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June 29, 2023

TO: Department of Health & Human Services Centers for Medicare and Medicaid Services (CMS)

FROM: NHMH – No Health w/o Mental Health
American Association on Health and Disability
Clinical Social Work Association
Lakeshore Foundation
International Society for Psychiatric Mental Health Nurses
The Policy Center for Maternal Mental Health

RE: Public Comments on New Medicaid Proposed Rules: (1)Ensuring Access to Medicaid Services and (2) Managed Care Access, Finance, and Quality

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The undersigned organizations acknowledge and appreciate that the above-referenced proposed Medicaid new rules send an important signal that primary care (inclusive of behavioral health integration) is of importance to the Administration. Further, we are appreciative of the opportunity to submit the following comments on the proposed rules as regards primary care wait times, network accountability, and transparency:

Summary of Key Points:

- While we support CMS' proposed new Medicaid rules regarding timely access, network accountability and provider payment transparency in primary care practices, we also believe this focus on primary care, and

proper investment in primary care, is long overdue. The national primary care scorecard finds that Medicaid spending on primary care has decreased over the last several years from 5.3% of total healthcare spending in 2014 to 4.2% in 2020.

- The proposed new Medicaid access and managed care rules appear insufficient to address the current overwhelming financial and operational challenges confronting primary care practices today after decades of underinvestment and neglect by our healthcare system, and legislative and regulatory policymakers. The thinking behind these rules should constitute a starting point for the nation to focus on priority implementation of high-quality primary care.

- Given the fragile, under-resourced state of most primary care practices, the Medicaid proposed new rules should be administered in a way that does not impose additional administrative burdens on an already overwhelmed primary care workforce.

- In addition to the problem of patient lack of access to quality care, the Medicaid proposed new rules should also focus on the lack of a trained, skilled behavioral health workforce. The integration of behavioral health services in primary care is critical to not only addressing unmet behavioral health needs, but also to making better use of the existing workforce.

PART ONE: REVIEWING THE STATE OF PRIMARY CARE TODAY

Medicaid programs should support access to innovative care delivery reforms including the integration of physical and behavioral health or whole-person care in primary care. Most patients with behavioral health needs use primary care as their main source of care, and given the nation's shortage of behavioral health clinicians, evidence-based integration approaches can augment access to behavioral health services and improve health outcomes for Medicaid enrollees.

But awareness, pragmatism and realism must guide change including a profound knowledge and understanding of what is occurring in the primary care environment today. NHMH, as a patient behavioral health advocacy nonprofit dedicated to making integrated behavioral health widely available in primary care, has for 15+ years participated in several national and regional integration clinical RCT trials, demos and spread projects. We have seen first-hand what decades of underinvestment in primary care in our country has meant in terms of weakening and destabilizing those essential care settings.

One of the studies NHMH participated in was a comparative effectiveness large-sale, national randomized control trial involving 44 primary care practices across 11 states all deploying evidence-based behavioral integration in primary care. The study was a large, complex multi-layered effort that sought to be applicable to a broad range of practices and, if successful, applicable to a large number of practices across the country. Community health centers, federally qualified health centers, academic medical centers, community group practices, privately-owned small independent practices all participated in the study.

As researchers-investigators attempted to assist clinicians in advancing their integration services, what they found was that those practices were overwhelmed by acute problems, 'horrible distractions' as one primary care provider put it, that interfered with their ability to provide integrated behavioral health care. They faced a remarkable array of intervening factors limiting their ability to make improvement, including: natural disasters, staffing and leadership changes, work stoppages, staff burnout, computer breakdowns, ownership changes, medical and behavioral health providers, managers and staff leaving in the middle of the study, hiring problems, computer outages and early stages of a global pandemic.

The study, originally planned to take 6-9 months to complete the intervention being tested, ended up taking up to 18 months or more. Delays were often due to local factors such as work stoppages, intervening priorities (e.g. new electronic records systems), hiring problems, and disasters including hurricanes, earthquakes and even a volcanic eruption.

Intervening external acute problems were a dominant problem throughout the study and providers were continually overwhelmed by these intervening factors limiting their ability to offer quality care and make improvements.

We believe it is critically important to keep this clinical care reality in mind as Medicaid seeks to support primary care, promote behavioral health integration models and increase patient access to primary care.

PART TWO: SPECIFIC ISSUES ON RULES' IMPACT ON PRIMARY CARE:

The undersigned organizations support the new Medicaid proposed rules highlighting the importance of primary care through an emphasis on primary care wait times, network accountability, and transparency. We support the following changes as set forth in the proposed Medicaid new rules:

Rule on Medicaid FFS:

*greater transparency re provider payment rates,
* requirement that all States make FFS rates pub in uniform manner,
* require quantification how States' FFS rates for E&M services for primary care, OB/GYN and behavioral health visits compare to Medicare rates,
* FFS analysis made public and accounting for rate differences.

Rule on Medicaid Managed Care:

*actual payment rates not shown publicly, but annually in health plans and provisions with States comparisons of their total Medicare rates for the 3 categories (primary care, OB/GYN, behavioral health) against what Medicare FFS would have paid,
*managed care analysis made public and accounting for differences,
* a new national standard for access in managed care would set maximum wait times for routine primary care, OB/GYN, behavioral health routine appointment services, with 10 business days for behavioral health and 15 business days for primary care and OB/GYN. We believe these wait time standards should be extended to States with 100% FFS programs.

*mandated annual satisfaction surveys of managed care enrollees plus revamped requirements for stakeholder advisory groups.

Additional Explanatory Comments:

Primary Care Administrative Burden: relevant to our Part One discussion of the current state of primary care, we suggest that States seeking to increase patient panel size or gain Medicaid participation may need to address the issue of administrative burden associated with Medicaid participation. As States have moved towards managed care, providers must contract with multiple entities and bill multiple partners. A 2019 Council for Affordable Quality Healthcare (CAQH) study found that providers maintained an average of 20 health plan contracts to cover their full patient population. This burden is significant and may result in reduced provider participation.

While agreeing that accurate provider directories are essential for promoting patient access, reporting processes for providers should be streamlined to ensure they are able to keep up with increased demands.

Addressing Workforce Constraints: while supporting the proposed rules, we believe they may be insufficient to address underlying workforce constraints. As they are significant changes, they may not be realistic based on current workforce shortages. Our recommendations for strengthening the healthcare workforce align with those of the Bipartisan Policy Center in its November 2021 submission to the Senate Committee on Finance, namely:

- Create pathways to behavioral-primary care integration thereby optimizing the existing inadequate workforce and improving screening, treatment and care coordination;
- Expand the National health Service Corps scholarship and loan repayment programs to include behavioral health professionals;
- Use grants to improve workforce diversity;
- Establish tax credits to improve staff retention in rural and underserved areas, and

- Encourage expansion of the behavioral health workforce through interstate licensure portability.

Mandatory Medicaid and CHIP Core Quality Measures

We commend CMS for the mandatory Medicaid and CHIP core quality measure set. Medicaid core measures apply to all Medicaid HCBS recipients, and will improve primary care and the integration of behavioral health and primary care.

We note that the American Board of Family Medicine (ABFM) has proposed to CMS, NQF, and CQMC primary care quality measures, including continuity of care and patient reported outcomes (PROs) measures.

We support a quality measure rejected by the 2022 Mathematica for CMS Medicaid and CHIP core quality measure panel. We support that an individual's Medicaid HCBS (home-and-community-based services) plan must be shared with the individual's primary care provider; and, that an individual's primary care plan be shared with the individual's HCBS provider.

Experience of Care and Medicaid Managed Care Quality

As requested by CMS, we support allowing States to report for their Medicaid managed care programs the same measurement and stratification methodologies and classifications as proposed in the mandatory Medicaid and CHIP core quality reporting.

We agree with the CMS observation that direct input from managed care enrollees is a "valuable source of information," both "actual and perceived." We support the "annual" enrollee experience of care survey for Medicaid managed care enrollees. We support the Managed Care Program Annual report including the results of enrollee experience surveys. We support that enrollee experience surveys must meet interpretation, translation, and tagline criteria.

CMS requests comments on the costs and feasibility of implementing enrollee experience surveys for each managed care program. CAHPS, CAHPS in HEDIS,

CAHPS HCBS, NCI, NCI-AD, and POM all are examples of feasible and effective experience surveys.

CONCLUSION:

In its rulemaking we urge CMS to be especially sensitive and responsive to the realities confronting U.S. primary care practices today as well as the lack of trained, skilled healthcare workforce. And, as it develops and administers new rules regarding access, transparency and accountability, CMS and its State partners also address and rectify the significant historical underinvestment in primary care with a careful, thoughtful strategic plan for primary care transformation towards delivering high-quality care as set forth by the National Academies of Science, Medicine & Engineering in its May 2022 report ("Implementing High-Quality Primary Care").

With best regards,

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