AAAHC

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

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Re: CMS Request for Information: Access to Coverage and Care in Medicaid and CHIP

RFI Objective 3: Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary's needs as a whole person.

CMS is seeking feedback on how to establish minimum standards or federal "floors" for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or "floors' would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices.

1. What would be the most important areas to focus on if CMS **develops minimum standards** for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the **state level**, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?

AAAHC supports CMS in its oversight responsibilities, including ensuring that Medicaid and CHIP enrollees have a sufficient network of providers to allow for timely access to care. We also appreciate recent agency efforts to maintain consistency across the CMS programs by aligning program network adequacy standards to the greatest extent possible while also ensuring that the unique needs of differing program populations are met.

Burden Impact

AAAHC urges CMS to remain mindful that any new data reporting requirements add additional burden and cost on health plans through additional operational tactics including system configurations, structured data capture, provider trainings and manual updates, contract updates, development of member information resources, and increased grievances and complaints handling. AAAHC Health Plan accreditation already requires all accredited health plans to analyze whether enrollees are harmed by access, availability, or equity matters and to then mitigate and correct those impairments once identified. AAAHC reminds CMS of the many existing data sources it already utilizes that could capture the desired data with no or minimal burden.

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Standardization Addresses Inconsistencies in Requirements for Medicaid Health Plans

AAAHC is concerned that both the lack of an accrediting requirement from CMS, as well as a lack of CMS-developed equity standards for Medicaid and CHIP health plans creates a gap in quality standards amongst health plans that serve the Medicaid population. Some states mandate health plan accreditation in their Medicaid programs, but in some of those states only one accreditation organization is allowed, in contrast to most other CMS and state programs that allow for accreditation organization deemed status, and also in contrast to President Biden's Executive Order 14039: Promoting Competition in the American Economy (86 FR 36987) that calls on government agencies to exercise their regulatory authority in a manner that maintains a fair, open, and competitive marketplace without excessive market concentration to create better choices, service, and prices, as well as provide the space for innovation and the pursuit of new ideas.

AAAHC recommends that CMS consider requiring Medicaid health plan accreditation in the same or similar manner as it does for Qualified Health Plans under 45 CFR 156.275 and Medicare Advantage plans under 42 CFR 422.156, to ensure that health plans are provided the opportunity to choose the accreditation organization that is the best fit and to promote competition in the accreditation marketplace. Most importantly, accreditation organization standards often exceed the baseline standards required by regulatory agencies, and accreditation organizations can support Medicaid in its oversight responsibilities through the accreditation organization commitment to regular updates to standards, thereby removing some burden from government operations. Requiring state Medicaid programs to allow all accreditation organizations a reasonable time to meet or exceed the new and existing Standards for qualification as an approved accreditation organization for Medicaid health plans can provide a fair, equitable, and standardized process for recognition of accreditation organizations.

Regarding health equity, the AAAHC health plan accreditation program already incorporates standards that address equity and that are comparable to those of other accreditation organization programs that are specific to health equity. As such, the AAAHC further recommends that CMS develop baseline Medicaid health equity standards for health plans through which accreditation organizations can demonstrate that standards meet or exceed the baseline through an accreditation requirement as noted above.

We are particularly concerned that in some instances, when determining accreditation requirements, state agencies may rely upon seemingly biased reports that are drafted to favor a single accreditation organization. Examples of this can be found in the Health Management Associates reports, *National Accreditation Bodies and Fit for Covered California*, viewable at https://hbex.coveredca.com/stakeholders/plan-management/library/National-Accreditation-Bodies-and-Fit-CCA.pdf and *NCQA Distinction in Multicultural Health Care: Assessment of the Benefits and Recommendation to Require that Issuers Achieve this Distinction*, viewable at https://www.healthmanagement.com/wp-content/uploads/Distinction-in-Multicultural-Health-Report-Accreditation-Report-2_HMA-finalized-082820.pdf. Since AAAHC was not provided the opportunity for meaningful discussion of our programs in the development of these reports, we urge CMS not to consider the content of these reports and instead engage with AAAHC as CMS moves forward with considering opportunities for improvement in its programs.

Network Adequacy Standards Address Potential Inequities

When analyzing network adequacy, AAAHC urges CMS to consider the frequency and logistics behind updating geographic designations and how large counties that incorporate both rural and metro areas will fit into the analysis. Furthermore, using both "time and distance" and "appointment wait time" measures as proposed in the CY2023 QHP rulemaking, CMS-9911-P (RIN 0938-AU65), makes determination of compliance more complex. The AAAHC suggests that quantitative network adequacy Standards are best treated as minimal thresholds.

The AAAHC recognizes that different regions, population classifications, and enrollees will have varying expectations for network adequacy. As an accreditation organization, AAAHC believes that standards for network adequacy must exist and health plans should ensure their provider network does not create or foster inequity. AAAHC Standards address inequities with requirements that beneficiaries are provided with up-to-date, easy-to-access, easy-to-interpret network information from health plans both before and throughout their enrollment, and AAAHC suggests that CMS might move forward in the goal for health equity through the implementation of similar health plan requirements instead of setting federal quantitative network adequacy standards.

The AAAHC urges CMS to consider the multitude of differences in network requirements across the states. For example, state populations utilize various specialists and provider types at different rates. Similarly, each state has differing access to resources for community services and supports that address at-risk patients and provide whole-person care. Since populations, needs, and resources vary significantly by state and the states themselves are in the best position to fully understand and address these nuances and variations, AAAHC suggests the strongest option might be for CMS to look directly to the states to determine what is best or most beneficial for state network adequacy requirements, as evidenced by their local referral and access patterns, thereby developing these "floors" at the state level.

As an additional alternative, CMS might consider the use of CAHPS surveys to set these "floors" for different states or regions. Although subjective, the CAHPS survey covers patient satisfaction across a broad scope and states, or health plans, could be required to meet a minimum CAHPS satisfaction threshold of 'x%', for example, based directly upon the data applicable to their populations.

1. How could CMS **monitor states' performance against those minimum standards**? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?

Reducing Burden through Telehealth Incentives

The AAAHC encourages CMS to focus on burden reduction and varied resource provider availability and especially to the difficulties caused by "the great resignation" within the healthcare industry. Encouraging telehealth through increased funding and provider requirements may be an option that could be implemented similarly to the incentives CMS offered when encouraging providers to convert to electronic health records under the Medicare and Medicaid EHR Incentive Programs (75 FR 44313), now known as the Promoting Interoperability Program. Instead of minimum wait time standards, CMS could consider requiring Medicaid providers to maintain some level of telehealth availability as an option for Medicaid patients. Even if a requirement of 'x' number of hours is implemented, the additional cost to providers would be minimal since most providers already have telehealth capabilities. Patient satisfaction would likely increase with the addition of dedicated telehealth services and hours for Medicaid patients.

Wait-Time Standards are too Prescriptive/ Suggestions for Alternative Areas of Focus

AAAHC does not support the implementation of prescriptive wait time Standards due to lack of health plan control and the excessive variation that occurs (i.e., patient volume changes by season, lack of patient response resulting in increased wait time at no fault of the provider, etc.). As an accreditation organization, AAAHC supports trusting health plans to implement network adequacy policies that best fit their organization and network population, as opposed to requiring peremptory wait time Standards that lie outside the direct control of a health plan and which are not capable of actual calculation. If wait time standards are implemented, we urge CMS to consider the following:

- "Appointment wait times" measurements may be based on optimal, midrange, or minimally acceptable measures;
- Wait times may be analyzed as an average per provider type and over a predetermined length of time;
- Wait time data will require a validation process;
- The additional burden of collecting, maintaining, and providing this data for analysis and by whom this burden will be shouldered;
- Variations in wait times throughout the year (i.e., PHE, flu season, etc.) may affect data analysis; and
- The effect on the analysis where a provider or provider type meets wait time requirements but falls short of time and distance requirements or meets time and distance requirements but falls short of wait time requirements.

There are many areas throughout the nation where patients must drive an hour or more to receive the care they require. Thus, instead of focusing on wait time measurements, AAAHC Health Plan Standards focus on access to care. When the Affordable Care Act was passed, hospitals closed resulting in the consequential relocation of their referring providers. AAAHC Standards require that health plans have a geographic access plan, a network development plan, and a plan for monitoring access to care policies and expectations and addressing any deficiencies that are found to exist. As an alternative to prescriptive wait times, AAAHC standards require health plans to address "appointment wait time mitigation", such as informing enrollees of their basic right to obtain appointments within a reasonable time, providing a complaint process, and requiring that where the health plan is timely made aware of an adequacy concern it acts sufficiently to provide relief, such as through the provision of additional resources or approval for coverage at an out-of-network provider. As previously discussed, telehealth can be utilized to support these efforts.

Health Services Delivery (HSD) Table Adaptation to Medicaid and CHIP

With consideration for the variability in patient responses regarding appointment wait times, AAAHC proposes that CMS may contemplate the use of Health Services Delivery (HSD) tables within the Medicaid and CHIP program, similar to those utilized in the Medicare Advantage program. The HSD sets baseline requirements for health plans to contract a minimum specified number of provider types within each zip code or area. CMS receives a large variety of data and could utilize existing data sets to determine what the appropriate minimum standards should be. Once this "floor" has been set, CMS can then analyze future data through the lens of the minimum standards set to continuously improve requirements for access and care availability. Further, based upon such data and information, CMS can determine what provider types are lacking proper access within certain areas or regions and then move the focus from where access is lacking to how CMS and the states can encourage necessary provider types to service the area in need.

1. How could CMS consider the **concepts of whole person care or care coordination** across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?

Patient Centered Medical Home Programs Focus on Whole Person Care

AAAHC encourages CMS and the states to utilize Patient-Centered Medical Home (PCMH) certification and accreditation in furtherance of the whole person care concept within the Medicaid and CHIP program. In alignment with other CMS programs, PCMH can be incentivized through bonus or incentive payments to encourage provider PCMH certification or recognition through programs developed by accreditation organizations, such as AAAHC, an effort already implemented by a variety of commercial payers and states. PCMH certification and accreditation is already being pursued across the United States, and, when done well, truly enhances whole person care. AAAHC firmly believes that providing for health plans, health facilities, and provider choice amongst accreditation organizations is of critical importance in commitment to compliance with accreditation or certification standards. As discussed previously, for any accreditation or certification program requirements considered for incentives, CMS should allow for PCMH recognition through all qualified accreditation organizations.

PCMH has already been evidenced to effectively address the concerns CMS has noted, as can be seen in studies and reports such as the Annals of Family Medicine article, *Principles of the Patient-Centered Medical Home and Preventive Services Delivery*, at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2834717/, the Medical Care journal article, *The Association of Patient-centered Medical Home Designation With Quality of Care of HRSA-funded Health Centers: A Longitudinal Analysis of 2012-2015*, viewable at https://pubmed.ncbi.nlm.nih.gov/29271822/, and The John A. Hartford Foundation issue brief, *Transforming Primary Care: How the Patient-Centered Medical Home (PCMH) Model Improves Care for Medicare Beneficiaries*, viewable at https://www.johnahartford.org/images/uploads/reports/140722_PCMH_Brief_v1.pdf.

4. In addition to existing legal obligations, how should CMS address **cultural competency and language preferences** in establishing minimum access standards? What activities have states and other stakeholders found the most meaningful in identifying cultural and language gaps among providers that might impact access to care?

AAAHC Programs Address Cultural Competency and Language Preferences

AAAHC Health Plan and PCMH Standards address cultural competency and language preferences. For example, AAAHC-accredited health plans are required to:

- recruit, monitor, and maintain a network of providers that ensure the health care needs of the membership are met,
- provide comprehensive care to membership through provision of services, the provider network, and knowledge of community resources,
- maintain an active and integrated quality improvement program of a broad scope, inclusive of defining goals and objectives that consider the cultural and linguistic needs of the membership,
- maintain a risk management system that accounts for member safety and other critical issues,
- ensure providers communicate using the primary language of the member and ensure interpretive services are used when needed, and
- collect, regularly assess, and improve member satisfaction, including adequacy of services and access to care.

Data Cannot Ascertain the Occurrence of Discrimination and Inequity

AAAHC supports equitable care and the reduction of disparities in health care. However, we do not believe that the addition of data collection activities is likely to result in documentation that either identifies when discrimination or inequity has occurred or proves that discrimination or inequity has not occurred. Because data collection cannot prove these points, AAAHC Health Plan accreditation requires the existence of policies and procedures that address these factors supported by evidence that such policies and procedures are being followed.

CMS currently maintains the "5% threshold" for language services, but cultural competency is more than removing language barriers. Cultural competency requires an understanding of the unintentional, and often unrecognized, bias within each individual. Cultural competency is not limited to physicians and providers but is applicable across the entire spectrum of healthcare services, from schedulers to receptionists, medical assistants to billing representatives. AAAHC encourages CMS to consider a meaningful way to identify gaps in cultural competency across that spectrum. Although difficult to measure, cultural competency is a core component of AAAHC's PCMH certification and accreditation programs, and the increased use of PCMH requirements would necessarily improve services and reduce culture and language gaps.

Additionally, data from the Low Income Subsidy (LIS) could be further utilized to advance these goals and provide balance in reducing the burden of additional data collection. Additional information can be gathered related to measures, risk scores, and cultural competency when processing for LIS. Obtaining this data through an existing process where all data points are reviewed in applicable subsets and analyzed down to the zip code level could provide meaningful analysis for use in the development of an action plan for the reduction of cultural and language gaps specifically identified within a given area.

Alternatively, CMS could consider incorporating a bonus or incentive for providers who complete a cultural competency assessment through a nationally recognized assessment tool. Under the Bureau of Primary Health Care (BPHC), health clinics submit data covering patient demographics, health services provided, clinical processes and health outcomes, staffing information, patient use of services, operational costs, and revenues through the Uniform Data System (UDS). The UDS was specifically developed with whole person care and PCMH standards in mind. Has CMS considered adapting the UDS program to support Medicaid and CHIP whole person care efforts? However, as with all added data and measures,

AAAHC encourages CMS to remain mindful of the additional costs and burdens that necessarily come to exist.

Whole Person Care vs. Population Health

As a final consideration, AAAHC would like to point out the thin line that exists between population health policies and policies in support of true whole person care. Population health is addressed by looking at the characteristics of the individuals making up a particular population. However, whole person care is not necessarily supported by population health principles. Population health strategies provide broad conclusions which in turn detract, at least partially, from whole person care. PCMH is a proven tool for lifting the veil created by population health strategies and policies, directing attention away from population-oriented conclusions and towards caring for the whole person as a unique individual.

5. What are specific ways that CMS can support states to **increase and diversify the pool of available providers** for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

AAAHC Supports Encouraging Service Delivery via Telehealth

As previously discussed in our response to Question 2 of Objective 3, AAAHC encourages CMS to focus on reduction of burden and varied resource availability of providers, especially with the difficulties caused by the reduction of practicing providers within the healthcare industry. Encouraging telehealth through increased funding and provider requirements may be an option, similar to the incentives CMS implemented when encouraging providers to convert to electronic health records through the Promoting Interoperability Program. In current times, access to communication devices is more common and wide-spread than ever before. Instead of minimum wait time standards, CMS could consider requiring Medicaid providers to maintain some level of Medicaid-dedicated telehealth availability as an option for Medicaid patients. AAAHC Standards, which were intentionally written in a broad manner to span across changing times, laws, and methodologies in healthcare are equally applicable to telehealth services, ensuring that encouraging or requiring additional telehealth services for Medicaid enrollees will not result in a quality gap for AAAHC-accredited health plans, health facilities, or providers.

Additional Suggestions for Increasing and Diversifying Available Providers

CMS could also consider expanding approved provider types, in line with recent efforts seen throughout the states through the increased approval of doulas and midwives as providers, or by extending cost-sharing protections where disparities and monetary barriers have proven to exist.

Supporting Effective EPSDT Benefits

As EPSDT requirements are already in existence across all states, AAAHC recommends that CMS consider performing population assessments through the analysis of EPSDT data results by area. The focus of this detailed analysis would rest upon the identification of cultural nuances for each data set and determining why EPSDT requirements are not being met. For example, EPSDT requirements may not be met where a specific provider is not expressing the importance of EPSDT services and timelines to their patients. Another potential possibility where EPSDT requirements may not be met is when a facility's lead testing machine is in need of repair, preventing completion of blood lead test screenings. AAAHC accreditation also addresses these issues since AAAHC-accredited health plans are required to analyze facility and provider data to develop and implement quality initiatives that make a meaningful difference in patient safety and quality of care.

Expansion of Caregiving Services to Include Services Provided by Family Members

The expansion of caregiving services to include family members may be a means of improving network adequacy and increasing whole person care but AAAHC encourages CMS to implement requirements that ensure family members providing care are properly trained and accurately reporting billable hours. In support of such an expansion of services, the applicable risks for fraud, and the need for family members providing caregiving services to obtain applicable education or certification, AAAHC Health Plan Standards require an established and appropriate system of financial management and accountability, compliance with contractual obligations, laws, and regulations, adequate accounting controls, and systematic credentialing.

PCMH Accreditation and Certification as an Alternative to an Additional Payment/Purchasing Initiative

The CMS Medicare Advantage program's Value-Based Insurance Design (VBID) with Wellness and Healthcare Planning (WHP) was implemented in CY2020 at 42 CFR 422.134. The purpose of this innovation is to reduce expenditure while enhancing quality of care and improving service delivery. Model components are updated each year. AAAHC PCMH accreditation and certification programs already provide focus on these principles and could be utilized for the Medicaid and CHIP program to further this focus while also discouraging health plans and their providers from competing for members based on member profiles in consideration of their underlying for-profit goals under a multi-payer program. Utilizing accreditation programs that already exist and have been shown effective in achieving similar goals may be more effective than creating a new payment system with increased compliance burdens for health plans and providers.

RFI Objective 4: CMS has data available to measure, monitor, and support improvement efforts related to access to services (i.e., potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations).

CMS is interested in feedback about what new data sources, existing data sources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

1. What should CMS consider when developing an **access monitoring approach that is as similar as possible** across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care programs) and programs (e.g., HCBS programs and dual eligibility in Medicaid and Medicare) and across services/benefits? Would including additional levels of data reporting and analyses (e.g., by delivery system or by managed care plan, etc.) make access monitoring more effective? What type of information from CMS would be useful in helping states identify and prioritize resources to address access issues for their beneficiaries? What are the most significant gaps where CMS can provide **technical or other types of assistance to support states in standardized monitoring and reporting** across delivery systems in areas related to access?

Data Sharing and Access Monitoring Improvements

CMS might consider increased data sharing between CMS, the states, and health plans. CMS currently maintains complete risk factor data for all Medicaid and CHIP patients and could consider sharing such risk factor data in full, beyond the risk factor number code. Sharing complete risk factor data with the states may allow states to use this data to attract necessary provider types and centers for excellence into the communities with the greatest need based on local population information to improve access to care.

AAAHC further proposes to CMS that access and access monitoring can and should be supported by increased incentives for telehealth services, as previously discussed in our responses under Objective 3, and by requiring data interoperability such as is currently required under the CMS program for Qualified Health Plans.