CLIENT ALERT: ACCESS TO CARE/NETWORK ADEQUACY

CMS Proposed Rule: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P) in the Federal Register

On May 3, 2023, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule titled: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P) in the Federal Register. Myers and Stauffer is providing this alert to states to make them aware of several notable provisions related to network adequacy and access and to help inform each state's evaluation of the proposed language and potential concerns.

For the full proposed rule text, see https://www.federalregister.gov/documents/2023/05/03/2023-08961/medicaid-program-medicaid-andchildrens-health-insurance-program-chip-managed-care-access-finance.

The proposed rule, aimed to strengthen the standards and monitoring applicable to access to care in the Medicaid managed care environment, would:

- Establish national maximum appointment wait time standards for routine primary care, obstetric/gynecological (OB/GYN), outpatient behavioral health and substance use disorder (SUD) services.
- Require secret shopper surveys as part of monitoring activities, using independent entities.
- Require an annual enrollee experience survey.
- Require the performance of an annual payment analysis to compare managed care organization (MCO) payment rates for certain services as a proportion of Medicare's payment rates and the state's Medicaid state plan payment rate.
- For any MCO with access issue(s) that need improvement, requires a remediation plan.
- Require reporting of assurances related to adequate capacity and services.
- Require public transparency.

Additional discussion for each of these elements is included below:

1. Establish maximum appointment wait-time standards for routine primary care, OB/GYN, outpatient behavioral health and SUD services and a state-selected service. (§§ 438.68(e), 457.1218).
2. Require secret-shopper surveys as part of monitoring activities and use independent entities (§§ 438.68(f), 457.1207, 457.1218).

MYERS AND STAUFFER LC

3. Conduct an annual enrollee experience survey (§§ 438.66(b) and (c), 457.1230(b)).
4. Annual payment analysis to compare MCO payment rates for certain services as a proportion of Medicare's payment rates and the state's Medicaid state plan payment rate (§§ 438.207(b), 457.1230(b)).
5. Implement a remedy plan for any MCO with access issue(s) that need improvement (§ 438.207(f)).
6. Assurances of Adequate Capacity and Services Reporting (§§ 438.207(d), 457.1230(b)) CMS' proposed rule would include the provision of additional assurances and reporting of capacity and services.
7. Transparency (§§ 438.10(c), 438.602(g), 457.1207, 457.1285).

1. Establish maximum appointment wait-time standards for routine primary care, OB/GYN, outpatient behavioral health and SUD services and a state-selected service. (§§ 438.68(e), 457.1218).

CMS is proposing in the rule to set the following national wait-time standards:

- No longer than 10 business days for routine outpatient mental health and SUD services
- No longer than 15 business days for routine primary care and OB/GYN services.

In addition to the service types listed above, states would need to select at least one additional type of service and establish corresponding wait time, using an evidence-based approach for Medicaid. It is understood that some services may not be covered for all health plans. The state would be required indicate the additional provider type(s) in the Managed Care Program Annual Report, per § 438.66(e), and the Network Adequacy and Access Assurances Report, per § 438.207(d).

The proposed standards are based on the Affordable Care Act (ACA) marketplace standards, which will become effective in 2024. States would have the authority to vary the wait times for the same provider type – for example, adult or pediatric; in person or telehealth; geography, etc. It is important to note that CMS is not defining "routine" and is expecting the states to work with the health plans to determine the definition for their state. States can take the initiative to set appointment wait times for urgent appointments, too.

The standards would be a requirement in the health contract. CMS also proposes to revise § 438.206(c)(1)(i) which would require including the appointment wait time standards as a required provision in the managed care plan Medicaid contract.

CMS is specifically requesting comment from states and stakeholders related to behavioral health prepaid inpatient health plans and prepaid ambulatory health plans regarding whether these health plans have other provider types to choose from for the state-specific requirement. States will want to consider if this requirement is feasible for all health plans. Also, CMS is considering other provider types to add, so an opportunity to provide feedback to CMS about state preferences is available.

Comments regarding alignment of the ACA Marketplace standards are also requested. States may wish to consider if these standards would be feasible in their unique Medicaid managed care programs.

While exceptions to the standards may be granted by states, CMS reminds states to consider whether low MCO reimbursements to providers is a factor to building a provider network, which may determine whether an exception will be granted.

Finally, a new § 438.214(d)(2) is being proposed to ensure health plan contracts contain a requirement that terminated providers cannot participate as a provider in any Medicaid managed care plan network.

Proposed applicability date: These standards would become effective by the first rating period beginning on or after three years after the effective date of the final rule.

2. Require secret-shopper surveys as part of monitoring activities and use independent entities (§§ 438.68(f), 457.1207, 457.1218).

To more effectively monitor access and identify any gaps, the proposed rule would require states to perform annual secret-shopper surveys and report the results. To ensure unbiased results, CMS' proposed rule would also require states to use an independent entity to perform this activity.

Four data elements accuracy need to be verified: active network status with MCO; street address (§ 438.10(h)(1)(ii)); telephone number (§ 438.10(h)(1)(iii)); and whether provider is accepting new enrollees (§ 438.10(h)(1)(vi)).

The survey process would also include a review of electronic provider directories (no paper) (§ 438.10(h)(1)), for primary care providers, OB/GYN, outpatient mental health and SUD providers, and the state-chosen provider type.

The proposed rule would require the secret-shopper survey be completed with a statistically valid sample of providers, using a random sample and including all areas of the state covered by the managed care contracts (§ 438.68(f)(4)).

For health plans to be considered compliant, the independent results need to show that the appointment availability standards were met at least 90 percent of the time. Offered telehealth appointments would only be counted for compliance purposes if in-person appointments are available, and telehealth appointment should be identified separately in the survey results.

In § 438.68(f)(1)(iii) and (iv) respectively, to maximize the value, identified errors from the secret-shopper survey must be communicated to states no later than three business days, and the state must send to the health plan within three days of receipt. The error information must be sufficient to facilitate correction. Health plans would have to update the provider directory within the time frames specified in § 438.10(h)(3)(i) and (ii).

Proposed applicability date: CMS is requesting comment on the type of technical assistance states would need and which would be most useful in implementing this requirement. The effective date would be by the first rating period beginning on or after four years after the effective date of the final rule.

3. Conduct an annual enrollee experience survey (§§ 438.66(b) and (c), 457.1230(b)).

The proposed rule will add the requirement that states conduct an annual survey of its enrollees to solicit comment and better understand the challenges that those individuals might face in obtaining timely and quality care to meet their needs. The disparities in access to care may be a function of the availability of providers who are willing to provide care to the medically underserved populations, and this could provide a means for states to address that issue.

These surveys can focus on matters important to enrollees, as well as on the perceived experience from the enrollees who participate in the survey. Some states are using this type of survey, like the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the National Core Indicators-Aging and Disabilities (NCI-AD®) Adult Consumer Survey.™ These surveys should support other network adequacy activities.

Most states are utilizing a CAHPS® survey as part of the external quality review voluntary protocols and includes an enhanced federal match up to 75 percent; however, for those states who are not or only periodically, this proposed change would impact the scope of work for the external quality review organization, if contracted to perform, or the health plans, if the requirement is added to the health plan contract. The frequency of the survey (proposed annually), while important to know how policies implemented are changing the managed care program, may impact the results of received in the survey. "Survey fatigue," which is when respondents lose interest in responding due to frequency or amount of effort to respond, could be a bias introduced into the results.

It is important to note that provider survey results alone would not be compliant for § 438.66(c)(5). CMS is not requiring provider surveys at this time; however, it is indicated in the proposed rule that the results of these surveys and the secret-shopper results may impact decisions at a later date.

The proposed rule would require posting the results of the survey on the state's website within 30 calendar days of submitting the report to CMS. The surveys would need to meet the interpretation, translation, and tagline criteria in § 438.10(d)(2).

Comments are requested for this requirement, especially related to cost and feasibility, and states may want to consider the impacts to the managed care programs and how this requirement may influence other policy decisions.

Proposed applicability date: The requirement would become effective by the first rating period beginning on or after three years after the effective date of the final rule.

4. Annual payment analysis to compare MCO payment rates for certain services as a proportion of Medicare's payment rates and the state's Medicaid state plan payment rate (§§ 438.207(b), 457.1230(b)). Quality Review Results (§§ 438.364 and 457.1250(a))

In its efforts to improve enrollee safety and quality of care, CMS has encouraged states to link Medicaid payments to quality measures. CMS believes that payment rates are linked to provider network sufficiency and that greater transparency of the rates is needed to determine if those rates are impacting enrollee access to care.

The proposed requirement in § 438.207(b)(3) would require the health plan to conduct a payment analysis and submit annual documentation to the state. The requirement includes the criteria for services to be included and the methodology for the comparison.

Although health plans are required to submit payment information to states as a component of the encounter data they provide, historically, it has been difficult to receive information from health plans if the health plan deems the information as proprietary to the business operations. Another concern could be the quality of the claims data being used for this analysis and how the state would ensure the data quality is in an acceptable range. The states would be receiving self-reported (health plan) data and would need to evaluate what validation steps would be needed to ensure the information the health plan submitted is accurate. In addition, CMS's proposed rule does not address how payments made outside of the claims adjudication, such as state-directed payments or value-based payment, will reflected in the annual payment analysis.

Proposed applicability date: This requirement would become effective by the first rating period beginning on or after two years after the effective date of the final rule.

5. **Implement a remedy plan for any MCO with access issue(s) that need improvement (§ 438.207(f)).**
   Under the proposed rule, if an issue is identified with a managed care plan's performance with regard to any state standard for access to care, the state would need follow the paragraphs (i) through (iv).
   - Submit remedy plan to CMS no later than 90 calendar days following the date the issue was identified.
   - Develop a remedy plan to address the identified issue that if addressed could improve access within 12 months and that identifies specific steps, timelines for implementation and completion, and responsible parties.
   - Some approaches to address the issues are located in § 438.207(f)(1)(ii) for states to consider.
   - Improvements in access to care need to be measurable and sustainable.
   - States would submit quarterly progress updates to CMS after the remedy plan has been implemented.
   - If progress is not sufficient, state may be required to continue past the initial 12 months or revise the remedy plan.

Proposed applicability date: This requirement would become effective for contracts beginning on or after four years after the effective date of the final rule.

6. **Assurances of Adequate Capacity and Services Reporting (§§ 438.207(d), 457.1230(b)) CMS' proposed rule would include the provision of additional assurances and reporting of capacity and services.**
   The proposed rule would require states to use a CMS-published template for reporting assurance of compliance. CMS published the "Network Adequacy and Access Assurances Report" template in a July 6, 2022, CMCS Informational Bulletin. The proposed rule would require the secret-shopper evaluation results as well as the payment analysis results as a component of the assurance report. The submission would be required at the time of a readiness review, on an annual basis no later than 180 days after the end of the contract year, or any time there is a significant change and with submission of an associated contract.

Proposed applicability date: The assurance report submission requirement would become effective for the first rating period beginning on or after one after the effective date of the final rule. The requirement to include the payment analysis results in the assurance report would become effective for the first rating period for contracts beginning on or after two years after the effective date of final rule. The requirement would be effective for the first rating period beginning on or after one after the effective date of the final rule.

7. Transparency (§§ 438.10(c), 438.602(g), 457.1207, 457.1285)

Ensuring that enrollees can easily and efficiently locate the information needed for them to obtain timely, quality care is the focus of this section of the proposed rule. CMS is proposing to build upon the requirements that states must already adhere to in the information that must be made available on a single, public-facing website, by proposing to impose a number of minimum qualities that each website must include, as well as information regarding the network adequacy standards that are required.

CMS also believes that states and MCOs should implement and use web analytics to monitor traffic on the website and inform needed changes in the design. States will need to check their websites quarterly to verify the website is functioning as expected and information is current. There are currently four types of information required to post; this proposed rule would add nine more items, including enrollee handbooks, provider directories, formularies, information on rate ranges, state-directed payment evaluation reports, network adequacy standards, documentation of compliance with Subpart K-Parity in Mental Health and Substance Use Disorders, reports required by §§ 438.66(g) and 438.207(d), and secret-shopper survey results.

Proposed applicability date: The requirement would become effective for the first rating period for contracts beginning on or after two years the effective date of the final rule.

Next Steps:

- Assess your managed care health plans' reporting in network adequacy. Determine if required information needed to be in compliance with the proposed requirements is currently being obtained.
- Assess other monitoring currently being performed to determine if these proposed requirements are already in place.
- Consider performing an environmental scan related to network adequacy. This exercise will provide each state with the current status regarding what requirements are in place, identify gaps, and reveal opportunities to enhance current processes.
- Consider including comments and concerns during the public comment period which ends July 3, 2023.

FOR MORE INFORMATION

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