

April 18, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Dan Tsai, Deputy Administrator
Centers for Medicare & Medicaid Services
Director, Center for Medicaid and CHIP
Services
Department of Health and Human Services
Baltimore, MD 21244

RE: Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP

Dear Administrator Brooks-LaSure and Deputy Administrator Tsai:

The Primary Care Collaborative (PCC) appreciates this opportunity to provide comments in response to CMS's Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP. PCC is a nonprofit, nonpartisan, multi-stakeholder coalition of more than 60 organizational Executive Members, ranging from clinicians and patient advocates to employer groups and health plans, that are dedicated to strengthening primary care. PCC applauds CMS for pursuing Medicaid and CHIP rulemaking to enhance coverage, expand access to care, and improve availability and quality of primary care practices and health care providers.

Primary care is the one component of the U.S. health care system where increased supply is associated with improved population health and more equitable outcomes.¹ Yet today, the U.S. devotes only 5% to 7% of health care dollars to primary care, a proportion that is trending down even as glaring health disparities persist.^{2,3} To shift these alarming trends, PCC launched *Better Health – Now* in March 2022. This new PCC campaign starts from a simple principle: We need strong primary care in every community so we can all have access to better health. This campaign will advocate for policy changes that reform how much we pay for primary care and how we pay for it to ensure every one of us can find a primary care professional to trust and rely on.

PCC supports CMS's commitment to advancing health equity. A strong Medicaid program that assures high-quality primary care across all communities is vital to supporting this strategic pillar of the agency's work. Medicaid and CHIP are sources of coverage and care for more than 85 million low-income or vulnerable enrollees.⁴ Approximately one in three Black American, Indian/Alaskan Native and Native Hawaiian and Other Pacific Islander adults under 65 are enrolled in Medicaid. More than one in five Hispanic adults under 65 are beneficiaries as well. Among children in these demographic groups, nearly half depend on Medicaid or CHIP for health

¹ McCauley L, Phillips RL, Meisnere M, Robinson SK. Read "Implementing high-quality primary care: Rebuilding the foundation of Health Care" at nap.edu. National Academies Press: OpenBook. <https://nap.nationalacademies.org/read/25983/chapter/1>. Published 2021. Accessed April 15, 2022.

² Greiner A, Kempinski A. Primary care spending: High stakes, low investment. Primary Care Collaborative. <https://www.pcpc.org/resource/evidence2020>. Published April 20, 2022. Accessed April 15, 2022.

³ 2021 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; December 2021. AHRQ Pub. No. 21(22)-0054-EF.

⁴ November 2021 Medicaid & Chip Enrollment Data Highlights. Medicaid. <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>. Accessed April 15, 2022.

coverage.⁵ A quarter of all rural adults and more than 10 million disabled adults under 65 depend on Medicaid.^{6,7}

Unfortunately, with primary care payment that lags both commercial payers and Medicare, the program today often fails to secure robust beneficiary access to necessary primary care services.⁸ This outcome runs contrary to the requirements of Section 1902(a)(30)(A) of the Social Security Act. This “Equal Access” provision of the Act states that Medicaid programs must:

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary...to ensure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area.

Evidence suggests that expanding investment in primary care can expand access.⁹ 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.¹⁰ To meet its statutory obligations and to make access to equitable care a reality, Medicaid policy must do much more to substantively invest in primary care.

With the remainder of this letter, PCC provides detailed responses to the specific questions included in the RFI. **To summarize, PCC recommends that CMS:**

- **Prioritize adoption of twelve-month continuous coverage for Medicaid and CHIP beneficiaries and to limit eligibility redeterminations;**
- **Consider access to and investment in primary care in development of any future minimum standards;**
- **Promote evidence-based models of primary care-behavioral health integration;**
- **Issue comprehensive guidance to states on payment for evidence-based community health worker services;**
- **Work with states to remove reimbursement barriers to the delivery of tele-mental health services to Medicaid beneficiaries by primary care practices; and**
- **Require higher-quality data collection and reporting from states regarding race/ethnicity data and other demographic data.**

⁵ Guth M, Artiga S. Medicaid and Racial Health Equity. KFF. <https://www.kff.org/medicaid/issuebrief/medicaid-and-racial-health-equity/>. Published March 17, 2022. Accessed April 15, 2022.

⁶ Medicaid and rural health - macpac. MACPAC. <https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf>. Published April 2021. Accessed April 15, 2022.

⁷ Medicaid Enrollees by Enrollment Group. Kaiser Family Foundation. 2019. <https://www.kff.org/medicaid/state-indicator/distribution-of-medicicaid-enrollees-by-enrollment-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁸ 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>

⁹ 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.

¹⁰ 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>

Detailed Comments

CMS QUESTION:

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage. CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income (SSI)/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).

1. 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?
3. What actions could CMS take to promote continuity of coverage for **beneficiaries transitioning** between Medicaid, CHIP, and other insurance affordability programs; between different types of Medicaid and CHIP services/benefits packages; or to a dual Medicaid-Medicare eligibility status? For example, how can CMS promote coverage continuity for beneficiaries moving between eligibility groups (e.g., a child receiving Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualified supports who transitions to other Medicaid services such as home and community-based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the Marketplace); or across state boundaries? Which of these actions would you prioritize first?

PCC RESPONSE:

PCC urges CMS to prioritize adoption of twelve-month continuous coverage for Medicaid and CHIP beneficiaries and to limit eligibility redeterminations to the extent possible.

Health coverage disruptions—leading to loss of coverage entirely or changes in provider networks—can disrupt the continuity of care that is essential to quality primary care and improved outcomes.¹¹

PCC is particularly concerned about the impact of the looming expiration of "Maintenance of Effort" provisions that have prevented states from terminating Medicaid coverage during the Public Health Emergency. PCC encourages CMS to **provide at least a 120-day lead time**

¹¹ van Walraven C, Oake N, Jennings A, Forster AJ. The association between continuity of care and outcomes: a systematic and critical review. *J Eval Clin Pract.* 2010;16(5):947-956. doi:10.1111/j.1365-2753.2009.01235.x

before unwinding the FMAP/MOE provisions of the Families First Coronavirus Response Act of 2020 so that enrollees have sufficient time to either re-establish their eligibility for Medicaid or determine their eligibility for subsidized coverage in the state or federally facilitated Marketplaces.

The unwinding of these provisions is not the only challenge to access and eligibility. Prior to the pandemic and the maintenance of effort provision, the instability associated with Medicaid coverage had harmful effects on patients—effects that could have been prevented by access to continuous, high-quality primary care. According to a MACPAC analysis of Medicaid enrollees experiencing coverage churn from 2017 to 2019, the rate of *ambulatory care-sensitive* hospitalizations for diabetes complications, heart failure, COPD/asthma in older adults and asthma in younger adults was nearly twice the rates of hospitalization for the same beneficiary populations prior to disenrollment.¹² Black, Hispanic, and American Indian and Alaska Native (AIAN) beneficiaries were more likely to experience these disruptions of coverage than other demographic groups.¹³

A clear path to addressing these challenges already exists. As the Medicaid.gov webpage explains, the twelve-month continuous coverage option for children has ensured that “children can receive appropriate preventive and primary care as well as treatment for any health issues that arise,” and “reduces state time and money wasted on unnecessary paperwork and preventable care needs.”¹⁴ PCC believes that continuous coverage can be just as valuable for the health of other beneficiaries as it is for children.

PCC supports permanent statutory change to provide continuous eligibility for all CHIP and Medicaid enrollees and urges CMS to work with Congress to realize this goal.

Until statutory change is achieved, PCC encourages CMS to use every available policy lever to support continuity of coverage. Specifically, CMS should:

- a) Continue to give states information about best practices for minimizing procedural disenrollment and for supporting transitions to other coverage for ineligible individuals, including, for example, the number of procedural disenrollment and the number of individuals transitioned to other coverage sources.**
- b) Work with states to expand automatic re-enrollment procedures and limit mid-year data checks leading to disenrollment.**
- c) Maintain CMS ongoing support for and cooperation with states, promoting all available options to extend coverage and promote continuity of coverage.**
- d) Make continuous coverage policies a top priority in communications to and discussions with states regarding waivers and state plans.**

¹² Jennings L, Nelb R. Churn and Coverage Transitions. MACPAC.<https://www.macpac.gov/wp-content/uploads/2022/04/Churn-and-Coverage-Transitions.pdf>. Published April 7, 2022. Accessed April 15, 2022.

¹³ Continuous eligibility for Medicaid and chip coverage. Medicaid.<https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html>. Published September 9, 2021. Accessed April 15, 2022.

¹⁴ Continuous eligibility for Medicaid and chip coverage. Medicaid.<https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html>. Published September 9, 2021. Accessed April 15, 2022.

Finally, those individuals who are deemed ineligible for Medicaid/CHIP during redeterminations should receive assistance in enrolling in an ACA plan to maintain insurance coverage.

CMS QUESTION:

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. CMS is seeking feedback on how to establish minimum standards or federal “floors” for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or “floors” would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices.

1. What would be the most important areas to focus on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?

PCC RESPONSE:

With Healthy People 2030, the Department of Health and Human Services has already identified access to primary care as a “key issue: for health care access and quality (one of five domains that make up the social determinants of health) and acknowledged the association between access to primary health care and positive health outcomes.¹⁵ **To deliver on Medicaid’s statutory aims and CMS’s health equity and value priorities, access to and investment in primary care should be considered in the future development of minimum standards.** To the extent CMS pursues minimum standards with respect to primary care access, PCC strongly supports NASEM’s recommendation that CMS provide technical assistance resources to state Medicaid agencies for implementing and attaining these standards and measure and publish state performance on these standards.¹⁶

As a first step, PCC suggests that CMS begin to measure primary care access and investment for each state Medicaid program as described below.

Access to a chosen source of primary care

To support the health of people on Medicaid and their communities, every enrollee should have an opportunity to select the primary care practice that will deliver needed care and upon which they can rely to coordinate specialty care and other services. **As part of the yearly state Medicaid Scorecard, CMS should consider including a metric assessing whether individuals enrolled in state Medicaid have a chosen source of primary care and stratify that measure by race and ethnicity, disability, geography, English proficiency, and other key demographic data.** At present, question 10 of the CAHPS Adult

¹⁵ Access to primary care. Access to Primary Care - Healthy People 2030. <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care>. Accessed April 15, 2022.

¹⁶ 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>.

Medicaid Survey 5.1 may be one way to measure access to this chosen source of care.¹⁷ In addition, 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.

Investment in Primary Care

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 in used states already reporting primary care spending.

Moving forward, PCC recognizes that identifying additional resources for primary care can be challenging in Medicaid. Yet research shows the value of these investments for population health and cost trajectory for the population overall and communities facing health inequities.¹⁸ **CMS should actively communicate with Medicaid programs regarding options to expand support for primary care in all communities.** Given current concerns about the value of some current supplemental payment mechanisms, CMS should specifically examine these mechanisms and consider how they might be used to direct more resources to primary care.

CMS QUESTION:

3. How could CMS consider the concepts of whole person care¹ 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?

PCC RESPONSE:

The training of primary care professionals is focused on the health of the whole person, rather than one aspect of health, disease state, or bodily system. This makes primary care teams uniquely positioned to coordinate across physical health, mental health services, substance use disorder care, and social care. However, neither the current level of primary care payment for primary care nor the predominant fee-based payment methodology adequately supports this sort of coordination. To ensure primary care practices have the needed resources to support whole-person care, Medicaid, working in tandem with other payers, should change both how and how much primary care is reimbursed.

Immediately below, we recommend steps to promote integration of behavioral health professionals and community health workers as part of the primary care team.

Mental Health and Substance Use/Alcohol Use Disorder

¹⁷ 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

¹⁸ Shi L. The impact of primary care: a focused review. *Scientifica (Cairo)*. 2012;2012:432892. doi:10.6064/2012/432892

Primary care teams with strong, ongoing patient relationships are uniquely able to identify behavioral health concerns, triage challenges, and help patients find the right level and setting of care. More mental health care is rendered in the primary care setting than anywhere else, including the mental health care sector where this has been the case for at least the past four decades.¹⁹ An adequate response to the multiple current behavioral health crises demands recognizing that reality. It also requires recognizing that primary care clinicians, particularly those who serve populations that have been historically marginalized, are overextended and desperately in need of enhanced support. Team-based, integrated behavioral health can improve outcomes and decrease costs. By leveraging the full health care team, the U.S. can most effectively make use of scarce behavioral health resources.

Unfortunately, public policy fails to provide either sufficient reimbursement or the practice-level training and support needed for integration. This is a lost opportunity to improve population health and combat disparities. **To scale behavioral health-primary care integration, CMS should work with states to:**

- 1. Strengthen reimbursement for evidence-based models of primary care integration, such as the collaborative care model and the primary care behavioral health model, and**
- 2. Provide upfront resources to support the training, workforce, and practice infrastructure needed to implement these models.** (For example, the Health Resources and Services Administration's Pediatric Mental Health Access Program provides telehealth-enabled training to participating practices implementing behavioral health integration. Similar support should be available for practices serving adults and children across state Medicaid programs.)

PCC has previously provided CMS with [detailed recommendations on steps CMS and HHS can take to support primary care-behavioral health integration.](#)

In addition, PCC supports the establishment of planning grants and a demonstration program to strengthen Medicaid provider capacity for mental health services, as called for in the Administration's proposed FY 2023 budget. Just as a similarly structured demonstration program, funded in Section 1003 of the SUPPORT Act, enhanced Substance Use Disorder Treatment capacity, PCC believes the proposed grants have the potential to improve the support and payment for behavioral health integration in primary care.

Community Health Workers

To promote whole-person care and achieve health equity, CMS should better support the full range of services provided by community health workers (CHWs). Medicaid policy should provide adequate funding, meaningful quality guardrails, and assurance that CHW roles and identities are preserved and not over-medicalized.

CHWs are trustworthy individuals who partner with individuals and families in their own communities to improve health. CHWs find and meet people where they are, get to know their clients' life stories, and ask each client what she thinks will improve her life and health. CHWs then provide tailored support based on these needs and preferences.

Under existing legislative authority, some states have partnered with CMS to pay for CHWs, promotores de salud, and community health representatives through several [mechanisms](#),

¹⁹ Regier et al JAMA 1978; Jetty et al Journal of Primary Care & Community Health 2021.

including State Plan Amendments, 1115 waivers, and arrangements with Medicaid managed care organizations (MCOs).

Broader Medicaid support for CHWs could offer substantial value to Medicaid primary care—particularly in communities impacted by health inequities. As one example, the Penn Center for Community Health Workers developed IMPACT, a standardized, scalable CHW program. IMPACT, which has been tested in three randomized controlled trials, improves chronic disease control, mental health, and quality of care while reducing total hospital days by 65%.²⁰ IMPACT has provided a \$2.47 to \$1 annual return on investment for the Medicaid program.²¹

Additional steps are required to help more primary care practices incorporate CHWs as an integral part of the care team

PCC recommends CMS issue comprehensive guidance to states on payment for evidence-based community health worker services under all available mechanisms, including:

- **Clarification that states can submit, and CMS will approve, a state plan amendment or 1115 waiver that provides coverage for the full range of evidence-based community health worker supports (including those addressing the social determinants of health, health promotion, advocacy and disease prevention).**
- **Guidance for Medicaid managed care arrangements that incorporate CHW services, including what can be considered medical costs and what can be included in the capitation rate, driving toward more robust funding for CHW services through these arrangements.**
- **Best practices on the inclusion of community-based organizations in Medicaid provider networks, including payment arrangements with Medicaid managed care organizations that do not require CBOs to track fee-for-service billing.**
- **Clarification that, rather than submitting qualifications of unlicensed providers delivering these services, states can use the National Committee on Quality Assurance’s guidance on critical inputs for community health workers.**

CMS QUESTION:

4. 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?

²⁰ Vasan A, Morgan JW, Mitra N, et al. Effects of a standardized community health worker intervention on hospitalization among disadvantaged patients with multiple chronic conditions: A pooled analysis of three clinical trials. *Health Serv Res.* 2020;55 Suppl 2(Suppl 2):894-901. doi:10.1111/1475-6773.13321

²¹ Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. *Health Aff (Millwood).* 2020;39(2):207-213. doi:10.1377/hlthaff.2019.00981

PCC RESPONSE:

According to the Kaiser Family Foundation, 16% of nonelderly adults living in households with at least one Medicaid enrollee have limited English proficiency, and 23% of children on Medicaid have a parent with limited English proficiency.²²

CMS should direct states to provide full payment for trained interpreter services for enrollees with limited English proficiency, ensure educational materials to families that are culturally effective and written at literacy levels and in languages used by Medicaid recipients, and create minimum essential standards across electronic health records (EHRs) that allow clinicians to indicate the unique language needs.

CMS QUESTION:

5. What are specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

PCC RESPONSE:

Today, many communities struggle with the limited availability of primary care. According to the latest quarterly report from the Health Resources and Services Administration, 91.5 million people reside in primary care Health Professional Shortage Areas.²³ As Medicaid works to strengthen the primary care workforce pipeline for underserved communities, broadening collaborative, inter-professional teams can also support access.

To support robust teams, however, the U.S. must change both how much is invested in primary care and the way those investments are made. Research from the Harvard Center for Primary Care shows that a large percentage of a primary care practice's revenue must be prospective in order for it to make financial sense for a practice to build out a more robust team and move away from visit-based care.²⁴

Primary care practices in all communities need pathways to rapidly transition from a predominantly fee-for-service model to predominantly population-based prospective payment (hybrid) models that would include adjustment for health status, risk, social drivers, and other elements. Such hybrid models should be implemented and aligned across payers while being mindful of practice heterogeneity and the need to support greater adoption of telehealth. To achieve rapid transition to and sustainability of comprehensive primary care practice models,

²² Artiga S, Haldar S, Rudowitz R, Damico A. Unwinding of the phe: Maintaining Medicaid for people with limited English proficiency. KFF. [²³ Health Resources and Services Administration. Designated Health Professional Shortage Area Statistics – Second Quarter of FY 2022. Accessed April 15, 2022. <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>](https://www.kff.org/medicaid/issue-brief/unwinding-of-the-phe-maintaining-medicaid-for-people-with-limited-english-proficiency/#:~:text=Overall%2C%2016%25%20of%20nonelderly%20adults,in%20Medicaid%20(Figure%201. Published March 3, 2022. Accessed April 15, 2022.</p></div><div data-bbox=)

²⁴ Basu S, Phillips RS, Song Z, Bitton A, Landon BE. High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care. *Health Aff (Millwood)*. 2017;36(9):1599-1605. doi:10.1377/hlthaff.2017.0367

overall healthcare spending, both in terms of ongoing payment and needed investment, must be rebalanced towards primary care.

Behavioral health services are an important component of comprehensive, whole-person primary care, and telehealth has a particularly important role in supporting this behavioral health integration. The distribution and availability of mental health professionals is inadequate to support in-person access to behavioral health care, particularly among rural communities and communities of color. During the pandemic, primary care teams in these communities have leveraged remote tele-mental health to care for and manage the health of their patients—often in communities where available mental health professionals are lacking.

Given the endemic rates of and disparities in mental health disorders predating the Public Health Emergency and increased prevalence during that emergency, **CMS should work with states to remove reimbursement barriers to the delivery of tele-mental health services to Medicaid beneficiaries by primary care practices.**

CMS QUESTION:

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). CMS is interested in feedback about what new data sources, existing data sources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home- and community-based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

5. How can CMS best leverage **T-MSIS data to monitor access** broadly and to help assess potential inequities in access? What additional data or specific variables would need to be collected through T-MSIS to achieve better access across states and delivery systems (e.g., provider taxonomy code set requirements to identify provider specialties, reporting of National Provider Identifiers [NPIs] for billing and servicing providers, uniform managed care plan ID submissions across all states, adding unique IDs for beneficiaries or for managed care corporations, etc.)?

PCC RESPONSE:

One of the greatest challenges to understanding disparities in health care access and outcomes is the failure to collect complete and accurate demographic data of enrollees. The Transformed Medicaid Statistical Information System (T-MSIS) is designed to improve standardization and streamline reporting and stratification of data by key demographics. Despite efforts, the quality of collected data differs significantly across states. A 2018 CMS analysis found more than 10% of race and ethnicity data is missing for most states, with some states missing as much as 50% of data.²⁵ Complete and accurate data for Asian American and Pacific Islanders (AAPI), Latinx (Hispanic), and Native American enrollees is poor, and other demographic data, such as disability and sexual orientation and gender identity (SOGI), is rarely collected. Missing data is indicative of at least two underlying issues—reporting is voluntary, and CMS guidance is not strong enough.

²⁵ Race/ethnicity data in CMS Medicaid (T-MSIS) analytic files updated December 2021 – features 2019 data. SHADAC. <https://www.shadac.org/news/raceethnicity-data-cms-medicaid-t-msis-analytic-files-updated-december-2021-%E2%80%93-features-2019>. Published February 1, 2022. Accessed April 15, 2022.

CMS should use regulatory and compliance standards to require higher-quality data collection and reporting from states. CMS should also support states in this effort. For example, CMS could provide technical assistance to states on approaches to capture data on race and ethnicity and other key data at enrollment and after enrollment by working with managed care plans.

Improving reporting on race and ethnicity and other key demographic data in T-MSIS is a necessary first step in efforts to monitor disparities in access, followed by the timely analysis and public reporting of performance or health outcomes by demographic characteristics. Without accurate and complete data, CMS and state Medicaid programs will continue to lag in developing targeted and impactful health equity initiatives.

PCC thanks CMS for prioritizing the issues addressed in this RfI and seeking stakeholder feedback in advance of rulemaking. If our team can answer any questions regarding these comments, please contact PCC's Director of Policy, Larry McNeely at lmcneely@thepcc.org.

Sincerely,



Ann Greiner
President & CEO

PCC Executive Members

Below is a list of the Primary Care Collaborative's executive members that pay dues to the organization and support its mission. Membership does not indicate explicit endorsement of this letter.

AARP

Accreditation Association for Ambulatory Health Care, Inc.
Alzheimer's Association
America's Agenda
American Academy of Child & Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Physician Associates
American Association of Nurse Practitioners
American Board of Family Medicine Foundation
American Board of Internal Medicine Foundation
American Cancer Society
American College of Clinical Pharmacy
American College of Lifestyle Medicine
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Physicians
American Psychiatric Association Foundation
American Psychological Association
Anthem, Inc.
Array Behavioral Care
Ascension Medical Group
Black Women's Health Imperative
Blue Cross Blue Shield of Michigan
CareFirst, BlueCross BlueShield
Catalyst Health Network
Community Care of North Carolina
CVS Health
Families USA
Harvard Medical School Center for Primary Care
HealthTeamWorks
IBM
Included Health
Innovaccer
Institute for Patient- and Family-Centered Care
Johns Hopkins Community Physicians, Inc.
Johnson & Johnson
Mathematica Policy Research
MedNetOne Health Solutions
Mental Health America
Merck
Morehouse School of Medicine - National Center for Primary Care
National Alliance of Healthcare Purchaser Coalitions
National Association of ACOs
National Coalition on Health Care
National Interprofessional Initiative on Oral Health
National PACE Association
National Partnership for Women & Families
National Rural Health Association
NCQA

Oak Street Health
One Medical
PCC Pediatric EHR Solutions
Pediatric Innovation Center
Penn Center for Community Health Workers
Primary Care Development Corporation
Purchaser Business Group on Health
Society of General Internal Medicine
Society of Teachers of Family Medicine
St. Louis Area Business Health Coalition
Takeda Pharmaceuticals
UPMC Health Plan
URAC