

June 30, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2439–P,
P.O. Box 8016, Baltimore, MD 21244–8016

Re: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality; CMS–2439–P

Dear Administrator Brooks-LaSure,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to provide input on the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Proposed Rule (CMS–2439–P).

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 Medicaid Managed Care Organizations (MCOs) serving more than 52 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries.

Below you will find our general comments in response to this rule, as well as detailed comments in response to specific provisions.

General Comments:

MHPA shares the Administration's stated goals of improving access to high quality services in the Medicaid program. We urge CMCS to delay implementation of this rule to ensure states can resume normal operations following the historic undertaking that is the current Medicaid redetermination process.

As we speak, Medicaid programs across the United States are in the process of redetermining the eligibility of over 92 million Americans who receive health coverage under Medicaid and CHIP. States are currently facing significant bandwidth constraints as they work through a three-year backlog with staff that have in some cases never processed an eligibility verification. The Administration is also experiencing significant pressure as it works with states to oversee redeterminations efforts and facilitate state mitigation plans. Providers are concerned about the impact of a potential increase in the number of uninsured individuals. Given the significant administrative lift related to implementing two new major regulations pertaining to Medicaid, we are concerned that the rapid implementation of new requirements could impede efforts by states to mitigate coverage losses for Medicaid enrollees. And although some provisions are likely to take effect after the unwinding period has concluded, states will be required to begin implementation in parallel with redeterminations to achieve compliance with new requirements.

Now, more than ever, states must have the resources they need to ensure coverage for individuals who are eligible for Medicaid. A reasonable implementation timeline – one that accounts for the time needed for states to stand up systems called for in these new requirements – would help to ensure that states can focus on the task at hand before shifting their attention to structural changes to their Medicaid programs. We therefore call on CMS to delay the enforcement timeline for these provisions by at least one year to ensure that states can fully focus their efforts on their mitigation plans in the context of their redeterminations' efforts.

Detailed Comments:

Access Standards

Appointment Wait Time Standards

MHPA shares in CMS's stated goal of improving access to services for Medicaid and CHIP beneficiaries. As CMS considers approaches to improve access to services, particularly in primary care, OB/GYN, and mental health and substance use disorder (SUD) services, MHPA recommends a focus on efforts to address foundational access issues prior to imposing maximum wait time thresholds, including the ongoing provider workforce shortage, which is particularly severe in the mental health space. Workforce challenges impacting all delivery systems complicate the ability of providers to meet these standards. In many instances, Medicaid MCOs have already contracted with all available providers in an area and continue to face access issues. Given the diversity in how states operate their Medicaid programs, varying geographic footprints (rural versus urban), and differing demographic characteristics in the populations of states, we recommend flexible network adequacy standards rather than a one-size-fits-all approach.

Should CMS move forward with maximum appointment wait time standards, we recommend that CMS consider a 30 or 45 day wait time standard, particularly for adults. For children, we would be supportive of a shorter 30 day wait time standard given the vulnerability of this population, and the importance of children receiving certain primary care visits, vaccines, and other services for their development. As CMS implements these standards, we encourage flexibility and ongoing monitoring, as access issues evolve with the wind down of the COVID-19 pandemic. Should CMS decide to move forward with the timelines listed in the proposed rule, we recommend a phase in to 10 or 15 days from 30 or 45 days to account for the changing environment and to allow data collection on whether there is an increase in provider availability as we move further away from the COVID-19 pandemic.

Also, we strongly recommend that the Administration allow telehealth-only appointments, particularly in the mental health and SUD space, to be factored into the development and implementation of wait time standards. The COVID-19 pandemic has demonstrated the value of telehealth in ensuring access to services for enrollees across government programs, and the clinical efficacy of telehealth for mental health and SUD is well established.

Further, to smooth implementation efforts by states, providers, and health plans, we strongly recommend that CMS consider a phase in of the compliance standards beginning at a 75% compliance threshold in the first year. A phase-in period will allow additional time for stakeholders to identify and address access issues as plans move towards full compliance. CMS can then gradually increase compliance thresholds in parallel with these monitoring efforts to support data-driven decision-making.

To improve comparability across states and to promote consistency in the program, we recommend that CMS define "routine" in the context of maximum appointment wait time standards.

MHPA also supports the inclusion of a robust exceptions process for maximum appointment wait time standards, accounting for uncontrollable factors such as natural disasters, Health Resources & Services Administration (HRSA) designated provider workforce shortage areas, or geographic regions where managed care plans have already contracted with all available providers in an area.

As an alternative proposal for CMS to consider, MHPA recommends the creation of an incentive program to reward providers who hold a certain percentage of their appointments for Medicaid enrollees. Such an incentive would encourage more providers to contract with Medicaid MCOs and could alleviate access disparities between Medicaid, Medicare, and commercial coverage.

Secret Shopper Surveys

MHPA aligns with CMS's objective of improving access for Medicaid enrollees but raises concerns with the feasibility of secret shopper surveys to accurately monitor appointment wait time standards. As states manage the unwinding of the public health emergency and its flexibilities, as well as the implementation of other requirements in this rule and other recent proposed rulemaking, the administrative burden tied to this requirement could inhibit the ability of states to implement other key priorities.

MHPA expresses reservations with the methodology and limited sample sizes tied to secret shopper surveys and is concerned that without improvements in health IT infrastructure to actively monitor wait times, this approach will result in inaccurate data and will ultimately burden states and providers without meaningfully improving access for Medicaid enrollees. Secret shopper surveys will not provide a complete, accurate, nor reliable assessment of beneficiary access since this enforcement approach is subjective and can lead to inaccurate scores due to human errors combined with limited considerations given to external variables outside the MCO's control.

For example, a provider office can refuse to answer secret shopper survey questions, as secret shoppers may not have access to a member ID number, plan name, or other information. We recommend that questions in surveys should be asked in a manner that does not confuse the person who is scheduling – managed care plans have experienced issues with misinterpretation in the past with similar surveys in states that require them. Secret shoppers would likely only capture findings for new patients, as the provision does not address the distinction between new and existing patients. Appointment availability can change day-to-day, even throughout the same day, due to cancellations and provider schedule changes, including those due to emergencies. Finally, provider networks can change significantly over the course of a year, and maintaining an updated provider directory can be challenging when providers do not provide updates to MCOs in a timely manner. While annual secret shopper monitoring may capture provider availability at a specific point in time, it likely would not reasonably represent access.

Currently, tracking and monitoring of compliance with appointment wait times (and availability of after-hours appointments) occurs in Medicaid programs but are not standardized or always reliable. Ensuring the programs work well across all states and MCOs would require specialized platforms and software, training, quality control, sufficient availability of vendors, and other elements. This would add burden to states and providers and would potentially add complexities to the existing processes used to measure appointment wait time compliance.

Apart from the administrative burden for the states and providers, requiring an annual secret shopper survey does not consider seasonality. For example, appointment wait times are higher during flu season.

States, providers, and managed care plans do not have the capacity to ensure administration of secret shopper surveys multiple times per year.

Given these concerns, we recommend that CMS not move forward with this requirement, and instead continue to allow State Medicaid Agencies the flexibility to implement their own version of secret shopper surveys which meets the unique needs of their populations. Should CMS move forward with this requirement, we recommend that robust technical assistance be provided to states.

Enrollee Experience Survey

MHPA supports robust engagement with enrollees to ensure that the member experience remains a key factor in identifying approaches to improve access to care in the Medicaid program. It is critical to give Medicaid enrollees the opportunity to have their voices heard, including to identify gaps in health equity and to ensure that the Medicaid program can meet the diverse needs of the populations it serves. Given that Medicaid MCOs already participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, we recommend that CMS leverage this existing vehicle to capture feedback from enrollees. Leveraging the CAHPS survey would improve comparability across states while minimizing the administrative burden on plans to implement a new survey. We raise concerns that multiple duplicative survey vehicles could result in reduced participation and response rates by Medicaid enrollees.

Should CMS choose to move forward with a separate enrollee experience survey, we believe it is important that CMS considers additional parameters when States administer the survey, such as ensuring the survey is not too long, the way the survey is distributed (mailing, phone, or email) as well as the complexity of the question. We believe that surveys should be targeted and not during just a designated timeframe. The enrollee experience is one of the most important aspects of any plan's work. Health plans always take this feedback to improve our work on an ongoing basis, however, it is important to note that enrollee experience surveys historically have low response rates which impacts insights into the full network's compliance.

Annual Payment Analysis

MHPA supports CMS in their objective of gathering data on payment rates to providers in the Medicaid program. We offer considerations as CMS finalizes provisions to collect this data. Given the proprietary nature of contract negotiations and payment rates between Medicaid MCOs and providers, we have reservations with the collection of data on plan-specific payment rates. Operationally, we are also concerned that this data collection effort will not factor in complex hospital, specialty hospital, and multi-functional inter-disciplinary health care delivery system arrangements which are negotiated in the context of the delivery of multiple services instead of on a one-off basis. As CMS increasingly promotes value-based contracting to drive improvements in health outcomes, we believe this approach does not capture the nuances of these arrangements.

We recommend that CMS collect payment data in an aggregate manner, capturing average payment rates for MCOs broken out by geographic and population areas, including rural and urban classifications. We also recommend that CMS compare payment rates to each state's Medicaid fee-for-service (FFS) schedule, rather than to the Medicare fee schedule. Leveraging Medicaid FFS data as a benchmark will provide a more nuanced benchmark that will allow for easy comparisons between managed care and FFS delivery systems.

Remedy Plan

We support robust technical assistance from CMS to assist states with the creation of remedy plans, which should represent a collaborative effort between the state, MCOs, and other stakeholders to improve access. Given the significant administrative burden to states tied to the implementation of this provision and others, we believe guidance will promote consistency in remedy plans and have a few recommendations. First, we ask that CMS define “access issue” in regulations to provide clarity on when a remedy plan would be appropriate. Second, we seek clarity on whether CMS defines access issues in the context of appointment wait time standards or more broadly. Finally, we reiterate our support for a robust exceptions process, particularly in areas with a severe workforce shortage. States should be able to exempt managed care plans from wait time standards in instances where access issues are outside of the control of Medicaid MCOs, such as a HRSA-designated Health Professional Shortage Area.

State Medicaid Website

We support CMS in their objective of monitoring quality and making key information on State Medicaid programs and Medicaid MCOs accessible to enrollees through state-maintained websites. However, as stated in our general comments, we express concern with the significant burden on states to create these websites. Given the ongoing administrative burden tied to the unwinding period, the creation of a new mandatory core measure set, implementation of network adequacy measures, and numerous new reporting requirements, we are concerned that states will lack the resources and bandwidth to be able to implement a website that meets CMS standards. We therefore recommend that CMS implement a mandatory core measure set and reserve the creation of a state website for future rulemaking, allowing for more robust stakeholder engagement. Should CMS decide to implement this requirement, we recommend that the implementation timeline be delayed, and that CMS provide robust assistance to states and additional opportunities for input to ensure that final products are accessible and usable by enrollees.

State Directed Payments (SDPs)

General comments

MHPA supports state directed payments that are prospective and appropriately funded. State directed payments provide states with the flexibility to finance their programs adequately while targeting additional funding to provider groups that may need resources to build capacity. States should continue to have the ability to fund their programs in a way that meets the needs of their enrollees.

Eliminate written prior approval for SDPs that are minimum fee schedules at the Medicare payment rate

We support CMS’s proposal to eliminate written prior approval for SDPs that are minimum fee schedules at the Medicare payment rate. Streamlining approval of SDPs to raise payment rates in the Medicaid program to achieve parity with the Medicare program will help to improve access and quality of care for enrollees.

We express concern with the proposal to include non-network providers in SDPs. Requiring MCOs to pay non-network providers a certain fee schedule level would be challenging to implement and track because MCOs do not have a formal contractual relationship with non-network providers. In addition, this proposal would undermine the value of formal network arrangements between MCOs and the provider community, which helps to ensure quality services and care coordination for enrollees.

Support for Value-Based Arrangements (VBAs)

We support CMS's objective of reducing regulatory burdens for the implementation of state-specific initiatives in Medicaid including VBAs. However, we have concerns that the provisions in this section would limit health plan flexibility to provide additional payments to providers to incentivize and support their participation in VBAs and limit innovation. We are specifically concerned about CMS's proposal that SDP payments under VBAs must replace the negotiated rate between MCOs and providers. Medicaid providers are limited in their ability to fund improvement efforts and we find that additional investments are often needed to ensure that providers have the resources necessary to take on the added work required to be successful in a VBA.

We believe that CMS should consider not allowing states to recoup unspent SDP for VBAs. Plans should retain the flexibility to implement VBAs in a way that drives high quality outcomes for Medicaid enrollees. Further, we recommend that CMS work with states to quantify the value of VBAs prior to the start of a rating period so that capitation rates can be adjusted accordingly.

Should CMS move forward with this proposal, we seek clarification on how recoupment of funds will be handled operationally. In some instances, SDPs are managed over several rating periods with varying time-periods by provider. Data pertaining to SDPs sometimes lags which could complicate implementation efforts. We recommend that unspent SDP dollars instead be directed to building provider capacity, beneficiary services, and value-added benefits which would improve access and the ability of plans to invest in the social needs of their members.

Tie to Utilization and Delivery of Services for Fee Schedule Arrangements

We appreciate CMS' desire to maintain the risk-based nature of managed care contracts by proposing to prohibit post payment reconciliation of SDPs. Managed care plans often do not have enough visibility into the SDP process to accurately assess our risk. Prohibiting post payment reconciliation could result in over or under-funding SDPs and undermine the purpose of these payments. We recommend that CMS not finalize this proposal and instead work with states and plans to create a payment structure that maintains adequate risk while ensuring all parties have visibility into the process. If CMS does move forward with finalizing these requirements, we have the following suggestions:

- We recommend that CMS make approved SDPs public, as well as state-submitted pre-prints.
- We recommend that CMS require actuarial involvement in all steps of the SDP pre-print process, not just the rate certification.
- We recommend that CMS require state actuaries who certify SDPs to provide documentation demonstrating that the funding is sound.
- We recommend that CMS require SDPs to be established in advance of the rating period.
- We suggest that CMS require states to include a risk margin and other non-benefit costs in SDP payments to support the risk and administrative burden borne by MCOs.
- We ask that CMS consider allowing symmetrical two-sided risk mitigation mechanisms around certain SDPs to limit how far off the premium can be from expenses. This would also help states to ensure that funding is being directed to their intended providers.

SDP Submission Timeframes

We recommend that CMS require SDP preprints to be submitted at the beginning of the rating period, allowing for prospective implementation.

We appreciate CMS's effort to provide states with time to submit required information by feasible deadlines. However, we note MCOs face significant expenses and operational challenges when states and plans implement SDPs retroactively and must reprocess already completed claims. This approach would help preserve resources and reduce the administrative burden and expenses in the program.

Medical Loss Ratios (MLRs)

MLR Reporting Requirements

MHPA supports transparency and reporting requirements tied to identified or recovered overpayments to states. It is critical that government partners have visibility into the full financial landscape surrounding the delivery of Medicaid managed care. However, we express concern with requiring that incentive payment contracts have a defined performance period that can be tied to the applicable MLR reporting period. In the Medicaid space, the contracting calendar year is dynamic. Provider incentives sometimes run on a calendar year rather than a state fiscal year, and quality incentive programs sometimes run over two contract years. That flexibility is valuable as it reduces provider burden and abrasion. We recommend that CMS continue to allow for the allocation of incentive payments across MLR rating periods to promote provider participation and to drive high quality care.

On the ten-day reporting timeframe for overpayments, we recommend shifting to a monthly, quarterly, or semi-annual reporting timeframe instead. Allowing periodic reporting rather than individual reports triggered by overpayments would improve the consistency of data, align with existing state-specified timing and review, and reduce administrative burden for states, plans, and CMS.

In Lieu-of Services (ILOS)

MHPA commends CMS for their codification of existing guidance on ILOS, which represents a significant step towards improving the ability of Medicaid managed care to address the social needs of the enrollees they serve. We recognize and appreciate the importance of addressing health related social needs (HRSNs), with MCOs making significant investments every day.

We appreciate the consistency between CMS's previous guidance on ILOS and the regulatory codification, but express concern that additional time was not allowed for pilot programs to develop and share best practices to improve the codification of this flexibility.

We recommend that CMS eliminate the 5% limit on ILOS, believing that services should be permissible if they are medically appropriate for enrollees. Limiting investments to 5% can stifle innovation and reduce the ability of states and plans to develop programs that can improve health outcomes and support health equity.

Further, to improve state adoption of ILOS flexibilities, we encourage CMS to finalize provisions that balance process standards that don't unintentionally hinder the approval of innovative or targeted services. We encourage CMS to leverage their authority to streamline and facilitate approvals of ILOS waivers as much as possible. Finally, we recommend that CMS release robust guidance and best practices to assist states with implementation of these flexibilities.

More broadly, we recommend that CMS consider allowing for HRSN expenses to be included in Medicaid capitation rates and in the numerator of the MLR, to give states additional tools to assist beneficiaries with their HRSNs.

Medicaid and CHIP Quality Rating System

We support CMS in their objective of improving transparency and quality measurement for the Medicaid program. As CMS looks to implement a MAC QRS framework, we offer the following considerations. We express reservations with the alternative QRS proposal. Increased variation across states will complicate the ability to compare health outcomes across the United States and will introduce additional administrative burden to multistate MCOs who may be seeking to implement aligned quality initiatives to improve health outcomes on a large scale. Instead of allowing states to develop alternative measures, we recommend CMS provide states with a menu of options to choose from, improving consistency in the measures that key stakeholders will have to account for. Further, we recommend that any core or alternative measures be required to meet six out of six of the criteria CMS lays out in the proposed rule to be included in addition to the 18 mandatory measures. New or alternative measures should also be required to undergo a two-year pilot period to allow states and CMS to collect benchmark data before being implemented in the QRS. These additional steps would ensure that new measures are meaningful to enrollees and other stakeholders in demonstrating plan performance while minimizing administrative burden and added complexity to the program. CMS should also consider regional procurements as they seek to implement quality metrics. Some Medicaid MCOs serve specific regions and are not statewide. We seek clarification on how this nuance will be accounted for.

On the oral evaluation, dental services measure, we recommend that CMS consider adopting the NCQA HEDIS measure. HEDIS measures are audited and certified by an NCQA auditor. Moving towards this measure would reduce the administrative burden for State agencies and their external quality review office by eliminating the need to perform separate measure audits. Finally, all parties would be confident that the rates published in the QRS were calculated the same way across all managed care plans. Broadly, we express concern with measure fatigue for enrollees and managed care plans. In addition to core sets for adult, child, and HCBS populations, plans experience significant variation between states in what measures must be captured. Further, plans are typically required to complete the CAHPS survey to capture the enrollee experience. CMS is also considering an enrollee experience survey in this proposed rule and is introducing an alternative pathway for states to continue introducing new measures into the program.

To alleviate administrative burden and to reduce costs and complexity in the program, we recommend that CMS seek ways to align existing measure sets rather than creating new and alternative measures for MCOs to account for. CMS should consider more outcome-based measures, that are focused on improving beneficiary outcomes instead of the more administrative measures in the mandatory measure set. Simplification and alignment will improve the ability of members to understand and make decisions based on plan performance and would improve the ability to compare plan performance and the member experience across states.

As stated above, we recommend that CMS focus on implementation of quality measures in this proposed rule and reserve the requirement that states create a website for future rulemaking. Given ongoing state burden tied to the unwinding period and other pending regulatory requirements, we believe that delaying implementation of a website would allow for more robust stakeholder engagement, facilitating the development of a vehicle which could meaningfully illustrate plan performance in a format that is accessible for enrollees.

Further, we recommend that to the extent that CMS moves forward with a state website that benchmark percentages be included alongside the plan metric to provide context for plan performance. For certain

metrics, a rate of 90% may indicate poor performance, for other metrics, a rate of 60% may indicate high performance compared to other plans in that region.

We express support for the stratification of data in the MAC QRS framework – stratifying data represents a critical first step to identifying gaps and to improving health equity for the diverse populations who receive care through the Medicaid program.

Once again, thank you for the opportunity to provide comments on the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Proposed Rule (CMS–2439–P). Supporting access to care and services for Medicaid beneficiaries is of paramount importance to MHPA. We appreciate the opportunity to share our perspective to address access challenges and barriers and look forward to continuing to work with CMS and our state partners to make a meaningful difference in the lives of Medicaid beneficiaries.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Vice President, Government Relations and Advocacy