National Rural Health Association

July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

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

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services' (CMS) Medicaid and CHIP Managed Care Access, Finance, and Quality proposed rule. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

I. Medicaid and CHIP Managed Care.

Medicaid is an important source of coverage for rural residents and payer for rural providers. About one quarter of rural adults under 65 are covered by Medicaid.[1] Rural residents are more likely to be low-income and unemployed[2] and for individuals that are employed, rural employers are less likely to provide insurance.[3] Thus Medicaid fills in gaps in coverage and access in rural America. With the majority of Medicaid enrollees being covered through a managed care plan, it is critical to maintain the same access, quality, and transparency standards as for fee-for-service enrollees.[4]

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[1] Timothy McBride, et al., *An Insurance Profile of Rural America: Chartbook*, RURAL POLICY RESEARCH INSTITUTE, UNIVERSITY OF IOWA COLLEGE OF PUBLIC HEALTH, (Oct. 2022), 12, https://rupri.public-health.uiowa.edu/publications/other/Rural%20Insurance%20Chartbook.pdf.

[2] Julia Foutz, Samantha Artiga, & Rachel Garfield, *The Role of Medicaid in Rural America*, KAISER FAMILY FOUNDATION, Apr. 25, 2017, https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/.

[3] CENTER FOR BUDGET AND POLICY PRIORITIES, *Medicaid Works for People in Rural Communities* (Jan. 19, 2018) https://www.cbpp.org/research/health/medicaid-works-for-people-in-rural-communities.

[4] Elizabeth Hinton & Jada Raphael, *10 Things to Know About Medicaid Managed Care*, KAISER FAMILY FOUNDATION, March 1, 2023, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-

B. Provisions of the Proposed Regulations.

a. Enrollee Experience Surveys (§§ 438.66(b) and (c), 457.1230(b)).

NRHA supports requiring states to conduct annual enrollee experience surveys as part of their monitoring system for managed care plans. We concur with CMS' explanation that enrollee experience surveys are a valuable way to collect information to determine if and how managed care plans are meeting the needs of underserved populations, like rural enrollees. These surveys may capture enrollee satisfaction with services that they received but can also gauge whether enrollees are able to access care and what barriers they experience.

NRHA asks that CMS define characteristics of acceptable surveys. CMS does not need to mandate a specific enrollee experience survey but should provide certain required elements for states to incorporate. NRHA believes that it is important to ask enrollees questions on their ability to access care to gather specific information on perceived or actual barriers to services in managed care plans. **NRHA urges CMS to include geographic barriers, such as available providers in the enrollee's geographic area, as a required survey element.** This element should capture what geographic barriers enrollees face, such as lack of transportation, provider inclusion in plan network, or distance from providers.

In order to collect comprehensive information through enrollee surveys, **NRHA urges CMS to ensure that surveys are available in non-electronic forms.** In the preamble of this proposed rule CMS notes that enrollee experience surveys "should be easy to understand, simple to compete, and readily accessible for all enrollees." NRHA maintains that this includes offering surveys in multiple formats. Rural enrollees are less likely to complete an online survey because of broadband and internet challenges and familiarity with online platforms, especially for older enrollees. CMS must make clear that state Medicaid offices or parties administering the survey make it accessible via telephone or paper forms. Complete and accurate results on enrollee experience surveys requires engaging all enrollees by using various means of communication.

NRHA appreciates the inclusion of oral interpretation and written translation services for enrollee surveys. Many rural communities have sizeable non-English speaking populations and CMS should ensure that they can participate. Enrollee surveys will be the most complete and actionable if they can capture results from all populations. NRHA again emphasizes that inclusive survey formats will yield the best information on how MCOs are providing care to rural communities.

b. Appointment Wait Time Standards (§§ 438.68(e), 457.1218).

NRHA is concerned about rural enrollee access to providers. Rural residents have less access to providers and health care services compared to urban residents, which ultimately results in poorer

care/#:~:text=In%20Most%20States%20With%20Comprehensive,Beneficiaries%20Are%20Enrolled%20in%20One.

health outcomes.[5] To compound rural provider shortages, we have heard from members that many providers are listed as Medicaid participating yet they accept very few, if any, Medicaid patients per year. NRHA has specifically heard that this is an issue with Medicaid-enrolled dentists. This practice by providers is misleading and harmful to enrollees. It may appear that MCOs meet network adequacy requirements but in reality these providers are not actually furthering access for rural enrollees.

NRHA generally supports appointment wait time standards as a means to ensure access to providers. However, we are concerned that due to rural provider shortages, especially in behavioral health, MCOs may not be able to meet 90% compliance with these standards NRHA believes that the state exception process described in § 438.68(d)(1) should be used in limited circumstances when providers are not physically in the rural area. Otherwise, MCOs should be expected to negotiate with existing rural providers to ensure the highest levels of access possible for rural enrollees.

Further, CMS proposes that MCOs must meet 90% compliance with appointment wait time standards. This means that 90% of enrollees must be able to make an appointment within the specified time frame for that provider. However, given the 90% threshold is across all enrollees, NRHA is concerned that MCOs could meet 90% compliance without including rural areas. We urge CMS to monitor the location and demographics of enrollees that are used to meet this standard and use any existing authority to ensure rural enrollees are not left behind.

NRHA urges CMS to align primary care and behavioral health appointment wait times. We are highly supportive of integrating primary and behavioral health care and believe that both providers should have the same appointment wait time of 10 days. NRHA firmly believes that behavioral health care is primary care and as such the two types of providers should not be differentiated for appointment wait time standards.

Last, NRHA encourages CMS to add additional provider types to appointment wait time requirements in future rulemaking cycles. We agree that the three types included in this proposed rule are critical; however, CMS should further explore what other provider types are most important to Medicaid enrollees and subject them to similar standards. For example, states should develop network adequacy standards for pediatric dental providers.[6] NRHA believes that eventually all MCO participating providers that are subject to network adequacy standards at 42 C.F.R. § 438.68(b) should also be subject to appointment wait times.

c. Secret Shopper Surveys (§§ 438.68(f), 457.1207, 457.1218).

NRHA supports secret shopper surveys to audit provider directories and appointment wait times. This may mitigate the issue of Medicaid-enrolled providers not serving Medicaid patients, referenced above. Secret shopper surveys have the potential to identify providers that are not accepting new Medicaid patients, or seeing few Medicaid patients per year, and assure that the MCO remedies this. Surveys should be administered in a manner representative of the location and demographics of

[5] Medicaid and CHIP Payment Access Commission, State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages (Mar. 2022), 2, https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief-on-HCBS-workforce.pdf

[6] 42 C.F.R. § 438.68(b)(vii).

enrollees. Additionally, we are supportive of an independent third-party administering the secret shopper surveys.

NRHA supports the proposed addition of telehealth services in provider directories. NRHA believes that adding this indicator in a provider directory will enable rural enrollees to find providers that are accessible and best meet their needs.

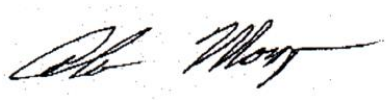
d. Assurances of Adequate Capacity and Services—Provider Payment Analysis (§§ 438.207(b), 457.1230(b))

CMS proposes that MCOs must submit to the state payment analyses for primary care, OBGYN, and behavioral health services to show that payment rates are adequate for provider participation. Of note, rural hospitals are increasingly forced to close their labor and delivery units due to financial vulnerability, workforce shortages, and low Medicaid reimbursement rates.[7] **NRHA supports this measure to enforce sufficient payment and therefore access to providers for enrollees.** We are also supportive of the proposal to compare payment rates to Medicare rates, including claim-specific breakdowns such as geography.

NRHA suggests that CMS include psychotherapy codes for the comparative analysis of behavioral health payment rates. While E/M codes are appropriate for the other categories of providers, they do not reflect the types of providers that rural enrollees often use to access care. E/M codes are only available to limited behavioral health providers, like psychiatrists, which are severely lacking in rural areas.[8] CMS should add psychotherapy codes so that psychologists, social workers, and counselors are covered by payment rate transparency. Rural communities often heavily rely upon these providers for behavioral health care.

NRHA thanks CMS for the opportunity to comment on this proposed rule. We look forward to working together in the future to continue improving access to care for rural Medicaid enrollees. If you have any questions or would like further information, please contact NRHA's Regulatory Affairs Manager Alexa McKinley (amckinley@ruralhealth.us).

Sincerely,



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[7] Roni Caryn Rabin, *Rural Hospitals Are Shuttering Their Maternity Units*, NEW YORK TIMES, Feb. 26, 2023, https://www.nytimes.com/2023/02/26/health/rural-hospitals-pregnancy-childbirth.html.
[8] C. Holly A. Andrilla, et al., *Geographic Variation in the Supply of Selected Behavioral Health Providers*, 54 AM. J. OF PREVENTIVE MEDICINE S199, S200 (2018) (65% of nonmetro counties lacked a psychiatrist compared to 27% of metro counties).