NATIONAL HEALTH LAW PROGRAM

Medicaid External Quality Review: An Updated Overview

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By David Machledt

Executive Summary

Introduction

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated Medicaid managed care regulations for the first time in over a decade. This included several new requirements for the External Quality Review (EQR) process. This issue brief reviews the updated EQR process and points out where States can take advantage of enhanced federal match to improve their managed care oversight in a cost-effective manner.

Generally, EQR is a flexible oversight tool that could push accountability and quality forward, but often remains underutilized. Already available EQR reports contain substantial information about plan performance, yearly recommendations for improvement with narratives on plans' responses to prior recommendations, and details on plans' compliance with regulations. But in many cases, states could do more.

States with more ambitious EQR may directly test provider networks or plan reported encounter data to ensure accuracy, rather than passively accepting what plans report. Others have used it to report on plans' actions to reduce health disparities. These activities increase plan transparency and also allow states to guage the efficiency and effectiveness of their health care spending. Because EQR-related performance data must be publicly posted, it can also help consumers make informed decisions about which health plan best suits their particular needs when they enroll.

In reviewing the recent EQR changes, this brief explores strengths and shortcomings in current state practices with major EQR elements and provides advocacy tips for strengthening state EQR and quality oversight activities. Recurrent themes include numerous ongoing delays in the implementation of important 2016 changes.

Finally, Appendix A. provides charts with links to key state quality resources, including contracted EQR organizations, recent EQR annual reports, state quality strategies, and, where applicable, links to state quality scorecards or health equity reports.

What is EQR and how has it changed?

Independent EQR can be a valuable oversight tool for states to track how well plans manage enrollee care. CMS mandates four required EQR activities: periodic compliance reviews, annual validation of performance measures, annual validation of plan performance improvement projects (PIPs), and the validation of provider network adequacy. States may also choose to add various optional activities to their EQR, including testing the accuracy of plan-reported encounter data or conducting patient surveys. Several states have used EQR direct testing, such as secret shopper surveys, to identify problems with wait times, provider availability, and the accuracy of plan

provider directories. States that contract with Medicaid managed care organizations (MCOs) may find EQR a cost-effective approach to oversight, because the federal government will pay seventy-five percent of EQR-related activities.

In 2016, CMS finalized revised managed care regulations that strengthened the EQR process. Major changes included adding the requirement to validate provider networks, mandating that states post annual EQR reports publicly, and expanding the types of plans subject to full EQR. Unfortunately, implementation of some of the 2016 changes has been slower than originally projected, and in some cases still has not occurred.

What makes an EQRO?
States contract with External Quality Review Organizations (EQROs) to conduct EQR. To meet the regulations, EQROs must demonstrate capacity and expertise to do the work and satisfy conflict-of-interest protections. The EQR industry is dominated by just a few companies. Just two companies, Health Services Advisory Group (HSAG) and Island Peer Review Organization (IPRO), cover 23 of the 44 states that use EQR.

Transparency & Timeliness
States have long failed to produce timely EQR reports that are accessible for the public. The new regulations for the first time required state to post annual reports by April 30 to improve timeliness. Unfortunately problems with transparency, data lag and enforcement persist, and timeliness varies substantially from state to state.

EQR and Quality Measure Validation
One key function of EQR is to validate plan-reported performance measures to ensure that plans collect and report required measures properly. Publicly posted annual EQR reports are often the easiest and sometimes the only way to obtain information on plan performance. Currently states decide which measures plans must report, but CMS has developed recommended core measures for adults and children. It encourages states to take up core measures, and the 2016 regulation revisions suggest a shift toward more federal standardization for at least a small set of core measures. A separate companion paper in this series, *Analyzing Core Measure Performance in Medicaid*, goes into greater detail on how advocates can find and evaluate their state's performance on EQR measures.

Performance Improvement Projects (PIPs)
Part of EQR involves validating managed care PIPs. PIPs are focused interventions aimed at specific problem areas identified by the plans, state, or federal government. Plans implement strategies to address the PIP topic and evaluate progress on specific target measures. For example, a state may ask plans to develop a PIP on reducing disparities in maternal mortality or improving outcomes for pediatric dental. Unfortunately, EQR reports show very uneven PIP results across states, often measuring little or no improvement at all with limited or no consequences for plans.

Evaluating Managed Long Term Supports and Services (MLTSS)
One of the important changes in Medicaid managed care over the last two decades has been a rapid increase in MLTSS, from eight states in 2004 to twenty-four in 2019. Program evaluation and oversight must evolve to accommodate this expansion, even

though traditionally, quality measurement has focused more on acute medical care delivery and coordination.This section describes new developments in measuring quality for long term care, especially related to new measurement tools specific to LTSS and HCBS quality. The revised regulations provide several new opportunities advocates can use to promote oversight in managed LTSS programs, but serious gaps remain.

Addressing Health Equity in Managed Care Quality

The COVID-19 pandemic has reemphasized the stark disparities in health outcomes for many conditions by race, ethnicity, disability, age, gender, sex, sexual orientation, and other demographic factors. While the data remain unclear on whether managed care helps to reduce health disparities, advocates should push their states to develop and execute a clear plan for holding managed care plans accountable for improving health equity. Several states already leverage the enhanced match available for EQR to conduct activities related to measuring and improving health equity, but there is still a lot of room for improvement. A separate paper in this series, *Addressing Health Equity in Managed Care*, goes into more detail on this topic.

Next Steps

Advocates have a number of new levers to push both states and CMS to improve accountability in Medicaid managed care through the independent EQR process. This tool has been underutilized and has its shortcomings, but does provide interesting and cost-effective opportunities for effective advocacy to improve managed care oversight.

Appendix A – EQROs and Web-Accessible Quality and EQR Data, by State

This chart links to important EQR and related quality documents for each state that runs a Medicaid managed care program requiring EQR. Advocates can use it to find the documents relevant to their state and to identify best practices from other states.

About this Series

This paper is part of a larger series that updates and expands NHeLP's 2015 Advocates' Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care. Companion papers in this series will include:
- *Analyzing Medicaid Core Quality Measures* (forthcoming)
- *Addressing Health Equity in Medicaid Managed Care Quality Oversight* (forthcoming)
- *Medicaid Managed Care: Using Sanctions to Improve Accountability* (forthcoming)
- State quality fact sheets

Introduction

Managed care promises to deliver more efficient health care in Medicaid by curbing or eliminating the fiscal incentives in the fee-for-service (FFS) system that reward providers for every test and procedure they perform. The most common managed care system replaces FFS with a risk-based, capitated model, where managed care organizations (MCOs) receive a fixed per member/per month payment. This reverses

the FFS incentive structure and financially rewards managed care plans that spend *less* on care (at least in the short term). If health care expenditures are lower than the fixed monthly payment, the MCO keeps the remainder as profit. Without effective mechanisms to monitor and evaluate care quality, capitated managed care replaces the perceived fiscal excess of FFS with a system that can lead to some plans denying or delaying medically necessary care to save money.

Congress addressed quality measurement when it passed legislation allowing Medicaid managed care.[1] Within their overall Medicaid managed care quality strategy, states must conduct annual independent external quality reviews (EQRs) in each managed care contract.[2] States select at least one independent EQR organization to validate performance measures, conduct compliance reviews, review network adequacy, and otherwise evaluate the performance of Medicaid managed care plans, and report results to the state.

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated Medicaid managed care regulations and included several new requirements for the EQR process. However, CMS has been slow to implement some of these important changes.

What is EQR?

EQR consists of an annual review and report analyzing the performance of managed care entities with risk-bearing contracts with the state Medicaid agency. There are various types of managed care entities subject to EQR.[3] Medicaid regulations have long required EQR for each MCO and prepaid inpatient health plan (PIHP) under state contract.[4] Revisions of the Medicaid manage care regulations in 2016 added EQR requirements for most prepaid ambulatory health plans (PAHPs) and for primary care case management (PCCM) entities that include shared savings agreements. Since 2009, all managed care plans in the Children's Health Insurance

Changes to EQR after 2016 Regulation Revisions

The Medicaid managed care regulations finalized in 2016 implemented several changes to the EQR process. Major changes are summarized below:

- Expands required EQR elements to more managed care entities (PAHPs and certain PCCM entities);

- Adds new mandatory EQR activity for validating network adequacy;

- Added new optional EQR activity for activities related to developing a Quality Rating System;

- Reduces federal match to fifty percent for EQR activities related to managed care entities that are not MCOs;

- Requires states to post annual EQR technical report on public website by April 30;

- Extends conflict-of-interest protections to prohibit an EQRO from reviewing competitors of managed care plans it controls or is controlled by; and

- Expands the EQR non-duplication provision so states may use comparable data from an accreditation process to validate PIPs and performance measures.

Program (CHIP) must also conduct annual EQRs. States have considerable flexibility to choose a reviewer (or to conduct the review themselves), identify required activities, and select applicable quality measures. For convenience, this paper at times refers to a collective "managed care plans," which includes all the above types.

The managed care regulations now require four activities for EQR:

1. The validation of state-required MCO performance improvement projects (PIPs) conducted in the review year;

2. The validation of state- and CMS-required performance measures;

3. A review, conducted at least every third year, of the MCO's compliance with state and federal quality standards; and

4. The validation of MCO, PIHP, or PAHP network adequacy during the review year.[5]

A detailed set of protocols outline acceptable methodologies for conducting the required elements of EQR. However, states have ample latitude within these parameters to define performance measures, identify areas for PIPs, and determine how to review network adequacy. Although the 2016 regulations require states to validate provider networks, CMS has yet to develop a detailed protocol for this activity.[6]

States may also conduct optional EQR-related activities and receive federal matching funds. These optional activities include:

1. Validating MCO encounter data;

2. Administering or validating consumer or providers surveys of care quality;

3. Calculating additional performance measures beyond what the MCO must report;

4. Conducting PIPs implemented by an External Quality Review Organization (EQRO) (in addition to the required PIPs run by managed care plans);

5. Conducting point-in-time studies on aspects of specific clinical or nonclinical services; and

6. Assisting with the quality rating of MCOs, PIHPs, and PAHPs consistent with the new Medicaid managed care Quality Rating System (QRS).[7]

The state must contract with at least one qualifying independent EQRO to review each contracted MCO, PIHP, PAHP, and/or PCCM entity.[8] Certain state entities may qualify as EQROs (as long as they meet requirements for independence from the Medicaid agency and the managed care plans), but most are separate non-profit organizations or for profit businesses.

In most cases, states have strong financial incentives to contract with a qualified EQRO. If the state reviews MCOs without an EQRO, those activities qualify for the Medicaid's standard fifty percent administrative Federal Medical Assistance Percentage (FMAP). However, EQR activities related to MCOs conducted by a qualified EQRO can receive enhanced FMAP covering seventy-five percent of the EQR costs.[9] Previously, PIHPs also qualified for this enhanced match, but CMS reinterpreted the statute in 2016 and limited the seventy-five percent match to activities specifically related to MCOs. EQR activities related to PAHPS and PCCM entities also only qualify for a fifty percent federal administrative match, regardless of who performs them.[10]

As noted, federal regulations require an annual technical report that compares and evaluates the health plans subject to review based on the EQR activities specified by the state. The contracted EQRO prepares this report. If the state conducts its own EQR without an EQRO, it must still contract with an independent EQRO to draft the annual report.[11] The report must be posted on the state website by April 30 each year and must include the following components:

- A detailed explanation of the methodology for data collection, aggregation and analysis for each required EQR activity;

- an evaluation of plan performance with regard to quality, timeliness and access to care, including the conclusions drawn from data collected;

- recommendations for each plan to improve its quality performance;

- an appraisal of how well each plan responded to recommendations for quality improvement in the prior year's report; and

- methodologically appropriate data that compares performance across plans.[12]

Compliance with required elements has been uneven. A 2008 report from the U.S. Department of Health & Human Services' Office of Inspector General (OIG) found that over half the states contracting with EQROs received annual reports missing either required elements or information on the mandatory EQR activities.[13] Timeliness is also a persistent issue. As of August 2020, eight of forty-three states have not posted an EQR technical report within the last year, despite the regulatory deadline of April 30.[14] This represents a slight improvement over past years.

To assist states, CMS issued EQR protocols in 2012 (updated in 2019) detailing the process and expectations for successful external quality review, along with other technical assistance documents on its website.[15] CMS also clarified the process by which states can avoid unnecessary duplication of EQR requirements by using comparable data collected during the MCO accreditation process or by Medicare.[16]

Advocacy Tip: Push for More Direct Testing through EQR

One goal behind the new EQR activity to validate network adequacy involved expanding direct testing of provider networks. In 2014, HHS' Office of the Inspector General conducted secret shopper surveys of Medicaid plans that found over half the provider directory entries were incorrect or not available for appointments.[17] A number of states have also found that direct testing of networks and provider directories through mechanisms like secret shopper surveys helps identify consumer access barriers. States including Texas, Maryland, Missouri, New Hampshire, and Ohio have conducted surveys that revealed massive error rates in provider directories and documented long wait times to obtain a scheduled appointment.[18] Maryland's extensive survey of on-line and paper provider directories led to nine corrective action plans for MCOs in 2019.[19] Texas' EQRO study, which only successfully contacted 52% of providers in 2018, includes a list of best practices for more accurate provider directories.[20]

Why secret shopper? Ohio's EQRO compared secret shopper against revealed caller surveys. When the caller identified themselves as an evaluator, 81.7% of primary care providers reported appointment wait times under thirty days for new patient well-check visits. Ohio's secret shopper survey, using the same sampling, found only 69.5% of PCPs reported wait times under thirty days.[21] This discrepancy shows the value of anonymous direct testing for accurately identifying access barriers.

Until the new CMS protocol is released, states that do not validate network adequacy face no penalties. Enhanced match for activities related to required network adequacy validation is also contingent on the new protocol. States may be able to classify direct testing of this kind under existing optional EQR activities that qualify for enhanced match. Advocates should push their states to use extensive direct testing in state EQR contracts, as it has proven time and again to provide valid, actionable data on plans' compliance with managed care requirements.

CMS also bears responsibility for delayed implementation. In January 2020, nearly four years after the updated 2016 managed care regulations, CMS posted updated EQR protocols that incorporated most of the 2016 changes. As noted above, the 2020 EQR protocols still do not include protocols for the new requirement to validate managed care networks or the optional EQR activity for work related to the new Medicaid quality rating system (QRS). Despite mounting evidence from HHS OIG and the states identifying problems with provider directories and network access (see box above), CMS has put a hold on these new protocols pending finalization of proposed regulatory changes, published in late 2018, for network adequacy and the QRS.

What makes an EQRO?

To qualify as an EQRO, organizations must demonstrate competence and independence. Any number of different types of entities can qualify as EQROs, including university-affiliated institutes, for-profit healthcare consultants, and non-profit health care foundations.[23] Several organizations specialize in this field and contract with multiple states. In all, eighteen EQROs contract with the forty-four states (including D.C.) that currently have EQR contracts.[24] The two largest EQROs – Health Services Advisory Group (HSAG) and Island Peer Review Organization (IPRO) – cover twenty-three states. Three other EQROs -- Qlarant, the Carolina

> **EQRO Independence**
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> Many EQROs perform various other duties for state Medicaid programs, including utilization review, functional assessments, and quality review activities.[22] A state must verify that these other activities do not compromise the EQRO's independence for the purpose of external quality review.

Center for Medical Excellence, and Qsource– cover eleven more states. According to its website, HSAG conducts EQR or EQR-like activities for sixteen states, including California.[25] Appendix A provides a current list of contracted EQROs. Other non-Medicaid state entities, such as public universities, can qualify as EQROs provided they are structured to ensure independence, but few states have pursued this option.[26]

The independence standards in Medicaid managed care regulations differ somewhat between state and non-state entities. Generally, EQROs may not review managed care entities (or their competitors) where either the managed care entity or the EQRO "exerts control" over the other through stock ownership, options or debentures, voting trusts, common management, or contractual relationships.[27] Also, EQROs may not provide health care services to Medicaid beneficiaries generally or engage in ongoing quality oversight operations of managed care entities' services for the state outside of the EQR. Nor may an EQRO review a managed care plan for which it has also performed an accreditation review within the previous three years. More generally, the EQRO may not have another type of present, or known future, direct or indirect financial relationship with any MCO, PIHP, PAHP or PCCM entity it reviews. The 2016 revisions also added a new requirement that a State may not substantively revise the content of EQR technical reports unless it identify errors or omissions.[28]

In addition to the above requirements, a state entity, such as a public university, can only qualify as an EQRO if it is governed by a board or similar body with no more than minority membership by government employees.[29] Furthermore, the state entity may not have Medicaid purchasing or managed care licensing authority.

Competence and capacity have presented ongoing problems that hinder the development of a robust external review process. The regulations generally require that EQROs have sufficient staff experienced in Medicaid policy and service delivery as well as quality assessment research design and methodologies.[30] States must also ensure that the contracted EQRO has adequate physical, technological and financial resources to complete the necessary activities. In past practice, states have reported frustration

with frequent EQRO staff turnover and a persistent need to offer technical support and training to assist contracted EQROs with their responsibilities.[31]

Transparency & Timeliness

The public availability of the annual EQR report(s) has improved due to changes in the 2016 regulations, such as the new April 30 deadline to post the most recent report. Most states continue to post prior reports online, which helps advocates track whether annual recommendations have been addressed.[32] The timeliness regulation has not, however, solved all the problems. EQR reports still remain difficult to find in many states and posting delays are common.

California has developed a robust website including years of EQR reports for each Medicaid MCO and County behavioral health plan as well as statewide reports that give a broader picture of quality and work on health disparities.[33] California's two EQROs, Health Services Advisory Group (HSAG) and Behavioral Health Concepts, standardize their reports to facilitate comparisons between plans. Several states – such as Arizona, Colorado, Louisiana, and Minnesota – post multiple years of easily accessible and well organized EQRO resources, which helps track plan performance over time (See Appendix A). Maryland's extensive 2019 EQR included optional activites like surveys to evaluate provider directory accuracy, encounter data validation, a focused review of grievances, appeals, and denials; and a medical record review of health screening for children and adolescents.

Other states conduct minimal EQRs and post them in obscure corners of their websites. For example, Nevada posts its annual EQR technical reports under a tab entitled "Caseload data" that includes no reference whatsoever to "quality" or "managed care." Delaware's reports are buried behind three vague subtabs under the Medicaid homepage (see box pg. 10).

Though recent regulations set an annual posting deadline, timeliness is still a problem. CMS has nudged states to regularize the reporting process and synchronize with other managed care quality data reporting timetables.[34] But many states fall far behind these posting deadlines. As of August 2020, the most recent posted EQR reports for Massachusetts completed in 2017. Reports from seven other states had not been updated since at least May 2019, some with data from 2017. Numerous states posted 2020 reports that covered data only through 2018. Data lags occasionally stem from the timing of state MCO contract renewals or other issues, but the persistent delays in reporting despite new timeliness requirements in the regulations signal a flaw where data is already stale the day it is released.

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Transparency Misplaced: Posting Reports

Several states have nominally complied with CMS's regulation to post the annual technical report but make it exceptionally difficult to find, even for someone looking for the report. In Delaware, for example, the state website does not list Medicaid or the health department on the state government homepage, de.gov. Users must look under "state agencies," then scroll down to "Division of Medicaid." From the Medicaid homepage, one must scroll to the bottom and click on a link to "Public Information and Statistics," then find the subtab labeled "Information," and then another labeled "Reports" to find the list of recent EQR technical reports. The EQR technical report is not cross-linked on the "Reports" tab listed across top banner on the Division of Medicaid homepage, nor is there any direct link or reference to "quality" or "oversight" on the Division of Medicaid homepage.

As of October 2020, Delaware's most recent posted EQR dates from March 2019. The bulk of the report reviews only a single MCO. Quality metric results are in three broad categories instead of specific percentages: over 90th percentile of the national average, under 50th percentile, and between the 50-89th percentile. This makes it difficult to know exactly what the outcomes are. Similarly, the results from validation of Performance Improvement Projects (PIPs) do not include outcomes from the PIPs, but rather the degree of confidence in the results.

This description is not intended to single out Delaware or to claim the state is not in compliance with the regulations, but rather to illustrate specifically the challenges and limitations of EQR as a tool for public oversight of managed care. Hawaii, Louisiana, New York, Nevada, and several other states also have confusing or hard-to-find EQR reports. CMS's EQR protocols lay out tips for making EQR reports more transparent and actionable.[35] Many of these reports contain valuable data for states and advocates to identify problems and see how responsive MCOs have been to prior recommendations. Making them hard to find devalues that data and hinders effective oversight.

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EQR and Quality Measure Validation

All independent EQR validate managed care performance measures required in state contracts. EQR annual reports typically include an analysis of the prior year's quality data and tables of how well plans scored on these measures. The technical report, because it must be publicly posted, may be the easiest way to obtain plan-level performance data in each state and evaluate it over time.[36]

Types of Measures

Generally, policymakers divide measures into three broad categories that provide different perspectives on care quality: structure, process, and outcome.

Structural measures evaluate health system capacity, often at the plan or state level. This could include the fraction of people with disabilities receiving care in the community, or how many individuals delay needed care due to cost.

Process measures track whether needed steps of health care delivery occur at the provider level. For example, plans can measure how many patients received a telephone follow-up after a hospital discharge, the share of children who received appropriate screenings for lead exposure, or the percentage of enrollees who receive interpretive services when they need it. These measures test adherence to policies and standards of practice, but not necessarily whether people are getting better due to quality care. Process measures often derive from administrative data and so can be relatively quick and inexpensive to generate.

Outcome measures track the effect of a health care intervention on a patient health status or quality of life. Examples include tracking how many enrollees have blood sugar under control, what proportion of individuals get readmitted to a hospital within thirty days of discharge, or the share of patient's who have controlled their high blood pressure with medication. Outcomes may be influenced by factors beyond the quality of health care delivered, so outcome measures alone may not tell the whole picture about care quality.

Planners choosing a core set for reporting typically seek balance across these types while weighing the ease of data reporting, the scientific evidence showing its validity and reliability, and whether the reported result points toward specific action steps for improvement. Each measure type may apply at different levels (provider, plan, program, state, etc.), and the level chosen may point to different kinds of potential interventions to improve quality.

The managed care regulations create the process by which states designate which measures plans will report for validation. Generally, the federal government has afforded states great flexibility. States develop their own quality strategies and required measures. They also designate EQROs and delineate required annual EQR activities.

Due to this flexibility, state standards for Medicaid quality reporting differ considerably. The lack of standardization makes it very hard to compare quality across states or across managed care entities (MCEs).[37] Some variation is inevitable due to, among other things, differences in the covered populations' risk characteristics from state to state, but this does not make standardized reporting a fruitless endeavor. Comparable data, when publicly available, promotes accountability and allows individuals to critically evaluate care quality across plans and over time. It also makes it easier for plans to share best practices. That's why the federal government has repeatedly emphasized the importance of improving standardization in quality reporting.

One way to improve standardization and comparability would be to strengthen federal requirements. CMS has the statutory authority to mandate reporting on specific measures, but has not exercised this authority in the past.[38] Instead, it issued recommended core sets of measures for children and adults since 2010 and 2012, respectively, and cajoled states to take them up, with some success. National reports have demonstrated gradual increases in state uptake of these measures over time. In 2018, every state reported data from least one of the 26 children's core measures, while forty-three states reported at least thirteen measures.[39]

In November 2019, CMS released updates its adult core measure set that included the addition of National Core Indicators, a widely used survey instrument measuring quality of life and outcomes related to long-term services and supports for people with intellectual and developmental disabilities.[40] This marks the first time CMS has included a specifically LTSS-focused performance measure in its adult core set.

For now, the best source for state and plan performance on core measures is typically the EQR annual technical report. Some states, like Louisiana and Texas, have created separate websites that allow users to explore performance data and sort results by plan.[41] Still others create scorecards or report cards that include performance measurement data statewide or by county.[42] NCQA also provides an annual summary of Medicaid plan ratings – based on Healthcare Effectiveness Data and Information Set (HEDIS®) and accreditation results – that can be filtered by state.[43]

In 2016, it appeared that change was afoot and that CMS would mandate some federal measures. The 2016 revisions laid out a process for CMS to create a federal Medicaid Quality Rating System, intended as a next step in promoting comparability, improving consumer informed choice, and increasing managed care accountability. CMS previously indicated it would put a draft QRS out for comment by 2018. However, the 2018 proposed rule weakened the federal QRS by making it easier for states to run their own alternative system, which would likely undermine standardization. As of this writing, those changes have yet to be finalized, and the QRS remains under development.

Congress has stepped in to hasten standardized federal reporting. In 2018, Congress mandated that states begin to report to CMS on the child core measure set by FY2024.[44] Later, it added that states must report all behavioral health measures in the adult core set by that same year.[45] There are eleven such measures in the current set.[46] CMS has yet to issue any guidance on how this transition to mandatory reporting measures will be implemented, including whether all core measures will be included, if and how the mandatory reporting will be phased in, and what degree of technical deviations from standardized reporting may be permitted.[47]

Another ongoing CMS initiative to promote cross-state quality comparisons is the Medicaid and CHIP Scorecard.[48] This tool includes cross-state comparison charts for nineteen child and adult core measures, but the current data represents only a small fraction of all the reported quality metrics. More detail on state participation in core measure sets and on how to interpret some of the recent comparative results is discussed in a separate issue brief in this series.[49]

Some key elements advocates should push for on any comparative platform include:

1. Longitudinal data that allows users to compare performance year-over-year;
2. Some benchmark, such as national averages or state-specific targets, to allow broader comparison of health plan performance;
3. Explanations in footnotes that provide context for any adjustments states have made for relative risk or other factors that might make straight comparisons across plans problematic.

Performance Improvement Projects (PIPs)

States can also address weaknesses in plan performance by requiring plans to implement PIPs. Several states have used this tool to improve health disparities reporting or address outcomes specifically related to long term care.

Annual EQR technical reports must include information validating how plans conducted and performed on required PIPs. Unfortunately, managed care plans have produced extremely uneven results in achieving sustained improvements through PIPs. For example, in California's 2019 EQR report, HSAG found that only five of fifty-three PIPs conducted from 2015-2017 achieved a high confidence rating, meaning they used an approved methodology, achieved their target outcomes, and could link improvments to specific tested interventions.[50] By contrast, thirty-three of the PIPs scored low confidence or were not credible.[51] Reporting of the poor performance lagged nearly two years behind the actual intervention, making it harder to act on problems.

Few technical reports provide meaningful analysis of why specific PIPs may not succeed. In many cases, it is not clear if the plans face any negative consequences for not successfully conducting a required PIP, let alone actually achieving positive results. Perhaps tying PIPs to performance bonuses or state sanctions (in the event of a poorly implemented PIP) would lead to more consistent positive results.

Evaluating Managed Long Term Supports and Services (MLTSS)

One of the newer and more challenging components of external quality review involves how states evaluate managed long term care. When CMS drafted the first EQR regulations in 2003, very few Medicaid programs contracted with capitated managed care organizations for long-term services and supports. In 2004, only eight states had any MLTSS program, and enrollment of MLTSS users barely exceeded 100,000 individuals nationwide, with over 70 percent of these individuals enrolled in Michigan or Arizona.[52] By July 2019, 24 states have implemented capitated Medicaid MLTSS programs, with several more in development.[53] Over 1.8 million individuals are now enrolled in these programs.[54]

Assessing LTSS Measurement Capacity

Until fairly recently, the quality measurement industry centered almost exclusively on acute care medical services. Long term care provides different measurement challenges. The population receiving LTSS has an extraordinarily diverse set of needs, making generalization difficult, and successful outcomes can be difficult to quantify.

The 2016 National Quality Forum workgroup on Measuring Home and Community-Based Services (HCBS) Quality produced a systematic assessment of both the current measurement capacity and substantial LTSS gaps.[55] This workgroup assembled experts and key public and private stakeholder organizations to assess available measures, identify gaps, and create a measurement framework for evaluating quality in HCBS.

Earlier work from NQF's Measure Applications Partnership (MAP), a series of stakeholder committees that evaluate measures applicable to various Medicaid populations, identified an initial core set of measures for individuals dually eligible for Medicaid and Medicare, including several relevant to LTSS.[56] Several disability and aging advocacy groups have also identified approaches to measuring LTSS quality.[57]

In response to this changing landscape, CMS recognized the need to expand oversight and incorporate MLTSS more explicitly into the EQR protocols. It released guidance in 2013 explaining how states should adjust their EQR requirements to accommodate the unique needs and challenges of MLTSS.[58] This includes making sure EQROs have access to data systems beyond medical records, such as case management files, so they can adequately evaluate provision of non-medical LTSS. Most of the 2013 guidance has been incorporated into the recent 2020 EQR protocol updates.

The 2016 managed care regulation update included additional quality requirements related to MLTSS. For the first time, the regulations require that plans covering LTSS include specific metrics to track community integration, rebalancing, and quality of life for individuals receiving these services.[59] More recently, as noted above, CMS included the NCI survey tool in its list of recommended adult core measures. Separate efforts are also underway within CMS to create a recommended measure set for HCBS.[60]

Proven LTSS performance measures have long been few and far between. But recently, several new LTSS and HCBS measures have come on-line or expanded their reach. In March 2019, CMS posted technical guidance for eight measures related to needs assessment, fall risk, care planning for individuals receiving LTSS, and transitioning individuals from institutions back to communities.[61] The National Committee for Quality Assurance (NCQA), the largest health plan accreditor and quality measure steward in the country, included four care planning measures from this set of eight into its HEDIS® measure set. HEDIS® is nearly ubiquitous in managed care plan quality measurement, which should facilitate the adoption of these process-oriented measures across MLTSS programs.

States may also choose to implement one of several participant survey tools that broadly measure quality of life and access to care. A CMS-developed HCBS experience of care survey became trademarked by the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) in June 2016. The CAHPS® family of surveys dominate the health consumer experience survey market in healthcare quality assessment. In fall 2016, the National Quality Forum endorsed part of this tool for measuring experience of care for HCBS recipients.[62] Nine states have tested the HCBS CAHPS® survey.[63]

The Personal Outcome Measures® (POMS) LTSS survey tool, developed by the Council on Quality and Leadership (CQL), focuses on participants security, community integration, personal relationships, and control over their daily life and services.[64] The CQL focuses its work on people with intellectual and developmental disabilities (IDD), and POMS is primarily used at the organization/provider level.[65] However, the organization has also developed a framework for designing and evaluating an MLTSS plan for people with IDD as well as several tools – basically subsets of POMS – appropriate to evaluate quality of services for an MLTSS plan.[66]

As mentioned above, the widely-used National Core Indicators (NCI) for individuals with intellectual or developmental disabilities is now part of the adult core measure set. HSRI and partners also adapted the NCI for aging adults and people with physical disabilities. The expanded NCI-Aging & Disabilities (AD) has been implemented in twenty-eight states, with results posted on the NCI-AD web page.[67] In 2020, participants in a CMS-sponsored stakeholder panel reviewed the core measure sets and recommended potential new measures for the 2021 adult set. The panel rejected the recommendation, citing concerns about the in-person nature of the survey during COVID-19 and questions about whether states would take it up. Ultimately, the final report included no new LTSS-specific measures for the 2021 adult and child core sets.[68]

These time-intensive survey tools produce valuable participant-reported data on quality of life and access to care. However, they require trained interviewers and more resources than typical administrative metrics. This results in sample sizes only large enough to provide valid data at the state level.[69] Several states, like Minnesota, have invested to expand the NCI-AD sample size to allow for stratification by waiver program and regions within the state.[70]

As managed care expands into LTSS delivery, advocates should ensure states incorporate more MLTSS specific evaluation into the EQR process. Significant efforts and financial resources have sought to improve the depth, effectiveness and accuracy of quality measurement. However, useful and proven measures for MLTSS services remain challenging, partly because the scope of these services stretches well beyond the quality measurement industry's traditional focal points – the clinic, the hospital, and the medical record. EQR, with its enhanced matching rate for MCOs, offers additional opportunities for states to expand the scope of LTSS oversight. A state with an MLTSS program can contract with an EQRO to conduct surveys, collect and analyze data for LTSS quality measures relevant to its MLTSS population in MCOs, or to review and validate the plan's LTSS network.[71]

New Jersey contracted with an EQRO to audit care management in its MLTSS program.[74] The EQRO reviewed 100 care plans from existing and newly eligible enrollees for completeness, responsiveness to changes in status, and adherence to person-centered planning principles. Overall, the audit revealed several areas of low compliance, particularly that only just over half developed plans using person-centered principles. But this same audit points toward the value of this kind of study in driving compliance. Four out of the seven measures documented double digit increases in compliance compared to the prior study year. The same person-centered planning metric that barely cleared 50% had actually increased from only 7.6% in 2018.[75]

Texas contracted with its EQRO to assist with interview training, developing the sample, and

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Advocacy Tips

Advocates can review their state quality strategies to identify which measures the state has adopted to cover the three required quality measurement topics outlined in the regulations. Several states that have implemented more LTSS measures quickly identified problems even with basic measures.

For example, Florida required MLTSS plans to report on seven LTSS measures in its 2020 EQR report. Each is process oriented, focusing on whether the plans completed comprehensive assessments and care planning for beneficiaries, whether the plan was shared with primary care providers, and how well plans did reassessing enrollees after discharge from a hospital.[72] The state did not hold plans accountable for these measures in 2019, and none of the statewide averages met the state's target. Some fell woefully short. For example, plans completed reassessments after inpatient discharge only 27.5 percent of the time, fully 54 percentage points short of the State's goal.[73] While most advocates would like to see more outcome oriented measures, the shortcomings on process are worrisome in themselves.

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implementing the data collection for its NCI-AD survey.[76] It also conducted EQR surveys of caregivers to audit an MLTSS program for children. Unfortunately, the state does not include the more recent NCI-AD reports on its managed care quality page. That report is only available through the NCI-AD website.[77] The 2017-2018 results show that among other things, only 65% of respondents felt their services meet all their needs and goals, fewer than half (49%) get to do things outside of home as much as they want, and just over a quarter (27%) are as active in the community as they would like to be.[78]

In Wisconsin, the state-contracted EQRO, Metastar, has conducted a personal outcomes evaluation for enrollees in Wisconsin's long term care programs, including the state's MLTSS programs.[79] The tool, known as the Personal Experience Outcomes iNtegrated Interview & Evaluation System (PEONIES), was developed by researchers at the University of Wisconsin's Center for Health Systems Research and Analysis to help evaluate quality of care for individuals with disabilities.[80] Based on hour long semi-structured interviews conducted by trained staff, the PEONIES system has been cited as a best practice for evaluating quality of life for LTSS users, but it has not been widely implemented.[81]

One area in need of further development involves evaluating network adequacy for LTSS services. Even though CMS has yet to publish its protocol on how states can use EQR to validate network adequacy, New Mexico was one of the few states to review time and distance standards for urban and rural MLTSS providers.[82] As noted above, several states have used EQR to perform secret shopper tests to evaluate the accuracy of provider network directories. Such a survey could be used to validate availability of LTSS providers, and also could include questions for other types of providers about their accessibility for people with disabilities.

Several states have also required MCOs to implement specific PIPs related to MLTSS quality. This might, for example, center on plans' success at shifting the needle from institutional LTSS to care in the community. Alternatively, a state could contract with an EQRO to implement an independent PIP centered on LTSS.

States that have developed PIP topics on specific MLTSS outcomes include:
- Florida (care for older adults – advance care planning),
- Massachusetts (recognizing early memory Impairment and needs assessment for Dementia),
- New Jersey (Reduction in Falls among HCBS Members in MLTSS; and
- New Mexico (Fall Risk Factors and Service Referrals for LTSS)[83]

These examples show how states can leverage the enhanced federal funding for EQR to implement and validate new MLTSS oversight mechanisms.

Addressing Health Equity in Managed Care Quality

Health equity should be at the forefront of any attempt to measure care quality and effectiveness. Health equity sets as a principle that everyone should have equal opportunity to attain their health potential and that no one is disadvantaged due to their social position or other socially-determined circumstances.[84] Perhaps the first key mechanism to achieving health equity is measuring disparities in health and in health care access.

CMS's national quality strategy, finalized in 2016, sets four "foundational principles" that guide the agency's efforts to improve health and healthcare. The very first principle is to eliminate racial and ethnic disparities.[85] Throughout the document, the strategy identifies actions that could help states improve health equity, such as:

- stratifying quality reporting by race, ethnicity, disability, and primary language to help identify health inequities;
- building IT infrastructure that can readily incorporate such demographic data;
- promoting stronger connections between health care settings and community resources;
- strengthening training for providers to deliver culturally competent care; and
- ensuring that educational programs, health information, and official communications are tailored to be accessible for all populations.[86]

Health Equity First Steps: Stratifying Data by Race/Ethnicity

Measuring health equity means identifying health disparities. To make disparities visible, states must require plans to report standard measures stratified by race/ethnicity and other key demographic data. This can reveal specific populations that should receive extra attention to improve care delivery.

For example, Michigan has produced annual health disparities reports that stratify fourteen measures by race/ethnicity. Without stratification, Michigan HEDIS results would show that 60.6% of pregnant women in Medicaid managed care received recommended post partum care. Separating the data by race/ethnicity revealed stark disparities, with African American women (54.1%) and Native Americans (57.8%) lagging far behind White women (63.3%) and Asian and Pacific Islanders (71.9%) in post partum care.[87] These results reveal an urgent need to develop interventions designed to meet the needs of African American and Native American women that would not have been visible without stratification.
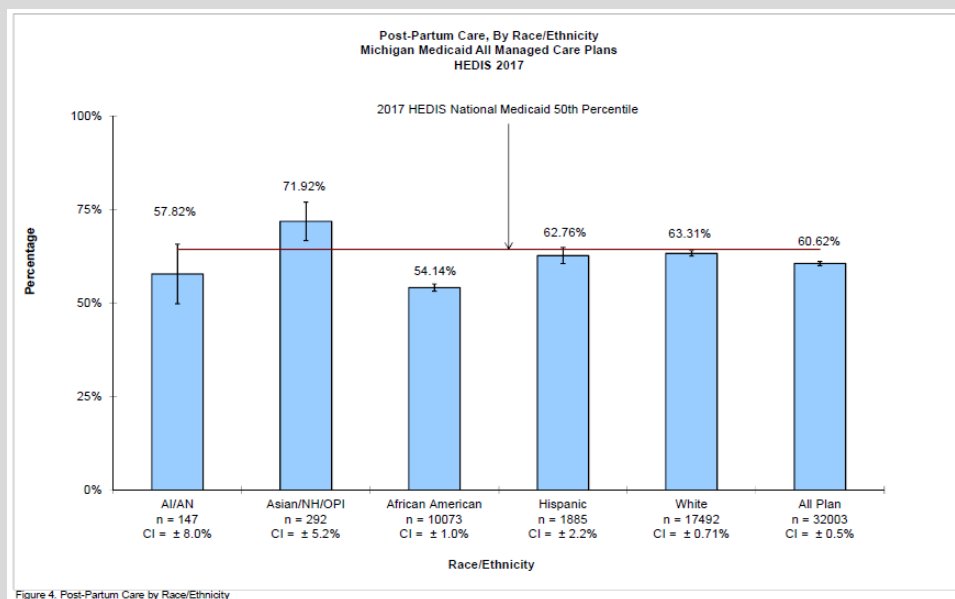

Figure 4. Post-Partum Care by Race/Ethnicity

Importantly, Michigan's disparities report tracks changes in disparities over time. Six years of reporting shows their stubborn persistence. Rates for African Americans have remained below that of Whites for ten measures since reporting began in 2012, and only a few have seen significant reductions.[88] Few other states have required this level of stratification in quality reporting.

States also must develop and periodically update their own quality strategies, which should reinforce the national priorities. Federal regulations establish minimum requirements for state managed care quality strategies. The 2016 managed care final rule requires states to include a plan for addressing health disparities in their quality strategies.[89] Inexplicably, CMS has yet to update the outdated 2012 Quality Strategy toolkit to reflect this new requirement, so many states still have no clearly articulated plan to address health equity through their quality oversight processes.[90]

A handful of states have used external quality review to evaluate whether their managed care programs have reduced health disparities. The results, unfortunately, have been decidedly mixed. For example, Minnesota required Medicaid plans to conduct and report on a three-year PIP to improve racial and ethnic disparities in depression management in its EQR technical report. The results were disappointing. Of eight participating plans, two showed markedly *worse* disparities after three years; two more showed little change in overall rates or disparities; two did not disaggregate their data by race; and the last two did not report or had too small a data sample.[91] Only one of eight plans reported an increase in depression management that met its stated goals, and that plan did not disaggregate the outcome by race.[92] It is unclear what consequences plans may have faced, if any, for this apparently unsuccessful PIP.

States have an opportunity to leverage the EQR enhanced match to improve data collection and reporting on health equity. Advocates should push for these changes. A number of states, including North Carolina, use EQR to develop annual health equity reports to report on measures specifically selected to track progress in health equity. Michigan produces a similar annual health disparities report and also requires stratification for fourteen core set measures (see box above).[93]

Especially in light of the recent COVID-19 pandemic with a tremendously disproportionate effect on people of color and people with disabilities, advocates should push states to require MCOs to stratify more health data by race, ethnicity, language, gender, age, and disability. Texas, Louisiana, Nevada, and Ohio all claim in their quality strategies that they require plans to stratify some performance data by demographics, but this is rarely included as part of the EQR technical reports. It is not even clear whether these stratified health measures are publicly available in all cases.

For more details on the ways that states have and should incorporate health equity analysis into their EQR and overall quality oversight infrastructure, please review the other brief in this series: *Addressing Health Equity in Managed Care Quality*.

Next Steps

Over the last decade, managed care delivery has evolved and the EQR process has changed with it. The time has come to actually enforce the updated regulations and adapt them to improve oversight in the current managed care environment.

CMS has taken incremental steps to improve quality assessment through recommended core measures, guidance on MLTSS measurement, and technical support for states. However, even with these improvements, problems and limitations persist.

A number of important changes adopted in 2016, from requiring states to develop health equity plans to developing a Quality Rating System to encouraging active testing and validation of network adequacy through EQR, remain largely unimplemented four years later. Transparency and comparability vary widely between the states, while the whole process has become something of a niche industry dominated by just a handful of companies.

These persistent delays signal to states that CMS may not be taking managed care oversight seriously. Without quick action, the EQR risks failing its mandate to strengthen independent oversight, boost plan accountability, promote innovation in quality measurement, and provide consumers with valuable tools to compare the best plans to suit their healthcare needs.

Still, EQR provides advocates with underutilized tools to leverage improved managed care oversight and access performance data. Specifically, in addition to state-level advocacy, advocates can push CMS to further strengthen the EQR through the following regulatory reforms:

- Publish a protocol for the new required EQR activity on validating network adequacy. This protocol should require states to include direct testing of their provider networks, such as through a secret shopper survey, and include technical assistance and suggestions for adequately measuring LTSS networks;

- Finish and publish the new toolkit on state quality strategies and require states to produce a meaningful plan, with benchmarks, to address health equity in their managed care programs. This should include how the state will collect and report performance measures stratified by key demographics;

- Require states to create a consumer-friendly document or platform that presents EQR and HEDIS® findings and facilitates easy comparison between health plans, such as Maryland's scorecard.[94] This platform must be publicly accessible to individuals with limited English proficiency, persons with disabilities, and individuals with low health literacy;

- Require states with MLTSS programs to design and execute MLTSS evaluation as part of their quality strategy and to incorporate EQR activities specifically related to MLTSS;

- Provide states with technical assistance on how to leverage the EQR process to conduct quality related activities specific to MLTSS.

Advocates can also use the existing regulations and these tips to push their states to make sure that health care plans show their work. That is, in many cases states can leverage the enhanced FMAP for EQR activities to increase direct testing through EQR, create detailed plans to achieve health equity, and require robust quality reporting from health plans.

Implementing the existing regulatory reforms would go a long way to modernizing the EQR process and further integrating EQR into each state's broader quality improvement strategy. Greater transparency will also allow EQR to develop its potential as a tool consumers and advocates can use to compare plans and identify performance problems. As health care delivery increasingly shifts toward pay for performance models, robust quality measurement will only increase in importance, and EQR should play a critical role in this process.

ENDNOTES

[1] P.L. 105-33, *The Balanced Budget Act of 1997*, § 4701-4710 (Aug. 5, 1997). This law included 42 U.S.C. § 1396u-2(c)(2) that establishes independent EQR.

[2] Federal regulations require EQRs for Managed Care Organizations (MCOs), Prepaid Inpatient Hospital Plans (PIHPs), and Health Insurance Organizations (HIOs), as defined in 42 C.F.R. § 438.2. *See also* 42 U.S.C. § 1396u-2.

[3] For explanation of the differences between these types, see definitions at 42 C.F.R. § 438.2.

[4] 42 C.F.R. § 438 subpart E.

[5] 42 C.F.R. § 438.358(b). Note that states need only complete activities 2 & 3 for PCCM entities.

[6] In 2018, CMS proposed regulatory changes to eliminate a federal requirement that States set provider time and distance standards. It delayed the protocol pending these changes, which have not been finalized. CMS, *Medicaid and Children's Health Insurance (CHIP) Managed Care Proposed Rule* (Nov. 14, 2018), https://www.govinfo.gov/content/pkg/FR-2018-11-14/pdf/2018-24626.pdf.

[7] 42 C.F.R. § 438.358(c).

[8] Certain state entities may qualify as EQROs if they have a governing board or similar entity comprised of no more than a minority of government employees, do not have Medicaid purchasing or managed care licensing authority, and satisfy the other conflict-of-interest requirements. *See below*, "What makes an EQRO?".

[9] 42 C.F.R. § 438.370.

[10] *Id.*

[11] 42 C.F.R. § 438.350. *See also* U.S. Dep't of Health & Human Servs. ("HHS"), Ctr. for Medicare & Medicaid Servs. ("CMS"), *CMS External Quality Review (EQR) Protocols*, 18 (Dec. 2018), https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/Downloads/CMS-R-305.zip.

[12] 42 C.F.R. § 438.364(a).

[13] HHS, Office Inspector Gen. ("OIG"), *External Quality Reviews in Medicaid Managed Care*, 11 (Jun. 2008), https://oig.hhs.gov/oei/reports/oei-01-06-00510.pdf.

[14] See Appendix A.

[15] *Quality of Care: External Quality Review (EQR)*, CMS, https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html (last visited Oct. 23, 2020).

[16] 42 C.F.R. § 438.360.

[17] HHS Off. Inspector Gen., *Access to Care: Provider Availability in Medicaid Managed Care*, 8 (Dec. 2014), https://oig.hhs.gov/oei/reports/oei-02-13-00670.asp. *See also,* HHS OIG, *State Standards for Access to Care in Medicaid Managed Care* (Sept. 2014), https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.

[18] *See, e.g.,* ICHP, *Summary of Activities and Value Added Services: Quality, Timeliness, and Access to Health Care for Texas Medicaid and CHIP Recipients*, 144 (May 2019), https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/eqro-summary-of-activites-report-contract-yr-2018.pdf; HSAG, *New Hampshire SFY 2020 Secret Shopper Survey Report* (2020), https://medicaidquality.nh.gov/sites/default/files/NH2020_Secret%20Shopper%20Survey_Report_F1_0720.pdf.

[19] Qlarant, *Medicaid Managed Care Organziation Annual Technical Report 2019*, 141-2 (Apr. 2020), https://mmcp.health.maryland.gov/healthchoice/Documents/2019%20MD%20ATR%20FINAL_508.pdf.

[20] ICHP, *Provider Directory Data Quality: Key Issues and Recommendations for Best Practices*, 3, 24 (Dec. 2018), https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/provider-directory-data-quality-issues-best-practices.pdf. See also, Texas Health & Human Services Comm., Off. Inspector Gen., *Data Integrity of Online Provider Directories* (Aug. 23, 2019), https://oig.hhsc.texas.gov/sites/default/files/documents/reports/IG-Inspections-Division-Online-Provider-Directories-FINAL-082319.pdf.

[21] QSource, *Annual EQRO Technical Report: State Fiscal Year 2019*, 41 (Apr. 2020), https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/SFY-2019-External-Quality-Review-Technical-Report.pdf.

[22] For example, QSource, Arkansas' new EQRO, also provides therapy review and prior authorization services for Medicaid recipients under 21. *Arkansas,* Qsource, http://www.qsource.org/states/arkansas/, (last visited Oct. 23, 2020). These other quality review activities cannot include ongoing quality oversight of MCO or PIHP services for the state beyond the contracted EQR activities. *See* 42 C.F.R. § 438.354(c)(3).

[23] These diverse types of EQROs include foundations (Kansas Healthcare Foundation), universities (The Institute for Child Health Policy at the University of Florida), and corporations (Behavioral Health Concepts, Inc.) *See* Appendix A.

[24] *See* Appendix A, Chart 1.

[25] *Medicaid External Quality Review*, Health Servs. Advisory Grp., https://www.hsag.com/en/medicaid-external-quality-review/ (last visited Oct. 23, 2020).

[26] One exception is Utah, where the Office of Health Statistics performed EQR for the Medicaid program in 2013. *See* Appendix A.

[27] 42 C.F.R. § 438.354(c).

[28] 42 C.F.R. § 438.364(b).

[29] *Id.*

[30] 42 C.F.R. § 438.354(b).

[31] HHS OIG, *supra* note 13, at 11.

[32] 42 C.F.R. § 438.364(b).

[33] *Medi-Cal Managed Care Quality Improvement Reports*, Cal. Dept. of Healthcare Servs., http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx (last visited Aug. 31, 2020).

[34] *See* 81 Fed. Reg. 27714 (May 6, 2016).

[35] CMS, *supra* note 11, at 19.

[36] For more information on analyzing plan performance data, see our accompanying brief in this series.

[37] HHS OIG, *supra* note 13, at ii.

[38] 42 U.S.C. § 1396u-2(c)(1)(B). *See also*, 42 C.F.R. § 438.330(a)(2).

[39] CMS, *Fact Sheet: Quality of Care for Children and Adults in Medicaid and CHIP: Overview of Findings from the 2018 Child and Adult Core Sets*, 1 (Sept. 2019), https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/ffy-2018-core-set-reporting.pdf. See also, CMS, *Findings from the 2018-2019 EQR Technical Reports, Table 5* (2019), https://www.medicaid.gov/medicaid/quality-of-care/downloads/2018-2019-chart-pack.zip.

[40] CMCS, *Information Bulletin: 2020 Updates to the Child and Adult Core Health Care Quality Measurement Sets*, (Nov. 19, 2019), https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf.

[41] See Appendix A for links to Texas and Louisiana HEDIS results pages.

[42] See, e.g., Arizona, Illinois (2017), Florida, Maryland, and Ohio in Appendix A for examples of state report cards.

[43] See NCQA, *NCQA Health Insurance Plan Ratings 2019-2020 – Summary Report (Medicaid)*, http://healthinsuranceratings.ncqa.org/2019/search/Medicaid, (Last visited Mar. 2, 2020.)

[44] Bipartisan Budget Act of 2018, Pub. L. 115-123, § 50102, 132 Stat. 175 (2018) [Amending 42 U.S.C. § 1320b-9a to mandate that states report annually on the child core measure set]

[45] Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. 115-271, § 5001, 132 Stat. 3961 (2018) [requiring states to report annually on all adult behavioral health core measures by 2024].

[46] MACPAC, *Chapter 2: State Readiness to Report Mandatory Core Set Measures*, 68 (Mar. 2020), https://www.macpac.gov/wp-content/uploads/2020/03/State-Readiness-to-Report-Mandatory-Core-Set-Measures.pdf.

[47] MACPAC, *Chapter 2: State Readiness to Report Mandatory Core Set Measures*, 68 (Mar. 2020), https://www.macpac.gov/wp-content/uploads/2020/03/State-Readiness-to-Report-Mandatory-Core-Set-Measures.pdf.

[48] CMS, Medicaid & CHIP Scorecard (last visited Oct. 16, 2020), https://www.medicaid.gov/state-overviews/scorecard/index.html.

[49] See NHeLP, *Analyzing Medicaid Core Quality Measures*.

[50] HSAG, *MediCal Managed Care Technical Report: July 1, 2017 – June 30, 2018*, 91 (Apr. 2019), https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2017-18_EQR_Technical_Report_F1.pdf.

[51] *Id.*

[52] Paul Saucier et al., Truven Health Analytics, *Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*, 9 (July 2012).

[53] Kathleen Gifford et al., Kaiser Fam. Found., *A View from the States: Key Medicaid Policy Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020*, 69 (Oct. 2019), https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-long-term-services-and-supports/.

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[55] Nat. Quality Forum, *Measuring HCBS Quality*, https://www.qualityforum.org/Measuring_HCBS_Quality.aspx, (Last visited Oct. 23, 2020).

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[58] CMS, *Application of Existing External Quality Review Protocols to Managed Long Term Services and Supports* (Oct. 22, 2013), https://www.medicaid.gov/Medicaid/downloads/cmcs-eqr-protocols.pdf.

[59] 42 C.F.R. § 438.330(c)(1)(ii).

[60] *See* CMS, *Request for Information: Recommended Measure Set for Medicaid-Funded Home and Community-Based Services Measuring and Improving Quality in Home and Community-Based Services (HCBS)* (Sept. 2020), https://www.medicaid.gov/medicaid/quality-of-care/downloads/rfi-hcbs-recommended-measure-set.pdf.

[61] Managed Long Term Services and Supports, CMS, https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html (Last visited Oct. 22, 2020).

[62] CMS, Testing Experience & Functional Tools, (last visited Oct. 16, 2020), https://www.medicaid.gov/medicaid/ltss/teft-program/index.html. The NQF measurement number is #2967.

[63] *Id.* The nine states are AZ, CO, CT, GA, KY, LA, MD, MN, NH.

[64] Personal Outcome Measures®, Council on Quality and Leadership [hereinafter "CQL", https://c-q-l.org/the-cql-difference/personal-outcome-measures (Last visited Feb. 20, 2020).

[65] CQL, *Personal Outcome Measures®: 25 Years of Person-Centered Discovery and Achieving Outcomes* (2018), https://www.c-q-l.org/wp-content/uploads/2019/12/2018-CQL-POMs-25th-Anniversary-Report.pdf.

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[68] Mathematica, Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP, D13 (Aug. 2020), https://www.mathematica.org/-/media/internet/files/additional-documents/coresetreviewdraftreport072019.pdf?la=en.

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[71] FMAP for most administrative expenses in Medicaid is 50%. 42 C.F.R. § 433.15.

[72] HSAG, *Florida State Fiscal Year 2018-2019 External Quality Review Technical Report*, 28 (June 2020), https://ahca.myflorida.com/Medicaid/quality_mc/pdfs/FL2018-19_EQR-TR_Report_FINAL.pdf.

[73] *Id.* at 29.

[74] IPRO, *New Jersey Core Medicaid and MLTSS Quality Technical Report* (Apr. 2020), https://www.state.nj.us/humanservices/dmahs/news/Medicaid_MLTSS_Quality_Report_2019.pdf.

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[76] ICHP, *Texas EQRO Summary of Activities and Value-Added Services SFY 2018,* 161 (May 2019), https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/eqro-summary-of-activites-report-contract-yr-2018.pdf.

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[83] CMS, *Findings from the 2018-2019 EQR Reports, Table 11*, note a (2019), https://www.medicaid.gov/medicaid/quality-of-care/downloads/2018-2019-chart-pack.zip.

[84] Health Equity, Centers for Disease Control and Prevention, https://www.cdc.gov/chronicdisease/healthequity/index.htm, (last visited Sept. 29, 2020).

[85] CMS, *CMS Quality Strategy 2016*, 5 (2016), http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf.

[86] *Id.* at 10.

[87] Mich. Dept. Health & Human Servs., *Medicaid Health Equity Project Year 7 Report*, 18 (Sept. 2018), https://www.michigan.gov/documents/mdhhs/2017_Medicaid_Health_Equity_Report_645736_7.pdf.

[88] *Id.* at 8.

[89] 42 C.F.R. §438.340(b)(6).

[90] CMS, *State Quality Strategies*, https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies/index.html (Last visited Oct. 22, 2020.)

[91] IPRO, *Minnesota EQR Technical Report 2017*, 15 (Apr. 2019), https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6888E-ENG. Blue Plus showed an increasing disparity of 8 percentage points over 3 years. Hennepin Health showed an increasing disparity of 14.3 percentage points over the same period.

[92] *Id.* at 55.

[93] See, *e.g.*, NY Dept. of Health, *2017 Health Care Disparities in New York State: A Report on Health Care Disparities for Government Sponsored Insurance Programs* (2017), https://www.health.ny.gov/health_care/managed_care/reports/docs/demographic_variation/demographic_variation_2017.pdf.

[94] *See, e.g.,* Louisiana Dept. of Health, *Medicaid Quality Initiatives* http://ldh.la.gov/index.cfm/subhome/47, (Last visited Mar. 2, 2020).

Appendix A – EQROs and Web-Accessible Quality and EQR Data, by State (through August 2020)

Chart 1: Contracted External Quality Review Organizations, by State

State	Contracted EQROs
Alabama	Per state quality strategy, Alabama is in process of procuring an EQRO to review plans in the Alabama Coordinated Health Network.
Alaska	No current MCO or PIHP contracts, so EQR not required. The state is implementing Coordinated Care Demonstration Projects in
Arizona	Health Care Excel Quality Quest, Inc. Health Services Advisory Group (HSAG)
Arkansas	Managed care is delivered through an § 1115 Marketplace premium assistance demonstration. Arkansas signed an EQRO contract with QSource in 2020.
California	HSAG Behavioral Health Concepts, Inc.
Colorado	HSAG
Connecticut	As of January 2012, CT no longer contracts with MCOs. The current primary care case management program does not require EQR. Prior to 2011, state contracted with Mercer Government Human Services Consulting.
Delaware	Mercer
District of Columbia	Qlarant[1]
Florida	HSAG Qsource
Georgia	HSAG
Hawaii	HSAG
Idaho	Telligen[2] (Dual Eligibles managed care plans) Optum (Behavioral Health Plans)
Illinois	HSAG
Indiana	Burns & Associates, Inc.
Iowa	HSAG (current) Telligen[3]
Kansas	Kansas Foundation for Medical Care, Inc.
Kentucky	Island Peer Review Organization (IPRO)
Louisiana	IPRO Louisiana posted its IPRO contract (2014-2017)
Maine	No MCO or PIHP contracts, so EQR not required. However, an ACO program is underway: https://www.maine.gov/dhhs/oms/vbp/index.html
Maryland	Qlarant
Massachusetts	KEPRO
Michigan	HSAG
Minnesota	IPRO
Mississippi	The Carolinas Center for Medical Excellence (CCME)
Missouri	Primaris (since 2017)
Montana	No MCO or PIHP contracts, so EQR not required.
Nebraska	IPRO
Nevada	HSAG
New Hampshire	HSAG

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State	Contracted EQROs
New Jersey	IPRO (Since 2011) MPRO (2008-2010)
New Mexico	HealthInsight New Mexico
New York	IPRO (2018-19) Burns & Associates, Inc.
North Carolina[4]	CCME (for behavioral health)
North Dakota	Qlarant
Ohio	QSource (current) HSAG (until 2019)
Oregon	HSAG (2018-now) HealthInsight Oregon (until 2018)
Pennsylvania	IPRO
Rhode Island	IPRO
South Carolina	CCME
South Dakota	No MCO, PIHP, or PAHP contracts, so EQR not required.
Tennessee	Qsource (2018-19) HSAG (to 2018)
Texas	ICHP
Utah	HSAG (Since 2015) HCE Quality Quest, Inc. (to 2012) Utah Dept. Health, Office of Health Care Statistics (2013)
Vermont	HSAG
Virginia	HSAG (2015 - present) Delmarva Found. (to 2014)
Washington	Qualis Health (Since 2015) HSAG (Previous)
West Virginia	Qlarant
Wisconsin	Metastar
Wyoming	Wyoming contracts with Navigant to conduct EQR on CHIP-only and Medicaid 1915(b)/(c) Children's Mental Health Waiver

Chart 2: Links to State Posted External Quality Review Annual Technical Reports
This chart links to the active EQR reports in each state with a Medicaid managed care contract that triggers the EQR requirement.

State	Links to Annual EQR Reports
Arizona	EQR reports for behavioral health plans, acute care plans, and long-term care. Also includes "Report Cards" with HEDIS® (2017 data) and accreditation results for each MCO: https://azahcccs.gov/Resources/HPRC/
California	Medi-Cal Managed Care EQR reports: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx Behavioral Health Plans EQR reports: https://www.caleqro.com/
Colorado	Behavioral & physical health plan EQR reports (through Nov. 2018): https://www.colorado.gov/pacific/hcpf/annual-technical-reports
Delaware	Quality reports including annual EQR reports: https://dhss.delaware.gov/dhss/dmma/reports.html 2018 EQR: https://dhss.delaware.gov/dhss/dmma/files/2018_eqro_compliance_report.PDF
District of Columbia	EQR Technical Reports: https://dhcf.dc.gov/page/mco-external-quality-review-annual-technical-reports
Florida	Recent EQR reports (2015-2020) posted on AHCA Medicaid website: https://ahca.myflorida.com/Medicaid/quality_mc/mgd_care_eqr.shtml Healthy Kids EQRO report by Qsource: https://www.healthykids.org/resources/quality/external-review/
Georgia	EQR annual reports and other quality measurement data[5]: http://dch.georgia.gov/medicaid-quality-reporting
Hawaii	EQR reports listed under Community Resources/Consumer Guides tab:[6] https://medquest.hawaii.gov/en/resources/consumer-guides.html
Idaho	Dual eligibles plan 2018 EQR report (Telligen): https://healthandwelfare.idaho.gov/Medical/Medicaid/Resources/tabid/4657/Default.aspx Behavioral health plan EQR report (Optum): https://healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=7_IK_IePeQQ%3d&tabid=1861&portalid=0&mid=10150
Illinois	EQR reports: https://www.illinois.gov/hfs/info/reports/Pages/default.aspx
Indiana	CHIP & Medicaid reports as well as quality strategy available at: https://www.in.gov/fssa/ompp/5533.htm
Iowa	Iowa's EQR includes its CHIP program, known as hawk-I, and its mental health and substance abuse MCO, Magellan Health: https://dhs.iowa.gov/ime/about/performance-data EQR reports by HSAG: https://dhs.iowa.gov/ime/about/performance-data/annualreports
Kansas	EQR Reports: https://www.kancare.ks.gov/policies-and-reports/quality-measurement/external-quality-review-reports
Kentucky	2020 EQR: https://chfs.ky.gov/agencies/dms/DMSMCOReports/2020TechReport.pdf Found via search (see category Technical Reports. Older compliance reports also available): https://chfs.ky.gov/agencies/dms/dpqo/mco-qb/Pages/reports.aspx
Louisiana	2020 EQR Page:[7] https://ldh.la.gov/index.cfm/page/3936 EQR Technical Report for Office of Behavioral Health – Yr 2 (2019) (Year 1 EQR): http://ldh.la.gov/assets/docs/BehavioralHealth/OBH_Magellan_CSoC_Technical_Report_Year_2_Final_Draft.pdf
Maryland	2019 EQR report: https://mmcp.health.maryland.gov/healthchoice/Documents/2019%20MD%20ATR%20FINAL_508.pdf
Massachusetts	HEDIS® and EQR reports (2017 most recent): https://www.mass.gov/service-details/masshealth-managed-care-reports-and-surveys
Michigan	Medicaid health plans EQR reports: https://www.michigan.gov/mdch/0,4612,7-132-2943_4860-28384--,00.html
Minnesota	EQR and other Quality Data Site: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp

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State	Links to Annual EQR Reports
Mississippi	EQR and other reports (2018 most recent): https://medicaid.ms.gov/mississippican-resources/ Encounter data validation EQR reports found substantial error rates (Reports here): Magnolia Health (see at 36) United HealthCare Community Plan
Missouri	EQR and other reports, including provider accessibility surveys (2018 most recent – released Dec. 2019): http://www.dss.mo.gov/mhd/mc/pages/reports.htm
Nebraska	EQR report (2018 most recent, posted 4/2019): http://dhhs.ne.gov/Pages/Heritage-Health-Resources.aspx.
Nevada	EQR report difficult to find. It's filed under "About" and then under "Caseload Data." EQR reports: http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/
New Hampshire	2019 EQR report: https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202019.pdf
New Jersey	EQR and Managed Care Performance Reports and NCI-AD survey results: http://www.state.nj.us/humanservices/dmahs/news/
New Mexico	EQR reports (2017 most recent –posted April 12, 2019): http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx
New York	Recent Health plan comparison quality data and outdated EQRs: https://www.health.ny.gov/health_care/managed_care/reports/ Individual plans 2017 EQR reports very hard to find (under "Quality Review Reports under tab for "Information for Health Plans"): https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/
North Carolina[8]	EQR for behavioral health plans: https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/lme-mco-contracts-and-reports EQR reports difficult to find, under LME-MCO Contracts and Reports tab on Behavioral Health I/DD page.
North Dakota	North Dakota has only one MCO, Sanford. EQR reports: http://www.nd.gov/dhs/info/pubs/medical.html
Ohio	EQR reports (three most recent years available) and quality strategy: https://medicaid.ohio.gov/MEDICAID-101/-Quality-Strategy-and-Measures
Oregon	HSAG Technical Reports (Search for "EQR" from the prompt on this reports page): https://www.oregon.gov/oha/HSD/OHP/Pages/Reports.aspx?wp2504=se:%22technical%22
Pennsylvania	HEDIS & EQR Reports on HealthChoices Physical Health plans: http://www.healthchoices.pa.gov/providers/resources/publications/physical/index.htm EQR Reports on HealthChoices Behavioral Health plans: http://www.dhs.pa.gov/publications/healthchoicesbehavioralhealthpublications/
Rhode Island	EQR and other Medicaid reports & evaluations: http://www.eohhs.ri.gov/ReferenceCenter/ReportstoGovernmentPartners.aspx Most recent EQR report: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ReferenceCenter/2018%20Aggregate%20EQR%20Technical%20Report.pdf
South Carolina	EQR Reports: https://msp.scdhhs.gov/managedcare/site-page/eqr-reports 2020 EQR Comprehensive Report: https://msp.scdhhs.gov/managedcare/sites/default/files/SCEQR_Comprehensive%20Technical%20Report%202020.pdf
Tennessee	HEDIS® reports and most recent EQR report: https://www.tn.gov/tenncare/information-statistics/mco-quality-data.html
Texas	EQR reports: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/medicaid-chip-quality-efficiency-improvement-data-reports
Utah	EQR and other reports: https://medicaid.utah.gov/Annual-Reports 2020 EQR is posted, but from a different location, under the resources tab here: https://medicaid.utah.gov/managed-care/
Vermont	Required under § 1115 demonstration approval to conduct EQR, but the managed care plan type does not fit with the definitions laid out in 42 C.F.R. § 438.350. EQR reports: https://dvha.vermont.gov/global-commitment-to-health/eqro-annual-technical-reports

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State	Links to Annual EQR Reports
Virginia	Compliance reports and Performance incentive awards for Medallion 4.0: https://www.dmas.virginia.gov/#/med4reports EQR and HEDIS reports for Medallion 3.0 (2014- 2018) (under tab studies and reports): https://www.dmas.virginia.gov/#/med3programinfo
Washington	EQR reports and HEDIS reports: https://www.hca.wa.gov/about-hca/apple-health-medicaid-reports#apple-health-quality-measures
West Virginia	Managed care reports including EQR reports: https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Pages/default.aspx
Wisconsin	Family Care EQR reports: http://www.dhs.wisconsin.gov/ltcare/statefedreqs/EQRO.htm LTSS Outcomes Survey 2012 Report (PEONIES—conducted by Metastar): http://www.chsra.wisc.edu/peonies/documents/PEONIES%20Final%20Report%20SFY2012%20-%20rev%2011-9-2012.pdf
Wyoming	CHIP EQR: https://health.wyo.gov/wp-content/uploads/2019/04/WY-EQR-technical-report-Final-Report-4-3-19.pdf Magellan Healthcare, Inc. has provided targeted case management for the state's Children's Mental Health 1915(b)/(c) waiver since 2015. Navigant is contracted for EQR, but annual EQR reports are not posted on the state's website.

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Chart 3: State Quality Strategies and other Quality Data

State	Links to State Quality Strategy & Related Quality Data
Alabama	Quality Strategy (2020) and quality measure performance data: https://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.5_ACHN_Quality_Measures.aspx Special quality initiatives: https://medicaid.alabama.gov/content/2.0_Newsroom/2.7_Special_Initiatives.aspx
Alaska	Alaska has proposed a limited shift to managed care. Draft Quality Strategy (2019): https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=192420 Medicaid Annual Report (2019): http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/FY-2019_Annual_Medicaid_Reform_Report.pdf
Arizona	Quality Strategy (2018): https://azahcccs.gov/PlansProviders/HealthPlans/strategy.html Arizona's Quality Strategy includes only passing reference to reducing disparities, but lists potential intermediate sanctions and has a clear list of annual contract deliverables, including ALTCS Member Council plan, Grievance and Appeal System Report, Cultural Competency Plan and Assessment and more (42-43).
Arkansas	Quality Strategy: HEDIS Reporting: https://humanservices.arkansas.gov/about-dhs/dms/aqg Quality initiative: https://afmc.org/services/provider-outreach/arkansas-medicaid-quality-improvement/
California	Quality Strategy: https://www.dhcs.ca.gov/formsandpubs/Pages/ManagedCareQSR.aspx
Colorado	Quality Strategy: https://www.colorado.gov/pacific/sites/default/files/2020%20Colorado%20Quality%20Strategy%20.pdf Quality related reports: https://www.colorado.gov/pacific/hcpf/quality-and-health-improvement-reports
Connecticut	No quality stratey because no managed care. HEDIS Reporting: https://www.huskyhealthct.org/providers/health-outcomes.html#
Delaware	2015 Quality strategy: http://www.dhss.delaware.gov/dhss/dmma/files/delaware_qms_draft.pdf 2018 draft quality strategy: https://dhss.delaware.gov/dhss/dmma/files/de_quality_strategy_draft_2018.pdf Other Quality Reports: https://dhss.delaware.gov/dhss/dmma/reports.html 2019 Delaware Health Equity Guide: https://dhss.delaware.gov/dhss/dmma/files/2018_eqro_compliance_report.PDF
District of Columbia	Quality Strategy (2020) and MCO Report Card: https://dhcf.dc.gov/managed-care-quality-strategy
Florida	Quality Homepage: https://ahca.myflorida.com/Medicaid/Policy_and_Quality/Quality/fee-for-service/index.shtml 2017 draft Quality Strategy: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/index.shtml Medicaid Managed Care Report Card (by county): https://www.floridahealthfinder.gov/HealthPlans/Search.aspx?p=5 Performance Measures data 2015-2018 (includes 2017 LTC measures): https://ahca.myflorida.com/medicaid/quality_mc/submission.shtml Complaint/Issues reports: https://ahca.myflorida.com/medicaid/statewide_mc/program_issues.shtml
Georgia	Quality Strategy (2016): https://dch.georgia.gov/document/document/2016-quality-strategic-plan/download
Hawaii	Quality Strategy (2016): https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/quality-strategy/7-7-2016-HI-MQD-Quality-Strategy-Approved.pdf

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State	Links to State Quality Strategy & Related Quality Data
Idaho	Quality Strategy (2018): https://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/MMCP/2018QualityStrategy.pdf Statewide report on behavioral health program: https://www.optumidaho.com/content/ops-optidaho/idaho/en/community-partners/statewide-reporting.html Behavioral Health Independent Assessment (2016): http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/ManagedCare/IndAssessOfIBHP.pdf
Illinois	Quality Strategy (2018) and Health Plan Report Cards: https://www.illinois.gov/hfs/info/reports/Pages/default.aspx Webpage for § 1115 waiver Illinois Integrated Care Program: https://www.illinois.gov/hfs/MedicalProviders/cc/icp/Pages/default.aspx
Indiana	CHIP & Medicaid reports as well as quality strategy available at: https://www.in.gov/fssa/ompp/5533.htm
Iowa	Quality Strategy (2018): https://dhs.iowa.gov/sites/default/files/2018%20Managed%20Care%20Quality%20Plan.pdf HEDIS and other performance reports: https://dhs.iowa.gov/ime/about/performance-data
Kansas	Quality Strategy: https://www.kancare.ks.gov/policies-and-reports/quality-measurement Kancare § 1115 demonstration evaluation: https://www.kancare.ks.gov/policies-and-reports/Section-1115-Waivers-Comments
Kentucky	Quality Strategy (2019): Not available PDFpresentation on quality strategy: https://chfs.ky.gov/agencies/dms/Documents/ProviderForums2019Quality.pdf Urban Institute has also evaluated Kentucky's managed care § 1115 demonstration: 2012: Urban Institute Year 1 Evaluation 2013: Urban Institute Year 2 Evaluation MCO Contracts: https://chfs.ky.gov/agencies/dms/dpqo/Pages/mco-contracts.aspx
Louisiana	Quality Strategy (2019): http://www.dhh.louisiana.gov/assets/docs/BayouHealth/Louisiana_Quality_Management_Strategy.pdf Quality Reporting and Accountability resources:[9] http://ldh.la.gov/index.cfm/page/1582 Quality Initiatives Tab:[10] http://ldh.la.gov/index.cfm/subhome/47 2019 Quality Companion Guide for Healthy LA Managed Care (an MCO "How to"): http://dhh.louisiana.gov/assets/docs/BayouHealth/CompanionGuides/LA_QCG_MCO.pdf CHIP Annual Reports: http://ldh.la.gov/index.cfm/newsroom/detail/2324 Medicaid expansion annual report 2016/17: http://ldh.la.gov/index.cfm/newsroom/detail/4285 Grievance, appeals and other quality measures by plan: http://new.dhh.louisiana.gov/index.cfm/page/1750 Medicaid Managed Care Transparency Report (2016-17): http://www.dhh.louisiana.gov/assets/docs/BayouHealth/2013Act212/Fiscal_Year_2016/SFY16_Final_Draft_06262017.pdf Managed Care Contracts: http://ldh.la.gov/index.cfm/page/1763
Maine	Quality strategy: N/A Accountable Communities Quality Metrics: https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/accountable-communities
Maryland	Quality strategy (2012-2016) (current quality strategy not available): https://mmcp.health.maryland.gov/healthchoice/Documents/Maryland%20Medicaid%20Quality%20Strategy%202012-2016%20(Final)%20(1).pdf Managed Care quality assurance resource page with 2020 Consumer MCO Report Cards: https://mmcp.health.maryland.gov/healthchoice/pages/HealthChoice-Quality-Assurance-Activities.aspx

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State	Links to State Quality Strategy & Related Quality Data
Massachusetts	Quality Strategy (2018): https://www.mass.gov/files/documents/2018/12/27/masshealth-comprehensive-quality-strategy-november2018.pdf 1115 Annual Reports (through 2018): https://www.mass.gov/service-details/1115-demonstration-waiver-reports OIG report on MassHealth (2019): https://www.mass.gov/doc/masshealth-and-health-safety-net-annual-report-march-2019/download
Michigan	Quality Strategy and other oversight reports: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78576---,00.html Medicaid Health Equity Reports: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-489167--,00.html
Minnesota	Quality Strategy (2020): https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4538C-ENG Quality data site (includes reports on grievances and appeals, controlling interest reports): https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp Quality Strategy details a Health Care Disparities report (through 2011)
Mississippi	Quality Strategy (2018): https://medicaid.ms.gov/wp-content/uploads/2018/07/Managed-Care-Quality-Strategy-submitted-to-CMS-7.23.18.pdf
Missouri	Quality Strategy (2018): https://dss.mo.gov/mhd/mc/pdf/2018-quality-strategy.pdf
Montana	Quality Strategy: N/A Medicaid expansion legislative reports: https://dphhs.mt.gov/HELPPlan/Policymakers
Nebraska	Quality Strategy (2020): http://dhhs.ne.gov/Documents/NE%20Quality%20Strategy.pdf
Nevada	Quality Strategy (used search function): http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Reports/NV2019-21_Quality%20Strategy_F1.pdf
New Hampshire	Quality Strategy (2020) and other resources: https://medicaidquality.nh.gov/standard-reports
New Jersey	MLTSS Quality Strategy (2014): https://www.state.nj.us/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf 1115 Renewal Application description of Quality Activities (2017): https://www.state.nj.us/humanservices/dmahs/home/NJCW_Renewal_App_B_Quality_Activities.pdf
New Mexico	Quality Strategy (2017, under "Providers" tab): https://www.hsd.state.nm.us/providers/2017-nm-quality-strategy-final.pdf Draft 2019 Quality Strategy: https://www.hsd.state.nm.us/uploads/files/Public%20Information/Public%20Notices%2C%20Proposed%20Rule%20and%20Waiver%20Changes/QS%20-%20Draft.pdf
New York	Quality Strategy: https://www.health.ny.gov/health_care/managed_care/quality_strategy.htm Health Disparities reports from 2015-2017 (also under "quality Review Reports" tab): 2017: https://www.health.ny.gov/health_care/managed_care/reports/docs/demographic_variation/demographic_variation_2017.pdf Managed Care Bill of Rights: https://www.health.ny.gov/health_care/managed_care/billofrights/bill.htm
North Carolina	Quality strategy/management page: https://medicaid.ncdhhs.gov/quality-management-and-improvement Quality Strategy (2019): https://files.nc.gov/ncdma/documents/Quality_Strategy_4.5.19.v2.pdf
North Dakota	Quality Strategy (Draft 2020): http://www.nd.gov/dhs/info/pubs/docs/medicaid/draft-medicaid-expansion-quality-strategy-plan-2020.pdf

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State	Links to State Quality Strategy & Related Quality Data
Ohio	Quality Strategy (2018): https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/MCQ-Strategy2018.pdf HEDIS reporting and other quality measurement resources: https://medicaid.ohio.gov/MEDICAID-101/-Quality-Strategy-and-Measures Managed Care Dashboard: https://medicaid.ohio.gov/Managed-Care/Dashboards#1942276-2020 2019 Quality report card for MCOs: https://medicaid.ohio.gov/Portals/0/Resources/Reports/mcp-reportcard.pdf?ver=2017-09-19-073153-957
Oklahoma	Quality strategy and other quality reports: http://www.okhca.org/research.aspx?id=87
Oregon	Transformation and Quality Strategy: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx Transformation Center page with reports and quality data: https://www.oregon.gov/oha/hpa/dsi-tc/Pages/index.aspx Oregon has a health equity measurement committee and an Office for Equity & Inclusion. Published data on performance measures disaggregated by race, a 2017 report on how OR Coordinated Care Organizations can promote health equity. See also: Using a Health Equity Lens in the Transformation and Quality Strategy (TQS).
Pennsylvania	Quality Strategy (2020): http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_303040.pdf Quality Resources and prior Quality Strategy (2017): http://www.healthchoices.pa.gov/providers/resources/publications/physical/index.htm
Rhode Island	Quality Strategy (Draft 2019): http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/QUALITY%20STRATEGY.DRAFT.5.3.19.pdf Various quality resources: http://www.eohhs.ri.gov/ReferenceCenter/ReportstoGovernmentPartners.aspx Long Term Care Finance and Performance Report: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ReferenceCenter/LTSS%20Legislative%20Performance%20Report_2020_Final.pdf MCO contracts: http://www.eohhs.ri.gov/ProvidersPartners/MedicaidManagedCare.aspx
South Carolina	2018 Quality Strategy not posted. MCO report cards (through NCQA): https://msp.scdhhs.gov/managedcare/site-page/scdhhs-quality-initiatives MCO contracts: https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp
South Dakota	Quality strategy: N/A Medicaid and long term care reports: https://dss.sd.gov/medicaid/reports.aspx
Tennessee	Quality Strategy 2018: https://www.tn.gov/content/dam/tn/tenncare/documents/qualitystrategy.pdf TennCare Enrollee Survey: https://www.tn.gov/tenncare/information-statistics/additional-tenncare-reports.html TennCare § 1115 annual report (2019): https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/TennCare-II/tn-tenncare-ii-dy16-annual-rpt.pdf
Texas	Quality Strategy: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/quality-strategy Centralized page for quality reporting, including Community integration data from NCI-AD: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/medicaid-chip-quality-efficiency-improvement-data-reports Detailed database of HEDIS® results by plan and program: https://thlcportal.com/measures/medical MCO Sanctions and Corrective Action Plans: https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-organization-sanctions
Utah	Quality Strategy (2014) also listed under resources tab: https://medicaid.utah.gov/Documents/pdfs/ManagedCareQualityStrategy.pdf
Vermont	Quality Strategy (2020): https://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy

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State	Links to State Quality Strategy & Related Quality Data
Virginia	2017-2019 Quality Strategy: http://www.dmas.virginia.gov/files/links/416/DMAS%2020172019%20Quality%20Strategy.pdf Compliance reports and Performance incentive awards for Medallion 4.0: https://www.dmas.virginia.gov/#/med4reports
Washington	Quality Strategy (draft 2020 – found by search function): https://www.hca.wa.gov/about-hca/tribal-affairs/apple-health-medicaid-quality-strategy-and-compliance-oversight
West Virginia	Quality Strategy (2019): https://dhhr.wv.gov/bms/Members/Managed%20Care/MHP/Documents/WV%20MHT%201915b%20Waiver%20Quality%20Strategy_7_8_19.pdf Quality Strategy for Children and Youth Program (2019): https://dhhr.wv.gov/bms/Members/Managed%20Care/MHP/Documents/WV%20Specialized%20Managed%20Care%20Plan%201915b%20Waiver%20Quality%20Strategy%20FINAL.pdf MCO contracts: https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOcontracts/Pages/default.aspx
Wisconsin	Quality Strategy (2018): https://www.dhs.wisconsin.gov/publications/p02156.pdf Family Care LTSS reports and evaluations: https://www.dhs.wisconsin.gov/familycare/reports/index.htm LTSS Outcomes Survey 2012 Report (PEONIES—conducted by Metastar): http://www.chsra.wisc.edu/peonies/documents/PEONIES%20Final%20Report%20SFY2012%20-%20rev%2011-9-2012.pdf NEMT Data Reports: https://www.dhs.wisconsin.gov/nemt/data.htm
Wyoming	Quality Strategy (2020 draft – focused on 1915(b) waiver for targeted case management for children): https://health.wyo.gov/wp-content/uploads/2020/10/WY-CME-Quality-Review-Strategy_DRAFT_10.1.2020.pdf Medicaid 2018 Health Outcomes Report: https://health.wyo.gov/wp-content/uploads/2019/07/SFY-2018-WY-Medicaid-Health-Outcomes-Report.pdf (Click on "publications" button from Medicaid home page

ENDNOTES

1 Qlarant formed in 2018 after merger of Delmarva Foundation and Quality Health Strategies.
2 Telligen was formerly Iowa Foundation for Medical Care (IFMC).
3 Telligen was formerly Iowa Foundation for Medical Care (IFMC).
4 Medicaid Managed Care program implementation is currently on hold.
5 Georgia: Not all categories of EQR reports are up to date, but 2020 EQR technical report is posted.
6 Hawaii: Website "Reports" tab lists quality strategy and the 2016 EQR report, but not more recent reports.
7 Louisiana: The EQR report was hard to find. It is nested under "Provider & Plan Resources/Reporting and Accountability" on the main website.
8 Medicaid Managed Care program implementation is currently on hold.
9 Louisiana: This tab includes Mental Health Parity reports, EQR, links to HEDIS measures, Medical Loss Ratio reports and more.
10 Louisiana: This tab includes the state Quality strategy, MC dashboard, PIPs, and membership/minutes from Medicaid Quality Committee. The Dashboard presents the quality data in a user friendly format, particularly for year-over-year comparisons.