July 3, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

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

Dear Administrator Brooks-LaSure:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Medicaid and CHIP Managed Care Access, Finance, and Quality Notice of Proposed Rulemaking (Proposed Rule) (CMS-2439-P).

The Task Force is a multistakeholder consortium that supports accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver a health system that achieves equitable outcomes through high-quality, affordable person-centered care. We strive to provide a critical mass of policy, operational, and technical support that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

The Task Force supports Medicaid and CHIP managed care proposals that serve to advance access and high-quality care; increase transparency and stakeholder engagement; encourage the movement to value-based care delivery and payment, and to the extent possible, align standards and processes across programs and delivery systems, to the extent feasible and appropriate. As a general comment, the Task Force recommends that CMS encourage states to work directly with hospitals and health systems to fully understand the quality measurement specific to hospitals, and the mechanisms for reporting that data and the opportunity for improvement. We share CMS's goals to improve quality of care for Medicaid patients, while limiting the increasing costs to both providers and the states administering these programs. And

in that vein, where possible, Medicaid should align with Medicare hospital measures to keep costs down and improve efficiencies.

Our comments offer feedback on several proposals as they relate to Medicaid and CHIP managed care organizations' ability to implement innovative value-based payment arrangements to improve care, improve outcomes, and reduce costs. These include proposals on State Directed Payments (SDP), Medical Loss Ratio (MLR), and Quality Measures.

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I. State Directed Payments

As a multi-stakeholder organization whose mission is to lead the transformation of health care payment from health care delivery through value-based payment, the Task Force recognizes and appreciates the importance of State Directed Payments (SDPs) as a tool for advancing Medicaid program goals and objectives.

CMS proposes removing existing regulatory prohibitions on states: (1) setting the amount or frequency of expenditures, and/or (2) recouping unspent funds allocated for SDPs which are used to implement VBP arrangements including value-based purchasing, delivery system reform, and performance improvement initiatives. Overall, the Task Force supports efforts to reduce regulatory burdens in Medicaid, but offers CMS the following comments:

- CMS proposes requiring that SDP payments used for VBP tied to a specific condition or set of services for a specific population replace the negotiated rate between a plan and providers for the Medicaid covered services to prevent duplicate payments. There is concern among our members that this may limit health plans' flexibility to provide incentive payments to providers and create confusion in the contracting process.
- CMS proposes to require health plans to include terms in their provider contracts that include each service for which SDP is used to offer incentive payments. The Task Force understands this is designed to promote transparency and assess the effect of these payments on actuarial soundness. However, Medicaid managed care plans currently have the ability to apply SDPs to incentive payments for services which may or may not be documented in the provider contract. That is, there is flexibility written into the provider contracts that allow providers to perform services in the goal of reaching specified SDP outcomes, without specifying the services themselves. The Task Force suggests CMS reconsider this proposal, so as to continue to allow providers to innovate in how they deliver care to achieve the state's Medicaid goals.

Regarding CMS' proposal to require that SDP-financed models include at least one quality measure as a pay-for-performance measure, the Task Force recommends the continued support of pay-for-reporting of measures in the initial years of a program. This will give states the time to establish and/or improve the data infrastructure for reporting, and allow for the necessary experience with new measures before they are moved into a value-based arrangement. Related to this, the Task Force recommends that the measures selected should be

in place for a minimum of three years, as changing measures on an annual basis can be detrimental to care transformation and the evolution of strategies to support meaningful improvements.

I. Medical Loss Ratio

The Task Force supports CMS' proposal to require that Medicaid managed care plans include State Directed Payments in their Medical Loss Ratio (MLR) reports. We view this as a reasonable step in the effort to increase transparency. Several of our members currently include this data in their MLR reports. The Task Force is also a proponent of alignment across markets where feasible, and thus supports the proposal that aligns the MLR reporting processes with those used by Marketplace plans. The Task Force suggests CMS consider additional opportunities to develop alignment in MLR reporting between Medicaid MCOs and Medicare Advantage.

II. Medicaid Managed Care Quality Rating System

Quality measurement and transparency of information are building blocks to successful value-based payment arrangements and to the successful delivery of patient-centered care. The Task Force supports modifying existing quality strategy and reporting requirements to increase the transparency of information available to Medicaid enrollees, as well as to expand the data available to support quality improvement by plans and providers. The Task Force offers the following comments on the quality and transparency proposals:

- The Task Force supports CMS' criteria for determining whether a measure will be included in the mandatory measure set, including:
    - The measure meets five of the six measure inclusion criteria proposed,
    - The measure would contribute to balanced representation of beneficiary subpopulations, age groups, health conditions, services, and performance areas within a concise set of mandatory measures; and
    - The burdens associated with including the measure do not outweigh the benefits to the overall QRS framework of including the new measure based on the measure inclusion criteria we are proposing.

  Our members suggest CMS also seek to use the Agency's Universal Foundation of Measures as the measure set evolves.
- Task Force members support the proposed initial mandatory measure set, in large part because of how it aligns with existing health plan reporting programs while adhering to the criteria described above. The Task Force strongly recommends that CMS, in its efforts to continue striving for alignment in quality measures across payment models and programs, align the mandatory measure set with the NCQA HEDIS measure specifications and timelines.

- The Task Force supports the aspirational goal of creating a "one-stop-shop" where Medicaid and CHIP enrollees can access information and quality data on managed care plans. We recommend CMS review examples of public reporting websites that are successful at conveying potentially complex quality information to individuals, and to use a multi-stakeholder process to develop and test this tool. Creating this tool will require significant time and resources; it is critical that the end-product reflect the perspectives, feedback, and experiences of individuals who are being asked to make challenging health care decisions based on this information.

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The Task Force appreciates the opportunity to respond to the Medicaid and CHIP Managed Care Access, Finance, and Quality proposed rule. Please contact HCTTF Senior Director Tanya Alteras (tanya.alteras@hcttf.org) with any questions.

Sincerely,

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