



April 18, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure,

On behalf of the American Academy of Family Physicians (AAFP), representing more than 127,600 family physicians and medical students across the country, I write in response to the request for information on Access to Coverage and Care in Medicaid and the Children's Health Insurance Program (CHIP), as [requested](#) on February 17, 2022.

As firm believers in access to affordable health care for all, the AAFP has long [advocated](#) for protecting and strengthening the Medicaid safety net. We maintain that Medicaid is essential to achieving our shared goals of advancing health equity, increasing health coverage, and facilitating access to comprehensive, person-centered primary care.

The AAFP was pleased that Administrator Brooks-LaSure and Deputy Administrator Dan Tsai [identified](#) protecting and expanding Medicaid beneficiaries' access to care as one of the agency's top priorities upon assuming their current roles. While the Medicaid program has facilitated access to needed health services for millions of beneficiaries, we agree that additional federal oversight and technical assistance is needed to improve equitable access to whole-person care, including primary care, behavioral health care, and specialty care for beneficiaries of all ages. We look forward to working with CMS to reinstate federal access standards and strengthen monitoring and oversight in order to achieve these shared goals.

The AAFP has also supported the maintenance of effort and continuous enrollment provisions included in the Families First Coronavirus Response Act (FFRCA) to avoid coverage disruptions and ensure Medicaid beneficiaries could access health care during the COVID-19 pandemic. We appreciate CMS' efforts to minimize coverage gaps during the eligibility redetermination process. Like CMS, we remain concerned that many currently enrolled Medicaid beneficiaries will lose coverage and be unable to get the care they need.

In addition to commenting on several other areas, we provide the following high-priority recommendations in this letter:

- **Reinstate and strengthen federal Medicaid access standards and operationalize a robust national monitoring approach.**

STRONG MEDICINE FOR AMERICA

President
Sterling Ransone, MD
Deltaville, VA

President-elect
Tochi Iroku-Malize, MD
Islip, NY

Board Chair
Ada Stewart, MD
Columbia, SC

Directors
Andrew Carroll, MD, *Chandler, AZ*
Steven Furr, MD, *Jackson, AL*
Teresa Lovins, MD, *Columbus, IN*
Jennifer Brull, MD, *Plainville, KS*
Mary Campagnolo, MD, *Borderstown, NJ*
Todd Shaffer, MD, *Lee's Summit, MO*

Gail Guerrero-Tucker, MD, *Thatcher, AZ*
Sarah Nosal, MD, *New York, NY*
Karen Smith, MD, *Raeford, NC*
Samuel Mathis, MD (New Physician Member), *Galveston, TX*
Amanda Stisher, MD (Resident Member), *Owens Cross Roads, AL*
Amy Hoffman (Student Member), *State College, PA*

Speaker
Russell Kohl, MD
Stilwell, KS

Vice Speaker
Daron Gersch, MD
Avon, MN

Executive Vice President
R. Shawn Martin
Leawood, KS

- **Implement race, ethnicity, and language data reporting requirements and enhance federal monitoring of racial, ethnic, and language-based disparities.**
- **Address low Medicaid payment rates and burdensome administrative processes, both of which create barriers to care for beneficiaries.**
- **Continue to provide flexibility, support, technical assistance, and oversight to state Medicaid agencies with the goal of minimizing coverage disruptions during eligibility redeterminations.**

Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage.

What are the specific ways that CMS can support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI-based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan, when applicable.

State Medicaid agencies have historically used different systems to determine applicants' eligibility for modified adjusted gross income (MAGI) eligibility groups and non-MAGI-based eligibility groups, such as those who are eligible on the basis of disability, those over the age of 65, and individuals living in certain institutions. States can integrate their Medicaid eligibility systems for MAGI groups and non-MAGI groups, as well as non-health programs including the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and childcare subsidies. This integration improves administrative efficiency by consolidating eligibility determinations and makes it easier for individuals to apply for multiple assistance programs at once. Aligning these eligibility systems also facilitates information sharing across these programs to verify eligibility and renewals. Thirty-six states [report](#) having integrated non-MAGI Medicaid and MAGI Medicaid and CHIP eligibility systems, 28 states have integrated SNAP and TANF into their Medicaid eligibility systems, and 15 states have integrated childcare subsidies. The AAFP encourages CMS to continue providing guidance and technical support to states on how best to align MAGI and non-MAGI eligibility systems and incorporate data from non-health programs. CMS should assist states with creating multi-benefit applications for these aligned programs and CMS can facilitate sharing best practices across states.

Under federal Medicaid regulations, before a state can send out renewal documents and require enrollees to respond, it must first attempt to renew coverage *ex parte*, or by reviewing available data sources and trying to confirm ongoing eligibility. Ex parte renewals help individuals retain coverage and reduce administrative burdens for both the state and enrollee. While 42 states process ex parte renewals, only 11 states [report](#) completing 50 percent or more of renewals using ex parte processes. Twenty-two states report completing less than 50 percent of renewals using ex parte processes, and 11 of those states use ex parte renewals for less than 25 percent of renewals. The AAFP appreciates recent CMS guidance notes states can expand the data sources they use to verify ongoing eligibility, and we urge CMS to further support states by issuing guidance about the scenarios states face when updating their eligibility systems, specifically, when ex parte processes are permitted and encouraged for renewals. This guidance should also provide technical support on best practices. **CMS should work with those states that are conducting few or no ex parte renewals to improve efficiency of the renewal process, especially ahead of the end of the PHE and the related continuous coverage provisions.**

In what ways can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups, which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?

As mentioned previously, encouraging and increasing ex parte renewals is a critical strategy for minimizing barriers to enrollment and retention, including for members of all of the listed groups. **We recommend CMS prioritize activities that will facilitate the use of ex parte renewals, including additional guidance, technical assistance, and other support CMS can provide states.**

CMS should assist states with strategies for targeted community outreach and funding support for community-based organizations who are connected with populations that may face barriers to enrollment. This includes CMS advising states with specific recommendations on how to effectively use United States Postal Service data to conduct outreach to enrollees. Community-based organizations, which may also increase access to interpreters and culturally competent patient navigators for applicants, can help applicants gather the appropriate documents, discuss requirements and applications, and appropriately plan for application or renewal deadlines. Community-based organizations can help disseminate information at local churches, daycare programs, social functions, various treatment facilities, and more, in a culturally competent way.

When used to remind enrollees of renewal requirements and health care appointments, aid with navigating plan benefits and resources, and provide fundamental health education, text messaging can be an effective method of communication for individuals with Medicaid. 92 percent of adults earning less than \$30,000 [own a mobile phone](#) and 97 percent of low-income phone owners [use text messaging](#). These phone owners indicated that 89 percent would [prefer](#) communicating by text to have more flexibility and privacy in situations like working in hourly positions that limit taking personal calls.

The AAFP appreciates the existing guidance CMS has issued promoting the use of text messaging to reduce coverage losses amid unwinding of the PHE. In the guidance, CMS recommended states use text messages to encourage consumers to apply for other health coverage if they are determined to no longer be eligible for Medicaid or CHIP and encouraged states to request that managed care plans use additional modalities, including text, to conduct outreach to beneficiaries to encourage them to complete renewal forms. The AAFP supports these recommendations but is concerned the Telephone Consumer Protection Act (TCPA) continues to be a barrier to outreach as many health care entities will not conduct text outreach out of fear of violating the TCPA. **CMS should work with FCC to develop guidance to states to assure health care entities can conduct outreach to applicants and enrollees beyond the end of the PHE without violating the TCPA.**

The AAFP is concerned about the barriers people who are experiencing unstable housing or homelessness face during enrollment. Identity verification is largely reliant on addresses and other documentation that is particularly difficult for people experiencing unstable housing or homelessness to access and appropriately document. Additionally, many of these individuals may not receive the appropriate notices, claims, or denial letters when sent only via mail. Black, Hispanic, and indigenous populations are more likely to experience homelessness, and transgender people experiencing

homelessness are more likely to be unsheltered compared to their cisgender peers.^{1, 2} Enrollment applications should include options to indicate when an individual is experiencing unstable housing to alert states that these individuals should be contacted through methods besides mail. We recommend CMS share these unique considerations with states and provide them with resources and technical assistance to ensure they are equipped to communicate with beneficiaries experiencing homelessness, including via text messaging.

What key indicators of enrollment in coverage should CMS consider monitoring? For example, how can CMS use indicators to monitor eligibility determination denial rates and the reasons for denial? Which indicators are more or less readily available based on existing data and systems? Which indicators would you prioritize?

The AAFP recommends CMS monitor enrollment indicators for groups that are particularly vulnerable and/or at risk of losing their coverage. For example, CMS could consider monitoring denials for children. About half of all children (nearly 40 million) are currently insured by Medicaid or CHIP, with the vast majority enrolled in Medicaid.³ Most children who lose their Medicaid coverage during redeterminations will experience a period of uninsurance because 1) they lose Medicaid eligibility and get lost in transition to another public program (most likely CHIP) or 2) they lose their Medicaid coverage for administrative or procedural reasons.⁴ These gaps in coverage can result in children not receiving the preventive and primary care they need, as well as expose families to high medical bills.

Individuals with limited English proficiency may face barriers to renewal and responding to enrollment-related requests due to the lack of accessible information. CMS should consider monitoring denials for this population to ensure states are taking steps to make enrollment forms and other information accessible across languages.

CMS should also monitor enrollment denials for people experiencing homelessness and members of the LGBTQ+ population. As noted above, people experiencing unstable housing or homelessness may be challenging to contact, face verification difficulties and, therefore be more likely to be denied enrollment. Additionally, current data on LGBTQ+ enrollment, particularly for transgender and gender non-binary (TNB) patients, is limited. Current estimates indicate approximately 152,000 TNB individuals are enrolled in Medicaid across the U.S.⁵ However, this estimate is based only on the state Medicaid-enrollment rate and size of LGBT population in each state because existing survey data does not disaggregate transgender and cisgender enrollees.⁶ The AAFP has long-supported improving gender-identity data and supports CMS' monitoring of enrollment denial rates to ensure TNB individuals are not facing discrimination. However, the AAFP recognizes this population faces higher rates of discriminatory treatment in and outside of health care settings, and TNB patients may feel unsafe disclosing their gender identity or TNB status in certain environments.

Any data collection and monitoring strategy implemented by CMS must balance the goal of monitoring denials of particularly vulnerable populations and avoiding erroneous denials with the potential harms of self-reporting sensitive demographic information.

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage.

How should states monitor eligibility redeterminations, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?

The AAFP applauds the recent [guidance](#) published by CMS providing states with more time to complete eligibility redeterminations and outlining waivers and other strategies states can use to update beneficiary information once the public health emergency ends. We were pleased that CMS focused heavily on various strategies states can use to minimize churn and instead facilitate continuous health coverage. We are also supportive of the requirements for states to submit redetermination plans, as well as CMS' planned monitoring and oversight activities to ensure states' redetermination operations are not resulting in errors or unnecessary coverage losses. The AAFP is strongly supportive of these goals.

We have several recommendations for how CMS could provide states with additional support. **First and foremost, [CMS should](#) provide states and managed care plans with at least 120 days' notice before unwinding the FMAP and Maintenance of Effort (MOE) provisions of the Families First Coronavirus Response Act (FFCRA).** This will allow states to more accurately plan their workstreams, hire necessary staff, update health IT systems, and any other steps needed to minimize erroneous denials. As policymakers have conversations about the timing of the end of the PHE, we urge CMS to continue working with states on a predictable, transparent, and evidence-informed wind down of the enhanced FMAP and continuous coverage requirements that provides sufficient guardrails to protect beneficiaries while also reflecting the trajectory of the COVID-19 pandemic.

CMS should also consider leveraging navigators and/or provide states with funding for navigators to assist state health officials and Medicaid enrollees with the redetermination process, including assisting individuals who are no longer eligible for Medicaid in enrolling in qualified health plans. Amid reports that state Medicaid agencies are short staffed, providing federal funding for navigator support could help ensure beneficiaries have the support they need when navigating the redetermination or special enrollment process while also lessening the burden on state agencies.

The AAFP has previously expressed [concerns](#) with the practices that may be used by enrollment broker organizations and have resulted in prospective QHP enrollees being steered away from affordable, comprehensive qualified health plans to limited benefit plans.⁷ Brokers are less likely than marketplace assister programs to help consumers who are uninsured, need help in another language, or who apply for Medicaid.⁸ We urge CMS to ensure that the entities it leverages or encourages states to use throughout the redetermination process will support our shared goals of facilitating access to affordable, comprehensive health coverage.

CMS should continue to support states in preparing IT systems for eligibility redeterminations, including the implementation of electronic health record (EHR) and patient portal reminder messages

for clinicians and patients. CMS could partner with major EHR developers to facilitate the implementation of automated EHR alerts at the point of care. that direct patients to contact their managed care plan or state Medicaid agency any time their contact information changes to ensure they receive timely notifications about application requirements. These alerts could prompt clinicians to inform patients when their Medicaid coverage may be up for redetermination and remind them to ensure contact information is up-to-date and respond to eligibility notices. Alerts in patient portals could include guidance and information on how to report contact information changes and changes in circumstance that might affect Medicaid eligibility as well as, direct patients to resources that can connect them with alternative coverage and safety net care in the event they lose Medicaid coverage.

CMS could also develop fliers and signs to be distributed and hung in physician offices, community health centers, hospitals, and other locations where enrollees may be regularly seeking care. Primary care practices, community health centers, and Title X clinics are also uniquely positioned to share information with patients in a culturally competent, accessible way. CMS should create educational materials that can be posted at these facilities and distributed to patients directing them to update their contact information and prepare for renewals or enrollment in QHPs. We appreciated the suite of tools that were included when CMS published its latest guidance to states but we believe materials specifically designed to be distributed in health care settings could help raise awareness about renewal requirements among enrollees, particularly for those with conditions that require regular contact with the health care system and therefore could be negatively impacted by gaps in coverage.

How should CMS consider setting standards for how states communicate with beneficiaries at-risk of disenrollment and intervene prior to a gap in coverage? For example, how should CMS consider setting standards for how often a state communicates with beneficiaries and what modes of communication they use? Are there specific resources that CMS can provide states to harness their data to identify eligible beneficiaries at-risk of disenrollment or of coverage gaps?

Contacting beneficiaries solely through traditional mail has proven to be vastly ineffective, due to changes in address and delays in mail delivery. We appreciate CMS advising Medicaid agencies to use multiple forms of communication to reach enrollees to discuss their eligibility or redetermination status and/or application status, including text messages, phone calls, and emails, in addition to traditional paper mail, which is still important for enrollees who may not have access to technology. Importantly, multiple renewal notices and follow-up reminders can increase the response rate to renewal requests. **The AAFP recommends CMS require states to send reminder notices using at least two different modes of communication before terminating coverage.**

The AAFP also appreciates CMS requiring states to provide beneficiaries who are eligible based on MAGI methodologies with a minimum of 30 days to return their pre-populated renewal form and any requested information. However, we remain concerned that 30 days is too short a time period for many beneficiaries to be able to return the requested information. **We recommend CMS extend this minimum period to 60 days to ensure beneficiaries have adequate time to respond to renewal requests.**

Outreach to enrollees is critically important, especially for hard-to-reach communities. CMS should equip states with resources to initiate targeted outreach through community partnerships to notify enrollees of potential coverage changes, obtain updated contact information, and assist with applications or renewals. These outreach strategies should be conducted with established community

leaders and key stakeholders to ensure messaging is culturally competent and appropriately tailored to various groups, so it is well-received and understood by enrollees. CMS should also consider providing funding to community-based organizations with established relationships with Medicaid populations that may face additional barriers to enrollment.

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?

Some enrollees will no longer be eligible for Medicaid coverage once COVID-19-related continuous coverage policies change and eligibility redeterminations begin. **We wholeheartedly agree with CMS' emphasis on ensuring those individuals continue to have access to affordable, comprehensive health coverage.** The AAFP is pleased that CMS' most recent [guidance](#) to state health officials reiterates the requirement for states to transfer to the marketplace the electronic accounts of beneficiaries who the state assess as potentially eligible for coverage through the Marketplace, including all eligibility-related information available to the state. The guidance directs states to consider all individuals who are determined ineligible for Medicaid or CHIP as potentially eligible for QHP enrollment and outlines additional strategies for states to facilitate successful transitions and enrollment in a QHP. We applaud these inclusions and encourage CMS to continue to build on these strategies and resources ahead of the redetermination period.

In addition to encouraging states to facilitate transitions from Medicaid to QHP coverage, **CMS should take steps to reduce the burden of the enrollment process on consumers.** Evidence indicates that potential QHP enrollees may be unaware of their ability to benefit from marketplace subsidies and choose not to enroll in a QHP because they do not believe they can afford to.⁹ Potential QHP enrollees also face administrative hurdles that can ultimately prevent successful enrollment.¹⁰ CMS could develop informational materials for state Medicaid agencies to send to enrollees that are no longer eligible for Medicaid/CHIP upon redetermination. These materials should provide clear instructions for how and when to enroll in a QHP, as well as detailed information on eligibility for marketplace subsidies. Studies show that government advertising and public outreach campaigns have successfully facilitated QHP enrollment during previous open and special enrollment periods.¹¹ CMS should also consider using its authority to lengthen the special enrollment period for individuals who lose their Medicaid/CHIP coverage during the redetermination process and may not be eligible for the new low-income special enrollment period.

CMS should also consider similar targeted outreach and educational resources for current Medicaid enrollees who may have become eligible for Medicare and missed their initial Medicare enrollment period. We appreciate that CMS encouraged states to reach out to these beneficiaries to advise them to enroll in Medicare as well as align redeterminations for these beneficiaries with a future Medicare enrollment period. The AAFP recommends CMS also conduct direct outreach to enrollees who missed their initial enrollment period and may face penalties and coverage gaps to provide them with technical assistance. CMS could consider using navigators to facilitate these processes.

What are the specific ways that CMS can support states that need to enhance their eligibility and enrollment system capabilities? For example, are there existing data sources that CMS could help states integrate into their eligibility system that would improve ex-parte redeterminations? What barriers to eligibility and enrollment system performance can CMS help states address at the system and eligibility worker levels? How can CMS support states in tracking denial reasons or codes for different eligibility groups?

We are pleased to see CMS encourage states to use SNAP and TANF data to automatically renew beneficiaries for coverage when they continue to be eligible without requiring paperwork. Several [states](#) also already use Supplemental Security Income (SSI) eligibility to determine Medicaid eligibility. These strategies help reduce burden on state Medicaid agency personnel and enrollees, as well as increase efficiency. CMS should continue encouraging states to employ these strategies and provide technical assistance to states when challenges arise with implementing them.

We recommend CMS further support states by re-issuing a previous exception to the cost allocation requirements set forth in the Office of Management and Budget (OMB) [Circular A-87](#) to allow federal programs to benefit from investments in the design and development of State eligibility-determination systems for State-operated Exchanges, Medicaid, and the Children's Health Insurance Program (CHIP). In 2011, HHS and the U.S. Department of Agriculture issued this exception to encourage states to leverage the technology investments and advances in streamlined enrollment required under the Affordable Care Act (ACA) for modernizing eligibility and enrollment for other safety-net benefits. Reviving this time-limited tool would help enable data connections between public agencies that conduct enrollment and renewal processes.

Providing an exception to the cost allocation requirements in OMB Circular A-87 would allow states to do more to integrate the eligibility determination and enrollment functions across programs, realizing efficiencies for States and serving individuals and families. Integrated eligibility systems would allow individuals and families to access critical safety-net services without having to complete multiple enrollment processes and without government workers processing the same information again and again.

States could also utilize this waiver to connect health programs to external sources of data that can verify eligibility without requiring individuals and families to complete repetitive paperwork. States could also simultaneously enroll eligible individuals into health coverage as well as other programs for which they are eligible by improving data matching, establishing more robust referral mechanisms, streamlining business processes, and notifying program participants of their potential eligibility for other benefits. By promoting more integration of IT systems across health and social services programs through the A-87 exception, CMS can assist states in implementing strategies included in the March 3 guidance related to syncing Medicaid and CHIP redeterminations with recertifications for human service programs including SNAP and TANF, and establishing linkages to the U.S. Postal Service National Change of Address database.

CMS can also use the A-87 exception to encourage states to integrate all safety-net programs, regardless of state agency. Given the millions of Americans who faced unemployment during the public health emergency and the technology challenges state unemployment agencies faced to meet the unprecedented demand, states will be looking to improve their unemployment IT systems. This presents an opportunity for CMS to partner with the U.S. Department of Labor to leverage federal

technology investments that will be made to improve access to unemployment to also improve access to health and social services. For example, creating more direct linkages between unemployment Insurance benefits and Medicaid, CHIP, and ACA-exchange plans could help consumers who may have lost employer-based coverage avoid a gap in coverage and disruption in treatment.

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.

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?

The AAFP has long [called](#) for CMS to implement federal access standards and a comprehensive national monitoring approach. **CMS should set minimum federal access standards for primary care, behavioral health, specialty, and emergency care for both children and adults.** These minimum standards should function as a floor for states, with the option to set higher standards if the state so chooses. The AAFP supports the use of time and distance standards across programs, including in Medicaid and CHIP. We [opposed](#) previous regulations that rescinded requirements for states to set time and distance standards and instead allowed states to set any “quantitative” standard and choose whether to set any minimum for specialists. Inconsistent approaches to setting network adequacy standards contribute to geographic disparities in access to care and ultimately health outcomes. We have long supported the use of federal time and distance standards to facilitate timely access to primary care.

In addition to creating separate standards for primary care, behavioral health, and specialty care, **the AAFP recommends CMS set separate standards for substance use disorder (SUD) treatment.** We are concerned that, if SUD treatment is only monitored as part of behavioral health care access, CMS, states, and other stakeholders will be unaware of beneficiaries' unique challenges with obtaining SUD treatment. We note that many family physicians provide buprenorphine treatment in their practices, often serving as the only source of outpatient SUD treatment in their communities. Time and distance standards should recognize the availability of SUD treatment in primary care clinics and also acknowledge the limited capacity these practices have to take on new patients due to regulatory and other requirements.

The AAFP also supports the establishment of appointment wait time standards (in addition to using appointment wait times in access monitoring). Maintaining a robust network of primary care physicians and ensuring timely access to routine primary care are foundational components of comprehensive health coverage. Patients often first seek care for an acute or chronic issue with their primary care physician and most rely on them completely for recommended preventive services. Existing appointment wait time standards for routine primary care vary across plans and coverage types. We've found that a 10-day maximum standard wait time is relatively common and we believe an appropriate maximum wait time in many areas.

CMS should consider implementing different appointment wait time standards for SUD treatment services and other behavioral health services. CMS should, at a minimum, monitor SUD appointment wait time separately. Given the well documented lack of SUD treatment providers, the importance of care continuity throughout SUD treatment, and the potential harm that could be caused by long appointment wait times, we believe different standards may be needed to ensure equitable access to SUD care for Medicaid beneficiaries. Further, many other behavioral health services, such as cognitive behavioral therapy, also require regular, reoccurring appointments. Separately measuring and monitoring behavioral health appointment wait times would ensure that states and CMS identify barriers to regular appointments, which may not be captured by time and distance standards and monitoring.

The AAFP recommends CMS monitor the availability of integrated behavioral health services in primary care and consider implementing access standards for these services in the future. Integrating behavioral health services into primary care can improve enrollees' access to and utilization of needed behavioral health services, can help mitigate disparate access to behavioral health clinicians, and has shown significant cost-savings for payers and physicians.^{12, 13} In considering this for future standards and measurement, we note that integrated behavioral health services are not yet defined but can include consistent coordination of referrals and exchange of information, colocation of services in the primary care setting, or full integration of treatment plans shared between primary care and behavioral health clinicians. In order to effectively measure access to integrated behavioral health services or create a future standard, CMS will need to work with stakeholders to outline what level of integration is required. The AAFP stands ready to work with CMS to advance access to and measurement of integrated behavioral health services.

Finally, the AAFP is strongly supportive of states expanding coverage and payment of telehealth services and believes that when implemented thoughtfully, telehealth can improve both access to care and patient experience. **To achieve the promise of telehealth and ensure that Medicaid beneficiaries have equitable access to virtual care, the AAFP recommends that CMS separately monitor telehealth services.** This will allow states and CMS to determine which patient groups are utilizing telehealth most/least in order to identify access disparities and potential barriers. If CMS or individual states implement specific telehealth access standards in the future, the AAFP urges that such standards apply to the availability of telehealth services provided by a patient's usual source of care.

Importantly, states and managed care plans should not be able to count the availability of telehealth services provided by virtual, direct-to-consumer companies toward meeting minimum federal access standards for primary and emergency care. These types of telehealth providers cannot serve as a substitute for comprehensive, longitudinal, person-centered primary care. Similarly, while telehealth can be used effectively to triage and treat some urgent, acute illnesses and injuries, it is inappropriate and dangerous to rely on virtual-only clinicians as a substitute for emergency care. **Primary care and emergency clinicians providing telehealth services should only be included in access standard calculations if the clinician is also providing in-person care for Medicaid beneficiaries within the established time and distance standard.**

We note that tele-mental health services provided by virtual, direct-to-consumer companies could, in some cases, be an appropriate substitute for in-person care and significantly increase beneficiaries' access to needed behavioral health services. Medicaid beneficiaries face significant barriers to accessing affordable, comprehensive behavioral health care. According to MACPAC, adults with

mental illness enrolled in Medicaid were more likely to report that they needed but did not receive mental health treatment or counseling in the past year than those with private coverage.¹⁴ Family physicians regularly report that they are unable to connect their patients to behavioral health services due to workforce shortages. As such, tele-mental health services could effectively improve Medicaid beneficiaries' access to counseling and other services. CMS could permit states and managed care plans to count mental health services provided by virtual, direct-to-consumer companies toward meeting time, distance, and appointment wait time standards. CMS should determine whether it is appropriate to apply an in-person requirement to access standards for other clinical specialties.

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?

CMS should require states to regularly report data demonstrating their performance on all minimum access standards. This includes regular reporting on access to care within set time and distance standards and appointment wait times. These reports should also be made publicly available in order to provide stakeholders with insight into access challenges and enable the public to engage in the development of solutions.

CMS' monitoring approach should focus on addressing racial and other well documented disparities in access and beneficiary experience. A recent study published in *Health Affairs* found that compared with White enrollees, minority Medicaid managed care enrollees reported significantly worse care experiences.¹⁵ These disparities were observed with respect to patients' reported access to needed care and access to a personal doctor. Similarly, a recent MACPAC issue brief found that Hispanic and Black, non-Hispanic adults were also less likely than white adult Medicaid beneficiaries to have received primary care visits and mental health care in the past 12 months.¹⁶ Similar disparities are observed among children covered by Medicaid: white children were more likely than those in most other racial and ethnic groups to self-report having very good or excellent health, receive their usual care at a doctor's office, and to have seen a general doctor and a medical specialist in the past 12 months.¹⁷

Comprehensive race and ethnicity data collection is an essential step to identifying and ultimately addressing racial access disparities. However, in a separate brief focused on the availability of race and ethnicity data, MACPAC found that only thirty states met the minimum data quality standards necessary for conducting analyses using 2019 race and ethnicity data.¹⁸ As such, the **AAFP recommends CMS assist states in improving race and ethnicity data collection among Medicaid beneficiaries.** Modifying the universal billing forms to collect race and ethnicity data is one way CMS could advance data collection.

The AAFP further recommends that CMS require states to report certain data stratified by race, ethnicity, and other demographic factors, such as dual-eligibility status or primary language. This requirement will facilitate the identification of access disparities. **CMS should then require states to submit plans for how the state will address access disparities and regularly report on their progress to close access gaps for beneficiaries of color, those with limited**

English proficiency, LGBTQ+ beneficiaries, and other populations experiencing systemic barriers to care.

In addition to requiring that states report access data stratified by demographic characteristics, **CMS should incorporate the patient experience into the federal monitoring strategy.** A [study](#) examining perceived discrimination in health care found that adults with Medicaid perceived more discrimination due to race or skin color compared to those with employer-sponsored coverage. Examining six reasons for lifetime discrimination in health care - including: dissatisfaction with the health care system, race or skin color, age, language (non-English), insurance status or type, and income or education - the study concluded that failure to address quality and patient experience will disproportionately affect low-income and underserved populations. Other [research](#) has found that individuals who report discrimination are less likely to receive preventative services, and a substantial number of individuals reporting recent discrimination, particularly among those in fair or poor health, have greater unmet needs or barriers to care. Intentionally incorporating patient experience data into state and federal monitoring will enable CMS and states to identify whether discrimination is creating barriers to care for beneficiaries, as well as more comprehensively measure beneficiaries' realized access to care.

To most effectively incorporate Medicaid beneficiaries' experience with primary care, **CMS should add [the Person-Centered Primary Care Patient Reported Outcome Performance Measure \(PCPCM PRO-PM\)](#) measure to the Adult and Child Core Sets.** The PCPCM is an 11-item patient-reported assessment of primary care from the patient's perspective that focuses on aspects including accessibility, continuity, comprehensiveness, coordination, advocacy, family and community context, and goal-oriented care. The measure moves beyond disease-specific measures and processes of care to assess aspects of primary care that are associated with better population health, lower costs, equity, and higher quality. The survey evaluates items that are valued by patients and physicians and are unique to primary care. Each of the 11 items included in the measure are immediately actionable and enable practices to address challenges and gaps patients report. The data collected through the PCPCM would also enhance the patient experience data collected by CMS, states, and other stakeholders and could help identify barriers to primary care access.

This measure was validated in the pediatric setting and is appropriate for measuring patient experience for both children and adults. The PCPCM PRO-PM received endorsement from the National Quality Forum (NQF) in 2021. Starting in 2022, it is available as a quality measure in the Merit-based Incentive Payment System (MIPS) and included in the family medicine and internal medicine measure sets. The AAFP is a strong supporter of the measure and we recommend CMS include it in the Medicaid Adult and Child Core sets.

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?

There are significant gaps in the provision of mental health care services in the U.S., especially for Black, Hispanic, and low-income populations.¹⁹ Today, 139 million Americans live in mental health professional shortage area.²⁰ Roughly two-thirds of primary care physicians are unable to connect their patients to outpatient mental health services.²¹ This results in the need for primary care physicians to assume a leading role in the management of mental health care services.²² In fact, primary care physicians see nearly 40 percent of all visits for depression, anxiety, or cases defined as “any mental illness” and are more likely to be the main source of physical and mental health care for patients with lower socioeconomic status and for those with co-morbidities.²³

The AAFP strongly supports integration of behavioral health services, including treatment for substance use disorder, within primary care practices. This care should be accessible, comprehensive, and coordinated across clinician types. Evidence supports behavioral health integration into primary care for its ability to improve access to behavioral health care, reduce care fragmentation, and save patients, physicians, and payers money²⁴. As the single largest payer for behavioral health services in the U.S., Medicaid is vital for facilitating equitable access to behavioral health care.²⁵ Managed care organizations are increasingly opting to cover behavioral health services, and some states are moving to remove carve-outs that exclude behavioral health care under Medicaid. However, some states still restrict same-day or double billing, which prevents a physician and other behavioral health provider from billing for a physical and mental health visit in the same day.²⁶ While designed to discourage unnecessary referral, this policy ultimately limits care coordination and behavioral health integration uptake.

Additionally, Medicaid coverage for certain behavioral health services and provider types is variable across states and current coverage limitations can inhibit integration of services within primary care.²⁷ Without further clarity, behavioral health integration and care coordination will remain limited under Medicaid programs. CMS should encourage or require states to eliminate policies that prohibit payment of a behavioral health encounter on the same day as a medical encounter. CMS should also advise states on how they could modify coverage for high-quality, evidence based behavioral health services provided by appropriate clinicians in order to facilitate integration and better access to care.

As mentioned above, the AAFP recommends CMS and HHS work with stakeholders to outline what level of behavioral health integration is required to meet patient need. At this time, the AAFP recognizes that having consistent coordination of referrals with exchange of information constitutes integrated care. While warm hand-offs and colocation of services with same-day physical and behavioral health visits may be more beneficial for certain patients, not all patients require this. **The AAFP supports efforts to ensure minimum standards are beneficial for patients but would also like to highlight the need for flexibility in providing integrated services.** The AAFP stands ready to work with HHS to advance access to and measurement of integrated behavioral health services.

Additionally, existing programs under Medicaid, like the early, periodic, screening, diagnostic, and treatment (EPSDT) benefit, have potential to improve access to early prevention and treatment for children and adolescents presenting with behavioral health concerns. However, state Medicaid programs implement EPSDT and medical necessity determinations differently, especially when contracting with Medicaid managed care plans. This variation has resulted in barriers to accessing mental health services treatment for children in some states. **To improve the coordination of behavioral health care for Medicaid beneficiaries, the AAFP recommends CMS evaluate EPSDT implementation in states and release an informational bulletin clarifying coverage of**

EPSDT services to facilitate access to prevention, early intervention, and mental health services.

The AAFP has long supported [mental health parity](#). The Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act requires parity for the payment and treatment limitations of mental health and substance use disorder treatment at the same level as medical and surgical treatments. However, monitoring and oversight of parity requirements is limited, and evidence shows existing laws have not led to improvements in behavioral health access. Historically, mental health and substance use disorder (MH/SUD) benefits have been accompanied by more non-quantitative treatment limitations (NQTL) than medical and surgical (M/S) benefits. States and plans reported that analysis of NQTLs, like prior authorization and step therapy, is difficult when comparing M/S and MH/SUD benefits. The AAFP remains hopeful that the CMS guidance and enforcement of NQTL comparative analyses that began in 2021 will continue to address the discrepancy between MH/SUD and M/S. However, physicians report prior authorizations and step therapy requirements overall continue to increase across services and treatments, indicating implementation and enforcement of MHPAEA may not sufficiently improve access to behavioral health services. Additional action is needed from CMS to improve timely access to care.

The AAFP also recognizes that broader reform, beyond NQTLs, is needed to ensure states and MCOs make changes to improve overall access to behavioral health care. Requirements to document and facilitate access to behavioral health services, when accompanied by more specific access standards and oversight and monitoring, could provide more meaningful improvements to access. As referenced above, the AAFP also supports creating separate standards for SUD treatment given unique concerns and barriers to obtaining SUD treatment. Time and distance standards should recognize the availability of SUD treatment in primary care clinics and also acknowledge the limited patient capacity due to regulations and other requirements.

Specifically for pregnant and postpartum individuals, Medicaid is a primary payer of maternity care in the U.S., covering 43 percent of births nationwide.²⁸ The American College of Obstetricians and Gynecologists recommends clinicians providing obstetric services provide comprehensive mood and emotional well-being screenings during the comprehensive postpartum visit and that treatment is initiated when needed.²⁹ This includes treatment with their physicians or referral to a mental health clinician and follow-up consultations.³⁰ The comprehensive postpartum visit generally occurs between 6 to 12 weeks after birth.³¹ Yet under longstanding federal law, Medicaid coverage based on pregnancy status ended 60 days postpartum. This arbitrary cutoff point leaves many individuals uninsured at a vulnerable time in their physical and mental health. Additionally, current guidance defines postpartum depression as developing within 6 weeks of birth, making it challenging for a postpartum patient to receive diagnosis and treatment before losing Medicaid coverage. The AAFP recently applauded the Administration's efforts to encourage states to extend postpartum Medicaid coverage from only 60 days to 12 months postpartum. Extending postpartum Medicaid coverage will provide birthing people with continuous coverage and improve access to mental and physical health care throughout the full, one-year postpartum period. Interruptions in health insurance coverage results in care fragmentation and makes it difficult for patients to continue seeing a physician who understands their full medical history and whom they trust. **The AAFP reiterates our support for efforts to extend Medicaid postpartum coverage for 12 months.**

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?

Family physicians report challenges to connecting with medical interpreters and translators, particularly for their Medicaid patients. Certification requirements and low pay have been cited as major hurdles to recruiting a sufficient interpreter workforce. **CMS should incorporate access to language appropriate care in minimum federal standards and in access monitoring. CMS should also work with states to provide affordable or no-cost quick-access virtual interpretation in physician practices and other medical facilities.** These services are particularly important for physician practices in rural and frontier areas, as well as those that do not have a robust interpreter workforce in their area.

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?

The AAFP recommends CMS prioritize initiatives to address low Medicaid payment rates, accelerate the transition to value-based care, improve transparency of Medicaid graduate medical education funding, and ensure permanent coverage and payment policies facilitate equitable access to telehealth services from a patient's usual source of care.

Medicaid Payment Rates

CMS should support states in raising Medicaid payment for primary care services to at least Medicare rates. As discussed in more detail below, low Medicaid physician payment rates have historically been a barrier to care for beneficiaries. Physicians cite inadequate payments as a primary reason for not accepting new Medicaid patients. These low rates negatively impact primary care physicians' overall compensation and deter medical students and residents from choosing to practice primary care. A recent analysis found that the median annual compensation rate for family physicians was almost half of the median compensation rate for some specialists.³² Increasing Medicaid payment rates for primary care would help address this compensation disparity and encourage more trainees to become primary care physicians, ultimately increasing the pool of Medicaid and CHIP clinicians.

Alternative Payment Models

CMS should continue its efforts to increase primary care alternative payment models (APMs) that are inclusive of Medicaid and CHIP beneficiaries. Accelerating the transition to value-based care has the potential to improve access to care for beneficiaries while also enabling practices to provide advanced primary care services. APMs provide primary care practices with a stable and predictable revenue stream, which provides them with the flexibility they need to transform care delivery and meet patients' health related social needs. Increasing the availability of models with stable, robust prospective payments would help address long standing challenges with low Medicaid payment rates, provided that the prospective payments adequately support the high-value care practices deliver. For example, practices participating in APMs often choose to hire social workers,

mental health professionals, pharmacists, or other additional staff that are equipped to provide behavioral health care, connect patients to community services, and expand care coordination and medication management services.

Unfortunately, there are currently few primary care models that incorporate Medicaid and CHIP beneficiaries. The AAFP is pleased that the Center for Medicare & Medicaid Innovation (CMMI) has acknowledged this gap and set a goal to have most Medicaid beneficiaries in an accountable care relationship by 2030. We are also pleased that CMMI is working to ensure that community health centers and other [safety net providers](#), including physician practices, can participate in alternative payment models and deliver advanced care to their patients. CMS should [make technical improvements](#) to existing models, broaden model opportunities across payers, and harmonize model requirements among payers, including Medicaid. This, along with developing transparent, stable APMs with ongoing input from physician stakeholders, will encourage physician participation in APMs and enable them to move into more advanced models over time. Incorporating Medicaid and CHIP beneficiaries in APMs will facilitate equitable access to high-quality primary care and is an important step to advancing health equity.

Medicaid Graduate Medical Education

The AAFP has long been concerned about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. After Medicare, Medicaid is the second largest source of funding (\$5.6 billion annually) for Graduate Medical Education (GME).³³ Unlike Medicare or other federal GME payment programs, there is no federal guidance for Medicaid GME, so, states have significant flexibility in designing and administering their Medicaid GME payments.

The lack of a diverse physician workforce also has significant implications for public health. The Medicaid beneficiary population is quite diverse - more than half (61.1 %) of the program's 73 million beneficiaries identify as Black, Hispanic, Asian American, or another non-white race or ethnicity.³⁴ Studies show that racial, ethnic and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.^{35,36} While primary care specialties fare better than other specialties in representation of racial and ethnic minorities in the workforce, the entire physician workforce lags significantly behind the racial and ethnic diversity of the U.S. population. Today, Black and Hispanic Americans account for nearly one-third of the U.S. population, but just 11 percent of physicians.^{37,38}

Together, physician shortages and the lack of diversity result in access barriers and health disparities for patients living in rural and underserved communities. **To correct the shortage and maldistribution of physicians, increase the diversity of physicians, and ultimately improve equitable access to high-quality care, we urge CMS to require states to report how Medicaid GME funding is addressing physician shortages – including information like specialty type, race, ethnicity, and practice patterns of physicians during and post-residency.**

Telehealth

Telehealth use will continue to grow beyond the COVID-19 pandemic, and the AAFP is strongly supportive of permanently expanding equitable, affordable access to telehealth services when provided within the context of the medical home and utilized as a component of, and coordinated with, longitudinal care. When telehealth is provided by a patient's usual primary care physician, it [enhances](#) the patient-physician relationship, increases timely access to quality care, and improves health outcomes. When implemented intentionally and appropriately, telehealth can [advance health equity](#) by enabling Medicaid patients with transportation, time, distance, and language barriers to connect with their trusted primary care physician.

Telehealth services provided by direct-to-consumer (DTC) companies are not integrated into patients' primary care or coordinated with the primary care physician and can result in care fragmentation. In order to promote equitable access to high-quality telehealth services, **CMS should prohibit telehealth carve-outs in Medicaid fee-for-service and managed care.** States and MCOs covering telehealth services should be required to cover services provided by all in-network providers and may not limit coverage to only select virtual-only or DTC providers. Further, CMS should advise states against incentivizing Medicaid enrollees to use DTC telehealth services, for example, by direct marketing or offering lower copays for those services, as this can lead to care fragmentation and in some cases steer patients to the inappropriate modality of care. **States should instead ensure telehealth coverage and payment policies prioritize care provided within the patient's medical home.** Such policies enable primary care physicians to fully integrate telehealth into their practices allowing them to offer a hybrid of virtual and in-person services readily available across their patient panel.

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).

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?

The AAFP recommends CMS implement a uniform monitoring approach that measures potential access to care, utilization or realized access, and patient experience. Within these three domains, CMS should monitor access to primary care, behavioral health care, and specialty care separately for both adults and children, with particular attention to substance use disorder treatment services as mentioned previously. Access to inclusive and linguistically appropriate care, in addition to culturally competent care, should be a priority. The uniform monitoring approach should include an enhanced focus on identifying and addressing access disparities on federal, state, and local levels.

We provide detailed recommendations for measuring potential access in response to the next question below.

It is particularly important to measure realized access and utilization of preventive and other primary care services. Unlike many types of specialty and behavioral health services, primary care services are recommended for all patients and can help prevent future illness or injury. The Medicaid Adult and Child Core Sets provide data on utilization of many preventive care services and therefore CMS should consider using those measures in its monitoring approach. Examples include cancer screenings and depression screenings, as well as contraceptive care. Some of the measures that focus on care for acute and chronic conditions can also provide insight into Medicaid beneficiaries' access to primary care, including controlling high blood pressure and comprehensive diabetes care.

With respect to monitoring behavioral health access and behavioral health integration in primary care, the Core Sets also offer a number of measures that could be used in monitoring. For example, many primary care practices are equipped to prescribe smoking cessation medications and perform antidepressant medication management, both of which are included in the 2022 Adult Core Set.

CMS should use TMSIS data to measure utilization of services that may not be captured in the Core Sets or to provide a more comprehensive understanding of access to various types of services. For example, TMSIS could be used to measure emergency department visits, ambulatory care visits, and dental care.

As previously recommended, we recommend CMS add the PCPM measure to the Medicaid Adult and Child Core Sets in order to incorporate patient experience into quality measurement and access monitoring. The PCPCM measure captures patients' perceived access to primary care, in addition to their experience with care once they've received it. CMS could also use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to capture patients' experience with other types of care in its access monitoring approach. Patient experience measures are also vital to monitoring beneficiaries' access to language accessible care, since the Core Measure Sets and TMSIS data do not capture this important measure.

CMS should minimize reporting requirements for physician practices, which are already overburdened with administrative tasks. Data elements should be standardized and integrated into physicians' EHRs to reduce burden in reporting and collecting data and improve interoperability.

What measures of potential access, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor (e.g., provider networks, availability of service providers such as direct service workers, appointment wait times, grievances and appeals based on the inability to access services, etc.)? How could CMS use data to monitor the robustness of provider networks across delivery systems (e.g., counting a provider based on a threshold of unique beneficiaries served, counting providers enrolled in multiple networks, providers taking new patients, etc.)?

The AAFP recommends CMS prioritize clinician networks and appointment wait times when measuring potential access. A recent Avalere analysis found that Medicaid networks were significantly narrower across clinician types when compared with commercial networks in the same area.³⁹ Another study found that physician turnover in narrow Medicaid managed care networks was

higher than in non-narrow networks, signaling that patients enrolled in plans with narrow networks may experience greater care fragmentation.⁴⁰ CMS should monitor the percentage of participating clinicians across specialties and clinician types, with a special focus on primary care, behavioral health, and pediatric subspecialists. CMS should also consider requiring states to conduct additional access assessments and track physician turnover in narrow networks. For example, CMS could require states to more regularly submit access data for managed care plans that contract with fewer than 30 percent of primary care physicians in their market. CMS should also encourage states to set minimum clinician network requirements that must be met before renewing their contracts with managed care plans.

Since primary care serves as patients' entry point into the health care system, appointment wait times are an essential measure of potential access to primary care. In addition to relying on primary care physicians for recommended preventive services, Medicaid beneficiaries need timely access to primary care in the event of acute illness or injury. **The AAFP recommends CMS set minimum federal appointment wait time standards and continuously monitor performance against those standards.** CMS should use secret shopper surveys to monitor appointment wait times throughout different times of the year in order to capture seasonal fluctuations. States and managed care plans with appointment wait times that are consistently longer than the established minimum standard should be required to submit plans for increasing appointment availability, bolstering clinician networks, or otherwise addressing long wait times.

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible.

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?

To ensure all Medicaid beneficiaries can access high-quality primary care when they need it, CMS should support states in raising Medicaid payment for primary care services to at least Medicare rates. The AAFP has [endorsed](#) legislation to permanently reinstate the ACA primary care payment increase and urges CMS to work with Congress to promptly pass it. Medicaid physician payment remains substantially below Medicare and private insurance payment. Medicaid payment is on [average](#) 66 percent of the Medicare rate for primary care services, but it can be as low as 33 percent in some states. These low rates have historically been a barrier to physicians accepting more Medicaid patients.

An internal analysis of the Medicaid and CHIP Payment and Access Commission (MACPAC) Report on Physician Acceptance of New Medicaid Patients from 2014-2017 revealed that physician acceptance worsens as the ratio of Medicaid payment rates to Medicare decreases. States with higher Medicaid-to Medicare payment ratios typically had higher acceptance rates. Physicians cite low payment as the primary reason they were unable to accept additional Medicaid patients. Managed care plans report caps on clinician's Medicaid patient panels and low physician participation in Medicaid are top [challenges](#) in ensuring access to care. Patients covered by Medicaid [experience](#) longer office wait times, and both low-income patients and their physicians [report](#) that low payment rates lead to shorter, inadequate visit times. On the other hand, evidence indicates patient access

improved when Congress raised Medicaid primary care payment rates to Medicare levels in 2013-2014.

[One study](#) found that appointment availability increased during the “primary care fee bump” and decreased after it expired. States with larger payment increases also had greater [improvements](#) in appointment availability and child health outcomes. Other [studies](#) found the fee bump did not significantly increase physicians’ participation in the Medicaid program, likely due to the temporary nature of the payment increase. MACPAC surveyed physicians about the primary care fee bump and found that it modestly increased willingness to accept new Medicaid patients, though physicians reported early operational issues delaying the start of increased payments were a major challenge.

Raising Medicaid payment for primary care services can improve access to care for Medicaid beneficiaries and in turn mitigate health disparities. Medicaid plays a particularly vital role in providing coverage to pregnant women, rural residents, individuals with disabilities, as well as Black, Indigenous, Hispanic, and other people of color. More than 30 percent of Black, Indigenous, and Hispanic adults and children have Medicaid coverage. By improving coverage and affordability of primary care, the ACA significantly [reduced](#) racial and ethnic disparities in care utilization and access. However, the [odds](#) of [residing](#) in a physician shortage area are much higher for predominantly Black neighborhoods. Sixty-one percent of Primary Care Medical Health Professional Shortage Areas are also in rural areas, suggesting these populations may be [impacted](#) most by changes in Medicaid physician participation. Increasing Medicaid rates would help to further mitigate health inequities.

While raising Medicaid payment rates would likely be the most impactful solution, we recognize federal legislation may be necessary for states to finance the increase for primary care. There are a number of steps CMS can take absent congressional action to improve the identification of payment-related access barriers. **As CMS develops minimum federal standards and strengthens access monitoring, we recommend enforcing existing access monitoring regulations and implementing a national monitoring approach to assess the impact of Medicaid rates on access.**

CMS previously recognized the negative impacts of low Medicaid rates and finalized regulations requiring states develop and submit to CMS an access monitoring review plan (AMRP) that is updated at least every three years for certain specified services and must identify a process to review and monitor access to care. When states reduce Medicaid payment rates or restructure them in circumstances when the changes could result in diminished access, they must implement special monitoring procedures to monitor the effects of the rate reduction or restructuring for at least 3 years after the effective date of the change. Any time an access deficiency is identified, the state must submit a corrective action plan to CMS within 90 days after discovery and work to address the issues within 12 months. When these regulations were finalized, the AAFP [expressed](#) appreciation that CMS was improving its monitoring of the impacts of Medicaid rate changes but called on the agency to implement a more comprehensive national monitoring approach.

Unfortunately, states have not been required to submit AMRPs since 2016 and therefore have not been required to measure changes in access to care. We are concerned that CMS has again [delayed](#) the requirement for states to submit updated AMRPs, which were previously due in October 2022, to October 2024. While we understand that states are under strain responding to the PHE and preparing for eligibility redeterminations, we fear this postponement will lead to undetected access challenges for beneficiaries. This situation illustrates the challenges and shortcomings of a state-based

monitoring system. **Enforcing existing regulatory requirements, including the submission of updated AMRPs and other reports, is an important first step in restoring federal oversight.**

The current monitoring approach focuses on how changes to Medicaid rates impact access and therefore may not detect long standing negative impacts of low Medicaid rates. **CMS should implement a national monitoring approach that regularly assesses the impact of Medicaid rates on access, instead of relying on states to report rate changes and monitor the effects.** A national approach could enable CMS to make helpful state comparisons and identify common rate-related access challenges across a number of states. For example, CMS could regularly assess the robustness of clinician networks and patient utilization of recommended services (like preventive care, chronic care management, or perinatal care) against states' Medicaid-to-Medicare payment ratios. This approach would allow CMS to examine how alternative payment models and other innovative payment arrangements that are implemented across the country impact access to care. CMS could also examine how new payment arrangements impact beneficiaries' perceived access and experience.

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 AAFP recommends CMS increase participation opportunities of APM that are inclusive of Medicaid beneficiaries and aligned across payers. As previously mentioned, APMs have the potential to address the payment-related barriers to access for Medicaid beneficiaries and enable practices to provide more comprehensive, whole-person care. Quality and performance measurement are built into APMs, which make it easier for states and CMS to evaluate how effective various models may be at improving access and quality of care.

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. 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?

Billing denials and utilization requirements are two major administrative hurdles that may discourage physician participation in Medicaid and CHIP. In addition to implementing the specific solutions outlined below, **the AAFP recommends CMS and/or states conduct surveys of physicians that are in managed care networks or otherwise participating in Medicaid to assess their satisfaction with program administration, identify potential barriers to care, and opportunities to increase physician participation.** These surveys could help identify barriers that are specific to certain states or managed care plans and enable states to make operational and policy changes to mitigate them.

Billing denials

Physicians experience significant administrative burdens when trying to receive Medicaid payments. A [recent study](#) estimates physicians lose 16 percent of Medicaid payments to billing problems,

compared with 7 percent for Medicare and 4 percent for commercial payers. Since physician practices lose a significant portion of their already much lower Medicaid payments to billing issues, the researchers found many practices respond by refusing to accept Medicaid patients in states with worse billing hurdles. Addressing the disproportionate burden of billing Medicaid may improve physicians' willingness to accept new Medicaid patients and in turn can improve timely access to care for Medicaid beneficiaries. **We urge CMS to include billing processes and denials in monitoring and oversight activities to understand where issues frequently arise. CMS should develop guidance for states and managed care plans with strategies for minimizing and resolving billing disruptions to streamline and optimize billing processes.**

Prior authorization and utilization management

Prior authorization continues to be a leading cause of physician burden and therefore the AAFP is strongly [supportive](#) of efforts to streamline the prior authorization process, including in Medicaid. To deliver the care that is most clinically appropriate for their patients, physicians must endure prior authorization requirements that can add significant cost and time burdens on their practices. In the most recent American Medical Association (AMA) [survey](#) of physicians, 88 percent of respondents reported prior authorization generates high or extremely high burden. Practices complete an average of 41 prior authorizations per physician per week, spend an average of almost two business days a week completing prior authorizations, and 40 percent of respondents have secured additional staff to work exclusively on prior authorization, including keeping up with varied requirements across payers. Prior authorization requests have only continued to grow over the years and throughout the COVID-19 pandemic.

Even once physicians complete prior authorization requirements, payers often do not sufficiently respond to prior authorization requests in a timely manner. California-based L.A. Care [failed to address](#) a backlog of more than 9,000 prior authorization requests and more than 67,000 complaints or appeals, including those from Medi-Cal. These unresolved requests led to negative impacts on patients, including delays in needed care, increased emergency department visits, and even death.

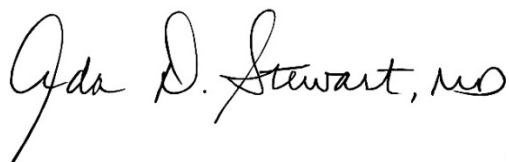
Evidence shows prior authorization requirements may be discriminatory and worsen health disparities, as documented in a [study](#) examining access to treatment for HIV pre-exposure prophylaxis and a [white paper](#) which examined the disproportionate impact of prior authorization requirements on cardiovascular care for Black and other patients of color. We are concerned that prior authorization requirements can worsen health disparities and create barriers to care for medically underserved patients, patients of color, LGBTQ+ patients, patients in rural areas, and those at risk for poor health outcomes, many of whom are enrolled in Medicaid. Federal oversight and action is needed to address the negative impacts prior authorizations are having on patients and physicians.

To promote program integrity in Medicaid, **AAFP recommends CMS include prior authorization and other utilization management practices, including step therapy, in its monitoring and oversight activities.** By reviewing the rate of acceptance, denials, and non-responses for various treatment plans, CMS can consider how these practices affect timely access to prescribed treatment and care, especially for Medicaid enrollees who already face barriers to care including concerns about out-of-pocket costs and difficulty obtaining appointments. **We recommend CMS require states to report prior authorization requirements in their Medicaid plans.**

Electronic prior authorization is one important solution to lessen the burden on physicians accepting Medicaid patients. Implementing electronic prior authorization standards will streamline some prior authorization processes by making prior authorization requirements, along with needed documentation to submit a request, response timelines, response rationale, and needed documentation to appeal a decision, readily available to the ordering physician in real-time. However, this burden and the resulting care delays cannot be eliminated, or even meaningfully reduced, by automating the existing workflows and volumes of prior authorizations. Electronic prior authorization is just one step in addressing the flaws of utilization management and comprehensive reform is needed. **We support CMS requiring state Medicaid agencies and managed care plans to adopt electronic prior authorization standards only after they are proven effective and adoptable in real world testing. However, additional federal action is needed to address the negative impacts of prior authorization on Medicaid beneficiaries' access to care.**

Thank you for the opportunity to provide comments on the RFI. The AAFP is committed to advancing equitable access to person-centered care for all Medicaid beneficiaries. We look forward to working with CMS to restore federal access standards and throughout the implementation of a robust monitoring approach. Should you have any questions, please contact Meredith Yinger, Manager, Regulatory Affairs, at myinger@aafp.org or (202) 235-5126.

Sincerely,

A handwritten signature in black ink that reads "Ada D. Stewart, MD". The signature is written in a cursive, flowing style.

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

-
- ¹ “State of Homelessness: 2021 Edition,” National Alliance to End Homelessness. <https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-2021/>
- ² “Transgender Homeless Adults & Unsheltered Homelessness: What the Data Tell Us,” National Alliance to End Homelessness, July 24, 2020. <https://endhomelessness.org/resource/transgender-homeless-adults-unsheltered-homelessness-what-the-data-tell-us/>
- ³ Center for Medicaid and CHIP Services. November 2021 Medicaid & CHIP Enrollment Data Highlights. March 28, 2022. Available at: <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>
- ⁴ Alker J and Brooks T. Millions of Children May Lose Medicaid: What Can be Done to Help Prevent Them from Becoming Uninsured? Georgetown Center for Children and Families. February 17, 2022. Available at: <https://ccf.georgetown.edu/2022/02/17/millions-of-children-may-lose-medicaid-what-can-be-done-to-help-prevent-them-from-becoming-uninsured/>
- ⁵ Mallory C, Tentindo W. MEDICAID COVERAGE FOR GENDER-AFFIRMING CARE. 2019. Accessed April 12, 2022. <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Medicaid-Gender-Care-Oct-2019.pdf>
- ⁶ Ibid.
- ⁷ Karen Pollitz et al., “Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need,” Kaiser Family Foundation, August 7, 2020, <https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/>.
- ⁸ Ibid.
- ⁹ Young CL, Capretta JC, Dorn S, Kendall D, Antos JR. "How To Boost Health Insurance Enrollment: Three Practical Steps That Merit Bipartisan Support", Health Affairs Blog, August 17, 2020. Available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20200814.107187/full/>
- ¹⁰ Ibid.
- ¹¹ Straw T. Marketplaces Poised for Further Gains as Open Enrollment Begins. Center on Budget and Policy Priorities. October 2021. Available at: <https://www.cbpp.org/research/health/marketplaces-poised-for-further-gains-as-open-enrollment-begins>
- ¹² Ross, K.M., Klein, B., Ferro, K. et al. The Cost Effectiveness of Embedding a Behavioral Health Clinician into an Existing Primary Care Practice to Facilitate the Integration of Care: A Prospective, Case–Control Program Evaluation. *J Clin Psychol Med Settings* 26, 59–67 (2019). <https://doi.org/10.1007/s10880-018-9564-9>
- ¹³ SY, L.-T., J, E., D, C., & PY, C. (2018). A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups. *Psychiatric Services* (Washington, D.C.), 69(6), 628–647. <https://doi.org/10.1176/APPI.PS.201700382>
- ¹⁴ Access to Mental Health Services for Adults Covered by Medicaid. MACPAC. 2021. Available at: <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf>
- ¹⁵ Nguyen KH et al. Disparities in Patient Experience of Care Among Nonelderly Medicaid Managed Care Enrollees. February 2022. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01331>
- ¹⁶ Medicaid and CHIP Payment and Access Commission. Access in Brief: Experiences in Accessing Medical Care by Race and Ethnicity. February 2022. Available at: https://www.macpac.gov/wp-content/uploads/2022/02/MACPAC-Access-in-Brief_Race-and-Ethnicity-Feb-2022.pdf
- ¹⁷ Ibid.
- ¹⁸ Medicaid and CHIP Payment and Access Commission. Availability of Race and Ethnicity Data for Medicaid Beneficiaries. March 2022. Available at: https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief_Race-and-Ethnicity-Data-Availability.pdf
- ¹⁹ McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health affairs (Project Hope)*, 27(2), 393–403. <https://doi.org/10.1377/hlthaff.27.2.393>
- ²⁰ Health Resources Services Administration. (2022). Health Professional Shortage Areas (HPSA). (Accessed 2/1/2022). <https://data.hrsa.gov/topics/health-workforce/shortage-areas>
- ²¹ Cunningham PJ. Beyond Parity: Primary Care Physicians’ Perspectives On Access To Mental Health Care. *Health Aff.* 2009;28(3):w490-w501
- ²² Xierali IM, Tong ST, Petterson SM, Puffer JC, Phillips RL, Bazemore AW. Family physicians are essential for mental health care delivery. *J Am Board Fam Med.* 2013;26(2):114-115

-
- ²³ Jetty, A., Petterson, S., Westfall, J. M., & Jabbarpour, Y. (2021). Assessing Primary Care Contributions to Behavioral Health: A Cross-sectional Study Using Medical Expenditure Panel Survey: <https://doi.org/10.1177/21501327211023871>
- ²⁴ MACPAC. Integration of Behavioral and Physical Health Services in Medicaid : MACPAC. Published March 2016. Accessed April 8, 2022. <https://www.macpac.gov/publication/integration-of-behavioral-and-physical-health-services-in-medicaid/>
- ²⁵ CMS. Behavioral Health Services | Medicaid. Accessed April 8, 2022. <https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html>
- ²⁶ MACPAC. Integration of Behavioral and Physical Health Services in Medicaid : MACPAC. Published March 2016. Accessed April 8, 2022. <https://www.macpac.gov/publication/integration-of-behavioral-and-physical-health-services-in-medicaid/>
- ²⁷ MACPAC. Integration of Behavioral and Physical Health Services in Medicaid : MACPAC. Published March 2016. Accessed April 8, 2022. <https://www.macpac.gov/publication/integration-of-behavioral-and-physical-health-services-in-medicaid/>
- ²⁸ Medicaid and CHIP Payment and Access Commission. Medicaid's Role in Financing Maternity Care. January 2020. Retrieved from: <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf>
- ²⁹ American College of Obstetricians and Gynecologists C on OP. ACOG COMMITTEE OPINION Number 757: Screening for Perinatal Depression . 2018;132(5). Accessed April 8, 2022. <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/11/screening-for-perinatal-depression.pdf>
- ³⁰ Ibid.
- ³¹ Presidential Task Force on Redefining the Postpartum Visit, Committee on Obstetric Practice. ACOG Committee Opinion Number 736: Optimizing Postpartum Care . 2018;131(5). Accessed April 8, 2022. <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/05/optimizing-postpartum-care.pdf>
- ³² Medicare Payment Advisory Commission. Report to Congress the Congress: Medicare Payment Policy. Chapter 5: Issues in Medicare beneficiaries' access to primary care. March 2021. Pages 132-133. Available at: http://www.medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf
- ³³ Thomas M. Henderson , "How Accountable to the Public Is Funding for Graduate Medical Education? The Case for State Medicaid GME Payments", *American Journal of Public Health* 111, no. 7 (July 1, 2021): pp. 1216-1219.
- ³⁴ <https://www.macpac.gov/wp-content/uploads/2021/04/Racial-and-Ethnic-Disparities-in-Medicaid-An-Annotated-Bibliography.pdf>
- ³⁵ Cooper LA, Powe NR. Disparities in patient experiences, health care processes, and outcomes: the role of patient-provider racial, ethnic, and language concordance. *The Commonwealth Fund*. Accessed March 22, 2022.
- ³⁶ Poma PA. Race/ethnicity concordance between patients and physicians. *J Natl Med Assoc*. 2017;109(1):6-8.
- ³⁷ United States Census Bureau. Quick Facts. Available at: <https://www.census.gov/quickfacts/fact/table/US/PST045219>
- ³⁸ Association of American Medical Colleges. Diversity in Medicine: Facts and Figures 2019. Available at: <https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018>
-
- ³⁹ Avalere. Medicaid Networks More Than 60% Narrower Than Commercial in Some Areas. March 2021. Available at: <https://avalere.com/press-releases/medicaid-networks-more-than-60-narrower-than-commercial-in-some-areas>
- ⁴⁰ Ndumele CD et al. Network Optimization and the Continuity of Physicians in Medicaid Managed Care. *Health Affairs*. June 2018. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1410>