February 9, 2023

Mr. John Giles
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Follow-up – MHPA-CMCS Medicaid Access Discussions

Dear Mr. Giles:

The Medicaid Health Plans of America (MHPA) would like to thank you and your colleagues from the Centers for Medicare and Medicaid Services (CMS)/Center for Medicaid and CHIP Services (CMCS) for your continued commitment to ensuring access to services and supports for Medicaid beneficiaries. We look forward to continuing to work with you and your team and colleagues in the best interests of Medicaid beneficiaries and in support of the stability and sustainability of the Medicaid program.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 managed care organizations (MCOs) serving more than 49 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost- effective, and quality health care for Medicaid beneficiaries.

On the MHPA-CMCS quarterly call on December 8th, 2022, and on a follow-up call on January 20th, 2023, MHPA shared our perspective on considerations for assessing and improving access to care and supports for Medicaid beneficiaries. As requested, we have compiled the key takeaways from our conversation and included additional information on issues that required follow-up in the body of this letter and in the appendix.

Specifically, this letter covers the following topics: Key Considerations for Defining and Measuring Access; Overview of Health Plan Monitoring and Reporting Tools; Wait Time Standard Considerations; and Related Corresponding Policy Positioning**.**

Key Considerations for Defining and Measuring Access

Establishing access and connecting consumers to high quality, appropriate and timely care is the focus of our health plans' missions. We are oriented to build networks, clinical programs, consumer services and quality initiatives to make meaningful strides on engaging and connecting consumers to care. This is a complex task and one that we continually strive to advance.

With this grounding in our engagement and commitment to connecting our consumers to care, it is important to acknowledge that this complex issue is difficult to translate into a simple definition or measure set that can be effectively applied broadly and uniformly across states, geographies, and populations. Provider participation and location, physician-to-enrollee ratios, appointment wait times, call center times, time and distance measures are important; however, any of these measures alone do not provide a holistic view of access or efforts health plans have in place to mitigate systemic barriers to care many of our consumers experience. For example, our teams regularly facilitate appointments, arrange for transportation, provide care navigation, provide nurse consultation, and offer telehealth appointments to ease barriers to care. Additionally, many of our health plans work alongside safety net providers and health systems committed to serving the Medicaid population to bolster efforts to engage and capacity to serve.

We encourage CMS to consider the following complexities when considering definitions and measurements of access for the Medicaid program:

- **Health System Capacity**. Even prior to the COVID-19 pandemic, the United States had significant issues with health care access due to the shortage of a wide variety of health care professionals. Today, more than 99 million people live in a federally designated primary care shortage area, 70 million live within dental shortage areas and 158 million live in areas with a shortage of mental health professionals. A lack of staffing and resources continues to cause significant disruptions to care delivery for clinics, hospitals, and communities, including permanent facility closures. Provider shortages have been universally reported across all states and geographies.

- **Contextual Factors.** Access should be considered in the context of an individual's ability to navigate the health care system and unique barriers to receiving care. Geographic variation, local characteristics, health care market variation, and distinct population differences, such as demographics, must be factored into access measurement. Access to health care is not uniformly experienced across populations and considering these differences is key to ensuring access and advancing health equity. Many health plans are working toward NCQA Health Equity accreditation as one of the many strategies they are implementing to continually improve how they are supporting members in accessing care.

- **Differences in Delivery System**. CMS should account for the broad range of differences between Medicaid managed care and the fee-for-service (FFS) delivery systems. Medicaid health plans may cover different populations, utilize unique contracting mechanisms, provide tools to increase access, and offer services that focus on prevention and may extend beyond state coverage requirements.

- **Quality Care.** A high volume of providers does not automatically translate into quality care for Medicaid enrollees. As health plans, we focus on specific HEDIS measures (see appendix) as an indicator of access to quality providers and care.

- **Timing.** We encourage CMS to consider whether states have the ability and bandwidth to implement new measures in the near term given the significant time and resources required to redetermine all Medicaid enrollees with the end of the public health emergency.

Overview of Health Plan Monitoring and Reporting Tools

Due to the complexities noted above, we developed the table (see Appendix) that was shared on the January 20th call and provides a sampling of the monitoring and reporting tools our health plans used to build, monitor, and report on access to care.

Wait Time Standard Considerations

We recognize that CMS is considering standardized wait time measures across federal health programs, including the Medicaid program. We understand that the standardization of wait times across programs (i.e., Medicaid, Medicare, Exchange) can clarify if differences in wait times are related to programmatic considerations (e.g., rates, population, transportation) or system capacity limitations. However, standard measures of access across states and geographies is particularly challenging and should be adjustable to account for the realistic systemic ability to meet specific thresholds. Additionally, measures of FFS experience accessing care should also be considered.

A key barrier to wait time standards is that no uniform data source on wait times exists or is "owned" by Medicaid health plans or states. Plans could continue to conduct secret shopper surveys as many already do; however, this does not provide standardized wait time data and relies on the providers for the information received. Moreover, provider shortages may create wait time challenges that are not within the control of plans or healthcare systems. Methods for identifying and addressing systemic capacity issues need to be prioritized and shared between states and health plans.

While MHPA would prefer a continued focus on HEDIS as a means of monitoring access to and receipt of care, should CMS seek to implement wait time standards applicable to the Medicaid program, MHPA offers the following recommendations:

- **Phased-in/Flexible Approach**. We recommend CMS consider an initial period of monitoring to better understand the current state of wait times across primary care, behavioral health, and specialty care. A measured approach that provides states with best practices and technical assistance to implement the state's own network requirements or access standards would help CMS better understand where state-identified gaps in access exist and allow CMS to work with individual states to address those barriers. Additionally, the data collected during the initial years, such as through a pilot program, could serve as an intentional assessment and evaluation to ensure data-informed wait-time requirements and thresholds.

- **Tiered Implementation.** We recommend CMS consider initial implementation in primary care so that lessons learned may be applied to behavioral health services and then to specialty care. By tiering implementation, we believe there will be increased efficiency and quality of measurement.

- **Exceptions Process.** CMS should also consider an exceptions process for health plans faced with access issues outside plan control such as a specialty provider shortage in a rural area.

- **Timing**. States, health plans, providers and consumers are currently under significant capacity limitations and stress as they move to implement the Public Health Emergency (PHE) unwinding. States are understaffed and providers are concerned about the impact of a potential increase in the number of uninsured. To implement the post-PHE changes, MCOs will need to: execute contract changes with providers in-network to require reporting of wait time data, MCOs and providers will need to update IT systems to ingest and report wait time data, and MCOs will need time to evaluate and begin efforts to build capacity where it may be needed to comply with new wait time standards.

We also emphasize that the measurement of wait times is nuanced and offer the following considerations related to specific elements of measurement when considering the establishment of wait time standards for the Medicaid program:

- **Telehealth.** Given the increased use of telehealth since the COVID-19 pandemic, CMS should consider how telehealth would be accounted for in any development of wait time standards. Telehealth does not easily fit into rigid time and distance standards either, but frameworks from Medicare on credits do provide a path to account for the added system capacity. CMS has the opportunity to encourage states to adopt more consistent definitions for provider types to support cross-walking of provider types necessary to meet minimum standards. Allowing plans to include telehealth appointments in the numerator and denominator of the measure of wait times may more accurately reflect patient access.

- **Availability of specific specialty providers**. Applying one standard to all "specialty care" can be challenging when access to certain specialty care providers may be limited due to geographic or national provider shortages.

- **Beneficiary Preferences.** A Medicaid beneficiary (like any consumer) may prefer to schedule an appointment for a particular date due to their personal calendar, transportation schedules, work or childcare obligations, or provider preference. Wait time measurement would need to account for member preference to schedule beyond the next available date and time.

- **No-Show Rates**. Providers may double book appointments because they anticipate high rates of no-shows. This provider practice would need to be accounted for in wait time measurement.

Additional Policy Recommendations

MHPA also recommends that CMS consider other policies for improving access to care for individuals and families served by Medicaid:

- **Scope of Practice.** An expanded scope of practice for nurse practitioners, physician assistants, pharmacists, and dental assistants, would bolster network capacity and increase the number of available providers; this is also a retention strategy to address longer term workforce attrition. We continue to see significant variability across states in the operating environment and the

level of autonomy with which they can practice. CMS could lean into efforts that encourage states to take a more proactive approach to leveraging these professionals.

- **Telehealth Support.** To be consistent with Medicare, we recommend a 10 percent credit towards the percent of time and distance standards calculation for organizations who provide access to telehealth. We also recommend standards that would establish consistency of telehealth offerings across states. Additionally, we recommend reassessing licensure and provider enrollment requirements for providers who are operating across states to reduce the administrative burden of providing telemedicine.

- **Centralized Credentialling and Registries.** Centralized credentialling and registries provide an opportunity to see system level gaps in provider capacity while also reducing provider burden.

- **Workforce Solutions.** Systemic, collaborative solutions on workforce challenges specific to common areas of provider shortage, such as residential psychiatric care for children and adolescents, are needed. CMS could establish a performance improvement process for states to establish clear targets and initiatives to address such systemic issues. A combination of incentives, technical support and resources alongside potential enforcement action could support greater engagement on state policy design decisions (e.g., rate, benefits, scope of practice) that support measurable progress on creating access.

- **Provider Participation.** While many providers and health systems regularly serve and support Medicaid, there are concerns about the relative rates and complexity of serving this population. For example, CMS could explore policies that leverage participation in other government programs such as Medicare as an incentive for serving Medicaid consumers.

Once again, thank you for taking the time to meet with our member health plans. Supporting access to care and services for Medicaid beneficiaries is of paramount importance to MHPA. We appreciate the opportunity to share our perspective to address access challenges and barriers and look forward to continuing to work with CMS and our state partners to make a meaningful difference in the lives of Medicaid beneficiaries.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Vice President, Government Relations and Advocacy

mhpa Medicaid Health Plans of America

Appendix

Sampling of the Health Plan Monitoring and Reporting Tools

Standard Reporting			
Measure	**Use**	**What works well**	**Additional Detail**
Access standard reports Time and distance reported as provider-to-member ratios	State standards and thresholds that are reported externally	Relatively easy to geo-map, established nationally today, complying with thresholds for different types of providers set by the state Time/distance standards are easier for smaller, more densely populated states	Rural and frontier applicability Accounting for geographic barriers (islands, mountains, lakes, etc.) can be a challenge. Need account for virtual offerings
HEDIS (provider-focused)	Evaluation of plan performance in supporting individuals in gaining access to timely and appropriate care / follow-up care.	Measure of people receiving care, ties to programmatic goals and incentives, leverages claims data, reportable, infrastructure exists. Focus on quality and effectiveness of care Health plans view this as a key measure of access	Sample of Specific HEDIS Measures In Use • Follow-Up After Hospitalization for Mental Illness (FUH) • Follow-Up After Emergency Department Visit for Mental Illness (FUM) • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) • Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) • Adults' Access to Preventive/Ambulatory Health Services (AAP) • Annual Dental Visit (ADV)

			• Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) • Prenatal and Postpartum Care (PPC) • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) • Identification of Alcohol and Other Drug Services (IAD
CAHPS (member-focused)	Survey with questions about member perceptions of access	Provides insights on the consumers' perception of access to care.	These are smaller sample sizes and response rates can be lower. Results are subjective. Specific questions: • In the last 6 months, how often did your personal doctor spend enough time with you? • In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?
Enhanced Network Monitoring (Internal monitoring; not standardized or required)			
Open and Closed Panel Reports - Some plans gather reported information from providers on their current state of open or closed patient panels to help monitor access.			
Over and Underutilization Reports - These reports are often developed and used as part of clinical and payment integrity programs but have insights to support network analysis and development. These reports support efforts to ensure quality care is being provided within the network.			
Non Par Usage Reports – These claim-based reporting provides insights on where and when consumers are accessing Out-of-Network (OON) benefits. These reports are reviewed to ascertain if certain providers should be considered for inclusion in the network. Non par usage may also indicate consumer preferences or state policies not just network limitations.			
Appeals and Grievances - Each state has separate reporting requirements; these reports can capture concerns related to delays to diagnosis or treatment			
Clinical Gap Exceptions – Provider agreements that support specific clinical care needs given a consumers set of circumstances. Reviewed for potential patterns that could improve network design.			
Patterns of Care or Provider Referral Pattern Reporting - Reporting primarily looking at quality and effectiveness of care. Provides insights into consumer choice and provider practices. Can support identification of network or community needs.			

Reports of Non-regular Business Hours – These reports provide insights on providers serving consumers in extended hours (e.g., telemedicine, weekend, and evening hours).
Additional Access Monitoring
Annual Quality Improvement Reporting - Pulls together network adequacy reporting, CAHPS scoring and grievance and appeals into one report for each state seeking accreditation as required by NCQA. This report then also pulls in HEDIS and non HEDIS measures and sets priority areas of focus for the coming year. It is a comprehensive process applied to plans completing NCQA accreditation only.
NCQA health equity accreditation standards - This newly available accreditation allows plans to distinguish themselves in serving the health equity needs of their members and the overall community. Health disparities are in large part driven by systemic issues, including access. Plans who earn this additional accreditation will demonstrate focused work to improve health equity including access for historically underserved communities.