Appointment

From: CMS CMCS_Unwinding (b)(6) (b)(6)

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

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CC: Astrin, Clarese (CMS/OC); (b)(6); (b)(6)

Subject: CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations
Attachments: 20221118_Stakeholder Workgroup Agenda_Final.docx
Location: https://cms.zoomgov.com/j/1614591010?pwd=T2NueGZGL2NtbkNxOTFkS29nWk5Tdz09

Start: 11/18/2022 7:00:00 PM
End: 11/18/2022 8:00:00 PM
Show Time As: Tentative

Required 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); 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; Flynn, Judith (CMS/OPOLE); 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); Hornbuckle, Carolyn (NIHB.ORG; 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; Liu, Beth (CMS/CCIIO); Lorsbach (she/her), Anna (CMS/CCIIO); Lovejoy, Shannon (CMS/CMCS); lrodriguez@americanprogress.org; Lyndsey Cavender; Mccloy, Tamara (CMS/OPOLE); mcheek@ahca.org; Melissa McChesney; minnocent@naacpnet.org; mmiller@communitycatalyst.org; Montz, Ellen (CMS/CCIIO); msnider@unidosus.org; Naomi Ali; O'Connor, Sarah (CMS/CMCS); Rachel Thornton; rb1686@georgetown.edu; rcarreon@unidosus.org; Reilly, Megan (CMS/OC); robinr@kff.org; Ross, Christy; rrosales@communitycatalyst.org; rtetlow@acog.org; sarah.nolan@seiu.org; sdorn@unidosus.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
Optional Attendees:	Astrin, Clarese (CMS/OC)

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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**

    - [HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf"]
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/ending-covrg-optnl-covid-grp-guidance.pdf"]
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/covid19-phe-end-prep-11032022.pdf"]
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/ex-parte-renewal-102022.pdf"]
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/ffm-ibat-match-function.pdf"]
    - [HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/ffm-d-trg-overview.pdf"]
        - Additional resources available under Medicaid/Marketplace Coordination on [HYPERLINK "https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html"]
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/consumer-research-to-inform-unwinding-outreach.pdf"]

- **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:* [HYPERLINK "https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fclick.icptrack.com%2Ficp%2Frelay.php%3Fr%3D66175517%26msgid%3D550578%26act%3D6DF9%26c%3D1185304%26pid%3D2072585%26destination%3Dhttps%253A%252F%252Fcms.zoomgov.com%252Fwebinar%252Fregister%252FWN_qma5AvyBQWCTB0vbNF3lTA%26cf%3D6316%26v%3D040043a0fccfded53dff7d8b2638d163f864e9bf61587af26305f387f9acf530&data=05%7C01%7CJessica.Stephens%40cms.hhs.gov%7Ca8cebe435ed24c09ed2c08da4ade91b6%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637904617648441725%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2l

uMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2FPMNi%2FrjbSzijdPSp7t%2FuWarboBizN7YtMwVR6ARsZI%3D&reserved=0"]

- Next Meeting: December 9, 2022

Appointment

From: CMS CMCS_Unwinding (b)(6) (b)(6)

Sent: 1/14/2023 2:15:02 PM

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(b)(6) Carr, Lisa (CMS/OC)

Subject: CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations
Attachments: Untitled Attachment; Untitled Attachment; Untitled Attachment
Location: https://cms.zoomgov.com/j/1618164200?pwd=ZDJMUnAwZE9la0FUR1pzb01rZDNwZz09

Start: 2/16/2023 6:00:00 PM
End: 2/16/2023 7:00:00 PM
Show Time As: Tentative

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

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Optional Attendees: Joanne Marie Stacy Campbell; Collins Offner, Molly; Giavana Gould; Onyejiuwa, Nnedi (CMS/OC); Stephanie Myers; Nicolas Wilhelm; Ginnis, Kate (CMS/CMCS); Carr, Lisa (CMS/OC)

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Appointment

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Attachments: 20230216_Stakeholder Workgroup Agenda_FINAL.docx

Start: 2/16/2023 6:00:00 PM
End: 2/16/2023 7:00:00 PM
Show Time As: Busy

Recurrence: (none)

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Optional Attendees: Brandi Howard; Burke Hays; Joanne Marie Stacy Campbell; Collins Offner, Molly; Giavana Gould; Lueth, Teresa; Onyejiuwa, Nnedi (CMS/OC)

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

- **Welcome and Opening Remarks**

- **Overview of Recent Highlights & CMS Releases**
  - [HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf"] on the Consolidated Appropriations Act
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall01312023.pdf"]
  - Telephone Consumer Protection Act (TCPA) Updates
    - [HYPERLINK "https://www.fcc.gov/document/fcc-provides-guidance-enable-critical-health-care-calls"], Jan. 23, 2023
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall01242023.pdf"] from Jan. 24, 2023, CMCS All-State Call
  - Updated [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf"]–
    - 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** [HYPERLINK "https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf"]

- **Open Q&A and Discussion** (20 min)

- **Closing** (3 min)
  - Unwinding National Partner/Stakeholder Webinar: Wednesday, February 22 (12-1pm ET)
    - *Registration Link:* [HYPERLINK "https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fclick.icptrack.com%2Ficp%2Frelay.php%3Fr%3D66175517%26msgid%3D550578%26act%3D6DF9%26c%3D1185304%26pid%3D2072585%26destination%3Dhttps%253A%252F%252Fcms.zoomgov.com%252Fwebinar%252Fregister%252FWN_qma5AvyBQWCTB0vbNF3lTA%26cf%3D6316%26v%3D040043a0fccfded53dff7d8b2638d163f864e9bf61587af26305f387f9acf530&data=05%7C01%7CJessica.Stephens%40cms.hhs.gov%7Ca8cebe435ed24c09ed2c08da4ade91b6%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637904617648441725%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJ

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- Next Meeting: March 16, 2023 (1-2pm ET)

Appointment

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End: 3/23/2023 7:00:00 PM
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Recurrence: (none)

Required Attendees: 'lrodriguez@americanprogress.org'; 'Wallace, Nick'; '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'; Clark, Liz (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'; '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'; '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'; Liu, Beth (CMS/CCIIO); Lorsbach (she/her), Anna (CMS/CCIIO); Lovejoy, Shannon (CMS/CMCS); '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); Weiss, Alice (CMS/CMCS); Wood (he/him), Elijah (CMS/CCIIO); 'youdelman@healthlaw.org'; Bellsdale (she/her), Amber (CMS/CCIIO); 'Bennett, Andrea D'; 'Cherie Compartore'; 'CKennedy@mhpa.org'; 'elizabeth.hall@elevancehealth.com'; Gentile, Amy (CMS/CMCS); Giles, John (CMS/CMCS); 'Ingram, Carolyn'; 'Jennifer Babcock'; 'Jessica Cromer'; Kennedy (she/her), Ariel (CMS/CCIIO); 'mbagel@achp.org'; 'mhamelburg@ahip.org'; 'Mikal.Sutton@bcbsa.com'; Miller (he/him), Dan (CMS/CCIIO); 'mmurray@communityplans.net'; 'nshaffi@achp.org'; 'Paris, Katherine'; 'rjones@ahip.org'; 'scozzo@amerihealthcaritas.com'; 'sdmyers@amerihealthcaritas.com'; 'Shannon Attanasio'; Bell, Stephanie (CMS/CMCS); 'ijosey@populardemocracy.org'; 'vkrishnan@populardemocracy.org'; Kuhn, Juliet (CMS/CMCS)

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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)
  - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/accessibility-unwinding-slides.pdf" \o "accessibility-unwinding-slides"]
  - [HYPERLINK

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    - 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
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf"]
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit-esp.pdf"]

- **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:* [HYPERLINK "https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fclick.icptrack.com%2Ficp%2Frelay.php%3Fr%3D66175517%26msgid%3D550578%26act%3D6DF9%26c%3D1185304%26pid%3D2072585%26destination%3Dhttps%253A%252F%252Fcms.zoomgov.com%252Fwebinar%252Fregister%252FWN_qma5AvyBQWCTB0vbNF3lTA%26cf%3D6316%26v%3D040043a0fccfded53dff7d8b2638d163f864e9bf61587af26305f387f9acf530&data=05%7C01%7CJessica.Stephens%40cms.hhs.gov%7Ca8cebe435ed24c09ed2c08da4ade91b6%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637904617648441725%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2FPMNi%2FrjbSzijdPSp7t%2FuWarboBizN7YtMwVR6ARsZI%3D&reserved=0"]
    - Next Meeting: April 20, 2023 (1-2pm ET)

Appointment

To: CMS CMCS_Unwinding [cmcsunwinding@cms.hhs.gov]; 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]; 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sdmyers@amerihealthcaritas.com; Shannon Attanasio [sattanasio@mhpa.org]; Bell, Stephanie (CMS/CMCS) [stephanie.bell@cms.hhs.gov]; ijosey@populardemocracy.org; vkrishnan@populardemocracy.org; Kuhn, Juliet (CMS/CMCS) [juliet.kuhn@cms.hhs.gov]; Heppner, Eliza (HRSA) [eheppner@hrsa.gov]; Patel, Nisha (HRSA) [npatel@hrsa.gov]; Satchell, Samantha (OS/IOS/) [samantha.satchell@hhs.gov]

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Attachments: 20230420_Stakeholder Workgroup Agenda_FINAL.docx

Start: 4/20/2023 5:00:00 PM
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Required 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, Liz (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'; 'ekong@apiahf.org'; 'emanuel@healthlaw.org'; Cischke, Erica G. (CMS/CCIIO); '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'; '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'; Liu, Beth (CMS/CCIIO); 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'; Bellsdale (she/her), Amber (CMS/CCIIO); 'Bennett, Andrea D'; 'Cherie Compartore'; 'CKennedy@mhpa.org'; 'elizabeth.hall@elevancehealth.com'; Gentile, Amy (CMS/CMCS); Giles, John (CMS/CMCS); 'Ingram, Carolyn'; 'Jennifer Babcock'; 'Jessica Cromer'; Kennedy (she/her), Ariel (CMS/CCIIO); 'mbagel@achp.org'; 'mhamelburg@ahip.org'; 'Mikal.Sutton@bcbsa.com'; Miller (he/him), Dan (CMS/CCIIO); 'mmurray@communityplans.net'; 'nshaffi@achp.org'; 'Paris, Katherine'; 'rjones@ahip.org'; 'scozzo@amerihealthcaritas.com'; 'sdmyers@amerihealthcaritas.com'; 'Shannon Attanasio'; Bell, Stephanie (CMS/CMCS); 'ijosey@populardemocracy.org'; 'vkrishnan@populardemocracy.org'; Kuhn, Juliet (CMS/CMCS); Heppner, Eliza (HRSA); Patel, Nisha (HRSA); Satchell, Samantha (OS/IOS/)

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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
  - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/support-resources-state-imp-rms.pdf"]

- **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:* [HYPERLINK "https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fclick.icptrack.com%2Ficp%2Frelay.php%3Fr%3D66175517%26msgid%3D550578%26act%3D6DF9%26c%3D1185304%26pid%3D2072585%26destination%3Dhttps%253A%252F%252Fcms.zoomgov.com%252Fwebinar%252Fregister%252FWN_qma5AvyBQWCTB0vbNF3lTA%26cf%3D6316%26v%3D040043a0fccfded53dff7d8b2638d163f864e9bf61587af26305f387f9acf530&data=05%7C01%7CJessica.Stephens%40cms.hhs.gov%7Ca8cebe435ed24c09ed2c08da4ade91b6%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637904617648441725%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2FPMNi%2FrjbSzijdPSp7t%2FuWarboBizN7YtMwVR6ARsZI%3D&reserved=0"]
  - Next Meeting: May 31, 2023 (3-4pm ET) – *rescheduled from May 18*

Appointment

To: CMS CMCS_Unwinding [redacted]; jca25@georgetown.edu; lrodriguez@americanprogress.org; aimee.ossman@childrenshospitals.org; akg72@georgetown.edu; Allison Orris [aorris@cbpp.org]; Arguello, Andres (OS/IOS) [redacted]; Banton, Kia (CMS/CMCS) [redacted]; Barbara Evman [bevman@evmanlaw.com]; Bentley (she/her), Katherine (CMS/CCIIO) [redacted]; bfeldpush@essentialhospitals.org; Black, Nicole (CMS/OC) [redacted]; Blanar, Jonathan (CMS/OC) [redacted]; Bonelli, Anna (CMS/CMCS) [redacted]; brucel@firstfocus.org; cdobson@ADvancingstates.org; Clark, Liz (CMS/CMCS) [redacted]; Costello, Anne Marie (CMS/CMCS) [redacted]; Costello, Stefanie (CMS/OC) [redacted]; creusch@communitycatalyst.org; crogers@communitycatalyst.org; Cross-Call, Jesse (OS/IEA) [redacted]; Delone, Sarah (CMS/CMCS) [redacted]; Dolly, Ed (CMS/CMCS) [redacted]; 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) [redacted]; Franklin, Julie (CMS/OC) [redacted]; Gibson, Alexis (CMS/CMCS) [redacted]; Glier, Stephanie [sglier@aap.org]; Grant, Jeff (CMS/CCIIO) [redacted]; Gutzmer, Hailey (CMS/OC) [redacted]; Hammarlund, John (CMS/OPOLE) [redacted]; Harris, Monica (CMS/CMCS) [redacted]; Hennessy, Amy (CMS/OC) [redacted]; hoshelton@naacpnet.org; JDBaker@mathematica-mpr.com; Jennifer Tolbert [JenniferT@kff.org]; JKozminski@essentialhospitals.org; Judy Solomon (solomon@cbpp.org) [solomon@cbpp.org]; Katch (she/her), Hannah (CMS/OA) [redacted]; Katie@Out2Enroll.org; Koepke, Christopher (CMS/OC) [redacted]; Lipscomb (she/her), Darla (CMS/CCIIO) [redacted]; Lisa Satterfield [lsatterfield@acog.org]; Liu, Beth (CMS/CCIIO) [redacted]; Lorsbach (she/her), Anna

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Attachments: 20230216_Stakeholder Workgroup Agenda_FINAL.docx

Start: 2/16/2023 6:00:00 PM
End: 2/16/2023 7:00:00 PM
Show Time As: Busy

Recurrence: (none)

Required Attendees: 'jca25@georgetown.edu'; 'lrodriguez@americanprogress.org'; '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, Liz (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'; 'JDBaker@mathematica-mpr.com'; 'Jennifer Tolbert'; 'JKozminski@essentialhospitals.org'; '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'; Liu, Beth (CMS/CCIIO); Lorsbach (she/her), Anna (CMS/CCIIO); Lovejoy, Shannon (CMS/CMCS); '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'; Bellsdale (she/her), Amber (CMS/CCIIO); 'Bennett, Andrea D'; 'Cherie Compartore'; 'CKennedy@mhpa.org'; 'elizabeth.hall@elevancehealth.com'; Gentile, Amy (CMS/CMCS); Giles, John (CMS/CMCS); 'Ingram, Carolyn'; 'Jennifer Babcock'; 'Jessica Cromer'; Kennedy (she/her), Ariel (CMS/CCIIO); 'mbagel@achp.org'; 'mhamelburg@ahip.org'; 'Mikal.Sutton@bcbsa.com'; Miller (he/him), Dan (CMS/CCIIO); 'mmurray@communityplans.net'; 'nshaffi@achp.org'; 'Paris, Katherine'; 'rjones@ahip.org'; 'scozzo@amerihealthcaritas.com'; 'sdmyers@amerihealthcaritas.com'; 'Shannon Attanasio'; Bell, Stephanie (CMS/CMCS); Beatley, Marisa (CMS/CCIIO); Leonis, Catherine (CMS/OPOLE)

Optional Attendees: Brandi Howard; Burke Hays; Joanne Marie Stacy Campbell; Collins Offner, Molly; Giavana Gould; Lueth, Teresa; Onyejiuwa, Nnedi (CMS/OC)

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

- **Welcome and Opening Remarks**

- **Overview of Recent Highlights & CMS Releases**
  - [HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf"] on the Consolidated Appropriations Act
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall01312023.pdf"]
  - Telephone Consumer Protection Act (TCPA) Updates
    - [HYPERLINK "https://www.fcc.gov/document/fcc-provides-guidance-enable-critical-health-care-calls"], Jan. 23, 2023
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall01242023.pdf"] from Jan. 24, 2023, CMCS All-State Call
  - Updated [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf"]_
    - 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** [HYPERLINK "https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf"]

- **Open Q&A and Discussion** (20 min)

- **Closing** (3 min)
  - Unwinding National Partner/Stakeholder Webinar: Wednesday, February 22 (12-1pm ET)
    - *Registration Link:* [HYPERLINK "https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fclick.icptrack.com%2Ficp%2Frelay.php%3Fr%3D66175517%26msgid%3D550578%26act%3D6DF9%26c%3D1185304%26pid%3D2072585%26destination%3Dhttps%253A%252F%252Fcms.zoomgov.com%252Fwebinar%252Fregister%252FWN_qma5AvyBQWCTB0vbNF3lTA%26cf%3D6316%26v%3D040043a0fccfded53dff7d8b2638d163f864e9bf61587af26305f387f9acf530&data=05%7C01%7CJessica.Stephens%40cms.hhs.gov%7Ca8cebe435ed24c09ed2c08da4ade91b6%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637904617648441725%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJ

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- Next Meeting: March 16, 2023 (1-2pm ET)

Appointment

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Attachments: 20230323_Stakeholder Workgroup Agenda.docx
Location: https://cms.zoomgov.com/j/1618164200?pwd=ZDJMUnAwZE9la0FUR1pzb01rZDNwZz09

Start: 3/23/2023 6:00:00 PM
End: 3/23/2023 7:00:00 PM
Show Time As: Busy

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Please remember to mute ---thank you

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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)
  - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/accessibility-unwinding-slides.pdf" \o "accessibility-unwinding-slides"]
  - [HYPERLINK

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    - 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
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf"]
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit-esp.pdf"]

- **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:* [HYPERLINK "https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fclick.icptrack.com%2Ficp%2Frelay.php%3Fr%3D66175517%26msgid%3D550578%26act%3D6DF9%26c%3D1185304%26pid%3D2072585%26destination%3Dhttps%253A%252F%252Fcms.zoomgov.com%252Fwebinar%252Fregister%252FWN_qma5AvyBQWCTB0vbNF3lTA%26cf%3D6316%26v%3D040043a0fccfded53dff7d8b2638d163f864e9bf61587af26305f387f9acf530&data=05%7C01%7CJessica.Stephens%40cms.hhs.gov%7Ca8cebe435ed24c09ed2c08da4ade91b6%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637904617648441725%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2FPMNi%2FrjbSzijdPSp7t%2FuWarboBizN7YtMwVR6ARsZI%3D&reserved=0"]
    - Next Meeting: April 20, 2023 (1-2pm ET)

Appointment

To: CMS CMCS Unwinding (b)(6) (b)(6) aimee.ossman@childrenshospitals.org; akg72@georgetown.edu; Allison Orris [aorris@cbpp.org]; Arguello, Andres (OS/IOS) (b)(6) (b)(6) Banton, Kia (CMS/CMCS) (b)(6) (b)(6) Barbara Eyman [beyman@eymanlaw.com]; Bentley (she/her), Katherine (CMS/CCIIO) (b)(6) (b)(6) bfeldpush@essentialhospitals.org; Black, Nicole (CMS/OC) (b)(6) (b)(6) Blanar, Jonathan (CMS/OC) (b)(6) (b)(6) Bonelli, Anna (CMS/CMCS) (b)(6) (b)(6) brucel@firstfocus.org; cdobson@ADvancingstates.org; Clark, Liz (CMS/CMCS) (b)(6) (b)(6) Costello, Anne Marie (CMS/CMCS (b)(6) (b)(6) Costello, Stefanie (CMS/OC) (b)(6) (b)(6) creusch@communitycatalyst.org; crogers@communitycatalyst.org; Cross-Call, Jesse (OS/IEA) (b)(6) (b)(6) davanzo@nilc.org; Delone, Sarah (CMS/CMCS) (b)(6) (b)(6) Dolly, Ed (CMS/CMCS) (b)(6) (b)(6) DWalter@aap.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) (b)(6) Franklin, Julie (CMS/OC) Gibson, Alexis (CMS/CMCS) (b)(6) (b)(6) Glier, Stephanie [sglier@aap.org]; Grant, Jeff (CMS/CCIIO) (b)(6) (b)(6) Gutzmer, Hailey (CMS/OC) (b)(6) (b)(6) Hammarlund, John (CMS/OPOLE) (b)(6) (b)(6) Harris, Monica (CMS/CMCS) (b)(6) (b)(6) Hennessy, Amy (CMS/OC) (b)(6) (b)(6) hoshelton@naacpnet.org; jca25@georgetown.edu; JDBaker@mathematica-mpr.com; Jennifer Tolbert [JenniferT@kff.org]; JKozminski@essentialhospitals.org; Judy Solomon (solomon@cbpp.org) [solomon@cbpp.org]; Katch (she/her), Hannah (CMS/OA) (b)(6) (b)(6) Katie@Out2Enroll.org; Koepke, Christopher (CMS/OC) (b)(6) (b)(6) Lessard@nilc.org; Lipscomb (she/her), Darla (CMS/CCIIO) (b)(6) (b)(6) 'Lisa Satterfield' [lsatterfield@acog.org]; Liu, Beth (CMS/CCIIO) (b)(6) Lorsbach (she/her), Anna (b)(6)

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scozzo@amerihealthcaritas.com; sdmyers@amerihealthcaritas.com; Shannon Attanasio [sattanasio@mhpa.org]; Bell, Stephanie (CMS/CMCS) [(b)(6) (b)(6)
ijosey@populardemocracy.org; vkrishnan@populardemocracy.org; Kuhn, Juliet (CMS/CMCS) [(b)(6) (b)(6) Heppner, Eliza (HRSA) [(b)(6)]; Patel, Nisha (HRSA) [(b)(6) (b)(6)]; Satchell, Samantha (OS/IOS/) [(b)(6) (b)(6)

CC: Joanne Marie Stacy Campbell [jcampbell@lacare.org]; Collins Offner, Molly [mcollins@aha.org]; Giavana Gould [GGould@acog.org]; Onyejiuwa, Nnedi (CMS/OC) [(b)(6) (b)(6)]; Stephanie Myers [sdmyers@mhpa.org]; Nicolas Wilhelm [nwilhelm@mhpa.org]; Ginnis, Kate (CMS/CMCS) [(b)(6)]

Attachments: 20230420_Stakeholder Workgroup Agenda_FINAL.docx

Start: 4/20/2023 5:00:00 PM
End: 4/20/2023 6:00:00 PM
Show Time As: Busy

Recurrence: (none)

Required 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, Liz (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'; 'ekong@apiahf.org'; 'emanuel@healthlaw.org'; Cischke, Erica G. (CMS/CCIIO); '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'; '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'; Liu, Beth (CMS/CCIIO); 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); (b)(6) 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'; Bellsdale (she/her), Amber (CMS/CCIIO); 'Bennett, Andrea D'; 'Cherie Compartore'; 'CKennedy@mhpa.org'; 'elizabeth.hall@elevancehealth.com'; Gentile, Amy (CMS/CMCS); Giles, John (CMS/CMCS); 'Ingram, Carolyn'; 'Jennifer Babcock'; 'Jessica Cromer'; Kennedy (she/her), Ariel (CMS/CCIIO); 'mbagel@achp.org'; 'mhamelburg@ahip.org'; 'Mikal.Sutton@bcbsa.com'; Miller (he/him), Dan (CMS/CCIIO); 'mmurray@communityplans.net'; 'nshaffi@achp.org'; 'Paris, Katherine'; 'rjones@ahip.org'; 'scozzo@amerihealthcaritas.com'; 'sdmyers@amerihealthcaritas.com'; 'Shannon Attanasio'; Bell, Stephanie (CMS/CMCS); 'ijosey@populardemocracy.org'; 'vkrishnan@populardemocracy.org'; Kuhn, Juliet (CMS/CMCS); Heppner, Eliza (HRSA); Patel, Nisha (HRSA); Satchell, Samantha (OS/IOS/)

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

Join ZoomGov Meeting
https://cms.zoomgov.com/j/1618164200?pwd=ZDJMUnAwZE9la0FUR1pzb01rZDNwZz09

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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
  - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/support-resources-state-imp-rms.pdf"]

- **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:* [HYPERLINK "https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fclick.icptrack.com%2Ficp%2Frelay.php%3Fr%3D66175517%26msgid%3D550578%26act%3D6DF9%26c%3D1185304%26pid%3D2072585%26destination%3Dhttps%253A%252F%252Fcms.zoomgov.com%252Fwebinar%252Fregister%252FWN_qma5AvyBQWCTB0vbNF3lTA%26cf%3D6316%26v%3D040043a0fccfded53dff7d8b2638d163f864e9bf61587af26305f387f9acf530&data=05%7C01%7CJessica.Stephens%40cms.hhs.gov%7Ca8cebe435ed24c09ed2c08da4ade91b6%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637904617648441725%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2FPMNi%2FrjbSzijdPSp7t%2FuWarboBizN7YtMwVR6ARsZI%3D&reserved=0"]
  - Next Meeting: May 31, 2023 (3-4pm ET) – *rescheduled from May 18*

Appointment

From: Peterson, Alanna [APeterson@manatt.com]
Sent: 8/1/2022 6:18:29 PM
To: Peterson, Alanna [APeterson@manatt.com]; 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) (b)(6) (b)(6) Gibson, Alexis E. (CMS/CMCS) (b)(6) (b)(6) Gentile, Amy A. (CMS/CMCS) (b)(6) (b)(6) (b)(6) barrazacannon@mitre.org; rebeccacase@mitre.org
CC: Llanos, Karen E.(CMS/CMCS) (b)(6) (b)(6)

Subject: [External] CMCS Access Policy Sprint Working Session
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
Location: https://manatt.zoom.us/j/91489218120?pwd=cnp0OXhhOG1yQzB3NWJXaVlYWVVHUT09

Start: 8/16/2022 4:00:00 PM
End: 8/16/2022 5:00:00 PM
Show Time As: Busy

Recurrence: (none)

[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.

Phone one-tap: US: or

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

Meeting ID: (b)(6)
Passcode:

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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)

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162.255.36.11 (US East)

Meeting ID: (b)(6)

Passcode:

SIP: (b)(6)

Passcode:

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] 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] 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] 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.

[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.

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

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

	1 Year After the Rule	*2 Years After the Rule*	*3 Years After the Rule*	*4+ Years After the Rule*
Illustrative, High-Level Glidepath	• 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* [HYPERLINK "https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023"]*.)*
- **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]) 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.

[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.

- 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] 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] 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-430/subpart-C/section-430.35"], CMS would end the penalty (and potentially return the payments) when the Administrator "is satisfied regarding the state's compliance."

Per [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-430/subpart-C/section-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.

[5] If handled in accordance with CMS' expectations, standards, and processes, corrective action plans have potential to achieve measurable improvement in access. (Also see [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-430"], Subparts C and D for federal regulations on enforcement of federal Medicaid requirements).

[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.

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 [HYPERLINK "https://www.medicaid.gov/state-overviews/scorecard/index.html"] or posting publicly access snapshots or a dashboard (see, for example, [HYPERLINK "https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/byCategory?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no" \l "1"] 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] 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 [HYPERLINK "https://www.macpac.gov/wp-content/uploads/2018/12/Network-Adequacy-in-Managed-Care-.pdf"] 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 [HYPERLINK "https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_100121_AMD_FINAL.pdf"] 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.

[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.

- 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) [HYPERLINK "https://media.bizj.us/view/img/10749348/cease-and-desist-dmhc-order-ehs-1.pdf"] 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 [HYPERLINK "https://www.dmhc.ca.gov/Portals/0/Docs/OLS/2022%20Knox-Keene%20Act%20and%20Title%2028%20Book/CA%20Knox-Keene%20Act%202022%20Edition_withBookmarks_rev_508.pdf?ver=2022-03-18-090928-670"], 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 [HYPERLINK "https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/cmc-members/plan-documents/potential-contract-termination"] of potential contract termination and this 2021 [HYPERLINK "https://www.chcf.org/wp-content/uploads/2021/12/NetworkAdequacyStandardsHowTheyWorkWhyTheyMatter.pdf"].)

Florida. While Florida's Medicaid managed care [HYPERLINK "https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf"] does appear to include more robust requirements (with an emphasis on liquidated damages and [HYPERLINK "https://ahca.myflorida.com/Medicaid/statewide_mc/report_guide_2019-09-01.shtml"]) related to ensuring access to provider networks, this [HYPERLINK "https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/ActionsTaken?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no" \l "1"] and local news [HYPERLINK "https://health.wusf.usf.edu/health-news-florida/2021-05-27/florida-hits-managed-care-plans-for-damages"] 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 [HYPERLINK "https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf"] 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] (for executed provider agreements with providers to participate in the specialist provider network and the HCBS provider networks);

[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

- $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).

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.

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]	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] • 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*

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

[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.

CMCS Access Strategy Development and Implementation: High-Level Workplan

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Updated August 12, 2022

#	Medicaid Managed Care Access Topic Area[1]	Proposed Deliverable	Status	August				September	
				8/8	8/15	8/22	8/29	9/5	9/12
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]	• 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)

[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.

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

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] 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]

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

[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.
[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.

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] 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] 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]

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] 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-

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[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 [HYPERLINK "https://journals.sagepub.com/doi/full/10.1177/0046958019838118"].

[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 [HYPERLINK "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 [HYPERLINK "https://pubmed.ncbi.nlm.nih.gov/34847230/"].

[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 [HYPERLINK "https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747"].

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

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.

	One Year After the Rule	*Two Years After the Rule*	*Three Years After the Rule*	*Four Years After the Rule*
Illustrative, High-Level Glidepath	• 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]

(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.

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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.

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[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 [HYPERLINK "https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20220114/CHNCT%20Presentation.pdf"] 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.

(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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Re: Strengthening Medicaid Managed Care Appointment Access Timeliness Standards

The Issue

While 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; the Centers for Medicare & Medicaid Services (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 considering establishing new, minimum federal appointment access timeliness requirements along with initial requirements for ensuring compliance with access requirements more broadly.

In the following, we discuss potential options for CMS to mandate adoption of and compliance with minimum appointment wait-time standards through regulation. We also discuss preliminary options for sub-regulatory guidance and technical resources for states to bolster CMS' efforts to assist state Medicaid/Children's Health Insurance Program (CHIP) agencies and their health plan partners with understanding and implementing existing and new requirements, and to allow for changes over time as necessary to ensure realized beneficiary access.

Background on Network Adequacy Requirements in Medicaid Managed Care, the Marketplace, and Medicare

Network adequacy standards to ensure beneficiary access vary significantly across [HYPERLINK "https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care"], the [HYPERLINK "https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023"], and [HYPERLINK "https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-c"]. 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[1] – 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-D/section-457.495"]), ***Medicaid FFS*** takes a different approach, wherein states must submit [HYPERLINK "https://www.medicaid.gov/medicaid/access-care/access-monitoring-review-plans/index.html"] every three years to

[1] 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.

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."[2]

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 [HYPERLINK "https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf"] 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422"] (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.

Summary of Request for Information (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.

CMS Proposals

Table 1, below, reflects CMS' working proposals for updating and building upon the 2020 Medicaid and CHIP Managed Care Final Rule to improve the availability, parity, and timeliness of provider access while balancing the administrative

[2] 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-B/section-447.203"] and [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-B/section-447.204"].

burden on states, health plans, providers, and beneficiaries. Working with CMS' Access Timeliness Standards Analysis, Manatt expanded on the national network adequacy proposal to offer: (1) high-level regulatory requirements; and (2) issues and considerations related to how CMS should proceed with promulgating regulations. This research is intended to support CMS as it determines whether and how to proceed with the regulatory proposal, including to inform preamble language for the notice of proposed rulemaking (NPRM) on access.

The companion Proposed Medicaid Managed Care Access Toolkit Roadmap provides a set of proposals for bolstering CMS' Medicaid provider network access guidance to states, through sub-regulatory guidance (e.g., State Medicaid Director (SMD) letters, Frequently Asked Questions (FAQ)), technical assistance (e.g., CMS All State Calls, webinars), and other resources (e.g., punchlists). While these preliminary proposals will need to be further developed, they will ultimately serve as critical supplements to the iterative process of policymaking, operationalizing the regulations and engaging states in focused efforts to improve access in their Medicaid managed care delivery systems.

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Table 1

Proposal	High-Level Proposed Regulatory Requirements	Context/Considerations for Promulgating Regulations *(To Inform/Be Leveraged By CMS For Preamble Language)*
**For each of the below proposals – with the exception of the consumer hotline proposal, we assume that current regulatory language (included in the appendix) remains intact; the potential Medicaid managed care requirements would be in addition to the existing requirements.*		
Establish Minimum Federal Appointment Access Timeliness Standards	**42 CFR § 438.68** (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.	As recommended by several commenters, the proposed regulations would establish a federal "floor" (or minimum) for appointment wait-times that generally align with [HYPERLINK "https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf"]. The appointment wait-time standards included in the [HYPERLINK "https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023"] were informed by prior federal network adequacy requirements, industry standards, and consultation with stakeholders, including Medicaid and MA. 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68"], which allow states to select any quantitative network adequacy standard, including appointment wait-time standards, for designated provider types. Many states [HYPERLINK "https://www.rwjf.org/content/dam/farm/reports/reports/2022/rwjf468272"] have (or have [HYPERLINK "https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf"] 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.

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	(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.	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 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 SMD letter. 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

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		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.[3]
Bolster the Beneficiary Support System	[HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.71"] (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:	The consumer hotline proposal would update and build upon the existing regulations at [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-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.

[3] 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, [HYPERLINK "https://www.urban.org/sites/default/files/publication/79551/2000736-Can-Telemedicine-Help-Address-Concerns-with-Network-Adequacy-Opportunities-and-Challenges-in-Six-States.pdf"].

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	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 [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.71" \l "p-438.71(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** (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.	

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Ensure Compliance With Access	**42 CFR § 438.358** (a) At a minimum, a State must conduct on an annual basis randomized surveys of providers to assess beneficiary access to care across all contracted MCOs, PIHPs, PAHPs, and PCCM entities. (b) Secret shopper surveys must, at minimum, assess the following: (1) Compliance with the State's 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 at its discretion. (2) Accuracy of provider directories. (3) Disparities in access to care (including, but not limited to, appointment wait-times and whether or not	CMS is prioritizing the need for a robust monitoring approach ("secret shopper") that states can stand up quickly in order to ensure that: (1) beneficiaries can access providers and needed services timely, and (2) federal and state partners can address access issues promptly as they arise and continuously make program improvements.[5] CMS expects states to report on and assess compliance with the appointment wait-time standards by each provider/facility type (rather than in the aggregate) based on the *State's* appointment wait-time standards established in accordance with [*regulatory citation*]. However, states will only be held accountable for corrective action if they are not meeting the *federal* minimum appointment wait-time standards threshold for each provider/facility type. CMS intends to establish in sub-regulatory guidance parameters for states to comply with the 90 percent threshold. In future years, CMS may consider developing a data-driven system and administrative complaint mechanism to ensure CMS is aware of and able to address systemic access issues. This could include the following: (1) Encouraging or requiring states to collect, analyze, and report on a core set of measures[6] and/or claims/encounter data to capture potential and realized access based on the enrolled population's demographics, as well as beneficiary perspectives and experiences (e.g., unmet health needs, barriers to care, provider accessibility). (2) Encouraging or requiring states to establish a formal administrative process by which complaints alleging systemic shortfalls in access are submitted, investigated,

[5] See companion memorandum for additional information on secret shopper surveys.

[6] In its June 2022 [HYPERLINK "https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf"], the Medicaid and CHIP Payment and Access Commission (MACPAC) provides additional considerations for developing a core set of measures for a broad range of services that are comparable across states and delivery systems. MACPAC recommends that access measures reflect three domains: provider availability and accessibility (i.e., potential access), use of services (i.e., realized access), and beneficiary perceptions and experiences.

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	providers are accepting new patients) for Medicaid/CHIP members generally (as compared to commercially covered patients), members with a disability, members for whom English is a second language, and members from other marginalized groups (e.g., racial/ethnic minority groups).[4] (c) States must ensure that secret shopper studies adhere to the following methodological standards: (1) Uses statistically valid sample sizes across provider/facility type. (2) Selects survey recipients on a randomized basis. (3) Examines all regions of the state, including all major urban areas and rural regions. (4) Uses a standardized approach for testing key measures of access, such as predetermined call scripts. (d) States must submit results of secret shopper surveys to CMS and make them publicly available. As part of public reporting, 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	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. (3) Requiring states to participate in a routine, standardized data review with respect to access (e.g., service utilization, access to providers, and stratification by key demographic characteristics, such as race and ethnicity), using Transformed Medicaid Statistical Information System (T-MSIS) data. States falling below average levels of utilization for different services/eligible populations would then be subject to deeper reviews and a CAP. (While a T-MSIS review with respect to access would be applicable to all states, the services and eligible populations examined could vary by state and over time.) Through its Network Adequacy Justification Form proposal, CMS has elected to align with the [HYPERLINK "https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023"], which similarly establishes a justification process for issuers that are unable to meet time and distance/appointment wait-time standards. CMS acknowledges and will work with states to address constrained workforces related to the federal PHE.

[4] 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 [HYPERLINK "https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20220114/CHNCT%20Presentation.pdf"] 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.

Proposal	High-Level Proposed Regulatory Requirements	Context/Considerations for Promulgating Regulations *(To Inform/Be Leveraged By CMS For Preamble Language)*
	status, and other factors, as determined appropriate by the State. **42 CFR § 438.68** (e) Based on secret shopper survey result data submitted to CMS, a State may be subject to compliance reviews at CMS' discretion for beneficiary access issues including, without limitation, non-compliance with federal minimum appointment wait-time standards as follows: (i) Beginning two years after the effective date of the rules finalized at [*regulatory citation*], a State has not achieved at least eighty percent (80%) compliance with federal minimum appointment wait-time standards for each provider/facility type; (ii) Beginning three years after the effective date of the rules finalized at [*regulatory citation*], a State has not achieved at least eighty-five percent (85%) compliance with federal minimum appointment wait-time standards for each provider/facility type; (iii) Beginning four years after the effective date of the rules finalized at [*regulatory citation*] and thereafter, a State has not achieved ninety percent (90%) compliance with federal minimum appointment wait-time standards for each provider/facility type. (f) A State with beneficiary access issues, including non-compliance with federal minimum appointment wait-time standards may:	States with CMS-identified beneficiary access issues, such as those not meeting the federal minimum appointment wait-time standards, will be required in accordance with the regulatory glidepath to develop and submit to CMS a written CAP to document and ensure compliant practices and to take affirmative steps to develop an adequate network of providers to meet patients' needs. CMS reminds states that sanctions can include imposing monetary penalties (e.g., fines, liquidated damages), appointing temporary management for the MCO, PIHP, PAHP, or PCCM, granting beneficiaries the right to terminate their enrollment without cause, suspending new enrollment, and suspending payment for enrollment, among other actions.

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Proposal	High-Level Proposed Regulatory Requirements	Context/Considerations for Promulgating Regulations *(To Inform/Be Leveraged By CMS For Preamble Language)*
	(1) At its option, submit a Network Adequacy Justification Form to CMS to explain the unique circumstances that justify non-compliance with beneficiary access standards. (2) At the discretion of CMS, be required to develop a corrective action plan (CAP).	

Date: June 23, 2022 REVISED
To: CMCS Sprint Team
From: Manatt Health
Re: Strengthening Medicaid Managed Care Appointment Access Timeliness Standards

Appendix: Current Federal Regulatory Language

For the purposes of the workstream 1 (Strengthening Medicaid Managed Care Network Adequacy Requirements), CMS directed MITRE/Manatt's focus to 42 CFR § 438.68; the table below includes additional federal citations that are relevant to the proposals outlined above.

Federal Citation	Regulatory Language
[HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68"]	(a) ***General rule.*** A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section. (b) ***Provider-specific network adequacy standards.*** -(1) *Provider types.* At a minimum, a State must develop a quantitative network adequacy standard for the following provider types, if covered under the contract: (i) Primary care, adult and pediatric. (ii) OB/GYN. (iii) Behavioral health (mental health and substance use disorder), adult and pediatric. (iv) Specialist (as designated by the State), adult, and pediatric. (v) Hospital. (vi) Pharmacy. (vii) Pediatric dental. (2) *LTSS.* States with MCO, PIHP, or PAHP contracts which cover LTSS must develop a quantitative network adequacy standard for LTSS provider types. (3) *Scope of network adequacy standards.* Network standards established in accordance with [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(b)(1)"] and [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(b)(2)"] of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas. (c) ***Development of network adequacy standards.*** (1) States developing network adequacy standards consistent with [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(b)(1)"] of this section must consider, at a minimum, the following elements: (i) The anticipated Medicaid enrollment. (ii) The expected utilization of services. (iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract.

Federal Citation	Regulatory Language
	(iv) The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services. (v) The numbers of network providers who are not accepting new Medicaid patients. (vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees. (vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language. (viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities. (ix) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions. (2) States developing standards consistent with [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(b)(2)"] of this section must consider the following: (i) All elements in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(c)(1)(i)"] through [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(c)(1)(ix)"] of this section. (ii) Elements that would support an enrollee's choice of provider. (iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee. (iv) Other considerations that are in the best interest of the enrollees that need LTSS. (d) ***Exceptions process.*** (1) To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be: (i) Specified in the MCO, PIHP or PAHP contract. (ii) Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area. (2) States that grant an exception in accordance with [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(d)(1)"] of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and

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	include the findings to CMS in the managed care program assessment report required under [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.66"].
[HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.66"]	(a) General requirement. The State agency must have in effect a monitoring system for all managed care programs. (b) The State's system must address all aspects of the managed care program, including the performance of each MCO, PIHP, PAHP, and PCCM entity (if applicable) in at least the following areas: (10) Provider network management, including provider directory standards. (11) Availability and accessibility of services, including network adequacy standards.
[HYPERLINK "https://www.ssa.gov/OP_Home/ssact/title19/1932.htm"]	(c) Quality Assurance Standards.— (1) Quality assessment and improvement strategy.— (A) In general.—If a State provides for contracts with Medicaid managed care organizations under section 1903(m), the State shall develop and implement a quality assessment and improvement strategy consistent with this paragraph. Such strategy shall include the following: (i) Access Standards.—Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.
42 CFR §§ [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68"], [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.206"], and [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.207"]	*High-Level Summary*: Requires that states obtain documentation from managed care plans attesting that the plans have the capacity to serve all enrollees and comply with all state access standards.
[HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.71"]	(a) General requirement. The State must develop and implement a beneficiary support system that provides support to beneficiaries both prior to and after enrollment in a MCO, PIHP, PAHP, PCCM or PCCM entity. (b) Elements of the support system. (1) A State beneficiary support system must include at a minimum:

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Also see [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-F"]	(i) Choice counseling for all beneficiaries. (ii) Assistance for enrollees in understanding managed care. (iii) Assistance as specified for enrollees who use, or express a desire to receive, LTSS in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.71" \l "p-438.71(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. (c) Choice counseling. (1) Choice counseling, as defined in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.2"], must be provided to all potential enrollees and enrollees who disenroll from a MCO, PIHP, PAHP, PCCM or PCCM entity for reasons specified in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.56" \l "p-438.56(b)"] and [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.56" \l "p-438.56(c)"]. (2) If an individual or entity provides choice counseling on the State's behalf under a memorandum of agreement or contract, it is considered an enrollment broker as defined in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.810" \l "p-438.810(a)"] and must meet the independence and freedom from conflict of interest standards in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.810" \l "p-438.810(b)(1)"] and [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.810" \l "p-438.810(b)(2)"]. (3) An entity that receives non-Medicaid funding to represent beneficiaries at hearings may provide choice counseling on behalf of the State so long as the State requires firewalls to ensure that the requirements for the provision of choice counseling are met. (d) Functions specific to LTSS activities. At a minimum, the beneficiary support system must provide the following support to enrollees who use, or express a desire to receive, LTSS: (1) An access point for complaints and concerns about MCO, PIHP, PAHP, PCCM, and PCCM entity enrollment, access to covered services, and other related matters. (2) Education on enrollees' grievance and appeal rights within the MCO, PIHP or PAHP; the State fair hearing process; enrollee rights and responsibilities; and additional resources outside of the MCO, PIHP or PAHP. (3) Assistance, upon request, in navigating the grievance and appeal process within the MCO, PIHP or PAHP, as well as appealing adverse benefit determinations by the MCO, PIHP, or PAHP

Federal Citation	Regulatory Language
	to a State fair hearing. The system may not provide representation to the enrollee at a State fair hearing but may refer enrollees to sources of legal representation. (4) Review and oversight of LTSS program data to provide guidance to the State Medicaid Agency on identification, remediation and resolution of systemic issues.

Appointment

From: CMS CMCS_Unwinding (b)(6) (b)(6)

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

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CC: Brandi Howard [BHoward@mathematica-mpr.com]; Burke Hays [BHays@mathematica-mpr.com]; Joanne Marie Stacy Campbell [jcampbell@lacare.org]; Collins Offner, Molly [mcollins@aha.org]; Giavana Gould [GGould@acog.org]; Lueth, Teresa [teresa.lueth@elevancehealth.com]; Onyejiuwa, Nnedi (CMS/OC) (b)(6)

Subject: CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations
Attachments: 20230216_Stakeholder Workgroup Agenda_FINAL.docx
Location: https://cms.zoomgov.com/j/1618164200?pwd=ZDJMUnAwZE9la0FUR1pzb01rZDNwZz09

Start: 2/16/2023 6:00:00 PM
End: 2/16/2023 7:00:00 PM
Show Time As: Tentative

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

Required Attendees: 'jca25@georgetown.edu'; 'lrodriguez@americanprogress.org'; '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, Liz (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'; 'JDBaker@mathematica-mpr.com'; 'Jennifer Tolbert'; 'JKozminski@essentialhospitals.org'; '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'; Liu, Beth (CMS/CCIIO); Lorsbach (she/her), Anna (CMS/CCIIO); Lovejoy, Shannon (CMS/CMCS); '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'; Bellsdale (she/her), Amber (CMS/CCIIO); 'Bennett, Andrea D'; 'Cherie Compartore'; 'CKennedy@mhpa.org'; 'elizabeth.hall@elevancehealth.com'; Gentile, Amy (CMS/CMCS); Giles, John (CMS/CMCS); 'Ingram, Carolyn'; 'Jennifer Babcock'; 'Jessica Cromer'; Kennedy (she/her), Ariel (CMS/CCIIO); 'mbagel@achp.org'; 'mhamelburg@ahip.org'; 'Mikal.Sutton@bcbsa.com'; Miller (he/him), Dan (CMS/CCIIO); 'mmurray@communityplans.net'; 'nshaffi@achp.org'; 'Paris, Katherine'; 'rjones@ahip.org';

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Optional Attendees: Brandi Howard; Burke Hays; Joanne Marie Stacy Campbell; Collins Offner, Molly; Giavana Gould; Lueth, Teresa; Onyejiuwa, Nnedi (CMS/OC)

Please remember to mute ---thank you

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

Join ZoomGov Meeting
https://cms.zoomgov.com/j/1618164200?pwd=ZDJMUnAwZE9la0FUR1pzb01rZDNwZz09

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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.

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

- **Welcome and Opening Remarks**

- **Overview of Recent Highlights & CMS Releases**
  - [HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf"] on the Consolidated Appropriations Act
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall01312023.pdf"]
  - Telephone Consumer Protection Act (TCPA) Updates
    - [HYPERLINK "https://www.fcc.gov/document/fcc-provides-guidance-enable-critical-health-care-calls"], Jan. 23, 2023
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall01242023.pdf"] from Jan. 24, 2023, CMCS All-State Call
  - Updated [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf"]_
    - 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** [HYPERLINK "https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf"]

- **Open Q&A and Discussion** (20 min)

- **Closing** (3 min)
  - Unwinding National Partner/Stakeholder Webinar: Wednesday, February 22 (12-1pm ET)
    - *Registration Link:* [HYPERLINK "https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fclick.icptrack.com%2Ficp%2Frelay.php%3Fr%3D66175517%26msgid%3D550578%26act%3D6DF9%26c%3D1185304%26pid%3D2072585%26destination%3Dhttps%253A%252F%252Fcms.zoomgov.com%252Fwebinar%252Fregister%252FWN_qma5AvyBQWCTB0vbNF3lTA%26cf%3D6316%26v%3D040043a0fccfded53dff7d8b2638d163f864e9bf61587af26305f387f9acf530&data=05%7C01%7CJessica.Stephens%40cms.hhs.gov%7Ca8cebe435ed24c09ed2c08da4ade91b6%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637904617648441725%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJ

XVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2FPMNi%2FrjbSzijdPSp7t%2FuWarboBizN7YtMwVR6ARsZI%3D&reserved=0"]

- Next Meeting: March 16, 2023 (1-2pm ET)

Appointment

From: Walker, Jonathan [JEWalker@manatt.com]
Sent: 8/1/2022 6:17:56 PM
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) (b)(6) (b)(6) Gibson, Alexis E. (CMS/CMCS) (b)(6) (b)(6); Gentile, Amy A. (CMS/CMCS) (b)(6) (b)(6); jbarrazacannon@mitre.org; rebeccacase@mitre.org
CC: Llanos, Karen E.(CMS/CMCS) (b)(6) (b)(6)

Subject: [External] CMCS Access Policy Sprint Working Session
Attachments: image001.jpg
Location: https://manatt.zoom.us (b)(6)

Start: 8/16/2022 4:00:00 PM
End: 8/16/2022 5:00:00 PM
Show Time As: Tentative

Recurrence: (none)

Hi there,

Alanna Peterson is inviting you to a scheduled Zoom meeting.

Phone one-tap: US: or

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

Meeting ID: (b)(6)
Passcode:

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162.255.36.11 (US East)

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SIP:

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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

Appointment

From: Peterson, Alanna [APeterson@manatt.com]
Sent: 8/16/2022 3:50:53 PM
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) (b)(6) (b)(6); Gibson, Alexis E. (CMS/CMCS) (b)(6) (b)(6); Gentile, Amy A. (CMS/CMCS) (b)(6); jbarrazacannon@mitre.org; rebeccacase@mitre.org
CC: Llanos, Karen E.(CMS/CMCS) (b)(6) (b)(6)

Subject: [External] CMCS Access Policy Sprint Working Session
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
Location: https://manatt.zoom.us/j/91489218120?pwd=cnp0OXhhOG1yQzB3NWJXaVlYWVVHUT09

Start: 8/16/2022 4:00:00 PM
End: 8/16/2022 5:00:00 PM
Show Time As: Tentative

Recurrence: (none)

[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.

Phone one-tap: US: or

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

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Meeting ID:

Passcode

SIP:

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(b)(6)

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] 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] 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] 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.

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[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.

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

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

	1 Year After the Rule	*2 Years After the Rule*	*3 Years After the Rule*	*4+ Years After the Rule*
Illustrative, High-Level Glidepath	• 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* [HYPERLINK "https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023"]*.)*
- **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]) 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.

[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.

- 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] 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] 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-430/subpart-C/section-430.35"], CMS would end the penalty (and potentially return the payments) when the Administrator "is satisfied regarding the state's compliance."

Per [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-430/subpart-C/section-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.

[5] If handled in accordance with CMS' expectations, standards, and processes, corrective action plans have potential to achieve measurable improvement in access. (Also see [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-430"], Subparts C and D for federal regulations on enforcement of federal Medicaid requirements).

[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.

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 [HYPERLINK "https://www.medicaid.gov/state-overviews/scorecard/index.html"] or posting publicly access snapshots or a dashboard (see, for example, [HYPERLINK "https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/byCategory?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no" \l "1"] 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] 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 [HYPERLINK "https://www.macpac.gov/wp-content/uploads/2018/12/Network-Adequacy-in-Managed-Care-.pdf"] 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 [HYPERLINK "https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_100121_AMD_FINAL.pdf"] 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.

[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.

- 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) [HYPERLINK "https://media.bizj.us/view/img/10749348/cease-and-desist-dmhc-order-ehs-1.pdf"] 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 [HYPERLINK "https://www.dmhc.ca.gov/Portals/0/Docs/OLS/2022%20Knox-Keene%20Act%20and%20Title%2028%20Book/CA%20Knox-Keene%20Act%202022%20Edition_withBookmarks_rev_508.pdf?ver=2022-03-18-090928-670"], 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 [HYPERLINK "https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/cmc-members/plan-documents/potential-contract-termination"] of potential contract termination and this 2021 [HYPERLINK "https://www.chcf.org/wp-content/uploads/2021/12/NetworkAdequacyStandardsHowTheyWorkWhyTheyMatter.pdf"].)

Florida. While Florida's Medicaid managed care [HYPERLINK "https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf"] does appear to include more robust requirements (with an emphasis on liquidated damages and [HYPERLINK "https://ahca.myflorida.com/Medicaid/statewide_mc/report_guide_2019-09-01.shtml"]) related to ensuring access to provider networks, this [HYPERLINK "https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/ActionsTaken?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no" \l "1"] and local news [HYPERLINK "https://health.wusf.usf.edu/health-news-florida/2021-05-27/florida-hits-managed-care-plans-for-damages"] 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 [HYPERLINK "https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf"] 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] (for executed provider agreements with providers to participate in the specialist provider network and the HCBS provider networks);

[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

- $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).

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.

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]	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] • 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*

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

[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.

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]	Proposed Deliverable	Status	August				September	
				8/8	8/15	8/22	8/29	9/5	9/12
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]	• 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)

[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.

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

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] 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]

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

[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.
[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.

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] 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] 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]

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] 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-

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[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 [HYPERLINK "https://journals.sagepub.com/doi/full/10.1177/0046958019838118"].

[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 [HYPERLINK "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 [HYPERLINK "https://pubmed.ncbi.nlm.nih.gov/34847230/"].

[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 [HYPERLINK "https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747"].

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

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.

	One Year After the Rule	*Two Years After the Rule*	*Three Years After the Rule*	*Four Years After the Rule*
Illustrative, High-Level Glidepath	• 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]

(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.

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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.

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[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 [HYPERLINK "https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20220114/CHNCT%20Presentation.pdf"] 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.

(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.

Date: June 23, 2022 REVISED
To: CMCS Sprint Team
From: Manatt Health
Re: Strengthening Medicaid Managed Care Appointment Access Timeliness Standards

The Issue

While 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; the Centers for Medicare & Medicaid Services (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 considering establishing new, minimum federal appointment access timeliness requirements along with initial requirements for ensuring compliance with access requirements more broadly.

In the following, we discuss potential options for CMS to mandate adoption of and compliance with minimum appointment wait-time standards through regulation. We also discuss preliminary options for sub-regulatory guidance and technical resources for states to bolster CMS' efforts to assist state Medicaid/Children's Health Insurance Program (CHIP) agencies and their health plan partners with understanding and implementing existing and new requirements, and to allow for changes over time as necessary to ensure realized beneficiary access.

Background on Network Adequacy Requirements in Medicaid Managed Care, the Marketplace, and Medicare

Network adequacy standards to ensure beneficiary access vary significantly across [HYPERLINK "https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care"], the [HYPERLINK "https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023"], and [HYPERLINK "https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-c"]. 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[1] – 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-D/section-457.495"]), ***Medicaid FFS*** takes a different approach, wherein states must submit [HYPERLINK "https://www.medicaid.gov/medicaid/access-care/access-monitoring-review-plans/index.html"] every three years to

[1] 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.

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."[2]

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 [HYPERLINK "https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf"] 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422"] (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.

Summary of Request for Information (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.

CMS Proposals

Table 1, below, reflects CMS' working proposals for updating and building upon the 2020 Medicaid and CHIP Managed Care Final Rule to improve the availability, parity, and timeliness of provider access while balancing the administrative

[2] 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-B/section-447.203"] and [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-B/section-447.204"].

burden on states, health plans, providers, and beneficiaries. Working with CMS' Access Timeliness Standards Analysis, Manatt expanded on the national network adequacy proposal to offer: (1) high-level regulatory requirements; and (2) issues and considerations related to how CMS should proceed with promulgating regulations. This research is intended to support CMS as it determines whether and how to proceed with the regulatory proposal, including to inform preamble language for the notice of proposed rulemaking (NPRM) on access.

The companion Proposed Medicaid Managed Care Access Toolkit Roadmap provides a set of proposals for bolstering CMS' Medicaid provider network access guidance to states, through sub-regulatory guidance (e.g., State Medicaid Director (SMD) letters, Frequently Asked Questions (FAQ)), technical assistance (e.g., CMS All State Calls, webinars), and other resources (e.g., punchlists). While these preliminary proposals will need to be further developed, they will ultimately serve as critical supplements to the iterative process of policymaking, operationalizing the regulations and engaging states in focused efforts to improve access in their Medicaid managed care delivery systems.

Date: June 23, 2022 REVISED
To: CMCS Sprint Team
From: Manatt Health
Re: Strengthening Medicaid Managed Care Appointment Access Timeliness Standards

Table 1

Proposal	High-Level Proposed Regulatory Requirements	Context/Considerations for Promulgating Regulations *(To Inform/Be Leveraged By CMS For Preamble Language)*
**For each of the below proposals – with the exception of the consumer hotline proposal, we assume that current regulatory language (included in the appendix) remains intact; the potential Medicaid managed care requirements would be in addition to the existing requirements.*		
Establish Minimum Federal Appointment Access Timeliness Standards	**42 CFR § 438.68** (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.	As recommended by several commenters, the proposed regulations would establish a federal "floor" (or minimum) for appointment wait-times that generally align with [HYPERLINK "https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf"]. The appointment wait-time standards included in the [HYPERLINK "https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023"] were informed by prior federal network adequacy requirements, industry standards, and consultation with stakeholders, including Medicaid and MA. 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68"], which allow states to select any quantitative network adequacy standard, including appointment wait-time standards, for designated provider types. Many states [HYPERLINK "https://www.rwjf.org/content/dam/farm/reports/reports/2022/rwjf468272"] have (or have [HYPERLINK "https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf"] 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.

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	(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.	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 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 SMD letter. 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

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		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.[3]
Bolster the Beneficiary Support System	[HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.71"] (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:	The consumer hotline proposal would update and build upon the existing regulations at [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-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.

[3] 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, [HYPERLINK "https://www.urban.org/sites/default/files/publication/79551/2000736-Can-Telemedicine-Help-Address-Concerns-with-Network-Adequacy-Opportunities-and-Challenges-in-Six-States.pdf"].

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	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 [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.71" \l "p-438.71(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** (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.	

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Ensure Compliance With Access	**42 CFR § 438.358** (a) At a minimum, a State must conduct on an annual basis randomized surveys of providers to assess beneficiary access to care across all contracted MCOs, PIHPs, PAHPs, and PCCM entities. (b) Secret shopper surveys must, at minimum, assess the following: (1) Compliance with the State's 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 at its discretion. (2) Accuracy of provider directories. (3) Disparities in access to care (including, but not limited to, appointment wait-times and whether or not	CMS is prioritizing the need for a robust monitoring approach ("secret shopper") that states can stand up quickly in order to ensure that: (1) beneficiaries can access providers and needed services timely, and (2) federal and state partners can address access issues promptly as they arise and continuously make program improvements.[5] CMS expects states to report on and assess compliance with the appointment wait-time standards by each provider/facility type (rather than in the aggregate) based on the *State's* appointment wait-time standards established in accordance with [*regulatory citation*]. However, states will only be held accountable for corrective action if they are not meeting the *federal* minimum appointment wait-time standards threshold for each provider/facility type. CMS intends to establish in sub-regulatory guidance parameters for states to comply with the 90 percent threshold. In future years, CMS may consider developing a data-driven system and administrative complaint mechanism to ensure CMS is aware of and able to address systemic access issues. This could include the following: (1) Encouraging or requiring states to collect, analyze, and report on a core set of measures[6] and/or claims/encounter data to capture potential and realized access based on the enrolled population's demographics, as well as beneficiary perspectives and experiences (e.g., unmet health needs, barriers to care, provider accessibility). (2) Encouraging or requiring states to establish a formal administrative process by which complaints alleging systemic shortfalls in access are submitted, investigated,

[5] See companion memorandum for additional information on secret shopper surveys.

[6] In its June 2022 [HYPERLINK "https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf"], the Medicaid and CHIP Payment and Access Commission (MACPAC) provides additional considerations for developing a core set of measures for a broad range of services that are comparable across states and delivery systems. MACPAC recommends that access measures reflect three domains: provider availability and accessibility (i.e., potential access), use of services (i.e., realized access), and beneficiary perceptions and experiences.

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	providers are accepting new patients) for Medicaid/CHIP members generally (as compared to commercially covered patients), members with a disability, members for whom English is a second language, and members from other marginalized groups (e.g., racial/ethnic minority groups).[4] (c) States must ensure that secret shopper studies adhere to the following methodological standards: (1) Uses statistically valid sample sizes across provider/facility type. (2) Selects survey recipients on a randomized basis. (3) Examines all regions of the state, including all major urban areas and rural regions. (4) Uses a standardized approach for testing key measures of access, such as predetermined call scripts. (d) States must submit results of secret shopper surveys to CMS and make them publicly available. As part of public reporting, 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	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. (3) Requiring states to participate in a routine, standardized data review with respect to access (e.g., service utilization, access to providers, and stratification by key demographic characteristics, such as race and ethnicity), using Transformed Medicaid Statistical Information System (T-MSIS) data. States falling below average levels of utilization for different services/eligible populations would then be subject to deeper reviews and a CAP. (While a T-MSIS review with respect to access would be applicable to all states, the services and eligible populations examined could vary by state and over time.) Through its Network Adequacy Justification Form proposal, CMS has elected to align with the [HYPERLINK "https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023"], which similarly establishes a justification process for issuers that are unable to meet time and distance/appointment wait-time standards. CMS acknowledges and will work with states to address constrained workforces related to the federal PHE.

[4] 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 [HYPERLINK "https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20220114/CHNCT%20Presentation.pdf"] 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.

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	status, and other factors, as determined appropriate by the State. **42 CFR § 438.68** (e) Based on secret shopper survey result data submitted to CMS, a State may be subject to compliance reviews at CMS' discretion for beneficiary access issues including, without limitation, non-compliance with federal minimum appointment wait-time standards as follows: (i) Beginning two years after the effective date of the rules finalized at [*regulatory citation*], a State has not achieved at least eighty percent (80%) compliance with federal minimum appointment wait-time standards for each provider/facility type; (ii) Beginning three years after the effective date of the rules finalized at [*regulatory citation*], a State has not achieved at least eighty-five percent (85%) compliance with federal minimum appointment wait-time standards for each provider/facility type; (iii) Beginning four years after the effective date of the rules finalized at [*regulatory citation*] and thereafter, a State has not achieved ninety percent (90%) compliance with federal minimum appointment wait-time standards for each provider/facility type. (f) A State with beneficiary access issues, including non-compliance with federal minimum appointment wait-time standards may:	States with CMS-identified beneficiary access issues, such as those not meeting the federal minimum appointment wait-time standards, will be required in accordance with the regulatory glidepath to develop and submit to CMS a written CAP to document and ensure compliant practices and to take affirmative steps to develop an adequate network of providers to meet patients' needs. CMS reminds states that sanctions can include imposing monetary penalties (e.g., fines, liquidated damages), appointing temporary management for the MCO, PIHP, PAHP, or PCCM, granting beneficiaries the right to terminate their enrollment without cause, suspending new enrollment, and suspending payment for enrollment, among other actions.

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	(1) At its option, submit a Network Adequacy Justification Form to CMS to explain the unique circumstances that justify non-compliance with beneficiary access standards. (2) At the discretion of CMS, be required to develop a corrective action plan (CAP).	

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Appendix: Current Federal Regulatory Language

For the purposes of the workstream 1 (Strengthening Medicaid Managed Care Network Adequacy Requirements), CMS directed MITRE/Manatt's focus to 42 CFR § 438.68; the table below includes additional federal citations that are relevant to the proposals outlined above.

Federal Citation	Regulatory Language
[HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68"]	(a) ***General rule.*** A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section. (b) ***Provider-specific network adequacy standards.*** -(1) *Provider types.* At a minimum, a State must develop a quantitative network adequacy standard for the following provider types, if covered under the contract: (i) Primary care, adult and pediatric. (ii) OB/GYN. (iii) Behavioral health (mental health and substance use disorder), adult and pediatric. (iv) Specialist (as designated by the State), adult, and pediatric. (v) Hospital. (vi) Pharmacy. (vii) Pediatric dental. (2) *LTSS.* States with MCO, PIHP, or PAHP contracts which cover LTSS must develop a quantitative network adequacy standard for LTSS provider types. (3) *Scope of network adequacy standards.* Network standards established in accordance with [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(b)(1)"] and [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(b)(2)"] of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas. (c) ***Development of network adequacy standards.*** (1) States developing network adequacy standards consistent with [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(b)(1)"] of this section must consider, at a minimum, the following elements: (i) The anticipated Medicaid enrollment. (ii) The expected utilization of services. (iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract.

Federal Citation	Regulatory Language
	(iv) The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services. (v) The numbers of network providers who are not accepting new Medicaid patients. (vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees. (vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language. (viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities. (ix) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions. (2) States developing standards consistent with [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(b)(2)"] of this section must consider the following: (i) All elements in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(c)(1)(i)"] through [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(c)(1)(ix)"] of this section. (ii) Elements that would support an enrollee's choice of provider. (iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee. (iv) Other considerations that are in the best interest of the enrollees that need LTSS. (d) ***Exceptions process.*** (1) To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be: (i) Specified in the MCO, PIHP or PAHP contract. (ii) Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area. (2) States that grant an exception in accordance with [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.68" \l "p-438.68(d)(1)"] of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and

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	include the findings to CMS in the managed care program assessment report required under [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.66"].
[HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.66"]	(a) General requirement. The State agency must have in effect a monitoring system for all managed care programs. (b) The State's system must address all aspects of the managed care program, including the performance of each MCO, PIHP, PAHP, and PCCM entity (if applicable) in at least the following areas: (10) Provider network management, including provider directory standards. (11) Availability and accessibility of services, including network adequacy standards.
[HYPERLINK "https://www.ssa.gov/OP_Home/ssact/title19/1932.htm"]	(c) Quality Assurance Standards.— (1) Quality assessment and improvement strategy.— (A) In general.—If a State provides for contracts with Medicaid managed care organizations under section 1903(m), the State shall develop and implement a quality assessment and improvement strategy consistent with this paragraph. Such strategy shall include the following: (i) Access Standards.—Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.
42 CFR §§ [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68"], [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.206"], and [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.207"]	*High-Level Summary*: Requires that states obtain documentation from managed care plans attesting that the plans have the capacity to serve all enrollees and comply with all state access standards.
[HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.71"]	(a) General requirement. The State must develop and implement a beneficiary support system that provides support to beneficiaries both prior to and after enrollment in a MCO, PIHP, PAHP, PCCM or PCCM entity. (b) Elements of the support system. (1) A State beneficiary support system must include at a minimum:

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Also see [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-F"]	(i) Choice counseling for all beneficiaries. (ii) Assistance for enrollees in understanding managed care. (iii) Assistance as specified for enrollees who use, or express a desire to receive, LTSS in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.71" \l "p-438.71(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. (c) Choice counseling. (1) Choice counseling, as defined in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.2"], must be provided to all potential enrollees and enrollees who disenroll from a MCO, PIHP, PAHP, PCCM or PCCM entity for reasons specified in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.56" \l "p-438.56(b)"] and [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.56" \l "p-438.56(c)"]. (2) If an individual or entity provides choice counseling on the State's behalf under a memorandum of agreement or contract, it is considered an enrollment broker as defined in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.810" \l "p-438.810(a)"] and must meet the independence and freedom from conflict of interest standards in [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.810" \l "p-438.810(b)(1)"] and [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.810" \l "p-438.810(b)(2)"]. (3) An entity that receives non-Medicaid funding to represent beneficiaries at hearings may provide choice counseling on behalf of the State so long as the State requires firewalls to ensure that the requirements for the provision of choice counseling are met. (d) Functions specific to LTSS activities. At a minimum, the beneficiary support system must provide the following support to enrollees who use, or express a desire to receive, LTSS: (1) An access point for complaints and concerns about MCO, PIHP, PAHP, PCCM, and PCCM entity enrollment, access to covered services, and other related matters. (2) Education on enrollees' grievance and appeal rights within the MCO, PIHP or PAHP; the State fair hearing process; enrollee rights and responsibilities; and additional resources outside of the MCO, PIHP or PAHP. (3) Assistance, upon request, in navigating the grievance and appeal process within the MCO, PIHP or PAHP, as well as appealing adverse benefit determinations by the MCO, PIHP, or PAHP

Federal Citation	Regulatory Language
	to a State fair hearing. The system may not provide representation to the enrollee at a State fair hearing but may refer enrollees to sources of legal representation. (4) Review and oversight of LTSS program data to provide guidance to the State Medicaid Agency on identification, remediation and resolution of systemic issues.

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 C
applicable and available). If a Medicare standard is not available (such as HCBS providers and pediatric dental), manag
paid by provider type as a percent of the state's Medicaid State Plan rates. This reporting must include base rates, pas
and any other payments made by managed care plans to non-institutional network providers. States would then weig
member months to determine a state percentage for each provider type.

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**			
SPENDING CATEGORY	**TOTAL MEDICAID SPENDING**	**MEDICARE EQUIVALENT**	**MEDICAID TO MEDICARE RATIO**	**TOTAL MEDICAID SPENDING**
CLAIMS	$ 40,000,000	$ 50,000,000		$ 30,000,000
STATE DIRECTED PAYMENTS	$ 2,000,000			$ 1,000,000
PASS THROUGH PAYMENTS	$ -			$ -
OTHER PAYMENTS	$ -			$ -
TOTAL	$ 42,000,000	$ 50,000,000	84%	$ 31,000,000

OB/GYN	**PLAN A**			
SPENDING CATEGORY	**TOTAL MEDICAID SPENDING**	**MEDICARE EQUIVALENT**	**MEDICAID TO MEDICARE RATIO**	**TOTAL MEDICAID SPENDING**
CLAIMS	$ 50,000,000	$ 60,000,000		$ 20,000,000
STATE DIRECTED PAYMENTS	$ 2,000,000			$ 1,000,000
PASS THROUGH PAYMENTS	$ -			$ -
OTHER PAYMENTS	$ -			$ -
TOTAL	$ 52,000,000	$ 60,000,000	87%	$ 21,000,000

SPECIALTY CARE	**PLAN A**

SPENDING CATEGORY	TOTAL MEDICAID SPENDING	MEDICARE EQUIVALENT	MEDICAID TO MEDICARE RATIO	TOTAL MEDICAID SPENDING
CLAIMS	$ 60,000,000	$ 75,000,000		$ 50,000,000
STATE DIRECTED PAYMENTS	$ 2,000,000			$ 1,000,000
PASS THROUGH PAYMENTS	$ -			$ -
OTHER PAYMENTS	$ -			$ -
TOTAL	$ 62,000,000	$ 75,000,000	83%	$ 51,000,000
MENTAL HEALTH/SUD		PLAN A		
SPENDING CATEGORY	TOTAL MEDICAID SPENDING	MEDICARE EQUIVALENT	MEDICAID TO MEDICARE RATIO	TOTAL MEDICAID SPENDING
CLAIMS	$ 30,000,000	$ 40,000,000		$ 25,000,000
STATE DIRECTED PAYMENTS	$ 2,000,000			$ 1,000,000
PASS THROUGH PAYMENTS	$ -			$ -
OTHER PAYMENTS	$ -			$ -
TOTAL	$ 32,000,000	$ 40,000,000	80%	$ 26,000,000
PEDIATRIC DENTAL		PLAN A		
SPENDING CATEGORY	TOTAL MEDICAID SPENDING	MEDICAID FFS EQUIVALENT	MEDICAID TO MEDICAID FFS RATIO	TOTAL MEDICAID SPENDING
CLAIMS	$ 5,000,000	$ 6,000,000		$ 10,000,000
STATE DIRECTED PAYMENTS	$ 2,000,000			$ 1,000,000
PASS THROUGH PAYMENTS	$ -			$ -
OTHER PAYMENTS	$ -			$ -
TOTAL	$ 7,000,000	$ 6,000,000	117%	$ 11,000,000
		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%	

FR 438.68(b)(1)-(2)) as a percent of Medicare (If
ged care plans should report their average rates
s-through payments, state directed payments,
ght the plans' reported percentages using

PLAN B		PLAN C			STATEWIDE
MEDICARE EQUIVALENT	MEDICAID TO MEDICARE RATIO	TOTAL MEDICAID SPENDING	MEDICARE EQUIVALENT	MEDICAID TO MEDICARE RATIO	WEIGHTED MEDICAID TO MEDICARE RATIO
$ 45,000,000		$ 25,000,000	$ 30,000,000		
		$ 500,000			
		$ -			
		$ -			
$ 45,000,000	69%	$ 25,500,000	$ 30,000,000	85%	80%

PLAN B		PLAN C			STATEWIDE
MEDICARE EQUIVALENT	MEDICAID TO MEDICARE RATIO	TOTAL MEDICAID SPENDING	MEDICARE EQUIVALENT	MEDICAID TO MEDICARE RATIO	WEIGHTED MEDICAID TO MEDICARE RATIO
$ 30,000,000		$ 30,000,000	$ 45,000,000		
		$ 500,000			
		$ -			
		$ -			
$ 30,000,000	70%	$ 30,500,000	$ 45,000,000	68%	73%

PLAN B	PLAN C	STATEWIDE

MEDICARE EQUIVALENT	MEDICAID TO MEDICARE RATIO	TOTAL MEDICAID SPENDING	MEDICARE EQUIVALENT	MEDICAID TO MEDICARE RATIO	WEIGHTED MEDICAID TO MEDICARE RATIO
$ 55,000,000		$ 45,000,000	$ 48,000,000		
		$ 500,000			
		$ -			
		$ -			
$ 55,000,000	93%	$ 45,500,000	$ 48,000,000	95%	91%
PLAN B			PLAN C		STATEWIDE
MEDICARE EQUIVALENT	MEDICAID TO MEDICARE RATIO	TOTAL MEDICAID SPENDING	MEDICARE EQUIVALENT	MEDICAID TO MEDICARE RATIO	WEIGHTED MEDICAID TO MEDICARE RATIO
$ 30,000,000		$ 45,000,000	$ 48,000,000		
		$ 500,000			
		$ -			
		$ -			
$ 30,000,000	87%	$ 45,500,000	$ 48,000,000	95%	88%
PLAN B			PLAN C		STATEWIDE
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
$ 11,000,000		$ 10,000,000	$ 12,000,000		
		$ 500,000			
		$ -			
		$ -			
$ 11,000,000	100%	$ 10,500,000	$ 12,000,000	88%	99%

Appointment

From: Kim, Lora [LYKim@manatt.com]
Sent: 11/30/2022 10:40:44 PM
To: 'Noelle.Simonick@dhcs.ca.gov' [Noelle.Simonick@dhcs.ca.gov]; 'janet.rudnick@dhcs.ca.gov' [janet.rudnick@dhcs.ca.gov]; 'rachel.nichols@cms.hhs.gov'; Ross, Heather (CMS/CMCS) (b)(6) Friedman, Kate (CMS/CMCS) (b)(6) (b)(6) 'Aaron.Toyama@dhcs.ca.gov'; 'Bambi.Cisneros@dhcs.ca.gov'; 'Benjamin.Mcgowan@dhcs.ca.gov'; Brumer, Justin@DHCS [Justin.Brumer@dhcs.ca.gov]; 'AnhThu.Bui@dhcs.ca.gov' [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) (b)(6) Rashid, Mehreen (CMS/CMCS) (b)(6) (b)(6) Decaro, Teresa (CMS/CMCS) (b)(6) (b)(6) Sadwith, Tyler@DHCS [Tyler.Sadwith@dhcs.ca.gov]; Samimi, Farrah@DHCS [Farrah.Samimi@dhcs.ca.gov]; 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 [Jacey.Cooper@dhcs.ca.gov]; Tsai, Daniel (CMS/CMCS) (b)(6) (b)(6) McClenathan, Jane (CMS/CMCS) (b)(6) (b)(6) ; Serafi, Kinda [KSerafi@manatt.com]; Boozang, Patricia [PBoozang@manatt.com]

Subject: CMS/DHCS Biweekly Waiver Check-in
Attachments: image001.jpg
Location: https://manatt.zoom.us/j/92009574479?pwd=TnRuRm1xdHFCQjRZVE5XMWdOQXVkZz09

Start: 12/1/2022 6:00:00 PM
End: 12/1/2022 6:30:00 PM
Show Time As: Tentative

Recurrence: (none)

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.

Phone one-tap: US: or

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

Meeting ID: (b)(6)

Passcode

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:

Passcode (b)(6)

SIP:

Passcode

Appointment

From: CMS Administrator [(b)(6) (b)(6)]
Sent: 11/25/2022 10:45:50 PM
To: CBL (she/her), Administrator (CMS/OA (b)(6) (b)(6); Ellis (she/her), Kyla (CMS/OA) (b)(6) (b)(6) McLemore, Monica (CMS/OSORA (b)(6) (b)(6)]; Khan, Farooq (CMS/OSORA) (b)(6) (b)(6)]; Tsai, Daniel (CMS/CMCS) (b)(6) Katch (she/her), Hannah (CMS/OA) (b)(6) (b)(6); Costello, Anne Marie (CMS/CMCS) (b)(6) (b)(6); Cash, Judith (CMS/CMCS (b)(6) (b)(6)]; Jackson, Marilyn (CMS/OSORA (b)(6) (b)(6)

Subject: [INTERNAL] ACBL Mtg w/Georgetown University's Medicaid Section 1115 Waiver Task Force
Attachments: External Meeting Request: Medicaid Section 1115 Waiver Task Force/Georgetown University
Location: Zoom; https://cms.zoomgov.com/j/1619012770?pwd=N0FRQ3FKSDFLZzVIaEYyb2RSWVVOZz09

Start: 12/1/2022 6:30:00 PM
End: 12/1/2022 7:00:00 PM
Show Time As: Tentative

Required Attendees: (b)(5) 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)

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:

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 (b)(6)
Password: (b)(6)
(b)(6)

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.

Message

From: McLemore, Monica (CMS/OSORA) (b)(6)
(b)(6)
Sent: 11/2/2022 4:21:56 PM
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
Cancer*Care*
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

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

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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).

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American Lung Association
Arthritis Foundation
Asian & Pacific Islander American Health Forum (APIAHF)
Autism Society of America
Autistic Self Advocacy Network
Black Mamas Matter Alliance
Cancer*Care*
Catholic Health Association of the United States
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Center for Law and Social Policy (CLASP)
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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

Appointment

From: CMS CMCS Unwinding [redacted]

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

To: 'aimee.ossman@childrenshospitals.org' [aimee.ossman@childrenshospitals.org]; 'akg72@georgetown.edu' [akg72@georgetown.edu]; 'Allison Orris' [aorris@cbpp.org]; Arguello, Andres (OS/IOS) [redacted]; Banton, Kia (CMS/CMCS) [redacted] Barbara Eyman' [beyman@eymanlaw.com]; Bentley (she/her), Katherine (CMS/CCIIO) [redacted]; 'bfeldpush@essentialhospitals.org' [bfeldpush@essentialhospitals.org]; Black, Nicole (CMS/OC) [redacted]; Blanar, Jonathan (CMS/OC) [redacted]; Bonelli, Anna (CMS/CMCS) [redacted]; 'brucel@firstfocus.org' [brucel@firstfocus.org]; 'cdobson@ADvancingstates.org' [cdobson@ADvancingstates.org]; Clark, Elizabeth (CMS/CMCS) [redacted]; Costello, Anne Marie (CMS/CMCS) [redacted]; Costello, Stefanie (CMS/OC) [redacted] 'creusch@communitycatalyst.org' [creusch@communitycatalyst.org]; 'crogers@communitycatalyst.org' [crogers@communitycatalyst.org]; Cross-Call, Jesse (OS/IEA) [redacted] 'davanzo@nilc.org' [davanzo@nilc.org]; Delone, Sarah (CMS/CMCS) [redacted]; Dolly, Ed (CMS/CMCS) [redacted]; 'DWalter@aap.org' [DWalter@aap.org]; 'EFishman@familiesusa.org' [EFishman@familiesusa.org]; 'ekong@apiahf.org' [ekong@apiahf.org]; 'emanuel@healthlaw.org' [emanuel@healthlaw.org]; 'Erica Cischke' [ecischke@aafp.org]; 'Erin O'Malley' [eomalley@essentialhospitals.org]; 'erodriguez@unidosus.org' [erodriguez@unidosus.org]; 'ferzouki@cbpp.org' [ferzouki@cbpp.org]; Fowler, Joanna (CMS/CCIIO [redacted] Franklin, Julie (CMS/OC) [redacted]; Gibson, Alexis (CMS/CMCS) [redacted] 'Glier, Stephanie' [redacted] Grant, Jeff (CMS/CCIIO) [redacted] Gutzmer, Hailey (CMS/OC) [redacted]; Hammarlund, John (CMS/OPOLE) [redacted]; Harris, Monica (CMS/CMCS) [redacted]; Hennessy, Amy (CMS/OC) [redacted] 'hoshelton@naacpnet.org' [hoshelton@naacpnet.org]; 'jca25@georgetown.edu' [jca25@georgetown.edu]; 'JDBaker@mathematica-mpr.com' [JDBaker@mathematica-mpr.com]; 'Jennifer Tolbert' [JenniferT@kff.org]; 'JKozminski@essentialhospitals.org' [JKozminski@essentialhospitals.org]; Johnston, James (CMS/OHI) [redacted]

(solomon@cbpp.org)' [solomon@cbpp.org]; Katch (she/her), Hannah (CMS/OA) (b)(6)
(b)(6)
'Katie@Out2Enroll.org' [Katie@Out2Enroll.org]; Koepke, Christopher (CMS/OC) (b)(6)
(b)(6)
'Lessard@nilc.org' [Lessard@nilc.org]; Lipscomb (she/her), Darla (CMS/CCIIO) (b)(6)
(b)(6)
'Lisa Satterfield' [lsatterfield@acog.org]; Lorsbach (she/her), Anna (CMS/CCIIO) (b)(6)
(b)(6)
Loveioy, Shannon (CMS/CMCS) (b)(6)
(b)(6)
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Trevino, Ethan (CMS/CCIIO) (b)(6)
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Wood (he/him), Elijah (CMS/CCIIO) (b)(6)
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'youdelman@healthlaw.org' [youdelman@healthlaw.org]

Subject: CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations
Attachments: 20230112_Stakeholder Workgroup Agenda.docx
Location: https://cms.zoomgov.com/j/1612157166?pwd=ZTljMXBKMURBU3d4L0V1K3Z5VnJoZz09

Start: 1/12/2023 8:00:00 PM
End: 1/12/2023 9:00:00 PM
Show Time As: Tentative

Required 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

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:

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Dial by your location
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Join by (b)(6)
Password: (b)(6)
(b)(6)

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: [HYPERLINK "https://www.medicaid.gov/sites/default/files/2023-01/cib010523_1.pdf"]
  - Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations (updated with scenarios): [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy-12062021.pdf"]
  - System Readiness Artifacts: A Refresher on Medicaid Enterprise Systems Artifacts for Unwinding: [HYPERLINK "https://www.medicaid.gov/sites/default/files/2023-01/systems-readiness-art-refresher-01062023.pdf"]

- **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:* [HYPERLINK "https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fclick.icptrack.com%2Ficp%2Frelay.php%3Fr%3D66175517%26msgid%3D550578%26act%3D6DF9%26c%3D1185304%26pid%3D2072585%26destination%3Dhttps%253A%252F%252Fcms.zoomgov.com%252Fwebinar%252Fregister%252FWN_qma5AvyBQWCTB0vbNF3lTA%26cf%3D6316%26v%3D040043a0fccfded53dff7d8b2638d163f864e9bf61587af26305f387f9acf530&data=05%7C01%7CJessica.Stephens%40cms.hhs.gov%7Ca8cebe435ed24c09ed2c08da4ade91b6%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637904617648441725%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2FPMNi%2FrjbSzijdPSp7t%2FuWarboBizN7YtMwVR6ARsZI%3D&reserved=0"]
  - Next Meeting: Rescheduling: To be confirmed

Appointment

From: Peterson, Alanna [APeterson@manatt.com]
Sent: 8/22/2022 3:48:55 PM
To: Peterson, Alanna [APeterson@manatt.com]; 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]; Giles, John (CMS/CMCS) (b)(6) (b)(6) (CMS/CMCS) (b)(6) (b)(6); Gentile, Amy A. (CMS/CMCS) (b)(6); TSCHENCK@mitre.org; jbarrazacannon@mitre.org; rebeccacase@mitre.org

Subject: [External] CMCS Access Policy Sprint Working Session
Attachments: image001.jpg
Location: https://manatt.zoom.us/j/94883599799?pwd=Q2Z3WHlIeDZJeERWcWJPdGFCWGJCZz09

Start: 9/29/2022 2:00:00 PM
End: 9/29/2022 3:00:00 PM
Show Time As: Tentative

Recurrence: (none)

Hi there,

Alanna Peterson is inviting you to a scheduled Zoom meeting.

Phone one-tap: US: or

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

Meeting ID: (b)(6)
Passcode

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

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:

Passcode (b)(6)

SIP:

Passcode

Message

From: Boozang, Patti [PBoozang@manatt.com]
Sent: 12/12/2022 7:31:39 PM
To: Giles, John (CMS/CMCS) (b)(6) (b)(6) Gibson, Alexis (CMS/CMCS) (b)(6) (b)(6) ; Gentile, Amy (CMS/CMCS) (b)(6) (b)(6)
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) (b)(6) (b)(6) ; Gentile, Amy (CMS/CMCS) (b)(6) (b)(6) ; Gibson, Alexis (CMS/CMCS (b)(6) (b)(6)
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

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
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State Strategies to Promote Access in Medicaid and CHIP Managed Care: Punchlist Outline

Draft as of December 12, 2022

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[TOC \o "1-3" \h \z \u]

State Strategies to Promote Access in Medicaid and CHIP Managed Care: Punchlist Outline

Draft as of December 12, 2022

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]

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:

1. Develop an Access Data Strategy.
2. Establish Data-Informed Access Priorities, Goals, and Measures.
3. Increase Provider Participation and Capacity.
4. Improve Provider Directories.
5. Monitor Access.
6. Enforce Network Access.
7. Expand Access to Services via Telehealth.
8. Ensure Access for High Need Beneficiaries.
9. 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.

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[1] Medicaid and CHIP Payment and Access Commission, Key findings on access to care. Available at: [HYPERLINK "https://www.macpac.gov/subtopic/access-for-adults-covered-by-medicaid/"]

State Strategies to Promote Access in Medicaid and CHIP Managed Care: Punchlist Outline

Draft as of December 12, 2022

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]
  - 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

[2] For example, APCDs can be used to assess disparities in access to care among Medicaid and CHIP beneficiaries relative to commercially insured individuals.

- ☐ 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), [HYPERLINK "https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf"], 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), [HYPERLINK "https://www.shvs.org/wp-content/uploads/2022/02/Demonstrations-Health-Equity-Strategies-final.pdf"] (February 2022).
- Grantmakers in Health and the National Committee for Quality Assurance (NCQA), [HYPERLINK "https://www.gih.org/wp-content/uploads/2021/12/GIH-Commonwealth-Fund-federal-data-report-part-2.pdf"] (December 2021).

- NORC, [HYPERLINK "https://www.norc.org/PDFs/Race%2C%20Ethnicity%2C%20and%20Lanugage%20Data%20Collection%20in%20Medicaid/The%20State%20of%20the%20Collection%20of%20Race%2C%20Ethnicity%2C%20and%20Language%20Data%20in%20Medicaid.pdf"] (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] 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).

[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.

- ☐ 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, [HYPERLINK "https://www.urban.org/sites/default/files/publication/79551/2000736-Can-Telemedicine-Help-Address-Concerns-with-Network-Adequacy-Opportunities-and-Challenges-in-Six-States.pdf"] (April 2016).
- CMS, [HYPERLINK "https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf"] (April 2017).
- CMS, [HYPERLINK "https://www.medicaid.gov/medicaid/downloads/behavior-health-provider-network-adequacy-toolkit.pdf"] (June 2021).
- CMS, [HYPERLINK "https://www.medicaid.gov/medicaid/long-term-services-supports/workforce-initiative/index.html"].
- Massachusetts Foundation, [HYPERLINK "https://www.bluecrossmafoundation.org/publication/creating-robust-diverse-and-resilient-behavioral-health-workforce-massachusetts"] (September 2022).
- Rhode Island Executive Office of Health & Human Services, [HYPERLINK "https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/Workforce/HWT-Report.pdf"] (May 2017).
- Health Resources and Services Administration (HRSA), [HYPERLINK "https://data.hrsa.gov/topics/health-workforce/data-research"].
- National Conference of State Legislatures (NCSL), [HYPERLINK "https://www.ncsl.org/blog/2021/02/01/improving-access-to-care-medicaid-telehealth-and-health-workforce-101.aspx"] (February 2021).
- National Governors Association, [HYPERLINK "https://www.nga.org/publications/addressing-wages-of-the-direct-care-workforce-through-medicaid-policies/"] (November 2022).
- Arnold Ventures and ATI Advisory, [HYPERLINK "https://atiadvisory.com/wp-content/uploads/2022/07/State-Approaches-to-Increase-Home-and-Community-Based-Service-Provider-Capacity.pdf"] (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, [HYPERLINK "https://www.ama-assn.org/system/files/improving-health-plan-provider-directories.pdf"].

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] and revealed[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]
- ☐ 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, [HYPERLINK "https://www.medicaid.gov/medicaid/downloads/behavior-health-provider-network-adequacy-toolkit.pdf"] (June 2021).
- Agency for Healthcare Research and Quality (AHRQ), [HYPERLINK "https://www.ahrq.gov/cahps/news-and-events/events/webinar-091019.html"] (November 2019).

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[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.

[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.

[6] States should also ensure compliance with the existing regulations at [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-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.

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, [HYPERLINK "https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/byCategory?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no" \l "1"] 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 [HYPERLINK "https://www.medicaid.gov/state-overviews/scorecard/index.html"] 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, [HYPERLINK "https://www.medicaid.gov/medicaid/downloads/behavior-health-provider-network-adequacy-toolkit.pdf"] (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]

- ☐ 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, [HYPERLINK "https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf"].

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].

[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].

State Strategies to Promote Access in Medicaid and CHIP Managed Care: Punchlist Outline

Draft as of December 12, 2022

- ☐ 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 [HYPERLINK "https://www.medicaid.gov/sites/default/files/2019-12/medicaid-buy-in-qa.pdf"] 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, [HYPERLINK "https://www.shvs.org/ensuring-continuity-of-coverage-and-care-for-high-need-enrollees-when-the-medicaid-continuous-coverage-ends-medicaid-strategies/"] (June 2022).
- SHVS, [HYPERLINK "https://www.shvs.org/resource/state-strategies-to-improve-maternal-health-and-promote-health-equity-compendium/"] (October 2022).
- CMS, [HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf"] (June 2022).
- CMS, Long-Term Services and Supports Rebalancing Toolkit (November 2020).
- National Center on Advancing Person-Centered Practices and Systems (NCAPPS), [HYPERLINK "https://ncapps.acl.gov/docs/Resources/NCAPPS%20SelfAssessment_Final_March2022%20-%20508%20Compliant.pdf"] (February 2022).
- BCBS Massachusetts Foundation, [HYPERLINK "https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2022-09/BH_Workforce_Final.pdf"] (September 2022).
- CMS, [HYPERLINK "https://www.medicaid.gov/medicaid/quality-of-care/downloads/strategies-to-improve-postpartum-care.pdf"] (February 2015).
- The American College of Obstetrics and Gynecologists (ACOG), [HYPERLINK "https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care"] (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, [HYPERLINK "https://www.medicaid.gov/state-resource-center/downloads/strategies-for-covrg-of-indiv.pdf"] (November 2021).
- The Commonwealth Fund, [HYPERLINK "https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact"] (August 17, 2022).
- Interaction Design Foundation, [HYPERLINK "https://www.interaction-design.org/literature/topics/user-centered-design"].

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 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.

[1] The current period of performance ends in December 2022—though we understand that it may be extended by a couple of months.

Toolkit Component	Tool Development Approach/Timing	Notes
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

From: Peterson, Alanna [APeterson@manatt.com]
Sent: 8/1/2022 6:19:32 PM
To: Peterson, Alanna [APeterson@manatt.com]; 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); (b)(6); (b)(6); Gibson, Alexis E. (CMS/CMCS); (b)(6); (b)(6); Gentile, Amy A. (CMS/CMCS); (b)(6); (b)(6); jbarrazacannon@mitre.org; rebeccacase@mitre.org
CC: Llanos, Karen E.(CMS/CMCS); (b)(6); (b)(6); Pauly, Nathan [NPauly@manatt.com]

Subject: [External] CMCS Access Policy Sprint Working Session
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
Location: https://manatt.zoom.us/j/92239463552?pwd=Z3ZXempJdTBtaFBhTTBDbjcxei83dz09

Start: 8/25/2022 8:00:00 PM
End: 8/25/2022 9:00:00 PM
Show Time As: Busy

Recurrence: (none)

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.

Phone one-tap: US: or

Meeting URL: https://manatt.zoom.us/j/92239463552?pwd=Z3ZXempJdTBtaFBhTTBDbjcxei83dz09

Meeting ID: (b)(6)
Passcode

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

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
SIP:
Passcode

Promoting Access though Provider Rate Transparency
Proposed CMS Preamble and Regulatory Language
DRAFT August 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.[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]

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.[3,4] Relatedly, researchers have found that increases in the Medicaid payment rates are directly associated with increases in provider acceptance of

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[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:[HYPERLINK "https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611?journalCode=hlthaff"].

[2] MACPAC, "Medicaid Hospital Payment: A Comparison Across States and to Medicare," April 2017, available at [HYPERLINK "https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf"].

[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: [HYPERLINK "https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf"]

[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:[HYPERLINK "https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611?journalCode=hlthaff"].

new Medicaid patients.[5,6] 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] 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] 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

[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

[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:[HYPERLINK "https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611?journalCode=hlthaff"].

[7] Sung Cho, "Hospital Capital Investment During the Great Recession," June 2017, available at https://journals.sagepub.com/doi/10.1177/0046958017708399.

[8] Congressional Budget Office, "Baseline Projections – Medicaid," May 2022, available at https://www.cbo.gov/system/files/2022-05/51301-2022-05-medicaid.pdf

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.

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Managed Care Access Policy Sprint

Leveraging Provider Surveys to Measure Access and CMS Enforcement of Appointment Wait-Time Standards Memorandum

Updated August 24, 2022

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] Provider surveys will assess compliance with the state and federal appointment wait-time standards for each provider/facility type, among other access areas.[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;

[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).

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

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]

- 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

[3] Also see this August 2022 Commonwealth Fund blog, [HYPERLINK "https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact"].

networks, provider directory accuracy, and other elements of access to care, CMS could utilize a number of additional tools to ensure network access.[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]

- **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 [HYPERLINK "http://www.njfamilycare.org/analytics/HEDIS_plan.html"] and [HYPERLINK "http://www.njfamilycare.org/analytics/CAHPS.html"] 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

[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.

[5] This proposal aligns with recent Medicaid And CHIP Access Commission (MACPAC) recommendations.

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 [HYPERLINK "https://www.medicaid.gov/state-overviews/scorecard/index.html"] or posting publicly access snapshots or a dashboard (see, for example, [HYPERLINK "https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/byCategory?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no" \l "1"] 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] CMS could expand on the enforcement process by considering the following enforcement mechanisms and options to promote transparency.[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] The state could appeal (on factual grounds) CMS' determination that they had not met the milestone. Consistent with the regulations at [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-430/subpart-C/section-430.35"], CMS would end the withhold (and return the payments) when the Administrator "is satisfied regarding the state's compliance."

[6] If handled in accordance with CMS' expectations, standards, and processes, corrective action plans have potential to achieve measurable improvement in access. (Also see [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-430"], Subparts C and D for federal regulations on enforcement of federal Medicaid requirements).

[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.

[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.

Per [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-430/subpart-C/section-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] 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] 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]

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 [HYPERLINK "https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf"]. The appointment wait-time standards included in the [HYPERLINK "https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023"] were informed by prior federal network adequacy requirements,

[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 [HYPERLINK "https://journals.sagepub.com/doi/full/10.1177/0046958019838118"].

[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 [HYPERLINK "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 [HYPERLINK "https://pubmed.ncbi.nlm.nih.gov/34847230/"].

[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 [HYPERLINK "https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747"].

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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68"], which allow states to select any quantitative network adequacy standard, including appointment wait-time standards, for designated provider types. Many states [HYPERLINK "https://www.rwjf.org/content/dam/farm/reports/reports/2022/rwjf468272"] have (or have [HYPERLINK "https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf"] 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]

[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,

Dedicated Access Support for Beneficiaries

The consumer hotline proposal would update and build upon the existing regulations at [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-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] 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.

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otolaryngology, neurology, ophthalmology, allergy and immunology, nephrology, primary care, gynecology/obstetrics, endocrinology, and infectious diseases. For more information, see Urban Institute's report, [HYPERLINK "https://www.urban.org/sites/default/files/publication/79551/2000736-Can-Telemedicine-Help-Address-Concerns-with-Network-Adequacy-Opportunities-and-Challenges-in-Six-States.pdf"].

[13] However, states would only be held accountable for meeting the *federal* minimum appointment wait-time standards.

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.

	1 Year After the Rule	*2 Years After the Rule*	*3 Years After the Rule*	*4+ Years After the Rule*
Illustrative, High-Level Glidepath	• 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/section-438.71" \l "p-438.71(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] 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]

(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.

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[14] Note to CMS: We did not include PCCM entities here.

[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 [HYPERLINK "https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20220114/CHNCT%20Presentation.pdf"] 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.

(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] 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]

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.[18,19] Relatedly, researchers have found that increases in the Medicaid payment rates are directly associated with increases in provider acceptance of new Medicaid patients.[20,21] In short, two key drivers of access – provider network size and capacity – are inextricably linked with Medicaid provider payment levels.

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[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:[HYPERLINK "https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611?journalCode=hlthaff"].
[17] MACPAC, "Medicaid Hospital Payment: A Comparison Across States and to Medicare," April 2017, available at [HYPERLINK "https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf"].
[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: [HYPERLINK "https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf"]
[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:[HYPERLINK "https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611?journalCode=hlthaff"].
[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
[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:[HYPERLINK "https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611?journalCode=hlthaff"].

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] 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] 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).

[22] Sung Cho, "Hospital Capital Investment During the Great Recession," June 2017, available at https://journals.sagepub.com/doi/10.1177/0046958017708399.

[23] Congressional Budget Office, "Baseline Projections – Medicaid," May 2022, available at https://www.cbo.gov/system/files/2022-05/51301-2022-05-medicaid.pdf

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] 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.

[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/

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] 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.

[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/

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.[26-2728] 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], 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 [HYPERLINK "https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D"], this has enormous implications for the overall consumer experience.[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.

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] 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.

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[26] Vernon J, Trujillo A, Rosenbaum S, and DeBuono B. Low Health Literacy: Implications for National Health Policy. University of Connecticut, 2007. [HYPERLINK "https://www.chcs.org/resource/health-literacy-fact-sheets/"].

[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. [HYPERLINK "https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5309146"].

[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. [HYPERLINK "https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158258/"].

[29] Myers CA. 2018. Advocates' guide to accessibility in Medicaid managed care grievances and appeals. Washington, DC: National Health Law Program. [HYPERLINK "https://healthlaw.org/wp-content/uploads/2016/05/2016_05_2016_Issue_Brief_2_MMC_%20Regs_Grievance_Appeals.pdf"].

[30] [HYPERLINK "https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D"].

[31] [HYPERLINK "https://www.interaction-design.org/literature/topics/user-centered-design"].

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] 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:

[32] [HYPERLINK "https://www.usertesting.com/blog/how-ideo-uses-customer-insights-to-design-innovative-products-users-love"].

- 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]
- **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]
- **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.

[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.

[34] [HYPERLINK "https://www.ajmc.com/view/beyond-regulatory-requirements-designing-aco-websites-to-enhance-stakeholder-engagement"].

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 [HYPERLINK "https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care"], the [HYPERLINK "https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023"], and [HYPERLINK "https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-c"]. 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] – 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-D/section-457.495"]), ***Medicaid FFS*** takes a different approach, wherein states must submit [HYPERLINK "https://www.medicaid.gov/medicaid/access-care/access-monitoring-review-plans/index.html"] 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]

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 [HYPERLINK "https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf"] 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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422"] (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.

[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.

[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 [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-B/section-447.203"] and [HYPERLINK "https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-B/section-447.204"].

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] 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]

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] 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] 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]

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.[42,43] 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] While not required, states may also conduct additional external quality review activities, including administering surveys or studies of beneficiary access and quality issues.[45] 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

[37] [HYPERLINK "https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2016.pdf"]
[38] [HYPERLINK "https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2020-PY-FFE-Summary.pdf"]
[39] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747.
[40] https://www.medicaid.gov/medicaid/downloads/behavior-health-provider-network-adequacy-toolkit.pdf.
[41] https://journals.sagepub.com/doi/full/10.1177/0046958019838118.
[42] https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.
[43] https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf.
[44] 42 CFR § 438.358(b).
[45] 42 CFR § 438.358(c).

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 [HYPERLINK "https://www.macpac.gov/wp-content/uploads/2018/12/Network-Adequacy-in-Managed-Care-.pdf"] 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 [HYPERLINK "https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_100121_AMD_FINAL.pdf"] 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) [HYPERLINK "https://media.bizj.us/view/img/10749348/cease-and-desist-dmhc-order-ehs-1.pdf"] 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 [HYPERLINK "https://www.dmhc.ca.gov/Portals/0/Docs/OLS/2022%20Knox-Keene%20Act%20and%20Title%2028%20Book/CA%20Knox-Keene%20Act%202022%20Edition_withBookmarks_rev_508.pdf?ver=2022-03-18-090928-670"], 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 [HYPERLINK "https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/cmc-members/plan-documents/potential-contract-termination"] of potential contract termination and this 2021 [HYPERLINK "https://www.chcf.org/wp-content/uploads/2021/12/NetworkAdequacyStandardsHowTheyWorkWhyTheyMatter.pdf"].)

Florida. While Florida's Medicaid managed care [HYPERLINK "https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2022-02-01/Attachment_II_Core_Contract_Provisions_2022-02-01.pdf"] does appear to include more robust requirements (with an emphasis on liquidated damages and [HYPERLINK "https://ahca.myflorida.com/Medicaid/statewide_mc/report_guide_2019-09-01.shtml"]) related to ensuring access to provider networks, this [HYPERLINK "https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/ActionsTaken?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no" \l "1"] and local news [HYPERLINK "https://health.wusf.usf.edu/health-news-florida/2021-05-27/florida-hits-managed-care-plans-for-damages"] 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 [HYPERLINK "https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf"] 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] (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).

[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.

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

Appointment

From: Briskin, Perrie (CMS/CMCS) (b)(6) (b)(6)

Sent: 12/21/2022 10:05:15 PM

To: CMS CMCS_Scheduling (b)(6) (b)(6); Tsai, Daniel (CMS/CMCS) (b)(6) (b)(6); Giles, John (CMS/CMCS) (b)(6) (b)(6) Deboy, Alissa (CMS/CMCS) (b)(6) (b)(6) LaBrown@INTERFAITHMEDICAL.org; WBernstein@manatt.com; CMann@manatt.com; Briskin, Perrie (CMS/CMCS) (b)(6) (b)(6); CCantrell@manatt.com; MMcNamara@manatt.com; Silanskis, Jeremy (CMS/CMCS) (b)(6) (b)(6); Bonelli, Anna (CMS/CMCS) (b)(6) (b)(6) Howe, Rory (CMS/CMCS) (b)(6) (b)(6)

CC: Dunn, Victoria (CMS/CMCS) (b)(6) (b)(6) McClenathan, Jane (CMS/CMCS) (b)(6) (b)(6); Cronin, Claire [CCronin@manatt.com]; Smith, Carrie (CMS/CMCS) (b)(6) (b)(6); Gibson, Alexis (CMS/CMCS) (b)(6) (b)(6); Caulder, Tara (CMS/CMCS) (b)(6) (b)(6)

Subject: CMCS / NY Safety Net Hospital Coalition

Attachments: NY Safety Net Coalition Summary Statistics (Dec 2022).docx

Location: https://cms.zoomgov.com/j/1615746141?pwd=L3hNemZWZGQvdHZ0QThPUnJkSjArQT09

Start: 12/22/2022 2:30:00 PM

End: 12/22/2022 3:15:00 PM

Show Time As: Tentative

Required Attendees: Daniel Tsai (CMS/OA) (daniel.tsai@cms.hhs.gov); Giles, John (CMS/CMCS); Deboy, Alissa M. (CMS/CMCS); LaBrown@INTERFAITHMEDICAL.org; WBernstein@manatt.com; CMann@manatt.com; Perrie Briskin (CMS/OA) (perrie.briskin@cms.hhs.gov); CCantrell@manatt.com; MMcNamara@manatt.com; Silanskis, Jeremy D. (CMS/CMCS) (Jeremy.Silanskis@cms.hhs.gov); Bonelli, Anna (CMS/CMCS); Howe, Rory (CMS/CMCS) (Rory.Howe@cms.hhs.gov)

Optional Attendees: Dunn, Victoria (CMS/CMCS); McClenathan, Jane (CMS/CMCS); Cronin, Claire; Smith, Carrie (CMS/CMCS); Gibson, Alexis (CMS/CMCS); Caulder, Tara (CMS/CMCS)

CMCS_Scheduling@cms.hhs.gov is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting
https://cms.zoomgov.com/j/1615746141?pwd=L3hNemZWZGQvdHZ0QThPUnJkSjArQT09

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

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833 568 8864 US Toll-free
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Password: (b)(6)
sip: (b)(6)

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.

NEW YORK SAFETY NET HOSPITAL COALITION

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.[i]

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).[ii]
- **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.[iii]

Figure 1: Percent of Services Delivered to Medicaid and Uninsured Patients

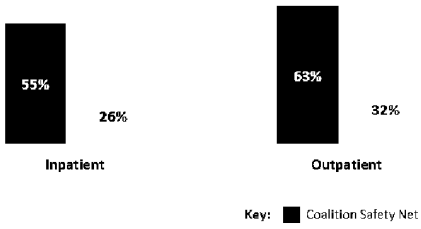
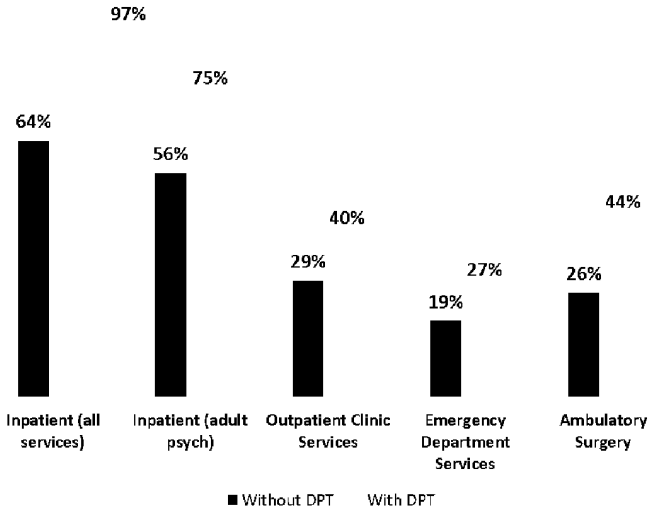


Figure 2: Percent of Services Delivered to Commercial Patients

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.[iv]
    - 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.**

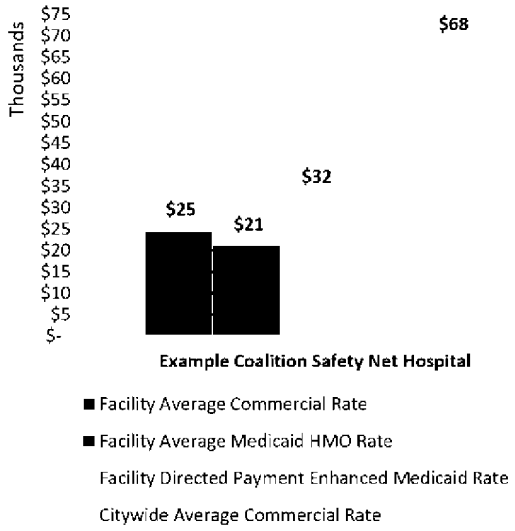
Figure 3: Percent of Costs Covered by NY Medicaid Managed Care Reimbursement Rates
(Example Coalition Safety Net Hospital – Excludes DSH Funding)



- 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).[v]

- **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).

Figure 4: IP Acute - Respiratory Infection
Average Allowed Amount for Total Stay



Lack of Adequate Funding Perpetuates Disparities in Safety Net Communities

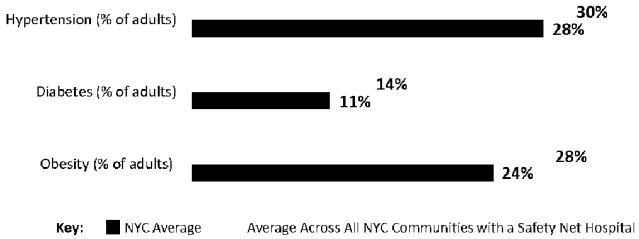
- **Due to the structural failures of the current system, safety net hospitals are in chronic financial distress, often facing cash flow challenges and almost always unable to invest in their infrastructure and facilities (see Figures 5-6).**

Figure 5: Safety Net Hospitals Operate Annually with Losses
Median Excess Margin (2019)

Figure 6: Safety Net Hospitals Are Unable to Update Older and Degraded Facilities
Median Age of Physical Plant (in years, 2019)

- **As our hospitals remain underfunded, the low-income communities of color we serve continue to be impacted by persistent disparities (see Figure 7).**

Figure 7: Safety Net Communities Have Higher Rates of Chronic Disease



[i] 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.

[ii] Coalition analysis of 2019-2020 New York Institutional Cost Reports.

[iii] Northwell Health, "[HYPERLINK "https://www.northwell.edu/sites/northwell.edu/files/d7/20830-Brooklyn-Healthcare-Transformation-Study_0.pdf"]."

[iv] 1199 SEIU Presentation, July 2021.

[v] 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.

Appointment

From: CMS CMCS_Unwinding (b)(6)
(b)(6)

Sent: 1/9/2023 2:09:27 PM

To: (b)(6)
'aimee.ossman@childrenshospitals.org' [aimee.ossman@childrenshospitals.org]; 'akg72@georgetown.edu' [akg72@georgetown.edu]; 'Allison Orris' [aorris@cbpp.org]; Arguello, Andres (OS/IOS) (b)(6); Banton, Kia (CMS/CMCS) (b)(6) (b)(6) 'Barbara Eyman' [beyman@eymanlaw.com]; Bentley (she/her), Katherine (CMS/CCIIO) (b)(6) (b)(6) 'bfeldpush@essentialhospitals.org' [bfeldpush@essentialhospitals.org]; Black, Nicole (CMS/OC) (b)(6) (b)(6); Blanar, Jonathan (CMS/OC) (b)(6) (b)(6); Bonelli, Anna (CMS/CMCS) (b)(6) (b)(6) 'brucel@firstfocus.org' [brucel@firstfocus.org]; 'cdobson@ADvancingstates.org' [cdobson@ADvancingstates.org]; Clark, Elizabeth (CMS/CMCS) (b)(6) (b)(6); Costello, Anne Marie (CMS/CMCS) (b)(6) (b)(6); Costello, Stefanie (CMS/OC) (b)(6) (b)(6) 'creusch@communitycatalyst.org' [creusch@communitycatalyst.org]; 'crogers@communitycatalyst.org' [crogers@communitycatalyst.org]; Cross-Call, Jesse (OS/IEA) (b)(6) (b)(6) 'davanzo@nilc.org' [davanzo@nilc.org]; Delone, Sarah (CMS/CMCS) (b)(6) (b)(6); Dolly, Ed (CMS/CMCS) (b)(6) 'DWalter@aap.org' [DWalter@aap.org]; 'EFishman@familiesusa.org' [EFishman@familiesusa.org]; 'ekong@apiahf.org' [ekong@apiahf.org]; 'emanuel@healthlaw.org' [emanuel@healthlaw.org]; 'Erica Cischke' [ecischke@aafp.org]; 'Erin O'Malley' [eomalley@essentialhospitals.org]; 'erodriguez@unidosus.org' [erodriguez@unidosus.org]; 'ferzouki@cbpp.org' [ferzouki@cbpp.org]; Fowler, Joanna (CMS/CCIIO) (b)(6) (b)(6) Franklin, Julie (CMS/OC) (b)(6) (b)(6) Gibson, Alexis (CMS/CMCS) (b)(6) (b)(6) 'Glier, Stephanie' [sglier@aap.org]; Grant, Jeff (CMS/CCIIO) (b)(6) (b)(6) Gutzmer, Hailey (CMS/OC) (b)(6); Hammarlund, John (CMS/OPOLE) (b)(6) (b)(6); Harris, Monica (CMS/CMCS) (b)(6) (b)(6); Hennessy, Amy (CMS/OC) (b)(6) (b)(6) 'hoshelton@naacpnet.org' [hoshelton@naacpnet.org]; 'jca25@georgetown.edu' [jca25@georgetown.edu]; 'JDBaker@mathematica-mpr.com' [JDBaker@mathematica-mpr.com]; 'Jennifer Tolbert' [JenniferT@kff.org]; 'JKozminski@essentialhospitals.org' [JKozminski@essentialhospitals.org]; Johnston, James (CMS/OHI)

(b)(6)
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'Lisa Satterfield' [lsatterfield@acog.org]; Lorsbach (she/her), Anna (CMS/CCIIO) (b)(6)
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Lovejoy, Shannon (CMS/CMCS) (b)(6)
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'mcheek@ahca.org' [mcheek@ahca.org]; 'minnocent@naacpnet.org' [minnocent@naacpnet.org]; 'mmiller@communitycatalyst.org' [mmiller@communitycatalyst.org]; Montz, Ellen (CMS/CCIIO)
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'msnider@unidosus.org' [msnider@unidosus.org]; 'Naomi Ali' [NAli@mathematica-mpr.com]; O'Connor, Sarah (CMS/CMCS) (b)(6)
(b)(6)
'rb1686@georgetown.edu' [rb1686@georgetown.edu]; 'rcarreon@unidosus.org' [rcarreon@unidosus.org]; Reilly, Megan (CMS/OC (b)(6)
(b)(6)
; 'robinr@kff.org' [robinr@kff.org]; 'Ross, Christy' [cross@naacpnet.org]; 'rtetlow@acog.org' [rtetlow@acog.org]; (b)(6) ; Seng, Suzette (CMS/CMCS) [/ (b)(6)
(b)(6)
Setala, Ashley (CMS/CMCS) (b)(6)
(b)(6)
[sfeliz@nul.org]; 'shughes@aha.org' [shughes@aha.org]; 'squinn@aafp.org' [squinn@aafp.org]; 'Stan Dorn' [SDorn@familiesusa.org]; Stephens, Jessica (CMS/CMCS) (b)(6)
(b)(6)
[tplatt@acog.org]; 'tharo (aap.org' [tharo@aap.org]; Thomas, Pam (CMS/OPOLE (b)(6)
(b)(6)
'Tiara Halstead' [THalstead@mathematica-mpr.com]; Toomey, Mary (CMS/OC) (b)(6)
(b)(6)
Trevino, Ethan (CMS/CCIIO) (b)(6)
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; 'Tricia Brooks' [pab62@georgetown.edu]; Tsai, Daniel (CMS/CMCS) (b)(6)
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(b)(6)
; Walen, Alyssa (CMS/OC)
(b)(6)
(b)(6)
'Wallace, Nick' [nwallace@aap.org]; Weiss, Alice (CMS/CMCS) (b)(6)
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Wood (he/him), Elijah (CMS/CCIIO) (b)(6)
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'youdelman@healthlaw.org' [youdelman@healthlaw.org]

Subject: Attends first 15 minutes: CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations
Attachments: 20230112_Stakeholder Workgroup Agenda.docx
Location: https://cms.zoomgov.com/j/1612157166?pwd=ZTljMXBKMURBU3d4L0V1K3Z5VnJoZz09

Start: 1/12/2023 8:00:00 PM

End: 1/12/2023 9:00:00 PM
Show Time As: Busy

Required 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

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: (b)(6)

Join by (b)(6)
Password: (b)(6)
(b)(6)

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: [HYPERLINK "https://www.medicaid.gov/sites/default/files/2023-01/cib010523_1.pdf"]
  - Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations (updated with scenarios): [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/health-plan-strategy-12062021.pdf"]
  - System Readiness Artifacts: A Refresher on Medicaid Enterprise Systems Artifacts for Unwinding: [HYPERLINK "https://www.medicaid.gov/sites/default/files/2023-01/systems-readiness-art-refresher-01062023.pdf"]

- **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:* [HYPERLINK "https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fclick.icptrack.com%2Ficp%2Frelay.php%3Fr%3D66175517%26msgid%3D550578%26act%3D6DF9%26c%3D1185304%26pid%3D2072585%26destination%3Dhttps%253A%252F%252Fcms.zoomgov.com%252Fwebinar%252Fregister%252FWN_qma5AvyBQWCTB0vbNF3lTA%26cf%3D6316%26v%3D040043a0fccfded53dff7d8b2638d163f864e9bf61587af26305f387f9acf530&data=05%7C01%7CJessica.Stephens%40cms.hhs.gov%7Ca8cebe435ed24c09ed2c08da4ade91b6%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637904617648441725%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2FPMNi%2FrjbSzijdPSp7t%2FuWarboBizN7YtMwVR6ARsZI%3D&reserved=0"]
  - Next Meeting: Rescheduling: To be confirmed

Message

From: Allexa Gardner [akg72@georgetown.edu]
Sent: 11/4/2022 8:18:23 PM
To: Tsai, Daniel (CMS/CMCS); (b)(6); (b)(6); Cash, Judith (CMS/CMCS); (b)(6); (b)(6)
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

Appointment

From: CalAIM Master Calendar [CalAIM_Master_Calendar@manatt.com]
Sent: 11/29/2022 7:40:25 PM
To: CalAIM Master Calendar [CalAIM_Master_Calendar@manatt.com]; 'Noelle.Simonick@dhcs.ca.gov' [Noelle.Simonick@dhcs.ca.gov]; 'janet.rudnick@dhcs.ca.gov' [janet.rudnick@dhcs.ca.gov]; 'rachel.nichols@cms.hhs.gov'; Ross, Heather (CMS/CMCS) (b)(6) (b)(6); Friedman, Kate (CMS/CMCS) (b)(6) (b)(6) 'Aaron.Toyama@dhcs.ca.gov'; 'Bambi.Cisneros@dhcs.ca.gov'; 'Benjamin.Mcgowan@dhcs.ca.gov'; Brumer, Justin@DHCS [Justin.Brumer@dhcs.ca.gov]; 'AnhThu.Bui@dhcs.ca.gov' [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) (b)(6) Rashid, Mehreen (CMS/CMCS) (b)(6) (b)(6); Decaro, Teresa (CMS/CMCS) (b)(6) (b)(6); Sadwith, Tyler@DHCS [Tyler.Sadwith@dhcs.ca.gov]; Samimi, Farrah@DHCS [Farrah.Samimi@dhcs.ca.gov]; 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 [Jacey.Cooper@dhcs.ca.gov]; Tsai, Daniel (CMS/CMCS) (b)(6) (b)(6) (CMS/CMCS) (b)(6) (b)(6)

Subject: CMS/DHCS Biweekly Waiver Check-in
Attachments: image001.jpg
Location: https://manatt.zoom.us/j/92009574479?pwd=TnRuRm1xdHFCQjRZVE5XMWdOQXVkZz09

Start: 12/1/2022 6:00:00 PM
End: 12/1/2022 6:30:00 PM
Show Time As: Tentative

Recurrence: (none)

Hi there,

Lora Kim is inviting you to a scheduled Zoom meeting.

Phone one-tap: US: or

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

Meeting ID: (b)(6)
Passcode

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

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
SIP:
Passcode

Message

From: Mann, Cindy [CMann@manatt.com]
Sent: 11/10/2022 6:54:56 PM
To: Tsai, Daniel (CMS/CMCS) (b)(6) (b)(6)
CC: Briskin, Perrie (CMS/CMCS) (b)(6) (b)(6)
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

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

NEW YORK SAFETY NET HOSPITAL COALITION

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

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[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.

Appointment

From: CMS Administrator (b)(6) (b)(6)
Sent: 11/7/2022 4:01:06 PM
To: CBL (she/her), Administrator (CMS/OA) (b)(6) (b)(6) Ellis (she/her), Kyla (CMS/OA) (b)(6); McLemore, Monica (CMS/OSORA) (b)(6) (b)(6); Khan, Farooq (CMS/OSORA) (b)(6) (b)(6); Tsai, Daniel (CMS/CMCS) (b)(6)

Subject: PREP: ACBL Mtg w/Georgetown University's Medicaid Section 1115 Waiver Task Force
Attachments: External Meeting Request: Medicaid Section 1115 Waiver Task Force/Georgetown University
Location: Zoom; https://cms.zoomgov.com/j/1603280271?pwd=UzY3Y2lFOGJIMG5aRmVRdHUyWGdKdz09

Start: 11/30/2022 8:00:00 PM
End: 11/30/2022 8:30:00 PM
Show Time As: Tentative

Required Attendees: (b)(6); Kyla Ellis (CMS/) (kyla.ellis@cms.hhs.gov); McLemore, Monica (CMS/OSORA); Khan, Farooq (CMS/OSORA); Tsai, Daniel (CMS/CMCS)

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 (b)(6)
Password: (b)(6)
(b)(6)

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.

Message

From: McLemore, Monica (CMS/OSORA) (b)(6) (b)(6)
Sent: 11/2/2022 4:21:56 PM
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
Cancer*Care*
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

Message

From: Tsai, Daniel (CMS/CMCS) (b)(6) (b)(6)
Sent: 7/20/2023 10:41:39 PM
To: Mann, Cindy [CMann@manatt.com]; Costello, Anne Marie (CMS/CMCS) (b)(6) (b)(6)
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
D (202) 585-6572 **F** (202) 595-0933
CMann@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

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Counsel for the Defendant

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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

Respectfully submitted,

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Attorney General and Reporter

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Counsel for the Defendant

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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Michael W. Kirk

Appointment

From: CMS Administrator (b)(6) (b)(6)
Sent: 11/7/2022 3:55:13 PM
To: CMS Administrator (b)(6) (b)(6) CBL (she/her), Administrator (CMS/OA) (b)(6) (b)(6) ; Ellis (she/her), Kyla (CMS/OA) (b)(6) (b)(6) ; McLemore, Monica (CMS/OSORA) (b)(6) (b)(6) ; Khan, Farooq (CMS/OSORA) (b)(6) (b)(6) Tsai, Daniel (CMS/CMCS) (b)(6)

Subject: [INTERNAL] ACBL Mtg w/Georgetown University's Medicaid Section 1115 Waiver Task Force
Attachments: External Meeting Request: Medicaid Section 1115 Waiver Task Force/Georgetown University
Location: Zoom Link to be Included

Start: 12/1/2022 6:30:00 PM
End: 12/1/2022 7:00:00 PM
Show Time As: Tentative

Required Attendees: (b)(6) Kyla Ellis (CMS/) (kyla.ellis@cms.hhs.gov); McLemore, Monica (CMS/OSORA); Khan, Farooq (CMS/OSORA); Tsai, Daniel (CMS/CMCS)

Message

From: McLemore, Monica (CMS/OSORA) (b)(6) (b)(6)
Sent: 11/2/2022 4:21:56 PM
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
Cancer*Care*
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

Message

From: Giles, John (CMS/CMCS) (b)(6)
(b)(6)
Sent: 7/18/2023 8:54:01 PM
To: Burch Mack, Rebecca (CMS/CMCS) (b)(6)
(b)(6)
Subject: FW: FW: Georgetwon and CBPP
Attachments: CBPP_CMS-2023-0071-0204-A1.pdf; Georgetown Hlth Policy Inst_CMS-2023-0071-0198-A1.pdf

John Giles, MPA
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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
Senior Fellow

Laura Harker
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.

CONTENTS

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.

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[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.

Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

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 elsewhere in 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

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[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, PHIP'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 waiting 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."

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 submitted by 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 must make the payment analysis submitted by 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 beginning on 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 them to use a minimum or maximum fee schedule, use value-based payment mechanisms, or make other rate increases. SDPs have been important to states, allowing them to 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 large undercount 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 impacting access 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 document the value of the *additional* SDP 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.

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[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.*

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. State 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, there has 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.

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[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 RE: Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care" (Jan. 4, 2023), https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf.

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.

<u>Recommendations</u>: 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

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[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 30th to December 31st.

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.

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).

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.

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[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,

(b)(6)

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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
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The Honorable Chiquita Brooks-LaSure
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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
Senior Fellow

Laura Harker
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.

CONTENTS

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.

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[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.

Appointment

From: Kim, Lora [LYKim@manatt.com]
Sent: 11/29/2022 7:40:02 PM
To: 'Noelle.Simonick@dhcs.ca.gov' [Noelle.Simonick@dhcs.ca.gov]; 'janet.rudnick@dhcs.ca.gov' [janet.rudnick@dhcs.ca.gov]; 'rachel.nichols@cms.hhs.gov'; Ross, Heather (CMS/CMCS) (b)(6) Friedman, Kate (CMS/CMCS) (b)(6) (b)(6); 'Aaron.Toyama@dhcs.ca.gov'; 'Bambi.Cisneros@dhcs.ca.gov'; 'Benjamin.Mcgowan@dhcs.ca.gov'; Brumer, Justin@DHCS [Justin.Brumer@dhcs.ca.gov]; 'AnhThu.Bui@dhcs.ca.gov' [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) (b)(6); Rashid, Mehreen (CMS/CMCS) (b)(6) (b)(6) Decaro, Teresa (CMS/CMCS) (b)(6) (b)(6); Sadwith, Tyler@DHCS [Tyler.Sadwith@dhcs.ca.gov]; Samimi, Farrah@DHCS [Farrah.Samimi@dhcs.ca.gov]; 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 [Jacey.Cooper@dhcs.ca.gov]; Tsai, Daniel (CMS/CMCS (b)(6) (b)(6)]; McClenathan, Jane (CMS/CMCS (b)(6) (b)(6)

Subject: CMS/DHCS Biweekly Waiver Check-in
Attachments: image001.jpg
Location: https://manatt.zoom.us/j/92009574479?pwd=TnRuRm1xdHFCQjRZVE5XMWdOQXVkZz09

Start: 12/1/2022 6:00:00 PM
End: 12/1/2022 6:30:00 PM
Show Time As: Tentative

Recurrence: (none)

Hi there,

Lora Kim is inviting you to a scheduled Zoom meeting.

Phone one-tap: US: or

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

Meeting ID: (b)(6)

Passcode

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

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:

Passcode: (b)(6)

SIP:

Passcode:

Appointment

From: CMS Administrator (b)(6)
(b)(6)
Sent: 11/25/2022 10:42:07 PM
To: CBL (she/her), Administrator (CMS/OA) (b)(6)
(b)(6) Ellis (she/her), Kyla (CMS/OA)
(b)(6) McLemore, Monica
(CMS/OSORA) (b)(6)
(b)(6) ; Khan, Farooq
(CMS/OSORA) (b)(6)
(b)(6) Tsai, Daniel (CMS/CMCS)
(b)(6)
(b)(6) ; Katch (she/her), Hannah
(CMS/OA) (b)(6)
(b)(6) ; Costello, Anne Marie
(CMS/CMCS) (b)(6)
(b)(6) ; Cash, Judith
(CMS/CMCS) (b)(6)
(b)(6) ; Jackson, Marilyn
(CMS/OSORA (b)(6)
(b)(6)

Subject: PREP: ACBL Mtg w/Georgetown University's Medicaid Section 1115 Waiver Task Force
Attachments: External Meeting Request: Medicaid Section 1115 Waiver Task Force/Georgetown University
Location: Zoom; https://cms.zoomgov.com/j/1603280271?pwd=UzY3Y2lFOGJIMG5aRmVRdHUyWGdKdz09

Start: 11/30/2022 6:30:00 PM
End: 11/30/2022 6:55:00 PM
Show Time As: Tentative

Required 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)

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 (b)(6)
Password: (b)(6)
(b)(6)

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.

Message

From: McLemore, Monica (CMS/OSORA) (b)(6) (b)(6)
Sent: 11/2/2022 4:21:56 PM
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
Cancer*Care*
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

Appointment

From: Peterson, Alanna [APeterson@manatt.com]
Sent: 8/1/2022 6:19:45 PM
To: Peterson, Alanna [APeterson@manatt.com]; 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) (b)(6) (b)(6) Gibson, Alexis E. (CMS/CMCS) (b)(6) (b)(6)]; Gentile, Amy A. (CMS/CMCS) jbarrazacannon@mitre.org; rebeccacase@mitre.org
CC: Llanos, Karen E.(CMS/CMCS) (b)(6) (b)(6)

Subject: [External] CMCS Access Policy Sprint Working Session
Attachments: image001.jpg
Location: https://manatt.zoom.us/j/96365790379?pwd=NUtwSVhjL0JoY0NHVlNkWjRTQXN6Zz09

Start: 8/10/2022 6:00:00 PM
End: 8/10/2022 7:00:00 PM
Show Time As: Busy

Recurrence: (none)

Hi there,

Alanna Peterson is inviting you to a scheduled Zoom meeting.

Phone one-tap: US: or

Meeting URL: https://manatt.zoom.us/j/96365790379?pwd=NUtwSVhjL0JoY0NHVlNkWjRTQXN6Zz09

Meeting ID: (b)(6)
Passcode

Join by Telephone

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

Dial:

US: +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 +1 253 215 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:

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:

Passcode: (b)(6)

SIP:

Passcode:

Appointment

From: Guyer, Jocelyn [JGuyer@manatt.com]
Sent: 7/17/2023 2:42:21 PM
To: Guyer, Jocelyn [JGuyer@manatt.com]; Howe, Rory (CMS/CMCS) (b)(6) Group (b)(6) ; Silanskis, Jeremy (CMS/CMCS) (b)(6) (b)(6) ; Maccarroll, Amber (CMS/CMCS) (b)(6) (b)(6) ; Kaminsky, Stephanie (CMS/CMCS) (b)(6) (b)(6) ; Thompson, Christopher (CMS/CMCS) (b)(6) (b)(6) Badaracco, Andrew (CMS/CMCS) (b)(6) (b)(6) Mann, Cindy [CMann@manatt.com]; Ginnis (she/her), Kate (CMS/CMCS) (b)(6) (b)(6) ; Briskin, Perrie (CMS/CMCS) (b)(6) (b)(6) Kimball (he,him), Richard (CMS/CMCS) (b)(6) (b)(6)]; Barnard, Zoe [ZBarnard@manatt.com]; Traub, Arielle [ATraub@manatt.com]
CC: Viswanathan, Pavitra [PViswanathan@manatt.com]

Subject: FW: FW: [External] SBS Claiming Guide Call
Attachments: image001.jpg
Location: https://manatt.zoom.us/j/94629706245?pwd=dnozTExEeDQveFFSQUp4WFVqMVZlZz09

Start: 7/17/2023 4:00:00 PM
End: 7/17/2023 4:30:00 PM
Show Time As: Tentative

Recurrence: (none)

FYI

-----Original Appointment-----
From: Guyer, Jocelyn <JGuyer@manatt.com>
Sent: Monday, July 17, 2023 9:51 AM
To: Guyer, Jocelyn; Thompson, Christopher (CMS/CMCS); Badaracco, Andrew (CMS/CMCS); Mann, Cindy; Ginnis (she/her), Kate (CMS/CMCS); Briskin, Perrie (CMS/CMCS); Kimball (he,him), Richard (CMS/CMCS); Barnard, Zoe; Traub, Arielle
Cc: Viswanathan, Pavitra
Subject: FW: [External] SBS Claiming Guide Call
When: Monday, July 17, 2023 12:00 PM-12:30 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://manatt.zoom.us/j/94629706245?pwd=dnozTExEeDQveFFSQUp4WFVqMVZlZz09

-----Original Appointment-----
From: Guyer, Jocelyn <JGuyer@manatt.com>
Sent: Monday, June 26, 2023 1:55 PM
To: Guyer, Jocelyn; Mann, Cindy; Ginnis, Kate (CMS/CMCS); Briskin, Perrie (CMS/CMCS); Kimball (he,him), Richard

(CMS/CMCS); Barnard, Zoe; Traub, Arielle
Cc: Viswanathan, Pavitra
Subject: [External] SBS Claiming Guide Call
When: Monday, July 17, 2023 12:00 PM-12:30 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://manatt.zoom.us/j/94629706245?pwd=dnozTExEeDQveFFSQUp4WFVqMVZlZz09

Hi there,

Jocelyn Guyer (she/her) is inviting you to a scheduled Zoom meeting.

Phone one-tap: US: or

Meeting URL: https://manatt.zoom.us/j/94629706245?pwd=dnozTExEeDQveFFSQUp4WFVqMVZlZz09

Meeting ID: (b)(6)
Passcode

Join by Telephone

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

US: +1 301 715 8592 or +1 305 224 1968 or +1 309 205 3325 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 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 +1 253 215 8782 or +1 346 248 7799 or 833 928 4609 (Toll Free) or 833 928 4610 (Toll Free) or 877 853 5247 (Toll Free) or 888 788 0099 (Toll Free) or 833 548 0276 (Toll Free) or 833 548 0282 (Toll Free) or 833 928 4608 (Toll Free)

Meeting ID: (b)(6)
Passcode

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:

Passcode:

SIP:

Passcode:

(b)(6)

Appointment

From: Dunn, Victoria (CMS/CMCS (b)(6)
(b)(6)
Sent: 11/14/2022 7:30:51 PM
To: Tsai, Daniel (CMS/CMCS (b)(6)
(b)(6)

Subject: PAPER - Georgetown University's Medicaid Section 1115 Waiver Task Force
Attachments: Waiver Task Force Meeting 1-page.docx; Alker CMCS Response.pdf; Letter to Secretary to Improve 1115 Waiver Process.pdf

Start: 12/1/2022 6:30:00 PM
End: 12/1/2022 7:00:00 PM
Show Time As: Busy

The Waiver Task Force is a coalition of over 150 organizations representing Medicaid advocates, researchers, patient groups, and provider organizations that engage on section 1115 demonstration waiver policy at the state and federal level.

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.

We urge CMS to issue regulations to achieve three key goals:

Define the Objectives of Medicaid for Purposes of Section 1115 Demonstrations
CMS should promulgate a regulation to set forth "the objectives of Medicaid" to avoid harmful demonstration and waiver approvals, such as work requirements or premiums in Medicaid. A definition of the objectives of Medicaid should be 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.

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. CMS should require that all demonstrations meet all specified 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.

Protect 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**.
- Second, the permissible exceptions to the transparency process in the case of a public health emergency needs to be tightened up.
- Third, CMS's regulation should set clear standards for the duration of demonstrations, not to exceed five years.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

November 8, 2022

Joan Alker
Executive Director
Center for Children and Families
Georgetown University, McCourt School of Public Policy
3300 Whitehaven St., NW
Suite 5000
Washington, DC 20057

Dear Joan Alker:

Thank you for your recommendations on the Centers for Medicare & Medicaid Services (CMS) promulgating regulations regarding the section 1115 Medicaid demonstration process.

The Department of Health and Human Services (HHS) appreciates your feedback on the need for a regulatory framework to provide clarity around the parameters for the use of section 1115 authority, including defining the objectives of Medicaid and strengthening the transparency process for all section 1115 demonstration actions. CMS recognizes that protecting the integrity and transparency of the review and approval process are key concerns for stakeholders. The agency will consider these recommendations as we work toward our shared goal of strengthening Medicaid and the Children's Health Insurance Program.

We also recognize the importance of clear guidance that affirms the objectives of Medicaid and a meaningful public comment process that informs CMS's review and decision making. The feedback provided in your correspondence will be used to inform future policy on these topics.

We thank you for your advocacy and support of the Medicaid program and the populations it serves. If you have additional questions regarding state section 1115 demonstrations, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services at 410-786-4473. Please share a copy of this response with the cosigners of your letter.

Sincerely,

(b)(6)

Daniel Tsai
Deputy Administrator and Director

cc:
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)
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Black Mamas Matter Alliance
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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

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).

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National Partnership for Women & Families
National Patient Advocate Foundation

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

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

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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).

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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

Message

From: Allison Orris [aorris@cbpp.org]
Sent: 12/2/2022 7:26:51 PM
To: Tsai, Daniel (CMS/CMCS (b)(6) (b)(6) Costello, Anne Marie (CMS/CMCS) (b)(6) (b)(6)
CC: andy.schneider@georgetown.edu
Subject: Managed Care Regulations - Transparency/Access Recommendations
Attachments: CCFCBPP re MCO regs 12-2-22.pdf

Hi Dan and Anne Marie. It was nice to see each of you in various meetings this week.

Andy and I wanted to share the attached recommendations regarding ways that Medicaid managed care rules could promote transparency at both the state and federal level, in serve to the access goals that we know the Administration is focusing on. We think the forthcoming rulemaking presents an opportunity for CMS to strengthen its transparency policies and processes to improve access and strengthen program integrity at minimal cost and with minimal new requirements on states. To that end, we are sharing the attached recommendations for your consideration.

Please let us know if you have any questions or would like to discuss.

Have a good weekend,
Allison

Allison Orris (she/her/hers)
Senior Fellow
Center on Budget and Policy Priorities
(202) 325-8347 | aorris@cbpp.org

To: Dan Tsai, CMS Deputy Administrator and CMCS Director
Anne Marie Costello, CMCS Deputy Director

From: Allison Orris, Center on Budget and Policy Priorities
Andy Schneider, Georgetown Center for Children and Families

Re: Recommended improvements to Medicaid managed care regulations to ensure access to care

Date: December 2, 2022

We understand that CMS is now developing an NPRM (CMS-2439) to propose changes to the current regulations that would make "policy and reporting changes to ensure the efficient operation of state managed care delivery systems and access to care for Medicaid managed care enrollees." This rule presents an opportunity for CMS to strengthen its transparency policies and processes to improve access and strengthen program integrity at minimal cost and with minimal new requirements on states. Enhancing data collection and reporting requirements in the managed care regulations could help advance health equity by facilitating the availability of transparent information that states and CMS could leverage to address disparities.

Background

The federal investment in Medicaid managed care in FY 23 is projected at $280 billion, or nearly 47% of total projected federal Medicaid spending (CBO May 2022 Baseline). However, there is little evidence to indicate whether or not the more than 58 million beneficiaries enrolled in Medicaid MCOs (CMS, 2020 reporting year) have access to care commensurate with that investment. This absence of transparency is a fundamental program integrity issue for the program. It is also a barrier to address health equity as health disparities are often exacerbated by challenges enrollees have in accessing providers and receiving timely care. Without high quality data about the quality of care that individuals receive, it is difficult for policymakers to target interventions or to ensure that dollars are being spent as efficiently as possible

By itself, CMS does not have the staffing resources to hold approximately 280 MCOs and the 41 state Medicaid agencies that select and contract with those MCOs accountable for their performance on access to care for enrollees. In addition, CMS's formal enforcement tools are limited; if access is grossly inadequate, its only recourse is deferring or disallowing FFP on the state's contract with the MCO or withholding approval of the contract at the next renewal.

Transparency of data on the performance of individual MCOs is a much less drastic but potentially more effective remedy. It can be a powerful motivator for both MCOs and state Medicaid agencies concerned about reputational risk; poorly performing MCOs will not want the public to know that their performance is sub-par, and state agencies will not want the public to know that they are contracting with a poorly performing MCO. In addition, transparency would impose almost no new costs on states or the federal government, since

they already pay for the performance data they collect from individual MCOs through monthly capitation.

The current CMS managed care regulations do not place enough emphasis on transparency of performance data for individual MCOs. They require only that state Medicaid agencies post (1) the contract with the MCO, (2) ownership and control information, (3) triennial audit results, (4) documentation of the availability and accessibility of services, and (5) the Annual Technical Review done by the EQRO. State compliance is spotty, but even if it was robust, this information would not be sufficient to assess the extent to which MCO enrollees have access to care.

As CMS proposes a new approach to measuring access standards in Medicaid managed care, we recommend that, as part of that rulemaking, CMS also undertake changes to strengthen its transparency policies and processes to improve access and strengthen program integrity at minimal cost and with minimal new requirements on states.

Recommendation for greater transparency at the federal level

We recommend that CMS issue regulations to stand up and maintain a Medicaid MCO performance dashboard with data on each MCO that includes (1) MCO name; (2) parent organization; (3) Medicaid enrollment stratified by age (under 21, 21-64, 65 and over) and, when available, race, and ethnicity; (4) Child Core Set measures; (5) Adult Core Set behavioral health measures; (6) maternal health measures from Adult Core Set; (7) EPSDT screening and treatment measures; (8) Medicaid capitation revenues; (9) MLR; and (10) enforcement actions taken by the state.

This data set builds on information in the *Medicaid Managed Care and Enrollment and Program Characteristics* prepared for CMS by Mathematica. https://www.medicaid.gov/medicaid/managed-care/downloads/2020-medicaid-managed-care-enrollment-report.pdf Every data element other than maternal health measures from the Adult Core Set is information that the states already have or that they will be required to report to CMS starting in 2024.

CMS currently has the authority to stand up and maintain an MCO performance dashboard. To reduce burden on CMS, items (4), (5), (7), and (10) could be met by establishing linkages to a state website if available on that website (see below); if a state is not in compliance with reporting obligations, the responsibility to post the information would be on CMS using data reported by the state.

To ensure continuity of the MCO performance dashboard from Administration to Administration, CMS should codify its obligation to maintain this dashboard in regulation, perhaps by adding a new section to Subpart H of Part 438, Additional Program Integrity Safeguards.

Recommendation for greater transparency at the state level

CMS should update its regulations to add to the documents and reports that state Medicaid agencies must post on their websites per 438.602(g) the following:

(1) All annual MLR reports submitted by each MCO to the state as required by current regulations. (This is not the summary description of these MLR reports that CMS now requires states to submit per the July 6, 2022 CIB at https://www.medicaid.gov/federal-policy-guidance/downloads/cib07062022.pdf; the full MLR reports should be made available)

Strengthen the current regulatory requirement at 438.8(k) regarding the content of an MCO's annual MLR report to require that the report must include each of the data elements specified in current CMS regulations necessary to calculate the numerator 438.8(e) and the denominator (f).

(2) The Child Core Set measures and the behavioral health measures in the Adult Core Set that each MCO submits to the state Medicaid agency on the basis of which the state agency meets its annual reporting obligation to CMS beginning in 2024 under the Bipartisan Budget Act of 2018.

(3) The EPSDT measures that each MCO the enrolls children under 21 submits to the state Medicaid agency on the basis of which the state Medicaid agency annually submits form CMS-416 to CMS as required by State Program Guidelines https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

(4) A listing of actions taken by the state against each MCO to enforce the terms of the risk contract, including a description of the noncompliance at issue, the type of action taken (CAPs, fines, liquidated damages, suspension of new enrollment, etc.), and the amount of any financial sanction imposed. (States are required by 438.724 to give CMS written notice within 30 days of when it imposes or lifts a sanction).

* * * * *

Promoting transparency is a critical first step to promoting both access and program integrity. Over time, CMS should require states to meet minimum performance standards and be transparent about performance improvement plans. However, this will require significant transition time for states. It may also require some flexibility to work with states or adjust measures for states with different geographic challenges, such as states with very rural areas. Working to develop data needed to identify and reduce disparities is a necessary precursor l to advancing not just health equity but also program integrity in Medicaid.

Appointment

From: Mann, Cindy [CMann@manatt.com]
Sent: 2/14/2023 3:33:52 PM
To: Mann, Cindy [CMann@manatt.com]; Tsai, Daniel (CMS/CMCS) (b)(6)
Group ((b)(6) Karl, Anne O. [AKarl@manatt.com]

Subject: [External] Dan Tsai/Cindy Mann/Anne Karl meeting
Attachments: image001.jpg
Location: https://manatt.zoom.us/j/99321686405?pwd=alJCNnpHdnZmWWpnZXV6S3ZwbWNpZz09

Start: 2/14/2023 8:30:00 PM
End: 2/14/2023 9:00:00 PM
Show Time As: Busy

Recurrence: (none)

Hi there,

Cindy Mann, Manatt is inviting you to a scheduled Zoom meeting.

Phone one-tap: US: or

Meeting URL: https://manatt.zoom.us/j/99321686405?pwd=alJCNnpHdnZmWWpnZXV6S3ZwbWNpZz09

Meeting ID: (b)(6)
Passcode

Join by Telephone

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

US: +1 305 224 1968 or +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 +1 386 347 5053 or +1 507 473 4847 or +1 564 217 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 +1 253 215 8782 or +1 346 248 7799 or +1 360 209 5623 or 888 788 0099 (Toll Free) or 877 853 5247 (Toll Free)

Meeting ID: (b)(6)

Passcode

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: 993 2168 6405

Passcode

SIP: (b)(6)

Passcode

Briefing Memo

February 23, 2023

TO: Dan Tsai, Deputy Administrator and Director of Center for Medicaid and CHIP\ Services

FROM: Office of Legislation

SUBJECT: Meeting with Rep. Lois Frankel (D-FL) on the Impact of Unwinding in Florida

---

Prep: **June 8, 2023 at 2:30 PM EST**
https://cms.zoomgov.com/j/1611651793?pwd=aDErZ2RxK0NRTUt0TStzMFBQRThuQT09
Conference Line: (b)(6)
Meeting ID: (b)(6)

Meeting: **June 9, 2023 at 11:30 AM EST**
https://ushr.zoomgov.com/meeting/register/vJItcuquqDwtHpcKeQMbKm8od66SLOEbkwM

You are scheduled to speak with Rep. Lois Frankel (D-FL) on Friday, June 9th at 11:30 AM EST. The Congresswoman would like to discuss CMS' assessment of the numbers of Medicaid enrollees being removed from Medicaid in Florida as a result of unwinding. The Congresswoman will likely ask at what point could and would CMS intervene. Also, Rep. Frankel has invited other Members of the Florida delegation to join this call.

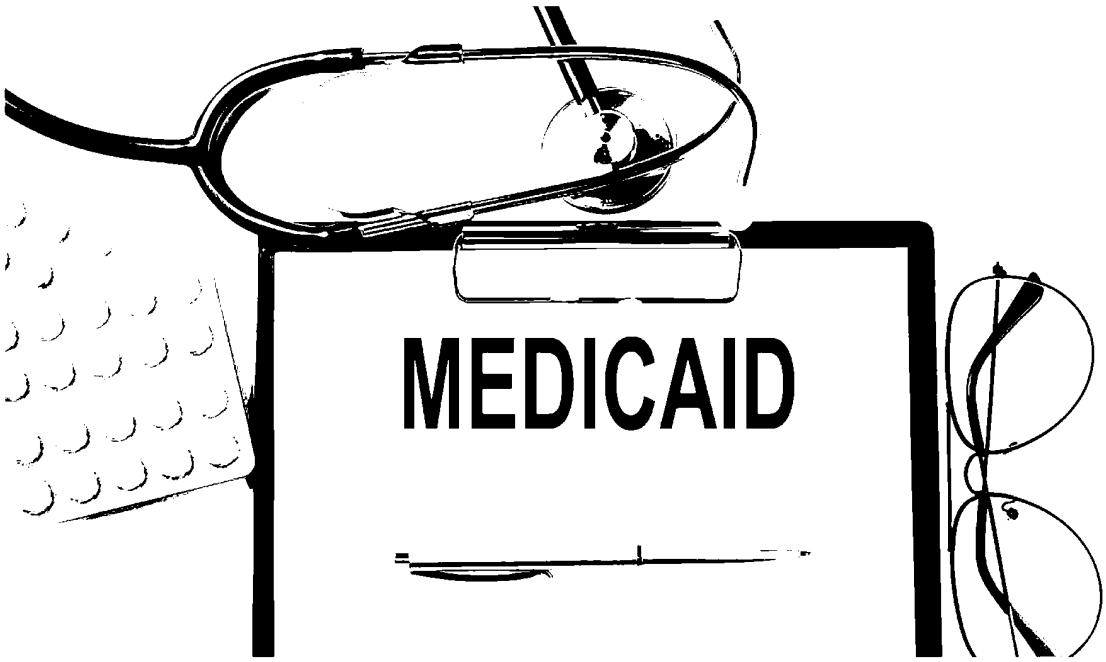
Since mid-May, the CMS Office of Legislation has heard from Rep. Kathy Castor (D-FL) and Rep. Sheila Cherfilus-McCormick (D-FL) on unwinding in Florida. After reading the May 16, 2023 release of the Georgetown University Health Policy Institute article that included a State of Florida report to CMS, the Members asked about the impact of unwinding in Florida.

Attached, we have included the Congresswoman's profile, the Georgetown article and State of Florida report to CMS. Your staff will brief you on what we can tell Rep. Frankel about unwinding in Florida.

https://ccf.georgetown.edu/2023/05/16/how-many-children-just-lost-coverage-in-florida/

Say Ahhh!

How Many Children Just Lost Coverage in Florida?



May 16, 2023 · Joan Alker

We just received a **copy of Florida's report to CMS** on its first month of "unwinding" the Medicaid continuous coverage provisions for April and the data is alarming. Of the 461,322 people whose eligibility was checked, more than half — 54% or 249,427 people — were terminated.

Most of those terminated (82%) had their cases closed, not because they were determined to be ineligible (that was only about 10% i.e. 44,305 who were transferred to the Marketplace), but for procedural or "red tape" reasons (205,122).

This is extremely troubling and is similar to the scary numbers we saw in **Arkansas** last week where approximately 80% of the terminations were for procedural reasons. A key difference though between Arkansas and Florida is, of course, that Florida has not

expanded Medicaid to adults, so the coverage losses in Florida will be concentrated among children, parents and young adults. When Governors see such large numbers of terminations of coverage for procedural reasons, they should pause the process and see what is going wrong. Are families actually getting the renewal packet? Are they having trouble getting through to the call center for help? Has their eligibility been properly assessed?

We have already heard numerous anecdotal reports of families in Florida finding out that their coverage was terminated when **going in for an appointment** and learning they have been terminated or **erroneously terminated**. Some will **undoubtedly fall** into the coverage gap because Florida has not expanded Medicaid. Among the nearly 250,000 being terminated from coverage in Florida was a **little boy** who had leukemia.

It's hard to compare apples to apples here because states are prioritizing different groups first, and reporting data differently, but we saw far less concerning data from **Arizona** last week – where 17% were terminated in the state's second month of unwinding. The **first month of data** from Arizona saw large losses amongst the **Temporary Medical Assistance (TMA)** population, which sort of makes sense as this is a time-limited category for parents who see their income rise due to earned income.

One thing we know for sure — because Florida is not an expansion state — is that the vast majority of the coverage losses will impact children, parents, young adults and new mothers. What we don't know is how many of the 250,000 people who just lost coverage fall into these groups. We do know that children are very likely to remain eligible for Medicaid and less likely to have another source of coverage.

There is no question that some people are going to lose Medicaid because they no longer qualify in every state. But when we see numbers of this magnitude, especially where children are concerned, this is a matter of grave concern.

Share

Joan Alker is the Executive Director of the Center for Children and Families and a Research Professor at the Georgetown McCourt School of Public Policy.

JoanAlker1

Unwinding Reports

Florida Unwinding Monthly Report (April 2023)

Information

Print

Unwinding Period Start Date: **April 2023**

Submission Date: **05/09/2023**

Last saved date and time: **Tuesday, 05-09-2023 - 20:32**

Submitted by:

Submitted status: **Yes**

APPLICATION PROCESSING

1. Total pending applications received between March 1, 2020 and the end of the month prior to the state's unwinding period	**152371**
Unable to report	**No**
1a. Total MAGI and other non-disability applications	**122904**
Unable to report	**No**

1b. Total disability-related applications	**29467**
Unable to report	**No**

Metric 1 Notes
{Empty}

2. Of those applications included in Monthly Metric 1, the total number of applications completed as of the last day of the reporting period	**140698**
Unable to report	**No**
2a. Completed MAGI and other non-disability related applications as of the last day of the reporting period	**113796**
Unable to report	**No**
2b. Completed disability-related applications as of the last day of the reporting period	**26902**
Unable to report	**No**

Metric 2 Notes
{Empty}

3. Of those applications included in Monthly Metric 1 the total number of applications that remain pending as of the last day of the reporting period	**11673**
Unable to report	**No**

3a. Pending MAGI and other non-disability applications as of the last day of the reporting period	**9108**
Unable to report	**No**
3b. Pending disability-related applications as of the last day of the reporting period	**2565**
Unable to report	**No**

Metric 3 Notes
{Empty}

RENEWALS INITIATED

4. Total beneficiaries for whom a renewal was initiated in the reporting period	**402232**
Unable to report	**No**

Metric 4 Notes
Awaiting data from FHK to add the total due from CHIP.

RENEWALS AND OUTCOMES

5. Total beneficiaries due for renewal in the reporting period	**606702**
Unable to report	**No**

Metric 5 Notes
{Empty}

5a. Of the beneficiaries included in Metric 5, the number renewed and retained in Medicaid or CHIP (those who remained enrolled)	**211895**
Unable to report	**No**
5a(1). Number of beneficiaries renewed on an ex parte basis	**81218**
Unable to report	**No**
5a(2). Number of beneficiaries renewed using a pre-populated renewal form	**130677**
Unable to report	**No**

Metric 5a Notes
{Empty}

5b. Of the beneficiaries included in Metric 5, the number determined ineligible for Medicaid or CHIP (and transferred to Marketplace)	**44305**
Unable to report	**No**

Metric 5b Notes
{Empty}

5c. Of the beneficiaries included in Metric 5, the number terminated for procedural reasons (i.e. failure to respond)	**205122**

Unable to report	**No**

Metric 5c Notes
{Empty}

5d. Of the beneficiaries included in Metric 5, the number whose renewal was not completed	**145380**
Unable to report	**No**

Metric 5d Notes
{Empty}

6. Month in which renewals due in the reporting month were initiated	**2023-03**
Unable to report	**No**

Metric 6 Notes
{Empty}

7. Number of beneficiaries due for a renewal since the beginning of the state's unwinding period whose renewal has not yet been completed	**4273783**
Unable to report	**No**

Metric 7 Notes
{Empty}

MEDICAID FAIR HEARINGS

8. Total number of Medicaid fair hearings pending more than 90 days at the end of the reporting period	**29**
Unable to report	**No**

Metric 8 Notes
{Empty}

REP. LOIS FRANKEL (D-FL)
Birth Date: May 16, 1948
District: 21st, Boca Raton
Hometown: West Palm Beach, FL
Profession: Lawyer, County Public Defender
CMS-Related Committees: Appropriations
Elected to the U. S. House of Representatives in 2016, 6th Term

Florida
Medicaid Expansion: No
Marketplace Type: Federally Facilitated Exchange (FFE)
Change in Uninsured Rate from 2019 to 2021: -1.2% (16.8% to 15.62%)

Profile

Rep. Frankel is a staunch reproductive and women's health advocate but has focused on a range of issues including LGBT rights, supporting veterans and sustaining the Medicare and Social Security programs. Rep. Frankel currently serves on the Appropriations Committee and the Veterans' Affairs Committee.

Recent Correspondence

Florida Hospital Medicaid Directed Payment Program. 5/25/23 — Rep. Frankel and 7 other Members urge CMS to reauthorize Florida's hospital directed payment program (DPP) for the 2022 Medicaid managed care contract rating period (October 1, 2022 through September 30, 2023). (Lead Signature, Rep. Castor). **Status: Response pending in CMCS.**

Contraceptive Coverage. 3/27/23 – Rep. Frankel and 90 other Members asked the President for specific actions to overcome barriers to contractive coverage. (Lead Signature, Rep. Frankel) **FYI ONLY**

Sponsored Legislation

H.R. 9546, Connected Maternal Online Monitoring Act, this bill requires the Centers for Medicare & Medicaid Services to report, and provide resources for states, on coverage of remote physiologic devices and related services (e.g., blood glucose monitors) under Medicaid, so as to improve maternal and child health outcomes for pregnant and postpartum women. (12/14/22)

Message

From: Mann, Cindy [CMann@manatt.com]
Sent: 8/4/2022 3:16:20 PM
To: Tsai, Daniel (CMS/OA) (b)(6)
(b)(6)
Subject: FW: FW: FW: KHN Morning Briefing: Aug. 4, 2022
Attachments: Hospitals serving Black patients get less financial help, study shows _ Modern Healthcare.pdf

This was flagged in today's KFF report so you may well have seen it (we are also doing a close look at data in three states on this point, as well as our ongoing NYC safety net work). Relates to both access work and directed payment issues.

And someday I'd love to hear more about TN. Excellent result all things considered.

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

August 03, 2022 02:37 PM | UPDATED 19 HOURS AGO

Hospitals serving Black patients get less financial help, study shows

CAROLINE HUDSON

MH Illustration/Getty Images

Researchers compiled data from Medicare and the AHA on 5,740 hospitals.

Hospitals serving a higher proportion of Black patients receive less financial support for providing care compared with those serving a lower proportion, according to a recent study from physician-researchers at the University of California Los Angeles and Princeton, Johns Hopkins and Harvard universities

The peer-reviewed study compiled data from Medicare and the American Hospital Association on 5,740 hospitals from 2016 to 2018. Of those hospitals, 574 were defined as "Black-serving," or those in the top 10% for the highest share of Black patients among Medicare inpatients. Most of the Black-serving hospitals were concentrated in Southern and/or urban environments.

Total reimbursements, which includes payments from patients and insurers for patient care per day, were an average of 21.6% lower at the Black-serving hospitals, researchers found. The hospitals serving more Black patients averaged a loss of $17 per patient each day, compared with an average profit of $126 per patient day among the study's other hospitals.

Mean profits were $111 lower per patient day at Black-serving hospitals, once adjusted for the variety in cases and facilities.

Much of the disparity stems from reimbursement rates and often leads to lower standards of care at hospitals with fewer resources, said Dr. Gracie Himmelstein, study author and an internal medicine resident at UCLA. Medicaid discharges accounted for 14.2% of discharges at Black-serving hospitals, compared with 9.5% at the other facilities, according to the study. Medicaid, in general, reimburses providers at a lower rate than Medicare or private agencies.

Medicaid reimbursements have been a contentious issue for years, with states battling over whether to accept the financial hit of expanded coverage. The COVID-19 pandemic has further highlighted the disparities created in government-funded coverage options.

"These differences in reimbursement rates from different insurances are not created in a vacuum, and the sort of racial dynamics of these programs are well-known," Himmelstein said. "What we're seeing here is this disparate impact."

She sees the disparity play out in her day-to-day work. Himmelstein, who also works at a private facility, attributes the different standards of care to different reimbursement rates and limited resources.

Himmelstein said the same trends are likely happening among other minority populations, although the Medicaid data is not as comprehensive for those demographics.

Source URL: *https://www.modernhealthcare.com/finance/hospitals-serving-black-patients-get-less-financial-help-study-shows*

Appointment

From: Mann, Cindy [CMann@manatt.com]
Sent: 2/14/2023 3:34:35 PM
To: Mann, Cindy [CMann@manatt.com]; Howe, Rory (CMS/CMCS) (b)(6) (b)(6) Tsai, Daniel (CMS/CMCS) (b)(6) (b)(6); Karl, Anne O. [AKarl@manatt.com]

Subject: FW: FW: [External] Dan Tsai/Cindy Mann/Anne Karl meeting
Attachments: image001.jpg
Location: https://manatt.zoom.us/j/99321686405?pwd=alJCNnpHdnZmWWpnZXV6S3ZwbWNpZz09

Start: 2/14/2023 8:30:00 PM
End: 2/14/2023 9:00:00 PM
Show Time As: Busy

Recurrence: (none)

-----Original Appointment-----
From: Mann, Cindy <CMann@manatt.com>
Sent: Tuesday, February 14, 2023 10:34 AM
To: Mann, Cindy; Tsai, Daniel (CMS/CMCS); Karl, Anne O.
Subject: [External] Dan Tsai/Cindy Mann/Anne Karl meeting
When: Tuesday, February 14, 2023 3:30 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://manatt.zoom.us/j/99321686405?pwd=alJCNnpHdnZmWWpnZXV6S3ZwbWNpZz09

Hi there,

Cindy Mann, Manatt is inviting you to a scheduled Zoom meeting.

Phone one-tap: US: or

Meeting URL: https://manatt.zoom.us/j/99321686405?pwd=alJCNnpHdnZmWWpnZXV6S3ZwbWNpZz09

Meeting ID: (b)(6)

Passcode (b)(6)

Join by Telephone

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

Dial:

US: +1 305 224 1968 or +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 +1 386 347 5053 or +1 507 473 4847 or +1 564 217 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 +1 253 215 8782 or +1 346 248 7799 or +1 360 209 5623 or 888 788 0099 (Toll Free) or 877 853 5247 (Toll Free)

Meeting ID: (b)(6)

Passcode

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:

Passcode (b)(6)

SIP:

Passcode

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Office of Strategic Operations and Regulatory Affairs

June 27, 2023

To: Chiquita Brooks-LaSure
Administrator

Through: Kathleen Cantwell, Director
Hannah Katch, Senior OA Advisor

From: Farooq Khan, Technical Advisor

SUBJECT: Meeting with Center on Budget and Policy Priorities (CBPP)
DATE: **Wednesday, June 28, 2023; 1:00pm – 1:30pm**
PLACE: Zoom

Purpose: CBPP requests to meet with the Administrator to discuss how the organization can support CMS's efforts in the next phases of unwinding the Medicaid continuous coverage provision. CBPP is interested in collaborating with CMS to use the Consolidated Appropriations Act, 2023 authority to hold states' accountable for continuous enrollment since the PHE has ended and to do outreach efforts to affected beneficiaries to gain coverage.

CMS Meeting Attendees: OA: Hannah Katch, Eden Tesfaye; CMCS: Dan Tsai

External Participants:
Sarah Lueck, Vice President for Health Policy
Allison Orris, Senior Fellow for Health Policy
Jennifer Wagner, Director of Medicaid Eligibility and Enrollment for Health Policy

CMS Information:
1. About CBPP – p.1
2. Issues for Discussion – p.1
3. CMS General Background – p.1
4. Issue #1: CMS Enforcement Action Against States that are Not Compliant with Renewal Requirements – p.1
5. Issues #2: Resources to Support Communications and Outreach Efforts – p.2

CBPP'S Information:
6. Participants' Biographies – p.3

Appendix:

7. OGC Analysis – p.4
8. Pre-development Decision Memo: Corrective Action and Enforcement Authority to Support State Compliance with Federal Medicaid and CHIP Renewal Requirements Interim Final Rule (CMS-2447-IFC) – p.5
9. CBPP Medicaid Unwinding & State Accountability White Paper – p.7

CMS Administrator Meeting with
Center on Budget and Policy Priorities (CBPP)
June 28, 2023

About CBPP

CBPP is a nonpartisan research and policy institute. CBPP advances federal and state policies designed to reduce poverty and inequality, and to restore fiscal responsibility in equitable and effective ways. CBPP applies deep expertise in budget and tax issues and in programs and policies that help low-income people, in order to help inform debates and achieve better policy outcomes.

Issues for Discussion

CBPP requests to meet with the Administrator to discuss how the organization can support CMS's efforts in the next phases of unwinding the Medicaid continuous coverage provision. CBPP is interested in collaborating with CMS to use the Consolidated Appropriations Act (CAA), 2023 authority to hold states' accountable for continuous enrollment since the PHE has ended and to do outreach efforts to affected beneficiaries to gain coverage.

CMS General Background

The expiration of the continuous enrollment condition authorized by the Families First Coronavirus Response Act (FFCRA) presents the single largest health coverage transition event since the first open enrollment period of the Affordable Care Act. As a condition of receiving a temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase under the FFCRA, states were required to maintain enrollment of nearly all Medicaid enrollees during the COVID-19 Public Health Emergency. The CAA delinked the end of the FFCRA's Medicaid continuous enrollment condition from the end of the COVID-19 Public Health Emergency. As a result, the Medicaid continuous enrollment condition ended on March 31, 2023. States are resuming normal operations, including restarting full Medicaid and CHIP eligibility renewals and terminations of coverage for individuals who are no longer eligible. Beginning April 1, 2023, states may terminate Medicaid enrollment for individuals no longer eligible. States will have up to 12 months to return to normal eligibility and enrollment operations.

CMCS meets with a group of advocates biweekly to discuss unwinding issues. CBPP participates in these meetings, specifically Allison Orris, and Jennifer Wagner. CBPP has been an active participant in these meetings. CBPP has issued numerous briefs, reports and other materials on Unwinding.

CBPP Position

Issue #1: CMS Enforcement Action Against States that are Not Compliant with Renewal Requirements

CBPP urges CMS to use CAA authority to pursue corrective action plans (CAPs) when states are not in compliance with redetermination requirements and to require states to pause procedural terminations if necessary to protect coverage.

Issues #2: Resources to Support Communications and Outreach Efforts
CBPP urges CMS to work with HHS and the White House to commit needed resources to support a massive communications and outreach effort.

CMS Response

- The Biden Administration is committed to maximizing number of people with affordable, high-quality coverage. We have been doing that work since day one, including by increasing the number of people that will be auto-renewed and encouraging states to take up a variety of strategies to ensure renewing Medicaid coverage is as easy as possible. We have a comprehensive monitoring approach: CMS/HHS teams are meeting constantly with states to review metrics and state level information to ensure the rules are followed. CMS has a robust monitoring strategy in place and will continue reviewing data, state activity, and other reliable information during the continuous enrollment unwinding period. If issues are identified, CMS will work with states to understand root-cause of issues, adjust mitigation plans or require states to adopt new mitigation strategies to address new issues identified. Where we find states not following federal rules, we will act swiftly with all levers at our disposal to ensure eligible Medicaid enrollees retain coverage they are entitled to. Congress laid out the parameters that we have to follow throughout this process, including for implementing CAPs, imposing civil monetary penalties (CMPs), and the process for pausing renewals. CMS will not hesitate to use the enforcement tools established by Congress if issues are not addressed/sufficient mitigations are not implemented.

- CMS has spent the past 2 years preparing states for unwinding, including increasing outreach efforts through healthcare.gov, and stakeholder meetings with health plans, providers, civil rights and advocacy organizations. This effort has included hundreds of hours of working sessions and technical assistance to states; hundreds of pieces of guidance, best practices, new flexibilities, and toolkits for partners in seven languages; dozens of new federal flexibilities to streamline and automate renewals and improve outreach regarding contact information, as well as working with the FCC to allow health plans to send text messages. We conducted "Kitchen cabinet" meetings across the country with local stakeholders and advocates. CMS also provided direct-to-consumer media in 10 states over the past several quarters to encourage consumers to update their contact information. CMS has engaged in unprecedented efforts to facilitate Medicaid-to- Marketplace transitions, including: open-enrollment-style outreach campaign, via direct email, phone, and text; direct Navigator outreach to individuals; as well as reminder letters and Direct Assister-to-Consumer Outreach.

- On June 12, 2023, HHS sent a letter to governors, encouraging states to use all available options to streamline Medicaid and CHIP redeterminations and prevent eligible enrollees from losing coverage due to procedural issues. To date, CMS has approved 188 waivers to help states and territories renew Medicaid coverage for eligible enrollees since the COVID-19 pandemic's continuous enrollment requirement ended March 31.

Participants' Biographies

Sarah Lueck, Vice President for Health Policy
Sarah Lueck is leads CBPP's work on Medicaid, the ACA, and other health care issues, with a focus on advancing policies that make health coverage more accessible and affordable for low-income people and reduce racial and ethnic health disparities. Before joining the Center, Lueck was a reporter for nine years in the Washington bureau of The Wall Street Journal. For much of that time, she wrote about health policy, including Medicare prescription-drug legislation, state and federal proposals to modify Medicaid, and the efforts of health care companies to influence policy changes.

Allison Orris, Senior Fellow for Health Policy
Allison Orris specializes in Medicaid and other health programs with a focus on policies to make coverage and health care services available and affordable for people with low incomes. She held various senior roles at CMS during the drafting, passage, and implementation of the ACA. While at CMS, Orris led Medicaid Section 1115 demonstration negotiations with states to advance Medicaid expansion and delivery system reforms. Orris previously worked as the Associate Administrator of OMB's Office of Information and Regulatory Affairs, serving as a presidentially appointed member of the bipartisan Commission on Evidence-Based Policymaking.

Jennifer Wagner, Director of Medicaid Eligibility and Enrollment for Health Policy
Jennifer Wagner joined CBPP in 2015 and is a member of the health team. She primarily focuses on Medicaid eligibility and enrollment issues, including the policy, operations, and technology that affects the enrollment experience for clients and staff. Wagner also coordinates with SNAP and TANF staff to analyze opportunities to improve access and advance coordination with Medicaid.

Appendix

OGC Analysis

- *Ethics Division* – OGC-Ethics has no specific comments on this meeting beyond the caveats for meetings with outside entities and a reminder that appointees may not accept gifts from registered lobbyists or lobbying organizations. Any gifts offered should be cleared through the Ethics Division.
- *CMS Division* – OGC-CMS Division has no legal comments.

DATE: 06/15/2023

TO: Xavier Becerra, Secretary

Through: Elizabeth J. Gramling, Executive Secretary
Rachel Pryor, Counselor to the Secretary

FROM: Chiquita Brooks-LaSure, Administrator

SUBJECT: PRE-DEVELOPMENT DECISION – Corrective Action and Enforcement Authority to Support State Compliance with Federal Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements Interim Final Rule (CMS-2447-IFC)

RECOMMENDED REGULATORY ACTION

CMS recommends that the Secretary approve the development of this new Interim Final Rule with Comment Period (IFC).

PROPOSED SCHEDULE OF DEVELOPMENT

Step	Date	Notes
Begin HHS Clearance	July 2023	
Begin Office of Management and Budget (OMB) Clearance	August 2023	
HHS/IOS Review and Secretarial Approval	September 2023	
OFR publication	September 2023	

Notable Timing Factors and Administration Priorities:
CMS recommends an expedited timeline for this IFC to ensure that we have the authority to use new tools, created under the Consolidated Appropriations Act of 2023 (CAA, 2023), to enforce unwinding redetermination and reporting requirements for states as soon as possible within the limited time range the enforcement authority is in effect. Importantly, states began initiating renewals of eligibility in February and terminations and transitions to new coverage in April of 2023. If states are non-compliant with certain redetermination or reporting requirements, interested parties will expect CMS to use new CAA enforcement tools as early as possible to prevent violations, in particular inappropriate terminations. The new enforcement authority created under the CAA, 2023 allows CMS to require noncompliant states to submit a corrective action plan, and if needed, to suspend procedural terminations and impose civil monetary penalties. This new time-limited authority is already in effect as of April 1, 2023, and will expire on June 30, 2024. CMS has already received letters from more than 100 interested organizations and several members of Congress exhorting CMS to take aggressive action to enforce CAA requirements to protect beneficiary coverage during the unwinding period. OGC has advised that CMS will need to issue a

rule to support enforcement of these requirements to minimize legal risk to the agency. Given these factors, we recommend implementing these statutory authorities in an IFC on an expedited basis.

BACKGROUND

On December 29, 2022, President Biden signed the CAA, 2023 into law as Public Law #117-328. Section 5131(a)(2)(C) of the CAA, 2023 separates the end of the continuous enrollment condition from the end of the COVID-19 PHE by amending section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) to end continuous Medicaid enrollment as a condition for claiming the temporary Federal Medical Assistance Percentage (FMAP) increase on March 31, 2023. This means that, starting April 1, 2023, states claiming the temporary FMAP increase will no longer be required to maintain the enrollment of a Medicaid beneficiary for whom the state completes a renewal that no longer meets Medicaid eligibility requirements.

CMS has been working with states to plan for the initiation of these renewals since well before the passage of the CAA, 2023. CMS released numerous pieces of state guidance, including, most recently, *COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies*[1]; *CMCS Informational Bulletin: Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023*[2]; and *SHO# 23-002, RE: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023*[3], outlining states' responsibilities to unwind from the continuous enrollment condition and resume normal operations. And in the first quarter of 2023, CMS ramped up technical assistance to identify and create mitigation plans for states to support their ability to receive the temporary increased FMAP under the CAA, 2023. In addition, CMS has launched significant new monitoring efforts to track state unwinding plans and implementation activities.

Section 1902(tt)(2) of the Social Security Act (added by section 5131(b) of the CAA, 2023) gives CMS new authority to enforce these unwinding requirements and to hold states accountable for minimizing inappropriate terminations of eligible enrollees. In addition to already existing authority to impose a corrective action plan (CAP) under section 1904 of the Social Security Act, section 1902(tt) gives CMS specific new authority to impose CAPs for states that fail to comply with federal redetermination or new CAA data reporting requirements. For states that fail to submit or implement a CAP within required timeframes, CMS may require states to suspend all procedural terminations of eligibility and/or impose civil monetary penalties (CMPs) of not more than $100,000 per day until the state comes into compliance with the unwinding requirements. We plan to outline these new requirements for states in more detail in the IFC.

We propose to add this new IFC to the Fall 2023 Unified Reg Agenda.

ISSUES

Since the statutory language in the CAA, 2023, allows that CMS "may" impose CMPs and/or "may" suspend terminations, we believe this allows some discretion in determining whether to impose CMPs and the appropriate amount in cases of a violation. CMS is proposing to outline in

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf
[2] https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf
[3] https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf

the IFC mitigating/aggravating factors that would influence the decision of whether to impose a penalty and the amount of such penalty, or to pursue a suspension of terminations or other actions allowable under existing enforcement authority under section 1904. We received initial consultation from OGC, who recommended that, were CMS to consider such mitigating/aggravating factors in states without outlining them in rulemaking, we would open the agency to more risk than if a stricter interpretation of the statute were implemented without such discretion. CMS believes Congress purposefully gave the agency such discretion as they drafted the statute, using "may" instead of "shall," and so propose to memorialize that discretion in rulemaking so that CMS may use it without risk of legal action from states.

Noteworthy Elements about Equity:
Even as the COVID-19 pandemic wanes, Medicaid and CHIP enrollees remain among the most vulnerable populations, and so limiting unnecessary loss of health coverage or churn between programs is critical to supporting continued access to care. Unwinding poses a substantial risk of loss of coverage if states don't provide fair and compliant reviews and follow new CAA, 2023 outreach requirements designed to mitigate these losses. Communities of color are at a disproportionate risk of loss of coverage. According to ASPE,[4] more than half of those expected to lose Medicaid during unwinding are people of color, including nearly 5 million Latinos, more than 2 million African Americans, and almost 1 million Asian Americans and Pacific Islanders. With the extra threat of CMS enforcement action under this proposed IFC, states may be more motivated to implement their unwinding plans to meet all federal requirements and limit inappropriate terminations of current Medicaid and CHIP enrollees, thereby protecting coverage for these communities.

Novel Elements to Consider:
Historically, CMS has not had the authority to suspend procedural terminations of eligibility or to impose CMPs on noncompliant states, so this will be the first time the agency will be able to exercise this authority. We rely on maintaining good working relationships with states and the provision of intensive technical assistance, which has largely achieved the desired results of bringing states into compliance. CMS has only infrequently requested corrective action plans from noncompliant states, and in even rarer instances, used its authority to withhold federal financial participation (FFP).[5]

Outstanding Questions:
CMS is still exploring the operational mechanism for collecting CMPs from states, whether via the CMS-64 or by billing states directly or via the Treasury.

ANTICIPATED STAKEHOLDER REACTION
We anticipate states will welcome CMS' consideration of mitigating factors before moving straight to compliance action, suspension of terminations, or full CMPs. We anticipate positive Congressional reception to this rulemaking as it shows that CMS is taking seriously the authority Congress granted the agency under the CAA, 2023.

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[4] Assistant Secretary for Planning and Evaluation (August 19, 2022). *Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches*. (Available at: https://aspe.hhs.gov/sites/default/files/documents/a892859839a80f8c3b9a1df1fcb79844/aspe-end-mcaid-continuous-coverage.pdf).

[5] 42 CFR § 430.35 - Withholding of payment for failure to comply with Federal requirements. (Available at: https://www.law.cornell.edu/cfr/text/42/430.35).

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Medicaid Unwinding & State Accountability

Thank you for meeting with us to discuss where things stand and where CMS is headed on unwinding the Medicaid continuous coverage protection. We appreciate the work you and your team have done to help states prepare for and implement Medicaid unwinding, as well as the work CMS is doing now to investigate the coverage losses we have seen during the initial months. We value your team's partnership and transparency and look forward to continuing to work together.

We are eager to discuss our recommendations about work CMS could undertake now to be ready to address even deeper coverage losses in months to come. We wish to focus on two areas:

Prepare Now to Use the Consolidated Appropriations Act, 2023 (CAA) Authority

Despite the extensive guidance, waivers, and technical assistance you have provided to states, there is a substantial risk that millions of eligible enrollees will lose coverage during unwinding. We support your initial approach to pursue voluntary mitigation plans with states to enable them to use alternative strategies to approximate compliance with redetermination regulations. Even so, we are concerned that mitigation plans will not keep eligible people from losing coverage in some states.

Congress was aware of the risk to eligible enrollees when, in the CAA, it provided you with authority to hold states accountable for keeping eligible people enrolled during unwinding. We urge CMS to use the CAA authority to pursue corrective action plans (CAPs) when states are not in compliance with redetermination requirements and to require states to pause procedural terminations if necessary to protect coverage. This authority will only keep eligible people covered if CAPs are initiated in a timely manner as soon as there is evidence that states are struggling to comply with applicable requirements. We understand that the timeline to initiate, implement, and take action under a CAP can be long and we therefore urge you to lay the groundwork now to pursue CAPs, potentially in a matter of months. Considering the rapid pace of renewals during unwinding, any delay in action will mean a substantial number of eligible enrollees losing coverage. Demonstrating early that you are committed to enforcement is important. It will help encourage states to commit resources to help improve their processes and systems. And it will reassure the public that the Administration is prepared to take decisive action to protect people's coverage.

Invest in a Large-Scale, Cross-Government Communications Effort

The early unwinding evidence points to a lack of awareness among Medicaid enrollees about the steps they need to take to retain coverage. We commend CMS for redoubling its communications efforts and reaching out to partner with an all hand on deck message. We urge CMS to work with the Department and the White House to commit needed resources to support a massive communications and outreach effort. The types of campaigns we have seen in the past related to ACA enrollment and Connecting Kids to Coverage are necessary now to continue getting the word out.