July 3, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

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

Dear Secretary Becerra,

The American College of Physicians (ACP) appreciates the opportunity to comment on the Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality proposed rule. 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 160,000 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.

Appointment Wait Time Standards (§§ 438.68)

ACP supports quantitative network adequacy standards to ensure Medicaid enrollees can access their preferred physician, cultivate and maintain the patient-physician relationship, and receive necessary care in a timely manner (i). The complex health needs of many Medicaid enrollees make broad "provider" networks especially important. Strong standards are necessary to prevent managed care organizations from developing narrow, insufficient provider networks, where primary care physician turnover (and the disruption of the patient-physician relationship) is common (ii) The College has supported mandatory time and distance standards for primary care and specialists (iii) 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. However, ACP has also urged Medicaid to adopt additional standards to

measure access, including appointment wait times, "provider"- to-patient ratios, and cultural competency standards, that will help provide a more accurate evaluation of clinician access. Appointment wait time standards are already used by several states to gauge network adequacy (iv). Thus, we support the proposed requirement that states establish and enforce maximum wait time standards for primary care, behavioral health, and obstetrics and gynecology appointments.

Secret shopper surveys (§§ 438.68(f), 457.1207, 457.1218)

ACP strongly supports stringent requirements and strategies to ensure "provider" directories accuracy. Such directories are notoriously inaccurate and may mislead enrollees about the breadth and scope of their plan's network (v). Federal oversight is necessary to ensure state Medicaid agencies enforce network adequacy requirements and assess and direct MCOs and other arrangements to correct inaccuracies (vi,vii). Further, requiring all states to adopt a consistent method of network adequacy oversight will help promote comparability and best practices. Evidence shows secret shopper surveys are an effective means of determining network adequacy and "provider" directory accuracy in commercial and QHP markets and have been recommended for Medicaid managed care (viii,ix). Although ACP believes that annual secret shopper surveys can be effective, we strongly encourage CMS to apply safeguards to prevent survey activities from having an undue administrative burden on physicians.

Since many Medicaid managed care plans also offer coverage through the Health Insurance Marketplace, the agency should consider aligning federal minimum network adequacy requirements for the two programs. We urge CMS to adopt wait time standards for non-urgent specialist appointments that are at least as stringent as those required of Qualified Health Plans offered through the Health Insurance Marketplace (x). We also recommend that the implementation timeline for the network adequacy standards and secret shopper survey requirements reflect requirements for the Health Insurance Marketplaces, i.e., plan year 2025.

Assurances of Adequate Capacity and Services—Provider Payment Analysis (§§ 438.207(b), 457.1230(b))

Payment rates are a major determinant of Medicaid participation among physicians (vii,viii). Spending on primary care provided by general internal medicine and other primary care physicians as a proportion of overall Medicaid health care spending dropped by 4.2% in 2020 (ix). In 2017, 63% of internal medicine physicians accepted new Medicaid patients, while 95% accepted new Medicare patients (x). 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" (xi).

Medicaid managed care payment rates are particularly opaque (xi). We strongly support the proposal to require managed care plans to submit a payment analysis comparing the total amount paid by Medicaid and Medicare for evaluation and management CPT codes for primary care, OB/GYN, and mental health and substance use disorder services (i.e., behavioral health). We also support the remedy plan provisions, including increasing payment rates, improving outreach and problem resolution, and reducing credentialing and contracting barriers for "providers." ACP policy recommends that state contracts with Medicaid managed care plans should include standards for accountability and management of the health plan and should include review of a health plan's medical necessity standards and preauthorization rules to ensure that the health plan's standards of care are consistent with those in the medical community and we support inclusion of addressing egregious prior authorization policies as part of a remedy plan.

In Lieu of Services and Settings (ILOSs) (§§ 438.2, 438.3, 438.7, 438.16, 438.66, 457.1201, 457.1207)

ACP strongly supports the concept of ILOS to address social drivers of health, achieve health equity, and implement population health goals. ACP has highlighted emerging managed care approaches to addressing food insecurity (xii). In a 2022 position paper, ACP called for payment approaches including "hybrid-type models that adjust for elements that affect the resources needed to achieve the best possible outcomes, including health status, risk, and the cost of caring for patients disproportionately affected by health disparities and social drivers of health that exacerbate those disparities...payments that are set at appropriate and sufficient amounts aid in ensuring access to care. Appropriate payments allow social drivers of health to be addressed by paying enough for primary care, specialist, and subspecialist practices to recruit and retain primary care physicians and clinicians and hire or partner with case managers, behavioral health clinicians, and others who can interface with community services and public health" (xiii).

State Directed Payments (§§ 438.6, 436.7)

State directed payments (SDPs) have been used to increase access to care by ensuring that managed care payments to physicians are at least on par with fee-for-service Medicaid or Medicare rates (xiv). SDPs also support value-based payment models designed to achieve a variety of goals, including facilitating care coordination and lowering health costs through a population health approach (xv). We encourage CMS to implement policies to provide state Medicaid agencies the flexibility to expand access to primary care, behavioral health, and other services where Medicaid enrollees may currently experience access problems. CMS should work with states to avoid potential unintended consequences, such as applying undue cost sharing on patients or setting insufficient payments to facilities that care for a higher share of Medicaid patients (including rural and safety net hospitals).

Thank you for the opportunity to comment. Please direct any questions to Ryan Crowley, Senior Associate, Health Policy at rcrowley@acponline.org.

Sincerely,

Omar Atiq, MD
President
American College of Physicians

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