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July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments in response to the Centers for Medicare & Medicaid Services (CMS) Proposed Rule on Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality [CMS-2439-P].

The AMA believes that health care is a basic human right and providing health care services is an ethical obligation of a civil society. Advancing health equity and access are major priorities of the AMA because it is both the right thing to do and fiscally sound policy because we know that access to health coverage improves population health, reducing downstream costs. We remain committed to advocating for expanded health insurance coverage for all and amplifying the voices of individuals from historically marginalized and minoritized communities regardless of whether a person is covered by Medicaid fee-for-service (FFS), a managed care plan, or a Medicaid waiver or demonstration program.

The AMA applauds CMS for taking these long awaited and important steps through these regulations to modernize and strengthen the Medicaid managed care program by aligning its rules and requirements with other major sources of coverage, such as qualified health plans (QHPs) operating in the Marketplaces and Medicare Advantage (MA) plans. The AMA generally supports alignment of rules across public and private plans to reduce administrative burden, improve patient care, and promote greater accountability. Taken together, we are hopeful the proposals in this rule will help to address current gaps and improve quality of care, outcomes, and access for Medicaid beneficiaries regardless of what type of plan they are enrolled in. We also welcome the complementary policies advanced in CMS' accompanying Medicaid access rule, which we have commented on separately here.

We appreciate that CMS recognizes in the rule the unique challenges that state Medicaid agencies are facing at this moment in time, including resuming enrollment verifications following the expiration of the continuous enrollment provision on March 31, 2023. We appreciate that many of the proposed policies have a multi-year implementation plan to allow states time to adapt to changes. In the comments that follow, we include several items for consideration and constructive recommendations intended to further mitigate potential adverse consequences or otherwise improve the effectiveness of the proposals informed by the collective knowledge of the nation's physicians with expertise in treating these patient populations.

Below we summarize a handful of key recommendations, which we expand on in the letter.

- We strongly urge CMS to require wait time standards and pricing transparency provisions for specialty services in addition to primary care and other types of services and to implement protections to prevent managed care plans from failing to expand their networks or to improve rates by passing the burden of compliance and potential penalties onto practices.
- CMS should work toward establishing a Medicaid payment floor at a minimum of 100 percent of Medicare rates.
- The AMA supports proposed changes to minimum medical loss ratio (MLR) requirements for Medicaid managed care plans to improve accuracy and strengthen their value.
- The AMA supports creating a Quality Rating System (QRS) for Medicaid managed care plans and making this information available to the public. We encourage CMS to make every effort to mitigate downstream burden on safety net practices and to ensure data is clinically relevant, actionable, and statistically valid.
- The AMA strongly supports requiring external quality review technical reports to include outcomes data, stratified performance data, and network adequacy validation. We recommend average wait times, service denial rates, prior authorization data, and provider selection standards also be included and made available to the public.
- The AMA supports independent secret shopper surveys and annual enrollee experience surveys as oversight mechanisms to verify the accuracy of provider directories, compliance with new federal wait time standards, and patient satisfaction and recommend they be extended to CHIP plans. In particular, we support including data pertaining to how many in-network providers are accepting new patients for a particular service.

I. National Appointment Wait Time Standards

The AMA strongly supports CMS' response to previous AMA calls **to implement new national maximum appointment wait time standards for certain core services,** which represents a significant step in helping to ensure sufficient Medicaid beneficiary access to these critical health care services. Wait times and other quantitative standards are critical to determining if a network can adequately serve the needs of its enrollees. Oftentimes, a network provider may be conveniently located but not be accepting new patients or have appointments available in the timeframe needed and wait time requirements would help address this problem.

The AMA supports including primary care (adult and pediatric), obstetrics and gynecology, outpatient mental health and substance use disorder (adult and pediatric) services, because we agree they are of critical importance to overall beneficiary health and can serve as connectors to other services. We further support the proposal that states also include at least one additional service type taking into consideration the unique needs of their specific programs and populations. **We strongly encourage CMS to expand on the number of additional services states track in the future, and to include specialty services and inpatient services in national wait time standards,** particularly those frequently in high demand and in short supply for Medicaid beneficiaries, including but not limited to cardiology and endocrinology. Access to specialty care is a perennial issue faced by Medicaid beneficiaries that is often worse in rural areas. Medicaid patients often have more complex health needs than other populations and effective disease management by specialists can be extremely important to improving care outcomes, so we highly encourage specialty services be included as well in order to improve Medicaid beneficiary access to these critical, potentially lifesaving services. We understand CMS is considering adding inpatient services pending additional information, and we urge the agency to finalize adding these services as soon as possible. We note that inpatient settings can be a critical way for rural beneficiaries to access care, so excluding them could exacerbate existing disparities faced by rural communities.

The AMA appreciates CMS recognizing the importance of leveraging telehealth to improve patient access and help meet proposed wait time standards while putting certain parameters in place to ensure patients have sufficient access to in-person services by requiring that providers who do offer telehealth services must have the ability to render in-person services in order to satisfy wait time standards. We believe determinations concerning when telehealth versus an in-person service is most appropriate should be left to the discretion of individual physicians and their patients, as opposed to states, and encourage monitoring changes in telehealth usage and outcomes after these new wait time standards are implemented.

The AMA strongly recommends CMS implement protections to prevent managed care plans from failing to expand their networks or improve rates by passing compliance pressures and potential penalties onto safety net practices. We are concerned that without these critical protections, plans may include clauses in their contracts that would simply penalize a plan's existing in-network providers for failing to accommodate increased patient loads without the plans taking any actions to make payments more sustainable or expand networks. As a result, instead of achieving its intended effect to expand networks and access for Medicaid beneficiaries, this policy would instead achieve the opposite effect by penalizing physician practices already treating Medicaid and other safety net populations.

We strongly recommend CMS require that wait time data evaluations be disaggregated by key social, demographic, and geographic variables to identify and address any access discrepancies for specific subpopulations and direct states and plans to compile this information from alternative data sources whenever possible to minimize additional reporting burden on physician practices. We further recommend that average wait time data be made available to the public.

The AMA generally supports requiring states to submit remedy plans with specific steps, timeframes, and responsible parties to achieve improvement if they fall short of wait time expectations. As part of these remedy plans, we recommend requiring plans to include data on denial rates, prior authorization requests, and other sources of administrative burden, which, in addition to payment rates, is another top reason physicians cite for not participating in plans. At the same time, we recommend remedy plans not be unduly burdensome to the point they would pull state Medicaid agency resources from other important tasks, including executing these plans.

Regarding definitional requirements, the AMA feels that a consistent federal minimum standard for routine appointments would help to ensure that a minimum standard is consistent across states, while allowing states to set additional standards above this floor. We similarly urge a consistent federal standard for which provider types would qualify.

II. Payment Rate Provisions

The AMA commends CMS for recognizing the important impact payment rates have on access to care. Because Medicaid accounts for an increasingly large portion of state budgets, states often cut physician rates for purely budgetary reasons and without consideration for the impact payment rates have on beneficiaries' ability to obtain health care services. Yet in enacting the equal access provision in section 1902(a)(30)(A) of the Social Security Act, Congress recognized that, "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program." Despite the Congressional mandate, Medicaid reimbursement rates commonly lag far behind private insurance and Medicare, participating Medicaid physicians remain sparse in many areas of the country, and access to health care services remains unequal. As managed care plans continue to take up an increasing market share, it becomes increasingly important to include them in price transparency proposals.

While physicians have a strong sense of responsibility to provide care for Medicaid beneficiaries, physician practices cannot afford to keep their doors open and continue to serve their communities if they consistently do not make enough on the care they provide to keep up with the rising costs of running a medical practice. Unfortunately, this means low Medicaid payment rates often limit the number of Medicaid beneficiaries that practices are able to accept and remain financially viable. Without an adequate supply of participating physician practices, Medicaid patients may have coverage but not real access to care in many areas of the country. Too often, beneficiaries must wait for unreasonable periods of time to receive needed care, travel long distances to find Medicaid participating physicians, or go without care altogether. Lack of access to participating physician practices can put beneficiaries at risk of harm or even death and is contrary to the intent of Congress and the overriding purpose of the Medicaid Act.

For these reasons, the AMA has previously called on CMS to strengthen transparency of Medicaid payment rates. We know that payment rate transparency is an important step in the direction of improving payments and therefore access. **Accordingly, the AMA supports CMS' proposal to require a payment analysis including total payment amounts and a comparison of Medicaid managed care rates to Medicare payment rates for primary care, obstetrics and gynecology, and outpatient mental health and substance use disorder services (with a further**

breakdown between adult/pediatric; specialty type; and geographic region if rates vary), as well as payment rates for home and community-based services relative to the state's payment rates for other services. The AMA agrees that the proposed service categories are important to include because they are of critical importance to overall beneficiary health and can serve as connectors to other care services.

However, **we believe that the payment transparency provisions should be broader. First, it is equally important that physician specialty services be included in the payment analyses,** particularly those that are often in high demand and short supply for Medicaid beneficiaries such as endocrinology, nephrology, and cardiology services**.** Medicaid patients often experience more complex health needs than other populations, yet access to specialty care is a perennial challenge faced by Medicaid beneficiaries, with specialists commonly citing inadequate payment rates as a primary reason for accepting fewer Medicaid patients. We also urge payment transparency for all covered services rather than only evaluation and management current procedural terminology codes, which would align with the proposed requirements that states publish all Medicaid FFS payment rates.

While the payment transparency provisions in the proposed rule make important progress towards identifying and addressing access problems resulting from inadequate payment rates, transparency alone is insufficient to ensure state accountability and, ultimately sufficient access to quality services for Medicaid beneficiaries. We continue to urge CMS to require a Medicaid payment floor at a minimum of 100 percent of Medicare rates for all Medicaid delivery systems, including FFS and managed care.

III. Medical Loss Ratio (MLR) Requirements

The AMA generally supports proposed changes to minimum medical loss ratio (MLR) requirements for Medicaid managed care plans, which will improve their accuracy and strengthen their value. It is critically important that an MLR calculation reflect the true value of services delivered and that methodologies are designed to incentivize increased value, as opposed to gamesmanship, so that they best serve Medicaid beneficiaries and the integrity of limited Medicaid program dollars. Specifically, the AMA supports CMS proposals to tighten requirements to ensure provider incentive payments are being directed to providers for true performance improvement, exclude overhead or indirect plan expenses not directly tied to quality improvement from MLR calculations, and require managed care plans to more fully describe why certain costs that apply across multiple lines of business were allocated to an MCO's Medicaid plan. The AMA additionally supports requiring states to report MLR data both in the aggregate for the state, as well as for each individual plan. These policies will result in more accurate MLR calculations to improve the value of managed care plans for Medicaid beneficiaries, better align with standards for ACA QHPs, and improve transparency of MLR data, all of which better protect Medicaid beneficiaries and their access to and quality of care.

IV. Medicaid Managed Care Quality Rating System (QRS)

Overall, the AMA supports CMS' proposal to establish a QRS for Medicaid managed care plans. Having a baseline of consistent, transparent metrics of quality of care and outcomes across plans and states could help to facilitate cross comparisons about performance and provide critical insights about the value that individual plans offer. The AMA also appreciates that CMS would give states flexibility to add additional measures or design their own rating framework, pending CMS approval. We think states should be further incentivized in some way to continue to develop new, innovative measures. CMS could also act as a conduit to share measures across states to promote collaboration so that multiple states can report new measures, which could serve as a natural experiment and onramp for possible future inclusion in the national data set.

At the same time, we recognize that many of these measures target clinical data, which would ultimately fall on physicians and facilities to report, thereby increasing burden on safety net practices. The AMA has repeatedly highlighted to CMS in our Medicare Advantage comments that health plan ratings should focus more on compliance and communication, as opposed to measures that rely solely on physician action. For example, plans are now requiring practices to submit data on all patient lab results and tests which plans attribute to meeting Healthcare Effectiveness Data and Information Set (HEDIS) requirements. Many of the proposed measures have more to do with physician quality than assessment of a health plan. Accordingly, we are concerned if CMS moves forward with

the mandatory Medicaid managed care measures as proposed, plans will institute similar policies that eventually pass this burden onto practices.

Practices already spend a great deal of time and resources complying with existing federal quality reporting programs. Safety net practices typically operate with fewer staffing and other resources due to their thin operating margins, so any additional reporting burden would represent a more pronounced drain of resources that could be allocated to direct patient care. Accordingly, we support CMS' intent to align measures and rating methodologies with MA, Part D, QHP, and other CMS quality programs when possible in an attempt to minimize burden. We also encourage CMS to continuously evaluate reporting burdens on safety net practices and to be responsive to feedback from physicians and other interested parties, particularly as it considers adding additional measures to the program in the future.

In addition, while we appreciate the range of types of services included in the proposed measures set, including behavioral health services, we worry that these measures simply will not be applicable to many plans who opt not to cover these services. We encourage CMS to take steps to ensure a reasonable proportion of plans are providing sufficient coverage of these critical services in the first place, and that this access is not encumbered by burdensome approval processes. We routinely hear from practices that managed care plans often do not adequately cover a complete range of behavioral health services and providers (e.g. evidence-based treatment for opioid use disorder (OUD) and other substance use disorders), or else they attach extremely burdensome and lengthy prior authorization requirements which can make it nearly impossible for patients to obtain care in a timely manner, ultimately impacting clinical effectiveness and outcomes. Some of the services that are most frequently omitted from coverage entirely or subject to burdensome approval processes include in-office buprenorphine for treating OUD and Opioid Treatment Programs, despite the proven positive effects both have on patient outcomes.

We appreciate that statistical reliability is one of the criteria for measures to remain in the program. The AMA has repeatedly recommended CMS set a transparent, robust reliability standard of no less than 0.75, which is generally the minimum standard for high statistical validity. We have repeatedly expressed that CMS' statistical validity minimums for other quality programs are much too low and undermine the integrity of the data.

The AMA supports stratifying certain measures by key demographic factors in the interest of advancing health equity and increasing beneficiary trust in the ratings, and we support CMS' proposed two-phased approach which would first require stratification by dual eligibility status, race and ethnicity, and sex while allowing states more time to incorporate additional demographic factors. We encourage payers and states to gather this information from community and other public data sets whenever possible in order to minimize the burden of additional data collection on safety net practices.

V. Public Facing Website

The AMA supports CMS' proposal to post quality ratings on state websites to help beneficiaries compare plans. We also support adding domain groupings such as behavioral health, and chronic conditions in the future to make it easier for beneficiaries to quickly evaluate differences across key service lines of particular relevance or importance to them.

We appreciate that this quality rating information would be supplemented with important information about plans to enable fully informed evaluations and comparisons, including premium and cost sharing information, eligibility criteria, covered benefits, access metrics, provider directories, drug coverage information, whether the plan offers an integrated Medicare-Medicaid plan or integrated MA D-SNP plan, and any grievances filed against the plan. Additionally, we agree that including plain language descriptions of each measure and how their data will be used will enhance beneficiary understanding, confidence, and trust in the data. We also appreciate that states would be required to provide beneficiaries with hands-on assistance to navigate the website and understand the measures.

We commend CMS for its efforts to prototype test with Medicaid beneficiaries to refine a user-friendly design that presents quality ratings in a way that maximizes beneficiaries' abilities to quickly filter, understand, and compare information across plans. We support proposals that provider directories include availability of telehealth services

and a search function. We support CMS' proposed two-phased implementation where states would have additional time to build up their websites to incorporate more technology-intensive interactive features and host centralized information directly on their own webpages. We appreciate proposed requirements that websites be easily navigable, use clearly defined terms and display information in such a way that promotes understanding by individuals with varied health care literacy and comprehension levels, and that states verify the functionality of sites at least quarterly. We also appreciate CMS acknowledging existing requirements that states must make reasonable accommodations to ensure managed care websites are accessible to all beneficiaries, including those with disabilities, language barriers, and other accessibility barriers.

Finally, the AMA supports CMS' proposal to engage website users including beneficiaries and their caregivers as part of a continuous improvement approach to ensure that websites continue to be useful tools and we welcome additional details as to what this process will look like.

VI. Monitoring & Enforcement

The AMA supports requiring external quality review technical reports to include data on outcomes, stratified performance, and network adequacy. The AMA recommends that managed care entities be further required to include service denial rates, prior authorization data, provider selection standards, and other information that may contribute to inadequate networks, and to make this data available to the public. We suggest requiring state regulators to actively approve networks submitted by managed care entities, rather than reviewing them on an as-needed basis.

The AMA supports independent secret shopper surveys and annual enrollee experience surveys as oversight mechanisms to verify the accuracy of provider directories, compliance with new federal wait time standards, and patient satisfaction. We recommend that audits be required more frequently for plans with identified deficiencies. The AMA has long called attention to the lack of accuracy of provider directories, and we were very pleased to see CMS specifically acknowledge in the rule that too often, a fraction of the providers listed as in network are actually accepting new patients, making networks appear more robust than they are in reality. While we appreciate CMS' desire not to impose additional burden on CHIP plans, which often serve smaller beneficiary populations, we do believe that monitoring network adequacy for CHIP plans is equally important and would encourage CMS to require this type of independent monitoring for CHIP plans in addition to Medicaid plans. Consistent with our recommendations to include specialists in rate comparisons, we strongly encourage CMS to require directory screenings to include information pertaining to availability of specialty services.

Regarding Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data being included in annual reviews, we agree that some of the data in these reports can be extremely valuable. However, these surveys do not comprehensively address the full spectrum of the patient experience, particularly when it comes to prospective patients seeking out care. This perspective is especially important to Medicaid populations that disproportionately experience barriers to care. We encourage CMS to work with national quality organizations and industry voices to further update and improve the actionability and comprehensiveness of the CAHPS survey with the Medicaid-specific audience in mind.

We support not requiring states and managed care plans to issue mandatory provider surveys, as it would add additional burden to safety net providers. However, we would encourage developing provider surveys and making them available on an optional basis for providers to provide feedback. Finally, we support requiring independent entities to conduct the shopping surveys in the interest of producing unbiased results.

We support the proposal to no longer subject primary care case managers to external quality reviews based on the reasoning that it would remove barriers to establishing these types of high-value arrangements, particularly for smaller contracts with individual practices or providers, which can be critical to expanding access to case managers in underserved areas.

VII. Services In Lieu of Service and Setting (ILOS)

The AMA generally supports ILOS, which can be innovative tools to help address unmet needs of enrollees, improve population health, address social determinants of health, and advance health equity. We also understand the importance of ensuring they are being used to best serve Medicaid beneficiaries, so we would support reasonable oversight parameters on managed care plans to improve the accuracy of the way ILOS services are reported and reflected towards total capitation rates. For example, we are supportive of proposals to ensure ILOS are accurately reflected in capitation rate calculations, ensuring ILOS data is included in annual performance reports and made available to the public, and that ILOS are evaluated for their impact on trends in utilization of covered services, as well as whether ILOS are positively improving access for underserved populations and advancing health equity efforts, or perhaps widening current gaps in access or outcomes. We agree that ILOS services be evaluated on a code-by-code basis to promote transparency and support states working towards developing CPT® and HCPCS codes through the CPT Editorial Panel and Relative Value Scale Update Committee (RUC) process. We further strongly support proposed patient protections, such as requiring prompt patient notification if an ILOS is terminated.

The AMA agrees that determinations of medical appropriateness of ILOS services for individual enrollees should be completed by a licensed provider using their professional judgment. However, we believe strongly that such judgments should be completed by the patient's own physician with specific knowledge of their current and past medical treatment and preferences, as opposed to a generic licensed network or managed care plan staff provider as proposed, particularly since CMS providers would need to document the determination of medical appropriateness within the enrollee's medical records and urge CMS to make this clear in the final rule.

The AMA supports the proposed exception to the requirement that ILOS services and settings are generally consistent with Medicaid coverage for short term stays for inpatient mental health or substance use disorder treatment, which will expand access to these critical services.

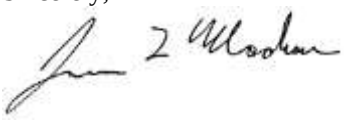
VIII. CHIP Alignment

The AMA generally supports CMS' proposals to make all policies generally applicable to CHIP plans except where provisions are not relevant, which both helps to ensure equal protections for CHIP recipients as well as promote consistency between federal programs to reduce burden on states and providers.

IX. In Conclusion

Thank you for this opportunity to comment on these impactful proposals that collectively stand to strengthen the viability, accessibility, and quality of health care services for millions of Medicaid beneficiaries. Please contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409 with any questions.

Sincerely,



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