

Centers for Medicare & Medicaid Services

Quality in Managed Care Strategies, Performance Improvement, and External Quality Review

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Medicaid Managed Care Training

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CMS Quality Improvement Roadmap

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VISION

“The right care for every person every time”

AIMS

“Make care safe, effective, efficient, person-centered, timely, and equitable”

Basis of the Medicaid Quality Strategy

July 2006

- Evidence-based Care and Quality Measurement
- Supporting Value-Based Payment Methodologies
- Health Information Technology
- Partnerships
- Information Dissemination and Technical Assistance

Early Quality in Managed Care

- 1991 – Quality Assurance Reform Initiative, technical assistance to States
- 1996 – Quality Improvement System for Managed Care – helped develop coordinated Medicare/Medicaid managed care quality
- 1997 – Balanced Budget Act – requires access/quality standards for MCOs
- 2002 – Medicaid Managed Care Final Rules

Where is the Quality in Managed Care?

- 42 CFR 438.204, Subparts D & E
- Subpart D – Quality Assessment and Performance Improvement = State Quality Strategy
- Subpart E – External Quality Review

How much Medicaid?

- About 65 percent of all Medicaid beneficiaries receive managed health care
- According to the CMS 64, of \$241B in Federal Share spent on Medicaid (excluding SCHIP) in 2006, \$47B went to “Managed Care Organizations”

The State Quality Strategy

- Each State must have an original/updated Quality Strategy on file at CMS
- CMS must approve and review the original document and any changes in the Strategy

Elements of the Quality Strategy

- Quality strategy development, review, & revision
- Managed care program goals & objectives
- Medicaid contract provisions
- State standards for access to care
- State standards for structure & operations
- State standards for quality measurement & improvement
- State monitoring & evaluation
- Procedures for race, ethnicity, & primary language
- National performance measures & levels
- Intermediate sanctions

The External Quality Review (EQR)

- Most State Medicaid Agencies competitively bid the EQR contract
- CMS provides enhanced FMAP for EQR activities (+/- 75 percent) – costs about \$.5-\$1M per year
- There are about twenty EQROs in the U.S.
- EQR applies to all MCOs, PIHPs, & HIOs
- EQR does not apply to PAHPS or PCCMs

Qualified EQROs Have:

- Competency
- Experienced staff
- Policies, data systems, processes
- Systems, organizations, financing
- Quality assessment & improvement methods
- Research design & methodology
- Sufficient resources
- Independence from the State Medicaid Agency & contractors

EQROs and Quality Improvement Organizations (QIOs)

Most EQROs (though this is not required) are also QIOs:

- Under the direction of CMS for the Medicare program
- Consist of a national network of 53 organizations
- Responsible for each State, territory, and DC
- Work with consumers, physicians, hospitals and other providers
- Ensure payment is made only for medically necessary services
- Investigate complaints regarding quality of care

Mandatory EQR Activities

1. Validate performance improvement projects (PIPs) undertaken the previous year
2. Validate performance measures undertaken the previous year
3. Conduct a compliance review of standards related to access, structure and operations, and measurement and improvement standards

Non-mandatory EQR Activities

- Validation of encounter data
- Administration of consumer/provider surveys
- Calculation of performance measures
- Conduct of performance improvement projects
- Conduct of focused studies on quality

Sample Performance Improvement Project Topics

- Adult diabetes management
- Children's oral health
- Asthma care
- High-risk pregnancy
- Emergency room utilization
- Lead screening
- Tobacco use
- Depression

Performance Measures

- Generally use the Healthcare Effectiveness Data and Information Set (HEDIS) methodology
- HEDIS was developed and is maintained by the National Committee for Quality Assurance:

<http://web.ncqa.org/>

HEDIS Measures

- Performance on various dimensions of care and service
- 70 measures across 8 domains of care
- Designed to provide purchasers/consumers with information to compare performance
- Address a broad range of health issues including:
 - Asthma Medication Use
 - Persistence of Beta-Blocker Treatment after a Heart Attack
 - Controlling High Blood Pressure
 - Comprehensive Diabetes Care
 - Breast Cancer Screening
 - Antidepressant Medication Management
 - Childhood and Adolescent Immunization Status
 - Advising Smokers to Quit

How is the process working?

States now have guidance and opportunities for enhanced funding to access and improve services to Medicaid beneficiaries!