improve access when plans report access issues to the state as part of their contract requirements
- Hold managed care plans accountable for adjusting their networks, such as through the development of corrective action plans, if access issues arise

Examples of Provider Supply Monitoring by States

States use many techniques to monitor provider supply.

Reviewing available data

- Compare lists of participating providers to licensed providers
- Compare the location of participating providers to the location of beneficiaries
- Use Health Resources and Services Administration (HRSA) definitions to identify provider shortages
- Administer physician workforce surveys and surveys of primary and specialty providers to determine the Medicaid share of patients
- Analyze MMIS quarterly reports on primary and specialty care providers
- Assess whether providers listed in a managed care plan's network actually accept new patients
- Monitor compliance with standards specified in managed care plan contracts, including network adequacy, provider-to-patient ratios, and geo-access analysis

Leveraging other resources

- Work with sister agencies to monitor provider shortage areas
- Require managed care plans to compare the number of providers enrolled in Medicaid to the number of licensed providers or report on the prevalence of specific services such as emergency department care