Managed Care External Quality Review

Managed care is the primary health care delivery approach in Medicaid, with 72 percent of beneficiaries enrolled in a comprehensive managed care plan (MACPAC 2022). States are required to contract with qualified independent entities, referred to as external quality review organizations (EQRO), to conduct periodic reviews of the quality, timeliness, and access to care provided by Medicaid managed care organizations (MCOs). Federal rules describe a number of specific quality review activities that EQROs must conduct and report on, as well as several optional activities that EQROs can conduct. The EQRO must provide the state and the Centers for Medicare & Medicaid Services (CMS) a detailed technical report on each MCO, which are used to monitor quality and outcomes, conduct oversight of MCOs, and hold plans accountable for their performance.

This issue brief provides background on the external quality review (EQR) process and how states and CMS use EQR to conduct oversight of managed care programs and improve quality and outcomes for Medicaid beneficiaries.

Medicaid Managed Care Quality Oversight

As Congress has amended federal Medicaid law to provide greater flexibility for states' use of managed care, it has also added provisions to ensure that the federal government holds states accountable—and that states hold managed care plans accountable—for the services they have agreed to provide to enrollees. The requirements related to the federal oversight of Medicaid managed care programs can be found in Section 1932 of the Social Security Act (the Act) as well as in part 438 of Title 42 of the Code of Federal Regulations (42 CFR 438).

The statute establishes a broad oversight role for CMS, with few specific federal responsibilities. Section 1932 of the Act prescribes the managed care enrollment process, beneficiary protections, and requirements governing information and communication, but establishes only two direct oversight and monitoring requirements:

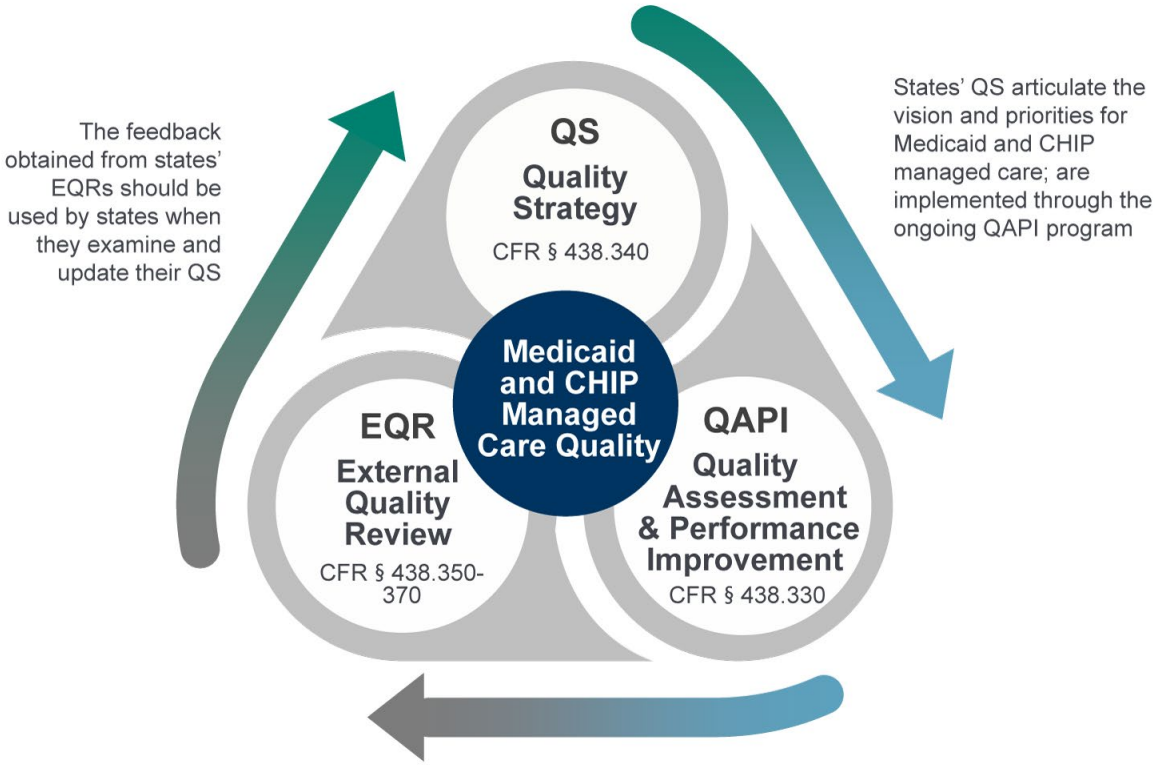
(1) A state must develop, implement and update a managed care quality assessment and improvement strategy that includes access standards and procedures for monitoring and evaluating the quality and appropriateness of care and services, meets the standards set by CMS, and is subject to monitoring by CMS;

(2) A state must conduct an annual external independent review of the quality of and access to services under each managed care contract.

CMS has promulgated detailed federal regulations and subregulatory guidance implementing these requirements. The first requirement is divided into two major components: states contracting with MCOs must develop and implement a quality strategy for assessing and improving the quality of care and services provided by plans (42 CFR §438.340), and MCOs must establish and implement an ongoing and comprehensive quality assessment and performance improvement (QAPI) program. The QAPI program must reflect the priorities articulated in the state quality strategy and include performance improvement projects (PIPs) aimed at driving "significant and sustained" improvement on measures and targets included in the quality strategy (42 CFR 438.330). Many detailed requirements relating to external quality review (e.g., guidelines for developing protocols, qualifications of external review organizations, mandatory and optional activities, and options for exemption and non-duplication) are described in regulation, while detailed review protocols are described in subregulatory guidance (42 CFR 438.350-370).

These three activities are intended to function as an interrelated set of compliance and quality requirements (Figure 1). For example, federal rules require the annual EQR process to validate performance measures and PIPs that are included in the QAPI, with results included in the state's annual EQR technical report. The EQR technical report must also include recommendations from the EQRO on how states can target quality strategy goals and objectives to support improvements in quality of care.

Figure 1. Managed Care Quality Oversight Requirements



Notes: EQR is External Quality Review. QS is quality strategy. CHIP is State Children's Health Insurance Program. QAPI is Quality assessment and performance improvement. CFR is Code of Federal Regulations.

Source: Adapted from Centers for Medicare & Medicaid Services (CMS). 2019. CMS External Quality Review (EQR) Protocols. October 2019.

External Quality Review Requirements

EQR is the annual process by which an independent EQRO reviews and validates the performance of a state's contracted Medicaid managed care plans (Box 1). Overall, state agencies in 44 states and the District of Columbia contract with plans that are subject to EQR.[1]

Requirements for EQR were established in the Balanced Budget Act of 1997 (BBA, P.L. 105-33) and initially codified in 2003 (CMS 2003). The rule defined which entities qualified to conduct EQR and what activities could be conducted as part of EQR and qualify for enhanced federal financial participation (FFP) at the 75 percent rate. The rule also specified the circumstances under which states could to use findings from Medicare or private

accreditation review activities to avoid duplicating EQR activities or exempt certain MCOs and prepaid inpatient health plans (PIHPs) from all EQR requirements. These initial EQR requirements applied only to comprehensive risk-based MCOs and PIHPs.

In 2016, CMS updated the Medicaid managed care regulations and made a number of changes to the requirements relating to EQR (CMS 2016a). These changes expanded EQR to cover prepaid ambulatory health plans (PAHPs) and primary care case management (PCCM) entities, added a new mandatory activity (validation of network adequacy) and optional activity (assisting with quality ratings of plans) to the EQR process, clarified that only EQR-related activities for MCOs were eligible for enhanced federal match, and strengthened conflict of interest provisions for entities serving as EQROs (CMS 2016a). In 2020, further regulatory changes added a new requirement for states to annually post online which Medicaid plans are exempt from EQRs and specify when the exemption began, as well as a requirement for states to identify exempted plans in the annual EQR technical report beginning July 1, 2021 (CMS 2020).

Box 1. Types of Medicaid managed care plans

State Medicaid programs have the option to implement different types of managed care approaches, including comprehensive risk-based managed care organizations (MCOs), primary care case management (PCCM) providers or entities, and two types of limited benefit plans—prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs). The scope of services and requirements vary across plan type.

Federal EQR requirements differentiate between these types of plans, depending on the amount of financial risk each type of plan holds, which quality requirements they are subject to, and whether there is a contracted provider network. States also vary in their approaches to using EQR to support state oversight, given the flexibilities available within the EQR framework.

States contract with MCOs through a comprehensive risk contract that covers a broad range of Medicaid services. MCOs receive a monthly capitation payment on behalf of each enrollee to cover the cost of providing covered services and are at financial risk for the cost of health care services and plan administration.

Primary care case management (PCCM) entities are non-risk contractors that perform a variety of functions in addition to the PCCM services provided by designated primary care providers (PCP). These additional coordinated care management features (e.g., intensive telephonic or face-to-face case management; operation of a nurse triage advice line; development of enrollee care plans) are intended to provide greater support for enrollees with high levels of need and their individual providers.

Limited benefit plans are generally paid on a capitated basis and may or may not be at risk. PIHPs cover, among other services, inpatient hospital and institutional services and frequently provide inpatient mental health or combined mental health and substance abuse inpatient benefits. PAHPs are generally very narrow in their service scope, typically covering just one type of service such as transportation benefits, oral health services, non-institutional mental health benefits, or disease management.

Mandatory and optional activities

States implementing Medicaid managed care through MCOs, PIHPs, and PAHPs (with some exceptions) are required to have an EQRO perform a set of mandatory activities. States that use managed care for their separate State Children's Health Insurance Program (CHIP) plans and Medicaid expansion CHIP plans are also subject to the EQR requirements. PCCM entities are only subject to EQR if the PCCM entity's contract with the state provides for shared savings, incentive payments, or other financial rewards for improved quality outcomes.

States must have an EQRO conduct the following activities:

- validate PIPs to determine the methodological soundness in the design, conduct, evaluation and reporting of a health plan's PIP (not required for PCCMs since they are not required to conduct a PIP);
- validate plan-reported performance measures to ensure plans collect and report required measures properly;
- review, within the previous three-year period, to determine the MCO's, PIHP's, or PAHP's compliance with standards in subpart D of 42 CFR 438 relating to access, care coordination, amount, duration and scope of covered services, and other applicable plan standards; and
- validate plan network adequacy.[2]

States can also choose to have their contracted EQRO conduct one or more optional activities that can help advance their program goals. These optional activities include:

- validate encounter data reported by plans;
- administer or validate enrollee or provider surveys of quality of care;
- calculate performance measures in addition to those reported by plans;
- conduct PIPs in addition to those conducted by plans;
- conduct quality studies that focus on a particular aspect of specific clinical or nonclinical services; and
- assist with developing quality ratings of MCOs, PIHPs, and PAHPs consistent with the Medicaid managed care quality rating system (42 CFR 438.334).[3]

As of 2022, a majority of states included one or more optional activities as part of their EQR and eight states included all optional activities in the EQRO scope of work (Table 1).[4] Ten states do not require the EQRO to conduct any optional activities.[5] The most common optional EQR activity is enrollee or provider surveys, followed by encounter data validation and focused studies. Several states included assistance with developing quality ratings in their EQRO contracts, although this activity is not yet required under federal rules.

TABLE 1. Number of States Subject to EQR that Conduct Optional Activities by Type of Activity, 2022

Optional Activity	Number of States (including DC)
Validate encounter data submitted by plans	24
Administer or validate enrollee or provider surveys of quality of care	31
Calculate performance measures in addition to those reported by plans	14
Conduct PIPs in addition to those conducted by plans	9
Conduct quality studies that focus on a particular aspect of clinical or non-clinic services (i.e., "focused studies")	24
Assist with developing quality ratings for plans	18

Notes: DC is District of Columbia; PIPs are performance improvement projects.

Source: MACPAC analysis of EQR reports published in 2022 and related documents.

EQR protocols

Both mandatory and optional EQR activities are governed by detailed protocols issued by CMS. The CMS protocols outline acceptable methodologies for conducting elements of the EQR and specify the data to be gathered; data sources; the activities and steps to be followed in collecting the data to promote its accuracy, validity, and reliability; proposed method or methods for validly analyzing and interpreting the data once obtained; and the instructions, guidelines, worksheets, and other documents or tools necessary for implementing the protocol.

The specific methodologies for conducting different aspects of EQR vary depending on the activity. For example, for each area of managed care operations that is subject to the compliance review, the EQR protocol lists the types of documents—such as provider contracts or practice guidelines adopted by the plan—that may be used to determine compliance with the requirements. The EQR protocol for validation of PIPs includes detailed worksheets for reviewing the PIP topic, aim statement, identified population, sampling method, PIP variables, data collection procedures, and analysis and interpretation of PIP results. However, states have latitude within these parameters; for example, to define plan performance measures and identify areas for PIPs.

Entities eligible to conduct EQR

States must contract with at least one qualifying independent EQRO to conduct the EQR. To qualify as an EQRO, an organization must have experience and knowledge of Medicaid policy and service delivery, quality improvement and performance measurement, and research design and methodology. They must also demonstrate sufficient physical, technical and financial resources, and relevant clinical or nonclinical skills to complete the necessary activities.

There are also conflict of interest provisions for eligible entities. An EQRO and its subcontractors must be independent from the state Medicaid agency and the health plans under review. EQROs may not review any managed care plan over which either the EQRO or plan exerts control over the other, such as through stock ownership, options, voting trusts, common management or contractual relationships. EQROs also may not deliver health care services to Medicaid beneficiaries, conduct quality activities outside of the EQR process on behalf of the state, review any plans for which it has conducted an accreditation review within the previous three years, or have a financial relationship with a managed care plan that it reviews.

In addition to the above, a state entity can qualify as an EQRO in limited circumstances if it does not have any Medicaid purchasing or managed care licensing authority, and it is governed by a Board or similar body, the majority of whose members are not government employees. In addition, states can perform EQR functions even if they do not meet the EQRO qualifications, in which case the state would receive the applicable administrative matching rate for federal financial participation. As of 2022, no state entities are conduting EQR activities.

Recent changes in federal rules related to EQRO independence requirements resulted in fewer entities eligible to be EQROs. As of 2022, 2 EQROs conducted reviews for more than half of the states with managed care programs subject to EQR, while 10 EQROs currently perform EQR activities in only one state each.

Federal funding for EQR

External quality review of MCOs by a qualified EQRO is eligible for 75 percent federal funding, instead of the regular 50 percent federal funding for administrative activities. This enhanced match is available for both mandatory and optional activities. States must submit EQRO contracts for CMS approval before receiving the enhanced match. Enhanced match for the newest mandatory EQR activity—network adequacy validation—is available for EQR on MCOs since CMS released the new protocol (CMS 2023a). Enhanced match for the optional

activity to assist with quality ratings will be available for EQR on MCOs after CMS releases a final protocol (CMS 2016b). Until that time, states that choose to engage in this optional activity will receive the standard administrative match of 50 percent.

A 50 percent match rate applies to EQR-related activities performed on entities other than MCOs, such as PIHPs, PAHPs, PCCM entities, or other types of integrated care models. Also, EQR-related activities that are performed by an entity that does not meet the requirements of an EQRO can only receive the standard 50 percent administrative match. Any EQRO activities that CMS determines are neither mandatory nor optional EQR activities are eligible for the standard administrative match of 50 percent.

Federal match for mandatory and optional EQR activities for standalone CHIP managed care plans is available at the state's Title XXI matching rate, subject to the 10 percent cap for administrative expenditures. States are eligible to receive the enhanced CHIP match rate for EQR and EQR-related activities, regardless of which entity completes the activity.

Use of accreditation from other entities

In 2016, CMS began requiring plans to disclose their accreditation status (42 CFR 438.332).[6] Managed care plans (MCOs, PIHPs, and PAHPs) that have been accredited by the National Committee for Quality Assurance (NCQA), URAC, the Accreditation Association for Ambulatory Health Care, or other accrediting body must provide a copy of their most recent accreditation review to the state along with other related information.

To avoid duplication of effort, states can use information from these accreditation reviews to complete PIP validation, performance measures validation, and managed care compliance review if the following conditions are met:

- the plan is compliant with the applicable Medicare Advantage or private accreditation standards;
- the Medicare or private accreditation review standards are comparable to those established through the applicable EQR protocols; and
- the plan provides the state with all applicable reports, findings, and other results of the Medicare or private accreditation review.

The use of this nonduplication approach is at the discretion of the state (not the plans).

A state electing to use nonduplication must document in its managed care quality strategy which EQR-related activities it will use this option for and how the accreditation review standards are comparable to those in the EQR protocols. The state must also ensure the completion of any EQR-related activities that are not addressed by the information from the Medicare or private accreditation review. For example, if an accreditation review did not validate certain measures required by the state as part of a plan's QAPI, the EQR would need to conduct that validation activity. However, if information from a Medicare or private accreditation review does not completely meet the requirements of an activity, that information can still be used to meet the nonduplication requirements. For example, if a state requires its health plans to include 10 measures in its QAPI program and 5 of the 10 measures are validated as part of an accreditation review, the state can exercise the nonduplication provision and have the EQRO validate only the 5 measures that were not included in the accreditation review. As of 2022, 14 states reported using a non-duplication approach to deem nationally accredited plans as being compliant with specific, limited federal rules that are part of EQR compliance activities.[7]

When information from a Medicare or private accreditation review of a managed care plan is used to support one or more mandatory EQR-related activities, the EQRO's analysis of the data is eligible for federal match. The accreditation activities that produce the information are not eligible for federal match.

State option to exempt plans from EQR

States can also exempt MCOs (but not PIHPs and PAHPs) from the annual EQR process, if each of the following conditions are met:

- the MCO has both a current Medicare Advantage contract and a current Medicaid contract;
- the two contracts cover all or part of the same geographic area in the state; and
- the Medicaid contract has been in effect for at least two consecutive years before the exemption date, and during those same two years, the MCO has been subject to EQR and met quality, timeliness, and access to health care services standards for Medicaid beneficiaries.

If a state wants to exempt an MCO from EQR, the state must obtain specific information from other external review entities. For MCOs reviewed by Medicare, the state must obtain annually the most recent Medicare review findings from the MCO, including all data, correspondence, information, and findings relevant to the MCO's compliance with Medicare standards for: (1) access, quality assessment and performance improvement, health services, or delegation of these activities; (2) all measures of the MCO's performance; and (3) results and findings of all performance improvement projects for Medicare enrollees.

For MCOs reviewed by a private, national accrediting organization that CMS approves and recognizes for Medicare Advantage Organization deeming, the state must require the MCO to provide a copy of all findings from its most recent accreditation review if that review was used to meet certain requirements for Medicare external review, or to determine compliance with Medicare requirements. At a minimum, findings must include accreditation review results of evaluation of compliance with individual accreditation standards, any deficiencies, corrective action plans, and summaries of unmet accreditation requirements.

Annual technical reports

Federal regulations require states to publish an annual technical report (ATR) that compares and evaluates the plans subject to review. The report must be prepared by the EQRO; if a state conducts its own EQR without an EQRO, the state must still contract with an independent EQRO to draft the annual report. The ATR must be posted on the state website by April 30th each year and must include the following components:

- a detailed explanation of the EQR's methodology for collecting, aggregating and analyzing data for each mandatory EQR activity;
- the EQRO's assessment of each managed care plan's performance on quality, timeliness and access to care;
- recommendations for improving the quality of health care services furnished by each managed care plan and recommendations for how the state can target goals and objectives in the state quality strategy;
- methodologically appropriate comparisons of performance across all plans; and
- an assessment of the degree to which each managed care plan addressed quality improvement recommendations from the previous year's EQR.

An MCO that is exempt from EQR will not be included in the annual EQR technical report but the state must note the exemption on its website and in its EQR report.

CMS publishes summary tables based on the EQR technical reports, including a list of the EQROs contracting with states, the number and type of plans included in each state's EQR technical report, validated performance measures, whether a state reported performance measure rates, and the areas of care and populations covered by PIPs.

Future Policy Changes

On May 3, 2023, CMS proposed changes to the federal rules governing the EQR process, which it notes are intended to eliminate unnecessary state burden and make EQR more meaningful for driving quality improvement (CMS 2023b). CMS is proposing to remove PCCM entities from the scope of mandatory external quality review, based on a reevaluation of PCCM entity contracts and a finding by CMS that there is wide variability in the size, structure, and scope of case management and other services provided by risk-bearing PCCM entities. CMS is also proposing that the EQR process incorporate new optional activities so that states can receive assistance at an enhanced match rate for conducting new quality and oversight activities that will be required if the proposed rule is finalized as written. Finally, CMS is proposing that EQR technical reports include outcomes data and results from quantitative assessments (in addition to the currently required validation results), to provide CMS and other stakeholders with more information on plan performance and on states' effectiveness in driving quality improvement. It is not known when the rule will be finalized or whether any of these provisions will be finalized as proposed or how they might be modified or amended.

Endnotes

[1] Alaska, Connecticut, Maine, Montana, Oklahoma, and South Dakota do not have managed care plans. Also, while Oklahoma does not have a managed care plan type subject to EQR as of the time of this publication, the state plans to establish a Medicaid managed care program in 2023, which will be subject to EQR.

[2] CMS released the final protocol for network adequacy validation in February 2023, which all states will be required to implement no later than a year from the protocol's release (CMS 2023a). Mandatory network adequacy validation does not apply to PCCM entities since they are not subject to network adequacy standards.

[3] As of April 2023, CMS has not released a final protocol for this optional service; the optional activity to assist with the QRS is effective no earlier than the issuance of the associated protocol. Any states that are using their EQROs to perform this activity prior to the final protocol being released will only receive regular administrative match.

[4] States contracting for all optional EQR activities include Arizona, Arkansas, Indiana, Louisiana, North Dakota, New York, Oklahoma, and Oregon. Although Oklahoma has contracted with an EQRO, the state's managed care program is not yet operational; it is expected to launch in early 2024.

[5] These states include Alabama, Massachusetts, Michigan, Missouri, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, and Wyoming.

[6] Health plan accreditation is a comprehensive evaluation process by which a private, independent external organization or "accrediting body" examines a health plan's systems, processes, and performance to ensure the plan is conducting business in a manner consistent with nationally recognized and accepted standards.

[7] These states include Florida, Georgia, Illinois, Massachusetts, Michigan, Minnesota, North Dakota, Nebraska, Ohio, Tennessee, Washington, West Virginia, Wisconsin and Washington, DC.

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