July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1771-P
7500 Security Boulevard
P.O. Box 8013, Baltimore, MD 21244
Attention: CMS-2439-P
Mail Stop: C4-26-05

RE: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

Dear Administrator Brooks-LaSure:

The Healthcare Leadership Council (HLC) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS') "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" proposed rule.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, homecare providers, group purchasing organizations, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

HLC shares the agency's goal to improve access to care, quality and health outcomes, and better address barriers to achieving health equity for Medicaid and CHIP managed care enrollees. While we support the intent of the proposed rule, we are concerned that certain provisions will increase burdens on states and Medicaid Managed Care Organizations (MCOs) at a time when they are already overwhelmed by multiple challenges, including the persistent workforce shortage, the unwinding of continuous enrollment and other time-limited policies implemented during the COVID-19 Public Health Emergency (PHE), and limited information technology reporting infrastructure due to lack of interoperability.

HLC thanks CMS for issuing flexibilities and guidance for the "All Hands-on-Deck" effort as states restart routine Medicaid renewals. Providers, plans, and other entities are playing a critical role in assisting enrollees to avoid unnecessary procedural terminations.

As CMS evaluates steps to improve access to care and enhance health equity goals, we encourage you to consider the following recommendations:

Access

As you are aware, the healthcare system is facing a system-wide worker shortage, including an estimated physician shortage of nearly 124,000 physicians by 2034.[1] This shortfall is likely to disproportionately affect rural and underserved communities. While HLC supports CMS' intent to ensure access to timely services in these communities, we are concerned that the proposed requirement for states to enforce maximum appointment wait time thresholds will not address the foundational issue of workforce shortages nor meaningfully improve access for Medicaid beneficiaries. We recommend that the agency establish flexibilities due to factors outside of direct health plan control that contribute to accessing services, including workforce shortages, provider shortages, facility closures, the likelihood for the adoption of interoperability standards to monitor and ensure timely access across unique Medicaid programs, and the feasibility of implementation and compliance.

Telehealth is a key tool to advance health equity by reducing barriers to care, such as transportation, and mitigating the workforce shortage. We urge CMS to not adopt its proposal to only count appointments offered via telehealth toward appointment wait time standard compliance if the provider also offers in-person appointments. Telehealth-only appointments should count toward compliance in any finalized appointment wait time standard.

If CMS finalizes requirements for states to audit wait time standards, we recommend that CMS pursue objective measures of compliance. Specifically, CMS should:

- Collaborate with MCOs and providers to develop a reporting system and interoperability standards that allow for the sharing of appointment and scheduling data between parties;
- Consider engaging Standards Developing Organizations such as Health Level Seven International (HL7) to update existing standards such as the Fast Healthcare Interoperability Resources (FHIR) Version 3.0.1 or develop new standards for both the data capture and information sharing between MCOs and providers; and,
- Following the finalization of technical standards, provide guidance on what information must be reported to demonstrate compliance with these standards.

CMS proposes to require MCOs to submit a payment analysis to states, showing their level of payment for certain services and including a comparison of payment rates to published Medicare payment rates for the same service. As CMS seeks to incorporate payment transparency to address barriers to access services in Medicaid, we urge the agency to ensure payment analysis requirements include safeguards against any risk to revealing health plan proprietary or competitive information. Additionally, any payment analysis required to compare payment rates to providers in managed care should use Medicaid FFS as a benchmark, which is more appropriate and relevant, instead of Medicare FFS as CMS proposes.

1 The Complexities of Physician Supply and Demand: Projections From 2019 to 2034, Association of American Medical Colleges (June 2021) https://www.aamc.org/media/54681/download?attachment

Medical Loss Ratio

As CMS further specifies requirements to Medical Loss Ratios (MLRs), we recommend the following considerations to current proposals and urge that Social Determinants of Health (SDOH) be incorporated in alignment with CMS' health equity goals.

We encourage CMS to take a meaningful step towards improving healthcare outcomes and reducing healthcare disparities by allowing expenses for activities related to addressing SDOH to be explicitly included in the numerator of the MLR calculation. The agency should also broaden the current interpretation of SDOH-related limits and 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.

We support the broad interpretation of "overpayments," which may be the result of fraud, waste, abuse (FW&A), or other billing errors. To help to mitigate potential FW&A or overpayments, we encourage CMS to allow health plans to apply direct cost for identifying, mitigating and recovering overpayments in the MLR numerator.

We support the standardization of MLR reporting to allow consistency of reporting among programs (i.e. CHIP, Medicaid, Medicare Advantage and Marketplace) and across states to incentivize overpayment detection and recovery. As CMS clarifies standards around provider incentives and prohibited administrative costs in Quality Improvement Activities (QIA) and allocation methodologies, HLC supports the incentive payments being administered and calculated based on the underlying care delivery and quantitative documentation of clinical or quality of care delivered. We would encourage CMS to include the direct costs associated with identifying, mitigating and recovering overpayments in the MLR numerator to create incentives for health plans to pursue FW&A and/or improper payments.

To address inconsistencies in reporting of overpayments, CMS proposes a definition of "prompt" payment that would require MCOs to report both identified and recovered overpayments to states within 10 days. CMS seeks comment on whether they should instead require routine reporting of overpayments. Continuous reporting of overpayments could lead to inaccurate or duplicative reporting resulting in frequent restatements. HLC recommends quarterly, aggregated reporting, which will be less burdensome for states and managed care plans while still providing sufficient time for investigation and verification.

Medicaid and CHIP Quality Rating System (MAC QRS)

CMS proposes to require states to implement MAC QRS (or alternative QRS) by the end of the fourth calendar year following the effective date of the final rule. Additionally, CMS proposes that in maintaining the MAC QRS mandatory measure set and rating methodology, CMS will align with other similar CMS programs and approaches when appropriate.

HLC supports general alignment of the MAC QRS measure set with other quality ratings systems, such as those for MA/Part D and Qualified Health Plans, when appropriate. We recommend that CMS incorporate a voluntary performance year to allow states and MCOs to identify and resolve any reporting, surveying, or other issues with the proposed MAC QRS framework before implementation becomes mandatory.

Thank you for the opportunity to provide feedback on potential changes to the Medicaid and CHIP programs. If you have any questions, please do not hesitate to contact Debbie Witchey at dwitchey@hlc.org or 202-449-3435

Sincerely,

Mary R. Grealy
President