FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

June 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via Regulations.gov

Re: CMS–2442–P and CMS–2439–P.

Dear Administrator Brooks-LaSure:

Families USA appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services (HHS) proposed rules, "Medicaid Program: Ensuring Access to Medicaid Services" and "Medicaid Program: Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality," hereafter referred to as "the access rule" and "the managed care rule." If finalized, these proposals would represent the most significant changes to federal Medicaid and CHIP regulations since CMS established the existing regulatory framework for managed care in 2016.

Families USA is a leading national, non-partisan voice for health care consumers, dedicated to achieving high-quality, affordable health care and improved health for all. For over 40 years, we have promoted comprehensive health coverage and advocated for a high-value health system centered on health equity, and we aim to ensure that no families face barriers to living a healthy life because of who they are, where they live, or how they identify. Central to that goal is ensuring that Medicaid and CHIP programs are healthy and effective, because together they provide health coverage to more than 90 million low- and middle-income people nationwide. Nearly three out of four of these individuals receive their Medicaid or CHIP benefits through managed care plans.

We strongly support the overall direction CMS is taking in these rules to advance the important goals of improving access to services, increasing transparency and monitoring of access, improving quality reporting, and advancing health equity. Our comments are focused on aspects of the proposed rules that would further improve transparency across the health care system and more fully center the needs and interests of Medicaid beneficiaries at the heart of proposed changes, including:

Access Rule:

- Strengthening the structure and makeup of the new Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG) to be more consumer focused.
- Commending the person-centered service plan proposal.
- Expanding the definition of Home and Community-Based Services (HCBS) workers included in the rule to maximize appropriate compensation for the delivery of this critical care.
- Ensuring the HCBS Quality Measure Set collects appropriate demographic data to support efforts to advance health equity.
- Further increasing transparency of service payment rates.

Managed Care Rule:

- Supporting codification of setting the cap for state-directed payments at average commercial rates and requiring additional transparency around these payments.

- Maximizing effectiveness of enrollee experience surveys.
- Improving proposed appointment wait time standards for people in need of time-sensitive reproductive health services, including abortion care.
- Strengthening the provision to assure adequate capacity and services via provider payment analysis.
- Clarifying framework for different states to implement a Medicaid and CHIP quality rating system.

Access rule: 2442–P

Families USA applauds CMS for proposing new guidance that will help ensure that Medicaid beneficiaries can access the services they are entitled to and improve the quality of care that beneficiaries receive. Finalizing the rule will help bring much needed transparency and minimum standards to fee-for-service (FFS) payments in Medicaid, which will help CMS fulfill its statutory responsibility to enforce access to services for Medicaid enrollees. We have listed our comments in the order they are discussed in the Access Rule.

§ 431.12 Medicaid Advisory Committee and Beneficiary Advisory Group:

Section 1902(a)(4) of the Social Security Act requires state Medicaid programs to operate a medical care advisory committee to advise states about health and medical services. Typically, this committee is comprised of providers, consumer advocates, and state agency staff. This requirement is presently implemented through the current version of section 431.12, which provides high-level rules for Medical Care Advisory Committees (MCACs), but the federal standards pertaining to MCACs are broad and the effectiveness of these committees varies significantly across states.[1] Although MCACs have been federally required for nearly 40 years, some states have seriously underutilized this important opportunity to monitor and improve their Medicaid programs.

We strongly support CMS's proposal to significantly strengthen requirements for MCACs, which would be renamed Medicaid Advisory Committees (MACs) and include a new requirement for a Beneficiary Advisory Group (BAG). These proposed regulations are a welcome step to meaningfully engage stakeholders, particularly Medicaid enrollees who have firsthand experience with the program's ability to meet the health needs of beneficiaries, its effectiveness, and deficiencies. But we recommend that CMS make additional improvements to the advisory groups to further center the health needs and interests of people who rely on Medicaid for health insurance. Families USA recommends the following improvements to the Advisory Committees:

- Increase the minimum percentage of Medicaid beneficiaries serving on the MAC and ensure Medicaid beneficiary input into meeting agendas: We generally support the proposal to require a minimum percent of MAC membership be Medicaid enrollees (25 percent under the proposed rule), who would also serve as part of the Beneficiary Advisory Group. However, we encourage CMS to consider going further to sufficiently ensure that the needs of Medicaid beneficiaries are centered in policy and program decisions to improve the Medicaid program. **To better serve the interests and needs of people who are covered by Medicaid, Families USA recommends that CMS require a minimum of 50% of MAC members to be from the BAG.**

  We support CMS's proposal to give states wide latitude to select topics of discussion in the MAC and BAG advisory meetings based on state and community need, under section (g). **We recommend that CMS maintain this flexibility while also requiring that all MAC and BAG meeting agendas are**

[1] https://ccf.georgetown.edu/2023/05/03/a-closer-look-at-cmss-proposed-rule-to-improve-access-to-care-in-medicaid-and-chip/

created with input from BAG members to ensure they will accurately reflect Medicaid beneficiaries' perspectives on state and community need.

- Ensure MAC and BAG transparency: The purpose of these advisory groups is to facilitate feedback between Medicaid stakeholders and the state on how to effectively administer the Medicaid program. To further this goal, **we recommend that CMS require all MAC and BAG meetings be open to the public and that all meetings include a dedicated time for members of the public to provide comments about their experiences in the Medicaid program.** This is a critical step to ensure that state agency staff hear directly from a broad representation of Medicaid enrollees in order to be able to incorporate these lived experiences into policy decisions regarding the administration of the Medicaid program. Accordingly, we strongly encourage CMS to revise subsection (f)(5) of the proposed rule to require a variety of in-person and virtual attendance options for the public (not just members of the committees).

- Ensure MAC and BAG accessibility: We strongly support CMS's proposal to make meetings accessible with reasonable modifications that can enable participation and communication for people with disabilities. **Additionally, we recommend that CMS strengthen the accessibility standard of the advisory group meetings by requiring states to meet minimum language and literacy requirements to reduce barriers to accessing the MAC and BAG meetings and ensure meaningful participation from a diverse set of members**. Specifically, we recommend that CMS should require real-time translation in American Sign Language (and closed captioning for virtual options) and at least one other non-English language applicable to a state's Medicaid population, and that all meeting materials be written at a sixth-grade level and translated into at least one language in addition to English.

§ 441.301(c) Person-Centered Service Plan:

This proposed rule represents a necessary step toward improving access to and quality of Home and Community-Based Services (HCBS). This is essential, as families across the United States are facing significant barriers to accessing HCBS, with over 656,000 people waiting for needed services in 37 states and an average wait time of 45 months.[2] The demand for these health care services is expected to increase substantially, with the U.S. adult population projected to double by 2060.[3] Given that 87% of people prefer to receive disability or aging services in their homes and communities, states are already working to meet the increased demand for HCBS in future years.[4,5]

Families USA strongly supports CMS's proposal to require states to demonstrate that 90% of people enrolled in HCBS care under 1915(c) waivers receive a reassessment of their needs at least annually. Annual reassessments of people's health needs are critical to ensuring that HCBS services and supports are effectively designed to meet the specific needs of the populations being served, and that HCBS services are provided in an appropriate manner that is consistent with the needs and care goals of each Medicaid beneficiary. Additionally, we support the requirement in § 441.540(c) and § 441.725(c) that a person-

[2] Alice Burns et al., A Look at Waiting Lists for Home and Community-Based Services from 2016 to 2021, KFF, November 28, 2022, https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-home-and-community-based-services-from-2016-to-2021/.
[3] Mark Mather, Paola Scommegna, and Lillian Kilduff, "Fact Sheet: Aging in the United States," Population Reference Bureau, July 15, 2019, https://www.prb.org/resources/fact-sheet-aging-in-the-united-states/.
[4] Hart Research Associates to Interested Parties, "Standing Up for Medicaid," April 13, 2023, https://caringacross.org/wp-content/uploads/2023/04/Caring-Across-Generations-Medicaid-Polling.pdf.
[5] State Management of Home- and Community-Based Services Waiting Lists (Washington, DC: Medicaid and CHIP Payment and Access Commission, August 2020), https://www.macpac.gov/wp-content/uploads/2020/08/StateManagement-of-Home-and-Community-Based-Services-Waiver-Waiting-Lists.pdf.

centered service plan be updated every 12 months, when an individual's circumstances or needs change, as well as at their specific request.

§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi)) HCBS Payment Adequacy:

Families USA supports language in the proposed rule to require that 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation for direct care versus administrative overhead or profit. This 80% includes, but is not limited to, base payments and supplemental payments, and would apply both to Medicaid fee-for-services and managed care delivery systems. Additionally, states would be required to report annually the percentage of payments that are spent on direct care worker compensation and report at least every other year the hourly rate paid to direct care workers. Families USA strongly supports this proposal as the additional transparency may ultimately lead to improved compensation for some direct care workers, such as home health aides and people providing critical health care services to eligible Medicaid enrollees to allow them to stay in their homes. These workers are often underpaid and undervalued in the health care delivery system, typically receiving wages that are not competitive with hourly wages in other industries.[6] In 2021, the median hourly wage for direct care workers was $14.27, with 40% of the workforce living in or near poverty and 43% also relying on public assistance programs.[7] This inadequate level of compensation negatively impacts the recruitment of a key group of health care providers – direct care workers – and ultimately limits options for beneficiaries in need of care. Insufficient compensation for direct care workers perpetuates cycles of poverty experienced by low-wage workers and their families.

To maximize the effectiveness of this proposal, Families USA encourages CMS to explore whether the included definition of home health aides and people delivering personal care services should be expanded to appropriately include a wide range of direct care workers are compensated at levels necessary to improve access and availability of key home and community-based services. Specifically, we urge CMS to work with HCBS advocates and disability groups to ensure the appropriate direct care worker definition is utilized in the payment adequacy portions of the proposed rule.

§ 441.312(d) HCBS Quality Measure Set:

We support CMS's proposal to update the HCBS Quality Measure Set to include new measures, inform states how to collect data, provide a standardized format and data collection process, identify specific populations for reporting, and define the subset of measures that must be stratified by race, ethnicity, tribal status, age, sex, rural/urban status, disability, language, or other such factors. To stratify HCBS data by race and ethnicity, as set forth in § 441.312(d), state agencies must improve their demographic data collection processes. The gold standard is to use self-reported data, typically collected from enrollment forms.[8] However, survey tools need to accurately represent the identities of respondents and should include sociodemographic information beyond race and ethnicity, including sexual orientation, gender identity, and education. Additionally, it is important that data categories be standardized across states so that CMS can use the HCBS Quality Measure Set to compare state performance. **As such, Families USA recommends that CMS release an updated sample application that states can use as a model to align with the current best practices of self-reported demographic data collection.**

[6] The State of America's Direct Support Workforce Crisis 2022. Alexandria, VA: ANCOR, 2022, https://www.ancor.org/wp-content/uploads/2022/10/The-State-of-Americas-Direct-Support-Workforce-Crisis-2022.pdf.
[7] Kezia Scales, Lina Stepick, Understanding the Direct Care Workforce, PHI, n.d., https://www.phinational.org/policy-research/key-facts-faq/.
[8] U.S. Department of Health and Human Services, Office of Inspector General Draft Data Brief, "Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability to Assess Health Disparities," March 2022, OEI-02-21-00100. https://oig.hhs.gov/oei/reports/OEI-02-21-00100.asp

§ 447.203 Documentation of Access to Care and Service Payment Rates:

We support CMS' proposal to rescind the Access Monitoring Review Plan (AMRP) requirements and replace them with new provisions, including requiring increased payment transparency. State Medicaid programs are required to ensure that payments to providers are sufficient to attract enough providers so that Medicaid services are available to Medicaid enrollees to the same extent as people in commercial coverage in the same geographic area. However, current Medicaid rules do not determine how much a state Medicaid program is required to pay a provider, which has resulted in significant variation for Medicaid payment rates across state Medicaid programs. Additionally, current Medicaid rules do not require states to publicly post payment rate information. States are required to conduct Access Monitoring Review Plans to determine whether sufficient access to health care services are being provided under FFS. To make changes to provider payment rates, states are required to use the AMRP and undergo a public process to receive input on the impact of the payment rate changes to beneficiary access to care.[9]

Under § 447.203(b) and (c), CMS proposes to repeal the AMRP requirement and instead use a new process through which states would be required to publish all Medicaid FFS payment rates in a clearly accessible location on a public website. Families USA strongly supports the proposal to increase transparency of Medicaid payment rates. This marks a significant step towards driving greater payment transparency across the U.S. health care system and a better understanding of how Medicaid payment rates impact access to care for Medicaid enrollees.

Families USA also supports CMS's proposal to require states to conduct a comparative payment rate analysis between their Medicaid rates and Medicare rates for primary care services, OB/GYN services, and outpatient behavioral health services to determine if their payment rates are consistent with "efficient, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." While reimbursement rates alone do not determine provider participation in Medicaid, they play a significant role in ensuring access to care for Medicaid enrollees.

Historically, Medicaid reimbursement rates are substantially lower than Medicare rates. In 2019, Medicaid FFS payments for physician services were 30 percent below Medicare payment levels, and for primary care it was even lower.[10] While Medicaid base reimbursement rates for hospital care are often low, many states make supplemental payments to some or all hospitals in their states to bolster their financing which ultimately results in Medicaid hospital payment rates that are on average 6 percent higher than Medicare rates.[11] Importantly, hospitals receiving supplemental payments pay the nonfederal share of the cost of these payments through provider taxes, or in the case of public hospitals, through intergovernmental transfers. Families USA supports the proposal that states would have to demonstrate that the new Medicaid payment rates in the aggregate (including base and supplemental payments) would be at or above 80% of the comparable Medicare rates before CMS would approve rate reductions or restructuring. Requiring FFS payment rate transparency, comparative payment rate analysis and payment rate disclosures for key Medicaid services is a critical step in being able to assess the payment differentials between public and private payers and ensure that Medicaid payment rates are adequate to ensure access to high quality health care providers and services. **We also encourage CMS to increase transparency around Medicaid reimbursement rates for independent providers, schools, community clinics, and hospitals for comparable services.**

[9] https://images.mwe.com/Web/MCDERMOTTWILLEMERYLLP/%7B7c0c6963-88b9-4223-af11-6e3c4924c479%7D_Medicaid_Access_Rule_Proposed_Rule.pdf
[10] https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact
[11] https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact

Finally, we urge that CMS require states with a fully FFS Medicaid system to demonstrate that they adhere to the same timeliness standards as required of states with Medicaid managed care organizations (MCOs). As proposed in this rule, states would have to develop appointment wait time standards for managed care plans that must be no longer than 10 business days for routine outpatient mental health and substance use disorder appointments, and no longer than 15 business days for routine primary care and OB/GYN appointments. We encourage CMS to apply these same standards to FFS Medicaid. That said, CMS should consider adjusting provider wait time standards to regional averages as some areas may have longer wait times across all payers, not just Medicaid.

Medicaid managed care rule: 2439–P

Ensuring beneficiaries can access covered services is a crucial element of the Medicaid program. Provided that over 70% of people with Medicaid or CHIP coverage are enrolled in managed plans, it is vital that CMS maintain effective regulations that hold plans accountable to ensuring people can access the services they are entitled to.[12] We have listed our comments in the order they are discussed in the Managed Care Rule.

§ 438.6(c)(2)(ii)(I) Establishment of Payment Rate Limitations for Certain SDPs:

The proposed rule would codify current policy to allow State Directed Payments to be capped at average commercial rates, under 438.6(c)(2)(ii)(I). Families USA supports this policy.

In 2016, CMS lifted the upper payment limit on state directed payments (SDPs) that capped rates at Medicare levels and instead allowed states to direct Medicaid MCOs to pay providers specific rates up to "average commercial rates."[13] CMS justified this policy change as a way to increase access to health care services for underserved populations by increasing provider participation in Medicaid.[14] Meaningful differences in the level of reimbursement between Medicaid and other payers can be a threat to access for Medicaid recipients. **Families USA strongly supports efforts to stop hospital pricing abuses, but believes those efforts should be directed across all payers and not only through the Medicaid program. For this reason we support the proposed codification of setting the ceiling at average commercial rates.**

MACPAC outlined in their June 2022 Report to Congress, that state directed payments are larger than Disproportionate Share Hospital (DSH) and upper payment limit supplemental payments, but there is much less data on who is receiving them.[15] **Thus we recommend that CMS require full transparency around state directed payments to hospitals.**

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

CMS proposes updating Medicaid Managed Care Organization (MCO) monitoring systems to better capture the enrollee experience, along with requiring states to conduct an annual enrollee experience survey, under § 438.66(c). **Families USA supports this revision and recommends that CMS endorse specific survey tools to align with the current best practices of self-reported demographic data collection and standardize data across states.** As discussed in our comments on the Access Rule, we appreciate CMS'

[12] "The Biden-Harris Administration Proposes New Standards to Help Ensure Access to Quality Health Care in Medicaid and CHIP," April 27, 2023. https://www.cms.gov/newsroom/press-releases/biden-harris-administration-proposes-new-standards-help-ensure-access-quality-health-care-medicaid
[13] 81 Fed. Reg. 27,498 (May 6, 2016) (amending 42 C.F.R. § 438.6(c))
[14] 81 Fed. Reg. 27,498 (May 6, 2016) (amending 42 C.F.R. § 438.6(c))
[15] Medicaid and CHIP Payment and Access Commission, "Oversight of Managed Care Directed Payments," June 2022, available at https://www.macpac.gov/wp-content/uploads/2022/06/Chapter-2-Oversight-of-Managed-Care-Directed-Payments-1.pdf

commitment to improving the measurement of health disparities through the stratification of state reporting on measures such as race, ethnicity, age, rural/urban status, disability, language, sex, sexual orientation, and gender identity, as well as social drivers of health to identify potential differences in access, quality, and outcomes. To obtain accurate data, state agencies need to improve their demographic data collection processes, including for enrollee experience surveys. The gold standard is to use self-reported data, typically collected from enrollment forms.[16] However, survey tools need to accurately represent the identities of respondents and should include sociodemographic information beyond just race and ethnicity, including sexual orientation, gender identity and education. Additionally, it is important that the data categories be standardized to allow for comparison of state performance.

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

CMS proposes that states develop and enforce wait time standards for routine appointments for four types of services: outpatient mental health and substance use disorder (SUD); adult and pediatric primary care; OB/GYN care, and an additional type of service determined by the state. CMS also proposes a floor for state-developed appointment wait times at no more than 10 business days for routine outpatient mental health and substance use disorder appointments, and no more than 15 business days for routine primary care and OB/GYN appointments. Families USA supports these proposed changes and is particularly pleased to see appointment time standards with a specific number of days for outpatient mental health and substance use disorder and primary care providers that are consistent with qualified health plans.

However, in light of the Dobbs v. Jackson Women's Health Organization Supreme Court decision, Families USA is concerned that the 15-business day standard for OB/GYN care is too long for people who suspect they may be pregnant or people of reproductive age who have not experienced a menstrual cycle within 28 days. Since the Dobbs decision, many states have begun to enact 6-week abortion bans. **Families USA recommends that CMS amend the proposal for people living in these states to a 3-business day standard to ensure they have the full array of reproductive health options available to them, including abortion care.**

§ 438.207(b), 457.1230(b) Assurances of Adequate Capacity and Services—Provider Payment Analysis:

As CMS notes in the proposed rule, there is no standardized, comprehensive, comparative data source available to assess Medicaid and CHIP payment rates across clinical specialties, health plans, and states and it is vital to get more transparency into how payment rates in Medicaid managed care affect provider participation and beneficiary access. CMS proposes requiring the disclosure of provider payment rates in Medicaid managed care and requiring states to compare reimbursement to Medicare rates for certain services. **Families USA supports this move toward transparency but recommends that rates be broken down by service and provider rather than reported in total or average.** It is critical to increase transparency around supplemental Medicaid payments, and the difference between what independent providers, schools, community clinics, and hospitals are reimbursed when base rates and supplemental payments are tallied together. **As mentioned above, there needs to be more transparency around Medicaid state directed payments and a reinstating of upper payment limits tied to Medicare.**

CMS should also ask providers for more information on their experience, particularly in managed care. As discussed in the rule, Medicaid reimbursement may be one barrier to greater provider participation in Medicaid and subsequently beneficiary access. But other barriers include the administrative processes to

[16] U.S. Department of Health and Human Services, Office of Inspector General Draft Data Brief, "Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability to Assess Health Disparities," March 2022, OEI-02-21-00100. https://oig.hhs.gov/oei/reports/OEI-02-21-00100.asp

contract with MCOs or the timeliness of payments for Medicaid patients. One study found that physicians lose18% of Medicaid payments to billing problems, compared to 4.7% for Medicare and just 2.4% for commercial payers.[17] If physician practices lose a significant portion of the lower Medicaid rates, physicians and practices are not incentivized to accept Medicaid patients. **CMS should also require reporting on these payment and claims metrics to better understand how they impact beneficiary access to Medicaid covered services.**

§ 438.334 and 457.1240: Establishing a framework for states to implement a Medicaid and CHIP quality rating system:

CMS proposes requiring states to create a "one-stop-shop" where beneficiaries can view information about Medicaid and CHIP eligibility, compare plans based on quality and other factors like drug formulary and provider network, and select a plan that best meets their needs. Families USA supports the move toward transparency and accountability and encouraging beneficiary choice. In many states, however, beneficiaries are assigned plans based on where they live and choosing between plans is not an option. As such, it may not be an efficient use of public resources to require all states to create a "one-stop-shop" for beneficiaries to compare plans. Plans should be evaluated and held accountable when they are performing poorly relative to their counterparts, but this regulation is not necessarily going to facilitate choice in states where there is not competition. **Therefore, we recommend that CMS require a one-stop-shop portal as proposed in states where beneficiaries select plans, and public reporting of plan quality metrics where beneficiaries do not select plans.**

We commend the commitment from CMS and HHS to work on improving access to Medicaid, and we appreciate the opportunity to provide comments. If there are any further questions, please contact Arielle Kane at akane@familiesusa.org.

Sincerely,

Frederick Isasi, JD, MPH
Executive Director
Families USA

[17] Dunn, Abe, Joshua D. Gottlieb, Adam Hale Shapiro, Daniel J. Sonnenstuhl, and Pietro Tebaldi. 2023. "A Denial a Day Keeps the Doctor Away," Federal Reserve Bank of San Francisco Working Paper 2023-03. https://www.nber.org/system/files/working_papers/w29010/w29010.pdf