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; Ensuring Access to Medicaid Services (CMS–2442–P)

Dear Secretary Becerra,

The American College of Physicians (ACP) is grateful for the opportunity to comment on the Medicaid Program; Ensuring Access to Medicaid Services 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.

Medical Care Advisory Committee (§ 431.12)

ACP supports meaningful engagement with Medicaid enrollees to identify care access problems and better understand their lived experiences with the program. A substantial number of enrollees have been disenrolled from the program during the Medicaid unwinding period due to administrative or procedural reasons (i). Enrollee input can help discern best practices regarding program administration and agency-enrollee communication. We agree that a greater diversity of beneficiary perspectives can inform "issues that States need to address, like cultural competency of providers, language accessibility, health equity, and disparities and biases in the Medicaid program, can be revealed through beneficiary experiences" and we encourage Medicaid Advisory Committees (MAC) to seek feedback on the type of services necessary to address social drivers of health, such as unstable housing and food insecurity (ii). We support the proposal to establish a separate Beneficiary Advisory Group to formally collect input from Medicaid enrollees.

However, we urge CMS to reconsider proposed changes to the Medicaid Advisory Committee membership and composition requirements to include "clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries and with the resources available and required for their care. This includes providers or administrators of primary care, specialty care, and long-term care." While we appreciate that CMS encourages states to include primary care "providers" such as Medicaid-participating internal medicine physicians among the MAC membership, we recommend CMS retain existing language at 431.12(d)(1) requiring advisory committees to include "board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care." By including a board-certified primary care and/or specialty physician, the MAC will cultivate meaningful engagement to increase physician participation in Medicaid, improve care coordination and quality, achieve health equity, and other goals.

HCBS Payment Adequacy (§§ 441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi))

In a 2022 policy paper ACP noted that workforce shortages in the long-term services and supports sector (LTSS) are a long-standing problem due in part to below-average compensation for direct care workers (iii). To fulfill rising demand for HCBS services we recommend that policymakers and employers address shortages in the LTSS workforce through comprehensive training, pay increases, benefit packages, and opportunities for career advancement and growth. ACP supports the intent of proposed changes at 441.302(k)(3)(i) to ensure at least 80 percent of all HCBS Medicaid payments be spent on compensation to direct care workers.

Documentation of Access to Care and Service Payment Rates (§ 447.203)

We appreciate CMS' attention to ensuring access to care. The 2015 Armstrong v. Exception Child Center, Inc., ruling limits options for patients, physicians, and other health care professionals to push for payment rates sufficient to meet Medicaid's equal access requirements. The proposal to make payment rates transparent and accessible to the public is an important step towards ensuring compliance with access requirements. Ultimately, state Medicaid agencies should monitor access based on "utilization, and beneficiary perceptions and experiences" recommended by Kenney and colleagues and others (iv,v) While rate transparency is important, it does not guarantee that states will adjust payment rates to comply with Medicaid's statutory access requirements. We strongly urge CMS to work with states to correct deficient payment rates.

Fully Fee-for-service States

Some of Medicaid's most vulnerable populations, including children and adults with disabilities, are enrolled in fee-for-service Medicaid. As of June 2022, 5 states deliver all Medicaid services through FFS (vi). 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. ACP has supported appointment wait time standards and other quantitative network adequacy standards to determine care access and we recommend that standards be applied across Medicaid FFS and managed care. We strongly encourage that if adopted, Medicaid take action to ensure that secret shopper survey activities do not impose an administrative burden on physicians.

Payment rate transparency (§ 447.203(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).

ACP strongly supports increased transparency of Medicaid payment rates. Currently, comprehensive information on Medicaid payment rates is collected by academic researchers, stakeholder organizations, and other sources (xii,xiii,xiv), but may not be easily obtainable through each State Medicaid program's public-facing website. While we previously supported the access monitoring review plan requirements (xv), we agree that they are a flawed mechanism for determining access to care. Transparent and publicly accessible payment rate information will help physicians, enrollees, policymakers, and other stakeholders determine if payment rates 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" as required by the Social Security Act. We agree that State plans should publicize rates based on provider type, geographic location, population (e.g., pediatric or adult), or other grouping, if applicable. We also concur that rates for individual services within a bundled payment or similar arrangement should be communicated. Payment information should be provided in a manner that is accessible to individuals with disabilities and people with limited English proficiency. Additionally, states should communicate that payment information is publicly available and where it can be accessed. We strongly encourage CMS to provide oversight to ensure state Medicaid programs fulfill these requirements within the mandated timeframe.

ACP also supports requiring state Medicaid programs to develop and publish a payment rate analysis comparing Medicaid and Medicare payment rates for certain services, including primary care. Rates should be presented by category (population, geographical area, etc.) if applicable. Although ACP has recommended extensive changes to the flawed volume-driven Medicare reimbursement policy, we believe that Medicaid-Medicare pay parity would improve access to care and encourage physician participation in the program. Evidence shows that

Medicaid-Medicare primary care pay parity is associated with improved appointment availability (xvi)

The inclusion of primary care in the rate comparison is particularly important and we appreciate acknowledgement of evidence "that the quality of the physician-patient relationship is positively associated with functional health among patients." Adequate investment in primary care is associated with lower health expenditures, higher patient satisfaction, reduced hospitalizations and emergency department visits, and lower mortality (xvii). Primary care plays an important role in addressing social drivers of health and achieving health equity (xviii). ACP strongly supports the integration of primary care and behavioral health (xix) and adequate payment rates for outpatient behavioral health services are crucial to supporting such reforms and addressing the behavioral health crisis. Similarly, nearly 1.5 million births were financed by Medicaid in 2021 (xx). At the same time, the U.S. also faces a devastating maternal health crisis. Access to obstetrical and gynecological services is vital to meeting demand for maternal care and the full spectrum of women's health services. Specialty care access problems have also been reported (xxi,xxii), potentially compromising patient's ability to receive treatment for chronic illnesses. We recommend that physician specialist services be added to the list of categories subject to a comparative payment rate analysis proposed at 447.203(b)(2).

State Analysis Procedures for Rate Reduction or Restructuring (§ 447.203(c))

We recommend that the proposed 80% threshold to qualify for the streamlined state plan amendment rate adjustment approval process proposed at 447.203(c)(1)(i) be changed to 100%. The November 2017 State Medicaid Director Letter states that "(f)or example, circumstances where a state's Medicaid FFS payment rates remain at least as high as the Medicare rates (including the applicable cost-sharing) for the same specific service after the reduction is implemented would be unlikely to result in diminished access" (xxiii) Further, states with high reimbursement rates tend to have above-average rates of physicians accepting new Medicaid patients. Alaska, Montana, Delaware, and North Dakota had primary care payment rates in 2019 that were on par with or exceeded Medicare rates and all had above-average rates of physicians accepting new Medicaid enrollees (xxiv,x).

Thank you for the opportunity to provide comments. Please contact Ryan Crowley, Senior Associate, Health Policy, at rcrowley@acponline.org if you have questions.

Sincerely,

Omar Atiq, MD
President
American College of Physicians

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