

Summary of External Quality Review Organization Solicitation

The MRMIB is releasing a Solicitation to secure an External Quality Review Organization (EQRO) to perform services required under CHIPRA. CHIPRA requires that contracts between CHIP agencies and managed care plans include mandatory annual external reviews of the quality of care provided by the plans. The EQRO will fulfill this statutory requirement and provide for annual external reviews of the timeliness of, access to, and quality outcomes of services provided by HFP plans. The EQRO's annual quality reviews will include the following activities:

Validation of Performance Measures

The EQRO will validate performance measures as directed by MRMIB to ensure that health plans have the capacity to gather and report data accurately. The EQRO will also assess the plans' information systems capabilities to determine the strength of the plans' system abilities to produce valid performance measures as well as encounter data and other data to support quality assessment and improvement.

Validation of Quality Improvement Projects (QIPs)

The process of validating QIPs involves identifying a target area for improvement (clinical or non-clinical), implementing interventions for improvement and analyzing the results. QIPs are typically done in three phases. In phase one, plans target an area they want to improve upon and collect data to establish a starting point from which to measure improvement. Phase two, plans identify and implement specific actions to correct problems they have identified. Phase three, plans re-measure their performance after they have put their improvement efforts into place and evaluate if they were successful. The benefits of QIPs are that they keep plans focused on improving performance and member satisfaction is improved. MRMIB intends for each plan to undertake two QIPs, Statewide QIP in which all plans will participate and another QIP chosen by each individual plan.

Compliance Review

This requirement determines how well MRMIB and HFP and plans comply with federal quality standards for managed care organizations. To ensure access to services, plans are required to maintain a comprehensive network of providers and also identify and coordinate efforts to meet subscribers' needs. Health plans must establish and maintain provider networks that have the capacity to provide timely and quality services to members. Care management teams must authorize, provide, arrange, and coordinate all services in the benefit package in a timely manner.

Validation of Encounter Data

Encounter data can be used to assess and improve quality, as well as monitor program integrity. However, in order for encounter data to effectively serve these purposes, it must be valid (i.e., complete and accurate). At present, completeness and accuracy of encounter data vary across States, and plans. This protocol specifies processes for assessing the completeness and accuracy of encounter data submitted by health plans

to the State. It also can assist in the improvement of the processes associated with the collection and submission of encounter data.

Conduct Consumer Satisfaction Surveys

The purpose of the subscriber surveys is to probe those aspects of care for which members are the best and/or the only source of information. MRMIB plans to use CAHPS, D-CAHPS and YAHCS subscriber surveys to determine members' ratings of and experiences with the medical and dental care they receive. Potential opportunities for improvement can be identified by examining members' health care experiences. Specifically, the results obtained from the surveys will allow MRMIB to determine how well health plans are meeting their members' expectations, provide feedback to the health plans to improve quality of care, encourage health plan accountability, and develop health plan action to improve members' experience of care.

Provide technical assistance regarding requirements for external quality reviews

This is intended to provide MRMIB and HFP health plans with a clear description of the scope and depth of quality review activities that are consistent with the current state of the art. The Centers for Medicare and Medicaid Services (CMS) have developed sample worksheets that can be used or modified at MRMIB's discretion. CMS' goal is to promote more standardization of common quality review practices across States.

Develop a Health Plan Report Card

Report card information can be used to provide valuable performance and quality information for subscribers who are considering selecting or changing their health plan. The Health Plan Report Card will be used to focus on information that consumers want when choosing a plan and present this information in an easy to understand format.

Coordinate an Annual Quality Improvement Conference

The EQRO will coordinate an annual quality improvement conference with the health plans.

Conduct Focused Quality Studies as requested by MRMIB

MRMIB may want to have a study conducted on a one-time basis for quality improvement purposes.

Special Consultative Services

The EQRO may be requested to provide special consultative services by a physician, nurse, biostatistician, health education consultant or communication and outreach consultant.