Overview of the Medicaid External Quality Review Process

The Balanced Budget Act of 1997 (BBA) established a quality monitoring system for Medicaid managed care and required the creation of Protocols to advise External Quality Review Organizations (EQROs) in conducting external quality reviews. This process is codified at Section 1932(c) of the Social Security Act and 42 C.F.R. Part 438, subpart E.

Important Definitions:

An External quality review organization (EQRO) is an organization that meets the competence and independence requirements set forth in 42 C.F.R. §438.354, and performs external quality review, other EQR-related activities as set forth in 42 C.F.R. §438.358, or both.

External quality review (EQR) means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors furnish to Medicaid recipients.

Validation means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

Applicability:

The EQR process applies to all Children's Health Insurance Program (CHIP) or Medicaid programs that contract with Managed Care Organizations (MCOs) and/or Prepaid Inpatient Health Plans (PIHPs).

Qualifications of EQROs:

States must contract with EQROs that have, at a minimum, the following:

- Staff with demonstrated experience and knowledge of Medicaid recipients, policies, data systems, and processes; managed care delivery systems, organizations, and financing; quality assessment and improvement methods; and research design and methodology, including statistical analysis;
- Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities; and
- Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.
- The EQRO and its subcontractors must be independent from the State Medicaid agency and from the MCOs or PIHPs that they review. An "independent" entity is one that is free of organizational or financial control over the State Medicaid agency and the MCOs/PIHPs it reviews.

Funding:

Federal matching funds are available at 75 percent for EQR (including the production of EQR results) and EQR-related activities that are conducted by EQROs and their subcontractors. Federal matching funds are available at 50 percent for EQR-related activities conducted by any entity that does not qualify as an EQRO. CMS Regional Offices are responsible for EQR contract review to ensure all activities contracted for are approved EQR activities.

State Responsibilities:

Each State contract for EQR must include three mandatory activities and may address five optional activities, all of which are described in the CMS EQR Protocols. The EQR Protocols are available on the following webpage: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Mandatory EQR Activities
1) Validation of Performance Improvement Projects (PIPs)
2) Validation of Performance Measures
3) Review, within the previous three-year period, to determine MCO/PIHP compliance with State standards for access to care, structure and operations, and quality measurement and improvement

Optional EQR Activities
1) Validation of encounter data reported by an MCO or PIHP
2) Administration or validation of consumer or provider surveys of quality of care
3) Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO
4) Conduct of PIPs in addition to those conducted by an MCO or PIHP and validated by an EQRO
5) Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time

EQR Results:

In accordance with 42 C.F.R. §438.364, the EQRO must produce for the State the following five deliverables:

- A detailed technical report describing the data aggregation and analysis and the way in which conclusions were drawn as to the timeliness, quality, and access to the care furnished;
- An assessment of each MCO/PIHP's strengths and weaknesses with respect to quality, timeliness, and access to care;
- Methodologically appropriate, comparative information about all plans;
- Recommendations for improving the quality of health care services furnished by the MCO/PIHPs;
- An assessment of the degree to which each plan has addressed effectively the quality improvement recommendation made by an EQRO during the prior year's review.

States must annually submit the detailed technical reports to CMS for follow-up and evaluation.

Contacts:

Melanie Johnson, Division of Quality, Evaluations, & Health Outcomes, Melanie.Johnson@cms.hhs.gov
TJ Shumard, Division of Quality, Evaluations, & Health Outcomes, Thomas.Shumard@cms.hhs.gov
Kristin Younger, Division of Quality, Evaluations, & Health Outcomes, Kristin.Younger@cms.hhs.gov

*Please visit the following site for updates to this summary:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

Last Updated: June 06, 2012