AMERICA'S PHYSICIAN GROUPS

July 3, 2023

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

Submitted via: https://www.regulations.gov/commenton/CMS-2023-0071-0001

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

Dear Administrator Brooks-LaSure:

America's Physician Groups (APG) appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS) proposed rule aimed at improving access to care, quality, and health outcomes, and at promoting greater health equity for Medicaid beneficiaries.

Below, (I) APG will first provide a brief description of our organization, followed by (II) a summary of CMS's proposal, (III) a summary of our comments, and then (IV) our detailed comments and recommendations. Together they reflect the voice of our membership and our commitment to working with the agency to ensure that all Americans have consistently accessible, coordinated, person-centered health care that is accountable for quality and cost.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for roughly 90 million patients, including nearly 30 percent of MA enrollees.

APG's motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

II. CMS' Proposed Rule

In its proposed rule, CMS put forward the following plans:

- To require states to conduct an annual enrollee experience survey for each Medicaid managed care plan
- To establish maximum appointment wait time standards for routine primary care (adult and pediatric), obstetric/gynecological services, outpatient mental health and substance use disorder services (adult and pediatric), and a state-selected service (adult and pediatric if appropriate)
- To establish requirements for the use of population-based and condition-based payments in VBP arrangements, in addition to existing performance-based payments, while not allowing performance-based payments to be used for administrative tasks, including "pay for reporting" arrangements
- To require states' contracts with managed care plans to specify how provider bonus or incentive payment arrangements would be structured, and to include more specific documentation requirements
- To require incentive payment contracts between managed care plans and network providers to include a defined performance period that can be tied to the applicable MLR reporting periods, and all incentive payment contracts to include well-defined quality improvement or performance metrics that the provider must meet to receive the incentive payment
- To establish the Medicaid and CHIP Quality Rating System (MAC QRS) framework and state requirements for the MAC QRS
- To broaden flexibility for states to implement an alternative QRS

III. Summary of APG's Comments

- Although it is in principle wise to implement a standardized measurement of patient experience, incorporating CHIP CAHPS® survey data could negatively affect organizations and providers treating diverse patient populations.

- Ongoing staffing and capacity constraints within the nation's health care system, particularly in mental health, would make achieving specific appointment wait-time standards difficult for provider organizations.

- As written, CMS' proposal to implement appointment wait time standards does not adequately consider differences in wait times between different types of primary care visits, e.g. wellness visits versus sick visits.

- Organizations engaged in downside risk contracts should be given the flexibility to dedicate a portion of their performance-based payments for some administrative tasks.

- CMS should implement threshold requirements for population-based models at the state and managed care organization levels.

- CMS should provide clarification on patient access standards when it comes to the inclusion of certain services such as telehealth visits and remote patient monitoring.

- APG has concerns regarding MLR rules being applied by health plan contracts for both risk-bearing organizations and IPAs.

- CMS should ensure that the proposed 18 measures in the quality rating system for managed care consider different state regulations and requirements for data exchange before the new measure set is fully implemented.

- Other differences among states' approaches to their managed Medicaid programs and the subsequent influence on quality scores must also be accounted for in any new mandated measure set.

- If the number of eligible patients for a measure becomes too small, it may make sense to exempt providers from that measure.

IV. **APG's Detailed Comments and Recommendations**

Enrollee Experience Surveys

CMS' proposed rule would require states to conduct an annual enrollee experience survey for each managed care program. Survey results would be included in the Managed Care Program Annual Report, and states would be required to post the report on their website within 30 calendar days of submitting it to CMS. States already collect CAHPS data for CHIP enrollees, and the proposed rule would require states to post comparative summary results of CAHPS surveys by managed care plans on state websites. Results would be updated annually, and states would be required to comply no later than the first managed care plan rating period three years after implementation.

Although APG member organizations favor implementing a standardized method of measuring and accounting for patient experience, they believe that using the CHIPS CAHPS experience survey results could present many issues pertaining to both selection bias and costs. The Medicaid program has historically experienced lower response rates for patient surveys. In addition, the experiences of specific patient populations with low literacy rates, or for whom English is a second language, are often inaccurately represented due to lower response rates (patient experience survey responses tend to be skewed toward English-speaking populations). The potentially mandatory use of CAHPS surveys for States and managed care plans that opt to incorporate them into their plans should take these factors into account.

APG member groups also believe that the costs of administering surveys for managed care plans serving diverse populations could be problematic. Plans will have to adopt the necessary tools and infrastructure to communicate with populations who may speak languages other than English, or who may not have access to technologies like broadband internet or smartphones. If plans do not communicate effectively, the care of these diverse populations could be compromised.

Appointment Wait Time Standards

CMS proposes requiring states to develop and enforce wait-time standards for routine appointments for outpatient mental health and substance use disorder; primary care; obstetrics and gynecology; and an

additional type of service to be determined by the state. CMS proposes to require 90 percent compliance with the 10- and 15-business-day maximum appointment wait time standards, creating parity with the standards set for Marketplace plans in plan year 2024. These provisions would only apply to routine services, not to those for complex conditions or to patient-specific protocols for urgent or emergency care.

APG questions the wisdom of adding a national set of standards on health plans when many have historically struggled to comply with state standards that currently exist, such as appointment wait-time standards for specialty care. Many of these health plans currently receive regular exemptions to access and time-and-distance standards, a fact that essentially makes standards ineffective or nonexistent. Additional national standards will add administrative burden without solving existing access problems.

APG further believes that CMS must consider the current staffing and capacity constraints that health care organizations are experiencing before implementing this proposal. A 2022 National Association of Community Health Centers (NACHC) survey found that 68 percent of community health centers have lost between five and twenty-five percent of their workforce. [1] The added strain of current staffing shortages, particularly in areas such as mental health, would only make it harder – if not impossible – for health care organizations to meet stringent wait time standards.

In San Diego County, California, for example, APG members that are Federally Qualified Health Centers currently struggle with inadequate staffing levels to treat patients with severe mental illness. The care of these patients is supposed to be a county responsibility, but in practice, the county often pushes the responsibility back to providers. The result is decreased availability of appointments and increased provider burnout.

In addition, as proposed, the new appointment wait-time standards set a common time frame for primary care visits without specifying any differences related to visit type. For instance, a wellness check visit would, on average, involve a longer wait time than a sick visit. Any new wait time standards should differentiate among visit types and recognize the varying amounts of administrative and clinical work that goes into each type of visit.

APG members provide patients the option of accessing various services, including specialty care, either in person or using telehealth. APG requests that CMS provide clarification of the extent to which visits provided by telehealth comply with any new appointment wait time standards.

Value-based Payment and Delivery System Reform Initiatives

The proposed rule establishes requirements for the use of population-based and condition-based payments in value-based payment (VBP) arrangements, in addition to existing performance-based payments. As proposed, performance-based payments could not be used for administrative tasks,

[1] The National Association of Community Health Centers. (2022, March). Current State of the Health Center Workforce. Pandemic Challenges and Policy Solutions to Strengthen the Workforce of the Future

including “pay for reporting” arrangements. Performance-based payments would have to include a baseline metric and use measurable performance targets relative to a baseline.

CMS’ proposal to not allow performance-based payments for administrative tasks, including “pay for reporting” arrangements, could present problems for provider organizations. For example, it is expensive to build and implement the systems needed to capture, track, report, and reconcile data needed for participation in value-based care arrangements. Health care organizations engaged in risk-based contracts that include the acceptance of downside risk should be able to use the quality payments earned by providing higher-quality care to patients at lower costs to defray some costs of building infrastructure to provide that same quality and cost control.

Medical Loss Ratio (MLR) Standards

CMS proposes to require states’ contracts with managed care plans to specify how provider bonus or incentive payment arrangements would be structured, and to include more specific documentation requirements.

Incentive payment contracts between managed care plans and network providers would have to include a defined performance period that can be tied to the applicable MLR reporting periods, and all incentive payment contracts would have to include well-defined quality improvement or performance metrics that the provider must meet to receive the incentive payment. Managed care plans would continue to have flexibility to determine the appropriate quality improvement or quantitative performance metrics to include in the incentive payment contracts, and contracts would have to specify a dollar amount that could be clearly linked to successful completion of these metrics, as well as a date of payment.

The proposed rule would also discontinue the annual update of the credibility factor that is applied to plans with fewer enrollees to adjust for the higher impact of claims variability on smaller plans. Finally, CMS proposes that Medicaid State Directed Payments and all associated revenue be separately identified in annual MLR reporting. CMS would require reporting of Medicaid managed care plan expenditures to providers that are directed by the state as well as revenue from the state to make these payments.

APG and its member organizations have concerns regarding how MLR rules are applied by health plan contracts. There is a lack of clarity and consistency among Medicaid managed care plans in how they expect medical and administrative expenses to be categorized for the purposes of MLR. This ambiguity requires APG member organizations to determine on their own the best practices regarding allowable expenses and just what should be counted as medical expenses. CMS should require clarification on the application of MLR standards to physician groups that contract with Medicaid managed care plans.

Mandatory Measure Set

The proposed rule would establish and modify a mandatory measure set for the Medicaid and CHIP Quality Rating System (MAC QRS). CMS has proposed 18 measures, many which overlap with other CMS programs and are commonly reported by states. Future updates to this initial mandatory measure set would be predicated on such factors as whether a given measure was meaningful and useful; aligned with other CMS rating programs; provided opportunity for plans to influence their performance; was based on

data that is available and feasible to report; demonstrated scientific acceptability; and that imposed burdens in excess of benefits of inclusion of the measure in the overall QRS framework.

Before implementing a mandatory measure set, APG recommends that CMS seek to account for differences in how states approach their managed Medicaid programs and the resulting influence on quality scores. For example, quality scores vary across states due to differing approaches to patient assignment versus attribution to a primary care provider. Patients must have two visits with providers to be attributed to a given provider for the purposes of quality measurement, whereas in other states, providers may be held responsible for the care of patients whom they have never seen or treated, and whom they are unable to locate or contact. These differences across states in the ways that patients are assigned or attributed to providers and plans must be accounted for before implementing any mandatory measures.

CMS should also ensure that the proposed 18 measures in the quality rating system take account of different state regulatory frameworks and requirements for data exchange. Consider the Oral Evaluation for Dental Services measure included in the 18 proposed measures by CMS. In some states, dental services are carved out for managed care – a fact that means that plans not responsible for dental services would lack the data necessary to conduct an oral evaluation. Some states such as New York have confidentiality clauses in contracts that forbid the exchange of any information pertaining to substance use disorder and HIV, which would affect the inclusion of both the proposed Initiation and Engagement of SUD Treatment and Follow-up After Hospitalization for Mental Illness (FUH) measures. CMS' accounting for these issues should be addressed before the new measurement system is fully implemented.

APG also points out that some of the proposed included measures apply to a minuscule number of patients by the time they reach the provider level, thus obviating any statistical relevancy with respect to quality scoring. If the number of eligible patients for a measure becomes too small, APG recommends that CMS consider exempting relevant providers from that measure to lessen the administrative burden on these organizations to not have to work to find such a small number of patients for analysis.

V. **Conclusion**

APG thanks CMS for the opportunity to provide comments on this proposed rule and appreciates CMS' efforts to improve the care of the nation's Medicaid beneficiaries. APG would welcome further opportunities to work with the agency as the proposed rule is finalized. If our organization can be of further assistance, please contact Garrett Eberhardt, Executive Director of Medicaid Policy, at geberhardt@apg.org.

Sincerely,

Susan Dentzer
President and CEO
America's Physician Groups