July 3, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2439-P
P.O. Box 8016
Baltimore, MD 21244

[CMS-2439-P] RIN 0938-AU99 Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

Submitted electronically via: https://www.regulations.gov/commenton/CMS-2023-0071-0001

Dear Administrator Brooks-LaSure,

LeadingAge appreciates the intent of CMS to improve the quality of and access to Medicaid covered services through rulemaking process. We are grateful for the opportunity to submit comments on the CMS notice of proposed rule-making: ([CMS-2439-P] RIN 0938-AU99) Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (Managed Care Rule).

The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 mission driven aging services providers that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services providers. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

As advocates for high quality long-term services and supports across the aging services continuum, LeadingAge applauds CMS' goals to move the Medicaid program towards more accountability, transparency, and quality. We feel the sentiment and major provisions of the rule are well intentioned and could meaningfully elevate expectations and minimum standards for programs already working towards equitable access to quality Medicaid service delivery through managed care organizations (MCOs).

LeadingAge is broadly supportive of the objectives CMS outlines in proposing these changes to state administration of managed care programs. We have identified some concerns, on behalf of our provider members, which we hope CMS will consider as they amend the rule and move towards final compliance.

Provider experience with MCOs is critical to an efficient and accessible Medicaid program.

Providers are an integral thread in the fabric of ensuring access to quality care and services in Medicaid managed care programs. As managed care proliferates, our members' ability to actually "negotiate" fair contracts has diminished. We also hear from beneficiaries about their variable experience with managed

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care including challenges accessing certain provider types, long wait times, and care denials. Proposed additions to the use of participant experience surveys to garner enrollee feedback on available services, access, and quality is welcome. LeadingAge urges CMS to consider ways in which network/contracted providers also can provide meaningful and analytic feedback to CMS on their experience with the MCO. Many providers experience bureaucratic hurdles with prior authorization, claims denials, or billing complexities particularly during early years of managed care implementation. Unnecessary administrative burdens caused by MCOs result in uncompensated administrative costs for providers. Creating an environment where states hold MCOs accountable for provider level concerns in contracting and increased administrative burden would allow providers to better allocate already inadequate Medicaid reimbursements for staff time.

Rate adequacy in managed care is loosely defined and in further jeopardy under these proposals.

CMS requested feedback on considerations about significant limitations on states' ability to direct payments in managed care programs. Imposing significant changes in how states finance provider rates and require MCOs to pay adequate rates will imperil access to specific services. We have heard from states that providers have the choice of whether to contract with a particular MCO, and if adequate rates aren't offered by the MCO that providers should continue to negotiate until they receive a favorable contract. This is untenable for providers in cases where a single MCO dominates a market and a large share of the provider's revenue is generated from Medicaid service provision. In addition, rate negotiations with one or more MCOs takes considerable organizational resources in the form of staff and time to be successful. Mission driven providers across the country have determined they will do all they can to continue serving their Medicaid participants, even as rates fall or remain static in the face of rising costs and inflation. This is particularly problematic in nursing facility services where a single payer in a geographic area is not subject to market pressures, but rather enjoys an anti-competitive market promoting unequal leverage in contract negotiations. We urge CMS to take care in requiring significant shifts in payment policy without ensuring adequate provider level protections and significant technical assistance to states to assure ongoing access to services.

The proposal requiring transparency of MCO provider level rates is welcome and will facilitate providers' ability to better negotiate contract rates by analyzing rates paid to other providers within the same capacity and quality bands. LeadingAge is supportive of payment analysis for particular services inclusive of homemaker, home health, and personal care to allow providers additional leverage in rate negotiations. We believe this provision coupled with claims analysis will demonstrate areas in which additional provider capacity would allow for service availability expansion. We applaud the proposal and encourage CMS to ensure meaningful use of analytic data collected at state and MCO levels.

Access to care and services through the implementation of "Remedial Plans"

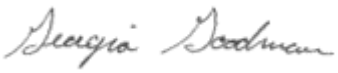
LeadingAge is supportive of ongoing network adequacy monitoring to assure Medicaid enrollees have access to covered services. We support the goal of remedial plans in the context of growing demand for services. We have concerns in the context of steady demand and decreased provider capacity. While remedy plans at the state level provide a way for CMS to monitor provider enrollment, we propose that CMS take an additional preemptive step to remediate inadequate access. Similar to our earlier recommendation that CMS require provider satisfaction and feedback surveys, we think those results would be related and applicable here.

Situations where analysis of provider feedback and trends indicate that providers are contemplating or intend to sunder Medicaid service provision because of inadequate rates or administrative challenges would provide a preventive opportunity for states to intervene. States could use this information to compel MCOs back to rate negotiation tables with providers to ensure continuity of care and services for current enrollees. Without these preventive protections, particularly participants receiving home and community-based services will experience service interruption and lack provider continuity if providers decide to stop participating with Medicaid MCOs. We are concerned that remedial plans will not be sufficient to prevent small providers from closing due to an inability to make ends meet with Medicaid reimbursement. Once a provider shutters their operation, a state's remedial plan will not bring them back into the Medicaid provider network. We believe CMS should consider additional similar but proactive protections over reactive and retrospective policy solutions.

Conclusion

LeadingAge thanks the administrator and CMS for their attention and ongoing commitment streamlining and improving the Medicaid delivery system for the providers and the participants they serve while increasing efficiency and quality across service delivery modes. We believe transparency and accountability coupled with adequate rates will elevate quality of services provided, and access to necessary services. As additional standards are considered, we hope CMS will use LeadingAge as a trusted resource and stakeholder in the aging services space.

Sincerely,



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