

# QUALITY STRATEGY TOOLKIT FOR STATES

Per 42 C.F.R. § 438.202(a), each state contracting with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) must have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The following provides a worksheet for states to use in the development and assessment of their quality strategy.

Instructions: Below is a recommended flow of key elements to incorporate in your state’s quality strategy. Any time there is a citation under the “regulatory reference” column, this indicates that the item is a regulatory requirement and states must include information associated with that item in the quality strategy. If there is no citation under the “regulatory reference” column, this indicates that the item is not a regulatory requirement, but instead, is a component that CMS strongly recommends states address in the quality strategy. The inclusion of these optional components will maximize your state’s ability to properly frame and then subsequently measure the effectiveness of your state’s quality strategy.

## SECTION I: INTRODUCTION

### Managed Care Goals, Objectives and Overview

This section should provide a brief description of managed care in the state, as well as the goals, guiding principles, and objectives of the managed care program.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	Include a brief history of the state’s Medicaid (and CHIP, if applicable) managed care programs.	
	Include an overview of the quality management structure that is in place at the state level.  For example, how is the leadership team structured, are there any quality task forces, an MCO collaborative, etc.?	
	Include general information about the state’s decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.	

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	<p>Include a description of the goals and objectives of the state’s managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state’s priorities and areas of concern for the population covered by the MCO/PIHP contracts.</p> <p>For example, “the state will demonstrate a 10 percent improvement in childhood immunization rates over the next three years” or “through expansion of the primary care network, as evidenced by geographical reporting, the state will demonstrate a 5 percent improvement in enrollee access to primary care”.</p>	

### Development & Review of Quality Strategy

This section should describe how the state initially developed the quality strategy, subsequently reviews the quality strategy for effectiveness, and the timeline/process for revision of the quality strategy.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.202(b)	Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.	
§438.202(b)	Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final.	
§438.202(d)	Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	
§438.202(d)	Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of “significant changes”, include the state’s definition of “significant changes”.	

## SECTION II: ASSESSMENT

### Quality and Appropriateness of Care

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.204(b)(1)	Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs. This must include the state’s definition of special health care needs.	
§438.204(b)(2)	Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee.  States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.	
	Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care.	

### National Performance Measures

At this time, CMS has not identified any required national performance measures. However, CMS has developed a voluntary set of core performance measures for children and adults in Medicaid and CHIP. Many of these measures have already been in widespread use as part of the HEDIS® data set and have readily available national and regional benchmarks. For a list of these measures, refer to <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care---Performance-Measurement.html>.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.204(c)	Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders.	
	Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP.  If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.	

## Monitoring and Compliance

This section must include methods and procedures the state will use to monitor MCO/PIHP compliance with Federal regulations.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.204(b)(3)	<p>Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards).</p> <p>Some examples of mechanisms that may be used for monitoring include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Member or provider surveys;</li> <li>• HEDIS® results;</li> <li>• Report Cards or profiles;</li> <li>• Required MCO/PIHP reporting of performance measures;</li> <li>• Required MCO/PIHP reporting on performance improvement projects;</li> <li>• Grievance/Appeal logs, etc.</li> </ul>	

## External Quality Review (EQR)

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.204(d)	<p>Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract.</p> <p>Identify what entity will perform the EQR and for what period of time.</p>	
	<p>Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform.</p> <p>The five optional activities include:</p> <ol style="list-style-type: none"> <li>1. Validation of encounter data reported by an MCO or PIHP;</li> <li>2. Administration or validation of consumer or provider surveys of quality of care;</li> <li>3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO;</li> </ol>	

	<p>4. Conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO; and</p> <p>5. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.</p>	
§438.360(b)(4)	If applicable, identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 C.F.R. §438.204(g).	
§438.360(c)(4)	If applicable, for MCOs or PIHPs serving only dual eligibles, identify the mandatory activities for which the state has exercised the non-duplication option under §438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under §§ 438.358(b)(1) and (b)(2).	

### SECTION III: STATE STANDARDS

#### Access Standards

This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for access to care, as required by 42 C.F.R. Part 438, subpart D. These standards should relate to the overall goals and objectives listed in the quality strategy’s introduction. States may either reference the access to care provisions from the state’s managed care contracts or provide a summary description of the contract provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.206	Availability of Services	
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	
§438.206(b)(2)	Female enrollees have direct access to a women's health specialist	
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional	
§438.206(b)(4)	Adequately and timely coverage of services not available in network	
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	
§438.206(b)(6)	Credential all providers as required by §438.214	
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service	
§438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week	

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.206(c)(1)	Mechanisms/monitoring to ensure compliance by providers	
§438.206(c)(2)	Culturally competent services to all enrollees	
§ 438.207	Assurances of Adequate Capacity and Services	
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	
§ 438.208	Coordination and Continuity of Care	
§438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs	
§438.208(b)(2)	All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP	
§438.208(b)(3)	Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	
§438.208(b)(4)	Protect enrollee privacy when coordinating care	
§438.208(c)(1)	State mechanisms to identify persons with special health care needs	
§438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	
§438.208(c)(3)	If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards	
§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	
§ 438.210	Coverage and Authorization of Services	
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	
§438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	
§438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	
§438.210(a)(3)(iii)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	
§438.210(a)(4)	Specify what constitutes “medically necessary services”	
§438.210(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	
§438.210(b)(2)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.210(c)	Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)	
§438.210(e)	Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services	

## Structure and Operations Standards

This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for structure and operations, as required by 42 C.F.R. Part 438, subpart D. These standards should relate to the overall objectives listed in the quality strategy's introduction. States may either reference the structure and operations provisions from the state's managed care contracts, or provide a summary description of such provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.214	Provider Selection	
§438.214(a)	Written policies and procedures for selection and retention of providers	
§438.214(b)(1)	Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	
§438.214(b)(2)	Documented process for credentialing and recredentialing that each MCO/PIHP must follow	
§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	
§438.218	Enrollee Information	
§438.218	Incorporate the requirements of §438.10	
§438.224	Confidentiality	
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	
§438.226	Enrollment and Disenrollment	
§438.226	Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in §438.56	

§438.228	Grievance Systems	
§438.228(a)	Grievance system meets the requirements of Part 438, subpart F	
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner	
§438.230	Subcontractual Relationships and Delegation	
§438.230(a)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	
§438.230(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	
§438.230(b)(2)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate	
§438.230(b)(3)	Monitoring of subcontractor performance on an ongoing basis	
§438.230(b)(4)	Corrective action for identified deficiencies or areas for improvement	

## Measurement and Improvement Standards

This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for measurement and improvement, as required by 42 C.F.R. Part 438, subpart D. These standards should relate to the overall objectives listed in the quality strategy's introduction. States may either reference the measurement and improvement provisions from the state's managed care contracts, or provide a summary description of such provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§ 438.236	Practice Guidelines	
§438.236(b)	Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.	
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees	
§ 438.240	Quality Assessment and Performance Improvement Program	
§438.240(a)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement program	
§438.240(b)(1) & §438.240(d)	Each MCO and PIHP must conduct PIPs and measure and report to the state its performance  List out PIPs in the quality strategy	

§438.240(b)(2) & §438.240(c)	Each MCO and PIHP must measure and report performance measurement data as specified by the state  List out performance measures in the quality strategy	
§438.240(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	
§438.240(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs	
§438.240(e)	Annual review by the state of each quality assessment and performance improvement program  If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.	
§ 438.242	Health Information Systems	
§438.242(a)	Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility	
§438.242(b)(1)	Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees	
§438.242(b)(2)	Each MCO and PIHP must ensure data received is accurate and complete	

#### SECTION IV: IMPROVEMENT and INTERVENTIONS

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	<p>Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to:</p> <ul style="list-style-type: none"> <li>• Cross-state agency collaborative;</li> <li>• Pay-for-performance or value-based purchasing initiatives;</li> <li>• Accreditation requirements;</li> <li>• Grants;</li> <li>• Disease management programs;</li> <li>• Changes in benefits for enrollees;</li> <li>• Provider network expansion, etc.</li> </ul>	

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.	

### Intermediate Sanctions

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.204(e)	For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 438, subpart I.	
	Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	

### Health Information Technology

Regulatory Reference	DESCRIPTION	Page Reference or Comment
438.204(f)	Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy.	
	Describe any innovative health information technology (HIT) initiatives that will support the objectives of the state's quality strategy and ensure the state is progressing toward its stated goals.	

## SECTION V: DELIVERY SYSTEM REFORMS

This section should be completed by states that have recently implemented or are planning to implement delivery system reforms. Examples of such delivery system reforms include, but are not limited to, the incorporation of the following services and/or populations into a managed care delivery

system: aged, blind, and disabled population; long-term services and supports; dental services; behavioral health; substance abuse services; children with special health care needs; foster care children; or dual eligibles.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying enrollees in this population.	
	List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.	
	List any performance improvement projects that are tailored to this population/service. This should include a description of the interventions associated with the performance improvement projects.	
	Address any assurances required in the state’s Special Terms and Conditions (STCs), if applicable.	

**SECTION VI: CONCLUSIONS and OPPORTUNITIES**

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	Identify any successes that the state considers to be best or promising practices.	
	Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.	
	Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.	
	Include recommendations that the state has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care enrollees, if applicable.	

## State Quality Strategy Reference Library

The following provides examples of potential sources of information that states may find helpful in developing the state quality strategy.

State Sources of Information	CMS/Federal Sources of Information
<ul style="list-style-type: none"> <li>• State-specific Medicaid statutes and regulations, if applicable</li> <li>• Medicaid Management Information Systems (MMIS) data</li> <li>• External Quality Review Technical Reports</li> <li>• State MCO Report Cards</li> <li>• Pay-for-Performance Program Results</li> <li>• Results from Performance Measurement or other Quality Reporting Efforts</li> <li>• Encounter Data</li> <li>• Results of NCQA accreditation reviews</li> <li>• Enrollee and Provider Survey results</li> <li>• Grievance and Appeals reporting</li> <li>• Focused Studies</li> <li>• Contract Compliance reviews</li> <li>• Regional or multi-state Health Information Technology Collaborative</li> <li>• Readiness Reviews</li> <li>• Telemedicine Initiatives</li> <li>• Cross-state Agency Collaborative</li> </ul>	<ul style="list-style-type: none"> <li>• Balanced Budget Act of 1997 and implementing regulations</li> <li>• External Quality Review Protocols, available at: <a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html">http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html</a></li> <li>• CMS Core Set of Child and Adult Performance Measures, available at: <a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care—Performance-Measurement.html">http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care—Performance-Measurement.html</a></li> <li>• Annual Report on the Quality of Care for Children in Medicaid and CHIP, available at: <a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html">http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html</a></li> <li>• National Strategy for Quality Improvement in Health Care, available at: <a href="http://www.healthcare.gov/law/resources/reports/quality03212011a.html">http://www.healthcare.gov/law/resources/reports/quality03212011a.html</a></li> <li>• HHS Action Plan to Reduce Racial and Ethnic Disparities, available at: <a href="http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf">http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf</a></li> </ul>