

Summary Memo on CMS Response to Comments Received on the Revised EQR Protocols

CMS received four formal sets of comments in response to the February 17, 2012 Federal Register notice on the proposed revisions to the managed care External Quality Review Protocols. The following parties submitted comments: Tennessee Medicaid Director; Health Services Advisory Group (HSAG); the Association for Community Affiliated Plans (ACAP); and Delmarva. CMS received one informal comment via email from the New Jersey Medicaid program.

The following chart details the comments and corresponding CMS responses.

Commenter	Comment	CMS Response
Tennessee Medicaid Director	The listing of MCO staff required for attendance at the EQRO compliance review is too prescriptive and executive level staff may not have flexible enough schedules to accommodate the EQRO site visit.	CMS agreed with this comment and added language to Protocol 1 to clarify that the EQRO has discretion to meet with select employees on the list.
HSAG	The use of the words variable and indicator are inconsistent throughout the Protocols.	CMS agreed that where the word “variable” is used with the same meaning as “indicator” we will uniformly use “indicator”.
HSAG	Reorder some activities/steps within the Protocols related to identification of the study population and identification of specific improvement strategies.	CMS agreed to switch the order of these steps.
ACAP	Address unnecessary duplication of costs in requiring an EQRO to revalidate performance measures where an approved HEDIS auditor has already done so	CMS recognizes that there is some duplication of activities between the EQRO and the HEDIS auditor. Under current regulations, the validation must be done by an “independent” entity not paid by the MCO. Until new regulations are issued, the protocols must comply with the existing rules.
ACAP	Include language that suggests States engage the MCOs earlier on decisions related to State-mandated performance improvement projects (PIPs)	While CMS does not have the authority to require that States consult MCOs prior to implementation, we have included language suggesting that States do so.
ACAP	MCOs should be allowed to append their response to an EQRO review to assure that their view is reflected in the final report	CMS does not have the authority to require or preclude States from appending MCO responses to the EQRO technical report. However, to ensure that there is no violation of the “independence” requirement under 42 C.F.R. § 438.354, it must be clearly identified in the EQRO technical report that the MCO response is separate and distinct from the EQRO’s assessment.
ACAP	Include federal timeframes to speed up the EQRO process	CMS does not have the authority to specify a timeframe, but has included language that strongly encourages States to submit EQRO reports by April of each year.

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Delmarva	Are the protocols applicable to other populations/organizations such as ACOs?	The protocols only apply to MCOs and PIHPs participating in Medicaid managed care. These organizations are subject to the managed care requirements for EQR under 42 CFR 438.
Delmarva	Does CMS plan to include guidelines for HITECH review?	CMS decided not to include guidelines regarding review of State HIT plans and meaningful use since they are covered elsewhere in regulations. Given that this activity is outside the jurisdiction of EQR, the Protocols are not the proper forum for technical guidance in this area. Information is, however, provided in Appendix V on the importance of adapting how emerging information system capabilities are assessed (page 4). Attachment B to Appendix V, under section E starting on page 29, addresses Meaningful Use of Electronic Health Records and the assessment by the EQRO in how MCO systems and processes address EHR in collection and/or reporting of performance information
Delmarva	Will CMS provide guidance on how to assess whether interventions are culturally and linguistically appropriate?	Protocol 3 has been edited to note that additional information on culturally and linguistically appropriate services may be found at the HHS Office of Minority Health’s website.
Delmarva	What is the difference between Protocol 3 (Validation of PIPs) and Protocol 7 (Implementation of PIPs)? The language is virtually identical.	CMS responded that while Protocol 7 frequently refers to Protocol 3 to minimize redundancy and duplication of information, it is still necessary to have a separate Protocol for guidance on this activity. Clarification was added to the introduction of Protocol 7 as to why States may choose this optional protocol.
Delmarva	Will CMS provide guidance related to the number/types of performance measures and PIPs that a state should mandate for review?	CMS does not intend to provide guidance on the number of performance measures or PIPS a State should review; however, suggestions for the types of measures and PIPs are included in the protocol. CMS recommends that States consider the collection of performance measures from the CMS child and adult core measure sets. CMS also recommends that States and MCOs consider performing at least one clinical and one administrative PIP, implement PIPs that align with CMS priorities, as set forth in Protocol 3 and Protocol 7 (e.g., related to the goals of the Partnership for Patients).
New Jersey Medicaid (<i>informal comment received via email</i>)	In Protocol 3, Step 8, the language “realistic and unambitious” is unclear.	The intended language was “realistic and unambiguous” and will be corrected.

To summarize, the EQR Protocols are drafted to provide guidance on implementation of the EQR regulations. In some cases, as noted above, the EQR regulations define the limits of the CMS Protocols. Where there is opportunity to encourage States to consider options in EQR contracting that align with CMS or HHS priorities, CMS has noted that.