NoHLA
Northwest Health Law Advocates

July 3, 2023

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

**Re: CMS-2439-P, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality**

Dear Administrator Brooks-LaSure,

Northwest Health Law Advocates appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, "Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" (proposed rule).

Northwest Health Law Advocates (NoHLA) is a nonprofit consumer advocacy organization in Washington State. For over two decades, NoHLA has worked to advance a health care system in which all Washington residents receive quality, affordable care on an equitable and timely basis, with basic rights and protections.

A robust Medicaid/CHIP program is central to this mission: 2.3 million Washington residents now rely on Washington Apple Health (Medicaid, CHIP, and related state programs) for their health care. All these enrollees face low income or other structural inequities, such as disability, age, or health conditions. Compared to the general population, Apple Health also covers a greater proportion of Black, Hispanic, Native Hawaiian/Pacific Islander, and American Indian/Alaska Native residents. Given these demographics, it is essential as a matter of equity to ensure that Medicaid/CHIP programs are delivering high quality care.

**We strongly support the proposed rule, which will be critical in reducing inequities that produce adverse health outcomes and compound disparities for structurally marginalized communities.** In Washington State, 86 percent of Apple Health beneficiaries receive services through Managed Care Organizations (MCOs). When compared to Washington's total population size, one fourth of Washington's total residents now rely on MCOs to deliver their health services.

Washington State began contracting with MCOs in 1985 with the goal of "manag[ing] cost, utilization, and quality" for the Medicaid population. Nearly 4 decades later, it is

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unclear whether Washington's five MCOs have made progress toward this goal compared to baseline. Washington State does not publish data that compares the care provided by MCOs to the care available in fee-for-service (FFS) programs. But based on over two decades of experience with MCOs in our state, we have observed that enrollees continue to face serious problems obtaining the services they need in a timely manner and struggle to obtain crucial information about how to obtain services, the quality of those services, and the underlying causes for access issues.

Recent survey data demonstrates the concern: the nonprofit Altarum Health Care Value Hub surveyed over 1,300 WA residents in 2022 about their health coverage and care experience. The survey was conducted in English and Spanish and examined affordability burdens by insurance type. **Shockingly, the survey found that respondents with Apple Health reported the highest rates of going without care and rationing medication due to cost of all insurance types at 70 percent** (compared to 57% of those with private insurance and 43% of those with Medicare) – even though Apple Health enrollees do not face cost-sharing. When asked to explain this counter-intuitive result, the researchers reviewed open-text responses and found that some respondents with Apple Health reported difficulty accessing certain services, including dental services, mental health and substance use services, eye care, and physical therapy. Some also noted a lack of providers who would accept their insurance.

The state's own data also suggests significant quality and access problems. The state's 2022 MCO "report card" indicates that across 7 performance areas, only one of the MCOs earned an "above average" rating for *any* of the measures, while one MCO earned a "below average" rating for nearly all areas. The state's CAHPS survey of Medicaid adult enrollees in spring 2022 indicated that only 74.6% reported getting needed care, a sharp *decline* compared to 82.1% in 2020. A 2021 analysis by Washington's external quality review organization (EQRO) showed that most MCOs in the state performed below the NCQA national 50th percentile in several important categories; adult access to preventive/ambulatory health services, prenatal and postpartum care, breast cancer and cervical cancer and chlamydia screenings, well-child visits from 3 to 6 years, adolescent well-care, and lead screening in children. A different 2021 report by the EQRO indicated spotty performance by MCOs in both availability of services and care coordination and stated that corrective action plans that had been in place for several years "continue to indicate little improvement." Despite these apparent failures, Washington has not re-procured its MCOs in over a decade and to our knowledge, has not publicized sanctions against any MCOs.

We therefore strongly support many of the provisions in this proposed rule and agree that these measures will advance the important goals of improving access to services, increasing transparency and access monitoring, and improving quality reporting. **We support and incorporate by reference the comments on the proposed rule submitted by the National Health Law Program. In addition, we offer the following specific Washington State perspective:**

**Enrollee Experience Surveys (§§ 438.66(b) and (c), 457.1230(b))**

We support the proposed requirement that states prioritize enrollee experience as part of monitoring system and performance improvement, requiring that the state conduct an annual enrollee experience survey and include the results in the Managed Care Program Annual Report. We particularly commend CMS's proposal to add these surveys to the list of items for which interpretation, translation, and auxiliary aids are available.

We recommend that CMS take the following *additional* steps to strengthen the enrollee experience survey requirement:

- CMS should specify that the survey instrument must assess MCO performance with respect to customer service, provider access, availability of benefits, any out-of-pocket cost burden, and the availability of language services and disability accommodations. Washington uses a CAHPS instrument that includes some of these measures but does not evaluate cost burden or availability of accommodations.
- CMS should require the survey to be conducted directly in languages of high prevalence, in addition to requiring language services to support respondents upon request. Here Washington offers a helpful example by conducting its CAHPS survey in English and Spanish.
- CMS should extend the survey to separate CHIPs and state-optional programs. Washington conducts its CAHPS surveys for Adult Medicaid and Children with Chronic Conditions.
- CMS should require the state to publish data and monitor trends over a 10-year period. Washington only lists its reports from 2020, 2021, and 2022, which makes it difficult to understand trends beyond this most recent period confounded by the pandemic.
- Finally, CMS should require an effective date for enrollee experience survey requirements, given that many states already work with an external survey vendor that is likely able to respond nimbly. Three years is too long to wait for better data about the health care experience of a quarter of our state residents.

**Medical Loss Ratio (MLR) Standards (§§ 438.8, 438.3, and 457.1203)**

We support the proposals to align Medicaid/CHIP medical loss ratio (MLR) standards with the MLR standards in place for Marketplace plans.

However, we urge CMS to add a requirement that states post the Annual Medical Loss ratio reports that 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. But to our knowledge, Washington does not post these reports publicly. Enrollees, providers, advocates, and other members of the public deserve to know how Medicaid capitated payments are being used.

**Appointment Wait Time Standards (§§ 438.68(e), 457.1218)**

We support CMS's decision to impose maximum wait times for routine appointments for adult and pediatric primary care (15 days), OB/GYN (15 days), and adult and pediatric mental health/SUD treatment (10 days). These proposed standards are mostly consistent with Washington's contractual wait time standards, but in some cases would improve access for Washington residents – for example, Washington's contract specifies that non-symptomatic/preventive care from an OB/GYN can be delayed for as long as 30 business days.

However, we are concerned that requiring wait time standards for these four services alone will not capture the urgent need to improve access to specialist care in Medicaid/CHIP. The Altarum survey noted above suggests there may be significant access challenges for certain kinds of care. We recommend that CMS add appointment wait time standards for specialist visits (30 business days), as similarly required for Marketplace plans. It is crucial that managed care enrollees be able to access not only routine care, but also specialty care, in a timely manner.

Further, we are concerned that Section 438.68(d) continues to permit exceptions that could swallow the rule. The preamble to the rule acknowledges that MCOs have trouble building networks that meet network adequacy standards due to low payment rates and appears to suggest that states should offer more leniency in granting exceptions when this is the case. Though we appreciate the challenges of low payment rates, we are concerned that the exceptions process reduces accountability for those challenges. It would be better for CMS to require strong contractual standards across the board but contextualize any shortcomings in meeting those standards when evaluating performance.

We also urge CMS to require states to come into compliance with the requirements of this portion of the regulation sooner than proposed.

**Secret Shopper Surveys (§§ 438.68(f), 457.1207, 457.1218)**

We enthusiastically support the proposal to require states to contract with independent entities to conduct secret shopper surveys. The results of the independent Altarum survey noted above confirm that existing state enrollee experience surveys are not providing the depth of information needed to fully understand access challenges.

Requiring secret shopper surveys would enable the public to understand if MCOs are complying with the contractual requirements for which they are compensated. For example, secret shopper surveys in Washington would enable us to know if MCOs are complying with key customer service standards (e.g., a <5% call abandonment rate; an average telephone response time of 30 seconds); whether the provider directory is current and providers are actually accepting patients; and whether there is accurate and language-appropriate information being provided to callers about eligibility, benefits, appeals, and other issues. Without this information, it is impossible to know whether MCOs are fulfilling their obligations to enrollees.

We do, however, urge CMS to require states to come into compliance with the requirements of this regulation sooner than proposed. 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.

**Assurances of Adequate Capacity and Services Reporting (§§ 438.207(d), 457.1230(b))**

We 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.

For example, in Washington State, low payment rates appear to have an impact on the number of available Applied Behavior Analysis (ABA) providers. Social service organizations report that few ABA providers here are willing to provide services for Medicaid enrollees because the payment amount from MCOs are so low or are quite delayed. This results in limiting access to ABA depending on which MCO the person is enrolled with and forces some enrollees to wait years to receive services for which they are authorized, effectively depriving them of needed medical care.

**Medicaid Managed Care Quality Rating System (§§ 438.334 and 457.1240)**

We strongly support CMS's broad and ambitious vision to help states build publicly available dashboards featuring core quality measures to help new and returning enrollees to select managed care plans that most suit their needs.

We are particularly supportive of CMS' vision of a "MAC QRS" as a one-stop shop for comparing quality measures alongside customer support/choice counseling that includes formulary and provider network information. It appears that CMS is contemplating a web portal that would offer a similar plan shopping experience as the experience available in the Marketplace today. Without such a tool, people are likely to choose their MCOs based on "value added benefits." While these benefits can be helpful to enrollees, they need to be contextualized with other valuable information about MCO quality, formulary, and networks – otherwise they can amount to little more than "freebies" meant to induce enrollment that may not have any bearing on the quality of care available under different MCOs.

We also note with caution that QRS information is only useful when paired with robust efforts to improve MCO quality. As noted above, all 5 of Washington's MCOs have relatively poor-quality performance at present. There is little point in offering QRS data to prospective enrollees if all the available options are deficient.

Finally, we encourage CMS to accelerate the timeframe for states to implement the QRS system. The proposed rule would allow states to defer implementation of "Phase 1" until 2029. It should not take states until 2029 to implement the requirements of Phase 1, which is essentially a static webpage with links to existing resources. We understand that implementation of "Phase 2" will take longer but encourage CMS to work with states on a timeline that is both feasible and recognizes the time-sensitive need for these tools.

**CONCLUSION**

Thank you for your attention to these comments. If you have further questions, please contact Emily Brice at emily@nohla.org or Janet Varon at janet@nohla.org.

Sincerely,

Janet Varon
Executive Director