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Updated Protocols for the External Quality Review (EQR) of Medicaid and CHIP Managed Care

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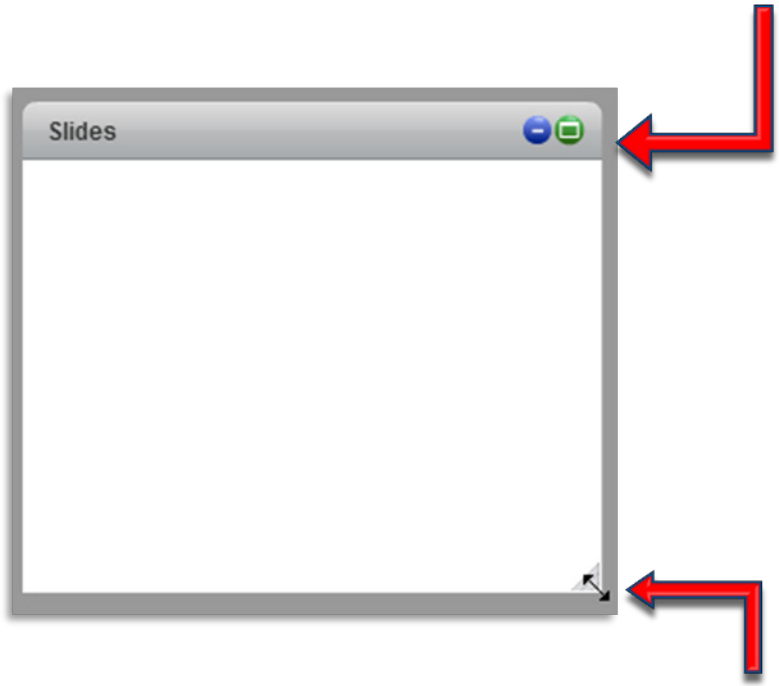

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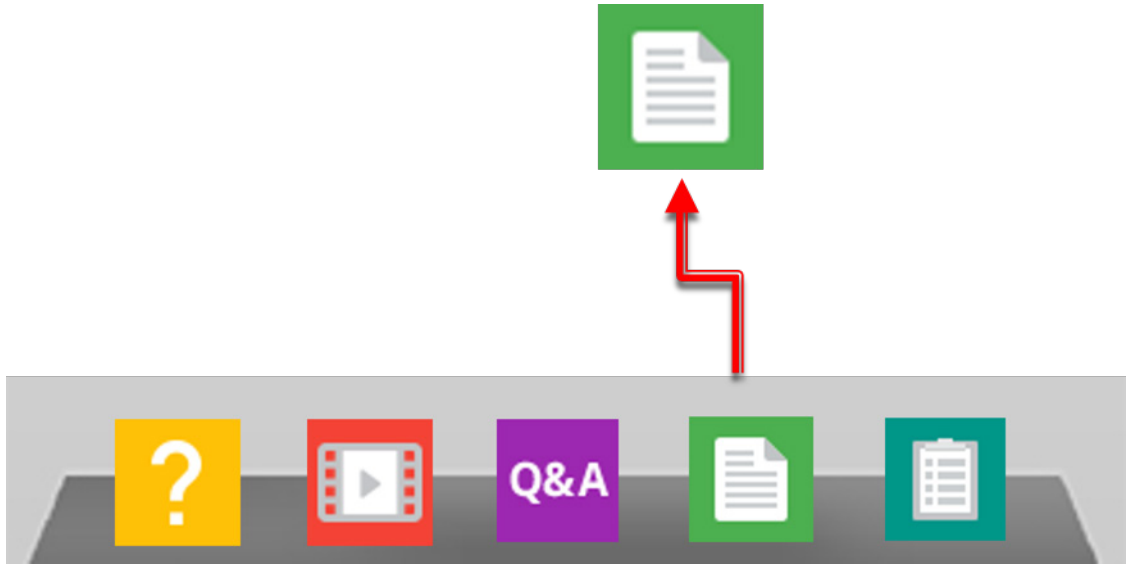

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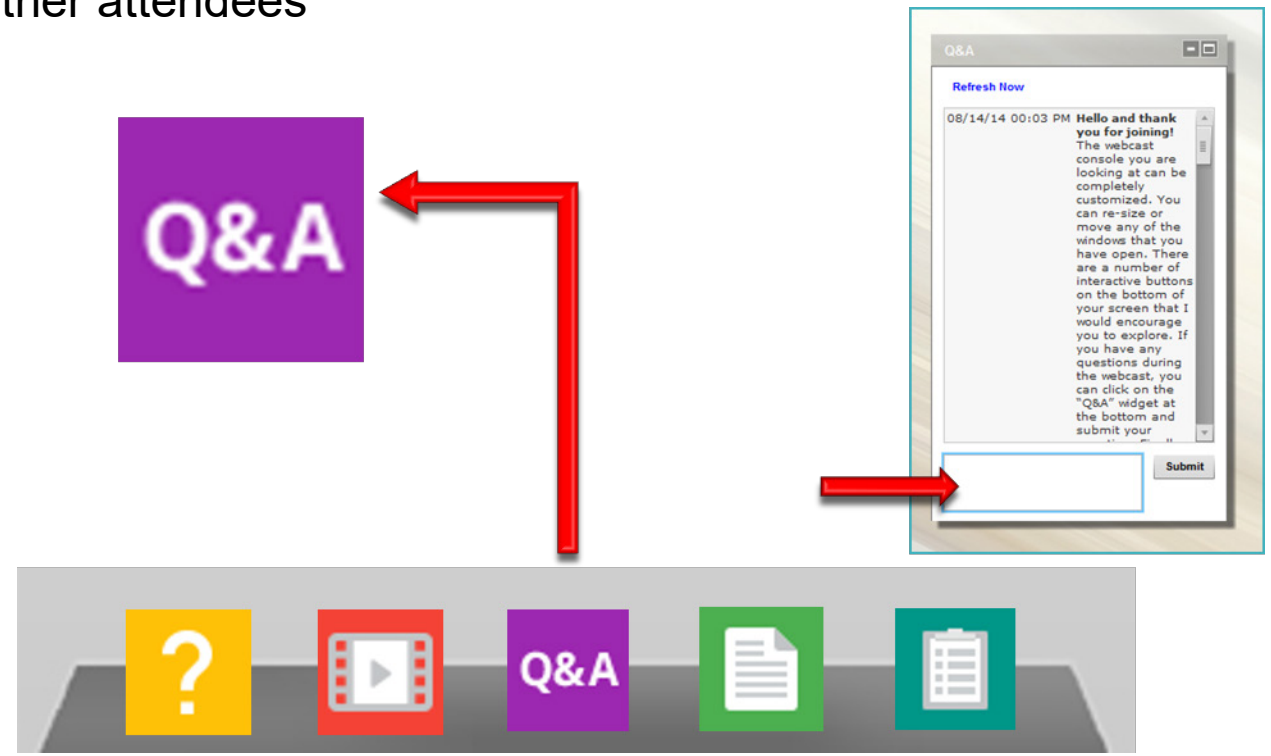

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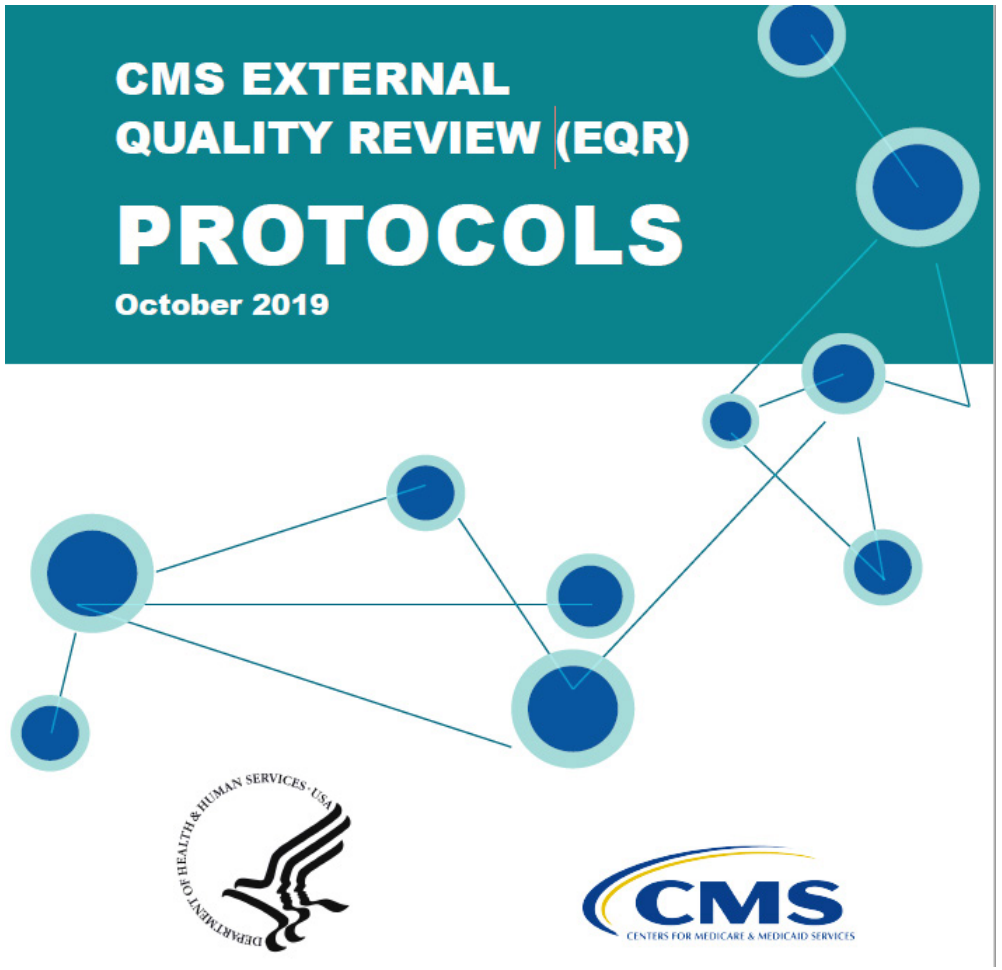
Webinar Agenda and Objectives

Agenda	Objective
EQR of Medicaid and CHIP Managed Care: Context for the updated protocols	Review the context for EQR and EQR-related activities and describe the role of the EQR as a quality improvement and oversight mechanism
The revised EQR protocols: What's new?	Highlight key changes to the EQR protocols and how the changes will help states and EQROs produce more meaningful EQR technical reports
In-depth discussion of the mandatory EQR protocol activities	Review protocol activities and tools for improved reporting in EQR technical reports
Drafting EQR technical reports	Share tips for drafting an effective EQR technical reports
Resources to guide the mandatory activities	Highlight technical assistance resources available to states and other stakeholders
Q&A	Please submit your questions through the Q&A widget in the webinar platform; we will answer as many questions as we can during the webinar

Audience Poll

Which type of organization do you represent?

A. State Medicaid or CHIP agency
B. Managed care plan
C. External Quality Review Organization (EQRO)
D. Centers for Medicare & Medicaid Services (CMS)
E. Other federal agency
F. Other federal or state contractor
G. Other



EQR of Medicaid and CHIP Managed Care: Context for the Updated Protocols

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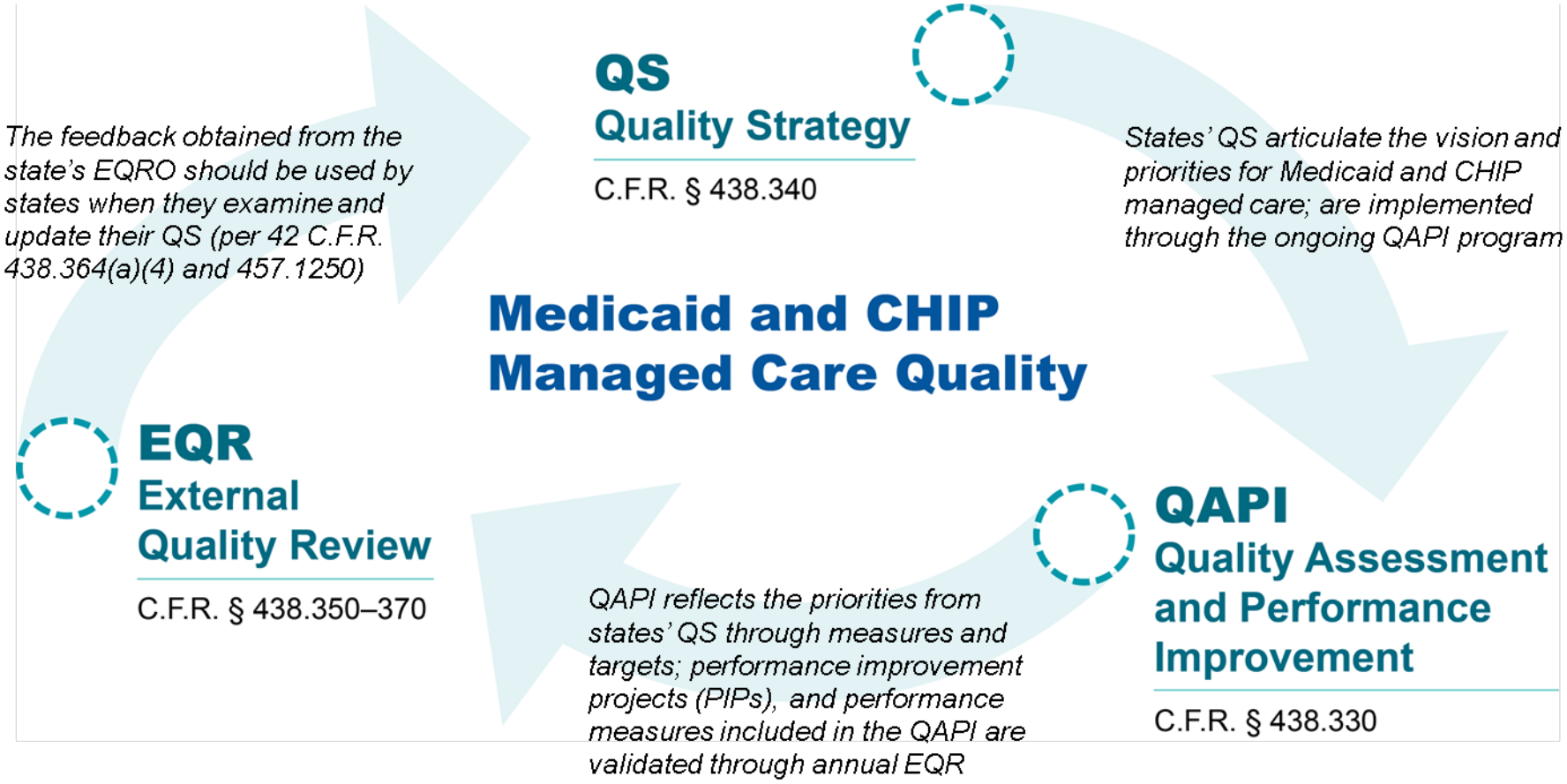
The Context for EQR

EQR is one part of an interrelated set of compliance and quality requirements that apply to Medicaid and CHIP managed care



EQR and EQR-Related Activities for Medicaid and CHIP

- **EQR** is the analysis and evaluation of aggregated information on quality, timeliness, and access to health services that a managed care plan or its contractors provide to Medicaid or CHIP beneficiaries (42 C.F.R. 438.320)
- **EQR-related activities** produce the data used to complete the annual EQR. EQR-related activities may be conducted by the state, its agent that is not a managed care plan, or a qualified External Quality Review Organization (EQRO) (42 C.F.R. 438.358)
- States that contract with any managed care plan to provide services for all or some of their Medicaid and/or CHIP beneficiaries must conduct an EQR
- States have flexibility regarding who can conduct the EQR-related activities:
  - If a state elects to contract with an EQRO to conduct the EQR-related activities, this can be the same EQRO that conducts the EQR for the state, or one or more additional EQROs
  - See 42 C.F.R. 438.356, cross referenced at 457.1250 for CHIP, for information on state contracting options for EQR
- States cannot substantively revise the **EQR technical report** without evidence of errors or omission of key information

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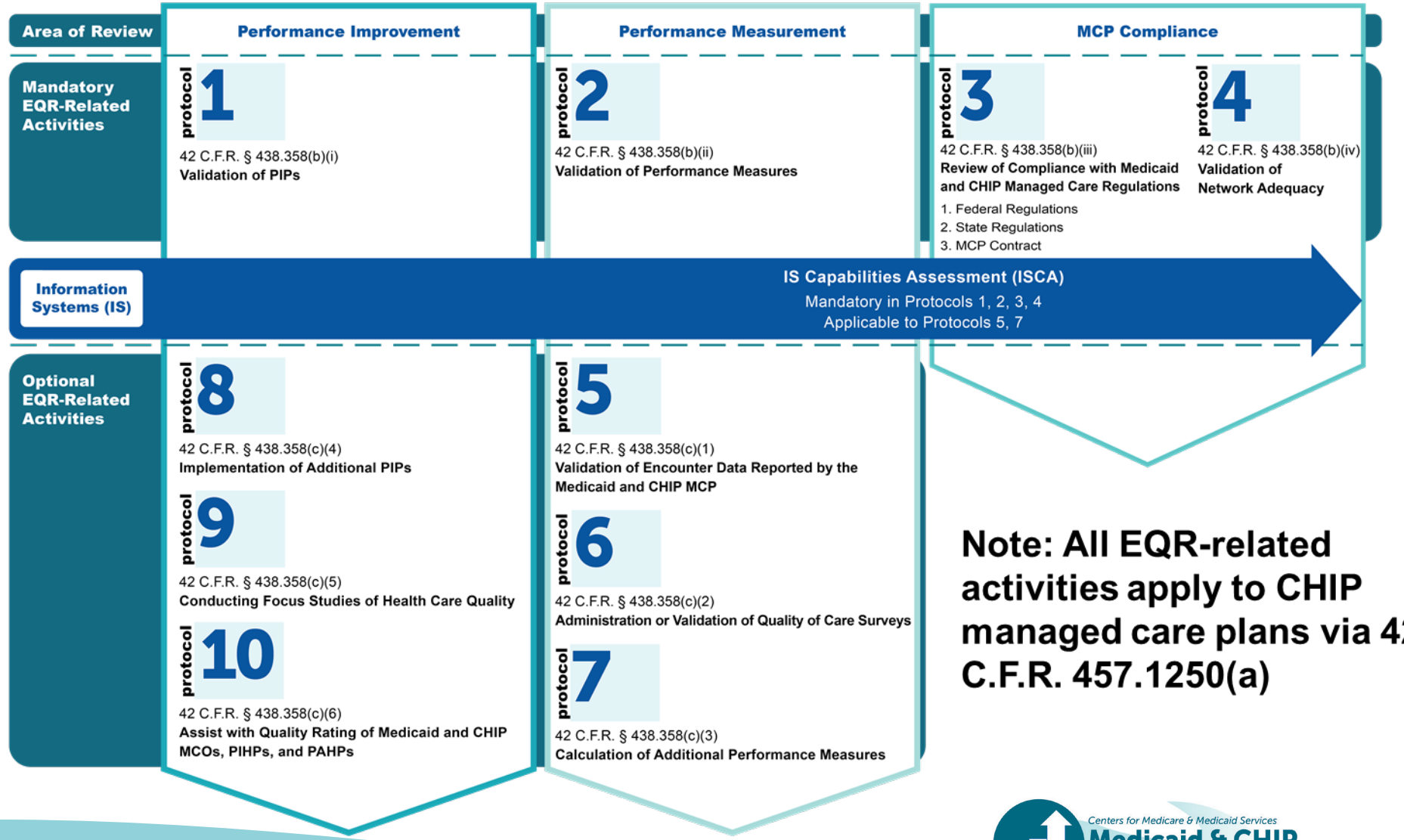
Mandatory and Optional EQR-Related Activities

EQR includes a set of *mandatory* and *optional* EQR-related activities



Note: All EQR-related activities apply to CHIP managed care plans via 42 C.F.R. 457.1250(a)

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EQR Goals: Quality Improvement and Oversight

- The EQR-related activities are intended to:
  - Improve states' ability to oversee and manage the managed care plans (MCPs) they contract with for services
  - Help MCPs improve their performance with respect to quality, timeliness, and access to care
- Effective implementation of the EQR-related activities will facilitate state efforts to:
  - Purchase high-value care
  - Achieve a higher performing health care delivery system for Medicaid and CHIP beneficiaries
- EQR technical reports are intended to help states:
  - Identify areas for quality improvement
  - Ensure alignment among a MCP's QAPI requirements, the state's quality strategy, and the annual EQR activities

The Revised EQR Protocols: What's New?

Changes to the EQR Protocols

The 2016 Medicaid and CHIP Managed Care Final Rule required substantive changes to the EQR protocols.* It was also an opportunity to revise the protocol design

Substantive

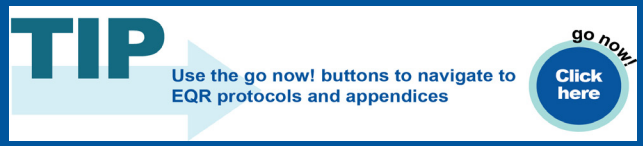
To accommodate changes to the quality provisions and requirements of EQR

- Revisions provide guidance to states and EQROs to comply with the modernization of the Final Rule's requirements

Design

To improve the user experience

- Orient the reader, increase readability and usability, and align the narrative with protocol worksheets
- "Go Now!" buttons:



*42 C.F.R. 438.350 – 438.370 and 457.1250

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1. Substantive Changes

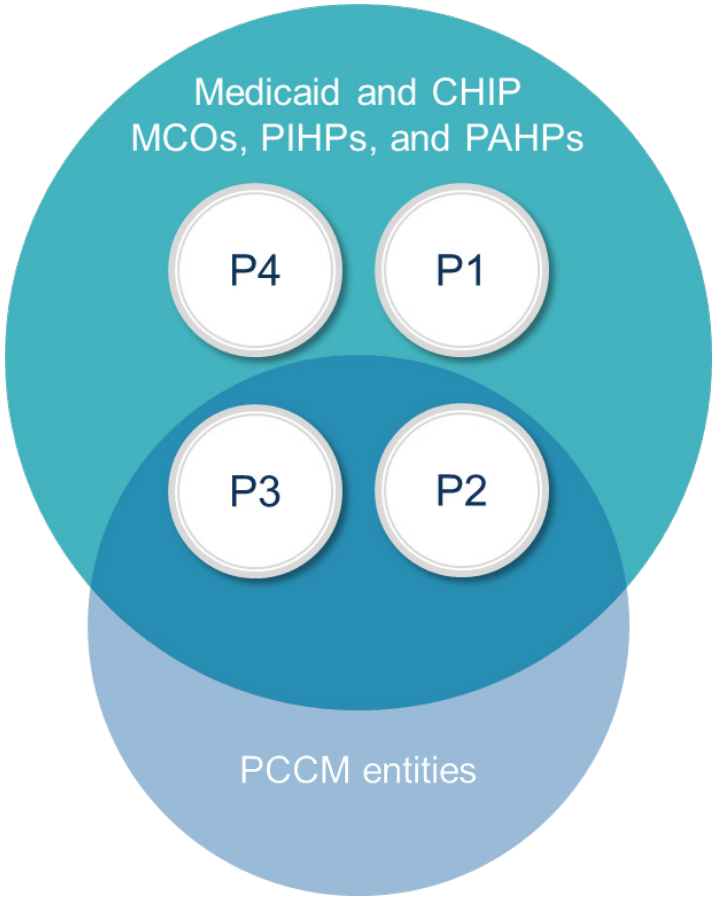
Substantive changes include:

- 1a. Applied all EQR-related activities to CHIP managed care plans
- 1b. Extended quality provisions to additional plan types
- 1c. Reordered protocols to follow the order in the Final Rule
- 1d. Applied changes to the Federal Financial Participation (FFP) match
- 1e. Expanded the nonduplication option for additional mandatory EQR-related activities
- 1f. Specified that all EQR-related activities and EQR technical reports must be consistent with HIPAA requirements
- 1g. Added placeholders for two new EQR-related activities

1a. Applied EQR to CHIP

- Applied all EQR-related activities to CHIP MCPs
  - EQR applies to both separate CHIP MCPs and Medicaid Expansion CHIP MCPs
  - Beginning with the state fiscal year on or after July 1, 2018 (42 C.F.R. 457.1250(a))

1b. Extended EQR to Additional Plan Types



- In addition to managed care organizations (MCOs), now includes prepaid inpatient health plans (PAHPs) and primary care case management (PCCM) entities* with financial incentives
  - Financial incentives include any plan whose contracts with the state provide for shared savings, incentive payments, or other financial rewards for the PCCM entity for improved quality outcomes

*All references to PCCM entities should be assumed to refer to the applicable subset of PCCM entities described at 42 C.F.R. 438.310(c)(2), and 457.1240(f)

1c. Reordered Protocols

Reordered protocols to follow the text of the Code of Federal Regulations (42 C.F.R. 438.358):

Area of Review	Performance Improvement	Performance Measurement	Plan Compliance	
Mandatory EQR-Related Activities	P1. Validation of PIPs • ***Now required*** of PIHPs and PAHPs, in addition to MCOs • ***At state discretion*** for PCCM entities	P2. Validation of Performance Measures • ***Now required*** of PIHPs, PAHPs, and PCCM entities, in addition to MCOs	P3. Review of Compliance with Medicaid and CHIP Managed Care Regulations • ***Now required*** of PIHPs, PAHPs, and PCCM entities, in addition to MCOs	P4. Validation of Network Adequacy* • ***Now required*** of PIHPs and PAHPs, in addition to MCOs
Optional EQR-Related Activities	P8. Implementation of Additional PIPs	P5. Validation of Encounter Data		
	P9. Conducting Focus Studies of Health Care Quality	P6. Administration or Validation of Quality of Care Surveys		
	P10. Assist with Quality Rating of Medicaid and CHIP MCOs, PIHPs, and PAHPs*	P7. Calculation of Additional Performance Measures		

PIP validation is now P1

Compliance review is now P3

*Reserved for future development

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1d. Applied Changes to the Federal Financial Participation (FFP)

- The Medicaid and CHIP Managed Care Final Rule updated the matching rates for EQR expenditures, including the production of EQR results and EQR-related activities when performed by an EQRO or entity other than a qualified EQRO
- See Appendix A in this slide deck for more detail on FFP for EQR-related activities conducted on MCOs, PIHPs, PAHPs, and PCCM entities, and eligibility of CHIP for FFP

1e. Expanded Nonduplication

- Nonduplication allows a state to use information from a Medicare or private accreditation review of a managed care plan in place of generating that information through one or more of the three mandatory EQR-related activities (Validation of PIPs, Validation of Performance Measures, and Review of Compliance)
- The Medicaid and CHIP Managed Care Final Rule expanded nonduplication to also include PIP and performance measure validation (42 C.F.R. 438.360)
- Nonduplication is intended to reduce the administrative burden on MCPs and states, while still ensuring relevant information is available to EQROs for the annual EQR
- Medicare or private accreditation review standards must be comparable to those in the EQR protocols
- See Appendix B in this slide deck for more details on nonduplication

1f. Specified HIPAA Requirements

States must:

- Ensure the privacy of patient information and that MCPs comply with the Health Insurance Portability (HIPAA) (42 C.F.R. 431 Subpart F and 457.1110)
- Comply with all other federal and state laws concerning confidentiality and disclosure

EQROs must:

- Ensure that EQR-related data collection and reporting activities are consistent with HIPAA requirements

The Medicaid and CHIP Managed Care Final Rule requires that EQR technical reports assure the privacy of patient information, consistent with HIPAA

1g. Future EQR Protocols

Validation of network adequacy

- Mandatory
- Effective no later than one year from the issuance of the associated protocol

Assistance with the quality rating of MCOs, PIHPs, and PAHPs required under a Medicaid and CHIP quality rating system (QRS)

- Optional
- Effective no earlier than the issuance of the associated protocol

Until the network adequacy validation protocol is issued, MCOs, PIHPs, PAHPs, and PCCM entities will only be subject to the 3 mandatory EQR-related activities:

1. Validation of PIPs
2. Validation of Performance Measures
3. Review of Compliance with Medicaid and CHIP Managed Care Regulations

2. Design Changes

Each protocol was restructured to follow the same layout:

- 2a. Protocol header indicating mandatory or optional activity
- 2b. Purpose of the activity and background
- 2c. Protocol activity figure: at-a-glance overview of each activity and step
- 2d. Call-out boxes: highlight key definitions, Q&A, worksheets and appendices to complete each activity/step
- 2e. Call-out "TIP" boxes hyperlink to worksheets
- 2f. Step-by-step description of the activity and step(s) within the protocol
- 2g. Proposed method(s) for analyzing and interpreting the data
- 2h. Instructions and guidance to implement the protocol

Highlights of Revised Protocol Structure

- 2b. Purpose of the activity and background
  - Provides a description of the purpose of the EQR-related activity and background, including the regulatory underpinnings of the EQR-related activity
- 2c. Protocol activity figure: at-a-glance overview of each activity and step
  - Presents a figure illustrating the protocol activities and steps, followed by links to supplemental resources
- 2f. Step-by-step description of the activity and step(s) within the protocol
  - Includes a step-by-step description of the activity and steps, along with:
    - Data sources and data collection activities to promote data accuracy, validity, and reliability
    - Proposed method(s) for analyzing and interpreting the data
- 2h. Instructions and guidance to implement the protocol
  - Offers supplemental resources (such as worksheets or appendices) that may be used in implementing the protocol

Updates to the Protocol Worksheets

- Each protocol is now accompanied by worksheets that are intended to improve reporting in EQR technical reports by:
  - Addressing variation in state reporting of measures, measure stewards, and measure specifications in both the validation of PIPs and performance measures
  - Addressing variation in state reporting of compliance ratings or scoring
- For the mandatory activities, the updated worksheets provide templates for:
  - Validating PIPs
  - Validating performance measures
  - Documenting compliance
- The worksheets can be adapted as needed

In-depth Discussion of the Mandatory EQR Protocol Activities

Protocol 1. Validation of Performance Improvement Projects (PIPs)

Protocol 1. Validation of PIPs

- Protocol 1 specifies procedures for EQROs to use in assessing the validity and reliability of a PIP (42 C.F.R. 438.358(b)(i))
- Protocol 1 identifies 3 activities and 2 supplemental resources, shown below

1

ACTIVITY ONE: ASSESS THE PIP METHODOLOGY

Step 1: Review the Selected PIP Topic
Step 2: Review the PIP AIM Statement
Step 3: Review the Identified PIP Population
Step 4: Review the Sampling Method
Step 5: Review the Selected PIP Variables and Performance Measures
Step 6: Review the Data Collection Procedures
Step 7: Review Data Analysis and Interpretation of PIP Results
Step 8: Assess the Improvement Strategies
Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred

ACTIVITY TWO: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

2

3

ACTIVITY THREE: VERIFY PIP FINDINGS (OPTIONAL)

Two supplemental resources to help EQROs validate PIPs include:

- PIP Validation Tools and Reporting Framework Worksheets
- Sampling Approaches for EQR Data Collection Activities

Worksheets for Validating PIPs

- 11 worksheets provide step-by-step templates for validating PIPs
- The findings from these worksheets are intended to help end users of EQR technical reports understand the PIP's aim, selected variables, interventions, and the PIP's results

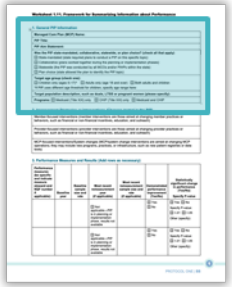
Worksheet name	Protocol activity and step
Worksheet 1.1. Review the PIP Topic	Activity 1. Step 1. Review the Selected PIP Topic
Worksheet 1.2. Review the PIP Aim Statement	Activity 1. Step. 2. Review the PIP Aim Statement
Worksheet 1.3. Review the Identified PIP Population	Activity 1. Step 3. Review the Identified PIP Population
Worksheet 1.4. Review the Sampling Method	Activity 1. Step 4. Review the Sampling Method
Worksheet 1.5. Review the Selected PIP Variables	Activity 1. Step 5. Review the Selected PIP Variables
Worksheet 1.6. Review the Data Collection Procedures	Activity 1. Step 6. Review the Data Collection Procedures
Worksheet 1.7. Review Data Analysis and Interpretation of PIP Results	Activity 1. Step 7. Review Data Analysis and Interpretation of PIP Results
Worksheet 1.8. Assess the Improvement Strategies	Activity 1. Step 8. Assess the Improvement Strategies
Worksheet 1.9. Assess the Likelihood that Significant and Sustained Improvement Occurred	Activity 1. Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred
Worksheet 1.10. Perform Overall Validation of PIP Results	Activity 2. Perform Overall Validation and Reporting of PIP Results
Worksheet 1.11. Framework for Summarizing Information about Performance Improvement Projects (PIPs)	Activity 2. Perform Overall Validation and Reporting of PIP Results

New

Worksheet 1.11. Framework for Summarizing Information about PIPs

- Worksheet 1.11 is a new framework for reporting on validated PIPs in EQR technical reports
  - Structured to easily distill and summarize PIP validation information
  - There are four sections included in this worksheet

Section 1. General PIP Information



Managed Care Plan (MCP) Name:
PIP Title:
PIP Aim Statement:
Was the PIP state-mandated, collaborative, statewide, or plan choice? (check all that apply) ☐ State-mandated (state required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the state) ☐ Plan choice (state allowed the plan to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as duals, LTSS or pregnant women (please specify):
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

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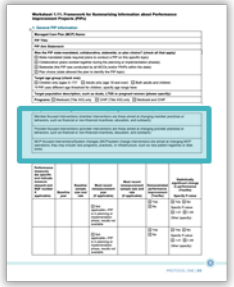
Worksheet 1.11. Framework for Summarizing Information about PIPs (cont.)

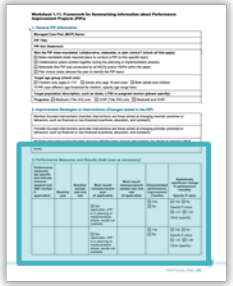
Section 2. Improvement Strategies or Interventions (Changes Tested in the PIP)



Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

Worksheet 1.11. Framework for Summarizing Information about PIPs (cont.)

Section 3. Performance Measures and Results



Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

The EQRO is required to report the performance measurement data for the PIP validation in the EQR technical report (42 C.F.R. 438.364(a)(2)(iii). Cross-referenced by CHIP at 42 CRF 457.1250)

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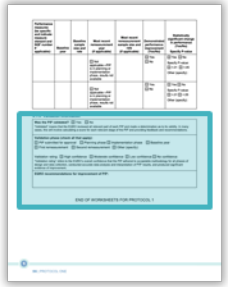
Worksheet 1.11. Framework for Summarizing Information about PIPs (cont.)

Section 4. PIP Validation Information



Was the PIP validated? ☐ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

The validation report in the EQR final technical report should include a description of the PIPs that were validated and the findings of the EQRO's validation review

The EQRO and the state must include the actual validation results of the PIPs in the final EQRO technical report for submission to CMS

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Protocol 2. Validation of Performance Measures

Protocol 2. Validation of Performance Measures

- MCPs must report standard performance measures as specified by the state. The state must provide the EQRO and managed care plan the performance measures to be calculated, the specifications for the measures, and the state reporting requirements
- Protocol 2 identifies 3 activities and 2 supplemental resources, shown below

1

ACTIVITY ONE: CONDUCT PRE-ONSITE VISIT ACTIVITIES
Step 1: Define the Scope of the Validation
Step 2: Assess the Integrity of the MCP's Information System
Step 3: Conduct Detailed Review of Measures
Step 4: Initiate Review of Medical Record Data Collection
Step 5: Prepare for the MCP Onsite Visit

ACTIVITY TWO: CONDUCT ONSITE VISIT ACTIVITIES
Step 1: Review Information Systems Underlying Performance Measurement
Step 2: Assess Data Integration and Control for Performance Measure Calculation
Step 3: Review Performance Measure Production
Step 4: Complete the Detailed Review of Measures
Step 5: Assess the Sampling Process (if applicable)
Step 6: Communicate Preliminary Findings and Outstanding Items

2

3

ACTIVITY THREE: CONDUCT POST-ONSITE VISIT ACTIVITIES
Step 1: Determine Preliminary Validation Findings for Each Measure
Step 2: Assess and Document the Accuracy of Performance Measure Reports
Step 3: Submit Validation Report to the State

Two supplemental resources to help EQROs validate performance measures include:

- Information Systems Capability Assessment (ISCA) Tool
- Performance Measurement Validation Tools and Reporting Framework Worksheets

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Updates to the Information Systems Capability Assessment (ISCA)

- The ISCA is used to validate managed care plan information systems (IS), processes, and data
  - The ISCA provides a foundation for the validation of performance measures
  - Appendix A of the protocols defines the recommended capabilities of a managed care plan's IS to meet regulatory requirements for managed care quality assessment and reporting, and provides an approach the EQRO can use to assess the strength of each plan's IS capabilities
    - Portions of the ISCA are voluntary; however, some components are required for the mandatory EQR-related activities protocols
- Major changes include:
  - Updated text about T-MSIS, value-based purchasing, alternative payment models, integrated care models, and the adoption and meaningful use of certified EHRs that are relevant to IS assessments

Revised Worksheet A.2, Information System Review Worksheet and Interview Guide can be used by the EQRO to prompt as needed on any issues identified in Worksheet A.1 (ISCA Tool)

Updates to the ISCA (cont.)

- There is no statutory or regulatory requirement for the frequency with which ISCAs should be conducted
- Each state must determine the maximum interval between assessments of each managed care plan's IS, balancing the cost to the state and burden on the plan with the need to ensure that changes to the plan's IS are assessed frequently enough to support accurate data collection, performance measurement, and encounter data transmission

Worksheets for Performance Measure Validation

- 14 worksheets provide templates to assist in validating performance measures
- The findings from Worksheets 2.1 – 2.14 are intended to help EQR technical report end users understand the selected performance measures, results, and validation status

Worksheet name	Protocol activity and step
Worksheet 2.1. List of Performance Measures to be Validated	Activity 1. Step 1. Define the Scope of the Validation
Worksheet 2.2. Performance Measure Validation Template	Activity 1. Step. 1. Define the Scope of the Validation Activity 1. Step 3. Conduct Detailed Review of Measures Activity 2. Step 4. Complete the Detailed Review of Measures
Worksheet 2.3. Medical Review Validation Template	Activity 1. Step 4. Initiate Review of Medical Record Data Collection Activity 3. Conduct Post-Site Visit Activities
Worksheet 2.4. Potential Documents and Process for Review	Activity 1. Step 5. Prepare for the MCP Onsite Visit
Worksheet 2.5. Interview Guide for MCP Data Integration and Control Personnel	Activity 2. Step 1. Review Information Systems Underlying Performance Measurement
Worksheet 2.6. Data Integration and Control Findings Tool	Activity 2. Step 2. Assess Data Integration and Control for Performance Measure Calculation Activity 3. Conduct Post-Site Visit Activities
Worksheet 2.7. Data Processes Used to Produce Performance Measures: Documentation and Review Checklist	Activity 2. Step 3. Revie Performance Measure Production
Worksheet 2.8. Data and Processes Used to Produce Performance Measures: Findings	Activity 2. Step 3. Review Performance Measure Production
Worksheet 2.9. Polices, Data, and Information Used to Produce Measures: Checklist	Activity 2. Step 4. Complete the Detailed Review of Measures
Worksheet 2.10. Measure Validation Findings	Activity 2. Step 4. Complete the Detailed Review of Measures Activity 3. Conduct Post-Site Visit Activities
Worksheet 2.11. Interview Guide for Assessing Processes Used to Produce Numerators and Denominators	Activity 2. Step 4. Complete the Detailed Review of Measures
Worksheet 2.12. Policies, Procedures, and Data Used to Implement Sampling: Review Checklist	Activity 2. Step 5. Assess the Sampling Process (if applicable)
Worksheet 2.13. Sampling Validation Findings	Activity 2. Step 5. Assess the Sampling Process (if applicable) Activity 3. Conduct Post-Onsite Visit Activities
Worksheet 2.14. Framework for Summarizing Information about Performance Measures	Activity 3. Step 3. Conduct Post-Onsite Visit Activities

New

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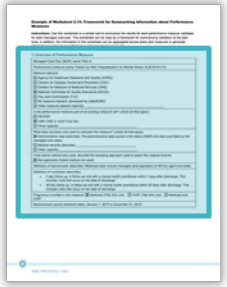
Performance Measure Validation: Worksheet 2.14

- Worksheet 2.14 is new; it is a framework for reporting validated performance measures in the EQR technical report
  - Structured to easily distill and summarize performance measure validation information
  - This worksheet can be used as a framework for summarizing validation at the plan level
  - It can also be used to aggregate across plans and measures to generate information on state-level performance and areas for improvement
  - The next three slides provide an example of how to use Worksheet 2.14 for one measure, Follow-Up After Hospitalization for Mental Illness: 6-20 (FUH-CH)

Worksheet 2.14. Framework for Summarizing Performance Measures Information

Performance Measure Overview: Follow-Up After Hospitalization for Mental Illness (FUH-CH)



Managed Care Plan (MCP) name: Plan A
Performance measure name: Follow-Up After Hospitalization for Mental Illness (FUH-CH)
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by state/EQRO ☐ Other measure steward (specify) _____
Is the performance measure part of an existing measure set? (check all that apply) ☒ HEDIS® ☒ CMS Child or Adult Core Set ☐ Other (specify) _____
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe): The administrative data source is data submitted by the managed care plans. ☐ Medical records (describe) _____ ☐ Other (specify) _____
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): Medicaid rates include managed care population (4 MCOs).
Definition of numerator (describe): • 7-day follow-up: A follow-up visit with a mental health practitioner within 7 days after discharge. This includes visits that occur on the date of discharge. • 30-day follow-up: A follow-up visit with a mental health practitioner within 30 days after discharge. This includes visits that occur on the date of discharge.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): January 1, 2018 to December 1, 2018.

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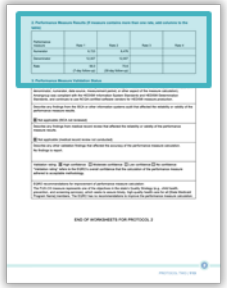
Worksheet 2.14. Framework for Summarizing Information about Performance Measures (cont.)

Performance Measure Results: Follow-Up After Hospitalization for Mental Illness (FUH-CH)

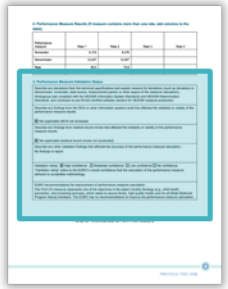


Performance measure	Rate 1	Rate 2	Rate 3	Rate 4
Numerator	6,723	8,476	N/A	N/A
Denominator	12,007	12,007	N/A	N/A
Rate	56.0 (7-day follow-up)	70.6 (30-day follow-up)	N/A	N/A

The report should include the actual results of the performance measures, not just the results of the validation

Worksheet 2.14. Framework for Summarizing Information about Performance Measures (cont.)

Performance Measure Validation Status: Follow-Up After Hospitalization for Mental Illness (FUH-CH)



Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). Plan A was compliant with the HEDIS® Information System Standards and HEDIS® Determination Standards, and continues to use NCQA-certified software vendors for HEDIS® measure production.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the performance measure results. ☒ Not applicable (ISCA not reviewed)
Describe any findings from medical record review that affected the reliability or validity of the performance measure results. ☒ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the performance measure calculation. No findings to report.
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the calculation of the performance measure adhered to acceptable methodology.
EQRO recommendations for improvement of performance measure calculation: The FUH-CH measure represents one of the objectives in the state's Quality Strategy (e.g., child health, prevention, and screening services), which seeks to assure timely, high-quality health care for all [State Medicaid Program Name] members. The EQRO has no recommendations to improve the performance measure calculation.

The report should include findings on the MCPs' IS capabilities and data integration, including documentation of the timing of the state's most recent ISCA and a description of what documentation was reviewed by the EQRO

Provide recommendations for improving the process for calculating and reporting performance measures, including implications for the MCPs' data systems, methods, and staffing (e.g., programming and analytic capacity)

The EQRO and the state must include the actual validation results of the performance measures in the final EQRO technical report for submission to CMS

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Tips for Performance Measure Validation

- When submitting the validation report to the state, the report should follow the state's required format, and include the following elements:
  - List of measures validated by the EQRO
  - Description of the EQRO's validation activities
  - Worksheets, tools, and other supporting documentation
  - Analyses and conclusions based on the validation process for each performance measure
- Worksheet 2.14, Framework for Summarizing Information about Performance Measures, can be used to summarize the results for each performance measure validated for each managed care plan

When possible, the validation report should also identify recommendations from the previous year's report submitted to the state, and discuss progress made on these recommendations over the past year based on information gathered during the validation process

Tips for Performance Measure Validation (cont.)

- Many states and MCPs use measures from the Child and Adult Core Sets to monitor and track quality of care in Medicaid and CHIP for their QAPI programs
  - Reporting of these measures is currently voluntary
  - Mandatory reporting of the Child Core Set and the behavioral health measures in the Adult Core Set will take effect in 2024
- CMS encourages states to adopt and use Core Set measures to support their managed care quality measurement and improvement initiatives, for example as performance measures or in PIPs

Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations

- Protocol 3 specifies procedures to determine the extent to which MCPs comply with standards at 42 C.F.R. 438.358(b)(iii), state standards, and managed care plan contract requirements
- Protocol 3 identifies 5 activities and 1 supplemental resource, shown below

1

ACTIVITY ONE: ESTABLISH COMPLIANCE THRESHOLDS
Step 1: Collect Information from the State
Step 2: Define Levels of Compliance

ACTIVITY TWO: PERFORM THE PRELIMINARY REVIEW (PRE-ONSITE VISIT)
Step 1: Establish Early Contact with the MCP
Step 2: Perform a Document Review

2

3

ACTIVITY THREE: CONDUCT MCP ONSITE VISIT
Step 1: Determine Onsite Visit Length and Dates
Step 2: Identify the Number and Types of Reviewers Needed
Step 3: Develop an Onsite Visit Agenda
Step 4: Provide Preparation Instructions and Guidance to the MCP
Step 5: Conduct MCP Interviews
Step 6: Conduct Exit MCP Interviews

ACTIVITY FOUR: COMPILE AND ANALYZE FINDINGS (POST-ONSITE VISIT)
Step 1: Collect Supplemental Information
Step 2: Compile Data and Information
Step 3: Analyze Findings

4

5

ACTIVITY FIVE: REPORT RESULTS TO THE STATE
Step 1: Submit a Report Outline to the State
Step 2: Submit a Final Determination Report to the State
Step 3: Submit Other Reports Requested by the State

One supplemental resource to help EQROs conduct the compliance review:

Compliance Review Worksheets

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Regulations Subject to Compliance Review

The standards subject to Protocol 3 are contained in 42 C.F.R. 438, Subparts D and E:*

Section	Citation
Availability of services	• 438.206 (Medicaid), 457.1230(a) (CHIP)
Assurances of adequate capacity and services	• 438.207 (Medicaid), 457.1230(b) (CHIP)
Coordination and continuity of care	• 438.208 (Medicaid), 457.1230(c) (CHIP)
Coverage and authorization of services	• 438.210 (Medicaid), 457.1230(d), 457.1228 (CHIP)
Provider selection	• 438.214 (Medicaid), 457.1233(a) (CHIP)
Confidentiality	• 438.224 (Medicaid), 457.1230(c) (CHIP)
Grievance and appeals system	• 438.228 (Medicaid), 457.1260 (CHIP)
Subcontractual relationships and delegation	• 438.230 (Medicaid), 457.1233(b) (CHIP)
Practice guidelines	• 438.236 (Medicaid), 457.1233(c) (CHIP)
Health information systems	• 438.242 (Medicaid), 457.1233(d) (CHIP)
QAPI	• 438.330 (Medicaid), 457.1240(b) (CHIP)

*Some requirements in Subparts A, B, C, and F are included into the compliance review through interaction with Subparts D and E

Frequency of Compliance Reviews and Manner of Reporting

- Federal regulations require MCPs to undergo a review at least once every three years to determine managed care plan compliance with federal standards as implemented by the state
- States may choose to direct their EQROs to review all applicable standards at once or may spread the review over a three-year cycle in any manner they choose
  - For example, fully reviewing a third of plans each year or conducting a third of the review on all plans each year
- However, if an EQR technical report summarizes a compliance review that does not include all required components, the report should clearly describe:
  - The three-year period covered by the current compliance review cycle
  - The quality standards not included in the current report
  - A summary of findings from all previous reviews within the current review cycle
  - The state's schedule for review of the remaining standards

Worksheets for Compliance Review Reporting

- The findings from Worksheets 3.1 – 3.4 are intended to help end users of EQR technical reports understand areas of compliance, partial compliance, and non-compliance
- EQR compliance reviews should include:
  - A list of health plans contracted by the state, the contract start date, and plan type
    - Indicate partial or full review by health plan
    - If full review was conducted, provide the year of the last full review and standards reviewed by plan
    - If partial review was conducted, provide the year(s) of the previous partial reviews in the cycle, and standards reviewed in previous partial reviews by plan (see slide 49)
  - A crosswalk of the standards reviewed to the federal standards and citation
  - Comparative results across plans by standard

Readiness Reviews vs. Compliance Reviews

Given the applicability of EQR to additional plan types, the next slides provide an overview of readiness reviews compared to compliance reviews as to the purpose, regulatory basis, and when they are required

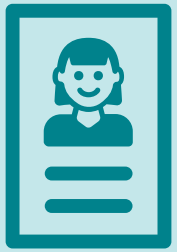
	Readiness review	Compliance review
Purpose	• Assesses the ability and capacity of a plan to perform satisfactorily in four areas: (1) operations and administration, (2) service delivery, (3) financial management, and (4) systems management • Informs state implementation of significant managed care related program change • Informs parties to the review about areas of strength and areas of improvement ***before*** implementation and/or careful monitoring during implementation. Informs CMS of the same	• A review to determine plan compliance with the standards under part 438 subpart D and QAPI requirements under 438.330 • Informs the state and its Medicaid and CHIP MCPs on plan performance and achieved compliance with federal regulations and state contract standards for ongoing service delivery • Provides insight into strengths and areas for improvement in service delivery ***after*** implementing a significant program change
	Readiness review is not a substitute for compliance review	***Compliance review is not a substitute for readiness review***

Readiness Reviews vs. Compliance Reviews (cont.)

	Readiness review	Compliance review
Regulatory basis	• 42 C.F.R. 438.66(d) – Medicaid	• 42 C.F.R. 438.358(b)(1)(iii) – Medicaid • 42 C.F.R. 457.1250(a) – CHIP
When required	Significant program changes occur in the state's managed care program, including: • New managed care program • New health plan • Program change to benefits, services, or eligibility group(s)	The state employs managed care to deliver Medicaid and CHIP services: • Under any of the following managed care program authorities (438.2-Managed care program): 1915(a), 1915(b), or 1115(a)
Required for which plan types	Required for MCOs, PIHPs, PAHPs, and PCCM entities	Required for MCOs, PIHPs, PAHPs, and PCCM entities described in 438.310(c)(2)
Frequency and timing	• One-time for each qualifying program change • Always occurs at least 3 months prior to a significant program change. Must conclude in time to facilitate implementation of program change(s) • Prerequisite to implementing the program change • Submit readiness reviews to CMS so that CMS can review and approve the contract or contract amendment that addresses the significant program change	• Triennial cycles for compliance review with certain mandatory annual activities for other mandatory EQR-related activities • Schedule of activities may be adjusted to accommodate major changes or events. The state must report results of annual activity to CMS by April 30th • Occurs independently of other significant program changes

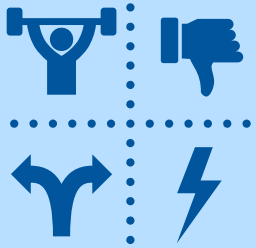
Drafting Effective EQR Technical Reports

Tips for Drafting Effective EQR Technical Reports



Use the names of MCPs when referring to plan performance

- Findings and comparisons should refer to plans by name for transparency and understanding of plan performance



Highlight substantive findings concerning the extent to which MCPs provide high quality, timely, and appropriate access to health care services

- Findings should focus on specific strengths and weaknesses (rather than on numerical ratings or validation scores obtained under the EQRO's review methodology)

Tips for Drafting Effective EQR Technical Reports (cont.)

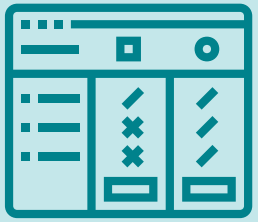
Include specific recommendations to improve identified weaknesses

- The report should include the EQRO's understanding of why the weakness exists and suggest steps for how the plan (potentially with the state) can best address the issue

Include assessments of MCPs' responses to previous recommendations

- Such assessments have historically been missing from some reports
- EQROs should conduct and report out on this activity, and should document assessments with the same specificity used when reporting on initial findings

Tips for Drafting Effective EQR Technical Reports (cont.)



Aggregate findings across plans and show comparisons among the state's plans

- This context makes it easier for stakeholders to understand the results of the review. It provides context for findings from individual plans, and to more readily determine if issues are localized or systemic

Consider using charts to display previous recommendations, plan responses and actions, and new recommendations

- This enables a comprehensive view of the history of each managed care plan's EQR reviews
- Comparative information should include tables presenting performance measure scores and PIP ratings and scores.
- Charts can be used to display non-compliance with each of the reviewed standards

Tips for Drafting Effective EQR Technical Reports (cont.)

Aim for clarity and concise presentation

- While every EQR review necessarily gathers and processes a substantial amount of material, non-essential narrative makes it difficult for readers to identify the most relevant information. **EQROs should attempt to limit the body of reports to less than 50 pages, and use tables to showcase key findings**
- Avoid technical language and jargon when possible; spell out acronyms
- To maximize interpretability of results, provide context for statistics included in the report
- To provide a comprehensive view of Medicaid and CHIP managed care quality, consider drafting an aggregate report that includes information from all MCPs, or all of a specific type of plan
- Submit a searchable PDF to enable stakeholders to review topics of interest to facilitate use of the reports for topic-specific analyses

Posting and Submitting EQR Technical Reports

- States must finalize their EQR technical report(s) by April 30th of each year and post it to the state's website
- States should also submit all EQR technical report(s) by April 30th to ManagedCareQualityTA@cms.hhs.gov

Technical Assistance Contacts and Resources

Technical Assistance Contacts

- For TA related to EQR and the revised protocols, please submit your questions to the TA mailbox at ManagedCareQualityTA@cms.hhs.gov
- For TA related to the Child and Adult Core Set measures, please contact MACQualityTA@cms.hhs.gov

Technical Assistance Resources

- CMS Medicaid Managed Care Quality webpage: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/index.html
- CMS Medicaid Quality of Care webpage: https://www.medicaid.gov/medicaid/quality-of-care/index.html
- Information about Child and Adult Core Set Measures is available on Medicaid.gov: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html
- Information about the National Quality Strategy is available from the Agency for Healthcare Research and Quality (AHRQ): https://www.ahrq.gov/workingforquality/about/index.html

Q&A

Reminder:

Please submit your questions through the Q&A widget in the webinar platform. We will answer as many questions as we can during the webinar.

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Thank you for participating in the webinar.

Please complete the evaluation as you exit the webinar.

Appendix

Appendix A. Federal Financial Participation (FFP) for EQR

FFP for EQR

- For Medicaid programs, EQR (including the production of the EQR technical report) and EQR-related activities performed on ***MCOs*** are eligible for the 75 percent match rate, when conducted by a qualified EQRO, and when the EQR-related activities are completed using methodologies consistent with the updated EQR protocols*
  - PIHPs are no longer eligible for the 75 percent match
- The EQRO's analysis is eligible for the 75 percent match rate when the information from a Medicare or private accreditation review of an ***MCO*** is used for the mandatory EQR-related activities
  - The accreditation activities that produce the information cannot receive the match

*See 42 C.F.R. 433.15 and 438.370(a) and the July 10, 2016 CMCS Informational Bulletin (CIB), Federal Financial Participation for Managed Care External Quality Review, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib061016.pdf

FFP for EQR (cont.)

- Medicaid programs are eligible for the 50 percent match rate:
  - If the state or the state's agent that is not a managed care plan conducts the EQR-related activity on a MCO (42 C.F.R. 433.15 and 438.370(b))
- EQR (including the production of the EQR technical report) and EQR-related activities conducted on PIHPs, PAHPs, and certain PCCM entities are eligible for the 50 percent match rate (42 C.F.R. 438.370(b))
- FFP in expenditures for mandatory and optional EQR activities for CHIP plans is available at the state's title XXI matching rate subject to the 10 percent cap for administrative expenditures
  - States are eligible to receive the enhanced CHIP FFP match rate for EQR and EQR-related activities, regardless of which entity complete the activity

Appendix B. Additional Information on Nonduplication

How Can States Elect to Use Nonduplication?

States must:

- Provide a description and rationale for nonduplication substitutions of EQR-related activities in the quality strategy
- Each MCO, PIHP, PAHP, or PCCM entity must provide the state with all reports, findings, and results of the Medicare or accreditation review applicable to the EQR-related activities
- Ensure the EQRO can access this information to include in the annual EQR report
- Ensure the completion of any EQR-related activities or components of those activities that are not addressed by the information from the Medicare or private accreditation review

EQROs must:

- Assess the completeness of information from the accreditation review or Medicare review
- Confirm that the comparable information meets the requirements for completing the analysis and developing EQR findings and recommendations

MCO Exemption from the Annual EQR Process

- Exemption is an option that allows states to exempt MCOs from the annual EQR process
- Exemption may be used at the state's discretion when the following three conditions are met:
  1. The MCO has both a current Medicare Advantage contract and current Medicaid contract
  2. The two contracts cover all or part of the same geographic area in the state
  3. The Medicaid contract has been in effect for at least 2 consecutive years before the exemption date AND during those 2 years, the MCO has been subject to EQR and has met the quality, timeliness, and access to health care services standards for Medicaid beneficiaries

Nonduplication and FFP

- The EQRO's analysis of the data is eligible for FFP when:
  - The information from a Medicare or private accreditation review is used to support one or more of the mandatory EQR-related activities
  - The accreditation activities that produce the information are not eligible for the FFP

MCO Exemption from the Annual EQR Process: Exemption Updates to the Proposed Final Rule

- Expected in late January 2020, the exemption updates will finalize changes to 42 C.F.R. 438.362 and 438.364. Changes include:
  - Adding new paragraph 438.362(c): Requires that states annually identify on their website, in the same location where EQR technical reports are posted, the names of the MCOs it has exempted from EQR, and when the current exemption period began
- The revised rule also sought comment on an alternative, to revise 438.364(a)(i), "External Quality Review Results-Information that must be produced," to require that states identify in the annual EQR technical report the same information proposed to add to 438.362

Review of MCO Exemption (cont.)

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

For MCOs reviewed by Medicare, the state must annually obtain the most recent Medicare review findings from the MCO. This includes all data, correspondence, information, and findings relevant to the MCO's compliance with Medicare standards for:

- Access, quality assessment and performance improvement, health services, or delegation of these activities
- All measures of the MCO's performance
- 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 the MCO provide a copy of 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
- Findings must include accreditation review results of evaluation of compliance with individual accreditation standards, any deficiencies, corrective action plans, and summaries of unmet accreditation requirements

Appendix C. Additional Worksheets for Validating PIPs

Activity 1. Assess the PIP Methodology

- Worksheets 1.1 – 1.9 accompany Activity 1, Steps 1 – 9
- Step 1. When reviewing the PIP topic, CMS suggests that:
  - States consider the aims of the National Quality Strategy when developing PIP topics
    - PIP topics align with CMS-identified priorities
  - Identify opportunities to improve performance on a quality measure(s) through a managed care PIP
    - States review performance on the CMS Child and Adult Core Set measures

Activity 1. Assess the PIP Methodology

- Step 2. The PIP aim statement should define the improvement strategy, population, and time period
  - It should be clear, concise, and actionable

Example PIP aim statements

	Example PIP aim statements	Comments
Poor PIP Aim Statement	Does the MCP adequately address psychological problems in patients recovering from myocardial infarction?	• The PIP intervention is not specified • It is unclear how impact will be measured • The population and time period are not clearly defined
Good PIP Aim Statement	Will the use of cognitive behavioral therapy in patients with depression and obesity improve depressive symptoms over a six-month period during 2017?	• Specifies the PIP intervention (cognitive behavioral therapy) • Defines the population (patients with depression and obesity) and time period (six-month period during 2017) • Specifies the measurable impact (improve depressive symptoms)

Activity 1. Assess the PIP Methodology

- Step 3. Determine if the PIP includes the entire population or a sample of the population
- Step 4. If a sampling method is required, Appendix B (of the protocols), Sampling Approaches for EQR Data Collection Activities provides an overview of sampling methodologies applicable to PIPs
  - The revised sampling protocol provides more comprehensive sampling guidance applicable to Protocols 1, 2, and 5 – 9

Activity 1. Assess the PIP Methodology

- Step 5. When reviewing selected PIP variables and performance measures:
  - CMS encourages MCPs to choose variables for PIPs that reflect health outcomes
  - When selecting PIP performance measures, the plan should consider existing measures
    - CMS encourages use of the Child and Adult Core Set, Core Quality Measure Collaborative, and certified community behavioral health clinics (CCBHC) measures
    - Additional examples of existing measures include NCQA's Healthcare Effectiveness Data Information Set (HEDIS®) or measures that have been developed by AHRQ (such as the prevention quality indicators, inpatient quality indicators, patient safety indicators, and pediatric quality indicators)

Activity 1. Assess the PIP Methodology

- Step 6. To ensure the validity and reliability of data collected as part of the PIP, the managed care plan should develop a data collection plan that specifies:
  - PIP data sources
  - Data to be collected, including how and when, frequency of data collection, and who will collect the data
  - Instruments used to collect the data
- Step 7. When reviewing data analysis and interpreting PIP results:
  - The analysis should assess the extent to which any change in performance is statistically significant
  - Plans should indicate which findings were statistically significant and the level of statistical significance used in the analysis
  - Note that Protocol 1 does not specify a level of statistical significance that must be met

Activity 1. Assess the PIP Methodology

- Step 8. When assessing the appropriateness of PIP interventions for achieving improvement:
  - Interventions should be evidence-based
  - The test of change should likely lead to the desired improvement in processes or outcomes
  - A common approach to guide improvement work is the Institute for Healthcare Improvement's (IHI) Model for Improvement
    - A Plan Do Study Act (PDSA) approach can be used to structure the testing

Activity 1. Assess the PIP Methodology

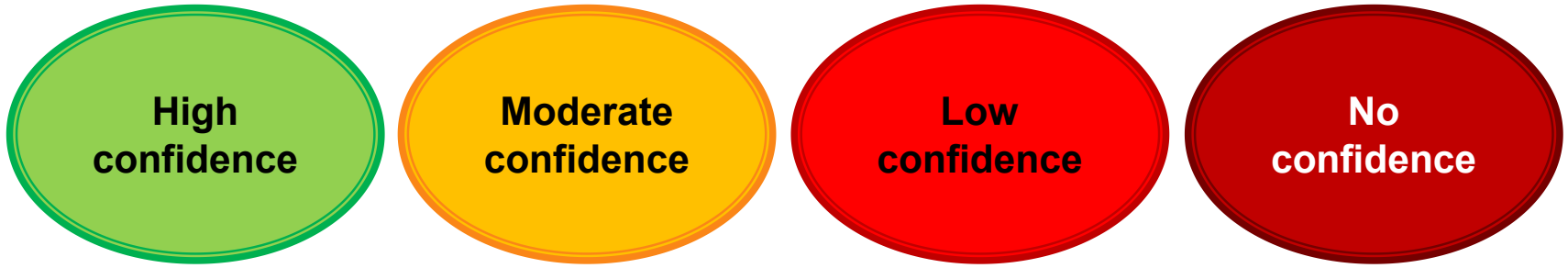
- Step 9. When assessing the likelihood that significant, sustained improvement occurred:
  - The EQRO should review the PIP methods and findings to assess whether there is evidence of statistically significant improvement that may be associated with the intervention implemented as part of the PIP
  - The EQRO should assess whether repeated measurements were conducted, and if so, whether significant change in performance relative to baseline measurement was observed
    - The repeat measurement should use the same methodology as the baseline measurement
  - The EQRO should state in its final report which findings were found to be significant either statistically, clinically, or programmatically over time

Potential sources of supporting information:

- Statistical significance testing calculated on baseline and repeat indicator measurements (clarify that the appropriate test was used, such as a t-test for small samples)
- Benchmarks for quality specified by the state Medicaid/CHIP agency or found in industry standards
- Interviews with plan staff and providers about the implementation and results of the PIP intervention

Activity 2. Perform Overall Validation and Reporting of PIP Results

- Worksheets 1.10 and 1.11 accompany Activity 2
- Activity 2 provides an overall rating of PIP results. The validation rating refers to the EQRO's overall confidence that the PIP
  - Worksheet 1.10 suggests a validation rating to facilitate comparisons across PIPs and across states as:



Appendix D. Selected Acronyms and Definitions

Note: For a complete list of acronyms and a glossary of terms, please refer to Appendix C and Appendix D, respectively, in the updated protocols

Selected Acronyms and Definitions

- **External Quality Review (EQR):** The analysis and evaluation by an external quality review organization (EQRO), of aggregated information on quality, timeliness, and access to the health services that an MCO, PIHP, PAHP, or PCCM entity (described at 42 C.F.R. 438.310(c)(2)), or their contractors furnish to Medicaid beneficiaries.
- **External Quality Review Organization (EQRO)**: An organization that meets the competence and independence requirements set forth at 42 C.F.R. 438.354, and performs external quality review or other EQR-related activities as set forth in 42 C.F.R. 438.358, or both. An EQRO is the only entity which may conduct the annual EQR, that is, the analysis and evaluation of information generated by the EQR-related activities (or via nonduplication, if applicable) regarding the quality, timeliness, and access to the health care services that an MCP, or its contractors, furnish to beneficiaries
- **EQR-related activities:** The activities addressed in the protocols. EQR-related activities may be conducted by the state, its agent that is not an MCO, PIHP, PAHP, or PCCM entity (described at 42 C.F.R. 438.310(c)(2)), or an EQRO. See 42 C.F.R. 438.358.
- **EQR technical report:** The end product of the EQR, which summarizes findings on access and quality of care, and must be drafted by the EQRO.
- **Managed Care Plans (MCP):** For the purposes of the EQR protocols, encompasses managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and the subset of primary care case management (PCCM) entities described in 42 C.F.R. 438.310(c)(2).
- **Mandatory and Optional Activities:** The EQR process includes a series of mandatory and optional EQR-related activities designed to provide a sound understanding of the strengths and weaknesses of Medicaid and CHIP MCP performance related to quality, timeliness, and access to care. Mandatory activities are Protocols 1-4; optional activities are Protocols 5-10
- **Prepaid Inpatient Health Plan (PIHP):** A prepaid health plan that provides services to enrollees under contract with the state and on the basis of capitation payments or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.
- **Prepaid Ambulatory Health Plan (PAHP):** An entity that provides services to enrollees under contract with the state and on the basis of capitation payments or other payment arrangement's 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.
- **Primary Care Case Management (PCCM) Entity:** The term PCCM entity in the EQR protocols 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 C.F.R. 438.310(c)(2).