Medicaid Managed Care Final Regulations:

Quality and Transparency

Issue Brief No. 4

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This issue brief will review selected provisions in the final rule, *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, implementing the requirements concerning quality and transparency in Medicaid managed care.[1] Accountability protections such as monitoring and reporting requirements, as well as quality performance metrics, are vital tools to ensure that Managed Care Organizations (MCOs) and other types of capitated plans provide necessary services when they are needed. This is particularly true as plans increasingly enroll vulnerable populations with disabling and chronic conditions who require more frequent care and specialty services.

The final rule significantly advances quality assessment, transparency, and oversight – including a new quality rating system, stronger monitoring requirements, direct testing of plan provider networks, and improved stakeholder engagement. We also include recommendations to help state advocates ensure robust implementation of these provisions in their states. These recommendations are highlighted throughout and also listed at the end of this brief.

State monitoring requirements (§ 438.66)

The final rule clarifies, consolidates, and expands state requirements for monitoring Medicaid managed care plans. In addition to establishing a system for monitoring plans, the final rule also requires states to use data collected to improve the performance of its managed care programs. The final rule also requires states to produce an annual report on its managed care program and monitoring activities. The state must publicly post the report and provide it to stakeholder advisory groups.

[1] Medicaid and Children's Health Insurance Program (CHIP) Programs, *Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, 81 Fed. Reg. 27,498-27,901 (May 6, 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

Monitoring systems (§ 438.66(b))

The new rules considerably strengthen states' obligations to monitor many aspects of its Medicaid managed care program. States must have systems for monitoring the performance of MCOs, Prepaid Inpatient Health Plans (PIHP) and Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Management (PCCM entities) in the follow areas:

• Administration and management; • Appeal and grievance systems; • Claims management; • Enrollee materials and customer services, including the activities of the beneficiary support system; • Finance, including medical loss ratio reporting; • Information systems, including encounter data reporting; • Marketing;	• Medical management, including utilization management and case management; • Program integrity; • Provider network management, including provider directory standards; • Availability and accessibility of services, including network adequacy standards; • Quality improvement; • Areas related to the delivery of Long Term Services and Supports (LTSS) as applicable to the managed care program; • Other provisions of the contract, as appropriate.[2]

In the final regulations, the U.S. Department of Health and Human Services (HHS) does not set specific parameters for performance monitoring, such as direct testing of provider networks, evaluating the adequacy of prescription drug formularies, and coordinating monitoring activities with state auditors and inspectors general.[3] Instead, HHS provides states with flexibility to design and implement their

State Advocacy Tips

- **Urge state officials to solicit and consider stakeholder input when designing and implementing the managed care monitoring system.**
- **Establish managed care monitoring work groups as part of advisory groups such as Medical Care Advisory Committee (MCAC) and the LTSS stakeholder groups and require regular updates on monitoring activities for ongoing program assessment.**

[2] 42 C.F.R. § 438.66(b).

[3] *See* NHeLP Comments (July 2, 2015) at 73-75, *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability* (Proposed Rule), 80 Fed. Reg. 31098 (June 1, 2015). *See also* Abbi Coursolle, NHeLP, *Medicaid Managed Care Regulations: Network Adequacy & Access* (May 26, 2016), http://www.healthlaw.org/publications/browse-all-publications/Brief-3-MMC-Final-Reg.

performance monitoring systems, using the means they choose.[4]

Requirements for state monitoring systems are effective no later than rating period for contracts starting on or after July 1, 2017.

Data collection (§ 438.66(c))

The final rule requires states to collect performance data from plans, including:

• Enrollment and disenrollment trends in each MCO, PIHP, or PAHP • Member grievance and appeal logs • Findings from the state's External Quality Review process • Provider complaint and appeal logs • Results from any enrollee or provider satisfaction survey conducted by the state or MCO, PIHP, or PAHP • Performance on required quality measures • Medical management committee reports and minutes	• The annual quality improvement plan for each MCO, PIHP, PAHP, or PCCM entity • Audited financial and encounter data submitted by each MCO, PIHP, or PAHP (*see* § 438.818) • The medical loss ratio summary reports (required by § 438.8) • Customer service performance data submitted by each MCO, PIHP, or PAHP and performance data submitted by the beneficiary support system • Any other data related to LTSS as applicable to the managed care program.[5]

NHeLP and other advocates urged HHS to require quarterly updates to each state's MCAC and other stakeholder advisory groups and to solicit their input on plan performance. HHS acknowledges that states can collect qualitative data from stakeholder groups, but it does not require states to share their data, "[w]hile we believe in transparency, not all data collected would be appropriate for public posting."[6] HHS notes the managed care program assessment report must be posted to the state's Medicaid website (described in the section below).[7]

It remains unclear how detailed the performance data in the publicly posted managed care program report will be, but it likely will not include all the data collected and reported through the state monitoring system. For example, HHS explains that states will not publish actual encounter data in the report, but rather an assessment "of each managed care plan's performance in this area."[8] The content

[4] 81 Fed. Reg. 27719.
[5] 42 C.F.R. § 438.66(c).
[6] 81 Fed. Reg. 27719.
[7] *Id*.; 42 C.F.R. § 438.66(e)(3).
[8] 81 Fed. Reg. 27722.

State Advocacy Tip

Advocates may be able to obtain Medicaid managed care data collected by the state but not included in the report by filing public records requests pursuant to state Freedom of Information or public records laws, including:

- **MCO medical management committee reports and minutes;**
- **Network adequacy performance including appointment wait times and compliance with access standards;**
- **Audited encounter data submitted by the plan.**

and form of the reports are subject to further guidance from the Centers for Medicare & Medicaid Services (CMS).[9]

Requirements for state data collection are effective no later than rating period for contracts starting on or after July 1, 2017.[10]

Managed care program report (§ 438.66(e))

The final regulations require states to produce an annual managed care program assessment report. The report must include: an assessment of the availability and accessibility of services within capitated plans; performance on quality measures; activities of the beneficiary support system; compliance with state network adequacy standards; information on grievances, appeals and state fair hearings; the financial performance of each plan including MLR; and encounter data reporting, and enrollment.[11]

States must submit the report to CMS no later than 180 days after the end of each contract year.[12] The final rule does not specify that the state must produce a separate report on each managed care plan; rather, the report must provide information and an assessment of each managed care program operated by the state, regardless of the authority for that program.[13]

States may operate all or some of its managed care program as a demonstration project authorized by § 1115 of the Social Security Act. If the state's § 1115 annual report contains the information required under the managed care program report (described in 42 C.F.R. § 438.66(e)(2)), the § 1115 report can

[9] 42 C.F.R. § 438.66(e)(1)(i).
[10] 42 C.F.R. § 438.66(f); 81 Fed. Reg. 27499.
[11] 42 C.F.R. § 438.66(e)(2).
[12] 42 C.F.R. § 438.66(e)(1).
[13] 42 C.F.R. § 438.66(e)(1), (2).

be deemed to satisfy the annual managed care program report for that portion of the state's managed care program.[14]

Although guidance on the content and form of the report is forthcoming, the final rule gives some indication of the type of information the annual reports are expected to provide.[15] For example, information on grievance, appeals and the state fair hearings is program-wide; whereas performance on qualify measures, MLR experience, enrollment, and benefits is specific to each capitated plan and PCCM entity (if applicable).

HHS did not establish a formal role for MCACs, the LTSS stakeholder, or other advisory groups in the development of its annual managed care program report. Nonetheless, "[w]e encourage states to work

NHeLP
State Advocacy Tip

Advocates can urge their state Medicaid agency to ensure a meaningful opportunity to provide feedback on the managed care program report, such as a formal notice and comment period or review by the MCAC, LTSS and other stakeholder groups.

with enrollees, providers, and other stakeholders to ensure that the report is meaningful and inclusive of stakeholder feedback."[16] The final regulations require states to share the managed care report with the MCAC and state-level LTSS stakeholder group and post it to the agency's website.[17]
States must comply with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.[18]

Subpart E—Quality Measurement and Improvement; External Quality Review

Basis, Scope and Applicability (§ 438.310)

The final rule expands the applicability of certain provisions of the managed care quality regulations to include PAHPs and PCCM entities with contracts that provide for shared savings, incentive payments or other financial reward for improved quality outcomes.

Definitions (§ 438.320)

[14] 42 C.F.R. § 438.66(e)(i)(ii).
[15] 42 C.F.R. § 438.66(e)(1)(i).
[16] 81 Fed. Reg. 27723.
[17] 42 C.F.R. § 438.66(e)(3).
[18] 42 C.F.R. § 438.66(f); 81 Fed. Reg. 27499.

The new regulations update several definitions relevant to quality care, mostly to clarify that LTSS encompass more than strictly a clinical or medical perspective and that quality assessment should incorporate these broader perspectives on health. To this end, HHS added new definitions of "health care services" and "outcomes" that specifically encompass all services covered in the managed care contract, not only those specifically related to "medical" care. HHS also revised the definition of "quality" to reflect this broader perspective inclusive of clinical and nonclinical "outcomes" relevant to LTSS quality, such as goal achievement and quality of life.

State Quality Strategy and Quality Assessment and Performance Improvement Programs (§§ 430.330 & 340)

The proposed managed care rules introduced a significant change that would have required states to develop a comprehensive state quality strategy to apply to both managed care and state plan fee-for-service (FFS).[19] But, HHS excluded FFS Medicaid from the comprehensive quality strategy in the final rule, acknowledging challenges related to resources, shrinking FFS populations, and shortcomings with state data systems. The regulations do, however, finalize an expanded managed care state quality system that now requires states to include PAHPs and PCCM entities in their managed care quality strategy.[20]

The state managed care quality strategy includes a number of required elements that advocates can use to shape state goals and priorities for performance improvement, improve quality reporting, require plans to stratify of data to help track health disparities, and strengthen oversight for individuals who use long-term services and supports.

Through their contracts, states must require each MCO, PIHP, PAHP and PCCM entity to develop a quality assessment and performance improvement (QAPI) program. At a minimum the QAPI includes:

- Performance Improvement Projects (PIPs);
- Performance data on all required measures;
- Mechanisms to detect underutilization and overutilization of services;
- Mechanisms to assess the quality and appropriateness of care for individuals with special health care needs; and,
- Additional requirements to assess quality and appropriateness of care individuals receiving managed LTSS, if these are covered by the plan.[21]

[19] *See* HHS, *Medicaid & Children's Health Insurance Program (CHIP) Programs: Medicaid Manage Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules*, 80 Fed. Reg. 31153 (June 1, 2015).
[20] 42 C.F.R. § 438.340.
[21] 42 C.F.R. § 438.330(b). Note that the regulations only require PCCM entities to fulfill the performance measurement and analysis of service utilization components of the QAPI.

While plans run their own QAPIs, the framework is laid out in the state's managed care quality strategy. In that document, the state details the standard PIPs and performance measures managed care entities must report on for each contract year.[22] HHS separately reserves its authority to establish and require standard national PIPs and performance measures, though it has yet to implement this authority.[23] The final regulations require a public notice and comment period for any federal standard measures or PIPs and also describe a process for states to request exceptions.[24]

In addition to defining a state's required standard measures and PIPs, the managed care state quality strategy must also provide an overview of the state's goals and objectives for quality assessment, detail state-defined network adequacy and availability of services standards, describe the state's arrangements for external quality review, its policy for transition of care, the appropriate use of intermediate sanctions for MCOs, its mechanisms for identifying individuals with special health needs or who require LTSS, and, if applicable, how it will assess performance and quality of its PCCM entities.[25] Notably, the final rule also adds a requirement for states to develop a plan to identify, evaluate and reduce health disparities based on age, race, ethnicity, sex, primary language and disability status. HHS declined to include sexual orientation in this list and requires only that states conduct these activities "to the extent practicable," but the requirement for a plan to address health disparities in the regulation creates an important advocacy opportunity.

The managed care state quality strategy must be reviewed and updated at least every 3 years and whenever it undergoes "significant" changes.[26] Prior to issuing an updated draft, the state must post results from its review and evaluation of the prior quality strategy. Each update must include a public notice and comment period, consultation with the state's MCAC and with federally recognized tribes, and evidence that the state has considered recommendations stemming from the external quality review process.[27] The final strategy document must also be posted to the state's web site.

[22] 42 C.F.R. § 438.340(b).
[23] CMS strongly encourages states to adopt its Medicaid adult and child core measure sets to improve consistency in reporting across the country. CMS regularly updates these core sets and produces annual reports tracking progress in state implementation. For more information, *see* Medicaid.gov, *Quality of Care*, www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care.html (Last visited June 7, 2016).
[24] 42 C.F.R. § 438.330(a)(2).
[25] 42 C.F.R. § 438.340(b).
[26] 42 C.F.R. § 438.340(c). States must also define "significant change" in their quality strategy. 42 C.F.R. § 438.340(b)(11).
[27] 42 C.F.R. § 438.340(c)(1).

State Advocacy Tips

State advocates should weigh in when the state updates its managed care quality strategy. At minimum urging states to require managed care plans to:

- **Stratify and report quality data by key demographic categories to allow for an analysis and tracking of health disparities;**
- **Require relevant adult and child core measures to improve data comparability across programs and states and include a robust set of measures for LTSS, if applicable;**
- **Incorporate robust direct testing mechanisms in their External Quality Review (EQR) contracts; and**
- **Adopt optional EQR-related activities such as beneficiary surveys and validation of encounter data that can improve oversight of capitated plans.**

States must comply with changes to the QAPI provision for any contracts that will begin on or after July 1, 2017. They have until July 1, 2018 to comply with the new quality strategy provisions in § 438.340.

Managed Care Quality and LTSS

Managed care continues to expand beyond acute care and into the area of long-term care delivery. The final regulations recognize this trend and have significantly strengthened requirements for quality assessment of LTSS delivery. For plans that cover LTSS, the QAPI must include several extra methods to evaluate quality and appropriateness of care, including:

- Standard performance measures specific to LTSS, including at least measures relating to quality of life, the relative proportion of LTSS delivered in community-based settings versus institutions, and community integration;[28]
- Participation in state efforts to prevent critical incidents;
- Assessing care across settings; and
- Comparisons of LTSS authorized in a service plan against services actually receive, where applicable.[29]

[28] 42 C.F.R. § 438.330(c)(1)(ii).
[29] 42 C.F.R. § 438.330(b)(5).

State Advocacy Tip

While the final rule takes important steps forward, advocates should also review earlier CMS guidance on Medicaid managed LTSS programs, which provides more detailed language on CMS's expectations for stakeholder engagement, beneficiary supports and quality and oversight systems.[1] These details could prove useful as states flesh out their approach to oversight of managed LTSS.encounter data that can improve oversight of capitated plans.

Stakeholder and Member Engagement in Long Term Services and Supports (LTSS) (§ 438.70 and § 438.110)

The final regulations establish new Long Term Services and Supports (LTSS) stakeholder advisory groups at the state and plan levels with minor changes from the proposed rule. HHS recognized that "stakeholder and member engagement plays a critical role in the success of a [managed] LTSS program."[30]

Under the new § 438.70, states must establish an LTSS stakeholder group consisting of beneficiaries, individuals representing beneficiaries, providers, and other stakeholders. The state must "solicit and address" stakeholder views on the "design, implementation, and oversight of a state's managed LTSS program." HHS declined to specify the LTSS group membership, meeting frequency, and scope of activities. Instead, HHS retained language from the proposed rule that the group's composition and meetings should be "sufficient to ensure meaningful stakeholder engagement."[31]

In § 438.110, HHS requires MCOs, PIHPs and PAHPs that provide LTSS to establish a member advisory committee. (Note: these terms are defined at 42 C.F.R. § 438.2.) These plan-level advisory groups consist of individuals receiving LTSS and their representatives that are "reasonably representative" of the populations served.[32]

NHeLP and other advocates urged HHS to provide detailed requirements for stakeholder groups, including composition, scope of authority, and state support for stakeholder group activities. However, in the final rule, HHS provided only broad requirements, deferring to states to establish the parameters and composition of plan and state-level LTSS groups.

[30] 81 Fed. Reg. 27655.
[31] 42 C.F.R. § 438.70.
[32] 42 C.F.R. § 438.110(b).

Advocates should urge state officials to provide detailed requirements when establishing the state-level LTSS stakeholder groups and plan-level member advisory groups. These can include:

- Governance structures and by-laws that allow for maximum participation of beneficiaries and their representatives;
- Membership requirements to ensure the group is representative of the LTSS population and well as trainings to promote meaningful participation, including public comment;
- Staff assistance from the agency or plan and independent technical assistance, as needed, to facilitate effective group recommendations;
- Financial arrangements, if necessary, to make possible the participation of beneficiary members, including transportation assistance, child care, and stipends for enrollees;[33]
- Accessible meeting sites in different locations across the state, as well as appropriate meeting times to allow working individuals the opportunity to participate and meeting materials available in accessible formats;
- Transparency requirements including public posting of meeting announcements, agenda, membership, minutes, and other resources and materials.

State Advocacy Tips

- **Determine whether your state should establish a state-level LTSS stakeholder group through either legislation or executive action and provide input.**
- **Urge officials to also include compliance monitoring to ensure that the state fulfills its obligation for meaningful stakeholder engagement.**
- **The plan contract should provide for plan-level LTSS member advisory groups and should also include compliance monitoring and reporting.**

The final regulations require LTSS stakeholder group consultation in developing quality improvement strategies, performance improvement plans, the development of quality star ratings, and reporting on state oversight activities. States must meet the requirements of §§ 438.70 and 438.110 no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.[34]

[33] Earlier CMS guidance on managed LTSS programs clearly states the expectation that managed care plans "must provide supports such as transportation, interpreters and personal care assistants…[and] may also compensate members." *See* CMS, *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs*, 7 (May 20, 2013), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf.

[34] 81 Fed. Reg. 27499.

Accreditation of Managed Care Entities (§ 430.332)

The 2015 proposed rules would have established a new requirement that states develop and implement an accreditation process for all contracted Medicaid MCOs, PIHPs and PAHPs. The proposed system would allow states to either develop their own accreditation process (with standards at least as stringent as CMS-recognized private accreditor) or to deem compliance for MCOs, PIHPs and PAHPs accredited by a CMS-recognized private accreditor.

In its final regulations, HHS did not finalize this proposal. While requiring private accreditation could provide yet another layer of oversight to improve quality and readiness, commenters noted a number of problems with the HHS proposal. Notably, private accreditation often covers the whole range of an MCO's insurance products, including commercial and employer-sponsored plans, and may not be specific to its Medicaid business line. Many aspects of Medicaid managed care differ substantially from commercial market coverage, including coverage for LTSS and expanded coverage for children. HHS acknowledged these concerns, along with the potential administrative burden, in its explanation for not finalizing the accreditation requirement, noting that "private accreditation may not adequately reflect elements of quality of care that are key to vulnerable populations disproportionately represented in the Medicaid program."[35]

HHS did emphasize that states retain the authority to require accreditation from plans they contract with. The finalized regulation also requires all MCOs, PIHPs and PAHPs contracting with a state to inform the state of their accreditation status and authorize the accrediting body to provide the state with its most recent accreditation review. The state must post the accreditation status for each contracted MCO, PIHP and PAHP on its web site and update that information at least annually.[36]

States must comply with this section no later than the rating period for contracts beginning on or after July 1, 2017.[37]

[35] 81 Fed. Reg. 27685.
[36] 42 C.F.R. § 438.332(c).
[37] 42 C.F.R. § 438.310(d)(1).

Medicaid Managed Care Quality Rating System (§ 430.334)

Another new accountability tool in the revised regulations is the Medicaid managed care Quality Rating System (QRS) for each capitated plan contracted by the state. This system will draw on existing "star-rating" systems for Qualified Health Plans (QHPs) in the Marketplace and for Medicare Advantage plans. In theory, star-rating systems can be an effective accountability tool that also facilitates informed consumer choice during the plan selection and enrollment. Plans with poor quality ratings would be at a competitive disadvantage, thus increasing the incentive to deliver high quality care and efficient customer service. The effectiveness of star-ratings systems in practice, unfortunately, has not always lived up to this promise.

Update on the Marketplace QRS

The Marketplace QRS will serve as a starting point for the Medicaid QRS. Details on the measures used and the scoring methodology for the Marketplace QRS are laid out in useful CMS technical guidance.[38] The 2016 measure set used for QHP quality ratings includes 43 total measures.[39] Twelve of these measures derive from questions on the Marketplace Enrollee survey, which is based on a Consumer Assessment of Healthcare Providers & Systems (CAHPS®) survey tool. All but one of the remaining measures are a subset of NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

Medicaid does not currently require an enrollee survey tool for all Medicaid managed care programs, but it will likely follow a similar model. Advocates may have an opportunity to push for the best available instrument.

CMS recently announced that public reporting for the Marketplace QRS will be piloted in five states that rely on healthcare.gov for the 2017 open enrollment period, and will expand to include all states for the 2018 plan year.[40] State-based Marketplaces may require public reporting for plan year 2017.

The development of a Medicaid QRS will be largely federally driven. The final regulations stipulate that the Medicaid QRS will align generally with the main summary indicators used in the Marketplace QRS.[41] However, because the Medicaid population differs substantially – including many more children, pregnant women and people with chronic and long-term care needs – CMS recognizes it will have to expand or adjust the summary indicators to accommodate Medicaid-specific populations

[38] CMS, *Quality Rating System and Qualified Health Plan Enrollee Survey: Technical Guidance for 2016*, 15 (January 2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QRS-and-QHP-Enrollee-Experience-Survey-Technical-Guidance-for-2016-V20.pdf.
[39] *Id.* at 9-10.
[40] CMS, *Quality Rating Information Bulletin*, 1 (April 29, 2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QRS-Bulletin-4292016.pdf.
[41] 42 C.F.R. § 438.334(b).

and priorities.[42] The public process for the CMS-developed Medicaid QRS will also mimic the Marketplace QRS approach, including multiple listening sessions and opportunities for public comment in the Federal Register.[43]

Some of the many controversial issues that CMS and stakeholders will need to resolve in the coming years include selecting the appropriate measures to include in a Medicaid QRS, determining whether and to what extent measure data should be "risk-adjusted" to compensate for demographic differences in plan populations, and developing mechanisms to ensure the timeliness of QRS data and its availability during the plan selection process.

States also have the option to develop their own alternative Medicaid QRS, subject to CMS approval. The final rule states that any such alternative must be "substantially comparable" to the CMS-developed Medicaid QRS.[44] In response to comments, the final rule expanded the public process requirements for the state-based alternative QRS, including at least a 30-day public notice and comment period, consultation with the state MCAC, and a response to public comments that identifies any modifications made to the state plan based on comments received.

HHS originally proposed to allow plans that only cover individuals dually eligible for Medicaid and Medicare to default to the Medicare Advantage (MA) five-star rating system. In response to comments, however, HHS abandoned this proposal. It acknowledged that the MA system does not account for important demographic differences with dually eligible individuals, who as a population have more chronic conditions, higher LTSS needs, and fewer financial resources than the general Medicare population. Moreover, the MA star rating system also does not include LTSS performance measures, which would be a key component of any robust Medicaid QRS for dual-eligible population.

The rollout of a Medicaid star-rating system remains several years down the road, with state implementation beginning three years after the publication of final notice in the Federal Register.[45] However, advocates and other stakeholders will have more immediate opportunities to weigh in on the design of this important accountability tool as soon as the federal public process begins.

[42] 81 Fed. Reg. 27687.
[43] 81 Fed. Reg. 27688.
[44] 42 C.F.R. § 438.334(c)(i).
[45] HHS expects to complete the QRS public notice and comment process by 2018. 81 Fed. Reg. 27689.

State Advocacy Tips

Here are some ways to prepare for the QRS public comment process:

- **Familiarize yourself with the strengths and weaknesses of the Marketplace QRS tool and formulate arguments to advocate for changes to adapt that system to Medicaid populations.**
- **Review and evaluate the CMS-recommended Medicaid core measure sets for adult and children, which will also contribute an important foundational role in developing the Medicaid QRS.**
- **Evaluate the various enrollee satisfaction surveys, particularly those for LTSS, most appropriate for different Medicaid populations.**
- **Identify areas to use EQR and the enhanced federal match to assist with activities related to Medicaid quality rating.**

External Quality Review (§§ 438.350 through 370)

Independent external quality review (EQR), has long held promise as a key mechanism to improve data transparency, hold managed care plans accountable to performance expectations, and provide states financial incentives and flexibilities to innovate with quality assessment activities. It has been a required activity for states that contract with MCOs and PIHPs for over a decade. NHeLP has previously described the general requirements of EQR, the major industry players, and current best practices.[46] This includes various instances of States using EQR-incentives, such as 75% enhanced federal match, to test innovative new quality metrics or conduct secret shopper surveys to test network adequacy.

Prior regulations applied EQR to all MCOs and PIHPs and required states to use EQR to validate performance measures and PIPs annually and to review plan compliance with state and federal regulations at least every three years. The updated final regulations expand the applicability of EQR to PAHPs and certain PCCM entities, while also adding an important new mandatory EQR activity to validate network adequacy for all contracted capitated plans annually.[47] HHS also added an option for states to use EQR for activities that assist with the Medicaid star-rating system described in § 438.334,

[46] David Machledt, NHeLP, *External Quality Review: An Overview* (June 2014), http://www.healthlaw.org/publications/search-publications/EQR-Overview06162014pdf.

[47] 42 C.F.R. § 438.358(b)(1)(iv). Note: Only PCCM entities with state contracts that provide for shared savings, incentive payments or other financial reward for improved quality outcomes are subject to EQR. See § 438.350(a). PCCM entities are only required to validate performance measures and undergo periodic compliance reviews in their EQR. *See* § 438.358(b)(2).

which could allow some States to receive enhanced match for activities related to developing and implementing that system.[48]

The network adequacy validation is a significant change. HHS explains in the Preamble that the new protocols related to this activity will require direct testing of plan networks through methods like secret shopper testing.[49] Two 2014 reports from the HHS Office of the Inspector General (OIG) found striking evidence that states using direct testing methods were far more likely to identify violations of state standards and initiate corrective actions.[50] For more information on the new network adequacy requirements under Medicaid managed care, see NHeLP's issue brief on network adequacy.[51]

State Advocacy Tip

Call for federal guidance to mandate robust and independent direct testing in the federal EQR protocols to validate network adequacy. Advocates have two opportunities: one at the federal level – when the new EQR protocols go out for public comment – and another at the state level – when each state determines its own EQR arrangements as part of its state quality strategy.[1]

Unfortunately, just as HHS expands the scope and applicability of EQR, it also restricts the availability of enhanced matching funds available to states. Due to a reinterpretation of the statutory language, HHS will now only permit enhanced match for activities performed by an EQRO on an MCO.[52] EQR-activities for PIHPs, PAHPs and PCCM entities will now be reimbursed at a 50% rate, regardless of whether the entity performing the EQR activities is a qualified EQRO, the state, or some other organization.[53]

States like California, which organizes its county-based behavioral health system as PIHPs, will likely incur increased costs for EQR related to that program, and will have much less incentive to conduct optional EQR-related activities. Moreover, because states will be reimbursed at 50% match regardless of who conducts the EQR of PIHPs and PAHPs, there is no incentive to contract with an EQRO that has met the independence and competence standards in § 438.354 to conduct required validations and

[48] 42 C.F.R. § 438.358(c)(6).
[49] 81 Fed. Reg. 27706. Note that HHS does not reference direct testing in the text of the regulation.
[50] See HHS, Office of the Inspector General, *Access to Care: Provider Availability in Medicaid Managed Care* (Dec. 2014); HHS OIG, *State Standards for Access to Care in Medicaid Managed Care* (Sept. 2014).
[51] Abbi Coursolle, NHeLP, *Managed Care Regulations: Network Adequacy and Access* (May 26, 2016), http://www.healthlaw.org/publications/search-publications/Brief-3-MMC-Final-Reg.
[52] The prior regulations permitted 75% enhanced match for EQR conducted by EQROs on PIHPs as well. HHS explains its reasoning for the reinterpretation in the Preamble at 81 Fed. Reg. 27715.
[53] 42 C.F.R. § 438.370.

plan compliance reviews for PIHPs, PAHPs and PCCM entities. In those cases, only the annual technical report must be produced by an EQRO.[54]

The final rule strengthens several elements of the requirements for EQRO independence.[55] It also modifies the standard that allows states to use information obtained from plan accreditation activities in lieu of EQR.[56] Previously, states could only use information from an accreditation review to substitute for the mandatory EQR compliance review, but not for validating PIPs or performance measures. The final rule expands the nonduplication provision to cover these three mandatory EQR activities, provided that the accreditation information is comparable to the EQR standards.[57] CMS will issue further guidance on what "comparable" means.[58] Non-duplication can also apply to MCOs, PIHPs and PAHPs subject to Medicare Advantage standards, but this longstanding policy has not been significantly altered in the final regulation.

The last critical component of EQR for advocates is transparency. EQR reports include valuable data, including quality performance metrics, an assessment of each plan's strengths and weaknesses, recommendations for improving each plan's care quality, and an assessment of how well each plan has responded to prior recommendations must be publicly posted on the agency's website.[59] The final rule requires states to contract with an EQRO to produce the annual report and prohibits states from substantively revising the content of the annual EQR report without evidence of error or omission.[60]

Formerly, states were required to make annual technical reports available on request, and the release of information was plagued by delays. Once the EQR report was finally released, its data was often already stale. In 2012, CMS released guidance requiring states to file their annual report by April 30 each year. That guidance has now been incorporated into the final rule, along with a requirement that states post the most recent annual technical report on their website and make printed or electronic copies available on request, including alternative format copies for people with disabilities.[61]

[54] 42 C.F.R. § 438.368(c).
[55] 42 C.F.R. § 438.354(c).
[56] 42 C.F.R. § 438.360(a).
[57] Note that the new mandatory activity to validate network adequacy is not subject to the non-duplication provision.
[58] The final rule weakens the standard from the proposed "substantially comparable" to "comparable." 42 C.F.R. § 438.360(a)(2). It will be up to advocates to push for high standards in subregulatory guidance. *See* 81 Fed. Reg. 27711.
[59] 42 C.F.R. § 438.364(c)(2)(i)..
[60] 42 C.F.R. § 438.364(b) & (c).
[61] 42 C.F.R. § 438.368.

State Advocacy Tips

EQR can provide a pathway for innovations as well as useful comparative information that advocates can use to cross-check other quality and oversight activities, such as compliance with the network adequacy standards. Advocates should:

- **Urge states to include archived EQR reports to make it easier to analyze how plans perform over time;**
- **Strategize over creative applications of EQR, particularly if your state contracts with MCOs. This could include piloting new measures, like LTSS beneficiary surveys for MLTSS programs, or testing new methods for evaluating network adequacy. the Medicaid QRS. Evaluate the various enrollee satisfaction surveys, particularly those for LTSS, most appropriate for different Medicaid populations.**

•Identify areas to use EQR and the enhanced federal match to assist with activities related to Medicaid quality rating.

States must comply with changes to EQR by July 1, 2018.[62] The regulations altering enhanced FMAP for EQR related activities at § 438.370 were effective immediately (May 6, 2016).[63]

State responsibilities - Transparency (§ 438.602)

In response to comments that HHS's transparency and reporting requirements proposed in § 438.602(g) would be overly burdensome, HHS narrowed those requirements in the final rule.[64] However, HHS also increased accessibility, making posting of this information mandatory, and not just available upon request. States are required to publicly post on the agency's website:

- MCO, PIHP, PAHP, and PCCM contracts;
- Information on ownership and control;
- Documentation showing access and availability of services including provider networks; and the
- Results of periodic audits.[65]

However, the final rule backtracks from the proposed rule, which required posting encounter data, information on the actuarial soundness of capitation rates, compliance with MLR requirements,

[62] *See* 42 C.F.R. § 438.310(d)(2).
[63] 81 Fed. Reg. 27499.
[64] 81 Fed. Reg. 27603.
[65] 42 C.F.R. § 438(g).

solvency reviews, and annual reports of overpayment recoveries. The final rule does not include these requirements. However, some of this information may be found in the annual managed care program report required under 42 C.F.R. § 438.66(e). In addition, state data collection requirements under § 438.66(c) include encounter data and MLR reports that may be obtained through a public records request.

State Advocacy Tip

Monitor your state's compliance with federal managed care transparency requirements. Review the state contracts with managed care plans to hold the companies and the state agencies accountable to their obligations to managed care enrollees.

Requirements for transparency and public posting no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.

Conclusion

These regulations seek to modernize the Medicaid managed care procedures and protect beneficiary rights to quality care. A number of opportunities exist for state advocates to strengthen or clarify the final regulations as CMS and states begin implementation. NHeLP recommends that state advocates monitor development of policies, contracts, practices, and implementation to ensure that state officials:

- Solicit and consider stakeholder input when designing and implementing the managed care monitoring system, and establish managed care monitoring work groups or subcommittees as part of advisory groups such as MCAC and the LTSS stakeholder groups and require regular updates on monitoring activities for ongoing program assessment.
- Ensure a meaningful opportunity to provide feedback on the managed care assessment report, such as a state comment period or review by the MCAC, LTSS and other stakeholder groups.
- Review earlier CMS guidance on Medicaid managed LTSS programs and use it as a basis for developing beneficiary supports and quality and oversight systems.
- Include specific quality measures when updating the state quality strategy, including;
    - data stratified by key demographic categories to track health disparities;
    - relevant adult- and child core measures to improve data comparability across programs;
    - direct testing mechanisms in EQR contracts;
    - optional EQR-related activities such as beneficiary surveys and validation of encounter data.

- Establish LTSS stakeholder groups that ensure meaningful stakeholder engagement membership, governance, and member support.
- Include detailed requirements and monitoring in managed care contracts to establish Plan-level LTSS member advisory groups.
- Conduct direct testing of provider networks and access to care at both the federal level (when EQR protocols go out for public comment) and as a state monitoring activity.
- Archive EQR reports to make it easier to analyze how plans perform over time.
- Strategize with advocates on creative applications of EQR, such as piloting beneficiary surveys for MLTSS programs and testing new measures.
- Gear up for the public engagement process required for Medicaid managed care star ratings system, working with stakeholders in identifying effective performance measures, assessment instruments, and scoring methodologies which may include:
    - the Marketplace QRS tool;
    - CMS-recommended adult and children Medicaid core measure sets;
    - enrollee satisfaction surveys.
- Comply with federal managed care transparency requirements. Advocates should review the state contracts with managed care plans to hold the companies and the state agencies accountable to their obligations to managed care enrollees.

For more information on how to implement these tips, please contact the National Health Law Program.