



How Can We Tell Whether Medicaid MCOs are Doing a Good Job for Kids?

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Key Findings

- Medicaid managed care organizations (MCOs) are responsible for the provision of needed health care services for the large majority of the 37 million low-income children enrolled in Medicaid.
- Federal and state governments have a major investment in Medicaid MCOs; in FY 2018, they are projected to spend about \$275 billion paying MCOs for all enrolled populations.
- Under their contracts with state Medicaid agencies, Medicaid MCOs assume financial risk for the provision of covered services to enrollees; as a result, they have an incentive not only to coordinate care for enrollees in order to reduce unnecessary use of high-cost services but also to limit enrollee access to services and shift risk to providers.
- Federal Medicaid regulations are designed to mitigate the incentives to limit services as well as to ensure accountability of MCOs for the accessibility and quality of care; transparency requirements are one of the key regulatory oversight mechanisms.
- Currently there is no single set of measures in common use by state Medicaid agencies and the Center for Medicare & Medicaid Services (CMS) to assess whether children enrolled in MCOs are receiving quality care, and there is no publicly accessible national database with information on how well individual MCOs are serving enrolled children.
- The federal Medicaid regulations are being reconsidered by CMS; if the transparency requirements are weakened, the public will have less information with which to tell whether individual Medicaid MCOs are doing a good job.

Introduction

Nearly 40 percent of the nation's children—37 million—are covered by Medicaid.¹ Of those, over two thirds are enrolled in managed care organizations (MCOs). While not all state Medicaid programs enroll children in MCOs, in 24 of the states that do, more than 80 percent of Medicaid beneficiaries who are children are enrolled in “comprehensive managed care”—i.e., MCOs.² In all likelihood, the percentage of Medicaid children enrolled in MCOs is even higher today.³

As of March 2017, a total of 275 Medicaid MCOs operated in 38 states and the District of Columbia to provide covered services to Medicaid beneficiaries; 12 state Medicaid programs did not contract with MCOs.⁴ Federal and state Medicaid spending on managed care (including MCOs and other types of managed care) will total an estimated \$275 billion in FY 2018.⁵

MCOs contract with state Medicaid agencies to ensure that beneficiaries receive covered Medicaid services when medically necessary. MCOs may be private for profit, private nonprofit, or public. Regardless of corporate structure, under the contract with the state Medicaid agency, MCOs agree to take responsibility for arranging for the provision of services specified by the state to enrolled beneficiaries through a network of providers that the MCOs (or their subcontractors) have assembled. In exchange, the MCOs receive a capitation payment from the state for each enrollee—a fixed amount per member per month (pmpm). The payment must be “actuarially sound”—basically, it must be sufficient to enable an MCO to assemble and pay a network of providers for the covered services



that are needed by the particular beneficiaries who enroll with the MCO and to do so without excessive administrative costs or profits.

To oversimplify, this contractual arrangement, with its use of capitation payments, shifts financial risk for the costs of Medicaid services from the state Medicaid agency and the federal government to the MCO.⁶ In doing so, it provides a measure of fiscal predictability for state and federal budgets. Within limits, if the MCO spends more on covered services than the capitation payments from the state Medicaid agency, the MCO absorbs the loss; if it spends less, it keeps the difference. This gives the MCO an incentive to limit what it pays its network providers, either by reducing the use of covered services by enrollees or constraining its reimbursements to providers, or both.⁷ Depending upon the capitation rates, the cost of an adequate provider network, the use of services by enrollees, and other factors, a Medicaid risk contract can be highly lucrative for an MCO⁸ and its management⁹ or a losing business proposition.¹⁰

The implications for Medicaid beneficiaries are fundamental. Under these risk contracts, the state Medicaid agency will pay only the MCO for the services covered under the contract; if the enrolled beneficiary is unable to obtain needed services from the MCO's provider network even though the services are covered under the contract, he or she may go without or seek care at the emergency room. If the capitation rates paid to an MCO are not adequate, it may not have the resources to pay its network providers adequately or to make the investments in information systems and case management to ensure adequate quality of care. If an MCO does not pay providers adequately, and is therefore unable to recruit or retain sufficient numbers of providers into its network, access to services may be compromised. And if the providers that the MCO does recruit to its network are not good at what they do, then the quality of care available to enrollees may be substandard. Finally, the complex corporate structure of some MCOs, involving multiple layers of "subcapitation," may enable bad actors to divert Medicaid funds from patient care and compromise the reporting of performance data.¹¹

Capitation payment can also provide incentives for MCOs to manage the care of enrollees more effectively than would occur in less formal, fee-for-service arrangements. If

MCOs implement strategies to improve the coordination of services, especially for high-cost enrollees, they can reduce the use of expensive inpatient services while at the same increasing access to primary and preventive care. There is evidence that preventable hospitalization rates are lower in Medicaid managed care than in Medicaid fee-for-service.¹² There is also evidence that some MCOs are implementing innovative approaches to care coordination of children with special health care needs.¹³

Federal regulations contain a number of beneficiary protections that are designed to ensure that the incentive inherent in capitation does not result in the denial of access to covered services or substandard quality of care.¹⁴ State Medicaid agencies that elect to contract with MCOs must incorporate these protections into the contracts¹⁵ and monitor compliance with them.¹⁶ Among the state agency oversight responsibilities are ensuring the transparency of information relating to the performance of individual MCOs.

These access and quality regulatory requirements do not apply to the Medicaid fee-for-service delivery system. This uneven regulatory playing field makes head-to-head comparisons between Medicaid managed care and fee-for-service delivery systems difficult. Because such a high percentage of Medicaid-eligible children are enrolled in MCOs, however, the more important question is how the quality of care received by children in one MCO compares with that in another. The Medicaid and CHIP Payment and Access Commission (MACPAC) recently noted, "it is difficult to evaluate the effect of managed care on quality of care," which may explain why research findings on Medicaid managed care quality outcome "are scarce and have mixed results."¹⁷

The purpose of this paper is to describe the current federal transparency requirements and explain how they can be used to assess how well individual MCOs are serving the Medicaid-eligible children enrolled with them. The paper starts with a summary of the obligations Medicaid MCOs have toward children, reviews the measures for MCO quality performance vis-à-vis enrolled children, and identifies the information that is required to be publicly available to assess the performance of individual MCOs. It concludes with suggestions for using transparency to improve the quality of care for children enrolled in MCOs.



What are the obligations of Medicaid MCOs to enrolled children?

Medicaid has a guaranteed benefit that is custom-made for children: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.¹⁸ In the case of children who are in mandatory eligibility categories—for example, all children under age 19 in families with incomes at or below 133 percent of the Federal Poverty Level—Medicaid does not impose copayments or other types of cost-sharing for EPSDT services.¹⁹ If a state Medicaid agency contracts with an MCO to furnish services to enrolled children, the contract must specify the EPSDT services for which the MCO is responsible; all other EPSDT services remain the responsibility of the agency, which can provide them on a fee-for-service basis or contract with another MCO to provide those services.²⁰

On paper, EPSDT articulates comprehensive health coverage for children.²¹ Each child enrolled in Medicaid is entitled to a periodic, age-appropriate screening that includes assessments of physical and mental health, tracks progress on developmental milestones, and provides appropriate immunizations, blood lead level tests, and health education. If a routine screening indicates that the child needs further evaluation of an illness or condition, the Medicaid program must pay for any necessary diagnostic services and any needed treatment, even if the program does not cover the diagnostic or treatment services for adults. EPSDT also includes vision, hearing, and dental services.

EPSDT is designed for children from low-income families, who are at higher risk for health problems and developmental delays. It is particularly valuable to children with special health care needs, children with disabilities, and children in foster care, because it ensures that they receive the diagnostic and treatment services they need. It is also important to children who are basically healthy, because it ensures that they have coverage for routine preventive care and for diagnostic and treatment services identified during regular check-ups. These services include eye exams and, if necessary, eyeglasses; dental exams and needed dental services; and hearing screens and services. Routine developmental screenings are especially

important for young children; these screens identify possible delays that trigger further evaluations and, if appropriate, lead to referrals for early intervention or other services to address the delays.

Whether EPSDT achieves its promise depends in large measure on how effectively the state Medicaid agency—or, in managed care states, the MCO—implements the benefit. How well the MCO implements the benefit depends in part on how well the contract between the state Medicaid agency and the MCO is drafted.²² The Center for Medicaid and CHIP Services (CMCS) collects information from states on form CMS-416, Annual EPSDT Participation Report, to assess how effectively they are implementing EPSDT.²³ CMCS posts national and state-specific data annually; the most recent are for FY 2016. The CMS-416 aggregates data for all eligible children, not just those in MCOs, and it does not break out data specific to individual MCOs.

The CMS-416 is the source of two key metrics for EPSDT implementation: the participant ratio (total eligible children receiving at least one initial or periodic screen/total eligible who should receive at least one initial or periodic screen); and the screening ratio (total screens received/expected number of screenings). These ratios are reported by age group (<1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20). In addition, the form allows CMCS and the states to manually calculate utilization ratios for a range of dental services.²⁴

There are significant limits to the CMS-416 and the performance metrics derived from it.²⁵ For example, the screening ratio does not tell whether a given child is receiving one screen per year or several, or whether children are receiving the right screenings at the right time.²⁶ Nor can the data enable tracking of the provision of different types of screens (e.g., developmental, vision, hearing or others identified within each state's periodicity schedule to address multiple aspects of a child's development).²⁷ In addition, the CMS-416 does not enable us to tell whether children are in fact accessing the follow-up services that may be needed as a result of a screen or evaluation—key to EPSDT's benefit guarantee for children.²⁸



What data are needed to know whether children enrolled in a Medicaid MCO are receiving quality care?

There is currently no single set of measures in use by CMS and state Medicaid agencies to assess whether children enrolled in MCOs are receiving quality care. This is unfortunate. As Tricia Brooks of the Center for Children and Families has observed

“Importantly, as Medicaid increasingly turns to private managed care as the primary delivery system, measuring quality is a critical check on plan performance in providing required services and benefits. Collecting and reporting data is not enough; data must be analyzed, compared, and trended over time to identify opportunities for improvement, to measure progress on quality improvement (QI) initiatives, and to meet specific performance targets.”²⁹

It would be helpful if state Medicaid agencies and CMS were all on the same page, using a common set of measures that would enable comparisons of MCO performance vis-à-vis-children and other enrolled populations across all states, not just within states. Some progress in this direction has taken place in recent years, but we are not yet at full alignment.

At the direction of Congress, CMS has developed a Child Core Set of Health Care Quality Measures, a set of standardized evidence-based measures.³⁰ CMS reviews and updates the Core Set annually.³¹ The 2018 version includes 26 measures organized into six buckets—1) primary care access and preventive care, 2) maternal and perinatal health, 3) care of acute and chronic conditions, 4) behavioral health care, 5) dental and oral health services, and 6) experience of care.³² State reporting of these measures is voluntary, and not all states report on all measures.³³ (State reporting will become mandatory with the annual report for FY 2024).³⁴ Moreover, the reported data are state-level only and do not describe which measures were reported by which MCOs, much less allow a head-to-head comparison of the performance of individual MCOs.

Different state Medicaid agencies use different measures in assessing the quality of care received by children enrolled in MCOs. Consider the two states with the most

children enrolled in Medicaid MCOs, California and New York.³⁵ California’s Department of Health Care Services posts a Medi-Cal Children’s Health Dashboard which sets forth the statewide average performance rates across all plans for 10 different performance measures³⁶ and links to the External Quality Review Organization (EQRO) report that provides the performance rates for each of the 10 measures for each MCO.³⁷ The New York State Department of Health posts a head-to-head comparison of the performance of each of its contracting MCOs (15 in 2017) that includes 18 separate measures of child and adolescent health quality.³⁸ Like California, New York also posts EQRO reports on the performance of each MCO that includes quality measures.³⁹

Both states present the nationally developed Healthcare Effectiveness Data and Information Set (HEDIS) measures⁴⁰ in comparing MCO performance; while there is some overlap, the measures are not identical.⁴¹ Neither state uses all of the 16 CMS Child Core Set measures in the domains of Primary Care Access and Preventive Care, Care of Acute and Chronic Conditions, and Behavioral Health Care.⁴² California, New York, and the CMS Child Core Set overlap on just five measures.⁴³

To understand why there is no single set of child health quality measures in common use, one need only look at the recent report prepared by the North Carolina Institute of Medicine for the state’s Medicaid agency.⁴⁴ The Institute was asked to develop a set of quality metrics to be used as the state moves to Medicaid managed care. The measures were to simultaneously address four policy goals (the Quadruple Aim): improving population health, enhancing patient experience, lowering health care costs, and improving the experience and work life of health care providers.

In the course of identifying the measures, an interdisciplinary Task Force under the auspices of the Institute “considered measures across a broad spectrum of health care, care settings, and populations, including but not limited to public



health, population health, whole-person health (integration of mental, physical, and oral health), pediatrics, oral health, key high-cost high-risk subpopulations, mothers and infants, those with chronic illnesses and foster children,” as well as “areas of health disparities, including racial and ethnic disparities and disparities between rural and urban areas.”

The result was a set of 30 measures organized into five broad areas: Improving Population Health; Preventive Care; Care of Acute and Chronic Conditions; Patient Experience of Care; Cost and Utilization; and Workforce Wellbeing. Of these measures, 10 overlap with the CMS Child Core Set.⁴⁵

Some of the recommended measures (Screening for Depression, Asthma Medication, Hospitalization Follow-Up) apply to both children and adults: “because of the large proportion of North Carolina’s Medicaid population who are children (approximately 50 percent), the Task Force sought to identify cross-cutting measures that would be applicable to both pediatric and adult beneficiaries.”⁴⁶

What quality data do federal Medicaid regulations require?

In May 2016, CMS published a comprehensive overhaul of the Medicaid regulations governing state contracting with MCOs.⁴⁷ Among many other things, this managed care rule upgrades the quality measurement and improvement requirements for MCOs and state agencies and increases the transparency of information about MCO financial and quality performance. Most of the new requirements were to be phased in over a three-year period starting July 2016.⁴⁸

In June 2017, however, CMS announced that it “intends to use our enforcement discretion to focus on working with states to achieve compliance with the managed care regulations when states are unable to implement new and potentially burdensome requirements of the final rule by the required compliance date, particularly provisions with a compliance deadline of contracts beginning on or after July 1, 2017.”⁴⁹ And in a major policy address to the National Association of Medicaid Directors in November 2017, CMS Administrator Seema Verma promised to “rollback burdensome regulations that the federal government has imposed on states,” specifically citing the managed care rule.⁵⁰ Thus, most of the compliance dates for the current managed care rule are negotiable with CMS, and the rule itself will be “rolled back.”

That being said, the managed care rule is, at least as of this writing, still in effect. Unlike the rules relating to the provision of EPSDT services described above, the managed care rule does not require that MCOs meet federally-specified minimum levels of quality for children or any other beneficiary population. Instead, the rule requires that state Medicaid agencies identify quality measures, require contracting MCOs to report on those quality measures, and make the results public so that the performance of individual MCOs can be compared. The rule also continues the previous requirement that state Medicaid agencies arrange for an annual independent review of each MCO’s performance by an External Quality Review Organization (EQRO).⁵¹

More specifically, under the rule, state Medicaid agencies must identify standard performance measures and require contracting MCOs, on an annual basis, to report on their performance using these measures.⁵² The rule contemplates that CMS “may” specify performance measures that all state Medicaid agencies would have to include in the measures they use; to date, CMS has not issued any such specifications. This provision of the rule was effective for contract rating periods beginning on or after July 1, 2017, subject to the CMS “enforcement discretion” described above.



The rule also requires that state Medicaid agencies engage EQROs to assess, on an annual basis, the accessibility and quality of care received by beneficiaries enrolled in each MCO with which the state contracts.⁵³ (There is at state option an exemption for MCOs that also have geographically overlapping contracts with Medicare Part C).⁵⁴ In conducting the reviews, the EQROs are to use protocols developed by CMS.⁵⁵ (The federal government pays 75 percent of the cost of these reviews.⁵⁶) Protocol 2 requires that EQROs assess the accuracy of the performance measures reported by the MCO.⁵⁷ The results of the review must be included in an annual detailed technical report that, among other things, sets forth “methodologically appropriate, comparative information” about all MCOs with which the state contracts.⁵⁸ The most recent report must be posted on the state Medicaid agency’s website by April 30 of each year.⁵⁹ The implementation date for these requirements is July 1, 2018, subject to CMS “enforcement discretion.”⁶⁰

There are other provisions in the managed care rule relating to quality which, while not specific to children, could promote transparency about the performance of individual MCOs. The two most notable are requirements

that states develop and implement a managed care quality strategy⁶¹ and that they implement a quality rating system (QRS) developed by CMS or adopt an alternative approved by CMS.⁶² The state quality strategy, which must be posted on the state’s website, should include the metrics and performance targets the state uses to measure the performance of each MCO with which it contracts.⁶³ Under the rating system, states would, on an annual basis, collect data and issue a quality rating for each MCO with which they contract; the quality rating would be “prominently” displayed on the agency’s website.⁶⁴

The compliance date for the state quality strategy is July 1, 2018, subject to CMS enforcement discretion.⁶⁵ The compliance date for the QRS is no later than three years from the date of a final notice published in the Federal Register.⁶⁶ As of this writing, CMS has not published a final notice. Given the uncertainties associated with implementation of many of the managed care rule’s quality requirements, this paper focuses on the MCO-specific performance measures and transparency requirements that are currently in place.

What MCO-specific data about the quality of care for children are publicly available?

National Data Sources

There are two publicly accessible sources of MCO-specific data at the national level.⁶⁷ One is a report on Medicaid managed care enrollment and program characteristics posted by the Center for Medicaid and CHIP Services (CMCS) on its Medicaid.gov website. The other is the Medicaid Managed Care Market Tracker maintained by the Kaiser Family Foundation. Neither data source provides information about the performance of individual Medicaid MCOs specific to the accessibility and quality of services for enrolled children or any other population of enrollees.⁶⁸

The CMCS report identifies each MCO in a state, the geographic region served by that MCO, the MCO’s Medicaid-only enrollment, and the MCO’s dual-eligible enrollment (see Table 5). The report does not break down the number of Medicaid enrollees in each MCO by age, and it does not provide quality indicators with respect to children or any other enrollee population for individual MCOs. The most recent report presents data from 2015.⁶⁹ CMCS also collects and posts managed care enrollment data for children in the CMS-416 Annual



EPSDT Participation Report, but the data are not specific to MCOs.⁷⁰ Finally, CMCS collects the annual EQRO technical report from each managed care state; the state-specific (but not MCO) results were included in the CMCS 2015 Child Quality Report.⁷¹

More recent data from March 2017, are available from the Kaiser Family Foundation (KFF's) Medicaid Managed Care Market Tracker. A total of 275 Medicaid MCOs contracted with state Medicaid agencies in 38 states and the District of Columbia; 12 states did not contract with Medicaid MCOs.⁷² For each state with MCO contracts, the Market Tracker provides the names of each of the MCOs participating, as well as each MCO's total Medicaid enrollment. The Market Tracker also provides MCO-specific NCQA quality ratings (2016-2017) and identifies parent firms, which operate plans in more than one state (September 2016).⁷³ KFF updates the Market Tracker every fall in conjunction with its Annual 50-State Medicaid Budget Survey with the National Association of Medicaid Directors (NAMDD).

The Medicaid and CHIP Payment and Access Commission (MACPAC) publishes state-level data on the percentage of Medicaid enrollees in managed care by state and by eligibility group.⁷⁴ Although plan-specific data are available in CMS public use files, there are questions about the reliability of these data, and they are not published by MACPAC.⁷⁵

State Data Sources

In the absence of a national data source on MCO-specific performance on the quality of care for children, advocates and other stakeholders must turn to state Medicaid agency and MCO websites.

State Medicaid agency websites vary considerably in the scope and type of MCO-specific information available. As the California and New York examples above make clear, however, some states post their EQRO Annual Technical Reports, and those reports provide MCO-specific results on quality performance measures relating to enrolled children as well as other beneficiary populations. A CMS

analysis of New York and five other high performing states (Connecticut, Maryland, Massachusetts, Michigan and Rhode Island) found that all of them use public reporting on health plan performance “to provide information to consumers and promote improvement among health plans.”⁷⁶

A survey of state Medicaid agency websites was beyond the scope of this paper. It is unclear how many states currently post EQRO Annual Technical Reports or how many of those states, like New York, use the MCO-specific results to present a head-to-head comparison of results from all contracting MCOs. Unless the compliance date for the federal Medicaid rule is postponed or the requirement is eliminated altogether, all state Medicaid agencies contracting with MCOs will at a minimum post these annual technical reports on their websites by July 1, 2018. (The contents of the reports will continue to vary depending on state specifications).

These reports are just one of the items of information subject to transparency requirements in the managed care rule. The others relevant to individual MCO performance are set forth in Table 1.⁷⁷ They include the MCO's contract with the state, which sets forth its specific obligations, including those relating to EPSDT and reporting of quality measures; the names and titles of the MCO's officers and directors, who are accountable for the MCO's performance under the contract; the MCO's accreditation status; and the MCO's provider network and documentation of its adequacy.

As shown in Appendix A, the implementation dates for these transparency requirements vary from July 1, 2017 to July 1, 2018. And, as noted above, CMS will use its “enforcement discretion” to allow states to develop their own implementation dates and is reconsidering the managed care rule in its entirety. Despite this regulatory uncertainty, the transparency requirements in the current managed care rule, if implemented, will make more MCO-specific performance data available to the public on the website of each state Medicaid agency than was available prior to the rule.



Table 1: Medicaid MCO Performance Data

| Type of Information | Description | State Medicaid Agency Website Posting Required | Alternate Source of Information if not on State Medicaid Agency website |
|--|---|--|---|
| Contracting MCO(s) and Parent Firm | Name of each MCO contracting with the state Medicaid agency | No | KFF Market Tracker* |
| Accountable Individuals | Officers and directors of MCO | Yes per 42 CFR 438.602(g)(3) | MCO's website? |
| Contract with State Medicaid Agency | Text of contract setting forth MCO obligations | Yes per 42 CFR 438.602(g)(1) | State Public Records Act? State Public Contracts website (RFPs)? |
| Current Enrollment Data | Number of children enrolled, broken down by age | No | KFF Market Tracker* |
| Capitation Payments | Total amounts paid to each plan for enrolled children | No | State Public Records Act? |
| Accreditation status | Whether MCO has been accredited by a private accrediting agency | Yes per 42 CFR 438.332(c) | KFF Market Tracker* |
| Current Encounter Data | Information relating to the provision of a covered service to an enrolled child, including the rendering provider, date of service, and type of service | No | Medicaid.gov website if Transformed Medicaid Statistical Information System (T-MSIS) data is made publicly accessible |
| Provider Network Composition | Providers contracting with MCO to furnish services to enrolled children | Yes per 42 CFR 438.10(c) (3), (h) | MCO's website |
| Documentation of Provider Network Adequacy | Documentation on which State Medicaid agency bases its determination that the MCO's provider network is adequate | Yes per 42 CFR 438.602(g)(2) | State Public Records Act? |
| EQRO Annual Technical Report | Annual detailed technical report prepared by External Quality Review Organization that assesses the quality, timeliness, and access to health care services furnished by each MCO to Medicaid beneficiaries | Yes per 42 CFR 438.364(c)(2) | State Public Records Act? |
| HEDIS Performance Measures (MCO-reported results)(not all states use HEDIS measures) | A set of standardized clinical health measures the allow MCO-to-MCO comparisons on access to care, including well-child visits and immunizations | No | EQRO Annual Technical Report, above; NCQA Quality Compass (for customers only) |
| CAHPS Surveys (MCO-specific results) | Annual surveys of that measure enrollees' experience of care with Medicaid providers and MCOs | No | EQRO Annual Technical Report, above; NCQA Quality Compass (for customers only) |
| EPSDT Compliance Data | Data that the state Medicaid agency is required to report to HHS on Form CMS-416 to document compliance with EPSDT requirements | No | State Public Records Act? |



Table 1: Medicaid MCO Performance Data (con'd)

| Type of Information | Description | State Medicaid Agency Website Posting Required | Alternate Source of Information if not on State Medicaid Agency website |
|-------------------------------------|---|--|---|
| Annual Managed Care Program Report | Report from state Medicaid agency to CMS that, among other things, assesses the financial performance and encounter data reporting by each MCO as well as the availability and accessibility of covered services within MCO contracts | Yes per 42 CFR 438.66(e)(3) | State Public Records Act? CMS? Freedom of Information Act? |
| Managed Care State Quality Strategy | State Medicaid agency's strategy for assessing and improving the quality of services furnished by an MCO, including quality metrics and performance targets | Yes per 42 CFR 438.340(d) | State Public Records Act? CMS? Freedom of Information Act? |
| Quality Rating System | State Medicaid agency's system for rating each MCO annually on the quality of care | Yes, per 42 CFR 438.334(e) | State Public Records Act? |
| State Fair Hearing Decisions | Outcome of a beneficiary appeal of a denial of a service by an MCO | Yes, per 42 CFR 431.244(g) | |

* See Appendix A for discussion of implementation dates for each requirement.

These required data, while considerably more robust than those provided prior to the managed care rule, do not include some basic information relating to the performance of individual MCOs in arranging needed services for enrolled children. Among the missing data are:

- the number of children enrolled, broken down by age and disability status;
- data documenting the provision of EPSDT services, such as whether required screenings are being done on a timely basis and whether necessary follow-up diagnostic and treatment services are being delivered; and
- the Child Core Set data.

There is, of course, no provision in the managed care rule that would prohibit a state Medicaid agency from posting these and other non-required data that would enable the public to assess the performance of individual MCOs in serving children and other beneficiary populations.



Assessing Performance Measures

The 2016 Annual Technical Report submitted to the District of Columbia Medicaid agency by its EQRO, the Delmarva Foundation, provides a wealth of information about the HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and EPSDT performance of each of the District's four participating MCOs.⁷⁸ The entire report is posted on the state agency's website.⁷⁹ It offers one model for child health advocates and providers to begin to understand the quality of care received by children enrolled in individual MCOs.

- Appendix 1 lists the HEDIS performance measures for each MCO for measurement year 2015, including childhood immunizations by type of vaccine, medication management for children with asthma, and weight assessment and counseling for nutrition and physical activity for children/adolescents. For each measure, the appendix compares the weighted average rating for the District's MCOs to the national Medicaid HMO benchmarks.
- Appendix 2 includes the Child CAHPS measures for each MCO from the 2016 CAHPS survey, including measures from the supplemental dental questions.⁸⁰ As in the case of the HEDIS measures, this appendix compares the weighted average for the District's contracting MCOs with the national Medicaid HMO benchmarks.
- Appendix 3 is the validation of 2016 EPSDT performance measure results conducted by the EQRO. The purpose of the validation is to ensure that the performance measure rates reported by each individual MCO are accurate and reliable. As noted by the report, "[t]he accuracy and reliability of the reported rates is essential to ascertaining whether the MCO's quality improvement efforts have resulted in improved health outcomes."⁸¹ The appendix presents the results for each plan of the EQRO's review of a sample of medical records for initial or periodic screens for each MCO. It also presents, for each MCO, the screening ratio (screenings received/expected screenings), the participant ratio (children receiving at least one initial or periodic screen/total children who should receive one initial or periodic screen), and the preventive dental services ratio (total children receiving preventive dental service from a dentist/total children who should receive one initial or periodic screen).

Taken together, these data enable the state Medicaid agency to compare the performance of each of its contracting MCOs against the other and to address any performance issues identified. They also enable the individual MCOs to compare their own performance with that of their competitors in, and potential entrants into, the DC Medicaid program. The D.C. City Council, in its oversight capacity, can use the data to hold the MCOs and the state Medicaid agency accountable. And advocates can use the data to work with individual MCOs, as well as the state Medicaid agency, to improve the accessibility and quality of care for enrolled children.



Discussion and Next Steps

Here, in brief, is the state of play. There is no single, common set of metrics in use by state Medicaid agencies and CMS for measuring quality of care for children enrolled in Medicaid MCOs. There is no publicly accessible, national source of data on the performance of individual MCOs with respect to EPSDT or quality of care for children. There are federal requirements relating to the transparency of data that would allow comparison of individual MCO performance at the state level, but those requirements are being reconsidered by CMS at the same time as they are being phased in. In short, much remains to be done in an uncertain regulatory environment.

There are three basic questions for child health advocates. First, what are the right measures for MCO performance on quality of care for children? Second, how do we persuade state Medicaid agencies to require MCOs to report on those measures, validate the data, and post the results? Finally, how can advocates use the posted results to improve MCO performance? These questions are far more easily asked than answered, but here are some initial thoughts to start the conversation.

The question of measuring performance is not a simple one (see the North Carolina Institute of Medicine report above). At a minimum, the relationship between metrics of EPSDT compliance and quality measures like HEDIS needs to be clarified. How can one best inform the other? For example, the 2018 Child Core Set includes HEDIS measures on childhood immunization status, well-child visits, and developmental screening in the first three years of life. Can performance on these measures inform the judgment about an MCO's compliance with EPSDT screening requirements as measured by its reporting for CMS-416 purposes?⁸² The 2018 Child Core Set also includes measures on medication management for children with asthma, follow-up care for children prescribed medication for attention deficit/hyperactivity disorder, and use of multiple current antipsychotics. Can performance on these measures give us insight into an MCO's compliance with EPSDT requirements for treatment?

The predicate for transparency is performance data, and the predicate for performance data is the state Medicaid agency. In seven years, all states will be reporting Child Core Set data, which in managed care states will necessarily require all MCOs to report on these measures so that the state has something to report to CMS. Until then, each state agency will determine what measures it requires its MCOs to report and what results it requires its EQRO to validate and report on. (By July 2018 all managed care states will have to post their EQRO Technical Reports). One model for the use of the EQRO Annual Technical Report is in the District of Columbia, where the EQRO report sets forth MCO-specific results on EPSDT and HEDIS measures and is posted on the state agency's website (see textbox).

If MCO-specific results on EPSDT and HEDIS performance measures are posted, how can advocates best deploy them? Advocates in Illinois report some success in using these data to directly engage MCOs: "MCOs are more open to directing effort and funds to EPSDT measures when we are able to show them concrete quality measures against the benefit mandates. Often they are convinced they are meeting the mandate, but the data are essential in advocates showing MCOs how they can improve and best practices."⁸³

Performance results may also be of interest to state legislators, who as part of their oversight responsibilities, may wish to hold both the state Medicaid agency and individual MCOs accountable if the results indicate poor performance. Finally, the state or local press may be interested in how effectively taxpayer funds are being spent on behalf of children.



Conclusion

In all but 12 states, MCOs largely determine whether low-income children covered by Medicaid have access to the high-quality services they need and to which they are entitled. State Medicaid agencies make capitation payments to MCOs to manage care for this population, shifting some financial risk to MCOs and creating an incentive to limit services. Given the millions of children enrolled in MCOs and the billions that the federal government and the states are paying MCOs on their behalf, it is essential that timely, accurate data on the quality of care provided by individual MCOs be transparent to all stakeholders, including child health advocates and child health providers.

The transparency of MCO-specific quality data could drive important program improvements for children, as well as other beneficiary populations. It would allow providers and beneficiaries to compare individual MCOs in a state against each other. Providers could use this information to decide whether they want to be associated with an MCO furnishing substandard care; parents could decide whether they want to enroll their children in poorly performing plans. And the public and its elected representatives could judge whether state Medicaid agencies were effectively running their programs by, say, contracting only with MCOs meeting high quality standards for children and rewarding MCOs for meeting quality targets with bonus payments.⁸⁴

Transparency would also end the current asymmetry of information enjoyed by national managed care firms, which can compare the performance of their subsidiaries in different state markets, while state purchasers, providers, beneficiaries and even the federal government cannot.⁸⁵ Having the ability to compare the quality of care provided by the subsidiaries of one national company with those of another would create additional opportunities

to motivate both parent and affiliate managements to improve their performance. The accountability of national plans and their state subsidiaries will become increasingly important if consolidation in the Medicaid managed care market (the acquisition of smaller plans by larger plans) continues.⁸⁶

Transparency has its limits as a tool for improving MCO quality for children (or any subpopulation, such as children with special health care needs). Transparency is only as good as the data that are being made transparent. If the state Medicaid agency does not require the MCO to collect the right EPSDT and quality performance measures, or if the MCO does not report the right measures, or if the data reported are of poor quality or not independently validated, it will be difficult for state policymakers, much less Medicaid beneficiaries and the public at large, to draw useful inferences about the quality of care available from individual MCOs. Resources available to state agencies almost never adequate to all of their responsibilities, and the collection and reporting of quality data is a resource-intensive activity.⁸⁷

Addressing these challenges will not be helped by the CMS Administrator's intention to "rollback" her agency's managed care rule in midstream. If the "rollback" occurs, and if its effect is to weaken or even eliminate the rule's transparency requirements relating to quality, CMS would become a much less effective steward of taxpayer dollars and beneficiary health. State Medicaid agencies, despite competing demands, would have to step up to protect their beneficiaries from poor quality MCOs with an effective quality strategy. As the managed care rule recognizes, to be successful, any such strategy will require transparency around individual MCO performance.



Appendix A: Implementation Dates of Federal Transparency Requirements

This table reflects the *Implementation Dates for the Medicaid and CHIP Managed Care Final Rule* issued by the Centers for Medicare & Medicaid Services (CMS) on April 25, 2016. On June 30, 2017, the Centers for Medicaid and CHIP Services (CMCS) issued an *Informational Bulletin* announcing that the agency would be using its “enforcement discretion” to allow states to develop “a timeline for future compliance with the regulatory provision” or provisions that they are unable to implement by the required compliance date.” CMCS considers each of the regulatory requirements listed below to be within its “enforcement discretion.”

Implementation Dates for the Medicaid and CHIP Managed Care Final Rule

| Requirement | Citation (42 CFR Part 438) | Rating Period for contracts starting on or after July 1, 2017 | Other Implementation Date |
|---|----------------------------|---|---|
| State Medicaid agency website | 438.10(c)(3) | X | |
| Network Provider Information | 438.10(c)(3) | X | |
| Annual Managed Care Program Report | 438.66(e)(3) | | Rating period for contracts that start after the release of CMS guidance* |
| Accreditation Status | 438.332(c)(1) | X | |
| Quality Rating System | 438.334(e) | | No later than 3 years from the date of a final notice published in the Federal Register** |
| External Quality Review (EQR) Technical Report | 438.364(c)(2)(i) | | No later than July 1, 2018 |
| State Medicaid Agency contract with MCO | 438.602(g)(1) | X | |
| Documentation of Provider Network Adequacy | 438.602(g)(2) | X | |
| Individuals with Ownership or Control | 438.602(g)(3) | X | |
| Results of audits of financial and encounter data | 438.602(g)(4) | X | |
| Managed Care State Quality Strategy | 438.340(d) | | No later than July 1, 2018 |
| State Fair Hearing decisions | 431.244(g) | | July 5, 2016 |

Note: A “rating period” is the 12-month period for which capitation rates are developed under a managed care contract.

* As of February 26, 2018, CMS had not released guidance

** As of February 26, 2018, CMS had not published notice



Endnotes

¹ Source for 40 percent: “Public Health Insurance Coverage by Type 2016: American Community Survey 1-Year Estimates,” U.S. Census Bureau’s 2016 American Community Survey, available at https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S2704&prodType=table; source for 37 million, “Unduplicated Number of Children Ever Enrolled, FY 2016,” Center for Medicaid and CHIP Services, available at <https://www.medicaid.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf> (37 million).

² MACSTATS, “Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, Updated FY 2013, 2014” (Washington: Medicaid and CHIP Access and Payment Commission, December 2017), available at <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-30.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2013-FY-2014.pdf>.

³ Total Medicaid enrollment in MCOs increased by 17.5 percent between 2014 and 2015. Given this trend, it is likely that the share and number of children enrolled in MCOs is currently higher than it was in FY 2013, as reflected in the MACStats data cited above. Centers for Medicare and Medicaid Services, “Medicaid Managed Care Enrollment and Program Characteristics, 2014” (Washington: Centers for Medicare and Medicaid Services, 2016), available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicicaid-managed-care-enrollment-report.pdf>.

⁴ The 12 states without MCOs were AL, AK, AR, CT, ID, ME, MT, NC, OK, SD, VT, and WY. Kaiser Family Foundation, “Total Medicaid MCOs” (Washington: Kaiser Family Foundation, September 2017), available at <https://www.kff.org/medicaid/state-indicator/total-medicicaid-mcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁵ The Congressional Budget Office estimates the federal government will spend \$174 billion on managed care in FY 2018 and that this amount will represent between 63 percent and 65 percent of total Medicaid spending, which implies a state expenditure of \$102 billion. Congressional Budget Office, “Detail of Spending and Enrollment for Medicaid for CBO’s January 2017 Baseline” (Washington: Congressional Budget Office), available at <https://www.cbo.gov/sites/default/files/recurringdata/51301-2017-01-medicicaid.pdf>.

⁶ The federal government is at risk because it matches the capitation payments that the state Medicaid agency makes to an MCO under an approved risk contract at the matching rate applicable to the population enrolled.

⁷ An MCO can also transfer some of its financial risk “downstream” to groups of providers by entering into subcapitation arrangements with those groups.

⁸ Chad Terhune and A. Gorman, “Enriched by the Poor: California Health Insurers Make Billions Through Medicaid,” *Kaiser Health News*, November 6, 2017, available at <https://khn.org/news/enriched-by-the-poor-california-health-insurers-make-billions-through-medicicaid/>.

⁹ Chad Terhune, “Couple Makes Millions Off of Medicaid Managed Care as Oversight Lags,” *Kaiser Health News*, February 22, 2018, available at <https://khn.org/news/couple-makes-millions-off-medicicaid-managed-care-as-oversight-lags/>. Texas State Auditor’s Office, “The Health and Human Services Commission’s Management of Its Medicaid Managed Care Contract with Superior HealthPlan, Inc. and Superior HealthPlan Network, and Superior’s Compliance with Reporting Requirements” (January 2018), Report No. 18-015,

finding that the State Medicaid agency allowed an MCO to report approximately \$29.6 million in bonus and incentive payments paid to affiliates’ employees even though the payments were unallowable under State’s contract with the MCO. See <http://www.sao.texas.gov/reports/main/18-015.pdf>.

¹⁰ Jason Clayworth, “Skepticism Over Iowa’s Medicaid Math Led AmeriHealth to Pull Out,” *Des Moines Register*, November 2, 2017, available at <https://www.desmoinesregister.com/story/news/investigations/2017/11/02/skepticism-over-iowas-medicicaid-math-led-amerihealth-pull-out/819515001/>.

¹¹ Chad Terhune, “Whistleblower: Medicaid Managed-Care Firm Improperly Denied Care to Thousands,” *Kaiser Health News*, (December 1, 2017), available at <https://khn.org/news/whistleblower-medicicaid-managed-care-firm-improperly-denied-care-to-thousands/>.

¹² A. B. Bindman et al., “The Impact of Medicaid Managed Care on Hospitalizations for Ambulatory Care Sensitive Conditions,” *Health Services Research* 40:1 (February 2005), pp. 19-38.

¹³ NORC at the University of Chicago, “Innovative Approaches in Care Coordination and Care Delivery for Children with Special Health Care Needs among Safety Net Health Plans,” (Washington: Association of Community-Affiliated Plans, February, 2017), available at <http://www.communityplans.net/wp-content/uploads/2017/01/Innovative-Approaches-in-Care-Coordination>.

¹⁴ For analyses for these regulations from the perspective of children, see Georgetown University Center for Children and Families, “Medicaid/CHIP Managed Care Series” (Washington: Georgetown University Center for Children and Families, June 22, 2016), available at <https://ccf.georgetown.edu/2016/06/22/medicaidchip-managed-care-series/>.

¹⁵ 42 CFR 438.3

¹⁶ 42 CFR 438.66

¹⁷ Medicaid and CHIP Payment and Access Commission, “Managed care’s effect on outcomes” (Washington: Medicaid and CHIP Payment and Access Commission, June 2017), available at www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/.

¹⁸ Centers for Medicare and Medicaid Services, “EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents” (Washington: Centers for Medicare and Medicaid Services, June 2014), available at https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.

¹⁹ Some states impose cost-sharing on children in families with incomes above 133 percent of the Federal Poverty Level. See T. Brooks et. al, “Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2017: Findings from a 50-State Survey” (Washington: Georgetown University Center for Children and Families and the Kaiser Family Foundation, January 2017), available at <https://ccf.georgetown.edu/wp-content/uploads/2017/01/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017-1.pdf>, p. 16.

²⁰ Centers for Medicare and CHIP Services, “The EPSDT benefit for children and youth in managed care,” *Informational Bulletin* (January 5, 2017), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib010517.pdf>.

²¹ T. Brooks and K. Whitener, “At Risk: Medicaid’s Child-Focused Benefit Structure Known as EPSDT,” (Washington: Georgetown University Center for Children and Families, June 2017), available at <https://ccf.georgetown.edu/wp-content/uploads/2017/06/EPSDT-At-Risk-Final.pdf>.



²² K. Whitener, “Three Ways to Ensure that EPSDT Works in Medicaid Managed Care,” (Washington: Georgetown University Center for Children and Families, January 9, 2017), available at <https://ccf.georgetown.edu/2017/01/09/three-ways-to-ensure-epsdt-works-in-managed-care>.

²³ Centers for Medicaid and CHIP Services, “Annual EPSDT Reporting Using the Form 416,” available at <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>.

²⁴ For example, Total Eligibles Receiving Preventive Dental Services (line 12b) can be divided by Total Individuals Eligible for EPSDT for 90 Continuous Days (line 1b).

²⁵ K. Whitener, “Using Data to Document and Improve EPSDT Participation,” (Washington: Georgetown Center for Children and Families, June 30, 2016), available at <https://ccf.georgetown.edu/2016/06/30/using-data-document-improve-epsdt-participation>.

²⁶ States determine their own schedules for screens in Medicaid. While most state Medicaid programs generally follow the American Academy of Pediatrics Bright Futures schedule for preventive care, details and reimbursement structures vary considerably. See American Academy of Pediatrics, “2015 Medicaid Reimbursement Reports,” (Elk Grove: American Academy of Pediatrics, 2015), available at https://www.aap.org/en-us/professional-resources/Research/Medicaid%20Reimbursement%20Reports/medicaid_reports_national_all.pdf. AAP Bright Future’s Preventive Care schedule is available at https://www.aap.org/en-us/documents/periodicity_schedule.pdf.

²⁷ E. Wright Burak and M. Odeh, “Developmental Screenings for Young Children in Medicaid” (Washington: Georgetown University Center for Children and Families, forthcoming).

²⁸ The exception to this is dental services. For example, the CMS-416 reports total eligibles receiving preventive dental services (line 12b), dental treatment services (12c), sealant on a permanent molar (12d), and dental diagnostic services (12e).

²⁹ T. Brooks, “Measuring and Improving Health Care Quality for Children in Medicaid and CHIP: A Primer for Child Health Stakeholders” (Washington: Georgetown University Center for Children and Families, March 2016), available at https://ccf.georgetown.edu/wp-content/uploads/2016/03/Measuring_Health_Quality_Medicaid_CHIP_Primer.pdf.

³⁰ Centers for Medicaid and CHIP Services, “Children’s Health Care Quality Measures,” available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html>.

³¹ Centers for Medicaid and CHIP Services, “2018 Updates to the Child and Adult Core Health Care Quality Measurement Sets” Informational Bulletin, (November 14, 2017), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf>.

³² Centers for Medicaid and CHIP Services, “2018 Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set)” (Washington: Centers for Medicaid and CHIP Services), available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf>.

³³ If at least 25 states report on a measure, CMS will post the results. Centers for Medicare and Medicaid Services, “Quality of Care for Children in Medicaid and CHIP: Findings from the 2015 Child Core Set Chart Pack” (Washington: Centers for Medicare and Medicaid Services, May 2017), available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2016-child-chart-pack.pdf>.

³⁴ Section 50102(b) of the Bipartisan Budget Act of 2018, P.L. 115-123.

³⁵ In FY 2014, about 3.4 million children in California and 2 million children in New York were enrolled in comprehensive managed care. Exhibits 14b and 30b of MACStats. Medicaid and CHIP Payment and Access Commission, “Medicaid and CHIP Data Book” (Washington: Medicaid and CHIP Payment and Access Commission, December 2017), available at <https://www.macpac.gov/publication/macstats-medicaid-and-chip-data-book-2/>.

³⁶ California Department of Health Care Services, “Medi-Cal Children’s Health Dashboard,” (see figure 5), Multi-Year Statewide Medi-Cal Managed Care Weighted Average Performance Measure results for Full-Scope Managed Care Health (California: California Department of Health Care Services, December 2017), available at <http://www.dhcs.ca.gov/services/Documents/December2017PediatricDashboard.pdf>. The Department also posts and updates on a quarterly basis a Medi-Cal Managed Care Performance Dashboard. The Dashboard provides a single score that reflects the performance of each of the 53 Medicaid plans on a set of HEDIS measures selected by the Department; neither the score nor the measures are specific to children and adolescents. California Department of Health Care Services, “Medi-Cal Managed Care Performance Dashboard” (California: California Department of Health Care Services), available at <http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx>.

³⁷ California Department of Health Care Services, “Medi-Cal Managed Care External Quality Review Technical Report July 1, 2015–June 30, 2016” (California: California Department of Health Care Services, April 2017), available at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/TechRpt/CA2015-16_Technical_Report_F1.pdf.

³⁸ New York State Department of Health, “2017 Health Plan Comparison Report: A Report Comparing Quality and Satisfaction Performance Results for Health Plans (QARR Report Series)” (New York: New York State Department of Health), Section 5, pp. 63-66, available at https://www.health.ny.gov/health_care/managed_care/reports/docs/health_comp_report/health_comp_report_2017.pdf.

³⁹ Plan-specific reports for 2015, compiled in April 2017, are posted at New York State Department of Health, Office of Quality and Patient Safety. For example “External Quality Review Technical Report for: HealthPlus, an AmeriGroup Company [AmeriGroup New York, LLC.], Reporting Year 2015” (New York: New York State Department of Health, April 2017), available at https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/amerigroup.pdf.

⁴⁰ Healthcare Effectiveness Data and Information Set (HEDIS) measures are developed by the National Committee for Quality Assurance (NCQA). They are used by many state Medicaid agencies to compare the performance of individual MCOs over time and well as against other MCOs. Background on HEDIS can be found at <http://www.ncqa.org/HEDISQualityMeasurement.aspx>.

⁴¹ Of the 18 measures used by New York, 5 are also used by California (Childhood Immunization Status—Combination 3; Immunization for Adolescents—Combination 1; Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile, Counseling for Nutrition, and Counseling for Physical Activity; and Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life).

⁴² The remaining 10 Core Set measures are in the domains of Maternal and Perinatal Health (7), Dental and Oral Health Services (2), and Experience of Care (1), which are removed from this comparison because state reporting is separate.



⁴³ The five overlapping measures are Childhood Immunization Status; Immunizations for Adolescents; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Children and Adolescents' Access to Primary Care Practitioners; and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents.

⁴⁴ North Carolina Institute of Medicine, “Metrics to Drive Improvements in Health: A Report of the Task Force on Health Care Analytics” (Morrisville: North Carolina Institute of Medicine, October 2017), available at <http://nciom.org/metrics-to-drive-improvements-in-health-a-report-of-the-task-force-on-health-care-analytics/>.

⁴⁵ The 10 overlapping with the Core Set are: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Ages 3-17); Chlamydia Screening in Women (Ages 16 – 24); Childhood Immunization Status; Immunizations for Adolescents; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well Care Visits; Screening for Clinical Depression and Follow Up Plan (Ages 12 and over); Medication Management for People with Asthma (Ages 5 to 64); and Follow Up After Hospitalization for Mental Illness (Ages 6 and older).

⁴⁶ North Carolina Institute of Medicine, p. 9.

⁴⁷ 81 Fed. Reg. 27498 (May 6, 2016), revising 42 CFR Part 438, available at <https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html>.

⁴⁸ Center for Medicaid and CHIP Services, “Medicaid and CHIP Managed Care Final Rule Implementation Dates (CMS-2390-F),” available at <https://www.medicaid.gov/medicaid/managed-care/downloads/implementation-dates.pdf>.

⁴⁹ “Center for Medicaid and CHIP Services Medicaid Managed Care Regulations with July 1, 2017 Compliance Dates,” *Informational Bulletin*, (June 30, 2017), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib063017.pdf>.

⁵⁰ Seema Verma, “Speech: Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference,” National Association of Medicaid Directors, November 7, 2016, available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-07.html>.

⁵¹ The requirement for an annual independent review was set forth in the prior managed care regulations at 42 CFR 438.310-438.370.

⁵² 42 CFR 438.330(c)

⁵³ 42 CFR 438.350

⁵⁴ 42 CFR 438.362. The exemption is at state option.

⁵⁵ 42 CFR 438.350(e)

⁵⁶ 42 CFR 438.370

⁵⁷ Department of Health and Human Services, “EQRO2 Validation of Performance Measures Reported by the MCO, Version 2.0” (Washington: Department of Health and Human Services, September 2012), available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf>

⁵⁸ 42 CFR 438.364(a)(5)

⁵⁹ 42 CFR 438.364(c)(2)

⁶⁰ See Centers for Medicare and Medicaid Services, “Medicaid and CHIP Managed Care Final Rule (CMS 2390-F): Implementation Dates” (Washington, Centers for Medicare and Medicaid Services, April 25, 2016), available at <https://www.medicaid.gov/medicaid/managed-care/downloads/implementation-dates.pdf>.

⁶¹ 42 CFR 438.340

⁶² 42 CFR 438.334

⁶³ 42 CFR 438.340(b)(3)(i)

⁶⁴ 42 CFR 438.334(e)

⁶⁵ Center for Medicaid and CHIP Services Medicaid and CHIP, “Managed Care Final Rule Implementation Dates (CMS-2390-F),” available at <https://www.medicaid.gov/medicaid/managed-care/downloads/implementation-dates.pdf>.

⁶⁶ 42 CFR 438.334(a)(3)

⁶⁷ The data published by the Medicaid and CHIP Payment and Access Commission (MACPAC) are specific to states but not to individual MCOs. See Medicaid and CHIP Payment and Access Commission, “Medicaid and CHIP Data Book” (Washington: Medicaid and CHIP Payment and Access Commission, December 2017), exhibits 29, 30a, and 30b, available at <https://www.macpac.gov/publication/macstats-medicaid-and-chip-data-book-2/>. Health Management Associates, a national research and consulting firm, tracks quarterly MCO enrollment data posted on state Medicaid agency websites. In many, but not all states, the data are MCO-specific. See A. Fairgrieve, “Medicaid Managed Care Enrollment Update – Q3 2017” (Washington: Health Management Associates, October 12, 2017), available at <https://www.healthmanagement.com/blog/medicaid-managed-care-enrollment-update-q3-2017/>.

⁶⁸ The National Committee for Quality Assurance (NCQA) offers a tool, the Quality Compass, that allows customers to compare the performance of those individual managed care plans that report HEDIS measures against competitors that report HEDIS data and against national, regional, and state benchmarks. The tool has data on three different product lines: commercial, Medicare, and Medicaid. See Quality Compass,” National Committee for Quality Assurance,” available at <http://www.ncqa.org/hedis-quality-measurement/quality-measurement-products/quality-compass>.

⁶⁹ Mathematica Policy Research, “Medicaid Managed Care Enrollment and Program Characteristics, 2015” (Washington: Centers for Medicare and Medicaid Services, 2016), available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf>.

⁷⁰ Line 13 of the CMS-416, “Total Eligibles Enrolled in Managed Care,” is the unduplicated number of individuals eligible for EPSDT for 90 continuous days enrolled in any type of managed care arrangement, whether medical or dental, at any time during the reporting year. In 2016, the national reported total was 36.7 million. CMS-416 Instructions, FY 2016 Data, posted at <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>.

⁷¹ Department of Health and Human Services, “2015 Annual Report on The Quality of Care for Children in Medicaid and CHIP,” Figure 4 (Washington: Department of Health and Human Services, February 2016), available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2015-child-sec-rept.pdf>.

⁷² The 12 states without MCOs were AL, AK, AR, CT, ID, ME, MT, NC, OK, SD, VT, and WY. See Kaiser Family Foundation “Total Medicaid MCOs” (Washington: Kaiser Family Foundation, September 2017), available at <https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁷³ Indicators across the Tracker have different time frames for posting, depending on the data source. See Kaiser Family Foundation, “Medicaid Managed Care Market Tracker” (Washington: Kaiser Family Foundation), available at <https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/>.



⁷⁴ Medicaid and CHIP Payment and Access Commission, “Program Enrollment and Spending: Medicaid Managed Care” (Washington: Medicaid and CHIP Payment and Access Commission), available at <https://www.macpac.gov/macstats/medicaid-managed-care/>.

⁷⁵ For a discussion of the limitations in the CMS data, see: Medicaid and CHIP Payment and Access Commission, Understanding Managed Care Enrollment and Spending Data in MACStats: Medicaid and CHIP Data Book (Washington: Medicaid and CHIP Payment and Access Commission, December 2017): pp. 152-153.

⁷⁶ Centers for Medicare and Medicaid Services, “The State of Children’s Health Care Quality in Medicaid and CHIP: State Strategies to Promote Reporting and Performance, Analytic Brief” (Washington: Centers for Medicare and Medicaid Services, March 2016), available at <https://www.medicare.gov/medicaid/quality-of-care/downloads/child-core-set-hps-strategies-brief.pdf>.

⁷⁷ The managed care rule requires other information, such as an enrollee handbook and provider directory, to be posted as well. See Centers for Medicare and Medicaid Services, “Information Required on a Public Website” (Washington: Centers for Medicare and Medicaid Services, August 16, 2016), available at <https://www.medicare.gov/medicaid/managed-care/downloads/information-required-on-public-website.pdf>.

⁷⁸ Three of the MCOs enroll children and adults: AmeriHealth Caritas, District of Columbia; MedStar Family Choice; and Trusted Health Plan. The fourth, Health Services for Children with Special Needs, enrolls only children.

⁷⁹ Delmarva Foundation, “Medicaid Managed Care Organizations 2016 Annual Technical Report” (Washington: Delmarva Foundation, April 2017), available at https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/2016%20DC%20ATR_FINAL_508c_0.pdf.

⁸⁰ CAHPS (Consumer Assessment of Healthcare Providers and Systems) beneficiary surveys are used by some state Medicaid agencies and managed care plans to measure performance and assess enrollee satisfaction with individual MCOs. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality. “CAHPS Surveys and Guidance,” Consumer Assessment of Healthcare Providers and Systems, available at <https://www.ahrq.gov/cahps/surveys-guidance/index.html>.

⁸¹ Delmarva Foundation, p. A3-1.

⁸² K. Whitener, “Using Data to Document and Improve EPSDT Participation,” (Washington: Georgetown University Center for Children and Families, June 2016), available at <https://ccf.georgetown.edu/2016/06/30/using-data-document-improve-epsdt-participation/>.

⁸³ Communication with Kaylan Szafranski, EverThrive Illinois, (February 13, 2018).

⁸⁴ K. Honsberger and C. Hanlon, “Tennessee: Using Managed Care Incentives to Improve Preventive Services and Care for Children” (Washington: National Academy for State Health Policy, January 2018), available at <https://nashp.org/wp-content/uploads/2018/01/Tennessee-Case-Study-2018.pdf>.

⁸⁵ In 2016, six national managed care companies controlled one third of all contracting MCOs—United Health (22), Anthem (18), Centene (17), Aetna (12), Molina (11), and WellCare (9). See Kaiser Family Foundation, “Medicaid Managed Care Market Tracker, Parent Firm-Level Data,” available at <https://www.kff.org/other/state-indicator/medicaid-mco-parent-firm-activity-by-state-and-insurance-market/?currentTimeframe=0>.

⁸⁶ Ari Gottlieb, “The Complicated State of Medicaid in the United States: Stability amidst considerable future uncertainty,” (PwC, October 2017), p. 9, available at <https://www.pwc.com/us/en/health-industries/health-services/assets/the-complicated-state-of-medicaid.pdf>.

⁸⁷ The National Academy for State Health Policy, “State Strategies for Medicaid Quality Improvement for Children and Youth with Special Health Care Needs (Washington: The National Academy for State Health Policy, November 2017),” p. 4, available at <https://nashp.org/wp-content/uploads/2017/11/MQM.pdf>.

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