April 18, 2022

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

Submitted electronically

RE: Request for Information (2022) Access to Coverage and Care in Medicaid & CHIP

Dear Administrator Brooks-LaSure:

LeadingAge appreciates the opportunity to provide feedback regarding the Centers for Medicare & Medicaid Services (CMS) Request for Information on Access to Coverage and Care in Medicaid and CHIP.

Objective 3: Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary's needs as a whole person. *CMS is seeking feedback on how to establish minimum standards or federal "floors" for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or "floors" would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices*

> 1. What would be the most important areas to focus on if CMS **develops minimum standards** for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?

LeadingAge recommends that CMS establish minimum access standards for medical services, behavioral health services, and long term services and supports. States should be permitted to add to these minimum access standards. Medicaid has grown to become the largest health coverage program in the United States and the current narrow networks are problematic. However, oversight of network adequacy has actually weakened in the last several years since the Supreme Court's *Armstrong v. Exceptional Child Care Inc.* decision eliminated the ability of providers to sue in federal court regarding lack of access in Medicaid and passed oversight to CMS. Under both the Obama Administration (in 2015-2016) and the Trump Administration, CMS held off on regulating national minimum standards for network adequacy and focused instead on requiring states to announce their own standards and report on Medicaid networks. Mandatory public planning was the basic structure of both Medicaid managed

care regulation and the fee-for-service Access regulation. This was not an impactful framework and essentially created empty paperwork obligations for states. CMS should reinstate the time and distance standards that the Trump Administration weakened and outline specific national time and distance minimums applicable in all states. States are now permitted significant latitude in making exceptions to the standards that increase enrollee travel distance and time. Consistent standards across states and delivery systems, if implemented thoughtfully, would reduce burden on payers, providers, and ultimately, beneficiaries.

In addition to time and distance standards, Medicaid managed care plans should be required to ensure adequate access to the required services to be covered. Factors that contribute to adequacy: anticipated plan enrollment; types of services likely to be utilized by enrollees in the plan based upon age, condition and geography; the number and types of providers needed to provide the required services, including which providers are not accepting new patients and what is the provider's capacity to deliver the services (e.g. what is the nursing home's average occupancy). It is not enough to have a provider in a plan network if they are not really available to serve plan enrollees. Given the current workforce challenges, adequate access may become a moving target that shifts regularly. CMS may choose to consider adding a provision that in cases where real-time access becomes an issue that plans should ensure access by allowing enrollees to use non-network providers at in-network rates until adequacy can be achieved again through network providers. There is a similar provision in the Medicare Advantage plan requirements section 422.100(m) and CMS has proposed to make further clarifications to this provision in the latest Plan Year 2023 Medicare Advantage rules. This might serve as a guide for what could be included in Medicaid as well.

Another often overlooked consideration regarding networks is whether beneficiaries have access to quality providers. We recommend that CMS consider adding a component to adequacy that ensures plans do not just build networks to the lowest common denominator. If we believe in equitable access to quality care, that should include Medicaid beneficiaries in managed care plans. When setting a national standard, it should read that the state establishes a quality component to their network adequacy requirements and that quality is defined either by state or national quality ratings for those providers.

While we strongly support creating national minimum standards, we would be remiss if we did not acknowledge the current reality of the workforce crisis. Our members strive to provide the highest quality care – both in nursing home settings, home health, and through a variety of home and community-based waivers. If CMS moves forward with setting federal floors related to access, we advocate that the definition of access include consideration of the current staffing availability to serve the needs of a service population. We would not want our members to be penalized or left out of networks for not being able to make a timely admission to care or not providing care at all if they cannot appropriately staff the patient or residents' needs.

CMS should have the long-term goal of creating a single national standard of network adequacy for provider types that are in common across its major health programs.

While CMS cannot require states to cover optional services without Congressional action, we

encourage CMS to provide guidance and/or incentives to states to promote adoption of optional HCBS services. For example, the Programs of All-Inclusive Care for the Elderly, or PACE, is an optional program that states may choose to offer. We strongly encourage CMS to work with states to ensure broader access to this program and other critical HCBS services like adult day, personal care services, and others. These services provide vulnerable beneficiaries with access to critical daily supports and services to manage their chronic conditions and live independently; and ultimately, help them avoid the need to access more costly care settings saving the entire system money.

2. How could CMS monitor states' performance against those minimum standards? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?

LeadingAge recommends that CMS provide public access to critical data collection already available from states:

Public Access to State Access Reports: The mandatory state reports on access in fee-for-service (described at § 447.203(b)(6), § 447.204(b), and § 447.204(c)) are currently only available to CMS. The public should also have access to these critical analyses. Public availability of this data and a public input process would provide stakeholders with more immediate insight into the potential impact and rationale for provider rate changes.

Supplement Medicaid Claims/Administrative Data with Provider/Beneficiary Experience Data: Much of the data required to comply with Medicaid Access Monitoring comes from claims or administrative sources. While it is administratively simpler for states to analyze their own data, claims and payment methodology data are not sufficient to provide a holistic picture of access. The triennial Access Monitoring Review Plan (§ 447.203(b)(4)) requires states to analyze provider/beneficiary experience measures. States should be required to establish systems to collect, analyze, and make public this information to contribute to our collective understanding of access in the Medicaid system. Additionally, these analyses should be stratified by race and ethnicity, the provider types listed in § 447.203(b)(5)(ii), as well as other key providers of interest such as medication assisted treatment. CMS should also modify universal billing forms to collect race and ethnicity data.

3. How could CMS consider the concepts of whole person care or care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?

LeadingAge proposes four concepts of whole person care necessary for establishing minimum standards for access to services:

Whole Person Care Coordinated through Payment: CMS could incentivize whole person care and care coordination through the payment system. Some examples could include:

- Utilizing Medicaid pay for performance for both fee-for-service and managed care plans that holds the health care system accountable for reduced health disparities;
- Providing greater flexibility, incentives and resources for health care providers and plans to build and staff relationships with social service providers and community-based organizations. This should include affordable senior housing. LeadingAge housing members have many dual eligible beneficiaries living in their affordable senior communities but are often not thought of for partnership and yet may serve Medicaid beneficiaries or near duals;
- Moving to risk-based provider payment with strong quality incentives tied to population health can create strong incentives to build more holistic care delivery

Care Manager and Care Coordination: We hear from our members that often they are dealing with multiple care managers for a single beneficiary. There might be a person responsible for these duties at our member organizations as well (such as a social worker at a nursing home or a service coordinator in affordable senior housing). However, care management may also be occurring through a health plan or through a doctor's office. One adult day member discussed how challenging it was to coordinate care when there were too many cooks in the kitchen. Additionally, it had the opposite of its intended effect – there was less continuity of care not more. CMS should consider ways to solve the "too many care managers" issue. Perhaps beneficiaries could elect a primary care manager if they are offered multiple options with a default option if the person does not choose. This may include making it clear that the individual must have a care manager, but that service can be delegated outside the Medicaid managed care plan to a provider care manager such as a nursing home social worker. This selection of care manager should be clearly documented in all the individual's records maintained by Medicaid providers.

Creating a New Survey Instrument: We recommend that CMS in partnership with the Assistant Secretary for Planning and Evaluation and others create and deploy new survey instrument to better quantify Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) needs in the United States. In order to truly understand LTSS needs and target HCBS services effectively, we need more data on the state of population. Currently, much of the development of survey instruments is left up to states leading to inconsistencies across the country in functional eligibility determinations. The Medicaid population is not stationary, many Medicaid beneficiaries move to multiple states over the course of their lives. The inconsistencies in tools used to assess individuals for access can lead to someone being denied access to essential services despite previously having services authorized in another state.

Incentivizing Bundling of Benefits: Adult day and transportation go hand in hand – in order for adult day to be a successful program, they need to be able to get their members to and from the center. However, transportation and adult day are separate benefits and thus our adult day members end up paying for transportation outside of the Medicaid rate that they receive. CMS and states should bundle logical

benefits together and allow passive enrollment by beneficiaries into multiple supporting benefits when the individual qualifies for one benefit but the other benefits support access and efficiencies.

> 5. What are specific ways that CMS can support states to **increase and diversify the pool of available providers** for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important*?*

CMS and states should work to ensure coverage of services and promote adoption of state laws and regulations that would expand the types of care team members that can participate and be reimbursed for providing care. Across all of our settings, the role of a certified medication aide is one that would expand the capacity of our members. Other types of roles that are utilized by some members are community health workers and peer support specialists. We urge CMS and state partners to consider making permanent, or at least extending, flexibilities permitted during the Public Health Emergency (PHE) which relaxed state licensure requirements and permitted providers to deliver care across state lines. This would support states' abilities to address workforce challenges and support beneficiary access to key providers regardless of whether they are in the same state.

We recommend CMS and states consider policies to support access to and reimbursement of remote patient monitoring (RPM) and telehealth, including audio only visits, which are critical in low-income communities or communities with limited broadband access. We also recommend CMS and states not only be sure to implement text-based services but potentially also allow reimbursement for certain text-based services, including a crisis text line. Extending temporary flexibilities or implementing permanent policies that remove certain state licensure requirements and expand reimbursement for telehealth and RPM can help meet patients where they are and also help states address workforce issues.

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible. *Section 1902(a)(30)(A) of the Social Security Act (the "Act") requires that Medicaid state plans "assure that payments are consistent with efficiency, 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." Section 1932 of the Act includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States "in an effective and efficient manner...." CMS is interested in leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.*

1. What are the opportunities for CMS to **align approaches and set minimum standards for payment regulation and compliance** across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?

LeadingAge appreciates this question, and we provide specific suggestions throughout this objective. We want to note up front that this issue is more complex than payment regulation and compliance. In our members' experience, there are many fundamental and cultural (people and institutions) practices that must evolve to make any real headway on payment and compliance.

We want to emphasize that anything CMS and states can do to educate and support collaborative dialogue between the state, managed care plans, and providers on mutual goals, processes, and mechanisms to reduce administrative burden would be most welcome. Most of what we hear from our members regarding their relationship with managed care is about the large administrative burden of dealing with different requirements from multiple plans, the lack of clarity as to why they are not getting paid in a timely manner, and challenges getting the right person at plans or at the state to work through issues. Members end up devoting full time employees, including clinicians, to administrative tasks rather than to providing care.

One cannot ensure provider access for Medicaid beneficiaries without addressing the adequacy of the rates Medicaid managed care plans pay to providers. Plans are assured actuarially sound rates, but providers often have little leverage in contract negotiations with plans and so can be left accepting contracts with below-cost rates. Some states have established that Medicaid fee-for-service rates are the floor as part of their contract terms with the Medicaid managed care plans. This should be an established national minimum standard. However, at the same time, we know that Medicaid rates often do not keep up with inflationary or cost-of-living increases. As CMS considers the role reimbursement rates may play in access to care, it might also consider if there is an opportunity for quality providers to be rewarded for their contributions to care through a pay-for-performance bonus that could be established as an expectation in plan contracts. Given Medicaid's historically low reimbursement rates, we would underscore that this should be a bonus, not an amount that is withheld and earned back. This would be one way to encourage participation by high quality providers in plan networks and further CMS goals to move more beneficiaries to accountable care relationships by engaging the providers in this work and rewarding them for achieving quality outcomes.

Value-based payment should be incentivized for plans as well. For example, we hear from home health members about plans reverting to per-visit models which is a step backward from the Medicare Patient-Driven Groupings Model PDGM system. Value-based payment arrangements should aim to utilize our provider networks to help reduce costs in high-cost areas such as hospital readmissions and unnecessary ER utilization. Plans should also be incentivized to collaborate with interested providers to explore more advanced value-based arrangements that share both upside and downside risk. We would like to see CMS and states share best practices or promising approaches for how providers and plans can work together to manage care. A federal standard could also set an expectation that Medicaid managed care

plans enter value-based payment arrangements with a certain percentage of their network providers and have this percentage increase each year.

CMS and the states should incentivize not only quality care but also reduction in administrative burden. In managed care environments, plans should not only be held to existing prompt pay laws but incentivized through payment or stricter regulation to pay claims more quickly. CMS should also ensure that medical loss ratio (MLR) requirements are in place across all states' managed care plans and that existing MLR requirements are enforced.

3. Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community based services (HCBS). What data sources, methods, or benchmarks might CMS consider to assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?

Even when there is an applicable Medicare rate, we hear time and time again from our members that they are not paid a sufficient amount for the services that they provide. Therefore, Medicare rates are not a good comparison or benchmark for Medicaid rates. Our adult day members, who serve a vulnerable population at a fraction of the cost of the other settings of care in which these older adults would end up, are usually paid below their costs by the Medicaid program. This is not a Medicare covered service. In this case, CMS could conduct an assessment of the actual cost of providing care and set a floor for payment. In the case of adult day, CMS could also look at what the VA reimburses as these rates tend to align with the actual cost of care.

A recent LeadingAge Pennsylvania study showed the vast differential between the cost of providing care in a nursing home and the amount of reimbursement from the state Medicaid program. This is a reality across all states and threatens providers ability to stay open and serve their communities. It also is a disservice to beneficiaries and in direct contrast with the Administration's stated goals related to health equity. Recently, one of our members announced they had to close due to years of underfunding from the Medicaid program. This leaves residents in a predominantly Black and economically disadvantaged community without a home. This is also not an isolated incident. Of course, our member will ensure safe transfer of care but if these types of closure continue, there will not be places for people to receive essential services.

Similar to home and community-based services like adult day, we recommend CMS look at the actual cost of providing long stay nursing home care and create a floor for payment. We also would ask that CMS look into ways to incentivize or require states to update Medicaid payment rates on a regular basis. Part of the issue with insufficient payments is that in some states, these reimbursement rates have not been updated for years and are not aligned with the current economic environment or yearly costs of inflation.

CMS should provide updated instructions, technical guidance and review criteria that includes requirements for states to have a plan of compliance when states are unable to demonstrate how rate adequacy was reviewed. Prior to implementation of new rates which will reduce reimbursement, a CMS interim review should be triggered to assess the justification of states for the reduction and an analysis of potential beneficiary access should be conducted. These rate reviews should be available for all provider types, whether nursing home or HCBS.

While Justice Breyer's concurrence in *Armstrong v. Exceptional Child Center Inc.* suggested that providers and beneficiaries had the opportunity to advocate for improvement of inadequate rates directly with the Department of Health and Human Services, we have found few means for providers and beneficiaries to share concerns with CMS regarding state developed rates. Therefore, CMS should design a specific access complaint process with required reviews and an outreach component to states to support stakeholder feedback regarding inadequate payments. For both mandatory benefits like nursing home care and home health, and HCBS benefits like adult day, PACE, transportation, personal care, and others, we ask that the cost of workforce be a required cost center built into any new rate methodologies and adjusted with federally defined regularity.

4. Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries.[2] What actions could CMS take to encourage states to **reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP** while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?

As noted throughout this response, LeadingAge hears about these administrative burdens frequently and offers the following suggestions.

All our members struggle with the administrative burden of tracking multiple contract requirements, credentialing requirements (as outlined in more detail below), ensuring timely payment, and lack of detail on what is being denied (or being paid) to manage appeals. While these are burdens to all our members, standalone smaller nursing homes, home health agencies and HCBS providers like adult day, really struggle with all of the administrative overhead. This is especially true in some states where there may be some combination of Medicaid fee-for-services, Medicaid managed care, and a duals demonstration like PACE going on simultaneously. While we are sensitive to the nature of state-federal partnership of the Medicaid program, any actions that CMS and their state partners could take to standardize, centralize, and reduce the amount of administrative overhead needed to collect payment, become part of a network, and coordinate care would only benefit Medicaid beneficiaries. We could imagine centralized coordinating centers in states that support centralized billing portals and standardized forms.

For example, specifically related to provider credentialing and recredentialing, all health plans require the same demographic information and documentation: license, insurance, w-9, proof of Medicaid/Medicare enrollment, etc. They also all ask some version of the same 10 – 13 questions (e.g.

has your license been suspended, malpractice, complaints, privileges revoked, etc.). It was thought that the Council for Affordable Quality Healthcare would help with this issue by being a portal where all providers could upload their data and where health plans can access the information. However, in practice, provider data is not kept current and health plans end up requesting additional information. Generally, this additional information is related to their accreditation entities.

States require Medicaid providers to re-enroll/recredential every 3-years to continue their Medicaid provider status. The health plans are also required to verify all the same data required in the Medicaid applications and re-enrollment on a three-year cycle. CMS and states should allow Medicaid health plans to utilize state required re-enrollment as the bulk of the health plans credentialing/recredentialing process. Health plans should have a standardized and short two-page questionnaire/attestation to meet the health plan's accreditation standards and/or state and federal contract requirements.

These types of changes should also be considered in billing, claims adjudication, accounts receivable, and contracting. The system as it stands today is hard for providers to navigate and favors large providers with more resources to spend on administration. It also takes time away from patient care which is the mutual goal.

Thank you for considering the feedback in these comments. If you have any questions, please do not hesitate to contact us to discuss these comments further.

Sincerely,
Mollie Gurian
Vice President, Home Based and HCBS Policy
LeadingAge
mgurian@leadingage.org