PROBLEMS WITH QUALITY MONITORING FOR MEDICAID MANAGED CARE: PERCEPTIONS OF INSTITUTIONAL AND PRIVATE PROVIDERS IN NEW YORK CITY*

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ABSTRACT

The study objective was to examine quality oversight efforts by Medicaid managed care organizations (MCOs) for children in a sample of ambulatory care institutions and private practices in New York City. This was a cross-sectional study of quality assurance priorities and strategies of MCOs and their impact date in institutions in New York City. Data were from structured interviews administered in 1997 to medical directors in the eight largest MCOs; and medical directors, heads of ambulatory pediatrics, and institutional pediatricians in a random sample of 15 institutions and 20 private office-based providers. Medical directors in MCOs reported that their main priority areas were the preventive care measures (e.g., immunization and lead screening) that they must report to the state. Knowledge of these MCO priority areas and monitoring activities was high for medical directors in the random sample, but decreased from these medical directors to heads of ambulatory pediatrics to institutional pediatricians, with the differences between the medical directors and institutional pediatricians significant ($P < .05$). However, 96% of the institutional pediatricians reported knowing their own institution's priorities and monitoring activities. In

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contrast, most private pediatricians reported they knew MCO priorities and monitoring activities (80%). Less than 33% of any group reported activities as "very effective" or felt any incentive to improve performance. There was a high level of overlap in provider networks, with institutions and private providers having children in many MCOs, and MCOs having children in many sites.

Conclusions. The current model of quality oversight is producing reports for the state, but is not translating into effective strategies at the provider level. The need to work through the leadership in institutions to influence quality is highlighted. The level of overlap in provider networks suggests the need for collaboration among MCOs in quality monitoring.

KEY WORDS Institutional providers, Medicaid managed care, Monitoring, Quality.

INTRODUCTION

Nationwide, the movement of Medicaid beneficiaries into managed care is progressing rapidly. By 1999, 17.8 million Medicaid recipients were enrolled in managed care, which was 56% of all recipients and 2.5 times the proportion enrolled 5 years earlier.¹ In New York City, the number of Medicaid recipients in managed care grew from approximately 100,000 to over 400,000 between 1993 and 1996 and has remained just under 400,000 from 1997 to 2000, or more than a quarter of all eligible individuals² (including 50,000 in a mandatory enrollment demonstration program in Brooklyn). Implementation of mandatory Medicaid managed care under a Section 1115 waiver began in New York City in July 1999 after the completion of the federal readiness review³; enrollment in managed care was voluntary before that time.

The reliance on managed care brought with it new opportunities and challenges for states in ensuring the quality of care provided to low-income children.^{4,5} States have responded in a variety of ways, most commonly by collecting data from managed care organizations (MCOs) on delivery of well child and preventive services, especially immunizations, and by imposing a wide range of other requirements and standards on MCOs.⁶ New York collects data on a series of measures designed to examine managed care performance in several key areas. The measures, which New York State calls the Quality Assurance Reporting Requirements (QARR), are adopted largely from the Health Plan Employer Data and Information Set (HEDIS) of the National Committee for Quality Assurance (NCQA)⁷ with New York-specific measures added to address public health issues of particular significance in New York State, such as lead screening of children.⁸ Since 1994, the State Department of Health has issued an annual report summarizing QARR measures for each MCO and recently started publishing a health plan report card for use by consumers.

Within this broad framework, MCOs have latitude to adopt their own corpo-

rate strategies for ensuring that quality standards are met and for setting priorities for quality improvement. While data collection around HEDIS/QARR performance indicators planwide is required, MCOs have latitude to monitor performance of individual providers and devise their own strategies for encouraging performance improvements.⁹ The state expects that, by collecting data from MCOs and attempting to compare their performance, MCOs will have incentive to design and implement interventions that will improve the quality of care. It is implied that, because MCOs enter into contracts with participating physicians, MCOs will have the legal and organizational ability to ensure compliance with the quality-of-care directives they issue.

This monitoring strategy is most appropriate for markets in which the majority of Medicaid recipients are enrolled in a small number of MCOs, each with a distinct, nonoverlapping provider network of individual physicians serving predominantly Medicaid patients and contracting directly with the MCO. In this type of environment, a performance measurement based on a sample or the universe of members from within the MCOs' provider network will be within the influence of the MCO. However, this monitoring strategy may be less well suited to markets characterized by a large number of MCOs with overlapping provider networks comprised not only of individual physicians, but also of ambulatory care institutions, which act as organizational and financial intermediaries between the MCO and individual physicians.¹⁰

The New York City Medicaid managed care program represents such a market and offers an opportunity to understand how MCOs attempt to influence and monitor the quality of pediatric care provided by physicians practicing in both private offices and ambulatory care institutions, such as neighborhood health centers and hospital outpatient clinics, where it is estimated that approximately half of New York City children receive their primary care.¹¹ Previous studies have focused almost exclusively on the relationship between MCOs and individual office-based physicians.¹²⁻¹⁴ However, less is known about potential differences in the abilities of MCOs to exert control over physicians under direct contract and over those employed by health care institutions of varying size, complexity, and mission. Little is known, in addition, about differences in corporate quality assurance strategies among MCOs serving poor children in New York City and the effect of these at the institutional and private provider levels.

This study describes the quality assurance priorities and strategies for the eight largest Medicaid managed care plans in New York City in 1997, presents the response of a representative sample of institutions and private office-based practices, and considers more generally the impact of Medicaid managed

care on health care in these institutions in comparison to its impact in private settings.

METHODS

This was a cross-sectional study of the quality assurance priorities and strategies of MCOs and their impact to date in institutions in New York City. It relies on structured interview data from medical directors in the eight largest managed care plans in New York City and from medical directors, heads of ambulatory pediatrics, and pediatricians in 15 institutions and 20 private office-based providers in New York City.

SELECTION OF MANAGED CARE ORGANIZATIONS, INSTITUTIONS, AND PROVIDERS

As of July 1997, although 22 managed care plans were approved to enroll Medicaid children in New York City, the eight largest MCOs together accounted for over 80% of the enrollment.¹⁵ These eight MCOs were included in this study. Consistent with the Medicaid emphasis, five of these MCOs were not for profit, four were provider sponsored, and only three had any commercial patients. At the time of the study, three were composed primarily of private practitioners in group or solo practice, three were center based, and two were hospital or center based. All eight had been established before 1992. Within each plan, the medical director was interviewed; in some cases, the medical director asked the director of quality assurance of the MCO to sit in on the interview.

The sampling frame consisted of institutions and private providers serving low-income children. For institutions, the sampling frame consisted of all municipal hospitals, voluntary hospitals, and neighborhood health centers located in neighborhoods where at least 40% of the population under age 15 was enrolled in Medicaid.¹⁶ There were 50 institutions included: 11 municipal hospitals, 13 voluntary hospitals, and 26 neighborhood health care centers (6 of which were municipal diagnostic and treatment centers). Within this universe, institutions were selected randomly proportional to the size of their pediatric population, with estimated volume of immunizations given as a measure of size, so that larger institutions were more likely to be chosen. Selection of 15 institutions was made: 6 municipal hospitals, 4 voluntary hospitals, 3 municipal diagnostic and treatment centers, and 2 nonmunicipal neighborhood health centers.

In each institution, the medical director and head of ambulatory pediatrics were included automatically for interviews; two attending physicians were selected randomly from each hospital and one from each center. All selected respondents agreed to be interviewed. In two cases, the medical director was also the head of ambulatory pediatrics and was counted only once. The final sample

included 15 medical directors, 13 heads of ambulatory pediatrics, and 25 attending pediatricians.

Private physicians were selected randomly from lists of physicians who participated in the Vaccines for Children (VFC) program. Because this program provides free vaccines and a substantially enhanced Medicaid administrative fee of \$17.85 for eligible children is used, virtually all the providers serving the Medicaid population participate in VFC.¹⁷ The New York City Department of Health puts considerable effort into finding physicians who might be VFC eligible, and the list compiled is an exhaustive one, with specialists as well as primary care physicians and physicians who are no longer practicing included. Physicians on the list were eliminated from the sampling pool if they had retired (13), could not be located (29), or were specialists who did not give primary care services or physicians who saw very few children (16). Another study sponsored by the Department of Health was ongoing in the same population to stimulate better immunization practices. The physicians participating in this study ($n = 56$) were also eliminated from the pool because we felt that the presence of immunization incentives would contaminate the results. Physicians participating in that study were selected randomly, and thus their elimination should not bias the remaining pool. The remaining pool was comprised of 131 VFC-participating physicians; 71 were selected randomly, and multiple attempts were made to contact them. Of those physicians, 42 selected were eliminated because they only accepted fee-for-service patients (21) or had fewer than 50 Medicaid managed care patients aged 2 years or less (21). Of the remaining 29 physicians, 20 agreed to participate (response rate 69%). The final sample included 12 pediatricians, 2 family practitioners, and 6 with missing designations. Of the sample, 75% were board certified, and another 15% were board eligible.

DATA COLLECTION

Interviews were conducted in person using a questionnaire that included both open- and close-ended questions. Interviews in the eight largest managed care plans took place between January and April 1997, with the exception of one plan, with an interview that was delayed until August 1997 at the plan's request to provide additional information about the study. All interviews at institutions took place between May and August 1997, with the exception of interviews at one hospital. (This hospital requested a delay in interviewing, which we honored; interviews in this hospital took place in April 1998.) Interviews at private practices took place between December 1997 and July 1998.

Interview instruments were designed to learn about corporate quality assur-

ance priorities and strategies at the MCO level and response or level of awareness to these at the provider level. Interview instruments at the plan level asked about pediatric quality of care priorities, the corporate quality assurance strategies for monitoring performance and encouraging performance in these areas, incentives/disincentives, and funding arrangements for primary care. Plans were asked specifically about the monitoring of the preventive care measures in the QARR, which is New York State's adaptation of the national HEDIS¹⁸ standards. New York State at that time had added three well child and preventive care reporting requirements to those specified in HEDIS 3.0 for children under 2 years old: lead screening, hemoglobin/hematocrit, and physical growth.¹⁹

Interviews with the medical director and head of ambulatory pediatrics at the institutions and pediatricians in both institutions and private settings asked about (1) the impact of managed care on clinical and administrative procedures, (2) knowledge of plan and institution priorities for pediatric quality of care, (3) awareness of corporate quality assurance strategies used to achieve goals, (4) provider incentives/disincentives to achieve quality objectives, and (5) effects of multiple plan enrollment on quality assurance and reimbursement. Medical directors were also asked to supply information on enrollment in Medicaid managed care from institutional databases.

ANALYSIS

Responses to the questionnaire were summed, and point estimates were calculated. Chi-square tests with a Mantel-Haenszel correction and Fisher exact tests were used to test differences in proportions.

RESULTS

KNOWLEDGE OF PRIORITY AREAS FOR PEDIATRIC CARE

Medical directors and quality assurance directors of the eight largest Medicaid managed care plans in New York City were asked to name quality-of-care priorities for enrolled children. Their main priority areas were the preventive care measures that they must report to the state as part of QARR, plus asthma. All (100%) named improving immunization coverage and improving asthma management as priorities. While fewer were able to name other QARR-reportable outcomes specifically, a full 75% said generally that QARR-reportable outcomes were priorities. Thus, although MCOs have the latitude to set performance goals beyond those required by QARR, they in fact were not doing this. MCOs further reported that they held providers responsible for the QARR-reportable preventive outcomes, while the MCOs took a more active role and responsibility in asthma

management. Thus, this report focuses exclusively on QARR variables and not asthma. MCOs further reported that they communicate their priorities to the leadership in institutions, usually to the medical director, and expect the leadership to communicate with relevant staff.

Respondents at institutions were asked in general if they believed they knew the pediatric quality-of-care priorities of the MCOs, without being asked to name specific items. Not surprisingly, belief that they knew plan priority areas decreased in descending order of the institutional hierarchy (Table, first row): Most of the medical directors (80%) and heads of ambulatory pediatrics (77%), but fewer than half of the pediatricians (48%) in hospital clinics and neighborhood health centers, believed that they knew the plan priority areas, with differences between medical directors and pediatricians reaching statistical significance ($P < .05$). However, despite not knowing plan priority areas, almost all of the pediatricians in institutions (96%) stated that they had a sense of their own institution's priority areas. Since MCOs generally were communicating with the leadership of an institution and relying on leadership to communicate with physicians on staff, individual pediatricians may have been aware of, and responding to, plan priority areas without knowing this as such. In contrast, most of the private office-based physicians (75%) believed they knew the managed care plan priority areas.

Because institutions or private physicians were affiliated with at least four MCOs (and many were affiliated with more), we asked if they were able to discern differences among priority areas for different MCOs. Almost all respondents in each of the levels reported seeing no difference (from 85% to 100%) in priority areas. Many respondents added that MCOs all had essentially the same priority areas, a belief consistent with the MCO medical directors' report.

ABILITY TO NAME PRIORITY AREAS FOR LARGEST MANAGED CARE ORGANIZATION

Medical directors, heads of ambulatory pediatrics, and institutional and private pediatricians then were asked to name the specific pediatric quality-of-care priorities of the largest MCOs in their institution or practice. The Table shows the percentage of respondents who could name specific priorities identified to us by the largest MCO in each institution (immunization, lead and anemia screening). Medical directors and private office-based providers were most able to name all three of the priority areas, with heads of ambulatory pediatrics and institutional pediatricians far less able to do so. Differences between medical directors and the institutional pediatricians were significant ($P < .05$) for all three priority areas, while differences between medical directors and heads of ambulatory pediatrics

TABLE Knowledge of Managed Care Organization (MCO) Priority Areas and Monitoring Activities

	Medical Directors (MD), N = 15, %	Heads of Ambulatory Pediatrics (HAP), n = 13, %	Institutional Pediatricians (IP), n = 25, %	Private Pediatricians (PP), n = 20, %	Differences, %			
					MD - HAP	MD - IP	MD - PP	IP - PP
Knowledge of plan and institutional priorities, belief that they knew								
MCO Priority Areas	80	77	48	75	+3	+32*	+5	-27
Institutional Priority Areas	—	92	96	—	—	—	—	—
Ability to name priority areas for largest MCO								
Immunization	93	69	52	75	+24	+41*	+18	-23
Lead	80	39	40	60	+41*	+40*	+20	-20
Anemia	73	39	40	60	+34	+33*	+13	-20
Knowledge of monitoring activities for largest MCO								
Immunization	80	46	44	80	+34	+36*	0	-36*
Other QARR	67	31	40	75	+36	+27	-8	-35*
Knowledge of monitoring activities for four largest MCOs and for the facility								
Largest MCO	87	69	48	85	+18	+39*	+2	-37*
2nd largest MCO	60	38	28	80	+22	+32*	-20	-52*
3rd largest MCO	47	31	28	50	+16	+19	-3	-22
4th largest MCO	33	31	24	35	+2	+9	-2	-11
Institution	—	100	96	—	—	—	—	—

*P < .05.

were significant ($P < .05$) for one area (lead screening) and showed a trend toward significance ($P < .1$) for the other two (immunization and anemia screening).

Knowledge of patient care priority areas of the institution's largest MCO decreased from medical director to head of ambulatory pediatrics to institutional physician, consistent with position in the institution and chain of communication from MCO to institution. The Table also shows that all respondent groups were best able to name immunization and, to a lesser extent, to name lead and anemia priorities of the dominant MCO. All respondents were best able to give the priority areas of the MCO with the largest enrollment and were less able to do so for the MCOs with smaller enrollments.

KNOWLEDGE OF PERFORMANCE MONITORING ACTIVITIES FOR LARGEST MANAGED CARE ORGANIZATION

To take the discussion beyond the simple knowledge of MCO-level patient care priority areas, questions were asked about actions taken by MCOs to monitor performance and to communicate results of the monitoring. Specifically, medical directors at the MCOs were asked how plans monitored performance and encouraged improvement. Follow-up questions were asked to determine whether respondents at various levels were familiar with the activities and how effective they were perceived to be.

Medical directors of the eight largest plans stated that they monitored performance for immunization coverage, lead screening, and the other QARR preventive measures through their administrative databases, supplemented with chart reviews. Administrative databases were thought to be incomplete; thus, information on performance was derived to a large extent from chart reviews. Medical directors reported that the MCOs encouraged improvement by feeding the results back to the sites.

Levels of familiarity with the monitoring activities of the largest MCO in each institution with regard to preventive screening measures followed previous trends (Table). In institutions, medical directors claimed the greatest knowledge of activities of the largest MCO, followed by heads of ambulatory pediatrics and institutional pediatricians. Private physicians were markedly more able to name quality-monitoring activities than institutional physicians ($P < .05$). Thus, for immunization, 80% of medical directors were familiar with the quality-monitoring activities, while only 46% of heads of ambulatory pediatrics and 44% of institutional pediatricians could name them. This is in contrast with private physicians, of whom 80% were able to name the monitoring activities for immunization. Levels of knowledge of monitoring were lower for the other QARR measures as

a group than for immunization, but the trend of declining familiarity from medical director to institutional pediatrician persisted.

KNOWLEDGE OF MONITORING ACTIVITIES FOR FOUR LARGEST MANAGED CARE ORGANIZATIONS

In keeping with their ability to identify priorities among MCOs, each group was most familiar with the activities of the largest plan with which they deal and was less familiar with each of the smaller plans. As shown in the Table, between the first and second largest plans, knowledge of quality-monitoring activities in institutions decreased by at least 20% in three of the groups, and the decrease continued for the third and fourth largest MCOs. For the largest plan, 87% of medical directors and 69% of heads of ambulatory pediatrics were familiar with the quality-monitoring activities. Yet, only 60% of medical directors and 38% of heads of ambulatory pediatrics were familiar with the monitoring activities of the second largest plan, a significant decrease ($P < .05$).

Within each plan, the pattern for naming priority areas was the same, with knowledge decreasing from medical directors to heads of ambulatory pediatrics to institutional physicians and with private physicians more aware than institutional physicians, significantly so for the first and second largest plans ($P < .05$). Heads of ambulatory pediatrics and institutional pediatricians were both far more familiar with the quality-monitoring activities of their own institution than they were with the quality monitoring of the largest plan (for heads of ambulatory pediatrics, 100% vs. 69%, $P < .05$; for institutional pediatricians, 96% vs. 48%, $P < .05$).

FEEDING BACK RESULTS OF PERFORMANCE MONITORING TO PROVIDERS

Because respondents at the plan level stated that they encouraged improvement in the priority areas by feeding the results back to institutions, we asked respondents at the sites whether they received the results of the performance monitoring, and if so, what they did with them. We asked about communication from the dominant MCO only. While 80% of the medical directors said they received results of monitoring for immunization from the institution's dominant MCO, only 67% thought they received results for other QARR priority areas. This is similar to results reported by private pediatricians; only 65% of private pediatricians stated they received feedback from their monitoring of both immunizations and other QARR by their largest MCO. Most Medical Directors in institutions communicated the results to staff in some manner (73% did so for immunization and 60% for other QARR measures), but the method of communication was limited to distribution at meetings or to physicians through the mail. Medical

directors at institutions said anecdotally that the samples were so small that the results were not meaningful, and they did not stress the results internally.

EFFECTIVENESS OF QUALITY ASSURANCE ACTIVITIES OF THE PLANS

None of the respondent groups believed that the quality assurance activities of the plans were having an impact: Less than one-third of any group reported activities as "very effective" for any of the QARR outcome variables. Furthermore, respondents at all levels reported that they felt few or no incentives or disincentives from managed care plans to improve performance. For the best known priority (immunization), only 33% of the medical directors, 8% of the heads of ambulatory pediatrics, 8% of the institutional pediatricians, and 10% of the private physicians felt an incentive from managed care plans to improve performance. However, for those that named one, the incentive named was always vague, such as a desire to practice good medicine. The largest proportion in all groups in institutions said they did not know whether or not incentives or disincentives were in place (medical directors 40%, heads of ambulatory pediatrics 46%, institutional pediatricians 52%), while the largest group of private office-based pediatricians were sure there were none (50%). No one reported feeling financial incentives for performance from MCOs.

As a final assessment of the effect of the quality assurance activities of MCOs on quality of care in institutions, heads of ambulatory pediatrics and both institutional and private pediatricians were asked whether they believed that the quality assurance standards and practices had changed in their institution due to the presence of Medicaid managed care. Most of the respondents in all groups said there had been no changes, or they did not know if there had been changes (92%, 80%, and 75%, respectively).

IMPACT OF MEDICAID MANAGED CARE ON CLINICAL AND ADMINISTRATIVE PRACTICES

Because we were not able to identify an impact in areas that plans themselves named as priority areas, we asked all respondents an open-ended question about what changes in clinical and administrative practice had come about due to managed care. Of note, approximately one-third of each group said that there had been little or no impact of managed care on clinical practices to date. Since the question was open ended, interviewees could give more than one response, and approximately two-thirds went on to cite at least some changes in clinical practices. Organizational changes to allow the same number of physicians to treat more patients were cited by nearly half the medical directors (47%) and heads of ambulatory pediatrics (46%) and by 60% of institutional pediatricians,

but by only 20% of private physicians. The specific organizational changes mentioned varied: Some respondents (primarily from municipal institutions) said that physicians were being asked to work extra clinic sessions with no additional compensation; others reported on steps to increase productivity, such as more efficient use of examining rooms and ensuring that the charts were in the clinic and laboratory results in the charts in time for the patient's visit. All these measures were cited as steps to minimize physician waiting time or physician time spent calling for laboratory results or charts so as to maximize patient contact time. Respondents in institutions generally attributed the emphasis on seeing more patients to the influence of managed care, but felt it was an institutional or municipal system priority as well.

There was more consistency among the respondents in both institutions and private practices as to the impact of Medicaid managed care on administrative practices, and the effects cited were negative. The most consistently cited administrative effect was that managed care created problems with referrals of patients to specialists (cited by 60% of medical directors, 77% of heads of ambulatory pediatrics, 68% of institutional physicians, and 90% of private physicians). Many respondents went on to explain that each MCO had a different referral form and its own network of specialists available to the child. Pediatricians had to know the child's MCO (something they are not accustomed to keeping in mind) so that they could fill out the correct form, and if the referral was to a named specialist, the referring pediatrician needed to verify that the specialist was in the MCO's network. Respondents most often cited this problem as an administrative issue because of the need to fill out forms properly. However, many went on to say that it is a clinical problem as well because the referral process was not functioning smoothly. Increased paperwork and administrative tasks was another impact of managed care cited by a little over half of the respondents in all groups (ranging from 52% to 65%).

PLAN DOMINANCE WITHIN INSTITUTIONS AND DISPERSION ACROSS SITES

The percentage of children on Medicaid enrolled in managed care averaged 26% among the institutions and private practices participating in the study, ranging from 6% to 48% for institutions and 2% to 90% for private practices. Each institution and private practice in the sample contracted with a minimum of four MCOs and some with many more. A number of respondents from the institutions indicated that they were contracting with as many plans as possible to maintain their pediatric patient base in the transition to managed care. Figure 1 shows plan dominance for institutions and private practices (keeping in mind that only

FIGURE 1 Medicaid managed care dominance in institutions and private practices. Data from interviews with medical directors ($n = 15$) and private physicians ($n = 20$).

one-quarter of the typical provider's Medicaid caseload was enrolled in managed care). As shown in this figure, about a quarter of the institutions and private practices (29% and 25%, respectively) had almost all (>90%) of their children in Medicaid managed care in one plan. Further, 65% of the institutions and 55% of the private practices had 70% or more of their children in Medicaid managed care in one plan. While these institutions and practices were dominated by one plan, the situation was more mixed for the remaining providers. In fact, 14% of the institutions and 15% of the private practices had fewer than half of their children in Medicaid managed care in the largest plan for that provider.

To affect quality of care for enrolled children, plans must influence the behavior of the providers seeing those children. This task is easier for a plan if enrolled children are concentrated in a few provider sites, and that plan is clearly dominant in the sites. It is more difficult if children are dispersed across many sites, and the concentration is low in the sites. Figure 2 shows the dispersion of children enrolled in the plans in our sample across institution and private practitioner sites. As shown in this figure, most plans had a few sites with a high proportion of children and many sites with few children. Taken together, the plans represented in the provider sites in our sample had 10 institutions and 11 private provider sites in which they were dominant (more than 70% of the children). However, the plans in our sample, taken together, had 28 institutions and 34 private provider sites with small proportions of children (fewer than 30%). This distribution of children over many sites has implications for logistics of monitoring, cost of monitoring, and level of influence a given plan can exert.

FIGURE 2 Dispersion of children across sites for managed care plans. Data from interviews with medical directors ($n = 15$) and private physicians ($n = 20$).

DISCUSSION

This study raises questions about the current model for ensuring quality of pediatric care in institutions in a managed care environment. The approach to quality monitoring of states regulation of MCOs (via contract standards and data reporting) and MCOs regulation of providers (via chart reviews and data feedback) may not be working. Respondents from both institutions and private practices in this study felt little impact from quality assurance standards and practices of MCOs, a fact that may be reflected in the actual performance on the indicators. As shown in the QARR reports from 1994 to 1998, the percentage of children in New York City immunized and screened for lead levels were low (61% and 71%, respectively, for 1998) and have remained stable for the last 3 years, after an initial rise of 10% between 1994 and 1996. The major influence of managed care, in the view of these respondents, was to spur efficiency improvements to accommodate increased patient volumes and to increase dramatically administrative and paperwork burdens. The limited impact on quality of care may be due to the fact that the study was conducted only 4 years after New York initiated its QARR reporting and during a time of relatively low penetration of Medicaid managed care. However, the limited perceived impact may also arise from the near-exclusive focus on MCOs as the vehicles of quality improvement and the insufficient attention paid to the role of institutions as intermediaries between MCOs and providers. Furthermore, the uncertainties of measuring qual-

ity in this environment of overlapping provider networks and limited enrollment tenure of Medicaid recipients suggests that states may need to reconsider their approach to quality.

INSTITUTIONS AS INTERMEDIARIES BETWEEN PLANS AND PROVIDERS

The approach of states in the regulation of MCOs and MCOs in the regulation of providers is based on a belief that MCOs exert a level of control over physicians that will allow them to accomplish quality goals. However, MCOs in New York and elsewhere do not contract directly with many of their network physicians. Rather, they often contract with community health centers, hospitals, and other institutions, which then oversee the performance of physicians. While the clinic leadership was aware of MCO priorities and quality monitoring, the pediatricians actually delivering care were not, and they did not feel incentives—financial or otherwise—from MCOs for performance, although they were aware acutely of institutional priorities, quality monitoring, and incentives. Even if institutional priorities had been influenced by managed care priorities, it is clear that pediatricians responded to institutional signals. If those signals are influenced by MCOs, it is less important for individual providers to be aware of MCO priorities as long as they are getting the message from their institution about what is needed. The lack of awareness, however, does highlight the need to work through the leadership of institutions to influence behavior at the provider level. Private pediatricians, on the other hand, contract directly with MCOs without institutional intermediaries, and this may contribute to their greater familiarity with MCO priority areas and quality assurance activities.

There has been scant attention in the literature to the role of institutions in quality oversight in a managed care environment. Yet, institutions in New York and elsewhere serve a significant share of the Medicaid population and are increasingly included in the managed care marketplace.²⁰ Furthermore, hospitals have been serving the Medicaid population much longer than MCOs have and, in New York, often have budgets far in excess of the budgets of most Medicaid managed care plans. The role that institutions play in this marketplace may increase in the future given the trend of commercial HMOs with their networks of private providers quitting the Medicaid market, leaving a larger share of this population to MCOs sponsored by hospitals and community health centers.²¹

PROBLEMS WITH MONITORING AND INFLUENCING PERFORMANCE

The findings of this study also raise questions about the strategy of the MCOs for monitoring and influencing performance at the provider level. The MCOs

studied here monitored provider performance by feeding back the results to providers from the same sample of children on which the QARR results were based. For most measures, these were based on a sample of 411 children (enrolled continuously for 12 months) planwide. While requirements permit MCOs to report performance of all members who meet the age and enrollment requirements using data in their own administrative databases, for the most part, MCOs did not do this. Instead, they reported performance on a systematic sample of children (usually 411) and relied heavily on chart reviews to augment the often-incomplete information in administrative databases.⁸ Feedback to providers consisted of notifying them of the performance of their children who happened to be drawn in the MCO-wide systematic sample of 411. However, because the 411 children were spread across numerous providers, the sample size drawn from any one site was too small for effective monitoring. Indeed, we found that most providers were not using the feedback reports that MCOs mentioned as the linchpin to their quality improvement efforts. Some providers specifically mentioned that the reports were not valid due to the small sample size. Given that states report increased reliance on provider feedback reports to ensure and improve quality,⁶ these limitations represent serious problems.

The overlapping networks, found in this study and substantiated by recent provider directories published by the New York City Department of Health,²³ also have implications for the viability of MCO-specific "report cards." It should be noted that New York State's quality monitoring and reporting is detailed and comprehensive and is considered a model for monitoring as it is conceived currently. (The Association for Health Services Research recognized the abstract from New York State entitled "The Quality Performance Matrix: New York State's Model for Targeting Quality Improvement in Managed Care Plans," which reported on the State's quality monitoring and reporting strategy, as best in the area "Quality: measuring, monitoring and improving quality of care.") The problem, then, is not with the implementation of the performance monitoring and reporting in New York, but with other factors. One of these factors is likely to be the lack of fit between the current strategy for monitoring and overlapping provider networks. Report cards constructed from MCOs with overlapping provider networks may not permit comparisons among MCOs because the performance of several MCOs may be based on samples of children from the same institution.²³

Quality measurement was hampered further by the limited enrollment tenure of Medicaid managed care beneficiaries.²⁴ In New York City at the time of this

study, approximately 5.8% of the total membership of MCOs was disenrolled each month, making it difficult to generate a large sample of continuously enrolled children.²⁵ Ironically, the children excluded from quality assurance sampling—those experiencing gaps in coverage—are probably at greatest risk for inappropriate or otherwise low-quality care.

NEED FOR NEW MODELS OF PERFORMANCE OVERSIGHT

In keeping with our observations, some authors are calling for the delegation of quality improvement activities to constituent provider groups and the exploration of collaborative approaches to quality improvement.^{26,27} The individual provider, not the MCO, provides the care. It is not realistic to expect each MCO to monitor performance of all providers who see MCO enrollees, especially with the large dispersion of enrollees across sites. Further, not only would this represent a burden to MCOs, but the provider is less likely to respond to an MCO that has a small proportion of the patients of the site. A provider-focused, rather than an MCO-focused, approach to quality may offer a more suitable framework for coordinating and reinforcing multiple activities (including those required of MCOs) aimed at improving care for a stable population of low-income children. Provider-oriented approaches can foster population-based medicine better and may yield more direct benefits to children remaining in the fee-for-service Medicaid, those served by other insurance programs (such as the State Child Health Insurance Program), and potentially those who remain uninsured. Collaborative activity among providers, MCOs, and states could also reduce the inefficiencies and intrusion caused by having many health plans ask for the same information.

LIMITATIONS

Limitations of this study include the fact that it relied on report and perceptions of respondents. Perceptions are useful, but not always accurate. Specifically, in this study, institutional pediatricians may not have been able to report the impact of managed care correctly because they perceived the impact as coming from the institution. Related to this, because the study did not examine the feedback from the MCOs, it was not possible to determine whether the problem was with feedback or perception and memory. A second limitation is that it was conducted during the voluntary phase of managed care and only 3 to 4 years after MCOs began reporting to the state. Results may be different after more time. Finally, it is a study of MCO impact in one environment: New York City. However, given that the features we describe in New York City exist elsewhere, we believe that the results have broad application.

CONCLUSIONS

This study has illustrated how quality is ensured in an environment in which multiple plans contract with multiple providers, many of which are ambulatory care institutions serving as intermediaries between MCOs and individual physicians. It suggests the need for collaboration among MCOs in quality monitoring, as well as the need to work through the leadership of institutions to achieve maximum gain.

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