



July 3, 2023

Dan Tsai  
Director, Center for Medicaid and CHIP Services  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Woodlawn, MD 21244

**Re:**

- **CMS-2439-P - Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality**
- **CMS-2442-P - Medicaid Program; Ensuring Access to Medicaid Services**

Dear Deputy Administrator Tsai:

On behalf of the Primary Care Collaborative (PCC) and PCC’s Better Health – NOW campaign (BHN), we appreciate the opportunity to offer comment on the proposed rules.

The Primary Care Collaborative (PCC) is a nonprofit, nonpartisan multi-stakeholder coalition of 70 organizational Executive Members ranging from clinicians and patient advocates to employer groups and health plans. PCC’s members share a commitment to an equitable, high value health care system with primary care at its base. Specifically, primary care that emphasizes comprehensiveness, longitudinal relationships, and “upstream” drivers to facilitate better patient experiences and better health outcomes (See the Shared Principles of Primary Care). In March 2022, PCC launched the Better Health – NOW (BHN) campaign to realize bold policy change rooted in a simple principle: We need strong primary care in every community so we can achieve better health for all.

Primary care is the one component of the health care delivery system where increased supply is consistently associated with improved population health, lower costs, and more equitable outcomes.<sup>1,2</sup> Foundational to public and population health, primary care knits together fragmented and uncoordinated parts of health care to produce better health. Strong Medicaid and CHIP programs are vital to assuring whole-person primary care access in all communities and to closing gaps in health outcomes across populations. Evidence suggests that expanding investment in primary care can expand healthcare

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<sup>1</sup> Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med.* 2019;179(4):506-514. doi:10.1001/jamainternmed.2018.7624

<sup>2</sup> Shi L. The impact of primary care: a focused review. *Scientifica (Cairo).* 2012;2012:432892. doi:10.6064/2012/432892

access.<sup>3</sup> In its 2021 report, the National Academies of Sciences, Engineering, and Medicine (NASEM) calls for a primary care strategy that addresses the low rates state Medicaid agencies and their contractors pay for primary care.<sup>4</sup> Addressing this challenge is an essential step to supporting innovation in payment and delivery and achieving health equity.<sup>5</sup>

PCC and our BHN Campaign participants strongly appreciate CMS' efforts to strengthen access standards across Medicaid and CHIP in both FFS and managed care delivery systems. We are particularly encouraged that CMS has acknowledged the link between inadequate investment in Medicaid primary care and inadequate access to care. Our key recommendations are summarized here and detailed comments on both proposed rules can be found below.

### **Better Health – NOW is pleased to offer support for**

- **Transparency: Enhanced payment transparency, comparing Medicaid payment against Medicare rates for non-facility primary care, behavioral health and OB/GYN services.**
- **Help with Unmet Needs: A clear path for Managed Care Organizations to address beneficiaries' health-related social needs through new In-Lieu-Of- Services regulations.**
- **Beneficiary Voice: New Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG) provisions which carve out stronger voice for beneficiaries in state Medicaid programs.**
- **Quality Care: A Medicaid and CHIP Quality Rating System to help beneficiaries and their caregivers choose the Medicaid plan that's right for them.**

**We are encouraged that CMS is proposing wait time standards for primary care as well as other crucial services, such as behavioral health and OB/GYN.** However, careful policy design with respect to alignment across federal programs, rate-setting and monitoring of the impacts on primary care will be needed to avoid unintended consequences.

**BHN does support additional federal review of state-proposed reimbursement cuts when they fail certain criteria, but we are concerned the thresholds for that scrutiny (80% or less of Medicare or more than a 4% a year reduction) will be insufficient to assure access over time.** To achieve the agency's value, quality and equity goals, CMS should work with states to enhance primary care investment whenever it falls below 100% of Medicare's level of investment.

Finally, while CMS' efforts to strengthen access standards are helpful, the agency's responsibility cannot end there. We urge CMS to press forward, utilizing other policy

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<sup>3</sup> Alexander D, Schnell M. The impacts of physician payments on patient access, use, and health. NBER. <https://www.nber.org/papers/w26095>. Published July 22, 2019. Accessed April 15, 2022.

<sup>4</sup> National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>

<sup>5</sup> Primary Care Collaborative, Morehouse School of Medicine National Center for Primary Care. May 2022. <https://www.pcpcc.org/sites/default/files/resources/PCC-NCPC%20Health%20Equity%20Report.pdf>

levers, including the annual Medicaid Scorecard and its ongoing communications with states. **Specifically, we call for comprehensive guidance that details how states can better invest in primary care access and the inclusion of a limited number of primary care spend and primary care access metrics in each state program's Medicaid Scorecard.**

### **Access to Medicaid Services NPRM:**

#### ***Medicaid Advisory Committee and Beneficiary Advisory Group (§ 431.12)***

##### ***CMS Proposal:***

CMS proposed an overhaul of existing regulations related to stakeholder input in Medicaid programs. The proposed rule would:

- Rename and expand the scope and use of states' Medical Care Advisory Committees. The renamed Medicaid Advisory Committees (MAC) would advise states on a range of issues including medical and non-medical services.
- Require states to establish a Beneficiary Advisory Group (BAG) with crossover membership with the MAC. The BAG would include Medicaid beneficiaries, their family members, and/or their caregivers, and BAG members would hold 25% of the seats on the MAC.
- Promote transparency and accountability between the state and its stakeholders by making information on the MAC and beneficiary advisory group activities publicly available. States will publicly share information about the feedback they receive by posting materials such as meeting schedules, meeting minutes, and annual reports.
- Establish minimum requirements for BAG representation on the MAC. At least 25 percent of the MAC membership would be reserved for BAG members.

##### ***PCC/Better Health – NOW Comment:***

PCC applauds the proposed rule's attention to strengthening stakeholder engagement in the work of state Medicaid programs. **In general, we support the renamed and refocused MAC requirements and the improved transparency provisions regarding the MAC and BAG.** We are particularly enthusiastic regarding the new requirement that states establish, support and consult a Beneficiary Advisory Group. **We encourage CMS to finalize a requirement that BAG members hold a certain, minimum percentage of the seats on their state's MAC.** Responsive to CMS' request for comment on the exact minimum percentage, we encourage CMS to go no lower than its proposed 25% and to consider a higher percentage either now or in later rulemaking. In any such consideration, CMS may wish to examine consumer and community governance requirements for other safety net programs, such as those required for the Federally Qualified Health Center (FQHC) and Certified Community Behavioral Health Center (CCBHC) programs.

CMS should ensure states compensate members of the BAG for their participation in these processes, including providing transportation assistance/reimbursement, childcare, financial reimbursement (for room, board, and any missed work), and varying meeting times and locations to allow participation of enrollees during working hours.

## ***Documentation of access to care and service payment rates (§ 447.203)***

### ***CMS Proposal: Payment Rate Transparency (§ 447.203(b))***

CMS proposes to require states to publish and update all FFS Medicaid fee schedule rates on a publicly available state website. Supplemental payments and Disproportionate Share Hospital payments are excluded from CMS' proposed transparency requirements.

Based on those published rates, CMS would also require states to report their state Medicaid base payments relative to Medicare rates for specified non-facility primary care, obstetrical and gynecological and outpatient behavioral health Evaluation & Management (E&M) services. The current proposal also limits this comparative rate analysis required under subsection (b)(2) to “the most recently published Medicare payment rates effective for the same time period for the evaluation and management (E/M) codes applicable to the category of service.”

### ***PCC/Better Health – NOW Comment:***

Transparent reporting of fee schedule rates under subsection (b)(1) should also account for DSH, supplemental, and state directed payments. This added transparency would allow the public and policymakers to better compare Medicaid's often meager investment in services like community-based primary care with the resources allocated to other provider categories (e.g., hospitals).

**The Better Health – NOW Campaign supports requiring states to compare Medicaid rates against Medicare and to report on those benchmarks.** We further believe the selection of primary care, OB/GYN, and behavioral health, along with one other service category chosen by the state is appropriate.

**The disaggregation of comparative payment analyses by child/adult status, geography, and provider type is crucial.** Such comparative, granular analyses are essential to discharging Medicaid's statutory obligations, particularly to “furnish care and services at least to the same extent that such care and services are available to the general population in the geographic area.”

For behavioral health, however, the limitation of the analysis to E&M codes misses an opportunity to support integrated, whole-person care for Medicaid beneficiaries. In behavioral health, E/M codes are typically used for psychotropic medication management not behavioral treatment modalities. As proposed, the analysis would neither compare reimbursement for commonly used psychotherapy services nor integrated care codes (i.e., Collaborative Care Model or General Behavioral Health Integration). To provide a more accurate view of the reimbursement rates for behavioral health and primary care-behavioral health integration, we recommend the comparative payment analysis include behavioral health integration and psychotherapy codes.

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

### ***CMS Proposal:***

CMS proposes to create a new two-tiered CMS review process for payment reduction or restructuring State Plan Amendments, considering impact by provider type and geography. The level or tier of CMS scrutiny applicable would depend on how the proposed Medicaid payment rates compare to Medicare rates, the size of the proposed rate reduction or restructuring, and whether access concerns have been raised through public comment processes.

*PCC/Better Health – NOW Comment:*

**The BHN Campaign supports applying additional review requirements when States’ proposed payment rate reductions or restructurings fail to meet certain criteria.** We further agree that whether the reduction is more than nominal, whether State rates are below a certain percentage of Medicare payment rates, and whether there are no evident access concerns raised through public processes are appropriate criteria.

However, the specific thresholds CMS proposes (4% as a threshold for ‘nominal and 80% of Medicare rates) do not support Medicaid’s aim of securing access to medical services.

**The proposed 80 percent fee ratio threshold proposed by CMS at § 447.203(c)(1)(i) should be increased to 100 percent of Medicare. CMS should require the more extensive access analysis outlined in § 447.203(c)(2) when a proposed rate reduction would take Medicaid payment below 100 percent of Medicare.**

With primary care payment that lags both commercial payers and Medicare, today’s Medicaid programs often fail to secure robust beneficiary access to necessary primary care services.<sup>6</sup> Permitting such a disparity in rates between Medicare and Medicaid is also inconsistent with the statutory guarantee that states “furnish care and services at least to the same extent that such care and services are available to the general population in the geographic area.” We are similarly concerned that allowing up to 4% reductions to primary care each year, without additional scrutiny, could meaningfully erode access to care.

Acceptance of base rates below Medicare rates is also inconsistent with this Administration’s equity and workforce goals. The persistence of lower payment in Medicaid relative to other payers financially penalizes those primary care practices who opt to serve communities and patients enrolled in Medicaid. This is particularly inexplicable at a time when the Department of Health and Human Services has recognized primary care shortages and when those shortages are most prevalent in the lower-income, rural and racially and ethnically diverse communities that disproportionately rely on Medicaid.<sup>7 8</sup>

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<sup>6</sup> National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>

<sup>7</sup> HHS Strategic Plan FY 2022-2026. US Department of Health and Human Services. March 2022. <https://www.hhs.gov/about/strategic-plan/2022-2026/goal-1/objective-1-5/index.html>

<sup>8</sup> Streeter RA, Snyder JE, Kepley H, Stahl AL, Li T, Washko MM. The geographic alignment of primary care Health Professional Shortage Areas with markers for social determinants of health. PLoS One. 2020;15(4):e0231443. Published 2020 Apr 24. doi:10.1371/journal.pone.0231443

We call CMS' attention to the remarkable disparity between states in Medicaid payment rates, relative to Medicare. An Urban Institute analysis of these disparities showed that 33 states paid base primary care rates below the 80% threshold, with six states falling below 50% of Medicare rates.

This suggests that the proposed revision to state analysis procedures must be only the first step of an ongoing and urgent effort to meet CMS' statutory guarantee of access to care for beneficiaries.

**Finally, in implementing its state analysis procedures, CMS should work proactively with states, payers, clinician organizations and consumer groups to assure primary care investment through innovative population-based, prospective payment models is fully recognized as part of the base payment analyses.**

***Additional Comment regarding access:***

While we appreciate the agency's proposals to strengthen access in the NPRMs, more must be done to bring the Department's broader value and equity goals within reach. CMS should leverage every additional tool available to help states connect their beneficiaries to whole-person primary care. Primary care is foundational for health. Better aligned investment in Medicaid primary care, alongside investment from other payers, is vital to strengthening that foundation.

**First, CMCS should develop and publish new, comprehensive guidance identifying mechanisms by which states may strengthen primary care through enhanced investment and population-based payment models.** States today confront overlapping crises in population health (e.g., cardiometabolic health, maternal/child health, mental health, and addiction). As the only component of our health system consistently associated with improved outcomes and health equity, whole-person primary care is the indispensable foundation of Medicaid programs' response to all these crises. Such guidance should outline policy mechanisms that enhance investment in primary care, open pathways to population-based, prospective payment models that are aligned across payers (e.g., hybrid payment), and help beneficiaries access a trusted usual source of primary care. Such policy mechanisms could include, but need not be limited to, managed care organization contracting, Primary Care Case Management approaches, State Plan Amendments, Section 1115 and other demonstration opportunities, CMS Innovation Center model opportunities, Special Directed Payments and the Medicaid Health Home Program.

Second, the annual state Medicaid Scorecard can and must become a tool to support strengthening primary care in Medicaid and CHIP.

- **As part of the yearly state Medicaid Scorecard, CMS should consider including a metric assessing whether enrolled individuals have a chosen source of primary care.** At present, question 10 of the CAHPS Adult Medicaid Survey 5.1 may be one way to measure access to this chosen source of

care.<sup>9</sup> Over time, working with stakeholders, CMS should work to identify additional measures of timely access to care with one's chosen source of primary care and continuity of care. CMS, states, and plans should work assiduously to ensure this metric can be stratified by race and ethnicity, geography, English proficiency and other key demographic data, while avoiding added administrative burden for primary care or Medicaid beneficiaries.

- **CMS should explore the inclusion of an additional data point in the yearly Medicaid Scorecard, indicating the percentage of each state's Medicaid health care spending (excluding LTSS) devoted to primary care.** Reported primary care spending should include both fee-for-service and managed care delivery systems as well as non-claims-based payments to the extent possible. CMS should encourage states to adopt consistent, standardized, broad and narrow primary care definitions built on those used in states already reporting primary care spending.

### **Managed Care NPRM**

#### **Access**

CMS Proposal: Assurances of adequate capacity and services- Provider payment analysis (§§ 438.207(b), 457.1230(b))

The proposed rule would require states to submit an annual payment analysis comparing base payment rates for non-facility primary care, obstetrics/gynecology, mental health and substance use disorder services.

PCC/Better Health – NOW Comment:

**The Better Health – NOW Campaign supports requiring an annual payment analysis benchmarking base managed care rates for primary care, obstetrics/gynecology, mental health and substance use disorder services against Medicare.** We agree with CMS' conclusion that two key drivers of access – provider network size and capacity – are inextricably linked with Medicaid provider payment levels and acceptance of new Medicaid patients. Providing analyses by child/adult status, geography, and provider type for each Managed Care Organization is crucial to discharging CMS' statutory obligations, particularly its responsibility, under Section 1902(a)(30)(A) of the Social Security Act, to “furnish care and services at least to the same extent that such care and services are available to the general population in the geographic area.”

CMS Proposal: Appointment Wait Time Standards § 438.68(e)(1)(i) through (iv).

The NPRM proposes that states must develop and enforce maximum appointment wait time standards for:

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<sup>9</sup> CAHPS Health Plan Survey. Agency for Healthcare Research and Quality. October 2020. [https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/hp/Adult\\_Med\\_Eng\\_HP51\\_2152a.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/hp/Adult_Med_Eng_HP51_2152a.pdf)

- Primary care services (adult and child) within 15 business days
- Mental health and substance use disorder services (adult and child) within 10 business days.
- Ob/Gyn services, within 15 business days; and
- A state-selected service type within a state-established time frame.

Managed care plans must achieve 90% compliance with these standards.

*PCC/Better Health – NOW Comment:*

**We are encouraged that CMS is proposing wait time standards for primary care as well as other crucial services, such as behavioral health and OB/GYN.** Over time, wait time standards have potential to encourage states and plans to invest in strengthening access to primary care in the Medicaid and CHIP populations.

To the extent there is insufficient provider capacity in a community to meet those standards, that should be a challenge for all, not a burden borne by in-network clinicians or Medicaid enrollees. For areas experiencing a shortage of primary care clinicians, stronger financial support for the clinical team around the patient can open up capacity (time) for the practice to provide more patient access.

**However, proper policy design and implementation will be essential to avoiding adverse unintended consequences.** Without meaningful investment in networks and payment changes, the most immediate effect would be added pressure on the primary care practices to accelerate volume of visits and shorten visits. This pressure would have adverse effects on both the primary care workforce and health equity.

A crucial first step is providing states and MCOs the time needed to make new investments and adopt payment changes. We thank CMS for providing three years for states to implement standards and would recommend the following additional steps:

- Alignment: We encourage CMS to continue moving toward alignment of wait time standards across federal programs.
- Sound rate-setting: CMS should work with states to ensure that increased investment in primary care and other networks is appropriately reflected in rate-setting for MCOs.
- Monitoring and Guardrails: CMS and states should monitor impact of finalized wait time standards and consider additional guardrails to ensure the wait time standards actually produce the hoped-for practice-level investment and payment changes that support strong primary care teams.

As CMS, states, plans and practices work toward implementation, it will be particularly important to monitor health professional shortage areas. Strengthening primary care networks in these rural and other underserved communities will be both particularly challenging and particularly important to CMS’ access and equity goals. In those circumstances where states and plans are engaged in robust efforts to invest in and strengthen networks in shortage areas, CMS may ultimately wish to consider extending the compliance date.

We also agree with CMS that “states need to balance the use of telehealth with the availability of providers that can provide in-person care and enrollees’ preferences for receiving care to ensure that they establish network adequacy standards under § 438.68

that accurately reflect the practical use of both types of care in their State.” When utilized in coordination with an individual’s medical home, telehealth technologies have the potential to contribute to safe, high-quality primary care. CMS should continue to prioritize access to whole-person relationship-based care, in the modality that best serves the needs and preferences of the beneficiaries.

### ***State Directed Payments***

CMS Proposal: State Directed Payments (42 CFR 438.6, 438.7, 430.3)

CMS proposes additional oversight and reporting for any payments to providers which states direct their contractors to make (“State Directed Payments - SDPs”). With the volume and variety of SDPs increasing, the policy goals for SDP oversight articulated in the NPRM are as follows:

1. Medicaid managed care enrollees receive access to high-quality care under SDP payment arrangements.
2. SDPs are appropriately linked to Medicaid quality goals and objectives for the providers participating in the SDP payment arrangements; and
3. CMS and States have the appropriate fiscal and program integrity guardrails in place to strengthen the accountability and transparency of SDP payment arrangements.

In its discussion of the NPRM, the agency references access challenges in primary care, maternal health and behavioral health. It specifically encourages states to leverage SDPs to improve access to these services and include measures of such access in any evaluation plan.

PCC/Better Health – NOW Comment:

The agency’s attention to SDPs is timely and appropriate, as is the opportunity for states’ Medicaid programs to learn from one another about their SDPs. **Better Health –NOW applauds CMS for encouraging states to invest in primary care, maternal health and behavioral health access through SDPs.**

We also appreciate the agency’s efforts to adjust SDP regulations to better support population-based payment models. BHN has called for the creation of pathways that help primary care rapidly transition from a predominantly fee-for-service model to a predominantly population-based prospective payment (hybrid) model. Within Medicaid, we are hopeful SDP investments in primary care can effectively support this goal.

### ***In Lieu of Services and Settings***

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

The proposed rule would codify standards that would apply when States use in lieu of services and settings (ILOSs). These standards are based on CMCS guidance, detailed in a January 2023 letter to State Medicaid Directors.<sup>10</sup>

*PCC/Better Health – NOW Comment:*

**PCC commends CMCS’ work to help address the health-related social needs of Medicaid beneficiaries through this year’s guidance, the proposed rule and its efforts to help address health-related social needs through the 1115 Demonstrations and other authorities.**

We encourage the agency to provide additional detail regarding beneficiary protections in the final rule and associated explanation, including a requirement for notice of the termination of an ILOS service and assurance that ILOS are not used to restrict beneficiary entitlement to services of FQHCs or other safety net primary care practices and clinics.

### ***Medicaid Managed Care Quality Rating System***

CMS Proposal: Medicaid Managed Care Quality Rating System (§§ 438.334 and 457.1240)

The NPRM proposes a Medicaid and CHIP Quality Rating System (MAC QRS) framework aiming to empower beneficiary choice and ensure monitoring of plan performance. Specific features include:

- Establishing the MAC QRS website as a state’s “one-stop-shop” for beneficiaries to access information about Medicaid and CHIP eligibility and managed care; compare plans based on quality and other factors key to beneficiary decision making, such as the plan’s drug formulary and provider network; and select a plan that meets their needs.
- Establishing state requirements under the MAC QRS framework, including an initial set of mandatory measures, quality rating methodology and requirements for displaying information on a State’s MAC QRS website.
- Broadening flexibility for states to implement an alternative QRS.

*PCC/Better Health – NOW Comment:*

As CMS works to finalize and implement changes to its MAC QRS, Better Health – NOW encourages the agency to work collaboratively with all stakeholders toward a common approach to quality and performance measurement. This approach should effectively track quality and outcomes, assure transparency and ensure clinicians’ time and resources can remain focused on patient care, not measurement burden.

### **CHIP**

CMS Proposal:

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<sup>10</sup> Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care. Centers for Medicare and Medicaid Services. January 2023. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf>

The NPRM includes provisions that would adapt several of the Medicaid proposals related to access, ILOS, medical loss ratio, and quality and apply them to the Children's Health Insurance Program.

*PCC/Better Health – NOW Comment:*

We appreciate efforts to align Medicaid and CHIP policies wherever appropriate and practicable. For primary care practices, alignment across payers is critical to both reduction in administrative burden and the impact of payment incentives for continuous, comprehensive primary care.

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PCC and our Better Health – NOW Campaign partners look forward to working with the CMS team to strengthen primary care in Medicaid/CHIP and across CMS' programs. If our team can answer any questions regarding these comments, please contact PCC's Director of Policy, Larry McNeely at [lmcneely@thepcc.org](mailto:lmcneely@thepcc.org).

Sincerely,



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President & CEO  
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