



July 3, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

Submitted electronically to <http://www.regulations.gov>

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

Dear Administrator Brooks-LaSure:

AARP, which advocates for the more than 100 million Americans age 50 and older, appreciates the opportunity to comment on the proposed Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality rule. Overall, we appreciate CMS’ efforts to obtain beneficiary and caregiver feedback during the rule development process. We applaud many proposed provisions that are designed to increase accountability and transparency in managed care programs, amplify the voices of beneficiaries and caregivers, and ensure that program information is easy to understand and available in multiple languages. We also commend and appreciate the focus and attention on improving health equity. The following is our feedback on specific sections, organized by the order, headings and numberings found in the proposed rule.

**1. Access**

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

The Medicaid enrollee population is diverse, and there is no substitute for understanding the lived experience of those enrolled in the program. AARP believes that enrollee and family caregiver feedback can be helpful in identifying issues to help programs address health disparities by understanding the challenges and preferences of those in the communities served. We therefore strongly support CMS’ proposed changes to 42 CFR Section 438.66(b) and (c)(5) to require states to conduct an annual enrollee experience survey as part of their managed care monitoring programs. We also support the proposed requirement that written survey materials comply with the interpretation, translation, and tag-line criteria in 42 CFR Section 438.10.(d)(2) so that they are fully accessible and easy to read and understand.

Further, AARP encourages CMS to consider the creation and administration of a family caregiver experience survey. This would allow family caregiver engagement and feedback on potential gaps in access and improvements in service, as well as support needed by family

caregivers. While separate from the enrollee survey, this family caregiver survey would allow for a more comprehensive look at the Medicaid managed care enrollee and care experience.

We are also mindful of the importance of the survey design process which must balance sometimes competing priorities, such as:

- Maximizing response rates
- Ensuring survey results are representative of diverse populations
- Minimizing the burden on beneficiaries who, for example, may be enrolled in more than one managed care program at the same time (e.g., a comprehensive managed care organization (MCO), a dental prepaid ambulatory health plan (PAHP), and a non-emergency medical transportation PAHP)
- Avoiding undue state costs and administrative burdens.

AARP therefore recommends that CMS consider offering technical assistance to states on best practices regarding modes for survey administration, and even developing evidence-based questions that states can use in their surveys to maximize efficiency in developing quality tools.

Finally, we believe that the proposed changes should be implemented as soon as feasible and believe that, in light of the importance of gaining enrollee feedback, a compliance deadline that is three years after the effective date of the rule is too long. States should be encouraged to implement sooner if it is possible to do so without sacrificing accuracy and quality.

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

Long wait times for medical care can increase morbidity and mortality risk for persons with underlying, preventable, and treatable medical conditions.<sup>i</sup> Patients are also more likely to miss an appointment booked many weeks in the future compared to a same-day or next day appointment.<sup>ii</sup> To avoid poor health outcomes, AARP believes that States should ensure that beneficiaries have reasonable and adequate access to providers. We therefore support CMS' proposal to impose maximum appointment wait time standards for routine care provided by certain provider types, subject to the following concern and caveat.

##### *Maximum Wait Times Proposed*

AARP is concerned that the maximum appointment wait times proposed for primary care and OB/GYN care (15 business days/3 weeks) are too long in some cases and urges CMS to reduce the maximum wait time, ideally, to 10 business days. We recognize, however, that States and MCOs are challenged by health care workforce shortages in some areas. We therefore support CMS' proposal to add a requirement for States to look at the provider reimbursement rates paid by plans seeking an exception to the State's network adequacy requirements before granting the exception. States could also be encouraged to conduct their own analysis, including reaching out to stakeholders, to ensure that managed care organizations are expanding their outreach and working with all community providers. We also urge CMS to provide technical assistance to States on best practices for shortening appointment wait times in provider shortages areas, for example, by encouraging the wider use of telehealth strategies and supporting providers' ability to work at the top of the scope of their license.

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

AARP supports making sure that managed care provider reimbursement rates are adequate to support robust networks and also believes that greater rate transparency will continue to support efforts to reduce fraud, waste, and abuse where it occurs. We therefore support the proposed provisions that would require managed care plans to annually submit a payment analysis to states showing their level of payment for certain services as a proportion of what Medicare would pay, and, for certain home and community-based services (including homemaker services, home health aide services, and personal care services), as a proportion of the State's Medicaid fee-for-service (FFS) payment level.

f. Remedy Plans to Improve Access (§ 438.207(f))

AARP supports the proposed requirement for states to submit for CMS approval a plan to remedy access issues identified for managed care plans. We support CMS' effort here to parallel the similar requirement for state remedy plans in fee for service programs. Since managed care plans limit the networks that their enrollees can access, and enrollees are often limited in their ability to change plans during year, a CMS-approved remedy plan is an important oversight tool to ensure that managed care plans offer appropriate network access. We also urge CMS to publish these plans publicly to ensure greater transparency and accountability in how the State and its managed care plans intend to work together to correct any access issue(s) in a timely manner. Allowing community stakeholders to understand how the state and its managed care plans intend to work together to correct the access issue(s) can not only help enrollees make informed enrollment choices, but also help ensure that all options for addressing the issues are considered.

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

AARP supports the proposed requirements for States to maintain a single state Medicaid program website that incorporates easily understood labels, contains information that is verified at least quarterly, provides directions for obtaining no-cost interpretation and translation assistance and auxiliary aids and services, and contains a toll-free and TTY/TDY telephone number. We also encourage states to engage enrollees and their family caregivers to gather feedback in the process of developing and improving their websites over time.

**4. In Lieu of Services and Settings (ILOSs) (§§ 438.2, 438.3, 438.7, 438.16, 438.66, 457.1201, 457.1207)**

AARP strongly supports the flexibility that in lieu of services and settings (ILOS) afford States and managed care plans to improve population health, reduce health inequities, and lower overall health care costs by addressing health related social needs (HRSNs) and social determinants of health (SDOH). Given that ensuring continuity of care is critical for Medicaid beneficiaries, we also support the proposed transition plan requirements when a State decides to terminate an ILOS, a managed care plan decides to stop offering an ILOS to its members, or CMS requires termination of an ILOS. In addition to notifying enrollees and making the transition plan publicly

available, as the proposed rule provides, States should also notify providers and family caregivers.

We are concerned, however, that the proposed ILOS cost limitations and documentation requirements described below may disincentivize States to take up this potentially transformative coverage option.

**b. ILOS General Parameters (§§ 438.16 (A) Through (D), 457.1201(C) and (E)) - Proposed limits on ILOS Expenditures (§ 438.16(c)(1)(i))**

The proposed rule would limit ILOS expenditures to no more than 5 percent of total capitation payments for each managed care program a State operates. While we are not opposed to a 5 percent cap, AARP believes that a State's ILOS criteria should consider more than cost and would instead encourage consideration of an ILOS if it can be expected to reduce or prevent the need for more acute or costly care in the future. AARP does not believe that the cost of a service or item should be the principal or determinative criterion in findings of medical necessity for Medicaid coverage. Where cost is a factor, programs should consider whether higher initial costs will result in future savings.

**d. Medically Appropriate and Cost Effective (§§ 438.16(D), 457.1201(E)) - Proposed ILOS Documentation Requirements § 438.16(d)(1)(i) and (ii)**

AARP supports the proposed requirement for States to document approved ILOSs in their managed care contracts, including the name and definition of each ILOS and the clinically defined target population for each ILOS. We also urge CMS to require States to include information on which ILOS are covered by which plans, including the name and definition of each ILOS and the clinically defined target population, on the State Medicaid program's public-facing website. This will ensure that enrollees and those who assist them can consider this information in enrollment choices.

**5. Quality Assessment and Performance Improvement Program, State Quality Strategies and External Quality Review (§§ 438.330, 438.340, 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250)**

**b. Managed Care State Quality Strategies (§§ 438.340, 457.1240)**

AARP agrees with CMS' goals of increasing transparency and opportunities for meaningful and ongoing public engagement around States' managed care quality strategies. We therefore support the proposed rule provisions that will require States to make their quality strategy available for public comment when significant changes are made and at the 3-year renewal, even if no significant changes are made at that time.

**c. External Quality Review (§§ 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250)**

***(2) EQR Review Period***

CMS notes that in some cases, States have reported on the results of External Quality Review (EQR) activities conducted three or more years ago, while other States have reported on the results of EQR activities conducted relatively close to the completion of required report.

AARP supports the proposed modifications to define the 12-month review period for which the EQR information is derived. We agree with CMS' goal of increasing uniformity across state EQR reports to enhance States' and CMS' ability to use the reports for quality improvement of care and timely oversight. Though we understand that, for some states, the 12-month period that begins on the first day of the contract year might be easiest, we encourage CMS to consider further standardizing the reporting periods to require that the 12-month period begin on the first day of the calendar year.

*(5) External Quality Review Results (§438.364(a)(2)(iii))*

We also strongly agree with CMS' proposal to require the inclusion of (1) outcomes data and results from quantitative assessments, and (2) data from the mandatory network adequacy validation activity in annual EQR reports. We agree that this data will result in more meaningful reports that can be used to drive quality improvement, oversight in managed care, and stronger managed care plan performance for beneficiaries.

**6. Medicaid Managed Care Quality Rating System (§§ 438.334 and 457.1240) Medicaid Managed Care Quality Rating System**

AARP applauds CMS for consulting with a broad range of stakeholders to obtain feedback on the Medicaid and CHIP Managed Care Quality Rating System (MAC QRS) through multiple approaches including beneficiary interviews, workgroup meetings, listening sessions, user testing of a MAC QRS prototype, and in-depth interviews with participants from State Medicaid programs, managed care plans, and EQROs. We also commend CMS for conducting beneficiary and caregiver interviews across diverse populations, age ranges, geographic locations and Medicaid experience and the use of Human Centered Design approach to ensure that a MAC QRS framework includes a user-friendly and intuitive website.

AARP supports the proposed inclusion criteria for the MAC QRS mandatory measure set: useful to beneficiaries, aligned with other rating programs, relevant to health plan performance, actionable, feasible, and scientifically acceptable. We also support the requirement that a mandatory measure must contribute to balanced representation of beneficiary subpopulations, age groups, health conditions, services, and performance areas (for example, preventive health, long term services and supports, etc.) within a concise mandatory measure set.

g. MAC QRS Website Display (§§ 438.334(e), 438.520, 457.1240(d)) - QRS Website Display Requirements

Seniors and family caregivers need meaningful and usable Medicaid information that is timely, concise, understandable, and easy to use without sacrificing necessary contextual information needed to make informed choices. This is particularly important for older Americans who are dually eligible for Medicare and Medicaid who may also need to navigate other non-state websites and information sources to inform their health care decisions. AARP therefore supports the requirement that States display managed care quality ratings as part of a comprehensive website with additional relevant information that efficiently guides users through the considerations for identifying a quality health plan.

While AARP is also generally supportive of the intent behind the proposed QRS website display, we urge CMS to ensure that there is quality and independently verifiable data used for the QRS website, to ensure consumers can rely on the integrity of the data to select a quality plan.

#### *Linking to Beneficiary Support Systems*

AARP also supports requiring states to provide information on the QRS Website on how to access the currently required beneficiary support system. We understand that current regulations already require beneficiary support systems to be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services (§438.71(b)(2)). In addition, all required information must be provided to enrollees and potential enrollees in an easily understood and readily accessible manner (§438.10(c)(1)), including the use of language interpretation and translation services. We encourage CMS to move forward with this provision to ensure that consumers and family caregivers can easily utilize the beneficiary support system to answer questions about using the QRS to select a managed care plan.

#### h. Alternative Quality Rating System (§§ 438.334(c), 438.525, and 457.1240(d)) - Alternative QRS

AARP supports the development of mandatory Medicaid managed care quality measures that are comparable across all states to better facilitate cross-state analysis and comparisons. While we do not oppose offering states flexibility to propose an Alternative QRS, we caution CMS to implement sufficient guardrails in the Alternative QRS approval process to ensure the goal of comparability across all managed care states is not undermined.

Thank you again for the opportunity to express our views on these important enhancements to improve the quality of Medicaid managed care for older Americans and their family caregivers. We look forward to continuing to work with you on this effort. If you have any additional questions, feel free to contact me or Gidget Benitez on our Government Affairs team at [gbenitez@aarp.org](mailto:gbenitez@aarp.org).

Sincerely,



David Certner  
Legislative Counsel and Legislative Policy Director  
Government Affairs

---

<sup>i</sup> Gertz AH, Pollack CC, Schultheiss MD, Brownstein JS. *Delayed medical care and underlying health in the United States during the COVID-19 pandemic: A cross-sectional study*. *Prev Med Rep*. 2022 August 28, 2022; accessed at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9254505/#:~:text=Delays%20in%20medical%20care%20may,Tapper%20and%20Asrani%2C%202020>.

<sup>ii</sup> Oliver Kharraz, *Long waits to see a doctor are a public health crisis*, *STAT*, May 2, 2023; accessed at <https://www.statnews.com/2023/05/02/doctor-appointment-wait-times-solutions/>.