[Jenn Gordon] Hello, everyone.

My name is Jenn Gordan. I'm a researcher at Mathematica. I'm pleased to welcome you to the webinar on the "Medicaid Program and Children's Health Insurance Program Quality Rating System: Notice of Proposed Rulemaking."

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Before we get started today, we wanted to cover a few technical instructions.

Closed captioning is available in the WebEx platform. To enable closed captioning, click on the "CC" icon in the lower-left corner of your screen. You can also click Ctrl+Shift+A on your keyboard to enable closed captioning.

With that, I will hand it over to Amanda Paige Burns to get us started.

[Amanda Paige Burns] Hi and welcome.

Today I will be providing an overview of the recently-released Proposed Rule for the Medicaid and CHIP Quality Rating System, which we refer to as the MAC QRS.

Before we start today, I want to note that we will not have an opportunity for Q&A given that the Proposed Rule is still out for public comment.

However, we strongly encourage you to submit suggestions, questions, and comments by the deadline on July 3rd. We (inaudible) extensively (inaudible) input (inaudible) interested parties throughout the drafting of the MAC QRS Proposed Rule, and we are eager to receive your comments and continue to refine the proposed policies.

You can access the Proposed Rule through the www.federalregister.gov website, and comments can be submitted at www.regulations.gov. Also very importantly, the slides we see today will be available on www.Medicaid.gov in the near future.

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So let's dive in. During today's webinar, we will provide background information on the MAC QRS; and we'll describe the proposed MAC QRS provisions and implementation guidelines.

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The MAC QRS Proposed Rule would require states to publish a website that displays measures of managed care plan quality identified by beneficiaries. Currently, managed care is the dominant delivery system in the Medicaid and Children's Health Insurance Program. As of January of this year, Medicaid and CHIP cover more than 93 million children/adults; and the majority of the individuals are enrolled in a type of managed care.

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This current Proposed Rule is our third cycle of rulemaking for the MAC QRS. Two previous Final Rules were published in 2016 and then in 2021. In this previous rulemaking, we established our authority to require states to operate a MAC QRS that would include public posting of quality ratings for managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans contracted by the State to provide Medicaid or CHIP services.

Second, we established that CMS would develop a MAC QRS framework in consultation with states and others that includes quality measures and a methodology for capturing quality ratings for those measures.

Third, we established that states would have the option to use the CMS-developed framework or establish an alternative QRS subject to our approval.

Finally, we established that states would have three years to implement a MAC QRS.

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In previous rulemaking, we also established three policy goals for the MAC QRS that further CMS's goals to provide access to high-quality care and improve health for Medicaid and CHIP beneficiaries. These include to hold states and plans accountable for the care provided to Medicaid and CHIP beneficiaries, to empower beneficiaries with useful information about the plans available to them, and to provide a tool for states to drive improvements in plan performance and the quality of care provided by their program.

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When we started working on the design of the MAC QRS, our driving focus was to identify what is desirable to the individuals that we serve through the Medicaid and CHIP programs. That is, we wanted to empower beneficiaries with useful information; and so we needed to know what was actually useful. We wanted to know how beneficiaries went about selecting a health plan, what was important to them, and what a quality health plan meant to them. We also wanted to know what is feasible and viable for states to implement and which of the beneficiary identified quality measures could help plans actually improve upon.

So we started our work with a lot of listening. In the past four years, we used a number of forums to consult with interested parties on a wide range of topics including current state quality measure collections and reporting efforts, as well as needs and preferences related to the selection of a health plan as (inaudible) by beneficiaries. Through these consultations, we were able to learn from over 800 individuals who participated in beneficiary interviews, work group meetings, listening sessions, user (inaudible) of the MAC QRS prototype, and in-depth interviews with participants from State Medicaid programs, managed care plans, and EQROs.

We engaged in an iterative practice of listening, reflecting on what we heard, then going back to see if what we heard reflected what was actually said. By repeating this process, the intersection of what is desirable to beneficiaries and feasible and viable for states to implement became clearer and clearer. If you were one of the individuals that participated in these consultations, our team would like to say thank you. The proposals that we are presenting today are the end result of this process and the ideas, questions, feedback, and concerns that you shared.

You'll hear me say this several times today, but we strongly encourage you to submit comments on our proposals so that we can continue our process of listening and reflecting.

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So let's get to the proposed provisions.

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You'll see here the topics that we will touch on today starting with the general rules and timelines.

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The current proposed rules (inaudible) in several ways.

First, our proposed rules would apply the proposed revisions to applicable managed care plans which would include the MCOs, PIPS, PAPS, specified in previous rulemaking; but we have proposed to exclude some contracts between states and Medicare Advantage Duel Eligible Special Needs Plans or DESNP.

Second, our previous rulemaking required us to develop a MAC QRS framework that aligns where appropriate with the measures and methodology of similar CMS programs and approaches. Under this proposed rule, we are proposing to require continued alignment where appropriate as part of CMS's framework of the MAC QRS framework over time.

Additionally, to provide states more time to make the operational and contractual changes necessary to meet the requirements in the Proposed Rule and also to give states flexibility to determine what time of year to publish their quality ratings, we are proposing to increase the time states have to implement a MAC QRS from three to four years. We are also proposing additional time beyond this four years to implement certain MAC QRS display features, and we'll talk about those later.

Finally, we are proposing that states must use their existing beneficiary support systems to help beneficiaries and enrollees seeking assistance using the state's MAC QRS. As you consider drafting comments on the rules, we are particularly interested in your feedback on the implementation timeline and whether the extension addresses the process that states would need to engage in to implement a MAC QRS.

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The majority of this Proposed Rule is focused on establishing the MAC QRS framework that we identified in our previous rulemaking. The next two slides will review the provisions related to the three proposed components of the MAC QRS framework. These include a set of mandatory measures that must be developed/displayed in a state's MAC QRS, a rating methodology used to calculate quality ratings for mandatory measures, and a website display with mandatory information and features which would be implemented in two phases.

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The quality measures that will be displayed in the MAC QRS are, of course, essential piece of a Quality Rating System. But in addition to the proposed mandatory measures, we are also proposing a process to how CMS would update the measure set, such as how measures would be added, removed, or updated; standards that would be applied to determine when a measure may be added or removed; and then also a practice for communicating any updates that result from the proposed process. We'll go by these one-by-one over the next couple of slides.

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In previous rulemaking, we established that states must include mandatory measures in their MAC QRS regardless of whether a state uses the MAC QRS framework *or* a CMS-approved alternative to MAC QRS. In this slide, you will see 18 proposed measures that represent the collective input we received during the several years of consultation with states, plans, beneficiaries, and other interested parties.

The Proposed Measure Set can be found in the Proposed Rule on page 28187. These proposed mandatory measures reflect a wide range of preventative and chronic care measures representative of Medicaid and CHIP beneficiaries as well as their experience of care. These measures were identified through extensive conversations with states, health plans, beneficiaries, and others.

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To ensure that the mandatory measures set continues to keep pace with changes in the quality field and to align with user preference, we are proposing that we would undergo a robust, two-step, subregulatory process that applies substantive regulatory standards to govern most changes to the mandatory set. This process would require extensive input from interested parties prior to finalizing certain types of changes to the mandatory set.

Under our proposal, CMS would start to engage with states and other interested parties to evaluate the current measure set and then make recommendations to add, remove, or update existing measures. We envision that these recommendations could be identified through forums such as a public work group, smaller meetings with interested parties, or publication of a Request for Information.

In the second step, CMS would provide notice and opportunity to comment through a Call Letter or similar subregulatory process that would identify the mandatory measures suggested for addition, removal, or updating following the public engagement step.

Our proposed process shares similarities with a qualified plan Quality Rating System which uses a Call Letter process to gather feedback on measure updates. It also aligns with the Core Sets Work group that convenes annually to develop a set of recommendations for changes to the Core Sets, which are subsequently posted for public comment; and then both the recommendations and public comments are used by CMS to finalize updates.

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Three distinct considerations were consistently raised throughout our engagement on the Mandatory Measure Set. These considerations were fundamental to identifying a concise set of MAC QRS measures, and we are therefore proposing to codify these considerations as standards that we would apply in the future to determine when to add measures to the mandatory set, when to make substantive updates to an existing mandatory measure, and in some circumstances when to remove a measure from the mandatory set.

Under our proposal, a measure would be added to the mandatory set if all three standards are met. The first standard would establish inclusion criteria. As we discussed potential measures, six themes emerged as inclusion criteria. These criteria are similar to the measure selecting criteria identified for the Medicare Advantage and (inaudible) Quality Rating System as well as the Core Sets. These include usefulness to beneficiaries; alignment with other federal or state reporting programs; relevant to identified health plan performance areas; actionability by managed care plans; feasibility of calculating the measure; and

Under our proposal, the measure would need to meet at least five of the six criteria to be considered for inclusion. We are requesting comment on these inclusion criteria, but we also want to note at that time we are requesting comment on how we have applied them to the proposed measure set. You'll find a more detailed description of these criteria and how each were assessed on page 28185 of the Proposed Rule.

For the second and third standards, in order to ensure that the MAC QRS Measure Set remains concise, we are proposing these two additional standards that will provide a process to identify further distinctions among measures that meet our inclusion criteria.

When considering whether an individual measure would be added to the mandatory set, our second proposed standard would require consideration of how the measure would impact the overall balance of representation within the existing measure set.

The third proposed standard would consider the burdens and benefits to the overall QRS framework of including the new measures. To determine whether a measure meets these standards, CMS would use available information, including input and information gathered through both sets of the subregulatory process.

On page 28,193 of the Proposed Rule, we provide an example of how we assess two measures for adherence to these standards, and I'm going to walk you through these now.

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In this example, we will take a look at two measures, Follow-up After ED Visit for Mental Illness (or FUM) or Follow-up After Hospitalization for Mental Illness (or FUH). Both of these measures were identified during their consultations as potential mandatory measures.

On the left, you will see the six standards we are proposing as inclusion criteria. Then you can see here that each measure was assessed for these six proposed inclusion criteria. Using the information available to us and information shared during our consultations, we identified that both of these measures meet all six of our inclusion criteria; and they would therefore meet the requirements of Standard 1.

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We then turn to apply Standards 2 and 3 to help further distinguish between the two measures. Under our proposed second standard, we would determine whether the measure contributes to balanced representation of beneficiary subpopulation, age groups, health conditions, services, and performance areas within a concise mandatory measure set.

To assess this standard, we would consider each suggested measure in relation to *other* suggested measures *and* the overall mandatory measure set in order to identify those that are very similar or duplicative, keeping in mind the need for a mandatory measure set that is both representative and concise.

Based on their consultations, we identified that the initial mandatory measure set should be limited to fewer than 20 measures. As both of these measures focus on assessing follow-up care for mental illness, it was concluded that including only one of the two measures would best maintain balanced representation within the overall measure set and within the behavioral health performance area.

Under the proposed third standard, we would ensure that the burdens do not outweigh the benefits to the overall metric framework if the measure was added to the mandatory set. To assess this standard, we would compare similar measures, so those suggested for inclusion, which measured performance within similar subpopulations of beneficiaries, health conditions, services, and performance areas, as well as the extent to which a contemplated new measure meets our inclusion criteria.

These two measures are similar in that they measure similar services *and* performance areas. We found that both measures had similar benefits and burdens but determined that the FUH measure had more benefits as it was more commonly collected or reported by both the State and Federal level, which is part of the alignment criteria and were frequently used by states to assess performance plans, which aligns with the actionability criteria. We therefore chose to include the FUH measure in the proposed mandatory set.

I hope these examples have been helpful. Again, the examples I just provided are also described in the Proposed Rule. I'll reiterate that we are seeking feedback not only on the proposed three standards but also how are proposing to assess measures for whether they meet these standards.

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This rule also proposes the circumstances under which CMS may remove or update existing measures in the mandatory measure set. We are proposing that CMS could remove existing mandatory measures if after following the subregulatory process CMS determines that the measure no longer meets each of the three measure standards *or* outside of that subregulatory process CMS could remove a measure under the three circumstances listed here.

Updates to existing measures may occur when the measure steward of a measure makes changes to the technical specifications for the measures. When these changes are non-substantive, such as changes that clarify instructions to identify services or procedures, CMS could update changes for the technical specifications. However, substantive updates such as a major change to how a measure is calculated could be adopted only after following the subregulatory process.

These proposed criteria for removing measures outside the subregulatory process align with the current regulations governing the Medicare Advantage and Part D Quality Ratings.

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We are proposing that any modifications to the mandatory measures set would be finalized in a technical resource manual published annually by CMS. This resource manual would also specify the timelines for State implementation of *any* finalized modifications. We are proposing that for new or substantively updated measures CMS would provide each state with at least two calendar years to display the new or updated measure. However, a state could elect to display the readings for a new mandatory measure sooner.

The technical resource manual would be published annually; but I want to highlight here that under our proposal, the subregulatory process would occur on a biannual basis, so every other year.

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The second component of the proposed MAC QRS framework is the MAC QRS methodology. On this slide, you will see the various pieces that make up the proposed MAC QRS methodology, including rules related to data collection, data validation, and calculating and issuing quality ratings.

During our consultations with the (inaudible) beneficiaries, states expressed concerns about the burden associated with data collection and quality rating calculations. While benefits are a desired transparent representative quality ratings. In developing the MAC QRS methodology, we sought to balance these two often competing preferences while ensuring that quality ratings remain comparable within and out of states.

In terms of data collection, we are proposing that states must collect the data necessary to calculate quality ratings for mandatory measures from their contracted managed care plans, which may also include data from Medicare and the State Fee-For-Service Program. We believe that the collection of data from these other sources is necessary to ensure that all mandatory measures are reported in each state, regardless of the way in which the state has chosen to structure its Medicaid program.

To reduce burden, we are proposing that states must collect data *only* for those managed care plans with 500 or more enrollees. However, states could choose to include plans with fewer than 500 enrollees; and we would encourage states to do so when appropriate and feasible.

Once the necessary data are collected to calculate quality ratings for each mandatory measure, we are proposing that states would be required to ensure that all collected data are validated. States may use the current optional activity under EQR for which enhanced matching may be available for Medicaid EQR activities performed by MCOs to assist with the calculation and validation of data used to generate quality ratings for the MAC QRS.

States would then use the validated data to calculate performance rates for managed care plans. This would require states to calculate for each mandatory measure a measure performance rate for each Medicare plan whose contract includes a service for action being assessed by the measure as determined by the State. Once calculated, states would issue quality ratings for each individual measure as an individual percentage rating.

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In the Proposed Rule, we provide an example of how a state may determine whether a managed care plan's contract includes a service or action being assessed by the measure. We'll walk through this example because I think it will be helpful in understanding this piece of the methodology. To do this, we will again use the Follow-up-Up after Hospitalization for Mental Illness measure, which is one of the measures proposed in our mandatory measure set.

The FUH measure assesses the percentage of inpatient discharges for a diagnosis of mental illness for intentional self-harm that resulted in follow-up care with a mental health provider within 7 and 30 days. To calculate this measure, a state would need both inpatient hospitalization data and mental health service data. As you know, states have flexibility to arrange their Medicaid programs; and that flexibility is a wonderful thing, but that flexibility can sometimes make things a bit complicated.

For our purposes here, the complication is that some states may offer inpatient and mental health services through a single program with both services provided by a single plan while others may offer their services through different programs, which may therefore be provided by different plans.

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To help navigate this situation, we are proposing a way for states to identify the plan that should be issued a quality rating regardless of how the state has structured their Medicaid program. Under this proposal, states would issue a rating to each managed care plan whose contract includes a service or action assessed by the measure as determined by the state.

In a state where a single program provides both inpatient and behavioral health service, this choice is pretty simple. There is really just one option.

However, in a state that offers these services through different programs, the state would need to determine which plans should be issued a quality rating for the FUH measure.

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In that situation, the state would need to go through these three steps. First, they would need to determine the service or action assessed by the measure. So for FUH, the state would need to determine is this measure assessing the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm? Is it assessing the provision of timely follow-up care by a mental health provider? Or is it assessing both?

For this example, we'll say that the state determines that the FUH measure is assessing timely follow-up with a mental health provider. Once a state determines which service or action is being assessed by the measure, the state would then be able to identify the plans who should be issued a quality rating by identifying the plans whose contract includes that service or action.

In our example, behavioral health services are offered through a separate program; and it's likely that the plans that provide care through this program are contracted to provide the follow-up care for mental illness assessed by the measure. Of course once the plans are identified, the state would issue quality ratings for FUH to these plans.

With this proposal, we want to consider what is fair to the plans; and we recognize that states are in the best position to determine which plans should receive a quality rating for each measure.

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The final component of the proposed MAC QRS framework is the website display. Our consultations and user testing revealed that the presentation of quality ratings greatly influences the usability and utility of the MAC QRS as a tool to assess beneficiaries in selecting a plan. During our user testing, it was clear that to truly empower beneficiaries as informed health care consumers, quality ratings are best presented as one part of a compensation website that efficiently guides the user through the considerations for identifying a quality health plan.

Our Proposed Rule establishes requirements for the MAC QRS website display which would be implemented in two phases with more interactive and resource-intensive features implemented in the second phase.

The first stage would be implemented by the end of the fourth year following the release of the Final Rule. . In this phase, states would develop the MAC QRS website; display quality ratings; and would ensure that users can access information on plan providers, drug coverage, and view quality ratings by sex, race, ethnicity, and dual eligibility status from the MAC QRS website.

In the second phase, states would be required to provide interactive tools on the website that allow users to compare plan formularies and networks and view quality ratings for measures stratified by additional factors identified by CMS. Implementation of the second phase would be required no earlier than six calendar years following a Final Rule, but states may implement one or more of these Phase 2 requirements during the initial phase.

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Given the visual nature of the proposed display requirements, we are providing additional resources on our MAC QRS website. These include two sample MAC QRS website prototypes, which are intended to illustrate an example of how states may choose to comply with the minimum proposed website display requirements in the two phases of website implementation.

I want to emphasize again that these are examples. The prototypes are *not* meant to show how a state *must* implement a proposed display requirement.

You will also find a video walk-through of both prototypes and a citation that assists users in locating where in each prototype a proposed display requirement is illustrated. Our intent in providing these resources is to help visualize the display requirements that we are proposing. Both prototypes reflect the prototype that was developed over the course of several cycles of user testing with beneficiaries and their caregivers.

As we developed these display requirements, we noticed that using the prototype as a visual helped clarify the ultimate vision behind the proposed requirements, and we hope that these help you in writing your comments on the proposed display requirements.

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On this slide, you can see a screenshot from both of the prototypes. I know it's really small, so that's why you should go to our website. On the left is Prototype A, which is meant to illustrate the minimum display requirements for Phase 1. Then on the right is a screenshot from Prototype B, which is meant to illustrate the minimum display requirements on Phase 2.

A little bit on how to use these prototypes – and, again, the video (inaudible) that I mentioned will help you with this as well.

On the right, you see a gray box. This box lists the regulatory requirements that are displayed on the page; that is, the proposed regulatory requirements that is displayed on the page. Each of those proposed regulatory requirements is assigned a number.

Each of the red dots that you see on the page indicate a display requirement, and each of these dots is also numbered. So if you see a red dot with a number 4, that means that that dot is showing an example of how the regulatory requirement with the same number could be displayed.

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Our previous rulemaking establishes states must adopt the QRS framework identified by CMS or an alternative QRS approved by CMS. This previous rulemaking requires states to obtain CMS approval to adopt either an alternative methodology *or* to display measures not included in the mandatory measure set.

To implement an alternative QRS, states are required to include mandatory measures identified by CMS. The alternative QRS must generate ratings that yield information regarding managed care plan performance which, to the extent feasible, is substantially comparable to that yielded by the CMS methodology and must be approved by CMS prior to implementation or modification to an existing alternative QRS previously approved by us.

In this Proposed Rule, we are proposing to remove the current requirement that states must obtain CMS approval to display quality ratings for additional measures not included in the mandatory set. Under this proposal, states would need to seek CMS approval *only* when they would like to adopt a methodology that differs from the one proposed by CMS.

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Finally, in this Proposed Rule we are also proposing that CMS will develop a MAC QRS technical resource manual no later than August 1st of 2025 and would update this technical resource manual annually thereafter. Additionally, upon request states would be required to submit certain information to CMS on their MAC QRS.

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Now we'll walk through the implementation time frame for the MAC QRS. First of all, I want to note that this time line assumes that the MAC QRS Final Rule is issued in 2024l but clearly, the year (inaudible) to change based on when the Final Rule is actually published.

So as you see here, the first yellow bar – this is the time duration that states have to implement the MAC QRS itself. So by December 31st of 2028, each state would need to implement a MAC QRS. Then, in the next phase related to the website or going to the website display requirements, this is also the phase in which the first phase of website display requirements would be required to be implemented.

During this phase, states should choose to implement one or more of the Phase 2 website display requirements; but states will not be required to implement those display requirements until at least two years after that initial phase of implementation. So in total, that would be six years following the Final Rule.

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I keep coming back to this. This is again the link for the proposed Rule. There's a lot of information and other examples in the Proposed Rule that we didn't go over today, so please take a look. Also, take a look at the website display prototypes. We really wanted to help you understand what it was that we were proposing, and we think that those will really help.

Again, you can submit your comments through Regulations.gov. I hope in this presentation I conveyed how important your feedback has been to our team and that we really want to hear from you. So please definitely submit our thoughts and comments, and I can promise that I will personally read each and every one of those. So please follow that link to Regulations.gov.