Chapter 1:

Examining the Role of External Quality Review in Managed Care Oversight and Accountability

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Recommendations

1.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 438.364(a)(2)(iii) to require the external quality review annual technical report include outcomes data and results from quantitative assessments collected and reviewed as part of the compliance review mandatory activity specified at 42 CFR 438.358(b)(1)(iii).

1.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to update external quality review (EQR) protocols to: (1) reduce areas of duplication with other federal quality and oversight reporting requirements, (2) create a more standardized structure in the annual technical report that summarizes EQR activities, results, and actions taken by state Medicaid agencies, and (3) identify key takeaways on plan performance.

1.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to require states to publish external quality review (EQR) annual technical reports in a 508-compliant format and for CMS to publicly post all state EQR reports in a central repository on the CMS website.

Key Points

- Managed care is the primary delivery system in Medicaid, with almost three-fourths of Medicaid beneficiaries enrolled in comprehensive, full-risk managed care. Stakeholders are increasingly prioritizing effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services.
- An annual external quality review (EQR) of a state's contracted Medicaid managed care plans and their performance is one of the few federal oversight requirements for managed care specified in Medicaid statute.
- The EQR process has focused primarily on validation and compliance with federal requirements. Accordingly, the findings presented in the EQR annual technical report (ATR) have reflected process and regulatory compliance rather than meaningful changes in plan performance and outcomes.
- MACPAC's review found ATRs are lengthy, detailed, and often hard for most audiences to comprehend. Additionally, ATRs can be hard to find on individual state websites.
- Including meaningful data on quality and outcomes that have been reviewed as part of EQR activities would make the ATR a more effective tool for quality improvement and managed care plan oversight.
- A more standardized structure for summarizing and reporting EQR results and actions taken in response to the findings would make it easier to review the ATR and glean the key takeaways on plan performance. Furthermore, posting the ATRs in a central repository will improve the transparency of the EQR findings for stakeholders.
- EQR is part of a larger federal quality and oversight strategy, and EQR activities may overlap with other federal monitoring activities on network adequacy and quality. The Secretary of the U.S. Department of Health and Human Services should also ease the administrative burden by reconciling EQR with other reporting requirements to reduce duplicative reporting.

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Managed care is the primary health care delivery approach in Medicaid, with 73 percent of beneficiaries enrolled in a comprehensive, full-risk managed care organization (MCO) (MACPAC 2024a). As enrollment in Medicaid managed care has increased, so too has the total share of Medicaid expenditures made through capitation payments to managed care plans; in fiscal year 2023, managed care capitation payments accounted for more than half (56 percent) of Medicaid benefit spending (MACPAC 2024b). Under contracts with state Medicaid agencies, managed care entities manage and provide health care services to beneficiaries enrolled in their plan. With the growth of managed care, federal and state stakeholders have increasingly prioritized the effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services. The requirements related to the federal oversight of Medicaid managed care programs can be found in Section 1932 of the Social Security Act (the Act) as well as in part 438 of Title 42 of the Code of Federal Regulations (CFR) (42 CFR 438). An important responsibility of state Medicaid agencies is to conduct an annual external independent review of the quality of and access to services under each managed care contract, known as the external quality review (EQR) process (42 CFR 438.350–370).

As part of its work on managed care oversight and accountability, MACPAC examined how states implement federal EQR requirements, the role the Centers for Medicare & Medicaid Services (CMS) plays in overseeing the EQR process, and if the EQR process supports accountability for states and managed care entities and improves care for beneficiaries. This report continues the Commission's focus on Medicaid managed care oversight that has included studying managed care procurement practices and making recommendations regarding denials and appeals in managed care (MACPAC 2024c, 2022).

This report examines challenges and limitations with the current EQR process based on a comprehensive federal policy review; environmental scan of annual technical reports (ATRs), external quality review organization (EQRO) procurement documents, and state quality strategies; and structured interviews with federal and state regulators, EQROs, health plans, consumer advocacy organizations, and national managed care and quality experts. Overall, the comprehensive analysis revealed gaps in how the EQR process and findings as reported are used to oversee managed care plans and improve quality. We found that EQR activities focus predominantly on process and compliance rather than measurement of the managed care plans' performance. Also, stakeholders expressed challenges with their understanding of states' reporting of EQR findings based on a lack of context and summarization as well as the length and complexity of reports. Finally, we found stakeholders, including beneficiaries, had difficulty accessing EQR reports due to the absence of a centralized repository.

To address these challenges and improve the usability and transparency of EQR findings, the Commission makes three recommendations:

1.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 438.364(a)(2)(iii) to require the external quality review annual technical report include outcomes data and results from quantitative assessments collected and reviewed as part of the compliance review mandatory activity specified at 42 CFR 438.358(b)(1)(iii).

1.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to update external quality review (EQR) protocols to: (1) reduce areas of duplication with other federal quality and oversight reporting requirements, (2) create a more standardized structure in the annual technical report that summarizes

EQR activities, results, and actions taken by state Medicaid agencies, and (3) identify key takeaways on plan performance.

1.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to require states to publish external quality review (EQR) annual technical reports in a 508-compliant format and for CMS to publicly post all state EQR reports in a central repository on the CMS website.

This chapter begins with background on the current EQR requirements and the evolution of federal policy in this area, including the 2024 managed care final rule. It then reviews challenges in the EQR process and gaps in the accessibility and usability of findings. Next, the chapter presents three recommendations, associated rationale, and implications for stakeholders. The chapter concludes with a look ahead at the Commission's continued work in Medicaid managed care accountability.

Background

As Congress has amended federal Medicaid law to provide greater flexibility for states' use of managed care, it has also added provisions to ensure the federal government holds states accountable—and that states hold managed care plans accountable—for the services they have agreed to provide to enrollees. The requirements related to the federal oversight of Medicaid managed care programs can be found in Section 1932 of the Act as well as in the managed care regulations at 42 CFR 438.

The Medicaid statute establishes a broad oversight role for CMS in regard to Medicaid managed care, with few specific federal responsibilities. Section 1932 of the Act prescribes the managed care enrollment process, beneficiary protections, and requirements governing information and communication but establishes only two direct oversight and monitoring requirements:

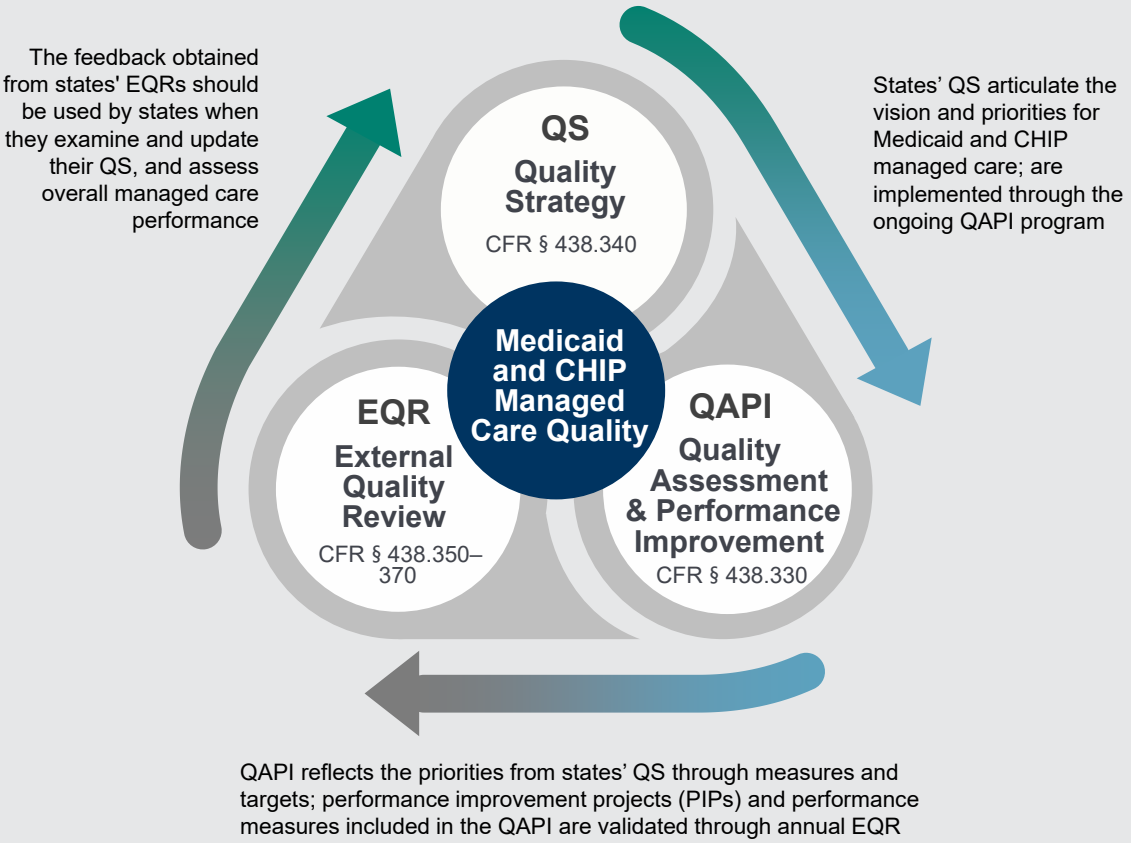
1. A state must develop, implement, and update a managed care quality assessment and improvement strategy that includes access standards and procedures for monitoring and evaluating the quality and appropriateness of care and services, meets the standards set by CMS, and is subject to monitoring by CMS; and

2. A state must conduct an annual external independent review of the quality of and access to services under each managed care contract.

CMS has promulgated detailed federal regulations and subregulatory guidance implementing these requirements (42 CFR 438). The first requirement is divided into two major components: states contracting with managed care plans must develop and implement a quality strategy for assessing and improving the quality of care and services provided by plans (42 CFR 438.340), and managed care plans must establish and implement an ongoing and comprehensive quality assessment and performance improvement (QAPI) program. The QAPI program must reflect the priorities articulated in the state quality strategy and include performance improvement projects (PIPs) aimed at driving "significant and sustained" improvement on measures and targets included in the quality strategy (42 CFR 438.330). Many detailed EQR requirements (e.g., guidelines for developing protocols, qualifications of EQROs, mandatory and optional activities, and options for exemption and non-duplication) are described in regulation, while detailed review protocols are described in subregulatory guidance (42 CFR 438.350–370).

These three activities are intended to function as an interrelated set of compliance and quality requirements (Figure 1-1). For example, federal rules require the annual EQR process to validate performance measures and PIPs that are included in the QAPI, with results included in the state's EQR ATR. The EQR ATR must also include recommendations from the EQRO on how states can target quality strategy goals and objectives to support improvements in quality of care.

FIGURE 1-1. Managed Care Quality Oversight Requirements



Notes: EQR is external quality review. CFR is Code of Federal Regulations. QS is quality strategy. CHIP is State Children's Health Insurance Program. QAPI is quality assessment and performance improvement.

Source: Adapted from Centers for Medicare & Medicaid Services (CMS). 2019. CMS External Quality Review (EQR) Protocols. October 2019.

External Quality Review

Each state contracting with MCOs, prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) must ensure that a qualified independent EQRO performs an annual review of the quality, timeliness, and access to services for each managed care contract (Section 1932(c)(2) of the Act, 42 CFR 438.350).[1] States that use managed care for their separate State Children's Health Insurance Program (CHIP) plans and Medicaid-expansion CHIP plans are also subject to the EQR requirements.

Federal rules describe a number of specific quality review activities that EQROs must conduct and report on as well as several activities that the state can choose to have its contracted EQRO conduct. The EQRO must provide the state and CMS with a detailed ATR, including an assessment of each managed care plan, and these reports are intended to be used by regulators to monitor quality and outcomes, conduct oversight of managed care contracts, and hold plans accountable for their performance. As of 2024, 45 states and the District of Columbia contract with plans that are subject to EQR.[2]

Requirements for EQR were established in the Balanced Budget Act of 1997 (BBA, P.L. 105-33) and initially codified in 2003 (CMS 2003). The rule defined which entities qualified to conduct EQR and what activities could be conducted as part of EQR and qualify for enhanced federal financial participation (FFP) at the 75 percent rate.[3] The rule also specified the circumstances under which states could use findings from Medicare or private accreditation review activities to avoid duplicating EQR activities or exempt certain MCOs and PIHPs from all EQR requirements. These initial EQR requirements applied only to comprehensive risk-based MCOs and PIHPs.

In 2016, CMS updated the Medicaid managed care regulations and made a number of changes to the requirements relating to EQR (CMS 2016). These changes expanded EQR to cover PAHPs and primary care case management (PCCM) entities, added a new mandatory activity (validation of network adequacy) and an optional activity (assisting with quality ratings of plans) to the EQR process, clarified that only EQR-related activities for MCOs were eligible for enhanced FFP, and strengthened conflict of interest provisions for entities serving as EQROs (CMS 2016). In 2020, further regulatory changes added a new requirement for states to annually post online which Medicaid plans are exempt from EQR and specify when the exemption began as well as a requirement for states to identify exempted plans in the ATR beginning July 1, 2021 (CMS 2020).[4]

On May 10, 2024, CMS issued a final rule on managed care access, finance, and quality in Medicaid and CHIP (CMS 2024). The 2024 managed care rule added new requirements to managed care access and quality monitoring and reporting, including the EQR process. The rule removes PCCM entities from the scope of mandatory EQR, adds new EQR requirements to report outcomes data for some mandatory activities, expands the optional activities that states may have their EQRO conduct, and adds new transparency requirements (CMS 2024).

Mandatory and optional activities

States implementing Medicaid managed care through MCOs, PIHPs, and PAHPs (with some exceptions) are required to perform four mandatory EQR activities:[5]

- validate PIPs to determine the methodological soundness in the design, conduct, evaluation, and reporting of a health plan's PIP;
- validate plan-reported performance measures to ensure plans collect and report required measures properly;
- review, within the previous three-year period, to determine the MCO's, PIHP's, or PAHP's compliance with standards in subpart D of 42 CFR 438 relating to access, care coordination, amount, duration, and scope of covered services and other applicable plan standards;[6] and
- validate plan network adequacy.[7]

In the 2024 managed care rule, CMS added a definition for the 12-month review period for all but one of the mandatory EQR-related activities (validation of PIPs, performance measures, and network adequacy) to create more consistency in reporting across states. For these activities, the 12-month review period begins on the first day of the most recently concluded contract year or calendar year, whichever is nearest to the date of the EQR-related activity.

Additionally, the 2024 managed care rule no longer requires states to include PCCM entities in the scope of mandatory EQR activities; however, the EQRO may validate performance measures and performance improvement projects conducted by PCCMs at the state's discretion.

States can also choose to conduct one or more optional activities that can help advance their program goals. These optional activities include the following:

- validate encounter data reported by plans;
- administer or validate enrollee or provider surveys of quality of care;
- calculate performance measures in addition to those reported by plans;
- conduct PIPs in addition to those conducted by plans;

- conduct quality studies that focus on a particular aspect of specific clinical or non-clinical services;
- assist with developing quality ratings of MCOs, PIHPs, and PAHPs consistent with the Medicaid managed care quality rating system (QRS);[8] and
- assist with the required evaluation of state quality strategies, state directed payments, and in lieu of services (newly added in the 2024 managed care rule).

Protocols

CMS is required to develop protocols for mandatory and optional EQR activities to guide and support the annual process for states and the EQROs with whom they contract. Section 1932(c)(2)(A)(iii) of the Act requires CMS to coordinate with the National Governor's Association and to contract with an independent entity, such as the National Committee for Quality Assurance, to develop the protocols.

EQR protocols provide tools and guidance to states and EQROs based on current industry methodologies and best practices for creating the ATR. The CMS protocols outline the purpose of the EQR-related activity; identify acceptable methodologies for conducting each activity within the protocol; specify data sources and data collection activities to promote data accuracy, validity, and reliability; propose methods for analyzing and interpreting the data; and provide instructions, guidelines, worksheets, and other tools that may be used in implementing the protocol (CMS 2023).

CMS issued the first set of protocols in 2003 and is required to review the protocols and make necessary revisions every three years. CMS updated the protocols in 2019 to incorporate regulatory changes contained in the May 2016 managed care final rule to be more user friendly for the EQRO conducting the activities and to offer practical tips for reporting EQR findings. In February 2023, CMS issued revised EQR protocols to incorporate regulatory changes contained in the 2020 managed care final rule, clarify federal requirements for the EQR process to promote compliance, respond to state and EQRO feedback about the protocols, and include the network adequacy validation protocol (CMS 2023). CMS will need to update the EQR protocols in response to the 2024 managed care final rule, and states will have one year from the issuance of the applicable protocol to comply.

Annual technical reports

Federal regulations require states to publish an ATR that compares and evaluates the managed care plans subject to EQR. A plan that is exempt from EQR will not be included in the ATR, but the state must note the exemption on its website and in its EQR report. The ATR must be posted on the state website by April 30 of each year and must include the following components:

- a detailed explanation of the EQRO's methodology for collecting, aggregating, and analyzing data from all EQR activities conducted;
- the EQRO's assessment of each managed care plan's performance on quality, timeliness, and access to care;
- recommendations for improving the quality of health care services furnished by each managed care plan and recommendations for how the state can target goals and objectives in the state quality strategy;
- methodologically appropriate comparisons of performance across all plans; and
- an assessment of the degree to which each managed care plan addressed quality improvement recommendations from the previous year's EQR.

In the 2024 managed care rule, EQROs are required to include any outcomes data and results from their quantitative assessments of PIPs, performance measures, and network adequacy in the ATR. The fourth mandatory EQR activity—the triennial compliance review of the managed care plans' compliance with standards in subpart D of 42 CFR 438—was not included in this updated requirement to include outcomes data. CMS will release protocols to implement these changes, and states will have one year from the issuance of the associated protocol to comply.

In the 2024 managed care rule, CMS added a requirement that states notify CMS within 14 calendar days of posting their ATR to their website. Additionally, CMS is requiring states maintain at least the previous five years of ATRs on their websites.

States must comply with this requirement to maintain five years of reports on their webpage no later than December 31, 2025.

CMS publishes summary tables based on the EQR ATRs, including a list of the EQROs contracting with states, the number and type of plans included in each state's EQR technical report, validated performance measures, whether a state reported performance measure rates, and the areas of care and populations covered by PIPs.

Challenges in the EQR Process

MACPAC conducted a comprehensive study of the EQR process and state practices to assess how states structure their EQR approaches, how states use EQR findings to hold plans accountable and improve care for beneficiaries, and how CMS engages in oversight of the EQR process to ensure states are in compliance with federal law and regulations. The study included a review of federal policy, ATRs, EQRO procurement documents, and state quality strategies as well as interviews with a range of stakeholders. Overall, the project identified five gaps in how the EQR process and findings are used to oversee managed care plans and improve quality, which are discussed further below:

- the connection between EQR and state quality strategies has been limited;
- the EQR process and protocols focus predominantly on process measures, validation, and compliance;
- states vary in whether they enforce EQRO findings and the tools used to improve plan performance;
- although states post their ATRs publicly, there can be challenges with accessibility and usefulness of report content; and
- CMS oversight of the EQR process appears limited.

The connection between EQR and state quality strategies has been limited

The EQR process should be connected to other federally required quality monitoring and improvement requirements in Medicaid managed care, including the state quality strategy (42 CFR 438.340(c)(2)(iii), 438.364(a)(4)). Together, these tools inform oversight and accountability of health plans and quality of care for beneficiaries. However, the environmental scan did not always find a clear link between the EQR process and the state managed care quality strategy. Interviewees agreed that historically, most states and EQROs did not attempt to align EQR activities with the state quality strategy. One interviewee noted that these two activities were, and often still are, not integrated activities, and other stakeholders described the EQR and quality strategy as parallel activities. However, a number of interviewees noted recent attempts by states to connect and integrate their EQR activities and technical reports to support their quality strategies. Some state Medicaid agencies indicated over time they have experienced increased communications from CMS regarding their quality strategies and posting of ATRs. For example, one state noted there has been more CMS feedback on its quality strategy since CMS issued the Managed Care Quality Strategy Toolkit in June 2021, which described how states could use information from the ATRs in revising and aligning the state's quality strategies (CMS 2021).

The EQR process and EQR protocols focus predominantly on process measures, validation, and compliance

The four mandatory EQR activities that states must conduct (validation of PIPs, validation of performance measures, triennial compliance review of 42 CFR 438 subpart D standards, and validation of network adequacy) have traditionally been focused on validation and compliance with federal managed care requirements and the elements of CMS-designed protocols. Accordingly, the findings presented in the ATRs have been reflective of process and regulatory compliance, rather than meaningful changes in plan performance and outcomes over time.

To a lesser extent, states focus on other managed care contractual requirements. For example, during compliance reviews of coverage denials, EQROs typically look at whether policies and procedures align with federal rules and state requirements, such as assessing health plan compliance with timelines, qualifications of plan staff who were involved in coverage determinations, and the content of notices to beneficiaries regarding decisions and their rights to appeals and grievances. EQRO representatives indicated that occasionally a state may ask them to review whether the coverage determination was medically appropriate, but that appears to be more of the exception than the rule.

The stakeholder interviews voiced a consistent theme that outcomes-driven EQR activities revealed trends in performance across states, plans, and quality measures that informed their work. State and federal officials indicated these trends highlight areas of concern for the Medicaid program and help determine where changes may be needed or where additional resources may be allocated. In general, consumer advocacy groups commented they would like to see the EQR process and report findings structured to allow comparisons across states and to national benchmarks for particular measures.

This limitation of EQR is somewhat addressed in the 2024 managed care rule under the new requirement that EQROs include any outcomes data and results from their quantitative assessments of PIPs, performance measures, and network adequacy in the ATR. However, this requirement for outcomes data and results from quantitative assessments does not apply to the fourth mandatory EQR activity—triennial compliance reviews—that evaluates compliance with federal Medicaid regulatory standards and related provisions in the contracts between the state Medicaid agency and its managed care plans (CMS 2024).

States vary in whether they enforce EQRO findings and the tools used to improve plan performance

States are not required by statute or regulation to act on the findings or recommendations included in the ATR. The federal regulations do require the ATR summary to include an assessment of how effectively each MCO, PIHP, or PAHP has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR (42 CFR 438.36(a)(6)). States vary in the degree to which they base their managed care plan oversight tools on findings from EQR activities, ranging from noting plan performance to financial penalties. Tools we heard about include using the results to inform potential contract changes with MCOs, corrective action plans (CAPs), financial penalties, reducing or freezing auto-assignment of enrollees to health plans, and including EQR results in scorecards used by enrollees when selecting a managed care plan. Notably, one state had a quality-based auto-assignment algorithm that calibrates to EQRO findings.

States we interviewed appear to take a collaborative and iterative approach with managed care plans to address areas of subpar performance or non-compliance revealed during EQR activities. States, their EQROs, or both will provide technical assistance to plans as needed and oftentimes provide an opportunity to address findings in the draft EQRO report before the report is finalized. In other words, nothing in the report is a surprise to the states, and by the time of publication, the plan may have already addressed the deficiency through a CAP.

Notably, some interviewees suggested the need for more assistance to states and more investments by states and CMS to effectively oversee managed care programs, which now serve a majority of Medicaid beneficiaries. It is worth noting that states engage in a competitive bid process for their EQRO contract and must pay the EQRO for the activities the state wants them to conduct. Although a state hires an EQRO to conduct a mandatory EQR activity using CMS-developed protocols, the state may not have the financial ability to pay that same EQRO to engage in optional activities to support ongoing monitoring, performance improvement, or revalidation of the findings from that activity.

Although states post their ATRs publicly, there can be challenges with accessibility and usefulness of report content

Although states typically meet the federally required April 30 deadline to post ATRs on their state websites, reports can sometimes be hard to find, and the information in them can be difficult to use, even for CMS and state Medicaid agencies. Given that EQR is an important statutory oversight mechanism related to managed care, the lack of accessibility of some reports can hinder the ability of stakeholders to monitor health plans' performance.

Although the ATRs are lengthy, highly technical reports that are designed to report on specific protocols, there is not a required template for reporting EQR activities or results. As such, it can be difficult for interested stakeholders to review these reports and glean the key takeaways on plan performance. ATRs lack consistency in layout and content that can make it easier for stakeholders to digest the findings and recommendations from EQROs. The organization of ATRs can vary considerably from state to state and sometimes even within a state across years. One interviewee noted that mismatched data made it hard to identify trends that could help identify areas to allocate resources or identify best practices that could be shared across states and plans. However, interviewees noted that CMS has recently been reviewing ATRs and EQR activities in closer detail and providing feedback on the presentation of information.

MACPAC's review found that, generally, it can be hard to find meaningful results in the ATRs. Many reports lack a clear synthesis of EQR findings. Some reports do not highlight substantial EQR results and instead report on aggregate results that may gloss over areas of deficiency for certain plans or certain components of the EQR. ATRs note areas for which all or certain MCOs were non-compliant or partially compliant for a particular EQR component. Often, a reader is not able to clearly determine the extent to which a plan's non-compliance was significant. Additionally, it can be challenging to identify what actions a state took to address plan non-compliance findings.

Additionally, MACPAC's review of ATRs found that states use different approaches for evaluating plan performance. Some EQR technical reports scored plans using a binary compliant or non-compliant approach. Other reports categorized plan compliance as being met, partially met, or not met. Some EQR technical reports referred to the percentage of reviewed components for which a plan or the group of plans was found to be compliant within each type of requirement, such as grievance and appeals. This variation in how states rate plans' compliance makes it difficult for individuals to clearly determine the extent to which a plan was compliant or the extent to which a plan's non-compliance was significant.

CMS oversight of the EQR process appears limited

CMS's role in EQR includes promulgating the regulations governing the EQR process; designing, reviewing, and updating EQR protocols when necessary; providing technical assistance to states with their EQR activities; reviewing both EQRO contracts with states and the ATRs drafted by EQROs for compliance with federal requirements; and ensuring states are undertaking the EQR process and monitoring managed care performance. However, our study did not reveal that any stakeholders saw CMS as using the EQR process to directly monitor or oversee the performance of managed care plans or states.

To date, CMS has primarily been concerned with state compliance with EQR protocols, but there are no regulations or guidance regarding possible CMS actions if a state fails to follow the established protocols. Similarly, there are no federal policies describing the process and criteria for reviewing and approving state EQRO contracts, although there is a requirement for states to receive enhanced FFP for EQR. Although CMS requires states to submit the EQR annual reports and publish summary tables derived from them, it is unclear if or how CMS uses the information for compliance monitoring or quality improvement.

Despite this lack of clarity regarding CMS's oversight role, feedback from stakeholder interviews suggests CMS is increasing its presence in the process. CMS is strengthening its review of health plan compliance, examining how EQROs record information in the ATRs, and providing more technical assistance to states. Interviewees noted that CMS is trying to strike a balance between having standardized components

with letting states have the flexibility to customize their EQR approaches. Consumer advocacy groups suggested that CMS should create a bigger role for itself with respect to sharing findings from ATRs, providing technical assistance to states on how to increase transparency of EQR findings, and using findings in their own oversight of managed care plans.

Commission Recommendations

The Commission makes three recommendations to the Secretary of the U.S. Department of Health and Human Services to direct CMS to make improvements to the current EQR process. The following recommendations seek to shift the focus of EQR activities from process and compliance to meaningful outcomes and actionable data and to improve the usability of EQR findings for all stakeholders through reporting consistency, summarization, and transparency. In carrying out the recommendations, CMS should take a holistic view of EQR in relation to other requirements within the overall federal quality and oversight strategy and identify ways to ease the administrative burden for CMS, state Medicaid agencies, and MCOs by reducing duplicative reporting.

Recommendation 1.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 438.364(a)(2)(iii) to require the external quality review annual technical report include outcomes data and results from quantitative assessments collected and reviewed as part of the compliance review mandatory activity specified at 42 CFR 438.358(b)(1)(iii).

Rationale

The triennial compliance review is one of the four mandatory EQR activities that states must have their contracted EQRO perform for managed care plans subject to the requirement. States and CMS use this review activity to determine the extent to which a state's managed care plans' policies and procedures are in compliance with 14 federal standards detailed in 42 CFR 438, including standards related to access, coverage and authorization of services, and care coordination. EQROs conducting this activity evaluate plans' compliance not only against the federal standards but also the related provisions in the plans' contract with the state Medicaid agency. The triennial compliance review is the most comprehensive EQR activity required by CMS, assessing each plan's core operational areas from health information systems, through coverage and authorization of services, to grievance and appeals systems. Many stakeholders we interviewed, including state officials and managed care plan representatives, identified the compliance review as the most important EQR activity and detailed the extensive time and resources devoted to preparing for, executing, and responding to the review.

In the Commission's view, it is important that the EQR ATR capture and report meaningful data on quality and outcomes that have been reviewed as part of the four mandatory EQR activities. Currently, EQROs may be collecting and reviewing outcomes data and results from quantitative assessments during the triennial compliance review; however, because there is no requirement that any such data be included in the ATR, it is unknown, not reported, and not available for review by stakeholders. This recommendation is consistent with the 2024 managed care rule's new requirement to include outcomes data and results from quantitative assessments from the mandatory EQR activities that validate PIPs, performance measures, and network adequacy in the ATR. In the preamble of the rule, CMS stated that the new requirement for reporting these data would result in more meaningful ATRs. Consequently, the ATR would become a more effective tool for states to use in quality improvement and managed care plan oversight. MACPAC and other stakeholders noted in their comments to the proposed rule that this change to require outcomes data and quantitative assessments for EQR activities may help place a greater emphasis on performance outcomes and comparability (CMS 2024).

In its commentary, CMS did not explain why the triennial compliance review activity was not included in this new requirement to report outcomes data and results from quantitative assessments in the ATR. In discussions with CMS after the release of the 2024 managed care rule, officials did not identify a specific rationale for excluding the triennial compliance review from this new requirement. As detailed in the CMS-

designed protocol, the triennial compliance review involves extensive review of state and plan documents as well as interviews with plan leadership and operational area staff. Although the compliance review protocols focus primarily on the managed care plan's policies and procedures, there are areas of review that could include such data.

The 2023 protocols identify several applicable plan documents for the EQRO to review, including measurement or analysis reports on service availability and accessibility, data on enrollee grievances and appeals, data on claims denials, and performance measure reports that could generate outcomes data. The EQRO should include in the ATR any outcomes data and the results from quantitative assessments reviewed or generated as part of the triennial compliance review activity, thus providing evidence of how the plan's policies and procedures were implemented. Areas of focus could include the availability and furnishing of services and timely access that would not necessarily be captured in other mandatory EQR activities. Reporting data on service authorization denials, grievances, and appeals that may have been reviewed as part of the EQR activity would be in line with recommendations the Commission made in the March 2024 report to Congress to collect, report, and use these data in monitoring and continuous improvement activities (MACPAC 2024b).

This recommendation is not intended to create new measures or mandate specific data be collected and reported but rather to report information that EQROs are already reviewing or generating as part of the compliance review. As such, it would not require fundamental changes to the triennial compliance review EQR protocol issued by CMS nor substantial preparations for this activity by state Medicaid agencies or managed care plans.

Implications

Federal spending. The Congressional Budget Office (CBO) does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that the recommendation could increase federal discretionary spending to cover CMS administrative activities related to implementation.

This recommendation would result in increased administrative effort for the federal government, including the rulemaking process to update the regulations and modifying the EQR protocol to include reporting of outcomes or quantitative assessments as part of the triennial compliance review activity. CMS will already have to update the protocols for the other three mandatory activities to incorporate the new reporting requirements from the 2024 managed care final rule, so some efficiencies may be gained by updating all four mandatory activity protocols simultaneously.

States. States with managed care plans subject to EQR already contract with EQROs to conduct the triennial compliance review activity. Additionally, the 14 federal standards evaluated by the EQRO are already required by CMS in states' contracts with managed care plans. Because the recommendation is expected to report on information that EQROs are already reviewing, states should not see a substantial increase in either cost or administrative burden. Furthermore, the new information could generate additional insights for states that would inform and improve its managed care program quality strategy.

Enrollees. With the inclusion of additional meaningful outcomes data in the ATR, such as information on the availability and furnishing of services or the grievance system, enrollees will have additional information on the quality of care and access being provided by different health plans. The public reporting of this information could create additional incentives for managed care plans to improve the quality of and access to care being provided to enrollees.

Plans. Managed care plans should not see a substantial increase in either cost or administrative burden because they are already providing data and reports as requested by the state and EQRO for the compliance review. Plans may face an increased administrative burden if the state and EQRO ask for information that the plans do not already collect; however, states and EQROs already have the ability to ask for this information under existing regulations.

Providers. This recommendation would not directly impact providers as they are not included in the triennial compliance review activity beyond information that has already been provided to the state Medicaid agency and managed care plans. Added transparency

in the EQR reporting may inform providers regarding areas for potential quality improvement or focus.

Recommendation 1.2

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to update external quality review (EQR) protocols to: (1) reduce areas of duplication with other federal quality and oversight reporting requirements, (2) create a more standardized structure in the annual technical report that summarizes EQR activities, results, and actions taken by state Medicaid agencies, and (3) identify key takeaways on plan performance.

Rationale

More than 20 years after the first EQR protocols were published by CMS in 2003, the EQR process has expanded along with the growth of managed care in states' Medicaid programs. States subject to EQR now have 11 total EQR activities, including 4 mandatory activities, intended to improve states' ability to oversee managed care plans and help plans improve their performance on quality, timeliness, and access to care for Medicaid beneficiaries. Additionally, EQR is part of a larger federal quality and oversight strategy that was expanded further with new reporting requirements on access and quality in the 2024 managed care rule.

CMS provides technical assistance to states, EQROs, and managed care plans with EQR protocols for each mandatory and optional activity. The protocols outline acceptable methodologies for how EQR activities are to be conducted, including suggested questions for the EQRO to ask plan representatives and recommended reports and documentation for the EQRO to collect and review. Federal regulations require state Medicaid agencies to publish an ATR in April for all EQR activities conducted the year prior that compares and evaluates the managed care plans subject to review. State Medicaid agencies customize use of their contracted EQROs based on the states' managed care program, budget, and overall resources. This flexibility includes how states and EQROs structure the EQR scope of work, conduct the EQR activities, and report findings in the ATR. Although the EQR protocols identify tips for drafting compliant and effective ATRs, there are few requirements in terms of content or structure (CMS 2023).

Stakeholders we interviewed voiced support for EQR protocols that require states to establish a clear link between EQR activities and the state managed care quality strategy. In our interviews, both state Medicaid agencies and plans valued the flexibility CMS has given states to design their EQR process, but they also thought it could be better balanced with standardization and consistency to help stakeholders find, interpret, and align EQR findings and bring efficiency to the EQR process. Some stakeholders we spoke to indicated that flexibilities in the implementation of EQR protocols can lead to inconsistent interpretation and reporting across states, programs, and EQROs. Additionally, inconsistent reporting makes it difficult for stakeholders, including state and federal officials, to extract key findings from the ATR, place EQR findings in context, or synthesize EQR findings with other required quality and oversight activities.

MACPAC's review found ATRs are lengthy, detailed, and often hard for most audiences to comprehend. The majority of ATRs are hundreds of pages long, often with additional appendices or attachments. Additionally, our review found states use different approaches for evaluating plan performance, making it difficult for individuals to clearly determine the extent to which a plan was compliant or the extent to which a plan's non-compliance was significant. Some EQROs scored plans using a binary compliant/non-compliant approach. Other reports categorize plan compliance as being met/partially met/not met. Some reports referred to the percentage of reviewed components for which a plan or the group of plans was found to be compliant within each type of requirement. This variation in how states rate plans' compliance makes it difficult for individuals to clearly determine the extent to which a plan was compliant or the extent to which a plan's non-compliance was significant.

A more standardized structure for summarizing and reporting EQR activities, results, or action taken by the state Medicaid agency in response to the findings would make it easier for interested stakeholders to review these reports and glean the key takeaways on plan performance. The organization of ATRs can vary considerably from state to state, and sometimes even within a state across years, especially if the state has

contracted with different EQROs for different activities or in different years. One interviewee we spoke to noted that mismatched data made it difficult to identify trends that could help regulators and managed care plans prioritize the allocation of resources or identify best practices that could be shared across states and plans.

The recommendation is focused on standardizing reporting structures and summarizing key findings. It is not intended to create new measures or mandate specific data be collected. Standardizing aspects of the ATR could improve the usability and digestibility of the findings while still maintaining state and EQRO flexibility to design and implement the EQR process to meet the state's needs. As such, CMS could develop a standardized template to summarize key findings and EQRO recommendations in an executive summary and still allow for flexibility in the structure and presentation of findings in the main body of the report. For the template, CMS could build on the guidance and tips for effective reporting that are included in the EQR protocols. For example, CMS suggests displaying previous recommendations, plan responses and actions, and new recommendations in one chart (CMS 2023). This chart could also include a description of how the state quality strategy has been updated to address the EQR findings and recommendations (CMS 2021).

Additionally, EQR is part of a larger federal quality and oversight strategy. Many EQR activities have some overlap with other federal requirements that were established in the 2024 managed care rule. For example, the network adequacy mandatory EQR activity may evaluate similar information as data in the Network Adequacy and Access Assurances Report (NAAAR). Similarly, the performance measures that are validated under the EQR activity may overlap with the mandatory measures included in the QRS. To help reduce the state's administrative burden, CMS should identify areas in which there is overlap with other federal monitoring activities, such as the NAAAR and QRS, to reduce duplicative reporting.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that the recommendation could increase federal discretionary spending to cover CMS administrative activities related to implementation. CMS would be operating within its current statutory and regulatory authority to make EQR mandatory activity protocols more consistent.[9] CMS would have some increase in administrative burden to update EQR protocols, develop EQRO and state Medicaid agency guidance, and offer technical assistance. This administrative burden could be offset if CMS identifies how EQR interacts with other federal quality and oversight reporting requirements and identifies how states can leverage findings and data across requirements to reduce burden on federal regulators reviewing state reports.

States. States would need to work with their EQRO to modify their ATRs to comply with the standardized reporting requirements. States could benefit from reduced administrative burden if CMS issues guidance and updates the protocols to reduce EQR reporting in areas in which information is duplicative of other federally mandated reports. States would have one year from the issuance of any updated protocols from CMS to comply.

Enrollees. Medicaid enrollees and other beneficiary advocacy organizations would be able to find information on the quality of care being provided by different managed care plans if ATRs were more transparent and accessible. The changes to the ATR could improve the oversight of managed care plans and result in improved performance in quality and outcomes.

Plans. Managed care plans would not necessarily see an increased burden unless the EQRO makes changes in the information requested from the plans. Plans could benefit to the extent that any standardization could lead to EQR activities being performed in a more predictable and consistent manner year after year and regardless of the EQRO selected by the state. Plans operating in multiple states could also benefit from a reduction in variability across states.

Providers. Added transparency in the EQR reporting may inform providers regarding areas for potential quality improvement or focus.

Recommendation 1.3

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to require

states to publish external quality review (EQR) annual technical reports in a 508-compliant format and for CMS to publicly post all state EQR reports in a central repository on the CMS website.

Rationale

Although there are federal requirements for states to post their ATRs publicly, our environmental scan found that the most recent reports can often be hard to find. CMS could improve transparency by developing a central repository for these ATRs on the Medicaid.gov website similar to the way they have recently begun posting the managed care program annual reports (MCPARs).

Federal regulations require states to post their ATRs by April 30 of each year for all activities conducted by the EQRO the previous calendar year. Although states typically meet this deadline with few exceptions, reports can sometimes be hard to find, and the information in them can be difficult to use even for CMS and state Medicaid agencies. Given that EQR is an important statutory oversight mechanism related to managed care, the lack of accessibility of reports can hinder the ability of stakeholders to monitor health plans' performance.

In the 2024 managed care rule, CMS added a requirement that states notify CMS within 14 calendar days of posting their ATRs to their state websites. Additionally, the rule requires that states maintain at least the previous five years of EQR technical reports on their websites. States must comply with this requirement to maintain five years of reports on their websites no later than December 31, 2025. Although these new regulations should improve the accessibility of ATRs, it may still be challenging for stakeholders to collect information across states. Posting all of the ATRs in a central location such as Medicaid.gov would reduce the effort needed to locate each state's report.

CMS publishes summary tables based on the ATRs on Medicaid.gov, including a list of the EQROs contracting with states, the number and type of plans included in each state's EQR technical report, validated performance measures, whether a state reported performance measure rates, and the areas of care and populations covered by PIPs. However, these summary tables are generally a count of states and do not include any findings from the ATRs. As such, stakeholders are not able to use these summary tables to assess plan performance.

Officials at CMS indicated that it would be challenging to post the ATRs on the Medicaid.gov website due to issues with ensuring compliance with accessibility requirements of Section 508 of the Rehabilitation Act of 1973. Due to the variation in style and format across states, CMS did not have the resources to ensure each ATR was 508 compliant before posting. CMS has been able to post other reports such as MCPARs because a standardized template is available. To address these issues, CMS should require states and their EQROs provide their EQR ATRs in a 508-compliant format. Existing regulations require that states make the EQR ATRs available in alternative formats for persons with disabilities when requested, including compliance with Section 508 guidelines (42 CFR 438.10(a), 438.10(c), 438.364(c)(3)). Requiring states and their EQROs to submit a 508-compliant ATR to CMS would ensure these reports are available and accessible to persons with disabilities. Alternatively, CMS could require a standardized executive summary in a 508-compliant format in addition to the entire report. This executive summary would simplify the process of making the EQR findings 508 compliant so that CMS could post these summaries in a central location and provide stakeholders easier access to the key EQR findings across states.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that the recommendation could increase federal discretionary spending to cover CMS administrative activities related to implementation. This recommendation would result in increased administrative effort for the federal government to post the ATRs in a central location.

States. States may incur an initial increase in administrative burden to coordinate with their EQROs to implement any new requirements on a standardized and 508-compliant format. This burden would diminish over time once the initial template was finalized.

Enrollees. This recommendation would benefit enrollees by having all EQR information in a central location.

Plans. Managed care plans may face an initial increased burden should the EQRO require any information in a different format. This burden would diminish over time once the initial template was finalized and could potentially result in reduced administrative burden for plans due to standardization.

Providers. Added transparency in the EQR reporting may inform providers regarding areas for potential quality improvement or focus.

Looking Ahead

The recommendations to improve the EQR process in this chapter are intended to build on MACPAC's ongoing work examining effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services. This work includes a current study of Medicaid managed care accountability and the tools available to state Medicaid agencies and CMS to oversee managed care performance, hold plans accountable if their performance is below expectations, and improve performance over time. The Commission will continue to examine data from MCPARs available through CMS and will continue to monitor the effect of requirements from the 2024 managed care rule as they are implemented over the next few years.

Endnotes

[1] To qualify as an EQRO, an organization must have experience and knowledge of Medicaid policy and service delivery, quality improvement and performance measurement, and research design and methodology. It must also demonstrate sufficient physical, technical, and financial resources and relevant clinical or non-clinical skills to complete the necessary activities. There are also conflict of interest provisions for eligible entities (42 CFR 438.354).

[2] Alaska, Connecticut, Maine, Montana, and South Dakota do not have managed care plans subject to EQR. Oklahoma implemented a Medicaid managed care program in 2024. Alabama has only primary care case management entities, which are now excluded from mandatory EQR activities as stated in the 2024 managed care rule (MACPAC 2023).

[3] The enhanced match of 75 percent is available for both mandatory and optional activities conducted by a qualified EQRO. States must submit EQRO contracts for CMS approval before receiving the enhanced match. A 50 percent match rate applies to EQR-related activities performed on entities other than MCOs, such as PIHPs, PAHPs, PCCM entities, or other types of integrated care models. Enhanced match for the optional activity to assist with quality ratings and the new optional evaluation activities added under the 2024 managed care rule will be available for EQR on MCOs after CMS releases a final protocol. Until that time, states that choose to engage EQROs in these optional activities will receive the standard administrative match of 50 percent.

[4] States can also exempt MCOs (but not PIHPs and PAHPs) from the annual EQR process if the MCO has both a current Medicare Advantage contract and a current Medicaid contract; the two contracts cover all or part of the same geographic area in the state; and the Medicaid contract has been in effect for at least two consecutive years before the exemption date, and during those same two years, the MCO has been subject to EQR and met quality, timeliness, and access to health care services standards for Medicaid beneficiaries (CMS 2020).

[5] The state, its agent that is not an MCO, PIHP, or PAHP, or an EQRO may perform the mandatory and optional EQR-related activities (42 CFR 438.358). The majority of states contract with a qualified EQRO to conduct some or all of the mandatory activities.

[6] The standards that are the subject of this protocol are contained in 42 CFR 438: parts 56, 100, 114; subpart D; and the quality assessment and performance improvement program. The scope of those sections includes disenrollment requirements and limitations (42 CFR 438.56), enrollee rights requirements (42 CFR 438.100), emergency and poststabilization services (42 CFR 438.114), availability of services (42 CFR 438.206), assurances of adequate capacity and services (42 CFR 438.207), coordination and continuity of care (42 CFR 438.208), coverage and authorization of services (42 CFR 438.210), provider selection (42 CFR 438.214), confidentiality (42 CFR 438.224), grievance and appeal systems (42 CFR 438.228), subcontractual relationships and delegation (42 CFR 438.230), practice guidelines (42 CFR 438.236), health information systems (42 CFR 438.242), and quality assessment and performance improvement program (42 CFR 438.330).

[7] CMS released the final protocol for network adequacy validation in February 2023, which all states will be required to implement no later than a year from the protocol's release (CMS 2023).

[8] CMS finalized its framework for the Medicaid quality rating system in the 2024 managed care rule (42 CFR 438, subpart G). States must implement the quality rating system by December 31, 2028.

[9] The authority for the Secretary of the U.S. Department of Health and Human Services to develop EQR protocols is established in statute at 1932(c)(2)(A)(iii) of the Act and the requirements set forth in 42 CFR 438.352.

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on January 24, 2025.

Examining the Role of External Quality Review in Managed Care Oversight and Accountability

1.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 438.364(a)(2)(iii) to require the external quality review annual technical report include outcomes data and results from quantitative assessments collected and reviewed as part of the compliance review mandatory activity specified at 42 CFR 438.358(b)(1)(iii).

1.1 voting result	#	Commissioner
Yes	16	Allen, Bjork, Brooks, Brown, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McCarthy, McFadden, Nardone, Snyder
Vacancy	1	

1.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to update external quality review (EQR) protocols to: (1) reduce areas of duplication with other federal quality and oversight reporting requirements, (2) create a more standardized structure in the annual technical report that summarizes EQR activities, results, and actions taken by state Medicaid agencies, and (3) identify key takeaways on plan performance.

1.2 voting result	#	Commissioner
Yes	15	Allen, Bjork, Brooks, Brown, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McFadden, Nardone, Snyder
No	1	McCarthy
Vacancy	1	

1.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to require states to publish external quality review (EQR) annual technical reports in a 508-compliant format and for CMS to publicly post all state EQR reports in a central repository on the CMS website.

1.3 voting result	#	Commissioner
Yes	15	Allen, Bjork, Brooks, Brown, Duncan, Gerstorff, Giardino, Heaphy, Hill, Johnson, Killingsworth, McCarthy, McFadden, Nardone, Snyder
Abstain	1	Ingram
Vacancy	1	