



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

Improving the Quality of Care for Medicaid Beneficiaries

Center for Medicaid & CHIP Services



Background

This final rule is the first update to Medicaid and CHIP managed care regulations in over a decade. The health care delivery landscape has changed and grown substantially since 2002.

- Today, the predominant form of service delivery in Medicaid is managed care, which are risk-based arrangements for the delivery of covered services
- The Children's Health Insurance Program Reauthorization Act of 2009 adopted key Medicaid managed care provisions for CHIP
- Many States have expanded managed care in Medicaid to enroll new populations, including seniors and persons with disabilities who need long-term services and supports, and individuals in the new adult eligibility group
- In 1998, 12.6 million (41%) of Medicaid beneficiaries received Medicaid through capitation managed care plans
- In 2013, 45.9 million (73.5%) of Medicaid beneficiaries received Medicaid through managed care (MCOs, PIHPs, PAHPs, PCCMs)
- As of December 2015, there are 25 states with approximately 2.7 million (73%) children enrolled in managed care in separate CHIP programs

Goals of the Final Rule

This final rule advances the agency's mission of *better care, smarter spending, and healthier people*

Key Goals

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

Key Dates

- Publication of Final Rule
 - On display at the **Federal Register** on April 25th
 - Will publish in the **Federal Register** May 6th
- Dates of Importance
 - Effective Date is July 5th
 - Provisions with implementation date as of July 5th
 - Phased implementation of new provisions primarily over 3 years, starting with contracts on or after July 1, 2017
 - Compliance with CHIP provisions beginning with the state fiscal year starting on or after July 1, 2018
 - Applicability dates/Relevance of some 2002 provisions

Resources

- [Medicaid.gov](https://www.Medicaid.gov) – Landing and Managed Care Pages
 - Link to the Final Rule
 - 8 fact sheets and implementation timeframe table
 - Link to the CMS Administrator’s “Medicaid Moving Forward” blog
- ManagedCareRule@cms.hhs.gov

Goal: Modernization and Improving Quality of Care

Recognizes advancements in State and managed care plan practices and federal oversight interests

Examples

- Network Adequacy
- Information Standards
- Quality of Care

Basic Terminology

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

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

Improving the Quality of Care

- To modernize and strengthen current quality standards, we finalized a quality framework built around three elements:
 - Transparency;
 - Alignment with other systems of care; and
 - Consumer and stakeholder engagement.

Topics for Today's Presentation:

- Quality rating system for risk-based managed care plans
- State Responsibilities
 - Extension of quality provisions to PAHPs and PCCM entities
 - Quality strategy
 - Review and posting of managed care plan accreditation status
- Managed Care Plan Responsibilities
 - Quality assessment and performance improvement program
- External Quality Review
 - New activities
 - FFP match
- CHIP quality provisions

Improving the Quality of Care: Quality Rating System (QRS)

- A QRS based on a common set of performance measures across States will:
 - Increase transparency in Medicaid and CHIP;
 - Allow States to compare plan performance;
 - Provide enrollees with comparative information regarding quality of care between Medicaid/CHIP plans similar to what is available to privately insured individuals.

Improving the Quality of Care: Quality Rating System (QRS)

- CMS to establish a common framework for all states contracting with MCOs, PIHPs and PAHPs to use in implementing a quality rating system (QRS)
 - Alignment with the summary indicators adopted by Marketplace QRS
 - Specific measures within each summary indicator may differ
- A public engagement process to develop a proposed QRS framework and methodology
 - Similar to process used for Marketplace QRS including multiple state and stakeholder listening sessions and technical expert panel
 - Publication of a proposed QRS in the *Federal Register*, with opportunity to comment, followed by notice of the final Medicaid and CHIP QRS expected in 2018

Improving the Quality of Care: Quality Rating System (QRS)

- States will have flexibility to adopt alternative QRS, with CMS approval
 - Ratings generated yield substantially comparable information to that yielded by the CMS-developed QRS.
 - State public notice and comment process: public comment of at least 30 days, input of State's MCAC, documentation requirements for application to CMS
 - Additional guidance will be provided through CMS public engagement and notice and comment processes
- States will have 3 years to implement a QRS following final notice in the *Federal Register*

Improving the Quality of Care: Extending Quality Provisions to All Plans

- Managed care quality strategy (QS), Quality Assessment and Performance Improvement (QAPI) Program, and External Quality Review (EQR) currently required for MCOs and PIHPs
- Extends these requirements to:
 - PAHPs
 - PCCM entities whose contracts provide for shared savings, incentive payments or other financial reward for -improved quality outcomes

This provision applies 60 days after publication; compliance with revisions made in the final rule to QS, QAPI, and EQR requirements discussed separately

Improving the Quality of Care: Managed Care Quality Strategy (QS)

- A State's managed care quality strategy (QS) must include goals, objectives, metrics and performance targets for all types of managed care plans*.
- Key New QS elements:
 - Plan for improving quality of care and services
 - Standards for network adequacy and availability of services
 - Plan to identify and reduce health disparities
 - Transition of care policy
 - Plan to identify persons needing LTSS or with special health care needs
- States must seek input from stakeholders in the development of the QS, make the draft available for public comment and maintain the document (including updates) online.

*States are not required to include PAHPs that provide only NEMT services in their managed care quality strategy.

This provision applies no later than July 1, 2018

Improving the Quality of Care: Quality Assessment and Performance Improvement (QAPI) Program

- Each MCO, PIHP, and PAHP must implement an ongoing and comprehensive QAPI program including key provisions:
 1. Performance improvement projects (PIPs) specified by the state and, if applicable, CMS;
 2. Collection and submission of performance measure data to the state;
 3. Mechanisms to:
 - detect under- and overutilization of services;
 - assess the quality and appropriateness of care furnished to enrollees using LTSS and/or with special health care needs;
 4. Participation in state efforts to prevent, detect, and remediate critical incidents for HCBS waiver program beneficiaries
- PCCM entities with financial incentives must at a minimum collect and submit performance data and implement mechanisms to detect inappropriate utilization of services

Improving the Quality of Care: Quality Assessment and Performance Improvement (QAPI) Program

- If CMS chooses to identify national performance measures and performance improvement project (PIP) topics, the final rule provides that:
 - CMS will use a public notice and comment process to obtain input from beneficiaries and stakeholders, and
 - States can request an exemption from any nationally identified performance measures and/or PIP topics.

This provision applies no later than the rating period for contracts starting on or after July 1, 2017

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

- Extends EQR to PAHPs and to PCCMs with financial incentives
- Adds two new EQR activities
 - Mandatory: validation of MCO, PIHP, and PAHP network adequacy during the preceding 12 months; *applies no later than one year from the issuance of the EQR protocol*
 - Optional: Assist with the quality rating of MCOs, PIHPs, and PAHPs under the QRS; *applies no earlier than the issuance of the EQR protocol*
- PCCMs with financial incentives required to undergo only 2 mandatory activities: validation of performance measures and compliance review

All EQR provisions apply no later than July 1, 2018, except FFP, which applies May 6, 2016 with final rule publication

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

- Changes to EQR process and policy:
 - An accrediting body may not serve as an EQRO for a health plan it accredited within the previous 3 years.
 - Information gained from the EQR-related activities must be used to complete the EQR.
 - State must contract with a qualified EQRO to produce the annual technical report
- Standard-publication date of April 30th of each year established

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

- Non-duplication
 - States have the option to rely on information from a review of an MCO, PIHP or PAHP performed by a Medicare or a private accrediting entity in lieu of conducting the following mandatory EQR-related activities:
 - compliance review
 - validation of PIPs
 - validation of performance measures
- Exemption from EQR for Medicare Advantage plans if conditions met
 - Exemption no longer applies to PIHPs because statute limits exemption to entities that fall under section 1903 (m) of the Act.

Improving the Quality of Care: External Quality Review FFP

- FFP at the 75 percent rate will be available only for EQR (including the production of EQR results) and EQR-related activities performed on MCOs and conducted by EQROs and their subcontractors.
- FFP at the 50 percent match rate will be available for EQR and EQR-related activities performed on entities other than MCOs (including PIHPs, PAHPs, PCCM entities, or other types of integrated care models) or performed by entities that do not meet the requirements of an EQRO.
- FFP at the 75 percent rate no longer available for EQR activities for PIHPs

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

Improving the Quality of Care: CHIP

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

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

Improving the Quality of Care: Stakeholder Engagement & Transparency

- New opportunities for public engagement required in development of state managed care quality strategies and QRS
- States must post on website:
 - Accreditation status of each managed care plan (or that plan is not accredited)
 - State managed care quality strategy
 - Annual external quality review reports

Posting of accreditation status applies no later than the rating period for contracts starting on or after July 1, 2017; QS and EQR provisions apply no later than July 1, 2018

Compliance

- Phased implementation of new provisions primarily over 3 years
- Implementation: Corresponding standard(s) codified in 42 CFR parts 430 to 481 as of October 1, 2015 remain in effect until the applicable compliance date for each revised quality provision.

Questions?

Additional Questions?

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

ManagedCareRule@cms.hhs.gov

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