

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**EXTERNAL QUALITY REVIEWS IN
MEDICAID MANAGED CARE**



Daniel R. Levinson
Inspector General

June 2008
OEI-01-06-00510

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

OBJECTIVES

To determine:

1. the extent to and ways in which States utilize external quality reviews of Medicaid managed care,
2. the extent to which external quality review organizations (EQRO) provided States with required information, and
3. limitations that States have identified with the external quality review process.

BACKGROUND

Medicaid is a joint Federal and State program that provides medical assistance to low-income groups, such as children, senior citizens, and people with disabilities. Many States utilize managed care to respond to Medicaid expenditures that have more than doubled since 2000. As of 2006, 65 percent of the 45.6 million Medicaid beneficiaries were enrolled in managed care.

The Social Security Act requires States that operate Medicaid managed care programs to provide for an external, independent review of their managed care organizations. States may contract with an independent entity called an EQRO to conduct the external quality review. The Centers for Medicare & Medicaid Services (CMS) provides States with matching Federal funds for review expenditures, including the production of results, depending on the qualifications of their EQRO contractors. Federal regulations require three mandatory activities as part of this review and offer States the choice of requiring up to five optional activities. Regulations also require the review to produce five specific deliverables, including a detailed technical report.

We reviewed EQRO reports for the 37 States that arrange for external quality reviews. We also reviewed the contracts and requests for proposals between these States and their EQROs. We then surveyed these 37 States regarding their use of EQRO reports and their experience with the review process. We received a 100-percent response rate. We also conducted structured interviews with representatives from six States.

FINDINGS

Most States are using the results of EQRO reviews. For example, 33 of the 37 States required their managed care plans to make changes based on EQRO reports, such as how plans document and conduct performance improvement projects and how plans meet State standards regarding members' access to care. Twenty-two States used EQRO reports to share knowledge across plans, for example, by targeting technical assistance to the plans and sharing best practices across plans. Fourteen States reported amending their contracts with plans based on EQRO reports and 16 States took other actions, such as setting new performance standards. Overall, 21 States rated the EQRO reports to be very useful. Furthermore, 25 States required their EQROs to conduct optional review activities during their last annual review period.

Some EQRO reports did not include all required information, despite the States' oversight. EQRO reports for 15 States were missing at least one of the five required deliverables. The two most common missing deliverables were an assessment of managed care plans' responses to previous EQRO recommendations and comparative information about all of the State's plans. EQRO reports for eight States were missing information on at least one of the three mandatory activities. All States reported regularly monitoring their EQROs through ongoing communication, written status reports, and contract provisions. Of the 37 contracts and requests for proposals that we reviewed, 34 included provisions to ensure EQRO compliance with Federal regulations.

More than half of the States cited concerns with the external quality review process. Sixteen States identified staffing concerns with the external quality review process, particularly turnover and training issues. Thirteen States raised concerns with the quality of EQRO reports, especially their timeliness and the degree to which their findings and recommendations could be implemented. Five States reported finding the mandatory activities redundant to other monitoring activities, such as those conducted by private accreditors. Many States requested technical support from CMS to help address these issues.

RECOMMENDATIONS

CMS should work with States to ensure that EQROs are providing complete information. CMS could, as part of its review of the contents of the EQRO reports, inform States if it finds that any of the required deliverables are missing. Further, CMS could amend its regulations to describe, as a condition for receiving enhanced reimbursement, the steps that States must take to ensure that all the required deliverables are included in the quality review results.

CMS should provide additional technical assistance and written guidance to States. CMS could do this by organizing teleconferences, offering written guidance, and sharing best practices. It should schedule these teleconferences regularly and make any written guidance available online. CMS could use a format similar to a teleconference it held with States in 2006. CMS should consider two priorities for its technical assistance and written guidance: minimum standards for EQRO report organization and content and use of accreditation data in external quality reviews.

AGENCY COMMENTS

CMS agreed with both of our recommendations and cited actions that it has taken in response to each. It provided feedback to Medicaid Directors in 15 States regarding deficiencies in EQRO reports. CMS also focused one of its triannual audio conferences, available to States and EQROs, on external quality reviews. Further, CMS assisted a managed care accrediting organization in creating a document for States on using accreditation data in their reviews.

▶ T A B L E O F C O N T E N T S

EXECUTIVE SUMMARY i

INTRODUCTION 1

FINDINGS 7

 Most States are using results of EQRO reviews 7

 EQRO reports for some States were missing required elements. . . 9

 More than half of States had concerns with the review process . . 11

RECOMMENDATIONS 14

APPENDIXES 16

 A: Status of States' Arrangements for Reviews 16

 B: Time Period of EQRO Reports Reviewed 17

 C: Agency Comments 18

ACKNOWLEDGMENTS 21

OBJECTIVES

To determine:

1. the extent to and ways in which States utilize external quality reviews of Medicaid managed care,
2. the extent to which external quality review organizations (EQRO) provided States with required information, and
3. limitations that States have identified with the external quality review process.

BACKGROUND

Medicaid and the Growth of Managed Care

Medicaid is a joint Federal and State program that provides medical assistance to low-income groups, such as children, senior citizens, and people with disabilities. Individual States establish eligibility requirements, benefits packages, and Medicaid payment rates under standards set by the Centers for Medicare & Medicaid Services (CMS).

Medicaid spending has increased at both the Federal and State levels. Federal expenditures increased from \$118 billion in 2000 to \$180 billion in 2006.¹ State expenditures rose by almost 60 percent, from \$89 billion in 2000 to \$142 billion in 2006. These expenditures account for almost one-quarter of all States' expenditures.²

In response to this growth, States have increasingly utilized managed care to deliver Medicaid services to beneficiaries. Managed care is a health care delivery system that aims to maximize efficiency by negotiating rates, coordinating care, and managing use of services. From 2000 to 2006, enrollment in Medicaid managed care grew 59 percent, from 18.8 million to 29.8 million beneficiaries. As of 2006, 65 percent of the 45.6 million Medicaid beneficiaries were enrolled in managed care.³

¹ Department of Health and Human Services, "Budget in Brief," 2002 and 2008. Available online at <http://www.hhs.gov/budget/docbudget.htm>. Accessed on May 20, 2008.

² National Association of State Budget Officers, "2006 State Expenditure Report," 2007.

³ CMS, "Medicaid Managed Care Enrollment Report as of June 30, 2006."

Concerns About Medicaid Managed Care Quality of Care

The Government Accountability Office found that the capitated (i.e., a predetermined amount per beneficiary) nature of managed care could create fiscal incentives to underserve beneficiaries. It recommended that States carefully monitor access to and quality of care delivered to Medicaid managed care populations.⁴ Other published studies have suggested that managed care reduces the quality and accessibility of health care, particularly in specific vulnerable subpopulations.⁵

State Oversight of Medicaid Managed Care

The Social Security Act requires contracts with Medicaid managed care organizations (MCO) to provide for an external independent review. Specifically, it mandates that each MCO contracted with the State must be reviewed annually by a “qualified independent entity.” This review must evaluate the MCO’s “quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible.”⁶

Requirements for External Quality Review Organizations

In January 2003, CMS issued a final rule to further specify requirements for external quality reviews and EQROs.⁷ To qualify as an EQRO, an organization must have knowledgeable staff and sufficient physical, financial, and technological resources. An EQRO and any of its subcontractors must also be independent from the State Medicaid agency and the MCOs under review. States are responsible for ensuring that EQROs meet these requirements.⁸ Some EQROs hold external quality review contracts with several States. For example, the Health Services Advisory Group holds EQRO contracts in 11 States.⁹

⁴ Government Accountability Office, GAO/T-HRD-93-10, “Medicaid: States Turn to Managed Care to Improve Access and Control Costs,” 1993. Available online at <http://archive.gao.gov/d42t14/148756.pdf>. Accessed on May 20, 2008.

⁵ E.C. Schneider, et al., “Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care,” *Journal of the American Medical Association*, 2002, Volume 287, pp. 1288–1294. D. G. Clement, et al., “Access and Outcomes of Elderly Patients Enrolled in Managed Care,” *Journal of the American Medical Association*, 1994, Volume 271, pp. 1487–1492.

⁶ Social Security Act § 1932(c)(2)(A)(i).

⁷ 42 CFR pt. 438, subpart E.

⁸ 42 CFR § 438.354.

⁹ “Florida Medicaid Selects HSAG for External Quality Review Services,” May 25, 2006. Available online at http://www.hsag.com/news/2006_0525.asp. Accessed on May 20, 2008.

Regulations also permit the State to conduct the review.¹⁰ Most States choose to contract with independent EQROs to conduct the required activities; however, some States perform one or more of the activities themselves. Even States conducting their own reviews usually contract with EQROs to write the final technical reports.

States receive an enhanced Federal match of 75 percent for their review expenditures, including the production of results, if they contract with qualified EQROs. They receive a Federal match of 50 percent for any activities conducted by nonqualified entities.¹¹ States are responsible for contracting with EQROs and ensuring that EQROs are producing the required deliverables.¹²

Mandatory and Optional Review Activities

Federal regulations require that external quality reviews include three mandatory activities. For each MCO or prepaid inpatient health plan¹³ (hereafter referred to as plans), the external quality review must include the following activities:

1. validation of performance improvement projects (PIP) required by the State and underway in the preceding 12 months;
2. validation of plan performance measures required by the State and reported by the MCO in the preceding 12 months; and
3. a review, conducted in the previous 3-year period, to determine the plan's compliance with State standards for access to care, structure and operations, and quality measurement and improvement.¹⁴

In addition, Federal regulations allow States to require up to five optional activities:

1. validation of encounter data reported by a plan,
2. administration and validation of consumer and provider surveys on quality of care,
3. calculation of additional performance measures,

¹⁰ 42 CFR § 438.358(a).

¹¹ 42 CFR § 438.370.

¹² 42 CFR §§ 438.356 and 438.364.

¹³ These are health plans that provide inpatient hospital or institutional services on an at-risk or other than State plan reimbursement basis.

¹⁴ 42 CFR § 438.358(b).

4. conduct of additional PIPs, and
5. conduct of studies on quality focused on a particular aspect of clinical or nonclinical services at a point in time.¹⁵

In May 2002, CMS issued a series of protocols for use in conducting Medicaid external quality review activities. These serve as guidelines for EQROs in conducting mandatory and optional external quality review activities.

External Quality Review Deliverables

After completing the review activities, an EQRO must produce the following information (hereinafter referred to as deliverables):

1. a detailed technical report describing the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to the care furnished by the plans;
2. an assessment of each plan’s strengths and weaknesses with respect to quality, timeliness, and access to care;
3. as the State determines, methodologically appropriate, comparative information about all plans;
4. recommendations for improving the quality of health care services furnished by the plans; and
5. an assessment of the degree to which each plan has addressed effectively the quality improvement recommendations made by an EQRO during the prior year’s review.¹⁶

Some EQROs issue one technical report encompassing all of the plans in the State; others issue multiple reports, each specific to one plan or activity. Generally, these reports are organized around the mandatory activities. However, even if a report is missing information on one of the mandatory activities, it may still contain all of the required deliverables. Regulations require States to make these reports available to interested parties upon request.¹⁷ Usually the States also provide CMS with copies of the deliverables.

¹⁵ 42 CFR § 438.358(c).

¹⁶ 42 CFR § 438.364(a).

¹⁷ 42 CFR §§ 438.364(b) and 438.350(f).

CMS Efforts To Improve the External Quality Review Process

In October 2006, CMS held an audio conference with State Medicaid agencies addressing the assessment, utility, and improvement of EQRO reports. During this conference, CMS presented its review and evaluation of reports from 22 States. According to the review, reports vary substantially in organization, length, detail, topics addressed, and presence and extent of recommendations. CMS found that many reports did not comply with at least one external quality review regulatory requirement.¹⁸

CMS prepared a “tool kit” based on that review.¹⁹ This tool kit offered a brief assessment of 2005 reports, identified key opportunities for improved reporting, recommended specific sections to be included in reports, and suggested a standardized format for submitting reports.²⁰ CMS provided the tool kit to States, who could then provide it to their EQROs.

METHODOLOGY

Scope

This evaluation is national in scope. Forty States, including the District of Columbia (hereafter referred to as States), contract with plans and thus must arrange for external quality reviews. Three of these States (Georgia, Maine, and New York) are currently working with CMS to implement the review process, so we excluded them from our analysis.²¹ We included the 37 States that have implemented the review process. States that do not contract with managed care organizations are not required to conduct reviews. See Appendix A for a list of all States and whether they contract with plans.

Data Sources

We collected and analyzed data from the following sources:

EQRO reports. We obtained from CMS and the States copies of all reports that EQROs produced pursuant to regulations. Because review periods differed across States, we could not review reports for all States

¹⁸ CMS, “State External Quality Review Tool Kit for State Medicaid Agencies,” October 2006.

¹⁹ Ibid.

²⁰ Ibid.

²¹ Since the completion of our review, Maine has discontinued its Medicaid managed care program and will not be implementing an external quality review process.

I N T R O D U C T I O N

for the same time period. See the table in Appendix B for the time periods covered by the reports we reviewed.

Contracts. We obtained from the States copies of their EQRO contracts or requests for proposals covering 2005.

Surveys. We sent surveys by mail to the Medicaid Directors of the 37 States and received a 100-percent response rate. The surveys asked States how they conduct oversight of their EQROs and utilize the results of previous EQRO reports. The surveys also asked about States' general experiences in implementing the external quality review process.

Interviews. We conducted structured telephone interviews (and one in-person interview) with representatives from Medicaid offices in six States. We purposively selected these States based on their survey responses.

Analysis

We reviewed each EQRO report to determine whether it included all elements required by Federal regulations. We counted elements as missing if they were not present in the report and the report or survey data did not explain why. For example, we did not count the assessment of prior recommendations as missing if the plan's report noted that the plan had not contracted with the State the previous year or if the State's survey reported that the State was currently only in its second review period. We also did not count any section as missing if the State was still in the process of implementing that aspect of the review, for example, if the State had not initiated any PIPs in the previous 12-month period.

Limitations

Data from the surveys and follow-up interviews were self reported by States. We did not independently verify these data.

We did not determine whether assessments of plan strengths and weaknesses were present in EQRO reports. Because the general scope of an external quality review is to examine plan strengths and weaknesses with respect to quality, timeliness, and access to care, all data in the report relate to these topics.

Standards

We conducted this study in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

► FINDINGS

Most States are using the results of EQRO reviews

Of the 37 States, 29 rated the external quality review process as very important in overseeing their

Medicaid managed care programs. States cited several benefits of the review process, including identifying and documenting concerns with plans, providing a comprehensive review of the State Medicaid programs and their plans, and providing additional monitoring that the States are unable to do on their own. Similarly, 21 States rated the EQRO reports as very useful, citing the data in the reports and the independence of the reviews.

Thirty-three of thirty-seven States required their managed care plans to make changes based on EQRO reports

The plans developed and implemented these State-required changes. The most common changes, required by 28 States, called for improving the documentation and conduct of PIPs. For example, plans had to document that they tested the statistical significance of reported improvements. They also had to create templates for developing and submitting PIPs. Twenty States reported requiring changes in how plans complied with State and Federal standards. These changes typically addressed standards regarding member grievances and appeals or access to care. See Table 1 for a list of changes States required plans to make based on EQRO reports.

Table 1: Managed Care Plan Changes Required by State

| Area in Which State Required Managed Care Plan Change | Number of States That Required Change* |
|---|--|
| Documentation and Conduct of Performance Improvement Projects | 28 |
| Compliance With State and Federal Standards | 20 |
| Calculation and Reporting of Performance Measures | 16 |
| Improvement in Information Systems | 10 |
| Other Change | 4 |

Source: Office of Inspector General analysis of State Medicaid Agency survey data, 2007.

* The numbers do not total 33 because some States required more than one change.

F I N D I N G S

States typically required the managed care plans to develop and complete corrective action plans (CAP) to address these changes. States also reported providing technical assistance to the plans to help them develop their CAPs. States used several methods to ensure that the plans made these changes, such as including contractual provisions, monitoring CAPs, and delegating oversight to EQROs.

According to eight States, their managed care plans initiated changes based on EQRO report data without the States requiring them to do so. For example, one plan made changes to its internal information systems after the EQRO pointed out shortcomings.

Twenty-two States used EQRO reports to share knowledge across managed care plans

Knowledge sharing included States targeting technical assistance to the plans (reported by 21 States). Eight of these States focused their assistance on improving PIPs. Often, EQROs provided assistance to plans (reported by 15 States). States also reported sharing best practices across their plans. Typically, these States convened periodic meetings with representatives from the States, EQROs, and all plans. Some States cited the potential value of identifying and sharing best practices at the national level.

Fourteen States reported amending their contracts with managed care plans based on EQRO findings

Of these States, 12 inserted new provisions into their contracts. The changes included strengthening and clarifying contract requirements, using external quality review results to justify contract extensions and renewals, and adjusting PIPs.

Sixteen States also reported taking other actions based on EQRO reports

Other commonly reported State changes included modifying the performance measures. Eleven States reported changes such as adding new measures and establishing new benchmarks for plans to meet. Additionally, nine States reported making changes such as standardizing quality assurance processes and implementing a tracking system for identifying and responding to adverse events.

Furthermore, 25 States required their EQROs to conduct optional review activities during their last annual review period

States reported requiring their EQROs to conduct at least one of the five optional review activities to provide additional information for States' quality improvement efforts. One of the two most common optional activities States reported was administering or validating surveys of

FINDINGS

quality of care either to consumers or to providers. In the reports we reviewed, many EQROs used the Consumer Assessment of Healthcare Providers and Systems survey instrument. This survey stems from a public-private initiative that developed standardized surveys of patients' experiences. The second of the two most common optional activities was conducting focused quality studies on particular aspects of care. Among the focused studies we saw, common topics included determining childhood immunization rates at a specific age and assessing trends in adolescent well care. See Table 2 for the number of optional activities States required their EQROs to conduct.

| Optional Activity | Number of States That Required EQROs To Conduct Activity |
|--|---|
| Administering or Validating Surveys on Quality of Care | 14 |
| Conducting Focused Quality Studies | 14 |
| Validating Encounter Data | 12 |
| Calculating Additional Performance Measures | 7 |
| Conducting Additional Performance Improvement Projects | 6 |

Source: Office of Inspector General analysis of State Medicaid Agency survey data, 2007.

Some EQRO reports did not include all required information, despite the States' oversight

Federal regulations require EQROs to produce five deliverables based on their review activities and provide them to the States.

EQRO reports for 15 States were missing at least one of the five required deliverables

Reports for 12 States were missing the assessment of managed care plans' responses to previous EQRO recommendations, and reports for 7 States were missing comparative information about all of the State's plans.

These deliverables can provide useful information. For example, some reports displayed the previous EQRO recommendations, plan responses and actions, and the new recommendations in one chart, thereby enabling the States to see a comprehensive history at a glance. The

F I N D I N G S

comparative information often included tables presenting, for all plans, performance measure scores, PIP ratings and scores, as well as charts showing those plans not in compliance with each of the reviewed State and Federal standards. In addition, some reports included a comparison of the States' plans with national averages.

Reports for 22 States included all of the required deliverables. Seven of these States contracted with the same EQRO to produce their reports. This EQRO structures its reports similarly, organized around each required deliverable.

EQRO reports for eight States were missing information on at least one of the three mandatory activities

External quality reviews must include three mandatory activities: validation of PIPs, validation of performance measures, and reviews of compliance with State standards. EQRO reports from five States were missing information on one mandatory activity, reports from two States were missing information on two activities, and a report from one State was missing information on all three activities. Because PIPs are typically multiyear endeavors, many of the reports that did include data on them could not draw full conclusions about the PIPs' efficacy. In reports we reviewed, plans completed only about 20 percent of the PIPs. In these cases, the reports included a summary of the PIPs' progress at that point and a review of the managed care plans' methodology.

All States reported regularly monitoring their EQROs

States rely on ongoing communication, written status reports, and contract provisions to oversee their EQROs.

All but 1 of the 37 States reported regularly communicating with their EQROs through telephone calls, e-mail, and in-person meetings.²² Typically, contact occurred weekly and involved the EQRO updating the State on its progress in completing particular review activities and how the EQRO was performing toward meeting its timeline. This gave both parties an opportunity to discuss any problems that may have arisen. Staff from one State told us that they had increased contact with their EQRO to weekly calls because of concerns over its performance.

²² The State that reported no ongoing communication with its EQRO performs the external quality reviews itself. This State contracts with EQROs only to produce the annual report.

FINDINGS

Twenty-four States also require their EQROs to submit ongoing status reports during the review period. These reports typically include information on the EQROs' progress toward completing deliverables. Contracts for 22 States require EQROs to submit written status reports or draft reports.

Of the 37 EQRO contracts and requests for proposals we reviewed, 34 included provisions to ensure EQRO compliance with Federal regulations. Contracts in 24 States require EQROs to show that they (1) have sufficient and qualified staff, (2) are entities independent of the State Medicaid agencies, and (3) possess sufficient resources to conduct the external quality reviews. One of these States required its EQRO to pass a readiness review prior to beginning review activities. That State designed its review to ensure that the EQRO had in place the infrastructure to successfully conduct external quality reviews.

Even though States had contractual remedies available to them, EQRO reports for 19 States were still missing either required deliverables or information on mandatory activities. Among the remedies were those allowing States to withhold payment from EQROs or requiring them to purchase a performance bond to be forfeited to a State if an EQRO failed to fulfill its contract. When asked whether they would change the review process based on their experiences to date, only one State specifically addressed the missing elements. That State reported that it was developing stricter requirements for the delivery of external quality review products.

More than half of the States cited concerns with the external quality review process

Twenty-four of the thirty-seven States reported three main concerns: staffing, EQRO report quality, and redundancy with other monitoring efforts.

Sixteen States identified staffing concerns with the external quality review process

Among these States, 15 reported that staff turnover at the managed care plans, State Medicaid agencies, or EQROs prevented them from implementing EQRO report recommendations because of the time needed to train new staff. Seven States specifically identified training EQRO staff as a barrier. These States reported that to get acceptable reports, they had to provide EQROs with technical assistance, thereby using States' time and resources that otherwise would have been spent on their own oversight.

Thirteen States raised concerns with the quality of EQRO reports

States identified concerns ranging from the timeliness of the reports to the degree to which the findings and recommendations could be implemented. In our review of the reports, the substance of recommendations varied widely. Some were extremely broad and difficult to interpret. For example, one report recommended:

Overall, and as seen from the data, tables, and graphs presented herein, the plan is responsible for addressing opportunities for quality improvement through the corrective action plan process established by the State. Although the plan is empowered to design and implement a corrective action plan that most suitably addresses substandard performance It will be imperative that the plan follow completely through with its corrective action plan(s) already approved by the State, which will also be monitored by the State.

Similarly, another EQRO recommended that a plan “monitor performance of health care utilization and health indicators, identify areas for improvement, implement intervention strategies, and monitor the effectiveness of the interventions” without offering any more specific information. Furthermore, two other States reported that, to get an acceptable report, they had to use their own resources to provide technical assistance to their EQROs. Finally, one State found that the EQRO wrote the report with CMS as its primary audience, thus diminishing the report’s value to the State.

Eleven States requested additional technical guidance and feedback from CMS, particularly regarding EQRO reports. Staff we spoke with from one State wanted more guidance from CMS at the national level rather than the regional, particularly regarding minimum standards for report organization.

Five States reported finding EQRO mandatory activities redundant to other monitoring activities

Many States require plans to use specific performance measures, known as the Healthcare Effectiveness Data and Information Set, which EQROs then validate. The National Council on Quality Assurance, which accredits almost 30 percent of the plans for which we reviewed

F I N D I N G S

reports, validates those same measures.²³ In other cases, the States conduct their own reviews as part of their contract with the plans. These duplicate activities can place a burden both on plans, which must provide similar data to EQROs, States, and/or accreditors, and on States, which must use their resources to ensure that plans submit data to EQROs, thus reducing time spent on other oversight issues.

Federal regulations permit States to use data from a Medicare or accreditation review in place of the EQRO review of plan compliance with State standards.²⁴ However, States reported receiving conflicting guidance from CMS, particularly from the regional offices, on this provision. A staff member from one State told us that she relied on their EQRO to determine what data it used in its review. Because of the States' uncertainty, six States requested increased guidance or flexibility from CMS regarding use of accreditation data in external quality reviews.

²³ National Council on Quality Assurance, "MCO Accreditation." Available online at <http://web.ncqa.org/tabid/67/Default.aspx>. Accessed on May 20, 2008.

²⁴ 42 CFR § 438.360.

We found that although most States are using the results of EQRO reviews and find value in the review process, more than half of the States raised concerns regarding the external quality review process, including concerns about staffing, the quality of reports, and redundant data reporting. States oversee the external quality review process through a variety of means, yet EQRO reports for some States are missing required information. To improve the quality and usefulness of the external quality review process, States requested additional guidance and feedback from CMS on these and other issues.

To help States ensure that all required elements are present and maximize the usefulness of external quality reviews, CMS should:

Work With States To Ensure That EQROs Are Providing Complete Information

CMS could, as part of its review of the contents of the EQRO reports, inform States if it finds that any of the required deliverables are missing. Further, CMS could amend its regulations to describe, as a condition for receiving enhanced reimbursement, the steps that States must take to ensure that all required deliverables are included in the quality review results.

Provide Additional Technical Assistance and Written Guidance to States

CMS could do this by organizing teleconferences, offering written guidance, and sharing best practices. CMS should continue to use a format similar to its 2006 teleconference. It should schedule these conferences regularly, perhaps annually or semiannually.

CMS should provide further written guidance to the States. This guidance could build on the tool kit that CMS has already developed. CMS should post its written guidance online to make it easily accessible to any new State Medicaid agency staff.

Because CMS usually receives and reviews the EQRO reports, it should consider culling best practices to share across the States. It could share these during teleconferences.

Finally, CMS should consider two priorities for its technical assistance and written guidance:

R E C O M M E N D A T I O N S

Provide States with minimum standards for report organization and content.

Further guidance could reduce the likelihood that any of the required deliverables would be missing from EQRO reports. Clarifying expectations for the content of reports could improve their level of detail and usefulness, particularly regarding the assessment of plan strengths and weaknesses. CMS could utilize best practices from reports to serve as a model for other States.

Clarify the degree to which Federal regulations allow the data from accreditation reviews to be used. Currently, States have received differing interpretations from CMS central and regional offices regarding whether Federal regulations allow them to use data from accreditation reviews in place of external quality reviews. Providing consistent and specific guidance could improve efficiency for States, plans, and EQROs.

AGENCY COMMENTS

CMS agreed with both of our recommendations and cited actions that it has taken in response to each. It provided feedback to Medicaid Directors in 15 States regarding deficiencies in EQRO reports. CMS also focused one of its triannual audio conferences, available to States and EQROs, on external quality reviews. Further, CMS assisted the National Committee on Quality Assurance in creating a document for States on using accreditation data in their reviews. CMS has begun working with a second managed care accreditation agency, the Utilization Review and Accreditation Committee, on a similar document. The complete text of CMS's comments can be found in Appendix C.

► A P P E N D I X ~ A

Status of States' Arrangements for External Quality Reviews at the Time of Our Review

States that are required to arrange for external quality reviews (because they have Medicaid managed care contracts):

| | | |
|----------------------|----------------|----------------|
| Alabama | Kentucky | Oregon |
| Arizona | Maine | Pennsylvania |
| California | Maryland | Rhode Island |
| Colorado | Massachusetts | South Carolina |
| Connecticut | Michigan | Tennessee |
| District of Columbia | Minnesota | Texas |
| Delaware | Missouri | Utah |
| Florida | Nebraska | Vermont |
| Georgia | Nevada | Virginia |
| Hawaii | New Jersey | Washington |
| Illinois | New Mexico | West Virginia |
| Indiana | New York | Wisconsin |
| Iowa | North Carolina | |
| Kansas | Ohio | |

States that are not required to arrange for external quality reviews (because they do not have Medicaid managed care contracts):

Alaska
Arkansas
Idaho
Louisiana
Mississippi
Montana
New Hampshire
North Dakota
Oklahoma
South Dakota
Wyoming


▶ A P P E N D I X ~ B

| Time Period of EQRO Reports Reviewed | |
|---|---------------------------------------|
| Time Period | Number of States' EQRO reports |
| Calendar Year 2004 | 2 |
| Calendar Year 2005 | 10 |
| Calendar Year 2006 | 3 |
| Fiscal Year 2005 | 4 |
| Fiscal Year 2006 | 4 |
| Fiscal Year 2007 | 1 |
| Other Time Period * | 13 |
| Total | 37 |

Source: Office of Inspector General analysis of State Medicaid agency survey data, 2007.

* Reports covering other time periods include those covering more than 12 months, 12-month periods that did not specify fiscal or calendar years, and periods that we were unable to identify.

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

2008 MAY -5 PM 12:20
GENERAL

DATE: MAY 02 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Wechsler *Kerry Wechsler*
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "External Quality Review in Medicaid Managed Care" (OEI-01-06-00510)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on the OIG's Draft Report entitled, "External Quality Review in Medicaid Managed Care" (OEI-01-06-00510). The objectives of the report are to determine-- 1) the extent to and ways in which States utilize external quality reviews of Medicaid managed care; 2) the extent to which external quality review organizations (EQRO) provided States with required information; and 3) limitations that States identified with the EQR process.

The CMS recognizes the importance of quality improvement for Medicaid beneficiaries and the significance of EQR in that process. Three years ago, CMS created the Division of Quality, Evaluation and Health Outcomes (DQEHQ) with the purpose of facilitating better coordination of Medicaid quality improvement activities throughout the country, including review of the EQR process in States. The EQR process continues to develop in scope given that the relevant regulations are only 5 years old, and that it was contemplated that the process could take 4 years from inception to completion. CMS appreciates the review findings from the OIG report which are, for the most part, consistent with CMS internal findings. In many cases (as noted on page 5 of OIG's Draft Report), CMS has already implemented the recommendations of the report prior to receipt of the report.

It is also very heartening to note that 29 of the 37 States participating in the EQRO review process felt that it was a very important component in the oversight of their Medicaid managed care programs. The CMS agrees with the States that EQR is an important tool in oversight and looks forward to working with the States in the further development of a complete and compliant EQR program and will work with the remaining States to determine how they can obtain value from the process.

OIG Recommendation:

Work with States to ensure that EQROs are providing complete information. CMS could, as part of its review of the contents of the EQRO reports, inform States if it finds that any of the required deliverables are missing. Further, CMS could amend its regulations to describe, as a condition for receiving enhanced reimbursement, the steps that States must take to ensure that all required deliverables are included in the quality review results.

Page 2 - Daniel R. Levinson

CMS Response

The CMS is in fact advising States of deficiencies in required activities and deliverables as they are identified. Every State, with a managed care delivery system, receives routine feedback from CMS on the State's EQR activity. Additionally, formal analysis and feedback through correspondence to Medicaid Directors has been forwarded to at least 15 States over the past year. For example, we have just recently completed an exchange with one of the eight States cited in this report that is not presently doing all of the three required EQRO activities. That State had failed to carry out the required compliance review to determine access to care, structure and operations, and quality measurement and improvement. This omission was discovered during a routine EQR assessment. CMS consulted with the State, clarified the requirements, and secured agreement from the Medicaid Director to address all three of the required activities in future EQRO reviews. Most States have voluntarily agreed to come into EQR regulation compliance once they become aware of specified issues. CMS will also consider reviewing the current regulations to determine if better enforcement mechanisms are required.

OIG Recommendation

Provide Additional Technical Assistance and Written Guidance to States. CMS could do this by organizing teleconferences, offering written guidance, and sharing best practices. CMS should continue to use a format similar to its 2006 teleconference. It should schedule these conferences regularly, perhaps annually or semiannually.

CMS should provide further written guidance to the States. This guidance could build on the tool kit that CMS has already developed. CMS should post its written guidance online to make it easily accessible to any new State Medicaid agency staff.

Because CMS usually receives and reviews the EQRO reports, it should consider culling best practices to share across the States. It could share these during teleconferences.

Finally, CMS should consider two priorities for its technical assistance and written guidance:

Provide States with minimum standards for report organization and content. Further guidance could reduce the likelihood that any of the required deliverables would be missing from EQRO reports. Clarifying expectations for the content of reports could improve their level of detail and usefulness, particularly regarding the assessment of plan strengths and weaknesses. CMS could utilize best practices from reports to serve as a model for other States.

Clarify the degree to which Federal regulations allow the data from accreditation reviews to be used. Currently, States have received differing interpretations from CMS central and regional offices regarding whether Federal regulations allow them to use data from accreditation reviews in place of EQRs. Providing consistent and specific guidance could improve efficiency for States, plans, and EQROs.

Page 3 - Daniel R. Levinson

CMS Response

Again, CMS concurs with OIG's recommendations and has already implemented many of the specific suggestions. While the Draft Report suggests annual or semiannual conferences, we have already instituted tri-annual audio-conferences that are available to States, EQROs, and other public and private entities and individuals on quality topics. While these are not limited to EQR topics, EQR was the main topic in one audio-conference and has been discussed in several others. As OIG acknowledges, CMS presently publishes on its website written guidance on EQR and EQRO contract issues. The suggestion to publish best practices is also already being done on the Medicaid and State Children's Health Insurance Program (SCHIP) Promising Practices Website. These materials can be found at <http://www.cms.hhs.gov/MedicaidSCHIPQualPrac>.

The two specified items listed at the end of the second OIG recommendation also have been the subject of DQEHO interventions. The "minimum standards" content of the EQRO report is specified in two documents ([State External Quality Review Tool Kit](#) and the [EQRO Technical Report Tool Kit](#)) widely distributed at previous conferences and available at the above website. As the feedback from these documents has reached the States and EQROs, we are seeing a marked improvement in EQRO compliance.

The CMS has worked with the National Committee for Quality Assurance (NCQA) on a crosswalk between NCQA standards and CMS regulations. While published by NCQA and not an official CMS publication, CMS worked extensively with NCQA in its preparation and reviews it yearly for the precise purpose of advising States on how to use accreditation data to assist them in showing CMS EQR compliance. CMS has been approached by the Utilization Review and Accreditation Committee (URAC), another managed care organization accreditation agency, to collaborate with them on their version of a crosswalk and has offered similar cooperation to URAC.

We appreciate the considerable effort that has gone into the preparation of this Draft Report and we believe that it is a positive contribution to the CMS goal of improving the quality of care received by our beneficiaries.

Additional Comments:

CMS offers the following additional technical comment on the Draft Report:

- The first paragraph on page 5 under Methodology mentions three States transitioning to EQRO compliance: Georgia, New York and Maine. This was correct when the Report was drafted, but, since that time, Maine has closed out Medicaid managed care, and hence will not be implementing EQRO.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Joyce M. Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston regional office, and Russell W. Hereford, Deputy Regional Inspector General.

Ivan Troy served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Boston regional office who contributed to the report include Rose Lichtenstein; other central office staff who contributed include Cynthia Thomas.