SECTION 1915(b)

WAIVER PROGRAM

INDEPENDENT ASSESSMENTS: GUIDANCE TO STATES

US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Center for Medicaid and State Operations

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APPENDIX A

SECTION 1915(b) WAIVER PROGRAM INDEPENDENT ASSESSMENTS: GUIDANCE TO STATES

The Social Security Act (the Act) authorizes the Secretary of the Department of Health and Human Services to waive requirements of Section 1902 of the Act to administer specific freedom of choice waiver programs to implement Medicaid managed care to the extent he or she finds it to be cost effective and efficient and not inconsistent with the purposes of Title XIX (emphasis added). In order for the Secretary to determine that this requirement has been met by States with Section 1915 (b) waivers, the States must comply with the specific requirements contained in 42 CFR 431.55(b)(2) which are as follows:

In applying for a waiver to implement an approvable project under paragraph (c), (d), (e), or (f) of this section, a Medicaid agency must document in the waiver request and maintain data regarding:

(i) The cost-effectiveness of the project;

(ii) The effect of the project on the accessibility and quality of services;

(iii) The anticipated impact of the project on the State's Medicaid program.

Further, pursuant to Section 2111(B) of the State Medicaid Manual States must arrange for an independent evaluation or assessment of their waiver program and submit the findings when renewing their waiver programs. At a minimum, the Independent Assessment (IA) is a requirement of the first two waiver periods. The 1915(b) Streamlined Waiver Application further specifies that the IA should be submitted with the waiver renewal request ninety (90) days before the expiration of the approved waiver program.

This document provides guidance to States on the IA including the following components:

I. CRITERIA FOR ENTITIES CONDUCTING INDEPENDENT ASSESSMENTS. This section discusses the following:

A) What is meant by "independent".

B) What expertise is necessary to conduct an IA.

C) What the IA agreement should contain

D) How to develop a reliable and valid methodology.

E) What should be included in the final report.

II. THE CONTENT OF THE INDEPENDENT ASSESSMENT. This section outlines issues related to access to services under the waiver, quality of waiver services, the cost effectiveness of the waiver and any other specific requirements made by HCFA in its approval of the waiver request.

A) **Beneficiary Access to Services Under the Waiver:** A waiver program under 1915(b) may not substantially impair a beneficiary's access to services as compared to accessibility of services prior to or without the waiver. The IA should evaluate or measure the availability of services under the waiver and compare it to the level of waiver services that existed prior to the waiver. Examples of measurements that could be made to demonstrate access are: ratio of primary care providers, specialists, hospitals, and pharmacies to beneficiaries; average distance and travel time to see a doctor; and waiting time for an appointment.

B) **Quality of Waiver Services:** The quality of services under a 1915(b) waiver program may not be less than the quality of services prior to or without the waiver. The IA should evaluate the impact of the quality of services provided to beneficiaries under the waiver and define measures to improve and ensure quality of care. Examples of tools that could be used to measure quality of care include the quality improvement system for managed care (QISMC), beneficiary surveys such as CAHPS, provider surveys, State quality improvement (QI) strategies, and encounter data.

C) **Cost Effectiveness of the Waiver:** The total costs of the waiver, including program benefits and administrative costs, must not be greater than the cost of providing like services without a waiver. The IA should compare the cost of the waiver program to the estimated cost of the same

services to an actuarially equivalent population without the waiver.

III. RELATED QUALITY IMPROVEMENT STRATEGIES, ACTIVITIES, AND REFERENCES. This section provides the following:

A) A brief description of related QI activities.

B) A reference section on documents that highlight quality improvement and quality assurance (QA) efforts.

I.CRITERIA FOR ENTITIES CONDUCTING INDEPENDENT ASSESSMENTS

A) CHOOSING AN APPROPRIATE INDEPENDENT ASSESSMENT ENTITY

- Independent Assessment entities must be external to and independent of the State Medicaid agency and must not have a direct or indirect relationship (e.g. financial) with any program managed care entities (MCEs).

Some examples of entities that may qualify to conduct an IA are:

- State universities;

- Research organizations;

- Independent State audit agencies;

- Health care consulting or management consulting organizations (i.e., Big 5 management consulting groups or small, specialized Medicaid managed care consulting firms); and

- External quality review organizations (EQROs).*

Some examples of entities that may not conduct an IA (or portions thereof) are:

- Actuaries contracted by the State to develop rates and do financial analyses; and

- Organizations, including State agencies, State universities and enrollment brokers, which provide services (whether administrative or medical) to enrollees in the managed care program being assessed.

B)DEFINING THE NECESSARY EXPERTISE

- Independent Assessment entities should have staff who have an understanding of:**

1. Health services research methodologies including:

- the principles of scientific research and statistical analysis;

- the epidemiologic and statistical measurement of health status indicators in defined populations;

- methodologies of data collection;

- the principles of data interpretation, including the social and economic factors that affect the interpretation of data (e.g. case load and cost estimates); and

- survey and focus group design and analysis.

2. Clinical study methodology, including experience and education in:

- assessing medical and health care services through QA technology;

- developing, evaluating, and implementing corrective action plans and quality improvement activities; and

- reviewing MCO and primary care case management (PCCM) programs (to the extent possible).

3. Financial management practices including:

- generally accepted accounting principles;

- budgeting and forecasting principles; and

- financial auditing principles.

4. Information systems and claims management.

5. The Medicaid population and Medicaid managed care.

C) INDEPENDENT ASSESSMENT AGREEMENT

- The agreement between the State and the organization performing the IA should include all necessary interagency agreements or contract provisions as required in regulation and in the State Medicaid Manual.

- The State should clearly define the scope of the IA in the following areas:

  - selection of review topics;

  - study design features;

  - analysis and interpretation of study findings; and

  - structure of follow-up work plans.

- The State should define the duration of the IA Contract.

- The State should clearly specify the data (paid claims, eligibility) available, including format, media, file layout, time span, and whether and to what extent the State will clean up and/or manipulate data prior to sending it to the contractor.

- The State should clearly outline the confidentiality and disclosure requirements of beneficiary and plan specific information for non-peer review organization (PRO) entities. PRO contracts should cite Section 1160 of the Act.

D)DEVELOPING A METHODOLOGY

- The quality, access and cost effectiveness topics should focus on the State level Medicaid managed care program. Analysis should include State and contractor functions such as EQR, enrollment broker, actuary, MCO and PCCM.

- The Independent Assessor should begin its review by analyzing existing documents, including federal waiver approval letters and reviews, EQRO reports, waiver request/renewal applications, complaint and grievance logs, any other quality/access reports produced by the State and by meeting with key stakeholders. The Independent Assessor should review resolution and QI activities undertaken by the State and MCE to ensure completion and compliance. The Independent Assessor should also recommend follow-up activities on previously identified issues and other problems identified through this discovery process.

- The Independent Assessor should utilize a comprehensive programmatic research design that can describe and evaluate the care delivered to Medicaid beneficiaries through the State's managed care program.

- In order to ensure an effective focused study, the State and Independent Assessor should work together to:

  - refine the study question to limit the aspects of care reviewed (also called framing the question);

  - define a point of comparison, e.g. pre-waiver experience or experience of actuarially equivalent population;

  - determine the methodology the Independent Assessor will use;

  - define the quality indicators to be assessed;

  - review conditions with highest prevalence or incidence, or those which have the potential to benefit certain subgroups of the eligible population (e.g. special needs populations);

  - develop objective criteria for assessing care;

  - define the potential for improving health status;

  - study service delivery in multiple settings;

  - ensure statistically valid sampling techniques; and

  - not duplicate EQRO efforts.

- The State should provide input to the Independent Assessor regarding the analysis of the data.

E) WRITING THE FINAL REPORT

- The IA should include a written report that:

  - concludes whether access, quality, and cost effectiveness are better than, equal to, or worse than prior to the waiver;

  - identifies the positive aspects of the State's process for monitoring the program and suggests/recommends processes in State monitoring that can be improved;

- highlights unresolved issues;

- identifies instances in which care can be improved;

- provides a baseline for future assessment;

- offers recommendations for concrete actions that can be undertaken by the State to improve the health care received through MCOs and PCCM programs; and

- provides a summary of the findings of the EQRO and the State's quality strategy.

II. CONTENT OF THE INDEPENDENT ASSESSMENT

The IA document is intended to confirm and supplement programmatic information provided by the State. The content of the IA should not duplicate the State's efforts to assess the program as part of the waiver program renewal process; the scope of the IA review should emphasize the State's efforts and ability to monitor the program. Ultimately, the State should utilize the Independent Assessor's results and recommendations as a tool to improve the program.

NOTE: To avoid duplication of effort, for any of the following components that are included in the State EQR or State quality strategy analysis, we suggest using that information where applicable as it relates to the 1915(b) waiver program for the waiver period being evaluated.

The following sections regarding access, quality, and cost effectiveness provide suggestions on tools and methodologies to be used in gathering programmatic data as well as the elements to be included in the content of the IA report. Some of the items are more useful when combined with other information; for example, qualitative measures of access (e.g surveys) are more useful when presented with quantitative measures of access (e.g. comparisons of provider availability pre and post waiver implementation).

Tools for Monitoring Access and Quality

The following resources can be used by Independent Assessors to gather information on access and quality in Medicaid managed care programs:

- HEDIS - Current Version.
- QISMC.
- Federal and State statutory and regulatory guidelines.
- EQRO reports.

- Beneficiary, provider, and subcontractor surveys (separate from those utilized by the State). We suggest that the Independent Assessor use the CAHPS Survey.

- Interviews or focus groups with beneficiaries, beneficiary representatives/care givers, providers, subcontractors, and advocacy groups.

- Claims, utilization, referral and encounter data.

- Information sent/given to beneficiaries and displayed in provider and intake offices.

- Enrollment procedures.

- MCO and State complaint, grievance, and fair hearing appeal logs, reports, and summaries.

- Provider requirements/credentialing requirements.

- Disenrollment statistics and reasons.

- State access monitoring reports and studies including provider geographical mapping documents.

- Medical records.

- State monitoring of quality.

- State administrative documents, such as State contracts; requests for proposals (RFP) for services, for enrollment brokers, with EQROs; waiver requests; and HCFA waiver approval letters.

- Qualitative data collected as a result of site visits with State officials.

- State quality of care reports, performance measures (e.g. HEDIS reports), and review of QA/QI plans.

Elements of the Independent Assessment Report

A) ACCESS TO CARE

The following elements are important to the assessment of access to care in Medicaid managed care programs (see Related Quality Improvement Strategies, Activities, and References). HCFA recommends that States work with the Independent Assessor to

include as many of these suggested elements as are practical and appropriate. The list is not all-inclusive; the State or the Independent Assessor may identify other areas of importance. If all elements are not addressed, States should ensure that the IA includes several elements because a single element may not give a true measure of access.

Evaluation of the State program's access monitoring and analysis:

- Analysis of State RFPs and/or contract provisions which incorporate access standards and protocols.

- State efforts to ensure all covered benefits are available and accessible.

Enrollment information:

- Adequacy of MCE provider directories:

- how current, clarity of the provider directory, when and how often sent out, includes pertinent information such as pharmacies, hospitals, specialists, etc.

- Effectiveness of development and distribution of marketing materials:

- ensure clarity, appropriate comprehension level, language and cultural appropriateness, and availability of information to enrollees with disabilities.

- Methods by which State ensures that marketing plans and materials are accurate and do not mislead, confuse, or defraud beneficiaries.

- Analysis of enrollment procedures:

- who is actually enrolling beneficiaries and helping them choose providers?
- what is the average time between enrollment and ability to get care?

- Report of autoassignment rates at the outset of program versus at time of evaluation, if applicable.

- Disenrollment information:

- rates of disenrollment, both voluntary and non/voluntary, provider/MCO specific information.
- State tracking and monitoring of disenrollments; reasons, effective time, process to transition back to previous type of care.

- Evidence of efforts in place to preserve current beneficiary/provider relationships.

- State standards and efforts to monitor/improve enrollment procedures.

Education and customer service information:

- Overview of State and provider outreach plan, measured effectiveness.

- Beneficiary, provider, subcontractor awareness/comprehension of program and of managed care system.

- Availability of adequate beneficiary hotline.

- Availability of adequate provider hotline.

- Effective education of Social Service Agencies, Social Security Offices, and any other agencies that have frequent contact with beneficiaries.

- Evaluation of effectiveness of enrollment broker agency, if applicable.

- State monitoring of education and customer service activities.

Provider Capacity:

- Account for duplication of providers across MCO networks or systems.

- Information on provider networks, including specialists, providers not accepting new enrollees, types of interpretive services available to non-English speaking beneficiaries, interpretive services available to hearing disabled beneficiaries.

- Levels of provider participation/caseload according to discipline, by MCO.

- Availability of providers during convenient hours of operation to enrollees.

- Beneficiary perception of access to providers for preventive and specialty care.

- State efforts to track/improve provider:beneficiary ratios and overall provider capacity.

- Availability of providers experienced in specific disease management, such as HIV/AIDS.

Urgent/Emergent care:

- Availability of care 24 hours per day.

- Increase or decreased emergency room utilization rates (over time of program).

- Assurances and standards in place for access to and timely authorization of urgent and emergent care.

- Assure compliance with Section 1932(b)(2) of the Act -- "prudent layperson" definition**.**

- State efforts to monitor/improve access to urgent/emergent care.

Travel and waiting times for primary care and specialty care (suggested at the beginning of the program -- under FFS-- and at period of evaluation):

- Average time to schedule an appointment.

- Availability of medical help over the phone.

- Availability of health care professional to obtain urgent or routine care.

- Average time in waiting area in office.

- State standards and efforts to monitor/improve above times.

- Availability of transportation services to medical appointments.

Referrals

- Availability of primary care doctor to see assigned enrollees.

- Ease/ability of enrollees to get necessary referrals:

- referrals to various providers such as: dentists, mental health providers, language interpretation services, obstetrical and prenatal care providers.

- Analysis of general referral procedures.

- State efforts to track referrals and address problematic areas.

- Review of process for feedback to providers.

B) QUALITY OF CARE

The following elements are important to the assessment of quality of care in Medicaid managed care programs (see Related Quality Improvement Strategies, Activities, and References). HCFA recommends that States work with the Independent Assessor to include as many of these suggested elements as are practical and appropriate. The list is not all-inclusive; the State or the Independent Assessor may identify other areas of importance. If all elements are not addressed, States should ensure that the IA includes several elements because a single element may not give a true measure of quality.

Evaluation of the State program's quality monitoring elements and analysis and review of EQRO reports:

- Standards and procedures for assessing quality and appropriateness of care and services furnished to all beneficiaries under the program.

- Appropriate application of intermediate sanctions.

- State's management of EQRO contract, including scope of contract compared to final EQRO product.

- Soundness of research methodology used by EQRO -- analysis and review of EQRO report.

- An information system that is sufficient to support initial and ongoing operation and review of the quality strategy.

Clinical review of utilization patterns (suggested at the beginning of the program -- under FFS-- and at period of evaluation):

- Analysis of preventive services for children and adolescents (e.g., vaccine-specific and combined immunization rates for 2-year-olds, well-child visits in the first year of life, adolescent well-care visits, substance counseling for adolescents).

- Analysis of preventive services for adult women (e.g., cervical cancer screening, mammography screening).

- Analysis of prenatal care (e.g., low birthweight, prenatal care utilization).

- Analysis of acute and chronic care (e.g., asthma inpatient admission rate, diabetic retinal exam).

- Analysis of mental health care (e.g., ambulatory follow-up after hospitalization for specified mental health disorders).

- Analysis of utilization data by service category for change in patterns from FFS to managed care and to include patterns of over/under utilization.

- Analysis of changes in prescription drug use.

- Impact of appropriate or inappropriate use of primary services or emergency services.

- Analysis of utilization patterns for select group of beneficiaries.

- State efforts to monitor and improve utilization patterns.

Grievances and appeals:

- Analyze the effectiveness of grievance and appeal process.

- Beneficiary, provider, and subcontractor understanding/knowledge of grievance processes.

- State efforts to monitor grievance patterns for MCEs and providers.

Beneficiary, provider and subcontractor satisfaction. We suggest that the Independent Assessor use the CAHPS Survey for beneficiary experience:

- Member rating/satisfaction with primary care doctor, nurse, specialist and MCE.

- Member satisfaction with the courtesy and respect of providers.

- General satisfaction of beneficiaries, advocacy groups, and provider groups with health care received.

- Involvement of beneficiaries and providers in QA activities.

- State efforts to monitor and follow-up on requests to change providers.

- Analysis of turnover in provider network (primary care providers, mental health providers, OB/GYN, dentists, etc.).

- Assessment of provider compensation arrangements on provision of satisfactory care.

- State efforts to gather information regarding beneficiary/provider satisfaction with the program.

State quality improvement measures:

- State/MCE incorporation of State quality improvement strategy/MCE Quality Assurance and Performance Improvement (QAPI) plan.

- Provider/MCE adherence to clinical practice guidelines and State monitoring of adherence.

- Evaluation of increase/decrease in quality of life, for example, gainful employment, loss of Medicaid eligibility, Global Assessment of Functioning (GAF) scale, etc.

- State efforts to evaluate and improve beneficiary quality of life.

- Review of focused clinical studies.

- State efforts to encourage/assist providers to utilize measures such as encounter data.

- Level and timeliness of feedback to providers.

- Analysis of QI systems, collection and analysis of encounter data, monitoring of quality through standard reports, use of data analysis for State QI activities.

C) COST EFFECTIVENESS

This section provides guidelines on the cost-effectiveness analysis that Independent Assessors may conduct to evaluate this component of the State's Medicaid managed care program. HCFA recommends that States consider the core approaches listed below as basic procedures and processes that should be used by Independent Assessors regardless of the program being evaluated. Additional approaches that could strengthen the cost effectiveness evaluation are also described below.

Core Cost Effectiveness Approaches

- Calculate the cost-effectiveness of the managed care program for the previous time period of the program. If this is the first IA for the waiver, the Independent Assessor should analyze the first full year of data. If this is the second IA of the waiver, the Independent Assessor should analyze the first three years of data (even though some of this data is from a different waiver period) to the extent that the data is available. Future IAs should analyze at least two years of data. The cost-effectiveness should be analyzed and risk-adjusted by age and sex to the extent available and appropriate (this applies to MCO, PHP, and PCCM waivers). If comparable populations are utilized, then a description of the population including a description of the similarities and dissimilarities of such factors such

as health status, age, and sex should be included. The calculation should include the 4-steps methodology outline in Appendix A.

- Review of the State's upper payment limit (UPL) calculation, ratesetting, and cost-effectiveness monitoring processes including:

  - Validation of the UPL's assumptions;

  - Validation of the UPL's methodology;

  - Validation of ratesetting methodology;

  - Validation of the inflation rate used by the State as well as a comparison of the inflation rate used to the actual experience of the State for the same or a similar set of services for a comparable population for the same period of time; and

  - Validation and evaluation of the State program's cost-effectiveness monitoring and analyses examining frequency, effectiveness, accuracy, and similarity of comparable populations (e.g. on factors such as health status, age, and sex) used in the State's cost-effectiveness calculations. If the State does not monitor cost-effectiveness for program management purposes, this omission should be noted.

- Analysis of the source of the cost savings in the program including:

  - Has utilization changed (i.e., are there fewer inpatient hospitalizations and more outpatient services)?

  - Is there evidence of a decrease in recipients or services being provided?

Additional Cost Effectiveness Approaches

- Analysis of possible cost-shifting from capitated service utilization to fee-for-service utilization (or PCCM services to fee-for-service utilization), including:

  - Analysis of side-by-side PCCM and MCO programs to determine if biased selection is occurring and high-cost beneficiaries are disproportionately selecting PCCM programs.

- Analysis of carve-out programs to determine if easily substitutable fee-for-service costs are being utilized to reduce Prepaid Health Plan (PHP) costs. For example, in mental health and substance abuse carve-out models, are pharmaceuticals being used to reduce the number of inpatient admissions? Another example would be if the PHP is shifting children with severe emotional disturbances into foster care or rehabilitation programs and reducing the costs of the PHP.

- Analysis of risk-comprehensive MCO or PCCM programs to determine the effects of cost-shifting to any fee-for-service services. For example, if pharmacy or mental health services are not included in the MCO or PCCM model, has there been a dramatic increase in the amount of mental health treatments or pharmaceuticals prescribed for the MCO or PCCM enrollees.

- Assess whether HCFA and the State are paying MCOs/PHPs and PCCM providers appropriately for services. The Independent Assessor in this analysis would be calculating the overall amount paid to MCOs/PHPs or PCCM providers by the State and comparing it against the contractor's costs for administration, profit and service delivery. For example, how do the State's incurred costs (the outlay of managed care dollars) to the MCOs relate to the actual costs incurred by the MCOs for providing services to the Medicaid enrollees? If on average, the State agency is paying an MCO $100 per member per month, but the MCO is only expending $75 per member per month, the Independent Assessor should note this in its report.

- Perform an analysis of the State's capitation payment system in paying capitation to MCOs. For example, does the State have adequate controls in place to assure that the dollars paid to MCOs are accurate and do not reflect FFS payments?

III. RELATED QUALITY IMPROVEMENT STRATEGIES, ACTIVITIES, AND REFERENCES

A) STRATEGIES AND ACTIVITIES

The IA requirement is distinct from other quality oversight activities; some of which result from the Balanced Budget Act of 1997 (BBA), some reflect HCFA policy issued through State Medicaid Directors letters, and some are products of HCFA contracts with outside entities. It is important to note several fundamental differences between the IA and the activities required under BBA. First, as noted throughout the document, the IA covers three broad areas of overall program impact including access to care, quality of

care, and program cost-effectiveness. The BBA provisions only focus on issues related to beneficiary access to and quality of care. Second, the IA is required for the initial two waiver periods and is seldom required beyond that time, whereas the BBA requirements are ongoing. Third, the IA is a State Medicaid program-level review, whereas many of the BBA requirements are MCE focused. For instance, EQRs generally assess MCOs, while the IA analyzes the State's overall program. State IA should be consistent with the State's quality strategy as dictated by the BBA.

The following sections describe five quality assurance and quality improvement strategies/activities currently underway that relate to the IA requirement.

BBA Regulation: Quality Assessment and Improvement Strategy

Section 4705 of the BBA requires States that contract for Medicaid managed care under Section 1903(m) of the Social Security Act (the Act) to develop and implement quality assessment and improvement strategies. At a minimum, these strategies must include access standards, measures that examine other aspects of care and services directly related to improving the quality of care (e.g., grievance procedures and marketing standards), procedures for monitoring and evaluating the quality and appropriateness of care and services that Medicaid enrollees receive, and requirements for the provision of data sets (e.g., HEDIS). A workgroup is currently developing a regulation that will implement this provision of the law.

Quality Improvement System for Managed Care (QISMC)

QISMC is a HCFA initiative to protect and improve the health and satisfaction of Medicare and Medicaid managed care enrollees. The first product of this initiative - health care quality improvement standards and guidelines for Medicare and Medicaid contracting MCOs - provides a model for HCFA and States to establish requirements pertaining to quality measurement and improvement and the delivery of health care and enrollee services. The QISMC quality standards direct MCOs to:

- Operate an internal program of quality assessment and performance improvement (QAPI) that achieves demonstrable improvements in enrollee health, functional status, and satisfaction across a broad spectrum of care and services.

- Collect and report data reflecting its performance on standardized measures of health care quality, and meet such performance levels on these measures as may be established under its contract with HCFA or the State.

- Demonstrate compliance with basic requirements for administrative structures and operations that promote quality of care and beneficiary protection.

The standards address only those areas of MCO operation and performance that are closely related to QI or to the delivery of health care and enrollee services. Separate regulations, standards and guidelines exist for other areas of organization operation, such

as marketing and enrollment and claims processing, that HCFA and States must also consider in evaluating organizations. Separate mechanisms also exist for external appeals, monitoring and enforcement. These mechanisms are part of HCFA's and the State's oversight protocols, not the QISMC standards.

The QISMC standards and guidelines update HCFA's 1993 Health Care Quality Improvement System for Medicaid Managed Care (QARI) guidelines for internal QA programs of Health Maintenance Organizations, Health Insuring Organizations and PHPs contracting with State Medicaid agencies. Other components of QARI (a framework for health care quality improvement systems of State managed care programs, and guidelines for external quality review) will also be updated as HCFA promulgates BBA regulations and additional guidance relating to State quality assessment and improvement strategies and EQR.

External Quality Review (EQR)

Currently, States contracting with Medicaid MCOs under section 1903 (m) of the Act must arrange for an annual independent, external review of the quality of services delivered by each MCO. Section 1902(a)(30)(c) of the Act gives States latitude in defining the scope of the reviews. The entities that conduct these reviews are not to be part of the State government, a MCO, or an association of MCOs. The entities can be PROs, private accreditation organizations approved by HCFA, or PRO-like entities approved by HCFA.

Section 4705 (a) of the BBA (Section 1932 (c)(2) to the Social Security Act) establishes State requirements for the EQR. This provision requires States to provide for EQR of quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract. This provision also requires the Secretary of the Department of Health and Human Services, in consultation with States, to establish a method for identifying entities that are qualified to perform EQR and to contract with an independent quality review organization to develop protocols to be used in the independent reviews. A HCFA workgroup is currently developing a regulation that will implement this provision of the law.

Focused Clinical Studies

HCFA has encouraged States to conduct focused clinical studies through Section 1115 research and demonstration waivers, and Section 1915(b) program waiver requirements. In addition QISMC's QAPI domain standards specify certain focused areas that must be addressed over time by MCOs (e.g., preventive services, care of beneficiaries with chronic conditions). Within these broad areas, MCOs can select particular topics for measurement and improvement.

Performance Measurement

The Government Performance and Results Act (GPRA) is the primary legislative framework through which government agencies are required to set strategic goals, measure performance, and report on the degree to which the goals are met. HCFA's GPRA goal on childhood immunization will track the rate of two-year old children enrolled in Medicaid who are fully immunized.

In addition, under a HCFA contract, MEDSTAT has undertaken the Key Operational Indicators Project to develop a set of performance measures reflecting key aspects of Medicaid managed care program operations. The project is intended to accomplish the following: (1) provide States with benchmarks for performance comparisons across programs and with other States; (2) provide HCFA Regional Offices with a standardized, systematic way of gathering information on operational performance measures collected by the States; and (3) provide HCFA Central Office with a mechanism for tracking operational performance trends across States and to formulate technical assistance strategies.

In December 1997, MEDSTAT developed a draft of an open-ended data collection tool. This survey tool was piloted in the first quarter of 1998 in four States. The tool has been modified and was administered to an additional 10 States in July. The information received from all 14 States was presented through a Picturetel on October 30, 1998 to the regions that had State participation. The actual tools that were completed by each State will have been sent to each of the corresponding regions by the end of November. A report on the findings is being consolidated and is due in January 1999. After reviewing the report a decision will be made on the projects next steps.

B) REFERENCES

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U.S. DHHS/HCFA and National Committee on Quality Assurance (NCQA), Health Care Quality Improvement Studies in Managed Care Settings: Design and Assessment: A Guide for State Medicaid Agencies, 1994, Purchase Order #HCFA-92-1279.

U.S. DHHS/HCFA/American Public Welfare Association (APWA), Monitoring Risk-Based Managed Care Plans: A Guide for State Medicaid Agencies.

Websites: www.hcfa.gov, www.ahcpr.gov or outside organizations such as www.ncqa.org, www.nashp.org.

THE FOLLOWING 4-STEP TECHNIQUE MAY BE USED TO CALCULATE WAIVER COST-EFFECTIVENESS:

- Step 1. **Create a single set of numbers of managed care eligibles** that can be related back to the waiver.
- Step 2. **Calculate total without waiver costs by first calculating per beneficiary without waiver costs.** The total without waiver costs are equal to the number of managed care enrolled beneficiaries utilizing services at the non-managed care utilization multiplied by non-managed care costs per beneficiary. To eliminate the effects of cost-shifting, all significant Medicaid costs, including fee-for-service costs, should be included in cost-effectiveness analyses of risk-comprehensive MCO and PCCM models. Easily substitutable fee-for-service costs should be included in cost-effectiveness analyses for PHP models (e.g., pharmacy costs in mental health carve-outs). The Independent Assessor may want to take actuarial adjustments such as Incurred But Not Yet Reported Claims into account to the extent possible. *The population/sex/age categories, as well as major service categories (e.g., physician, hospital, pharmacy, other services), should at a minimum be calculated separately before*

being combined in a summary table for each year and for the waiver period.

- Method 1: Comparable population cost-effectiveness methodology

  Method 1: (managed care enrolled eligible member months x non-managed care utilization***) x non-managed care cost per beneficiary per month by category of service = Total without waiver costs

- Method 2: Trend fee-for-service costs forward methodology

  Method 2: Per beneficiary base year costs for all services updated to account for policy changes, inflation, etc occurring under the fee-for-service program = without waiver costs

- Step 3: **Calculate total with waiver costs by first calculating per beneficiary with waiver costs.** Total with waiver costs are equal to the number of managed care enrolled beneficiaries multiplied by the managed care costs per beneficiary plus administrative fees for managed care. The Independent Assessor may want to take actuarial adjustments such as Incurred But Not Yet Reported Claims into account to the extent possible. *The population/sex/age categories should at a minimum be calculated separately before being combined in a summary table for each year and for the waiver period.*

  Methods 1 and 2: (managed care enrolled eligible member months x managed care per beneficiary costs by category of services) + administration costs of the waiver as listed in Table 2 = with waiver costs

- Step 4: **Calculate savings per beneficiary and the overall waiver savings for the current waiver period**. Multiply the per beneficiary costs by the number of beneficiaries for both Year 1 and Year 2. Add the two years costs together. *The population/sex/age categories, as well as major service categories (e.g., physician, hospital, pharmacy, other services), should at a minimum be calculated separately before being combined in a summary table for each year and for the waiver period.*

  Without waiver costs - with waiver costs = savings

Table 1: Number of Enrollees and Enrolled Member Months

Table 1 Instructions. Create a table showing the number of enrollees and member months by population, age, and sex (for capitation should be each rate cell). Please create tables for each of the rate categories and a summary table. These tables should be consistent with the submittal of the cost-effectiveness calculations, Section C's, Appendices, and calculations. The table should be tailored to the actual needs of each State.

The following are examples of possible rate cells (if capitated program, use the rate cells developed by the actuary):

- TANF eligible enrollees age 18 and under
- TANF eligible enrollees age 19 and older
- SSI eligible enrollees age 18 and under
- SSI eligible enrollees age 19 and older
- Medicaid-Medicare dual eligible enrollees

TANF 0-18 Sample Table 1

	Number of Enrollees	
	Enrollees	Member Months
Year 1		
Year 2		
Current Waiver Total		

Table 2: Administration Costs for the Waiver

Report administrative costs in a table-like form (see sample below). The table should be tailored to the actual needs of each State. One-time only costs associated with program

initial implementation should be included. The State should document these costs and the effect upon cost-effectiveness in that period. For more information, see the 1915(b) streamlined waiver application preprint instructions 5.c and 7 and Appendix C.7 in the PCCM renewal and C.6 and Appendix C.7 in the capitated initial form.

Sample Table 2

	Year 1	Year 2	Current Waiver Total
Management Fees			
Salaries			
Supplies			
Contract Administration			
Systems Modification			
Marketing, Educating Recipients			
Handling Grievances/Appeals			
Utilization Review System			
Additional Staff			
Enrollment Broker			

Encounter Data/MMIS			
EQRO			
Hotline Operation			
Other (Peer Education, Health Assessment, and Consulting) Please specify.			
Total			

NOTE: Administrative overhead costs in fee-for-service that would be comparable in managed care should not be calculated in waiver cost effectiveness determination (e.g. State Medicaid Director salary). However, cost directly associated with providing administrative functions applicable to both fee-for-service and managed care but which are not equivalent, such as surveillance and utilization reviews, Medicaid management information system claims payment, should be noted and the fee-for-service costs should be subtracted from the managed care costs. Or, this information could be built into the UPL.