June 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-2439-P, Medicaid Program; Managed Care Access

Dear Administrator Brooks-LaSure:

The National Health Law Program (NHeLP) is a public interest law firm that works to advance equitable access to health care and protect the health rights of people with low incomes and underserved populations. For over fifty years, we have litigated, advocated, and educated at the federal and state levels to advance health and civil rights in the United States. Consistent with our mission, we strongly believe that health care is a human right. Every individual should have access to high quality, affordable, and comprehensive health care and be able to achieve their own highest attainable standard of health.

We appreciate the opportunity to comment on these proposed regulations. Below, please find our comments expressing our support for many of the proposed changes. In particular, we support the measures designed to increase transparency in managed care; improve monitoring and assure adequacy of payments in managed care; increase accountability, transparency, and participant input into external quality review; and help states to make information about quality measures widely available.

§ 438.6 Special contract provisions related to payment

We support CMS's proposals to increase transparency and accountability of the growing number of State Directed Payments (SDPs) in managed care. These payments allow states to dictate some parameters for how plans pay their providers, including such mechanisms as value-based payment or minimum and maximum fee schedules, and to implement rate increases for providers of a specific service. States have increasingly used SDPs to replace supplemental payments that are common in fee-for-service Medicaid but not allowed in managed care.[1] MACPAC now projects that states will spend $69.3 billion annually, up from just $25.7 billion in 2020, on SDPs.[2] Most of the spending is concentrated in just a few arrangements, as the largest 22 of nearly 250 approved SDPs account for 69% of the total share of SDP spending.[3] With such a large and growing share of Medicaid managed care spending utilizing this payment structure, we strongly support CMS's proposals to create more detailed, publicly available payment reporting that more clearly establish that SDPs are actuarially sound and linked to Medicaid reimbursable services.

A. EVALUATION REPORTS AND OTHER TRANSPARENCY AND OVERSIGHT IMPROVEMENTS

We support the proposed requirement to require a more detailed evaluation report for larger SDPs, including relevant performance metrics and information on spending. In addition, we recommend that CMS require any SDP arrangement to have clear, timely, and public data on how much money from each arrangement is going to each provider.

We have concerns about the number of SDPs that would be excluded from the requirement of proposed § 438.6(c)(2)(v) to perform an evaluation because they comprise less than 1.5% of total managed care program costs. In larger states with high managed care enrollment, 1.5% of program costs could range into the hundreds of millions of dollars. We recommend eliminating, or at least substantially lowering, the threshold that triggers the requirement for performing an evaluation. In the alternative, CMS could set the evaluation trigger in absolute dollars instead of a percentage share. This would make it much easier to calculate whether an SDP needs an evaluation, and would minimize the "large state" bias in the percentage-based threshold.

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[1] MACPAC, *Directed Payments in Medicaid Managed Care*, 1 (June 2023), https://www.macpac.gov/wp-content/uploads/2023/06/Directed-Payments-in-Medicaid-Managed-Care.pdf.
[2] *Id.* at 4.
[3] *Id.* at 4.

Given the growing size and importance of this payment mechanism, stakeholders should have public access to the information states and plans report related to SDPs. We strongly support the proposal requiring SDP evaluation reports to be posted on the State's centralized website. This transparency will make it easier to track the SDP's progress toward their stated goals and help hold states accountable.

However, we do not support proposed § 438.6(c)(2)(v), which would delay the release of the first evaluation of an SDP as much as five years after implementation. It should not take three years to determine whether an SDP is succeeding, particularly for the most common types of SDPs. Relatively simple minimum and maximum fee schedules and uniform rate increases comprise 90% (223 of 249) approved SDPs that should not require such a delay to evaluate their effect.[4] We recommend shortening to a two-year evaluation schedule with one added year to report. If CMS retains the current three-year cycle, states should, at the very least, have to submit interim evaluations after the first two years.

Finally, to further increase transparency, we recommend that CMS also require states to post: SDP preprints, evaluation plans, CMS approvals, rate certifications, and all short and long-term reporting on payments under proposed § 438.6(c)(4). We also recommend that CMS make this information available through Medicaid.gov.

RECOMMENDATION: Amend § 438.6(c)(2)(v) as follows:

> (A) (2) include ~~three~~ **two** most recent and complete years of annual results for each metric as required by (c)(2)(iv)(A) of this section; and
> (B) States must submit the initial evaluation report as described in paragraph (c)(2)(v)(A) of this section to CMS no later than ~~2~~ **one** year~~s~~ after the conclusion of the ~~3-year~~ **2-year** evaluation period. . . .

RECOMMENDATION: Amend this section by adding a new section (f):

> **(f)** ***States shall post and make accessible on the Web site required under § 438.10(c)(3) SDP preprints, SDP evaluation plans, CMS approvals, rate certifications, and all short and long-term reporting on payments required by (c)(4).***

[4] *Id.* at 5.

B. OTHER RECOMMENDATIONS

We do not recommend imposing a limit on the amount of SDP expenditures at this poin in time. *See* 88 Fed. Reg. 28127. We are concerned that such a limit might have unintended consequences. For example, the wage payment pass-through percentage for certain Medicaid HCBS that CMS just proposed may necessitate a substantial increase in SDPs in order for states to ensure that uniform rate increases for personal care, homemaker, and home health services actually reach the direct care workforce they are intended to help.[5] In New York, for example, HCBS providers and advocates have complained that when the state increased capitation rates to cover minimum wage increases for home health direct care workers, the plans did not uniformly increase rates for HCBS providers.[6] Wisconsin is one of the few states with a managed LTSS program that has already made use of SDP authority to exert more control over how funding increases funnel to workers.[7] We expect the new rule will lead to more such arrangements, and we urge you to consider that possibility when deciding whether or how high to set a maximum share of total capitation rates that states can dedicate to SDPs.

If SDPs continue to proliferate, CMS will have to ask states for more evidence to justify SDP expenditures. Managed care capitation rates are already supposed to be actuarially sound and sufficiently resourced to ensure timely access to necessary covered services. We see important future roles for some types of SDPs, like value-based purchasing mechanisms and directed payments to HCBS providers, but CMS ultimately needs adequate documentation to verify the efficacy of such investments. Full, publicly available reports on SDP spending at the provider level are a necessary step to ensure they promote value and minimize the risk of inappropriate use of SDPs that could threaten public trust in the Medicaid program.
Finally, we recommend that CMS add SDP evaluations required by § 438.6(c)(2)(iv) to the list of items required to be posted on the state's website required by § 438.10(c)(3).

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[5] *See* proposed § 438.207(b)(3)(ii).
[6] Lily Meyersohn, *Insurance Companies are Destroying New York's Home Care Industry* (Apr. 14, 2023), https://inthesetimes.com/article/insurance-companies-are-destroying-new-yorks-home-care-industry.
[7] Wisc. Dept. Health Servs., *Medicaid: Direct Care Workforce Funding Initiative Information and FAQs* (Last visited June 27, 2023), https://www.dhs.wisconsin.gov/medicaid/ltc-workforce-funding-faq.htm.

RECOMMENDATION: Amend § 438.6 as follows:

(c)(2)(iv) . . . the evaluation plan must contain the following elements . . .
(D) a commitment by the State to submit an evaluation report in accordance with § 438.6(c)(2)(v) if the final State directed payment cost exceeds 1.5% ***and post that evaluation report on the Web site required under §*** **438.10(c)(3).**

§ 438.10 Information requirements

We strongly support the proposed additions to this section. CMS already requires states and managed care entities to provide important information in an easily understood and accessible manner and format. However, potential and current enrollees, advocates, and others still have difficulty finding necessary information about managed care.[8] Therefore, we support the new requirement that managed care contracts and other important information be accessible through a single webpage and that documents and links have clear labels that enable users to clearly identify information contained in them.

We also 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.

RECOMMENDATION: Amend § 438.74 as follows:

(a) State reporting requirement.
(3) This summary description, and the individual managed care medical loss ratio reports required by § 438.8(k), must be:
(i) Posted on the Web site required under § 438.10(c)(3).
(ii) Provided to the Medicaid Advisory Committee, required under § 431.12 of this chapter.
(iii) Provided to the stakeholder consultation group specified in § 438.70 to the extent that the managed care program includes LTSS.

[8] *See, e.g.,* David Machledt, National Health Law Program, *Medicaid External Quality Review: An Updated Overview,* (2020), https://healthlaw.org/resource/medicaid-external-quality-review-an-updated-overview/.

§ 438.16 In lieu of services and settings

We support CMS's decision to codify its recent guidance on In Lieu of Services (ILOS). In particular, we welcome CMS's clarification of the fact that enrollees offered or receiving ILOS retain all rights and protections conferred by the Medicaid managed care regulations. Moreover, the proposal to require monitoring and reporting on appeals, grievance, and state fair hearing data will help ensure that enrollees receiving ILOS retain these rights and protections.

§ 438.66 State monitoring requirements

We strongly support the proposed requirement that states conduct an annual enrollee experience survey. We also commend CMS's proposal to add these surveys to the list of items in § 438.10(d)(2) for which interpretation, translation, and auxiliary aids are available, which is consistent with CMS' health equity goals and necessary to ensure a representative sample of Medicaid enrollees that includes those with barriers to information. To further CMS' goal of advancing health equity, we recommend that CMS provide guidance to states requiring that results be stratified by key demographics and that states use mechanisms such as oversampling to ensure that the experience of people with disabilities, limited English proficiency, or those in other marginalized communities are well represented in these surveys.

We also strongly support the requirement that states post the results from these annual surveys on their centralized website as part of the Managed Care Program Annual Report required by § 438.66. We urge CMS to use the results of these surveys to formulate guidance to states and plans on how to improve access, services, and the overall experience for beneficiaries.

Additionally, we encourage CMS to require states to survey providers as part of their annual surveying process. CMS recognizes the value of information that enrolled providers can share as they have encouraged states to survey them but chose not to compel them to do so. Mandating that states conduct a provider survey will offer further perspective to states and managed care plans about network adequacy from those who are actually delivering the services. Providers can offer valuable stakeholder insight into challenges beneficiaries face navigating their health benefits and improvements that can be made to the Medicaid program writ large.

RECOMMENDATION: Amend § 438.66(c) as follows:

> (5) Results from an annual enrollee experience survey conducted by the State and ~~any~~ ***a*** provider satisfaction survey conducted by the State, **and any provider satisfaction survey conducted by an** MCO, PIHP, or PAHP.

§ 438.68 Network adequacy standards

CMS has proposed a number of changes to this regulation that we support and we commend the agency for improving and strengthening this crucial component of the managed care system. As CMS recognizes in the preamble, studies have shown that Medicaid managed care enrollees lack access to needed services covered under the plan.[9] Thus, NHeLP has long advocated for specific, quantitative network adequacy standards with rigorous enforcement mechanisms.[10] We recognize that over the last several years, CMS has added and amended this section to add detail to guide states and Medicaid plans in developing their networks to ensure adequacy. These proposed amendments take important steps that will help ensure that Medicaid managed care enrollees have access to covered services.

A. § 438.68(b) PROVIDER-SPECIFIC NETWORK ADEQUACY STANDARDS

We suggest that CMS make some minor changes to the provider categories subject to this provision. For example, to ensure coverage of the full range of reproductive and sexual health services, rather than defining the category as "OB/GYN," we suggest

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[9] *See, e.g.,* Avital B. Ludomirsky et al., *In Medicaid Managed Care Networks, Care Is Highly Concentrated Among A Small Percentage Of Physicians,* 41 HEALTH AFF. 760 (2022); Walter R. Hsiang et al., *Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis*, 56 J. HEALTH CARE ORG. 1 (2019); Suzanne Murrin, Dept. of Health & Human Servs., Office of Inspector General, *State Standards for Access to Care in Medicaid Managed Care* 19 (2014) ("CMS and States need to do more to ensure that all States have adequate access standards and strategies for assessing compliance."), http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf. *Cf. Michael Sparer, Robertwood Johnson Found., Medicaid Managed Care: Costs, Access, and Quality of Care* 15-16 (2012) (synthesizing studies and finding that research shows mixed results regarding Medicaid Managed Care enrollees access to care).

[10] *See, e.g.,* Abbi Coursolle, Nat'l Health L. Prog., *Medicaid Managed Care Model Provisions: Network Adequacy* (2014), http://www.healthlaw.org/issues/medicaid/managed-care/medicaid-managed-Care-model-provisions-issue-3.

using the term “reproductive and sexual health” to account for the overlap in the scope of practice performed by OB/GYNs, family planning providers, urologists, and other reproductive and sexual health specialists. A narrow focus on OB/GYNs will fail to accurately reflect the adequacy of a plan’s network, which must include a broader scope of practitioners who offer such services, which include pre- and postnatal care, family planning counseling and treatment, and screening and treatment for genital infections and sexually transmitted infections (STIs). Since, in many states, these services are performed by Physician Assistants, Nurse Practitioners, Certified Nurse Midwives, and other, non-physician provider types, a more expansive category name will better capture the adequacy of a plan’s network. We also suggest that CMS expand the category for pediatric dental to explicitly include providers of dental sealants and fluoride varnish. We are aware that in many states, there are particular shortages and unmet needs related to pediatric dental care that have resulted in gaps in access to these important preventive services in particular.[11] Given states’ obligations to ensure that child enrollees have access to necessary dental care pursuant to EPSDT, we believe that CMS and states will better be able to monitor compliance if this category is defined with more specificity.

We encourage CMS to again amend this section to provide for geographic access (distance) standards, as the regulations did from 2016 to 2020. CMS first proposed to employ geographic access standards in 2015, noting that this measure of network adequacy was commonly employed in Medicare Advantage and in the commercial market, and noting that “time and distance standards present a[n] accurate measure of the enrollee's ability to have timely access to covered services.” 80 Fed. Reg. 31145.

Geographic access standards are particularly beneficial to enrollees because they are easily understood, and people fairly easily determine if the managed care entity is not meeting the standard. For example, if an enrollee is struggling to find a provider and searches for the standard, they can determine through online maps or their own experience that there is no provider within a certain time and distance. They can then file a grievance or a fair hearing based on reasonable promptness to enforce their access to a provider. In comparison, other quantitative measures, such as percentage of providers accepting new patients or provider to enrollee ratios, while helpful, cannot be are not easily ascertained by an individual or oftentimes even by advocates.

[11] See, e.g., Ashley M. Kranz et al., M*edicaid Payment and Fluoride Varnish Application During Pediatric Medical Visits,* 79 MED. CARE RES. & REV. 834 (2022); Wendy E. Mouradian et al., *Disparities in Children's Oral Health and Access to Dental Care,* 284 JAMA 2865 (2000).

Moreover, geographic access and timely access standards work together in tandem to ensure that enrollees have access to the services they need. After all, a plan that offers a next day appointment with a provider who is 500 miles away from the enrollee is no more ensuring access than a plan that offers an appointment with a provider next door to the enrollee, when the first available appointment is 12 months away. Thus we urge CMS to require states to employ both geographic access and timely access standards of network adequacy. We therefore encourage CMS to engage in future rulemaking to revive the 2016 version of the regulations that imposed geographic standards.

Regardless of whether federal regulations require that states have geographic access standards, many states already do.[12] Thus, we recommend that CMS make more explicit plans' obligations when no provider is available within the state's network adequacy standard. In these cases, we suggest that CMS require states to require plans to either arrange for care to be provided by a geographically proximate provider who is out-of-network, provide transportation for the enrollee to travel to see an in-network provider who is located beyond the maximum travel time or distance, arrange for a provider to travel to the enrollee or a designated location that is geographically proximate to the enrollee's home or workplace, or provide telehealth. Currently, even in some states with robust geographic access standards, plans have little accountability to ensure care when they are not able to meet the standard. We recognize that it will be difficult for plans to meet the standard in some regions, due to provider shortages, existing travel patterns, or other factors. But too often, where the Medicaid plan is granted an alternate access standard in those regions, the alternate access standard becomes a "no access" standard, since plans are exempted from the prevailing standard but not required to use alternative methods to ensure that enrollees have access to care. We urge CMS to explicitly require states to ensure that *all* enrollees have access, even if they fall within the 10% of enrollees whose residence or workplace is not within the designated geographic area, or if the plan has been exempted from the standard.

RECOMMENDATION: Amend § 438.68(b)(1) as follows:

> (1) Provider types. At a minimum, a State must develop ***time and distance standards*** ~~a quantitative network adequacy standard, other than appointment wait times,~~ for the following provider types, if covered under the contract . . .

[12] Jane M. Zhu, et al., *Variation in Network Adequacy Standards in Medicaid Managed Care,* 28 AM J MANAGED CARE 288 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9236159/.

(ii) ***reproductive and sexual health services, which may be provided by OB/GYNs Family Practitioners, Nurse Midwives, Nurse Practitioners, Physician Assistants, and other providers,***
(vii) Pediatric dental, including dental sealants and fluoride varnish for enrollees under age 21,
(x) Whenever medically necessary care is not available within the state's network standard, the MCO, PIHP or PAHP shall arrange for the enrollee to receive medically necessary care by:

(A) Arranging for the enrollee to see an out-of-network provider;
(B) Providing transportation, including the costs of food, lodging, and attended, when necessary, to a contracted provider to whom travel exceeds the standard;
(C) Arranging for a provider to travel to the enrollee or a designated location that is within the state's standard for travel time and distance; or
(D) Where medically appropriate, arranging for telehealth.

B. § 438.68(c) DEVELOPMENT OF NETWORK ADEQUACY STANDARDS

While CMS has not proposed any amendments to this subsection, we nevertheless believe improvements could be made to it to better ensure access to covered services.

We urge CMS to require that, in developing and enforcing quantitative standards, states to closely review plan networks to ensure that enrollee's access to care is not hampered by exclusive contracts with providers who refuse to provide certain health services. Too often, Medicaid managed care enrollees who have been denied access to contraception, miscarriage management, gender-affirming treatment for gender dysphoria, HIV treatment, treatment for ectopic pregnancies, and a range of other services as a result of state or federal provider refusal laws.[13] Where providers have a legal right to refuse to provide a covered service, the state and the plan must ensure that the plan's network will provide sufficient access to those covered services that providers may refuse to provide. We have suggested specific language below.

[13] *See* Madeline Morcelle et al., *National Health Law Program Comments on HHS's Proposed Changes to Health Care Refusal Regulations* (March 7, 2023), https://healthlaw.org/resource/national-health-law-program-comments-on-hhss-proposed-changes-to-health-care-refusal-regulations/.

We also recommend that CMS require states to take into account the experience of enrollees who rely upon public transit when formulating time and distance standards. A recent survey indicated that only five responding states developed such standards that take these enrollees into account.[14] Given the high likelihood that the millions of enrollees in large urban areas will be using public transit, this is a serious limitation in adequacy standards.

We further recommend that CMS require states account for their networks ability to provide culturally competent care to limited English proficient enrollees, Black, Indigenous, and other People of Color (BIPOC), and to Lesbian, Gay, Bisexual, Transgender, Queer Plus (LGBTQ+) people. Networks that do not deliver culturally competent care will leave enrollees without real access to the care they need. With respect to limited English proficient enrollees, CMS should require states to ensure that in-language services are provided by qualified interpreters and translators, since the cost of a miscommunication in a health care setting can be very high.[15] In addition, CMS should require states to evaluate the accessibility of plan providers to people with disabilities to likewise ensure that all enrollees have true access to care. We have suggested language to accomplish these objectives below.

RECOMMENDATION: We recommend amending a § 438.68(c) as follows:

(c) Development of network adequacy standards.

(1) States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements:

(vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees. ***If the majority of Medicaid enrollees in the service area of a MCO, PIHP, or PAHP use public transportation, the travel times and distances must be calculated based on public transportation schedules and routes. Similarly, if roads are frequently closed in the***

[14] Elizabeth Hinton and Jada Raphael, Kaiser Family Foundation, *Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes* (June 15, 2023), https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes/.

[15] *See, e.g.,* Melanie Au et al., Mathematica, *Improving Access to Language Services in Health Care: A Look at National and State Efforts* 7-8 (2009), https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/factsheets/literacy/langserv/languageservicesbr.pdf.

region due to weather, the travel times and distances must account for potential road closures.

(vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language ***using qualified interpreters and translators, and their ability to provide culturally competent care to limited English proficient enrollees***.

(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.

(x) The ability of network providers to provide culturally competent care to all enrollees, including Black, Indigenous, and Enrollees of Color, and LGBTQ+ enrollees.

(xi) The extent to which network providers provide a full range of covered services including high risk pregnancy care, family planning services and supplies, treatment for HIV and AIDS, gender-affirming care, and abortion. If an MCO, PIHP, or PAHP contracts with institutions or individual providers who refuse to provide a full range of health services, the MCO, PIHP, or PAHP must also demonstrate that it:

> ***(I) Contracts with at least one institutional provider and one professional provider within the same geographic area that provides covered services in-network providers refuse to provide;***
>
> ***(II) If there is no provider in the geographic area that offers the covered services, contracts with additional providers in nearby regions and provide transportation services; and***
>
> ***(III) Ensures a protocol is in place to allow enrollees to obtain covered services when a primary care provider refuses or is unable to make a referral to needed services.***

C. § 438.68(d) EXCEPTIONS PROCESS

We strongly support the addition of a provision requiring states to consider rates of payment in evaluating whether to grant a plan an exception to a quantitative network adequacy standard. This addition is an important step toward parity in the way CMS and states evaluate access in Medicaid managed care and Medicaid FFS. We continue to emphasize, however, that the § 1902(a)(30)(A) requirement is a broad Medicaid state plan requirement – like many others in § 1902(a). The statute draws no distinction between managed care and FFS. When Congress intends to exempt Medicaid managed care from foundational § 1902(a) requirements, Congress does so explicitly. For example, in § 1932(a)(1)(A), the statute explicitly authorizes state plans to include managed care "notwithstanding paragraph … (23)(A) of section 1902(a)" (the freedom of choice provision). No exemption like the explicit one for (a)(23)(A) exists anywhere in the statute for (a)(30)(A), and CMS has no authority to create such an exemption on behalf of Congress. Thus, we continue to urge CMS to apply the same standards and metrics across the Medicaid program including both Managed Care and FFS Medicaid.

Furthermore, as we have previously written, exceptions to network adequacy standards should be construed narrowly, and granted only when truly necessary. We commend CMS for including consideration of payment rates in the exceptions process. Such consideration should be used to ensure that exceptions are truly limited to exceptional circumstances – for example when there is no provider of a particular service practicing in a particular region, or when a provider refuses to accept Medicaid payment regardless of payment rates. Today, we are concerned that too often, low rates are a component of access issues in Medicaid, when providers who would otherwise participate in Medicaid managed care networks decline, because the rates are substantially lower than their other lines of business, and in some cases, are too low to sustain the provider's practice.[16] We encourage CMS to continue to closely scrutinize State exceptions to network adequacy requirements closely to ensure that the exceptions are not swallowing the rule.

[16] *See, e.g.,* Diane Alexander & Molly Schnell, *The Impacts of Physician Payments on Patient Access, Use, and Health* 31-34 (2019), https://www.nber.org/system/files/working_papers/w26095/w26095.pdf; Kayla Holgash & Martha Heberlein, *Physician Acceptance Of New Medicaid Patients: What Matters And What Doesn't,* HEALTH AFFAIRS BLOG, April 10, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190401.678690/full.

D. § 438.68(e) – PUBLICATION OF NETWORK ADEQUACY STANDARDS

We enthusiastically support CMS' proposal to implement, for the first time, national minimum timely access standards in Medicaid managed care. NHeLP has long advocated for such minimum standards, and we appreciate that CMS is proposing to take this important step to ensure access for managed care enrollees. Timely access standards are an important measure of realized access to care, since they accurately reflect the ability of enrollees to obtain the care they need. Over the last decade, timely access standards have become a foundational component of network adequacy monitoring and enforcement in Medicare Advantage, Marketplace plans, and many state-regulated commercial insurance plans. In addition, several states and Medicaid plans already use some form of timely access standard to evaluate network adequacy. By setting a national minimum standard for Medicaid managed care, which is aligned with marketplace standards, CMS will bring clarity and consistency to network adequacy monitoring and measurement across the program. In particular, as discussed in more detail below, we strongly praise CMS's proposal to monitor and enforce compliance with timely access standards using secret shopper surveys, and for setting a compliance standard as determined by these annual surveys.

We commend CMS for proposing to set national minimum timely access standards for behavioral health services, primary care, and OB/GYN. For the reasons set forth above, we recommend amendments to the proposed regulatory language to replace the term "obstetrics and gynecological," with "reproductive and sexual health."

We also recommend that CMS adjust the regulatory language to make clear that these wait times apply not only to initial visits but also to necessary follow-up appointments. This clarification is especially important in the area of behavioral health, where many people need regular, ongoing treatment and it is important not only that people can see a provider for a timely initial appointment, but also that they are able to schedule those regular follow-up appointments within clinically appropriate timeframes. Further, while the minimum timeframes established should be appropriate for the vast majority of appointments, we urge CMS to include explicit language clarifying that appointments must be made available earlier when a shorter wait is medically necessary.

We support CMS's proposal to impose a 90% compliance rate on plans. Setting a precise compliance threshold will ensure that stakeholders—including states, insurance regulators, enrollees, providers, and advocates—have a common benchmark to evaluate whether managed care plans' networks comply with the standard.

We urge CMS to consider also setting a timely access standard for specialty care. Many Medicaid managed care enrollees have chronic conditions and disabilities that require access to specialists such as cardiologists, endocrinologists, orthopedists, neurologists, and oncologists.[17] In many locations, wait times of six or more months to see these specialists are common.[18] Thus, imposing a wait time standard in some of these specialties could dramatically improve access and the overall quality of health care provided to managed care enrollees. Moreover, a standard of 30 calendar days would be consistent with standards for QHPs in the Marketplace.[19] We suggest that CMS require that one of the state-selected services described in (e)(1)(4) be a specialty service. We encourage CMS to consider requiring additional types of specialist care, perhaps by requiring states to consult the Medicaid Advisory Committee and Beneficiary Advisory Group.

We also recommend that CMS consider requiring plans to provide a 24-hour telephone line to provide triage or screening services. These telephone lines are commonly used in the private insurance market and studies have found that they are associated with reductions in inappropriate use of emergency services.[20] We believe that by requiring plans to use some kind of telephonic screening system that is available 24/7, CMS can improve access to care by helping enrollees to quickly determine what level of care they need. We appreciate that CMS has included the availability of such lines as a factor for consideration in evaluating quantitative network standards in § 438.68(c), and we

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[17] *See, e.g.,* Justin W. Timbie et al., *Specialty Care Access for Medicaid Enrollees in Expansion States,* 25 AM. J. MANAGED CARE e83 (2019); Joseph T. Labrum IV et al., *Does Medicaid Insurance Confer Adequate Access to Adult Orthopaedic Care in the Era of the Patient Protection and Affordable Care Act?,* 475 CLIN. ORTHOP. RELAT. RES. 1527 (2017).

[18] See, e.g., ANM Healthcare, Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates (2022), https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/News_and_Insights/Articles/mha-2022-wait-time-survey.pdf.

[19] CMS, 2023 Letter to Issuers in Federally-facilitated Exchanges, Jan. 7, 2022, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf.

[20] See, e.g., Elena Bissell et al., *Effectiveness of a 24/7 Nurse Advice Line in Reducing Non-Emergent Visits to the Emergency Room in Rural New Mexico*, 58 J. INVESTIGATIVE MED. 126 (2010); Gregory M. Bogdan et al., *Evaluating Patient Compliance With Nurse Advice Line Recommendations and the Impact on Healthcare Costs*, 10 AM. J. MANAGED CARE 534 (2004); Steven R. Poole et al., *After-Hours Telephone Coverage: The Application of an Area-Wide Telephone Triage and Advice System for Pediatric Practices*, 92 PEDIATRICS 670 (1993).

believe the time is ripe to require Medicaid managed care plans to implement these telephone lines.

Additionally, we also encourage CMS to set standards for and require states to monitor calls to Medicaid plans customer service lines. Too often, enrollees who cannot find a provider, need assistance with transportation, or who wish to file a grievance languish on hold with their plan's telephone line for hours, or are unable to get through on the line at all. CMS should set minimum standards to ensure that telephone wait times are reasonable so that enrollees' can address problems with their plans.

Finally, we again recommend that CMS make clearer plans' obligations when no provider is available within the state's timely access standard. In these cases, we suggest that CMS require states to require plans to either arrange for care to be provided by a provider who is out-of-network, or arrange for an appointment by telehealth, where appropriate. Currently, even in some states with robust timely access standards, plans have little accountability to ensure care when they are not able to meet the standard. We recognize that it will sometimes be difficult for plans to meet the timeliness standard in some regions, due to provider shortages or other factors. But too often, where the Medicaid plan fails to comply with timely access, there is no remedy offered to the enrollee to ensure that they get the care they need a and no consequences to the plan that would motivate change. We urge CMS to explicitly require states to ensure that *all* enrollees have access.

RECOMMENDATION: amending § 438.68(e) as follows:

> (e) Publication of network adequacy standards. States must establish and enforce appointment wait time standards.
>
> (1) Routine appointments. Standards must be established for routine appointments ***including initial appointments and necessary follow-up appointments*** with the following provider types and within the specified limits:
>
> (i) If covered in the MCO's, PIHP's, or PAHP's contract, outpatient mental health and substance use disorder, adult and pediatric, within State-established time frames but no longer than 10 business days from the date of request.
>
> (ii) If covered in the MCO's, PIHP's, or PAHP's contract, primary care, adult and pediatric, within State-established time frames but no longer than 15 business days from the date of request.

(iii) If covered in the MCO's, PIHP's, or PAHP's contract, obstetrics and gynecological within State-established time frames but no longer than 15 business days from the date of request.
(iv) **One** State-selected **specialty service**~~, other than those listed in paragraphs (e)(1)(i) through (iii) of this section,~~ chosen in an evidence-based manner within State-established time frames, **but no longer than 30 days from the date of the request.**
(v) The applicable waiting time for a particular appointment must be shortened if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined that it is medically necessary for the enrollee to receive care more quickly.

(2) ***24/7 Triage Phone Line. Each MCO, PIHP, and PAHP shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone.***

(i) Each MCO, PIHP, and PAHP shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.
(ii) A MCO, PIHP, and PAHP may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services; telephone medical advice services; the plan's contracted primary care and mental health care provider network; or other method that provides triage or screening services consistent with the requirements of this subsection.

(4) Minimum compliance. MCOs, PIHPs, and PAHPs will be deemed compliant with the standards established in paragraph (e)(1) of this section when secret shopper results, consistent with paragraph (f)(2) of this section, reflect a rate of appointment availability that meets the standards established at paragraph (e)(1)(i) through (iv) of at least 90 percent.

(**5**) Selection of additional types of providers. After consulting with States and other interested parties and providing public notice and opportunity to comment, CMS may select additional types of providers to be added to paragraph (e)(1) of this section.

(6) Whenever medically necessary care is not available within the state's appointment wait time standards, the MCO, PIHP or PAHP shall arrange for the enrollee to receive medically necessary care by, within the applicable wait time:

(i) Arranging for the enrollee to see an out-of-network provider; or

(ii) Where medically appropriate, arranging for telehealth.

E. § 438.68(f) INDEPENDENTLY-CONDUCTED SECRET SHOPPER SURVEYS

We enthusiastically support the proposal to require states to contract with independent entities and conduct secret shopper surveys to verify the accuracy of provider directories and to measure compliance with appointment wait time standards. This direct test of plan compliance with critical network adequacy standards will provide valuable information to states, plans, and advocates. Moreover, we strongly approve the proposal to use annual secret shopper surveys to help enforce a 90% compliance rate with timely access standards. We also commend CMS for proposing to require states to employ secret shopper surveys to evaluate the accuracy of provider directories. With respect to the scope of these surveys, we recommend that the defined provider types be amended to replace the term "OB/GYN" with "reproductive and sexual health," and to include specialists, mirroring our recommendations above regarding proposed § 438.68(e). Further, we recommend that CMS make amendments to strengthen this section by establishing a compliance standard for provider directory accuracy of 90%, and require its verification through secret shopper as well.

In 2014, CMS' Office of the Inspector General conducted secret shopper surveys of Medicaid plans that found over half the provider directory entries were incorrect or not available for appointments.[21] A number of states have also found that direct testing of networks and provider directories through mechanisms like secret shopper surveys helps identify consumer access barriers. States including Texas, Maryland, Connecticut, Missouri, New Hampshire, and Ohio have conducted surveys that revealed massive

[21] HHS OIG, *Access to Care: Provider Availability in Medicaid Managed Care,* 8 (Dec. 2014), https://oig.hhs.gov/oei/reports/oei-02-13-00670.asp; See also, HHS OIG, *State Standards for Access to Care in Medicaid Managed Care* (Sept. 2014), https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.

error rates in provider directories and documented long wait times to obtain a scheduled appointment.[22] Maryland's extensive survey of on-line and paper provider directories led to nine corrective action plans for MCOs in 2019.[23] Texas' EQRO study, which only successfully contacted 52.7% of providers in 2018, includes a list of best practices for more accurate provider directories.[24] Together, these efforts all point to an urgent need for better oversight and accountability.

Ohio's EQRO compared secret shopper against revealed caller surveys. When the caller identified themselves as an evaluator, 81.7% of primary care providers reported appointment wait times under thirty days for new patient well-check visits. Ohio's secret shopper survey, using the same sampling, found only 69.5% of PCPs reported wait times under thirty days.[25] We realize that there may be some issues with secret shopper survey design whereby some providers may not schedule appointments unless a caller provides proof of identity, but these results may also suggest that some providers are not being forthcoming in their interactions with revealed callers.

We agree that the four elements of the secret shopping survey (the active network status, the provider's street address, the provider's telephone number, and their status as accepting new Medicaid enrollees), are essential pieces of information in assessing the true availability of in- network providers. We also agree that appointments via

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[22] See, e.g., ICHP, *Summary of Activities and Value Added Services: Quality, Timeliness, and Access to Health Care for Texas Medicaid and CHIP Recipients*, 144 (May 2019), https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/eqro-summary-of-activites-report-contract-yr-2018.pdf; HSAG, New Hampshire SFY 2020 Secret Shopper Survey Report (2020), https://medicaidquality.nh.gov/sites/default/files/._NH2020_Secret%20Shopper%20Survey_Report_F1_0720.pdf.

[23] Qlarant, Medicaid Managed Care Organization Annual Technical Report 2019, 141-2 (Apr. 2020), https://mmcp.health.maryland.gov/healthchoice/Documents/2019%20MD%20ATR%20FINAL_508.pdf.

[24] ICHP, *Provider Directory Data Quality: Key Issues and Recommendations for Best Practices*, 3, 24 (Dec. 2018), https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/provider-directory-data-quality-issues-best-practices.pdf. See also, Texas Health & Human Services Comm., Off. Inspector Gen., *Data Integrity of Online Provider Directories* (Aug. 23, 2019), https://oig.hhsc.texas.gov/sites/default/files/documents/reports/IG-Inspections-Division-Online-Provider-Directories-FINAL-082319.pdf.

[25] QSource, Annual EQRO Technical Report: State Fiscal Year 2019, 41 (Apr. 2020), https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/SFY-2019-External-Quality-Review-Technical-Report.pdf.

telehealth should only be counted toward compliance with wait time standards if the provider offers in-person appointments in the same timeframe.

CMS has proposed to require secret shopper surveys for the three provider types for which it will establish federal wait time standards (primary care; reproductive and sexual health providers; and mental health and substance use). CMS notes that these service providers have the highest utilization in many Medicaid managed care programs. We submit, however, that other providers may have lower relative utilization partly because access to specialists remains difficult for Medicaid patients. Secret shopper survey data may be even more helpful for specialty providers, since people have a harder time getting appointments with them in general.[26] We recommend that CMS expand the scope of secret shopper review to include more specialty provider types. As an initial step, as with timely access standards, we recommend that CMS require that the state's option for a fourth provider type must be a specialist provider type. In the future, we encourage CMS require states to add additional types of specialty care, based in part on recommendations by the MAC and BAG.

In the final rule or in future guidance, we strongly recommend that CMS also consider requiring states to use the independent secret shopper surveys as tools to identify barriers to care for marginalized groups. For example, people with disabilities often face accessibility challenges not only with office buildings of certain providers, but also with accessing certain types of medical equipment – from examination tables to sophisticated imaging technology.[27] Using the secret shopper method to ask about physical accessibility could be a very powerful tool to measure health care inequities. Similarly, a 2006 Connecticut Medicaid secret shopper survey included a subsample of Spanish-speaking callers. Perhaps not surprisingly, it found substantially lower rates of successfully scheduled appointments (16.7% of all calls compared to 26% of English calls.) Over a third of the sample calls were told the provider had no process in place to accommodate Spanish-speaking callers.[28] More recently a different Connecticut secret shopper survey had callers identify themselves with "multicultural" or "non-multicultural" names, alternatively. Callers identifying with multicultural names encountered fewer providers who said they were accepting new patients 90.4% accepting versus 82.4% n=343).[29] This trend was consistent across all provider types surveys except for

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[26] Walter R. Hsiang, et al., *supra* n. 9.
[27] Elizabeth Pendo, *Disability, Equipment Barriers, and Women's Health: Using the ADA to Provide Meaningful Access* 2 SLU J. HEALTH LAW & POL'Y 15, (2008), https://ssrn.com/abstract=1435543.
[28] Mercer for the Conn. Dept. Soc. Servs., Mystery Shopper Project, 18 (Oct. 25, 2006).
[29] Community Health Network of Conn., Presentation to the Medical Assistance Program Oversight Council, 25, (2022),

pediatricians. The compelling results of these survey designs suggest that secret shopper surveys have potential not only to improve provider networks and access to care for managed care enrollees, but also might be powerful tools to advance health equity.

In terms of reporting requirements, we appreciate the quick timeframe for posting survey results publicly and agree with the suggestion that the state and managed care entity should receive the report at the same time in order to expeditiously remedy any problems.

Finally, we support the requirement that states post the results of their secret shopper surveys on their websites. This will enable enrollees, advocates, and providers to track plan performance, and hold plans and policymakers accountable to implement remedial measures to address and correct any deficiencies. We encourage CMS to consider compiling these reports and publishing them in one place on its Medicaid.gov website as well, to make it easier to find and compare the reports of different states, or to evaluate the performance of an MCO across various states.

We do, however, urge CMS to require states to come into compliance with the requirements of this regulation sooner than proposed. In particular, allowing four years before States implement the independent secret shopper requirements seems far too long when many states already have experience conducting such surveys. Under this proposal, beneficiaries and other stakeholders will not see this crucial information until 2028 or later, with any results from improvement coming even later. We urge CMS to shorten this timeframe.

RECOMMENDATION: We recommend amending a § 438.68(f) as follows:

* * *

(1) Provider directories.

(i) A secret shopper survey must be conducted to determine the accuracy of the information specified in paragraph (f)(1)(ii) of this section in each MCO's, PIHP's, and PAHP's most current electronic provider directories, as required at § 438.10(h), for the following provider types:

(A) Primary care providers, if they are included in the MCO's, PIHP's, or PAHP's provider directory;

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

(B) ~~Obstetric and gynecological providers~~ **reproductive and sexual health providers**, if they are included in the MCO's, PIHP's, or PAHP's provider directory;
(C) Outpatient mental health and substance use disorder providers, if they are included in the MCO's, PIHP's, or PAHP's provider directory; ~~and~~
(D) ***One type of specialist, selected by the state pursuant to (e)(1)(iv), that is included in the MCO's, PIHP's, or PAHP's provider directory; and***

* * *

(iii) States must receive information, sufficient to facilitate correction by the MCO, PIHP, or PAHP, on errors in directory data identified in secret shopper surveys from the entity conducting the secret shopper survey no later than 3 business days from the day the error is identified by the entity conducting the secret shopper survey.
(iv) States must send information required in paragraph (f)(1)(iii) of this section to the applicable MCO, PIHP, or PAHP no later than 3 business days from receipt.
(v) Minimum compliance. MCOs, PIHPs, and PAHPs will be deemed compliant with the standards established in § 438.10(h) when secret shopper results, consistent with this paragraph, reflect a rate of accuracy of provider directory listings that meet the standards established at § 438.10(h) of at least 90 percent.

F. § 438.68(g) PUBLICATION OF NETWORK ADEQUACY STANDARDS

We support the proposal to require states to publish their network adequacy standards. We suggest a small amendment to this section to make clear that published standards should be accessible and easy-to-understand for enrollees.

RECOMMENDATION: We recommend amending a § 438.68(f) as follows:

(g) Publication of network adequacy standards. States must publish ***in an accessible, easy-to-understand format,*** the standards developed in accordance with paragraphs (b)(1) and (2), and (e) of this section on the website required by § 438.10(c)(3). Upon request, network adequacy standards must also be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.

§ 438.207 Assurances of adequate capacity and services

We enthusiastically support CMS's proposal to require a payment analysis of rates paid by MCOs to providers, as well as the broader goal of establishing a standardized comparative data source available to assess Medicaid and CHIP payment rates across specialties, plans, and states. It is abundantly clear that low payment rates harm Medicaid beneficiaries, as they limit physician and other practitioner participation, especially in specialties and some long term care services.

We also support the requirement that states post the report of the analysis within thirty days of submission to CMS. A lot of information about managed care becomes available after a significant lag time, when it is much less useful. Ensuring that beneficiaries, providers, and advocates have access to the study results in a meaningful time frame.

We strongly support the proposal to require states to promptly submit a remedy plan when CMS identifies areas for improvement for access to services, and requiring that the remedy plan identify specific steps and timelines to achieve the goals of the remedy plan. This requirement would impose much-needed transparency and accountability to managed care rates. Combined with CMS's ability to disallow FFP for payments made under managed care contracts when the state fails to ensure access to care, this would significantly advance the goal of ensuring that beneficiaries have access to the services they need. We also recommend that the remedy plans, once approved, be posted on the state's website and that the state agency be required to share them with the MAC and the BAG.

Finally, we note with approval CMS's comment in the preamble, in the context of remedy plans, stating that it has the authority to disallow FFP for payments made under the state's contract with a plan if the state fails to ensure adequate access to care. 88 Fed. Reg. 28107. We encourage CMS to use this authority when necessary to ensure true accountability that drives real change.

§ 438.340 Managed care state quality strategy

This proposed rule includes numerous provisions that boost accountability, transparency, and participant input into managed care oversight systems, which we enthusiastically support.

We support the proposed requirement to make the quality strategy available for public comment regardless of whether the state has made substantial changes at §

438.340(c)(3). This will allow stakeholders to provide input based on the results of the quality strategy effectiveness evaluation – and suggest areas for improvement – even if the state has proposed no revisions. In conjunction with this change, we appreciate the clarification that the evaluation of the effectiveness of the prior quality strategy must be included as part of the review the state posts publicly pursuant to 438.340(c)(2).

We note that this evaluation should be made available with sufficient time prior to the public comment period and the stakeholder input process to allow interested parties to use that information to meaningfully engage in the updating process. We suggest adding clarifying language to the regulation emphasizing this point.

RECOMMENDATION: Add the following phrase to proposed § 438.340(c)(2)(ii):

> (c)(2)(ii) The State must make the results of the review, including the evaluation conducted pursuant to paragraph (c)(2)(i) of this section, available on the website required under § 438,10(c)(3) ***at least 30 days prior to opening the public comment period required under paragraph (c)(1) of this section***.

§ 438.360 Nonduplication of mandatory activities with Medicare or accreditation review and § 438.362 Exemption from external quality review

We support the streamlining of EQR by facilitating the use of accreditation data as long as the standards are equivalent to EQR and the use of accreditation data does not compromise the integrity, transparency, and timeliness of the plan quality data.

§ 438.364 External quality review results

We also support the proposed changes to EQR, that will make the data more accessible, reduce data lags, and allow for more participant input into quality strategies and core measure review. These changes include:

- § 438.364(c)(1) – Changing the submission date for annual technical reports to December 31 to align better with the reporting cycle for HEDIS and reduce the data lag to no more than 1 year after the data collection period closes. Our experience with state annual technical reports shows that the data lag in some states continues to exceed 18-24 months, which seriously compromises the usefulness of the results for current enrollees. This change would shorten that lag in many cases to less than 12 months.

- § 438.364(c)(2)(iii) – Requiring states to post at least 5 prior years of annual technical reports on their website is an important improvement. However, there is virtually no administrative burden to keep technical reports available to the public over an extended period of time. An EQR archive makes it easier to track responses to recommendations, evaluate progress on Performance Improvement Projects, and monitor changes in quality performance. Given the lack of administrative burden, we see no reason not to extend this requirement to posting at least 10 years of reports.

- § 438.364 (a)(2)(iii) – Ensuring that annual technical reports include the actual results of performance measures and performance improvement projects. Some states have limited their technical reports to data only about the validation of the quality data, while not including the specific data on quality metric outcomes.[30] This validation information, absent the actual results, is of limited value to advocates and the public.

§§ 438.500 - 535 Quality Rating System

We support CMS's broad and ambitious vision to help states build public dashboards featuring core quality measures and other important information about managed care plans to help new and returning enrollees to select managed care plans that most suit their needs.

The initial set of eighteen measures for the Quality Rating System (QRS) spans a broad range of populations and service types with well-tested measures. While the inclusion of only one measure related to Long Term Supports and Services (LTSS) limits the tool's usefulness for older adults and people with disabilities to evaluate the quality of HCBS services across health plans, we recognize that the tool will still help inform decisions about common chronic and preventive care conditions that also affect these groups.

We have some concerns that the proposed QRS selection process may make it harder for new HCBS measures to be included in future versions. Given the large proportion of Medicaid expenditures that HCBS comprises, the managed care QRS structure should be designed to be more, not less inclusive of HCBS measures. The rule requires that measures must meet at least five of six listed conditions listed in § 438.510(c)(1) to be considered for the core set, including one that the measure "aligns" with quality

[30] *See, e.g.,* Mercer, *2018 External Quality Review Medicaid Managed Care Organization Performance Report for the State of Delaware* (Mar. 4, 2019), https://dhss.delaware.gov/dhss/dmma/files/2018_eqro_compliance_report.PDF.

initiatives in other CMS programs, namely Medicare and the Marketplace. While CMS acknowledges HCBS in the preamble, we have concerns that HCBS is not explicitly mentioned in the regulation as a key component of the Medicaid program that should be fairly represented in the QRS measure set, even if it will never "align" with Medicare or Marketplace QRS precisely because those programs do not cover HCBS. One solution would be to add language to the criterion at § 438.510(c)(2) to highlight that the QRS "balance" needs to account for services more-or-less unique to the Medicaid program.

We also recommend that the criteria for measure selection better reflect CMS's strategic priority to reduce health disparities in Medicaid. The proposed selection criteria only mention health equity as one of a number of permissible topics for health plan performance measures. While the QRS includes a provision for CMS to select measures for stratified reporting to identify disparities, it is not clear in the regulation text what priorities, principles, or standards CMS will use to decide which demographic features and which measures. None of the measure selection criteria in § 438.510(c)(1), (2), or (3) are structured to drive forward the importance of stratifying measures by key demographics to identify disparities. In other words, aside from a vague reference to "balanced representation" in § 438.510(c)(2), there is nothing in the selection criteria that identifies health equity as a priority goal for effective quality care or that would necessarily encourage a shift toward better stratified reporting in the future. For this reason, we urge CMS to add a seventh criterion for CMS and stakeholders to consider when evaluating measures for inclusion in the QRS: Is the measure likely to inform efforts to advance health equity?

RECOMMENDATION: Add the following provision to § 438.510(c)(1):

> ***(vii) Is likely to inform efforts to advance health equity.***

RECOMMENDATION: Amend § 438.510(c)(2) as follows:

> (2) The proposed measure contributes to balanced representation of beneficiary subpopulations, age groups, health conditions, services ***– including services not typically covered by other CMS programs described in § 438.505(c) –*** and performance areas within a concise mandatory measure set; and

RECOMMENDATION: Correct a minor grammatical error in proposed § 438.510(c)(3):

> (3) The burdens associated with including the measure ~~does~~ ***do*** not outweigh the benefits…."

We appreciate proposed milestones for states to begin reporting measures stratified by race and ethnicity and other demographic factors, but we urge CMS to establish a shorter timeline for some elements to reinforce CMS's prioritization of health equity. We recommend shortening the time frame for states to report required quality ratings stratified by age, language, and geographic region to four years. These data are already available and should not be very challenging for states to include in Phase 1 of the QRS rollout where appropriate.

We recommend setting a clear maximum implementation timeline for Phase 2 of the rollout, which currently reads as "no earlier than 2 years after" QRS implementation. Such an open-ended timeline leaves the impression that this bold vision to create an interactive, one-stop shop for plan information, including the ability to customize search for providers and see stratified quality information tailored to the consumer's needs, may never happen. We recommend finalizing the rule with a clear deadline of no more than 2 years for states to develop the fully-interactive Phase 2 QRS website. If CMS believes more time is needed to realistically implement Phase 2, we suggest implementing key components of Phase 2 within 2 years after Phase 1 and then setting a reasonable outer deadline for the most challenging elements.

We also recommend expanding the scope of populations on which states must report stratified quality ratings. While disability is mentioned in the list of demographics for stratification in proposed 438.520(a)(6)(iii), the proposed language does not clearly require that states stratify by all these demographic factors for Phase 2. More importantly, as noted above, the proposed rule creates a mechanism for CMS to require stratified reporting of QRS measures, but no process to inform which measures and factors CMS should prioritize for stratified reporting. We recommend changing language of this provision to set up an expectation that states will stratify measures by all relevant listed factors unless the Secretary specifies a reason not to in the process of updating the measure set. In addition, following CMS's own commitments in the CMS *Framework for Health Equity* and in the *Federal Evidence Agenda on LGBTQI+ Equity*, the regulation should include sexual orientation/gender identity/sexual characteristics as demographic factors used to stratify QRS results.[31]

We look forward to working with CMS to develop data infrastructure for more accurate and comprehensive collection of disability-related data. Current approaches that use

[31] National Science and Technology Council, *Federal Evidence Agenda on LGBTQI+ Equity*, (Jan. 2023), https://www.whitehouse.gov/wp-content/uploads/2023/01/Federal-Evidence-Agenda-on-LGBTQI-Equity.pdf; CMS, *CMS Framework for Health Equity 2022-2032*, 5 (Apr. 2022), https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf.

disability eligibility categories leave out large swaths of participants who qualify for Medicaid through other eligibility pathways, like the adult Medicaid expansion. Current Medicaid application questions typically are not detailed enough to accurately capture self-reported disabilities by type. Claims-based disability flags often fall short as well. Having a standardized flag for disability would facilitate the stratification of Medicaid core measure sets by disability to identify disparities affecting people with disabilities' access to acute and preventive care. It would also make it easier to identify and address intersectional disparities for people with disabilities who are also marginalized due to race, ethnicity, geography, age, language, sexual orientation, gender identity, or other demographic characteristics.

Finally, we want CMS to affirmatively and clearly state that states reporting on the QRS, as well as reporting on other Medicaid core measure sets, should include all Medicaid HCBS recipients in managed care. HCBS participants are Medicaid-enrolled individuals, and they should never be left out of reporting that covers preventive care, chronic disease management, enrollee satisfaction, mental health, and other aspects of health care that core measure sets cover. Discussions and decisions during the 2022 Adult and Child core quality measure meetings hosted by Mathematica raised questions about whether participants in some HCBS programs are included in reporting on those sets. If it is true that they are not included, they should be.

RECOMMENDATION: Amend § 438.520(a)(6)(iii) as follows:

> (iii) The quality ratings described in § 438.520(a)(iv) calculated by the State for each managed care plan in accordance with § 438.515 for mandatory measures identified by CMS, including the display of such measures stratified by dual eligibility status, race and ethnicity, sex, ***sexual orientation, gender identity and sexual characteristics,*** age, rural/urban status, disability, language of the enrollee, ~~or~~***and*** any other factors specified by CMS in the annual technical resource manual.

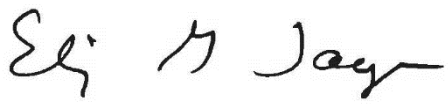
As a matter of process, we wholeheartedly endorse CMS's decision to pre-test web prototypes for the QRS with Medicaid enrollees to identify approaches that work best for them. We appreciate how CMS clearly used the feedback to adjust its proposed policy requirements. This is a wise and obviously fruitful method to create more effective and responsive federal policy and we encourage its broader use in the future. We recommend that such user testing also include people with disabilities and those with limited English proficiency to identify and address accessibility issues.

CONCLUSION

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.

Thank you for consideration of these comments. If you have any questions or need any further information, please feel free to contact Sarah Somers (somers@healthlaw.org).

Sincerely,



Elizabeth G. Taylor
Executive Director