Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit

June 2021

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Appendices

This toolkit includes the following three appendices. Use the clickable blue "Go now!" buttons to navigate to the appendices.

I. Introduction

Together, Medicaid and the Children's Health Insurance Program (CHIP) cover more than 80 million children and adults,[1] representing about 1 in 4 people in the United States and covering 42 percent of births.[2] About 70 percent of adults and children in Medicaid and CHIP are enrolled in a comprehensive managed care plan, although the rate of managed care enrollment varies widely across states.[3]

Acronyms and Glossary

See **Appendix A** for a list of acronyms used in the Quality Strategy Toolkit. See **Appendix B** for a glossary of terms.

Under regulations at 42 CFR 438.340(a) and 42 CFR 457.1240(e), CMS requires state Medicaid and CHIP agencies that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and certain primary care case management (PCCM) entities[4] to develop and maintain a Medicaid and CHIP quality strategy to assess and improve the quality of health care and services provided by Managed Care Plans (MCPs). Quality strategies offer states an opportunity to describe their population health and quality improvement priorities, to articulate their vision for health delivery reform, and to provide a road map for how to achieve those goals.

Quality strategies are one part of a multipronged approach to Medicaid and CHIP managed care quality. The strategies work best when aligned with other key components, such as Medicaid and CHIP Adult[5] and Child[6] Core Set measure reporting; performance improvement projects (PIPs), as part of Quality Assessment and Performance Improvement (QAPI) programs; quality rating systems (QRSs); state directed payments; and annual EQRs.[7] These managed care quality tools are interrelated, with each one informing and reinforcing the others (Figure 1).

The quality strategy is the foundational managed care tool that articulates managed care priorities, including goals and objectives for quality improvement. In formulating those goals and

[1] January 2021 Medicaid & CHIP Enrollment Data Highlights. Available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[2] Medicaid and CHIP Beneficiary Profile: Maternal and Infant Health, December 2020. Available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-beneficiary-profile.pdf.

[3] 2018 CMS Managed Care Enrollment Report. Available at https://www.medicaid.gov/medicaid/managed-care/downloads/2018-medicaid-managed-care-enrollment-report.pdf.

[4] The PCCM entities that states must address in their quality strategies are described at 42 CFR 438.310(c)(2) and 42 CFR 457.1240(f). Specifically, these are PCCM entities whose contracts with the state provide for shared savings, incentive payments, or other financial rewards for improved quality outcomes.

[5] More information about the Medicaid Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set/index.html.

[6] More information about the Medicaid and CHIP Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set/index.html.

[7] See 42 CFR 438.330, 438.334, 438.6(c), 438.350, 42 CFR 457.1240(b), 457.1240(d), and 457.1250 for more information on QAPI, QRS, state directed payments, and EQR. CMS and states have not yet implemented the QRS.

objectives, states are encouraged to review their performance on the Medicaid and CHIP Child[8] and Adult[9] Core Sets relative to their peers and use their quality strategies to prioritize and articulate quality improvement goals in those areas where their performance can improve.

Additionally, the QAPI programs should reflect the priorities articulated in the quality strategy and include specific measures and targets from the quality strategy, with PIPs aimed at driving improvement on those measures and reaching those targets.[10] These performance measures and PIPs are then validated during the annual EQR, with results included in the EQR technical report.[11] The EQR technical report also includes recommendations from the external quality review organization (EQRO) on how states can target quality strategy goals and objectives in order to support improvements in quality of care.[12]

Finally, state directed payments under 42 CFR 438.6(c) must demonstrate how the payment arrangement will further the goals and objectives of the quality strategy. When used as part of state directed payment arrangements, alternative payment models such as pay-for-performance or shared savings models that reward improvement on the performance measures used in QAPI programs and validated through EQR further facilitate quality improvement by aligning payment incentives to desired outcomes. By thinking holistically about these managed care quality components, states can maximize the impact of their managed care quality initiatives.

[8] More information on the Medicaid and CHIP Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html.

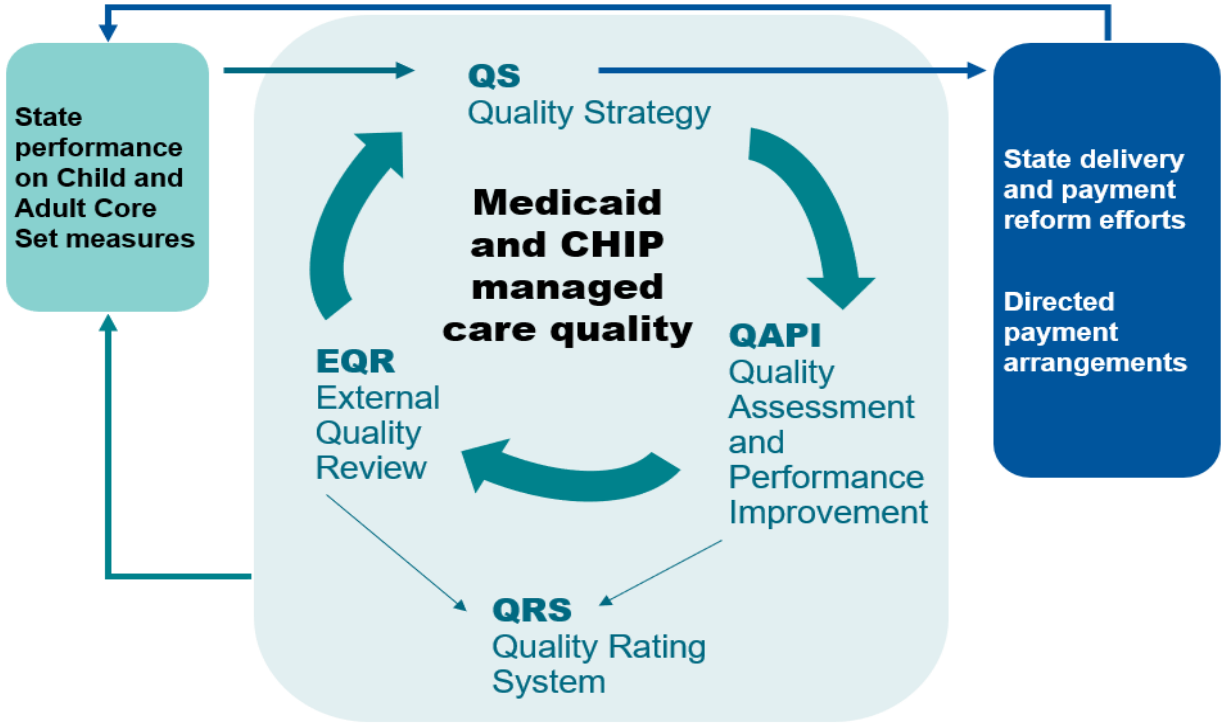
[9] More information on the Medicaid Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

[10] 42 CFR 438.340(b)(3)(i) and 42 CFR 457.1240(e).

[11] 42 CFR 438.358(b)(1)(i) and (ii) and 42 CFR 457.1250.

[12] 42 CFR 438.364(a)(4) and 42 CFR 457.1250.

Figure 1. Relationship between state Medicaid and CHIP managed care quality initiatives



A. Changes to Quality Strategy Requirements

In May 2016, CMS published the Medicaid and CHIP managed care final rule ("2016 final rule"), which aligns key Medicaid and CHIP rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience as well as key consumer protections.[13] In amendments to 42 CFR 438.340(a) and 42 CFR 457.1240(e), the 2016 final rule also updated quality strategy requirements by expanding on the types of MCPs that quality strategies must address (PAHPs, PCCM entities, and CHIP MCPs); by requiring that states seek input from stakeholders; and by mandating that states create processes to reduce health care disparities, describe procedures for the transition of care, and identify persons in need of long-term services and supports (LTSS) and other special health care services.[14, 15]

[13] More information about the 2016 Medicaid and CHIP managed care final rule is available at https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html and in the *Federal Register* at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

[14] CHIP regulations at 42 CFR 457.1240(e) cross-reference to the Medicaid managed care state quality strategy requirements at 42 CFR 438.340.

[15] All CHIP regulations, including those for quality strategies, in the 2016 final rule were effective as of state fiscal years beginning on or after July 1, 2018. Changes to the Medicaid quality strategy regulations in the 2016 final rule were effective on July 1, 2018. For more details, see the final rule at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

In November 2020, CMS amended certain regulatory provisions adopted in the final rule.[16] The 2020 final rule made a variety of technical changes to clarify how states should incorporate PCCM entities, as described in 42 CFR 438.310(c)(2) and 42 CFR 457.1240(f), in their quality strategies. In addition, because an individual's disability status can change over time and because enrollment on the basis of disability may only be one indicator of an enrollee's disability status, the 2020 rule clarified that "disability status" means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability. The rule provides states with flexibility above that minimum definition to define disability status as appropriate, so long as they include in their quality strategies how they define disability status if they use definitions that differ from the minimum standard. Further, the rule requires states to explain in their quality strategies how they determine whether a Medicaid enrollee meets those standards and what data sources states use to identify enrollees with disability status, considering the standards they adopt. The Medicaid quality strategy regulations also apply to CHIP via 42 CFR 457.1240(e). However, there is no minimum standard for determining disability status in CHIP like there is in Medicaid, since individuals cannot qualify for CHIP based on disability. Therefore, it will be particularly important for states to define disability status, as it relates to their CHIP population. States must comply with 42 CFR 438.340 as amended for all quality strategies submitted after July 1, 2021.

B. Using the Quality Strategy Toolkit

To support states in implementing managed care quality strategy requirements, CMS developed this Medicaid and CHIP Managed Care Quality Strategy Toolkit. Use of this toolkit is voluntary. However, to ensure that quality strategies address regulatory requirements and leverage best practices, CMS recommends that states use this toolkit as a part of their quality strategy development, revision, and submission processes. This toolkit replaces the 2013 Quality Strategy Toolkit for States.

This toolkit describes quality strategy regulatory requirements and provides considerations for states to improve their quality strategies. Chapter II describes the quality strategy development and revision processes, and Chapter III describes the quality strategy submission process. The appendices include acronyms, definitions, and additional information. CMS offers technical assistance (TA) to states that have questions related to drafting or revising a quality strategy and/or using this toolkit. States interested in TA may contact CMS via the TA mailbox at ManagedCareQualityTA@cms.hhs.gov.

[16] The 2020 final rule is available at https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care.

II. Developing a Quality Strategy

This chapter describes the regulatory requirements that each state must address in its quality strategy and provides considerations for the state to improve its quality strategy. It contains seven sections.

Section A: Steps for developing the quality strategy

Describes nine steps that the state can use to develop its quality strategy.

Section B: Cross-cutting considerations

Contains cross-cutting considerations for the state as it reviews sections C - G of this chapter as well as Chapter III.

Section C: Drafting and implementing the quality strategy

Describes what is required of states and provides considerations for drafting and implementing the quality strategy.

Section D: Goals and objectives

Describes what is required of states and provides considerations for measurable goals and objectives for continuous quality improvement.

Section E: Quality of care

Describes what states are required to include with regard to presenting quality of care information, such as quality metrics and performance targets, LTSS performance measures, and transition of care policies.

Section F: Monitoring and compliance

Describes what is required of states and provides considerations for presenting monitoring and compliance information, such as network adequacy standards and intermediate sections.

Section G: External quality review arrangements

Describes what is required of states and provides considerations for presenting EQR arrangements, such as the EQR non-duplication option.

A. Steps for Developing the Quality Strategy

Figure 2 shows nine steps that the state can use to develop its quality strategy, including creating a drafting team, reviewing relevant regulations and documents, drafting the quality strategy, conducting the public comment process, and submitting the quality strategy to CMS. CMS recommends that the state follow these steps and develop a timeline for completing each step in the process.

Figure 2. Nine steps for developing the quality strategy

1. Convene an interdisciplinary team to develop each component of the quality strategy.
2. Review all applicable federal quality strategy regulations in 42 CFR 438.340 and 42 CFR 457.1240(e). The remainder of this chapter and Chapter III detail the requirements in these regulations.
3. Gather the following resources:
   - The state's existing quality strategy, including its goals and objectives, quality measures, methods for evaluating MCPs, and EQR arrangements.
   - Medicaid and CHIP Child[17] and Adult[18] Core Sets.
   - Information on the state's performance on the Medicaid and CHIP Child and Adult Core Sets, either from the Annual State Measure Trend Snapshot CMS sends to State Medicaid

[17] More information on the Medicaid and CHIP Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html.

[18] More information on the Medicaid Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

Directors each year, from the Chart Packs for the Child Core Set[19] and Adult Core Set,[20] or on the State Profile pages on Medicaid.gov.[21]

- Measures selected by the Core Quality Measures Collaborative.
- Other existing validated measures, such as the CMS Measures Inventory Tool[22] and the National Quality Forum measure database, the Quality Positioning System.[23]
- Recent EQR technical reports, to include beneficiary appeals and grievances.
- Annual work plans (if available).
- All current Medicaid and CHIP managed care contracts.
- Information on recent significant program changes (if any).
- Relevant demonstration and waiver terms and conditions.
- State plan sections that define important care and eligibility concepts.
- Stakeholder feedback on the state's current quality strategy.
- State demographic data and trend reports, including information on trends related to health disparities and social determinants of health.
- Information system descriptions of how the state captures enrollee demographic information.
- State public health agency health disparities reduction plans.
- Other relevant state-specific reports by advisory committees, areas of legislature concern, or audit findings.

4. Using the resources above, work with the interdisciplinary team to draft the quality strategy. Reference Chapter II of this toolkit to guide the development of the quality strategy. If needed, contact CMS for TA via the TA mailbox at ManagedCareQualityTA@cms.hhs.gov.
5. Publish the draft quality strategy for public comment. The state may want to budget approximately six months for the whole process of gathering public comments, which accounts for preparation, a 30- to 60-day comment period, time to review comments, and time to update the quality strategy based on the public input. This time frame does not include the creation of the quality strategy (Step 4). In addition to soliciting public comments, coordinate with the Medical Care Advisory Committee, Tribes, and tribal

[19] Chart Packs for the Medicaid and CHIP Child Core Set are available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html#AnnualReporting.

[20] Chart Packs for the Medicaid Adult Core Set are available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html#AnnualReporting.

[21] Medicaid.gov State Profiles are available at https://www.medicaid.gov/state-overviews/state-profiles/index.html.

[22] The CMS Measures Inventory Tool is available at https://cmit.cms.gov/CMIT_public/ListMeasures.

[23] The National Quality Forum Quality Positioning System is available at https://www.qualityforum.org/QPS/QPSTool.aspx.

providers (where applicable) to obtain their input and comments. This process is described in more detail in Chapter III of this toolkit.

6. Submit a copy of the initial quality strategy to CMS for comment and feedback prior to adopting it as final. The state can review quality strategy submission requirements in Chapter III of this toolkit. The state can submit its quality strategy to CMS via the TA mailbox at ManagedCareQualityTA@cms.hhs.gov.
7. Work with the interdisciplinary team to revise the quality strategy based on CMS feedback.
8. Post the final quality strategy on the state's website. This involves ensuring that appropriate translation services are available and that websites are accessible in order to provide all information needed by beneficiaries.
9. Review and update quality strategy as needed, but no less than once every three years. When revising the quality strategy, consider the state's evaluation of its quality strategy and the recommendations provided by the state's EQRO in its annual EQR technical reports.[24] Submit a copy of the revised quality strategy whenever state-defined significant changes occur or whenever significant changes occur within the state's Medicaid program.

B. Cross-cutting Considerations

When developing its quality strategy, the state should take into account these cross-cutting considerations:

- **Child and Adult Core Set measures**. States are encouraged to review their performance on the Medicaid and CHIP Child[25] and Adult[26] Core Sets relative to their peers and use their quality strategies to prioritize and articulate quality improvement goals in those areas where their performance can improve. This is particularly important if the state's performance falls below the national median and/or the state's performance has decreased statistically significantly over time (states are sent an individualized State Measure Trend Snapshot annually with this information for any measures that are publicly reported).
- **Align the quality strategy with other managed care tools.** Ensure that the state's quality strategy aligns with its state directed payments, EQR-related activities and recommendations included in the annual EQR technical reports, QAPI program, Child and Adult Core Sets, compliance activities, and other quality programs. This applies to all components of the quality strategy, including:

[24] See 42 CFR 438.364(a)(4) and 42 CFR 457.1250(a).

[25] More information on the Medicaid and CHIP Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html#AnnualReporting.

[26] More information on the Medicaid Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html#AnnualReporting.

- **QAPI programs**. The quality strategy must include the quality metrics and performance targets to be used in measuring the performance and improvement of each MCP, including but not limited to, the performance measures reported in MCP QAPI programs. States should include specific measures and targets from their quality strategies in their QAPI programs, with PIPs designed to drive improvement on those measures and attain those targets.
- **Annual EQR technical reports.** The state should engage its EQRO to review results from PIPs and EQR PIP validation findings to inform the development of, and monitor progress towards, meeting its goals and objectives.
- **State directed payments**. For example, if the state develops a state directed payment focusing on network adequacy, the state should tie a goal and objective to network adequacy when it revises its quality strategy.
- **Quality measures, including LTSS performance measures**. For example, the state can include (and CMS suggests including) measures from the Child or Adult Core Sets in the state's quality strategy and using its quality strategy to develop and prioritize quality improvement goals in those measure areas so that quality improvement at the health plan level will drive quality improvement at the state level. Whenever appropriate, states should also align quality measures across managed care tools. For example, if the state uses a quality measure in its quality strategy, CMS suggests that it use the same measure in its state directed payment initiatives, as appropriate.
- **Disparity initiatives.** The state's quality strategy must include 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. CMS suggests that the state also address these disparities in its QAPI program.
- **Intermediate sanctions.** If the state uses intermediate sanctions, corrective action plans, or other enforcement mechanisms to address quality of care issues, the state's quality strategy should address that per 42 CFR 438.340(b)(7).

- **Leverage related resources.** When developing goals and objectives or identifying quality measures and performance targets, review recent MCP and state quality performance resources. Example resources include stakeholder feedback and related quality strategies, such as quality strategies used in state demonstration and waiver programs.

C. Drafting and Implementing the Quality Strategy

This section describes what is required and provides considerations for drafting and implementing the quality strategy.

- **Regulatory Citation:** 42 CFR 438.340(a), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).[27]
- **Regulatory Requirement:** The state must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by each MCO, PIHP, PAHP, and PCCM entity it contracts with.

Cross-cutting Considerations

See recommended cross-cutting considerations when drafting and implementing the quality strategy.

Exhibit 1 provides considerations for the state as it addresses this requirement. Template 1 shows how the state can present managed care contract information in the quality strategy.

[27] The May 6, 2016 final rule removed the quality strategy regulations of 42 CFR 438.202 and 438.204. These regulations are out of date.

Exhibit 1. Drafting and implementing the quality strategy

Considerations for drafting and implementing the quality strategy

• Review existing resources to begin drafting a quality strategy:
  ○ Quality strategy provisions in the 2016 final rule, available at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered
  ○ Quality strategy provisions in the 2020 final rule, available at https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care
  ○ CMS' Medicaid and CHIP State Quality Strategy website, available at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/state-quality-strategy/index.html
  ○ CMS' Managed Care Authorities website for a description of waivers that the state may use to implement managed care, available at https://www.medicaid.gov/medicaid/managed-care/authorities/index.html
• Describe the types of MCPs (such as MCOs and PIHPs) that the state contracts with to deliver services to beneficiaries; the managed care authorities, including relevant state plans (for example, Medicaid, CHIP) and waiver types (such as Section 1115 demonstrations), that the state uses for each MCP; and the types of benefits (such as LTSS and dental) that each MCP provides to beneficiaries. The state should also specify which populations are addressed; children with disabilities may be included with children or people with disabilities. Use this information to ensure that the quality strategy addresses all plans and populations in the state's managed care programs. For example, the state can create a table with each MCP as a row and the MCP type, waiver authority or authorities, and populations served indicated in columns. See Template 1 for an example.
• Indicate whether the state's CHIP program type is expansion, separate, or combined; whether the state provides CHIP benefits through managed care; and which MCPs provide CHIP benefits. If the state provides CHIP benefits through managed care, indicate whether the quality strategy addresses the state's CHIP program. If not, provide a link to where its CHIP quality strategy is located.
• Indicate in the footer of the cover page of the initial quality strategy the date when the state submitted the quality strategy to CMS for comment and feedback. If the quality strategy is a revision of a previous version, indicate when the state published the previous version. Also indicate whether the quality strategy is an initial version or a revised version.

Template 1. Example of how to present managed care contract information in the quality strategy

Plan name	MCP type	Managed care authority	Populations served
"Plan A"	PIHP	1915(b)	Medicaid adults with qualifying behavioral health conditions
"Plan B"	MCO	1915(b)	Medicaid children without disabilities, parents, and expansion adults ages 20-64
"Plan C"	Dual-Eligible Special Needs Plan (D-SNP)	1115	Beneficiaries dually eligible for Medicaid and Medicare
"Plan D"	PCCM	1932(a)	Medicaid children, pregnant women, and parents.

D. Goals and Objectives

This section describes what is required and provides considerations for developing measurable goals and objectives for continuous quality improvement.

- **Regulatory Citation:** 42 CFR 438.340(b)(2), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).
- **Regulatory Requirement:** The state must identify its goals and objectives for continuous quality improvement. These goals and objectives must be measurable and take into consideration the health status of all populations served by the state's MCPs.

Exhibit 2 provides considerations for the state as it addresses this requirement. Template 2 shows how the state can present its goals and objectives in the quality strategy.

Exhibit 2. Measurable goals and objectives

Considerations for developing measurable goals and objectives

• Review the state's performance on the Medicaid and CHIP Child and Adult Core Sets.
  ○ Assess the state's performance on publicly reported measures relative to rates reported across all states, the national median, and 75th percentile.
  ○ Review state measure trend snapshots on Medicaid.gov or the individualized State Measure Trend Snapshots sent out annually by CMS.
  ○ Use this information to determine which measures need improvement and to set iterative goals for rate improvement over time.
  ○ Child and Adult Core Sets, annual reports, and reporting resources, are available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html
• Review the state's existing quality measures, methods for evaluating MCPs, and EQR arrangements.
• Review existing resources to begin developing goals and objectives:
  ○ CMS' Essential Elements of MLTSS Programs, available at https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html
  ○ CMS' QAPI goal-setting worksheet, available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPIGoalSetting.pdf
• Include measurable goals and objectives in the quality strategy.
  ○ Goals are defined as high-level managed care performance aims that provide direction for the state.
  ○ Objectives are defined as measurable steps toward meeting the state's goals, and typically include quality measures.
• Link each goal to one or more objectives. Together, CMS recommends that the goals and objectives be specific, measurable, attainable, relevant, and time-bound (SMART).
• Crosswalk the goals and objectives to the populations and plans included in the state's managed care program to ensure that the goals and objectives address each population and plan.

Template 2. Example of how to present goals and objectives in the quality strategy

Instructions: List the state's quality strategy goals and link each goal to one or more objectives in column 1, include an objective number that indicates which goal the objective aligns with. In column 2, include a description of each objective. In column 3, list a quality measure to measure progress for each objective. In column 4, indicate statewide baseline performance for each measure, taken from the most recent year of data. In column 5, indicate statewide performance targets for each objective. Add rows to account for additional goals and objectives.

Objective (col. 1)	Objective description (col. 2)	Quality measure (col. 3)	Statewide performance baseline (year) (col. 4)	Statewide performance target for objective (year) (col. 5)
Goal 1: Improve the health and wellness of the state's Medicaid and CHIP populations through use of preventive services				
1.1	Increase flu vaccinations for adults	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	82.43% (2018)	87.0% (2019)
1.2	Increase early detection of breast cancer in adults	Breast Cancer Screening (BCS-AD)	54.3% (2019)	58.0% (2021)
Goal 2: Improve the health and wellness of new mothers and infants				
2.1	Increase use of prenatal services	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	75.6% (2019)	80.0% (2022)
2.2	Increase use of postpartum services	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	79.3% (2019)	85.0% (2022)
Goal 3: Improve the quality of life for beneficiaries with LTSS needs				
3.1	Decrease readmissions for enrollee population with LTSS needs	Plan All-Cause Readmissions (PCR-AD)	72.43% (2018)	80.0% (2019)
3.2	Address mental illness in enrollee population with LTSS needs	Follow-Up After Hospitalization for Mental Illness (FUA-AD)	60.71% (2018)	65.0% (2019)
Goal 4: Improve management of behavioral health conditions				
4.1	Increase adherence to antipsychotic medications	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	46.3% (2019)	57.3% (2022)
4.2	Decrease emergency department readmissions for alcohol or other drug abuse or dependence	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	36.8% (2019)	40.0% (2022)

E. Quality of Care

This section describes what is required of states and considerations for seven quality of care requirements in the quality strategy.

E.1. Quality metrics and performance targets

- **Regulatory Citation:** 42 CFR 438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.330(c).
- **Regulatory Requirement:** The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, or PCCM entity with which it contracts. This must include, but is not limited to, the state's QAPI metrics. After consulting with states and other stakeholders, and providing public notice and opportunity to comment, CMS may specify national performance measures.[28] The state must include a description of these measures in its quality strategy.

Exhibit 3 provides considerations for the state as it addresses this requirement. Templates 3.1 and 3.2 show how the state can present its quality metrics and performance targets in the quality strategy.

Exhibit 3. Quality metrics and performance targets

Considerations for presenting quality metrics and performance targets

• Review existing resources to select quality metrics:
  ○ Medicaid and CHIP Child and Adult Core Set Measures, available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html
  ○ Medicaid Innovation Accelerator Program's quality measurement functional area, available at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/index.html
• Review metric results when revising the quality strategy and address areas of poor performance in the state's goals and objectives.
• Use measure results to monitor progress toward meeting the state's goals and objectives. CMS recommends that the state also review measure results when revising its quality strategy and address areas of poor performance in its goals and objectives.
• If CMS specifies performance measures, include them in the EQR performance measure validation activity. Through its EQR report, the state can reference information on these measures. The state may request an exemption from including these measures by submitting a written request to CMS explaining the basis for the request.
• For more information on EQR performance measure activities, see CMS' EQR website at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

[28] 42 CFR 438.330(a) and 42 CFR 457.1240(b).

Template 3.1. Example of how to present quality metrics and performance targets in the quality strategy

Instructions: In column 1, include the full metric name and any sub-metrics. For example, if the state intends to stratify a metric by age, include each age stratification. In column 2, indicate what specifications the state uses for each metric (for example, Child or Adult Core Sets, HEDIS, or state-developed). In column 3, indicate baseline performance for each metric, taken from the most recent year for which data are available. In column 4, include a performance target (and year) for each metric. In columns 5 and 6, indicate the programs or benefit packages that each metric applies to, such as CHIP, dental, and LTSS. In this example, the table indicates metric use in Medicaid and CHIP programs. The state can customize these columns and add or remove columns as needed to reflect its managed care program. If the state chooses to create separate tables for each program and uses metrics across more than one program, consider using consistent metric names across all tables. If a state chooses not to use this template in its quality strategy, CMS recommends that the state include all requested information in another format.

Metric name (col. 1)	Metric specifications (col. 2)	Baseline performance (year) (col. 3)	Performance target (year) (col. 4)	Program	
				Medicaid (col. 5)	CHIP (col. 6)
Follow-Up After Hospitalization for Mental Illness—7 Day (FUH)					
Ages 6–17 (FUH-CH)	Child Core Set	65.72% (2018)	70.0% (2019)	✓	✓
Ages 18 and older (FUH-AD)	Adult Core Set	56.81% (2018)	60.0% (2019)	✓	
Overall	HEDIS	60.71% (2018)	65.0% (2019)	✓	
Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)					
Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Adult Core Set	82.43% (2018)	87.0% (2019)	✓	
Plan All-Cause Readmissions (PCR-AD)					
Plan All-Cause Readmissions (PCR-AD)	Adult Core Set	72.43% (2018)	80.0% (2019)	✓	
Asthma Medication Ratio (AMR)					
Ages 5–11	HEDIS	40.62% (2018)	45.0% (2019)	✓	✓
Ages 12–18	HEDIS	43.31% (2018)	48.0% (2019)	✓	✓
Ages 19–50	HEDIS	40.62% (2018)	45.0% (2019)	✓	
Ages 51–54	HEDIS	42.34% (2018)	47.0% (2019)	✓	
Overall	HEDIS	42.42% (2018)	47.0% (2019)	✓	

Template 3.2. Example of how to present quality metrics and performance targets in the quality strategy (continued)

Metric name (col. 1)	Metric specifications (col. 2)	Baseline performance (year) (col. 3)	Performance target (year) (col. 4)	Program	
				Medicaid (col. 5)	CHIP (col. 6)
Breast Cancer Screening (BCS-AD)					
Breast Cancer Screening (BCS-AD)	Adult Core Set	54.3% (2019)	58.0% (2021)	✓	
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care (PPC-CH)	Child Core Set	75.6% (2019)	80.0% (2022)	✓	✓
Postpartum Care (PPC-AD)	Adult Core Set	79.3% (2019)	85.0% (2022)	✓	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)					
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	Adult Core Set	36.8% (2019)	40.0% (2022)	✓	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Adult Core Set	46.3% (2019)	57.3% (2022)	✓	

E.2. Public posting of quality measures and performance outcomes

- **Regulatory Citation:** 42 CFR 438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).
- **Regulatory Requirement:** The state must identify which quality measures and performance outcomes it will publish at least annually on its website.

Exhibit 4 provides considerations for the state as it addresses this requirement.

Exhibit 4. Public posting of quality measures and performance outcomes

Considerations for identifying which quality measures and performance outcomes the state will publish on its website

• Review examples of publicly posting quality measures and performance outcomes:
  ○ CMS' Medicaid and CHIP Scorecard website, available at https://www.medicaid.gov/state-overviews/scorecard/index.html
  ○ Child Core Set performance measure data, available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html#AnnualReporting
  ○ Adult Core Set performance measure data, available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html#AnnualReporting
• Include a link in the quality strategy to where the state publishes measures and performance outcomes online.
• Consider which measures are most meaningful and responsive to stakeholders and which would best illustrate progress on the quality strategy.
• Consider selecting from measures for public posting that pertain to health conditions and/or Medicaid and CHIP populations marked by a large degree of health disparity, such as sickle cell disease in children or unnecessary cesarean section for pregnant women.
  ○ For more information, the state can review the Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid and CHIP (July 11, 2019), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/core-set-stratification-webinar.pdf
• Ensure that appropriate translation services are available and that websites are accessible in order to provide all information needed by beneficiaries.

E.3. LTSS performance measures

- **Regulatory Citation:** 42 CFR 438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.330(c)(1)(ii).
- **Regulatory Requirement:** If the state contracts with MCOs, PIHPs, PAHPs, and/or PCCM entities to provide LTSS, the state must describe the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving LTSS. If the state does not provide LTSS through managed care, this requirement does not apply.

Exhibit 5 provides considerations for the state as it addresses this requirement. Template 4 shows how the state can indicate the LTSS performance measures it uses to monitor the performance of the MCPs with which it contracts.

Exhibit 5. LTSS performance measures

Considerations for presenting LTSS performance measures

• Review existing resources to begin selecting LTSS performance measures:
  ○ Measures for Medicaid Long Term Services and Supports Plans: Technical Specifications and Resource Manual, available at https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html
  ○ Medicaid Innovation Accelerator Program's quality measurement functional area, available at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/index.html
  ○ CMS' LTSS website, available at https://www.medicaid.gov/medicaid/ltss/index.html
• Indicate in the quality strategy whether the state delivers LTSS through managed care.
• For concurrent managed care and home and community-based services (HCBS) authorities, review HCBS quality assurance provisions required for HCBS for those programs with and without an institutional level of care need, found at: 42 CFR 441.302(a)-(c), 441.303(a)-(e), 441.715(a) and 441.745(b).
• Use measure results to monitor progress toward meeting the state's goals and objectives. CMS recommends that the state also review measure results when revising its quality strategy and address areas of poor performance in its goals and objectives.

Template 4. Example of how to present LTSS performance measures in the quality strategy

Instructions: In column 1, include the full measure name and any sub-measures, such as age groups or disability type. In column 2, indicate the measure specification the state uses for each measure (for example, Adult Core Set, HEDIS, or state-developed). In column 3, indicate baseline performance for each measure, taken from the most recent year for which data are available. In column 4, include a performance target (and year) for each measure. If the state chooses not to use this template in its quality strategy, CMS recommends that the state include all requested information in another format.

Measure name (col. 1)	Measure specifications (col. 2)	Baseline performance (year) (col. 3)	Performance measure target (year) (col. 4)
Long-Term Services and Supports Comprehensive Assessment and Update			
Assessment of Core Elements	CMS/HEDIS	71.4% (2019)	75.0% (2020)
Assessment of Supplemental Elements	CMS/HEDIS	65.7% (2019)	70.0% (2020)
Long-Term Services and Supports Shared Care Plan With Primary Care Practitioner			
Long-Term Services and Supports Shared Care Plan with Primary Care Practitioner	CMS/HEDIS	81.3% (2019)	90.0% (2020)

E.4. Performance Improvement Projects (PIP) and PIP interventions

- **Regulatory Citation:** 42 CFR 438.340(b)(3)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.330(d) and 457.1240(b).
- **Regulatory Requirement:** The state must identify the PIPs to be implemented in accordance with the state's QAPI program, including a description of any interventions it proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, PAHP, or PCCM entity. If CMS has specified a PIP, the state must include a description of PIPs required by CMS.

Exhibit 6 provides considerations for the state as it addresses this requirement. Template 5 shows an example of how to present PIP topics, aims, and interventions in the quality strategy.

Exhibit 6. PIPs and PIP interventions

Considerations for presenting PIPs and PIP interventions
• Review existing resources on PIPs and EQR PIP activities: ○ CMS' EQR website, available at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html • For each PIP that MCPs implement, consider including information on the PIP topic, aim, and intervention. Template 5 shows how the state can describe PIP topics, aims, and interventions in its quality strategy. • All PIPs should be included in the EQR PIP validation activity. Therefore, the state can reference its EQR reports for information on them.

Template 5. Example of how to present PIP topics, aims, and interventions in the quality strategy

Instructions: In column 1, include the PIP topic. In column 2, indicate the PIP aim. In column 3, summarize the PIP intervention. If a state chooses not to use this template in its quality strategy, CMS recommends that the state include all requested information in another format.

Example PIP topic (col. 1)	Example PIP aim (col. 2)	Example PIP intervention (col. 3)
Well-child visits	Improve use of well-child visits for children ages 3 to 6. The PIP aims to increase the use of well-child visits in the third, fourth, fifth, and sixth years of life from 69 percent to 75 percent by December 31, 2020.	The state will (1) offer a transportation benefit to help facilitate well-child visits; (2) and require its managed care plans to provide data to providers on members' gaps in care.
Preventive dental visits	Improve use of preventive dental visits. The PIP aims to increase the use of preventive dental visits among beneficiaries ages 1 through 20 from 52 percent to 57 percent by December 31, 2021.	The state will require its managed care plans to contact beneficiaries to identify barriers to preventive dental visits and encourage them to schedule preventive dental visits.

E.5. Transition of care policy

- **Regulatory Citation:** 42 CFR 438.340(b)(5), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.62(b).
- **Regulatory Requirement:** The state must include a description of its transition of care policy.

Exhibit 7 provides considerations for the state as it addresses this requirement.

Exhibit 7. Transition of care policy

Considerations for presenting the state's transition of care policy

• Review existing resources on improving care transitions:
  ○ CMS' Improving Care Transitions website, available at https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/care-transitions/index.html
• Review the transition of care policy to ensure the following requirements are addressed:
  ○ The beneficiary has access to services consistent with the access that the beneficiary previously had and is permitted to retain a current provider for a period of time if that provider is not in the MCO, PIHP, or PAHP network.
  ○ The beneficiary is referred to appropriate providers of services that are in the network.
  ○ The state (if the beneficiary was enrolled in fee-for-service (FFS) Medicaid), or an MCO, PIHP, PAHP, PCCM, or PCCM entity will fully and timely comply with requests for historical utilization data from the new MCO, PIHP, PAHP, PCCM, or PCCM entity.
  ○ Consistent with federal and state law, the enrollee's new providers are able to obtain copies of the enrollee's medical records, as appropriate.
  ○ The process for the electronic exchange of beneficiary data.
  ○ Any other necessary procedures, as specified by the state, to ensure continued access to services to 1) prevent serious detriment to the enrollee's health or 2) reduce the risk of hospitalization or institutionalization.

E.6. Disparities plan

- **Regulatory Citation:** 42 CFR 438.340(b)(6), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).
- **Regulatory Requirement:** The state must include its plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.[29] The state must include in this plan the state's definition of disability status and how the state will make the determination that a Medicaid enrollee meets the standard.

[29] For purposes of 42 CFR 438.340(b)(6) (applicable also to CHIP managed care programs per 42 CFR 457.1240[e]), "disability status" means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability.

Exhibit 8 provides considerations for the state as it addresses this requirement.

Exhibit 8. Disparities plan

Considerations for including the state's disparity plan

• Review existing resources on addressing disparities:
  ○ Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid and CHIP (July 11, 2019), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/core-set-stratification-webinar.pdf
  ○ CMS' Quality of Care Health Disparities website, available at https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/health-disparities/index.html
• Include the following elements for each disparity factor (age, race, ethnicity, sex, primary language, and disability status):
  ○ Disparity identification and evaluation method, such as an analysis of health plan information, beneficiary and provider outreach, and stratifying quality metrics by eligibility and enrollment demographic data.
  ○ A description of the state's plan to reduce disparities, by target programs and populations, such as CHIP, LTSS, and beneficiaries with behavioral health needs.
  ○ A description of the state's progress towards reducing disparities.
  ○ A description of the state's progress on any initiatives described in its previous quality strategy.
• Coordinate to the extent practicable with public health authorities on plans for disparities reduction implemented outside of the state Medicaid and CHIP agencies.
• Identify and use measures that pertain to health care conditions and/or Medicaid and CHIP populations marked by a high degree of health disparities, and then stratify those measures by using available indicators to capture disparities—for instance, by linking to other available data sources such as eligibility and enrollment demographic data to stratify by race, ethnicity, sex, language, disability status, or geography. States can also collect information on sociodemographic characteristics and then stratify the measure to detect disparities.
• Capture data on social determinants of health and chronic conditions associated with disability when feasible.

E.7. Identification of persons who need LTSS or persons with special health care needs

- **Regulatory Citation:** 42 CFR 438.340(b)(8), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.208(c)(1) and 457.1230(c).
- **Regulatory Requirement:** The state must describe its mechanisms to identify persons who need LTSS or persons with special health care needs.

Exhibit 9 provides considerations for the state as it addresses this requirement.

Exhibit 9. Identification of persons who need LTSS or persons with special health care needs

Considerations for identifying persons who need LTSS or persons with special health care needs
• Indicate in the quality strategy whether the state provides LTSS benefits through managed care. • In the description of the mechanisms the state uses to identify persons who need LTSS or persons with special health care needs, indicate whether the state uses its staff, the state's enrollment broker, or the state's MCPs to identify these persons.

F. Monitoring and Compliance

This section describes what is required of states and consideration for monitoring and compliance requirements in the quality strategy, including network adequacy and availability of services, clinical practice guidelines, and intermediate sanctions.

F.1. Network adequacy and availability of services

- **Regulatory Citation:** 42 CFR 438.340(b)(1), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.68, 438.206, 457.1218, and 457.1230(a).
- **Regulatory Requirement:** The state must include its network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs.

Exhibit 10 provides considerations for the state as it addresses this requirement.

Exhibit 10. Network adequacy and availability of services

Considerations for presenting network adequacy and availability of services
• Review existing network adequacy resources: ○ CMS' Medicaid and CHIP network access guidance, available at https://www.medicaid.gov/medicaid/managed-care/guidance/additional-guidance/index.html • Provide detail for each of the state's network adequacy and availability of services standards under 42 CFR 438.68 and 438.206 for Medicaid managed care programs. These standards apply to CHIP managed care programs under 42 CFR 457.1218 and 457.1230(a). For example, detail the state's standards for each provider type included in 42 CFR 438.68, such as primary care, behavioral health, and LTSS. • Detail the state's network adequacy standards or link to standards contained in a separate document.

F.2. Clinical practice guidelines

- **Regulatory Citation:** 42 CFR 438.340(b)(1), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.236 and 457.1233(c).
- **Regulatory Requirement:** The state must include examples of evidence-based clinical practice guidelines that it requires plans to use.

Exhibit 11 provides a consideration for the state as it addresses this requirement.

Exhibit 11. Clinical practice guidelines

Consideration for presenting clinical practice guidelines
• Detail examples of clinical practice guidelines or link to guidelines contained in a separate document.

F.3. Intermediate sanctions

- **Regulatory Citation:** 42 CFR 438.340(b)(7), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing Part 438 Subpart I.
- **Regulatory Requirement:** For MCOs, the state must include appropriate use of intermediate sanctions that, at a minimum, meet the sanctions requirements in Part 438 subpart I.

Subpart I: Intermediate Sanctions

42 CFR Subpart I details intermediate sanctions, contract terminations, and other enforcement provisions. Intermediate sanctions include civil monetary penalties, temporary management, termination of enrollment, suspension of enrollment, and suspension of payment.

Exhibit 12 provides considerations for the state as it addresses this requirement.

Exhibit 12. Intermediate sanctions

Considerations for presenting intermediate sanctions
• Indicate whether the state applied any intermediate sanctions to any MCP in the past three years, the number and types of those sanctions, and for what reasons. The state can determine whether to describe the sanctions it applied at the MCP level or the aggregate level. • Describe other actions taken in the past three years to enforce MCP compliance with state and federal rules, such as corrective action plans.

G. External Quality Review Arrangements

This section describes how the state must address EQR arrangements in its quality strategy.

G.1. EQR arrangements

- **Regulatory Citation:** 42 CFR 438.340(b)(4), applicable to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.350, which is applicable to CHIP per 42 CFR 457.1250.
- **Regulatory Requirement:** The state must provide a description of its arrangements for annual, external, independent reviews of the quality outcomes, timeliness of, and access to the services covered under each MCO, PIHP, PAHP, and PCCM entity.

Exhibit 13 provides considerations for the state as it addresses this requirement.

Exhibit 13. EQR arrangements

Considerations for presenting EQR arrangements
• Review existing resources on EQR: ○ CMS' EQR website, available at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html • Describe what mandatory and optional tasks the EQRO will perform and whether the state contracts with a separate EQRO for certain types of managed care, such as behavioral health. • Identify the EQRO that will perform the EQR and the length of the EQRO's contract. • Review prior EQR technical reports, paying special attention to areas of low performance. • Ensure that performance measures, PIPs, and standards related to elements in 42 CFR 438 subpart D and 438.330 are validated and then reported by an EQRO per 42 CFR 438.364.

G.2. EQR non-duplication option

- **Regulatory Citation:** 42 CFR 438.340(b)(9), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.360(c), which is applicable to CHIP per 42 CFR 457.1250(a).

Information on Non-duplication

See Appendix C for more information on the non-duplication option.

- **Regulatory Requirement:** If the state leverages the non-duplication option described in 42 CFR 438.360 to use information from an MCP review described in 438.360(a) for the annual EQR instead of conducting one or more of the mandatory EQR-related activities described in 438.358(b)(1)(i) through (iii), the state's quality strategy must:
  - Identify the EQR-related activities for which it has exercised this option.
  - Explain the rationale for its determination that the Medicare review or private accreditation activity is comparable to such EQR-related activities.

Exhibit 14 provides considerations for the state as it addresses this requirement.

Exhibit 14. EQR non-duplication option

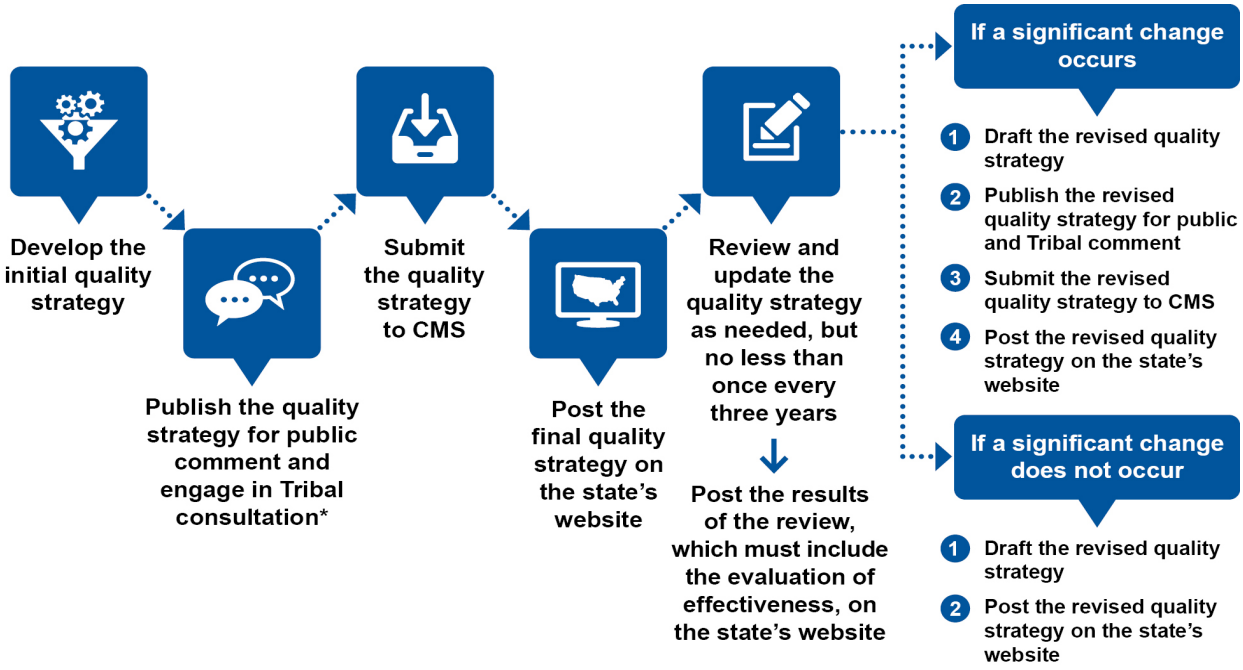
Considerations for addressing the EQR non-duplication option

• Review existing resources on non-duplication:
  ○ The non-duplication information located in Appendix C
  ○ CMS' EQR website, available at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html
• It is recommended that all states indicate in their quality strategies whether the state does or does not leverage the non-duplication option. A state that does leverage the non-duplication option *must* include the information discussed under the regulatory requirements section in its quality strategy.
• If a state does leverage the non-duplication option, it should consider including sufficient information to establish that all information relied upon for the purposes of non-duplication meets the conditions identified in 42 CFR 438.360(a)(1) and (a)(3) in addition to the required explanation of the rationale for the determination required by 438.360(a)(2).

III. Updating the Quality Strategy

The state must review and update its managed care quality strategy as needed, but no less than once every three years, as required by managed care regulations at 42 CFR 438.340(c) and 457.1240(e). This chapter describes when and how to revise the state's quality strategy. Figure 3 shows the quality strategy lifecycle, which includes the quality strategy revision requirements described in this section.

Figure 3. Quality strategy lifecycle



*Note: For Medicaid managed care, the state must also seek input from its Medical Care Advisory Committee.

A. Updates to the Quality Strategy Due to Significant Changes

This section describes the requirement and provides considerations for updating the quality strategy due to a significant change.

A.1. Updates for state-defined significant changes

- **Regulatory Citation:** 42 CFR 438.340(b)(10) and (c)(3)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).

- **Regulatory Requirements:** The state must include in its quality strategy a definition for a "significant change" for the purpose of revising the quality strategy. If such a significant change occurs, the state must update its quality strategy.

Exhibit 15 provides a consideration for the state as it addresses this requirement to develop a definition for "significant change".

Exhibit 15. State definition of a significant change

Considerations for defining a significant change

• Consider factors to define as a significant change, such as, but not limited to:
  ○ Adding or removing goals and objectives.
  ○ Changes that trigger public comment, tribal consultation, and input from the state's Medical Care Advisory Committee.
  ○ Substantive changes to the state's managed care quality laws.

A.2. Updates for significant changes that occur within the state's Medicaid program

- **Regulatory Citation:** 42 CFR 438.340(c)(3)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).
- **Regulatory Requirements:** In addition to updates made to reflect significant changes as defined by the state, the state must also update its quality strategy whenever significant changes occur within the state's Medicaid program.

Examples of significant changes within the state's Medicaid program

Significant changes to the state's Medicaid program can include, but are not limited to, adding populations to the state's managed care program or enrolling a managed care population in a new program, such as an 1115 demonstration.

B. Updates as Needed, but No Less than Every Three Years

This section describes the requirements and provides considerations for reviewing and updating the quality strategy.

B.1. Review and evaluation of the quality strategy

- **Regulatory Citation:** 42 CFR 438.340(c)(2), 438.340(c)(2)(i), and 438.340(c)(2)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).
- **Regulatory Requirement:** In addition to updating the state's quality strategy whenever significant changes occur, the state must review and update its quality strategy as needed, but no less than every three years. The state's review of the quality strategy must include an

evaluation of the effectiveness of the quality strategy conducted within the previous three years. The state must make the results of the review and evaluation available on its website.

Exhibit 16 provides considerations for the state as it addresses this requirement.

Exhibit 16. Review and evaluation of the quality strategy

Considerations for addressing the review and evaluation of the quality strategy

• Consider the scope and format of the evaluation process. The state could: (1) include in the quality strategy a short summary of the effectiveness evaluation process with a link to the full effectiveness evaluation and review or (2) include a full discussion of the effectiveness evaluation process and most recent review in the quality strategy. If the state discusses the evaluation process and review in different locations in the quality strategy, the state can consider posting on its website a brief document that links to the quality strategy and includes page numbers for where all evaluation and review elements are located.
• Assess whether the state met or made progress on its quality strategy goals and objectives.
• CMS recommends that the state include the following steps and information in its evaluation:
  ○ Describe the state's methodology.
  ○ Provide baseline data for each measure in the goals and objectives and the improvement made over time. Calculate results for each measure annually.
  ○ If the state did not meet or make progress on any of its goals and objectives, explain why and how the state has modified its approach in the revised quality strategy considering those reasons.
  ○ Indicate whether the state's managed care quality provisions, as detailed in its quality strategy, are aligned and focus on consistent aims and goals. For example, assess whether the state includes consistent measures across its goals and objectives required under 42 CFR 438.340(b)(2) and those it uses to measure plan performance and improvement (including QAPI measures) required under 438.340(b)(3)(i).
  ○ Indicate whether the state's managed care quality provisions, as detailed in its quality strategy, address MCP performance on the Child and Adult Core Set measures. For example, assess whether the state addressed low MCP performance on the Child and Adult Core Set measures in its goals and objectives.
  ○ Describe 1) whether the state is making progress on its quality strategy goals and objectives and 2) whether the state is continuing with or revising its goals and objectives based on the evaluation.
  ○ Indicate whether and how the state acted on EQR recommendations in its quality strategy.
• Provide a link to where the results of the review are posted on the state's website.

B.2. EQRO recommendations

- **Regulatory Citation:** 42 CFR 438.340(c)(2)(iii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.364(a)(4) and 457.1250(a).
- **Regulatory Requirement:** The state must ensure that updates to the quality strategy take into consideration the recommendations provided by an EQRO and should describe how updates to the quality strategy take those recommendations into consideration.

Exhibit 17 provides considerations for the state as it addresses this requirement.

Using EQR to Address Goals and Objectives

Per 42 CFR 438.364(a)(4), the state's EQR report must include recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity. This includes how the state can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

Exhibit 17. EQRO recommendations

Considerations for presenting EQRO recommendations
• Review findings and recommendations from the state's EQR reports to develop and monitor progress toward meeting its goals and objectives. • Summarize findings and recommendations from the state's latest EQR reports and describe how the quality strategy has been updated to address them.

IV. Quality Strategy Submission Process

Managed care regulations (42 CFR 438.340(c)(3) and 457.1240(e)) require the state to submit a copy of its quality strategy to CMS based on two events: (1) when the state completes a draft of its initial quality strategy and (2) when there has been a significant change, either to the quality strategy (per the state's definition of a significant change) or to the state's Medicaid or CHIP program. This chapter describes requirements and considerations for the quality strategy submission process.

Cross-cutting Considerations

See recommended cross-cutting considerations when drafting and submitting the state's quality strategy.

The effective date of any quality strategy is the date that the state posts the quality strategy on its website. If there are no significant changes, as described in scenario (2) above, the state is not required to submit its revised quality strategy to CMS. However, the state can always submit its updated quality strategy to CMS for feedback. The most recent quality strategy submitted to CMS or posted on the state's website is the state's current quality strategy.

Transparency Requirements

Under 42 CFR 438.340(d), the state must make its quality strategy available on its website.

Please refer to Figure 3 on page 28 for the quality strategy lifecycle, which includes the quality strategy submission requirements described in this chapter.

A. Public and Tribal Comment Process

This section describes what is required of states and considerations for addressing the public and Tribal comment process.

- **Regulatory Citation:** 42 CFR 438.340(c)(1)(i) and 438.340(c)(1)(ii), cross-referencing 42 CFR 431.12, applicable also to CHIP managed care programs per 42 CFR 457.1240(e).

- **Regulatory Requirement:** The state must make the strategy available for public comment before submitting the strategy to CMS for review, including by obtaining input from its Medical Care Advisory Committee (Medicaid only), beneficiaries, and other stakeholders. In addition, the state must consult with Tribes in accordance with the state's Tribal consultation policy established pursuant to 1902(a)(73) of the Social

Input from Medical Care Advisory Committee

As part of the public comment process, the state must obtain input from its Medical Care Advisory Committee. However, establishing an advisory committee for CHIP is not a requirement, though the state may consult its advisory committee for purposes of incorporating CHIP in its quality strategy.

Security Act, if the state enrolls American Indians and Alaska Natives (AI/ANs) in any of its MCPs.

If the state does not enroll AI/ANs in managed care or have Indian Health Programs or Urban Indian Organizations that furnish health care services, it is not required to consult with Tribes.

Exhibit 18 provides considerations for the state as it addresses this requirement.

Exhibit 18. Public and Tribal comment process

Considerations for addressing the public comment process
• Indicate whether the state enrolls AI/ANs in managed care and whether the state has officially recognized Tribes; comply with the state's Tribal consultation policy. • Detail the public and Tribal comment process or provide a link in the quality strategy to a document posted on the state's website that details how the state addressed this requirement. • Consider including comments received during the public comment and Tribal consultation period as an appendix to the quality strategy. • Indicate when the state made the quality strategy available for public comment and Tribal consultation. If the state has not made its quality strategy available for public comment and Tribal consultation, indicate when it will do so. • Describe comments and input received, along with whether and how the state refined its quality strategy based on the comments and input. • Budget approximately six months for the whole process of gathering comments, which accounts for preparation, a 30- to 60-day comment period, time to review comments, and time to update the quality strategy based on the public input.

B. Submit the Initial Quality Strategy to CMS for Comment and Feedback

This section describes the requirement and provides considerations for submitting the initial quality strategy to CMS for comment and feedback.

- **Regulatory Citation:** 42 CFR 438.340(c)(3)(i), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).
- **Regulatory Requirement:** The state must submit a copy of the initial strategy for CMS comment and feedback prior to adopting it as final.

Exhibit 19 provides considerations for the state as it addresses this requirement.

Exhibit 19. Submit the initial quality strategy for CMS comment and feedback

Considerations for submitting the quality strategy for CMS comment and feedback
• Detail the CMS comment and feedback process in the quality strategy or provide a link in the quality strategy to a document posted on the state's website that details how the state addressed this requirement. • Indicate in the footer of the cover page of the quality strategy the date when the state submitted the quality strategy to CMS for review and feedback.

C. Submit the Quality Strategy to CMS Due to Significant Changes

This section describes the requirement and provides considerations for submitting the quality strategy due to significant changes.

- **Regulatory Citation:** 42 CFR 438.340(c)(3)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).
- **Regulatory Requirement:** The state must submit a copy of its revised quality strategy whenever significant changes, as defined in the state's quality strategy, are made to the document, or whenever significant changes occur within the state's Medicaid or CHIP program.

Significant Change Resulting from CMS Review

During the CMS review and feedback process, CMS may provide compliance feedback to the state that will require changes to the quality strategy. CMS and the state will determine whether these revisions to its quality strategy meet the state's definition of a significant change or result in changes to the state's Medicaid or CHIP program.

Exhibit 20 provides considerations for the state as it addresses this requirement.

Exhibit 20. Quality strategy revisions due to significant changes

Considerations for submitting the quality strategy due to significant changes

• Indicate the reason(s) the state revised its quality strategy:
  ○ Due to a change in the quality strategy, as defined under the state's own definition of significant change.
  ○ Due to significant changes that occurred within the state's Medicaid or CHIP programs.
  ○ Due to significant revisions as a result of CMS feedback.
• Detail this information in the quality strategy or provide a link to a document posted on the state's website that details this information.

D. Submitting the Quality Strategy and TA Requests

Please submit the state's quality strategy and any questions or requests for TA to ManagedCareQualityTA@cms.hhs.gov. CMS recommends that the state review its draft quality strategy against the regulations detailed in Chapters II and III of this toolkit before submitting it to CMS.

Appendix A: Acronyms

CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
EQR	External quality review
EQRO	External quality review organization
FFP	Federal financial participation
HEDIS	Healthcare Effectiveness Data and Information Set
LTSS	Long-term services and supports
MCO	Managed care organization
MCP	Managed care plan
PAHP	Prepaid ambulatory health plan
PAO	Private accrediting organization
PCCM	Primary care case management
PIHP	Prepaid inpatient health plan
PIP	Performance improvement project
QAPI	Quality assessment and performance improvement
QRS	Quality rating system
TA	Technical assistance

Appendix B: Glossary of Terms[30]

External quality review (EQR)	The analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health services that an MCO, PIHP, PAHP, or PCCM entity (described at 42 CFR 438.310(c)(2) and in CHIP at 42 CFR 457.1240(f)) or their contractors furnish to Medicaid and CHIP beneficiaries.
External quality review organization (EQRO)	An organization that meets the competence and independence requirements set forth at 42 CFR 438.354 (applicable also to CHIP managed care programs per 42 CFR 457.1250[a]) and performs EQR or other EQR-related activities as set forth in 42 CFR 438.358 (applicable also to CHIP managed care programs per 42 CFR 457.1250[a]), or both.
External quality review (EQR)-related activities	Mandatory and optional activities, such as PIP validation and performance measure validation, completed for annual EQR. EQR-related activities may be conducted by the state; its agent that is not an MCO, PIHP, PAHP, or PCCM entity (described at 42 CFR 438.310(c)(2) and in CHIP at 42 CFR 457.1240(f)); or an EQRO. See 42 CFR 438.358.
Managed care organization (MCO)	An entity that has a comprehensive risk contract under 42 CFR Part 438, and that is (1) A Federally qualified Health Maintenance Organization that meets the advance directives requirements of subpart I of Part 489; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) 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; (ii) Meets the solvency standards of 42 CFR 438.116.
Managed care plan (MCP)	For the purposes of quality strategy requirements, includes MCOs, PIHPs, PAHPs, and PCCM entities described in 42 CFR 438.310(c)(2) and 42 CFR 457.1240(f).

[30] Definitions of several of these and related terms are also in 42 CFR 438.2 and 438.320.

Measure/Metric	For the purposes of this toolkit, used to monitor the performance of MCPs at a point in time, to track plan performance over time, to compare performance among plans, and to inform the selection and evaluation of quality improvement activities.
Performance improvement project (PIP)	An intervention that is designed to achieve and sustain significant improvement in health outcomes over time. In the Medicaid and CHIP managed care context, PIPs are defined by the state agency and implemented by the MCP.
Prepaid ambulatory health plan (PAHP)	An MCP under contract with the state that provides services to enrollees 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)	An MCP under contract with the state that provides services to enrollees on the basis of capitation payments or other payment arrangements that do not use state plan payment rates; provides, arranges, 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) entity	An entity which provides functions such as case management and enrollee education in addition to PCCM services. For the purposes of this toolkit, the term PCCM entity only applies to those PCCM entities whose contracts with a state provide for shared savings, incentive payments, or other financial reward for the PCCM entity for improved quality outcomes, as described at 42 CFR 438.310(c)(2). For CHIP, the term applies to a PCCM entity whose contract with the state provides for shared savings, incentive payments, or other financial reward for improved quality outcomes, as described at 42 CFR 457.1240(f).

Quality	The degree to which an MCO, PIHP, PAHP, or PCCM entity (described at 42 CFR 438.310(c)(2) and 42 CFR 457.1240(f)) increases the likelihood of the desired health outcomes of its enrollees through structural and operational characteristics; the provision of services that are consistent with current, professional, evidence-based knowledge; and interventions for performance improvement.
Quality strategy	A written strategy to assess and improve the quality of Medicaid and CHIP managed care services within a state per 42 CFR 438.340 and applicable also to CHIP managed care programs per 42 CFR 457.1240(e).

Appendix C: Non-Duplication for Mandatory EQR-Related Activities

A. Non-duplication Guidance

Non-duplication is intended to provide additional flexibility and reduce administrative burden on MCPs and states while ensuring that relevant information is available to EQROs for the annual EQR. Specifically, it allows a state to use information from a Medicare or private accreditation review of an MCP in place of generating that information through one or more of three mandatory EQR-related activities (validation of PIPs, validation of performance measures, and review of compliance with Medicaid managed care regulations).[31]

It is an option available for states that contract with Medicaid managed care MCOs, PIHPs, and PAHPs[32] only when the Medicare or accreditation review standards are comparable to the EQR protocols (not vice versa). If a state elects to use non-duplication, it must document in its quality strategy the EQR-related activities for which it will utilize non-duplication, along with the state's rationale for its determination that the Medicare or private accreditation review standards are comparable to those in the EQR protocols.[33] The federal requirements related to non-duplication of mandatory activities are described in 42 CFR 438.360. Like Medicaid, a state may use information from the private accreditation review of a CHIP MCO, PIHP, or PAHP to avoid the duplication of certain EQR-related activities consistent with the Medicaid nonduplication regulation; however, in the CHIP context, information documenting compliance with Medicare Advantage standards is not applicable as described in 42 CFR 457.1250(a) (incorporating 42 CFR 438.360 "only with respect to nonduplication of EQR activities with private accreditation").

For a state to rely on the non-duplication provision, the following conditions must be met:

- The MCP has (1) obtained accreditation from a private accrediting organization (PAO) recognized by CMS as applying standards at least as stringent as Medicare under the procedures in 42 CFR 422.158 or (2) is in compliance with the applicable Medicare Advantage standards established by CMS, as determined by CMS or its contractor for Medicare.
- The Medicare standards[34] or private accreditation review standards (submitted by the PAO) are comparable to those established through the EQR protocols for the three mandatory EQR-related activities.[35]

[31] Prior to issuance of the Medicaid and CHIP final rule, such information could only be used to provide information that would otherwise be gathered from performing the mandatory EQR-related compliance review.

[32] References to MCPs in this section are only to those types of plans

[33] See 42 CFR 438.360(c) and 438.340(b)(9).

[34] See 42 CFR part 422.

[35] See 42 CFR 438.358(b)(1) identifying four mandatory EQR-related activities:

- The MCP provides the state with all reports, findings, and other results of the Medicare or private accreditation review activities applicable to the standards for the EQR-related activities.

For a state to rely on the non-duplication provision in 42 CFR 438.360(a) and use information from a private accreditation review of an MCP in place of generating that information through one or more of three mandatory EQR-related activities, the MCP must have "obtained accreditation from a private accrediting organization recognized by CMS". To use information from a successful private accreditation review of an MCP for the purposes of non-duplication, the review must be conducted by a PAO recognized by CMS as applying standards at least as stringent as Medicare under the procedures in under 42 CFR 422.158 (the standards used by CMS to recognize an accrediting organization in the Medicare Advantage program). Such recognition must be in place at the time the information is generated by the PAO and also when the PAO makes a final decision on the MCP's accreditation review. For example, if a PAO lacks CMS recognition in March when it conducts an accreditation review activity for an MCP, but obtains CMS recognition in June prior to reaching a final decision on the MCP's accreditation in August, a state and the MCP may not rely on information generated by the March activities for purposes of applying the non-duplication provision. However, if the newly-recognized PAO conducts additional accreditation review activities in July, information generated during those activities may be used for non-duplication, so long as the remaining requirements in 42 CFR 438.360 are met. If the same PAO were to subsequently lose its CMS recognition in December of the same year, a state and the MCP may rely on information generated by activities performed as part of the PAO's accreditation review in July, so long as the remaining requirements in 42 CFR 438.360 are met.

The state is responsible for providing the EQRO with all information from the Medicare or private accreditation review that is being used for non-duplication purposes. The EQRO then assesses the completeness of information from the accreditation review to determine the extent of non-duplication, including confirming that the comparable information fully meets the requirements for completing the analysis and developing EQR findings and recommendations. If a state chooses non-duplication, it must ensure the completion of any EQR-related activities (or components of those activities) that are not addressed by the information from the Medicare or

(i) Validation of performance improvement projects required in accordance with §438.330(b)(1) that were underway during the preceding 12 months.

(ii) (ii) Validation of MCO, PIHP, or PAHP performance measures required in accordance with §438.330(b)(2) or MCO, PIHP, or PAHP performance measures calculated by the State during the preceding 12 months.

(iii) (iii) A review, conducted within the previous 3-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in subpart D of this part, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

(iv) (iv) Validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements set forth in §438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, §438.14(b)(1).)

private accreditation review[36]. For example, if an accreditation review did not validate LTSS or other non-HEDIS measures required by the state as a part of an MCP's QAPI program, that validation activity would need to be completed for those measures.

Even when information from a Medicare or private accreditation review does not completely meet the requirements of an activity, that information can still be used under the non-duplication regulation to partially fulfill the EQR requirements. For example, under the non-duplication provisions, a state may be able to use information from a PAO to satisfy a subset of the regulatory requirements that are subjects of the EQR compliance review. In this example, the EQRO could use information from the non-duplication source for that subset of requirements, and then the EQR-related activity would only need to be conducted on the remaining requirements to fully assess compliance. Similarly, if a state requires its MCPs to include 10 measures in QAPI and five measures are validated as a part of an accreditation review, only the other five measures would need to be validated through the EQR-related activity. States would provide validation information on all 10 measures to the EQRO for the EQR.

When information from a Medicare or private accreditation review of an MCP is used to support one or more mandatory EQR-related activities, the state's expenses for the EQRO's analysis of the data is eligible for federal financial participation (FFP). The accreditation activities that produce the information are not eligible for the FFP. Note that use of information from Medicare review or accreditation for under the non-duplication authority is a decision made by the state, not its MCPs.

B. Differences between Non-duplication and Exemption

Non-duplication is a way to provide information for the annual EQR without conducting part or all of one or more EQR-related activities by using information yielded by a comparable review process. Under 42 CFR 438.360 and 42 CFR 457.1250(a), an MCO, PIHP, or PAHP is still subject to EQR and will be included in the annual EQR technical report.

Per 42 CFR 438.362, exemption is an option which allows a state to exempt an MCO (but not a PIHP or PAHP) from the annual Medicaid managed care EQR process under certain circumstances. If a state exempts an MCO from the EQR, the MCO will not be included in the annual EQR technical report. A state may elect to exempt an MCO from EQR when the following three conditions are met:

1. The MCO has both a current Medicare Advantage contract and a current Medicaid contract.
2. The two contracts cover all or part of the same geographic area in the state.
3. The Medicaid contract was in effect for at least two consecutive years before the exemption date and, during those same two years, the MCO was subject to the EQR and met the quality, timeliness, and access to health care services standards for Medicaid beneficiaries.

[36] 42 CFR 438.364.

If a state wants to exempt an MCO from the EQR, it must obtain either of the following:

- For MCOs reviewed by Medicare, the state must obtain annually the most recent Medicare review findings from the MCO, including all data, correspondence, information, and findings relevant to the MCO's compliance with Medicare standards for (1) access, quality assessment and performance improvement, health services, or delegation of these activities; (2) all measures of the MCO's performance; and (3) results and findings of all performance improvement projects for Medicare enrollees.
- For MCOs reviewed by a private, national accrediting organization that CMS approves and recognizes for Medicare Advantage Organization deeming, the state must require that the MCO provide a copy of all findings from its most recent accreditation review, if that review was used to meet certain requirements for Medicare external review or to determine compliance with Medicare requirements. At a minimum, findings must include the results of an evaluation of compliance with individual accreditation standards, any deficiencies, corrective action plans, and summaries of unmet accreditation requirements.

Complete requirements for exemption of MCOs are available at 42 CFR 438.362.