Toward a 21st Century Quality-Measurement System for Managed-Care Organizations

Rodney C. Armstead, M.D., Paul Elstein, Ph.D., and John Gorman

As the Nation's largest managed-care purchaser, the Health Care Financing Administration (HCFA) is working to develop a uniform data and performance-measurement system for all enrollees in managed-care plans. This effort will ultimately hold managed-care plans accountable for continuous improvement in the quality of care they provide and will provide information to consumers and purchasers to make responsible managed-care choices. The effort entails overhauling peer review organization (PRO) conduct of health maintenance organization (HMO) quality review, pilot testing a new HMO performance-measurement system, establishing criteria for Medicaid HMO quality-assurance (QA) programs, adapting employers' HMO performance reporting systems to the needs of Medicare and Medicaid, and participation in a new alliance between public and private sector managed-care purchasers to promote quality improvement and accountability for health plans.

INTRODUCTION

As part of its Strategic Plan and as the Nation's largest managed-care purchaser, HCFA is working to promote improved quality of care, responsiveness, and outcomes for Medicare and Medicaid beneficiaries in managed-care settings. There is wide agreement that current methods of monitoring the quality of care provided by Medicare and Medicaid managed-care organizations (MCOs) are antiquated and cumbersome. New methods of assessing quality of care and outcomes in managed care will have their roots in data on how health plans are responding to the needs of beneficiaries in patient encounters. HCFA's efforts to develop these new methods of quality and performance measurement are being undertaken in partnership with other purchasers, the managed-care industry, States, and other public and private organizations.

For the last 20 years, America's health care system has been embroiled in a revolution of industrialization driven by spiraling costs. Today, the dust of the first stage of the managed-care revolution—the struggle between capitation and fee-for-service payment methods—is settling. In all likelihood, indemnity products will represent only about 10 percent of the insurance market within the next 5 years. The majority of privately insured individuals—some 65 percent—are already enrolled in some form of managed-care plan, with double-digit annual increases in managed-care enrollment. Medicare and Medicaid have lagged substantially behind the private sector during this transition and therefore represent the "last frontier" of untapped markets for the managed-care industry.

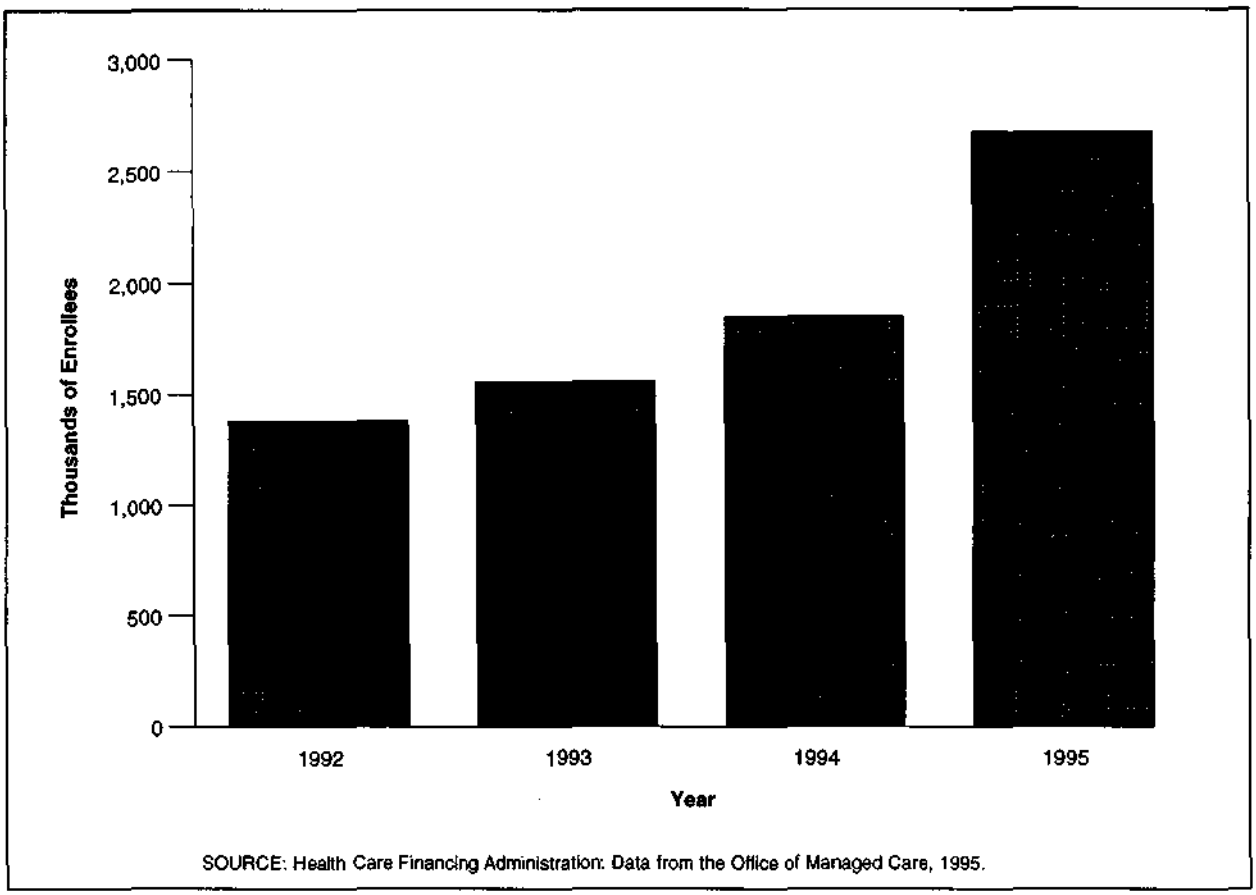
Two major factors will characterize the second stage of the managed-care revolution:

- Costs will become a constant, as managed-care markets mature and prices level off, and improved quality of care—particularly outcomes—will become the dominant objective.
- The greatest growth in managed-care enrollment in the 1990s will come from

The authors are with the Office of Managed Care, HCFA. The opinions expressed are those of the authors and do not necessarily reflect those of HCFA.

Figure 1

Medicare Managed-Care Enrollment: United States, 1992-95



SOURCE: Health Care Financing Administration: Data from the Office of Managed Care, 1995.

Medicare and Medicaid. Millions of poor families and frail, chronically ill seniors will descend upon managed-care plans.

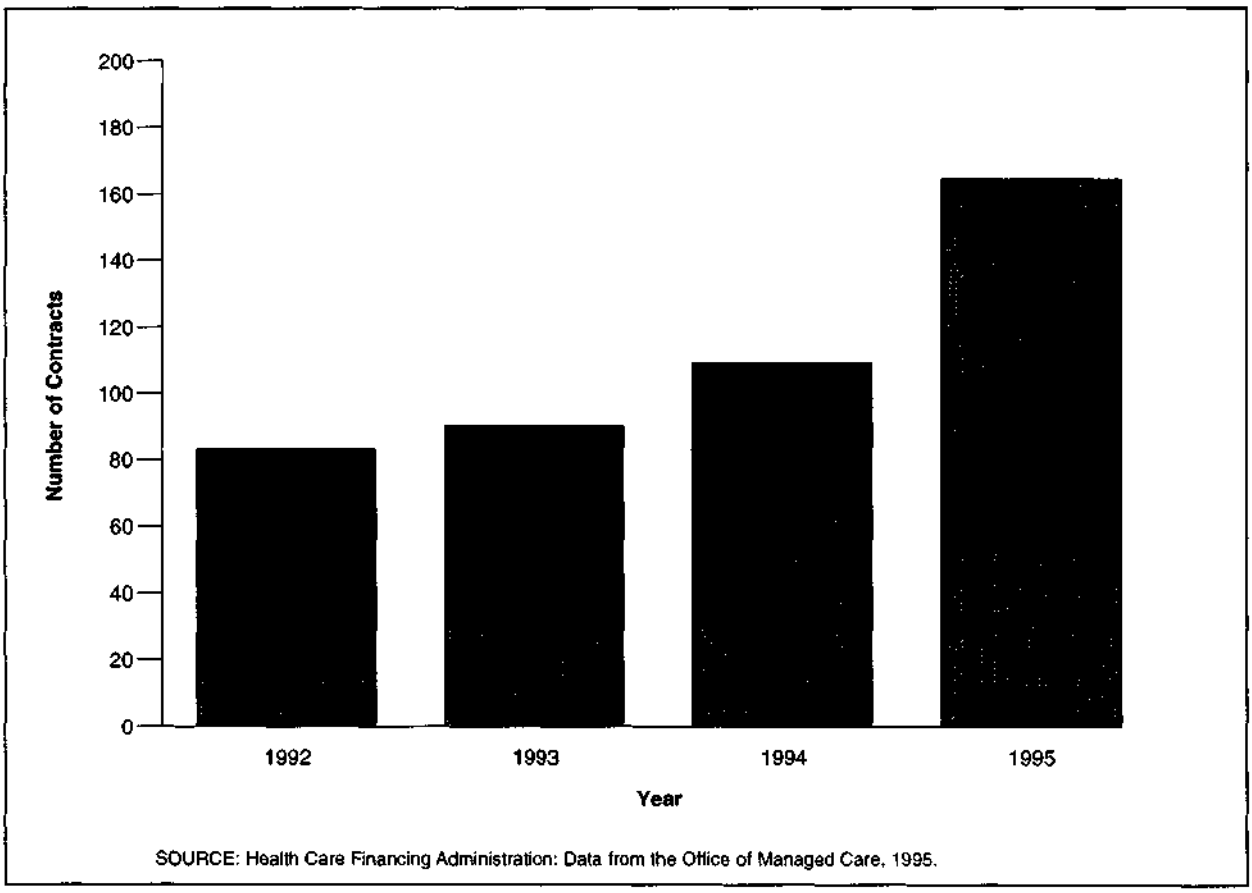
Medicare

In many respects, Stage 2 has already begun. Since the inception of the Medicare managed-care program under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 , enrollment of beneficiaries in Medicare managed-care contracts has increased steadily (Figure 1). In 1987, about 1.7 million beneficiaries were enrolled in managed-care plans. This figure increased to more than 2 million in 1992. As of July 1, 1995, there were more than 3.5 million Medicare beneficiaries enrolled in the 253 Medicare-contracting managed-care plans, an increase of more than 18 percent over the previous year. TEFRA established three types of Medicare contracts: risk- and cost-based contracts, authorized under section 1876 of the Social Security Act, and Health Care Prepayment Plan agreements, authorized under section 1833.

The number of Medicare risk HMOs has increased rapidly during the past few years, consistent with trends in the private sector (Figure 2). In 1992, Medicare had risk contracts with 83 HMOs. As of July 1995, there were 165 HMOs with Medicare risk-based contracts, with a 20-percent increase in contractor applications in 1994. Risk-based arrangements are viewed as having greater profitmaking potential by managed-care plans and are favored by some policymak-

Figure 2

Growth of Medicare Risk Contracts: United States, 1992-95



SOURCE: Health Care Financing Administration: Data from the Office of Managed Care, 1995.

ers as a vehicle through which health care budgets can be stabilized by shifting deficits onto the private sector.

Most of these Medicare-contracting HMOs are in areas of the country where there are large numbers of Medicare-eligible seniors. Enrollment in managed-care organizations with Medicare risk-based contracts is concentrated in five States: California, Florida, Arizona, New York, and Oregon. Indeed, in certain parts of Oregon and a handful of other States, the Medicare managed-care penetration rate actually outpaces the rate in the private sector.

Managed care is entirely voluntary in Medicare. All eligible seniors have the option of enrolling in a managed care plan if one is available in their area; some 74 percent of Medicare beneficiaries have access to at least one plan, and 57 percent have a choice between two or more.

Medicaid

The proliferation of managed-care in Medicaid is astounding, especially considering that, as late as 1980, managed-care was virtually unknown in Medicaid. During the 1980s, virtually uncontrolled growth in Medicaid costs compelled States to pursue managed care as the primary mechanism to restrain costs, while increasing access to care for beneficiaries who faced limited numbers of providers available to serve them.

By 1990, there were more than 1.5 million Medicaid enrollees in managed-care programs. From 1990 to 1992, this figure more

than doubled to 3.6 million; between July 1992 and July 1993, it increased by another 33 percent to 4.8 million. In 1994, we witnessed growth in excess of 60 percent, taking the number of Medicaid managed-care enrollees over the 8-million mark. Today, more than 24 percent of all Medicaid recipients nationwide are enrolled in managed-care arrangements (Table 1).

The programs in which these millions of beneficiaries are enrolled include a wide variety of "managed" fee-for-service programs and prepaid capitation arrangements:

- About one-third of these enrollees are in primary-care case management (PCCM) models. Some 27 States now have some form of full-risk program in place, and 31 have some form of PCCM.
- About 63 percent are in some form of capitated program, such as HMOs, health insuring organizations (HIOs), and prepaid health plans (PHPs), utilizing partial- and full-risk capitation arrangements.

Medicaid managed-care programs exist in 44 States and the District of Columbia, with many remaining States planning to adopt some form of managed-care arrangement in the near future.

Managed care is overwhelmingly mandatory in Medicaid, with beneficiaries given some choice among participating plans. Two waiver authorities granted to HCFA in the Social Security Act are the principal vehicles for Medicaid managed-care enrollment growth:

Table 1

Medicaid Managed-Care Enrollment and Plan Data: June 30, 1994

Program Type	Number of Programs	Number of Enrollees
Health Insuring Organizations	6	222,814
Health Maintenance Organizations	210	3,954,712
Prepaid Health Plans	74	1,231,567
Primary-Care Case Management	50	2,385,157

SOURCE: Health Care Financing Administration: Data from the Office of Managed Care, 1994.

- Section 1115 waivers give States broad authority for demonstrations, and every one approved under the Clinton Administration thus far has been used to implement some form of statewide Medicaid managed-care system.
- Section 1915(b)—"Freedom-of-Choice"—waivers are exclusively for Medicaid managed-care programs, such as implementation of a PCCM program for at-risk pregnant women. Under the narrower 1915(b) authority, the Medicaid beneficiary's freedom of choice of provider is waived so he or she can be "locked into" a managed-care arrangement. The majority of Medicaid managed-care enrollment in 1994 occurred under 1915(b) waivers, not 1115s.

Since President Clinton took office, section 1115 waiver applications have been approved for Delaware, Massachusetts, Minnesota, Oregon, Hawaii, Tennessee, Kentucky, Rhode Island, Florida, South Carolina, and Ohio. HCFA has 7 more 1115 waiver applications pending from New York, Illinois, New Hampshire, Georgia, Oklahoma, Vermont, and Missouri, and as many as 10 more could be submitted this year. If these waivers currently under review by HCFA are approved, it will mean that more than one-half of the States will be pursuing their own managed-care plans—with more than one-half of all Medicaid beneficiaries enrolled in managed-care.

HCFA's Perspectives on Managed Care and Quality

Ensuring the quality of care and responsiveness, and consistently improving outcomes for Medicare and Medicaid beneficiaries in managed-care arrangements are top priorities for HCFA. With the right combination of system sensitivity and patient responsibility, managed care can improve

the results of health care services while saving substantial sums of program dollars. Managed care offers a dedicated primary-care provider for every patient and a continuum of coordinated care in which the provider follows the patient. This construct can increase beneficiary access to care while reducing inappropriate use of health care services, such as seeking primary-care services in an emergency department.

The prepaid nature of managed-care financing offers incentives to providers to ensure the good health of their patients, thereby avoiding costly specialists and hospitalization. Often this leads to strategies that address unfavorable beneficiary behaviors, such as smoking or substance abuse. It also frequently results in innovative outreach programs and other "enabling" services that enhance the effectiveness of preventive care. These include transportation, case management, health and nutrition education, and so on. Above all, managed care provides a framework for the continuous delivery of quality services that can be monitored and consistently improved upon.

HCFA is also acutely aware that Medicare and Medicaid beneficiaries are dramatically different from traditional managed-care enrollees. They are disproportionately poorer: Around 86 percent of Medicaid recipients are poor or low-income, and of this group, 59 percent are minorities. Eighty–three percent of Medicare spending last year was on behalf of those with incomes below $25,000—meaning Medicare is predominantly a low-income insurance program as well. Beneficiaries are disproportionately sicker, as poverty and aging are known to bring with them a host of medical and psychosocial conditions. Therefore, in implementing Medicare and Medicaid managed-care programs, millions of people, including impoverished children and cash-assisted adults, the indigent disabled, the frail and chronically ill elderly, people with acquired immunodeficiency syndrome (AIDS), and drug abusers, are entering health care delivery systems that to date have had little experience in providing care to them.

HCFA's approach to quality and performance measurement, therefore, follows this line of logic:

- We cannot have consistently improving, quality managed-care for the diverse populations in Medicare and Medicaid until we have sensitivity and responsiveness to their unique needs.
- We cannot have sensitivity and responsiveness until we have consistent data that show where the problems are and how to adjust the payment system so that providers will address these problems.

Therefore, the key to improving the quality of managed-care for Medicare and Medicaid beneficiaries is sensitivity to the different and greater needs of these diverse populations—sensitivity that is reflected in responsive decisionmaking at all levels for Continuous Quality Improvement (CQI).

Trends in the managed-care marketplace are also fueling demands for data and for quality- and performance-measurement systems as competition intensifies in the second stage of the managed-care revolution. Managed-care markets are maturing, and penetration rates are growing: Several States are approaching 50 percent already. Consolidation and competition in the marketplace are bringing costs down; in Los Angeles, there is only a $7–$8 difference in the premiums between the two leading plans.

In the growing number of mature managed-care markets, costs will cease to be the primary factor in consumer and purchaser decisionmaking in the near future. Quality will become the variable, the key to long-term survival for managed-care plans. As prices level off in these mature markets,

unassailable business advantage will go to the plans that have the best outcomes, but only if these plans are capable of demonstrating this to consumers and purchasers such as HCFA.

HCFA's role, therefore, as the Nation's largest managed-care purchaser, is to be the catalyst for an effort to develop a seamless, uniform data and performance-measurement system for all enrollees in all managed-care plans. This effort, ultimately, should provide consumers, purchasers, and providers alike with the data they need to make informed, accountable choices. HCFA is engaged in a number of collaborative projects with other purchasers and the managed-care industry toward that end.

As there is wide agreement that HCFA's current system of QA for MCOs is not currently meeting these goals, it is worth examining the system to understand how it must be reinvented.

MEDICARE

Internal QA

Medicare-contracting HMOs are required to have an internal quality-assessment and improvement (QAI) program. In addition, those that receive risk-based payment are subject to additional external quality review of the care they provide. The QAI program involves the following:

- An ongoing program evidenced by: a written plan describing the structure, responsibilities, types of activities, and specific quality-improvement projects for the coming year; a committee of practicing physicians and other representative practitioners with the commitment of adequate resources, including staff; and board accountability for the QAI program.
- An approach that stresses health outcomes, covering the entire range of care provided, and that examines the effects of provider compensation and incentive arrangements to ensure that appropriate services are, in fact, provided.
- A systematic, iterative process to identify problems and areas for improvement, make appropriate changes, and monitor changes over time for effectiveness.
- Peer review by physicians and other health professionals of the processes of clinical care.
- Systematic data collection of performance and patient outcomes, and interpretation and feedback of these data to practitioners.
- Written procedures for taking appropriate action to change areas needing improvement, and a process to determine overall effectiveness of the program and individual action plans.

In carrying out the QAI activities, HCFA's Office of Managed Care and regional offices expect the HMO to use an integrated approach, addressing all operational areas that affect the quality of care delivered.

Once HCFA contracts with an MCO to provide services to Medicare beneficiaries, monitoring activities are carried out on an ongoing basis and on-site biennial reviews are conducted. HCFA receives a variety of information from the MCOs, which is reviewed against prior plan data. By looking at appeals and reconsiderations, disenrollment patterns, PRO concerns, and member complaints, as well as financial reports, HCFA staff are alerted to possible access and quality problems. If a potential problem is identified, HCFA can request information from the plan and, if necessary, conduct site visits that will allow HCFA to identify problems that need to be addressed by the plan.

The biennial review assesses all aspects of the plan's operations, including eligibility requirements and Medicare contracting

operations (marketing materials and activities, enrollment, disenrollment, appeals and grievances, claims processing), and efforts are underway to move to a system of annual review of Medicare MCOs. If deficiencies are noted, the plan is requested to develop a corrective action plan. Following approval, the plan is monitored to ensure that the appropriate changes are made.

External Review

PROs review the quality of care delivered in Medicare risk-contracting HMOs. Under their present contracts, PROs perform case review for two types of random samples:

- Between 50 and 300 records (depending on the size of the HMO or competitive medical plan [CMP]) of current Medicare enrollees.
- Ten percent of all Medicare deaths.

All beneficiary complaints received by the PROs are also reviewed.

For all the selected records, PROs review the quality of care across all settings for 1 year. Normally, when a pattern of quality concerns is identified, an action plan is developed by the plan in concert with the PRO. The PRO then monitors performance under the plan to ensure that necessary improvements have been effected.

Neither the PROs, HMOs, nor HCFA believe that the current system is working effectively. Research has shown that, in general, such review is unreliable and does not take the HMOs' internal QA into account; further, experience suggests that it does not lead to substantial quality improvement.

Thus, HCFA is moving to bring PRO review of managed-care plans into the Health Care Quality Improvement Program (HCQIP), now implemented in the fee-for-service sector. HCQIP represents a fundamental change in the focus of the PRO program by moving away from its prior emphasis on identifying individual (and often isolated) clinical errors to helping plans, providers, and practitioners improve the mainstream of medical care. Under HCQIP, PROs now use statistical data analysis to examine the variations in both the processes and outcomes of care, share this information with hospitals and physicians, and work with them to interpret and apply the findings.

Three initiatives have been undertaken to implement HCQIP for PRO review of managed care. They are:

- Encouragement of PRO proposals for alternative managed-care review methodologies.
- Development of a pilot project to test the use of quality indicators to improve care.
- Development of the next PRO contract to reflect HCQIP.

HCFA's work with the PROs on HCQIP and the PROs' shift to data analysis illuminated the need for the development of uniform and consistent encounter data as the building blocks of any performance-measurement system for managed care. With comprehensive and comparable data, plans would be able to provide reports to purchasers such as HCFA, to consumers, and to providers.

HCFA is working in partnership with the managed-care industry, States, and others in several important efforts to define encounter data standards for managed-care plans. This is a sensitive effort because plan collection of encounter data will, in many cases, be burdensome: Although encounter data are a necessary byproduct of fee-for-service care as the basis of payment, the prepaid nature of managed care does not require it, and many plans do not collect it.

As HCFA works to develop standards for encounter data for both Medicare and Medicaid, we are pursuing parallel efforts

to structure a performance-measurement system in which encounter data can be used. An illustration of this is HCFA's contract with the Delmarva Foundation for Medical Care, Inc.

Delmarva Contract

In order to move away from individual case review and toward analysis of patterns of care provided by HMOs, in September 1993, HCFA contracted competitively with the Delmarva Foundation for Medical Care, Inc. (Although Delmarva is the PRO for Maryland and the District of Columbia, it was not working as a PRO for the purposes of this contract.) Dr. R. Heather Palmer of the Harvard School of Public Health was the principal investigator for the project.

HCFA asked Delmarva to collaborate with a panel of QA experts from the managed-care industry and academia to develop a set of performance measures or quality indicators to identify the minimum data needed for the indicators and to develop a new review methodology for external (medical third-party) review.

The contract was intended to help HCFA shift from the current mode of HMO oversight to one based on measurement and improving the mainstream of care for entire populations. HCFA asked the contractor to survey performance indicators that are already in use, so that HCFA could build on the efforts of others and move expeditiously to a more state-of-the-art review system. Further, in the interest of minimizing burdens on managed-care plans, HCFA asked the contractor to use a panel of experts to evaluate which of the indicators currently in practice were most likely to be of value in quality management for Medicare risk-contracting HMOs.

In the team's final report of August 1994, Delmarva recommended three core measures to be drawn from the HMOs' administrative data. These core measures, which would apply to all Medicare enrollees in the HMO, included access to services (defined as one or more services from plan practitioners), annual influenza vaccination, and screening mammography for women.

Delmarva also recommended adopting two diagnostically related measure sets (DRMS) to measure clinical performance. A DRMS uses both administrative and medical record information to measure performance of care for patients with specific diagnoses or conditions. For the initial DRMS, Delmarva recommended diabetes mellitus and ischemic heart disease/hypertension. These conditions are common among Medicare beneficiaries. Among the measures that Delmarva suggested be included in those DRMS were leg and foot examinations for beneficiaries with diabetes, and blood pressure screening for patients with ischemic heart disease.

The measures were drawn from a number of existing data sets. The most prevalent were the Health Plan Employer Data and Information Set (HEDIS) and the Develop and Evaluate Methods to Promote Ambulatory Care Quality (DEMPAQ) project, an earlier HCFA-funded project to develop an approach to review fee-for-service care provided in physicians' offices.

Following release of the Delmarva report, HCFA asked PROs and HMOs whether they would participate in a pilot test of the proposed methodology. Because of the need to have a sufficient number of beneficiaries from which to draw our sample, HCFA required that each HMO have at least 5,000 Medicare enrollees in 1994. It was estimated that this number would provide the desired sample of 300 beneficiaries in each DRMS estimated for the project. In addition, HCFA asked that any PRO that wished to be considered for the pilot have at least two such HMOs in their State willing to participate. This limited the

potential field of PROs to 17; of those, 10 came in with proposals meeting the criteria for consideration.

Prior to implementation of the pilot project, HCFA and Delmarva convened two additional panels to establish priorities for the indicators in terms of clinical and operational importance. The first panel was comprised of practicing physicians and nurses; the second, a small group of HMO and PRO representatives. The groups made substantial revisions to the indicators and added new indicators that they believed were important. One of the recommended changes was to concentrate on diabetes and the core measures in the pilot project.

The pilot test of the Medicare Managed Care Quality Improvement Project (MMC-QIP) began in May 1995 in 5 States and 23 HMOs. A preliminary report from the Delmarva pilot project is expected by spring 1996.

PRO Proposals

HCFA has encouraged the PROs to contact the HMOs and CMPs they review to discuss alternative review methods under which the PROs and the plans could work collaboratively to improve care. PROs in at least seven States have initiated dialogues with the plans they review. The most comprehensive alternative review methodology resulting from these discussions has been implemented in Arizona. The Health Services Advisory Group, Inc. (the PRO for Arizona), in collaboration with six Arizona HMOs and CMPs, has implemented a strategy for improving care that includes an enhanced beneficiary-complaint monitoring process, data collection by medical-record abstraction of a diagnosis-specific (diabetes) random sample, and data collection by medical-record abstraction of use of preventive services (pneumococcal and influenza vaccines, pap smears, mammography, and patient histories and physical examinations).

The first data reports from these efforts are being prepared. The PRO will share these reports with the HMOs and CMPs and work with them to develop plans to improve care in areas delineated by the reports.

Thus, although HCFA is committed to supporting the Delmarva approach, this does not preclude the development of alternative methods of improving the quality of care provided to Medicare beneficiaries in managed care. The scope of work for the next PRO contracts beginning in 1996 will encompass HCQIP and will be constructed to enable PROs and HMOs to work collaboratively on new quality indicators and outcome measurements and new strategies for quality improvement that can be shared with HCFA.

MEDICAID

Quality Assurance Reform Initiative

Medicaid presents similar but different challenges in quality and performance measurement than does Medicare. The Medicaid statute requires internal and external quality review of contracting MCOs by States and independent entities, and State health departments and insurance commissions carry out the important tasks of licensing HMOs and other insuring organizations. Increasingly, States are emphasizing quality-measurement systems, particularly in mandatory managed-care programs, though they lack uniformity. However, unlike in Medicare, there were no federally prescribed internal QA guidelines or requirements for managed-care plans contracting with Medicaid, and therefore there was no starting point for data development or performance measurement.

In 1991, HCFA initiated the Quality Assurance Reform Initiative (QARI), the purpose of which was to develop a better approach to monitoring and improving the quality of managed-care services offered to Medicaid beneficiaries. QARI was a collaborative effort of HCFA, the States, the National Academy for State Health Policy (NASHP), the managed-care industry, and advocacy groups. NASHP convened a medical directors' group, consisting of physicians and State health officials, to evaluate a compilation of existing QA standards and to propose a uniform set of guidelines for managed-care organizations contracting with Medicaid.

Phase I of QARI was completed in July 1993. It resulted in the publication of *A Health Care Quality Improvement System for Medicaid Managed Care—A Guide for States* (Health Care Financing Administration, 1993). This document spells out specific criteria for managed-care plans to use in designing their internal QA programs, and has four major components:

- The document details a systems framework for improving QA programs in Medicaid risk-contracting plans. The plans are directed to have internal QA systems, with States monitoring compliance and Federal authorities in an oversight capacity.
- Guidelines are offered for the internal QA programs for Medicaid managed-care plans, describing a plan's CQI process, credentialing, governing board duties, and standards for enrollee rights and responsibilities, and how these things should be communicated.
- The report defines priority areas for quality measurement and examination, identifying the clinical areas of greatest relevance to the Medicaid population. For two of these areas, prenatal care and childhood immunization, the report specifies the data that should be routinely collected and analyzed by plans and State authorities.
- Finally, the document outlines alternative approaches for conducting the annual, external, and independent quality review of managed-care plans required in the Medicaid statute.

In February 1993, three States—Minnesota, Washington, and Ohio—entered into a 2-year NASHP demonstration funded by the Henry J. Kaiser Family Foundation to test the effectiveness of the QARI guidelines. Upon completion, the project will be independently evaluated. In the meantime, several other States are already using the QARI guidelines or plan to do so in the near future.

Under Phase II of QARI, HCFA is providing participants in the Medicaid managed-care system with other tools that will complete the foundation of our quality-improvement efforts in Medicaid. One such effort provides State Medicaid agencies, responsible for conducting quality-of-care reviews, with a manual from the National Committee for Quality Assurance (NCQA) on how to design and carry out those reviews more effectively. In 1995, HCFA and its QARI partners will release other materials to assist the States in improving Medicaid managed-care quality.

Medicaid HEDIS

Last April, HCFA embarked on a collaborative project to develop the Medicaid version of HEDIS; that is, our core set of Medicaid managed-care performance measures. HCFA is working jointly with NCQA, State Medicaid directors, consumer and provider groups, the U.S. Public Health Service, and the managed-care industry to adapt this promising commercial-sector reporting tool to the needs of

the Medicaid program. The Medicaid HEDIS project is funded by the David and Lucille Packard Foundation.

The project has two objectives:

- To produce, by the end of 1995, a Medicaid performance-measurement set that HCFA can provide to State Medicaid programs. A discussion draft of this set was released for comment on July 11, 1995.
- To introduce Medicaid-relevant measures into the next version (3.0) of HEDIS.

HCFA chose to use HEDIS as the template for its Medicaid effort because the managed-care industry has used it for several years, and the first step toward quality care is obtaining uniform, consistent data. Further, using HEDIS for Medicaid will establish a cutting-edge reporting system while minimizing reporting burdens on managed-care plans.

HCFA and its collaborators are making several changes to HEDIS 2.0 to address the particular demands of the Medicaid program and its beneficiaries. The Medicaid population is, of course, different from the commercial population for which HEDIS 2.0 was developed. Therefore, HEDIS must be adjusted to respond to the unique needs of the Medicaid population and to assess the quality of care they receive.

Another wrinkle in the effort is in Medicaid program rules. Between the work of the Congress in Washington and that of State legislators and governors in State capitals across America, we have State Medicaid programs that look and act far differently than commercial managed-care programs. But perhaps the biggest difference lies in Medicaid eligibility and beneficiary enrollment patterns. Medicaid eligibility is largely tied to welfare eligibility, and thousands of Americans enroll and disenroll every day, causing erratic enrollment patterns in Medicaid managed-care plans. Few Medicaid beneficiaries remain with a single plan for an extended period of time—posing a challenge to those seeking to hold plans accountable for providing consistent, quality care.

In the project to date, the participants are building on most of the essential content of HEDIS 2.0. Most of the new measures under consideration involve maternal and child health—HCFA's biggest concern in Medicaid. The participants are also examining new prenatal care measures and a series of well-child preventive care measures.

Other changes the group is exploring are more technical in nature and attempt to respond to Medicaid's programmatic idiosyncrasies. For example, HEDIS 2.0 measures the childhood immunization rates of children continuously enrolled in a health plan from birth through their second birthday. But such an approach will not work in Medicaid because of the enrollment patterns of these clients. Most of the children in Medicaid would not be counted in the denominator, and the measure would not tell HCFA much about a health plan's performance. Therefore, the group is thinking about changing the age limit for the denominator from 2 years to 6 or 9 months. That way, we will be able to catch the vast majority of the children in Medicaid.

Also last April, HCFA launched a parallel effort to develop a Medicare version of HEDIS. HCFA is working with NCQA and others to develop a variety of measures for the Medicare population that could be incorporated into a future version of HEDIS. This is an exciting new project, also supported by the Kaiser Family Foundation, and one that will be very important in using performance measures to continuously improve the quality

of care provided to Medicare beneficiaries enrolled in HMOs.

CONVERGENCE

As HCFA pursues the promise of improved performance measurement in managed-care settings, we are well aware of the technical difficulties that lie ahead, particularly in the data systems arena.

HCFA's Office of Managed Care and Health Standards and Quality Bureau are working together and in partnership with other public and private entities to bring about what we call "convergence" in performance-measurement systems for the entire Medicare, Medicaid, and private populations—regardless of payment structure or delivery model.

We are under no illusion that performance-measurement projects such as MMCQIP and Medicaid HEDIS will answer all of the data needs of plans, States, and the Federal Government. Nor is HCFA deceiving itself that the current restructuring of managed-care delivery systems will make data collection and performance standards any easier.

Our performance-measurement goals entail a long-term effort. HCFA's over-arching aim is to work with the industry, the medical community, advocates, and others to develop a single set of measures that address the full range of a health plan's membership and performance, regardless of type of insurance.

HCFA's work on encounter data as the building blocks, on HEDIS as the reporting template, and on MMCQIP as a first attempt at examining compliance with performance measures, are early steps down the road to a performance-measurement system that will enable managed-care plans to continuously improve their quality of care and empower consumers to make responsible, informed choices.

Foundation for Accountability

In June, HCFA, together with the Federal Employees Health Benefits Plan and the Department of Defense, joined many of the Nation's largest private-sector health care purchasers in an unprecedented partnership to explore the formation of a new organization for quality improvement and accountability in managed care. Private sector participants in this initiative—called the Foundation for Accountability, or FAcct—include GTE, PepsiCo, and AT&T. The current membership of this organization—brought together by the Jackson Hole Group—represents more than 80 million insured individuals.

The Foundation will develop a new generation of quality performance measures for health plans with a goal of providing purchasers and consumers with relevant information for health care decisionmaking. The organization will be backed by the collective buying power of its members and will eliminate duplication of individual HMO accountability and quality-improvement efforts, thereby reducing reporting burdens on HMOs.

HCFA intends to be closely involved in the development of this organization. FAcct expects to complement efforts of existing QA organizations, such as NCQA and the Joint Committee on the Accreditation of Healthcare Organizations, and has received their support.

CONCLUSION

HCFA expects that there will be continued rapid and significant growth in the Medicare and Medicaid managed-care programs and that these program beneficiaries will account for the greatest enrollment growth for the managed-care industry in the 1990s. Ensuring the continuous improvement of the quality of care provid-

ed to our beneficiaries in managed-care arrangements is a top priority for HCFA. We also know that we cannot have a Stage 2 of the managed-care revolution characterized by an emphasis on quality without sensitivity and responsiveness; that we cannot have responsiveness without data and appropriate standards.

The establishment of a seamless data and performance-measurement system for quality care for all patients in all plans is a massive undertaking. HCFA's work on encounter data standards, the Delmarva study, and Medicaid/Medicare HEDIS are early efforts toward a fundamental shift in the way HCFA does business with managed-care plans and monitors the quality of care they provide to our beneficiaries. A data structure, plan standards, and a general environment of partnership with the industry and other purchasers in the private sector will help us capitalize on the opportunity presented by the managed-care revolution to end the two-tiered health care system as it exists today in this country. Data and appropriate standards and guidelines will bring accountability:

- For consumers, who will have the information they need to make informed, responsible choices.
- For providers, who will have the figures they need for CQI and sensitivity.
- For plans, which will have the numbers to target resources and respond to the needs of diverse populations.

HCFA looks forward to new partnerships and new ideas as we work toward a 21st century quality-measurement system for MCOs.

REFERENCE

Health Care Financing Administration: *A Health Care Quality Improvement System for Medicaid Managed Care—A Guide for States.* Medicaid Bureau. Baltimore, MD. July 6, 1993.

Reprint Requests: John Gorman, Office of Managed Care, Health Care Financing Administration, Room 4360 Cohen Building, 330 Independence Avenue, SW., Washington, DC 20201.