External Quality Review: An Overview

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Introduction

Managed care promises to deliver more efficient health care by curbing or eliminating the fiscal incentives in the fee-for-service (FFS) system that reward providers for every test and procedure they perform. The most common managed care system replaces FFS with a capitated model, where managed care organizations (MCOs) receive a fixed per member/per month payment regardless of how many services an individual may require. This reverses the current FFS incentive structure and instead financially rewards managed care plans for providing *less* care. As a result, the delivery system needs to include robust mechanisms to monitor and evaluate care quality; otherwise, the structure of capitated managed care threatens to replace the "fiscal excess" of FFS with a system that leads to some plans denying or delaying medically necessary care to save money.

Congress addressed quality measurement when it passed legislation allowing Medicaid managed care. Part of the overall quality strategy mandated by the Medicaid Act and regulations requires states to include annual independent external quality reviews (EQRs) in each managed care contract.[1] This approach requires an independent organization to validate performance measures, conduct compliance reviews and otherwise evaluate the performance of Medicaid managed care plans. This issue brief reviews the EQR requirements, explores their strengths and shortcomings in current practices, and recommends several changes to strengthen the EQR process and improve transparency.

What is EQR?

EQR consists of an annual review and report analyzing the performance of each MCO, prepaid inpatient hospital plan (PIHP) or health insuring organization (HIO) that contracts with the state Medicaid agency. Since 2009, all managed care plans in the Children's Health Insurance Program (CHIP) must also conduct annual EQRs. Medicaid regulations detail the substance of the EQR.[2] States have considerable flexibility to

[1] Federal regulations require EQRs for Managed Care Organizations (MCOs), Prepaid Inpatient Hospital Plans (PIHPs), and Health Insurance Organizations (HIOs), as defined in 42 C.F.R. § 438.2. *See also* 42 U.S.C. § 1396u-2.
[2] 42 C.F.R. § 438 subpart E.

choose a reviewer (or to conduct the review themselves), identify required activities, and select applicable quality measures.

The managed care regulations require only three activities for any EQR:

1. The validation of state-required MCO performance improvement projects (PIPs) conducted in the review year;

2. The validation of state- and Centers for Medicare & Medicaid Services (CMS)-required performance measures; and

3. A review, conducted at least every third year, of the MCO's compliance with state and federal quality standards.[3]

A detailed set of protocols outline acceptable methodologies for conducting the required elements of EQR, but states have ample latitude even within these parameters to define performance measures and identify areas for PIPs.

States may also conduct optional EQR-related activities and receive federal matching funds. These optional activities include:

1. Validating MCO encounter data;

2. Administering or validating consumer or providers surveys of care quality;

3. Calculating additional performance measures beyond what the MCO must report;

4. Conducting PIPs in addition to MCO PIPs; and

5. Conducting point-in-time studies on aspects of specific clinical or nonclinical services.[4]

The state may conduct the EQR itself (as long as the reviewing department is not the Medicaid agency) or contract with a qualifying independent External Quality Review Organization (EQRO).[5] Strong financial incentives encourage the state to contract with an independent entity. If the state conducts its own review without an EQRO, the EQR qualifies for the Medicaid's standard 50% administrative Federal Medical Assistance Percentage (FMAP). However, if the state contracts with a qualified EQRO, it can receive enhanced FMAP covering 75% of the EQR costs.[6]

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[3] 42 C.F.R. § 438.358(b).
[4] 42 C.F.R. § 438.358(c).
[5] Certain state entities may qualify as EQROs if they have a governing board or similar entity comprised of no more than a minority of government employees, do not have Medicaid purchasing or managed care licensing authority, and satisfy the other conflict-of-interest requirements. *See below*, "What makes an EQRO?".
[6] 42 C.F.R. § 438.370.

As noted, federal regulations require an annual technical report that compares and evaluates the health plans subject to review based on the EQR activities specified by the state. The contracted EQRO prepares this report. If the state conducts its own EQR without an EQRO, it must still contract with an independent organization to draft the annual report.[7] The report must include the following components:

- A detailed explanation of the methodology for data collection, aggregation and analysis for each required EQR activity;
- an evaluation of plan performance with regard to quality, timeliness and access to care, including the conclusions drawn from data collected;
- recommendations for each plan to improve its quality performance; and
- an appraisal of how well each plan responded to recommendations for quality improvement in the prior year's report.[8]

States may also require the EQR to include methodologically appropriate data that allows for comparison across plans, but the regulations do not require a robust comparative framework. Compliance with required elements has also been a problem. A 2008 report from the U.S. Department of Health & Human Services' Office of Inspector General (OIG) found that over half the states contracting with EQROs received annual reports missing either required elements or information on the three mandatory EQR activities.[9]

What makes an EQRO?

To qualify as an EQRO, organizations must demonstrate competence and independence. Any number of different types of entities can qualify as EQROs, including university-affiliated institutes, for-profit healthcare consultants, and non-profit health care foundations.[10] Several organizations specialize in this field and contract with multiple states. In all, just 18 EQROs contract with the 40 states (including D.C.) that currently have EQR contracts.[11] The three largest EQROs – Health Services Advisory Group (HSAG), Island Peer Review Organization (IPRO), and Delmarva Healthcare

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[7] 42 C.F.R. § 438.350. *See also* U.S. Dep't of Health & Human Servs. ("HHS"), Ctr. for Medicare & Medicaid Servs. ("CMS"), *EQR Protocols Introduction Version 1.0*, 11 (Sept. 2012), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EQR-Protocols.zip.

[8] 42 C.F.R. § 438.364(a).

[9] HHS, Office Inspector Gen. ("OIG"), *External Quality Reviews in Medicaid Managed Care*, 11 (Jun. 2008), http://oig.hhs.gov/oei/reports/oei-01-06-00510.pdf.

[10] These diverse types of EQROs include foundations (Kansas Healthcare Foundation), universities (The Institute for Child Health Policy at the University of Florida), and corporations (Behavioral Health Concepts, Inc.) *See* Appendix A.

[11] *See* Appendix A.

Foundation – cover 25 states. According to its website, HSAG conducts EQR or EQR-like activities for 14 states, including California.[12] Appendix A provides a current list of EQROs. Other non-Medicaid state entities, such as universities, can qualify as EQROs provided they are structured to ensure independence. As of now, few states have pursued this option.[13]

Medicaid managed care regulations establish EQRO standards for both independence and organizational capacity and competence. The independence standards differ somewhat between state and non-state entities. Generally, no EQRO may review any MCO "where either the MCO or the EQRO 'exerts control' over the other" through stock ownership, options or debentures, voting trusts, common management, or contractual relationships.[15] Also, EQROs may not provide health care services to Medicaid beneficiaries generally, engage in ongoing quality oversight operations of MCO or PIHP services for the state outside of the EQR, or have another type of present, or known future, direct or indirect financial relationship with any MCO or PIHP it reviews. These restrictions apparently do not extend to other Medicaid-related activities or to activities performed for Medicaid agencies in other states. For example, Delmarva, a health foundation that conducts EQR activities for five states including the District of Columbia, also oversees utilization management review for the District. Telligen, the contracted EQRO for Iowa's managed care program, administers Oklahoma's Soonercare Health Management Program, a Medicaid service that provides health coaches for beneficiaries with chronic conditions. In addition to the above requirements, a state entity, such as a public university, can only qualify as an EQRO if it is governed by a Board or similar body with no more than minority membership by government employees.[16] Furthermore, the state entity may not have Medicaid purchasing or managed care licensing authority.

NOTE: Many EQROs perform various other duties for state Medicaid programs, including utilization review, functional assessments, and other quality review activities.[14] A state must verify that these other activities do not compromise the EQRO's independence for the purposes of External Quality Review.

Competence and capacity have presented ongoing problems that hinder the development of a robust external review process. The regulations generally require that EQROs have sufficient staff experienced in Medicaid policy and service delivery as well as quality assessment research design and methodologies.[17] States must also ensure that the contracted EQRO have adequate physical, technological and financial

[12] *Accreditations/Certifications*, Health Servs. Advisory Grp., http://www.hsag.com/about/accreditation.aspx (last visited May 23, 2014).
[13] One exception is Utah, where the Office of Health Statistics performs EQR for the Medicaid program. *See* Appendix A.
[14] These other quality review activities cannot include ongoing quality oversight of MCO or PIHP services for the state beyond the contracted EQR activities. *See* 42 C.F.R. § 438.354(c)(3).
[15] 42 C.F.R. § 438.354(c).
[16] *Id.*
[17] 42 C.F.R. § 438.354(b).

resources to complete the necessary activities. In practice, states have reported frustration with frequent EQRO staff turnover and a persistent need to offer technical support and training to assist contracted EQROs with their responsibilities.[18]

To assist the states, CMS issued revised EQR protocols in 2012 detailing the process and expectations for successful external quality review and posted an "EQR toolkit" along with other technical assistance documents on its website.[19] CMS also took steps to clarify the process by which states can avoid unnecessary duplication of EQR requirements by using comparable data collected during the MCO accreditation process or by Medicare.[20]

Transparency & Timeliness

The public availability of the annual EQR report(s), submitted to the state and usually to the CMS as well, varies widely across the states. Regulations require states to make reports available on request to interested parties, but do not require states to post the reports online.[21]

California has developed a robust website including years of EQR reports for each Medicaid MCO and County behavioral health plan as well as statewide reports that give a broader picture of quality.[22] California's two EQROs, Health Services Advisory Group (HSAG) and APS Healthcare CA, standardize their reports to facilitate comparisons between plans or measurement of changes in an individual plan over time. Other states with multiple years of easily accessible and well organized EQRO resources include Arizona, Colorado, Florida, and Minnesota (See Appendix A).

Other Medicaid programs conduct these external reviews with little fanfare, do not post them online and require consumers to submit formal requests to receive a copy. CMS has posted a database of states' EQR annual technical reports on its website, but this resource is far from comprehensive. As of this writing, the database includes only 28 reports from 17 states dating from 2011. CMS has posted 2013 reports from eight states.[23]

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[18] HHS OIG, *supra* note 9, at 11.
[19] *Quality of Care: External Quality Review (EQR)*, CMS, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html (last visited June 14, 2014).
[20] 42 C.F.R. § 438.360.
[21] 42 C.F.R. § 438.364(b).
[22] *Medi-Cal Managed Care - Quality Improvement & Performance Measurement Reports*, Cal. Dept. of Healthcare Servs., http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx (last visited May 25, 2014); *California EQRO Web Share Site*, caeqro.org, http://caeqro.com/webx/Reports%20and%20Presentations/ (last visited May 25, 2014).
[23] *External Quality Review Technical Reports*, CMS, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/External-Quality-Review-Technical-Reports.html (last visited June 2, 2014).

Another recurrent problem with EQR annual reports is timeliness. For example, in March 2014, Texas posted its *EQRO Summary of Activities and Trends in Healthcare Quality* – for contract year 2012.[25] The Medicaid and CHIP data analyzed in this report covered calendar years 2009 through the end of 2011.

CMS has nudged states to regularize the reporting process and synchronize with other managed care quality data reporting timetables. In its protocols, CMS now encourages states to require annual reports to be available by April for data collected within the prior 15 months, which aligns the EQR with other requirements to report managed care data to CMS.[26] While CMS' encouragement is a positive step, the fact that states are still issuing reports with significant delays indicates the need for stronger oversight.

D.C. EQR: Transparency in Progress

In May 2013, the District's Department of Health Care Financing issued a press release and posted its EQR annual report on-line for the first time. The report details the performance of the District's three MCOs on a number of Healthcare Effectiveness Data and Information Set (HEDIS®) measures and in so doing identifies a number of areas for improvement.[24] The experience of reading the report, however, emphasizes the opacity of the process. First, the report is posted only through a DHCF press release and is not readily accessible to an individual looking for quality-related data. Second, Delmarva (the EQRO) designates the MCOs by letter in every chart and table. The actual names of the corresponding MCOs are buried in a footnote on the first page of the introduction. Third, while the report was posted in May 2013, the data in the report relates to services rendered in 2010 and 2011. Finally, while the report helpfully compares individual MCO outcomes to national HEDIS averages, it fails to explain discrepancies in quality outcomes between the three MCOs.

Core Quality Measures and Comparability

The managed care regulations provide great flexibility to states to designate EQROs and delineate their required annual activities. While some states make good use of the process to encourage plan improvement and compliance, other states require less from their EQR or end up with reviews that give highly positive, and perhaps not very useful, reviews.[27] The 2008 OIG report noted that the lack of standardization in reporting

[24] HEDIS measures, published by published by the National Committee for Quality Assurance (NCQA), are the predominant set of quality measurement tools in healthcare today.
[25] Instit. for Child Health Policy at the Univ. of Fla. ("ICHP"), *Texas Medicaid Managed Care and Children's Health Insurance Program: EQRO Summary of Activities and Trends in Healthcare Quality* (Mar. 2014), http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf.
[26] CMS, *supra* note 7, at 4.
[27] For example, Louisiana's EQR reports found that contracting MCOs are between 96 to 99 percent compliant with regulations and contractual requirements. *See Bayou Health – EQRO Health Plan Results*, La. Dep't. Health & Hosps., http://new.dhh.louisiana.gov/index.cfm/page/1745, (last visited May 29, 2014).

hinders comparability across states and MCOs.[28] Limits to comparability between MCOs will always exist due to, among other things, differences in the covered population's risk characteristics. However, the capacity to evaluate plans against each other is an essential component of quality review. It allows plans to learn from each other and, when readily accessible to the public, promotes accountability and allows individuals to critically evaluate care quality across plans and over time.

The lack of standardization is partly due to state flexibility in determining the scope of the EQR process. On the positive side, Minnesota issues thorough EQR reports that include rates of voluntary disenrollment, grievance resolutions, as well as the results of state-required performance measures.[29] Minnesota's annual EQR report details specific strengths and weaknesses for each MCO and includes responses from each MCO on steps taken to address weaknesses over the prior two years.[30] By contrast, Texas contracts with an EQRO to perform encounter data validation, compliance reviews, member satisfaction surveys and telephone interviews, but the annual report posted on line aggregates these data by Medicaid program rather than by individual MCO.[31] Only the mandatory reviews of MCO PIPs are presented comparatively in the report.[32] The State posts individual MCO performance profiles elsewhere on its website but includes no reference to performance trajectories, no comparison with national averages, and no discussion of how MCOs have responded to prior EQRO recommendations.[33]

One way to improve standardization and comparability would be to strengthen federal standards. Under the Medicaid managed care regulations CMS may require reporting on particular quality measures, but to this point it has not done so.[34] CMS has, however, issued recommendations. It released a core set of 24 (later reduced to 23) quality measures for children in 2009, followed by a 26 measure adult core set in 2012.[35] CMS strongly encourages but does not require states to adopt these measures.

Notably, states have increased their use of core measures over the last few years. In 2012, every state reported using at least two of the children's core measures, while the median state used 14 and nine states reported using at least 20 of the 22 included core

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[28] HHS OIG, *supra* note 9, at ii.
[29] Mich. Peer Review Org., *Minnesota Department of Human Services 2012 Annual Technical Report*, (Dec. 2013), https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6888-ENG.
[30] *Id.*
[31] ICHP, *supra* note 25.
[32] *Id*., at 62.
[33] *Texas Medicaid and CHIP Health Plan Profiles*, Tex. Health & Human Servs. Comm'n, http://www.hhsc.state.tx.us/medicaid/managed-care/mco-profiles.shtml (last visited May 27, 2014).
[34] 42 C.F.R. § 438.240(a)(2). *See also* 42 C.F.R. § 438.358(b)(2).
[35] For initial child core measures, *see* 74 FR 68846 (Dec. 29, 2009). For initial adult core measures, *see* 77 Fed. Reg. 286 (Jan. 4, 2012). For updated 2014 core measures, *see* Ctr. for Medicaid & CHIP Servs., Informational Bulletin, *2014 Updates to the Child and Adult Core Health Care Quality Measurement Sets* (Dec. 19, 2013), http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf.

set measures.[36] In 2013, CMS published its third annual report on care quality for children in Medicaid and CHIP managed care plans, which included a synthesis of EQR technical reports provided by 33 of 41 states that covered children or pregnant women in managed care plans.[37] On the adult side, the first reporting period for the 26 core adult measures ended on January 20, 2014. Later this year CMS will compile a report, including EQR data, that evaluates how well states are adopting these core measures for adults.

Incorporating Managed Long Term Supports and Services (MLTSS)

The broad adoption of CMS core measures for children and adults would undoubtedly strengthen Medicaid quality measurement. However, neither set addresses the need to develop comprehensive mechanisms to evaluate the quality of MLTSS. When CMS drafted the EQR regulations over a decade ago, very few Medicaid programs contracted with capitated managed care organizations for long-term services and supports. In 2004, only eight states had any MLTSS program, and enrollment of MLTSS users barely exceeded 100,000 individuals nationwide, with over 70% of these individuals enrolled in Michigan or Arizona.[38] Unsurprisingly, the current EQR regulations are silent on how to analyze and evaluate the quality of care for MLTSS.

By 2012, MLTSS enrollment had increased to 16 states and nearly 400,000 enrollees, while several other states have initiated large programs in the last two years.[39] CMS recognized the need to incorporate MLTSS more explicitly into the EQR protocols and released guidance in 2013 explaining how states should adjust their EQR requirements to accommodate the unique needs and challenges of MLTSS.[40] This includes ensuring that EQROs have access to data systems beyond medical records, such as case management files, so they can adequately evaluate provision of non-medical LTSS. While this guidance represents an important first step, states also have an opportunity to leverage the EQR process to improve MLTSS quality measurement.

Significant efforts and financial resources have gone into improving the effectiveness and accuracy of quality measurement in the last two decades. However, useful and proven measures for MLTSS services are just getting off the ground, partly because the

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[36] Two child core measures were not included in the Secretary's report. HHS, *2013 Annual Report on the Quality of Care for Children in Medicaid and CHIP*, xviii, xxii (2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf.

[37] *Id.*

[38] Paul Saucier et al., Truven Health Analytics, *Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*, 9 (July 2012), www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.

[39] *Id.* In 2013, Kansas, New York, Florida, and New Jersey all instituted or expanded their MLTSS programs.

[40] CMS, *Application of Existing External Quality Review Protocols to Managed Long Term Services and Supports* (Oct. 22, 2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/CMCS-EQR-Protocols.pdf.

Assessing LTSS Measurement Capacity

Perhaps the most comprehensive effort to systemically assess both the current measurement capacity and substantial LTSS gaps is National Quality Forum's Measure Applications Partnership (MAP). This group of experts and key public and private stakeholder organizations have met since 2011 to evaluate and endorse measures applicable to various Medicaid populations, including those dually eligible for Medicare and Medicaid. The MAP initiative has endorsed an initial core set of measures for individuals with dual eligibility, including several relevant to LTSS, and more importantly has identified key gaps where more LTSS measure development and research is needed.[41] Several disability and aging advocacy groups have also made significant contributions identifying promising approaches that might become part of a new CMS "core set of measures" dedicated to LTSS quality.[42]

scope of these services stretches well beyond the quality measurement industry's traditional focal points – the clinic, the hospital, and the medical record. Existing validated measures for LTSS, especially home-and community based services, are few and far between. Some existing measurement systems, such as the National Core Indicators (NCI) for individuals with developmental disabilities, address specific segments of the population utilizing MLTSS.[43] Only recently, the National Association of States United for Aging and Disabilities, in collaboration with the Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services, has launched an effort to expand NCI to cover aging adults and people with physical disabilities as well. That project will be piloted in three states in 2014.[44] A number of other survey instruments measure consumer experience and outcomes, such as CMS' Personal Experiences Survey, but most are limited in applicability or scope.

The EQR process represents an opportunity to forward this type of research. A state with an MLTSS program can receive enhanced 75% federal match to contract with an EQRO to collect and analyze data for LTSS quality measures relevant to its MLTSS population.[45] In Wisconsin, the state-contracted EQRO, Metastar, has conducted a

[41] Nat. Quality Forum, *Measurement Application Partnership: Measuring Healthcare Quality for the Dual Eligible Beneficiary Population Final Report to HHS*, 21-28 (June 2012), http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71218.
[42] Disability Rights Educ. & Def. Fund and Nat'l Senior Citizens Law Ctr., *Identifying and Selecting Long-Term Services and Supports Outcome Measures* (Jan. 2013), http://dredf.org/2013-documents/Guide-LTSS-Outcome-Measures.pdf. NHeLP is currently a member of the NQF board and participates in the MAP dual eligibles work group.
[43] *About National Core Indicators,* Nat. Core Indicators, http://www.nationalcoreindicators.org/about (last visited May 27, 2014).
[44] *National Core Indicators - Aging and Disabilities*, Nat. Ass'n of States United for Aging & Disabilities, http://nasuad.org/initiatives/national-core-indicators-aging-and-disabilities (last visited May 25, 2014).
[45] FMAP for most administrative expenses in Medicaid is 50%. 42 C.F.R. § 433.15.

personal outcomes evaluation for enrollees in Wisconsin's long term care programs, including the state's MLTSS programs.[46] The tool, known as the Personal Experience Outcomes iNtegrated Interview & Evaluation System (PEONIES), was developed by researchers at the University of Wisconsin's Center for Health Systems Research and Analysis to help evaluate quality of care for individuals with disabilities.[47] Based on hour long semi-structured interviews conducted by trained staff, the PEONIES system has been cited as a best practice for evaluating quality of life for LTSS users.[48] Moreover, the collaboration paves a pathway other states could follow to leverage the enhanced federal funding to implement and validate new LTSS measures.

Minnesota, one of the most experienced states in the MLTSS arena, developed its own quality review process in consultation with multiple stakeholders, including community members, enrollees, providers and county administrators. In its "LTSS Gaps" analysis, the State surveys county administrators to identify areas in need of improvement. In addition, Minnesota has developed an on-line searchable nursing facility scorecard and conducted a Community Services Input Study consisting of focus groups, an on-line survey and interviews with key community stakeholders to collect feedback on its MLTSS program. All the resources and reports are posted on-line and serve as a model for other states.[49]

These efforts do not, however, appear to be well connected with Minnesota's EQR process, which should encompass MLTSS. The state's EQRO, Michigan Peer Review Organization, noted in its 2013 annual report that the state-required MCO performance measures it validated include only one measure specific to adults 65 years and older and none that directly evaluated care for people with disabilities.[50]

As managed care becomes increasingly influential in LTSS delivery, advocates should ensure states incorporate more MLTSS specific evaluation into the EQR process. Beyond performance measures, states could also require MCOs to implement specific Performance Improvement Projects (PIPs) related to MLTSS performance. This might, for example, center on plans' success at "rebalancing" LTSS, or shifting the needle from institutional LTSS to care in the community. Alternatively, a state could contract with an EQRO to implement an independent PIP centered on LTSS. Because conducting PIPs

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[46] Sara Karon and Mary Schlaak, Ctr. for Health Sys. Research & Analysis ("CHSRA"), *PEONIES Member Interviews State Fiscal Year 2012 Final Report*, 4 (Sept. 2012), http://www.chsra.wisc.edu/peonies/documents/PEONIES%20Final%20Report%20SFY2012%20-%20rev%2011-9-2012.pdf.

[47] *PEONIES*, CHSRA, http://www.chsra.wisc.edu/peonies/PEONIES_Index.html (last visited May 27, 2014).

[48] Alice Lind, Ctr. for Healthcare Strategies, *Contracting for Managed LTSS: Best Practices and Cautionary Tales*, 25 (June 11, 2013), http://www.oregon.gov/dhs/cms/Meeting%20files/MLTSS%20for%20OR%20Stakeholders-June%2011.pdf. Implementation of PEONIES in Wisconsin stalled after 2012.

[49] *2012 Long-Term Services and Supports Gaps Analysis*, Minn. Dep't. of Human Servs., http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_141764 (last visited Apr. 23, 2014).

[50] Mich. Peer Review Org., *supra* note 29, at 196-7.

is an optional EQR-related activity listed in the regulations, the state would be eligible for enhanced 75% federal match for expenses related to such an independent PIP.

Validating Encounter Data

Encounter data are records of actual payments MCOs make to providers for services rendered – a managed care equivalent to FFS claims. Encounter data self-reported by MCOs to the state form the basis of many performance measures. Accurate encounter data are thus foundational to quality measurement. They also support program integrity oversight and undergirds key managed care components such as setting capitation rates, and tracking utilization patterns. States must collect encounter data and enter them into CMS' claims database, the Medicaid Statistical Information System (MSIS).[51] Medicaid regulations require states to ensure that MCO's provide timely, complete and accurate encounter records, and until recently CMS has only done sporadic validation and verification of the state data it receives.[52] Mathematica's 2011 review of nine states' encounter data validation processes details substantially state variability and documents that many managed care programs take years to develop sufficient oversight to produce reliable encounter data.[53] Given the importance of this information to program efficiency and integrity, such delays are unacceptable.

In the last few years, increasing the reliability of encounter data has become a clear federal priority. Congress included a provision in the Affordable Care Act requiring CMS to withhold federal matching dollars for medical assistance used by any individuals for whom the state does not report encounter data to MSIS.[54] To facilitate compliance, CMS contracted with Mathematica to produce the 2011 review, several webinars and finally an *Encounter Data Toolkit* for states that lays out in detail how to develop an effective collection and reporting system.[55]

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[51] 42 U.S.C. § 1396b(r)(1)(F).
[52] 42 C.F.R. § 438.242; Vivian Byrd and Allison Hedley Dodd, Mathematica Policy Research, *Assessing the Usability of Encounter Data for Enrollees in Comprehensive Managed Care Across MAX 2007–2009*, 1 (December 2012), https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX_IB_15_AssessingUsability.pdf.
[53] Vivian L. H. Byrd & James Verdier, Mathematica Policy Research, *Collecting, Using, and Reporting Medicaid Encounter Data: A Primer for States*, 5 (Oct. 19, 2011), http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/MAX_PDQ_Task_X_EncounterDataPrimerforStates.pdf. *See also* Medicaid & CHIP Payment & Access Comm'n, *The Evolution of Medicaid Managed Care*, 89 (June 2011), http://www.macpac.gov/reports.
[54] ACA § 6402(c), adding 42 U.S.C. § 1396b(i)(25).
[55] Vivian Byrd, Jessica Nysenbaum, and Debra Lipson, Mathematica Policy Research, *Encounter Data Toolkit* (Nov. 30, 2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/Medicaid-Encounter-Data-toolkit.pdf; CMS, State Technical Assistance Training Webinar Series, *Collecting and Validating Medicaid Managed Care Encounter Data*, (Apr. 9, 2013).

The EQR can play an important role in this process. Several states, including Pennsylvania and Texas, have a long track record of using an EQRO for such validation. Not only do they receive enhanced 75% federal match for this critical task, but the EQRO provides an additional layer of independent oversight that bolsters accuracy, transparency and accountability.[56] For example, Texas performs a review that matches a randomized sample of encounter data against the actual provider records. Despite the clear federal priority on ensuring accurate and complete encounter data, CMS merely "strongly encourages" states to include encounter data validation as an EQR activity.[57] Given the key role encounter data plays in both setting capitation rates and evaluating quality measures, CMS has reason to require states to incorporate encounter data validation into their EQR, provided that it includes a non-duplication provision to ensure the EQRO is not merely replicating work already performed by a different independent entity for the state.[58] Naturally, such a requirement will only benefit the program to the extent that the EQR is truly independent and effective.

Conclusion: Next Steps

Over the last decade, managed care delivery has evolved and the EQR process has changed with it. The time has come to reevaluate the regulations and adapt them to the current managed care environment.

CMS has already taken steps to improve the EQR through recommended core measures, guidance on MLTSS and technical support for states. However, even with these improvements, problems and limitations persist with EQR as now constituted. Transparency and comparability vary widely between the states, while the whole process has become something of a niche industry dominated by just a handful of companies. Without reform, the EQR risks failing to achieve its potential to strengthen independent oversight, boost plan accountability, and provide consumers with valuable tools to compare the best plans to suit their healthcare needs.

CMS could further strengthen the EQR through the following regulatory reforms:

- Require states to validate plans' performance on all relevant elements of CMS' core measure sets for children and adults through the EQR;

- Require that states post all EQR reports in a timely manner on their publicly accessible website;

[56] The current encounter data validation process has no public disclosure requirement, except for validation activities related to EQR. Byrd et al., *supra* note 54, at 5.
[57] CMS, *EQR Protocol 4: Validation of Encounter Data Reported by the MCO*, 4 (Sept. 2012), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EQR-Protocols.zip.
[58] States using an EQRO would receive 75% federal match for such expenses. 42 C.F.R. § 438.370.

- Require states to create a consumer-friendly document or platform that presents EQR findings and facilitates easy comparison between health plans, such as Kentucky's MCO dashboard or South Carolina's Health Plan Report Card.[59] This platform must be publicly accessible to individuals with limited English proficiency, persons with disabilities, and individuals with low health literacy;

- Require states with MLTSS programs to design and execute MLTSS evaluation as part of their EQR;

- Shift certain optional EQR-related activities, such as validation of encounter data, to mandatory EQR activities;

Implementing these regulatory reforms would go a long way to modernizing the EQR process and further integrating EQR into each state's broader quality improvement strategy. Greater transparency will also allow EQR to develop its potential as a tool for consumers and advocates to compare plans and identify performance problems. As health care delivery increasingly shifts toward pay for performance models, robust quality measurement will only increase in importance, and EQR could play a critical role in this process.

[59] *See MCO Dashboard*, Kentucky.gov, http://ky.mco.ipro.org (last visited May 30, 2014); *Quality Improvement: Health Plan Performance Report Card*, SC Health Viz, http://www.schealthviz.sc.edu/health-plan-performance-report-card (last visited May 30, 2014).

Appendix A – EQROs and Web-Accessible Quality and EQR Data, by State (Through May 2014)

This chart links to the active EQROs in each state with a Medicaid or CHIP managed care contract that triggers the EQR requirement. While not comprehensive, it provides an overview of transparency and variability between states and makes it easier to compare across Medicaid programs.

State	EQRO	Website for Annual EQR Reports & Related Quality Data
Alabama	No current MCO or PIHP contracts, so EQR not required.	
Alaska	No current MCO or PIHP contracts, so EQR not required.	
Arizona	Health Care Excel (HCE) Quality Quest, Inc. Health Services Advisory Group (HSAG)[60]	EQR reports for behavioral health plans, acute care plans, and long-term care: http://www.azahcccs.gov/reporting/reports/EQR.aspx
Arkansas	Managed care is delivered through an § 1115 Marketplace premium assistance demonstration. Independent review is required, but not necessarily an EQRO. The evaluation design is still in process.	
California	HSAG APS Healthcare, Inc.	Medi-Cal Managed Care EQR reports: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx Mental Health Plans EQR reports: http://caegro.com/webx/Reports%20and%20Presentations/
Colorado	HSAG	Behavioral & physical health plan EQR reports: http://www.colorado.gov/cs/Satellite?c=Page&childpagename=HCPF%2FHCPFLayout&cid=1251580848959&pagename=HCPFWrapper
Connecticut	Mercer Government Human Services Consulting (Mercer) (Through 2011)	As of January 2012, CT no longer contracts with MCOs. The current primary care case management program does not require EQR. 2011 EQR powerpoint: http://www.cga.ct.gov/med/council/2011/0311/20110311ATTACH_External%20Quality%20Review.pdf
Delaware	Mercer	Quality strategy: http://www.dhss.delaware.gov/dhss/dmma/dshpplus.html EQR reports not readily available online.

[60] Federal regulations permit states to contract with more than one EQRO to conduct EQR and EQR-related activities. Subcontracting is also permitted. 42 C.F.R. § 438.356.

Appendix A – EQR Web Accessibility by State

State	EQRO	Website for Annual EQR Reports & Related Quality Data
District of Columbia	Delmarva Foundation	2011-12 EQR report (also available on CMS EQRO website): http://dhcf.dc.gov/release/dhcf-cy-2011-2012-managed-care-organization-technical-report
Florida	HSAG Institute for Child Health Policy at the University of Florida (ICHP)	Medicaid managed care reports, PIP plans and quality measures data since 2006 (conducted by HSAG): http://www.myfloridaeqro.com/Resources.aspx CHIP EQR reports (conducted by ICHP): https://www.healthykids.org/resources/research/institute/
Georgia	HSAG	EQR annual reports and other quality measurement data: http://dch.georgia.gov/medicaid-quality-reporting
Hawaii	HSAG	EQR reports: http://www.med-quest.us/ManagedCare/consumerguides.html
Idaho	No MCO or PIHP contracts, so EQR not required.	
Illinois	HSAG	EQR reports through 2011: http://www2.illinois.gov/hfs/ManagedCare/Pages/EQRTR.aspx Evaluation of Illinois' Integrated Care Program managed care § 1115 demonstration (conducted by the Institute on Disability and Human Development at University of Illinois at Chicago): Year 1: http://www.ahs.uic.edu/media/uicedu/ahs/documents/dhd/publications/An,Independent,Evaluation,of,the,Integrated,Care,Program,(full).pdf
Indiana	Burns & Associates, Inc.	CHIP & Medicaid (Only most recent year available online): http://www.burnshealthpolicy.com/publications/
Iowa	Iowa Foundation for Medical Care (IFMC), now Telligen	Iowa EQR includes its CHIP program, known as hawk-I, and its mental health and substance abuse MCO, Magellan Health. Recent quality and EQR reports are not readily available on the Medicaid or hawk-i website.It is unclear how EQR regulations will apply to Iowa's new premium assistance Medicaid Expansion. 2008 EQR report for Magellan Health (mental health and substance abuse MCO): http://www.ime.state.ia.us/docs/EQR-2006-07.doc
Kansas	Kansas Foundation for Medical Care, Inc.	Kancare § 1115 demonstration evaluation quarterly reports: http://www.kancare.ks.gov/reports.htm

Appendix A – EQR Web Accessibility by State

State	EQRO	Website for Annual EQR Reports & Related Quality Data
Kentucky	Island Peer Review Organization (IPRO)	IPRO 2012-13 *Managed Care Program Progress Report* (EQR technical report not available online): http://chfs.ky.gov/nr/rdonlyres/82c340a5-d0bf-4852-8300-93e98a8dfe5d/0/2managedcareprogramprogressreport_20122013final21114.pdf IPRO has created an MCO performance dashboard based on HEDIS measures: http://ky.mco.ipro.org/ Urban Institute has also evaluated Kentucky's managed care § 1115 demonstration: 2012: Urban Institute Year 1 Evaluation 2013: Urban Institute Year 2 Evaluation
Louisiana	IPRO	EQR reports (Summary only): http://new.dhh.louisiana.gov/index.cfm/subhome/6 Grievance, appeals and other quality measures by plan: http://new.dhh.louisiana.gov/index.cfm/page/1750
Maine	No MCO or PIHP contracts, so EQR not required.	
Maryland	Delmarva Foundation	EQR & PIP reports: https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/CY%202012.aspx MCO Report Card: https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/HealthChoice%20Quality%20Assurance%20Activities.aspx
Massachusetts	APS Healthcare, Inc.	HEDIS results, CHIP annual reports: http://www.mass.gov/eohhs/researcher/insurance/masshealth-annual-reports.html Details of 2013 EQRO activities: http://www.mass.gov/eohhs/docs/masshealth/research/qualitystrategy-05.pdf
Michigan	HSAG	Medicaid health plans: https://www.michigan.gov/mdch/0,4612,7-132-2943_4860-28384--,00.html
Minnesota	Michigan Peer Review Organization (MPRO)	EQR and other Quality Data Site: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_159905#
Mississippi	The Carolinas Center for Medical Excellence (CCME)	EQR and other quality data for Mississippi Coordinated Access Network not readily available on the website.

Appendix A – EQR Web Accessibility by State

State	EQRO	Website for Annual EQR Reports & Related Quality Data
Missouri	Behavioral Health Concepts, Inc. (BHC)	EQR Protocols: http://www.dss.mo.gov/mhd/mc/pages/eqr-protocols.htm EQR and other Quality Evaluations: http://www.dss.mo.gov/mhd/mc/pages/reports.htm
Montana	No MCO or PIHP contracts, so EQR not required.	
Nebraska	IPRO	EQR and other quality data for physical health managed care not readily available online. Nebraska's behavioral health managed care program, which began in September 2013, has not yet compiled its first EQRO report.
Nevada	HSAG	EQR report and quality strategy: https://dhcfp.nv.gov/ManagedCare/EQRO.htm
New Hampshire	No MCO or PIHP contracts, so EQR not required.	
New Jersey	MPRO (2008-2010) IPRO (2011-present)	Managed Care Performance Reports: http://www.state.nj.us/humanservices/dmahs/news/
New Mexico	HealthInsight New Mexico	EQR reports: http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx
New York	IPRO Burns & Associates, Inc.	2011 report summary available on CMS' EQRO website. Healthy NY Program (2009-2010): http://www.burnshealthpolicy.com/report/healthy-ny/
North Carolina	CCME	HEDIS results & other performance data: http://www.ncdhhs.gov/dma/quality/ EQR reports not readily available online.
North Dakota	Delmarva Foundation	Draft Quality Strategy Plan 2014: http://www.nd.gov/dhs/info/pubs/docs/medicaid/draft-quality-strategy-plan.pdf EQR reports pending initiation of managed care program.

Appendix A – EQR Web Accessibility by State

State	EQRO	Website for Annual EQR Reports & Related Quality Data
Ohio	HSAG	EQR activities website: www.myohioeqro.com Member satisfaction reports and other managed care data for Covered Families and Children program: http://medicaid.ohio.gov/RESOURCES/Research/MedicaidManagedHealthCareReports.aspx#1202500-2012 Aged, Blind, Disabled: http://medicaid.ohio.gov/RESOURCES/Research/MedicaidManagedCareReports.aspx#1199505-2008-combined-abd-and-cfc-reports
Oklahoma	Burns & Associates, Inc. (2008) None currently.	InsureOK program (2008 only): http://www.burnshealthpolicy.com/publications/ Pacific Health Policy Group conducts independent quality reviews of the Soonercare Health Management Program (2011-2013): http://www.telligen.com/state-government-medicaid/program-success
Oregon	Acumentra Health	Oregon Coordinated Care Organizations & Mental Health Plans evaluations: http://www.acumentra.org/publications/external-quality-review-reports/
Pennsylvania	IPRO	HEDIS & EQR reports: http://www.dpw.state.pa.us/publications/healthchoicespublications/index.htm
Rhode Island	IPRO	Summary of EQR and other quality measures: http://www.eohhs.ri.gov/ReferenceCenter/ResearchAnalysis.aspx 2012 EQR report: http://www.ohhs.ri.gov/documents/documents13/Aggregate_EQR_Report.pdf 2011 Lewin Group evaluation of RI § 1115 demonstration: http://www.ohhs.ri.gov/documents/documents13/
South Carolina	CCME	2009 EQR process & contact info: http://www.thecarolinascenter.org/documents/SCEQR_EQRProcessPresentation.ppt 2009 EQR report for Medical Homes Network: https://www.thecarolinascenter.org/documents/SCEQR_PIPOverview200910.doc Health Plan report cards: http://www.schealthviz.sc.edu/health-plan-performance-report-card Other EQR reports not readily available online.
South Dakota	No MCO or PIHP contracts, so EQR not required.	

Appendix A – EQR Web Accessibility by State

State	EQRO	Website for Annual EQR Reports & Related Quality Data
Tennessee	Qsource HSAG	HEDIS reports: http://www.tn.gov/tenncare/pro-hedis.shtml Quality Assessment and Improvement Strategy reports: http://www.tn.gov/tenncare/news-reports.shtml EQR reports not readily available online.
Texas	ICHP	EQRO survey reports: Contract year 2012: http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf Contract year 2011: http://www.hhsc.state.tx.us/reports/2012/2011-EQRO-Summary-Activities.pdf Other: http://www.hhsc.state.tx.us/about_hhsc/reports/search/Search_Reports.asp (Search by report type "Medicaid." Additional results under report type "EQRO") MCO performance profiles: http://www.hhsc.state.tx.us/medicaid/managed-care/mco-profiles.shtml
Utah	HCE Quality Quest, Inc. (to 2012) Utah Department of Health, Office of Health Care Statistics (Since 2013)	2013 CAHPS survey results and MCO performance reports available at: http://health.utah.gov/hda/
Vermont	HSAG	http://humanservices.vermont.gov/news-info/whats-new
Virginia	Delmarva Foundation	EQR reports not readily available online.
Washington	Acumentra Health HSAG (Subcontractor)	Sort by EQR in: http://www.hca.wa.gov/medicaid/healthyoptions/documents/ For EQR updates see: https://www.acumentra.org/assets/WA-EQR-Update-2013-12-31.pdf
West Virginia	Delmarva Foundation	2009-2011 EQR reports: http://www.dhhr.wv.gov/bms/mco/Pages/Reports.aspx
Wisconsin	Metastar	Badgercare (only 2007 report available online): https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/reportsData.htm.spage Long-term Care: http://www.dhs.wisconsin.gov/ltcare/statefedregs/EQRO.htm LTSS Outcomes Survey 2012 Report (PEONIES—conducted by Metastar): http://www.chsra.wisc.edu/peonies/documents/PEONIES%20Final%20Report%20SFY2012%20-%20rev%2011-9-2012.pdf
Wyoming	No MCO or PIHP contracts, so EQR not required.	