

January 10, 2019

Re: CMS-2408-P

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8013

**Re: Medicaid Program; Medicaid and Children's Health Insurance Plan
(CHIP) Managed Care**

Dear Administrator Verma:

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On behalf of nearly 38,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on a proposed rule that would revise current Medicaid and CHIP managed care regulations. A couple of the regulations addressed in the rule have a direct impact on our members and the patients we serve.

Network Adequacy

CMS is proposing to replace the current network adequacy requirement for states to establish time and distance standards with more flexible “quantitative standards” that CMS believes may more accurately reflect provider availability. For example, if states rely on telehealth services to reach people in certain areas, it may be more meaningful to measure access by determining a provider to enrollee ratio rather than using time or distance. Quantitative standards that states can use include, but are not limited to: minimum provider-to-enrollee ratios; maximum travel time or distance to providers; a minimum percentage of contracted providers that are accepting new patients; maximum wait times for an appointment; hours of operation requirement; and combinations of these quantitative measures.

ACEP has long advocated for CMS to enforce strong network adequacy standards in Medicaid managed care. Medicaid managed care organization (MCO) patients have been particularly vulnerable to less than adequate networks and access to primary care. Unfortunately, emergency physicians have witnessed this trend for years. We strongly believe that all Medicaid patients must access a full range of health care services. People who do not have access to care are more likely to defer seeking more routine care or visiting a primary care physician or specialist for more minor conditions or symptoms. 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 more routine care in a physician's office.

In the proposed rule, CMS does not specifically address how the agency would enforce these new, more flexible standards. As noted above, enforcement is already an area of concern, and without uniform, national standards in place for network adequacy, it will become even more difficult to ensure that Medicaid MCOs are applying them appropriately. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), a lack of uniform standards also makes it harder for stakeholders to determine whether any state benchmark for measuring network adequacy is “appropriate since each state could be using not only its benchmarks but its mix of standards and measures.”¹ Given these concerns with more flexible standards, we recommend that, if CMS were to finalize this proposal, the agency clearly state in the final rule how it would plan to enforce the new standards and measure patient access across states in a meaningful way.

Another issue that the rule attempts to address is how to define “specialist” in the context of network adequacy requirements. Current Medicaid Managed Care regulations list the provider types for which states are required to establish network adequacy standards, but in doing so, leave a general placeholder for “specialist, adult and pediatric.” The proposed rule clarifies that states have the authority to define “specialist” in the most appropriate way for their programs. According to CMS, this proposed change would eliminate potential uncertainty regarding who has a responsibility to select the provider types included in this. In addition, it would reduce the burden on a state by eliminating the need to set a standard for every possible specialist, as a few states are currently doing. ACEP notes that emergency physicians often are not included in the definition of a specialist. We believe that it is essential for Medicaid enrollees to know from their MCO in advance of an emergency (NOT during or after an emergency has occurred) if the physician treating them is in-network. The very nature of emergency conditions and 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. **Therefore, we strongly recommend that CMS require states to include emergency physicians and other safety net providers in this definition of a specialist.**

Although we generally remain concerned about any changes to network adequacy requirements that potentially impact patients' access to care, we do support CMS' effort to reward states that promote alternative delivery models such as telehealth to help reach people in certain areas. There are established examples of high quality, cost-effective telemedicine programs in the ED setting that allow greater access to an emergency physician in the inner city or rural EDs that would not normally be able to economically support that level of provider. Studies have shown that access to physicians via telemedicine after discharge from acute care settings, such as the ED, helps to prevent short term returns to the ED and readmissions for patients with chronic health conditions. Additionally, telehealth access from the ED setting to other medical specialists such as neurologists or psychiatrists can help provide faster access to specialty care and reduce delays in critically needed treatment and the time patients are boarding in the ED. As more and more small and rural hospitals close, EDs close too, leaving a gap in unscheduled acute care in a region. To fill these gaps, emergency physicians housed in what may be a state's only large or teaching hospital to provide telemedicine services to patients and providers in smaller rural or community hospitals that are staffed by RNs and Advance Practice Nurses (APNs). These valuable services provide clinical expertise in real time to stabilize patients who may need to be transferred long distances or may be observed at timely intervals over several hours by the emergency physician team at the academic medical center before a decision is made to transfer, admit locally, or release the patients. In all, ACEP continues to support the coverage of emergency telehealth services that would benefit patient care both in and out of the ED.

¹ Transcript of the December 2018 MACPAC Public Meeting, available at: <https://www.macpac.gov/wp-content/uploads/2017/07/December-2018-Meeting-Transcript.pdf>.

Medicaid IMD Exclusion

In the proposed rule, CMS discusses the current limitations to payments for the enrollees who receive inpatient treatment in an institution for mental disease (IMD) but does not propose any regulatory changes. Rather, CMS encourages states to apply for 1115 state waivers to help get around these limitations. ACEP has long advocated for the full repeal of the Medicaid IMD exclusion, as we believe it has been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health service. 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. The new waiver opportunity expands upon the current waivers available for states to treat patients with substance abuse disorders (SUDs). Understanding that a full repeal of the Medicaid IMD exclusion would require legislation from Congress, ACEP strongly supports this recently announced demonstration opportunity and believes that it will be extremely beneficial to patients with mental illnesses. We have therefore reached out to our state chapters across the country and have encouraged them to ask their respective states to consider applying for the demonstration waiver.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Vidor E. Friedman". The signature is fluid and cursive, with a large, sweeping loop at the end.

Vidor E. Friedman, MD, FACEP
ACEP President