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Medicaid/CHIP Managed Care Rules: Assuring Quality

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Children in Managed Care

- CMS finalized sweeping changes to Medicaid and CHIP managed care regulations in May 2016
- Regulations set minimum standards; states have flexibility to do more
- Many opportunities for legal and health advocates to take action

Flag potential actions for legal and health advocates

Why are these rules so important?

11% of children in Medicaid/ CHIP are enrolled in FFS

22% of children in Medicaid/ CHIP are enrolled in PCCMs

66% of children in Medicaid/CHIP are enrolled in MCOs

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Source: CMS Medicaid Managed Care Enrollment Report 2013

Managed Care Project

- Series of six explainer briefs and webinars
  1. Looking at the Rule through a Children's Lens (6/9)
  2. Improving Consumer Information (6/23)
  3. Enhancing the Beneficiary Experience (7/19)
  4. Assuring Network Adequacy and Access to Services (8/5)
  5. Advancing Quality (9/8)
  6. Ensuring Accountability and Transparency (9/29)
- Fall meeting in D.C. with child health and legal advocates to strategize over implementation
- Thanks to Robert Wood Johnson Foundation
- Links to past reports and webinar slides: http://ccf.georgetown.edu/2016/06/22/medicaidchip-managed-care-series/

Our Topic Today: Assuring Quality

- Health Information Systems and Encounter Data
- Managed Care Plan Quality Assessment and Performance Improvement Program (QAPI)
- Accreditation Status
- Managed Care Quality Rating System
- State Quality Strategy
- External Quality Review

Flag potential actions for legal and health advocates

Background – Why these Rules?

- Significant improvements in science of quality measurement and improvement
- Intended to advance quality assurance efforts by strengthening data and expanding external quality review
- Focused attention on LTSS
- Provides consumers with information to assess quality in choosing a plan
- Improves data transparency and timeliness
- Provides opportunity for stakeholder engagement

Applicability

- All MCO's, PIHPs, and PAHPs
- A limited set of provisions apply to PCCM entities with contracts that allow for shared savings, financial reward, or performance incentives
- State quality strategy does not encompass fee-for-service as initially proposed

Timeline

- Implementation timelines vary for different provisions from immediate to contract rating periods that start July 1, 2017 to 3 years from release of CMS guidance on the quality rating system (expected in 2018).
- Provisions that modify current rules are effective sooner than new provisions, such as the quality rating system

Health Information Systems

Applies to, MCOs, PIHPs, PAHPs

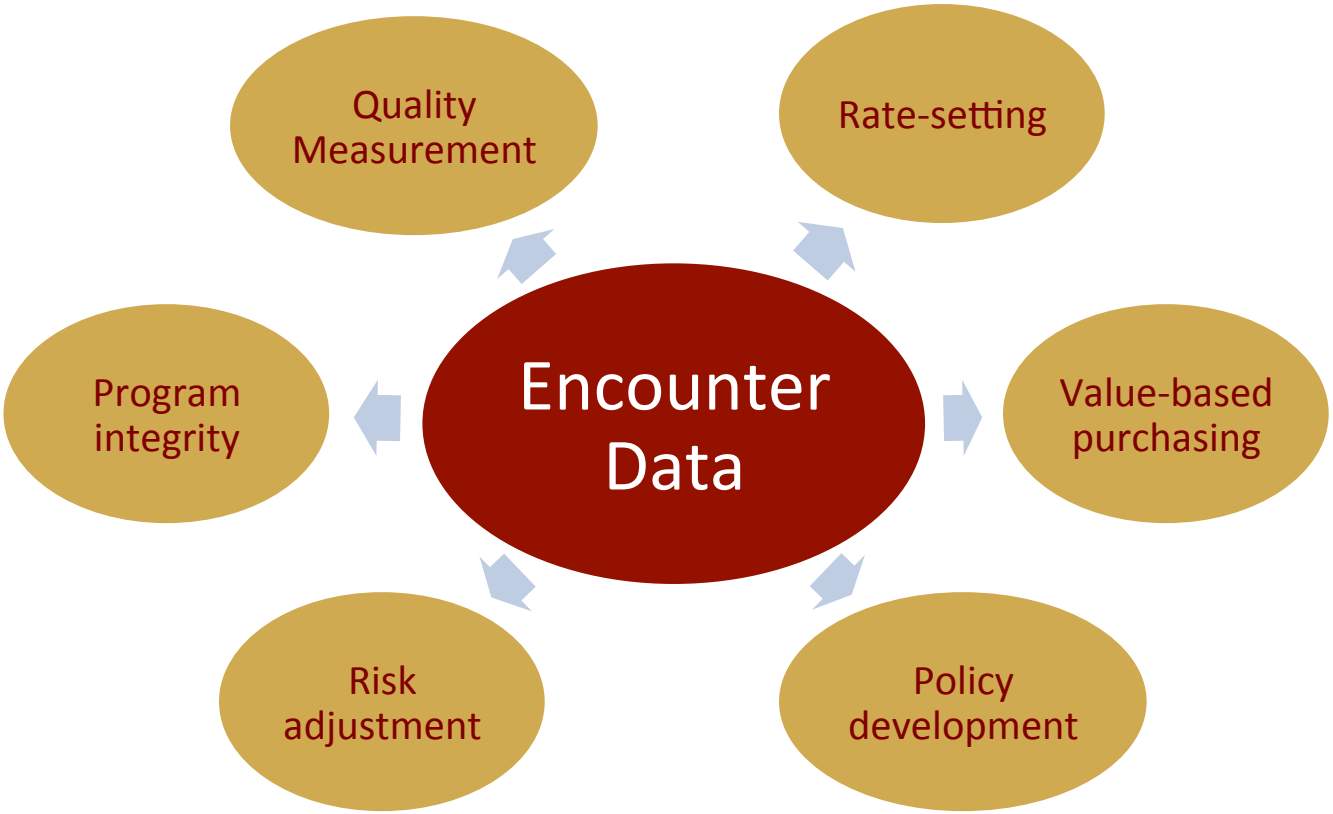
Contract rating periods ≥ July 1, 2017

- State contracts must require each plan to maintain a health information system
- System must collect, analyze, integrate and report special data
- Data must *minimally* include utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of eligibility

Basic Elements of Health Information Systems

1. Meet specific standards for claims processing
2. Collect data on enrollee and provider characteristics as specified by the state
3. Collect encounter level data on services furnished to enrollees
4. Ensure that data received from providers is accurate and complete
5. Make all collected data available to the state and upon request to CMS

Encounter Level Data



Encounter Level Data

Applies to, MCOs, PIHPs, PAHPs

Contract rating periods ≥ July 1, 2018

- CMS may specify the level of detail and frequency required in state contracts with plans
- States must review and validate the data and have protocols to ensure that it is accurate and complete
- Monthly submission to CMS is required

Encounter Level Data Financial Implications

- States may use an EQRO to validate encounter data but match varies:
  - 75% funding for MCOs only
  - 50% match for PIHPs and PAHPs
- If CMS assesses that a state's submission is not accurate and complete, it will notify the state
- CMS may withhold or disallow matching funds to enforce compliance

New or Updated Definitions

- Access, Quality, Health Care Services, Outcomes
- Articulates a broader view of health beyond clinical care and medical outcomes
- Defines services as those provided in any setting but not limited to medical care, behavioral health care, and LTSS
- Outcomes include patient health, functional status, satisfaction, or goal achievement

Quality Assessment & Performance Improvement Program (QAPI)

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

Contract rating periods ≥ July 1, 2017

- Not the state quality strategy
- State contracts must require plans to establish an ongoing comprehensive QAPI

Basic Elements of QAPI

- Performance Improvement Projects (detail next slide)
- Collection and submission of performance data*
- Mechanisms to:
  - Detect both underutilization and overutilization*
  - Assess quality/appropriateness of care for individuals with special health care needs
  - Assess quality of care for individuals receiving LTSS and in home/community-based waivers

**** Only these provisions apply to PCCM entities with contracts the provide for shared savings, financial reward, or performance incentives.***

Performance Improvement Projects (PIPs)

- Use objective quality indicators
- Implement interventions to achieve improvement in access to services and quality of care
- Evaluate the effectiveness of interventions based on the quality indicators
- Include activities to increase/sustain improvements in health outcomes and enrollee satisfaction
- Focus on clinical and non-clinical areas
- At least annual reporting

CMS retains authority to specify federal PIPs after formal public notice and comment process

Performance Measures

- State must identify the standard performance measures to be reported annually
- CMS has authority to require specific measures
- MLTSS must address quality of life, rebalancing, and community integration

Options for Reporting

- Plan calculates and reports based on standard measures
- Plan submits data for state to calculate the measures
- Combination of these

QAPI Program Review

- State must review the impact and effectiveness of each plan's QAPI program at least annually
- Review must include the plan's performance on required measures, outcomes and trended results of PIPs, and community integration for LTSS
- States may require a plan to evaluate the impact and effectiveness of its own QAPI

Accreditation

Accreditation is a comprehensive evaluation process in which a plan's systems, processes and performance are examined by an independent accrediting entity (e.g. NCQA).

- Not required in final rule, although initially proposed
- States have flexibility to require accreditation

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

If a Plan Has Undergone the Accreditation Process

Applies to, MCOs, PIHPs, PAHPs

Contract rating periods ≥ July 1, 2018

- Regardless of whether a state requires accreditation
  - The plan must disclose the status and authorize the accrediting entity to provide specific information to the state.
  - The state must post and update accreditation status annually, along with name of accrediting entity, program, and level.

Quality Rating System (QRS)

- CMS will develop a model MMC QRS focusing on:
  - clinical quality management;
  - member experience; and
  - plan efficiency, affordability and management
- Aligned with the Marketplace QRS but tailored for Medicaid enrollees
- Stakeholder consultation & public comment required
- States may adopt model MMC QRS or develop an alternative

Applies states to contracting with MCOs, PIHPs, PAHPs

No later than 3 years > CMS publishes guidance

State QRS Alternative

- Must yield substantially comparable information
- CMS approval before implementation or changes
- Obtain input from MCAC and provide opportunity for public comment
- Document issues raised and state's response

Federal level: ***Provide input to CMS on the development of the model MMC QRS, and the need for a robust and transparent public process and how to define "substantially comparable" for a state alternative.***

State level: ***Encourage your state to involve a robust group of stakeholders in determining whether to adopt the model QRS, and in developing a state alternative if deemed best.***

State Managed Care Quality Strategy

- A written quality strategy for assessing and improving the quality of managed care
- Provides comprehensive details about the state's MC programs and its oversight and quality assurance
- Must be reviewed and updated after significant changes (and no less than every 3 years)
- Review process includes public comments and feedback from CMS
  - State responsiveness to EQR recommendations
  - Evaluation of effectiveness of prior quality strategy

Minimal Elements of State Quality Strategy

- Strategy must reflect state's goals and objectives and how the state will:
  - Measure and improve quality
  - Define network adequacy
  - Arrange for independent EQR review
  - **Address health disparities**
  - Ensure quality through transitions
  - Identify individuals with special health care needs or who need LTSS
  - Impose sanctions on MCOs that violate federal law
  - Define significant change that requires that the strategy be updated
  - More (see page 7 of the brief)

Write comments to recommend performance measures, PIPs, EQR review activities, and better disparities tracking to be required in all state managed care contracts.

External Quality Review = A Key Tool

- A required activity for more than a decade
- Has not always lived up to potential; but now stronger
- Improve data transparency and timeliness
- Hold MC plans accountable to performance expectations
- Provide states with financial incentives to innovate quality activities

External Quality Review Protocols

- Methodology for conducting EQR laid out in detailed protocols for each activity
- Revisions will be necessary to current activities
- New protocols for new activities: validating network adequacy and assisting with the QRS

Federal level: ***Take advantage of the comment period to weigh in on the new protocols.***

State level: ***Engage in opportunities to provide input to your state's quality strategy development as it determines its own EQR arrangements.***

Qualifications of an EQR Organization

- Establishes competence, financial security, and independence of EQRO
- Special rules for a government entity
- New rule strengthens several elements relating to independence
  - the disallowance of allowing an EQRO to review a managed care entity it owns or controls has been extended to review of competitor managed care plans in the state.

State Contract Options for EQR

- States must contract with one or more EQROs to compile and review all collected data and prepare the annual technical report
- Contract must allow open, competitive procurement process
- EQROs may subcontract with entities that meet the independence requirements but EQRO remains accountable

EQR Activities

Mandatory Activities	Optional Activities
• Validation of PIPs • Validation of required performance measures • Review of compliance with managed care and QAPI standards every 3 years • Validation of network adequacy every 12 months	• Validation of encounter data • Administration or validation of consumer/provider surveys • Calculation of additional performance measures • Conduct additional PIPs • Conduct special studies • Assist with QRS

Encourage your state to adopt optional activities to ensure that quality review is comprehensive and conducted independently.

Direct Testing of Network Adequacy

Direct testing is centered on active evaluation of plan compliance, such as conducting a secret shopper survey as opposed to a desk review of a plan's policies and provider directories.

- Validating network adequacy is a significant change
- OIG found that three states (out of 33 surveyed) found 77% of all the network adequacy violations from 2008-2013. All three called providers directly.*

Urge CMS to develop guidance mandating robust and independent direct testing to validate network adequacy.

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*HHS OIG, *State Standards for Access to Care in Medicaid Managed Care*, 15-16 (Sept. 2014).

Non-Duplication

- Avoids unnecessary duplication of work
- Allows substitution of information from private accreditation (or Medicare Advantage)
- Newly allows substitute for validation of PIPs and performance measures if states provide a detailed description and rationale of substitutions in their quality strategy
- Explicitly does not allow substitution of the required validation of network adequacy

EQR Results

- EQR reports can provide valuable data about plan performance
  - including implementation of prior recommendations
- States must contract with an EQRO to produce the annual report
- States cannot substantively revise the content without evidence of error or omission
- Reports must be:
  - Filed by April 30 of each year
  - Posted on the state website
  - Provided in paper or alternative formats upon request

Federal Financial Participation (FMAP)

- Previously, an enhanced federal match of 75% was allowed for EQR activities conducted by EQROs
- The new rule reinterprets the law and only permits the enhanced match as it applies to EQR activities associated with MCOs
- Even if required, EQR activities associated with PIHPs, PAHPs, or PCCM entities will receive 50% match
- Could have chilling effect on state willingness to adopt more than the mandatory activities

Creative Ways to Use EQR Financial Incentives

- Test a new measure or a consumer survey
  - Ex. National Core Indicators – Adults and People with Disabilities
- Direct testing of encounter data
- Stratification of quality data to examine health disparities
- How do you interpret: "Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time."

Applicability to PCCM Entities

- Applies only to PCCM entities with contracts that provide for shared savings, financial reward, or performance incentives for outcomes
- Limited required QAPI for PCCM entities
  - Collect and report state-identified performance measures
  - Have mechanisms to detect both underutilization and overutilization
- Limited required EQR for PCCM entities
  - Validation of performance measures
  - Compliance review
  - Annual report produced by EQRO

CHIP Applicability

Quality Measurement and Improvement

- Health information systems
- Encounter data submission and validation
- QAPI
- State review of plan accreditation

External Quality Review

- EQR provisions generally apply across the board
- Non-duplication only applies to private accreditation; Medicare cannot substitute
- EQR is matched at CHIP rate

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 more information on Medicaid MC EQR, see NHeLP's External Quality Review: An Overview.

For More Information

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