

HHS-CMS-CMCS

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Coordinator: Welcome and thank you for standing by. At this time, I'd like to inform all participants that today's call is being recorded. If you have any objections, you may disconnect at this time. All lines have been placed in a listen only mode for the duration of today's conference. I would now like to turn the call over to Miss Jackie Glaze. Thank you. Ma'am you may begin.

Jackie Glaze: Thank you and good afternoon, and welcome everyone to today's all state call webinar. I'll now turn to Anne Marie Costello, our Deputy Center Director, for opening remarks. Anne Marie.

Anne Marie Costello: Thanks, Jackie. And hi everyone. And welcome to today's all state call. We're dedicating most of today's call to discuss the two notices of proposed rulemaking that were released on April 27th. The first is ensuring access to Medicaid services or what we fondly refer to as the access NPRM. And then the second is the managed care access, finance, and quality, or what we refer to as the managed care NPRM. Together, these rules proposed to further strengthen access to quality of care across Medicaid and the Children's Health Insurance Program.

But before we get into the access to managed care NPRMs, I have one quick reminder. As the date of the end of the public health emergency approaches and states are making decisions about whether to continue home community based services flexibilities implemented under Appendix K, we are making a last call for all new Appendix K submissions. We strongly encourage states to have final Appendix K submissions sent to CMS by July 11, 2023, which is two months after the end of the public health emergency.

Our team is happy to provide you with any technical assistance you might need and to approve the Appendix K as quickly as possible. Our goal for requesting final submissions by July 11th, is to provide you with maximum support and resources and unwinding HCBS flexibilities, and amending HCBS waivers to continue relevant Appendix K provisions.

Now I'm pleased to introduce Karen Llanos from our Medicaid Innovation Accelerator Program; Jeremy Silanskis, from our Financial Management Group; Jen Bowdoin from our Disabled and Elderly Health Programs Group; John Giles, from our Managed Care Division; and Carlye Burd from the Children and Adult Health Programs Group, who will present the new access to managed care NPRM.

Before we get started, we will be using the webinar platform today. If you are not already logged in, I suggest you do so now, so that you can see the slides for today's presentation. You can also submit any questions you have into the chat at any time during the presentation. Just as a reminder, we are doing today's presentation on the NPRM, to provide you with an overview of the rules. Any comments you have should be submitted as outlined in the NPRM, no later than July 3rd. With that, I'll turn things over to Karen Yarrick, to get today's presentation started. Karen.

Karen Llanos: Thanks, Anne Marie. Next slide please. So we are really excited to speak with all of you about our newly released NPRMs. And the way that we're going to spend the next 40 or so minutes, is to give you a little bit of an overview of some of the key provisions in there. And I will just say that we have fact sheets and a press release, that all contain the type of information that is summarized here today as well.

So the way that we're going to split our time is I'll give you a very high level overview of some key points to be aware of across the two NPRMs. As Ann Marie said, we have two ensuring access to Medicaid services and managed care access, finance, and equality. And many of these provisions tie into CMS's access strategy. So I'll spend a little bit of time just giving you some background on how these connect. We'll do a deep dive into how each of the NPRMs fit into, or enhances access, across our Medicaid and CHIP populations.

And then in addition to that, we have provisions in the managed care NPRM that go beyond the topic of access. And you'll hear about those two. And lastly, we'll follow it up with some questions and answers. Next slide. So as Anne Marie said, we recently released these two NPRMs not too long ago, last Thursday, April 27th. We feel that these NPRMs really tie into the administration's efforts to advance really groundbreaking solutions to ensure access to our Medicaid and CHIP services for Medicaid beneficiaries.

If adopted, as proposed, these rules would establish, and you'll hear more about these national standards for access to care, whether or not care is provided in managed care or by states and fee for service. And this is really one of the components that we'll talk a lot about today, which is how we really try to approach this in a more comprehensive way. I'm sure many of you are wondering about the effective dates. So because these are very complex

NPRMs, there are a lot of effective dates, as you can imagine. So we wanted to just note the range.

So we've got 60 days to four years in general. However, there are proposed stratifications of certain HCBS quality measures that are phased in over seven years. Across our teams at CMCS, we also really took into account the burden of unwinding and how all of this could take into account. So many of our NPRM provisions seek comment on the proposed implementation timelines as well. Next slide please.

So I'm going to take a high level pass at these key provisions. As I said, we have fact sheets in addition to an overview fact sheet that includes all of these bullets. So I just want to level set there in case you are wanting additional detail. We'll also cover many of these topics in greater detail on our webinar today. So within the managed care NPRM we are establishing national maximum standards for certain appointment times for Medicaid and CHIP managed care and enrollees.

In addition to that, we're requiring states to conduct independent secret shopper surveys for their Medicaid or CHIP managed care plans, to verify compliance with those wait time standards, and to identify where provider directories are inaccurate. Next, we delve into transparency. And we have provisions that look at creating new payment transparency requirements for states, by requiring disclosure of provider payment rates and a comparison to Medicare rates for certain services. And we have those in both the fee for service and managed care portions of our NPRM.

Next, we establish requirements for transparency in an interested party or stakeholder's group for setting Medicaid payment rates, and that's within fee for service. We also have a requirement that at least 80% of Medicaid

payments for personal care, homemaker, and home health aid services, be spent on compensation for direct care workers. And you'll hear more about that when we cover the HCBS provisions. Finally, under HCBS - next slide, please, you'll hear about timeliness of access measures for HCBS as the way to strengthen necessary safeguards, to ensure beneficiary health and welfare as well as to promote health equity.

And you'll see health equity reflected across both of these NPRMs. Finally, the last section that I wanted to highlight, is the way that we're empowering and/or engaging the beneficiary voice. You'll hear me talk later about how we're using, proposing to use the medical care advisory committee in a different way; where we strengthen a way for stakeholders to provide guidance to Medicaid agencies about health and medical services.

And we talk about how we would restructure how our proposed policies would restructure this committee in a way that would really take into account the experience of Medicaid beneficiaries, or their caretakers, and other interested parties and stakeholders. You'll also hear today about proposals within the managed care NPRM, to require states to conduct and enroll experience surveys and Medicaid managed care annually, for each managed care plan.

And you'll also hear about requirements to establish a framework for states to implement a Medicaid and CHIP quality rating system, or a one stop shop for enrollees is to compare Medicaid and CHIP managed care plans. So as I said, I covered a lot of different topics - our NPRMs cover a lot of ground, and we have lots of fact sheets in addition to the NPRMs, to help you navigate. Next slide, please.

So I wanted to spend a little bit of time about how these two NPRMs tie specifically to engage around access. Next slide. So just a very quick background on CMS's access strategy. We know that our Medicaid and CHIP program is strong and powerful and provides essential healthcare coverage for 92 million people. So it is very vital that we consider ways to enhance access for our beneficiaries. We also know that beneficiaries access their healthcare using managed care and fee for service delivery systems.

So we really want to propose regulations that look across both of these delivery systems in a more comprehensive way. In order to do that, we set two goals. This helps strengthen and improve the Medicaid and CHIP that looks at all aspects of access. And what I mean by that is, getting people into coverage, getting people access to care once they are covered. So our two goals are remove barriers to eligible people when enrolling and maintaining coverage, enrolling in and maintaining coverage, and second, ensure equitable access to Medicaid covered health care services and support.

And the way that we met these goals was through a three-pronged regulatory agenda. So we released earlier this last year, eligibility and enrollment NPRM, that hits that first goal of looking at how to support eligible people enrolling in and maintaining coverage. And these two NPRMs look at that second goal of how we can ensure equitable access to Medicaid and CHIP covered services and supports. Next slide.

So this is just a visual in terms of how these fit together. So the way that we're thinking about this is our three themes across our two NPRMs. So you'll hear about transparency and access monitoring and fee for service; and then you'll hear about how we can promote transparency and standardized reporting and enhanced accountability in home and community based services, or HCBS. I'll

talk a little bit about empowering the voice through the expanded medical care committee.

And these first three, A, B, C, are all related to ensuring access NPRMs, and then we will turn it over to the managed care NPRM team, that's going to talk a lot about how they're looking at ensuring access to care, how they are looking at quality based provider payments, and a range of quality improvement for managed care. Next slide.

So we will kick it off in that first NPRM area, which is ensuring access to Medicaid services. This notice of proposed rulemaking has three key areas. So we're going to hear from Jeremy Silanskis next. He's going to cover fee for service. Then we'll move to HCBS. And then we'll finish that NPRM up with the medical care advisory committee. And with that, I'll turn it over to Jeremy.

Jeremy Silanskis: Thank you, Karen. All right. Fee for service - so the overarching requirement for fee for service is in Section 1902.830(a), and essentially says that Medicaid rates have to be sufficient so that access and Medicaid is consistent with that available to a general population. And we, you know, we're invested here. We spend \$734 billion on Medicaid. So the federal government is invested; states are invested. But with that, we've always had trouble enforcing what a sufficient rate is in the program. And that's the primary motivator of this rulemaking.

We attempted to regulate on access to care. Back in 2015 we issued a notice of proposed rulemaking and a subsequent final rule. And that rule requires its own books, and access monitoring review plan which states we're to establish and then update every three years. And then when they reduced their rates, also update. And that was intended to demonstrate and support states' conclusion of sufficient access.

But with that publication, we received a lot of pushback from states, particularly states with high managed care, that the administrative burden associated with the requirements and the relative usefulness of the analysis, you know, it wasn't consistent enough to warrant what we were requiring in that rule. So we looked at what we were doing, and decided to rescind and replace with this new NPRM. Next slide, please.

So that's where we are right now. We are proposing to rescind and replace those 2015 AMRP requirements with a new set of regulatory requirements. And I'm going to go through this relatively quickly, because we have a lot to cover today. So please read the rule thoroughly. We welcome comments. Please do comment on the rule provisions. We would love to hear from you all. So I'm going to go through the four, you know, big area provisions that are in the proposed rule.

The first of which is that we would require states to benchmark and report the Medicaid base rates compared to Medicare rates. And that would be for primary care services, obstetrical and gynecological, and outpatient behavioral health services. And the way we would have states do this, is through a comparison of evaluation and management codes that are available both in Medicare and Medicaid programs, and to do so as a comparison to CPT and HCPC code level services, using the most available data from CMS, and to do so as a percentage comparison between Medicare and Medicaid.

In addition to that, we would have states publish the average hourly payments for certain HCBS services, which generally don't have equivalent Medicare coverage and payments. And so this would more so be a disclosure report where states would show us on an hourly basis, how they pay for certain HCBS. And again, the idea there is that folks would have information

available to them to see how Medicaid rates compare to Medicare, and then again, just the average hourly rate for those HCBS services.

The second major provision of the proposed fee for service requirement, is that states would establish advisory groups to advise and consult on the fee for service rates paid for personal care, home health aid, and homemaker services. And that advisory group would be made up of direct care workers, beneficiaries, beneficiary authorized representatives, and other interested parties.

That group would have information available to them furnished by the Medicaid agency, to know what the Medicaid rates are, and other data, to assess access to care. And they would meet every two years and make recommendations to the Medicaid agency on the sufficiency of direct care worker payment rates. The proposed rule would also have states publish all Medicaid fee for service rate schedules and have them publicly available and accessible on state Web sites. Most states already do this, but they come in a variety of forms; some are more easily accessed than others.

So we want to have everybody on the same footing and to have those publications in place no later than January 1, 2026. And finally, to replace the analysis that CMS would receive from states as part of rate reduction proposals, we would propose a two stage process that's really risk based, and based on the nature of a state's proposed rate reduction or restructuring. And those would largely be established based on a number of criteria.

One would be that the state would analyze its rates in comparison to Medicare. And if the rates are at or above 80% of Medicare then that would be one set of criteria. In addition, states would look at the rate reduction proposal. And if the result would be no more than 4% in aggregate spending for a

benefit category, that's the second tier of evaluative criteria. And then finally, we look at public processes and whether there were any concerns raised out of public processes around access to care as kind of the third evaluated criteria to understand the level of analysis that a state would be required to conduct.

And if all three of those things are met, then a state would provide assurance to us that there's consistency with 1902.830(a), they'd provide data and information to support that analysis, and we would go from there. If any of those criteria are not met those rate reductions would fall into a secondary review and analysis where we would specify certain data and metrics that states would need to submit to us through a format, and that we would evaluate to ensure that access to care is consistent with 1902.830(a).

And those measures indeed, are specified in the NPRM. Again, we ask folks to take a look at that and please comment on the feasibility and, you know, ideas that you have around that set of information. So those are the highlights of the fee for service provisions. And I am going to turn it over to Jen Bowdoin to talk about HCBS.

Jen Bowdoin: Next slide please. Thanks Jeremy and hi, everyone. This is Jen Bowdoin from the Disabled and Elderly Health Programs Group. So I am happy to talk with you all about the home and community based services or HCBS provisions, in the access proposed role. So as we discussed in the preamble to the proposed roles, these provisions focus on specific challenges related to HCBS. And among other things, these challenges include that workforce shortages are reducing access to HCBS and those workforce shortages are expected to worsen in the future.

That there is variation within across state incident management systems, and that this variation can result in a lack of oversight and intervention, to prevent

recurrence of negative outcomes. And that there are gaps in measurement and reporting that are hampering efforts to CMS and of states, to assess and improve HCBS quality and outcomes, and address racial and other disparities. Next slide, please.

So the HCBS provisions in the access proposed rule would essentially establish a new strategy for oversight monitoring, quality assurance, and quality improvement for HCBS programs. And just to note at the outset, that with certain exceptions the proposed requirements would apply to HCBS under Sections 1915(c), (i), (j), and (k) authorities, and to HCBS delivered under both fee for service and managed care.

So we have a number of (just in) provisions. I'm going to kind of roll through just kind of quickly, in the interest of time, but similar to Jeremy, would definitely encourage you to read the proposed rule and absolutely submit comments. Particularly we ask for a comment in a number of different areas, and we would be very interested to receive comments from a broad range of interested parties.

So we are first proposing to establish new reporting requirements in minimum performance standards related to person-centered planning and incident management systems in HCBS. We're also proposing to require states to establish grievance or complaint systems in their fee for service HCBS programs. And this is to ensure that Medicaid beneficiaries receiving HCBS through fee for service delivery systems, have the same opportunities as people enrolled in managed care delivery systems, to file complaints related to the states or providers' compliance with person-centered planning and service plan requirements, and with HCBS settings requirements.

Related to payment rates and compensation for direct care workers, in addition to the proposals related to HCBS in the fee for service provisions that Jeremy talked about, we are proposing to require that at least 80% of Medicaid payments for personal care, homemaker, and home health aid services, be spent on compensation for the direct care workforce as opposed to administrative overhead or profits. Next slide, please.

We're also proposing to require states to report on a number of different areas, including waiting lists in Section 1915(c) waiver programs. And this would include how states maintain their waiting lists, the number of people on their waiting lists, and the average amount of time that people newly enrolled in a waiver in the past year, were on the waiting list. We're also proposing to require states to report on access to personal care, homemaker, and home health aid services, including how long it took from when services were approved to when individuals began receiving services, and the percent of the authorized services that are provided annually.

And we're also proposing to require states to report on the standard set of HCBS quality measures. And this would include, as Karen mentioned, phased in requirements for states to stratify their data for certain measures by demographic and other factors, in order to assess disparities in advanced health equity. And then finally, we are proposing to promote public transparency by requiring states to publicly report the quality performance and compliance data that they would report to us. And CMS would also publicly report the data and information across all states. Next slide please.

So I'm now going to hand it back over to Karen Llanos to discuss the proposed Medical Care Advisory Committee Provision.

Karen Llanos: Thanks Jen. So, as I mentioned earlier, we have a lot of provisions across our NPRMs, that really look at empowering the beneficiary and consumer voice, and this is one of them. So we've got current regulations already on the books, that require states to establish medical care advisory committees or MCACs. The annuities committees are limited to medical - by statute, these committees are limited to medical topics. And they don't always address the beneficiary perspective for the lived experience. And we want to propose ways to change that.

We know that there are topics that impact the Medicaid program and their beneficiaries that go beyond medical related issues. Certainly changing the scope is one of the things that you'll see in the NPRM. We also know that it's critical for states to be able to capture and to make Medicaid beneficiary perspectives central, to how the Medicaid program is run. So, as we spoke to states, we know that there are - as we spoke to our state partners, we know that there's a wide variation across states on how these medical care advisory committees are currently used.

So we really see these as great opportunities to propose more robust requirements that really seek to ensure that states are leveraging these committees in optimal ways, that speak to engaging consumers and stakeholders in this process. Next slide. So a quick recap of these proposed policies at a high level - so I already mentioned that I think right off the bat, we're proposing to rename and expand the scope and the use of the medical care advisory committees to a renamed Medicaid Advisory Committee, that really would speak to advising the state on a range of issues that would include both medical and non-medical services.

We also know that in order to really strengthen and put the beneficiary at the forefront, we need to be able to require states to establish a standalone group

or a beneficiary advisory group that has crossover into the MAC, or the Medicaid Advisory Committee. We proposed that the BAG would include Medicaid beneficiaries, their family members, and/or their caregivers. This group would meet separately before MAC meetings, and would have state support in order to really ensure that the participants and the members of the BAG, have the ability to participate fully in MAC meetings.

We also propose and seek comments specifically, on minimum requirements of what percentage of the MAC membership should be reserved for the beneficiary advisory group. We proposed 25% based on some factors that you'll read in the NPRM. But we would love to be able to hear comment on this in particular. All of our proposed policies within this provision, really seek to promote transparency and accountability between the state and stakeholders in a variety of different ways, but specifically, in supporting the state in posting publicly, information about the MAC and their beneficiary advisory group on certain activities.

So we propose a state post on its Web site, information about meeting schedules, meeting minutes, membership lists, when meetings are happening, if they're open to the public or not. And then finally, I wanted to highlight that we also think that it's very critical, particularly when we're talking about transparency and accountability, and even bidirectional feedback or two-way feedback, that there should be a requirement. And we propose this in the NPRM about the states creating an annual report that describes how they took the MAC feedback into account, or how they used the feedback in different ways. And this would be also posted on the states' Web sites.

So again, I will echo my colleagues in saying this is a very high overview. We've got a fact sheet on this one as well. And we are excited and

encouraging for comments related to this. And I will turn it over to our next speaker. Next slide.

John Giles: Thanks, Karen. Hi everyone. So I'm John Giles, and I'm here with our managed care team, and we're going to walk you through the managed care proposed rule. So the topics in the managed care rule include access in lieu of services, state directed payments, medical loss ratio, and program integrity provisions, quality rating system, and then we will address requirements that apply to separate CHIP programs. Next slide.

So just a little background on managed care - so Medicaid managed care accounts for about 70% to 80% of all Medicaid beneficiaries enrolled in Medicaid. It represents more than 60% of total Medicaid spending. And what we're hoping to achieve with this particular proposed rule is to continue to advance all of the great access policies that you've heard about so far, but also specifically to strengthen states as well as CMS's ability to monitor and oversee the effectiveness of state managed care programs. Next slide.

So starting with the access topic - so in the managed care rule we are proposing to establish a national standard around appointment wait times. And this is consistent with what you've seen in the marketplace. So as part of this proposed rule we are specifically proposing appointment wait time standards for primary care services, both adults and pediatric, setting those at 15 business days; mental health and substance use disorder services, again, adults and pediatrics, within 10 business days; OBGYN services within 15 business days; and in additional state selected service types in which the state would establish the timeframe for the appointment wait time.

As part of our proposed rule, we would propose that managed care plans would achieve at least 90% compliance with these appointment wait time

standards. In addition, we are proposing the requirements around remedy plans to address any areas where managed care plans or states may need to improve access to care for Medicaid and CHIP managed care enrollees. These remedy plans would include specific steps, timeframes, and the responsible parties to achieve improvement on access within a 12-month period, with a proposal to extend that remedy plan for an additional 12-month time period.

Next slide. Some additional proposals around access to care - as part of this rule we are proposing an annual independent secret shopper survey that would be used to validate managed care plan performance with not just the appointment wait time standards that we just covered, but also the accuracy of provider directories. We would also be proposing that states conduct an annual enrollee experience survey that will be posted on states Web sites, and reported to CMS as part of our monitoring and oversight vehicles.

We would be requiring states to submit an annual payment analysis in alignment with what you've heard already about Medicaid fee for service, that would compare certain managed care provider rates to Medicare rates or Medicaid fee for service rates for specific personal care, homemaker, and home health aid services. And again, we would require states to develop and implement remedy plans to address any access issues across any of these topics. Next slide.

So moving to in lieu of services - so many of you know that this administration is very committed to advancing policies around social determinants of health and health related social needs, including tackling issues related to nutrition and housing support. In December 2021 we approved a set of innovative in lieu of services in the State of California. And additionally, published a state Medicaid director letter in January of this year,

that announced an exciting, innovative opportunity to utilize in lieu of services in settings, to address issues specifically related to health related social needs.

In this proposed rule we are proposing to codify many of the same standards and requirements that were published in that guidance in January. Next slide. Specifically, as part of this proposed rule, we are proposing to require that in lieu of services can be used as immediate or longer term substitutes for covered state plan services or settings. And that in lieu of services can be used to reduce or prevent the future need for state plan services or settings.

Additionally, in line with the guidance we put out in January, we're requiring that in lieu of services must be approvable under a state plan or Section 1915(c) waiver or other HCBS authority. And proposing to limit total in lieu of service spending in the capitation rate at 5%. Next slide. There are some additional requirements around in lieu of services included in this proposed rule, again, in alignment with the January guidance that we published, including that all in lieu of services need to be represented and defined in the managed care contract.

This includes in lieu of service definitions, linking in lieu of services to specific services and settings, identifying clinically oriented target populations, and specifying specific codes that will be used for encounter data. We're also reinforcing very important enrollee protections, such as appeals and grievances, for all in lieu of services at large. And proposing to require a retrospective (unintelligible) evaluation for states with in lieu of service spending above a minimum amount.

Again, all of these proposed policies, in alignment with what we've published in our guidance in January of this year. Next slide. All right. I'm going to turn to my colleague, Laura Snyder, who will cover some of our financial topics.

Laura Snyder: Thank you, John. So first off, we'll start with state directed payments. And just as a reminder, state directed payments are contractual obligations where states direct Medicaid managed care plans' expenditures for services under the contract. They have become a significant payment vehicle for states accounting for more than \$25 billion annually, across 37 states, virtually all managed care states. They allow states to take a more proactive role in directing managed care plans toward key policy and delivery systems investments.

However, some (SCP)s are correlated with some financing challenges. Next slide, please. Next slide, please.

(Krista): Hi. I am not seeing an additional slide here. Moderator, are you able to support?

Laura Snyder: Should I keep going?

John Giles: Yes.

Laura Snyder: Okay. While we're working on the slides, I will tell you the proposed policies - there are quite a few of them, but a few highlights in this section - we are proposing to establish a payment ceiling at the average commercial rate for our hospital services, nursing facility services, and professional services furnished at academic medical centers. We are proposing to eliminate unnecessary regulatory limitations on value-based purchasing arrangements.

We are proposing to ensure that existing requirements for allowable sources of the non-federal share, are explicitly applied to SDPs, noting that CMS may disapprove and take enforcement action on SDPs that do not comply.

Additionally, requiring states to ensure that providers attest they do not participate in a full harmless arrangement as defined as statutes and regulations. We are also proposing to require states to condition fee schedule SDPs, on actual utilizations during the ratings period, and prohibit post payment reconciliation processes that condition payment on historical utilization outside the rating period.

Finally, we also propose to strengthen evaluation requirements for SDPs. And require states to submit evaluation results to CMS and post those publicly. I will note, this is just a high level summary. There are quite a few proposals in this section, and we do as other colleagues have, note a list of public comments and encourage you to read the entire proposal. Moving to the next section, we also do propose some changes in medical loss ratio as well. And this is a reminder that medical loss ratio, or MLR, represents the proportion of revenue used by the plan to fund claim expenditures, their claim expenses, and quality improvement activities.

In the proposed rule, we have policies that were proposing to include SDPs that states must include SDPs in their annual summaries, and that plans must include SDPs in their MLR reports to states, as a separate line item. We also are proposing several modifications to these regulations, based on reviews of plan and state summary reports, as well as to align with recent MLR regulatory changes for the marketplace, that are more technical in nature.

Again, we encourage you to read the proposed rule and provide public comment on the provision. With that, I am now going to turn it over to my colleagues, Carlye Burd, to cover more.

Carlye Burd: Great. Next slide, please. Thank you, Laura. The quality provisions proposed largely focused on increasing transparency of plan quality and access

information. Next slide, please. I'll just keep going through the background. States are currently required to develop and maintain a managed care quality strategy, which serves as a foundational tool for state managed care programs. And the quality strategy includes performance measures and the improvement projects implemented by plans.

Each year, states are required to perform an external quality review or EQR, to validate each plan's quality programs. And every three years, to review plan compliance with managed care standards. Additionally, previous rulemaking established that states would be required to set up a Medicaid and CHIP quality rating system or MAC QRS, using the CMS developed framework or an alternative that is substantially comparable.

And we'll go to slide 29 - hopefully we can get that reconnected. In this rule for quality, we are proposing some changes to modify the existing quality strategy and EQR requirements, aimed at making reporting more transparent and meaningful for quality improvement. Some proposals also aim to reduce burden associated with EQR requirements. The MAC QRS policies, which make up the majority of the quality section, establish a framework aimed to empower beneficiary choice, and monitor a plan performance.

These policies were largely informed by a beneficiary focus group, interviews, and several rounds of consultations with states and other interested parties. Specifically, the policies would establish the states' MAC QRS Web sites as a one stop shop for beneficiaries to access information about eligibility and managed care, and ultimately compare plans based on quality and other key factors in decision making, such as a plan's drug formulary and provider network.

A proposal's established state requirement for the MAC QRS framework, including an initial set of mandatory measures, a methodology to calculate plan quality ratings using those measures, and requirements for displaying all this information on the state's Web site. Finally, the proposals would broaden flexibility for states to implement an alternative QRS by narrowing the circumstances under which states would require CMS approval. Next slide.

The MAC QRS proposals are very unique due to the visual nature of the Web site display requirements. And I know you guys can't see the slide yet. Hopefully we can get it pulled up because there is a prototype of the MAC QRS that we are showing a screenshot of on this slide. And we've actually developed two sample prototypes to demonstrate how states could comply with the proposed display requirements. We've developed two prototypes because we are proposing to phase in some of the more interactive and technology intensive features, over time.

The screenshot that is shown on the slide, but you can find on the Medicaid managed care Web site, is a more interactive prototype. And the prototype would display a side by side comparison of the (unintelligible). So you can go on the Web site and find PDFs of the two prototypes - Prototype A and Prototype B, as well as video walkthroughs of both prototypes. And we are really encouraging you all to use these resources as you are reading through the rule, and provide comments on the actual prototypes through the public comment process.

There's meant to be a guide in understanding the requirements we've proposed. And finally, I'll just note that these prototypes aren't meant to prescribe exactly what the display of a state's MAC QRS Web site should look like, but rather represent an example of how a state may implement the

minimum requirements in each phase of implementation. And with that, I will turn it back over to John Giles, to finish this up.

John Giles: Thanks, Carlye. So I'm going to close our managed care proposed rule discussion with talking about some of the requirements in how they've applied to separate CHIP programs. So on slide 31, a little background here. In most previous rulemaking CMS has mostly aligned our separate CHIP requirements with Medicaid managed care with a few exceptions. So for example, highlighting here that in past rulemaking we have not applied the managed care program annual report requirement or affectionately called MAC PAR, or the SDP state directed payment regulations, to separate CHIP programs.

Moving to slide 32, talking through some of the proposed policies in this rule, and how they apply to separate CHIP - in the access provisions generally aligning all of the Medicaid requirements with CHIP. However, the proposed enrollee experience survey provision will be slightly different. States currently meeting this requirement for CHIP will be done through an annual CAP survey. And we were proposing to require that separate CHIPs will post a summary comparative CAPS results on the state Web site, and review the CAPS results in the state's annual analysis of network adequacy, rather than through the MAC PAR reports.

Related to the in lieu of service provision, requiring alignment with most Medicaid provision except that there is no actuarial certification and the SDP requirements, state directed payment requirements, do not apply. On slide 33, again the state directed payment requirements are not being adopted for separate CHIPs. The medical loss ratio program integrity provisions are aligning with Medicaid. However, again, any of the requirements around state directed payments, as well as the reporting for duly eligible, does not apply.

And on the quality provisions, requiring general alignment with Medicaid except again, the requirements around duly eligible, do not apply. So that concludes the managed care portion of the call. And I believe I'm handing this back over to Jackie Glaze, to facilitate our questions and answers.

Jackie Glaze: Thank you. Thank you, John and team. And I also want to apologize for the technical difficulty we've had with advancing the slides. We're working to get that corrected. And we will get the slides posted tomorrow morning, so you'll see them. And then we'll also have the transcript and recording within the next week. So again, apologies. And we're working to get this corrected. So with that said, we're ready to move on to the state questions.

And so we'll follow the process that we have in the past. We'll ask that you submit your questions through the chat function. And then we'll follow by taking your questions over the phone. So I do see a few questions right now. So I'll turn to you (Krista) to begin that part.

(Krista): Great. And I am just going to flip back to the slide that did have the visual, just so that folks can see it while we do go through the Q and A, as a request from the team. So our first question here is, can MHPs contract with these organizations? We know that MHPs cannot do this themselves. So we are only asking if they're allowed to contract with registered assisters, who will assist their members in completing their renewal packets and submit their renewal forms for them.

John Giles: Hi, (Krista). This is John. I will tackle this one. I'm going to make some assumptions about this question that MHPs is managed health plans. And I don't know exactly what the question is referring to contract with these organizations, but I think the question might be asking can managed care plans participate in contracting with registered assisters to help with renewals?

I will note as part of our unwinding work, we have a dedicated slide deck on Medicaid.gov, and I'm happy to connect this individual to that slide deck, that talks about a number of strategies that state managed care plans can utilize to help with redeterminations, renewals, all of that great stuff.

So again, I think the commenter is correct, right, managed care plans can't actually do actual renewals or enrollments, but there are a number of strategies where they can assist the state in educating members highlighting the importance of renewals and redeterminations. And we have a whole slide deck of those strategies. And so I'm happy to connect this individual with that guidance.

(Krista): Great. Thank you so much, John. We have another question here in the chat. If the rate reduction is due to a Medicare rate reduction, are states required to perform the two-tiered analysis process?

Jeremy Silanskis: Hey. This is Jeremy. So it depends. So, it depends. So all of the rate reduction provisions that are described in the NPRM, are really based on a state submission of a state plan amendment. And many states have state plan provisions that simply say that they pay the current Medicare payment rates. And so if, as a product of those payment provisions, the Medicare rates go up and down, there is no submission of a state plan amendment.

Now, if there's a different circumstance where a state submits a state plan amendment reaction to changes in Medicare, and the requirements of the rule that I laid out earlier are not met, then seemingly, a state would need to do the extra analysis.

(Krista): Great. Thank you so much, Jeremy. One additional question here - what is the timeframe for implementation of the HCBS proposed policies on slide 13 and 14?

Jen Bowdoin: Hi. This is Jen Bowdoin. So I can take this one. So most of the HCBS provisions have a three year effective date, but there are some exceptions. So the proposed requirement for states to implement grievance systems in their fee for service HCBS programs, would have a two year effective date. The proposed requirement that at least 80% of Medicaid payments per personal care, homemaker, and home health aid services be sent on compensation for the direct care workforce, would have a four year effective date.

And not specifically, on slides 13 and 14, but the ones that Jeremy discussed in the fee for service provisions, states would have two years to comply with the proposed requirements to publish the average hourly rate paid for delivering personal care, home health aid, and homemaker services. And the proposed requirement that states establish an advisory group for interested parties to advise and consult on provider payment rates for personal care, home health aid, and homemaker services. So those two would have a two year compliance date.

And then in addition, the proposed requirement for states to report on a standardized set of HCBS quality measures, has a proposed three year effective date. But we are proposing that requirements for states to stratify their data for certain measures by demographic and other factors, would be phased in over seven years. And we are requesting comment on the proposed effective date for each provision.

(Krista): Fantastic. Thank you so much, Jen. We have one more question in the chat. ILOS are only for managed care, or is this also for the fee for service HCBS?

John Giles: Hi. This is John again. I can take this question. So in lieu of services or ILOS, is uniquely a managed care concept. So the proposed policies related to in lieu of services, are specific to managed care. But I will note that our policies around in lieu of services are really intended to support the agency's commitment to addressing health related social needs through a number of strategies, including authorities under home and community based service waivers, as well as policies in 1115 demonstrations. So again, I think in concept, we're supporting access, and policies around HRSN. But in lieu of services specifically, is a managed care concept.

(Krista): Thank you, John. So we'll now transition to the phone line. So I'll ask the operator to please provide instructions for registering the questions. And if you can please open the phone lines. Thank you.

Coordinator: Yes. If you would like to ask a question over the phone, please press star followed by 1. Please make sure your phone is unmuted and record your name when prompted. If you wish to withdraw your question, you can press star 2. Please allow a moment for questions to come in. Thank you. I'm not seeing any questions on the phone at this time.

Jackie Glaze: Thank you. I'll send it back to you, (Krista). I see one additional question in the chat.

(Krista): Great. Thank you so much, Jackie. The question in the chat is, what is the definition used for personal care, home health aid, and homemaker services for HCBS?

Jen Bowdoin: So hi, this is Jen Bowdoin. So I'm going to - if we can come back to that in one second, we actually refer to a different regulatory citation for those definitions, and I can look up the specific one. But I don't remember it offhand. So if we can come back to that in just a second, that would be great.

(Krista): Jen, I think that's our last question. Would you like for us to follow back up with the requester?

Jen Bowdoin: No. I understand the question. I just want to make sure I pull up the correct citation for that.

Jeremy Silanskis: Hey, Jen, I have it up right here.

Jen Bowdoin: Oh, that would be great, if you could do that.

Jeremy Silanskis: Sure. It's Section 441.302(a)(1)(2). And Section 440.180(b)(2)-(4). So if you take a look at those cited provisions, it will explain.

Jackie Glaze: Thank you, Jeremy. So I believe that is all the questions we have today. So I think we ask one additional time, if you could repeat that one additional time, Jeremy.

Jeremy Silanskis: Sure thing. I'm glad I didn't close it. Section 441.302(a)(1)(2), so I I. That's for self-directed. Or agency directed services at Section 440.180(b)(2)-(4). And if you take a look at the provisions of the proposed rule, those are referenced in there as well. So if you look at the version that's on Medicaid.gov, you'll be able to find that within the provisions of the proposed rule.

Jackie Glaze: And I'd just like to put out one - and thank you, Jeremy. Just so one additional reminder that the fact sheets on managed care and the access NPRM, those

will be found on Medicaid.gov. So in closing, I do want to thank our presenters for their presentations today. Looking forward, we will be sending out the topics and invitations for the next call. If you do have questions before we speak again, please feel free to reach out to us or state leads, or bring your questions to the next call.

So we do thank you again for joining us, and hope you all have a great afternoon. Thank you.

Coordinator: Thank you. That does conclude today's conference. You may disconnect at this time. And thank you for joining.

[End]