How Well Will HEDIS 3.0 Address the Medicaid Population?

T. HERSHEL GARDIN, PHD

State Medicaid agencies have been looking for a standardized method to assess the performance of managed care plans with which they contract. Although the recent release of the Health Plan Employer Data and Information Set for Medicaid plans was intended to satisfy this need, in the current and rapid evolution of performance measurement, it may be too little and too late. The author, one of the members of the original Medicaid HEDIS work group, describes some of the core challenges HEDIS 3.0 will face in improving on the Medicaid data set.

By the time this article is published, the first draft of version 3.0 of the Health Plan Employer Data and Information Set (HEDIS 3.0) should be made available for public comment. The National Committee for Quality Assurance's (NCQA's) schedule also calls for the final version of HEDIS 3.0 to be released for national testing by the end of 1996.[1] This creates a quandary for MCOs serving Medicaid populations and attempting to make some sense out of Medicaid HEDIS.[2]

The forthcoming version of HEDIS is considered by NCQA to be an evolution of, rather than an addition to, HEDIS 2.5[3] and Medicaid HEDIS. According to NCQA, "The next generation of HEDIS, HEDIS 3.0, will: address the needs of a broader population (including Medicare and Medicaid); include more outcome measures and measures related to acute and chronic care; and incorporate a standard member satisfaction survey."[1]

It is assumed that HEDIS 2.5 and Medicaid HEDIS will become antiquated documents, useful only in charting the development of HEDIS 3.0. Although this evolution is important in the overall field of HMO quality and performance measurement, it means that Medicaid HEDIS as a standalone document is, essentially, stillborn.

Officially released by NCQA in February 1996, Medicaid HEDIS was intended to provide state purchasers of managed care services for their Medicaid populations with a quality or performance measurement tool similar to the tools available to commercial purchasers of the same services. As will be described below, the process of creating a Medicaid-specific HEDIS tool required nearly two years and the efforts of dozens of contributors. The NCQA and the task force of contributors understood that the commercially based HEDIS 2.0/2.5 did not adequately measure factors relevant to a Medicaid population. Consequently, it was believed that development of a separate, specific tool was critical to standardized measurement of the quality of services delivered to Medicaid populations. It was anticipated that once such a measuring tool became available, those health plans contracting with state departments of social services would incorporate the tool into

Dr. Gardin is Director of Corporate Development and Quality for The Wellness Plan, an HMO based in Detroit.

their systems, alongside HEDIS 2.5. This is now not likely to occur for very practical reasons.

Managed care plans already participating in HEDIS reporting projects have just finished updating their systems to accommodate 1996 changes in HEDIS 2.5. This has been a worthwhile but expensive process. It was anticipated that Medicaid HEDIS would be incorporated into the systems of those HMOs with substantial numbers of Medicaid patients (or with state contracts dictating the reporting of Medicaid HEDIS data). Certainly, with a February 1996 release of Medicaid HEDIS, HMOs could be expected to program their systems in the ensuing months and report their 1996 data by mid-1997 using the Medicaid-focused tool. Unfortunately, with the anticipated arrival of HEDIS 3.0, which will be inclusive of commercial, Medicaid, and Medicare measures, it hardly seems a worthwhile effort.

Managed care plans and the states that contract with them are faced with a serious problem. Should 1996 data be collected using a Medicaid HEDIS format or should all relevant parties wait until the July 1996 release of HEDIS 3.0? If HEDIS 3.0 is intended to be the next stage of the developing managed care performance measurement science, and if it addresses the basic flaws inherent in the current Medicaid HEDIS instrument, it makes sense to wait.

WHO CREATED MEDICAID HEDIS?

Medicaid HEDIS was created by a heterogeneous group, representing a number of different constituencies, including:

- U.S. government—the Health Care Financing Administration and the U.S. Public Health Service
- States—Medicaid agencies from California, Massachusetts, Minnesota, New York, Oregon, and Wisconsin
- Managed care plans—Arizona Physicians IPA, Bronx Health Plan, DC Charter Health Plan, HIP of NY, Kaiser Permanente, Prudential Health Care, The Wellness Plan, and U.S. Healthcare
- Advocacy groups—The Center for Health Policy at George Washington University, McManus Health Policy, and the American Public Welfare Association
- Physician groups—the American Academy of Pediatrics
- The grantee—National Committee for Quality Assurance
- The funding agency—Packard Family Foundation

This array of independent participants was one of the strongest features of the project's development, coming together because each wanted to develop a standardized performance measurement device that would reduce the varying and ever-growing number of requests for information (RFIs) received from state and federal governments.

DID THE CONSENSUS STRATEGY WORK?

The stated ground rules for the Medicaid HEDIS work group were that it would be written as a consensus document, and not one "yet" based on scientifically established measuring principles and objectively collected data. In fact, these limitations are stated in the document's introduction.[2]

"Consensus" is an unusual term when used in this context. It does not really mean compromise or majority rule. Most importantly, it does not mean that a particular consensual decision is based on the best objective data, science, and knowledge available. For the Medicaid HEDIS work group, it sometimes meant that the most energetic champion of an issue carried the day. Sometimes political expediency ruled (e.g., the number of women who should receive mammography in a Medicaid population is typically small; the question of whether mammography screening should be included was hotly contested. By the time the final version was prepared, this measure was made an "option").

IS THE CURRENT TOOL USABLE AND READY FOR STATES?

The July 6, 1995 cover letter that was included with the publication of the draft document[2] clearly stated that the work group looked ". . .forward to the continuous improvement and refinement of this document."

The letter ended with the statement that "We hope it will become a useful tool for performance measurement in Medicaid managed care." This same message is elaborated on in the Executive Summary of the final document[3].

Many members of the Medicaid HEDIS work group (this author included) strongly believe that a scientifically rigorous pilot testing period is necessary. This should occur before any of the measures can be universally accepted as appropriate means by which states can evaluate, in a reliable and valid manner, the performance of HMOs with which they contract. Considering its current state of development, some states are moving much faster than is justified (or intended by the work group itself) in adopting the present and untested performance measurement tool.

Moreover, managed health care plans have not been able to engage in a considered analysis

and evaluation of the measures' ramifications on their protocols and practices. Additionally, as some state agencies are already requiring that 1996 Medicaid HEDIS data be reported by their contracting health plans, there likely may not be enough time to set up the necessary data systems. Finally, neither states nor the plans they contract with yet know the ultimate cost of implementation of the measures. The cost of modifying data systems and engaging in the large numbers of chart reviews could be prohibitive.

Finally, state agencies are not off the data collection "hook" either. States need to evaluate the demands Medicaid HEDIS places on them. For instance:

- Are state agencies prepared to collect and provide health plans with the "cultural diversity of their Medicaid membership?"[2]
- Will states be able to appropriately aggregate data from smaller HMOs, whose data cell sizes are too small to be independently statistically significant?
- Will states guarantee health plans enough eligible recipients for the amount of time necessary to make many of the measures meaningful?

All those state agencies interested in implementing Medicaid HEDIS will have to address these issues, and more, before the measures proposed by Medicaid HEDIS are workable in their own right or as a subset of HEDIS 3.0.

THE STRENGTHS AND LIMITATIONS OF MEDICAID HEDIS

Strengths. Perhaps the only strength of Medicaid HEDIS involves the diverse entities that created the performance measure set. These work group members worked to address a wide variety of Medicaid-specific issues. The issues discussed were essentially a function of those entities represented and the initial public response to the draft document issued in July 1995.

The work group also attempted to remain consistent with HEDIS 2.5. Indeed, those reviewing and evaluating the resulting Medicaid HEDIS will discover many similarities. Managed care organizations will find this helpful because (1) measures in HEDIS have been piloted and tested and (2) similar measures equate to fewer resources needed to retool data collection methods and administrative data sets.

There was much cognitive reflection and deliberation on each measure. The entire process took almost two years, and the work group convened several times to discuss and debate the merits of every proposed measure. Finally, the nationwide invitation for additional comment produced more than 120 comprehensive comments and suggestions for improvement. Many of these were attended to in the production of the final document.

Weaknesses. Some of the measures are included only because they are high-frequency events in the Medicaid population. The ability of these measures to evaluate performance or the quality of services delivered remains unexplained and untested. These include tonsillectomies and/or adenoidectomies, myringotomies, and nonobstetric dilation and curettage, to mention a few. Similarly, most health and managed care literature is equivocal on the appropriate rates (utilization) for many of the measures, especially for Medicaid populations. These include those mentioned above and, most importantly for the youthful Medicaid population, the number of prenatal care visits. The numbers produced by the measures cannot indica te whether there is over- or underutilization of specific services.

At least one dozen measures in Medicaid HEDIS are unavailable in the current administrative data sets of many MCOs.

It is interesting to note that for prenatal care, U.S. literature appears to stress what activities take place during the prenatal care visit rather than the absolute number of visits.[4] The Wellness Plan's own research on prenatal care indicates that it is the comprehensiveness of services provided that affect birth outcome rather than simply the raw number of visits to the doctor.[4]

In the attempt to be consistent with HEDIS 2.5, Medicaid HEDIS includes some of the same critical core measures. However, the Medicaid population is very different from the commercial sector in terms of continuity of enrollment and health care–seeking behavior. A case in point is childhood immunization. HEDIS 2.5 specifies that only patients with continuous enrollment between 42 days and two years of age be considered in the analysis.

Medicaid HEDIS specifies a continuous enrollment period of 12 months before the second birthday, allowing for one break in service not to exceed 30 days or one month, because of the instability of enrollment in the Medicaid population.[2]

The Herculean problem for MCOs: There will be a target population of young children for whom the health plan has had only about 12 months of membership contact before their second birthday. During this brief time period, the plan is to be held responsible for determining the immunization status of the child and "catching up" on any immunization deficits. It is understood that the narrow window of opportunity provided is an attempt to recognize the instability in Medicaid eligibility. However, this makes it extraordinarily difficult for health plans to comply with the specifications.

As with HEDIS 2.5, there is no risk adjustment for different population mixes nor are there any real outcome measures. Hopefully, HEDIS 3.0 will begin to address these issues as well.

It appears that when measures such as immunization history are considered, managed care's role and responsibilities are being expanded to include population-based health status in addition to the delivery of health care and treatment to "customers." The lines of responsibility between private health plans and governmental public health agencies are becoming blurred. On the other hand, the fee-for-service environment has never been, and still is not, being held accountable for some of the reporting responsibilities and standards that health plans now face. Thus, the ability of managed care to contain costs is being seriously compromised by increased reporting requirements that may not increase the actual quality of delivered services.

At least one dozen measures in Medicaid HEDIS are unavailable in the current administrative data sets of many MCOs. Therefore, extensive chart reviews will be required to obtain these data. The document indicates a sample size of up to 384 charts per measure.[2] Using a conservative estimate of one dozen samples, this results in at least 4,608 chart reviews the first year. Using an estimate of one full-time equivalent (FTE) per 2,000 chart reviews, about 2.25 FTEs will have to be added to a managed care plan's staff in order to fully comply with the Medicaid measures (this estimate assumes that one person can reliably review 10 charts per day). When added to HEDIS 2.5, a staff of approximately five people could be necessary just to complete HEDIS-related chart reviews. Indeed, the work group stated, ". . . health plans should anticipate the need to newly dedicate or redeploy resources to the production and use of Medicaid HEDIS information."[2] Since some administrative data sets are incomplete, the hybrid approach will have to be used on those measures as well, adding to the overall chart review burden.

Furthermore, both HEDIS documents (commercial and Medicaid) recommend the addition of a statistician to insure appropriate sampling and data collection. Will states alter capitation rates to fund these new positions? Or will states assist in the development and financing of sophisticated data systems that will permit administrative data set analyses?

Medicaid HEDIS requires such confidential information as provider-specific compensation.[3] Payments to intermediary organizations (such as hospitals, physician–hospital organizations, and other networks) are not sufficient.[2] Unfortunately, be-

IMPLEMENTATION PLANNING HURDLES

The Wellness Plan, a 25-year-old HMO whose current Medicaid membership is in excess of 137,000, is one of a handful of similar HMOs across the nation serving large Medicaid populations. Most of these plans, including The Wellness Plan, already assess performance of health delivery to Medicaid on many levels. Yet, it is unrealistic to expect even such experienced plans to comply immediately with every one of the specifications in the Medicaid HEDIS document. Therefore, it would be best to phase-in the process of implementing final and scientifically proved Medicaid HEDIS measures. Only the most meaningful measures for Medicaid should be initially pilot tested and implemented over time at health plans with substantial numbers of Medicaid members. The current number, depth, and breadth of measures are too complex to properly engage at once.

The implementation of the commercial HEDIS 2.0, including the report card pilot study, selected only a subset of HEDIS 2.0 measures. Not all the proposed measures were tested at once.[5] The report card study also strongly recommended that future measures (i.e., Medicaid HEDIS) be subjected to longer developmental periods with extensive testing before implementation.

Continued on page 85

Continued from page 81

cause of the complex relationships health plans have with health systems, it will not likely be possible to whittle down the compensation data to all specific providers (e.g., what is the specific compensation provided to hospital-based radiologists for reading a specific health plan's x-rays?). Additionally, it is not clear that health plans or the providers with whom they contract will be willing to reveal such information when it is available.

Many of the measures were developed in consideration of the observation that about half the HMOs with Medicaid contracts have fewer than 6,000 Medicaid members and only eight plans (3%) have more than 100,000 members.[2] Clearly, and as stated throughout the Medicaid HEDIS document, many of the measures were designed to accommodate this distribution. Little attention was paid to the degree of effort and cost that would be required of the larger HMOs. This is doubly worrisome, as it is reasonable to expect that over the next few years, financing and states' own predilections will lead to larger populations of recipients in fewer plans. The document and its intended audience would have been better served had the work group focused its measures development on HMOs with large numbers of Medicaid members rather than on those who may temporarily have smaller numbers.

HOW SHOULD MEDICAID HEDIS BE IMPLEMENTED?

After the July 1995 draft was released and members of the work group had an opportunity to both review the document as a whole and hear from other interested parties, it became obvious that the draft was fairly silent on the issue of implementation. Consequently, a section on implementation strategies was added to the final version.

Planning by state agencies and health plans is required before the initiation of any Medicaid performance measuring system. The developing measurement systems need to be designed to accommodate the anticipated and ever-changing expectations of performance measurement. Obtaining all necessary data in statistically meaningful amounts will pose enormous challenges for both states and health plans, because current enrollment patterns of the Medicaid population are quite different than the commercial population in terms of continuity of care. Some of these challenges may only be met by an expensive creation of new automated systems or reengineering of existing systems where they are already in place. These systems will be needed by both state agencies and health plans.

At the same time that these systems are being designed, states and health plans must assess each of the proposed measures using scientifically rigorous pilot testing. In a staged approach, each measure will have to be evaluated for its usefulness. Through such evaluation, it should be expected that some measures will be redesigned, others will be dropped, and new ones will emerge.

States will have to understand and publicly communicate the many limitations of Medicaid HEDIS with regard to comparing performance across health plans. Until implementation activities have controlled for variation in risk, small numbers, variations in data collection methods, and differences in technologies, and until reported data can be reliably and independently verified, the issuance and use of comparative report cards on Medicaid performance will continue to be unwarranted.

THE ULTIMATE QUESTION

In an era of contracting public interest in support for and funding of Medicaid programs, in an era of a federal government shifting more Medicaid control and costs to states, and in an era of states reducing the cost and/or growth of Medicaid programs, who is going to pay for the additional costs of Medicaid HEDIS performance measurement, regardless of the form it takes?

REFERENCES

1. Cocotas C: *CPM Update on HEDIS 3.0.* Ed. 4. Washington. DC, National Committee for Quality Assurance, March 1996.
2. *Medicaid HEDIS: An Adaptation of NCQA's Health Plan Employer Data and Information Set 2.0/2.5.* Washington, DC, National Committee for Quality Assurance, Draft version, July 1995; final version, February 1996.
3. *Health Plan Employer Data and Information Set 2.0.* Washington, DC, National Committee for Quality Assurance, November 1993.
4. Gardin TH, Ryan V: *Development and Demonstration of a Successful Obstetrics Clinic Model: Reduction of Perinatal and Infant Morbidity and Mortality.* Detroit, The Wellness Plan, October 1995.
5. *Report Card Pilot Project: Technical Report.* Washington, D.C., National Committee for Quality Assurance, 1995.

Address for correspondence/reprint requests: T. Hershel Gardin, PhD, Office of the Chief Executive Officer, The Wellness Plan, 2875 West Grand Boulevard, Detroit, Michigan 48202.