AMERICAN ACADEMY OF FAMILY PHYSICIANS

July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing 129,600 family physicians and medical students across the country, I write in response to the notice of proposed rulemaking, "Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" as published in the May 3, 2023 Federal Register.

More than seventy percent of beneficiaries receive most or all Medicaid and CHIP services through managed care plans. As CMS and other federal government entities have repeatedly acknowledged, beneficiaries continue to face serious problems obtaining the services they need in a timely manner and struggle to obtain crucial information about how to obtain services, the quality of those services, and the underlying causes for access issues. The AAFP appreciates CMS undergoing rulemaking to ensure that Medicaid enrollment translates into meaningful coverage and timely access to comprehensive care for beneficiaries.

The AAFP supports many of the provisions in this Proposed Rule and agree that these measures will advance the important goals of improving access to services, increasing transparency and monitoring of access, and improving quality reporting. Among several other recommendations detailed below, the AAFP strongly recommends CMS:

- **Implement regulations to protect in-network clinicians and physician practices and ensure they are held harmless in the implementation of new appointment wait time standards;**
- **Finalize the proposal to implement appointment wait time standards for routine primary care, behavioral health, and obstetric and gynecologic services that are aligned with standards for Marketplace plans alongside protections for in-network clinicians and practices;**
- **Finalize the proposal to require managed care plans to conduct payment analyses comparing Medicaid payment rates for primary care and other services to Medicare payment rates;**
- **Incorporate prior authorization requirements, claim denials, and other major sources of administrative burden in the provider payment analysis;**

1133 CONNECTICUT AVE., N.W., STE. 1100 | WASHINGTON, DC 20036-4305 | (800) 794-7481 | (202) 232-9033

- **Advance alignment of quality measurement requirements with measures used across other payers and federal programs.**

Access

Wait Time Standards

CMS is proposing to require that states develop and enforce wait time standards for routine appointments for adults and pediatric populations in outpatient mental health and substance use disorder (SUD) and primary care, obstetrics and gynecology (OB/GYN) in adult populations , and an additional type of service determined by the state in and evidence-based manner. CMS proposes maximum appointment wait time standards of 10 business days for routine outpatient mental health and SUD appointments and 15 business days for routine primary care and OB/GYN appointments, both of which are in alignment with new appointment wait time standards for Marketplace plans. CMS does not propose maximum wait times for the State-selected service or provider type. CMS proposes to defer to states on the definition of "routine." CMS proposes to defer to the states on whether and how to vary appointment wait time standards for the same provider type; for example, by adult versus pediatric, telehealth versus in-person, geography, service type, or other ways. CMS proposes to implement appointment wait time standards four years after this rule is finalized.

The AAFP strongly supports efforts to ensure timely access to health care for Medicaid beneficiaries and we agree that implementing minimum appointment wait time standards will help advance this goal. However, we are concerned that plans will hold primary care physicians accountable for meeting appointment wait time standards, as opposed to expanding their network or taking other appropriate action to comply with federal standards. Additional regulatory protections are needed to prevent managed care plans from passing appointment wait time requirements onto their in-network practices or otherwise penalizing or burdening practices as a result of these new standards. These actions could have the unintended consequence of worsening beneficiaries' access to care as physician practices are forced to see fewer Medicaid patients or opt out of the program altogether.

To protect physician practices caring for Medicaid beneficiaries and ensure managed care plans take appropriate actions to comply with wait time standards, **the AAFP recommends CMS require states to include a clause in managed care contracts holding physicians and practices harmless if their wait times are longer than the finalized standards for managed care plans**. **The onus for meeting wait time standards must be on the managed care plan. Thus, CMS should consider additional regulatory guardrails to ensure that managed care plans do not pass on wait time standards requirements to their in-network clinicians and practices by requiring them to schedule appointments within a certain timeframe, accept a certain number of Medicaid patients, or including other stipulations in contracts.** Primary care physicians are often a patient's first, and sometimes only, point of contact with the health care system. Unfortunately, their time with patients is increasingly being crowded out by a growing number of administrative tasks that place undue burden on primary care physicians and their teams. Requiring physicians to meet the needs of multiple plans' wait time standards without requiring a plan to expand its network would further burden physicians, could force them to reduce the amount of time they spend with

each patient, hinder their ability to provide whole-person care, and ultimately exacerbate already concerning access issues. Pushing these requirements onto clinicians could also cause them to stop accepting Medicaid beneficiaries, worsening timely access to care.

As long as the aforementioned protections are included in a final rule, the AAFP would support aligning the wait time standards and implementation timeline with Marketplace standards and implementation timeline to simplify compliance for states. We urge CMS to finalize the proposed 10- and 15- day maximum wait time standards. Medicaid beneficiaries should have equitable access to primary care and other essential services. Timely access to routine care is essential for meaningful health care coverage to translate into better health outcomes. Aligning wait time standards with those in the Marketplace advances this shared goal.

Family physicians report barriers and long wait times for patients seeking sub-specialty care. In many regions, these long wait times are particularly challenging for pediatric sub-specialty care. The AAFP urges CMS to consider adopting the 30-day appointment wait time standard for specialty care that was finalized for Marketplace plans in order to address these challenges.

The AAFP strongly supports CMS' proposal to count appointments offered only via telehealth toward compliance with appointment wait time standards if the clinician also offers in-person appointments. We noted in our comments on the Medicaid Access RFI that virtual-only care is not a replacement for in-person care and therefore should not count towards meeting access standards. Recent reports regarding the provision of virtual-only care raise concerns about negative impacts on patient safety and wellbeing, in addition to a lack of oversight. CMS notes that this proposal is consistent with Marketplace regulations that will go into effect in 2024. The AAFP appreciates the alignment with Marketplace standards and CMS recognizing the value of longitudinal primary care access for Medicaid beneficiaries. We also applaud CMS for proposing to separately monitor telehealth access and utilization, as recommended in our RFI comments.

As it relates to behavioral health care, the AAFP shares CMS' concern regarding the shortage of SUD and mental health professionals. Patients are increasingly turning to primary care physicians for behavioral health needs. While family physicians are trained to provide certain high-quality, whole-person behavioral health services, including SUD treatment, patients and physicians sometimes benefit from care coordination with other behavioral health professionals or more intensive, specialized care. The ongoing shortage of behavioral health professionals has made it difficult, and sometimes impossible, for family physicians to integrate behavioral health into their practice and to make referrals for patients requiring additional care. The AAFP also recognizes that telehealth visits are often uniquely suited for behavioral health care, and there is a robust evidence base supporting this modality, including audio-only and telehealth appointments for SUD treatment. **The AAFP supports the use of telehealth-only services specifically for mental health and SUD treatment when no other or too few in-person options are available in the area**.

Finally, the AAFP urges CMS not to delay the implementation of appointment wait time standards beyond the proposed four-year timeframe.

Secret Shopper Surveys

CMS proposes to require that States use independent entities to conduct annual secret shopper surveys of managed care plan compliance with appointment wait time standards and the accuracy of certain data in all managed care plans' electronic provider directories.

The AAFP is supportive of this proposal and agrees that accurate and transparent plan information is vital to ensuring Medicaid Managed Care populations have access to the care they need. However, the AAFP encourages CMS to clearly stipulate that any secret shopper surveys may not request information on reproductive health information, gender affirming care, or other highly sensitive care that may be used against a physician, practice, patient, or other entity by the state, locality, or other law enforcement agency. The AAFP provided detailed comments to the Office of Civil Rights on the protection of highly sensitive health information and encourages CMS to work with HHS and other entities to ensure any secret shopper requirements also protect patient and clinician privacy.

Provider Payment Analysis

CMS proposes to require a payment analysis that Medicaid and separate CHIP managed care plans would submit to states and states would review and include in the assurance and analysis to CMS required in regulation, noting that states are expected to take action to address deficiencies. The required analysis would require managed care plans to:

1. Identify all paid claims in the prior rating period for each service type.
2. Identify the appropriate CPT codes for evaluation and management visits for primary care, ob-gyn, mental health, and SUD services and aggregate the payment amounts for these service types.
3. Calculate the total amount that would be paid for the same codes on the claims at 100 percent of the published Medicare rate applicable on the date of service. Then divide the total amount paid by the managed care plan by the amount for the same claims at the Medicare rate.

FQHCs and RHCs would be excluded due to their unique payment systems. CMS proposes managed care and separate CHIP plans would report their analysis separately for adult and pediatric services to ensure sufficient detail. CMS also proposes to exclude payments for claims for the services for which the managed care plan is not the primary payer. CMS would require these analyses beginning no later than the first rating period that begins on or after two years after the effective date of the final rule. States would have to post the results of these analyses within thirty days of submission to CMS.

The AAFP enthusiastically supports this proposal and urges CMS to finalize it. As CMS notes in the preamble of the proposed rule, ample evidence indicates that Medicaid payment rates for primary care and other services are much lower than other payers. Medicaid payment is on average 66 percent of the Medicare rate for primary care services, but it can be as low as 33 percent in some states. As we detailed in our comments on the Medicaid Access RFI, evidence also demonstrates that lower payment rates translate to narrower networks and access challenges for beneficiaries. Given that Medicaid provides coverage to people who are low-income, disabled, and disproportionately living in rural and other medically underserved communities, improving Medicaid payment rates has the potential to mitigate access disparities and advance health equity. In recent testimony to the Senate Finance Committee, the AAFP's

Executive Vice President and Chief Executive Officer noted that inadequate Medicaid payments contribute to health care consolidation, which ultimately increases prices and worsens barriers to access for beneficiaries.

Managed care plans cover an increasing proportion of Medicaid beneficiaries across the nation, but the payment rates paid by managed care plans are largely unknown to the public. Improving transparency of these payments to primary care and other physicians would enable states, CMS, and other stakeholders to better understand factors impacting beneficiaries' access to care and help address challenges. In our comments on CMS' recent Medicaid Access RFI, the AAFP urged CMS to implement a national monitoring approach to assess the impact of Medicaid payment rates on access to care for beneficiaries. We encouraged CMS to pursue a strategy that would assess longstanding access challenges caused by low payment rates instead of relying on states to report rate changes. We believe the proposed payment analysis requirement is one important step in implementing such an approach.

The AAFP urges CMS to consider for future rulemaking how prospective, population-based payments can be included in these analyses. As we discussed in our RFI response and below, advancing prospective, population-based payments is one essential strategy for advancing equitable access to longitudinal, whole-person primary care. Prioritizing less administratively burdensome population-based payments that support primary care practices' ability to invest in team-based care is central to the AAFP Guiding Principles for Value-Based Payment. Physician-led team-based care is a proven strategy for effectively expanding access. Monitoring the impact of well-designed value-based payments on access to care will be important to evaluating success and scaling what works. We strongly recommend CMS pursue additional regulations, guidance and other mechanisms to increase the availability of value-based payment models designed specifically for primary care that are inclusive of and appropriate for Medicaid patients and their primary care physicians.

The AAFP greatly appreciates CMS noting that these payment analyses should be reviewed by states and leveraged to address access deficiencies. We strongly agree that states and managed care plans should leverage physician payment rates in order to bolster equitable access to care for Medicaid beneficiaries. We are encouraged by the approach CMS is taking to strengthen federal access standards, clarify requirements for states to monitor and address challenges, as well as clearly indicate that payment analyses and rate changes should be considered to address barriers to access. These proposals, coupled with those in the companion Medicaid Access rule that addresses fee-for-service coverage, will help shed light on inadequate Medicaid payment rates and advance state and federal action to improve them.

The AAFP recommends CMS incorporate prior authorization requirements, claim denials, and other major sources of administrative burden in this required analysis. Family physicians report and evidence confirms that contracting with Medicaid managed care plans is often quite burdensome for physician practices. A recent study estimates physicians lose 18 percent of Medicaid payments to billing problems, compared with 7 percent for Medicare and 4 percent for commercial payers. Since physician practices lose a significant portion of their already much lower Medicaid payments to billing issues, the researchers found many practices respond by refusing to accept Medicaid patients in states with greater billing hurdles. Addressing the disproportionate burden of billing Medicaid may improve physicians' willingness

to accept new Medicaid patients and in turn, can improve timely access and better care for Medicaid beneficiaries.

Reports indicate that managed care plans often do not respond to prior authorization requests in a timely manner. For example, California-based L.A. Care failed to address a backlog of more than 9,000 prior authorization requests and more than 67,000 complaints or appeals, including those from Medi-Cal. These unresolved requests led to negative impacts on patients, including delays in needed care, increased emergency department visits, and even death. Family physicians report that prior authorization requirements are a primary source of administrative overload, driving physician burnout, and ultimately harming patient care.

These administrative tasks and failures negatively impact physician practices' ability to accept more Medicaid patients and ultimately can worsen timely access to care for beneficiaries. Therefore, the AAFP strongly urges CMS to require additional reporting of these major pain points so they can be evaluated and addressed. CMS should direct states to address problematic administrative requirements or claim denial patterns in their contracting process with managed care plans, as well as develop guidance for how states should address access deficiencies arising from these administrative tasks and challenges.

While the AAFP strongly supported a recent proposed rule that would make prior authorizations less burdensome by requiring Medicaid and CHIP managed care plans to implement electronic prior authorization processes using an application programming interface, **we again urge CMS to take action to reduce the overall volume of prior authorization requirements across federal programs.**

Remedy Plans to Improve Access

We strongly support the proposal to require states to promptly submit a remedy plan when CMS identifies areas for improvement for access to services and requiring that the remedy plan identify specific steps and timelines to achieve the goals of the remedy plan. We again recommend that the administrative reports recommended above be included in the remedy plan requirement. This requirement would impose much-needed transparency and accountability to managed care rates. Combined with CMS's ability to disallow federal financial participation for payments made under managed care contracts when the state fails to ensure access to care, this would significantly advance the goal of ensuring that beneficiaries have access to the services they need. We also recommend that the remedy plans, once approved, be posted on the state's website and that the state agency be required to share them with the MAC and the BAG.

State Directed Payments

CMS proposes additional oversight and reporting for any payments to providers which states direct their contractors to make, known as State Directed Payments (SDPs). In its discussion of the NPRM, the agency references access challenges to primary care, maternal health and behavioral health and specifically encourages states to leverage SDPs to improve access to these services and include measures of such access in any evaluation plan.

The AAFP appreciates CMS encouraging states to use SDPs to improve access to comprehensive primary care, maternal health, and behavioral health for Medicaid beneficiaries.

We also appreciate the agency's efforts to adjust SDP regulations to better support population-based payment models. The AAFP advocates to increase value-based payment models that are inclusive of Medicaid clinicians and beneficiaries. We believe SDPs could be leveraged by states to provide prospective, population-based payments for primary care that are aligned with other payers, reflect an increased investment in primary care, and better support the provision of longitudinal, whole-person primary care. The AAFP notes that states should also put mechanisms in place to ensure these payments invest in and directly support the primary care practices providing care to patients. We strongly recommend CMS use its available authorities to encourage the use of value-based payments for primary care in Medicaid.

Medical Loss Ratio (MLR) Standards

MLRs are one tool that CMS and States can use to assess whether capitation rates are appropriately set by generally illustrating how capitation funds are spent on claims and quality improvement activities as compared to administrative expenses. CMS is concerned that managed care plans are paying provider bonuses and incentive payments that may not be explicitly tied to performance requirements or standards, and that managed care plans could be using these payments to avoid paying remittances. CMS proposes to institute new requirements for contracting and reporting of incentive payments and administrative costs to address these concerns.

The AAFP supports this proposal. We supported a similar proposal which was recently finalized for Marketplace plans. As we discussed above, the AAFP supports aligning regulations across Marketplace and Medicaid programs to advance equity for beneficiaries. The AAFP has long noted that MLR regulations should promote affordable access to high-quality coverage for beneficiaries over insurer profits. Our Principles for Value-based Payment support physicians sharing in the financial rewards that accrue from their performance, such as improving quality or reducing costs. These same incentives should be reflected in physician compensation and be prioritized relative to measures of productivity. We also concur that incentives and bonuses should be tied to specific metrics or standards. However, we note that the metrics or standards used in contracts for such incentives should be aligned with those used across plans and payers, such as the Core Quality Measure Collaborative set or CMS' Universal Foundation. Managing disparate measures and requirements across plans and lines of business is a significant source of administrative burden for family physicians. These disparate measure sets also undermine meaningful quality improvement and care delivery transformation. Therefore, the AAFP recommends CMS specify that managed care plans must demonstrate alignment in the metrics used for incentive payments or bonuses.

The AAFP supports CMS' proposal to prohibit the inclusion of overhead or indirect expenses that are not directly related to health care quality improvement activity (QIA) reporting. The AAFP agrees that including these types of activities in the MLR numerator could inappropriately inflate MLRs. The AAFP also agrees the change would provide States with more detailed QIA information to improve MLR reporting consistency, allow for better MLR data comparisons between the Marketplace and Medicaid and CHIP markets, and reduce administrative burden for managed care plans that participate in both Medicaid and CHIP and the Marketplace.

Quality Assessment and Performance Improvement Program, State Quality Strategies and External Quality Review

CMS is proposing that states increase public engagement with Medicaid managed care quality strategies by:

- Requiring states to make their quality strategy available for public comment at every three-year renewal, regardless of whether or not the state intends to make significant changes.
- State Medicaid agencies must post the results of their three-year review on their website.
- Requiring states, prior to finalizing a revised or renewed quality strategy as final, to submit a copy of the revised strategy to CMS at minimum every three years or when significant changes are made.

The AAFP supports the proposal for states to increase public engagement in their care quality strategies for Medicaid but urges CMS to implement accountability for states to respond to public comments. Feedback on large programs like Medicaid is imperative to quality improvement and should include a wide variety of stakeholders. However, as proposed, states are only required to make their quality strategy available for public comment but are not required to respond to or act upon the comments and feedback they receive. The AAFP encourages CMS to require states to publicly document the actions they took and/or revisions they made in response to the public feedback they received. This could be done when they post the results of their three-year review. When states choose not to act upon feedback, they should share their rationale.

The proposal to require states to submit a copy of their revised quality strategy to CMS at a minimum of every three years seems reasonable. However, it is important that state quality strategies align with and do not contradict the overall CMS National Quality Strategy. Alignment across CMS programs is imperative. As such, we encourage the Agency to continue to focus on aligning strategies broadly across programs and to condense and align performance measures across programs by further honing its Universal Foundation, further detailed below.

Quality Improvement—Quality Rating System

CMS is proposing to establish the Medicaid and CHIP Managed Care Quality Rating System (MAC QRS) website as a state's "one-stop-shop" where beneficiaries could access information about Medicaid and CHIP eligibility and managed care. **The AAFP supports the goal of this proposal and encourages CMS to make the information accessible to all populations, including those with limited English proficiency and those with disabilities.** We agree that, like Medicare and Marketplace beneficiaries, Medicaid enrollees should be able to compare plans and easily access useful information about the quality of care provided. The AAFP recommends that publicly reported measures are understandable, readily available when the public wants them, relevant to the service being sought, and address issues of importance to patients. Existing websites, like Care Compare and Medicare Plan Finder have demonstrated that developing and executing these one-stop-shop websites is both challenging, costly, and may not ultimately meet beneficiaries' needs. The proposed MAC QRS website should build upon lessons learned from other websites to better fulfill patients' needs. We note that the proposal to display quality ratings in percentage points for each measure may not be the most effective way to compare quality across plans.

CMS is also proposing to establish an initial set of mandatory measures for the QRS, which CMS would require states to publicly display quality ratings for. CMS also proposes a set of standards new measures must meet to gain inclusion on the MAC QRS list of measures.

We acknowledge the proposed initial set of measures for the QRS are intended to be health-plan level measures. The AAFP appreciates CMS's push to optimize health plan performance on measures of quality, and we share this goal. The set seems appropriate for health plans. However, we caution CMS to recognize that health plans often push these measures down upon individual clinicians in their network (even when some of the measures have not been tested, validated, and specified for use at the individual clinician level and/or may add undue administrative burden to clinicians). This is particularly challenging for primary care clinicians who often provide the high-quality care needed for plans to perform well on these measures, but the physicians do not share in the incentives of other benefits of their performance. The AAFP urges CMS to include regulations specifying that the onus of reporting these measures should fall on the plans and should not be pushed down to individual clinicians or physician practices.

When health plans force copious and burdensome measures onto their contracted physicians, this can lead to a decrease in the number of physicians willing to accept Medicaid. There are several challenges that contribute to quality measurement burden in Medicaid, including but not limited to the following:

- There is currently no alignment or standardization for the measures that are pushed down to physicians. This increases the burden on physicians who care for a higher percentage of Medicaid patients.
- Attribution is often inaccurate and problematic; primary care physicians are often "assigned" patients whom they have never seen by Medicaid plans.
- Measures are sometimes not stratified or risk adjusted to account for the medical and social complexity of beneficiaries. Stratification or risk adjustment must happen for measurement to be fair, accurate, and effective in reducing health disparities and in properly incentivizing health plans and their contracted physicians.
- Constant change in Medicaid enrollment leads to fluid denominators for the measures. Plans and physicians should only be measured on beneficiaries who have had a specified date range of continuous enrollment in the plan.

We appreciate CMS' efforts to better align quality measures across its programs using the Universal Foundation. We acknowledge several of the proposed measures are part of CMS's new Universal Foundation. There are a few measures included that are not part of the Universal Foundation that may be particularly relevant for Medicaid beneficiaries. However, measure alignment reduces the burden of reporting, better enables clinicians to implement care delivery innovations and improve quality, and it improves stakeholders ability to compare quality across different states, payers, and programs. The Core Quality Measures Collaborative (CQMC) offers core measure sets that have been heavily vetted and agreed upon by stakeholders across the industry. It is also important for Medicaid reporting requirements to keep pace with reporting requirements for Medicare and commercial plans. The AAFP urges CMS to limit quality measurement to those measures that are both meaningful and align with other CMS programs and payers. When measurement is strategic, streamlined, meaningful, and aligned, it can serve as a powerful tool to decrease health disparities.

The AAFP has long advocated and supported recent CMS action to reduce enrollment churn in Medicaid. In addition to improving continuous access to primary care and other essential services, lessening churn will allow for more accurate attribution and quality measurement. The AAFP further urges CMS to ensure the aligned quality measures selected for the QRS and other programs are properly risk stratified to account for medical and social complexity of beneficiaries. The AAFP's position paper on Quality Measurement notes performance measures used in value-based payment must be properly risk-adjusted, when appropriate, to account for factors such as demographics, comorbidities, patient behavior and preference, competing patient priorities, and social needs to level the playing field and avoid financially penalizing entities or health care professionals for factors outside their control. Measures can be risk-stratified and/or populations can be segmented so that complex patients can be included in measures but the data can be analyzed by subpopulations. Exceptions and exclusions can be added to measure specifications to account for patient behavior, values, and choices and to avoid penalizing clinicians for delivering care according to patient-centered goals.

The AAFP supports the proposed standards new measures must meet to gain inclusion on the MAC QRS and encourages CMS to review our Performance Measures Criteria policy for further refinement of the criteria. However, we urge CMS to include physicians and other clinicians in the inclusion criterion regarding data readily available or available without undue burden for states and plans.

Thank you for the opportunity to provide these comments and we look forward to continuing to work with your agency to improve care under Medicaid Managed Care plans. For additional questions, please contact Meredith Yinger, Senior Manager of Federal Policy, at myinger@aafp.org.

Sterling Ransone, Jr., MD, FAAFP
American Academy of Family Physicians, Board Chair