CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)

Improving Quality of Care Through External Quality Review and Federal Financial Participation

Center for Medicaid and CHIP Services

Medicaid Managed Care Final Rule

- The Medicaid Managed Care Final Rule was published in the Federal Register on May 6th
- This final rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade
- This final rule advances the agency's mission of *better care, smarter spending, and healthier people*

Key Goals

- To support State efforts to advance **delivery system reform** and **improve the quality of care**
- To strengthen the **beneficiary experience of care** and key beneficiary protections
- To strengthen program integrity by **improving accountability and transparency**
- To **align** key Medicaid and CHIP managed care requirements with other health coverage programs

Topics for Today's Presentation

- **Extension of Quality Provisions to All Plan Types**
  - Extension of quality provisions to PAHPs and PCCM entities
  - Extension of most quality provisions, including EQR requirements, to CHIP
- **External Quality Review**
  - Reporting requirements
  - New activities
  - Nonduplication and exemption
- **Changes to FFP match**

Basic Terminology

The Medicaid managed care final rule impacts the following arrangements to varying degrees:

- Managed Care Organizations (MCOs)
- Prepaid Inpatient Health Plans (PIHPs)
- Prepaid Ambulatory Health Plans (PAHPs)
- Primary Care Case Management (PCCMs)
- Primary Care Case Management Entities (PCCM Entities)

Improving the Quality of Care: Changes to External Quality Review (EQR)

- Adds two new EQR activities
  - Mandatory: Validation of MCO, PIHP, and PAHP network adequacy; *applies no later than one year from issuance of EQR protocol*
  - Optional: Assist with the quality rating of MCOs, PIHPs, and PAHPs under the QRS; *applies no earlier than the issuance of the EQR protocol*
- Extends EQR to PAHPs and PCCMs with financial incentives; required beginning July 1, 2018
  - PCCMs with financial incentives required to undergo only 2 mandatory activities: validation of performance measures and compliance review

Improving the Quality of Care:
External Quality Review

- Once new EQR activities are implemented, the annual EQR process will consist of 4 mandatory and 6 optional activities:
  - 4 mandatory activities
    - Performance Improvement Project Validation
    - Performance Measurement Validation
    - A review, conducted within the previous 3-year period, to determine plans' compliance with the standards set forth in subpart D of 42 CFR 438
      - Relating to access; care coordination; amount, duration, and scope of covered services; and other plan standards
    - Network Adequacy Validation (new)

Improving the Quality of Care: External Quality Review…continued

– 6 optional activities
  - Validation of encounter data
  - Administration or validation of consumer or provider surveys of quality of care
  - Calculation of performance measures in addition to those reported by health plans
  - Conduct of PIPs in addition to those conducted by health plans
  - Focus studies
  - Assistance with the QRS (new)

Improving the Quality of Care: Changes to EQR Process and Policy

- Changes to EQR process and policy:
  - An accrediting body may not serve as an EQRO for a health plan it accredited within the previous 3 years
  - Information from the EQR-related activities must be used to complete the EQR technical report - States may not substantively revise the content of the report by its EQRO without evidence of error or omission
- Standard publication date of April 30th of each year, posted on the State's website

Improving the Quality of Care: EQR Annual Technical Report

- In addition to the current requirements, the annual technical report also will be required to:
  - Include validated performance measurement data for each activity conducted in accordance with performance of PIP and performance measurement activities
  - Include recommendations for how the State can target goals and objectives in the Quality Strategy to better support improvement in quality, timelines and access

Improving the Quality of Care: EQR Non-Duplication Provision

- States have the option to rely on information from a review of an MCO, PIHP or PAHP performed by a Medicare or a private accrediting entity in contributing to the findings by the EQRO in annual technical reporting of the following mandatory EQR-related activities:
  - Compliance review
  - Validation of PIPs (new)
  - Validation of performance measures (new)
- Is not extended to validation of network adequacy activity
- States must specify in their quality strategy what Medicare review or private accreditation information will be comparably used and why
- States must provide that information directly to their EQRO for analysis and inclusion in annual technical report findings and recommendations

Improving the Quality of Care:
EQR Exemption for Certain Medicare Advantage Plans

- Exemption from EQR for Medicare Advantage plans if conditions met:
  - The MCO has a current Medicare contract under part C of Title XVIII or under section 1876 of the Act, and a current Medicaid contract under section 1903(m) of the Act
  - The two contracts cover all or part of the same geographic area within the State
  - The Medicaid contract has been in effect for at least 2 consecutive years before the effective date of the exemption and during those 2 years the MCO has been subject to Medicaid EQR, and found to be performing acceptably
- New - Exemption no longer applies to PIHPs because statute limits exemption to entities that fall under section 1903 (m) of the Act

Improving the Quality of Care: CHIP

- EQR regulations apply to CHIP, with limited exceptions:
  - Provisions specific to dual eligibles (§§438.330(d)(3), 438.334(d))
  - Exemption from external quality review for Medicare Advantage plans (§438.362)
  - Non-duplication of EQR activities based on information from a Medicare accreditation review (§438.360); non-duplication based on private accreditation is applied to CHIP

All new managed care provisions apply to CHIP MC contracts as of the state fiscal year beginning on or after July 1, 2018

Improving the Quality of Care: EQR Protocols Revision Timeline

- Original protocols were issued in 2003
- Revised protocols were issued in 2012
- CMS plans to issue revised protocols in 2017
  - Modernize the protocols to reflect advances in the field of quality measurement and improvement
  - Ensure compliance with changes to regulations
  - Reflect applicability to standalone CHIP programs
  - Relate appropriately to PCCMs and PAHPs
- 2018
  - Network Adequacy Validation protocol
- 2019
  - QRS support protocol

Improving the Quality of Care: Changes to FFP for EQR

- FFP at the 75 percent rate now available only for EQR (including the production of EQR results) and EQR-related activities performed on MCOs by a qualified EQRO
- FFP at the 50 percent match rate is available for EQR and EQR-related activities performed on entities other than MCOs (including PIHPs, PAHPs, PCCM entities, or other types of integrated care models)
- FFP at the 50 percent match rate is available for EQR activities performed on any type of plan by entities that do not meet the requirements of an EQRO
- FFP at the 75 percent rate no longer available for EQR activities for PIHPs
- Revisions to CMS 64.10 Base Form will reflect the changes in available matching rates for EQR
  - An information bulletin was released on June 10, 2016; the CMS 64.10 Base Form update will be released in the Medicaid Budget and Expenditure System by June 30, 2016.
- EQRO contracts must be submitted for approval prior to receiving the enhanced matching rate for MCOs

  This provision applies on May 6, 2016, the publication date of the Final Rule

Improving the Quality of Care: Informational Bulletin

- Released June 10, 2016
- Clarifies the changes to 42 CFR 438.370
  - 75% matching rate only applies to MCOs
  - 50% matching rate applies to PIHPs, PAHPs and PCCM entities for EQR activities
- Provides a basic overview of the changes to the Form CMS 64 expenditure reporting for EQR

Improving the Quality of Care:
Updates to the CMS 64

- Updated CMS 64.10 Base Form enables states to separately report expenditures for EQR-related activities eligible for the 75 percent enhanced match
- CMS 64.10 Base Form pop-up menu for EQR line 17 updated to aid states in entering these details separately from reporting expenditures at the 50% enhanced match
  - See Attachment A of the Informational Bulletin for examples
- Separate line for reporting PIHP expenditures prior to May 6

Compliance Dates

- May 6, 2016
  - 42 CFR 438.370 – Federal financial participation (FFP)
    - Only MCOs will receive a 75% enhanced match
    - PIHPs, PAHPs and PCCM entities will receive a 50% match
- July 1, 2018
  - 42 CFR 438.350 – External Quality Review
  - 42 CFR 438.354 – Qualifications of EQROs
  - 42 CFR 438.356 – State Contract options for EQR
  - 42 CFR 438.358 – Activities related to EQR
  - 42 CFR 438.360 – Nonduplication of mandatory activities
  - 42 CFR 438.362 – Exemption from EQR
  - 42 CFR 438.364 – External Quality Review Results
- Compliance with 2003 regulations required until new regulations implemented

Resources

- Medicaid.gov – Landing and Managed Care Pages
  - Link to the Final Rule
  - 8 fact sheets and implementation timeframe table
  - Link to the CMS Administrator's "Medicaid Moving Forward" blog
- ManagedCareRule@cms.hhs.gov

QUESTIONS?

Additional Questions?

- Please send additional questions to the mailbox dedicated to this rule:

- **ManagedCareRule@cms.hhs.gov**

- While we cannot guarantee individualized responses, inquiries will inform future guidance and presentations