



November 7, 2022



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

Re: Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (CMS-2421-P)

Dear Deputy Administrator Tsai:

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

PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 67 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: care that emphasizes comprehensiveness, longitudinal relationships, and “upstream” drivers for a better patient experience and better health outcomes. (See the Shared Principles of Primary Care). This year, PCC, with fifty other organizations, launched the Better Health – NOW Campaign to win bold policy change that realizes the recommendations of the 2021 National Academy of Science, Engineering, and Medicine’s (NASEM) report, *Implementing High Quality Primary Care*. The principles guiding our Campaign are outlined in PCC’s Concordance Recommendations for Primary Care Payment and Investment but rooted in a simple idea: We need strong primary care in every community so we can all have access to better health.

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.^{1,2} 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 high-quality primary care across all communities and CMS’ own efforts to close gaps in outcomes across populations.

However, 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.³ Cost barriers can similarly disrupt access and delivery of primary care. For the vulnerable individuals and families who are eligible for Medicaid and CHIP, these challenges are particularly serious barriers to health.

Therefore, we applaud the efforts by the CMS and CMCS teams to craft streamlined Medicaid and CHIP eligibility and enrollment policies that support better health. We

¹ 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

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

³ 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

offer comments below on specific provisions of the rule relevant to cost sharing barriers and care continuity. We then conclude this letter by identifying broader improvements urgently needed to strengthen primary care in Medicaid and CHIP.

Comments on Provisions of the Proposed Rule

Removing cost-sharing barriers to primary care

PCC and our Better Health – NOW Campaign have called for removing cost-sharing barriers to primary care across public programs and the private sector. Cost-sharing can impede access to primary care – access that is essential to fighting today’s simultaneous epidemics of poor mental health, substance use, cardiometabolic disorders and infectious diseases. Access to comprehensive, whole-person primary care, inclusive of integrated behavioral health is crucial in Medicaid as well as other sources of health coverage, public and private.

II.A. Facilitating Medicaid Enrollment

CMS Proposal Description:

CMS proposes to

- Require states to utilize Medicare Part B Low-Income Subsidy applications to facilitate enrollment in Medicare Savings Programs; (II.A.1)
- Restrict states’ ability to require additional information to those instances when either that information is not available to the agency or the information available to the agency through an electronic data match or other means is not reasonably compatible with information provided by or on behalf of the individual (II.A.1); and
- Auto-enroll Supplemental Security Income and Medicare Part A-eligible beneficiaries in the Qualified Medicare Beneficiary program. (II.A.3)

PCC/Better Health-NOW Comment

We applaud CMS for its efforts in the NPRM to ensure more Medicaid beneficiaries access the MSP benefits and support the proposals identified immediately above. Access to primary care is essential to fighting today’s simultaneous epidemics of poor mental health, substance use, cardiometabolic disorders and infectious diseases. Cost-sharing can be a barrier to accessing primary care. These barriers can be particularly harmful for the lower-income individuals and vulnerable populations served by Medicaid. Unfortunately, MSP enrollment currently lags far behind eligibility. By contrast, the largely automated process for Medicare Part D’s Low-Income Subsidy (LIS) ensures more beneficiaries benefit from cost-sharing assistance. Aligning enrollment in MSPs with LIS is a sound approach that supports access to primary care.

Supporting Continuous Coverage in Medicaid and CHIP

PCC and the Better Health – NOW Campaign support continuous eligibility for all individuals on CHIP and Medicaid. Until statutory change is achieved, PCC encourages CMS to use every available policy lever to support continuity of coverage, including;

- a) Giving 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) Maintaining CMS’ ongoing support for and cooperation with states, promoting all available options to extend coverage and promote continuity of coverage,
- c) Making continuous coverage policies a top priority in communications to and discussions with states regarding waivers and state plans.

II.B. Promoting Enrollment and Retention of Eligible Individuals

CMS Proposal Description:

CMS proposes new requirements for Medicaid renewal and redetermination procedures. States would be required to use one renewal procedure for both MAGI and non-MAGI populations, limit use of required in-person interviews, limit redeterminations to no more than once every twelve months, and, for those denied Medicaid coverage, determine eligibility for other coverage options (e.g., CHIP or Marketplace plans) and transfer the account. The proposed rule also sets guidelines for states to check available data prior to terminating eligibility when a beneficiary cannot be reached due to returned mail and requires that beneficiaries be given sufficient time to produce documentation needed to retain enrollment.

II.E. CHIP Proposed Changes—Streamlining Enrollment and Promoting Retention and Beneficiary Protections in CHIP

Transitions Between CHIP and Medicaid (§§ 457.340, 457.348, and 457.350)

CMS Proposal Description:

CMS proposes to require state CHIP programs to coordinate enrollment procedures with Medicaid, similar to the requirements proposed for state Medicaid programs.

PCC/Better Health—NOW Comment:

Medicaid enrollees often experience income volatility and as a result “churn” on and off coverage, making care inconsistent and leading to poorer health outcomes. Stable, continuous coverage creates greater access to care, in turn improving health outcomes and promoting health equity by limiting gaps in care for individuals who experience disproportionate rates of health disparities.

We strongly support CMS’ proposals to promote enrollment and eligibility in Medicaid and its proposals to facilitate transitions between CHIP and Medicaid, described above. We urge CMS to continue working to minimize disruptions to coverage and high-quality care. To better support both patient-clinician relationships and accountability for population health outcomes, we believe patients should be encouraged to choose a regular source of accessible, culturally centered primary care. The looming wave of disenrollment, associated with the unwinding of the Public Health Emergency, threatens to disrupt those relationships. This will impact both beneficiary access to care and the effectiveness of population-based payment models. Continuous coverage is essential to the longitudinal, comprehensive primary care approach that better health and increased equity require.

II. F. Eliminating Access Barriers in CHIP

Prohibit Premium Lock-Out Periods (§§ 457.570 and 600.525(b)(2))

CMS Proposal Description:

CMS proposes to prohibit lockouts for nonpayment for CHIP as well as the Basic Health Program (BHP).

PCC/Better Health–NOW Comment:

We support eliminating lock outs in CHIP. We agree with CMS that disruptions in coverage can have detrimental effects on individuals' health. Lockouts create barriers to care, which lower health outcomes and exacerbate health disparities. When the affected individuals are the children and pregnant individuals that rely on CHIP, the consequences for public health can be particularly serious and extend for generations. We also agree that lockouts should be prohibited in the BHP, to assure consistency across similar coverage programs. Although we do not have specific recommendations on the structure of any annual enrollment fees, we are pleased to see CMS exploring, with stakeholder input, options to further facilitate continuous coverage and minimize disruptions in care.

Prohibit Waiting Periods (§§ 457.65, 457.340, 457.350, 457.805, and 457.810)

CMS Proposal Description:

The proposed rule would prohibit state CHIP programs from requiring a 'period of uninsurance,' or 'waiting period,' for individuals who have recently disenrolled from a group health plan prior to allowing them to enroll in a separate CHIP."

PCC/Better Health–NOW Comment:

Any waiting periods for CHIP-covered children and pregnant individuals can result in disrupted or foregone care. Because of the importance of health in childhood and pregnancy to future health outcomes, these gaps in care can have lasting impacts across the lifespan. We strongly support CMS' proposals and believe that they support the continuity of care needed to sustain the health of individuals and populations

Broader Medicaid and CHIP Improvements Needed

We greatly appreciate CMS' proposals to streamline eligibility and enrollment processes in Medicaid and CHIP. However, additional bold policy change will be needed to assure that Medicaid and CHIP beneficiaries in all communities can benefit from high-quality primary care. We detail our recommendations below.

Investing in Medicaid Primary Care

With primary care payment that lags both commercial payers and Medicare, the Medicaid program today often fails to secure robust beneficiary access to necessary primary care services.⁴ 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.

⁴ 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>

Evidence suggests that expanding investment in primary care can expand access.⁵ 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.⁶ Addressing this challenge is an essential step to supporting innovation in payment and delivery and achieving health equity.

CMS should work with Congress and others in the Administration to enact legislation that helps close the gap between low Medicaid primary care reimbursement and other payers. Until such reforms are enacted, CMCS should continue to pursue creative solutions, working collaboratively with states and primary care stakeholders.

In one new approach, recently approved Oregon, Massachusetts, and Arizona Section 1115 waivers included new reimbursement standards, that would require Medicaid payment increases for primary care, behavioral health and obstetrics services, if the Medicaid program's payments fall below 80% of Medicare's payment for similar services. States are not permitted to decrease provider payment rates for other Medicaid- or demonstration-covered services to finance these required rate increases (i.e., cost-shifting).

CMS should build on this approach to support primary care in other states, by

- targeting resources to other states to close reimbursement gaps between Medicaid and other payers, and
- working with states to increase primary care investment whenever it falls short of full Medicare rates - while preventing cost-shifting that could impact reimbursement or access elsewhere in the program.

To further help Medicaid and CHIP support high-quality primary care in all communities, PCC and the Better Health – NOW Campaign also recommends

- including measures of primary care access and primary care spending in State Medicaid Scorecards, and
- incorporating both primary care access and investment in primary care within any future proposed minimum access standards.

Invest in and Support Primary Care - Behavioral Health Integration:

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.⁷ An adequate response to the multiple current behavioral health crises demands recognizing this 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

⁵ 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.

⁶ 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>

⁷ Regier et al JAMA 1978; Jetty et al Journal of Primary Care & Community Health 2021.

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.

PCC has previously provided CMS with detailed recommendations on steps CMS and HHS can take to support primary care-behavioral health integration.⁸

In addition, CMS should work with Congress to establish planning grants and a demonstration program to strengthen Medicaid provider capacity for behavioral 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.

PCC and our Better Health-NOW campaign appreciate this opportunity to provide comment on the proposed rule and look forward to working with the CMS team to strengthen primary care in Medicaid and CHIP. 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
Primary Care Collaborative

⁸ See <https://www.pcpc.org/resource/pcc-sends-behavioral-health-integration-recommendation-letter-hhscms>