AAAHC

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

July 3, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicaid Program; Medicaid and CHIP Managed Care Access, Finance, and Quality, RIN 0938-AU99

Dear Administrator Brooks-LaSure,

The Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) appreciates the opportunity to submit comment to the Centers for Medicare & Medicaid Services (CMS) regarding the recently proposed Medicaid and CHIP Managed Care Access, Finance, and Quality rule.

The AAAHC is a private and independent 501(c)(3) non-profit accreditation organization formed in 1979. Since its inception, AAAHC has promoted a voluntary, peer-based, and educational survey process to advance patient care. These values hold today, as embodied in our mission statement: Improving health care quality through accreditation. With more than 6,700 accredited organizations in a variety of ambulatory health care settings, AAAHC is a leader in developing Standards to advance and promote patient safety, quality care, and value for ambulatory health care through its accreditation programs, education, research, and other resources. Currently, more than 30 health plans are committed to excellence through AAAHC accreditation.

AAAHC is a recognized health plan accreditor through several federal and state agency regulatory agencies including the CMS Center for Consumer Information and Insurance Oversight (CCIIO) for Qualified Health Plans (QHPs), the U.S Office of Personnel Management (OPM) for Federal Employee Health Benefits plans (FEHBs), the Florida Agency for Health Care Administration (AHCA) for Health Maintenance Organizations (HMOs) and prepaid health clinics, and various state health insurance oversight agencies in Arizona, Georgia, Illinois, Kansas, Louisiana, Minnesota, Missouri, Nevada, New Mexico, Oklahoma, and Pennsylvania. AAAHC also provides accreditation services to the United States Coast Guard ambulatory health centers, Federally Qualified Health Centers that receive funds from the United States Health Resource and Services Administration (HRSA), Indian Health Services (IHS) funded health centers, and Correctional Healthcare units under the United States Federal Bureau of Prisons (BOP). Other AAAHC-Accredited Organizations include Ambulatory Surgical Centers, Community Health Centers, Indian Health Centers, Student Health Centers, Medical Group Practices, and Office-based Surgery Centers.

AAAHC continues to support and applaud the agency's efforts to reduce redundancy, lower burden, improve consistency, advance transparency, enhance accuracy, and strengthen equity across all programs. We appreciate the time and effort that CMS has put into developing work groups, hosting feedback sessions with stakeholders, and ensuring plans for continued progress and improvement are reasonable and workable for parties on all sides of the agency's programs.

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I. Medicaid and CHIP Managed Care

a. Enrollee experience surveys (§§ 438.66(b) and (c), 457.1230(b))

CMS is proposing to require that States conduct an annual enrollee experience survey (currently allowed but not required). AAAHC supports increased transparency through the implementation of mandated enrollee experience surveys and the posting of results to state websites. AAAHC Standard 3.I.1 supports this improvement, requiring AAAHC accredited health plans to conduct annual surveys to assess member satisfaction with the network for all lines of business. Additionally, AAAHC encourages CMS to indicate specific enrollee experience surveys that are acceptable for use to ensure consistency and meaningfulness in implementation, results, and analysis.

b. Appointment wait time standards (§§ 438.68(e), 457.1218)

CMS proposes that States develop and enforce wait time standards for routine appointments for four types of services. AAAHC supports defining network adequacy in terms of quantifiable values related to either wait times or distance and aligning these requirements with those which are already in place for Qualified Health Plans. AAAHC also supports the services selected by CMS as indicators of core population health: outpatient mental health and substance use disorder (SUD)—adult and pediatric, primary care—adult and pediatric, obstetrics and gynecology (OB/GYN), and an additional type of service determined by the State and included in coverage for the plan (in addition to the three listed).

One point of concern we would like to bring to the agency's attention is the potential impact of implementing the longer, 15-day standard for primary care and OB/GYN services. The inconsistencies in State laws related to reproductive rights—through which some states now ban abortion and multiple others are restricting abortion services to between six- and twelve-weeks gestation coupled with the implementation of a shorter 15-day standard for these services could unintentionally impede access to pregnancy care for women across the country.

According to Advancing New Standards in Reproductive Health (ANSIRH), based at the University of California San Francisco (UCSF), "[O]ne in three people confirm their pregnancies past six weeks, and one in five past seven weeks. Later confirmation of pregnancy is even higher among young people, people of color, and those living with food insecurity, suggesting that gestational bans on abortion in the first trimester will disproportionately hurt these populations."[1] As restrictions to reproductive care continue to be put into place across our nation, the need for timely access to these services is more urgent. By the time a woman misses her first menstrual cycle, she is already considered to be four weeks pregnant. Therefore, even if a woman requests an appointment with her primary care or OB/GYN provider on the first day of a missed menstrual cycle or after taking a positive home pregnancy test, once the 15-day wait time standard is met she will likely be beyond six weeks gestation and reproductive options may be limited.

Additionally, the maternal mortality crisis experienced in our country continues to worsen, with maternal mortality in the U.S. being experienced at greater levels than within other high-income countries, and maternal mortality rates for Black women within the U.S. being nearly twice as great as the rates experience by Hispanic and white women. One strategy for improving these rates is to improve access to primary care and postpartum care services.[2]

[1] https://www.ansirh.org/research/research/one-three-people-learn-theyre-pregnant-past-six-weeks-gestation
[2] https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison

Under these circumstances, we question why access to primary care and OB/GYN care would be deemed sufficient at a longer access standard than that put into place for the outpatient mental health and substance use disorder (SUD) access standard. Where both mental health/SUD and maternal/reproductive health needs are not sufficiently being met within the United States today, AAAHC requests that CMS treats both national crises with a similar sense of urgency.

f. Remedy plans to improve access (§ 438.207(f))

CMS already requires States to submit corrective action plans when access to care issues are identified in fee-for-service programs. CMS indicates that it intends to implement a similar process for managed care programs. CMS proposes to require States to carefully develop and enforce their managed care plans' use of appointment wait time standards to ensure access to care for Medicaid managed care enrollees.

As an accreditation organization, AAAHC believes that corrective action plans are an essential tool for meaningful development and improvement. AAAHC supports and commends CMS for utilizing data results to drive accountability and compliance to ensure corrective action.

5. Quality Assessment and Performance Improvement Program, State Quality Strategies and External Quality Review (§§ 438.330, 438.340, 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250)

b. Managed Care State Quality Strategies (§§ 438.340, 457.1240)

CMS requires States to draft and implement a written quality strategy for assessing and improving the quality of health care and services. This quality strategy serves as a foundational tool for States to set goals and objectives related to quality of care and access for their managed care programs.

AAAHC supports improving transparency, public engagement, and CMS oversight through the proposed changes to managed care quality strategies, including making State quality strategies available for public comment, requiring State quality strategies to be posted on State Medicaid agency websites, and implementing reviews by CMS prior to the finalization of State quality strategies.

c. External Quality Review (§§ 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250)

(4) Non-duplication of mandatory EQR activities with Medicare or accreditation review

CMS has proposed to remove the requirement that private, national accreditation organizations (PAOs) must apply for Medicare Advantage deeming authority from CMS for States to rely on PAO accreditation reviews in lieu of EQR activities. CMS indicates that this proposed change is intended to reduce administrative burden among the private accreditation industry, as well as create more flexibility for States to leverage PAO reviews for nonduplication. Under this proposal, States will still be required to ensure the review standards used by any PAO are comparable to standards established through the EQR protocols and will need to explain the rationale for the State's determination that the activity is comparable within the State's written quality strategy.

Requiring each State to individually analyze AO applicability is duplicative and redundant, and the burden on accrediting bodies to create a wholly independent review process with each State while attempting to navigate differences that exist between State requirements, policies, and resources is a significant administrative burden for all parties involved, including the health plans that operate across multiple states.

Our research into State laws, State Plan Amendments, and State Medicaid contracts indicates, in many cases, approval of only one Medicaid or MCO health plan accreditation organization, thereby preventing the plans from choosing the accreditation organization that best fits its needs or discourage transition to a new accreditor if the health plan finds a better match for its needs and those of the beneficiary population served. Executive Order 14039: Promoting Competition in the American Economy (86 FR 36987) calls upon 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.

In furtherance of EO 14039, AAAHC proposes that an alternative to placing the burden of AO review on the states that CMS instead expand EQR provisions at 42 CFR § 438.360(a)(1) to allow State utilization of *any* CMS-approved health plan accreditation organization, including those approved for QHPs in lieu of EQR activities. We make this suggestion to eliminate the reallocation of burden onto CMS regions, State Medicaid agencies, and accreditation organizations, maintain State and health plan flexibilities, and to allow for more choices in the health plan accreditation marketplace.

It is essential for health plans to be provided with the opportunity to choose the accreditation organization that is the best fit for their unique company goals and beneficiaries. A failure to promote competition in the accreditation marketplace could result in detrimental results for continued innovation and improvement. Most importantly, accreditation organization standards often exceed the minimum standards required by regulatory agencies. The AAAHC and its competitor accreditation organizations mitigate the burden on government agency oversight responsibilities through a commitment to regular updates to standards and quality review of health plan operations.

6. Medicaid Managed Care Quality Rating System (§§ 438.334 and 457.1240)

e. Establishing and Modifying a Mandatory Measure Set for MAC QRS (§§ 438.334(b), 438.510 and 457.1240(d))

CMS proposes to codify standards to be applied when determining when to add measures to the mandatory measure set, when to make substantive updates to an existing mandatory measure, and in some circumstances, when to remove a measure from the mandatory measure set. AAAHC supports alignment between programs with meaningful and scientifically acceptable measures that assess performance in areas that are able to be improved and are based on readily available data. CMS proposes implementing a requirement that five of the following six named inclusion criteria be met for any accepted quality measure:

1. The measure is meaningful and useful for beneficiaries and their caregivers when choosing a managed care plan–assessed by seeking beneficiaries' feedback on which measures of health plan performance are most relevant to them and giving preference to measures that assess the quality of care or services most commonly identified as relevant to selection of a health plan or assessment of a health plan's quality;

2. The measure aligns with other CMS rating programs–assessed by identifying the extent to which States and other Federal programs currently collect or report the measure and considering feedback on measures commonly used to assess performance as well as challenges and concerns associated with these measures;

3. The measure assesses health plan performance in at least one of the following areas: customer experience, access to services, health outcomes, quality of care, health plan administration, and health equity–assessed by determining which of the areas each measure evaluates and giving preference to measures that evaluate or measure multiple areas;

4. The measure provides an opportunity for managed care plans to influence their performance on the measure–assessed by considering input on what actions plans may take to improve or maintain measure performance and the extent to which the plans control, or are capable of influencing, what is being measured, meaning that measure specifications are available to calculate the measure at the plan level;

5. The measure is based on data that are readily available, or available without undue burden on States and plans, such that it is feasible to report by most States and managed care plans–assessed by considering the accessibility of the data required to calculate the measures and the proportion of plans or States that currently collect data for the measure with preference for measures that require easily accessible data; and

6. The measure demonstrates scientific acceptability, meaning that the measure produces consistent and credible results–assessed by reviewing evidence that use of the measure results in reasonable conclusions about care.

Within this proposal, CMS concludes that requiring all six criteria could prevent the inclusion of measures that are meaningful to beneficiaries but not commonly used by States or measures aligned with State priorities for managed care quality and plan performance but less useful to beneficiaries. Therefore, CMS proposes that a measure must meet at least five of the six measure inclusion criteria to be considered and included in the mandatory measure set.

AAAHC proposes that inclusion criteria items 4 and 6 should be mandatory criteria. Whether based on structural, process, or outcome data, measures that do not provide an opportunity for improved performance or that are not scientifically acceptable with consistent and credible results fail to meet the crucial purposes that measures serve: identifying weaknesses, prioritizing opportunities, and driving improvements.

CMS has also proposed standards to determine when to add measures to the mandatory measure set, when to make substantive updates to an existing mandatory measure, and in some circumstances, when to remove a measure from the mandatory measure set. AAAHC supports ensuring that current measures are regularly updated to meet current needs and that any burdens associated with the measures do not outweigh their benefits. However, AAAHC would like to see criteria developed and published related to how these factors will be analyzed, similar to the detailed analysis provisions proposed for the measure inclusion criteria.

f. MAC QRS Methodology (§§ 438.334(d), 438.515, 457.1240(d))

After extensive engagement with States and other interested parties, CMS identified two main themes to consider in the development of a MAC QRS methodology: (1) the burden associated with data collection and quality rating calculation, and (2) transparent, representative quality ratings. CMS is seeking to balance these two competing preferences, while ensuring that quality ratings remain comparable within and among States by proposing that States must collect the data necessary to calculate quality ratings for mandatory measures from their contracted managed care plans and, as applicable and available without undue burden, the State's Medicaid FFS program and Medicare. The proposal requires that data be collected from managed care plans that meet a minimum enrollment threshold of 500 or more enrollees on July 1 of the measurement year, as is required for QHPs, because calculating quality ratings for plans with fewer than 500 enrollees would be overly burdensome, as these plans may have limited resources for collecting and reporting data, and are more likely to have small denominator sizes that would make it inappropriate to issue and display quality ratings for some measures.

AAAHC supports balancing the burden of calculation with benefits of transparency. We agree that having a required minimum enrollee count keeps data meaningful but are concerned that quality ratings for only some plans does not provide beneficiaries with the opportunity to choose equally amongst plans. AAAHC recommends that an alternative quality indicator, such as health plan accreditation, be required of all participating plans as is similarly required under the ACA for QHPs.