June 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Administrator Brooks-LaSure:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (May 3, 2023).

In MACPAC's June 2022 *Report to Congress on Medicaid and CHIP*, the Commission made a number of recommendations for actions that CMS could take to improve access monitoring and oversight of managed care directed payments (MACPAC 2022a, MACPAC 2022b). As discussed below, the Commission supports efforts in this proposed rule to advance these recommendations and suggests additional steps that CMS can take to further address these goals.

This letter concludes with technical comments on other aspects of the proposed rule based on the Commission's prior analyses of managed care policies. As the Commission continues to examine Medicaid managed care policy issues, we will keep CMS informed of our findings.

Access monitoring

CMS proposes to change the approach to access monitoring in managed care by adding several new requirements for beneficiary surveys, minimum appointment wait times, and payment analyses. Some of these proposed changes are similar to provisions of the proposed rule on ensuring access to Medicaid services in fee for service (FFS) that was also published on May 3, 2023 (CMS-2442-P).

In general, the Commission supports efforts to broaden the measures used to monitor access in managed care, since current requirements overly rely on structural measures (e.g., network adequacy) rather than direct measures of care. In June 2022, MACPAC recommended that CMS develop a new Medicaid access monitoring system that consists of a core set of measures that capture three key domains of access: provider availability and accessibility, service use, and beneficiary perceptions and experiences of care (MACPAC 2022a).

However, the Commission is concerned about the lack of alignment between proposed FFS and managed care requirements. In June 2022, MACPAC

recommended that a new access monitoring system apply consistent requirements and comparable measures across delivery systems (MACPAC 2022a). Below we highlight potential opportunities to align the proposed managed care access requirements with FFS. The Commission is also submitting comments on proposed rule CMS-2442-P, suggesting opportunities for CMS to strengthen the proposed FFS access requirements (MACPAC 2023a).

Beneficiary survey. In June 2022, MACPAC recommended that CMS field an annual Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care, which are an important component of access that are not currently available through administrative data (MACPAC 2022a). However, the proposed rule would only require states to conduct an annual enrollee experience survey for beneficiaries enrolled in managed care and does not propose to collect similar information in FFS. As a result, the Commission is concerned that the lack of comparable information for beneficiaries enrolled in FFS will limit the ability of states, CMS, and other stakeholders to compare access across delivery systems.

CMS requests comments on whether it should require states to use a specific enrollee experience survey. In the Commission's view, standardizing a core set of access measures would help ensure comparability across states, but states should have the flexibility to add additional measures to meet their priorities. To reduce administrative burden, it would be helpful for CMS to capitalize on existing efforts.

Appointment wait time standards. The rule proposes a maximum 15-day wait time for selected services, which would be validated by secret shopper surveys. Like the beneficiary survey, the requirement would only apply to managed care and not FFS, creating greater misalignment between delivery systems.

Although MACPAC's June 2022 report discusses the value of considering measures of appointment availability, the Commission did not make recommendations on specific measures or benchmarks that CMS should use. However, the Commission's prior research and key informant interviews have highlighted several issues for CMS to consider when implementing this proposed requirement:

- When setting a benchmark for appointment wait times or other measures of access, many stakeholders we interviewed suggested that CMS start by calculating baseline measures for states over a multi-year period. Doing so could help inform the development of a benchmark for improved access over time that is both feasible and meaningful. Although the Commission supports efforts to reduce appointment wait times for Medicaid beneficiaries, we are not aware of baseline data available to assess the effects of the new proposed standards.
- When measuring appointment wait times using secret shopper surveys, it is important to consider the shortcomings of this approach. In our prior reviews we have found that secret shopper surveys are not used consistently across states and the results may not be representative for all provider types. Additionally, these efforts are often resource intensive for states and providers, so CMS should consider whether the value of the information obtained from these surveys is worth the effort needed to conduct them.

Payment analyses. The rule proposes that states conduct annual analyses of managed care payment rates for primary care, obstetrics/ gynecology, and mental health and substance use disorder services in order to demonstrate that rates are sufficient to ensure access to these services. The proposed FFS access rule includes similar requirements, but it also includes additional transparency standards that are not proposed in the managed care rule.

In general, the Commission supports efforts to promote greater payment transparency and encourages CMS to align transparency requirements in FFS and managed care. Below, we note a number of technical issues for CMS to consider when implementing this requirement to ensure that payment analyses are accurate and complete.

One concern about the proposed method of measuring provider payment rates is that it does not consider all of the factors that can affect Medicaid payment rates. For example, although the rule proposes distinguishing payment rates by patient age, it does not account for variations by provider type, geographic factors, and site of service, which are common adjustments used in Medicaid FFS physician payment methods (MACPAC 2017). The preamble to the proposed rule acknowledges that the published Medicare rate may include some of these adjustments, but without more granular analysis, it may be difficult to understand how these factors affect the payment analyses. To prevent provider-level variations from distorting the average payment rates reported, it could be helpful to report payment data at the provider level or use commonly used groupings of sites of service (e.g., office-based and hospital-based physicians) and provider types (e.g., physicians and mid-level providers). The proposed FFS access rule includes some of these additional factors, so CMS should use consistent reporting standards in FFS and managed care. It could also be helpful for states to provide additional descriptions of their payment methodologies, including the definition of children used to stratify payment rates by age, to help stakeholders better interpret the payment rate information provided.

It is also unclear how directed payments will be factored into the payment analyses. As noted below, directed payments are a large and growing share of Medicaid payments and these payments can have a significant effect on the payment analyses. For example, in our recent review of approved directed payment arrangements, one of the states we interviewed used directed payments to pay physicians affiliated with academic medical centers about three times the rate paid to other physicians in the state (MACPAC 2023b). In this case, not including the directed payment would substantially understate payment rates, but including the directed payments without distinguishing the subsets of providers who do and do not receive them would skew the average. To ensure that the payment analyses are complete and useful for analysis, it could be helpful for states to report payment rates with and without directed payments, similar to the information states currently provide on CMS's directed payment preprint template.

States also may face challenges reporting payment rates for services included in value-based payment models. Many states currently require managed care plans to increase their use of advanced alternative payment models that are not based on FFS (Bailit Health 2020). As a result, it is unclear how states and health plans should report payment rates for these services in a way that is comparable with Medicare FFS rates. In addition, for health plans with pay-for-performance incentives, the final payments that providers receive depend on their achievement of quality goals.

Finally, the Commission is concerned about the lack of transparency of managed care payment rates for other services. In particular, the Commission has recommended that CMS collect and report facility-level data on managed care payments to hospitals and nursing facilities (MACPAC 2016, 2023b). The proposed FFS access rule includes a requirement for states to report FFS payment rates for these services, but the proposed managed care rule does not include a similar requirement. Although MACPAC has access to some managed care payment information through the Transformed Medicaid Statistical Information System (T-MSIS), this information is masked in the research files available to other researchers. Moreover, T-MSIS does not have complete information about resident contributions to their cost of care for nursing facility services, so state payment rate information is needed to accurately calculate total per diem payments for Medicaid-covered nursing facility residents (MACPAC 2023b). CMS should consider requiring consistent reporting standards in FFS and managed care to promote transparency and enable further analyses of Medicaid payment policies.

Directed payments

The Commission strongly supports CMS's efforts to improve the oversight of managed care directed payments because these arrangements have become a large and growing share of Medicaid payments. According to MACPAC's most recent review of directed payment arrangements approved as of February 1, 2023, total

projected directed payment spending is more than $69 billion a year, which is substantially larger than spending on FFS supplemental payments (MACPAC 2023c). Our latest estimate of directed payment spending is larger than the $48 billion estimated in the proposed rule because of the continued growth in new directed payment arrangements approved after CMS completed its analysis in March 2022.

Policymakers and the public have an interest in knowing more about where this money is being spent and the extent to which these payment arrangements are advancing quality and access goals for Medicaid beneficiaries. The Commission has long been concerned about the transparency and oversight of FFS supplemental payments, and so we are particularly concerned that directed payments have less transparency. In addition, the Commission is concerned about the potential of some directed payment arrangements to undermine the integrity of the managed care rate setting process. In particular, it is not always clear what additional value is obtained when states use directed payments to substantially increase payments above rates that were previously certified as actuarially sound.

Overall, the Commission supports the proposed changes to improve transparency and evaluations of directed payments, which are consistent with MACPAC's 2022 recommendations to improve the oversight of managed care directed payments (MACPAC 2022b). We note that more can be done to make directed payment approval documents available to the public and clarify how directed payments relate to existing access standards.

Directed payment transparency. The Commission strongly supports the proposed changes to better document directed payment amounts in rate certifications and collect information on actual directed payment spending. Because directed payments are such a large and growing share of Medicaid spending, policymakers and the public have an interest in knowing more about where this money is being spent. We appreciate CMS's efforts to clarify "grey area" payments that should also be reported as directed payments, since this step will also help to improve transparency. Collecting information on actual directed payment spending is also important because we have found in our prior interviews with state officials that actual spending on directed payments is sometimes higher or lower than the amount projected on directed payment approval documents. We also support including directed payments in the medical loss ratio (MLR) reports because they are a large share of managed care spending in many states.

CMS requests comments on whether directed payment spending is best reported in T-MSIS or on CMS-64 reports submitted through the Medicaid Budget and Expenditure System (MBES). Because there are currently several gaps in reporting of managed care spending in T-MSIS, reporting aggregate spending on directed payments as a separate line on CMS-64 reports could help validate whether the data submitted to T-MSIS are complete.

In the Commission's view, the administrative burden of the data collection should be reduced where possible and should be commensurate with the size of the payment. For many smaller directed payment arrangements that adjust base payment rates, this spending may already be captured in T-MSIS, and it may not be worthwhile to distinguish the amount of funding attributable to the directed payment from the base payment rate negotiated by the managed care plan. However, for large directed payments that are similar to FFS supplemental payments and are not currently being reported in T-MSIS, additional reporting is likely needed. Instead of using T-MSIS to collect data on these payments, CMS could also consider updating the MBES forms used to collect provider-level data on UPL payments (CMS 2021b). Similar principles could also be used to reduce administrative burden of reporting directed payment spending in MLR reports.

In our review of spending approved as of February 2023, we have noticed some inconsistencies in how states report projected directed payment requirements that merit additional clarification from CMS. Specifically, for some directed payment arrangements that involve minimum or maximum fee schedules, some states appear to report

total spending for the covered service instead of separately reporting the additional payment attributable to the directed payment arrangement. Similarly, in one state that uses a directed payment to require participation in an accountable care organization (ACO) program, the state appears to count all spending to the participating ACOs, including payments for services that would have otherwise been covered without the directed payment.

Public availability of directed payment approval documents and rate certifications. The Commission remains concerned that CMS has not proposed a process to make directed payment approval documents and rate certifications publicly available. Directed payment approval documents include information about how directed payments are being targeted and how they are intended to improve quality and access for specific Medicaid populations, which is important context needed to evaluate whether these payments are achieving their stated goals. Currently, information about directed payment approvals, managed care rate certifications, and evaluation plans are only available to the public through a Freedom of Information Act (FOIA, P.L. 89-487) request, which can be complicated and time consuming to pursue. Moreover, because states do not need to provide public notice about directed payment arrangements, some stakeholders may not even know whether there are directed payments for which they can request information.

CMS already makes approval documents for many other similar types of payments publicly available on its website. For example, CMS currently posts approval documents for Medicaid state plan amendments, which describe FFS supplemental payments, and approval documents for Section 1115 demonstrations, which include Delivery System Reform Incentive Payments (DSRIP) and other supplemental payments. However, when states transition FFS supplemental payments or DSRIP into directed payments, information about these payment arrangements is no longer publicly available.

Managed care rate certifications are an important complement to directed payment approval documents because they provide information on how the directed payment arrangement is incorporated into managed care rates. Such information is also useful for informing oversight of managed care rate setting more generally. Although actuaries may use some proprietary data from health plans when developing capitation rates, the final rate certification document is intended to be a public document and is already publicly available in some states. Prior CMS regulations have clarified that managed care spending data should be publicly available even though some stakeholders viewed this information as proprietary so CMS could apply a similar standard to justify making rate certification information available (CMS 2020).

Directed payment evaluations. MACPAC supports CMS's proposed changes to strengthen evaluations of directed payments, which respond to many of the Commission's concerns described in its June 2022 report (MACPAC 2022b). The proposed rules help to clarify CMS expectations for directed payment evaluation plans and the timing for submitting results.

The Commission supports the application of more rigorous evaluation standards for a subset of directed payments that make substantial additional payments to providers. In the Commission's view, the rigor of the evaluation should be commensurate with the level of new federal spending associated with these arrangements. CMS specifically proposes to require more rigorous evaluations for directed payments that are more than 1.5 percent of the capitation rate. Although the Commission cannot comment on what this threshold should be, we can share our analysis that 75 of the 249 distinct directed payment arrangements approved as of February 1, 2023 had projected spending that is greater than 1.5 percent of the state's fiscal year (FY) 2022 managed care spending; overall, these arrangements accounted for 86 percent of all projected directed payment spending.

The Commission supports the proposed changes to allow multiyear evaluations and to make directed payment evaluation results available on state websites, which are also consistent with MACPAC's recommendations. CMS

could also consider making directed payment evaluations publicly available on Medicaid.gov, similar to the process currently used for Section 1115 demonstration evaluations.

Clarifying goals of directed payments and relation to existing access standards. The proposed rule does not fully clarify the goals of directed payments and how they relate to existing managed care access standards. The Commission remains concerned that a lack of clarity about directed payment goals will make it difficult for policymakers to assess whether directed payments are meeting their objectives.

In particular, it is unclear how existing access standards set parameters guiding the intersection of managed care capitation rates and directed payment arrangements. Most of the directed payment preprints we reviewed described maintaining or improving access as the primary goal of the directed payment. However, managed care plans are already required to ensure access to services in a timely manner, including access to an adequate network of providers.

When clarifying how directed payments relate to existing access standards, CMS could consider how directed payments compare to prior supplemental payments, including prior pass-through payments that are similar to FFS supplemental payments. For example, if the directed payment is intended to replace pass-through payments that were previously part of the actuarially sound capitation payment, then it may be reasonable for the state to attest that this payment is necessary to meet existing access standards. However, if the directed payment substantially increases payment rates above levels that actuaries previously certified as sufficient, then it may be reasonable to expect the payment to result in improvements in access and quality above existing levels. Because spending on prior pass-through payments is not publicly available, quantifying the amount of these payments in the directed payment preprint would be particularly helpful to inform this analysis.

CMS could also consider how its proposal to allow states to make directed payments to providers who are not part of a managed care plan's network may affect health plan's ability to meet network adequacy standards. During our interviews with states, health plans, and providers about their experiences implementing directed payments, some stakeholders noted that the existing requirements for providers to be in-network to receive directed payments helped improve access to care for beneficiaries.

Considerations for setting upper limits. To limit the growth of directed payment spending, the rule proposes to set an upper limit on directed payment spending at no more than the average commercial rate (ACR) for inpatient and outpatient hospital services, qualified practitioner services at academic medical centers, and nursing facility services. Although MACPAC has not made formal recommendations on whether or how CMS should set limits on directed payment spending, the Commission's June 2022 report discusses several policy issues to consider.

Without an upper limit on directed payment spending, there is a potential risk that federal spending will continue to increase substantially. For example, between 1990 and 1992, after Congress clarified that disproportionate share hospital (DSH) payments were not subject to the upper payment limit (UPL) that applies to other FFS spending, the total amount of DSH payments increased from $1.3 billion to $17.7 billion (Holahan et al. 1998). We observe a rapid growth in estimated directed payment spending: from $25 billion as of December 2020 to $48 billion in March 2022 and $69 billion as of February 1, 2023.

Although CMS has already approved several directed payments that pay providers up to the ACR, this limit is substantially higher than the Medicare payment rate, which is used as the UPL for FFS payments to hospitals, nursing facilities, and other institutional providers. According to a recent Congressional Budget Office (CBO) review of studies comparing commercial prices to Medicare, commercial prices for physician services were 129 percent of Medicare and commercial prices for hospital services were 223 percent of Medicare on average; CBO also found considerable state variation in the differences between commercial rates and Medicare (CBO 2022).

Unlike Medicare payment rates, which are publicly available and are consistent for all providers, the rates that private insurers pay are not readily available and can vary widely based on providers' ability to negotiate their payment rate.

Because states can make directed payments that are much higher than the current limits for other types of Medicaid payments, we have observed some states using directed payments as a substitute for DSH and other supplemental payments to hospitals (Marks et al. 2018). As a result, it is important for CMS to consider how its proposed directed payment policies relate to current policies for other types of Medicaid payments to hospitals. Overall, the Commission has long held that development of Medicaid hospital payment policy should consider all types of Medicaid payments that hospitals receive (MACPAC 2016).

CMS requests comments on alternate standards that could be used to limit directed payment spending, such as setting a limit based on the share of a state's managed care capitation rate. Although CMS currently uses the share of a state's managed care capitation rate as a benchmark for other policies, current directed payments spending appears to be above the 5 percent limit that is proposed for in lieu of services (ILOS) and is currently used for managed care incentive arrangements (42 CFR 438.6(b)(2)). Although the Commission has not recommended a specific limit, our recent review of directed payments approved as of February 1, 2023 found that total spending ($69 billion) was 18 percent of total managed care spending reported in FY 2022.

In March 2023, MACPAC outlined a series of principles to consider when assessing nursing facility payment policies, which can inform consideration of the proposed limit on directed payments to nursing facilities. Given that few nursing facility residents are privately insured, the average commercial rate may not be an appropriate benchmark for this service. The Commission has also noted that Medicare payment rates are not an appropriate benchmark because of differences in the acuity of short- and long-stay nursing facility residents and the different services covered by the Medicaid and Medicare nursing facility benefit. Instead, the Commission recommended that CMS should direct states to compare Medicaid payments to the costs of care for Medicaid-covered nursing facility residents and consider how payments related to quality outcomes and health disparities (MACPAC 2023b).

Exemption for minimum fee schedules based on Medicare payment rates. CMS requests comments on its proposal to exempt minimum fee schedules based on Medicare payment rates from needing prior CMS approval. This policy is similar to the change that CMS made in 2020 to no longer require prior approval for directed payments based on state plan rates and it is intended to reduce state administrative burden. One limitation of this approach is that CMS would no longer receive evaluations for some minimum fee schedules that substantially increase Medicaid payment rates. For example, in our recent reviews, we have identified some minimum fee schedules that would increase Medicaid nursing facility payments to Medicare payment rates, which are substantially higher than the cost of care for Medicaid-covered residents. The projected spending on these arrangements is greater than 1.5 percent of the state's FY 2022 managed care spending, which is the threshold proposed for additional evaluation requirements for other types of directed payments.

Additional technical comments on managed care provisions

Although the Commission has not made formal recommendations on the other proposed managed care changes, we offer technical comments for CMS to consider based on our prior work on these topics.

In lieu of services. During our recent interviews with states, health plans, and their actuaries on managed care rate setting, stakeholders noted the value of ILOS, but they underscored a need for more guidance on which substitute services and settings could be provided as ILOS and how those costs should be included in capitation rates and MLR calculations (MACPAC 2022c). The proposed rule responds to this request for additional clarity by providing a more substantive definition of ILOS and the specific parameters for getting ILOS approved in

managed care contracts and capitation rates. The proposed rule requires a retrospective evaluation for states with a final ILOS cost percentage that exceeds 1.5 percent, but it does not specify that this evaluation would be publicly available. The Commission supports further evaluations of ILOS and their effects on access to care for Medicaid beneficiaries. Consistent with the Commission's efforts to promote greater transparency, we encourage CMS to make ILOS evaluations publicly available. The Commission also supports efforts to evaluate the effects of ILOS on health disparities. MACPAC recently made recommendations on ways to improve the collection and reporting of race and ethnicity data that could support this type of analysis (MACPAC 2023d).

The Commission plans to continue to monitor the implementation of these new ILOS requirements in order to understand more about how they are being used and whether there are additional opportunities to improve federal policy in this area. In particular, it will be important to monitor how ILOS services are being used to address known access challenges in home- and community-based services and other settings. Even if spending on ILOS in these areas are not large enough to require a formal evaluation under the proposed rule, CMS could consider other ways to learn from state experiences implementing ILOS and share these findings with other states who are facing similar challenges.

External Quality Review (EQR). The rule proposes a number of changes to the EQR process. CMS proposes that EQR technical reports include outcomes data and results from quantitative assessments, including for the mandatory network adequacy validation activity. MACPAC recently conducted a comprehensive study of EQR processes and state practices. This examination included interviews with state officials, external quality review organizations and other key stakeholders. MACPAC found that the EQR technical reports are lengthy, highly technical, and can be hard for stakeholders to access and interpret. In addition, we found that the reports do not focus on changes in performance and outcomes over time, and stakeholders would like EQR process and findings to place more emphasis on outcomes and comparability (MACPAC 2023e). The proposal to include outcomes data and results may help to address these concerns.

The proposed rule also notes that CMS is considering guidance in the EQR protocol for states to stratify performance measures collected and reported in the EQR technical reports under the performance measure validation activity. As noted above, the Commission supports efforts to monitor health disparities, and MACPAC recently made recommendations on ways to improve the collection and reporting of race and ethnicity data that could support this type of analysis (MACPAC 2023d).

Quality rating systems (QRS). The rule proposes a new quality rating system for managed care that includes a set of mandatory core measures and a new website for beneficiaries to compare quality across plans in their state. Findings from MACPAC's interviews with states, health plans, and other stakeholders about the implementation of current QRS can help inform the development of CMS policy in this area (Rowan, Hsu, et al 2021).

State and national stakeholders we interviewed generally agreed that a uniform set of measures in state QRSs was important for monitoring the performance of Medicaid programs across states, but there was not clear consensus on the most appropriate measures for a mandatory set. State Medicaid officials reported that making state QRS useful for beneficiaries requires substantial time and resources. This effort includes ensuring that information is presented in plain language at an appropriate reading level and providing guidance on how to interpret health plan performance on the QRS. However, study states are not monitoring the use of the QRS, which could provide more insight on the utility of the QRS.

Thank you for the opportunity to comment on this proposed rule. The Commission appreciates CMS's efforts to improve access and quality of care for Medicaid and CHIP beneficiaries enrolled in managed care. Please let us know if there is any further information MACPAC can provide you to aid in your consideration of our comments.

Sincerely,

Melanie Bella, MBA
Chair

cc: The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member, Senate Finance Committee
The Honorable Cathy McMorris Rodgers, Chair, House Energy and Commerce Committee
The Honorable Frank Pallone, Jr., Ranking Member, House Energy and Commerce Committee

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