May 2024

Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule Summary

Internal

On Apr. 22, the Centers for Medicare and Medicaid Services released the Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality final rule. This rule includes provisions that aim to improve state managed care programs by expanding state and plan requirements related to access, state directed payments, in lieu of services and settings (ILOSs), medical loss ratios (MLRs), and quality.

Highlights of the final rule:

- Establishes maximum appointment wait time standards for primary care, outpatient mental health and substance use disorder services, and obstetric/gynecological services. These standards are specified as being for both adult and pediatric services.
- Sets the average commercial rate as the limit for total state directed payments for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center.
- Postpones CMS enforcement over provider hold harmless arrangements until January 2028.

The detailed summary below outlines the key provisions of this final rule that have implications for children's health and hospitals. Several of the finalized provisions align with CHA comments on the proposed rule.

Please reach out to Milena Berhane with any questions.

KEY PROVISIONS WITHIN THE RULE

<table>
<tr><th>Issue</th><th>Provision in the Final Rule</th><th>CHA Proposed Rule Comments</th><th>Compliance Date</th></tr>
<tr><td colspan="4">Medicaid Managed Care – Access</td></tr>
<tr><td>Medicaid Managed Care
-
Access
-
Enrollee Experience Surveys

(§§ 438.66(b), (c), 457.1230(b))</td><td>(1) States are required to conduct an annual enrollee experience survey of their choice for each of their Medicaid managed care programs. States are required to evaluate enrollee experience data as part of their Managed Care Program Annual Reports and post the report on their website 30 calendar days after submission to CMS.

(2) States are required to use CHIP Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data to evaluate network adequacy. States will also be required to annually post comparative summary results of CHIP CAHPS surveys by plan on their website.</td><td>CHA did not comment on this provision.</td><td>The first rating period beginning on or after Jul. 9, 2027.</td></tr>
<tr><td>Medicaid Managed Care
-
Access
-
Appointment Wait Time Standards

(§§ 438.68(e), 457.1218)</td><td>CMS establishes the following maximum appointment wait time standards:

<table><tr><th>Appointment Type</th><th>Wait time must not exceed</th></tr><tr><td>Primary Care - adult and pediatric</td><td>15 business days from date of request</td></tr><tr><td>Outpatient mental health and substance use disorder (SUD) - adult and pediatric</td><td>10 business days from date of request</td></tr><tr><td>OB/GYN</td><td>15 business days from date of request</td></tr><tr><td>An additional appointment type(s) selected by the state in an evidence-based manner</td><td>The state would establish its own standard(s)</td></tr></table></td><td>CHA supported this provision. We highlighted existing workforce shortages and provider protections that should be considered to avoid provider penalization. In addition, we emphasized the importance of applying these standards for specialty care and the need to address out-of-state care.</td><td>The first rating period beginning on or after Jul. 9, 2027.</td></tr>
</table>

Medicaid Managed Care **-** **Access** **-** **Secret Shopper Surveys** **(§§ 438.68(f), 457.1207, 457.121)**	(1) States are required to use independent entities to conduct annual secret shopper surveys as part of their monitoring activities regarding compliance with wait time standards and to determine the accuracy of information located in provider directories. • Accuracy of information requirements are applicable to primary care, OBGYN, and outpatient mental health and SUD providers, as well as the additional provider type selected by the state (in compliance with wait time standards). (2) States are required to report the results of these surveys to CMS annually, as well as being required to post it on the state's website within 30 calendar days of being submitted to CMS.	CHA did not comment on this provision.	The first rating period beginning on or after Jul. 10, 2028.
Medicaid Managed Care **-** **Access** **-** **Provider Payment Analysis** **(§§ 438.207(b), 457.1230(b))**	(1) Managed care plans are required to submit a payment analysis to states for primary care, OB/GYN, outpatient mental health, and SUD services covered under the plan's contract (for both Medicaid and CHIP). Analyses must include the following information: • Total amounts paid for each service during the immediate prior rating period. • A comparison against Medicare FFS rates. Plans must calculate the percentage that results from dividing the total amount that the Medicaid managed care plan actually paid for each service type by what the total payment would have been under Medicare using the most recent published payment rate for the relevant code(s). • Percentages that differ between adult and pediatric care would have to be reported separately. (2) Managed care plans are required to submit a separate payment analysis for home and community-based services (HCBS). • Since Medicare does not cover similar HCBS services, CMS requires a comparison of the managed care plan's total payments to the amount paid for the same services under Medicaid FFS. • This analysis must include separate percentages being reported for adult and pediatric services, if they differ. (3) States are required to aggregate and submit analyses from each plan to CMS. States are also required to use the data submitted by plans to produce a weighted statewide average payment percentage for each service type.	CHA supported this provision. We also emphasized the need for more adequate Medicaid payment for behavioral health services across the continuum. We also asked that CMS explore what benchmark works best for pediatrics, since Medicare may not be a perfect benchmark.	The first rating period beginning on or after Jul. 9, 2026.

Medicaid Managed Care **-** **Access** **-** **Assurances of Adequate Capacity and Services Reporting** **(§§ 438.207(d), 457.1230(b))**	(1) States are required to include the results from the required secret shopper surveys and required payment analysis in their assurance and analyses reporting. This is required annually no later than 180 calendar days after each rating period. (2) States are required to publicly post these assurance reports and analysis on their websites within 30 calendar days of submitting the reports to CMS.	CHA did not comment on this provision.	The first rating period beginning on or after Jul. 9, 2025.
Medicaid Managed Care **-** **Access** **-** **Remedy Plans to Improve Access** **(§ 438.207(f))**	(1) States are required to develop and enforce their managed care plans' use of appointment wait time standards. If access issues are identified, states are then required to submit a plan to remedy those issues. • States must submit a remedy plan to CMS no longer than 90 days following the date that the state becomes aware of a plan's issue. • The remedy plan must be developed to address the issue within 12 months, and include specific steps, timelines for implementation and completion, and responsible parties.	CHA did not comment on this provision.	The first rating period beginning on or after Jul. 10, 2028.
Medicaid Managed Care **-** **Access** **-** **Transparency** **(§§ 438.10(c), 438.602(g), 457.1207, 457.1285)**	(1) States are required to have the following minimal qualities for their Medicaid and CHIP webpages, to improve user navigation and accessibility: • Including or linking to required content on a single website. • Direct links to the specific information requested on a plan website, rather than a general MCO, PIHP, PAHP, or PCCM website. • Utilize clear and understandable labels on documents and links. • Including the availability for user assistance for accessing information. States must check their websites quarterly to ensure they are functioning as required.	CHA did not comment on this provision.	The first rating period beginning on or after Jul. 9, 2026.

Medicaid Managed Care – State Directed Payments			
Medicaid Managed Care - State Directed Payments - Contract Requirements Considered to be SDPs (Grey Area Payments) (§§ 438.6)	CMS finalized the definition of grey area payments to be payments that are similar to pass-through payments, but do not meet the requirements to be considered permissible pass-through payments. CMS finalizes that such contractual agreements do not meet statutory requirements to be permissible pass-through payments and will continue this interpretation of the statute.	CHA did not comment on this provision.	Beginning on Jul. 9, 2024.
Medicaid Managed Care - State Directed Payments - Medicare Exemption, SDP Standards and Prior Approval (§ 438.6(c)(1)(iii)(B), § 438.6(c)(2), and § 438.6(c)(5)(iii)(A)(5))	(1) SDP arrangements that are a minimum fee schedule using 100 percent of total published Medicare payment rates in effect no more than 3 years prior to the start of the rating period will not require written pre-approval. • These SDPs will still have to be documented in the corresponding managed care contracts and rate certifications. (2) CMS added a new paragraph titled "Requirements for Medicaid Managed Care Contract Terms for State Directed Payments." • This is for oversight and audit purposes. Contracts would have to specify which Medicare fee schedules(s) the state directed the managed care plan to use and any relevant adjustments, time period and rating period.	CHA did not comment on this provision.	Beginning on Jul. 9, 2024.
Medicaid Managed Care - State Directed Payments - Non-Network Providers (§ 438.6(c)(1)(iii))	States are allowed to set minimum provider payment levels regardless of whether a provider is in network with a plan. SDPs are permitted for both network and non-network providers. **CMS reiterated children's hospitals as an example of a provider type that is relied on for access to specialty services for enrollees from out-of-state.**	CHA did not comment on this provision.	Beginning on Jul 9, 2024.

Medicaid Managed Care **-** **State Directed Payments** **-** **SDP Submission Timeframes** **(§ 438.6(c)(2)(viii) and (ix))**	(1) All SDPs that require written prior approval from CMS must be submitted to CMS before the start date of the SDP. (2) States must also submit related contract requirements and rate certification documentation to CMS before the start date of the SDP.	CHA did not comment on this provision.	The first rating period beginning on or after Jul. 9, 2026.
Medicaid Managed Care **-** **State Directed Payments** **-** **Standard for Total Payment Rates for each SDP, Establishment of Payment Rate Limitations for Certain SDPs, and Expenditures Limits for All SDPs** **(§ 438.6(c)(2)(ii)(I), 438.6(c)(2)(iii))**	*Standard for Total Payment Rates for each SDP.* (1) CMS finalizes the "total payment rate" as the aggregate for each managed care program of: • The average payment rate paid by all MCOs, PIHPs, or PAHPs to all providers included in the specified provider class for each service identified in the SDP; • The effect of the SDP on the average rate paid to providers included in the specified provider class for the same service for which the State is seeking written prior approval; • The effect of any and all other SDPs on the average rate paid to providers included in the specified provider class for the same service for which the State is seeking written prior approval; • The effect of any and all allowable pass-through payments paid to any and all providers in the provider class specified in the SDP for which the State is seeking written prior approval on the average rate paid to providers in the specified provider class. (2) States are required to provide documentation demonstrating the total payment rate for each service and provider class, upon request from CMS. *Establishment of Payment Rate Limitations for Certain SDPs.* (1) The average commercial rate (ACR) is implemented as the limit for projected total payment rate for inpatient services, outpatient hospital services, qualified practitioner services at an academic medical center, and	CHA strongly supported this provision to codify the Average Commercial Rate as the SDP payment ceiling for hospitals. We emphasized that imposing any other limit would detrimentally affect critical Medicaid funding to children's hospitals.	The first rating period beginning on or after Jul. 9, 2024.

	nursing facility services. This would apply to all SDPs in a managed care program. (2) States are required to provide CMS with an (1) ACR demonstration and (2) total payment rate comparison to the ACR to ensure compliance that payment rate for SDPs that require written prior approval from CMS for the four service types above do not exceed the ACR. CMS increases flexibilities on how states can calculate the ACR. States are allowed to demonstrate the ACR based on the set of services included in the SDP, without having to restrict the demonstration to the SDP provider class. This is beneficial to the high Medicaid providers that tend to receive lower commercial rates. *Expenditure Limit for SDPs.* (1) States are required to produce the same type of calculation for the final State directed payment cost percentage except that for the numerator, States would be required to account for all SDPs applicable to that managed care program instead of just one SDP. (2) The limit for total SDP expenditures is a portion of the total costs for each Medicaid managed care program, but only for the costs related to inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers.		

Medicaid Managed Care **-** **State Directed Payments** **-** **Financing** **(§ 438.6(c)(2)(ii)(G) and (H))**	States are required to ensure each provider that receives a state directed payment to attest that it does not participate in any arrangement that holds taxpayers harmless for the cost of a tax. • CMS adds the modification that states may, as applicable, provide an explanation that is satisfactory to CMS about why specific providers are unable or unwilling to make such attestations. • CMS will not enforce this provision until 2028, as stated in this informational bulletin. These provisions would apply to all SDPs, regardless of whether they require prior approval.	CHA did not support the proposed requirement for states to collect attestations from providers stating that they do not participate in a hold harmless arrangement. We stated that the issue is currently being litigated and therefore, this proposal would be premature to consider within this proposed rule.	The first rating period beginning on or after Jan. 1, 2028.
Medicaid Managed Care **-** **State Directed Payments** **-** **Tie to Utilization and Delivery of Services for Fee Schedule Arrangements** **(§ 438.6(c)(2)(vii))**	States are prohibited from using post-payment reconciliation processes for SDPs. • States cannot make any SDP payments based on historical utilization or any other basis that is not tied to the delivery of services in the rating period itself. • States establishing fee schedules cannot require that plans pay providers using a post-payment reconciliation process.	CHA did not comment on this provision.	The first rating period beginning on or after Jul. 9, 2027.
Medicaid Managed Care **-** **State Directed Payments** **-** **Value-Based Payments and Delivery System Reform Initiatives** **(§ 438.6(c)(2)(vi))**	(1) States are allowed to set the amount or frequency of the plan's expenditures. (2) States are allowed to recoup excess funds from plans.	CHA did not comment on this provision.	Beginning on Jul 9, 2024.
	Population- or Condition-Based Models. (1) Regarding SDPs for population- or condition-based models, states are required to tie them to the delivery of services or attribution of enrollees covered under the contract.		The first rating period beginning on or after Jul. 9, 2024.

Medicaid Managed Care **-** **State Directed Payments** **-** **Quality and Evaluation** **(§ 438.6(c)(2)(ii)(D) and (F), (c)(2)(iv) and (v), and (c)(7))**	For SDPs that require prior approval, states are required to: 1. Include at least one performance measure and one access measure in an SDP evaluation plan submitted as part of the preprint process. 2. Include specified baseline measures and performance targets in their evaluation plans. 3. Submit an evaluation report if the final State directed payment cost percentage exceeds 1.5%. 4. Submit evaluation reports every 3 years.	CHA did not comment on this provision.	The first rating period beginning on or after Jul. 9, 2027.
Medicaid Managed Care **-** **State Directed Payments** **-** **Contract Term Requirements** **(§ 438.6(c)(5) and 438.6(c)(6))**	*Contract Requirements.* 1. States are required to specify the information that must be documented in the managed care contract for each SDP, including the following: a. Start date, and if applicable, the end date within the applicable rating period. b. Descriptions of the provider class eligible for the payment arrangement and all eligibility requirements. c. A description of each payment arrangement in the managed care contracts. d. Certain data points for minimum, uniform, and maximum fee schedules. e. Certain data points for performance-based payments, as well as population- or condition-based payments. 2. States are required to document all SDPs in MCO, PIHP, and PAHP contracts no later than 120 days after the start of the SDP or approval of the SDP, whichever is later.	CHA did not comment on these provisions.	The first rating period beginning on or after Jul. 10, 2028.
	Separate Payment Terms. States are prohibited from the use of separate payment terms and are required to incorporate all SDPs into Medicaid managed care capitation rates.		The first rating period beginning on or after Jul. 9, 2027.

Medicaid Managed Care **-** **State Directed Payments** **-** **SDPs Included through Adjustments to Base Capitation Rates** **(§ 438.7(c)(5)**	States are prohibited from implementing retroactive adjustments to base capitation rates to account for larger-than-anticipated directed payments.	CHA did not comment on this provision.	Beginning on Jul. 9, 2024.
Medicaid Managed Care **-** **State Directed Payments** **-** **Appeals** **(§ 430.3(3))**	CMS establishes a new appeals process for states to dispute written disapprovals of SDPs. • States can be heard by the Health and Human Services (HHS) Department Appeals Board. • States can request a hearing or oral argument, or the Board may call for one should it determine its decision-making would be enhanced by such proceedings. • The CMS Administrator would then issue the final decision.	CHA did not comment on this provision.	Beginning on Jul. 9, 2024.
Medicaid Managed Care **-** **State Directed Payments** **-** **Reporting Requirements** **(§ 438.6(c)(4))**	(1) Managed care plans are required to include near-term reporting of actual expenditure data using existing MLR reporting. This includes the following: • The amount of payments to providers made under SDPs that direct the managed care plan's expenditures. • The payments from the State to the managed care plans for expenditures related to these SDPs. (2) States are required to conduct longer-term reporting of provider-level data through the Transformed Medicaid Statistical Information System (T-MSIS). This includes the following: • The paid amount that represents the managed care plan's negotiated payment amount. • The amount of the State directed payments. • The amount for any pass-through payments. • Any other amounts included in the total paid to the provider.	CHA highlighted that children's hospitals receive significant funding through SDPs, but this is because they are high Medicaid providers and face significant Medicaid shortfall. To account for this, we asked CMS to explore ways that this additional context can be included to accompany the dollar amounts being reported.	Beginning the first rating period following the release of reporting instructions by CMS.

Medicaid Managed Care - Medical Loss Ratio (MLR Standards)			
Medicaid Managed Care - Medical Loss Ratio Standards - Standards for Provider Incentives **(§§ 438.3(i), 438.8(e)(2), 457.1201, 457.1203)**	(1) States are required to implement the following requirements for managed care plans to include in their provider incentive payment arrangements: • A defined performance period that can be tied to the applicable reporting period. • Well-defined quality improvement or performance metrics that the provider must meet to receive the incentive payment. • A percentage of a verifiable dollar amount that can be clearly linked to successful completion of these metrics, and date of payment. (2) States must prohibit managed care plans from using attestations as documentation to support provider incentive payments. (3) To include provider incentive payments in the MLR numerator, the provider bonus or incentive arrangement must require providers to meet clearly-defined, objectively measurable, and well documented clinical or quality improvement standards.	CHA did not comment on this provision.	The first rating period beginning on or after Jul. 9, 2025.
Medicaid Managed Care - Medical Loss Ratio Standards - Contract Requirements for Overpayments **(§§ 438.608(a)(2), (d)(3), 457.1285)**	Managed care plans are required to "promptly" report any overpayment (both identified or recovered). • "Prompt" reporting is defined as within 30 calendar days of identifying or recovering the overpayment. • Managed care plans must report all overpayments to the state annually.	CHA did not comment on this provision.	The first rating period beginning on or after Jul. 9, 2025.

Medicaid Managed Care **-** **Medical Loss Ratio Standards** **-** **Reporting of SDPs in the Medical Loss Ratio (MLR)** **(§§ 438.8(e)(2)(iii), (f)(2), 438.74, 457.1203(e), (f))**	(1) Managed care plans are required to include SDP payments and associated revenue as separate lines in annual MLR reports to states. • Managed care plans' expenditures to providers that are directed by the State, including those that do and do not require prior CMS approval, must be included in the MLR numerator. • State payments made to Medicaid MCOs, PIHPs, or PAHPs for approved arrangements must be included in the MLR denominator as premium revenue. (2) States are required to report these separate line items in their annual summary MLR reports to CMS.	CHA did not comment on this provision.	Beginning on or after Sept. 9, 2024.
Medicaid Managed Care – In Lieu of Services and Settings (ILOSs)			
Medicaid Managed Care **-** **In Lieu of Services and Settings** **-** **Overview of ILOS Requirements** **(§§ 438.2, 438.3(e), 438.16, 457.1201(e))**	(1) CMS defines ILOS as a service or setting that can be used as an immediate or longer- term substitute (usually to address health related social needs) for a covered service or setting under the state plan. • For states to cover these services, they must meet certain criteria to be considered medically appropriate and cost-effective. (2) The ILOS provisions within this rule (below) would not apply to coverage of short-term stays in institutions for mental disease (IMD) when authorized as an ILOS.	CHA stated that we support and recognize the importance of addressing health-related social needs for children and families through ILOSs. We also highlighted the need for additional Medicaid supports to accompany the expansion of ILOSs.	Beginning on or after Sept. 9, 2024.
Medicaid Managed Care **-** **In Lieu of Services and Settings** **-** **ILOS General Parameters** **(§§ 438.16(a)-(d), 457.1201(c), (e))**	(1) An ILOS must be a service or setting that would be approvable via a SPA or as a 1915(c) HCBS waiver. 2) States must not exceed an "ILOS cost percentage," which is the limit for the amount states can spend on ILOS for each managed care program. This limit is up to 5% of approved capitation payments. (3) States must provide an annual summary report of the actual cost of delivering ILOS for each managed care program. This would be based on claims and encounter data. • This report must be submitted in the same report that includes the final ILOS cost percentage.	CHA did not comment on this provision.	The first rating period beginning on or after Sept. 9, 2024. This does not apply to separate CHIP.

Medicaid Managed Care **-** **In Lieu of Services and Settings** **-** **Enrollee Rights and Protections** **(§§ 438.3(e), 457.1201(e), 457.1207**	CMS codifies the following enrollee rights and protections: (1) If an enrollee chooses not to receive an ILOS, they will retain their right to receive the service or setting covered under the State plan on the same terms as would apply if an ILOS was not an option. (2) A managed care plan may not deny an enrollee access to a service or setting covered under the State plan on the basis that an enrollee has: • been offered an ILOS as a substitute for a service or setting covered under the State plan; • is currently receiving an ILOS as a substitute for a service or setting covered under the State plan; • or has utilized an ILOS in the past. (3) States' managed care contracts must clearly document enrollee rights and protections.	CHA did not comment on this provision.	The first rating period beginning on or after Sept. 9, 2024. This does not apply to separate CHIP.
Medicaid Managed Care **-** **In Lieu of Services and Settings** **-** **Medically Appropriate and Cost-Effective** **(§§ 438.16(d), 457.1201(e))**	(1) States are required to include the following information for each ILOS in managed care contracts: • The name and definition of each ILOS. • The state plan covered service for which the ILOS has been determined to be a medically appropriate and cost-effective substitute. • The clinically defined target population(s) for which the ILOS has been determined to be a medically appropriate and cost-effective substitute. • The process by which a licensed network or managed care plan staff provider uses to determine that an ILOS is medically appropriate for a specific enrollee. (2) States with a projected ILOS cost percentage above 1.5% of the capitation rate in a given managed care program are required to submit additional documentation on the process used to determine that each ILOS is medically appropriate and cost-effective.	CHA did not comment on this provision.	The first rating period beginning on or after Sept. 9, 2024.

Medicaid Managed Care **-** **In Lieu of Services and Settings** **-** **Retrospective Evaluation** **(§§ 438.16(e), 457.1201(e))**	(1) States with a final ILOS cost percentage exceeding 1.5% are required to conduct a retrospective evaluation of their ILOSs. • States must complete a separate evaluation for each managed care program that includes one or more ILOSs and assess the impact and effectiveness of each individual ILOS. • The evaluation must be based on the five most recent years of accurate and validated data for each ILOS. • The evaluation would cover costs, utilization, access, quality of care, health equity, and grievances and appeals.	CHA did not comment on this provision.	The first rating period beginning on or after Sept. 9, 2024.
Medicaid Managed Care **-** **In Lieu of Services and Settings** **-** **State and CMS Oversight** **(§§ 438.16(e), 457.1201(e))**	(1) States are required to notify CMS within 30 calendar days if it identifies an area of non-compliance in the provision of ILOS, or if the service was no longer determined to be medically appropriate or cost-effective. • CMS is permitted to terminate the use of an ILOS if it is deemed noncompliant by CMS or through state notification. • The state is required to submit an ILOS transition plan to CMS for review and approval within 30 days after the decision to terminate an ILOS. The state must include a process for notifying enrollees of any changes to ILOS offerings and developing a transition of care to other state plan services. • If an ILOS is terminated, states are required to remove the ILOS from the contract and submit an updated contract to CMS for review and approval.	CHA did not comment on this provision.	The first rating period beginning on or after Sept. 9, 2024.
Medicaid Managed Care – Quality Assessment and Performance Improvement Program, State Quality Strategies and External Quality Review (Quality Assessment and Review)			
Medicaid Managed Care **-** **Quality Assessment and Review** **-** **Quality Assessment and Performance Improvement Program** **(§ 438.330)**	CMS permits managed care plans that exclusively serve dual eligibles to substitute a Medicare Advantage (MA) plan's Quality Improvement Project (QIP) in the place of a Medicaid Performance Improvement Project (PIP). • This is meant to streamline state requirements for the Quality Assessment and Performance Improvement (QAPI) program.	CHA did not comment on this provision.	Beginning on Jul 9, 2024.

Medicaid Managed Care **-** **Quality Assessment and Review** **-** **Managed Care State Quality Strategies** **(§§ 438.340, 457.1240**	(1) States are required to make their quality strategy available for public comment at the 3-year renewal, regardless of whether or not the state intends to make significant changes, as well as whenever significant changes are made. (2) State Medicaid agencies are required to post the results of the 3-year review to their websites. (3) States are required to submit a copy of their revised strategies to CMS at a minimum of every 3 years, prior to finalizing a revised or renewed quality strategy as final.	CHA supported this provision. We also encouraged CMS to pose requirements for states to include pediatric-specific measures in their written quality strategies.	States must comply no later than Jul. 9, 2025.
Medicaid Managed Care **-** **Quality Assessment and Review** **-** **External Quality Review** **(§§ 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250)**	CMS made the following changes to the External Quality Review (EQR): (1) Primary care case management (PCCM) entities are removed from the managed care entities subject to EQR requirements. (2) The 12-month review period is defined for all but one of the EQR-related activities. • EQR-related activities must be performed in the 12 months preceding the finalization and publication of the annual report. (3) A new optional EQR activity is added to assist in evaluations of quality strategies, SDPs, and ILOSs, that pertain to outcomes, quality, or access to health care services. • CMS will develop a protocol for this optional activity.	CHA did not comment on this provision.	Beginning on Jul 9, 2024.

Medicaid Managed Care **-** **Quality Assessment and Review** **-** **External Quality Review Results** **(§ 438.364)**	(1) States are required to include the following information in their EQR technical reports: • Any outcomes data and results from quantitative assessment for the applicable EQR activities in addition to whether or not the data has been validated. • Similar data from the mandatory network adequacy validation activity. CMS plans to release an updated EQR protocol to implement these changes.	CHA did not comment on this provision.	(1) Beginning one year after CMS releases the updated protocol.
	(2) States must notify CMS within 14 calendar days of posting their EQR technical reports to their website.		(2) Beginning on Jul. 9, 2024.
	(3) States are required to maintain at least 5 years of EQR technical reports on their websites. (4) CMS is considering releasing guidance regarding the stratification of performance measures in EQR reports, to improve monitoring disparities and addressing health equity gaps.		(3) States must comply no later than Dec. 31, 2025.

Medicaid Managed Care – Medicaid Managed Care Quality Rating System (MAC QRS)			
Medicaid Managed Care **-** **MAC QRS** **-** **Establishing and Modifying a Mandatory Measure Set for MAC QRS** **(§§ 438.334(b), 438.510, 457.1240(d))**	(1) CMS is continuing the requirement for the MAC QRS framework to align, where feasible, with the quality rating systems for QHPs, Medicare Advantage and Part D plans, and other related CMS quality rating approaches. *Mandatory Measure Sets.* (2) States must include the 18 mandatory measures listed by CMS (Table 1) in their Medicaid and CHIP quality rating systems. Measures included in the mandatory set have to meet the following criteria: • Usefulness to beneficiaries • Alignment (with principles of existing quality reporting programs) • Relevance • Actionability • Feasibility (including provider and state burden) • Scientific Acceptability To be included, measures must meet 5 out of these 6 criteria.	CHA supported CMS' efforts to align Medicaid managed care quality rating systems with those of marketplace plans. We also commended CMS for including pediatric measures in the mandatory measure set. We raised concerns with the asthma medication ratio (AMR) measure and encouraged CMS to consider an alternative measure.	(1) and (2) Beginning on Jul. 9, 2024.
	Subregulatory Process to Update Mandatory Measure Set. (3) CMS implements a two-step process: • CMS will engage with states and other interested parties to evaluate the current mandatory measure set and make recommendations to add, remove, or update existing measures. • CMS will provide public notice of changes and allow states and others to comment through letters or other written guidance.		(3) CMS anticipates this biennial process beginning in 2029.
	Finalization and Display of Mandatory Measures and Updates. (4) CMS will communicate modifications to the mandatory measure set and the timeline states would be given to implement modifications to the mandatory measure set in the annual technical resource manual.		(4) CMS will release the first technical resource manual in 2027.

Medicaid Managed Care **-** **MAC QRS** **-** **MAC QRS Methodology** **(§§ 438.334(d), 438.515, 457.1240(d))**	(1) States are required to collect the data necessary to calculate quality ratings for mandatory measures from their contracted managed care plans and, as applicable and available without undue burden, the state's Medicaid fee-for-service program and Medicare. • Excludes managed care plans with less than 500 enrollees. • If all necessary data cannot be provided by the managed care plans for the measures, states are required to collect available data from the state's Medicaid fee-for-service (FFS) program and Medicare program (including Medicare Advantage plans). (2) States are required to calculate, for each mandatory measure, a measure performance rate for each managed care plan whose contract includes a service or action being assessed by the measure, as determined by the state. (3) States are required to issue for each managed care plan a quality rating for each mandatory measure for which the managed care plan is accountable. • States must calculate quality ratings at the plan level by program. • States that offer multiple managed care programs must calculate plan level ratings for each managed care plan participating in a single managed care program using only the service data of beneficiaries enrolled in that managed care plan under that managed care program. *CMS notes that states are able to receive an enhanced match for assistance with quality ratings of managed care organizations performed by an EQRO, under the external quality review optional activity.	CHA did not comment on this provision.	Beginning on Jul. 9, 2024.

Medicaid Managed Care **-** **MAC QRS** **-** **MAC QRS Website Display** **(§§ 438.334(e), 438.520, 457.1240(d))**	States are required to establish a website to describe the MAC QRS and include the following information on their websites: • Clear information that is understandable and usable for navigating a MAC QRS website. • Interactive features that allow users to tailor specific information, such as formulary, provider directory, and quality ratings based on their entered data. • Standardized information so that users can compare managed care programs and plans, based on identified information. This includes information on whether access to benefits requires prior authorization from the plan. • Information that promotes beneficiary understanding of and trust in the displayed quality ratings, such as data collection timeframes and validation confirmation. • Access to Medicaid and CHIP enrollment and eligibility information, either directly on the website or through external resources.	CHA did not comment on this provision.	CMS will specify an effective date, which will be no earlier than 2 years after the implementation date for the quality rating system.
Medicaid Managed Care **-** **MAC QRS** **-** **Alternative Quality Rating System** **(§§ 438.334(c), 438.525, 457.1240(d))**	CMS further defines the criteria and process for determining if an alternative QRS system is substantially comparable to the MAC QRS methodology. • Includes the information that states must submit as part of their request to implement an alternative QRS applicable to both Medicaid and CHIP.	CHA did not comment on this provision.	Beginning on Jul. 9, 2024.

Medicaid Managed Care **-** **MAC QRS** **-** **Reporting** **(§§ 438.334, 438.535, 457.1240(d))**	States are required to report information on their MAC QRS. Information would include a list of all measures included in the state's MAC QRS: • Identification of mandatory measures that are not included in the MAC QRS due to not being applicable; • an explanation for why certain measures are not applicable; • identification of which applicable measures are for which managed care plans; • attestation that quality ratings for all mandatory measures were calculated and issued in compliance with regulation; • description of and required documentation for any additional quality measures; • data on which the state publishes or updates their quality ratings; a link to the state's MAC QRS website; • use of any technical specification adjustments to MAC QRS mandatory measures; • and a summary of each alternative QRS approved by CMS and their effective dates. States do not have report this information any more frequently than annually.	CHA did not comment on this provision.	Beginning on Jul. 9, 2024.

Table 1. MAC QRS Mandatory Measure Set

NQF#	Measure Steward	Name of Measure
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
0004	NCQA	Initiation and Engagement of Substance Use Disorder (SUD) Treatment
0418	CMS	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CDF)
3489	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)
1392	NCQA	Well-Child Visits in the First 30 Months of Life (W30)
1516	NCQA	Child and Adolescent Well-Care Visits (WCV)
2372	NCQA	Breast Cancer Screening (BCS)
0032	NCQA	Cervical Cancer Screening (CCS)
0034	NCQA	Colorectal Cancer Screening (COL)
2517	DQA	Oral Evaluation, Dental Services (OEV)
2902	OPA	Contraceptive Care - Postpartum Women (CCP)
1517	NCQA	Prenatal and Postpartum Care (PPC)
0575/0059	NCQA	Hemoglobin A1c Control for Patients with Diabetes (HBD)
1800	NCQA	Asthma Medication Ratio (AMR)
0018	NCQA	Controlling High Blood Pressure (CBP)
0006	AHRQ	CAHPS – How people rated their health plan
0006	AHRQ	CAHPS – Getting care quickly
0006	AHRQ	CAHPS – Getting needed care
0006	AHRQ	CAHPS – How well doctors communicate
0006	AHRQ	CAHPS – Health plan customer service