Message

From: Boozang, Patricia [PBoozang@manatt.com]
Sent: 9/27/2022 7:27:13 PM
To: Giles, John (CMS/CMCS) [(b)(6)]; Gibson, Alexis (CMS/CMCS) [(b)(6)]; Gentile, Amy (CMS/CMCS) [(b)(6)]
CC: Thomas W Schenck [TSCHENCK@mitre.org]; Johanna L Barraza-Cannon [jbarrazacannon@mitre.org]; Rebecca Case [rebeccacase@mitre.org]; Mann, Cindy [CMann@manatt.com]; Serafi, Kinda [KSerafi@manatt.com]; O'Connor, Kaylee [KOConnor@manatt.com]; Striar, Adam [AStriar@manatt.com]; Peterson, Alanna [APeterson@manatt.com]
Subject: FW: FW: CMS Policy Sprint Working Session Agenda: 9/29
Attachments: MMC Access-Related Tools; Summary Document (One Stop Shop) Package of Preamble_Regulatory Language and Roadmap Deliverables 09.16.22.docx

John, Alexis and Amy – see below and attached. Let us know if you have any changes to our planned agenda for Thursday – look forward to speaking then,

Patti

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From: Boozang, Patricia <PBoozang@manatt.com>
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Cc: TSCHENCK@mitre.org; jbarrazacannon@mitre.org; rebeccacase@mitre.org; Serafi, Kinda <KSerafi@manatt.com>; Mann, Cindy <CMann@manatt.com>; O'Connor, Kaylee <KOConnor@manatt.com>; Striar, Adam <AStriar@manatt.com>; Peterson, Alanna <APeterson@manatt.com>
Subject: CMS Policy Sprint Working Session Agenda: 9/29

John, Amy, and Alexis—we wanted to check-in regarding our next CMCS Access Policy Sprint Working Session scheduled for Thursday, 9/29 at 10 am ET. We've included below a proposed agenda, and welcome any additions or changes you might have. Looking forward to reconnecting next week.

Thanks,
Patti

[External] CMCS Access Policy Sprint Working Session Thursday, Sept 29, 2022 10:00 am – 11:00 am	• Check-In on NPRM Drafting and Any Updates on Work Underway (CMS) • Update on Proposed MMC Access-Related Tools (see attached) (Manatt) • Check-in on Access Interviews (Manatt) ○ Florida Medicaid Access Interview (9/15) (see attached "one stop shop" document • Confirm Next Steps (Manatt)

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Message

From: Boozang, Patricia [PBoozang@manatt.com]
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Subject: MMC Access-Related Tools

John, Amy and Alexis,

Over the last week or so, we have given some thought to potential Medicaid-related access tools to improve access that Manatt Health, in partnership with MITRE and Aurrera Health Group. We focused on tools well-suited to development between September and December 2022, leveraging the access "sprint" work conducted to date. We're planning to share with Karen Llanos the below "menu of options" from which priority deliverables would be chosen by OCD. The table shared with OCD will also include potential deliverables related to the other sprints – e.g., the Medicaid Advisory Committee, HCBS Direct Care Worker Payment Requirements.

Given the collaborative nature of our sprint work to date, we want to make sure that you had an opportunity to review and provide input. We welcome any feedback on the below proposals, whether there are other tools that would be high-value that we have not reflected here, and your thoughts on prioritization. We plan to share the proposals with Karen by Tuesday morning, so we'd ask for your thoughts **by EOD on Monday, 9/19**. We are sorry for the short notice – and we are happy to jump on the phone if you prefer to discuss.

Thanks,

Patti

	Proposed Tool	Lead Resource	Level of Effort	Description of Tools/Notes
Short-Term (October – December 2022) Proposed Tools to Promote Access				
1	Draft MMC Access Guidance (SMDL and FAQs)[1]	Manatt, MITRE	High	Following the release of MMC-related access requirements in regulation, CMS could release sub-regulatory guidance providing states with concrete guidelines and supportive technical information related to implementing and meeting the new regulatory requirements. Manatt could support CMS by developing draft sub-regulatory guidance in the following areas: • Implementing appointment wait-time standards, such as: 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; defining "routine" for each provider type; allowable ways to select specialist provider types based on identified provider access issues and corresponding appointment wait-time standards; considerations for varying appointment wait-time standards (e.g., by adult vs. pediatric, geography, service type); and how/the degree to which states should apply telehealth in meeting the standards.

[1] To develop this proposal by December 2022, Manatt would require draft regulations from CMS.

	Proposed Tool	Lead Resource	Level of Effort	Description of Tools/Notes
				• Designing and implementing provider surveys, including secret and revealed shopper studies and mechanisms to identify disparities in access. • The 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; alternative benchmarks that could be used in instances where Medicare payment rates are not available; and how to account for supplemental payments.
2	First in the MMC Punch List Series: *Improving Provider Access in MMC*	Manatt, MITRE	Medium	Separate from the proposed rule, CMS could release a series of punch lists focused on best practice strategies for improving access in MMC. The first punch list in the series, "Improving Provider Access in MMC" would be tied to the MMC-related access requirements in regulation. It could amplify best practices and mitigation strategies for states to strengthen access to key provider types and diversity/cultural competency of provider networks. Topics could include 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; and identifying and addressing disparities in access.
3	Updated Access and Network Adequacy Assurances Reporting Tool[2]	Manatt, MITRE	Medium	CMS could update the Access and Network Adequacy Assurances Reporting Tool to provide states with a standardized template for reporting provider rate comparisons. Providing states with a standardized template for reporting this information would ease administrative burden on states and ensure CMS receives standardized, comparable datapoints across states. Ultimately, this tool will help promote greater transparency in Medicaid provider payment rates and enable CMS (and states) to monitor and mitigate payment-related access barriers and disparities.
4	Toolkit on promoting access to address health disparities	MITRE	Medium/ High	Each sprint considered health disparities at some level and some of the tools proposed in this table consider health disparities specifically. We are proposing a specific tool aimed at improving access and eliminating health disparities that would cut across all access topics. The toolkit would expand on steps that states can take *now* to promote access in their Medicaid programs and address racial/ethnic inequities. More specifically, the toolkit could facilitate the development of access-related solutions (e.g., to provide sustainable and equitable Medicaid reimbursement for providers—such as those in rural areas; improve data resources that shed light on racism/disparities; and address inequities in quality of care). *Note: this punch list is not connected to specific regulations but across regulatory and sub-regulatory guidance.*
Longer-Term Proposed Tools to Promote Access				
5	MMC Provider Survey Toolkit	Manatt	High	Once the provider survey requirements are finalized, CMS could release a provider survey toolkit including information for states to field provider surveys to meet state-specific needs and comply with new federal requirements. Manatt could commence the work on developing the

[2] To develop this proposal by December 2022, Manatt would require draft regulations from CMS.

	Proposed Tool	Lead Resource	Level of Effort	Description of Tools/Notes
				provider survey toolkit in parallel to CMS' drafting of the proposed rule. 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. • Guidance on timing and frequency of surveys. • Guidance on survey strategies to identify disparities in access related to race, ethnicity, primary language, gender/gender identity, sexual orientation. • Unique considerations related to secret and revealed surveys. • Detailed guidance on statistical approaches for analyzing survey results. • 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. *Note: 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.*
6	Cross-cutting tools, toolkit, on model state practices for promoting transparency for beneficiaries	MITRE	Medium	Promoting transparency has come up in each sprint and across the topic of access. Could create toolkit that promotes transparency as a whole versus for specific access provisions or Medicaid program components. Could tie to work on state website requirements. For example, CMS could conduct consumer usability assessments of three to five state Medicaid/CHIP websites (using an independent UX vendor and not to be publicly shared) to uncover pain points and navigational challenges. This would lend credibility to and inform recommendations to state Medicaid and CHIP agencies on website.
Parking Lot				
7	MMC Access Learning Collaborative	TBD (this work may be underway by a contractor)	High	• CMS could convene a series of learning collaborative meetings on the new access requirements, which could entail a review of federal requirements, description of policy and operational options and implementation considerations, direct technical assistance and subject matter expertise, state best practices, and cross-state information sharing discussions. To best position CMS to facilitate these webinars once the regulations are released, Manatt could commence work on developing webinar meeting materials that would be leveraged later. Topics could include: • Strategies for states to examine their current provider networks, identify access issues, and increase provider participation. • Best practices for ensuring diverse and culturally competent provider networks.

	Proposed Tool	Lead Resource	Level of Effort	Description of Tools/Notes
				• Best practices for identifying and addressing disparities in access. • Best practices for leveraging telehealth to address network adequacy and increase access. • Provider survey program design and implementation to facilitate cross-state learnings on methodological and operational best practices and key challenges. • Best practices for ensuring accuracy of provider directories. • Using Transformed Medicaid Statistical Information System (T-MSIS) and other state data sources to quantify Medicaid and Children's Health Insurance Program (CHIP) access issues.

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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 September 16, 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 8/29/2022

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. CMS seeks comment on potential alternative benchmarks that could be used in instances where Medicare payment rates are not

[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

available. These could include Medicaid state plan rates, commercial health plan rates, state employee health plan rates, rates paid in peer states, or other appropriate benchmarks.

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. For purposes of this requirement, CMS proposes that states include all supplemental payments made by states through MCOs, PIHPs, and PAHPs, which could include directed payments (as defined in § 438.6(c)) and pass-through payments (as defined in § 438.6(c)). CMS does not propose to collect information on supplemental payments made on a fee-for-service basis as part of paragraph (b)(3)(ii), including Upper Payment Limit (UPL) payments, Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments, and pool payments authorized under 1115 waivers (including uncompensated care pools and delivery system reform incentive payment programs).

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. CMS believes that attaching an enforcement mechanism to these new requirements will ensure that states are supplying CMS with needed data in a timely fashion and support CMS in its goals to increase transparency of Medicaid managed care payment rates as it continues to work with states to improve the quality of data submitted to T-MSIS.

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 or another benchmark, as determined appropriate by CMS. The rate analysis must include percentage comparisons made on the basis of:

(A) Medicaid base payments; and

(B) Medicaid base and supplemental payments combined. For purposes of this paragraph, supplemental payments include those defined in § 438.6(c) and § 438.6(d), including directed payments and pass-through payments.

(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 9/16/2022

Medicaid Managed Care Access Interview Takeaway Themes

Interview Takeaway Themes

- **Minimum Federal Appointment Wait-Time Standards**
  - Broad support for CMCS establishing federal minimum appointment wait-time standards for state Medicaid MMC programs.
  - Appointment wait-time standards tend to be more effective than other quantitative network adequacy standards, such as time and distance.
  - General agreement that CCIIO's proposed appointment wait-time standards for QHPs seem appropriate.
  - Open questions about appointment wait-time standards (e.g., how to define routine, what network adequacy exceptions will entail, how to account for geographic differences and good faith negations).

- **Provider Surveys (Including Secret and Revealed Shopping)**
  - General consensus that provider surveys are generally effective in identifying access issues.
  - "Secret Shopper" term is misleading; states do both "secret" and "revealed" provider surveys.
  - While many states utilize (or have previously used) secret shopper programs, some expressed opposition; however, a few of these same states have in place and were more receptive to *revealed* provider surveys.
  - Support for EQRO role in provider surveys and enhanced match (with the caveat that plans sometimes get different results when they conduct surveys, which could be tied to state-level MMC contract requirements).
  - Survey frequency in states ranges from quarterly to annually—though states tend to conduct surveys annually.
  - State challenges in standing up provider survey programs include funding and capacity; interviewees did not suggest that provider surveys are otherwise difficult or time intensive to implement, but for these issues, which could be mitigated with enhanced match.
  - Rural geographies have unique challenges with regard to provider surveys (e.g., "Strawmodel Patient" personas for secret shopping are easy to spot).
  - Support for CMS technical assistance, including a template and considerations around how to operationalize provider surveys (e.g., whether to call from state phones vs. personal phones, normal business hours vs. weekends).

- **Overall Access Strategy**
  - Caution with regard to CMS being overly prescriptive with access requirements; states require flexibility.
  - Similar to the enhanced match for EQRO activities, an enhanced match for state staff focused on network adequacy (capacity building, etc.) could improve state capacity to monitor and improve access in a meaningful way.
  - Suggestions that CMS provide access-related technical assistance to address regional access challenges (e.g., best practices for New England states are not best practices for frontier states). Some access issues, in rural areas, in particular, present significant challenges that are harder to address.
  - CMS should consider using and requiring state use of other effective mechanisms to identify access issues, including: T-MSIS data, encounter/claims data, appeals and complaints data, provider network files, EQRO audits, etc.
  - Enforcement of access should happen gradually and on a continuum. Before imposing penalties, interviewees suggested working collaboratively with plans (e.g., engaging in discussion, reminding them of

contract requirements, conducting a plan performance review with supporting data, providing technical assistance). If issues persist, states can utilize other levers, such as corrective action plans leading to sanctions.

Medicaid Managed Care Access Summary of Interviews
Jonathan Bick, New York State Dept. of Health *(June 27, 2022)*

- General overview of state approach to secret shopper program
  - State uses EQRO to conduct secret shopper studies
  - EQROs survey PCPs, plan member services hotlines, and provider directories
    - For PCPs, surveyors assess appointment wait-times for routine and urgent appointments
    - For member services hotlines, surveyors assess the following:
      - Accuracy of provider network information
      - Approaches to prior authorization
      - Whether certain services are covered
    - For provider directories, surveyor uses "revealed survey" approach to assess against 75% accuracy level
  - Surveys are conducted once per year
  - Providers are selected on a randomized basis from each plan's network list
  - Providers with closed panels are not surveyed
  - Survey results can lead to a plan receiving a statement of deficiency or a plan of correction; plans can also be assessed financial penalties after multiple violations, but this is rare
  - Survey results are not made public
- Other impressions
  - Program has been subject to budget cuts in the past; this is not related to concerns about this specific program but rather overall state budgetary concerns
  - State has uncovered significant issues around appointment wait-times through secret shopper studies
  - State feels that program does what it is intended to do

Tom Betlach, Speire Healthcare Strategies *(July 19, 2022)*

- Overall thoughts
  - CMS should ensure it considers fee-for-service (FFS) Medicaid in establishing access/secret shopper requirements
    - States generally have less infrastructure/coordination in their FFS programs
    - FFS programs often include vulnerable populations
    - FFS reimbursement lags managed care in many states, exacerbating access issues
  - Secret shopper
    - Secret shopper studies are generally an effective tool for measuring access
    - They are particularly helpful for providing real-time feedback to states on access issues; states have the ability to target studies based on emerging concerns
    - Studies generally do not require advanced analytics; possible to get a large sample size relatively quickly
- Secret shopper
  - Survey entity – Good idea to encourage States to use EQROs to conduct secret shopper studies; states generally underutilize EQROs; they can serve as a staff multiplier and are independent from plans

  - Supportive of CMS providing technical support, including a template, as long as it is not prescriptive (i.e., help states do it, don't require them to do it a specific way)
  - States need to be able to quickly target their unique and emerging access concerns; study design flexibility helps with this
  - Studies need to measure against "community access standard"; some states may not have particular kinds of specialists in certain areas
  - CMS should consider how to account for telehealth
- General access considerations
  - CMS should consider which access metrics are important beyond just time and distance
  - Appeal/grievance volume is a strong indicator of access issues; indicates that beneficiaries are struggling to access needed care
  - CMS should be careful in establishing new requirements to not increase states' risk of litigation

Mary Beth Dyer, Bailit Health *(July 29, 2022)*

- General perspective on secret shopper
  - Many states have done these surveys
  - Some use EQROs – these are valuable because they let states be efficient with staff resources and access enhanced matching funds
  - States should be thinking about how to prioritize high volume providers and areas where there are documented access concerns
  - States should be pushing plans to ensure surveys are sufficiently robust and catching providers with many Medicaid members
  - Live secret shopper surveys are most valuable for assessing appointment wait-times; states may be able to leverage centralized provider enrollment data to do automated checks of provider directories
  - States/CMS could consider monitoring for "open block scheduling" (important for dealing with urgent issues)
  - Some states pose as beneficiaries; some reveal that they are working with the state – revealing state affiliation can be beneficial since providers "know they're being watched"
- Independent entities vs. delegating to plans
  - States should be doing both
  - Plans should be doing their own surveys to monitor their networks
  - EQROs are efficient from a match rate/staffing perspective, but CMS will need to provide TA
- How to do a better job of assessing network adequacy
  - Unclear if EQROs currently have the expertise to do this since network adequacy monitoring is new
  - Regional variation is a huge issue – networks look very different across states/regions; could CMS leverage regional offices to support TA?
  - Large states generally have more robust machinery in place to do network monitoring since they have many plans/providers
  - CMS could look to leverage MA requirements
  - States should survey providers that have not submitted a single claim over the previous year; it signals access issues for that provider
  - States should also survey high volume providers
  - Other ways to look at access issues – e.g., CA looks at high risk members with an ED visit and no PCP visit; CMS/other states could consider leveraging this type of data approach through T-MSIS, claims/encounter data
- Secret shopper value proposition

  - States don't have the resources in-house to do these surveys; leveraging EQROs can be helpful
  - EQRO processes are very regimented; CMS will need to let states be flexible/responsive in administering these surveys – important that results be made available quickly (i.e., this is monitoring, not evaluation)
- Enforcement
  - California is doing interesting work here but advocates think there are too many exceptions for plans and that it is too easy for them to get around rules
  - Florida has a very IT-focused approach to assessing against contract requirements; plans think state is too aggressive with liquidated damages
  - Generally big states are better at enforcement than small states
- Appointment wait-time standards
  - Will be difficult to find a standard that is applicable across the country; huge network variation by region
  - CMS should provide TA, but consider state best practices looking at different regions (i.e., what works in Rhode Island may not be helpful to Montana)

Amber Saldivar, Health Services Advisory Group (EQRO) *(August 2, 2022)*

- Overview of secret shopper activities
  - Conduct both secret and "revealed" shopper surveys
  - Currently serving approximately 7-8 states
  - Assist states with survey design and implementation, including sampling, script development, data aggregation/reporting
  - Surveys examine whether providers accept health plan coverage and appointment availability
  - Providers examined include primary care, dental, and OB; surveyors look for both urgent and routine appointments
- Secret vs. "revealed" surveys
  - Revealed surveys allow for collection of more data from providers
  - Revealed surveys work better for certain appointment/provider types; for example, it is difficult to test access to behavioral health treatment using secret shopper surveys (since this generally requires a detailed accounting of symptoms). Similarly "established patient" access can only be tested through revealed surveys.
- Survey focus priorities
  - Appointment wait-times
  - Provider directory accuracy (including contact information, location, and types of services provided)
- Timing considerations
  - Launching a new program takes approximately 6 months
  - Surveys take approximately 4-6 weeks to administer
  - Able to make survey results available within three months from completion of survey
  - Most states conduct annual studies; some use a quarterly cycle
- Sample size considerations
  - Attempt to ensure a 95% confidence level but sometimes sample sizes are limited based on state budget considerations
  - Samples are sometimes stratified by subspecialty or region (these decisions are driven by the state)
- Advantages of using an EQRO
  - EQROs are independent from plans
  - Plan surveys tend to be smaller and are not always statistically representative
- Access issues identified

  - Provider directories often contain bad phone numbers/addresses
  - Some providers make new beneficiaries jump through hoops to schedule appointments
- Key challenges
  - Some states do not have accurate information on specialty type by provider
- Other considerations
  - Studies are most effective when linked to penalties and posted publicly
  - "Straw model" Medicaid IDs may help surveyors get further along in appointment scheduling process

Paul Henfield, IPRO (EQRO) *(August 4, 2022)*

- Overview of secret shopper activities
  - Conduct secret shopper surveys for approximately half of states where IPRO has an EQRO contract
  - Conduct surveys of PCPs, BH providers, dentists, and certain other specialists using provider lists provided by plans
  - Develop survey scenarios in conjunction with states
  - Look at urgent, non-urgent, and after hours visits
  - Check against appointment wait-time standards and whether a provider has an open panel; providers with closed panels are not surveyed
  - Also review provider directories for accuracy
  - Conduct both secret and revealed surveys
    - Secret shopper surveys are valuable because they mimic the actual beneficiary experience
    - Generally regard revealed survey findings to be less reliable
- Best practices
  - Important to engage plans and providers in rolling out surveys
  - Important for surveyors to cancel "straw model" appointments before end of each call; failing to do so can lead to backlash from providers
  - Use blinded telephone numbers; large provider call centers can catch on to repeat callers
  - Screen provider lists for duplicates
- Key challenges
  - Many states do not establish "straw model" Medicaid IDs; this makes scheduling appointments more challenging
  - Difficult to assess BH provider access; often very difficult to reach a live person and providers often require triage before beneficiaries can get scheduled for an appointment
- Timing considerations
  - Most states conduct annual surveys; some do quarterly assessments
  - IPRO can launch a new survey within one month and publish results quickly based on state need
- Access issues identified
  - Access to BH providers is very poor for Medicaid beneficiaries; often very difficult to access appointments in a timely manner

Martha Heberlein, MACPAC *(August 4, 2022)*

- Perspective on secret shopper studies
  - Studies are not consistently done across states
  - Studies can be burdensome
  - Challenging to survey for access issues for certain types of services (e.g., HCBS)

  - States that assign panels to providers are more challenging to survey since members generally cannot schedule an appointment unless they are assigned to that provider
  - Surveys are challenging in rural areas because providers tend to know community members and can recognize a "straw model" caller
  - Assessing provider access through annual licensure process may be more effective
  - T-MSIS may also be more effective, but CMS would need to improve the quality of provider service data
  - Beneficiary surveys may also be effective for measuring wait-times
- How to make secret shopper surveys successful
  - Need to provide TA and funding to states
  - CMS should consider standardizing data collection
  - Providing states with a template would be helpful
  - Using EQROs may be helpful for solving state capacity issues

Lisa Truitt, DC Medicaid *(August 15, 2022)*

- Overall approach
  - DC contracts with its EQRO to conduct provider surveys; MCOs are also required to conduct their own surveys
  - EQRO conducts "revealed" surveys; MCOs conduct secret shopper surveys
  - Believe combined approach is most effective
- MCO secret shopper surveys
  - Medicaid managed care plans are required under contract to conduct secret shopper surveys at least annually
  - Secret shopper surveys assess member access to services, appointment wait-times, provider availability, member difficulty in getting an appointment
  - Surveys target high volume provider practices specifically
- EQRO revealed provider surveys
  - EQRO conducts a network adequacy verification project annually and publishes reports of findings, including results from revealed shopper surveys, validation of accuracy of provider directory information and appointment wait-times[35], and appropriate provider-to-enrollee ratios
  - Results from EQRO revealed provider interviews are shared with plan
  - EQRO reports give plans additional information to hold their providers accountable
  - EQRO shares updates to provider directories with plans in real time, and coordinates to ensure providers are not called by plans and an EQRO in the same month
  - DC claims 75% FMAP for expenditures associated with the EQRO provider survey
- Secret vs. revealed survey considerations
  - Both secret and revealed shopper surveys work well if they are highly coordinated but each have their own advantages
  - Advantages of secret shopper surveys
    - Providers tend to tell callers "what they want to hear" during revealed surveys (i.e., there is greater confidence in the accuracy of information obtained through secret shopper surveys)
    - MCO-led secret shopper surveys ensure plans are held responsible for identifying and addressing access issues and give plans a sense of accountability

[35] The EQRO monitors select appointment waiting time standards, including 30 days for PCPs and 24 hours for urgent appointments. DC does not set appointment waiting time standards for plans, but rather, allows plans to define their own appointment waiting times as part of their network adequacy strategy for review and approval.

  - Advantages of revealed surveys
    - DC obtains candid information from revealed surveys about provider concerns (e.g., overscheduling policies to compensate for no shows that lead to longer appointment wait-times); surveys offer an opportunity for providers to report on what is not working well and offices are often eager to share information
    - Revealed surveys work well in smaller areas, where the providers get calls often
    - Provider groups are generally more appreciative if surveys are revealed; providers sometimes react negatively to scheduling appointments for fake Medicaid members as part of secret shopper surveys
- Access measures
  - DC is planning to add "third next available appointment," or 3NAA, a new NCQA new measure and PCMH standard to measure true appointment availability more accurately.[36]
  - DC is focused on appointment wait-times and wants to do more in this area
- Results/accountability
  - Results from EQRO revealed provider surveys are made public
  - Plans are currently not held accountable based on survey findings due to procurement challenges, but DC is looking at MD's EQRO access report as a model, which does hold plans accountable
  - DC plan to add confidence intervals around network adequacy access measures and may potentially put plans on Corrective Action Plans (CAPs)s based on these intervals
- Access issues identified
  - DC has not uncovered lack of available providers (DC currently contracts with 480 providers), but has identified access issues related to lack of transportation, appointment no shows
  - Provider directories are usually 50% accurate across all required components (i.e., provider practices at the practice called, provides desired service, is accepting new patients, accepts insurance, has the same name listed in the provider directory)
- Provider survey cost estimate/staffing
  - DC estimates cost of approximately $100,000/year for revelated shopper surveys
  - EQRO subcontracts survey administration; DC does not have details on FTE or staff hours required to conduct the survey
  - One DC Medicaid FTE oversees the EQRO and a second oversees MCO network adequacy activities
- Access data analysis
  - DC runs reports on their own data, including geo-access reports; they do not analyze T-MSIS data
  - DC conducts routine conversations with providers to assess access issues
  - DC does thorough analyses and evaluations of grievances and appeals, and identify concerns with specific providers or service areas indicated in these reports

Jennifer Langer Jacobs and Lynda Grajeda, New Jersey Medicaid *(August 22, 2022)*

- Provider surveys
  - NJ does not currently utilize secret shopper surveys

[36] 3NAA is defined as: average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability. Source: [HYPERLINK "https://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx" \l ":~:text=Average%20length%20of%20time%20in,exam%2C%20or%20return%20visit%20exam"]

        - Surveys utilized in the past generated point-in-time findings from a subset of providers that the state could not validate
        - Secret shopper surveys were resource intensive, and the state could not rely on the data collected
        - NJ had a negative experience related to an exposé based on findings from a secret shopper study conducted by a graduate school program that came to inaccurate conclusions
        - NJ noted that when plans (versus the state or an EQRO) conducted provider surveys, they often got different results
    - Interestingly, the state utilizes annual PCP after-hour availability studies (i.e., requirement for MCOs to conduct a targeted revealed provider surveys on PCP after-hour availability specifically as part of their overall access strategy)
        - When plans conduct the calls, they reveal which MCO they are affiliated with
        - Surveys help to verify provider names and contact information, practice type/specialty, MCO participation status, office hours, open/closed panel status, and provider's ability to accommodate special needs of members
    - NJ also requires MCOs to conduct monthly provider network spot checks to verify the accuracy of the provider network file
        - Spot checks only include providers who are actively seeing patients and billing Medicaid and target PCP, Ob/Gyn, Dental, and specialty network providers
        - The full provider network must be reviewed biannually
- Network monitoring and oversight
    - The EQRO audits the plans on the above activities, including conducting the monthly network spot checks, PCP after hour surveys, and other reporting requirements related to access
        - The EQRO's role is comprehensive in ensuring the plans meet all contractual requirements related to access.
        - The EQRO also conducts case file audits to confirm that members are getting services timely, and if not, that the plan is performing activities to address access barriers as expected by the state
    - NJ utilizes "360 Reviews" of each MCO to assess plan performance on network adequacy and access
        - NJ holds monthly 90 minute internal calls to assess MCO performance; personnel from across the agency (e.g., finance, business intelligence, quality, MLTSS, pharmacy, dental, behavioral health, etc.) present findings from their perspective and the state identifies MCO strengths, weaknesses, mixed results requiring further understanding or discussion, and concerning findings gleaned from information shared across the various departments
        - Information included in 360 reviews include network access files, geoaccess files, analysis of low activity providers, HEDIS quality measures, CAHPS consumer satisfaction measures, unstaffed cases, provider inquiries, grievances and appeals, encounter/claims data analysis, response times for provider and member inquiries, etc.
        - Findings are then presented to the MCOs individually in the same format; the state focuses the MCO on the top priorities and provides expectations about how MCOs should attempt to address access barriers (e.g., attempt to contract with all available providers in a region and demonstrate good faith effort, offer enhanced rates to providers to address access gaps)
        - NJ works collaboratively with plans to identify and address access issues, but will impose sanctions on an as needed basis
- Provider directory and appointment wait-times
    - The MMC contract includes a requirement that providers in the network have claims; providers do not contribute to adequacy if they don't have claims (though they may remain in network if they are contracted and available)

  - NJ's contract includes appointment wait-times, so they did not raise any concern about the potential for federal minimum standards ("we manage this like bread and butter")
  - NJ stressed the importance of defining "routine" — recognizing physicals can be difficult to schedule
  - NJ will follow-up via email to share information on appointment wait-times
- Enforcement mechanisms and other mitigation strategies
  - NJ values its collaborative relationship with its plans and is reluctant to impose harsh financial penalties, though they do use liquidated damages and sanctions on an as needed and gradual basis
    - Sometimes moving the needle on access just requires a conversation with a plan (e.g., reminding them of state expectations around providing enhanced rates to certain providers, demonstrating good faith effort to contract with providers)
  - MCOs must also document corrective actions taken associated with findings, including: updating provider contact or other information, requesting a CAP from the provider, indicating that the provider's panel is closed, or removing the provider from the network
  - In terms of transparency, plan performance measures (HEDIS and CAHPS) are published as a public report card on NJ's state website: [HYPERLINK "http://www.njfamilycare.org/analytics/home.html"]

Tom Betlach, John McCarthy, and Darin Gordon – Speire Healthcare Strategies & Former Medicaid Directors from Arizona, Ohio, and Tennessee *(August 23, 2022)*

- Provider surveys
  - Speire expressed support of provider surveys (including secret and revealed shopping) and noted they are "one tool in the toolbox" that should be paired with other strategies to identify access issues (e.g., grievances and appeals, informal resolution process —such as the Quality of Care Call Line in AZ, EQRO audits, encounter data, provider network files)
  - Provider surveys have been used to spot check regions and specialties with known access issues to validate information received that suggest access issues
  - Secret shopper implementation can be burdensome, including staff training, setting up Medicaid IDs, assigning fake members to provider panels, defining hours to call and which phone lines to call from (state phone or cell phones)
  - Plans may be more successful in getting appointments for members compared to a secret shopper calling a provider directly, as the plan is responsible to ensuring members get timely access to care and can leverage contractual relationships to get a member an appointment when a provider may be less willing to take a secret shopper "member" calling directly
  - Speire recommended that provider survey requirements apply to both MMC and FFS members, as FFS members may have an even harder time getting appointments without assistance from a plan
  - Secret shopper programs need to be tailored locally; plans that conduct secret shopper surveys themselves can help keep providers honest
  - EQROs are best positioned to externally validate data, such as provider information
- Compliance/enforcement approach
  - Enforcement should happen gradually and on a continuum
    - Before imposing penalties, Speire suggested working collaboratively both internally and with plans (e.g., engaging in discussion, reminding plans of contract requirements—such as providing enhanced rates, conducting a plan performance review with supporting data)
    - If issues persist, states utilize other levers, such as CAPs leading to sanctions
    - States also utilize public transparency mechanisms to encourage compliance

  - Speire cautioned about overly prescriptive compliance approaches and encouraged good working relationships between states and plans as a way to ensure compliance, with sanctions/financial penalties to be used as needed
- Appointment wait-time standards
  - Speire supported CMCS establishing federal minimum appointment wait-time standards for state Medicaid MMC programs, and noted that appointment wait-time standards tend to be more effective than other quantitative network adequacy standards, such as time and distance
  - Speire agreed that CCIIO's proposed appointment wait-time standards for QHPs seemed appropriate (and flagged that existing appointment wait-time standards in AZ and TN generally align and are effective)
  - Speire highlighted the importance of understanding the capacity of local provider networks when implementing appointment wait-time standards to ensure these wait-times are achievable, and that regional variation is common based on provider availability and geography, which may make national comparisons challenging
- Data strategy to monitor access
  - Speire reported leveraging data sources, including encounter data, grievances and appeals, and dedicated consumer access issue lines to inform their understanding of the access landscape and issue spot
    - Key measures to track access at the state level may include: number of licensed clinicians by region/specialty, the share taking Medicaid in-network, and the share of those accepting new patients.
    - Validation using data is important (e.g., validating providers are accepting appropriate share of Medicaid patients, confirming providers with Certificate of Need to expand access to Medicaid members)
  - Speire noted the strong incentive to outsource network management to the plans or EQRO, but underscored the importance of doing access work at the state level on an ongoing basis
    - Enhanced rates available to hire state employees could help to ensure states build this capacity internally
  - Speire cautioned that network adequacy and new access requirements are ripe for litigation, and good data and systems in place to monitor access can refute potential litigation
- Overall access strategy
  - Speire stated that states need to dedicate sufficient resources to improving network adequacy (training SMEs, time, funding); an enhanced match for state staff focused on network adequacy (i.e., capacity building) could move the needle on access
  - CMS should provide flexibility to states to account for state-specific differences and nuances as it develops new access requirements (e.g., the way in which states define routine, allow network adequacy exceptions (based on geographic differences, good faith negotiation efforts), determine the "community standard" or art of the possible)
  - States must have flexibility to navigate contracting with providers/health systems that try to extract unreasonably high rates, particularly in rural areas with limited workforce
  - Speire suggested that any access strategy developed for MMC should also be applied to FFS, to the extent possible

Tom Wallace, Brian Meyer, and Pam Hull – Florida Medicaid *(September 15, 2022)*

- Florida Medicaid is supportive of secret shopper and views it as a necessary component of the state's comprehensive access strategy, but noted that the program can be resource intensive. Florida would be amenable to CMS providing technical support, including best practices and guidance, as long as it is not prescriptive.
    - Given Florida's staffing limitations, the network oversight division leverages plans to conduct the secret shopper surveys on a monthly basis. To conduct the surveys, the state generates and shares with plans a list of providers (the sample is generated based on identified areas of concern, complaints, or randomly). The plans then self-report deficiencies to the state Medicaid agency, which may impose liquidated damages.
- Florida currently utilizes and is supportive of access timeliness standards.
- Florida believes that their use of liquidated damages drives plan behavior and supports meaningful network access. The state also leverages corrective action plans as a general enforcement mechanism; however, they shared that they rarely (if ever) impose monetary damages for failure to implement the corrective action plan to the satisfaction of the agency (as is described in the MMC contract).
- Florida requires plans to offer enhanced rates to address network adequacy issues and permits plans to leverage telehealth to address network adequacy gaps.

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[37] – 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."[38]

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.

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

[37] 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.

[38] 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"].

Organization (MAO) provider directories, including by working with external contractors to conduct secret shopper studies.[39] 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.[40]

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.[41] 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.[42] 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.[43]

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.[44,45] 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).[46] While not required, states may also conduct additional external quality review activities, including administering surveys or studies of beneficiary access and quality issues.[47] A number of states have taken advantage of this opportunity and leveraged external quality review organizations (EQROs) or other external vendors to conduct secret shopper surveys focused on issues of beneficiary access. While study approaches vary considerably across states, they typically focus on assessing appointment wait-times and the accuracy of provider directories.

Summary of RFI Comments on Access to Care

[39] [HYPERLINK "https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2016.pdf"]
[40] [HYPERLINK "https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2020-PY-FFE-Summary.pdf"]
[41] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747.
[42] https://www.medicaid.gov/medicaid/downloads/behavior-health-provider-network-adequacy-toolkit.pdf.
[43] https://journals.sagepub.com/doi/full/10.1177/0046958019838118.
[44] https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.
[45] https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf.
[46] 42 CFR § 438.358(b).
[47] 42 CFR § 438.358(c).

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[48] (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).

[48] 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.

Message

From: Mann, Cindy [CMann@manatt.com]
Sent: 12/21/2022 6:03:34 PM
To: Tsai, Daniel (CMS/CMCS); (b)(6); Giles, John (CMS/CMCS); (b)(6); Deboy, Alissa (CMS/CMCS); (b)(6); (b)(6)
CC: Briskin, Perrie (CMS/CMCS); (b)(6); (b)(6); Brown, LaRay [labrown@interfaithmedical.org]; Bernstein, William S. [WBernstein@manatt.com]; Cantrell, Christopher [CCantrell@manatt.com]
Subject: NY Safety Net Coalition backgrounder
Attachments: NY Safety Net Coalition Summary Statistics (Dec 2022).docx

Hello
We are looking forward to the meeting with you tomorrow and the NY Safety Net Coalition leaders. As background, attached are some key facts and figures about the Coalition members, the issues they are confronting relative to reimbursement rates and the intersection with some key issues CMS is grappling with.

Thanks in advance for taking the time to meet-

Cindy

Cindy Mann
Partner

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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

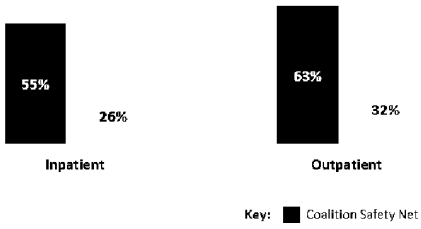
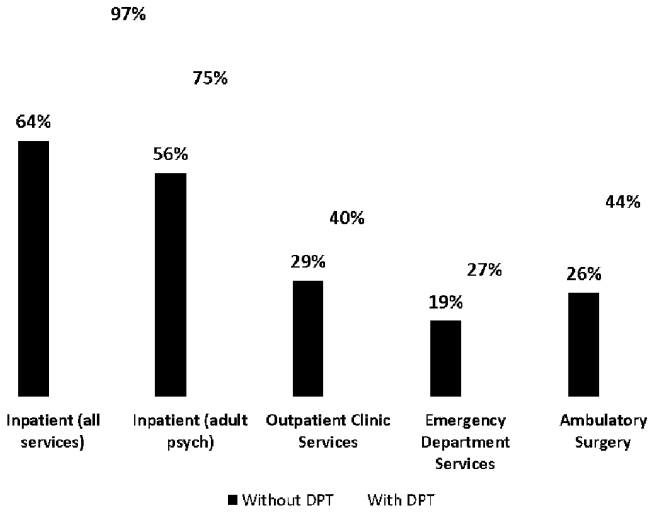


Figure 2: Percent of Services Delivered to Commercial Patients

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.**

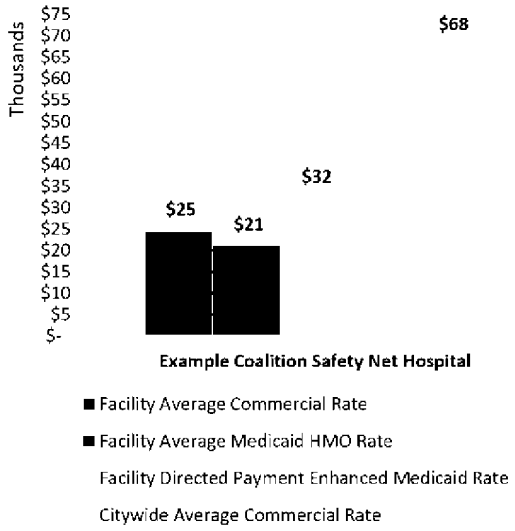
Figure 3: Percent of Costs Covered by NY Medicaid Managed Care Reimbursement Rates
(Example Coalition Safety Net Hospital – Excludes DSH Funding)



- 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

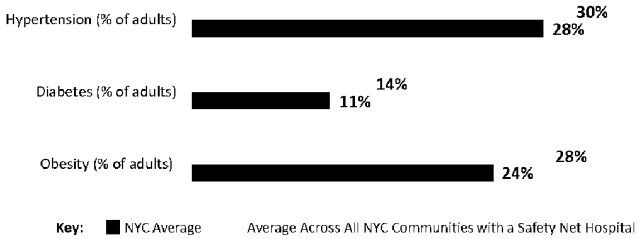
- **Due to the structural failures of the current system, safety net hospitals are in chronic financial distress, often facing cash flow challenges and almost always unable to invest in their infrastructure and facilities (see Figures 5-6).**

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: Walker, Jonathan [JEWalker@manatt.com]
Sent: 8/1/2022 6:18:33 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
Location: https://manatt.zoom.us; (b)(6)

Start: 8/10/2022 6:00:00 PM
End: 8/10/2022 7:00:00 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 (b)(6)

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: (b)(6)

Passcode

SIP: (b)(6)

Passcode

Appointment

From: Peterson, Alanna [APeterson@manatt.com]
Sent: 8/24/2022 3:39:05 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); Gentile, Amy A. (CMS/CMCS); (b)(6); jbarrazacannon@mitre.org; rebeccacase@mitre.org; Page, Claudia [CPage@manatt.com]; Pauly, Nathan [NPauly@manatt.com]
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; (b)(6)

Start: 8/29/2022 2:00:00 PM
End: 8/29/2022 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/; (b)(6)

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 +1 309 205 3325 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 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: (b)(6)

Passcode

Message

From: Boozang, Patricia [PBoozang@manatt.com]
Sent: 8/23/2022 8:29:42 PM
To: Giles, John (CMS/CMCS); (b)(6); (b)(6); Gibson, Alexis E. (CMS/CMCS); (b)(6); (b)(6); Gentile, Amy A. (CMS/CMCS); (b)(6)
CC: Llanos, Karen E.(CMS/CMCS); (b)(6); (b)(6); Pauly, Nathan [NPauly@manatt.com]; Peterson, Alanna [APeterson@manatt.com]; O'Connor, Kaylee [KOConnor@manatt.com]; Serafi, Kinda [KSerafi@manatt.com]; TSCHENCK@mitre.org; jbarrazacannon@mitre.org; rebeccacase@mitre.org; Striar, Adam [AStriar@manatt.com]; Mann, Cindy [CMann@manatt.com]; Page, Claudia [CPage@manatt.com]
Subject: CMCS Managed Care Access Sprint: Deliverables and Proposed Agenda for 8/25 Working Session
Attachments: CMCS Access TMSIS Data memo 8-23.docx; CMCS Access Strategy Enrollee Website Navigation 8.16.22..docx

John, Amy and Alexis,

We are looking forward to our next Working Session with you on Thursday 8/25 at 4:00PM ET. In advance of the session, I wanted to provide two Sprint deliverables, and propose an agenda for Thursday.

1. **CMCS Access TMSIS Data Memo (attached)**. In one of our prior working sessions, you asked our team to provide additional information and insights regarding how CMS and states might leverage existing data assets to promote adoption, monitoring and enforcement of Medicaid and CHIP managed care access standards. This memo describes a proposed data-focused 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 previews proposed CMS' plans to leverage these data for its own oversight and enforcement efforts.

2. **CMCS Access Strategy Enrollee Website Navigation Memo (attached).** Your team shared with us CMCS's desire to improve transparency of data, reporting and information of state Medicaid managed care programs, especially for Medicaid enrollees and their families/caregivers. Specifically, you indicated that CMCS may be requiring states to create easily accessible and navigable web landing pages with all relevant, public facing MMC program information. The attached memo lays out: (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.

3. **Agenda for Thursday Working Session:**
    a. Review Discussion Draft: Provider Rate Analysis/Transparency Preamble and Proposed Rule Language (forthcoming with discussion questions)
    b. Review Final Deliverable: Package of Preamble, Proposed Rule Language and Research on Appt. Wait Time Standards/Monitoring/Enforcement (forthcoming)
    c. Next Steps/Priorities for Managed Care Access Team

    ***Note**: we do not propose to review the two new deliverables provided above during our working session, but can reprioritize our agenda based on your feedback.*

Please provide us with feedback on the proposed agenda, including whether you have other priorities you would like to discuss (including the two new deliverables, which we attach.) We will otherwise send a final agenda and materials along tomorrow, and plan to bring our data and consumer experience SMEs to our next working session with your team.

Thank you,

Patti

Patricia Boozang
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Using T-MSIS and Other State Data Sources to Oversee and Monitor Network Adequacy: Proposed Approach for Providing Technical Assistance to States

August 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.[1] 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.

[1] 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/

These data toolkits could directly key into the types of data analyses CMS will conduct to carry out its oversight responsibilities. These toolkits would be informed by state partners via the State Data Learning Collaborative described above and would likely be iterated over time as new approaches and best practices are developed and disseminated. Examples of tools could include: technical specifications for calculating access measures; code sets to identify conditions, providers, or services of interest; and guidance for reporting and interpreting results of quantitative analyses. The toolkits should provide resources that are applicable in diverse states and should provide flexibility for states to tailor analyses to their state-specific needs. CMS could also consider developing multiple different toolkits structured to investigate different aspects of Medicaid access issues, including for example:

- *Assessing key measures of Medicaid and CHIP service utilization*: This toolkit would focus on approaches to using T-MSIS data to calculate standardized measures of Medicaid and CHIP service utilization and how these results can be used to diagnose potential Medicaid and CHIP access issues. CMS could provide example measures and associated technical specifications that states could use to calculate key measures of Medicaid service utilization.
    - CMS could provide guidance to states on how T-MSIS data on utilization can be used to better understand and enhance network adequacy. Overtime, state utilization data might be made publicly available, allowing states and CMS to rely on appropriate utilization benchmarks.
    - CMS may also promote an approach where states stratify key utilization measures by managed care plan. These results could be used by states to understand whether individuals enrolled in a particular managed care plan experience lower measures of Medicaid and CHIP service utilization relative to similar individuals enrolled in different managed care plans. Managed care plans that have significantly lower rates of Medicaid and CHIP service utilization relative to others may be prime candidates for network enhancement efforts.
    - CMS currently provides technical assistance for calculating the adult and child core measure sets and could leverage a similar model for this data toolkit. CMS could work with states to hone in on existing measures in the adult and child core set that may be useful for understanding Medicaid and CHIP network adequacy issues or could go a step farther by introducing new measures or variations on existing measures.

- *Identifying inequities in access to care:* This toolkit would focus on approaches to using T-MSIS and other state data sources to identify inequities in access to care and how these results can be used to advance health equity. This toolkit could be a companion to the other toolkits to highlight the importance of an equity-focused review of access. CMS could provide example measures and associated technical specifications that states could use to assess potential inequities in access, for example, approaches that assess variability in key measures of Medicaid and CHIP service utilization based on beneficiary race and ethnicity. CMS may also work with states to promote efforts to improve the

collection and reliability of race and ethnicity information in the T-MSIS data to enhance analyses of racial and ethnic inequities in access to care. Other state-level datasets, including all-payer claims databases (APCDs) may also be leveraged to assess potential inequities in Medicaid and CHIP access. For example, APCDs can be used to assess disparities in access to care among Medicaid and CHIP beneficiaries relative to commercially insured individuals. CMS could provide guidance to states on how to use APCD data to compare measures of service utilization among Medicaid beneficiaries relative to commercially insured individuals in the same area. States may use this information – or potentially other available data - to identify areas with particularly large disparities in service utilization between the commercially insured vs. Medicaid and CHIP insured populations, and these areas may be prime targets for Medicaid and CHIP network enhancement efforts.

- *Improving the utility of Medicaid provider directories:* This toolkit would focus on approaches to using T-MSIS data to better understand the accuracy of managed care provider directories and inform strategies to improve these directories by providing states example measures and technical specifications . For example, CMS may promote an approach where states examine T-MSIS data to identify providers included in Medicaid and CHIP managed care provider directories who have not billed Medicaid and CHIP claims for some duration of time. States could then reach out to plans to have them confirm participation and re-assess access in light of the data. Further, CMS may suggest that states regularly remove providers from Medicaid and CHIP managed care provider directories if the provider has not submitted any Medicaid or CHIP claims for some duration of time. CMS could also provide guidance to states on approaches to using T-MSIS data to confirm or update the practice locations of providers included on Medicaid and CHIP managed care provider directories.

- *Supporting public reporting and transparency:* This toolkit would focus on approaches to collating and reporting Medicaid and CHIP access measures to support transparency and accountability. CMS could work with states to develop internal executive-level dashboards that could be used by state Medicaid and CHIP leadership to identify and address network adequacy issues. CMS could also provide guidance to states on approaches to abstracting high-level information from internal dashboards that could be shared publicly. This public information sharing would promote transparency and accountability for the Medicaid agency and their contracting health plans 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.[2] Ensuring access in managed care is a shared responsibility: states, their health plans 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.

[2] 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/

Optimizing the Online Experience for Individuals Enrolled in Medicaid Managed Care: Proposed CMS Sub-Regulatory Guidance to States

August 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.[1-23] 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[4], 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.[5]

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)[6] which includes utilizing iterative and ongoing User Experience (UX) research to streamline path flows, identify enrollee needs

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[1] 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/"]

[2] 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"].

[3] 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/"]

[4] 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"].

[5] [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"]

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

and reduce access barriers. The use of beneficiary surveys and web analytics are also important methods for ensuring websites are as effective and user friendly as possible.

Minimum Enrollee UX Expectations for State Medicaid/CHIP Websites. At a minimum, state Medicaid and CHIP agency websites must provide:

- An easy way for consumers to find the consumer section of the state's Medicaid website;
- A clean and clear Medicaid/CHIP Managed Care "home page" or "landing page" that provides an obvious and distinct entry point for enrollees;
- A content menu with intuitive offerings (see below);
- Navigation that enables visitors to find content by searching and browsing and move easily between different sections of the website;
- Connections to other real-time assistance (e.g., consumer hotline) with real people during reasonable hours and follow up outside of those hours; and
- Varied and ongoing consumer usability feedback channels, including moderated usability testing using a third party vendor that is an entity distinct from the IT vendor.

State websites should be built and enhanced using UCD processes, which include a continuous cycle of observation, ideation, rapid prototyping, user feedback, iteration and implementation.[7]

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

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

- Changing Plans
- Covered Benefits and Prescriptions in a Plan
- Understanding Your Plan's Quality and Performance Data

***Selecting a Provider**:*

- Provider Sort and Search
- Find Plans with My Provider
- Choosing a Provider
- Changing a Provider
- Availability of Telehealth Services
- Provider Availability and Consumer Rights With Making an Appointment

Consumer Rights:

- Know Your Rights Overview
- Continuity of Care Rights
- Non-Discrimination Requirements
- Grievances and Appeals
- Provide Feedback or Fill Out a Survey

Additional Recommendations for Improving Enrollees UX with Medicaid and CHIP Websites.
The following outlines additional best practices for improving enrollees' when seeking to navigate their Medicaid and CHIP managed care websites.

- **Conduct UX Assessments.** States should conduct independent assessments of existing Medicaid and CHIP websites before undertaking any changes regarding the managed care functionality. The "as is" is a critical starting point. Consumer assessments should be ongoing; they are not a one-time activity.[8]

- **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.[9]

[8] 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

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

- **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.

Message

From: Boozang, Patricia [PBoozang@manatt.com]
Sent: 8/9/2022 3:57:44 PM
To: Giles, John (CMS/CMCS) [(b)(6)]; [(b)(6)]; Gentile, Amy A. (CMS/CMCS); [(b)(6)]; Gibson, Alexis E. (CMS/CMCS); [(b)(6)]
CC: Thomas W Schenck [TSCHENCK@mitre.org]; Johanna L Barraza-Cannon [jbarrazacannon@mitre.org]; Rebecca Case [rebeccacase@mitre.org]; O'Connor, Kaylee [KOConnor@manatt.com]; Serafi, Kinda [KSerafi@manatt.com]; Mann, Cindy [CMann@manatt.com]; Peterson, Alanna [APeterson@manatt.com]; Striar, Adam [AStriar@manatt.com]
Subject: CMS Access Call Agenda and Materials: 8/10
Attachments: Appointment Wait-Time Enforcement Recommendations 08.09.2022.docx; Provider Survey_Secret Shopper Interview Takeaways_8.7.2022.docx; CMS Access Manatt Sprint Workplan_8.8.2022.docx; Hospitals serving Black patients get less financial help, study shows _ Modern Healthcare.pdf; Managed Care Access Policy Spring: FW: [EXT] Medicaid MCOs, SDOH, MLR

John, Amy and Alexis,

We are providing below and attached a proposed agenda and materials for our meeting with your team tomorrow at 2p ET. Assuming you have limited time, the priority document for your review before we speak (if possible) is **Appointment Wait-Time Enforcement Recommendations 8.09.2022**. A second priority would be to review the proposed **Workplan** to flag for us where our timelines might not comport with yours.

Please let us know if you have questions or would like to add or drop anything from our agenda. We will also add all of this to the meeting invite on Outlook.

CMCS Managed Care Access Policy Sprint Working Session Agenda Wednesday, August 10, 2:00 -3:00 PM ET	1. Review Discussion Draft of Preliminary Recommendations for CMS Approach to Implementation and Enforcement of Appointment Wait-Time Standards – *see attached* (Manatt) 2. Provider Survey/Secret Shopper Research and Recommendations (Manatt) • Interview Takeaways to Date – *see attached* • Proposed deliverable and timing 3. Manatt/MITRE Managed Care Access Sprint Support Workplan – *see attached* (Manatt) 4. Next Steps (Manatt) • Check-In on Participation in the NAMD Access Workgroup Meetings (CMS) • Next Meeting: 8/16 – Proposed Agenda: ○ Discuss CMS Comments/Feedback on Preliminary Recommendations for CMS Approach to Implementation and Enforcement of Appointment Wait-Time Standards ○ Review Discussion Draft of Preliminary Recommendations for CMS Approach to Provider Survey Requirements and Technical Assistance Memorandum

Attachments:

1. Preliminary Recommendations for CMS Approach to Implementation and Enforcement of Appointment Wait-Time Standards: Memorandum
2. Provider Survey/Secret Shopper Interview Takeaways

3. Manatt/MITRE Medicaid Managed Care Access Sprint Support Workplan
4. Other Research Flags:
    - Modern Healthcare Article: Hospitals Serving Black Patients Get Less Financial Help, Study Shows – *see attached*
    - ACAP slides/AmidaCare White Paper on SDOH and MLR – *see attached*

Upcoming Medicaid Managed Care Access Spring Meetings with CMS/Manatt/MITRE:

- **Tuesday, August 16, 12:00 – 1:00 PM ET**
- **Thursday, August 25, 4:00 – 5:00 PM ET**
- **Week of August 29** – TBD
- **Week of September 12 -** TBD (and bi-weekly thereafter)

*PM Note: We have calls with CMS scheduled weekly thought the week of August 22, and we are looking for times to offer for the week of Aug 29 and Sept 12, with the intention of skipping the week of 9/5 (Labor Day Weekend week). We are also planning to schedule bi-weekly calls thereafter, and admins are working on this as well. I hope to have options to offer MITRE/CMS today. Please let me know if you have any questions or concerns about this proposed meeting cadence. The current workplan aligns with this schedule.

Regards,

Patti

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Recommendations for CMS Enforcement of Appointment Wait-Time Standards
Tuesday, August 9th, 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 6/32)

- **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.)

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.

Date: Updated 8/7/2022
To: CMCS Sprint Team
From: Manatt Health
Re: Provider Survey/Secret Shopper Interview Takeaways

Table of Contents

Interview Takeaway Themes

- "Secret Shopper" term is misleading; states do both "secret" and "revealed" **provider surveys**
- "Many" states do provider surveys
- Provider surveys are effective in identifying access issues
- Support for EQRO role in provider surveys
- Support for CMS technical assistance (TA), including a template
- Caution with regard to CMS being overly prescriptive in setting requirements for provider surveys; states require flexibility
- CMS will need to tailor TA and enforcement to regional access challenges
    - Need to tailor TA to state variation – best practices for New England states are not best practices for frontier states
    - Some access issues, in rural areas in particular, present significant and hard to address challenges
- Survey frequency in states ranges from quarterly to annually; most states conduct surveys annually
- CMS should consider using and requiring state use of other effective mechanisms to identify access issues, including: T-MSIS data, encounter/claims data, appeals and complaints data
- Rural geographies have unique challenges with regard to provider surveys (e.g., "Stawmodel Patient" personas for secret shopping are easy to spot.)
- State challenges in standing up provider survey programs including funding and capacity; interviewees did not suggest that provider surveys are otherwise difficult or time intensive to implement, but for these issues
- Several interviewees suggested guidance and using EQROs with enhanced match would mitigate the funding and capacity issues

Summary of Interviews

Interview Takeaways – Jonathan Bick and colleagues, New York State Dept. of Health (June 27, 2022)

- General overview of state approach to secret shopper program
    - State uses EQRO to conduct secret shopper studies
    - EQROs survey PCPs, plan member services hotlines, and provider directories
        - For PCPs, surveyors assess appointment wait times for routine and urgent appointments
        - For member services hotlines, surveyors assess the following:
            - Accuracy of provider network information
            - Approaches to prior authorization
            - Whether certain services are covered
        - For provider directories, surveyor uses "revealed survey" approach to assess against 75% accuracy level
    - Surveys are conducted once per year

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  - Providers are selected on a randomized basis from each plan's network list
  - Providers with closed panels are not surveyed
  - Survey results can lead to a plan receiving a statement of deficiency or a plan of correction; plans can also be assessed financial penalties after multiple violations, but this is rare
  - Survey results are not made public
- Other impressions
  - Program has been subject to budget cuts in the past; this is not related to concerns about this specific program but rather overall state budgetary concerns
  - State has uncovered significant issues around appointment wait times through secret shopper studies
  - State feels that program does what it is intended to do

Interview Takeaways – Tom Betlach, Speire Healthcare Strategies (July 19, 2022)

- Overall thoughts
  - CMS should ensure it considers fee-for-service (FFS) Medicaid in establishing access/secret shopper requirements
    - States generally have less infrastructure/coordination in their FFS programs
    - FFS programs often include vulnerable populations
    - FFS reimbursement lags managed care in many states, exacerbating access issues
  - Secret shopper
    - Secret shopper studies are generally an effective tool for measuring access
    - They are particularly helpful for providing real-time feedback to states on access issues; states have the ability to target studies based on emerging concerns
    - Studies generally do not require advanced analytics; possible to get a large sample size relatively quickly
- Secret shopper – survey entity
  - Good idea to encourage States to use EQROs to conduct secret shopper studies
  - States generally underutilize EQROs; they can serve as a staff multiplier and are independent from plans
- Secret shopper
  - Supportive of CMS providing technical support, including a template, as long as it is not prescriptive (i.e., help states do it, don't require them to do it a specific way)
  - States need to be able to quickly target their unique and emerging access concerns; study design flexibility helps with this
  - Studies need to measure against "community access standard"; some states may not have particular kinds of specialists in certain areas
  - CMS should consider how to account for telehealth
- General access considerations
  - CMS should consider which access metrics are important beyond just time and distance
  - Appeal/grievance volume is a strong indicator of access issues; indicates that beneficiaries are struggling to access needed care
  - CMS should be careful in establishing new requirements to not increase states' risk of litigation

Interview Takeaways – Mary Beth Dyer, Bailit Health (July 29, 2022)

- General perspective on secret shopper
  - Many states have done these surveys

  - Some use EQROs – these are valuable because they let states be efficient with staff resources and access enhanced matching funds
  - States should be thinking about how to prioritize high volume providers and areas where there are documented access concerns
  - States should be pushing plans to ensure surveys are sufficiently robust and catching providers with many Medicaid members
  - Live secret shopper surveys are most valuable for assessing appointment wait times; states may be able to leverage centralized provider enrollment data to do automated checks of provider directories
  - States/CMS could consider monitoring for "open block scheduling" (important for dealing with urgent issues)
  - Some states pose as beneficiaries; some reveal that they are working with the state – revealing state affiliation can be beneficial since providers "know they're being watched"
- Independent entities vs. delegating to plans
  - States should be doing both
  - Plans should be doing their own surveys to monitor their networks
  - EQROs are efficient from a match rate/staffing perspective, but CMS will need to provide TA
- How to do a better job of assessing network adequacy
  - Unclear if EQROs currently have the expertise to do this since network adequacy monitoring is new
  - Regional variation is a huge issue – networks look very different across states/regions; could CMS leverage regional offices to support TA?
  - Large states generally have more robust machinery in place to do network monitoring since they have many plans/providers
  - CMS could look to leverage MA requirements
  - States should survey providers that have not submitted a single claim over the previous year; it signals access issues for that provider
  - States should also survey high volume providers
  - Other ways to look at access issues – e.g., CA looks at high risk members with an ED visit and no PCP visit; CMS/other states could consider leveraging this type of data approach through T-MSIS, claims/encounter data
- Secret shopper value proposition
  - States don't have the resources in-house to do these surveys; leveraging EQROs can be helpful
  - EQRO processes are very regimented; CMS will need to let states be flexible/responsive in administering these surveys – important that results be made available quickly (i.e., this is monitoring, not evaluation)
- Enforcement
  - California is doing interesting work here but advocates think there are too many exceptions for plans and that it is too easy for them to get around rules
  - Florida has a very IT-focused approach to assessing against contract requirements; plans think state is too aggressive with liquidated damages
  - Generally big states are better at enforcement than small states
- Appointment wait time standards
  - Will be difficult to find a standard that is applicable across the country; huge network variation by region
  - CMS should provide TA, but consider state best practices looking at different regions (i.e., what works in Rhode Island may not be helpful to Montana)

Date: Updated 8/7/2022
To: CMCS Sprint Team
From: Manatt Health
Re: Provider Survey/Secret Shopper Interview Takeaways

Amber Saldivar and colleague, Health Services Advisory Group (EQRO) (August 2, 2022)

- Overview of secret shopper activities
  - Conduct both secret and "revealed" shopper surveys
  - Currently serving approximately 7-8 states
  - Assist states with survey design and implementation, including sampling, script development, data aggregation/reporting
  - Surveys examine whether providers accept health plan coverage and appointment availability
  - Providers examined include primary care, dental, and OB; surveyors look for both urgent and routine appointments
- Secret vs. "revealed" surveys
  - Revealed surveys allow for collection of more data from providers
  - Revealed surveys work better for certain appointment/provider types; for example, it is difficult to test access to behavioral health treatment using secret shopper surveys (since this generally requires a detailed accounting of symptoms). Similarly "established patient" access can only be tested through revealed surveys.
- Survey focus priorities
  - Appointment wait times
  - Provider directory accuracy (including contact information, location, and types of services provided)
- Timing considerations
  - Launching a new program takes approximately 6 months
  - Surveys take approximately 4-6 weeks to administer
  - Able to make survey results available within three months from completion of survey
  - Most states conduct annual studies; some use a quarterly cycle
- Sample size considerations
  - Attempt to ensure a 95% confidence level but sometimes sample sizes are limited based on state budget considerations
  - Samples are sometimes stratified by subspecialty or region (these decisions are driven by the state)
- Advantages of using an EQRO
  - EQROs are independent from plans
  - Plan surveys tend to be smaller and are not always statistically representative
- Access issues identified
  - Provider directories often contain bad phone numbers/addresses
  - Some providers make new beneficiaries jump through hoops to schedule appointments
- Key challenges
  - Some states do not have accurate information on specialty type by provider
- Other considerations
  - Studies are most effective when linked to penalties and posted publicly
  - "Straw model" Medicaid IDs may help surveyors get further along in appointment scheduling process

Paul Henfield and colleague, IPRO (EQRO) (August 4, 2022)

- Overview of secret shopper activities
  - Conduct secret shopper surveys for approximately half of states where IPRO has an EQRO contract
  - Conduct surveys of PCPs, BH providers, dentists, and certain other specialists using provider lists provided by plans

  - Develop survey scenarios in conjunction with states
  - Look at urgent, non-urgent, and after hours visits
  - Check against appointment wait time standards and whether a provider has an open panel; providers with closed panels are not surveyed
  - Also review provider directories for accuracy
  - Conduct both secret and revealed surveys
    - Secret shopper surveys are valuable because they mimic the actual beneficiary experience
    - Generally regard revealed survey findings to be less reliable
- Best practices
  - Important to engage plans and providers in rolling out surveys
  - Important for surveyors to cancel "straw model" appointments before end of each call; failing to do so can lead to backlash from providers
  - Use blinded telephone numbers; large provider call centers can catch on to repeat callers
  - Screen provider lists for duplicates
- Key challenges
  - Many states do not establish "straw model" Medicaid IDs; this makes scheduling appointments more challenging
  - Difficult to assess BH provider access; often very difficult to reach a live person and providers often require triage before beneficiaries can get scheduled for an appointment
- Timing considerations
  - Most states conduct annual surveys; some do quarterly assessments
  - IPRO can launch a new survey within one month and publish results quickly based on state need
- Access issues identified
  - Access to BH providers is very poor for Medicaid beneficiaries; often very difficult to access appointments in a timely manner

Martha Heberlein and colleague, MACPAC (August 4, 2022)

- Perspective on secret shopper studies
  - Studies are not consistently done across states
  - Studies can be burdensome
  - Challenging to survey for access issues for certain types of services (e.g., HCBS)
  - States that assign panels to providers are more challenging to survey since members generally cannot schedule an appointment unless they are assigned to that provider
  - Surveys are challenging in rural areas because providers tend to know community members and can recognize a "straw model" caller
  - Assessing provider access through annual licensure process may be more effective
  - T-MSIS may also be more effective, but CMS would need to improve the quality of provider service data
  - Beneficiary surveys may also be effective for measuring wait times
- How to make secret shopper surveys successful
  - Need to provide TA and funding to states
  - CMS should consider standardizing data collection
  - Providing states with a template would be helpful
  - Using EQROs may be helpful for solving state capacity issues

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 8, 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									
1	CMS Approach to Implementation and Enforcement of Appointment Wait Time Standards	• Approach memorandum, proposed regulatory language, proposed preamble language • Summary slides on recommended approach	In Progress	Discussion Draft		Final Draft	Slides		
Provider Survey/Secret Shopper Program									
2	Provider Survey/Secret Shopper/Appointment Wait-Time Interviews Takeaways	• Takeaways memorandum	In Progress	Initial Feedback Memo		Final Feedback Memo			
3	Provider Survey/Secret Shopper Program Requirements and Technical Assistance for States	• Approach memorandum, proposed regulatory language, proposed preamble language • Summary slides on recommended approach	In Progress		Discussion Draft		Final Draft		Slides
4	Provider Survey/Secret Shopper Technical Assistance Tools	• TBD	Not Started						
Other Policy Areas									
5	MLR: Recommendations on MLR Related to SDOH and Health Care Quality Improvement Activities	• TBD	In Progress						
6	Transparency: Best Practices for Beneficiary Ease of Use/Accessibility	• Best practices memorandum	In Progress			Discussion Draft	Final Draft/ Slides		

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

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 8, 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
7	Provider Rate Transparency: Compliance, Monitoring/Oversight, and Enforcement (aligned across both FFS and MMC delivery systems—pending further discussion with CMS)[2]	• Summary slides on best practices • 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
- Week of August 29 – TBD
- Week of September 12 – TBD (and bi-weekly thereafter)

[2] 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.

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*

Message

From: Thomas W Schenck [TSCHENCK@mitre.org]
Sent: 8/8/2022 1:32:24 PM
To: Giles, John (CMS/CMCS) [john.giles1@cms.hhs.gov]
CC: Gibson, Alexis E. (CMS/CMCS) [alexis.gibson@cms.hhs.gov]; Gentile, Amy A. (CMS/CMCS) [amy.gentile@cms.hhs.gov]; Johanna L Barraza-Cannon [jbarrazacannon@mitre.org]; Boozang, Patricia [PBoozang@manatt.com]; Serafi, Kinda [KSerafi@manatt.com]; Striar, Adam [AStriar@manatt.com]; O'Connor, Kaylee [KOConnor@manatt.com]; Peterson, Alanna [APeterson@manatt.com]; Mann, Cindy [CMann@manatt.com]
Subject: Managed Care Access Policy Spring: FW: [EXT] Medicaid MCOs, SDOH, MLR
Attachments: Medicaid as a Change Agent (Final).pdf

Hi John,

In our most recent meeting, you mentioned ongoing discussions regarding the inclusion of SDOH activities in the MLR numerator. Through a separate policy sprint related to the upcoming Access Regulation, this topic came up in conversations between my colleague Johanna and ACAP, and they provided recent materials reflecting their work and conversations on the issue:

- The linked presentation in the e-mail below contains the results of ACAP's 2020 SDOH survey, and slides 15-18 are particularly pertinent.
- Separately, ACAP shared the attached white paper which was written by the CEO of Amida Care, an HIV Medicaid SNP in NY, and which discusses the value of including SDOH within the MLR numerator.

As noted in the e-mail below, this topic is an ongoing area of work for ACAP.

Hopefully these materials are useful as you continue deliberations regarding the MLR. If you have any questions, please let us know.

We look forward to our conversation on Wednesday.

Thanks!

Tom Schenck
Health Program Analysis and Transformation, Principal
The MITRE Corporation | Health FFRDC
CMS Coverage, Payment, and Equity
781-261-1393

From: Johanna L Barraza-Cannon <jbarrazacannon@mitre.org>
Sent: Thursday, August 4, 2022 12:55 PM
To: Thomas W Schenck <TSCHENCK@mitre.org>
Subject: Fwd: [EXT] Medicaid MCOs, SDOH, MLR

I think we should share with John and the sprint

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From: Jennifer Babcock <jbabcock@communityplans.net>
Sent: Wednesday, August 3, 2022 1:44:14 PM
To: Johanna L Barraza-Cannon <jbarrazacannon@mitre.org>; Enrique Martinez-Vidal <emartinez-vidal@communityplans.net>
Subject: [EXT] Medicaid MCOs, SDOH, MLR

Hi, Johanna! Again, it was so nice being in a meeting with you last week. Per your question about whether and how plans include SDOH activities in MLR, here is what we have below. I have cc'd my colleague Enrique here – he is doing a lot of operational support work with the plans on SDOH and will be able to add more to this, I am sure. If you have questions or want to talk, we would be happy to.

1. ACAP's 2020 SDOH benchmark assessment survey findings are available here.
    a. Slide 16 shows whether and how responding plans include SDOH expenditures in their Medicaid MLRs. As you can see, 55% never included SDOH in administrative expenses, and 50% never included it in medical or other allowable expenses, although some did. We are doing this assessment again soon – it will be interesting to see how this shifts with time.
        i. For comparison with Marketplace and Medicare, see slides 17 and 18.
    b. Slide 15 shows the various sources of funding for the respondents' SDOH activities – when this survey was conducted in 2020, the vast majority of SDOH projects are still paid for out of administrative dollars or reserves. I am very curious too about how this changes with time.

2. As I mentioned last week, we just started working on a research report with Diana Crumley & Tricia McGinnis at CHCS to study how well various Medicaid SDOH payment levers work in a practical way. As part of this, we are exploring whether a selection of 12 states that are advanced in SDOH provide guidance to plans re how to include SDOH in MLR calculations. I am happy to share data with you as we get it.

3. I do not know much about this at all but I have an email or two from the past couple of years from our Marketplace lead who mentioned that the NBPP included something about SDOH & MLR.

Jennifer McGuigan Babcock | Senior Vice President for Medicaid Policy **|** Association for Community Affiliated Plans **|** 202-204-7518 p **|** (b)(6) **|** jbabcock@communityplans.net
Pronouns: she, her, hers

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Medicaid as a Change Agent

New York's Medicaid program was thoughtfully built, and presents a unique tool to address disparities and health care inequality in our state. Medicaid Managed Care serves upwards of 78% of the 7 million Medicaid recipients, coordinating the provision of, quality and cost of care for enrolled members. Unfortunately, over the last few years, the program has been targeted for funding reductions that were driven by a desire to reduce the cost of the program without enough consideration of preserving the program's core benefits.

We believe that innovation within the program can control costs while investing in our state's future. We urge your administration to invest in the program and engage in meaningful community and legislative input. If we want to remain true to New York's progressive values, we must protect Medicaid and make changes in an open, transparent process which preserves the core benefits of the program that millions of individuals and families rely on for essential health care. High utilization of the managed care infrastructure presents an opportunity to align incentives within the program to address health inequities and disparities.

The following are two proposals that could strengthen Medicaid Managed Care while controlling costs, and one that would improve access to safe affordable housing for people living with HIV.

Create a Social Determinants of Health Loss Ratio (SDHLR)

Create a Social Determinants of Health Loss Ratio (SDHLR) whereby managed care organizations could utilize a small portion of existing medical spend to advance work on key SDH interventions including housing stability, medically tailored meals/food security, and livable wage employment.

Given federal denial of DSRIP2, the State should use existing authority under value-based payment and in-lieu-of-service activities, to advance SDH-focused work within SMI, SUD and HIV populations – communities with high needs that will drive higher costs if we do not innovate.

SDHLR would advance efforts to address avoidable admissions within high need/high cost Medicaid sub-populations, which DSRIP was designed to advance. Research in patients with HIV shows that lack of stable, secure, housing is a significant barrier to consistent and appropriate medical care, and increases the risk for forward HIV transmission from the virally unsuppressed. Lack of housing drives longer hospital stays and increased use of rehabilitation services. Similarly, poor nutrition is tied to risk of hypertension and diabetes. Investments in SDH interventions create stability and the foundation for proper use of expensive medical care.

For example, if a SNP/HARP had a 90% MLR last year, and they redirected .5% of medical spend from the prior year to advance/fund SDH work, whereby the current year total cost of care was reduced to 89.5% of premium (or 89% MLR plus a .5% SDHLR); this could represent a game-changing opportunity for NYS Medicaid.

This innovative proposal would also avert concerns related to increased Medicaid spend. Health Plans could be required to document the return on investment of their chosen SDH actions in year 1, before receiving subsequent approvals to redirect higher percentages of medical spend to SDH work.

Projected Savings:
Amida Care estimates that if HARP and SNP plans realize a .5% reduction in medical costs at current PMPM rates; this would translate into a $22.2 million cost reduction. The reduced costs will help slow the trended Medicaid increase and savings will be derived from improved health outcomes that stem from addressing SDH.

Inclusion of HIV Viral Load Suppression Incentives as Medical Costs

40% of people living with HIV who are in care, rely on Medicaid for vital health care, making the program essential for maintaining the great progress New York has made toward the goal of ending HIV in New York.

Viral load suppression (VLS) initiatives implemented through Ending the HIV Epidemic (EtE) programs and DSRIP have been critical in increasing rates of HIV viral suppression statewide from 54% in 2012 to 68% in 2018. A key component has been quarterly $100 incentives for lab results demonstrating a viral load (<200mL/copy), along with tailored adherence supports (e.g., pillboxing and care management).

Two SNPs—Amida Care and VNSNY/SelectHealth—have adopted VLS programs, which per guidance are currently paid from the Plans' limited administrative costs. Treating these growing and ongoing cost-saving programs as administrative vs. medical costs creates an unintentional disincentive for their uptake. As they generate significant medical savings, VLS incentives should be considered medical costs and implemented as such immediately to support scale up.

While there would be an increase in short-term costs for incentive payments, outpatient care and pharmacy costs, there would be a decrease in costly facility- and hospital-based medical services over the long-term. The total inpatient cost for unsuppressed Amida Care members is approximately $1,000 PMPM. Total Amida Care population inpatient PMPM is $660. The difference is the greater likelihood of inpatient admission. The annual cost for VLS incentives is $400/year/eligible member, which is more than offset by the savings to be achieved monthly. Cost effectiveness studies show that VLS incentives cost approximately $50,000 per QALY gained, significantly lower than the standard $100,000/QALY measure of cost effectiveness.

A 5% increase in viral suppression among those currently unsuppressed in Medicaid (7,000), would translate to $140,000/year in incentive costs. A cost effectiveness study found that for every 200 patients offered an incentive, one HIV infection was prevented. Compared to lifetime costs of averted HIV infections ($379,000) this is a cost-saving intervention.

Projected Savings: 350 newly virally suppressed members (5% of 7,000 unsuppressed) will avert 1.75 infections saving $663,250 in lifetime HIV costs for an annual expense of $140,000. An additional $1.4M in annual savings for reduced inpatient costs will accrue.

By investing in VLS incentives, in year 5 NYS can save $6.3M in averted inpatient costs on 1,750 patients and 3.3M million in averted lifetime HIV treatment costs.

Extend Access to Safe Affordable Housing for People Living With HIV outside of New York City

Enact *Point of Access to Housing and Services* (PATHS) legislation to provide all low-income people with HIV (PWH) experiencing homelessness or housing instability in New York State the same NYS HIV Enhanced Shelter Allowance program assistance that has long been available to PWH who live in NYC.

Safe, stable housing is essential to support effective antiretroviral treatment that sustains optimal health for people with HIV and makes it impossible to transmit HIV to others. For New Yorkers with HIV, unstable housing has been identified as the single strongest predictor of poor outcomes and health disparities.

As many as 4,200 very low-income households living with HIV who live outside of NYC remain homeless or unstably housed, because under State law only residents of NYC are entitled to the 30% rent cap, and the 1980's regulations governing the HIV Enhanced Shelter Allowance (HIV ESA) set the maximum rent that can be paid by an individual with HIV at just $480 per month – far too low to secure decent housing anywhere in the State. Only the NYC local department of social services approves HIV ESA rental subsidies in line with fair market rents.

The proposed *Point of Access to Housing and Services* (PATHS) bill will extend the following protections to PWH who reside outside of New York City:

- Standardize HIV Enhanced Shelter Allowance rental assistance program rents statewide in line with 110% of FMR (consistent with the Section 8 standard);
- Cap the share of rent for all extremely low-income PWH with disability or other income at 30% of income;
- Require that access to public assistance in every local department of social services is provided in a manner that respects the unique needs of people with HIV and preserves confidentiality; and
- Provide NYS funding to support 100% of the costs of the enhanced HIV ESA rental assistance that exceed local departments' 71% share of the $480/month basic assistance set by the HIV ESA regulation.

The accompanying Rest of State rental assistance issue brief from the End AIDS New York coalition provides additional background on this proposal.

Appointment

From: Peterson, Alanna [APeterson@manatt.com]
Sent: 8/29/2022 1:44:53 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) (CMS/CMCS) (b)(6) (b)(6) ; Gentile, Amy A. (CMS/CMCS) (b)(6) jbarrazacannon@mitre.org; rebeccacase@mitre.org; Page, Claudia [CPage@manatt.com]; Pauly, Nathan [NPauly@manatt.com]
CC: Llanos, Karen E.(CMS/CMCS) (b)(6) (b)(6)

Subject: [External] CMCS Access Policy Sprint Working Session
Attachments: image001.jpg; Rate Transparency Preamble + Reg - 8.29.2022.docx; CMCS Access TMSIS Data memo 8-23.docx; CMCS Access Strategy Enrollee Website Navigation 8.16.22..docx
Location: https://manatt.zoom.us (b)(6)

Start: 8/29/2022 2:00:00 PM
End: 8/29/2022 3:00:00 PM
Show Time As: Tentative

Recurrence: (none)

Meeting	Proposed Agenda
[External] CMCS/Manatt/MITRE Access Sprint Meeting Monday, 8/29 10:00 – 11:00 AM ET	• Review ***REVISED** Provider Rate Analysis/Transparency Preamble and Proposed Rule Language (attached) • Review ***NEW** Using T-MSIS and Other State Data Sources to Oversee and Monitor Network Adequacy Memorandum (attached) • Review ***NEW** Optimizing the Online Experience for Individuals Enrolled in Medicaid Managed Care memorandum • Next Steps/Priorities for Managed Care Access Team ○ Flag CMCS/Manatt/MITRE Access Sprint Meetings scheduled for 9/15 and 9/29 ○ Update and share with CMCS the Summary Document ("One Stop Shop") Package of Preamble/Regulatory Language and Roadmap Deliverables

Hi there,

Alanna Peterson is inviting you to a scheduled Zoom meeting.

Phone one-tap: US: or

Meeting URL: https://manatt.zoom.us/j/ (b)(6)

Meeting ID: (b)(6)

Passcode

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US: +1 301 715 8592 or +1 309 205 3325 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 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)

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International numbers

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162.255.36.11 (US East)

Meeting ID: (b)(6)

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SIP: (b)(6)

Passcode

Promoting Access though Provider Rate Transparency
Proposed CMS Preamble and Regulatory Language
DRAFT August 29, 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. CMS seeks comment on potential alternative benchmarks that could be used in instances where Medicare payment rates are not available. These could include Medicaid state plan rates, commercial health plan rates, state employee health plan rates, rates paid in peer states, or other appropriate benchmarks.

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. For purposes of this requirement, CMS proposes that states include all supplemental payments made by states through MCOs, PIHPs, and PAHPs, which could include directed payments (as defined in § 438.6(c)) and pass-through payments (as defined in § 438.6(c)). CMS does not propose to collect information on supplemental payments made on a fee-for-service basis as part of paragraph (b)(3)(ii), including Upper Payment Limit (UPL) payments, Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments, and pool payments authorized under 1115 waivers (including uncompensated care pools and delivery system reform incentive payment programs).

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. CMS believes that attaching an enforcement mechanism to these new requirements will ensure that states are supplying CMS with needed data in a timely fashion and support CMS in its goals to increase transparency of Medicaid managed care payment rates as it continues to work with states to improve the quality of data submitted to T-MSIS.

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 or another benchmark, as determined appropriate by CMS. The rate analysis must include percentage comparisons made on the basis of:

(A) Medicaid base payments; and

(B) Medicaid base and supplemental payments combined. For purposes of this paragraph, supplemental payments include those defined in § 438.6(c) and § 438.6(d), including directed payments and pass-through payments.

(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.

Using T-MSIS and Other State Data Sources to Oversee and Monitor Network Adequacy: Proposed Approach for Providing Technical Assistance to States

August 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.[1] 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.

[1] 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/

These data toolkits could directly key into the types of data analyses CMS will conduct to carry out its oversight responsibilities. These toolkits would be informed by state partners via the State Data Learning Collaborative described above and would likely be iterated over time as new approaches and best practices are developed and disseminated. Examples of tools could include: technical specifications for calculating access measures; code sets to identify conditions, providers, or services of interest; and guidance for reporting and interpreting results of quantitative analyses. The toolkits should provide resources that are applicable in diverse states and should provide flexibility for states to tailor analyses to their state-specific needs. CMS could also consider developing multiple different toolkits structured to investigate different aspects of Medicaid access issues, including for example:

- *Assessing key measures of Medicaid and CHIP service utilization*: This toolkit would focus on approaches to using T-MSIS data to calculate standardized measures of Medicaid and CHIP service utilization and how these results can be used to diagnose potential Medicaid and CHIP access issues. CMS could provide example measures and associated technical specifications that states could use to calculate key measures of Medicaid service utilization.
  - CMS could provide guidance to states on how T-MSIS data on utilization can be used to better understand and enhance network adequacy. Overtime, state utilization data might be made publicly available, allowing states and CMS to rely on appropriate utilization benchmarks.
  - CMS may also promote an approach where states stratify key utilization measures by managed care plan. These results could be used by states to understand whether individuals enrolled in a particular managed care plan experience lower measures of Medicaid and CHIP service utilization relative to similar individuals enrolled in different managed care plans. Managed care plans that have significantly lower rates of Medicaid and CHIP service utilization relative to others may be prime candidates for network enhancement efforts.
  - CMS currently provides technical assistance for calculating the adult and child core measure sets and could leverage a similar model for this data toolkit. CMS could work with states to hone in on existing measures in the adult and child core set that may be useful for understanding Medicaid and CHIP network adequacy issues or could go a step farther by introducing new measures or variations on existing measures.

- *Identifying inequities in access to care:* This toolkit would focus on approaches to using T-MSIS and other state data sources to identify inequities in access to care and how these results can be used to advance health equity. This toolkit could be a companion to the other toolkits to highlight the importance of an equity-focused review of access. CMS could provide example measures and associated technical specifications that states could use to assess potential inequities in access, for example, approaches that assess variability in key measures of Medicaid and CHIP service utilization based on beneficiary race and ethnicity. CMS may also work with states to promote efforts to improve the

collection and reliability of race and ethnicity information in the T-MSIS data to enhance analyses of racial and ethnic inequities in access to care. Other state-level datasets, including all-payer claims databases (APCDs) may also be leveraged to assess potential inequities in Medicaid and CHIP access. For example, APCDs can be used to assess disparities in access to care among Medicaid and CHIP beneficiaries relative to commercially insured individuals. CMS could provide guidance to states on how to use APCD data to compare measures of service utilization among Medicaid beneficiaries relative to commercially insured individuals in the same area. States may use this information – or potentially other available data - to identify areas with particularly large disparities in service utilization between the commercially insured vs. Medicaid and CHIP insured populations, and these areas may be prime targets for Medicaid and CHIP network enhancement efforts.

- *Improving the utility of Medicaid provider directories:* This toolkit would focus on approaches to using T-MSIS data to better understand the accuracy of managed care provider directories and inform strategies to improve these directories by providing states example measures and technical specifications . For example, CMS may promote an approach where states examine T-MSIS data to identify providers included in Medicaid and CHIP managed care provider directories who have not billed Medicaid and CHIP claims for some duration of time. States could then reach out to plans to have them confirm participation and re-assess access in light of the data. Further, CMS may suggest that states regularly remove providers from Medicaid and CHIP managed care provider directories if the provider has not submitted any Medicaid or CHIP claims for some duration of time. CMS could also provide guidance to states on approaches to using T-MSIS data to confirm or update the practice locations of providers included on Medicaid and CHIP managed care provider directories.

- *Supporting public reporting and transparency:* This toolkit would focus on approaches to collating and reporting Medicaid and CHIP access measures to support transparency and accountability. CMS could work with states to develop internal executive-level dashboards that could be used by state Medicaid and CHIP leadership to identify and address network adequacy issues. CMS could also provide guidance to states on approaches to abstracting high-level information from internal dashboards that could be shared publicly. This public information sharing would promote transparency and accountability for the Medicaid agency and their contracting health plans 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.[2] Ensuring access in managed care is a shared responsibility: states, their health plans 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.

[2] 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/

Message

From: Boozang, Patricia [PBoozang@manatt.com]
Sent: 8/12/2022 10:36:00 PM
To: Giles, John (CMS/CMCS); (b)(6); Gentile, Amy A. (CMS/CMCS); (b)(6); Gibson, Alexis E. (CMS/CMCS); (b)(6)
CC: tschenck@mitre.org; jbarrazacannon@mitre.org; rebeccacase@mitre.org; Llanos, Karen E.(CMS/CMCS); (b)(6); Mann, Cindy [CMann@manatt.com]; Serafi, Kinda [KSerafi@manatt.com]; O'Connor, Kaylee [KOConnor@manatt.com]; Striar, Adam [AStriar@manatt.com]; Peterson, Alanna [APeterson@manatt.com]
Subject: CMCS/Manatt/MITRE Access Spring Meeting Agenda and Materials + Provider Survey Memo
Attachments: 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

CMCS Managed Care Access Sprint Team,

Below and attached, I am sharing the agenda and meeting materials for our meeting this Tuesday, August 16. We look forward to speaking then. Have a wonderful weekend.

Regards,

Patti

[External] CMCS/Manatt/MITRE Access Spring Meeting Tuesday, August 16, 2022, 12:00-1:00 pm ET	1. Review Draft Secret Shopper/Provider Survey Preamble and Regulatory Text Memorandum (see Provider Survey Memo 8.12.22 attached) - Manatt • Share Key Takeaways from Interview with DC (8/15) (forthcoming) 2. Update on Status of Appointment Wait-Time Implementation and Enforcement Recommendations Memorandum (see Appointment Wait-Time 8.10.22 attached) - CMS 3. Discuss Next Steps/Timing for to Data-Driven Strategy for Monitoring Access - Manatt 4. Discuss how MITRE/Manatt can best support CMS during August through year-end (see revised Workplan attached) – Manatt 5. Next Steps (Manatt) • Check-In on Participation in the NAMD Access Workgroup Meetings (CMS) • Next Meeting: 8/25 – Proposed Agenda (Manatt) ○ Discuss Optimizing the Online Experience for Individuals Enrolled in Medicaid Managed Care Memorandum ○ Review Final Draft of Appointment Wait-Time Implementation and Enforcement Recommendations Memorandum ○ Continue Discussing CMS Comments/Feedback on Status of Secret Shopper/Provider Survey Memorandum (as needed)

Attachments:

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

Upcoming Medicaid Managed Care Access Spring Meetings with CMS/Manatt/MITRE:

- Thursday, August 25, 4:00 – 5:00 PM ET
- Monday, August 29, 10:00 – 11:00 am ET
- Month of September – TBD

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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.

Proposal	High-Level Proposed Regulatory Requirements	Context/Considerations for Promulgating Regulations *(To Inform/Be Leveraged By CMS For Preamble Language)*
	(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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Proposal	High-Level Proposed Regulatory Requirements	Context/Considerations for Promulgating Regulations *(To Inform/Be Leveraged By CMS For Preamble Language)*
		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"].

Proposal	High-Level Proposed Regulatory Requirements	Context/Considerations for Promulgating Regulations *(To Inform/Be Leveraged By CMS For Preamble Language)*
	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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From: Manatt Health
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Proposal	High-Level Proposed Regulatory Requirements	Context/Considerations for Promulgating Regulations *(To Inform/Be Leveraged By CMS For Preamble Language)*
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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	(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.

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	(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:

Federal Citation	Regulatory Language
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.

Message

From: Mann, Cindy [CMann@manatt.com]
Sent: 4/6/2023 8:42:29 PM
To: Tsai, Daniel (CMS/CMCS (b)(6)
(b)(6)
CC: Briskin, Perrie (CMS/CMCS) (b)(6)
(b)(6)
Subject: CAA and continuous coverage and CHIP
Attachments: Applying the Inmate Exclusion to Children Subject to 12 Months Continuous Eligibility (007)3.28.docx

Hi,
I suspect this is not top of mind for you given everything else going on, but we prepared this memo on the CHIP continuous enrollment issue that popped up at the end of the CA justice waiver discussions, when CMCS advised CA that under its interpretation of current rules, when a state adopts the optional 1 -year CE provision for kids, it must cover all CHIP-enrolled kids with full benefits once they enter a carceral setting. If you recall, we all punted on the issue as it was a new one for many. The issue is also implicated in the multi-year CE waivers (one already approved in OR where this issue was never raised and one in the pending WA waiver which is nearing conclusion).

This memo is NOT about the CE or the justice waivers- those need to be negotiated with the states. Rather, it focuses on the one year mandatory CE provision that was in the Congressional Appropriations Act. It seems to me the first order of business is to figure out the intersection between justice and CE within the CAA since that CE provision will be effective 1/24. While this issue ultimately affects a small number of kids it will affect all states with separate CHIP programs, and the concern is the new mandatory CE ought not to be read as a mandatory directive for all states to cover with full chip benefits chip enrolled kids who end up in carceral settings. The legal argument on that point is presented in this memo. Once you figure out how you are going to interpret the CAA provision, more thought can be given to what to do with the multi-year and justice CE waivers. I've done some checking in with Joan Alker, Mel Nathanson and Jacey (and Rachel P) but intentionally haven't gone broader than that at this point. All are on the same page re the CAA interpretation and the implications for CHIP as laid out in the memo.

Happy to talk more but didn't want to delay getting this to you since I suspect CMCS is beginning to work on CAA guidance and the WA waiver is before you. I hope this is helpful

Thanks
Cindy

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Avoiding Unintended Consequences Under the New Continuous Eligibility Provisions

March 17, 2023

Under federal CHIP law, youth who are inmates of public institutions ("incarcerated youth") are not eligible for CHIP. However, in conversations during the final stages of the review of the California justice-involved waiver, CMS expressed the view that under current law states that provide continuous eligibility (CE) in their separate CHIP must continue to cover these youth even when they enter a carceral setting and provide full CHIP benefits during their incarceration. CMS has not articulated this view in any public guidance. Notably, as explained below, this interpretation only applies to children enrolled in separate CHIP programs, not to lower income children enrolled in Medicaid (including MCHIP programs).

Looking beyond the circumstances of states that are seeking to provide targeted pre-release services to incarcerated youth[1] and states approved or seeking to implement multi-year CE for young children through section 1115 waivers, the implication of this view takes on new significance given the enactment of the Consolidated Appropriations Act, 2023 ("CAA"). Under the CAA, all states with separate CHIP programs will be required to provide 12 months of CE for CHIP-enrolled children.

We believe that no one—not the Congress, nor CMS, nor stakeholders seeking to advance the CE requirement adopted in the CAA, or stakeholders focused on providing re-entry oriented services to incarcerated youth—intended or anticipated that the CAA CE provision would result in a mandate for all states with separate CHIP programs to cover CHIP-enrolled youth who are in correctional settings and provide full CHIP benefits during incarceration. This interpretation, which we believe is not compatible with the CAA and underlying CHIP law, would have several unintended consequences. These include the provision of benefits for CHIP-enrolled youth during incarceration that are not available to lower-income children enrolled in Medicaid, the supplantation of state and local dollars now spent on health services in carceral settings with federal funds matched at the enhanced CHIP matching rate, and the potential for pushback given new mandates and administrative burdens for states that could spur efforts to roll back the CE requirement itself.

The more sound, equitable, and pragmatic position, which we lay out in this memorandum, is that the CAA's CE provision *does not create*, through the backdoor, a nationwide mandate to provide full CHIP services to CHIP-enrolled youth in carceral settings. This reading of the law would not prevent states from seeking section 1115 waiver authority to provide enhanced pre-release services to CHIP-enrolled youth in carceral settings or from establishing other coverage policies designed to improve health and health outcomes for justice-involved youth. Indeed, the CAA itself includes new Medicaid and CHIP options and mandates for states to provide health care services to youth in carceral settings.

We believe that, under the best reading of the CAA in conjunction with pre-CAA CHIP statutory requirements relative to incarcerated individuals, Congress directed the following:

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[1] More than a dozen states are seeking (or in the case of California, have been granted) authority under section 1115 of the Social Security Act to provide health care services to individuals in carceral settings; we expect that the issue of the scope of coverage for CHIP-enrolled children pre-release will be resolved through the state/CMS negotiations relating to those waivers.

- Effective January 1, 2024, all states must provide 12 months of CE for CHIP-enrolled children. However, the CHIP eligibility exclusion relating to carceral settings remains in place, except as specifically provided in the CAA to promote access to services in such settings.[2]
- Effective January 1, 2025, states: (1) may no longer terminate CHIP eligibility "but may suspend coverage" during incarceration; (2) must adhere to certain redetermination and application processing requirements to ensure timely coverage upon release; (3) must provide targeted services pre-release; and (4) at state option, may provide full CHIP benefits to youth who are incarcerated pending disposition of charges.[3]

In the first section of this memorandum, we describe current policy applicable to Medicaid and CHIP and the lack of clarity relating to the treatment of incarcerated youth in states with CHIP CE. In the following section, we discuss the provisions of the CAA and argue that, taken together, they do not support the view that CHIP CE trumps the CHIP inmate eligibility exclusion and requires full benefits for CHIP-enrolled youth during incarceration.

1. Background Pre-CAA

A. Under the Social Security Act Pre-CAA, Youth in Carceral Settings May Qualify for Medicaid, Subject to a "Benefits Exclusion," but Are Ineligible for CHIP

Medicaid's "inmate exclusion," set forth in section 1905(a) of the Social Security Act, allows for ongoing eligibility for Medicaid for incarcerated children and youth (if other requirements are met), but imposes a ban on payment for most services during incarceration. Inpatient care in a medical institution (mostly commonly hospitals) is the only service that can be covered,[4] except through a waiver. To promote continuity of coverage upon re-entry to the community, under the SUPPORT Act, states may not terminate Medicaid eligibility for an "eligible juvenile," defined as an individual who is under 21 or enrolled in the mandatory eligibility group for former foster care children, solely because the eligible juvenile becomes incarcerated, but may suspend coverage.[5]

By contrast, in the legislation establishing CHIP Congress established a *bar to eligibility* for incarcerated youth. Specifically, under section 2110 of the Social Security Act, a child who is an "inmate of a public institution" is excluded from the definition of a targeted low-income child eligible for CHIP.[6]

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[2] CAA § 5112(b).
[3] *Id.* at § 5121(c).
[4] Specifically, under Section 1905(a) of the Social Security Act ("SSA"), in subdivision (A) after paragraph 31, codified at 42 U.S.C. § 1396d(a), "payments with respect to care or services" for an "inmate[s] of a public institution," except "as a patient in a medical institution" are excluded from the definition of "medical assistance," making federal financial participation (FFP) unavailable for such services. This exclusion is modified by the CAA which provides a new exception to the payment exclusion for limited pre-release services for eligible juveniles and, at state option, full coverage for eligible juveniles pending disposition of charges, as set forth in sections 5121 and 5122 of the CAA, respectively. CAA §§ 5121-22.
[5] SSA § 1902(a)(84), 42 U.S.C. § 1396a(a)(84); *see* State Medicaid Director Letter (SMD) #21-002, Re: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act), January 19, 2021, *available at* [HYPERLINK "https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf."]
[6] SSA § 2110(b)(2)(A), 42 U.S.C. § 1397jj(b)(2)(A); 42 C.F.R. § 457.310(c)(2)(i).

B. Continuous Enrollment Implications for Justice-Involved Youth under Medicaid and CHIP, Pre-CAA

Since 1997, states have had the option to provide up to 12 months CE for Medicaid for children under 19, or a younger age selected by the state.[7] Through rulemaking in 2016,[8] CMS provided that a state that adopts the CE Medicaid option may not terminate a child's eligibility for Medicaid during a CE period, "regardless of any change in circumstance," unless the child attains the maximum age specified by the state, the child ceases to be a resident of the state, the child dies, the child or the child's representative requests a voluntary termination of eligibility, or the agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal.[9] CE, however, does not affect the statutorily-established Medicaid inmate benefits exclusion; in states that have adopted CE, incarcerated youth enrolled in Medicaid are currently covered for inpatient care only.

The Social Security Act did not include an explicit option for states to provide CE in CHIP, but given the flexibility under federal CHIP law, states may extend CE to CHIP children. States seeking to adopt CHIP CE may do so through their state plan, and many states did so even before CMS issued CHIP CE regulations.[10] Given the broad grant of programmatic flexibility in CHIP, states were able to establish their own rules for CHIP CE. In 2016, however, when CMS established the regulation governing CE for Medicaid, it also established a parallel rule governing CE for CHIP.[11] To align CHIP and Medicaid rules, but without any discussion of the implications relating to justice-involved youth, CMS required states that sought to provide CE in CHIP to apply the same exceptions to CE that CMS established for Medicaid, with two additions: states are permitted to terminate an individual's eligibility for CHIP during a CE period for nonpayment of required premiums or enrollment fees[12] and states must terminate CHIP and transfer a child to Medicaid if during the CE period the child becomes eligible for Medicaid.[13] Incarceration was not identified as an allowable basis for terminating CHIP coverage under CHIP CE.

While neither the text of the CE rule, nor the preamble to the proposed[14]or final rule,[15] explicitly addresses how incarceration impacts eligibility and benefits under CHIP CE, CMS' current position is that

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[7] *Id.* at § 1902(e)(12), 42 U.S.C. § 1396a(e)(12); 42 C.F.R. § 435.926.

[8] CMS, "Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP", 81 Fed. Reg. 86382, 86412-14 (Nov. 30, 2016) ("CE Final Rule").

[9] 42 C.F.R. § 435.926(d).

[10] *See e.g.,* early guidance on CHIP provided in State Health Official Letter (September 10, 1998) which notes that states have the flexibility in CHIP to provide for continuous enrollment. [HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/sho091098.pdf"]. Congress referenced the option to provide continuous enrollment in CHIP as a feature of the "performance bonus" provision which was added to the statute in 2009.

[11] 42 C.F.R. § 457.342; CE Final Rule at 86413-14.

[12] *Id.* at § 457.342(b).

[13] *Id.* at § 457.342(a).

[14] CMS, Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, 78 Fed. Reg. 4593, 4609 (Jan. 22, 2013) ("CE Proposed Rule").

[15] CE Final Rule at 86413-14.

the implication of those regulations is to *require* states that opt to establish CE in CHIP to cover CHIP enrolled children when they are incarcerated, and, moreover, since there is no inmate *benefit* exclusion in CHIP, to require that they cover all CHIP services during incarceration. Even before enactment of the CAA, this position was not compelled by the statute, and as discussed in Section 2 of this memorandum below, it is inconsistent with the new language enacted by the CAA.

C. Current State: No Formal Guidance on State Obligations Under CHIP CE to Incarcerated Youth, or Knowledge by States that Full Coverage Is Required by CMS

It does not appear that CMS has issued any formal guidance to states on what CHIP CE requires for incarcerated youth. In fact, the only published guidance on the point that we could identify—a footnote in State Medicaid Director Letter #21-002 addressing state Medicaid obligations under the SUPPORT Act—suggests that states have the option to establish incarceration as an exception to their CE policy.[16] CMS has since informally indicated that this footnote was in error as it is contrary to the 2016 regulations which do not permit such an exemption.

While it is possible that some states are aware of CMS's pre-CAA view that full benefits must be provided to a CHIP-enrolled individual who becomes incarcerated if the state has adopted CHIP CE, most, we believe, are operating under the assumption that under CHIP children are not eligible for services while incarcerated. To our knowledge, no state with CE in its CHIP program provides coverage and pays for services with CHIP funds during incarceration. And, it would follow that not only these states but also states that do not currently provide CE for CHIP have no idea that, beginning January 1, 2024, they may be required to provide full CHIP benefits to juvenile inmates as a function of the CAA's requirement to provide 12 months of CE.

2. Interpreting The CAA

This "sleeper" issue relating to the intersection of CHIP and CE is now much more of an issue given the CAA's requirement that all states provide children and youth with 12 months of continuous enrollment.[17] As discussed below, the CAA provisions, read together, require a different reading of how CHIP CE and the ban on eligibility for CHIP children in carceral settings interact. Most notably, the CAA provision amends but clearly *retains* the ban on eligibility for children in carceral settings, except as provided in the CAA provisions that address justice-involved youth.

It is critical for CMS to adopt this reading of the new CAA CE provision. While it is likely that only a small number of children will actually be affected if CMS interprets the CAA as requiring eligibility with full CHIP benefits during incarceration, many, if not most, states would face significant challenges meeting the requirements of the new law. Presumably they would either contract with carceral facilities that

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[16] State Medicaid Director (SMD) Letter #21-002, RE: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act), January 19, 2021, at 10, Footnote 21, [HYPERLINK "https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf"] ("[A] child who becomes an inmate of a public institution generally is no longer eligible for CHIP, unless the state has elected to provide continuous eligibility (CE) and did not include incarceration as an exception to its CE policy.")

[17] CMS options for how to address the CHIP CE issue before the CAA provisions are effective are not addressed in this memorandum. Given widespread noncompliance, CMS could, for example, determine not to enforce its current policy in the short interim period.

include youth to provide the full scope of CHIP services (retaining oversight responsibilities over facilities) or establish arrangements with every such facility for community-based providers to provide these services. These challenges to state CHIP programs, which would include setting up new requirements for the provision of health services applicable to CHIP-enrolled children, modifying billing and data sharing systems, and overseeing implementation in jails and prisons despite often having no legal authority to enforce CHIP rules in carceral settings could lead to widespread noncompliance and potentially efforts to undo the important advance that mandatory CE represents for children in Medicaid and CHIP.[18] A backdoor mandate to provide services to youth in carceral settings is also likely not the optimal way for states interested in improving health care outcomes for youth leaving carceral settings to productively engage prison and jail officials. Fortunately, the better reading of the CAA provisions avoids these consequences while providing robust coverage protections for all CHIP-enrolled children and new coverage opportunities for CHIP-enrolled youth in carceral settings.

A. The CAA Is Irreconcilable with the View that CE Requires Ongoing Eligibility and Full Benefits for Justice-Involved CHIP Enrollees

The CAA includes four provisions affecting CHIP eligibility and payment which— taken togetherand read in conjunction with the pre-CAA eligibility exclusion in CHIP for incarcerated youth—strongly suggest that the new CE provision does not require states to provide full CHIP benefits to incarcerated youth.[19] None of these provisions are compatible with the view that CE requires the provision of ongoing CHIP eligibility and coverage of full benefits for a CHIP-enrolled child who becomes incarcerated. Perhaps most notable is that the CAA explicitly retains and modifies the CHIP eligibility exclusion to allow for the new provisions, making it clear that these provisions, including the CE provision enacted as part of the CAA, were not intended to override the longstanding eligibility exclusion.

The relevant CAA provisions relating to CHIP are:

(1) Effective, January 1, 2024, states must provide 12 months of CE under CHIP.[20]

(2) Effective, January 1, 2025, states, "may not terminate eligibility . . . but may suspend coverage" during a child's incarceration.[21]

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[18] By contrast, states proposing justice involved pre-release services through an 1115 waiver have made these program and process changes a priority, which require establishing new relationships (in some cases necessitating state statutory changes), months of planning and negotiations and ongoing collaboration and oversight.

[19] *See* Scialabba v. Cuellar de Osorio, 573 U.S. 41, 87 (2014), *citing* A. Scalia & B. Garner, Reading Law: The Interpretation of Legal Texts 180 (2012) ("The provisions of a text should be interpreted in a way that renders them compatible, not contradictory.... [T]here can be no justification for needlessly rendering provisions in conflict if they can be interpreted harmoniously").

[20] CAA § 5112(b). This provision does not specifically reference the eligibility exclusion, nor does it add a "notwithstanding" clause that would signal Congress' intent to maintain the exclusion except as otherwise modified by the new law.

[21] *Id.* at § 5121(c)(1). In addition, for a child determined eligible immediately before incarceration, the state must conduct a redetermination prior to release (without requiring a new application) and, if the child continues to meet the eligibility requirements, restore coverage upon release. For a child determined eligible while incarcerated, the state must process the application submitted by or on behalf of the child such that the state makes a determination of eligibility upon release. *Id.*

(3) Effective January 1, 2025, states must provide certain statutorily delineated benefits - screening, diagnostic services, referrals, and case management services otherwise covered under the CHIP plan- to all CHIP-eligible incarcerated youth in the 30-day time period prior to their release to the community.[22]

(4) Effective January 1, 2025, states may provide full coverage for a CHIP-enrolled youth who is incarcerated "pending disposition of charges."[23]

Read together, these provisions underscore that the CE provision was not intended to override the eligibility exclusion for CHIP. If CE alone overrides the eligibility exclusion for CHIP and states are therefore required to provide full benefits to incarcerated CHIP youth in 2024, it would make no sense to then require targeted benefits in 2025 or to (also in 2025) allow states to provide full coverage for youth who are incarcerated pending disposition of charges.

Particularly compelling from a legal perspective is that sections 5121 and 5122 of the CAA - the sections specifically focused on services provided to incarcerated youth - explicitly modify the CHIP eligibility exclusion for incarcerated youth but only to the extent needed to require the provision of targeted services 30 days pre-release (section 5121) and permit the provision of all services pre-disposition of charges (section 5122). A clear reading of the amended statute, therefore, is that except as modified by these two exceptions, the eligibility exclusion remains in effect, notwithstanding mandatory CE.[24] In other words, the eligibility exclusion trumps CE, and otherwise remains in place except with respect to the delineated pre-release services and, at state option, for all services for youth who are incarcerated pending disposition of charges.

B. Other Considerations Also Support This Reading of the CAA

This reading of the CAA—that the eligibility exclusion trumps CE, except with respect to limited pre-release services and, at state option, with respect to individuals who are incarcerated pending disposition—is not only the most natural interpretation of the statute, but also compatible with an array of legal, policy, and practical considerations.

To the best of our knowledge, none of the 24 states that provide CE in CHIP now provide full CHIP benefits to incarcerated youth; the CAA would apply to all of these states in addition to 13 others who administer separate CHIP programs but have yet to opt for CE.[25] The challenges of providing even limited services prior to release, let alone for the whole period of incarceration, are significant even for

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[22] *Id.* at § 5121(c)(2). If it would otherwise be covered under the CHIP plan, states must also provide targeted case management, including referrals, for at least 30 days following release.

[23] *Id.* at § 5122(b).

[24] *See* Andrus v. Glover Const. Co., 446 U.S. 608, 616-17 (1980) (*citing* Continental Casualty Co. v. United States, 314 U.S. 527, 533 (1942)) ("Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent.")

[25] Kaiser Family Foundation (KFF), CHIP Program Name and Type (as of Sept. 1, 2022), [HYPERLINK "https://www.kff.org/other/state-indicator/chip-program-name-and-type/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22CHIP%20Program%20Type%22%2C%22sort%22%3A%22desc%22%7D"]; KFF, State Adoption of 12-Month Continuous Eligibility for Children's Medicaid and CHIP (as of Jan. 1, 2022), [HYPERLINK "https://www.kff.org/health-reform/state-indicator/state-adoption-of-12-month-continuous-eligibility-for-childrens-medicaid-and-chip/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D."]

states that have voluntarily taken on the challenge. States are simply not prepared or expecting to move from providing zero covered services during incarceration to the full CHIP benefit package. They need a glide path toward enhancing coverage, which the CAA provides.

CMS's view of the interaction between CHIP and CE pre-CAA also results in an incarcerated youth enrolled in CHIP receiving full benefits while a youth enrolled in Medicaid is limited to inpatient care only until the more targeted 30-day provision takes effect in 2025. This runs counter to the longstanding statutory design of Medicaid and CHIP, under which lower-income Medicaid enrollees receive protections greater than or equal to those afforded higher income CHIP enrollees.[26] By contrast, the reading of the CAA proposed in this memorandum aligns protections for Medicaid and CHIP.[27]

CMS's interpretation of the interaction between CHIP and CE pre-CAA is also at odds with the longstanding federal policy against supplantation of state and local spending. If implemented, in each of the 50 states, state and local spending on healthcare for CHIP-eligible incarcerated youth would be replaced with federal CHIP funds, matched at the CHIP enhanced rate with no obligation for the state to re-invest the savings in improving care and outcomes for justice-involved youth. While the numbers will be small because the population is likely to be small, the approach is counter to CMS and OMB principles, and inconsistent with the requirements CMS is including in justice-involved waivers under Section 1115.

3. Conclusion

For all the foregoing reasons, in interpreting the CAA continuous enrollment provision and ensuring that that this important provision is implemented for Medicaid and CHIP children and youth nationwide, we believe the following is the view most compatible with the relevant provisions of the CAA:

(1) All states must provide 12 months of CE for CHIP-enrolled children, effective January 1, 2024. While not a central focus of CMS's guidance on the CAA CE provision, the guidance would confirm that the eligibility exclusion relating to carceral settings remains in place, except as specifically amended to promote access to services in such settings.[28]

(2) On January 1, 2025, states:

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[26] In addition, under CMS' pre-CAA interpretation of CE requirements in CHIP, a CHIP-enrolled incarcerated youth subject a state CE policy who became eligible for and was enrolled in Medicaid during incarceration as required under 42 C.F.R. § 457.342 would lose access to all covered benefits other than inpatient care and, in 2025, limited pre-release benefits, by virtue of enrollment in Medicaid. This result—under which enrollment in Medicaid results in the loss of coverage—is not likely what Congress intended, or what CMS intended in the 2016 regulations when it made eligibility for Medicaid an exception to CE under CHIP.

[27] The one exception is with respect to inpatient care, which may be covered under Medicaid but not CHIP. But this difference is consistent with the design of Medicaid and CHIP, under which children in Medicaid receive equal to or greater benefits than those in CHIP.

[28] We leave open the possibility that CMS could find that it has the authority to permit states without a waiver to provide full CHIP coverage during incarceration.

(a) may no longer terminate CHIP eligibility "but may suspend coverage" during incarceration[29] consistent with SUPPORT Act requirements pertaining to Medicaid;

(b) must provide limited pre-release coverage for both Medicaid and CHIP-enrolled youth, as set forth in section 5121 of the CAA; and

(d) may, at state option, provide full coverage for Medicaid and CHIP enrolled youth who are incarcerated pending disposition of charges as set forth in section 5122 of the CAA.

[29] *Id.* at § 5121.

Appointment

From: Walker, Jonathan [JEWalker@manatt.com]
Sent: 8/12/2022 8:07:15 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
Location: https://manatt.zoom.us/; (b)(6)

Start: 8/29/2022 2:00:00 PM
End: 8/29/2022 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/; (b)(6)
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 +1 309 205 3325 or +1 312 626 6799 or +1 646 931 3860 or +1 929 205 6099 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: (b)(6)

Passcode:

Appointment

From: Peterson, Alanna [APeterson@manatt.com]
Sent: 8/24/2022 11:41:22 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) ; 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/ (b)(6)

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

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/ (b)(6)

Meeting ID: (b)(6)

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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 +1 669 444 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)

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Passcode:

International numbers

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H.323: 162.255.37.11 (US West)
162.255.36.11 (US East)

Meeting ID: (b)(6)

Passcode:

SIP: (b)(6)

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.

Appointment

From: CMS CMCS_Scheduling [(b)(6)]

Sent: 9/8/2022 7:59:39 PM

To: aimee.ossman@childrenshospitals.org; Banton, Kia (CMS/CMCS) [(b)(6)]; Barbara Eyman [beyman@eymanlaw.com]; Bentley (she/her), Katherine (CMS/CCIIO) [(b)(6)]; bfeldpush@essentialhospitals.org; Blanar, Jonathan (CMS/OC) [(b)(6)]; brucel@firstfocus.org; cdobson@ADvancingstates.org; Costello, Anne Marie (CMS/CMCS) [(b)(6)]; davanzo@nilc.org; Delope, Sarah (CMS/CMCS) [(b)(6)]; rrosales@communitycatalyst.org; crogers@communitycatalyst.org; Dolly, Ed (CMS/CMCS) [(b)(6)]; EFishman@familiesusa.org; ekong@apiahf.org; Erica Cischke [ecischke@aafp.org]; erodriguez@unidosus.org; Franklin, Julie (CMS/OC) [(b)(6)]; Gibson, Alexis (CMS/CMCS) [(b)(6)]; Glier, Stephanie [sglier@aap.org]; Grant, Jeff (CMS/CCIIO) [(b)(6)]; Gutzmer, Hailey (CMS/OC) [(b)(6)]; Hammarlund, John (CMS/OPOLE) [(b)(6)]; Hennessy, Amy (CMS/OC) [(b)(6)]; Hornbuckle, Carolyn (NIHB.ORG) [chornbuckle@nihb.org]; hoshelton@naacpnet.org; jca25@georgetown.edu; JDBaker@mathematica-mpr.com; Katch (she/her), Hannah (CMS/OA) [(b)(6)]; Katie@Out2Enroll.org; Leshak, Brian (CMS/CMCS) [(b)(6)]; Lessard@nilc.org; Lisa Satterfield [lsatterfield@acog.org]; Liu, Beth (CMS/CCIIO) [(b)(6)]; Lovejoy, Shannon (CMS/CMCS) [(b)(6)]; Lyndsey Cavender [LCavender@mathematica-mpr.com]; Lynk, Beth (CMS/OC) [(b)(6)]; Mccloy, Tamara (CMS/OPOLE) [(b)(6)]; mcheek@ahca.org; Melissa McChesney [mmcchesney@unidosus.org]; minnocent@naacpnet.org; mmiller@communitycatalyst.org; Montz, Ellen (CMS/CCIIO) [(b)(6)]; Naomi Ali [NAli@mathematica-mpr.com]; Rachel Thornton [rthornton@acog.org]; rcarreon@unidosus.org; Reilly, Megan (CMS/OC) [(b)(6)]; robinr@kff.org; Ross, Christy [cross@naacpnet.org]; rtetlow@acog.org; sarah.nolan@seiu.org; Seng, Suzette (CMS/CMCS) [(b)(6)]; Setala, Ashley (CMS/CMCS) [(b)(6)]; sfeliz@nul.org; shughes@aha.org; solomon@cbpp.org; squinn@aafp.org; Stan Dorn [SDorn@familiesusa.org]; Stephens, Jessica (CMS/CMCS [(b)(6)]

(b)(6); tharo (aap.org) [tharo@aap.org]; Thomas, Pam (CMS/OPOLE) (b)(6); (b)(6); Toomey, Mary (CMS/OC) (b)(6); (b)(6); Trevino, Ethan (CMS/CCIIO) (b)(6); (b)(6); Tricia Brooks [pab62@georgetown.edu]; Tsai, Daniel (CMS/CMCS) (b)(6); (b)(6); Wagstaffe, Leslie (CMS/CCIIO) (b)(6); (b)(6); Wood (he/him), Elijah (CMS/CCIIO) (b)(6); (b)(6); youdelman@healthlaw.org; UnwindingSupport@mathematica-mpr.com; lrodriguez@americanprogress.org; rb1686@georgetown.edu; emanuel@healthlaw.org; Weiss, Alice (CMS/CMCS) (b)(6); (b)(6); DWalter@aap.org; JKozminski@essentialhospitals.org; msnider@unidosus.org; Cross-Call, Jesse (OS/IEA) (b)(6); Fowler, Joanna (CMS/CCIIO) (b)(6); (b)(6); Lorsbach (she/her), Anna (CMS/CCIIO) (b)(6); (b)(6); akg72@georgetown.edu; sdorn@unidosus.org; aorris@cbpp.org; ferzouki@cbpp.org

CC: Erin O'Malley [eomalley@essentialhospitals.org]; Lipscomb (she/her), Darla (CMS/CCIIO) (b)(6); Tiara Halstead [THalstead@mathematica-mpr.com]; Wallace, Nick [nwallace@aap.org]; Taylor Platt [tplatt@acog.org]; Jennifer Tolbert [JenniferT@kff.org]; Lutzky, Amy (CMS/CMCS) (b)(6); (b)(6); Koepke, Christopher (CMS/OC) (b)(6); (b)(6); Black, Nicole (CMS/OC) (b)(6); Flynn, Judith (CMS/OPOLE) (b)(6); (b)(6); Oconnor, Sarah (CMS/CMCS) (b)(6); (b)(6); Walen, Alyssa (CMS/OC) (b)(6); (b)(6); Arguello, Andres (OS/IOS) (b)(6); (b)(6); Lara, Anthony (CMS/CCIIO) (b)(6); (b)(6); Costello, Stefanie (CMS/OC) (b)(6); (b)(6)

Subject: Unwinding/Preparing for return to regular Medicaid/CHIP operations - Stakeholder Meeting
Attachments: 20220909_Stakeholder Workgroup Agenda_Final.docx
Location: https://cms.zoomgov.com/j/(b)(6)

Start: 9/9/2022 7:00:00 PM
End: 9/9/2022 8:00:00 PM
Show Time As: Tentative

Recurrence: Monthly
the second Friday of every 1 month(s) from 3:00 PM to 4:00 PM

Required Attendees:	aimee.ossman@childrenshospitals.org; Banton, Kia (CMS/CMCS); Barbara Eyman; Bentley, Katherine (CMS/CCIIO); bfeldpush@essentialhospitals.org; Blanar, Jonathan R. (CMS/OC); brucel@firstfocus.org; cdobson@ADvancingstates.org; Costello, Anne Marie (CMS/CMCS); davanzo@nilc.org; Delone, Sarah (CMS/CMCS); rrosales@communitycatalyst.org; crogers@communitycatalyst.org; Dolly, Edward (CMS/CMCS); EFishman@familiesusa.org; ekong@apiahf.org; Erica Cischke; erodriguez@unidosus.org; Franklin, Julie G. (CMS/OC); Gibson, Alexis E. (CMS/CMCS); Glier, Stephanie; Grant, Jeffrey (CMS/CCIIO); Gutzmer, Hailey (CMS/OC); Hammarlund, John T. (CMS/OPOLE); Hennessy, Amy K. (CMS/OC); Hornbuckle, Carolyn (NIHB.ORG); hoshelton@naacpnet.org; jca25@georgetown.edu; JDBaker@mathematica-mpr.com; Katch, Hannah (CMS/OA); Katie@Out2Enroll.org; Leshak, Brian (CMS/CMCS); Lessard@nilc.org; Lisa Satterfield; Liu, Beth C. (CMS/CCIIO); Lovejoy, Shannon (CMS/CMCS); Lyndsey Cavender; Lynk, Beth (CMS/OC); Mccloy, Tamara M. (CMS/OPOLE); mcheek@ahca.org; Melissa McChesney; minnocent@naacpnet.org; mmiller@communitycatalyst.org; Montz, Ellen (CMS/CCIIO); Naomi Ali; Rachel Thornton; rcarreon@unidosus.org; Reilly, Megan C. (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; solomon@cbpp.org; squinn@aafp.org; Stan Dorn; Stephens, Jessica O. (CMS/CMCS); tharo (aap.org); Thomas, Pam L. (CMS/OPOLE); Toomey, Mimi C. (CMS/OC); Trevino, Ethan (CMS/CCIIO); Tricia Brooks; Tsai, Daniel (CMS/OA); Wagstaffe, Leslie M. (CMS/CCIIO); Wood, Elijah P. (CMS/CCIIO); youdelman@healthlaw.org; UnwindingSupport@mathematica-mpr.com; lrodriguez@americanprogress.org; rb1686@georgetown.edu; emanuel@healthlaw.org; Weiss, Alice (CMS/CMCS); DWalter@aap.org; JKozminski@essentialhospitals.org; msnider@unidosus.org; Cross-Call, Jesse (OS/IEA); Fowler, Joanna (CMS/CCIIO); Lorsbach, Anna W. (CMS/CCIIO); akg72@georgetown.edu; sdorn@unidosus.org; aorris@cbpp.org; ferzouki@cbpp.org
Optional Attendees:	Erin O'Malley; Darla Lipscomb (CMS/CCIIO) (darla.lipscomb@cms.hhs.gov); Tiara Halstead; Wallace, Nick; Taylor Platt; Jennifer Tolbert; Lutzky, Amy (CMS/CMCS); Koepke, Christopher P. (CMS/OC); Black, Nicole L. (CMS/OC); Flynn, Judith A. (CMS/OPOLE); Sarah M. OConnor (CMS/CMCHO) (Sarah.OConnor@cms.hhs.gov); Walen, Alyssa (CMS/OC); Arguello, Andres (OS/IOS); Anthony S. Lara (CMS/CCIIO) (Anthony.Lara@cms.hhs.gov); Costello, Stefanie (CMS/OC)

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

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

CMS Unwinding Stakeholder Workgroup Agenda
September 9, 2022| 3:00-4:00 PM ET

- **Welcome & Opening Remarks**

- **CMS Updates**
  - Recent Releases:
    - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/strengthening-tribal-partner-to-prepare-unwinding-081822.pdf"]: Strengthening Tribal and State Partnerships to Prepare for Unwinding
    - [HYPERLINK "https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html"]: COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals
  - Focus for upcoming months
  - Increased Navigator funding

- **Unwinding National Stakeholder Call Series**

  - Potential meeting topic ideas
  - Best practices for partnerships between states & advocacy organizations

- **Feedback from the Field & Open Discussion**

  - What have you been hearing from partners in the states?
  - Have you identified any successful new strategies or initiatives to promote retention that may be worth highlighting?
  - What are your biggest outstanding questions and concerns?
  - If the PHE ends in early 2023, what do you see as the priorities for CMS, states, and partners in the coming months?

- **Wrap Up and Next Steps**

  - Ideas for next month's meeting
  - Unwinding National Partner/Stakeholder Webinar: Wednesday, September 28 (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: October 7, 2022

Message

From: Allison Orris [aorris@cbpp.org]
Sent: 5/31/2023 1:48:53 AM
To: Tsai, Daniel (CMS/CMCS [redacted (b)(6)]
[redacted (b)(6)]
Subject: FW: FW: Memo on Unwinding Enforcement
Attachments: CBPP Memo on Unwinding Enforcement 5-12-23 (final).docx

Hi – Resending just in case.
Safe travels!

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

From: Allison Orris
Sent: Friday, May 12, 2023 12:55 PM
To: Tsai, Daniel (CMS/OA) <daniel.tsai@cms.hhs.gov>; Anne Marie Costello (CMS/CMCS) (annemarie.costello@cms.hhs.gov) <annemarie.costello@cms.hhs.gov>
Cc: Jennifer Wagner <jwagner@cbpp.org>
Subject: Memo on Unwinding Enforcement

Dan and Anne Marie,

I know it's been a busy week at CMS – thank you for all you are doing.

Unrelated to this week's news, we've been putting pen to paper on some thoughts about what we see as the next phase of work on unwinding: leveraging the authorities Congress provided in the CAA to hold states accountable when violations are identified. We know you have expressed intent to pursue corrective action authority where needed, and we support you in that approach.

We particularly wanted to share our view that the CAA provision has a broad reach and that in addition to 42 C.F.R. 435.916, other sections of Medicaid regulations, such as 42 C.F.R. 435.901 (requiring adherence to the Constitution, Social Security Act, Title VI, Section 504, the American with Disabilities Act, and Section 1557), 435.902 (simplicity of administration) and 435.930 (continuing Medicaid until an enrollee is found ineligible) are clearly applicable to eligibility redeterminations. We contend that when data CMS collects through unwinding reports and performance indicators show problems in the redetermination process, these problems are likely to indicate a violation of a federal requirement applicable to redeterminations and should also be the basis for potential corrective action.

Please let us know if it would be helpful to discuss at any point.

Allison & Jen

Allison Orris (she/her/hers)
Senior Fellow
Center on Budget and Policy Priorities
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Center on Budget and Policy Priorities

1275 First Street NE < Suite 1200 < Washington DC 20002
(202)408-1080< fax (202)408-1056 < center@cbpp.org < www.cbpp.org

TO: Dan Tsai, Anne Marie Costello, Center for Medicaid and CHIP Services, CMS

DATE: May 12, 2023

FROM: Allison Orris and Jennifer Wagner, Center on Budget and Policy Priorities

SUBJECT: Importance of Corrective Action Plans in Holding States Accountable During Unwinding

Thank you to you and your team for your extensive work with states to help them prepare for and implement Medicaid unwinding. We know that you have been working tirelessly to avoid large scale coverage loss among eligible people and ensure that those who are no longer eligible transition to other coverage. Yet, 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. Staffing shortages, outdated technology, and – in some states – deliberate policy choices will likely lead to massive backlogs, long waits at call centers, and an inability to timely process documents in many states.

Congress was aware of the risk to eligible enrollees when, in the Consolidated Appropriation Act, 2023 (CAA), it provided you with authority to hold states accountable for keeping eligible people enrolled during unwinding. Central to holding states accountable is the use of corrective action plans (CAPs), which allow CMS to require states to pause procedural terminations should a state fail to submit or effectively implement such a plan. But 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 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 these mitigation plans will not keep eligible people from losing coverage in some states, including states with large numbers of Medicaid enrollees. Many states may successfully implement their mitigation plans, or already be in compliance with regulations, yet could still struggle to accurately determine Medicaid eligibility in a timely manner.

Mitigation plans should lead to outcomes consistent with regulatory compliance. If a state's outcomes are inconsistent because the plan is insufficient, doesn't address core deficiencies like staffing, or the state is unable or unwilling to follow its terms, there is a need for CMS to step in. The fact that the state was excused from full compliance through alternative strategies authorized in the mitigation plan does not excuse their accountability if the measures in the plan prove insufficient

or other issues create barriers to access. Technology challenges, understaffing, and other obstacles to streamlined eligibility determinations will leave some states unable to process the number of renewals, calls, and reapplications during unwinding. While we recognize that CAPs can be viewed as adversarial and change a dynamic with a state, we urge you to use your authority to require CAPs and, if necessary, pause procedural terminations (where a state will not do so voluntarily) when states struggle during unwinding at the expense of people's coverage.

Timely Action to Prevent Coverage Loss is Essential

When there are indications that a state is struggling and that large numbers of eligible enrollees are losing coverage, despite mitigations that it may have in place, CMS should immediately notify the state that they must submit a CAP. If CMS waits until more data are available, or gives the state a few months to improve, valuable time will be lost and eligible people will continue to lose coverage. We recognize that partnering with states to push for improvement has been an effective strategy leading up to unwinding, but we urge you to rapidly move toward compliance action when there are indications of eligible people losing access.

Due to the nature of the renewal process and the fact that many who lose coverage will reapply, states are likely to fall further behind as unwinding progresses. In addition, even if CMS and the state followed the timelines in the CAA, it will take almost 2 months to begin implementation of a CAP. And we anticipate that CMS would likely give states a month or two to implement the plan before pausing procedural terminations or imposing civil penalties, thus extending the timeline for relief for enrollees even more and likely leading to thousands of eligible enrollees losing access to Medicaid.

If a state is unable or unwilling to implement remedies specified in the CAP quickly enough, CMS should act quickly to temporarily require states to suspend procedural terminations. This is the only way to ensure that eligible enrollees retain Medicaid coverage until the state can take the necessary actions to improve program administration. If such action is insufficient to compel compliance, CMS should use its authority to implement civil monetary penalties as well. Considering the rapid pace of renewals during unwinding, any delay in action will mean a substantial number of eligible enrollees losing coverage.

The Authority Congress Provided to Pursue CAPs is Not Limited to 42 CFR 435.916 and Should be Construed Broadly

The CAA authorizes CMS to require CAPs when a state fails to comply with the CAA's reporting requirements or "federal requirements applicable to eligibility redeterminations." This provision has a broad reach and should not be regarded as constraining your authority. While it without question includes the requirements at 42 C.F.R. 435.916, it should not be limited to these requirements. Federal requirements in other sections of the regulation, such as 435.901 (requiring adherence to the Constitution, Social Security Act, Title VI, Section 504, the American with Disabilities Act, and Section 1557), 435.902 (simplicity of administration) and 435.930 (continuing Medicaid until an enrollee is found ineligible) are clearly applicable to eligibility redeterminations.

When data CMS collects through unwinding reports and performance indicators show problems in the redetermination process, these problems are likely to indicate a violation of a federal requirement applicable to redeterminations. For example:

- **Call center wait times** – Long call center wait times keep enrollees from renewing by phone (435.916(a)(3)(i)) and conflict with the requirement of simplicity of administration (435.902). While states are not required to have a call center to administer their Medicaid programs, they are clearly not meeting their obligation to allow phone renewals if call centers have excessive wait times.
- **Procedural terminations** – If a state has an excessively high rate of procedural terminations, it is indicative of problems in their process. The agency may be behind on scanning and/or processing submitted renewals and the eligibility system may be terminating coverage on these cases, meaning the agency is not continuing Medicaid until the enrollee is found ineligible (435.930(b)). The agency may also be violating the requirement of simplicity of administration (435.902). While all states will have some procedural terminations, a rate in excess of their peers (when taking into account renewal redistribution plans) would indicate that people are not receiving their notices, are unable to understand them, or are unable to submit their renewal through the required modalities and eligible individuals are losing coverage.
- **Disparate impacts** – In some states, the available data is likely to indicate disparate impacts on certain groups in violation of Section 504, the Americans with Disabilities Act, Title VI, Section 1557, or other protections. This could include wait times for Spanish-speaking clients in excess of those for English-speaking clients or high termination rates for elderly, blind, and disabled enrollees.

CMS should not be hesitant to require states to submit CAPs. State agencies may be incentivized and able to quickly turn things around and improve their performance, and their CAPs can be considered complete. But in states that continue to struggle and show deterioration in their performance, CMS should be prepared to timely intervene and stop procedural terminations. Every month a state has excessive call center wait times, delays in processing, and large volumes of procedural terminations, eligible people will lose coverage, and be at risk of not being reconnected to the health insurance they rely on.

Unwinding is the most significant event in Medicaid since implementation of the ACA. The health coverage of millions is at stake. While some bumps are inevitable, we should not accept state dysfunction that leads to access barriers and millions of eligible people losing coverage. States have many tools at their disposal to manage during unwinding and should be held accountable if they fail to commit sufficient resources to effectively administer their programs. We urge CMS to use the new authority provided in the CAA to hold states accountable and protect eligible enrollees.

Thank you for your consideration. Please reach out to us if you have any questions.

Jennifer Michael
PHONE: (202) 827-2960
FAX: (615) 742-6293
E-MAIL: jennifer.michael@bassberry.com

June 30, 2023

VIA EMAIL

Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-2442-P
P.O. Box 8016
Baltimore, MD 21244-1850

Re: Proposed Rule – Medicaid Program; Ensuring Access to Medicaid Services (CMS-2442-P)

To Whom It May Concern:

Bass Berry & Sims PLC submits this letter to the Centers for Medicare & Medicaid Services ("CMS") to provide comments on the proposed regulation, "Medicaid Program; Ensuring Access to Medicaid Services" (the "Proposed Rule"). We submit these comments based on our deep and long-standing experience representing a variety of home and community-based services ("HCBS") providers across the country.

We applaud CMS's efforts to address a range of access-related challenges that impact how beneficiaries are served by Medicaid across all of its delivery systems. As CMS noted in the Proposed Rule, many beneficiaries prefer to receive care in their home whenever possible, and HCBS have become a critical component of the Medicaid Program. As CMS also noted in the Proposed Rule, Medicaid coverage of HCBS varies by state and can include a variety of medical and non-medical services such as case management, homemaker, personal care, adult day health, and respite care services.

Our comments focus on the HCBS Payment Adequacy rules proposed at §§441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi). Although the intentions behind the HCBS Payment Adequacy rules are noble, we do not believe that CMS has the authority to promulgate them as proposed. Furthermore, even if CMS does believe it has the authority to promulgate these rules, the agency's "one size fits all" approach to payment adequacy is likely to result in widespread and significant care disruptions that would reduce, rather than improve, beneficiaries' access to care. A far better approach would be for Congress to provide funding to increase Medicaid payment rates and to require or provide an incentive to states that receive funding to implement wage pass-through requirements. If, however, CMS nonetheless elects to promulgate a single, national financial threshold, it should mandate a thoughtfully selected floor that is no higher than 60 percent, with appropriate definitions around the inputs for the calculation. Imposing such a floor would provide each state the opportunity to formulate a higher threshold, if appropriate, that addresses its unique population, compliance requirements, and concerns.

CMS does not have statutory authority to promulgate the HCBS Payment Adequacy provisions of the Proposed Rule.

CMS states in the Proposed Rule that its authority to promulgate the Payment Adequacy rules is "[c]onsistent with section 1902(a)(30)(A) of the [Social Security] Act and sections 2402(a)(1) and 2402(a)(3)(B)(iii) of the Affordable Care Act" ("ACA"). But none of these statutory provisions provides CMS the authority to require states to impose upon HCBS providers, across all state Medicaid programs, a single, national financial threshold.

Section 1902(a)(30)(A) of the Social Security Act requires each "*State plan* for medical assistance [to] … provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan … as may be necessary to … assure that *payments* are consistent with efficiency, economy, and quality of care and *are sufficient to enlist enough providers so that care and services are available under the plan* at least to the extent that such care and services are available to the general population in the geographic area[.]" (Emphasis added.) This statutory provision applies to state plans, not CMS, and speaks to the adequacy of payments to *providers* (i.e., the Medicaid-enrolled healthcare providers), not the providers' workforce. In other words, this provision requires states to ensure that enough entities enroll with Medicaid to provide the services covered by the plans, commensurate with the degree to which such care and services are available to the general public in the area. Even under an expansive interpretation, this statutory provision cannot be read to delegate authority to CMS to prescribe specific wage-pass through requirements that states must impose upon providers.

Section 2402(a)(1) of the ACA requires the Secretary of the Department of Health and Human Services ("HHS") to promulgate regulations "to ensure that *all States develop service systems* that are designed to . . . *allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries* receiving non-institutionally-based long-term services and supports … and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers[.]" (Emphasis added.) Although this provision speaks to HHS's authority to promulgate regulations, the statute is clear that those regulations must pertain to ensuring that states develop *systems* to appropriately allocate resources to the types of services their beneficiaries need. While this provision would allow HHS to, for example, require states to assess whether they should provide services such as delivering healthy meals to certain populations or allow beneficiaries to hire a family member to assist them (and fund the wages), it does not provide HHS the authority to require states to impose upon providers wage pass-through requirements that are set at a specific threshold.

Finally, section 2402(a)(3)(B)(iii) of the ACA requires the HHS Secretary to promulgate regulations "to ensure that *all States develop service systems* that are designed to . . . improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to . . . *oversee and monitor* all service system functions to assure . . . an *adequate number of qualified direct care workers to provide self-directed personal assistance services*." This statutory provision both bestows authority upon HHS to promulgate regulations and specifically references the need to ensure an adequate number of direct care workers. However, like section 2402(a)(1) of the ACA, section 2402(a)(3)(B)(iii) specifies that HHS's role—and its authority to promulgate such regulations—is limited to ensuring that states develop service

systems that "assure . . . an adequate number of qualified direct care workers to provide self-directed personal assistance services." This statutory provision applies only to the self-directed service delivery model, which promotes personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided. Participants are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services. Because this statutory provision applies only to the self-directed service delivery model, it does not authorize HHS to promulgate wage pass-through requirements with respect to the agency model. Furthermore, the statutory provision's scope—which requires HHS to ensure that each state develops its own system to oversee and monitor service system functions—is consistent with the Medicaid program's fundamental premise, which is to allow each state or territory the ability to tailor its program to reflect its unique needs. Because this provision limits HHS's authority to promulgating regulations governing the states' development of systems and does not grant the authority to impose individual mandates within a state program, it does not provide HHS the authority to impose upon states a prescriptive wage pass-through requirement that states must, in turn, impose upon providers.

CMS should decline to promulgate the requirement that at least 80 percent of all Medicaid payments be spent on compensation to direct care workers.

We agree with CMS's observation that the shortage of direct care workers, combined with high turnover rates, are among HCBS providers' greatest challenges to ensuring beneficiaries' access to high-quality, cost-effective HCBS. We also agree that wages significantly impact HCBS providers' ability to hire direct care workers. However, CMS's proposal to impose a "one size fits all" financial threshold—at any percentage—is misguided because it does not account for the extreme variations in state reimbursement rates, state and local wage requirements, prevailing wages, and administrative and supervision requirements.

Moreover, the proposed 80 percent threshold is arbitrary and likely to result in unintended consequences, including a decline in the number of rural and frontier and minority-owned and minority-focused HCBS providers, the withdrawal by larger providers from certain states or areas within states, and diminished worker capacity in cases where workers may lose eligibility for certain government benefits. In particular, a decline in minority-owned and minority-focused providers, who often are smaller and consequently less able to benefit from economies of scale, could have potentially devastating impacts on the vulnerable communities they serve, including communities primarily comprised of individuals for whom English is a second language or who do not speak English at all.

Finally, even in cases where Congress has imposed a federal mandate with respect to Medicaid programs, such as the requirement to use an electronic visit verification ("EVV") system for HCBS, the federal government typically sets minimum thresholds and provides broad flexibility to states to determine the best approach to meet or exceed those thresholds. In the case of EVV, the federal government required states to provide for a stakeholder process to solicit input from HCBS providers, beneficiaries, caregivers, and other stakeholders regarding the states' implementation of the EVV requirement. In addition, the federal government provided additional matching funds for certain state-determined enhancements as a way to both maintain flexibility and simultaneously encourage states to exceed the minimum requirements. The federal

government's approach to the EVV system mandate highlights why it is necessary to allow each state to evaluate its unique needs and determine the best solution for its Medicaid programs. CMS's proposal to implement an across-the-board 80 percent threshold is directly counter to the approach the federal government historically has taken when regulating Medicaid programs and deprives states of the ability to adopt the requirements that are best-suited to their needs.

A single national threshold will not account for the extreme variation in state program requirements.

The 80 percent threshold that CMS proposes in the Proposed Rule is poorly suited to the Medicaid program given states' disparate geographies, reimbursement levels, costs of living, state and local wage requirements, prevailing wages, and state administrative and supervision requirements. In 2003, the Office of Inspector General (OIG) attempted to impose an analogous "one size fits all" standard by defining the term "substantially in excess" to mean charges that were more than 120 percent of a provider's usual charges.[1] When proposing the rule, OIG highlighted the difficulties associated with how to apply such a rule within the Medicaid program, stating, "[b]ecause Medicaid programs vary by State, we cannot develop a uniform rule applicable to all Medicaid physician services" and that "Medicaid reimbursement schemes would need to be analyzed on a case-by-case basis."[2] OIG later withdrew the proposed rule because the agency "[did] not have sufficient information…to establish a single, fixed numerical benchmark for 'substantially in excess' that could be applied equitably across health care sectors and across items and services."[3] OIG also acknowledged that the agency did not have sufficient information to ensure that the 120 percent benchmark would not have the unintended consequence of increasing health care costs.[4]

Not only do reimbursement levels and administrative and supervision requirements vary dramatically across state Medicaid programs, but the Medicaid program also allows for substantial variability among waiver programs *within* a single state. According to the state waivers list on Medicaid.gov, CMS has approved 525 HCBS 1915(c) waivers,[5] each of which is unique with respect to the population served, the services provided, the level of staff required to provide the service, the training and supervision those staff require, and the level of reimbursement received. It is simply not possible for CMS to impose a single, national financial threshold that will appropriately account for the variability inherent across 56 different Medicaid programs and over 500 individual waiver programs. If CMS wishes to impose a single, national financial threshold, it must first consider the effect that threshold will have on each unique program.

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[1] Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 69 Fed. Reg. 53939 (Sept. 15, 2003), available at https://www.govinfo.gov/content/pkg/FR-2003-09-15/pdf/03-23351.pdf.

[2] Id. at 53940.

[3] Medicare and State Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 72 Fed. Reg. 33430 (June 18, 2007), available at https://www.govinfo.gov/content/pkg/FR-2007-06-18/pdf/E7-11663.pdf.

[4] Id. at 33432.

[5] Medicaid.gov State Waivers List, *available at* https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html?search_api_fulltext=&items_per_page=10&f%5B0%5D=state_waiver_status_facet%3A1561&f%5B1%5D=waiver_authority_facet%3A1571#content#content.

The 80 percent threshold is arbitrary.

CMS's own history further demonstrates why the Medicaid program's structure makes it uniquely ill-suited to across-the-board mandates. In March 2018, CMS issued a proposed rule that would have exempted states with Medicaid managed care enrollment rates exceeding 85 percent of the state's total Medicaid population from the access monitoring review plan requirements set forth at 42 C.F.R. 447.203(b).[6] In that proposed rule, CMS stated that it had chosen the 85 percent threshold based on comments the agency had received from states "suggest[ing] thresholds ranging from 75 percent to 95 percent."[7] CMS declined to finalize the proposed exemptions, stating that "an overwhelming number of commenters [had] raised concerns that the exemption thresholds were arbitrarily set without data to support them."[8]

The 80 percent threshold CMS proposes in the Proposed Rule is similarly arbitrary and lacks supporting data. Using reasoning that is remarkably similar to that used in the withdrawn 2018 proposal, CMS states in the Proposed Rule that certain states "indicated an 80 percent threshold is an appropriate threshold" and that the 80 percent threshold "takes into account the expected portion of payments that are necessary for provider administrative and other costs, aside from direct care worker compensation." While an 80 percent threshold may be appropriate for the unidentified states at issue, state administrative, training, and supervision requirements vary significantly, precluding the extrapolation of this reasoning to all 56 Medicaid programs. For example, the number of required training hours for HCBS workers ranges from 40 in New York and Virginia to 75 in Washington.[9]

As another example, because the government does not require the use of a particular or uniform EVV system, EVV systems vary significantly by state. Certain states, including Connecticut, New Mexico and South Carolina, use the state-mandated system model, in which HCBS providers must use the EVV system selected by the state even if they have deployed their own EVV system. This variability leads to increased administrative costs to purchase, support and integrate systems. In addition, EVV systems typically are required to integrate with the state's data aggregator; however, the data elements each state requires (and thus the administrative cost) can vary widely. For these reasons, the administrative costs related to EVV alone can vary materially from state to state; however, the Proposed Rule's 80 percent threshold does not account for this variability.

Other costs, such as costs related to the frequency and level of supervisory visits and recruitment and retention, vary significantly by state, and directly impact the amount of reimbursement that an HCBS provider may pass through to its direct care workers. For instance, some states require supervisory visits whereas others do not. In states requiring supervisory visits, some require registered nurses to perform them, whereas others allow for non-clinical staff to perform visits.

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[6] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services—Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold, 83 Fed. Reg. 12696 (Mar. 23, 2018), *available at* https://www.govinfo.gov/content/pkg/FR-2018-03-23/pdf/2018-05898.pdf.

[7] 83 Fed. Reg. at 12699.

[8] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services—Rescission, 84 Fed. Reg. 33722 (July 15, 2019), available at https://www.govinfo.gov/content/pkg/FR-2019-07-15/pdf/2019-14943.pdf.

[9] State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages, MACPAC Issue Brief, March 2022, available at https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief-on-HCBS-workforce.pdf.

Moreover, the frequency with which supervisory visits must be performed, their duration, and the level of documentation required to support the visit can all vary dramatically among states and even among different programs within the same state. Because most programs do not reimburse for supervisory visits, these requirements further increase the administrative costs HBCS providers incur. Consequently, whether a threshold appropriately accounts for the supervision requirements and other administrative costs in one state has no bearing on whether that threshold may appropriately be applied to another state.

CMS goes on to state in the Proposed Rule that its research indicates "some States have successfully implemented other thresholds, ranging from a low of around 75 percent to a high of 90 percent." However, CMS cites to only two states—Minnesota and Illinois—which have minimum thresholds of 72.5 percent, and 77 percent, respectively. CMS does not cite to any data that would support its proposal to require HCBS providers to spend at least 80 percent of *all* payments on compensation for direct care workers, let alone the 90 percent threshold that CMS claims at least one state has imposed. Our understanding is that, although some states have required 90% of *increases in reimbursement* to be used on direct care, no state has imposed a 90% across-the-board threshold.

Finally, although CMS characterizes its proposal as "similar" to Minnesota's and Illinois' direct care wage requirements, both states allow for a wider range of costs to count toward their thresholds. This distinction further undermines CMS's reliance upon these states' thresholds as a basis to support its proposed 80 percent threshold.

As the saying goes, "if you've seen one Medicaid program, you've seen one Medicaid program."[10] CMS must either conduct a state-by-state analysis to determine the appropriate threshold for each state or leave the authority to impose payment adequacy thresholds to the states, where it currently resides.

> An 80 percent threshold is likely to result in a decline in the number of rural and frontier and minority-owned and minority-focused HCBS providers.

States' Medicaid payment rates vary widely but generally are significantly less than Medicare rates, which themselves tend to be substantially less than commercial rates. In addition, the per-recipient cost to provide HCBS is higher in rural and frontier areas than in urban areas. For example, the Washington Rural Health Access Preservation Project reported that it is difficult for Washington's rural residents to obtain home health and hospice services because payers generally do not pay enough to cover the higher costs of delivering home care services in rural areas where long travel times are required to reach residents' homes.[11] A direct rate increase could help address these

[10] See, e.g., Five Myths about the Medicaid Cap, Georgetown University Health Policy Institute Center for Children and Families, available at https://ccf.georgetown.edu/2017/05/03/five-myths-about-the-medicaid-cap/; Vermont Medicaid: A High-Level Overview, Ashley Berliner, Dept. of Vermont Health Access (Jan. 2023), available at https://ljfo.vermont.gov/assets/Subjects/Global-Commitment-to-Health/de064771fa/Mediciad-101-2022-Final.pdf.

[11] Delivering High-Value Healthcare Services in Rural Areas of Washington State, Phase 1 Findings and Recommendations of the Washington Rural Health Access Preservation (WRHAP) Project (Jan. 2017), available at https://ruralhospitals.chqpr.org/downloads/Delivering_High-Value_Healthcare_in_Rural_Areas_of_Washington_State.pdf.

issues, particularly if the increase was paired with a requirement to pass on a percentage of the increase to direct care workers.

We are concerned that the proposed 80 percent threshold will disproportionately impact HCBS providers who treat a significant number of rural and frontier Medicaid beneficiaries and who cannot rely upon commercial payors to subsidize the care they provide to these beneficiaries. Such providers may opt to stop providing services in rural and frontier communities or shut down entirely. Larger providers similarly may opt to limit or cease providing services in rural and frontier areas if they can no longer rely upon the margins they generate from providing care to urban residents to subsidize the costs to provide care to rural and frontier residents.

Moreover, CMS notes in the Proposed Rule that some of the most common feedback the agency received in response to its spring 2022 RFI related to ways that CMS can promote health equity through cultural competency. CMS further noted that commenters responding to the RFI shared the importance that cultural competency plays in how beneficiaries access health care and in the quality of health services received by beneficiaries.

One way to promote health equity through cultural competency is to ensure that Medicaid beneficiaries can receive care from direct care workers who speak the same language. We are concerned that the Proposed Rule's 80 percent threshold will disproportionately impact minority-owned and minority-focused providers, who often are smaller and consequently less able to benefit from economies of scale. Such small, minority-owned and minority-focused HCBS providers often rely principally on Medicaid revenues and are crucial to providing services to Medicaid beneficiaries in communities with large concentrations of residents from a common place of origin who may speak little or no English. These smaller providers are more likely to be disproportionately impacted by a "one size fits all" national threshold, and therefore more likely to cease operations if CMS were to promulgate such a threshold. Such a result would be devastating for CMS's goals to promote health equity, as larger HCBS providers typically do not have access to direct care workers with the same language skills and cultural ties and thus are highly unlikely to attempt to fill the gap if these providers were to cease operations.

An 80 percent threshold could further exacerbate the shortage of direct care workers.

Before promulgating a single national financial threshold, CMS must study the potential impact such a threshold would have on direct care workers, and in particular, on direct care workers in states with low minimum wage rates. We are aware of instances in which direct care workers have refused increases in compensation or additional shifts because the increase in income would negatively impact the benefits they receive under government programs such as the Supplemental Nutrition Assistance Program. Although we understand examples such as these are anecdotal, they underscore the need for CMS to study the impact a single national financial threshold would have on direct care workers' wages, including any resulting impact to their eligibility to participate in government programs for low-income individuals, before promulgating such a rule.

> An 80 percent threshold is likely to result in the withdrawal by larger providers from certain states or areas within states.

Finally, the 80 percent threshold may cause larger providers to choose to stop providing HCBS services in states where reimbursement is low, or in certain areas within states such as rural or frontier areas, particularly if the 80 percent threshold would further reduce already thin margins.

Rather than promulgate the 80 percent threshold, Congress should provide funding to increase reimbursement for HBCS and encourage states to implement wage pass-through requirements.

A state-led solution to increase direct care workers' wages is already underway. CMS notes in the Proposed Rule that "many States have already voluntarily established" minimum payment thresholds, including by "requir[ing] that a minimum percentage of rate increases and supplemental payments go to the direct care workforce." CMS goes on to state that the 80 percent threshold "is designed to affect the inextricable link between sufficient payments being received by the direct care workforce and access to and, ultimately, the quality of HCBS received by Medicare beneficiaries."

Of course, an 80 percent threshold is not the only way to ensure that direct care workers receive a fair wage. Studies demonstrate that payment rates are a key lever to ensuring access, and that healthcare providers who rely principally on Medicaid revenues face greater workforce recruitment challenges than those who primarily serve commercial patients.[12] Given these realities, the most obvious and straightforward solution would be for Congress to provide funding to increase Medicaid payment rates and to require or provide an incentive to states that receive funding to implement wage pass-through requirements.

The MACPAC report CMS cites in the Proposed Rule describes some of the different ways states structure and implement wage pass-through laws:

> Some states require a percentage of the rate increase to be passed on while other states require a specific dollar amount. These laws may also be implemented in a variety of ways. For example, Washington's law is negotiated through union contracts, requiring that raises in pay to independent providers negotiated through the union also apply to agency-employed HCBS workers. New York's wage pass-through law uses a formula to calculate the dollar amount required for the wage pass-through, and the formula is based on the minimum wage, which varies by county.

The MACPAC report highlights just some of the reasons why a "one size fits all" approach does not work and why it is critical for CMS to allow states to tailor wage pass-through laws to their unique payment circumstances and challenges.

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[12] Cindy Mann and Adam Striar, "How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost," *To the Point* (blog), Commonwealth Fund, Aug. 17, 2022, available at https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact.

If CMS does impose a single national financial threshold, it should set a floor that is no higher than 60 percent, expand the definition of compensation, and define the term payment.

The floor should be no higher than 60 percent.

If CMS nonetheless continues to believe that it has the authority to impose a minimum national threshold and that such a threshold is necessary despite the likely negative consequences, it must choose a threshold significantly below 80 percent to accommodate states' varied programs and disparate reimbursement levels, costs of living, state and local wage requirements, prevailing wages, and administrative, training, and supervision requirements. Although we believe any threshold CMS selects likely would be arbitrary, requiring HCBS providers to pass through 60 percent of all Medicaid payments would both protect direct care workers in states that have low minimum wage requirements and reduce the risk that HCBS providers would stop providing services in certain areas or shut down entirely. Most importantly, this approach would allow states to retain the flexibility they need to ensure that direct care workers are fairly compensated and that Medicaid beneficiaries may continue to receive access to high-quality care.

We use Alabama as an example to demonstrate why the floor must be no higher than 60 percent. Alabama's state minimum wage rate is $9.50 per hour, and reimbursement rates for the primary Medicaid Waiver Programs (E&D, ACT, SAIL, ID) average between ~ $17-18 per hour. Alabama has a significant rural population, which, for the reasons described above, increases the per-resident cost to provide HCBS. At the same time, Alabama has nursing supervision requirements, very active auditing practices, and a manual process for billing, claim review, and remittance, all of which increase administrative costs. In addition, claims in Alabama are processed only on specific dates of the year (so-called "check write dates"), which delays payment and creates cash flow issues, making it difficult for some HCBS providers to meet payroll. Alabama also has indicated that it intends to change EVV systems again in 2024, which will result in additional administrative costs. We expect to see similar changes across multiple states based on the states' experiences with first generation EVV.

If CMS were to require HCBS providers to pass through 80 percent of their total reimbursement to direct care workers, HCBS providers in Alabama could be left with as little as ~$3.50 per visit hour to cover all of their administrative, supervision, overhead, and other costs, including EVV system conversions of the type noted above. In other states, such as Texas, this amount could be as little as $3 per visit hour. For many providers, this amount likely will not be sufficient to sustain operations and meet compliance requirements. HCBS providers who rely primarily on Medicaid reimbursement or who provide services primarily or exclusively in rural or frontier areas would find it particularly difficult to sustain compliant operations in low-reimbursement states.

Reducing the threshold to a maximum of 60 percent would increase the likelihood that HCBS providers in states with low reimbursement rates could continue to provide HCBS services. Although we believe that a floor of 60 percent will still disproportionately harm rural and frontier and minority-owned and minority-focused HCBS providers, it would reduce the burden imposed upon them as compared to an 80 percent threshold. Moreover, imposing a floor would provide

each state the opportunity to formulate a threshold that addresses its unique population, compliance requirements and concerns.

If CMS were to take this approach, we recommend that the agency look to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which establishes a floor of federal privacy protections and rights for individuals, as a model. Under HIPAA, if a provision of state law provides greater privacy protection than a provision of the HIPAA privacy rule and it is possible to comply with both, there is no conflict between the state law and the privacy rule, and no preemption. Similarly, if CMS were to impose a 60 percent threshold, we recommend that CMS require HCBS providers to follow state laws that require a higher percentage of Medicaid reimbursement to be passed through to direct care workers. Such an approach would also be similar to the approach taken with respect to the EVV system requirements, which establish federal minimums but defer to states to determine whether to impose higher requirements.

CMS should expand the definition of compensation and define the term payment.

If CMS promulgates a single national financial threshold, it should expand the definition of compensation to include all of the costs HCBS providers incur with respect to their direct care workers. CMS proposes to define compensation to include salary, wages, and other remuneration as defined by the Fair Labor Standards Act and implementing regulations; benefits; and the employer share of payroll taxes for direct care workers. However, this definition fails to incorporate many of the costs that HCBS providers incur for the benefit of direct care workers, including training, background check costs, stipend or expense reimbursements for mobile devices used for EVV, workers' compensation insurance premiums, and other related costs. If CMS promulgates a national financial threshold, the agency should ensure that it defines compensation in a manner that fairly and accurately captures HCBS providers' total costs to employ direct care workers.

Finally, CMS states in the Proposed Rule that the threshold applies to "all Medicaid payments, including but not limited to base payments and supplemental payments…." CMS should clearly define the universe of payments to which the threshold would apply, and should exclude bad debt, chargebacks, and recoupments from the definition of payments.

* * *

We appreciate CMS's efforts to improve Medicaid beneficiaries' access to HCBS and address health equity issues in the Medicaid program. Although many of the proposals set forth in the Proposed Rule have the potential to promote these goals, we are concerned that the Payment Adequacy Rules will be counterproductive to the achievement of these goals and result in unintended negative consequences. For the reasons set forth in this letter, we urge CMS to withdraw the proposed 80 percent threshold and recommend that the agency instead encourage states to increase reimbursement for HBCS through greater transparency related to individual state rate determinations and implement wage pass-through laws.

Thank you for the opportunity to comment on these important proposals.

Sincerely,

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Appointment

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CC: Weissfeld, Joe (CMS/CMCS); (b)(6) (b)(6)

Subject: CMS/Stakeholder Workgroup: Unwinding/Preparing for return to regular Medicaid/CHIP Operations
Attachments: 20230720_Stakeholder Workgroup Agenda.docx
Location: https://cms.zoomgov.com/ (b)(6)

Start: 7/20/2023 5:00:00 PM
End: 7/20/2023 6:00:00 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: 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; 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); '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); '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

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Optional Attendees: Weissfeld, Joe (CMS/CMCS)

Please remember to mute ---thank you

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CMS Unwinding Stakeholder Workgroup Agenda
July 20, 2023| 1:00 – 2:00 PM ET

- **Welcome and Opening Remarks**

- **CMS Recent Releases**
  - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/renewals-for-monitoring-state-systems.pdf"]
  - [HYPERLINK "https://www.medicaid.gov/resources-for-states/downloads/sum-st-mit-strat-comply-medi-renew-req.pdf"]

- **Public Reporting Overview**

- **Update on Implementation of New Strategies**

- **Feedback from the Field & Open Discussion**

- **Closing**
  - Unwinding National Partner/Stakeholder Webinar: June 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: August 17, 2023 (1-2pm ET)

Message

From: Gentile, Amy (CMS/CMCS) (b)(6)
(b)(6)
Sent: 7/18/2023 2:59:20 PM
To: Giles, John (CMS/CMCS); (b)(6)
(b)(6)
Subject: Georgetwon and CBPP
Attachments: CBPP_CMS-2023-0071-0204-A1.pdf; Georgetown Hlth Policy Inst_CMS-2023-0071-0198-A1.pdf

Amy Gentile
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Center on Budget and Policy Priorities

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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.*
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> *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)

Joan Alker
Research Professor
Executive Director

Message

From: O'Connor, Kaylee [KOConnor@manatt.com]
Sent: 9/6/2022 6:50:02 PM
To: Giles, John (CMS/CMCS) (b)(6); (b)(6); Gentile, Amy (CMS/CMCS) (b)(6); Gibson, Alexis (CMS/CMCS) (b)(6); (b)(6)
CC: Llanos, Karen (CMS/CMCS) (b)(6); (b)(6); Mann, Cindy [CMann@manatt.com]; Serafi, Kinda [KSerafi@manatt.com]; Striar, Adam [AStriar@manatt.com]; Peterson, Alanna [APeterson@manatt.com]; jbarrazacannon@mitre.org; TSCHENCK@mitre.org; Boozang, Patricia [PBoozang@manatt.com]
Subject: RE: RE: CMCS Access Policy Sprint Working Session Next Steps: 8/29
Attachments: Summary Document (One Stop Shop) Package of Preamble_Regulatory Language and Roadmap Deliverables 09.02.22.docx

Good afternoon, John, Amy and Alexis. I hope you had a great holiday weekend. Please find attached an updated "one stop shop" document, which now includes key takeaways and summary notes from our access-related interviews conducted to date (starting on page 27).

Thanks,
Kaylee

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Subject: CMCS Access Policy Sprint Working Session Next Steps: 8/29

Hi John, Amy and Alexis. Please find next steps from our call below and an updated summary "one stop shop" document attached, which now includes all of our recommendations memos in one place, for your reference. An updated

compilation of all state interview notes and key takeaways will also be provided later this week for your reference. Please do not hesitate to reach out if we can be of any assistance as you turn to drafting preamble and regulatory language.

[External] CMCS Access Policy Sprint Working Session Next Steps
Monday, August 29, 2022, 10:00 - 11:00 AM ET

CMS:

- Let MITRE/Manatt know of additional ways to support CMS needs in September (e.g., emerging questions from CMS leadership; ad hoc TA or "phone a friend" approach; product, tools, guidance development; preamble/regulatory language drafting).

MITRE/Manatt:

- Update the Summary Document ("One Stop Shop") Package of Preamble/Regulatory Language and Roadmap Deliverables to include redlined proposed regulatory language, the revised Promoting Access Though Provider Rate Transparency memorandum, and key takeaways/notes from access-related interviews conducted to date (see attached; key takeaways are forthcoming).
- Check-in with CMS in advance of the upcoming CMCS Access Policy Sprint Working Sessions scheduled for 9/15 and 9/29 to confirm the agenda and determine whether to maintain the meetings.
- Revisit in a few months CMS' capacity and the approach for development of data toolkits (in partnership with the Data and Systems Group (DSG) and Data Quality (DQ)) and other technical assistance resources for states to improve access.

Thank you and have a wonderful, long holiday weekend

Patti

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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 September 2, 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 8/29/2022

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. CMS seeks comment on potential alternative benchmarks that could be used in instances where Medicare payment rates are not

[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

available. These could include Medicaid state plan rates, commercial health plan rates, state employee health plan rates, rates paid in peer states, or other appropriate benchmarks.

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. For purposes of this requirement, CMS proposes that states include all supplemental payments made by states through MCOs, PIHPs, and PAHPs, which could include directed payments (as defined in § 438.6(c)) and pass-through payments (as defined in § 438.6(c)). CMS does not propose to collect information on supplemental payments made on a fee-for-service basis as part of paragraph (b)(3)(ii), including Upper Payment Limit (UPL) payments, Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments, and pool payments authorized under 1115 waivers (including uncompensated care pools and delivery system reform incentive payment programs).

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. CMS believes that attaching an enforcement mechanism to these new requirements will ensure that states are supplying CMS with needed data in a timely fashion and support CMS in its goals to increase transparency of Medicaid managed care payment rates as it continues to work with states to improve the quality of data submitted to T-MSIS.

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 or another benchmark, as determined appropriate by CMS. The rate analysis must include percentage comparisons made on the basis of:

(A) Medicaid base payments; and

(B) Medicaid base and supplemental payments combined. For purposes of this paragraph, supplemental payments include those defined in § 438.6(c) and § 438.6(d), including directed payments and pass-through payments.

(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 9/2/2022

Medicaid Managed Care Access Interview Takeaway Themes

Interview Takeaway Themes

- **Minimum Federal Appointment Wait-Time Standards**
  - Broad support for CMCS establishing federal minimum appointment wait-time standards for state Medicaid MMC programs.
  - Appointment wait-time standards tend to be more effective than other quantitative network adequacy standards, such as time and distance.
  - General agreement that CCIIO's proposed appointment wait-time standards for QHPs seem appropriate.
  - Open questions about appointment wait-time standards (e.g., how to define routine, what network adequacy exceptions will entail, how to account for geographic differences and good faith negations).

- **Provider Surveys (Including Secret and Revealed Shopping)**
  - General consensus that provider surveys are generally effective in identifying access issues.
  - "Secret Shopper" term is misleading; states do both "secret" and "revealed" provider surveys.
  - While many states utilize (or have previously used) secret shopper programs, some expressed opposition; however, a few of these same states have in place and were more receptive to *revealed* provider surveys.
  - Support for EQRO role in provider surveys and enhanced match (with the caveat that plans sometimes get different results when they conduct surveys, which could be tied to state-level MMC contract requirements).
  - Survey frequency in states ranges from quarterly to annually—though states tend to conduct surveys annually.
  - State challenges in standing up provider survey programs include funding and capacity; interviewees did not suggest that provider surveys are otherwise difficult or time intensive to implement, but for these issues, which could be mitigated with enhanced match.
  - Rural geographies have unique challenges with regard to provider surveys (e.g., "Strawmodel Patient" personas for secret shopping are easy to spot).
  - Support for CMS technical assistance, including a template and considerations around how to operationalize provider surveys (e.g., whether to call from state phones vs. personal phones, normal business hours vs. weekends).

- **Overall Access Strategy**
  - Caution with regard to CMS being overly prescriptive with access requirements; states require flexibility.
  - Similar to the enhanced match for EQRO activities, an enhanced match for state staff focused on network adequacy (capacity building, etc.) could improve state capacity to monitor and improve access in a meaningful way.
  - Suggestions that CMS provide access-related technical assistance to address regional access challenges (e.g., best practices for New England states are not best practices for frontier states). Some access issues, in rural areas, in particular, present significant challenges that are harder to address.
  - CMS should consider using and requiring state use of other effective mechanisms to identify access issues, including: T-MSIS data, encounter/claims data, appeals and complaints data, provider network files, EQRO audits, etc.
  - Enforcement of access should happen gradually and on a continuum. Before imposing penalties, interviewees suggested working collaboratively with plans (e.g., engaging in discussion, reminding them of

contract requirements, conducting a plan performance review with supporting data, providing technical assistance). If issues persist, states can utilize other levers, such as corrective action plans leading to sanctions.

Medicaid Managed Care Access Summary of Interviews
Jonathan Bick, New York State Dept. of Health *(June 27, 2022)*

- General overview of state approach to secret shopper program
  - State uses EQRO to conduct secret shopper studies
  - EQROs survey PCPs, plan member services hotlines, and provider directories
    - For PCPs, surveyors assess appointment wait-times for routine and urgent appointments
    - For member services hotlines, surveyors assess the following:
      - Accuracy of provider network information
      - Approaches to prior authorization
      - Whether certain services are covered
    - For provider directories, surveyor uses "revealed survey" approach to assess against 75% accuracy level
  - Surveys are conducted once per year
  - Providers are selected on a randomized basis from each plan's network list
  - Providers with closed panels are not surveyed
  - Survey results can lead to a plan receiving a statement of deficiency or a plan of correction; plans can also be assessed financial penalties after multiple violations, but this is rare
  - Survey results are not made public
- Other impressions
  - Program has been subject to budget cuts in the past; this is not related to concerns about this specific program but rather overall state budgetary concerns
  - State has uncovered significant issues around appointment wait-times through secret shopper studies
  - State feels that program does what it is intended to do

Tom Betlach, Speire Healthcare Strategies *(July 19, 2022)*

- Overall thoughts
  - CMS should ensure it considers fee-for-service (FFS) Medicaid in establishing access/secret shopper requirements
    - States generally have less infrastructure/coordination in their FFS programs
    - FFS programs often include vulnerable populations
    - FFS reimbursement lags managed care in many states, exacerbating access issues
  - Secret shopper
    - Secret shopper studies are generally an effective tool for measuring access
    - They are particularly helpful for providing real-time feedback to states on access issues; states have the ability to target studies based on emerging concerns
    - Studies generally do not require advanced analytics; possible to get a large sample size relatively quickly
- Secret shopper
  - Survey entity – Good idea to encourage States to use EQROs to conduct secret shopper studies; states generally underutilize EQROs; they can serve as a staff multiplier and are independent from plans

  - Supportive of CMS providing technical support, including a template, as long as it is not prescriptive (i.e., help states do it, don't require them to do it a specific way)
  - States need to be able to quickly target their unique and emerging access concerns; study design flexibility helps with this
  - Studies need to measure against "community access standard"; some states may not have particular kinds of specialists in certain areas
  - CMS should consider how to account for telehealth
- General access considerations
  - CMS should consider which access metrics are important beyond just time and distance
  - Appeal/grievance volume is a strong indicator of access issues; indicates that beneficiaries are struggling to access needed care
  - CMS should be careful in establishing new requirements to not increase states' risk of litigation

Mary Beth Dyer, Bailit Health *(July 29, 2022)*

- General perspective on secret shopper
  - Many states have done these surveys
  - Some use EQROs – these are valuable because they let states be efficient with staff resources and access enhanced matching funds
  - States should be thinking about how to prioritize high volume providers and areas where there are documented access concerns
  - States should be pushing plans to ensure surveys are sufficiently robust and catching providers with many Medicaid members
  - Live secret shopper surveys are most valuable for assessing appointment wait-times; states may be able to leverage centralized provider enrollment data to do automated checks of provider directories
  - States/CMS could consider monitoring for "open block scheduling" (important for dealing with urgent issues)
  - Some states pose as beneficiaries; some reveal that they are working with the state – revealing state affiliation can be beneficial since providers "know they're being watched"
- Independent entities vs. delegating to plans
  - States should be doing both
  - Plans should be doing their own surveys to monitor their networks
  - EQROs are efficient from a match rate/staffing perspective, but CMS will need to provide TA
- How to do a better job of assessing network adequacy
  - Unclear if EQROs currently have the expertise to do this since network adequacy monitoring is new
  - Regional variation is a huge issue – networks look very different across states/regions; could CMS leverage regional offices to support TA?
  - Large states generally have more robust machinery in place to do network monitoring since they have many plans/providers
  - CMS could look to leverage MA requirements
  - States should survey providers that have not submitted a single claim over the previous year; it signals access issues for that provider
  - States should also survey high volume providers
  - Other ways to look at access issues – e.g., CA looks at high risk members with an ED visit and no PCP visit; CMS/other states could consider leveraging this type of data approach through T-MSIS, claims/encounter data
- Secret shopper value proposition

  - States don't have the resources in-house to do these surveys; leveraging EQROs can be helpful
  - EQRO processes are very regimented; CMS will need to let states be flexible/responsive in administering these surveys – important that results be made available quickly (i.e., this is monitoring, not evaluation)
- Enforcement
  - California is doing interesting work here but advocates think there are too many exceptions for plans and that it is too easy for them to get around rules
  - Florida has a very IT-focused approach to assessing against contract requirements; plans think state is too aggressive with liquidated damages
  - Generally big states are better at enforcement than small states
- Appointment wait-time standards
  - Will be difficult to find a standard that is applicable across the country; huge network variation by region
  - CMS should provide TA, but consider state best practices looking at different regions (i.e., what works in Rhode Island may not be helpful to Montana)

Amber Saldivar, Health Services Advisory Group (EQRO) *(August 2, 2022)*

- Overview of secret shopper activities
  - Conduct both secret and "revealed" shopper surveys
  - Currently serving approximately 7-8 states
  - Assist states with survey design and implementation, including sampling, script development, data aggregation/reporting
  - Surveys examine whether providers accept health plan coverage and appointment availability
  - Providers examined include primary care, dental, and OB; surveyors look for both urgent and routine appointments
- Secret vs. "revealed" surveys
  - Revealed surveys allow for collection of more data from providers
  - Revealed surveys work better for certain appointment/provider types; for example, it is difficult to test access to behavioral health treatment using secret shopper surveys (since this generally requires a detailed accounting of symptoms). Similarly "established patient" access can only be tested through revealed surveys.
- Survey focus priorities
  - Appointment wait-times
  - Provider directory accuracy (including contact information, location, and types of services provided)
- Timing considerations
  - Launching a new program takes approximately 6 months
  - Surveys take approximately 4-6 weeks to administer
  - Able to make survey results available within three months from completion of survey
  - Most states conduct annual studies; some use a quarterly cycle
- Sample size considerations
  - Attempt to ensure a 95% confidence level but sometimes sample sizes are limited based on state budget considerations
  - Samples are sometimes stratified by subspecialty or region (these decisions are driven by the state)
- Advantages of using an EQRO
  - EQROs are independent from plans
  - Plan surveys tend to be smaller and are not always statistically representative
- Access issues identified

  - Provider directories often contain bad phone numbers/addresses
  - Some providers make new beneficiaries jump through hoops to schedule appointments
- Key challenges
  - Some states do not have accurate information on specialty type by provider
- Other considerations
  - Studies are most effective when linked to penalties and posted publicly
  - "Straw model" Medicaid IDs may help surveyors get further along in appointment scheduling process

Paul Henfield, IPRO (EQRO) *(August 4, 2022)*

- Overview of secret shopper activities
  - Conduct secret shopper surveys for approximately half of states where IPRO has an EQRO contract
  - Conduct surveys of PCPs, BH providers, dentists, and certain other specialists using provider lists provided by plans
  - Develop survey scenarios in conjunction with states
  - Look at urgent, non-urgent, and after hours visits
  - Check against appointment wait-time standards and whether a provider has an open panel; providers with closed panels are not surveyed
  - Also review provider directories for accuracy
  - Conduct both secret and revealed surveys
    - Secret shopper surveys are valuable because they mimic the actual beneficiary experience
    - Generally regard revealed survey findings to be less reliable
- Best practices
  - Important to engage plans and providers in rolling out surveys
  - Important for surveyors to cancel "straw model" appointments before end of each call; failing to do so can lead to backlash from providers
  - Use blinded telephone numbers; large provider call centers can catch on to repeat callers
  - Screen provider lists for duplicates
- Key challenges
  - Many states do not establish "straw model" Medicaid IDs; this makes scheduling appointments more challenging
  - Difficult to assess BH provider access; often very difficult to reach a live person and providers often require triage before beneficiaries can get scheduled for an appointment
- Timing considerations
  - Most states conduct annual surveys; some do quarterly assessments
  - IPRO can launch a new survey within one month and publish results quickly based on state need
- Access issues identified
  - Access to BH providers is very poor for Medicaid beneficiaries; often very difficult to access appointments in a timely manner

Martha Heberlein, MACPAC *(August 4, 2022)*

- Perspective on secret shopper studies
  - Studies are not consistently done across states
  - Studies can be burdensome
  - Challenging to survey for access issues for certain types of services (e.g., HCBS)

- States that assign panels to providers are more challenging to survey since members generally cannot schedule an appointment unless they are assigned to that provider
- Surveys are challenging in rural areas because providers tend to know community members and can recognize a "straw model" caller
- Assessing provider access through annual licensure process may be more effective
- T-MSIS may also be more effective, but CMS would need to improve the quality of provider service data
- Beneficiary surveys may also be effective for measuring wait-times

- How to make secret shopper surveys successful
  - Need to provide TA and funding to states
  - CMS should consider standardizing data collection
  - Providing states with a template would be helpful
  - Using EQROs may be helpful for solving state capacity issues

Lisa Truitt, DC Medicaid *(August 15, 2022)*

- Overall approach
  - DC contracts with its EQRO to conduct provider surveys; MCOs are also required to conduct their own surveys
  - EQRO conducts "revealed" surveys; MCOs conduct secret shopper surveys
  - Believe combined approach is most effective
- MCO secret shopper surveys
  - Medicaid managed care plans are required under contract to conduct secret shopper surveys at least annually
  - Secret shopper surveys assess member access to services, appointment wait-times, provider availability, member difficulty in getting an appointment
  - Surveys target high volume provider practices specifically
- EQRO revealed provider surveys
  - EQRO conducts a network adequacy verification project annually and publishes reports of findings, including results from revealed shopper surveys, validation of accuracy of provider directory information and appointment wait-times[35], and appropriate provider-to-enrollee ratios
  - Results from EQRO revealed provider interviews are shared with plan
  - EQRO reports give plans additional information to hold their providers accountable
  - EQRO shares updates to provider directories with plans in real time, and coordinates to ensure providers are not called by plans and an EQRO in the same month
  - DC claims 75% FMAP for expenditures associated with the EQRO provider survey
- Secret vs. revealed survey considerations
  - Both secret and revealed shopper surveys work well if they are highly coordinated but each have their own advantages
  - Advantages of secret shopper surveys
    - Providers tend to tell callers "what they want to hear" during revealed surveys (i.e., there is greater confidence in the accuracy of information obtained through secret shopper surveys)
    - MCO-led secret shopper surveys ensure plans are held responsible for identifying and addressing access issues and give plans a sense of accountability

[35] The EQRO monitors select appointment waiting time standards, including 30 days for PCPs and 24 hours for urgent appointments. DC does not set appointment waiting time standards for plans, but rather, allows plans to define their own appointment waiting times as part of their network adequacy strategy for review and approval.

  - Advantages of revealed surveys
    - DC obtains candid information from revealed surveys about provider concerns (e.g., overscheduling policies to compensate for no shows that lead to longer appointment wait-times); surveys offer an opportunity for providers to report on what is not working well and offices are often eager to share information
    - Revealed surveys work well in smaller areas, where the providers get calls often
    - Provider groups are generally more appreciative if surveys are revealed; providers sometimes react negatively to scheduling appointments for fake Medicaid members as part of secret shopper surveys
- Access measures
  - DC is planning to add "third next available appointment," or 3NAA, a new NCQA new measure and PCMH standard to measure true appointment availability more accurately.[36]
  - DC is focused on appointment wait-times and wants to do more in this area
- Results/accountability
  - Results from EQRO revealed provider surveys are made public
  - Plans are currently not held accountable based on survey findings due to procurement challenges, but DC is looking at MD's EQRO access report as a model, which does hold plans accountable
  - DC plan to add confidence intervals around network adequacy access measures and may potentially put plans on Corrective Action Plans (CAPs)s based on these intervals
- Access issues identified
  - DC has not uncovered lack of available providers (DC currently contracts with 480 providers), but has identified access issues related to lack of transportation, appointment no shows
  - Provider directories are usually 50% accurate across all required components (i.e., provider practices at the practice called, provides desired service, is accepting new patients, accepts insurance, has the same name listed in the provider directory)
- Provider survey cost estimate/staffing
  - DC estimates cost of approximately $100,000/year for revelated shopper surveys
  - EQRO subcontracts survey administration; DC does not have details on FTE or staff hours required to conduct the survey
  - One DC Medicaid FTE oversees the EQRO and a second oversees MCO network adequacy activities
- Access data analysis
  - DC runs reports on their own data, including geo-access reports; they do not analyze T-MSIS data
  - DC conducts routine conversations with providers to assess access issues
  - DC does thorough analyses and evaluations of grievances and appeals, and identify concerns with specific providers or service areas indicated in these reports

Jennifer Langer Jacobs and Lynda Grajeda, New Jersey Medicaid *(August 22, 2022)*

- Provider surveys
  - NJ does not currently utilize secret shopper surveys

[36] 3NAA is defined as: average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability. Source: [HYPERLINK "https://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx" \l ":~:text=Average%20length%20of%20time%20in,exam%2C%20or%20return%20visit%20exam"]

        - Surveys utilized in the past generated point-in-time findings from a subset of providers that the state could not validate
        - Secret shopper surveys were resource intensive, and the state could not rely on the data collected
        - NJ had a negative experience related to an exposé based on findings from a secret shopper study conducted by a graduate school program that came to inaccurate conclusions
        - NJ noted that when plans (versus the state or an EQRO) conducted provider surveys, they often got different results
    - Interestingly, the state utilizes annual PCP after-hour availability studies (i.e., requirement for MCOs to conduct a targeted revealed provider surveys on PCP after-hour availability specifically as part of their overall access strategy)
        - When plans conduct the calls, they reveal which MCO they are affiliated with
        - Surveys help to verify provider names and contact information, practice type/specialty, MCO participation status, office hours, open/closed panel status, and provider's ability to accommodate special needs of members
    - NJ also requires MCOs to conduct monthly provider network spot checks to verify the accuracy of the provider network file
        - Spot checks only include providers who are actively seeing patients and billing Medicaid and target PCP, Ob/Gyn, Dental, and specialty network providers
        - The full provider network must be reviewed biannually
- Network monitoring and oversight
    - The EQRO audits the plans on the above activities, including conducting the monthly network spot checks, PCP after hour surveys, and other reporting requirements related to access
        - The EQRO's role is comprehensive in ensuring the plans meet all contractual requirements related to access.
        - The EQRO also conducts case file audits to confirm that members are getting services timely, and if not, that the plan is performing activities to address access barriers as expected by the state
    - NJ utilizes "360 Reviews" of each MCO to assess plan performance on network adequacy and access
        - NJ holds monthly 90 minute internal calls to assess MCO performance; personnel from across the agency (e.g., finance, business intelligence, quality, MLTSS, pharmacy, dental, behavioral health, etc.) present findings from their perspective and the state identifies MCO strengths, weaknesses, mixed results requiring further understanding or discussion, and concerning findings gleaned from information shared across the various departments
        - Information included in 360 reviews include network access files, geoaccess files, analysis of low activity providers, HEDIS quality measures, CAHPS consumer satisfaction measures, unstaffed cases, provider inquiries, grievances and appeals, encounter/claims data analysis, response times for provider and member inquiries, etc.
        - Findings are then presented to the MCOs individually in the same format; the state focuses the MCO on the top priorities and provides expectations about how MCOs should attempt to address access barriers (e.g., attempt to contract with all available providers in a region and demonstrate good faith effort, offer enhanced rates to providers to address access gaps)
        - NJ works collaboratively with plans to identify and address access issues, but will impose sanctions on an as needed basis
- Provider directory and appointment wait-times
    - The MMC contract includes a requirement that providers in the network have claims; providers do not contribute to adequacy if they don't have claims (though they may remain in network if they are contracted and available)

  - NJ's contract includes appointment wait-times, so they did not raise any concern about the potential for federal minimum standards ("we manage this like bread and butter")
  - NJ stressed the importance of defining "routine" — recognizing physicals can be difficult to schedule
  - NJ will follow-up via email to share information on appointment wait-times
- Enforcement mechanisms and other mitigation strategies
  - NJ values its collaborative relationship with its plans and is reluctant to impose harsh financial penalties, though they do use liquidated damages and sanctions on an as needed and gradual basis
    - Sometimes moving the needle on access just requires a conversation with a plan (e.g., reminding them of state expectations around providing enhanced rates to certain providers, demonstrating good faith effort to contract with providers)
  - MCOs must also document corrective actions taken associated with findings, including: updating provider contact or other information, requesting a CAP from the provider, indicating that the provider's panel is closed, or removing the provider from the network
  - In terms of transparency, plan performance measures (HEDIS and CAHPS) are published as a public report card on NJ's state website: [HYPERLINK "http://www.njfamilycare.org/analytics/home.html"]

Tom Betlach, John McCarthy, and Darin Gordon – Speire Healthcare Strategies & Former Medicaid Directors from Arizona, Ohio, and Tennessee *(August 23, 2022)*

- Provider surveys
  - Speire expressed support of provider surveys (including secret and revealed shopping) and noted they are "one tool in the toolbox" that should be paired with other strategies to identify access issues (e.g., grievances and appeals, informal resolution process —such as the Quality of Care Call Line in AZ, EQRO audits, encounter data, provider network files)
  - Provider surveys have been used to spot check regions and specialties with known access issues to validate information received that suggest access issues
  - Secret shopper implementation can be burdensome, including staff training, setting up Medicaid IDs, assigning fake members to provider panels, defining hours to call and which phone lines to call from (state phone or cell phones)
  - Plans may be more successful in getting appointments for members compared to a secret shopper calling a provider directly, as the plan is responsible to ensuring members get timely access to care and can leverage contractual relationships to get a member an appointment when a provider may be less willing to take a secret shopper "member" calling directly
  - Speire recommended that provider survey requirements apply to both MMC and FFS members, as FFS members may have an even harder time getting appointments without assistance from a plan
  - Secret shopper programs need to be tailored locally; plans that conduct secret shopper surveys themselves can help keep providers honest
  - EQROs are best positioned to externally validate data, such as provider information
- Compliance/enforcement approach
  - Enforcement should happen gradually and on a continuum
    - Before imposing penalties, Speire suggested working collaboratively both internally and with plans (e.g., engaging in discussion, reminding plans of contract requirements—such as providing enhanced rates, conducting a plan performance review with supporting data)
    - If issues persist, states utilize other levers, such as CAPs leading to sanctions
    - States also utilize public transparency mechanisms to encourage compliance

  - Speire cautioned about overly prescriptive compliance approaches and encouraged good working relationships between states and plans as a way to ensure compliance, with sanctions/financial penalties to be used as needed
- Appointment wait-time standards
  - Speire supported CMCS establishing federal minimum appointment wait-time standards for state Medicaid MMC programs, and noted that appointment wait-time standards tend to be more effective than other quantitative network adequacy standards, such as time and distance
  - Speire agreed that CCIIO's proposed appointment wait-time standards for QHPs seemed appropriate (and flagged that existing appointment wait-time standards in AZ and TN generally align and are effective)
  - Speire highlighted the importance of understanding the capacity of local provider networks when implementing appointment wait-time standards to ensure these wait-times are achievable, and that regional variation is common based on provider availability and geography, which may make national comparisons challenging
- Data strategy to monitor access
  - Speire reported leveraging data sources, including encounter data, grievances and appeals, and dedicated consumer access issue lines to inform their understanding of the access landscape and issue spot
    - Key measures to track access at the state level may include: number of licensed clinicians by region/specialty, the share taking Medicaid in-network, and the share of those accepting new patients.
    - Validation using data is important (e.g., validating providers are accepting appropriate share of Medicaid patients, confirming providers with Certificate of Need to expand access to Medicaid members)
  - Speire noted the strong incentive to outsource network management to the plans or EQRO, but underscored the importance of doing access work at the state level on an ongoing basis
    - Enhanced rates available to hire state employees could help to ensure states build this capacity internally
  - Speire cautioned that network adequacy and new access requirements are ripe for litigation, and good data and systems in place to monitor access can refute potential litigation
- Overall access strategy
  - Speire stated that states need to dedicate sufficient resources to improving network adequacy (training SMEs, time, funding); an enhanced match for state staff focused on network adequacy (i.e., capacity building) could move the needle on access
  - CMS should provide flexibility to states to account for state-specific differences and nuances as it develops new access requirements (e.g., the way in which states define routine, allow network adequacy exceptions (based on geographic differences, good faith negotiation efforts), determine the "community standard" or art of the possible)
  - States must have flexibility to navigate contracting with providers/health systems that try to extract unreasonably high rates, particularly in rural areas with limited workforce
  - Speire suggested that any access strategy developed for MMC should also be applied to FFS, to the extent possible

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[37] – 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."[38]

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.

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

[37] 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.

[38] 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"].

Organization (MAO) provider directories, including by working with external contractors to conduct secret shopper studies.[39] 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.[40]

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.[41] 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.[42] 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.[43]

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.[44,45] 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).[46] While not required, states may also conduct additional external quality review activities, including administering surveys or studies of beneficiary access and quality issues.[47] A number of states have taken advantage of this opportunity and leveraged external quality review organizations (EQROs) or other external vendors to conduct secret shopper surveys focused on issues of beneficiary access. While study approaches vary considerably across states, they typically focus on assessing appointment wait-times and the accuracy of provider directories.

Summary of RFI Comments on Access to Care

[39] [HYPERLINK "https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2016.pdf"]
[40] [HYPERLINK "https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2020-PY-FFE-Summary.pdf"]
[41] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747.
[42] https://www.medicaid.gov/medicaid/downloads/behavior-health-provider-network-adequacy-toolkit.pdf.
[43] https://journals.sagepub.com/doi/full/10.1177/0046958019838118.
[44] https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.
[45] https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf.
[46] 42 CFR § 438.358(b).
[47] 42 CFR § 438.358(c).

Managed Care Access Policy Sprint
Leveraging Provider Surveys to Measure Access and CMS Enforcement of Appointment Wait-Time Standards Memorandum
Updated September 2, 2022

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[48] (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).

[48] 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.

Message

From: Elizabeth Edwards [edwards@healthlaw.org]
Sent: 7/19/2023 7:21:04 PM
To: Costello, Anne Marie (CMS/CMCS) (b)(6) (b)(6)
CC: Jennifer Wagner [jwagner@cbpp.org]; CMS CMCS Unwinding (b)(6) (b)(6); Kahlaa Cannady [KCannady@mathematica-mpr.com]; akg72@georgetown.edu; Allison Orris [aorris@cbpp.org]; Barry, Meg (CMS/CMCS (b)(6) (b)(6); Bonelli, Anna (CMS/CMCS) (b)(6) (b)(6); Briskin, Perrie (CMS/CMCS) (b)(6) (b)(6) Delone, Sarah (CMS/CMCS) (b)(6) (b)(6) Harris, Monica (CMS/CMCS) (b)(6) (b)(6) Idil Samantar [isamantar@cbpp.org]; Joan Alker [jca25@georgetown.edu]; Kim Lewis [lewis@healthlaw.org]; Lovejoy, Shannon (CMS/CMCS) (b)(6) (b)(6) voudelman@healthlaw.org; O'Connor, Sarah (CMS/CMCS) (b)(6) (b)(6) perkins@healthlaw.org; Seng, Suzette (CMS/CMCS) (b)(6) (b)(6); Spector, Sarah (CMS/CMCS) (b)(6) (b)(6); Steinberg, Marc (CMS/CMCS) (b)(6) (b)(6) Stephens, Jessica (CMS/CMCS) (b)(6) (b)(6) Teal, Lela (CMS/CMCS) (b)(6); pab62@georgetown.edu; Tsai, Daniel (CMS/CMCS) (b)(6) Weiss, Alice (CMS/CMCS) (b)(6) (b)(6) Unwinding Support [UnwindingSupport@mathematica-mpr.com]; Katch (she/her), Hannah (CMS/OA) (b)(6) (b)(6) Ginnis (she/her), Kate (CMS/CMCS) (b)(6) (b)(6); Kuhn, Juliet (CMS/CMCS) (b)(6) (b)(6)
Subject: Re: Re: Unwinding Stakeholder Small-Group
Attachments: NE English_Spanish Redacted.pdf

As a follow up to our 7/13 meeting, attached is an example of the mixed English and Spanish notice from Nebraska that we mentioned. I believe this person had requested notices in Spanish.

Elizabeth

On Wed, Jul 12, 2023 at 9:09 AM Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov> wrote:

We would also like to share a preview on our approach to public reporting. I do not think we will have time to do through everything on the list below.

Anne Marie

From: Jennifer Wagner <jwagner@cbpp.org>
Sent: Wednesday, July 12, 2023 7:01 AM
To: CMS CMCS_Unwinding <CMCSUnwinding@cms.hhs.gov>; Kahlaa Cannady <KCannady@mathematica-mpr.com>; akg72@georgetown.edu; Allison Orris <aorris@cbpp.org>; Barry, Meg (CMS/CMCS) <meg.barry@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Delone, Sarah (CMS/CMCS) <Sarah.Delone2@CMS.hhs.gov>; edwards@healthlaw.org; Harris, Monica (CMS/CMCS) <Monica.Harris@cms.hhs.gov>; Idil Samantar <isamantar@cbpp.org>; Joan Alker <jca25@georgetown.edu>; Kim Lewis <lewis@healthlaw.org>; Lovejoy, Shannon (CMS/CMCS) <Shannon.Lovejoy@cms.hhs.gov>; youdelman@healthlaw.org; O'Connor, Sarah (CMS/CMCS) <Sarah.OConnor@cms.hhs.gov>; perkins@healthlaw.org; Seng, Suzette (CMS/CMCS) <Suzette.Seng@cms.hhs.gov>; Spector, Sarah (CMS/CMCS) <Sarah.Spector@cms.hhs.gov>; Steinberg, Marc (CMS/CMCS) <Marc.Steinberg@cms.hhs.gov>; Stephens, Jessica (CMS/CMCS) <Jessica.Stephens@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; pab62@georgetown.edu; Tsai, Daniel (CMS/CMCS) <Daniel.Tsai@cms.hhs.gov>; Weiss, Alice (CMS/CMCS) <Alice.Weiss@cms.hhs.gov>; Unwinding Support <UnwindingSupport@mathematica-mpr.com>; Katch (she/her), Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>; Ginnis, Kate (CMS/CMCS) <katherine.ginnis@cms.hhs.gov>; Kuhn, Juliet (CMS/CMCS) <Juliet.Kuhn@cms.hhs.gov>
Subject: RE: Unwinding Stakeholder Small-Group

Good morning –

Please see below for proposed agenda for tomorrow's meeting:

1. Data walkthrough – CMCS
2. Issues
    a. TMA – guidance on how states should handle?
    b. Which states have taken the waiver to delay procedural terminations by 30 days?
    c. Mitigation strategy columns on e14 chart – do these represent all mitigation strategies? Is some sort of high level summary still in the works?
    d. Rule on data reporting/enforcement
3. States
    a. Texas data?
    b. Kentucky – SSI cases (SSI recipients receiving renewal form, people who lost SSI during pandemic receiving termination notice without renewal)
    c. Montana – enrollees in renewal backlog losing coverage

d. Alabama call center – no telephonic renewal
e. Georgia call center – requires valid SSN/DOB or case ID to enter renewal queue; can't apply by phone
f. Nebraska – some notices have mixes of English and Spanish

Thanks,

Jen

Jennifer H. Wagner

Director of Medicaid Eligibility and Enrollment

Center on Budget and Policy Priorities

(312) 636-7437

-----Original Appointment-----
From: CMS CMCS_Unwinding <CMCSUnwinding@cms.hhs.gov>
Sent: Wednesday, April 5, 2023 10:13 AM
To: CMS CMCS_Unwinding; Kahlaa Cannady; akg72@georgetown.edu; Allison Orris; Barry, Meg (CMS/CMCS); Bonelli, Anna (CMS/CMCS); Briskin, Perrie (CMS/CMCS); Costello, Anne Marie (CMS/CMCS); Delone, Sarah (CMS/CMCS); edwards@healthlaw.org; Harris, Monica (CMS/CMCS); Idil Samantar; Joan Alker; Jennifer Wagner; Kim Lewis; Lovejoy, Shannon (CMS/CMCS); youdelman@healthlaw.org; O'Connor, Sarah (CMS/CMCS); perkins@healthlaw.org; Seng, Suzette (CMS/CMCS); Spector, Sarah (CMS/CMCS); Steinberg, Marc (CMS/CMCS); Stephens, Jessica (CMS/CMCS); Teal, Lela (CMS/CMCS); pab62@georgetown.edu; Tsai, Daniel (CMS/CMCS); Weiss, Alice (CMS/CMCS); Unwinding Support; Katch (she/her), Hannah (CMS/OA); Ginnis, Kate (CMS/CMCS); Kuhn, Juliet (CMS/CMCS)
Subject: Unwinding Stakeholder Small-Group
When: Thursday, July 13, 2023 4:30 PM-5:15 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://cms.zoomgov.com/j (b)(6)

Formerly known as NHELP and CBPP Meeting with CMCS

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

Join ZoomGov Meeting

https://cms.zoomgov.com/j/ (b)(6)

Meeting ID: (b)(6)

Password: (b)(6)

One tap mobile

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Meeting ID: (b)(6)

Find your local number: https://cms.zoomgov.com/u/a51XuLVsp

Join by SIP

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.

--

Elizabeth Edwards (she/her/hers)
Senior Attorney
National Health Law Program
1512 E. Franklin Street, Suite 110
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(984) 278-7664
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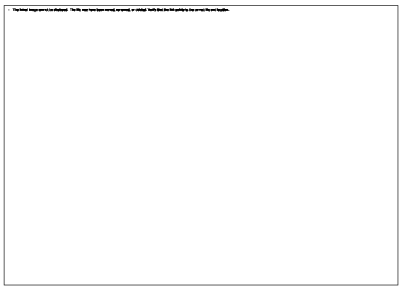

"Securing Health Rights for Those in Need"

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 2992
OMAHA NE 68103-2992

Case Number - [redacted]
Case Name -
CONTACT - Medicaid
Fax Number - (402)742-2351
Date of Notice - 03-23-2023

[redacted]

VERIFICATION REQUEST

In order to determine initial or continued eligibility for assistance, you must **return the following verification items by 04-22-2023. DHHS is required to assist you in obtaining requested verifications.** Contact us at the telephone number below if you are unable to obtain the requested verifications. Provide the requested verifications to the office address listed above or FAX to the number above or submit online at http://www.ACCESSNebraska.ne.gov.

Do not send original documents as the Department will not be able to return your documents.

Failure to provide verifications by 04-22-2023 could result in the denial, termination or decrease in your benefits.

Listed below are the verification items needed, the person we need them for, and the programs that require them in order to determine eligibility.

Earned Income

- Self-Employed Ledger (includes rental property)
  [redacted] MEDICAID

Comment(s) - Por favor proporcione verificación de ingreso y gastos de drywall de [redacted] para los meses de 12-22. Libros de contabilidad están incluidos para su conveniencia, pero no son requeridos. También puede proporcionar archivos de contabilidad de empleo-propio, y/o recibos de gastos de su negocio para el mes/los meses solicitados como verificación de ingreso y gastos de empleo-propio. Gracias.

Please make sure that your Master Case number is noted on anything that you send in to the agency. You may submit verifications to our agency in a number of ways:
1. In the enclosed return envelope or to the Department of Health & Human Services, PO Box 2992, Omaha, NE 68103
2. Via fax to 402-742-2351
3. Via email DHHS.ANDICenter@nebraska.gov
4. Electronically through the ACCESS Nebraska website (www.AccessNebraska.ne.gov)

Nebraska Medicaid Eligibility Toll Free: (855)632-7633 Lincoln: (402)473-7000 Omaha: (402)595-1178	Go online: ACCESSNebraska.ne.gov	Federal Health Insurance Marketplace Go online: Healthcare.gov Customer Service Center: (800)318-2596

Center on Budget and Policy Priorities

1275 First Street NE < Suite 1200 < Washington DC 20002
(202)408-1080< fax (202)408-1056 < center@cbpp.org < www.cbpp.org

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.

Message

From: Boozang, Patricia [PBoozang@manatt.com]
Sent: 8/16/2022 10:20:55 PM
To: Giles, John /CMS/CMCS (b)(6) (b)(6) Gentile, Amy A. (CMS/CMCS) (b)(6) ; Gibson, Alexis E. (CMS/CMCS) (b)(6)
CC: Llanos, Karen E.(CMS/CMCS) (b)(6) (b)(6) Thomas W Schenck [TSCHENCK@mitre.org]; Johanna L Barraza-Cannon [jbarrazacannon@mitre.org]; Serafi, Kinda [KSerafi@manatt.com]; Mann, Cindy [CMann@manatt.com]; O'Connor, Kaylee [KOConnor@manatt.com]; Striar, Adam [AStriar@manatt.com]; Peterson, Alanna [APeterson@manatt.com]
Subject: CMCS Medicaid Managed Care Access Sprint: Next Steps 8/16 Working Session
Attachments: Provider Survey_Secret Shopper Interview Takeaways_8.15.2022.docx; Provider Survey Memo 8.12.22..docx; Appointment Wait-Time Enforcement Recommendations 08.10.22.docx; Manatt_MITRE Medicaid Managed Care Access Sprint Support Workplan 08.12.2022 (002).docx; Follow-up on Rate Transparency; CMCS Access Strategy Enrollee Website Navigation 8.12.22.v.2.docx

John, Amy and Alexis,

Sharing below the next steps from our meeting earlier today, with supporting documents attached (and referenced below). Please let us know if you have any questions for us on the following, otherwise we will be in touch via email and plan to speak again next Thursday at our next working session.

Regards,

Patti

CMCS Access Policy Sprint Working Session Next Steps
Tuesday, August 16th, 12:00-1:00 PM ET

CMS:

- Share with CMS leadership updates from access discussions with states (including states convened by NAMD and Manatt, leveraging the attached ***Provider Survey_Secret Shopper Interview Takeaways*** for the latter).
- Discuss internally how prescriptive CMS would like to be for the secret shopper/provider survey proposed regulation, (b)(3), related to assessing disparities in access to care; and review the additional language related to methodological standards (see ***Provider Survey Memo 8.12.22*** attached for reference).
- Following discussions with leadership, share with MITRE/Manatt any additional feedback/questions on the ***Appointment Wait-Time Enforcement Recommendations 8.10.22*** Memorandum (attached for reference).
- Consider additional opportunities for states to access enhanced federal matching rates for access-related activities.
- Review revised Access Sprint Workplan (***Manatt_MITRE Medicaid Managed Care Access Sprint Support Workplan 8.12.22***) and provide feedback by email or during next week's 8/25 CMCS Access Policy Sprint Working Session.
- ***NEW SPRINT DELIVERABLE**: Review and provide feedback on new attached Memorandum related to optimizing the online experience for individuals enrolled in Medicaid Managed Care (see ***CMCS Access Strategy Enrollee Website Navigation 8.12.22*** attached for review.)

MITRE:

- Revisit comments provided on the Access RFI and share with this group any suggestions related to provider rate transparency in MMC.

- Share with CMS materials/resources from MITRE's ongoing rate transparency work with FMG in the FFS "skinny" rule (complete – see attached).

Manatt:

- Revise draft Secret Shopper/Provider Survey Preamble and Regulatory Text Memorandum to address state concerns while achieving CMS goals, describe how provider surveys can be used in conjunction with other tools to assess and ensure access to care, and define what other components or tools CMS might consider bundling with provider surveys
- Revise draft Appointment Wait-Time Implementation and Enforcement Recommendations Memorandum to reconsider specific data inputs that will trigger enforcement actions.
- Draft for CMS a memorandum outlining a structured NPRM approach to provider rate transparency in MMC — including draft regulations and preamble language, supporting research, and other considerations (e.g., alignment across Medicaid, the Marketplace, and Medicare).
- Share with CMS key takeaways from state interviews conducted to date on provider surveys/secret shopping; and, following forthcoming access interviews with NJ, AZ, FL, and TN, share additional takeaways with CMS. (complete, see attached)

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Date: Updated 8/15/2022
To: CMCS Sprint Team
From: Manatt Health
Re: Provider Survey/Secret Shopper Interview Takeaways

Table of Contents

Interview Takeaway Themes

- "Secret Shopper" term is misleading; states do both "secret" and "revealed" **provider surveys**
- "Many" states do provider surveys
- Provider surveys are effective in identifying access issues
- Support for EQRO role in provider surveys
- Support for CMS technical assistance (TA), including a template
- Caution with regard to CMS being overly prescriptive in setting requirements for provider surveys; states require flexibility
- CMS will need to tailor TA and enforcement to regional access challenges
    - Need to tailor TA to state variation – best practices for New England states are not best practices for frontier states
    - Some access issues, in rural areas in particular, present significant and hard to address challenges
- Survey frequency in states ranges from quarterly to annually; most states conduct surveys annually
- CMS should consider using and requiring state use of other effective mechanisms to identify access issues, including: T-MSIS data, encounter/claims data, appeals and complaints data
- Rural geographies have unique challenges with regard to provider surveys (e.g., "Stawmodel Patient" personas for secret shopping are easy to spot.)
- State challenges in standing up provider survey programs including funding and capacity; interviewees did not suggest that provider surveys are otherwise difficult or time intensive to implement, but for these issues
- Several interviewees suggested guidance and using EQROs with enhanced match would mitigate the funding and capacity issues

Summary of Interviews

Interview Takeaways – Jonathan Bick and colleagues, New York State Dept. of Health (June 27, 2022)

- General overview of state approach to secret shopper program
    - State uses EQRO to conduct secret shopper studies
    - EQROs survey PCPs, plan member services hotlines, and provider directories
        - For PCPs, surveyors assess appointment wait times for routine and urgent appointments
        - For member services hotlines, surveyors assess the following:
            - Accuracy of provider network information
            - Approaches to prior authorization
            - Whether certain services are covered
        - For provider directories, surveyor uses "revealed survey" approach to assess against 75% accuracy level

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Re: Provider Survey/Secret Shopper Interview Takeaways

  - Surveys are conducted once per year
  - Providers are selected on a randomized basis from each plan's network list
  - Providers with closed panels are not surveyed
  - Survey results can lead to a plan receiving a statement of deficiency or a plan of correction; plans can also be assessed financial penalties after multiple violations, but this is rare
  - Survey results are not made public
- Other impressions
  - Program has been subject to budget cuts in the past; this is not related to concerns about this specific program but rather overall state budgetary concerns
  - State has uncovered significant issues around appointment wait times through secret shopper studies
  - State feels that program does what it is intended to do

Interview Takeaways – Tom Betlach, Speire Healthcare Strategies (July 19, 2022)

- Overall thoughts
  - CMS should ensure it considers fee-for-service (FFS) Medicaid in establishing access/secret shopper requirements
    - States generally have less infrastructure/coordination in their FFS programs
    - FFS programs often include vulnerable populations
    - FFS reimbursement lags managed care in many states, exacerbating access issues
  - Secret shopper
    - Secret shopper studies are generally an effective tool for measuring access
    - They are particularly helpful for providing real-time feedback to states on access issues; states have the ability to target studies based on emerging concerns
    - Studies generally do not require advanced analytics; possible to get a large sample size relatively quickly
- Secret shopper – survey entity
  - Good idea to encourage States to use EQROs to conduct secret shopper studies
  - States generally underutilize EQROs; they can serve as a staff multiplier and are independent from plans
- Secret shopper
  - Supportive of CMS providing technical support, including a template, as long as it is not prescriptive (i.e., help states do it, don't require them to do it a specific way)
  - States need to be able to quickly target their unique and emerging access concerns; study design flexibility helps with this
  - Studies need to measure against "community access standard"; some states may not have particular kinds of specialists in certain areas
  - CMS should consider how to account for telehealth
- General access considerations
  - CMS should consider which access metrics are important beyond just time and distance
  - Appeal/grievance volume is a strong indicator of access issues; indicates that beneficiaries are struggling to access needed care
  - CMS should be careful in establishing new requirements to not increase states' risk of litigation

Interview Takeaways – Mary Beth Dyer, Bailit Health (July 29, 2022)

- General perspective on secret shopper

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Re: Provider Survey/Secret Shopper Interview Takeaways

  - Many states have done these surveys
  - Some use EQROs – these are valuable because they let states be efficient with staff resources and access enhanced matching funds
  - States should be thinking about how to prioritize high volume providers and areas where there are documented access concerns
  - States should be pushing plans to ensure surveys are sufficiently robust and catching providers with many Medicaid members
  - Live secret shopper surveys are most valuable for assessing appointment wait times; states may be able to leverage centralized provider enrollment data to do automated checks of provider directories
  - States/CMS could consider monitoring for "open block scheduling" (important for dealing with urgent issues)
  - Some states pose as beneficiaries; some reveal that they are working with the state – revealing state affiliation can be beneficial since providers "know they're being watched"
- Independent entities vs. delegating to plans
  - States should be doing both
  - Plans should be doing their own surveys to monitor their networks
  - EQROs are efficient from a match rate/staffing perspective, but CMS will need to provide TA
- How to do a better job of assessing network adequacy
  - Unclear if EQROs currently have the expertise to do this since network adequacy monitoring is new
  - Regional variation is a huge issue – networks look very different across states/regions; could CMS leverage regional offices to support TA?
  - Large states generally have more robust machinery in place to do network monitoring since they have many plans/providers
  - CMS could look to leverage MA requirements
  - States should survey providers that have not submitted a single claim over the previous year; it signals access issues for that provider
  - States should also survey high volume providers
  - Other ways to look at access issues – e.g., CA looks at high risk members with an ED visit and no PCP visit; CMS/other states could consider leveraging this type of data approach through T-MSIS, claims/encounter data
- Secret shopper value proposition
  - States don't have the resources in-house to do these surveys; leveraging EQROs can be helpful
  - EQRO processes are very regimented; CMS will need to let states be flexible/responsive in administering these surveys – important that results be made available quickly (i.e., this is monitoring, not evaluation)
- Enforcement
  - California is doing interesting work here but advocates think there are too many exceptions for plans and that it is too easy for them to get around rules
  - Florida has a very IT-focused approach to assessing against contract requirements; plans think state is too aggressive with liquidated damages
  - Generally big states are better at enforcement than small states
- Appointment wait time standards
  - Will be difficult to find a standard that is applicable across the country; huge network variation by region
  - CMS should provide TA, but consider state best practices looking at different regions (i.e., what works in Rhode Island may not be helpful to Montana)

Date: Updated 8/15/2022
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Re: Provider Survey/Secret Shopper Interview Takeaways

Amber Saldivar and colleague, Health Services Advisory Group (EQRO) (August 2, 2022)

- Overview of secret shopper activities
  - Conduct both secret and "revealed" shopper surveys
  - Currently serving approximately 7-8 states
  - Assist states with survey design and implementation, including sampling, script development, data aggregation/reporting
  - Surveys examine whether providers accept health plan coverage and appointment availability
  - Providers examined include primary care, dental, and OB; surveyors look for both urgent and routine appointments
- Secret vs. "revealed" surveys
  - Revealed surveys allow for collection of more data from providers
  - Revealed surveys work better for certain appointment/provider types; for example, it is difficult to test access to behavioral health treatment using secret shopper surveys (since this generally requires a detailed accounting of symptoms). Similarly "established patient" access can only be tested through revealed surveys.
- Survey focus priorities
  - Appointment wait times
  - Provider directory accuracy (including contact information, location, and types of services provided)
- Timing considerations
  - Launching a new program takes approximately 6 months
  - Surveys take approximately 4-6 weeks to administer
  - Able to make survey results available within three months from completion of survey
  - Most states conduct annual studies; some use a quarterly cycle
- Sample size considerations
  - Attempt to ensure a 95% confidence level but sometimes sample sizes are limited based on state budget considerations
  - Samples are sometimes stratified by subspecialty or region (these decisions are driven by the state)
- Advantages of using an EQRO
  - EQROs are independent from plans
  - Plan surveys tend to be smaller and are not always statistically representative
- Access issues identified
  - Provider directories often contain bad phone numbers/addresses
  - Some providers make new beneficiaries jump through hoops to schedule appointments
- Key challenges
  - Some states do not have accurate information on specialty type by provider
- Other considerations
  - Studies are most effective when linked to penalties and posted publicly
  - "Straw model" Medicaid IDs may help surveyors get further along in appointment scheduling process

Paul Henfield and colleague, IPRO (EQRO) (August 4, 2022)

- Overview of secret shopper activities
  - Conduct secret shopper surveys for approximately half of states where IPRO has an EQRO contract

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  - Conduct surveys of PCPs, BH providers, dentists, and certain other specialists using provider lists provided by plans
  - Develop survey scenarios in conjunction with states
  - Look at urgent, non-urgent, and after hours visits
  - Check against appointment wait time standards and whether a provider has an open panel; providers with closed panels are not surveyed
  - Also review provider directories for accuracy
  - Conduct both secret and revealed surveys
    - Secret shopper surveys are valuable because they mimic the actual beneficiary experience
    - Generally regard revealed survey findings to be less reliable
- Best practices
  - Important to engage plans and providers in rolling out surveys
  - Important for surveyors to cancel "straw model" appointments before end of each call; failing to do so can lead to backlash from providers
  - Use blinded telephone numbers; large provider call centers can catch on to repeat callers
  - Screen provider lists for duplicates
- Key challenges
  - Many states do not establish "straw model" Medicaid IDs; this makes scheduling appointments more challenging
  - Difficult to assess BH provider access; often very difficult to reach a live person and providers often require triage before beneficiaries can get scheduled for an appointment
- Timing considerations
  - Most states conduct annual surveys; some do quarterly assessments
  - IPRO can launch a new survey within one month and publish results quickly based on state need
- Access issues identified
  - Access to BH providers is very poor for Medicaid beneficiaries; often very difficult to access appointments in a timely manner

Martha Heberlein and colleague, MACPAC (August 4, 2022)

- Perspective on secret shopper studies
  - Studies are not consistently done across states
  - Studies can be burdensome
  - Challenging to survey for access issues for certain types of services (e.g., HCBS)
  - States that assign panels to providers are more challenging to survey since members generally cannot schedule an appointment unless they are assigned to that provider
  - Surveys are challenging in rural areas because providers tend to know community members and can recognize a "straw model" caller
  - Assessing provider access through annual licensure process may be more effective
  - T-MSIS may also be more effective, but CMS would need to improve the quality of provider service data
  - Beneficiary surveys may also be effective for measuring wait times
- How to make secret shopper surveys successful
  - Need to provide TA and funding to states
  - CMS should consider standardizing data collection
  - Providing states with a template would be helpful
  - Using EQROs may be helpful for solving state capacity issues

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Re: Provider Survey/Secret Shopper Interview Takeaways

Lisa Truitt and colleague, DC Medicaid (August 15, 2022)

- Overall approach
  - DC contracts with its EQRO to conduct provider surveys; MCOs are also required to conduct their own surveys
  - EQRO conducts "revealed" surveys; MCOs conduct secret shopper surveys
  - Believe combined approach is most effective
- MCO secret shopper surveys
  - Medicaid managed care plans are required under contract to conduct secret shopper surveys at least annually
  - Secret shopper surveys assess member access to services, appointment wait times, provider availability, member difficulty in getting an appointment
  - Surveys target high volume provider practices specifically
- EQRO revealed provider surveys
  - EQRO conducts a network adequacy verification project annually and publishes reports of findings, including results from revealed shopper surveys, validation of accuracy of provider directory information and appointment wait times[1], and appropriate provider-to-enrollee ratios
  - Results from EQRO revealed provider interviews are shared with plan
  - EQRO reports give plans additional information to hold their providers accountable
  - EQRO shares updates to provider directories with plans in real time, and coordinates to ensure providers are not called by plans and an EQRO in the same month
  - DC claims 75% FMAP for expenditures associated with the EQRO provider survey
- Secret vs. revealed survey considerations
  - Both secret and revealed shopper surveys work well if they are highly coordinated but each have their own advantages
  - Advantages of secret shopper surveys
    - Providers tend to tell callers "what they want to hear" during revealed surveys (i.e., there is greater confidence in the accuracy of information obtained through secret shopper surveys)
    - MCO-led secret shopper surveys ensure plans are held responsible for identifying and addressing access issues and give plans a sense of accountability
  - Advantages of revealed surveys
    - DC obtains candid information from revealed surveys about provider concerns (e.g., overscheduling policies to compensate for no shows that lead to longer appointment wait times); surveys offer an opportunity for providers to report on what is not working well and offices are often eager to share information
    - Revealed surveys work well in smaller areas, where the providers get calls often
    - Provider groups are generally more appreciative if surveys are revealed; providers sometimes react negatively to scheduling appointments for fake Medicaid members as part of secret shopper surveys
- Access measures

[1] The EQRO monitors select appointment waiting time standards, including 30 days for PCPs and 24 hours for urgent appointments. DC does not set appointment waiting time standards for plans, but rather, allows plans to define their own appointment waiting times as part of their network adequacy strategy for review and approval.

  - DC is planning to add "third next available appointment," or 3NAA, a new NCQA new measure and PCMH standard to measure true appointment availability more accurately.[2]
  - DC is focused on appointment wait times and wants to do more in this area
- Results/accountability
  - Results from EQRO revealed provider surveys are made public
  - Plans are currently not held accountable based on survey findings due to procurement challenges, but DC is looking at MD's EQRO access report as a model, which does hold plans accountable
  - DC plan to add confidence intervals around network adequacy access measures and may potentially put plans on Corrective Action Plans (CAPs)s based on these intervals.
- Access issues identified
  - DC has not uncovered lack of available providers (DC currently contracts with 480 providers), but has identified access issues related to lack of transportation, appointment no shows
  - Provider directories are usually 50% accurate across all required components (i.e., provider practices at the practice called, provides desired service, is accepting new patients, accepts insurance, has the same name listed in the provider directory)
- Provider survey cost estimate/staffing
  - DC estimates cost of approximately $100,000/year for revelated shopper surveys
  - EQRO subcontracts survey administration; DC does not have details on FTE or staff hours required to conduct the survey
  - One DC Medicaid FTE oversees the EQRO and a second oversees MCO network adequacy activities
- Access data analysis
  - DC runs reports on their own data, including geo-access reports; they do not analyze T-MSIS data
  - DC conducts routine conversations with providers to assess access issues
  - DC does thorough analyses and evaluations of grievances and appeals, and identify concerns with specific providers or service areas indicated in these reports

[2] 3NAA is defined as: average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability. Source: [HYPERLINK "https://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx" \l ":~:text=Average%20length%20of%20time%20in,exam%2C%20or%20return%20visit%20exam"]

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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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.

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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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Proposal	High-Level Proposed Regulatory Requirements	Context/Considerations for Promulgating Regulations *(To Inform/Be Leveraged By CMS For Preamble Language)*
	(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

Proposal	High-Level Proposed Regulatory Requirements	Context/Considerations for Promulgating Regulations *(To Inform/Be Leveraged By CMS For Preamble Language)*
		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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	(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.

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	(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.

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.

Message

From: Thomas W Schenck [TSCHENCK@mitre.org]
Sent: 8/16/2022 5:20:25 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) [john.giles1@cms.hhs.gov]; Gibson, Alexis E. (CMS/CMCS) [alexis.gibson@cms.hhs.gov]; Gentile, Amy A. (CMS/CMCS) [amy.gentile@cms.hhs.gov]; Johanna L Barraza-Cannon [jbarrazacannon@mitre.org]; Rebecca Case [rebeccacase@mitre.org]
CC: Llanos, Karen E.(CMS/CMCS) [karen.llanos@cms.hhs.gov]
Subject: Follow-up on Rate Transparency
Attachments: 20220621_Attachment A_Annotated Bibliography_Rate Reduction Policy Sprint_MITRE.docx; 20220621_Literature Review Summary_Rate Reduction Policy Sprint_MITRE.docx

Hi John et al,

Following up on our call just now (I was trying to get off mute, but the audio gods were not in my favor), I did want to mention that MITRE is supporting FMG with their rate transparency provision in the FFS skinny rule. They mentioned that they are having discussions with DMCP, but they know that we are also in talks and are ok with us sharing insight into their direction during our managed care rate transparency talks. To the degree the goal is alignment with the FFS policy, we're happy to provide insight into our FFS discussions on future calls.

I have also attached a literature review summary and annotated bibliography that we provided to FMG earlier this summer. This looked more generally at the association between provider rates and measures of access, but many of the studies quantified their findings in terms of the Medicaid/Medicare fee ratio. I'll also flag for context that FMG's policy is looking at both transparency and exploring a fee ratio threshold which would trigger additional access analysis, which influences the structure of the lit review summary somewhat.

Thanks,

Tom Schenck
Health Program Analysis and Transformation, Principal
The MITRE Corporation | Health FFRDC
CMS Coverage, Payment, and Equity
781-261-1393

Attachment A

Annotated Bibliography: Associations between Provider Reimbursement and Access

1. Alexander, D., and Molly Schnell. "The Impacts of Physician Payments on Patient Access, Use, and Health", National Bureau of Economic Research, Working Paper 26095, July 2019 (revised August 2020), p. 1-74. [HYPERLINK "https://www.nber.org/papers/w26095"], Accessed June 16, 2022

   Research Question: How do provider fee increases and decreases impact beneficiary access to office visits, self-reported health, and school absenteeism?

   Findings: Using the ACA's mandatory primary care physician fee increase up to Medicare reimbursement from 2013-2014, the authors found that there was a linear association between provider fee increases and decreases and Medicaid office-visit availability, the number of beneficiary office visits, beneficiary self-reported health, and school absenteeism among children.

   Key Excerpt: "The difficulties that Medicaid patients face accessing care is commonly attributed to a combination of complex patient needs, billing complications, and low reimbursement rates. This has led policy makers, practitioners, and researchers alike to argue that increasing reimbursement rates alone will not be enough to improve the provision of care to Medicaid beneficiaries (Goroll, 2018). In turn, efforts to promote health care access and use have largely focused on dimensions of demand-side insurance generosity, such as program eligibility and patient cost-sharing. In contrast, we find that the majority of differences in access between Medicaid beneficiaries and privately insured patients are driven by differences in physician reimbursement. Not only does increasing Medicaid reimbursement rates improve access, but these improvements in access lead to meaningful improvements in self-reported health and school absenteeism among the program's beneficiaries." (P. 34-35).

2. Atherly, Adam, and Karoline Mortensen. "Medicaid Primary Care Physician Fees and the Use of Preventive Services among Medicaid Enrollees", *Health Services Research*, Volume 49, Issue 4, August 2014, p. 1306-1328. [HYPERLINK "https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12169"] Accessed June 16, 2022

   Research Question: This study modeled the relationship between Medicaid preventive care payment rates and the use of U.S. Preventive Services Task Force (USPSTF) services among Medicaid enrollees.

   Findings: Although temporary changes in primary care provider payments for preventive services for Medicaid enrollees may have other desirable effects, they are unlikely to substantially increase the use of these selected USPSTF-recommended preventive care services among Medicaid enrollees.

Key Excerpt: "Although Medicaid enrollees had a lower rate of use of the five preventive services (breast cancer, cervical cancer, cholesterol, blood pressure, and colorectal cancer) in univariate analysis, neither Medicaid enrollment nor changes in Medicaid payment rates had statistically significant effects on meeting screening recommendations for the five screenings." (p. 1306)

3. Berman, S., et al. "Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients" *Pediatrics,* Volume 110, Issue 2, August 2002, p. 239-248 [HYPERLINK "https://publications.aap.org/pediatrics/article-abstract/110/2/239/64380/Factors-That-Influence-the-Willingness-of-Private?redirectedFrom=fulltext"] Accessed June 16, 2022

Research Question: How do payment levels, prevalence of capitated Medicaid payment, and paperwork concerns influence Medicaid participation by office-based primary care pediatricians?

Findings: The authors found that pediatrician participation increased with state Medicaid payment levels, both in terms of provider accepting all new Medicaid patients and as far as providers' relative participation with non-Medicaid payers and patients.

Key Excerpt: "These data indicate a strong relationship between low payment and low participation rates. The findings hold true using 2 alternative measures of pediatrician participation: 1) the proportion of private office-based primary care pediatricians who accept all Medicaid patients who request care ("full participation") and 2) the ratio of pediatricians who accept all Medicaid versus all non-Medicaid patients ("relative participation"). By both measures (full and relative participation), providers in states in the lower quartiles of Medicaid payments in terms of 1) overall payment for primary care services and 2) child-specific payments for 3 frequently used primary care pediatric codes have significantly lower participation rates than those in higher paying states." (p. 247-248)

4. Candon, M., et al. "Declining Medicaid Fees and Primary Care Appointment Availability for New Medicaid Patients" *JAMA Internal Medicine*, Volume 178, Number 1, January 2018, p. 145-146. [HYPERLINK "https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2663253"] Accessed June 16, 2022

Research Question: How did declining Medicaid fees following the expiration of the ACA Medicaid Primary Care Payment increase impact primary care appointment availability for new Medicaid patients?

Findings: The authors found a statistically significant decrease in primary care appointment availability when Medicaid fees decreased following the expiration of the ACA PCP bump. This decrease was consistent with the level of the increase in appointment availability following the ACA PCP bump's enactment.

Key Excerpt: "The association between Medicaid fees and primary care appointment availability for new Medicaid patients is robust and not dependent on whether fees increase or decrease. Historically, reductions in Medicaid funding have led to states lowering their Medicaid fees. These findings indicate that reductions in Medicaid funding would affect the breadth of primary care physician participation in Medicaid and may compromise access to primary care for new Medicaid patients." (p. 146)

5. Chen, A. "Do the Poor Benefit from More Generous Medicaid Policies" SSRN Electronic Journal, January 2014, p. 1-46. [HYPERLINK "https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2444286"] Accessed June 16, 2022

   Research Question: How do increases in reimbursement impact physician participation in Medicaid, physician delivery of services to Medicaid beneficiaries, volume of physician charity care, and Medicaid enrollment?

   Findings: This study finds a positive association between Medicaid rate increases and Medicaid physician participation as well as Medicaid physicians' willingness to accept all new Medicaid patients. It also finds a positive association between rate increases and Medicaid enrollment, which it suggests could be a result of providers encouraging patients to enroll in Medicaid (it notes a corresponding negative association between Medicaid payment rates and volume of charity care delivered by physicians).

   Key Excerpt: "I show that when Medicaid payment rates increase by 10%, 0.6 out of 100 non-participating physicians will newly participate in Medicaid, 1.2 of 100 active physicians will begin to accept all new Medicaid patients, and the percent of revenue from Medicaid will increase...Row (1) demonstrates that a 10% increase in the average Medicaid payment rate is associated with a 2.3% increase in Medicaid enrollment." (p. 14-15)

6. Chatterji, P. et al. "Medicaid Physician Fees and Access to Care Among Children with Special Health Care Needs" National Bureau of Economic Research, Working Paper 26769, February 2020, p. 2-54. [HYPERLINK "https://www.nber.org/papers/w26769"] Accessed June 16, 2022

   Research Question: Are Medicaid physician fees correlated with access to health services and adequacy of insurance coverage among children with special health care needs (CSHCN).

   Findings: The study finds a positive association between increasing Medicaid physician fees and increased likelihood of having a usual source of care, improved access to specialty doctor care, and large improvements in caregivers' satisfaction with the adequacy of health insurance coverage, among publicly-insured CSHCN.

   Key Excerpt: "Our findings indicate that raising the Medicaid primary care fee level close to at least 90 percent of the Medicare level reduces the likelihood that publicly-insured CSHCN lack a usual source of care in a doctor's office by about 15 percent." (p. 5)

7. Cohen, J.W., and Peter J. Cunningham "Medicaid Physician Fee Levels and Children's Access to Care" *Health Affairs: DataWatch,* Volume 14, Number 1, Spring 1995, p. 255-257. [HYPERLINK "https://www.healthaffairs.org/doi/10.1377/hlthaff.14.1.255" \l ":~:text=In%20the%20least%20generous%20states%20%28fee%20ratios%20less,where%20the%20fee%20ratio%20is%20about%2080-89%20percent."] Accessed June 16, 2022

   Research Question: The study examines the effects of physician fees on children's use of preventive and illness-related ambulatory physician services under the Medicaid program.

   Findings: There is a strong association between the relative generosity of Medicaid reimbursement and Medicaid children receiving care. The higher the fee ratio, the more likely children will go to a doctor's office for care rather than a hospital-based facility.

   Key Excerpt: "In states where fee ratios less than 50%, 20% of Medicaid children would access hospital-based facilities, but in states where ratios are 80-89%, only 6% of children used hospital-based facilities." (p. 256)

8. Cohen, J. W., "Medicaid Physician Fees and Use of Physician and Hospital Services", *Inquiry,* Volume 30, Number 3, Fall 1993, p. 281-292 [HYPERLINK "https://www.jstor.org/stable/29772389?utm_source=pdf_workspace&utm_medium=pdf_workspace&utm_campaign=0e28ab3f-4ca5-4794-8b6f-d2b8a08bb895&utm_content=stable"] Accessed June 16, 2022

   Research Question: How do Medicaid physician fees affect physician service utilization, the site of physician care, and the probability of beneficiary hospitalization?

   Findings: The author found no association between the Medicaid-Medicare provider fee ratio and physician utilization. However, the author did find a positive association between the Medicaid-Medicare provider fee ratio and the use of office-based physician care. Higher utilization of office-based physician care in turn was found to be associated with a lower chance of hospital admission. The author suggested that the corresponding decrease in hospital admissions could off-set any Medicaid spending associated with raising physician reimbursement rates.

   Key Excerpt: "The results indicate the Medicaid fee ratio is associated with where Medicaid beneficiaries usually receive ambulatory physician care. With other factors held constant at the mean, the results indicate that a 10% increase in the fee ratio is associated with a 1.5% increase in the probability of having an office-based physician as a usual source of such care." (p. 287)

9. Decker, S. "No Association Found Between the Medicaid Primary Care Fee Bump and Physician-Reported Participation in Medicaid", *Health Affairs,* Volume 37, Number 7. July 2018, p. 1092-1098 [HYPERLINK "https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0078" \l ":~:text=The%20result%20was%20an%20average%2073%20percent%20increase,participation%20in%20Medicaid.%20No%20such%20association%20was%20found."] Accessed June 16, 2022

Research Question: Was the ACA's Medicaid PCP bump associated with an increase in physician-reported Medicaid participation?

Findings: The author did not find an association between the ACA's PCP bump and increased physician participation in Medicaid. However, the author did note higher physician participation in states that had a highest Medicaid-Medicare fee ratio before the ACA's PCP increase was implemented and observed a small increase in physician participation among those states high ratio states while the ACA PCP bump was in effect. This led the author to suggest that it was the temporary nature of the fee increase that may have blunted its impact.

Key Excerpt: "In each year, both measures of physician participation in Medicaid on the extensive margin were significantly higher for states with high pre-bump fee ratios than for those with low ratios. However, the percentages of physicians accepting new Medicaid patients did not increase over time, overall or to an extent that was larger for states with low 2012 fee ratios and therefore larger fee bumps. The percentage of physicians reporting more than 1 percent of patients on Medicaid showed a small upward trend between 2011 and 2013–14, although the increase came from the states in the lowest fee bump category—that is, states that had the highest Medicaid fees to begin with." (p. 1095)

10. Decker, S. "Changes in Medicaid Physician Fees and Patterns of Ambulatory Care" *Inquiry*, Volume 46, Fall 2009, p. 291-304 [HYPERLINK "https://journals.sagepub.com/doi/pdf/10.5034/inquiryjrnl_46.03.291"] Accessed June 16, 2022

Research Question: Do Medicaid physician payment levels affect the volume of visits or site of care for Medicaid patients?

Findings: The author found a 'significant link' between Medicaid-Medicare fee ratio and the volume and site of care for Medicaid beneficiaries. The author noted this association was larger than associations observed in previous studies using older data.

Key Excerpt: "All else equal, decreasing the fee ratio from 1 to .64 increases by 10.7 percentage points the probability that a Medicaid visit takes place in an outpatient hospital department rather than a physician's office...The difference in difference estimate of the effect on the probability that a Medicaid visit takes place in the emergency department when the ratio is cut from 1 to .64 is five percentage points, a 23.6% increase relative to the average percentage of Medicaid visits that take place in an ED (21.2%) at a fee ratio of 1." (p. 298)

11. Fakhraei, H. "Payments for Physician Services: An analysis of Maryland Medicaid Reimbursement Rates" *International Journal of Healthcare Technology and Management, Volume 7,* Numbers 1-2, January 2005, p. 129-142 [HYPERLINK "https://www.researchgate.net/publication/228637758_Payments_for_physician_services_An_analysis_of_Maryland_Medicaid_reimbursement_rates"] Accessed June 16, 2022

Research Question: How did improving the Medicaid-Medicare fee ratio impact primary care physician participation in Medicaid in Maryland?

Findings: The author found that improving the Medicaid-Medicare fee ratio in Maryland from 36% in 2001 to 62% in 2002 led to an increase in primary care physician participation.

Key Excerpt: "Following the increase in reimbursement rates, physicians substantially increased their participation in the fee-for-service program. However, prior to the fee increase, many MCOs had sufficient numbers of primary care physicians in their networks. Therefore, they did not substantially increase the number of their contracting primary care physicians. This led to a modest overall increase in the number of primary care physicians who participate in the Medicaid program." (p. 138)

12. Fox, M., et al. "Effect of Medicaid Payment Levels on Access to Obstetrical Care", *Health Affairs: DataWatch,* Volume 11, Number 4, Winter 1992, p. 150-161 [HYPERLINK "https://www.healthaffairs.org/doi/10.1377/hlthaff.11.4.150"] Accessed June 16, 2022

Research Question: How did increasing Medicaid fees impact obstetric provider participation in Maryland Medicaid?

Findings: The authors found that increases in obstetric fees resulted in a short-term increase in provider participation that waned over time, but a moderate and sustained increase in caseload among participating providers. This increased caseload was particularly pronounced among those providers that were in the upper quartile of participants initially.

Key Excerpt: "The relationship of fees to participation appears to be valid only for providers whose increase in participation placed them in the upper quartile of all participants at whom the fee increase was targeted." (p. 158)

13. Holgash, K. and Martha Heberlein "Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't" *Health Affairs,* April 10, 2019. [HYPERLINK "https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/" \l ":~:text=Physicians%E2%80%99%20acceptance%20of%20new%20Medicaid%20patients%20is%20only,of%20Medicaid%20patients%20already%20in%20the%20physician%E2%80%99s%20care."] Accessed June 16, 2022

Research Question: Have the following state policies affected acceptance of new Medicaid patients: 1) managed care penetration; 2) expansion status; 3) Medicaid payment rates (compared to Medicare)?

Findings: Of the three policy levers examined, only higher Medicaid fees were tied to higher Medicaid acceptance rates. Authors noted a limitation of the study is that physicians' acceptance of new Medicaid patients is only one access measure. Making appointments can still

be challenging, physicians' acceptance of new patients may be limited, and wait times can be long. Also, the analysis did not include other types of clinicians and settings where Medicaid beneficiaries may be receiving care.

Key Excerpt: "We found that physicians in states that pay above the median Medicaid-to-Medicare fee ratio accepted new Medicaid patients at higher rates than those in states that pay below the median, with acceptance rates increasing by nearly 1 percentage point (0.78) for every percentage point increase in the fee ratio."

14. MACPAC "An Update on the Medicaid Primary Care Payment Increase", *Report to Congress on Medicaid and CHIP. Chapter 8: An Update to the Medicaid Primary Care Payment Increase*. March 2015, p. 130-138. [HYPERLINK "https://www.macpac.gov/publication/an-update-on-the-medicaid-primary-care-payment-increase-3/"] Accessed June 16, 2022

Research Question: MACPAC's qualitative study examined the impact of the ACA's PCP bump on primary care provider participation in Medicaid.

Findings: States generally reported little to no impact on access as a result of the payment increase; however, MACPAC acknowledged the limitations of the study –in particular, the payment increase was delayed in all states to varying degrees, and the interviews took place prior to the expiration of the payment increase (i.e., not too long after it had gone into effect in many states). All states also noted that they did not have resources to conduct a formal evaluation of the impact.

Key Excerpt: "We interviewed state Medicaid agencies, Medicaid MCOs, and provider organizations between June and September 2014. We learned that although early operational issues had largely been resolved, uneven implementation led to payment delays. These delays, combined with the short time frame in which the provision was in effect, made it difficult to measure its effects before it expired." (p. 131)

15. Mulcahey, A. et al "Associations Between the Patient Protection and Affordable Care Act Medicaid Primary Care Payment Increase and Physician Participation in Medicaid." *Jama Internal Medicine,* August 2018, p. 1042-1048 [HYPERLINK "https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2687526"] Accessed June 16, 2022

Research Question: This study assessed whether the ACA Medicaid PCP pay bump was associated with changes in Medicaid participation rates or Medicaid service volume among PCPs.

Findings: This study used 2012 to 2015 IMS Health aggregated medical claims and encounter data from PCPs eligible for the payment increase practicing in all states except Alaska and Hawaii. Among 20 723 PCPs, the payment increase had no association with PCP participation in Medicaid or Medicaid service volume.

Key Excerpt: "Our findings suggest that the ACA payment increase had little or no association with Medicaid participation and service volume. This does not mean that a differently formulated payment policy could not have achieved more robust outcomes or that states spending some of their own funds to maintain higher payment rates are erring. The short duration of the ACA payment increase, its delayed implementation, and its complicated attestation process may have contributed to our results."

16. Polsky, D. et al. "Appointment Availability after Increases in Medicaid Payments for Primary Care." *New England Journal of Medicine*, February 5, 2015, p. 537-545. [HYPERLINK "https://www.nejm.org/doi/10.1056/NEJMsa1413299?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200www.ncbi.nlm.nih.gov"] Accessed June 16, 2022

Research Question: Did ACA Medicaid PCP bump impact primary care appointment availability for doctors participating in Medicaid.

Findings: Researchers found that increasing Medicaid PCP payment rates led to an increase in Medicaid appointment availability without increasing wait times for new-patient appointments.

Key Excerpt: "The availability of primary care appointments in the Medicaid group increased by 7.7 percentage points, from 58.7% to 66.4%, between the two time periods [from November 2012 through March 2013 and from May 2014 through July 2014]. The states with the largest increases in availability tended to be those with the largest increases in reimbursements, with an estimated increase of 1.25 percentage points in availability per 10% increase in Medicaid reimbursements (P = 0.03). No such association was observed in the private-insurance group. During the same periods, waiting times to a scheduled new-patient appointment remained stable over time in the two study groups." (p. 537)

17. Sloan, F. et al "Physician Participation in State Medicaid Programs." *The Journal of Human Resources,* Volume 13, Supplement: National Bureau of Economic Research Conference on the Economics of Physician and Patient Behavior, 1978, p. 211-245. [HYPERLINK "https://www.jstor.org/stable/145253?seq=1"] Accessed June 16, 2022

Research Question: What is the impact of physician reimbursement and administrative burdens on physician participation in Medicaid?

Findings: The authors found a direct link between physician reimbursement levels and Medicaid participation. This study was the first of its kind in the Medicaid space.

Key Excerpt: "Low fee schedules were most frequently mentioned as a reason for physician nonparticipation in Medicaid; almost half (44.4 percent) of all physicians questioned attributed their nonparticipation to excessively low fees." (p. 223)

18. Suk-fong S., Tang, et al "Increased Medicaid Payment and Participation by Office-Based Primary Care Pediatricians", *Pediatrics*, Volume 141, number 1, January 2018, p. 1-9 [HYPERLINK "https://publications.aap.org/pediatrics/article/141/1/e20172570/37705/Increased-Medicaid-Payment-and-Participation-by"] Accessed June 16, 2022

Research Question: Did the ACA PCP bump increase pediatrician participation in the Medicaid program?

Findings: The authors found a positive association between Medicaid fee increases and multiple measures of provider participation. They found an increase in pediatricians accepting at least some Medicaid beneficiaries; an increase in pediatricians accepting all Medicaid beneficiaries; an increase in pediatricians accepting Medicaid at least as often as privately insured patients; and an increase in the number of Medicaid patients by provider panel among pediatricians.

Key Excerpt: "our study adds to a growing body of empirical evidence that documents potential relationships between Medicaid payment increase and pediatrician participation change. In addition to finding overall increases in self-reported Medicaid participation by office-based primary care pediatricians nationally after Medicaid parity, the multiple participation indicators used in our study demonstrated the various ways in which participation gains were achieved in different states." (p. 5)

19. Zuckerman, S. et al. "Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare in 2019.", *Health Affairs,* Volume 40, Number 2, February 2021, p. 343-348. [HYPERLINK "https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00611"] Accessed June 16, 2022

Research Question: The article reports on Medicaid physician fees, across states and service types, in comparison to Medicare fees in 2019.

Findings: The Medicaid-to-Medicare fee index was 0.72 in 2019. The fee index for primary care was 0.67, obstetric care was 0.80, and other services were 0.78. States with more than 1.5 million Medicaid enrollees had an average Medicaid-to-Medicare fee index of 0.68 compared with 0.82 in states with fewer than 500,000 Medicaid enrollees.

Key Excerpt: "In 2019, states with higher Medicaid enrollment had a lower Medicaid-to-Medicare fee index than lower-enrollment states, suggesting that states with large Medicaid populations may face budgetary pressure to keep physician fees low. Low Medicaid physician fees have important implications for Medicaid enrollees' access to care." (p. 345)

20. Zuckerman, S. et al. "Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation." *Health Affairs,* Volume 23, Number Supplement 1: Web Exclusives, 2004. [HYPERLINK "https://www.healthaffairs.org/doi/10.1377/hlthaff.W4.374" \l ":~:text=After%20slow%20growth%20during%20much%20of%20the%201990s%2C,their%20position%20relative%20to%20other%20states%20or%20Medicare."] Accessed June 16, 2022

Research Question: The study examines the association between Medicaid fee levels and changes in physicians' willingness to accept Medicaid patients.

Findings: The study found that those physicians that were receiving very low Medicaid rates were more likely to accept more Medicaid patients if the Medicaid rates increase. Physicians that already receive moderate or high Medicaid rates do not have an association of accepting more Medicaid patients.

Key Excerpt: "...acceptance of new patients did increase among primary care physicians in states that had the lowest 1998 Medicaid-to-Medicare fee ratios, which is consistent with the fact that fee increases were generally greatest for these physicians."

Date: June 21, 2022
To: CMCS Rate Reduction Policy Sprint
From: MITRE

Literature Review Summary: Associations Between Provider Reimbursement and Access

Background

Section 1902(a)(30(A) of the Social Security Act[i] establishes a statutory link between provider payment levels, provider participation, and beneficiary access in Medicaid. As the Center for Medicaid and CHIP Services (CMCS) considers rate reduction thresholds which would trigger more rigorous federal access reviews, it is important to understand research findings regarding the association between Medicaid provider reimbursement and various measures of access to providers and services. This literature review summary summarizes findings from studies published from the 1970s through the present. ***A body of research supports a positive association between Medicaid provider reimbursement rates and a range of access measures, including physician participation, beneficiaries' reported ability to find appointments, and more.*** This summary focuses on these findings by summarizing the various measures of access that are impacted by increases or decreases in provider reimbursement rates. It also examines how the association between reimbursement rates and access have been quantified by various researchers.

This summary is accompanied by an annotated bibliography of reviewed studies (Attachment A), which lists the citations of all reviewed studies and describes their respective research questions, high-level findings, and key excerpts which could be useful to CMCS. These documents are presented to support CMCS in establishing appropriate thresholds to initiate a focused access review when a state proposes to reduce Medicaid reimbursement levels.

Associations between Provider Reimbursement and Provider Participation

The significant majority of reviewed research studies found a positive association between provider reimbursement rates and physician participation in the Medicaid program. This association was observed across multiple measures of physician participation, including the number of providers accepting any Medicaid patients, the number of providers accepting all new Medicaid patients, and number of providers accepting all new Medicaid patients relative to the number of providers accepting all new non-Medicaid patients ('relative participation'). Sloan et al first established an association between Medicaid reimbursement and physician participation in 1978[ii], when its analysis found that low Medicaid fee schedules were the most common reason for physician non-participation across five distinct types of physicians (Sloan, et al, 223). These findings have been supported and expanded upon by numerous researchers since, in broad-based studies[iiiivv], studies looking at specific provider types[vivii], and state-specific studies[viii]. These studies found a direct, positive association between Medicaid fee levels and provider participation. While some (Fakhraei, H., p. 138) (Holgash K. and Martha Heberlein) found general associations between provider participation and fee increases and the number of providers accepting Medicaid beneficiaries, the majority found that this association remains positive for both the number of providers accepting any new Medicaid beneficiaries and the number of providers accepting all new Medicaid beneficiaries.

Associations between Provider Reimbursement and Beneficiary Access

Researchers also found numerous links between provider reimbursement and Medicaid beneficiary access. ***Multiple studies found positive associations between provider reimbursement rates and beneficiary-reported appointment availability[ixx] or having a usual source of care[xi]. Others found an association between provider reimbursement levels and the frequency of office-based care[xiixiiixiv]*** (as opposed to hospital-based care). In addition, various studies have found relationships between provider reimbursement and self-reported health (Alexander, D., and Molly Schnell, p. 3), school absenteeism (Alexander, D., and Molly Schnell, p. 3), caregiver satisfaction (Chatterji, P. et al., p. 6), and even Medicaid enrollment (Chen, A., p. 15).

Research on the Affordable Care Act's Primary Care Provider Fee Increase (the 'PCP fee bump')

While researchers have been examining the relationship between Medicaid reimbursement rates, provider participation, and beneficiary access for decades, a significant body of work has emerged specific to the PCP fee bump. This mandatory provision offered a unique research opportunity, in that it mandated all states to increase PCP rates up to Medicare levels and did so with 100% federal funds. The structure of the policy removed many confounding or state-specific factors that have limited other research studies (Alexander, D., and Molly Schnell, p. 4-5). Additionally, the expiration of the PCP fee bump, and the reversion to pre-PCP fee bump rates in many states, offered researchers an opportunity to examine whether associations between reimbursement rates and measures of provider participation and beneficiary access were consistent regardless of whether rates were increased or decreased.

In 2015, MACPAC released a qualitative report on the PCP fee bump based on interviews with state officials that did not indicate a connection between the fee bump and improvements in access measures[xv]. However, MACPAC acknowledged that the interviews took place in 2014, not long after most states had implemented the PCP fee bump (p. 131), and the states had not performed a formal study of the fee bump's impact (p. 136). In the years since, numerous quantitative studies found a positive association between Medicaid provider reimbursement and various measures of provider participation and beneficiary access[xvi] (Alexander, D., and Molly Schnell) (Polsky, D. et al) (Suk-fong S., Tang, et al). ***Some of these studies found that the correlation between provider rates and physician participation/beneficiary access was consistent regardless of whether rates increased following the PCP fee bump's implementation, or decreased following its expiration (Alexander, D., and Molly Schnell, p. 31) (Candon, M., et al., p. 146). And one study (Alexander, D., and Molly Schnell, p. 34-35) found that despite previous findings to the contrary, it was provider reimbursement levels (as opposed to patient complexity, administrative burdens, or billing delays), that was primarily responsible for changes in access measures.*** A separate non-PCP fee bump study (Holgash, K. and Martha Heberlein) also found that it was provider reimbursement levels, as opposed to managed care penetration or Medicaid expansion status, that drove shifts in Medicaid access.

Quantifying Established Associations

All studies discussed in this brief established an association between provider reimbursement and various measures of access. These associations are quantified in various ways. Some researchers quantified the relationship between the Medicaid-Medicare fee ratio and the researchers' chosen measures of access, while others quantified the relationship between a percent or dollar Medicaid rate increase or decrease and the respective access measures. As shown in Table 1, some of these studies derived normalized factors to describe the relationship between provider reimbursement and access.

*Table [SEQ Table * ARABIC]: Select Quantified Associations Between Reimbursement and Access*

Study, Page number	Unit of Financial Measurement	Quantified Association
Holgash, K. and Martha Herberlein, 2019	**% Change in Medicaid-Medicare fee ratio**	For every percentage point increase in the Medicaid-Medicare fee ratio, physician acceptance rates of new Medicaid patients increase by .78%.
Cohen, J. W., 1993; p. 287-289	**% Change in Medicaid-Medicare fee ratio**	A 10% increase in the Medicaid-Medicare fee ratio is associated with a 1.5% increase in the probability of having an office-based physician as a usual source of care. In turn, Medicaid beneficiaries with an office-based site of care are 5% less likely to have an inpatient admission than beneficiaries with a hospital-based usual site of care.
Chen, A., 2014; p. 14-15	**% Change in Medicaid payment rates**	A 10% increase in Medicaid payment rates is associated with: a .6% increase in enrolled providers; a 1.2% increase in the number of active Medicaid providers accepting all new Medicaid patients; and a 2.3% increase in Medicaid enrollment
Polsky, D., et al, 2015; p. 537	**% Change in Medicaid payment rates**	A 10% increase in Medicaid reimbursements is associated with a 1.25% increase in primary care appointment availability.
Alexander, D., and Molly Schnell, 2019; p. 2-3	**$ Change in Medicaid Payments**	A $10 increase in Medicaid payments is associated with: a 13% reduction in doctors not accepting new patients; an 11% reduction in doctors not accepting Medicaid; a 25% reduction in parents reporting trouble finding a doctor for their Medicaid-enrolled children; a 1.4% increase in probability that beneficiaries visited a doctor in the past two weeks; a 1.1% increase in self-reported health of very good or excellent; a 14% reduction in chronic school absenteeism due to illness or injury.
Candon, M., et al, 2018; p. 146	**$ Change in Medicaid Payments**	A $10 change in Medicaid fees is associated with a 1.7 percentage point change in appointment availability for new Medicaid patients

Other studies categorized their findings in terms of deciles, quartiles, or other markers that could support CMCS in setting appropriate thresholds for conducting a rigorous access review. For example:

- Chatterji, et al, focused on access to care for publicly insured children with special health care needs, and assessed access when the Medicaid-Medicare fee ratio was above or below certain deciles. With the threshold set at a ratio of .80, the study found statistically significant improvements in measures such as having 'no regular health care provider', 'difficulty/delay in access due to waiting lists', and 'insurance never or sometimes covers needed providers' in states above the .80 threshold (p. 41). When the threshold was raised to a fee ratio of .90, statistically significant improvements were found in additional measures including 'No usual source of care,' 'did not get needed routing care', 'did not get needed specialty doctor care', and 'did not get needed mental health care' were also noted (p. 31).
- Berman, et al, focused on pediatricians looked at Medicaid-Medicare fee ratio quartiles and found that the percent of pediatricians accepting all Medicaid patients and relative pediatrician

participation in Medicaid increased at each quartile, but improvement was most significant up to the third quartile (p. 247-248). According to the Kaiser Family Foundation, in 2016, following the expiration of the PCP fee bump, the third quartile of states had Medicaid-Medicare fee ratios of between .79-.86[xvii].

- J.W. Cohen and Peter J. Cunningham (1995) found that in states with fee ratios less than 50%, 20% of Medicaid children accessed hospital-based facilities, whereas in states with ratios between 80%-89%, only 6% of children used hospital-based facilities (p. 256).
- S. Decker published one study that did not generally support an association between the PCP fee bump and physician participation; however, it did note a small increase in participation in states with high Medicaid-Medicare fee ratios prior to the fee increase[xviii]. The author used these findings to hypothesize that the temporary nature of the PCP fee bump may have reduced its impact in states where a reversion to low fees was anticipated, whereas states with higher fee ratios to begin still received some benefit from the policy (p. 1095). For the purposes of the study discussed here, 'high fee ratio' states were considered states with fee ratios above .75 prior to the PCP fee bump. In 2012, 27 states fell in that category. As of 2016, 27 states had a fee ratio of at least .78.
- In another study by S. Decker, the author modeled measures of access at a 'high' Medicaid-Medicare fee ratio of 1 and a 'low' fee ratio of .64 (Decker, S., 2009). She found that beneficiaries in programs with a 'low' fee ratio would be 17.3% more likely to have no doctor visits in the past year and would be 106.7% more likely to have a Medicaid visit in an outpatient hospital department (Decker, S., 2009; p. 296-298).

While these studies did not set out to determine the precise threshold at which point access becomes concerning, their findings could support CMCS' work to establish a threshold that would trigger a more concentrated access review.

Conclusion

There is now over four decades of research to support a positive association between provider reimbursement and numerous measures of access. These include measures of physician participation such as Medicaid physician enrollment, the number of physicians accepting any or all Medicaid beneficiaries, physician acceptance of Medicaid patients relative non-Medicaid patients, and caregiver satisfaction. They also include other measures of beneficiary access such as appointment availability, having an office-based provider as a usual site of care, parent reports of difficulty finding their child a doctor, as well as self-reported beneficiary health.

All studies examined during this literature review quantified their findings in some fashion. These findings were presented in various ways, many of which could support CMCS in justifying specific thresholds to conduct an access review. For example, multiple studies categorized their findings by Medicaid-Medicare fee ratio deciles or quartiles that could specifically support an access review when a state's fee ratio fell below a threshold between 80%-90% (Berman, S., et al) (Chatterji, P., et al) (Cohen, J.W. and Peter J. Cunningham, 1995) (Decker, S., 2018). Other studies offered normalized factors (see Table 1) that could be used to support access review thresholds based on either the Medicaid-Medicare fee ratio or a percent of total Medicaid spend by category of service.

In aggregate, the existing literature offers strong evidence that provider reimbursement levels impact physician participation and beneficiary access.

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