Monitoring and Evaluating the Delivery of Services Under Managed Care

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This overview discusses the importance of monitoring and evaluating the delivery of services under managed care, particularly with respect to assessing access and quality in managed care. It also lists recent Health Care Financing Administration (HCFA) initiatives in this area, and presents an introduction to the articles published in this issue of the Review. The topics addressed by these articles range from assessing and monitoring access and quality provided by traditional types of managed care organizations (MCOs) serving Medicare and Medicaid beneficiaries to issues that must be considered in developing and monitoring new delivery system models.

The Spring 1996 issue of the Health Care Financing Review focused on articles dealing with challenges and recent developments in paying managed care organizations. This issue, "Service Delivery in an Evolving Managed Care Environment," extends the discussion to monitoring and evaluating the services delivered by MCOs. As reflected in the range of this issue's articles, monitoring and evaluating service delivery is extremely important for a variety of reasons. It allows managed care's impacts on costs and utilization to be assessed and allows for an examination of the adequacy and accuracy of payment mechanisms. Perhaps the most important reason, however, is to assure the adequacy of the quality of care and access to care provided by the plans.

As the number of beneficiaries enrolled in managed care plans has increased, the Federal Government has worked closely with States, insurers, health care professionals, and consumers to assure access to care and the quality of the care provided in MCOs serving Medicare and Medicaid beneficiaries. Some current examples of these initiatives are:

- *Medicaid Health Plan Employer Data Information Set (HEDIS)* was developed in partnership with the National Committee for Quality Assurance to provide States, managed care plans, health care professionals, and consumers with the information and tools they need to assure high quality in managed care plans serving Medicaid beneficiaries, Medicaid HEDIS adapts the commercial sector's health maintenance organization (HMO) performance measurement system to use with the Medicaid population. Medicaid HEDIS was released to the States in February 1996.
- *Medicare HEDIS* is a parallel effort developed by HCFA in partnership with the Kaiser Family Foundation and in consultation with the managed care industry. It establishes a performance-measurement system designed to provide important monitoring information while minimizing reporting burdens on managed care plans. Medicare HEDIS is expected to be implemented in early 1997.
- *The Foundation for Accountability (FAcct)* is a collaboration of private and public health care purchasers (including HCFA) and consumer groups working to develop outcomes measures that will

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allow comparison of the quality of care delivered in managed care settings to that provided in fee-for-service (FFS) settings. Information will be released later in 1996.

- *Quality Assurance Reform Initiative (QARI)* is a collaborative effort by HCFA, States, the managed care industry, consumer advocates, and others to design and test practical and credible approaches to monitoring and improving the quality of Medicaid managed care services.
- *The Medicare Managed Care Quality Improvement Project* is being conducted through a contract with the Delmarva Foundation for Medical Care. The purpose of this project is the development of performance measures to be used in overhauling the external peer review of HMO contractors and promoting quality improvement in Medicare managed care. These measures are currently being tested in five States. Results of this test are expected in Spring 1997.
- The *HHS Interagency Managed Care Forum* is chaired by HCFA Administrator Bruce C. Vladeck and Assistant Secretary for Health Philip R. Lee, M.D., and is made up of representatives from operating and staff divisions of the Department of Health and Human Services. The forum meets regularly to share information concerning ongoing managed care activities and to coordinate managed care policy on cross-cutting issues before the Department. Managed care quality is a top priority for this group.

These initiatives focus primarily on monitoring quality. Quality monitoring is stressed here because it is perhaps one of the most important activities to pursue as the number of beneficiaries in managed care systems increases. Managed care has the potential to provide excellent quality care because of its ability to coordinate care provided to patients, reduce unnecessary hospitalizations and treatments (with a potential for a corresponding decrease in iatrogenic illness), and provide primary and secondary preventive services. However, there is also a concern that, with the economic incentives inherent in managed care systems, there is the potential for access and quality of care to be adversely affected as well. While these concerns are applicable for both the Medicare and Medicaid populations, Medicare beneficiaries are assured by law that they can enroll or disenroll from a managed care plan at any time and for any reason with only 30 days notice and move to another managed care plan or even return to receiving care on a FFS basis. In contrast to the legal protections afforded Medicare beneficiaries, many of the Medicaid managed care enrollees do not have the option of choosing an alternate plan and, in many cases, do not have a FFS alternative to return to if they are dissatisfied with the quality of care they receive or have trouble accessing needed services in the plan. Considering that a significant number of disadvantaged and vulnerable individuals make up the Medicaid population, the need for effective monitoring and evaluation of the access and quality of care provided to this population is particularly apparent.

As the wide range of articles in this issue of the *Review* indicate, monitoring quality is only one of numerous activities that rely on service delivery information from managed care organizations. This issue of the *Review* looks at both Medicare and Medicaid. It begins with an article by Docteur, Colby, and Gold which emphasizes the need to develop a framework for monitoring Medicare beneficiaries' ability to obtain needed medical services on a timely basis in a managed care plan.

The authors review components of the monitoring approach currently used in FFS Medicare and discuss the adaptation of that system for managed care. The authors note that, while some of the traditional approaches used to monitor access in the FFS system can be transferred to monitor access in a managed care environment, further work is needed to identify access measures, data, and groups for targeted monitoring efforts specific to managed care systems.

Parente, Weiner, Garnick, Fowles, Lawthers, and Palmer follow with an examination of the impact of physician variables (e.g., provider specialty, practice type, size, and location) on beneficiary utilization of services and the importance of these variables in designating primary-care gatekeepers in a managed care system.

Tompkins, Wallack, Bhalotra, Chilingerian, Glavin, Ritter, and Hodgkin then address the question of whether government can retain both the insurance function (e.g., risk pooling) and the management of the delivery of services, rather than turning these functions over to other organizations (e.g., HMOs). They suggest that HCFA could do so by working with "qualified physician organizations" and providing incentives based on meeting targets they call "Group-Specific Volume Performance Standards" (GVPS), which would, in turn, generate savings in total reimbursements for Medicare patients. Under such a system, HCFA could use new and existing data systems to monitor access, utilization patterns, cost outcomes, and quality.

In the conclusion to the Medicare portion of this issue, Riley, Tudor, Chiang, and Ingber examine the health status of Medicare beneficiaries in HMOs versus FFS in 1994—providing the most recent assessment to date. Their findings of substantial differences in demographics and a variety of health status measures support previous findings that the current Medicare payment formula for HMOs does not adjust adequately for the better health and lower expected costs of HMO enrollees, leading to payments that are, on average, 7 percent higher than the costs of treating these patients in the FFS system.

Buck and Silverman's article shifts the focus to Medicaid in their examination of the impact of the various utilization management (UM) approaches currently being employed by States in their attempt to hold down Medicaid expenditures. The authors surveyed State Medicaid agencies to rate each of their UM method's perceived impact on program costs, quality of care, and beneficiary access to care. While the State's judgments about the benefits of specific techniques varied, none of the UM methods were perceived to have an adverse effect on quality of care; some of the techniques were perceived as enhancing quality.

Howell's article offers a timely primer on the need for Medicaid managed care encounter data. With Medicaid's ongoing movement away from FFS payment (and associated claims-based data systems) to capitation, the data needed to monitor and evaluate the various State programs is rapidly evaporating. Encounter data is needed for these purposes. HCFA and State governments must balance the need for collecting such data with claims that forcing managed care organizations to collect such data poses an undue burden and increases the cost of providing care to their beneficiaries. Howell reviews the types of encounter data currently being required of plans and the problems and issues with providing and analyzing such data.

Smith, Cotter, and Rossiter's article demonstrates the need for good data in State Medicaid programs. They present a case study of Virginia's redesign of Quality

Assessment and Improvement for Medicaid, which adapts QARI guidelines and incorporates the important features of feedback loops and continuous quality improvements techniques which benefit both patients and providers.

Muller and Baker review the performance of a Medicaid primary-care case management program, in which physicians are paid a small fee to assume a "gatekeeper" or care manager function, implemented February 1994 in Arkansas. Their evaluation focuses on the program's effect on both expenditures and utilization of the enrolled population. They found somewhat reduced program expenditures with improved access to primary-care services as well as beneficiary perceived improvements in quality of care and access to primary care.

The two final articles examine the effects—both real and potential—of managed care and managed competition on specific provider groups and the implications for choice of provider and access to care in medically undeserved areas.

Henderson and Markus describe the approaches adopted by community health centers (CHCs) to adapt to the evolving managed care marketplace. Defined in the health care reform debate as "essential providers," CHCs are federally-funded primary-care clinics located in medically underserved areas. Confined to inner-city communities, rural areas, and along the "migrant stream," CHCs represent an oasis for Medicaid beneficiaries in underserved areas. However, there is the potential for them to be financially vulnerable under the impact of managed care. The authors find that CHCs are able to maintain financial stability as they retool and reorganize their operations under managed care, but that their mission is threatened by forces ranging from both Federal and State budget cuts to implementation of block grants in Medicaid.

Adapting managed care to rural areas has always been a challenge. Some believe that access to health care in rural areas is already too limited and that the central tenant of managed care's cost-saving strategy, reducing overutilization, does not apply in these areas. Others point to the need bring a system of care into these areas that could provide the additional providers and coordination of care that are lacking. Complicating the issue is the desire to bring competition into the marketplace as a way of increasing choice, improving quality, and holding down costs. Slifkin, Ricketts, and Howard attempt to address some of these issues by seeking answers to three questions in their article: (1) To what extent do rural providers currently have a choice of providers, (2) for those individuals with a limited provider option, do their providers compete for other segments of the market and (3) if State-level reform includes some type of collective purchasing agents, what would be the impact on consumer choice and access if restrictions or financial penalties are placed on crossing State boundaries to receive health care?

These articles make an important contribution to our understanding of the issues we need to address in monitoring and evaluating service delivery under managed care. It is our hope that such activities will lead to improved beneficiary access to care and the quality of the care they receive.

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