Best Practices for Medicaid Secret Shopper Survey Implementation

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Introduction

Medicaid enrollees face significant gaps in access to care, including long appointment wait times, persistent provider directory inaccuracies, and ghost networks.[1] According to one 2023 survey, 1 in 3 Medicaid enrollees report that in the past year an in-network provider they needed to see did not have available appointments.[2] Numerous studies employing secret shopper surveys have also demonstrated that Medicaid enrollees often experience difficulty scheduling appointments for primary care and, particularly, for specialty services.[3]

The 2024 Managed Care Access rule enables states to hold Medicaid managed care plans more accountable for network adequacy failures by establishing new federal appointment wait time standards. It requires states to conduct annual independent secret shopper surveys to evaluate compliance with these new standards. While the secret shopper survey requirement will not be fully effective until 2028, many states already use this potentially powerful accountability tool to monitor and enforce network adequacy for Medicaid plans. Advocates should understand now what best practices make secret shopper methodologies most effective to monitor equitable access to care in Medicaid managed care.

This issue brief summarizes the new Medicaid requirements, presents several of the methodological challenges that can complicate this approach, and provides advocacy tips for secret shopper survey implementation.

Current Use of Secret Shopper Surveys

Secret shopper surveys involve callers who pose as enrollees or relatives trying to schedule an appointment with a provider. By putting the evaluator directly into the enrollee's shoes, these surveys produce credible and actionable data that reflect the true experience of an enrollee trying to schedule an appointment with a new provider.

Many states already have prior experience conducting secret shopper surveys within their existing external quality review (EQR) processes. In 2022, 28 states reported using secret shopper surveys to monitor managed care plan compliance with network adequacy.[4] Additionally, secret shopper surveys are commonly used within the academic research community to evaluate appointment availability and access to care across different health coverage types.[5] In some states, other offices, such as the attorney general, have used this methodology to investigate network adequacy in managed care.[6]

There are some unique challenges inherent to the anonymous nature of the secret shopper methodology. For example, secret shopper callers may encounter providers who will not schedule appointments without proof of identity. When attempting to survey multiple providers within the same practice group, callers may also reach the same centralized appointment scheduler and run the risk of being identified as conducting a survey. However, evaluators can successfully navigate these challenges through carefully thought-out call scripts and survey protocols.

A related methodology, known as a revealed caller survey, involves callers who identify themselves as an evaluator when they contact a provider. Revealed caller surveys may be logistically simpler than secret shopper since they do not require an extensive call script, but they risk the possibility that providers may not be entirely forthcoming in their answers, since they know they are being evaluated.

States are entitled to receive up to a 75% enhanced federal match for conducting secret shopper or revealed caller surveys as an optional EQR activity related to managed care organizations, which helps address concerns regarding cost and resources necessary for implementation.[7]

New Secret Shopper Survey Requirements

The 2024 Managed Care Access rule requires states to contract with independent entities to conduct annual secret shopper surveys to verify the accuracy of managed care plans' provider directories and measure compliance with the new federal maximum appointment wait time standards (*see* Table 1).[8] Secret shopper surveys will be the primary method used to enforce compliance with the federal appointment wait time standards.[9]

Table 1. Medicaid Managed Care Appointment Wait Times Standards[10]

Service Type	Routine Appointments Must be Available Within*
Outpatient Mental Health and Substance Use Disorder (Adult and Pediatric)	10 business days
Primary Care (Adult and Pediatric)	15 business days
Obstetrics and Gynecology	15 business days
State-selected[11]	State-established timeframe

*States may establish shorter wait time standards than the CMS standard

States must conduct secret shopper surveys covering all three service categories for which CMS designated appointment wait time standards. States must also choose at least one additional service type.[12] They have the option to establish time standards stricter than CMS the other required service types, including for subsets like pediatric care. Annual surveys must assess and verify at least four critical elements of provider information in each managed care plan's most current electronic provider directory: (1) active network status, (2) street address, (3) telephone number, and (4) whether a provider is accepting new Medicaid enrollees.[13] The surveys must also determine each managed care plan's rate of network compliance with the new federal appointment wait time standards.[14] In this case, compliance means that 90 percent of surveyed providers can offer an appointment within the state's designated wait time standard.[15] Note that telehealth appointments may only be counted toward compliance if the surveyed provider also offers in-person appointments, meaning managed care plans are prohibited from meeting appointment wait time standards with telehealth appointments alone.[16] Telehealth appointments must also be identified separately from in-person appointments in the survey results.[17]

The rule only includes a few methodological standards. To enable validity, secret shopper surveys must use a random, representative sample and include all areas of the state that are covered by the managed care plan's contract.[18] When determining plan compliance with the new appointment wait time standards, the surveys must also be completed for a statistically valid sample of providers.[19]

The rule also establishes certain reporting requirements for the secret shopper surveys. States must receive information on all provider directory data errors identified through the secret shopper surveys no later than 3 business days from the day of identification.[20] States must then send that information to the applicable managed care plan no later than 3 business days

from receipt.[21] Managed care plans must use this data to make timely corrections to their electronic provider directories no later than 30 calendar days after receiving the information.[22]

The secret shopper survey results must also be annually reported to CMS and publicly posted on state websites no later than 30 calendar days after submission to CMS.[23] This transparency will enable CMS, states, enrollees, and advocates to track plan performance and compliance with appointment wait time standards and provider directory requirements in order to hold plans accountable.

Promising Practices for Secret Shopper Survey Implementation

Because CMS' regulations established only a few methodological standards for the required secret shopper surveys, we have gathered some additional promising practices for advocates regarding effective secret shopper survey implementation. These tips reflect the rule's requirements, but also draw from related CMS guidance for Marketplace secret shoppers, posted methodologies from state-level Medicaid secret shopper surveys, and academic research articles authored by groups experienced in secret shopper research design.[24] Advocates can use this information to push states to do more than the minimum with their secret shopper design, such as using the tool as a way to measure equitable access to care.

A. Selecting Service Types to Monitor

Identify a range of high priority service types as targets for secret shopper. Perhaps the most important opportunity for advocates to shape the secret shopper process involves the state-selected fourth provider type. States must use an evidence-based process to select this fourth provider type. Because access to Medicaid providers is often most challenging for specialist care, this is a good opportunity for advocates to provide states with evidence on what might be the most impactful provider type to evaluate. States are not limited to just one additional provider type, but must select at least one.

In recent years, states that already utilize regular secret shopper survey tools have evaluated access to pediatricians (KY), dental providers (IL, IA, KY), endocrinologists (KY), and physical health specialists (NH), among others.[25] Notably, Kentucky has changed its focus for surveys annually since 2019, providing a broader picture on the state's overall MCO network adequacy.[26] However, the lack of repeated surveys of the same provider type has made it more difficult to track access and directory improvements in previously studied service types. Advocates should seek to provide direct input on state selection of service categories for secret shopper surveys. Even if a state is unwilling to create a separate stakeholder process on which

services to prioritize for Medicaid access challenges, advocates can leverage the comment process on their state's quality strategy (when under review) or the new Medicaid Advisory Committee (MAC) as a mechanism to provide suggestions.[27]

B. Selecting an Appropriate Provider Network Data Source

Identify the provider population to be surveyed from the managed care plan's most current electronic provider directory that actual enrollees would have access to and use. Unless and until CMS releases further guidance on the methodology, the provider data source that independent evaluators will use to conduct their surveys has not been clearly specified.

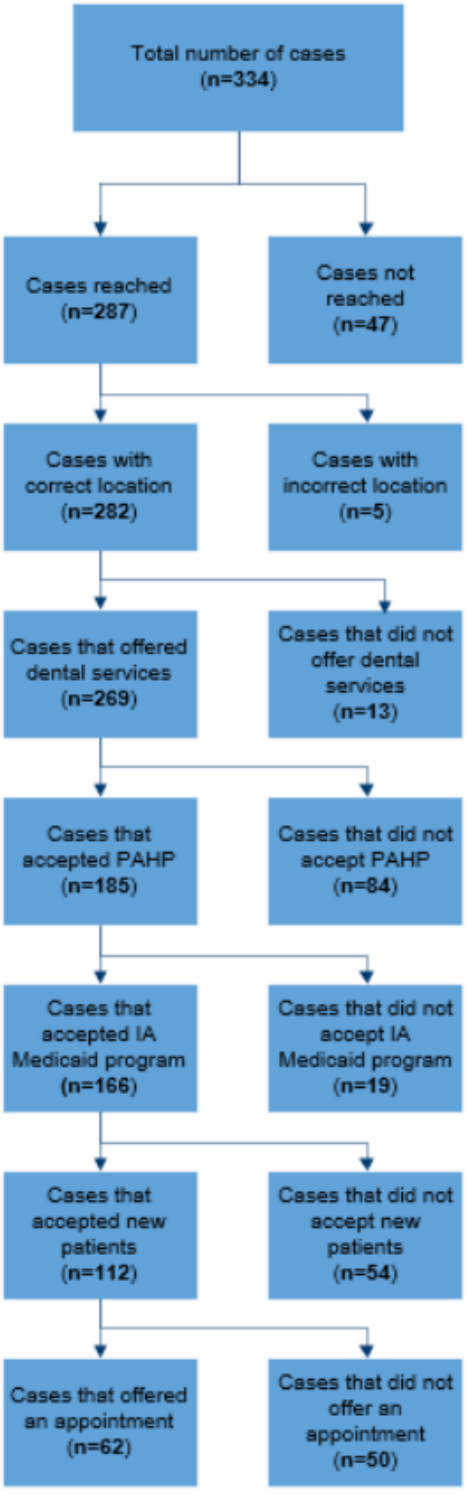
In guidance for the Marketplace, CMS provides the evaluator with a network provider population file for each plan network based on each issuer's network provider data submitted during the annual certification process.[28] That guidance is less clear about the relationship between the provider population files CMS supplies to Marketplace plans and the provider directories that enrollees actually use. If these data sources differ substantially, then the value of the secret shopper outcomes to enrollees' actual experience finding providers would diminish.

Medicaid regulations clearly orient secret shopper surveys around evaluating plan provider directory accuracy, so the sampling approach used for Marketplace plans that relies on submitted provider network data may not be appropriate for Medicaid secret shopper surveys.[29] Advocates should explicitly ask their states about these how the data sources are related and focus the sampling on the user experience, which begins with each plan's provider directory. Weighing in with CMS on the differences between these provider data sources may also help shape the forthcoming Medicaid secret shopper guidance.

C. Using a Valid Sampling Approach

Select a sample of providers that is random, statistically valid, and geographically representative of all areas of the state covered by the managed care plan. If a state chooses to review a smaller specialty, it may be necessary to oversample from the provider list to ensure that results are statistically sound. Some state-led or plan-led secret shopper surveys have limited value because their provider sample is too small to convey a statistically valid portrait of enrollee access.[30]

Fig. 1. Flowchart of Iowa 2023 Secret Shopper Call Outcomes



Source: Iowa Calendar Year 2023 External Quality Review Technical Report, Health Services Advisory Group (HSAG), (Apr. 2024), https://hhs.iowa.gov/media/13134/download?inline.

CMS has developed a convenient sampling chart with minimum survey sample sizes for Marketplace plan networks, and a similar approach should translate to the Medicaid context.[31] If a state chooses to evaluate a specialty that has a smaller number of participating providers, the sample may have to include all or substantially all of the listed providers to be statistically valid.

Define plan compliance using an inclusive definition of the sample size, which most closely tracks a user's experience finding providers. The final Medicaid regulation requires 90% compliance with timely appointment standards, but leaves an important question less clear: 90% of what? It turns out that states use different definitions in what counts in the denominator of that compliance standard.

For example, the Marketplace secret shopper guidance requires surveyors to draw an initial sample and a reserve sample prior to making calls. Listed providers who do not respond to calls, who report they are not contracted with the issuer, or who report they are not practicing within the target provider type get excluded from final reference sample used to determine compliance with Marketplace wait time standards. Surveyors replace these excluded providers with others drawn from the reserve sample.

The Marketplace approach helps provide a statistically significant final sample based on providers who actively report participating in the issuer's network. But it also effectively screens out provider directory errors like wrong numbers or providers not accepting that insurance from the compliance analysis. The Marketplace guidance does require the independent entity to report separately the share of the sample that was non-responsive or non-participating, but the consequences to the plan for having a high share of such providers in its submitted network is not articulated in CMS guidance.[32]

Medicaid secret shopper surveys should utilize a different protocol. States currently use an array of different denominators in recent EQR provider availability studies. Figure 1, reproduced from Iowa's 2023 survey of dental providers, shows a clear flowchart of how appointment failures occurred. In this case, Iowa's survey reported a 21.6% success rate for scheduling appointments.[33] The reported denominator included only cases reached (287 out of the 334 providers in the original sample.) Illinois' revealed caller analysis of dental and primary care providers did include non-responsive providers in its compliance denominator.[34] If Iowa had used the same denominator as Illinois, Iowa health plans' reported successful appointment rate would have dipped to 18.5%. On the other end of the scale, Oregon's secret shopper survey found timely appointment compliance rates much higher for dental (75.3%) and primary care providers (65.9%) across its managed care plans.[35] But Oregon's study defined the compliance denominator to exclude most sampled providers.[36] In fact, from an initial sample of 2573 providers called, Oregon's compliance denominator included only 251![37] If Iowa used the same standard as Oregon, its reported appointment success rate would spike to 55%. Importantly, Oregon's EQR report did include other charts showing the low share of contacted providers who were actually able to schedule appointments for new patients (17.4% for dental and 12.7% for primary care), but even these percentages exclude non-responsive providers.[38] These limited comparisons illustrate the importance of defining an appropriate standard denominator for compliance with federal regulations, even as they also show how much work plans have ahead of them to reach a meaningful 90% compliance threshold.

CMS should define the expected compliance denominator for these new federal standards to include nonresponsive and non-participating providers. From the perspective of an enrollee trying to set an appointment with a new provider, listings with wrong numbers and non-participating providers only make the process more burdensome and time-consuming. Separating those directory errors from the overall outcomes makes it easier for plans to achieve false "compliance" with the federal standard without addressing the burdens that incorrect listings create for enrollees. An inclusive federal standard would also promote comparability across the states. If CMS does not specify an inclusive compliance denominator, advocates should push their state to do so.

D. Creating Call Script Design

Create a realistic and detailed simulated enrollee scenario for callers to use. For example, a caller may pose as the caretaker or relative who is attempting to schedule an appointment on an enrollee's behalf. Calling on behalf of an enrollee may help create more maneuverability around common questions regarding proof of identity.

Each call script must confirm at least the four required elements of provider information (active network status, street address, telephone number, and acceptance of new Medicaid enrollees) and obtain appointment availability for the particular provider type being surveyed (primary care, outpatient mental health and substance use disorder, OB/GYN, or state-selected provider type). One experienced team of survey designers, Kelsey Rankin et al., have put together helpful tips for developing effective secret shopper methodologies.[39] They recommend that scripts should also:

- Ask about and differentiate between whether the provider has in-person and/or telehealth appointments available.
- Provide the caller with standardized responses to common scenarios (*e.g.,* provider is not accepting new patients, provider requires a referral, the caller is directed to voicemail/hold, etc.).
- Include standardized responses to avoid scheduling an actual appointment and to divert any questions that are aimed at scheduling an actual appointment;[40]

After developing a working call script, survey designers recommend piloting the draft scripts to identify unanticipated scenarios and facilitate the development of standardized responses to these situations.[41] This testing will help streamline the script to prioritize efficiency in an effort to reduce provider fatigue and improve the completeness of survey responses.

Develop scenarios that address access for enrollees with additional access barriers. Advocates should urge states to consider incorporating health equity considerations into the caller's simulated enrollee scenario (*e.g.,* enrollee only speaks X language, enrollee uses a wheelchair, etc.).[42] Conducting a subsample of calls to require interpretation services, or to test availability of certain services for an individual who requires a disability accommodation can reveal provider access issues that lead to health care inequities for specific groups.

While regulations do not require this level of analysis, states are clearly permitted to investigate the accuracy of provider directory information, which includes each provider's cultural and linguistic capabilities and their ability to provide accommodations.[43] One Connecticut EQR secret shopper found that Spanish-speaking callers experienced substantially

lower success rates scheduling an appointment (16.7% vs. 26% for the whole sample). Over a third of the Spanish-speaking callers were told there was no accommodation for Spanish language speakers.[44] States could apply secret shopper with these cultural and linguistic scripts to other Medicaid administrative processes, from consumer help lines to Medicaid applications and renewals.

E. Improving Responsiveness with Caller Survey Protocols

Train secret shopper callers to sound authentic and avoid common pitfalls without overly burdening provider scheduling systems. Surveys should maintain a conversational tone and deliver standardized responses to common questions.[45] Callers should not proactively provide identifying information that could be used to schedule an actual appointment or create an enrollee profile in their system. If an operator or provider staff asks if the caller is conducting a survey due to multiple calls, one option is to use a standardized response about "trying to get a better sense of the options available."[46]

To improve response rates, callers can mask the phone numbers they are using to make the calls as a basic privacy precaution.[47] Where possible, they should attempt to look online for direct extensions that would lead to individual providers. This avoids centralized phone numbers of operating systems that could lead to nonresponse. Most current surveys allow two or three successive calls before declaring a provider nonresponsive, but surveyors should space out calls to the same provider by at least 2 weeks, and consider calling from a different phone number on a different day and time.[48]

States can also work with the independent surveyor to generate provisional Medicaid ID numbers and other necessary information that providers may require before scheduling an appointment. This can help minimize potential barriers to scheduling that occur when providers require specific patient information before booking an appointment.

F. Reporting Data Transparently

Push states to post both the survey outcomes and detailed methodologies for their annual secret shopper. The final rule requires states to post secret shopper results publicly within 30 days of submitting the report to CMS with assurances that its contracted plans meet network adequacy and appointment wait time standards.[49] Advocates will want to push to include methodological details that clearly delineate the pool of providers used as a denominator for compliance purposes. As noted above, states currently use a variety of definitions, with some excluding nonresponsive providers, providers who refuse to participate, and/or providers who report not accepting the plan under which they are listed. CMS should

clarify the standard denominator at the federal level, and we recommend an inclusive denominator of all providers called to best reflect the experience of an enrollee trying to reach a new provider using the plan's directory.

Even if CMS elects to set a different federal compliance denominator or leaves that definition to the states, states should continue to report transparently how providers get screened out of the sample (see Fig. 1 above). Such methodological detail can facilitate limited comparisons across states – such as in the examples above – even absent a consistent standard. Most states already do this, and it is necessary information to understand the relationship between provider directory accuracy and actual network access.

Separate regulations require states to communicate to plans any provider directory errors found in the course of the survey process and plans must quickly correct those errors.[50] A state truly interested in meaningful oversight should require more. For service types with many network providers, like primary care, the survey sample may only represent a small fraction of all providers listed in the directory. Using the Marketplace guidance as a model, if a plan's network has 2500 listed primary care providers, the required survey sample would be just 133 (plus 67 as reserve). If 30% of those in the representative sample are wrong numbers or non-participating, it would suggest that across the full directory approximately 750 of the listed primary care providers may have similar errors. But the survey itself would only positively identify around 50 errors from those directly called for the survey. That would leave untouched roughly 700 other directory errors that one would expect based on the high call error rate. In cases with high error rates like this, simply correcting the errors found by the surveyor is insufficient. States should also require the plan to take corrective actions to identify and correct expected directory errors beyond those found directly through survey calls.

G. Freelancing Secret Shopper

Advocates do not necessarily have to wait for states to resolve all the problems with network adequacy and provider directory errors in their states. While these surveys can be resource intensive, university groups, medical researchers, and media have actively engaged in successful secret shopper surveys outside the scope of formal Medicaid managed care oversight.

In Missouri, advocates and academics collaborated to conduct secret shopper surveys in two rural counties. Operating on a shoestring budget, they trained students to conduct calls and found substantial barriers in plan networks that led to appointment success rates, with timely appointment success rates of 11-17%.[51]

In 2018, as part of an investigation of profound failures in the Medicaid managed care program in Texas, reporters at the *Dallas Morning News* conducted their own secret shopper survey of listed behavioral health providers.[52] The reporters called every psychiatrist listed in one plan's network and found that only 9% could schedule a new appointment for a foster child. Across the state for a program with 30,000 foster kids – a third of whom need counselling – the reporters found only 34 psychiatrists who accepted new patients.[53]

Conclusion: Secret Shopper Enforcement is Key to Improving Access

Requiring states to establish and monitor appointment wait times through annual secret shopper surveys represents a big win for Medicaid enrollees and for states that want to make sure their Medicaid contracts lead to efficient, high quality care. But surveys and reports will not be enough to move the needle to improve access to care. Poor results from secret shopper surveys will only matter if they lead to meaningful reductions in network gaps and directory errors. That requires enforcement.

A recent investigation from ProPublica called attention to an alarming secret shopper report conducted by New York's Attorney General Office.[54] Fully 86% of listed mental health providers were nonresponsive, out of network, or not accepting new patients.[55] But perhaps even more noteworthy, a year after the report's release, state officials could not identify any fines, penalties, or other enforcement actions associated with provider directories or network adequacy. ProPublica contacted insurance regulators in nearly state and found more of the same. Despite a plethora of studies across dozens of states, they found an average of less than a dozen fines per year since 2019. Not a dozen per state, but a dozen across all the states!

Without effective enforcement, secret shopper's powerful methodology will only lead to frustration and hopelessness. State Medicaid agencies have to more proactive and more creative with how they enforce network adequacy with contracted managed care plans. In addition to significant fines for directory errors, officials can explore other corrective actions that bite. For example, allowing Medicaid enrollees who cannot readily find an in-network provider to seek out-of-network care at the plan's expense could improve access and incentivize plans to correct their directories. But whatever the method, relying on the good faith of managed care companies to self-correct has proven insufficient to solve these problems.

Secret shopper surveys can be a powerful oversight tool to make sure Medicaid enrollees can get care they need when they need it. The flexible methodology powerfully illustrates a

growing problem with managed care ghost networks. This brief has shown that advocates have some opportunities to weigh in and make state implementation of the new requirement even more effective. But new appointment wait time standards will not be meaningful if CMS or states allow the secret shopper methodology to be watered down through exclusions in the sample or reduced transparency. And when the surveys reveal provider network gaps, errors, and inadequacies, access will not improve without effective enforcement. Equipped with the recommendations in this brief, advocates can push at the federal and state level to make sure this important new requirement leads to meaningful improvements in access to care.

ENDNOTES

[1] *See* Off. Inspector Gen., U.S. Dep't. Health & Human Servs., *Access to Care: Provider Availability in Medicaid Managed Care* (2014), https://oig.hhs.gov/oei/reports/oei-02-13-00670.asp; Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*, 40 YALE L. & POL'Y REV. 78 (2021); AMN Healthcare & Merritt Hawkins, *2022 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates* (2022), https://www.wsha.org/wp-content/uploads/mha2022waittimesurveyfinal.pdf.

[2] Karen Pollitz et al., Kaiser Fam. Found., *KFF Survey of Consumer Experiences with Health Insurance* (Jun. 15, 2023), https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/.

[3] Walter R. Hsiang et al., *Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared with Private Insurance Patients: A Meta-Analysis*, 56 INQUIRY 1 (2019); Diksha Brahmbhatt & William L. Schpero, *Access to Psychiatric Appointments for Medicaid Enrollees in 4 Large US Cities*, 332 JAMA 668 (2024).

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

[5] Hsiang et al., *supra* note 3.

[6] Off. of the N.Y. State Attorney Gen., *Inaccurate and Inadequate: Health Plans' Mental Health Provider Network Directories* (Dec. 7, 2023), https://ag.ny.gov/sites/default/files/reports/mental-health-report_0.pdf; Ariz. Dept. Insurance & Financial Insts., *Report on Mental Health Parity* (Jan. 6, 2023), https://difi.az.gov/sites/default/files/MHP%20Report%20Jan%202023%20final%201.5.23%20%282%29.pdf;.

[7] 42 CFR § 438.358(c)(5); *see* 89 Fed. Reg. 41021.

[8] 42 C.F.R. §§ 438.68(e)-(f).

[9] 42 C.F.R. § 438.68(e)(2).

[10] 42 C.F.R. § 438.68(e)(1).

[11] 42 C.F.R. § 438.68(e)(1)(iv); 89 Fed. Reg. 41012.

[12] 42 C.F.R. § 438.68(f)(1)(i).

[13] 42 C.F.R. § 438.68(f)(1)(ii).

[14] 42 C.F.R. § 438.68(f)(2); *see* Table 1.

[15] The specific methodology for calculating the compliance rate – including which sampled providers will be included in the numerator and denominator – will be forthcoming in subregulatory guidance, targeted for 2025.

[16] 42 C.F.R. § 438.68(f)(2)(ii).

[17] *Id.*

[18] 42 C.F.R. § 438.68(f)(4)(i)-(ii).
[19] 42 C.F.R. § 438.68(f)(4)(iii).
[20] 42 C.F.R. § 438.68(f)(1)(iii).
[21] 42 C.F.R. § 438.68(f)(1)(iv).
[22] 42 C.F.R. § 438.10(h)(3)(ii)-(iii).
[23] 42 C.F.R. § 438.68(f)(5).
[24] 42 C.F.R. § 438.68(f); Ctrs. for Medicare & Medicaid Servs. ("CMS"), *Appointment Wait Time Secret Shopper Survey Technical Guidance for Qualified Health Plan (QHP) Issuers in the Federally-Facilitated Exchanges (FFEs)* (Apr. 2024), https://www.cms.gov/files/document/awt-sss-tech-guide-qhp-ffe-508.pdf; Kelsey A. Rankin et al., *Secret Shopper Studies: An Unorthodox Design that Measures Inequities in Healthcare Access* 80 ARCHIVES PUB. HEALTH (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9635177/.
[25] Island Peer Review Organization ("IPRO") for Kentucky Dept. Medicaid Services, *Kentucky Access and Availability: Pediatrician Access and Availability Survey, FY 2023*, (Mar. 2023), https://www.chfs.ky.gov/agencies/dms/DMSMCOReports/Pediatrician%20Access%20and%20Availability%20Survey%20Report%20FY%202023.pdf; IPRO for Kent. Dept. Medicaid Servs., *Kentucky Access and Availability: Dental Access and Availability Survey, FY 2022*, (Apr. 2022), https://www.chfs.ky.gov/agencies/dms/DMSMCOReports/Dental%20Access%20and%20Availability%20Survey%20Report%20FY%202022.pdf; IPRO for Kent. Dept. Medicaid Servs. *Kentucky Access and Availability: Endocrinology Survey, FY 2020*, (Mar. 2020), https://www.chfs.ky.gov/agencies/dms/DMSMCOReports/Endocrinology%20Access%20and%20Availability%20Survey%20Report%20FY%202020.pdf; Health Services Advisory Group ("HSAG") for Iowa DHHS, *Iowa Calendar Year 2023 External Quality Review Technical Report*, (Apr. 2024), https://hhs.iowa.gov/media/13134/download?inline; HSAG for Ill. Dept. Healthcare & Fam. Srvs., *External Quality Review Annual Report: State Fiscal Years 2022-2023 (July 1, 2022-June 30, 2023)*, 122 (2024), https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/20222023externalqualityreviewtechnicalreport.pdf; HSAG for N.H. DHHS, *State Fiscal Year 2023 Revealed Provider Network Survey Report*, (Sept. 2023), https://medicaidquality.nh.gov/sites/default/files/NH2023_Revealed%20Provider%20Network%20Survey_Report_F1.pdf.
[26] Kent. Cabinet for Health and Family Services, Quality Reports, https://www.chfs.ky.gov/agencies/dms/dpqo/mco-qb/Pages/reports.aspx (Last visited Nov. 8, 2024).
[27] States must update their quality strategy at least every 3 years or when there are significant changes to the state's Medicaid program. 42 C.F.R. § 438.340(c)(3). External quality review activities are one of the core elements of each state's quality strategy. 42 C.F.R. § 438.340(b)(4).

[28] CMS, *Appointment Wait Time Secret Shopper Survey Technical Guidance for Qualified Health Plan (QHP) Issuers in the Federally-facilitated Exchanges (FFEs)*, 2-5 (Apr. 26, 2024), https://www.cms.gov/files/document/awt-sss-tech-guide-qhp-ffe-508.pdf.
[29] 42 C.F.R. § 438.68(f).
[30] Qlarant, *West Virginia Managed Care Programs 2023 External Quality Review Annual Technical Report* (Apr. 2024), https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Documents/WV%202023%20ATR_FINAL%20508.pdf; Qsource, *2023 Annual DMO EQRO Technical Report: Arkansas External Quality Review Organization* (Apr. 2024), https://humanservices.arkansas.gov/wp-content/uploads/2024_DHS_AR_EQRO_Technical_Report_DMO_Final.pdf.
[31] CMS, *supra* note 28.
[32] Regulations do require that plans make timely corrections in their provider directories for non-participating providers, providers not practicing in that provider category, and for incorrect phone numbers. However, if the provider category is large, such as for primary care providers, then the sample may represent only a small fraction of all the errors in a plan's directory.
[33] HSAG for Iowa DHHS, *Iowa Calendar Year 2023 External Quality Review Technical Report*, 7-15 (Apr. 2024), https://hhs.iowa.gov/media/13134/download?inline.
[34] Health Services Advisory Group (HSAG) for Ill. Dept. Healthcare & Fam. Srvs., *External Quality Review Annual Report: State Fiscal Years 2022-2023 (July 1, 2022-June 30, 2023)*, 1 (2024), https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/20222023externalqualityreviewtechnicalreport.pdf. Illinois' revealed caller analysis of dental and primary care providers reported timely appointment success rates of 34% and 13%, respectively.
[35] HSAG for Ore. Health Authority, *Oregon 2023 External Quality Review Technical Report*, 4-70 (Apr. 2024), https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/External%20Quality%20Review%20Technical%20Report%202023.pdf.
[36] Specifically, the denominator excluded providers who did not respond, who were not accepting new patients, who did not accept the specific plan, who did not accept Medicaid, who did not provide the relevant services, or who were not practicing at the listed location. *Id.*
[37] *Id.* at 4-45.
[38] *Id.* at 4-66, 4-67.
[39] Kelsey A. Rankin et al., *supra* note 24.
[40] *Id.*
[41] *Id.*
[42] Several states already ask about language or disability accommodations in revealed caller surveys testing provider directory accuracy, but we have not seen these components included in secret shopper surveys conducted by EQR organizations. *See, e.g., id.*; Qlarant, *Maryland HealthChoice Program Annual Technical Report Calendar Year 2023*, (Apr., 2024),

https://health.maryland.gov/mmcp/healthchoice/Documents/annual-technical-reports/MD%20ATR%20FINAL_508.pdf.

[43] 42 C.F.R. § 439.10(h)(1).

[44] Mercer for the Conn. Dept. Soc. Servs., *Mystery Shopper Project*, (Oct. 25, 2006).

[45] Kesley A. Rankin et al., *supra,* note 24.

[46] *Id.*

[47] *Id*.

[48] *Id*.

[49] 42 C.F.R. § 438.68(f)(5).

[50] 42 C.F.R. § 438.68(f)(1)(iii) & (iv).

[51] Sidney Watson and Leslie Hinyard, *Implementing Medicaid Secret Shopper Surveys: Tips and Methods for Better Results*, Webinar for the National Health Law Program (Sept. 19, 2024), https://healthlaw.org/resource/webinar-implementing-medicaid-secret-shopper-surveys-tips-and-methods-for-better-results/.

[52] J. David McSwane & Andrew Chavez, Dallas Morning News, *Pain & Profit Part #3: Texas Pays Companies Billions for 'Sham Networks' of Doctors* (Jun. 4, 2018), https://interactives.dallasnews.com/2018/pain-and-profit/part3.html.

[53] *Id.*

[54] Max Blau, ProPublica, *State Regulators Know Health Insurance Directories Are Full of Wrong Information. They're Doing Little to Fix It.* (Nov. 14, 2024), https://www.propublica.org/article/ghost-networks-health-insurance-regulators.

[55] Off. of the NY State Attorney General, *supra* note 6.