



June 29, 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

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 and Administrator Brooks-LaSure:

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 rule.

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including millions of individuals who rely upon Medicaid and CHIP coverage. Our organizations have a unique perspective on what patients need to prevent

disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In March 2017, our organizations agreed upon three overarching principles¹ to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit package.

In April 2022, many of our organizations submitted recommendations to the Centers for Medicare and Medicaid Services (CMS) in response to the Request for Information: Access to Coverage and Care in Medicaid and CHIP.² We appreciate that CMS incorporated some of our feedback into the development of this proposed rule. While Medicaid is incredibly beneficial to people with serious and chronic illnesses, access problems in both fee-for-service and managed care have negative impacts on health status and outcomes. The proposed rule will improve access to Medicaid for patients that are enrolled in managed care. We provide several suggestions in our comments below to strengthen the proposed rule.

Access and network standards

Access to providers is a challenge for Medicaid enrollees with chronic illnesses. Currently, states are required to develop a "quantitative" network adequacy standard for each of the following provider types: (1) primary care, adult and pediatric; (2) OB/GYN; (3) behavioral health, adult and pediatric; (4) specialist (as designated by the state), adult and pediatric; (5) hospital; (6) pharmacy; and (7) pediatric dental. However, there is no federal floor for the "quantitative standard" and no federally-specified enforcement mechanism. In addition, even when individuals do identify providers, they may face a long wait time before they are able to receive care.

The proposed rule would add a new requirement that states adopt and enforce standards for appointment waiting times. These standards would require that routine appointments be made within the following timeframes:

- for primary care, pediatric and adult, within 15 business days of request,
- for OB/GYN care, within 15 business days of request,
- for outpatient mental health and substance use disorder (SUD) services, pediatric and adult, within 10 business days of request, and
- for state-selected services, within state-established timeframes.

Compliance with these standards would be a rate of appointment availability of at least 90 percent, as determined by "secret shopper" surveys. States would be required to conduct "secret shopper" surveys on an annual basis, using entities that are independent of the state Medicaid agency and the managed care organizations (MCOs). The "secret shopper" surveys would also be required to test the accuracy of the MCO provider directories with respect to primary care, OB/GYN, and outpatient mental health and

¹ Consensus Health Reform Principles. Available at: <https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/ppc-coalition-principles-final.pdf>.

² Response to Request for Information: Access to Coverage and Care in Medicaid and CHIP, April 28, 2022. Available at: [https://www.lung.org/getmedia/e339447c-cfa0-4bc1-bdd5-4a0f4818a2c0/PPC-Medicaid-Access-RFI-4-18-22-\(FINAL\).pdf](https://www.lung.org/getmedia/e339447c-cfa0-4bc1-bdd5-4a0f4818a2c0/PPC-Medicaid-Access-RFI-4-18-22-(FINAL).pdf).

SUD providers. State Medicaid agencies would be required to report the results of the “secret shopper” surveys to CMS and post the results on their websites. The proposed rule would also require states to conduct enrollee experience surveys and report on them as part of their annual managed care reports.

We strongly support the addition of waiting time standards to improve access to care in Medicaid. We support the adoption of waiting time limits and the specific 10 and 15-day standards that CMS has established in the rule. However, we have several suggestions to strengthen the rule.

First, patients with chronic illnesses depend heavily on access to specialists, and in some cases a specialist may be the provider they see the most and depend upon for vital treatments. Therefore, we recommend that CMS should also implement a similar wait time standard for access to specialists. The federally run Marketplaces will begin implementing waiting time standards for Qualified Health Plans (QHPs) in 2025, including a standard for specialists, and so this change would help to align Medicaid with Marketplace policy. There is no reason that Medicaid should have weaker standards than the Marketplace.

Second, while we support the addition of wait times, we do not believe wait time standards alone are sufficient to promote access. State quantitative standards should include time/distance standards or some similar geographic measure of access, which would also create alignment with Marketplace policy. Distance standards are critical to enrollees, particularly those in rural areas, who may otherwise have to travel unreasonable distances for simple medical appointments.

Third, we believe CMS needs to develop a method to factor accessibility into network adequacy. For example, though a network may be generally adequate, it may not meet the needs of subpopulations who need linguistically (including ASL) or culturally competent care or physically accessible care. For example, some individuals with chronic illnesses can only access medical appointments with the fraction of providers that offer buildings, medical equipment, and personnel that can treat someone in a wheelchair. CMS should consider how to rigorously assess (including using secret shoppers) whether networks include sufficient providers with the necessary capabilities. This is important for individual access to care, and also critical to addressing health disparities for underserved Medicaid populations, including people of color, immigrants, people with disabilities, and LGBTQI+ individuals.

Fourth, we recommend that CMS consider developing more enforcement mechanisms to ensure managed care plans comply with waiting times and other network adequacy standards. One recent survey found that one third of individuals with Medicaid coverage reported that a doctor they needed to see did not have available appointments.³ Given the serious access problems that Medicaid beneficiaries face, stronger enforcement is clearly needed.

We also strongly support the requirements for conducting secret shopper surveys and enrollee experience surveys. Secret shopper surveys will help individuals with chronic illnesses in a number of ways. They will allow for monitoring of wait times (and potentially other access standards) and allow evaluation of actual managed care plan provider availability. Individuals with chronic illnesses frequently

³ Kaiser Family Foundation, KFF Survey Shows Complexity, Red Tape, Denials, Confusion Rivals Affordability as a Problem for Insured Consumers, With Some Saying It Caused Them to Go Without or Delay Care. June 15, 2023. Available at: <https://www.kff.org/health-costs/press-release/kff-survey-shows-complexity-red-tape-denials-confusion-rivals-affordability-as-a-problem-for-insured-consumers-with-some-saying-it-caused-them-to-go-without-or-delay-care/>.

struggle to find providers, and when they consult their MCO provider directories the given information is often inaccurate. For example, the providers may be no longer in-network or not accepting patients. Among the general population, insured adults with chronic conditions are more than twice as likely to struggle to find providers as those without chronic conditions.⁴ We recommend that CMS additionally use the secret shopper to develop or verify other key metrics, such as telehealth capacity, linguistically and culturally competent services, and accessibility. Additionally, for enrollee experience surveys, we recommend that CMS use a single instrument (CAHPS) to facilitate comparison of data across states.

Finally, we recommend that the new appointment waiting time standards, secret shoppers, enrollee experience surveys, and other provisions discussed above be implemented in 2025. This will both align with Marketplace implementation of a similar standards and ensure that these important policies to help patients access the care they need are implemented in a reasonable timeframe.

State directed payments

State directed payments (SDP) are a mechanism allowing a state Medicaid agency to “direct” some of the payments that MCOs make to their network providers. SDPs give states limited authority to set parameters on MCO payments, including requirements for value-based purchasing, adopting a minimum fee schedule, or making a uniform rate increase. 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.⁵ In addition, both GAO and MACPAC have expressed concerns about the lack of sufficient evaluation information for SDPs.⁶ The proposed rule would make a number of changes designed to ensure that SDPs operate with greater transparency, including requiring reporting on actual spending at the provider level and public evaluation reports.

We support the provisions of the proposed rule that require increased transparency for SDP funding. The public and stakeholders should be able to ascertain how many Medicaid dollars have actually been paid to specific providers, and CMS should not allow SDPs to operate without collecting this critical information. Likewise, we support the requirement for final evaluation reports. While we commend CMS’s requirement that the evaluation report be publicly posted, we believe CMS should also explicitly require public posting of SDP preprints, evaluation plans, CMS approvals, rate certifications, and all short- and long-term reporting on payments (such as under proposed 42 C.F.R. § 438.6(c)(4)).

Finally, we urge CMS to consider policy to ensure that SDPs are not used to make up for inefficient state policies, such as not expanding Medicaid. Numerous studies have shown the economic benefits of Medicaid expansion for providers⁷ and SDPs should not reduce the financial incentives for states to expand lifesaving coverage to millions of patients.

⁴ Teresa A. Coughlin, et al., “Many Insured Adults Report Problems Trying to Find New Health Care Providers,” Urban Institute (Aug. 14, 2020), <https://www.urban.org/urban-wire/many-insured-adults-report-problems-trying-find-new-health-care-providers>.

⁵ 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>.

⁶ Id.; U.S. Government Accountability Office, “Medicaid: State Directed Payments in Managed Care” (June 28, 2022), <https://www.gao.gov/assets/gao-22-105731.pdf>.

⁷ Kaiser Family Foundation, What Does the Recent Literature Say About Medicaid Expansion?: Economic Impacts on Providers, January 2023. Available at: <https://www.kff.org/medicaid/issue-brief/what-does-the-recent-literature-say-about-medicaid-expansion-economic-impacts-on-providers/>.

In lieu of services

Medicaid managed care plans can offer “in lieu of services” (ILOS) in substitution for state plan covered services. ILOS are of particular interest to patients with chronic illnesses because, if used positively, they could allow states to develop a wider range of treatments and help address health-related social needs. However, there is currently 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 for prevention) to reduce the need for more expensive health care treatments.

We support many of the provisions in the proposed rule as it will create better transparency and standards for ILOS services and encourage longer-term investments through ILOS. First, we specifically support broadening the definition of ILOS to include substitutions that are based on longer-term investments in care. Some services and supports for individuals with chronic illnesses may take years to yield “savings” in the form of reduced use of state plan services, but providing these services and supports are important to improving health. We also support the provisions ensuring that ILOS must be medically appropriate substitutions.

Second, we support the requirement for states to develop an annual report of ILOS spending, specifically based on claims and encounter data. It is imperative that we learn which ILOS investments are benefiting individuals with chronic illnesses. However, we recommend that CMS require this spending data to be public.

Third, we strongly support the provisions of the proposed rule that support enrollee protections for ILOS, including that enrollees cannot be forced to use ILOS or denied access to state plan services, and that enrollees retain all of their managed care rights with respect to ILOS, including the right to file appeals. We also support the requirements to include these protections in enrollee handbooks and plan contracts. While we appreciate these protections, we suggest that CMS require states to develop a public list of available ILOS services, and do outreach to providers and enrollees, so that providers and enrollees understand what special service options may be available. We also recommend that CMS consider explicit provisions guiding actuarial rate-setting for longer-term ILOS, to ensure that (just as individuals can access both an ILOS and state plan service at the same time) managed care financing requires capitation that allows consideration of both ILOS and state plan services being provided together.

Finally, we support the requirements for retrospective evaluation for each ILOS service and transition plans if ILOS are terminated by CMS, the state, or the MCO. These provisions will ensure that we learn which experimental services have benefited individuals with chronic illnesses while at the same time reducing any harm if the experiment doesn’t work.

Quality

Current Medicaid regulations require states to implement a written quality strategy for assessing and improving the quality of health care services furnished in managed care. 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 rule would increase opportunities for interested parties to provide input on the state’s managed care plan, including requiring states to seek public comment on the state’s quality strategy at least every three years regardless of whether significant changes are made. We support this improvement, as it will allow individuals with chronic illnesses, who depend on effective care management to manage their health, to shape the purpose and function of

their state's managed care programs. We also support the requirement for states to publicly post the full evaluation of the effectiveness and results of the triennial review of the quality strategy.

Further, we support the creation of new optional external quality review (EQR) activities to support evaluation requirements, including for quality strategies, SDPs, and ILOS. This will facilitate the development of high-value evaluations for these initiatives that could be valuable to individuals with chronic illnesses. We also recommend (in response to CMS's request in the preamble) that CMS add guidance in the EQR protocols for states to stratify performance measures collected and reported in EQR technical reports, as this will facilitate monitoring health disparities.

In addition, we support the improvements to the Medicaid managed care Quality Rating System (QRS). The proposed framework includes mandatory measures, a rating methodology, and a mandatory website format. It would allow enrollees to compare plans based on quality and other factors key to plan selection, such as the plan's drug formulary and provider network. The robust website envisioned in the proposed 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. These changes will be valuable to individuals with chronic illnesses who will be better able to find out information about the potential plan options and supported in selecting a plan that meets their needs.

Finally, we recommend that CMS accelerate the timelines in the proposed rule, requiring implementation by 2026 and website changes by 2028. The timeline will more appropriately balance the time needed for states to implement these policies with the need for patients to have access to this critical information as soon as possible.

Conclusion

Thank you for the opportunity to provide these comments. We look forward to continuing to partner with you on the implementation of these critical policies to improve access to care in Medicaid. If you have any questions about our comments, please contact Hannah Green with the American Lung Association at hannah.green@lung.org.

Sincerely,

Alpha-1 Foundation
American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
CancerCare
Child Neurology Foundation
Chronic Disease Coalition
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Immune Deficiency Foundation

Lupus Foundation of America
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Eczema Association
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
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