April 18, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

The American College of Physicians appreciates the opportunity to comment on the Request for Information on Medicaid Access to Care. The American College of Physicians is the largest medical specialty organization and the second-largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

Medicaid is a vital component of the nation's health care system. Its importance in providing comprehensive coverage was highlighted during the COVID-19 public health emergency as enrollment grew to record levels. As the health care sector confronts the next stage of the pandemic, we encourage the Centers for Medicare and Medicaid Services to orient Medicaid's mission toward achieving health equity, supporting effective prevention and management of chronic diseases, addressing social determinants of health, and expanding access to behavioral health care. ACP believes internal medicine physicians can play a key role in caring for the adult Medicaid population and we applaud CMS for seeking input on ways to ensure Medicaid enrollees have access to high-quality care when they need it.

> **Objective 2, Question 3: What actions could CMS take to promote continuity of coverage for beneficiaries transitioning between Medicaid, CHIP, and other insurance affordability programs; between different types of Medicaid and CHIP services/benefits packages; or to a dual Medicaid-Medicare eligibility status? For example, how can CMS promote coverage continuity for beneficiaries moving between eligibility groups (e.g., a child receiving Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualified supports who transitions to other Medicaid services such as home and community based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the**

Marketplace); or across state boundaries? Which of these actions would you prioritize first?

Medicaid enrollment increased to record levels during the COVID-19 pandemic, with nearly 86 million enrolled in Medicaid and CHIP in November 2021. Once the continuous coverage requirements are lifted, states will face the extraordinary task of redetermining eligibility. Millions of people could lose Medicaid coverage, including almost 7 million children, when the Public Health Emergency (PHE) expires. ACP strongly supports strategies to improve the Medicaid enrollment and redetermination process, reduce churn, and ensure continuity of care, including through ex parte or automated renewal strategies, continuous coverage for children and adults, simplified application forms, and enhanced culturally and linguistically competent outreach and education.

It is estimated that one-third of adults losing Medicaid coverage after the PHE would be eligible for advance premium tax credits through the Health Insurance Marketplace. We urge CMS to work with state Medicaid agencies and federally facilitated and state-based Marketplaces to help transition this population to Marketplace plans that provide continuous care and preserve the patient-physician relationship. Navigators and other entities should also educate Marketplace coverage enrollees about differences between Medicaid and Marketplace coverage and assist them in selecting plans that meet their financial needs and physician preferences, especially important in areas with a high number of narrow network plans. According to one state-based Marketplace official, "We have seen a frightening narrowing of [provider] networks in [Marketplace plans] over the years. If you have 200,000 people coming out of Medicaid and they can't keep their providers…this is not acceptable." Further, Medicaid managed care has more robust federal regulatory protections than Marketplace-based qualified health plans. As a member of HHS' Champions of Coverage program, we urge CMS to encourage state Medicaid agencies to engage with Medicaid-participating physicians, particularly practices with above-average Medicaid caseloads, to help spread awareness of the post-PHE coverage transition.

Objective 3, Question 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?

A core set of Medicaid access to care measures and benchmarks should be established to help determine potential and realized access. Minimum access standards should ensure that Medicaid enrollees are able to access the right care at the right time at an affordable cost, while achieving the program's goals related to health equity, culturally and linguistically competent care, and racial and ethnic health disparities. In 2016, Kenney and colleagues proposed a core set of 22 access measures on which states would be required to report through access monitoring review plans, within the categories of "provider" availability and accessibility, beneficiary utilization, and beneficiary perceptions and experiences. Many of these overlapped

with existing measures, monitoring and data collection activities, including Adult and Child Core Sets and Consumer Assessment of Healthcare Providers and Systems surveys. However, in absence of federal standards, states vary widely in how they measure and report access. According to a 2017 Medicaid and CHIP Payment and Access Commission (MACPAC) report, states use beneficiary experience, utilization, and clinician supply measures to determine access, but only 13 of 37 states surveyed collected data on all these categories. Access monitoring should be based on a set of minimum standards across states, so that enrollees, physicians, and other clinicians, CMS, and other stakeholders have a clearer understanding of whether access requirements are being met.

Regarding Medicaid managed care, ACP supports robust network adequacy rules to ensure that Medicaid enrollees can access their preferred physician and receive necessary care in a timely manner. Mandatory network adequacy standards have been established for Medicare Advantage plans and proposed for Marketplace-based Qualified Health Plans. The complex health needs of many Medicaid enrollees make broad "provider" networks especially important. MCOs have a history of discriminating against physicians and other health care professionals that serve a disproportionate number of high-need, vulnerable patients. The College has supported mandatory time and distance standards for primary care and subspecialists and we remain concerned about the negative effect the 2020 Medicaid managed care final rule revisions to network adequacy requirements may have on access to care. ACP has also urged Medicaid to adopt additional standards to measure access, including "provider"-to-patient ratios, appointment wait times, and cultural competency standards, that will help provide a more accurate evaluation of clinician access. Since many Medicaid managed care plans also offer coverage through the Health Insurance Marketplace, the agency should consider strengthening and aligning federal minimum network adequacy requirements for the two programs. The proposed Benefit and Payment Parameters for Plan Year 2023 would create a federal standard based on quantitative time and distance standards and appointment wait time standards. Importantly, CMS should engage stakeholders, including states, enrollees and physicians and other health professionals, when developing a core measure set.

- **Objective 3, Question 3: How could CMS consider the concepts of whole person care[5] 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?**

Adult Medicaid enrollees report higher rates of chronic conditions, including asthma, hypertension, and depression, than adults with private insurance and uninsured adults. They are less likely than private insurance enrollees or the uninsured to report that they are in very good or excellent health. Medicaid enrollment is associated with better access to care and utilization of preventive services, but gaps exist. According to MACPAC adult Medicaid enrollees

generally can access necessary care when they need it, but a lower proportion of adult Medicaid enrollees report having a usual source of care than those with private insurance. Many are confronted with financial hurdles to care: MACPAC reports that Medicaid-enrolled adults are more likely to be concerned about paying medical bills and more likely to delay or forego care due to cost than those with private insurance. Racial and ethnic disparities in access to care also exist. For example, White Medicaid enrollees are more likely to have seen a physician or receive counseling or therapy from a mental health professional than Black, non-Hispanic or Hispanic enrollees. Black and Hispanic enrollees were less likely than their White counterparts to use a physician's office as their usual source of care. ACP supports policies to achieve health equity, address social determinants of health, promote better care coordination and whole-person treatment, and address access and racial and ethnic health care disparities.

Integrating Behavioral Health and Primary Care

Medicaid programs should support innovative delivery system reforms such as the patient centered medical home, a team-based care model that emphasizes care coordination, a strong physician-patient relationship, and preventive services. Additionally, MACPAC states, "Integrating physical and behavioral health has been shown to reduce fragmentation of services and promote patient-centered care for adults with depression and anxiety disorders." Behavioral health integration also reduces stigma associated with behavioral health and improves patient satisfaction. ACP has noted that physicians and other health care professionals should consider the behavioral and physical health of the patient if they are to be treated as a "whole person." Most patients with behavioral health needs use the primary care office as their main source of care, and given the nation's shortage of behavioral health clinicians, integrated approaches can augment access to behavioral health services and improve health outcomes for Medicaid enrollees.

Changes to the health care delivery system, payment models, education and training, health insurance coverage, and societal and cultural perceptions are necessary to encourage communication and cooperation between the behavioral and physical health disciplines. Medicaid can promote behavioral health integration models and remove payment, administrative, and other barriers that impede behavioral health and primary care integration. Funding to assist practices with workforce, health IT infrastructure, training and education costs is also crucial. The Medicaid health home model, based on the patient-centered medical home, is one approach to behavioral health integration and coordinating and managing care. Missouri HealthNet's Primary Care Health Home model, which includes a behavioral health consultant in the clinical team, has reduced hospitalizations and avoidable visits to the emergency room and cut costs. We urge CMS to evaluate states that have used innovative delivery models to increase access to care when developing a core access measure set. Further, Medicaid should support evidence-based primary care-behavioral health integration models like the collaborative care model, through adequate payment rates (i.e., at least at parity with Medicare) and funding for health information technology infrastructure, workforce, and technical assistance.

Achieving Mental Health and Substance Use Disorder Treatment Parity

One of the barriers to true integrated primary and behavioral health care is noncompliance with mental and substance use disorder parity required by federal law. The Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act required that quantitative and nonquantitative treatment limits and financial requirements for behavioral health services be no more restrictive than for medical and surgical services. The Affordable Care Act extended these protections to Medicaid. Despite improvements in coverage and affordability resulting from parity laws, problems with nonquantitative treatment limit compliance and behavioral health workforce shortages persist. We urge CMS to strengthen oversight by requiring plans to clearly disclose behavioral health-related utilization management practices (including prior authorization); improving enrollee education about parity, complaint filing and appeals processes; and assisting states in their parity oversight activities.

Addressing Social Determinants of Health

According to the Centers for Disease Control and Prevention, social determinants (or drivers) of health are "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." ACP appreciates Medicaid's existing efforts to address social drivers of health and health equity and strongly recommends that Medicaid continue to comprehensively address the interconnected contributors to health and health care disparities, including the role of racism, discrimination, lack of coverage and access to care, and poverty. Several states are using funding from the Centers for Medicare and Medicaid Innovation to link primary care and community-based services. Connecticut's State Innovation Model builds on the Advanced Medical Home to improve care coordination, chronic diseases-related health outcomes, and address environmental and socioeconomic factors that affect health. Many states require managed care organizations to address social determinants of health including by screening for behavioral health and social needs, providing referrals to social service agencies, and employing community health workers. We encourage Medicaid to continue to test innovative models and interventions that address social drivers of health and oppose attempts to impede care access, including work requirements and excessive cost-sharing.

> **Objective 3, Question 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?I**

Telehealth has served as a crucial link between patients and their physicians during the COVID-19 pandemic and has expanded access to care, particularly for enrollees in rural areas. ACP has offered policy recommendations for the practice, use, and reimbursement of telemedicine in primary care. Additionally, we support expanding broadband infrastructure, since 25% of Medicaid enrollees have limited computer or internet access.

In 2019, only 36 state Medicaid programs permitted primary care services to be delivered via telehealth; during the COVID-19 public health emergency, all state Medicaid programs covered primary care and behavioral health services delivered via telehealth. We urge CMS to continue Medicaid telehealth flexibilities after the expiration of the PHE, including modifications to geographic site policies, for a minimum of two years. Further, ACP supports reimbursing 2-way video-audio telehealth services and other modalities at the same level as in-person services. Audio-only should be reimbursed at a sufficient rate. Most states established pay parity during the PHE, but it is unclear whether these changes will be permanent. ACP also calls for the collection and reporting of telehealth data stratified by race, ethnicity, language, gender, and other key demographic factors to ensure policies are equitably improving access to and quality of care. Since telehealth use during the PHE was lower among Medicaid enrollees with limited English proficiency, Medicaid should support reimbursement and other policies to promote language assistance for enrollees with limited English proficiency as well as interpretation services for people with hearing loss.

Objective 5, Question 1: What are the opportunities for CMS to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?

Medicaid payment rates must be adequate to reimburse physicians for the cost of providing services, to encourage physician participation, and to ensure access to covered services. ACP believes that policymakers must permanently increase payment for Medicaid primary care and other specialists' services to at least the level of Medicare reimbursement. Such action is especially important for physicians and facilities that serve a disproportionate number of Medicaid beneficiaries, since evidence shows they experienced significant financial struggles during COVID-19 pandemic.

Medicaid has historically reimbursed primary care and specialty physicians below Medicare and commercial plan rates. In 2016, average Medicaid rates for primary care services were 66% of Medicare. One state paid 33% of Medicare rates. The evidence clearly demonstrates that physician participation in Medicaid is tied to reimbursement rates. A 2019 MACPAC report on physician acceptance of new Medicaid patients considered the impact of managed care penetration, state Medicaid expansion status, and Medicaid payment rates compared to Medicare, on physician participation. It concluded that "the only policy lever that was associated with Medicaid acceptance was Medicaid fees." The report also determined that a "1 percentage point increase in the Medicaid-to-Medicare fee ratio would increase acceptance by 0.78 percentage points."

ACP strongly supported the Affordable Care Act's Medicaid pay parity provisions, which ensured that evaluation and management services were reimbursed at Medicare levels in 2013 and 2014, and we continue to advocate for making pay parity permanent. Evidence shows that pay parity successfully increased appointment availability for Medicaid enrollees, yet only a handful of states extended the provision after it expired. Further, fee-for-service rates often

serve as a guide or floor for managed care organizations reimbursement policies. We urge Medicaid to support sufficient reimbursement for primary care and specialty physicians.

Objective 5, Question 2: How can CMS assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?

The fee-for-service Medicaid equal access provision requires that states "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Prior to 2015, states had wide latitude regarding monitoring and reporting access. After the Armstrong v. Exceptional Child Center, Inc. prohibited Medicaid "providers" and beneficiaries from legally challenging reimbursement rates, HHS established a framework requiring states to measure and monitor access in fee-for-service Medicaid. States were obligated to submit access monitoring review plans, which track beneficiary access to primary care, specialty services, and other service categories. If access monitoring review plans (AMRPs) expose access problems, states are required to increase payment rates, reduce "provider" enrollment barriers, address transportation problems, or take other action. AMRPs can provide patients and physicians with a clearer understanding, and opportunity to provide input, as to whether the equal access provision is being met and if payment rate changes are sufficient. Once states resume submitting AMRPs states should conduct stronger oversight by monitoring enrollees' "provider" encounter data. CMS and states should also regularly track complaints against managed care organizations to determine network adequacy problems.

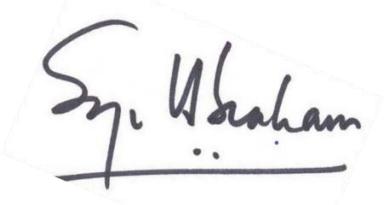
- **Objective 5 Question 4: Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries.[6] What actions could CMS take to encourage states to reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?**

In addition to insufficient payment rates, administrative burdens discourage physician participation in Medicaid. ACP recommends that CMS, State Medicaid agencies, MCOs, and other stakeholders work to improve physician and patient interaction with the Medicaid program. Solutions should include reducing administrative barriers and onerous paperwork requirements. Claims denials are especially prevalent in Medicaid: Dunn and colleagues found that "25% of Medicaid claims have payment denied for at least one service upon doctors' initial claim submission" compared to 7.3% for Medicare and 4.3% for commercial insurers. They also concluded that Medicaid-participating physicians lose 17% of revenue to billing problems.

Prior authorization (PA) should be streamlined and/or eliminated. PA can frustrate patients and physicians alike and may dissuade patients from seeking care altogether. ACP members estimate spending, on average, 30 minutes of either their time or staff time on each prior authorization request, diverting time away from delivering patient care. ACP has given qualified support to previous CMS efforts to reduce prior authorization burdens, but called for substantial improvements, specifically, additional action on prior authorization for prescription drugs and inclusion of Medicare Advantage, to ensure streamlined, coordinated policies. In March 2022, ACP submitted extensive comments to the Office of the National Coordinator for Health Information Technology (ONC) regarding electronic prior authorization standards, implementation specifications, and certification criteria. Medicaid should encourage testing and adoption of value-based payment models that provide relief from PA requirements. For example, North Carolina proposed that Medicaid Accountable Care Organizations exposed to downside risk would circumvent PA for certain services. Administrative burdens are especially harmful to solo and small group practices with limited staff or financial resources. Since Medicaid participation rates tend to be lower for small, independent physician practices, CMS should work to better understand the administrative barriers to participation that these practices face. Additionally, during the COVID-19 PHE, many states lifted PA requirements for medications. Medicaid should encourage states to extend these policies to increase access to prescription drugs for patients and alleviate the administrative burden for physicians.

Thank you for considering our comments. If you have questions, please contact Ryan Crowley, Senior Associate for Health Policy at rcrowley@acponline.org.

Sincerely,



George M. Abraham, MD, MPH, MACP, FIDSA
President
American College of Physicians