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Welcome to "Washington Update," the weekly e-newsletter on the latest health care happenings in the nation's capital that affect APG's members.

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Center for Medicare and Medicaid Innovation (CMMI) to Develop New Framework to Assess Models' Impact

Addressing concerns that evaluation criteria for alternative payment models are too narrow and stringent, the Center for Medicare and Medicaid Innovation (CMMI) plans to revamp how it gauges the impact on cost and quality of the models under its purview, CMMI Director Liz Fowler told attendees at the CMS Quality Conference earlier this week.

The new framework will include more granular examinations of quality outcomes for specific populations, especially on the topic of improvements in health equity, Fowler

said. Additionally, the framework will explore differences among providers' experience with models to learn how workflow changes may have increased collaboration among providers and contributed to a "value-based mindset" among participants.

Established with the enactment of the Affordable Care Act (ACA) in 2010, CMMI was charged with developing and testing new payment and service delivery models in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Together with its parent agency, CMS, which has direct oversight over the Medicare Shared Savings Program, CMMI has helped to shift providers away from fee-for-service to value-based arrangements in which payment is linked to cost parameters as well as quality and outcomes.

Overall, CMMI results have been mixed, with just four models out of the more than 50 that have been launched deemed successful enough to be added to the overall Medicare program – specifically because they met required criteria of lowering federal spending without adversely affecting the quality of care, or improved quality without added spending. This threshold is especially challenging for models focused on services in which the nation has historically under-invested, such as primary care.

APG will closely watch and report to members as the new framework is developed further, to better understand the impact on existing and future CMMI models and the implications for participating member groups.

Senate Signals Future Legislation on "Ghost Networks" in Medicare Advantage

So-called "ghost networks," or health plan provider directories that include outdated, inaccurate, or unavailable listings, constitute "a breach of contract for insurance companies" and should be eliminated, Senate Finance Committee Chairman Ron Wyden (D-OR) said during a hearing this week. He strongly hinted that bipartisan legislation may be developed this year to curb the problem.

The hearing focused particularly on inadequacies of Medicare Advantage plans' directories of mental health providers, and followed a new report by Finance Committee Democratic staff reviewing 12 health plan providers in six states. The report found that more than 80 percent of the listed, in-network mental health providers were either unreachable, not accepting new patients, or were out-of-network.

Acknowledging the severe shortage of mental health providers, Wyden said that the Centers for Medicare & Medicaid Services (CMS) should nonetheless increase its oversight and auditing of MA plan directories and require more transparency and financial penalties for non-compliance. Legislative efforts are likely to focus on those measures, but could also include other provisions, such as holding consumers financially harmless for any unexpected bills that result from erroneous directory information.

APG will monitor any legislation as it emerges, particularly with respect to its potential impact on APG member groups that are in delegated relationships with health plans. Meanwhile, APG has supported CMS's concept of creating a National Directory of Healthcare Providers and Services (NDH) that would modernize and streamline the reporting process for both payers and providers alike.

Centers for Medicare and Medicaid Services (CMS) Seeks New Standards for Medicaid Access to Care and Payment Transparency

New national standards would govern access to care for both Medicaid managed care plans and traditional fee-for-service Medicaid under two notices of proposed rulemaking that CMS released this week. The proposed rules, Ensuring Access to Medicaid Services and Managed Care Access, Finance, and Quality, would also increase transparency for Medicaid payment rates to providers across states, and allow Medicaid enrollees to compare Medicaid plans based on quality and access to providers through state websites.

Other provisions include the following:

- National maximum standards for certain appointment wait times for Medicaid or CHIP managed care enrollees, and stronger state monitoring and reporting requirements related to access and network adequacy;
- New requirements for states to deploy "secret shoppers" to verify compliance with appointment wait time standards and to identify provider directory inaccuracies;
- Transparency and interested-party engagement requirements for setting Medicaid payment rates for home and community-based services (HCBS), as well as a requirement that at least 80 percent of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation for direct care workers;
- Timeliness-of-access measures for HCBS and strengthened safeguards to ensure beneficiary health and welfare as well as promote health equity;
- New annual requirements for states to conduct enrollee experience surveys in Medicaid managed care; and
- The development of a framework for states to implement a Medicaid or CHIP quality rating system where enrollees can easily compare plans based on quality, access covered benefits and more.

Comments on both proposed rules are due by July 3, 2023. APG will discuss the proposals through its Medicaid Coalition, which meets monthly. For more information, click HERE.

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