



July 3, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC, 20201

**Re: CMS-2439-P – Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality**

Dear Administrator Brooks-LaSure:

The undersigned members of the Consortium for Constituents with Disabilities (CCD) appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services’ (CMS’s) proposed regulation on Medicaid managed care. Except where specified below, we generally support the proposed changes that improve transparency and accountability in managed care payments and quality measurement, along with proposed provisions that strengthen enrollee protections and due process.

CCD is the largest coalition of national organizations working together to advocate for Federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance.

### **Aligning HCBS Across Medicaid Delivery Systems**

We appreciate that CMS seeks to align enrollee protections and transparency requirements for Medicaid HCBS across the managed care and fee-for-service (FFS) delivery systems. We support efforts to reduce fragmentation across Home and Community Based Services (HCBS) authorities, to set federal standards across authorities, and generally to shift toward HCBS policy that encompasses the broader definition adopted in the American Rescue Plan Act (ARPA).

Generally, we encourage CMS to apply a principle that when standardizing across HCBS authorities, the minimum federal standard should be no weaker than the strongest enrollee protections from the existing HCBS authorities. For example, if conflict of interest protections are strongest in § 1915(i) state plan HCBS, any federal HCBS policy that applies across all HCBS authorities should be *at least* as strong as the 1915(i) conflict-of-interest protections.

Following this principle, we appreciate that CMS has proposed a new HCBS grievance process for FFS Medicaid to parallel the grievance process that already exists in Medicaid managed care. However, we see that there are elements in the proposed FFS grievance model that are not currently part of the managed care grievance regulations, including ensuring that punitive action is neither threatened nor taken against an individual filing a grievance and establishing a timeline to request and resolve expedited grievances. To be equitable and to meet CMS's stated goal that HCBS protections will apply across delivery systems, CMS should at least add these two provisions to the managed care grievance process regulations at § 438.408. We recommend conducting a careful crosswalk of the two grievance processes to ensure they are aligned. We also strongly support extending these two reasonable protections across all enrollees in Medicaid managed care, not just HCBS participants.

Per CMS's preamble request, we also urge CMS to extend HCBS person-centered planning, access/wait time, HCBS settings, and other related requirements to relevant § 1905(a) state plan HCBS services using the more expansive definition of HCBS enacted under ARPA.<sup>1</sup> The enrollee protections in those requirements – along with the oversight, quality, transportation and accountability provisions that adhere to those HCBS requirements – should apply across the Medicaid HCBS landscape, regardless of delivery system or authorizing authority. Section 1905(a) state plan HCBS represent a substantial fraction of HCBS delivered in a substantial number of states. Persons with disabilities living in community settings, should not have different rights and protections simply due to the manner in which their Medicaid HCBS are authorized. This is the moment to move towards more effective consistency, coordination, and alignment.

Likewise, CMS Medicaid and Medicare efforts to integrate mental health, substance use, and primary care should apply to Medicaid HCBS programs.

### **Enrollee Experience Surveys**

We appreciate that CMS will require states to gather feedback from Medicaid enrollees about their experiences in receiving Medicaid health services. We agree that it will

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<sup>1</sup> 88 Fed. Reg. 27975.

provide valuable insight into program offerings by creating a reporting structure for beneficiary input and the opportunity for managed care plans and States to identify access problems, particularly if the results are stratified by key demographics. Making survey forms accessible in a variety of formats will be essential to ensure participation from a truly representative sample of the population.<sup>2</sup> We recommend that future CMS guidance require oversampling or find other mechanisms to document the enrollee experience of people with disabilities, people with limited English Proficiency, and other marginalized groups who are more likely to face access barriers and/or discrimination.<sup>3</sup>

The enrollee feedback gathered has the potential to inform important plan reforms. We understand that CMS is supplying managed care plans with a variety of tools for information gathering in order to make informed changes to their networks and improve the quality of their programs. We are optimistic that this new information will assist them in doing so. After all, a survey is only as useful as the programmatic changes it compels. We also strongly support the requirement that states post the results from these annual surveys on their centralized website as part of the Managed Care Annual Report, and we hope to see future guidance that helps document how plans have adjusted their policies based on information from these surveys.

Additionally, we encourage CMS to require states to survey providers as part of their annual surveying process. CMS recognizes the value of information that enrolled providers can share as they have encouraged states to survey them but chose not to compel them to do so. Mandating that states conduct a provider survey will offer further perspective to states and managed care plans about network adequacy from those who are actually delivering the services. Providers can offer valuable stakeholder insight into challenges beneficiaries face navigating their health benefits and improvements that can be made to the Medicaid program writ large.

### **Appointment Wait Time Standards**

Thank you for carefully evaluating the responses to the spring 2022 Request for Information about access to Medicaid services and taking the feedback of so many stakeholders who suggested adding additional quantitative network adequacy standards. We appreciate that the proposed rule establishes wait time standards for outpatient mental health and substance use adult and pediatric, primary care-adult and pediatric, obstetrics and gynecology (OB/GYN), and an additional type of service

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<sup>2</sup> 88 Fed. Reg. 28096 [referring to §§438.66(b), (c), and 457.1230(b)].

<sup>3</sup> Lisa I. Iezzoni et al., *Physicians' Perceptions of People with Disability and Their Health Care*, 40 HEALTH AFFAIRS 297 (2021).

determined by the state. We support standards for these services, but we have concerns that focusing solely on these particular types of services will not be enough.

The proposed rule indicates that these services were chosen because they are indicators of core population health.<sup>4</sup> While population health is one metric to consider, Medicaid enrollees often face the biggest hurdles accessing specialty care. There are 14 million people with disabilities who are Medicaid beneficiaries.<sup>5</sup> These individuals are often the folks who need care by specialists the most. Limiting the possible benefits of wait time standards to the proposed provider types would be a missed opportunity to help people with disabilities who struggle to find specialists who are available and in network. Since CMS has the regulatory authority to compel appointment wait time standards, they should utilize that authority to create the most robust network of providers possible, including specialists.

We encourage CMS to consider broadening the appointment wait time standard across all types of services to Medicaid enrollees, but at least to incorporate more specialty providers. The proposed rule itself cites a study that finds a 3.3 fold lower likelihood in successfully scheduling an appointment with a specialty provider when compared with private insurance.<sup>6</sup> That same study shared that the primary care and OB/GYN services already have some of the highest acceptance rates for Medicaid.

In addition, classifying various outpatient mental health and substance use services within the same aggregate wait time standard may still lead to problems accessing care. This category covers a wide variety of provider types covering quite distinct patient populations. For example, while both psychiatrists and substance use counselors serve important purposes in the field of mental health, they each have distinct areas of expertise and services offered. Psychiatrists are physicians and among the providers most difficult for Medicaid beneficiaries to access, with only 35 percent of psychiatrists

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<sup>4</sup> 88 Fed. Reg. 28097.

<sup>5</sup> Marybeth Musumeci et al., Kaiser Fam. Found., *Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey* (June 14, 2018), <https://www.kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/>.

<sup>6</sup> Walter R. Hsiang et al., *Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared with Private Insurance Patients: A Meta-Analysis*, 56 INQUIRY 0046958019838118 (2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6452575/#:~:text=Specifically%2C%20Medicaid%20patients%20have%20a,appointments%20for%20pediatric%20Medicaid%20patients.>

accepting Medicaid.<sup>7</sup> We would like to see a secret shopper survey designed to discriminate between average wait times for appointments with these different subtypes of mental health and substance use providers. Lumping all mental health providers into a single number could mask potentially substantial access issues with particular types of mental health services (particularly access to specialists like psychiatrists). If a managed care plan made it very easy and quick to schedule common substance use counseling services, for example, to offset the fact that it still took months to see a psychiatrist to secure a needed medication, the plan might meet the proposed mental health and substance use wait time network adequacy standard. But patient access would not be satisfied.

### **Secret Shopper Surveys**

We appreciate that CMS proposes to require that states use independent entities to conduct annual secret shopper surveys of managed care plan to gauge compliance with appointment wait time standards and to survey the accuracy of plan provider directories. These surveys will provide valuable information to plans and advocates on the real state of plan networks, and provide a mechanism to drive improvements in accuracy and specificity of provider directories. The horror stories of beneficiaries struggling to set up appointments with available in-network providers has been thoroughly documented, and numerous studies have pointed to widespread and persistent inaccuracies in provider directories – so called “ghost networks” – across public and private managed care plans.<sup>8</sup>

In 2014, HHS’ Office of the Inspector General conducted secret shopper surveys of Medicaid plans that found over half the provider directory entries were incorrect or not available for appointments.<sup>9</sup> A number of states have also found that direct testing of networks and provider directories through mechanisms like secret shopper surveys helps identify consumer access barriers. States including Texas, Maryland, Connecticut,

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<sup>7</sup> Kayla Holgash and Martha Heberlein, Medicaid and CHIP Payment and Access Commission, *Physician Acceptance of Medicaid Patients* (Jan. 24, 2019), <https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf>.

<sup>8</sup> Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*, 40 YALE LAW & POL’Y REV. 78 (2021); Abigail Burman & Simon F. Haeder, *Without a Dedicated Enforcement Mechanism, New Federal Protections Are Unlikely to Improve Provider Directory Accuracy*, Health Affairs Blog (2021), <https://www.healthaffairs.org/content/forefront/without-dedicated-enforcement-mechanism-new-federal-protections-unlikely-improve>.

<sup>9</sup> HHS Off. Inspector Gen., *Access to Care: Provider Availability in Medicaid Managed Care*, 8 (Dec. 2014), <https://oig.hhs.gov/oei/reports/oei-02-13-00670.asp>. See also, HHS OIG, *State Standards for Access to Care in Medicaid Managed Care* (Sept. 2014), <https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>.

Missouri, New Hampshire, and Ohio have conducted surveys that revealed massive error rates in provider directories and documented long wait times to obtain a scheduled appointment.<sup>10</sup> Maryland's extensive survey of on-line and paper provider directories led to nine corrective action plans for Managed Care Organizations (MCOs) in 2019.<sup>11</sup> Texas' External Quality Review Organization (EQRO) study, which only successfully contacted 52% of providers in 2018, includes a list of best practices for more accurate provider directories.<sup>12</sup> Together, these efforts all point to an urgent need for better oversight and accountability.

Ohio's EQRO compared secret shopper against revealed caller surveys. When the caller identified themselves as an evaluator, 81.7% of primary care providers reported appointment wait times under thirty days for new patient well-check visits. Ohio's secret shopper survey, using the same sampling, found only 69.5% of primary care providers reported wait times under thirty days.<sup>13</sup> We realize that there may be some issues with secret shopper survey design whereby some providers may not schedule appointments unless a caller provides proof of identity, but these results may also suggest that some providers are not being forthcoming in their interactions with revealed callers.

We agree that the four elements of the secret shopping survey (the active network status, the provider's street address, the provider's telephone number, and their status

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<sup>10</sup> See, e.g., ICHP, *Summary of Activities and Value Added Services: Quality, Timeliness, and Access to Health Care for Texas Medicaid and CHIP Recipients*, 144 (May 2019), <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/eqro-summary-of-activites-report-contract-yr-2018.pdf>; HSAG, *New Hampshire SFY 2020 Secret Shopper Survey Report* (2020), [https://medicaidquality.nh.gov/sites/default/files/NH2020 Secret%20Shopper%20Survey Report F1 0720.pdf](https://medicaidquality.nh.gov/sites/default/files/NH2020%20Secret%20Shopper%20Survey%20Report%20F1%200720.pdf).

<sup>11</sup> Qlarant, *Medicaid Managed Care Organization Annual Technical Report 2019*, 141-2 (Apr. 2020), [https://mmcp.health.maryland.gov/healthchoice/Documents/2019%20MD%20ATR%20FINAL\\_508.pdf](https://mmcp.health.maryland.gov/healthchoice/Documents/2019%20MD%20ATR%20FINAL_508.pdf).

<sup>12</sup> ICHP, *Provider Directory Data Quality: Key Issues and Recommendations for Best Practices*, 3, 24 (Dec. 2018), <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/provider-directory-data-quality-issues-best-practices.pdf>. See also, Texas Health & Human Services Comm., Off. Inspector Gen., *Data Integrity of Online Provider Directories* (Aug. 23, 2019), <https://oig.hhs.texas.gov/sites/default/files/documents/reports/IG-Inspections-Division-Online-Provider-Directories-FINAL-082319.pdf>.

<sup>13</sup> QSource, *Annual EQRO Technical Report: State Fiscal Year 2019*, 41 (Apr. 2020), <https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/SFY-2019-External-Quality-Review-Technical-Report.pdf>.

as accepting new Medicaid enrollees), are essential pieces of information in assessing the true availability of in-network providers.

We also agree that appointments via telehealth should only be counted toward compliance with wait time standards if the provider offers in-person appointments in the same timeframe. Though telehealth is a valuable service delivery method for people with disabilities, it should not replace in-service appointments.<sup>14</sup>

CMS has chosen three provider types for secret shopper surveys – the same for which it proposes wait time standards – noting that these service providers have the highest utilization in many Medicaid managed care programs. We would submit that other providers have lower relative utilization partly because access to specialists remains difficult for Medicaid patients. Secret shopper survey data may be even more helpful for specialty providers, since people have a harder time getting appointments with them in general.<sup>15</sup>

We recommend that CMS expand the scope of secret shopper review to include more specialty provider types. For example, at a bare minimum CMS could require that the state selected fourth provider type must be a specialist provider type, based on recommendations of providers that likely are the most challenging to access from the beneficiary advisory group, and the expand the number of required specialists and other provider types in future years.

In the final rule or in future guidance, we strongly recommend that CMS also consider requiring states to use the independent secret shopper surveys as tools to identify barriers to care for marginalized groups. For example, people with disabilities often face accessibility challenges not only with office buildings of certain providers, but also with accessing certain types of medical equipment – from examination tables to sophisticated imaging technology.<sup>16</sup> Using the secret shopper method to ask about physical accessibility could be a very powerful tool to measure health care inequities. Similarly, a 2006 Connecticut Medicaid secret shopper survey included a subsample of Spanish-speaking callers. Perhaps not surprisingly, it found substantially lower rates of successfully scheduled appointments (16.7% of all calls compared to 26% of English calls.) Over a third of the sample calls were told the provider had no process in place to

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<sup>14</sup> Carli Friedman and Laura VanPuymbrouck, *Telehealth Use By Persons with Disabilities During the COVID-19 Pandemic*, 13 INT. J. TELEREHABILITATION e6402 (2021).

<sup>15</sup> Walter R. Hsiang et al., *supra* note 6.

<sup>16</sup> Elizabeth Pendo, *Disability, Equipment Barriers, and Women's Health: Using the ADA to Provide Meaningful Access* 2 SLU J. Health Law & Pol'y 15, (2008), <https://ssrn.com/abstract=1435543>.

accommodate Spanish-speaking callers.<sup>17</sup> More recently another Connecticut secret shopper survey asked callers to identify themselves with “multicultural” or “non-multicultural” names, alternatively. Callers identifying with multicultural names encountered fewer providers who said they were accepting new patients (82.4% accepting versus 90.4%, n=343).<sup>18</sup> This trend was consistent across all provider types surveys except for pediatricians. The compelling results of these survey designs suggest that secret shopper surveys have potential not only to improve provider networks and access to care for managed care enrollees, but also might be powerful tools to advance health equity.

In terms of reporting requirements, we appreciate the quick timeframe for posting survey results publicly and agree with the suggestion that the state and managed care entity should receive the report at the same time in order to expeditiously remedy any problems.

### **Assurances of Adequate Capacity and Services**

As CMS points out many times in this proposed rule, higher provider reimbursement rates are strongly correlated with increased acceptance of Medicaid insurance.<sup>19</sup> We strongly support the proposal that managed care plans must submit a provider payment analysis for expenditures related to covered primary care, OB/GYN care, mental health and substance use disorder services, and certain HCBS to the state. We agree with the requirement that states certify the rates are sufficient to ensure adequate availability of covered services at § 438.207(d), and that the state will post the results on the state’s website at proposed § 438.207(d)(3). Comparing Medicaid rate data as a percentage of with Medicare rates for these services, or, if the service has no Medicare correlate, the Medicaid fee-for-service rates for those services will help establish benchmarks that can be linked to specific provider access problems. Both the rate analysis itself and the public reporting could help inform stakeholders of the true gaps in access and encourage managed care plans to make changes to their rates to support a more robust network of providers. We also agree with the possible remedies that CMS enumerates, including support for interstate provider licensing compacts, increasing provider

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<sup>17</sup> Mercer for the Conn. Dept. Soc. Servs., *Mystery Shopper Project*, 18 (Oct. 25, 2006).

<sup>18</sup> Community Health Network of Conn., Presentation to the Medical Assistance Program Oversight Council, 25, (2022), [https://www.cga.ct.gov/ph/med/related/20190106\\_Council%20Meetings%20&%20Presentations/20220114/CHNCT%20Presentation.pdf](https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20220114/CHNCT%20Presentation.pdf).

<sup>19</sup> 88 Fed. Reg. 28104 (citing Nat’l Bureau Econ. Res. (NBER), *Increased Medicaid Reimbursement Rates Expand Access to Care*, BULLETIN ON HEALTH, (Oct. 2019), <https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care>.)



reimbursement rates, improving credentialing, claims processing, and prior authorization procedures, among others listed. We would like to see this kind of payment analysis spread to other provider types, particularly some hard to reach specialists, like psychiatrists.

Additionally, while we strongly support the new requirement for states to submit remedy plans to improve access, we respectfully question the length of time required to complete the remedy. In this proposal, CMS suggests that plans have 12 months to implement actions to address the access issue(s) and improve access to services. If plans have 12 months to implement, while providing quarterly updates as a check-in procedure, the idea of granting an additional 12 months after that point would seem to allow plans to stretch the timeline to finish implementing a remedy plan up to two years or more. With as many issues of access to care as have already been cited, allowing for two years to remedy a specifically identified problem with multiple progress report opportunities would be too long for beneficiaries to wait to see the benefits. Unless an extreme scenario occurs, we recommend that CMS employ a 12-month timeframe, with no 12-month extension, to remedy an identified and tracked access issue.

### **Transparency**

We support efforts to increase transparency by requiring states to shift to one-stop centralized websites for posting information related to managed care plans. With such wide variation in website performance and design, this required improvement for the 13 listed metrics would be very valuable. We appreciate that § 438.10(c)(3) requires states to at least post direct links to the appropriate correlate on the managed care plan's site, but future guidance should shift the standard toward posting direct links to the required information. This would minimize enrollees having to navigate multiple websites to get the information they need. We appreciate that CMS has identified this as a problem in its user-testing of the proposed Medicaid Quality Rating System (QRS) website and point out that the same best practices should apply here.<sup>20</sup>

### **State Directed Payments**

States may only direct expenditures of contracted Medicaid managed care plans under limited circumstances, such as through value-based payments or setting maximum or minimum fee schedules. We support CMS's proposals to increase transparency and accountability of State Directed Payments (SDPs), including requirements for more detailed payment reporting that more clearly establish that SDPs are actuarially sound and linked to Medicaid reimbursable services. Given the growing size and importance of

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<sup>20</sup> 88 Fed. Reg. 28202.

this payment mechanism, stakeholders should have public access to the information states and plans report related to SDPs.

We also want to point out that the wage payment pass-through percentage for certain Medicaid HCBS may necessitate a substantial increase in SDPs so states can ensure that rate increases for personal care, homemaker, and home health services actually reach the direct care workforce they are intended to help.<sup>21</sup> In New York, for example, HCBS providers and advocates have complained that when the state increased capitation rates to cover minimum wage increases for home health direct care workers, the plans did not uniformly increase rates for HCBS providers.<sup>22</sup> Wisconsin is one of the few states with a managed LTSS program that has already made use of SDP authority to exert more control over how funding increases funnel to workers.<sup>23</sup> We expect the new rule will lead to more such arrangements, and we urge you to consider that possibility when deciding on whether or how high to set a maximum share of total capitation rates that states can dedicate to SDPs.

### **Medical Loss Ratio**

We urge CMS to add a requirement that States post the Annual Medical Loss Ratio reports that MCOs must submit to the state Medicaid agencies pursuant to §438.8(k)(1). These reports provide crucial information about how MCOs are spending money on items and activities other than providing services – including how much profit they are earning. Enrollees, providers, advocates, and other members of the public deserve to know how Medicaid capitated rate payments are being used.

### **In Lieu of Services and Settings**

We support CMS's decision to codify its recent guidance on In Lieu of Services (ILOS).<sup>24</sup> In particular, we welcome CMS's clarification of the fact that enrollees offered or receiving ILOS retain all rights and protections conferred by the Medicaid managed

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<sup>21</sup> See proposed § 438.207(b)(3)(ii).

<sup>22</sup> Lily Meyersohn, *Insurance Companies are Destroying New York's Home Care Industry* (Apr. 14, 2023), <https://inthesetimes.com/article/insurance-companies-are-destroying-new-yorks-home-care-industry>.

<sup>23</sup> Wisc. Dept. Health Servs., *Medicaid: Direct Care Workforce Funding Initiative Information and FAQs* (Last visited June 27, 2023), <https://www.dhs.wisconsin.gov/medicaid/ltc-workforce-funding-faq.htm>.

<sup>24</sup> CMS, *Dear State Medicaid Director Letter re: Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care* (Jan. 4, 2023), <https://www.medicare.gov/federal-policy-guidance/downloads/smd23001.pdf>.

care regulations. Moreover, the proposal to require monitoring and reporting on appeals, grievance, and state fair hearing data will help ensure that enrollees receiving ILOS retain these rights and protections.

### **Quality Strategy and External Quality Review (§§ 438.310 to .364)**

This proposed rule includes provisions that boost accountability, transparency, and participant input into managed care oversight systems, which we enthusiastically support. We also support changes to the quality strategy and external quality review processes that will make the data more accessible, reduce data lags, and allow for more participant input into quality strategies and core measure review.

We support the changes that seek to improve the transparency and stakeholder input into the quality strategy process, including:

- § 438.340(c)(1) – The proposed requirement that each state posts publicly its evaluation of the effectiveness of the prior quality strategy. This evaluation should be made available with sufficient time prior to the public comment period and the stakeholder input process so interested parties can use that information to meaningfully engage in the updating process; and
- § 438.340(c)(3) – The proposed requirement to make the quality strategy available for public comment regardless of whether the state has made substantial changes. This will allow stakeholders to provide input based on the results of the quality strategy effectiveness review and evaluation – and suggest areas for improvement – even if the state has proposed no revisions.

We also support the proposed changes to External Quality Review (EQR), that will make the data more accessible, reduce data lags, and allow for more participant input into quality strategies and core measure review. These changes include:

- § 438.364(c)(1) – Changing the submission date for annual technical reports to December 31 to align better with the reporting cycle for Healthcare Effectiveness Data and Information Set (HEDIS) and reduce the data lag to no more than 1 year after the data collection period closes. Our experience with state annual technical reports shows that the data lag in some states continues to exceed 18-24 months, which seriously compromises the usefulness of the results for current enrollees.
- § 438.364(c)(2)(iii) – Requiring states to post at least 5 prior years of annual technical reports on their website is an important improvement. There is virtually no administrative burden related to keeping technical reports available to the public over an extended period of time. An EQR archive makes it easier to track

responses to recommendations, evaluate progress on Performance Improvement Projects, and monitor changes in quality performance. Given the lack of administrative burden, we see no reason not to extend this requirement to posting at least 10 years of reports.

- § 438.364 (a)(2)(iii) – Ensuring that annual technical reports include the actual results of performance measures and performance improvement projects. Some states have limited their technical reports to data only about the validation of the quality data, while not including the actual data they validated. This validation information, absent the actual results, is of limited value to advocates and the public.
- §§ 438.360(a)(1) and 362(b)(2) – streamlining EQR by facilitating the use of comparable accreditation data. We support this as long as the standards are equivalent to EQR and the use of accreditation data does not compromise the integrity, transparency, and timeliness of the plan’s quality data.

### **Quality Rating System (§§ 438.500 to .535)**

We support CMS’s broad and ambitious vision to help states build public dashboards featuring core quality measures and other important information about managed care plans to help new and returning enrollees to select managed care plans that most suit their needs.

The initial set of eighteen measures for the Quality Rating System (QRS) spans a broad range of populations and service types with well-tested measures. While the inclusion of only one measure related to Long Term Supports and Services (LTSS) limits the tool’s usefulness for older adults and people with disabilities to evaluate the quality of HCBS services across health plans, we recognize that the tool will still help inform decisions about common chronic and preventive care conditions that also affect these groups.

We have some concerns that the proposed QRS selection process may make it harder for new HCBS measures to be included. Given the large proportion of Medicaid expenditures that HCBS comprises, the managed care QRS structure should be designed to be more, not less inclusive of HCBS measures. The rule requires that measures must meet at least five of six listed conditions listed in § 438.510(c)(1) to be considered for the core set, including one that the measure “aligns” with quality initiatives in other CMS programs, namely Medicare and the Marketplace. While CMS acknowledges HCBS in the preamble, we have concerns that HCBS might remain underrepresented in the QRS precisely because they will never “align” with Medicare or Marketplace QRS since those programs do not cover HCBS. One solution would be to add language directly to the regulatory text at § 438.510(c)(2) to highlight that the QRS “balance” needs to account for services more-or-less unique to the Medicaid program.

We also recommend that the criteria for measure selection better reflect CMS's strategic priority to reduce health disparities in Medicaid. The proposed selection criteria only mention health equity as one of a number of permissible topics for health plan performance measures. While the QRS includes a mechanism for CMS to require measure stratification to identify disparities, none of the measure selection criteria in § 438.510(c) are structured to drive forward the importance of stratifying measures by key demographics. In other words, aside from a vague reference to "balanced representation" in § 438.510(c)(2), there is nothing in the selection criteria that identifies health equity as a priority goal for effective quality measurement or that would necessarily encourage a shift toward better stratified reporting in the future. For this reason, we urge CMS to add a seventh criterion for CMS and stakeholders to consider when evaluating measures for inclusion in the QRS: Is the measure likely to inform efforts to advance health equity?

**Recommendation:** Add the following provision to § 438.510(c)(1):  
*(vii) Is likely to inform efforts to advance health equity.*

**Recommendation:** Amend § 438.510(c)(2) as follows:

(2) The proposed measure contributes to balanced representation of beneficiary subpopulations, age groups, health conditions, services – ***including services not typically covered by other CMS programs described in § 438.505(c)*** – and performance areas within a concise mandatory measure set; and

**Recommendation:** Correct a minor grammatical error in proposed § 438.510(c)(3):

(3) The burdens associated with including the measure ~~does~~ ***do*** not outweigh the benefits...."

We appreciate the proposed milestones for states to begin reporting measures stratified by race and ethnicity and other demographic factors, but we urge CMS to establish a shorter timeline for some elements to reinforce HHS's prioritization of health equity. We recommend shortening the time frame for states to report required quality ratings stratified by age, language, and geographic region to four years. These data are already available and should not be very challenging for states to include in Phase 1 of the QRS rollout where appropriate.

We recommend setting a clear maximum implementation timeline for Phase 2 of the rollout, which currently reads as "no earlier than 2 years after" QRS implementation. Such an open-ended timeline leaves the impression that this bold vision to create an interactive, one-stop shop for plan information, including the ability to customize searches for providers and see stratified quality information tailored to the consumer's

needs, may never happen. We recommend finalizing the rule with a clear deadline of no more than 2 years for states to develop the fully-interactive Phase 2 QRS website. If CMS believes more time is needed to realistically implement Phase 2, we suggest implementing key components of Phase 2 within 2 years after Phase 1 and then setting a reasonable later deadline for the most challenging elements.

We also recommend expanding the scope of populations on which states must report stratified quality ratings. While disability is mentioned in the list of demographics for stratification in proposed 438.520(a)(6)(iii), the proposed language does not clearly require that states stratify by all these demographic factors for Phase 2. More importantly, as noted above, the proposed rule creates a mechanism for CMS to require stratified reporting of QRS measures, but no process to inform which measures and factors CMS should prioritize for stratified reporting. We recommend changing language of this provision to set up an expectation that states will stratify measures by all relevant listed factors unless the Secretary specifies a reason not to in the process of updating the measure set. In addition, following HHS's own commitments in the CMS Framework for Health Equity and HHS's LGBTQ+ Evidence Agenda, the regulation should include sexual orientation/gender identity/sexual characteristics as demographic factors used to stratify QRS results.<sup>25</sup>

We look forward to working with CMS to develop data infrastructure for more accurate and comprehensive collection of disability-related data. Current approaches that use disability eligibility categories leave out large swaths of participants who qualify for Medicaid through other eligibility pathways, like the adult Medicaid expansion. Current Medicaid application questions typically are not detailed enough to accurately capture self-reported disabilities by type. Claims-based disability flags often fall short as well. Having a standardized flag for disability would facilitate the stratification of Medicaid core measure sets by disability to identify disparities affecting people with disabilities' access to acute and preventive care. It would also make it easier to identify and address intersectional disparities for people with disabilities who are also marginalized due to race, ethnicity, geography, age, language, sexual orientation, gender identity, or other demographic characteristics.

Additionally, we want CMS to affirmatively and clearly state that states reporting on the QRS, as well as reporting on other Medicaid core measure sets, should include all continuously enrolled managed care Medicaid HCBS enrollees. HCBS participants are

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<sup>25</sup> National Science and Technology Council, *Federal Evidence Agenda on LGBTQI+ Equity*, (Jan. 2023), <https://www.whitehouse.gov/wp-content/uploads/2023/01/Federal-Evidence-Agenda-on-LGBTQI-Equity.pdf>; CMS, *CMS Framework for Health Equity 2022-2032*, 5 (Apr. 2022), <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>.

Medicaid-enrolled individuals, and they should never be left out of reporting that covers preventive care, chronic disease management, enrollee satisfaction, mental health, and other aspects of health care that core measure sets cover. Discussions and decisions during the 2022 Adult and Child core quality measure meetings hosted by Mathematica raised questions about whether participants in some HCBS programs are included in reporting on those core sets. If it is true that they are not included, we strongly urge CMS to require their inclusion.

**Recommendation: Amend § 438.520(a)(6)(iii) as follows:**

(iii) The quality ratings described in § 438.520(a)(iv) calculated by the State for each managed care plan in accordance with § 438.515 for mandatory measures identified by CMS, including the display of such measures stratified by dual eligibility status, race and ethnicity, sex, ***sexual orientation, gender identity and sexual characteristics***, age, rural/urban status, disability, language of the enrollee, ~~or~~ ***and*** any other factors specified by CMS in the annual technical resource manual.

As a matter of process, we wholeheartedly endorse CMS's decision to pre-test web prototypes for the QRS with Medicaid enrollees to identify approaches that work best for them. We appreciate how CMS clearly used the feedback to adjust its proposed policy requirements. This is a wise and obviously fruitful method to create more effective and responsive federal policy and we encourage its broader use in the future. We recommend that such user testing also include people with disabilities and those with limited English proficiency to identify and address accessibility issues.

**Conclusion**

Thank you for considering these comments. This proposed rule makes many positive changes that will lead to a better-informed Medicaid participants and provide much more data to evaluate plan performance, particularly to evaluate how well plans ensure timely access to needed services. We believe our suggestions will make the final rule even stronger and look forward to the finalization and implementation of these important changes for Medicaid managed care programs.

If you have any questions or need any further information, please contact David Machledt ([machledt@healthlaw.org](mailto:machledt@healthlaw.org)) or Caroline Bergner ([cbergner@asha.org](mailto:cbergner@asha.org)).

Sincerely,

Access Ready  
Allies for Independence

American Association of People with Disabilities  
American Association on Health and Disability  
American Music Therapy Association  
American Occupational Therapy Association  
American Physical Therapy Association  
American Speech-Language-Hearing Association  
American Therapeutic Recreation Association  
Amputee Coalition  
Autism Society of America  
Autistic People of Color Fund  
Autistic Self Advocacy Network  
Autistic Women & Nonbinary Network  
Bazelon Center for Mental Health Law  
Brain Injury Association of America  
Center for Law and Social Policy  
CommunicationFIRST  
Disability Rights Education and Defense Fund (DREDF)  
Epilepsy Foundation  
Family Voices  
Justice in Aging  
Lakeshore Foundation  
National Academy of Elder Law Attorneys  
National Association of Councils on Developmental Disabilities  
National Center for Parent Leadership, Advocacy, and Community Empowerment  
(National PLACE)  
National Disability Rights Network (NDRN)  
National Health Law Program  
National Respite Coalition  
TASH  
The Arc of the US