

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

June 30, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
PO Box 8016
Baltimore, Maryland 21244-8016

Submitted via regulations.gov

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

Justice in Aging appreciates the opportunity to comment on the Medicaid Managed Care Access, Finance, and Quality notice of proposed rulemaking (NPRM) issued by the Centers for Medicare & Medicaid Services (CMS). We strongly support many of CMS's proposals in this NPRM to improve access to Medicaid services that low-income older adults rely on.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on populations who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency.

We thank CMS for developing the proposed regulations to improve Medicaid managed care for enrollees. Since 2016 when CMS finalized regulations setting forth new standards for Medicaid managed care organizations (MCOs)¹, States have enrolled more individuals dually eligible for Medicare and Medicaid into managed care while also carving in additional Medicaid benefits older adults rely on, including most long-term services and supports (LTSS). Today, over seventy percent of Medicaid recipients are enrolled in managed care for most or all of their Medicaid benefits and twenty-four States operate MLTSS plans, up from eighteen States in 2017.² Additionally, States are increasingly contracting with Medicare Advantage Duals Special Needs Plans (D-SNPs) and requiring these plans to be aligned

¹ For brevity, our comments refer to an "MCO" rather than listing multiple types of entities: an MCO (managed care organization), a PIHP (Pre-paid Inpatient Health Plan), a PAHP (Pre-paid Ambulatory Health Plan), and/or a PCCM (Primary Care Case Manager).

² Advancing States & Center for Health Care Strategies, [Demonstrating the Value of Medicaid MLTSS Programs](#) (2021). Two additional States are implementing MLTSS plans: Indiana is implementing an MLTSS program in January 2024, and Oklahoma is implementing an MLTSS program in 2025.

Washington, DC



Los Angeles, CA



Oakland, CA

and better integrated with their states' Medicaid MCOs to improve access to care for people dually eligible.

In light of this growth and the ongoing issues Medicaid enrollees—and in particular dually enrolled people—face in obtaining quality care in MCOs, we are pleased to see many of the proposals set forth in the NPRM reflect recommendations we made in our 2015 comments.³ We specifically appreciate the provisions that focus on advancing health equity. Individuals dually eligible for Medicare and Medicaid are diverse: nearly half are people of color, 20 percent were born outside the United States, and 13 percent have limited English proficiency.⁴ Data demonstrates significant health disparities for this population, and Medicaid managed care has a critical role to play in addressing those disparities.⁵

Our comments focus on how the proposals can be strengthened to improve the experience of older adults and people dually eligible for Medicare and Medicaid. We draw on our expertise and extensive experience with Medicaid managed care in California and across the country.

[Access](#)

Enrollee Experience Surveys

We strongly support CMS's proposal at sections 438.66(b) and (c), to require states to conduct an annual enrollee experience survey as part of their managed care monitoring. Inviting direct feedback from enrollees will provide invaluable candid information on how MCO enrollees experience care. As CMS notes, this feedback is essential to obtaining information about enrollees' actual and perceived access to care to address disparities. Recent 2023 data collected by the LeadingAge LTSS Center supports this intention. Their findings revealed significant disparities by race, socioeconomic status, and where people live in the country, on whether people feel their care preferences are taken into consideration by their providers.⁶ For example, 83 percent of white adults age 50 and over reported having their care preferences considered compared to just 52 percent of Hispanic adults and 62 percent of Black adults. Likewise, individuals living in the southern region of the United States felt that their care preferences were considered less than people living in other regions of the country. A nationwide requirement would ensure Medicaid enrollees, regardless of where they live, are being heard, and importantly the survey results would inform strategies to improve the performance of MCOs.

We encourage CMS to also require MCOs to coordinate and align their annual survey reporting with surveys conducted by Medicare Advantage plans to maximize participation of dually eligible people. States should also be required to report survey results disaggregated by demographic factors including dual eligible status.

We also support the requirement that states include the results of their enrollee experience surveys in their Managed Care Plan Annual Report (MCPAR) and that the MCPAR be posted on the state's website within 30 days following the state's submission of the report to CMS (section 438.66(e)). This

³ Justice in Aging, [Comments on Proposed Medicaid Managed Care Regulations; File Code CMS-2390-P](#) (Jul. 27, 2015).

⁴ DHCS, [Cultural and Linguistic Demographics of the California Medicare Population](#), 2023.

⁵ See for example, CMS, [Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility or Eligibility for a Low-Income Subsidy and Disability](#) (May 2023).

⁶ The SCAN Foundation, [For People 50+ Care Preferences Matter](#), June 2023.

requirement will ensure the timely public reporting of the results, improve transparency, and strengthen the state's accountability to improve managed care plan performance.

Lastly, we strongly support the proposal to add enrollee experience surveys to the list of documents that are subject to interpretation, translation, and tagline criteria. As these surveys are voluntary to complete, these requirements are essential to ensure people with disabilities and people with limited English proficiency can participate. We also recommend adding the Section 1557 regulations here, as §§ 92.201 - 92.205 of the 2022 proposed rules would provide additional specificity to these accessibility requirements.

We ask CMS to consider an earlier compliance timeframe than three years given that many states already conduct surveys in their Medicaid program. For example, California, the state with the largest Medicaid enrollment in the country, already conducts the Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey every two years and will move to annual surveys in 2024.⁷ As of 2021, only 8 states were not using experience of care surveys for LTSS users.⁸

Appointment Wait Times and Network Adequacy Standards

We strongly support CMS's proposal to require MCOs to implement standard appointment wait times for adult and pediatric primary care, OB/GYN, and adult and pediatric mental health/SUD treatment at section 438.68(e). We also strongly recommend that CMS extend standard appointment wait times to specialty care consistent with Marketplace plans. Most often, Medicaid enrollees report that they have issues accessing specialists. Marketplace plans include a 30-day wait time for specialty care, and states like California, for example, have a shorter wait time period for specialty care of 15 days for the majority of Medicaid managed care members as well as all Marketplace enrollees.⁹

Although not addressed in the current NPRM, we urge CMS to consider additional rulemaking to strengthen LTSS network adequacy standards and enforcement. We were encouraged by the 2016 Medicaid Managed Care Rule that required states to establish network adequacy standards for LTSS, including time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services, and different standards for LTSS provider types that travel to the enrollee to deliver service.¹⁰ Yet, we question whether these standards are ensuring access.

For example, California's adult day program, Community Based Adult Services (CBAS), is authorized under California's 1115 waiver and theoretically available to any Medicaid enrollee who meets clinical eligibility for the program. However, 30 of California's 58 counties have no CBAS providers. The majority of counties without providers are rural. California's network adequacy standard for CBAS only requires MCOs to maintain the level of provider participation as of April 1, 2012, when CBAS became a Medicaid managed care benefit.¹¹ In other words, MCOs across the State are considered to have an adequate network of CBAS providers if the aggregate provider participation across the State is maintained at the

⁷ 28 Cal. Code Regs. § 1300.67.2.2(c)(5)(D),(G); and 10 Cal. Code Regs. § 2240.15(b)(5)(D),(G).

⁸ Medicaid.gov, [State Use of Experience of Care Surveys for Beneficiaries Using Long-Term Services and Supports](#), last accessed June 27, 2023.

⁹ California Department of Managed Health Care, Timely Access to Care Fact Sheet (2022), available at https://www.dmhca.gov/Portals/0/Docs/DO/TAC_accessible.pdf.

¹⁰ 42 CFR § 438.68(b)(2)

¹¹ DHCS, [Medicaid Managed Care Final Rule: Network Adequacy Standards](#), p. 9 (March 26, 2018).

same levels they were in 2012. This policy maintains an inequitable status quo and fails to comply with the Medicaid managed care final rule. CMS should consider additional rule making with more clarification of how States can develop LTSS adequacy standards that are meaningful and include additional requirements for oversight and enforcement.¹²

Secret Shopper Surveys

We strongly support the proposal to require States to conduct secret shopper surveys at section 438.68(f). Direct measurement is one of the best ways to ensure that network adequacy is real. For example, recent secret shopper surveys discovered extensive “ghost networks” among Medicare Advantage plans’ mental health providers. The report found that

“Of the total 120 provider listings contacted by phone, 33% were inaccurate, non-working numbers, or unreturned calls. Staff could only make appointments 18% of the time. Appointment rates varied by plan and state, ranging from 0% in Oregon to 50% in Colorado. More than 80% of the listed, in-network, mental health providers staff attempted to contact were therefore ‘ghosts,’ as they were either unreachable, not accepting new patients, or not in-network.”¹³

Inaccurate network provider directories are a source of frustration and lead to delays in care. Inaccurate provider directories can also expose Medicaid recipients to balance billing and exhaust limited resources and capacity to contest instances of improper billing. The use of independent secret shopper entities will provide valuable information by testing a plan’s publicly available directory.

We also support CMS’s proposal to require States to make their secret shopper results publicly available on their State website. 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.

Consistent with our above recommendation, we urge CMS to include specialists as a required provider type in secret shopping surveys. We also encourage CMS to include equity factors in secret shopper survey requirements. The extent to which Medicaid providers are available to people with limited English proficiency, to people with disabilities, and can provide culturally competent care to LGBTQ+ individuals should be evaluated.

Finally, we recommend CMS consider a compliance timeframe of less than four years. Currently, 28 States conduct secret shopper surveys to assess their network adequacy.¹⁴ It should not take four years for remaining States to implement these requirements.

Assurances of Adequate Capacity and Services

We strongly support CMS’s proposal to require a payment analysis of rates paid by MCOs to providers at section 438.207(b). CMS points out repeatedly, that inadequate payment rates impede access to

¹² See for example, [Community Living Policy Center, Managed Long-Term Services and Supports: Assessing Provider Network Adequacy](#) (December 2018).

¹³ Senate Committee on Finance, [Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks](#) (May 3, 2023).

¹⁴ KFF, [Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes](#) (June 15, 2023).

Medicaid recipients. People dually eligible for Medicare and Medicaid are particularly harmed by low reimbursement rates for LTSS and dental care, services not covered by Medicare. Accordingly, we urge CMS to extend payment rate analysis to these services. Returning to the example of CBAS in California, MCOs are only required to pay rates sufficient to maintain the network that was in place in 2012 and there is no rate floor. As a result, CBAS remains a ‘ghost benefit’ for the majority of older adults and people with disabilities in the State. Similarly, reimbursement for dental care is exceedingly low, leading to low provider participation in Medicaid. As of 2020, the average Medicaid reimbursement for adult dental services was 53 percent of private insurance reimbursement.¹⁵ We appreciate that the NPRM requires MCOs to annually compare (and States to report) managed care payment rates for each managed care program as a percent of Medicaid FFS rates for homemaker, home health aide, and personal care services, but this reporting does not address the payment adequacy concerns raised above.

We agree that Medicare payment rates can be a reliable benchmark. However, we urge CMS not to limit services subject to comparative analysis to those that Medicare covers. Medicare does not cover many services that older adults and people dually eligible need, including HCBS, dental, vision, and hearing. Thus, Medicaid is the primary payer and the only source of coverage for this population with low incomes. Inadequate payment and providers means people dually eligible cannot access these critical services, leading to worse health outcomes and unnecessary institutionalization. For services that do not have a comparable Medicare FFS rate, comparison to private insurance rates could be useful. We recommend CMS consider using Medicare Advantage (MA) as an alternative point of comparison for dental, vision, and hearing.

We also encourage CMS to require MCOs to report by service whether Medicaid is the primary payor or secondary payor to Medicare. Forty-two States have adopted the “lesser-of” policy for physician services and are therefore only responsible for reimbursing Medicare providers up to the Medicaid rate.¹⁶ Low Medicaid payment rates mean that Medicare providers often do not receive any reimbursement from the State for the 20% Medicare coinsurance. The result is that many providers refuse to take dually-eligible individuals as patients, limiting access to care. Requiring MCOs to report when Medicaid is primary versus secondary will help the State evaluate the impact of lesser of policies on access to care for dually eligible people.

Lastly, 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 to require that the remedy plan identify specific steps and timelines to achieve its goals. 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

¹⁵ American Dental Association, [Reimbursement Rates for Child and Adult Dental Services in Medicaid by State](#) (Oct. 2021).

¹⁶ Roberts, E.T., et al., [New evidence of state variation in Medicaid payment policies for dual Medicare-Medicaid enrollees](#) (Sep. 25, 2020).

also recommend that the remedy plans, once approved, be posted on the State’s website and that the State Medicaid agency be required to share them with the MAC and the BAG.

In Lieu of Services

We support the proposed rule’s codification of the guidance CMS recently released on In Lieu of Services (ILOS). ILOS provide an opportunity for States to significantly expand their HCBS and LTSS offerings. We particularly appreciate that the NPRM makes clear that “an enrollee who is offered or utilizes an ILOS would retain all rights and protections afforded under part 438, and if an enrollee chooses not to receive an ILOS, they would retain their right to receive the service or setting covered under the State plan on the same terms as would apply if an ILOS was not an option.”

We also appreciate that the guidance specifically requires the State to evaluate the impact each ILOS has on health equity. We encourage CMS to expand on the guidance in the NPRM to further advance equity by requiring the evaluation reporting to include how many ILOS were utilized, with demographic data on age, disability, race/ethnicity, dual eligible status, etc. The current requirements to report appeals, grievances, and state fair hearings data separately and for each ILOS should also include demographic data. Our experience in California with its implementation of ILOS – known as Community Supports – illustrates the importance of these requirements. To date, of the total number of individuals receiving Community Supports, 18 percent were age 65 and over.¹⁷ Considering that ILOS are intended to avoid institutionalization, older adults should represent a higher proportion of those receiving Community Supports since they represent the highest proportion of people currently residing in nursing facilities and at risk of institutionalization. It is critical to put in place at the outset robust requirements to evaluate whether ILOS are equitably being made available.

We appreciate that the NPRM reminds MCOs of their obligation to report T-MSIS data. We encourage CMS to work with States to ensure that ILOS are accurately captured in T-MSIS data. The quality of T-MSIS data for LTSS is currently very unreliable. CMS should ensure this is not compounded by inaccurate coding of ILOS in T-MSIS.

Quality Assessment and Improvement Program

We are generally supportive of amended section 438.340. Public review and comment are vital, and will be advanced by the proposed requirement for a State to publicly post 1) quality strategies at the three-year renewal and 2) the State’s three-year review of its quality strategy. Likewise, system quality will be increased by the proposal for States to consistently submit all revised quality strategies to CMS.

External Quality Review

Because we believe in consistent application of standards, we oppose the proposed revisions of sections 438.360(a)(1) and 438.362(b)(2), relating to private accreditation. Current regulations require that private accreditation organizations, in order to be used within external quality review, apply to CMS for a determination that their accreditation is an adequate substitute for Medicare certification. The proposed revision would require instead that States ensure that private accreditation review standards are comparable to standards established through external quality review protocols and consistent with the State’s quality strategy. In general, we believe that private accreditation should not substitute for federal or state monitoring, due to the risk that private accreditation agencies will be overly deferential

¹⁷ DHCS, [Enhanced Care Management and Community Supports Early Implementation Q1-Q3 2022](#) (April 2023).

to the providers that pay for their services. The CMS Medicare Advantage deeming review¹⁸ has provided some protection in this area, to make private accreditation more accountable, but that protection will be compromised by the proposed revision. Also, it is more efficient for CMS to make one determination regarding an accreditation organization, rather than expecting 50 individual States to make individual ad hoc determinations.

Regarding section 438.364(a)(2)(iii), we agree that validation alone is insufficient information for CMS and other interested parties, and support the expansion of requirements to include outcomes data and results from qualitative assessments. This data is available, and its availability will enable States and others to better make quality improvements. We also support CMS's proposal to add guidance in the external quality review protocols to stratify performance measure data in order to monitor disparities and address equity gaps.

We support the proposed revision of section 438.364(c)(2)(iii) to require States to retain external quality review technical reports for at least five years, and recommend that this period be extended to ten years. Making this information available to CMS and the general public is important, and the benefit of the technical reports is lessened drastically if they are not made publicly available. Particularly given the many regulatory provisions designed to make the technical reports both comprehensive and useful, it would be perverse if those reports then were relatively unavailable. Any extra expense is minimal compared to the usefulness of the reports and the expense already incurred in creating them.

Quality Rating System

We strongly support CMS's proposals to strengthen regulations relating to quality ratings systems as set forth in the new subpart G to part 438.

Specifically, we support the new requirement at section 438.505(a)(3) that the State's beneficiary support system include the capacity to assist persons who are using the quality rating system. Medicaid enrollees generally will be unfamiliar with managed care and quality ratings, and would greatly benefit from personalized assistance as needed. This is particularly true for individuals dually eligible for Medicare and Medicaid who face an overwhelming amount of information and choice of enrollment options. States should be required to ensure their choice counselors are well-trained in both Medicare and Medicaid and integrated care options.

Regarding the "conciseness" of the measure set, we question the goal of no more than 20 measures. The Medicaid population is extremely diverse, and a measure set of no more than 20 measures translates in many cases to just one, two or three measures that are relevant to a particular person or population. For example, from the current proposed mandatory measure set, only two measures relate to LTSS: one measure on assessments, and another on community discharges from nursing facilities. Those two measures are slim evidence for an older enrollee to choose one Medicaid managed care plan over others, when their primary concern is access to high-quality LTSS.

We support an every-other-year sub-regulatory process to revise the mandatory quality measures, as set forth in proposed section 438.510(b).

¹⁸ 42 CFR § 422.158

Regarding the standards for adding mandatory measures in section 438.510(c), we note that measures for HCBS might tend to “fail” the requirement in subsection (c)(1)(ii) that a measure aligns with other CMS programs, since many other health programs do not include home and community-based services. To address this, we recommend the following revision to (c)(1)(ii): “Aligns with other CMS programs described in § 438.505(c), or is a measure for a service that is not provided under such other CMS program.”

We support the requirement at section 438.515(a)(1)(ii) that the State collect Medicare data and fee-for-service data as necessary to calculate measures, provided that collection can be done without undue burden. Given the fractured nature of health care systems, it would be unfair if measures were made unavailable due to the relatively common situation of some portion of an enrollee’s care being provided outside of Medicaid.

We also support the requirement at section 438.515(b)(2) that quality ratings be issued to each plan at the plan level, by the managed care program. We also support the requirement at section 438.515(c) that CMS will propose to implement domain-level quality ratings. The more focused the quality ratings, the better. And domain-level quality ratings are consistent with our earlier comment that certain enrollees and populations will be much more interested in some areas than others, e.g., older enrollees interested in LTSS.

In general, we support the required content for the consumer-facing website in section 438.520(a). We note the importance of (a)(1), which requires introductory information such as information on choosing a plan and access to the beneficiary support system. Most enrollees will be unfamiliar with the type of information on the website, so it is crucial that the website provides enough background so that enrollees can actually use the website, rather than giving up in frustration. We also appreciate that the NPRM would require the website to identify which MCOs are integrated plans for dually eligible people.

We also recommend that state-maintained managed care information on websites and disseminated to Medicaid enrollees and MCO communications with enrollees be tailored for dually eligible individuals. Today, States and MCOs provide explanations that are broadly written for the Medicaid population that assumes that that Medicaid is the primary payor. This causes confusion for dually enrolled individuals who rely on Medicaid for services not covered by Medicare. For example, communications that say you have to select a primary care physician when enrolling with your Medicaid MCO make no sense for a dually eligible person whose primary care doctor is enrolled in Medicare. Materials should make clear what Medicaid MCOs pay for and provide for dually enrolled people.

We commend CMS for including in section 438.520(a)(4) a requirement that websites include explanatory material about quality measures. Consumers may be skeptical about quality measures, so the proposed regulatory language would appropriately require States to include explanatory information about how quality measures are calculated and validated.

In contrast to our general support of these quality-related requirements, we strongly oppose the provisions at section 438.525 for an alternative quality rating system. Designing a quality system is difficult, as CMS well knows, which makes it likely that any “alternative” system would be substandard. And, of course, every alternative system would entail substantial extra work for CMS and the State involved. We understand that some States may have preexisting ratings systems, but now is an

opportune time to standardize systems, given the substantial changes required of all States under the proposed regulations.

The proposed regulations require stratification in Phase 1 for dual eligibility status, race and ethnicity and, in Phase 2, add age, rural/urban status, disability, language of the enrollee, or other factors specified by CMS in the annual technical resource manual. We recommend that age, language and rural/urban status be moved into Phase 1 (4 years) through amendments to section 438.520(a)(2)(v) and (6)(iii), since this information is easily accessible to plans and the State. We also recommend that stratification also be required for sex characteristics, gender identity, and sexual orientation.

The proposed regulation requires that Phase 2 be implemented no earlier than two years after the implementation of Phase 1. We recommend revising section 438.520(a)(6) so that implementation of Phase 2 would take place *no later than* two years after implementation of Phase 1. At a minimum, the regulation should set a limit on the Phase 2 implementation date; “no earlier than” language, would allow a State to delay implementation of Phase 2 indefinitely.

Conclusion

Thank you again for the opportunity to comment on this rulemaking. If any questions arise concerning this submission, please contact Amber Christ, at achrist@justiceinaging.org.

Sincerely,



Amber C. Christ
Managing Director, Health Advocacy