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July 3, 2023

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

VIA ELECTRONIC TRANSMISSION

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

Dear Administrator Brooks-LaSure,

First Focus on Children appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule, **Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality** (hereinafter "Managed Care Rule"). First Focus on Children is a bipartisan advocacy organization that prioritizes children and families in federal budget and policy decisions. We advocate for the over 42 million children covered by Medicaid and the Children's Health Insurance Program (CHIP) to ensure they have access to timely, affordable, and high-quality care. The proposed Managed Care Rule, along with the simultaneously proposed Access Rule, represent much needed steps toward improving the Medicaid program, especially for children. Overall, we believe these measures will help advance the important goals of improving access to services, increasing transparency and monitoring of access, improving quality reporting, and further CMS' commitment to advancing health equity.

In general, First Focus on Children supports CMS finalizing the Managed Care Rule subject to our comments below that we believe will help improve the proposals for children. We support CMS requiring compliance with the finalized version of these proposals at the soonest practicable dates.

Medicaid and CHIP provide health care coverage to more than 50% of children in the United States,¹ including foster youth, children with complex and special health care needs, and many children of color. As CMS works toward improving access to care, it must consider the unique needs of children. Unfortunately, having Medicaid or CHIP coverage is only one piece of the puzzle for children to be able to access care. The access pathway is often peppered with barriers that prevent children from accessing the care that they critically need. These barriers include overly lengthy wait times for appointments and/or needing to travel incredibly long distances to receive care. In some cases, these barriers are too much for families to overcome and children go without care altogether. With both this and the Access Proposed Rule, we applaud CMS for trying to set standards that attempt to tackle these barriers and that are more comprehensive and consistent across delivery systems.

Information Requirements

First Focus on Children supports 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, families, advocates, and others still have difficulty finding necessary information about managed care. Therefore, we support the 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. To strengthen the proposal, however, we 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. Families with children enrolled in Medicaid along with other stakeholders, deserve to know how Medicaid capitated payments are being used.

Access

1. State monitoring requirements

We support the proposed requirement that states prioritize enrollee experience as part of its 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' proposal to add these surveys to the list of items for which interpretation, translation, and auxiliary aids are available.

2. Network Adequacy

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.

¹ Centers for Medicare & Medicaid Services, Medicaid and CHIP Enrollment Trend Snapshot (March 2023), <https://www.medicare.gov/medicaid/national-medicare-chip-program-information/downloads/march-2023-medicare-chip-enrollment-trend-snapshot.pdf>.

a) Timeliness Standards

First Focus on Children supports CMS' decision to impose maximum wait times for appointments. The proposal represents a significant improvement for how access is defined and monitored, which we hope will lead to more positive health outcomes for children. We also appreciate that CMS has differentiated between pediatric and adult care in the standards, including geographic location, helping to highlight the importance of supporting out-of-state care for children. An area for improvement that we highly recommend CMS.

While we are generally supportive wait time standards as proposed, we recommend several ways that CMS can strengthen the proposal for children:

- CMS should expand the proposed wait time standards to specialist visits, particularly for pediatric specialty care. We recommend that CMS align the wait time standard with the 30-day standard required for Marketplace plans. It is crucial that children enrolled in Medicaid managed care be able to access not only routine care, but also specialty care, in a timely manner.
- At a minimum, CMS should align the maximum wait time thresholds and time and distance standards for pediatric primary, behavioral health, and specialty care with those set to take effect in the Marketplace in 2025.
- Finally, we strongly encourage CMS to expand the timeliness standards to all children enrolled in Medicaid fee-for-service (FFS).

b) Compliance Rate

First Focus on Children supports CMS' proposal for a 90% compliance rate for managed care plans. This benchmark will help evaluate whether the plans' networks meet the required standards, benefiting children enrolled in Medicaid as well as other stakeholders, such as states, insurance regulators, enrollees, providers, and advocates.

c) Secret Shopper Surveys

First Focus on Children strongly supports the requirement for states to contract with independent entities to conduct secret shopper surveys. These surveys directly assess plan compliance with network adequacy standards and enable effective enforcement. Publishing the survey results on state websites will promote transparency and accountability, allowing enrollees, advocates, and providers to track plan performance, improve accountability, and prompt necessary improvements. To improve the proposal, First Focus on Children suggests that CMS compile and publish these reports on the Medicaid.gov website for easy access and comparison.

d) Effective Dates

First Focus on Children urges CMS to expedite the implementation of the regulation's requirements. The proposed four-year timeline for states to comply is too lengthy, particularly for the secret shopper surveys because states already have experience with these tools. In the time between now and the proposed implementation of these requirements, inadequate MCO networks, will likely

remain inadequate, and children enrolled in those MCOs will have difficulty accessing care. Delaying the compliance with and the availability of crucial information until 2028 or later will negatively impact children enrolled in the program, delaying any resulting improvements. Wait time standards will apply in the Marketplace in 2025. We recommend that CMS align Medicaid effective dates accordingly.

3. Assurances of adequate capacity and services

First Focus on Children supports CMS' 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. Low payment rates limit physician and other practitioner participation, harming children's access to care. This is especially critical to address for CMS' efforts toward health equity to find any success. Low provider participation rates can contribute to health inequalities among children enrolled in Medicaid. If certain specialties or services are not adequately covered by participating providers, children from historically excluded populations may face disparities in accessing crucial healthcare interventions, preventive care, or specialized treatments. This can perpetuate existing health inequities and exacerbate disparities in health outcomes.

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 families with children enrolled in Medicaid, 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. 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.

State Directed Payments

States may only direct expenditures of contracted Medicaid managed care plans under limited circumstances, such as through value-based payments or setting maximum or minimum fee schedules. We support CMS' proposals to increase transparency and accountability of these State Directed Payments (SDPs), including requirements for more detailed payment reporting that more clearly establish that SDPs are actuarially sound and linked to Medicaid reimbursable services. 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.

Overall, this move toward transparency should provide more oversight and accountability. Stakeholders, particularly families with children enrolled Medicaid, should have a clear view of how funds are allocated and used in the Medicaid program. This increased visibility will help in identifying disparities and gaps, allowing for better policymaking and informing advocacy for interventions that address disparities and ensure children have access to necessary care and services.

In Lieu of Services

We support CMS' decision to codify its recent guidance on In Lieu of Services (ILOS). In particular, we welcome CMS' 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. We see this clarification as especially important for children. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit plays a critical role in safeguarding the health and well-being of children in Medicaid. While ILOS offers the states the flexibility in meeting the unique health needs of children, it is important to remind managed care organizations that it is not a flexibility to be used to replace or undermine the core tenets of EPSDT in any form.

Managed Care Quality

1. External Quality Review (EQR)

This proposed rule includes provisions that boost accountability, transparency, and participant input into managed care oversight systems, which we support. We also support changes to the quality strategy and external quality review processes that will make the data more accessible, reduce data lags, and allow for more participant input into quality strategies and core measure review. Specifically, expanding the requirement to require public comment on quality strategies even if proposed changes are minimal will allow the public to weigh in on results from the state's (now) publicly accessible evaluation. Other proposals, from the date of annual publication, the tightening of language on External Quality Review Organization conflicts of interest, and the requirement for posting at least 5 prior years of EQR technical reports will improve data transparency, reduce data lag, and increase confidence in the EQR process.

2. Quality Rating System

We support CMS' 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 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 HHS'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 make public sooner.

First Focus on Children also recommends expanding the scope of required populations on which states must report stratified quality ratings. For example, children with disabilities often face additional barriers to accessing medical care, but those barriers may not show up in standard quality reporting. We recommend that CMS clarify in the final QRS provision that stratification of quality ratings by disability, and ideally by disability type, will be a required element.

Finally, we recommend that CMS add a seventh criterion for CMS and stakeholders to consider when evaluating measures for inclusion in the QRS: does the measure advance health equity?

Conclusion

First Focus on Children thanks you for your work and the opportunity to comment on these issues. Should you have any further questions, please contact Abuko Estrada, Vice President of Medicaid and Child Health Policy, at abukoe@firstfocus.org.

Respectfully,



Bruce Lesley
President, First Focus on Children