Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

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Medicaid/CHIP Managed Care Regulations: Assuring Quality

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Georgetown University Center for Children and Families (CCF) and the National Health Law Program (NHeLP) have teamed up to bring advocates for children and low-income families critical information about the recently finalized Medicaid and CHIP managed care regulations. This paper is the fifth in the series, and it describes how the new rules advance quality measurement and improvement. Other briefs in this series include:

- Looking at the New Medicaid/CHIP Managed Care Regulations Through a Children's Lens, *which gives an overview of the rules with an appendix detailing which Medicaid provisions also apply to the Children's Health Insurance Program (CHIP).*
- Medicaid/CHIP Managed Care Regulations: Improving Consumer Information, *which covers new provisions for accurate, timely, accessible, and complete consumer information.*
- Medicaid/CHIP Managed Care Regulations: Enhancing the Beneficiary Experience, *which describes how the new rules improve enrollment processes and establishes a new beneficiary support system.*
- Medicaid/CHIP Managed Care Regulations: Network Adequacy and Access to Services, *which describes how the new rules assure network adequacy and access to services.*

The final brief in the series will dive into contracting issues and ensuring accountability and transparency. It is important to note at the outset that these new managed care rules lay out the minimum standards states must meet in Medicaid and CHIP, but they also provide health and legal advocates a tremendous opportunity to improve care delivery for low-income families through strategic engagement with states and health plans as the rules are implemented over the next few years. States can and should do more than adopt the minimum standards for children and families. This issue brief series will identify those opportunities for action.

Background

Over the past decade, there have been significant advances in assessing quality, access, and timeliness of care in health coverage programs. Meanwhile, managed care arrangements—and particularly mandatory managed care programs—have become the predominant model for delivering care in Medicaid and the Children's Health Insurance Program (CHIP). During this time, there has been a growing recognition of the need to ensure that the care delivered in capitated managed care arrangements is focused not only on controlling costs by managing and coordinating care but also on assuring high value, high quality care. To this end, the modernization of federal Medicaid and CHIP Managed Care regulations released in May 2016 seeks to advance state quality assurance efforts by ensuring the use of meaningful and reliable data and expanding requirements for external quality review of managed care plans. The new rules require states to develop and maintain a comprehensive statewide quality strategy and establish a quality rating system to aid beneficiaries in comparing the performance of plans. Noting that public reporting of quality is "a key tool for driving quality improvement," the regulations require states to engage stakeholders in their quality strategy development. Importantly, the rules increase state and managed care accountability and promote transparency by requiring states to provide quality-related information online and in paper and alternative formats upon request.

The rules also seek to align quality measurement and improvement with other programs—namely private coverage through the health insurance marketplaces and Medicare. They extend certain quality requirements beyond managed care organizations (MCO) but fall short of extending the requirement for a comprehensive quality strategy that encompasses all delivery systems as proposed in the initial rules. All provisions are applicable to MCOs, Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs), while a few provisions, which are summarized on page 12, apply to Primary Care Case Management (PCCM) entities if the contract provides for shared savings, incentive payments, or other financial reward for the entity for improved quality outcomes.[1] (See the appendix on page 13 for definitions of different managed care arrangements.) While these rules apply to dental PAHPs, non-emergency medical transportation services (NEMT) PAHPs are not subject to the quality provisions.

States that have implemented CHIP as a Medicaid expansion program, also known as M-CHIP, must follow the Medicaid rules. Separate CHIP programs are governed by different rules that may or may not mirror the Medicaid rules. Provisions that apply to separate CHIP programs are summarized at the end of this brief (see page 12).

Health Information Systems § 438.242

Applies to MCOs, PIHPs, and PAHPs.

Timeline:

Contract rating periods beginning on or after July 1, 2017.

Quality improvement starts with collecting data needed to measure quality, access, and beneficiary satisfaction. States must ensure through their contracts that each MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports specific data. The system must minimally provide information on utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. These data are critical to assessing the overall performance of plans, not just the quality of care.

The rules define the basic elements of a health information system as those that: 1) meet specific standards for claims processing; 2) collect data on enrollee and provider characteristics as specified by the state; 3) collect data on all services furnished to enrollees through encounter level data; 4) ensure that data received from providers is accurate and complete; and 5) make all collected data available to the state and upon request to the Centers for Medicare & Medicaid Services (CMS).

Encounter Level Data § 438.818

Applies to states contracting with MCOs, PIHPs, and PAHPs.

Timeline:

Contract rating periods beginning on or after July 1, 2018.

State contracts must require each MCO, PIHP, and PAHP to collect sufficient enrollee encounter data to be submitted in a standard format to the state at a frequency and level of detail, including identifying the provider, specified by CMS and the state. Importantly, in addition to quality measurement, encounter data are the basis for any number of required or voluntary activities, including rate setting, risk adjustment, value-based purchasing, program integrity, and policy development. The state must review and validate encounter data, and have the protocols in place to assure that the data is complete and accurate. States may receive federal matching funds to contract with an external quality review organization (EQRO) to validate encounter data received from MCOs (75 percent match) and other managed care entities (50 percent match).

The validation of encounter data is not new. However, the rules strengthen the language regarding the submission of encounter level data on a monthly basis into the CMS Medicaid Statistical Information System (MSIS) (or any

successor system). CMS will assess whether a state's submission complies with current criteria[2] for accuracy and completeness and will notify the state of its findings. If the state is unable to make a data submission compliant, CMS will take steps to defer and/or disallow federal matching funds on all of part of an MCO, PHIP, or PAHP contract based on the enrollee- and service-type of the noncompliant data.

Definitions § 438.320

The rules establish a new definition for "access" as it relates to external quality review, update and broaden the definition of "quality," and newly define "health care services" and "outcomes." The language in the prior definitions could be read to focus narrowly on clinical care and medical outcomes. The updates and new definitions clarify that Medicaid services, particularly long-term services and supports (LTSS), encompass more than strictly a clinical or medical perspective and that quality assessment should utilize a broader view of health:

- **Access**, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under the network adequacy standards at § 438.68 and the availability of services at § 438.206.
- **Health care services** means all Medicaid services provided by an MCO, PIHP, or PAHP under contract with the State Medicaid agency in any setting, including but not limited to medical care, behavioral health care, and LTSS.
- **Outcomes** means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services.
- **Quality**, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired outcomes of its enrollees through: 1) its structural and operational characteristics; 2) the provision of services that are consistent with current professional, evidenced-based-knowledge; and 3) interventions for performance improvement.

Additional definitions relating to quality measurement and improvement include: external quality review (EQR), EQRO, financial relationship, and validation, but these definitions remain unchanged.

Quality Assessment and Performance Improvement Program § 438.330

Applies to MCOs, PIHPs, PAHPs, and certain PCCM entities.

Timeline:

Contract rating periods beginning on or after July 1, 2017.

This section of the regulations defines the types of quality programs that states must require of each managed care entity, which has been expanded to include PAHPs and certain PCCM entities in addition to MCOs and PIHPs. It differs from the state quality strategy, which will be described later in this brief. States must require through their contracts that each MCO, PIHP, PAHP, and PCCM entity establish an ongoing comprehensive quality assessment and performance improvement program (QAPI) for the services it furnishes to its enrollees as noted in the box on page 4. Note: The regulations only require PCCM entities to collect and submit performance measurement data and put in place mechanisms to detect over- and underutilization of services.

Basic Elements of a Managed Care Entity's QAPI

A comprehensive quality assessment and performance improvement program must minimally include:

- Performance improvement projects (PIPs) that:
  - Use objective quality indicators;
  - Implement interventions to achieve improvement in access to and quality of care;
  - Evaluate the effectiveness of interventions based on the quality indicators noted above; and
  - Plan and initiate activities for increasing or sustaining improvement.
- Collection and submission of performance data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs as defined by the state in its state quality strategy.
- Additional mechanisms to assess quality of care for individuals receiving long-term services and supports and in home and community-based waiver programs.

Performance Measures

The state must identify the standard performance measures, including measures that may be specified by CMS, relating to the performance of MCOs, PIHPs, PAHPs, and PCCM entities. For managed care entities providing LTSS, the measures must also address quality of life, rebalancing the relative proportion of LTSS delivered in the community, and community integration. States must require that each plan: 1) measure and report on its performance, using the standard measures, on an annual basis; 2) submit data specified by the state, which enables the state to calculate the entity's performance using the standard measures; or 3) a combination of the two.

Performance Improvement Projects

PIPs must minimally: 1) include a focus on both clinical and nonclinical areas, including projects specified by CMS; 2) be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction; and 3) report on the status and results of each PIP no less than once a year. CMS retains its authority to also specify federal PIPs, though only after a formal public notice and comment process.

Program Review by the State

The state is also required to review, at least annually, the impact and effectiveness of each plan's QAPI program. The rules stipulate that the review must include the managed care entity's performance on the measures it is required to report; the outcomes and trended results of each plan's PIPs; and the results of plan efforts to support community integration for enrollees using LTSS. The state may also require a plan to develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement project.

Work with your state to establish or update the definition of children with special health care needs and to identify quality measures that address key priorities for children. One starting point could be the Medicaid child core measure set, or a subset thereof, which CMS strongly encourages (but does not require) all states to adopt. Additionally, data should be disaggregated by select demographics in order to identify more targeted performance improvement opportunities.

Applies to states contracting with MCOs, PIHPs, and PAHPs.

Timeline:

Contract rating periods beginning on or after July 1, 2017.

Accreditation Status § 438.332

Accreditation is a comprehensive evaluation process in which a health plan's systems, processes, and performance are examined by a private independent accrediting entity, such as the National Committee on Quality Assurance (NCQA).[3] The entity determines if a plan's practices meet national standards and provides an impartial opinion about the plan's quality. Health plan accreditation may be awarded in levels, such as excellent, commendable, and accredited, or may simply be listed as accredited or denied depending on the accreditation entity.

Federal regulations require accreditation for plans operating in the health insurance marketplaces. CMS initially proposed a similar requirement for Medicaid, but did not finalize that proposal and instead continues to allow states to decide whether to require accreditation for Medicaid managed care entities. Regardless of a state's decision, MCOs, PIHPs, and PAHPs that have undergone the accreditation process are required to disclose their status. In their managed care contracts, states must require plans to inform the state if they have been accredited and to authorize the accrediting entity to provide a copy of the plan's most recently accreditation review to the state. This information has to include the current status, survey type, level of the review, expiration date and the accreditation results, including recommended actions or improvements, corrective action plans, and summaries of the findings.

States must post on their website the accreditation status for each applicable MCO, PIHP, or PAHP, along with the name of accrediting entity, the accreditation program, and accreditation level. This information must be updated at least annually.

TIP

Encourage your state to require accreditation to ensure that managed care plans meet national standards.

Medicaid Managed Care Quality Rating System § 438.334

Applies to states contracting with MCOs, PIHPs, and PAHPs.

Timeline:

No later than May 6, 2019.

In consultation with stakeholders and through a public comment opportunity, CMS plans to develop a Medicaid managed care quality rating system (MMC QRS) that aligns with the star rating system for qualified health plans in the Marketplace.[4] The MMC QRS will utilize the same three summary indicators—clinical quality management; member experience; and plan efficiency, affordability, and management—that currently frame the Marketplace QRS. However, in the preamble to the regulations, CMS recognizes that the populations served by Medicaid and Marketplace differ. Medicaid covers a larger population of children, pregnant women, seniors, and people with disabilities, and also includes a number of services, such as LTSS and nonemergency medical transportation, that Marketplace plans rarely cover. The MMC QRS will have to be tailored to include a robust set of measures that assess access and care quality relevant to these populations served by Medicaid.

States may adopt the CMS model MMC QRS or create an alternative system, provided that the alternative yields substantially comparable information to the model MMC QRS and receives CMS approval prior to implementation or modification. Before seeking CMS approval, the state must obtain input from the state's Medical Care Advisory Committee[5] and provide an opportunity for public comment. In its request for an alternative QRS, the state must document issues raised by stakeholders and any policy revisions or changes it made in response to comments.

Each year the state must collect data from each MCO, PIHP, and PAHP and issue an annual quality rating based on the QRS adopted. The quality ratings must be prominently displayed on the state's website in a manner that complies with consumer information requirements discussed in the second explainer brief in this series.

TIP

Engage in opportunities at the federal level to inform the development of the model MMC QRS and encourage CMS to adopt a robust and transparent public process for the state alternative QRS. Advocate for CMS to establish clear guardrails around the meaning of 'substantially comparable' and to commit to public posting of official communications with the state (similar to the process required for 1115 demonstrations). At the state level, encourage your state to involve additional stakeholders (not just the Medical Care Advisory Committee) in determining whether to adopt the model MMC QRS and in developing a state alternate QRS, if deemed the best approach.

Managed Care State Quality Strategy § 438.340

Applies to states contracting with MCO, PIHPs, PAHPs, and certain PCCM entities.

Timeline:
July 1, 2018.

Each state must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished through a contracted MCO, PIHP, PAHP, and certain PCCM entities. PCCM entities subject to these provisions include those with state contracts that provide for shared savings, incentive payments, or other financial reward for the entity for improved quality outcomes. (For a list of the provisions that apply to PCCM entities, see page 12).

The quality strategy is intended to provide comprehensive details about the state's managed care programs and how the state proposes to measure and improve quality, ensure the quality of care during transitions, arrange for an annual external independent quality review, address health disparities, impose appropriate sanctions on MCOs that violate federal laws, identify individuals with special health care needs or those who need LTSS, and more. Details of the minimal elements required by the strategy are listed in the box on page 7.

In drafting or revising its quality strategy, the state must obtain input from the Medical Care Advisory Committee, consult with tribes (if applicable), and provide an opportunity for public comment. The quality strategy must be reviewed and updated as needed, but no less than every three years. The review must include an evaluation of the effectiveness of the strategy. Updates to the quality strategy must incorporate recommendations for improving quality as determined by the EQR process.[6] States must submit a copy of the initial strategy for CMS comment and feedback prior to adopting the final strategy. When there are significant changes to the quality strategy or to the state's Medicaid managed care program, the strategy must be updated and a copy of the revised strategy must also be submitted to CMS. The state's final quality strategy, updates, and all reviews must also be posted on the state's website.

TIP

Take advantage of the public comment process to weigh in and recommend performance measures, PIPs, and key elements of External Quality Review for your state to require in its managed care contracts.

Elements the state quality strategy minimally include:

- The state defined network adequacy standards and availability of services. For more information see the fourth brief in this series, Medicaid/CHIP Managed Care Regulations: Network Adequacy and Access to Services.
- The state's goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of all populations served by the managed care entities.
- A description of the quality metrics and performance targets to be used in measuring the performance of the plans, including performance measures specified by CMS.
- The quality measures and performance outcomes that the state will publish at least annually on its website.
- The performance improvement projects to be implemented and a description of any interventions the state proposes to improve access, quality, or timeliness of care for enrollees of MCOs, PIHPs, and PAHPs.
- Arrangements for annual EQR of the quality outcomes, timeliness of care, and access to services.
- A description of the state's transition of care policy.[7]
- The state's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.
- For MCOs, appropriate use of intermediate sanctions.
- A description of how the state will assess the performance and quality outcomes achieved by each PCCM entity impacted by these rules, as defined above.
- The mechanisms implemented related to identifying individuals with special health care needs or those who need LTSS.[8]
- The required information relating to non-duplication of EQR activities with Medicare or accreditation review.
- The state's definition of a "significant change" as it relates to revisions in the state's quality strategy or whenever significant changes occur within the state's Medicaid program.

Applies to states contracting with MCO, PIHPs, PAHPs, and certain PCCM entities.

Timeline:

May 6, 2016 (for FMAP revisions in § 438.370); July 1, 2018 (for other EQR changes).

External Quality Review § 438.350

Independent external quality review (EQR), has long held promise as a key mechanism to improve data transparency, hold managed care plans accountable to performance expectations, and provide states financial incentives and flexibilities to innovate with quality assessment activities. It has been a required activity for states that contract with MCOs and PIHPs for over a decade. Various states have used EQR-incentives, such as 75 percent enhanced federal match, to test innovative new quality metrics or conduct secret shopper surveys to test network adequacy.

Prior Medicaid regulations applied EQR to all MCOs and PIHPs. Required EQR elements included the annual validation of performance measures and PIPs and a review of plan compliance with state and federal regulations at least every three years. The updated final regulations expand the applicability of EQR to PAHPs and certain PCCM entities, while also adding several important new components that could significantly strengthen EQR. (See below, § 438.358.)

External Quality Review Protocols § 438.352

The process of how precisely to conduct EQR is complex and has been laid out in rather extensive protocols for each separate EQR activity. These protocols were last updated in 2012, but will have to be revised in the wake of the new managed care regulations. New protocols will also need to be developed to flesh out the two new EQR activities: validation of network adequacy and activities that assist with the quality rating system described in § 438.334.

Though not specified in the regulatory text, these protocols will be open to public comment. This comment period will be particularly important for advocates to weigh in on the network adequacy validation process. Only the preamble indicates that direct testing will be a required component of this EQR activity; the extent and character of any mandated direct testing of networks will be specified as the protocols are developed.

Qualifications of External Quality Review Organizations § 438.354

The Medicaid managed care rules lay out specific requirements to establish the competence, financial security, and independence of EQROs. Mostly, these have remained unchanged in the recent revisions, but the final rules strengthen several elements of the requirements for EQRO independence.[9] For example, an EQRO sensibly has never been permitted to review a managed care entity it either controls or is controlled by, but the regulation now extends that prohibition to review of competitor managed care plans in the state.

State Contract Options for External Quality Review § 438.356

States must contract with an EQRO to compile and review all collected data and prepare the annual technical report. States may contract with one or multiple EQROs to complete different EQR-related activities listed in § 438.358 (see box on page 9). All EQRO contracts must follow an open, competitive procurement process, and can be reimbursed with enhanced federal match (75 percent) but only for activities related to MCOs (see § 438.370 below).

EQROs may use subcontractors, provided that they also meet the independence requirements, but the EQRO itself remains accountable for and must oversee all the subcontractor functions.

Activities Related to External Quality Review § 438.358

CMS lays out four required and six optional activities related to EQR (see box below). These activities can be conducted by an EQRO *or* by the state (or its agent that is not an MCO, PIHP, PAHP, or PCCM entity). However, enhanced federal match (75 percent) is only available for activities conducted by an EQRO for activities related to MCOs.

The final regulations added an important new mandatory EQR activity to validate network adequacy for all contracted capitated plans annually.[10] CMS also added an option for states to use EQROs for activities that assist with the Medicaid star-rating system described in § 438.334, which could allow some states to receive enhanced match for activities related to developing and implementing that system.[11]

The network adequacy validation is a significant change. CMS explains in the preamble that the new protocols related to this activity will require direct testing of plan networks through methods like secret shopper surveys.[12] Two 2014 reports from the HHS Office of the Inspector General (OIG) found striking evidence that states using direct testing methods were far more likely to identify violations of state standards and initiate corrective actions.[13]

Urge CMS and states to develop guidance mandating robust and independent direct testing to validate network adequacy and verify plan compliance more generally. Advocates will have two opportunities: 1) at the federal level, when the new EQR protocols go out for public comment; and 2) at the state level, when each state determines its own EQR arrangements as part of its state quality strategy.[14]

Mandatory EQR-related activities for each MCO, PIHP, and PAHP:

- Validation of required PIPs (last 12 months);
- Validation of required performance measures (last 12 months);
- Review of compliance with the managed care and QAPI standards (at least every three years); and
- Validation of network adequacy standards (last 12 months).

Optional EQR-related activities:

- Validation of encounter data;
- Administration or validation of consumer or provider quality surveys;
- Calculation of additional performance measures;
- Conduct of PIPs in addition to those conducted by managed care entities;
- Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time; and
- Assist with the quality rating system consistent with § 438.334.

Encourage your state to adopt optional EQR activities to ensure that its overall quality review is comprehensive and conducted by an independent organization.

Non-Duplication of Mandatory Activities with Medicare or Accreditation Review § 438.360

In writing the Medicaid managed care statute, Congress took steps to ensure that states could avoid unnecessary duplication of work and substitute, where appropriate, information from private accreditation or Medicare to use for EQR. Under prior regulations, states could only use information from an accreditation review to substitute for the mandatory EQR compliance review, not for validating PIPs and performance measures. At the time, accreditation data often was not specific to Medicaid-only populations and thus was not appropriate for Medicaid EQR purposes. However, in the intervening years, several accreditation organizations have developed procedures to review and accredit performance measures and PIPs specific to Medicaid managed care plans, which resolves this issue.

The new final regulations thus expand the non-duplication provision to include PIP and performance measure validation, provided that the private accreditation review standards are comparable to those in the EQR protocols. To use this option, the state must provide a detailed description and rationale for its non-duplication substitutions in the comprehensive quality strategy. Each MCO, PIHP, or PAHP must provide the state with all the reports, findings, and other results of the accreditation or Medicare review applicable to EQR, and the state must ensure that its contracted EQRO can access that information to include in its annual technical report.

Importantly, the regulations do not permit states to rely on accreditation or Medicare reviews for the required validation of network adequacy.

Congress also permitted states to exempt certain MCOs from EQR if the MCO has both an active Medicare Advantage contract and a long-standing (at least two years) Medicaid managed care contract with an overlapping service area in the state, provided that certain other conditions are also satisfied. Section 438.362 details these conditions. This provision remained substantively unchanged in the revised regulations.

External Quality Review Results § 438.364

The last critical component of EQR for advocates is transparency. EQR reports provide valuable data, including quality performance metrics, an assessment of each plan's strengths and weaknesses, recommendations for improving each plan's care quality, and an assessment of how well each plan has responded to prior recommendations.[15] The final regulations require states to contract with an EQRO to produce the annual report and prohibit states from substantively revising the content of the annual EQR report without evidence of error or omission.[16]

Formerly, states were required to make annual technical reports available on request, and the release of information was plagued by delays. Once the EQR report was finally released, its data were often already stale. In 2012, CMS released guidance requiring states to file their annual report by April 30 each year. That guidance has now been incorporated into the final rules, along with a requirement that states post the most recent annual technical report on their website and make printed or electronic copies available on request, including alternative formats for people with disabilities.[17]

External Quality Review can provide a pathway for innovations as well as useful comparative information that advocates can use to cross-check other quality and oversight activities. Advocates should:

- Urge your state to include archived EQR reports to make it easier to analyze how plans perform over time;
- Strategize with other advocates and with state officials over creative applications of EQR, particularly if your state contracts with MCOs and could get the enhanced federal match (75 percent). This could include piloting new measures or testing new methods for evaluating network adequacy.

Federal Financial Participation § 438.370

Unfortunately, just as CMS expanded the scope and applicability of EQR, it also restricted the availability of enhanced federal matching funds (75 percent) available to states. Due to a reinterpretation of the statutory language, CMS will now only permit enhanced match for activities performed by an EQRO on an MCO.[18] EQR-activities for PIHPs, PAHPs, and PCCM entities will now be reimbursed at the 50 percent administrative rate, regardless of whether the entity performing the EQR activities is a qualified EQRO, the state, or some other organization.[19]

This is likely to impact how far states will go beyond minimal requirements related to EQR. For example, states like California, which organizes its county-based behavioral health system as PIHPs, will likely incur increased costs for EQR related to that program, and will have much less incentive to conduct optional EQR-related activities. Moreover, states will have no incentive to contract with an independent EQRO to conduct required validations and plan compliance reviews for PIHPs, PAHPs, and PCCM entities, and may elect to do that work in-house. In those cases, only the annual technical report must be produced by an EQRO.[20]

Additional Resources

For a primer on the basics, background, and status of quality measurement and improvement in Medicaid and CHIP, see "Measuring and Improving Health Care Quality for Children in Medicaid and CHIP: A Primer for Child Health Stakeholders."

To access each of the briefs in this series, including recordings of webinars and presentations on each of the topics, see CCF's Medicaid and CHIP Managed Care Series webpage.

For additional information on various other aspects of the new managed care regulations, see NHeLP's Managed Care webpage.

For addition information on Medicaid managed care external quality review, see NHeLP's "External Quality Review: An Overview."

Applicability to Separate CHIP Program

States that have implemented CHIP as a Medicaid expansion program, also known as M-CHIP, must follow the Medicaid rules outlined above. Separate CHIP programs are governed by different rules that may or may not mirror the Medicaid rules.

Quality Measurement and Improvement § 457.1240

All of the provisions regarding health information systems (§ 438.242), the quality assessment and performance improvement program (§ 438.330), and state review of plan accreditation (§ 438.332) apply to CHIP without modification except § 438.330(d)(4) related to dual eligibles is not applicable. CHIP programs must also comply with Subpart H of the Medicaid managed rules on program integrity. This includes the submission of encounter data at § 438.604(a)(1) as defined at § 438.818.

External Quality Review § 457.1250

External quality review provisions at §§ 438.350, 352, 354, 356, 358 and 364 apply to CHIP without modification. Section 438.360 only applies to CHIP with respect to private accreditation (Medicare accreditation may not substitute for EQR in CHIP). Note that unlike Medicaid, CHIP EQR activities are matched at the CHIP match and subject to the 10 percent administrative limit. States may amend an existing Medicaid EQRO contract to include CHIP.

Applicability to PCCM Entities

The following provisions in the quality section of the rules (subpart E) apply to states contracting with PCCM entities, as defined at § 438.310(c)(2), if the contract provides for shared savings, incentive payments, or other financial reward for the entity for improved quality outcomes:

PCCM Entity Assessment and Performance Improvement Program (§ 438.330(a)(3))

The state must require, through its contracts, that each PCCM entity as defined above, establish and implement an ongoing comprehensive assessment and performance improvement program that, at a minimum, incorporates:

- Collection and submission of performance measurement data (§ 438.330(b)(2))
- Mechanisms to detect both underutilization and overutilization of services. (§ 438.330 (b)(3))

Performance Measures (§ 438.330(c))

The state must identify the standard performance measures, including measures that may be specified by CMS, relating to the performance of MCOs, PIHPs, and PAHPs. For managed care entities providing LTSS, the measures must also relate to quality of life, rebalancing, and community integration. States must require that each plan: 1) measure and report on its performance, using the standard measures, on an annual basis; 2) submit data specified by the state, which enables the state to calculate the entity's performance using the standard measures; or 3) a combination of the two.

Program Review by the State (§ 438.330(e))

The state is also required to review, at least annually, the impact and effectiveness of each plan's QAPI program. The rules stipulate that the review include the managed care entity's performance on the measures it is required to report, the outcomes and trended results of each plan's PIPs, and the results of plan efforts to support community integration for enrollees using long term services and support (LTSS). The state may also require a plan to develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement project.

Inclusion in the managed care state quality strategy (§ 438.340)

The written quality strategy for assessing and improving the quality of health care and services must incorporate PCCM entities that may receive shared savings or performance incentives as defined above.

Inclusion in external quality review (§ 438.350)

A qualified EQRO must perform an annual external quality review on PCCM entities described in § 438.310(c)(2)).

Appendix: Definitions Applicable to Managed Care Entities

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is –

- A federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or
- Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
  - Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
  - Meets the solvency standards of § 438.116.

Prepaid ambulatory health plan (PAHP) means an entity that –

- Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates;
- Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and,
- Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that—

- Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates;
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
- Does not have a comprehensive risk contract.

Primary care case management (PCCM) is a system whereby the state contracts with a primary care case manager to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries. Primary care case manager means a physician, a physician group practice or, at state option, any of the following: a physician assistant; a nurse practitioner; a certified nurse-midwife.

Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the state –

- Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.
- Development of enrollee care plans.
- Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.
- Provision of payments to FFS providers on behalf of the state.
- Provision of enrollee outreach and education activities.
- Operation of a customer service call center.
- Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.
- Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- Coordination with behavioral health systems/providers.
- Coordination with long-term services and supports systems/providers.

Risk contract means a contract under which the contractor –

- Assumes risk for the cost of the services covered under the contract; and
- Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Nonrisk contract means a contract under which the contractor—

- Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in §447.362 of this chapter; and
- May be reimbursed by the state at end of contract period on the basis of the incurred costs, subject to the specified limits.

Endnotes

[1] 42 C.F.R. § 438.310(c)(2).

[2] CMS released guidance in 2013 that clarified the data elements, reporting structure for, and frequency of enrollee encounter data in the Medicaid Statistical Information System (MSIS). States must submit data monthly for all FFS and managed care services as required by SSA § 1903(r). For additional information, see http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf.

[3] "Accreditation to Approve Health Plans and Providers," National Conference of State Legislatures, April 2011, available at http://www.ncsl.org/documents/health/HRHealthPlans.pdf.

[4] 45 C.F.R. § 156.1120.

[5] 42 C.F.R. § 431.12.

[6] Id. 438.364(a)(4).

[7] Id. § 438.62(b)(3).

[8] Id. § 438.208(c)(1).

[9] Id. § 438.354(c).

[10] Id. § 438.358(b)(1)(iv). Note: Only PCCM entities with state contracts that provide for shared savings, incentive payments or other financial reward for improved quality outcomes are subject to EQR. See § 438.350(a). PCCM entities are only required to validate performance measures and undergo periodic compliance reviews in their EQR. See § 438.358(b)(2).

[11] 42 C.F.R. § 438.358(c)(6).

[12] 81 Fed. Reg. 27706. Note that CMS does not reference direct testing in the text of the regulation.

[13] See HHS, Office of the Inspector General, Access to Care: Provider Availability in Medicaid Managed Care (Dec. 2014); HHS OIG, State Standards for Access to Care in Medicaid Managed Care (Sept. 2014).

[14] CMS states in the Preamble that the EQR protocols will be subject to a federal public comment process. See 81 Fed. Reg. 27707.

[15] 42 C.F.R. § 438.364(c)(2)(i).

[16] Id. § 438.364(b) & (c).

[17] Id. § 438.368.

[18] The prior regulations permitted 75 percent enhanced match for EQR conducted by EQROs on PIHPs as well. CMS explains its reasoning for the reinterpretation in the Preamble at 81 Fed. Reg. 27715.

[19] 42 C.F.R. § 438.370.

[20] Id. § 438.368(c).

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