July 3, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2439–P
P.O. Box 8016
Baltimore, MD 21244

RE: Medicaid Program; Ensuring Access to Medicaid Services

To Whom It May Concern:

The Primary Care Development Corporation appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule change that aims to improve access to Medicaid services through increased transparency and active beneficiary engagement.

As background, PCDC is a national non-profit organization and Community Development Financial Institution (CDFI) founded and based in New York City. Our mission is to create healthier and more equitable communities by building, expanding, and strengthening access to quality primary care through capital investment and practice transformation, as well as policy and advocacy. Over the past three decades, PCDC has leveraged more than $1.5 billion to finance over 249 primary care projects, with strategic community investments that have built the capacity to provide 4.7 million primary care visits annually, created or preserved nearly 20,000 jobs in low-income communities, and transformed more than 2.6 million square feet of space into fully functioning primary care and integrated behavioral health practices. Our staff have also trained and coached thousands of health workers to deliver superior patient-centered care. Over 30 years, PCDC's work has impacted more than 62 million primary care patients across 45 states as well as the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

High-quality, integrated, patient-centered primary care saves lives, leads to better individual and community health, and is central to health equity. Primary care is the foundation of our health care system and is key to prevention, early detection, and treatment to ensure that chronic diseases like diabetes and heart disease do not turn into acute conditions. It is the ongoing care everyone needs in their lives that keeps people healthy while reducing costs.

Medicaid is a critical source of access to primary care that, together with the Children's Health Insurance Program (CHIP), provides health coverage to about 90 million Americans.[1] Moreover, Medicaid and CHIP disproportionately provide coverage for people of color in the United States who not only frequently lack access to care but also may have experienced racism and discrimination when they have had access.[2]

Expansions of Medicaid coverage have decreased racial disparities in health care coverage.[3] In contrast, failing to expand access to Medicaid exacerbates racial inequity: In states that have failed to adopt the Affordable Care Act's (ACA) Medicaid expansion, over 2 million people who would otherwise be eligible for Medicaid are unable to access such coverage with over sixty percent of those being people of color.[4]

PCDC is dedicated to expanding affordable health care access, while improving the quality of primary care for patients across the country. Our organization advocates for policies that will help achieve those goals, including those that improve beneficiary experiences with health care and health coverage and

contribute to health equity. Therefore, PCDC supports the proposed Rule's provisions that would increase transparency and beneficiary engagement in the hopes that they will help improve access to care.

I. Proposal to Publish Medicaid Rates

Health care providers are often disincentivized from accepting Medicaid by low reimbursement rates, excessive administrative burden, delays in payment and other factors. Notoriously poor reimbursement rates for Medicaid contribute significantly to providers being reluctant to accept Medicaid, which hurts overall healthcare access in communities with many Medicaid patients.[5] According to a 2020 analysis, hospitals received only 88 cents for every dollar spent caring for Medicaid patients – a $24.8 billion underpayment.[6] Administrative issues such as complexity and errors in the billing process also create an unnecessary burden for providers when treating Medicaid patients, with physicians estimated to lose 18% of Medicaid revenue to billing problems, compared with 4.7% for Medicare and 2.4% for commercial insurers.[7] These challenges for providers directly impact patients, who have Medicaid coverage but are often unable to find and therefore utilize quality care, leading to delayed care and other adverse outcomes.[8] Notably, Medicaid spending on primary care, already low, has decreased in recent years, falling from 5.3% of total healthcare spending in 2014 to 4.2% in 2020, indicating inadequate utilization among other problems.[9]

In order to increase reimbursement rates and ensure equitable access to health care, it is critical to first understand where health care funds are being spent. PCDC strongly supports the proposed requirement that each state publish Medicaid payment rates on a state website, along with the requirement that each state conduct a comparative payment rate analysis between their Medicaid payment rates and Medicare rates for services that include primary care. A critical factor in providers' unwillingness to accept Medicaid is that Medicaid reimburses providers at far lower rates than other insurance programs, including both private plans and Medicare plans.[10] To improve access for Medicaid patients, some, but by no means all, states have already begun to require that providers are compensated similarly for caring for Medicaid patients as other patients. An instructive experiment with paying identically for Medicaid and Medicare services took place in 2013 and 2014, after the passage of the ACA. The ACA contained a temporary provision that mandated parity between Medicaid and Medicare reimbursement, specifically for primary care providers.[11] Some states continued this parity after the expiration of the mandate, while many others did not.[12] While the program was short lived in most places, the benefits were nonetheless clear – a 2018 study found that appointment availability for Medicaid patients increased during the period of reimbursement parity and decreased after it expired.[13].

This year, CMS has imposed a requirement for many 1115 waiver programs that states must attempt to reach a Medicaid/Medicare ratio of at least 80% for primary care, obstetrical care and behavioral health care, and if their ratio is lower than that, must increase those rates by 2 percent during the waiver period.[14] California Massachusetts and Oregon have all received approval for their waiver programs with this condition, and because all three states' Medicaid reimbursement rates for primary care were already above 70% of Medicare, they will functionally be required to come close to the 80% threshold during their waiver periods.[15] In addition, New York State increased its own Medicaid reimbursement rates for primary care to 80% of Medicare rates in its annual budget.[16]

PCDC appreciates CMS's requirements in the 1115 waiver application and supports these increases but urges state Medicaid agencies and CMS alike to require that reimbursement rates for Medicaid services, especially primary care services, reach 100% of Medicare rates. PCDC recommends following the leadership of New Mexico, which this year enacted legislation to increase Medicaid reimbursement for primary care and maternal and child health to 120% of Medicare rates.

While requiring transparency in this proposed rule will not create parity, it is an important first step towards policymakers and stakeholders having the data they need to understand how inequitable payment has become and, ideally, be able to take steps to address the problem. However, we urge CMS to further require that the data be provided in a format that policymakers and stakeholders can analyze, in order to ensure that this effort is effective.

II. Proposal to Establish Beneficiary Advisory Group and Revise Medical Care Advisory Committee

Finally, PCDC supports the proposed Rule's establishment of a Beneficiary Advisory Group (BAG), which would require each state Medicaid program to submit a plan that includes an outline of how they will meaningfully engage Medicaid beneficiaries and other low-income people with the newly established Committee. While Medicaid already requires a Medical Care Advisory Committee (MCAC), CMS's own research indicates that some states are not using these Committees to fully understand the concerns of and engage beneficiaries in solving concerns about the state implementation of Medicaid. Many communities understandably lack trust in the health system, with specific groups having been subjected both to historical racism and present day bias in care delivery,[17] and this mistrust can lead directly to concrete health harms – a third of those who mistrust their health providers have reported skipping care.[18] Unfortunately, 7 in 10 African Americans say they have been mistreated by the healthcare system and 55% say they mistrust it,[19] and African Americans are disproportionately represented in the Medicaid population. On the other hand, building trust in health care providers has been proven to lead to better health outcomes.[20] Giving beneficiaries the opportunity to provide information about their own experiences would provide CMS with first-hand knowledge of the flaws within the Medicaid and CHIP program that they could not find through engagement with providers alone, and could lead to solutions more likely to improve patient experiences and increase appropriate patient utilization.

The proposed renamed Medicaid Advisory Committee (MAC), working in tandem with BAG to advise on matters related to the effective administration of the Medicaid program, would better reflect both the experiences and lived expertise of Medicaid beneficiaries and lead to more accountability and more equitable solutions. To avoid a repeat of the problems that have occurred with the current MCACs, PCDC supports the proposed Rule's requirement that each state submit their plan for meaningfully engage Medicaid beneficiaries and other low-income people with the new Committee. PCDC further supports the requirement that at least 25% of MAC members must be individuals from the BAG who are currently or have been a Medicaid beneficiary or the family member of a Medicaid beneficiary, which will help ensure that beneficiary voices are heard. We further encourage CMS to consider increasing that percentage, looking to the model used for community involvement in the Boards of Federally Qualified Health Centers. Finally, we encourage CMS to require states to support effective participation of the members of the BAG by compensating them for their time, reimbursing for transportation, childcare and any other needs, including missed work, and considering work schedules and location when scheduling meetings.

III. Conclusion

Once again, PCDC thanks CMS for the opportunity to comment on CMS's attempts to improve access to care and address issues about health equity, access, and transparency for Medicaid beneficiaries.

We would be happy to follow up on any of these key points if more information would be useful – feel free to reach out to our Director of Policy, Jordan Goldberg, at jgoldberg@pcdc.org or (212) 437-3947, for any further information.

Sincerely,

Louise Cohen
Chief Executive Officer
Primary Care Development Corporation

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[1] Medicaid.gov, August 2022 Medicaid & CHIP Enrollment Data Highlights, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited January 3, 2023).

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[15] *See* KFF, State Health Facts: Medicaid-to-Medicare Ratio, 2019, https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Primary%20Care%22,%22sort%22:%22desc%22%7D (last visited June 28, 2023) (As measured by KFF in 2019, specifically for primary care, California's Medicaid rates were 76% of Medicare, Oregon's rates were 73% and Massachusetts' rates were 71%).
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