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

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Medicaid Managed Care Training

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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
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- 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
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
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!