AMERICA'S PHYSICIAN GROUPS

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Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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Re: CMS-2449-P "Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments" Proposed Rule

Dear Administrator Oz:

America's Physician Groups (APG) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS's) Proposed Rule regarding Medicaid Managed Care State Directed Payments (SDPs), as referenced above.

Below, APG will first provide a brief description of our organization and our interests in this proposed regulation, followed by our fuller analysis, comments, and recommendations, and our conclusion. Together they reflect the voice of APG's membership and the commitment to working with the agency to ensure that all Medicaid beneficiaries have consistently accessible, high-quality, equitable, person-centered health care.

I. Introduction: About America's Physician Groups

APG is a national association representing more than 300 physician groups, whose more than 260,000 physicians and other clinicians provide care to nearly 90 million patients, including an estimated 1 in 4 Americans. APG's motto, 'Taking Responsibility for America's Health,' represents our members' commitment to clinically integrated, coordinated, value-based health care in which physician groups are accountable for both costs and quality. This approach is consistent with CMS's multiple efforts across the years to institute alternative payment models more broadly within U.S. health care and produce higher levels of quality in health care at more affordable costs.

APG's member organizations have successfully operated under such budget-responsible care models for decades, including through capitated and delegated relationships with Medicare Advantage plans and in concert with Medicaid managed care plans operating in multiple states. Collectively, APG groups deliver care for millions of patients on Medicaid and have consistently supported and advocated for this vitally important form of publicly financed health care.

APG fully supports appropriate oversight of financing of all forms of health coverage, including Medicaid, and shares CMS's commitment to fiscal accountability. At the same time, APG recognizes that State-Directed Payments (SDPs) have been a vitally important mechanism to preserve beneficiaries' access to care by directing managed care organizations (MCOs) to pay above-Medicaid rates to specified types of health care providers.

APG is concerned that, in its blunt-instrument approach to limiting such payments, the proposed rule will cause many more physicians and other clinicians to cease providing care to Medicaid patients, making it impossible for MCOs to maintain adequate networks of providers to care for patients. Implemented as currently proposed, the rule would also imperil the operating model of APG groups -- which depends on providing high quality and cost-effective care to insured patients, whose coverage is provided by entities with which provider groups can negotiate appropriate payment arrangements.

Along with multiple other parties that have considered the rule, APG also believes that, as currently written, its provisions would exceed Congressional direction; introduce significant operational uncertainty; harm beneficiaries' access to care, including high quality and cost-effective care; and thwart the ongoing progress within the health care system toward value-based care. Below, in items I through IX, APG offers its further analysis of the proposed rule and recommendations for CMS revisions and other actions.

II. Summary of APG's Recommendations

APG appreciates CMS's commitment to strengthening the transparency, consistency, and fiscal integrity of Medicaid payment policy. APG also supports the agency's efforts to establish a more predictable framework for SDPs while ensuring appropriate stewardship of Medicaid resources. At the same time, several aspects of the proposed rule would benefit from additional clarification and refinement to avoid unintended consequences for physician organizations, preserve state flexibility, and maintain beneficiary access to high-quality, coordinated care. The following recommendations are intended to help CMS achieve the objectives of the proposed rule while ensuring that SDPs remain an effective tool for advancing value-based care, addressing workforce shortages, and improving health outcomes for Medicaid beneficiaries.

Specifically, APG requests that CMS:

- **Limit implementation of limits on SDPs to those provider categories expressly identified in the statute.**
- **Reconsider provisions extending payment limits beyond Congressional direction.**
- **Conduct additional analysis regarding physician participation and beneficiary access.**
- **Preserve state flexibility to address local workforce and access challenges.**
- **Protect SDPs that support value-based care and delivery system transformation.**
- **Clarify applicability to physician organizations and integrated delivery systems.**
- **Address the potential impact of limits on SDPs on independent physician practices and market consolidation.**
- **Provide additional guidance regarding grandfathering, provider classes, and payment methodologies.**
- **Simplify operational requirements to reduce administrative burden while preserving accountability.**
- **Continue working collaboratively with physician organizations, states, and managed care plans to ensure that Medicaid payment policy advances both fiscal integrity and access to high-quality care.**

III. APG's Detailed Comments and Recommendations

A. CMS Should Implement the Statute Consistent with Congressional Intent

The proposed rule implements Section 71116 of Public Law 119-21, which establishes payment limitations for certain categories of SDPs. APG recognizes CMS's responsibility to implement the statute faithfully. However, the proposed regulation extends well beyond Congress' express direction in several important respects.

Most notably, in the original statute, Congress specifically identified four categories of services subject to new payment limitations: inpatient hospital services; outpatient hospital services; nursing facility services; and qualified practitioner services at academic medical centers. In the proposed rule, CMS instead sets forth a regulatory framework that ultimately extends similar payment limitations across virtually all SDPs well beyond these four categories specified in law and applies analogous concepts to additional Medicaid financing mechanisms over time. Similarly, the proposed rule reaches beyond the statutory language by extending significant portions of the regulatory framework to Medicaid fee-for-service (FFS) supplemental payment methodologies that were not expressly addressed in the legislation.

These expansions constitute important policy choices. Although Congress clearly directed CMS to implement payment limits for specified services, it did not direct CMS to comprehensively redesign the broader SDP framework.

Recommendation: APG therefore specifically recommends that CMS limit the final rule to the original four provider categories and payment arrangements specifically identified in the statute unless and until Congress provides additional authority.

B. The Scope of the Proposal Raises Significant Administrative Law Concerns

Beyond questions regarding statutory authority, APG is concerned that the magnitude of the proposal raises important issues under the Administrative Procedure Act. For example, CMS estimates that the proposed rule would reduce federal Medicaid spending by approximately $510 billion and total Medicaid spending by approximately $775 billion over ten years. These projected savings are dramatically larger than the Congressional Budget Office estimate associated with the SDP provisions enacted by Congress. Such a substantial increase in projected savings suggests that the regulatory proposal reaches significantly beyond the statutory changes scored by Congress.

When a regulation produces fiscal effects that substantially exceed those anticipated during enactment of the underlying legislation, CMS should clearly explain the following: the legal basis supporting the broader regulatory approach; the assumptions underlying its economic analysis; the anticipated effects on physician participation; the expected impact on Medicaid beneficiary access; and the likely effects on state Medicaid financing and delivery system reform.

Recommendation: Given the magnitude of the proposed changes, APG respectfully recommends that CMS undertake additional analysis regarding provider participation, beneficiary access, and market stability before finalizing the rule, and publish this analysis for stakeholder consideration before implementing any rule changes.

C. State Directed Payments Have Become Essential to Maintaining Access to Care in Medicaid

Over the past decade, SDPs have evolved into one of the most important mechanisms available to states to address chronic Medicaid underpayment while supporting delivery system innovation. Although originally intended as a targeted policy tool, SDPs have increasingly become the primary vehicle through which states narrow the longstanding gap between Medicaid reimbursement and the actual costs of

furnishing care.

For physician organizations, these payments support numerous activities that are essential to the maintenance of operations and provision of care to Medicaid and other enrollees. These activities include the recruitment and retention of physicians; providing access to specialty care; sustaining the financial viability of rural practices; integrating behavioral health with primary care; sustaining maternal care; undertaking primary care transformation; providing care coordination; and investing in and maintaining the technology, personnel, and other infrastructure needed to provide value-based care.

Reducing permissible payment levels to Medicare levels, or below many existing supplemental payment levels, is likely to have multiple adverse consequences, including less provider participation in Medicaid managed care networks; reduced investment in care management infrastructure; the curtailing of specialty services and Medicaid enrollees' access to them; and delayed recruitment of new personnel. These consequences would be felt most acutely by medically underserved communities and Medicaid beneficiaries who already experience difficulty obtaining timely access to care.

Recommendation: CMS should thus carefully evaluate whether the proposed payment limits could unintentionally undermine the very access goals the Medicaid program is intended to achieve. CMS should undertake an analysis of the effect of the proposed rule on the potential of the adverse consequences described above and publish this analysis for review by stakeholders before finalizing any SDP regulation.

D. State Directed Payments Are Essential to the Advance of Value-Based Health Care

CMS has consistently encouraged providers and states to move toward value-based care, and SDPs have been a key component of this movement. Many SDPs no longer resemble traditional supplemental fee schedules, and instead, support sophisticated value-based payment arrangements that reward physicians for improving outcomes, coordinating care, reducing avoidable utilization, and managing population health.

Examples of these payment arrangements covered under existing SDPs are shared savings programs; quality incentive payments; prospective care management payments; integrated behavioral health models; maternal health initiatives; primary care transformation; accountable care arrangements; and population-based payment methodologies. These arrangements differ fundamentally from fee-for-service based payments and enhancements to the existing Medicare fee schedule.

What's more, as written, the, the proposed rule applies to SDPs Medicare-based payment limits at the service-code level and requires retrospective reconciliation of payments. Again, these payments implicitly are Medicare fee-for-service payments, constituting a fundamental misalignment with value-based care. APG is concerned that rigid application of Medicare payment limits to these payment methodologies may discourage states from continuing investments in these avenues for delivery system transformation. In obviating or preventing such features of value-based care as shared savings, the proposed rule would wreck incentives for health care providers to enter such arrangements and instead incentivize a return to traditional fee-for-service reimbursement.

Recommendation: The final rule should preserve the policy objective of moving more public program payment toward value-based care by recognizing that payment models designed to improve quality and outcomes warrant different treatment than supplemental payments that simply increase reimbursement levels.

Specifically, language in a revised rule should be set forth to accomplish the following:

- **Preserve state and MCO flexibility to contract with providers in risk-based and value-based payment arrangements, prioritizing total cost of care arrangements.**
- **Exempt value-based care providers and/or outpatient, community-based services from service level limits at Medicare fee-for-service payment levels .**
- **Accordingly, ensure continued use of features of value-based payments, including per member per month prospective payments and bundled payments, and the ability of providers contracted with MCOs to earned share savings.**
- **Permit up-front certification that such value-based arrangements are actuarially sound, eliminating the need for retrospective reconciliation that could undermine shared savings.**
- **Evaluate value-based care models in managed Medicaid based on their ability to improve quality, expand access, and reduce total cost of care.**
- **Establish a structure of value-based care governance to ensure compliance with applicable laws and regulations. Assess compliance at the aggregate level, aligning oversight with how VBC models generate savings across populations.**

E. The Proposed Rule Is Likely To have Deleterious Effects On Independent Physician Practices

Independent physician organizations often operate with substantially narrower financial margins than large integrated health systems that may also employ physicians or contract with physician groups such as APG's members. Unlike vertically integrated health systems, independent physician groups generally lack significant capital reserves to absorb major reductions in supplemental Medicaid revenue. Those that do serve these enrollees, and that see lower payment levels as a consequence of the proposed rule, will face even greater pressure on their operating margins than they do now. These payment reductions also make it likely that fewer independent physician organizations will be able to continue serving Medicaid enrollees.

Consequently, reductions in SDP payments may accelerate trends that multiple policymakers and analysts have sought to prevent or attenuate, such as ongoing consolidation within health care; acquisition of physician practices by hospitals and/or private equity groups; and increased health care prices resulting from greater market concentration.

Recommendation: CMS should evaluate these potential broader market effects of the proposed rule and publish an analysis for stakeholders' consideration before adopting any final SDP regulation.

F. The Proposed Rule Will Bar States From Exercising the Flexibilities Needed to Adapt The Medicaid Program To Their Specific Situations and Beneficiaries' Needs

One of Medicaid's greatest strengths has historically been the flexibility afforded to states to address such factors as local workforce shortages, provider market conditions, and variability in beneficiary needs. As such, SDPs have enabled states to improve access to obstetrical care; strengthen behavioral health services; stabilize rural hospitals and physician networks; expand primary care capacity; encourage integrated care delivery; and promote value-based payment reform. Implemented as written, the proposed rule would substantially narrow that flexibility.

An important State flexibility that is aligned closely with CMS priorities in this respect are those payment

models that have been designed to support integrated care for dually eligible Medicaid and Medicare beneficiaries enrolled in a Dual-Special Needs Plan (D-SNP). Without SDPs, Medicaid payments to providers are often not tied to Medicare Advantage/D-SNP integration goals. SDPs give states a lever to encourage providers to actively collaborate with D-SNPs; align financial incentives across Medicare and Medicaid; and build infrastructure (data sharing, care coordination workflows) that directly benefits dual-eligible individuals. Broad limits on SDPs will thwart these goals.

Recommendation: Although APG supports the existence of appropriate guardrails, the final rule should continue allowing states to tailor SDPs to address unique regional challenges. Rather than imposing rigid national payment standards, CMS should preserve sufficient flexibility for states to continue experimenting with innovative delivery system reforms that improve quality and access while maintaining fiscal accountability.

G. Multiple Specific Provisions in the Proposed Rule are Ambiguous or Vague and Require Further Clarification

In drafting the proposed rule, CMS left open to interpretation many terms and definitions, such that states may implement provisions inconsistently and create unnecessary administrative complexity that could lead to inequitable treatment of similarly situated physician organizations. Below, APG offers a list of terms and definitions that should be further clarified by CMS in a revised regulation, as follows:

1. **Clarify the Definition and Scope of "Qualified Practitioner Services"**

   The proposed rule establishes payment limitations applicable to qualified practitioner services furnished at academic medical centers (AMCs). But the regulatory text leaves significant ambiguity regarding how these provisions apply to physician organizations that participate in Medicaid managed care through a variety of organizational structures, including multispecialty physician groups; faculty practice plans; independent physician associations (IPAs); clinically integrated networks (CINs); physician-led accountable care organizations; employed physician organizations; and management service organizations (MSOs) supporting physician practices. Many of these organizations furnish services under the same SDP while billing through different legal entities or contractual arrangements. Without additional clarification, states may implement these provisions inconsistently, creating unnecessary administrative complexity and inequitable treatment of similarly situated physician organizations.

   Recommendation: As a result, CMS should clarify the following:

   - **whether the limitation applies based upon the billing entity, or the individual rendering physician;**
   - **whether faculty practice plans are treated differently than independent physician organizations;**
   - **whether physician organizations affiliated with—but legally distinct from—academic medical centers are included;**
   - **whether employed physicians participating through integrated delivery systems are treated differently than independent physician organizations; and**
   - **whether physician organizations participating in delegated managed care arrangements remain eligible for existing SDPs.**

2. **Clarify How Payment Limits Will Be Calculated**

The proposed rule would establish payment ceilings tied to Medicare payment rates or Medicaid State Plan rates for specified services. Although APG appreciates CMS's effort to establish objective payment benchmarks, the agency has not clarified at what level limits on payment at Medicare levels are to be assessed, and how, given that physician organizations often participate in multiple State Directed Payments simultaneously. Without further clarification, consistent implementation across states and provider categories will be impossible.

Recommendation: CMS should clarify in a revised regulation whether the payment ceilings tied to Medicare rates are to be assessed at the individual CPT or HCPCS code level; by provider class; by physician specialty; by managed care organization; by SDP arrangement; or across all SDPs collectively. Similarly, since physician organizations frequently participate in multiple SDPs simultaneously, CMS should explain whether overlapping SDPs must be aggregated; how payment limits will be calculated when multiple managed care organizations participate; how retrospective reconciliations affect compliance; how encounter data timing will affect payment calculations; and whether prospective payment methodologies will be reconciled after the rating period concludes.

Since these additional regulatory decisions would have differential impact across organizations, CMS should consult broadly with physician organizations, managed care organizations, and other stakeholders before publishing revised regulations.

3. **Clarify Treatment of Value-Based Payment Methodologies**

As noted above, one of APG's greatest concerns is that the proposed rule may unintentionally discourage states from continuing sophisticated value-based payment models that have become part of many states' embrace of managed care organizations to administer Medicaid coverage. Many SDPs thus support many aspects of Medicaid payment to providers that are fundamentally different from supplemental fee schedule increases. As noted, these include shared savings; quality incentive payments; prospective care management fees; integrated behavioral health programs; maternal health initiatives; primary care transformation; episodic payments; population-based payment models; and other accountable care arrangements.

Recommendation: Accordingly, CMS should clarify whether all these aspects of value-based payment arrangements cited above count toward the proposed Medicare payment limits or whether they can be maintained outside those limits and can be financed separately through state and federal Medicaid contributions. Absent this clarification, MCOs may cease these payment arrangements and default back to straight fee-for-service Medicaid. States may also conclude that the administrative burden associated with these arrangements outweighs their benefits, halting and reversing the transition toward value-based care.

4. **Clarify Provider Class Definitions and Applicability of SDP Limits to Different Types of Physician Organizations**

The proposed rule frequently invokes the phrase "provider classes" as well as "physician practices," without supplying detail as to how these terms should be provided. In the proposed rule's preamble, CMS requests comment and additional information to inform future rulemaking efforts on SDP provider class definitions. However, elsewhere in discussing potential approaches to SDPs, CMS refers to physician practices as a potential category of participating entities, but the proposed rule does not specify what constitutes a physician practice or establish standards for distinguishing physician practices from other provider organizations.

Instead, the term in a general sense while reserving consideration of provider class definitions for future rulemaking.

The result is that the proposed rule neglects the fact that physician organizations frequently include physicians practicing across multiple specialties and settings, leaving further uncertainties as to how limiting payments to Medicare levels would be operationalized. In addition, many APG member organizations participate in Medicaid through physician-led organizations that are independent of larger health and hospital systems, and it is unclear how the SDP limits will be applied to them. It is important to ensure that physician organizations are not inadvertently disadvantaged relative to vertically integrated health systems.

Recommendation: As a result, CMS should clarify how provider classes are established and by whom; whether physician organizations spanning multiple specialties constitute one provider class or multiple classes; how advanced practice clinicians are categorized; whether hospital-employed physicians and independent physicians may participate within the same provider class; whether provider classes may evolve during an SDP rating period; and how provider mergers or acquisitions affect provider class eligibility. Clearer definitions will reduce implementation uncertainty while preserving flexibility for physician-led organizations.

CMS's proposal appropriately recognizes the need for additional stakeholder input on provider class definitions. However, absent clear parameters regarding how "provider classes" and "physician practices" should be defined, the proposal could inadvertently disadvantage independent physician organizations relative to vertically integrated health systems. Integrated systems that own hospitals, outpatient facilities, and physician practices are better positioned to qualify for, administer, and benefit from broadly defined provider classes, while independent physician organizations may be excluded from comparable payment opportunities or placed into narrower classes with less favorable reimbursement.

This disparity could reinforce existing market consolidation trends, limiting states' ability to use SDPs to support physician-led, value-based care models that improve access, care coordination, and outcomes for Medicaid beneficiaries. APG encourages CMS to establish provider class policies that ensure that physician organizations have equitable access to SDP participation, regardless of whether they are part of a vertically integrated health system.

5. Clarify Grandfathering Requirements

Section 71116(b) of the underlying statute provides for the temporary grandfathering period for certain SDPs and requires a phase down beginning with the first rating period that starts on or after January 1, 2028. APG appreciates CMS's effort to provide temporary grandfathering for certain existing SDPs but is concerned that multiple important implementation questions as to the terms of grandfathered SDPs, or providers' participation in them, remain unanswered in the proposed rule.

Recommendation: CMS should clarify the following: what constitutes a material modification sufficient to terminate grandfathered status; whether provider participation may expand during grandfathering by permitting new providers to join grandfathered arrangements; whether physician organizations joining an existing SDP would be eligible for its above-Medicare payments; whether amendments to managed care contracts affect grandfathered status; and how mergers among physician organizations would affect eligibility.

6. Clarify Monitoring and Compliance Requirements

APG supports appropriate program oversight but requests additional guidance regarding the proposed compliance framework. Because Medicaid managed care payments frequently undergo reconciliation months after services are delivered, compliance methodologies should accommodate ordinary payment adjustments rather than requiring repeated recalculation of payment limits.

Without additional clarification, physician organizations participating in SDP arrangements could face significant administrative burden and uncertainty as retrospective payment adjustments trigger repeated compliance analyses, increasing reporting costs and complicating financial planning. These challenges are particularly acute for independent physician organizations, which often lack the administrative infrastructure of larger, vertically integrated health systems.

Recommendation: CMS should clarify how routine reconciliations, payment corrections, and other post-payment adjustments will be treated to ensure compliance requirements are operationally feasible while maintaining appropriate program integrity. **Specifically, CMS should clarify these compliance provisions: what constitute acceptable encounter data sources, and how incomplete encounter data will be treated; what is the timing for compliance reporting; what will be allowed reconciliation processes; what are expectations regarding retrospective payment adjustments; and what are necessary documentation standards, audit procedures, and corrective action processes.**

IV. Conclusion

APG appreciates the opportunity to submit comments on this important aspect of proposed rulemaking. APG encourages CMS to consider the modifications to the proposed policies described in this letter to further refine them and help to avoid unintended consequences that could seriously harm the health care system, set back progress on value-based care, and impede the delivery of optimal care to patients.

Sincerely,

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