MEDICARE AND MEDICAID MANAGED CARE:
QUALITY CARE

The health care market is changing rapidly. Today there are many new initiatives that offer the potential for better service to millions of American families as well as significant cost savings. Since 1993, President Clinton has encouraged the expansion of health care choices available to Medicare and Medicaid beneficiaries, including managed care options.

An increasing number of Medicare and Medicaid beneficiaries are joining managed care plans. Today, 16 million beneficiaries receive health services through managed care. Since 1993, there has been an 87% increase in enrollment in Medicare managed care plans and 142% increase in enrollment in Medicaid managed care. In fact, an average of nearly 80,000 beneficiaries a month voluntarily enrolled in Medicare managed care this year.

The Clinton Administration seeks to ensure that beneficiaries in managed care plans, like their counterparts in traditional health plans, have access to high quality health care services when they need them. To that end, the Clinton Administration has undertaken a number of new initiatives to guarantee that managed care is quality care.

Measuring Quality

Remarkable improvements have been made to measure quality in managed care. Together with the private sector, the Clinton Administration has fostered ways for managed care entities to measure the quality of care they provide.

- HEDIS gives companies information to compare the value of competing health care plans. To date, HEDIS is used by __ states and 330 plans nationwide. HEDIS collects data on five major categories: health plan quality, access and patient satisfaction, membership and utilization, finance, and management and activities. This measure was developed with the National Committee for Quality Assurance (NCQA).

- The public and private sectors joined together to develop a way to monitor the quality of Medicaid managed care. Through the Quality Assurance Reform Initiative (QARI), states may use federal guidelines to help them review their existing quality improvement efforts and develop new quality improvement systems. QARI allows for great state flexibility in utilization. To date, three states have implemented QARI.

- The Foundation for Acountability (FAcct), a non-profit organization, aims to provide consumers with information they need to make better decisions about their health care. In particular, FAcct measures how health plans treat certain conditions such as depression, breast cancer, and diabetes. This organization consists of both private and public health purchasers and consumer groups.

Empowering Consumers

Americans are demanding greater value and quality in their health care. But to achieve this goal in today's rapidly changing health care environment, consumers need solid, reliable information to help them choose among health care plans, practitioners, and facilities, and participate more actively in their personal health care decisions. The Clinton Administration is working to help provide the information consumers need and want.

- Report cards can be an important tool to help consumers and other health care purchasers select health care plans, practitioners, and facilities based on quality and value. Report cards provide comparitive information on plans' abilities to provide high-quality, accessible services. The Department of Health and Human Services is currently developing a national database to develop report cards on Medicare HMOs.

- Information on consumer satisfaction can help consumers select health care plans and services appropriate for their needs. The Consumer Assessments of Health Plans Study (CAHPS) will primarily assist consumers, and purchasers acting on their behalf, in making more informed and appropriate selections of health plans and services. This survey will ask consumers about the quality of health plans and services, including access to care, technical quality of care, and communications skills of providers and staff. The survey is being developed by the Department of Health and Human Services.

Enhancing Consumer Protections

Consumers should be guaranteed basic protections regardless of the type of health plan to which they belong. All consumers need complete and accurate information about the benefits, providers, and costs associated with their health plan. In addition, consumers should have access to a simple and fair process to address problems.

- A responsive appeals and grievance system protects managed care enrollees from being inappropriately denied care. The Clinton Administration encourages many activities to ensure that beneficiaries receive all the services that they need. These activities include: a shortened review process for some claims, improved accountability of health plans based on process results, and better information about beneficiaries' rights.

- Beneficiaries should be informed about financial arrangements that may provide incentives to inappropriately deny care. The Clinton Administration remains committed to implementing the physician incentive regulation that requires: (1) plans to report any financial arrangements where physicians have incentives to underutilize or inappropriately provide health care, (2) disclose to beneficiaries a summary of the financial arrangement and a summary of customer satisfaction with the plan, and (3) provide insurance to assure that beneficiaries are protected against any excessive financial incentives of physicians to withhold care.

- Beneficiaries should be guaranteed coverage for needed health services. Decisions about medical care for newborns and their mothers should be left with doctors, nurses, and mothers themselves, not insurers. President Clinton strongly supports legislation to guaranteed all mothers 48 hours of care after giving birth.

- Providers should not be restricted in what they can say to their patients. The Clinton Administration opposes "gag orders" that have been used by plans to inappropriately limit physicians from discussing recommendations for referrals and alternative treatments.

Monitoring and Enforcing

Federal efforts to ensure consumer protections are only as good as state oversight and enforcement of such efforts. President Clinton has been aggressive in developing and implementing new strategies to combat managed care fraud and abuse. The President has pursued cooperative working relationships with the law enforcement community and others in the heatlh care marketplace in the fight against fraud and abuse.

- Intensified oversight of managed care entities works to ensure that managed care is quality care. Currently, the Federal government annually reviews all aspects of Medicare and Medicaid managed care plans including: the way plans enroll and disenroll members, accessibility and availability of quality services, and financial soundness. The Clinton Administration initiated a new program to investigate specific problems or identify patterns that adversely affect beneficiaries.

- Efforts to root out fraud and abuse in managed care may prevent beneficiaries from receiving inappropriate care or being charged too much for services. The Managed Care Fraud Working Group, an interagency work group, aims to identify fraud and abuse in managed care organizations and to develop methods to prosecute suspected cases of fraud. Participants in the work group include: the Department of Justice and the Health Care Financing Administration.

- Beneficiaries should be educated about potential fraud and abuse. Information will be made available to beneficiaries to help them identify fraud and abuse as well as what to do and who to call if they uncover an abusive situation. The Office of the Inspector General and the Health Care Financing Administration are working jointly on this project.

Improving Quality

The Clinton Administration is firmly committed to improving the quality of health care in our country. In this context, is working to improve overall patient care.

- The Medicare Managed Care Quality Improvement Project (MMCQIP) seeks to improve the quality of ambulatory care for Medicare beneficiaries. The initial pilot study focuses on improving the quality of care for Medicare patients with diabetes. It is a collaborative effort between the public and private sector, involving 23 HMOs from 5 states (California, Florida, New York, Pennsylvania, and Minnesota).