

ACEP Responses to the Medicaid [Request for Information \(RFI\) on Access to Care and Coverage in Medicaid and CHIP](#) Online Survey

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, valuebased 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?

ACEP believes that Medicaid enrollees, at the very minimum, should have access to all services that fall under the ten “essential health benefits,” which most private health plans must cover under the Affordable Care Act. Without access to a wide range of services needed to manage their health conditions, Medicaid enrollees may wind up deferring necessary care. Such deferral or delay will often result in their condition or symptoms becoming exacerbated, and eventually result in a trip to the emergency department (ED). At this point, due to the progression of their condition, their care in the ED will be much costlier and more complex than if they had earlier access to treatment.

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? What are other ways that CMS can promote whole person care and care coordination?

In recent years, providers and health plans have begun to recognize the importance of social determinants of health to a patient's overall health. Many interventions help identify barriers to health such as transportation and access to food and housing. One such tool that ACEP supports to help manage care for patients with complex needs is the Collective Medical Technologies' (CMT) Edie™ (a.k.a. PreManage ED) software. Edie™ is an information exchange that provides critical information on patients, such as how many ED visits patients have had in the last year, where they presented, their drug history, other providers who are involved with the patients, and finally, whether there is a patient-specific care management plan that could guide treatment. The platform improves patient care by allowing emergency physicians to make more informed clinical decisions and better direct a patient's follow-up care. It also lowers health care costs through a reduction in redundant tests and through better case management that reduces hospital readmissions. Through an alliance with CMT, ACEP has seen this system mature in approximately 17 states. Washington state, in the first year alone, [experienced](#) a 24 percent decrease in opioid prescriptions written from emergency departments, a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than \$32 million.

Some EDs across the country are attempting to create care coordination and case management programs that help improve follow up appointment scheduling from the ED and target social interventions and primary medical care to high ED utilizers. One such program in Maryland applies mobile technology to use paramedics in a community health worker role to follow up on discharged patients at risk for readmission. Many of these patients are Medicare beneficiaries. Another program in the East Bay, California has a help desk for health-related social needs with four integrated medical-legal partnerships, called Health Advocates, to help patients navigate housing and transportation challenges, immigration challenges, and benefit eligibility.

ACEP is continuing to explore other innovative ways our physicians can help coordinate care for high-risk patients, including through participation in alternative payment models. We have developed a physician-focused payment model (PFPM) called the [Acute Unscheduled Care Model \(AUCM\)](#), which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recently recommended to the HHS Secretary for full implementation. The AUCM provides incentives to participants to safely discharge patients from the ED by facilitating and rewarding post discharge care coordination. Under the model, a person who presents to the ED will undergo a safe discharge assessment (SDA) concurrent to receiving clinical care to identify socioeconomic factors and potential barriers to safe discharge back to the home or community, needs related to care coordination, and additional assistance that may be necessary. If the participating emergency physician, in collaboration with the primary care physician or designated specialist, determines that the patient is a candidate for discharge, the information captured during the SDA will be used to generate unique patient discharge instructions including identifying symptoms that would require rapid reassessment and return to the ED. After the initial ED visit, the patient will receive appropriate follow-up care from the ED physician, his or her primary care physician, and other specialists as needed. ACEP is excited about the infinite possibility this model has in terms of improving care for patients and is eager to work with HHS on implementation.

Understanding the full significance that specific social determinants of health have on a patient also requires comprehensive screening by trained professionals. While screening can be burdensome, it

can help highlight those patients who may need additional services (such as nurse follow up calls, peer counseling, or a visiting dietitian) to prevent the next acute care episode. There are many screening techniques and tools that exist, and while ACEP supports the concept of screening, we have not endorsed a particular approach.

Beyond screening, another way to identify patients with social risk factors is to simply look at utilization, particularly in acute care settings such as emergency departments. Edie™, which is described above, can help identify individuals that have gone to the ED frequently. Once these beneficiaries are identified, ACEP believes that it is important to create targeted care coordination plans that can help get the appropriate care to each individual patient.

CMS can also do more to support mental health patients and ensure that Medicaid Managed Care Organizations (MCOs) are complying with the Mental Health Parity and Addiction Equity Act. This is a critical time for mental health care in our country. As you well know, our nation's mental health and substance use disorder (SUD) crises have been exacerbated by the myriad impacts of COVID-19. EDs throughout the country have witnessed the worrisome trends in Americans' overall mental health and continued lack of access to desperately needed acute and long-term mental health care services. More than 100,000 Americans died due to overdose in 2021 – what some have noted as an “epidemic within a pandemic.” We have also seen sharp increases in ED visits related to mental health, especially for children and young adults. As a recent U.S. Department of Education report, [“Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs,”](#) notes, children have experienced isolation, bereavement, depression, worry, and other issues throughout the pandemic, leading to reports of anxiety, mood, and eating disorders, as well as increased self-harm behavior and suicidal ideation at nearly twice the rate of adults. Pediatric emergency department visits related to mental health significantly increased during the pandemic – a 24 percent increase for children 5-11 years of age, and 31 percent for children 12-17. These stressors affect children's development and ability to learn in both the immediate and long-term with lasting consequences should their mental health needs not be adequately addressed.

CMS needs do more to ensure that mental health services are covered and appropriately reimbursed. In Maryland, for example, Optum instituted a policy applying to its Medicaid managed care population that only allowed certain specialists who identify as “mental health practitioners” to bill for services delivered to patients in the ED who have a primary diagnosis related to a mental health condition. Therefore, emergency physicians in Maryland who treat people with mental health disorders on a routine basis were not allowed to bill for any mental health services they delivered to their Medicaid patients. Although this particular policy has been rescinded, these types of policies do jeopardize the overall goal to ensure parity between physical and mental health services.

While the ED is the critical frontline safety net and the most appropriate setting for acute unscheduled care for individuals suffering from a mental health crisis, it is not ideal for long-term treatment of mental and behavioral health needs. However, due to the fragmented nature of the mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for the longer-term follow-up treatment they need and deserve. These challenges contribute to long ED wait times and aggravate “boarding” issues, a scenario where patients are kept in the ED for extended periods of time due to a lack of available inpatient beds or space in other facilities

where they could be transferred. Overcrowding and boarding are not failures of the emergency department; rather, they are symptoms of larger systemic issues that must be addressed to eliminate bottlenecks in health care delivery and reduce the burden on the already-strained health care safety net.

Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and their overall health, especially for those with mental or behavioral health needs. ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system. Some research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental health care.

CMS must do more to address boarding and overcrowding in the ED. Currently, the only mechanism that CMS uses to monitor ED boarding is through its Medicare hospital quality reporting programs. In both the inpatient and outpatient quality reporting programs, there are quality metrics on ED boarding. The inpatient quality metric measures the median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status and the outpatient metric measures the median time from ED arrival to time of departure for patients discharged from the ED. CMS, [despite our objections](#), decided to sunset the inpatient measure starting in 2024. According to CMS, there is limited evidence that ED boarding is associated with adverse outcomes such as in-patient mortality (despite ACEP and other organizations presenting studies and other evidence to the contrary). CMS stated that it still thinks ED boarding is an important issue to track, but going forward starting in 2024, will only use the outpatient metric to monitor ED boarding. CMS also does not believe that removing the inpatient measure will impact hospitals' commitment to reducing ED boarding times. However, if this is the case, the agency should try to develop additional policies that would help address this issue.

In addition, improving coordination of care across the health care continuum must be one of the highest priorities for any mental health reform effort. The ED serves as the critical health care safety net not only for acute injuries, but for psychiatric emergencies as well. However, most EDs are not ideal facilities to provide longer-term care for patients experiencing a mental health crisis – they are often hectic, noisy, and particularly disruptive for behavioral health patients.

Across the country, communities have adopted innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding. Some examples include:

- Behavioral Health Emergency Rooms (BHERs). BHERs are separate areas of the ED that specialize in proactive rapid-assessment, stabilization, and treatment of patients in experiencing a behavioral health crisis. Care is delivered via a multidisciplinary team of emergency physicians, psychiatrists, psychiatric nurses, and social workers. This service is operational 24 hours a day, 7 days a week, 365 days a year. These dedicated spaces provide patients with a safer, private, and more peaceful setting in which to deescalate and receive specialized care.

By initiating proactive assessments in a BHER, 40-50 percent of patients can be safely discharged home, reducing ED boarding time. Additionally, optimizing transition of care through Integrated Outpatient Care clinics ensures ongoing high-quality medical and behavioral health care follow-up with convenient and comprehensive treatment options for patients.

- EmPath (Emergency Psychiatric Assessment Treatment and Healing) Units. The EmPath Unit is a separate, hospital-based setting solely for psychiatric emergencies with the safe, calming, homelike environment of a community mental health crisis clinic with the ED's ability to take care of any patient who presents for treatment. This unit accepts all suitable patients regardless of the severity of their illness, legal status, dangerousness, substance use intoxication or withdrawal, or co-morbid medical problems, as these patients are typically excluded from community programs and thus would likely experience boarding in an ED in the traditional medical system.

EmPath units provide immediate access to individualized care from a comprehensive mental health care team of psychiatrists, psychologists, mental health nurses, social workers, and other licensed mental health care professionals. This team partners directly with patients and their families to address the immediate mental crisis and to develop a longer-term care plan through appropriate follow-up services. In some instances, EmPath Units have reduced regional ED boarding by 80 percent, and have also reduced the need for—and incidence of—coercive measures (such as physical restraints), episodes of agitation, and psychiatric hospitalization.

- Psychiatric Emergency Service (PES). The PES model is a multipronged approach for emergency psychiatric patients treated in the ED based on increased availability of psychiatrists and dedicated case managers who focus on psychiatric patients. This model is referred to as a “hub-and-spoke” model with a dedicated psychiatric ED serving as a central hub with bidirectional spokes going out to a wide variety of mental, behavioral, and physical care, as well as social services. Recognizing that psychiatric patients have vastly different needs and circumstances affecting their overall health, this model helps address the patient's immediate mental health needs and swiftly directs them to the most appropriate follow-up services, which helps alleviate the overall load on the mental health care system. These two-way spokes may also serve to reconnect patients with the psychiatric ED should they require acute stabilization while receiving follow-up services, potentially avoiding an inpatient hospitalization and ensuring the patient receives the most appropriate care and treatment throughout the mental health care continuum.

These innovative approaches have helped communities improve coordination of emergency psychiatric care, and they can serve as models for other communities to implement and build upon. However, what is clear from experience is that the ultimate success of any model hinges on the availability of resources, whether monetary, staffing, or access to follow-up services and patient access to long-term mental and behavioral health care. One persistent challenge of emergency medicine is that “one emergency department is one emergency department” – i.e., the needs of each

community and the resources available to local EDs, hospitals, and other facilities vary widely, and a model that is successful in one community may not be the best fit for another community.

For example, in 2017, Oregon implemented a dedicated psychiatric ED model in Portland based closely on the Alameda Model (California), but the transition has been marked by challenges for both the dedicated psychiatric ED and surrounding facilities. The dedicated psychiatric ED that was intended to reduce the burden on individual EDs is frequently at capacity or overcrowded, but emergency physicians at other facilities have noted that they are still seeing the same number of acute psychiatric patients in their own EDs. Additionally, the dedicated psychiatric ED has struggled to transfer patients to long-term follow-up treatment at Oregon State Hospital, contributing to long wait times, crowding, and poor outcomes for patients. Despite these challenges, stakeholders have been working to address the shortcomings of the system and adapt the model to better meet the needs of the Portland community, but the experience has highlighted that new care models are not necessarily “plug-and-play” and do not guarantee immediate results.

Another longstanding barrier to providing adequate mental health treatment services is the Medicaid Institutions for Mental Disease (IMD) exclusion. The Medicaid IMD exclusion prohibits the use of federal Medicaid financing for care provided to most patients in non-hospital inpatient mental health treatment facilities larger than 16 beds. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21, and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services. The IMD exclusion has been part of the Medicaid program since Medicaid’s enactment in 1965.

Congress modified (but did not repeal) the Medicaid IMD exclusion in the “Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act” or the “SUPPORT for Patients and Communities Act,” which was signed into law on October 24, 2018. The SUPPORT Act creates a five-year state plan option, from October 2019 through September 2023, to allow states to receive federal Medicaid payments for IMD services only for adults ages 21 to 64 with at least one SUD. IMD payments are limited to any 30 days in a 12-month period. To effectuate the law, on November 13, 2018, CMS sent out a [letter](#) to State Medicaid directors that included a new demonstration opportunity for states to treat adults and children with serious mental illnesses.

Applying for a Section 1115 Medicaid waiver has been a common approach that states have used to receive federal Medicaid funds for IMD services for nonelderly adults. Prior to the SUPPORT Act and CMS’ demonstration, 1115 waivers were only available to treat patients with SUD. Although they are now available to cover mental health treatment as well, only 8 states have taken advantage of that waiver opportunity according to the [Kaiser Family Foundation](#) (with 6 state waivers pending). ACEP therefore supports broader use of the waiver for now, and in the long term, supports the full repeal of the IMD exclusion by Congress.

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?

ACEP notes that Section 1557 of the Affordable Care Act of 2010 (Ensuring Meaningful Access to Individuals with Limited English Proficiency) requires that “covered entities take reasonable steps to provide meaningful access to each individual with limited English proficiency who is eligible to be served or likely to be encountered within the entities’ health programs and activities.” While the section outlines required actions, such as posting a notice of right to communication assistance, taglines about the availability of language assistance, prohibitions against low-quality remote interpreting services and reliance on unqualified staff, it only encourages covered entities to develop and implement a language access plan. Several studies have demonstrated a lack of familiarity of healthcare staff with hospital policies on language services. ACEP urges CMS to specify how covered entities can develop and implement a language access plan. Language access plans should also specify the continuous need for using interpreter services throughout the course of the encounter, from gathering the initial history, to discussing results, to discharge planning. CMS should consider subsidizing language access services for critical access hospitals and providers with infrequent need for such services.

Other studies have demonstrated that patients with limited English proficiency are more likely to have negative health outcomes because of poor communication, have fewer tests and medications administered, and receive fewer intensive services. As a cost benefit analysis, CMS should collect and analyze data that looks at outcomes of patients that had access to language services compared to those that did not in order to evaluate certain costly encounters, such as re-hospitalization and return emergency department (ED) visits.

While every state has enacted laws about language access in healthcare settings, the provisions within these laws vary. For example, some laws are comprehensive, while others focus on a particular patient population or service. In addition, some laws give detailed guidance while others address the general importance of access. Finally, some laws include elements of cultural competencies and training while others do not. ACEP strongly supports additional guidance that would equitably assure that all health institutions and clinical staff provide trained interpreter services (in-person where possible or telehealth) for all limited-English speaking patients while understanding that the ED presents a unique, dynamic, episodic and acute setting where exceptions in the interest of patient care can be made. We also suggest that CMS reimburse for culturally and linguistically appropriate services based on the timeliness and quality of the services. Additionally, healthcare workers that can provide language access services and are frequently asked to interpret should be able to demonstrate their competence through a standardized process.

Finally, CMS should consider funding innovative, bottom-up approaches that take into account the clinical urgency of ED workflows, such as embedded interpreters for common languages or accredited healthcare workers. Such an effort to bolster interpretation and translation policies could be incorporated into new or existing Center for Medicare and Medicaid Innovation (CMMI) models.

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.

2. What measures of potential access, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor (e.g., provider networks, availability of service providers such as direct service workers, appointment wait times, grievances and appeals based on the inability to access services, etc.)? How could CMS use data to monitor the robustness of provider networks across delivery systems (e.g., counting a provider based on a threshold of unique beneficiaries served, counting providers enrolled in multiple networks, providers taking new patients, etc.)?

ACEP has long advocated for CMS to enforce strong network adequacy standards across Medicare, Medicaid, and the Exchange as a way to ensure that all insured patients have access to a full range of health care services. To that end, we were pleased that in the “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 Proposed Rule,” CMS proposed to add emergency physicians to the provider specialty list for time and distance standards. In previous years, we have [specifically requested](#) to CMS that emergency medicine be added to the provider specialty list for Medicare Advantage (MA) plans, and again, we support CMS’ proposal for qualified health plans participating in the federal Exchange. We believe that CMS should apply that same policy to MA plans and, to the extent possible, to Medicaid managed care plans.

It is essential for all insured patients to know from their health plan in advance of an emergency if the emergency physician treating them is in-network (NOT during or after an emergency has occurred). The very nature of ED care, more than any other type of specialty care, precludes the opportunity for patients to preferentially go to facilities with in-network emergency physicians.

Strong network adequacy requirements are important for the Medicaid program in particular. An Assistant Secretary of Planning and Evaluation (ASPE) [study](#) cited barriers to accessing other sources of care such as outpatient providers for low-income populations as a potential factor contributing to the reported higher frequency of Medicaid enrollees going to the ED than privately-insured individuals. For example, among general practice physicians accepting new patients, [providers were less likely to accept new patients with Medicaid than new patients with Medicare or private insurance](#) (68.2% compared to 89.8% and 91.0%, respectively).

While creating strong network adequacy requirements is extremely important, ACEP notes that strong **enforcement** of these standards is also crucial to ensure their execution. Creating these standards without proper enforcement would definitely undermine their overall effectiveness. As such, we believe CMS should impose strong penalties for health plans that are non-compliant with network adequacy requirements.

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible. Section 1902(a)(30)(A) of the Social Security Act (the “Act”) requires that Medicaid state plans “assure 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 extent that such care and services are available to the general population in the geographic area.” Section 1932 of the Act includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States “in an effective and efficient manner...” CMS is interested in leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.

1. What are the opportunities for CMS to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?

a. Align Approaches:

CMS has previously attempted to address the imbalance of physician to beneficiary ratio; however, there are many complex factors which affect access to services: the beneficiaries' demonstrated health care needs; state and/or local service delivery models; procedures for enrolling and reimbursing physicians; the availability of physicians in the community; the capacity of Medicaid participating physicians; and Medicaid service payment rates to physicians. To align with the statutory requirements, states may employ any number of strategies to ensure or improve access to care that are targeted toward one or more of these factors.

Budget-driven changes in payment to physicians in states have led to access problems for beneficiaries, made worse by a lack of planning and oversight. CMS should align the process of reviewing state payment rate methodologies for compliance so that states are required to update the projected effects to beneficiary access before budget-driven changes can be implemented.

The 2011 *Medicaid Program; Methods for Assuring Access to Covered Medicaid Services* Final Rule required that states conduct regular reviews of Medicaid access to care including payment data, trends in utilization, provider enrollment, feedback from providers and beneficiaries, and other data points on access to Medicaid services. However, the final rule specified that states must conduct a public process when reducing Medicaid payment rates and monitor changes in access to care after payment reductions are approved by CMS and go into effect.

The 2015 *Medicaid Program; Methods for Assuring Access to Covered Medicaid Services* Final Rule attempted to strengthen CMS review and enforcement capabilities by providing more transparency on access in

Medicaid FFS systems and how data-driven decisions and CMS decisions are made when considering proposed rate reductions and other methodology changes that may reduce beneficiaries' abilities to receive needed care. While these changes allowed for physicians and beneficiaries to better advocate for rate methodologies and policies that enlist and retain enough physicians to provide adequate service coverage, we believe there are additional ways in which CMS can align approaches with states.

In subsequent years, CMS has focused on the quality of services and availability of participating physicians; however, **ACEP believes CMS should reexamine the process of enrolling and reimbursing physicians. CMS could have an immediate impact on ensuring payments are adequate for providers by improving the State Plan Amendment (SPA) approval process.** Currently, states that submit a SPA have, in most cases, pursued a dual-track approach in which the state budget approved by the legislature matches the SPA application. This approach pressures both the state's FFS Medicaid program and CMS to make reimbursement decisions driven by legislatures with statutory deadlines. Since the 2015 Supreme Court decision in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378, the Medicaid statute does not provide a private right of action to physicians to enforce state compliance with section 1902(a)(30)(A) of the Act in federal court. As a result, legal challenges are not available to supplement CMS review and enforcement to ensure beneficiary access to covered services. **ACEP strongly urges CMS to adopt a streamlined approach to approving SPAs so that physicians can submit their comments and data to CMS for consideration immediately after a SPA is filed by a state for approval.** Physicians have asked for due process. CMS adopting more transparent SPA approval procedures which values their input is likely to promote participation.

b. Set Minimum Standards for Payment Regulation and Compliance

States have flexibility to establish beneficiary service delivery systems, designate procedures for enrolling providers of such care, and to set the methods for establishing provider payment rates. This broad flexibility for Medicaid and CHIP has created programs that seek to limit fraud, waste, and abuse, however ACEP believes many of these programs instead unfairly target physician reimbursement and create onerous requirements for beneficiaries.

1115 Waivers have given states the flexibility to create approaches to beneficiary enrollment separate from CMS rules. The waiver provisions approved by CMS include work requirements, the ability to charge premiums based on income, premium surcharges based on health risk factors, and fees for missed appointments. While some states have used this flexibility to create programs which address specific social needs of Medicaid beneficiaries such as housing instability, transportation and food insecurity, and interpersonal violence and stress, ACEP is concerned that many programs seek to disenroll certain individuals and families. ACEP is particularly concerned with states that have onerous work requirement reporting mechanisms. **CMS should provide guidance to states on best practices for granted waiver provisions, including work requirements, to avoid Medicaid beneficiaries unnecessarily losing eligibility.**

Temporary COVID FMAP increases under the Families First Coronavirus Response Act are likely to end after the Public Health Emergency (PHE) is over unless CMS acts. **ACEP encourages CMS to maintain a minimum standard for states that accept increased FMAP percentages after the PHE ends.** This includes maintaining current eligibility requirements that are less restrictive,

preventing termination of individuals no longer eligible for a set period of time (transition period), and a phase-in period for any increase in premiums or cost-sharing amounts to avoid unnecessary drops in enrollment due to financial hardship.

The Affordable Care Act (ACA) created a coverage gap for non-expansion states in which individuals and families above 43% of the federal poverty level (FPL) cannot qualify for Medicaid coverage or a subsidy to purchase an Exchange plan. **ACEP believes that CMS should close the coverage gap by making the Exchange available to uninsured individuals below 138% of the FPL that currently do not qualify for Medicaid FFS in non-expansion states.** Coverage through the Exchange would provide a low or no monthly premium option, closing a coverage gap and giving low-income individuals and families the ability to access services that would otherwise not be covered.

2. How can CMS assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?

Since the passage of the ACA, states have adopted service delivery models that emphasize medical homes, health homes, or broader integrated care models to provide and coordinate services. The accompanying payment methodologies can significantly shape beneficiaries' abilities to access care. While many states have created and/or improved upon a delivery system model and payment methodologies that improved access to care by reimbursing telehealth services during the PHE, it is vital for CMS to ensure continuation of coordinated care and services in a setting and timeframe that meet beneficiary needs.

ACEP strongly supports CMS approving the use of telehealth services in the emergency department beyond the PHE to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. Telehealth is an important part of delivery of quality services to beneficiaries in areas which currently lack enough physicians to meet beneficiaries' needs.

As state delivery systems have evolved, provider payment systems have become increasingly frustrating for physicians. Traditionally, states have developed rates based on the direct and indirect costs of providing a service, followed by a review of the amount paid by commercial payers in the same or similar geographic area, or as a percentage of what Medicare pays for equivalent services. However, CMS found in 2015 that rates are updated based largely on specific trending factors such as the Medicare Economic Index or a Medicaid trend factor that incorporates a state-determined inflation adjustment rate. Rates that include incentive payments encouraging physicians to care for Medicaid populations and improve care continue to be inadequate. **ACEP strongly suggests that CMS encourage states to authorize additional separate payments for care coordination and management as well as achievement of certain specified quality or health outcome measures.** We believe this would encourage greater physician participation and in turn result in beneficiaries having greater access to seek quality care in the appropriate setting.

ACEP also believes CMS should work directly with states to design payment and service delivery systems to ensure program savings are aligned with better care quality and promote

rather than reduce access to services. By working closely with individual states, CMS could assess the effect of state payment policies and contracting arrangements in a short time frame, avoiding the implementation of programs that have a negative impact on access.

CMS has created stronger processes at both the state and federal levels for developing data on beneficiary access and reviewing the effect of changes to payment methodologies over the past decade. In the 2015 PFS final rule, CMS reviewed options to ensure that states were adhering to Medicaid access requirements in section 1902(a)(30)(A) and established approaches for states to demonstrate consistency with requirements using a transparent process, rather than setting nationwide standards. **To better assess the effects of state payment policies and contracting arrangements, ACEP believes that CMS should re-evaluate how states reduce or restructure rates in ways that reduce access to care. Additionally, CMS should assist states in developing and monitoring indices to ensure sustained access after implementing rate changes.** States would continue to have the discretion to choose the data used to measure and analyze access to care; however, CMS would ensure that beneficiary access must be considered in setting and adjusting payment methodologies for Medicaid services. CMS should continue to review access issues when making SPA approval decisions.

CMS should also continue to require state Medicaid agencies demonstrate access to care by documenting the availability of care and providers and the utilization of services in an access monitoring review plan. **ACEP believes the experiences of beneficiaries and physicians should be a primary determinant of whether access is sufficient.** CMS should continue to disapprove a proposed rate reduction or restructuring SPA that does not include or consider data review and a public process. States should not have authority to implement Medicaid FFS rate reductions and should continue to pay providers according to the rate methodology described in the state plan.

To better assess the effect of state payment policies and contracting arrangements, CMS should hold additional listening sessions with Medicaid beneficiaries and physicians to hear concerns regarding Medicaid access to care and how states and CMS could work jointly to address access issues.

3. Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community based services (HCBS). What data sources, methods, or benchmarks might CMS consider to assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?

Overall, ACEP is extremely concerned that inadequate Medicaid payment rates in many states throughout the country will lead to significant access issues. Though Medicare is available for comparison and often used as a benchmark for Medicaid rates, ACEP cautions the use of Medicare payment rates for this purpose. Based on a [Kaiser Family Foundation analysis](#), current Medicaid fee-for-service rates are, on average, 72% of Medicare fees for the same service. **However, Medicare payment rates themselves are inadequate.** An analysis conducted by ACEP found that Medicare payments have decreased by 53 percent when comparing Medicare payments to inflation between the

start of the Resourced-based Relative Value Scale (RBRVS) in 1992 and 2016. Even the 2021 Medicare Trustees Report acknowledges that updates for physician reimbursement are not sufficient. The Trustees believe that, absent a change in the delivery system, access to Medicare-participating physicians will become a significant issue in the long term. Given the fact that Medicaid rates only represent 72 percent of Medicare fees, and the Trustees conclude that Medicare rates are too low, we urge CMS to take immediate action to increase Medicaid rates to reasonable payment levels.

The level of both Medicare and Medicaid payment rates is simply unsustainable, and clinicians, especially front-line providers, need a stable level of reimbursement—especially considering what we have faced during the COVID-19 public health emergency (PHE). With respect to emergency medicine particularly, it has been more expensive than usual to provide appropriate care to patients, as emergency physician groups have had to incur additional expenses for treatment, such as developing and implementing protocols for alternative sites of care, enhancing telehealth capabilities, purchasing personal protective equipment (PPE), and taking on other new administrative costs due to staffing shortages (such as taking over nursing functions including as triaging, treating, and performing nurse discharge responsibilities for patients with potential COVID symptoms in ways that limit possible exposure to the disease). All of these additional costs are weighing down on group practices as they try to maintain the minimum staffing levels necessary to serve patients night and day in the emergency department (ED) and prepare for surge staffing when COVID-19 cases actually do increase in their area. These additional needs and expenses likely will carry on throughout 2022 and perhaps even into 2023.

Looking forward, many emergency physicians are already very concerned about the viability of their group. We believe that CMS has an obligation to health care professionals and patients to do everything in its power to address payment deficiencies in both Medicare and Medicaid and impose payment rates that increase with inflation.

4. Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries.² What actions could CMS take to encourage states to reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?

As emergency physicians, we appreciate our essential role in strengthening the health care safety net for our communities. We treat all patients who come through our doors, regardless of their insurance status or ability to pay. Over the years, certain laws have been put into place to help enforce and protect patients and the emergency healthcare safety net, including the “prudent layperson” (PLP) standard. First established under the Balanced Budget Act of 1997, the PLP allows people who reasonably think they are having an emergency to come to the ED without worrying about whether the services they receive will be covered by their insurance. Under the PLP, payors cannot deny reimbursement to providers based on the patient’s final diagnosis. An “emergency” versus a “non-

emergency” must be determined on a case-by-case basis based on whether the patient’s symptoms and complaints reasonably represented to them as a prudent layperson a potential emergency condition. In all, if the PLP standard applies (which happens almost all the time), ACEP asserts that the care provided to patients meets the requirements of medical necessity and therefore, should be covered by insurers.

Unfortunately, ED claims are denied by insurers, including Medicaid managed care organizations (MCOs), due to a “lack of medical necessity” after seeing a final diagnosis. ACEP strongly believes that such a denial represents a fundamental violation of the PLP standard. Patients with symptoms consistent with a possible emergency health condition should not be expected to self-diagnose before deciding whether to come to the ED. Even as experienced emergency physicians, we cannot determine a patient’s final diagnosis (or whether they have an emergency or non-emergent medical condition) based on the patient’s symptoms when they first present to the ED. Many conditions share very similar symptoms, and a full work-up and examination (sometimes with additional diagnostic tests) is frequently required before the ultimate diagnosis becomes clear.

Claims denials violate the PLP standard, but they are not the only bad practice by payors that discourages provider participation in programs including Medicaid and CHIP. Downcoding, in which services are still covered by the payors (rather than denied), but the level of service on the claim is changed, has become a major issue in emergency medicine. Payors have instituted algorithms or lists of final diagnosis to automatically down code certain claims without a medical chart review—again based on the final diagnosis and thus in violation of the PLP standard.

CMS has issued statements dating back to 1995 that clearly dictate that modifying payments for emergency services based on a list of diagnosis codes is a violation of the PLP standard. However, given that this practice is still occurring in states such as Virginia, we ask that CMS take more direct actions to enforce the PLP standard.

It is important to note that both the Obama and Trump Administrations have clearly stated that the PLP standard prevents plans from modifying payment of (downcoding)—emergency claims based on diagnosis. In 2016, the Obama Administration issued the [Medicaid Managed Care Rule](#) which states “*The final determination of coverage **and payment** must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that **providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens***” (emphasis added). In a March 15, 2018, letter to EDPMA, former CMS Administrator Seema Verma reiterated that “Whenever a payer [...] denies coverage **or modifies a claim for payment**, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must make take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional)” (emphasis added).

Beyond payment denials and downcoding, another harmful practice employed by insurers is prior authorization. Emergency services are exempt from prior authorization in most cases. It would be extremely unsafe and impractical to require patients in the emergency department (ED) to receive prior authorization before being able to receive critical services. However, as emergency physicians,

we still see how prior authorization can affect the ability of our patients to receive the most appropriate treatment in the most appropriate care setting. We have experienced numerous occasions where patients who are unable to receive services in other care locations because of a prior authorization denial come to the ED to receive those services (sometimes at the direction of their provider). Patients come to the ED because they and or their physician recognize that the patient can receive the service without undergoing prior authorization. This clearly is not an appropriate reason for a patient to receive treatment in the ED, but it reflects a fundamental flaw in the health care system resulting from extremely stringent prior authorization protocols. Therefore, ACEP recommends that CMS address this issue as quickly as possible and do more to streamline and automate the prior authorization processes under all federal health programs, including Medicaid and CHIP.