Meeting Title:
CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations

From:
CMS CMCS_Unwinding <CMCSUnwinding@cms.hhs.gov>

Sent:
11/17/2022 9:38:40 PM +0000

To:
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Location:
https://cms.zoomgov.com/j/1614591010?pwd=T2NueGZGL2NtbkNxOTFkS29nWk5Tdz09

Start Time:
11/18/2022 7:00:00 PM +0000

End Time:
11/18/2022 8:00:00 PM +0000

Duration:
1 hours

Reminder Time:
11/18/2022 7:00:00 PM +0000

Is Recurring:
false

Recurrence Type:
Not

Recurrence Pattern:

Response Status:
5

Busy Status:
Tentative

Attachments:
20221118_Stakeholder Workgroup Agenda_Final.docx

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CMS Unwinding Stakeholder Workgroup Agenda
November 18, 2022| 2:00-3:00 PM ET

Welcome & Opening Remarks

CMS Updates & Recent Releases

Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies
Ending Coverage in the Optional COVID-19 Group
Opportunities to Support Medicaid and SNAP Unwinding Efforts
Ex Parte Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts
FFM Inbound Account Transfer Matching Functionality
Technical Resource Guide - Overview: State Medicaid/CHIP Agencies Accepting Federally facilitated Marketplace Eligibility Decisions
Additional resources available under Medicaid/Marketplace Coordination on Medicaid.gov/Unwinding
Consumer Research to Inform Unwinding Outreach: Messaging to Promote the Use of HealthCare.gov

Preview of Phase II Consumer Research on Unwinding

Feedback from the Field & Open Discussion

What do you see as the priorities for CMS, states, and partners for the coming months?
What are your biggest outstanding questions and concerns?
What have you been hearing from partners in the states?

Wrap Up & Next Steps
Ideas for next month's meeting
Unwinding National Partner/Stakeholder Webinar: Wednesday, December 7 (12-1pm ET)
Registration Link: here
Next Meeting: December 9, 2022

Appointment Title:
CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations

Organizer:
CMS CMCS_Unwinding

Attendees:
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Location:
https://cms.zoomgov.com/j/1618164200?pwd=ZDJMUnAwZE9la0FUR1pzb01rZDNwZz09

Start Time:
2/16/2023 6:00:00 PM +0000

End Time:
2/16/2023 7:00:00 PM +0000

Reminder Time:
7/20/2023 4:45:00 PM +0000

Reminder Set:
true

Duration:
1 hours

Is Recurring:
true

Reccurrance Type:
3

Reccurrance Pattern:
the third Thursday of every 1 month(s) from 1:00 PM to 2:00 PM

Response Status:
2

Busy Status:
Tentative

Attachments:
Untitled; Untitled; Untitled

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Attachments:
20230216_Stakeholder Workgroup Agenda_FINAL.docx

CMS Unwinding Stakeholder Workgroup Agenda
February 16, 2023| 3:00 - 4:00 PM ET

Welcome and Opening Remarks

Overview of Recent Highlights & CMS Releases
State Health Official Letter #23-002 on the Consolidated Appropriations Act
Slide deck
Telephone Consumer Protection Act (TCPA) Updates
FCC Declaratory Ruling, Jan. 23, 2023
FCC Presentation from Jan. 24, 2023, CMCS All-State Call
Updated Communications Toolkit –
Tip Sheet for CMS Partners to help someone who lost Medicaid or CHIP coverage (Page 15)

State and Partner Engagement Updates
Kitchen Cabinet Meetings

Marketplace Updates and Unwinding Special Enrollment Period (SEP) FAQ

Open Q&A and Discussion (20 min)

Closing (3 min)
Unwinding National Partner/Stakeholder Webinar: Wednesday, February 22 (12-1pm ET)
Registration Link: here
Next Meeting: March 16, 2023 (1-2pm ET)

Attachments:
20230323_Stakeholder Workgroup Agenda.docx

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Updated with agenda.

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CMS Unwinding Stakeholder Workgroup Agenda
March 23, 2023| 2:00 - 3:00 PM ET

Welcome and Opening Remarks (2 min)

Overview of Recent Highlights & CMS Releases (10 min)
Medicaid and Children's Health Insurance Program (CHIP) Disability and Language Access Requirements Slide Deck
Anticipated Timelines for States Initiating Unwinding-related Renewals
New Materials in the Toolkit Supporting Materials Zip Folder
Phase 2 Post card
Factsheet on Medicare SEP
Unwinding Factsheet
Tip Sheet for CMS Partners
Phase 2 Social Media Graphics
Unwinding Communications Toolkit Phase 2 updates
English
Spanish

Discussion on the Framework for Ensuring Compliance with CAA, 2023 (15 min)

Communications to Children and Families (10 min)

Feedback from the Field & Open Discussion (20 min)

Closing (3 min)
Unwinding National Partner/Stakeholder Webinar: Wednesday, April 26, 2023 (12-1pm ET)
Registration Link: here
Next Meeting: April 20, 2023 (1-2pm ET)

Attachments:
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CMS Unwinding Stakeholder Workgroup Agenda
April 20, 2023| 2:00 - 3:00 PM ET

Welcome and Opening Remarks

Overview of Recent Highlights & CMS Releases
Update on the end of the COVID-19 Emergency
Resources to Support State Implementation of Renewal Mitigation Strategies

Highlights from the Health Resources & Services Administration (HRSA)'s Work on Medicaid Unwinding - Eliza Heppner (HRSA)

Group Discussion – Other Stakeholder Work to Promote Retention During Unwinding

Feedback from the Field

Closing
Unwinding National Partner/Stakeholder Webinar: Wednesday, April 26, 2023 (12-1pm ET)
Registration Link: here
Next Meeting: May 31, 2023 (3-4pm ET) – rescheduled from May 18

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Appointment Title:
[External] CMCS Access Policy Sprint Working Session

Organizer:
Peterson, Alanna

Attendees:
Boozang, Patricia; Mann, Cindy; O'Connor, Kaylee; Striar, Adam; Serafi, Kinda; TSCHENCK@mitre.org; Giles, John (CMS/CMCS); Gibson, Alexis E. (CMS/CMCS); Gentile, Amy A. (CMS/CMCS); jbarrazacannon@mitre.org; rebeccacase@mitre.org; Llanos, Karen E.(CMS/CMCS)

Location:
https://manatt.zoom.us/j/91489218120?pwd=cnp0OXhhOG1yQzB3NWJXaVlYWVVHUT09

Start Time:
8/16/2022 4:00:00 PM +0000

End Time:
8/16/2022 5:00:00 PM +0000

Reminder Time:
8/16/2022 3:45:00 PM +0000

Reminder Set:
true

Duration:
1 hours

Is Recurring:
false

Reccurrance Pattern:

Response Status:
3

Busy Status:
Busy

Attachments:
image001.jpg; Appointment Wait-Time Enforcement Recommendations 08.10.22.docx; Manatt_MITRE Medicaid Managed Care Access Sprint Support Workplan 08.12.2022 (002).docx; Provider Survey Memo 8.12.22..docx

[External] CMCS/Manatt/MITRE Access Spring Meeting

Tuesday, August 16, 2022, 12:00-1:00 pm ET

1. Review Draft Secret Shopper/Provider Survey Preamble and Regulatory Text Memorandum (see Provider Survey Memo 8.12.22 attached) - Manatt
- Share Key Takeaways from Interview with DC (8/15) (forthcoming)

2. Update on Status of Appointment Wait-Time Implementation and Enforcement Recommendations Memorandum (see Appointment Wait-Time 8.10.22 attached) - CMS

3. Discuss Next Steps/Timing for to Data-Driven Strategy for Monitoring Access - Manatt

4. Discuss how MITRE/Manatt can best support CMS during August through year-end (see revised Workplan attached) * Manatt

5. Next Steps (Manatt)
- Check-In on Participation in the NAMD Access Workgroup Meetings (CMS)
- Next Meeting: 8/25 * Proposed Agenda (Manatt)

? Discuss Optimizing the Online Experience for Individuals Enrolled in Medicaid Managed Care Memorandum
? Review Final Draft of Appointment Wait-Time Implementation and Enforcement Recommendations Memorandum
? Continue Discussing CMS Comments/Feedback on Status of Secret Shopper/Provider Survey Memorandum (as needed)

Attachments:
1. Secret Shopper/Provider Survey Memorandum
2. Appointment Wait-Time Implementation and Enforcement Recommendations Memorandum
3. Manatt/MITRE Medicaid Managed Care Access Sprint Support Workplan

Upcoming Medicaid Managed Care Access Spring Meetings with CMS/Manatt/MITRE:
- Thursday, August 25, 4:00 * 5:00 PM ET
- Monday, August 29, 10:00 * 11:00 am ET
- Month of September * TBD

Hi there,

Alanna Peterson is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting

Phone one-tap:

US: +13017158592,,91489218120# or +13126266799,,91489218120#

Meeting URL:

https://manatt.zoom.us/j/91489218120?pwd=cnp0OXhhOG1yQzB3NWJXaVlYWVVHUT09

Meeting ID:

(b)(6)

Passcode:

(b)(6)

Join by Telephone

For higher quality, dial a number based on your current location.

Dial:

US: +1 301 715 8592 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 or +1 253 215 8782 or +1 346 248 7799 or +1 386 347 5053 or +1 564 217 2000 or +1 669 444 9171 or +1 669 900 6833 or 877 853 5247 (Toll Free) or 888 788 0099 (Toll Free)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

International numbers

Join from an H.323/SIP room system

H.323:

162.255.37.11 (US West)
162.255.36.11 (US East)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

SIP:

(b)(6) @zoomcrc.com

Passcode:

(b)(6)

Manatt Health

2022-08-08T22:29:00Z

Manatt
CMS: Based on interview findings, we are recommending pivoting away from “secret shopper” language to “provider surveys” that may include both secret shopping and “revealed” shopping (which is required to determine some specific aspects of access).

Manatt Health

2022-08-08T22:30:00Z

Manatt
CMS: You could also consider a preemptive corrective action plan that you and the state could initiate prior to this point OR allowing a state to propose its own glidepath to come into compliance.

This might be appropriate if a state is taking aggressive steps to improve access, but will need time to see the fruits of its labor. For example, a state could work to increase rates, but changes might be contingent on state legislation, providers need time to enroll, etc.; or a state could have an IT fix related to provider enrollment and simplification but implementation won’t begin until year 3.

On the flipside, we worry this might give states an excuse to not meet the 3 year time period. It would have to be administered tightly, and perhaps with public notice/input.

Manatt Health

2022-08-08T22:30:00Z

Manatt
CMS: We are continuing to look into state examples so that we can make a recommendation that aligns with leading practices

Recommendations for CMS Enforcement of Appointment Wait-Time Standards
Wednesday, August 10th, 2022

Background
The Centers for Medicare & Medicaid Services (CMS) requested research and options on a structured Notice of Proposed Rulemaking (NPRM) approach to implementation and enforcement of state compliance with new appointment wait-time standards in Medicaid managed care.

1 States must adopt and enforce, at a minimum, appointment wait-times for: primary care (routine), adult and pediatric: 15 calendar days; OB/GYN (routine): 15 calendar days; outpatient behavioral health (mental health and SUD) (routine), adult and pediatric: 10 calendar days; and specialist (targeting identified gaps in access as determined by the State in an evidence-based manner), adult and pediatric: Number of calendar days as designated by the State based on targeted specialty and population.

1
As context for this request, CMS conveyed leadership's concern that the proposed appointment wait-times and 90 percent compliance threshold are aggressive, while acknowledging that the standards achieve the Administration's objective of bold access goals that are aligned across Medicaid, Medicare, and the Marketplace. CMS also shared leadership's desire to meaningfully enforce compliance with the new standards.

Below, we discuss several options for CMS to achieve a balance of (1) robust technical assistance (TA) to help states implement and meet new federal minimum appoint wait-time standards and related oversight requirements (e.g. provider surveys) with (2) effective enforcement when states fall short of compliance, and (3) options to promote transparency. These options will be further refined and prioritized through discussions with CMS, states, and other stakeholders.

Reminder: Summary of Straw Model Approach to Regulatory Requirements (Proposed on 6/23)

Establish minimum federal standards for appointment wait-times that: permit states to impose more stringent requirements and adopt additional requirements; and provide flexibility for CMS to evolve the "floor" over time.
Set a 90 percent compliance threshold for each provider/facility type (based on appointment wait-time standards established by the state in accordance with federal regulations). States and their health plans will also need to ensure that at least 90 percent of provider directory entries are accurate at all times.
Require states to conduct annual randomized surveys of providers to assess beneficiary access across plans, and submit to CMS and make public randomized provider survey results. Provider surveys will assess compliance with the state and federal appointment wait-time standards for each provider/facility type, among other access areas.

2 Note: We recommend updating the NPRM so that the survey documents compliance with both state and federal compliance (to the extent they diverge).

2
As part of public reporting, states must make available through an annual report data on service utilization across a range of enrollee characteristics.
Subject states to compliance reviews (at CMS discretion) for beneficiary access issues based on provider survey result data and in accordance with the newly refined proposed glidepath (see below – additional detail is forthcoming).

3 CMS plans to seek comment from stakeholders on an appropriate timeline for rolling out provider survey requirements.

3
Access issues will include noncompliance with federal minimum appointment wait-time standards and inaccurate provider directories.

Beginning 1 year after the effective date of the rule: States will be expected to procure vendors and conduct other preparations necessary to begin administering the provider surveys. CMS would provide robust TA for all states related to provider surveys and the new access requirements.
Beginning 2 years after the effective date of the rule: States will be expected to conduct a one year "beta test," wherein states would administer test surveys and report data to CMS; during the beta test year, states would not face enforcement actions from CMS based on survey results. CMS would continue to provide robust TA to all states.
Beginning 3 years after the effective date of the rule: CMS would begin holding states accountable for achieving at least 80% or 85% (TBD) compliance with the federal minimum appointment wait-time and provider directory accuracy standards based on survey results. CMS would provide targeted TA for states that are out of compliance with access requirements.
Beginning 4 years after the effective date of the rule and thereafter: CMS would hold states accountable for achieving at least 90% compliance with the federal minimum appointment wait-time and provider directory accuracy standards based on survey results. CMS would continue to provide targeted TA.

Illustrative, High-Level Glidepath
1 Year After the Rule
2 Years After the Rule
3 Years After the Rule
4+ Years After the Rule

States prepare to implement provider surveys
Robust CMS TA for all states
Beta test period for provider surveys
Robust CMS TA for all states
States held accountable for 80% or 85% compliance with access requirements
Targeted TA for non-compliant states
States held accountable for 90% compliance with access requirements
Targeted TA for non-compliant states

*Note: Manatt is continuing to refine this glidepath; additional detail and potential changes are forthcoming.

Give states with access issues the option to submit a Network Adequacy Justification Form to CMS to justify noncompliance with access standards. (We understand that CMS is moving away from this proposal, but wanted to flag that we originally included it to align with the 2023 NBPP.)
Require states to develop and submit a corrective action plan (at CMS' discretion) to document/ensure compliant practices and take affirmative steps to improve access.

Options: CMS Appointment Wait Time Standards: Implementation TA, Enforcement, and Transparency
Below we outline for CMS' consideration an approach to implementation and enforcement that includes an implementation glidepath inclusive of TA for states, CMS enforcement mechanisms, and options to promote transparency. This approach is designed to ensure that (1) states are able to efficiently design and implement new appointment wait-time standards and compliance oversight/reporting; and (2) federal and state partners can identify and address promptly access issues and continuously make program improvements, including through effective enforcement.

As noted above, CMS will receive provider survey results and hold states accountable for access issues, including not meeting the federal minimum appointment wait-time standards. While states have significant flexibility in imposing a continuum of enforcement actions on their health plans, CMS will need to determine/clearly define its own enforcement policy—ensuring it is robust enough to drive proactive state behavior as well as prompt corrective action as needed. While the pathway discussed below focuses specifically on appointment wait-time standards, CMS should also consider an implementation glidepath inclusive of TA as well as enforcement mechanisms/mitigation strategies for provider surveys (forthcoming

4 For example, CMS could (1) consider hosting learning collaborative meetings on provider survey program design and implementation as a standalone or as part of a broader Access Learning Collaborative to facilitate cross-state learnings on methodological and operational best practices and key challenges; and (2) provide states with a toolkit outlining detailed methodological best practices and potential study approaches in order to support states in complying with new survey requirements.

4
) and provider directory standards.

Implementation TA. In lead-up to and during the three-year period following the effective date of the rule (i.e., the period of time that states will have to implement provider surveys and come into compliance with appointment wait-time and provider directory standards), CMS' explicit drumbeat would be that every state should be using the time to come into compliance. To that end, CMS could provide early and ongoing intensive TA. For appointment wait-time standards, this could include:
A state-administered Access Diagnostic Assessment Tool for states to examine their current provider networks and identify access issues.
An Access Punch List of strategies for states to increase provider participation. Through the punch list, CMS could amplify best practices and mitigation strategies (e.g., assessing provider payment rates, coordinating and streamlining provider recruitment and credentialing, reducing provider administrative burden, timely enforcement mechanisms, etc.).
Learning Collaboratives and All State Calls/Webinars to roll out the assessment tool and punch list and tackle other thorny implementation issues that states (and their health plans) are grappling with as they ramp-up their processes to comply with the new access requirements. (As noted above, CMS' TA could also extend to provider surveys and provider directory requirements—though the TA approaches may differ.)

Enforcement. Beginning three years after the effective date of the rule, CMS would begin to hold states with beneficiary access issues accountable for meeting the federal standards.

5 If handled in accordance with CMS' expectations, standards, and processes, corrective action plans have potential to achieve measurable improvement in access. (Also see 42 CFR Part 430, Subparts C and D for federal regulations on enforcement of federal Medicaid requirements).

5
For appointment wait-time standards, CMS could expand on the enforcement process detailed in the strawmodel and summarized above by:
Requiring states that are noncompliant to develop within a specific period of time (e.g., one month) their own plans of corrective action and propose the remedy, which would require CMS approval. Rather than leaving this open-ended, CMS could develop a checklist (mirroring the Access Punch List provided during the TA period) wherein states would select the remedy (or remedies) themselves or propose an alternative, to be agreed upon and determined by the severity and nature of noncompliance. Clear timetables for taking the corrective action would be written into the plan. Any action undertaken by CMS and the corrective action plan itself would be publicly available through both the state and CMS websites.
In addition, the corrective action plan would reflect when a state is late in meeting or has otherwise failed to achieve the agreed-upon milestones. In this instance, CMS could automatically impose a financial penalty (e.g., a monetary sanction

6 At least one state, Florida, imposes a monetary sanction of $200 per day for each day the plan doesn't implement, to the satisfaction of the agency, the approved corrective action plan.

6
or withhold (see below) for each day the state does not satisfy CMS expectations). The state could appeal (on factual grounds) CMS's determination that they had not met the milestone. Consistent with the regulations at 42 CFR § 430.35(d)(1)(i), CMS would end the penalty (and potentially return the payments) when the Administrator "is satisfied regarding the state's compliance."

Per 42 CFR § 430.35, CMS can withhold payments (e.g., by reducing the Federal Medical Assistance Percentage (FMAP) or the amount of state expenditures subject to federal financial participation (FFP)) to a state Medicaid agency for failure to meet federal access requirements.
If the state subsequently achieves compliance and CMS is satisfied with the state's performance, CMS would need to resume payments. In determining the withhold amount, CMS could take into account factors, such as the degree to which the state is out of compliance (e.g., whether deficiencies are isolated or widespread, if they constitute a pattern of repeated noncompliance), level of harm done (or potential for harm) to beneficiaries, and state resources (e.g., workforce and budgetary constraints).
CMS also could return all or a portion of the financial penalties imposed by "investing" a share of savings from the withhold in state initiatives to make improvements in access.

Additionally, CMS could explore financial incentives, such as providing bonus payments to high-performing states (as it did for CHIPRA)—though this would require further exploration of the legal authority absent legislation. CMS could tier payments and provide higher bonuses based on the degree to which states exceed the federal compliance threshold. This extra financial support would demonstrate CMS' commitment to improving access and reward those states that similarly bear additional access-related costs to improve network adequacy.

Transparency on Access. In addition to the TA and enforcement approach described above, CMS could consider public transparency mechanisms to encourage compliance and allow for public input about compliance and any proposed corrective action. For example:
Public Reporting. Beyond requiring states to make public provider survey result data and submit the annual report (referenced above), CMS could post the results of state performance against appointment wait-time standards (and accuracy of provider directories/progress addressing disparities in access to care) to encourage compliance and recognize achievements. This could entail leveraging the Medicaid and CHIP (MAC) Scorecard or posting publicly access snapshots or a dashboard (see, for example, Florida's Medicaid Statewide Medicaid Managed Care Compliance Actions). If CMS ultimately decides to tie financial awards and/or penalties to state performance on access, this tool could also detail the financial breakdown by state.
Public Input. CMS could establish a process by which consumer groups, providers, and other interested parties could (1) comment on provider survey results, compliance plans, and enforcement actions, and (2) report ongoing systemic issues of access (as proposed in our straw model).

7 CMS could encourage or require states to establish a formal administrative process through which complaints alleging systemic shortfalls in access are submitted, investigated, and resolved. The process could be designed such that only complaints with sufficient initial information/evidence would proceed to investigation and resolution. The process would be different than and significantly more impactful than monitoring grievances filed by an individual beneficiary who cannot find a provider, for example. CMS encourages states to take on this oversight role and establish their own processes to ensure access. Also see recommendations to bolster the beneficiary support system.

7
At CMS' option, the complaints could be used as input into its oversight mechanism or as part of a more formal adjudicatory process (in light of the Armstrong Supreme Court case).

Quality Rating. CMS could create a quality rating system, as it has done for other programs (such as the Five-Star Quality Rating System for nursing homes), wherein it gives each state a rating between one and five stars. For example, states with three stars would be in compliance with federal standards, and those with five stars would be significantly exceeding the standards. (If CMS were to move forward with this proposal, we could further refine the proposed approach, taking into account the 90 percent threshold.)

Appendix: State Research

States use a multitude of network adequacy enforcement mechanisms—ranging from corrective action plans and sanctions to liquidated damages and contract terminations. Below, we highlight practices from select states that consider themselves leaders on network access.

Arizona. Based on a review of the state's Medicaid managed care contract, it's not entirely clear which enforcement mechanisms have been successful (from the state's perspective) in ensuring network adequacy. The state maintains the ability to impose a range of administrative actions (e.g., sanctions, notice to cure, and TA).
The contract includes the following provisions of note:
AHCCCS may impose Administrative Actions for material deficiencies in the Contractor's provider network.
AHCCCS will disenroll the member from the Contractor when not all related services are available within the provider network.
The Contractor shall develop and maintain a Network Development and Management Plan (NDMP) to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area and which ensures the provision of covered services. The submission of the NDMP to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The NDMP Plan shall be evaluated, updated annually, and submitted to AHCCCS.
The Contractor shall continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, member grievances, appeals, quality data, quality improvement data, utilization of services, member satisfaction surveys, and demographic data requirements. The Contractor shall also develop non-financial incentive programs to increase participation in its provider network when feasible.
The Contractor may request an exception to these network standards; it shall submit such a request for AHCCCS approval. In the event a Contractor is not able to meet set network standards, AHCCCS may review requested exceptions based upon a number of factors, including but not limited to, availability of out of network providers and geographic limitations of the service area.
The PBM subcontract shall include: a clause that allows for an annual review of the contract for rate setting, adjustments to market conditions, and to ensure network adequacy.

California. The California Department of Managed Health Care (DMHC) issued an order in Dec 2017 requiring nine health plans to terminate contracts with Employee Health Systems Medical Group as a result of blocking patient access to specialists. The basis for doing so was the Knox-Keene Act, which regulates health plans (and any provider or subcontractor providing services) and the health plan business in California to protect and promote the interests of enrollees. (Also see the Blue Shield of California Promise Health Plan's notice of potential contract termination and this 2021 CHCF brief.)

Florida. While Florida's Medicaid managed care contract does appear to include more robust requirements (with an emphasis on liquidated damages and reporting) related to ensuring access to provider networks, this dashboard and local news article suggest that network adequacy remains a significant issue (for health and dental plans, alike). The contract includes the following provisions of note:
The Managed Care Plan shall submit a provider network file of all participating providers to the Agency or its agent(s) on a weekly basis and at any time upon request of the Agency with sufficient evidence that the Managed Care Plan has the capacity to provide covered services to all enrollees.
The Managed Care Plan shall develop and maintain an annual network development plan, including processes and methods to develop, maintain, and monitor an appropriate provider network that is sufficient to provide adequate access to all covered services covered; interventions to address network gaps; evaluation of the effectiveness of interventions to address gaps; results of secret shopper activities; among other factors.
Liquidated damages, including but not limited to:

Failure to timely report, or provide notice for, significant network changes ($5,000 per occurrence).
Failure to comply with provider network requirements in the contract ($1,000 per occurrence).
Failure to update online and printed provider directory ($1,000 per occurrence).
Failure to provide covered services within the timely access standards ($500 per day, per occurrence).
Failure to provide covered services within the geographic access standards ($500 per day, per occurrence).
Failure to submit a provider network file that meets the agency's specifications ($250 per occurrence).
Any liquidated damages assessed by the Agency shall be due and payable to the Agency within 30 days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice. The Agency shall have sole authority to determine the application of an occurrence (e.g., per unit of service, per date of service, per episode of service, per complaint, per enrollee, etc.). The Agency may elect to collect liquidated damages: through direct assessment and demand for payment delivered to the Managed Care Plan; or by deduction of amounts assessed as liquidated damages from, and as set-off against payments then due to the Managed Care Plan or that become due at any time after assessment of the liquidated damages.
The Managed Care Plan agrees that failure to comply with all provisions of this Contract and 42 CFR 438.100 may result in the assessment of sanctions and/or termination of this Contract.

Tennessee. Tennessee similarly utilizes liquidated damages (in addition to corrective action plans) for violations related to time and distance standards, provider information accuracy, adequacy of provider networks, and provider network documentation. The contract includes the following provisions of note:
The CONTRACTOR shall monitor provider compliance with access requirements, including but not limited to appointment and wait times and take corrective action for failure to comply.
The CONTRACTOR shall submit monthly Provider Enrollment Files as follows: include information on all providers of covered services and shall provide a complete replacement for any previous Provider Enrollment File submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.
The CONTRACTOR shall submit an annual Provider Compliance with Access Requirements Report that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access standards as well as an emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. This report/plan shall also be available upon request.
For behavioral health and specialty care: At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency. The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.
Liquidated damages, including but not limited to:
$25,000 if ANY of the listed standards are not met, either individually or in combination, on a monthly basis (Time and travel distance as measured by provider network analytics software described by TENNCARE).
$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis

8 The liquidated damage may be waived if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of CHOICES HCBS provider serving the county and the CONTRACTOR has used good faith efforts to develop CHOICES HCBS providers to serve the county. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE.

(for executed provider agreements with providers to participate in the specialist provider network and the HCBS provider networks);
$25,000 per quarter if less than 90% of providers confirm participation in the CONTRACTOR's network (based on a

statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the CONTRACTOR's network).
$1,000 for each provider for which the CONTRACTOR cannot provide a signature page from the provider agreement between the provider and the CONTRACTOR (related to the provider enrollment file).

Manatt Health

2022-08-11T12:51:00Z

Manatt
CMS: Would PowerPoint slides (here and below) be helpful in advancing the work and driving decisions, or are you primarily relying on the memorandums?

Manatt Health

2022-08-11T12:51:00Z

Manatt
CMS: Following our discussion with you on 8/16, please let us know if you need additional detail to support the drafting of preamble language around the type of provider survey/secret shopper TA support that will be available to states — or if what we have provided is sufficient.

Manatt

2022-08-11T10:39:00Z

ks
CMS: Since you'll be heads-down on drafting in September, we'd suggest scheduling two 60 minute working sessions mid-month and at the end of the month. We can, of course, cancel as needed but thought it would be helpful to hold the time to discuss substantive issues as they arise

Manatt Health

2022-08-11T13:00:00Z

Manatt
CMS: We'd also welcome your input on how Manatt can best support your needs in September (e.g., ad hoc TA or "phone a friend" approach; product, tools, guidance development).

CMCS Access Strategy Development and Implementation: High-Level Workplan
MITRE and Manatt Health Proposed Topic Areas and Deliverables for August and September 2022
Updated August 12, 2022

#
Medicaid Managed Care Access Topic Area

1 Manatt is also continuing to provide limited support to the Medical Care Advisory Committee (MCAC) workstream that Aurrera and MITRE are leading.

1

Proposed Deliverable
Status
August
September

8/8
8/15
8/22
8/29
9/5
9/12

Appointment Wait Time Standards and Provider Survey/Secret Shopper Program

1
CMS Approach to Implementation and Enforcement of Appointment Wait Time Standards
Approach memorandum
Findings from state research and interviews

2 Manatt plans to share with CMS—based on additional research and interviews with states including Arizona, Florida, and Tennessee—detail on the enforcement mechanisms that are effective in addressing access issues and specific examples of states that impose penalties on plans for unsatisfactory performance against corrective action plans.

2

Proposed regulatory language, proposed preamble language, and/or proposed policy approach
Summary slides on recommended approach
In Progress
Discussion Draft (complete)
CMS Feedback on Draft
Final Draft
Slides

2

Provider Survey/Secret Shopper/Appointment Wait-Time Interviews Takeaways

Takeaways memorandum

In Progress
Initial Takeaways
Interim Takeaways
Final Takeaways

3
Provider Survey/Secret Shopper Program Requirements and Technical Assistance for States
Approach memorandum, including proposed regulatory and preamble language
Summary slides on recommended approach
In Progress

Discussion Draft

Final Draft and Slides

4
Provider Survey/Secret Shopper Technical Assistance Tools
TBD
Not Started

5
CMS Approach to Data-Driven Strategy for Monitoring Access
Approach memorandum, including proposed preamble language and preliminary strategy
Not Started

Discussion Draft

Targeting late Sept. or Early Oct. for Final Draft

Other Policy Areas

6

MLR: Recommendations on MLR Related to SDOH and Health Care Quality Improvement Activities

TBD
In Progress

7
Transparency: Optimizing the Online Experience for Individuals Enrolled in Medicaid Managed Care
Best practices memorandum
Summary slides on best practices
In Progress

Discussion Draft
Final Draft/
Slides

8
Provider Rate Transparency: Compliance, Monitoring/Oversight, and Enforcement (aligned across both FFS and MMC delivery systems—pending further discussion with CMS)

3 From Discussion with CMS: To promote alignment across delivery systems, states will be required to report on base rates benchmarked to Medicare, or the state plan fee schedule (i.e., FFS) when states cannot crosswalk to Medicare (e.g. for children's services, HCBS). States will also need to report separately on the impact of pass-through, supplemental, and directed payments on provider reimbursement. CMS clarified that the requirements will not include a rate floor and shared that, at this time, they are focused on the primary care, OB/GYN, behavioral health, and specialist provider types. CMS is interested in MITRE/Manatt's thinking and research around a compliance, monitoring, and oversight strategy.

3

TBD
Not Started

CMS/Manatt MITRE Meetings
Tuesday, August 16, 12:00 – 1:00 PM ET
Thursday, August 25, 4:00 – 5:00 PM ET
Monday, August 29 – 10:00 – 11:00 AM ET (scheduling in progress)
Month of September– TBD (proposing two meetings)

Manatt

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Manatt

2022-08-10T12:34:00Z

ks
Note to CMS: We did not include PCCM entities here.

Leveraging Provider Surveys to Measure Access:
Proposed CMS Roadmap, Preamble and Regulatory Language
DRAFT August 12, 2022

DRAFT

DRAFT

Introduction
In order to assess Medicaid managed care plans' compliance with network adequacy standards, including forthcoming regulatory wait-time standards, the Centers for Medicare and Medicaid Services (CMS) intends to require states to conduct randomized provider surveys

1 In our previous memorandum, we referred to these surveys as "secret shopper studies". In this memorandum, we will refer to them as "provider surveys" in order to account for the potential for states to conduct both "secret" and

"revealed" surveys. We discuss the role of both of these survey types throughout this memorandum.

1 including "secret shopper" studies, and similar approaches except that the surveyors would reveal their affiliation with the state Medicaid agency. These types of provider surveys have been recognized by CMS and numerous stakeholders as an effective approach for helping to monitor Medicaid managed care plan provider networks, provider directory accuracy, and other elements of access to care.

2 It is notable given its purview that MACPAC did not recommend CMS rely on secret shoppers in its access recommendations. In our follow up conversation with them they attributed that decision more to not having the time to fully run to ground the issues identified; they did not conclude that the process had no value.

Building on the June 23, 2022 memorandum shared with CMS and our Managed Care Access Policy Sprint working session on July 14, 2022, the following: (1) lays out a proposed CMS Roadmap for implementing the provider survey, including secret shopper, requirements; and (2) offers proposed Preamble and regulatory language to inform the development of CMS' Notice of Proposed Rulemaking.

CMS "Roadmap" for Provider Survey/Secret Shopper Requirements
In order to support successful implementation of new provider surveys, including secret shopper studies, as a tool to improve Medicaid managed care access CMS may wish to consider a multi-pronged approach involving: regulatory requirements, sub-regulatory guidance, targeted technical assistance, and milestone reporting. We describe each of these steps in more detail below:

Regulatory Requirements. As described in Manatt's June 23, 2022 memorandum, we recommend that CMS promulgate regulations to establish the requirement for state provider surveys including minimum standards for survey design and implementation. This would allow CMS to establish a durable requirement for states to conduct provider surveys and provide minimum standards and high level expectations to ensure that states' survey approaches are consistent nationally, to the extent feasible, and meet CMS's goals. Proposed regulations should be drafted to provide CMS the flexibility to articulate more detailed provider survey requirements through sub-regulatory guidance, as CMS begins to work with states and other managed care implementation stakeholders to refine its point of view on provider surveys as a tool for access monitoring and oversight. Proposed regulation preamble language should signal to states that CMS recognizes that provider surveys are a significant undertaking, states will have flexibility with designing their provider surveys within federal regulatory and sub-regulatory parameters, that CMS intends to offer targeted policy and operational implementation technical assistance support to states, and that CMS intends to seek comment on an implementation glide path ranging over the course of five years. (See proposed regulatory and Preamble language below.)

Sub-regulatory Guidance. Following the release of minimum requirements in regulation, CMS will have an opportunity to release a more detailed and nuanced set of provider survey requirements through sub-regulatory guidance that may include a State Medicaid Director Letter and Frequently Asked Questions. Establishing more detailed requirements through sub-regulatory guidance would enable CMS to provide states with concrete guidelines about how to meet the new regulatory requirements and provide CMS with flexibility to nimbly modify survey requirements over time as CMS and states gain experience with provider survey development and implementation.

State Technical Assistance. During the glidepath leading up to the date when states are required to submit provider

surveys to CMS, and states are subject to compliance with the wait time requirements, and for several years thereafter as necessary, CMS will provide technical assistance to states, which may include:

Provider Survey Learning Collaborative. CMS could host a series of learning collaborative (LC) meetings on provider survey program design and implementation as a standalone or as part of a broader Managed Care Access LC to facilitate cross-state learnings on methodological and operational best practices and key challenges. CMS could leverage other CMS LC models in structuring this LC which generally include: a review of federal requirements, description of policy and operational options and implementation considerations, direct technical assistance and subject matter expertise through CMS and its contractors, highlights of state best practices (which are best received coming directly from state Medicaid officials), and a cross-state information sharing discussion facilitated by a set of structured discussion questions and an opportunity for states to ask direct questions to the CMS team.

Toolkit. CMS could also provide states with a toolkit that includes releasing tools and technical assistance documents that detail approaches, methodologies and best practices to support states in complying with new survey requirements. The toolkit, informed by state feedback and likely to be iterated upon over the course of the implementation ramp-up period, would include actionable information that states can use to field provider surveys to meet state-specific needs and comply with new federal requirements. Examples of tools may include example study protocol/methodological specifications, call scripts for different surveys (both secret shopper and revealed survey scenarios), provider sampling considerations and approaches to ensure adequate statistical accuracy and geographic and demographic representation, technical guidance on establishing "straw model" Medicaid shopping personas, unique considerations related to secret and revealed surveys, and detailed guidance on statistical approaches for analyzing survey results. The toolkit could also include a template provider survey design "template" that outlines the components of provider survey, including sample size specifications, consistent with CMS guidance, with help text and references to specific TA tools related to each survey component. The toolkit should provide resources that are applicable in diverse state scenarios, allowing them flexibility to tailor their studies to state-specific needs (e.g. frontier states versus smaller geography states that are densely populated).

Milestone Reporting. CMS may also wish to consider requiring states to report on the implementation status of their provider surveys based on milestones to be developed by CMS. CMS can then provide targeted technical assistance to states that appear to be delayed in the development and launch of their provider surveys.

Proposed Provider Survey Preamble Language

While states continue to make progress on strengthening access to care, CMS recognizes that there continues to be significant gaps in access to care for Medicaid beneficiaries, despite previous efforts by states Medicaid agencies and CMS. Evidence suggests that in some localities and for some services, it takes Medicaid beneficiaries longer to access medical appointments compared to individuals with other types of health coverage.

3 W. Hsiang, A. Lukasiewicz, and M. Gentry, "Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis," SAGE Journals, April 5, 2019, available at https://journals.sagepub.com/doi/full/10.1177/0046958019838118.

This may be exacerbated by difficulties in accessing accurate information about health plans' provider networks; while Medicaid managed care plans are required to make regular updates to their online provider directories, analyses of these directories suggest that a significant share of provider listings include inaccurate information on, for example, how to contact the provider, the provider's network participation, and whether the provider is accepting new patients.

4 A. Burman and S. Haeder, "Directory Accuracy and Timely Access in Maryland's Medicaid Managed Care Program," Journal of Health Care for the Poor and Underserved, available at https://pubmed.ncbi.nlm.nih.gov/35574863/; A.Bauman and S.Haeder, "Potemkin Protections: Assessing Provider Directory Accuracy an Timely Access for Four Specialties in California," Journal of Health Politics, Policy and Law, 2022, available at https://pubmed.ncbi.nlm.nih.gov/34847230/.

4
Relatedly, analyses have shown that the vast majority of services delivered to Medicaid beneficiaries are provided by a small subset of health providers listed in their directories, with a substantial share of listed providers delivering little or no care for Medicaid beneficiaries.

5 A. Ludomirsky, et. al., "In Medicaid Managed Care Networks, Care is Highly Concentrated Among a Small Percentage of Physicians," Health Affairs, May 2022, available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747.

5

CMS received several comments to the Access RFI requesting that CMS require more robust efforts by states to monitor against network adequacy and other access requirements, including through the use of direct provider surveys, transparency of the results of the surveys, and better CMS oversight and enforcement when surveys demonstrate that states and their contractors are not meeting access requirements. Many states - as well commercial plans- currently use these types of surveys to monitor access. States currently use a range of different approaches to designing these provider surveys. Some use so-called "secret shopper" approaches, whereby an individual posing as a fictional Medicaid beneficiary attempts to set up an appointment with a Medicaid provider listed as part of a health plan's network. Others rely on "revealed" survey approaches, where the surveyor acknowledges that they are conducting an access survey on behalf of the state Medicaid agency. States also vary in their approach to administering provider surveys. Some require managed care plans to monitor their own provider networks, while others rely on an independent entity (such as an EQRO or other third-party entity), still others do both plan and state driven surveys. These surveys are also varied in terms of scope of providers surveyed, types of services and providers surveyed, and the frequency of the surveys.

CMS agrees with commenters that provider surveys are a valuable tool for states to identify access barriers. Accordingly, CMS proposes to revise 42 CFR § 438.358(b) to require as part of external quality review activities that states conduct provider surveys, including secret shopper studies, on a frequency no less than annually for purposes of monitoring access to care. As described in [TBD SECTION], states must ensure that their health plans meet the state's appointment wait-time standards for each provider/facility type at least 90% of the time.

6 However, states would only be held accountable for meeting the federal minimum appointment wait-time standards.

6
States and their health plans will also be required to ensure that at least 90% of provider directory entries are accurate at all times. These surveys will be an important tool for states to ensure their plans are meeting these standards. Similarly, they will be an important indicator for CMS as it meets its responsibilities to assess compliance with appointment wait-time standards and provider directory accuracy requirements established in this proposed rule. CMS plans to leverage the results of these surveys for oversight and enforcement purposes.

CMS recognizes that provider surveys are a significant undertaking and that states will need sufficient time as well as support from CMS to be successful in implementing these requirements. CMS notes that by including provider surveys a mandatory EQR-related activity, states will have the opportunity to access the 75% federal matching rate for these activities as long as they are conducted by a CMS-approved EQRO. States will still have the option to use an organization other than an EQRO, provided that entity is independent and has no ties to a managed care plan, to conduct these studies, as permitted under 42 CFR § 438.358(a)(1). However, states that do not rely on an EQRO would only be

able to access the 50% administrative matching rate, as required by 42 CFR § 438.370, for associated expenditures.

CMS also intends to provide comprehensive support to states as they launch new surveys and seeks comment on the types of technical assistance that would be most valuable to states. Technical assistance activities that CMS is considering include:
A State Medicaid Director Letter with additional guidance for designing and implementing provider surveys, including secret shopper studies.
A dedicated learning collaborative through which CMS will convening with states and subject matter experts to share best practices on provider surveys and access monitoring.
A toolkit to provide states with detailed methodological guidance on administering and analyzing results from provider surveys potentially including secret shopper and revealed survey scenarios, provider sampling considerations and approaches to ensure adequate statistical accuracy and geographic and demographic representation, technical guidance on establishing "straw model" Medicaid shopping personas, timing and frequency of the surveys, unique considerations related to secret and revealed surveys, and detailed guidance on statistical approaches for analyzing survey results.
A provider survey design tool that can be customized by the state and that outlines the minimum components of a provider survey, consistent with CMS guidance, with fillable text fields, help text and references to specific technical assistance tools related to each survey component.

In general, states will have the option to adopt best practices outlined in the toolkit, deploy the specifications set out in the model survey, or develop their own approaches provided they are consistent with regulatory and sub-regulatory requirements issued by CMS. CMS seeks comment on the types of tools that will be most helpful to states, the frequency in which provider surveys should be collected, and requirements for conducting both "secret" and "revealed" surveys. CMS also seeks comment on the proposed rule's requirements to assess for accuracy of provider directories and disparities in access to care as well as the proposed methodological standards.
To accommodate states' need for time to adopt, test and implement the surveys, CMS proposes to provide states with a multiyear "glide path" to ramp up new surveys and comply with new access requirements. CMS seeks comment on an appropriate timeline, and whether more or less time is needed, for rolling out provider survey requirements and has proposed the following approach for consideration.
Beginning one year after the effective date of the rule: States will be expected to procure vendors and conduct other preparations necessary to begin administering the provider surveys. CMS would provide robust technical assistance for all states related to provider surveys and the new access requirements.
Beginning two years after the effective date of the rule: States will be expected to conduct a one year "beta test," wherein states would administer test surveys and report data to CMS; during the beta test year, states would not face enforcement actions from CMS based on survey results. CMS would continue to provide robust technical assistance to all states.
Beginning three years after the effective date of the rule: CMS would begin holding states accountable for achieving at least 80% or 85% [TBD] compliance with the federal minimum appointment wait-time and provider directory accuracy standards based on survey results. CMS would provide targeted technical assistance for states that are out of compliance with access requirements.
Beginning four years after the effective date of the rule and thereafter: CMS would hold states accountable, through the use of corrective action plans and other enforcement mechanisms, for achieving at least 90% compliance with the federal minimum appointment wait-time and provider directory accuracy standards based on survey results. CMS would continue to provide targeted technical assistance to support on-going implementation efforts for non-compliant states.

Illustrative, High-Level Glidepath

One Year After the Rule
Two Years After the Rule
Three Years After the Rule
Four Years After the Rule

States prepare to implement provider surveys
Robust CMS TA for all states

Beta test period for provider surveys
Robust CMS TA for all states
States held accountable for 80% or 85% compliance with access requirements
Targeted TA for non-compliant states
States held accountable for 90% compliance with access requirements
Targeted TA for non-compliant states

Proposed Regulatory Language
42 CFR § 438.358(b) Mandatory Activities.
(1) For each MCO, PIHP, or PAHP the following EQR-related activities must be performed:

* * *

(v) Randomized provider surveys:

(a) At minimum, states must conduct provider surveys across contracted MCOs, PIHPs, and PAHPs to assess the compliance with areas of access in paragraph (b) of this section at least annually.
(b) Provider surveys must, at minimum, assess the following:
(1) Compliance with federal and state appointment wait-time standards established in accordance with [regulatory citation], for each applicable provider/facility type, including:
(i) Primary care (routine), adult and pediatric.
(ii) OB/GYN (routine).
(iii) Outpatient behavioral health (mental health and SUD) (routine), adult and pediatric.
(iv) Specialist (targeting identified gaps in access as determined by the State in an evidence-based manner), adult and pediatric.
(v) Other provider/facility types as defined by CMS.
(2) Accuracy of provider directories.
(3) Disparities in access to care (including, but not limited to, appointment wait-times and whether or not providers are accepting new patients) for Medicaid/CHIP members generally (as compared to commercially covered patients), members residing in rural, urban and frontier geographies, members with disabilities, members for whom English is a second language, members from other marginalized groups (e.g., racial/ethnic groups and American Indian/Alaska Natives), and other focused inquiries as CMS requires .

7 CMS would need to work to develop an approach that states could use to measure disparities in access for different marginalized groups. For example, one state assessed through a previous secret shopper study differences in appointment wait-times between callers with “multicultural” names compared to those with non-multicultural names and found significant differences. CMS would need to provide states with clear guidance on how to use these types of approaches to assess disparities through secret shopper studies.

7

(c) States must ensure that provider surveys adhere to the following methodological standards:
(1) Uses statistically valid sample sizes across provider/facility type.
(2) Selects providers to be surveyed on a randomized basis.
(3) Examines all regions of the state, including all major urban areas, rural, and frontier regions.
(4) Uses a standardized approach for testing key measures of access, such as predetermined call scripts for surveyors.
(5) Utilizes a combination of both “secret shopper” or masked and revealed survey approaches, consistent with federal guidance.
(i) Masked approaches are surveys where the caller poses as a Medicaid beneficiary.
(ii) Revealed approaches are surveys where the caller volunteers that they are calling on behalf of the state Medicaid

agency for the purposes of monitoring an MCO, PIHP, or PAHP provider network.
(d) States must submit results of provider surveys to CMS and make them publicly available. As part of public reporting and disclosure, states must make available through an annual report data on service utilization across a range of enrollee characteristics, including by race and ethnicity, eligibility category, age, geography, disability status, and other factors, as determined appropriate by the state.
(e) States must comply with applicable sub-regulatory guidance promulgated by CMS in relation to provider surveys described in this section.

42 CFR §?438.68 Network Adequacy Standards.
(a) Beginning one year after the effective date of the rules finalized at [regulatory citation], a State must have procured a vendor and conducted other preparations necessary to begin administering the provider surveys.
(b) Beginning two years after the effective date of the rules finalized at [regulatory citation], a State must conduct a one year of testing wherein the State administers test surveys and reports data to CMS.
(c) Beginning three years after the effective date of the rules finalized at [regulatory citation], a State would be subject to compliance reviews and enforcement at CMS' discretion if it has not achieved at least eighty percent (80%) or eighty-five percent (85%) [TBD – for discussion with CMS] compliance with the federal minimum appointment wait-time standards for each provider/facility type and the provider directory accuracy standards, based on survey results.
(d) Beginning four years after the effective date of the rules finalized at [regulatory citation] and thereafter, a State would be subject to compliance reviews and enforcement at CMS' discretion if it has not achieved ninety percent (90%) compliance with the federal minimum appointment wait-time standards for each provider/facility type and the provider directory accuracy standards, based on survey results.

Tier 1 Provisions in the Managed Care Access, Finance and Quality Rule – Preliminary Analysis of Comments & Recommendations

NOTE: 419 comments were received on the Managed Care Access, Finance and Quality NPRM. Processing of the comments is ongoing. The issues and recommendations described below are preliminary Tier 1 provisions based on the comments that have been reviewed to-date. Potential Tier 2 items to discuss in August are outlined at the bottom of this document.

Provision Title
Proposed Provisions/Preamble Discussion
Comments in Support
Comments Opposing
Recommendation(s)

Access

Appointment Wait Time Standards (§§ 438.68(e), 457.1218)

States must establish and enforce appointment wait time standards for routine appointments for:
(i) Outpatient mental health and substance use disorder, adult and pediatric, within State-established time frames but no longer than 10 business days from the date of request.
(ii) Primary care, adult and pediatric, within State-established time frames but no longer than 15 business days from the date of request.
(iii) Obstetrics and gynecological within State-established time frames but no longer than 15 business days from the date of request.
(iv) State-selected chosen in an evidence-based manner within State-established time frames.
Most comments from advocates and some provider associations supported this provision. Provider comments consistently also noted a need for improved reimbursement and a contractual provision that ensures they are held harmless when standards are not met.

Most States, NAMD, managed care plans, and some providers expressed concern about the time frames (10- and 15-business days) being unrealistic and untested.

Strongest and most prevalent concerns were related to meeting the standards given the national shortage of behavioral health providers as well as shortages in rural areas and health professional shortage areas (HPSAs).

Additional comments included recommendations to:
Align with Medicare Advantage (30-business days) or to use 30- and 45-day maximums.
Delay compliance date or phase in the appointment standards over time, starting with fewer provider types or by gradually adjusting wait time maximums or compliance rate.
Define “routine” appointment.
Permit all telehealth appointments to count toward compliance.
Measure appointment wait times for new patients separately from existing patients.
We recommend finalizing the 10- and 15-business days to maintain alignment with the Marketplace. See attached 3M Chart regarding appointment wait time policies across Medicaid and CHIP managed care, Medicare Advantage, and the

Marketplace.
We also recommend clarifying in this final rule that States can define "routine" for the purpose of setting appointment wait time standards.

If we consider longer time frames given the public comments, we recommend 30 business days to align with Medicare Advantage. This approach would not align with CCIIO's current approach in the Marketplace.

Appointment Wait Time Standards Compliance
(§§ 438.68(e)(2), 457.1218)
Minimum compliance.
Managed care plans will be deemed compliant with appointment wait time standards when secret shopper results reflect a rate of appointment availability of at least 90 percent.
Most comments from advocates and some provider associations supported this provision. Provider comments consistently also noted a need for improved reimbursement and a contractual provision that ensures they are held harmless when standards are not met.
Most States, NAMD, and managed care plans, and some providers expressed concern that a 90% compliance rate, given the proposed appointment wait time maximums, was not immediately attainable.

Additional comments included recommendations to:
Start with 50-75% and gradually increase to 90%.
Allow all telehealth appointments to count toward compliance or use Medicare Advantage's 10% credit methodology for time/distance standards.
Conduct pilot of wait time compliance to gather data to inform selection of a reasonable compliance standard.
We recommend finalizing a minimum compliance rate of 90% (consistent with the Marketplace) and that only telehealth appointments by providers that also provide in-person appointments count toward compliance (also consistent with the Marketplace).

We would also recommend finalizing an applicability date of 5 years after the effective date rather than the proposed 4 years. This would provide more time for States to ramp-up to the 90% compliance standard.

State Directed Payments (SDPs)
Note: For SDP preprints approved through September 2022, there are 109 SDPs across 34 states that have SDPs that are projected to result in a total reimbursement rate above Medicare (or up to an average commercial rate (ACR)). State's projections of total spending on these proposals equals $39.9 billion for the most recent rating period. There is significant overlap between SDPs that increase total provider rates up to the ACR and the use of provider taxes and intergovernmental transfers, reconciliation processes and separate payment terms. Therefore, our Tier 1 SDP proposals below are focused on addressing these intersecting challenges. For example, for SDP preprint approvals through September 2022, the majority of SDPs (approximately 64%) that result in total payment rates above Medicare are paid through separate payment terms. Most of these are financed through provider taxes and IGTs. The separate payment term, in at least some of these instances, provides certainty to those entities providing the non-federal share so that they know approximately how much they will receive through the payment arrangement. While we don't have data that identifies the number of SDPs that use a post-payment reconciliation process, our experience with SDPs indicates there is significant overlap.

Provision Title
Proposed Provisions/Preamble Discussion
Comments in Support
Comments Opposing
Recommendation(s)

SDP Provider Payment Limit (§?438.6(c)(2)(iii))
At §?438.6(c)(2)(iii)), we proposed to establish a provider payment limit at ACR for SDPs that require prior approval for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioners at an

academic medical center. We acknowledged that this was precedent setting and not in alignment with the upper payment limits (UPL) in Medicaid fee-for-service (FFS) which utilizes Medicare as a standard. However, this ACR proposal was in alignment with our historical internal benchmark since 2018 and with current practice for FFS supplemental payments for the professional services at academic medical centers. We also solicited feedback on several alternative benchmarks for a payment limit for these four service types or for all service types. These alternatives included: (1) 100 percent of the Medicare rate; (2) a level between Medicare and the ACR; (3) a Medicare equivalent of the ACR; and (4) at the Medicare rate for fee schedules and uniform increases, and at the ACR for value-based payment (VBP) arrangements for these four service types. We proposed a 2-year effective date for this provision.
The American Hospital Association (AHA) supported the ACR limit and opposed all alternative benchmarks.

NAMD indicated that "states and territories are comfortable" with the ACR limit which they believe is preferrable to Medicare.

Some States (e.g., AZ, CA, KY, MI, NH, SC, TN) supported establishing the payment ceiling at ACR for these four service types. PA supported ACR as the payment limit for inpatient hospital services, outpatient hospital services, and qualified practitioners at an academic medical center.

FL supported establishing the total payment rate limit at ACR, but for all services, not just the four we proposed.

CBPP and Georgetown University Health Policy Institute opposed the ACR limit. Both raised concerns about a higher reimbursement level in managed care versus FFS, and how that may disincentive States from models besides managed care citing Kentucky as an example.

CBPP supported a Medicare limit. Georgetown generally supported a Medicare limit, and commented that Medicare rates enabled adequate access, were easily ascertained and more transparent. Georgetown further noted that "allowing SDPs to rise to ACR levels is not an efficient solution; it leads to a windfall for a few providers, but most providers do not benefit from the policy."

MACPAC did not take a position on a limit but noted that without a limit there is a risk that Federal spending will continue to increase substantially. MACPAC noted that Medicare is publicly available and consistent for all providers while ACR is not readily available and can vary widely.

NC's state treasurer opposed ACR and supported to "return" to Medicare. The treasurer noted concerns that increasing payment rates will lead to further hospital consolidation and increased prices in commercial markets.

NAMD, some States (e.g., DE, PA) and the American Academy of Actuaries (AAA) opposed an ACR limit for nursing facility services.

AZ and PA opposed Medicare as the limit for nursing facility services since Medicare adopted the Patient-Driven Payment Model reimbursement methodology, as CMS acknowledged in SMD 22-005 [hyperlink added]. MACPAC also expressed similar concerns.

MA opposed an ACR limit on qualified practitioner services at an academic medical center.

TX opposed a limit and noted "this inequitable treatment of hospital services, nursing facility services, or services provided by a qualified practitioner at an academic medical center does not have a basis in statute nor is it in the best interest of Medicaid clients."
We recommend finalizing the SDP payment limit for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioners at an academic medical center at: (1) 100 percent of Medicare for fee schedules and uniform increases; and (2) 100 percent of average commercial rate for VBPs. We believe this option would better align managed care SDP fee schedules and uniform increases with Medicaid FFS UPLs, incentivize States to pursue value-based care and quality-based payment models and ensure more accountability in payment while not taking money out of the system which could raise access to care or health equity concerns from stakeholders. We recognize this would be a shift for many States, and we recommend considering a 3-year glidepath rather than the

proposed 2 years.

We could consider setting the payment limit for SDPs at 100 percent of Medicare. This is a standardized benchmark used in the industry and is often a standard utilized in Medicaid FFS under UPL demonstrations in 42 CFR part 447. This is a standard that FMG, OACT and OMB support. Setting such a limit under the final rule would remove SDP spending from the system and may negatively impact access to care. States would need a transition period to move from ACR to Medicare.

Alternatively, we could consider finalizing the rule as proposed and finalize with a payment limit of 100 percent of the average commercial rate. This approach may align with our historical operational practices since 2018 but may significantly increase Federal spending on SDPs. See the attached paper on the fiscal impact of SDP spending.

Note: We strongly recommend that a provider payment limit for SDPs be finalized as no limit would allow SDP funding to grow unfettered and continue to raise significant concerns by oversight bodies including GAO, OIG, MACPAC as well as the CMS Office of the Actuary.

Additionally, we consulted with OGC on our ability to "grandfather" existing ACR proposals that are already approved by CMS, and OGC advised that CMS did not specifically explore the idea of "grandfathering" in the proposed rule, and therefore, we lack logical outgrowth. Additionally, OGC strongly advised against such an approach, as it would likely be challenged as arbitrary.

SDP Fiscal Integrity Provisions

Post payment reconciliation (§ 438.6(c)(2)(vii)(B))

Separate payment terms (SPTs)

1 Separate payment terms are payments made to a managed care plan in addition to the capitation rates to account for any portion of the cost of complying with the SDP not already accounted for in the actuarially sound capitation rates.

(§§ 438.6(c)(6), and 438.7(f))

Federal legal requirements for the financing of the non-Federal share ((§?438.6(c)(2)(ii)(G))

Provider attestations that they do not participate in a hold harmless arrangement ((§?438.6(c)(2)(ii)(H))

There are other fiscal integrity provisions that will be discussed in Tier 2 discussions.
At § 438.6(c)(2)(vii)(B), for SDPs that are fee schedules or uniform increases, we proposed to prohibit States' practices of conditioning payment from the managed care plan to the provider on utilization and delivery of services outside of the rating period and then requiring that payments be reconciled to utilization during the rating period. We have significant concerns with this practice as we believe it suggests an intent by States to ensure payment of a specific aggregate amount to certain providers or, in some cases, removal of all risk related to these SDPs from managed care plans.

At §§ 438.6(c)(6), and 438.7(f)), we proposed guardrails on States' use of separate payment terms for SDPs. Proposed guardrails included review and approval of these in the preprint, and associated documentation requirements in the managed care plan contracts and rate certifications. We also solicited feedback on the prohibition of separate payment terms as we have concerns that the use separate payment terms are contrary to the risk-based nature of Medicaid managed care. The use of separate payment terms can also result in perverse incentives for plans that can result in shifting utilization to providers in ways that are not consistent with Medicaid program goals.

At §?438.6(c)(2)(ii)(G), we proposed to require compliance with all Federal legal requirements for the financing of the non-Federal share.

At §?438.6(c)(2)(ii)(H), we proposed to require States to ensure that providers attest that they do not participate in a hold harmless arrangement, as defined by statute and regulation. Note that in early July, a federal court granted a motion (Texas v. CMS 23-cv-161) sought by Texas enjoining CMS from enforcing a related CIB. CMCS is working with OGC/DOJ to determine the scope of the injunction and next steps.

Proposed effective dates for these four provisions varied. For (1), (2) and (4), we proposed a 3-year effective date for this provision. For (3), we proposed this be effective the first rating period following the effective date of the Final

Rule.
CBPP supported a prohibition as post payment reconciliation does not benefit Medicaid beneficiaries, undermines the actuarial soundness of capitation rates, and absolves plans of risk.

CA supported a prohibition on post payment reconciliation outside the rating period and noted that "this narrower form of post payment reconciliation is aligned with the requirement to ensure payments are based on the utilization and delivery of services for the rating period and is consistent with CMS' aims of ensuring MCOs retain and are able to manage risk under the contract."

NAMD supported continued use of separate payment terms.

CA, SC and TN opposed any prohibition of separate payment terms. CA recommended that if any prohibition on separate payment terms was finalized that there should be a 3-year effective date.

Georgetown Health Policy Institute and CBPP supported program integrity guardrails as to how States finance their SDPs and the hold harmless attestation requirements. CBPP noted that SDPs "…should be tied to the services received by enrollees and be at a rate that is adequate but not excessive. When payments are redirected to providers to compensate them for the tax they paid, these payments are not benefiting Medicaid enrollees. Such payments also suggest that the payment rates may be higher than what is needed to assure adequate access and quality or, in the alternative, that they are being redirected in a way that undermines access and quality." However, CBPP commented that the compliance date for the provider attestation should be shorter.

Centene supported provider attestations and noted CMS should be clear this a state obligation and not a plan obligation.

NAMD noted that interim payments used in post payment reconciliation can be important to mitigate cash flow challenges that safety-net providers face, given their thin operating margins. NAMD noted that at a minimum CMS should permit interim payments based on current contract period utilization and reconcile to actual utilization as the contract year progresses.

AHA opposed a prohibition and acknowledged that interim payments used in post payment reconciliations are "meaningful" for providers that contributed to financing the non-Federal share.

2 "Interim payments are an important tool states adopt to help mitigate cash flow challenges that Medicaid providers may experience by permitting SDP payments to be made on an interim basis throughout the year. This may be especially meaningful for providers that contributed to financing the non-federal share of the SDP up front [emphasis added] …. We recognize that CMS' proposals regarding how states incorporate SDPs into managed care rate

certifications through separate payment terms allows states continued flexibility in structuring payments but believe interim payments and reconciliation are important tools available to states to ease provider cash flow burdens while also tying fixed funding sources to actual utilization."

2

Some States (e.g., AZ, IL, KY, LA, MI, MO, NH, SC, TN, VT) and MHPA opposed a prohibition on post payment reconciliation. DE recommended that any prohibition focuses on larger payments or certain provider types.

Georgetown Health Policy Institute commented that SDPs are best implemented through adjustments to base capitation rates, and if CMS does not eliminate the use of separate payment terms, CMS should reduce their use.

AHA opposed restrictions on state sources of financing.

NAMD raised concerns regarding CMS' "expansive policy position" on state obligations to identify indirect hold harmless arrangements which they noted fail to recognize the limits to a State Medicaid agency's authority. NAMD recommended CMS oversight on providers.

Some States (e.g., AZ, CA, FL, TX) opposed obtaining attestations. TX commented that "requiring attestations from providers is improper and not consistent with the statutory definition of "hold harmless.""

A few other States (IL, LA, MI, MO, TN, VT) joined together to submit joint comments and indicated that CMS's proposal is not consistent with the statute and should not be finalized and commented that "While many of the Commenting States are not aware of any such situations in their own States, the Commenting States are concerned about the burden of inserting themselves into private relationships between providers to secure the required attestations. The statutory provisions defining a "hold harmless" are all properly directed only to government (state or local) action, not to agreements between private parties over which the State has no knowledge or control…"
We recommend finalizing the following SDP fiscal integrity provisions: (1) prohibit post payment reconciliation for fee schedules and uniform increases; (2) prohibit the use of separate payment terms for all SDPs; and (3) require compliance with all Federal legal requirements for the financing of the non-Federal share. We believe finalizing these three provisions will implement appropriate fiscal guardrails in SDPs and curtail some concerning practices that we believe link payment to state financing practices that may be concerning or problematic. OACT supports this recommendation. CMS continues to engage with legal counsel on our options related to proposal (4) to require States to ensure that providers attest that they do not participate in a hold harmless arrangement given an injunction in Texas v. CMS 23-cv-161. Critically, we are awaiting the court's reply to a DOJ request to clarify whether the injunction is national. CMS also continues to review comments for other fiscal integrity provisions and assess recommendations for

associated changes to applicability dates (see Tier 2 at the bottom of this document). We recommend finalizing a 3-year glidepath on these provisions (e.g., a 3-year transition for existing separate payment terms/post reconciliation practices, and a prohibition on new ones effective immediately), except for the general compliance with all Federal legal requirements for the financing of the non-Federal share, which we recommend finalizing the effective date as proposed.

Alternatively, we could consider finalizing some but not all of these fiscal integrity provisions. While we understand that the prohibition on the use of separate payment terms may be difficult for some states, we strongly recommend this approach given the strong link between the use of separate payment terms and the use of provider taxes and intergovernmental transfers.

Preliminary list of Tier 2 issues for future discussion in August:
Access Remedy Plans
Payment Transparency
State Directed Payments
Global Budgets – Performance-Based Payments and Condition-Based Payments
Reimbursement Analyses
Evaluations
Submission Timelines for SDP Preprints
Submission Timelines for SDP Documentation in Managed Care Plan Contracts/Rate Certifications
Applicability Dates

Meeting Title:
CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations

From:
CMS CMCS_Unwinding <CMCSUnwinding@cms.hhs.gov>

Sent:
2/16/2023 5:08:34 PM +0000

To:
'jca25@georgetown.edu'; 'lrodriguez@americanprogress.org'; 'aimee.ossman@childrenshospitals.org'; 'akg72@georgetown.edu'; 'Allison Orris' <aorris@cbpp.org>; "Arguello, Andres (OS/IOS)" <Andres.Arguello@hhs.gov>; "Banton, Kia (CMS/CMCS)" <Kia.Banton@cms.hhs.gov>; 'Barbara Eyman' <beyman@eymanlaw.com>; "Bentley (she/her), Katherine (CMS/CCIIO)" <Katherine.Bentley2@cms.hhs.gov>; 'bfeldpush@essentialhospitals.org'; "Black, Nicole (CMS/OC)" <Nicole.Black@cms.hhs.gov>; "Blanar, Jonathan (CMS/OC)" <Jonathan.Blanar@cms.hhs.gov>; "Bonelli, Anna (CMS/CMCS)" <Anna.Bonelli@cms.hhs.gov>; 'brucel@firstfocus.org'; 'cdobson@ADvancingstates.org'; "Clark, Liz (CMS/CMCS)" <Elizabeth.Clark@cms.hhs.gov>; "Costello, Anne Marie (CMS/CMCS)" <AnneMarie.Costello@cms.hhs.gov>; "Costello, Stefanie (CMS/OC)" <Stefanie.Costello@cms.hhs.gov>; 'creusch@communitycatalyst.org'; 'crogers@communitycatalyst.org'; "Cross-Call, Jesse (OS/IEA)" <Jesse.Cross-call@hhs.gov>; 'davanzo@nilc.org'; "Delone, Sarah (CMS/CMCS)" <Sarah.Delone2@CMS.hhs.gov>; "Dolly, Ed (CMS/CMCS)" <Edward.Dolly@cms.hhs.gov>; 'DWalter@aap.org'; 'EFishman@familiesusa.org'; 'ekong@apiahf.org'; 'emanuel@healthlaw.org'; 'Erica Cischke' <ecischke@aafp.org>; 'Erin O'Malley' <eomalley@essentialhospitals.org>; 'erodriguez@unidosus.org'; 'ferzouki@cbpp.org'; "Fowler, Joanna (CMS/CCIIO)" <Joanna.Fowler@cms.hhs.gov>; "Franklin, Julie (CMS/OC)" <Julie.Franklin@cms.hhs.gov>; "Gibson, Alexis (CMS/CMCS)" <alexis.gibson@cms.hhs.gov>; "'Glier, Stephanie'" <sglier@aap.org>; "Grant, Jeff (CMS/CCIIO)" <jeffrey.grant1@cms.hhs.gov>; "Gutzmer, Hailey (CMS/OC)" <Hailey.Gutzmer@cms.hhs.gov>; "Hammarlund, John (CMS/OPOLE)" <john.hammarlund@cms.hhs.gov>; "Harris, Monica (CMS/CMCS)" <Monica.Harris@cms.hhs.gov>; "Hennessy, Amy (CMS/OC)" <Amy.Hennessy@cms.hhs.gov>; 'hoshelton@naacpnet.org'; 'JDBaker@mathematica-mpr.com'; 'Jennifer Tolbert' <JenniferT@kff.org>; 'JKozminski@essentialhospitals.org'; 'Judy Solomon (solomon@cbpp.org)'; "Katch (she/her), Hannah (CMS/OA)" <Hannah.Katch@cms.hhs.gov>; 'Katie@Out2Enroll.org'; "Koepke, Christopher (CMS/OC)" <Christopher.Koepke@cms.hhs.gov>; 'Lessard@nilc.org'; "Lipscomb (she/her), Darla (CMS/CCIIO)" <darla.lipscomb@cms.hhs.gov>; 'Lisa Satterfield' <lsatterfield@acog.org>; "Liu, Beth (CMS/CCIIO)" <BETH.LIU1@cms.hhs.gov>; "Lorsbach (she/her), Anna (CMS/CCIIO)" <anna.lorsbach@cms.hhs.gov>; "Lovejoy, Shannon (CMS/CMCS)" <Shannon.Lovejoy@cms.hhs.gov>; 'Lyndsey Cavender' <LCavender@mathematica-mpr.com>; "Mccloy, Tamara (CMS/OPOLE)" <Tamara.Mccloy@cms.hhs.gov>; 'mcheek@ahca.org'; 'minnocent@naacpnet.org'; 'mmiller@communitycatalyst.org'; "Montz, Ellen (CMS/CCIIO)" <Ellen.Montz@cms.hhs.gov>; 'msnider@unidosus.org'; 'Naomi Ali' <NAli@mathematica-mpr.com>; "O'Connor, Sarah (CMS/CMCS)" <Sarah.OConnor@cms.hhs.gov>; 'rb1686@georgetown.edu'; 'rcarreon@unidosus.org'; "Reilly, Megan (CMS/OC)" <Megan.Reilly@cms.hhs.gov>; 'robinr@kff.org'; "'Ross, Christy'" <cross@naacpnet.org>; 'rtetlow@acog.org'; 'sarah.nolan@seiu.org'; "Seng, Suzette (CMS/CMCS)" <Suzette.Seng@cms.hhs.gov>; "Setala, Ashley (CMS/CMCS)" <Ashley.Setala@cms.hhs.gov>; 'sfeliz@nul.org'; 'shughes@aha.org'; 'squinn@aafp.org'; 'Stan Dorn' <sdorn@unidosus.org>; "Stephens, Jessica (CMS/CMCS)" <Jessica.Stephens@cms.hhs.gov>; 'Taylor Platt' <tplatt@acog.org>; "'tharo (aap.org'" <tharo@aap.org>; "Thomas, Pam (CMS/OPOLE)" <Pam.Thomas@cms.hhs.gov>; 'Tiara Halstead' <THalstead@mathematica-mpr.com>; "Toomey, Mary (CMS/OC)" <Mimi.Toomey@cms.hhs.gov>; "Trevino, Ethan (CMS/CCIIO)" <Ethan.Trevino1@cms.hhs.gov>; 'Tricia Brooks' <pab62@georgetown.edu>; "Tsai, Daniel (CMS/CMCS)" <Daniel.Tsai@cms.hhs.gov>; 'UnwindingSupport@mathematica-mpr.com'; "Wagstaffe, Leslie (CMS/CCIIO)" <leslie.wagstaffe@cms.hhs.gov>; "Walen, Alyssa (CMS/OC)" <Alyssa.Walen@cms.hhs.gov>; "'Wallace, Nick'" <nwallace@aap.org>; "Weiss, Alice (CMS/CMCS)" <Alice.Weiss@cms.hhs.gov>; "Wood (he/him), Elijah (CMS/CCIIO)" <Elijah.Wood@cms.hhs.gov>; 'youdelman@healthlaw.org'; "Bellsdale (she/her), Amber (CMS/CCIIO)" <Amber.Bellsdale@cms.hhs.gov>; "'Bennett, Andrea D'" <BennettA10@cvshealth.com>; 'Cherie Compartore' <CCompartore@lacare.org>; 'CKennedy@mhpa.org'; 'elizabeth.hall@elevancehealth.com'; "Gentile, Amy (CMS/CMCS)" <Amy.Gentile@cms.hhs.gov>; "Giles, John

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Location:
https://cms.zoomgov.com/j/1618164200?pwd=ZDJMUnAwZE9la0FUR1pzb01rZDNwZz09

Start Time:
2/16/2023 6:00:00 PM +0000

End Time:
2/16/2023 7:00:00 PM +0000

Duration:
1 hours

Reminder Time:
2/16/2023 6:00:00 PM +0000

Is Recurring:
false

Recurrence Type:
3

Recurrence Pattern:
the third Thursday of every 1 month(s) from 1:00 PM to 2:00 PM

Response Status:
5

Busy Status:
Tentative

Attachments:
20230216_Stakeholder Workgroup Agenda_FINAL.docx

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CMS Unwinding Stakeholder Workgroup Agenda
February 16, 2023| 3:00 - 4:00 PM ET

Welcome and Opening Remarks

Overview of Recent Highlights & CMS Releases
State Health Official Letter #23-002 on the Consolidated Appropriations Act
Slide deck
Telephone Consumer Protection Act (TCPA) Updates
FCC Declaratory Ruling, Jan. 23, 2023
FCC Presentation from Jan. 24, 2023, CMCS All-State Call
Updated Communications Toolkit –
Tip Sheet for CMS Partners to help someone who lost Medicaid or CHIP coverage (Page 15)

State and Partner Engagement Updates
Kitchen Cabinet Meetings

Marketplace Updates and Unwinding Special Enrollment Period (SEP) FAQ

Open Q&A and Discussion (20 min)

Closing (3 min)
Unwinding National Partner/Stakeholder Webinar: Wednesday, February 22 (12-1pm ET)
Registration Link: here
Next Meeting: March 16, 2023 (1-2pm ET)

Appointment Title:
CMS/DHCS CalAIM Waiver Biweekly Check-in

Organizer:
CalAIM Master Calendar

Attendees:

Location:
https://manatt.zoom.us/j/92765438501?pwd=clFnblNTUTNtMFpIYTVWREhSZHpYZz09

Start Time:
3/15/2023 7:00:00 PM +0000

End Time:
3/15/2023 8:00:00 PM +0000

Reminder Time:
8/16/2023 6:45:00 PM +0000

Reminder Set:
true

Duration:
1 hours

Is Recurring:
true

Reccurrance Type:
Weekly

Reccurrance Pattern:
Occurs on Wednesday every other week from 3:00 PM to 4:00 PM effective 3/15/2023.

Response Status:
2

Busy Status:
Tentative

Attachments:
Untitled; Untitled; Untitled; Untitled

-----Original Appointment-----
From: CalAIM Master Calendar <CalAIM_Master_Calendar@manatt.com>
Sent: Wednesday, March 1, 2023 10:14 AM
To: CalAIM Master Calendar; Ross, Heather (CMS/CMCS); Young, Cheryl (CMS/CMCS); Friedman, Kate (CMS/CMCS); Moulton, Shane (CMS/CMCS); Kazi, Paula (CMS/CMCS); Simonson, Claudia (CMS/CMCS); Nelson, Frederick (CMS/CMCS); Wang, Yixi (CMS/CMCS); Burdullis, Brian (CMS/CMCS); Delvecchio, Lynn (CMS/CMCS);

Kato, Kitaho (CMS/CMCS); Duan, Lewei (CMS/CMCS); Casart, Andrea (CMS/CMCS); Nawara, Lorraine (CMS/CMCS); 'Jacey.Cooper@dhcs.ca.gov'; Toyama, Aaron; 'Benjamin.McGowan@dhcs.ca.gov'; Harrington, Lindy; Phillip, Susan; Cisneros, Bambi; Retke, Michelle; Fitzgerald, Brian; Lam, Jacob; 'Rafael.Davtian@dhcs.ca.gov'; Babaria, Palav; Mark, Karen; Sadwith, Tyler@DHCS; Hansen, Brian; Boylan, Autumn; Cristo, Erika; Wilhelm, Paula@DHCS; Mollow, Rene; Huang, Yingjia; Armendariz, Sydney@DHCS; Boozang, Patti; Mann, Cindy; Lam, Alice; Reyneri, Dori Glanz; Punukollu, Nina; Kim, Lora
Cc: Wallis, Kier; Guyer, Jocelyn; Barnard, Zoe; Rogari, Gina; Serafi, Kinda; Morgan, Gini
Subject: CMS/DHCS CalAIM Waiver Biweekly Check-in
When: Occurs every 2 week(s) on Wednesday effective 03/15/2023 from 3:00 PM to 4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://manatt.zoom.us/j/92765438501?pwd=clFnblNTUTNtMFpIYTVWREhSZHpYZz09

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Attachments:
California Responses to CMS Questions on Managed Care Amendment_CMS follow up.docx

CMS/DHCS CalAIM Waiver Biweekly Check-in
Wednesday, April 26th from 12:00 * 1:00 PM PT // 3:00 * 4:00 PM ET

- Discuss California*s MCP Model Change amendment
- Share timeline update on Reentry Demonstration Initiative STC Technical Corrections (including Attachments N and O)
- Update on conversations and STC changes around provider enrollment requirements for the Reentry Demonstration Initiative

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92765438501@zoomcrc.com

Passcode:

(b)(6)

Kate Friedman

2023-04-19T10:02:00Z

KF
DHCS: Please confirm these counties will have one plan.

Kate Friedman

2023-04-19T10:02:00Z

KF
DHCS: Please confirm these counties will have two plans.

Kate Friedman

2023-04-19T10:03:00Z

KF
DHCS: What will be the increase in members for each remaining plan?

Kate Friedman

2023-04-19T10:48:00Z

KF
DHCS: Please provide details on these expectations, and the result of not meeting those expectations.

Kate Friedman

2023-04-19T10:47:00Z

KF
DHCS: Will all reports be in one location?

Kate Friedman

2023-04-19T10:48:00Z

KF
DHCS: Please provide what measurements MCPs are to exceed, the timing of these expectations, and the recourse if they do not meet expectations.

Kate Friedman

2023-04-19T10:48:00Z

KF
DHCS: What is the timing of these reports and their review?

DHCS

2023-03-20T21:49:00Z

DHCS
Note: New question shared by CMS on March 20.

CMS: DHCS is working on this response and will follow-up as soon as possible.

Kate Friedman

2023-04-19T10:53:00Z

KF
Copy/pasted responses into this document.

Kate Friedman

2023-04-19T12:26:00Z

KF
DHCS: Please see two additional question we have.

DHCS Responses to Questions on California's CalAIM Managed Care Model Amendments Shared by CMS on March 13, 2023
Updated March 20, 2023

Can the state provide a map of California that lays out which counties are requesting to move to a COHS or Single Plan model, which are current COHS counties, which will have 2+ plans, etc.

The following table summarizes the conditionally approved model changes across counties. We also provide maps outlining: 1) the current Medi-Cal Managed Care (MCMC) models by county for 2023; and 2) future MCMC models by county following implementation of the model changes in 2024.

County / Counties
Description of Conditionally Approved Model Change

Alameda
Transitioning from a Two-Plan to a Single Plan Model with the Alameda Alliance for Health

Contra Costa
Transitioning from a Two-Plan to a Single Plan Model with Contra Costa Health Plan

Imperial
Transitioning from the Imperial Model with two commercial plans to a Single Plan Model with the Community Health Plan of Imperial Valley

Mariposa
Transitioning from a Regional Model with two commercial plans to a County Organized Health System (COHS) model with Central California Alliance for Health

San Benito
Transitioning from the San Benito Model, with one commercial plan, to a COHS model with Central California Alliance for Health

Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba
Transitioning from the Regional Model with two commercial plans to a COHS model with Partnership HealthPlan

Alpine & El Dorado
Transitioning from the Regional Model with two commercial plans to the Two-Plan Model with Health Plan of San Joaquin as their Local Initiative

Current MCMC Models, 2023

Future MCMC Models Post-County Model Changes, 2024

Can the state provide an estimate of how many beneficiaries will be affected? Specifically, how many individuals will be bumped from their current plan, or moved from one plan to another in these counties?

We estimate that about 500,000 Medi-Cal managed care members would move from one plan to another because of the county plan model changes. We made the following assumptions in calculating this estimate:
A member enrolled in a managed care plan (MCP) that will remain as an MCP in that county in 2024 will retain that MCP membership. These members were not counted as needing to change.
A member enrolled with Kaiser (as a direct or subcontracting plan now) would retain Kaiser. These members were not counted as needing to change.
All members of an exiting MCP would need to change MCPs. These members were included in the total count.

Can the state provide in writing how this change is going to impact access? As the state is aware, beneficiary access is very important to this administration, so understanding how this change may improve access for beneficiaries or in other ways benefit beneficiaries is useful.

As described in the County-led Model Change Letter of Intent process, DHCS has authority to determine which, and how many, MCPs the State contracts with for Medi-Cal services in counties. DHCS' determination is ultimately guided by the best interests of Medi-Cal members and the State's goals for the Medi-Cal managed care delivery system under CalAIM, namely, to drive quality of care improvements, streamline and reduce complexity, and build on whole person care approaches. DHCS' evaluation assessed historical quality of care performance and the financial health and viability of the entity.

Based on composite quality scores which factor in quality outcomes, provider network adequacy, access to care, and data quality, Counties with one or two MCPs score far higher than Counties with more than two MCPs. This is the case even in Counties/Plan Model Types with two commercial plans. See below:

Average Aggregate Quality Factor Score by Plan Model (1)

Plan Model Type
Plan Type and Number
Average Score

County Organized Health System
1 Local Plan
4.0

Imperial
2 Commercial Plans
3.3

San Benito
1 Commercial Plan
3.2

Two Plan
1 Commercial Plan & 1 Local Plan
3.1

Regional Model
2 Commercial Plans
3.0

Geographic Managed Care (GMC)
Multiple Commercial Plans
2.4

The Aggregated Quality Factor Score (AQFS) is a single score that accounts for plan performance on all DHCS-selected Health Effectiveness Data and Information Set (HEDIS) measures. DHCS-selected HEDIS measures include those related to preventive care (such as screenings and well-care visits); chronic disease management (such as diabetes control); care transitions, and maternity care.

As indicated, fewer MCPs within the county are associated with higher quality composite scores. This suggests that fewer plans—no more than two—with a track record of good performance will significantly improve quality performance not only in the respective counties but will consequently improve the statewide quality performance as well.

Our findings are consistent with a California Health Care Foundation (CHCF)-sponsored review of the quality and satisfaction scores for members in Geographic Managed Care (GMC) Counties in comparison with other counties. They found that from 2015-2018, the quality of care delivered by MCPs in GMC counties was lower, on average, for 22 of 30 measures compared with MCPs in the comparison counties. In terms of patient satisfaction, they found that the multiplicity of MCP options under the GMC model does not clearly manifest in better scores.

1 https://www.chcf.org/publication/close-look-medi-cal-managed-care-quality-gmc/

In addition, having multiple MCPs on a county basis can result in administrative burden and complexity for providers and community-based organizations who would have to contract with multiple MCPs to serve Medi-Cal members. From a compliance, oversight, and monitoring perspective, having fewer MCPs on a county basis also simplifies processes at the State, MCP, and network provider level.

For example, with the implementation of Enhanced Care Management (ECM) benefit and Community Support/Health-Related Service Need (HRSN) services, there is an expectation that community-based providers will engage with MCPs to provide wrap-around services to address social drivers of health needs for populations of focus and MCP members. As ECM providers, including community-based organizations, are brought into the MCP networks, simplifying the number of MCP contracts for providers to work will help further CalAIM goals of simplification and streamlining the delivery system.
‘
Across all MCP managed care model types, DHCS’ strategy for the Managed Care Plan program in 2024 and beyond is to increase accountability of MCPs. Through the 2024 Contract, MCPs must demonstrate robust accountability, compliance, monitoring, and oversight programs, including for delegated entities, to ensure members receive quality care and have access to services.

For example, MCPs will be required to meet the following new and enhanced contract requirements:
Access to Care. MCPs will be required to meet more robust expectations in assisting members and their families with navigating delivery systems and care management services. MCPs will maintain comprehensive networks that provide all members timely access to care that is appropriate, culturally and linguistically competent, high quality, and within geographic access standards, and that include timely access to interpreter services, auxiliary aids and services, and appropriate telehealth modalities.
Transparency. MCPs will now be required to routinely and publicly report on access, quality improvement, and health equity activities, including their fully delegated subcontractors’ performance and consumer satisfaction. These reports

will be posted publicly by DHCS to help members choose their MCP. MCPs will also be required to post their financial performance information and Memoranda of Understanding with third parties.
High-Quality Care. MCPs will be expected to exceed quality improvement benchmarks and create a culture of continuous quality improvement with a focus on primary care, physical and behavioral health, access to and engagement of providers, and continuity and coordination across settings and all levels of care. MCPs will be held accountable for their own quality as well as that of their subcontractors. MCPs failing to achieve quality benchmarks will face sanctions and potentially be required to surrender a portion of their net income. MCPs will be newly required to review utilization reports to identify members not using primary care, and to address those members' needs and health disparities. Plan payment will be linked to quality and equity, and MCPs will be required to comply with new provider shared risk/savings and incentive arrangements. MCPs and their subcontracted plans are expected to achieve National Committee for Quality Assurance (NCQA) Health Plan Accreditation by 2026.
Increased Health Equity and Reduced Health Disparities. MCPs will meet new requirements related to reducing health disparities among specific populations and measures identified by DHCS. MCPs will be required to identify physical and behavioral health disparities and inequities in access, utilization, and outcomes by race, ethnicity, language (including limited English proficiency), and sexual orientation, and to have focused efforts to improve health outcomes within the most impacted groups and communities. For the first time, MCPs will be required to have a Chief Health Equity Officer. Furthermore, both the MCPs and their subcontracted health plans will be mandated to achieve NCQA Health Equity Accreditation, a new standards program focused on advancing the delivery of more equitable and culturally and linguistically appropriate services across member populations.
Continuum of Care. MCPs will help members manage their health over time through a comprehensive array of person-centered health care and social services spanning all levels of care, from birth to dignified end of life. MCPs will be obligated to strengthen their coordination and continuity of care for out-of-network providers and to educate members on, for example, what an advance directive is and their right to have one.

Can the state help us understand the timing for the implementation of this amendment? Our understanding is that there would be a freeze in enrollment in October 2023 so that beneficiaries couldn't change plans, in preparation for the full expenditure authority that begins in January 2024. Can the state lay out what expenditure authority is needed during which time periods?

As CMS noted above, beginning October 1, 2023, and through December 31, 2023, DHCS will freeze new enrollment in exiting MCPs to maximize continuity of care and minimize member disruption, which has specific implications in counties with only one continuing MCP and no new market entrants (i.e., in future Single Plan counties). Given this transition policy, DHCS will need Section 1115 expenditure authority to limit plan choice in the affected counties starting October 1, 2023 and going forward through the end of the CalAIM demonstration (December 31, 2026).

California law imposes a minimum performance level (MPL), below which DHCS "may" sanction plans. Last year, how many and which plans were performing beneath this MPL, and on how many measures? By approving this amendment, will any beneficiaries be forced into plans performing beneath MPLs? Given some California contracting plans performance on quality measures, how will California continue to drive improvement among plans with plan choice removed as an available tool?

All MCPs had at least one measure below the MPL as depicted in the Table 1 below; however, there were varying degrees of plan performance. Quality metrics are determined based on DHCS identified key priorities for the state, statewide performance, and disparities. To better align members with higher performing plans, DHCS adjusts the auto-assignment into plans based on their aggregated quality scores. Higher performing plans will have a higher ratio of members entering Medi-Cal than lower performing plans within the same county. DHCS also continues to allow members to choose which plan they would like to enter.

To help inform members on plan quality performance, a public facing factsheet was released explaining what the quality metrics were and how all plans performed (See: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Enhancing-Quality-for-Medi-Cal-Members.pdf & https://www.dhcs.ca.gov/dataandstats/reports/Documents/Graphic-Fact-Sheet-all-domains.pdf). California continues to work very closely with all plans striving toward higher quality and equitable care for members.

Depending on which measures are below the MPL, DHCS mandates a certain amount of quality/equity projects that focus on improving lower performing measures. Additionally, DHCS staff work closely with the plans providing technical assistance in driving continuous improvement efforts. For plans that have larger numbers of measures below the MPL, they are placed under a Corrective Action Plan (CAP). For plans under a CAP, both executive teams from the plans and DHCS meet routinely to discuss alignment in quality and work toward improving systemic barriers preventing high quality/equitable care. If approved, California will continue to work toward better quality and equitable services for all Medi-Cal Members.

Table 1: Performance Measures Subject to Sanctions by MCP and County, 2023

Medi-Cal MCP	Sanctioned Based on Performance	Reporting Unit	Number of Measures Below the MPL (out of 15 measures)
Aetna*	Yes	Sacramento County	10
		San Diego County	10
Alameda Alliance for Health	Yes	Alameda County	3
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan*	Yes	Alameda County	5
		Contra Costa County	7
		Fresno County	8
		Kings County	6
		Madera County	2

Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties)
7

Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Tuba counties)
8

Sacramento County
7

San Benito County
6

San Francisco County
8

Santa Clara County
7

Tulare County
4

Blue Shield of California Promise Health Plan
Yes
San Diego County
6

California Health & Wellness Plan*
Yes
Imperial County
5

Region 1 (Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama counties)
10

Region 2 (Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Tuba

counties)
9

CalOptima
Yes
Orange County
2

CalViva Health
Yes
Fresno County
4

Kings County
4

Madera County
0

CenCal Health
No
San Luis Obispo County
2

Santa Barbara County
1

Central California Alliance of Health
Yes
Merced County
8

Monterey/Santa Cruz Counties
1

Community Health Group Partnership Plan
No
San Diego County
2

Contra Costa Health Plan
Yes
Contra Costa County
2

Gold Coast Health Plan

Yes
Ventura County
5

Health Net Community Solutions, Inc.*
Yes
Kern County
10

Los Angeles County
8

Sacramento County
8

San Diego County
5

San Joaquin County
11

Stanislaus County
14

Tulare County
2

Health Plan of San Joaquin
Yes
San Joaquin County
5

Stanislaus County
9

Health Plan of San Mateo
Yes
San Mateo County
3

Inland Empire Health Plan
Yes
Riverside/San Bernardino Counties
6

Kaiser NorCal (KP Cal, LLC)
No
KP North (Sacramento, Amador, El Dorado, and Placer counties)
1

Kaiser SoCal (KP Cal, LLC)
No
San Diego County
1

Kern Health Systems, DBA Kern Family Health Care*
Yes
Kern County
10

L.A. Care Health Plan
Yes
Los Angeles County
3

Molina Healthcare of California*
Yes
Imperial County
10

Riverside/San Bernardino Counties
11

Sacramento County
11

San Diego County
2

Partnership HealthPlan of California*
Yes
Northeast (Lassen, Modoc, Shasta, Siskiyou, and Trinity counties)
10

Northwest (Del Norte and Humboldt counties)
10

Southeast (Napa, Solano, and Yolo counties)
4

Southwest (Lake, Marin, Mendocino, and Sonoma counties)
4

San Francisco Health Plan
Yes
San Francisco County
2

Santa Clara Family Health Plan
Yes
Santa Clara County
2

UnitedHealthcare Community Plan
Yes
San Diego County
6

Total Amount:
21
56
327

*Under a Corrective Action Plan

DHCS' top priority is ensuring our members have high quality care. We acknowledge that our MCP partners have not achieved high quality standards in the past. Our 2024 contract incorporates key provisions that effectuate tactics to realize our Comprehensive Quality Strategy.

Specifically, MCP partners will be expected to exceed quality improvement benchmarks and create a culture of continuous quality improvement with a focus on primary care, physical and behavioral health integration, access to and engagement of providers, and continuity and coordination across settings and all levels of care. MCPs will be held accountable for their own quality as well as the quality of their subcontractors. MCPs failing to achieve quality benchmarks will face sanctions and potentially be required to surrender a portion of their net income. This will be in addition to the potential imposition of corrective actions, sanctions, and liquidated damages.

How will this amendment request affect the delivery and support of HRSN services?

Members are not expected to face disruption in Community Supports/HRSN services or providers resulting from the MCP transition. Receiving MCPs will be required to proactively offer continuity of Community Supports/HRSN services to members already receiving such services, when Community Supports/HRSN services offered overlap with exiting MCPs. DHCS anticipates a high degree of overlap in Community Supports services offered and is encouraging full alignment. In those instances, receiving MCPs will be required to assign the member to the same Community Supports/HRSN provider. DHCS will provide incoming MCPs a list of Community Supports/HRSN providers in the exiting MCPs' networks, including contact information. If the provider is not in network already, the receiving MCP will be required to make good faith efforts to contract with Community Support/HRSN providers from exiting MCPs'

networks. Individuals will not have to request continuity of provider or be concerned about a change in services as the receiving MCP should work with the provider to ensure that the transition is seamless. DHCS is current developing the operational guidance to MCPs on how to implement these requirements, including providing guidance on data that must be exchanged.

Can the state please describe how and to what extent Medi-Cal or the county authorities will be conducting outreach to federally funded aging and disability networks (including Centers for Independent Living and Area Agencies on Aging) to ensure that eligible consumers are made aware of and educated about these new options, how they will work, the additional safeguards/ benefits and how they can be accessed?

DHCS will coordinate with the California Department of Aging and share information about the January 2024 enrollment transition with local Health Insurance Counseling and Advocacy Program (HICAP) organizations (California's SHIP) and Aging and Disability Resource Centers.

DHCS will also include the 2024 MCP transitions in the topics for statewide webinars attended by providers, community groups, and members. In addition, DHCS is developing a coordinated outreach and education effort geared at members and providers in transitioning counties. Messaging will focus on plan selection and processes, continuity of care protections, and [2024 contract what to expect] available resources, including where to go for more information. These efforts will use lessons learned and partnerships built from the extensive outreach DHCS conducted in fall 2022 for the transition of dual eligible members from the financial alignment demonstration to the EAE D-SNP model, and the statewide mandatory enrollment of seniors and persons with disabilities into Medi-Cal managed care, both effective January 1, 2023.

Can the state clarify that when there is churn from one MCO to another, that the community-based organizations providing ECM services can help support the transition process?

Members receiving ECM are not expected to face disruption in ECM services or providers resulting from the MCP transition. Receiving MCPs will be required to ensure continuity of ECM service authorization and maximize continuity of community-based ECM providers to all members who are enrolled in ECM at the time of transition. DHCS will provide receiving MCPs a list of ECM providers in the exiting MCPs' networks, including contact information. MCPs will be required to make good faith efforts to contract with ECM providers from exiting MCPs' networks. Individuals will not have to request continuity of provider or ECM services as the receiving MCP should work with the provider to ensure that the transition is seamless. Transitioning members' ECM providers will be responsible for assisting transitioning members with obtaining needed referral services before, during and after the transition.

Regardless of the plan that is chosen, will managed care organizations be open to delegate to local community-based organizations to provide local continuity?

Yes, this is a core tenant of the Continuity of Care policies that DHCS is putting into place for the transition period. See responses to questions #6 and #8.

Can the state provide a breakdown for members effected by a) Kaiser members and b) non-Kaiser individuals? Based on Kaiser's Medicaid eligibility criteria, Kaiser's members tend to have higher baselines of socioeconomic status, health status, support networks than conventional Medicaid beneficiaries. Can the results from the demonstration be generalized to a broader Medicaid population? CMS is interested in learning how the state plans to address the external validity issue.

We are addressing this question in three parts:

A. [Modified] Can the state provide a breakdown of members who would change plans are a result of county plan model change who are Kaiser members versus non-Kaiser members.
The estimates we provided under question #2 above assume that Kaiser members would stay with Kaiser and thus are not included in the "affected members" total. There are currently approximately 100,000 members in plan model change counties currently enrolled with Kaiser, who are expected to remain in Kaiser during the 2024 transition. Of the

approximately 945,000 Medi-Cal managed care members not enrolled with Kaiser in the model change counties, about 500,000 are estimated to change plans as the result of county plan model changes.

B. Based on Kaiser's Medicaid eligibility criteria, Kaiser's members tend to have higher baselines of socioeconomic status, health status, support networks than conventional Medicaid beneficiaries.

There have been assertions that Kaiser's past policies to allow enrollment based on family linkage and continuity of care from other business lines can be seen as risk selection. However, the rationale for allowing such enrollment has been to allow families to have membership and access to Kaiser's delivery system and to ensure continuity of care of Kaiser members when their payer source changes. At this time, DHCS has not performed detailed analysis of the acuity of the Kaiser members relative to the local plan's remaining membership in CY 2024; such analysis will be performed as part of CY 2024 rate setting. However, it should be noted that under AB 2724, the state has expanded and standardized the limited enrollment parameters for Kaiser from what they are today. Kaiser will not "pick" its members but rather individuals who have picked Kaiser can maintain/obtain their coverage in Kaiser in the Medi-Cal program. Finally, with no enrollment caps on duals and foster care members, Kaiser would be an option for populations known to have higher acuity, social services needs, and lower socio-economic status.

C. Can the results from the demonstration be generalized to a broader Medicaid population? CMS is interested in learning how the state plans to address the external validity issue.

The State will compare Kaiser enrollees to other enrollees starting in 2024 when the data becomes available, and is committed to assessing quality for Kaiser as part of the formal evaluation, including examining any potential differences in demographics.

11. Can the state clarify if contracting with a community care hub (single entity that organizes and supports a network of CBOs providing services to address health-related social needs) to offer access to Community Supports is allowable? If so, can this be reflected in public guidance? Through this model, MCPs (and their beneficiaries) would have access to a range of CBOs and their relevant services through a single contract.

12. DHCS says that all plans are beneath Minimum Performance Levels on one or more measures, but some plans are put on Corrective Action Plans. How does the state determine which plans are put on CAPs if not by performance beneath the minimum? Is this threshold public?

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CMS/DHCS CalAIM Waiver Biweekly Check-in
Wednesday, June 7th from 3:00 * 4:00 PM ET // 12:00 * 1:00 PM PT

- Discuss proposed DSHP request for BH workforce initiative
- Other?

Hi there,

Lora Kim is inviting you to a scheduled Zoom meeting.

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217 2000 or +1 669 444 9171 or +1 669 900 6833 or +1 689 278 1000 or +1 719 359 4580 or +1 253 205 0468 or 888 788 0099 (Toll Free) or 877 853 5247 (Toll Free)

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SIP:

92765438501@zoomcrc.com

Passcode:

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Attachments:
RE: CA CalAIM 1115 Waiver Reentry Initiative Implementation and Reinvestment Plans; CA Attachment CC - Reentry Demonstration Initiative Implementation Plan_CMS07172023.docx; RE: [External]CMS*DHCS CalAIM Waiver Biweekly Check-in

CMS/DHCS CalAIM Waiver Biweekly Check-in
Wednesday, July 19th from 3:00 * 4:00 PM ET // 12:00 * 1:00 PM PT

MCP Model Change Amendment
• Discuss DHCS* comments on draft language for Section 1115 MCP Model Change amendment
? State's question on page 1 section B-2 DHCS requests any background or rationale for the 10% requirement. DHCS believes the regulatory context and/or history will assist with its efforts to ensure compliance. For example, are there other States with similar STCs?

? Follow up on section B-1 (emailed question)

• Check in on timing of approval of Section 1115 MCP Model Change amendment

Re-Entry Implementation Plan
• Re-Entry Implementation plan comments- comments in the document (document attached)
• Re-Entry Implementation plan provider enrollment discussion (emailed questions- see attached)

Other
• Flag: Request for CMS review of BH-CONNECT application and CalAIM transitional rent services amendment by July 24th

Hi there,

Lora Kim is inviting you to a scheduled Zoom meeting.

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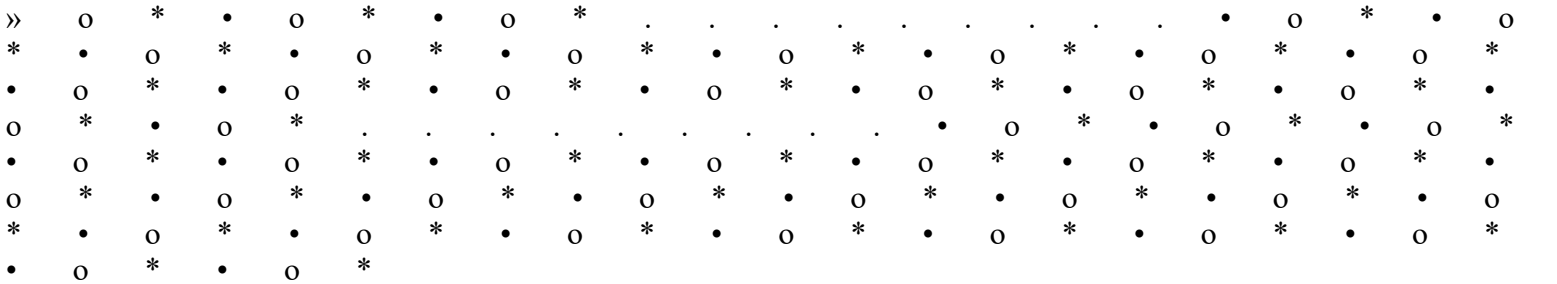

Author

A
Does the state have any estimate on when the first facilities will be deemed ready? Any estimate on how many facilities will be deemed ready per quarter?

Author

A
Corrected SMD#

Author

A
Data and Systems Infrastructure is missing from this implementation plan.

Author

A
For all requirements in the table on the subsequent pages per the SMDL: The state will need to identify, in addition to current and future state, “an implementation plan per CMS guidance that describes the activities and associated timelines for achieving the demonstration milestones”. Also, “Among other things, a state will be expected to identify for each milestone what it anticipates to be the key implementation challenges and the state’s specific plans to address these challenges.”

It appears a few action items might be captured and incorporated broadly in future state, but should be clearly delineated with associated timelines, as well as challenges/plans to address those challenges.

Author

A

Recommend that CA reframe this item as a challenge and clearly identify scenarios in which problems could arise

Author

A
Since the milestone mentions that individuals will be in FFS be auto-enrolled and or select a managed care plan for services upon release, we recommend including information about the warm handoff to the health plan CM to ensure individuals are supported in getting their cards and including a responsibility for pre- and post-release Case Managers to ensure beneficiaries have a card.

Author

A
Is there any uniformity beyond eligibility criteria (standards for elements being screened) of is California considering establishing standards or a standardized screening process in the future?

Author

A
Per overarching comment, we are looking to the implementation plan to include the activities and associated timelines for achieving the demonstration milestones, which would include implementing these benefits, as well as challenges. This level of detail describes coverage but not the plan items: activities and timelines to launch.

Author

A
Is this something that would be suitably described as a challenge?

Author

A
How are peer support specialists being implemented? I do not see it in this plan, but they are included in the approved application.

Author

A
CMS would like to discuss this on a call to get a better understanding of provider enrollment in California in this demonstration.

Author

A
Are there any program integrity standards you can provide that ensure inappropriate billing or cost shifting?

Author

A
Please describe in more detail to provide clarity to explain that this would not apply to general transfers between two prisons, or when the expected release is known to be more than 90 days at the time of service, etc.. Adding some caveats to the example sentence could accomplish this (90-day pre-release from county jail to community was unexpectedly transferred to a state prison). According to this description, beyond pre-disposition of charges and unknown release dates, coverage greater than 90 days could be exceeded in aggregate post-sentencing. We believe transfers between facilities could be common in some instances.

Author

A
Recommend indicating the plan will be reviewed together in the warm handoff with the beneficiary present. That does not mean that won't be happening, but it is recommended to clarify.

Author

A
Please list, generally the HRSNs that will be captured and included in the assessments.

Author

A
Per comment in 2.c. recommend indicating the plan will be reviewed together in the warm handoff with the beneficiary present, not just shared (which is not a warm handoff)

Author

A
How will this be monitored (high-level) rather than assured? This step should include more detail to describe monitoring rather than indicate it will be developed, and timeframes.

Author

A
This step should include more detail about what monitoring will entail at a high level and when that plan will be developed.

Author

A
This step should include a little more detail to describe what will be included in the monitoring plan (high level) and the date, rather than just indicate it will be developed?

Author

A
Similar to the comment above, this step should include more detail to describe the monitoring (high-level) and timeline for finalizing this part of the plan, rather than indicate it will be developed.

Author

A
Please provide more context for almost total readiness. In what circumstances would that apply? What is the criteria and timeline to get to total readiness?

Author

A
Is this to inform design or to generally share, engage and inform? Does the Advisory Group described in the previous paragraph also include individuals with lived experience as encouraged in the SMDL? If not, does CA have any plans to expand the advisory group to include those individuals to inform design and implementation?

Attachment CC: Reentry Demonstration Initiative Implementation Plan

Introduction:

On January 26, 2023, the Centers for Medicare & Medicaid Services (CMS) granted approval of California's request to amend the Section 1115(a) demonstration "California Advancing and Innovating Medi-Cal (CalAIM)" to provide limited coverage for services furnished to a subset of incarcerated individuals for up to 90 days immediately prior to their expected dates of release.

1 11-W-00193/9: "California CalAIM Demonstration." Available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf.

1

CalAIM Demonstration Special Term and Condition (STC) 9.9 requires California to submit a Reentry Demonstration Initiative Implementation Plan (hereinafter "Implementation Plan"). The following Implementation Plan details California's approach for meeting the five milestones outlined in STC 9.9 and additional conditions articulated in the CMS State Medicaid Director (SMD) Letter# 23-0-003, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated."

2 SMD# 230-3, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated," April 17, 2023. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

2

The Implementation Plan is organized around the following five Reentry Section 1115 Demonstration milestones:

Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.

Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community.

Promoting continuity of care.

Connecting to services available post-release to meet the needs of the reentering population.

Ensuring cross-system collaboration.

For each milestone, the Implementation Plan describes (1) a summary of how the State already meets any expectation and specific activities related to each milestone, and (2) any actions needed to be completed by the State to meet all the expectations for each milestone, including the persons or entities responsible for completing these actions and the timelines and activities the State will undertake to achieve the milestone.

In addition to this Implementation Plan, DHCS will release the "Policy and Operational Guide for Planning and Implementing CalAIM Demonstration Reentry Initiative."

3 The Policy and Operational Guide, along with all other publicly available material on the CalAIM Reentry Demonstration Initiative, will be available here: https://www.dhcs.ca.gov/CalAIM/Pages/Justice.aspx. The expected time of release is summer 2023.

3
(hereinafter "Policy and Operational Guide".). This Policy and Operational Guide will provide detailed policy requirements and operational expectations for implementation of the CalAIM Demonstration Reentry Initiative. The audience of the Policy and Operational Guide is the State's implementation partners, including, without limitation, correctional facilities, county behavioral health agencies, county social service departments (SSDs),

4 County social service departments are responsible for processing Medi-Cal applications and enrollment.

4
Medi-Cal Managed Care Plans (MCPs), Mental Health Plans/Drug Medi-Cal and Drug Medi-Cal Organized Delivery Systems (DMC/DMC-ODS), and community-based providers. The Policy and Operational Guide will be updated on an ongoing basis as implementation partners begin the process of standing up the CalAIM Demonstration Reentry Initiative.

Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated
STC 9.9.a. The State must describe its plans to fully effectuate, no later than two years from approval of the expenditure authority, a state policy to identify Medicaid- eligible individuals or individuals who would be eligible for CHIP, except for their incarceration status, and suspend a beneficiary's eligibility or benefits during incarceration. It must describe its processes to undertake robust outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid application, enrollment, and renewal processes. Other aspects to be included in the Implementation Plan related to this milestone include the State's plan to make available a Medicaid and/or managed care plan identification number or card to an individual, as applicable, upon release; and establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another State, e.g., relevant State Medicaid agency website, if the individual will be moving to a different State upon release.

CMS State Medicaid Director Letter Specific Requirements
Implementation Approach

1.a. Implement a State policy for a suspension strategy during incarceration (or implement an alternative proposal to ensure that only allowable benefits are covered and paid for during incarceration, while ensuring coverage and payment of full benefits as soon as possible upon release), with up to a two-year glide path to fully effectuate.
Current State:
Effective January 1, 2023, all California county SSDs were required to suspend, rather than terminate, Medicaid coverage for the duration of an individual's incarceration.

5 See ACWDL 21-22 (October 28, 2021) for more information on suspension of Medi-Cal benefits for youth.

5
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6 Public Health Omnibus Bill, SB 184 (Chapter 47, Statutes of 2022), amended Welfare and Institutions Code § 14011.10(d).

6
Both adult and youth coverage is suspended for the duration of incarceration.

7 Public Health Omnibus Bill, Senate Bill (SB) 184 (Chapter 47, Statutes of 2022) amended Welfare and Institutions Code § 14011.10(d) in 2022.

7
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8 Under SB 184, beginning January 1, 2023, Medi-Cal benefits for adults must be kept in suspended status until the individual is no longer an inmate of a public institution. For individuals under the age of 21 or Former Foster Youth (FFY) under the age of 26, under the federal SUPPORT Act and State law (Welfare & Institutions Code § 14011.10 (e) (1) & (2)), the State and counties are prohibited from terminating Medicaid eligibility because the individual is an inmate of a public institution.

8

State guidance, published in November 2022, provides information related to implementing DHCS' Medicaid benefit suspension and unsuspension (activation) policies, including guidance on suspension timelines for individuals with short-term stays.

9 See ACWDL 22-26 (October 28, 2022) for more information on suspension/unsuspension for individuals incarcerated and released to different counties, the annual renewal policy, change in circumstance redeterminations, and notices of action.

9
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10 See ACWDL 22-27 (November 10, 2022) for more information on pre-release application processes for juvenile and adult inmates of county correctional facilities and county youth correctional facilities.

10
The following summarizes the State's policy and operational approach:
Through the benefit suspension process, the correctional facility reports the member's incarceration status to the county SSD; the SSD will change an individual's Medi-Cal status from "active" to "suspended." While in the suspension period, the individual will be eligible to receive inpatient hospitalization and pre-release services (for no more than 90 days) only. Individuals receive a notice of action when their Medi-Cal coverage is suspended and again upon reactivation.
If inpatient hospital services are required during an individual's incarceration, the correctional facility can submit an application for the county or State Medi-Cal Incarceration Eligibility Program (MCIEP). MCIEP occurs at both a State and county level and allows Medi-Cal reimbursement for inpatient hospital stays of 24 or more hours for incarcerated individuals who are determined eligible for Medi-Cal.
For individuals likely subject to a short-term stay of incarceration, the benefit suspension will only be activated after the individual has been incarcerated for at least 28 days. The objective of this approach is to minimize gaps in coverage and ensure the individual has access to full benefits as quickly as possible upon release.
All individuals found eligible for pre-release services, including individuals who were incarcerated for 28 days or less, will be assigned a specific aid code that will ensure the only services that will be provided and paid for are Reentry Demonstration Initiative services.

DHCS required SSDs, County Sheriff's Departments and County Probation Departments to complete and submit readiness assessments in November 2022, through which they attested to their readiness to implement pre-release Medi-Cal application processes.

11 See MEDIL 22-46 and MEDIL 22-47 (November 10, 2022) for more information on the Pre-Release Medi-Cal Application Mandate Readiness Assessments for County SSDs and County Sheriff's Departments and County Probation Departments.

11
DHCS also implemented a monitoring plan to assess compliance with the mandate, including suspension and unsuspension processes, and ongoing implementation of the mandate.

Future State:
DHCS requires all counties to be in full compliance with the CalAIM Medi-Cal Pre-Release Application mandate by June 30, 2023; this mandate includes implementing suspension and reactivation processes described above. Counties that are not in compliance by this date will be required to complete an ongoing Plan of Action and Milestones (POAM) until they are deemed compliant. SSDs, County Sheriff's Departments, and County Probation Departments must complete and submit to DHCS a Current Progress Report by May 31, 2023, to provide an update on the implementation of their process. (June 2023)
To track implementation progress, DHCS will also require SSDs, County Sheriff's Departments, and County Probation Departments to submit Pre-Release Medi-Cal application data on a quarterly basis, starting October 1, 2023.

12 See MEDIL 23-24 (April 13, 2023) for more information on reporting requirements for pre-release application data.

12
(October 2023)

DHCS will continue to monitor and evaluate the State's pre-release suspension processes and make program changes, as needed, as pre-releases go live.

13 See MEDIL 23-24 (April 13, 2023) for more information on DHCS' monitoring plan for the CalAIM mandated pre-release Medi-Cal application process implementation.

13
(Ongoing)
DHCS will continue to monitor and evaluate compliance with suspension processes and provide ongoing technical assistance to implementation stakeholders, including correctional facilities and county SSDs, as needed. (Ongoing)

1.b. Ensure that any Medicaid-eligible person who is incarcerated at a participating facility but not yet enrolled is afforded the opportunity to apply for Medicaid in the most feasible and efficient manner and is offered assistance with the Medicaid application process in accordance with 42 CFR § 435.906 and § 435.908. This could include applications online, by telephone, in person, or via mail or common electronic means in accordance with 42 CFR § 435.907. All individuals enrolled in Medicaid during their incarceration must be provided notice of any Medicaid eligibility determinations and actions pursuant to 42 CFR § 435.917 and § 431.211.
Current State:
State prisons already have standardized Medicaid application processes in place, consistent with State policy and CMS sub-regulatory guidance.
Effective January 1, 2023, correctional facilities and SSDs were mandated to implement pre-release Medi-Cal application processes.

14 In accordance with Penal Code Section 4011.11 and as outlined in ACWDL 22-27 (November 10, 2022).

14

County jails and youth correctional facilities are in various States of readiness to implement pre-release Medi-Cal application processes. All County Welfare Directors' Letter (ACWDL) 14-24 describes policies and procedures for the pre-release Medi-Cal application process for State prisons.

15 See ACWDL 14-24 (May 6, 2014) for more information on the State inmate pre-release Medi-Cal application process.

15

ACWDL 22-27 provides detailed guidance and directives for implementing the mandatory pre-release Medi-Cal application process for county SSDs and county correctional facilities.

16 See ACWDL 22-27 (November 10, 2022) for more information on pre-release application processes for juvenile and adult inmates of county correctional facilities and county youth correctional facilities.

16

As part of the technical assistance provided to correctional facilities and SSDs, DHCS developed and shared minimum Medicaid application and enrollment processes to ensure all potentially eligible individuals are screened for Medicaid eligibility at or near intake or at minimum 135 days prior to release when the release date is known.

17 A slide deck that provides an overview of the pre-release Medi-Cal application mandate is available here. An issue brief titled Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails brief describing best practices for pre-release Medi-Cal enrollment can be found here.

17
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18 A slide deck that provides an overview of the pre-release Medi-Cal application mandate is available here. An issue brief titled Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails brief describing best practices for pre-release Medi-Cal enrollment can be found here.

18

Correctional facilities or their designated entity will be expected to facilitate and submit, and SSDs must receive and process, pre-release Medi-Cal applications from individuals in correctional facilities submitted online or via mail, telephone, or fax. Because individuals are incarcerated, they will not be able to submit applications in person, and submissions via online portals and telephones may be restricted due to the unique nature of correctional facilities. While DHCS will provide clear guidance that these standards for enrollment pathways do apply in all correctional facilities, the State cannot guarantee all pathways will be available in every facility. The State will monitor Medicaid enrollment against these expectations and will work with correctional facilities and SSDs to continue to refine operational processes related to Medicaid enrollment in correctional settings.
In accordance with Medicaid regulations, DHCS' Medi-Cal Eligibility Division published Informational Letter 23-13, which requires SSDs to notify applicants of the outcome of their eligibility determination through an eligibility determination notice (aka Notice of Action) and issue a Benefits Identification Card (BIC), both sent to the correctional facility. SSDs and correctional facilities are expected to work together to ensure processes are in place for individuals to receive all communications sent by the SSD to the applicant.

19 See ACWDL 22-27 (November 10, 2022) for more information on pre-release application processes for juvenile and adult inmates of county correctional facilities and county youth correctional facilities.

19

The State has also worked to establish data-sharing processes between SSDs and correctional facilities, including allowing correctional facilities to access the State's electronic verification systems.

20 See MEDIL 23-13 (March 6, 2023) for more information on the Eligibility Verification System and its utilization by county correctional facilities and county youth correctional facilities.

20

DHCS will encourage correctional facilities or their designees to leverage an Accelerated Enrollment (AE) portal for incarcerated individuals for whom it would be infeasible to complete the Medi-Cal application and enrollment process before the individual's release date (e.g., individuals with very short incarcerations or unpredictable release dates). The AE program provides Medi-Cal applicants with temporary full-scope benefits while their self-attested eligibility information, including income, is being verified; those benefits continue until the final eligibility determination is made on the application.
Individuals will be afforded the right to request a fair hearing (in writing, online, and by telephone, but not in person) regarding any adverse actions related to Medicaid coverage or services. For individuals who remain incarcerated during their scheduled fair hearing date, correctional facilities will be required to implement a process by which the incarcerated individual can attend the hearing by telephone, at minimum, or virtually if the individual is able to participate via videoconferencing . Many correctional facilities already have capabilities in place to support telephone or virtual court hearings, and DHCS expects these facilities to leverage this existing infrastructure to support Medicaid fair hearings. While these expectations, guidance, and standards apply and the State will monitor for compliance with them, the State cannot guarantee these processes will be implemented in every instance given the unique nature of carceral settings. DHCS will work with correctional facilities to continue to refine operational processes related to requests for fair hearings.
In order to support planning for and implementation of pre-release Medi-Cal applications, DHCS provided two rounds of capacity building PATH (Providing Access and Transforming Health Initiative) grant funding to correctional facilities and SSDs.

21 Guidance regarding the first round of capacity building grant funding can be found here.

21
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22 Guidance regarding the second round of capacity building grant funding can be found here.

22
The first round of capacity building grant funding supported collaborative planning activities (e.g., collaborative planning sessions, identification of operational gaps, and hiring processes for staff to support pre-release application processing). The second round of capacity building grant funding supported implementation and administration activities related to pre-release Medi-Cal applications (e.g., IT systems upgrades, physical infrastructure modification, development of protocols and procedures, and staff training to coordinate pre-release applications).

Future State:
County and youth correctional facilities and SSDs are required to be in full compliance with pre-release Medi-Cal application mandate by June 30, 2023. In order to ensure compliance with this mandate, DHCS will require that all counties report pre-release application data on a quarterly basis.

23 See MEDIL 23-24 (April 13, 2023) for more information on policies and procedures for county Medicaid eligibility departments and county correctional facilities to document implementation efforts of the pre-release Medicaid mandate.

23
(June 2023)
DHCS will continue to monitor compliance with the pre-release application mandate throughout the implementation of pre-release services. (Ongoing)
DHCS will provide ongoing technical assistance to stakeholders, as needed. (Ongoing)

1.c. Ensure that all individuals at a participating facility who were enrolled in Medicaid prior to their incarceration are offered assistance with the Medicaid renewal or redetermination process requirements in accordance with 42 CFR § 435.908 and § 435.916. All individuals enrolled in Medicaid during their incarceration must be provided notice of any Medicaid eligibility determinations and actions pursuant to 42 CFR § 435.917 and § 431.211.
Current State:
As described in Section 1.a, SSDs must suspend coverage for Medi-Cal members who are incarcerated for the duration of their incarceration. Individuals who were enrolled in Medicaid at the time of incarceration will not need to reapply for Medicaid. Once correctional facilities report the beneficiary's incarceration release date to the SSD, Medicaid benefits will be activated upon release.
Effective January 1, 2023, annual redeterminations are not required for individuals who are incarcerated if they are the only individual on their Medi-Cal case. If the incarcerated member is part of a household, the household will still be subject to an annual redetermination.

24 See ACWDL 22-26 (October 28, 2022) for more information on suspension/unsuspension for individuals incarcerated and released to different counties, the annual renewal policy, change in circumstance redeterminations, and notices of action.

24

Upon the individual's release, a redetermination would only be required if one had not been completed within the 12 months prior to the release date, barring any other known changes in circumstance which would require a change of circumstance redetermination under existing policy.
DHCS, in partnership with SSDs, will work with correctional facilities to ensure annual and change of circumstance redeterminations are completed, as needed.

Future State:
DHCS will continue monitoring compliance with redetermination processes throughout the implementation of pre-release services. (Ongoing)
DHCS will provide ongoing technical assistance to stakeholders, as needed. (Ongoing)

1.d. Implement a State requirement to ensure that all Medicaid-enrolled individuals who are incarcerated at a participating facility have Medicaid and/or managed care plan cards or some other Medicaid and/or managed care enrollment documentation (e.g., identification number, digital documentation, instructions on how to print a card) provided to the individual upon release, along with information on how to use their coverage (coordinated with the requirements under milestone #3 below).
Current State:
As outlined in State guidance, SSDs are required to notify applicants of the outcome of their eligibility through an eligibility determination notice (aka Notice of Action) and issue a BIC.

25 See MEDIL 23-13 (March 6, 2023) for more information on the Eligibility Verification System and its utilization by county correctional facilities and county youth correctional facilities.

25

Future State:
To mitigate the challenges related to timely issuance of BICs, especially for individuals with unplanned release dates or short-term stays, SSDs will be required to send a temporary BIC to the individual while they are incarcerated so that they can access Medi-Cal immediately upon release. A permanent BIC will be mailed to the community address listed on the Medicaid application or on file.

Individuals will receive pre-release services via the fee-for-service delivery system. Individuals will be auto-assigned to a managed care plan for when they are released into the community. The managed care plan will send all plan materials and plan card to the community address listed on the Medicaid application or on file.

DHCS will continue monitoring compliance of the requirement to ensure individuals are able to receive Medicaid-related communication and materials throughout the implementation of pre-release services.

26 See MEDIL 23-24 (April 13, 2023) for more information on policies and procedures for county Medicaid eligibility departments and county correctional facilities to document implementation efforts of the pre-release Medicaid mandate.

26
(Ongoing)

DHCS will provide ongoing technical assistance to stakeholders, as needed. (Ongoing)

1.e. Establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another State (e.g., relevant State Medicaid agency website, if the individual will be moving to a different State upon release).
Current State:
As outlined in 1.b., correctional facilities and SSDs are mandated to implement pre-release Medi-Cal application processes.
As part of this mandate, DHCS developed and distributed technical assistance materials

27 A slide deck that provides an overview of the pre-release Medi-Cal application mandate is available here. An issue brief titled Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails brief describing best practices for pre-release Medi-Cal enrollment can be found here.

27
and a Policy and Operational Guide chapter that describes expectations that Medi-Cal application processes should occur in correctional facilities at or near intake in order to ensure all potentially eligible individuals are screened for and enrolled in Medi-Cal.

Future State:
The Policy and Operational Guide will include clear guidance to reentry care managers to provide individuals who may be moving to a different State upon release with Medicaid application information (e.g., State Medicaid agency website or hotline number) to the State in which they will reside. (Summer 2023)
DHCS will continue monitoring compliance with the pre-release application mandate throughout implementation of pre-release services. (Ongoing)
DHCS will continue to provide ongoing technical assistance to stakeholders, as needed. (Ongoing)

Milestone 2: Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community
STC 9.9.b. The State must describe its plan to implement a screening process to identify individuals who qualify for pre-release services, consistent with the qualifying criteria outlined in these STCs. The State must detail how the facilities will ensure that beneficiaries can access the demonstration benefit package, as clinically appropriate. The State must describe its approach and plans for implementing processes to assure that all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and care managers have knowledge of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release. Further, as applicable, the State must establish State requirements for carceral health providers who are not participating in Medicaid or CHIP that are similar to Medicaid provider standards, as well as program integrity standards to ensure appropriate billing.
CMS State Medicaid Director Letter Specific Requirements
Implementation Approach

2.a. Implement State processes to identify individuals who are incarcerated who qualify for pre-release services under the State's proposed demonstration design (e.g., by chronic condition, incarceration in a participating facility).

Current State:
DHCS developed detailed definitions for its pre-release eligibility criteria, which are available in Attachment W of the approved 1115 Demonstration.

28 Please see Attachment W in the CalAIM Reentry Demonstration approval available here.

28

DHCS does not yet have State processes in place to identify individuals who are incarcerated who qualify for pre-release services.

Future State:
Correctional facilities will be responsible for operationalizing the pre-release screening process to identify adults eligible for pre-release services. Note, all youth in youth correctional facilities will be eligible for pre-release services and will not need to be screened.

29 Under this demonstration, eligibility determination is based on facility as opposed to age. Individuals in custody of a youth correctional facility will be subject to youth eligibility criteria. Individuals in custody of a jail or State prison will be subject to adult eligibility criteria. Young people up to and inclusive of age 25 may be in custody of youth correctional facilities. Individuals 18 and older may be in custody of adult facilities.

29
DHCS will develop a proposed approach that is memorialized in detail in the Policy and Operational Guide. (Summer 2023)

DHCS will:
Require that the correctional facility screen all incarcerated Medi-Cal eligible adults for any qualifying conditions.
Allow flexibility for correctional facilities in how they implement the screening process, so long as they are screening for all eligibility criteria (including for behavioral health linkages), and allow individuals to be screened or otherwise identified as qualifying for pre-release services/behavioral health linkages at any time during incarceration (e.g., as part of initial screening at booking, as part of a later screening, through available medical records/diagnoses information, and through self-attestation). Screening tools for behavioral health linkages must be validated, State-approved screening instruments or another State-approved option.
Encourage correctional facilities to leverage existing health screening and assessment processes that are already in place to screen individuals for eligibility to receive pre-release services (e.g., based on information collected through a facility's existing screening/assessment processes).
Require correctional facilities to demonstrate how they will meet this requirement as part of the readiness assessments. No correctional facility will be able to bill for pre-release services until it demonstrates that it has a screening process that meets policy and operational requirements. (April 2024-April 2026)
Provide technical assistance to stakeholders, as needed. (Ongoing)
Develop a pre-release services eligibility screening portal for correctional facilities to use to support screening and identification of qualifying individuals. This technical solution, known as the Justice-Involved Screening Portal, will allow correctional facilities to document eligibility for pre-release services, triggering the appropriate aid code for the individual's case in State Medicaid systems. The Portal will also allow the facility to access information about an individual's Medicaid eligibility, status of any other aid codes that may be active, and managed care enrollment, as applicable, to support service delivery. (April 2024)
Administer a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up a screening process. (May 2023)

2.b. Cover and ensure access to the minimum short-term, pre-release benefit package, including case management to assess and address physical and behavioral health needs and HRSN, MAT services for all types of SUD as clinically appropriate with accompanying counseling, and a 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release, to Medicaid-eligible individuals identified as participating in the Reentry Section 1115 Demonstration Opportunity. In addition, the State should specify any additional pre-release services that the State proposes to cover for beneficiaries.
Current State:
DHCS developed definitions for its targeted pre-release services as listed below. Additional details are available in Attachment W of the approved 1115 waiver.

30 Please see Attachment W in the CalAIM Reentry Demonstration approval available here.

30

Case Management: Case management will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to facilitate reentry planning into the community in order to (1) support the coordination of services delivered during the pre-release period and upon reentry, (2) ensure smooth linkages to social services and supports, and (3) ensure arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community.
Medication-Assisted Treatment (MAT): Covered services for MAT are as follows:
MAT for Opioid Use Disorders (OUD) includes all medications approved under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under Section 351 of the Public Health Service

Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29).
MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs.
Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan 1905(a)(29) MAT benefit, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan 1905(a)(13) rehabilitation benefit, including assessment; individual/group counseling; patient education; and prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT.
Note that MAT services may be provided by correctional facilities that are not Drug Medi-Cal (DMC)-certified providers as otherwise required under the State Plan for the provision of the MAT benefit.
Physical and Behavioral Health Clinical Consultation Services: Physical and behavioral health clinical consultation services include targeted preventive, physical, and behavioral health clinical consultation services related to the qualifying conditions. Clinical consultation services are intended to support the creation of a comprehensive, robust, and successful reentry plan, including conducting diagnosis, stabilization, and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); providing recommendations or orders for needed medications and durable medical equipment (DME) that will be needed upon release; and consulting with the pre-release care manager to help inform the pre-release care plan. Clinical consultation services are also intended to provide opportunities for individuals to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers, and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the members after release. Note that behavioral health clinical consultation services may be provided by correctional facilities that are not certified mental health organizations or agencies as otherwise required under the State Plan.
Laboratory and Radiology Services: Laboratory and radiology services will be provided consistent with the State Plan.
Medications and Medication Administration: Medications and medication administration will be provided consistent with the State Plan.
Community Health Worker Services: Community Health Worker Services will be provided consistent with the Community Health Worker State Plan.
Services Provided Upon Release: Services provided upon release include:
Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan).
DME consistent with Medi-Cal State Plan requirements.

Future State:
Readiness for Pre-Release Services
To ensure the delivery of services in the pre-release period, and as required by the demonstration's STCs, DHCS established policy will require all correctional facilities to demonstrate their readiness to be able to provide pre-release services in order to participate in the Reentry Demonstration Initiative prior to going live with pre-release services. (See Section 5.a. for more details on readiness assessments.)

Correctional agencies must submit their readiness assessments on behalf of all correctional facilities within their jurisdiction to DHCS at least five months prior to their proposed go-live date, on behalf of all facilities under their authority. (November 2022-April 2026) As part of the correctional facility readiness assessment, DHCS will assess correctional facilities' ability to provide pre-release services to individuals who are eligible. Correctional facilities will need to demonstrate readiness related to Medi-Cal application and suspension processes as well as the following service provision-related activities:
90-Day Pre-Release Eligibility and Behavioral Health Linkage Screening
Screening for Pre-Release Services
Screening for Behavioral Health Linkages
90-Day Pre-Release Service Delivery
Medi-Cal Billing and Provider Enrollment (more on this below)
Support of Pre-Release Care Management
Clinical Consultation
Virtual/In-Person In-Reach Provider Support

Support for Medications
Support for MAT
Support for Prescriptions Upon Release
Support for DME Upon Release
Reentry Planning and Coordination
Release Date Notification
Care Management Reentry Plan Finalization
Reentry Care Management Warm Handoff
Reentry Behavioral Health Linkage
Oversight and Project Management
Staffing Structure and Plan
Governance Structure for Partnerships
Reporting and Oversight Process

Provider Enrollment Processes
In order for correctional facilities to deliver and be reimbursed for targeted pre-release services (e.g., care management, medications, MAT, and labs/radiology), each facility will need to enroll as a Medi-Cal provider. (November 2022-April 2026)

Correctional facilities will enroll in Medi-Cal through the following provider enrollment pathways:
Correctional Pharmacy Enrollment: DHCS will require that each State prison, county jail, and youth correctional facility with an on-site pharmacy enroll as a Medi-Cal pharmacy. Enrollment will be location-specific, and only one pharmacy per site must enroll.

Correctional Provider Enrollment: DHCS will require that each State prison, county jail, and youth correctional facility enroll as a Medi-Cal provider under the Medi-Cal exempt from licensure clinic status. Enrollment will be location-specific, and only one provider enrollment per site will be required. The clinic that is enrolled in Medi-Cal within the correctional facility must oversee all billing submitted to DHCS, with the exception of community-based, in-reach providers who will be separately enrolled as Medi-Cal providers and directly bill DHCS for services.

Required processes for all providers delivering pre-release services include the following:
All providers delivering services within the correctional facility will be licensed, registered, certified, or otherwise appropriately credentialed consistent with Medicaid State Plan requirements.
The State will leverage existing program integrity processes for ongoing oversight and monitoring.

A limited number of correctional facility-based providers who order, prescribe, or refer services and medications may not be required to enroll in Medi-Cal but will be required to meet the State's Medi-Cal provider participation requirements.

Pre-release care management may be provided by embedded care managers or in-reach care managers and will be reimbursed on a fee-for-service (FFS) basis. To ensure continuity between the pre- and post-release periods, community-based care managers who will serve the justice-involved population must agree to enroll as FFS Medi-Cal providers and be willing to, at minimum, conduct in-reach warm handoffs with an embedded pre-release care manager.

Operational Guidance for Short-Term Stays
To support the provision of services to individuals who have short stays in correctional facilities and unpredictable release dates (e.g., non-sentenced individuals in jails or youth in county youth correctional facilities), DHCS developed a chapter in the Policy and Operational Guide on how to provide pre-release services to individuals with short-term stays and/or unknown release dates. The Policy and Operational Guide includes minimum requirements and timelines for correctional facilities to provide Medi-Cal screening, pre-release eligibility screening, provision of pre-release services, and reentry planning and coordination as well as best practices based on duration of stay at a correctional facility. Examples of minimum requirements for correctional facilities include screening for pre-release service eligibility and behavioral health needs for all individuals incarcerated at least 48 hours, submitting Medi-Cal applications to the SSD for all individuals incarcerated at least 72 hours, and completing a care needs assessment within

the first seven days of incarceration.

In addition to the readiness assessment and short-term model, DHCS will establish clear guidance for care managers on their role and responsibility to ensure correctional facilities and in-reach providers are able to deliver pre-release services.

Duration of Pre-Release Services
DHCS will track the duration of service provision to ensure coverage of pre-release services does not exceed 90 days per facility stay. For example, there may be circumstances where an individual could receive 90 days of pre-release services in a county jail and then be transferred to a State prison and receive 90 days of pre-release services in that facility prior to their release. While the individual may receive pre-release services under these circumstances, such time period may not exceed 90 days per facility. In addition, in the rare circumstances that an individual was provided pre-release services in a county jail and not released to the community, the State's tracking system will monitor length of stay and ensure that no payment will be made for services provided to an individual whose length of stay exceeds 90 days.

2.c. Develop State process to ensure care managers have knowledge of community-based providers in communities where individuals will be returning upon release or have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar.

Current State:
DHCS does not yet have pre-release care management processes in place.

Future State:
Care management is a critical component of the State's Justice-Involved Reentry Initiative and essential to supporting individuals preparing for community reentry.

DHCS will require that all individuals receiving pre-release services are assigned a pre-release care manager within 48 hours of being identified as eligible for pre-release services. Pre-release care managers will either be in-reach, community-based care managers or embedded correctional facility providers. DHCS defines "in-reach care management model" as a model through which Medi-Cal-enrolled, community-based care management providers deliver care management services to individuals in correctional facilities, either in person or via telehealth. "Embedded care management" is a model through which the correctional facility employs or contracts with care managers to provide services in the correctional facility. All pre-release care managers will bill for services on a fee-for-service basis. Upon release, individuals who received pre-release service and who are eligible for managed care will be auto-assigned (with subsequent choice period) into a managed care plan and qualify for the Enhanced Care Management (ECM) benefit.

31 More information on CalAIM's enhanced care management benefit is available here: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

DHCS aims to maximize continuity of care management across the pre- and post-release periods. DHCS will strongly encourage correctional facilities to use a community-based, in-reach care manager that serves the individuals during both their pre- and post-release periods, such as community-based ECM providers that will continue to provide ECM services to individuals following their reentry into the community.

32 In the post-release period, once the individual is enrolled in managed care, the care management provider will provide ECM services.

32

If the correctional facility elects an embedded care management model, the pre-release care management provider will be required to facilitate a warm handoff to the community-based, post-release ECM care manager prior to release (ideally at least two weeks prior to release). DHCS will establish standard requirements for embedded care managers to implement warm handoffs with community-based care managers during the reentry process.

As part of the warm handoff process, an embedded care manager is expected to work closely with the individual's assigned community-based, post-release ECM care manager to identify necessary community resources, as needed. As part of the care model, embedded and community-based care managers should have information about providers in the communities in which the individual is being released, and the skill and resources to connect the individual to those providers. Upon release, individuals who receive reentry services and are eligible for Medi-Cal managed care will be auto-assigned (with subsequent choice period) to a managed care plan and qualify for ECM.

33 More information on CalAIM's enhanced care management benefit is available here: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

33

To facilitate assignment of community-based, in-reach care management, as part of the provider directory requirements under the Medi-Cal managed care plan (MCP) contracts, DHCS will require MCPs to develop and maintain a list of care managers that have agreed to serve as pre-release care managers (via fee-for-service) and post-release ECM providers (via managed care).

Correctional facilities will be required to update their internal processes to accommodate the pre-release services care management model, including the use of the care manager provider directory.

DHCS will release the Policy and Operations Guide to stakeholders to support implementation of pre- and post-release care management to ensure individuals are able to access needed services upon their reentry into the community. (Summer 2023) DHCS will also release an All Plan Letter that will reference the requirements as laid out in the Policy and Operations Guide. (Summer 2023)

Milestone 3: Promoting continuity of care
STC Language: The State must describe its process to ensure that beneficiaries receive a person-centered plan for coordination post-release to address health needs, as well as HRSN and LTSS, as applicable. The State must detail its plans and timeline for implementing State policies to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the care management assessment and the development of the person-centered care plan. The State must describe its processes for promoting and ensuring collaboration between care managers, providers of pre-release services, and providers of post-release services to ensure that appropriate care coordination is taking place. As applicable, the State must also describe the planning or projected activities to ensure that Medicaid managed care plan and county behavioral health plan contracts include requirements and processes for transfer of relevant health information from the carceral facility, community-based providers, and/or State Medicaid agency to the managed care plan to support continuity and coordination of care post-release.
Prompts
Summary

3.a. Implement a State requirement that individuals who are incarcerated receive a person-centered care plan prior to release to address any physical and behavioral health needs, as well as HRSN and consideration for long term services and supports (LTSS) needs that should be coordinated post-release, that were identified as part of pre-release care management activities and the development of the person-centered care plan.
Current State:
DHCS does not have pre-release care management processes in place.

Future State:
Care management is a critical component of the State's Reentry Demonstration Initiative and is essential to supporting individuals in preparing for community reentry. As a part of pre-release care management for Medi-Cal enrolled individuals who are incarcerated, a pre-release care manager must develop a transitional care plan with and for the individual.

This transitional care plan must include, at minimum:
A completed whole-person care plan assessment that includes an assessment of mental health, substance use, physical health, long-term services and supports (LTSS) needs, health related social needs (HRSN), and functional needs. This assessment must be completed by a licensed professional (e.g., RN care manager, LCSW).
A post-release service needs assessment, including assessment related to functioning in the community upon release such as HRSN; considerations for LTSS; medication management; scheduling community-based appointments; paying bills; and utilizing electronic communication.
Plans for post-release medications, including ensuring that the medications have undergone any prior authorizations (PAs) or other requirements for coverage, if necessary.
Plans for DME, including ensuring that DME prescriptions have undergone any treatment authorization reviews (TARs) or other requirements for coverage, if necessary.
Coordination, scheduling, and linkages to required reentry services, including:
MAT and psychotropic medications.
Identification of a primary care provider and follow-up appointment scheduled at appropriate time post-release.
Required specialty, mental health, substance use, dental, and MCP community supports appointments.
Community service referrals.
HRSN referrals (e.g., nutrition, housing, transportation).
LTSS referrals.
Scheduled follow-up appointments with community-based providers, including primary care and others as clinically indicated, to ensure they have access to needed clinical services as soon as necessary and no later than 30 days from release.
Scheduled follow-up appointments with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary, no later than 30 days from release.
Coordination of reentry logistics, including transportation.
Ensuring that, as allowed under federal and State laws and always through consent with the beneficiary, data are shared with MCPs, county mental health plans, DMC/DMC-ODS, and, as relevant, with physical and behavioral health providers to enable timely and seamless handoffs.
A plan for engagement of identified supports for the member (e.g., probation/parole officer, family, others).
A list of individuals/organizations that will receive the finalized transitional care plan prior to release.
Documentation of any additional consents needed to share information for seamless care.

The person-centered care transitional plan should be shared with the post-release ECM provider, if different than the pre-release care manager, and additionally shared with the individual upon their release. (See Section 3.d. for additional details.)

DHCS will release the Policy and Operations Guide to stakeholders to support implementation of pre- and post-release care management to ensure individuals are able to access needed services upon their reentry into the community. (Summer 2023) DHCS will also release an All Plan Letter that will reference the requirements as laid out in the Policy and Operations Guide. (Summer 2023)

DHCS will administer a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up pre-release and post-release care management processes. (May 2023)

3.b. Implement State policies to provide or facilitate timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health care needs identified in the course of care management and the development of the person-centered care plan.
Current State:
DHCS does not yet have processes in place to provide or facilitate timely access to post-release health care items and services.

Future State:
As described in Section 3.a., as a component of transitional care planning, the pre-release care manager must coordinate and schedule necessary post-release health care services, including but not limited to fills or refills of prescribed medications and medical supplies as well as DME, diagnostic, family planning, primary care, specialty, mental health, substance use, dental, or other services. For example:
Medications in Hand Upon Release. Correctional facilities will be required to provide a full supply of prescribed medications in hand to eligible individuals upon their release from a correctional setting for, at minimum, all individuals who have been incarcerated for more than 24 hours.

34 Full supply is defined as the maximum amount that is medically appropriate and allowed by the Medi-Cal State Plan. DHCS will provide additional guidance on minimum requirements for short-term stays in the Policy and Operational Guide.

34
Correctional facilities will also be required to provide naloxone upon release and a clinically appropriate supply of MAT with follow-up to support overdose prevention. In addition to providing the medications in hand upon release, the correctional facility will be required to submit a prescription for any active medication to a community pharmacy as appropriate and feasible so that the individual has access to refills. Correctional facilities and pre-release care managers are required to work with the post-release care manager (if different) to submit prescriptions and transfer medication refill orders to the individual's preferred community pharmacy, near the individual's anticipated residence in the community, as clinically appropriate.

35 DHCS understands there will be operational complexities for many individuals leaving prison who do not have an established residence/pharmacy. DHCS expects, at a minimum, that the care manager will be able to facilitate this linkage for individuals leaving prison. DHCS does not expect the same operational complexities to exist for those with shorter stays who have preexisting relationships with outpatient pharmacies and permanent preexisting addresses, such as those leaving jails.

35

Durable Medical Equipment. Correctional facilities will be required to screen for and provide necessary DME upon release for any individual who is incarcerated for longer than 14 days. Correctional facilities must ensure that, at a minimum, individuals who use DME reenter the community with a prescription for their DME in hand; the prescription should also be provided to the post-release ECM provider/care manager. Individuals entering the community with DME

in hand should also be provided with prescriptions for all necessary DME at the time of release in case the DME in hand is lost, stolen, or broken.

For individuals requiring new DME upon their release in the community, the correctional facility, pre-release care manager, and post-release ECM provider/care manager will be required to coordinate to ensure that residential DME is in place when needed. If the necessary residential DME cannot be set up by the time of release, the provider prescribing the DME must share a copy of the prescription and necessary clinical documentation with the individual and the post-release ECM provider/care manager to be filled in the community.

Behavioral Health Linkages. As part of the Reentry Demonstration Initiative, DHCS will require correctional facilities, county behavioral health agencies, and Medi-Cal managed care plans to implement behavioral health linkages to initiate behavioral health care services in the community and to ensure continuity in care management through professional-to-professional clinical handoffs.

36 Behavioral Health Linkage requirements are outlined in California Penal Code section 4011.11(h)(5) and consistent with the CalAIM behavioral health linkages initiative (see page 51 of the CalAIM Proposal and AB 133).

The State mandate to implement behavioral health linkages requires State prisons, county jails, youth correctional facilities, county behavioral health departments, and Medi-Cal managed care plans to implement processes for facilitated referrals and linkages to continue behavioral health treatment in the community for individuals who receive behavioral health services while incarcerated.

The State will provide services with reasonable promptness consistent with the unique circumstances and constraints of the carceral setting. DHCS will detail in the Policy and Operational Guide the requirements related to timeliness of provision of pre-release services and follow-up activities in the community (summer 2023), monitor reasonable promptness against these expectations (ongoing), and work with correctional facilities and community-based providers to continue to refine operational processes (ongoing).

DHCS will administer a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up pre-release and post-release care management processes. (May 2023)

3.c. Implement State processes to ensure, if applicable, that managed care plan contracts reflect clear requirements and processes for transfer of the member's relevant health information for purposes of continuity of care (e.g., active prior authorizations, care management information, or other information) to another managed care plan or, if applicable, State Medicaid agency (e.g., if the beneficiary is moving to a region of the State served by a different managed care plan or to another State after release) to ensure continuity of coverage and care upon release (coordinated with the requirements under milestone #1 above).

Current State:
DHCS does not yet have processes in place for the transfer of the member's relevant health information for the purposes of continuity of care.

Future State:
DHCS will take a multi-pronged approach to ensure continuity of coverage, information sharing, and alignment across the pre- and post-release periods. DHCS will require all pre-release care managers to share information gathered during the pre-release period, including the needs assessment and transitional care plan, with the post-release care manager, if

they are different. The elements of the transitional care plan that must be shared are described above. This information shall also include information related to all active prior authorizations and prescriptions. Everyone who is eligible for pre-release services will be eligible for a post-release ECM care manager, who will be responsible for assisting the individual in connecting to services in the post-release period.

Pre-release services will be delivered on a fee-for-service basis. To ensure smooth reentry, continuity of care management relationships, and access to providers as soon as possible when the individual is released into the community, DHCS will (1) auto-assign individuals to a managed care plan based on the County of Residence in MEDS at the time of release (with choice period post-plan assignment) and (2) establish current month enrollment (i.e., an individual would be enrolled in a managed care plan beginning the first of the month in which they are released).

DHCS will update managed care contracts (Medi-Cal managed care plans, county mental health plans, County Drug Medi-Cal Organized Delivery System, and Drug Medi-Cal State Plan) to reflect the requirements described above. (April 2024)

DHCS will release the Policy and Operations Guide that lays out requirements for information sharing across the pre- and post-release periods. (Summer 2023)

3.d. Implement State processes to ensure care managers coordinate with providers of pre-release services and community-based providers, if they are different providers. Implement a State policy to require care managers to facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care and seamless transitions without administratively burdening the beneficiary (e.g., identifying providers of post-release services, making appointments, having discussions with the post-release care manager, if different, to facilitate a warm handoff and continuity of services). A simple referral is not sufficient. Warm hand-offs to a post-release care manager and follow-up are expected, consistent with guidance language in the care management section.
Current State:
DHCS does not yet have processes in place to ensure care managers coordinate with providers of pre-release services and community-based providers, if they are different.

Future State:
In cases where pre- and post-release care managers are different (i.e., if the correctional facility leverages an embedded care management model or the individual is released to a different county from the correctional facility in which they are incarcerated), the two care managers must conduct a warm handoff with the individual prior to release. The warm handoff is the first step in establishing a trusted relationship between the individual and the new care manager and ensures seamless service delivery and coordination.

Minimum requirements for the pre- and post-release care managers conducting warm handoffs are as follows:
Sharing the transitional care plan with the post-release care manager and the individual's assigned MCPs;
Scheduling and conducting a warm handoff meeting that includes the individual and both the pre- and post-release care managers to begin establishing a trusted relationship, review the transitional care plan and address questions, and identify any outstanding service needs and supports required for successful community reentry.

For individuals with known release dates, DHCS recommends that the warm handoff meeting occur at least 14 days prior to release. Telehealth may be used to conduct warm handoffs. If it is not possible for the warm handoff, including the requirements listed above, to occur prior to the individual's release (e.g., if the individual is released by court order earlier than expected or has a very short stay), the pre- and post-release care managers must conduct the warm handoff in the community post-release within one week, but the pre-release care manager must share the reentry plan and other pertinent information with the post-release care manager and the assigned managed care plan within a clinically appropriate time frame (e.g., 24 hours after release).

In addition, correctional facilities, county behavioral health agencies, and MCPs must facilitate behavioral health linkages for all individuals who receive behavioral health services while incarcerated, including professional-to-professional clinical handoffs, facilitated referrals, and linkages to continued behavioral health treatment.

DHCS will release the Policy and Operations Guide that details the requirements as described above. (Summer 2023)
DHCS will also provide technical assistance to implementation stakeholders, as needed. (Ongoing)

DHCS will administer a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up processes for facilitating health service linkages upon release. (May 2023)

Milestone 4: Connecting to services available post-release to meet the needs of the reentering population
STC Language: The State must describe how it will develop and implement a system to monitor the delivery of post-release services and ensure that such services are delivered within the appropriate time frame, per the guidelines in the forthcoming State Medical Director Letter (SMDL). The Implementation Plan must also capture how the State will monitor and adjust, as needed, ongoing post-release care management and describe its process to help ensure the scheduling and receipt of needed services, as well as other services needed to address HRSN and LTSS. Additionally, the State must describe how it will ensure that care managers are able to effectively serve demonstration beneficiaries transitioning into the community and recently released beneficiaries who are no longer demonstration beneficiaries.
Prompts
Summary

4.a. Develop State systems to monitor individuals who are incarcerated and their person-centered care plans to ensure that post-release services are delivered within an appropriate time frame. We expect this generally will include a scheduled contact between the reentering individual and the care managers that occurs within one to two days post-release and a second appointment that occurs within one week of release to ensure continuity of care and seamless transition to monitor progress and care plan implementation. These short-term follow-ups should include the pre-release and post-release (if different) care managers, as possible, to ensure longer-term post-release care management is as seamless as possible. In keeping with the person-centered care plan and individual needs, CMS is providing these general time frames as suggestions but recognizes that depending on the beneficiary's individualized needs and risk factors, a care manager may determine that the first scheduled contact with the beneficiary should occur, for example, within the first 24 hours after release and on a more frequent cadence in order to advance the goals of this demonstration.
Current State:
DHCS does not yet have State processes in place to monitor individuals who are incarcerated to ensure that post-release services are delivered within appropriate time frames.

Future State:
DHCS will require that an individual have a scheduled contact with a post-release ECM care manager as close to release as possible (e.g., within one or two days post-release) and a second appointment that occurs within one week of release to ensure continuity and seamless transitions.

Individuals transitioning from incarceration into the community will be eligible to receive the ECM benefit from their managed care plans in order to address clinical and non-clinical needs through intensive coordination of health and health-related services, as described in Section 3.c. above. Post-release care management will be delivered by ECM providers and monitored by managed care plans. ECM care managers will be responsible for meeting with the individual as close to the release date as possible (e.g., within one or two days) and make a follow-up appointment one week after release to ensure continuity of coverage. ECM care management includes:

37 See CalAIM Enhanced Care Management Policy Guide for more details on ECM services.

Conducting outreach and engaging individuals.
Updating the individual's needs assessment and care plan with newly identified needs.
Coordinating the services necessary to implement the care plan.
Providing health promotion services to encourage and support individuals to engage in healthy behaviors.
Supporting individuals and their support networks during discharge from the hospital or institutional settings.
Ensuring individuals and their support networks are knowledgeable about the individual's conditions.
Coordinating referrals and transportation to community and social services.

Additionally, justice-involved members enrolled in managed care plans will be eligible to receive in-lieu-of-services benefits (referred to as Community Supports in California) to meet their social needs, including medically supportive foods and housing supports. Once in the community, members will have a single ECM provider who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems, making it easier for them to get the right care at the right time.

DHCS will ensure post-release care managers are able to deliver post-release services in an appropriate time frame as part of the warm handoff requirements to a community-based care manager prior to release. The post-release care manager will be responsible for ensuring follow-up appointments are scheduled, work with the individual to attend these appointments (for example, helping with transportation), and follow up with the individual if an appointment is missed to ensure it is rescheduled and services are delivered. Post-release care managers will be based in the same geographic community that the member will reenter, ensuring the care manager will be familiar with local resources and provider networks.

DHCS will develop clear requirements on the development of whole-person care plan assessments—including assessment of mental health, substance use, physical health, health-related social needs, long-term services and supports, and functional needs—and the scope of these care plans, which should include plans that address the needs of the member in the community upon release.

As described in Section 3.c., DHCS will develop managed care plan auto-assignment enrollment processes for individuals eligible for pre-release services who are not currently enrolled in a managed care plan, ensuring members will be able to access the ECM benefit and Community Supports services in the community. (April 2024)

As described in Section in 3.d., the Policy and Operational Guide will provide guidance on the division of responsibilities during the warm handoff between pre- and post-release care managers (if applicable) and different entities involved in warm handoffs (correctional facilities, county behavioral health agencies, and managed care plans) to ensure continuity of care in the community. (Summer 2023)

DHCS will administer a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up processes for ensuring coordination across the pre- and post-release periods to ensure continuity of care. (May 2023)

4.b. Develop State processes to monitor and ensure ongoing care management to ensure successful transitions to the community and continuity of care post-release; to provide an assessment; monitor the person-centered care plan implementation and to adjust it, as needed; and to ensure scheduling and receipt of needed covered services.
Current State:
DHCS does not yet have State processes in place to monitor ongoing care management to ensure successful transition to the community and continuity of care post-release.

Future State:
When released into the community, individuals will be enrolled in a managed care plan and receive ECM services. Managed care plans oversee the delivery of the ECM services, and the State will continue to oversee and monitor the delivery of ECM for this population, as part of its overall ECM oversight and monitoring processes.

Every managed care plan will be expected to submit to the State a Model of Care on the plan to provide ECM to its Justice-Involved Population of Focus (which includes all individuals who were found eligible for pre-release services). DHCS will release the Model of Care template to managed care plans. (Summer 2023) MCPs must submit their Model of Care plans to DHCS for review and approval. (Fall 2023) The State will review and approve the plans' Model of Care and continue to oversee and monitor each plan's implementation. (November 2023) This process will be built into the State's overall managed care plan oversight and monitoring processes.

As a companion to the Model of Care, DHCS will detail in the Policy and Operational Guide all the requirements for the ECM post-release care manager. (Summer 2023)

DHCS will meet regularly with the managed care plans to provide ongoing technical assistance, as needed.

4.c. Develop State processes to ensure that individuals who are receiving services through the Reentry Section 1115 Demonstration Opportunity are connected to other services needed to address LTSS and HRSN, such as housing, employment support, and other social supports as identified in the development of the person-centered care plan.
Current State:
DHCS does not yet have processes in place to connect individuals eligible for pre-release services to services post-release.

Future State:
As described in Section 3.c., part of pre-release care management for Medi-Cal-enrolled individuals who are incarcerated includes the development of a transitional care plan with the individual; this transitional care plan will include a plan to address LTSS, HRSN, and other social supports available to members once they are in the community. Additionally, as described in Section 4.a., members eligible for managed care will be automatically enrolled into a managed care plan and eligible for the ECM benefit and Community Supports. (Community Supports are available at plan discretion, and individuals must meet eligibility criteria to receive Community Supports.)

DHCS will develop monitoring and evaluation protocols with managed care plans to ensure JI members have access to LTSS, HRSN, and other social support services identified through care needs assessments.

DHCS will detail in the Policy and Operational Guide requirements related to connecting individuals to LTSS, HRSNs, and other social supports. (Summer 2023)

DHCS will meet regularly with the managed care plans to provide ongoing technical assistance, as needed.

4.d. Implement State policies to monitor and ensure that care managers have the necessary time needed to respond effectively to individuals who are incarcerated who will likely have a high need for assistance with navigating the transition into the community.
Current State:
DHCS does not yet have processes in place to connect individuals eligible for pre-release services to services post-release.

Future State:
As described in Section 5.a. below, correctional facilities will be required to demonstrate readiness for providing pre-release services. This readiness assessment will include process development and capacity building for delivering care management services and connecting incarcerated individuals to community-based providers.

DHCS will provide operational guidance for correctional facilities on navigating short-stay situations, including minimum requirements and timelines for correctional facilities to provide pre-release care management services and coordinate with community-based providers.

Upon release, individuals who are eligible for pre-release services will also be eligible to receive ECM, which is a managed care plan benefit available to high-need managed care plan members that provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. ECM providers will coordinate all care across the physical and behavioral health delivery systems. ECM providers will play a critical role in supporting individuals' transitions into the community. More information about ECM can be found in the ECM Policy Guide.

38 ECM Policy Guide is available here: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

DHCS will release the Policy and Operations Guide that details the requirements as described above. (Summer 2023)
DHCS will also provide technical assistance to implementation stakeholders, as needed. (Ongoing)

DHCS will administer a PATH capacity building funds process to support correctional facilities in their implementation processes. Correctional facilities may use PATH funds to set up processes for facilitating health service linkages upon release. (May 2023)

DHCS will develop monitoring and evaluation protocols to monitor managed care plans and correctional facilities to ensure justice-involved members are accessing pre-release care management services in a timely manner.

Milestone 5: Ensuring cross-system collaboration
STC Language: The State must describe how correctional facilities will facilitate access to incarcerated beneficiaries for community health care providers, including care managers, either in person or via telehealth. The State must also document its plans for establishing communication and engagement between corrections systems, community supervision entities, health care organizations, the State Medicaid agency, and supported employment and housing organizations. The State must also develop a system (e.g., a data exchange, with requisite data-sharing agreements) and establish processes to monitor individuals' health care needs, HRSN, and access to and receipt of health care services pre-and post-release, and identify anticipated challenges and potential solutions. Further, the State must develop and share its strategies to improve awareness about Medicaid coverage and access among stakeholders, including those who are incarcerated.
Prompts
Summary

5.a. Establish an assessment outlining how the State's Medicaid agency and participating correctional system/s will confirm they are ready to ensure the provision of pre-release services to eligible beneficiaries, including but not limited to how facilities participating in the Reentry Section 1115 Demonstration Opportunity will facilitate access within the correctional facilities for community health care providers, including care managers, in person and/or via telehealth, as

appropriate. A State could phase in implementation of pre-release services based on the readiness of various participating facilities and/or systems.
Current State:
To ensure the delivery of high-quality services in the pre-release period, and as required by the 1115 Waiver's Special Terms and Conditions, DHCS developed readiness assessment elements that lay out what correctional facilities must demonstrate in order to be eligible to "go live" with the delivery of pre-release services.

Correctional agencies must submit their readiness assessments to DHCS on behalf of all facilities under their authority at least five months prior to their proposed go-live date. (As early as November 2023) DHCS recognizes that some agencies may not have all the required capabilities in place for all five focus areas described below (and/or for each of their facilities) at the time of submitting their readiness assessment. In these instances, agencies will be asked to describe their plan for achieving readiness prior to (or shortly after) the planned go-live date.

The correctional facility readiness assessment will assess the ability of correctional facilities to implement and support the focus areas listed below. All correctional facilities will be required to demonstrate ability to designate space for in-reach meetings, including physical space for in-person visits and/or space and technology for individuals to connect to virtual consultation (e.g., laptop or similar device, webcam, internet access, telephone line) while ensuring appropriate security protections remain in place (e.g., Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance). While DHCS will have certain elements marked as minimum requirements, all aspects of the readiness assessment must still be supported and ready to go live by March 31, 2026; however, DHCS may use discretion when reviewing these elements to determine whether an agency is ready to go live.

The focus areas are:
Medi-Cal Application Processes
Screening
Application Support
Unsuspension/Activation of Benefits
90-Day Pre-Release Eligibility and Behavioral Health Linkage Screening
Screening for Pre-Release Services
Screening for Behavioral Health Linkages
90-Day Pre-Release Service Delivery
Medi-Cal Billing and Provider Enrollment
Support of Pre-Release Care Management
Clinical Consultation
Virtual/In-Person In-Reach Provider Support
Support for Medications
Support for MAT
Support for Prescriptions Upon Release
Support for DME Upon Release
Reentry Planning and Coordination
Release Date Notification
Care Management Reentry Plan Finalization
Reentry Care Management Warm Handoff
Reentry Behavioral Health Linkage
Oversight and Project Management
Staffing Structure and Plan
Governance Structure for Partnerships
Reporting and Oversight Process

For each of the five focus areas, DHCS will determine a score based on the correctional agency's attestation and documentation of their readiness for implementing pre-release services. The team will use the following scoring rubric to determine the score for each focus area:
Pass: Correctional agency's response is complete and indicates total or almost total readiness in the focus area across all facilities.

Partial Pass: Correctional agency's response is complete and indicates that some, but not all, facilities within the agency are ready to go live.
Fail: Correctional agency's response is incomplete, the provided response does not sufficiently address the question, or the provided response does not indicate readiness to go live.

To receive approval from DHCS to go live, a correctional agency must receive a "Pass" in all five focus areas and for each element categorized as a minimum requirement, indicating that the correctional agency is ready to go live. In some cases, a correctional agency may receive a "Partial Pass," indicating that some, but not all, facilities are ready to go live. In these cases, DHCS will work with the correctional agency to provide partial approval to allow facilities that are ready to go live to do so rather than require them to wait until the remaining facilities in the county are ready. If a correctional agency receives a "Fail" in any focus area, DHCS will engage the correctional agency on corrective actions to work toward readiness by the proposed go-live date or for a future go-live date.

Future State: DHCS will finalize the correctional facility readiness assessment and release it to the market in Q4 of 2023. (November 2023) DHCS will review assessments and provide approval, on a rolling basis, to facilities demonstrating readiness to go live, with an earliest anticipated go-live date of April 1, 2024.

5.b. Develop a plan for organizational-level engagement, coordination, and communication between the corrections systems, community supervision entities, health care providers and provider organizations, State Medicaid agencies, and supported employment and supported housing agencies or organizations.
Current State: DHCS has been facilitating regular meetings of the cross-sector stakeholder Justice-Involved Advisory Group since 2021. The purpose of the Advisory Group is to communicate program policy, solicit stakeholder feedback, and share best practices among implementing entities. Members of the Advisory Group include representatives of corrections systems, community supervision entities, health care providers and provider organizations, county entities, and social services organizations.

DHCS has also been facilitating, and intends to continue to facilitate, one-on-one technical assistance sessions with implementation stakeholders including but not limited to State prisons, county jails, providers, individuals with lived experiences, and managed care plans. Based on the implementing stakeholder, DHCS has been meeting on a weekly, biweekly, monthly, or quarterly basis.

DHCS has also taken steps to support information sharing between implementing entities. In July 2021, Governor Newsom signed into law the health omnibus trailer bill legislation for the 2021-2022 California Budget (AB 133; Chapter 143 of Statutes of 2021). In recognition of the importance of information sharing in supporting collaboration and communication as part of the implementation of the Reentry Demonstration Initiative and other components of CalAIM, AB 133 included provisions to permit CalAIM participants to disclose personally identifiable information—including protected health information—among one another so long as such disclosure is (1) necessary to implement CalAIM components or the CalAIM terms and conditions and (2) consistent with federal law. AB 133 also modified the California Penal Code to promote information sharing for the purposes of health insurance affordability program enrollment and the provision of behavioral health services post-release. DHCS released guidance on these provisions to the public in March 2022.

39 Guidance is available here: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance.pdf.

As part of the CalAIM Reentry Demonstration Initiative approval, DHCS received authority to provide capacity

building grants to implementation partners, known as the PATH initiative. DHCS will disseminate up to $410 million in capacity building funds to support cross-stakeholder planning and implementation of pre-release and reentry services in the 90 days prior to an individual's release into the community. The capacity building funds will provide funding to support the planning and implementation of the provision of targeted pre-release Medi-Cal services to individuals in State prisons, county jails, and youth correctional facilities who meet the eligibility criteria as outlined in the CalAIM Reentry Demonstration approval.

40 Additional guidance on this funding can be found on the DHCS CalAIM JI website under the Providing Access and Transforming Health Initiative section, available here: https://www.dhcs.ca.gov/CalAIM/Pages/Justice.aspx.

PATH capacity building funds for pre-release services are available to correctional facilities and county behavioral health agencies and are intended to support cross-stakeholder coordination. PATH funds may be used toward "activities to promote collaboration," i.e., expenditures related to facilitating collaborative planning activities between correctional agencies, MCPs, county behavioral health agencies, and other stakeholders as needed to support planning, implementation, and modification of Medi-Cal pre-release service processes. PATH grant awardees are also required to submit periodic progress reports, which include a description of collaborations or working sessions with local SSDs, local Medi-Cal MCPs, in-reach providers, and correctional agencies/county behavioral health agencies.

Future State:
DHCS will continue to facilitate the Advisory Group and one-on-one technical assistance sessions with implementation partners. (Ongoing)

DHCS will update the data-sharing guidance to include additional use cases and clarifications. The revised guidance is planned for release in June 2023, and additional updates may be released in the future.

DHCS will release the Policy and Operations Guide that details the requirements as described above. (Summer 2023)
DHCS will also provide technical assistance to implementation stakeholders, as needed. (Ongoing)

DHCS will administer a PATH capacity building funds process to support correctional facilities in their implementation processes. (May 2023)

5.c. Develop strategies to improve awareness and education about Medicaid coverage and health care access among various stakeholders, including individuals who are incarcerated, community supervision agencies, corrections institutions, health care providers, and relevant community organizations (including community organizations serving the reentering population).
Current State: DHCS has taken a multi-pronged approach to improving stakeholder awareness about the Medicaid program and its Reentry Demonstration Initiative. Since 2021, DHCS has hosted 10 Advisory Group webinars about the Reentry Demonstration Initiative to inform the key stakeholders about design decisions, program requirements, and key milestones; these webinars were also open to the public and allowed a chance for non-advisory group members to provide feedback on the Reentry Demonstration Initiative. DHCS has also regularly facilitated meetings of a cross-sector stakeholder advisory group to inform program design, with representation from corrections systems, community supervision entities, health care providers and provider organizations, county entities, and social services organizations. DHCS has also pursued targeted engagement of an array of stakeholders to provide one-on-one ongoing education and technical assistance (e.g., meeting weekly with the State prison system, establishing a small working group of correctional facilities and providers to inform the initiative's billing and claiming approach).

DHCS has also released formal policy and guidance to support program implementation. In 2022, DHCS released guidance to help correctional agencies, county social services departments, and other implicated entities fulfill their obligation to support incarcerated individuals in completing an application for Medi-Cal coverage prior to their release.

41 See ACWDL 22-27 (November 10, 2022) for more information on pre-release application processes.

41
In 2023, DHCS also released State guidance to provide information to correctional agencies on how to access a tool to verify an individual's enrollment in Medi-Cal.

42 See MEDIL 23-24 (April 13, 2023) for more information on policies and procedures for county Medicaid eligibility departments and county correctional facilities to document implementation efforts of the pre-release Medicaid mandate.

42

Future State: DHCS will release the Policy and Operational Guide to support stakeholder implementation of the Reentry Demonstration Initiative. Guidance will leverage standard DHCS processes and instruments and will include:
Release Policy and Operational Guide laying out operational and information sharing expectations. (Intended audience: all interested stakeholders) (Summer 2023)
All County Welfare Directors Letter (ACWDL) that provides an overview of the Reentry Demonstration Initiative. (Intended audience: primarily county social service departments) (Summer 2023)
Behavioral Health Information Notice (BHIN) that provides an overview of the Reentry Demonstration Initiative. (Intended audience: primarily county behavioral health agencies) (Summer 2023)
All-Plan Letters that provide an overview of the Reentry Demonstration Initiative. (Intended audience: primarily Medi-Cal managed care plans) (Summer 2023)
Updates to the Medi-Cal Provider Manual, as needed. (Intended audience: Medi-Cal-enrolled providers) (Summer-Fall 2023)

DHCS will announce the release of guidance through standard channels including press releases, email listservs, social media, and presentation at meetings with stakeholder representation.

DHCS will also continue to provide targeted stakeholder engagement and technical assistance to implementing entities (e.g., correctional facilities, county agencies) partially informed by entities' responses to the justice-involved readiness assessments. (See 5.a. for additional information on readiness assessments.)

5.d. Develop systems or establish processes to monitor the health care needs and HRSN of individuals who are exiting carceral settings, as well as the services they received pre-release and the care they received post-release. This includes identifying any anticipated data challenges and potential solutions, articulating the details of the data exchanges, and executing related data-sharing agreements to facilitate monitoring of the demonstration, as described below.
Current State:
DHCS does not yet have a monitoring process in place to monitor the health care needs and HRSN of individuals who are exiting correctional facilities as well as the services required post-release.
Reentry Demonstration Initiative.

Future State:
DHCS will establish a comprehensive monitoring approach for the Reentry Demonstration Initiative, in alignment with the approved federal waiver and State monitoring priorities. The approved demonstration requires DHCS to submit a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration and regular Quarterly and Annual Monitoring Reports throughout the duration of the demonstration.

DHCS' monitoring approach will include:
A selection of quality-of-care and health outcomes metrics and population stratifications based on CMS' upcoming guidance on the Health Equity Measure Slate.
Standardized reporting on categories of metrics, including but not limited to beneficiary participation in demonstration components, number of primary and specialist provider participation, utilization of services, quality of care, and health outcomes.
Metrics related to:
Number of beneficiaries served, and types of services rendered under the demonstration.
Administration of screenings to identify individuals who qualify for pre-release services.
Utilization of applicable pre-release and post-release services (e.g., care management, MAT, clinical/behavioral health assessment pre-release and primary and behavioral health services post-release).
Provision of health or social service referral pre-release.
Participants who received care management pre-release and were enrolled in care management post-release.
Take-up of data system enhancements among participating carceral settings.
Methods and timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics.

DHCS will also convene stakeholders to understand anticipated data challenges and potential solutions (e.g., as part of a stakeholder advisory group meeting, engaging a targeted group of implementers).

In addition to the Reentry Demonstration monitoring, DHCS also intends to establish an overall program monitoring and evaluation approach. Building upon the readiness assessment process described above, DHCS will establish ongoing monitoring and oversight within the correctional facilities to ensure delivery of pre-release services consistent with the approved Demonstration and the State's Policy and Operational Guide.

DHCS will leverage available administrative data to support ongoing monitoring and oversight of the Reentry Demonstration Initiative, including but not limited to claims data of services provided to individuals during both the pre- and post-release periods. DHCS also expects to leverage data from the Justice-Involved Screening Portal to support data collection for individuals who were found to be eligible for services, with metrics to include the number of individuals found to be eligible and the duration of services received. DHCS is also exploring opportunities to partner with other State departments (e.g., California Department of Corrections and Rehabilitation) and implementing entities to leverage additional data to support ongoing oversight and monitoring.

DHCS will also administer PATH capacity building funding opportunities to support implementing entities in establishing the IT systems and processes to support monitoring. PATH funding opportunities will permit implementing entities to apply for funding to support the following activities, among other priorities:
Implementing Billing Systems: This includes expenditures related to modifying IT systems needed to support delivery of and billing for Medi-Cal Reentry Services (e.g., adoption of certified electronic health record (EHR) technology, purchase of billing systems).
Adoption of Certified EHR Technology: This includes expenditures for providers' purchase or necessary upgrades of certified EHR technology and training for the staff that will use the EHR.
Technology and IT Services: This includes the development of electronic interfaces for prisons, jails, and youth correctional facilities to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with correctional facilities, local county social services departments, county behavioral health agencies, and others, such as

MCPs and community-based providers.

Meeting Title:
[External] CMCS Access Policy Sprint Working Session

From:
"Walker, Jonathan" <JEWalker@manatt.com>

Sent:
8/1/2022 6:17:56 PM +0000

To:
"Boozang, Patricia" <PBoozang@manatt.com>; "Mann, Cindy" <CMann@manatt.com>; "O'Connor, Kaylee" <KOConnor@manatt.com>; "Striar, Adam" <AStriar@manatt.com>; "Serafi, Kinda" <KSerafi@manatt.com>; TSCHENCK@mitre.org; "Giles, John (CMS/CMCS)" <John.Giles1@cms.hhs.gov>; "Gibson, Alexis E. (CMS/CMCS)" <alexis.gibson@cms.hhs.gov>; "Gentile, Amy A. (CMS/CMCS)" <Amy.Gentile@cms.hhs.gov>; jbarrazacannon@mitre.org; rebeccacase@mitre.org

CC:
"Llanos, Karen E.(CMS/CMCS)" <Karen.Llanos@cms.hhs.gov>

Attendees:
Boozang, Patricia; Mann, Cindy; O'Connor, Kaylee; Striar, Adam; Serafi, Kinda; TSCHENCK@mitre.org; Giles, John (CMS/CMCS); Gibson, Alexis E. (CMS/CMCS); Gentile, Amy A. (CMS/CMCS); jbarrazacannon@mitre.org; rebeccacase@mitre.org; Llanos, Karen E.(CMS/CMCS)

Location:
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Start Time:
8/16/2022 4:00:00 PM +0000

End Time:
8/16/2022 5:00:00 PM +0000

Reminder Time:
8/16/2022 3:45:00 PM +0000

Is Recurring:
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Tentative

Attachments:
image001.jpg

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November 4, 2022

Daniel Tsai, Deputy Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Sent via email

Re: Healthy Michigan Plan Section 1115 Demonstration Extension Application

Dear Deputy Administrator Tsai:

We are writing with respect to Michigan's extension application for its section 1115 Medicaid demonstration, "Healthy Michigan Plan," which is set to expire December 31, 2023. The proposal, for which the state comment period just closed, seeks to extend the state's demonstration project for five years. The application that was posted for state public comment lacked the required information to comply with CMS's demonstration transparency requirements that are set out at 42 CFR § 431.408, failing to provide even a basic description of some of the waiver and expenditure authorities the state is requesting to continue. As a result, the State's forthcoming application to CMS cannot be deemed complete as set forth at 42 CFR § 431.412. We therefore ask that upon receipt of the state's application, you withhold your certification of completeness and instead return the application to the agency with direction to modify the application to meet the completeness requirements and to conduct an additional 30-day comment period so that the public has a meaningful opportunity to provide feedback on the state's proposals.

CMS regulations identify seven different elements that a demonstration extension application must include to be determined complete. At a minimum, Michigan's application that was posted in draft form for state-level comment fails to meet 42 CFR § 431.412(c)(2)(vii), which specifies that state must document their compliance with the public notice process set forth in 42 CFR § 431.408. Under this regulation, at 42 CFR § 408(a)(1)(i) a state's extension application must include "a comprehensive description of the demonstration application or extension to be submitted to CMS that contains a sufficient level of detail to ensure meaningful input from the public."

Michigan's application fails to provide a sufficient level of detail in its extension application as required by § 431.408(a)(1)(i). The sparse seventeen-page application does not contain key information about a number of the proposals the state seeks to continue, specifically those that would affect beneficiaries' access to care. A few examples of key missing details include:

- A description of the premium requirements for individuals with income above 100 percent of the federal poverty line with less than 48 cumulative months of coverage;
- A description of cost-sharing requirements, including who would be subject to copayments and the services for which copayments would be required;
- A description of the Healthy Behaviors Incentives Program, including what actions would qualify as a "healthy behavior" and the amount of cost-sharing reductions beneficiaries would receive for completing a "healthy behavior;" and
- A description of the penalty for individuals with incomes above 100 percent of the federal poverty line with 48 or more months of cumulative enrollment for non-payment of premiums

and not completing a health risk assessment – namely, the loss of coverage and undefined lockout period.

Additionally, the application fails include the hypothesis and evaluation parameters of the demonstration extension as required by 42 CFR § 431.408(a)(1)(i)(D). The state includes the goals for the demonstration extension and a summary of the evaluation of the current demonstration, but does not have the two elements specified in the regulation above. As you know, a section 1115 demonstration is an experiment – so to test the experiments authorized through these demonstrations a hypothesis is needed to explain the legitimate demonstration purpose while evaluation parameters explain how the state plans to identify the outcomes of the experiment. Without these details included in extension application, the experimental nature of the demonstration is undermined.

While the state provides high-level estimates of total enrollment over the proposed five-year extension period as required by 42 CFR § 431.408(a)(1)(i)(C), it does not provide estimates on how each provision would affect enrollment, namely the disenrollment and lockout from coverage for those with 48 or more cumulative months of enrollment. Furthermore, a study of the state's own evaluation data has shown that premiums imposed on Healthy Michigan beneficiaries increased the likelihood of individuals voluntarily disenrolling from coverage; yet, there is no analysis highlighting the potential enrollment effects of this policy, or others. This is especially important given that several provisions have yet to be implemented due to the Families First Act continuous coverage protection so the extent of enrollment harms may be even larger than current data suggests.

This missing information significantly inhibits meaningful input from the public. Without the inclusion of key details about each provision and given the absence of hypotheses and evaluation parameters as well as the lack of detailed enrollment estimates, individuals who sought to submit comments on Michigan's extension application will have had no way to understand the full scope of what the state was proposing. Even if the state submits a more robust application to CMS to review for the federal comment period, that is not a sufficient remedy; the state must redo its state comment period with an improved application that provides a comprehensive description of the provisions the state is requesting to continue. The state's failure to include the information described above means that the state's extension application does not meet the regulatory requirement at 42 CFR § 431.408 for containing a sufficient level of detail to provide the public with an opportunity to provide meaningful input during the state comment period.

As such, we believe that the application does not meet the requirements for section 1115 extension applications under 42 CFR § 431.412 and should not be certified as complete. Instead, CMS should return the application to the state and advise the state to revise its proposal to include more information and re-open a full comment period so that the public can comment on the proposal in a meaningful way.

Please let us know if you have any questions.

Sincerely,

Joan Alker
Executive Director and Research Professor, Center for Children and Families Georgetown University McCourt School of Public Policy

Allison Orris
Senior Fellow, Center on Budget and Policy Priorities

Author: Allie Gardner
Creator: Microsoft Word
CreationDate: 2022-11-04 20:11:46
ModDate: 2022-11-04 20:11:46

Meeting Title:
[External] CMCS Access Policy Sprint Working Session

From:
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8/16/2022 3:50:53 PM +0000

To:
"Boozang, Patricia" <PBoozang@manatt.com>; "Mann, Cindy" <CMann@manatt.com>; "O'Connor, Kaylee" <KOConnor@manatt.com>; "Striar, Adam" <AStriar@manatt.com>; "Serafi, Kinda" <KSerafi@manatt.com>; TSCHENCK@mitre.org; "Giles, John (CMS/CMCS)" <John.Giles1@cms.hhs.gov>; "Gibson, Alexis E. (CMS/CMCS)" <alexis.gibson@cms.hhs.gov>; "Gentile, Amy A. (CMS/CMCS)" <Amy.Gentile@cms.hhs.gov>; jbarrazacannon@mitre.org; rebeccacase@mitre.org

CC:
"Llanos, Karen E.(CMS/CMCS)" <Karen.Llanos@cms.hhs.gov>

Attendees:
Boozang, Patricia; Mann, Cindy; O'Connor, Kaylee; Striar, Adam; Serafi, Kinda; TSCHENCK@mitre.org; Giles, John (CMS/CMCS); Gibson, Alexis E. (CMS/CMCS); Gentile, Amy A. (CMS/CMCS); jbarrazacannon@mitre.org; rebeccacase@mitre.org; Llanos, Karen E.(CMS/CMCS)

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8/16/2022 5:00:00 PM +0000

Reminder Time:
8/16/2022 3:45:00 PM +0000

Is Recurring:
false

Busy Status:
Tentative

Attachments:
image001.jpg; Appointment Wait-Time Enforcement Recommendations 08.10.22.docx; Manatt_MITRE Medicaid Managed Care Access Sprint Support Workplan 08.12.2022 (002).docx; Provider Survey Memo 8.12.22..docx; Reimbursement analysis example for Mitre.xlsx

[External] CMCS/Manatt/MITRE Access Spring Meeting

Tuesday, August 16, 2022, 12:00-1:00 pm ET

1. Review Draft Secret Shopper/Provider Survey Preamble and Regulatory Text Memorandum (see Provider Survey Memo 8.12.22 attached) - Manatt

• Share Key Takeaways from Interview with DC (8/15) (forthcoming)

2. Update on Status of Appointment Wait-Time Implementation and Enforcement Recommendations Memorandum (see Appointment Wait-Time 8.10.22 attached) - CMS

3. Discuss Next Steps/Timing for to Data-Driven Strategy for Monitoring Access - Manatt

4. Discuss how MITRE/Manatt can best support CMS during August through year-end (see revised Workplan attached) * Manatt

5. Next Steps (Manatt)
• Check-In on Participation in the NAMD Access Workgroup Meetings (CMS)
• Next Meeting: 8/25 * Proposed Agenda (Manatt)

? Discuss Optimizing the Online Experience for Individuals Enrolled in Medicaid Managed Care Memorandum
? Review Final Draft of Appointment Wait-Time Implementation and Enforcement Recommendations Memorandum
? Continue Discussing CMS Comments/Feedback on Status of Secret Shopper/Provider Survey Memorandum (as needed)

Attachments:
1. Secret Shopper/Provider Survey Memorandum
2. Appointment Wait-Time Implementation and Enforcement Recommendations Memorandum
3. Manatt/MITRE Medicaid Managed Care Access Sprint Support Workplan

Upcoming Medicaid Managed Care Access Spring Meetings with CMS/Manatt/MITRE:
• Thursday, August 25, 4:00 * 5:00 PM ET
• Monday, August 29, 10:00 * 11:00 am ET
• Month of September * TBD

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Manatt Health

2022-08-08T22:29:00Z

Manatt
CMS: Based on interview findings, we are recommending pivoting away from “secret shopper” language to “provider surveys” that may include both secret shopping and “revealed” shopping (which is required to determine some specific aspects of access).

Manatt Health

2022-08-08T22:30:00Z

Manatt
CMS: You could also consider a preemptive corrective action plan that you and the state could initiate prior to this point OR allowing a state to propose its own glidepath to come into compliance.

This might be appropriate if a state is taking aggressive steps to improve access, but will need time to see the fruits of its labor. For example, a state could work to increase rates, but changes might be contingent on state legislation, providers need time to enroll, etc.; or a state could have an IT fix related to provider enrollment and simplification but implementation won’t begin until year 3.

On the flipside, we worry this might give states an excuse to not meet the 3 year time period. It would have to be administered tightly, and perhaps with public notice/input.

Manatt Health

2022-08-08T22:30:00Z

Manatt
CMS: We are continuing to look into state examples so that we can make a recommendation that aligns with leading practices

Recommendations for CMS Enforcement of Appointment Wait-Time Standards
Wednesday, August 10th, 2022

Background
The Centers for Medicare & Medicaid Services (CMS) requested research and options on a structured Notice of Proposed Rulemaking (NPRM) approach to implementation and enforcement of state compliance with new appointment wait-time standards in Medicaid managed care.

1 States must adopt and enforce, at a minimum, appointment wait-times for: primary care (routine), adult and pediatric: 15 calendar days; OB/GYN (routine): 15 calendar days; outpatient behavioral health (mental health and SUD) (routine), adult and pediatric: 10 calendar days; and specialist (targeting identified gaps in access as determined by the State in an evidence-based manner), adult and pediatric: Number of calendar days as designated by the State based on targeted specialty and population.

1
As context for this request, CMS conveyed leadership's concern that the proposed appointment wait-times and 90 percent compliance threshold are aggressive, while acknowledging that the standards achieve the Administration's objective of bold access goals that are aligned across Medicaid, Medicare, and the Marketplace. CMS also shared leadership's desire to meaningfully enforce compliance with the new standards.

Below, we discuss several options for CMS to achieve a balance of (1) robust technical assistance (TA) to help states implement and meet new federal minimum appoint wait-time standards and related oversight requirements (e.g. provider surveys) with (2) effective enforcement when states fall short of compliance, and (3) options to promote transparency. These options will be further refined and prioritized through discussions with CMS, states, and other stakeholders.

Reminder: Summary of Straw Model Approach to Regulatory Requirements (Proposed on 6/23)

Establish minimum federal standards for appointment wait-times that: permit states to impose more stringent requirements and adopt additional requirements; and provide flexibility for CMS to evolve the "floor" over time.
Set a 90 percent compliance threshold for each provider/facility type (based on appointment wait-time standards established by the state in accordance with federal regulations). States and their health plans will also need to ensure that at least 90 percent of provider directory entries are accurate at all times.
Require states to conduct annual randomized surveys of providers to assess beneficiary access across plans, and submit to CMS and make public randomized provider survey results. Provider surveys will assess compliance with the state and federal appointment wait-time standards for each provider/facility type, among other access areas.

2 Note: We recommend updating the NPRM so that the survey documents compliance with both state and federal compliance (to the extent they diverge).

2
As part of public reporting, states must make available through an annual report data on service utilization across a range of enrollee characteristics.
Subject states to compliance reviews (at CMS discretion) for beneficiary access issues based on provider survey result data and in accordance with the newly refined proposed glidepath (see below – additional detail is forthcoming).

3 CMS plans to seek comment from stakeholders on an appropriate timeline for rolling out provider survey requirements.

3
Access issues will include noncompliance with federal minimum appointment wait-time standards and inaccurate provider directories.

Beginning 1 year after the effective date of the rule: States will be expected to procure vendors and conduct other preparations necessary to begin administering the provider surveys. CMS would provide robust TA for all states related to provider surveys and the new access requirements.
Beginning 2 years after the effective date of the rule: States will be expected to conduct a one year "beta test," wherein states would administer test surveys and report data to CMS; during the beta test year, states would not face enforcement actions from CMS based on survey results. CMS would continue to provide robust TA to all states.
Beginning 3 years after the effective date of the rule: CMS would begin holding states accountable for achieving at least 80% or 85% (TBD) compliance with the federal minimum appointment wait-time and provider directory accuracy standards based on survey results. CMS would provide targeted TA for states that are out of compliance with access requirements.
Beginning 4 years after the effective date of the rule and thereafter: CMS would hold states accountable for achieving at least 90% compliance with the federal minimum appointment wait-time and provider directory accuracy standards based on survey results. CMS would continue to provide targeted TA.

Illustrative, High-Level Glidepath
1 Year After the Rule
2 Years After the Rule
3 Years After the Rule
4+ Years After the Rule

States prepare to implement provider surveys
Robust CMS TA for all states
Beta test period for provider surveys
Robust CMS TA for all states
States held accountable for 80% or 85% compliance with access requirements
Targeted TA for non-compliant states
States held accountable for 90% compliance with access requirements
Targeted TA for non-compliant states

*Note: Manatt is continuing to refine this glidepath; additional detail and potential changes are forthcoming.

Give states with access issues the option to submit a Network Adequacy Justification Form to CMS to justify noncompliance with access standards. (We understand that CMS is moving away from this proposal, but wanted to flag that we originally included it to align with the 2023 NBPP.)
Require states to develop and submit a corrective action plan (at CMS' discretion) to document/ensure compliant practices and take affirmative steps to improve access.

Options: CMS Appointment Wait Time Standards: Implementation TA, Enforcement, and Transparency
Below we outline for CMS' consideration an approach to implementation and enforcement that includes an implementation glidepath inclusive of TA for states, CMS enforcement mechanisms, and options to promote transparency. This approach is designed to ensure that (1) states are able to efficiently design and implement new appointment wait-time standards and compliance oversight/reporting; and (2) federal and state partners can identify and address promptly access issues and continuously make program improvements, including through effective enforcement.

As noted above, CMS will receive provider survey results and hold states accountable for access issues, including not meeting the federal minimum appointment wait-time standards. While states have significant flexibility in imposing a continuum of enforcement actions on their health plans, CMS will need to determine/clearly define its own enforcement policy—ensuring it is robust enough to drive proactive state behavior as well as prompt corrective action as needed. While the pathway discussed below focuses specifically on appointment wait-time standards, CMS should also consider an implementation glidepath inclusive of TA as well as enforcement mechanisms/mitigation strategies for provider surveys (forthcoming

4 For example, CMS could (1) consider hosting learning collaborative meetings on provider survey program design and implementation as a standalone or as part of a broader Access Learning Collaborative to facilitate cross-state learnings on methodological and operational best practices and key challenges; and (2) provide states with a toolkit outlining detailed methodological best practices and potential study approaches in order to support states in complying with new survey requirements.

4
) and provider directory standards.

Implementation TA. In lead-up to and during the three-year period following the effective date of the rule (i.e., the period of time that states will have to implement provider surveys and come into compliance with appointment wait-time and provider directory standards), CMS' explicit drumbeat would be that every state should be using the time to come into compliance. To that end, CMS could provide early and ongoing intensive TA. For appointment wait-time standards, this could include:
A state-administered Access Diagnostic Assessment Tool for states to examine their current provider networks and identify access issues.
An Access Punch List of strategies for states to increase provider participation. Through the punch list, CMS could amplify best practices and mitigation strategies (e.g., assessing provider payment rates, coordinating and streamlining provider recruitment and credentialing, reducing provider administrative burden, timely enforcement mechanisms, etc.).
Learning Collaboratives and All State Calls/Webinars to roll out the assessment tool and punch list and tackle other thorny implementation issues that states (and their health plans) are grappling with as they ramp-up their processes to comply with the new access requirements. (As noted above, CMS' TA could also extend to provider surveys and provider directory requirements—though the TA approaches may differ.)

Enforcement. Beginning three years after the effective date of the rule, CMS would begin to hold states with beneficiary access issues accountable for meeting the federal standards.

5 If handled in accordance with CMS' expectations, standards, and processes, corrective action plans have potential to achieve measurable improvement in access. (Also see 42 CFR Part 430, Subparts C and D for federal regulations on enforcement of federal Medicaid requirements).

5
For appointment wait-time standards, CMS could expand on the enforcement process detailed in the strawmodel and summarized above by:
Requiring states that are noncompliant to develop within a specific period of time (e.g., one month) their own plans of corrective action and propose the remedy, which would require CMS approval. Rather than leaving this open-ended, CMS could develop a checklist (mirroring the Access Punch List provided during the TA period) wherein states would select the remedy (or remedies) themselves or propose an alternative, to be agreed upon and determined by the severity and nature of noncompliance. Clear timetables for taking the corrective action would be written into the plan. Any action undertaken by CMS and the corrective action plan itself would be publicly available through both the state and CMS websites.
In addition, the corrective action plan would reflect when a state is late in meeting or has otherwise failed to achieve the agreed-upon milestones. In this instance, CMS could automatically impose a financial penalty (e.g., a monetary sanction

6 At least one state, Florida, imposes a monetary sanction of $200 per day for each day the plan doesn't implement, to the satisfaction of the agency, the approved corrective action plan.

6
or withhold (see below) for each day the state does not satisfy CMS expectations). The state could appeal (on factual grounds) CMS's determination that they had not met the milestone. Consistent with the regulations at 42 CFR § 430.35(d)(1)(i), CMS would end the penalty (and potentially return the payments) when the Administrator "is satisfied regarding the state's compliance."

Per 42 CFR § 430.35, CMS can withhold payments (e.g., by reducing the Federal Medical Assistance Percentage (FMAP) or the amount of state expenditures subject to federal financial participation (FFP)) to a state Medicaid agency for failure to meet federal access requirements.
If the state subsequently achieves compliance and CMS is satisfied with the state's performance, CMS would need to resume payments. In determining the withhold amount, CMS could take into account factors, such as the degree to which the state is out of compliance (e.g., whether deficiencies are isolated or widespread, if they constitute a pattern of repeated noncompliance), level of harm done (or potential for harm) to beneficiaries, and state resources (e.g., workforce and budgetary constraints).
CMS also could return all or a portion of the financial penalties imposed by "investing" a share of savings from the withhold in state initiatives to make improvements in access.

Additionally, CMS could explore financial incentives, such as providing bonus payments to high-performing states (as it did for CHIPRA)—though this would require further exploration of the legal authority absent legislation. CMS could tier payments and provide higher bonuses based on the degree to which states exceed the federal compliance threshold. This extra financial support would demonstrate CMS' commitment to improving access and reward those states that similarly bear additional access-related costs to improve network adequacy.

Transparency on Access. In addition to the TA and enforcement approach described above, CMS could consider public transparency mechanisms to encourage compliance and allow for public input about compliance and any proposed corrective action. For example:
Public Reporting. Beyond requiring states to make public provider survey result data and submit the annual report (referenced above), CMS could post the results of state performance against appointment wait-time standards (and accuracy of provider directories/progress addressing disparities in access to care) to encourage compliance and recognize achievements. This could entail leveraging the Medicaid and CHIP (MAC) Scorecard or posting publicly access snapshots or a dashboard (see, for example, Florida's Medicaid Statewide Medicaid Managed Care Compliance Actions). If CMS ultimately decides to tie financial awards and/or penalties to state performance on access, this tool could also detail the financial breakdown by state.
Public Input. CMS could establish a process by which consumer groups, providers, and other interested parties could (1) comment on provider survey results, compliance plans, and enforcement actions, and (2) report ongoing systemic issues of access (as proposed in our straw model).

7 CMS could encourage or require states to establish a formal administrative process through which complaints alleging systemic shortfalls in access are submitted, investigated, and resolved. The process could be designed such that only complaints with sufficient initial information/evidence would proceed to investigation and resolution. The process would be different than and significantly more impactful than monitoring grievances filed by an individual beneficiary who cannot find a provider, for example. CMS encourages states to take on this oversight role and establish their own processes to ensure access. Also see recommendations to bolster the beneficiary support system.

7
At CMS' option, the complaints could be used as input into its oversight mechanism or as part of a more formal adjudicatory process (in light of the Armstrong Supreme Court case).

Quality Rating. CMS could create a quality rating system, as it has done for other programs (such as the Five-Star Quality Rating System for nursing homes), wherein it gives each state a rating between one and five stars. For example, states with three stars would be in compliance with federal standards, and those with five stars would be significantly exceeding the standards. (If CMS were to move forward with this proposal, we could further refine the proposed approach, taking into account the 90 percent threshold.)

Appendix: State Research

States use a multitude of network adequacy enforcement mechanisms—ranging from corrective action plans and sanctions to liquidated damages and contract terminations. Below, we highlight practices from select states that consider themselves leaders on network access.

Arizona. Based on a review of the state's Medicaid managed care contract, it's not entirely clear which enforcement mechanisms have been successful (from the state's perspective) in ensuring network adequacy. The state maintains the ability to impose a range of administrative actions (e.g., sanctions, notice to cure, and TA).
The contract includes the following provisions of note:
AHCCCS may impose Administrative Actions for material deficiencies in the Contractor's provider network.
AHCCCS will disenroll the member from the Contractor when not all related services are available within the provider network.
The Contractor shall develop and maintain a Network Development and Management Plan (NDMP) to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area and which ensures the provision of covered services. The submission of the NDMP to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The NDMP Plan shall be evaluated, updated annually, and submitted to AHCCCS.
The Contractor shall continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, member grievances, appeals, quality data, quality improvement data, utilization of services, member satisfaction surveys, and demographic data requirements. The Contractor shall also develop non-financial incentive programs to increase participation in its provider network when feasible.
The Contractor may request an exception to these network standards; it shall submit such a request for AHCCCS approval. In the event a Contractor is not able to meet set network standards, AHCCCS may review requested exceptions based upon a number of factors, including but not limited to, availability of out of network providers and geographic limitations of the service area.
The PBM subcontract shall include: a clause that allows for an annual review of the contract for rate setting, adjustments to market conditions, and to ensure network adequacy.

California. The California Department of Managed Health Care (DMHC) issued an order in Dec 2017 requiring nine health plans to terminate contracts with Employee Health Systems Medical Group as a result of blocking patient access to specialists. The basis for doing so was the Knox-Keene Act, which regulates health plans (and any provider or subcontractor providing services) and the health plan business in California to protect and promote the interests of enrollees. (Also see the Blue Shield of California Promise Health Plan's notice of potential contract termination and this 2021 CHCF brief.)

Florida. While Florida's Medicaid managed care contract does appear to include more robust requirements (with an emphasis on liquidated damages and reporting) related to ensuring access to provider networks, this dashboard and local news article suggest that network adequacy remains a significant issue (for health and dental plans, alike). The contract includes the following provisions of note:
The Managed Care Plan shall submit a provider network file of all participating providers to the Agency or its agent(s) on a weekly basis and at any time upon request of the Agency with sufficient evidence that the Managed Care Plan has the capacity to provide covered services to all enrollees.
The Managed Care Plan shall develop and maintain an annual network development plan, including processes and methods to develop, maintain, and monitor an appropriate provider network that is sufficient to provide adequate access to all covered services covered; interventions to address network gaps; evaluation of the effectiveness of interventions to address gaps; results of secret shopper activities; among other factors.
Liquidated damages, including but not limited to:

Failure to timely report, or provide notice for, significant network changes ($5,000 per occurrence).
Failure to comply with provider network requirements in the contract ($1,000 per occurrence).
Failure to update online and printed provider directory ($1,000 per occurrence).
Failure to provide covered services within the timely access standards ($500 per day, per occurrence).
Failure to provide covered services within the geographic access standards ($500 per day, per occurrence).
Failure to submit a provider network file that meets the agency's specifications ($250 per occurrence).
Any liquidated damages assessed by the Agency shall be due and payable to the Agency within 30 days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice. The Agency shall have sole authority to determine the application of an occurrence (e.g., per unit of service, per date of service, per episode of service, per complaint, per enrollee, etc.). The Agency may elect to collect liquidated damages: through direct assessment and demand for payment delivered to the Managed Care Plan; or by deduction of amounts assessed as liquidated damages from, and as set-off against payments then due to the Managed Care Plan or that become due at any time after assessment of the liquidated damages.
The Managed Care Plan agrees that failure to comply with all provisions of this Contract and 42 CFR 438.100 may result in the assessment of sanctions and/or termination of this Contract.

Tennessee. Tennessee similarly utilizes liquidated damages (in addition to corrective action plans) for violations related to time and distance standards, provider information accuracy, adequacy of provider networks, and provider network documentation. The contract includes the following provisions of note:
The CONTRACTOR shall monitor provider compliance with access requirements, including but not limited to appointment and wait times and take corrective action for failure to comply.
The CONTRACTOR shall submit monthly Provider Enrollment Files as follows: include information on all providers of covered services and shall provide a complete replacement for any previous Provider Enrollment File submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.
The CONTRACTOR shall submit an annual Provider Compliance with Access Requirements Report that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access standards as well as an emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. This report/plan shall also be available upon request.
For behavioral health and specialty care: At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency. The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.
Liquidated damages, including but not limited to:
$25,000 if ANY of the listed standards are not met, either individually or in combination, on a monthly basis (Time and travel distance as measured by provider network analytics software described by TENNCARE).
$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis

8 The liquidated damage may be waived if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of CHOICES HCBS provider serving the county and the CONTRACTOR has used good faith efforts to develop CHOICES HCBS providers to serve the county. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE.

(for executed provider agreements with providers to participate in the specialist provider network and the HCBS provider networks);
$25,000 per quarter if less than 90% of providers confirm participation in the CONTRACTOR's network (based on a

statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the CONTRACTOR's network).
$1,000 for each provider for which the CONTRACTOR cannot provide a signature page from the provider agreement between the provider and the CONTRACTOR (related to the provider enrollment file).

Manatt Health

2022-08-11T12:51:00Z

Manatt
CMS: Would PowerPoint slides (here and below) be helpful in advancing the work and driving decisions, or are you primarily relying on the memorandums?

Manatt Health

2022-08-11T12:51:00Z

Manatt
CMS: Following our discussion with you on 8/16, please let us know if you need additional detail to support the drafting of preamble language around the type of provider survey/secret shopper TA support that will be available to states — or if what we have provided is sufficient.

Manatt

2022-08-11T10:39:00Z

ks
CMS: Since you'll be heads-down on drafting in September, we'd suggest scheduling two 60 minute working sessions mid-month and at the end of the month. We can, of course, cancel as needed but thought it would be helpful to hold the time to discuss substantive issues as they arise

Manatt Health

2022-08-11T13:00:00Z

Manatt
CMS: We'd also welcome your input on how Manatt can best support your needs in September (e.g., ad hoc TA or "phone a friend" approach; product, tools, guidance development).

CMCS Access Strategy Development and Implementation: High-Level Workplan
MITRE and Manatt Health Proposed Topic Areas and Deliverables for August and September 2022
Updated August 12, 2022

#
Medicaid Managed Care Access Topic Area

1 Manatt is also continuing to provide limited support to the Medical Care Advisory Committee (MCAC) workstream that Aurrera and MITRE are leading.

1

Proposed Deliverable
Status
August
September

8/8
8/15
8/22
8/29
9/5
9/12

Appointment Wait Time Standards and Provider Survey/Secret Shopper Program

1
CMS Approach to Implementation and Enforcement of Appointment Wait Time Standards
Approach memorandum
Findings from state research and interviews

2 Manatt plans to share with CMS—based on additional research and interviews with states including Arizona, Florida, and Tennessee—detail on the enforcement mechanisms that are effective in addressing access issues and specific examples of states that impose penalties on plans for unsatisfactory performance against corrective action plans.

2

Proposed regulatory language, proposed preamble language, and/or proposed policy approach
Summary slides on recommended approach
In Progress
Discussion Draft (complete)
CMS Feedback on Draft
Final Draft
Slides

2

Provider Survey/Secret Shopper/Appointment Wait-Time Interviews Takeaways

Takeaways memorandum

In Progress
Initial Takeaways
Interim Takeaways
Final Takeaways

3
Provider Survey/Secret Shopper Program Requirements and Technical Assistance for States
Approach memorandum, including proposed regulatory and preamble language
Summary slides on recommended approach
In Progress

Discussion Draft

Final Draft and Slides

4
Provider Survey/Secret Shopper Technical Assistance Tools
TBD
Not Started

5
CMS Approach to Data-Driven Strategy for Monitoring Access
Approach memorandum, including proposed preamble language and preliminary strategy
Not Started

Discussion Draft

Targeting late Sept. or Early Oct. for Final Draft

Other Policy Areas

6

MLR: Recommendations on MLR Related to SDOH and Health Care Quality Improvement Activities

TBD
In Progress

7
Transparency: Optimizing the Online Experience for Individuals Enrolled in Medicaid Managed Care
Best practices memorandum
Summary slides on best practices
In Progress

Discussion Draft
Final Draft/
Slides

8
Provider Rate Transparency: Compliance, Monitoring/Oversight, and Enforcement (aligned across both FFS and MMC delivery systems—pending further discussion with CMS)

3 From Discussion with CMS: To promote alignment across delivery systems, states will be required to report on base rates benchmarked to Medicare, or the state plan fee schedule (i.e., FFS) when states cannot crosswalk to Medicare (e.g. for children's services, HCBS). States will also need to report separately on the impact of pass-through, supplemental, and directed payments on provider reimbursement. CMS clarified that the requirements will not include a rate floor and shared that, at this time, they are focused on the primary care, OB/GYN, behavioral health, and specialist provider types. CMS is interested in MITRE/Manatt's thinking and research around a compliance, monitoring, and oversight strategy.

3

TBD
Not Started

CMS/Manatt MITRE Meetings
Tuesday, August 16, 12:00 – 1:00 PM ET
Thursday, August 25, 4:00 – 5:00 PM ET
Monday, August 29 – 10:00 – 11:00 AM ET (scheduling in progress)
Month of September– TBD (proposing two meetings)

Manatt

2022-08-12T11:54:00Z

ks

Manatt

2022-08-10T12:34:00Z

ks
Note to CMS: We did not include PCCM entities here.

Leveraging Provider Surveys to Measure Access:
Proposed CMS Roadmap, Preamble and Regulatory Language
DRAFT August 12, 2022

DRAFT

DRAFT

Introduction
In order to assess Medicaid managed care plans' compliance with network adequacy standards, including forthcoming regulatory wait-time standards, the Centers for Medicare and Medicaid Services (CMS) intends to require states to conduct randomized provider surveys

1 In our previous memorandum, we referred to these surveys as "secret shopper studies". In this memorandum, we will refer to them as "provider surveys" in order to account for the potential for states to conduct both "secret" and

"revealed" surveys. We discuss the role of both of these survey types throughout this memorandum.

1 including "secret shopper" studies, and similar approaches except that the surveyors would reveal their affiliation with the state Medicaid agency. These types of provider surveys have been recognized by CMS and numerous stakeholders as an effective approach for helping to monitor Medicaid managed care plan provider networks, provider directory accuracy, and other elements of access to care.

2 It is notable given its purview that MACPAC did not recommend CMS rely on secret shoppers in its access recommendations. In our follow up conversation with them they attributed that decision more to not having the time to fully run to ground the issues identified; they did not conclude that the process had no value.

Building on the June 23, 2022 memorandum shared with CMS and our Managed Care Access Policy Sprint working session on July 14, 2022, the following: (1) lays out a proposed CMS Roadmap for implementing the provider survey, including secret shopper, requirements; and (2) offers proposed Preamble and regulatory language to inform the development of CMS' Notice of Proposed Rulemaking.

CMS "Roadmap" for Provider Survey/Secret Shopper Requirements
In order to support successful implementation of new provider surveys, including secret shopper studies, as a tool to improve Medicaid managed care access CMS may wish to consider a multi-pronged approach involving: regulatory requirements, sub-regulatory guidance, targeted technical assistance, and milestone reporting. We describe each of these steps in more detail below:

Regulatory Requirements. As described in Manatt's June 23, 2022 memorandum, we recommend that CMS promulgate regulations to establish the requirement for state provider surveys including minimum standards for survey design and implementation. This would allow CMS to establish a durable requirement for states to conduct provider surveys and provide minimum standards and high level expectations to ensure that states' survey approaches are consistent nationally, to the extent feasible, and meet CMS's goals. Proposed regulations should be drafted to provide CMS the flexibility to articulate more detailed provider survey requirements through sub-regulatory guidance, as CMS begins to work with states and other managed care implementation stakeholders to refine its point of view on provider surveys as a tool for access monitoring and oversight. Proposed regulation preamble language should signal to states that CMS recognizes that provider surveys are a significant undertaking, states will have flexibility with designing their provider surveys within federal regulatory and sub-regulatory parameters, that CMS intends to offer targeted policy and operational implementation technical assistance support to states, and that CMS intends to seek comment on an implementation glide path ranging over the course of five years. (See proposed regulatory and Preamble language below.)

Sub-regulatory Guidance. Following the release of minimum requirements in regulation, CMS will have an opportunity to release a more detailed and nuanced set of provider survey requirements through sub-regulatory guidance that may include a State Medicaid Director Letter and Frequently Asked Questions. Establishing more detailed requirements through sub-regulatory guidance would enable CMS to provide states with concrete guidelines about how to meet the new regulatory requirements and provide CMS with flexibility to nimbly modify survey requirements over time as CMS and states gain experience with provider survey development and implementation.

State Technical Assistance. During the glidepath leading up to the date when states are required to submit provider

surveys to CMS, and states are subject to compliance with the wait time requirements, and for several years thereafter as necessary, CMS will provide technical assistance to states, which may include:

Provider Survey Learning Collaborative. CMS could host a series of learning collaborative (LC) meetings on provider survey program design and implementation as a standalone or as part of a broader Managed Care Access LC to facilitate cross-state learnings on methodological and operational best practices and key challenges. CMS could leverage other CMS LC models in structuring this LC which generally include: a review of federal requirements, description of policy and operational options and implementation considerations, direct technical assistance and subject matter expertise through CMS and its contractors, highlights of state best practices (which are best received coming directly from state Medicaid officials), and a cross-state information sharing discussion facilitated by a set of structured discussion questions and an opportunity for states to ask direct questions to the CMS team.

Toolkit. CMS could also provide states with a toolkit that includes releasing tools and technical assistance documents that detail approaches, methodologies and best practices to support states in complying with new survey requirements. The toolkit, informed by state feedback and likely to be iterated upon over the course of the implementation ramp-up period, would include actionable information that states can use to field provider surveys to meet state-specific needs and comply with new federal requirements. Examples of tools may include example study protocol/methodological specifications, call scripts for different surveys (both secret shopper and revealed survey scenarios), provider sampling considerations and approaches to ensure adequate statistical accuracy and geographic and demographic representation, technical guidance on establishing "straw model" Medicaid shopping personas, unique considerations related to secret and revealed surveys, and detailed guidance on statistical approaches for analyzing survey results. The toolkit could also include a template provider survey design "template" that outlines the components of provider survey, including sample size specifications, consistent with CMS guidance, with help text and references to specific TA tools related to each survey component. The toolkit should provide resources that are applicable in diverse state scenarios, allowing them flexibility to tailor their studies to state-specific needs (e.g. frontier states versus smaller geography states that are densely populated).

Milestone Reporting. CMS may also wish to consider requiring states to report on the implementation status of their provider surveys based on milestones to be developed by CMS. CMS can then provide targeted technical assistance to states that appear to be delayed in the development and launch of their provider surveys.

Proposed Provider Survey Preamble Language

While states continue to make progress on strengthening access to care, CMS recognizes that there continues to be significant gaps in access to care for Medicaid beneficiaries, despite previous efforts by states Medicaid agencies and CMS. Evidence suggests that in some localities and for some services, it takes Medicaid beneficiaries longer to access medical appointments compared to individuals with other types of health coverage.

3 W. Hsiang, A. Lukasiewicz, and M. Gentry, "Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis," SAGE Journals, April 5, 2019, available at https://journals.sagepub.com/doi/full/10.1177/0046958019838118.

This may be exacerbated by difficulties in accessing accurate information about health plans' provider networks; while Medicaid managed care plans are required to make regular updates to their online provider directories, analyses of these directories suggest that a significant share of provider listings include inaccurate information on, for example, how to contact the provider, the provider's network participation, and whether the provider is accepting new patients.

4 A. Burman and S. Haeder, "Directory Accuracy and Timely Access in Maryland's Medicaid Managed Care Program," Journal of Health Care for the Poor and Underserved, available at https://pubmed.ncbi.nlm.nih.gov/35574863/; A.Bauman and S.Haeder, "Potemkin Protections: Assessing Provider Directory Accuracy an Timely Access for Four Specialties in California," Journal of Health Politics, Policy and Law, 2022, available at https://pubmed.ncbi.nlm.nih.gov/34847230/.

4
Relatedly, analyses have shown that the vast majority of services delivered to Medicaid beneficiaries are provided by a small subset of health providers listed in their directories, with a substantial share of listed providers delivering little or no care for Medicaid beneficiaries.

5 A. Ludomirsky, et. al., "In Medicaid Managed Care Networks, Care is Highly Concentrated Among a Small Percentage of Physicians," Health Affairs, May 2022, available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747.

5

CMS received several comments to the Access RFI requesting that CMS require more robust efforts by states to monitor against network adequacy and other access requirements, including through the use of direct provider surveys, transparency of the results of the surveys, and better CMS oversight and enforcement when surveys demonstrate that states and their contractors are not meeting access requirements. Many states - as well commercial plans- currently use these types of surveys to monitor access. States currently use a range of different approaches to designing these provider surveys. Some use so-called "secret shopper" approaches, whereby an individual posing as a fictional Medicaid beneficiary attempts to set up an appointment with a Medicaid provider listed as part of a health plan's network. Others rely on "revealed" survey approaches, where the surveyor acknowledges that they are conducting an access survey on behalf of the state Medicaid agency. States also vary in their approach to administering provider surveys. Some require managed care plans to monitor their own provider networks, while others rely on an independent entity (such as an EQRO or other third-party entity), still others do both plan and state driven surveys. These surveys are also varied in terms of scope of providers surveyed, types of services and providers surveyed, and the frequency of the surveys.

CMS agrees with commenters that provider surveys are a valuable tool for states to identify access barriers. Accordingly, CMS proposes to revise 42 CFR § 438.358(b) to require as part of external quality review activities that states conduct provider surveys, including secret shopper studies, on a frequency no less than annually for purposes of monitoring access to care. As described in [TBD SECTION], states must ensure that their health plans meet the state's appointment wait-time standards for each provider/facility type at least 90% of the time.

6 However, states would only be held accountable for meeting the federal minimum appointment wait-time standards.

6
States and their health plans will also be required to ensure that at least 90% of provider directory entries are accurate at all times. These surveys will be an important tool for states to ensure their plans are meeting these standards. Similarly, they will be an important indicator for CMS as it meets its responsibilities to assess compliance with appointment wait-time standards and provider directory accuracy requirements established in this proposed rule. CMS plans to leverage the results of these surveys for oversight and enforcement purposes.

CMS recognizes that provider surveys are a significant undertaking and that states will need sufficient time as well as support from CMS to be successful in implementing these requirements. CMS notes that by including provider surveys a mandatory EQR-related activity, states will have the opportunity to access the 75% federal matching rate for these activities as long as they are conducted by a CMS-approved EQRO. States will still have the option to use an organization other than an EQRO, provided that entity is independent and has no ties to a managed care plan, to conduct these studies, as permitted under 42 CFR § 438.358(a)(1). However, states that do not rely on an EQRO would only be

able to access the 50% administrative matching rate, as required by 42 CFR § 438.370, for associated expenditures.

CMS also intends to provide comprehensive support to states as they launch new surveys and seeks comment on the types of technical assistance that would be most valuable to states. Technical assistance activities that CMS is considering include:
A State Medicaid Director Letter with additional guidance for designing and implementing provider surveys, including secret shopper studies.
A dedicated learning collaborative through which CMS will convening with states and subject matter experts to share best practices on provider surveys and access monitoring.
A toolkit to provide states with detailed methodological guidance on administering and analyzing results from provider surveys potentially including secret shopper and revealed survey scenarios, provider sampling considerations and approaches to ensure adequate statistical accuracy and geographic and demographic representation, technical guidance on establishing "straw model" Medicaid shopping personas, timing and frequency of the surveys, unique considerations related to secret and revealed surveys, and detailed guidance on statistical approaches for analyzing survey results.
A provider survey design tool that can be customized by the state and that outlines the minimum components of a provider survey, consistent with CMS guidance, with fillable text fields, help text and references to specific technical assistance tools related to each survey component.

In general, states will have the option to adopt best practices outlined in the toolkit, deploy the specifications set out in the model survey, or develop their own approaches provided they are consistent with regulatory and sub-regulatory requirements issued by CMS. CMS seeks comment on the types of tools that will be most helpful to states, the frequency in which provider surveys should be collected, and requirements for conducting both "secret" and "revealed" surveys. CMS also seeks comment on the proposed rule's requirements to assess for accuracy of provider directories and disparities in access to care as well as the proposed methodological standards.
To accommodate states' need for time to adopt, test and implement the surveys, CMS proposes to provide states with a multiyear "glide path" to ramp up new surveys and comply with new access requirements. CMS seeks comment on an appropriate timeline, and whether more or less time is needed, for rolling out provider survey requirements and has proposed the following approach for consideration.
Beginning one year after the effective date of the rule: States will be expected to procure vendors and conduct other preparations necessary to begin administering the provider surveys. CMS would provide robust technical assistance for all states related to provider surveys and the new access requirements.
Beginning two years after the effective date of the rule: States will be expected to conduct a one year "beta test," wherein states would administer test surveys and report data to CMS; during the beta test year, states would not face enforcement actions from CMS based on survey results. CMS would continue to provide robust technical assistance to all states.
Beginning three years after the effective date of the rule: CMS would begin holding states accountable for achieving at least 80% or 85% [TBD] compliance with the federal minimum appointment wait-time and provider directory accuracy standards based on survey results. CMS would provide targeted technical assistance for states that are out of compliance with access requirements.
Beginning four years after the effective date of the rule and thereafter: CMS would hold states accountable, through the use of corrective action plans and other enforcement mechanisms, for achieving at least 90% compliance with the federal minimum appointment wait-time and provider directory accuracy standards based on survey results. CMS would continue to provide targeted technical assistance to support on-going implementation efforts for non-compliant states.

Illustrative, High-Level Glidepath

One Year After the Rule
Two Years After the Rule
Three Years After the Rule
Four Years After the Rule

States prepare to implement provider surveys
Robust CMS TA for all states

Beta test period for provider surveys
Robust CMS TA for all states
States held accountable for 80% or 85% compliance with access requirements
Targeted TA for non-compliant states
States held accountable for 90% compliance with access requirements
Targeted TA for non-compliant states

Proposed Regulatory Language
42 CFR § 438.358(b) Mandatory Activities.
(1) For each MCO, PIHP, or PAHP the following EQR-related activities must be performed:

* * *

(v) Randomized provider surveys:

(a) At minimum, states must conduct provider surveys across contracted MCOs, PIHPs, and PAHPs to assess the compliance with areas of access in paragraph (b) of this section at least annually.
(b) Provider surveys must, at minimum, assess the following:
(1) Compliance with federal and state appointment wait-time standards established in accordance with [regulatory citation], for each applicable provider/facility type, including:
(i) Primary care (routine), adult and pediatric.
(ii) OB/GYN (routine).
(iii) Outpatient behavioral health (mental health and SUD) (routine), adult and pediatric.
(iv) Specialist (targeting identified gaps in access as determined by the State in an evidence-based manner), adult and pediatric.
(v) Other provider/facility types as defined by CMS.
(2) Accuracy of provider directories.
(3) Disparities in access to care (including, but not limited to, appointment wait-times and whether or not providers are accepting new patients) for Medicaid/CHIP members generally (as compared to commercially covered patients), members residing in rural, urban and frontier geographies, members with disabilities, members for whom English is a second language, members from other marginalized groups (e.g., racial/ethnic groups and American Indian/Alaska Natives), and other focused inquiries as CMS requires .

7 CMS would need to work to develop an approach that states could use to measure disparities in access for different marginalized groups. For example, one state assessed through a previous secret shopper study differences in appointment wait-times between callers with “multicultural” names compared to those with non-multicultural names and found significant differences. CMS would need to provide states with clear guidance on how to use these types of approaches to assess disparities through secret shopper studies.

7

(c) States must ensure that provider surveys adhere to the following methodological standards:
(1) Uses statistically valid sample sizes across provider/facility type.
(2) Selects providers to be surveyed on a randomized basis.
(3) Examines all regions of the state, including all major urban areas, rural, and frontier regions.
(4) Uses a standardized approach for testing key measures of access, such as predetermined call scripts for surveyors.
(5) Utilizes a combination of both “secret shopper” or masked and revealed survey approaches, consistent with federal guidance.
(i) Masked approaches are surveys where the caller poses as a Medicaid beneficiary.
(ii) Revealed approaches are surveys where the caller volunteers that they are calling on behalf of the state Medicaid

agency for the purposes of monitoring an MCO, PIHP, or PAHP provider network.
(d) States must submit results of provider surveys to CMS and make them publicly available. As part of public reporting and disclosure, states must make available through an annual report data on service utilization across a range of enrollee characteristics, including by race and ethnicity, eligibility category, age, geography, disability status, and other factors, as determined appropriate by the state.
(e) States must comply with applicable sub-regulatory guidance promulgated by CMS in relation to provider surveys described in this section.

42 CFR §?438.68 Network Adequacy Standards.
(a) Beginning one year after the effective date of the rules finalized at [regulatory citation], a State must have procured a vendor and conducted other preparations necessary to begin administering the provider surveys.
(b) Beginning two years after the effective date of the rules finalized at [regulatory citation], a State must conduct a one year of testing wherein the State administers test surveys and reports data to CMS.
(c) Beginning three years after the effective date of the rules finalized at [regulatory citation], a State would be subject to compliance reviews and enforcement at CMS' discretion if it has not achieved at least eighty percent (80%) or eighty-five percent (85%) [TBD – for discussion with CMS] compliance with the federal minimum appointment wait-time standards for each provider/facility type and the provider directory accuracy standards, based on survey results.
(d) Beginning four years after the effective date of the rules finalized at [regulatory citation] and thereafter, a State would be subject to compliance reviews and enforcement at CMS' discretion if it has not achieved ninety percent (90%) compliance with the federal minimum appointment wait-time standards for each provider/facility type and the provider directory accuracy standards, based on survey results.

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$ $ ()$ -::::??????? Non-institutional network provider REIMBURSEMENT ANALYSIS EXAMPLE
Require that managed care plans report to states their average rates paid by provider type (for provider types in 42 CFR 438.68(b)(1)-(2)) as a percent of Medicare (if applicable and available). If a Medicare standard is not available (such as HCBS providers and pediatric dental), managed care plans should report their average rates paid by provider type as a percent of the state's Medicaid State Plan rates. This reporting must include base rates, pass-through payments, state directed payments, and any other payments made by managed care plans to non-institutional network providers. States would then weight the plans' reported percentages using member months to determine a state percentage for each provider type.
Non-institutional provider types in 438.68: Primary care- adult and pediatric, OB/GYN, mental health and SUD- adult and pediatric, specialist (as designated by the State), adult, and pediatric, pediatric dental, and LTSS.
STATE NAME
Rhode Island
STATE ENTERS DATA

REPORT PERIOD BEGIN DATE
7/1/2022

FORMULA
REPORT PERIOD END DATE
6/30/2023

MEMBER MONTHS
PLAN A
250,000

PLAN B
300,000

PLAN C
400,000

TOTAL
950,000

PRIMARY CARE
PLAN A
PLAN B
PLAN C
STATEWIDE
SPENDING CATEGORY
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
WEIGHTED MEDICAID TO MEDICARE RATIO
CLAIMS
$ 40,000,000

$ 50,000,000

$ 30,000,000

$ 45,000,000

$ 25,000,000

$ 30,000,000

STATE DIRECTED PAYMENTS
$ 2,000,000

$ 1,000,000

$ 500,000

PASS THROUGH PAYMENTS
$ -

$ -

$ -

OTHER PAYMENTS
$ -

$ -

$ -

TOTAL
$ 42,000,000

$ 50,000,000

84%

$ 31,000,000

$ 45,000,000

69%

$ 25,500,000

$ 30,000,000

85%

80%

OB/GYN
PLAN A
PLAN B
PLAN C
STATEWIDE
SPENDING CATEGORY
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
WEIGHTED MEDICAID TO MEDICARE RATIO
CLAIMS

$ 50,000,000

$ 60,000,000

$ 20,000,000

$ 30,000,000

$ 30,000,000

$ 45,000,000

STATE DIRECTED PAYMENTS
$ 2,000,000

$ 1,000,000

$ 500,000

PASS THROUGH PAYMENTS
$ -

$ -

$ -

OTHER PAYMENTS
$ -

$ -

$ -

TOTAL
$ 52,000,000

$ 60,000,000

87%

$ 21,000,000

$ 30,000,000

70%

$ 30,500,000

$ 45,000,000

68%

73%

SPECIALTY CARE
PLAN A
PLAN B
PLAN C
STATEWIDE
SPENDING CATEGORY
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
WEIGHTED MEDICAID TO MEDICARE RATIO
CLAIMS
$ 60,000,000

$ 75,000,000

$ 50,000,000

$ 55,000,000

$ 45,000,000

$ 48,000,000

STATE DIRECTED PAYMENTS
$ 2,000,000

$ 1,000,000

$ 500,000

PASS THROUGH PAYMENTS
$ -

$ -

$ -

OTHER PAYMENTS
$ -

$ -

$ -

TOTAL
$ 62,000,000

$ 75,000,000

83%

$ 51,000,000

$ 55,000,000

93%

$ 45,500,000

$ 48,000,000

95%

91%

MENTAL HEALTH/SUD
PLAN A
PLAN B
PLAN C
STATEWIDE
SPENDING CATEGORY
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
TOTAL MEDICAID SPENDING
MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
WEIGHTED MEDICAID TO MEDICARE RATIO
CLAIMS
$ 30,000,000

$ 40,000,000

$ 25,000,000

$ 30,000,000

$ 45,000,000

$ 48,000,000

STATE DIRECTED PAYMENTS
$ 2,000,000

$ 1,000,000

$ 500,000

PASS THROUGH PAYMENTS

$ -

$ -

$ -

OTHER PAYMENTS
$ -

$ -

$ -

TOTAL
$ 32,000,000

$ 40,000,000

80%

$ 26,000,000

$ 30,000,000

87%

$ 45,500,000

$ 48,000,000

95%

88%

PEDIATRIC DENTAL
PLAN A
PLAN B
PLAN C
STATEWIDE
SPENDING CATEGORY
TOTAL MEDICAID SPENDING
MEDICAID FFS EQUIVALENT
MEDICAID TO MEDICAID FFS RATIO
TOTAL MEDICAID SPENDING
MEDICAID FFS EQUIVALENT
MEDICAID TO MEDICAID FFS RATIO
TOTAL MEDICAID SPENDING
MEDICAID FFS EQUIVALENT
MEDICAID TO MEDICAID FFS RATIO
WEIGHTED MEDICAID TO MEDICAID FFS RATIO
CLAIMS
$ 5,000,000

$ 6,000,000

$ 10,000,000

$ 11,000,000

$ 10,000,000

$ 12,000,000

STATE DIRECTED PAYMENTS
$ 2,000,000

$ 1,000,000

$ 500,000

PASS THROUGH PAYMENTS
$ -

$ -

$ -

OTHER PAYMENTS
$ -

$ -

$ -

TOTAL
$ 7,000,000

$ 6,000,000

117%

$ 11,000,000

$ 11,000,000

100%

$ 10,500,000

$ 12,000,000

88%

99%

STATEWIDE
ALL SERVICES
TOTAL MEDICAID SPENDING

MEDICARE EQUIVALENT
MEDICAID TO MEDICARE RATIO
PLAN A
$ 195,000,000

$ 231,000,000

84%

PLAN B
$ 140,000,000

$ 171,000,000

82%

PLAN C
$ 157,500,000

$ 183,000,000

86%

STATEWIDE RATIO (WEIGHTED)
84%

Meeting Title:
CMS/DHCS Biweekly Waiver Check-in

From:
"Kim, Lora" <LYKim@manatt.com>

Sent:
11/30/2022 10:40:44 PM +0000

To:
'Noelle.Simonick@dhcs.ca.gov'; 'janet.rudnick@dhcs.ca.gov'; 'rachel.nichols@cms.hhs.gov'; "Ross, Heather (CMS/CMCS)" <Heather.Ross@cms.hhs.gov>; "Friedman, Kate (CMS/CMCS)" <Katherine.Friedman@cms.hhs.gov>; 'Aaron.Toyama@dhcs.ca.gov'; 'Bambi.Cisneros@dhcs.ca.gov'; 'Benjamin.Mcgowan@dhcs.ca.gov'; Brumer, Justin@DHCS; 'AnhThu.Bui@dhcs.ca.gov'; 'Dana.Durham@dhcs.ca.gov'; "Font, Amanda" <Amanda.font@dhcs.ca.gov>; 'Jacey.cooper@dhcs.ca.gov'; "Lee, Angeli" <Angeli.Lee@dhcs.ca.gov>; 'Lindy.Harrington@dhcs.ca.gov'; 'Rafael.Davtian@dhcs.ca.gov'; 'Rene.Mollow@dhcs.ca.gov'; 'farrah.samimi@dhcs.ca.gov'; 'Saralyn.Ang-olson@dhcs.ca.gov'; 'susan.philip@dhcs.ca.gov'; 'tyler.sadwith@dhcs.ca.gov'; 'yingjia.huang@dhcs.ca.gov'; "Guyer, Jocelyn" <JGuyer@manatt.com>; "Lam, Alice" <ALam@manatt.com>; "Mann, Cindy" <CMann@manatt.com>; "Punukollu, Nina" <NPunukollu@manatt.com>; "Reyneri, Dori Glanz" <dreyneri@manatt.com>; "Traube, Ashley" <ATraube@manatt.com>; "Govender, Ahimsa" <AGovender@manatt.com>; "Kim, Lora" <LYKim@manatt.com>; "Cash, Judith (CMS/CMCS)" <Judith.Cash@cms.hhs.gov>; "Rashid, Mehreen (CMS/CMCS)" <mehreen.rashid@cms.hhs.gov>; "Decaro, Teresa (CMS/CMCS)" <teresa.decaro@cms.hhs.gov>; Sadwith, Tyler@DHCS; Samimi, Farrah@DHCS; "Cisneros, Bambi" <Bambi.cisneros@dhcs.ca.gov>; "Phillip, Susan" <Susan.Philip@dhcs.ca.gov>; "Williams, Sandra" <Sandra.Williams@dhcs.ca.gov>; "Toyama, Aaron" <Aaron.Toyama@dhcs.ca.gov>; Cooper, Jacey@DHCS; "Tsai, Daniel (CMS/CMCS)" <Daniel.Tsai@cms.hhs.gov>; "McClenathan, Jane (CMS/CMCS)" <Jane.McClenathan@cms.hhs.gov>; "Serafi, Kinda" <KSerafi@manatt.com>; "Boozang, Patricia" <PBoozang@manatt.com>

Attendees:
'Noelle.Simonick@dhcs.ca.gov'; 'janet.rudnick@dhcs.ca.gov'; 'rachel.nichols@cms.hhs.gov'; Ross, Heather (CMS/CMCS); Friedman, Kate (CMS/CMCS); 'Aaron.Toyama@dhcs.ca.gov'; 'Bambi.Cisneros@dhcs.ca.gov'; 'Benjamin.Mcgowan@dhcs.ca.gov'; Brumer, Justin@DHCS; 'AnhThu.Bui@dhcs.ca.gov'; 'Dana.Durham@dhcs.ca.gov'; Font, Amanda; 'Jacey.cooper@dhcs.ca.gov'; Lee, Angeli; 'Lindy.Harrington@dhcs.ca.gov'; 'Rafael.Davtian@dhcs.ca.gov'; 'Rene.Mollow@dhcs.ca.gov'; 'farrah.samimi@dhcs.ca.gov'; 'Saralyn.Ang-olson@dhcs.ca.gov'; 'susan.philip@dhcs.ca.gov'; 'tyler.sadwith@dhcs.ca.gov'; 'yingjia.huang@dhcs.ca.gov'; Guyer, Jocelyn; Lam, Alice; Mann, Cindy; Punukollu, Nina; Reyneri, Dori Glanz; Traube, Ashley; Govender, Ahimsa; Kim, Lora; Cash, Judith (CMS/CMCS); Rashid, Mehreen (CMS/CMCS); Decaro, Teresa (CMS/CMCS); Sadwith, Tyler@DHCS; Samimi, Farrah@DHCS; Cisneros, Bambi; Phillip, Susan; Williams, Sandra; Toyama, Aaron; Cooper, Jacey@DHCS; Tsai, Daniel (CMS/CMCS); McClenathan, Jane (CMS/CMCS); Serafi, Kinda; Boozang, Patricia

Location:
https://manatt.zoom.us/j/92009574479?pwd=TnRuRm1xdHFCQjRZVE5XMWdOQXVkZz09

Start Time:
12/1/2022 6:00:00 PM +0000

End Time:
12/1/2022 6:30:00 PM +0000

Reminder Time:
12/1/2022 5:45:00 PM +0000

Is Recurring:
false

Busy Status:
Tentative

Attachments:
image001.jpg

CMS/DHCS Biweekly Waiver Check-in
Thursday, December 1st, 10:00 * 10:30 AM PT // 1:00 * 1:30 PM ET

- Discuss DSHP approach and provider rate analysis
- Next steps

Hi there,

Lora Kim is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting

Phone one-tap:

US: +13092053325,,92009574479# or +13126266799,,92009574479#

Meeting URL:

https://manatt.zoom.us/j/92009574479?pwd=TnRuRm1xdHFCQjRZVE5XMWdOQXVkZz09

Meeting ID:

(b)(6)

Passcode:

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Join by Telephone

For higher quality, dial a number based on your current location.

Dial:

US: +1 309 205 3325 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 or +1 301 715 8592 or +1 564 217 2000 or +1 669 444 9171 or +1 669 900 6833 or +1 719 359 4580 or +1 253 215 8782 or +1 346 248 7799 or +1 386 347 5053 or 888 788 0099 (Toll Free) or 877 853 5247 (Toll Free)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

International numbers

Join from an H.323/SIP room system

H.323:

162.255.37.11 (US West)
162.255.36.11 (US East)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

SIP:

92009574479@zoomcrc.com

Passcode:

(b)(6)

CMS 2439-F: Medicaid and CHIP Quality Rating System (MAC QRS) and External Quality Review (EQR) – OCD awareness table
July 27, 2023

We would like to flag two things for OCD:
As of Monday 7/24/23, the comment log from the contractor (Ripple) had not been delivered due to software issues. Therefore some of the numbers of comments in the table below may be tweaked once we receive the final log and reconcile it with our own team's comment log. We do believe we captured the majority of the comments and do not expect the recommendations to change.
We also note we received many thoughtful suggestions for how to reduce the overall burden of the QRS on states and plans. The team is diligently working to implement as many of these suggestions as possible within our current clearance timeline. We may need additional input from OCD on recommended changes that are identified from this work in the coming weeks.
MAC QRS: General Rule & Applicability (§?438.505) We received 58 comments on returned mail from 64 commenters, including 3 states.

Provision Title
Proposed Provisions/Preamble discussion
Comments in Support
Comments Opposing
Recommendation

MAC QRS: General Rule & Applicability
438.505(a)(2)

Each State contracting with an applicable managed care plan to furnish services to Medicaid beneficiaries must implement a managed care quality rating system by the end of the fourth calendar year following the effective date of the final rule published in the federal register.
All comment letters acknowledge the utility and need for a Medicaid and CHIP quality rating system.

58 letters offer their explicit strong support for the MAC QRS as a one-stop-shop. These letters represent 64 advocacy organizations, 4 pharmaceutical companies, 5 provider organizations, 5 health plans or associations, 3 hospitals, and 3 states (WI, MA, MI).
We received no comments opposing implementation of the MAC QRS.

However, we did receive comments questioning whether the MAC QRS is the best use of Medicaid resources at the moment, especially in small states or those with a small number of managed care plans (NAMD, VT, NH, Families USA).
We recommend moving forward with the requirement to implement the MAC QRS and we are working to implement the many thoughtful recommendations from the comments on how we could reduce the burden of implementation.

MAC QRS: General Rule & Applicability and Website Display (§§?438.505) (§?438.520)) We received 95 comments on returned mail from 95 commenters, including 10 states.

MAC QRS: General Rule & Applicability

MAC QRS: Website Display
438.505(a)(2); 438.520(a)(1)-(5)

Phase 1: States must implement a MAC QRS website by the end of the 4th calendar year following the final rule that includes the website display component identified in 438.520(a)(1)-(5).

As a reminder, we added one more year to the implementation date in the NPRM. (The 2020 final rule indicates 3 years for implementation.)

Phase 2: No earlier than two years after Phase 1, States must implement the additional interactive features identified in 438.520(a)(6).
These interactive features include a searchable formulary and provider directory, and additional stratifiers such as rural/urban status, disability, and language of the enrollee.
40 health care and patient advocacy organizations requested that the implementation of the MAC QRS be accelerated 1-2 years. These comments note strong support for the website and the need for patients to have access to the information.

11 states explicitly or implicity support the feasibility of the timeline:
5 states explicitly indicate that the proposed QRS timelines are feasible (NY, MA, NM, TN, WI).
3 states explicitly address timeline concerns on other aspects of the NPRM, but do not mention the QRS as part of those concerns (CA, MI, NC).
3 additional states comment extensively, detailing their concerns on the QRS, but do not include the timeline as a concern (OR, PA, TX).

37 advocacy and patient organizations explicitly noted their strong support for Phase 2 (more interactive features) and requested we modify our proposal to require implementation "no later than 2 years" after Phase 1 as opposed to the proposal of "no earlier than 2 years" after Phase 1.
5 states (AZ, IN, NH, RI, VT) express that the proposed timeline is not feasible due to the time, financial, and personnel investments that will be required. These states urge CMS to provide financial assistance to support additional personnel and administrative burdens associated with the QRS and to provide an additional year in each phase of implementation.

NAMD requests extending the implementation deadline an additional year in each phase of implementation, with an optional extension for states who face "significant barriers during implementation." 3 states (RI, VT, NH) support NAMD's optional extension proposal. Elevance Health and the Healthcare Leadership Council recommend implementing a voluntary performance year prior to implementation, effectively adding an additional year to Phase 1.

2 health plans (AmeriHealth, CareFirst) and 3 health plan associations (AHIP, MHPA, National MLTSS Health Plan Association) encourage CMS to allow states flexibility to implement the MAC QRS website by providing additional resources and time.

AHIP and AmeriHealth suggest that CMS phase in the initial set of mandatory measures over time, beginning with a smaller set in the initial year.

The National MLTSS Health Plan Association and CVS Health and the state of Wisconsin encourage CMS to considering forgoing Phase 2 altogether.
We recommend maintaining the proposed implementation dates for both phases, but we recommend adding an option for states to request an exemption for specific website design components and methodology requirements.

Under the exemption policy, all states would implement a MAC QRS by the implementation date, but some states may include fewer Phase 1 requirements if they have been granted exemptions, including exemptions for displaying mandatory measures. The exemption policy would be available for Phase 2, once we set a date for implementation.

The exemption could be for a year at a time.

EQR Results – Report Due Date (§§?438.364(c)) We received 14 comments on returned mail from 14 commenters, including 8 states.
Provision Title
Proposed Provisions/Preamble discussion
Comments in Support
Comments Opposing
Recommendation(s)

External Quality Review Results – Annual Report Due Date
We proposed to change the due date for states to submit EQR reports from April 30th to December 31st -- representing a 4 month earlier deadline than is currently in place. We believed this proposed change would align better with the HEDIS timeframes because the EQR performance measurement activity could then follow the HEDIS audit and would have resulted in data being at most 1 year old at the time the reports are posted on the State's website.

We proposed that States would come into compliance with this new due date by December 31, 2025.
5 comments from non-state organizations, including an MCO (Centene), two advocacy groups (Consortium for Constitutes with Disabilities and Kansas Action for Children), NCQA, and Georgetown Health Policy Institute offered general support; however, Georgetown seemed to misunderstand the proposal as providing more time to complete the reports. NCQA commented that this change would allow the states that use HEDIS for its performance measurement platform to incorporate the most recent performance rates into their submitted reports, leading to better comparability across states.

3 states supported this proposal (CA, IN, MA). IN didn't provide specific support for this proposal but rather generally supported quality reporting proposals. CA noted that additional costs would likely occur, there could be a gap in data reported to CMS, and EQRO contracts would need to be restructured. MA appreciated the effort to make the reports more actionable and noted that some of the measures may not make the "cut-off" date and would have to be included in the following year's report.
5 states (AZ, CO, FL, MI, NM) and the National Association of Medicaid Directors (NAMD) specifically opposed the proposal citing the burden and time constraints. State commenters noted how it would be challenging to complete all the required EQR activities, and for EQROs to complete their analysis and compilation of results by December 31. One state (NM) detailed out their process of reviewing and approving the EQR reports before finalizing, noting that the four mandatory activities take place throughout the year, the state review begins in January and entails 3 levels of leadership review, making the December 31 date very difficult.

NAMD commented that Medicaid agencies oppose this change and that it would be extremely challenging to complete mandatory EQR activities.

We recommend not finalizing this proposed change and maintaining the current annual due date of April 30. We believe the burden this policy would impose on states outweighs the benefits of posting reports 4 months earlier than they are currently posted.

Though initially there was some concern about CMS' ability to aggregate the data by the September 30th due date given the increasing use of managed care, we believe there are ways to streamline this aggregation process through future standardization of reports and electronic reporting.

Meeting Title:
[INTERNAL] (b)(6) Mtg w/Georgetown University's Medicaid Section 1115 Waiver Task Force

From:
CMS Administrator <CMSAdministrator@cms.hhs.gov>

Sent:
11/25/2022 10:45:50 PM +0000

To:
(b)(6) (she/her), Administrator (CMS/OA)" (b)(6) "Ellis (she/her), Kyla (CMS/OA)" <Kyla.Ellis@cms.hhs.gov>; "McLemore, Monica (CMS/OSORA)" <Monica.McLemore@cms.hhs.gov>; "Khan, Farooq (CMS/OSORA)" <Farooq.Khan@cms.hhs.gov>; "Tsai, Daniel (CMS/CMCS)" <Daniel.Tsai@cms.hhs.gov>; "Katch (she/her), Hannah (CMS/OA)" <Hannah.Katch@cms.hhs.gov>; "Costello, Anne Marie (CMS/CMCS)" <AnneMarie.Costello@cms.hhs.gov>; "Cash, Judith (CMS/CMCS)" <Judith.Cash@cms.hhs.gov>; "Jackson, Marilyn (CMS/OSORA)" <Marilyn.Jackson@cms.hhs.gov>

Attendees:
(b)(6) Kyla Ellis (CMS/) (kyla.ellis@cms.hhs.gov); McLemore, Monica (CMS/OSORA); Khan, Farooq (CMS/OSORA); Tsai, Daniel (CMS/CMCS); Hannah Katch (CMS/OA) (hannah.katch@cms.hhs.gov); Costello, Anne Marie (CMS/CMCS); Cash, Judith (CMS/CMCS); Jackson, Marilyn (CMS/OSORA)

Location:
Zoom; https://cms.zoomgov.com/j/1619012770?pwd=N0FRQ3FKSDFLZzVIaEYyb2RSWVVOZz09

Start Time:
12/1/2022 6:30:00 PM +0000

End Time:
12/1/2022 7:00:00 PM +0000

Duration:
30 minutes

Reminder Time:
12/1/2022 6:30:00 PM +0000

Is Recurring:
false

Recurrence Type:
Not

Recurrence Pattern:

Response Status:
5

Busy Status:
Tentative

Attachments:

External Meeting Request: Medicaid Section 1115 Waiver Task Force*Georgetown University

CMS Administrator is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting
https://cms.zoomgov.com/j/1619012770?pwd=N0FRQ3FKSDFLZzVIaEYyb2RSWVVOZz09

Meeting ID: (b)(6)
Password (b)(6)

One tap mobile
+16692545252,,1619012770# US (San Jose)
+16468287666,,1619012770# US (New York)

Dial by your location
+1 669 254 5252 US (San Jose)
+1 646 828 7666 US (New York)
833 568 8864 US Toll-free
Meeting ID: (b)(6)
Find your local number: https://cms.zoomgov.com/u/abw6qDZVea

Join by SIP
Password: (b)(6)
sip: (b)(6) @sip.zoomgov.com

This meeting may be recorded. The host is responsible for maintaining any official recordings/transcripts of this meeting. If recorded, this meeting becomes an official record and shall be retained by the host in their files for 3 years or if longer needed for agency business. If a recording intends be fully transcribed or is being captured for the purpose of creating meeting minutes, the host shall retain the record in their files for 3 years or if no longer needed for agency business, whichever is later.

External Meeting Request: Medicaid Section 1115 Waiver Task Force*Georgetown University
From:
"McLemore, Monica (CMS/OSORA)" <Monica.McLemore@cms.hhs.gov>

Sent:
11/2/2022 12:21:56 PM -0400

To:
"Neal, Phaedra (CMS/OA)" <Phaedra.Neal@cms.hhs.gov>

CC:
"Khan, Farooq (CMS/OSORA)" <Farooq.Khan@cms.hhs.gov>

Subject:
External Meeting Request: Medicaid Section 1115 Waiver Task Force/Georgetown University

Attachments:
Letter to Secretary to Improve 1115 Waiver Process.pdf

Hi Phaedra,

Georgetown University has provided the following availability for representatives of the Medicaid Waiver Task Force to meet with the Administrator. Please let me know if any of these work for a 30-minute slot:
Friday, November 18 from 12-1 or 2-2:30
Monday, November 28 from 11-12:30 or 1:30-2
Tuesday, November 29 from 12:30-4pm
Thursday, December 1 from 1-5pm

Meeting Participants:
Joan Alker, Co-Founder, Center for Children and Families
Allexa Gardner, Research Associate, Center for Children and Families
Others TBD

Contact:
Joan Alker
Executive Director, Research Professor
Center for Children and Families
Georgetown University McCourt School of Public Policy
(202)306-8383
jca25@georgetown.edu

The Medicaid Waiver Task Force, comprised of fifty-one organizations representing patient, provider, and advocacy groups, undersigned a letter to Secretary Becerra, dated 8/17/2022 (attached), urging CMS to strengthen the current regulations to ensure that section 1115 demonstrations promote coverage and improve the transparency of the process of approving, amending, and renewing demonstrations. As a follow-up to the letter, the group requests a virtual meeting with the Administrator and Dan Tsai to discuss this matter.

Thanks,
Monica

August 17, 2022

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Recommended Regulatory Actions for Section 1115 Medicaid Demonstration Process

Dear Secretary Becerra,

The undersigned organizations write to urge you to promulgate regulations regarding the section 1115 Medicaid demonstration process. A substantial and growing portion of Medicaid is funded through section 1115 and there is a critical need to develop a regulatory framework that clarifies the parameters of the authority, clears up confusion among states and courts, strengthens the transparency rules, and protects the integrity of the Medicaid program. This is among the most important things the administration can do for the long-term security of the Medicaid program and the millions of people who rely on the program for their health insurance.

CMS must set out a definition of "the objectives of Medicaid" and establish related principles to avoid harmful demonstration and waiver approvals, such as work requirements or premiums in Medicaid. CMS's regulation should address several specific and important problems in the 1115 process.

Defining the Objectives of Medicaid for Purposes of Section 1115 Demonstrations

CMS should promulgate a regulation which requires that section 1115 demonstrations promote the objectives of Medicaid, with a definition of the objectives of Medicaid based primarily in the purpose of the program identified in section 1901, namely to furnish medical assistance, rehabilitation, and other services. CMS should also ensure that the new definition of the objectives of Medicaid explicitly affirms the Medicaid entitlement and open-ended matching payment structure.

CMS's definition should also clarify that the clause "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care" cannot be interpreted to allow demonstrations that "promote independence" if they do not furnish services or if they reduce access to services.

CMS Should Create 1115 Guardrails for Promoting the Objectives of Medicaid

CMS's regulation should further operationalize the definition of the objectives of Medicaid by creating 1115 "guardrails," similar to the section 1332 guardrails, that ensure demonstrations promote, not undercut, the purpose of Medicaid. Such guardrails should include:

1. Demonstrations cannot be approved if they would likely reduce the number of individuals covered by Medicaid in a state, or otherwise reduce the number of individuals who have health insurance in the state.

2. Demonstrations cannot be approved if they would likely reduce the available services, or amount, duration, and scope of any services, provided to Medicaid enrollees; this includes maintaining access to community-based services.

3. Demonstrations cannot be approved if they would reduce the affordability of services for enrollees, including cost-sharing, premiums, and any other costs, unless they comply with the standards in section 1916(f).
4. Demonstrations should not otherwise reduce access to care, such as by making application, enrollment, or renewal more difficult.

CMS should require that all demonstrations meet all four guardrails for the full population eligible for the demonstration and for specific sub-populations when the guardrail impacts are disaggregated by race/ethnicity and other factors. Existing regulations should be supplemented to require that state applications for section 1115 demonstrations include specific and disaggregated estimates for each of the guardrails as well as a comprehensive equity assessment, explaining the effect the proposal would likely have on health coverage and access to care.

Protecting the Integrity and Transparency of the Demonstration Process

We recommend that CMS's regulation additionally make three changes to strengthen demonstration processes.

First, the regulation should require the full transparency process (including notice and comments) for all 1115 demonstrations that would impact eligibility, enrollment, benefits, cost-sharing, or financing – including new applications, extensions, and amendments. Adding amendments is key as so many states have existing section 1115 demonstrations and major changes are frequently made through amendments. Just like CMS's current regulations include slightly different requirements for new applications and extensions, new regulations could specify reasonable requirements for significant amendments that balance transparency with states' needs to make timely changes. Meaningful changes to eligibility, benefits, cost-sharing, enrollment or financing all require public comment in our view.

Second, the permissible exceptions to the transparency process in the case of a public health emergency needs to be tightened up. The regulation should clarify or strengthen existing regulations to prevent pretextual exemptions from the transparency process. Exemption from the transparency process should be very rare, and only used for demonstrations that are directly related to emergency response (i.e., not just coincidentally contemporaneous) and when use of a comment period would materially delay such emergency response.

Third, CMS's regulation should set clear standards for the duration of demonstrations, not to exceed five years. Section 1115 authorizes "experimental, pilot, or demonstration" projects. Ten years are generally not needed to assess the value of an experiment, and ten years is a long time to have an unsuccessful waiver in place. Ten years also creates the possibility that an outgoing administration can bind a new administration for the entirety of its two terms. Some ten-year approvals do not comport with the statute. We recommend that, consistent with long-standing practice, CMS should implement an unambiguous 5-year limit for new demonstrations, extensions, and amendments.

Thank you for your consideration of our views. If you have questions, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

American Academy of Family Physicians
American Academy of Pediatrics
American Association on Health and Disability
American Cancer Society Cancer Action Network

American College of Obstetricians and Gynecologists
American Heart Association
American Lung Association
Arthritis Foundation
Asian & Pacific Islander American Health Forum (APIAHF)
Autism Society of America
Autistic Self Advocacy Network
Black Mamas Matter Alliance
CancerCare
Catholic Health Association of the United States
Center for Disability Rights
Center for Law and Social Policy (CLASP)
Center on Budget and Policy Priorities
Community Catalyst
Cystic Fibrosis Foundation
Easterseals
Epilepsy Foundation
Families USA
First Focus on Children
Georgetown University Center for Children and Families
Hemophilia Federation of America
Justice in Aging
Lakeshore Foundation
March of Dimes
Medical Transportation Access Coalition
Medicare Rights Center
NASTAD
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Disability Rights Network (NDRN)
National Family Planning & Reproductive Health Association
National Health Care for the Homeless Council
National Health Law Program
National Immigration Law Center
National Multiple Sclerosis Society
National Network for Arab American Communities (NNAAC)
National Organization for Rare Disorders
National Partnership for Women & Families
National Patient Advocate Foundation

Physicians for Reproductive Health
Primary Care Development Corporation
The Arc of the United States
The Leukemia & Lymphoma Society
UnidosUS
Union for Reform Judaism

Author: Microsoft Office User
CreationDate: 2022-08-17 21:18:40
Creator: Microsoft Word
ModDate: 2022-11-02 14:07:46

Meeting Title:
CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations

From:
CMS CMCS_Unwinding <CMCSUnwinding@cms.hhs.gov>

Sent:
1/11/2023 6:08:57 PM +0000

To:
'aimee.ossman@childrenshospitals.org'; 'akg72@georgetown.edu'; 'Allison Orris' <aorris@cbpp.org>; "Arguello, Andres (OS/IOS)" <Andres.Arguello@hhs.gov>; "Banton, Kia (CMS/CMCS)" <Kia.Banton@cms.hhs.gov>; 'Barbara Eyman' <beyman@eymanlaw.com>; "Bentley (she/her), Katherine (CMS/CCIIO)" <Katherine.Bentley2@cms.hhs.gov>; 'bfeldpush@essentialhospitals.org'; "Black, Nicole (CMS/OC)" <Nicole.Black@cms.hhs.gov>; "Blanar, Jonathan (CMS/OC)" <Jonathan.Blanar@cms.hhs.gov>; "Bonelli, Anna (CMS/CMCS)" <Anna.Bonelli@cms.hhs.gov>; 'brucel@firstfocus.org'; 'cdobson@ADvancingstates.org'; "Clark, Elizabeth (CMS/CMCS)" <Elizabeth.Clark@cms.hhs.gov>; "Costello, Anne Marie (CMS/CMCS)" <AnneMarie.Costello@cms.hhs.gov>; "Costello, Stefanie (CMS/OC)" <Stefanie.Costello@cms.hhs.gov>; 'creusch@communitycatalyst.org'; 'crogers@communitycatalyst.org'; "Cross-Call, Jesse (OS/IEA)" <Jesse.Cross-call@hhs.gov>; 'davanzo@nilc.org'; "Delone, Sarah (CMS/CMCS)" <Sarah.Delone2@CMS.hhs.gov>; "Dolly, Ed (CMS/CMCS)" <Edward.Dolly@cms.hhs.gov>; 'DWalter@aap.org'; 'EFishman@familiesusa.org'; 'ekong@apiahf.org'; 'emanuel@healthlaw.org'; 'Erica Cischke' <ecischke@aafp.org>; 'Erin O'Malley' <eomalley@essentialhospitals.org>; 'erodriguez@unidosus.org'; 'ferzouki@cbpp.org'; "Fowler, Joanna (CMS/CCIIO)" <Joanna.Fowler@cms.hhs.gov>; "Franklin, Julie (CMS/OC)" <Julie.Franklin@cms.hhs.gov>; "Gibson, Alexis (CMS/CMCS)" <alexis.gibson@cms.hhs.gov>; "'Glier, Stephanie'" <sglier@aap.org>; "Grant, Jeff (CMS/CCIIO)" <jeffrey.grant1@cms.hhs.gov>; "Gutzmer, Hailey (CMS/OC)" <Hailey.Gutzmer@cms.hhs.gov>; "Hammarlund, John (CMS/OPOLE)" <john.hammarlund@cms.hhs.gov>; "Harris, Monica (CMS/CMCS)" <Monica.Harris@cms.hhs.gov>; "Hennessy, Amy (CMS/OC)" <Amy.Hennessy@cms.hhs.gov>; 'hoshelton@naacpnet.org'; 'jca25@georgetown.edu'; 'JDBaker@mathematica-mpr.com'; 'Jennifer Tolbert' <JenniferT@kff.org>; 'JKozminski@essentialhospitals.org'; "Johnston, James (CMS/OHI)" <James.Johnston@cms.hhs.gov>; 'Judy Solomon (solomon@cbpp.org)'; "Katch (she/her), Hannah (CMS/OA)" <Hannah.Katch@cms.hhs.gov>; 'Katie@Out2Enroll.org'; "Koepke, Christopher (CMS/OC)" <Christopher.Koepke@cms.hhs.gov>; 'Lessard@nilc.org'; "Lipscomb (she/her), Darla (CMS/CCIIO)" <darla.lipscomb@cms.hhs.gov>; 'Lisa Satterfield' <lsatterfield@acog.org>; "Lorsbach (she/her), Anna (CMS/CCIIO)" <anna.lorsbach@cms.hhs.gov>; "Lovejoy, Shannon (CMS/CMCS)" <Shannon.Lovejoy@cms.hhs.gov>; 'lrodriguez@americanprogress.org'; 'Lyndsey Cavender' <LCavender@mathematica-mpr.com>; "Mccloy, Tamara (CMS/OPOLE)" <Tamara.Mccloy@cms.hhs.gov>; 'mcheek@ahca.org'; 'minnocent@naacpnet.org'; 'mmiller@communitycatalyst.org'; "Montz, Ellen (CMS/CCIIO)" <Ellen.Montz@cms.hhs.gov>; 'msnider@unidosus.org'; 'Naomi Ali' <NAli@mathematica-mpr.com>; "O'Connor, Sarah (CMS/CMCS)" <Sarah.OConnor@cms.hhs.gov>; 'rb1686@georgetown.edu'; 'rcarreon@unidosus.org'; "Reilly, Megan (CMS/OC)" <Megan.Reilly@cms.hhs.gov>; 'robinr@kff.org'; "'Ross, Christy'" <cross@naacpnet.org>; 'rtetlow@acog.org'; 'sarah.nolan@seiu.org'; "Seng, Suzette (CMS/CMCS)" <Suzette.Seng@cms.hhs.gov>; "Setala, Ashley (CMS/CMCS)" <Ashley.Setala@cms.hhs.gov>; 'sfeliz@nul.org'; 'shughes@aha.org'; 'squinn@aafp.org'; 'Stan Dorn' <SDorn@familiesusa.org>; "Stephens, Jessica (CMS/CMCS)" <Jessica.Stephens@cms.hhs.gov>; 'Taylor Platt' <tplatt@acog.org>; "'tharo (aap.org'" <tharo@aap.org>; "Thomas, Pam (CMS/OPOLE)" <Pam.Thomas@cms.hhs.gov>; 'Tiara Halstead' <THalstead@mathematica-mpr.com>; "Toomey, Mary (CMS/OC)" <Mimi.Toomey@cms.hhs.gov>; "Trevino, Ethan (CMS/CCIIO)" <Ethan.Trevino1@cms.hhs.gov>; 'Tricia Brooks' <pab62@georgetown.edu>; "Tsai, Daniel (CMS/CMCS)" <Daniel.Tsai@cms.hhs.gov>; 'UnwindingSupport@mathematica-mpr.com'; "Wagstaffe, Leslie (CMS/CCIIO)" <leslie.wagstaffe@cms.hhs.gov>; "Walen, Alyssa (CMS/OC)" <Alyssa.Walen@cms.hhs.gov>; "'Wallace, Nick'" <nwallace@aap.org>; "Weiss, Alice (CMS/CMCS)" <Alice.Weiss@cms.hhs.gov>; "Wood (he/him), Elijah (CMS/CCIIO)" <Elijah.Wood@cms.hhs.gov>; 'youdelman@healthlaw.org'

Attendees:

aimee.ossman@childrenshospitals.org; akg72@georgetown.edu; Allison Orris; Arguello, Andres (OS/IOS); Banton, Kia (CMS/CMCS); Barbara Eyman; Bentley (she/her), Katherine (CMS/CCIIO); bfeldpush@essentialhospitals.org; Black, Nicole (CMS/OC); Blanar, Jonathan (CMS/OC); Bonelli, Anna (CMS/CMCS); brucel@firstfocus.org; cdobson@ADvancingstates.org; Clark, Elizabeth (CMS/CMCS); Costello, Anne Marie (CMS/CMCS); Costello, Stefanie (CMS/OC); creusch@communitycatalyst.org; crogers@communitycatalyst.org; Cross-Call, Jesse (OS/IEA); davanzo@nilc.org; Delone, Sarah (CMS/CMCS); Dolly, Ed (CMS/CMCS); DWalter@aap.org; EFishman@familiesusa.org; ekong@apiahf.org; emanuel@healthlaw.org; Erica Cischke; Erin O'Malley; erodriguez@unidosus.org; ferzouki@cbpp.org; Fowler, Joanna (CMS/CCIIO); Franklin, Julie (CMS/OC); Gibson, Alexis (CMS/CMCS); Glier, Stephanie; Grant, Jeff (CMS/CCIIO); Gutzmer, Hailey (CMS/OC); Hammarlund, John (CMS/OPOLE); Harris, Monica (CMS/CMCS); Hennessy, Amy (CMS/OC); hoshelton@naacpnet.org; jca25@georgetown.edu; JDBaker@mathematica-mpr.com; Jennifer Tolbert; JKozminski@essentialhospitals.org; Johnston, James (CMS/OHI); Judy Solomon (solomon@cbpp.org); Katch (she/her), Hannah (CMS/OA); Katie@Out2Enroll.org; Koepke, Christopher (CMS/OC); Lessard@nilc.org; Lipscomb (she/her), Darla (CMS/CCIIO); Lisa Satterfield; Lorsbach (she/her), Anna (CMS/CCIIO); Lovejoy, Shannon (CMS/CMCS); lrodriguez@americanprogress.org; Lyndsey Cavender; Mccloy, Tamara (CMS/OPOLE); mcheek@ahca.org; minnocent@naacpnet.org; mmiller@communitycatalyst.org; Montz, Ellen (CMS/CCIIO); msnider@unidosus.org; Naomi Ali; O'Connor, Sarah (CMS/CMCS); rb1686@georgetown.edu; rcarreon@unidosus.org; Reilly, Megan (CMS/OC); robinr@kff.org; Ross, Christy; rtetlow@acog.org; sarah.nolan@seiu.org; Seng, Suzette (CMS/CMCS); Setala, Ashley (CMS/CMCS); sfeliz@nul.org; shughes@aha.org; squinn@aafp.org; Stan Dorn; Stephens, Jessica (CMS/CMCS); Taylor Platt; tharo (aap.org; Thomas, Pam (CMS/OPOLE); Tiara Halstead; Toomey, Mary (CMS/OC); Trevino, Ethan (CMS/CCIIO); Tricia Brooks; Tsai, Daniel (CMS/CMCS); UnwindingSupport@mathematica-mpr.com; Wagstaffe, Leslie (CMS/CCIIO); Walen, Alyssa (CMS/OC); Wallace, Nick; Weiss, Alice (CMS/CMCS); Wood (he/him), Elijah (CMS/CCIIO); youdelman@healthlaw.org

Location:
https://cms.zoomgov.com/j/1612157166?pwd=ZTljMXBKMURBU3d4L0V1K3Z5VnJoZz09

Start Time:
1/12/2023 8:00:00 PM +0000

End Time:
1/12/2023 9:00:00 PM +0000

Duration:
1 hours

Reminder Time:
1/12/2023 8:00:00 PM +0000

Is Recurring:
false

Recurrence Type:
Not

Recurrence Pattern:

Response Status:
5

Busy Status:
Tentative

Attachments:
20230112_Stakeholder Workgroup Agenda.docx

1.9.23: Moved to accommodate calendars

CMS CMCS Unwinding is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting
https://cms.zoomgov.com/j/1612157166?pwd=ZTljMXBKMURBU3d4L0V1K3Z5VnJoZz09

Meeting ID: (b)(6)
Password: (b)(6)

One tap mobile
+16692545252,,1612157166# US (San Jose)
+16468287666,,1612157166# US (New York)

Dial by your location
+1 669 254 5252 US (San Jose)
+1 646 828 7666 US (New York)
833 568 8864 US Toll-free
Meeting ID: (b)(6)
Find your local number: https://cms.zoomgov.com/u/aYte4pvvV

Join by SIP
Password: (b)(6)
sip: (b)(6) @sip.zoomgov.com

This meeting may be recorded. The host is responsible for maintaining any official recordings/transcripts of this meeting. If recorded, this meeting becomes an official record and shall be retained by the host in their files for 3 years or if longer needed for agency business. If a recording intends be fully transcribed or is being captured for the purpose of creating meeting minutes, the host shall retain the record in their files for 3 years or if no longer needed for agency business, whichever is later.

CMS Unwinding Stakeholder Workgroup Agenda
January 12, 2023| 3:00 - 4:00 PM ET

Welcome and Opening Remarks

Recent Releases
CMCS Informational Bulletin: Medicaid Continuous Enrollment Requirement Provisions in the Consolidated Appropriations Act, 2023: link
Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations (updated with scenarios): link
System Readiness Artifacts: A Refresher on Medicaid Enterprise Systems Artifacts for Unwinding: link

Forthcoming Guidance

Discussion of New CAA, 2023 Unwinding CIB

Feedback from the Field & Open Discussion

Wrap Up & Next Steps
Unwinding National Partner/Stakeholder Webinar: Wednesday, January 25 (12-1pm ET)
Registration Link: here
Next Meeting: Rescheduling: To be confirmed

Appointment Title:
[External] CMCS Access Policy Sprint Working Session

Organizer:
Peterson, Alanna

Attendees:
Boozang, Patricia; Mann, Cindy; O'Connor, Kaylee; Striar, Adam; Serafi, Kinda; Giles, John (CMS/CMCS); Gibson, Alexis E. (CMS/CMCS); Gentile, Amy A. (CMS/CMCS); TSCHENCK@mitre.org; jbarrazacannon@mitre.org; rebeccacase@mitre.org

Location:
https://manatt.zoom.us/j/94883599799?pwd=Q2Z3WHlIeDZJeERWcWJPdGFCWGJCZz09

Start Time:
9/29/2022 2:00:00 PM +0000

End Time:
9/29/2022 3:00:00 PM +0000

Reminder Time:
9/29/2022 1:45:00 PM +0000

Reminder Set:
true

Duration:
1 hours

Is Recurring:
false

Reccurrance Pattern:

Response Status:
5

Busy Status:
Tentative

Attachments:
image001.jpg

Hi there,

Alanna Peterson is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting

Phone one-tap:

US: +13092053325,,94883599799# or +13126266799,,94883599799#

Meeting URL:

https://manatt.zoom.us/j/94883599799?pwd=Q2Z3WHlIeDZJeERWcWJPdGFCWGJCZz09

Meeting ID:

(b)(6)

Passcode:

(b)(6)

Join by Telephone

For higher quality, dial a number based on your current location.

Dial:

US: +1 309 205 3325 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 or +1 301 715 8592 or +1 669 900 6833 or +1 719 359 4580 or +1 253 215 8782 or +1 346 248 7799 or +1 386 347 5053 or +1 564 217 2000 or +1 669 444 9171 or 888 788 0099 (Toll Free) or 877 853 5247 (Toll Free)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

International numbers

Join from an H.323/SIP room system

H.323:

162.255.37.11 (US West)
162.255.36.11 (US East)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

SIP:

94883599799@zoomcrc.com

Passcode:

(b)(6)

RE: RE: Reconnecting on Access Work
From:
"Boozang, Patti" <PBoozang@manatt.com>

Sent:
12/12/2022 2:31:39 PM -0500

To:
"Giles, John (CMS/CMCS)" <John.Giles1@cms.hhs.gov>; "Gibson, Alexis (CMS/CMCS)" <alexis.gibson@cms.hhs.gov>; "Gentile, Amy (CMS/CMCS)" <Amy.Gentile@cms.hhs.gov>

CC:
"Serafi, Kinda" <KSerafi@manatt.com>; "Mann, Cindy" <CMann@manatt.com>; "Striar, Adam" <AStriar@manatt.com>; "Peterson, Alanna" <APeterson@manatt.com>; Johanna L Barraza-Cannon <jbarrazacannon@mitre.org>; Thomas W Schenck <TSCHENCK@mitre.org>; "Llanos, Karen (CMS/CMCS)" <Karen.Llanos@cms.hhs.gov>; "Gentile, Amy (CMS/CMCS)" <Amy.Gentile@cms.hhs.gov>; "Gibson, Alexis (CMS/CMCS)" <alexis.gibson@cms.hhs.gov>

Subject:
RE: RE: Reconnecting on Access Work

Attachments:
CMS Access Punchlist Outline_DRAFT_12.12.2022.docx; Provider Survey Toolkit Approach - 12.5.2022.docx

John and team,

In advance of our call later this week, please find an agenda below and the current versions of the two draft access tools: an Access Punchlist and a Provider Survey toolkit outline. Please note that to date, we have focused our work on access punch list strategies to those applicable under Medicaid managed care. As we mentioned previously, we are in the remaining few weeks of this performance period to work on these deliverables, so we would like to get your input on the high priorities for getting these to a next draft that will be helpful to you as you turn your attention from rule making to tools and state TA. We look forward to discussing with you on Thursday.

[External] CMS Access Call
Date: Thursday, December 15, 2022, 2:30 * 3:00 pm

Agenda:
- CMS update on status of MMC Access rules
- Manatt recap of work on draft Access Tools (see attached)
? Access Punchlist
? Provider Survey Toolkit
- Discuss CMS priorities for additional Access Tool work by year-end (end of current performance period)
- Next Steps

Patti

Patricia M. Boozang

Senior Managing Director - Manatt Health Strategies

Manatt, Phelps & Phillips, LLP

177 Huntington Avenue
Suite 2500

Boston, MA 02115

D (212) 790-4523 F (212) 536-1883

PBoozang@manatt.com

manatt.com

From: Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>
Sent: Monday, December 5, 2022 4:01 PM
To: Boozang, Patti <PBoozang@manatt.com>; Gibson, Alexis (CMS/CMCS) <alexis.gibson@cms.hhs.gov>
Cc: Serafi, Kinda <KSerafi@manatt.com>; Mann, Cindy <CMann@manatt.com>; Striar, Adam <AStriar@manatt.com>; Peterson, Alanna <APeterson@manatt.com>; Johanna L Barraza-Cannon <jbarrazacannon@mitre.org>; Thomas W Schenck <TSCHENCK@mitre.org>; Llanos, Karen (CMS/CMCS) <Karen.Llanos@cms.hhs.gov>; Gentile, Amy (CMS/CMCS) <Amy.Gentile@cms.hhs.gov>; Gibson, Alexis (CMS/CMCS) <alexis.gibson@cms.hhs.gov>; Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>
Subject: RE: Reconnecting on Access Work

Hi Patti *

Happy to meet and discuss these tools. Here are some potential options on our side:

12/13 * 12:30pm or 4:00pm ET
12/14 * 3:00pm, 3:30pm, or 4:00pm ET
12/15 * 2:00 or 2:30pm ET

Let me know what is best for you. Thank you!

John Giles, MPA
Director, Division of Managed Care Policy
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Phone: 240-904-2341
E-mail: John.Giles1@cms.hhs.gov

From: Boozang, Patricia <PBoozang@manatt.com>
Sent: Saturday, December 3, 2022 11:42 AM
To: Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Gibson, Alexis (CMS/CMCS) <alexis.gibson@cms.hhs.gov>
Cc: Serafi, Kinda <KSerafi@manatt.com>; Mann, Cindy <CMann@manatt.com>; Striar, Adam <AStriar@manatt.com>; Peterson, Alanna <APeterson@manatt.com>; Johanna L Barraza-Cannon <jbarrazacannon@mitre.org>; Thomas W Schenck <TSCHENCK@mitre.org>; Llanos, Karen (CMS/CMCS) <Karen.Llanos@cms.hhs.gov>
Subject: Reconnecting on Access Work

John and Team *

Happy December * hard to believe it*s year-end 2022* I am getting in touch to suggest we schedule some time with your team to review two draft access tools that we have been developing under our subcontract to MITRE to support CMCS access work: an Access Punchlist and a Provider Survey toolkit outline. Since we are in the remaining few weeks of this performance period to work on these deliverables, we would like to get your input on the high priorities for getting these to a next draft that will be helpful to you as you turn your attention from rule making to tools and state TA.

If you agree, Alanna, copied here, will swing into scheduling mode * and we will send an agenda and the draft tools well in advance of our meeting.

Thank you * and have a wonderful weekend.
Patti

Patricia Boozang

Senior Managing Director - Manatt Health Strategies

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Manatt Health

2022-10-18T22:05:00Z

Manatt
CMS: To date, we have focused our work on access strategies applicable under Medicaid managed care. We understand that some strategies are also applicable under FFS, and that CMS will want to produce punch list strategies for both MMC and FFS delivery systems. We suggest that separate, tailored punch lists for FFS and MMC would be most helpful to states.

Manatt is seeking CMS' feedback on punch list topic areas that are highest priority in terms of state guidance and TA. We would intend to focus our time in the remainder of the current period of performance on further developing those topic areas. Potential priorities could include:

- Crosswalk Part 438 to identify punch list gaps.

- Identify a subset of priority areas in which to build out more detailed punch list strategies (i.e. prioritize strategies specifically related to implementation of draft MMC access regulations.)

- Build out additional resources and state examples in key priority areas.

Manatt Health

2022-11-04T16:03:00Z

Manatt
CMS: We proposed this initial structure/ordering of the topical areas but can revise with CMS input.

Manatt

2022-12-12T11:13:00Z

MH

CMS: To confirm if there are other new requirements related to annual pubic access reports.

Manatt

2022-12-08T11:16:00Z

MH
CMS: Resources sections could be built out further to provide examples and more detail related to the strategies listed above.

Manatt

2022-12-12T09:18:00Z

MH
CMS: This section could be built out with additional resources.

Manatt

2022-12-12T10:32:00Z

MH
CMS: To confirm that these public reporting recommendations align with new rules, including specific frequency of reporting (annual vs. monthly/quarterly).

Manatt

2022-12-12T10:08:00Z

MH
CMS: Manatt could identify and add additional state examples throughout, as appropriate.

Manatt

2022-12-12T10:48:00Z

MH
CMS: Telehealth could be its own standalone punch list that is much more detailed and specific to subpopulations (e.g. HCBS, pregnant/postpartum women, BH (youth/adults).

Manatt

2022-11-03T14:09:00Z

MH
CMS: Are these the populations that you would like highlighted here? Are there any others to add – e.g., AI/AN?

Manatt

2022-12-08T15:17:00Z

MH
CMS: We think a population-specific punch list for each of these priority populations may make sense. There are likely targeted strategies related to data, telehealth, oversight and enforcement, community engagement, provider capacity, etc. that would be more specific and actionable if applied to a particular population, which might be helpful to states, in addition to a list of high-level, overall strategies.

Manatt

2022-12-08T12:06:00Z

MH
CMS: This could be built out in much more detail related to data and monitoring strategies for HCBS specifically.

Manatt

2022-12-08T14:13:00Z

MH
CMS: HCBS payment approaches and state examples to support community living could be built out further

Manatt

2022-12-12T10:25:00Z

MH
CMS: This section could be built out further.

Manatt

2022-12-12T09:14:00Z

MH
CMS: This section could be built out with targeted strategies.

Manatt

2022-12-12T10:48:00Z

MH
CMS: This section could be built out further, leveraging the E&E unwinding punchlist and other resources.

DRAFT

State Strategies to Promote Access in Medicaid and CHIP Managed Care: Punchlist Outline
Draft as of December 12, 2022

Table of Contents

INTRODUCTION

Medicaid and the Children's Health Insurance Program (CHIP) play an important role in providing health coverage and access for low-income adults, children, pregnant women, and people with disabilities. These programs are also essential in addressing health disparities among historically underserved people in the United States; more than 58% of Medicaid beneficiaries and 68% of CHIP beneficiaries identify as Black, Hispanic, Asian American, American Indian or Alaska Native, or Multi-Racial.

1 Medicaid and CHIP Payment and Access Commission, Key findings on access to care. Available at: https://www.macpac.gov/subtopic/access-for-adults-covered-by-medicaid/

Health insurance coverage is critical for ensuring access to health care services, but there are a number of important factors beyond health insurance coverage that impact access to health care, including provider availability and capacity, timeliness of service delivery, travel distance to providers, and access to telehealth. Robust access to care in Medicaid/CHIP is essential to ensuring that beneficiaries receive the health care services and supports they need and to which they are entitled to maintain good health and address health-related needs efficiently and effectively. Lack of access to care can have severe implications for health, health equity, quality of life, and costs to families and state Medicaid/CHIP programs.

Current Federal regulations require that states monitor access to care in Medicaid and CHIP, and, if gaps are identified, actively work to address those gaps. While there are separate statutory and regulatory requirements for how states and managed care plans must monitor and ensure access to care, there are common barriers and strategies to address barriers to access regardless of the delivery system.

The Centers for Medicare and Medicaid Services (CMS) developed a set of policy and operational strategies informed by state best practices that states can implement to strengthen access to care in Medicaid managed care. The strategies defined in the following pages are designed to be used individually or together to identify and address access gaps and to drive continuous program improvement. The strategies included in this tool offer actionable steps that states can take to strengthen access to care across nine key areas:

Develop an Access Data Strategy.
Establish Data-Informed Access Priorities, Goals, and Measures.
Increase Provider Participation and Capacity.
Improve Provider Directories.
Monitor Access.
Enforce Network Access.
Expand Access to Services via Telehealth.
Ensure Access for High Need Beneficiaries.
Strengthen Consumer Engagement.

This resource is part of an overall CMS initiative to support states in improving access to care in their Medicaid/CHIP programs and is complementary to forthcoming regulations, sub-regulatory guidance, and additional tools that the CMS intends to release to support Medicaid/CHIP access improvement.
Implementing the strategies described herein will require states to work with CMS and, in some cases, may require that states submit state plan amendments (SPAs), make changes to Medicaid managed care contracts, among other implementation activities. To the extent these additional steps are required, CMS is available to provide technical assistance to states, as needed.

STRATEGIES TO PROMOTE ACCESS IN MEDICAID/CHIP

I. Develop an Access Data Strategy

States can developed a comprehensive data strategy to identify potential access issues, specific access barriers and disparities in access, stratified by race, ethnicity, gender, sexual orientation, age, geography, and other factors.

Data Collection

Improve accuracy, quality and completeness of beneficiary-reported race, ethnicity, and language (REL) data collected using the following strategies:
Expand the number of race and ethnicity categories in the Medicaid/CHIP application beyond the Office of Management and Budget (OMB) categories, ensuring categories can “roll-up” to OMB categories.
Offer Medicaid application, enrollment, and renewal information and forms in multiple languages and modalities.
Provide clear explanation in the Medicaid/CHIP application regarding why the state is collecting this REL data and how it is used.
Develop educational materials and programming on REL data collection and translate those materials into multiple languages.
Provide training for state and county workers, navigators/assisters and other eligibility and enrollment organizations and staff on best practices for collecting REL data;
Facilitate new data sharing arrangements across state agencies and with state or regional health information exchanges to support demographic data exchange.

Data Review and Analysis

Analyze quantitative and qualitative data to identify access issues and inequities (e.g., Transformed Medicaid Statistical Information System (T-MSIS), all-payer claims databases (APCDs), network access files, Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, provider inquiries, provider survey results, grievances and appeals,

ombudsman reports, encounter/claims data, etc.) (see Section X on monitoring access). For example:
Use T-MSIS data to calculate standardized measures of Medicaid/CHIP service utilization and use these results to diagnose potential Medicaid/CHIP access issues.
Stratify T-MSIS data across key measures of Medicaid/CHIP service utilization to identify areas of variability /CHIP based on beneficiary geography of residence, race and ethnicity, and other demographic factors.

2 For example, APCDs can be used to assess disparities in access to care among Medicaid and CHIP beneficiaries relative to commercially insured individuals.

2

Leverage measures in the adult and child core set to enhance understanding of Medicaid/CHIP network adequacy issues.
Conduct spot checks through provider surveys (see Section X on provider surveys) to verify the accuracy of the provider network file (e.g., include providers who are actively seeing patients and billing Medicaid).
Analyze available social drivers of health (SDOH) data to understand social, economic, geographic and environmental factors influencing health care access.
Incorporate qualitative data from community members (see Section X on strengthening consumer engagement) and community-based organizations (CBOs) to put quantitative data in context.

Annual Access Report

Produce Annual Medicaid and CHIP Access Reports based on a comprehensive review and analysis of quantitative and qualitative data (see above).
Identify access gaps by provider specialty, geography, beneficiary demographics, and other relevant factors.
Disseminate annual Medicaid/CHIP Access Report publicly, ensuring it is accessible to all beneficiaries.

Resources:
Centers for Medicare and Medicaid Services (CMS), Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability, April 2017.

II. Establish Data-Informed Access Priorities, Goals, and Measures
States can leverage their access data strategies and input from beneficiaries (including community members and people with lived experience) to establish access priorities, specific goals for improvement, and measurable benchmarks/standards, to improve the health care system holistically and address access disparities.

Priorities and Goals
Leverage quantitative/qualitative access data and analysis to inform clear and specific access priorities and goals (see Section X on developing a data strategy).
Include community members and people with lived experience when setting access-related priorities and goals by actively soliciting perspectives and feedback (e.g., community forums, focus groups).
Identify best practices (e.g., from the literature, other state Medicaid programs) and appropriate policy solutions to advance access goals, with particular focus on strategies to address access disparities.
Identify best practices and policy solutions to address structural inequities in the health care system that generate access disparities.
Collaborate with managed care plans, beneficiaries, and other partners to develop access priorities and goals(see section X on strengthening consumer engagement.
Publicly report access goals and priorities).

Benchmarks and Standards
Leverage quantitative/qualitative access data and analysis to establish clear and measurable benchmarks to enable states to assess the impact of system improvement efforts on observed disparities (see Section X on developing a data

strategy).
Include community members and people with lived experience when setting access-related benchmarks and standards by actively soliciting perspectives and feedback.
Communicate benchmarks and progress against benchmarks with managed care plans, providers, beneficiaries, and other partners.
Define and continuously build upon network adequacy standards in a manner that comports with state access priorities and goals.
Require reporting of Medicaid access measures tied directly to access goals to support transparency and accountability.
Establish regular cadence throughout the year where the state is evaluating access metrics through regular reports and identifying operational strategies to improve upon those findings.

Resources:
State Health & Value Strategies (SHVS), Centering Health Equity in Medicaid Section 1115 Demonstrations: A Roadmap for States (February 2022).
Grantmakers in Health and the National Committee for Quality Assurance (NCQA), Improving Data on Race and Ethnicity: A Roadmap to Measure and Advance Health Equity (December 2021).
NORC, The State of the Collection of Race, Ethnicity, and Language Data in Medicaid (February 2022).

III. Increase Provider Participation and Capacity
Robust provider participation in the Medicaid program and provider capacity to actually see patients are fundamental to access.

Broadly Applicable Provider Strategies
Conduct a comprehensive workforce needs assessment to better understand the supply of and identify gaps in various provider types by specialty – especially in the areas of primary care, OB/GYN care, behavioral health, and home and community-based services (HCBS) providers. Consider demographics, cultural competency, diversity and geography of the workforce.
Develop a multi-year workforce development plan of short-term and long-term strategies to address provider workforce gaps.
During managed care procurement processes, request data and qualitative information on prospective plans' networks and strategies to ensure access by specialty, particularly among specialties with known access gaps.
Modify managed care contracts to require plans to expand provider workforce and workforce capacity and to submit data demonstrating on activities and progress among specialties with known access gaps.
Develop standards for use of telehealth to meet provider access standards (see Section X on telehealth).
Analyze provider payment rates

3 Payment influences access, with low rates of payment limiting the network of providers willing to accept Medicaid patients, capacity of those providers who do participate in Medicaid, and investments in capital improvements and emerging technology among providers that serve large numbers of Medicaid beneficiaries.

by specialty and geography to determine if payment may be creating access barriers.
Consider provider payment increases based on rate analysis.
Offer financial incentives to recruit providers to deliver services in remote or underserved areas.
Provide or ensure equitable Medicaid reimbursement for providers in underserved areas. Require managed care plans to contract with all licensed and qualified providers in specific specialty areas ("any willing provider" law) to address identified gaps in access (e.g. primary care, OB/GYN, behavioral health, HCBS, other identified gaps).
Enter reciprocity agreements with other states, join interstate licensing compacts, or adopt requirements established by national organizations that develop standardized certifications and facilitate reciprocity for specific licensed provider types.

Primary Care Providers
Amend scope of practice requirements to allow nurse practitioners and advanced practice registered nurses broader practice authority, including prescribing authority.
Invest in health IT infrastructure and capacity building for primary care physicians unaffiliated with hospitals or medical groups
Consider implementing targeted payment changes for primary care providers, including rate enhancements (see above), bonus payments for managing complex patients, or other alternative payment strategies.
Assess managed care plan payment timeliness to primary care providers and establish new contractual requirements as necessary to mitigate payment delays.
Require plans to report timeliness of provider payment; hold plans accountable for delays in payments through financial penalties, corrective action plans, or other enforcement mechanisms (see Section X on enforcing network access).
Offer telehealth-based technical assistance or other support for providers.

OB/GYN Providers
Allow for Medicaid participation and payment for a broader range of maternal health providers (e.g., Direct Entry Midwives) and practice settings (e.g., freestanding birth centers).
Amend scope of practice requirements to allow certified nurse midwives broader practice authority, including prescribing authority.
Amend licensing and certification requirements or otherwise allow and encourage the inclusion of paraprofessional provider types in areas where there are gaps in capacity (e.g., community health workers, doulas).
Establish training programs and grants to increase the number of maternal health care providers practicing in underserved areas.

Behavioral Health Providers
Compare payment for behavioral health services with similar physical health services in Medicaid and act to address gaps in payment parity.
Assess and reduce differences in behavioral health payment rates between Medicaid and other payers (e.g., Medicare, commercial plans).
Amend scope of practice requirements to allow nurse practitioners and advanced practice registered nurses broader practice authority, including prescribing authority.
Amend licensing and certification requirements or otherwise allow and encourage the inclusion of paraprofessional provider types in areas where there are gaps in capacity (e.g., community health workers, peer and family support specialists, recovery specialists).
Expand psychiatry residency programs at academic medical institutions and fund training programs for other graduate behavioral health students at academic institutions, provider organizations, and community-based organizations.
Develop and implement certification and training programs for paraprofessionals, such as community health workers and peer and family supports specialists, while ensuring that certification exams are not cost-prohibitive and are accessible to individuals who are non-native English speakers. Develop and offer training programs for supervisors of paraprofessionals to ensure that these staff members are well-integrated into the clinical team.
Provide additional social supports to behavioral health providers to promote workforce retention, such as child care and transportation stipends.

HCBS Providers
Create a statewide direct care workforce strategy and leverage partners (e.g., managed care plans) to test and report on various recruitment, retention, and training approaches.
Partner with schools of higher education, residency programs, and other partners to establish or expand educational/clinical training opportunities (e.g., internships, residency programs) and expand the paraprofessional workforce.
Include informal and/or family caregiver supports as required elements in HCBS care models.
Consider implementing informal caregiver programs.
[Callout box: Hawaii's Informal Caregiver Programs. 1) Senior Companion Program- a program for low-income, volunteer seniors age 55+ to provide respite for caregivers of frail older adults through in-home companionship and limited personal care services; 2) Respite Companion Program- an employment and training program for low-income

seniors age 55+ who can work 19+ hours per week to serve frail homebound elders].

Resources:
Urban Institute, Can Telemedicine Help Address Concerns with Network Adequacy? Opportunities and Challenges in Six States (April 2016).
CMS, Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability (April 2017).
CMS, Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit (June 2021).
CMS, Workforce Initiative.
Massachusetts Foundation, Creating a Robust, Diverse, and Resilient Behavioral Health Workforce in Massachusetts (September 2022).
Rhode Island Executive Office of Health & Human Services, Healthcare Workforce Transformation (May 2017).
Health Resources and Services Administration (HRSA), National Center for Health Workforce Analysis.
National Conference of State Legislatures (NCSL), Improving Access to Care: Medicaid, Telehealth and Health Workforce 101 (February 2021).
National Governors Association, Addressing Wages Of The Direct Care Workforce Through Medicaid Policies (November 2022).
Arnold Ventures and ATI Advisory, State Approaches to Increase Home and Community-Based Service (HCBS) Provider Capacity (June 2022).

IV. Improve Provider Directories
Most Medicaid beneficiaries use provider directories to access care. States have an opportunity to improve the utility of provider directories, recognizing that the accuracy of provider directories has been a longstanding problem resulting in delays in accessing care, which can exacerbate disparities.

Ensure that provider directory information is accurate and current (e.g., through use of provider/member surveys, claims data). (See section X on provider surveys).
Ensure information in the provider directory is culturally competent (e.g., Include provider language, race/ethnicity, and gender/gender identity in provider directories; ensure provider directory is available in multiple languages).
Include specific information on telemedicine access.
Include practice specific information (e.g., whether the practice offers LGBTQIA-friendly services, languages spoken by the provider, services available for special populations, etc.).
Examine T-MSIS data to identify providers included in provider directory who have not billed Medicaid for services for some duration of time. States could then reach out to managed care plans to have them confirm participation and reassess access in light of the data; they could also regularly remove providers from the directory if the provider has not submitted any Medicaid claims and use the T-MSIS data to confirm or update the practice locations of providers.
Exclude providers who have not submitted any Medicaid claims from network adequacy analysis.
Ensure timely and accurate updates to the directory when key information (e.g., provider location, phone number) changes.

Resources:
American Medical Association and Council for Affordable Quality Healthcare, Improving Health Plan Provider Directories.

V. Monitor Access
To monitor compliance with access standards in Medicaid, states can engage in a number of activities to identify and review access issues.

Provider and Consumer Surveys

Field provider surveys ((including both secret

4 A “secret shopper” survey approach is one in which an individual posing as a fictional Medicaid beneficiary attempts to set up an appointment with a Medicaid provider listed as part of a health plan’s network.

4
and revealed

5 A “revealed” survey approach is one in which the surveyor acknowledges that they are conducting an access survey on behalf of the state Medicaid agency or managed care plan.

5
surveys) to monitor Medicaid plan provider networks, provider directory accuracy, and other elements of access to care (see Provider Survey Toolkit).
Conduct beneficiary surveys (such as Consumer Assessment of Healthcare Providers and Systems (CAHPS)) to understand the beneficiary experience related to Medicaid access.
Submit CAHPS surveys (health plan, HCBS, etc.) to the AHRQ CAHPS database to better understand how beneficiary experience compares to the beneficiary experience in other states.
Take steps to increase beneficiary survey response rates by (1) utilizing multiple modalities (e.g., mail with phone follow-up, e-mail, text), and (2) crafting informative subject lines and invitation letters that offer beneficiaries a clear reason they should consider responding.
Consider employing an oversampling methodology or performing case-mix adjustment when conducting beneficiary surveys to ensure data analysis accurately represents the beneficiary population.

Complaints, Grievances and Appeals
Monitor access to services through grievance and appeals files, which states require managed care plans to submit regularly.
Make available processes by which consumer groups, providers, and other parties can report ongoing systemic issues of access that the state investigates and resolves (e.g., a toll-free consumer hotline intended to facilitate informal dispute resolutions for all beneficiaries, including those for whom English is a second language and members from other marginalized groups).

6 States should also ensure compliance with the existing regulations at 42 CFR §?438.71 that require states to establish an access point for complaints and concerns about access to covered services for enrollees who use, or express a desire to receive, LTSS.

6

Establish an ombudsman’s office to assist beneficiaries in explaining the rules, understanding the scope of services available, navigating the system, and appealing denials or service limitations; this can be an important source of information on the kinds of access issues that are arising.
Implement robust HCBS grievance and critical incident reporting processes, and provide actionable training to state staff to respond to and resolve beneficiary-reported concerns.
Publicly report all complaints, grievances and appeals by managed care plan, provider, service type, reason filed, and status/outcome.

Resources:
CMS, Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit (June 2021).
Agency for Healthcare Research and Quality (AHRQ), Developing Invitation Messages That Increase CAHPS Survey Response Rates (November 2019).

VI. Enforce Network Access

States should consider utilizing a continuum of enforcement actions to ensure accountability for beneficiary access issues.

Collaboration and Partnerships

Work collaboratively and leverage information from across all agencies and divisions with oversight responsibility for Medicaid and Medicaid managed care plans to identify and remedy access issues.
[Call-out box: New Jersey example – monthly "360 review" conducted to assess managed care plan performance on network adequacy and access through discussion with subject matter experts and agency personnel who present findings and perspectives. State identifies managed care plan strengths, weaknesses, and mixed results for discussion with the plan.]
Regularly meet with plans to review access data, discuss access issues, and provide technical assistance on access improvement solutions before deploying other enforcement levers.
Leverage the External Quality Review Organization (EQRO) to ensure managed care plans meet all contractual requirements related to access and ensure members are getting services timely.
[Call-out box: A 75% federal matching rate is available for these activities.]

Transparency

Develop internal executive-level dashboards used by state Medicaid leadership to identify and address network adequacy issues, as well as external access dashboards available to the public to promote transparency and accountability.
[Call-out box: See, for example, Florida's Medicaid statewide Medicaid managed care compliance actions.]
Make public the results of access indicators (e.g., provider survey data, consumer survey data, stakeholder comments/complaints, performance time and distance standards, accuracy of provider directories, identified disparities in access to care) to encourage compliance and recognize achievements.
Use state report cards that can include access measures comparing managed care plans performance in assuring access to care, and may provide consumers with information that allows them to select plans in which current enrollees report higher levels of access[Call-out box: This could entail leveraging the Medicaid and CHIP (MAC) Scorecard or posting publicly access snapshots or a dashboard.]
Make public provider payments to influence key drivers of access—provider network size and capacity.

Penalties and Rewards

Use corrective action plans (CAPs) clearly describing the remedy (or remedies) based on the severity and nature of noncompliance, with clear timetables for meeting milestones.
Impose financial penalties, such as withhold payments or sanctions, commensurate with the severity of access issues.
Offer financial incentives, such as bonus payments, to reward managed care plans that bear additional access-related costs to improve network adequacy and address health disparities.

Resources:
CMS, Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit (June 2021).

VII. Expand Access to Services via Telehealth

Of the course of the COVID-19 pandemic, the use of telehealth in health care delivery has increased at a rapid pace. States have broad flexibility with respect to covering Medicaid/CHIP services provided via telehealth and may wish to

include quantitative network adequacy standards for telehealth, as appropriate based on current practices and the extent to which network providers offer telehealth services.

7 [Placeholder for note about technical guidance from CMS on how telehealth supports access and how it should be considered in network adequacy and access measurement].

7

Explore use of telehealth for new services/provider types to ensure access to care—especially for rural and underserved communities.
Consider making permanent the temporary telehealth flexibilities adopted during the federal public health emergency (PHE) (e.g., by codifying flexibilities into state statute, or incorporating them into regulation, policy, guidance, etc.).
Remove policy barriers that limit access to telehealth (e.g., originating site requirements).
Require telehealth payment parity for appropriate services at the state's discretion.
Expand telehealth workforce across state lines.

Resources:
CMS, State Medicaid & CHIP Telehealth Toolkit Policy Considerations for States Expanding Use of Telehealth.

VIII. Ensure Access for High Need Beneficiaries
States may consider targeted strategies to improve access to care for high need beneficiaries.

Beneficiaries Receiving HCBS
Collect and report access measures from the HCBS core set. Stratify results by beneficiary characteristics (race/ethnicity, geography, disability, etc.) to ensure equitable access.
Develop strong HCBS person-centered contract requirements and policy guidance for managed care plans.
Develop data monitoring systems to promote understanding of utilization trends and ensure access to services.
Integrate Medicaid and Medicare and other relevant data sets (such as housing records, public health data) to enable a comprehensive view of access, costs, and outcomes.
Partner with Medicaid managed care plans to develop data-sharing agreements across health systems, plans, case management entities, and other community-based providers to ensure individuals at high risk for institutionalization can be identified early and receive assistance with discharge planning and returning to community settings.
Establish information-sharing requirements in managed care contracts related to hospital and skilled nursing facility (SNF) admissions.
Utilize event notification systems that share hospital and SNF admissions data.
Develop and strengthen community-based partnerships and referral networks.
Develop cross-agency housing and health partnerships to coordinate and integrate housing-related supports, share information, and connect individuals eligible for HCBS with increased housing opportunities.
Leverage flexibility under certain Medicaid authorities to cover housing-related supports and services such as one-time community transition costs, pre-tenancy and tenancy supports, home accessibility modifications, and state-level housing-related collaborative activities, as well as personal care services to enable individuals to stay in their own homes [See CMS, Long-Term Services and Supports Rebalancing Toolkit (November 2020) for details].
Institute incentives and payment reform approaches to facilitate the delivery of high quality and effective services that support successful community living, such as x
Offer supported employment services such as job coaching and and/or self-directed employment support services, in which an individual hires their own job coaches and supported employment staff.
Consider adopting the optional Medicaid Buy-In to allow workers with disabilities who have earnings in excess of traditional Medicaid income limits to access to Medicaid services and supports.
Cover and pay for peer supports.

Partner with state programs and agencies that provide employment supports to programming and leverage cross-agency funding opportunities to support individuals with disabilities to secure and retain employment.
Establishing Memorandums of Understanding with State Vocational Rehabilitation and the State Department of Education to ensure close coordination of services.
Invest in state non-emergency medical transportation (NEMT) information technology infrastructure to improve efficiency and quality of NEMT services.
Work with NEMT brokers, vendors, and managed care plans to promote the use of NEMT technologies to improve beneficiary experience, such as scheduling, route development, automated ride reminders, on-time ride-request functionality, and real-time information on vehicle location and wait time.

Beneficiaries with Behavioral Health/Substance Use Disorder Needs
Utilize paraprofessionals and staff specialized in addressing unmet social needs, such as peer and family supports, care managers, housing support specialists, etc.
Invest in mental health crisis services, such as mobile crisis services and walk-in centers.
[Callout box: Enhanced ARPA funding available to mobile crisis services that meets federal definition for 3 years].
Partner with digital health companies to offer digital apps and digital therapeutics tailored to individuals with BH needs.
[Callout Box: Digital Health Examples. 1) Eleanor Health has partnered with x state Medicaid programs to offer mental health and substance use disorder treatment remotely, including telehealth-based Medication Assisted Treatment (MAT), psychiatry, nursing, therapy and recovery support services. 2) Bicycle Health has partnered with x state Medicaid programs to offer MAT to patients with opioid use disorder via telehealth.]
Assess gaps in behavioral health continuum of care (e.g., detoxification facilities)
Develop partnerships with Emergency Medical Technicians (EMTs)/Community Paramedics to offer community-based behavioral health crisis response, physical evaluations outside of the Emergency Department, and transportation to inpatient facilities or detoxification centers, as needed.
Ensure pharmaceutical drug decisions are not based primarily on cost, but overall value of medication to individuals with serious and persistent mental illness (SPMI).

Individuals in a Pregnant/Postpartum Eligibility Group
Extend postpartum coverage to 12 months.
Require plans to assess pregnant members on potential health and social risk factors and develop personalized care plans.
Require plans to offer educational information on community resources, including WIC, lactation support groups, etc.
Allow plans to offer member incentives (e.g., baby care items, gift cards) to encourage beneficiaries to keep appointments.
Require plans to ensure that providers follow-up with beneficiaries after missed appointments to identify and address barriers.
Cover and pay for transportation to/from medical appointments.
Cover and pay for navigator or peer support assistance with scheduling prenatal, postpartum care and referrals, as needed.
Cover case managers and/or community navigators to help address unmet social needs.
Cover targeted high-risk OB case management and track data-driven outcomes.
Provide postpartum depression educational materials targeted to mothers of newborns and their families to post-delivery letter sent to new mothers.
Ensure postpartum reimbursement policies support postpartum care as an ongoing process, rather than an isolated visit.

Children and Youth with Special Health Care Needs (CYSHN)
TBD

Resources:
SHVS, Ensuring Continuity of Coverage and Care for High Need Enrollees When the Medicaid Continuous Coverage Ends: Medicaid Strategies (June 2022).
SHVS, State Strategies to Improve Maternal Health and Promote Health Equity Compendium (October 2022).
CMS, Home and Community-Based Services Quality Measure Set (June 2022).
CMS, Long-Term Services and Supports Rebalancing Toolkit (November 2020).

National Center on Advancing Person-Centered Practices and Systems (NCAPPS), Person-Centered Practices Self-Assessment (February 2022).
BCBS Massachusetts Foundation, Creating a Robust, Diverse, and Resilient Behavioral Health Workforce in Massachusetts (September 2022).
CMS, Resources on Strategies to Improve Postpartum Care Among Medicaid and CHIP Populations (February 2015).
The American College of Obstetrics and Gynecologists (ACOG), Optimizing Postpartum Care Committee Opinion (May 2018).

IX. Strengthen Consumer Engagement

States can engage consumers (as well as other stakeholders) as they develop policies and make decisions that will impact access. It is critically important that states consider the needs of all beneficiaries—including members with a disability, members for whom English is a second language, and members from other marginalized groups (e.g., racial/ethnic minority groups).

Culturally Competent Care

Review language access plan to provide written translation of key documents (e.g., notices, provider directories) into multiple languages, oral interpretation, and information about how individuals with limited English proficiency (LEP) can access language services free of charge, provided in a culturally competent manner.
Ensure culturally competent state workforce, managed care plans, and providers (e.g., through trainings to address racial and ethnic disparities, implicit bias).

Beneficiary Notices

Ensure beneficiary notices are provided to beneficiaries in plain language and in multiple formats, when possible (e.g., by phone, in writing).
Ensure beneficiaries are able to contact a resource to address questions or concerns related to beneficiary notices in their native language.
Ensure Medicaid member handbooks are easily accessible to beneficiaries electronically or in paper format, as needed.
Ensure all Medicaid beneficiary information is available in the beneficiary's native language.

Consumer Supports

Ensure consumers have access to a customer call center for assistance with questions related to coverage, access to services, and access to information in other languages or formats.
Ensure call centers have evening and/or weekend hours.

Medicaid Advisory Committee (MAC)

Work with community-based organizations to recruit diverse beneficiary members representative of the Medicaid population, such as parents of children, elderly beneficiaries, people with disabilities, and reflective of memberships racial, ethnic, geographical, and language diversity.
Maximize meeting accessibility by leveraging multiple meeting modalities (e.g., in-person, virtual) and ensuring language accessibility (e.g., interpreters, closed captioning).
Offer trainings to beneficiary members in relevant Medicaid policies and topics, leveraging technology (e.g., Zoom) , to ensure robust beneficiary participation.
Consider compensation or accommodations to facilitate beneficiary participation, such as travel stipends or childcare.
Work with beneficiary members and/or community-based organizations to understand the most effective financial accommodations necessary to maximize beneficiary participation.

Online Experience

Conduct independent assessments of existing Medicaid websites before undertaking any changes regarding the managed care functionality.
Include contract requirements that mandate consumer usability and independent consumer UX assessment when contracting with vendors for IT development and enhancement, leveraging a 90/10 FMAP.
Optimize the online experience for beneficiaries tying to navigate the Medicaid delivery system by applying best practices in User Centered Design (UCD) including utilizing iterative and ongoing User Experience (UX) research to

streamline path flows, identifying beneficiary needs, and reducing access barriers.
Utilize web analytics to track website utilization and inform design changes; create a dashboard to quantify website traffic, reach, engagement, sticking points and audience characteristics; and ask about consumer experiences with Medicaid and CHIP websites in their beneficiary utilization and satisfaction surveys.

Additional Resources:
CMS, Strategies States and the U.S. Territories Can Adopt to Maintain Coverage of Eligible Individuals as They Return to Normal Operation (November 2021).
The Commonwealth Fund, How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost (August 17, 2022).
Interaction Design Foundation, User Centered Design.

Striar, Adam

2022-12-05T12:04:00Z

SA
Patti – I've added some commentary below on what I think we could advance over the next few weeks. Please let me know if you have any thoughts.

Striar, Adam

2022-12-05T12:08:00Z

SA
Overall, I think it would be helpful to develop a more complete outline of the Toolkit product, with targeted built out areas as described below

Striar, Adam

2022-12-05T12:03:00Z

SA
Start internal research/analysis

Striar, Adam

2022-12-01T19:21:00Z

SA
Attempt to set up interviews with previous interviewees. My suggestions below:
Jonathan Bick – NY State
Amber Saldivar - HSAG
Paul Henfield - IPRO

Striar, Adam

2022-12-05T12:03:00Z

SA
Develop one draft call script

Note: dependent on being able to schedule interviews

Striar, Adam

2022-12-05T12:07:00Z

SA
Draft guidance based on findings from previous interviews

Striar, Adam

2022-12-01T19:13:00Z

SA
Attempt to schedule 1-2 interviews

Patti – do you know of state experts we can talk to?

Striar, Adam

2022-12-05T12:06:00Z

SA
Draft technical guidance

Note: dependent on being able to schedule interviews

Striar, Adam

2022-12-05T12:07:00Z

SA
Draft guidance based on literature review/findings from interviews

Striar, Adam

2022-12-05T12:09:00Z

SA
We did not hear of any states currently doing this, so we may need to do a bit of digging to figure out if this is

something that any states monitor through secret shopper surveys and then work to set up interviews.

CMCS Access Strategy
Medicaid Managed Care Provider Survey Toolkit – Proposed Work Approach
DRAFT – 10/31/2022

In the following table, we summarize for the MITRE contracting team and CMCS' consideration key components of the proposed Medicaid Managed Care Provider Survey Toolkit ("the toolkit") and Manatt's proposed approach for beginning this work during the current period of performance.

1 The current period of performance ends in December 2022—though we understand that it may be extended by a couple of months.

1
The toolkit is intended to provide states with a suite of practical tools to help them implement provider surveys in Medicaid managed care. Manatt proposes to begin work on several key components of the toolkit through the end of 2022, as described below. Several pieces of the toolkit will require engagement with CMCS and/or a statistical/survey methods expert; Manatt proposes to hold the development of these components until 2023.

Toolkit Component	Tool Development Approach/Timing	Notes
Provider survey call script templates and model questions for different survey scenarios (e.g., "secret shopper," revealed surveys, provider directory validation scenarios).	Completed Draft December 2022 Review literature on approaches to provider surveys. Reach out to "leader" states and survey contractors for example scripts/call guides. Produce draft call scripts/call guides.	
Discussion of unique considerations related to secret and revealed surveys.	Completed Draft December 2022 Develop technical guidance summarizing optimal use of secret vs. revealed shopper surveys and potential issues/challenges related to appropriate use of each.	
Technical guidance on establishing straw model Medicaid shopping personas.	Completed Draft December 2022 Facilitate discussions with state MMIS experts to identify best practices for establishing straw model beneficiary IDs. Develop draft technical guidance.	
Guidance on survey and analytical strategies to identify disparities in access related to race, ethnicity, primary language, gender/gender identity, sexual orientation.	Partial Draft December 2022 Draft guidance summarizing evidence and key concerns around disparities in access and annotated list of disparities that	

states should monitor through provider surveys.
Gather information on survey strategies with "leader" states and survey contractors.
Hold on development of approaches for analyzing data, which will likely require consultation with survey methods/statistical expert and CMCS.

Technical guidance on study protocol/methodological specifications, including:
Sampling approaches (to ensure adequate geographic/demographic representativeness and statistical power)
Timing and frequency of surveys
Statistical approaches for analyzing survey results
Hold on Drafting
Literature review on methodological approaches to analyzing provider survey data.
Discuss survey/analytical approaches with "leader" states.
Consult with survey methods/statistical expert and CMCS.
Develop draft technical guidance.

Guidance outlining CMS's expectations regarding the use of provider survey results for monitoring network adequacy/access and conducting state oversight.
Hold on Drafting
Consult with CMCS on the appropriate role of provider survey results in oversight/monitoring.
Develop draft guidance.

Provider survey design template that could be customized by the state and outlines the minimum components of a provider survey, consistent with CMS guidance, with fillable text fields, help text, and references to specific technical assistance tools related to each survey component.
Hold on Drafting
Consult with survey methods/statistical expert, "leader" states, and CMCS.
Develop survey design template.

Appointment Title:
[External] CMCS Access Policy Sprint Working Session

Organizer:
Peterson, Alanna

Attendees:
Boozang, Patricia; Mann, Cindy; O'Connor, Kaylee; Striar, Adam; Serafi, Kinda; TSCHENCK@mitre.org; Giles, John (CMS/CMCS); Gibson, Alexis E. (CMS/CMCS); Gentile, Amy A. (CMS/CMCS); jbarrazacannon@mitre.org; rebeccacase@mitre.org; Llanos, Karen E.(CMS/CMCS); Pauly, Nathan

Location:
https://manatt.zoom.us/j/92239463552?pwd=Z3ZXempJdTBtaFBhTTBDbjcxei83dz09

Start Time:
8/25/2022 8:00:00 PM +0000

End Time:
8/25/2022 9:00:00 PM +0000

Reminder Time:
8/25/2022 7:45:00 PM +0000

Reminder Set:
true

Duration:
1 hours

Is Recurring:
false

Reccurrance Pattern:

Response Status:
3

Busy Status:
Busy

Attachments:
image001.jpg; Rate Transparency Preamble + Reg - 8.24.2022 vF.docx; Managed Care Access Sprint - Preamble_Regulatory Language and Implementation Roadmap 08.24.2022.docx

Meeting

Proposed Agenda

[External] CMCS/Manatt/MITRE Access Sprint Meeting
Thursday, 8/25
4:00 * 5:00 PM ET

• Review *NEW Discussion Draft: Provider Rate Analysis/Transparency Preamble and Proposed Rule Language (attached)
• Review *NEW Summary Document (*All in one place*): Package of Preamble/Regulatory Language and Roadmap deliverables (attached)
• Share Key Takeaways from Access Interviews
? NJ Interview (8/22)
? Speire Interview with Former Medicaid Directors from AZ, OH, TN (8/23)
• Confirm Proposed Agenda for Next Meeting (8/29)
? Discuss Open Questions on Sprint Materials (as needed)
? Provider Rate Analysis/Transparency
? CMCS Access TMSIS Data Memo
? CMCS Access Strategy Enrollee Website Navigation Memo
? Next Steps/Priorities for Managed Care Access Team
? Confirm CMS Needs Related to MLR Recommendations
? CMCS/Manatt/MITRE Access Sprint Meetings scheduled for 9/15 and 9/29

Hi there,

Alanna Peterson is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting

Phone one-tap:

US: +13017158592,,92239463552# or +13126266799,,92239463552#

Meeting URL:

https://manatt.zoom.us/j/92239463552?pwd=Z3ZXempJdTBtaFBhTTBDbjcxei83dz09

Meeting ID:

(b)(6)

Passcode:

(b)(6)

Join by Telephone

For higher quality, dial a number based on your current location.

Dial:

US: +1 301 715 8592 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 or +1 669 444 9171 or +1 669 900 6833 or +1 253 215 8782 or +1 346 248 7799 or +1 386 347 5053 or +1 564 217 2000 or 877 853 5247 (Toll Free) or 888 788 0099 (Toll Free)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

International numbers

Join from an H.323/SIP room system

H.323:

162.255.37.11 (US West)
162.255.36.11 (US East)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

SIP:

92239463552@zoomcrc.com

Passcode:

(b)(6)

Author

A
CMS: Is this the proposed approach? Or would CMS would come up with a Medicare rate for things that don't relate directly to Medicaid?

Author

A
CMS: Which supplemental payments will be included in this analysis? Will need to include and cross-reference.

Author

A
CMS: For discussion: "logical outgrowth" we included these other options on which CMS may want comment related to treatment/approach to supplemental payments – which seems to us to be the thorniest piece of this.

Author

A
CMS: Would be good to explain how CMS plans to do this, e.g. take the Medicare rate for the comparable service and multiply it by the same number of claims used to do the Medicaid analysis." Adding a table/model into the preamble might help.

Author

A
CMS: Noting that in the proposed FFS provider transparency regs, CMS proposes to establish new requirements that states adequately consider and justify significant SPA rate range reductions. Specifically, states would be required to provide CMS with data and a justification demonstrating that significant SPA rate range reductions would not reduce beneficiary access. CMS would consider proposed rate reductions that results in provider type rates less than 80% of Medicare or a decrease of more than 4% in overall spending, or which yields significant access concerns from the public to be a significant decrease requiring justification. Will there be any parallel in MMC rate range reductions?

Author

A
CMS: We pulled this over from the FFS proposed reg. Does CMS intend to include parallel enforcement language in

438? If so, confirm it's for both existing and new documentation requirements (can't think of why it wouldn't be?)

Author

A
CMS: can you confirm this is the tool you are planning to update?

https://www.medicaid.gov/medicaid/managed-care/downloads/network-assurances-template.xlsx

Author

A
CMS: Do we need to include parameters here? Or would that come in subreg guidance?

Author

A
CMS: For discussion: Definition of supplemental payments? Directed payments and remaining pass throughs but not GME, DSH (which is already subject to an audit), UPL? Would DSH audit analysis combined with this new analysis be helpful?

Promoting Access though Provider Rate Transparency
Proposed CMS Preamble and Regulatory Language
DRAFT August 24, 2022

DRAFT

DRAFT

Introduction
There is considerable evidence that Medicaid payment rates, on average, are lower than Medicare and commercial rates

for the same services and that provider payment influences access, with low rates of payment limiting the network of providers willing to accept Medicaid patients, capacity of those providers who do participate in Medicaid, and investments in capital improvements and emerging technology among providers that serve large numbers of Medicaid beneficiaries. Currently there is no standardized, comprehensive, cross-state comparative data source available to assess Medicaid payment rates across clinical specialties , health plans, and states. CMS believes that there needs to be greater transparency in Medicaid provider payment rates in order for states and CMS to monitor and mitigate payment-related access barriers. Accordingly, CMS is proposing to establish new requirements at 42 CFR § 438.207 directing states to report aggregate Medicaid payment levels for a common basket of services by provider type and health plan, and compare those payment levels to the equivalent Medicare payment levels. CMS is seeking to align provider payment transparency requirements within Medicaid, and, as such, is also proposing fee-for-service transparency regulations and is exploring further alignment of Medicare and the Marketplace rate transparency policy. In the following, we propose preamble language for forthcoming proposed Medicaid Managed Care provider rate transparency regulations.

Lower provider payment rates can harm access to quality care. Recent estimates based on an analysis of fee-for-service rates suggest that Medicaid physician fees were approximately 72% of Medicare in 2019 across a common basket of services, including 67% of Medicare for primary care and 80% of Medicare for obstetric care.

1 Zuckerman S, Skopec L, and Aarons J. Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. Health Aff (Millwood). 2021;40(2). doi:10.1377/hlthaff.2020.00611.

1
For hospital services, the Medicaid and Payment Access Commission (MACPAC) found in 2017 that Medicaid base rates were approximately 78% of Medicare. While accounting for supplemental payments brings Medicaid rates into relative parity with Medicare on average, the value of these payments varies widely across states and, within states, across providers (and can be diminished by financing arrangements where hospitals finance the nonfederal share of Medicaid costs).

2 MACPAC, “Medicaid Hospital Payment: A Comparison Across States and to Medicare,” April 2017, available at https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf.

2

Low reimbursement rates can harm access to care for Medicaid beneficiaries in a number of ways. Evidence suggests that low Medicaid physician fees limit physicians’ participation in the program, particularly for behavioral health and primary care providers.

3 Holgash K, Heberlein M. Physician acceptance of new Medicaid patients. Washington (DC): Medicaid and CHIP Payment and Access Commission; 2019 Jan 24. Available from: https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf

3
,

4 Zuckerman S, Skopec L, and Aarons J. Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. Health Aff (Millwood). 2021;40(2). doi:10.1377/hlthaff.2020.00611.

4
Relatedly, researchers have found that increases in the Medicaid payment rates are directly associated with increases in provider acceptance of new Medicaid patients.

5 National Bureau of Economic Research, "Increased Medicaid Reimbursement Rates Expand Access to Care," October 2019, available at https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care

5
,

6 Zuckerman S, Skopec L, and Aarons J. Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. Health Aff (Millwood). 2021;40(2). doi:10.1377/hlthaff.2020.00611.

6
In short, two key drivers of access – provider network size and capacity – are inextricably linked with Medicaid provider payment levels.

Low reimbursement rates also limit the ability of critical access providers (i.e. providers that do participate in Medicaid, and serve a large number of Medicaid patients) to invest in staff, capital improvements and cutting edge medical technologies.

7 Sung Cho, "Hospital Capital Investment During the Great Recession," June 2017, available at https://journals.sagepub.com/doi/10.1177/0046958017708399.

7
Several commenters on CMS's Access RFI echoed these concerns, noting that low reimbursement rates also exacerbate provider workforce stability and capacity in an already challenging labor market for health care providers. The impact on providers is particularly acute for those for whom Medicaid beneficiaries account for a large share of their patients. It can also result in providers putting a cap on the number of Medicaid patients they serve.

While many factors affect provider participation, given the important role rates play in assuring access CMS believes that greater transparency is needed in order to understand when and to what extent provider payment may influence access in state Medicaid programs to specific provider types or for Medicaid beneficiaries enrolled in specific plans. CMS also believes that greater transparency and oversight is warranted as managed care payments have grown significantly as a share of total Medicaid payments – in FY 2021, the federal government spent nearly $250 billion on payments to managed care plans.

8 Congressional Budget Office, "Baseline Projections – Medicaid," May 2022, available at

https://www.cbo.gov/system/files/2022-05/51301-2022-05-medicaid.pdf

8
CMS seeks to develop, use, and facilitate state use of data to generate insights for CMS and states into important, provider rate related indicators of access including: (1) particular provider types and services for which Medicaid payment may impede access and lead to underinvestment in capacity building and (2) particular plans with payment levels that may create access barriers for their members.
Preamble Language

§ 438.207 Assurances of Adequate Capacity and Services.
Section 1903(m)(2)(A)(iii) of the Act requires contracts between states and MCOs to provide capitation payments for services and associated administrative costs that are actuarially sound. Actuarial soundness is further defined at § 438.4 as requiring states to ensure that capitation rates provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract. States are required under § 438.206(b)(1) to ensure that health plans maintain adequate provider networks. Commenters to the Access Request for Information (RFI) and a broad body of literature suggest that low provider payment rates in state Medicaid managed care programs can create access barriers. In light of these federal regulatory requirements and stakeholder feedback, CMS concludes that provider payment rates in managed care are inextricably linked with provider network sufficiency and capacity and
seeks to codify an updated process through which health plans must report, and states must document, managed care payment rates to providers as a component of states' responsibility to ensure actuarial sound rates, health plan provider network adequacy and beneficiary access consistent with state and federal access to care standards.

CMS proposes in § 438.207(b)(3) and (d)(2) a streamlined and standardized process for provider rate analysis and transparency. With these proposed provisions, CMS aims to balance the need to minimize administrative burden on states with the obligation – imposed both on states and on CMS- to ensure that Medicaid managed care provider rates are sufficient to allow for sufficiently robust provider networks (as required at § 438.206(b)(1)).

In § 438.207(b), we propose to expand the documentation that states are required to produce related to access and the availability of services. In paragraph (b)(3), CMS proposes a new process for states to analyze, report to CMS, and publish on the State's website a percentage comparison of each contracted health plan's Medicaid payment rates, by provider type, to the most recently published Medicare payment rates effective for the time period (or to Medicaid state plan rates for services for which there is no published Medicare payment rate).

In paragraph (b)(3)(i), we specify that the types of services this analysis must include. We have aligned this list with the provider types listed at § 438.68(b)(1): adult and pediatric primary care, OB/GYN, adult and pediatric behavioral health, adult and pediatric specialist services designated by the State, hospital, pharmacy and pediatric dental.

In paragraph (b)(3)(ii) we describe the components of the required rate analysis. Here we propose that provider type rate comparisons should be aggregated rate analyses for each of the service categories specified in paragraph (b)(3)(i). We also specify that the rate analysis must include percentage comparisons made on the basis of each of the following: Medicaid base payments, and Medicaid base and supplemental payments combined. CMS recognizes the challenges of combining supplemental payments with based payments, including that the resulting analysis may paint an inaccurate picture of actual payment rates for many Medicaid providers, since many do not receive supplemental payments or receive payments that are substantially smaller than others. CMS may consider eliminating supplemental payments from this analysis, and using existing state data and reporting on directed and passthrough payments to determine their impact on overall provider payment. CMS is also considering adding a requirement that states document the number of providers associated each provider type and how many providers within each provider type receive supplemental payments. CMS seeks comment on its proposed approach to accounting for supplemental payments, and potential alternative approaches. We also propose that if a Medicare standard is not available (such as for Home and Community Based Service providers), states are required to collect and report for each managed care plan their average rates paid by provider type as a percent of the State's Medicaid State Plan fee for service rates.

CMS proposes that the new documentation requirements in paragraph (b) be submitted consistent with existing requirements at paragraph (c). In paragraph (d)(2), CMS proposes that in addition to submitting required documentation to CMS, states are required to publish on the State's website the documentation required in paragraph (b).

In new paragraph (f) we describe our proposed mechanism for ensuring compliance with documentation requirements in this section. Similar to state practices where penalties are imposed on managed care plans for not providing timely encounter and other data, we propose that CMS may take a compliance action when a state that fails to meet the requirements of the provisions in preceding current and proposed paragraphs in § 438.207 that may include a deferral or disallowance of the State's administrative expenditures. We also indicate that any disallowance would follow the procedures described at Part 430 Subpart C of Title 42, which serve as the regular enforcement process for program compliance. We also note that CMS plans to update the Access and Network Adequacy Assurances Reporting Tool to provide states with a standardized template for reporting this information.

In new paragraph (g), CMS proposes that the new documentation requirements become effective MONTH DAY, 202X.

CMS seeks comment on the proposed process for analysis and documentation of provider rate analysis at § 438.207(b), including considerations and alternative approaches related to accounting for supplemental payments. CMS also seeks comment on proposed transparency requirements at § 438.207(d)(3), as well as the proposed method for ensuring compliance as described in proposed § 438.207(f). CMS also seeks comment on proposed modifications to the Access and Network Adequacy Assurances Reporting Tool and any additional tools and technical assistance that CMS should provide that would facilitate state and health plan compliance with the new provider rate analysis and transparency requirements.

Proposed Rule
§ 438.207 Assurances of adequate capacity and services.
(a) Basic rule. The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this part, including the standards at § 438.68 and § 438.206(c)(1).
(b) Nature of supporting documentation. Each MCO, PIHP, and PAHP must submit the following documentation to the State, in a format specified by the State:
(1) Documentation demonstrating that the MCO, PIHP, or PAHP offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area.
(2) Documentation demonstrating that the MCO, PIHP, or PAHP maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.
(3) Analysis of Medicaid provider payment rates. The analysis must meet the following specifications:
(i) Rate analysis must segment by the following service types to the extent the state contracts with health plans to provide these services:
(A) Primary care services for adults and pediatrics.
(B) OB/GYN services.
(C) Behavioral health services (including mental health and substance use disorder) for adults and pediatrics.
(D) Specialist services (as designated by the State) for adults and pediatrics.
(E) Hospital services.
(F) Pharmacy services.
(G) Pediatric dental services.
(H) Long Term Services & Supports.
(ii) Rate analysis must calculate an aggregate, percentage comparison of all of the MCO, PIHP, or PAHP's Medicaid payment rates relative to the most recently published Medicare payment rates effective for the time period. To the extent Medicare rates are not available, the MCO, PIHP, or PAHP must calculate its rates as a percent of the State's Medicaid State plan rates. The rate analysis must include percentage comparisons made on the basis of:
(A) Medicaid base payments and;
(B) Medicaid base and supplemental payments combined.
(c) Timing of documentation. Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following:

(1) At the time it enters into a contract with the State.
(2) On an annual basis.
(3) At any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect the adequacy of capacity and services, including -
(i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its provider network; or
(ii) Enrollment of a new population in the MCO, PIHP, or PAHP.
(d) State review and certification to CMS.
(1) After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must submit an assurance of compliance to CMS that the MCO, PIHP, or PAHP meets the State's requirements for availability of services, as set forth in § 438.68 and § 438.206. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO, PIHP or PAHP related to its provider network.
(2) Beginning MONTH DAY, 202X the State agency must publish the rate analysis of its Medicaid payment rates as described in paragraph (b)(3) by MONTH DAY, 202X and update the rate analysis every two years by MONTH DAY.
(e) CMS' right to inspect documentation. The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP.
(f) In the event the State does not publish its rate analysis in the manner and timeframe described in paragraphs (b)(3) and (d)(2), CMS may take a compliance action against the State that may include a deferral or disallowance of the State’s administrative expenditures. Any such disallowance would follow the procedures described at part 430 Subpart C of this title.
(g) Applicability date. This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after MONTH DAY, 202X. Until that applicability date, states are required to continue to comply with § 438.207 contained in the 42 CFR parts 430 to 481, edition revised as of July 1, 2018.

Manatt Health

2022-08-24T16:30:00Z

Manatt
CMS: Depending on where you land with the CAP/enforcement approach, you might consider drafting preamble language and seeking comment. We're happy to assist with doing so if helpful. As a reminder, the regs we propose are relatively high-level: A State with beneficiary access issues … may at the discretion of CMS, be required to develop a CAP.

Manatt Health

2022-08-22T17:47:00Z

Manatt
CMS: We presume that (1) the data proposal would not be required, and (2) the beneficiary survey proposal is already advancing. Would it be helpful for us to draft reg text for the public comments proposal?

Manatt Health

2022-08-19T14:32:00Z

Manatt
CMS: We feel that this is sufficient for logical outgrowth. Please also see comment below.

Manatt Health

2022-08-19T13:43:00Z

Manatt
CMS: Reminder of Next Step - Discuss internally how prescriptive CMS would like to be for the secret shopper/provider survey proposed regulation, (b)(3), related to assessing disparities in access to care; and review the additional language related to methodological standards.

Manatt Health

2022-08-19T14:22:00Z

Manatt
CMS: Reminder of Next Step - Discuss internally how the proposed glidepath comports with with logical outgrowth and the enforcmenet approach.

Author

A
CMS: Is this the proposed approach? Or would CMS would come up with a Medicare rate for things that don't relate directly to Medicaid?

Author

A
CMS: Which supplemental payments will be included in this analysis? Will need to include and cross-reference.

Author

A
CMS: For discussion: "logical outgrowth" we included these other options on which CMS may want comment related to treatment/approach to supplemental payments – which seems to us to be the thorniest piece of this.

Author

A
CMS: Would be good to explain how CMS plans to do this, e.g. take the Medicare rate for the comparable service and multiply it by the same number of claims used to do the Medicaid analysis." Adding a table/model into the preamble might help.

Author

A
CMS: Noting that in the proposed FFS provider transparency regs, CMS proposes to establish new requirements that states adequately consider and justify significant SPA rate range reductions. Specifically, states would be required to provide CMS with data and a justification demonstrating that significant SPA rate range reductions would not reduce beneficiary access. CMS would consider proposed rate reductions that results in provider type rates less than 80% of Medicare or a decrease of more than 4% in overall spending, or which yields significant access concerns from the public to be a significant decrease requiring justification. Will there be any parallel in MMC rate range reductions?

Author

A
CMS: We pulled this over from the FFS proposed reg. Does CMS intend to include parallel enforcement language in 438? If so, confirm it's for both existing and new documentation requirements (can't think of why it wouldn't be?)

Author

A
CMS: can you confirm this is the tool you are planning to update?

https://www.medicaid.gov/medicaid/managed-care/downloads/network-assurances-template.xlsx

Author

A
CMS: Do we need to include parameters here? Or would that come in subreg guidance?

Author

A
CMS: For discussion: Definition of supplemental payments? Directed payments and remaining pass throughs but not GME, DSH (which is already subject to an audit), UPL? Would DSH audit analysis combined with this new analysis be helpful?

Managed Care Access Policy Sprint
Leveraging Provider Surveys to Measure Access and CMS Enforcement of Appointment Wait-Time Standards
Memorandum
Updated August 24, 2022

Table of Contents

Introduction

This document summarizes and compiles Manatt Health deliverables supporting the CMCS Managed Care Access Policy Sprint, building on research and memoranda previously shared with CMS and Managed Care Access Policy Sprint working sessions conducted to date. This document lays out a holistic approach to implementation, monitoring/oversight, and transparency/enforcement of new, proposed managed care access requirements related to: appointment wait-time minimum standards; provider surveys (including secret and revealed shopping surveys); information and data transparency with respect to state Medicaid managed care program and provider access; and, documentation of provider rates as an indicator of provider network adequacy. More specifically, this memorandum:

Describes at a high-level the proposed access regulatory requirements;
Lays out a proposed CMS "Roadmap" for ensuring the new requirements result in improved access; and
Provides detailed, supplemental materials in the appendices to inform the development of CMS' Notice of Proposed Rulemaking (NPRM), including, but not limited to, preamble language and proposed regulatory language for the access requirements.

Summary Approach to Access Regulatory Requirements

CMS intends to issue a notice of proposed rulemaking that modifies Medicaid managed care regulations at 42 CFR 438 by bolstering state requirements related to provider access. Specifically, CMS intends to:

Establish minimum federal standards for appointment wait-times that: permit states to impose more stringent requirements and adopt additional requirements; and provide flexibility for CMS to evolve the "floor" over time.
Set a 90% compliance threshold for each provider/facility type (based on appointment wait-time standards established by the state in accordance with federal regulations). States and their managed care organizations will also need to ensure that at least 90% of provider directory entries are accurate at all times.
Require states to conduct annual randomized surveys of providers to assess beneficiary access across plans, and submit to CMS and make public provider survey results.

1 Based on interview findings, we are recommending pivoting away from "secret shopper" language to "provider surveys" that may include both secret shopping and "revealed" shopping (which is required to determine some specific aspects of access).

1
Provider surveys will assess compliance with the state and federal appointment wait-time standards for each provider/facility type, among other access areas.

2 Note: We recommend updating the NPRM so that the survey documents compliance with both state and federal

compliance (to the extent they diverge).

2

As part of public reporting, states must make available through an annual report data on service utilization across a range of beneficiary characteristics.

Subject states to compliance reviews (at CMS discretion) for beneficiary access issues based on provider survey results and other access data and in accordance with the newly refined proposed glidepath (see Appendix A. Preamble Language for Access Requirements and Appendix B. Access Regulatory Language). Access issues will include noncompliance with federal minimum appointment wait-time standards and inaccurate provider directories.

Require states to develop and submit a corrective action plan (at CMS' discretion) to document/ensure compliant practices and take affirmative steps to improve access.

Establish a new, streamlined and standardized process for analyzing and documenting provider rates as an indicator of network adequacy and access.

CMS "Roadmap" for Access Requirements

Below we outline for CMS' consideration a holistic approach to implementation (inclusive of technical assistance for states), monitoring/oversight, and enforcement (including options to promote transparency) for the newly proposed access requirements. This approach is designed to ensure that (1) states are able to efficiently design, implement, and comply with new appointment wait-time standards, provider directory accuracy requirements, and provider surveys; and (2) federal and state partners can identify and address promptly access issues and continuously make program improvements, including through effective enforcement.

New Access Requirements and Implementation

In order to support successful implementation of the new access requirements, CMS may wish to consider a multi-pronged approach involving: regulatory requirements, sub-regulatory guidance, targeted TA, and milestone reporting. We describe each of these steps in more detail below.

Regulatory Requirements. CMS intends to propose new state managed care access requirements including: appointment wait-time minimum and provider directory accuracy standards; state provider surveys (including minimum standards for survey design and implementation) to assess compliance with appointment wait-time standards and accuracy of provider directories; transparency of state Medicaid managed care program provider access; and, a streamlined and standardized process for provider rate analysis. (See Appendix A. Preamble Language for Access Requirements, Appendix B. Access Regulatory Language, and Appendix C. Promoting Access Though Provider Rate Transparency.)

Sub-Regulatory Guidance. Following the release of access requirements in regulation, CMS will have an opportunity to release a more detailed and nuanced set of sub-regulatory guidance that may include a State Medicaid Director Letter (SMDL) and Frequently Asked Questions (FAQs). Establishing more detailed requirements through sub-regulatory guidance would enable CMS to provide states with concrete guidelines about how to meet the new regulatory requirements and provide CMS with flexibility to nimbly modify requirements over time as CMS and states gain experience with implementation. Similarly, CMS will have an opportunity to explain in sub-regulatory guidance the ways in which states may vary appointment wait-time standards and how it will define initial vs. routine appointments for each of the provider types listed. CMS' approach to issuing sub-regulatory guidance would evolve over-time based on state progress and need related to the new access requirements.

State TA. In lead-up to and during the period following the effective date of the rule (i.e., the period of time that states will have to implement provider surveys and come into compliance with appointment wait-time and provider directory standards), CMS' explicit drumbeat would be that every state should be using the time to assess access in the state consistent with the new standards; and, if gaps are identified, to come into compliance. To that end, CMS could provide early and ongoing intensive technical assistance, which may include:

Access Learning Collaborative (LC). CMS could host a series of LC meetings on the new access requirements, leveraging other CMS LC models in structuring this LC, which generally include: a review of federal requirements,

description of policy and operational options and implementation considerations, direct technical assistance and subject matter expertise through CMS and its contractors, highlights of state best practices (which are best received coming directly from state Medicaid officials), and cross-state information sharing discussions. Topics could include:
Strategies for states to examine their current provider networks, identify access issues, and increase provider participation.
Provider survey program design and implementation to facilitate cross-state learnings on methodological and operational best practices and key challenges.
Promising practices for ensuring accuracy of provider directories.
Using T-MSIS and other state data sources to quantify Medicaid and Children's Health Insurance Program (CHIP) access issues.

An Access Punch List. A potential CMS punch list could describe tactics for addressing thorny implementation issues that states (and their managed care organizations) are grappling with as they ramp-up their processes to comply with the new access requirements as well as strategies for states to increase provider participation. Through the punch list, CMS could amplify best practices and mitigation strategies (e.g., assessing provider payment rates, coordinating and streamlining provider recruitment and credentialing, reducing provider administrative burden, issues specific to rural and frontier states, timely enforcement mechanisms, etc.). For more information on mitigating payment-related access barriers, see Appendix C. Promoting Access Though Provider Rate Transparency.

3 Also see this August 2022 Commonwealth Fund blog, How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost.

Toolkits. CMS could also release tools and technical assistance documents that detail approaches, methodologies, and best practices to support states in complying with new access requirements. For example:
A provider survey toolkit, informed by state feedback and likely to be iterated upon over the course of the implementation ramp-up period, could include actionable information for states to field provider surveys to meet state-specific needs and comply with new federal requirements. States that do not want to develop their own survey design and approach could essentially customize and implement the federal toolkit (i.e., "plug and play"). States that choose to develop their own approach (or modify their current approach to meet federal specifications) could use the toolkit as guidance and support. Examples of tools may include example study protocol/methodological specifications, call scripts for different surveys (both secret shopper and revealed survey scenarios), provider sampling considerations and approaches to ensure adequate statistical accuracy and geographic and demographic representation, technical guidance on establishing "straw model" Medicaid shopping personas, unique considerations related to secret and revealed surveys, and detailed guidance on statistical approaches for analyzing survey results. The toolkit could also include a template provider survey design that outlines the components of provider survey, including sample size specifications, consistent with CMS guidance, with help text and references to specific technical assistance tools related to each survey component. The toolkit should provide resources that are applicable in diverse state scenarios, allowing them flexibility to tailor their studies to state-specific needs (e.g. frontier states versus smaller geography states that are densely populated).
CMS could develop a variety of data toolkits to help states operationalize Medicaid and CHIP access measures using T-MSIS or other state data sources. These data toolkits could directly key into the types of data analyses CMS will conduct to carry out its oversight responsibilities and would likely be iterated over time as new approaches and best practices are developed and disseminated. (See Appendix D. Using T-MSIS and Other State Data Sources to Oversee and Monitor Network Adequacy for additional detail.)

Milestone Reporting to Support State Adoption of Provider Surveys. CMS may also wish to consider requiring states to report on the implementation status of their provider surveys based on milestones to be developed by CMS. CMS could then provide targeted technical assistance to states that appear to be delayed in the development and launch of their

provider surveys.

Monitoring and Oversight
In addition to leveraging provider surveys (including secret and revealed shopping) that have been recognized by CMS and numerous stakeholders as an effective approach for helping to monitor Medicaid managed care plan provider networks, provider directory accuracy, and other elements of access to care, CMS could utilize a number of additional tools to ensure network access.

4 It is notable given its purview that MACPAC did not recommend CMS rely on secret shoppers in its access recommendations. In our follow up conversation with them they attributed that decision more to not having the time to fully run to ground the issues identified; they did not conclude that the process had no value.

4

Provider Surveys. As noted above, CMS will receive provider survey results and hold states accountable for access issues, including not meeting the federal minimum appointment wait-time standards.

Data Inputs. In conjunction with provider surveys, CMS (and states) could leverage T-MSIS and other data, such as all-payer claims datasets (APCDs), as a key component of oversight and enforcement activities. (See Appendix D. Using T-MSIS and Other State Data Sources to Oversee and Monitor Network Adequacy for additional detail—including on ways to improve the utility of provider directories and identify inequities in access to care.)

5 This proposal aligns with recent Medicaid And CHIP Access Commission (MACPAC) recommendations.

5

Provider Rate Analysis. Recognizing that provider payment rates in managed care are inextricably linked with provider network sufficiency and capacity, CMS intends to codify an streamlined and standard process through which health plans report, and states document, managed care payment rates to providers. The new provider rate analysis requirements will serve as a component of states' responsibility to ensure actuarial sound rates, health plan provider network adequacy and beneficiary access consistent with state and federal access to care standards. (See Appendix C. Promoting Access Though Provider Rate Transparency for proposed preamble and regulatory language.)

Beneficiary Surveys. CMS could leverage beneficiary survey data (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS)) to understand the consumer experience related to Medicaid managed care access. (See, for example, New Jersey's Healthcare Effectiveness Data and Information Set and CAHPS analytics dashboards; the latter highlights satisfaction ratings for personal doctors and specialists.) CMS would then review/monitor the beneficiary survey data as part of the oversight process and leverage it to pinpoint access issues. (Note that CMS may wish to contemplate this proposal in the context of ongoing beneficiary experience-related work with MITRE.)

Public Comments. CMS could establish a process by which consumer groups, providers, and other interested parties could report ongoing systemic issues of access. At CMS' option, the comments could be used as input into its oversight mechanism or as part of a more formal adjudicatory process. For example, CMS could encourage or require states to establish a formal administrative process through which complaints alleging systemic shortfalls in access are submitted, investigated, and resolved. The process could be designed such that only complaints with sufficient initial information/evidence would proceed to investigation and resolution. CMS would review the state-level complaints and

follow-up state action as part of its oversight responsibilities and could establish a parallel complaint process at the federal level. The process would be different than and significantly more impactful than monitoring grievances filed by an individual beneficiary who cannot find a provider, for example.

Transparency and Enforcement

Public Reporting. CMS may consider public transparency mechanisms to encourage compliance and allow for public input about compliance and any proposed corrective action (described in more detail below and in Appendix E. Optimizing the Online Experience for Individuals Enrolled in Medicaid Managed Care). Beyond requiring states to make public provider survey result data and submit the annual report, CMS could post and require states to post the results of other indicators (e.g., data analyses, consumer surveys, comments/complaints) of state performance against appointment wait-time standards and accuracy of provider directories/progress addressing disparities in access to care to encourage compliance and recognize achievements. This could entail leveraging the Medicaid and CHIP (MAC) Scorecard or posting publicly access snapshots or a dashboard (see, for example, Florida's Medicaid Statewide Medicaid Managed Care Compliance Actions). Also see Appendix D. Using T-MSIS and Other State Data Sources to Oversee and Monitor Network Adequacy for recommendations on ways CMS could work with states to develop internal executive-level dashboards that could be used by state Medicaid and CHIP leadership to identify and address network adequacy issues.

Corrective Action Plans. While states have significant flexibility in imposing a continuum of enforcement actions on their managed care organizations, CMS will need to determine/clearly define its own enforcement policy—ensuring it is robust enough to drive proactive state behavior as well as prompt corrective action as needed. We propose that, beginning three years after the effective date of the rule, CMS would begin to hold states with beneficiary access issues accountable for meeting the provider directory and wait-time standards.

6 If handled in accordance with CMS' expectations, standards, and processes, corrective action plans have potential to achieve measurable improvement in access. (Also see 42 CFR Part 430, Subparts C and D for federal regulations on enforcement of federal Medicaid requirements).

6
CMS could expand on the enforcement process by considering the following enforcement mechanisms and options to promote transparency.

7 CMS could also consider a preemptive corrective action plan that you and the state could initiate prior to this point OR allowing a state to propose its own glidepath to come into compliance. This might be appropriate if a state is taking aggressive steps to improve access, but will need time to see the fruits of its labor. For example, a state could work to increase rates, but changes might be contingent on state legislation, providers need time to enroll, etc.; or a state could have an IT fix related to provider enrollment and simplification but implementation won't begin until year 3. On the flipside, we worry this might give states an excuse to not meet the three year time period. It would have to be administered tightly, and perhaps with public notice/input.

7

Requiring states that are noncompliant to develop within a specific period of time (e.g., one month) their own plans of corrective action and propose the remedy, which would require CMS approval. Rather than leaving this open-ended, CMS could develop a checklist wherein states would select the remedy (or remedies) themselves or propose an alternative, to be agreed upon and determined by the severity and nature of noncompliance. Clear timetables for taking the corrective action would be written into the plan. Any action undertaken by CMS and the corrective action plan itself

would be publicly available through both the state and CMS websites.

In addition, the corrective action plan would include clear timeframes for meeting the milestones. The plan could explicitly provide for withholds that CMS would automatically impose if a milestone was not met (e.g., for each day the state does not satisfy CMS expectations).

8 For example, Florida, imposes a monetary sanction of $200 per day for each day the plan doesn't implement, to the satisfaction of the agency, the approved corrective action plan. Similarly, New Jersey requires plans to correct a network deficiency within 60 days from the date of the network file submission (unless they negotiate a good faith negotiations waiver), or the state applies liquidated damages (as a portion of the monthly capitation payment); failure to submit a CAP within 10 days or a timeframe requested by the state can trigger monetary damages of $100 to $250 per day deducted from the capitation payment.

8
The state could appeal (on factual grounds) CMS' determination that they had not met the milestone. Consistent with the regulations at 42 CFR § 430.35(d)(1)(i), CMS would end the withhold (and return the payments) when the Administrator "is satisfied regarding the state's compliance."

Per 42 CFR § 430.35, CMS can withhold payments (e.g., by reducing the Federal Medical Assistance Percentage (FMAP) or the amount of state expenditures subject to federal financial participation (FFP)) to a state Medicaid agency for failure to meet federal access requirements.
If the state subsequently achieves compliance and CMS is satisfied with the state's performance, CMS would need to resume payments. In determining the withhold amount, CMS could take into account factors, such as the degree to which the state is out of compliance (e.g., whether deficiencies are isolated or widespread, if they constitute a pattern of repeated noncompliance), level of harm done (or potential for harm) to beneficiaries, and state resources (e.g., workforce and budgetary constraints).
CMS also could return all or a portion of the financial penalties imposed by "investing" a share of savings from the withhold in state initiatives to make improvements in access.

Additionally, CMS could explore financial incentives, such as providing bonus payments to high-performing states (as it did for CHIPRA)—though this would require further exploration of the legal authority absent legislation. CMS could tier payments and provide higher bonuses based on the degree to which states exceed the federal compliance threshold. This extra financial support would demonstrate CMS' commitment to improving access and reward those states that similarly bear additional access-related costs to improve network adequacy.

Appendices

Appendix A. Preamble Language for Access Requirements
Updated as of 8/24/2022

While states continue to make progress on strengthening access to care, CMS recognizes that in some states or areas within a state and for some services, Medicaid beneficiaries face significant gaps in access to care. Evidence suggests that in some localities and for some services, it takes Medicaid beneficiaries longer to access medical appointments compared to individuals with other types of health coverage.

9 W. Hsiang, A. Lukasiewicz, and M. Gentry, "Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis," SAGE Journals, April 5, 2019, available

at https://journals.sagepub.com/doi/full/10.1177/0046958019838118.

9
This may be exacerbated by difficulties in accessing accurate information about managed care organizations' provider networks; while Medicaid managed care plans are required to make regular updates to their online provider directories, analyses of these directories suggest that a significant share of provider listings include inaccurate information on, for example, how to contact the provider, the provider's network participation, and whether the provider is accepting new patients.

10 A. Burman and S. Haeder, "Directory Accuracy and Timely Access in Maryland's Medicaid Managed Care Program," Journal of Health Care for the Poor and Underserved, available at https://pubmed.ncbi.nlm.nih.gov/35574863/; A.Bauman and S.Haeder, "Potemkin Protections: Assessing Provider Directory Accuracy an Timely Access for Four Specialties in California," Journal of Health Politics, Policy and Law, 2022, available at https://pubmed.ncbi.nlm.nih.gov/34847230/.

10
Relatedly, analyses have shown that the vast majority of services delivered to Medicaid beneficiaries are provided by a small subset of health providers listed in their directories, with a substantial share of listed providers delivering little or no care for Medicaid beneficiaries.

11 A. Ludomirsky, et. al., "In Medicaid Managed Care Networks, Care is Highly Concentrated Among a Small Percentage of Physicians," Health Affairs, May 2022, available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747.

11

The federal government and states are jointly responsible for ensuring that Medicaid provides access to services. Historical attempts to address the availability, parity, and timeliness of provider networks have demonstrated that network adequacy requirements do not always achieve their intended goal. Measures such as minimum provider-to-enrollee ratios as well as time and distance standards are not guaranteed to be meaningful, particularly if providers "participate in Medicaid" but are not actually accepting new Medicaid enrollees or impose a cap on the number of Medicaid enrollees they will see. Additionally, rigor of state oversight and transparency of oversight findings are highly variable across states; CMS and states often lack a clear line of sight to network adequacy issues and gaps that impact access for Medicaid beneficiaries.

Key to the effectiveness of the Medicaid program is ensuring it provides timely access to high-quality services in a manner that is equitable and consistent across delivery systems, including fee-for-service (FFS) and managed care. In an effort to ensure greater fidelity to federal network adequacy requirements in the Medicaid managed care delivery system, CMS is proposing new, minimum federal appointment access timeliness requirements along with initial requirements for ensuring compliance with access requirements more broadly.

Minimum Appointment Wait-Time Standards
As recommended by several commenters, the proposed regulations would establish a federal "floor" (or minimum) for appointment wait-times that generally align with Marketplace standards. The appointment wait-time standards included in the 2023 NBPP were informed by prior federal network adequacy requirements, industry standards, and consultation

with stakeholders, including Medicaid and Medicare Advantage. CMS shares the goal of alignment across Medicaid, the Marketplace, and Medicare to ensure continuity of coverage and care for individuals and to enable more effective and standardized comparison, monitoring, and oversight across programs. In addition, the proposed regulations comport with existing Medicaid managed care regulations at 42 CFR § 438.68, which allow states to select any quantitative network adequacy standard, including appointment wait-time standards, for designated provider types. Many states currently have (or have previously had in place) access timeliness standards and should be familiar with standards that consider wait-times.

CMS recognizes that the development and implementation of appointment wait-time standards and the corresponding compliance threshold will need to be an iterative and flexible process; as such, CMS intends to evolve the floor over-time through regulatory changes and/or sub-regulatory guidance and will consider changes that address health disparities or that are needed based on stakeholder experience and feedback.

In recognition of geographical differences and other variation among states, CMS is providing flexibility to build upon the minimum federal appointment wait-time standards as states deem appropriate and meaningful for their programs and populations. More specifically, states will retain the flexibility to impose more stringent requirements (e.g., 10 calendar days for routine primary care) and to adopt additional requirements, including for whether and how to vary appointment wait-time standards for the same provider type—by adult vs. pediatric, geography, service type, or other ways. CMS encourages states to consider the unique access needs of certain beneficiaries, such as children and people in treatment for substance use disorder (SUD). States that choose to impose state-specific appointment wait-time standards that exceed the federal floor will need to describe such requirements in their Medicaid managed care contract(s). CMS will further explain in sub-regulatory guidance: (1) the ways in which states may vary appointment wait-time standards, and (2) how states should assess whether they/their plans are meeting the 90 percent threshold for the State's appointment wait-time standards—including considerations related to sample size.

CMS will define in forthcoming sub-regulatory guidance "routine" consistently across primary care, OB/GYN, and outpatient behavioral health. CMS is requesting comment from stakeholders on definition of "routine" appointments. In designating the specialist type for which the state-designated appointment wait-time standards will apply, states must select a provider/facility type based on an identified provider access issue experienced by beneficiaries. If states uncover additional access issues among key specialist provider types, they should develop additive standards that apply specifically to these providers. CMS may also amend the Medicaid and CHIP managed care requirements for specialist access and/or sharpen them through an SMDL.

The COVID-19 Public Health Emergency (PHE) significantly accelerated telehealth adoption and utilization, so CMS is exploring considerations related to the role of telehealth in ensuring access to care (e.g., for rural communities, to address barriers to receiving mental health and SUD treatment) and when it can be used as a substitute for in-person appointments. CMS intends to issue sub-regulatory guidance on how and the degree to which states should apply telehealth in meeting the standards, and welcomes input from commenters. CMS reminds states that they have broad flexibility with respect to covering Medicaid/CHIP services provided via telehealth and may wish to include quantitative network adequacy standards and/or specific appointment wait-time standards for telehealth in addition to in-person appointment wait-time standards, as appropriate based on current practices and the extent to which network providers offer telehealth services.

12 The 2023 NBPP requires states to submit information on whether network providers offer telehealth services. In MA, plans can contract with certain provider types for telehealth services and obtain a credit toward their network determination – i.e., dermatology, psychiatry, cardiology, otolaryngology, neurology, ophthalmology, allergy and immunology, nephrology, primary care, gynecology/obstetrics, endocrinology, and infectious diseases. For more information, see Urban Institute's report, Can Telemedicine Help Address Concerns with Network Adequacy? Opportunities and Challenges in Six States.

Dedicated Access Support for Beneficiaries
The consumer hotline proposal would update and build upon the existing regulations at 42 CFR §?438.71. States are currently required to establish an access point for complaints and concerns about access to covered services for enrollees who use, or express a desire to receive, LTSS. Recognizing the importance of ensuring access for members with a disability, members for whom English is a second language, and members from other marginalized groups (e.g., racial/ethnic minority groups) in particular, CMS is proposing to extend the requirement to all beneficiaries. CMS is also clarifying that the access point must include, at a minimum, a toll-free consumer hotline intended to facilitate informal dispute resolutions.

Provider Surveys
CMS agrees with commenters that provider surveys are one of several key tools for states to monitor access and identify and address access barriers. Many states, as well as commercial plans, currently use these types of surveys to monitor access. States use a range of different approaches to designing these provider surveys. Some use so-called "secret shopper" approaches, whereby an individual posing as a fictional Medicaid beneficiary attempts to set up an appointment with a Medicaid provider listed as part of a health plan's network. Others rely on "revealed" survey approaches, wherein the surveyor acknowledges that they are conducting an access survey on behalf of the state Medicaid agency or managed care organization. States also vary in their approaches to administering provider surveys. Some require managed care organizations to monitor their own provider networks, while others rely on an independent entity (such as an EQRO or other third-party entity); still others do both managed care organization- and state-driven surveys. These surveys are also varied in terms of scope of providers surveyed, types of services and providers surveyed, and the frequency of the surveys.

Accordingly, CMS proposes to revise 42 CFR § 438.358(b) to require as part of external quality review activities that states conduct provider surveys, including secret and revealed shopper studies, on a frequency no less than annually for purposes of monitoring access to care. As described in [TBD SECTION], states must ensure that their managed care organizations meet the state's appointment wait-time standards for each provider/facility type at least 90 percent of the time.

13 However, states would only be held accountable for meeting the federal minimum appointment wait-time standards.

13
States and their managed care organizations will also be required to ensure that at least 90 percent of provider directory entries are accurate at all times. These surveys will be one important tool for states to ensure their plans are meeting these standards. Similarly, they will be an important indicator for CMS to assess compliance with appointment wait-time standards and provider directory accuracy requirements established in this proposed rule. In addition to the results of provider surveys, CMS may leverage other inputs for oversight and enforcement purposes. CMS is contemplating the following inputs that would offer key insights into access issues for CMS and states alike: T-MSIS and other data sources, beneficiary surveys to understand the consumer experience related to Medicaid managed care access (as described in [CMS to insert cross-reference]), and public comments whereby consumer groups, providers, and other interested parties could report ongoing systemic issues of access. CMS seeks comment on these tools as well as recommendations for other tools that are most effective in helping to monitor Medicaid managed care organization provider networks, provider directory accuracy, and other elements of access to care.

CMS recognizes that provider surveys are a significant undertaking and that states will need sufficient time as well as support from CMS to be successful in implementing these requirements. CMS notes that by including provider surveys as a mandatory EQR-related activity, states will have the opportunity to access the 75% federal matching rate for these activities as long as they are conducted by a CMS-approved EQRO. States will still have the option to use an organization other than an EQRO, provided that entity is independent and has no ties to a managed care plan, to conduct these studies, as permitted under 42 CFR § 438.358(a)(1). However, states that do not rely on an EQRO would only be

able to access the 50% administrative matching rate, as required by 42 CFR § 438.370, for associated expenditures.

CMS intends to provide intensive support to states related to the new access requirements—including as they launch new surveys or accommodate their existing surveys to federal standards. Technical assistance activities that CMS is considering include:
A State Medicaid Director Letter with additional guidance for designing and implementing provider surveys, including secret shopper studies.
A dedicated learning collaborative through which CMS will convene with states and subject matter experts to share best practices on provider surveys and access requirements more broadly.
An access punch list to support states in addressing implementation issues as they ramp-up their processes to comply with the new access requirements and strategies to increase provider participation.
Toolkits (1) to provide states with detailed methodological guidance on administering and analyzing results from provider surveys potentially including secret shopper and revealed survey scenarios, provider sampling considerations and approaches to ensure adequate statistical accuracy and geographic and demographic representation, technical guidance on establishing "straw model" Medicaid shopping personas, timing and frequency of the surveys, unique considerations related to secret and revealed surveys, and detailed guidance on statistical approaches for analyzing survey results, and (2) to help states operationalize Medicaid and CHIP access measures using T-MSIS and/or other state data sources.
A provider survey design template that can be customized by the state and that outlines the minimum components of a provider survey, consistent with CMS guidance, with fillable text fields, help text and references to specific technical assistance tools related to each survey component.

In general, states will have the option to adopt best practices outlined in the toolkit, deploy the specifications set out in the model survey, or develop their own approaches provided they are consistent with regulatory and sub-regulatory requirements issued by CMS. CMS seeks comment on the types of technical assistance that will be most helpful to states, the frequency in which provider surveys should be collected, requirements for conducting both "secret" and "revealed" surveys, and other potential mechanisms for effective monitoring of access. CMS also seeks comment on the proposed rule's requirements to assess for accuracy of provider directories and disparities in access to care as well as the proposed methodological standards.

Implementation Glidepath
To accommodate states' need for time to adopt, test, and implement the provider surveys and comply with the appointment wait-time and provider directory requirements, CMS proposes to provide states with a multiyear "glidepath" to ramp up new surveys and comply with new access requirements:
Beginning one year after the effective date of the rule: States will be expected to procure vendors and conduct other preparations necessary to begin administering the provider surveys. CMS would provide robust technical assistance for all states related to provider surveys and the new access requirements.
Beginning two years after the effective date of the rule: States will be expected to conduct a one year "beta test," wherein states would administer test surveys and report data to CMS; during the beta test year, states would not face enforcement actions from CMS based on survey results. CMS would continue to provide robust technical assistance to all states.
Beginning three years after the effective date of the rule: CMS would begin holding states accountable for achieving at least 80% or 85% [TBD] compliance with the federal minimum appointment wait-time and provider directory accuracy standards based on survey results. CMS would provide targeted technical assistance for states that are out of compliance with access requirements.
Beginning four years after the effective date of the rule and thereafter: CMS would hold states accountable, through the use of corrective action plans and other enforcement mechanisms, for achieving at least 90% compliance with the federal minimum appointment wait-time and provider directory accuracy standards based on survey results. CMS would continue to provide targeted technical assistance to support on-going implementation efforts for non-compliant states.

Illustrative, High-Level Glidepath
1 Year After the Rule
2 Years After the Rule
3 Years After the Rule

4+ Years After the Rule

States prepare to implement provider surveys
Robust CMS TA for all states
Beta test period for provider surveys
Robust CMS TA for all states
States held accountable for 80% or 85% compliance with access requirements
Targeted TA for non-compliant states
States held accountable for 90% compliance with access requirements
Targeted TA for non-compliant states

CMS seeks comment on an appropriate timeline, and whether more or less time is needed, for rolling out provider survey and other access requirements and has proposed this glidepath approach for consideration. CMS intends to work closely with states, stakeholders, and experts in the field as states and CMS implement the new access requirements and, over time, may refine provider survey requirements through sub-regulatory guidance.

Appendix B. Access Regulatory Language
Updated as of 8/24/2022

Minimum Appointment Wait-Time Standards
42 CFR § 438.68 Network Adequacy Standards.
(a) Definition – "Specialist" means any provider type, as defined by the state, that is not one of the following provider types: primary care; OB/GYN; behavioral health; hospital; pharmacy; pediatric dental; LTSS; or other provider/facilitate types identified by CMS in sub-regulatory guidance at its discretion. (Some common specialists include cardiology, dermatology, ophthalmology, orthopedics, radiology, urology, oncology, neurology, and surgery.)
(b) A State that contracts with an MCO, PIHP, PAHP, or PCCM to deliver Medicaid services must adopt and enforce the following:
(1) At a minimum, appointment wait-time standards for each of the provider/facility types listed, if covered under the contract:
(i) Primary care (routine), adult and pediatric: 15 calendar days.
(ii) OB/GYN (routine): 15 calendar days.
(iii) Outpatient behavioral health (mental health and SUD) (routine), adult and pediatric: 10 calendar days.
(iv): Specialist (targeting identified gaps in access as determined by the State in an evidence-based manner), adult and pediatric: Number of calendar days as designated by the State based on targeted specialty and population.
(v) Other provider/facility types as defined by CMS at its discretion.
(2) Other quantitative network adequacy standards to improve access, as defined by CMS either in regulation or sub-regulatory guidance at its discretion.
(c) A State must ensure, through its contracts, that the MCO, PIHP, PAHP, or PCCM meets the State's appointment wait-time standards, established in accordance with this section, for each provider/facility type at least ninety percent (90%) of the time.

Dedicated Access Support for Beneficiaries
42 CFR §?438.71 Beneficiary Support System.
(1) A State beneficiary support system must include at a minimum:
(i) Choice counseling for all beneficiaries.
(ii) Assistance for enrollees in understanding managed care.
(iii) An access point including, at a minimum, a toll-free consumer hotline for all beneficiaries for questions, complaints, and concerns about access to providers and/or covered services. A State must establish and maintain, either directly or through its MCO, PIHP, PAHP, or PCCM contractors a record of: inquiries and complaints; and the outcome of such inquiries and complaints (e.g., whether there was a resolution, what actions were taken in response).

(iv) Assistance as specified for enrollees who use, or express a desire to receive, LTSS in paragraph (d) of this section.
(2) The beneficiary support system must perform outreach to beneficiaries and/or authorized representatives and be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.

42 CFR §?438.68 Network Adequacy Standards.
(d) Using data from the consumer hotline calls described at [regulatory citation] and complaints, grievances and appeals, beneficiary surveys, and other sources, a State must ensure that the MCO, PIHP, PAHP, or PCCM takes steps to identify and address barriers to and disparities in provider access experienced by beneficiaries.

Provider Surveys
42 CFR § 438.358(b) Mandatory Activities.
(1) For each MCO, PIHP, or PAHP the following EQR-related activities must be performed:

* * *

(v) Randomized provider surveys:

(a) At minimum, states must conduct provider surveys across contracted MCOs, PIHPs, and PAHPs

14 Note to CMS: We did not include PCCM entities here.

14
to assess the compliance with areas of access in paragraph (b) of this section at least annually.
(b) Provider surveys must, at minimum, assess the following:
(1) Compliance with federal and state appointment wait-time standards established in accordance with [regulatory citation], for each applicable provider/facility type, including:
(i) Primary care (routine), adult and pediatric.
(ii) OB/GYN (routine).
(iii) Outpatient behavioral health (mental health and SUD) (routine), adult and pediatric.
(iv) Specialist (targeting identified gaps in access as determined by the State in an evidence-based manner), adult and pediatric.
(v) Other provider/facility types as defined by CMS.
(2) Accuracy of provider directories.
(3) Disparities in access to care (including, but not limited to, appointment wait-times and whether providers are accepting new patients) for Medicaid/CHIP members generally (as compared to commercially covered patients), members residing in rural, urban and frontier geographies, members with disabilities, members for whom English is a second language, members from other marginalized groups (e.g., racial/ethnic groups and American Indian/Alaska Natives), and other focused inquiries as CMS requires.

15 CMS would need to work to develop an approach that states could use to measure disparities in access for different marginalized groups. For example, one state assessed through a previous secret shopper study differences in appointment wait-times between callers with “multicultural” names compared to those with non-multicultural names and found significant differences. CMS would need to provide states with clear guidance on how to use these types of approaches to assess disparities through secret shopper studies.

(c) States must ensure that provider surveys adhere to the following methodological standards:
(1) Uses statistically valid sample sizes across provider/facility type.
(2) Selects providers to be surveyed on a randomized basis.
(3) Examines all regions of the state, including all major urban areas, rural, and frontier regions.
(4) Uses a standardized approach for testing key measures of access, such as predetermined call scripts for surveyors.
(5) Utilizes a combination of both "secret shopper" or masked and revealed survey approaches, consistent with federal guidance.
(i) Masked approaches are surveys where the caller poses as a Medicaid beneficiary.
(ii) Revealed approaches are surveys where the caller volunteers that they are calling on behalf of the state Medicaid agency for the purposes of monitoring an MCO, PIHP, or PAHP provider network.
(d) States must submit results of provider surveys to CMS and make them publicly available. As part of public reporting and disclosure, states must make available through an annual report data on service utilization across a range of beneficiary characteristics, including by race and ethnicity, eligibility category, age, geography, disability status, and other factors, as determined appropriate by the state.
(e) States must comply with applicable sub-regulatory guidance promulgated by CMS in relation to provider surveys described in this section.

Implementation Glidepath
42 CFR §?438.68 Network Adequacy Standards.
(e) Beginning one year after the effective date of the rules finalized at [regulatory citation], a State must have procured a vendor and conducted other preparations necessary to begin administering the provider surveys.
(f) Beginning two years after the effective date of the rules finalized at [regulatory citation], a State must conduct a one year of testing wherein the State administers test surveys and reports data to CMS.
(g) Beginning three years after the effective date of the rules finalized at [regulatory citation], a State would be subject to compliance reviews and enforcement at CMS' discretion if it has not achieved at least eighty percent (80%) or eighty-five percent (85%) [TBD – for discussion with CMS] compliance with the federal minimum appointment wait-time standards for each provider/facility type and the provider directory accuracy standards, based on survey results.
(h) Beginning four years after the effective date of the rules finalized at [regulatory citation] and thereafter, a State would be subject to compliance reviews and enforcement at CMS' discretion if it has not achieved ninety percent (90%) compliance with the federal minimum appointment wait-time standards for each provider/facility type and the provider directory accuracy standards, based on survey results.
(i) A State with beneficiary access issues, including non-compliance with federal minimum appointment wait-time standards may at the discretion of CMS, be required to develop a corrective action plan (CAP).

Appendix C. Promoting Access Though Provider Rate Transparency
Updated as of 8/24/2022

Introduction
There is considerable evidence that Medicaid payment rates, on average, are lower than Medicare and commercial rates for the same services and that provider payment influences access, with low rates of payment limiting the network of providers willing to accept Medicaid patients, capacity of those providers who do participate in Medicaid, and investments in capital improvements and emerging technology among providers that serve large numbers of Medicaid beneficiaries. Currently there is no standardized, comprehensive, cross-state comparative data source available to assess Medicaid payment rates across clinical specialties , health plans, and states. CMS believes that there needs to be greater transparency in Medicaid provider payment rates in order for states and CMS to monitor and mitigate payment-related access barriers. Accordingly, CMS is proposing to establish new requirements at 42 CFR § 438.207 directing states to report aggregate Medicaid payment levels for a common basket of services by provider type and health plan, and compare those payment levels to the equivalent Medicare payment levels. CMS is seeking to align provider payment transparency requirements within Medicaid, and, as such, is also proposing fee-for-service transparency regulations and is exploring further alignment of Medicare and the Marketplace rate transparency policy. In the following, we propose preamble language for forthcoming proposed Medicaid Managed Care provider rate transparency regulations.

Lower provider payment rates can harm access to quality care. Recent estimates based on an analysis of fee-for-service

rates suggest that Medicaid physician fees were approximately 72% of Medicare in 2019 across a common basket of services, including 67% of Medicare for primary care and 80% of Medicare for obstetric care.

16 Zuckerman S, Skopec L, and Aarons J. Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. Health Aff (Millwood). 2021;40(2). doi:10.1377/hlthaff.2020.00611.

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For hospital services, the Medicaid and Payment Access Commission (MACPAC) found in 2017 that Medicaid base rates were approximately 78% of Medicare. While accounting for supplemental payments brings Medicaid rates into relative parity with Medicare on average, the value of these payments varies widely across states and, within states, across providers (and can be diminished by financing arrangements where hospitals finance the nonfederal share of Medicaid costs).

17 MACPAC, "Medicaid Hospital Payment: A Comparison Across States and to Medicare," April 2017, available at https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf.

17

Low reimbursement rates can harm access to care for Medicaid beneficiaries in a number of ways. Evidence suggests that low Medicaid physician fees limit physicians' participation in the program, particularly for behavioral health and primary care providers.

18 Holgash K, Heberlein M. Physician acceptance of new Medicaid patients. Washington (DC): Medicaid and CHIP Payment and Access Commission; 2019 Jan 24. Available from: https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf

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19 Zuckerman S, Skopec L, and Aarons J. Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. Health Aff (Millwood). 2021;40(2). doi:10.1377/hlthaff.2020.00611.

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Relatedly, researchers have found that increases in the Medicaid payment rates are directly associated with increases in provider acceptance of new Medicaid patients.

20 National Bureau of Economic Research, "Increased Medicaid Reimbursement Rates Expand Access to Care," October 2019, available at https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care

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21 Zuckerman S, Skopec L, and Aarons J. Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. Health Aff (Millwood). 2021;40(2). doi:10.1377/hlthaff.2020.00611.

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In short, two key drivers of access – provider network size and capacity – are inextricably linked with Medicaid provider payment levels.
Low reimbursement rates also limit the ability of critical access providers (i.e. providers that do participate in Medicaid, and serve a large number of Medicaid patients) to invest in staff, capital improvements and cutting edge medical technologies.

22 Sung Cho, "Hospital Capital Investment During the Great Recession," June 2017, available at https://journals.sagepub.com/doi/10.1177/0046958017708399.

22
Several commenters on CMS's Access RFI echoed these concerns, noting that low reimbursement rates also exacerbate provider workforce stability and capacity in an already challenging labor market for health care providers. The impact on providers is particularly acute for those for whom Medicaid beneficiaries account for a large share of their patients. It can also result in providers putting a cap on the number of Medicaid patients they serve.

While many factors affect provider participation, given the important role rates play in assuring access CMS believes that greater transparency is needed in order to understand when and to what extent provider payment may influence access in state Medicaid programs to specific provider types or for Medicaid beneficiaries enrolled in specific plans. CMS also believes that greater transparency and oversight is warranted as managed care payments have grown significantly as a share of total Medicaid payments – in FY 2021, the federal government spent nearly $250 billion on payments to managed care plans.

23 Congressional Budget Office, "Baseline Projections – Medicaid," May 2022, available at https://www.cbo.gov/system/files/2022-05/51301-2022-05-medicaid.pdf

23
CMS seeks to develop, use, and facilitate state use of data to generate insights for CMS and states into important, provider rate related indicators of access including: (1) particular provider types and services for which Medicaid payment may impede access and lead to underinvestment in capacity building and (2) particular plans with payment levels that may create access barriers for their members.

Preamble Language
§ 438.207 Assurances of Adequate Capacity and Services.
Section 1903(m)(2)(A)(iii) of the Act requires contracts between states and MCOs to provide capitation payments for services and associated administrative costs that are actuarially sound. Actuarial soundness is further defined at § 438.4 as requiring states to ensure that capitation rates provide for all reasonable, appropriate, and attainable costs that are

required under the terms of the contract. States are required under § 438.206(b)(1) to ensure that health plans maintain adequate provider networks. Commenters to the Access Request for Information (RFI) and a broad body of literature suggest that low provider payment rates in state Medicaid managed care programs can create access barriers. In light of these federal regulatory requirements and stakeholder feedback, CMS concludes that provider payment rates in managed care are inextricably linked with provider network sufficiency and capacity and
seeks to codify an updated process through which health plans must report, and states must document, managed care payment rates to providers as a component of states' responsibility to ensure actuarial sound rates, health plan provider network adequacy and beneficiary access consistent with state and federal access to care standards.

CMS proposes in § 438.207(b)(3) and (d)(2) a streamlined and standardized process for provider rate analysis and transparency. With these proposed provisions, CMS aims to balance the need to minimize administrative burden on states with the obligation – imposed both on states and on CMS- to ensure that Medicaid managed care provider rates are sufficient to allow for sufficiently robust provider networks (as required at § 438.206(b)(1)).

In § 438.207(b), we propose to expand the documentation that states are required to produce related to access and the availability of services. In paragraph (b)(3), CMS proposes a new process for states to analyze, report to CMS, and publish on the State's website a percentage comparison of each contracted health plan's Medicaid payment rates, by provider type, to the most recently published Medicare payment rates effective for the time period (or to Medicaid state plan rates for services for which there is no published Medicare payment rate).

In paragraph (b)(3)(i), we specify that the types of services this analysis must include. We have aligned this list with the provider types listed at § 438.68(b)(1): adult and pediatric primary care, OB/GYN, adult and pediatric behavioral health, adult and pediatric specialist services designated by the State, hospital, pharmacy and pediatric dental.

In paragraph (b)(3)(ii) we describe the components of the required rate analysis. Here we propose that provider type rate comparisons should be aggregated rate analyses for each of the service categories specified in paragraph (b)(3)(i). We also specify that the rate analysis must include percentage comparisons made on the basis of each of the following: Medicaid base payments, and Medicaid base and supplemental payments combined. CMS recognizes the challenges of combining supplemental payments with based payments, including that the resulting analysis may paint an inaccurate picture of actual payment rates for many Medicaid providers, since many do not receive supplemental payments or receive payments that are substantially smaller than others. CMS may consider eliminating supplemental payments from this analysis, and using existing state data and reporting on directed and passthrough payments to determine their impact on overall provider payment. CMS is also considering adding a requirement that states document the number of providers associated each provider type and how many providers within each provider type receive supplemental payments. CMS seeks comment on its proposed approach to accounting for supplemental payments, and potential alternative approaches. We also propose that if a Medicare standard is not available (such as for Home and Community Based Service providers), states are required to collect and report for each managed care plan their average rates paid by provider type as a percent of the State's Medicaid State Plan fee for service rates.

CMS proposes that the new documentation requirements in paragraph (b) be submitted consistent with existing requirements at paragraph (c). In paragraph (d)(2), CMS proposes that in addition to submitting required documentation to CMS, states are required to publish on the State's website the documentation required in paragraph (b).

In new paragraph (f) we describe our proposed mechanism for ensuring compliance with documentation requirements in this section. Similar to state practices where penalties are imposed on managed care plans for not providing timely encounter and other data, we propose that CMS may take a compliance action when a state that fails to meet the requirements of the provisions in preceding current and proposed paragraphs in § 438.207 that may include a deferral or disallowance of the State's administrative expenditures. We also indicate that any disallowance would follow the procedures described at Part 430 Subpart C of Title 42, which serve as the regular enforcement process for program compliance. We also note that CMS plans to update the Access and Network Adequacy Assurances Reporting Tool to provide states with a standardized template for reporting this information.

In new paragraph (g), CMS proposes that the new documentation requirements become effective MONTH DAY, 202X.

CMS seeks comment on the proposed process for analysis and documentation of provider rate analysis at § 438.207(b), including considerations and alternative approaches related to accounting for supplemental payments. CMS also seeks comment on proposed transparency requirements at § 438.207(d)(3), as well as the proposed method for ensuring compliance as described in proposed § 438.207(f). CMS also seeks comment on proposed modifications to the Access and Network Adequacy Assurances Reporting Tool and any additional tools and technical assistance that CMS should provide that would facilitate state and health plan compliance with the new provider rate analysis and transparency requirements.

Proposed Rule
§ 438.207 Assurances of adequate capacity and services.
(a) Basic rule. The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this part, including the standards at § 438.68 and § 438.206(c)(1).
(b) Nature of supporting documentation. Each MCO, PIHP, and PAHP must submit the following documentation to the State, in a format specified by the State:
(1) Documentation demonstrating that the MCO, PIHP, or PAHP offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area.
(2) Documentation demonstrating that the MCO, PIHP, or PAHP maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.
(3) Analysis of Medicaid provider payment rates. The analysis must meet the following specifications:
(i) Rate analysis must segment by the following service types to the extent the state contracts with health plans to provide these services:
(A) Primary care services for adults and pediatrics.
(B) OB/GYN services.
(C) Behavioral health services (including mental health and substance use disorder) for adults and pediatrics.
(D) Specialist services (as designated by the State) for adults and pediatrics.
(E) Hospital services.
(F) Pharmacy services.
(G) Pediatric dental services.
(H) Long Term Services & Supports.
(ii) Rate analysis must calculate an aggregate, percentage comparison of all of the MCO, PIHP, or PAHP's Medicaid payment rates relative to the most recently published Medicare payment rates effective for the time period. To the extent Medicare rates are not available, the MCO, PIHP, or PAHP must calculate its rates as a percent of the State's Medicaid State plan rates. The rate analysis must include percentage comparisons made on the basis of:
(A) Medicaid base payments and;
(B) Medicaid base and supplemental payments combined.
(c) Timing of documentation. Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following:
(1) At the time it enters into a contract with the State.
(2) On an annual basis.
(3) At any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect the adequacy of capacity and services, including -
(i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its provider network; or
(ii) Enrollment of a new population in the MCO, PIHP, or PAHP.
(d) State review and certification to CMS.
(1) After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must submit an assurance of compliance to CMS that the MCO, PIHP, or PAHP meets the State's requirements for availability of services, as set forth in § 438.68 and § 438.206. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO, PIHP or PAHP related to its provider network.
(2) Beginning MONTH DAY, 202X the State agency must publish the rate analysis of its Medicaid payment rates as described in paragraph (b)(3) by MONTH DAY, 202X and update the rate analysis every two years by MONTH DAY.

(e) CMS' right to inspect documentation. The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP.
(f) In the event the State does not publish its rate analysis in the manner and timeframe described in paragraphs (b)(3) and (d)(2), CMS may take a compliance action against the State that may include a deferral or disallowance of the State's administrative expenditures. Any such disallowance would follow the procedures described at part 430 Subpart C of this title.
(g) Applicability date. This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after MONTH DAY, 202X. Until that applicability date, states are required to continue to comply with § 438.207 contained in the 42 CFR parts 430 to 481, edition revised as of July 1, 2018.
Appendix D. Using T-MSIS and Other State Data Sources to Oversee and Monitor Network Adequacy
Updated as of 8/23/2022

Background
The Centers for Medicare and Medicaid Services (CMS) intends to use a variety of levers to promote adoption and enforcement of Medicaid and CHIP managed care access standards, including through new regulatory requirements, sub-regulatory guidance, and targeted technical assistance to states. To complement and bolster these levers, CMS is also exploring how it can support state Medicaid and CHIP agencies to better leverage existing state data sources, including the Transformed Medicaid Statistical Information System (T-MSIS), to oversee and monitor managed care network adequacy in their states.

24 This approach aligns with the Medicaid and CHIP Payment and Access Commission (MACPAC)'s June 2022 report that highlights the need for a new Medicaid access monitoring system with a core set of standardized access measures. https://www.macpac.gov/publication/june-2022-report-to-congress-on-medicaid-and-chip/

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These efforts will help empower states to use their own data to better understand network adequacy issues and drive improvements, and will also promote state compliance efforts by signaling to states that CMS will also be leveraging these data to help inform its enforcement of access standards.
The purpose of this memo is to describe a potential dual-tracked data-focused effort which includes robust technical assistance (TA) that CMS can provide to states. Below, we propose a technical assistance framework including implementation of a State Data Learning Collaborative and development of data toolkits that can be leveraged to help state partners strengthen compliance with network adequacy standards. The memo also offers Preamble language to inform the development of CMS' Notice of Proposed Rulemaking that also previews CMS' plans to leverage these data for its own oversight and enforcement efforts.

CMS Framework for Data-Related Technical Assistance
CMS may wish to consider providing targeted technical assistance to states in order to support ongoing compliance with and successful implementation of new Medicaid and CHIP access measures through the use of T-MSIS or other state data sources. This technical assistance could include:

State Data Learning Collaborative: CMS could host a series of State Data Learning Collaborative sessions that would focus on current efforts, challenges, and best practices in using T-MSIS and other state data sources to quantify Medicaid and CHIP access issues. The State Data Learning Collaborative could operate as standalone convenings or they could be integrated with broader Access Learning Collaboratives. A proposed State Data Learning Collaborative model could include: a review of current state efforts to examine access issues using T-MSIS or other state data sources; highlights of best practices and lessons learned from states currently engaged in these analyses; discussion of tools and resources needed by Medicaid and CHIP agencies to operationalize potential Medicaid and CHIP access measures; subject matter expertise provided by CMS and its contractors; and a cross-state information sharing discussion facilitated with a set of structured discussion questions and an opportunity for states to ask direct questions to the CMS team.

State Data Toolkits: CMS could also develop a variety of data toolkits to help state partners operationalize Medicaid and CHIP access measures using T-MSIS or other state data sources. These data toolkits could directly key into the types of data analyses CMS will conduct to carry out its oversight responsibilities. These toolkits would be informed by state partners via the State Data Learning Collaborative described above and would likely be iterated over time as new approaches and best practices are developed and disseminated. Examples of tools could include: technical specifications for calculating access measures; code sets to identify conditions, providers, or services of interest; and guidance for reporting and interpreting results of quantitative analyses. The toolkits should provide resources that are applicable in diverse states and should provide flexibility for states to tailor analyses to their state-specific needs. CMS could also consider developing multiple different toolkits structured to investigate different aspects of Medicaid access issues, including for example:

Assessing key measures of Medicaid and CHIP service utilization: This toolkit would focus on approaches to using T-MSIS data to calculate standardized measures of Medicaid and CHIP service utilization and how these results can be used to diagnose potential Medicaid and CHIP access issues. CMS could provide example measures and associated technical specifications that states could use to calculate key measures of Medicaid service utilization.

CMS could provide guidance to states on how T-MSIS data on utilization can be used to better understand and enhance network adequacy. Overtime, state utilization data might be made publicly available, allowing states and CMS to rely on appropriate utilization benchmarks.

CMS may also promote an approach where states stratify key utilization measures by managed care plan. These results could be used by states to understand whether individuals enrolled in a particular managed care plan experience lower measures of Medicaid and CHIP service utilization relative to similar individuals enrolled in different managed care plans. Managed care plans that have significantly lower rates of Medicaid and CHIP service utilization relative to others may be prime candidates for network enhancement efforts.

CMS currently provides technical assistance for calculating the adult and child core measure sets and could leverage a similar model for this data toolkit. CMS could work with states to hone in on existing measures in the adult and child core set that may be useful for understanding Medicaid and CHIP network adequacy issues or could go a step farther by introducing new measures or variations on existing measures.

Identifying inequities in access to care: This toolkit would focus on approaches to using T-MSIS and other state data sources to identify inequities in access to care and how these results can be used to advance health equity. This toolkit could be a companion to the other toolkits to highlight the importance of an equity-focused review of access. CMS could provide example measures and associated technical specifications that states could use to assess potential inequities in access, for example, approaches that assess variability in key measures of Medicaid and CHIP service utilization based on beneficiary race and ethnicity. CMS may also work with states to promote efforts to improve the collection and reliability of race and ethnicity information in the T-MSIS data to enhance analyses of racial and ethnic inequities in access to care. Other state-level datasets, including all-payer claims databases (APCDs) may also be leveraged to assess potential inequities in Medicaid and CHIP access. For example, APCDs can be used to assess disparities in access to care among Medicaid and CHIP beneficiaries relative to commercially insured individuals. CMS could provide guidance to states on how to use APCD data to compare measures of service utilization among Medicaid beneficiaries relative to commercially insured individuals in the same area. States may use this information – or potentially other available data - to identify areas with particularly large disparities in service utilization between the commercially insured vs. Medicaid and CHIP insured populations, and these areas may be prime targets for Medicaid and CHIP network enhancement efforts.

Improving the utility of Medicaid provider directories: This toolkit would focus on approaches to using T-MSIS data to better understand the accuracy of managed care provider directories and inform strategies to improve these directories by providing states example measures and technical specifications . For example, CMS may promote an approach where states examine T-MSIS data to identify providers included in Medicaid and CHIP managed care provider directories who have not billed Medicaid and CHIP claims for some duration of time. States could then reach out to plans to have them confirm participation and re-assess access in light of the data. Further, CMS may suggest that states regularly remove providers from Medicaid and CHIP managed care provider directories if the provider has not submitted any Medicaid or CHIP claims for some duration of time. CMS could also provide guidance to states on approaches to using T-MSIS data to confirm or update the practice locations of providers included on Medicaid and CHIP managed care provider directories.

Supporting public reporting and transparency: This toolkit would focus on approaches to collating and reporting Medicaid and CHIP access measures to support transparency and accountability. CMS could work with states to develop internal executive-level dashboards that could be used by state Medicaid and CHIP leadership to identify and

address network adequacy issues. CMS could also provide guidance to states on approaches to abstracting high-level information from internal dashboards that could be shared publicly. This public information sharing would promote transparency and accountability for the Medicaid agency and their contracting managed care organizations and would also be a useful tool for beneficiaries and other stakeholders to understand Medicaid access issues. CMS could work with states to identify appropriate venues and formats to publicly report measures and could elevate best practices identified via the State Data Learning Collaborative.

As noted above, throughout this process of working with states to develop toolkits, CMS could hone in on its approach to relying on T-MSIS and other data as a key component of its oversight and enforcement activities. The more CMS is transparent about the data it will use, the more likely it will be that states will take up the toolkit approaches, even without specific regulatory directives to do so.

Proposed Data-Related Technical Assistance Preamble Language
T-MSIS and other data sources, like all-payer claims datasets (APCDs) can offer key insights into access issues for both states as well as CMS. Notably, the Medicaid And CHIP Access Commission (MACPAC) has recommended these data drive oversight and monitoring.

25 Medicaid and CHIP Payment and Access Commission. June 2022 Report to Congress on Medicaid and CHIP. https://www.macpac.gov/publication/june-2022-report-to-congress-on-medicaid-and-chip/

Ensuring access in managed care is a shared responsibility: states, their managed care organizations and CMS all have important roles to play. CMS intends to use T-MSIS and other state data sources to carry out its monitoring and oversight responsibilities and encourages states to similarly rely on data to support local network enhancement efforts. By working together on developing measures and approaches to oversight, states will have new or improved tools to identify and address ongoing or emerging access issues and will be informed of how CMS will rely on data as it ensures compliance.

CMS recognizes that robust analyses of T-MSIS data can be a significant undertaking and that states will need support from CMS to standardize and operationalize analyses of these data. CMS proposes to provide targeted technical assistance to states via a coordinated State Data Learning Collaborative as well as a series of data toolkits. The State Data Learning Collaborative will convene states to discuss current efforts, challenges, and best practices to leverage T-MSIS and other state data sources to better understand Medicaid network adequacy issues. CMS will also develop data toolkits help states operationalize analyses of T-MSIS and other state data sources. Examples of such tools may include: technical specifications for calculating access measures; code sets to identify conditions, providers, and services of interest; and guidance for reporting and interpreting results of quantitative analyses. Informed by the State Data Learning Collaboratives, CMS intends to develop several toolkits that will focus on different aspects of Medicaid access issues, including for example: assessing key measures of Medicaid service utilization; identifying inequities in access to care; improving the utility of Medicaid provider directories; and supporting public reporting and transparency. These toolkits will be iterated over time as new approaches and best practices are developed.

Appendix E. Optimizing the Online Experience for Individuals Enrolled in Medicaid Managed Care
Updated as of 8/16/2022

Introduction
The Centers for Medicare & Medicaid Services (CMS) is seeking input on best practices to share with states to improve Medicaid and CHIP enrollees' online experience when seeking to obtain information about and engage with a state's managed care delivery system.

Research shows that Medicaid and CHIP enrollees experience challenges when trying to understand and navigate the managed care delivery system.

26 Vernon J, Trujillo A, Rosenbaum S, and DeBuono B. Low Health Literacy: Implications for National Health Policy. University of Connecticut, 2007. https://www.chcs.org/resource/health-literacy-fact-sheets/.

26
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27 Allen EM, Call KT, Beebe TJ, McAlpine DD, Johnson PJ. Barriers to Care and Health Care Utilization Among the Publicly Insured. Med Care. 2017 Mar;55(3):207-214. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5309146.

27

28 See also Martin LT, Bharmal N, Blanchard JC, et. al. Barriers to enrollment in health coverage in Colorado. Rand Health Q. 2015 Mar 20;4(4):2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158258/.

28
Navigation challenges include, for example, selecting a plan, changing a plan, choosing a primary care or specialty provider, getting timely access to services, coordinating care, filing a grievance or appeal

29 Myers CA. 2018. Advocates' guide to accessibility in Medicaid managed care grievances and appeals. Washington, DC: National Health Law Program. https://healthlaw.org/wp-content/uploads/2016/05/2016_05_2016_Issue_Brief_2_MMC_ Regs_Grievance_Appeals.pdf.

29
, and understanding consumer rights In addition, Medicaid and CHIP enrollees generally do not know how to access managed care plan quality and performance data in order to make informed decisions related to plan selection or changes.

Many of these enrollee navigation activities should be facilitated by effective and high-functioning state Medicaid and CHIP websites, yet most state websites fall short on delivering streamlined, easy to navigate, comprehensive information to enrollees. With almost 70% of Medicaid and CHIP enrollees nationwide enrolled in comprehensive managed care plans, this has enormous implications for the overall consumer experience.

30 Total Medicaid MCO Enrollment | KFF.

30

The following briefing memo provides: (1) potential sub-regulatory guidance that CMS could share with states on best practices for improving state Medicaid/CHIP agency web design; and (2) recommended activities CMS and states could take to improve enrollees' online user experience.
Int
Potential Sub-Regulatory Guidance on Web Design State Best Practices
Objective. This sub-regulatory guidance advances CMS' priority of improving timely access to high-quality and appropriate care by promoting a strategy of continuous and iterative improvement in the enrollee online experience, supporting ongoing state innovation and consumer engagement, and advancing equity and efficiency in accessing care and interacting with managed care plans.

CMS supports the application of best practices in User Centered Design (UCD)

31 What is User Centered Design? | Interaction Design Foundation (IxDF) (interaction-design.org).

31
which includes utilizing iterative and ongoing User Experience (UX) research to streamline path flows, identify enrollee needs and reduce access barriers. The use of beneficiary surveys and web analytics are also important methods for ensuring websites are as effective and user friendly as possible.

Minimum Enrollee UX Expectations for State Medicaid/CHIP Websites. At a minimum, state Medicaid and CHIP agency websites must provide:
An easy way for consumers to find the consumer section of the state's Medicaid website;
A clean and clear Medicaid/CHIP Managed Care "home page" or "landing page" that provides an obvious and distinct entry point for enrollees;
A content menu with intuitive offerings (see below);
Navigation that enables visitors to find content by searching and browsing and move easily between different sections of the website;
Connections to other real-time assistance (e.g., consumer hotline) with real people during reasonable hours and follow up outside of those hours; and
Varied and ongoing consumer usability feedback channels, including moderated usability testing using a third party vendor that is an entity distinct from the IT vendor.

State websites should be built and enhanced using UCD processes, which include a continuous cycle of observation, ideation, rapid prototyping, user feedback, iteration and implementation.

32 IDEO's Human Centered Design Process: How to Make Things People Love (usertesting.com).

32
State websites should also use current design principles, which include: clear purpose; easily understood language; intuitive navigation and functionality; visual hierarchies, and; ample white space and engaging colors and graphics.

Expectations for Medicaid websites should be no different than those in other industries and should deliver high quality performance, reliability and usability, including:
Optimal performance on mobile devices and smart phones;
Prompt load times;
Technical stability;
Dynamic search tools;
Language toggles;

Multiple channels for assistance; and,
ADA compliance.

Recommended Content Menu for Medicaid and CHIP Agency Websites. Medicaid and CHIP enrollees and other potential health care consumers should be able to easily access a range of information on state Medicaid websites. They should also have easy access to consumer decision support tools such as plan comparison and selection, provider search, and plan quality information. In all instances, consumers should have access to readily available chat, phone and text assistance, with referrals as needed to in-person assistance. The following are recommended content menu items:

Plan Selection:
Overview / Purpose
Compare and Select a Plan
Find Plans With My Provider
Changing Plans
Covered Benefits and Prescriptions in a Plan
Understanding Your Plan's Quality and Performance Data

Selecting a Provider:
Provider Sort and Search
Find Plans with My Provider
Choosing a Provider
Changing a Provider
Availability of Telehealth Services
Provider Availability and Consumer Rights With Making an Appointment

Consumer Rights:
Know Your Rights Overview
Continuity of Care Rights
Non-Discrimination Requirements
Grievances and Appeals
Provide Feedback or Fill Out a Survey

Additional Recommendations for Improving Enrollees UX with Medicaid and CHIP Websites. The following outlines additional best practices for improving enrollees' when seeking to navigate their Medicaid and CHIP managed care websites.
Conduct UX Assessments. States should conduct independent assessments of existing Medicaid and CHIP websites before undertaking any changes regarding the managed care functionality. The "as is" is a critical starting point. Consumer assessments should be ongoing; they are not a one-time activity.

33 CMS may also wish to conduct consumer usability assessments of three to five state Medicaid or CHIP websites (using an independent UX vendor and not to be publicly shared) to uncover pain points and navigational challenges. This will lend credibility to and inform recommendations to state Medicaid and CHIP agencies on website.

Build in Consumer UX Assessments Into IT Contracts. When a state contract with vendors for IT development and enhancement, leveraging a 90/10 FMAP, states should be sure to include contract requirements that mandate consumer usability and independent consumer UX assessment in their contract terms and conditions.
Use Web Analytics. States should be using Web analytics to track website utilization and inform design changes. States should create a dashboard to quantify website traffic, reach, engagement, sticking points and audience characteristics.

34 Beyond Regulatory Requirements: Designing ACO Websites to Enhance Stakeholder Engagement (ajmc.com).

34

Include User Online Experience Questions in State Surveys. States should ask about consumer experiences with Medicaid and CHIP websites in their beneficiary utilization and satisfaction surveys.
Ensure Transparency. State Medicaid and CHIP agencies should also maintain publicly available dashboards on managed care plan-specific performance data. Dashboards should be available on consumer websites and designed with beneficiary input and testing.

Appendix F. Additional Research and Background Information
Updated as of 8/23/2022

Network Adequacy Requirements in Medicaid Managed Care, the Marketplace, and Medicare
Network adequacy standards to ensure beneficiary access vary significantly across Medicaid, the Marketplace, and Medicare. The standards also vary by delivery system and across states, making it difficult to draw meaningful comparisons and deploy collective improvements. There is significant opportunity to strengthen and align network adequacy and access requirements across coverage programs and delivery systems.

In 2020, CMS moved to allowing states in Medicaid managed care to choose any quantitative network adequacy standard for designated provider types

35 Provider types include: primary care, adult and pediatric; OB/GYN; behavioral health (mental health and substance use disorder (SUD)), adult and pediatric; specialist (as designated by the State), adult, and pediatric; hospital; pharmacy; pediatric dental; and long-term services and supports (LTSS), as applicable.

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– a departure from the time and distance standards that were previously required. Quantitative standards may still entail time and distance standards, but they can also include provider-to-enrollee ratios, appointment wait-times, percentage of contracted providers accepting new patients, hours of operation requirements, or a combination of standards. While these standards generally apply to CHIP (with the exception of state monitoring requirements), Medicaid FFS takes a different approach, wherein states must submit Access and Monitoring Review plans every three years to demonstrate that payment rates are “sufficient to enlist enough providers so that care and services are available under the state plan at least to the extent that such care and services are available to the general population in the geographic area.”

36 States must conduct the analysis for: primary care services (including those provided by a physician, federally-qualified health centers, clinic, or dental care); physician specialist services; behavioral health services, including mental health and SUD; pre- and post-natal obstetric services, including labor and delivery; and home health services. See also 42 CFR § 447.203 and § 447.204.

36

In accordance with the Marketplace network adequacy standards proposed for plan year 2023, Federally Facilitated-Marketplace (FFM) and State-Based Marketplace (SBM)-Federal Platform (FP) states would be required to comply

with prescriptive time and distance standards for individual provider/facility specialty types as well as appointment wait-time standards for behavioral health, primary care (routine), and specialty care (non-urgent). While qualified health plan (QHP) standards are more stringent than Medicaid standards in this regard, Marketplace requirements do not prioritize provider language and cultural competency or accessibility for people with disabilities. In Medicare Advantage (MA), plans must similarly meet specific time and distance standards for certain providers, though the standards are not the same as in the Marketplace. MA plans must also contract with a specified minimum number of each provider and facility-specialty type, and ensure that services are provided in a culturally competent manner.

Moreover, like in the Medicaid program, there are no statutory or regulatory requirements that CMS or other organizations use secret shopper approaches to assess network adequacy and other access issues in the Medicare program or for Marketplace plans. However, CMS has at times leveraged secret shopper studies to assess these issues. CMS previously announced that it would take additional measures to monitor the accuracy of Medicare Advantage Organization (MAO) provider directories, including by working with external contractors to conduct secret shopper studies.

37 https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2016.pdf

37
CMS also uses secret shopper approaches to assess the accuracy of Qualified Health Plan (QHP) provider directories as part of its annual compliance review of issuers on the federally facilitated marketplace.

38 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2020-PY-FFE-Summary.pdf

38

Research/Background on Provider Survey Approaches to Measure Access
While the federal government and states are jointly responsible for ensuring that Medicaid provides access to services through network adequacy standards, these standards are often not appropriately monitored or enforced, leading to gaps in access for many beneficiaries. States are required to conduct external quality reviews to assess managed care entity compliance with federal network adequacy standards. However, numerous studies have demonstrated that Medicaid beneficiaries still struggle to access needed services and that managed care plans are not always in compliance with state and federal standards. For example, a 2022 study from Ludomirsky et al showed that a small percentage of primary care and specialist providers listed in Medicaid managed care provider directories deliver the overwhelming majority of services, suggesting that many listed providers are not actually serving Medicaid patients.

39 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747.

39
A 2019 study conducted by Mathematica for CMS showed that Medicaid beneficiaries faced significant difficulty in securing psychiatry appointments, even when they had access to plan provider directories.

40 https://www.medicaid.gov/medicaid/downloads/behavior-health-provider-network-adequacy-toolkit.pdf.

40
 Additionally, a 2019 meta-analysis from Hsiang et al found Medicaid beneficiaries had a 1.6-fold lower likelihood of successfully scheduling a primary care appointment and a 3.3-fold lower likelihood of successfully scheduling a specialty appointment when compared to individuals with private insurance.

41 https://journals.sagepub.com/doi/full/10.1177/0046958019838118.

41

Some states have utilized so-called “secret shopper” studies to assess managed care plans’ compliance with network adequacy standards and protect beneficiary access. These studies generally involve an individual posing as a fictional patient calling or using other means to attempt to set up an appointment with a health care provider in a managed care plans’ network. Despite the fact that only some states have conducted these studies, there is evidence of their value: many such studies have identified significant beneficiary access concerns, and they have been recognized by the HHS Office of the Inspector General and the Medicaid and CHIP Payment and Access Commission (MACPAC) as an effective approach for monitoring access to care.

42 https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.

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43 https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf.

43
 States are required to conduct external quality review activities to assess various aspects of managed care plan performance, including validating performance improvement projects and plan performance measures, ensuring compliance with service availability and provider capacity standards, and validating compliance with network adequacy standards (among other requirements).

44 42 CFR § 438.358(b).

44
 While not required, states may also conduct additional external quality review activities, including administering surveys or studies of beneficiary access and quality issues.

45 42 CFR § 438.358(c).

A number of states have taken advantage of this opportunity and leveraged external quality review organizations (EQROs) or other external vendors to conduct secret shopper surveys focused on issues of beneficiary access. While study approaches vary considerably across states, they typically focus on assessing appointment wait-times and the accuracy of provider directories.

Summary of RFI Comments on Access to Care

To inform the development of appointment access timeliness standards and related guidance, CMS issued on February 17, 2022 an RFI soliciting public input on improving access in Medicaid and CHIP, including ways to promote equitable and timely access to providers and services. Barriers to accessing care represented a significant portion of comments received, with common themes related to providers not accepting Medicaid and recommendations calling for setting specific quantitative access standards.

Many commenters urged CMS to consider developing a federal "floor" (or minimum) for timely access to providers and services, providing state Medicaid/CHIP agencies the flexibility to impose more stringent and/or expansive requirements. Some commenters recommended that CMS consider varying such standards – for example, by provider type (primary care, behavioral health, dental, home and community-based services), for children versus adults, or by geography. Other commenters expressed support for state-specific quantitative access standards, inclusive of appointment wait-times. Among those who opposed minimum standards for timely access, they pointed to concern over operational feasibility – for example, administrative burden and the potential impact on provider participation in the Medicaid program; and variation across regions, provider types, payers, and eligibility groups potentially resulting in insignificant cross-state comparisons/evaluations. Commenters were, however, unified in the goal of meaningful beneficiary access to timely, high-quality, and appropriate care. Beyond establishing access timeliness standards, commenters stressed the importance of measuring, monitoring, and enforcing access more broadly, including encouraging CMS to make public state performance on the standards.

Several commenters on the CMS's Access RFI supported CMS strengthening requirements related to enforcement of network adequacy and beneficiary access standards. The National Health Law Program (NHeLP) urged CMS to employ direct testing methods, such as secret shopper studies, to monitor both appointment wait-times and provider directory accuracy. The American Hospital Association (AHA) encouraged CMS to strengthen requirements around ensuring the accuracy of provider directories. And while they did not call for specific secret shopper requirements, several commenters, including the American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP), urged CMS to articulate available methods for enforcing national access standards.

State Examples: Network Adequacy Enforcement Mechanisms

States use a multitude of network adequacy enforcement mechanisms—ranging from corrective action plans and sanctions to liquidated damages and contract terminations. Below, we highlight practices from select states that consider themselves leaders on network access.

Arizona. Based on a review of the state's Medicaid managed care contract, it's not entirely clear which enforcement mechanisms have been successful (from the state's perspective) in ensuring network adequacy. The state maintains the ability to impose a range of administrative actions (e.g., sanctions, notice to cure, and TA).

The contract includes the following provisions of note:

AHCCCS may impose Administrative Actions for material deficiencies in the Contractor's provider network.

AHCCCS will disenroll the member from the Contractor when not all related services are available within the provider network.

The Contractor shall develop and maintain a Network Development and Management Plan (NDMP) to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area and which ensures the provision of covered services. The submission of the NDMP to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The NDMP Plan shall be evaluated, updated annually, and submitted to AHCCCS.

The Contractor shall continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, member grievances, appeals, quality data, quality improvement data, utilization of services, member satisfaction surveys, and demographic data requirements. The Contractor shall also develop non-financial incentive programs to increase participation in its provider network when feasible.
The Contractor may request an exception to these network standards; it shall submit such a request for AHCCCS approval. In the event a Contractor is not able to meet set network standards, AHCCCS may review requested exceptions based upon a number of factors, including but not limited to, availability of out of network providers and geographic limitations of the service area.
The PBM subcontract shall include: a clause that allows for an annual review of the contract for rate setting, adjustments to market conditions, and to ensure network adequacy.
Arizona does not appear to tie financial penalties or sanctions to corrective action plans (though the state retains the right to impose penalties, withholds, and terminate contracts if terms of the contract are not met).

California. The California Department of Managed Health Care (DMHC) issued an order in Dec 2017 requiring nine health plans to terminate contracts with Employee Health Systems Medical Group as a result of blocking patient access to specialists. The basis for doing so was the Knox-Keene Act, which regulates health plans (and any provider or subcontractor providing services) and the health plan business in California to protect and promote the interests of enrollees. (Also see the Blue Shield of California Promise Health Plan's notice of potential contract termination and this 2021 CHCF brief.)

Florida. While Florida's Medicaid managed care contract does appear to include more robust requirements (with an emphasis on liquidated damages and reporting) related to ensuring access to provider networks, this dashboard and local news article suggest that network adequacy remains a significant issue (for health and dental plans, alike). The contract includes the following provisions of note:
The Managed Care Plan shall submit a provider network file of all participating providers to the Agency or its agent(s) on a weekly basis and at any time upon request of the Agency with sufficient evidence that the Managed Care Plan has the capacity to provide covered services to all enrollees.
The Managed Care Plan shall develop and maintain an annual network development plan, including processes and methods to develop, maintain, and monitor an appropriate provider network that is sufficient to provide adequate access to all covered services covered; interventions to address network gaps; evaluation of the effectiveness of interventions to address gaps; results of secret shopper activities; among other factors.
Liquidated damages, including but not limited to:
Failure to timely report, or provide notice for, significant network changes ($5,000 per occurrence).
Failure to comply with provider network requirements in the contract ($1,000 per occurrence).
Failure to update online and printed provider directory ($1,000 per occurrence).
Failure to provide covered services within the timely access standards ($500 per day, per occurrence).
Failure to provide covered services within the geographic access standards ($500 per day, per occurrence).
Failure to submit a provider network file that meets the agency's specifications ($250 per occurrence).
Any liquidated damages assessed by the Agency shall be due and payable to the Agency within 30 days after the Managed Care Plan's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice. The Agency shall have sole authority to determine the application of an occurrence (e.g., per unit of service, per date of service, per episode of service, per complaint, per enrollee, etc.). The Agency may elect to collect liquidated damages: through direct assessment and demand for payment delivered to the Managed Care Plan; or by deduction of amounts assessed as liquidated damages from, and as set-off against payments then due to the Managed Care Plan or that become due at any time after assessment of the liquidated damages.
The Managed Care Plan agrees that failure to comply with all provisions of this Contract and 42 CFR 438.100 may result in the assessment of sanctions and/or termination of this Contract.

Tennessee. Tennessee similarly utilizes liquidated damages (in addition to corrective action plans) for violations related to time and distance standards, provider information accuracy, adequacy of provider networks, and provider network documentation. The contract includes the following provisions of note:
The CONTRACTOR shall monitor provider compliance with access requirements, including but not limited to appointment and wait-times and take corrective action for failure to comply.
The CONTRACTOR shall submit monthly Provider Enrollment Files as follows: include information on all providers of

covered services and shall provide a complete replacement for any previous Provider Enrollment File submission. Any changes in a provider's contract status from the previous submission shall be indicated in the file generated in the month the change became effective and shall be submitted in the next monthly file.
The CONTRACTOR shall submit an annual Provider Compliance with Access Requirements Report that summarizes the CONTRACTOR's monitoring activities, findings, and opportunities for improvement regarding provider compliance with applicable access standards as well as an emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. This report/plan shall also be available upon request.
For behavioral health and specialty care: At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency. The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.
Liquidated damages, including but not limited to:
$25,000 if ANY of the listed standards are not met, either individually or in combination, on a monthly basis (Time and travel distance as measured by provider network analytics software described by TENNCARE).
$25,000 if ANY of the listed standards are not met, either individually or in combination on a monthly basis

46 The liquidated damage may be waived if the CONTRACTOR provides sufficient documentation to demonstrate that the deficiency is attributable to a lack of CHOICES HCBS provider serving the county and the CONTRACTOR has used good faith efforts to develop CHOICES HCBS providers to serve the county. The liquidated damage may be lowered to $5,000 in the event the CONTRACTOR provides a corrective action plan that is accepted by TENNCARE.

(for executed provider agreements with providers to participate in the specialist provider network and the HCBS provider networks);
$25,000 per quarter if less than 90% of providers confirm participation in the CONTRACTOR's network (based on a statistically valid sample of participating providers on the most recent monthly provider enrollment file confirm that they are participating in the CONTRACTOR's network).
$1,000 for each provider for which the CONTRACTOR cannot provide a signature page from the provider agreement between the provider and the CONTRACTOR (related to the provider enrollment file).
TENNCARE may impose intermediate sanctions on the CONTRACTOR simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe and/or numerous. TENNCARE will provide the CONTRACTOR with timely written notice before imposing any intermediate sanction (other than required temporary management).

November 4, 2022

Daniel Tsai, Deputy Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Sent via email

Re: Healthy Michigan Plan Section 1115 Demonstration Extension Application

Dear Deputy Administrator Tsai:

We are writing with respect to Michigan's extension application for its section 1115 Medicaid demonstration, "Healthy Michigan Plan," which is set to expire December 31, 2023. The proposal, for which the state comment period just closed, seeks to extend the state's demonstration project for five years. The application that was posted for state public comment lacked the required information to comply with CMS's demonstration transparency requirements that are set out at 42 CFR § 431.408, failing to provide even a basic description of some of the waiver and expenditure authorities the state is requesting to continue. As a result, the State's forthcoming application to CMS cannot be deemed complete as set forth at 42 CFR § 431.412. We therefore ask that upon receipt of the state's application, you withhold your certification of completeness and instead return the application to the agency with direction to modify the application to meet the completeness requirements and to conduct an additional 30-day comment period so that the public has a meaningful opportunity to provide feedback on the state's proposals.

CMS regulations identify seven different elements that a demonstration extension application must include to be determined complete. At a minimum, Michigan's application that was posted in draft form for state-level comment fails to meet 42 CFR § 431.412(c)(2)(vii), which specifies that state must document their compliance with the public notice process set forth in 42 CFR § 431.408. Under this regulation, at 42 CFR § 408(a)(1)(i) a state's extension application must include "a comprehensive description of the demonstration application or extension to be submitted to CMS that contains a sufficient level of detail to ensure meaningful input from the public."

Michigan's application fails to provide a sufficient level of detail in its extension application as required by § 431.408(a)(1)(i). The sparse seventeen-page application does not contain key information about a number of the proposals the state seeks to continue, specifically those that would affect beneficiaries' access to care. A few examples of key missing details include:

- A description of the premium requirements for individuals with income above 100 percent of the federal poverty line with less than 48 cumulative months of coverage;
- A description of cost-sharing requirements, including who would be subject to copayments and the services for which copayments would be required;
- A description of the Healthy Behaviors Incentives Program, including what actions would qualify as a "healthy behavior" and the amount of cost-sharing reductions beneficiaries would receive for completing a "healthy behavior;" and
- A description of the penalty for individuals with incomes above 100 percent of the federal poverty line with 48 or more months of cumulative enrollment for non-payment of premiums

and not completing a health risk assessment – namely, the loss of coverage and undefined lockout period.

Additionally, the application fails include the hypothesis and evaluation parameters of the demonstration extension as required by 42 CFR § 431.408(a)(1)(i)(D). The state includes the goals for the demonstration extension and a summary of the evaluation of the current demonstration, but does not have the two elements specified in the regulation above. As you know, a section 1115 demonstration is an experiment – so to test the experiments authorized through these demonstrations a hypothesis is needed to explain the legitimate demonstration purpose while evaluation parameters explain how the state plans to identify the outcomes of the experiment. Without these details included in extension application, the experimental nature of the demonstration is undermined.

While the state provides high-level estimates of total enrollment over the proposed five-year extension period as required by 42 CFR § 431.408(a)(1)(i)(C), it does not provide estimates on how each provision would affect enrollment, namely the disenrollment and lockout from coverage for those with 48 or more cumulative months of enrollment. Furthermore, a study of the state's own evaluation data has shown that premiums imposed on Healthy Michigan beneficiaries increased the likelihood of individuals voluntarily disenrolling from coverage; yet, there is no analysis highlighting the potential enrollment effects of this policy, or others. This is especially important given that several provisions have yet to be implemented due to the Families First Act continuous coverage protection so the extent of enrollment harms may be even larger than current data suggests.

This missing information significantly inhibits meaningful input from the public. Without the inclusion of key details about each provision and given the absence of hypotheses and evaluation parameters as well as the lack of detailed enrollment estimates, individuals who sought to submit comments on Michigan's extension application will have had no way to understand the full scope of what the state was proposing. Even if the state submits a more robust application to CMS to review for the federal comment period, that is not a sufficient remedy; the state must redo its state comment period with an improved application that provides a comprehensive description of the provisions the state is requesting to continue. The state's failure to include the information described above means that the state's extension application does not meet the regulatory requirement at 42 CFR § 431.408 for containing a sufficient level of detail to provide the public with an opportunity to provide meaningful input during the state comment period.

As such, we believe that the application does not meet the requirements for section 1115 extension applications under 42 CFR § 431.412 and should not be certified as complete. Instead, CMS should return the application to the state and advise the state to revise its proposal to include more information and re-open a full comment period so that the public can comment on the proposal in a meaningful way.

Please let us know if you have any questions.

Sincerely,

Joan Alker
Executive Director and Research Professor, Center for Children and Families Georgetown University McCourt School of Public Policy

Allison Orris
Senior Fellow, Center on Budget and Policy Priorities

Author: Allie Gardner
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CreationDate: 2022-11-04 20:11:46
ModDate: 2022-11-04 20:11:46

Appointment Title:
CMCS / NY Safety Net Hospital Coalition

Organizer:
CMS CMCS_Scheduling

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Location:
https://cms.zoomgov.com/j/1615746141?pwd=L3hNemZWZGQvdHZ0QThPUnJkSjArQT09

Start Time:
12/22/2022 2:30:00 PM +0000

End Time:
12/22/2022 3:15:00 PM +0000

Reminder Time:
N/A

Reminder Set:
false

Duration:
45 minutes

Is Recurring:
false

Reccurrance Type:
Not

Reccurrance Pattern:

Response Status:
5

Busy Status:
Tentative

Attachments:
NY Safety Net Coalition Summary Statistics (Dec 2022).docx

CMCS_Scheduling@cms.hhs.gov is inviting you to a scheduled ZoomGov meeting.

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This meeting may be recorded. The host is responsible for maintaining any official recordings/transcripts of this meeting. If recorded, this meeting becomes an official record and shall be retained by the host in their files for 3 years or if longer needed for agency business. If a recording intends be fully transcribed or is being captured for the purpose of creating meeting minutes, the host shall retain the record in their files for 3 years or if no longer needed for agency business, whichever is later.

Safety Net Hospital Summary Statistics
December 2022

Note: 29 facilities in upstate and downstate New York meet the Coalition's definition of a safety net hospital, of which 20 facilities (across 7 systems) are formal members of our Coalition.

1 Our Coalition defines safety net hospital as all public and non-public inpatient facilities with at least 36% of inpatient/outpatient services attributed to Medicaid and uninsured patients, and no more than 20% of inpatient services attributed to commercial patients. Facilities in this category must also not be a sole community hospital, critical access hospital, specialty hospital, or part of a non-public hospital system with $10 billion or more in annual total patient revenue.

1

New York Safety Net Hospitals Primarily Serve Low-Income Communities of Color
More than half of safety net hospital patients on average are insured by Medicaid or uninsured, reinforcing our role as critical access points for low-income communities (see Figure 1).

2 Coalition analysis of 2019-2020 New York Institutional Cost Reports.

2

Relatively few commercially-insured patients seek care in our facilities, with most commercially-insured patients seeking care at wealthier institutions (see Figure 2).

An analysis of safety net hospitals in Brooklyn found that 72% of commercially insured patients and 49% of Medicare patients in the hospitals' service area receive inpatient care at other facilities in Brooklyn or Manhattan.

3 Northwell Health, "The Brooklyn Study: Reshaping the Future of Healthcare."

3

Safety Net Hospitals Are Paid Far Less for Providing the Same Services as Other Hospitals

In New York, Medicaid does not cover the cost of care that safety net hospitals provide, even after accounting for supplemental payments (see Figure 3).
While medical costs have risen substantially over the past decade (more than 43%), base fee-for-service and Medicaid managed care reimbursement rates have remained flat for both inpatient and outpatient rates.

4 1199 SEIU Presentation, July 2021.

These issues have been exacerbated with the ending of COVID-related funding and inflation in staffing and other operational expenses.

Since we see few commercial patients, we lack negotiating power to secure favorable rates from private payers that could cross-subsidize low Medicaid rates.

As a result, our hospitals are paid far less for providing the same services compared to wealthier hospitals.
Citywide average commercial rates are far higher (up to 7 times greater in some cases) than safety net hospitals' average commercial rates (see Figure 4).

5 Coalition analysis based on FAIR Health data, an independent nonprofit that collects data for and manages the nation's largest database of privately billed health insurance claims.

CMS recently approved a directed payment template (DPT) program in New York for safety net hospitals with at least 36% of services attributed to Medicaid across both inpatient and outpatient settings.
This was an important step, but it does not fully address the need of all safety net hospitals that serve significant volumes of Medicaid and uninsured patients, particularly in outpatient settings.
For example, even after accounting for enhanced rates under the DPT program, the Medicaid rates do not cover all safety net hospital costs, especially for outpatient clinic, ED, and ambulatory surgery services (see Figure 3).

Lack of Adequate Funding Perpetuates Disparities in Safety Net Communities
Due to the structural failures of the current system, safety net hospitals are in chronic financial distress, often facing cash flow challenges and almost always unable to invest in their infrastructure and facilities (see Figures 5-6).

As our hospitals remain underfunded, the low-income communities of color we serve continue to be impacted by persistent disparities (see Figure 7).

Appointment Title:
CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations

Organizer:
CMS CMCS_Unwinding

Attendees:

Location:
https://cms.zoomgov.com/j/1612157166?pwd=ZTljMXBKMURBU3d4L0V1K3Z5VnJoZz09

Start Time:
1/12/2023 8:00:00 PM +0000

End Time:
1/12/2023 9:00:00 PM +0000

Reminder Time:
N/A

Reminder Set:
false

Duration:
1 hours

Is Recurring:
false

Reccurrance Type:
Not

Reccurrance Pattern:

Response Status:
3

Busy Status:
Busy

Attachments:
20230112_Stakeholder Workgroup Agenda.docx

1.9.23: Moved to accommodate calendars

CMS CMCS Unwinding is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting
https://cms.zoomgov.com/j/1612157166?pwd=ZTljMXBKMURBU3d4L0V1K3Z5VnJoZz09

Meeting ID: (b)(6)

Password: (b)(6)

One tap mobile
+16692545252,,1612157166# US (San Jose)
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Dial by your location
+1 669 254 5252 US (San Jose)
+1 646 828 7666 US (New York)
833 568 8864 US Toll-free
Meeting ID: (b)(6)
Find your local number: https://cms.zoomgov.com/u/aYte4pvvV

Join by SIP
Password: (b)(6)
sip (b)(6) @sip.zoomgov.com

This meeting may be recorded. The host is responsible for maintaining any official recordings/transcripts of this meeting. If recorded, this meeting becomes an official record and shall be retained by the host in their files for 3 years or if longer needed for agency business. If a recording intends be fully transcribed or is being captured for the purpose of creating meeting minutes, the host shall retain the record in their files for 3 years or if no longer needed for agency business, whichever is later.

CMS Unwinding Stakeholder Workgroup Agenda
January 12, 2023| 3:00 - 4:00 PM ET

Welcome and Opening Remarks

Recent Releases
CMCS Informational Bulletin: Medicaid Continuous Enrollment Requirement Provisions in the Consolidated Appropriations Act, 2023: link
Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations (updated with scenarios): link
System Readiness Artifacts: A Refresher on Medicaid Enterprise Systems Artifacts for Unwinding: link

Forthcoming Guidance

Discussion of New CAA, 2023 Unwinding CIB

Feedback from the Field & Open Discussion

Wrap Up & Next Steps
Unwinding National Partner/Stakeholder Webinar: Wednesday, January 25 (12-1pm ET)
Registration Link: here
Next Meeting: Rescheduling: To be confirmed

Daniel

2023-07-26T08:40:00Z

D
Thanks

1 - Can we clarify telehealth visits satisfy appointment access (do we agree w that?)
2 - For routine - shouldn't we put out some standard definition for ease of comparison and simplicity. Could we opine that post finalization we'd discuss w states and stakeholders to put out a definition
3 - Can we re-emphasize the "remedy plan" approach that states must submit when their plans do not meet the standard. Remind me also if that would need to be the case if an individual plan does not mean the standard vs a statewide piece
4 - I'm inclined to stay at 4 years. I don't think 4 vs 5 would have much impact on state ability to "ramp up" - and part of this is identifying where there are issues and working through the remedy plan
5 - can we also opine on what CMS expects in the remedy plans (combo of rates, state workforce initiatives, telehealth policies, longer term delivery system reforms, etc. etc.)

Tier 1 Provisions in the Managed Care Access, Finance and Quality Rule – Preliminary Analysis of Comments & Recommendations

NOTE: 419 comments were received on the Managed Care Access, Finance and Quality NPRM. Processing of the comments is ongoing. The issues and recommendations described below are preliminary Tier 1 provisions based on the comments that have been reviewed to-date. Potential Tier 2 items to discuss in August are outlined at the bottom of this document.

Provision Title
Proposed Provisions/Preamble Discussion
Comments in Support
Comments Opposing
Recommendation(s)

Access

Appointment Wait Time Standards (§§ 438.68(e), 457.1218)

States must establish and enforce appointment wait time standards for routine appointments for:
(i) Outpatient mental health and substance use disorder, adult and pediatric, within State-established time frames but no longer than 10 business days from the date of request.
(ii) Primary care, adult and pediatric, within State-established time frames but no longer than 15 business days from the date of request.
(iii) Obstetrics and gynecological within State-established time frames but no longer than 15 business days from the date of request.
(iv) State-selected chosen in an evidence-based manner within State-established time frames.
Most comments from advocates and some provider associations supported this provision. Provider comments

consistently also noted a need for improved reimbursement and a contractual provision that ensures they are held harmless when standards are not met.

Most States, NAMD, managed care plans, and some providers expressed concern about the time frames (10- and 15-business days) being unrealistic and untested.

Strongest and most prevalent concerns were related to meeting the standards given the national shortage of behavioral health providers as well as shortages in rural areas and health professional shortage areas (HPSAs).

Additional comments included recommendations to:
Align with Medicare Advantage (30-business days) or to use 30- and 45-day maximums.
Delay compliance date or phase in the appointment standards over time, starting with fewer provider types or by gradually adjusting wait time maximums or compliance rate.
Define "routine" appointment.
Permit all telehealth appointments to count toward compliance.
Measure appointment wait times for new patients separately from existing patients.
We recommend finalizing the 10- and 15-business days to maintain alignment with the Marketplace. See attached 3M Chart regarding appointment wait time policies across Medicaid and CHIP managed care, Medicare Advantage, and the Marketplace.
We also recommend clarifying in this final rule that States can define "routine" for the purpose of setting appointment wait time standards.

If we consider longer time frames given the public comments, we recommend 30 business days to align with Medicare Advantage. This approach would not align with CCIIO's current approach in the Marketplace.

Appointment Wait Time Standards Compliance
(§§ 438.68(e)(2), 457.1218)
Minimum compliance.
Managed care plans will be deemed compliant with appointment wait time standards when secret shopper results reflect a rate of appointment availability of at least 90 percent.
Most comments from advocates and some provider associations supported this provision. Provider comments consistently also noted a need for improved reimbursement and a contractual provision that ensures they are held harmless when standards are not met.
Most States, NAMD, and managed care plans, and some providers expressed concern that a 90% compliance rate, given the proposed appointment wait time maximums, was not immediately attainable.

Additional comments included recommendations to:
Start with 50-75% and gradually increase to 90%.
Allow all telehealth appointments to count toward compliance or use Medicare Advantage's 10% credit methodology for time/distance standards.
Conduct pilot of wait time compliance to gather data to inform selection of a reasonable compliance standard.
We recommend finalizing a minimum compliance rate of 90% (consistent with the Marketplace) and that only telehealth appointments by providers that also provide in-person appointments count toward compliance (also consistent with the Marketplace).

We would also recommend finalizing an applicability date of 5 years after the effective date rather than the proposed 4 years. This would provide more time for States to ramp-up to the 90% compliance standard.

State Directed Payments (SDPs)
Note: For SDP preprints approved through September 2022, there are 109 SDPs across 34 states that have SDPs that are projected to result in a total reimbursement rate above Medicare (or up to an average commercial rate (ACR)). State's projections of total spending on these proposals equals $39.9 billion for the most recent rating period. There is significant overlap between SDPs that increase total provider rates up to the ACR and the use of provider taxes and

intergovernmental transfers, reconciliation processes and separate payment terms. Therefore, our Tier 1 SDP proposals below are focused on addressing these intersecting challenges. For example, for SDP preprint approvals through September 2022, the majority of SDPs (approximately 64%) that result in total payment rates above Medicare are paid through separate payment terms. Most of these are financed through provider taxes and IGTs. The separate payment term, in at least some of these instances, provides certainty to those entities providing the non-federal share so that they know approximately how much they will receive through the payment arrangement. While we don't have data that identifies the number of SDPs that use a post-payment reconciliation process, our experience with SDPs indicates there is significant overlap.

Provision Title
Proposed Provisions/Preamble Discussion
Comments in Support
Comments Opposing
Recommendation(s)

SDP Provider Payment Limit (§?438.6(c)(2)(iii))
At §?438.6(c)(2)(iii)), we proposed to establish a provider payment limit at ACR for SDPs that require prior approval for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioners at an academic medical center. We acknowledged that this was precedent setting and not in alignment with the upper payment limits (UPL) in Medicaid fee-for-service (FFS) which utilizes Medicare as a standard. However, this ACR proposal was in alignment with our historical internal benchmark since 2018 and with current practice for FFS supplemental payments for the professional services at academic medical centers. We also solicited feedback on several alternative benchmarks for a payment limit for these four service types or for all service types. These alternatives included: (1) 100 percent of the Medicare rate; (2) a level between Medicare and the ACR; (3) a Medicare equivalent of the ACR; and (4) at the Medicare rate for fee schedules and uniform increases, and at the ACR for value-based payment (VBP) arrangements for these four service types. We proposed a 2-year effective date for this provision.
The American Hospital Association (AHA) supported the ACR limit and opposed all alternative benchmarks.

NAMD indicated that "states and territories are comfortable" with the ACR limit which they believe is preferrable to Medicare.

Some States (e.g., AZ, CA, KY, MI, NH, SC, TN) supported establishing the payment ceiling at ACR for these four service types. PA supported ACR as the payment limit for inpatient hospital services, outpatient hospital services, and qualified practitioners at an academic medical center.

FL supported establishing the total payment rate limit at ACR, but for all services, not just the four we proposed.

CBPP and Georgetown University Health Policy Institute opposed the ACR limit. Both raised concerns about a higher reimbursement level in managed care versus FFS, and how that may disincentive States from models besides managed care citing Kentucky as an example.

CBPP supported a Medicare limit. Georgetown generally supported a Medicare limit, and commented that Medicare rates enabled adequate access, were easily ascertained and more transparent. Georgetown further noted that "allowing SDPs to rise to ACR levels is not an efficient solution; it leads to a windfall for a few providers, but most providers do not benefit from the policy."

MACPAC did not take a position on a limit but noted that without a limit there is a risk that Federal spending will continue to increase substantially. MACPAC noted that Medicare is publicly available and consistent for all providers while ACR is not readily available and can vary widely.

NC's state treasurer opposed ACR and supported to "return" to Medicare. The treasurer noted concerns that increasing payment rates will lead to further hospital consolidation and increased prices in commercial markets.

NAMD, some States (e.g., DE, PA) and the American Academy of Actuaries (AAA) opposed an ACR limit for nursing

facility services.

AZ and PA opposed Medicare as the limit for nursing facility services since Medicare adopted the Patient-Driven Payment Model reimbursement methodology, as CMS acknowledged in SMD 22-005 [hyperlink added]. MACPAC also expressed similar concerns.

MA opposed an ACR limit on qualified practitioner services at an academic medical center.

TX opposed a limit and noted "this inequitable treatment of hospital services, nursing facility services, or services provided by a qualified practitioner at an academic medical center does not have a basis in statute nor is it in the best interest of Medicaid clients."
We recommend finalizing the SDP payment limit for inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioners at an academic medical center at: (1) 100 percent of Medicare for fee schedules and uniform increases; and (2) 100 percent of average commercial rate for VBPs. We believe this option would better align managed care SDP fee schedules and uniform increases with Medicaid FFS UPLs, incentivize States to pursue value-based care and quality-based payment models and ensure more accountability in payment while not taking money out of the system which could raise access to care or health equity concerns from stakeholders. We recognize this would be a shift for many States, and we recommend considering a 3-year glidepath rather than the proposed 2 years.

We could consider setting the payment limit for SDPs at 100 percent of Medicare. This is a standardized benchmark used in the industry and is often a standard utilized in Medicaid FFS under UPL demonstrations in 42 CFR part 447. This is a standard that FMG, OACT and OMB support. Setting such a limit under the final rule would remove SDP spending from the system and may negatively impact access to care. States would need a transition period to move from ACR to Medicare.

Alternatively, we could consider finalizing the rule as proposed and finalize with a payment limit of 100 percent of the average commercial rate. This approach may align with our historical operational practices since 2018 but may significantly increase Federal spending on SDPs. See the attached paper on the fiscal impact of SDP spending.

Note: We strongly recommend that a provider payment limit for SDPs be finalized as no limit would allow SDP funding to grow unfettered and continue to raise significant concerns by oversight bodies including GAO, OIG, MACPAC as well as the CMS Office of the Actuary.

Additionally, we consulted with OGC on our ability to "grandfather" existing ACR proposals that are already approved by CMS, and OGC advised that CMS did not specifically explore the idea of "grandfathering" in the proposed rule, and therefore, we lack logical outgrowth. Additionally, OGC strongly advised against such an approach, as it would likely be challenged as arbitrary.

SDP Fiscal Integrity Provisions

Post payment reconciliation (§ 438.6(c)(2)(vii)(B))

Separate payment terms (SPTs)

1 Separate payment terms are payments made to a managed care plan in addition to the capitation rates to account for any portion of the cost of complying with the SDP not already accounted for in the actuarially sound capitation rates.

1
(§§ 438.6(c)(6), and 438.7(f))

Federal legal requirements for the financing of the non-Federal share ((§?438.6(c)(2)(ii)(G))

Provider attestations that they do not participate in a hold harmless arrangement ((§?438.6(c)(2)(ii)(H))

There are other fiscal integrity provisions that will be discussed in Tier 2 discussions.
At § 438.6(c)(2)(vii)(B), for SDPs that are fee schedules or uniform increases, we proposed to prohibit States' practices of conditioning payment from the managed care plan to the provider on utilization and delivery of services outside of the rating period and then requiring that payments be reconciled to utilization during the rating period. We have significant concerns with this practice as we believe it suggests an intent by States to ensure payment of a specific aggregate amount to certain providers or, in some cases, removal of all risk related to these SDPs from managed care plans.

At §§ 438.6(c)(6), and 438.7(f)), we proposed guardrails on States' use of separate payment terms for SDPs. Proposed guardrails included review and approval of these in the preprint, and associated documentation requirements in the managed care plan contracts and rate certifications. We also solicited feedback on the prohibition of separate payment terms as we have concerns that the use separate payment terms are contrary to the risk-based nature of Medicaid managed care. The use of separate payment terms can also result in perverse incentives for plans that can result in shifting utilization to providers in ways that are not consistent with Medicaid program goals.

At §?438.6(c)(2)(ii)(G), we proposed to require compliance with all Federal legal requirements for the financing of the non-Federal share.

At §?438.6(c)(2)(ii)(H), we proposed to require States to ensure that providers attest that they do not participate in a hold harmless arrangement, as defined by statute and regulation. Note that in early July, a federal court granted a motion (Texas v. CMS 23-cv-161) sought by Texas enjoining CMS from enforcing a related CIB. CMCS is working with OGC/DOJ to determine the scope of the injunction and next steps.

Proposed effective dates for these four provisions varied. For (1), (2) and (4), we proposed a 3-year effective date for this provision. For (3), we proposed this be effective the first rating period following the effective date of the Final Rule.
CBPP supported a prohibition as post payment reconciliation does not benefit Medicaid beneficiaries, undermines the actuarial soundness of capitation rates, and absolves plans of risk.

CA supported a prohibition on post payment reconciliation outside the rating period and noted that "this narrower form of post payment reconciliation is aligned with the requirement to ensure payments are based on the utilization and delivery of services for the rating period and is consistent with CMS' aims of ensuring MCOs retain and are able to manage risk under the contract."

NAMD supported continued use of separate payment terms.

CA, SC and TN opposed any prohibition of separate payment terms. CA recommended that if any prohibition on separate payment terms was finalized that there should be a 3-year effective date.

Georgetown Health Policy Institute and CBPP supported program integrity guardrails as to how States finance their SDPs and the hold harmless attestation requirements. CBPP noted that SDPs "…should be tied to the services received by enrollees and be at a rate that is adequate but not excessive. When payments are redirected to providers to compensate them for the tax they paid, these payments are not benefiting Medicaid enrollees. Such payments also suggest that the payment rates may be higher than what is needed to assure adequate access and quality or, in the alternative, that they are being redirected in a way that undermines access and quality." However, CBPP commented that the compliance date for the provider attestation should be shorter.

Centene supported provider attestations and noted CMS should be clear this a state obligation and not a plan obligation.

NAMD noted that interim payments used in post payment reconciliation can be important to mitigate cash flow challenges that safety-net providers face, given their thin operating margins. NAMD noted that at a minimum CMS should permit interim payments based on current contract period utilization and reconcile to actual utilization as the contract year progresses.

AHA opposed a prohibition and acknowledged that interim payments used in post payment reconciliations are "meaningful" for providers that contributed to financing the non-Federal share.

2 "Interim payments are an important tool states adopt to help mitigate cash flow challenges that Medicaid providers may experience by permitting SDP payments to be made on an interim basis throughout the year. This may be especially meaningful for providers that contributed to financing the non-federal share of the SDP up front [emphasis added] …. We recognize that CMS' proposals regarding how states incorporate SDPs into managed care rate certifications through separate payment terms allows states continued flexibility in structuring payments but believe interim payments and reconciliation are important tools available to states to ease provider cash flow burdens while also tying fixed funding sources to actual utilization."

2

Some States (e.g., AZ, IL, KY, LA, MI, MO, NH, SC, TN, VT) and MHPA opposed a prohibition on post payment reconciliation. DE recommended that any prohibition focuses on larger payments or certain provider types.

Georgetown Health Policy Institute commented that SDPs are best implemented through adjustments to base capitation rates, and if CMS does not eliminate the use of separate payment terms, CMS should reduce their use.

AHA opposed restrictions on state sources of financing.

NAMD raised concerns regarding CMS' "expansive policy position" on state obligations to identify indirect hold harmless arrangements which they noted fail to recognize the limits to a State Medicaid agency's authority. NAMD recommended CMS oversight on providers.

Some States (e.g., AZ, CA, FL, TX) opposed obtaining attestations. TX commented that "requiring attestations from providers is improper and not consistent with the statutory definition of "hold harmless.""

A few other States (IL, LA, MI, MO, TN, VT) joined together to submit joint comments and indicated that CMS's proposal is not consistent with the statute and should not be finalized and commented that "While many of the Commenting States are not aware of any such situations in their own States, the Commenting States are concerned about the burden of inserting themselves into private relationships between providers to secure the required attestations. The statutory provisions defining a "hold harmless" are all properly directed only to government (state or local) action, not to agreements between private parties over which the State has no knowledge or control…"
We recommend finalizing the following SDP fiscal integrity provisions: (1) prohibit post payment reconciliation for fee schedules and uniform increases; (2) prohibit the use of separate payment terms for all SDPs; and (3) require compliance with all Federal legal requirements for the financing of the non-Federal share. We believe finalizing these three provisions will implement appropriate fiscal guardrails in SDPs and curtail some concerning practices that we believe link payment to state financing practices that may be concerning or problematic. OACT supports this recommendation. CMS continues to engage with legal counsel on our options related to proposal (4) to require States to ensure that providers attest that they do not participate in a hold harmless arrangement given an injunction in Texas v. CMS 23-cv-161. Critically, we are awaiting the court's reply to a DOJ request to clarify whether the injunction is national. CMS also continues to review comments for other fiscal integrity provisions and assess recommendations for associated changes to applicability dates (see Tier 2 at the bottom of this document). We recommend finalizing a 3-year glidepath on these provisions (e.g., a 3-year transition for existing separate payment terms/post reconciliation practices, and a prohibition on new ones effective immediately), except for the general compliance with all Federal legal requirements for the financing of the non-Federal share, which we recommend finalizing the effective date as proposed.

Alternatively, we could consider finalizing some but not all of these fiscal integrity provisions. While we understand that the prohibition on the use of separate payment terms may be difficult for some states, we strongly recommend this approach given the strong link between the use of separate payment terms and the use of provider taxes and intergovernmental transfers.

Preliminary list of Tier 2 issues for future discussion in August:
Access Remedy Plans
Payment Transparency
State Directed Payments
Global Budgets – Performance-Based Payments and Condition-Based Payments
Reimbursement Analyses
Evaluations
Submission Timelines for SDP Preprints
Submission Timelines for SDP Documentation in Managed Care Plan Contracts/Rate Certifications
Applicability Dates

Letter Regarding Forthcoming Healthy Michigan Plan 1115 Extension Request
From:
Allexa Gardner <akg72@georgetown.edu>

Sent:
11/4/2022 4:18:23 PM -0400

To:
"Tsai, Daniel (CMS/CMCS)" <Daniel.Tsai@cms.hhs.gov>; "Cash, Judith (CMS/CMCS)" <Judith.Cash@cms.hhs.gov>

CC:
Allison Orris <aorris@cbpp.org>; Joan Alker <jca25@georgetown.edu>; Leo Cuello <lc1247@georgetown.edu>

Subject:
Letter Regarding Forthcoming Healthy Michigan Plan 1115 Extension Request

Attachments:
CCF_CBPP_Healthy Michigan Plan Extension Letter.pdf

Good afternoon Deputy Administrator Tsai,
On behalf of Georgetown Center for Children and Families and the Center on Budget and Policy Priorities, I have attached a letter below regarding transparency and process concerns for Michigan*s forthcoming extension application for its *Healthy Michigan Plan* section 1115 demonstration.

Please let us know if you have any questions. We appreciate your time.

Have a wonderful weekend!

Best,
Allie
--
Allie Gardner
Research Associate
Center for Children and Families
Georgetown University McCourt School of Public Policy
(678)-634-6854
akg72@georgetown.edu

November 4, 2022

Daniel Tsai, Deputy Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Sent via email

Re: Healthy Michigan Plan Section 1115 Demonstration Extension Application

Dear Deputy Administrator Tsai:

We are writing with respect to Michigan's extension application for its section 1115 Medicaid demonstration, "Healthy Michigan Plan," which is set to expire December 31, 2023. The proposal, for which the state comment period just closed, seeks to extend the state's demonstration project for five years. The application that was posted for state public comment lacked the required information to comply with CMS's demonstration transparency requirements that are set out at 42 CFR § 431.408, failing to provide even a basic description of some of the waiver and expenditure authorities the state is requesting to continue. As a result, the State's forthcoming application to CMS cannot be deemed complete as set forth at 42 CFR § 431.412. We therefore ask that upon receipt of the state's application, you withhold your certification of completeness and instead return the application to the agency with direction to modify the application to meet the completeness requirements and to conduct an additional 30-day comment period so that the public has a meaningful opportunity to provide feedback on the state's proposals.

CMS regulations identify seven different elements that a demonstration extension application must include to be determined complete. At a minimum, Michigan's application that was posted in draft form for state-level comment fails to meet 42 CFR § 431.412(c)(2)(vii), which specifies that state must document their compliance with the public notice process set forth in 42 CFR § 431.408. Under this regulation, at 42 CFR § 408(a)(1)(i) a state's extension application must include "a comprehensive description of the demonstration application or extension to be submitted to CMS that contains a sufficient level of detail to ensure meaningful input from the public."

Michigan's application fails to provide a sufficient level of detail in its extension application as required by § 431.408(a)(1)(i). The sparse seventeen-page application does not contain key information about a number of the proposals the state seeks to continue, specifically those that would affect beneficiaries' access to care. A few examples of key missing details include:

- A description of the premium requirements for individuals with income above 100 percent of the federal poverty line with less than 48 cumulative months of coverage;
- A description of cost-sharing requirements, including who would be subject to copayments and the services for which copayments would be required;
- A description of the Healthy Behaviors Incentives Program, including what actions would qualify as a "healthy behavior" and the amount of cost-sharing reductions beneficiaries would receive for completing a "healthy behavior;" and
- A description of the penalty for individuals with incomes above 100 percent of the federal poverty line with 48 or more months of cumulative enrollment for non-payment of premiums

and not completing a health risk assessment – namely, the loss of coverage and undefined lockout period.

Additionally, the application fails include the hypothesis and evaluation parameters of the demonstration extension as required by 42 CFR § 431.408(a)(1)(i)(D). The state includes the goals for the demonstration extension and a summary of the evaluation of the current demonstration, but does not have the two elements specified in the regulation above. As you know, a section 1115 demonstration is an experiment – so to test the experiments authorized through these demonstrations a hypothesis is needed to explain the legitimate demonstration purpose while evaluation parameters explain how the state plans to identify the outcomes of the experiment. Without these details included in extension application, the experimental nature of the demonstration is undermined.

While the state provides high-level estimates of total enrollment over the proposed five-year extension period as required by 42 CFR § 431.408(a)(1)(i)(C), it does not provide estimates on how each provision would affect enrollment, namely the disenrollment and lockout from coverage for those with 48 or more cumulative months of enrollment. Furthermore, a study of the state's own evaluation data has shown that premiums imposed on Healthy Michigan beneficiaries increased the likelihood of individuals voluntarily disenrolling from coverage; yet, there is no analysis highlighting the potential enrollment effects of this policy, or others. This is especially important given that several provisions have yet to be implemented due to the Families First Act continuous coverage protection so the extent of enrollment harms may be even larger than current data suggests.

This missing information significantly inhibits meaningful input from the public. Without the inclusion of key details about each provision and given the absence of hypotheses and evaluation parameters as well as the lack of detailed enrollment estimates, individuals who sought to submit comments on Michigan's extension application will have had no way to understand the full scope of what the state was proposing. Even if the state submits a more robust application to CMS to review for the federal comment period, that is not a sufficient remedy; the state must redo its state comment period with an improved application that provides a comprehensive description of the provisions the state is requesting to continue. The state's failure to include the information described above means that the state's extension application does not meet the regulatory requirement at 42 CFR § 431.408 for containing a sufficient level of detail to provide the public with an opportunity to provide meaningful input during the state comment period.

As such, we believe that the application does not meet the requirements for section 1115 extension applications under 42 CFR § 431.412 and should not be certified as complete. Instead, CMS should return the application to the state and advise the state to revise its proposal to include more information and re-open a full comment period so that the public can comment on the proposal in a meaningful way.

Please let us know if you have any questions.

Sincerely,

Joan Alker
Executive Director and Research Professor, Center for Children and Families Georgetown University McCourt School of Public Policy

Allison Orris
Senior Fellow, Center on Budget and Policy Priorities

Author: Allie Gardner
Creator: Microsoft Word
CreationDate: 2022-11-04 20:11:46
ModDate: 2022-11-04 20:11:46

Appointment Title:
CMS/DHCS Biweekly Waiver Check-in

Organizer:
CalAIM Master Calendar

Attendees:
'Noelle.Simonick@dhcs.ca.gov'; 'janet.rudnick@dhcs.ca.gov'; 'rachel.nichols@cms.hhs.gov'; Ross, Heather (CMS/CMCS); Friedman, Kate (CMS/CMCS); 'Aaron.Toyama@dhcs.ca.gov'; 'Bambi.Cisneros@dhcs.ca.gov'; 'Benjamin.Mcgowan@dhcs.ca.gov'; Brumer, Justin@DHCS; 'AnhThu.Bui@dhcs.ca.gov'; 'Dana.Durham@dhcs.ca.gov'; Font, Amanda; 'Jacey.cooper@dhcs.ca.gov'; Lee, Angeli; 'Lindy.Harrington@dhcs.ca.gov'; 'Rafael.Davtian@dhcs.ca.gov'; 'Rene.Mollow@dhcs.ca.gov'; 'farrah.samimi@dhcs.ca.gov'; 'Saralyn.Ang-olson@dhcs.ca.gov'; 'susan.philip@dhcs.ca.gov'; 'tyler.sadwith@dhcs.ca.gov'; 'yingjia.huang@dhcs.ca.gov'; Guyer, Jocelyn; Lam, Alice; Mann, Cindy; Punukollu, Nina; Reyneri, Dori Glanz; Traube, Ashley; Govender, Ahimsa; Kim, Lora; Cash, Judith (CMS/CMCS); Rashid, Mehreen (CMS/CMCS); Decaro, Teresa (CMS/CMCS); Sadwith, Tyler@DHCS; Samimi, Farrah@DHCS; Cisneros, Bambi; Phillip, Susan; Williams, Sandra; Toyama, Aaron; Cooper, Jacey@DHCS; Tsai, Daniel (CMS/CMCS); McClenathan, Jane (CMS/CMCS)

Location:
https://manatt.zoom.us/j/92009574479?pwd=TnRuRm1xdHFCQjRZVE5XMWdOQXVkZz09

Start Time:
12/1/2022 6:00:00 PM +0000

End Time:
12/1/2022 6:30:00 PM +0000

Reminder Time:
12/1/2022 5:45:00 PM +0000

Reminder Set:
true

Duration:
30 minutes

Is Recurring:
false

Reccurrance Pattern:

Response Status:
5

Busy Status:
Tentative

Attachments:
image001.jpg

Hi there,

Lora Kim is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting

Phone one-tap:

US: +13092053325,,92009574479# or +13126266799,,92009574479#

Meeting URL:

https://manatt.zoom.us/j/92009574479?pwd=TnRuRm1xdHFCQjRZVE5XMWdOQXVkZz09

Meeting ID:

(b)(6)

Passcode:

(b)(6)

Join by Telephone

For higher quality, dial a number based on your current location.

Dial:

US: +1 309 205 3325 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 or +1 301 715 8592 or +1 564 217 2000 or +1 669 444 9171 or +1 669 900 6833 or +1 719 359 4580 or +1 253 215 8782 or +1 346 248 7799 or +1 386 347 5053 or 888 788 0099 (Toll Free) or 877 853 5247 (Toll Free)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

International numbers

Join from an H.323/SIP room system

H.323:

162.255.37.11 (US West)
162.255.36.11 (US East)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

SIP:

92009574479@zoomcrc.com

Passcode:

496787

FW: FW: Request for Meeting with NY Safety Net Hospital Coalition
From:
"Mann, Cindy" <CMann@manatt.com>

Sent:
11/10/2022 1:54:56 PM -0500

To:
"Tsai, Daniel (CMS/CMCS)" <Daniel.Tsai@cms.hhs.gov>

CC:
"Briskin, Perrie (CMS/CMCS)" <Perrie.Briskin@cms.hhs.gov>

Subject:
FW: FW: Request for Meeting with NY Safety Net Hospital Coalition

Attachments:
SNH Coalition CMS Directed Payment Letter.pdf

Flagging, Dan, that this is the NYC safety net coalition we*ve discussed from time to time, seeking a meeting to talk to you in advance of any rulemaking on directed payments.

Cindy Mann

Partner

Manatt, Phelps & Phillips, LLP

Washington Square
1050 Connecticut Avenue, NW, Suite 600

Washington, D. C., 20036

D (202) 585-6572 F (202) 595-0933

CMann@manatt.com

manatt.com

From: Brown, LaRay <LaBrown@INTERFAITHMEDICAL.org>
Sent: Thursday, November 10, 2022 9:52 AM
To: Daniel.Tsai@cms.hhs.gov
Cc: Perrie.Briskin@cms.hhs.gov; Hannah.Katch@cms.hhs.gov; Bernstein, William S. <WBernstein@manatt.com>; McNamara, Meghan <MMcNamara@manatt.com>; Mann, Cindy <CMann@manatt.com>; Cantrell, Christopher <CCantrell@manatt.com>
Subject: Request for Meeting with NY Safety Net Hospital Coalition

Director Tsai,

On behalf of the New York Safety Net Hospital Coalition, please find attached here a letter requesting a meeting with you to discuss how directed payment authority can help address the structural inequities and gaps in how safety net hospitals are financed. This issue is of critical importance to our Coalition and we are eager to partner with CMS and New York State to build more stability and predictability in how safety net hospitals are funded so we can better serve our patients and communities.

I look forward to hearing from you soon and hope that we are able to find some time to discuss further.

Sincerely,
LaRay Brown

November 8, 2022

Submitted Electronically
Daniel Tsai
Deputy Administrator and Director
Center for Medicaid and CHIP Services (CMCS)
7500 Security Boulevard
Baltimore, Maryland 21244-1850

cc: Perrie Briskin

Re: New York Safety Net Hospital Coalition Request for a Meeting on Directed Payment Program for Safety Net Hospitals

Dear Dan,

In light of CMS' intent to address directed payment authority in the context of its revisions to the Medicaid managed care regulations, the New York Safety Net Hospital Coalition (hereafter, "the Coalition") is requesting a meeting with Director Tsai to discuss the potential for directed payment authority to help states address the structural gaps in financing faced by safety net hospitals serving low-income people in communities of color.

As background, the Coalition formed in 2021 in response to the urgent need for significant, structural payment reforms for safety net hospitals in New York. The seven members of the Coalition are significant providers of care for low-income patients, each with at least 36 percent of inpatient and outpatient services covered by Medicaid or uninsured. Few of our patients are commercially-insured, representing less than 20 percent of the patient mix. We serve historically marginalized neighborhoods which are home to more than 4.7 million New Yorkers where up to 76 percent of the residents are people of color, including Black and Latinx residents. The neighborhoods served by our hospitals have also experienced disproportionately higher rates of COVID-related hospitalizations and deaths compared to other areas in New York City.

The fundamental, structural challenge facing our hospitals is that Medicaid pays our facilities 61 cents for every dollar we spend on care. [i] Since we see few commercial patients, we are unable to cross-subsidize with more favorable commercial rates that other facilities receive, which can be up to seven times greater than the Medicaid and commercial rates that our hospitals receive for the same services. [ii] As a result of continued underpayment, our hospitals remain in financial distress and we are unable to invest in our facilities. The average age of physical plant for safety net hospitals in the City is 19 years, compared to 11 years for other hospitals in the City and nationwide. [iii] An aging physical plant is not just a cosmetic issue, it manifests itself through care infrastructure that does not meet the current standards of medical care, crowded emergency departments, HVAC systems in need of repair, and generally substandard conditions. We also lack funding to invest in new care models, such as virtual care, to ensure that low-income patients have equitable access to care. In short, decades of underinvestment in the safety net have created a self-reinforcing disparity where commercially insured patients seek care at wealthier hospitals with upgraded facilities, leaving safety net hospitals with even fewer resources to address these critical needs.

New York State has taken steps to address the structural failures in the Medicaid financing system, but more is needed. The state's Directed Payment Template (DPT) program, which directs Medicaid managed care plans to provide enhanced payment rates to designated classes of hospitals, has been evolving. [iv] With CMS approval, New York recently implemented a DPT program for safety net hospitals

with at least 36 percent of services attributed to Medicaid across both inpatient and outpatient settings.

This was an important step, but it does not fully address the need of all safety net hospitals that serve significant volumes of Medicaid and uninsured patients, particularly in outpatient settings. For example, even after accounting for enhanced rates under the DPT program, the Medicaid rates for three Coalition safety net hospitals only cover 48-81 percent of costs for outpatient clinic services and 45-67 percent of costs for ED services. Furthermore, enhanced rates under the DPT program do not fully cover the costs associated with delivering inpatient psychiatric services, which are sorely needed in our communities. v

We emphasize these points not to criticize the DPT program as a mechanism, which is critical to providing funding to our facilities, but rather highlight that without sufficient funding we are unable to cover the costs of services delivered to Medicaid beneficiaries and invest in our infrastructure and services needed by the community.

The Coalition plans to work with New York State during the upcoming legislative session to further evolve the DPT program and is eager to engage with CMS on this issue. As CMS considers regulatory action for the DPT program, the Coalition requests a meeting to share our data and discuss the importance of the program to our hospitals and how it might evolve to better meet the needs of hospitals like ours. Given the priorities of the Biden Administration, we are confident that CMS does not intend to limit states' flexibility to take meaningful steps forward to improve access and quality for safety net hospitals that serve low-income populations and communities of color, but acknowledge that issues arising across all states on the DPT program are complex and challenging. We are eager to partner with both the State and CMS on this critical issue to build more stability and predictability in how safety net hospitals are funded so that we can better serve our patients and communities.

We appreciate your consideration of these important issues to our hospitals and communities and hope that we can find time to discuss them further. Please contact Chris Cantrell (ccantrell@manatt.com) who can coordinate a meeting on behalf of the Coalition CEOs. We look forward to hearing from you soon.

Sincerely,

LaRay Brown
CEO, One Brooklyn Health System
Chair, New York Safety Net Hospital Coalition

Kenneth Gibbs
CEO, Maimonides Medical Center

Bruce Flanz
CEO, Medisys Health Network

Mitchell Katz
CEO, NYC Health + Hospitals

David Perlstein
CEO, SBH Health System

Gerard Walsh
CEO, St. John's Episcopal Hospital

Ramón Rodriguez
CEO, Wyckoff Heights Medical Center

i Healthcare Association of New York State, Statewide Report, February 2022. Available at: https://www.hanys.org/government_affairs/community_benefit/docs/statewide/statewide.pdf
ii Based on an analysis of Citywide and Manhattan estimated commercial allowed amounts based on data compiled and maintained by FAIR
Health, Inc. FAIR Health is not responsible for any of the opinions or conclusions expressed herein. Data (c) 2021 FAIR Health, Inc.
iii King, D., et al., "A closer look at U.S. health care infrastructure," Health Facilities Management. January 2018. Available at:
https://www.hfmmagazine.com/articles/3239-a-closer-look-at-infrastructure#:~:text=For%20example%2C%20the%20median%20average,2004%2C%20and%208.6%20in%201994
iv Several hospitals that were not part of the State's DPT program last year, including NYC Health + Hospitals, are now part of the Coalition and
working to advance the proposal for financing reform that would address the needs of a broader class of safety net hospitals.
v Based on Coalition analysis of hospital financials.

Author: Paulsen, Michael
Company: Manatt Phelps Phillips LLP
CreationDate: 2022-11-08 19:57:05
Creator: Acrobat PDFMaker 22 for Word
ModDate: 2022-11-08 19:57:07
Producer: Adobe PDF Library 22.3.39

Meeting Title:
PREP: (b)(6) Mtg w/Georgetown University's Medicaid Section 1115 Waiver Task Force

From:
CMS Administrator <CMSAdministrator@cms.hhs.gov>

Sent:
11/7/2022 4:01:06 PM +0000

To:
"(b)(6) she/her), Administrator (CMS/OA)" (b)(6) "Ellis (she/her), Kyla (CMS/OA)" <Kyla.Ellis@cms.hhs.gov>; "McLemore, Monica (CMS/OSORA)" <Monica.McLemore@cms.hhs.gov>; "Khan, Farooq (CMS/OSORA)" <Farooq.Khan@cms.hhs.gov>; "Tsai, Daniel (CMS/CMCS)" <Daniel.Tsai@cms.hhs.gov>

Attendees:
(b)(6) Kyla Ellis (CMS/) (kyla.ellis@cms.hhs.gov); McLemore, Monica (CMS/OSORA); Khan, Farooq (CMS/OSORA); Tsai, Daniel (CMS/CMCS)

Location:
Zoom; https://cms.zoomgov.com/j/1603280271?pwd=UzY3Y2lFOGJIMG5aRmVRdHUyWGdKdz09

Start Time:
11/30/2022 8:00:00 PM +0000

End Time:
11/30/2022 8:30:00 PM +0000

Duration:
30 minutes

Reminder Time:
11/30/2022 8:00:00 PM +0000

Is Recurring:
false

Recurrence Type:
Not

Recurrence Pattern:

Response Status:
5

Busy Status:
Tentative

Attachments:
External Meeting Request: Medicaid Section 1115 Waiver Task Force*Georgetown University

CMS Administrator is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting
https://cms.zoomgov.com/j/1603280271?pwd=UzY3Y2lFOGJIMG5aRmVRdHUyWGdKdz09

Meeting ID: (b)(6)
Password: (b)(6)

One tap mobile
+16692545252,,1603280271# US (San Jose)
+16468287666,,1603280271# US (New York)

Dial by your location
+1 669 254 5252 US (San Jose)
+1 646 828 7666 US (New York)
833 568 8864 US Toll-free
Meeting ID: (b)(6)
Find your local num(b)(6)? https://cms.zoomgov.com/u/abJXDWi6XG

Join by SIP
Password: (b)(6)
sip: (b)(6) @sip.zoomgov.com

This meeting may be recorded. The host is responsible for maintaining any official recordings/transcripts of this meeting. If recorded, this meeting becomes an official record and shall be retained by the host in their files for 3 years or if longer needed for agency business. If a recording intends be fully transcribed or is being captured for the purpose of creating meeting minutes, the host shall retain the record in their files for 3 years or if no longer needed for agency business, whichever is later.

External Meeting Request: Medicaid Section 1115 Waiver Task Force*Georgetown University
From:
"McLemore, Monica (CMS/OSORA)" <Monica.McLemore@cms.hhs.gov>

Sent:
11/2/2022 12:21:56 PM -0400

To:
"Neal, Phaedra (CMS/OA)" <Phaedra.Neal@cms.hhs.gov>

CC:
"Khan, Farooq (CMS/OSORA)" <Farooq.Khan@cms.hhs.gov>

Subject:
External Meeting Request: Medicaid Section 1115 Waiver Task Force/Georgetown University

Attachments:
Letter to Secretary to Improve 1115 Waiver Process.pdf

Hi Phaedra,

Georgetown University has provided the following availability for representatives of the Medicaid Waiver Task Force to meet with the Administrator. Please let me know if any of these work for a 30-minute slot:
Friday, November 18 from 12-1 or 2-2:30
Monday, November 28 from 11-12:30 or 1:30-2
Tuesday, November 29 from 12:30-4pm
Thursday, December 1 from 1-5pm

Meeting Participants:
Joan Alker, Co-Founder, Center for Children and Families
Allexa Gardner, Research Associate, Center for Children and Families
Others TBD

Contact:
Joan Alker
Executive Director, Research Professor
Center for Children and Families
Georgetown University McCourt School of Public Policy
(202)306-8383
jca25@georgetown.edu

The Medicaid Waiver Task Force, comprised of fifty-one organizations representing patient, provider, and advocacy groups, undersigned a letter to Secretary Becerra, dated 8/17/2022 (attached), urging CMS to strengthen the current regulations to ensure that section 1115 demonstrations promote coverage and improve the transparency of the process of approving, amending, and renewing demonstrations. As a follow-up to the letter, the group requests a virtual meeting with the Administrator and Dan Tsai to discuss this matter.

Thanks,
Monica

August 17, 2022

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Recommended Regulatory Actions for Section 1115 Medicaid Demonstration Process

Dear Secretary Becerra,

The undersigned organizations write to urge you to promulgate regulations regarding the section 1115 Medicaid demonstration process. A substantial and growing portion of Medicaid is funded through section 1115 and there is a critical need to develop a regulatory framework that clarifies the parameters of the authority, clears up confusion among states and courts, strengthens the transparency rules, and protects the integrity of the Medicaid program. This is among the most important things the administration can do for the long-term security of the Medicaid program and the millions of people who rely on the program for their health insurance.

CMS must set out a definition of "the objectives of Medicaid" and establish related principles to avoid harmful demonstration and waiver approvals, such as work requirements or premiums in Medicaid. CMS's regulation should address several specific and important problems in the 1115 process.

Defining the Objectives of Medicaid for Purposes of Section 1115 Demonstrations

CMS should promulgate a regulation which requires that section 1115 demonstrations promote the objectives of Medicaid, with a definition of the objectives of Medicaid based primarily in the purpose of the program identified in section 1901, namely to furnish medical assistance, rehabilitation, and other services. CMS should also ensure that the new definition of the objectives of Medicaid explicitly affirms the Medicaid entitlement and open-ended matching payment structure.

CMS's definition should also clarify that the clause "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care" cannot be interpreted to allow demonstrations that "promote independence" if they do not furnish services or if they reduce access to services.

CMS Should Create 1115 Guardrails for Promoting the Objectives of Medicaid

CMS's regulation should further operationalize the definition of the objectives of Medicaid by creating 1115 "guardrails," similar to the section 1332 guardrails, that ensure demonstrations promote, not undercut, the purpose of Medicaid. Such guardrails should include:

1. Demonstrations cannot be approved if they would likely reduce the number of individuals covered by Medicaid in a state, or otherwise reduce the number of individuals who have health insurance in the state.

2. Demonstrations cannot be approved if they would likely reduce the available services, or amount, duration, and scope of any services, provided to Medicaid enrollees; this includes maintaining access to community-based services.

3. Demonstrations cannot be approved if they would reduce the affordability of services for enrollees, including cost-sharing, premiums, and any other costs, unless they comply with the standards in section 1916(f).
4. Demonstrations should not otherwise reduce access to care, such as by making application, enrollment, or renewal more difficult.

CMS should require that all demonstrations meet all four guardrails for the full population eligible for the demonstration and for specific sub-populations when the guardrail impacts are disaggregated by race/ethnicity and other factors. Existing regulations should be supplemented to require that state applications for section 1115 demonstrations include specific and disaggregated estimates for each of the guardrails as well as a comprehensive equity assessment, explaining the effect the proposal would likely have on health coverage and access to care.

Protecting the Integrity and Transparency of the Demonstration Process

We recommend that CMS's regulation additionally make three changes to strengthen demonstration processes.

First, the regulation should require the full transparency process (including notice and comments) for all 1115 demonstrations that would impact eligibility, enrollment, benefits, cost-sharing, or financing – including new applications, extensions, and amendments. Adding amendments is key as so many states have existing section 1115 demonstrations and major changes are frequently made through amendments. Just like CMS's current regulations include slightly different requirements for new applications and extensions, new regulations could specify reasonable requirements for significant amendments that balance transparency with states' needs to make timely changes. Meaningful changes to eligibility, benefits, cost-sharing, enrollment or financing all require public comment in our view.

Second, the permissible exceptions to the transparency process in the case of a public health emergency needs to be tightened up. The regulation should clarify or strengthen existing regulations to prevent pretextual exemptions from the transparency process. Exemption from the transparency process should be very rare, and only used for demonstrations that are directly related to emergency response (i.e., not just coincidentally contemporaneous) and when use of a comment period would materially delay such emergency response.

Third, CMS's regulation should set clear standards for the duration of demonstrations, not to exceed five years. Section 1115 authorizes "experimental, pilot, or demonstration" projects. Ten years are generally not needed to assess the value of an experiment, and ten years is a long time to have an unsuccessful waiver in place. Ten years also creates the possibility that an outgoing administration can bind a new administration for the entirety of its two terms. Some ten-year approvals do not comport with the statute. We recommend that, consistent with long-standing practice, CMS should implement an unambiguous 5-year limit for new demonstrations, extensions, and amendments.

Thank you for your consideration of our views. If you have questions, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

American Academy of Family Physicians
American Academy of Pediatrics
American Association on Health and Disability
American Cancer Society Cancer Action Network

American College of Obstetricians and Gynecologists
American Heart Association
American Lung Association
Arthritis Foundation
Asian & Pacific Islander American Health Forum (APIAHF)
Autism Society of America
Autistic Self Advocacy Network
Black Mamas Matter Alliance
CancerCare
Catholic Health Association of the United States
Center for Disability Rights
Center for Law and Social Policy (CLASP)
Center on Budget and Policy Priorities
Community Catalyst
Cystic Fibrosis Foundation
Easterseals
Epilepsy Foundation
Families USA
First Focus on Children
Georgetown University Center for Children and Families
Hemophilia Federation of America
Justice in Aging
Lakeshore Foundation
March of Dimes
Medical Transportation Access Coalition
Medicare Rights Center
NASTAD
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Disability Rights Network (NDRN)
National Family Planning & Reproductive Health Association
National Health Care for the Homeless Council
National Health Law Program
National Immigration Law Center
National Multiple Sclerosis Society
National Network for Arab American Communities (NNAAC)
National Organization for Rare Disorders
National Partnership for Women & Families
National Patient Advocate Foundation

Physicians for Reproductive Health
Primary Care Development Corporation
The Arc of the United States
The Leukemia & Lymphoma Society
UnidosUS
Union for Reform Judaism

Author: Microsoft Office User
CreationDate: 2022-08-17 21:18:40
Creator: Microsoft Word
ModDate: 2022-11-02 14:07:46

FW: FW: Yet another imposition
From:
"Tsai, Daniel (CMS/CMCS)" <EXCHANGELABS/EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/RECIPIENTS/9674B3F2D2F04614A448D4A931C5F8C5-DANIEL.TSAI>

Sent:
7/20/2023 6:41:39 PM -0400

To:
"Mann, Cindy" <CMann@manatt.com>; "Costello, Anne Marie (CMS/CMCS)" <AnneMarie.Costello@cms.hhs.gov>

Subject:
FW: FW: Yet another imposition

Attachments:
309 Def Memo ISO MSJ.pdf

Thanks. Noted this for Anne Marie as well.

From: Mann, Cindy <CMann@manatt.com>
Sent: Thursday, July 20, 2023 6:37 PM
To: Tsai, Daniel (CMS/CMCS) <Daniel.Tsai@cms.hhs.gov>
Subject: FW: Yet another imposition

I know this is not top of mind for you but this is the TN submission in the matter I flagged for you, including statements that essentially CMS has signed off on the TN process.

Cindy Mann

Partner

Manatt, Phelps & Phillips, LLP

177 Huntington Avenue
Suite 2500

Boston, MA 02115

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CMann@manatt.com

manatt.com

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

A.M.C., by her next friend, C.D.C., et al.,

Plaintiffs,

v.

STEPHEN SMITH, in his official capacity as Deputy Commissioner of Finance and Administration and Director of the Division of TennCare,

Defendant.

Civil Action No. 3:20-cv-00240
Chief District Judge Crenshaw
Magistrate Judge Newbern

DEFENDANT'S MEMORANDUM IN SUPPORT OF HIS MOTION FOR SUMMARY JUDGMENT

Jonathan Skrmetti
Attorney General and Reporter

Meredith Bowen TN BPR #34044
Assistant Attorney General
Matthew Dykstra TN BPR #38237
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*Appearing pro hac vice

Counsel for the Defendant

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Statutes and Regulations

INTRODUCTION

This case involves claims that the Division of TennCare, the single state agency that partners with the Centers for Medicare and Medicaid Services ("CMS") and oversees the Tennessee state Medicaid program known as TennCare, violates the Due Process Clause of the Fourteenth Amendment, the Medicaid Act, and the Americans with Disabilities Act ("ADA") in operating that program's eligibility redetermination process. See Defs.' Statement of Undisputed Material Facts in Supp. of Summ. J., ¶ 1 (July 10, 2023) ("SUMF"). Plaintiffs represent a class of "all individuals who, since March 19, 2019, have been or will be disenrolled from TennCare, excluding individuals, and the parents and legal guardians of individuals, who requested withdrawal from TennCare." Mem. Op. & Order, Doc. 234 at 40 (Aug. 9, 2022). The "Disability Subclass" includes members of the plaintiff class who are "qualified individuals with a disability' as defined in 42 U.S.C. § 12131(2)." Doc. 234 at 40. Though Plaintiffs raised many issues with TennCare's processes in their complaint, the Court recognized that not all of them were susceptible to class-wide consideration, Doc. 234 at 1, 19, 21, and limited this case to the litigation of 15 specific issues related to TennCare's redetermination processes, see Proposed Am. Case Mgmt. Order, Doc. 249 at 4–5 (Nov. 1, 2022); see also SUMF ¶ 154. TennCare is entitled to summary judgment on all 15 issues.

As an initial matter, Plaintiffs have failed to show any violation of the Medicaid Act. Plaintiffs' claims have been brought under 42 U.S.C. § 1983, which provides a right of action for

plaintiffs seeking to vindicate rights created by federal statute or the Constitution. But the basis of all of Plaintiffs' Medicaid Act claims is federal regulation, which the Supreme Court has repeatedly held is insufficient to create a Section 1983 enforceable right. Plaintiffs' due process and ADA claims fare no better. Due process is a flexible standard that permits reasonable

judgments by TennCare regarding how best to serve its members. On the issues certified by the Court for class-wide resolution—broadly pertaining to the contents of TennCare's notices, its provision of hearings, and its consideration of all the ways an enrollee could be eligible for Medicaid—Plaintiffs have failed to demonstrate any policy or practice employed by TennCare that has denied them their rights under the Fourteenth Amendment. As for Plaintiffs' ADA claims, the Court correctly recognized in its decision granting class certification that many ADA issues are highly individualized and not susceptible to class-wide resolution. On the three issues the Court determined could be resolved on a class-wide basis, the undisputed record demonstrates that TennCare provides reasonable accommodations and in-person assistance, and it always screens for every category of disability-related eligibility. Finally, the fact that CMS has reviewed and approved TennCare's processes and notices for determining eligibility as part of CMS's certification of the Tennessee Eligibility Determination System ("TEDS") provides an additional reason why this Court should grant judgment in TennCare's favor on each issue.

ARGUMENT

I. Defendant is entitled to summary judgment on each of the certified class issues.

Eight of the issues certified by the Court are purely legal—e.g., "[whether] the NOD's uniform omission of information about the 90-day reconsideration period" violates the Medicaid Act or due process. Doc. 234 at 13, 18 n.10; see Cabrera-Ramos v. Gonzales, 233 F. App'x 449, 453 (6th Cir. 2007). The evidence on the remaining issues is undisputed—e.g., "whether the State systematically fails to provide fair hearings at any time." Doc. 234 at 18 n.10 (internal quotation omitted). Summary judgment is appropriate.

A. Plaintiffs cannot show a single Medicaid Act violation.

At this stage in the litigation, Plaintiffs must substantiate their claims both legally and factually. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 256 (1986). For all but three of the

certified issues that implicate the disability subclass, the Court asked whether TennCare's policy or practice violated Plaintiffs' rights under the Medicaid Act or the Due Process Clause, thus giving rise to liability under 42 U.S.C. § 1983. As an initial matter, Plaintiffs' claims under the Medicaid Act must be rejected across the board. On each certified issue, Plaintiffs' argument that TennCare violates the Medicaid Act rests on a single provision of that statute, which requires that TennCare "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3); see also generally, Pls.' Resps. and Objs. to Defs.' First Set of Interrogs. and Requests for Produc. to All Pls.' ("Pls.' R&Os") (Dec. 22, 2022) attached as SUMF Exhibit F. This general provision of the statute, however, speaks to almost none of the certified issues and Plaintiffs really base these claims on the regulations promulgated under that statute. Id.

The regulations cannot create rights enforceable through Section 1983 and so they are irrelevant. Johnson v. City of Detroit, 446 F.3d 614, 628–29 (6th Cir. 2006). Such rights must be

found in a statute, and that statute must confer the right "in 'clear and unambiguous terms.' " Caswell v. City of Detroit Housing Comm'n, 418 F.3d 615, 619 (6th Cir. 2005) (quoting Gonzaga Univ. v. Doe, 536 U.S. 273, 290 (2002)). Accordingly, Plaintiffs must show that, on each of the certified issues, the fair hearing provision of 42 U.S.C. § 1396a(a)(3) "unambiguously" creates a right that TennCare is violating. See Gonzaga, 536 U.S. at 284. They cannot do so.

Caswell is instructive. In that case, the Sixth Circuit addressed a claim that an individual's rights had been violated by his allegedly improper termination from a housing voucher program while in the process of being (unsuccessfully) evicted. 418 F.3d at 617. A federal regulation unambiguously entitled the plaintiff to continued assistance payments while the eviction

proceedings were pending. See 24 C.F.R. § 982.311(b); see also Caswell, 418 F.3d at 619. But a regulation cannot create a right enforceable under Section 1983, so the Sixth Circuit held that Caswell could only rely on a much more general statutory provision to support his claim. Caswell, 418 F.3d at 620 (citing 42 U.S.C. § 1437f(o)(2)). The statute, unlike the regulation, said nothing about when an individual should be eligible for benefits and, despite the clear regulation, the Sixth Circuit held that the claim failed as a matter of law. Id.

As in Caswell, Plaintiffs cannot find the rights they claim in federal statute. Even assuming Section 1396a(a)(3) creates an enforceable right, that right is limited to an opportunity for the granting of a fair hearing when claims are denied "or not acted upon with reasonable promptness." The statutory provision says nothing, for instance, about what information must be included in TennCare's notices of determination ("NODs") or TennCare's obligation to screen for all categories of eligibility. Section 1396a(a)(3) is directly relevant only to the issue of "whether TennCare systematically fails to provide fair hearings at any time." Doc. 234 at 18 n.10 (internal quotations omitted), but as discussed below, the undisputed evidence in the record establishes that TennCare does provide fair hearings. The statute is no more than tangentially related to whether TennCare's "valid factual dispute" policy is lawful (since that policy denies individuals hearings when they have only a legal dispute with TennCare's decision), and to the issue of whether TennCare is required to provide hearings within 90 days of appeal. But there is nothing in the statute that "unambiguously" speaks to either of those issues. As to the valid factual dispute policy, the statute does not say TennCare must always provide a hearing when one is requested; it says TennCare must "provide for granting an opportunity for a fair hearing"—recognizing there are circumstances where a hearing is unnecessary. Likewise, the statute says nothing about a 90-day

deadline for holding a hearing. The Medicaid Act is, therefore, with the exception of whether TennCare fails to provide fair hearings at any time, irrelevant to the certified issues.

B. The legal citations in the notices of determination are and were lawful.

The first certified issue is whether a stock citation to the full set of TennCare's eligibility rules previously included in all NODs violates TennCare's obligations under the Medicaid Act or the Due Process Clause of the Fourteenth Amendment. Doc. 234 at 13. When Plaintiffs filed this case, a NOD terminating or denying coverage stated, inter alia: "We looked at the facts we have for you. We use those facts to review you for our coverage groups to decide if you qualify. But you don't qualify. [Tenn.Comp.R&Reg. 1200-13-20]." See SUMF ¶ 40. The bracketed citation references the set of regulations that prescribe the technical and financial eligibility criteria for coverage in all categories. Just after the quoted language, every NOD included a short explanation

of precisely why an individual was ineligible. SUMF ¶ 41. For instance, in the case of an individual who is over an income limit, the notice went on to state: "The monthly income limit for the kind of coverage you could get is <$xxx.xx>. Our records show your monthly income is over this limit." See SUMF ¶ 42.

Including the same generic citation in every NOD followed by a more specific plain English explanation of the denial or termination reason was necessary at the time because the eligibility rules were undergoing significant changes and including more specific citations could have led to errors. See SUMF ¶¶ 43–44. The citation to the full set of eligibility rules was never intended to be permanent, and TennCare has, since December 2022, provided citations tailored to an individual's specific termination reason. See SUMF ¶¶ 45–51. For instance, an NOD to an individual who is over the income threshold for QMB coverage includes citations to 42 C.F.R. § 400.200, Tenn. Comp. R&R 1200-13-20-.02(110) (both defining "QMB"), and Tenn. Compl. R&R 1200-13-20-.08(7)(a)(5) (explaining that QMB eligibility requires income "[a]t or below one

hundred percent (100%) of the [federal poverty level]"). SUMF ¶ 52. The notice still includes a specific statement of what the income limit for that individual is (in dollars) and that TennCare's records show that the individual makes more than that limit. SUMF ¶¶ 41–42.

Plaintiffs cannot challenge TennCare's former use of this stock citation. First, Plaintiffs lack standing because they have not identified anyone who was harmed by the citations at issue. See Lewis v. Casey, 518 U.S. 343, 358 n.6 (1996); see also Rosen v. Tenn. Comm'r of Fin. and Admin., 288 F.3d 918, 931 (6th Cir. 2002). Second, this claim is moot. Plaintiffs may only seek prospective injunctive relief, see Edelman v. Jordan, 415 U.S. 651, 677 (1974), and Plaintiffs cannot show they face a "real or immediate threat that the state will repeat the alleged violation." Kanuszewski v. Mich. Dep't of Health & Human Servs., 927 F.3d 396, 408 (6th Cir. 2019).

The Sixth Circuit has held that:

> a case is considered moot by the defendant's voluntary cessation of the conduct at issue where the defendant can show: (1) there is no reasonable expectation that the alleged violation will recur; and (2) interim relief or events have completely and irrevocably eradicated the effects of the alleged violation.

Thomas v. City of Memphis, 996 F.3d 318, 324 (6th Cir. 2021). Showing mootness is ordinarily a "heavy burden," but that burden is lessened "when it is the government that has voluntarily ceased its conduct," thus "provid[ing] a secure foundation for a dismissal based on mootness so long as the change appears genuine." Id. (cleaned up). Here, TennCare's prior citation was a temporary measure designed to avoid the risk of issuing incorrect and misleading notices while changes to eligibility rules were being finalized. SUMF ¶¶ 43–44. It was always TennCare's intention to update the legal citations in the NOD, and TennCare has now done so. SUMF ¶ 45. Moreover, TennCare has no intention of reinstating the old citation, which would require TennCare to go through the same formal, months-long process (involving multiple units within TennCare and a

TennCare contractor) that was initially required to improve the NODs to include more specific legal citations. SUMF ¶¶ 47–51.

In Thomas, the Sixth Circuit explained that when a policy change has been "formally promulgated and approved by [a senior official] who provided a sworn declaration that [it] would remain in place going forward," and the agency would have to go through the same process again

if it wished to change the policy further, the change in policy is treated more seriously by the court. 996 F.3d at 325–26. In particular, the Thomas court placed significant importance on the sworn testimony from a government official. Id. at 326–27 ("Our sister circuits have mooted claims based on government policy that was changed through sworn testimony provided by government officials."). We have such sworn testimony here. See SUMF ¶ 49. As "[t]here is nothing in the record that would suggest [TennCare] is likely to return to its old ways," the possibility of reversion "is merely theoretical, and the theoretical possibility of reversion to an allegedly unconstitutional policy is simply not sufficient to warrant an exception to mootness in this case." 996 F.3d at 327–28. Indeed, this Court employed similar reasoning when it denied Plaintiffs' motion for a preliminary injunction, noting that TennCare's changes to its practices and policies designed to identify and correct errors made reversion to those prior practices unlikely. See Doc. 234 at 24.
Mootness aside, TennCare is also entitled to summary judgment on this issue on the merits. Section 1396a(a)(3) does not address the contents of Medicaid notices, so Plaintiffs' claim rests exclusively on the Due Process Clause. To satisfy due process, "notice [must be] reasonably calculated, under all circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." Mullane v. Cent. Hanover Bank & Tr. Co., 339 U.S. 306, 314 (1950). "[A] recipient [must] have timely and adequate notice detailing the reasons for a proposed termination, and an effective opportunity to defend." Goldberg v. Kelly,

397 U.S. 254, 267–68 (1970). A notice is adequate if it accurately informs a person of the basis for their termination permits them to adequately prepare for an appeal hearing. Hamby v. Neel, 368 F.3d 549, 562 (6th Cir. 2004). The notices containing the "stock citation" meet this standard. Though Plaintiffs focus on the citation, the notices all also contained (and still do contain) a plain English explanation of what TennCare's eligibility rules required, and how TennCare believed the individual being terminated failed to satisfy that requirement. That is all that is required to give an individual the opportunity to "adequately prepare for an appeal hearing." Id. at 562; see also Cahoo v. SAS Inst., Inc., 2023 WL 4014172, at *5 (6th Cir. June 15, 2023).
In certifying this issue for class resolution, the Court cited Rodriguez By & Through Corella v. Chen, 985 F. Supp. 1189 (D. Ariz. 1996), which raised a similar challenge to the contents, including legal citations, of Arizona's Medicaid notices. Rodriguez is distinguishable. The Arizona court held the notices did not provide "meaningful" notice as required by due process because they did not "detail the reasons for the proposed action. The reason given for [plaintiff's] termination was '[Plaintiff] is now in a new category for his age and no longer is eligible due to household excess income,' " and for another notice the reason given was simply "net income exceeds maximum allowable." 985 F. Supp. at 1194. The Court found both formulations "vague in as much as they fail to provide any basis upon which to test the accuracy of the decision." Id. TennCare NODs, by contrast, when denying an individual based on income, always contain a statement of what the maximum allowable monthly income is for a given category, and the assertion that the applicant's income exceeds that limit. See, e.g., SUMF ¶ 52. This difference means that not only do TennCare notices give enrollees more information than the notices in Rodriguez, they provide everything an enrollee would need to challenge TennCare's decision.

To the extent Rodriguez required more detail, like an individualized income calculation, it is inconsistent with binding precedent. The Sixth Circuit has held that notices stating that "[t]he

total income which had to be counted for your family is more than 150% of the Department's need standard so your case must be closed," Garrett v. Puett, 557 F. Supp. 9, 12 (M.D. Tenn. 1982), aff'd 707 F.2d 930 (6th Cir. 1983), "satisfy due process and statutory requirements." 707 F.2d at 931. The Garrett formulation is much less clear than TennCare's (it does not state what the agency thinks the individual's income is, or what the threshold is, in dollar terms). If the Garrett notices are adequate, then so are TennCare's.

Nor does Rodriguez support the claim that the citation violates the Medicaid Act. As discussed above, the Medicaid Act says nothing about the types of citations that must be included in the NODs. Rodriguez found that the citations in Arizona failed to comply with 42 C.F.R. § 210, which requires, inter alia, a notice to "contain . . . the specific regulations that support . . . the action." See Rodriguez, 985 F. Supp. at 1191, 1195; see also Pls.' R&Os at 9. But Rodriguez predates the binding Supreme Court and Sixth Circuit precedent, discussed above, that makes clear that Section 1983—the basis for Plaintiffs' suit—cannot be used to enforce a federal regulation. Johnson, 446 F.3d at 628–29 (discussing impact of Alexander v. Sandoval, 532 U.S. 275 (2001) and Gonzaga, 536 U.S. 273). There is no provision of the Medicaid Act that, "in clear and unambiguous terms, confers a particular right" to receive an NOD with a specific legal citation, so Plaintiffs' claim based on the citations in earlier NODs must fail. Caswell, 418 F.3d at 620.

C. TennCare's good cause policies are lawful.

The Court certified four issues regarding the "good cause exception" and "good cause hearings": (1) whether the NOD's uniform omission of information concerning good cause violates the Medicaid Act or due process, (2) whether the State is required to offer the exception or hearings at all, (3) whether the State, in fact, provides such hearings, and (4) whether TennCare's

policy of denying good cause exceptions or hearings based on "allegations of non-receipt" of a notice is lawful. See Doc. 234 at 13 n.5 & 18 n.10. As with the stock-citations issue, Plaintiffs lack standing to challenge these policies because they "have not identified anyone who should have received a good cause exception and lacks coverage." Doc. 234 at 29; see also DaimlerChrysler Corp. v. Cuno, 547 U.S. 332, 352 (2006) ("[A] plaintiff must demonstrate standing for each claim he seeks to press."). Summary judgment is also justified on Plaintiffs' Medicaid Act challenge with respect to these issues because "good cause" is a creation of TennCare rules. Neither the Medicaid Act nor the Medicaid regulations mention it, so Plaintiffs have no right to it that is enforceable under Section 1983.

The "good cause" in question is a reprieve TennCare provides from ordinary deadlines for filing an appeal if "good cause can be shown as to why the appeal or request for a hearing could not be filed within the required time limit." TENN. COMP. R. & REGS. 1200-13-19-.06(3); SUMF ¶¶ 73–74. "Good cause" is defined as "a legally sufficient reason," meaning "a reason based on circumstances outside the party's control and despite the party's reasonable efforts." TENN. COMP. R. & REGS. 1200-13-19-.02(20). It is undisputed that TennCare does not include information about good cause in its NODs, does not grant good cause hearings, and does not automatically provide a good cause exception to individuals who allege (without further support) that they did not receive a notice. See SUMF ¶¶ 76, 81, 84. All untimely appeals are reviewed for good cause before they are closed. SUMF ¶ 73. In this review, a legal review team that has been trained to err on the side of the appellant looks for any evidence of returned mail, any attempt to update an address, or any allegations of circumstances justifying a missed deadline (e.g., car wreck, hospitalization, illness). SUMF ¶¶ 78–79. If an appeal is closed as untimely, the appellant is told in a closure notice that they can still submit information about potential good cause and TennCare will then consider that

appeal for good cause a second time. SUMF ¶ 80. If an appellant disagrees with the decision to close an appeal as untimely, she may petition for review in the Chancery Court. SUMF ¶ 85.

1. NOD language and good cause hearings.

Plaintiffs allege that TennCare violates due process by failing to include an explanation of the good cause exception in NODs and failing to provide good cause hearings. "[D]ue process requires the government to provide notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." Jones v. Flowers, 547 U.S. 220, 226 (2006). It is "flexible and calls for such procedural protections as the particular situation demands." Mathews v. Eldridge, 424 U.S. 319, 334 (1976). The NODs, which contain an explanation of the deadlines to file an appeal, satisfy that standard. As a practical matter, TennCare does not inform individuals of the potential exception unless and until their appeal has been deemed untimely because informing enrollees in their NOD of the existence of the possible exception could be detrimental to those members who might then fail to file a timely appeal on the assumption that tardiness will be overlooked. SUMF ¶ 77.

Due process likewise does not require TennCare to provide a hearing on whether "good cause" exists. "[D]ue process generally does not entitle parties to an evidentiary hearing where the [agency] has properly determined that a default summary judgment is appropriate due to a party's failure to file a timely response." Arch of Ky., Inc. v. Dir., Office Workers' Compensation Programs, 556 F.3d 472, 478 (6th Cir. 2009) (cleaned up). Courts have repeatedly rejected the contention that due process requires an agency to provide a hearing on whether good cause exists to reopen a case or appeal following a missed deadline. For example, in Cunningham v. Railroad Retirement Board, 392 F.3d 567 (3d Cir. 2004), the Court rejected a petitioner's claim that due process required good cause hearings for "pro se claimants [who] are otherwise unable to argue

persuasively and present evidence in favor of their good cause explanations." 392 F.3d at 576. The Court noted the petitioner had "cited [no] authority to this Court under which an oral hearing in connection with the evaluation of a motion to reopen a claim for benefits was found to be constitutionally required as a matter of due process," and it was,

> troubled by the implication of [petitioner's] position, which would require the Board to provide an oral hearing each time a pro se claimant sought to show good cause to reopen an untimely appeal. Such hearings would be a significant strain on the agency's resources, yet it is not entirely clear . . . what additional value would be gained.

Id. at 577 (citing Mathews, 424 U.S. at 347, for the proposition that " . . . the administrative burden" must be considered when "striking the appropriate due process balance").

The same is true here. The uncontradicted testimony of TennCare's witnesses demonstrates that the agency is open to good cause requests and places a thumb on the scale in favor of granting good cause to an appellant. The Sixth Circuit has held that individuals seeking good cause exceptions to an appeals deadline with an agency have no due process claim when they are afforded an "ample opportunity to present [their] reasons for filing the hearing request . . . late" in writing. Hilmes v. Sec'y of Health & Human Servs., 983 F.2d 67, 70 (6th Cir. 1993). That opportunity is afforded to all appellants as part of TennCare's appeal process; thus, Plaintiffs have no due process right to a hearing on good cause.

2. Allegations of nonreceipt are insufficient to establish good cause.

Plaintiffs claim that TennCare violates due process by not automatically applying the good

cause exception (or granting a good cause hearing) in every case where an enrollee alleges that she did not receive a notice or request for additional information. Doc. 234 at 18 n.10. Notice is "constitutionally sufficient if it was reasonably calculated to reach the intended recipient when sent." Jones, 547 U.S. at 226. Unless it receives returned mail, TennCare has every reason to believe that its mailed notices are received. And it is very common for enrollees, realizing they

have missed a deadline, to falsely claim that they never received a notice which they are told they are now too late to appeal. SUMF ¶ 82. Due process does not require TennCare to take an enrollee's word for it that mail was undelivered with no other corroborating evidence. Such a rule would defy "the commonsensical proposition that a bare, uncorroborated, self-serving denial of receipt, even if sworn, is weak evidence." Joshi v. Ashcroft, 389 F.3d 732, 735 (7th Cir. 2004). Indeed, the Sixth Circuit has already rejected the proposition that an individual could overcome the presumption that mail was delivered with this sort of self-serving allegation. Singh v. Garland, 2022 WL 4283249, at *5 (6th Cir. Sept. 16, 2022) (citing Ba v. Holder, 561 F.3d 604, 607 (6th Cir. 2009)) ("Most mail reaches its destination …. Indeed, we have already suggested that an immigrant generally cannot rebut the presumption of receipt merely by testifying, 'I never received any notice of the hearing.' "); see also Citizens Ins. Co. v. Harris, 2016 WL 3743133, at *3 (E.D. Mich. July 13, 2016) ("If a party were permitted to defeat the presumption of receipt of [a] notice resulting from the certificate of mailing by a simple affidavit to the contrary, the scheme of deadlines and bar dates under the Bankruptcy Code would become unraveled.").

Nevertheless, Plaintiffs argue that unsworn statements alleging nonreceipt are enough to rebut the presumption that notice was effective, or at least require a hearing. Such a rule would violate Sixth Circuit precedent (as well as unraveling the system of deadlines on which the program relies). Appellants who have additional evidence of nonreceipt can provide that evidence without a hearing, SUMF ¶ 80; see Mathews, 424 U.S. at 343 (taking into account "the probable value, if any, of additional procedural safeguards"), and as already mentioned, most enrollees who make such allegations do not have any corroborating evidence.

Indeed, Plaintiffs' allegations in this case, made under oath, demonstrate the ubiquity of incorrect claims of nonreceipt. Plaintiffs' initial verified complaint and their verified amended

complaint alleged that Plaintiff Barnes never received the NOD terminating her Medicaid benefits. Doc. 1, ¶ 205 (Mar. 19, 2020); Doc. 202 ¶ 209 (May 5, 2022). They further alleged that Ms. Barnes' daughter, Glenda Surrett, informed TennCare that her mother had not received the NOD, and TennCare still refused to accept her appeal. Id. This was incorrect. Ms. Surrett acknowledged on a recorded call that she had received the NOD, but had misunderstood it. SUMF ¶¶ 168, 170. Furthermore, Ms. Surrett never sought to appeal, and TennCare never denied such a request. SUMF ¶¶ 171–72. Due process does not require TennCare to accept these sort of unsworn post hac excuses for missed filing deadlines.

D. TennCare's 90-day reconsideration policies are lawful.

The Court certified the issue of whether the NOD's uniform omission of information concerning the 90-day reconsideration period is lawful. Doc. 234 at 13. The 90-day reconsideration period refers to TennCare's practice of providing enrollees going through annual renewal with a 90-day grace period, following the date of termination, to return their Renewal Packets or additional information needed to determine eligibility. SUMF ¶ 57. It is undisputed that NODs do

not reference the 90-day reconsideration period, but they do inform enrollees that if they return their Renewal Packets or additional information prior to termination they will keep their coverage pending review of the late submitted information. SUMF ¶ 57. Further, it is TennCare's policy, consistent with federal regulations, that if the missing information is received within 90 days, that information will be reviewed, and if it shows that an individual is eligible for coverage, coverage will be reinstated and backdated to fill in the gap. SUMF ¶ 57.

TennCare is required to provide a 90-day reconsideration period only as part of the annual renewal process, not when eligibility is being reviewed due to a reported change. See 42 C.F.R. §§ 435.916(a)(3)(iii); 457.340(g); 457.343. TennCare does not include information regarding the 90-day reconsideration period in its NODs for the same reason it does not include information about

the "good cause" exception. SUMF ¶¶ 60–61 . When an NOD goes out, the enrollee has not yet lost coverage and can still abide by ordinary deadlines. TennCare believes that disclosing the existence of the 90-day reconsideration period at that point will deter individuals from providing information in a timely manner and potentially cause a temporary loss of coverage. SUMF ¶ 61. TennCare does, however, inform all individuals in the cover letter accompanying their Renewal Packet that it will consider responsive information and make an eligibility determination even if the information is returned after a termination notice is issued. SUMF ¶ 62.

For the same reasons that TennCare's practice of not initially informing individuals of the "good cause" exception is constitutionally adequate, see supra at 11, TennCare's notice of the deadlines surrounding reconsideration of termination during renewal are constitutionally adequate. See Cabrera-Ramos, 233 F. App'x at 455; see also Rolen v. Barnhart, 273 F.3d 1189, 1191–92 (9th Cir. 2001) (rejecting plaintiff's argument that he was denied due process when a notice advised him of his right to appeal the dismissal of his benefits application but not that "he could have his claim considered on the merits by filing a new application").

E. TennCare's valid factual dispute policy is lawful.

The Court certified the issue of "whether TennCare's valid factual dispute policy is lawful." Doc. 234 at 13 n.6. This policy, as set forth in TENN. COMP. R. & REGS. 1200-13-19-.05(2) and (3), complies with the Due Process Clause, the Medicaid Act, and all applicable regulations. The valid factual dispute policy provides that an appellant will not receive a fair hearing unless she alleges a factual mistake in determining eligibility (including a mistake in applying the law to Plaintiffs' facts) that, if resolved in favor of the appellant, would entitle the appellant to relief. SUMF ¶¶ 91–92. TennCare's policy is a valid expression of the applicable Medicaid regulation, 42 C.F.R. § 431.220, and the Sixth Circuit has upheld TennCare's policy of denying hearings "to beneficiaries who have failed to raise a 'valid factual dispute' about their eligibility for coverage."

Rosen v. Goetz, 410 F.3d 919, 926 (6th Cir. 2005); see also id. (holding that "this approach plausibly interprets the language of the regulations"). In so holding, the Sixth Circuit explained that TennCare's interpretation of the regulations in question is plausible and adheres to precedent holding that hearings are not required for challenges to "matters of law and policy" but only to factual disputes. Id.; see also Benton v. Rhodes, 586 F.2d 1, 3 (6th Cir. 1978).

The Sixth Circuit also found it persuasive that "CMS, the agency that authored and promulgated the regulations, has approved the State's policies as fully compliant with its regulations, a determination to which [courts] owe 'substantial deference.'" Rosen, 410 F.3d at

927 (citation omitted). The "valid factual dispute" policy in place today is the same one that was in place in Rosen and approved by CMS. In the CMS State Medicaid Manual, § 2901.3, available at https://go.cms.gov/3Mhci5K, CMS has confirmed that States "do not have to grant a hearing if the sole issue being appealed is a State or Federal law or policy." Elsewhere, CMS explained that state Medicaid programs should, when a hearing is requested "[d]etermine whether the appeal involves issues of law or policy, or issues of fact or judgment. The decision will affect whether a hearing is granted . . . . The distinction between issues of fact or judgment and issues of State law or agency policy will not usually be difficult to make." Id. § 2902.4. The reason that no hearing need be provided in these situations is straightforward—it would do no good. In these cases, "the agency is not in a position to rule in favor of the appellant without a change in agency policy or, in some instances, in State law." Id.

Like the Sixth Circuit, this Court has upheld TennCare's valid factual dispute policy, noting that "the Sixth Circuit definitively rejected Plaintiffs' argument that the State must hold a hearing . . . if the only issue is one of law or policy." Grier v. Goetz, 402 F. Supp. 2d 876, 921 (M.D. Tenn. 2005). And Plaintiffs are bound by Grier because all members of the class in this

case were members of the Grier class. See id. at 881; see also Parklane Hosiery Co., Inc. v. Shore, 439 U.S. 322, 326 (1979) ("Collateral estoppel, like the related doctrine of res judicata, has the dual purpose of protecting litigants from the burden of relitigating an identical issue with the same party or his privy and of promoting judicial [efficiency] by preventing needless litigation."). Furthermore, the requirement of a valid factual dispute is by no means a unique feature of TennCare procedures. The Sixth Circuit's decisions in Rosen and Benton were in line with other decisions that make clear that due process does not require the provision of an appeal hearing if the hearing could not help the appellant. See, e.g., Flaim v. Med. Coll. of Ohio, 418 F.3d 629, 642–43 (6th Cir. 2005). As the Supreme Court has explained in another context, "if [a] hearing mandated by the Due Process Clause is to serve any useful purpose, there must be some factual dispute between an employer and a discharged employee which has some significant bearing [on the case]." Codd v. Velger, 429 U.S. 624, 627 (1977). Indeed, under Plaintiffs' theory, this Court violates due process every time it refuses to provide a litigant with a trial after concluding that there is no "genuine" dispute over a "material" issue of fact. But see FED. R. CIV. P. 56. Ultimately, "[d]ue process is flexible and calls for such procedural protections as the particular situation demands." Mathews, 424 U.S. at 334 (quotation omitted). Individuals who have no factual disagreement with TennCare's eligibility decision could gain nothing from a hearing, so due process does not require one to be provided.

F. Language included in notices of decision regarding the valid factual dispute policy is lawful.

The Court certified closely related issues regarding the way TennCare informs individuals about the valid factual dispute process. Specifically, the Court certified the issues whether (1) "TennCare's prior use of language, in some NODs, telling recipients they could only get a hearing if they thought TennCare made a 'mistake about a fact,' " Doc. 234 at 18 n.10, and (2) TennCare's

uniform statement in all NODs requiring individuals who wish to appeal "to describe the reasons they want to appeal and the facts supporting the appeal," Doc. 234 at 13, violate the Medicaid Act or due process.

TennCare does not dispute that some of its NODs denying new coverage used to say: "If you still think we made a mistake about a fact, you can have a fair hearing. If you don't think we made a mistake about a fact, you can't have a fair hearing." SUMF ¶ 95. Less than five percent of NODs, sent to only 5,238 class members, contained this language. SUMF ¶ 96. This language was intended to inform individuals who were denied new coverage of the valid factual dispute policy. In light of concerns expressed by the Court, see Tr. of Proceedings, Doc. 179 at 20:11–15 (Mar. 6, 2022), TennCare voluntarily changed these notices. They now state: "You can have a fair hearing if you still think we made a mistake and, if you're right, you would qualify for our program." SUMF ¶ 97.

Regardless of whether the former language was insufficient, Plaintiffs lack standing to challenge it and their claim is moot. "The only claimants who could have been injured by the inadequacy are those who detrimentally relied on the inadequate denial notice." Day v. Shalala, 23 F.3d 1052, 1066 (6th Cir. 1994). Thus, only individuals who would have appealed but were deterred from doing so by the now discarded language, and either remained without coverage or filed a new application and were left with a gap in their coverage history, have standing. At most, some unidentified subset of the 5,238 class members who ever received a notice with this language could have been injured by it, but (unlike in Day) there is not one identified class member who was so injured. And the new language used to describe the valid factual dispute policy moots Plaintiffs' claims for prospective injunctive relief. The change was made formally and TennCare has no intention to revert to the previous language. SUMF ¶ 98; see Thomas, 996 F.3d at 325–26.

In any event, the former language did not violate due process. Plaintiffs' argument to the contrary is founded upon their belief that TennCare's duty to provide a hearing "is not limited to those instances in which the individual can identify a 'mistake about a fact.'" SUMF Ex. C at 15. But this amounts to a challenge to the valid factual dispute process itself which, as discussed above, is foreclosed and without merit. An enrollee must have a factual dispute (including a dispute regarding the application of the law to facts) to maintain an appeal; it is not a violation of the Medicaid Act to inform enrollees of that requirement. Nor does it violate due process, which requires that "notice [be] reasonably calculated, under all circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." Hamby, 368 F.3d at 560 (quoting Mullane, 339 U.S. at 314) (brackets in original). Notice must provide enrollees with an "[effective] opportunity to be heard," Goldberg, 397 U.S. at 268. TennCare's notice language does this by informing appellants about the standard against which their request for an appeal hearing will be judged.

For the same reason, TennCare's uniform language in its NODs informing individuals who wish to appeal that they should describe the reasons why they want to appeal and lay out the facts supporting their appeal does not violate due process. SUMF ¶ 93. Just as a litigant in federal appeals court must file a brief explaining why she thinks the district court's decision is flawed, appealing enrollees must tell TennCare the reason for their appeal. This requirement is necessary to permit TennCare to adequately assess an individual's appeal. It does not violate due process, which "is flexible and calls for such procedural protections as the particular situation demands." Mathews, 424 U.S. at 334.

It should be noted that Plaintiffs' underlying theory for all of these valid-factual-dispute-related claims, that TennCare should never be permitted to disenroll anyone consistent with due

process without first affording them a hearing, is impossible to square with the Supreme Court's treatment of due process. The Sixth Circuit has emphasized that in Mathews itself, the Supreme Court "upheld 'carefully structured procedures' that permitted the [agency] to disenroll individuals from Social Security's disability benefits program without a hearing." Rosen, 410 F.3d at 928–29. Those procedures included instructions, similar to those challenged by plaintiffs, that appealing beneficiaries must submit additional evidence and complete a "detailed questionnaire" that would enable the agency to understand the basis for the appeal. Id. at 929.

G. TennCare provides timely appeal hearings.

The Court also certified the issue of whether TennCare is required to provide fair hearings within 90 days of appeal and, if so, whether it fails to do so. As to the factual component of this question, TennCare ordinarily resolves all appeals within 90 days, and has not had a hearing more than 90 days after a termination appeal was filed (without a request for continuance by the appellant) since August 2022. SUMF ¶¶ 64–65. And recently, as part of the restarted renewal process, TennCare has received a waiver from CMS that explicitly permits it to allow appeals to go beyond 90 days as long as it provides continuation of benefits. SUMF ¶¶ 66, 146.

In any event, neither the Medicaid Act nor due process requires hearings to be held within 90 days, given that an individual whose appeal is delayed is given continuation of benefits and therefore has not suffered an adverse action. The Medicaid Act does not specify how quickly hearings must be held, stating only that they must be provided "with reasonable promptness." 42 U.S.C. § 1396a(a)(3). As for due process, in Mathews, the Supreme Court explained that it "consistently has held that some form of hearing is required before an individual is finally deprived of a property interest." 424 U.S. at 333. Here, any individual whose right to a hearing is delayed has the assurance that they will not be deprived of their Medicaid benefits until they are afforded a hearing. Cf. Cotten v. Davis, 215 F. App'x 464, 467 (6th Cir. 2007) (prisoner did not have a due

process right to a parole revocation hearing when the warrant related to his violation had not yet been executed).

H. TennCare provides fair hearings and considers all categories of eligibility.

The Court certified two purely factual issues: "whether TennCare systematically fails to provide fair hearings at any time," Doc. 234 at 18 n.10, and "whether Defendant considers all categories of eligibility before terminating enrollees' coverage," id. at 14. [1] The undisputed evidence in the record demonstrates that TennCare does not systematically fail to provide fair hearings at any time. See SUMF ¶ 68. There are only four situations in which a filed appeal will not go to hearing: when the appeal is (1) withdrawn, (2) found to be untimely or otherwise procedurally improper, (3) lacking a valid factual dispute, or (4) resolved in favor of the appellant prior to hearing. SUMF ¶ 69. These four permissible exceptions aside, TennCare regularly sends appeals to hearings. See SUMF ¶ 71. Plaintiffs can point to no evidence to the contrary.

Likewise, the undisputed evidence in the record demonstrates that TennCare considers all categories of eligibility. TEDS is programmed, and TennCare workers are trained, to review for eligibility in all categories under a "category of eligibility hierarchy" that seeks to determine eligibility for the "richest" level of benefits first and works its way down the list until the list is exhausted or an individual is found to be eligible in a category. SUMF ¶¶ 21–27. Again, Plaintiffs can point to no evidence to the contrary. Indeed, they concede that TennCare functions this way, suggesting instead that TennCare "fails to reliably consider all categories of eligibility." SUMF Ex. C at 17–19. But that is not the issue certified by the Court and it is not a common issue

1 The Court also certified this question: if TennCare fails to consider all categories of eligibility, do their notices unlawfully mislead recipients on that score? Doc. 234 at 14 n.7. If

TennCare systematically fails to consider all categories of eligibility, the State agrees that its notices—which state that it checks for eligibility in "each kind of group we have," Doc. 141-1 at 10, would be misleading. But as will be explained, TennCare's notices are accurate because TennCare does consider all categories of eligibility.

susceptible to class-wide resolution. See Doc. 234 at 1 (noting the Court was exercising its power "to trim and refine [this] collective action[] such that dysfunctional elements do not contaminate [an] otherwise functional class[]").

In fact, as the Court recognized when it denied a preliminary injunction in this case, the idiosyncratic errors related to accurately determining eligibility in a relatively small number of cases—not one of which involved a systematic failure to screen for eligibility in a certain category—do not show that TennCare fails to consider all categories of eligibility; those cases merely show that TennCare, like any agency processing millions of cases, sometimes makes mistakes and, when it discovers mistakes, it promptly rectifies them and ensures they do not recur. See, e.g., Doc. 234 at 27 ("That Defendant found the 400 individuals and reinstated their coverage indicates Defendant has a process for identifying and remedying income miscalculations."). Even if such an issue could be considered appropriate for class-wide relief (and it cannot), at present, TennCare is not aware of any outstanding systematic issue negatively affecting TennCare's ability to accurately determine eligibility in any category of coverage, and Plaintiffs have not identified any such issues.

I. TennCare's notices adequately explain why an individual is found ineligible.

The Court certified the issue of whether "the NODs' omission of an explanation as to why its recipients do not qualify for other Medicaid categories" is unlawful. Doc. 234 at 14 (quotations omitted). Although TennCare screens for every category of eligibility, NODs terminating or denying coverage do not explain why, for each of the dozens of categories of eligibility, an individual failed to qualify. SUMF ¶¶ 54. For example, someone who was never in foster care will not receive a specific explanation for why they do not qualify for foster care categories of coverage. SUMF ¶ 55. Instead, when an individual is ineligible for TennCare coverage because they do not belong to any group for which some type of coverage is available, they receive a general statement

of denial, along with a description of some of the most common groups that do qualify for coverage. SUMF ¶ 54. If an individual is part of a covered group but still not eligible, their NOD will explain why they do not qualify for benefits in each group for which they otherwise may appear qualified, with the reasons they were found ineligible—for example, their income is too high for a given category or they failed to satisfy a procedural requirement (like getting a Pre Admission Evaluation for institutional coverage). SUMF ¶¶ 53.

Due process requires only that a notice inform a person of the basis for their termination in a way that permits them to prepare for an appeal hearing. Hamby, 368 F.3d at 562. TennCare's existing notices provide enough detail about why an individual was found ineligible to permit them to appeal, without providing them "a potentially confusing laundry list more likely to confuse than to clarify." Reigh v. Schleigh, 784 F.2d 1191, 1195 (4th Cir. 1986) (quotation marks omitted).

J. The Disability Subclass questions.

The Court certified two issues specific to the disability subclass. First, does TennCare have a system for granting reasonable accommodations, and if not, does the ADA require such a system?

Second, does TennCare provide adequate "in-person assistance" to disabled persons, and if not, does that violate the ADA? See Doc. 234 at 20 & n.12. 2

1. TennCare has a system for granting reasonable accommodations.

Title II of the ADA requires that "no [otherwise] qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. In implementing this statute, programs like TennCare are required to

2 The Court also certified the question of whether TennCare evaluates all categories of disability-related eligibility pre-termination. Id. Because this is a subset of the broader question of whether TennCare evaluates enrollees and applicants for all categories of eligibility, it is fully addressed above.

afford disabled individuals "reasonable accommodations" (also referred to as "reasonable modifications" of the program), or changes to its "policies, practices, [and] procedures, . . . necessary to avoid discrimination on the basis of disability" and permit them to access the program. 28 C.F.R. § 35.130(b)(7)(i); see Hindel v. Husted, 875 F.3d 344, 347 (6th Cir. 2017). In contrast, "fundamental alterations"—disability accommodations that "would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens" —need not be provided. Hindel, 875 F.3d at 347.

There is no dispute that TennCare has a system for granting reasonable accommodations. See SUMF ¶¶ 127–140. Indeed, Plaintiffs' expert testified affirmatively that he "agreed that there are systems in TennCare for providing assistance and offering reasonable accommodations," and that evaluating TennCare's system and processes for granting reasonable accommodations "was the main focus of [his] report." SUMF ¶ 128.

Because they do not dispute that a system exists, Plaintiffs have shifted to argue that TennCare's system for granting reasonable accommodations is inadequate. See SUMF Ex. C at 19–21. That is a different issue than the one certified by the Court, see Doc. 234 at 21 ("Defendant has allegedly 'refused to act on grounds that apply generally to the class' by failing to implement a system to grant reasonable accommodation requests."). "Few disabilities are amenable to one-size-fits-all accommodations." Ward v. McDonald, 762 F.3d 24, 31 (D.C. Cir. 2014). Rather, reasonable accommodation questions are individual-specific and rarely appropriate for class-wide resolution. See Hindel, 875 F.3d at 347 ("It is a factual issue whether a plaintiff's proposed modifications amount to 'reasonable modifications' which should be implemented, or 'fundamental alterations,' which a state may reject." (quoting Mary Jo C. v. N.Y. State & Local Ret. Sys., 707 F.3d 144, 153 (2d Cir. 2013)); see also Anderson v. City of Blue Ash, 798 F.3d 338,

356 (6th Cir. 2015) (noting the "highly fact-specific' balancing of the [government's] interests against the plaintiffs'" that the reasonable accommodation inquiry requires).

This is not the rare case. Courts will only find reasonable accommodation questions amenable to class-wide resolution when all class members all have the same disability and that disability would permit some uniform type of relief. See Hindel, 875 F.3d at 345 (considering a class-wide request for an accommodation for blind voters to allow them to vote without assistance). Here, the disability subclass includes "all individuals who, since March 19, 2019, have

been or will be disenrolled from TennCare" (excluding those who request to be disenrolled) and "'are qualified individuals with a disability' as defined in 42 U.S.C. § 12131(2)." Doc. 234 at 40. It would be plainly inappropriate to litigate the adequacy of TennCare's reasonable accommodations for all types of disabilities on a class-wide basis. In fact, responding to such a claim recreates the very problems that caused this Court to limit the plaintiff class to certain discrete issues. "TennCare has not acted 'on a ground that is applicable to the entire class'" regarding their specific reasonable accommodations, and thus there is no ground to resolve this issue as to the entire disability subclass. Doc. 234 at 19 (quoting Gooch, 672 F.3d at 428).

If the Court does consider this modified claim, and to be clear, it should not, TennCare is still entitled to summary judgment. It is a necessary element of an ADA violation that the plaintiff "is being excluded from participation in, being denied the benefits of, or being subjected to discrimination under the program solely because of her disability." Jones v. City of Monroe, Mich., 341 F.3d 474, 477 (6th Cir. 2003), abrogated in part on other grounds, Lewis v. Humboldt Acquisition Corp., Inc., 681 F.3d 312 (6th Cir. 2012) (en banc); see also Henrietta D. v. Bloomberg, 331 F.3d 261, 272 (2d Cir. 2003). In other words, a system for granting reasonable accommodations is adequate under the ADA if disabled individuals have "meaningful access to

state-provided services." Mark H. v. Lemahieu, 513 F.3d 922, 937 (9th Cir. 2008) (citation omitted) (discussing reasonable accommodations under the Rehabilitation Act of 1973); see Henrietta D., 331 F.3d at 272 (standards governing reasonable accommodations under the Rehabilitation Act and the ADA are generally the same).

Furthermore, before TennCare can be required to grant a reasonable accommodation, a disabled enrollee (or applicant) must request it. See Jovanovic v. In-Sink-Erator Div. of Emerson Elec. Co., 201 F.3d 894, 899 (7th Cir. 2000); see also Mole v. Buckhorn Rubber Prods., Inc., 165 F.3d 1212, 1218 (8th Cir. 1999) ("Only [the employee] could accurately identify the need for accommodations specific to her job and workplace."). "[T]here is no statutory requirement to impose nonmandatory services on disabled individuals who do not desire them." Dunlap v. City of Sandy, 846 F. App'x 511, 512 (9th Cir. 2021) (Mem.) (citing Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 602 (1999)); see also 28 C.F.R. § 35.130(e)(1) ("Nothing in this part shall be construed to require an individual with a disability to accept an accommodation . . . provided under the ADA or this part which such individual chooses not to accept."). Indeed, the purpose of the ADA is "to protect the dignity of disabled individuals," a purpose that would be contravened by a rule requiring TennCare to presume that disabled individuals are incapable of navigating TennCare without accommodations they have not requested. Dunlap, 846 F. App'x at 512 (9th Cir. 2021).

Plaintiffs have failed to identify any TennCare enrollee who requested an accommodation, was denied, and lacked meaningful access to state provided services as a result. SUMF ¶ 141. Plaintiffs insist their disabilities (and hence, their required accommodations) "should be evident to TennCare" based on the limited information TennCare has on its enrollees, including their "category of eligibility, claims information, or other communication with TennCare." SUMF Ex. C at 6–8. Even accepting, for the sake of argument, that this sort of claim could possibly be

resolved on a class-wide basis, Plaintiffs have failed to show an actionable ADA violation because they have not identified anyone who was injured by TennCare's reasonable accommodation policies in a manner that prevented them from accessing the benefits of the program.

But that predicate should not be accepted. The Plaintiffs unintentionally demonstrate why it would be inappropriate for TennCare to provide un-asked-for accommodations by admitting that there are only two disability sub-class representatives who are not currently assisted by family or friends and who claim to currently need accommodations: Linda Rebeaud and Johnny Walker. See SUMF Ex. C at 3–5. Ms. Rebeaud's case illustrates well the problems with the theory that TennCare should divine the need for accommodations from an enrollee's medical history. She is eligible for TennCare through the Breast or Cervical Cancer category of eligibility, which is only available to individuals who are being actively treated for breast or cervical cancer. SUMF ¶¶ 182–83. She has never made an accommodation request to TennCare, SUMF ¶ 186, but Plaintiffs suggest that her "disability should be evident to TennCare based on her category of eligibility, claims information and other [unspecified] communication with TennCare," SUMF Ex. C at 8. From the fact that she has either breast or cervical cancer, Plaintiffs expect TennCare to divine that Ms. Rebeaud requires accommodations that "include but are not limited to: in-person assistance from an agency employee, simpler explanations, letters that are easier to read, simplified instructions, and follow-up in writing, by telephone, or in person." Id. at 5 (emphasis added); see also SUMF ¶¶ 184–85. Of course, if she will not identify her needed accommodations, it is difficult to imagine how TennCare could do so adequately based on the fact that it knows she is being treated for cancer. In any event, it is impossible for Ms. Rebeaud to show that the absence of these unrequested accommodations has denied her access to TennCare given that she remains covered.

Plaintiffs have failed to show a violation of the ADA based on TennCare's reasonable accommodation policies.

2. TennCare has a system for providing in-person assistance.

Plaintiffs also argue that TennCare violates the ADA by not providing adequate "in-person assistance" for disabled persons who request it. There is no special requirement to provide in-person assistance, only the general rule that a state must provide reasonable accommodations. See SUMF Ex. C at 21. In any case, as with reasonable accommodations generally, the undisputed evidence in the record demonstrates that TennCare provides in-person assistance to anyone—regardless of disability—who requests it and the availability of in-person assistance is disclosed in every renewal packet TennCare sends. See SUMF ¶¶ 110–14.

The system TennCare has is adequate. As with reasonable accommodations generally, Plaintiffs have not identified a single case in which the failure to provide in-person assistance denied a disabled individual meaningful access to TennCare. To the contrary, the record shows that TennCare provides such assistance when necessary. Plaintiff Monroe requested and received at-home in-person assistance from the AAAD, which interviewed him and provided a functional assessment related to his request for in-home services. SUMF ¶ 115. And of course, it would be both completely infeasible and utterly inappropriate for TennCare to presume to provide in-person assistance to an enrollee who has not requested it.

II. CMS has certified that TennCare's policies and systems comply with all relevant statutory authority.

Summary judgment is appropriate on each of the Plaintiffs' claims for the independent reason that CMS has reviewed and certified TennCare's processes for determining eligibility and has found, among other things, that it is consistent with the requirements of the federal disability rights and civil rights laws, as well as providing for "prompt eligibility verification and for

processing claims" for individuals who are eligible for Medicare and Medicaid. See 42 C.F.R. § 433.112(b)(1), (3), (12), (14), (16), (17), (18).

CMS certified TEDS through a robust review process that took place over several years. SUMF ¶ 13. In its cover letter to the Certification Report, CMS noted that its evaluations covered compliance with the Social Security Act, Affordable Care Act, 42 CFR Part 433, Subpart C (regarding "mechanized claims processing and information retrieval systems"); 42 CFR Part 435 (regarding Medicaid eligibility); the Health Insurance Portability and Accountability Act; and "[c]urrent legislation and CMS policies." SUMF ¶ 13. The Certification Report states that CMS "performed a comprehensive review of functionality [of TEDS] for both Modified Adjusted Gross Income (MAGI)-based and non-MAGI based eligibility supported by [TEDS]." SUMF ¶ 14. CMS also confirmed that TEDS complies with relevant federal regulations and statutory requirements for making eligibility determinations, including annual redeterminations. CMS certified TEDS, concluding that "there were no critical findings." SUMF ¶ 15. In other words, as to the Medicaid Act and ADA claims raised by Plaintiffs, CMS has already investigated and found that TennCare's processes for determining eligibility, ensuring the provision of fair hearings on appeal, and accommodating disabilities comport with all relevant statutory and regulatory requirements.

The Sixth Circuit affords "substantial deference" to decisions made by CMS when administering the Medicaid statute. See Rosen, 410 F.3d at 927; cf. Harris v. Olszewski, 442 F.3d 456, 465–68 (6th Cir. 2006). In particular, the Court has afforded this deference to agency determinations that a state plan or procedure complies with a relevant Medicaid statutory requirement or regulation. For example, the Sixth Circuit has afforded Chevron deference to the Department of Health and Human Service ("HHS") determination that a state Medicaid program lawfully offered eligible enrollees the freedom to choose a medical

provider. See Harris, 442 F.3d at 460, 466–68. The Court has also given CMS substantial deference in approving a state's proposed disenrollment process. See Rosen, 410 F.3d at 927. CMS's decision that TEDS is functioning in compliance with the applicable federal regulations and TennCare is entitled to enhanced FFP is likewise entitled to substantial deference due to the role that the Congress has assigned to the federal agency to supervise state Medicaid programs.

Finally, CMS has effectively reiterated its findings that TennCare's processes for determining eligibility are consistent with the requirements of the Medicaid Act and other federal disability rights and civil rights laws, by making Tennessee one of only 16 states that CMS did not place under a mitigation plan as a result of deficiencies in the state's eligibility processes. SUMF ¶ 148.

CONCLUSION

For the foregoing reasons, Defendant is entitled to summary judgment in his favor on all issues certified by the Court.

July 10, 2023

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served via the Court's electronic filing system on this 10th day of July, 2023.
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Appointment Title:
[INTERNAL] (b)(6) Mtg w/Georgetown University's Medicaid Section 1115 Waiver Task Force

Organizer:
CMS Administrator

Attendees:
(b)(6) Kyla Ellis (CMS/) (kyla.ellis@cms.hhs.gov); McLemore, Monica (CMS/OSORA); Khan, Farooq (CMS/OSORA); Tsai, Daniel (CMS/CMCS)

Location:
Zoom Link to be Included

Start Time:
12/1/2022 6:30:00 PM +0000

End Time:
12/1/2022 7:00:00 PM +0000

Reminder Time:
12/1/2022 6:15:00 PM +0000

Reminder Set:
true

Duration:
30 minutes

Is Recurring:
false

Reccurrance Type:
Not

Reccurrance Pattern:

Response Status:
5

Busy Status:
Tentative

Attachments:
External Meeting Request: Medicaid Section 1115 Waiver Task Force*Georgetown University

External Meeting Request: Medicaid Section 1115 Waiver Task Force*Georgetown University
From:
"McLemore, Monica (CMS/OSORA)" <Monica.McLemore@cms.hhs.gov>

Sent:
11/2/2022 12:21:56 PM -0400

To:
"Neal, Phaedra (CMS/OA)" <Phaedra.Neal@cms.hhs.gov>

CC:
"Khan, Farooq (CMS/OSORA)" <Farooq.Khan@cms.hhs.gov>

Subject:
External Meeting Request: Medicaid Section 1115 Waiver Task Force/Georgetown University

Attachments:
Letter to Secretary to Improve 1115 Waiver Process.pdf

Hi Phaedra,

Georgetown University has provided the following availability for representatives of the Medicaid Waiver Task Force to meet with the Administrator. Please let me know if any of these work for a 30-minute slot:
Friday, November 18 from 12-1 or 2-2:30
Monday, November 28 from 11-12:30 or 1:30-2
Tuesday, November 29 from 12:30-4pm
Thursday, December 1 from 1-5pm

Meeting Participants:
Joan Alker, Co-Founder, Center for Children and Families
Allexa Gardner, Research Associate, Center for Children and Families
Others TBD

Contact:
Joan Alker
Executive Director, Research Professor
Center for Children and Families
Georgetown University McCourt School of Public Policy
(202)306-8383
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The Medicaid Waiver Task Force, comprised of fifty-one organizations representing patient, provider, and advocacy groups, undersigned a letter to Secretary Becerra, dated 8/17/2022 (attached), urging CMS to strengthen the current regulations to ensure that section 1115 demonstrations promote coverage and improve the transparency of the process of approving, amending, and renewing demonstrations. As a follow-up to the letter, the group requests a virtual meeting with the Administrator and Dan Tsai to discuss this matter.

Thanks,
Monica

August 17, 2022

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Recommended Regulatory Actions for Section 1115 Medicaid Demonstration Process

Dear Secretary Becerra,

The undersigned organizations write to urge you to promulgate regulations regarding the section 1115 Medicaid demonstration process. A substantial and growing portion of Medicaid is funded through section 1115 and there is a critical need to develop a regulatory framework that clarifies the parameters of the authority, clears up confusion among states and courts, strengthens the transparency rules, and protects the integrity of the Medicaid program. This is among the most important things the administration can do for the long-term security of the Medicaid program and the millions of people who rely on the program for their health insurance.

CMS must set out a definition of "the objectives of Medicaid" and establish related principles to avoid harmful demonstration and waiver approvals, such as work requirements or premiums in Medicaid. CMS's regulation should address several specific and important problems in the 1115 process.

Defining the Objectives of Medicaid for Purposes of Section 1115 Demonstrations

CMS should promulgate a regulation which requires that section 1115 demonstrations promote the objectives of Medicaid, with a definition of the objectives of Medicaid based primarily in the purpose of the program identified in section 1901, namely to furnish medical assistance, rehabilitation, and other services. CMS should also ensure that the new definition of the objectives of Medicaid explicitly affirms the Medicaid entitlement and open-ended matching payment structure.

CMS's definition should also clarify that the clause "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care" cannot be interpreted to allow demonstrations that "promote independence" if they do not furnish services or if they reduce access to services.

CMS Should Create 1115 Guardrails for Promoting the Objectives of Medicaid

CMS's regulation should further operationalize the definition of the objectives of Medicaid by creating 1115 "guardrails," similar to the section 1332 guardrails, that ensure demonstrations promote, not undercut, the purpose of Medicaid. Such guardrails should include:

1. Demonstrations cannot be approved if they would likely reduce the number of individuals covered by Medicaid in a state, or otherwise reduce the number of individuals who have health insurance in the state.

2. Demonstrations cannot be approved if they would likely reduce the available services, or amount, duration, and scope of any services, provided to Medicaid enrollees; this includes maintaining access to community-based services.

3. Demonstrations cannot be approved if they would reduce the affordability of services for enrollees, including cost-sharing, premiums, and any other costs, unless they comply with the standards in section 1916(f).
4. Demonstrations should not otherwise reduce access to care, such as by making application, enrollment, or renewal more difficult.

CMS should require that all demonstrations meet all four guardrails for the full population eligible for the demonstration and for specific sub-populations when the guardrail impacts are disaggregated by race/ethnicity and other factors. Existing regulations should be supplemented to require that state applications for section 1115 demonstrations include specific and disaggregated estimates for each of the guardrails as well as a comprehensive equity assessment, explaining the effect the proposal would likely have on health coverage and access to care.

Protecting the Integrity and Transparency of the Demonstration Process

We recommend that CMS's regulation additionally make three changes to strengthen demonstration processes.

First, the regulation should require the full transparency process (including notice and comments) for all 1115 demonstrations that would impact eligibility, enrollment, benefits, cost-sharing, or financing – including new applications, extensions, and amendments. Adding amendments is key as so many states have existing section 1115 demonstrations and major changes are frequently made through amendments. Just like CMS's current regulations include slightly different requirements for new applications and extensions, new regulations could specify reasonable requirements for significant amendments that balance transparency with states' needs to make timely changes. Meaningful changes to eligibility, benefits, cost-sharing, enrollment or financing all require public comment in our view.

Second, the permissible exceptions to the transparency process in the case of a public health emergency needs to be tightened up. The regulation should clarify or strengthen existing regulations to prevent pretextual exemptions from the transparency process. Exemption from the transparency process should be very rare, and only used for demonstrations that are directly related to emergency response (i.e., not just coincidentally contemporaneous) and when use of a comment period would materially delay such emergency response.

Third, CMS's regulation should set clear standards for the duration of demonstrations, not to exceed five years. Section 1115 authorizes "experimental, pilot, or demonstration" projects. Ten years are generally not needed to assess the value of an experiment, and ten years is a long time to have an unsuccessful waiver in place. Ten years also creates the possibility that an outgoing administration can bind a new administration for the entirety of its two terms. Some ten-year approvals do not comport with the statute. We recommend that, consistent with long-standing practice, CMS should implement an unambiguous 5-year limit for new demonstrations, extensions, and amendments.

Thank you for your consideration of our views. If you have questions, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

American Academy of Family Physicians
American Academy of Pediatrics
American Association on Health and Disability
American Cancer Society Cancer Action Network

American College of Obstetricians and Gynecologists
American Heart Association
American Lung Association
Arthritis Foundation
Asian & Pacific Islander American Health Forum (APIAHF)
Autism Society of America
Autistic Self Advocacy Network
Black Mamas Matter Alliance
CancerCare
Catholic Health Association of the United States
Center for Disability Rights
Center for Law and Social Policy (CLASP)
Center on Budget and Policy Priorities
Community Catalyst
Cystic Fibrosis Foundation
Easterseals
Epilepsy Foundation
Families USA
First Focus on Children
Georgetown University Center for Children and Families
Hemophilia Federation of America
Justice in Aging
Lakeshore Foundation
March of Dimes
Medical Transportation Access Coalition
Medicare Rights Center
NASTAD
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Disability Rights Network (NDRN)
National Family Planning & Reproductive Health Association
National Health Care for the Homeless Council
National Health Law Program
National Immigration Law Center
National Multiple Sclerosis Society
National Network for Arab American Communities (NNAAC)
National Organization for Rare Disorders
National Partnership for Women & Families
National Patient Advocate Foundation

Physicians for Reproductive Health
Primary Care Development Corporation
The Arc of the United States
The Leukemia & Lymphoma Society
UnidosUS
Union for Reform Judaism

Author: Microsoft Office User
CreationDate: 2022-08-17 21:18:40
Creator: Microsoft Word
ModDate: 2022-11-02 14:07:46

FW: FW: Georgetwon and CBPP
From:
"Giles, John (CMS/CMCS)" <EXCHANGELABS/EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/RECIPIENTS/979675CBCECA42FFA0FAE7B42C8CD016-JOHN.GILES1>

Sent:
7/18/2023 4:54:01 PM -0400

To:
"Burch Mack, Rebecca (CMS/CMCS)" <Rebecca.BurchMack@cms.hhs.gov>

Subject:
FW: FW: Georgetwon and CBPP

Attachments:
CBPP_CMS-2023-0071-0204-A1.pdf; Georgetown Hlth Policy Inst_CMS-2023-0071-0198-A1.pdf

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Phone: 410-786-5545
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From: Gentile, Amy (CMS/CMCS) <Amy.Gentile@cms.hhs.gov>
Sent: Tuesday, July 18, 2023 10:59 AM
To: Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>
Subject: Georgetwon and CBPP

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June 30, 2023

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Electronically via Regulations.Gov

RE: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P; RIN 0938-AU99)

Dear Secretary Becerra and Administrator Brooks-LaSure,

Thank you for the opportunity to comment on the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P; RIN 0938-AU99) proposed rule.

The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. CBPP staff have deep expertise on the Medicaid, SNAP, and TANF programs, including each program's rules and how they work in the states, and has done extensive research on the impact these programs have had on low-income individuals and families. We work closely with states, advocates, and health care providers across the country, providing technical assistance and other support to ensure that Medicaid and other programs work as effectively and efficiently as possible to meet the needs of low-income individuals and families.

Medicaid managed care is now the predominant delivery system for Medicaid enrollees. Yet many people face barriers to obtaining the services they need in a timely manner and struggle to obtain

crucial information about how to obtain services, the quality of those services, and the underlying causes of access issues. Therefore, we support the Center for Medicare & Medicaid Services' (CMS') proposals to improve access to care, quality and health outcomes; increase payment rate transparency and program integrity; and better address health equity issues for Medicaid and CHIP managed care enrollees. The proposed rule would specifically address standards for timely access to care and States' monitoring and enforcement efforts, reduce burden and increase transparency for State directed payments and certain quality reporting requirements, add new standards that would apply when States use in lieu of services and settings (ILOSs) to promote effective utilization and identify the scope and nature of ILOS, specify medical loss ratio (MLR) requirements, and establish a quality rating system (QRS) for Medicaid and CHIP managed care plans. Throughout our comments below, we note various areas where we recommend that CMS accelerate implementation timelines to assure that enrollees benefit from the proposed changes as soon as is practicable.

The rule represents an important starting point to improve access to care for managed care enrollees, setting the stage for greater state accountability over managed care organizations (MCOs), which now deliver care to approximately three quarters of Medicaid enrollees, and greater CMS oversight over states contracting with MCOs. The rule is consistent with sections 1903(m) and 1932 of the Social Security Act (the Act), which require MCOs to show the state and the Centers for Medicare & Medicaid Services (CMS) that they contract with a number, mix, and geographic distribution of providers sufficient to serve enrollees. MCOs must also have procedures in place to monitor and evaluate the quality and appropriateness of care and services to enrollees. The proposed changes to the Medicaid and CHIP managed care rules will enhance standards, consistent with the statute, for MCOs to document that their networks are sufficient to enable enrollees to access services within reasonable timelines.

Requiring more transparency about payment rates, enrollee experiences, and quality will help improve access to care if CMS and states use the information that this rule, if finalized, will generate, to appropriately oversee managed care organizations. Providing CMS with the information and tools it needs to properly oversee access to services delivered through managed care plans is essential. States, CMS and stakeholders will be better able to assess whether managed care enrollees truly can access services to which they are entitled. It will be imperative that CMS use the information it receives from these new provisions to oversee plans and take steps to address access.

While this rule includes important proposals, in the future and to truly realize CMS' vision – and responsibility – to assure access to services for Medicaid enrollees, CMS should consider setting payment benchmark rates in managed care, as it is doing in the fee for service system.

Finally, we also urge CMS to consider developing resources to support states as they implement the new requirements proposed in this rule and in the companion Medicaid access rule. We recognize that states will have to rely on contractors and vendors to retool systems and processes to implement the rules, and we believe that CMS can promote efficiency for both states and the federal government by providing tools and technical assistance resources to avoid duplicative costs across states. Setting out clear technical specifications and providing states with templates (as it has already done with the proposed Quality Rating System) will help ease implementation costs and burdens.

Please see attached for our detailed comments on the rule. We have included numerous citations to supporting research, including direct links to the research. We direct CMS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the

formal administrative record for purposes of the Administrative Procedure Act. If CMS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

If you have any questions, please feel free to contact us at aorris@cbpp.org or lharker@cbpp.org.

Sincerely,

Allison Orris Laura Harker
Senior Fellow Senior Policy Analyst

Our comments on the provisions of the Proposed Rule are as follows. We have listed the comments in the order they are discussed in the preamble to the Proposed Rule, with references to the corresponding regulatory sections.

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I. ACCESS

Enrollee Experience Surveys (§§ 438.66(b) and (c), 457.1230(b))

We support the proposed revisions to §§ 438.66(b) and (c) to require that states conduct an annual enrollee experience survey. We commend CMS's decision to more explicitly recognize the importance of surveying enrollees' experiences on a consistent basis and to ensure that state monitoring activities do not only rely on provider surveys.

While we do not have a recommendation on whether or not to mandate that states use a specific survey, we recommend setting standards for what would make an acceptable enrollee experience survey in compliance with the proposed revised regulation. One standard to consider is ensuring the survey instrument asks the enrollee about how they felt they were treated by the provider. The ability to access services and the perceived quality of care they received is important, but asking people about how they were treated is helpful to fully understand people's experiences and the impact of bias that exists in the health care system. Including a question about wait times for follow-up appointments in these surveys will also be valuable information in measuring wait time compliance, beyond the initial appointment data provided by secret shopper surveys. Other standards to consider include collecting data about specific barriers people face, such as transportation or language access, and including standards to inform health equity such as collecting information on enrollee's race and ethnicity, sexual orientation and gender identity and disability status. The CAHPS survey, which CMS cites as the most commonly used enrollee experience survey, has several strong elements, including questions about getting care when it was needed, satisfaction with the care provided and about how the enrollee felt like they were treated (e.g., did they feel respected or listened to by their provider). These are important elements that could be incorporated into enrollee surveys if states opt to create new surveys.

We also support CMS' proposal to promote transparency and consistency in requiring states to share the annual managed care program report within 30 calendar days of submission to CMS. Transparency is key to managed care accountability and CMS should also consider making state reports available in a central place on the CMS website.

Aligning the enrollee experience survey requirements with the criteria related to interpretation, translation and taglines is an important change (reflected in proposed 438.10(d)(2)) to allow more people – especially people who do not speak English as a primary language or people with visual or hearing impairments – to complete the survey. Other accessibility considerations include making surveys available in different formats (e.g., online, paper, phone). CBPP is part of a project focused on monitoring the Medicaid program by centering the lived experience of Medicaid enrollees. In recruiting Medicaid enrollees to participate in interviews and surveys, we learned about some participation barriers people faced, including limited access to smart phones, computer technology or adequate data plans – challenges that were more pronounced in rural areas. [1] Barriers like these

1 Jessica Greene et al., "Monitoring Medicaid Using Lived Experience: Interim Report," April 2022, https://www.cbpp.org/sites/default/files/Monitoring%20Medicaid%20Using%20Lived%20Experience.pdf.

should be considered as CMS provides additional guidance to states about designing enrollee experience surveys.

Given the importance of enrollee experience surveys, we strongly believe that the cost of implementing enrollee experience surveys for each managed care program is justified by the information that surveys will yield. We agree with CMS's assertion in the preamble that surveys are authorized by section 1932(b)(5) of the Act, which requires managed care organizations to demonstration adequate capacity and services, and by section 1902(a)(4) for PIHPs and PAHPS. Enrollee surveys will give managed care plans, and states, the information they need to make assurances that their networks offer an appropriate range of services and access as well as if it provides a sufficient number, mix, and geographic distribution of providers to meet enrollee needs.

Finally, we recommend that CMS consider accelerating the three-year effective date, to implement the new requirement two years after the effective date of the final rule. Because CMS is proposing more limited changes to CHIP, we support requiring states to use CAHPS data, which they already collect, to evaluate network adequacy in CHIP 60 days after the rule is published.

Appointment Wait Time Standards (§§ 438.68(e), 457.1218)

We support setting wait time standards as a positive step in the direction of not only improving access for Medicaid enrollees, but also reducing disparities in access between patients with Medicaid coverage and those with private coverage. With increased attention to the crises in maternal health and behavioral health, we are pleased to see proposed wait time standards include OB/GYN and mental health and SUD appointment types, along with primary care. We also support CMS' proposal to include a fourth category of services to which wait time standards would apply. Giving states the opportunity to choose this service will allow states to focus attention on a priority area in their state and can produce evidence to inform future national standards, too. We appreciate, too, that CMS proposes that any appointment wait time standards for telehealth must be in addition to, and not a substitute for, in person appointment standards.

Requiring states to achieve a 90% compliance standard with wait time standards (as measured by the newly proposed secret shopper surveys) is a reasonable and appropriate standard to promote access. We recommend that wait time standards be measured not only on a statewide basis, but that compliance standards also take into account geographic variation to identify geographic regions of the state where wait time standards may exceed the minimum standards.

Setting the standard for primary care is a first step to ensure timely referral to specialty care, but we also recommend CMS set a separate standard for specialty care appointment types. We encourage CMS to reconsider the decision not to adopt the 30 business days standard in the Marketplace for routine specialist appointments. Taking steps to address specialty care access issues is important to promote health equity. Due to structural racism, people of color face are more likely to experience barriers like lack of access to care and chronic stress due to discrimination, which

leaves them with a higher risk of certain chronic illness like cardiovascular disease that require specialty care services. [2]

We support CMS' proposal at 438.68(g) to require states to publish appointment wait time standards on the state's website. We also support the alignment of wait time standards with the standards set in the Marketplace. This not only sends the message that there should be similar access in private coverage and Medicaid but will also set a consistent goal across the health system. Consistent with the mission to ensure alignment across programs, we recommend CMS reduce the number of years for states to start complying with the standards. We recommend requiring state compliance by one year after the effective date of the final rule to ensure alignment with the Marketplace by 2025.

Secret Shopper Surveys (§§ 438.68(f), 457.1207, 457.1218)

Requiring states to use secret shopper surveys will reveal valuable information about provider directories that may not be identified in enrollee experience surveys. Specifically, secret shopper surveys are helpful in addressing issues with ghost networks, which continue to be a source of concern and a barrier to access for Medicaid enrollees. We therefore strongly support CMS's proposal to require states to use independent secret shopper surveys to assess plans' compliance with provider directory requirements in 438.10(h), and we agree with CMS' proposal to require that errors in the provider directory be disclosed and corrected quickly.

Secret shopper surveys can also help with monitoring wait times for appointments, but they should not be the only strategy CMS and states use to gauge wait times. Secret shopper surveys have shortcomings like the secret shopper not being able to schedule an appointment (due to not being an enrollee in the plan); secret shopper surveys also have limited ability to track changes to the initial appointment or to assess the availability of follow up appointments. To better assess follow up appointment times, it could help to include questions about wait times among the components that should be included in an enrollee experience survey. As noted above, we agree with CMS' proposal to determine states to be in compliance with wait time standards if they meet state-established standards at least 90% of the time. We also support the proposal to ensure alignment of the secret shopper survey requirements with the four categories of appointment to which wait time standards are proposed.

We support the transparency requirements, including requiring states report secret shopper survey results to CMS and also requiring that results be posted on the state's website within 30 days of submission to CMS. This is a good first step to promote accountability in meeting wait time standards and ensuring adequate provider networks, but a clear enforcement plan is needed to address any issues that may come up in these surveys. As noted below in our discussion of proposed 438.207(d), we also recommend that CMS design a reporting format for the secret shopper surveys that gives enrollees and stakeholders robust information about the findings

2 Javed Z, Haisum Maqsood M, Yahya T, et al. Race, racism, and cardiovascular health: applying a social determinants of
health framework to racial/ethnic disparities in cardiovascular disease. Circ Cardiovasc Qual Outcomes 2022;15: e007917. Retrieved from: https://www.ahajournals.org/doi/full/10.1161/CIRCOUTCOMES.121.007917.

of the survey and make the full reports available on CMS' website as well. CMS could consider compiling these reports and publishing them in one place on its own website, to make it easier to find and compare the reports of different states, or to evaluate the performance of a plan across various states.

We recommended shortening the timeframe for compliance for the appointment wait time standard by at least 3 years – from the first rating period beginning on or after four years following the rule's effective date to one year. We recommend the same shorter compliance timeframe to align across Medicaid and marketplace rules. Accelerating this requirement may not be particularly burdensome for many states because in 2017 a little over half of managed care plans reported already using secret shopper surveys. 3

Assurances of Adequate Capacity and Services—Provider Payment Analysis (§§ 438.207(b), 457.1230(b))

We strongly support CMS' proposals to require MCOs to disclose aggregate payment rates and to conduct provider payment analyses for certain services to provide enhanced information to states, and CMS, about access to services for managed care enrollees. Establishing a standardized, comparative data source available to assess Medicaid and CHIP payment rates will help improve

access over time.

Today, MCOs make assurances of adequate capacity and services to states, and states in turn make such assurances to CMS, based on little and untransparent information. The managed care plan payment analysis proposed in 42 CFR § 438.207(b) (and incorporated by reference into CHIP via 42 CFR § 457.1230(b)) is similar to the payment transparency and rate analyses simultaneously proposed in 42 CFR §447.203(b). Providing information both about the total amount paid by code as well as a comparison to Medicare rates will provide a relevant benchmark by which access can be assessed. We support the consistency in approach to generate similar information across fee for service and managed care delivery systems. Enhancing transparency about payment rates will not only help advance access by giving states and CMS important information they need to oversee the program but will also help advance quality of care; the proposals are consistent with requirements related to States' quality strategies to include examination of other aspects of care and service directly related to improvement in quality of care. We believe that this approach is consistent with sections 1903(m) and 1932 of the Act, and an important step to assure that Medicaid enrollees have access to services.

The proposal to require payment analysis related to OG/GYN, primary care, mental health, and substance use disorder services is an important starting point and we support the proposal to require separate pediatric and adult payment rates, where rates differ. While Medicare provides a ready benchmark for most services, we are concerned that comparing mental health and SUD services to Medicare could miss the mark since Medicare does not typically cover services that are common in

3 Rachel Garfield et al., Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans, KFF, March 5, 2018, https://www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-networks-and-access-to-care/.

Medicaid (like peer support services). Therefore, CMS should consider benchmarking these services to commercial plan rates. Alternatively, CMS could finalize the rule as proposed and also undertake a study to evaluate payment rates where there is no Medicare or commercial equivalent and compare access and outcomes based on payment rates for selected services.

The rule represents a strong starting point for transparency; once states and MCO begin to report under this rule, reporting could easily be extended to specialty services as well. The proposed analyses will provide important insights into Medicaid managed care enrollees' access to services, but only a partial view that CMS should expand over time.

For HCBS services, we support the proposal to require payment analysis related to the following services: homemaker services, home health aide services, and personal care services. We agree that these three services have high impact to help keep enrollees safely in the community and avoid institutionalization. We support adding in-home habilitation provided to enrollees with IDD in the analysis as well, as the same rationale applies.

We support CMS's proposal that managed care organizations submit their analysis to the state 180 days after the close of the rating period. We agree with CMS' rationale that this timing gives states and CMS ample time to adjust future rates before new contracts are approved, even if the analysis is based on partial claims data. CMS proposes that the payment analysis should go into effect 2 years after the rule is finalized; we recommend a one-year effective date if feasible.

Finally, we understand that this new proposed analysis will take time and resources for plans to

implement, but we strongly believe that the costs justify the benefits of conducting this analysis. Without standardized, transparent information that states, CMS, and stakeholders can study, it is impossible to truly measure – and improve – access to care.

Assurances of Adequate Capacity and Services Reporting (§§ 438.207(d), 457.1230(b))

We strongly support new requirements proposed in 42 CFR 438.207(d) that states use the new payment analysis proposed in 438.207(b) and the results of the secret shopper survey proposed in 438.68(f) as the basis for their required assurances to CMS regarding the availability of services and adequacy of their networks. More clearly specifying the basis upon which states will make required assurances to CMS will help assure compliance with standards set out in sections 1903(m) and 1932. The proposal that states create a state level payment percentage at the plan level and a weighted statewide average for each specified service type, will give states, and CMS, the ability to better assess access care.

CMS proposes that states would submit an assurance to CMS in a format prescribed by CMS, and that states would also be required to submit to CMS the payment analysis submitted by each plan, as required by proposed 438.207(b). We agree with this approach and recommend that all data be made available to the public, including disaggregated data with breakdowns by service types. We also urge CMS ensure that its template for state assurances include the supporting documentation so that all relevant information is available to enrollees and stakeholders.

We strongly support CMS' proposed requirement that states post their reports within 30 calendar days of submission; this will help avoid lag times and ensure that the data is more actionable. CMS should also consider posting reports on its own website to ensure that all reports and supporting documentation are readily available and can be compared across states.

We concur with the timeless for assurances and analyses proposed in this section; the compliance date should not be extended beyond what is proposed. Going forward, we strongly support requiring states to submit these reports to CMS within 180 days after the end of the rating period and to post these reports publicly within a month of submission of CMS; public posting is essential to ensure transparency and to help enrollees and stakeholders hold states and MCOs responsible for continuing to improve access to services for Medicaid enrollees.

Remedy Plans to Improve Access (§ 438.207(f))

Pairing the new MCO payment analyses, wait time standards, and secret shopper results with remedy plans is an important strategy to ensure that states appropriately respond to evidence that access to care is insufficient. We also support CMS's intent to align its approach to improving access in the managed care delivery system with the proposed fee-for-service corrective action plans in 447.208(b)(8).

Requiring that states submit remedy plans for CMS approval within 90 days of identifying an area where plans' performance under the access standard could be improved is an appropriate amount of time to give states time to consider reasonable and effective remedies. CMS's proposal to ensure that remedy plans clearly specify the responsible party to address issues as well as to ensure that improvements are measurable and sustainable will help hold states and managed care organizations responsible for improving access. We also support CMS' proposal to require quarterly reporting and to extend remedy plans, preferably with amendments to address the first year's failure to remedy the lack of access, for an additional year if changes are not observed. Of course, if access issues rise to the level of violations of access under the statute, CMS can and should disallow FFP as discussed in the preamble. We recommend that these plans be made public to advance

transparency and aid accountability; they could be added as a required element to be included at 42 CFR 438.602(g). Consumers should also have access to this information so they can make informed plan selections.
Given the importance of addressing identified access issues, we recommend that this provision go into effect no later than 3 years after the final rule goes into effect; this would give states a one-year gap between the effective date of the proposed payment analysis. Although the secret shopper analysis is not proposed to take effect until 4 years after the final rule's effective date, the remedy plans could take effect earlier and then account for secret shopper results once those are available.

Transparency (§§ 438.10(c), 438.602(g), 457.1207, 457.1285)
We strongly support CMS's proposals to ensure that information about the managed care delivery system is clear, user-friendly, and accessible, and that there is "one stop" shopping for people to find information in a clear, readable manner. Therefore, we strongly support CMS' proposed updates to 438.10(c) to improve website transparency and accessibility by requiring that states make all relevant information about their managed care delivery system available via one web page and that materials are clear and easy to understand. We also support the requirement the states validate the information no less than quarterly. Having accurate, accessible information is an important element of CMS' overall approach to advancing access by giving enrollees, advocates, and other stakeholders access to information they can use to assess access – including when making plan selections – and advocate for changes, when needed.

We also support CMS's proposal to more clearly specify materials that must be included in a single location on state websites at 42 CFR § 438.602(g). CMS notes that the only new items included in this reorganized rule are: the payment analysis report required by new 438.207(d); secret shopper results required by new 438.68(f), and State directed payment evaluation reports at 438.6(c)(2)(v)(c). As noted elsewhere in our comments, we support these new policies and agree that results and reports should be made public on managed care plan websites so that they are accessible.

However, we urge CMS to add a requirement that states post the Annual Medical Loss Ratio reports that Managed Care Organizations (MCOs) must submit to the state Medicaid agencies. These reports provide crucial information about how MCOs are spending money on items and activities other than providing services – including how much profit they are earning. Enrollees, providers, advocates, and other members of the public deserve to know how Medicaid capitated payments are being used.

Compliance with these website transparency and posting requirements no later than the first managed care plan rating period that begins on or after 2 years after the effective date of the final rule is reasonable.
Terminology (§§ 438.2, 438.3(e), 438.10(h), 438.68(b), 438.214(b))
We support CMS' proposals to update and modernize language in the regulations to better reflect current usage and clarity. We support changing references to "behavioral health" throughout 42 CFR Part 438 to explicitly capture both mental health and SUD, and we support changing references to "psychiatric" in § 438.3(e)(2)(v) and § 438.6(e) to "mental health" to capture the full spectrum of services that can be provided in an IMD. We recommend CMS adopt these changes in the companion Access Rule as well.

II. STATE DIRECTED PAYMENTS (§§ 438.6, 438.7, 430.3)

The proposed rule would more closely regulate state directed payments (SDPs), which allow states to direct managed care programs to make payments to providers deemed necessary to carry out state-defined objectives, including participation in value-based purchasing models and ensuring adequate provider payments, among other policies. SDPs are an exception to the general rule prohibiting states from directing expenditures by managed care plans to providers, and while they serve an important role in promoting access, we support the changes that CMS is proposing to advance both transparency and program integrity.

SDPs have become much more prevalent in state managed care programs since the 2016 managed care rule was issued. This growth is apparent just from comparing 2020 data included in the preamble against data that the Medicaid and CHIP Advisory Commission's (MACPAC's) recently released based on its review of directed payments approved as of February 1, 2023. MACPAC reports that between July 1, 2021 and February 1, 2023, CMS approved 249 distinct directed payment arrangements in 40 states, the District of Columbia, and Puerto Rico totaling $69.3 billion a year. [4] While SDPs can ensure that Medicaid managed care enrollees have adequate access to health care services by guaranteeing adequate payments to providers, particularly safety net providers, and can advance quality initiatives, they should be carefully bounded to meet these purposes and maintain the fiscal integrity of the Medicaid program.

CBPP generally agrees that the proposed rule strikes the right balance in giving states flexibility to design SDPs to meet their managed care goals while putting in place fiscal and program integrity guardrails to strengthen accountability, particularly as to how states finance their SDPs. We support the proposal to set standards for SDPs that would closely tie SDPs to utilization and quality and ensure adequate payments to providers without compromising the fiscal integrity of the program.

We are concerned, however, that the proposed rule does not go far enough to ensure transparency of Medicaid spending, as recommended by MACPAC. We agree with MACPAC that CMS should make SDP approval documents and rate certifications publicly available, along with evaluation reports as the rule does propose. We also agree with MACPAC that CMS should make provider-level payments publicly available in a standard format that enables analysis. All this information is needed to determine whether the payments are reasonable and whether they advance access and quality.

We share the concerns of MACPAC, the Office of the Inspector General (OIG) and the Government Accountability Office (GAO) about the rapid growth of SDPs and agree that they can reduce the risk managed care plans bear to effectively manage care. Moreover, without more effective regulation, it will remain unclear whether SDPs are in fact necessary to advance access and utilization for managed care enrollees. We would support a 10 to 15 percent limit on SDPs, which would allow states to advance their strategies while maintaining fiscal integrity for at least the period needed to assess the impact of better regulation and oversight.

4 MACPAC, "Directed Payments in Medicaid Managed Care," June 2023, https://www.macpac.gov/wp-content/uploads/2023/06/Directed-Payments-in-Medicaid-Managed-Care.pdf.

Our comments on specific provisions of the rule follow:

? Exempt minimum fee schedules based on Medicare payment rates. (§ 438.6(c)(1)(iii)). The rule would exempt minimum fee schedules set at 100 percent of Medicare rates in effect no more than three years prior to the start of the rating period. As the preamble notes, separate approval of these rates is unnecessary and duplicative given CMS' approval of the rates for Medicare. We agree that fee schedules below Medicare rates should be subject to approval, because they may not be adequate and could negatively impact access to care. And, regardless of whether approval is required, minimum fee schedules should be posted on the state's website.
? Extend SDPs to non-network providers. (§ 438.6(c)(1)(iii)). Allowing states to direct payments to non-network providers is especially important to assure access for managed care enrollees who may need to receive care from border state providers and non-participating specialty providers. We support this proposal as an important step to address access and promote health equity.
? Assure total payment rates to providers, including all SDPs, are reasonable, appropriate, and attainable and require states to provide documentation demonstrating the total payment rate. (§ 438.6(c)(2)(ii)). As the preamble notes, SDPs are now responsible for $48 billion in spending a year and they continue to grow. We therefore support the standards CMS is proposing for these payments, but we would go further in requiring even more transparency by making information on the payments available not just to CMS on request, but to the public. As the Regulatory Impact Assessment (RIA) accompanying the rule states, more robust regulation of SDPs is needed to ensure that they would be used to "meet state and federal policy goals to improve access and quality, used for the provision of services to enrollees under the contract, and improve fiscal safeguards and transparency."5 Increased transparency on the use of SDPs is needed to ensure that these objectives are realized, particularly because, as discussed below, allowing rates to exceed Medicare rates, as the rule proposes, would increase overall costs according to the RIA.
? Establish a total payment limit at the average commercial rate (ACR) for inpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center. (§ 438.6(c)(2)(iii)). The proposed rule would further define "reasonable, appropriate, and attainable" by limiting payments to the ACR for certain services. We agree that these are the appropriate services to cap given they are the services most likely to be services where SDPs do not directly tie to access and utilization of covered services and the services where states have been most likely to pay above the Medicare rate. The preamble notes that capping these services at the ACR would balance the need for fiscal guardrails while providing states flexibility to pursue delivery system reforms that advance access and quality. But, as the preamble notes, it could also provide an incentive for states to raise rates to a level beyond what is needed to assure access and quality and facilitate redistribution arrangements among providers.

5 88 Fed Reg 28092 at 28229.

Given the prevalence of Medicare beneficiaries utilizing hospitals and nursing homes, it is difficult to understand why a higher payment limit would be needed for Medicaid. Moreover, Medicare is the limit for fee-for-service payments to hospitals and allowing higher payments in managed care may skew state decision-making on how to structure their programs. This has reportedly already occurred in Kentucky where the state decided not to move to an administrative services organization model because of provider objections to the lower Medicare rates.
If a cap at the ACR is allowed for these services, the state should fully document the

necessity of rates above Medicare and show that the rates are needed to assure access and quality. To avoid SDPs that are excessive and not tied to access and utilization, we support the proposed rule's requirement that providers attest that they do not participate in direct or indirect hold harmless arrangements (as discussed in more detail below). If payment rates at the ACR are needed to achieve access and quality, states should be allowed to ensure MCOs pay providers accordingly, but SDPs should not be a vehicle for hold harmless arrangements, which transfer funds from providers with a greater share of Medicaid patients to those with fewer such patients.

Finally, CMS seeks comment on whether there should be an overall expenditure limit for SDPs to help support fiscal protections and ensure that plans continue to have incentives to manage risk. Particularly if a cap at the ACR is allowed, we would support a 10 to 15 percent limit on SDPs, for at least the time period needed to assess the impact of better regulation and oversight. Capping SDPs at this level would allow states to advance their strategies while maintaining fiscal integrity and giving CMS a chance to determine the impact of its proposed regulations. For example, if a cap is later determined to divert needed funding away from safety net providers that serve a high volume of Medicaid enrollees, it would be important to revisit the standard.

? Add standards for financing of SDPs. (§ 438.6(c)(2)(ii)(G) and (H)). The proposed rule would explicitly require that SDPs comply with all federal financing requirements for the non-federal share of the payments and require that providers receiving SDPs attest that they do not participate in hold harmless arrangements with respect to any provider tax. These standards are intended to address increasingly prevalent arrangements whereby providers with a high volume of Medicaid patients redirect payments they receive to providers with fewer or no Medicaid patients to hold them harmless from the tax they paid.

While these arrangements may ensure support for a provider tax among the designated, broad-based provider class, we agree with CMS that they are a prohibited hold harmless arrangement that undermines the fiscal integrity of the Medicaid program. As the preamble notes, by redirecting Medicaid payments away from providers serving a high percentage of Medicaid enrollees to those who don't, "these arrangements reward providers based on their ability to fund the State share, and disconnect the Medicaid payment from Medicaid services, quality of care, health outcomes, or other Medicaid program goals." 6

We agree with CMS that regardless of how Medicaid payments are made, whether directly for services or through SDPs, they should be tied to the services received by enrollees and

6 88 Fed Reg 28092 at 28131.

be at a rate that is adequate but not excessive. When payments are redirected to providers to compensate them for the tax they paid, these payments are not benefiting Medicaid enrollees. Such payments also suggest that the payment rates may be higher than what is needed to assure adequate access and quality or, in the alternative, that they are being redirected in a way that undermines access and quality.

The Medicaid statute clearly prohibits these types of arrangements in section 1903(w)(4) of the Social Security Act, which defines a hold harmless arrangement in part as when "the State or other unity of government imposing the tax provides (directly or indirectly) for any payment offset, or waiver that guarantees to hold taxpayers harmless for any part of the costs of the tax." We agree with CMS that the inclusion of the word "indirectly" in the statute and implementing regulations means that this prohibition includes situations where the state does not itself make the expenditure. Hold harmless agreements among providers are prohibited regardless of whether the state is a party to the agreement. It is therefore allowable and necessary for CMS to take steps to ensure that SDPs being financed by

provider taxes are not being used to facilitate hold harmless arrangements.
Finally, we think the proposed compliance date for the provider attestation in 438.6(c)(2)(ii)(H) should be shorter. This provision would not take effect until the first rating period on or after 2 years of the effective date of the rule. We recommend that this provision take effect in the first rating period on after one year of the rule's effective date.
? Require that SDPs be based on the utilization and delivery of services during the rating period. (§ 438.6(c)(2)(vii)). The proposed rule clarifies that SDPs that direct managed care plans to reimburse providers at a set schedule must be based on the delivery of services during the rating period. This would prohibit a practice whereby states provide funding to managed care plans based on historical utilization, reconcile the payments based on utilization during the rating period, and then amend the SDPs to allow the managed care plans to keep the original payments rather than refund any overpayments they received. We agree that this practice undermines the actuarial soundness of the rates paid to managed care plans and absolves them of risk. Moreover, it does not benefit Medicaid enrollees, because the excess payments are not tied to the services they received.
? Address barriers to the implementation of value-based purchasing (VBP). (§ 438.6(c)(2)(vi)). We support changes to the rule, which are intended to facilitate VBP initiatives while strengthening the link between SDPs and quality of care. States should be allowed to recoup payments from managed care plans when performance targets are not met so that plans do not profit from poor performance on the part of plan providers.
? Strengthen requirements for evaluation of SDPs (§§ 438.6(c)(2)(ii)(D) and (F), (c)(2)(iv) and (v), and (c)(7)). The proposed rule would strengthen requirements for evaluation of SDPs to help CMS determine whether they do, in fact, advance a state's managed care quality strategy. As the preamble notes, there is low compliance with existing requirements. We agree that all SDPs requiring prior approval should have an accompanying evaluation plan that includes at least two metrics to measure its effectiveness along with baseline statistics on the chosen metrics. However, we would not limit the requirement of an evaluation report to just SDPs that end up with a directed payment cost payment

above 1.5 percent. Given the history of inadequate compliance with evaluation requirements, requiring a plan without a report falls short of what is needed to allow CMS and the public to determine whether an SDP is meeting its intended purpose on renewal of the SDP. We agree that a more robust evaluation, including the use of an independent evaluator, is appropriate for SDPs with higher costs, but we recommend that CMS require submission of an evaluation report for each SDP.
We also would have a shorter timeline for evaluation reports. As currently drafted, the first evaluation report would not be due until five years after the SDP was first approved, and the evaluation requirements of the proposed rule would not even take effect until the first rating period beginning on or after 3 years of the final rule's effective date. The long timeline for reports coupled with the extended period for compliance would allow ineffective and potentially wasteful SDPs to continue over multiple approval periods. We suggest that the first report cover two years and be due within one year after that and that subsequent reports cover a two-year period and that the evaluation requirements become effective for the rate period beginning one year after the rule's effective date.
We agree that the evaluation reports be posted on the state's website, but we suggest that CMS also post them on its website to allow for easy comparison across states.
? Specify the information on SDPs that must be included in managed care contracts, including for separate payment terms. (§ 438.6(c)(5) and (6)). We support the detailed requirements regarding the information that must be included in managed care contracts,

which would differ based on the type of SDP. All this information should be available to the public.
? Establish a process for disapproval of SDPs and state appeals of disapprovals. (§ 430.3(d)). Currently, there is no process for CMS to formally disapprove a state's SDP request. We support the proposal to establish such a process by allowing disputes concerning SDPs to be heard by the HHS Department Appeals Board utilizing the Board's well-established procedures.
? Set new reporting requirements to support oversight. (§ 438.6(c)(4)). With the increasing importance and prevalence of SDPs, we agree that there is a need for greater transparency and oversight to ensure that they are advancing quality and access and maintaining program and fiscal integrity. As both GAO and MACPAC have recommended there is especially a need for provider-level expenditure data. This information is needed as quickly as possible, so we agree with the proposed rule's strategy of first requiring that SDP information be provided as part of a state's MLR report and that subsequently the information be reported through the T-MSIS system.

III. MEDICAL LOSS RATIO (MLR) STANDARDS (§§ 438.8, 438.3, AND 457.1203)

We support changes to existing MLR standards to bring enhanced transparency to Medicaid managed care expenditures and to hold managed care organizations accountable for the use of Medicaid funds. We also support proposals to align MLR reporting with recent changes to

Marketplace MLR reporting standards. 7 As these policies are finalized, it also is imperative that CMS follow through on its plans to publicly post MLR reports on its website. Transparency in state and MCO spending is essential and CMS should commit to robust and public MLR reporting.
Standards for Provider Incentives (§§ 438.3(i), 438.8(e)(2), 457.1201, and 457.1203)
We support changes to require states, through their contracts with managed care plans, to include more details on provider incentive contracts. Defined performance periods, and signatures before the applicable performance period are key, as is the proposed requirement to include well-defined quality improvement or performance metrics that the provider must meet to receive the incentive payment, and to specify a dollar amount that can be clearly linked to successful completion of payment. Implementing this requirement for rating period that being on or after 60 days following the effective date of the final rule is appropriate to promote program integrity and transparency.

We also support proposed changes to align provider incentive arrangements in Medicaid with recently finalized Marketplace regulations at 45 CFR 158.140(b)(2)(iii). We support changes to specify that only provider incentives and bonuses that are tied to clearly defined, objectively measurable and well documented clinical or quality improvement standards that apply to providers may be included in incurred claims for MLR reporting. Applying the same standards across delivery systems will promote efficiency as well as transparency into how federal and state funds are being spent. These are important goals and should be implemented as soon as possible. We support the proposal to implement these changes within 60 days of the final rule (rather than the rating period that begins on/after 60 days from final rule).

Prohibited Costs in Quality Improvement Activities (§§ 438.8(e)(3) and 457.1203(c))
Similarly, we support alignment of Medicaid and Marketplace standards with the proposed elimination of the inclusion of indirect or overhead expenses that are not directly related to health care quality improvement. We agree with CMS that this would improve MLR reporting consistency, allow for better MLR data comparisons between Marketplace, Medicaid and CHIP markets, and reduce administrative burden for plans that participate across multiple delivery systems. We support

making this change effective 60 days after effective date of the rule to promote administrative efficiency and fiscal integrity.

Level of MLR Data Aggregation (§§ 438.74 and 457.1203(e))

To ensure that MLR reporting supports the goals of transparency reflected throughout this rule, we support the proposed clarification to ensure that MLR information is listed for each managed care plan, not aggregated across the state. Since this is a clarification of prior rulemaking, we agree with CMS's proposal to make this change effective 60 days after the final rule is published to bring greater clarity and accuracy to MLR reporting.

7 CIB: Guidance for States on the Availability of an Extension of the Enhanced Federal Medical Assistance Percentage (FMAP) Period for Certain Medicaid Health Homes for Individuals with Substance Use Disorders (SUD).

Contract Requirements for Overpayments (§§ 438.608(a)(2) and(d)(3), and 457.1285)

We concur with CMS's' goal of assuring that the MLR numerator excludes overpayments to prevent otherwise inappropriate inflation of MLR. We therefore support proposed changes to define "prompt" reporting of overpayment data as requiring reporting within 10 days of identifying or recovering an overpayment; we would recommend further clarification to recommend reporting within 10 days of identifying the overpayment, even if recovery takes longer. We also support clarifications of previous rulemaking to be clear that any overpayment (whether identified or recovered) must be reported by MCPs to the state. Both provisions are important clarifications to improve program integrity and should be finalized and effective 60 days after the effective date of the rule.

Reporting of SDPs in the Medical Loss Ratio (MLR) (§§ 438.8(e)(2)(iii) and (f)(2), 438.74, 457.1203(e) and (f))

As discussed elsewhere in these comments, we support CMS' efforts to bring enhanced transparency to the use of SDPs and support CMS reporting requirements that will help improve CMS' understanding of provider-based payment across delivery systems. One important element of that strategy is to require new reporting requirements for both state and managed care plan reporting of actual SDP expenditures. We support CMS's proposal to require plans to include SDPs and associated revenue as separate lines in MLR reports and support making these requirements 60 days after the rule is finalized.

IV. IN LIEU OF SERVICES AND SETTINGS (ILOS) (§§ 438.2, 438.3, 438.7, 438.16,438.66, 457.1201, 457.1207)

In lieu of services and settings (ILOS) are an important strategy that states are increasingly using to address unmet health related social needs (HRSN). The proposed definition and changes in 42 CFR §§ 438.3, 438.7, 438.16, and 438.66 codify subregulatory guidance issued earlier this year and clarify standards previously reflected in CMS' approval of an expanded range of ILOS in California. We support finalizing this framework as proposed, as it appropriately balances more flexibility to address HRSN with guardrails to protect enrollees' access to underlying state plan services, spending transparency, and appropriate financial controls on overall Medicaid spending on HRSN.

We particularly support CMS's changes, including a new definition at 438.2, to clarify that ILOS refer to both services and settings, that ILOS may be used as either an immediate or long-term substitute for state plan services or to reduce or prevent the need to utilize covered services or settings. These clarifications will help ensure that state and managed care organizations can use ILOS to respond to unmet social needs in a manner that will help prevent longer-term health care needs while also retaining important guardrails, like the continued prohibition on Medicaid spending for room and board.

We also support CMS' reinforcement that ILOS are voluntary for both the managed care organization and enrollees and especially support the inclusion of details (in 438.3(e)(2)(ii)(A)-(B))

about enrollee protections, including the availability of appeal rights. As states and MCOs adopt ILOS, it will be important for CMS to oversee implementation to assure that the availability of ILOS does not undermine financial support for or in any other way impede access to state plan services and settings that enrollees may prefer.

The standards that CMS is proposing in 438.16 to establish an ILOS cost percentage, to limit overall spending on ILOS to 5 percent of total capitation payments for each managed care program, and to apply more rigorous monitoring standards if ILOS spending exceeds 1.5 percent of capitation should be finalized as proposed. These standards are an appropriate starting place to ensure that ILOS do not crowd out state investments in underlying state plan services and to ensure that ILOS spending beyond de minimis amounts is carefully monitored. Clear and consistent standards are important and should not vary across states until CMS has developed an evidence base to inform the selection of alternate standards.

We also support the various requirements that CMS is proposing (at 438.16(d)(1)) to document that ILOS are medically appropriate and cost-effective substitutes. We also support robust evaluation requirements as proposed (at 438.16(e)), including proposals to evaluate the impact that ILOS have on quality of care and health equity efforts undertaken by the state to mitigate health disparities. Finally, we support the proposal to require state to notify CMS within 30 days if they identify that an ILOS is no longer cost-effective; we agree that is important to correct course quickly, so long as enrollees have adequate notice that services they may depend on will be ending and are transitioned to other appropriate services.

Given the interest states have in addressing unmet social needs, and steps states have already taken to do so consistent with CMS's aforementioned guidance, we support the proposed 60-day effective date for these changes.

V. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM, STATE QUALITY STRATEGIES AND EXTERNAL QUALITY REVIEW (§§ 438.330, 438.340, 438.350, 438.354,438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250)

We enthusiastically support proposed provisions to boost accountability, transparency, and participant input into managed care oversight systems, including changes that will make quality data more accessible, reduce data lags, and allow for more participant input into quality strategies and core measure review.

Managed Care State Quality Strategies (§§ 438.340, 457.1240)

The rule proposes important changes to increase transparency and the opportunity for meaningful ongoing public engagement around states' managed care quality strategies. We support proposed changes, to be effective no later than one year after the effective date of the rule, to increase opportunities that interested parties have to provide input into the development of the managed care quality strategy; to clarify that the state agency must post on its website results of

three-year reviews; and to revise standards for when states must submit quality strategy to CMS so CMS can give feedback before strategies are finalized or when changes are made.

External Quality Review (§§ 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250)

We support CMS's goal in this section to eliminate unnecessary and burdensome requirements and to make EQRs a more meaningful tool to drive quality improvement.

We comment specifically to endorse inclusion of an optional EQR activity to support current or proposed managed care evaluation requirements related to ILOS and SDPs. These are growing areas of investment in Medicaid managed care and it is important that quality and outcomes be assessed. Adding an optional EQR activity would give states access to technical assistance to support stronger evaluation methodologies and would enable states to claim enhanced match for important evaluation activities. Finally, to support program integrity, we also support CMS' clarifications regarding non-duplication of mandatory EQR activities with Medicare or accreditation reviews.

VI. QUALITY IMPROVEMENT – QUALITY RATING SYSTEM (§§ 438.334 AND 457.1240 AND NEW 438 SUBPART G)

We support new 438 Subpart G, which would bring much-needed transparency to the Medicaid managed care delivery system and would create a new and valuable tool for enrollees to compare plans in an accessible, user-friendly way. We appreciate CMS's work to pre-test web prototypes for the new Quality Rating System (QRS) with Medicaid enrollees and believe the prototypes will help facilitate states' adoption of the QRS, once finalized. Overall, we strongly believe that it is essential for stakeholders to have access to transparent and representative quality ratings and conclude that the data collection and calculation responsibilities that states would have to undertake if the rule is finalized are well-justified by the benefits the information will yield for enrollees and stakeholders.

Here, as in other parts of the proposed rule, we support aligning Medicaid and CHIP standards, to the extent practicable, with QHP and MA/Part D standards; therefore we support proposed 438.505(c) align the mandatory measure set to the extent appropriate across CMS quality measurement and rating initiatives, so long as benefits and services unique to the Medicaid/CHIP population are included in the QRS so that this new system can be maximally beneficial to Medicaid enrollees.

We agree with the standards that CMS has set for the website display, and also support the subregulatory process CMS proposes to use to make updates to required quality measures over time. Although the information collection request analysis suggests that the costs of implementing the new QRS will be high, we strongly believe that the costs justify the benefits; today, enrollees do not have sufficient information about the benefits that MCOs provide or the quality of their services. Creating a more transparent, consistent system is an important investment that will help improve health for millions of Medicaid enrollees.

Proposed 438.525 would require states to obtain input from the state's Medical Care Advisory Committee prior to submitting a request for (or modification of) an alternative Medicaid managed care quality rating system to CMS. We support requiring this input and recommend that the reference to the MCAC in 438.525(b)(1) be updated to align with proposed changes to 431.12, renaming the MCAC as the Medicaid Advisory Group, and creating a new Beneficiary Advisory Group. Both entities should be consulted in the development of an alternative quality rating system.

The proposed 4-year timeline to launch the QRS would give states ample time to launch the new system and should not be extended.

While we appreciate that HHS proposes milestones (in 42 CFR 438.520(a)(6)) for states to begin reporting measures stratified by race and ethnicity, we urge CMS to consider a more ambitious scope and timeline to make clear to states that health equity is a major priority for the federal government. Therefore, we recommend reducing the timeline for states to report all required stratified measures (including age, language, and geographic region) to no more than 4 years. We also recommend expanding the scope of populations on which states should expect to report by identifying a mechanism to more easily flag disability; we recommend required reporting of report core measures by disability status to help identify challenges that many people with disabilities face accessing routine preventive care and treatment for chronic conditions. Following HHS's own commitments in the CMS Framework for Health Equity and HHS's LGBTQ+ Evidence Agenda, CMS also should require states to include sexual orientation/gender identity/sexual characteristics as one of the demographic factors used to stratify Quality Rating Systems results.

When new measures are selected, we support giving states at least two calendar years from the start of the measurement year immediately following release of the technical manual before new measures have to be displayed (438.510(f)).

VII. IMPLEMENTATION AND COMPLIANCE TIMELINES

In response to CMS' requests for input on the appropriate compliance dates for various provisions in this proposed rule, we urge CMS to finalize the rule quickly with staggered compliance dates. We recommend that CMS prioritize compliance dates for provisions that are clarifications of existing requirements, and thus should require less effort to implement, 60 days after the final rule is published. For other requirements, our recommendations are included above.

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VIA ELECTRONIC TRANSMISSION

June 30, 2023

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Secretary Becerra,

Thank you for the opportunity to comment on, "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality; Proposed Rule - CMS-2439-P," hereinafter referred to as the "proposed managed care rule." The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

We broadly support the framework of CMS's proposed managed care rule; our comments include suggestions below to improve it. We strongly support CMS's efforts to improve access in Medicaid managed care, bring transparency and public reporting to managed care spending, improve quality systems, and facilitate the use of "in lieu of services" to address health-related social needs. We urge CMS to implement regulatory provisions on a faster timeline to begin improving access as soon as is feasible. We also recommend that CMS consider how it can pursue policies that promote alignment across fee-for-service and managed care, using this proposed regulation and the companion proposed access rule as an opportunity for alignment. CMS should also consider how it can, through these regulations: 1) improve access by setting Marketplace policies as minimums for Medicaid, and 2) align Medicaid payment rates with Medicare. Finally, we recommend that CMS consider how it can design network and payment policies to level the playing field in managed care and improve access to primary, pediatric, and maternity care.

I. Access

We support the provisions of the proposed rule intended to ensure that Medicaid beneficiaries enrolled in managed care organizations (MCOs) have access to the services they need and to which they are entitled. We have a number of recommendations for strengthening some of those provisions.

a. Information requirements (§§ 438.10 (c), 457.1207)

Current regulations require that the state Medicaid agency operate a website that provides certain specified information, either directly or by linking to individual MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity websites. The proposed rule would require that state agencies include all content, either directly or by linking to individual MCO, PIHP, PAHP, or PCCM entity websites, on one web page; include clear and easy-to-understand labels on documents and links; verify at least every three months the accurate function of the website and the timeliness of the information presented; and explain that assistance in accessing the information on the website, including oral interpretation and written translation, is available at no cost. These requirements would become effective for the first rating period beginning two years after the effective date of the final rule.

We strongly support the proposed requirements for one web page; clear and easy-to-understand labels; quarterly verification of the accurate function and timeliness of information; and the availability of assistance. However, we do not believe that it is appropriate for a state Medicaid agency to outsource its transparency obligations to its contracting MCOs through the use of links to their websites. There should be one source of required information at the state level for beneficiaries and other stakeholders and the public: the state Medicaid agency website. Navigating multiple websites makes it challenging for enrollees and assisters to make comparisons across plans.

We do not object to the state Medicaid agency providing links to the websites of its MCOs and other contractors, but those links should not be allowed as a substitute for the state posting all required information on the agency website. We note that the requirements for one webpage, understandability, quarterly verification, and availability do not apply to the websites of MCOs or other contractors, raising questions about the user-friendliness of those websites. Referring beneficiaries and other stakeholders to MCO and other contractor websites increases barriers to the required information and shields the state agency from accountability for making the required information readily accessible to beneficiaries and the public at large.

Finally, the proposed implementation timeframe is too long. Assuming the effective date of the final rule is May 3, 2024 (one year from publication of the proposed rule), the earliest these requirements would apply is July 1, 2026. There is no reason why state Medicaid agencies cannot operate compliant websites by January 1, 2025.

Recommendations:

Revise § 438.10(c)(3) to read as follows:
"(3). The State must operate a website that provides the content specified at § 438.602(g) and elsewhere in this part. States must: (i) Include all content on one web page; ***

Revise the first sentence of § 438.10(j) to read as follows:
"States will not be held out of compliance with the requirements of paragraph (c)(3) of this section prior to January 1, 2025, so long as they comply ***"

b. State monitoring requirements (§ 438.66(e))

Current regulations require that states submit to CMS within 180 days after each contract year a report on each managed care program administered by the state (MCPAR). The

regulations specify ten items of information the MCPAR(s) must contain. The proposed rule would add two additional items: the availability and accessibility of any in lieu of services (ILOS) within the MCO, PIHP, or PAHP contracts, and the results of an enrollee experience survey. The proposed rule would also require that the state agency post the MCPAR(s) on its website within 30 days of submitting it to CMS.

We support the inclusion of ILOS and enrollee experience survey results in the MCPAR and the requirement that state agencies post MCPARs within 30 days of submission to CMS. However, we are unclear on the effective date of the posting requirement with respect to current MCPARs. Under the current MCPAR submission schedule, all states are required to submit their first reports by September 27, 2023. Presumably, all of the second reports will be submitted by the end of September 2024. There is no reason why state Medicaid agencies cannot post their first two MCPAR reports by January 1, 2025.

In addition, based on past noncompliance on the part of some states with the current posting requirements,[1] we do not believe that this state posting requirement is sufficient to ensure beneficiary and other stakeholder access to the MCPAR(s) in all states. As a practical matter, CMS does not have the capacity to monitor and enforce compliance with this posting requirement by all managed care states; CMS does, however, have the capacity to post on Medicaid.gov the MCPARs it receives from each state, and it should do so. That will ensure that beneficiaries and other stakeholders in states that do not comply with the posting requirement will still have ready access to the MCPARs. It will also make an important statement that the information in these reports is important, that public access to these reports matters, and that CMS has a role to play in ensuring their full transparency for stakeholders in all states.

1 Corcoran, A. et al., "Transparency in Medicaid Managed Care: Findings from the 13-State Scan," (September 2021), https://ccf.georgetown.edu/wp-content/uploads/2021/09/MCO-13-state-scan-v3.pdf, at p. 15.

Recommendations:

Revise § 438.66(e) to add a new paragraph (4) to read as follows: "(4) CMS will post on the agency's Medicaid website each annual report submitted to CMS under paragraph (e)(1) within 30 days of receipt."

Revise proposed § 438.66(f) to add a sentence at the end to read as follows: "The requirement of paragraph (e)(3)(i) is effective January 1, 2025."

c. Network adequacy standards (§§ 438.68, 457.1218)

Current regulations require that state Medicaid agencies develop a quantitative network adequacy standard for each of seven provider types (if their services are covered by the MCO's risk contract) taking into consideration nine different elements. These quantitative standards may include appointment wait times. States may permit exceptions to any of their standards based on the number of providers of a given type practicing in an MCO's service area. State agencies are required to post their standards on their websites.

The proposed managed care rule would require states to establish and enforce appointment wait time standards for routine visits to primary care providers, both pediatric and adult (15 business days from request), obstetrics and gynecological

(OB/GYN) providers (15 business days from request), and outpatient mental health and substance use providers, both pediatric and adult (10 business days from request). For each standard, compliance would be defined as a 90 percent rate of appointment availability as determined by the results of secret shopper surveys for which states would be required to contract with an independent entity. Critically, the results of secret shopper surveys would have to be submitted to CMS and posted on the state agency's website. In permitting exceptions from the standards, states would be required to consider the payment rates offered by the MCO for the provider type for which the exception is sought. The requirements relating to appointment wait time standards would be effective the first rating period beginning on or after three years after the effective date of the rule. The requirement for contracting with independent entities to conduct secret shopper surveys would be effective the first rating period beginning on or after four years after the effective date of the rule.

We support all of the proposed changes described above except for the effective dates, which are much too delayed. The current regulations have demonstrably not produced robust provider networks that result in broad access to covered services by all MCO enrollees. 2 A recent Kaiser Family Foundation survey of health insurance consumers, including 815 adults with Medicaid coverage, found that one third of those with Medicaid coverage reported that a doctor who is covered by their insurance and whom they need to

2 Ludomirsky, et al., "In Medicaid Managed Care Networks, Care is Highly Concentrated Among a Small Percentage of Physicians," 41 Health Affairs (May 2022) https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.01747?journalCode=hlthaff.

see did not have available appointments. 3 The minimum appointment wait time standards, combined with monitoring by secret shopper surveys and the posting of the survey results, have the potential to improve MCO provider networks, thereby increasing enrollee access to needed care. This approach can and should be improved with three additional changes.

First, while the proposed rule represents a welcome effort to align Medicaid and Marketplace Qualified Health Plan (QHP) standards, adding appointment wait time standards specific to OB/GYNs to those for primary care and mental health and substance use disorder services, more alignment is needed with respect to time and distance standards and appointment wait times for specialty care. The Medicaid network adequacy standards should be more closely aligned with those in the federally-run Marketplaces, with the Marketplace standards serving as a bare minimum standard for Medicaid. In some cases, the Medicaid population may have higher needs and, in many cases (due to lower income eligibility levels), less ability to pay out of pocket to access an urgent service. Thus, Medicaid may need to have a higher standard. Medicaid's standard should never be lower than the Marketplace.

Marketplace plans are required to adhere to over 40 different time and distance standards at the individual provider level (e.g., OB/GYN) and at the facility level (e.g., intensive care units) that vary by county population size and density. 4 Uniform time and distance standards should be applied to Medicaid managed care too. CMS could implement such standards over time, starting with critical services such as primary care (adult and pediatric), OB/GYN and outpatient clinical behavioral health as is proposed elsewherein the rule. The proposed rule also does not include the minimum wait time standard of 30 business days for a non-urgent visit to specialists that will also apply to QHPs in Plan Year 2025, 5 thus we recommend that requirement be added to Medicaid.

There is no principled rationale for such disparate treatment of Medicaid beneficiaries and

QHP enrollees, either with respect to the specific wait time or time-and-distance standards, or with respect to the effective dates. A scan of state Medicaid programs found that between 2017 and 2020 most states (90 percent) used time and distance standards and the large majority (75 percent) used appointment availability standards,[6] so in most cases states already have the necessary operational experience and would only need to adjust to the federal minimum, if at all. Moreover, non-alignment could prove particularly problematic in states where insurers offer products in both the federally-run Marketplace

3 Politz, et al., "KFF Survey of Consumer Experiences with Health Insurance," (June 15, 2023), https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/.
4 CMS, "2023 Final Letter to Issuers in the Federally-facilitated Exchanges" (April 28, 2022), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf.
5 HHS, "Notice of Benefit and Payment Parameters for 2024," 88 FR 25740 (April 27, 2023) at 25879, https://www.govinfo.gov/content/pkg/FR-2023-04-27/pdf/2023-08368.pdf.
6 Zhu, et al., "Variation in Network Adequacy Standards in Medicaid Managed Care," Am. J. Manag. Care (June 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9236159/.

and Medicaid and, because of the difference in wait time as well as time-and-distance standards, cause them to focus on compliance by their QHP provider networks, giving less priority to the accessibility of providers in the provider networks of their Medicaid product.

Second, the requirement that the entities contracting with the state to conduct secret shopper surveys be independent of the MCOs, PIHPs, or PAHPs subject to the surveys needs to be tightened. As proposed, an entity would be considered independent of an MCO, PIHP, or PAHP subject to the secret shopper surveys if the entity is not an MCO, PIHP, or PAHP, is not owned or controlled by any of the MCOs, PIHPs, or PAHPs subject to the surveys, and does not own or control any of the MCOs, PIHPs, or PAHPs subject to the surveys. This limited definition of independence does not exclude entities that may have some kind of contractual relationship with any of the MCOs, PIHPs, or PAHPs subject to the surveys. It also would not exclude any person who is an owner, employee, or consultant of the entity, and also contracts with, or has a direct or indirect financial interest in, any of the MCOs, PIHPs, or PAHPs subject to the surveys. These obvious loopholes would compromise the independence of the entity conducting the secret shopper surveys.

Third, the effective dates for implementation of the minimum appointment wait time standards are far later than those for the federally-run Marketplaces. Assuming the rulemaking process on this proposed rule takes one year, the effective date of the final rule would be May 3, 2024, and the proposed effective date for the minimum appointment wait time standards would be the first rating period three years after that, or July 1, 2027 at the earliest (some states have later rating period start times). This would leave Medicaid enrollees in MCOs without the same minimum wait times for at least two and one-half years.

Recommendations:

Alignment with QHPs—

Revise proposed § 438.68(b)(1) by adding at the end the following: "The quantitative standards developed by the State with respect to the provider types specified in paragraphs (b)(1)(i), (b)(1)(ii), and (b)(1)(iii) of this section must be at least as stringent as the time and distance standards established by the Federally-facilitated Exchange under 45 CFR § 156.230(a)(2)(i)(A)." This language would align Medicaid and Marketplace time and distance standards for primary care, OB/GYN, and outpatient clinical behavioral health providers.

Revise proposed § 438.68(e)(1) by redesignating paragraph (e)(1)(iv) as (e)(1)(v) and inserting a new paragraph (e)(1)(iv) to read as follows: "If covered in the MCO's, PIHP's, or PAHP's contract, non-urgent specialty care within State-established time frames but no longer than 30 business days from the date of request." This language would add the appointment wait time standard in the federally-run Marketplace for non-urgent specialty care to the other two Marketplace appointment wait time standards that state Medicaid agencies must, at a minimum, apply.

Revise proposed § 438.68(f)(3)(ii) to read as follows: "An entity will be considered independent of an MCO, PIHP, or PAHP subject to the secret shopper surveys if: (A) The entity is not such an MCO, PIHP, or PAHP, is not owned by such an MCO, PIHP, or PAHP, and does not own such an MCO, PIHP, or PAHP; (B) The entity does not contract with such an MCO, PIHP, or PAHP, or with any subcontractor of such an MCO, PIHP, or PAHP; (C) No person who is an owner, employee, or consultant of the entity contracts with, or has a direct or indirect financial interest in, any of such MCOs, PIHPs, or PAHPs.

Revise proposed § 438.68(h) by striking "on or after 3 years after" each time it appears and inserting in lieu thereof "on or after 1 year after." This language would align the effective dates for time and distance standards, appointment wait time standards, and publication of network adequacy standards with the latest effective date for network adequacy standards in the federally run Marketplace, Plan Year 2025.

We also suggest a few other improvements. First, we recommend that CMS develop protections to ensure that providers are not held liable if and when wait time standards are not met. The purpose of these new standards is to improve managed care plan contracting, not to create a basis for plans to punish providers. While neither plans nor providers may be in the position to "fix" a true provider shortage, only managed care plans control the capacity of the network. Thus, providers should not be held liable or otherwise punished when network adequacy standards are not met. Second, we recommend that CMS define "routine" in order to support a national standard rather than allowing states to define this term. Third, we recommend that CMS continually evaluate whether the proposed wait time standards (10 days for mental health and substance use providers and 15 days for primary care and OB/GYN providers) are sufficient to promote access to needed services. Some states have already imposed tighter standards, such as shorter wait times for high-risk pregnancies.

d. Assurances of adequate capacity and services (§§ 438.207, 457.1230)

Current regulations require that each MCO, PIHP, and PAHP provide to the state Medicaid

agency documentation that demonstrates that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. The state agency, in turn, is required to submit to CMS an analysis that supports the assurance of the adequacy of the network of each MCO, along with supporting documentation.

The proposed rule would require that each MCO, PIHP and PAHP submit a "payment analysis" to the state Medicaid agency that compares the total amount paid by the plan for evaluation and management (E&M) codes for primary care, OB/GYN, mental health, and substance use disorder services during the prior rating period with the total that would have been paid by the plan if the plan had used published Medicare payment rates for those services. The state agency, in turn, would be required to include these payment analyses in the analysis it must submit to CMS and to post its analysis on the state agency's website

within 30 calendar days of submission. These new requirements would apply for the first rating period for contracts beginning on or after two years after the effective date of the final rule, except that the posting requirement would apply one year after.

We strongly support the provisions of the proposed rule relating to payment analysis, especially the requirement that percentages must be reported separately if they differ between adult and pediatric services. These provisions would begin to bring transparency to the sufficiency of payment rates to network providers furnishing primary care, OB/GYN, and mental health and substance use disorder services. Insufficient payment rates effectively guarantee inadequate provider networks; these payment analyses have the potential to flag insufficient rates and to allow stakeholder comparison of payment rates as a percentage of Medicare rates among MCOs within the same state and from state to state. We have six recommendations for strengthening these proposals.

First, there should be a clear timeframe for submission of the payment analysis by each MCO to the state Medicaid agency; we recommend no later than 90 calendar days after the end of the rating period. We recommend that the state Medicaid agency be required to submit its certification of network adequacy to CMS on the same timeframe as it is required to submit its MCPAR under § 438.66(e)(1): 180 days after each contract year. These timeframes will allow the state agency to review the payment analyses, submit its certification to CMS, and take another six months to make any necessary adjustments in the payment rates for the following rate period.

Second, in the preamble to the proposed companion access rule, CMS indicates the agency will publish the E&M codes to be used for the payment rate analysis in subregulatory guidance along with the final rule (88 FR 28008). We support this approach because it ensures that all of the rate analyses will be conducted on the same set of codes, making it easier to compare across states. CMS should also require MCOs to use this published list of codes when conducting their payment analyses in order to ensure consistency across delivery systems.

Third, in order to ensure consistency in payment analyses from MCO to MCO within the same state and from state to state, the term "primary care services" should be specifically defined for purpose of this analysis. We recommend that CMS include any of the codes described above for the access rule payment analysis and any additional codes in the current regulatory definition of "primary care services" found at 42 CFR § 447.400(c): E&M codes 99201 through 99499, and CPT vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474. States and CMS both have operational experience working with these E&M and CPT codes in connection with the application of minimum

Medicare Part B fee schedule rates during 2013 and 2014 under 42 CFR § 447.405.

Fourth, to ensure that the payment analysis submitted by each MCO is accurate, complete, and truthful, we recommend that the rule expressly clarify that each payment analysis is subject to certification by the chief executive officer (CEO), chief financial officer (CFO), or delegated individual under § 438.606. We recognize that documentation described in § 438.207(b) is currently subject to certification, but in light of the long-standing and

vigorous resistance of many MCOs to financial transparency, we believe that eliminating any ambiguity on this point will significantly reduce litigation risk for state Medicaid agencies and CMS.

Fifth, we recommend that the transparency proposals be strengthened by requiring the state Medicaid agency to post on its website not just the report it submits to CMS but also the individual payment analyses submitted by each MCO. The state agency should also be required to make the payment analysis submitted by an MCO available to the state Medicaid Advisory Committee and Beneficiary Advisory Group to inform their oversight of the performance of individual MCOs.

Finally, we recommend that the effective date for all of the new requirements relating to payment analyses be accelerated. Specifically, the payment analyses should apply with respect to the first rating period starting on or after the effective date of the final rule. Assuming a final rule effective date of May 1, 2024, this would require MCOs to provide, and state Medicaid agencies to review, payment analyses for rates paid to providers during the rating period beginning July 1, 2024. The submissions by the MCOs to the state Medicaid agency, and the submissions by the state agencies to CMS, would not be due until October 1, 2025 and December 31, 2025, respectively.

Recommendations: The recommendations above can be executed with the following modifications to the proposed text.

Revise proposed § 438.207(b)(3) by adding a sentence immediately prior to paragraph (b)(3)(i) to read as follows: "The payment analysis must be submitted to the State within 90 days of the end of the rating period to which the payment analysis applies." Additionally, revise proposed § 438.207(d) in the matter before paragraph (d)(1) to read: "After the State reviews the documentation submitted by the MCO, PHIP, or PAHP as specified in paragraph (b) of this section and the secret shopper survey results as required at § 438.68(f), but in no case later than 180 days after the end of the most recent rating period, the State must submit an assurance of compliance to CMS…."

Revise proposed § 438.207(b)(3) by adding at the end the following new paragraph (b)(3)(v): "The payment analysis must include all of the E&M CPT/HCPCS codes issued in the most recent subregulatory guidance related to implementation of the requirements in § 447.203(b)(2)(i)-(iii)."

Revise proposed § 438.207(b)(3) by adding at the end the following new paragraph (b)(3)(vi): "For purpose of this section, the term "primary care … services" means "primary care services" as defined in § 447.400(c) and any additional E&M codes identified by the agency."

Further revise proposed § 438.207(b)(3) by adding at the end a new paragraph (b)(3)(vii) to read as follows: "The payment analysis described in paragraph (b)(3) of this section is subject to the certification requirements set forth at § 438.606."

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Revise proposed § 438.207(d)(3) to read as follows: "States must…post the submission to CMS described in paragraph(d)(1) and the payment analysis submittedby each MCO, PIHP, or PAHP, as required in paragraph(b)(3) of this section, on the State's website required in § 438.10(c)(3) within 30 calendar days of submission to CMS and mustmake the payment analysis submittedby an MCO, PIPH, or PAHP available to any member of the Medicaid Advisory Committee under § 431.12 upon request."

Revise the first sentence of proposed § 438.207(g) to read as follows: "Paragraphs (b)(3) and (d)(2) of this section apply with respect to the first rating period for contracts with MCOs, PHIPs, or PAHPs beginningon or after [insert the effective date of the final rule]."

II. State Directed Payments

Since being established in 2016 regulations, state directed payments (SDP) have allowed states some limited flexibility to direct the payments made by their managed care contractors, including requiring themto use a minimum or maximum fee schedule, use value-based payment mechanisms, or make other rate increases. SDPs have been important to states, allowing themto continue supplemental payments to Medicaid providers after transitions to managed care, where traditional supplemental payments are often prohibited by regulation. Without the SDP payments, the Medicaid providers would suffer an effective loss of revenue in managed care. Consequently, the use of SDPs has grown quickly in just a short time. By 2020, states had already channeled over $25 billion dollars to providers through SDPs (and this is likely a largeundercount due to data limitations). 7 In just the first four years, SDPs already surpassed other long-standing supplemental payment mechanisms, including disproportionate share hospital and upper payment limit payments. 8 However, CMS has insufficient information about how access to care is being improved. CMS also does not have adequate information about how the money is being spent. It is critical to Medicaid program integrity and efficiency– and ultimately to access to care – that CMS better understand where the dollars are going and how they are impactingaccess to Medicaid services.

We believe CMS's proposed managed care rule is an important step forward to improve SDP processes, accountability, and transparency. Our comments support finalizing many of the proposed managed care rule policies, though we do make recommendations to improve or not finalize certain provisions. We believe that in the coming years CMS will need to do more to require states to justify the expenditure of SDP dollars. In the context of managed care programs which are already supposed to be actuarially sound and have adequate networks, CMS ultimately needs to examine the evidence and documentthe value of the additionalSDP dollars. If CMS fails to require states to fully report on SDP spending, and ensure it promotes value, the risk of inappropriate use of SDPs will rise and threaten public trust and support for the Medicaid program.

7 MACPAC, June 2022 Report to Congress on Medicaid and CHIP, 33 (June 2022), https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf.
8 Id.

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a. Evaluation and reporting

The Medicaid and CHIP Payment and Access Commission (MACPAC) has expressed concern that CMS's current review of SDPs is only prospective, and CMS cannot determine how much states are ultimately paying through SDPs, nor how much is being paid to which providers. 9 In the managed care rule, CMS proposes a short and long-term approach to getting data on actual spending. Short-term, CMS proposes to use existing medical loss ratio (MLR) reporting as a vehicle to collect actual expenditure data. Longer-term, CMS proposes annual provider-specific data reporting through the transformed Medicaid statistical information system, specifying the total dollars expended by each MCO for SDPs, including amounts paid to individual providers. CMS indicates it will develop a uniform template with minimum data fields.

Both the Government Accountability Office (GAO) and MACPAC have expressed concerns about the lack of sufficient evaluation information for SDPs. 10 Current regulations require states to have an evaluation plan for SDPs, but do not provide details for the plan content or require a final evaluation report. The managed care rule proposes specific elements for the evaluation plan and requires states to submit an evaluation report for most types of SDPs if the SDP amounts to more than 1.5 percent of managed care program costs. CMS specifies some requirements for the evaluation report, including that it must be publicly available on a website and that states must file it within two years of the conclusion of a three-year evaluation period (and every three years thereafter).

Our comments support the proposals for reporting on actual SDP spending and evaluations, but recommend dropping the 1.5 percent threshold for evaluations.

We strongly support the requirement for final reporting on SDP payments, including the specific requirement to have provider-level payment amounts. It is critical that CMS get clear data on how many SDP dollars are being paid to which providers. We also strongly support the creation of required elements for evaluation plans and the requirement for an evaluation report. We specifically support the requirement to publicly post the evaluation report.

We have not recommended in these comments that CMS establish a total limit on SDP spending, in part because of concerns that such a limit could effectively cap payment increases for providers with less political clout. Instead of setting such a limit, we believe CMS should require evaluation of all SDPs that require written approval, without the 1.5 percent (or other) threshold. We believe that 1.5 percent of managed care program costs could be a very large sum, particularly considering that the SDP could be targeted toward a narrow group of providers. Given the need to understand more about the value and impact

9 Id. at 46.
10 MACPAC, "Directed Payments in Medicaid Managed Care" (June 2022), https://www.macpac.gov/wp-content/uploads/2022/06/June-2022-Directed-Payments-Issue-Brief-FINAL.pdf; U.S. Government Accountability Office, ''Medicaid: State Directed Payments in Managed Care'' (June 28, 2022), https://www.gao.gov/assets/gao-22-105731.pdf.

of SDP programs, it is critical for CMS to require evaluations of all SDPs. We note that the regulatory definition already excludes fee-schedule based SDPs, which tend to be the smallest in terms of spending, and we agree with that exclusion.

Recommendations: We strongly recommend that CMS finalize the proposals for reporting on SDP spending, including specifically reporting at the provider level. CMS should require any SDP arrangement to have clear, timely, and public data on how much money from each

arrangement is going to each provider. We also support the evaluation plan requirements and the evaluation report requirements, including public posting of the evaluation report, with one suggested change. We recommend that CMS remove the 1.5 percent threshold for evaluation reports and require evaluations for all SDPs that require prior written approval.

While we strongly support the requirement to publicly post evaluation reports, we recommend that CMS do more to promote transparency. We recommend that CMS require public posting of: SDP preprints, evaluation plans, CMS approvals, rate certifications, and all short and long-term reporting on payments under proposed § 438.6(c)(4).

We recommend that CMS require independent evaluators for SDPs.

Finally, we recommend that CMS reduce the five-year total timeline for evaluation reports. Currently, the vast majority of SDP funding goes to fee-schedule or uniform rate increase (at least 83 percent of spending) SDPs which do not represent a classic "investment" model requiring three years to pay off. 11 Additionally, states should not need two years to issue a report which will be heavily based on the two required § 438.6(c)(2)(iv)(A) metrics. We recommend that CMS implement a two-year evaluation period and allow states one year to issue their initial report. (Subsequent reports should be every two years.)

b. Limits on SDP payment rates

CMS generally requires that SDP payment rates be reasonable, though this is not a regulatory requirement. In addition, while CMS sets outer limits for FFS supplemental payments based on Medicare payment rates, CMS has allowed states to set SDP rates up to the Average Commercial Rate (ACR), which can be a significantly higher rate for many services. The proposed managed care rule would codify in regulation the general requirement that SDP rates be reasonable. CMS also proposes to maintain the current ACR maximum for some SDP payments, but requests comment on whether it should revert to a Medicare limit for all SDP payments. Our comments recommend setting the SDP maximum at the Medicare payment level, except for services that have no corresponding Medicare payment rate.

We strongly support CMS codifying the requirement to use reasonable rates and make documentation available to CMS upon request.

11 MACPAC, "Directed Payments in Medicaid Managed Care" 4 (June 2022), https://www.macpac.gov/wp-content/uploads/2022/06/June-2022-Directed-Payments-Issue-Brief-FINAL.pdf.

Our comments, here and in response to CMS's companion access rule, more broadly recommend that CMS align Medicaid payment rates with Medicare rates, which is the most impactful step CMS can take in promoting access through Medicaid rate-setting as it would be like a tide that raises all boats. Allowing SDPs to rise to ACR levels is not an efficient solution; it leads to a windfall for a few providers, but most providers do not benefit from the policy. At the same time, we believe that for most services there is no need to go above Medicare payment rates to enable adequate access. As such, we do not believe CMS should generally allow SDP payment to ACR levels. We believe CMS should set Medicare levels as the default maximum for SDP rates (elsewhere in our comments we have recommended that CMS work to lift all Medicaid rates to Medicare rates), but allow an exception for Medicaid services which have no Medicare equivalent. We support the designation of another payment benchmark by CMS (such as ACR or a percentage of ACR) in these

circumstances where Medicare offers no benchmark.

We believe setting the maximum limit for SDPs at Medicare levels (with a very limited exception) is the best policy option for several reasons. First, the use of Medicare levels will avert potential program integrity concerns that could create problems for Medicaid. Second, we believe any ACR allowance creates a problematic misalignment with FFS limits, and CMS should minimize the misalignment. SDPs were established in part to solve a misalignment (created by the direct pay prohibition) making it hard for states to migrate supplemental funding from FFS to managed care systems, but CMS's current ACR policy creates the same problem in the reverse direction. States now face a new barrier in transitioning away from managed care, and we are aware of this materially impacting delivery systems in at least one state, Kentucky. Finally, Medicare rates are easily ascertained and more transparent. We note that there may be some services for which Medicare has a rate, but it is not a reliable comparison because it is used so infrequently or under meaningfully different circumstances. In our comments on the companion access rule, we urge CMS to consider developing a research project, for example with MedPAC and MACPAC, to evaluate any missing services and identify a more appropriate benchmark. If CMS proceeds with this type of research project, it could also evaluate services for which the Medicare benchmark is inadequate, and the findings could be used to support use of ACRs in SDPs even when there is a Medicare rate available.

If, against our recommendation, CMS continues to allow SDPs up to ACRs even when there is a Medicare equivalent rate, CMS should consider an immediate policy of requiring a state to pay all Medicaid services at least at 100 percent of Medicare levels prior to authorizing new rate increases for some services above Medicare levels toward ACR levels.

Recommendations: We recommend that CMS finalize the proposal to require states to use reasonable SDP payment rates and provide documentation upon request. We further recommend that CMS should set the default maximum payment level for SDPs based on Medicare payment rates (as per FFS limits), but offer a limited exception using some alternative benchmark for Medicaid services that have no equivalent Medicare payment rate.

Finally, if CMS continues policy allowing payment to ACR levels, with respect to calculating the ACR, we specifically recommend that CMS finalize the provision at (c)(2)(iii)(A) as written

to include consideration of the services addressed by the SDP, but not the provider class. We also recommend that CMS require states to pay all Medicaid services at least at 100 percent of Medicare prior to authorizing new rate increases for some services above Medicare levels.

c. Hold Harmless arrangements

As CMS guidance has repeatedly noted and we have previously written in public comments, provider taxes are a critical Medicaid financing mechanism, well-established in law and practice. Provider taxes allow providers to make essential contributions to Medicaid financing, which states use to strengthen Medicaid programs so long as such provider taxes are implemented in accordance with statutory and regulatory requirements. For example, the tax must not unfairly target certain providers and must be applied uniformly.

Another such basic requirement, set out in federal law, is that states cannot allow "hold harmless" arrangements, under which the money collected in taxes is guaranteed to be returned to the taxpayer. Since the original provider tax is collected from a wide range of providers within a provider class, including low-volume Medicaid providers that do not get back much in the form of Medicaid payments and tend to be better financed hospitals in

higher income areas, the hold harmless payments typically go from high-volume Medicaid providers to the low-volume providers, to ensure that the low-volume providers "break even." As of 2019, all but one state had at least one health care tax in place, and likely only a handful of states had any improper hold harmless arrangement in place. Such hold harmless arrangements are not necessary for states to utilize provider taxes.

CMS has been pressed by oversight agencies about its lack of monitoring for inappropriate hold harmless arrangements that may violate the statutory prohibition. In an attempt to prevent hold harmless arrangements, including indirect arrangements administered by providers, CMS's managed care rule reasonably proposes to require: (1) states to comply with the prohibition to have direct or indirect hold harmless provisions in SDPs; (2) providers receiving SDP payments to attest that they do not participate in an unlawful hold harmless arrangement; and (3) states to make the attestations available to CMS upon request. CMS indicates it will require states to confirm compliance with the hold harmless prohibition in SDP preprints. Our comments support CMS's proposed hold harmless proposal.

We support CMS's policy to ensure that prohibited hold harmless arrangements, including indirect arrangements, are not occurring in Medicaid managed care. We support CMS's proposed regulation as an administratively simple policy (and an improvement on current guidance) to prevent improper hold harmless arrangements without creating an untenable obligation on states to affirmatively monitor every financial arrangement their providers enter into. States need only collect attestations and make them available upon request. We recommend that, first, as per our recommendations above regarding payment analysis in § 438.207, attestations should be subject to certification by a provider CEO or CFO (or delegated individual). Second, we recommend that CMS consider clarifying (or, if needed, develop conforming policy) that the attestations would be obligations covered under the False Claims Act.

We also agree that for clarity, CMS should require states to confirm compliance in the SDP preprint. Nonetheless, prior to finalizing the requirement, we suggest that CMS evaluate the impact the policy would have on existing provider tax financing. It is our understanding and assumption that only a few, if any, states may be in violation of the currently proposed standards, and that the new policy would primarily prevent the proliferation of future hold harmless arrangements in the new world of SDP programs.

Recommendation: We recommend that CMS finalize the proposed rules on hold harmless arrangements in SDPs, subject to analysis on the impact of the change. We also recommend that CMS require CEO or CFO certification of attestations and clarify their applicability to False Claims Act enforcement.

d. Separate Payment Terms

SDPs are currently paid through adjustments to base rates or separate payment terms (SPT). SPTs are additional provider payments, coming from of a dedicated funding pool, that are made outside of capitation base rates—a mechanism that is unique to SDPs. In the preamble to the managed care rule, CMS expresses its strong preference for payments made through base rates, but notes several reasons states use of SPTs (and that over half of SDP payments were made through SPTs in 2023). CMS's managed care rule proposes to regulate SPTs as a contract term subject to Social Security Act section 1903(m). CMS proposes to require a state actuary to certify the total dollar amount for each SPT and codifies many current review practices. CMS also would require states to submit a rate

certification or amendment incorporating the SPT. However, CMS solicits comments on whether SPTs should be eliminated and SDPs should be funded only through adjustments to base capitation rates.

We support CMS's proposals to regulate and document the actuarial soundness of arrangements that include SPTs. We agree with CMS that SDPs are best implemented through adjustments to base capitation rates. If CMS does not eliminate SPTs, CMS should reduce their use to the limited situations where states could not achieve the same purpose by adjusting base rates.

Recommendation: We recommend that CMS finalize the proposed provisions to regulate SPTs and limit their use to situations where states could not achieve the same purpose by adjusting base rates.

e. Other provisions

Current regulations allow states to implement SDPs requiring MCOs to use the state's Medicaid fee schedule as the minimum for payment to providers. CMS proposes to add a similar flexibility for states to require payments based on a fee schedule that is exactly 100 percent of the Medicare payment rate. CMS also proposes to allow states to choose to not implement an SDP or eliminate an approved SDP without notice.

We support CMS's proposal to allow for SDPs based on the Medicare fee schedule as a minimum payment level. This is consistent with the flexibility states have to pay up to this rate through other arrangements, and it is more closely tied to services provided if built into the payment itself. There is no reason CMS should not allow this flexibility. In contrast, we do not support the flexibility for states to not implement or eliminate SDPs without notice. States should be required to provide public notice if not moving forward with or eliminating an SDP.

Recommendations: We recommend CMS finalize the proposal to allow use of SDPs based on the Medicare fee schedules. We recommend that CMS rescind the proposal to allow states to not implement or eliminate SDPs without notice, and instead recommend that CMS require public notice.

III. State Oversight of the minimum Medical Loss Ratio (§ 438.74)

Current regulations require state Medicaid agencies to submit to CMS annually a "summary description" of the annual MLR reports received from each MCO with which they contract. The regulations specify that the summary description must include the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed. The proposed managed care rule would clarify that the summary description must be provided for each MCO under contract with the state and that it also includes line items for the amount of SDPs made by the MCO to its providers and the amount of SDPs made by the state Medicaid agency to each MCO.

We support the provisions in the proposed managed care rule, which would give CMS greater ability to oversee the financial performance of individual MCOs as well as the deployment of SDPs by state Medicaid agencies and individual MCOs. However, the proposed managed care rule does not go nearly far enough in advancing transparency around individual MCO financial performance. State risk contracts with MCOs in total

mediate hundreds of billions of federal and state dollars; individual contracts can mediate billions of dollars. It is not sufficient that only state Medicaid agencies, MCOs, and CMS know how those funds are being spent. Other Medicaid stakeholders, including providers, Medicaid Advisory Committees, beneficiaries, and the public have a compelling interest in understanding how MCOs are using Medicaid funds. In particular, as the September 2022 Office of Inspector General study 12 demonstrates, there is a strong public interest in how much each MCO is spending on quality-improving activities and non-claims costs.

Recommendations: To advance transparency, we recommend the following revisions.

12 Office of Inspector General, "CMS Has Opportunities to Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratios," OEI-03-20-00231 (September 22, 2022), https://oig.hhs.gov/oei/reports/OEI-03-20-00231.asp.

1. Revise § 438.74(a)(2) by inserting "the amount of expenditures on quality-improving activities and the amount of non-claims costs" after "the amount of the denominator." This revision would enable CMS to assess how much MCOs spend on administrative costs nationally and on a statewide basis, and to compare individual MCO spending on quality-improving activities and non-claims costs with peer MCOs in the same state and other states.

2. Revise § 438.74 by inserting a new paragraph (a)(5) to read as follows: "CMS shall post on Medicaid.gov the summary description submitted by each State under paragraph (a)(1) within 30 days of receipt." This revision will enable other stakeholders and the public to conduct the assessments and comparisons described above.

3. Further revise § 438.602(g), which the proposed managed care rule would revise (see our comments above), to add a new paragraph (g)(14) to read as follows: "the annual report submitted by each MCO, PIHP, or PAHP under section 438.8(k)." This revision adds the annual MLR reports submitted by each MCO to the information that the state Medicaid agency is required to post on its website.

4. Further revise § 438.602(g), which the proposed managed care rule would revise (see our comments above), to add at the end a new paragraph (j) to read as follows: "Medicaid Advisory Committee and Beneficiary Advisory Group. The State must make available to the Medicaid Advisory Committee and Beneficiary Advisory Group described in § 431.12, upon the request of any member of the Committee, any of the documents and reports described in paragraph (g) of this section and any of the data, information, and documentation described in § 438.604(a)." This revision is needed to enable MACs in states contracting with MCOs to carry out their responsibility under § 431.12 (as proposed in the companion access rule, CMS-2442-P, 88 FR 27960) to advise the Medicaid Agency Director on "matters related to the effective administration of the Medicaid program." The performance on individual MCOs is by definition such a matter.

IV. In Lieu of Services and Settings

Medicaid managed care plans have long had authority to cover "in lieu of services" (ILOS) in substitution of traditional state plan services. ILOS have been a favored flexibility for states and managed care plans because the new services that are included can be factored

into rate-setting, thus giving the health plans an incentive to provide the services. However, therehas been insufficient standardization of ILOS processes and services. Additionally, a narrow definition of substitution has made it historically difficult for states to make strategic ILOS investments (such as prevention) to reduce the need for more expensive health care treatments over time (such as acute care).

CMS's managed care rule is intended to address some of these long-standing concerns. The proposed rule would bring uniformity and transparency to the delivery of ILOS and open the door to states making longer-term investments through ILOS, including ILOS that may

begin to address health-related social needs. Our comments are supportive of CMS's approach, with some suggestions to improve the proposed regulations.

a. ILOS definition and general parameters (§§ 438.2, 438.16, 457.10)

CMS's proposed managed care rule builds upon 2016 regulations 13 and recent guidance 14 by establishing a new and broader definition of ILOS, allowing both immediate and longer-term substitution of services. CMS also clarifies the types of services that can be ILOS and sets new fiscal protections for use of ILOS – including an outer limit of five percent of capitation on ILOS for managed care plans. States will also be required to provide cost percentage calculations and an annual report of actual managed care plan ILOS spending based on claims and encounter data. Our comments support these provisions.

We support the new proposed definition of ILOS, and specifically the inclusion of ILOS substitutions that are based on longer-term investments in care. Many community-based services may take time to produce the substitution effect, and states should be able to make strategic investments in such services. We also support the creation of a five percent cost percentage threshold for ILOS. CMS should set a limit on ILOS usage to ensure program integrity and to give CMS, states, and plans an opportunity to evaluate how well ILOS investments are achieving their objectives prior to broader expansion. We also support the requirement for states to provide cost percentages and an annual report of ILOS spending, specifically based on claims and encounter data. We believe CMS should make this data public.

Recommendations: We recommend that CMS finalize the proposed provisions, but add requirements for public reporting of cost percentages and annual reports.

b. Enrollee rights and protections (§§ 438.3(e)(2), 438.10(g)(2)(ix), 457.1201(e), 457.1207)

The proposed managed care rule sets enrollee rights and protections as one of its "key principles." CMS includes several new provisions for enrollees in the proposed managed care rule that CMS states are current policy: (1) enrollees retain all rights and protections available under part 438 (including appeals rights); (2) enrollees retain the right to receive state plan services, regardless of being offered, using, or previously using ILOS; (3) ILOS may not be used to discourage access to state plan services; (4) a requirement for plans to include these protections in enrollee handbooks; and (5) a requirement for states to include these requirements in plan contracts. Our comments support this proposal, but make suggestions for improvement.

13 CMS, Final Rule, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability," 81

FR 27498 (May 6, 2016), https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
14 CMS State Medicaid Director Letter 23-001, "Services and Settings in Medicaid Managed Care" (Jan. 4, 2023), https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf. RE: Additional Guidance on Use of In Lieu of Services

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We strongly support the inclusion of beneficiary protections for ILOS in the managed care rule, including all of the provisions in §§ 438.3(e)(2), 438.10(g)(2), and 438.16(d)(1).

While we strongly support the general requirement for Part 438 protections, inclusive of due process, we have two concerns. First, we are concerned that tying the protections only to those for managed care plans in Part 438 may ignore some Medicaid protections in other parts of the statute, such as Fair Hearing processes and other due process protections against the state. Second, we believe that CMS must address practical problems for the ILOS system to achieve the equivalent due process of state plan services. Enrollees, and in particular their providers, will need some simple way to understand what ILOS services are available and who is eligible for them (i.e., targeting criteria). In addition, under CMS's design, managed care plans always retain the right "to not offer ILOS," which may create confusion since health care providers would often be the expected prescribers of ILOS services. CMS must address these issues in regulation or else ILOS will exist in theory but be a mystery in practice.

We also strongly support the requirement that ILOS cannot be forced upon consumers, nor that their being offered or used can block access to state plan services. Since ILOS are conceptually substitution services, we are particularly concerned that consumers will have an "either-or" choice between ILOS or state plan services, particularly in the case of "longer-term" ILOS where ILOS access may have no impact on shorter-term continued need for state plan services. We appreciate the specific protections CMS built into the regulation. However, we also believe that it is vital that CMS address this in the rate-setting process. Enrollees retain the right to use all medically appropriate services, therefore the capitation rate must reflect that in many cases there will be payment for both a state plan service and its substitution ILOS. We are particularly concerned that, in the context of state budget pressure or managed care plans desire for profits, there will be an incentive to assume unrealistically short payoffs on ILOS investments, that will in practice erode access to state plan services. We urge CMS to ensure that all services are appropriately captured in the rate setting process to help prevent an unintended erosion in access to needed care.

Recommendations: We strongly recommend that CMS finalize the beneficiary protections for ILOS in the managed care rule, including all of the provisions in §§ 438.3(e)(2), 438.10(g)(2), and 438.16(d)(1).

We recommend that CMS improve the regulations by clarifying that all Medicaid access protections (and not only those in Part 438), such as due process, apply in the context of ILOS.
We further recommend that CMS require states or plans to create a simple one-stop-shop ILOS webpage for each plan detailing the available ILOS services and related targeting criteria, as well as providing this information directly to enrollees (via enrollee handbooks) and providers (via direct mailing). If an ILOS is identified in state contract, and yet the managed care plan chooses not to make it available, that too should be clearly and prominently identified. Finally, we believe that CMS should develop explicit rate-setting regulations clarifying that capitation can and should include "two treatments" for one unit of need, where a longer-term ILOS is implicated, and that CMS should require systems to evaluate if consumers are being "forced to choose" between a state plan service and a longer-

term ILOS, as well as systems to ensure that longer-term ILOS are actually being provided as per the capitation assumptions.

c. Medically appropriate and cost effective (§§ 438.16(d), 457.1201(e))

Although current regulations require that states determine that ILOS must be medically appropriate and cost effective, there are not strong requirements to document this. The managed care rule proposes numerous documentation requirements for states implementing ILOS, including the name and definition of ILOS, what service is being substituted, documentation of medical appropriateness and cost effectiveness of the ILOS, and the clinically defined target population for the ILOS. Our comments support these documentation requirements.

We generally support the documentation requirements proposed in § 438.16(d). We believe these requirements will support transparency and program integrity. However, we recommend that CMS review the documentation requirement at § 438.16(d)(iv), as we are concerned that it may create a burden for prescribers that may limit the success of ILOS.

Recommendation: We recommend CMS finalize § 438.16(d) as proposed, though (d)(iv) may need to be revised to avoid creating overly burdensome documentation requirements.

d. Payment and rate development (§§ 438.3(c), 438.7(b), 457.1201(c))

CMS regulations consider ILOS utilization and costs in rate development, but are not explicit about including them in final capitation rates and payments (though CMS's preamble says this is current policy). In the managed care rule, CMS proposes to codify the current practice and adds documentation requirements. Additionally, in the preamble at Fed. Reg. 28169, CMS notes that based on current regulations, state actuaries should adjust capitation rates to account for whether plans offer ILOS and enrollees actually use ILOS. Our comments support these provisions, with an addition.

We support the proposed provisions to explicitly include ILOS in capitation rates, as well as the related rate documentation requirements.

We believe CMS must do more to ensure that states adjust capitation rates based on actual provision of ILOS. Given that many ILOS will be a new frontier of services, it will be hard for actuaries to predict utilization and cost in prospective capitation calculations. In addition, it is important for CMS to ensure that plans do not get a windfall of ILOS dollars for services that are never ultimately provided.

Recommendations: We recommend CMS finalize the proposed regulations, and add regulatory requirements explicitly requiring states to adjust capitation rates when their regular actuarial reviews determine they meaningfully diverge from the actual costs for ILOS.

e. Other requirements for ILOS: state monitoring, retrospective evaluation, and transition plans

The proposed managed care rule would require contracts between the state and the plan to provide for submission of encounter data to states as specified by CMS and the state, and states must review and validate the data. CMS also proposes to require that states include a contractual requirement that managed care plans use specific coding to identify each ILOS and clarifies that states should report ILOS in MCPAR.

In addition, CMS proposes that states must submit a retrospective evaluation for each managed care program using ILOS, if ILOS are being used above a 1.5 percent of cost percentage threshold. CMS seeks comment on whether evaluations should be specific to each program. CMS proposes a minimum set of required elements for retrospective evaluation, including for each ILOS: impact on state plan service use and costs, trends in use of ILOS, cost-effectiveness and medical appropriateness, detailed reporting on grievances and appeals, impact on health equity, impact on quality of care, and final ILOS cost percentage. CMS solicits comment on whether there should be an independent ILOS evaluator.

Lastly, CMS proposes that states must notify CMS within 30 days if an ILOS is no longer compliant with requirements around medical appropriateness, cost-effectiveness, or enrollee protections. CMS proposes that it can terminate noncompliant ILOS and that any termination (by CMS, state, or MCO), would require a transition plan including notice for enrollees and a plan for timely access to state plan services and settings.

We support the requirements for contracts to provide for encounter data per CMS or state specifications, state validation of the data, and use of specific coding to identify ILOS, as well as the clarification that states should report ILOS in MCPAR. It is critical for CMS to have encounter level data to do analysis on the ILOS being used and the enrollees using them. In addition, we strongly support the requirement for retrospective evaluation for ILOS above the 1.5 percent threshold, including specifically information about both state plan and ILOS utilization, appeals and grievances, and impacts on equity. Tracking utilization will be necessary for CMS to connect health and cost outcomes, whether positive or negative, to the substitution of state plan services. We recommend that CMS require states to use an independent evaluator to ensure that there is an objective review of the efficiency of state spending and impacts. Finally, we support the requirements for states to inform CMS about noncompliant ILOS and develop transition plans.

Recommendations: We recommend CMS finalize its proposals for state monitoring, retrospective evaluation, and transition plans. We recommend that CMS make evaluations specific to each state program and use an independent evaluator.

V. Quality Assessment and Performance Improvement Programs, State Quality Strategies and External Quality Review

a. Managed Care Quality Strategies (§§ 438.340, 457.1240)

Current Medicaid regulations at § 438.340, and in CHIP at § 457.1240(e), require states to implement a written quality strategy for assessing and improving the quality of health care services furnished by an MCO, PIHP, or PAHP. The quality strategy is intended to serve as a foundational tool for states to set goals and objectives relating to the quality of care and access for managed care programs. The proposed managed care rule would increase

opportunities for interested parties to provide input on the state's managed care plan. It requires states to seek public comment on the state's quality strategy at least every three years regardless of whether significant changes are made. States must post the full evaluation of the effectiveness and results of the triennial review of the quality strategy, not just the state's proposed plan. States would also be required to submit the plan for CMS review and input.

Recommendations: We support these changes to the quality strategy review process. We note that while the proposed managed care rule was silent on the purpose of quality reviews and strategies, other documents including the national quality strategy and the managed care quality strategy toolkit reinforce that quality strategies are intended to promote health equity by addressing disparities and improving health care access and outcomes.[15,16] We encourage CMS to reinforce this messaging and use its review process to ensure that state quality strategies continue to close the gap on disparities that disproportionately affect children and families of color and people with disabilities.

b. External Quality Review (EQR) Period (§§ 438.358(b)(1), 457.1520(a))

The current rules lack uniformity in the EQR review periods and do not specify when the EQR activity must take place relative to finalization and posting of the annual report. As a result, states may report the results of EQR activities that are three or more years old and less useful for quality improvement and oversight. The proposed rules would ensure consistency and align data in the annual reports with the most recently available information used to conduct the EQR activities.

Recommendations: We support these changes to the EQR review periods. Aligning the review periods and requiring states to conduct EQR activities in the twelve months preceding finalization and publication of the annual report will result in more current data being publicly posted in the annual EQR technical reports. This will ensure that EQR technical reports are a more meaningful tool for monitoring and comparing quality between plans.

c. Optional EQR Activity (§ 438.358(c)(7))

The proposed managed care rules would establish a new optional EQR activity to support current and proposed managed care evaluation requirements. Specifically, the rule would allow states to conduct evaluation requirements for quality strategies, SDPs, ILOS that

15 CMS, National Quality Strategy, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy.
16 CMS, Medicaid and CHIP Managed Care Quality Strategy Toolkit (June 2021), https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf.

pertain to outcomes, quality, or access to health care services as an EQR activity. The rule would apply to CHIP except the provision relating to SDPs, which are not applicable to CHIP.

Recommendations: We support these changes that would provide states with enhanced matching funds to use the EQR process and technical assistance to support more robust evaluations, which could lead to greater transparency and quality improvement.

d. EQR Results (§ 438.364)

i. Data to be included in EQR technical reports

Current regulations limit the data that must be included in technical reports to performance measurement data and do not require other types of data that may be used to measure the outcomes associated with performance improvement projects (PIPs). As a result, the reports often focus on whether the methods used to implement or evaluate a PIP were validated, but do not include measurable data such as the percentage of enrollees who participated in the PIP or patient satisfaction based the outcomes of the PIP. Additionally, the regulations do not currently require the reports to include data obtained from the mandatory network adequacy validation data.

The proposed managed care rule at § 438.364(a)(2)(iii) would require EQR technical reports to include any outcomes data and results from quantitative assessments, as well as data from the mandatory network adequacy validation activity.

Recommendations: We support these proposed changes and believe they will result in more meaningful EQR technical reports that can be used to drive quality improvement and oversight in managed care.

ii. Guidance on stratification in EQR protocols

In the preamble to the NPRM, CMS asked for comment on whether it should consider adding guidance in the EQR protocols for states to stratify performance measures collected and reported in the EQR technical reports to facilitate monitoring of efforts to monitor disparities and address equity gaps.

Recommendations: We encourage CMS to include guidance on stratification of performance measures in future updates to EQR protocols to ensure consistency in reporting that aligns with proposed requirements for mandatory reporting of the Core Sets of Health Care Quality Measures and proposed requirements for the Medicaid and CHIP managed care quality rating system (MAC QRS).

iii. Revising the date annual EQR technical reports must be finalized and posted (§ 438.364(c)(1))

The proposed managed care rule would change the required date for finalizing and posting EQR technical reports from April 30 th to December 31 st .

Recommendations: We support this change to better align with HEDIS measures that are audited and finalized annually in June. While this moves the posting date out, other proposed changes to EQR review periods discussed above will ensure that data reflected in the EQR technical reports remain timely.

iv. State posting of EQR technical reports

The proposed rules at § 438.364(c)(2) would require states to notify CMS when annual EQR technical reports are posted and to maintain EQR reports on state websites for five years. Prompt notification will facilitate CMS's review and aggregation of the required data, including ensuring that data are complete, before inclusion in the annual report to the Secretary. Additionally, the proposed managed care rule would require states to maintain at least five years of EQR technical reports on their website.

Recommendations: We support these changes that would provide access to historical data and information for CMS and other stakeholders. Notably, many PIPs are conducted over a three-year period and the current reporting structure does not provide the longevity needed

to follow results.

Recommendations: We recommend that CMS take steps to specify more rigor in how outcomes and lessons learned from PIPs are documented in technical reports. We also believe CMS should specifically require an assessment of health equity activities and outcomes.

e. Medicaid and CHIP Managed Care Quality Rating System (QRS) (§§ 438.334, 457.1240)

The 2016 final managed care rules established the authority to require states to create and maintain a managed care quality rating system. Its purpose is to hold states and plans accountable for care provided to Medicaid and CHIP enrollees; to arm enrollees with useful information about plans available to them; and to provide a tool for states to drive improvements in plan performance and the quality of care provided by their programs. The proposed managed care rule would advance the QRS as a one-stop-shop where enrollees could access information about Medicaid and CHIP eligibility and managed care; compare plans based on quality and other factors key to plan selection, such as the plan's drug formulary and provider network; and to aid enrollees in selecting a plan that meets their needs.

The preamble of the proposed managed care rule goes describes in detail the extensive consultations, research, and consumer testing that CMS has embarked upon to inform the MAC QRS framework proposed in the rule. The proposed framework includes mandatory measures, a rating methodology, and a mandatory website format. The robust website envisioned in the proposed managed care rule recognizes that quality ratings alone are not useful in selecting a health plan without additional information. It also intends to align QRS

website information with beneficiary choice counseling to aid beneficiaries in selecting a plan that meets their unique needs (although this is one of a few provisions in the proposed managed care rule that does not apply to CHIP since separate CHIP programs are not required to have a beneficiary support system). The proposed QRS framework would align, where appropriate, with Medicare Advantage and Part D quality rating system and other related CMS quality rating approaches to reduce state burden across federal quality reporting systems.

Recommendations: We applaud CMS for its more robust approach to the QRS and generally support these changes and the proposed QRS framework.

i. Timeline

The proposed managed care rule requires that states implement their MAC QRS (or CMS approved alternative) by the end of the fourth year following effective date of the rule. However, more interactive features of the QRS to aid beneficiaries in plan selection would be delayed for at least an additional two years.

Recommendations: We recommend that states be required to implement the second phase of the QRS in two years rather than "at least" two years, which is open-ended and could lead to further delays in providing beneficiaries with the tools and information they need to make informed decisions in choosing a plan. Already, the QRS has been delayed beyond the initial implementation date of 2018 and states have four years to implement phase one. That provides six years for states to achieve the vision of the QRS framework.

ii. Mandatory measures (§§ 438.510(c), 457.1240(d))

The proposed managed care rule would require state QRSs to include all mandatory measures, regardless of whether the state implements the model MAC QRS or adopts a CMS-approved alternative QRS. The proposed rule includes 19 mandatory measures, all but one of which are also required for the current Child and/or Adult Core Sets of Health Care Quality Measures. CMS notes three considerations that guided the process of selecting the initial mandatory measure set and in making future changes: 1) the measure must meet five of out six specific measure inclusion criteria; 2) it would contribute to balanced representation of beneficiary subpopulations, age groups, health conditions, services, and performance areas (e.g., preventive health, long term services and supports); and 3) the burdens associated with the measure do not outweigh the benefits to the QRS framework. To determine whether a measure meets these standards, CMS would rely on the input of a sub regulatory process like the current process used in reviewing the Child and Adult Core Sets, which is described below.

The six measure inclusion criteria are: 1) the measure is meaningful and useful to enrollees in choosing a managed care plan; 2) the measure aligns with other CMS rating programs; 3) the measure assesses health plan performance in at least one of the following areas: customer experience, access to services, health outcomes, quality of care, health plan administration, and health equity; 4) the measure provides an opportunity for MCOs to

influence their performance; 5) the measure is based on data that are readily available and feasible for states to report; and 6) the measure demonstrates scientific acceptability – meaning the measure produces consistent and credible results. These criteria are described in more detail in the preamble to the rule.

Recommendations: We support these criteria but recommend a seventh criterion be considered: Does the measure advance health equity?

The proposed managed care rule would establish these criteria for removal of a measure: 1) the external measure steward retires or stops maintaining a mandatory measure; 2) there are changes in clinical guidelines associated with the measure; or 3) there is low statistical reliability in the measure.

The rule proposes a biennial stakeholder process for updating mandatory measures like the process used for the annual review of the Child and Adult Core Sets. Additionally, a second step in the process would be for CMS to provide public notice and opportunity to comment on mandatory measures identified for addition, removal, or updating through public engagement.

CMS will update guidance to states on mandatory measures in an annual technical resource manual. States would be given at least two calendar years from the start of the measurement year immediately following the technical resource manual to report (required by August 1, 2025, and annually thereafter).

Recommendations: We recommend that states be given no more than two calendar years to report a new or revised mandatory measure. As the proposed managed care rule currently reads there is no outer limit to when states would be required to report a mandatory measure.

f. MAC QRS Rating Methodology (§§ 438.334(d), 438.515, 457.1240(d))

The proposed QRS rating methodology seeks to balance two themes – state burden

associated with data collection and quality rating calculations with beneficiary need for transparent, representative quality ratings.

Currently states are only required to publish a single quality rating for each MCO, PIHP, or PAHP on the website. Under the proposed rule, states would be required to issue a quality rating for each mandatory measure, not a single overarching rating for each plan. Reporting on a domain level basis (e.g., preventive care or behavioral health) remains under consideration and may be included in future rulemaking.

The proposed managed care rule would require states to not only collect data from each managed care plan but also validate the data used to calculate and issue quality ratings for each mandatory measure on an annual basis. Under the NPRM, states would use the validated data to calculate a measure performance rate for each managed care plan that is contracted to provide the service. Additionally, states must report quality ratings at the plan level for each managed care program. For example, states may have separate physical

and behavioral health managed care programs, which might include dual participation by a plan. In those cases, the state would report separate quality ratings for the plan separately for each program.

The proposed methodology also requires states to include FFS or other delivery system data if all necessary data cannot be provided by the MCO. For example, follow-up after hospitalization for a mental illness requires data on two services: hospitalization and mental health services through separate health plans. The quality rating for the measure would be reported for the plan responsible for follow-up services.

States can receive an enhanced match for assistance with quality ratings of MCOs performed by an EQRO, including the calculation and validation of data as an optional external quality review activity.

Recommendations: We support these provisions requiring states to validate, calculate, and publish quality ratings for each mandatory measure for each plan separately for all managed care programs in which the plan participates.

g. QRS Website Display (§§ 438.334(e), 438.520, 457.1240(d))

The NPRM would establish new requirements for a robust, interactive website display, which were informed by intensive consultation with prospective users and iterative testing of a MAC QRS website prototype. The display components identified as most critical fall into three categories: 1) information to help navigate and understand the content of the QRS website; 2) information to allow users to identify available managed care plans and features to tailor information displayed; and 3) features that allow beneficiaries to compare plans on standardized information, including plan performance, cost, and coverage of services and pharmaceuticals, and provider network.

Based on user testing, CMS proposes that a MAC QRS website include: 1) clear information that is understandable and usable for navigating the website; 2) interactive features that allow users to tailor specific information, such as formulary, provider directory, or quality ratings based on the selection criteria they enter; 3) standardized information so users can compare plans and programs; 4) information that promotes beneficiary understanding of and trust in the quality ratings; and 5) access to Medicaid and CHIP eligibility and enrollment information, either through the website or through external sources.

Because these provisions would require more technology-intensive implementation, the

rule establishes two phases for development of the QRS website. In phase one, states would develop and implement the website not later than the fourth year after the rule is finalized. In this phase, states would develop the website, display quality ratings, and would ensure that users can access information on plan providers, drug coverage, and view quality ratings by sex, race, ethnicity, and dual eligibility status. In the second phase, states would be required to modify the website to provide a more interactive user experience with more information accessible to users directly on the MAC QRS. States would be given at least an additional two years after initial QRS website implementation to comply with phase two

requirements. In phase two states would be required to stratify quality ratings further by age, rural/urban status, disability, and language spoken by the user.

Recommendations: As noted above, providing "at least" an additional two years sets no firm date by which a state must have a fully functional QRS website. We recommend that the final rule set the phase two implementation date at no more than two years after phase one.

States would be required to provide standardized information for each managed care plan that allows users to compare plans and programs, including name, website, and customer service telephone hot line, premiums and cost-sharing, summary of covered benefits, certain metrics of access and performance (such as results of the secret shopper survey or information on grievances and appeals), and whether the plan offers an integrated Medicare-Medicaid plan. The proposed managed care rule does not address whether states would be required to include functionality for an individual to use the QRS website to enroll in a plan if they were already determined eligible.

Recommendations: We encourage CMS to describe in the final rule how the QRS website should align with the ability of a user who has been determined eligible to select and enroll in a plan.

Early user testing revealed that participants were skeptical of quality ratings, leading CMS to test clear and comprehensive language that would result in increased trust of the quality ratings. Thus, the NPRM requires the QRS website to include a description of the quality ratings in plain language, how recent the data are, and how the data were verified.

The NPRM proposes certain navigational requirements for the website display. First, states must provide users with information on the purpose of the website, relevant information on dual eligibility and enrollment through Medicare, Medicaid, and CHIP, and an overview of how the site can be used to select a managed care plan. The state would also be required to provide information on how to access the beneficiary support system currently required under §438.71, although this element does not apply to CHIP programs.

To better understand the visual nature of the website display, CMS has developed two prototypes to illustrate the information required in phase one and phase two. CMS also plans to release a MAC QRS design guide following the final rule, which will include a comprehensive overview of the results of user testing that can inform state design. User testing found that participants responded positively to features that allowed them to reduce the number of plans displayed based on specific criteria, such as geographic location or eligibility requirements. Users also wanted to be able to narrow the information displayed to plans for which they may be eligible.

Under the proposed managed care rule, states would have the option to display additional measures not included in the mandatory measure if the state has obtained input from prospective users and documents input from prospective users and the state's response,

including rationale for not accepting such input.

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States would continue to have the option to create an alternative quality rating system that is comparable to the QRS framework but would be limited in the changes they could make. However, states would no longer be allowed to substitute different performance measures for the mandatory measures. States will retain the ability to include additional performance measures and would no longer be required to obtain CMS approval to do so. The rule further defines the criteria and process for determining if an alternative QRS system is substantially comparable to the MAC QRS methodology. CMS intends to issue instructions on the procedures and dates by which states must submit an alternative QRS for approval.

Under the proposed managed care rule, CMS will develop and update annually a MAC QRS technical resource manual no later than August 1, 2025. The manual will include the mandatory measure set; measures newly added or removed; the subset of measures that would be stratified by race, ethnicity, sex, age, rural/urban status, disability, language, and other factors; how to use the methodology to calculate quality ratings; and technical specification for the mandatory measures. When identifying measures to be stratified, CMS will consider stratification guidance by the measure steward and alignment with stratification requirements in the Child and Adult Core Sets.

The proposed policy requires states to submit to CMS, upon request, information on their MAC QRS to support the agency's oversight of Medicaid and CHIP and compliance with QRS requirements; to ensure that enrollees can meaningfully compare ratings between plans; and to help monitor trends in additional measures and use of permissible modifications to measure specifications to inform future updates to measures and the QRS methodology.

Recommendations: The NPRM sets out a robust vision for a user-friendly, interactive tool for Medicaid beneficiaries. As noted previously, we support this acceleration and standardization of best practices in providing Medicaid beneficiaries with the information and support they need to evaluate and choose a managed care plan that meets their unique needs.

VI. CHIP

Under current regulations, federal requirements applicable to state CHIP agencies and the MCOs with which they contract are generally, but not entirely, aligned with those applicable to state Medicaid agencies and the MCOs with which they contract. Because of this alignment, many of the changes made by the proposed managed care rule with respect to Medicaid will by cross-reference automatically apply to separate CHIP programs.

These include new requirements relating to MLR (§ 438.8, incorporated into § 457.1203); network adequacy (§ 438.68, incorporated into § 457.1218); availability of services (§ 438.206, incorporated into § 457.1230); adequate capacity and services (§ 438.207, incorporated into § 457.1230); provider selection (§ 438.214, incorporated into § 457.1233); quality measurement and improvement (§ 438.330, incorporated into § 457.1240); and external quality review (§§ 438.350 – 364, incorporated into § 457.1250).

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Recommendations: We support aligning these requirements, as revised per our recommendations elsewhere in these comments, between Medicaid and separate CHIP programs.

We have additional comments on other proposed changes to the CHIP regulations.

a. Information requirements (§ 457.1207)

Current regulations require state CHIP agencies contracting with MCOs to post all notices and informational and instructional materials related to enrollees directly on the agency website or by linking to individual MCO websites. The proposed managed care rule would require the state CHIP agency to annually post MCO-specific comparative summary results of enrollee experience surveys conducted by the state. This requirement would take effect the first rating period beginning on or after three years after the final rule is effective; as a practical matter, that means 2027 at the earliest.

We support the proposal to require the state CHIP agency to annually post comparative summary results of enrollee experiences by MCO. However, we believe that this posting requirement should be effective in the first rating period beginning one year after the final rule is effective; we see no justification for states to wait until 2027 to conduct enrollee experience surveys as part of their monitoring and oversight responsibilities.

We also believe that separate state CHIP programs contracting with MCOs should be held to the same transparency requirements as CHIP programs that enroll covered children in Medicaid MCOs (at § 438.602(g)). Currently they are not, and our research has found that separate CHIP managed care programs are not as transparent as Medicaid programs that enroll CHIP children.[17] The interest of CHIP children and their parents (as well as other stakeholders and the public) in understanding how MCOs are performing is equally compelling whether the CHIP child is enrolled in an MCO contracting with a separate CHIP agency or with the Medicaid agency. In addition, the transparency interest of the federal government is even greater in CHIP than in Medicaid because of the substantially higher federal matching rate for CHIP payments to MCOs.

Recommendation: Revise current § 457.1207 by adding at the end the following sentence: "The State must post, on the State's website as described § 438.10(c)(3) of this chapter, the information described in § 438.602(g) with respect to MCOs, PIHPs, and PAHPs as defined in § 457.10, and the results of the annual enrollee experience surveys for each MCO." This revision would fully align the transparency requirements relating to Medicaid MCOs at § 438.602(g) as revised by this proposed rule with those relating to MCOs serving CHIP children in separate CHIP programs. It would also ensure that the results of the annual enrollee experience

17 Schneider, et al., "An Introduction to Managed Care in CHIP," (March 2023), https://ccf.georgetown.edu/2023/03/24/an-introduction-to-managed-care-in-chip/.

surveys, and not just a summary comparison, will be publicly available on the state CHIP agency's website.

b. Quality measurement and improvement (§ 457.1240)

The proposed managed care rule elsewhere sets forth, in a new Subpart G, requirements for a MAC QRS. The proposed rule adds a new § 457.1240(d) that applies these requirements to separate CHIP programs that enroll CHIP children in MCOs, PIHPs, and PAHPs that do not contract with the state Medicaid program (and would therefore be subject to the MAC QRS).

Recommendations: We support the application of the MAC QRS, with the revisions we have suggested elsewhere in these comments, to CHIP programs.

c. Program integrity safeguards (§ 457.1285)

Current regulations align CHIP program integrity safeguards relating to managed care with those in Medicaid. The only exceptions relate to the Medicaid requirement that capitation rates be actuarially sound, a requirement not found in the CHIP statute. The proposed managed care rule would exempt CHIP programs from submitting annual managed care program reports to CMS as state Medicaid programs are required to do by § 438.66(e). In prior comment periods, we have urged CMS to apply all of the state reporting requirements in § 438.66 to CHIP, and we reiterate that recommendation now. These reports include, among other things, information on the financial performance of each MCO, including MLR experience; encounter data reporting by each MCO; and availability and accessibility of services, including network adequacy.

We can see no program integrity reason why CMS should not receive the same information about MCOs contracting with separate CHIP programs as it receives about those contracting with Medicaid programs—particularly since the federal share of payments to the CHIP MCOs is substantially higher than the federal share of payments to Medicaid MCOs. We have reviewed the current CHIP annual reports and they are utterly inadequate to the program integrity task.[18] The program integrity risk is elevated in cases where the same insurer offers a Medicaid product and a separate CHIP product, knowing that the CHIP product is not subject to the same transparency as the Medicaid product.

Recommendations: Revise the proposed change to § 457.1285 by striking the reference to § 438.66(e).

Apply § 438.66 to CHIP. Data elements that are already captured by the CHIP annual reports under § 457.750 would not need to be repeated, but the additional state monitoring requirements for managed care should be incorporated into subpart L of § 457 to ensure adequate oversight of managed care in separate CHIP programs.

18 Id.

VII. Conclusion

If finalized as proposed, this managed care regulation would make significant advancements to improve access to care for Medicaid and CHIP beneficiaries. We applaud CMS's commitment to transparency as a means to improve quality and advance health equity. We generally believe that CMS, states, and managed care plans can and should adopt these provisions faster than proposed so that beneficiaries may benefit from improved access to care as soon as is feasible. We also believe that some provisions of the rule would benefit from greater alignment across delivery systems, such as provider payment rules in FFS versus managed care, as outlined in our detailed comments above. Finally, we believe that CMS should consider additional ways to achieve alignment across federal programs by using Medicare payments and Marketplace network adequacy standards as the benchmarks for Medicaid. Given their often lower incomes, in no circumstances should Medicaid beneficiaries have fewer access protections than Marketplace enrollees.

Our comments include numerous citations to supporting research for the benefit of the

CMS. We direct CMS to each of the studies cited and made available through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the formal administrative record on this proposed rule for purposes of the Administrative Procedures Act.

Thank you for considering our comments; if you need more information, please contact Leo Cuello (leo.cuello@georgetown.edu) or Kelly Whitener (kelly.whitener@georgetown.edu).

Sincerely,

Joan Alker
Research Professor
Executive Director

CreationDate: 2023-06-30 20:54:19
Creator: Word
ModDate: 2023-07-14 11:18:29
Producer: macOS Version 13.4 (Build 22F66) Quartz PDFContext
Title: Microsoft Word - CCF Managed Care Comment FINAL.docx

Meeting Title:
CMS/DHCS Biweekly Waiver Check-in

From:
"Kim, Lora" <LYKim@manatt.com>

Sent:
11/29/2022 7:40:02 PM +0000

To:
'Noelle.Simonick@dhcs.ca.gov'; 'janet.rudnick@dhcs.ca.gov'; 'rachel.nichols@cms.hhs.gov'; "Ross, Heather (CMS/CMCS)" <Heather.Ross@cms.hhs.gov>; "Friedman, Kate (CMS/CMCS)" <Katherine.Friedman@cms.hhs.gov>; 'Aaron.Toyama@dhcs.ca.gov'; 'Bambi.Cisneros@dhcs.ca.gov'; 'Benjamin.Mcgowan@dhcs.ca.gov'; Brumer, Justin@DHCS; 'AnhThu.Bui@dhcs.ca.gov'; 'Dana.Durham@dhcs.ca.gov'; "Font, Amanda" <Amanda.font@dhcs.ca.gov>; 'Jacey.cooper@dhcs.ca.gov'; "Lee, Angeli" <Angeli.Lee@dhcs.ca.gov>; 'Lindy.Harrington@dhcs.ca.gov'; 'Rafael.Davtian@dhcs.ca.gov'; 'Rene.Mollow@dhcs.ca.gov'; 'farrah.samimi@dhcs.ca.gov'; 'Saralyn.Ang-olson@dhcs.ca.gov'; 'susan.philip@dhcs.ca.gov'; 'tyler.sadwith@dhcs.ca.gov'; 'yingjia.huang@dhcs.ca.gov'; "Guyer, Jocelyn" <JGuyer@manatt.com>; "Lam, Alice" <ALam@manatt.com>; "Mann, Cindy" <CMann@manatt.com>; "Punukollu, Nina" <NPunukollu@manatt.com>; "Reyneri, Dori Glanz" <dreyneri@manatt.com>; "Traube, Ashley" <ATraube@manatt.com>; "Govender, Ahimsa" <AGovender@manatt.com>; "Kim, Lora" <LYKim@manatt.com>; "Cash, Judith (CMS/CMCS)" <Judith.Cash@cms.hhs.gov>; "Rashid, Mehreen (CMS/CMCS)" <mehreen.rashid@cms.hhs.gov>; "Decaro, Teresa (CMS/CMCS)" <teresa.decaro@cms.hhs.gov>; Sadwith, Tyler@DHCS; Samimi, Farrah@DHCS; "Cisneros, Bambi" <Bambi.cisneros@dhcs.ca.gov>; "Phillip, Susan" <Susan.Philip@dhcs.ca.gov>; "Williams, Sandra" <Sandra.Williams@dhcs.ca.gov>; "Toyama, Aaron" <Aaron.Toyama@dhcs.ca.gov>; Cooper, Jacey@DHCS; "Tsai, Daniel (CMS/CMCS)" <Daniel.Tsai@cms.hhs.gov>; "McClenathan, Jane (CMS/CMCS)" <Jane.McClenathan@cms.hhs.gov>

Attendees:
'Noelle.Simonick@dhcs.ca.gov'; 'janet.rudnick@dhcs.ca.gov'; 'rachel.nichols@cms.hhs.gov'; Ross, Heather (CMS/CMCS); Friedman, Kate (CMS/CMCS); 'Aaron.Toyama@dhcs.ca.gov'; 'Bambi.Cisneros@dhcs.ca.gov'; 'Benjamin.Mcgowan@dhcs.ca.gov'; Brumer, Justin@DHCS; 'AnhThu.Bui@dhcs.ca.gov'; 'Dana.Durham@dhcs.ca.gov'; Font, Amanda; 'Jacey.cooper@dhcs.ca.gov'; Lee, Angeli; 'Lindy.Harrington@dhcs.ca.gov'; 'Rafael.Davtian@dhcs.ca.gov'; 'Rene.Mollow@dhcs.ca.gov'; 'farrah.samimi@dhcs.ca.gov'; 'Saralyn.Ang-olson@dhcs.ca.gov'; 'susan.philip@dhcs.ca.gov'; 'tyler.sadwith@dhcs.ca.gov'; 'yingjia.huang@dhcs.ca.gov'; Guyer, Jocelyn; Lam, Alice; Mann, Cindy; Punukollu, Nina; Reyneri, Dori Glanz; Traube, Ashley; Govender, Ahimsa; Kim, Lora; Cash, Judith (CMS/CMCS); Rashid, Mehreen (CMS/CMCS); Decaro, Teresa (CMS/CMCS); Sadwith, Tyler@DHCS; Samimi, Farrah@DHCS; Cisneros, Bambi; Phillip, Susan; Williams, Sandra; Toyama, Aaron; Cooper, Jacey@DHCS; Tsai, Daniel (CMS/CMCS); McClenathan, Jane (CMS/CMCS)

Location:
https://manatt.zoom.us/j/92009574479?pwd=TnRuRm1xdHFCQjRZVE5XMWdOQXVkZz09

Start Time:
12/1/2022 6:00:00 PM +0000

End Time:
12/1/2022 6:30:00 PM +0000

Reminder Time:
12/1/2022 5:45:00 PM +0000

Is Recurring:

false

Busy Status:
Tentative

Attachments:
image001.jpg

Hi there,

Lora Kim is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting

Phone one-tap:

US: +13092053325,,92009574479# or +13126266799,,92009574479#

Meeting URL:

https://manatt.zoom.us/j/92009574479?pwd=TnRuRm1xdHFCQjRZVE5XMWdOQXVkZz09

Meeting ID:

(b)(6)

Passcode:

(b)(6)

Join by Telephone

For higher quality, dial a number based on your current location.

Dial:

US: +1 309 205 3325 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 or +1 301 715 8592 or +1 564 217 2000 or +1 669 444 9171 or +1 669 900 6833 or +1 719 359 4580 or +1 253 215 8782 or +1 346 248 7799 or +1 386 347 5053 or 888 788 0099 (Toll Free) or 877 853 5247 (Toll Free)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

International numbers

Join from an H.323/SIP room system

H.323:

162.255.37.11 (US West)
162.255.36.11 (US East)

Meeting ID:

(b)(6)

Passcode:

(b)(6)

SIP:

92009574479@zoomcrc.com

Passcode:

(b)(6)

Meeting Title:
PREP: (b)(6) Mtg w/Georgetown University's Medicaid Section 1115 Waiver Task Force

From:
CMS Administrator <CMSAdministrator@cms.hhs.gov>

Sent:
11/25/2022 10:42:07 PM +0000

To:
"(b)(6) (she/her), Administrator (CMS/OA)" (b)(6) "Ellis (she/her), Kyla (CMS/OA)" <Kyla.Ellis@cms.hhs.gov>; "McLemore, Monica (CMS/OSORA)" <Monica.McLemore@cms.hhs.gov>; "Khan, Farooq (CMS/OSORA)" <Farooq.Khan@cms.hhs.gov>; "Tsai, Daniel (CMS/CMCS)" <Daniel.Tsai@cms.hhs.gov>; "Katch (she/her), Hannah (CMS/OA)" <Hannah.Katch@cms.hhs.gov>; "Costello, Anne Marie (CMS/CMCS)" <AnneMarie.Costello@cms.hhs.gov>; "Cash, Judith (CMS/CMCS)" <Judith.Cash@cms.hhs.gov>; "Jackson, Marilyn (CMS/OSORA)" <Marilyn.Jackson@cms.hhs.gov>

Attendees:
(b)(6) Kyla Ellis (CMS/) (kyla.ellis@cms.hhs.gov); McLemore, Monica (CMS/OSORA); Khan, Farooq (CMS/OSORA); Tsai, Daniel (CMS/CMCS); Hannah Katch (CMS/OA) (hannah.katch@cms.hhs.gov); Costello, Anne Marie (CMS/CMCS); Cash, Judith (CMS/CMCS); Jackson, Marilyn (CMS/OSORA)

Location:
Zoom; https://cms.zoomgov.com/j/1603280271?pwd=UzY3Y2lFOGJIMG5aRmVRdHUyWGdKdz09

Start Time:
11/30/2022 6:30:00 PM +0000

End Time:
11/30/2022 6:55:00 PM +0000

Duration:
25 minutes

Reminder Time:
11/30/2022 6:30:00 PM +0000

Is Recurring:
false

Recurrence Type:
Not

Recurrence Pattern:

Response Status:
5

Busy Status:
Tentative

Attachments:

External Meeting Request: Medicaid Section 1115 Waiver Task Force*Georgetown University

CMS Administrator is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting
https://cms.zoomgov.com/j/1603280271?pwd=UzY3Y2lFOGJIMG5aRmVRdHUyWGdKdz09

Meeting ID: (b)(6)
Password: (b)(6)

One tap mobile
+16692545252,,1603280271# US (San Jose)
+16468287666,,1603280271# US (New York)

Dial by your location
+1 669 254 5252 US (San Jose)
+1 646 828 7666 US (New York)
833 568 8864 US Toll-free
Meeting ID: (b)(6)
Find your local number: https://cms.zoomgov.com/u/abJXDWi6XG

Join by SIP
Password: (b)(6)
sip: (b)(6) sip.zoomgov.com

This meeting may be recorded. The host is responsible for maintaining any official recordings/transcripts of this meeting. If recorded, this meeting becomes an official record and shall be retained by the host in their files for 3 years or if longer needed for agency business. If a recording intends be fully transcribed or is being captured for the purpose of creating meeting minutes, the host shall retain the record in their files for 3 years or if no longer needed for agency business, whichever is later.

External Meeting Request: Medicaid Section 1115 Waiver Task Force*Georgetown University
From:
"McLemore, Monica (CMS/OSORA)" <Monica.McLemore@cms.hhs.gov>

Sent:
11/2/2022 12:21:56 PM -0400

To:
"Neal, Phaedra (CMS/OA)" <Phaedra.Neal@cms.hhs.gov>

CC:
"Khan, Farooq (CMS/OSORA)" <Farooq.Khan@cms.hhs.gov>

Subject:
External Meeting Request: Medicaid Section 1115 Waiver Task Force/Georgetown University

Attachments:
Letter to Secretary to Improve 1115 Waiver Process.pdf

Hi Phaedra,

Georgetown University has provided the following availability for representatives of the Medicaid Waiver Task Force to meet with the Administrator. Please let me know if any of these work for a 30-minute slot:
Friday, November 18 from 12-1 or 2-2:30
Monday, November 28 from 11-12:30 or 1:30-2
Tuesday, November 29 from 12:30-4pm
Thursday, December 1 from 1-5pm

Meeting Participants:
Joan Alker, Co-Founder, Center for Children and Families
Allexa Gardner, Research Associate, Center for Children and Families
Others TBD

Contact:
Joan Alker
Executive Director, Research Professor
Center for Children and Families
Georgetown University McCourt School of Public Policy
(202)306-8383
jca25@georgetown.edu

The Medicaid Waiver Task Force, comprised of fifty-one organizations representing patient, provider, and advocacy groups, undersigned a letter to Secretary Becerra, dated 8/17/2022 (attached), urging CMS to strengthen the current regulations to ensure that section 1115 demonstrations promote coverage and improve the transparency of the process of approving, amending, and renewing demonstrations. As a follow-up to the letter, the group requests a virtual meeting with the Administrator and Dan Tsai to discuss this matter.

Thanks,
Monica

August 17, 2022

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Recommended Regulatory Actions for Section 1115 Medicaid Demonstration Process

Dear Secretary Becerra,

The undersigned organizations write to urge you to promulgate regulations regarding the section 1115 Medicaid demonstration process. A substantial and growing portion of Medicaid is funded through section 1115 and there is a critical need to develop a regulatory framework that clarifies the parameters of the authority, clears up confusion among states and courts, strengthens the transparency rules, and protects the integrity of the Medicaid program. This is among the most important things the administration can do for the long-term security of the Medicaid program and the millions of people who rely on the program for their health insurance.

CMS must set out a definition of "the objectives of Medicaid" and establish related principles to avoid harmful demonstration and waiver approvals, such as work requirements or premiums in Medicaid. CMS's regulation should address several specific and important problems in the 1115 process.

Defining the Objectives of Medicaid for Purposes of Section 1115 Demonstrations

CMS should promulgate a regulation which requires that section 1115 demonstrations promote the objectives of Medicaid, with a definition of the objectives of Medicaid based primarily in the purpose of the program identified in section 1901, namely to furnish medical assistance, rehabilitation, and other services. CMS should also ensure that the new definition of the objectives of Medicaid explicitly affirms the Medicaid entitlement and open-ended matching payment structure.

CMS's definition should also clarify that the clause "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care" cannot be interpreted to allow demonstrations that "promote independence" if they do not furnish services or if they reduce access to services.

CMS Should Create 1115 Guardrails for Promoting the Objectives of Medicaid

CMS's regulation should further operationalize the definition of the objectives of Medicaid by creating 1115 "guardrails," similar to the section 1332 guardrails, that ensure demonstrations promote, not undercut, the purpose of Medicaid. Such guardrails should include:

1. Demonstrations cannot be approved if they would likely reduce the number of individuals covered by Medicaid in a state, or otherwise reduce the number of individuals who have health insurance in the state.

2. Demonstrations cannot be approved if they would likely reduce the available services, or amount, duration, and scope of any services, provided to Medicaid enrollees; this includes maintaining access to community-based services.

3. Demonstrations cannot be approved if they would reduce the affordability of services for enrollees, including cost-sharing, premiums, and any other costs, unless they comply with the standards in section 1916(f).
4. Demonstrations should not otherwise reduce access to care, such as by making application, enrollment, or renewal more difficult.

CMS should require that all demonstrations meet all four guardrails for the full population eligible for the demonstration and for specific sub-populations when the guardrail impacts are disaggregated by race/ethnicity and other factors. Existing regulations should be supplemented to require that state applications for section 1115 demonstrations include specific and disaggregated estimates for each of the guardrails as well as a comprehensive equity assessment, explaining the effect the proposal would likely have on health coverage and access to care.

Protecting the Integrity and Transparency of the Demonstration Process

We recommend that CMS's regulation additionally make three changes to strengthen demonstration processes.

First, the regulation should require the full transparency process (including notice and comments) for all 1115 demonstrations that would impact eligibility, enrollment, benefits, cost-sharing, or financing – including new applications, extensions, and amendments. Adding amendments is key as so many states have existing section 1115 demonstrations and major changes are frequently made through amendments. Just like CMS's current regulations include slightly different requirements for new applications and extensions, new regulations could specify reasonable requirements for significant amendments that balance transparency with states' needs to make timely changes. Meaningful changes to eligibility, benefits, cost-sharing, enrollment or financing all require public comment in our view.

Second, the permissible exceptions to the transparency process in the case of a public health emergency needs to be tightened up. The regulation should clarify or strengthen existing regulations to prevent pretextual exemptions from the transparency process. Exemption from the transparency process should be very rare, and only used for demonstrations that are directly related to emergency response (i.e., not just coincidentally contemporaneous) and when use of a comment period would materially delay such emergency response.

Third, CMS's regulation should set clear standards for the duration of demonstrations, not to exceed five years. Section 1115 authorizes "experimental, pilot, or demonstration" projects. Ten years are generally not needed to assess the value of an experiment, and ten years is a long time to have an unsuccessful waiver in place. Ten years also creates the possibility that an outgoing administration can bind a new administration for the entirety of its two terms. Some ten-year approvals do not comport with the statute. We recommend that, consistent with long-standing practice, CMS should implement an unambiguous 5-year limit for new demonstrations, extensions, and amendments.

Thank you for your consideration of our views. If you have questions, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

American Academy of Family Physicians
American Academy of Pediatrics
American Association on Health and Disability
American Cancer Society Cancer Action Network

American College of Obstetricians and Gynecologists
American Heart Association
American Lung Association
Arthritis Foundation
Asian & Pacific Islander American Health Forum (APIAHF)
Autism Society of America
Autistic Self Advocacy Network
Black Mamas Matter Alliance
CancerCare
Catholic Health Association of the United States
Center for Disability Rights
Center for Law and Social Policy (CLASP)
Center on Budget and Policy Priorities
Community Catalyst
Cystic Fibrosis Foundation
Easterseals
Epilepsy Foundation
Families USA
First Focus on Children
Georgetown University Center for Children and Families
Hemophilia Federation of America
Justice in Aging
Lakeshore Foundation
March of Dimes
Medical Transportation Access Coalition
Medicare Rights Center
NASTAD
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Disability Rights Network (NDRN)
National Family Planning & Reproductive Health Association
National Health Care for the Homeless Council
National Health Law Program
National Immigration Law Center
National Multiple Sclerosis Society
National Network for Arab American Communities (NNAAC)
National Organization for Rare Disorders
National Partnership for Women & Families
National Patient Advocate Foundation

Physicians for Reproductive Health
Primary Care Development Corporation
The Arc of the United States
The Leukemia & Lymphoma Society
UnidosUS
Union for Reform Judaism

Author: Microsoft Office User
CreationDate: 2022-08-17 21:18:40
Creator: Microsoft Word
ModDate: 2022-11-02 14:07:46

Center for Medicaid and CHIP Services – Mental Health and Substance Use Disorder Strategy
Introduction
As the largest single source of funding for mental health (MH) and substance use disorder (SUD) treatment and support services,

1 The Medicaid and CHIP Payment and Access Commission. Behavioral Health in the Medicaid Program – People, Use, and Expenditure. Report to Congress, Chapter 4. June 2015. https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf

1
Medicaid along with the Children's Health Insurance Program (CHIP) underpin delivery of care for MH conditions and SUDs across the United States and provide critical support for millions of people with these conditions. Improving access to good quality MH and SUD treatment is among the highest priorities of the Centers for Medicare & Medicaid Services (CMS) and is integral to the Center for Medicaid and CHIP Services' (CMCS') partnership with states to provide health care coverage. CMCS also collaborates closely with other federal agencies, particularly the Substance Abuse and Mental Health Services Administration (SAMHSA), to improve the quality and availability of MH and SUD services for Medicaid and CHIP enrollees.
Medicaid and CHIP can provide coverage for a full array of services and supports for people with MH conditions and SUDs, including services that generally are not covered by other health care programs or plans. This feature of Medicaid and CHIP is particularly critical for individuals with more serious MH conditions and/or SUDs who are more likely to be enrolled in Medicaid and CHIP.

2 Saunder H, Rudowitz R. Demographics and Health Insurance Coverage of Nonelderly Adults with Mental Illness and Substance Use Disorders in 2020. Kaiser Family Foundation Brief. June 2022. https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/

2
In addition, special protections incorporated into Medicaid and CHIP, including the mandatory Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, provide assurance that enrollees struggling with serious MH conditions or SUDs have coverage for the care they need.
As highlighted in a recent CMCS Informational Bulletin "Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth", the mandatory EPSDT benefit requires coverage of all medically necessary care for children and adolescents under the age of 21 enrolled in Medicaid, including coverage of prevention, screening, assessment, and treatment services for MH conditions and SUDs. This clarification is critically important since MH and SUD conditions are among the most prevalent health conditions affecting children,

3 Whitney DG, Peterson MD. US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. JAMA Pediatr,173(2):389-391 (2019). https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377 ; Bitsko RH, Claussen AH, Lichstein J, et al. Mental Health Surveillance Among Children — United States, 2013–2019. MMWR Suppl 2022;71(Suppl-2):1–42 (Feb. 2022). https://www.cdc.gov/mmwr/volumes/71/su/su7102a1.htm?s_cid=su7102a1_w .

3

and Medicaid and CHIP provide health care coverage for about half of the children and adolescents in the U.S.

4 Alker J, Brooks T. Millions of Children May Lose Medicaid: What Can be Done to Help Prevent them from Becoming Uninsured. Georgetown University Health Policy Institute Center for Children and Families Report. Feb. 17, 2022. https://ccf.georgetown.edu/2022/02/17/millions-of-children-may-lose-medicaid-what-can-be-done-to-help-prevent-them-from-becoming-uninsured .

4

Coverage of MH and SUD treatment and services through Medicaid and CHIP was expanded and strengthened by the Affordable Care Act. One key outcome of this expansion has been significantly improved access to MH and SUD treatment among low-income adults.

5 Guth L, Ammula M. Building on the Evidence Base: Studies on the Effect of Medicaid Expansion, February 2020 to March 2021. Kaiser Family Foundation Report. May 6, 2021. https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/ .

5

These individuals are among a number of groups at heightened risk of MH conditions and SUDs who depend on Medicaid and CHIP.

Ethnic and racial minorities and people with disabilities also experience higher rates of MH conditions and SUDs than the general population. These groups also rely on Medicaid to a higher degree than other forms of coverage.

6 Donohue JM, Cole ES, James CV, et a. The US Medicaid Program: Coverage, Financing, Reforms, and Implications for Health Equity. JAMA, 328(11):1085–1099 (2022). https://jamanetwork.com/journals/jama/fullarticle/2796374

6

Thus, addressing disparities in coverage and access to MH and SUD treatment and services, with the goal of increasing equity, is central to CMCS' mission.

Another hallmark of Medicaid and CHIP, coverage of home and community-based services (HCBS), is particularly essential for individuals with more serious MH conditions and SUDs. States' HCBS programs are vital safety net programs that promote community engagement in treatment, which is fundamental for improving outcomes for individuals with MH conditions or SUDs. Beyond providing clinical services and treatment, HCBS include social supports to address basic human needs, including linkages and services to support stable housing, access to food, and assurance of transportation. These services support individuals with more serious MH conditions and SUDs in their homes and communities and enable them to pursue self-identified goals. Ultimately, HCBS covered by Medicaid and CHIP provide a foundation for recovery among people with mental illnesses and/or SUDs by providing hope and a sense of purpose.

Improving engagement in treatment for MH and SUD services is also critical for improving physical health care outcomes among these high need populations.

7 Chapel JM, Ritchey MD, Zhang D, et al. Prevalence and Medical Costs of Chronic Diseases Among Adult Medicaid Beneficiaries. American Journal of Preventive Medicine, 53(6):S143-S154 (2017). https://www.ajpmonline.org/article/S0749-3797(17)30426-9/fulltext .

7
Individuals with MH conditions or SUDs have high rates of co-occurring physical health conditions that drive much of the elevated cost of treating these individuals.

8Melek SP, Norris DT, Paulus J, et al. Potential economic impact of integrated medical-behavioral healthcare. Milliman Research Report. Jan. 2018. https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx

8
Medicaid and CHIP policies aimed at improving integration of MH and SUD services with primary care, like the recent policy clarification encouraging coverage of interprofessional consultations, such as by MH and SUD treatment specialists for primary care and other providers, can help engage individuals in treatment by offering a more familiar care setting. In addition, this support for more integrated care can also improve outcomes for physical health conditions and help manage health care costs associated with individuals with MH conditions and SUDs.
Unfortunately, the COVID-19 pandemic has had a particularly detrimental impact on mental health and substance use.

9 Panchal N, Saunders H, Rudowitz R, et al. The Implications of Covid-19 for Mental Health and Substance Use. Kaiser Family Foundation Issue Brief. Updated March 20, 2023. https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

9
The increased need for MH and SUD treatment has occurred at a time when capacity to provide these services and supports has decreased. Currently, provider workforce shortages are common with nearly half of the U.S. population living in a mental health workforce shortage area.

10 Health Resources and Services Administration, Health Workforce Shortage Areas Dashboard. Accessed April 2023. https://data.hrsa.gov/topics/health-workforce/shortage-areas .

10

Rural areas are especially impacted by shortages of MH and SUD providers, given that individuals living in those areas experience similar and by some estimates higher rates of MH conditions and SUDs.

11 The Medicaid and CHIP Payment and Access Commission, Issue Brief: Medicaid and Rural Health, April 2021. https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf

11
Consequently, individuals in these areas generally have less access to treatment services or supports for these conditions.

12 Mack B, Whetsell H, Graves JM. Mental Health in Rural Areas. National Rural Health Association Policy Brief. Feb 2022. https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Mental-health-in-rural-areas-policy-brief-2022.pdf

12

Children and adolescents have been particularly affected by the impact of COVID-19 on MH and substance use.

13 Centers for Disease Control and Prevention. Youth Risk Behavior Survey Data: 2011-2021. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf .

13

Pediatric emergency department (ED) visits for mental health conditions increased throughout the pandemic.

14 Radhakrishnan L, Leeb RT, Bitsko RH, et al. Pediatric Emergency Department Visits Associated with Mental Health Conditions Before and During the COVID-19 Pandemic — United States, January 2019–January 2022. MMWR Morb Mortal Wkly Rep, 71:319–324 (2022). http://dx.doi.org/10.15585/mmwr.mm7108e2

14

Moreover, ED boarding, which occurs when people wait for extended periods in these settings for access mental health treatment, was common before the pandemic

15 McEnany FB, Ojugbele O, Doherty JR, et al. Pediatric Mental Health Boarding. Pediatrics. 146(4) (Oct 2020). https://publications.aap.org/pediatrics/issue/146/4

15

and now has also increased.

16 Ibeziako P, Kaufman K, Scheer KN, et al. Pediatric Mental Health Presentations and Boarding: First Year of the Covid-19 Pandemic. Hosp Pediatrics, 12(9): 751-760 (2022).

16

Of further concern, adults and adolescents with serious mental illness (SMI) and/or SUD – particularly those from marginalized groups – continue to experience high rates of incarceration. Millions of individuals with SMI and SUDs are booked into jail every year; many for minor crimes such as loitering or vagrancy.

17 Balfour ME, Stephenson AH, Winsky J, et al. Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies. National Association of State Mental Health Program Directors Paper. Aug 2020. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf.

17
They tend to stay in jail far longer than other individuals and often do not receive needed MH or SUD treatment.

18 Balfour ME, Stephenson AH, Winsky J, et al. Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies. National Association of State Mental Health Program Directors Paper. Aug 2020. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf.

18
Disciplinary or legal actions are a frequent response to children and adolescents struggling with mental health or substance use disorders.

19 Fabelo T, Thompson MD, Plotkin M, et al. (2011). Breaking schools' rules: A statewide study of how school discipline relates to students' success and juvenile justice involvement. Council of State Governments Justice Center. 2011. https://csgjusticecenter.org/wp-content/uploads/2020/01/Breaking_Schools_Rules_Report_Final.pdf ; Mallett CA. The School-to-Prison Pipeline: A Critical Review of the Punitive Paradigm Shift. Child and Adolescent Social Work Journal, 33(1), 15–24 (April 2015). https://link.springer.com/article/10.1007/s10560-015-0397-1

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Tragically, nearly 70 percent of children in the juvenile justice system have a diagnosable MH condition or SUD.

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To help address these issues, CMCS has engaged in a multifaceted approach to strengthen coverage of MH and SUD treatment in Medicaid and CHIP across all care delivery systems. As a part of this effort, CMCS released a Request for Information (RFI) from February 17, 2022, to April 18, 2022, that asked the public for suggestions on increasing access in Medicaid and CHIP. Major themes in the public comments included the need to improve network adequacy for MH and SUD providers and to support greater transparency in coverage policies including payment rates.
Accordingly, CMCS has prioritized developing new strategies for improving participation of MH and SUD providers in Medicaid and CHIP. To further that objective, the recent Access and Managed Care Notices of Proposed Rulemaking propose significant regulatory changes aimed at improving access to MH and SUD treatment services and supports.
Moreover, as the public health emergency (PHE) winds down, maintaining health care coverage is critical for ensuring access to MH and SUD treatment services and supports. Since March 2020, as a condition of receiving temporary, increased federal Medicaid matching funds, states have been required to maintain enrollment of nearly all Medicaid enrollees. This continuous enrollment condition ended on March 31, 2023, and states are returning to normal eligibility and enrollment operations. States will have 12 months to initiate and 14 months to complete redeterminations for everyone enrolled in Medicaid and CHIP. This process is commonly referred to as "unwinding". CMCS is working

proactively with state Medicaid and CHIP agencies and other stakeholders to ensure that people stay connected to coverage either by remaining enrolled in Medicaid or CHIP, if they are still eligible, or transitioning to another coverage option, such as Marketplace coverage.

CMCS also has a number of initiatives underway aimed at making MH and SUD treatment more readily available where people regularly go to seek care, including non-specialized health care settings such as primary care, and other non-traditional settings, such as schools, jails and prisons, as well as through programs that address health-related social needs (HRSN). Increased availability of MH and SUD treatment services and supports in these non-specialized and non-traditional settings can encourage engagement in MH and SUD treatment and reduce the stigma associated with these conditions.

As an illustration of this dynamic, when mental health care is available in school settings, youth are far more likely to be identified early and to initiate and complete care.

21 Rones M, Hoagwood K. (2000). School-based mental health services: A research review. Clinical Child and Family Psychology Review, 3(4), 223-241. https://pubmed.ncbi.nlm.nih.gov/11225738/ ; Burns B J, Costello E J, Angold A, et al. Children's mental health service use across service sectors. Health Affairs, 14(3), 147-159 (1995). https://www.healthaffairs.org/doi/10.1377/hlthaff.14.3.147

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School-based MH and SUD programs incorporating prevention, early intervention, and graduated levels of treatment services and supports have been associated with enhanced academic performance,

22 Greenberg M, Weissberg, R., O'Brien M, et al. Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. American Psychologist, 58: 466 (2003). https://psycnet.apa.org/fulltext/2003-05959-009.pdf .

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23 Zins JE, Bloodworth MR, Weissberg R P, et al. The scientific based linking social and emotional learning to school success. In Zins J, Weissberg R, Wang M, et al. (Eds.). Building academic success on social and emotional learning: What does the research say? (pp. 3-22). NY: Teachers College Press (2004). https://www.researchgate.net/publication/242224840_The_Scientific_Base_Linking_Social_and_Emotional_Learning_to_School_Success

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decreased need for special education,

24 Bruns E J, Walwrath C, Glass-Siegel M, et al. School-based mental health services in Baltimore: Association with school climate and special education referrals. Behavior Modification, 28, 491-512(2004). https://pubmed.ncbi.nlm.nih.gov/15186512/

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fewer disciplinary encounters,

25 Jennings J, Pearson G, Harris M. Implementing and maintaining school-based mental health services in a large, urban school district. Journal of School Health, 70, 201-206 (2000). https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1746-1561.2000.tb06473.x

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increased engagement with school,

26 Greenberg MT, Domitrovich CE, Graczyk PA, et al. The study of implementation in school-based prevention interventions: Theory, research, and practice (Vol. 3). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. 2005. https://www.academia.edu/28690843/The_study_of_implementation_in_school_based_preventive_interventions_Theory_research_and_practice

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and elevated rates of graduation.

27 Lehr C A, Johnson DR, Bremer CD, et al. Essential tools: Increasing rates of school completion: Moving from policy and research to practice. University of Minnesota, Institute on Community Integration, National Center on Secondary Education and Transition. 2004. https://conservancy.umn.edu/bitstream/handle/11299/172999/dropout.pdf?sequence=1&isAllowed=y

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CMCS actions to bolster Medicaid and CHIP support for enrollees with mental health conditions or SUDs are outlined in the following strategy. Priorities include improving coverage and integration to increase access to prevention and treatment services. CMCS is also focused on encouraging engagement in care through increased availability of HCBS and coverage of non-traditional services and settings where individuals with mental illnesses and/or SUDs are often found. In addition, CMCS has numerous actions geared toward improving quality of care. Woven throughout these priority areas is a commitment to advancing equity and promoting integrated, whole-person care.
Strategy Overview
In summary, the three overarching goals with prioritized strategies that guide CMCS's actions to improve treatment and support for Medicaid and CHIP beneficiaries with MH conditions and/or SUDs are --
Increase Access to Prevention and Treatment by
Improving Coverage of MH and SUD Screening and Therapies and Promoting Parity
Supporting Integration and Coordination of MH and SUD Treatment with Other Health Care
Improve Engagement in Care by
Increasing Treatment and Support in Home and Community-Based Settings
Supporting Access to MH and SUD Services through Non-Traditional Settings
Enhance Quality of Care by
Encouraging Implementation of Evidence-Based Practices
Enhancing Quality Measurement
Analyzing and Publicizing Data on Key Topics
Prioritized Activities

Some high priority actions underway or under development for each of these goals and strategies are outlined below.
Increase Access to Prevention and Treatment
Strategies:
Improving Coverage of MH and SUD Treatment and Promoting Parity
Actions:
Supporting Connections to Health Care Coverage

Engagement with States on Unwinding:
CMCS has prioritized ensuring that individuals who were covered by Medicaid and CHIP during the COVID-19 PHE are connected to continued health care coverage as the Medicaid continuous enrollment condition ends. Maintaining health care coverage for the more than 92 million individuals enrolled in Medicaid and CHIP is critical, especially for those with MH conditions and SUDs. As we have seen in states that expanded Medicaid under the Affordable Care Act, a significant benefit of expanded health care coverage is improved access to MH and SUD treatment.

28 Guth L, Ammula M. Building on the Evidence Base: Studies on the Effect of Medicaid Expansion, February 2020 to March 2021, Kaiser Family Foundation Report. May 6, 2021. https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/ .

Similarly, ensuring continued enrollment of eligible individuals will be essential for maintaining access to MH and SUD services for millions of low-income adults and youth.

Connecting Kids to Coverage Campaign:
The Connecting Kids to Coverage National Campaign is a national outreach and enrollment initiative that reaches out to families with children and teens eligible for Medicaid and provides a full range of outreach and enrollment materials (including customizable posters and flyers, social media messaging, as well as radio and TV public service announcements, videos featuring successful outreach strategies, and outreach strategy and social media guides). These materials can help states, community organizations, schools, health care providers and others organize and conduct successful outreach activities. Campaign resources include a radio media tour, which is conducted annually. This year, the radio media tour focused on Medicaid and CHIP coverage of mental health services. Information about the mental health initiative is available at: https://www.insurekidsnow.gov/initiatives/mental-health/index.html.

Increasing Network Adequacy and Participation by MH and SUD Treatment Providers

Managed Care and Access Rulemaking:
Significant new requirements included in the recently proposed rules on “Assuring Access to Medicaid Services” and “Managed Care Access, Finance, and Quality”, published on April 27, 2023 demonstrate CMCS’ strong commitment to improving access to MH and SUD services. These proposed regulatory changes are focused on strengthening access to and quality of care in Medicaid and CHIP by establishing certain national standards for timely access to care under managed care plans, through which a majority of Medicaid beneficiaries receive benefits. These rules would also establish transparency for Medicaid and CHIP payment rates for providers, other access standards for transparency and accountability, and options to empower beneficiary choice. Proposed managed care maximum appointment wait time standards for managed care plans that apply to outpatient MH and SUD services and requirements for secret shopper surveys to assess appointment wait times and provider directory accuracy. In addition, states would be required to submit an annual payment analysis for managed care and biennial payment analysis for fee-for-service that compares payment rates for certain services, including outpatient MH and SUD services as a proportion of Medicare’s payment rates.

Improved Reimbursement through Section 1115 Demonstrations:
CMCS has incorporated provisions in certain section 1115 demonstrations, including those that address HRSN, Designated State Health Programs, and Health Equity, that require states to assess and make progress on closing the gap

between that state's Medicaid payment rates and Medicare rates for certain types of services, including MH and SUD services. These types of provisions have been included, for example, in Section 1115 demonstrations for Oregon and Massachusetts.

Demonstration to Increase SUD Provider Capacity:
Through this initiative, CMCS has been working with states to improve SUD treatment provider participation in Medicaid and will issue, in collaboration with federal agency partners, three reports to Congress over the next few years on findings from this initiative that ends in September 2024.

Ensuring Compliance with Mental Health Parity and Addiction Equity Act and Other Requirements

CMCS is developing new tools and processes to improve oversight of parity compliance and continues to work with states to enforce parity requirements. In addition, CMS continues to work closely with states to ensure coverage of services to prevent, diagnose, and treat a broad range of MH and SUD symptoms and disorders in every state's CHIP program as called for by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment Act (SUPPORT Act). CMCS requires that states incorporate age appropriate, validated screening tools, such as those recommended by the American Academy of Pediatrics and the United States Preventive Services Taskforce, and that the behavioral health services are provided in a culturally and linguistically appropriate manner.

Improving Implementation of Early Periodic Screening, Diagnostic and Treatment Services Requirements (EPSDT)

The Bipartisan Safer Communities Act (BSCA) requires CMS to review states' compliance with the Medicaid EPSDT benefit, provide technical assistance to states, issue guidance on best practices, and provide a report to Congress on its findings by June of 2024 Through these activities, CMCS will actively engage with states to ensure they are complying with the EPSDT benefit, including ensuring that states are providing children and adolescents with MH conditions and SUDs access to all medically necessary care. CMCS recently issued an information bulletin reminding states of their obligation to cover mental health and SUD services under EPSDT.
Supporting Integration and Coordination of MH and SUD Treatment with Other Health Care
Actions:
Encouraging Support for Use of Health Information Technology (HIT) among MH and SUD Treatment Providers

As a component of the Section 1115 demonstrations focused on SMI and serious emotional (SED) disturbance, CMCS requires states to develop plans for implementing HIT to support improvements to delivery of mental health care through those demonstrations. In addition, the State Medicaid Directors Letter (SMDL) regarding section 1115 demonstration opportunities to support community reentry and improve care transitions for individuals who were incarcerated (also discussed below) encourages states to consider supporting improvements in HIT to improve care transitions as part of those demonstrations. CMCS will also issue new technical guidance in collaboration with federal partners on how states can receive enhanced federal financial participation for qualified activities (e.g., 90 percent and 75 percent) for HIT systems that support care delivery by MH and SUD treatment providers.
Supporting Continued and Improved Coverage of Telehealth

By the end of 2023, CMCS will issue additional guidance for states on use of telehealth to provide services coverable by Medicaid and CHIP, which has been shown to be particularly effective for improving access to MH and SUD treatment.

29 Mace S, Boccanelli A, Dormond M. The Use of Telehealth within Behavioral Health Settings: Utilization, Opportunities, and Challenges. Behavioral Health Workforce Research Center, University of Michigan, (March 2018) https://behavioralhealthworkforce.org/wp-content/uploads/2018/05/Telehealth-Full-Paper_5.17.18-clean.pdf ; Bashshur RL, Shannon GW, Bashshur N, et al. The empirical evidence for telemedicine interventions in mental disorders. Telemed J E Health, 22(2): 7-113 (Jan. 2016). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4744872/ ; Lin L, Casteel D, Shigekawa E, et al. Telemedicine-delivered treatment interventions for substance use disorders: A systematic review. Journal of Substance Abuse Treatment, 101: 38-49 (June 2019). https://www.sciencedirect.com/science/article/pii/S0740547218304288?via%3Dihub

This guidance will build on the "State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth" and a supplement that were developed by CMCS during the COVID-19 PHE.

Increasing Availability of MH and SUD Treatment through Interprofessional Consultation

CMCS will build on new guidance on coverage and reimbursement for interprofessional consultations. Through direct technical assistance and engagement with state Medicaid agencies, CMCS is focused on raising awareness about opportunities this policy creates for improving integration of MH and SUD treatment into additional settings including primary care and pediatricians' offices, EDs, and school-based health centers as well as the potential to mitigate workforce shortages by better leveraging the existing supply of MH and SUD specialists.

Improve Engagement in Care
Strategies:
Increasing Treatment and Support in Home and Community-Based Settings
Actions:
Funding a Continuum of Crisis Stabilization Services

Mobile Crisis Intervention Services Grants and State Plan Amendments:
As authorized in the American Rescue Plan, CMCS provided $15 million in planning grants to 20 states to support implementation of Medicaid qualifying community-based mobile crisis intervention services. CMCS continues to engage regularly with states awarded planning grants and extended the deadline for using these funds until September 2023. As part of these efforts, CMCS is working with a number of states to implement state plan amendments to qualify for temporary enhanced federal Medicaid funding for mobile crisis intervention services. Foundational to these efforts has been a State Health Official Letter issued by CMCS specifying the requirements for mobile crisis intervention services to be eligible for the temporary increased federal matching funds and also describing a number of additional ways states may support crisis services for Medicaid and CHIP beneficiaries.

Guidance and Technical Assistance on Medicaid & CHIP Support for Crisis Services
CMCS is partnering with SAMHSA to develop and issue additional guidance on Medicaid and CHIP support for crisis stabilization services as well as working together to establish a technical assistance center on this topic and develop a compendium of best practices.

Support for Crisis Response by Certified Community Behavioral Health Clinics
CMCS is working with SAMHSA to expand availability of Certified Community Behavioral Health Clinics (CCBHCs) nationwide (described below). As part of this work, we are proposing a new payment policy to encourage states to improve support for crisis response services by CCBHCs including mobile units and facility-based walk-in/urgent care services at CCBHCs. CMCS is incorporating this new policy into technical guidance and resources for the CCBHC demonstration.

Expanding the CCBHC Demonstration

In the CCBHC demonstration, participating state Medicaid programs receive enhanced federal funding for clinics that meet specific federal criteria including offering comprehensive services and evidence-based programs, improving care coordination, and reporting quality measures. CMCS is actively collaborating with SAMHSA and the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation to expand the demonstration as authorized in the BSCA and will start engaging with planning grant awardees in spring/summer of 2023 as these states prepare to apply for the demonstration in 2024. As a part of this effort, CMCS is developing and updating guidance on prospective payment system options including the performance measures and policies for the quality bonus component of these reimbursement methodologies.
Strengthening Support for HCBS