



MONITORING AND ASSESSING THE USE OF EXTERNAL QUALITY REVIEW ORGANIZATIONS TO IMPROVE SERVICES FOR YOUNG CHILDREN: A TOOLKIT FOR STATE MEDICAID AGENCIES

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ABSTRACT: Federal regulations encourage state Medicaid agencies to use external quality review organizations (EQROs) to help implement strategies for assessing and improving the quality of medical services provided to beneficiaries enrolled in managed care plans. However, many states have not availed themselves of this opportunity and may lack guidance on how to do so. This report provides agencies with specifications for developing a scope of work that will lead to conceptually and methodologically sound studies of the quality of preventive and developmental services for young children enrolled in Medicaid. Among other recommendations, the authors note that states may require EQROs to conduct activities like determining compliance with federal Medicaid managed care regulations, measuring performance in terms of preventive and developmental services; and recommending and evaluating performance improvement projects. Creating an infrastructure to monitor the quality of care will have a lasting impact on the health of children, their families, and society.

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EXECUTIVE SUMMARY

Background

Federal regulations issued by the Centers for Medicare and Medicaid Services (CMS) encourage state Medicaid agencies to use external quality review organizations (EQROs) to help implement strategies for assessing the quality of services provided to Medicaid beneficiaries enrolled in managed care organizations (MCOs). The regulations, which took effect in 2003, obligate states to develop a written strategy for assessing and improving care for Medicaid beneficiaries; adopt standardized methods for quality review activities; specify mandatory and optional review activities; and provide specific protocols for conducting the activities. In late 2006, CMS built on this regulatory framework by publishing two “toolkits” designed to help states 1) develop comprehensive quality strategies and 2) implement them through contracts with their EQROs.

While the rules, regulations, and protocols governing EQROs offer states the opportunity to monitor and assess the quality of preventive and developmental services for young children enrolled in Medicaid managed care, many states have not availed themselves of this opportunity. As a 2005 Commonwealth Fund study entitled *Using External Quality Review Organizations to Improve the Quality of Preventive and Developmental Services for Children* indicated, states have a continuing interest in improving the quality of these services but lack specific guidance on how to do so.¹ The CMS toolkits do not provide details regarding quality review activities for particular topics, such as preventive and developmental services. Access to additional technical resources, including specifications for an EQRO’s scope of work, may help states move forward and use current regulations to monitor and assess the quality of preventive and developmental services provided to Medicaid managed care-enrolled children.

About the Study

This study is intended to build on the work of the 2005 Commonwealth Fund study mentioned above that determined the extent to which state Medicaid agencies have used or are planning to use EQROs to improve the quality of preventive and developmental services for young children. The study suggested that only a few states have used EQROs to assess and improve the quality of these services, but more states could do so if appropriate resources were available.

These resources include the influence of “champions” within the state; availability of attention-getting data demonstrating problems in providing preventive and developmental services; access to special funds related to the quality of child health;

political or public perceptions about the quality of child health services; and specific recommendations from CMS, EQROs, or MCOs.

In addition, the study recommended that state Medicaid staff strengthen their knowledge base related to quality-of-care studies of preventive and developmental services. They could then draw from that base to develop appropriate language for specifying a relevant scope of work in requests for proposals (RFPs) and contracts with EQROs.

This study takes the next step by providing Medicaid agency staff with a new toolkit containing guidance on designing a scope of work for EQROs that will lead to conceptually and methodologically sound studies of the quality of preventive and developmental services for Medicaid managed care-enrolled children. State staff can use this guidance in two ways: 1) for ideas about what to include in a scope of work (as part of an RFP for a new contract or as specifications for the next year's work on an existing contract) and 2) as a source of information needed to judge bidders' responses to an RFP.

To develop this toolkit, the authors re-examined reports and RFPs gathered for the previous study and reviewed additional RFPs and contracts from 19 states (contacted because they were identified as having undertaken a pay-for-performance or value-based purchasing effort in their state Medicaid program) to identify various methods used to procure EQROs. Three states participated in follow-up interviews—Illinois, Minnesota, and Washington—either because their RFPs emphasized child health or their procurement processes were unique.

Major Findings

If a state decides to use an EQRO to assess child health services, it either 1) commissions the EQRO with which it contracts for all Medicaid-related quality review activities to conduct designated review activities related to child health or 2) contracts with a separate EQRO with demonstrated experience in assessing child health. The first approach is most common among states, but the EQROs with which they contract may lack substantial experience in assessing the quality of child health services. In either case, if a state wants to ensure that an EQRO will effectively assess child health services, it must ensure that the organization can demonstrate the following attributes:

- comprehensive knowledge of the Medicaid program (especially the child health components);
- ability to apply child health standards to performance measurement;

- capacity to identify relevant outcomes for the state quality improvement strategy; and
- experience in comprehensive assessment of child health services.

After a state selects an EQRO, it typically defines the scope of work by referencing the RFP. A review of state RFPs for EQRO work, however, found that the scope of work defined in most proposals is general and does not focus specifically on preventive and developmental services for children. Given that most states do not contract with an EQRO specifically for activities related to assessing these services, the scope of work is often defined in the context of a broader, overall contract. Any specifications related to preventive and developmental services are likely to be incorporated into a negotiated agreement that defines work for a particular year within a broader multiyear contract.

Recommendations

The RFP provides a critical opportunity for defining the activities of an EQRO. By specifying certain monitoring and assessment EQRO activities in the RFP's scope of work, states can implement goals related to improving the quality of preventive and developmental services and thus exercise the leverage needed to ensure that critical actions are taken. To define such a scope of work, states may include specifications that require EQROs to conduct the following activities related to young children in Medicaid managed care:

- determine MCO compliance with federal Medicaid managed care regulations related to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program;
- measure the performance of a MCO in relation to ensuring the delivery of preventive and developmental services;
- recommend and subsequently evaluate a performance improvement project implemented by the state's MCOs to improve the quality of preventive and developmental services;
- assess a MCO's information system related to preventive and developmental services; and
- conduct a focused study related to preventive and developmental services.

As state staff develop the appropriate scope of work, they will build a knowledge base about child health services that will assist them in judging bidders' responses to the RFP and assessing the quality of deliverables after the contract award. States can take two other steps to contribute to a long-term commitment toward enhancing preventive and

developmental services for young children enrolled in Medicaid. One involves including providers in the policymaking process. Pediatric providers are essential participants for identifying the processes needed to improve the delivery of comprehensive well-child care, particularly since the delivery of preventive and developmental services must be documented accurately.

A second step, therefore, involves planning for the use of electronic medical records to document the provision of developmental screens and their results. This emerging technology offers important opportunities for states to improve standards for providing and documenting preventive and developmental services. To the extent possible, states may want to incorporate these two steps into future contracts with EQROs.

Because preventive and developmental services promote healthy development throughout a child's life and reduce the onset of serious physical and behavioral problems, states have many compelling reasons for making long-term commitments toward improving the quality of these services for young children enrolled in Medicaid. Creating the infrastructure to monitor and assess the quality of preventive and developmental care can have a lasting impact on the health of children and their families, and thus on society as a whole.

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INTRODUCTION

State Medicaid programs play a critical role in promoting the health of children and improving the quality of their health care. Preventive and developmental services are especially important components of these programs because they promote healthy development, reduce morbidity, and prevent the onset of serious physical and behavioral problems.² They generally include an array of screenings and interventions aimed at the prevention, detection, and treatment of physical, cognitive, and behavioral delays or conditions. Examples of such services include vision, hearing, and dental assessments; health education and anticipatory guidance; mental health counseling; and physical examinations.^{3,4}

States are required to provide preventive and developmental services under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Despite the legislative emphasis on early identification and intervention of health problems, many Medicaid-enrolled children do not receive complete developmental assessments; consequently, many developmental problems remain unidentified or go untreated.^{5,6} States also are required to assess the quality of care for Medicaid beneficiaries in managed care plans. As part of that effort, a few states have chosen to examine the quality of preventive and developmental services for children in Medicaid. Policymakers, program administrators, foundations, providers, and consumer groups concerned with child health services should be especially interested in the strategies that states have used or could use to assess and improve the services of interest.

The challenges involved in assessing the quality of child health services became somewhat more complex following enactment of the Deficit Reduction Act (DRA) of 2005, which was signed into law in February 2006. The law gives states an opportunity to make major changes in the benefit packages offered by Medicaid programs, the standards for establishing coverage parameters (such as medical necessity definitions), and the procedures by which children become Medicaid-eligible (such as requiring proof of citizenship).

The DRA contains numerous overlapping provisions, some of them mandatory and some optional.⁷ As a result, the law's affect on children's access to preventive and

developmental services may vary across states, depending on how they implement the DRA's provisions. The DRA's overall long-term impact on access, use, and quality of EPSDT services will not be known for some time, but early analyses suggest the law has changed the use of these services so that they have become the primary means for setting standards of care for Medicaid-enrolled children.⁸

Although the DRA has generated questions about state responsibilities for covering children's health services through Medicaid, states remain obligated under federal regulations established by the Balanced Budget Act (BBA) of 1997 and issued by the Centers for Medicare and Medicaid Services (CMS) to assess the quality of care for Medicaid beneficiaries in managed care organizations (MCOs). The regulations, which took effect in March 2003, require states to develop and implement a written quality assessment and improvement strategy, adopt standardized methods for quality review activities, and conduct annual independent reviews of quality outcomes (Table 1). In return, the regulations give states an enhanced federal funding match for quality review activities and make several types of organizations—usually referred to as external quality review organizations (EQROs)⁹—eligible to conduct the independent reviews.

As Table 1 indicates, the regulations require states to conduct three quality review activities by following standard protocols: determining MCO compliance with federal regulations, validating performance measures used by MCOs, and validating performance improvement projects undertaken by MCOs. For these *mandated* activities, states have two options: EQROs may function as an independent entity to validate MCOs' quality review processes, structures, and activities, or states may conduct those activities themselves. In addition, as part of the *optional* activities, states may turn to EQROs to conduct focused studies, serve as technical resources, or consolidate quality review findings into a comprehensive annual report. Under current federal regulations, a wide range of entities may qualify as EQROs, including medical review organizations, universities, and consulting firms.

Table 1. Major Federal Documents Pertaining to Medicaid External Quality Review Activities

Title	Source	Comments
Medicaid Program; Medicaid Managed Care: New Provisions	<p><i>Federal Register</i>, Vol. 67, No. 115/Friday, June 14, 2002/ Rules and Regulations (See especially p. 41096 and pp. 41105-41109 for the rule and pp. 41031-41054 for comments on an early version and the government’s response.)</p>	<p>Explains the requirement in Section 1932(c) of the Social Security Act for state Medicaid agencies to develop and implement a quality assessment and improvement strategy that includes:</p> <ul style="list-style-type: none"> • standards for access to care; structure and operations; and quality measurement and improvement; • examination of other aspects of care and services related to improving quality; and • regular and periodic review of the improvement strategy.
Medicaid Program; External Quality Review of Medicaid Managed Care Organizations	<p><i>Federal Register</i>, Vol. 68, No. 16/Friday, January 24, 2003/ Rules and Regulations</p>	<p>Explains the requirement in Section 1932(c) of the Social Security Act for state Medicaid agencies that contract with MCOs to provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state and the MCO; establishes the distinction between mandatory and optional EQRO activities as outlined below.</p>
Protocols for External Quality Review of Medicaid MCOs and Prepaid Inpatient Health Plans (PIHPs)	<p>www.cms.hhs.gov/Medicaid/managed_care/mceqrhmp.asp</p>	<p>Provides nine protocols to help implement the provisions in the External Quality Review (EQR) of Medicaid Managed Care Organizations rule published on January 24, 2003.</p> <p>EQR activities are to be conducted in a manner consistent with the protocols.</p> <p>Three <i>mandatory</i> protocols:</p> <ul style="list-style-type: none"> • determining MCO/PIHP compliance with federal Medicaid managed care regulations; • validating performance measures produced by a MCO/PIHP; and • validating performance improvement projects undertaken by a MCO/PIHP. <p>Six <i>optional</i> protocols:</p> <ul style="list-style-type: none"> • calculating measures of the performance of a MCO/PIHP; • validating encounter data; • conducting a performance improvement project for the MCO/PIHP; • conducting focused studies of health care quality independent of undertaking a quality improvement effort; • administering or validating surveys; and • assessing MCO/PIHP information systems.

In late 2006, CMS built on the above regulatory framework by publishing two “toolkits” designed to help states 1) develop comprehensive quality strategies and 2) translate those strategies into EQRO contracts. The first toolkit covers the components that CMS expects states to address in their quality strategies and includes a recommended structure for the written document.¹⁰ CMS, for example, expects states to identify quantifiable performance-driven objectives that demonstrate “success or challenges in meeting intended outcomes.” The second toolkit provides states with guidance on contracting with EQROs. It includes, for

example, recommendations for the structure and content of an EQRO's annual summary report on the quality review activities supported by the state and the MCOs with which the state contracts.¹¹

These regulations and toolkits reflect CMS's interest in broadening the states' repertoire of quality review activities by providing the primary framework and recipes for necessary quality reviews. Specifically, the regulations and toolkits are shaping state quality review activities by:

- standardizing study methods and reporting formats;
- charging MCOs with primary responsibility for conducting quality reviews and implementing quality improvement projects;
- emphasizing EQROs' quality oversight, consultative, and reporting roles;
- influencing the process for developing and implementing focused quality-of-care or quality improvement studies;
- underscoring the need for states to ensure they include appropriate provisions in contracts with both their MCOs and EQROs; and
- broadening the types of entities that qualify as EQROs.

The regulations and toolkits do not, however, provide details on quality review activities for particular topics, such as preventive and developmental services for young children. This report is intended to fill that gap by providing states with examples of specifications for a scope of work that will lead to conceptually and methodologically sound studies of the quality of preventive and developmental services for Medicaid-enrolled children. The purpose of this guidance is to:

- improve the quality of preventive and developmental services for young children enrolled in Medicaid by building on information available through the CMS toolkits;
- show how states can implement quality assessments of children's preventive and developmental services that are consistent with CMS rules, regulations, and protocols noted in Table 1; and
- provide states with the technical resources they need to monitor the quality of preventive and developmental services for Medicaid-enrolled children.

State staff can use this report in two ways: 1) for ideas about what to include in a scope of work (as part of an RFP for a new contract or in specifications for the next year's work on an existing contract) and 2) as a source of needed information for judging bidders' responses to an RFP.

METHODS

This study extends earlier Commonwealth Fund-supported work demonstrating that several factors influence states' decisions to use EQROs to assess the quality of preventive and developmental services for children enrolled in Medicaid.¹² These factors include influential “champions” within the state; availability of attention-getting data demonstrating problems in providing preventive and developmental services; access to special funds related to the quality of child health; the passage of relevant legislation; political or public perceptions about the quality of child health services; and specific recommendations from CMS, EQROs, or MCOs.

Information gathered for the earlier study showed that few states have asked their EQROs to conduct studies related to preventive and developmental services for Medicaid-enrolled children. The present study expanded on that finding to determine what technical guidance states would find useful in monitoring and assessing the quality of these services. To develop the current report, project staff:

- re-examined RFPs and reports gathered for the previous study;
- obtained and reviewed additional RFPs and contracts from 19 states to understand further the various methods used by states to select and contract with EQROs;¹³
- conducted telephone interviews with staff in three selected states (Illinois, Minnesota, and Washington);¹⁴ and
- convened an advisory panel of representatives from state and federal agencies, a MCO, and an EQRO to help identify specific informational needs for the target audience.

Based on this information and in consultation with The Commonwealth Fund and the panel of experts, project staff developed this report and the accompanying toolkit material.

FINDINGS

Information gathered from state documents, discussions with staff from selected states, and meetings with members of the advisory panel led to two main findings and one secondary finding.

First, EQRO contracts typically reference the relevant RFP and other documents (e.g., the state quality strategy) to define the scope of work that a state expects from an EQRO. State quality improvement strategies and virtually all RFPs, however, include only general language related to the types of activities expected from EQROs during the contract period (typically three to five years); they do not focus on quality review

activities related to particular areas, such as preventive and developmental services for young children. While this approach preserves a state's flexibility to define a set of activities for an EQRO in any given year of the contract period, it also means that state staff must negotiate an annual scope of work that defines specific activities. Moreover, few states have developed scopes of work specifically related to preventive and developmental services; those that have done so have incorporated them into annual work plans that generally are not publicly available.

Second, states take one of two approaches to contracting with an EQRO to conduct studies related to child health care:

- commission the EQRO with which they contract for all Medicaid-related quality review activities to conduct designated review activities related to child health; and
- contract with an EQRO, which may or may not be the same EQRO that engages in other quality review activities, to undertake specific activities related to child health services.

The first approach is the most common among states and the most administratively simple because a state contracts with only one EQRO. Under this approach, however, an EQRO needs to have the requisite skills to conduct quality review activities across all of the many topic areas and populations with which state Medicaid programs are involved (e.g., chronic care services for the elderly, mental health services, disability-related programs). If, however, the EQRO lacks these skills, it must subcontract with an appropriately skilled entity. Moreover, at the time of the decision to award a multiyear contract to an EQRO, states need to ensure that the EQRO has the specific knowledge and capacity related to child health services if it is to conduct quality reviews of preventive and developmental services for young children. States can ask bidders responding to an RFP to document past work on preventive and developmental services for children or provide examples of hypothetical studies that include appropriate measurement strategies and data analytic methods.

The second approach allows states to hire an EQRO with specific experience in assessing the quality of child health services. Washington State, for example, commissioned an EQRO specifically to implement a multiyear initiative related to children's preventive services, and Minnesota contracted with an EQRO specifically to conduct a study of its EPSDT program.

Finally, information gathered through document reviews and discussions with key stakeholders led to an additional finding: the involvement of providers is an essential component in a long-term plan to improve the quality of children's preventive and developmental services. Washington State, for example, has worked successfully with providers and its EQRO through the Children's Preventive Healthcare Initiative (CPHI). Washington implemented the initiative in 2003 to assist MCOs in meeting federal requirements for children's preventive care, including EPSDT services and immunizations. Through the CPHI, providers developed and applied interventions to improve well-child care, and the EQRO provided performance feedback to clinics and MCOs. The EQRO also conducted training sessions so that the state, providers, and MCOs could further enhance their respective quality improvement methods and define additional interventions to improve children's preventive health care. According to state staff, the CPHI was recently reborn as the Children's Health Improvement Collaborative. The purpose of this learning collaborative is to improve the delivery of care for low-income children diagnosed with asthma, attention deficit-hyperactivity disorder, or weight problems. Through the collaborative, medical teams learn to measure and improve the quality of care delivered by their practices.

North Carolina and Vermont also have developed statewide partnerships of providers and quality experts to help pediatric practices engage in practice-based quality improvement activities.¹⁵ Both states have participated in the Healthy Development Learning Collaborative, a partnership of providers, state agencies, and academic institutions committed to improving preventive and developmental services for children up to five years of age. The collaborative supports providers in engaging families in a partnership to ensure that children and their parents receive the support needed to promote healthy development.¹⁶ Physicians who participate in the collaborative receive Continuing Medical Education (CME) credit. Studies of these practices have shown success in improving children's receipt of preventive and developmental services.¹⁷

In another example of collaboration, providers have had a strong influence in North Carolina as a result of working closely with the state through primary care case management networks. In addition to its work with the learning collaborative, North Carolina has changed its EPSDT requirements to require primary care providers to use a formal, validated developmental screening tool at well-child visits. Since then, the proportion of children screened for developmental problems has steadily increased.¹⁸ The state also has developed resources to guide providers in implementing developmental screening and surveillance, including an office resource guide, anticipatory guidance for use at each well-child visit, and a video workbook.

IMPLICATIONS

The study's findings have two implications for states. First, as states continue demonstrating increased interest and capacity in assessing the quality of preventive and developmental services for Medicaid-enrolled children, they will need to develop scope-of-work specifications for their EQROs. To assist states in this process, this section outlines five model specifications. The appendix provides an example of a scope of work that includes technical language defining EQRO activities related to the assessment and improvement of preventive and developmental services for young children.

A second implication involves building the capacity of staff to assess EQRO experience in conducting quality reviews of child health services. As mentioned earlier, states need to ensure that their EQROs have the knowledge and capacity related to child health services if the organizations are to conduct quality reviews of preventive and developmental services. To help states in their selection processes, this section also describes four core competencies.

Scope of Work for an EQRO to Assess and Improve Preventive and Developmental Services for Medicaid-Enrolled Children

The quality review framework established by federal regulations charges MCOs with primary responsibility for conducting quality review activities and vests EQROs with an oversight and consultative role. Consequently, states need to ensure they include appropriate provisions in contracts with both their MCOs and EQROs. Five quality-related specifications for an EQRO's scope of work are noted below and then described in greater detail.

- The EQRO will determine MCO compliance with federal Medicaid managed care regulations related to EPSDT.
- The EQRO will measure the performance of a MCO relative to ensuring the delivery of children's preventive and developmental services.
- The EQRO will recommend and subsequently evaluate a performance improvement project for implementation by the state's MCOs to improve the quality of preventive and developmental services.
- The EQRO will assess a MCO's information system related to preventive and developmental services.
- The EQRO will conduct a focused study related to children's preventive and developmental services.

The specifications above are keyed to CMS mandatory and optional activities. Few states will contract with an EQRO exclusively to assess preventive and developmental

services; hence, any specifications governing the assessment of these services must likely be incorporated into a larger scope of work for a contract or take the form of a negotiated agreement that defines work for a particular year within a broader multiyear contract.

The EQRO will determine MCO compliance with federal Medicaid managed care regulations related to EPSDT. In explaining how it would conduct the assessment activity, an EQRO may discuss practical strategies for assessing MCOs' delivery of services required under the EPSDT provisions. The 1967 Medicaid statute mandates that states must provide EPSDT services to Medicaid-eligible children under age 21.¹⁹ The EPSDT program is designed to provide children with preventive services; early detection of health and developmental problems; and medical services to treat these problems effectively. The program is also designed to ensure that states conduct outreach, arrange transportation, and schedule appointments. Over the years, various amendments to the statute have defined the EPSDT benefit further. Most significantly, the 1989 Omnibus Budget Reconciliation Act (OBRA-89) clarified and strengthened state requirements for implementing and reporting on EPSDT screening. OBRA-89 also required the U.S. Secretary of Health and Human Services to set state-specific annual goals for children's participation in EPSDT.²⁰

Throughout the last decade, states have increasingly looked to managed care as a mechanism to deliver Medicaid benefits, including EPSDT. In 2005, 63 percent of the entire Medicaid population was enrolled in managed care.²¹ To ensure that states meet their obligations to Medicaid beneficiaries enrolled in managed care, the federal government issued Medicaid managed care regulations. Among the several regulations, states are obligated to ensure that MCOs implement procedures to deliver primary care to all MCO enrollees; adopt, make broadly available, and apply appropriate practice guidelines; develop an ongoing quality assessment and performance improvement program for the services delivered to enrollees; and use encounter data (or another method specified by the state) to maintain a health information system that collects and reports data on enrollee and provider characteristics, as well as on services furnished to enrollees.

States contracting with MCOs to serve Medicaid-enrolled children face challenges in ensuring the receipt of EPSDT services. EQROs can assist states by determining MCO compliance and assessing whether preventive and developmental services have been provided. Strategies to determine compliance could include:

- establishing whether MCOs require providers to use standardized, validated screening tools such as the Parents' Evaluation of Developmental Status or the Ages and Stages Questionnaire;

- assessing children’s access to preventive and developmental services as a 1) mandatory activity by determining MCO compliance with the federal managed care regulations related to access or 2) an optional focused study on disparities in children’s access to preventive and developmental services;
- verifying the accuracy and timeliness of MCO data systems (i.e., coding and data entry) to assess whether data (including encounter data) on EPSDT service utilization are being captured;
- conducting focus groups or interviews with panels of beneficiaries and their families to determine the content of well-child visits; and
- conducting medical record reviews that drill down to the level of preventive and developmental services (e.g., examining records for evidence of developmental screening, including use of a validated developmental screening instrument, or for evidence of mental health screening of adolescents).

States cannot avoid EPSDT obligations by simply contracting with MCOs and requiring the organizations to meet state obligations. Ultimately, it is the states’ responsibility to ensure that Medicaid children receive comprehensive services in a timely fashion.

The EQRO will measure the performance of a MCO in relation to ensuring the delivery of children’s preventive and developmental services. Focusing solely on the number of well-child visits does not adequately measure content or quality of care. An EQRO’s approach to assessing service delivery activities should include a discussion of appropriate indices of the delivery of preventive and developmental services. Appropriate measures could include the following.

- **Network adequacy.** An EQRO can determine if the number of primary care physicians (PCPs) for Medicaid enrolled-children is sufficient by examining provider availability and accessibility. A measure of network adequacy also should establish the extent to which PCPs can provide an appropriate “medical home” for Medicaid children. A medical home is a comprehensive approach to providing medical services, including well-child care. According to the American Academy of Pediatrics, a medical home provides care that is “accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”²²
- **Education in preventive and developmental services.** An EQRO can ascertain whether PCPs are asked to document how they maintain current knowledge about measurements, screening, and treatment activities related to

children's preventive and developmental services. For instance, are PCPs required to document a certain number of CME credits or activities related to children's services? Do any educational programs train physicians in screening guidelines, coding procedures, and billing? Such educational efforts help ensure that physicians recognize the importance of preventive and developmental services and correctly deliver and document such services.

- **Provider support for appropriate documentation of service delivery.** An EQRO can establish how the Medicaid agency supports providers in ensuring appropriate documentation of preventive and developmental services. Does the agency offer providers training on documentation? A state may have sophisticated data storage capacity, but without substantial provider training and support, it will miss opportunities for documenting the content of service delivery. With the emergence of electronic medical records (EMRs), it is particularly important to train providers in the accurate documentation of services, including preventive and developmental services. Furthermore, the Medicaid agency should support all providers and ensure that training does not exclude those who, for instance, may lack the technical means to access a web-based training tool.
- **Rate of well-child visits per age group.** An EQRO can document the rate of well-child visits for each age group. Although federal regulations establish the standard of an 80 percent compliance rate overall, that rate is not easy to attain for certain age groups, such as adolescents. An EQRO may suggest appropriate age- and gender-specific benchmarks for progress toward this standard and identify obstacles that must be addressed to reach it.

The EQRO will recommend and subsequently evaluate a performance improvement project for implementation by the state's MCOs to improve the quality of preventive and developmental services. An EQRO's approach to quality improvement should address at least two strategies for helping MCOs reduce the gap between what is known about the appropriate use of preventive and developmental services and the extent to which PCPs deliver such services. Learning collaboratives and programs designed to implement best practices are two possible strategies for EQRO quality improvement efforts.

- **Learning collaboratives.** Learning collaboratives are partnerships of health care provider teams that participate in joint educational and planning efforts to reduce barriers to high-quality care by implementing new procedures and measuring

selected outcomes. In one state, a learning collaborative had strong positive effects on the number of children in 14 pediatric practices who received preventive services such as immunizations, anemia screening, dental assessments, and blood pressure screening.²³ A scope of work could encourage an EQRO to use learning collaboratives as a means to improve preventive and developmental services. EQROs could work with MCOs to support the application of collaboratives to pediatric practices in MCO networks.

- **Best practices programs.** Several groups have recently led efforts to promote consistent use of best practices related to preventive and developmental services. In North Carolina, for example, providers worked together to enhance the use of standard screening tools to identify behavioral and developmental problems. A group of pediatricians in leadership positions in the state focused on pediatric offices, first in a few counties, and then across the entire state to encourage consistent use of screening tools (either the Ages and Stages Questionnaire or the Parents Evaluation of Developmental Status) at designated well-child visits.²⁴ The EQRO's scope of work should reflect an awareness of those efforts and outline potential strategies for supporting MCOs in ensuring consistent use of best practices and evaluating such efforts. Best practices may include:
 - consistent use of validated developmental screening tools;
 - standard information on critical developmental challenges as part of anticipatory guidance; and
 - strategies for improving documentation of the content of well-child visits.

As EQROs undertake quality improvement efforts, they will likely face complicated relationships arising from interactions between providers and MCOs. Providers may have strained relationships with the MCOs with which they contract, and they may be unfamiliar with EQROs or the Medicaid regulations governing quality of care. As a result, state Medicaid staff may have to broker provider-MCO relationships and work with EQROs to resolve tensions. Staff must first identify an effective means for initiating and supporting a collaborative planning process that involves several stakeholders and then support the EQRO in initiating and sustaining such a collaboration.

Other possible performance improvement projects related to preventive and developmental services that EQROs might suggest to MCOs include the following:

- assessing the impact of educational campaigns designed to increase consumer awareness of preventive and developmental services and enhance provider support for documenting the delivery of these services; assessing the impact of system-wide innovations for delivering preventive and developmental services (e.g., reimbursement for use of a standardized developmental screening instrument);
- requiring MCOs to develop and submit annual corrective action plans for review by the state or EQRO;
- assessing documentation methods currently used by contracted providers and facilitating a process for developing forms that are well-suited to collecting information on preventive and developmental services (e.g., a standard medical record form that cues physicians to provide uniform developmental screenings and anticipatory guidance);
- evaluating the impact on practice patterns of the use of standard, online provider training programs related to preventive and developmental services;
- evaluating alternative reminder systems (e.g., telephone calls and incentives) to increase the percentage of well-child visit appointments kept by parents; and
- examining the system of referral tracking (e.g., an automated tracking system that can show whether a child referred for further evaluation actually obtains that service);

The EQRO will assess a MCO’s information system related to preventive and developmental services. Federal regulations (CFR 438.242) require states to ensure that each MCO uses encounter data (or other methods specified by the state) to maintain a health information system that collects and reports data on enrollee and provider characteristics and services furnished to enrollees; the regulations also require states to ensure that MCOs maintain accurate and complete data. If specific data on preventive and developmental services can be included in the data system, the state can ask its EQRO to synthesize the data across MCOs and develop a report on the extent of service delivery. A system that includes data on complete well-child examinations could include documentation on a child’s birth date and health history; findings from physical examinations; height, weight, body mass index, or head circumference as appropriate; findings from developmental and mental health screenings; immunizations received; results of lead screening; provision of education and anticipatory guidance; and whether a referral was made (and, if so, for what type of service).

Most MCO encounter data systems, however, do not include all (or even most) of the information listed above. Data on claims also do not reliably convey basic information about preventive and developmental services. Many MCOs pay PCPs on the basis of fee-

for-service claims that include standard diagnostic and procedure codes. Procedure codes, however, provide little information about what actually occurs during a well-child visit. The code for a well-child visit, for example, does not indicate whether a pediatrician provided anticipatory guidance, performed an unclothed physical examination, or reviewed the child's immunization status. A pediatrician could have provided all of these services or only one of them but would still submit the same code for billing purposes. Even medical records do not necessarily provide reliable documentation of preventive and developmental services. Providers rarely note, for example, the specific anticipatory guidance that they provide (e.g., Johnny was told to wear his bicycle helmet).

A state could ask an EQRO to analyze the data problem and suggest potential steps to ensure that information systems address data gaps. An effective approach could include several actions that an EQRO could take, including:

- a flow chart indicating in detail what and how information about preventive and developmental services moves through the system (e.g., from provider to MCO to the state);
- identification of barriers and solutions to developing an effective reporting and information-sharing system that would support quality reviews of the delivery of preventive and developmental services; and
- the extent to which a MCO or the state gives information about the delivery of preventive and developmental services back to providers in such a way that providers may use it to improve services.

The EQRO will conduct a focused study on children's preventive and developmental services. A study on the quality of children's preventive and developmental services could focus on any one of several topics, including developmental screening, anticipatory guidance, rates of maternal depression, lead screening, barriers to full immunization, oral health, or nutrition and obesity. Prioritizing these and other topics should take place through a collaborative process with key stakeholders, including representatives of the pediatric provider community, MCO leaders, and staff from the state maternal and child health agency, and should account for emerging public health and health care delivery issues in the state. The scope of work should explain the process of topic selection (e.g., who is involved in the process, how topics are prioritized, and so forth).

In addition to explaining the process used to select topics, states should ask EQROs to describe in their proposals what research methods will yield the most scientifically

credible evidence for addressing important research questions. Depending on the topic and specific questions, several research designs could be feasible, including chart reviews, analyses of claims and administrative data, surveys of parents or children, or qualitative interviews with key informants. EQROs should be expected to explain the benefits and drawbacks of several approaches and indicate their recommended approach. If an EQRO decides to rely on surveys or qualitative interviews, it will have to address questions of sample selection (e.g., a convenience sample or a random sample?). CMS has developed templates that may be useful in preparing an RFP that calls for focused studies.²⁵

EQROs may undertake studies of the quality of preventive and developmental services that:

- use consumer or provider surveys to assess perceptions of the quality of preventive and developmental services;
- examine MCOs' use of practice guidelines related to preventive and developmental services;
- use surveys to assess family experiences in relation to preventive and developmental services;
- use administrative and claims data to examine geographic or racial disparities across age groups in rates of well-child visits;
- use a combination of administrative and survey data to examine the relationship between the provision of preventive and developmental services and specific indices of risk for future problems, such as high body mass indexes and behavioral problems in school;
- use claims and administrative data to track the long-term relationship between well-child visits in the first two years of life and the use of medical services from ages three through five;
- evaluate the effects of alternative periodicity schedules on service use and health outcomes; and
- examine the effects of changes in reimbursement methods on the content and quality of well-child examinations.

Skills, Experiences, and Competencies Needed by EQROs

EQROs can have an important impact on both the lives of the Medicaid population and the performance of providers. They are expected to serve as technical resources to both the state and MCOs, but their capabilities vary, particularly that of conducting studies on children's preventive and developmental services. As discussed in an earlier report,

even if a state has identified a strong champion and maintains the data needed to push the issue of preventive and developmental services to the top of the state's priority list, it needs an EQRO with appropriate skills, experiences, and competencies.²⁶ Specifically, to conduct studies of preventive and developmental services, an EQRO needs 1) staff with a comprehensive knowledge of the Medicaid program (especially the child health components), 2) the ability to apply child health standards to performance measurement, 3) the capacity to identify relevant outcomes, and 4) experience in assessing the quality of child health services.

Knowledge of Medicaid. A state's RFP for an EQRO should require a capability statement demonstrating the organization's general knowledge of Medicaid and its intricacies, including the EPSDT program. With the Medicaid managed care environment in constant flux, quality review organizations that are not entrenched in Medicaid might find difficulty in keeping abreast of changes. An EQRO should not only understand the complexity of state Medicaid programs; it also must demonstrate experience with Medicaid populations, policies, data systems, and processes. In addition, it must be able to document its familiarity with managed care delivery systems, organizations, and financing. Specifically, an EQRO should understand the calculation methods for CMS Form 416 (the standard form required by CMS for the provision of child health services); strategies for conducting audits of the data provided by MCOs; the strengths and drawbacks of various research methods for assessing the delivery of child health services; and the rationale for using other indices of child health care quality.

Bidders also should be familiar with the specific needs of the state's Medicaid agency and with any changes in the Medicaid managed care program, such as recent redefinitions of case management or rehabilitation services or changes in access to care as related to implementation of the DRA. The EQRO should be especially familiar with emerging trends in public health and service delivery relevant to child health (e.g., recent data on childhood obesity).

Applying child health standards to performance measurement. In their oversight role, EQROs can assist states in ensuring that children's developmental needs are identified and addressed. EQROs should be familiar with measurement issues related to evaluating care provided to Medicaid-enrolled children, including the Consumer Assessment of Healthcare Providers and Services for children and the relevant Health Plan Employer Data Information Set measures.²⁷ To conduct a comprehensive study of preventive and developmental services, EQROs need a working knowledge of data sources and strategies for measuring the quality of preventive and developmental services in terms of the process of service delivery and service outcomes.

By measuring the delivery of children's health services, EQROs can assess whether MCOs are ensuring the delivery of EPSDT services and determine the accuracy of MCO reports of EPSDT data. EQROs should understand the special challenges of measuring children's health and development and be able to apply appropriate benchmarks, such as standards developed by the American Pediatrics Association for the delivery of well-child care.

Identifying relevant objectives. CMS expects states to include in their strategies a set of quantifiable, performance-driven objectives that provide the basis for demonstrating success or improving performance. Unless they have already defined objectives relevant to preventive and developmental services as part of their overall quality strategy, states could ask EQROs to provide a list of potential objectives that are relevant, measurable, and achievable. Examples of such objectives include the following.

- Increase by 50 percent the number of pediatric practices that use a standard developmental screening tool.
- Increase by 25 percent the number of children ages five years and under who undergo all recommended well-child examinations.
- Double the number of practices that distribute written information related to the topics for which the PCP has provided anticipatory guidance.
- Decrease by 25 percent the disparity between rates of primary care visits for white and non-white children.
- Increase by 10 percent the number of practices using EMRs that include documentation of all components of an EPSDT screen.

The set of objectives related to preventive and developmental services must necessarily be specific to each state and possibly to each MCO; therefore, they must be shaped by the state's pediatric leadership and recent state activities in this area of well-child care. EQROs could play a vital role in developing these specific objectives based on consensus conferences, key informant interviews, and focus groups.

Experience in comprehensive assessment of the quality of child health services.

An EQRO should be experienced with the range of analytic and survey methods needed to conduct research on the quality of child health services. Many states rely on their EQROs to examine rates of occurrence of specific services rather than directing them to investigate the content of well-child visits. EQROs often use encounter data, for example,

to document the number of well-child visits or provision rates of a specific service (e.g., immunization). CMS Form 416 encourages states to use counts of encounters as measures of the delivery of preventive or developmental services, but this strategy is a poor proxy for determining whether these specific services were actually provided during a well-child visit.

To assess the actual content and quality of well-child visits, an EQRO should be experienced in the following methodologies.

- **Survey data.** One of the optional EQRO activities included in the CMS protocols is the administration or validation of surveys. MCOs often conduct surveys, but they may not ask about the content of well-child visits or may not use nationally standardized items with acceptable levels of reliability or validity. Parent-reported surveys such as the Promoting Healthy Development Survey provide a comprehensive assessment of the provision of well-child care and include information not found in administrative and electronic data systems.
- **Claims and administrative records.** The protocols that accompany the federal EQRO regulations require familiarity with and analysis of administrative data. Administrative data include encounter forms that document well-child visits, but, as discussed above, the data often omit details on preventive and developmental services and may require the EQRO to drill down further into children's medical records. Familiarity with the strengths and weaknesses of Medicaid billing claims is also essential for assessing quality of care.
- **Qualitative interviewing and record reviews.** Conducting interviews with key informants as well as focus groups with beneficiaries and their families is a useful strategy for assessing projects or identifying innovative ideas. The ability to conduct medical record reviews is also important. Such reviews may gather information on preventive and developmental services that may not be available through other methods. Although qualitative interviews and record reviews usually involve limited samples and therefore may not be generalized to all children in a state's Medicaid program, they can be useful for gathering information on experiences with program implementation and suggesting program improvements.

SUMMARY AND RECOMMENDATIONS

Despite the importance of early identification and intervention, many children enrolled in Medicaid do not receive the comprehensive developmental assessments that states are required to provide through the EPSDT program. Moreover, few state Medicaid programs have systematically examined the extent and quality of children's preventive and developmental services, even though they are required to do so for children in Medicaid

managed care plans. Children are the single largest group of Medicaid beneficiaries, and states can contribute substantially to improving their health outcomes by ensuring the quality of required preventive and developmental services.

Since March 2003, federal regulations have obligated states to assess the quality of care for Medicaid beneficiaries enrolled in managed care plans, and many states have contracted with EQROs to assist them in this process. The regulations require states to:

- develop and implement a written quality assessment and improvement strategy;
- adopt standardized methods for quality review activities; and
- conduct annual independent reviews of quality outcomes.

In late 2006, CMS enhanced its regulatory framework by publishing two toolkits designed to help states 1) develop comprehensive quality strategies and 2) translate these strategies into effective contracts with their EQROs. The new toolkit discussed in this report enhances CMS guidance by providing specifications for EQRO activities related to assessing the quality of preventive and developmental services for young children enrolled in Medicaid. For states interested in this assessment, staff in the Medicaid agency should perform the following:

- develop a sufficient understanding of contemporary strategies for assessing the quality of children's preventive and developmental services in order to evaluate EQROs with respect to their:
 - knowledge of the child health components of the Medicaid program;
 - ability to apply child health standards to performance measurement;
 - capacity to identify relevant health outcomes; and
 - experience in assessing the quality of child health services;
- ensure appropriate alignment of the state's quality strategy, EQRO scope of work, and MCO contracts; and
- generate the necessary scope of work specifications for the EQRO contract.

For many states, ensuring the implementation of quality improvement activities requires bringing together staff with different areas of expertise, such as the quality measurement expert and the child health expert. Infrequently, the necessary expertise resides in one person. It is critical to bring all the relevant perspectives to the table when trying to implement the objectives outlined above.

The scope-of-work specifications require that each EQRO undertake the following:

- determine MCO compliance with federal Medicaid managed care regulations;
- measure MCO performance in relation to ensuring the delivery of preventive and developmental services for young children in Medicaid;
- recommend and subsequently evaluate a performance improvement project implemented by the state's MCOs;
- assess a MCO's information system related to preventive and developmental services; and
- conduct a focused study on children's preventive and developmental services.

Implementing an appropriate scope of work for EQROs is only one step in building a sustainable commitment to improving preventive and developmental services for children enrolled in Medicaid. As state staff integrate child health outcomes into an overall quality improvement strategy and align their RFPs and EQRO contracts to support such a strategy, they can begin to put in place other processes that will contribute to a long-term commitment to enhancing preventive and developmental services. States must 1) involve providers in the policymaking process and 2) plan for the use of EMRs.

As noted, North Carolina, Vermont, and Washington State all have had success in collaborating with providers to help improve children's preventive and developmental services. One way that states can replicate such success is by including in their contracts a requirement for MCOs and EQROs to participate in a collaborative project with providers. For contracts with MCOs, states could also include collaborative projects as part of their mandatory quality improvement activities. Stakeholder collaboration is essential to identifying and implementing sustainable activities that may lead to improved quality of preventive and developmental services.

Continued growth in EMR systems presents important opportunities for state agencies to improve standards for providing and documenting preventive and developmental services. Through the cues embedded in standard screens, data fields, and automatic reminders, EMRs can help improve the quality of services that children receive.²⁸ To improve the delivery of such services, pediatric practices can use EMRs for decision support (e.g., deficiency alerts for immunizations or prompts for preventive services) or for links to specific screening questions or anticipatory scripts and handouts.²⁹

Studies have indicated an association between the use of an EMR system in a pediatric practice and improved quality of care, particularly in the area of preventive service delivery.^{30,31,32} One study found that pediatric primary care delivered in a practice using EMRs was better than that delivered in non-EMR practices in every area evaluated, including health history, risk assessment, developmental screening, and anticipatory

guidance.³³ It is worth noting, though, that even encounter data systems with EMRs do not always capture information systematically. Even so, as the number of pediatric practices using EMR systems increases, states should recognize that this emerging technology offers an opportunity for improving pediatric care, including the delivery of preventive and developmental services.

An enduring commitment to children's health means that states must implement an appropriate scope of work that will provide EQROs with the necessary direction to conduct quality improvement activities, involve providers in the policymaking process, and plan for the use of EMRs. In a continually evolving regulatory environment, states often focus on meeting requirements and operating within budget constraints. Regardless of the regulatory climate, however, states have many compelling reasons for making long-term commitments to improving the quality of preventive and developmental services for young children enrolled in Medicaid. These services promote healthy development throughout a child's life and reduce the onset of serious physical and behavioral problems. Creating the infrastructure to monitor and assess the quality of preventive and developmental care can have a lasting impact on the health of children and their families, and thus on society as a whole.

APPENDIX: SAMPLE REQUEST FOR PROPOSALS AND CONTRACT LANGUAGE ON SCOPE OF WORK

SAMPLE RFP AND CONTRACT LANGUAGE ON SCOPE OF WORK

Note: The following document is intended to illustrate the type of provisions that a state may use for its EQRO. It was developed based on a review of actual state documents and the tasks described relate to the mandatory and optional EQRO activities required by the Federal regulations. The document is not prescriptive and a state may choose to alter the language to ensure compliance with its own state procurement process and laws.

SECTION #1: GENERAL CONTRACTOR DUTIES

(a) Overview

The Balanced Budget Act of 1997 (BBA) and Federal Regulations 42 CFR 433 and 438, require that State Medicaid Agencies must contract with qualified outside entities, External Quality Review Organizations (EQROs), to conduct the analysis and evaluation of the data and information collected in specified mandatory activities and may also utilize the EQROs for optional activities. This Request for Proposal (RFP) seeks qualified organizations that are able to perform EQRO functions as outlined in the Federal Regulations noted above and incorporated by reference in [Section #] below.

OPTION FOR STATES WITH SEPARATE SCHIP PROGRAMS THAT USE MANAGED CARE:

The separate SCHIP programs are required by federal law to monitor and improve quality of care, though an EQRO is not necessary to perform these functions. [State Medicaid Agency] anticipates that the EQRO obtained pursuant to this procurement will also assume responsibility for assessing SCHIP activities. Therefore, within the remainder of this document, all references to review activities apply to both Medicaid and SCHIP, unless otherwise indicated.

(b) Performance of Tasks Set in RFP and/or contract

It is expected that the Contractor will address and perform the tasks set forth in this RFP. At this time, [State Medicaid Agency] shall require the Contractor, at a minimum, to perform the analysis and evaluation of the following mandatory activities:

- (i) Validation of performance improvement projects conducted by the Managed Care Organization/Prepaid Inpatient Health Plan (MCO/PIHP);
- (ii) Validation of performance measures calculated by the MCO/PIHP; and

(iii) Review of MCO/PIHP compliance with federal and state structural and operational standards, including:

- a. Availability of services
- b. Continuity and coordination of care
- c. Coverage and authorization of services
- d. Establishment of provider networks
- e. Enrollee rights
- f. Confidentiality
- g. Enrollment and disenrollment
- h. Grievance systems
- i. Subcontractual relationships and delegation
- j. Use of practice guidelines
- k. Health information systems
- l. Mechanisms to detect under and over-utilization of services

(c) Performance of Other Elements of Work if Deemed Appropriate

It is also understood that the above listing of tasks and activities is not all-inclusive and that other elements of work may be addressed within the Contractor's proposal, if deemed appropriate. [State Medicaid Agency] shall have the option of utilizing the Contractor for, at a minimum, the following optional activities:

- (i) Validating client level data such as claims and encounters;
- (ii) Administrating or validating a patient and/or provider survey;
- (iii) Calculating performance measures;
- (iv) Conducting performance improvement projects; or
- (v) Conducting focused studies of quality of care

[State Medicaid Agency] may also ask EQRO to provide technical assistance to the State and MCOs as they attempt to fulfill their quality of care obligations (the number of hours to be determined).

Section #2: Federally-Defined Mandatory Activities (42 CFR 438.358(b))

a) Validation of MCO Performance Improvement Projects (PIPs)

Description: The validation of performance improvement projects (PIPs) as required by the state to comply with requirements set forth in 42 CFR.438.310 et. Seq., and that were underway during the preceding 12 months includes: (1) the validation of performance improvement projects conducted by MCOs or (2) the analysis and evaluation of the

[State Medicaid Agency]'s validation of PIPs if the state has assumed the responsibility of validating PIPs.

Service Tasks include, but are not limited to:

- (i) The Contractor will work with [State Medicaid Agency] to annually review and validate the methodology to be utilized for MCO or PIHP performance improvement projects meeting the BBA mandatory definition.
- (ii) The Contractor will work with [State Medicaid Agency] to annually validate the procedure of the MCO or PIHP meeting the BBA mandatory performance improvement project definition.
- (iii) The Contractor will work with [State Medicaid Agency] to annually validate the results of the MCO or PIHP BBA mandatory performance improvement projects.
- (iv) The Contractor will follow standard research methodology practices in validating the MCOs' performance improvement methodologies and results including, but not limited to:
 - Developing a work plan for the duration of the validation process
 - Validating any necessary background research
 - Validating population/sample selection criteria
 - Validating data collection methods and tool; data verification; and data analysis and interpretation processes, including tables and graphics
 - Validating results/final reports and executive summary, according to standard research reporting guidelines
 - Ensuring validation process is in compliance with current BBA requirements
- (v) The Contractor shall submit a work plan for the performance improvement project to [State Medicaid Agency] for review and approval prior to implementation.
- (vi) [State Medicaid Agency] and Contractor may consider child preventive and developmental services in the list of potential topics for MCO PIPs for year 2 and subsequent years.

(b) Validation of MCO performance measures

Description: The validation of the performance measures calculated by MCOs, the analysis and evaluation of the [State Medicaid Agency]'s validation of MCO or PIHP performance measures reported (as required by the state), or MCO or PIHP performance measures calculated by the state during the preceding 12 months to comply with the requirements set forth in 42 CFR.438.310 et. seq.

Service Tasks include, but are not limited to:

- (i) The Contractor will work with [State Medicaid Agency] to annually review and validate the methodology to be utilized for measuring MCO or PIHP performance measures meeting the BBA mandatory definition.
- (ii) The Contractor will work with [State Medicaid Agency] to annually validate the procedure utilized by the MCO or PIHP to conduct BBA mandatory performance measures.
- (iii) The Contractor will work with [State Medicaid Agency] to annually validate the results of the MCO or PIHP BBA mandatory performance measures.
- (iv) The Contractor will follow standard research methodology practices in validating the performance tracking methodologies and results including, but not limited to:
 - Developing a work plan for the duration of the validation process
 - Validating any necessary background research
 - Validating population/sample selection criteria
 - Validating data collection methods and tools, data verification; and data analysis and interpretation process, including tables and graphics
 - Validating results/final reports and executive summary, according to standard research reporting guidelines
 - Ensuring validation process is in compliance with current BBA requirements
- (v) The Contractor shall submit a work plan for the validation of performance measures to [State Medicaid Agency] for review and approval prior to implementation.
- (vi) [State Medicaid Agency] and Contractor may consider child preventive and developmental services in the list of potential topics for MCO performance measures for each year. Examples of such domains for MCO performance measures include the following:
 - EPSDT screen/well-child visits
 - Childhood immunizations
 - Adolescent immunizations
 - Blood lead testing in children
 - Child dental visits
 - SSI child access to care
 - Mental health treatment rates by age group and disorder
 - Network access to outpatient mental health providers

- Initial comprehensive physician examination within 45 days of enrollment
- Spending on mental health and substance abuse for children
- Mental health and substance abuse treatment rates for children with developmental disabilities
- Complaints regarding timeliness of access to care

(c) Verification of MCO compliance with federal and state structural and operational standards

Description: The verification of MCO compliance with federal and state structural and operational standards during the preceding 12 months, or the analysis and evaluation of the [State Medicaid Agency]’s review conducted during the preceding 12 months, to determine the MCO’s or PIHP’s compliance with standards under 42 CFR 438.310 et. seq.

Service Tasks include, but are not limited to:

- (i) The Contractor will work with [State Medicaid Agency] to annually review and validate the methodology to be utilized to ensure MCO’s or PIHP’s compliance with standards meeting the BBA mandatory definition.
- (ii) The Contractor will work with [State Medicaid Agency] to annually validate the procedure of the MCO or PIHP to ensure compliance with standards meeting the BBA mandatory definition.
- (iii) The Contractor will work with [State Medicaid Agency] to annually validate the results of the process utilized to ensure the MCO’s or PIHP’s compliance with standards included in the BBA mandatory activities.
- (iv) The Contractor will follow standard methodology practices in validating the methodologies and results of processes and tools utilized to determine MCO’s or PIHP’s compliance with standards including, but not limited to:
 - Developing a work plan for the duration of the validation process
 - Validating standards used to determine compliance
 - Validating data collection methods and tools; data verification; and data analysis and interpretation process
 - Validating results/final reports and executive summary, according to standard reporting guidelines
 - Ensuring validation process is in compliance with current BBA requirements
 - The Contractor shall submit the work plan for the validation of compliance with standards to [State Medicaid Agency] for review and approval prior to implementation.

- (v) Contractor shall review compliance with standards related to child development specified in the MCO contract.

Section #3: Federally-Defined Optional Activities (42 CFR 438.358(c))

(a) Validate claims/encounter data

Description: Validation of encounter data reported by an MCO or PIHP required by the state to comply with requirements set forth in 42 CFR 438.310 et. seq.

Service Tasks include, but are not limited to:

- (i) The Contractor will work with [State Medicaid Agency] to review and validate the encounter data reported by an MCO or PIHP.
- (ii) The Contractor will work with [State Medicaid Agency] to validate the MCO or PIHP encounter data reporting process/procedure.
- (iii) The Contractor will work with [State Medicaid Agency] to validate the MCO or PIHP encounter data reporting results.
- (iv) The Contractor will follow standard research methodology practices in validating the MCO or PIHP encounter data reporting activities including, but not limited to:
 - Developing a work plan for the duration of the validation process
 - Conducting any necessary background research
 - Calculating population/sample selection criteria
 - Developing data collection methods and tools
 - Completing any relevant data verification and validation
 - Conducting data analysis and interpretation process, including tables and graphics
 - Developing results/final reports, according to standard research reporting guidelines and executive summary
 - Ensuring validation process is in compliance with current BBA requirements
- (v) The Contractor shall submit the work plan for each encounter data validation project to [State Medicaid Agency] for review and approval prior to implementation
- (vi) The Contractor shall consider validation of data on child development as an option.

(b) Administer or validate patient and/or provider surveys

Description: Administration of validation of consumer or provider surveys of quality of care required by the state to comply with requirements set forth in 42 CFR 438.310 et. seq.

Service Tasks include, but are not limited to:

- (i) The Contractor will work with [State Medicaid Agency] to administer or validate consumer or provider survey tool(s).
- (ii) The Contractor will work with [State Medicaid Agency] to administer or validate consumer or provider survey process/procedure.
- (iii) The Contractor will work with [State Medicaid Agency] to administer or validate consumer or provider survey results.
- (iv) The Contractor will follow standard research methodology practices in administering or validating consumer or provider surveys including but not limited to:
 - Developing a work plan for the duration of the validation process
 - Conducting any necessary background research
 - Calculating population/sample selection criteria
 - Developing data collection methods and tools
 - Conducting any relevant data verification and validation
 - Completing data analysis and interpretation process, including tables and graphics
 - Developing results/final reports, according to standard research reporting guidelines and executive summary
 - Ensuring validation process is in compliance with current BBA requirements
- (v) The Contractor shall submit a work plan for each survey to [State Medicaid Agency] for review and approval prior to implementation.
- (vi) The Contractor shall consider the development and administration of surveys related to child development. Such activities could entail:
 - Including questions on satisfaction with child preventive and developmental services in the consumer survey.
 - Developing and administering patient surveys of children with special health care needs
 - Administering the Promoting Healthy Development Survey on a pilot basis

(c) Calculate performance measures

Description: Calculation of performance measures in addition to those reported by an MCO or PIHP as required by the state to comply with requirements set forth in 42 CFR 438.310 et. seq.

Service Tasks include, but are not limited to:

- (i) The Contractor will work with [State Medicaid Agency] in the development of tools for the calculation of performance measures in addition to those reported by an MCO or PIHP(s).
- (ii) The Contractor will work with [State Medicaid Agency] to develop processes/ procedures for the calculation of performance measures in addition to those reported by an MCO or PIHP(s).
- (iii) The Contractor will work with [State Medicaid Agency] to calculate and report the results of performance measures in addition to those reported by an MCO or PIHP(s).
- (iv) The Contractor will follow standard research methodology in calculating the performance measures in addition to those reported by an MCO or PIHP including but not limited to:
 - Developing a work plan for the duration of the validation process
 - Conducting any necessary background research
 - Calculating population/sample selection criteria
 - Developing data collection methods and tools
 - Conducting any relevant data verification and validation
 - Completing data analysis and interpretation process, including tables and graphics
 - Developing results/final reports, according to standard research reporting guidelines and executive summary
 - Ensuring validation process is in compliance with current BBA requirements
- (v) The Contractor shall submit a work plan for the performance measure to [State Medicaid Agency] for review and approval prior to implementation
- (vi) Contractor shall consider performance measures on child preventive and developmental services. Such measures may assess: child immunizations, adolescent immunizations, provision of anticipatory guidance, screening for maternal depression, or early childhood caries detection and treatment.

(d) Conduct PIPs

Description: Conduct performance improvement projects required by the state to comply with requirements set forth in 42 CFR 438.310 et. seq. and that were underway during the preceding 12 months.

Service Tasks include, but are not limited to:

- (i) The Contractor will work with [State Medicaid Agency] to develop the methodology to be utilized for performance improvement projects meeting the BBA definition.
- (ii) The Contractor will work with [State Medicaid Agency] to develop the procedure for the performance improvement projects.
- (iii) The Contractor will work with [State Medicaid Agency] to calculate and report results of the performance improvement projects.
- (iv) The Contractor will follow standard research methodology practices in developing and conducting the performance improvement methodologies and results including, but not limited to:
 - Developing a work plan for the duration of the validation process
 - Any necessary background research
 - Identifying population/sample selection criteria
 - Developing data collection methods and tools
 - Completing any relevant data verification and validation
 - Conducting data analysis and interpretation process, including tables and graphics
 - Developing results/final reports and executive summary, according to standard research reporting guidelines
 - Ensuring process is in compliance with current BBA requirements
- (vii) The Contractor shall submit a work plan for each performance improvement project to [State Medicaid Agency] for review and approval prior to implementation.
- (viii) The Contractor shall consider child development in the list of potential topics for PIPs. Examples of “collaborative” PIPs that the Contractor could develop and evaluate include the following:
 - Improving the health outcomes of premature newborns
 - Improving the health outcomes of children with mental health disorders who are also developmentally disabled
 - Well-child and pregnancy outcomes
 - Maternal and/or child/adolescent depression in primary care
 - Case management/care coordination
 - Topics of particular importance to pediatric health care delivery
 - EPSDT rates for children with chronic conditions 0-12 months old, young children 0-18 months old and 3-6 years old, and foster children 0-18 years old
 - Conditions such as asthma, obesity, and ADHD

(e) Conduct focused studies of quality of care

Description: Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services at a point in time.

Service Tasks include, but are not limited to:

- (i) The Contractor will work with [State Medicaid Agency] to identify which clinical or non-clinical service topic area will be selected for the study.
- (ii) The Contractor will follow standard research methodology practices in conducting the studies, including, but not limited to:
 - Developing a work plan for the duration of the study
 - Conducting any necessary background research
 - Reviewing population/sample selection criteria
 - Devising data collection methods and tools
 - Performing any relevant data verification and validation
 - Performing appropriate data analysis and interpretation, including provision of tables and graphics
 - Preparing final report, following standard research reporting guidelines and including executive summary and any needed presentation materials
- (iii) The Contractor shall submit the work plan for each quality study to [State Medicaid Agency] for review and approval prior to implementation.
- (iv) The Contractor shall consider child development in the list of potential topics for focused studies. Examples of topics for such studies include:
 - EPSDT services compliance rates
 - EPSDT participation rates, including assessment and immunization rates
 - Studies relevant to children with special health care needs, such as asthma, and case management/coordination of care
 - Anticipatory guidance/health education
 - Well-child care and pregnancy
 - Depression in primary care

(f) Technical Assistance Activities

[State Medicaid Agency] may also ask the Contractor to provide technical assistance to the State and MCOs as they attempt to fulfill their quality of care obligations. Such tasks could include:

- Technical assistance to the state to update the state's overall quality strategy
- Technical assistance to the state to monitor EPSDT corrective action plans
- Technical assistance to MCOs on PIPs

Section #4: Other, State-Required Activities

In addition to the federally required activities, a state may require activities with a child health focus. [State Medicaid Agency] may ask the Contractor to complete other tasks. Examples of such tasks include:

- Conduct bi-annual focused immunization clinical study using the CDC ACIP standard of care and practice guidelines, sampling, and methodology
- Perform EPSDT screening rate validation
- Review all EPSDT components provided to children from a statistically valid sample of health plan medical records
- Evaluate disease management programs for asthma and common chronic conditions in Medicaid and SCHIP

NOTES

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- ³ A. Markus, S. Rosenbaum, and A. Stewart, *How Medical Claims Simplification Can Impede Delivery of Child Developmental Services* (New York: The Commonwealth Fund, Aug. 2005).
- ⁴ N. Halfon M. Regalado, and K. T. McLearn, *Building a Bridge from Birth to School: Improving Developmental and Behavioral Health Services for Young Children* (New York: The Commonwealth Fund, May 2003); M. Regalado and N. Halfon, “Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years: Review of the Literature,” *Archives of Pediatrics and Adolescent Medicine*, Dec. 2001 (155)12: 1311–22; M. Regalado and N. Halfon, *Primary Care Services: Promoting Optimal Child Development from Birth to Three Years* (New York: The Commonwealth Fund, Sept. 2002).
- ⁵ N. Halfon, M. Inkelas, M. Abrams et al., *Quality of Preventive Health Care for Young Children: Strategies for Improvement* (New York: The Commonwealth Fund, May 2005).
- ⁶ C.P. Reuland and C. Bethell, *Key Measurement Issues in Screening, Referral, and Follow-Up Care for Young Children’s Social and Emotional Development* (Portland, Me.: National Academy for State Health Policy, Apr. 2005).
- ⁷ Section 1937 of the Social Security Act, as amended by Section 6044 of Public Law 109-171, outlines state flexibility in benefit packages. State benchmark flexibility is extended to all low-income children and EPSDT is retained as a wraparound to the benefit.
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- ⁹ These organizations are sometimes referred to as external quality improvement organizations (EQIOs). We have elected to use the term EQRO because it is commonly used for organizations conducting quality reviews of Medicaid services.
- ¹⁰ Centers for Medicare and Medicaid Services, *State Quality Strategy Tool Kit for State Medicaid Agencies* (Washington, D.C.: Centers for Medicare and Medicaid Services, Oct. 2006), <http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/Downloads/qtkitwtablec.pdf>.
- ¹¹ Centers for Medicare and Medicaid Services, *State External Quality Review Tool Kit for State Medicaid Agencies* (Washington, D.C.: Centers for Medicare and Medicaid Services, Oct. 2006), <http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/Downloads/eqrotoolkit2.pdf>.
- ¹² Ireys, Krissik, Verdier et al., *Using External Quality Review Organizations*, 2005.

- ¹³ We attempted to collect documents from 23 states identified by CMS, Mathematica Policy Research, Inc., and George Washington University as having a pay-for-performance or value-based purchasing effort implemented in their state Medicaid program, with or without an emphasis on pediatric care.
- ¹⁴ We selected Illinois and Washington because we learned that they commissioned their EQROs to assess children's health. We selected Minnesota because we learned in our earlier study that its procurement process is unique.
- ¹⁵ P. C. Young, G. B. Glade, G. J. Stoddard et al., "Evaluation of a Learning Collaborative to Improve the Delivery of Preventive Services by Pediatric Practices," *Pediatrics*, May 2006 117(5): 1469–76.
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- ¹⁹ Social Security Amendments of 1967, §302(a), Pub. L. No. 90–248, 42 U.S.C. §1396d(a)((4)(B).
- ²⁰ Omnibus Budget Reconciliation Act of 1989, §6403, Pub. L. No. 101–239. See 42 U.S.C. §§1396d(a)(4)(B), 1396d(r), and 1396a(a)(43).
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- ²⁶ Ireys, Krissik, Verdier et al., *Using External Quality Review Organizations*, 2005.
- ²⁷ Consumer Assessment of Healthcare Providers and Systems (CAHPS) is sponsored by the Agency for Healthcare Research and Quality; Health Plan Employer Data and Information Set (HEDIS) is managed by the National Committee for Quality Assurance.
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- ²⁹ A. R. Kemper, R. L. Uren, and S. J. Clark, "Adoption of Electronic Health Records in Primary Care Pediatric Practices," *Pediatrics*, July 2006 118(1): e20–24.

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