mhpa Medicaid Health Plans of America

July 30, 2021

Mr. John Giles
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Follow-up from 2Q2021 CMCS-MHPA Quarterly Call

Dear Mr. Giles:

On behalf of the Medicaid Health Plans of America (MHPA), I would like to thank you and your colleagues from the Centers for Medicare and Medicaid Services (CMS)/Center for Medicaid and CHIP Services (CMCS) for your continued commitment to the MHPA-CMCS quarterly calls. Your active participation and engagement with our member health plans is greatly appreciated and we look forward to continuing to work with you and your team and colleagues in the best interests of Medicaid beneficiaries and in support of the stability and sustainability of the Medicaid program.

Our most recent quarterly call on June 17th covered a number of timely and highly relevant issues including how to prepare for the winding down of the public health emergency, what steps can be taken to address issues of health equity, and general feedback on the Medicaid managed care final rule. We found the discussion to be greatly informative. As you requested, we have compiled the key take-aways from our conversation and included them in the attached appendix as three tables. For each topic area, we have identified specific issues and key considerations and provided our recommendations for CMS/CMCS action.

In addition, you had also asked for any plan input or feedback on the agency's effort to review Medical Loss Ratio (MLR) standards across programs - Medicaid, Medicare and the marketplace. MHPA welcomes the opportunity to work with CMCS on ideas to improve alignment. One focus area to consider would be incentivizing fraud prevention activities by allowing inclusion of a certain percent of health plan expenditures to be included in the numerator of the MLR (a similar proposal was included in the Medicaid managed care proposed rule of 2015/2016) that would help MCOs and the broader Medicaid program deliver on important program integrity goals. Additionally, we believe that health plan investments in combating COVID-19 should also be considered for inclusion in the MLR numerator as well. If you would like, we would be happy to include this as an agenda item on our next quarterly call in August.

Once again, thank you for taking the time to engage in these thoughtful discussions with our members. We recognize the importance of working collaboratively to address the multitude of issues stemming from the COVID-19 pandemic, its impacts on our nation's most vulnerable

communities, and the need to prepare for the future. MHPA's member plans are well-positioned to help the Medicaid program remain a viable and sustainable approach to meeting public health needs.

We look forward to connecting with you on the next quarterly call. Should you have any questions in the meantime, please feel free to reach out to me directly via email at sattanasio@mhpa.org.

Sincerely,

Shannon Attanasio

Shannon Attanasio
Vice President, Government Relations and Advocacy
Medicaid Health Plans of America

APPENDIX

Access to Health Care *Support for Continued Flexibility & Medicaid Beneficiary Coverage Stability*		
COVID-19 Pandemic/PHE-related Activity		
Issue	**Considerations**	**Recommendations**
Supporting Coverage During Public Health Emergency (PHE) Wind-Down	***Ensure Stability of Medicaid Beneficiary Coverage post-PHE*** ➢ ***Winding down with sufficient time and support***. Nearing the end of the PHE, states will need plenty of lead-time, guidance, and support to ensure a stable transition to resuming certain pre-pandemic Medicaid functions, including performing eligibility verifications and redeterminations.	➢ We would recommend a sufficient time period to allow catch up on redeterminations (e.g., 12 months). ➢ CMS should provide states with sufficient time for winding down any expiring program flexibilities to avoid an abrupt stop of the MOE and associated FMAP bump(s). ➢ CMS should maintain a strong interpretation of Medicaid eligibility requirements for states accessing enhanced funding during the PHE. Continuous eligibility throughout the PHE has been critical to ensuring access to COVID-19 testing, treatment, and vaccines.
PHE Wind-Down: Notice	➢ ***Notice***. We appreciate the advance notice that HHS told states it would provide ahead of the eventual termination or expiration of the PHE (January 22nd HHS letter said PHE likely to remain in place for 2021, but that the agency would provide states with 60 days prior notice).	➢ We support continued assurance of this advance communication for states, and also recommend that CMS encourage states to notify MCOs early regarding upcoming state eligibility processes (e.g., reverification) that stand to affect member eligibility, enrollment, and access to tailored care management approaches.
PHE Wind-Down: Beneficiary/Member Communications	➢ ***Communications*** should better enable MCOs to help members with fulfilling any necessary administrative and paperwork requirements to maximize their likelihood of maintaining their Medicaid coverage.	➢ CMS should encourage states to collaborate with MCOs as essential partners on strategies to communicate with beneficiaries well in advance of any potential changes to their eligibility and coverage.
Telehealth	***Flexibilities During the Public Health Emergency (PHE) and Beyond:***	➢ We recommend maintaining and building upon Medicaid's telehealth flexibilities that allow beneficiaries to receive care in

	• ***Telehealth.*** MHPA member plans appreciate CMS' Medicaid toolkit describing the broad authority state Medicaid programs have to utilize telehealth within their Medicaid programs, including using telehealth or telephonic consultations in place of typical face-to-face requirements when certain conditions are met. • ***Rural/frontier communities.*** Additional funding should be provided and invested in initiatives to expand telehealth and remote monitoring in Medicaid to help improve healthcare access for Medicaid beneficiaries and underserved communities, especially in rural areas with provider access issues. • ***Telehealth and MH/SUD services.*** We support increasing access to services to assist individuals with Mental Health (MH) and Substance Use Disorder (SUD) through telehealth which can expedite relevant service delivery, achieve desired outcomes and help address provider shortage issues and make MH/SUD services available to beneficiaries more widely. • ***Broadband infrastructure.*** Affordable, reliable, and accessible internet provides multiple benefits for Medicaid beneficiaries, providers, and MCOs. Without appropriate access to connectivity, telehealth and remote monitoring will be deficient and underutilized.	their own home and establish a patient-provider relationship via a live, two-way video encounter. ➢ We also support state flexibility to allow providers to practice across state lines when they hold the appropriate medical licensure. We support the promotion of interstate licensure compacts that recognize out-of-state licenses. This will increase access to services and address areas that may face provider shortages. ➢ We encourage CMS to be proactive in ongoing discussions across agencies related to broadband infrastructure and to work toward solutions for increasing access to broadband internet services and smart-enabled devices.

Health Equity *Support for Data Access and Use as a Pathway for Meeting Population Needs & Achieving Health Equity*		
Focus on Meeting Population Needs		
Focus Areas	**Considerations**	**Recommendations**
Maternal health	➢ ***MHPA strongly supports the CMS focus on addressing disparities in health care quality and access.*** ➢ We support addressing maternal health disparities, especially for women of color, and commend CMS' actions for approving Medicaid 1115 waivers that extend coverage for postpartum women. ➢ MHPA supported the five-year Medicaid postpartum coverage extension in the COVID-19 Relief Bill, and we continue to advocate for Congress to make this a permanent option for states, as well as for Congress to pass the "Momnibus".	➢ We encourage CMS to continue swiftly acting on any pending waiver requests (IL, GA, MO are approved. IN, VA, NJ, MA are pending).
Social Determinants of Health (SDOH)	➢ ***Appropriate reimbursement and other incentives for MCOs to address health-related social needs*** *(food insecurity, housing instability, transportation, employment, education) and other issues impact healthcare access, drive healthcare costs, and impact health outcomes.*	➢ CMS should allow expenses for activities related to SDOH to be explicitly included in the numerator of the MLR calculation. Additionally, CMS could broaden the current interpretation of SDOH-related limits and clarify what investments are allowed by plans for SDOH. ➢ CMS should publish guidance encouraging states to include SDOH activities within their Medicaid State Plan Amendments (SPAs) to assist in developing capitation rates that include these activities.
Community Health Projects	➢ ***Community health projects are important avenues for impacting social determinants of health and can support innovative approaches for reaching and serving underserved communities.***	➢ ***CMS should support investment in community health projects.*** CMS should consult with states, health plans, and other stakeholders to explore strategies and pathways that would allow states and MCOs to flexibly reinvest program savings and surpluses in community health projects that embrace SDOH-oriented innovation and associated approaches.

		○ This could include investing in mobile health clinics to address member needs in underserved areas or areas with provider shortages. ➢ We recommend that any requirements to reinvest in the community be noted in the rate-setting process to ensure such requitements do not impact actuarial soundness.

Focus on Data: Pathway to Inform Actions in Furtherance of Health Equity		
Focus Areas	**Considerations**	**Recommendations**
Access	***Health Equity and Data*** ➢ ***Medicaid health plans understand the importance of health equity.*** ○ The Medicaid program ***IS*** a health equity program – designed to support individuals who are underserved and face complex socioeconomic and clinical circumstances ○ We want to emphasize that CMS can use the Medicaid MCO community as a resource in that area and we have information ready to share. ➢ ***Accurate, consistent data is needed to ground health equity work.*** ○ Recognized consistently by the leaders in the field, the data is not about further study of the problem of health inequity, but rather enhancing our ability to deploy effective, targeted effort to improve health outcomes and drive programs that enable health equity. ○ MCOs need timely, relevant, and high-quality data to understand their markets and be able to effectively implement programs to address their populations' health disparities.	➢ *Data Availability, Access, and Quality.* ○ We recommend having specific data fields for race, ethnicity, sex, gender identity, primary language, and disability status that are not prescriptive today. ○ Federal standards for a minimum demographic dataset across all states would be a way to achieve this. This would also allow MCOs with a national presence to better compare markets to identify potential best practices or tailor specific interventions. ○ We also recommend Technical Guidance to states on the datasets as well as the technical requirements for data management on race, ethnicity, language, sex, and disability. ➢ *Regulatory/Policy barriers.* ○ CMCS could support improved data management by conducting a thorough review of the regulatory rules and guidance that present barriers or concerns for Medicaid stakeholders as they seek to build collaborative community focused public health and health equity solutions. ○ By either lowering such regulatory barriers or providing clarifying guidance or toolkits, CMS could support health plans, states, providers and community-based organizations in coalescing to identify and target issues that are driving inequities.

	○ MCOs need timely and complete data to inform quality measures to continuously improve their ability to improve health equity. ○ Today, archaic terminology is used by some states. Other states limit selections of race or ethnicity. States are also often unable to select multiple races, making it difficult for individuals of multiple races to identify themselves. In addition, some states limit the information they share with MCOs. Cultural competency yields appropriate understanding and action based upon beneficiary healthcare related behavior and tendencies.	
Quality	➢ ***CMCS could play a critical role in advancing data quality and the health equity conversation by standardizing demographic data collection for 834 files/enrollment data.*** ○ We recognize the Office of Minority Health's (OMH) COVID-19 Health Equity Task Force has highlighted data as a piece of the puzzle to reduce health disparities. ○ Today, in some markets less than 50% of members have race or ethnicity information on file. Conversely, other markets are able to garner significantly higher and more consistent data. ○ Just as health is not solely defined by healthcare, health equity extends beyond healthcare programs. As such, efforts to align data from other social support programs is critical for enhancing equity efforts.	➢ *Alignment across programs.* ○ CMS could encourage or require states to enhance their Medicaid data warehouse capabilities to include other human services agency data and vital records data could improve the timeliness and quality of data available (like what had been done for Michigan's equity project). ○ CMS could provide enhanced funding opportunities to make such investments. ○ Participation in and leadership of efforts to align demographic data collection across federal programs and agencies could support the achievement of more consistent and desirable outcomes.

	▪ Other programs (WIC, SNAP, Unemployment, HUD, etc.) represent additional areas of demographic data capture. They also represent an opportunity to maximizing data sources to verify missing data to improve overall data quality and associated decision making. ○ Standardization across programs, lays the foundation for streamlined data sharing. Single system enrollment and integrated data systems or use of Health Information Exchange (HIE) for SDOH could and should follow.	

Access to Health Care *Support for Balancing Standards with Continued Flexibility*		
Regulatory Activity		
Rule/Guidance	**Considerations**	**Recommendations**
Medicaid Managed Care Final Rule	• ***Time/distance standards***. Among many provisions we support, we appreciate that CMS removed the stricter requirements for states to set time and distance standards for measuring access and instead finalized the more flexible requirement that states set a quantitative minimum access standard for healthcare providers • ***Provider network adequacy*****.** States are well positioned to review and develop provider network adequacy. • ***Measure selection*****.** The finalized standards permit states to select measures that reflect their unique markets and populations • ***Increased flexibility and innovation*****.** While time and distance standards are commonly used by states to measure network sufficiency, they are not always the best measure of access. o The newly added flexibility can allow states and contracted MCOs to be more innovative in care delivery, including through telehealth approaches. o Given that these new standards were established during the COVID-19 pandemic, it is unlikely that states have had the resources or capacity to leverage this new network flexibility.	➢ We recommend that CMS provide adequate time for states to implement new state-level network requirements or other standards and assess their impacts on access before considering revisiting these standards or imposing any new requirements.