Anthem
Public Policy Institute

Key Considerations for Transforming Quality Measurement and Reporting in Medicaid Managed Care

EXECUTIVE SUMMARY

Quality measurement and reporting in state Medicaid programs has become increasingly critical as more Medicaid beneficiaries, including more diverse populations, have moved into managed care plans. Medicaid managed care enrollment doubled between 2006 and 2015, as states expanded eligibility and began shifting individuals with more complex heath needs into managed care organizations (MCOs).[1] Quality measurement is essential for judging the impact of changes like these on the individuals they are intended to benefit.

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States require MCOs to achieve goals for access, quality, and cost. States have had much flexibility to design their quality measurement systems including selecting the metrics, developing specifications for reporting, establishing benchmarks and goals, devising topics for performance improvement projects, and creating incentives tied to quality measures such as pay-for-performance (P4P) and value-based payments.

The State of State Quality Measurement and Reporting Systems

States typically choose HEDIS® and oftentimes CAHPS® measures to monitor quality in Medicaid managed care, and most states require that health plans report other quality metrics that are relevant to state-specific initiatives, demographics, and covered benefits. While there is an abundance of quality metrics in certain areas, there are notable gaps for behavioral health and long-term services and supports (LTSS), and for high-risk, high-cost populations such as individuals eligible for both Medicaid and Medicare (dual eligibles), the frail elderly, individuals with severe mental illness, and individuals with multiple chronic illnesses.

Some state Medicaid programs have developed quality rating systems to help consumers more easily compare quality among health plans and consider quality when selecting a plan. There is little evidence on the impact of Medicaid rating systems to date, but it appears that simply providing the quality ratings does not ensure consumers will use them. Rather, the degree to which ratings influence consumers' choice of plans is dependent, in part, on the extent to which the information displayed is comprehensible and relevant to consumers. Likewise, little research has examined the impact of plan quality ratings on health plan and provider behavior change, though both are focused on demonstrating value to consumers and purchasers.

Considerations for the Future of Quality Measurement and Reporting

New federal regulations released by the Centers for Medicaid & Medicaid Services (CMS) in April 2016 emphasize greater consistency in Medicaid quality measures across states and greater alignment across programs (e.g., Medicaid, health insurance marketplaces).[2] The rules require states to develop and implement a quality rating system over the next three years, and CMS expects to determine a core set of measures and

State Flexibility to Design Their Quality Measurement Systems

- Selecting the metrics
- Developing specifications for reporting
- Establishing benchmarks and goals
- Devising topics for performance improvement projects
- Creating incentives tied to quality measures

corresponding methodology for all MCOs. Payers, providers, and quality measurement organizations also are shaping quality measurement strategies by convening workgroups, developing recommendations for new measure sets, and testing new measures in select states' Medicaid programs. Over the next few years, stakeholders should take into account several key considerations:

- Quality measures should be well-tested, evidence-based, peer-reviewed, and focused on measuring the health outcomes of individuals – with particular attention to populations newly entering managed care such as individuals with behavioral health conditions, individuals with intellectual and/or developmental disabilities, and individuals enrolled in managed LTSS programs.
- As CMS continues to develop a quality rating strategy, it should be mindful of the diverse needs of the populations served through Medicaid managed care. CMS should also take into account the work already done in many states to build successful quality strategies that offer tools and "best practices" to others. States should continue to serve as testing grounds for innovative quality measurement and reporting approaches.
- As Medicaid managed care quality rating systems grow, it is imperative to assess on an ongoing basis whether and to what extent these systems are able to effectively drive changes in consumer, health plan and provider behavior. Additional work should focus on ensuring that consumer-facing quality ratings are comprehensible, relevant, and align with consumers' other priorities and considerations related to health plan selection.

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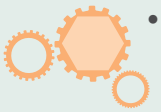
Three papers from the Anthem Public Policy Institute discuss these issues in greater detail:



- ***The "Nuts and Bolts" Behind Quality Measurement in Medicaid Managed Care***
  This first paper explores the state of quality measurement in state Medicaid programs and makes several recommendations to improve quality measures.

- ***Balancing Standardization and State Flexibility in Medicaid Quality Measurement and Reporting***
  This paper analyzes the variation in current state approaches to quality measurement for Medicaid MCOs and discusses the trade-offs between standardization of measures and state flexibility to innovate and use state-specific measures.

- ***The Impact of Medicaid Quality Rating Systems on Consumer, Health Plan and Provider Behavior***
  The final paper examines state-developed quality rating systems that help consumers compare quality among health plans, with the goal of encouraging them to consider health plan quality when selecting a plan.

These papers are available on the Anthem Public Policy Institute website at http://anthempublicpolicyinstitute.com.

[1.] Nersessian, G., Fairgrieve, A., & Nenko, A. (Eds.). (2016, January 6). Medicaid Managed Care Spending in 2015. HMA Weekly Roundup: Trends in State Health Policy, 1-7. Retrieved June 2, 2016, from https://www.healthmanagement.com/wp-content/uploads/010616-HMA-Roundup.pdf.

[2.] U.S. Department of Health & Human Services. (2016, April 25). Medicaid and CHIP Managed Care Final Rule. Retrieved April 28, 2016, from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-final-rule.html.