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SUNSHINE AND ACCOUNTABILITY: THE PURSUIT OF INFORMATION ON QUALITY IN MEDICAID MANAGED CARE

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“Publicity is justly commended as a remedy for social and industrial diseases. Sunlight is said to be the best of disinfectants; electric light the most efficient policeman.”¹

I. INTRODUCTION

Millions of low-income Americans have their health care services covered by Medicaid, the public insurance program jointly funded and administered by the federal and state governments.² There are nearly 60 million Medicaid enrollees—mainly children and their caretaker relatives, people with disabilities, and people over age 65.³ And, after 2014, millions more Americans will qualify for the program due to the expansion of eligibility included in the Affordable Care Act.⁴ They receive most of their services from private providers, including doctors, nurses, therapists, private clinics, and hospitals.⁵ In addition, a large and increasing number of

* Portions of this article have been adapted from earlier versions of whitepapers produced by the National Health Law Program (NHELP), and have been used with the permission of NHELP. Sections which include significant portions of adaptations have been noted by the authors.

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1. Louis D. Brandeis, *What Publicity Can Do*, HARPER’S WEEKLY, Dec. 20, 1913, at 10, 10.

2. KAISER COMM’N ON MEDICAID & THE UNINSURED, NO. 7235-04, MEDICAID FACTS: THE MEDICAID PROGRAM AT A GLANCE (2010) [hereinafter MEDICAID FACTS].

3. *Id.*

4. ACA § 2001 (to be codified at 42 U.S.C. § 2000(a)(1)); see also KATHLEEN GIFFORD ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, NO. 8220, A PROFILE OF MEDICAID MANAGED CARE PROGRAMS IN 2010: FINDINGS FROM A 50-STATE SURVEY, 1 (2011).

5. MEDICAID FACTS, *supra* note 2.

Medicaid beneficiaries are enrolled in managed care.⁶ These managed care organizations, many of them for-profit entities, are paid millions of taxpayer dollars to manage and provide care.⁷ And, with prepaid managed care arrangements, there are clear incentives for plans to limit the care provided in order to maximize profits.⁸ It is therefore crucial for Medicaid beneficiaries, policymakers, and the general public to have access to information indicating whether public money is being well spent and used so as to ensure that people obtain quality health care services. In some cases, it is not. For example:

- In 2007, Deamonte Driver died of a brain infection caused by an untreated dental infection. He was enrolled in a Medicaid HMO in Maryland. The family could not find a UnitedHealth dentist who accepted Medicaid. UnitedHealth enrolls thousands of Medicaid beneficiaries across the country and enrolled in plans operated by UniversalHealth. In the year Deamonte died, about 20% of the insurance premium dollars paid to UnitedHealth were spent on items other than health care, including salary, benefits, profits, and compensation for the CEO.⁹ Congress launched an investigation of UnitedHealth and, in 2007, the company admitted that nearly 11,000 Medicaid children enrolled with UnitedHealth in Maryland have not seen a dentist in more than four years. And, few dentists in the company's network actually serve children.¹⁰
- In Florida, a dental group was paid \$4.25 per month per beneficiary to be responsible for providing care to 790 child Medicaid recipients. During one six month period, the plan provided care to only forty-five children

6. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T HEALTH & HUMAN SERVS., NATIONAL SUMMARY OF MEDICAID MANAGED CARE PROGRAMS AND ENROLLMENT AS OF JULY 1, 2010 (2010), available at <https://www.cms.gov/medicaiddatasourcesgeninfo/downloads/2010Trends.pdf>.

7. KATHLEEN GIFFORD ET AL., *supra* note 4, at 9.

8. See, e.g., NHELP SUNSHINE & ACCOUNTABILITY PROJECT, NAT'L HEALTH LAW PROGRAM (NHELP), REPORT: THE PURSUIT OF MEDICAID MANAGED CARE QUALITY INFORMATION IN SIX STATES (2010) [hereinafter SUNSHINE & ACCOUNTABILITY], available at http://www.healthlaw.org/images/stories/Pursuit_of_Medicaid_Managed_Care_Quality.pdf.

9. *Evaluating Pediatric Dental Care Under Medicaid*, Hearing Before the H. Subcomm. on Domestic Policy of the Comm. on Gov't Oversight & Reform, 110th Cong. 2, 4, 13-14, 137, 143 (2007) [hereinafter *Hearing*] (statement of Rep. Dennis J. Kucinich, Chairman, Subcomm. On Domestic Policy).

10. *Medicaid's Efforts to Reform since the Preventable Death of Deamonte Driver: A Progress Report Before the Subcomm. on Domestic Policy of the Comm. on Gov't Oversight & Reform*, 111th Cong. 2 (2009) (opening statement of Rep. Dennis J. Kucinich, Chairman, Subcomm. on Domestic Policy), available at http://democrats.oversight.house.gov/images/stories/Hearings/Domestic_Policy/100609_Deamonte_Driver/100709_DP_Chairman_Kucinichs_Opening_Statement_100709.pdf.

(5.7% of the enrollees). The group was therefore paid \$20,145 of taxpayer money to provide care to fewer than fifty children.¹¹

- A study of births in California Medicaid managed care plans found that Medicaid managed care in California reduced the utilization and quality of care and increased low birth weights, prematurity, and neonatal death, “provid[ing] strong evidence that health care providers respond to incentives to reduce cost by limiting care.”¹²

There is an urgent need to make information like this public, so that beneficiaries can be aware of the quality of care that they may obtain and the public can know how their tax dollars are being spent. For this reason, in 2008, the National Health Law Program launched the Sunshine and Accountability Project, through which we attempted to collect purportedly publicly-available information about the quality of Medicaid managed care in selected states.¹³

Part II of this paper will describe Medicaid managed care, including the statutory and regulatory requirements that mandate or encourage reporting of the Healthcare Effectiveness Data and Information Set (“HEDIS”) measures and other crucial data.¹⁴ Part III will discuss the HEDIS measures themselves, what they indicate and how to weigh the information they provide about a state’s Medicaid program.¹⁵ Part IV will describe the National Health Law’s Sunshine and Accountability project, and discuss the relative performances of Medicaid managed care in various states in the mid-2000s.¹⁶

II. STATUTORY AND REGULATORY MEDICAID REPORTING REQUIREMENTS

A. *Medicaid and Managed Care*

Medicaid is a cooperative federal-state insurance program for people with limited ability to pay for their health care.¹⁷ States are not required to participate in the Medicaid program, but all do and are therefore required to comply with all federal statutory, regulatory, and agency requirements.¹⁸

11. *Hearing, supra* note 9, at 129.

12. See Anna Aizer et al., *Does Managed Care Hurt Health? Evidence from Medicaid Mothers*, 89 REV. OF ECON. & STAT. 385, 386, 398 (2007).

13. See generally SUNSHINE & ACCOUNTABILITY, *supra* note 8.

14. See *infra* pp. 3-11.

15. See *infra* pp. 11-14.

16. See *infra* pp. 14-27.

17. MEDICAID FACTS, *supra* note 2.

18. *E.g.*, *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 502 (1990) (“Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human

The program is cooperative in several respects. It is authorized by federal statute, Title XIX of the Social Security Act,¹⁹ and governed by federal regulations and sub-regulatory guidance.²⁰ States also have state statutory and regulatory requirements that provide specifics for their programs.²¹ In addition, all state Medicaid expenditures are matched by federal dollars.²² The Federal Medical Assistance Percentage is based upon a state's per capita income and, for the current fiscal year, ranges from 50% to approximately 75%.²³ This means that, for every dollar a state spends on Medicaid services, the federal government matches it by at least one dollar—and often more. The entire program is overseen and administered by the Centers for Medicare & Medicaid Services (“CMS”) at the U.S. Department of Health and Human Services;²⁴ each state is also required to designate a single state agency that is responsible for administering the program and ensuring adherence to all Medicaid requirements.²⁵

Currently, federal Medicaid law requires states to cover certain categories of individuals and types of services—mostly groups of children, caretaker relatives, people with disabilities, and low income Medicare beneficiaries.²⁶ For example, all state Medicaid programs must cover pregnant women and infants with family incomes below 133% of the federal poverty level (“FPL”).²⁷ Nearly 60 million people are enrolled in Medicaid.²⁸ Moreover, after 2014, states will be required to cover most individuals with incomes below 133% of FPL, which is estimated to bring an additional 16 million enrollees into the program.²⁹ They must also cover certain services,

Services.”); see also *Moore v. Reese*, 637 F.3d 1220, 1232 (11th Cir. 2011) (“All states . . . have chosen to participate in Medicaid.”); 42 U.S.C. § 1396a (2006).

19. 42 U.S.C. §§ 1396-1396w-5 (2006).

20. See 42 C.F.R. §§ 430.0-.104 (2010).

21. See *id.* § 430.0.

22. See 42 U.S.C. §§ 1396b(a)(1), 1396d(b).

23. Kaiser Family Found., *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4> (last visited Aug. 28, 2011).

24. HHS: *What We Do*, U.S. DEP'T OF HEALTH & HUMAN SERVICES, <http://www.hhs.gov/about/whatwedo.html> (last visited Sept. 23, 2011).

25. See 42 U.S.C. § 1396a(5) (2006).

26. *Id.* § 1396a(a)(10)(A).

27. *Id.* §§ 1396a(a)(10)(A)(i)(III), 1396d(n).

28. KAISER COMM'N ON MEDICAID & THE UNINSURED, No. 8165, MEDICAID MATTERS: UNDERSTANDING MEDICAID'S ROLE IN OUR HEALTH CARE SYSTEM (Mar. 2011), available at <http://www.kff.org/medicaid/upload/8165.pdf>.

29. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); KAISER FAMILY FOUND., NO. 7952-03, MEDICAID AND CHILDREN'S HEALTH PROVISIONS IN THE NEW HEALTH REFORM LAW 1, 2, available at <http://www.kff.org/healthreform/upload/7952-03.pdf> (last modified Apr. 7, 2010).

such as physician and hospital services.³⁰ The Medicaid Act specifies categories of eligibility and services that states may choose to cover, but are not required to do so, such as personal care and private duty nursing services.³¹ And, there are a number of mandatory Medicaid requirements governing eligibility, scope of services, provider reimbursement rates, and other aspects of the program.³² Accordingly, all state Medicaid programs have similar structures, but vary in their individual eligibility and service coverage rules.

States must allow Medicaid enrollees to obtain services from any willing provider. States may, however, with permission from the Department of Health and Human Services, waive this requirement so that states may require beneficiaries to enroll in managed care; however, such managed care arrangements may not substantially impair access to medically necessary services.³³ States are also authorized to require most beneficiaries to enroll in managed care by section 1115 of the Social Security Act, which permits states to waive certain Medicaid requirements, including choice of provider, in order to operate experimental, pilot, or demonstration programs likely to promote the objectives of the Medicaid Act.³⁴

The Balanced Budget Act of 1997 (“BBA-97”) made it easier for states to implement mandatory managed care for more populations through a state plan amendment, which is a simpler process than the waiver.³⁵ States are not allowed to require certain populations to enroll, including: (1) certain children under 19 years old with special needs; (2) beneficiaries who were eligible for both Medicare and Medicaid; and (3) Native Americans.³⁶

Pursuant to these authorities, several types of managed care entities (“MCEs”) may be used, including Managed Care Organizations (“MCOs”), Primary Care Case Management entities (“PCCMs”), and Health Insuring Organizations (“HIOs”).³⁷ Most of these arrangements are risk based, meaning that the managed care entity accepts responsibility for covering

30. 42 U.S.C. § 1396d(a)(1), (2), (5) (2006).

31. *Id.* § 1396d(a)(8), (24).

32. *See generally id.* 42 U.S.C. §§ 1396u-8(b)(4)(B), 1396r(b)(2), 1396r-8(a)(5)(C).

33. *Id.* 1396n(b)(2).

34. *Id.* 1315(a).

35. 42 U.S.C. § 1396u-2(a)(1) (2006).

36. *Id.* § 1396u-2(a)(2). These populations can, however, be required to enroll in managed care pursuant to sections 1915(b) or 1115. *Id.* § 1396u-2(a)(1)(A).

37. *Id.* §§ 1396b(m), 1396d(t). This paper refers to the various types of managed care plans as “managed care entities,” (MCEs) rather than managed care organizations (MCOs). Under the regulations, by definition, MCOs have comprehensive risk contracts. In contrast, Primary Care Case Management arrangements (PCCMs), do not. *See* 42 C.F.R. § 438.2 (2010). The requirements for disclosure of information discussed here apply to all types of MCEs, regardless of whether they have risk contracts or not.

services for a certain population in exchange for a set payment and incurs a loss if the cost of providing the services exceeds the contracted payment.³⁸ Other basic characteristics are summarized in Table 1.

TABLE 1: TYPES OF MANAGED CARE ENTITIES

Type of MCE	Description	Legal Authority	Risk-Based?
Managed Care Organization ("MCO")	An entity that qualifies for a comprehensive risk contract and fulfills other Medicaid requirements.	42 U.S.C. § 1396b(m); 42 C.F.R. § 438.2	Y
Health Insuring Organization ("HIO")	A county-operated entity that covers services for beneficiaries in exchange for capitated payments.	42 C.F.R. § 438.2	Y
Prepaid Inpatient Health Plan ("PIHP")	An entity that provides medical services on the basis of prepaid capitation payments and provides or arranges for inpatient or institutional hospital services.	42 C.F.R. § 438.2	Y
Prepaid Ambulatory Health Plan ("PIHP")	An entity that provides medical services on the basis of prepaid capitation payments but does not provide or arrange for inpatient or institutional hospital services.	42 C.F.R. § 438.2	Y
Primary Care Case Management ("PCCM")	A system under which a primary care case manager ("PCCM") contracts to provide case management services. A PCCM can be a physician or, at state option, physician assistant, nurse practitioner, or certified nurse-midwife.	42 C.F.R. § 438.2	N

The numbers of beneficiaries enrolled in Medicaid managed care have expanded in recent years. In 2001, slightly less than 57% of the Medicaid

38. See, e.g., 42 C.F.R. § 438.2 (2010) (defining comprehensive risk contracts).

population was enrolled in managed care.³⁹ As of June 2009, more than 70% of all Medicaid enrollees participated in managed care—over 36 million people.⁴⁰ In seven states and territories—Colorado, District of Columbia, Georgia, Missouri, Puerto Rico, South Carolina, and Tennessee—more than 90% of Medicaid beneficiaries are enrolled in managed care.⁴¹ In all but four states or territories, more than 50% of all Medicaid beneficiaries are enrolled in managed care.⁴² The majority of beneficiaries are enrolled in risk-based, prepaid plans—commercial MCOs, Medicaid MCOs, or PIHPs.⁴³

B. Reporting and Informational Requirements

Congress and the U.S. Department of Health and Human Services (“HHS”) have established safeguards to protect individuals who are enrolled in managed care. Notably, MCEs may not discriminate against individuals on the basis of health status and need, beneficiaries must have rights to disenroll under certain circumstances, the state must be able to audit and inspect the MCEs books and records, and the MCE must maintain adequate patient encounter data.⁴⁴

A number of provisions require states and plans to make information available to Medicaid beneficiaries who might enroll in managed care. States and Medicaid-participating MCEs must provide all informational materials that are related to current and potential enrollees in an easily-understandable manner and format.⁴⁵ Information must be available in alternative formats and in a manner that is accessible to people with disabilities or limited literacy.⁴⁶ The BBA-97 regulations require that states and MCEs make specific information available including information about providers, services and items available, how to access benefits not covered

39. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T HEALTH & HUMAN SERVS., NATIONAL SUMMARY OF MEDICAID MANAGED CARE PROGRAMS AND ENROLLMENT AS OF JULY 2010 (2010), available at <https://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/2010Trends.pdf>.

40. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T HEALTH & HUMAN SERVS., 2009 MEDICAID MANAGED CARE ENROLLMENT REPORT SUMMARY STATISTICS AS OF JUNE 30, 2009, at 4 (2009) [hereinafter 2009 Medicaid Enrollment], available at <http://www.ahcahp.org/LinkClick.aspx?fileticket=4vQninXYS3U%3D&tabid=66>.

41. *Id.*

42. *Id.* Those four are West Virginia, Wyoming, Virgin Islands, and Alaska. *Id.*

43. 2009 MEDICAID ENROLLMENT, *supra* note 40, at 5.

44. 42 U.S.C. § 1396b(m) (2006); 42 C.F.R. § 438.6(d) (2010).

45. 42 C.F.R. § 438.10(b).

46. *Id.* § 438.10(d)(ii).

by the MCE, procedures available to challenge problems with enrollment and services, and the service quality and MCE performance.⁴⁷

There are several types of quality and performance information that must be collected and made available to help assess the performance of Medicaid MCOs and PIHPs. Some are required by law, others recommended. Federal regulations require states to “have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs”; obtain input of recipients and other stakeholders in the development of the strategy; make it available for public comment; and review and periodically update the strategy.⁴⁸ In addition, states must submit a copy of the initial strategy to CMS, make periodic reports informing CMS of any significant changes, and provide regular reports on strategy implementation and effectiveness.⁴⁹ Also, “state[s] must require, through contract, [that each MCE] have an ongoing quality assessment and performance improvement program.”⁵⁰ Such programs must be based on ongoing measurements and interventions, improvement in care.⁵¹ The MCOs and PIHPs must measure quality and performance and submit resulting data to the states annually.⁵² States must also ensure through contracts with plans, that the MCEs maintain a health information system to collect and report data about their enrollees and performance.⁵³

47. Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. 40,989, 41,089, 41,099-41,101 (proposed June 14, 2002) (codified at 42 C.F.R. § 438).

48. 42 C.F.R. § 438.202(a)-(d).

49. *Id.* § 438.240(a).

50. *Id.* § 438.240(a).

51. *Id.* § 438.240(b)(1).

52. *Id.* § 438.240(c).

53. 42 C.F.R. § 438-242.

TABLE 2: TYPE OF INFORMATION THAT MUST BE MADE PUBLICLY AVAILABLE

Type of Information Required	Legal Authority ⁵⁴	Required of which entity
Names, locations, qualifications and availability of health care providers that participate in an MCE, including non-English language spoken by current contracted providers and information on providers who are not accepting new Medicaid patients.	42 U.S.C. § 1396u-2(a)(5)(B)(i); 42 C.F.R. § 438.10 (e)(2), (f)(6).	State (current and potential enrollees), MCEs (current enrollees)
Responsibilities of MCE for coordination of care.	42 C.F.R. § 438.10(e)(2)(i)(C)(i).	State (potential enrollees)
Services and items available through the MCE and any cost sharing.	42 U.S.C. § 1396u-2(a)(5)(B)(iv), (C)(i); 42 C.F.R. § 438.10(e)(2)(ii), (f)(6)(v), (ii).	State (current and potential enrollees); MCEs (current enrollees)
Benefits available through the Medicaid program that are not covered by the MCE, including how and where the enrollee can obtain those benefits, any cost sharing and how transportation is provided.	42 U.S.C. § 1396u-2(a)(D); 42 C.F.R. § 438.10(e)(2)(ii)(E), (f)(6)(vii),(xi),(xii).	State (current and potential enrollees); MCEs (current enrollees)
Procedures available to challenge problems with enrollment and services in the MCE.	42 U.S.C. § 1396u-2(a)(5)(B)(iii); 42 C.F.R. § 438.10(f)(1), (6), (g)(1), (h)(1).	State (current and potential enrollees); MCEs (current enrollees)
Information related to quality and performance.	42 U.S.C. § 1396u-2(a)(5)(C)(iii); 42 C.F.R. § 438.202	State (current and potential enrollees); MCEs (current enrollees)

54. This statutory section applies only to managed care arrangements operated under a state plan amendment, but the regulatory requirements apply to managed care entities authorized by all types of authority.

The federal regulations set forth requirements governing annual external quality reviews (“EQRs”) for MCOs and PIHPs.⁵⁵ Such reviews must be conducted by an outside organization that meets certain standards of competence and independence.⁵⁶ The review must consider information from performance improvement projects, performance measures, and include a review of compliance with quality standards established by the state.⁵⁷ The results of the EQRs must include, at a minimum: (1) a detailed technical report of all activities conducted in furtherance of the review; (2) “assessment of . . . [the] strengths and weaknesses of the plan with respect to quality, timeliness, and access to health care services furnished to Medicaid recipients”; (3) recommendations for improvement; (4) “comparative information about all MCOs and PIHPs”; and (5) “an assessment of the degree to which the MCO or PIHP has addressed . . . recommendations . . . from the previous year’s EQR.”⁵⁸ Finally, the state must provide copies of this information upon request to interested parties “such as participating health care providers, enrollees and potential enrollees of the MCO or PIHP, recipient advocacy groups, and members of the general public.”⁵⁹

Finally, CMS recommends, but does not require that Medicaid managed care programs report using standard performance measures such as the Healthcare Effectiveness Data and Information Set.⁶⁰ The analysis in this article is based on these measures.

III. THE HEDIS MEASURES

A. *Background*

The Healthcare Effectiveness Data and Information Set (“HEDIS”) is a set of quality indicators used to measure performance on aspects of care and services provided by health plans. Currently, there are seventy-five HEDIS measures related to eight healthcare domains, including effectiveness of care, access/availability of care, and use of services.⁶¹ Measures include:

55. 42 C.F.R. § 438.310(a)-(b) (2010).

56. *Id.* § 438.354.

57. *Id.* § 438.358(b).

58. *Id.* § 438.364(a).

59. *Id.* § 438.364(b).

60. See FAMILY & CHILDREN’S HEALTH PROGRAMS GRP., DIV. OF QUALITY, EVALUATION & HEALTH OUTCOMES, CTRS. FOR MEDICARE & MEDICAID SERVS., QUALITY MEASURES COMPENDIUM: MEDICAID & SCHIP QUALITY IMPROVEMENT, VOL. 2.0 (2007).

61. NAT’L COMM. FOR QUALITY ASSURANCE (NCQA), HEDIS 2011 SUMMARY TABLE OF MEASURES, PRODUCT LINES AND CHANGES (2011), available at <http://www.ncqa.org/portals/0/hedisqm/hedis%202011/hedis%202011%20measures.pdf>. The other five domains are (1) satisfaction with experience of care; (2) health plan descriptive information; (3) cost of care;

(1) asthma medication use; (2) breast and cervical cancer screening; (3) childhood and adolescent immunization status; (4) various aspects of diabetes care; and (5) antidepressant medication management.⁶²

HEDIS, originally called the Health Employer Data and Information Set, is developed and published by the non-profit National Committee for Quality Assurance ("NCQA").⁶³ The first version of the HEDIS measures were drafted and refined in the early 1990s.⁶⁴ The primary purpose of HEDIS is to enable purchasers and consumers to compare the performance of health care plans.⁶⁵ The HEDIS measures also provide data that can help improve the quality of care.⁶⁶ The measures were originally created for commercial health plans; a later version was adapted for Medicaid plans.⁶⁷ By 1997, HEDIS contained performance measures reported by Medicaid, Medicare, and commercial managed care plans.⁶⁸ In addition to developing the HEDIS measures, NCQA accredits managed care organizations and verifies physician organizations.⁶⁹ According to NCQA, many large employers will not contract with health plans that are not NCQA accredited.⁷⁰ NCQA states that in order to be accredited, plans must voluntarily submit to review by a third party, during which they are evaluated on how they measure up on clinical quality, service, structure, and organization.⁷¹

Managed care plans report the information to NCQA upon which the HEDIS data is based.⁷² In general, the measures indicate the percentage of enrollees that received a certain test or treatment during a measurement year.⁷³ NCQA publishes detailed specifications for each HEDIS measure and defines appropriate sampling methodologies and data collection

(4) health plan stability; and (5) informed health care choices. *Id.* This article does not discuss measures related to these domains.

62. *Id.*

63. *What is HEDIS?*, NCQA, <http://www.ncqa.org/tabid/187/Default.aspx> (last visited Aug. 15, 2011).

64. Andrea Ohldin & Adrienne Mims, *The Search for Value in Health Care: A Review of the National Committee for Quality Assurance Efforts*, 94 J. NAT'L MED. ASS'N 344, 345 (2002).

65. *What is HEDIS?*, *supra* note 63.

66. *Id.*

67. Ohldin & Mims, *supra* note 64, at 345-46.

68. *Id.* at 346.

69. *Id.* at 345.

70. *The Basics: Assessing Quality*, NCQA, <http://www.ncqa.org/tabid/440/Default.aspx> (last visited Sept. 21, 2011).

71. *Health Plan Report Card*, NCQA, <http://reportcard.ncqa.org/plan/external/Resources.aspx?Header=yes&Tab=HowToChooseAHealthPlan> (last visited Sept. 21, 2011).

72. See Ohldin & Mims, *supra* note 64, at 346.

73. *Id.* at 345-46 (explaining the methodology of HEDIS).

procedures.⁷⁴ It specifies that data may be obtained through administrative claims, the “administrative” method, and may also include medical record review of random samples, known as the “hybrid” method.⁷⁵

In 2009, 979 health plans submitted HEDIS data to NCQA⁷⁶—more than ever before.⁷⁷ CMS requires managed care plans participating in Medicare to report audited summary data on specified HEDIS measures.⁷⁸ CMS encourages but does not require states to report HEDIS data from Medicaid managed care plans.⁷⁹ Thus, many states report on some HEDIS measures, but there is no guarantee of uniformity as to which measures are reported.⁸⁰ And, while many commercial MCEs are accredited by NCQA, only 25% of Medicaid beneficiaries are in HEDIS accredited plans.⁸¹

There is evidence of a link between making HEDIS information publicly available and the quality of care. One study concluded that managed care plans that make their data available to the public perform significantly better on the HEDIS quality domains than those that do not, including adolescent and child immunization, women’s care, chronic illness and medication management.⁸²

74. NAT’L COMM. FOR QUALITY ASSURANCE (NCQA), HEDIS: TECHNICAL SPECIFICATIONS FOR HEALTH PLANS, available at http://www.ncqa.org/tabid/78/Default.aspx#Vol_2.

75. HEDIS, MANAGED HEALTH SERVICES, <http://www.mhsindiana.com/providers/quality-improvement/hedis/>; see Bruce E. Landon et al., *Quality of Care in Medicaid Managed Care and Commercial Health Plans*, 298 JAMA 1674, 1675 (2007) (discussing compilation of data upon which HEDIS measures are based).

76. Press Release, NCQA, U.S. Health Care Quality: Stuck in Neutral Slowdown Has Implications for Reform (Oct. 22, 2009), available at <http://www.ncqa.org/tabid/1077/Default.aspx>.

77. *Id.*

78. 42 C.F.R. §§ 422.152, .516 (2010).

79. NAT’L COMM. FOR QUALITY ASSURANCE (NCQA), MEDICAID MANAGED CARE QUALITY BENCHMARKING PROJECT: FINAL REPORT 3 (2010), available at <https://www.cms.gov/MedicaidCHIPQualPrac/Downloads/NCQAMBench.pdf>.

80. NHELP SUNSHINE & ACCOUNTABILITY PROJECT, NAT’L HEALTH LAW PROGRAM (NHELP), MEDICAID SUNSHINE AND ACCOUNTABILITY: LISTING OF REQUIREMENTS FOR INFORMATION 3 (2010), available at http://www.healthlaw.org/images/stories/Medicaid_Sunshine_and_Accountability_Listing_of_Legal_Requirements_for_Information.pdf. “According to NCQA, the following 20 states legally require the use of at least some HEDIS measures: AK, CA, CO, DC, FL, MD, MA, MN, MO, NE, NV, NJ, NM, NY, OH, PA, RI, TN, UT, VA.” *Id.*

81. NAT’L COMM. FOR QUALITY ASSURANCE (NCQA), THE STATE OF HEALTH CARE QUALITY 2009: VALUE, VARIATION AND VULNERABLE POPULATIONS 8 (2009) [hereinafter HEALTH CARE QUALITY 2009], available at http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_2009.pdf.

82. Dennis P. Scanlon et al., *Competition and Health Plan Performance: Evidence from Health Maintenance Organization Insurance Markets*, 43 MED. CARE 338, 341, 344 (2005).

B. *Limitations: What the HEDIS Measures Don't Show*

While widely acknowledged to be valuable sources of information, academics, clinicians and policy analysts have raised questions and concerns about various aspects of the HEDIS measures. Issues range from the general, such as the reliability of the reported data or the cost of implementing the measures, to concerns about the accuracy and usefulness of specific measures.⁸³

Some studies have found that there is a wide variation in the quality and reliability of data submitted by the various health plans.⁸⁴ Simple arithmetic errors, overly small data sets, failure to submit all required data, and inconsistent interpretation of measures have been found with some regularity.⁸⁵ And, despite the fact that the HEDIS measures have been used for Medicaid plans for more than a decade, some commentators have criticized the measures for a perceived bias toward commercial plan populations.⁸⁶ It has therefore been suggested that the measures would be more accurate if they took into account variations in health status, disability, age, socioeconomic status, continuity of care, receipt of public assistance, and access.⁸⁷

IV. HOW DID THEY DO? COMPARING HEDIS MEASURES ACROSS STATES AND PLANS

A. *Background: Data Collection Project*

In September 2008, the National Health Law Program ("NHeLP") launched its Sunshine and Accountability Project.⁸⁸ The purpose of the project was to collect data related to Medicaid managed care that was, at least theoretically, available to the public.⁸⁹ We were joined in our efforts by partners from six states: Connecticut, Florida, Missouri, New Mexico,

83. See Arch G. Mainous III & Jeffery Talbert, *Assessing Quality of Care via HEDIS 3.0: Is There a Better Way?*, 7 ARCHIVES FAM. MED. 410, 412 (1998).

84. Ohldin & Mims, *supra* note 64, at 347; see Mainous & Talbert, *supra* note 83, at 411.

85. Ohldin & Mims, *supra* note 83, at 347.

86. Alan M. Zaslavsky & Arnold M. Epstein, *How Patients' Sociodemographic Characteristics Affect Comparisons of Competing Health Plans in California on HEDIS Quality Measures*, 17 INT'L J. FOR QUALITY HEALTH CARE 67, 73 (2005); Ohldin & Mims, *supra* note 64, at 349.

87. See, e.g., Arnold M. Epstein, *Performance Reports on Quality—Prototypes, Problems, and Prospects*, 333 NEW ENG. J. MED. 57, 61 (1995).

88. SUNSHINE & ACCOUNTABILITY, *supra* note 8, at 1.

89. Zaslavsky & Epstein, *supra* note 86.

Virginia and Washington.⁹⁰ These states were chosen in part because a high proportion of their Medicaid population is served through risk-based managed care.

In December 2008 and January 2009 our partners sent out requests for information to the state Medicaid agencies and the Medicaid-participating managed care organizations operating in their states. The following information was requested:

- A list of the specific HEDIS performance measures used by the agency to measure MCO performance in 2006, 2007, 2008, and 2009;
- Specific HEDIS performance results, as reported by each Medicaid-participating MCO for the three most recent years available;
- State Medicaid standards for access to care to ensure that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services available; and
- State's strategy for assessing, reviewing and improving the quality of available managed care services, including any reports submitted to CMS discussing the strategy.

As discussed in Part II,⁹¹ federal statutes and regulations require that this information be made available to current and prospective enrollees.⁹² In addition, although this information is not explicitly required to be made public, partners in every state except Connecticut requested the current policies, procedures and standards for obtaining prescription drugs that are not included on participating managed care plans, formularies or preferred drug lists.⁹³ Arguably, in order to obtain the information specified in the Medicaid statute and managed care regulations, current or potential Medicaid managed care enrollees should not need to cite additional authority in support of their request.⁹⁴ In order to avoid possible delays, however, our state partners cited the relevant state open record laws in support of their requests. Each of our partner states has broad freedom of

90. SUNSHINE & ACCOUNTABILITY, *supra* note 8, at 1. The partner organizations were the New Haven Legal Assistance Association, Florida Legal Services, Legal Services of Eastern Missouri, the New Mexico Center on Law and Poverty, the Virginia Poverty Law Center, and Northwest Health Law Advocates. *Id.* at 1 n.3.

91. See *supra* Part II.

92. 42 C.F.R. § 438.10 (2010); 42 U.S.C. § 1396u-2(a)(5)(B), -2(c)(2)(A) (2006).

93. Our state partners in Connecticut did not request this information because of ongoing litigation related to the issue. See *Heath Net of Conn. v. Freedom of Info. Comm'n*, No. CV064010428S, 2006 WL 3691796 (Conn. Super. Ct. Nov. 29, 2006).

94. See 42 C.F.R. § 438.10 (e), (f).

information statutes,⁹⁵ and we believe that the information our partners requested fit within the scope of those laws. None of the states asserted that these laws did not cover the information requested.

TABLE 3: HEDIS MEASURES REQUESTED

HEDIS Measures	
Well-Child Visits/First fifteen months/six visits	Six well-care visits (at least two weeks apart) with a PCP. Must show evidence of all of the following: <ul style="list-style-type: none"> • Health and developmental history (physical and mental) • Physical exam • Health education/anticipatory guidance
Well-Child Visits/3rd, 4th, 5th, & 6th year of life	Annual well-care visit with a PCP each year. Must show evidence of all of the following: <ul style="list-style-type: none"> • Health and developmental history (physical and mental) • Physical exam • Health education/anticipatory guidance
Adolescent Well-Child Visit	Annual well-care visit with a PCP or OB/GYN. Must show evidence of all of the following: <ul style="list-style-type: none"> • Health and developmental history (physical and mental) • Physical exam • Health education/anticipatory guidance

95. CONN. GEN. STAT. § 1-210 (2011); FLA. STAT. § 119.01 (2005); MO. STAT. §§ 610.023-610.026 (2004); N.M. STAT. § 14-2-1 (2011); VA. CODE § 2.2-3704 (2011); WASH. REV. CODE § 42.56.070 (2006).

Childhood Immunization Combo 2	The percentage of children who turned two years old during the measurement year that received the following vaccinations by their second birthday: <ul style="list-style-type: none"> • Four doses of DTaP (diphtheria-tetanus) • Three doses of IPV (polio) • One doses MMR (measles-mumps-rubella) • Two doses of Hib (Haemophilus influenza type b) • One dose of VZV (chicken pox)
Timeliness of Prenatal Care	Prenatal visit within first trimester or within forty-two days of enrollment.
Postpartum Care	Postpartum visit between twenty-one and fifty-six days after delivery.
Comprehensive Diabetes Care—Eye Exam	Percentage of patients 18-75 years of age with diabetes who had a dilated or retinal eye exam during the measurement year or a negative retinal eye exam during the prior year.

Partners also requested the following information from each of the Medicaid MCEs in their states:

- Descriptions of physician incentive plans used by the plans.
- Lists of specified types of providers, including the name, location, qualifications and availability, including the non-English languages spoken, information on whether the provider is accepting new Medicaid patients, and any other information legally required to be provided or other information provided in the course of business. Providers specified were (1) pediatricians; (2) orthopedists; (3) dermatologists; (4) endocrinologists; and (5) neurologists. In every state except Connecticut, this information was also requested for psychiatrists and in Missouri, Florida, and New Mexico, this information was requested for dentists.⁹⁶
- For plans in every state except Connecticut and Missouri, the number of requests for payment of a prescription drug covered under the

96. This information was not requested in these states because behavioral health is not delivered through managed care in Connecticut, *About Us*, CONN. DEP'T. SOC. SERVICES, <https://www.ctdssmap.com/CTPortal/Home/AboutUs/tabid/38/Default.aspx> (last visited Oct. 6, 2011), and dental care is not delivered through managed care in Virginia, Washington, and Connecticut, *SUNSHINE & ACCOUNTABILITY*, *supra* note 8, at 2 n.6.

plan’s contract for which payment was: (1) electronically approved at point of service; (2) electronically rejected at point of service even though the drug was not on an excluded drug list; and (3) for those included in (2), the number that were later approved after initial payment rejection.

Responses from the States: All of the states sent responses to the information requests. These responses are summarized in Table 4, below.⁹⁷ Response times ranged from fourteen days for Virginia to 160 days for Connecticut.⁹⁸ Two of the slower-responding states, Washington and New Mexico, did provide an initial response within a month stating that they needed more time to comply with the request.⁹⁹ Substantively, all of the states except Connecticut ultimately provided all of the information that was requested. Some states were, however, more accommodating than others.

TABLE 4: NUMBER OF DAYS BETWEEN REQUEST FOR AND PROVISION OF INFORMATION

Connecticut	Florida	Missouri	New Mexico	Virginia	Washington
160	81	24	51	14	86

Virginia: The state agency responded promptly, but stated that it would charge \$190.64 for copying costs to provide the necessary documents. Our state partner, however, was able to convince the agency to provide electronic copies of the materials for free and the agency sent electronic versions of contracts, performance reports, and spreadsheets containing the HEDIS measures. All of the requested information was provided by mid-January. The HEDIS measures were in an organized format that was easy to read. It was necessary to glean other information—standards for access to and quality of care—from lengthy contracts and performance reports.

New Mexico: The state agency promptly responded by telephone stating that it would need until the end of December 2008 to fulfill the request and that it would charge copying costs. The state partner requested that the information be provided electronically and was referred to materials on the state agency’s website. The state agency maintains a website that contains a series of reports for recent years: HEDIS Reports, numerous External Quality Review Organization (“ERQO”) reports, Consumer

97. See *infra* Table 4.

98. See *infra* Table 4.

99. See *infra* Table 4.

Satisfaction Surveys, Managed Care Performance Analyses, and the Quality Strategy for the current year.¹⁰⁰

The HEDIS 2008 and 2009 reports were not posted on the website during the first phase of our research. We contacted the agency and were put in touch with a helpful employee in the Quality Assurance Bureau. She informed us that the reports were still being finalized, but promptly provided information on specific HEDIS measures.¹⁰¹

Missouri: The state agency provided a nearly complete response by February 2009. Initially, it requested a payment of \$35 for copying, but the state partner requested that the information be provided electronically, making payment unnecessary. A number of HEDIS measures that the state claimed to report were missing. In response to the request for information on obtaining prescription drugs not included on formularies or preferred drug lists, the state provided a generic grievance and appeals procedure.

Washington: The state agency sent an initial response in January indicating that the request was being forwarded to the public disclosure section and a response would be sent by March 5. The agency initially requested that the advocates pay for the copies they requested, but the state partner requested that information be provided electronically and received it all in that form.

Connecticut: While the state agency promptly responded that it was working on the request, it took more than six months for it to provide information. After repeated reminders, the state finally sent information on June 23, 2009. The information, which was provided in paper format, was disorganized, confusing, and incomplete. No list of the HEDIS measures reported was provided. A number of EQRO reports were included, but were missing many pages. Information on a few HEDIS measures from one of the three plans was included. Outside research indicated that Connecticut does not require HEDIS reporting for its Medicaid population and it is therefore not possible to compare the state's Medicaid plan with outside benchmarks.¹⁰²

Florida: The state agency did not respond to the initial December 2008 request for information. The state partner telephoned to inquire about the status of the request. She was told that the agency had drafted a response but that it had been reviewed and rejected by the legal department and the agency was redrafting it. A written response letter was finally provided on March 6, 2009, which contained website links to the requested information.

100. See *Reports*, N.M. HUMAN SERVICES DEP'T, <http://www.hsd.state.nm.us/mad/RcomplianceAudit.html> (last visited Aug. 15, 2011).

101. Email correspondence on file with NHeLP.

102. THE LEWIN GRP., ASSESSMENT OF HUSKY, CONNECTICUT'S MEDICAID MANAGED CARE PROGRAM 28 (2007).

For the pharmacy information, the agency referred to information that had previously been provided to the state partners in connection with another matter.

Summary: The states showed varying degrees of cooperativeness in responding to these requests for information that is required to be publicly available. Four of the states requested payment for copies and had to be prompted to provide the information in electronic form. This is particularly interesting in the case of New Mexico and Washington, given that their HEDIS and other reports were accessible on their websites.¹⁰³ Obtaining the information, however, was only one purpose of this project. In addition, we wanted to assess how difficult it would be for a Medicaid managed care enrollee or potential enrollee to obtain this information, given the legal requirements mandating that it be made public. If a Medicaid beneficiary were to encounter these obstacles—non-responsiveness, requests to pay—it is likely that they would give up. It may be that our partners' requests triggered a more defensive response because they are law firms that have engaged in litigation against the state Medicaid agencies. On the other hand, if lawyers who are familiar with Medicaid regulations and statutes and sophisticated in the ways of state agencies cannot obtain this information easily, it suggests that it might be very difficult for a layperson to do so.

Managed Care Plans

It was more difficult to obtain the requested information from the MCEs. There were a few plans that cooperated without issue, while others refused to provide any information. Their responses to our state partners' requests for information, state by state, are summarized below.

Connecticut: One managed care plan, *Aetna*, provided a letter purporting to be a complete response; however, the information it included did not provide all of the information requested. Among other deficiencies, it did not indicate which of its providers were accepting new patients. Another plan called to inform the state partner that the state Medicaid agency had instructed the plan not to respond until it received further instructions.

Florida: Our state partner sent requests to fifteen managed care plans—more than any other state. Five plans provided minimal partial responses and three plans provided more complete responses. *Universal HealthCare* had not responded two months after the response was sent. After the second request was sent, the plan was responsive and attempted to

103. See *HEDIS Reports*, N.M. HUMAN SERVICES DEP'T, <http://www.hsd.state.nm.us/mad/HeDisReports.html> (last visited Aug. 29, 2011); *Reports*, WASH. STATE HEALTH CARE AUTH., <http://maa.dshs.wa.gov/healthyoptions/newho/reports/reports.htm> (last visited Aug. 29, 2011).

cooperate. It answered the questions about physician incentives and provider networks. It also indicated a willingness to provide the pharmacy data. After several emails and calls, however, it provided data which appeared to be unresponsive and incomprehensible. The plan reported that it had undergone personnel changes, but still expressed a willingness to cooperate and promised to try again to get the requested data.

Two plans, *Sunshine* and *Healthease* responded by telephone, but never sent any information. *Sunshine* explained that they had just opened and did not have all the information requested. *Prestige*, *Jackson Memorial Health Plan*, *Preferred*, *Amerigroup*, and *Molina* provided minimal, partial responses. One plan, the *Health Care District of Palm Beach County*, sent a letter referring the state partner to its website. This was surprising, because no request had been sent to that plan.

A hostile response came from *UnitedHealthcare*, which refused to provide responses to the requests for information about physician incentive programs and the provider network unless the state partner provided the name and contact information of a beneficiary enrolled in the plan. It would not answer the question about pharmacy requests without a subpoena "or citation of legal authority."¹⁰⁴ None of the other plans contacted: *Humana*, *Total Health Choice*, *Freedom Health*, *Personal Health Plan*, *Vista/Buena Vista*, and *Citrus Health Care* responded.

Missouri: Three plans, *Health Care USA*, *Kansas City Children's Hospital*, and *Children's Mercy (Family Health Partners)* provided prompt and nearly complete responses. The online provider directory that the plans provided did indicate whether primary care providers were accepting new patients, but did not include the same information for specialists. Other plans responses were less complete. The pharmacy information for *Health Care USA* was missing some information. Both *Blue Advantage Plus* and *Harmony* denied that they were required to give any response, but referred to their website for provider information. No information was found for physician incentive plans for either plan. *Missouri Care Health Plan (Aetna)* sent its member handbook and provider directory, but the directory did not indicate whether the provider was accepting new patients. After a follow up request, the plan stated that it did not have a physician incentive plan. *Molina* provided some of the information requested, indicating that there were no physician incentive plans, referring to its website for information about participating providers, and referring to the state Medicaid agency for information about prescription drug claims. But, it also stated that it:

104. See Letter from Max Ramsey, Assoc. Gen. Counsel, UnitedHealthcare, to Miriam Harmatz, Att'y, Fla. Legal Servs. (Jan. 21, 2009) (on file with NHeLP).

considers much of the information you requested, confidential and protected and we are unable to provide you with that information. The information is only available by court order or subpoena and most likely not in the specific format you have requested.¹⁰⁵

The state partner sent a follow up letter requesting additional information, to which *Molina* did not respond.

New Mexico: Shortly after the state partner sent out requests, representatives from several MCEs called to ask why the information was being requested. Two plans subsequently sent links to information on their websites. Lawyers representing two other plans called the state partner and asked for information about the project. A little more than a month after the response was mailed, *BlueCross BlueShield* sent a provider list and physician incentive plan. It reported that it did not have pharmacy data because they had only been participating in Medicaid since 2008. *Amerigroup* provided a nearly complete response by April 1, 2009; however, they cautioned that they had only been providing services in New Mexico for a little over a year so were not warranting that their provider directory was complete. *Evercare* did not respond to two letter requests, one sent in December and a follow-up in March.

Lovelace provided an incomplete response on January 30, 2009, which it supplemented on request on March 5, 2009. *Molina* responded that it had no physician incentive plans and referred to the website for its contracted providers. It suggested that the state partner should try to get the information about prescription drugs from the state. Finally, *Presbyterian Salud Health Plan* responded on April 30, 2009. It noted that it was not required to provide the information, but provided a copy of the quality incentive program aimed at encouraging physicians not to have prescriptions denied (because of prescribing off formulary or failing to get prior authorization) and a link to the website where the provider directory could be found. It denied having the requested pharmacy information, but offered to discuss whether it could provide other information that might be useful.

Virginia: All five plans contacted, *Anthem*, *Amerigroup*, *Optima*, *CareNet*, and *Premier*, responded to the requests and provided information in response to the first two requests, but none provided information in response to the question about pharmacy refusals.

Washington: Our state partner made her requests on behalf of a group with a membership that included potential and current Medicaid beneficiaries. Two plans, *Columbia United Providers* and *Community*

105. Letter from Joanne Volovar, President, Molina Healthcare, to Joel Ferber, Dir. of Advocacy, Legal Servs. of Eastern Mo. (Feb. 11, 2009) (on file with NHeLP).

Health Plan responded promptly that they would not provide the requested information because the request was not made on behalf of a particular enrollee from the plan. After being reminded by letter, about two months after the original request *Asuris Northwest Health* and, *Group Health Cooperative* wrote to the state partner to indicate that they would not respond to the requests unless it was made on behalf of a particular enrollee. Neither *Regence Blue Shield* nor *Molina Healthcare of Washington* responded.¹⁰⁶

Summary: Each of these plans has a contract with the state Medicaid agency to provide services to Medicaid beneficiaries and each receive hundreds of thousands—if not millions—of dollars in compensation. Accordingly, the Medicaid statute and regulations require that they disclose certain information upon request.¹⁰⁷ Despite these facts, only a few of the thirty-eight plans surveyed in our project provided complete answers to our partners' requests and nearly half did not even bother to respond. Their lack of cooperation is disappointing and suggests that that Medicaid enrollees would have difficulty obtaining this important information.

B. Comparison Between States

We faced challenges in comparing states' and plans' performances. Because states are free to choose which HEDIS measures they will report on,¹⁰⁸ if any, there is no guarantee that states will report on the same measures and allow comparisons. Thus, in order to make a meaningful comparison, to the greatest extent possible, we chose the scores that were reported by each of the states in our survey. Even so, because some of the states changed which measures they used from one year to the next, we were left with gaps in our data.

In addition, we were unable to obtain some information from public sources. NCQA makes only limited data publicly available.¹⁰⁹ Much of it can be obtained only by purchasing NCQA's *Quality Compass* product, which costs hundreds of dollars.¹¹⁰ The organization issues an annual *State of Health Care Quality*, in which it provides data from Medicaid and

106. It is interesting that *Asuris* responded and *Regence* did not, because *Asuris* is a wholly owned subsidiary of *Regence*. See *ASURIS NORTHWEST HEALTH*, <http://www.asurisnorthwesthealth.com/ethics.html> (last visited Sept. 23, 2011).

107. 42 U.S.C. § 1396u-2 (2006); 42 C.F.R. § 438.10 (2010).

108. Joseph W. Thompson et al., *Health Plan Quality-of-Care Information is Undermined by Voluntary Reporting*, 24 AM. J. PREVENTATIVE MED. 62, 62 (2003).

109. See NAT'L COMM. FOR QUALITY ASSURANCE (NCQA), <http://www.ncqa.org/tabid/62/Default.aspx> (last visited Nov. 6, 2011).

110. See NCQA: *Quality Compass 2011*, NAT'L COMM. FOR QUALITY ASSURANCE (NCQA), <http://www.ncqa.org/tabid/177/Default.aspx> (last visited Aug. 28, 2011).

commercial plans on selected HEDIS measures.¹¹¹ Unfortunately, the reports for the three most recent years did not include all of the seven measures on which all of the states we surveyed reported.¹¹² Thus, our source for the national Medicaid averages were the states themselves; Missouri, New Mexico, Virginia, and Washington each included the NCQA national Medicaid average with their HEDIS data.

111. See HEALTH CARE QUALITY 2009, *supra* note 81 (example of State of Health Care Quality Report).

112. See NAT'L COMM. FOR QUALITY ASSURANCE (NCQA), THE STATE OF HEALTH CARE QUALITY 19 (2008), available at http://www.ncqa.org/portals/0/newsroom/sohc/SOHC_08.pdf; NAT'L COMM. FOR QUALITY ASSURANCE (NCQA), THE STATE OF HEALTH CARE QUALITY 16 (2009), available at http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_2009.pdf; NAT'L COMM. FOR QUALITY ASSURANCE (NCQA), THE STATE OF HEALTH CARE QUALITY 23 (2010), available at <http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf>.

Table 5: Reported HEDIS 2008 Data

HEDIS ¹¹³ 2008	Immunizations- Child Combo 2		Well-Child Visit— First 15 Months (6 or more visits)		Well-Child Visit— 3rd, 4th, 5th, and 6th Year of Life		Adolescent Well-Child Visit		Prenatal Care (Timeliness)		Post-Partum Care		Eye Exam (Diabetes Care)	
	Reform	Non-ref.	Reform	Non-ref.	Reform	Non-ref.	Reform	Non-ref.	Reform	Non-ref.	Reform	Non-ref.	Reform	Non-ref.
National Medicaid ¹¹⁴	72.1%		52.8%		65.3%		42.1%		81.2%		58.5%		49.79%	
Florida ¹¹⁵	n/a	n/a	44.4%	44.0%	71.3%	71.1%	44.2%	41.9%	66.6%	71.7%	53.0%	58.5%	35.7%	36.3%
Missouri	55.7%		51.2%		53.7%		33.4%		78.0%		58.7%		n/a	
New Mexico ¹¹⁶	77.7%		62.4%		63.1%		49.4%		83.5%		56.4%		55.3%	
Virginia ¹¹⁷	70.0%		56.2%		68.3%		41.9%		84.3%		63.9%		40.9%	
Washington	70.3%		53.3%		58.7%		36.2%		n/a		62.5%		54.8%	

113. NAT'L COMM. FOR QUALITY ASSURANCE (NCQA), HEDIS 2008 SUMMARY TABLE OF MEASURES, PRODUCT LINES AND CHANGES (2008), available at http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2008_Measures.pdf. The HEDIS report indicates the year the report was issued. The data reflect care given in the preceding year.

114. We were unable to obtain this data directly from NCQA. These scores come from the Washington and New Mexico state reports of the NCQA national Medicaid plan average.

115. Florida began a Medicaid Reform project in 2007. Some managed care plans participated in Medicaid under the new rules established by the Reform. Florida reports the HEDIS scores for these Reform plans separately from pre-existing, or non-Reform, plans. After the Reform began, Florida no longer reported average scores for the entire state.

116. New Mexico did not report statewide average HEDIS scores, but only reported individual scores for three managed care plans. We inquired whether they calculate statewide averages. A specialist in the quality control section informed us that, if they needed a statewide average, they would add the three percentages together and divide by three. We did so in preparing these charts.

117. Virginia's scores were reported to the hundredth of a percent; figures were rounded up to the tenth of a percent.

For the purpose of interpreting this table, it is important to note that unlike some other quality measures (e.g. grievances and appeals), HEDIS reporting is not in real time. A HEDIS reporting year reflects data from the preceding year. For example, HEDIS 2008 results reflect results from "measurement year" 2007, the calendar year in which care is given.¹¹⁸

In addition to considering the limitations of the data we collected, it is important to place this information in the national context. Overall, according to NCQA, performance on many key HEDIS indicators had been flat.¹¹⁹ 2008 was the third consecutive year of stagnation in HEDIS scores in Medicaid and Medicare plans.¹²⁰ Only 36% of Medicaid HEDIS measures showed a statistical improvement in 2008.¹²¹ In particular, performance on mental health and substance abuse indicators "dreadful," lagging below 50%, which NCQA deemed "unacceptable."¹²²

Interestingly, contrary to the trend noted by NCQA, none of the national average scores for our seven measures declined between 2005 and 2007. (See Tables 1-3). Our sample states showed some improvement over a three year period, but also had many scores below average and several below 50%.¹²³ All but one of Virginia's scores improved between 2005 and 2007.¹²⁴ The three well-child visits scores each gained about 10%.¹²⁵ The prenatal care timeliness measure declined .3%, which is likely not statistically significant.¹²⁶ At the same time, the adolescent well-care visit and the eye exam scores remained below 50%.¹²⁷ Missouri's scores were notably poor. In 2005, none of the scores exceeded 60%.¹²⁸ By 2007, scores on two measures (immunization and well-child visits in 3rd-6th year of life) actually

118. See, e.g., ACUMENTRA HEALTH, 2008 PERFORMANCE MEASURE COMPARATIVE ANALYSIS REPORT 1 (2008), available at <http://hrsa.dshs.wa.gov/healthyoptions/newho/reports/08HEDIS.pdf>.

119. HEALTH CARE QUALITY 2009, *supra* note 81, at 4.

120. *Id.* at 7-8.

121. *Id.* at 7 fig.1.

122. *Id.* at 8.

123. NHELP SUNSHINE & ACCOUNTABILITY PROJECT, NAT'L HEALTH LAW PROGRAM (NHELP), MEDICAID MANAGED CARE QUALITY: HEDIS MEASURE COMPARISONS FOR FIVE STATES, CHART 2 (2010) [hereinafter NHELP FIVE STATES], available at http://www.healthlaw.org/images/stories/HEDIS_Measure_Comparisons_Five_States.pdf (listing scores after 2007 do not include statewide average scores because that was when Florida Medicaid Reform began in which some managed care plans participated; Florida reports the HEDIS scores for those Reform plans separately from pre-existing, or non-Reform, plans).

124. *Id.* at Charts 2, 3 & 4.

125. *Id.*

126. *Id.*

127. *Id.*

128. NHELP FIVE STATES, *supra* note 123, at Chart 4.

declined.¹²⁹ The score on prenatal care jumped almost 20%, from 56% to 78%.¹³⁰ Performances on the remaining measures remained dismal; in particular, the adolescent well-child visit rate remained at 33%.¹³¹ New Mexico and Washington both showed improvement over the three year period. Washington's scores on five measures either improved or remained the same (the exceptions were prenatal care, which was discontinued in 2007, and eye exam, which was added in 2006).¹³² Some of New Mexico's scores improved as well, some dramatically: immunization rates jumped from 67.7% to 77.7%,¹³³ and well child visits in the first 15 months jumped from 43.1% to 62.4%.¹³⁴ Prenatal care dipped very slightly, in an amount that was probably not statistically significant, while the others remained stable.¹³⁵

All of the states had very low adolescent well-child visits—all were in the below-50% range and Washington and Missouri were in the 30s.¹³⁶

For this article, we attempted to update the Missouri measures to include the most recent years for which data are available. But, Missouri no longer reports results for timeliness of prenatal care, postpartum care, or immunization combo 2. This underlines one of the problems with the current use of the HEDIS measures. Because reporting is voluntary, there is no guarantee that states will choose to report the same measures or that they will report on the measures for which NCQA makes national data available. Thus, it is difficult to compare progress across states and over subsequent years.

V. CONCLUSION

The federal Medicaid statute and regulations require states and MCEs to provide information about enrollee protections and rights as well as service availability and quality. In addition, state statutes and, in some cases, state regulations also require states to disclose a wide variety of information. These requirements are particularly important because Medicaid beneficiaries need this information to make informed decisions about choosing a managed care plan. Policy makers and health care providers can use the information to improve quality and target resources. The HEDIS scores from the states we surveyed show room for significant improvement.

129. *Id.* at Charts 2, 3 & 4.

130. *Id.*

131. *Id.*

132. *Id.*

133. NHELP FIVE STATES, *supra* note 123, at Charts 2, 3 & 4.

134. *Id.*

135. *Id.*

136. *Supra* Table 5.

Despite the importance of making this information public, some of the state Medicaid agencies were uncooperative. And, the failure of many of the managed care plans to provide this information was disappointing. Millions more Americans will be receiving their health care through managed care as a result of federal healthcare reform. Thus, it is particularly important that policy makers and taxpayers are aware of governmental and plan responsibilities and work to ensure their accountability.

