
**Managed Care:
A Strategy for Data Collection and Reporting**

Pennsylvania Health Care Cost Containment Council

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Managed Care Reporting

What is the Council working toward?

The flexibility to produce various types of managed care “report cards” that include comparative information on health plans. Ultimately the Council would work toward reports that incorporate a number of different measures:

- outcome measures
- process variables
- patient satisfaction information
- “HEDIS-type” information
- financial data

While each of these components would add a different piece of information by which to evaluate plan performance, there are disparate views about the “value” of each one. Outcome measures would be the Council’s particular focus. Outcomes—as a measure of quality of care—can focus on the relationship between providers and payers in determining whether plan practices might be affecting provider results.

While other efforts have included patient satisfaction and/or HEDIS-type information, the Council has the capability to add the essential outcome component.

How does the Council accomplish this goal?

Build a foundation that would allow flexibility in managed care reporting. Rather than focus on one report at a time, the Council’s plan is to concentrate first on some important building blocks that would ultimately position the Council to complete different types of managed care reports.

- One of the most important “building blocks” is to more clearly define the payer fields that hospitals submit to the Council *and* to identify ways to improve the accuracy and specificity of these fields. Assigning cases to the correct payer is central to managed care reporting.

Other “building blocks” include:

- Reevaluate the payer data that the Council already receives to establish better linkage to hospital-submitted data.
- Identify important managed care elements that the Council does not collect but that might be obtained through collaboration with other sources. (An Appendix contains a list of data elements collected by other entities.)

- Continue to build collaborative relationships. Work with other state agencies and payers to improve data sharing and develop appropriate methodology. Work with purchaser and consumer groups to identify specific reporting interests. Working with groups such as the Working Together Consortium and the Lehigh Valley Business Conference on Health Care has taught the Council that these groups are just beginning to understand how data can help them make health care decisions. Ultimately, however, purchaser and consumer groups want to move toward the goal of having comparative information on health plans.
- Work through the Data Systems Committee and the Council's advisory groups, particularly the Payer Advisory Group, to implement approaches and develop report card prototypes.
- Continue to follow the development of two unique identifier systems required under the Health Insurance Portability and Accountability Act (one for health plans and one for individual patients). These identifiers would be important in linking data. Issues of confidentiality are of particular interest with the individual patient identifier.
- Finally, the successful completion of the migration from a mainframe network to a client-server environment is fundamental to the Council's managed care reporting efforts. Obtaining more accurate payer data and building in the capability to incorporate additional data into our system are crucial components.

How does the Council maintain momentum as the “building blocks” are put in place?

Begin work on a project that can be accomplished in the short term that includes the Council's hospital data as well as some information obtained directly from managed care plans. Diabetes might be an appropriate topic for this first report because (1) appropriate management of the disease could affect outcomes, (2) there is risk associated with diabetes, (3) diabetics are enrolled in all types of health plans, and (4) most managed care organizations already collect some data on diabetes.

What are others doing with regard to managed care reporting?

In considering the Council's managed care-reporting goals, the Council reviewed report card initiatives underway in other states and considered legislative efforts underway in Pennsylvania and at the federal level. This information can serve as a focal point in determining what the Council wants (and doesn't want) to do.

Other Report Card Initiatives

Some of Pennsylvania's neighboring states have already developed managed care report cards. New Jersey and Maryland produced report cards in 1997 and 1998. These report cards were produced in cooperation with the National Committee on Quality Assurance (NCQA) and combine quantitative data and consumer satisfaction information.

These report cards include measures such as:

- *Access/service* – overall rating of the HMO, quality of care, ease of obtaining information about the HMO, ease of finding a primary care provider, ease of obtaining a referral to a specialist, amount of paperwork and customer service, number of physicians in network, ease of making appointments.
- *Patient Care* – rating of the primary care provider, rating of the specialist, doctor's communication ability, amount of time the doctor spent with the patient, doctor's understanding of impact of health on daily life, and the courtesy of the staff.
- *Keeping People Healthy* – portion of members seen by a primary care provider, child immunization rates, provision of prenatal care, after delivery checkup rates, mammography rate, cervical cancer test rate, and smoking cessation programs.
- *Caring for the Sick* – rating given by sick members about the HMO, the quality of care, ability to get care, whether the HMO has asthma and diabetes management programs, the rates of diabetic eye exams, and mental illness follow-up care.

Report cards might also include information on whether the health care plan is accredited by a national organization. Other report cards have sections on the rate of turnover among the physicians in a plan or allow physicians to rate the plans. Some report cards list the recommendations on preventive care issued by national health groups such as the U.S. Preventive Services Task Force.

Information from other states indicates report cards can be costly. For example, Maryland spent an estimated \$930,000 over the course of four years to complete their first health maintenance organization report card in 1997. Report cards for future years are projected to cost approximately \$400,000 to \$500,000.

At the national level, the National Committee for Quality Assurance (NCQA) produces a "State of Managed Care Quality Report" that compares the quality of managed care in different regions of the country using 10 specific measures and a consumer satisfaction survey.

Non-profit business groups are also publishing report cards. Examples include the Greater Detroit Area Health Council and the Pacific Business Group on Health. Some individual managed care plans also publish reports on their plans which include consumer satisfaction surveys and/or data submitted as a basis for accreditation.

Legislative Efforts

Managed care report cards have generated interest in the Pennsylvania General Assembly. Three initiatives have been introduced which require report cards for managed care organizations within the Commonwealth. These proposals generally call for comparative data to aid consumers in evaluating a managed care plan. They focus on quality of care outcomes and performance measurements. Some reporting measures specifically mentioned include: HEDIS data from NCQA, the Foundation for Accountability's Consumer Information Framework, or the Consumer Assessment of Health Plans Survey (CAHPS) from the Agency for Health Care Policy and Research.

At the federal government level, there has also been discussion on managed care report cards. One proposal (S. 2208) has taken report cards one step further and seeks to establish an annual report on national trends in the quality of healthcare, not limiting the scope of the report to managed care organizations.

Other Pennsylvania Efforts

Other efforts aimed at providing information on managed care are ongoing in Pennsylvania. Of particular note are the reports issued by the Hospital and Healthsystem Association of Pennsylvania (HAP). HAP prepares reports using data reported to the Department of Health, the Department of Insurance and the National Committee for Quality Assurance. These reports are entitled (1) "Profiles in Managed Care: Demographics," (2) "Profiles in Managed Care: Premium Allocation," (3) "Profiles in Managed Care: Quality Report," and (4) A Profile of HMOs in... Pennsylvania, New

How does the Council tie these components together to reach the goals?

First, build the necessary foundations:

- obtain more accurate payer information from submitted hospitalization data
- work collaboratively with other entities to supplement Council data
- complete the migration from the mainframe to a client-server environment

Second, include outcomes. While the managed care report cards in other states have provided useful information, none has incorporated outcome measures. The Council's goal is to develop a system that would allow the reporting of outcome measures.

Finally, focus on developing a *system* that would give the Council the flexibility to report managed care data—not just one report at a time—but for various types of reports.

Appendix

Managed Care Data

Pennsylvania Health Care Cost Containment Council

- Hospital and ambulatory surgical facility modified UB-92 billing forms (this list focuses on those fields relevant to the Council's identification of payers):
 - Payer identification: Primary, secondary and tertiary
 - Employer of patient: Primary, secondary and tertiary
 - Employment status: Primary, secondary and tertiary
 - Patient relationship to the insured: Primary, secondary and tertiary
 - Payer group number: Primary, secondary and tertiary
 - Insured's unique identification number assigned by the payer organization: Primary, secondary and tertiary
 - NAIC Uniform Identifier of Primary Payer

- Payer Data Reporting Requirements
 - Insured's unique identification number assigned by the payer organization
 - Date of admission/start of care/date of service
 - Date of discharge/end of care/last date of service
 - Identifier of physician
 - Other payments
 - Patient control number
 - Patient's birthdate
 - Patient – Uniform Identification
 - Patient relationship to insured
 - Patient's sex
 - Payer group number
 - Place of service
 - Primary payer payments
 - Procedure code
 - Procedure coding method used
 - Record type
 - Reserve field
 - Total charges
 - Type of professional service
 - Uniform identifier of health care facility
 - Units of service

- MCO and Hospital databases on Utilization (by geographical area and payer categories), Payment (by outpatient/inpatient charges), and some Quality Indicators

- Atlas II data collection software.

- Supplemental Hospital Financial Data - what proportion of inpatient and outpatient revenue is derived from Medicare, Medicaid and commercial (including Blue Cross HMO products) managed care lines of business.

- Supplemental Ambulatory Care Financial Data – number of admissions and payment dollars received in each of these areas.
 - Billed Charges
 - Usual and Customary Rate
 - Per Diem Payments
 - Global Case Rate
 - DRG Payment
 - Capitation

Pennsylvania Department of Health

In attempting to identify managed care data collected by other state agencies, the Council developed the following list of elements that it is believed the Department of Health collects. *The Department has not yet verified this information.*

- Service Area of each plan.
- Identification of each product offered by a managed care organization (Point-Of-Service, HMO, Medicare risk contract, etc.).
- Membership by model type and source of enrollment.
- Enrollment by age and sex of members.
- Membership by county of residence.
- Enrollment by type of prepayment contract.
- Number of contacts/number of members by size of employer.
- Number of Primary Care Providers (PCPs), Specialty Care Providers (SCPs), Health Centers, Medical Residents and Directly Owned Sites for each plan.
- Typical mode of physician reimbursement (Capitation/Salary/Modified Fee-for-Service/Fee Schedule/Combination).
- Type of Financial Arrangement the plan has negotiated with hospitals and other health facilities.
- Number of first and second-level grievances which 1) action is pending from the previous year and from this year; 2) were filed during the year; 3) were withdrawn during the year; and 4) were decided during this year, broken into those decided for and against the plan.
- Number of plan members who disenrolled by reason of termination and if the termination was voluntary or involuntary.
- Data results and methodology of any consumer satisfaction surveys completed by the plan.
- Inpatient utilization by type of service, broken into medical/surgical/obstetric/mental health encounters.
- Outpatient utilization of ambulatory services with PCPs/SCPs/Non-physicians and total encounters.
- Number of claims for emergency health delivery services.
- Average co-payment required.
- Whether a plan subcontracts for behavioral health benefits and, if so, the details of that contractual relationship.
- Information on substance abuse (SA) benefits including: if a plan offers SA benefits, number of members treated during the year, number of visits per 1,000

members, number of admissions per 1,000 subscribers, number of inpatient days per 1,000 members per year, average length of stay (LOS), and Per Member Per Month costs for each category of service.

The Department of Health also maintains a database of death certificates issued in the Commonwealth. Collaboration with the Department in linking Council data to this database may provide the means to examine mortality after release from the hospital.

Pennsylvania Department of Insurance

The Department of Insurance sends out an annual survey of financial indicators to all managed care organizations in Pennsylvania. The Department collects both annual and quarterly data from all plans. In attempting to identify managed care data collected by other state agencies, the Council developed the following list of elements that it is believed the Department of Insurance collects. *The Department has not yet verified this information.*

- Assets of plan (including cash, short- and long-term investments of plans, receivables, property and equipment).
- Liabilities and Net Worth of plan (including accounts payable, claims payable, unearned premiums, and loans for liabilities and stock, contributed capital, contingency reserves, and retained earnings for net worth).
- Revenues of plan (from premiums, fee-for-service, Medicare, Medicaid and investment).
- Expenses of plan including medical and hospital expenses (for physician and other professional services, outside referrals, emergency department, inpatient, occupancy and incentive pool adjustments) and administrative expenses (for compensation, depreciation, interest and marketing) LESS co-payments.
- Statement of Cash Flows.
- Table of Enrollment and Utilization (broken into source of enrollment at end of each quarter, total ambulatory encounters and total hospital patient days incurred)
- Table of Premiums, Enrollment and Utilization (broken into members in each group, ambulatory encounters, hospital days, premiums collected, amount paid for provision of services, and amount unpaid for services).
- Medicare policies (including number issued, premiums earned, amount of incurred claims, percent of premiums earned and number of covered lives).
- General questions including: changes in by-laws or provider contracts, date of last financial examination, ownership of HMO, capital stock, loans to officers, status of malpractice insurance, damage claims against HMO, general liability coverage, number of formal grievances against the HMO during the previous year, and whether plan is a subject of merger or takeover negotiations.
- Summary of transactions with any affiliates.
- Listing of states in which the HMO is licensed or operates.

National Committee for Quality Assurance (NCQA) Data

NCQA sends out surveys to all plans asking for information on various measures for inclusion in their annual Health Plan Employer Data and Information Set (HEDIS). Reporting is voluntary, although NCQA requires the data for their accreditation process.

NCQA prepares an annual summary of health plan quality performance measures entitled *Quality Compass*. This summary offers a broad representation of measures across a plan's performance including access, quality and service utilization. The data is available to the public for a price (\$10,000 for all data to be used by one user), but any reports prepared using this data are contractually limited to fifteen measures.

Data categories chosen for inclusion in HEDIS are selected because they are: **Relevant** (useful to purchasers and consumers, addressing issues that can affect outcomes, and helping plans address quality insurance efforts), **Scientifically Sound** (reproducible, valid, accurate and statistically powerful), and **Feasible** (possible to produce at a reasonable price, possible to precisely define, and not breaching patient confidentiality). There are eight Domains of Measures:

- **Effectiveness of Care** – Information about the quality of clinical care provided by the health plan
 - Childhood Immunization Status - % of two-year olds who received certain immunizations.
 - Adolescent Immunization Status - % of 13-year olds who received 2nd MMR shot and hepatitis B and varicella, with the possible addition of tetanus and diphtheria in the future.
 - Advising Smokers to Quit - % of adults who received advice to quit.
 - Flu Shots for Older Adults - % of seniors who received a flu vaccine during the previous year.
 - Breast Cancer Screening - % of women ages 52-69 who had a mammogram during the previous two years.
 - Cervical Cancer Screening - % of women ages 21-64 who received a Pap test within the past three years.
 - Prenatal Care in the First Trimester - % of women who had a live birth who had a prenatal visit during the first trimester.
 - Low Birth Weight Babies - % of infants whose birth weight is less than 1,500 grams and % less than 2,500 grams.
 - Checkups After Delivery - % of women who had a live birth who had a postpartum visit within 42 days of delivery.
 - Treating Children's Ear Infections - % of children who had an uncomplicated acute otitis media who were dispensed an antibiotic other than a preferred antibiotic (looking for improper use of broad-spectrum antibiotics for uncomplicated infections).
 - Beta Blocker Treatment After Heart Attack - % of 35+ members who were dispensed a prescription for beta blockers after discharge with an AMI.
 - Eye Exams for People with Diabetes - % of Type I and II diabetics who have had a retinal exam during the previous year.
 - Health of Seniors – Medicare risk members whose self-reported health status (using SF-36) improved, stayed the same or worsened.
 - Follow-up after Mental Illness Hospitalization - % of members who were seen on an ambulatory basis or received day/night treatment w/in 30 days of discharge.

- **Access/Availability of Care** – Information on how many members are using basic services and whether plan has adequate staff
 - How many members are using basic services
 - Whether plan has adequate staff
 - Adults’ access to preventive health services
 - Children’s access to PCPs
 - Annual dental visits
 - Low-birth-weight deliveries at neonatal facilities
 - Availability of language interpretation services
 - % of pregnant women who had their first prenatal visit w/in 6 weeks of enrollment in plan
 - Availability of PCPs – number and % who serve each population and who accept new members
 - Availability of mental health/drug providers
 - Availability of OB providers
 - Availability of dentists

- **Satisfaction with the Experience of Care** - Information on member satisfaction
 - % of commercial members “satisfied” with the health plan (based on Annual Member Satisfaction Survey)

- **Health Plan Stability** – Information about the stability, finances, providers and membership
 - Rate of Member disenrollment (does NOT distinguish between voluntary and involuntary disenrollment)
 - Provider Turnover - % of PCPs who left the plan during the reporting year
 - Indicators of Financial Stability – years in business, total membership, financial indicators (performance, liquidity, efficiency, statutory)

- **Use of Services** – Information on how the plan manages and expends its resources
 - Well child visits in first 15 months of life
 - Well child visits in 3rd, 4th, 5th, and 6th year of life
 - Adolescent well-care visits
 - Inpatient utilization
 - Ambulatory care
 - Maternity discharges and ALOS
 - Newborn births and ALOS
 - Mental Health/Chemical Dependency utilization – inpatient discharge, ALOS, readmissions, outpatient drug utilization)
 - Frequency of ongoing prenatal care
 - Frequency of selected procedure (number and rate)

- **Cost of Care** – Information about costs for purchasers and consumers
 - Prospective rate trend assumptions used to calculate premiums
 - Actual expense Per Member/Per Month
 - High-Occurrence/High Cost Diagnosis Related Groups – number of discharges, average charge per discharge, total days, ALOS

- **Informed Health Care Services** – Information of how well plans help members make health care decisions

- New member orientation/education
- Language translation services
- **Health Plan Descriptive Information** – Information on plan structure, rules, staffing, and management philosophy
 - Board certification/residency completion requirement
 - Provider compensation methods – looking for possible incentives for over/under treatment
 - Physicians under capitation
 - Case management
 - Utilization management
 - Risk management
 - Quality assessment and improvement
 - Recredentialing
 - Preventive care/health promotion
 - Arrangements w/ public health, educational and social service entities
 - Total enrollment
 - Enrollment by payer (member years or months)
 - Unduplicated count of Medicaid members
 - Diversity of Medicaid membership
 - Weeks of pregnancy at time of enrollment
 - Pediatric mental health services
 - Chemical dependency services
 - Family planning services
- Data Collection is broken into seven functional groupings of the source for the data.
 - Clinical – 17 of the above categories
 - Survey – 5 Categories
 - Providers – 13 categories
 - Customer Service – 3 categories
 - Membership/Utilization – 22 categories
 - Financial – 3 categories
 - Care Management/Misc. – 6 categories
- **‘Quality Compass Program’**– Collects information from NCQA’s accreditation program, in which 330 plans covering ¾ of all HMO enrollees participate, and HEDIS, which is used by 90% of health plans. NCQA’s document “*The State of Managed Care Quality*” is based on information submitted by 447 MCOs (292 who submitted information for accreditation and 155 who contributed data for calculating benchmarks) for use in Quality Compass and focuses on ten HEDIS measures and eight member satisfaction measures. These measures are broken into clinical and member satisfaction categories:
 - Clinical Measures:
 - Adolescent Immunizations
 - Advising smokers to quit
 - Beta Blocker Treatment
 - Breast Cancer Screening
 - Cervical Cancer Screening
 - Cesarean Section Rates
 - Childhood Immunizations
 - Diabetic Eye Exams

- Follow-up after hospitalization for mental illness
- Prenatal care in the first trimester

- **Member Satisfaction Measures**
 - Overall Satisfaction
 - Problems receiving necessary care
 - Problems with referrals to specialists
 - Delays in waiting for approved services
 - Number of doctors to choose from
 - Length of time between appointment and visit
 - Availability of information
 - Ease of making appointments

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