CMS Medicaid Managed Care

Proposed Rule Comment Summary

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EXECUTIVE SUMMARY

On April 27, 2023, the Centers for Medicare & Medicaid Services (CMS) released for public inspection a notice of proposed rulemaking, "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality." The proposed rule was published in the *Federal Register* on May 3, 2023. CMS accepted public comment on the proposed rulemaking through July 3, 2023.

19 state agencies commented on the proposed rules. Brown and Peisch submitted a comment on behalf of several states: Louisiana, Illinois, Michigan, Missouri, Tennessee, and Vermont. Three states, Michigan, Missouri, and Tennessee chose to submit additional comments. Overwhelmingly, state agencies requested additional time, resources, and flexibility to reach compliance should the rules be finalized. Three health plans submitted comments: Blue Cross Blue Shield Association, Centene, and United Healthcare. These commenters **emphasized time and flexibility** to assist states in reaching compliance. Often, plans requested clarification on provisions as they related to dual eligibles. More than 60 hospitals and 60 hospital associations submitted comments. Most focused primarily on the **State Directed Payments (SDPs) proposals, opposing limitations on SDP spending, opposing the use of attestations for provider-financed programs, and supporting the use of the average commercial rate (ACR) as the standard for payment level**. Many also commented on, and opposed, a prohibition on interim payments with subsequent reconciliation.

Stakeholders shared support of the goals in the Access provisions, but states expressed concerns on the feasibility of operationalizing wait time standards, costs of shopper and enrollee experience surveys, and expectations for administering remedy plans. Health plans and associations shared in state concerns, with emphasis on **the need to extend wait times, maintain flexibility for states, and enhance network adequacy requirements and accountability**.

State-directed payment (SDP) proposals received significant opposition and concerns for implementation. In general, comments showed support of SDPs but a common theme was that a **cap on SDP expenditures should not be set**. States acknowledged high-risk agreements should have additional oversight but suggested a distinction between high-risk and low-risk agreements so as not to attach burden to innocuous arrangements. Comments from trade associations reflected similar concerns and sought clarification on specific aspects of the proposal. Health plans had limited comments on the SDP expenditure cap but did **request additional flexibilities and options to reduce administrative burden**. Commentators shared various opinions on requirements around value-based care initiatives and quality, with some favoring flexibility to design and implement value-based payments while others requested **further guidance on establishing performance measures** for evaluation and modifications to proposed evaluation requirements.

There were few state comments on the medical loss ratio (MLR) standards, but contract requirements and timelines for implementation were a primary concern. Comments by trade associations reiterated timeframe changes for implementations and issues around payments. Suggestions for enhanced flexibility and additional clarification were provided by health plans.

State comments reflected opposition to the in lieu of services and settings (ILOS) provisions, but few comments were on specific areas. **Burden, unfeasible timelines, and requiring ILOS under a State Plan or 1915(c) waiver** were a primary consideration for why these provisions could limit innovation and cost-effective substitutions. Comments across trade associations requested clarification around types of services or settings that would be approved, with recommendations to allow HRSN expenditures to be included in Medicaid capitation rates and in the numerator of the MLR. Health plans also provided recommendations for standardization.

State comments on the quality assessment proposals focused on External Quality Review (EQR) processes including recommendations to **enhance flexibility around scope, design, and implementation with concern around administrative burden**. Comments by trade associations were associated with support as well as recommendations for a longer timeframe for compliance with these requirements. Health plans likewise were supportive; however, there was opposition to the public comment requirements.

Comments by states were **generally supportive, but reiterated administrative burden should be considered** as well as if their measures are meaningful to beneficiaries. There was disagreement across states on using a standardized set of measures or promoting flexibility for states to choose what is appropriate for their state. These disagreements were also seen in health plan and state agency comments. Whereas health plans endorsed a standardized measure set, state agencies promoted more flexibility. Several comments reiterated that CMS should help ease burden and promote alignment in measures across programs. Further guidance was sought for **standardized data collection on demographics** as well as consideration on feasibility to collect and verify information.

Workforce shortage and administrative burden were a primary consideration across all comments submitted. Stakeholders shared support for many of the goals but acknowledged concerns on feasibility to implement and comply with the proposed requirements.

ACCESS

Most state agencies commented on the Access provisions. States also had the most commonality in this section, with **overwhelming concerns about the feasibility of these proposed rules**. States were particularly concerned about appointment wait time standards and their ability, or lack thereof, to comply and voiced opposition to finalizing these standards. States referenced the **provider shortage** and several states made note of the fact that there were **many rural areas that were difficult to support**. Finally, states were hesitant to fully support these wait time standards that have yet to be implemented in other federally supported programs such as Medicare and the Marketplace. The secret shopper and enrollee experience surveys were also commented on by most states. Though supportive of the goals of the surveys, **states emphasized flexibility in selecting what worked best for their program** and population. Several states made note of the **increased administrative burden and costs** of these surveys. Behind wait times, remedy plans were also commented on frequently. States seemed somewhat supportive but wanted clarification as to the expectations for starting and enforcing a remedy plan. Overall, states were supportive of the goals for this section but were concerned about their ability to achieve what CMS proposed.

Like state agencies, most trade associations commented on the Access provisions and had the most commonality. Much of the concerns and feedback from the trade associations echo those expressed by the states. Regarding wait time standards, there was a central theme of issues surrounding **workforce shortages and state-specific geographic and demographic variations**. Overall, across all provisions in this section, there was a consistent concern on **administrative burden for the states and agencies as they continue their unwinding efforts**. Meanwhile on the plans side, trade associations urged more leniency and exemptions in provision requirements as well as extended timeframes for compliance.

All three health plans also commented on the Access provisions and agreed with both states and trade associations. Though supportive of the goals of the provisions, health plans were uncertain that these goals would be achieved through these proposed rules as written. As such, these organizations requested that the proposed rules be modified to **increase the times and retain flexibility** for states to plan and implement the surveys.

Hospital associations also voiced support for CMS' efforts to enhance network adequacy requirements for Medicaid managed care programs using quantitative network adequacy standards. At least one strongly

urged CMS to ensure compliance with these requirements, noting that the **responsibility falls to the managed care plans and states, not providers**.

Some noted that time and distance standards do not always reflect true access to care when considering appointment availability and different practice patterns within provider groups and that more is needed to hold plans accountable for maintaining a provider network. They also recommend requirements that plans must post network adequacy measures on: The percent of in-network providers that received payment in the measurement year, by provider type; Out-of-network payments as a percent of total claims payments, by provider type; Out-of-network claims paid as a percent of total claims paid, by provider type; and Percent of total membership that used an out-of-network provider in the measurement year.

Enrollee experience surveys

§§ 438.66(b) and (c), 457.1230(b)

Ten states commented on enrollee experience surveys and the majority (8 out of 10) were supportive of the goals of the proposed rule but had additional comments and suggestions for implementation. The states often cited the administrative burden of another survey and found this specific survey to be **duplicative of work they already conduct**. Texas, Michigan, and Oregon spoke to the need for flexibility in implementation, requesting that states be able to **choose the survey tools and frequency**. States also requested additional funding from the Federal government to help achieve these goals.

Five trade associations commented on enrollee experience surveys. While there was general support over improving enrollee experiences, there was also concern over duplicative efforts to assess **experience, enrollee survey burnout, and administrative burnout**. Most of the commenters requested CMS to incorporate enrollee experience survey questions into existing surveys (like CAHPS) or allow states to choose their own survey instrument.

Blue Cross and Centene commented on enrollee experience surveys, expressing some support for the provisions. However, CMS noted that these surveys would be **burdensome and that the state should retain flexibility in scheduling the survey distribution**. Blue Cross requested that CMS offer additional guidance, especially as it relates to dually eligible beneficiaries.

Appointment Wait Time Standards

§§ 438.68(e), 457.1218

Notably, 13 out of 17 state agencies that commented on the appointment wait time standards explicitly **opposed the proposed rule and asked CMS to not finalize this proposal**. They cited many external challenges to implementing this rule such as provider workforce shortages and Medicaid unwinding. Some states, though opposed to the proposed rule, suggested revisions at minimum should the rule be implemented. New Hampshire suggested **working with other Federal agencies** such as Health Resources and Services Administration or the Department of Education to **help provide initiatives to grow the provider workforce**. Rhode Island requested that CMS create a phased-in approach to wait times and create an exemption process for designated shortage areas. Other states made note of the fact that these **wait time standards are more rigorous than even Medicare or Marketplace plans**.

Additionally, 8 out of 11 trade associations that commented on the appointment wait time standards strongly opposed the proposed rule and had significant concerns. **The main concerns voiced by trade associations include provider workforce shortages, state demographic and geographic variations, and unrealistic wait time and compliance standards**. Few commenters recommended incorporating telehealth innovations when considering standardizing wait times for services. Notably, the Tennessee Hospital Association and the American Medical Association were in support of the proposed standards with no additional feedback or recommendations.

Like the other organizations, all three health plans did not support the implementation of the appointment wait time standards as written. Health plans were concerned about the ability to reach compliance with the wait time standards as written. **Plans noted provider shortages, facility closures, and other external factors that impact the ability to reduce wait times**. Like state agencies, health plans suggested that CMS work with other entities to create policy solutions to increase the number of available providers and encouraged CMS to count telehealth services toward compliance.

Hospital Associations supported the requirement for wait time standards for primary care, obstetrics and gynecology, outpatient mental health and substance use disorder services along with a state-selected additional service area. **Associations also strongly supported CMS establishing maximum wait times for each of the areas to ensure some standards are achieved across states.** Further, Associations also generally feel there should be network adequacy standards required as it relates to home care, skilled

nursing, rehabilitation, and long-term acute care services and encouraged CMS to provide greater authority for plans to count access to telehealth services towards compliance with appointment wait time standards.

Secret shopper surveys

§§ 438.68(f), 457.1207, 457.1218

Like the enrollee experience surveys, most state agencies that commented (10 out of 12) were supportive of secret shopper surveys but reflected some of the same concerns around administrative burden and a strain on resources. Most states that commented on this proposal felt that the **timeline for correcting errors found by the survey was too short and not feasible**. Additionally, states sought to include telehealth in reaching compliance with both wait times and the secret shopper surveys. Consistently, states sought additional financial and technical support from CMS in implementing these provisions. States such as Pennsylvania, Iowa, and Michigan made note of the burden this would place on states without additional funds to support the work.

Trade associations had mixed feedback with the secret shopper survey **with some fully in support, others requesting additional information, and one with serious concerns over the design and implementation of the survey**. Some trade associations requested that CMS work with states and key stakeholders to develop a meaningful survey and reporting system. AHIP, notably, has serious issues with this section of the proposed rule specifically on how survey questions are phrased, asked, and who will be responding. Furthermore, AHIP also had an issue with the survey being only a "point-of-time" view and not representing overall enrollee experience.

Blue Cross and Centene commented on this provision. Blue Cross recommended that CMS provide more guidance and extend the timeline for correcting information, similar to state agencies. Centene was not supportive of secret shopper surveys and points out that there may be potential for inaccuracies as this is a point-in-time measurement. Both recommend that CMS conduct further outreach to revise this provision. United did not provide comment.

There were recommendations from hospitals that **CMS adopt a lower percentage in initial years and then adjust it over time** as plans and providers acclimate to the new standards. Some also urge CMS to provide additional funding to states to ensure the completion of the process independently and accurately, without diverting funds from provider rate funding.

Assurances of adequate capacity and services - Provider payment analysis

§§ 438.207(b), 457.1230(b)

Eight states commented on this provision and the majority sought additional clarification and were supportive if CMS made additional revisions. The concerns brought up by states were regarding potential issues when faced with bundled payments or other payments that are not code specific. Brown and Peisch as well as other states submitted comments asking for clarification on the purpose of including "trade secret" information regarding rates.

Trade associations are generally supportive of CMS' efforts to ensure provider payments are adequate. However, they raised the issue of several challenges when comparing Medicaid rates to Medicare rates.

Centene and United were not supportive of this provision, citing that it may be burdensome and duplicative of other data that is already submitted. United also commented that this provision risks disclosing proprietary information. This was a position held by at least one hospital/health system, BJC HealthCare.

Assurances of Adequate Capacity and Services Reporting

§§ 438.207(d), 457.1230(b)

Fewer states (6) commented on this proposal and were generally supportive but provided additional suggestions for revision to reduce the administrative burden. Several of the states requested technical assistance. New York requested to delay implementation of this proposed rule.

Remedy Plans to Improve Access

§ 438.207(f)

Remedy plans were commented on by 11 states and none were fully supportive of this provision. Four states opposed the provision, and seven states **were somewhat supportive but strongly suggested an extended timeline and additional clarification from CMS** regarding expectations from the states. New Hampshire, Nebraska, and Oregon all recommended providing additional flexibility on submission and enforcement of plans. Tennessee felt that remedy plans would be ineffective at addressing what they see as the real issue of access, provider shortages.

Four trade associations commented on this section of the proposed rule. Two expressed general support for the remedy plans to improve access while the other two (AHIP and NAMD) expressed significant concerns. NAMD expressed concerns over timelines for remedy plans and did not think it is appropriate division of state and federal responsibilities. AHIP further noted that CMS should give states and MCOs more flexibility in developing remedy plans.

Transparency

§§ 438.10(c), 438.602(g), 457.1207, 457.1285

Few states commented on this provision and were generally supportive but had concerns and requested additional clarification on requirements for the state. Massachusetts recommended that CMS provide additional technical assistance for implementation.

The trade associations that commented on this proposed provision were in support of additional transparency.

Terminology

§§ 438.2, 438.3(e), 438.10(h), 438.68(b), 438.214(b)

Iowa urged CMS to have further dialogue with states about the potential impact of terminology changes but did not discuss in further detail what these potential impacts might be.

STATE DIRECTED PAYMENTS

This section also had many comments, **most opposing the proposed rules**. State agencies were **unanimously opposed to a cap on SDP expenditures**. States felt that a cap on expenditures would have a harmful impact on their programs. Throughout the comments, there was a general agreement that high-risk arrangements should have additional oversight to ensure the integrity of the Medicaid program. However, states felt that this level of oversight for routine, low-risk arrangements was unnecessary and burdensome, and a distinction should be made between the two types of SDPs. On the other hand, states were agreeable to codifying the ACR as the total payment limit, except for California, and supportive of the submission timeframe provisions. There was some variance on other provisions, but **most states were hesitant to support the Appeals provision**, offering suggestions for better platforms to speed up the appeals process. Iowa recommended that CMS conduct and publish a comprehensive impact analysis of the proposed SDP changes and Utah suggested that CMS should provide additional time for implementation.

12 trade associations commented, most of them expressing concerns about various provisions while a few wanted clarification. Like states, **most trade associations oppose a cap on SDP expenditures and support changes that would provide more state flexibility around the use of SDPs**. On the state level, hospital trade associations had very specific comments and clarifying requests. The Texas Association of Community Health Centers (TACHC) wanted to clarity from CMS that FQHCs can take advantage of both incentive and value-based payment arrangements as an SDP and that these amounts should be excluded from the FQHC supplemental payment calculation. Healthcare Association of New York State (HANYS) urges CMS to allow states the option to use the regional provider ACR as the UPL, reconsider its proposal to prohibit interim payments with reconciliation and continue allowing states flexibility in their approach to tying SDPs to utilization of Medicaid services. Meanwhile, the Health System Alliance of Arizona wants CMS to not impose any expenditure limits on SDP beyond the requirement that SDPs be actuarially sound (measured based on ACR) and disagrees with the agency considering SDP proportional expenditure limits.

Among health plans, Blue Cross and Centene submitted comments on SDPs with each having differing opinions. These organizations largely did not comment on SDP expenditure caps and instead focused their comments on requesting additional flexibilities and options to reduce administrative burden.

As mentioned above, there were many comments on this section of the proposed rule from hospitals and hospital associations, who were unanimously supportive of SDPs generally, with maximum flexibility for states to administer these payment programs. All were in opposition to any limitations or caps on total SDP spending levels.

Definitions

§ 438.6(a)

There was at least one comment, from the California Hospital Association, sharing their concern that the **definition of "academic medical center" was too narrow** and would not account for certain arrangements in use today, namely a facility that is affiliated with but does not include a health professional school. Accordingly, CHA recommended CMS amend the definition to read: "Academic medical center means a facility that includes a teaching hospital and is affiliated with a health professional school."

Medicare Exemption, SDP Standards and Prior Approval

§ 438.6(c)

Eight states commented on this provision with mixed support. Some states did not support this proposal based on prior authorization and hold harmless provisions. Others supported but recommended more flexibility for exempting a narrow range of Medicare.

Non-Network Providers

§ 438.6(c)(1)(iii)

Four states commented on this provision. Comments were supportive but California recommended changes to ensure that incentives for in-network providers were maintained.

The Texas Council of Community Centers (Texas Council) strongly supports amending the existing rule to allow states to direct payments to non-network providers. However, MHPA expressed concern with the proposal to include non-network providers in SDPs.

Blue Cross strongly opposes this provision including non-network providers. However, Centene was explicitly supportive of non-network providers being allowed to participate in these arrangements and

allowing states to set minimum fee schedules for non-network providers as long as it is "reasonable." Centene also requested that states have flexibility to implement maximum fee schedules for non-network providers that are lower than the fee schedules for in-network providers to maintain incentives.

Most hospitals/associations were silent or supportive on this point with one exception from the Texas Hospital Association. They said that without a financial model, it is difficult to ascertain the net direction SDP dollars would flow into and out of states and encouraged CMS to perform a quantitative analysis to this effect before moving ahead. Regardless, any benefit to one state comes at the expense of another. They suggested that the non-network provision be limited to non-network providers within a state.

SDP Submission Timeframes

§ 438.6(c)(2)(viii) and (ix)

The six states that commented were overall supportive of this provision and a 90-day timeframe (prior to the end of rate period) for preprints.

Centene is supportive of the 90-day timeframe for SDP preprints and recommended a requirement that the rate certification must update rates retroactively. Blue Cross recommended that CMS require preprints to be submitted at the beginning of the rating period.

Standard for Total Payment Rates for each SDP, Establishment of Payment Rate Limitations for Certain SDPs and Expenditure Limit for All SDPs

§ 438.6(c)(2)(ii)(I), 438.6(c)(2)(iii)

Many states (10 out of 20) commented on this provision. All states that commented on this provision did so in **opposition to a cap on SDPs**. However, of the seven states that also commented on the ACR limit, the majority were supportive of codifying the ACR as the total payment rate limit. In contrast, California was the only state that did not support any changes to the ACR policy or the adoption of any alternative.

The only comment made on SDP limits by health plans was from Centene, suggesting that CMS provide clarification on "reasonable, appropriate, and attainable" as it applies to provider payment rates.

Nearly all hospitals and hospital associations commented on this section. **Hospital Associations strongly opposed CMS' proposed limit on SDP expenditures and urges CMS not to finalize either SDP cap proposed as these would artificially and arbitrarily limit the growth in SDPs**, particularly for hospital-based SDPs. They supported CMS' codification of the Average Commercial Rate (ACR) as the upper payment limit for SDPs for the service areas identified (inpatient/outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center) and opposed any alternatives to ACR as the upper limit. The Oklahoma Association noted that the use of Medicare as the payment limit, or even a percentage of Medicare, would represent a significant threat to hospitals' ability to participate in Medicaid managed care during a period of rapid cost inflation.

Several hospitals/associations noted that **using the ACR brings Medicaid payment rates in line with higher rates of commercial insurance and helps prevent hospital closures** by decreasing unreimbursed costs for Medicaid services and encourages more healthcare providers to accept Medicaid patients. Through SDPs, there has been significant hospital investment in workforce maintenance and development as well as quality improvement initiatives focused on reducing c-section rates, emergency room visits, and readmissions in the Medicaid population.

Hospital Associations supported increasing state flexibility to use ACR data from a broader set of providers (ACR by service) to target funding to financially vulnerable urban or rural hospitals. As each state Medicaid program is different, a one-size fits all expenditure cap on SDP programs is not consistent with the flexibility states need to operate their Medicaid programs in the way that works best for each state.

Financing

§ 438.6(c)(2)(ii)(G) and (H)

Though not opposed, Pennsylvania has concerns about providers not paying the tax but receiving benefits. **Hospital Associations strongly opposed further restrictions on states' use of taxes to finance Medicaid payments**, suggesting this could have dire consequences for coverage and access to care, particularly for historically marginalized populations, as it is unlikely that states would be able to replace any lost funds with other sources of revenue. Associations opposed CMS having discretion to withhold or retroactively deny SDP approvals based on an objection to certain nonfederal share financing arrangements. Associations argue that this is outside CMS' scope of authority and that this provision should be withdrawn pending a federal court case in Texas on this matter.

Hospital Associations were also concerned that requirements around **hospital attestations are ambiguous and require more clarity**. Specifically, the final rule must make clear that any provider that makes an attestation based on its own good faith belief of compliance with federal statutes or regulations — not sub-regulatory guidance — has satisfied subsections (G) and (H).

Tie to Utilization and Delivery of Services for Fee Schedule Arrangements

§ 438.6(c)(2)(vii)

This provision had mixed reception among state agencies, with two states opposed to the provision and two states supportive. Pennsylvania requested additional clarification regarding interim payments.

Hospital Associations were more uniform in their opposition to this provision. They encouraged CMS not to adopt its proposal to prohibit states from performing post-payment reconciliations to actual utilization in SDPs. The Virginia Association pointed out that this would be an "unworkable administrative nightmare," with state agencies and MCOs needing to keep multiple rating periods open for many years, as payments and retractions often cross rating periods and each rating period would have a different uniform increase.

Value-Based Payments and Delivery System Reform Initiatives

§ 438.6(c)(2)(vi)

Like other proposals in this section, there was a mixed response. Massachusetts was supportive, whereas Pennsylvania was opposed. California voiced concern and emphasized flexibility for states regarding VBP.

There were mixed opinions from trade associations on this proposal. The National MLTSS Health Plan Association is concerned by CMS' proposal that state-directed payments under VBP arrangements **replace the negotiated rates between MCOs and providers**. On the other hand, the Texas Council of Community Centers supports the proposed provisions that increase states' flexibility in designing and implementing value-based payments by removing certain barriers. AHIP urged CMS to preserve current regulatory requirements for now and facilitate a broad discussion with stakeholders involving states, plans, and providers about the barriers to VBP and effective solutions.

Hospital Associations urged CMS to reconsider prohibiting the use of pay-for-reporting metrics in delivery system reform initiatives that are included in SDPs. They encouraged CMS to allow for time-limited periods (e.g., two years) of payment for reporting in VBP directed payments and consider allowing states to apply differential standards for earning payment in circumstances when a high-performing provider has failed to improve over self in a single program year, such as requiring a multi-year trend of absolute and relative performance decline to occur before failing to reward a high-performing provider (TX).

The Alliance of Safety Net Hospitals also recommended that CMS give states the option to develop performance metrics based not on a provider's ability to improve on baseline data but on their ability to shift a predicted trend.

Quality and Evaluation

§ 438.6(c)(2)(ii)(D) and (F), (c)(2)(iv) and (v), and (c)(7)

Of the six states that commented on this provision, all but one was in opposition. States commented on the burden of this requirement and urged CMS to reconsider. New Hampshire was concerned that this provision created a "perverse incentive to 'aim low'." California was the only commenter who expressed any support for the provision but offered additional suggestions to improve the final rule.

Hospital Associations urged CMS to provide state Medicaid agencies with meaningful guidance on setting performance measures that are within the control of the hospital receiving the SDP and that improve care for the Medicaid patient population it serves. Several associations suggested that CMS **should allow states flexibility to select measures applicable to the type of hospital** and encouraged CMS to provide states with meaningful guidance that further aligns Medicaid quality measures for SDP evaluation plans with Medicare hospital measures, where appropriate.

The California Hospital Association did not support hospitals' SDPs being based on HEDIS-specified measures. CMS should not limit the measures specified for selection to the Medicaid Managed Care population. And the Georgia association specifically opposes the two-metric requirement for SDPs that solely provide a uniform increase in payment rates, particularly those limited to a Medicare equivalent.

Contract Term Requirements

§438.6(c)(5)

This provision was not commented on frequently and had a mixed reception. Only Massachusetts was supportive of the proposal. Tennessee commented in opposition to the proposal and believes that it will add considerable administrative burden to states and to CMS.

Including SDPs in Rate Certifications and Separate Payment Terms

§§ 438.6(c)(2)(ii)(J), (c)(6) and 438.7(f)

Similarly, this provision was not frequently addressed by states directly. Those that did comment did so in opposition to the proposal, apart from California. California was supportive of modifications to the proposed rule that separate payment terms "*be reasonably projected* not to exceed the total amount documented in the written prior approval," allowing states some flexibility.

Hospital Associations urged CMS not to prohibit interim payments with reconciliation and to continue allowing states flexibility in their approach to tying SDPs to the utilization of Medicaid services, including through interim payments and year-end reconciliations. A common argument for interim payments and reconciliation is that the approach helps providers receive reimbursement in a timelier manner instead of waiting several months for the final adjudication of more medically complex claims (usually the most expensive claims). Later reconciliation based on actual utilization allows the state to ensure that SDPs are based on the delivery and utilization of covered services rendered to Medicaid beneficiaries during the rating period.

The California Association encouraged CMS to reconsider the previously accepted practice of states incorporating approved SDP preprints by reference in the managed care contract, as they do not believe it is necessary nor efficient to subject SDPs to an additional approval process on top of preprints and rate certifications.

SDPs Included through Adjustments to Base Capitation Rates

§ 438.7(c)(4) through (6)

California was the only state that provided comment and strongly opposed the proposed rule, citing that the 120-day timeframe is insufficient.

Appeals

§430.3(d)

Seven states commented on the proposed appeals process for SDPs. States were supportive of an appeals process, but many felt that DAB was not the appropriate forum for this. Other suggestions were for CMS to use MBES (Nebraska) or OHI (Tennessee).

Reporting Requirements to Support Oversight

§438.6(c)(4)

Three states commented on this provision and were seeking additional clarification.

MEDICAL LOSS RATIO (MLR) STANDARDS

Few states commented on specific MLR provisions, except for contract requirements for overpayments. States that did comment on MLR were **generally supportive but requested additional time for implementation**. Pennsylvania noted that these changes were not in alignment with the contract cycle and would be difficult to implement otherwise.

Trade associations that commented on the MLR standards had general feedback that included various timeframe changes for the implementation of enhanced standards for documentation of provider incentives, prompt reporting of overpayments, and issues with requiring that incentive payment contracts have a defined performance period that can be tied to the applicable MLR reporting period. ACAP specifically had broad comments on this section of the proposed rule urging CMS to:

1) Ensure that health plan costs of seeking and maintaining accreditation, including health equity accreditation, be included as recognized direct expenses of quality improvement activities;
2) Extend the compliance timeline; and
3) Consider the administrative changes that are likely to occur due to the proposed changes to the MLR calculations and overpayment reporting requirements.

All three health plans commented on the MLR provisions and suggested revisions to **reduce administrative burden, provide further clarification, and enhance flexibility.**

Some hospital associations shared their concerns about the ways in which vertical integration within some of the largest insurers can enable plans to channel healthcare dollars to their affiliated healthcare and data services providers at patients' expense. Specifically, vertical integration may allow managed health plans to pay themselves or their subsidiaries for services in a way that counts as medical spending for the purpose of MLR, while allowing them to extract greater profit from government programs — and in fact, circumventing the precise reason MLR reporting exists. MLR requirements — and oversight of those requirements — is key to ensuring appropriate spending by health plans.

Standards for Provider Incentives

§ 438.3(i), § 438.8(e)(2)

The National MLTSS Health Plan Association requests that CMS maintain a degree of flexibility in the types of provider incentive payments that can be included. They recommend additional clarity on how these types of arrangements would be accounted for under MLR. AHIP recommends that CMS allow states and MCOs to meet the enhanced standards for documentation of provider incentive arrangements within one year (instead of 60 days) following the effective date of the final rule.

Centene requested that CMS retain some flexibility for payment levels and retroactive contracts in these payment arrangements. They also asked for additional clarification on metrics. As such, Centene requested that CMS not finalize this proposal as written given the constraints of the contracting calendar.

Prohibited Costs in Quality Improvement Activities

§ 438.8(e)(3)

Hospital Associations urged CMS to review how insurers are categorizing their utilization management expenses and set clear guardrails around when, if ever, such activities can be categorized as quality improvement activities. Furthermore, we encourage CMS and states to ensure that MLR requirements disallow any form of manipulation and that oversight of required reporting includes active monitoring for such potential abuse.

MCO, PIHP, PAHP MLR Reporting Resubmission Requirements

§ 438.8(m)

California was the only state agency to comment and supported the provision, Centene did not support it.

Contract Requirements for Overpayments

§§ 438.608(a)(2) and (d)(3)

All states that commented on this provision felt that the timeframe was inadequate and recommended that CMS increase the time for MCOs and states to correct overpayments. One suggestion was a monthly cadence.

MPHA commented on this provision and recommend shifting to a monthly, quarterly, or semi-annual reporting timeframe instead. While AHIP recommends CMS adopt a standard definition of at least 30 calendar days for prompt reporting of overpayments to states if it finalizes this proposal.

All plans felt that the prompt reporting timeline was not feasible and recommended changing to a more regular cadence of reporting overpayments.

Reporting of SDPs in the Medical Loss Ratio (MLR)

§§ 438.8(e)(2)(iii) and (f)(2), § 438.74

The California Hospital Association commented that CMS should consider having states and health plans report their MLR both with and without SDPs.

IN LIEU OF SERVICES AND SETTINGS (ILOS)

Many states commented on the ILOS provisions in **opposition to the proposed rules**. However, few states commented on specific provisions. Overall, the states felt that these proposed rules would **create significant hurdles to their use and ultimately inhibit or reduce the use of ILOS**. States frequently commented that the provisions were a significant burden with unfeasible timelines. Several states commented that requiring ILOS to be otherwise covered under the State Plan or 1915(c) waiver was unreasonable and would severely limit the ability of managed care plans to innovate and provide cost-effective substitutions.

Eight trade associations commented on the ILOS section of the proposed rule. All eight expressed general support for the provisions with some additional recommendations and clarifications. Meanwhile, on the state level, the Texas Association of Community Health Centers (TACHC) wants security from CMS that it will protect FQHCs' PPS so the FQHC Medicaid benefit is preserved and cannot be substituted for an ILOS, specifically, states are not allowed to substitute ILOS for any of the non-ambulatory, Medicare-defined components of the Medicaid FQHC benefit. Alliance of Community Health Plans asked for clarity on the types of services or settings that would qualify as ILOS while the National MLTSS Health Plan Association recommended CMS broaden the types of services approved as ILOS. NAMD asked CMS to not apply a cap to ILOS and consider a grandfathering approach to maintain current ILOS practices as well as requiring documentation updates every five years. MHPA broadly recommends CMS consider allowing HRSN expenses to be included in Medicaid capitation rates and in the numerator of the MLR.

Blue Cross and Centene submitted comments for this section. They provided less feedback than state agencies or trade associations but recommended more standardization for ILOS across the country.

Overview of ILOS Requirements

§§ 438.2, 438.3(e), 438.16, 457.1201(e)

As mentioned above, 11 states commented on the ILOS provisions overall. These states were adamant that **these provisions would significantly change and inhibit the use of ILOS to the detriment of the Medicaid program**. States that opposed the implementation of these provisions include Michigan, Pennsylvania, North Dakota, Delaware, California, and Tennessee. States commented on the administrative

burden that would be required. Utah requested additional guidance related to monitoring and reporting of ILOS versus EPSDT services.

ILOS General Parameters

§§ 438.16(a) through (d), 457.1201(c) and (e)

In the few states that submitted additional comments on ILOS general parameters, they were not supportive of the 5% proposed limit.

MHPA recommended that CMS eliminate the 5% limit on ILOS and believes that services should be permissible if they are medically appropriate. ACAP wants to ensure that standardizing and streamlining the ILOS delivery process does not stifle innovations specifically with restrictive caps and standards on ILOS; safety net health plans are concerned limiting ILOS expenditures to 5% of total capitation payments could discourage utilization of ILOS and reduce the provision of services to address HRSN.

Blue Cross was supportive of the definition of ILOS and the exclusion of short-term stays in an IMD from the cost percentage cap. However, they recommended that CMS identify consistent ILOS codes that can be used across states. Similarly, Centene recommended more standardization by using a list set by CMS that state agencies could choose from when selecting ILOS services.

America's Essential Hospitals strongly supported the use of ILOS, particularly to target health-related social needs (HRSNs). And as substitutes for state plan-covered services and settings. The urged CMS to not finalize any limit on the extent to which states may adopt ILOS to help achieve program goals. The Virginia Hospital Association, however, supported the 1.5% limit as they have some concern that states may lower capitation payments based on an assumption that ILOS would lower hospital utilization.

Enrollee Rights and Protections

§§ 438.3(e), 457.1201(e), 457.1207

California was supportive of the proposed provision.

Medically Appropriate and Cost-Effective

§§ 438.16(d), 457.1201(e)

Pennsylvania was one of the only states to comment on these additional provisions. The state was generally supportive but requested a modification every 5 years.

AMA prefers that determinations of medical appropriateness of ILOS services for individual enrollees be completed by the patient's own physician (with specific knowledge of their current and past medical treatment and preferences), as opposed to a generic licensed network or managed care plan staff provider as proposed.

State Monitoring

§§ 438.16(d) and (e), 438.66(e), 457.1201(c)

Pennsylvania was concerned about value-add services and the availability of encounter data for reporting. However, California was supportive. AHIP notes that CMS should identify and assign HCPCS codes for approved ILOS that would become a national standard rather than specific codes established by the state.

Retrospective Evaluation

§§ 438.16(d) and (e), 438.66(e), 457.1201(c)

Both California and Pennsylvania were supportive but raised additional concerns about the administrative burden of this provision.

The National MLTSS Health Plan Association asked CMS to consider ways to reduce the administrative burden of the retrospective evaluation of ILOS such as through templates to streamline the process for states and plans.

State and CMS Oversight

§§ 438.16(e) and 457.1201(e)

Both states that commented were unsupportive of this provision and felt that the timeframe of notification was insufficient.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM, STATE QUALITY STRATEGIES AND EXTERNAL QUALITY REVIEW

Few states commented on specific provisions in this section, with the exception of EQR. **Seven states commented on EQR and were generally supportive but made recommendations to increase flexibility for states regarding scope, design, and implementation of the provision**. Three states, Texas, Iowa, and California were concerned about the administrative burden of contracting for these services.

Three trade associations commented on this section of the proposed rule **and all three expressed support for the provisions with some additional recommendations**. AMA recommends average wait times, service denial rates, prior authorization data, and provider selection standards should also be included in EQR technical reports and made available to the public. AHIP recommends CMS to establish a longer timeframe for compliance with the quality strategy reporting and comment requirement.

Blue Cross and Centene commented on this section and **were generally supportive with some additional recommendations**. Blue Cross was supportive of the use of MA Chronic Care Improvement Programs in the place of PIPs for dual eligibles. Centene was supportive of the proposal to revise the EQR technical report date to December 31, in contrast to state agencies. Centene was not supportive of the proposal to require public comment on states' quality strategies every three years out of concern for administrative burden.

Quality Assessment and Performance Improvement Program

§ 438.330

The California Hospital Association urged CMS to encourage states to work directly with hospitals and health systems to understand the opportunity more fully for quality measurement, reporting, and opportunity for improvement at the provider level. Ascension Health System shared their concerns that the annual time frame to select measures and the potential turnover rate for adding and or changing measures would not allow for meaningful quality improvement and care transformation.

QUALITY IMPROVEMENT-QUALITY RATING SYSTEM

States were largely supportive of the goals put forth in this provision. However, states commented on the administrative burden that these requirements would put on agencies. They voiced concerns that these measures may be duplicative or irrelevant to beneficiaries. States consistently requested additional time, resources, and flexibility to implement these provisions in a manner that the state could support. There was some disagreement among states between using a standard, core set of metrics across the country (Rhode Island) or allowing states flexibility to choose what measurements were best for their populations (New York).

The AMA supports CMS' proposal to establish a QRS for Medicaid managed care plans and make this information available to the public. However, AMA is requesting CMS to make every effort to mitigate downstream burden on safety net practices and to ensure data is clinically relevant, actionable, and statistically valid.

AHIP has several recommended improvements for the proposed QRS. CMS should explore ways to better align the specific measures selected with state and private-sector programs and across CMS health benefit programs; work to ensure administrative reporting is available for mandatory measures given current challenges with electronic reporting processes; and require context around the performance rates that would be displayed under the quality rating system until more complex scoring methodologies can be tested for future years.

All three health plans commented on this section of the proposed rule. Plans were generally in agreement with one another. However, there was some disagreement between health plans and state agencies. **Health plans emphasized standardization across measures** and United was not supportive of alternative QRS measures as they considered this as an "unnecessary complexity." However, **some state agencies sought more flexibility in choosing measures that best fit their populations**. Other requests from Blue Cross were concerning additional guidance and support from CMS to states as they implement this provision. Centene suggested that CMS enhance guidance and standardize data collection for race, ethnicity, sexual orientation, gender identity, and SDOH information. Though state agencies were supportive of improving data collection, some states such as Texas were concerned about their ability to collect and verify this information due to small sample sizes.

Establishing and Modifying a Mandatory Measure Set for MAC QRS

§§ 438.334(b), 438.510 and 457.1240(d)

AHIP has concerns that efforts to improve and implement MAC QRS will need more time as states are experiencing other challenges specifically relating to Medicaid redeterminations, resumption of normal activities following the COVID-19 PHE, and competing priorities for state IT resources. AHIP further notes that CMS could reduce this implementation burden by phasing in the initial set of mandatory measures.

In addition to standardizing and enhancing data collection, Centene also recommends that CMS **align MAC QRS measures with the Universal Foundation Measures**. Blue Cross recommended that CMS require "actionability" and "feasibility" as the baseline for the criteria in the mandatory measure set. They also seek to include an additional measure regarding childhood immunization status.

Mandatory Measure Set

The National MLTSS Health Plan Association recommends CMS align its core measure set with NCQA endorsed measures. Likewise, MHPA recommends CMS provide states with a menu of options to choose from, improving consistency in the measures that key stakeholders will have to account for and on the oral evaluation, dental service measure, recommend CMS consider using the NCQA HEDIS measures.

The California Hospital Association and Ascension Health System both suggested that this be further narrowed to focus improvement efforts by limiting both the state variation in quality measures used and the rating methodologies developed, and limit provider burden but expand in meaningful ways over time.

Adding Mandatory Measures

§§ 438.510(b)(2), (d) and (e) and 457.1240(d)

To reduce administrative burden and costs and complexity in the program, MHPA recommends CMS seek ways to align existing measure sets rather than creating new and alternative measures for MCOs.

MAC QRS Methodology

§§ 438.334(d), 438.515, 457.1240(d)

NAMD believes that if CMS moves forward with this provision, they should provide a standardized data set of Medicare quality data to Medicaid agencies, along with TA on how to use this data to calculate MAC QRS measures.

Blue Cross requests clarification on dual eligibles, asking if they should only be included in a plan's MAC QRS ratings if the plan covers the beneficiary for both Medicaid and Medicare.

MAC QRS Website Display

§§ 438.334(e), 438.520, 457.1240(d)

The MLTSS Association appreciates CMS' efforts to establish requirements for a MAC QRS website that serves as a state's one-stop-shop where beneficiaries can compare plans based on quality and other factors but **asks for a delay in implementation of the website, recommend against use of Prototype B, and request CMS work with states to mutually agree upon a feasible timeline**. The MLTSS Association is also concerned operationally how the state will attribute measurement across multiple managed care and FFS programs to develop a measure score for a single beneficiary.

MPHA is concerned with the **significant burden on states to create these websites given the ongoing unwinding period**. They 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. AHIP has concerns that the proposed website does not provide sufficient information for enrollees to review quality measurement information in context. AHIP recommends CMS to make the website display more useful to beneficiaries and to provide important data to all stakeholders.

Centene encourages CMS to work with states to determine the feasibility of these websites and adjust the requirements and/or timeline if necessary.

Alternative Quality Rating System

§§ 438.334(c), 438.525, and 457.1240(d)

United and Centene were hesitant to support alternatives, given that they wish to see increased standardization in this area. Centene suggested that states have the option of adding additional measures they can choose to implement.

Annual Technical Resource Manual

§§ 438.334, 438.530, and 457.1240(d)

Blue Cross recommends that CMS aligns measure specifications and reporting guidance with the NCQA standards for that measure.