Opportunities for Medicaid Inclusion in Performance Measurement and Public Reporting

Introduction

One of the core principles of the *Aligning Forces for Quality (AF4Q)* initiative is that better information about doctors and hospitals will enable consumers to make more informed health care choices, driving higher-quality care in the community. As the 17 *AF4Q* alliances work to increase publicly available information about provider performance across payers, they are striving to include Medicaid data in their strategy. This is critical given that Medicaid, the nation's largest payer in terms of covered lives, accounts for 11 to 29% of a state's population. When alliances include Medicaid data in their performance measurement and public reporting (PM/PR), consumers and providers have a more complete picture of health care quality. Furthermore, because Medicaid comprises a higher proportion of racially and ethnically diverse patients, as well as individuals with complex and chronic conditions compared to those in the commercial sector, its data supports alliances in identifying and addressing disparities in care.

That said, incorporating Medicaid into a PM/PR strategy is not without challenges:

- Providers' concerns about the implications of PM/PR are magnified with the inclusion of Medicaid data. Medicaid beneficiaries tend to be sicker and more complex, and have HEDIS rates that are typically 10 to 20% lower than those in the commercial sector. ² Some providers may worry that reported poor performance will lead to the loss of patients and plan contracts, as well as reflect unfavorably on them among their peers.
- State Medicaid agencies are concerned about alienating an already-fragile provider network through public reporting that may be unflattering to physicians. Many primary care providers (PCPs) and specialists are already reluctant to serve Medicaid patients given low reimbursement rates and the complexity and challenges of treatment needs.
- Some Medicaid programs sanction their health plans financially for low performance, causing the plans to be similarly sensitive to public reporting of their provider networks.

This technical assistance brief describes the following five strategies for addressing the above challenges while incorporating Medicaid data into *AF4Q* alliance public reporting efforts:

- 1. Bring Medicaid data into an alliance's overall PM/PR strategy;
- 2. Understand how performance measures (e.g., HEDIS specifications) for the commercial sector differ for Medicaid populations;

¹ Kaiser State Health Facts, based on 2006 data, available at http://www.statehealthfacts.org/comparemaptable.jsp?ind=199&cat=4.

² E.A. McGlynn et al. "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine* 348, no. 26 (2003); National Committee for Quality Assurance's Quality Compass 2008, available at http://www.ncqa.org/tabid/177/Default.aspx.

- 3. Identify strategies and a rationale for aggregating and reporting Medicaid and commercial data together;
- 4. Understand when it may make sense to risk-adjust performance rates and risk adjustment considerations; and
- 5. Explore what motivates Medicaid programs and plans, as well as other purchasers, plans and providers, to participate in multi-payer PM/PR efforts.

Strategy 1: Bring Medicaid into an alliance's overall PM/PR strategy.

Although Medicaid is a singular health insurance program administered by the state, the program itself is often quite decentralized. A Medicaid program can use different delivery systems, managed by different health plans and other contractors, for different patient populations. And although states are moving toward greater alignment and standardization, Medicaid data are typically found in multiple places. The following 10 steps can help to overcome these challenges and bring Medicaid into the overall PM/PR strategy:

- 1) Understand the state's Medicaid delivery system The type of delivery system(s) (e.g., feefor-service, primary care case management (similar to a point of service plan) managed care, or a mixture of both) that Medicaid employs will often dictate where data resides. For example, if the state contracts with health plans, claims data will reside within each plan. If the state uses a fee-for-service program, the state likely will hold the claims data, although some Medicaid programs may allow a third-party entity (e.g., a quality improvement organization or university) to access it. While most states use multiple delivery systems, more than 70% of Medicaid recipients nationwide are enrolled in managed care.³ As a result, health plans likely will be the primary source of this data in many regions. If this is the case, it will be important to prioritize and approach the plans with larger member enrollment in a given region to maximize the amount of data submitted by Medicaid.
- 2) Identify which Medicaid beneficiaries are served by which delivery system It is important to consider how the alliance's target populations are being served. For example, low-income mothers and children are typically the first populations that states enroll in managed care, while more complex patients are more likely to remain in the state's fee-for-service program. If an alliance wants to measure performance for adults with complex or chronic conditions, efforts should be directed at the fee-for-service program serving that population.
- 3) Understand where and how race, ethnicity and language (R/E/L) data are collected The state, county agencies, or an enrollment broker will typically collect R/E/L data during the Medicaid eligibility and/or enrollment process, providing what arguably is the richest source of such data currently available. That said, R/E/L data collection may not be standardized throughout the state's Medicaid program.
- 4) **Identify how pharmacy services are provided** Inclusion of pharmacy data is critical in determining quality of care, particularly for complex populations. Even in managed care delivery systems, some states retain responsibility for pharmacy services, while others delegate

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³ Medicaid Managed Care Penetration Rates by State as of June 30, 2008, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, special data request, August 2009.

it to a pharmacy benefits manager or health plans; the entity responsible for services has access to related claims data. In Western New York, for example, the state collects pharmacy data, but shares it with the plans – therefore, either could support PM/PR.

- 5) Understand how mental health services are provided Medicaid health plans are rarely responsible for both physical and behavioral health services for those with serious mental illnesses; states often contract with one or more separate health plans that specialize in behavioral health care management or carve out these behavioral health services, leaving them in the fee-for-service system. A Medicaid beneficiary may also access these services through the fee-for-service delivery system. If the PM/PR strategy includes mental health measures, it will be important to identify where this data resides.
- 6) Weigh the pros and cons of requesting raw claims data from Medicaid versus precalculated performance rates Getting a claims "data dump" from a state may be expeditious; however, this requires significant time to understand and clean the data in order to calculate rates. Requesting pre-calculated provider-level rates from the state also will take considerable state resources. Kansas City is one alliance that is asking Medicaid for precalculated HEDIS rates at the provider level, as both the Kansas and Missouri Medicaid agencies can produce this information, an atypical scenario.
- 7) Identify how patients are linked to providers in the Medicaid delivery system Medicaid health plans strive to assign each member to a PCP, which may reduce the number of patients that will need to be attributed to a particular physician during measurement and reporting (often a very complicated, technical process). That said, plans rarely adopt a common attribution methodology, unless standardization is required by the state. After giving beneficiaries the opportunity to select a PCP, states typically auto-assign beneficiaries to plans. Similarly, plans encourage their enrollees to choose, then alternatively auto-assign members to network providers. In states with unmanaged fee-for-service programs, Medicaid patients are not assigned to a PCP.
- 8) Identify existing quality improvement strategies adopted by the Medicaid program It is important to know, for example, which HEDIS performance measures are being collected, for which delivery system(s), and at what level (e.g., plan, medical group, or physician). States have their own established PM/PR strategies for managed care delivery systems; less so for fee-for-service programs. Notably, the Detroit alliance has been working closely with Michigan's Medicaid department to find the "sweet spot" where the alliance's quality improvement efforts align with the state's.
- 9) Identify Medicaid's existing financial incentive programs linked to quality improvement and performance More than half of state Medicaid programs have adopted pay-for-participation or pay-for-performance programs and have financial incentives associated with a PM strategy. Understanding where opportunities exist to create synergies and economies of scale with these programs can help target efforts.
- 10) Finally, consider time and other resources when trying to incorporate Medicaid data into a PM/PR strategy When working with a state, it is important to start conversations early, as Medicaid agencies need a long lead time to access and submit data. This is particularly true when the state legislature is in session (usually the first half of the year), and Medicaid leadership is largely unavailable. Also consider that Medicaid agencies do not have flexible funding to purchase membership in regional coalitions, while Medicaid health plans often do.

Exploring the above issues will help alliances determine what data they need to request, and how they should direct and/or prioritize these requests.

It is important to note that if an alliance has built its PM/PR strategy upon clinical data submission, as has Cleveland, these issues will be more or less critical. For example, if a provider serves Medicaid patients, clinical data for these patients will already be "mixed into" the provider's clinical data submission (though only a small percentage of Medicaid providers have access to electronic medical records that allow clinical data submission). Practices also may be less likely to collect R/E/L data, although R/E/L data collected at the point of care is considered of higher quality.

Strategy 2: Understand how performance measures (e.g., HEDIS specifications) for the commercial sector differ from those for Medicaid populations.

While HEDIS specifications do not vary greatly for commercial versus Medicaid plans, slight differences may be seen in: (1) continuous enrollment, (2) data collection, and (3) measure selection.

- 1. Continuous enrollment Continuous enrollment specifies the minimum amount of time that a member must be enrolled in the health plan before becoming eligible for a measure. The transient nature of the Medicaid population, as well as state Medicaid enrollment laws and regulations, can cause lapses in coverage and reduce the length of time beneficiaries are continuously enrolled in a Medicaid plan. For some measures, HEDIS specifications for this differ for commercial and Medicaid plans. For example, the cervical cancer screening measure requires the commercial population to have continuous enrollment for the measurement year and two years prior, but requires the Medicaid population to be enrolled only for the measurement year. For Medicaid plans that verify enrollment monthly, HEDIS generally allows for no more than a one-month gap in coverage during the measurement year for enrollment to be continuous.
- 2. Data collection HEDIS measures are collected through either administrative data (i.e., claims or encounters) or a sampling of administrative data that is supplemented with medical record data (the hybrid method). Specifications for data collection are primarily the same across product lines, but for some measures (e.g., cervical cancer screening, well-child visits and adolescent well-child visits), HEDIS requires administrative data only for commercial plans, and allows Medicaid plans to use either collection method. Furthermore, some state Medicaid agencies require Medicaid managed care plans to use a specific data collection methodology, even if HEDIS allows either method. It is important to check with the state Medicaid agency and its health plans to identify any such rules or regulations around data collection methods.
- 3. **Measure selection** Not every HEDIS measure is specified for Medicaid (e.g., Colorectal Screening), and some HEDIS measures are for Medicaid patients only (e.g., Lead Screening). Accordingly, if an alliance is looking to collect measures across product lines, it should ensure that the specifications are applicable to all payer types.

As mentioned above, some states choose to carve out certain Medicaid benefits, such as behavioral health or pharmacy services. There are some HEDIS measures that require pharmaceutical, lab or behavioral health data that may be captured in the carve-out program. Medicaid health plans may have difficulty reporting these measures if they do not have access to the necessary data; alliances can work with their state Medicaid agency to supply this.

Strategy 3: Identify strategies and a rationale for aggregating and reporting Medicaid and commercial data together.

When an alliance has access to both commercial and Medicaid data, it must decide whether to aggregate the data for the purposes of PM/PR, based on the following considerations:

- Whether providers serving Medicaid and commercial patients are segregated If the provider network is more segregated (i.e., any one practice predominantly serves either commercial/Medicare or Medicaid/uninsured), there is likely to be a "clustering" of high-volume Medicaid practices. Clustering often occurs when a state's Medicaid reimbursement rate is a low percentage of its Medicare reimbursement rate. The Detroit alliance, for example, plans initially to report Medicaid data separately from commercial data since there is little overlap between providers who predominantly serve Medicaid and those serving others. Albuquerque provides a contrasting example: with almost 30% of residents enrolled in Medicaid and a high Medicaid reimbursement rate (almost 100% of Medicare), its provider community is relatively desegregated. Accordingly, a large proportion of providers in the region likely will be represented if the alliance uses only Medicaid data, driving the alliance to consider this approach.
- Whether there is enough Medicaid data to calculate meaningful rates As a related point, there must be enough Medicaid data to calculate meaningful performance rates. If a provider's panel has only a small percentage of Medicaid patients, stratifying data by payer will be meaningless and unreliable. An individual physician will be more interested in understanding performance across his/her entire patient panel. Stratification will be more meaningful as the unit of analysis becomes larger (e.g., a medical group).
- Where there is a history of public reporting Like most providers, Medicaid practices are unfamiliar with public reporting. While they may receive confidential multiple performance reports -- each representing a sliver of their patient population -- they are not accustomed to receiving aggregated performance data at the provider level, particularly in a public forum. Aggregated performance data is a powerful and valuable tool for increasing a provider's awareness about performance; however, it is wise to "ease into" PM/PR to build trust between practices and payers over time. Minnesota's Medicaid program, for example, has been working towards greater transparency and public reporting for a few years, and has willing to share Medicaid data publicly.
- The ambulatory quality improvement supports available to address disparities in care The alliance should consider its next steps after measuring and reporting information. Specifically, as low-quality and disparate care is identified, how will the alliance/ Medicaid support low-performing providers in improving quality? Sharing potential interventions with providers beforehand will encourage them to collaborate.

Perhaps for the reasons above, the majority of alliances aggregated data during their initial PM/PR efforts, moving towards stratification and more explicit identification of disparities over time. Minnesota and Puget Sound provide examples of how alliances can shift over time from aggregated to stratified performance measures.

Regardless of whether Medicaid data are aggregated with other payer data, there are several steps an alliance should consider when publicly reporting Medicaid data:

- Be clear on the purpose of publicly reporting data by payer and consider how differences between payers will be explained The purpose of reporting is to identify gaps in performance and target resources to those who need assistance most, and to identify best practices among higher Medicaid performers. The gap between Medicaid and non-Medicaid performance is well-documented. Results should focus on increasing transparency in health care as a vehicle for promoting quality improvement.
- Consider how the alliance will incorporate state, Medicaid health plans, and providers into the report design and data review process How will providers serving Medicaid patients be involved in the PM/PR process? How will they be educated about public reporting and why Medicaid-specific data are valuable? The alliance and Medicaid can partner to reach out to and educate providers about the PM/PR strategy. PM/PR is best done in incremental stages, where practices gain trust in the alliance; they will become more comfortable after understanding the rationale for reporting, the use of data, the messaging around it, and the regional ambulatory quality improvement support that the practice will receive as a result of identifying disparities and gaps in care. An alliance should develop a strong data validation process; give providers the opportunity to correct data, as appropriate; and reassure them that they will have this opportunity for review before data is released.
- Consider adding benchmarks from other states or alliances that report Medicaid performance data publicly State decision-makers are often motivated by the actions and results from their peers, especially in neighboring or similar states (in size, demographics, political culture, etc.) This provides a basis for comparison with providers in their region. The National Commission on Quality Assurance (NCQA) can provide such benchmarks at the state or health plan level.⁴
- Consider how data will be shared with low-income consumer populations The public report will need to address unique and complex social, economic and health care challenges faced in the Medicaid program and be written at an appropriate reading level for the patient population.

Strategy 4: Understand when it may make sense to consider risk-adjusted performance rates and how to do so

Before deciding whether to use risk-adjustment, it is important to understand what it is. Patient characteristics (or risk factors) differ across heath care organizations and payer types. Risk adjustment is a statistical process that adjusts for variation in these characteristics to make comparisons across organizations fairer. As risk adjustment is complex and time-consuming, it is highly recommended that an alliance include a statistician familiar with the process.

One way to think about risk adjustment is an analogy to sports. A simple comparison of won-lost records may not provide the best insight into which team is better. The team that is 10-0 may have played easier teams than the team that is 8-2. One might try to "risk adjust" for the caliber of opponents that each team played to determine, in essence, how the 8-2 team would have done playing the teams on the 10-0 team's schedule, and vice versa.

⁴ For more information, visit www.ncga.org.

Similarly, performance on a particular health care measure often depends on factors outside the control of the physician/organization: one practice may serve a low-income population with a high incidence of chronic health conditions, while another may serve a high-income population with a low incidence. While the former may have higher rates of uncontrolled blood pressure than the latter, this would be expected due to differences in their patients' health. To compare control of blood pressure rates between the two practices fairly, we need to adjust for this difference in health risk.

Before deciding an appropriate risk-adjustment strategy, it is important to answer the following questions:

- What is the purpose of the risk adjustment?
- Will risk adjustment be applied to just the provider's Medicaid panel or to all patients?
- For what type of health outcomes are the adjustments?
- What is the unit of observation that will identify the risk? A year? An episode of care? (Timeframes, or units of observation, can affect the range of risk factors that should be considered.)
- What are the available data sources?
- Which risk adjustment method is appropriate?
- What risk factors need to be adjusted for (e.g., demographic, clinical, socioeconomic, health-related behaviors, health-related perceptions)?

Often there are many characteristics that influence performance: attributes of the physician and of the patient; attributes of the region or health system they operate in; and attributes of the practice itself (e.g., is it independent or part of a hospital clinic). As the number of attributes grows, advanced regression techniques are used to account for multiple attributes simultaneously.

Because risk adjustment uses data and statistical techniques, problems that affect data availability or the soundness of the statistical judgment are the main threats. For example, to risk adjust by race/ethnicity, R/E/L data must be collected and reliably recorded. Confidence that a particular risk adjustor is predictive of performance depends on a sufficient sample size to support the conclusion.

Strategy 5: Explore what motivates Medicaid programs and plans to participate in multi-payer PM/PR efforts.

State Medicaid agency and health plan leaders have many motivations to join a multi-payer, regional PM/PR effort, including:

- Creating economies of scale with other payers States recognize the rewards of aligning with other payers, including the opportunity to benefit from an alliance's "heavy lifting." States will need a partner who will find the "sweet spot" of commercial and Medicaid alignment across practices, performance measures, and quality improvement strategies.
- Reducing PCPs' administrative hassles and levels of confusion around reporting Plans understand that presenting disaggregated performance information to providers is inefficient, ineffective and costly. They recognize the potential for longer-term cost savings through aggregated performance reporting. However, there remains a very strong competitive instinct among health plans, even around quality. Increasingly, plans understand that they must change this "modus operandi" in order to remain relevant and valuable in the health care system.

- Identifying and reducing disparities in care, while recognizing the unique challenges of the Medicaid population Medicaid is a mission-driven program, and improving the quality of care for low-income and disabled beneficiaries is at the heart of the business. Medicaid programs are also well-versed about disparities and are committed to closing the gap between public and private payers. That said, it is critical to acknowledge the factors contributing to disparities (e.g., social, economic, cultural, etc.) and the many strategies that states have adopted to close that gap (e.g., aggressive and tailored member outreach; adoption of cultural competency tools and training; use of health literacy strategies; adoption of financial incentives, etc.).
- Maintaining and improving standing in community Like commercial plans, Medicaid plans respond to the "peer pressure" of other Medicaid plans that have joined regional quality improvement efforts. No one wants to be the only Medicaid plan not participating.
- Addressing the federal requirement for a quality improvement project (QIP) Lastly, state Medicaid programs are required by the Centers for Medicare and Medicaid Services to have a QIP for health plans. In many cases, participation in a regional PM/PR effort can serve as the QIP.

Conclusion

This document was prepared in April 2010 by the Center for Health Care Strategies and the National Committee for Quality Assurance, which are providing technical assistance to alliances participating in the *Aligning Forces for Quality initiative*. The issue brief was designed to provide guidance and insights from the Medicaid perspective to the *AF4Q* alliances as they continue to implement and achieve their PM/PR strategies.