State CHECKLIST ✓

Medicaid and CHIP Managed Care Final Rule (CMS 2390-F): Subpart D and E of 438–Quality of Care

- ✓ Ensure that all terms as they appear in state statute comport with the definitions in the final rule.
- ✓ **Availability of services.** State managed care contracts must meet certain requirements to ensure access to services through a sufficient delivery network, compliance with timely access standards, and cultural consideration requirements for all contracts beginning on or after July 1, 2018.
- ✓ **Assurances of adequate capacity and services.** States must require that each contracted managed care entity give assurances to the state and provide supporting documentation that demonstrated their capacity to serve the expected enrollment in its service area in accordance with state standards for access of care.
  - States must review all documentation and submit an assurance of compliance to the Centers for Medicare and Medicaid Services (CMS), and make available all documentation upon request.
  - Applies to the rating period for contracts with managed care entities beginning on or after July 1, 2018.
- ✓ **Coordination and continuity of care.** The state must ensure that each managed care entity complies with coordination and continuity of care requirements.
  - The state must determine if *Pre-paid Ambulatory Health Plans* (PAHPs) or *Prepaid Inpatient Health Plans* (PIHPs) will be required to implement mechanisms to develop and maintain a treatment plan for individuals with special health care needs.
  - Managed care entities must implement procedures to deliver care and coordinate services that meet state requirements and certain other requirements outlined in the final rule.
  - Identification of persons with long-term services and supports (LTSS) and other special health care needs to managed care entities.
  - These provisions apply to the rating period for contracts with managed care entities beginning on or after July 1, 2017.
- ✓ **Coverage and authorization of services.** Each contract between a state and a managed care entity must do the following:
  - Identify the scope of services.
  - Ensures network adequacy.
  - Sets utilization control parameters.
  - Specifies what constitutes "*medically necessary services*" as indicated in state statutes and regulations, the state plan, and other state policy and procedures.
- ✓ **Authorization of services**. Each contract must require that there are mechanisms to ensure consistent application of review criteria for authorization decisions based on written policies and procedures, and sets timeframes for standard and expedited authorization decisions.
  - **Covered outpatient drug decisions**–For all covered outpatient drug authorization decisions, notice of a determination must be given within 24 hours of a request for prior authorization.
  - **Compensation for utilization management activities**–Each contract between a state and a managed care entity musty provide that compensation provided to utilization review (UR) agents to conduct UR activities is not structured so as to provide an incentive to deny, limit, or discontinue medically necessary services to any enrollee.
  - These provisions apply to the rating period for contracts with managed care entities beginning on or after July 1, 2017.
- ✓ **Credentialing and re-credentialing requirements.** Each state must establish a uniform, and nondiscriminatory credentialing and re-credentialing policy that address acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate, and requires each managed care entity to follow those policies.
- ✓ **Confidentiality.** The state must ensure that each managed care entity adheres to privacy requirements relative to individually identified health information.
- ✓ **Subcontractural relationships and delegation.** The state must ensure that contracted managed care entities maintain ultimate responsibility for adhering to and fully complying with all terms and conditions of its contract with the state.
  - The subcontractor must agree to comply with all Medicaid laws and regulations including applicable sub-regulatory guidance and contract provisions.

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- ✓ **Health information systems.** States must ensure that managed care entities maintain a health information system that collects, analyzes, integrates and reports data, and can achieve the objectives.
  - The state must review and validate that the encounter data collected, maintained, and submitted to the state by the managed care entity meets the requirements of the final rule.
  - The state must have procedures and quality assurance protocols to ensure that enrollee's encounter data submitted is a complete and accurate representation of the services provided to the enrollees under the contract between the state and the managed care entity.
  - These provisions apply to the rating period for contracts with managed care entities beginning on or after July 1, 2017.
- ✓ **Quality assessment and performance improvement program.** States must require that each managed care entity establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees.
  - Managed care entities must annually measure and report to the state on its performance using the standard measure required by the state.
  - Managed care entities must also conduct performance improvement projects including performance improvement projects required by CMS, which focus on clinical and non-clinical areas, and report the status and results to the state as requested.
  - The state must review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program.
- ✓ **State review of the accreditation status of managed care entities.** The state must require that each managed care entity inform them whether it has been accredited by a private independent accrediting entity, and must authorize that accrediting body to provide the state with copies of its most recent review documentation.
  - The accreditation status must be made available on the Web site, including the accreditation entity, the program, and the accreditation level.
  - The information must be updated at least annually.
- ✓ **Medicaid managed care quality rating system (QRS).** Each state offering Medicaid and CHIP benefits through a managed care entity must:
  - Adopt the Medicaid managed care quality rating system developed by CMS,
  - Adopt an alternative Medicaid managed care quality rating system, or
  - Implement a Medicaid managed care quality rating system by May 2019.
  - Quality ratings–states must collect data from each contracted managed care entity annually and issue an annual quality rating for each one based on the data collected using the quality rating system they've adopted.
- ✓ **Managed care state quality strategy.** States must draft and implement a written quality strategy for assessing and improving the quality of health care services furnished by managed care entities providing Medicaid and CHIP benefits to their beneficiaries.
  - States will have three years to implement a QRS system following final notice in the *Federal Register*.
  - The state must identify and publish quality measures and performance outcomes at least annually on the Web site.
  - The states' quality strategy must include network-adequacy and service availability standards.
  - States must identify demographic information for each Medicaid enrollee inclusive of their age, race, ethnicity, sex, primary language, and disability status, and provide this information to the managed care entity contracted to provide their benefits at the time of enrollment. For the purpose of this section "*disability status*" means whether the individual qualified for Medicaid on the basis of a disability.
  - States must determine how the term "*significant change*" will be used as it applies to their state Medicaid programs. A copy of the revised managed care state strategy must be submitted to CMS whenever significant changes are made or significant changes to the program are made, but the definition of the term has been left to each state to define.

State CHECKLIST ✓
Medicaid and CHIP Managed Care Final Rule (CMS 2390-F): Subpart D and E of 438–Quality of Care

- ✓ **State contract options for external quality review.** For each contract the state must follow an open, competitive procurement process that is in accordance with state law and regulations, and federal rules governing state procurement of Medicaid services.
- ✓ **Federal financial participation (FFP)**.
  - **FFP at the 75 percent rate** will be available only for EQR expenditures (including the production of the EQR report) and the 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 expenditures 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.
  - In order to claim the FFP at the 75 percent rate **the state must submit each EQRO contract to CMS** for review and approval. The rate is no longer available for EQR activities for PIHPs.

  The provision applies on May 6 2016, the publication date of the final rule.

  CMCS Informational Bulletin: Federal Financial Participation for Managed Care External Quality Review (6/10/2016)

NCSL State Federal Relations Staff Contacts:

Joy Johnson Wilson, NCSL Federal Affairs Counsel, Health Policy Director at joy.wilson@ncsl.org or Rachel B. Morgan RN, BSN, NCSL Senior Committee Director, NCSL Standing Committee on Health and Human Services at rachel.morgan@ncsl.org.