

Case Studies in Medicaid Managed-Care

**THE USES OF DATA IN
MEDICAID MANAGED-CARE:
A TEN-STATE COMPARISON**



Malcolm L. Goggin



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Nelson A.
Rockefeller
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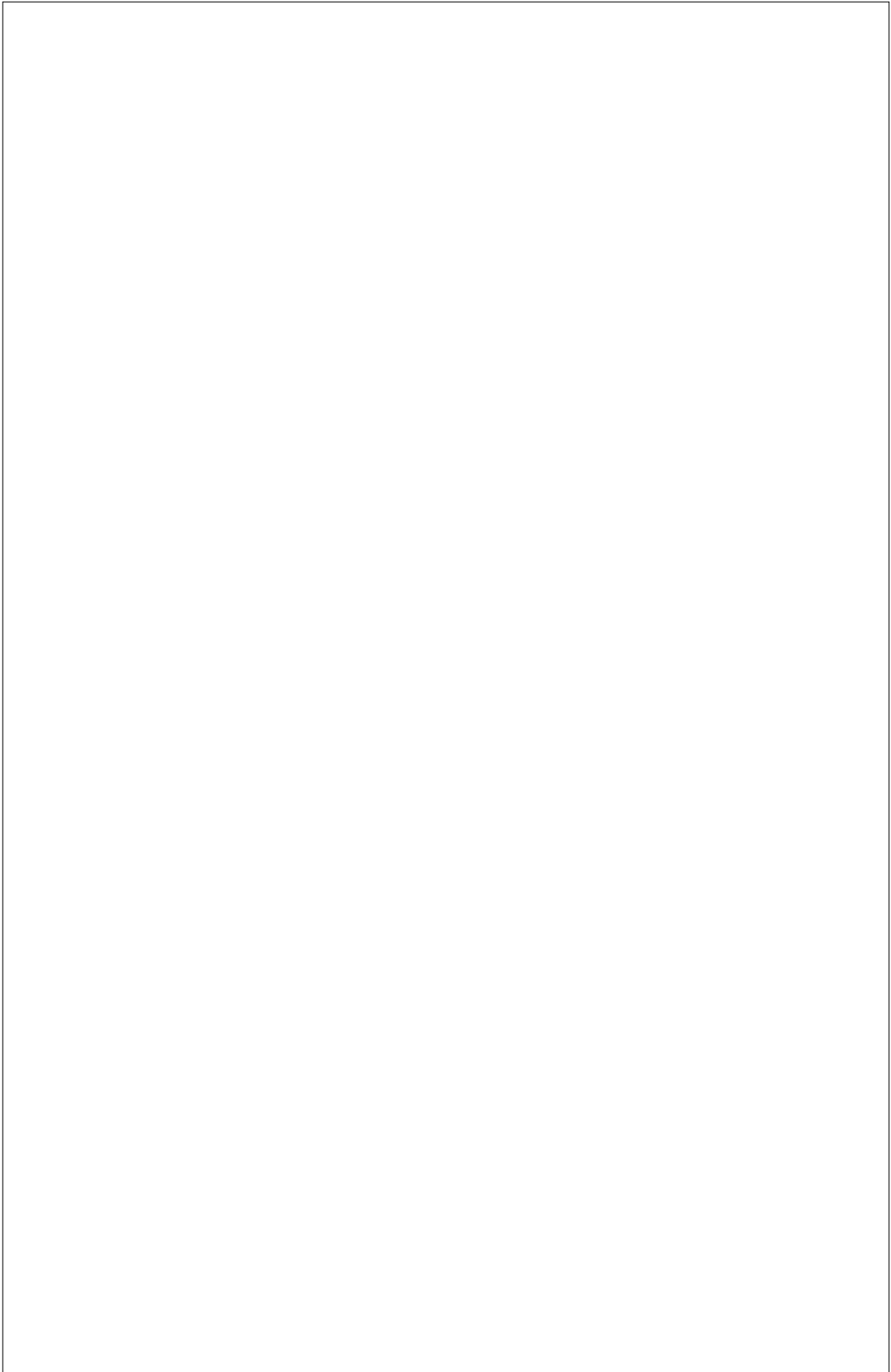
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In Brief

- ❖ Recognizing that it is virtually impossible to manage Medicaid managed-care programs without data, all states in the sample do a reasonably good job of collecting the data specified in contracts with Medicaid managed-care organizations.
- ❖ Nevertheless, all states have had to wrestle with a number of data “problems.”
- ❖ In states where the market is non-competitive, it is hard to get health plans to comply with federal and state data requirements.
- ❖ Once a Medicaid office collects data, analysts often limit their analyses to descriptive statistics.
- ❖ All ten Medicaid offices use data for monitoring plans and “putting out fires,” or for fixing an immediate problem. A few incorporate their findings from reports into policy decisions. Only Arizona uses performance measures routinely to hold plans accountable. The crucial difference between what Arizona does and what other states are doing is that in Arizona data analysis and use for managerial and policy decisions are institutionalized. In other states, they are not.
- ❖ There are at least seven alternative explanations for why state Medicaid offices are not using data effectively to manage their Medicaid managed-care programs.
- ❖ Medicaid directors can take accessible steps to improve their use of data.

Executive Summary

To realize managed-care's promise of access to quality care for low-income Medicaid clients at a reasonable cost, state Medicaid offices have had to become "value" or "prudent" purchasers. In an earlier study of the use of data on Medicaid managed-care for oversight in five states,¹ our team pointed out that to become a prudent purchaser, a state must: 1) reach a formal agreement, usually by signing a contract with a managed-care organization, on measurable performance requirements; 2) create a system of data reporting and analysis that allows the state to monitor compliance with the contractual requirements; and 3) be willing and able to penalize plans if they do not meet agreed-upon performance criteria, and reward plans for meeting or exceeding standards. The earlier report concluded that, with the exception of Arizona's Office of Health Care Cost Containment System, most state Medicaid offices would not fully qualify as prudent purchasers: "They [the states] have been less successful in ensuring data quality that is adequate to support contracting decisions and in developing the analytical or political capacity to use data to "manage" the managed care system. Becoming a prudent purchaser appears to be a complex task for states that may prove to be difficult for more than a few to achieve."²

As every director of a state Medicaid managed-care program knows, it is almost impossible to manage such a program without data. Moreover, regulations under the federal government's Balanced Budget Act of 1997 (BBA) as well as HEDIS and other performance measure initiatives, are predicated on the assumption that state Medicaid agencies are capable of data collection, analysis,

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1. J. W. Fossett et al., "Managing Medicaid Managed Care: Are States Becoming Prudent Purchasers?" *Health Affairs* 19 (July/August 2000), pp. 36-49.
 2. J. W. Fossett et al., p. 37

and use. This report analyzes what ten state Medicaid managed-care programs around the country were doing in 1999 in acquiring, analyzing, and using data to manage MMC programs. The investigations by twelve Rockefeller Institute of Government field researchers suggest that some states are better equipped than others to implement plans to collect, analyze, and use data. However, while many states will not be able to achieve the “gold standard” set by the Arizona system, every state can adopt at least some measures to move in that direction. This report suggest how they can do that.

This report also argues that what a state Medicaid director can accomplish *depends in large part on the state context* — that is, its resources, the maturity of the state’s managed-care system, the individual state’s managed-care marketplace (competitive or non-competitive), the political climate, and the skills of the personnel involved in acquiring, analyzing, and using data. Because of differences in state contexts, we have found that what works in one state may not work in another. A Medicaid director needs to exercise leadership, in part by adapting to the historical, political, bureaucratic, fiscal and health care marketplace context in which he or she operates.

Within these contextual constraints, Medicaid managed-care managers can take several steps to use data to manage their state programs more effectively.

- ❖ Frame the questions that need to be answered before designing the measures to answer the questions.
- ❖ Audit HEDIS and other data from HMOs to improve reliability and validity of the data.
- ❖ Collect data and report results that are comparable and useful to the Medicaid agency, as the purchasers, and to Medicaid enrollees, the ultimate health-care consumers.

- ❖ Cross-train agency personnel so program generalists understand the way data specialists work and vice versa. Cross the cultural divide.
- ❖ Make better use of the information already available.
- ❖ Develop strategies and tactics for using information in order to understand the alternatives and the arguments for and against health system changes that have either been adopted or are under consideration.
- ❖ Develop strategies and tactics to use information in order to make better, more informed management decisions.
- ❖ If indicated, reorganize the agency so the director of quality assurance reports directly to the Medicaid director.
- ❖ If indicated, hire personnel trained to conduct sophisticated data analyses that offer explanations and rule out alternative explanations for effects of the MMC program.
- ❖ If indicated, hire personnel who have experience in the private or nonprofit managed-care sectors, and be prepared to compete for those services in a tight labor market.
- ❖ If indicated, contract with an external quality review organization to conduct different types of studies and prepare different types of reports.
- ❖ If indicated, apply for outside public or foundation funding to conduct sophisticated needs assessment and other studies that will increase the likelihood that the organizations serving Medicaid clients can ensure access to high-quality care at a reasonable cost.

The Uses of Data in Medicaid Managed-Care: A 10-State Comparison

Introduction

To realize managed-care's promise of access to quality care for low-income Medicaid clients at a reasonable cost, state Medicaid offices have had to become "value" or "prudent" purchasers. In an earlier study of the use of Medicaid managed-care data for oversight in five states,¹ our team pointed out that to become a prudent purchaser, a state must: 1) reach a formal agreement, usually by signing a contract with a managed-care organization, on measurable performance requirements; 2) create a system of data reporting and analysis that allows the state to monitor compliance with the contractual requirements; and 3) be willing and able to penalize plans if they do not meet agreed-upon performance criteria and reward plans for reaching or exceeding standards. The earlier report concluded that, with the exception of Arizona's Office of Health Care Cost Containment System, most state Medicaid offices would not fully qualify as prudent purchasers. We concluded, "They [the states] have been less successful in ensuring data quality that is adequate to support contracting decisions and in developing the analytical or political capacity to use data to 'manage' the managed care system. Becoming a prudent purchaser appears to be a complex task for states that may prove to be difficult for more than a few to achieve."²

As every director of a state Medicaid managed-care program knows, it is almost impossible to manage such a program without data. Moreover, the June 14, 2002, final rule of the federal Balanced Budget Act of 1997, as well as Health Plan Employer Data and Information Set (HEDIS) and other performance measure initiatives, are predicated on the assumption that state Medicaid agencies are

1 J. W. Fossett et al., "Managing Medicaid Managed Care: Are States Becoming Prudent Purchasers?" *Health Affairs* 19 (July/August 2000), pp. 36-49.

2 *Ibid.*, p. 37.

capable of data collection, analysis, and use. This report analyzes what ten state Medicaid managed-care programs around the country were doing in 1999 with respect to acquiring, analyzing, and using data. The reports of twelve Rockefeller Institute of Government field researchers suggest that some states are better equipped than others to implement plans to collect, analyze, and use data to manage their Medicaid managed care programs. Yet while many states will not be able to achieve the “gold standard” set by the Arizona’s Health Care Cost Containment System, every state can adopt at least some measures to move in that direction. This report offers practical steps.

The Situation: Few States Use Data Routinely to Manage Their MMC Programs

What kinds of data are states collecting? How have the ten states in this sample analyzed their data? How and to what extent have states used the data, once analyzed? With the exception of Arizona, the states in our sample do not routinely use financial data, or information on providers or patient encounters and satisfaction to make managerial decisions — that is, for managing their Medicaid managed-care programs. Occasionally, a state uses data to improve the performance of managed-care plans, or set rates that the state will pay for care, build support among constituents, or educate Medicaid enrollees and the public. However, the use of data for these purposes is often not institutionalized, and varies with market and political conditions and the maturity of the Medicaid program, as well as the quality assurance resources at the state Medicaid agency’s disposal. However, while most of the ten states in our sample are not fully realizing the potential of prudent purchasing, many are doing well, and all have achieved partial success. These experiences provide many important lessons.

This report takes as its starting point the results of an earlier Rockefeller Institute of Government study showing that it is virtually impossible to manage Medicaid managed-care programs without

data that have been transformed into useful information.³ This report expands the study from five states to ten and examines how Medicaid offices in Arizona, Colorado, Florida, Georgia, Kansas, Michigan, New Jersey, North Carolina, Ohio, and West Virginia have dealt with the challenges of becoming prudent purchasers. As in the earlier study, I rely on reports from Rockefeller Institute field researchers who are familiar with Medicaid policies and practices in their states.⁴

After briefly highlighting variations in how states collect, analyze, and use data, I offer a number of reasons why some fall short. Then, by describing how two exemplary states – one mature and one just getting started – use data as an effective management tool, I demonstrate what is possible. Finally, I recommend a number of practical measures that Medicaid directors might take to enhance their use of data to improve program performance and to make managerial and policy decisions for two types of Medicaid managed-care markets, one competitive and one non-competitive. The goal is to give Medicaid directors the tools to become better “value” purchasers in today’s climate and to prepare them for the challenges in quality assurance that the final rule of the Balanced Budget Act of 1997 will likely present. Given the limitations of state capacity, my suggestions are within the grasp of most Medicaid directors.

It is important for directors to take steps now to shore up capacity not only to collect and analyze data but also to use them to make managerial decisions. This is especially true in light of the stringent guidelines for national electronic data and confidentiality standards set forth in the Health Insurance and Portability and Accountability Act of 1996, in the Quality Improvement System for Managed-Care of the Health Care Financing Administration, and

3 Ibid.

4 The twelve Rockefeller Institute Research Associates used a common report form, and what follows is a summary of my findings, based on a comparative analysis of the information that field researchers reported in 2000. For a description of the field network evaluation approach, see R. P. Nathan, *The Methodology for Field Network Evaluation Studies*, in W. Williams, ed., *Studying Implementation* (Chatham, N.J.: Chatham House, 1992).

in the final Medicaid Managed Care rule of the Balanced Budget Act of 1997.⁵

On February 26, 2001, HCFA published a notice in the Federal Register stating that the effective date of the final BBA rule would be delayed until June 18, 2001. As the proposed effective date approached, Secretary of Health and Human Services Tommy Thompson announced an extension of the deadline for implementation. The final rule was published in the *Federal Register* on June 14, 2002, and states were given until August 13, 2002, to come into compliance. This final rule will have important implications for the reporting requirements of managed-care organizations in the states. At a minimum, states would be required to monitor enrollment and disenrollment, grievances and appeals, and violations of the law, and meet a number of performance criteria. These new rules require states to develop written quality assessment and performance improvement strategies with input from beneficiaries and stakeholders, fund reviews of quality and timeliness of services, and access to services covered under each contract, and create a state information system that supports the implementation and operation of the state plan.⁶

What Are State Medicaid Offices Doing with Respect to Data Collection?

- ❖ ***Recognizing that it is virtually impossible to manage Medicaid managed-care programs without data, all states in the sample do a reasonably good job of collecting the data specified in contracts with Medicaid managed-care organizations.***

All ten states used HMO contracts to specify the data that they require for performance contracting. These contracts include a

5 See The Lewin Group, "The Impact of the Proposed Medicaid BBA Regulations in Medicaid Managed Care." Center for Health Care Strategies, 2001.

6 For a detailed description and analysis of the proposed rule, see Families USA, "Field Report: Medicaid Managed Care Regulations Issued: What do they do? Will they be Implemented?" March 2001.

schedule for reporting data and specify the consequences for non-compliance.

Each of the states in the sample collected four types of data: financial information such as ownership, operating income, medical expense ratios, and claims payment trends, as well as plan performance, network performance, and consumer satisfaction, including grievances and complaints. Several states also collected or are making plans to collect true outcomes measures, using clinical practice guidelines. For example, New Jersey requires HMOs to adhere to a written quality management program, which includes utilization review. The contract includes goals, objectives, scope, specific activities, continuous performance of activities, review of Medicaid client utilization patterns by physicians and other health professionals, and a focus on health outcomes. The plan must also establish a quality management committee.⁷ Michigan requires plans to achieve health outcomes in certain areas and provides bonuses to plans that meet certain immunization and well-child targets.

A number of states have experienced difficulty collecting timely, reliable data. In Ohio, for example, the issue has been, and continues to be, the poor financial performance of health plans, which threatens the very existence of the state's Medicaid managed-care program. Apparently, the state bureaucracy cannot agree on who is responsible for *financial monitoring* — the Ohio Department of Insurance or the state's Bureau of Managed Health Care.⁸ In New Jersey, data-collection issues revolve around *quality assurance*: doctors receiving capitated payments do not have any financial incentive to completely fill out patients' medical records, since they do not bill insurers for services provided. To monitor quality assurance better, the New Jersey Bureau of Managed Health Care Monitoring works closely with the Quality Management Council, composed of ten public and state government members. The council meets quarterly and hosts two public meetings annually. Kansas deals with data-collection problems on an ad hoc basis, either through informal contacts between state Medicaid

7 New Jersey field report, p. 25.

8 Ohio field report, pp. 30-31.

officials and plan administrators or at the monthly meeting of the Peer Education Resource Council. The council represents a broad array of interests and perspectives, and the Council's members include physicians, pharmacists, plan representatives, Medicaid officials, and state administrators from other health-related departments.

Florida has adopted a team approach to both collecting data on *consumer satisfaction* and responding to complaints and grievances. Florida was one of the earliest of the ten states to move Medicaid clients from fee-for-service to managed care. The number of subscriber complaints increased dramatically during the 1980s as more and more Medicaid clients were automatically assigned to a primary care physician. In response to these mounting complaints, in 1993 the state created a Statewide Provider and Subscriber Assistance Panel. Located in the Florida Agency for Health Care Administration, its purpose is to review customer enrollment/disenrollment, and quality-of-care complaints that are not resolved to the client's satisfaction. Each health-care plan must submit a grievance report within forty-five days of the end of each quarter. Like many other states, Florida also instituted a hotline to receive and respond quickly to emergency or urgent quality-of-care complaints. Responding to customer complaints has become a team effort: workers in local Medicaid offices monitor complaints and channel them to headquarters in Tallahassee. People from headquarters go into the field every six months to conduct site visits to systematically examine and resolve complaints. In addition, the state has a contract with Westat to survey clients and with Florida State University faculty to analyze the data.⁹

❖ *All states have had to wrestle with a number of data "problems."*

Every state has had to address challenges with respect to its collection, analysis, and use of data. Some common data problems concern data variability, reliability, validity, "non-response" bias in consumer satisfaction surveys, and the viability and relevance of

⁹ Florida field report, pp. 18-19.

the chosen indicators. Reliability is the accuracy with which the measuring process measures what it says it is measuring. Validity is the degree to which the measuring process adequately measures the concept it purports to measure. One of the fundamental questions that Medicaid offices have to ask themselves is, “Are we collecting data that are both reliable and valid, and are we reporting results that are comparable and useful to us, as purchasers, and to Medicaid enrollees?”

Health plans in some states have complained about reporting requirements. In Ohio, plans complained about requirements imposed under the Balanced Budget Act of 1997. In West Virginia, one HMO (Optimum Choice) cited “uncompensated mandates” imposed by regulatory requirements, especially by HCFA.¹⁰ Moreover, in Michigan, small plans complained about the cost of collecting data. Part of the explanation is that plans have to pay their network providers for data.¹¹ Some of these same plan administrators also believe that the state Medicaid office uses a “shotgun” approach to data collection, asking for data that it does not need and never uses, while sometimes posing the wrong questions. One plan administrator in Michigan, who is a physician, complained that the outcomes measures that the state is using are too simplistic. In light of these legitimate complaints, one of the questions that Medicaid directors should be asking themselves is, “Are we framing the questions that need to be answered before designing the measures to answer the questions?”

❖ *In states where the market is non-competitive, it is hard to get health plans to comply with federal and state data requirements.*

All ten states in this comparative study have provisions for penalties if a health plan does not comply with reporting requirements. But in many states, especially where the Medicaid managed-care market is less competitive, penalties are often not

10 West Virginia field report, p. 34.

11 Another potential problem, at least in states where financial incentives are attached to performance, is the possibility that participating health plans will misrepresent the data.

enforced. And, as I have pointed out elsewhere,¹² when penalties are neither certain nor severe, they are virtually meaningless. In states where there is significant competition among plans, for example, in Arizona and Florida, penalties for non-compliance have been enforced incrementally. The strategy in Florida is to threaten first, then act. The first step is to levy fines, then freeze enrollments, then terminate the contract.

Georgia's experience illustrates the difficulties of enforcement when plans are not competing vigorously. The contract of Georgia's Department of Medical Assistance with Grady HealthCare required that the HMO meet certain performance standards. For example, the contract required a screening rate of 80 percent in its Health Check program and an immunization rate of 90 percent. The Department of Medical Assistance relied on an annual audit to check for compliance, and could impose penalties that ranged from \$10 per member per month for 60 to 80 percent compliance to \$100 if the attainment rate was lower than fee-for-service and/or 40 percent compliance. However, the Georgia Medicaid agency never enforced the penalties; rather, it forgave the penalties in Grady HealthCare's first year of operation and by the second year the state Department of Medical Assistance had already decided to terminate the contract with Grady.¹³

In Kansas, another non-competitive state, Medicaid managers address data collection problems on an ad hoc basis, either through informal contacts with participating HMOs or at the monthly meeting of the state's Peer Education Resource Council. For plans that do not supply the required data, corrective action can occur in one of three forms: 1) an informal action plan that establishes a timeline for completion; 2) a formal corrective action plan; and 3) a sanction, which is usually financial. Because of the nature of the market and physician hostility towards managed

12 Malcolm L. Goggin, *Policy Design and the Politics of Implementation: The Case of Child Health Care in the American States* (Knoxville: University of Tennessee Press, 1987).

13 Georgia field report, pp. 75-76. At least the measurements that were in place allowed the state to respond to plans that were non-compliant.

care, the state has not exercised sanctions. As the Rockefeller Institute field researcher in Kansas summed it up, "The absence of HMO competition has limited its enforcement power in collecting encounter and other data to be used for performance analysis."¹⁴

Enforcing performance criteria is also difficult when a plan is failing financially, even if the state can collect data. Kansas is one of the least competitive states, and is typical. Horizon, an HMO owned by the Kansas Medical Society, contracted to provide services on a capitated basis to state Medicaid and CHIP enrollees. Horizon experienced financial difficulties from the outset, yet it was the only plan that provided care to CHIP enrollees in two-thirds of the state. As one state official explained, because the state legislature insisted on capitated services for CHIP enrollees, "We don't have a fallback for CHIP if the plan fails."¹⁵ So rather than penalizing Horizon, the state tried to help it through financial hard times. For example, in 1998, the state received permission from HCFA to provide lump-sum payments for Medicaid-eligible pregnant women. But eventually the plan failed, and the state came up with a \$1.9 million contribution to First Guard so the HMO could take over the ailing Horizon and provide the contracted services.

What Kinds of Analyses Are State Medicaid Offices Conducting?

- ❖ ***Once a Medicaid office collects data, analysts often limit their analyses to descriptive statistics.***

Data are often collected and summarized using simple frequency distributions, percentages, and other basic techniques. These *descriptive statistics* are in contrast to *inferential statistics* that are based on probability theory, which allows the analyst to, first, draw inferences about a general population from a sample, and, second, test hypotheses as a way to rule out rival explanations. However, even where these descriptive statistics *are* used, the

¹⁴ As quoted in the Kansas field report, p. 45.

¹⁵ *Ibid.*, p. 31.

presentation of these data is not always convincing. A cursory review of some of the state “report cards” shows a lack of sophistication in graphics, for example.

Several states lack the technical expertise to conduct sophisticated analyses. In Ohio, for example, the provider agreements specify targets for the administrative component such as encounter data accuracy and completeness, or a clinical focus area (75 percent or better) as well as customer satisfaction (70 percent or better). However, the Rockefeller Institute field researchers in Ohio report that “At present, most of the information collected on quality is seen as fulfilling a program requirement, and the emphasis is on compliance rather than analysis ... There is a need for technical expertise. External observers familiar with the [state Medicaid agency] felt that the staff simply did not use the statistical and other resources to do much beyond the largely descriptive statistics and summary reports that it now produces.”¹⁶ Part of the explanation is that, in Ohio and undoubtedly in other states, there is enormous variation in skill level and experience among those who are assigned the tasks of gathering data and analyzing them.¹⁷ As our Ohio field researchers put it, “the Program Development and Analysis Section is primarily staffed for the maintenance of data sets and the production of routine reports.”¹⁸ Data analysis where analysts make comparisons, explain variations among plans for various populations, and draw inferences, is a neglected art in Ohio and many other states. Furthermore, in many of the ten states in our study in-house staff members do not have experience with survey research, an essential tool to measure client satisfaction.

¹⁶ Ohio field report, p. 34; see also p. 45.

¹⁷ Although this needs to be explored further, it is conceivable that this lack of sophistication in analysis is a function of the lack of analytical skills of the people who are analyzing the data. If they are trained in schools of public health, for example, their curriculum undoubtedly included epidemiology, but not necessarily OLS regression analysis. On the other hand, if the analyst was awarded an advanced degree from a school of public policy, she or he was probably trained in economic analysis, where the main skill learned was how to conduct benefit-cost analysis, which is not necessarily helpful in analyzing survey data.

¹⁸ Ohio field report, p. 45.

Although the evidence from the ten Rockefeller Institute state reports is scant, a tension may also arise between the users of the data and those who collect and analyze them — a clash of “two cultures.” Quality assurance managers are trained to be “number crunchers” and are sensitive to issues like reliability and validity, whereas line managers are often more interested in providing needed services and improving the health status of low income women and children; in their quest for results they may not always pay attention to numbers and may even question the use of scarce resources for data collection and analysis at the expense of services. A question that Medicaid directors should be asking themselves is, “Are we doing enough to cross-train our personnel so that program generalists understand the way data specialists think and work and vice versa?”

How Do State Medicaid Offices Use the Data They Have Collected and Analyzed?

- ❖ *All ten Medicaid offices use data to monitor plans and “put out fires,” or for fixing an immediate problem. A few incorporated their findings from reports into policy decisions. Only Arizona uses performance measures routinely to hold plans accountable. The crucial difference between what Arizona does and what other states are doing is that in Arizona data analysis and use for managerial and policy decisions are institutionalized. In other states, they are not.*

Most states use data to monitor compliance with federal, state, and contractual requirements, to observe who is doing what, where and how, and for spotting problems. Most states do not use data on a routine basis to make management decisions. In essence, many states use data as part of a “management by exception” strategy to spot problems and to hold plans accountable *only for fixing an immediate problem*, for example, for helping a financially troubled plan get out of a tight fix. As one team of field researchers put it, state agencies were acting like “firefighters.”¹⁹ They went on to

¹⁹ Ibid., p. 45.

point out that this is at least partly due to the market: in a non-competitive environment, the emphasis seems to be on meeting minimum criteria for eligibility, not on rewarding quality performance or penalizing plans that do not measure up.²⁰

Similarly, the West Virginia field researcher described oversight by the Bureau for Medical Services of plans' financial condition as "passive and reactive."²¹ In general, West Virginia has more rather than fewer regulations than other states, as well as "fairly rigorous information and reporting requirements," in part imposed by its waiver plan. For example, a plan must report quarterly and annually on matters dealing with quality assurance and improvement. However, reliance on a few plans has created an "informal culture of program management and review" that results in a dearth of systematic analysis across time. What's more, information is not widely distributed, and there are no mechanisms for feedback to the public.²² West Virginia also relies heavily on outside contractors for data analysis and advice. In fact, the state's MMC program director is a self-described "contract administrator."

States in the study used *financial data* to monitor the "health" of participating plans, but in several instances these reports did not uncover financial problems early on, partly due to the fact that financial audits are done only periodically. New Jersey has decided to use financial data to assess market conditions and set premiums accordingly. The state distributes comparative information on plan performance in an annual publication sold to the public for a small fee. This document is not a financial report card but rather an assortment of facts and figures that simply reflect the state's reporting requirements, thus making it not very accessible. West Virginia uses financial data to track past and forecast future trends, and Florida uses these data to identify industry trends.

20 Ibid., p. 36

21 West Virginia field report, p. 50.

22 Ibid., p. 50.

For the most part, *network data* are used to measure provider performance. For example, in Georgia, Georgia Better Health Care monitors the quality of network providers through quarterly reports, which examine eleven different categories of service. These reports are then used by the state Medicaid agency to compare primary-care case management physicians, to educate providers about the best clinical practices, and to identify practices that deviate from the norm. A letter is sent to providers asking them to explain why their practice varies from the norm. However, Georgia does not use this quality assurance information to generate “report cards.” Two states where there is competition among plans, Arizona and Michigan, use network data to award contracts and to monitor access, respectively.

States rely heavily on *HEDIS encounter data* to monitor the quality and appropriateness of services. States used *data on consumer satisfaction*, including reports on grievances and complaints, to create “report cards,” sometimes released to the public, and usually to Medicaid enrollees. In Michigan, the state Medicaid director used comparisons across plans when he testified before a committee of the state legislature. In Colorado, the quality assurance manager admitted that Colorado has no real performance standards in the sense of a bar. She maintained that the state agency needed to collect the data first, then set the standards. She went on to say that there is “not much the Colorado Medicaid agency can do” when plans do not meet performance standards. “We use site reviews, review of medical records, and we ask them to submit a corrective action plan when there is a problem. Right now our biggest tool is the ‘report card.’”²³ However, when a “report card” merely reports the responses of Medicaid clients who are enrolled in different HMOs without explanation, for example, without controlling for differences in Medicaid populations across plans, it is hard to make meaningful comparisons and even more difficult to draw conclusions.

²³ Colorado field report, p. 78.

There is little evidence that states are using policy-relevant data such as needs assessment to make policy decisions or to effectively manage their Medicaid managed-care programs. One of the best examples of the problem comes from New Jersey, where Paul Langevin, head of the New Jersey Association of Health Plans, believes “the state fails to use the information it collects properly.”²⁴ Despite a management decision to extend managed-care to the disabled population in New Jersey, most state agency staff members were uninformed about the nature of that special population, even though they had access to relevant data. If the state Medicaid agency staff members had done their homework, they would have been able to make much more informed decisions about what kind of providers ought to be in HMO networks, for example. A question that Medicaid directors should be asking themselves is, “Are we using information to understand the alternatives, and the arguments for and against all the health system changes that we have either adopted or are contemplating?”

Explanations for the Non-Use of Data for Managing Managed-Care Programs

- ❖ *There are at least seven explanations for why state Medicaid offices are not using data effectively to manage their Medicaid managed-care programs.*

Medicaid directors have different ideas about the purposes of data collection and analysis. These ideas range from improving plan performance, to building support among stakeholders, to educating Medicaid clients and the public. States use data strategically, that is, for a variety of purposes that fit the needs of federal and state appointed and elected officials. However, the emphasis in each state

²⁴ As quoted in the New Jersey field report, p. 27. James Verdier with Mathematica Policy Research, a consultant for New Jersey’s DMAHS, disagrees. He thinks New Jersey is no better and no worse than other states, which “don’t do a very good job of this [information use].” See New Jersey field report, p. 36.

depends on the market and political context, and the maturity of the Medicaid program, as well as available material resources.

Moreover, different states devote different levels of human resources to data collection, analysis, and use. States like Arizona and Michigan have ample, well-trained quality assurance experts; other states, like Colorado, have a small staff, but rely heavily on the expertise of outside consultants. West Virginia, too, relies on outside consultants, but still lacks analytic capability for three reasons: the state's expectations for program success are unrealistic, the state relies too heavily on contractors and consultants for program management, and state personnel tend to rely on informal communications and incremental and experiential knowledge at the expense of more coordinated and comprehensive policy review.²⁵

In states where performance measures show fair or poor results among competing plans, publication of valid and reliable data would shine a spotlight on the state agency that is ultimately responsible for the quality, accessibility, and cost of services to Medicaid clients as well as on the plans that are under-performing. Thus, states where plans are not required to report performance or outcomes measures may decide to withhold information that is not flattering, especially in a competitive market. Competition among plans has the potential to raise the quality of care, but data that clients can use to make decisions about enrollment assignment, for example, may discourage plans from reporting on performance measures.

State Medicaid agencies may also be reluctant to report on plans' performance or outcomes fully if there is little competition in the market, or if plans are experiencing financial difficulties, fearing that plans will pick up their marbles and go home. In states where the state Medicaid agency and/or the HMOs that provide services to the Medicaid clients are struggling financially, the cost of data collection and use is also a deterrent to upgrading skills, buying new hardware and software, and recruiting top talent.

²⁵ West Virginia field report, p. 49.

In some states, a “missionary” culture of experienced Medicaid program managers clashes with the culture of quality assurance managers who are trained to collect and analyze data, not necessarily use them. This clash may manifest itself when management decisions about how to allocate scarce resources are debated and made. The staff quality assurance manager, for example, may argue that more resources should be devoted to upgrading a management information system to track encounters, utilization, or plan performance using outcomes measures. On the other hand, the line manager who has his or her eye on the health status of Medicaid clients may want to divert funds from MIS to buy more existing services, expand services in new directions, or target new classes of beneficiaries. As this hypothetical situation illustrates, data users and data collectors are often in two different worlds and often have difficulty finding common ground.

Finally, states with a tight job market find it difficult to hire people who, by training, know how to translate data into useful information. Many states have an adequate number of personnel, but they lack people with experience in private-sector management, or have inherited personnel from the old Medicaid agency where bill paying and bill processing and not analytical skills were highly valued.

Case Studies:

Best Practices in Prudent Purchasing

To illustrate how prudent purchasing works in practice, let us examine the Arizona Health Care Cost Containment System. Arizona is one of three states in our sample with a mandatory full risk managed care program statewide. Arizona’s culture is one that values “public-private partnerships” and has traditionally relied heavily on the private sector to deliver public services.

*Prudent Purchasing in Arizona: The Gold Standard*²⁶

The Arizona HCCCS (AHCCCS) meets all of the criteria of a value purchaser. It obtains written agreement on performance criteria. It collects data that measure performance in a number of critical program areas. It analyzes the data that are collected as a means of monitoring performance. And it uses rewards and sanctions to improve performance. In sum, it uses data to manage its Medicaid managed care program. As John Hall, the Rockefeller Institute's Arizona field researcher, and Melinda Hollinghead point out, "The ability to record, process and interpret a broad range of financial and encounter data is critical to not only the oversight responsibility of the agencies, but also the continued success of the plans. Data collection is an instrument to control health care costs in the state. Data analysis is the process of transforming data into useful information, and that requires adequate staff that have the necessary training. Arizona is one of the states that have the staff that is able to analyze and use complex financial information, for example; other states often have to depend on insurance departments for financial analysis."²⁷ In essence, Arizona is a model for the nation. Let us review the steps that Arizona takes to fulfill its mission as a value purchaser.

Arizona relies on a *competitive bid process* to select participating plans. Prospective plans submit proposals that must include capitation rates — a fixed rate per member per month for various rate codes. Plans must also meet strict state information-processing requirements. To make best use of the encounter and financial data that plans submit to the state, AHCCCS has developed an extensive information system, the Prepaid Medicaid Management Information System (PMMIS), adopted in 1991 after five years of planning. When a prospective plan submits a proposal it must agree to supply specific periodic financial data, encounter reports,

²⁶ The following case study is based on the Arizona field report.

²⁷ John Stuart Hall and Melinda Hollinghead, "Connecting Public Policy with Management: The Arizona Health Care Cost Containment System Experiment," Paper prepared for presentation at the 21st Annual Association of Public Policy and Management Conference, Washington, D.C., 1999, p. 19.

data on network capacity and accessibility of care, as well as reports on customer satisfaction using the state's Prepaid Medicaid Management Information System. PMMIS evaluates the overall quality and cost effectiveness of the program as well as that of the individual health plan and the program coordinator. The state also uses the system to develop and evaluate capitation rates and initiate reinsurance claims.

Then, in the second step, the state *collects the data that are agreed upon in the contract*. Plans have 240 days from the date of the service to report encounter data to the state, using the state's Medicaid management information system. To help plans comply with these reporting requirements, AHCCCS provides technical assistance and training to health plans and program contractors.

In the third step AHCCCS *monitors* plan performance through an annual on-site review process. For example, the state Medicaid agency surveys the satisfaction of clients and care providers to identify areas for improvement, such as faster phone access, better and faster payments, more efficient ways of processing referrals, and improved transportation for Medicaid clients. The state also uses teams from three different AHCCCS divisions to conduct on-site reviews of all health plans and program contractors. These reviews are collaborative, coordinated, and designed to promote an integrated approach, and also require considerable resources. As John Hall points out, "This information did not come cheaply or quickly, and it is continually evolving."²⁸

The final step is *rewarding plans for good performance or sanctioning them for poor performance*. In Arizona, plans with a good record are rewarded with a full score, and thus, do not have to fill out some sections of the RFP, which can often be a burdensome, time-consuming process. As of the summer of 1999, the state was working on a plan called the Program Incentive Policy that would use moneys collected from fines to reward excellence. Arizona has also been tough on plans that do not meet their contractual requirements for reporting data. Financial sanctions, enrollment caps,

²⁸ Arizona field report, p. 65.

corrective action plans, and loss of contract are part of the arsenal of sanctions available to the state. Arizona's sanctions for non-compliance are both certain and severe.

To summarize, Arizona's Health Care Cost Containment System has been a smashing success, and any explanation for Arizona's success at using data to manage its Medicaid managed-care program must take into account the context of the system's adoption and implementation. First, the AHCCCS system was adopted early and has had many years to mature. Second, Arizona has devoted considerable resources to making the system work: the state has hired experienced, highly-trained personnel, invested in a sophisticated management information system, and contracted with outside consultants for advice. Third, the Medicaid managed-care market in the state is very competitive, and Arizona has taken steps to nurture and facilitate competition. Finally, the steps that state officials have taken over the years have had the support of the governor and the state legislature. All these *contextual factors* help explain the state's success at institutionalizing prudent purchasing in its Medicaid managed-care program.

Prudent Purchasing in Colorado: Just Getting Started²⁹

To illustrate how prudent purchasing can begin to work, even in a relatively non-competitive market, let us now turn to Colorado. Colorado maintains fee-for-service, a primary case management system, mostly in the rural parts of the state, and a mandatory full-risk managed-care program in Colorado's Front Range, the urban part of the state.³⁰ The state has only a handful of HMOs serving the Medicaid population. As of mid-1999, Colorado had no competitive bid process; the state contracts with "any willing provider," as long as it is a state-licensed HMO. Colorado maintains an "open" system for disseminating information designed to move the state toward greater reliance on managed-care. The manager of quality assurance at Colorado's Office of Medical Assistance

²⁹ The following case study is based on the Colorado field report.

³⁰ Rocky Mountain HMO, a home-grown health plan, serves the Western Slope, which is a mix of urban and rural.

observed that, “We hope that information will also create a more competitive environment that might lead to lower rates — as a means of spurring HMOs on to bigger and better things.”

Although Colorado’s efforts at data collection are “just getting started,” the state has made much progress since the mid-1990s and has much to teach other states, especially about how to use an outside contractor — an external quality review organization, or EQRO — to help move the state in the direction of “full-value” purchasing.³¹ The state contracts with an HMO that accepts a set fee for providing all covered services, standards are defined in the contract, and the HMO is held accountable for meeting performance expectations. The agency monitors performance along a number of dimensions, and if the health plan does not meet those expectations, the agency has a number of sanctions at its disposal. Whether these sanctions have ever been used is another question, and this uncertainty is at least partly due to the non-competitive nature of the Medicaid managed care market.

A quality assurance section within the Colorado Department of Health Care Policy and Financing (DHCPF) supports department-wide quality assurance and utilization management programs. This section is also charged with the job of detecting and pursuing fraudulent and abusive use of Medicaid resources. One of the section’s principal goals is to make the transition from traditional quality and utilization review activities to an outcome-based process. As part of this new emphasis, the section has designed and

31 Not everyone in the Colorado Medicaid agency would agree with my assessment. According to one of the agency officials who must use rather than collect data on access, network, and physician capacity, the agency does not use information on providers or networks. In his words, “Other than case-by-case requests for network changes based on anecdotal information, we have no good network information available.” On only one occasion did the Medicaid agency threaten a plan for poor performance, and that was a threat of a financial penalty for failure to submit a quality assurance measure on schedule. In that case, the department backed down when the plan agreed to submit the information. As for other sources besides encounter data that the agency has to make judgments about the availability of care to Medicaid clients, the agency has only “reports from clients.” There are no independent checks to verify appointment availability or disenrollment, for example.

used instruments to measure the performance of participating plans, and oversees the design and completion of consumer satisfaction surveys. To improve quality of care for Medicaid clients, it has contracted with an outside consultant to conduct three different types of focus studies to improve quality of care, and prepare Health Plan Employer Data and Information Set (HEDIS) data for HMOs and fee-for-service. The section has also developed a complaint and grievance procedure for HMO clients. Finally, the director and her staff of five conduct site reviews and recover inappropriate Medicaid payments.

Colorado's effort to use data to assure and improve quality is instructive. This effort begins with a contract between the Colorado Department of Health Care Policy and Financing and an HMO that requires the health plan to maintain an internal quality assurance program. This program must be comprehensive and include standards for quality, accessibility, and availability of services for members, monitoring and evaluation of important aspects of care and services, systematic improvement, and corrective action and follow-up by the HMO, its participating providers, and its subcontractors.

The next step is collecting and reporting data. The contract specifies that the HMO must submit an annual written report, and make it available to its members, the DHCPF, and the public upon request. This information includes an annual written summary of the quality assurance program, its accomplishments during the previous contract year, activities planned for the upcoming contract year, and a description of quality improvement activities that address the special needs of members.

The HMO submits an annual report to the department that describes techniques that it uses to allow more efficient use of health care services, better health status for populations served, and better health outcomes for individuals. Upon request, this information must be made available to providers and members at cost. Moreover, under the provisions of the HMO contract, the contractor establishes guidelines for perinatal, prenatal, and postpartum care for women, birthing and neonatal care for infants,

care for persons with disabilities, and well child care. The standards and indicators are based on nationally approved guidelines, although the department may grant modifications to address regional variations.

The contract stipulates that the health plan must participate in a quality improvement work group established by the department, and must submit itself to an annual external review by a review entity. One state official observed that some plans were more cooperative than others when it came to quality improvement.

In 1997, DHCPF released an RFP to contract with a consultant to design and carry out a number of separate but related quality assurance studies during the contract period, which began on December 15, 1997 and expired on December 31, 1998. These activities included three focused studies of patterns of care, encounter data validation, and two analyses of HEDIS data among the fee-for-service Medicaid population. The winning bidder, First Peer Review Colorado, was authorized to review medical records and other data sources, as needed.

Many interested parties, including HMOs, consumers, and providers, were involved in developing the form and content of the section's work on quality review. Ultimately, however, all contractor activities required department consultation, approval, and oversight. As the quality assurance section manager described it, "I meet with the QA people with the HMOs on a monthly basis. We are definitely driving the boat, but we consult with our constituents. We work with them — both client advocacy groups and HMOs. We are especially sensitive to what the Medical Advisory Committee on Persons with Disabilities has to say."

But according to one authoritative source, getting claims-based data proved to be problematic in Colorado in the late 1990s. From the perspective of DHCPF, "HEDIS is burdensome for the health plans to collect. Medical records review is also burdensome. They have to pull a lot of records." But other complications arose as well. First Peer Review Colorado (FPRC) was supposed to have tested and established operational online capacity with the

department's new information system by the start of the contract. But according to one manager, "We have had a tough time lately because we have changed fiscal agents. Blue Cross/ Blue Shield had the first contract, from 1976 to 1985. Then Computer Science Corporation had the contract from 1985 to 1987 and went belly up. Blue Cross/ Blue Shield had it again from 1988 until December of 1998. Then in December, Consultec got the contract. They have a very good system, but we had delays during the transition." But Consultec was not the only source of potential data problems. When the department conducted a validation study of encounter data,³² it "found that the data were pretty accurate but underreported." As of the end of August 1999, the quality assurance section was still "waiting for the 1998 HEDIS data."

The first of the three focused studies was a *clinical focused study* using the medical records of representative samples of populations identified by the department. FPRC was obligated to work with the department, the HMOs, and constituency groups to determine the topic of this study, taking into account Medicaid's special populations, such as persons with disabilities and chronic illnesses, children, mothers and the elderly. FPRC coordinated with the department to develop sampling methodology. The samples had to be representative of each HMO, the unassigned fee-for-service program, and the Primary Care Physician Program population selected.³³

A *health care systems focused study* addressed the timeliness of and access to services as well as quality outcomes. Data collection was not supposed to include medical record review unless otherwise determined by the department in consultation with FPRC. A *primary care physician program study* measured provider compliance with the program's quality-of-care and case management guidelines.

32 Comparing them with medical records validates encounter data.

33 The study was supposed to provide a 95 percent confidence interval, with a sampling error of 8 percent. The units of review for the clinical focused study were client-based (not episode-based), unless otherwise determined by the department in consultation with FPRC. FPRC reviews all diagnosis-applicable levels of care for that client for the dates of services stated.

As it turned out, the Department of Health Care Policy and Financing negotiated with the contractor and stakeholders to conduct the focus studies on three large subpopulations: adults with diabetes, children who were receiving EPSDT services and immunizations, and persons with disabilities. According to one administrator, “We chose these focus topics in consultation with advocate groups. The disability organization is a small but vocal political force in the state. We are starting our second year studies and have included prenatal care and a provider survey on cultural competency and disabilities. These are based on medical record review.” As a condition of the contract, the EQRO was required to submit a number of additional reports such as meeting agendas at weekly or biweekly meetings with the department, and a monthly report.³⁴

Colorado illustrates what is possible for a state that has started late, has limited resources, is in a relatively non-competitive market, and has a limited number of trained personnel. Colorado relied heavily on an EQRO for technical assistance. Other states may wish to imitate Colorado, or instead build capacity in-house. But whatever path is chosen — either contracting out or building capacity within the state agency — steps in the direction of “full value” purchasing are not only available but also feasible.

Recommendations

To provide low-cost, quality care to Medicaid clients in a managed-care setting, it is imperative that state Medicaid directors have at their disposal relevant data from participating health plans on their financial health as well as on network, provider, and client encounters and satisfaction. What’s more, directors must have the needed number and quality of trained personnel — either in-house or contracted out — to enable them to use these data routinely to make better management decisions. While all ten Medicaid offices use data to monitor plans and to “put out fires,” and a few occasionally incorporate their findings from reports into policy

³⁴ A brief version of the report was created for distribution to legislators and other interested parties.

decisions, only Arizona uses performance measures routinely to hold plans fully accountable for their actions and uses data routinely to manage its Medicaid Managed-Care Program. In Arizona, data use for management is institutionalized.

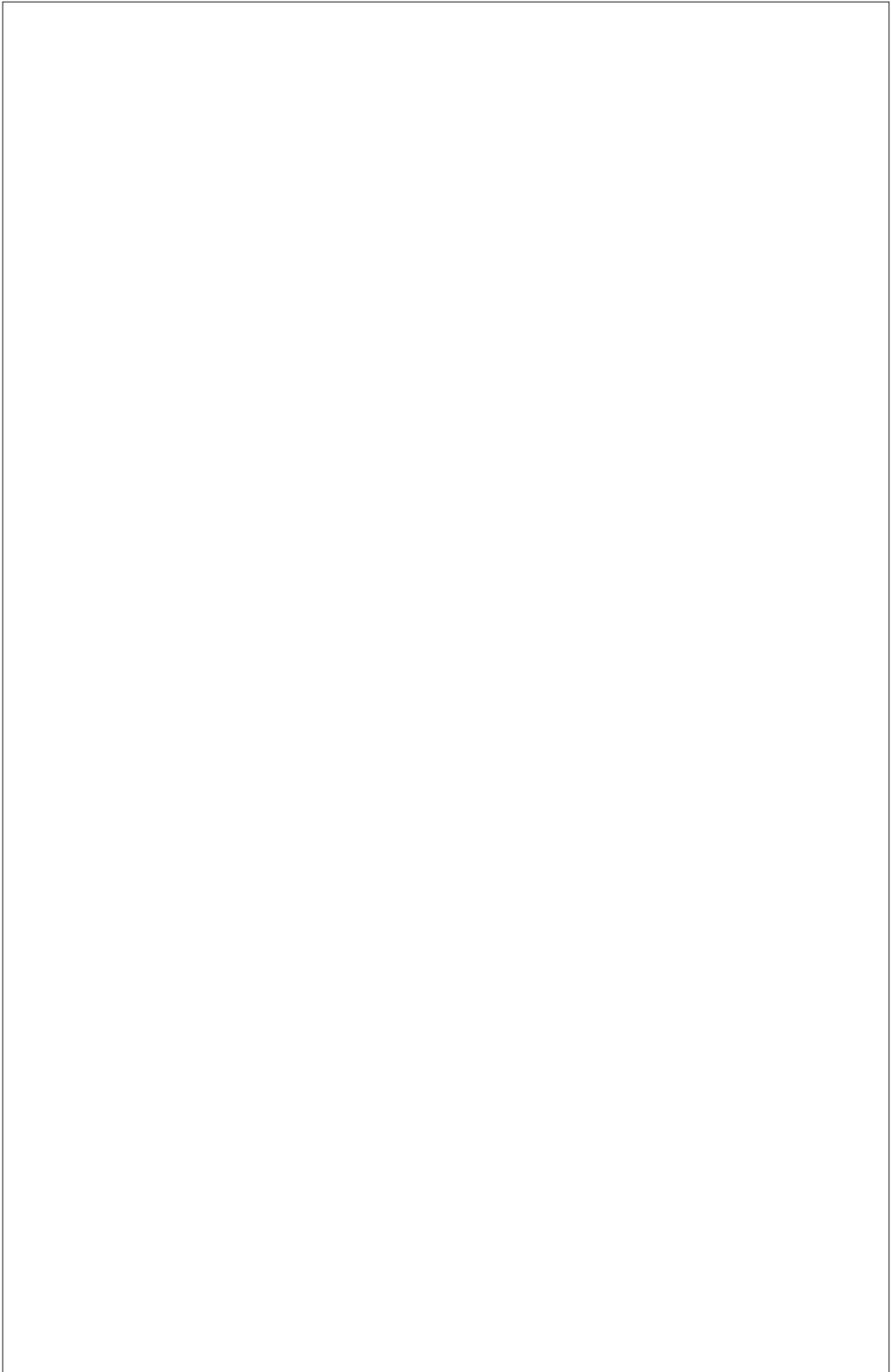
The reports of twelve Rockefeller Institute research associates in ten states illustrate why it is so difficult for states to use data to manage their programs. The experiences of two states — Arizona and Colorado — dramatize the importance of context — market and political conditions and the maturity of the Medicaid program, as well as the resources at the state Medicaid agency's disposal. State Medicaid directors can pursue several strategies to overcome barriers to moving toward "the gold standard" set by Arizona. Now that the BBA regulations pertaining to quality assurance are on the immediate horizon, acquiring, analyzing, and using data to manage state Medicaid Managed-Care Programs is no longer an option. It is a necessity.

I offer my advice about how Medicaid directors can enhance their use of data for managerial and policy decisions. These recommendations are designed to give Medicaid directors the tools to become better "value" purchasers in today's climate and to better prepare them for the challenges that the final rule of the Balanced Budget Act of 1997 will likely present in the near future. My suggestions to Medicaid directors include:

- ❖ Frame the questions that need to be answered before designing the measures to answer the questions.
- ❖ Audit HEDIS and other data from HMOs to improve reliability and validity of the data.
- ❖ Collect data and report results that are comparable and useful to the Medicaid agency, as the purchasers, and to Medicaid enrollees, the ultimate health-care consumers.
- ❖ Cross-train agency personnel so program generalists understand the way data specialists work and vice versa. Cross the cultural divide.

- ❖ Make better use of the information already available.
- ❖ Develop strategies and tactics for using information in order to understand the alternatives and the arguments for and against health system changes that have either been adopted or are under consideration.
- ❖ Develop strategies and tactics to use information in order to make better, more informed management decisions.
- ❖ If indicated, reorganize the agency so the director of quality assurance reports directly to the Medicaid director.
- ❖ If indicated, hire personnel trained to conduct sophisticated data analyses that offer explanations and rule out alternative explanations for effects of the MMC program.
- ❖ If indicated, hire personnel who have experience in the private or nonprofit managed-care sectors, and be prepared to compete for those services in a tight labor market.
- ❖ If indicated, contract with an external quality review organization to conduct different types of studies and prepare different types of reports.
- ❖ If indicated, apply for outside public or foundation funding to conduct sophisticated needs assessment and other studies that will increase the likelihood that the organizations serving Medicaid clients can ensure access to high-quality care at a reasonable cost.

Some states have already adopted many of these suggestions; for other states, they are easily within reach.





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