AMERICAN ACADEMY OF FAMILY PHYSICIANS

October 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244

Re: CMS-2440-P; Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing 127,600 family physicians and medical students across the country, I write to provide comments on the Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting proposed rule, as published in the August 22, 2022 version of the Federal Register.

Per requirements enacted in federal law, CMS proposes to require states and territories to annually report on the Child Core Set measures, certain adult behavioral health Core Set measures, and the Health Home Core Set. The AAFP supports the proposal to mandate annual reporting of these measures and has previously urged CMS to use Core Set data to enhance access monitoring and oversight. Requiring states to annually report performance on a standardized set of measures will improve Core Set data, enhance CMS' ability to conduct oversight, and enable comparisons across states. We are hopeful that these improvements will advance CMS' and the AAFP's shared goals of improving access to person-centered care and advancing health equity in Medicaid and CHIP.

The AAFP urges CMS to consider the impact of these proposals on the clinicians caring for Medicaid and CHIP beneficiaries and ensure the final regulations do not worsen their administrative workload. Previous experience indicates that state Medicaid agencies and managed care plans will pass on quality measure reporting requirements to participating clinicians. Family physicians continue to cite administrative burdens as their biggest challenge, with quality measure reporting being one major contributor. Mounting administrative requirements take time and resources away from patient care and drive clinician burnout.[i,ii] Alleviating these burdens are a key strategy to support community-based physician practices and ensuring timely access to care for beneficiaries.

CMS can meaningfully streamline administrative requirements by aligning quality measures across payers. On average, family medicine practices contract with about 10 different payers. Keeping track of and successfully reporting different measures for each of these payers creates confusion and additional reporting burden and can actually undermine meaningful practice improvements. We urge CMS to ensure the new standardized Core Sets align with measure sets used by other payers, both

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public and private. As stated in our Principles for Administrative Simplification, "all payers (Medicare, **Medicaid**, Veterans Administration, commercial insurers, ERISA plans, and any third-party administrator plan) should implement the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative (CQMC) to ensure parsimony, alignment, harmonization, and the avoidance of competing quality measures." Aligning measures across payers will also help to identify disparities in care quality (and, in some cases, utilization and access) across different payers, states, and lines of service. Greater alignment will also drive improvements in data collection automation, which will reduce reporting burden on family physicians and other clinicians. Primary care practices should not have to spend their limited resources tracking down data in order to provide what is required for a state Medicaid agency to report on the core measures. **The AAFP strongly urges CMS to align the Medicaid and CHIP Core Sets with the CQMC Core Measure Sets and to remove measures that have lost endorsement from the National Quality Forum (NQF).**

While measurement is important, it is even more important to ensure that the standardized measurement motivates or incentivizes positive change in health care delivery to improve outcomes. Measures should be more oriented to aspects of care that are important to patients, including a greater focus on outcomes measures and patient experience. These types of measures equip practices, states, payers, and federal policymakers with more actionable data that can be used to improve quality and invest in primary care.

The AAFP supports required reporting of adult behavioral health measures. The AAFP is a staunch supporter of improving access to behavioral health services, including by increasing the integration of behavioral health services into the primary care setting. However, practices face several challenges with fully integrating behavioral health care. The practices serving a high proportion of Medicaid beneficiaries often operate on thin financial margins and do not have the capital they need to hire behavioral health professionals or invest in tools and trainings to meet their patients' behavioral health needs. Existing fee-for-service payment systems do not sufficiently support behavioral health integration in the primary care setting. Further, primary care practices are generally not equipped to treat serious mental illness, and ongoing behavioral health workforce shortages make referrals to other mental health professionals difficult and often untimely. We are advocating for Congress to support behavioral health integration and address these workforce shortages but note that these barriers are likely to create challenges for states in reporting or demonstrating progress on the behavioral health access and outcomes. Thus, the AAFP supports the required reporting of behavioral health measures, but we emphasize that meaningful improvements in behavioral health outcomes will require additional investments from state and federal policymakers. Primary care practices should not be penalized by state Medicaid agencies, managed care plans, or other stakeholders for these systemic failures.

CMS proposes that the agency will provide annual guidance to Medicaid agencies to set attribution rules, requirements for stratifications across demographic characteristics and delivery types, and other issues. CMS recognizes a number of challenges to stratification and proposes a phased-in approach. States would be required to submit stratified data for 25 percent of the measures on each of the Core sets for which the guidance specifies stratification is required by the second year of annual reporting; 50 percent of measures for the third and fourth years; and 100 percent of measures beginning in the fifth year of reporting.

The AAFP supports the requirement for states to stratify certain measures by demographics, delivery types, and other characteristics to enable better care comparisons and identification

of health disparities. We've advocated for CMS to improve standardization of demographic, social needs, and other data that could be used in stratification. We recently urged CMS to assist states in improving race and ethnicity data collection among Medicaid beneficiaries, as well as require states to report certain data stratified by race, ethnicity, and other demographic factors, such as dual-eligibility status or primary language. The AAFP is pleased to see CMS taking significant steps to implement these recommendations and we believed the phased in approach is reasonable.

CMS notes that enhanced FMAP is available at 90 percent for the design, development, installation, or enhancement of mechanized claims processing and information retrieval systems, and 75 percent for operations of such systems in accordance with federal requirements. The AAFP appreciates CMS highlighting these supports for states.

Once annual Core Set reporting and stratification is underway, we encourage CMS to assist states in using these data to identify and address health disparities among their Medicaid and CHIP beneficiaries. CMS should require states to submit plans for mitigating persistent disparities and regularly report on their progress to close access and quality gaps for beneficiaries of color, those with limited English proficiency, LGBTQ+ beneficiaries, and other populations experiencing systemic barriers to care. We also recommend that CMS pursue strategies for supporting states in these efforts.

CMS proposes that certain measures would be reported by CMS on behalf of states. The annual reporting guidance would note which measures CMS will report and which measures states can elect to have CMS report. The AAFP supports this approach and appreciates CMS using available data to reduce the reporting burden on states.

CMS seeks comments on how best to phase-in reporting of health outcome and survey measures for Medicaid and CHIP and the frequency of reporting these measures. CMS proposes that CMS' annual guidance will identify measures that are optional for fiscal year 2024 and subsequent years. Further, when a new measure is added to the Core Sets, reporting may not be required immediately. The AAFP is generally supportive of this proposal, but **we again urge CMS to ensure the Core Sets are aligned with CMS' Meaningful Measures initiative and focus on aspects of health care that are important to patients. Health outcome and survey measures are typically more in-line with these goals than process measures.**

As CMS plans to phase-in survey measures, **we strongly urge the Agency to add the Person-Centered Primary Care Patient Reported Outcome Performance Measure (PCPCM PRO-PM) measure to the Adult and Child Core Sets.** The PCPCM PRO-PM is an 11-item patient-reported assessment of primary care from the patient's perspective that focuses on aspects including accessibility, continuity, comprehensiveness, coordination, advocacy, family and community context, and goal-oriented care. The measure moves beyond disease-specific measures and processes of care to assess aspects of primary care that are associated with better population health, lower costs, equity, and higher quality. The survey evaluates items that are valued by patients and physicians and are unique to primary care. Each of the 11 items included in the measure are immediately actionable and enable practices to address challenges and gaps patients report. The data collected through the PCPCM PRO-PM would also enhance the patient experience data collected by CMS, states, and other stakeholders and could help identify barriers to primary care access.

This measure was validated in both the adult and pediatric settings and is appropriate for measuring patient experience for both children and adults. The PCPCM PRO-PM received endorsement from the National Quality Forum (NQF) in 2021. Starting in 2022, it was available as a quality measure in the Merit-based Incentive Payment System (MIPS) and included in the family medicine and internal medicine measure sets. The AAFP is engaged in efforts with our partners to add this measure to the CQMC Core Set. The AAFP is a strong supporter of the measure, and we recommend CMS include it in the Medicaid Adult and Child Core sets.

Thank you for the opportunity to provide comments on the proposed rule. The AAFP looks forward to working with CMS to improve equitable access to high-quality primary care in Medicaid and CHIP. Should you have any questions, please contact Meredith Yinger, Manager, Regulatory Affairs at myinger@aafp.org or (202) 235-5126.

Sincerely,

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Board Chair, American Academy of Family Physicians

[i] Sinsky C, et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Annals of Internal Medicine. 2016. Available at: https://www.acpjournals.org/doi/10.7326/M16-0961?articleid=2546704

[ii] Reith TP. Burnout in United States Healthcare Professionals: A Narrative Review. Cureus. 2018 Dec 4;10(12):e3681. doi: 10.7759/cureus.3681. PMID: 30761233; PMCID: PMC6367114.