



EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
COMMONWEALTH OF MASSACHUSETTS
OFFICE OF MEDICAID
ONE ASHBURTON PLACE, BOSTON, MA 02108



MAURA T. HEALEY
GOVERNOR

KATHLEEN E. WALSH
SECRETARY

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

MIKE LEVINE
ASSISTANT SECRETARY
FOR MASSHEALTH

July 3, 2023

Xavier Becerra, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, D.C. 20201

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments on Proposed Rule, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P)

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of the Massachusetts Medicaid and Children's Health Insurance Program (MassHealth), I am writing to comment on the Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality proposed rule¹ issued by the Centers for Medicare and Medicaid on May 3, 2023 (Proposed Rule). MassHealth appreciates the opportunity to provide comments on the issues raised by the Proposed Rule, and more generally CMS's dedication to soliciting and considering input from the various stakeholders impacted by these issues.

MassHealth provides comprehensive, affordable health care coverage for over two million low-income Massachusetts residents, including 40% of all Massachusetts children and 60% of all residents with disabilities. MassHealth's mission is to improve the health outcomes of our diverse members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life.

¹ [2023-08961.pdf \(govinfo.gov\)](#)

Over half of MassHealth's members are enrolled in one of the state's seven different managed care programs, which include Managed Care Organizations, two models of Accountable Care Organizations (i.e., Accountable Care Partnership Plans (which are managed care organizations under Part 438) and Primary Care ACOs (which are primary care case management entities under Part 438)), a behavioral health prepaid inpatient health plan (PIHP), a primary care case management program (i.e., the Primary Care Clinician Plan), an MCO operating under a financial alignment demonstration for adult members who are dually eligible for Medicare and Medicaid (i.e., One Care), and a fully-integrated dual eligible special needs plan (FIDE-SNP) for members age 65 and older (i.e., Senior Care Options). MassHealth's comments are informed by the breadth of types of managed care programs offered by MassHealth, and the diversity of populations served by MassHealth's managed care programs.

Operating this array of managed care programs has highlighted for MassHealth the importance of ensuring that the federal managed care regulatory requirements can be implemented across the range of managed care programs. For example, Medicaid managed care rules, standards, and oversight must align sensibly with Medicare constructs to serve the dually eligible population fully and effectively. Rate setting requirements and standards must be flexible enough to accommodate programs that cover everything from comprehensive Medicaid services to specialized coverage of just behavioral health.

Additionally, MassHealth has been moving towards greater alignment in the management and pricing of services between its managed care and fee-for-service (FFS) programs as a means to promote health equity, enhance continuity of member experience, streamline program management, and ensure appropriate oversight of provider investments. For example, MassHealth was an early adopter of, and continues to meaningfully leverage, state directed payments (SDPs) to drive important policy outcomes and create alignment between FFS and managed care. MassHealth believes that directing payments through managed care is an important tool in advancing delivery system reform, promoting quality and equity outcomes, bolstering the state's investments in service providers (especially behavioral health and safety net providers), and ensuring there is a stable market of service providers across its delivery systems. Managed care regulations should support the state's ability to achieve these goals.

MassHealth strongly supports CMS's goals of promoting access and transparency for members regarding the services they receive through managed care and appropriately monitoring plan payments and performance. However, in light of MassHealth's experiences navigating the variances and nuances of our managed care landscape and our efforts to promote alignment between and across the delivery systems experienced by our members, MassHealth is concerned that the increased levels of specificity and prescriptiveness of the Proposed Rule may create or exacerbate disconnects between delivery systems and will increase administrative burden on states and plans. MassHealth offers the following comments on specific areas of the Proposed Rule in this context.

Access and Availability

Appointment Wait Times

MassHealth appreciates and supports the intention of establishing wait time standards. Indeed, we have had wait time standards in our managed care contracts for primary care, specialty care, and behavioral health care, differentiated by type and urgency of appointment, for a number of years. We appreciate aspects of the proposal that allow for state flexibility in defining the proposed required category of “routine” services and the opportunity to select a fourth category of services to monitor.

However, we have several concerns with the proposal as written. Firstly, we are concerned with the feasibility of meeting the proposed standards due to the existing health workforce shortages in Massachusetts and nationwide. Previous literature that has studied appointment wait times across, or agnostic of the payer indicates that CMS’s proposed standards do not reflect on-the-ground provider availability today. For example:

- The average wait time for primary care services across payers in Massachusetts is 24 days for both Medicaid and commercial plans, with no significant difference between the two²;
- The average wait time for primary care services in New England for Veterans is 28 days at the Veterans’ Health Administration and 50 days in the community³;
- 40% of individuals, agnostic of payer, had a wait time of greater than 2 weeks for an outpatient appointment with a Massachusetts mental health provider organization⁴, even prior to the pandemic;
- The average wait time in the Boston metropolitan area for OB-GYN care is 35 days, agnostic of payer, and the national average is 31 days⁵; and
- The average wait time in the Boston metropolitan area for Family Medicine appointments is 40 days⁶, agnostic of payer.

Notably, workforce constraints have worsened significantly both nationally and in Massachusetts since this data was published, suggesting these data are a likely conservative estimate and not fully representative of present-day workforce capacity. Mandating that states and managed care plans meet a specific wait time standard, set nationally without consideration for regional

² Gotlieb, E. G., Rhodes, K. V., & Candon, M. K. (2021). Disparities in Primary Care Wait Times in Medicaid versus Commercial Insurance. *Journal of the American Board of Family Medicine : JABFM*, 34(3), 571–578. <https://doi.org/10.3122/jabfm.2021.03.200496>.

³ Feyman Y, Asfaw DA, Griffith KN. Geographic Variation in Appointment Wait Times for US Military Veterans. *JAMA Netw Open*. 2022 Aug 1;5(8):e2228783. doi: 10.1001/jamanetworkopen.2022.28783.

⁴ Blue Cross Blue Shield of Massachusetts Foundation. “Access to Outpatient Mental Health Services in Massachusetts.” 2017. www.bluecrossmafoundation.org/publication/access-outpatient-mental-health-services-massachusetts.

⁵ AMN Healthcare, and Merritt Hawkins. *Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates 2022*.

2022. www.merrithawkins.com/uploadedFiles/MerrittHawkins/Content/News_and_Insights/Articles/mha-2022-wait-time-survey.pdf.

⁶ [ibid](#)

variances, market makeup, or workforce constraints, is overly rigid and, despite states' and plans' best efforts, may simply prove unachievable.

Further, we are concerned that the construction of the Proposed Rule effectively measures wait times at the provider level, rather than at the plan level. Measuring access in this manner may result in pressure on providers to inappropriately increase patient panels, thereby exacerbating provider burnout and potentially limiting access for existing patients. Specifically, there are numerous situations where it is appropriate for an individual provider or for a provider practice to manage their patient capacity, for example, by limiting availability of appointments for new patients, to preserve access for current patients.

Relatedly, to avoid the consequences of poor results on secret shopper surveys, plans may be incentivized to distort or manipulate their networking arrangements. For example, plans may over-utilize single case agreements with low-capacity providers (rather than bringing them in network) to avoid having those providers sampled as part of the secret shopper surveys or may attempt to contractually reserve access to providers for only their enrollees, at the expense of providers' availability to members in other plans or delivery systems. Plans may also refuse to contract with or terminate agreements with low-capacity providers to the detriment of member relationships and continuity of member care. These practices, and their consequences, would increase the burden on states to monitor and manage and could negatively impact member access and continuity of care.

Additionally, as CMS has noted, data on wait times is inconsistent and hard to compare, and we are supportive of the intent to enable more apples-to-apples comparisons across plans and states. However, the Proposed Rule as written does not appropriately account for important nuances in access, insofar as the rule does not distinguish between wait times for new and existing patients. Nor would the proposed measurement vehicle (i.e., secret shopper surveys) readily account for these variances, where the secret shopper would most likely only be able to pose as a new patient, rather than an existing one, when requesting appointments. And, to the extent the measurement standards are solely focused on new patient wait times, measured at the provider level, the proposed requirements may not reflect actual member experiences within managed care. The standards do not account for the number or percentage of enrollees already engaged with a provider for the category of service. Additionally, a secret shopper's finding that wait times exceeded the standards at the specific providers surveyed may not provide a meaningful picture to potential enrollees regarding their experiences with the plan or the ability to get a timely appointment with other providers in network.

Instead, CMS should consider the following alternative recommendations to ensure wait time standards have the intended positive impact on access to care.

- Instead of mandating specific wait times within the regulations, require states to set their own wait times that ensure that services are available at least to the extent that such services are available to the general population in the geographic area, to be determined in consideration of wait times for Medicare, Medicare Advantage, Marketplace plans, or commercial payers in their geographic area as benchmarks.
- Alternatively, if CMS finalizes the national wait time standards, adopt the appointment wait time standards in Medicare Advantage (30-45 days), rather than the Marketplace

standards that have not yet been implemented. These are not only more realistic standards but would also align standards within the Dual Eligible Special Needs Plan (D-SNP) construct.

- Additionally, if a national standard is set, explicitly allow exceptions to the wait time standards when states or plans demonstrate that wait times for a given service for Medicaid members are comparable to those for Medicare, Marketplace plans, and commercial payers in the geographic area.
- Allow flexibility for states to set variable wait time standards that are longer than the proposed 10 and 15-day standards, including for new patients vs. existing patients and for preventive care appointments, for which a longer wait may be clinically appropriate.
- Incorporate telehealth access more thoroughly into wait time standards and allow the availability of telehealth appointments to count towards meeting standards where clinically appropriate, such as for behavioral health services. While we agree that telehealth is not equivalent to in-person care for all service types, it is a critical tool for ensuring members have access to certain types of care, including behavioral health services. The inability to count telehealth appointment availability on par with in-person appointment availability for behavioral health would result in an inaccurate reflection of the actual availability of services.
- Consider member experience surveys more broadly for assessing member satisfaction and obtaining feedback regarding access and quality of care instead of setting the standard based on specific numbers of days. MassHealth has been conducting member surveys since 2018, and we have found them highly valuable. However, we have found that respondents take a holistic view of their overall care experience, rather than giving feedback specifically on wait times. Individuals seeking access to services are best positioned to reflect on whether the wait time for an appointment met their need for services, regardless of the number of business days that have elapsed.

Finally, we encourage CMS to provide authority and funding to support states' and plans' investments in cross-payer workforce initiatives, such as student loan repayment programs, tuition remission, professional training, and community-based recruitment and retention programs, to more holistically address workforce shortages. Massachusetts has sought out avenues for federal partnerships on such initiatives and would welcome continued opportunities to partner with CMS and harness federal investments in workforce support.

Secret Shopper

MassHealth supports the Proposed Rule's intent of ensuring accurate, up-to-date provider directories and to holding plans accountable to wait time standards. Additionally, we appreciate the opportunity to use outside vendors, such as External Quality Review Organizations (EQROs), for secret shoppers. This will allow states to leverage expertise from vendors who have contracts across Medicaid programs and promote shared learnings.

Although we generally support the use of secret shoppers, in particular for validating provider directories, we have some areas of concern regarding the proposed methodology of the secret shopper programs. In our discussions with other Medicaid agencies that have implemented secret shopper programs, we have learned that these initiatives require long planning and information-gathering periods, may create a high administrative burden for the state, and are best implemented as one part of a broader compliance framework.

If CMS decides to finalize the requirement that states utilize a secret shopper as part of its oversight of managed care plans, MassHealth has several recommendations to support successful secret shopper implementation:

- Establish a process that reviews compliance across a plan's network, rather than for individual providers and practices. For example, secret shoppers could start by calling plans and requesting a list of providers with open appointments within the specified timeframes. Then, the secret shopper could verify the availability of those providers and appointment times. This construct would appropriately put the onus on plans to maintain up to date and valid information regarding their provider availability, would hold the plans accountable for maintaining a robust network that provides necessary appointment availability to its enrollees, and would more accurately reflect member experience by looking at access across the plans' network instead of randomly sampled providers.
- Increase the expected amount of time for secret shoppers to notify states and plans of issues and for states and plans to correct those issues (currently proposed at three business days). We have found that the identification and final correction of issues can involve back-and-forth communication among multiple parties, which could reasonably take more than three business days to resolve.
- Increase the expected amount of time for plans to complete remediation plans in response to findings from the secret shopper, especially in consideration of provider shortages. We have found that the most effective workforce recruitment and retention efforts may take more than 12 months to yield full results. While we would still expect to see documented progress in a 12-month timeframe (for example, a reduction in wait times, or an increase in the percentage of identified providers meeting the threshold), we do not think complete remediation of access compliance is always achievable in a 12-month timeframe. Setting this timeline as the requirement under the rules is overly rigid and may be unrealistic in many circumstances.

Other

MassHealth supports the proposals for ensuring clear and transparent information is available for members on state websites. We would appreciate technical assistance from CMS, as well as the opportunity to share feedback on any suggested templates. We additionally support the transparent payment reporting and analysis process proposed. As points of feedback, we would request:

- CMS be mindful of the administrative burden for plans and providers while building out this process and would recommend a longer timeframe between collecting reports from

the plans and when they must be submitted to CMS. Due to the breadth of our managed care programs, we often spend several months' time validating and standardizing data such as these to ensure full and accurate completion. MassHealth recommends a period of 180 days, given the newness of the requirement and the anticipated volume of information reported.

- To ensure apples-to-apples reporting, CMS should consider piloting MCO rate reporting and comparisons with a small subset of E/M CPT and HCPCS codes. This would allow CMS to address key implementation challenges before requiring national reporting on the broader subset of codes.

State Directed Payments (SDPs)

Prior Approval Requirements and SDP Limits

MassHealth is supportive of CMS's actions to decrease or remove requirements and restrictions that impede states' ability to implement SDPs. Specifically, MassHealth supports CMS's elimination of certain requirements and limitations as applied to value-based purchasing (VBP) alternative payment methodologies (APM). For example, we support allowing states to set the amount and frequency of payments and to allow states to recoup unspent funds.

MassHealth also supports CMS's proposal to eliminate the preprint requirement for minimum fee schedules that are set at 100% of the Medicare equivalent rates. MassHealth encourages CMS to go further, however, by removing the preprint requirement for any minimum fee schedules, in particular any minimum fee schedule for behavioral health services and home and community-based services (HCBS). This will help alleviate administrative burdens for low-risk payment arrangements without undermining the principles of risk-based managed care contracting.

Additionally, removing the preprint requirement for all minimum fee schedules will allow states that direct payments for services for which there is no Medicare equivalent or for which there is no state plan rate (e.g., services authorized under a waiver or demonstration) the same flexibility that would apply to similar payment arrangements under the state plan. In MassHealth's experience, the services for which there is no Medicare or state plan benchmark are predominantly behavioral health and HCBS. Removing barriers to states in directing minimum fee schedules for services, and specifically for behavioral health services and HCBS, will advance CMS's and the states' shared goals of increasing investment in and supporting member access to these crucial services and programs.

Further, MassHealth strongly agrees with CMS that SDPs impacting behavioral health services and HCBS should not be subject to a limit of 100% of the average commercial rate (ACR). CMS should make this exclusion explicit by exempting behavioral health services and HCBS from the ACR limit in the regulation, including those behavioral health services provided by hospitals (inpatient and outpatient), nursing facilities, and "qualified practitioners" at academic medical centers. In light of the historic underfunding of behavioral health services and HCBS across payers and the unprecedented needs for these services following the pandemic, imposing the

ACR as a limit on SDPs for these services would frustrate states' ability to be a leader in advancing market-wide rate increases for these services.

Furthermore, MassHealth does not support the imposition of the ACR as a limit on "qualified practitioner services at an academic medical center." As drafted, this proposal is unclear as to which types of services or practitioners it encompasses, potentially encompassing large percentages of providers across service types and causing administrative difficulties in implementation. For example, Massachusetts has a high number of providers who might be considered "affiliated with" an academic medical center, and MassHealth would not be able to readily discern whether payments made under an SDP flow to those practitioners or not. Additionally, the penetration of academic medical centers in all areas of health care delivery (including behavioral health, hospital services, etc.) make them vital partners in the Massachusetts health care landscape. An ACR limit on SDPs for these providers would be difficult to implement and would unduly inhibit MassHealth's ability to drive delivery system reform, health quality and equity, and provider investments through these providers.

MassHealth strongly opposes any proposal to cap the percentage of a capitation rate that can be subject to an SDP. MassHealth has, for many years, maintained SDPs for the majority of our behavioral health services and, during the pandemic, implemented many new SDPs for HCBS as a means for driving investments in these services and enhancing member access to care. Capitation payments for certain managed care types, such as our behavioral health PIHP and our Senior Care Options program (which is a FIDE-SNP), are exclusively or predominantly comprised of behavioral health services and HCBS. Placing a cap on the percentage of capitation that can be subject to SDPs would inhibit MassHealth's ability to continue leveraging this important tool for investments in these services in support of access for our members.

Evaluation and Contract Terms

MassHealth appreciates CMS's requirement to evaluate the performance of SDPs by establishing an evaluation plan. While this requirement is understandable for value-based payments and performance improvement initiatives, we do not think that this requirement is particularly useful or relevant to SDPs that set minimum fee schedules. We recommend that CMS remove this requirement for minimum fee schedule SDPs.

The Proposed Rule intends to codify that payment under certain SDPs must be based on performance measures, not "administrative" activities. MassHealth disagrees with this distinction for purposes of SDPs and sees value in incentivizing activities that meaningfully advance program and agency quality goals through SDPs. We recommend that CMS continue to allow payment for such activities so long as the SDP advances one of the state's quality goals, rather than distinguishing between performance and "administrative" measures.

MassHealth is also concerned with the proposed requirements that would add significant administrative burden to implementation of SDPs. For example, the level of detail of the proposed contract requirements will prove to be extremely burdensome for states, like Massachusetts, that direct minimum fee schedules and uniform percentage increases on large numbers of behavioral health services and HCBS through multiple managed care contracts and

programs. MassHealth already finds it challenging to maintain accurate and timely lists of services and rates within the contracts. Mandating this in the regulation would exacerbate the difficulties in keeping contracts up to date and accurate.

Finally, CMS is proposing that states require that all providers that receive a payment subject to an SDP attest to non-participation in a hold harmless agreement for a health-care related tax. While MassHealth is fully committed to ensuring state compliance with federal laws that apply to health-care related taxes, MassHealth opposes this proposed requirement, as this will impose significant burden on state Medicaid agencies, plans, and providers. MassHealth has heard numerous times from stakeholders that the documentation requirements for participation in Medicaid and across managed care plans are a barrier for provider participation in our networks. Imposing additional requirements on providers that participate in Medicaid managed care networks would only serve to further dissuade network participation, which will have a negative impact on member access to care. Additionally, state Medicaid agencies are not appropriately situated to police agreements between and among providers. Finally, the proposed rule is overbroad insofar as it applies to all providers that receive payments under an SDP, regardless of whether a provider is even subject to a health-care related tax in the state. MassHealth urges CMS not to finalize this aspect of the proposed rule, or, in the alternative, not to apply the requirement to fee schedule SDPs and only apply the requirement to those providers that are actually subject to a health-care related tax.

Quality

Managed Care State Quality Strategies

The managed care quality strategy is a comprehensive document that serves as a blueprint for the State's Quality Assurance and Performance Improvement (QAPI) program. MassHealth carefully considers CMS guidance in developing and updating its strategy and therefore provides the following feedback on CMS's Proposed Rule as it relates to quality.

MassHealth supports the proposed changes for increasing accessibility to a state's quality strategy, including updating the quality strategy every three years and seeking public comment regardless of whether there are significant changes. MassHealth also supports the concept that quality strategy updates should be made after the state's quality strategy evaluation. By doing so, a state's quality strategy can be revised to address the findings of the quality strategy evaluation. MassHealth agrees that greater technical assistance in the evaluation of the quality strategy is needed and supports the addition of an optional External Quality Review (EQR) activity to support evaluation requirements. CMS stated that this optional activity would provide states critical technical assistance via a CMS-developed protocol that would enable more robust evaluations; MassHealth agrees. MassHealth also recommends that CMS update its Managed Care Quality Strategy Toolkit to provide additional guidance regarding the quality strategy evaluation and when available, reference the new proposed protocol.

External Quality Review (EQR)

Several of the quality provisions within CMS's Proposed Rule apply directly to External Quality Review (EQR) requirements. Many of these provisions will not materially impact the way in which MassHealth conducts its EQR activities and serve mostly to clarify ambiguities and reduce burden to participating stakeholders. However, MassHealth provides the following feedback on specific EQR-related provisions.

Removal of PCCM Entities from EQR Requirements

MassHealth supports CMS's proposal to remove PCCM entities from mandatory participation in EQR activities while allowing states discretion to continue to monitor PCCM entities. In the past, MassHealth had found that PCCM entity participation in certain EQR activities, particularly the compliance review, to be challenging given the PCCM entity structure, e.g., where the state serves as the "plan administrator." MassHealth will likely continue to exercise optional participation for PCCM entities in the performance measure validation activity, especially where performance measures are not otherwise evaluated by an independent auditor. MassHealth appreciates the flexibility for optional participation.

Modifications to EQR Technical Requirements

CMS has proposed stratifying performance measures collected and reported in the EQR annual technical reports (ATRs). MassHealth supports this proposal as it aligns with MassHealth's own health equity framework. However, prior to implementing any changes, MassHealth recommends that CMS develop and provide clear guidance regarding expectations for stratification while allowing states some flexibility in reporting. MassHealth recommends that CMS revise the EQR protocols to include such guidance and provide states with ample time for implementation, recognizing the need of states and contracted managed care plans to work with their HEDIS and other vendors to meet these requirements.

Annual Technical Reports

MassHealth appreciates CMS's thoughtful consideration in defining EQR review periods and extending the timeline for completing and posting EQR annual technical reports from April 30th to December 31st each year. As CMS noted, this change permits states the opportunity to obtain the most recent performance measurement data relevant to the review period resulting in a more actionable ATR. Although most of MassHealth's performance measures are calculated on a HEDIS schedule, which the new proposed deadline accommodates, there are several metrics that are calculated later in the calendar year that would impact the EQRO's ability to timely conduct performance measure validation and report those results by December 31st. To address this concern, MassHealth does not recommend extending the ATR due date past December 31st, but rather suggests that CMS consider permitting states to report on the most recent available data even if such data is tied to a prior measurement year.

Adoption of New Medicaid Managed Care Quality Rating System (MAC QRS)

MassHealth supports public posting of quality ratings intended to provide members and their caregivers with a web-based interface to compare Medicaid and CHIP managed care plans based on performance indicators and ratings. MassHealth appreciates the guidance and opportunity to comment on the proposed Medicaid managed care quality rating system (MAC QRS) framework, which includes mandatory measures, a rating methodology (either the CMS-developed methodology or an alternate methodology approved by CMS), and a new mandatory website display.

Required Mandatory Measures for MAC QRS

MassHealth supports a QRS framework that includes a mandatory measure set that will prioritize and limit measures initially to promote consistency and comparability among our state managed care plans as well as across managed care plans in other states. MassHealth also supports the option and flexibility to include non-mandatory measures within the same QRS framework to leverage a standard template to include additional measures that may be important to the state. With respect to the proposed mandatory measure set, MassHealth supports most of CMS's proposed measures. However, MassHealth recommends removing the MLTSS-1 LTSS Comprehensive Assessment and Update measure because the measure is currently not endorsed and requires case management and record review. Requiring this measure would create an additional burden on top of an already ambitious requirement. MassHealth would encourage CMS's flexibility to replace or remove this measure in this initial mandatory measure set selecting from the CMS core measures and utilizing administrative measures where possible. MassHealth supports the inclusion of the mandatory CAHPS measure, however, MassHealth encourages CMS to consider utilizing the current AHRQ database directly to report out the CAHPS measures. For example, CMS could populate the templates using the CAHPS data and states could link to the templated page. This would reduce burden and promote consistency in the display of these data across states.

MAC QRS Methodology and Website Display, Including Stratification and Option for an Alternative Rating Systems

The MAC QRS described methodology seems feasible where states are required to calculate and assign domain level quality ratings for managed care plans only. MassHealth encourages CMS to finalize the methodology and provide technical assistance (e.g., methodology with clear examples and calculations) to states as part of the process to ensure consistency and accuracy in implementation. MassHealth also supports CMS's proposal to collect data from other sources and populations, where there is not undue burden, to obtain a more comprehensive view of the state's populations (e.g., FFS, Medicare Advantage, dually eligible populations).

With respect to CMS's proposal for website display requirements, MassHealth supports CMS's proposal for stratification by factors including dual eligibility status, race and ethnicity, and sex. CMS should also include stratification by age category (e.g., children, adults, 65+) where supported by the measure specifications. Allowing quality ratings of plans to be stratified by demographics of the populations served (e.g., age, disability) and enrollment status (e.g., dual

eligibility, managed care plan type) will help ensure that comparisons are made among plans serving like populations within a state and between states.

MassHealth supports adopting a standard CMS quality rating system and website display but appreciates the flexibility of an alternative quality rating system. This alternative option provides flexibility to states that have already committed efforts and resources to their current quality rating system and/or public displays and reporting activity.

MAC QRS: Required Implementation Date

The proposed MAC QRS framework will be burdensome to implement. MassHealth therefore strongly supports CMS allowing states until the end of the fourth calendar year following the effective date of the final rule to implement their MAC QRS or alternative QRS. MassHealth urges that, at the time of the effective date of the final rule, CMS finalize the mandatory measures and other required information and provide a clear CMS rating methodology and standard display format that the State can implement to ease the transition. To the extent the mandatory measures and rating methodology are not finalized at the time of the final rule, CMS should delay implementation of the MAC QRS. MassHealth further encourages CMS to provide templates and opportunities for technical assistance in the implementation process if possible. MassHealth also supports the proposed timing for completing phase one website display requirements for stratified data to be no earlier than two years after the initial implementation of the QRS. This proposed timing addresses both the burden and time needed in the public reporting/display process and, where many states are actively starting to collect standard robust data for stratification, this proposed timing would provide time to collect and thus report more meaningful information.

MAC QRS: Request for Clarification

In addition to providing specific feedback on the MAC QRS, MassHealth requests clarification regarding the implementation of the MAC QRS in the context of D-SNPs. Specifically, MassHealth would appreciate clarification from CMS on the following questions:

- Will the MAC QRS for D-SNPs be determined independently from their corresponding Medicare Advantage plans' Medicare Star Ratings?
- Will the MAC QRS for D-SNPs be determined based on Medicaid-only services, or will it also be required to include services covered as part of the Medicare cost sharing responsibilities of the plan?

MassHealth requests that CMS make specialized technical assistance available to states to assist in implementing the MAC QRS requirements for D-SNPs and other managed care plans that serve dually eligible members and members with third-party liability.

Program Integrity Overpayment Reporting Requirements

MassHealth appreciates and supports the intention of clarification and consistency in managed care plan reporting on overpayment data. Accordingly, MassHealth's managed care contracts already satisfy numerous aspects of the proposal to address overpayment reporting. Effective

calendar year 2023, all MassHealth's managed care plan contracts have been, or are in the process of being, amended to reflect clear and consistent requirements for reporting overpayment activity.

While MassHealth agrees that it is helpful for the rules to define a timeframe for ad hoc reporting from the date of overpayment identification, as well as routine reporting of overpayment recovery, MassHealth is concerned that the proposed 10-day reporting requirement for plans to report overpayments recovered is unnecessarily burdensome on plans and states and is unnecessary to meet the state's programmatic and business needs.

MassHealth supports the proposed 10-day timeframe for ad-hoc reporting of identified overpayments. Currently, MassHealth's managed care plans are required to notify MassHealth within five business days after the identification of the overpayment. These ad hoc reports meet MassHealth's business needs to execute program integrity efforts, including but not limited to screening overpayments identified by managed care plans for any related investigatory activity by MassHealth or an external entity such as the Office of the Attorney General Medicaid Fraud Division.

Regarding reporting of recovered overpayments, however, MassHealth does not believe that 10-day reporting is necessary or useful. Currently, MassHealth requires its managed care plans to submit a semi-annual Summary of Provider Overpayments Report to MassHealth, which must include all overpayments identified, as well as all investigatory and recovery activity related to those overpayments. This report includes complete claim-level detail regarding the overpayments as well as summary-level information for all contract year recovery activity. The semi-annual reporting timeframe for overpayments recovered is a critical tool for MassHealth in meeting MassHealth's business needs to execute program integrity efforts and develop actuarially sound capitation rates, while appropriately balancing the burden that such detailed reporting places on the plans and the state. CMS should consider a longer, and regular (as opposed to ad-hoc) reporting timeframe for the reporting of recovered overpayments.

Thank you for your consideration of these important issues. If there is any information we can provide as you evaluate these matters, we would be happy to assist.

Sincerely,

A handwritten signature in cursive script that reads "Mike Levine".

Mike Levine, Assistant Secretary for MassHealth

cc: Kathleen E. Walsh, Secretary