Minnesota Prepaid Medical Assistance Program (PMAP) Performance Measures

How the Minnesota Department of Human Services is Serving Medicaid Clients Under Managed Care

Minnesota Department of Human Services
Performance Measurement & Quality Improvement
Health Program Quality Section
444 Lafayette Road North
St. Paul, MN 55155-3865

MS-1492 (6-99)

For more information, contact:

Timothy Beebe, Ph.D.
Manager, Health Program Quality
Performance Measurement and Quality Improvement
Minnesota Department of Human Services
(651) 296-4617

Upon request this information will be provided in another form, such as Braille, large print, or audiotape.

A Message from the State Medicaid Director

June, 1999

It is my pleasure to introduce our first performance report on the quality of health care provided to public clients under the Prepaid Medical Assistance Program (PMAP). This program, a managed care system started in 1985, currently provides comprehensive health coverage to approximately 170,000 low-income and medically needy children, families, and seniors through contracts with health plans and other managed care organizations.

The Department of Human Services is committed to ensuring that the health care services we purchase for our clients are of high quality. We can take pride in the patient protections Minnesota has adopted that often go beyond the federal recommendations. In 1996 we installed a data warehouse to allow reporting of claims information from both our fee-for-service and managed care systems. We are continuing to build our capacity to measure performance through ongoing studies that will produce key indicators of quality and outcomes. Our plans also include the development of report cards on the managed care organizations so that clients can make informed choices and the Department can establish standards of access and quality that are implemented in our purchasing contracts.

This report illustrates our efforts to bring accountability to the health care provided to public clients. The report highlights a variety of specific measures used to assess care, including client satisfaction, quality of care, access, availability and outcomes. Overall, participating managed health care organizations have made progress toward meeting targeted care and service goals. There are still areas for improvement. We believe that in cooperation with our health care partners we will successfully meet our goals.

Mary Kennedy, Assistant Commissioner, Medicaid Director
Health Care Administration, Department of Human Services

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Patient Protections

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A Comparison of Current Minnesota Enrollee Protections with the Proposed Federal Consumer Bill of Rights.*

Proposed Federal Consumer Bill of Rights and Responsibilities	Patient Protections in Minnesota Law *including* the Patient Protection Act of 1997 (PPA)
Information must be disclosed concerning health plan benefits, health professional credentials and health care facilities.	Health plan evidence or certificate of coverage must disclose information concerning health plan benefits. PPA requires disclosure of provider reimbursement methodologies used.
Provider network must be adequate to assure that all health care services are accessible without unreasonable delay.	HMO access rules require that health services are available based upon set standards for time and distance.
Access to qualified specialists for women's health services is required.	Minnesota Statutes § 62Q.52 (1997) require direct access to obstetricians and gynecologists in the enrollee's network.
Access to specialists when necessary and documented on an approved treatment plan.	Minnesota Statutes § 62Q.58 (1997) PPA and the HMO access rules require that a health plan provide access to specialty care.
Transitional care when patients with chronic conditions involuntarily change health plans.	Minnesota Statutes § 62Q.56 (1997) PPA and the HMO access rules require health plans to have a written plan to provide for continuity of care in the event of a provider's contract terminating or an employer changing health plans.
Access to emergency services requiring "prudent layperson" standard for payment determinations.	Minnesota Statutes § 62Q.55 (1997) PPA and HMO access rules require a "reasonable layperson" standard for payment determinations.
Participation in treatment decisions.	Minnesota Statutes § 62D.07, subd.3, the HMO Enrollee Bill of Rights, provides HMO enrollees the right to information about health problems, treatment alternatives, and risks of treatment.
Disclosure of provider compensation arrangements and ownership interests that might influence treatment decisions.	Minnesota Statutes § 62J.72 (1997) PPA require disclosure of a general description (and a specific description upon request), of reimbursement methodologies used by the health plans that provide an incentive to limit or restrict health care.
Ensure that provider contracts do not contain clauses that restrict a provider's ability to communicate with patients about treatment options.	Minnesota Statutes § 62J.71 (1997) PPA prohibit contracts that prevent health care providers from communicating appropriately with enrollees about health status, treatment options, or financial arrangements.
Prohibits plans from retaliating against a provider who advocates for a patient.	Minnesota Statutes § 62J.71 (1997) PPA prohibit health plans from taking retaliatory action against a provider who discloses accurate information regarding coverage or expresses disagreement with a health plan's treatment decision.
Consumers have a right to respectful care and without discrimination.	Minnesota has no similar provision.
Consumers have a right to confidentiality of individually identifiable health information and a right to copy their own medical records. Health plans have right to use patient data without written consent for health purposes only.	Minnesota Statutes § 62D.07, subd.3, the HMO Enrollee Bill of Rights and Minnesota Statutes § 144.335 provide for confidentiality of and patient access to their health records, release with written consent and penalties for the release of health records without consent or for unlawful purposes.
Complaint and appeal process that includes external review.	Minnesota Statutes § 62D.11 and HMO rules provide a complaint and appeal process with external arbitration. A Work Group established by Minn. Laws 1997, Ch. 237, § 20, is currently meeting to make recommendations for a uniform complaint process with external appeal mechanisms.

*Prepared by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry

Overall Satisfaction

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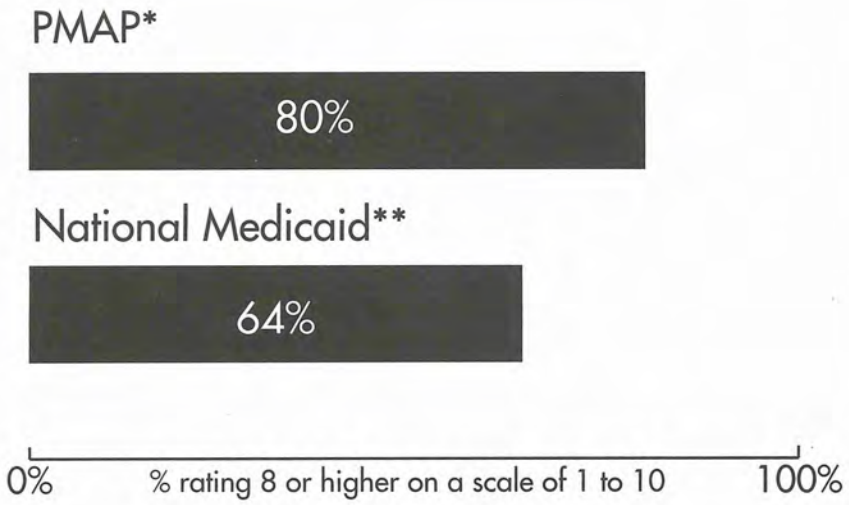
Overall satisfaction with health care

The majority of PMAP members rate their health care highly. The rating is substantially higher than the national average.

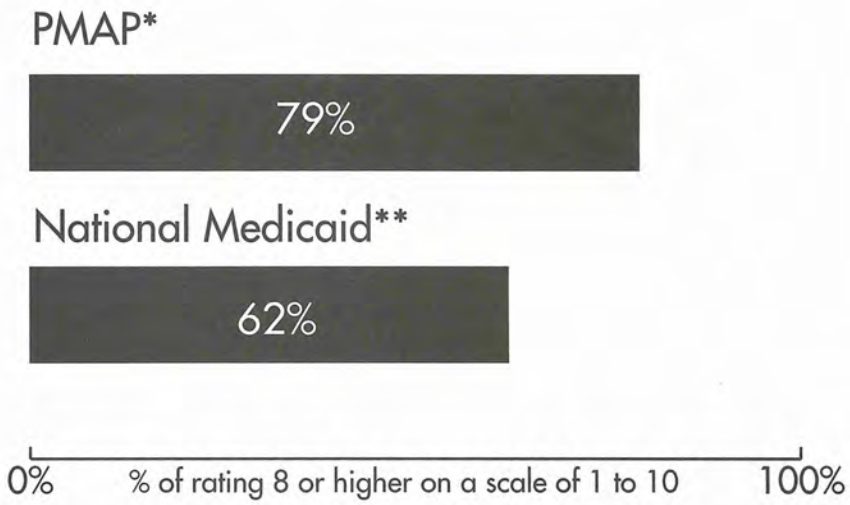


* 1997 Minnesota Medicaid and MinnesotaCare Managed Care Member Satisfaction Survey, Minnesota Department of Human Services and Minnesota Health Data Institute. 1997.

** National CAHPS Benchmarking Database (NCBD), Quality Measurement Advisory Service (QMAS) and The Picker Institute.

Overall satisfaction with health plans

PMAP members are also quite satisfied with their health plans and give ratings that outstrip the national average.



* 1997 Minnesota Medicaid and MinnesotaCare Managed Care Member Satisfaction Survey, Minnesota Department of Human Services and Minnesota Health Data Institute. 1997.

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Access: Availability of Doctors

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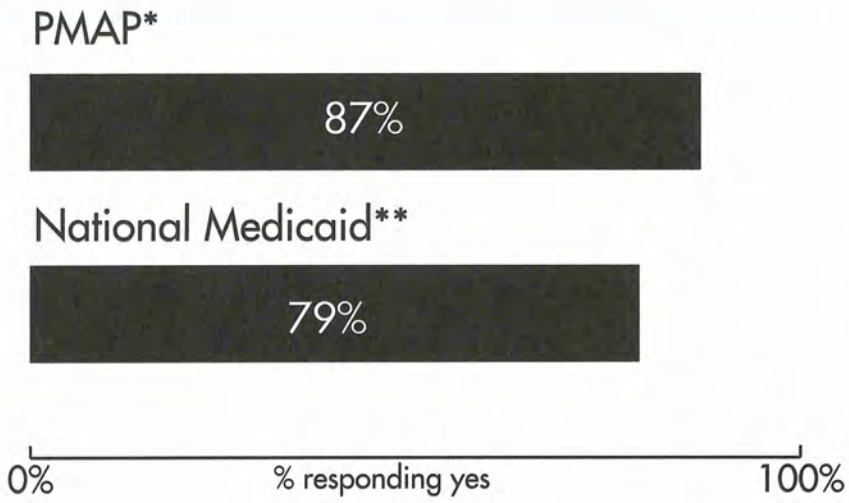
Ease of finding a personal doctor

Nearly nine in ten PMAP members report that it is easy to find an acceptable personal doctor. This rate is higher than the national average.



* 1997 Minnesota Medicaid and MinnesotaCare Managed Care Member Satisfaction Survey, Minnesota Department of Human Services and Minnesota Health Data Institute. 1997.

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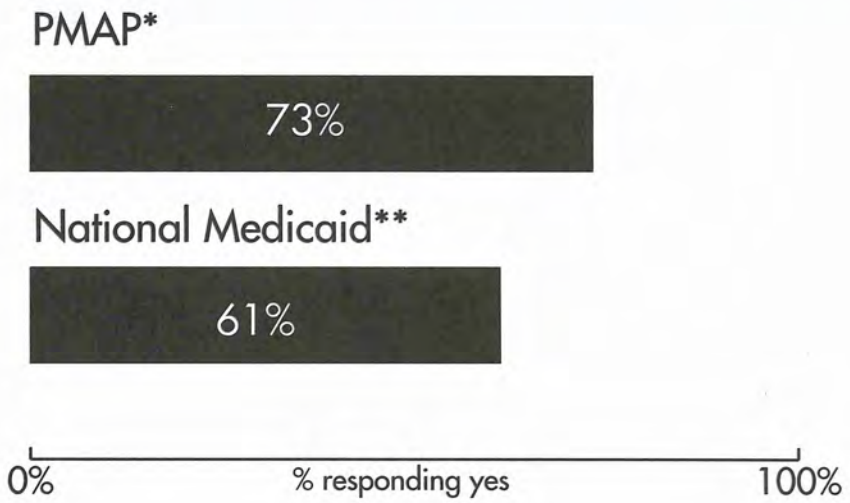
Ease of getting a referral

Nearly three-quarters of PMAP members find it easy to get a referral to a specialist. This rate is higher than the national average.



* 1997 Minnesota Medicaid and MinnesotaCare Managed Care Member Satisfaction Survey, Minnesota Department of Human Services and Minnesota Health Data Institute. 1997.

** National CAHPS Benchmarking Database (NCBD), Quality Measurement Advisory Service (QMAS) and The Picker Institute.

Access: Getting Care

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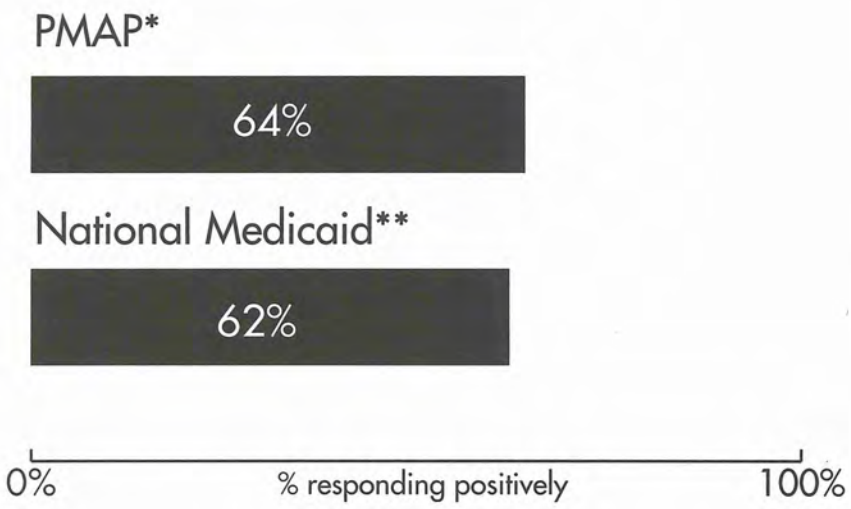
Getting care

Almost two-thirds of PMAP members report that it is easy to get the care they need. This rate is slightly higher than the national average.

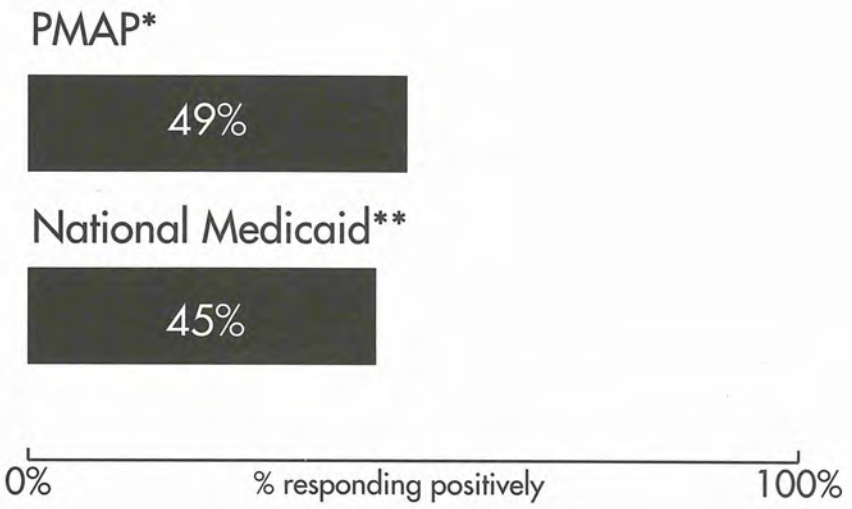


* 1997 Minnesota Medicaid and MinnesotaCare Managed Care Member Satisfaction Survey, Minnesota Department of Human Services and Minnesota Health Data Institute. 1997.

** National CAHPS Benchmarking Database (NCBD), Quality Measurement Advisory Service (QMAS) and The Picker Institute.

Getting care without long waits

About half of PMAP members get the care they need without long waits. This rate is somewhat higher than the national average.



* 1997 Minnesota Medicaid and MinnesotaCare Managed Care Member Satisfaction Survey, Minnesota Department of Human Services and Minnesota Health Data Institute. 1997.

** National CAHPS Benchmarking Database (NCBD), Quality Measurement Advisory Service (QMAS) and The Picker Institute.

Ratings of Doctors

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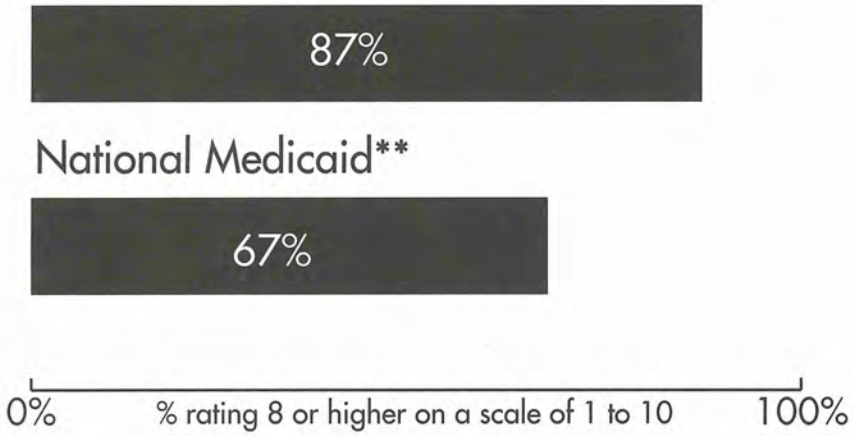
Rating of personal doctor

PMAP members give high marks to their personal doctor. These marks are substantially higher than the national Medicaid average.



* 1997 Minnesota Medicaid and MinnesotaCare Managed Care Member Satisfaction Survey, Minnesota Department of Human Services and Minnesota Health Data Institute. 1997.

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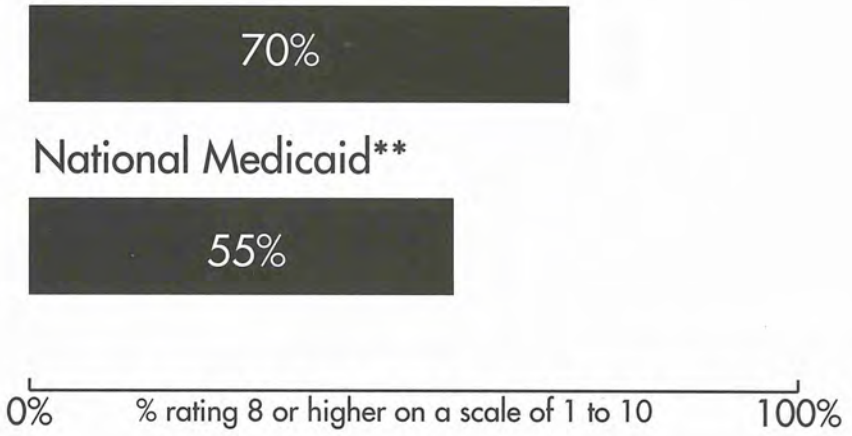
Rating of specialists

PMAP members are more likely than their national Medicaid counterparts to rate their specialists highly.



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Experiences with Medical Staff

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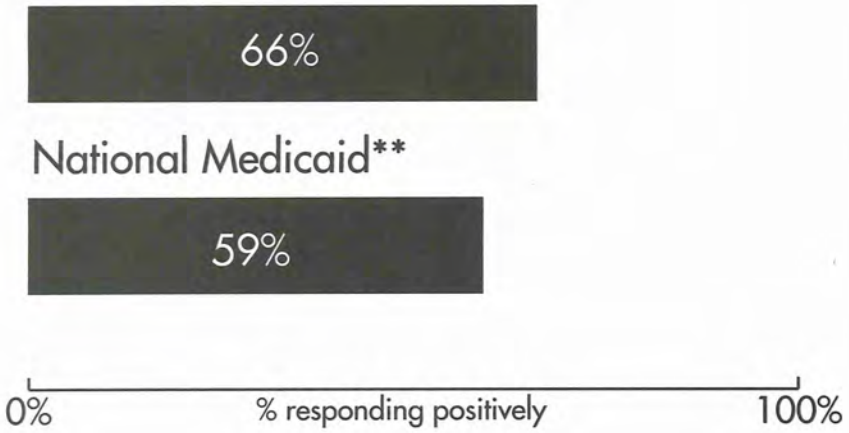
Doctors who communicate

PMAP members are more likely than their national counterparts to report that their doctors communicate well.

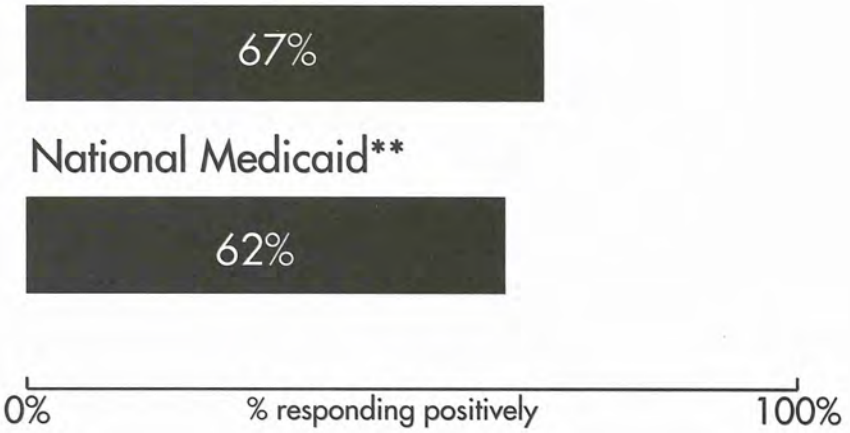


* 1997 Minnesota Medicaid and MinnesotaCare Managed Care Member Satisfaction Survey, Minnesota Department of Human Services and Minnesota Health Data Institute. 1997.

** National CAHPS Benchmarking Database (NCBD), Quality Measurement Advisory Service (QMAS) and The Picker Institute.

Courteous and helpful office staff

About two-thirds of PMAP members report that office staff were courteous and helpful; this proportion is higher than the national average.



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Women's Health

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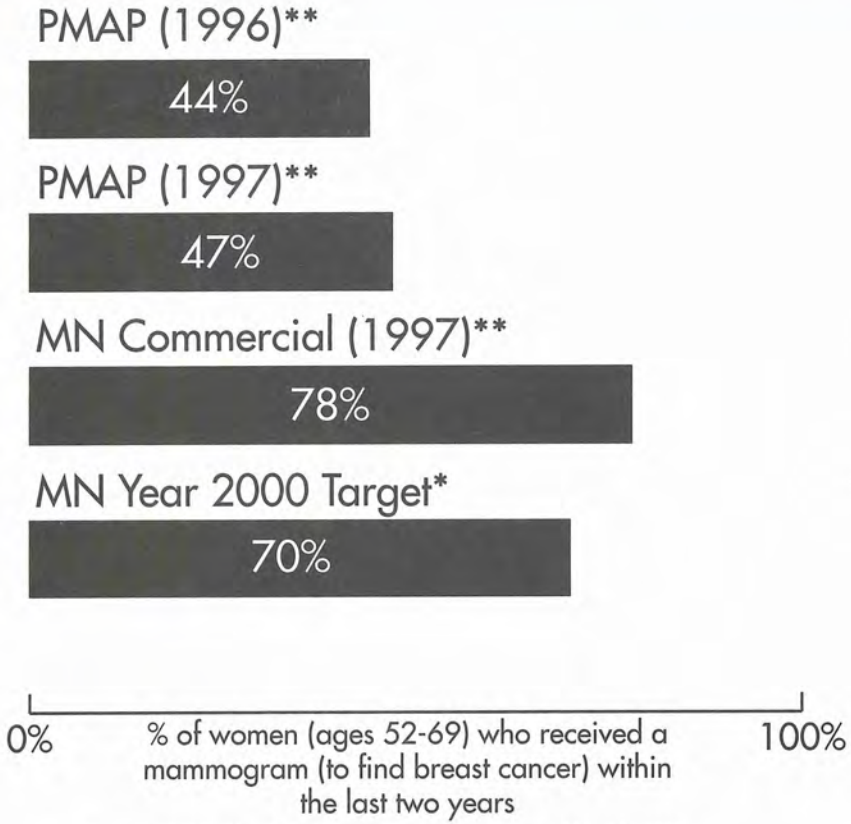
Breast cancer screening

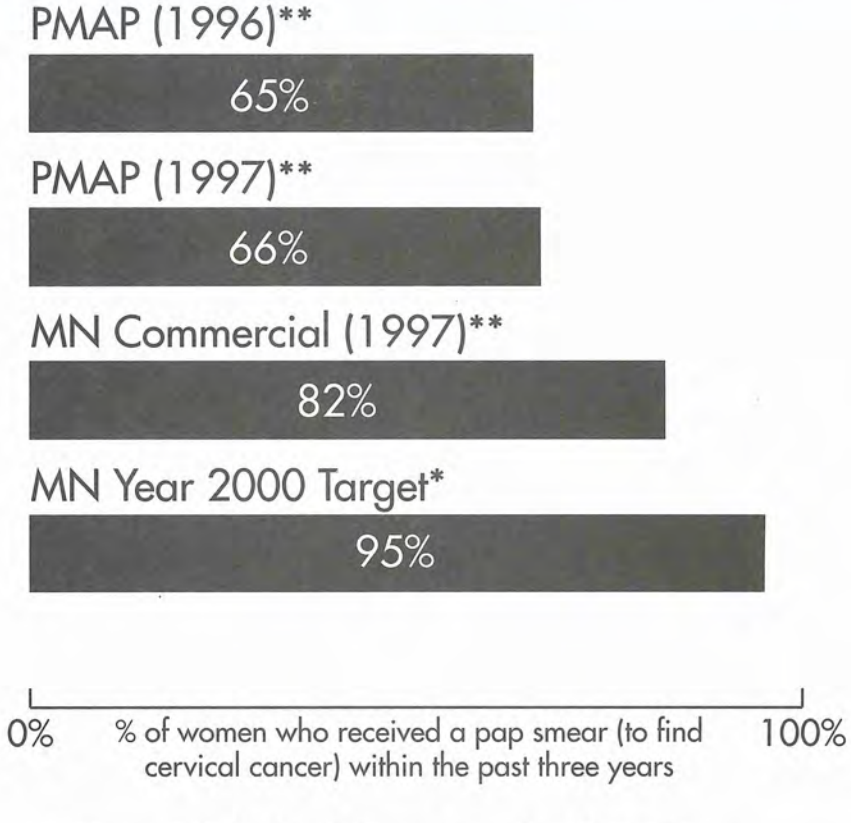
Although the PMAP rate of screening for breast cancer falls below both the rate attained in the commercial managed care population and the Minnesota Year 2000 objective, it did improve somewhat between 1996 and 1997.



* Minnesota Public Health Goals, Minnesota Department of Health, 1995.
** Healthplan Employer Data Information Set (HEDIS), Minnesota Department of Health. 1996 and 1997.

Cervical cancer screening

PMAP cervical cancer screening rates fall below the rate attained in the commercial managed care population and the Minnesota Year 2000 objective.



* Minnesota Public Health Goals, Minnesota Department of Health, 1995.
** Healthplan Employer Data Information Set (HEDIS), Minnesota Department of Health. 1996 and 1997.

Perinatal Care

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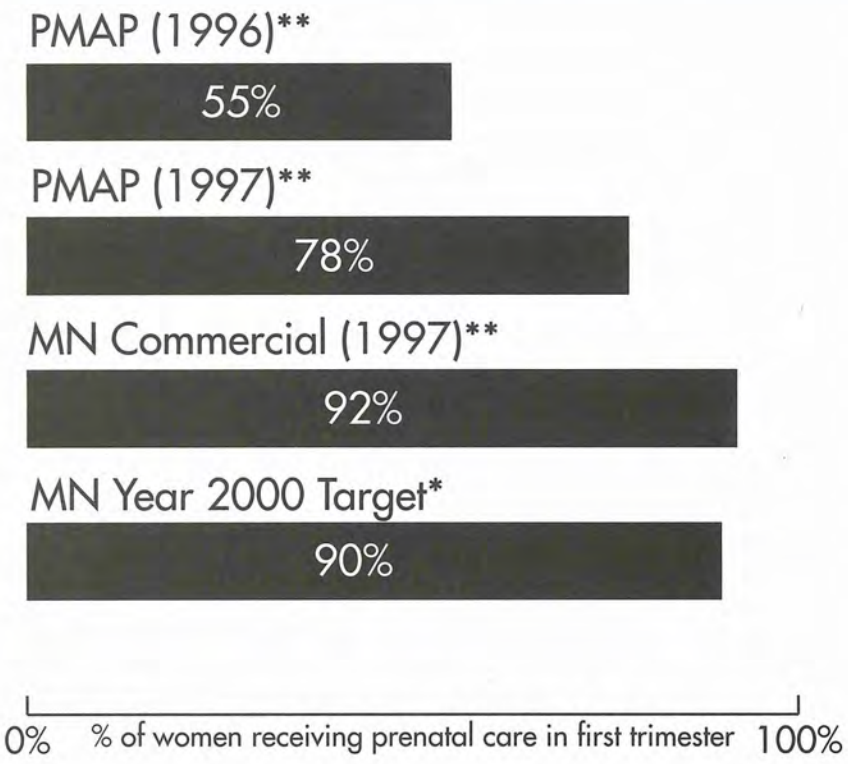
Prenatal care in first trimester

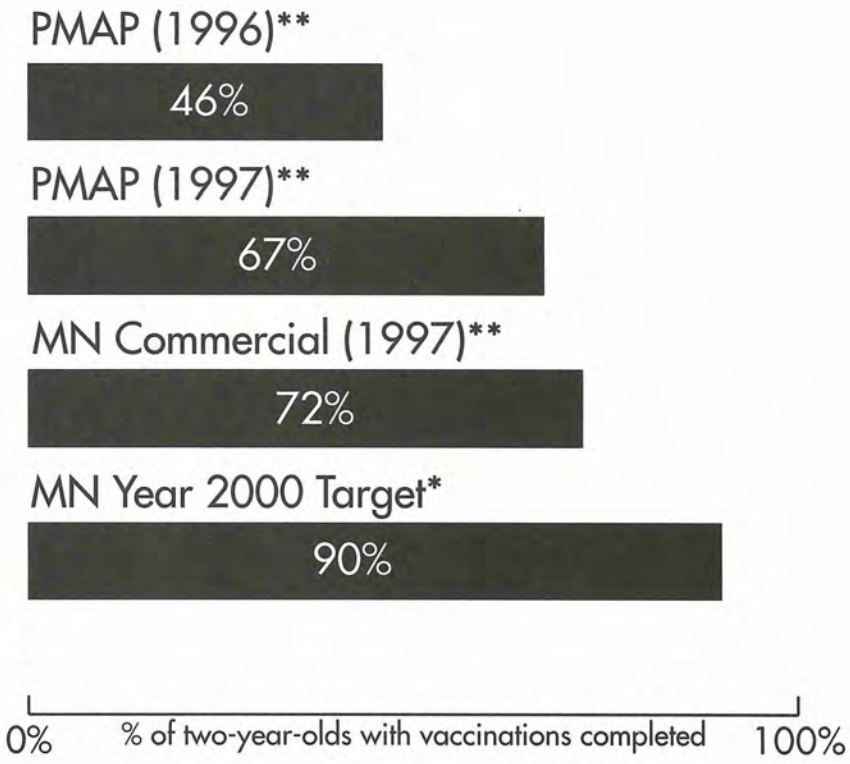
While the PMAP rate falls below the commercial managed care rate and the Minnesota Year 2000 objective, the percentage of PMAP women seeking prenatal care in the first trimester increased substantially between 1996 and 1997.



* Minnesota Public Health Goals, Minnesota Department of Health, 1995
** Healthplan Employer Data Information Set (HEDIS), Minnesota Department of Health. 1996 and 1997.

Childhood immunization

While the PMAP rate of childhood immunization falls below the Minnesota year 2000 objective, it is close to the commercial managed care average and increased substantially in just a one-year period.



* Minnesota Public Health Goals, Minnesota Department of Health, 1995
** Healthplan Employer Data Information Set (HEDIS), Minnesota Department of Health. 1996 and 1997.

Birth Outcomes

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Birth weight

While the PMAP percentage of low birth weight babies (<2500 grams) is higher than the Minnesota year 2000 objective, the rate of delivery of very low birth weight babies (<1500 grams) in PMAP already meets the Minnesota year 2004 objective of 1%.

Low birth weight babies

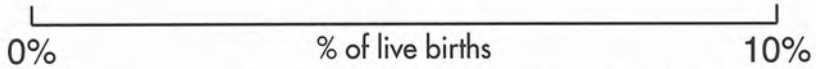
PMAP (1996)**

MN Year 2000 Target*

Very low birth weight babies

PMAP (1996)**

MN Year 2004 Target***



* Minnesota Public Health Goals, Minnesota Department of Health, 1995
** Perinatal Care Study, Minnesota Department of Human Services, 1997
*** Healthy Minnesotans Public Health Improvement Goals 2004, Minnesota Department of Health, 1998

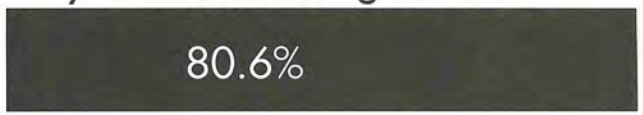
Low birth weight babies delivered at facilities for high-risk deliveries and neonates

The PMAP percentage of low or very low birth weight deliveries at appropriate facilities approaches the Minnesota year 2004 target.

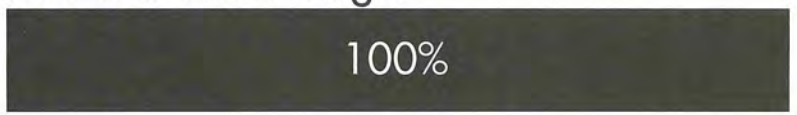
PMAP births at special facilities (1996)

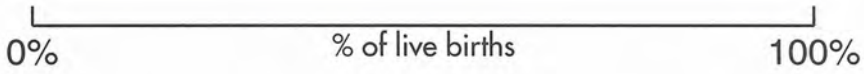
Low Birth Weight**

Very Low Birth Weight**



MN Year 2004 Target*





* Healthy Minnesotans Public Health Improvement Goals 2004, Minnesota Department of Health, 1998
** Perinatal Care Study, Minnesota Department of Human Services, 1997

Dental Care

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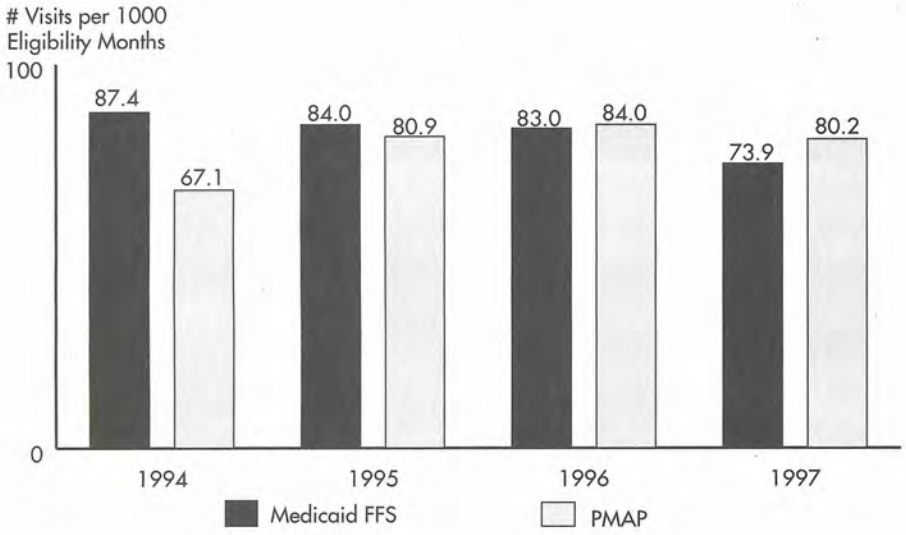
Dental services

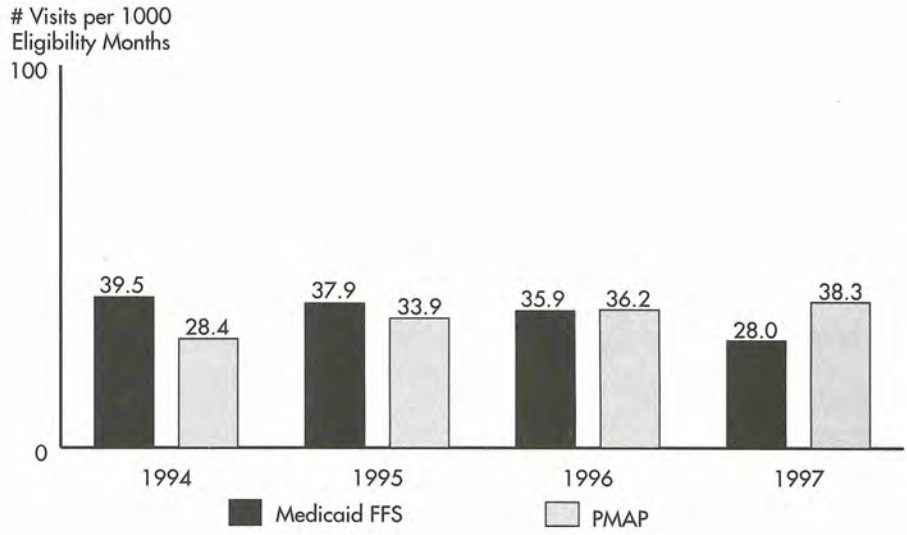
The following graph shows that dental services (diagnostic, preventive, and treatment) provided by managed care programs were well below that of fee-for-service in 1994. However, the performance of fee-for-service declined, while the performance of managed care improved. In 1997, managed care performed better than fee-for-service.



NOTE: (1) 1994 figures are based on the third and fourth quarters.
(2) Fee-for-service figures are based on a sample of fee-for-service eligibles that excludes those groups of persons categorically excluded from managed care.
(3) Managed care figures are based only on those plans that reported services for the year. HealthPartners has not yet reported services for 1996 and 1997.

Preventive dental services

Preventive dental services include fluoride treatment, nutritional counseling, tobacco counseling, oral hygiene instruction, dental prophylaxis, and space maintenance. The following graph shows that the performance of managed care has consistently improved, while the performance of fee-for-service declined, reversing the initial advantage of fee-for-service.



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Future Projects

Current Studies
(to be completed 1999)

Adult Diabetes (AD)

Diabetes is among the leading causes of death in Minnesota and a major cause of blindness and kidney failure. The purpose of the AD study is to assess the quality of health care delivered to individuals with this condition who are enrolled in DHS health care programs. Enrollee health behaviors, understanding of diabetes, and satisfaction with care are being assessed by a mail survey. Outcomes of care, use of services, and adherence to disease management guidelines are being assessed by medical record review and claims data analysis. Results of the study will be used to identify opportunities to improve the care provided to enrollees with diabetes by participating health plans.

Urinary Incontinence (UI)

This disease process has significant impact on the quality of life of enrollees living in both the community and institutional settings. Agency for Health Care Policy and Research guidelines will be used to assess the prevalence, management and treatment of UI in the 65-and-older Minnesota Senior Health Options (MSHO) and PMAP populations. Study findings will provide a basis for a cooperative effort between DHS and participating health plans to identify areas of needed improvement in the care and management of urinary incontinence.

Future Studies
(to be completed 2000)

Child & Teen Checkups (C&TC)

The C&TC program provides comprehensive health care to children under age 21. It is designed to discover and treat health problems in early stages. C&TC participation rates have inexplicably declined under managed care. The C&TC study explores possible explanations for this decrease. Study results will be used to identify mechanisms for maximizing provider and enrollee participation in the program.

Mental Health Treatment Needs Assessment

Assessing the adequacy of mental health care is complicated by a lack of information concerning the need for and utilization of services by enrolled populations. The treatment needs assessment will compare enrollees receiving treatment with those who need it but either do not seek it or do not receive it. Findings will be used to identify existing gaps in service availability, utilization and need. Barriers to treatment will also be identified. This information will help plans allocate resources and direct program planning efforts to increase enrollees' ability to obtain appropriate mental health care.