Comments – Medicaid/CHIP Managed Care Access Proposed Rule

Introduction

On May 3, 2023, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule (CMS–2439–P) relating to *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*. Within this notice of proposed rulemaking (NPRM) are a number of provisions addressing the accessibility and availability of services for Medicaid/CHIP enrollees in Medicaid Managed Care Organization (MCO) offerings.

In this communication, the National Organization of State Offices of Rural Health (NOSORH) provides input to CMS on the accessibility and availability provisions in the NPRM. NOSORH's comments highlight the special access and availability issues facing rural Medicaid/CHIP MCO plan enrollees. The comments include specific recommendations about possible changes in the provisions which will improve rural enrollee access to services.

NOSORH was established in 1995 to assist State Offices of Rural Health (SORHs) in their efforts to improve access to, and the quality of, health care for over 60 million rural Americans. All 50 states have a SORH, and each SORH helps their state's rural communities to build effective health care delivery systems. NOSORH and its members work closely with rural providers nationwide, including Rural Health Clinics, Federally Qualified Health Centers and rural hospitals. NOSORH brings its knowledge of rural essential community providers to the provisions of this NPRM.

NOSORH is encouraged that CMS is exploring how access to Medicaid/CHIP MCO plan services can be improved. NOSORH is particularly supportive of efforts to establish appointment waiting time standards and plans to use secret shopper surveys to verify actual access for enrollees. NOSORH believes that these, and other provisions, can have a significant impact on the accessibility of important health care services.

Background – Access Problems

NOSORH and others have identified substantial disparities in accessible health care between rural and urban areas. While the nation's rural population comprises less than 20% of the total population, the vast majority of designated Health Professional Shortage Areas (HPSAs) are either rural or partially rural. A recent data analysis conducted by NOSORH indicated that **84.0%** of all ***geographic primary medical care HPSAs*** are in rural or partially rural locations. Similarly, **81.9%** of all ***geographic mental health HPSAs*** are in rural or partially rural locations. Finally, **88.0%** of all *geographic dental HPSAs* are in rural or partially rural locations.

Geographic HPSA designations of an area's total population are the best indicator of underservice. When an area cannot be designated for its total population, it can be

designated for the needs of *subpopulations*, including low-income and Medicaid-eligible populations. Rural and partially rural areas comprise a disproportionately large percentage of all the nation's population-designated HPSAs.

The NOSORH data analysis showed that **69.4%** of all the nation's ***population-designated primary medical care HPSAs*** are in rural or partially rural areas. Similarly, **54.7%** of all the nation's ***population-designated mental health HPSAs*** are in rural or partially rural areas. Lastly, **72.3%** all the nation's ***population-designated dental HPSAs*** are in rural or partially rural areas.

The substantial extent of underservice for rural populations highlights this massive health service access problem. It is one of the nation's most serious health equity issues.

Several recent studies have highlighted the issue of ***health care deserts***. These are the most severe areas of underservice - locations with ***no*** available health care. Studies have highlighted multiple types of healthcare deserts, including:

- Physician Deserts,
- Hospital Deserts,
- Ambulance Deserts,
- Dental Deserts,
- Pharmacy Deserts, and
- Maternity Care Deserts.

The majority of these deserts are in rural areas. See a recent summary here:

- https://hitconsultant.net/2021/09/10/healthcare-deserts-goodrx-report/

Maternity care deserts – locations without hospitals providing obstetric care, birthing centers, OB/GYN physicians or certified nurse midwives – are increasingly recognized as being a challenge to the nation's health. See the following descriptions of the problem:

- https://www.pbs.org/newshour/show/why-the-problem-of-maternity-care-deserts-is-getting-worse
- https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx

36% of all the nation's counties - home to 2.2 million women of childbearing age and almost 150,000 babies – are maternity care deserts.

The number of maternity care deserts is growing, as hospitals and obstetric care providers, many in rural areas, are unable to sustain these services financially. ***Two out of three maternity care deserts are rural counties, and only 7% of obstetric providers serve rural communities.*** This emphasizes the fact that the problem of maternity care deserts is disproportionately a rural population issue.

Maternity care deserts often result in poor pregnancy outcomes including pregnancy-related deaths. A disproportionate percentage of these poor outcomes are in rural areas. As many of these poor outcomes are preventable, they become an important target for public policy.

A major impact of the health care access disparities described above is ***foregone or postponed care for rural populations*** – including screening and preventive care. A second impact is ***discontinuous care***, with poor or non-existent care coordination. The subsequent impact of these access disparities is more costly care resulting from delayed interventions, and poorer health outcomes.

These access issues are compounded for Medicaid/CHIP program enrollees. Not all providers in rural communities accept Medicaid. This is routinely verified by SORHs who conduct surveys for the purpose of designating Low-Income Population HPSAs. As part of this effort, SORHs routinely uncover provider practices that are inaccessible to Medicaid patients. Communities that might otherwise have adequate capacity to meet the needs of the total population may have practice restrictions that make them shortage areas for low-income and Medicaid residents.

NOSORH believes that the standards and verification approaches proposed in the NPRM can help identify accessibility problems within Medicaid/CHIP MCO provider networks. NOSORH also believes that there are Medicaid program responses which can help address accessibility problems

Comments

NOSORH comments on specific proposed measures and possible responses are presented below.

Appointment Wait Time Standards

NOSORH strongly supports the proposed rule requiring States to develop and enforce appointment wait time standards for key services offered by their Medicaid/CHIP MCOs. Wait times are one of the best measures of a health provider network's adequacy and availability performance. NOSORH notes that the distance requirements and the quantitative enrollee/provider standards recommended by CMS to state Medicaid programs are important requirements in addition to the wait time standards. For rural Medicaid enrollees, availability to services requires ***access to necessary services within a reasonable distance within a reasonable wait time.***

NOSORH agrees with the first three types of services for which CMS proposes establishing wait time standards:

- primary care- adult and pediatric,
- obstetrics and gynecology (OB/GYN), and

- outpatient mental health and substance use disorder (SUD)-adult and pediatric.

NOSORH believes, however, that several *additional* categories of medical service should also have wait time standards:

- Cardiologists,
- Oncologists,
- Pulmonologists,
- Endocrinologists, and
- Nephrologists.

These sub-specialists are needed to manage the chronic diseases that are among the leading causes of death in the nation. Without adequate availability of these providers, chronically ill Medicaid/CHIP eligibles will not get the disease/condition management services they need. This will result in preventable complications of illness, overutilization of services and hospitalization – all of which will increase the cost of care for Medicaid/CHIP programs.

NOSORH believes that the maximum appointment wait times proposed in the NPRM reflect reasonable expectations for availability of services. The maximum appointment wait time requirements of ***15 business days*** for routine primary care and OB/GYN appointments are acceptable, as is the wait time requirement of ***10 business days*** for routine outpatient mental health and substance use disorder appointments. NOSORH recommends that maximum appointment wait times for essential sub-specialists, as described previously, be no more than ***15 business days***.

Secret Shopper Surveys

NOSORH strongly supports the use of secret shopper surveys to evaluate the accessibility of a Medicaid/CHIP MCO's provider network. NOSORH believes that these surveys can be effective in verifying three things: ***directory accuracy***, ***provider availability***, and ***appointment wait times***. A single survey should be able to capture all three topics, but separate supplemental survey efforts may be required. NOSORH also notes that surveys should be appropriately designed to evaluate accessibility in rural and urban communities throughout the state, highlighting any disparities. Surveys should also be conducted on a frequent or continuous basis to assure timeliness of information.

NOSORH's comments on each of these three purposes are discussed below.

> **Secret Shopper Surveys – Directory Verification**: There are multiple studies highlighting the inaccuracies of provider directories for managed care. Providers listed in these directories can change their participation, and it may take months or even years before that change in status is reflected in printed or online directories. This is a major challenge to Medicaid/CHIP eligibles who are trying to select a MCO plan which includes the provider of their choice.
>
> Directory inaccuracy is a particular issue in rural communities where the number of participating providers is generally smaller. If a rural provider is no longer

participating in an MCO's network, MCO enrollees may be left without choice of a local provider, crippling the accessibility of key services.

Secret Shopper Surveys – Provider Availability Verification: Some providers listed in a directory may not be accepting new patients or may cap the number of Medicaid/CHIP eligible patients they accept. Information on whether providers are accepting new Medicaid/CHIP patients should be included as a required part of MCO provider directories. NOSORH notes that provider availability may change quickly in the course of a normal year, and that frequent surveys will be needed to uncover these changes.

Secret Shopper Surveys – Appointment Wait Time Verification: Providers in an MCO's directory may be taking new patients, but may not be able to schedule an appointment to see them in a reasonable period of time. Similarly, a provider's existing Medicaid/CHIP patients may not be able to schedule an appointment in a reasonable period of time. Secret shopper surveys can uncover these problems.

Nevada conducted this type of survey for several years and uncovered a fairly shocking lack of accessibility. In the Nevada surveys OB/GYN care for pregnant mothers was particularly inaccessible, with more than half of all newly pregnant mothers facing delays in getting prenatal care until unacceptably late in their pregnancy. This problem was significantly worse in rural communities. In the Nevada case, the use of secret shopper surveys was able to uncover these issues and allow initiation of corrective action.

It should be noted that wait times can change rapidly during the course of a year. Demand for most services can vary seasonally. Secret shopper surveys must take this variability into account and identify appointment wait time issues in both peak and slack seasons.

Emergency and Urgent Care – Definitions and Wait Times

The NPRM seeks input on defining *urgent care* and *emergency care*. There are multiple accepted definitions of urgent care and emergency care. The definitions presented on the *Healthcare.gov* website are reasonable examples. Emergency care is defined as care provided, most often in an emergency room ,for *"an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm*." Severe harm relates to possible death, permanent injury or loss of limb. Urgent care is defined as "*care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care*."

In these definitions, the implication is that ***emergency care should be available immediately***, and that ***urgent care should be available on the same day.*** NOSORH believes that CMS should establish these times as an access standard for Medicaid MCOs. NOSORH notes that telehealth services can be used for consultation and triage of patients. Telehealth has been shown to be an effective way of differentiating urgent and routine care needs – helping to reduce unnecessary utilization of urgent and emergency care. Telehealth services can be very important for rural residents, and can reduce the

need for travel to care sites. NOSORH suggests that CMS require Medicaid/CHIP MCOs to provide 24/7 telehealth consultation, advice and triage.

Telehealth Considerations

NOSORH believes that CMS should establish a national standard for Medicaid/CHIP MCOs related to availability of telehealth services. The NPRM leaves this matter largely to state Medicaid programs, but does set this requirement:

> "Appointments offered via telehealth can only be counted toward compliance with the appointment wait time standards … if the provider being surveyed also offers in-person appointments … and must be identified separately from in-person appointments in survey results."

This is somewhat ambiguous, and NOSORH believes that a more precise national standard is needed.

NOSORH understands that telehealth services are very useful, but they are not a true substitute for many types of in-person service delivery. NOSORH differentiates between two types of telehealth service. In one category is telecommunication – audio or audiovisual – between a patient at home and a health care provider. In a second category is telecommunication between a provider and patient in a health care service site with a provider in a remote site – for example, a telecommunication consult from a primary care provider's office with a specialist physician at a remote location.

The first category of telehealth is useful for limited initial assessment and some health care management where no additional diagnostic testing is required. The second category is more useful, particularly in rural communities. In the second type of telehealth, many types of follow-up diagnostics could be conducted within the downstream service site, if needed. Similarly, the downstream provider could conduct additional physical examinations, as appropriate. This type of telehealth is more equivalent to face-to-face health service provision.

NOSORH recommends that appointment wait times be established for both of these types of telehealth encounter. The first type of encounter is described previously in the discussion of urgent care consultation and triage. NOSORH recommends that the second type of provider-mediated telehealth have appointment wait time standards the same as outpatient appointment wait times.

Appointment Wait Times Standards for Additional Services

NOSORH believes that appointment wait time standards should be established for two additional service categories – ***dental health services*** and ***ancillary services***.

Dental health services for children are required of all Medicaid/CHIP programs as part of the EPSDT treatment benefit. These services must include:

- Relief of pain and infections,
- Restoration of teeth, and
- Maintenance of dental health.

Some states optionally cover adult dental services, with some or all of the same benefits. Dental health services are critical to overall health of patients. Failure to provide timely access to these services can lead to significant and more costly health problems.

Ancillary services – including some laboratory and radiology services – are important to health service effectiveness. Certain diagnostic services, including colonoscopy and mammography, are important components of comprehensive prevention for adults. In certain parts of the nation, there may be significant wait times, often of several months, for non-emergent procedures. This is unacceptable for patient health.

NOSORH recommends that CMS establish appropriate Medicaid/CHIP MCO appointment wait time standards for both dental and select ancillary services. These should be established in consultation with appropriate experts. Most dental services should likely have standards similar to medical outpatient services, both for prevention and treatment. Ancillary services may, realistically, need somewhat longer wait times, but these should, in most cases, be no more than 30 days. MCO performance on availability and appointment wait time standards for these additional services can be evaluated as part of the larger secret shopper survey effort.

NOSORH notes that pharmacy services are also a type of ancillary service. Pharmacy services will seldom have significant wait times. There may, however, be pharmacy accessibility problems. Some rural Medicaid enrollees may not have a participating pharmacy in their community, forcing them to travel or rely upon mail order for their medications. These issues should be addressed in Medicaid/CHIP MCO distance standards.

Enrollee Experience Surveys

NOSORH strongly supports the use of *enrollee experience surveys*, as proposed in the NPRM. NOSORH believes that an appropriately designed survey will collect information on the perspective of Medicaid/CHIP enrollees regarding provider availability, accessibility and service quality. This is an important supplement to information collected through secret shopper surveys, and provides an additional dimension to MCO evaluation.

NOSORH believes, however, that not all Medicaid enrollees have the same experiences. NOSORH is particularly interested in assuring that experience surveys differentiate the viewpoints of rural enrollees. NOSORH also recommends that information from the surveys be compiled for subareas of the state, allowing for the identification of regional disparities.

Medicaid/CHIP MCO Accessibility Corrective Action Plans

NOSORH understands that it will be difficult to achieve full compliance with any set of accessibility or availability standards. NOSORH does believe, however, that MCOs should be required to make *continuous, good faith efforts to improve the accessibility of enrollees to their services*. Towards this end, NOSORH recommends that MCOs be required to make an ***annual accessibility corrective action plan***, identifying specific targets for access improvement. In addition, NOSORH recommends that MCOs report regularly on progress made on the corrective action plan.

Access is a particular concern in shortage areas – when there is a critical shortage of providers for the general population. In these areas, many of which are rural areas, attempts to improve accessibility will require some ***addition of provider capacity*** from outside the area. For example, if an area is a geographic primary care HPSA, this means that there is a supply of primary care services sufficient to meet the needs of fewer than half the population. In this instance, no rearrangement of existing provider supply will meet the needs of the population.

NOSORH believes that Medicaid/CHIP MCOs can take meaningful steps to improve access in shortage areas. Among the possible approaches:

- **Maximize participation of existing providers within a shortage area**. This may mean paying higher reimbursement rates or shortage area bonuses for all providers in a shortage area.
- **Support the expansion of supply within shortage areas**. This could include financial incentives to participating provider practices who bring in extra staff, including, for medical care, nurse practitioners, physician assistants and nurse midwives.
- **Provider circuit riding into shortage areas**. MCOs can contract with providers to travel to shortage areas and provide services, most likely on a part-time basis. This circuit-riding approach will be particularly useful for OB/GYN, behavioral health and sub-specialist care.
- **Expand telehealth offerings**: MCOs can expand support for telehealth services – particularly those services which connect local provider practices in shortage areas with upstream healthcare providers. This approach will supplement the capacity within shortage areas with the services of those remote providers. MCOs can help facilitate those arrangements from within their networks and provide financial incentives for participation.

All these approaches will require extra Medicaid/CHIP MCO expense. NOSORH suggests that CMS consider requiring a minimum amount of MCO investments in their Accessibility Corrective Action Plan efforts.