USING EXTERNAL QUALITY REVIEW ORGANIZATIONS TO IMPROVE THE QUALITY OF PREVENTIVE AND DEVELOPMENTAL SERVICES FOR CHILDREN

Henry T. Ireys, Tara Krissik, James M. Verdier, and Melissa Faux
Mathematica Policy Research, Inc.

May 2005

ABSTRACT: Federal regulations 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 plans. This study provides state Medicaid programs, managed care organizations, EQROs, and other child health professionals with strategies for using EQROs to enhance the quality of preventive and developmental services for young children. The authors' findings indicate that only a few states are now using EQROs to assess preventive and developmental services, but more states could do so if a key stakeholder elects to champion the issue and if state staff and EQROs have the relevant knowledge base. They also underscore the importance of building a strong argument for improving preventive and developmental services and suggest a critical need to provide state Medicaid agency staff with the knowledge and experience to play a leadership role in this area.

See the Fund's Web site for EQRO guidelines for states.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

Additional copies of this and other Commonwealth Fund publications are available online at www.cwmf.org. To learn more about new Fund publications when they appear, visit the Fund's Web site and register to receive e-mail alerts.

Commonwealth Fund pub. no. 814.

CONTENTS

About the Authors iv

Acknowledgments v

Executive Summary vi

Introduction 1

Methods 4

Findings 5

Summary and Recommendations 17

Glossary of Terms 22

Appendix 1. Summary of Survey and Description of EQRO Reports and RFPs 24

Appendix 2. State Case Study Summaries 33

- Michigan 34
- North Carolina 39
- Oregon 44
- Texas 50
- Washington 54

Notes 58

References 59

LIST OF TABLES

Table 1 Major Federal Documents Pertaining to Medicaid EQRO Activities 2

Table A1 Survey Responses, by State 25

Table A2 EQRO Reports, by State and Topic Area 27

Table A3 Methodology for EQRO Reports, by State 30

Table A4 Summary of Selected RFPs 31

ABOUT THE AUTHORS

Henry T. Ireys, Ph.D., a senior researcher at Mathematica Policy Research, has extensive experience in policy analysis and program evaluation related to maternal and child health and children with special health care needs. Since 1999, Dr. Ireys has been the court monitor for a major class action suit involving Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in the District of Columbia that pertains to oversight of the Department of Health's efforts to enhance the quality of such services. He has been a consultant to numerous state departments of health concerning programs for children and young adults with chronic illnesses and disabilities. Dr. Ireys holds a Ph.D. in clinical psychology from Case Western Reserve University. He joined Mathematica from the faculty of the Bloomberg School of Public Health at the Johns Hopkins University.

Tara Krissik, M.P.P., is a research analyst at Mathematica Policy Research, where her work has focused on policy analysis related to EPSDT and children's health services. Ms. Krissik has worked with Dr. Ireys to provide technical assistance to state Medicaid programs and has been involved with program evaluations related to Medicaid managed care. She received a master of public policy degree from the Georgetown Public Policy Institute.

James M. Verdier, J.D., has been a senior fellow at Mathematica Policy Research since 1998. A former Medicaid director in Indiana, Mr. Verdier has worked directly with a number of states on organizational design, restructuring, and program monitoring issues in Medicaid managed care programs. He recently completed reports for The Commonwealth Fund on the fiscal and policy implications of Medicare coverage of prescription drugs for dual eligibles and coverage of Social Security Disability Insurance beneficiaries in the two-year Medicare waiting period. He received his law degree from Harvard Law School.

Melissa Faux, B.A., is a research assistant/programmer at Mathematica Policy Research, where she has conducted research into various social and health policy issues, including the Food Stamp program, Temporary Assistance to Needy Families (TANF), and the Medicaid Buy-In program.

ACKNOWLEDGMENTS

The authors wish to thank The Commonwealth Fund for funding this study and particularly appreciate the valuable guidance provided by Melinda Abrams and Ed Schor. This report would not have been possible without the cooperation of committed staff in state Medicaid agencies, managed care organizations, and external quality review organizations. In particular, we thank the staff of these organizations in Michigan, North Carolina, Oregon, Texas, and Washington State for their time and effort. We also are grateful to members of our advisory panel for their substantial input:

- Mary Fermazin and Mary Ellen Dalton, Health Services Advisory Group
- Julie Jones and Sharon Gilles, Centers for Medicare and Medicaid Services
- Barbara Lantz, Washington State Department of Social & Health Services
- Jane Perkins, National Health Law Program
- Colleen Peck Reuland, Child and Adolescent Health Measurement Initiative, Oregon Health & Science University
- Sara Rosenbaum, Center for Health Services Research and Policy
- Mark Weissman, Children's National Medical Center

At Mathematica Policy Research, Margo Rosenbach and Robert Whitaker offered many thoughtful suggestions in the course of the study. Sharon Clark provided administrative support with her usual good cheer.

EXECUTIVE SUMMARY

Background

Current federal regulations issued by the Centers for Medicare and Medicaid Services (CMS) obligate states to develop a written strategy for assessing the quality of care for Medicaid beneficiaries in managed care plans. These regulations, which took effect in March 2003, require states to adopt standardized methods for quality review activities, specify mandatory and optional quality review activities, and provide specific protocols for conducting quality reviews. In return, the regulations give states an enhanced federal match for quality review activities and broaden the types of organizations eligible to conduct reviews.

State Medicaid agencies typically contract with external quality review organizations (EQROs) to conduct quality-of-care studies. The new federal regulations encourage states to use EQROs to (1) perform mandatory review activities, such as determining managed care organization (MCO) compliance with federal managed care regulations or validating quality improvement projects completed by MCOs; (2) conduct focused studies and other optional activities; (3) serve as technical resources; and (4) consolidate quality review findings into a comprehensive annual report.

Child health policymakers and researchers have registered considerable interest in the extent to which states rely on EQROs to examine the quality of preventive and developmental services for children enrolled in Medicaid (or to evaluate studies conducted by MCOs on the same topic). There has been no effort, however, to gather systematic data on the involvement of EQROs in states' quality improvement efforts related to these services. Better information about this topic should prove useful to states as they develop and implement the quality review strategies now being mandated.

About the Study

This study was undertaken to determine 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. It was the researchers' goal to provide state Medicaid programs, MCOs, EQROs, and other child health professionals with information on quality improvement activities that will enhance the quality of such services.

Relying on a variety of data sources—including a survey of Medicaid directors, interviews with staffs from state Medicaid agencies, EQROs, and MCOs, and published EQRO reports and federal regulations—the researchers addressed the following questions:

- How many states have used or are planning to use EQROs to conduct studies of well-child care?
- What are some examples of quality review studies on this topic, and what methods have they used?
- What factors enhance the likelihood that states will examine the topic of preventive and developmental services for young children?
- What factors are influencing states' capacity to conduct quality reviews of preventive and developmental services?
- What actions will promote further use of EQROs to improve the quality of services for young children enrolled in Medicaid?

Key Findings

Using the information gathered, the researchers found the following:

- In any given year, only a limited number of states use EQROs to conduct studies for the purpose of improving the quality of preventive and developmental services for young children in Medicaid. In 2003–04, these states included Delaware, Michigan, Oregon, Texas, and Washington.
- With a few important exceptions, most states use EQROs to examine rates of occurrence of specific services rather than the content of well-child visits.
- Two factors play critical roles in driving states to focus on preventive and developmental services: influential champions and attention-getting data demonstrating problems in providing preventive and developmental services.
- Current federal regulations and experience are prompting states to expand the methods used in quality-of-care studies beyond medical record reviews (e.g., analysis of claims and survey data), but medical record reviews may remain necessary for studies of preventive and developmental services.
- Variability in EQROs' capability to conduct studies of preventive and developmental services presents a challenge to states interested in focusing on such services.
- Some state Medicaid staffers believe that federal regulations limit their ability to conduct studies of preventive and developmental services. But other states and the researchers' own independent analysis found that the regulations offer substantial opportunities for assessing and improving the quality of these services if states undertake appropriate strategic planning and obtain appropriate technical assistance.

These results suggest that (1) improving the quality of preventive and developmental services for young children enrolled in Medicaid requires a champion who can make a convincing case that the issue of quality deserves attention in a state's overall strategy for improving services for Medicaid beneficiaries; (2) a convincing case depends on the availability of methodologically strong information about gaps in the provision of preventive and developmental services, the cost of failure to provide them, or consumer demand for them; and (3) steps should be taken to strengthen the knowledge base for quality-of-care studies of preventive and developmental services for young children in Medicaid, and to ensure that staffers in Medicaid agencies draw from this knowledge base to develop appropriate language for MCO contracts.

Recommendations

The authors recommend that CMS or private foundations consider designating funds that could be allocated through contracts or grants to accomplish two tasks:

- Develop training programs to a) help Medicaid staff, EQROs, and MCOs incorporate quality improvement activities into the current regulatory framework and b) make the case for targeting quality improvement activities on preventive and developmental services.
- Develop a model set of specifications for both RFPs and contracts that would help state agencies select and implement appropriate quality-of-care activities.

Our findings also lead to two recommendations for the states themselves:

- Develop models of stakeholder collaboration for quality improvement projects, essential for identifying and implementing sustainable activities that lead to improved preventive and developmental services.
- Consider using limited dollars more efficiently by conducting mandatory quality review activities in-house to preserve some dollars for independent quality improvement projects.

USING EXTERNAL QUALITY REVIEW ORGANIZATIONS TO IMPROVE THE QUALITY OF PREVENTIVE AND DEVELOPMENTAL SERVICES FOR CHILDREN

INTRODUCTION

State Medicaid programs play critical roles in promoting the health of children and improving the quality of their health care. Preventive and developmental services—which federal law requires states to provide—are especially important components of Medicaid programs because they promote healthy development, reduce morbidity, and prevent the onset of serious physical and behavioral problems. It follows that policymakers, program administrators, foundations, and consumer groups concerned with child health care should be especially interested in state strategies for assessing and improving the quality of preventive and developmental services for children enrolled in Medicaid.

Federal regulations established under the Balanced Budget Act (BBA) of 1997 and issued by the Centers for Medicare and Medicaid Services (CMS) now obligate states to develop a written strategy for assessing the quality of care for Medicaid beneficiaries in managed care plans. The regulations, which took effect in March 2003, require states to adopt standardized methods for quality review activities, specify mandatory and optional quality review activities, and provide specific protocols for conducting quality reviews (Table 1). In return, the regulations give states an enhanced federal match for quality review activities and broaden the types of organization eligible to conduct reviews.[1]

Before 1997, federal regulations provided states with few guidelines or standards for conducting quality reviews. Many quality-of-care studies, often referred to as "focused studies," included small samples narrowly aimed toward specific subgroups and required time-consuming medical record reviews. By the mid-1990s, Medicaid officials began to question the utility of focused studies. As one report noted, "[T]hey fail to offer a broad assessment of the care delivered to all those enrolled in the State's Medicaid program" (Office of Inspector General 1998). The current regulations represent, in part, an effort to broaden the states' repertoire of quality review activities and provide the primary framework and recipe for a state's quality review activities, including those designed to improve preventive and developmental services.

State Medicaid agencies typically contract with external quality review organizations (EQROs)[2] to conduct quality-of-care studies. As Table 1 indicates, current

Table 1. Major Federal Documents Pertaining to Medicaid EQRO Activities

Title	Source	Comments
Medicaid Program; Medicaid Managed Care: New Provisions	*Federal Register,* vol. 67, no. 115/Friday, June 14, 2002/Rules and Regulations (see especially, p. 41096 and pp. 41105–09 for the rule and pp. 41031–54 for comments on an early version and the government's response)	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: – 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 – Regular and periodic review of the strategy
Medicaid Program; External Quality Review of Medicaid Managed Care Organizations	*Federal Register,* vol. 68, no. 16/Friday, January 24, 2003/Rules and Regulations	Explains the requirement in Section 1932(c) of the SSA 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 (outlined further below) between mandatory and optional EQRO activities
Protocols for External Quality Review of Medicaid MCOs and Prepaid Inpatient Health Plans (PIHPs)	http://www.cms.hhs.gov/medicaid/managedcare/mceqrhmp.asp	Provides nine protocols to help implement the provisions in the External Quality Review of Medicaid Managed Care Organizations rule published on January 24, 2003. EQR activities are to be conducted in a manner consistent with the protocols. Three *mandatory* protocols: – Determining MCO/PIHP compliance with federal Medicaid managed care regulations – Validating performance measures produced by an MCO/PIHP – Validating performance improvement projects undertaken by an MCO/PIHP Six *optional* protocols: – Calculating measures of the performance of an 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 – Assessing MCO/PIHP information systems

federal regulations require states to conduct three quality review activities using standard protocols (determining MCO compliance with federal regulations, validating performance measures used by the MCO, and validating performance improvement projects undertaken by an MCO). For these mandated activities, EQROs function as an independent entity to validate the MCOs' quality review processes, structures, and activities. In addition, as part of the optional activities, states can use EQROs to conduct focused studies, serve as technical resources, and consolidate quality review findings into a comprehensive annual report. Under current federal regulations, a wide range of entities can qualify as an EQRO, including medical review organizations, universities, and consulting firms.

The quality review framework established by current federal regulations has important implications. It assigns MCOs the primary responsibility for conducting quality review activities, gives EQROs an oversight and consultative role, and underscores the need for states to ensure that they include appropriate provisions in contracts with both their MCOs and their EQROs. The framework also defines opportunities for quality improvement projects related to preventive and developmental services for young children.

Overall, the current federal regulations are shaping state quality review activities by influencing the priorities for quality-of-care studies, standardizing study methods, emphasizing the primary role of MCOs in conducting quality reviews and implementing quality improvement projects, and broadening the types of entity that qualify as an EQRO.

Child health policymakers and researchers have voiced considerable interest in the extent to which states are using EQROs to examine the quality of preventive and developmental services for young children enrolled in Medicaid (or to evaluate studies conducted by MCOs on the same topic); however, there has been no effort to gather systematic data on the extent of reliance on EQROs for studies of child health services. Better information concerning this topic should prove useful to states as they develop and implement the quality review strategies now mandated by federal regulations.

The Commonwealth Fund asked Mathematica Policy Research, Inc. (MPR), to examine the extent to which state Medicaid agencies have used or are planning to use EQROs in state efforts to improve the quality of preventive and developmental services for young children. The overall goal of the study was to provide state Medicaid programs, MCOs, EQROs, and other child health professionals with information about strategies for

quality improvement activities that will enhance the quality of such services. The study addressed the following questions:

- How many states have used or are planning to use EQROs to conduct studies of well-child care, including preventive and developmental services?
- What are some examples of quality review studies on this topic, and what methods have they used?
- When faced with many services for which quality-of-care studies are needed, what factors enhance the likelihood that states will examine preventive and developmental services for young children in Medicaid?
- What factors (e.g., federal regulations, constrained Medicaid budgets, or EQRO skills) influence states' capacity to conduct quality reviews of preventive and developmental services?
- What actions are needed to promote further use of EQROs in improving the quality of preventive and developmental services for young children in Medicaid?

METHODS

The present study used several methods and sources of data to increase the validity of our research and to ensure that we identified the major lessons learned from the states that have used EQROs to assess the quality of developmental and preventive services for children enrolled in Medicaid managed care plans:

- A systematic review of the literature and relevant state and federal documents, including pertinent Medicaid rules and regulations, written strategies for assessing quality of care developed by selected states, selected requests for proposals (RFPs) developed by states for EQROs, and EQRO reports on a wide range of topics related to well-child care and EPSDT services
- A structured one-page mail survey of state Medicaid directors that allowed us to determine whether states had undertaken quality-of-care work in preventive and developmental services or were planning such work (as of December 2003) and to identify key informants for follow-up interviews
- Semistructured interviews with (1) staff members in state Medicaid agencies and (2) representatives of EQROs who were identified through the literature review, from the survey of Medicaid directors, or by the study's advisory panel

- Structured interviews with key informants in five case study states: Michigan, North Carolina, Oregon, Texas, and Washington, including staffs in state Medicaid agencies, EQROs, MCOs, and child health clinics. These states were selected because their survey responses indicated they had completed, or were working on, relevant quality improvement projects.

In consultation with staff from The Commonwealth Fund and members of an advisory panel, we chose case study states based on evidence from the structured survey, preliminary key informant interviews, and reviews of selected EQRO reports. Appendices to this report contain further information about our methods, tables summarizing the information we reviewed, and summaries of the case studies.

FINDINGS

We have synthesized the information collected through our survey, document reviews, and interviews into six findings described below. Appendix 2 includes further details regarding specific quality review activities in the case study states.

In any single year, only a limited number of states use EQROs to conduct studies that analyze data for the purpose of improving the quality of preventive and developmental services for young children in Medicaid.

Forty-eight of the 51 states (including the District of Columbia) responded to our survey, which was designed to determine how many states were using their EQROs to conduct studies in the general area of preventive and developmental services for young children in Medicaid. Twenty-four states (50%) reported that they commissioned such a study in the past; 21 states (44%) planned to do so in the future; 22 states (46%) had neither commissioned a study nor had plans to do so. Although many states reported work in the general area of preventive and developmental services, further investigation showed that only five states (Delaware, Michigan, Oregon, Texas, and Washington) had commissioned EQRO reports that included substantive data analysis pertaining to the quality of specific preventive and developmental services, such as use of formal screenings to detect developmental problems, supplying parents with written information about child behavior, and providing general anticipatory guidance.

Our investigation of survey responses began by obtaining 32 reports from the 24 states indicating that they had commissioned EQRO studies in the area of preventive and developmental services. The studies covered a wide range of topics such as immunizations, lead screening, overall EPSDT participation rates, referral problems, and services to children with chronic health problems (e.g., obesity, diabetes, or sickle-cell anemia). The

reports differed widely in the extent to which they included findings or data analysis related to the quality of service delivery. For example, some reports presented charts with no interpretation of the data; others presented simple frequencies of events, such as well-child visits, based on results of medical record reviews. Of the 32 reports, eight used recent data to assess specifically the quality of preventive and developmental services. The five states noted above commissioned the eight reports.

Some states that were planning to conduct studies may have decided not to do so. For instance, while Connecticut reported that it intended to conduct a study of preventive and developmental services, subsequent interviews indicated that the state would not implement the study because of changes in personnel, the need to conduct the federally mandated quality review activities, and budget constraints.

State and MCO Responses to Findings in EQRO Reports

States that commissioned studies from EQROs on preventive and developmental services responded to the studies' findings in various ways. In some cases, states required MCOs to submit corrective action plans based on a report's findings or recommendations. In other cases, state staff worked with MCOs to identify actions needed to address problems noted in a report, and these actions were incorporated into contract amendments. One Medicaid official noted that contract language was changed as a result of an EQRO study and that MCOs are now required to conduct a quality improvement project if their rates for either EPSDT services or immunizations fall below 60 percent. Although EQRO reports may include specific recommendations to MCOs, some MCOs reported they do not change their practices unless the state specifically changes its benchmarks or contract language.

With a few important exceptions, most states use EQROs to examine rates of occurrence of specific services rather than the content of well-child visits.

Our key informant interviews and reviews of RFPs and final EQRO reports indicated that most states ask their EQROs to conduct studies that focus on the occurrence of EPSDT or well-child visits. Many states ask their EQROs to examine rates of a specific service provision (e.g., immunization) across a state's MCOs to determine compliance with state standards. Only a few states have used their EQRO to examine the content of preventive and developmental services for Medicaid-enrolled children.

Texas is a premier example of a state commissioning its EQRO to focus specifically on the content of preventive care services for children in Medicaid, including anticipatory guidance. The EQRO for Texas recently produced a report, entitled "Children's Preventive Care in the STAR Managed Care Organization and in the

Children's Health Insurance Program in Texas," that integrated person-level encounter data, MCO interviews and questionnaires, and surveys of adolescents and parents to examine both the occurrence of preventive care visits and the issues addressed during the visits. The report indicated that the average percentage of children in the STAR MCO program receiving preventive care visits met or exceeded the average for Medicaid plans reporting to the National Committee for Quality Assurance (NCQA) and underscored the need to improve the provision of anticipatory guidance to adolescents in the STAR MCO program and Children's Health Insurance Program (CHIP).

Michigan has required its EQRO to conduct studies of EPSDT since 1999. Over time, the state recognized that examining the documentation of whether an EPSDT visit was completed does not fully evaluate the delivery of EPSDT services. The state has therefore recently required its EQRO to produce a more comprehensive report to assess whether children have received all EPSDT components and to determine what follow-up occurred. For instance, the 2001 EQRO report assessing EPSDT services considered an EPSDT visit comprehensive if a preventive visit was billed and all required components of EPSDT were documented in the medical record, including developmental assessments.

A few states are using their EQRO to enhance state initiatives intended to improve preventive and developmental services. For example, the Children's Preventive Healthcare Initiative (CPHI) in the state of Washington is a quality improvement program funded by the state and coordinated by the state's EQRO. Washington implemented the initiative to assist MCOs in meeting federal requirements for children's preventive care, including EPSDT services and immunizations. Through the CPHI, clinics have developed and applied interventions to improve well-child care, and the EQRO has provided performance feedback to the clinics and MCOs. The EQRO is currently conducting training sessions so that providers, managed care plans, and the state can enhance further their quality improvement methods and define additional interventions to improve preventive health care for children.

In addition, some states develop contracts that allow the EQRO to participate in or lead quality review activities beyond what is defined specifically in the contract. This practice gives states opportunities to take advantage of EQRO resources and skills for new projects. For example, the state of Washington has used grant funds to pay their EQRO to implement a survey of the extent to which pediatric practices and clinics are focusing on preventive and developmental services—an activity that was not planned when the EQRO contract was originally developed.

Use of Entities Other Than EQROs
Some states are conducting quality improvement activities related to preventive and developmental services but are not commissioning their EQROs for assistance. North Carolina, for instance, has used grant funding to develop a comprehensive community model for developmental screening and has held training sessions to teach providers to use a standard screening tool. For its quality review reports, North Carolina relies on its EQRO solely for medical record abstraction and uses a state statistical center to analyze the data and produce the reports. The EQRO is not involved in the state's grant-related projects.

In some states, MCOs themselves are aiming to improve preventive and developmental services through various initiatives. For example, MCOs play a major role in Washington's CPHI program. In Michigan, an MCO successfully implemented a program to improve well-child care and screenings for children from birth to age three. The MCO worked with the state's Medicaid agency to receive approval for certain components of its project and to collaborate in an EPSDT workgroup, but the plan undertook the project on its own.

Two factors play critical roles in driving states to focus on preventive and developmental services: influential champions, and attention-getting data demonstrating problems in providing preventive and developmental services. When selecting study topics for quality review, states consider various factors, including the topic's potential for cost savings or its potential to improve quality. With many study topics competing for attention in fiscally tight environments, how does the topic of preventive and developmental services rise to the top? When asked why their states chose to conduct quality review activities related to preventive and developmental services for children, several states credited an individual with championing the idea of focusing state efforts in this area. The champions were able to steer the state's focus toward preventive and developmental services because they were able to influence decision makers or were in decision-making positions, themselves.

Following are examples of individuals in two states whose interest in improving preventive and developmental services for children influenced the states' quality improvement initiatives:

- In Washington, a contract manager in the Medicaid agency generated the idea for the Children's Preventive Healthcare Initiative (CPHI) after determining that the state should focus more on quality improvement rather than on measurement. She

recognized that simply relying on provider-reported data was insufficient to improve services for children, and advocated for the agency to become more quality-focused. She had sufficient authority within the agency to push the state in this direction.

- In North Carolina, state staff credits a developmental and behavioral physician with championing the state's initiative to improve developmental screening. Providers have a strong influence in North Carolina as a result of working closely with the state through the primary care case management (PCCM) networks. In addition to the provider champion, two staff members in the Medicaid agency and the state office that coordinates grant activities have been able to promote initiatives aimed at improving developmental services through state technical support.

The availability of attention-getting data that unambiguously demonstrate problems in providing preventive and developmental services also can influence a state's decision to examine the topic and take steps to address matters. For example, staffers in Washington's Medicaid agency reported that they first began focusing state efforts on improving children's preventive care after they examined Health Plan Employer Data and Information Set (HEDIS) data from the MCOs indicating that well-child care and immunization rates had stagnated, even though the MCOs had taken a number of actions to improve care (e.g., use of well-child care examination forms, distribution of reminder letters). Based on the recognition of significant opportunities to improve well-child care, the state developed the CPHI and subsequently commissioned additional EQRO reports.

State Medicaid staff consistently underscored the importance of using available data to guide decisions regarding quality assessment and improvement activities. For example, a report produced for Texas in 2001 revealed that provider documentation of preventive services for children was not meeting HEDIS guidelines. This finding influenced the state's decision in 2003 to examine the issue further and to commission an EQRO study, produced in 2004, that assessed preventive services for children in Texas's Medicaid program. In addition, an official in Washington's Medicaid agency who is involved with the CPHI emphasized the importance of using data for quality improvement: "Clinics don't always know who they are serving and, as a result, don't always know who is and is not receiving the standard of care. Helping clinics mine and use data is critical to successful quality improvement efforts, particularly where the larger goal is to spread and sustain change efforts."

Influence of Other Factors

Our interviews with state staff members revealed that additional factors can influence a state's decision to commission an EQRO report on preventive and developmental services, including grant funding, legislation, and recommendations from CMS, EQROs, or MCOs. For example:

- Both Washington and North Carolina received grants from The Commonwealth Fund that helped facilitate their initiatives to improve preventive and developmental care for children in Medicaid. Washington used grant funds to support initiatives (different from the CPHI) that focused on improving developmental screening in three counties.[3] North Carolina used the grant to develop a "best practices" model to improve developmental screening.
- A legislative mandate in Michigan in 2003 that required the Medicaid agency to commission an EQRO report on EPSDT and develop a strategic plan for improving access to EPSDT services influenced the state's recent quality improvement activities. Concern voiced by CMS and advocates as to whether children receive adequate EPSDT services in Michigan's Medicaid managed care program also contributed to the state's focus on well-child care.
- Although data from an earlier EQRO report influenced Texas's decision to produce a report on preventive services, the state's EQRO also had extensive experience with children's health services research, and the state relied on the EQRO's expertise and recommendations to determine the study topic and methods.
- In Oregon, the MCOs help determine the topics for EQRO studies. In conjunction with state staff, the EQRO selects 10 study topics that the medical directors of the MCOs then narrow down to five. In 2000 and 2001, the state commissioned focused studies on preventive care in accordance with the MCOs' recommendations.

Political and public perceptions also influence states' decisions concerning quality review activities. In Michigan, for example, public opinion influenced the development of a lead-poisoning task force and a lead-testing mandate for the MCOs after a series of newspaper articles highlighted the issue of lead toxicity and the failure of the state to take significant action in this area. Political support also is important to sustain certain quality review activities, as seen in Washington State where legislative support figured heavily in continued funding of preventive care initiatives for children.

Current federal regulations and experience are prompting states to expand the methods used in quality-of-care studies beyond medical record reviews (e.g., analysis of claims and survey data), but medical record reviews may remain necessary for studies of preventive and developmental services. Many EQROs continue to rely on medical record reviews for their reports to state Medicaid agencies. Seven of the eight reports directly related to preventive and developmental services that we reviewed for this study included medical record reviews, but most reports also referenced methods such as the analysis of administrative, claims, and encounter data; implementation of surveys and analysis of the data; analysis of qualitative data from interviews and focus groups; or literature reviews. For example, the EQRO report on preventive and developmental services completed for Texas included analysis of encounter and questionnaire data and information from systematic qualitative interviews. In Oregon, the state now specifically encourages its EQRO to use encounter data in its reports rather than medical record reviews.

Some states recognize that encounter data can help determine the frequency of well-child visits but do not provide the specificity required for a full assessment of the *content* of these visits. For example, the CMS Form 416 (which states are required to submit under EPSDT rules) encourages states to use counts of encounters as measures of preventive and developmental services provided, but this strategy is a poor proxy for determining whether these specific services were actually provided during a well-child visit. A few states and EQROs are beginning to address this problem by developing new data-gathering strategies that should shed light on the content of well-child visits.

The long period between the initial announcement of the quality-of-care regulations (in 1998) and the publication of final versions (in 2002 and 2003), as well as the extensive steps related to the production and review of early versions of the protocols, suggests that CMS made a considerable effort to enhance states' methodological sophistication for conducting quality-of-care studies. The protocols that accompany the final regulations require familiarity with and analysis of administrative and survey data, information technology systems used for database management and file sharing, and approaches for systematic qualitative interviewing. The regulations also emphasize the importance of quality reviews that synthesize information gathered by individual MCOs.

Although methodological approaches to assessing quality of care are expanding, some MCOs reported that medical record reviews may remain necessary for an extended period. They noted that quality review teams need to "drill down" into medical records

because current administrative data on well-child visits do not include details of individual preventive and developmental services.

The variability of EQROs' capability to conduct studies of preventive and developmental services presents a challenge to states interested in focusing on this area.

Even if a state has a strong champion or the data needed to push to the forefront the issue of preventive and developmental services, it might not commission its EQRO to conduct a study of such services if the organization lacks the appropriate experience or skills. For an EQRO to conduct a comprehensive study on preventive and developmental services, it must have (1) a working knowledge of data sources and strategies for measuring the quality of preventive and developmental services and (2) experience with the range of analytic and survey methods needed to conduct research on the quality of child health services (e.g., claims data analysis, sampling methods for surveys, and systematic analysis of qualitative data). Current regulations also suggest that EQROs or EQRO-like entities should have explicit experience in methods for assessing quality of child health services because EQROs are expected to serve as technical resources to both the state and MCOs.

In part because it was based in an academic center with access to a broad range of individuals with relevant research experience and skills, the EQRO in Texas had the knowledge and ability to conduct a comprehensive study of preventive and developmental services for children. Some EQROs may not have the same breadth and depth of experience and may be unfamiliar with issues related to measurement of children's health care or the complexity of state Medicaid programs.

States' experience and satisfaction with their EQROs varies widely. Some states contract with new EQROs often (e.g., each time new RFPs are let) while others have maintained the same EQRO for many years and RFP cycles. Many states reported positive experiences with their EQROs and praised the organizations' expertise and skill sets. Several state staff members noted that they are "very happy" with their EQROs, that the EQROs have done "an exceptional job," and that working relationships between Medicaid and the EQRO are "positive." In contrast, staffers in a few states expressed strong criticisms of their EQROs, including poor writing skills, a lack of knowledge about the managed care environment and the Medicaid program, and an inadequate appreciation for data-related problems. One interviewee observed that EQROs "lack flexibility; they cannot expand, they do not have depth, and they are not stable."

Other Quality Review Options for States

States unsatisfied with their EQRO now have the option of using other mechanisms for quality reviews. The federal regulations offer states the possibility of increased competition for RFPs from EQRO-like entities (e.g., a university, research institute, or consulting firm that meets federal criteria for conducting independent quality reviews). States currently not using EQRO-like entities were uncertain whether they would choose to use them in the future. Some states were not certain whether they would still receive an enhanced federal match if they contracted with one of these entities. (They would if the entities can document that they can conduct an *independent* external review.) Other states that were highly satisfied with their EQROs said they would not look to other organizations to perform quality review activities. One state official asserted that the credibility of findings is enhanced when a recognized EQRO conducts an assessment. He questioned whether other organizations would lend the same credibility. Another state official reported, "I am not convinced that other organizations [such as those in university settings] have the skills or expertise to do such work. In reality, most organizations that conduct or facilitate quality improvement work are in the learning stages of managing such work."

When questioned about the possibility of competing against EQRO-like entities for contracts, one EQRO expressed concern that current federal regulations provided "cookbook" protocols that anyone could follow to become an EQRO. Another EQRO thought that the activities required by the regulations might "narrow the field a bit" since they require expertise in validation of HEDIS and other data. EQROs also raised the possibility that more states may choose to contract with more than one EQRO for various activities. Some RFPs now include language indicating that the state reserves the right to contract with additional EQROs. EQROs speculated, however, that contracting with numerous EQROs or EQRO-like entities would be a costly and time-consuming administrative process for states.

With the Medicaid managed care environment in continued flux, quality review organizations that are not entrenched in Medicaid may find it difficult to stay current. Furthermore, the ability to conduct a comprehensive study on preventive and developmental services requires substantial experience in assessing children's health and health care. For organizations accustomed to working with Medicare or in areas other than Medicaid, a study of child health care may prove particularly challenging.

Some states have already elected to use "non-EQRO entities" to conduct quality review activities. For example, Michigan's Medicaid agency has a close relationship with Michigan State University through its Institute for Health Care Studies (IHCS). IHCS has

produced several reports for Michigan regarding EPSDT, including a few studies on beneficiary and clinician perspectives on well-child care. IHCS has also developed an EPSDT Clinician Toolkit for providers and is involved in a collaborative workgroup with the state and MCOs to improve the rate of EPSDT service delivery for Medicaid beneficiaries.

North Carolina also has used entities other than its EQRO for quality review reports. Although North Carolina does not question the skill or capability of its EQRO in performing additional functions, the state's EQRO contract requires the EQRO to conduct medical record abstractions only. The state relies on its own statisticians to analyze the data and publish the quality review reports. North Carolina has a strong relationship with its providers, and its PCCM networks continually assess the needs of their enrollees and actively implement quality improvement initiatives. As a result, the state has less need to use an EQRO to report on provider activities.

Some state Medicaid staff members believe that federal regulations limit their ability to conduct studies of preventive and developmental services, but other states and our own independent analysis suggest that the regulations offer substantial opportunities for assessing and improving the quality of these services if states undertake appropriate strategic planning and obtain appropriate technical assistance.

Medicaid staffs in some states reported that federal regulations constrict their capacity to commission EQRO reports on topics such as preventive and developmental services because the activities now mandated by the regulations limit the studies that the state might otherwise commission. For example, staff reported that "the regulations have made things more restrictive" and "have taken away our flexibility." Staff in one Medicaid agency said the additional responsibilities now placed on the state for MCO oversight translate into the reallocation of resources from quality improvement work to MCO monitoring. An official from another state said that she understands the reasoning behind the current regulations but perceives the regulations as requiring states to spend too much time assessing MCO functions rather than allowing states to address quality issues. The official said that the current regulations focus on activities more related to the process of evaluations than to outcomes.

States also report that constrained budgets have prevented them from exploring content-specific studies such as those related to preventive and developmental services. While a state can conduct optional activities after it completes the mandatory activities specified by the regulations, the number of optional studies conducted by an EQRO depends on what a state can afford. States report that, given budget constraints, the

regulations limit them to the required activities. One state official said, "To do the compliance projects now required under BBA, we will need more money. The scope of work under the new regulations is much higher than [under] the old regulations." Another official reported, "The mandatory requirements will take additional funds because the required activities are complex." An official in one Medicaid agency whose budget was significantly reduced lamented the fact that the state may not be able to undertake "quality initiatives" any longer because it expends all its funding on mandatory activities, which, in her opinion, are not sufficiently focused on quality improvement.

Flexibility and Opportunities in the Federal EQRO Regulations

Other states whose quality review work was consistent with the federal regulations do not view the regulations as limiting flexibility. Such states reported that the requirement for plans to conduct quality improvement projects and the opportunity for EQROs to assist plans in the development of quality improvement activities was "good news." Some states believe that the regulations allow Medicaid agencies to have more influence over the MCOs. As one state official said, "It's allowed us to leverage a better product from the plans. . .[I]t gives our agency more authority if we can say to a plan 'the federal government wants you to do this.'" Furthermore, budget constraints have not prevented some states from commissioning content-specific studies. In Texas, the state instructed its EQRO to conduct the mandatory studies first and then the optional studies, if funds permitted. The EQRO completed the mandatory studies and still had sufficient funds to conduct the preventive care study described above.

Our own review of the regulations indicates that they do not constrain states' capacity to conduct studies in the area of preventive and developmental services. Opportunities exist for states to use EQROs to assess the quality of preventive and developmental services for Medicaid-enrolled children, although taking advantage of these opportunities requires strategic planning and appropriate technical assistance.

First, the federal rules and regulations now governing a state's quality review activities frequently reference the state's Medicaid plan and the corresponding contracts with the state's MCOs. The most certain route to ensuring that states can use EQROs to improve the quality of preventive and developmental services is to ensure that specific procedures and standards for these services are referenced in the state Medicaid plan and specifically incorporated into MCO contracts in more detail than is usually included in the general provisions related to EPSDT. If MCO contracts specifically reference these services and standards, MCOs will be obligated both to ensure that the services are

available and to document the extent to which they are used. States then can use their EQROs to assess the extent to which the MCOs are meeting these standards.

Second, the rules, regulations, and protocols themselves provide several opportunities for EQROs to assess the quality of preventive and developmental services for Medicaid-enrolled children. These opportunities include:

- **Integrating specific provisions or standards for developmental and preventive services into the state strategy for quality review activities.** Federal regulations (CFR 438.202) require states to: submit to CMS a strategy for assessing and improving the quality of managed care services offered by all MCOs, revise the strategy when significant changes are made, and submit regular reports on the strategy's implementation and effectiveness. The strategy also must aim to ensure that MCOs comply with standards established by the state. If states include in their overall strategy a section that mentions preventive and developmental services and specific standards for these services, then the states can establish a foundation on which to build pertinent quality review activities.
- **Developing specific state definitions that operationalize the federal requirement for providing primary care to children in MCOs.** Federal regulations (CFR 438.208) require states to ensure that each MCO implements procedures to deliver primary care to all MCO enrollees. Because primary care is defined as including developmental and preventive services, the state has the basis for evaluating the quality of these services as part of mandatory federal quality review activities.
- **Developing practice guidelines for developmental and preventive services and integrating them into the state strategy.** Federal regulations (CFR 438.236) require states to ensure that each MCO adopts, makes broadly available, and applies appropriate practice guidelines. The inclusion of practice guidelines for preventive and developmental services in a state strategy will mean that states can ask EQROs to assess, as part of the mandatory quality review activities, whether the guidelines are followed.
- **Incorporating attention to preventive and developmental services into mandatory performance improvement projects.** Under federal regulations (CFR 438.240), states must require, through their contracts, that each MCO develops an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. Ensuring that these programs include an assessment of preventive and developmental services provides states with an

opportunity to ask the EQRO to synthesize and report on the quality of the services across their MCOs. Federal regulations (CFR 438.240(a)(2)) note that CMS, "in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs."

- **Ensuring that required health information systems include data on preventive and developmental services.** Federal regulations (CFR 438.242) require states to ensure that each MCO, using encounter data (or other methods specified by the state), maintains a health information system that collects and reports data on enrollee and provider characteristics, and on services furnished to enrollees. The data must be accurate and complete. If specific information about preventive and developmental services can be included in the data system, the state will be able to ask its EQRO to synthesize data across the MCOs and develop a report on the extent to which the services are delivered.
- **Including a study of preventive and developmental services as an optional activity.** Federal regulations (CFR 438.358) offer states the option of undertaking additional quality review activities for which states can obtain the enhanced federal match. The optional activities include (1) conducting performance improvement projects for the MCO, (2) conducting focused studies related to a particular aspect of clinical or nonclinical services at a given time, and (3) administering or validating consumer or provider surveys of quality of care. States can incorporate a study on preventive and developmental services into their optional EQR activities, particularly as a focused study.
- **Conducting studies that assess access to preventive and developmental services.** Federal regulations (CFR 438.206) require states to ensure that all services provided under the state plan are available and accessible to enrollees of managed care plans. To implement this regulation, states may ask their EQRO to conduct a study of access to services (including preventive and developmental services for children) and the adequacy of their network of primary care providers.

SUMMARY AND RECOMMENDATIONS

Our findings suggest that only a few states are now using, or recently have used, EQROs to assess and improve preventive and developmental services for young children enrolled in Medicaid, but more states could do so if the appropriate resources were available. In addition to a receptive state environment, needed resources include individuals who can champion preventive and developmental services, program staff members who understand the opportunities afforded under current regulations, and an EQRO with both the

knowledge of child health services and experience in integrating several data-gathering and analytic methods into a comprehensive report on quality of care.

Our findings have three major implications. First, improving the quality of preventive and developmental services for young children in Medicaid starts with a convincing case that quality improvement deserves attention in a state's overall strategy for improving services to Medicaid beneficiaries. Medicaid agencies face many hurdles in assessing and improving quality of care for various groups of beneficiaries. The problems in providing preventive services to children in general may not be as compelling to program administrators as problems in providing mental health services to youth with serious emotional disabilities, prescription drugs to disabled beneficiaries, or specialty care to individuals with high-cost chronic illnesses. Some individual or group must take on the task of making the argument for pushing to the forefront the topic of preventive and developmental services for young children.

Champions for preventive and developmental services may be found within state Medicaid agencies, MCOs, EQROs, or provider organizations, but they are unlikely to make a convincing case without some state-based data on gaps in the provision of needed services, the cost of failure to provide such services, or consumer demand for them. Consumer groups, provider organizations, and private foundations interested in improving the quality of preventive and developmental services need to develop strategies for (1) gathering state data on gaps and inadequacies in these services, (2) marshalling arguments for studies that will assess the quality of preventive and developmental services, and (3) identifying the means for incorporating such studies into a state's overall strategy to improve quality of care to Medicaid beneficiaries.

The second implication of our findings involves the need to strengthen the knowledge base for quality-of-care studies of preventive and developmental services for young children in Medicaid and to ensure that appropriate staff in Medicaid agencies has access to such knowledge. Ongoing work by a wide range of researchers and policymakers reflects important components of this knowledge base:

- Continued development and improvement of measures of preventive and developmental services (Bethell et al. 2001).
- Recent studies documenting national gaps in the delivery of preventive care services (Zuckerman et al. 2004).
- Reviews of well-child care that have proposed innovative ideas for adaptations in the periodicity schedule that underlies preventive care (Schor 2004).

- Strategies for MCOs to use in monitoring and improving delivery of preventive and developmental services through performance improvement projects (Center for Health Care Strategies 2002).
- Examples of reports that integrate diverse sources of data on preventive and developmental services (Shenkman 2004).
- Specific steps for integrating quality-of-care studies of preventive and developmental services and relevant practice guidelines into state strategies for improving Medicaid quality (Texas Health and Human Services Commission 2003).

Third, even a strong knowledge base is insufficient to ensure the actual implementation of quality review activities related to preventive and developmental services. Regulations must be translated into contractual language that references contemporary methods for measuring and improving quality of health care for children. While champions and knowledgeable staff may drive a state to focus on preventive and developmental services, integrating specific provisions related to these services in MCO or EQRO contracts provides the leverage needed to ensure that critical actions are actually taken.

The application of new findings and insights to the practical problems of improving preventive and developmental services for children enrolled in Medicaid will depend on whether state Medicaid officials and staff have the interest, experience, and background needed to play a leadership role and serve as partners with EQROs and MCOs. Although the directors of EQROs and MCOs must ensure that staff in their organizations has appropriate experience and training in the assessment of child health services, it will be up to key staff in the Medicaid program to provide the necessary leadership and establish the standards for studies of preventive and developmental services. Specifically, Medicaid staff must take the lead in establishing a coordinated effort to identify study topics, make the case for their importance, select appropriate methods, and implement the necessary changes to enhance quality of care. New efforts will be needed to ensure that staff from Medicaid agencies has the capacity to take on this leadership role and to ensure that EQROs and MCOs develop the skills needed to evaluate preventive and developmental services and implement projects designed to improve the quality of these critical services.

Based on our findings, we recommend that CMS or private foundations concerned specifically with child health care consider designating funds that could be allocated through contracts or grants to accomplish two tasks:

- **Develop training programs for Medicaid staff, EQROs, and MCOs in relation to:**
  - Strategies for incorporating quality improvement activities into the current regulatory framework, with special attention to activities focused on preventive and developmental services
  - Information needed to make the case for the importance of focusing quality improvement activities on preventive and developmental services
  - Current and emerging measurement approaches for preventive and developmental services, including how these approaches fit into quality improvement activities and can be used to move beyond simple counts of encounters.
- **Develop a model set of specifications for both RFPs and contracts that would help state agencies select and implement appropriate quality-of-care activities.** Clear contract specifications related to preventive and developmental services can assist states that want to conduct EQRO studies in this area, but are uncertain how to incorporate such studies into the EQRO contract. States also would benefit from examples of contract language for MCOs to ensure that the plans are focusing on preventive and developmental services.

Our findings also lead to two recommendations for the states, themselves:

- **Develop model strategies for building the stakeholder collaboration essential to identifying and implementing sustainable activities that lead to improved preventive and developmental services.** A single agency acting alone will make little progress toward improving the quality of these services for young children. Instead, collaborative and synergistic activities among states, EQROs, and MCOs are needed to make sustained progress toward better preventive and developmental care. To begin developing such collaboratives, states may want to include in their contracts a requirement for MCOs and the EQRO to participate in a collaborative project. For the MCOs, collaborative projects could be included as one of the plan's mandatory quality improvement activities.
- **Consider using limited dollars more efficiently by conducting mandatory quality review activities in-house to preserve some dollars for independent quality improvement projects.** Some states have developed the capacity to conduct mandatory quality review activities in-house, such as analyzing performance data or generating quality measures. North Carolina, for instance,

relies on statisticians employed by the state to conduct the data analysis for quality review reports. By conducting certain quality review activities in-house, rather than relying on the EQRO, states may be able to complete the three mandatory quality review activities and have dollars remaining to spend on optional studies.

GLOSSARY OF TERMS

Anticipatory guidance — In its recommendations for preventive pediatric health care, the American Academy of Pediatrics defines anticipatory guidance as the provision of age-appropriate discussion and counseling. Areas for counseling include injury prevention, violence prevention, sleep positioning counseling, and nutrition counseling. Providers of adolescent health care are advised to discuss the hazards of alcohol and other drug use with their patients as a routine part of risk behavior assessment. See http://www.aap.org/.

CAHPS — A group of surveys that ask consumers and patients with all types of insurance coverage to evaluate the interpersonal aspects of health care. CAHPS is designed to provide consumers with standardized data to influence their decisions about health. States often ask their EQROs to conduct CAHPS surveys. The CAHPS program is funded and managed by the Agency for Healthcare Research and Quality; see http://www.cahps-sun.org/.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) — The comprehensive and preventive child health program for individuals in Medicaid under age 21. The program includes periodic screening, vision, dental, and hearing services and was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation. EPSDT consists of two mutually supportive operational components: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources. See http://www.cms.hhs.gov/medicaid/epsdt/.

Health Plan Employer Data and Information Set (HEDIS) — A collection of standardized performance measures and their definitions designed to ensure that purchasers and consumers can reliably compare the performance of managed health care plans. The performance measures are related to public health issues such as cancer, heart disease, and asthma and also include well-child visits. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance. See http://www.ncqa.org/Programs/HEDIS/.

Preventive services — Services that focus on detecting and preventing health problems, including the documentation of the child's medical history, a physical exam, immunizations, and anticipatory guidance.

Primary care case management (PCCM) — A PCCM program utilizes physicians, physician group practices, or an entity employing or having other arrangements with such

physicians to locate, coordinate, and monitor covered primary care (and sometimes additional services) for Medicaid enrollees. See http://www.cms.gov/.

Well-child care — Well-child examinations are intended to assess children's growth and development, recognize problems early on, provide immunizations, educate parents, and provide treatment for existing problems. The American Academy of Pediatrics provides guidelines and a schedule for well-child visits.

APPENDIX 1. SUMMARY OF SURVEY AND DESCRIPTION OF EQRO REPORTS AND RFPS

Table A1 presents the results of the state Medicaid director survey. Table A2 details the topics of the EQRO reports subjected to review. Table A3 describes the methodology used to produce the eight EQRO reports related to preventive and developmental services for children in Medicaid.

Table A4 summarizes findings from a review of 10 state RFPs for EQROs. Seven of the 10 RFPs were issued after January 2003 and three before that time. The review of RFPs indicated the following:

- Virtually all of the recent RFPs conform with the regulations but show evidence of variation in their specificity of studies. In general, the RFPs emphasize the need for bidders to demonstrate experience in methods (chart review, analysis of large-scale data sets, measures of quality, and so forth) rather than in content areas such as child health.
- Four of the seven RFPs issued after January 2003 mention a study on EPSDT or well-child care (Arizona, Connecticut, Kansas, and Michigan) while the others do not (Delaware, Ohio, and Washington). These four RFPs varied in content and specifications. For example, Michigan's RFP included a "focused study" of "regional and/or geographical variation in EPSDT service compliance rates" but provided few criteria for the study. Connecticut's RFP noted that the state may want optional studies such as "a medical record audit examining anticipatory guidance, risk screening, and follow-up care" but provided few specifications regarding these possible studies. The other two RFPs asked bidders to conduct immunization studies only.
- The three RFPs issued before 2003 included two RFPs for general EQR work that mentioned EPSDT or well-child care as examples of possible focused studies (Colorado and Virginia) and one RFP for a report on sexually transmitted diseases (Minnesota).

Table A1. Survey Responses, by State

State	No Commissioned Work in the Area of Preventive and Developmental Services/No Plans for Such Work	Commissioned Work in the Area of Preventive and Developmental Services: Has Done So	Commissioned Work in the Area of Preventive and Developmental Services: Plans to Do So	Court Order or Legislative Mandate
Alabama	X			
Alaska	X			
Arizona		X	X	
Arkansas		X	X	
California		X	X	X
Colorado		X		
Connecticut		X	X	
Delaware		X	X	
District of Columbia		X	X	X
Florida	X			
Georgia	X			
Hawaii	X			
Idaho	X			
Indiana	X			
Iowa	X			
Kansas	X			
Kentucky	X			X
Louisiana	X			X
Maine	X			
Maryland	X			
Massachusetts		X	X	
Michigan		X	X	X
Minnesota		X	X	
Mississippi		X	X	
Missouri		X	X	
Nebraska	X			
Nevada		X	X	
New Hampshire		X		X
New Jersey		X	X	
New Mexico	X			
New York	X			
North Carolina		X	X	X
North Dakota	X			
Ohio	X			
Oklahoma		X	X	
Oregon		X		
Pennsylvania		X	X	
Rhode Island		X	X	
South Carolina	X			
Tennessee			X	X

State	No Commissioned Work in the Area of Preventive and Developmental Services/No Plans for Such Work	Commissioned Work in the Area of Preventive and Developmental Services		Court Order or Legislative Mandate
		Has Done So	Plans to Do So	
Texas		X		X
Utah	X			
Vermont	X			
Virginia		X	X	
Washington		X	X	
West Virginia		X		
Wisconsin	X			
Wyoming			X	
TOTALS	22	24	21	9

Note: The following three states did not complete a survey: Illinois, Montana, and South Dakota.

Table A2. EQRO Reports, by State and Topic Area

State	Preventive Care	Well-Child Care	Immunization	Lead Screening	General EPSDT Service Delivery	Disease-Specific Topics
Arizona			Immunization Status of Arizona Health Care Cost Containment System (AHCCCS) Members Two Years of Age (2001) Immunization Status of AHCCCS Members Two Years of Age (2002)			
Arkansas		Measuring More of What Matters: A Report to the Community on HEDIS Measures (2003)	Measuring More of What Matters: A Report to the Community on HEDIS Measures (2003)			
California						Asthma Management/ Pharmaceutical Utilization Report (2002)
Colorado		Use & Delivery of EPSDT Services for Colorado Medicaid Clients (1999)	Use & Delivery of EPSDT Services for Colorado Medicaid Clients (1999)	Blood Lead Screening Intervention Final Report (2002)	Use & Delivery of EPSDT Services for Colorado Medicaid Clients (1999)	
Connecticut					Data Validation Study (2002)	
Delaware	Primary Care Screening for Obesity in Children and Adolescents (2003)		Annual EQR Comprehensive Report for 1999	Annual EQR Comprehensive Report for 1999	Annual EQR Comprehensive Report for 1999	Findings of Delaware EQRO (2000) (focused study on sickle-cell disease)

State	Preventive Care	Well-Child Care	Immunization	Lead Screening	General EPSDT Service Delivery	Disease-Specific Topics
Massachusetts						Clinical Topic Review (2003) (focused study on asthma)
Michigan	Michigan 2001 EQR Report on EPSDT					
Minnesota					1999 EQR: Child & Teen Checkups (EPSDT) Participation Rate Review	
Missouri					External Review of Managed Care and Medicaid Managed Care in MO (2000, 2001, and 2002 reports)	
Nevada					Report of Results of the Evaluation of EPSDT Services (2001) Member Satisfaction Survey: Plan-Specific Report (2003)	
North Carolina			Health Check & Immunization Compliance: A Medical Record Study among North Carolina Medicaid Children (2002)		Health Check & Immunization Compliance: A Medical Record Study among North Carolina Medicaid Children (2002)	
Oklahoma					Minding Our Ps & Qs: Performance & Quality for OK SoonerCare Programs (2003) Final Reports: Results of EPSDT Year III QISMC Project for SoonerCare Plus MCOs and SoonerCare CHOICE Program (2003)	

State	Preventive Care	Well-Child Care	Immunization	Lead Screening	General EPSDT Service Delivery	Disease-Specific Topics
Oregon	Findings of Oregon External Quality Review (2000)	Findings of Oregon External Quality Review (2001)				
Pennsylvania						Commonwealth of PA Physical Health EQRO Project: Final Report Utilizing 2001 Data (2002)
Texas	Children's Preventive Care in MCOs and CHIP (2004)	Well-Child Focused Study (2001)				
Virginia			Immunization Status Review (2002)			Pediatric Asthma Study (2000)
Washington	Healthy Options Focused Review: EPSDT (2001) Healthy Options Focused Review: EPSDT (2002)	Healthy Options Focused Review: EPSDT (2001) Healthy Options Focused Review: EPSDT (2002)				
West Virginia			External Quality Review Report of The Health Plan (2002)		External Quality Review Report of The Health Plan (2002)	

Note: Some reports include data relevant to more than one of the key topics.

Table A3. Methodology for EQRO Reports, by State

State	Report Title	Method: Medical Record Review	Method: Administrative, Encounter, or Claims Data	Method: Survey Data	Method: Interviews/ Focus Groups	Method: Literature Review
Delaware	Primary Care Screening for Obesity in Children and Adolescents (2003)	X	X			X
Michigan	Michigan 2001 External Quality Review EPSDT Study	X	X			
Oregon	Findings of Oregon External Quality Review (2000)	X	X			X
	Findings of Oregon External Quality Review (2001)	X	X			
Texas	Children's Preventive Care in MCOs and CHIP (2004)		X	X	X	
	Well-Child Focused Study (2001)	X				X
Washington	Healthy Options Focused Review: EPSDT (2001)	X				
	Healthy Options Focused Review: EPSDT (2002)	X			X	
TOTALS		7	5	1	2	3

Note: The eight reports included in this table were selected because they contain analyses related to preventive and developmental services for children enrolled in Medicaid.

Table A4. Summary of Selected RFPs

State	Title of RFP	Due Date	Scope of Work: Conforms to Federal Regulations	Scope of Work: Includes Focused Studies	Scope of Work: Mentions EPSDT	Comments
Arizona	External Quality Review Services	March 2004	X	X		Validation of MCO compliance, performance measures, performance improvement projects; requires biannual focused immunization clinical study.
Colorado	None	December 2000	Not applicable	X	X	Two focused studies (to be proposed by offeror), one of which must be a clinical or encounter validation study; requires annual HEDIS calculation and audit; mentions EPSDT only as an example of a past study.
Connecticut	External Quality Review Organization RFP	March 2004	X	X		Optional activities: validation of encounter data; focused reviews such as "a medical record audit examining anticipatory guidance, risk screening and follow-up care," examination of provider network capacity, polypharmacy for children; efficacy of medications to treat behavioral health conditions; access to care for Children with Special Health Care Needs (CSHCN).
Delaware†	RFP for an External Quality Review Organization	August 2003	X			Primary goal: Validation of performance improvement projects, which for 2002 are Improving Diabetes Care Management and Improving the Rate of Mammography Screening; validation of performance measures of MCOs; administering a provider survey of quality of care.
Kansas	External Quality Review for Medicaid Managed Care	July 2003	X			Validation of two performance improvement projects (to be defined by the state in conjunction with the EQRO); validation of MCO performance measures; a review to determine MCO compliance with standards; provider mapping; evaluation and validation of CAHPS and provider satisfaction survey conducted by MCOs; calculation of annual childhood immunization rate; validation of encounter data reported by MCOs; assessment of MCOs' information systems; consumers' access to care; and possibly other optional studies to be specified.

† Although Delaware indicated they had used an EQRO to conduct a study related to preventive and developmental services in 2003, they declined the invitation to participate in developing a case study.

State	Title of RFP	Due Date	Scope of Work			Comments
			Conforms to Federal Regulations	Includes Focused Studies	Mentions EPSDT	
Michigan	Invitation to Bid	March 2004	X	X	X	Assessment of quality of MCO's performance improvement project; assess quality of MCO's outcomes, timeliness of and access to services; conduct a focused study of regional variation in EPSDT service compliance rates; other focused study to be determined.
Minnesota	2002 EQR Study: Sexually Transmitted Diseases	July 2002	Not applicable	X		Comprehensive report on evaluation of prevention, screening, and care provided to enrollees at risk of acquiring STDs; report to provide information that will assist MCOs in improving care and services.
Ohio	RFP: Medicaid External Quality Review	May 2003	X	X	X	Evaluation of MCO compliance; focused studies of clinical health care quality to be determined; validation of encounter data, performance measures, information systems, and performance improvement projects; consumer satisfaction surveys; enhanced care management review; focused study of EPSDT in 2007.
Oregon	Professional Services Contract, No. 105570	May 2003	X	X		Oregon sent the executed contract with its EQRO (OMPRO), not the RFP. The contract lists several tasks and deliverables that are consistent with CMS's mandatory and optional quality review activities. Oregon also sent a report from OMPRO that recommends 10 topics for quality review. One topic was well-child care, and the report proposed using selected HEDIS and EPSDT measures to compare MCO performance.
Virginia	External Quality Review	November 2000	Not applicable	X	X	Conduct CAHPS; conduct focused studies on immunization compliance, adequacy of prenatal care, services for children with asthma, care provided to CSHCN, well-child care; encounter validation study; telephone access to primary care providers.
Washington	RFP for External Quality Review Organization	March 2004	X			Conduct reviews of PIHPs; validate performance measures, performance improvement projects, data systems, state's overall quality strategy.

APPENDIX 2. STATE CASE STUDY SUMMARIES

This appendix includes the summaries of five states selected as case studies: Michigan, North Carolina, Oregon, Texas, and Washington. The purpose of the case studies was to gather additional information on how states are using EQROs or EQRO-like entities to conduct studies of the quality of preventive and developmental services provided to young children enrolled in state Medicaid programs. State selection was based on evidence of past interest in preventive and developmental services for young children, as shown by commissioned EQRO reports; evidence of future interest in this area, as shown by responses to the state Medicaid director survey; or exemplary EQRO reports on relevant topics, detailed RFPs, or procedures for selecting topics for quality review studies.

MICHIGAN CASE STUDY SUMMARY[4]

I. RECENT ACTIVITIES

As a result of advocates' concern, a recommendation from the Centers for Medicare and Medicaid Services (CMS), and the state's own perception of the importance of EPSDT, Michigan has required its EQRO to produce reports on EPSDT since 1999. When the state changed its Medicaid managed care program from a primary care case management program (PCCM) to a risk-based program in 1997, advocates noted that the MCOs might have financial incentives to withhold services, including EPSDT. CMS also wanted to ensure that the MCOs provided appropriate services. The federally mandated EQRO activity for Michigan's managed care program therefore required the state to monitor and report on the quality of services, including EPSDT. The most recent EQRO report on EPSDT, published in 2003 by the state's former EQRO, assessed EPSDT services provided to Medicaid children in 2001. By conducting medical record reviews, the EQRO determined that almost 100 percent of children in the study received some type of preventive service and that the quality of documented EPSDT services was particularly high, although rates varied among the health plans and by enrollee demographics.

In 2003, the Michigan legislature required the Michigan Department of Community Health (MDCH) to do the following[5]: (1) ensure that (a) all Medicaid children have timely access to EPSDT services as required by federal law and that (b) Medicaid MCOs provide EPSDT services to child members in accordance with EPSDT policy; (2) require the EQRO contractor to conduct a review of all EPSDT components provided to children from a statistically valid sample of health plan medical records; and (3) develop and implement a plan to improve access to health screening services under the EPSDT program for all Medicaid-eligible persons under age 21. As required by the legislative mandate, MDCH submitted to the legislature in June 2004 a comprehensive plan to improve EPSDT service delivery to Medicaid beneficiaries. The report describes recent MDCH efforts such as the implementation of beneficiary and provider surveys; the development of provider education materials; and the implementation of a managed care performance plan to award bonus funds to plans with good performance reports. As also required by the legislation, Michigan's contract with its new EQRO—Health Services Advisory Group (HSAG)—includes a focused study of EPSDT as an optional activity. HSAG staffers said that they are still determining the methodology for the study but that it will involve a medical record review and a gathering of administrative data, as well as an examination of all required components of EPSDT.

MDCH also participates in a collaborative EPSDT workgroup that includes MCOs, local health departments, and the Michigan State University Institute for Health Care Studies (IHCS). The workgroup aims to improve the rate of EPSDT service delivery for Medicaid enrollees and has undertaken various activities described in the comprehensive plan submitted to the legislature, such as conducting focus groups and surveys and revising the EPSDT beneficiary pamphlet. The workgroup also developed an EPSDT Clinician Toolkit to provide clinicians with practical tools to assist in the identification, provision, and documentation of appropriate well-child preventive services, such as immunizations, well-child examinations, and blood lead testing. The workgroup has distributed the toolkit widely, and the MCOs use it as part of their provider education programs.

In addition, MDCH is collaborating with IHCS and three MCOs in a project applying disease management strategies to a population of well children aged birth to six years. The goal of the project is to improve EPSDT and immunization rates for children enrolled in the plans. The project includes a data registry, beneficiary selection and stratification criteria, and case management for children with no record of well-child examinations or immunizations. Outcomes are measured to assess improvements in the EPSDT and immunization rates as well as the impact of case management for the target population.

An initiative focused on improving preventive and developmental services for children is also under way in one of Michigan's Medicaid MCOs. Molina Healthcare of Michigan has recently implemented an internal program called Baby Steps Towards Health to improve well-child care and screenings for children from birth to three years.[6] The pilot, implemented in one county, involved the creation of an EPSDT database to identify children overdue for visits, track outreach to parents (including mailings and reminder telephone calls), and monitor education to providers. At the end of the pilot, Molina's EPSDT rate for children aged birth to three years had increased from 46 to 76 percent. As a result of its success, Molina has expanded the initiative statewide.

II. PATHWAYS TO SELECTING QUALITY IMPROVEMENT INITIATIVES

CMS and legislative requirements have influenced Michigan's quality improvement initiatives. As mentioned, the mandated federal EQRO activity required Michigan to report on the quality of specific services, such as EPSDT. The legislature also pushed MDCH to develop a plan with details on all of the department's activities aimed at improving EPSDT. Over the years, MDCH further refined its EPSDT reports when it recognized that the studies conducted by the EQROs were not fully assessing the documentation of EPSDT. MDCH realized that just examining the documentation of a

well-child visit does not mean that all components of EPSDT have been received and documented. As a result, the state expanded the focus of the EQRO study to include an assessment of all components of well-child visits, including developmental assessments.

Political and public perceptions also have influenced the quality improvement initiatives on which Michigan chooses to focus its efforts. MDCH informed us that, in 2003, the *Detroit Free Press* published a series of stories highlighting the issue of lead poisoning and the failure of the state to take significant action. In response to the articles, the governor established a lead-poisoning task force. One initiative that emerged from the task force was a lead testing mandate for the MCOs. The MCO contract now includes a requirement that every plan must have 50 percent of its enrollees tested for lead by age three, with the standard increasing to 60 percent in 2005, 70 percent in 2006, and 80 percent in 2007.

Although staffers from one MCO said that they had not been actively involved in the development of the RFP for the EQRO or study topics, MDCH officials said that the department makes extensive efforts to engage the MCOs in deliberations regarding EQRO study topics and relies on several strategies to elicit MCO views. The department holds quarterly Clinical Advisory Committee meetings during which it shares plans about EQRO activities and solicits feedback from plans. MDCH also holds several meetings during the year to advise plans about regulations and EQRO activities and to discuss EPSDT study results. Another arena in which MDCH says it provides plans with status updates is through the Michigan Association of Health Plans (MAHP), the MCO trade association.

III. IMPACT OF NEW FEDERAL REGULATIONS

Michigan has maintained a focus on EPSDT while implementing the new regulations, but state staff members did say that they are forgoing other study topics because of the regulations. While MDCH once required the EQRO to conduct focused studies on issues such as diabetes or asthma, it no longer does so. MDCH officials pointed out that, because the MCOs are required to generate HEDIS measures, the state already has access to considerable data and does not need to rely on an EQRO for studies related to HEDIS. MDCH says that the new regulations complement the other methods developed by the state to evaluate plan performance, such as HEDIS; the goal is to eliminate redundant efforts and to supplement rather than duplicate information. For example, the EQRO no longer conducts immunization studies because HEDIS data include information on immunizations. MDCH officials said the MCOs had been encouraging the department to move away from focused studies before the regulations even took effect. As one official

reported, "The new federal regulations have essentially pushed us in the same direction as the health plans had suggested by making activities such as focused studies optional. We have no problem with the mandatory activities in the new regulations. We think it is very helpful to have a comprehensive overview of health plan efforts, which is what the mandatory activities support."

The new regulations have changed some EQRO and MCO activities in Michigan. For instance, HSAG staff members indicated that a new activity specified in their contract is the examination of results from MCOs' compliance reviews. Furthermore, MCO representatives informed us that if the MCOs do not meet a benchmark set by the state, they are required to submit a corrective action plan, which is considered a performance improvement project required under the new regulations.

IV. EFFECTS OF EQRO STUDIES

MDCH officials reported that they share the results of EQRO studies with the MCOs, EPSDT program officers, and the legislature, but historically the MCOs have not viewed EQRO activities as particularly helpful. One reason is that it can take up to 24 months before the MCOs receive focus study results, by which time many of the plans have already generated more recent data on their own. The MCO with which we spoke for our case study reported that the plan has not made any changes to its activities as a direct result of the EQRO reports. Since the plans focus their efforts on meeting state benchmarks, the MCOs will probably not make changes unless the state changes its benchmarks as a result of EQRO findings. In addition, the plan we interviewed for the case study is NCQA-accredited and focuses on meeting NCQA standards, as well. The MCO did report that the state is beginning to "mimic the benchmarks for accreditation."

V. THE ROLE OF EQROS: LESSONS LEARNED

States are using entities other than EQROs to improve preventive and developmental services for children. The collaborative relationship between MDCH and the university-based IHCS provides an example of how a state can use an entity other than an EQRO to implement initiatives focused on improving preventive and developmental services for children. While MDCH says that it relies on its EQRO to conduct focused studies in topical areas suggested by the department, it uses IHCS for issues related to process, management, and relationship-building with the MCOs. IHCS works closely with MDCH on initiatives related to improving EPSDT services.

Variability of EQRO skills affects whether states ask EQROs to conduct studies of preventive and developmental services. MDCH officials emphasized the

importance of an EQRO's knowledge of the managed care environment. Based on its knowledge of the industry, IHCS has recently produced reports for the state on the quality of managed care in Michigan. MDCH officials questioned whether most EQROs recognize the need to understand the "changing landscape of the managed care environment." As one official noted, "If an EQRO wants to remain competitive in the managed care industry, it must stay abreast of current tools [e.g., CAHPS, HEDIS] and initiatives. Just being able to speak managed care lingo and understand managed care principles will take them a long way." EQROs vary in their level of sophistication and expertise, particularly regarding managed care, and thus are likely to be affecting a state's decision whether to request the EQRO to undertake a process-centered study, such as one focused on preventive and developmental services.

Political and public perceptions can influence quality improvement initiatives. CMS, legislative mandates, and public opinion (via newspaper articles) have brought pressure to bear on the state to concentrate its quality improvement efforts in certain areas, particularly EPSDT. In fact, the state has expanded its EPSDT-focused activities in response to legislative requirements and has implemented new lead screening standards in response to newspaper articles describing children's problems with lead. Although a story about preventive and developmental services might not capture as much public attention as the series on lead, it is possible that additional studies might be conducted in the area of preventive and development services if sufficient public interest can be generated.

MCO responses to EQRO findings depend on state reactions. Michigan encourages its plans to become accredited and is raising its benchmarks closer to those required by the accrediting organizations. The MCOs say that unless the state responds to EQRO findings by adjusting the performance measures the MCOs are required to meet, the plans will likely not implement changes. If the state decides to raise the benchmarks because of an EQRO report, the MCOs will respond by changing their activities.

NORTH CAROLINA CASE STUDY SUMMARY[7]

I. RECENT ACTIVITIES

In North Carolina, approximately 70 percent of Medicaid eligibles are enrolled in managed care. Of these beneficiaries, 99 percent are enrolled in either a PCCM (Carolina Access) or enhanced PCCM program (Community Care of North Carolina), and just 1 percent are enrolled in a Medicaid MCO (South Care). The MCO exists in just one county (Mecklenburg); it counts 11,000 enrollees, with enrollment voluntary. The state has a long history of working directly with the provider community through its PCCM programs. In this largely PCCM environment, North Carolina usually does not rely on its EQRO as a primary source for quality improvement activities. Although its EQRO has not been involved, the state recently implemented a number of quality improvement activities, including an initiative to improve developmental services for children in Medicaid.

Carolina Access began operations in 1991 to enhance recipient access to primary care, to improve the coordination of care, and to reduce recipient reliance on hospital emergency departments. Community Care of North Carolina (CCNC), launched in 1998, aims to build on Carolina Access by working with community providers to ensure better management of the enrolled Medicaid populations and to improve quality of care through a group management approach. In 2000, the North Carolina Division of Medical Assistance (DMA) was awarded a grant from The Commonwealth Fund—an Assuring Better Child Health and Development (ABCD) grant—to build state Medicaid capacity for child development services. The DMA took a two-tiered approach: (1) to develop a comprehensive community model to be used as a template for replication and (2) to form a state policy group of key agency members who would work in concert with first-tier activities. CCNC provided the state with the necessary infrastructure for testing this "best practices" model for developmental screening and surveillance for later replication in other communities throughout the state. With the Office of Research, Demonstrations, and Rural Health Development (ORDRH) providing technical assistance for the expansion of the CCNC program, ORDRH and DMA have worked in concert to develop and implement enhanced child development services. The state has used lessons learned from the activity to shape Medicaid policy and improve developmental screening rates.

The quality management nurse consultant for the state's EPSDT program (Health Check) indicated that the EPSDT program needs to ensure that children receive developmental screenings, which have generally received low status on providers' priority lists. The Healthy Development Collaborative has been helpful in training providers to use

the screening tool that is part of the best practices model. The collaborative was formed with funding from foundations such as the Duke Endowment, the North Carolina Center for Children's Healthcare Improvement (NC CHI) and partnered with organizations (e.g., the National Institute for Children's Healthcare Quality [NICHQ], The Commonwealth Fund, and DMA) to assist primary care providers in improving the delivery of anticipatory guidance, parental education, and developmental services. Six DMA managed care consultants discuss with providers the importance of screenings and work with them to integrate the screening tool into their practices. DMA officials said that they learned through the process that many providers are not trained in providing developmental services. The ABCD physician champion (Dr. Marian Earls), local ABCD community staffers, and staffs from the respective state agencies offered four practice quality improvement trainings (for 140 people from 40 different regions) that covered the rationale for screening, office systems/processes, community relationships, and performance management. The ABCD program staff has conducted surveys to assess providers' knowledge and practices regarding developmental services (again, without any EQRO involvement).

Neither the MCO in North Carolina nor the EQRO—Medical Review of North Carolina (MRNC)—has been engaged in the state's activities to improve developmental services. With the MCO serving such a small population, the state has not involved it in the initiatives, but DMA officials informed us that they would like to work with the EQRO in the future. MRNC's current contract limits its activities to strictly conducting medical record reviews for studies selected by the state. Officials at MRNC and DMA said that the state dictates the topic and provides the EQRO with the study population. The EQRO then develops the data dictionary and directs its abstracters to perform the medical record abstractions. Statisticians at the North Carolina State Center for Health Statistics (SCHS) then analyze the data and publish the reports.[8] MRNC staff reported that MRNC performed the analysis when it first contracted with North Carolina. Now, the state uses its own statisticians (most likely for financial reasons, as MRNC staff speculated), making it easier for DMA to use the data for other purposes.

II. PATHWAYS TO SELECTING QUALITY IMPROVEMENT INITIATIVES

DMA officials try to be "data-driven and topic-driven" when selecting EQRO study topics. They also are cognizant of issues important to the state legislature and the legislative language indicating the topics of concern to legislators (e.g., "The Division of Medical Assistance shall engage in disease management programs for X and Y conditions"). The state also examines data such as national HEDIS measures to determine areas of care in need of improvement and topics to be studied.

Given that the EQRO is contracted only for medical record reviews, North Carolina tries to focus on topics requiring significant medical record abstraction. DMA officials said that, while the state selects the topics, it is open to hearing from MRNC about issues to be addressed. Although the MRNC contract is highly specific about EQRO activities, DMA tries to take a "global perspective about what is needed" when selecting topics. In considering the functions of the EQRO, DMA officials conceded that, in states with a strong MCO presence, an EQRO would be in a good position to make recommendations to the state based on a large volume of MCO data. North Carolina, on the other hand, "really values" MRNC and its "very important role" but nonetheless enjoys a strong relationship with its PCCM network and receives useful administrative data directly from providers. Using information gathered both locally and through Medicaid claims, the CCNC networks assess the needs and health status of their Medicaid enrollees in order to target care and disease management initiatives toward those enrollees at greatest risk. The clinical directors from the networks meet regularly to identify the quality improvement and care management initiatives to be undertaken by the networks. Consequently, they have less need to use an EQRO to learn about provider activities.

Another potential avenue for quality improvement activities in North Carolina is the Area Health Education Centers (AHECs), which are funded by the state in nine regions to provide training and education to health care professionals. DMA officials informed us that the AHECs are collaborating with NC CHI to educate providers about asthma, using the topic as a pilot. If the program succeeds, the AHECs plan to introduce other issues, possibly preventive and developmental services.

III. IMPACT OF NEW FEDERAL REGULATIONS

The new regulations have somewhat influenced North Carolina's EQR activities. For 2004, the state has asked MRNC to conduct the mandatory EQR validation of performance data and performance improvement projects, activities not undertaken in the past. State officials voiced concern that the regulations would prevent the EQRO from conducting focused studies; however, given that the EQRO contract was already in place and called for focused studies when the new regulations took effect, funding for EQRO activities remained unchanged.

IV. EFFECTS OF EQRO STUDIES

In 2000, SCHS released a report entitled, *Health Check and Immunization Compliance: A Medical Record Study among North Carolina Medicaid Children 6 through 24 Months of Age,* which evaluated screening and immunization compliance rates in the state's Medicaid managed care program. We could not determine from our interviews whether the 2000

report has had any impact on the state's Medicaid managed care program. MRNC conducted the medical record review for the report, and while the state had originally planned to conduct an all-inclusive follow-up study in 2004, it decided to target Health Check services provided to children with special health care needs. MRNC is performing medical record abstractions for the report. DMA officials indicated that they are planning a study on prenatal care in 2005 and well-child care for adolescents in 2006.

Although the contract with MRNC involves a specialized scope of work, limited to one primary activity (medical record abstraction), state staff members suggested it might be useful to add a standard component to the EQRO's data collection tool to determine whether the well-child visit extends to developmental services. Said one respondent, "We have enough information right now for the EQRO to be able to give us feedback on this. With the Healthy Development Collaborative, part of what we're doing is learning how to collect information and document how we're doing over time." While the ABCD grant provided the state with the luxury of resources to collect information, staffers said that the enhanced PCCM networks have existing mechanisms for measuring performance of developmental and preventive services. Moreover, within the Healthy Development Collaborative training sessions and ABCD training sessions, providers learn how they can collect information within their own systems without relying on external resources such as grant funding.

V. THE ROLE OF EQROS: LESSONS LEARNED

EQRO activity is limited in PCCM environments but still plays a role. In a state such as North Carolina with only one MCO and a narrow scope of work in its EQRO contract, the opportunities for the EQRO to help improve developmental and preventive services are somewhat limited. The state commands in-house sources for data collection and analysis and has access to a committed and active provider community involved in quality improvement activities absent the EQRO.

Champions are important. The ABCD project coordinator and the quality management nurse consultant for Health Check each characterized the other as championing the state's activities to improve developmental services through technical support at the state level. Both appear devoted to improving developmental services for children in North Carolina; their enthusiasm and commitment to these initiatives have no doubt fostered quality improvement. The ABCD project coordinator largely credits the actions of the developmental and behavioral pediatrician in the community (Dr. Earls), who has championed the ABCD initiative. The Health Check consultant said that the

Medicaid office also has a champion in its medical director for managed care, who is committed to all components of preventive care.

Resources are critical. North Carolina has been fortunate in the resources it has available for conducting quality improvement activities. In addition to grant funding from The Commonwealth Fund, the state has in-house capability for data analysis, six managed care consultants who work with physicians in both the PCCM and MCO programs to improve screenings, Health Check coordinators in 80 counties working to promote developmental screenings, and a contract with the University of North Carolina-Greensboro for data analysis. State staff members said, "The luxury of our grant resources has enabled us to use other sources. We went that route of using other expertise in this area because the Medicaid office is already overburdened." Cost is still a huge factor, however, and DMA officials said that they operate on a "shoestring budget." In view of the budget, state staff members reported that, if they wanted to expand the scope of their quality review activities, they would first look internally rather than to the EQRO because of considerations of cost.

Physician support is pivotal to improving developmental services. As DMA officials said, "We're in a unique situation because our PCPs are very engaged in caring for the Medicaid population. We've worked collaboratively with our providers." In fact, it was a pediatrician (Dr. Earls) who suggested the ABCD grant. State staffers reported that a key to their success in implementing their quality improvement initiatives is that they are locally driven. The North Carolina Pediatric Society works closely with Medicaid to promote the screening tool. The ABCD project coordinator also works closely with the Academy of Family Physicians and suggested, "Finding a physician champion and getting their support from the beginning is key."

OREGON CASE STUDY SUMMARY[9]

I. RECENT ACTIVITIES

Oregon's Medicaid managed care program operates under a federal Section 1115 waiver as the Oregon Health Plan (OHP). The state expects the MCOs to manage all components of children's health care (e.g., immunizations, well-child visits, early childhood caries prevention, and so forth); the responsibility for ensuring that children receive well-child services thus falls on the MCOs, with the state performing an oversight role. The state's role, however, has consistently involved activities aimed at ensuring that the MCOs focus on improving the quality of children's health care.

In 2000 and 2001, Oregon's former EQRO produced reports that reviewed and evaluated children's receipt of well-child care in the state's Medicaid managed care program. By conducting medical record reviews on a sample of children, the EQRO investigated the extent to which children had received all components of a comprehensive well-child visit, including physical examinations, updated health history, developmental assessments, preventive screenings, and anticipatory guidance. The two studies yielded similar findings and indicated that medical records inadequately documented both developmental/behavioral assessments and anticipatory guidance. The records did, however, demonstrate a high rate of documentation of the physical components of the well-child examination as well as of treatment and follow-up of both physical and mental health conditions.

Additional studies on well-child care are not planned for the near future in Oregon. Officials in the state Medicaid agency (the Office of Medical Assistance Programs or OMAP) said that they rely on an internal process to determine the delivery of well-child visits by examining the encounter data collected by the MCOs. An MCO representative said that no future studies on well-child care are planned because, "[t]here is a feeling that there is already statewide activity going on with the child population. Earlier studies about well-child care were conducted, and the state probably felt we were already doing something with this population to measure quality." A representative from the state's current EQRO—Oregon Medical Professional Review Organization (OMPRO)—said he did not know why preventive care studies were not a top priority for the state but speculated, "It may be that the plans do not see it as a priority." OMAP officials did say that, because of Oregon's waiver, the Centers for Medicare and Medicaid Services (CMS) had recently contracted with Research Triangle Institute to complete a study on the care of children with special health care needs in OHP. OMAP plans to undertake a

subanalysis of the study and may examine preventive care services provided to the special needs population.

Although it is not currently directing its EQR activities to well-child care, OMAP has maintained a focus on early childhood caries detection and prevention. The state also continues to monitor access to care through its CAHPS child survey, which is part of OMPRO's contract, and through state-calculated access-to-care measures modeled after HEDIS. In addition, OMAP assists MCOs with immunizations by providing an immunization registry also used to monitor plan performance.

II. PATHWAYS TO SELECTING QUALITY IMPROVEMENT INITIATIVES

Oregon's quality improvement strategy includes a unique component called the Rapid Cycle Improvement Process, which involves the following steps after the EQRO contract is awarded:

- The first step requires the EQRO to develop a draft clinical practice summary (CPS) with recommendations of 10 clinical and nonclinical topics for evaluation.[10] Among other methods to develop its CPS in 2003, OMPRO consulted with state and MCO staff and clinical experts and read peer-reviewed literature detailing evidence-based best practices related to Medicaid managed care populations, preventive services, and quality and performance measures.[11] The CPS must describe a strategy for measuring quality and performance in each of the recommended topic areas, summarize support for the topics and measures from existing clinical practice standards or evidence-based research, and rank the topics based on factors and criteria provided by OMAP.
- The second step requires the EQRO to present the draft CPS to a performance improvement workgroup, whose members include OMAP staff and quality improvement coordinators from the MCOs.
- The third step, after OMAP approves the draft CPS, requires medical directors from the MCOs to recommend five of the ten topics on which studies will be conducted. At that point, the CPS becomes final, and the EQRO is required to conduct the five studies over its two-year contract period. The draft CPS that OMPRO submitted in 2003 included well-child care as one of its ten proposed study areas. When the topics were narrowed down to five, however, well-child care was not on the list.

Overall, Oregon's MCOs have an important role in the selection of study topics. The quality improvement coordinators from two MCOs indicated that they enjoy their

involvement with the performance improvement workgroup. The coordinators call the workgroup an "information forum" during which they serve as an advisory board and make recommendations regarding issues that support contract clarification. They propose study topics based not only on issues of concern to the MCOs but also on the MCOs' ability to measure and report performance. One coordinator said, "It's an opportunity to work cohesively with the state and the EQRO . . . toward goals." The collaboration among the state, the MCOs, and the EQRO began several years ago with the intention that, by working together, the entities could enhance each other's quality improvement activities.

Fiscal concerns also have an impact upon Oregon's priorities for EQRO work, especially given the state's recent budget problems. For instance, the workgroup recommended emergency department utilization as the first EQRO study topic during the contract period. OMPRO said that one of the criteria used to rank the CPS topics is the study's potential for cost reduction. Activities that may result in cost savings receive a higher rating. In 2004, both OMAP and the MCOs perceived emergency department utilization as a valuable topic; each thought a study in this topic area had a strong possibility for enhancing both quality of care and cost reduction.

In the future, it is possible that providers in Oregon might influence quality improvement activities. A project director at the Child Development and Rehabilitation Center (CDRC)—the organization that administers Oregon's Title V Services for Children with Special Health Needs Program—said that CDRC works with Oregon's MCOs on various quality-related activities. He also said that CDRC has a working relationship with OMAP and expressed interest in working with OMPRO to improve children's health services. We also learned that the new president of the Oregon Academy of Pediatrics is a developmental pediatrician. Interest from the Oregon Academy of Pediatrics and other providers in improving developmental services and the existing relationships between CDRC and the MCOs and between CDRC and OMAP may eventually lead to more involvement by providers in quality improvement initiatives for Medicaid beneficiaries.

III. IMPACT OF NEW FEDERAL REGULATIONS

Oregon appears to have accommodated its EQRO activities to the new federal regulations without major difficulties. Given that OMAP had anticipated the changes, it "integrated the concepts right away." An OMAP official said that the mandatory requirements are "a good fit in our quality improvement cycle" but that the idea of nonclinical studies was new to EQRO applicants. The official also said that the regulations have not resulted in

the increased flexibility expected by the state. The official expressed disappointment that there was no formal process for review and improvement when the protocols were established.

The new regulations did affect Oregon's RFP for its EQRO. To develop its most recent RFP, OMAP (1) asked other states about their current EQRO activities, RFPs, and contracts and (2) surveyed the MCOs' quality improvement coordinators and medical directors and asked them to prioritize EQRO topic areas and processes. As a result of the new regulations and the findings disclosed by the MCO survey, Oregon modified its EQRO contract and processes. In addition to implementing the changes required by the new regulations (such as incorporating mandatory and optional activities into the contract), Oregon asked the EQRO to use encounter data in its studies. In asking respondents to rate the importance of assessment methods, the survey disclosed that the use of encounter data earned a high ranking. Furthermore, OMAP wanted study results to be timely while medical record reviews were viewed as time-consuming and labor-intensive. Rather than rely on medical record reviews, the state decided that the EQRO should use encounter and administrative data for its studies. Another new requirement in the EQRO contract is a CAHPS study, previously conducted under a separate contract.

OMPRO staffers said that Oregon's sole reliance on encounter and administrative data for EQRO studies makes the state unique. OMPRO recently completed an assessment of encounter data completeness to determine the number of claims over time and found that the data were relatively complete overall. MCO staffers also said the encounter data they receive from providers is improving. One MCO representative noted that information about well-child visits in the plan's encounter data does not include details of the preventive and developmental services provided. To get a sense of preventive and developmental services, a medical record review is necessary, but, according to the same representative, Oregon has moved away from that activity. Another MCO representative said that, until this year, the plan had more closely examined the services provided during well-child visits, but, with rapid plan enrollment over the year, it now examines only a sample of claims data to assess well-child visits.

OMPRO staffers said that they try to integrate the new regulations into their efforts as often as possible. As they look at performance improvement measures collected by OMAP, they consider validation of the measures and make recommendations concerning the state's quality strategy. OMPRO is advocating for more collaboration with the state and the MCOs and would like the process to flow in a way that facilitates translation of focused EQRO studies into specific plan quality improvement activities in

the following year. As an OMPRO representative said, "We need integration so we're not working at cross-purposes or in silos, and so plans aren't overwhelmed." He cited OMPRO's emergency room study as an example of integrating MCO and state priorities.

IV. EFFECTS OF EQRO STUDIES

The well-child care reports produced in 2000 and 2001 included recommendations to the MCOs to improve compliance with the guidelines recommended by the American Academy of Pediatrics. For example, one recommendation called for implementing active preventive measures at the preteen level while another called for educating parents about the importance of early counseling and anticipatory guidance. We learned from speaking with the MCOs, however, that they appeared to have taken no action in response to the recommendations. The MCO representatives with whom we spoke for the case study could not recall whether the plans had implemented any changes as a result of the reports' findings because they were not employed by the MCOs when the reports were published.

OMAP officials informed us that findings from the well-child care reports did lead to the inclusion of performance measures in the most recent MCO contracts (specifically, performance measures related to immunization rates). Officials also said that the reports have contributed to the idea that the monitoring of services for the population served is a shared responsibility among providers, MCOs, the state, and parents.

V. THE ROLE OF EQROS: LESSONS LEARNED

Reliance on encounter data may limit studies on preventive and developmental services. Encounter data from the MCOs in Oregon do not include details of preventive and developmental services. Medical record reviews are therefore necessary to obtain that information. However, Oregon now requires OMPRO to use only encounter or administrative data for quality-related studies.

Fiscal constraints affect the selection of study topics. With tight budgets, states are searching for opportunities to save costs. In Oregon, both the state and the MCOs assign high priority to EQRO studies with cost-saving potential. As discussed, a study of emergency department visits earned a high ranking for this reason. Studies of preventive and developmental services also involve issues related to cost savings, but the topic's potential to improve quality of services may be greater than its potential to save costs, especially in the short term. States and MCOs may therefore view study topics other than preventive and developmental services as higher priorities.

Other issues take precedence over studies of preventive and developmental services. Oregon's selection process for EQRO study topics involves feedback from state staff, MCOs, and the EQRO. This collaborative process means that if a particular topic is important to any of the stakeholders, it has the potential to become an EQRO study. Therefore, if a medical director of an MCO, for example, is especially interested in preventive and developmental services, he or she may recommend that the EQRO conduct a study in this area. For a topic to make the final cut, however, it must be important to most of the stakeholders involved in the selection process and be approved by OMAP. While well-child care was a salient study topic in Oregon a few years ago, the state and the MCOs are currently addressing other issues, such as access and emergency department utilization.

TEXAS CASE STUDY SUMMARY[12]

I. RECENT ACTIVITIES

Working with its EQRO, the Texas Medicaid agency (the Health and Human Services Commission or HHSC) has recently focused on the quality of preventive services for children and adolescents in its Medicaid managed care program (State of Texas Access Reform or STAR) and its children's health insurance program (CHIP). In January 2004, the state's EQRO—the Institute for Child Health Policy (ICHP)—produced a report entitled "Children's Preventive Care in the STAR Managed Care Organization and in the Children's Health Insurance Program in Texas." ICHP used encounter data, MCO interviews and questionnaires, and surveys of adolescents and parents to examine both the occurrence of preventive care visits and the issues addressed during the visits as reported by parents and adolescents. The report included recommendations to the MCOs regarding improvements in the delivery of preventive care visits, screening processes, and anticipatory guidance provided during visits.

Staff at an MCO in Texas indicated that plans are also involved with activities to improve well-child care. The given plan recently increased its reimbursement rate for EPSDT services and is offering incentives (e.g., gift cards) to members who keep their scheduled visits. Separating the specific EPSDT component of preventive and developmental services has not been a high priority for the MCO; however, if a child makes an EPSDT visit, the plan assumes that the child is receiving all the required screens.

During the third year of its contract with Texas, ICHP is required to conduct focused studies similar to the previously completed preventive care study; it is currently in the process of discussing with HHSC its priorities for additional studies. MCO officials reported that they would like ICHP to conduct studies on topics such as child obesity and immunizations, but topics have not been finalized.

II. PATHWAYS TO SELECTING QUALITY IMPROVEMENT INITIATIVES

Texas's review of reports on population needs drives topic selection for EQRO studies. The state receives encounter data from the health plans as well as reports based on HEDIS measures and CAHPS surveys. HHSC staff reviews the data and then develops a list of topics. With children representing the majority of the Medicaid program's enrollees, topics often focus on this population.[13] The state's previous EQRO (2001) conducted studies on well-child care and preventive services utilization, and, most recently, ICHP conducted the preventive care study. Texas chose to contract with ICHP because of its expertise in areas of interest to the state, such as pediatric health. HHSC officials said that

ICHP was extremely knowledgeable about the populations HHSC serves and that it proposed a rigorous methodology for studies that greatly interested the state.

HHSC officials reported that topic selection is also somewhat the result of burning issues within the state. If a number of legislators are interested in a certain issue, the state will work with its EQRO to develop a related study. For instance, ICHP members said that they are especially focused now on issues related to the expansion of the Medicaid managed care program—an issue of importance to the Texas legislature.

The decision to conduct the recent study on preventive care resulted from a collaboration between the state and ICHP. ICHP's contract requires two focused studies for both the STAR and CHIP programs. After reviewing data from the MCOs, state staff developed a list of study topics. Then, ICHP gave the state staff a sense of which topics were worth pursuing. HHSC officials reported that they "relied on ICHP's expertise." Together, the state and ICHP settled on the study of preventive care, a topic of mutual interest. According to ICHP staff, the delivery of preventive care was not meeting HEDIS guidelines, and HHSC was concerned with findings about poor utilization rates reported by the previous EQRO. Further, both the state and ICHP recognized that preventive care is fundamental to well-child care visits and were interested in studying the MCOs' provision of such services.

Health plans are not involved in the selection of study topics but do provide feedback for the development of the EQRO RFP. The MCOs receive a draft of the RFP and can comment on the requirements and make suggestions. The health plan with which we spoke for the case study agreed that topics are primarily population-driven, with some influenced by the legislative environment. The same is true for quality review activities undertaken by plans. For example, a given MCO was focusing on improving the quality of diabetes care as addressed by recent legislation. The plan said that new legislation has a major impact on the issues it researches.

III. IMPACT OF NEW FEDERAL REGULATIONS

According to ICHP staff, the activities required by the new federal regulations (in particular, the validation of encounter data through medical record review) have involved a "huge undertaking" and have consumed considerable time and energy. HHSC officials reported that the quality improvement framework included in the new regulations has helped the state, allowing it to leverage a better product from the plans. The agency has more authority when it can say to the plans, "The federal government wants you to do

this." With HHSC tracking the regulations in draft form, it knew what to expect and easily incorporated the regulations into the RFP for its EQRO.

While other states have reported difficulties in conducting optional studies in addition to the mandatory studies required by the regulations, Texas has faced no such problem. HHSC officials indicated that they direct the EQRO to concentrate on the mandatory studies and, if funds remain, to conduct the optional studies. As a nonprofit academic institution, ICHP has not faced budget difficulties and has been able to conduct the mandatory studies in addition to optional studies.

IV. EFFECTS OF EQRO STUDIES

HHSC's internal process requires staff to recognize any quality-of-care issues raised in the EQRO reports and to identify opportunities for improvement. If the issues relate to the MCOs, HHSC will "tailor a remedy to fit the problem area" and will work with the MCOs to implement changes intended to improve outcomes. The state may integrate the study findings into corrective action plans for the MCOs or amend the MCO contracts.

HHSC officials also use information from the reports to define the topics for Quality Improvement Forums, which they host for the MCOs. The state is currently working to link purchasing to performance improvement; in fact, during the next procurement process, HHSC will include a "performance dashboard," which includes child measures, to provide information on how the MCOs are performing. HHSC hopes the initiative will encourage plans to make improvements as they learn how they rank against other plans. ICHP also has agreed to be more specific in its future reports about the steps plans can take to make improvements.

At the time of our interviews, it was too early to assess the impact of the preventive care study.

V. THE ROLE OF EQROS: LESSONS LEARNED

Money matters. ICHP staffers said that, as members of an academic institution, they are "not looking to make a profit" but that, if fiscal considerations drove decisions, the situation in Texas might be different. By contracting with an academic policy center, Texas has "had a financial break that other states might not have" because of ICHP's relatively low rates. Other states have indicated that, unlike the situation in Texas, limited resources have prevented their EQROs from conducting additional studies.

Getting preventive care on the radar screen. With more national attention focused on and additional studies addressing the importance of early childhood health services, ICHP staff members are optimistic that more states will commit to examining children's health care. When ICHP's preventive care report was released, the public was struck by the finding that adolescents were receiving few counseling services. State officials and ICHP reported that, in Texas, the content of well-child visits is of great interest to the public. Getting MCOs to improve preventive care services, however, involves increased financing. HHSC officials speculated that issues become meaningful for the MCOs when they consider quality and financing in combination. Contract modifications that embed the preventive care issue would help raise the importance of preventive services by making "plans go where the money is." Staff members offered this caveat, though, "[Y]ou can put all you want in a contract, but you still need the resources to manage and monitor." When Texas next procures its CHIP and Medicaid managed care services, it will start implementing a value-based purchasing approach. At the time of the interviews, the MCOs were responding to the state's RFP, with the new contracts scheduled to begin in January 2005.

The EQRO makes a difference. In addition to the fact that ICHP does not face budgetary issues, the nonprofit group has provided the state with a unique opportunity to capitalize on its experience related to pediatric health services research. The skills and knowledge it possesses for conducting studies on preventive care services may not apply to other EQROs. ICHP requires the MCOs in Texas to adhere to a rigorous research methodology (perhaps *too* rigorous for a business setting, according to some MCO staff members) and currently offers general recommendations to the MCOs on how to improve services. Other EQROs may not have all these characteristics, perhaps making it difficult for other states to undertake a preventive care study similar to the one completed in Texas.

WASHINGTON CASE STUDY SUMMARY[14]

I. RECENT ACTIVITIES

The state of Washington has included EPSDT measurement and improvement activities in its EQRO contracts for at least eight years. The current contract with its EQRO—Oregon Medical Professional Review Organization (OMPRO)—requires a study of the "quantity and quality" of well-child care in 101 clinics targeted in a similar 2002 study. The primary purpose of the study is to assess the effectiveness of the Children's Preventive Healthcare Initiative (CPHI)—a three-year learning initiative begun in 2002 to help the state's Medicaid managed care program meet federal requirements for children's preventive care, including EPSDT and age-appropriate immunizations.

As part of its contract, OMPRO coordinates the CPHI in collaboration with the Washington Medical Assistance Administration (MAA) and five health plans. In 2002, OMPRO conducted a measurement study of well-child care visits, using samples of children from birth to 18 months, 3 to 6 years, and 12 to 20 years. After calculating rates of performance for services such as developmental screening, mental health screening, and anticipatory guidance, OMPRO provided clinic-specific performance feedback to the clinics by using the Achievable Benchmarks of Care (ABC)™ method. OMPRO also conducted focus groups of parents and providers to gain an understanding of the barriers to receiving well-child care.

Through the CPHI, clinics have participated in interactive Learning Labs since 2003 to figure out how to plan and implement individual, rapid-cycle, quality-improvement projects. The laboratories provide a forum wherein clinics can exchange success stories with one another and find help with implementation challenges. In 2004, 12 clinics participated in the Learning Labs. MAA hopes that, by the end of 2005, the CPHI will have helped participating clinics improve statewide well-child visit and immunization rates.

OMPRO is also required to provide performance feedback by using HEDIS two-year-old immunization data collected from the health plans.

II. PATHWAYS TO SELECTING QUALITY IMPROVEMENT INITIATIVES

For the most part, Washington's quality improvement initiatives have grown out of MAA's commitment to improving preventive health care for children. For example, since 1994, the agency's assessments of well-child care visit rates consistently indicated a need to improve rates, prompting additional quality improvement activities.

Topic selection for EQRO studies in Washington is based primarily on Medicaid population and health care trends and the state's experience with HEDIS measures. During the RFP process, MAA staff develops a list of projects consistent with the EQRO regulations and state priorities and provides the list to stakeholders, including senior managers within MAA, the Department of Health, and the MCOs. After much discussion and often several additions to the list, MAA and stakeholder staffers rank the projects; only the top projects receive funding.

III. IMPACT OF NEW FEDERAL REGULATIONS

The new federal EQRO regulations present both promises and challenges. Some of the promises include the requirement that the MCOs conduct projects to improve the quality of care and service provided to the Medicaid population. MAA staff views the improvement projects as offering the state an opportunity to require specific performance improvement activities, some of which may focus on preventive and developmental services. The regulations also allow EQROs to provide technical guidance to groups of MCOs to assist them in conducting quality improvement activities.

Nonetheless, the process of meeting required EQRO activities, validating performance measures and performance improvement projects, and monitoring health plans is time-consuming and cost-intensive. To date, the greatest impact of the regulations has been the realigning of resources to meet new requirements, which means redirecting resources from quality improvement to MCO monitoring. For example, before the new EQR regulations took effect, MAA required the MCOs to submit audited HEDIS performance measures performed by NCQA-accredited auditors. Washington must now fund and arrange for the audit itself per the regulations' requirement for an independent audit. The audit costs the state approximately $20,000 per health plan. Such changes, along with state budget cuts, have reduced Washington's ability to expand the CPHI program beyond 2004 unless external private funding is forthcoming.

IV. EFFECTS OF EQRO STUDIES

When the measurement studies noted above were completed, OMPRO provided health plans with feedback regarding their performance. In addition, the state responded to the studies by strengthening its managed care contract language related to EPSDT and immunization services. Health plans now are required to conduct a quality improvement project if the rates for either EPSDT or immunizations fall below 60 percent. The state also has implemented value-based purchasing. The value-based purchasing model includes measures covering both EPSDT and immunizations for two-year-olds. MAA has set aside $1 million to be paid for each of two analyses. Each calculation involves a point system

that rewards health plans for both their 2003 performance relative to other plans and their performance from 2002 to 2003 relative to other plans. Sums of the two rankings are completed and assigned a rate based on health plan performance.

The collaborative efforts around the CPHI project allowed for greater communication among stakeholders and for the identification of prevalent problems. For example, one of the clinics noted the growing number of parents who called in and said that they were confused about the reminder letters they received. The calls prompted a review of the letters for content and wording as well as translation of the letter into Spanish for the state's Hispanic population.

Other effects included a change in various types of documentation of encounters and services and timelier documentation of encounters. In addition, at least one clinic improved its tracking procedures to ensure that children re-enrolling in Medicaid were not mistakenly counted as new enrollees.

V. THE ROLE OF EQROS: LESSONS LEARNED

A strategic plan and stakeholder support are important. Perhaps the most basic and compelling advice provided by state staff called for developing a strategic plan for children's health care and including a broad group of stakeholders in plan development. The stakeholders should include senior staff members from the state (e.g., the Department of Health and the Medicaid agency), health plans, EQROs (or similar entities), clinician interest groups, and the legislature. The inclusion of such stakeholders establishes a strong base of support for the strategic plan and can help in obtaining needed financing for quality improvement activities and value-based purchasing. The CPHI is a unique initiative that brings together the Medicaid agency, the EQRO, the MCOs, local providers, and the American Academy of Pediatrics to improve the quality of care for children.

Quality improvement "champions" facilitate a focus on preventive and developmental services. Washington's success in the area of improving developmental services for children is attributable in part to the state's initial shift from measurement and data reporting to quality-focused studies. EQRO staff credited the shift to the MAA contract manager, who pushed for such quality-focused projects as the CPHI. State staff members mentioned "senior management's willingness to risk trying something new; to take a 'bite off the elephant' to improve health care." Key MAA staffers also demonstrated a long-term commitment and dedication to improving children's preventive and developmental services.

Available data may lead states to focus on preventive and developmental services. In several of our interviews, both state and EQRO staffs noted that the availability of data on child health services was critical in topic selection and prioritization. Many topics initially proposed for consideration for further study were rejected due to the lack of available data. Furthermore, state staff members reiterated the appropriate use of data, saying, "Never underestimate the importance of data; clinics don't always know who they are serving and as a result don't always know who is and is not receiving the standard of care. Helping clinics mine and use data [is] critical to successful quality improvement efforts, particularly if the larger goal is to spread and sustain change efforts."

NOTES

[1] When we began this project in August 2003, many individuals in state Medicaid agencies referred to the regulations as "new regulations" because they took effect in March 2003.

[2] 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.

[3] With its grant, Washington implemented interventions in three counties to improve the receipt of well-child care, developmental screening, and anticipatory guidance. One county instituted a health promotion function and trained parents to screen their children for developmental problems. The second county focused on outreach to parents and providers. The third county relied on an immunization nurse to promote the use of well-child forms in county clinics.

[4] This case study was prepared by Tara Krissik and Jim Verdier at Mathematica Policy Research, Inc. (MPR).

[5] Act No. 159, Public Acts of 2003, approved by the governor, August 10, 2003. See http://www.michiganlegislature.org/documents/2003-2004/publicact/pdf/2003-PA-0159.pdf.

[6] Molina implemented the project as part of its participation in the Center for Health Care Strategies Best Clinical and Administrative Practices (BCAP) workgroup, Enhancing Early Child Development Services in Medicaid Managed Care, which runs from 2003 to 2005. The pilot lasted from January to July 2003.

[7] This case study was prepared by Tara Krissik and Jim Verdier at MPR.

[8] Since the DMA budget funds staff at the State Center for Health Statistics (SCHS), DMA does not have to pay SCHS to develop the reports. SCHS was created as the North Carolina Bureau of Vital Statistics by the legislature in 1913 and evolved into SCHS by 1980. At that time, the governor directed SCHS to coordinate all health data activity in the state and to explore new ways of obtaining, analyzing, and disseminating health data. See http://www.schs.state.nc.us/SCHS.

[9] This case study was prepared by Tara Krissik and Jim Verdier at MPR.

[10] The CMP EQRO protocol related to focused studies of health care quality indicates that such studies can address nonclinical areas. "For example, focused studies that address continuity or coordination of care can study the manner in which care is provided when a patient receives care from multiple providers and across multiple episodes of care. Such studies may be disease or condition-specific or may target continuity and coordination across multiple conditions. Projects in other non-clinical areas can also address, over time, appeals, grievances, and complaints; or access to and availability of services."

[11] "Oregon EQRO: Draft Clinical Practice Summary," presented by OMPRO, July 30, 2003, Oregon Contract No. 105570.

[12] This case study was prepared by Tara Krissik and Henry Ireys at MPR.

[13] The MCO with which we spoke reported that 80 percent of its business involves children.

[14] This case study was prepared by Melissa Faux and Jim Verdier at MPR.

REFERENCES

Bethell, Christina D., et al., "Measuring the Quality of Preventive and Developmental Services for Young Children: National Estimates and Patterns of Clinicians' Performance," *Pediatrics* 113 (June 2004): 1973–83.

Center for Health Care Strategies, Inc., *Improving Preventive Care Services for Children: A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans* (Lawrenceville, N.J.: Center for Health Care Strategies, Inc., 2002).

Office of Inspector General, U.S. Department of Health and Human Services, *Lessons Learned from Medicaid's Use of External Quality Review Organizations* (OEI-01-98-00210, September 1998). See http://oig.hhs.gov/oei/reports/oei-01-98-00210.pdf.

Schor, Edward L., "Rethinking Well-Child Care," *Pediatrics* 114 (July 2004): 210–16.

Shenkman, Elizabeth, *Children's Preventive Care in the STAR Managed Care Organization Program and in the Children's Health Insurance Program in Texas* (Gainesville, Fla.: Institute for Child Health Policy, University of Florida, 2004).

Texas Health and Human Services Commission, *Medicaid Managed Care Quality Assessment and Improvement Strategy* (Austin, Texas: Texas Health and Human Services Commission, 2003).

Zuckerman, Barry, et al., "Prevalence and Correlates of High-Quality Basic Pediatric Preventive Care," *Pediatrics* 114 (December 2004): 1522–29.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

#822 *Quality of Preventive Health Care for Young Children: Strategies for Improvement* (May 2005). Neal Halfon, Moira Inkelas, Melinda Abrams, and Gregory Stevens. In analyzing data from the National Survey of Early Childhood Health, the authors say that only about half of parents of young children report ever discussing their child's development with a pediatrician.

#787 *Dialing for Help: State Telephone Hotlines as Vital Resources for Parents of Young Children* (November 2004). Meg Booth, Treeby Brown, and Malia Richmond-Crum, Association of Maternal and Child Health Programs. According to the authors of this issue brief, toll-free telephone hotlines operated by the states are increasingly being used by families to obtain reliable advice on their young children's health and well-being. Originally created for prenatal-care assistance alone, these lines now cover a wide range of early-childhood issues.

#785 *A Need for Faculty Development in Developmental and Behavioral Pediatrics* (November 2004). Edward L. Schor and Caren Elfenbein. The authors of this issue brief argue that identifying and managing issues of child development and behavior is a crucial part of primary care pediatrics, yet despite its importance, many pediatricians do not receive adequate training in developmental and behavioral pediatrics.

#778 *Early Child Development in Social Context: A Chartbook* (September 2004). Brett Brown, Michael Weitzman et al. This chartbook reviews more than 30 key indicators of development and health for children up to age 6, as well as social factors in families and communities that affect these outcomes. It also offers practical implications for practitioners and parents.

#757 *Rethinking Well Child Care* (July 2004). Edward L. Schor. *Pediatrics,* vol. 114, no. 1 (*In the Literature* summary). According to this article's author, the nation's system of preventive pediatric care requires major revisions if chronic health problems and unmet behavioral and developmental needs among American children are to be addressed.

#705 *Using Medicaid to Support Young Children's Healthy Mental Development* (Sept. 2003, revised Jan. 2004). Kay Johnson and Neva Kaye. This report examines both why and how Medicaid can support children's healthy mental development, including a discussion of how states can use Medicaid to better support young children's social/emotional development even in the current economic climate.

#706 *ABCD: Lessons from a Four-State Consortium* (December 2003). Helen Pelletier and Melinda Abrams. This report examines the work of Medicaid agencies in four states—North Carolina, Utah, Vermont, and Washington—that were selected to participate in the first phase of the Fund's Assuring Better Child Health and Development initiative.

#697 *A Practice-Based Intervention to Enhance Quality of Care in the First 3 Years of Life* (December 17, 2003). Cynthia S. Minkovitz et al. *Journal of the American Medical Association,* vol. 290, no. 23 (*In the Literature* summary). In this national evaluation of the Fund's Healthy Steps for Young Children Program, the authors report that physician practices with childhood developmental specialists on staff showed "significant improvements" in parental satisfaction with the services they

received; timelier preventive care such as immunizations; and receipt of more developmental services.

#689 *Developmental Specialists in Pediatric Practices: Perspectives of Clinicians and Staff* (November/December 2003). Cynthia S. Minkovitz et al. *Ambulatory Pediatrics,* vol. 3, no. 6 (*In the Literature* summary). As part of the Fund's Healthy Steps for Young Children initiative, 15 pediatric practices across the country incorporated early child development specialists into their teams; these "Healthy Steps Specialists" meet with families in offices and conduct home visits, address behavioral concerns, and make referrals. This article reports on a survey of clinicians and staff at the 15 practices and finds that the specialists have become well integrated into pediatric practice, are a trusted source of information, and are being consulted for a variety of developmental concerns.

#564 *Building a Bridge from Birth to School: Improving Developmental and Behavioral Health Services for Young Children* (May 2003). Neal Halfon, Michael Regalado, Kathryn Taaffe McLearn, Alice A. Kuo, and Kynna Wright. The authors review existing guidelines for developmental care of young children and assess the effectiveness of providing such care in primary care settings.

#481 *Using the Title V Maternal and Child Health Services Block Grant to Support Child Development Services* (January 2002). Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, George Washington University. This report, the fourth in a series of analyses exploring federal and state health policy in the area of early childhood development, notes that states have the policy flexibility to use Title V funds to improve the provision of preventive health services to low-income children under age 3 who are eligible for Medicaid or CHIP (as well as those who are not). The report presents four approaches state Title V agencies can take to coordinate with their state Medicaid and CHIP programs.

#480 *Child Development Programs in Community Health Centers* (January 2002). Sara Rosenbaum, Michelle Proser, Peter Shin, Sara E. Wilensky, and Colleen Sonosky, George Washington University. This report, the third in a series of analyses exploring federal and state health policy in the area of early childhood development, argues that states can potentially increase reimbursements to CHCs under a change enacted in the Benefits Improvement and Protection Act (BIPA) of 2000. CHCs served 4.5 million low-income children in 1998, including 1.3 million under age 6.

#451 *Room to Grow: The Role of Medicaid and CHIP in Aiding Child Development Through Preventive Health Services* (July 2001). Sara Rosenbaum, Michelle Proser, Andy Schneider, and Colleen Sonosky, George Washington University. This report, the second in a series of analyses exploring federal and state health policy in the area of early childhood development, examines how public insurance programs covering low-income children—namely, Medicaid and the State Children's Health Insurance Program (CHIP)—can be used to support and foster optimal child development interventions.

#450 *Health Policy and Early Child Development: An Overview* (July 2001). Sara Rosenbaum, Michelle Proser, and Colleen Sonosky, George Washington University. This report is the first in a series of analyses exploring federal and state health policy in the area of early childhood development. It provides an overview of the evolution of federal health policy related to the financing and provision of preventive health services for young children.