



July 3, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard Baltimore, MD 21244

RE: Medicaid and CHIP Managed Care Finance, Access and Quality [CMS-2439-P]; Ensuring Access to Medicaid Services, [CMS-2442-P]

Dear Administrator Brooks-LaSure:

The Alliance of Community Health Plans (ACHP) supports the Centers for Medicare and Medicaid Services' (CMS) efforts to promote efficiency, transparency, quality and increase access in the Medicaid program across fee-for-service (FFS) and managed care delivery. We appreciate the opportunity to provide comments that align with the Agency's efforts to create a seamless care journey for patients through enhanced access to coverage.

ACHP represents the nation's top-performing, nonprofit health plans that provide high-quality coverage and care to tens of millions of Americans in nearly 40 states, and D.C. Our member companies serve diverse populations across all lines of business, particularly in Medicaid where collectively our members serve millions of consumers nationwide.

ACHP strongly supports enhancing consumer choice and beneficiary engagement in the Medicaid program. Medicaid enrollees deserve a robust market with fierce competition that is at minimum on par with the commercial market. We support efforts to modernize the Medicaid program by introducing standards that foster consistency, rigor, discipline and alignment across Medicaid FFS and managed care delivery.

ACHP offers comments on the following priority areas across both the Managed Care and Access proposed rules.

- Suspend or delay implementation of requirements for maximum appointment wait times.
- Provide further clarification on how Secret Shopper Surveys will be implemented for health plans in integrated care models (provider and payer integrated systems).



- Continue efforts to increase transparency of payment rates for Medicaid providers and accessibility of Medicaid program websites.
- Clarify the types of services or settings that would qualify as In Lieu of Services (ILOS).
- Provide further detail on the implementation of a Medicaid and CHIP Quality Rating System and its new set of mandatory measures.
- Factor the characteristics of a diverse Medicaid population when establishing transparency in the rate setting process.

Medicaid and CHIP Managed Care Finance, Access and Quality [CMS-2439-P]

Access

Appointment Wait Times

ACHP recommends CMS suspend or delay implementation of requirements for maximum appointment wait times, especially if there is a Health Resources and Services Administration (HRSA)-designated shortage of the provider type. ACHP supports consumers' ability to access timely care. However, the nation is currently grappling with a workforce shortage, which has acutely disrupted access. The provider types listed in the proposed rule – mental health and substance use disorder, primary care, obstetrics and gynecology – were selected due to higher rates of utilization for these specialties. These specialties are particularly dearth of providers, making it especially challenging to find available appointments. Enforced maximum appointment wait time standards are especially challenging for rural plans that face a shortage of providers by virtue of their geographic limitations.

Rather than requiring the use of time or geography-based measures that do not provide assurances of enrollee access, we recommend CMS afford states the flexibility to determine whether their Medicaid managed care populations have sufficient access to providers. CMS should continue to rely on reviews already performed by state regulators and national accrediting organizations that have expertise in evaluating how well a plan's network is serving its members, taking local and regional factors into consideration rather than establishing arbitrary standards in a time where provider capacity is challenged.

We are also concerned with proposals requiring a 90-day compliance rate, because in some states there are no mechanisms in place to assess compliance with existing wait time standards. Implementation of these standards will require a more localized assessment.



If CMS intends to direct states to establish specific network adequacy standards, we urge CMS to develop a framework of standards for states that appropriately recognize that the health care landscape is shifting toward a more coordinated and integrated model of care delivery. The overarching standard of access should ensure that members have timely access to appropriate, high-quality care.

Secret Shopper Surveys

ACHP recommends CMS clarify how secret shopper surveys will be implemented for health plans in integrated care models (provider and payer integrated systems). The proposed rule requires states to conduct “secret shopper” surveys to ensure compliance with appointment wait times and to assess the accuracy of provider directories. Among the key data points required to validate the accuracy of provider directories are the active network status of the managed care plan and whether the provider is accepting new enrollees. A consistent process that is state run, with one vendor, would be preferable to having multiple surveys out in the market, adding to provider abrasion.

We are also wary of the potential for a poor assessment to be posted publicly without the validity of survey results being verified. We encourage CMS to incorporate requirements to ensure the validity of secret shopper surveys, such as requiring that survey results be analyzed with statistical rigor, including multivariate analysis. Another guardrail that would help ensure only accurate survey data are posted would be to allow managed care organizations to review the data from the surveys before it is posted publicly and contest or correct errors to receive an updated compliance score. In the interest of transparency, it is important that public-facing information be accurate, verifiable and meaningfully representative of a plan’s network availability and performance.

We recognize the importance of accurate provider directories and encourage CMS to require that the publicly posted accuracy rating reflect how managed care organizations compare to one another, or to an established benchmark, rather than simply being rated on a 100-point percentage scale. **ACHP encourages CMS to ensure the secret shopper survey results related to provider accuracy are consistent.**

The proposed rule would require that secret shopper surveys verify providers’ active network status, street address, telephone number and whether the provider is accepting new enrollees. It



is important that each of these elements are scored separately, rather than the entire provider entry being scored “inaccurate” based on, for example, an inaccurate phone number only. Individual inaccurate elements should be measured differently than a provider entry that is entirely inaccurate, and the results of the surveys should be validated to ensure secret shoppers are complying with the established data collection standards.

Payment Rates

ACHP supports CMS’ efforts to increase transparency of payment rates for Medicaid providers. Payment rates for Medicaid providers have historically been lower than any other coverage type. This has a significant impact on access to providers for consumers as Medicaid providers are paid less than their commercial counterparts and are thus at a disadvantage financially. Increasing transparency regarding payment rates among Medicaid providers would incentivize needed change to ensure providers are compensated adequately for their expertise.

Transparency

ACHP supports CMS’ efforts to increase transparency and accessibility within Medicaid program websites. The proposed rule requires state Medicaid program websites to use clear and easy to understand labels and that websites clearly indicate that assistance in accessing information is available at no cost to the consumer. This includes information on how to obtain oral translation in all languages and written translation in each prevalent non-English language, alternate formats, auxiliary aids and services and a toll-free telephone number. This proposal is aligned with other regulatory efforts to ensure consistency and availability of language services for enrollees. We appreciate the consistency in CMS’ commitment to scale these efforts across government programs.

In Lieu of Services (ILOS)

ACHP requests clarification on what types of services or settings would qualify for the new definition for an In Lieu of Services (ILOS). Redefining ILOS as a service or setting that is provided to an enrollee as a substitute for a covered service or setting under the state plan provides states with greater flexibility to expand services to consumers via unconventional modalities. We request CMS provide further details regarding what kind of services would fall under these criteria. We support continued efforts to identify evidence-based interventions at the intersection of health and social needs. The imposition of a five percent cap could inadvertently limit the development of evidence-based models of care. The future focus for ILOS should be on



evidence based medical and social appropriateness and cost effectiveness. Further, a five percent cap seems arbitrary without adequate research done to assess whether this is an unfair distribution among varying services.

In this proposal, CMS indicates that these ILOS need to be medically appropriate and cost effective, but not necessarily “budget neutral.” We share CMS’ view that for certain ILOS that are provided in lieu of a future service, cost effectiveness may not be realized in the short term, and instead a longer view, even over a period of years, may be more appropriate in determining cost effectiveness. We encourage CMS to include guidance about how this proposed change will be implemented in the annual Medicaid Managed Care Rate Development Guide.

Quality Improvement

ACHP requests additional information regarding the implementation of a Medicaid and CHIP Quality Rating System and its new set of mandatory measures. We support CMS’ efforts to create cohesiveness around the various quality measures that are required by states from across various sources (e.g., system performance reviews, value-based purchasing programs, child and adult core sets, etc.). Creating a unified reporting structure on mandatory measures would bring a level of discipline and consistency that would foster more reliable data across the Medicaid program.

For these efforts to create significant improvement in the quality improvement space, we request additional clarification regarding the implementation of these reporting structures. Considering that these measures could open pathways towards greater quality incentives, it is imperative to create alignment for data collection across states.

Ensuring Access to Medicaid Services [CMS-2442-P]

Beneficiary Engagement

ACHP supports the creation of a Beneficiary Advisory Group (BAG) to support beneficiary engagement in their care. We support requirements for states to maintain a Medicaid Advisory Committee (MAC) and a Benefit Advisory Groups (BAG), with overlapping membership from beneficiaries, caretakers and advocates invested in patients’ care delivery. These groups would provide bi-directional feedback between stakeholders and the state on the administration of the



Medicaid program. If finalized, this effort would realize CMS' goal toward advancing health equity by prioritizing beneficiary voices and lived experiences. We recommend that MACs solicit information from members with lived experiences on enrollment processes, specifically, barriers to enrollment. This information would be crucial to support maintenance of Medicaid coverage and transitions to other forms of coverage throughout redeterminations.

Payment Rate Transparency, Documentation of access to care and service payment rates, State Analysis Procedures for Rate Reduction or Restructuring and Medicaid provider participation and public process to inform access to care.

ACHP requests CMS consider the need for variable rate assumptions consistent with the characteristics of different Medicaid eligibility groups in efforts to enhance transparency in the rate setting process. CMS proposes to replace the current process that states must follow if they submit a state plan amendment proposing to reduce provider payment rates or restructure provider payments. The proposed regulation includes a four percent threshold on cumulative provider payment rate reductions throughout a single state fiscal year as one of the criteria of the streamlined process.

We support efforts to bring more transparency to the rate setting process. However, we are concerned that the proposal to establish an across-the-board threshold for provider payment rate reductions subject to the access review process fails to recognize the need for variable rate assumptions consistent with the characteristics of different Medicaid eligibility groups. It is not always appropriate to use the same assumptions for all populations or providers serving these eligibility groups, especially for complex populations served under the Temporary Aid for Needy Families (TANF), Aged, Blind, and Disabled (ABD), and Long-Term Services and Supports (LTSS) eligibility groups.

Implementation Time

The proposals detailed in these rules have implementation timeframes that range from 60 days to seven years. States currently face barriers in effectively conducting redeterminations due to inadequate resources devoted to this effort. This is further demonstrated by the egregious rates of procedural denials of Medicaid coverage for hundreds of thousands of consumers across the country. A majority of these beneficiaries are children. As states conduct Medicaid enrollment and renewal processes, we request that CMS considers the timeline of redeterminations and modify



implementation requirements to help support states during this labor and resource-intensive time.

Conclusion

ACHP appreciates the opportunity to comment and provide recommendations on these important proposals to encourage the continued evolution of the Medicaid program. Innovation often stems from Medicaid, which often influences system-wide change in healthcare. ACHP is committed to working with CMS to ensure consumers can access care in FFS and managed care that is on par with commercial coverage. Please contact Nissa Shaffi, ACHP's Associate Director of Public Policy, at nshaffi@achp.org or (202) 524-7773, with any questions or if we can provide further information.

Sincerely,

Dan Jones

Dan Jones
Senior Vice President, Federal Affairs
Alliance of Community Health Plans