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Quality Assurance For Medicaid Managed Care

Lessons from a quality-improvement demonstration in three states.

by Suzanne Felt-Lisk and Robert St. Peter

The Quality Assurance Reform Initiative (QARI) system, developed in 1991, is now the only model of a comprehensive, state-based system for ensuring and improving quality of care in Medicaid managed care. As Medicaid managed care enrollment continues to grow rapidly, the results of the three-state demonstration of the QARI system are particularly important, given the system’s comprehensive nature in the context of limited federal and uneven state requirements related to quality of care. In this report, we summarize findings from the evaluation of the QARI demonstration and their implications for policy.

Federal regulations for Medicaid managed care, though more extensive than for fee-for-service Medicaid, simply require states to provide for an annual, external review of quality of care in health plans serving Medicaid beneficiaries, require such plans to have a quality-assurance program, and require states and these plans to have a process for addressing enrollee grievances. Most states have additional requirements, either as part of the Medicaid program or as part of state licensure for health maintenance organizations (HMOs), though these requirements vary widely. Given this regulatory context, along with accelerating growth in Medicaid managed care and isolated reports of abuses where oversight was lacking, the Health Care Financing Administration (HCFA) and others believed additional guidance was needed.

Working with the National Academy for State Health Policy, medical directors of health plans, states, and others, HCFA developed guidelines for the QARI system. Through a competitive process, three states—Minnesota, Ohio, and Washington—were selected to participate in a demonstration to test the guidelines. Here, we discuss the results of a three-and-one-half year evaluation of that demonstration. Mathematica Policy Research, Inc., conducted the evaluation under a grant from The Henry J. Kaiser Family Foundation.

The QARI system calls for health plans to have internal quality-assurance programs and for states to set, and monitor compliance with, standards for an acceptable program. QARI emphasizes quality measurement, continuous quality improvement, and involvement of health plans and Medicaid beneficiaries in quality oversight.

The Demonstration And Evaluation

The three demonstration states implemented the QARI system in very different state environments. Washington’s Medicaid managed care program was small before QARI, with 35,000 enrollees (6 percent of all beneficiaries) and almost no quality oversight process in place. Ohio and Minnesota were similar in having larger programs (159,000 and 97,000 enrollees, respectively) and existing quality-oversight processes, but they differed in that Minnesota’s program was mandatory in the context of a mature commercial managed care market, whereas Ohio’s program was mostly voluntary and operated in a less mature commercial market.

In evaluating the QARI demonstration we found that QARI was feasible to implement, but it required several years and substantial resources. We also identified specific ways to...
refine QARI and to better support states’ and plans’ implementation of the system. This report summarizes findings for policymakers on how well QARI protects quality. The evaluation findings are based largely on annual site visits to the three states in 1993, 1994, and 1995 and review of related documents. In addition, a diverse set of health plans (three plans in each state) was selected for in-depth case studies. The week-long annual site visits included interviews with state Medicaid program staff and management, staff in other state agencies with related responsibilities, health plan representatives, staff at the external review entity, and representatives of Medicaid beneficiaries.

Results

Substantial changes were made in each state over the course of the demonstration, both in state systems for quality oversight and improvement (Exhibit 1) and in health plans’ quality-improvement programs. These changes resulted in a more cooperative, coordinated environment for quality improvement and a stronger voice for Medicaid beneficiaries; better quality-improvement programs in health plans; and better knowledge about health plans’ performance on quality measures across several clinical areas of concern.

COORDINATION. The QARI demonstration contributed to a more coordinated and cooperative environment for states and plans to address quality-improvement issues. QARI did so by reinforcing the states’ decisions to move from a more regulatory approach toward a partnership approach with health plans and by providing a reason for states and plans to meet and share information over an extended period. Although there were numerous glitches in this partnership process (for example, because of meetings led by state staff lacking strong facilitation skills), there were benefits too: State staff were better educated on the status of health plans’ information systems and quality-improvement programs, and there was better communication between state staff and health plans about the usefulness and interpretation of quality measures and results of reviews.

We found that coordination was key for health plans concerned with the burden of multiple overlapping reviews and requests. The three states worked to coordinate their requests and reviews within their states and increased this focus as the demonstration progressed. One state coordinated its Medicaid agency’s requests for information on quality during the health plan contracting process with other state contracting requirements. One state conducted an abbreviated “look-behind” review of a plan’s quality-improvement program when the plan had recently been accredited by the National Committee for Quality Assurance (NCQA). Two of the states were planning to include some Health Plan Employer Data and Information Set (HEDIS) or Medicaid HEDIS quality indicators in the next round of reviews, rather than developing many new measures. The states were hoping to achieve more coordination of requests and reviews in the future. Turf issues and different perspectives among state agencies were barriers to more complete coordination during the demonstration period.

MEDICAID ENROLLEES. Medicaid managed care enrollees have a stronger voice in the states’ systems than they did before QARI because of the implementation of beneficiary satisfaction surveys in all three states and an improved complaint system in one state. QARI also influenced HMOs to pay more attention to the experience of their Medicaid enrollees as a distinct population and encouraged plans to compare Medicaid-specific information with that of other enrollment groups. The demonstration supports the need for population-specific analysis, since measures such as immunization rates for the Medicaid population were substantially below those for the overall population in the plans we visited and statewide rates.

QUALITY-IMPROVEMENT PROGRAMS. QARI succeeded in better aligning the quality-improvement programs of the Medicaid-serving plans with industry standards. Although plans with less sophisticated programs were generally not able to close the gap with commercial plans, their efforts to establish internal quality programs and comply with the QARI standards...
moved them in the right direction.

The QARI component calling for states to monitor health plans’ compliance with standards for internal quality improvement fell seriously short of providing a comprehensive approach for evaluating such programs. States tended to rely on a checklist approach to documenting compliance with their standards but did little to assess overall effectiveness of the programs.

For example, two plans rated highly by a state’s review differed substantially in their programs’ ability to identify problems. Quality monitoring and improvement efforts in the plan with a relatively well-functioning program (Plan A) included participating in a monitoring system that provided monthly indicators on a wide variety of clinical measures by payer. Plan A had used these data to identify adverse events for asthma as a problem

<table>
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<td>Washington</td>
<td>New unit created with six staff at end of demonstration&lt;br&gt;Enrollee satisfaction survey conducted and complaint system redesigned&lt;br&gt;Site visits conducted by state staff to monitor implementation of QARI&lt;br&gt;Coordinated contracting process established between Medicaid and basic health plan agencies</td>
<td>Standards incorporated into contracting process, with recognition that new plans will not fully meet all standards immediately</td>
<td>Focused studies implemented and repeated&lt;br&gt;Health plan input sought to help to shape next round of studies</td>
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<td>Minnesota</td>
<td>Number of state staff with responsibility for quality improvement increased to five&lt;br&gt;Satisfaction survey conducted jointly with others; results widely disseminated&lt;br&gt;Ongoing quality advisory committee in place</td>
<td>Requirements continue to follow the outline of QARI without its details&lt;br&gt;Plans agreed to work toward implementing most of the QARI standards with accompanying detail</td>
<td>Focused studies implemented in collaboration with plans&lt;br&gt;Plans required to explain their response to areas identified as weak</td>
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<td>Ohio</td>
<td>Notable shift in staff’s view from regulatory oversight without outside involvement to quality improvement with input from health plans and others&lt;br&gt;Deemed status policy prepared so that NCQA-accredited plans would not be subject to duplicate review</td>
<td>Standards incorporated into regulation but add little to prior regulations</td>
<td>Focused studies implemented in collaboration with plans&lt;br&gt;Plans required to take corrective action where “key” items are identified as weak</td>
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Changes are noted relative to the year prior to beginning QARI; in some cases a state may have had a particular policy in the more distant past that was not considered if not implemented just prior to QARI.

Since the demonstration period, Washington staffers have worked to tighten their approach to follow-up and have met with each plan to discuss how it will follow up on the study results.
area and then contracted for intensive case management for asthma patients with a specialized firm. The plan also had identified the preterm birth rate for Medicaid enrollees as a problem and thus instituted an intensive prenatal education program that included nurse visits. In contrast, Plan B analyzed the characteristics of asthma patients by age group, counted the number of hysterectomies (thirty-four) and reviewed those charts for quality issues, and calculated the cesarean-section rate and the rate of C-section complications and reviewed those eight charts for quality problems. A plan physician suggested these focus areas.

Given these activities—which meet state requirements and QARI guidelines read narrowly—Plan B could not give a reasonable example of how its system had worked to identify problems and improve quality for its members. This and other similar examples led us to conclude that QARI standards on state monitoring should be revised—or reviewer guidelines developed—that would assist states in monitoring more effectively. For example, rather than emphasizing the number of quality studies that a plan conducted or a plan’s compliance with each phrase of state requirements alone, the monitoring could focus on how its system as a whole has worked to (1) identify and assess areas needing improvement and then focus on areas deemed important for the plan’s population, (2) address these areas, and (3) follow up to track improvement.

HEALTH PLAN PERFORMANCE. Focused studies provided states with a useful but blunt tool for monitoring changes in the quality of care statewide and, when properly designed, among individual plans. A total of seventeen such studies were conducted during the demonstration and covered seven clinical areas of concern: immunizations, asthma, prenatal care, asthma-related diseases, diabetes, emergency care, and well-child screenings under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The states worked with health plans and external review organizations to design the studies, which included many specific performance indicators in addition to the relatively small number of indicators specified by QARI for pregnancy and immunization.6

All of the demonstration states now have baseline information on the quality of care delivered to Medicaid enrollees, which covers several clinical areas of concern for this population. Most of the statewide studies were successful in identifying areas that needed quality improvement and areas in which plans were performing well. This information prompted or reinforced support for new quality-improvement initiatives by health plans; if successfully implemented, the initiatives should result in higher-quality care.

The focused studies also highlighted Medicaid enrollees, an emphasis that otherwise would have been missing from many of the plans’ ongoing quality-improvement projects. For plans with less sophisticated quality-assurance programs, their participation in the focused studies gave them some of the experience needed to begin to use this approach in quality-improvement initiatives that were unrelated to QARI. Perhaps most important, the sharing of information from these studies among plans and their providers created the potential to change providers’ or clients’ behavior, thus improving the quality of care. Assessing the effect of this information sharing, however, would require a longer time frame and additional data for analysis.

STUDY LIMITATIONS. During the demonstration period several important limitations of the focused studies reduced their potential to improve quality. These included (1) the absence of benchmarks or comparable data on fee-for-service enrollees; (2) the significant lag in reporting results from the studies, which diminished their usefulness to clinicians and plans; and (3) the sampling and design features of some of the studies, which limited the usefulness or the credibility of the resulting data. For example, results for a plan that were based on sample sizes of five or ten medical charts, as we found in some studies, do not support a state’s request for a health plan to take corrective action.

Conclusion

Results from the evaluation generally sup-
port the conceptual framework of QARI as an effective system for monitoring and improving the quality of care for Medicaid managed care enrollees. However, delays and implementation problems weakened the demonstration’s expected impact on quality. States may be able to avoid similar implementation problems by reviewing the lessons from the demonstration. HCFA can assist states in integrating new quality initiatives into the QARI framework by updating and refining national QARI guidelines so that they better suggest effective monitoring techniques, incorporate HEDIS 3.0 measures, and encourage states to take advantage of the NCQA accreditation process. The demonstration experience also confirms the importance of planning and having adequate lead time for introducing Medicaid managed care. Both states and plans found that it took several years and significant resources to develop quality-assurance and -improvement systems where they previously did not exist.

QARI has enhanced the ability of state agencies and health plans to identify and address quality-improvement issues, motivating systemic changes in their infrastructure and operations. These changes have great potential to spur continued improvements in quality of care over time. The effects, however, were not equal among all participants. The demonstration most benefited the state with a less developed quality-assurance structure in place at the beginning of the demonstration. It also had a more positive effect on plans with less sophisticated quality-assurance programs or programs needing major revisions. Conversely, plans that applied for NCQA accreditation improved their programs substantially during the demonstration, but QARI contributed far less to these improvements than the accreditation process did.

Thus, QARI worked alongside a number of other initiatives that were prompted by private purchasers to enhance the quality of managed care. The development of HEDIS 3.0 performance measures and the increasing prevalence of NCQA accreditation among commercial plans should lessen the effort required to implement a QARI-type quality-improvement system, but they do not reduce the need for such a system. QARI’s greatest promise within the Medicaid context is to encourage the development of quality-improvement systems in states and plans where they are as yet undeveloped. As such, QARI provides a useful protection for Medicaid managed care enrollees. The views presented here are solely the authors’ and do not necessarily reflect those of Mathematica Policy Research or The Henry J. Kaiser Family Foundation (KFF). Marsha Lillie-Blanton, formerly of KFF and now at the U.S. General Accounting Office, oversaw this project for KFF and provided valuable comments on the evaluation report on which this report is based. Marsha Gold of Mathematica designed the evaluation, directed it in the beginning, and provided valuable comments on an earlier version of this report.

NOTES
1. Social Security Act, sec. 1902(a)(30)(C), and 42 CFR 434.53.
6. In the future, the states are planning to incorporate some HEDIS measures. However, HEDIS, unlike the QARI system, does not provide a framework or process for targeting areas of particular concern, analyzing the data that are collected, and following up on problem areas.