AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

December 19, 2014

Diane Rowland, Chair
David Sundwall, MD, Vice Chair
Medicaid and CHIP Payment and Access Commission
1800 M Street NW
Suite 650 South
Washington, DC 20036

Dear Chair Rowland and Vice Chair Sundwall,

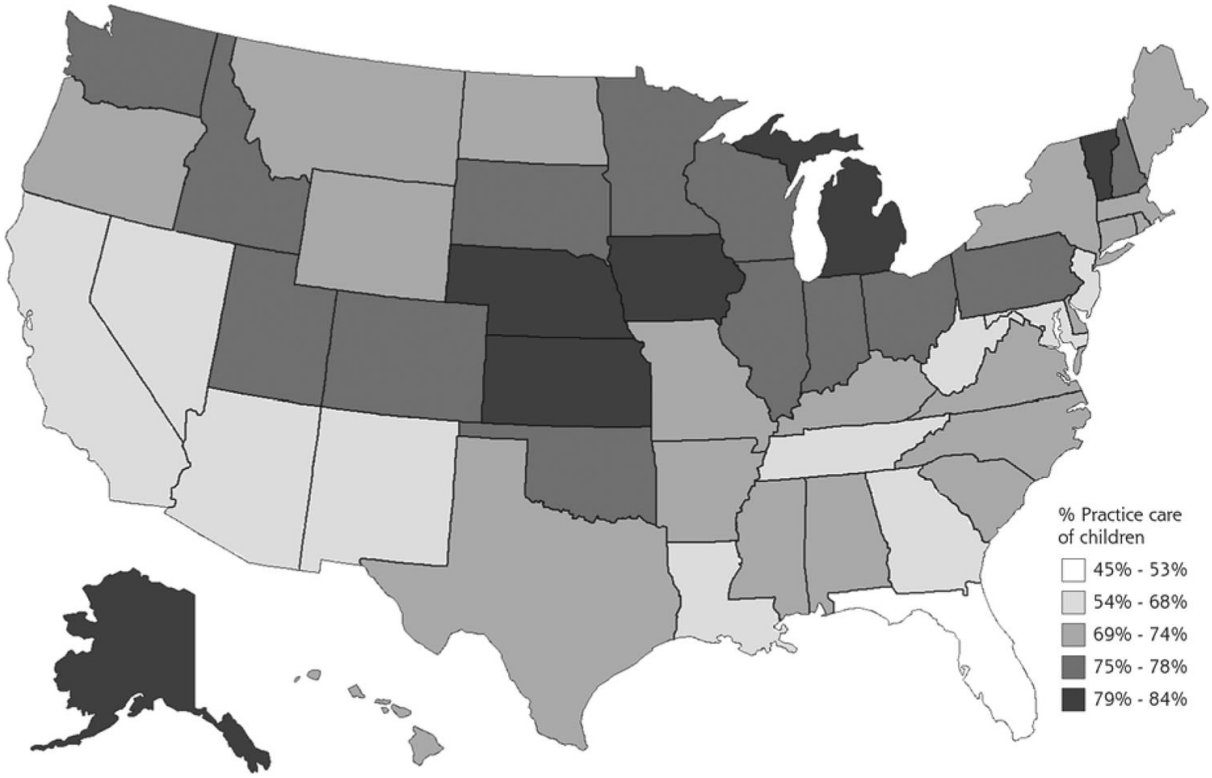
On behalf of the American Academy of Family Physicians (AAFP), which represents 115,900 family physicians and medical students across the country, we thank the Medicaid and CHIP Payment and Access Commission (MACPAC) for the opportunity to submit formal comments concerning affordability and the adequacy of health care coverage under the Children's Health Insurance Program (CHIP). Almost three quarters of AAFP's membership see CHIP-eligible patients in their day to day office appointments[1]. As such, we appreciate that MACPAC has dedicated a substantial amount of its time to the study and improvement of CHIP which provides coverage to many of the children that family physicians treat every day. As MACPAC further studies CHIP, we hope that our comments, along with other data and analytics on the success of the program, will assist the commission in recommending that Congress fully fund the program before current funding expires on September 30, 2015.

CHIP currently covers over eight million children whose families' incomes are too high to qualify for Medicaid and do not qualify for Marketplace subsidies as a result of the unintended, so-called "kid gap" in the *Affordable Care Act* (ACA). According to a study done by Mathematica Policy Research, participation in CHIP decreases the uninsured rate of low-income children from 25 percent in 1997 to less than 13 percent in 2012. The same study finds that children in Medicaid and CHIP have better access to care and fewer unmet health care needs than do children without insurance, and that their parents have better financial protection than those with uninsured children. In addition, the study determined that CHIP enrollees actually had better access to dental benefits, and that the families of these children had lower financial burdens and stress in meeting their health care needs compared to their privately insured peers.

Another study done by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care, found that family physicians account for between 16 to 21 percent of child care visits. The average family physician spends about 10 percent of his or her time caring for children and family physicians are the usual source of care for about one-third of the pediatric patient population. However, in a state-by-state breakdown, family physicians in Nebraska provided a high of 84 percent of care for children. According to these researchers, the number of children that family physicians count as part of their patient panels directly relates to the number of children and the availability of pediatricians practicing in the same geographic area. The authors of this study commented in an *AAFP News* article that family physicians in

[1] 2013 Practice Profile, AAFP Member Survey, April 2014.

rural areas or locales with a higher percentage of children are more likely to provide care for the minor population. A map from this study displays the proportion of family physicians providing care of children between 2006 – 2009.



One of the most important factors in the success of the CHIP program is that it is implemented differently in each state in order to meet the needs of the state's eligible population. According to the comments from governors to the U.S. Senate's solicitation for CHIP feedback over the summer of 2014, all of the governors appreciated the flexibility in program design that the CHIP program allows. Further, both CHIP and *the Children's Health Insurance Program Reauthorization Act* of 2009 (CHIPRA) pre-date the *Affordable Care Act*. As a result, children's benefits, provider networks, and cost sharing protections were designed before today's health insurance marketplaces and therefore benefits may need updating. The governors overwhelmingly supported the extension of CHIP funding and almost all respondents (35 of 39) to the Senate's inquiry indicated that the annual federal allocation formula that determines CHIP payments for each state works well. Additionally, more than half of the responding governors called for an extension of CHIP funding for at least four years. The AAFP urges MACPAC to support with this recommendation. Continued state flexibility bodes well for marketplace reform and coverage improvement that enables CHIP to work more seamlessly within the state health care marketplace.

Affordability of Coverage and Out-of-Pocket Costs

Though primary care doctors have seen tremendous increases in the number of patients enrolled in health insurance due to the ACA, some of the law's promises to provide affordable, high quality, and timely access to primary care have fallen short and need further attention. Rising out-of-pocket costs and affordability of coverage are significant concerns for family physicians. Statistics from the most recent AAFP member marketing research report show that in an average week, 76 percent of AAFP members provide at least one or more free or discounted episodes of care to uninsured or underinsured patients. Of these, 42 percent provide one to five patients free or discounted care per week, 5 percent of members provided six to ten patients free or discounted care per week, and 29 percent provided more than 10 patients free or discounted care per week. As it stands, this unsustainable cycle of uncompensated care jeopardizes patients access to a regular primary care physician. It is vital that CHIP and Medicaid continue to be available and affordable sources of coverage for children. More importantly, according to a report by the Georgetown University Health Policy Institute Center for Children and Families, if families were forced to move their children from CHIP programs to the health insurance marketplaces, nearly all of these families would pay more out-of-pocket costs, despite assistance from tax credits and cost-sharing reductions. Further, as MACPAC indicated in prior reports, nearly 2 million children currently covered by CHIP would be deemed ineligible for federal subsidies to pay for marketplace insurance because of the "family glitch." This issue needs to be addressed in order to ensure that children are given access to thorough, continued care throughout these important years of growth and development.

Adequacy of Covered Benefits in Exchanges

Comprehensive benefit packages designed with a specific population of patients in mind tend to work better than generically designed packages applied to different patient groups with specific needs. CHIP is an illustrative example of this concept. In states that expanded Medicaid, children covered by CHIP receive Medicaid's Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The EPSDT benefit is particularly important for children with special health care needs. However, in states that choose not to expand Medicaid eligibility, or that depend solely on the federally facilitated marketplace, plans must adhere to the essential health benefits (EHB) required by the *Affordable Care Act*. Unfortunately in these states, EHBs have not been implemented in the same way as state-developed CHIP benefits, and these EHB requirements do not take children's needs into account during the development and reform of benefit packages. Gaps and omissions in covered benefits during these important years of child growth can result in long-term, and sometimes life-long negative health consequences. Therefore the AAFP urges that benefit packages made available for children enrolled in CHIP be rewritten to mandate a primary-care centric plan, such as a Patient Centered Medical Home, that includes child and adolescent-specific essential health benefits. In addition, AAFP recommends that services for habilitative therapies and other ancillary services for children with complex chronic conditions should be covered under approved CHIP plans.

Adequacy and Appropriateness of Provider Networks for Children in Exchanges

While we understand the need to keep costs low, network adequacy for underage patients is a concern for family physicians. The practice of "network optimization" is not a new concept; however, the particularly disruptive manner in which it is being implemented by some insurance plans is confusing and inefficient for families with children enrolled in CHIP. Peer-reviewed studies show strong correlations between health care coverage and a usual source of care leads to better health outcomes for individuals, including children. Research also shows that patients who have a continuous, longitudinal relationship with a primary care physician have more positive health outcomes that cost less when compared to similar patients who

do not have such a relationship with a primary care physician. Consequently, we encourage the Commission to examine network adequacy practices and policies within state-specific CHIP plans, as well as in plans offered in the state and federal exchange and by private plans.

Greatest Areas of Concern with Transitions between Coverage

As more families enroll in health insurance through the marketplaces, one of the most daunting tasks for states and the federal marketplace is to ensure seamless transitions between different types of coverage. Throughout the year, a family's income could fluctuate enough that a child may move from Medicaid to CHIP, or from CHIP to a private plan. These transitions of care are often confusing for families, and wrought with obstacles preventing continuity of care. When transitioning between public or private health insurance, families should have access to clear, concise, and accurate information to assist them in making these important plan coverage decisions for their children. The rapid development of children makes it even more imperative that they be able to access a regular source of care, unaffected by changes in insurance coverage and gaps in network adequacy. The AAFP urges that MACPAC recommend CHIP reauthorization provisions that will protect children's access to their regularly established family physicians under these health plans, while also guaranteeing continuity of benefits, and a seamless transition from one plan to another for patients. The AAFP also urges that MACPAC recommend that CHIP plans maintain transparent, up-to-date networks that can be easily navigated by parents when transitioning their children's insurance between plans.

Medicaid and CHIP Provider Payment Levels

Medicaid covers more than 65 million Americans, and that number continues to grow as more people enroll for health insurance. As the number of Medicaid and CHIP enrollees increases, it is vital that policymakers ensure that patients have access to primary care physicians.

Research has shown that having health insurance does not guarantee access to timely, appropriate healthcare[2]. This is particularly true of the Medicaid program, which has struggled to attract participating physicians because of low payment rates[3]. As a result, low-income children and other qualifying adults have difficulty finding in-network primary care physicians. Prior to the implementation of the two-year Medicaid primary care payment program, the average payment for primary care services was 40 percent less than Medicare payment rates. Of AAFP's membership, 85 percent reported that they have the capacity to accept newly insured patients, while just under two-thirds currently accept Medicaid patients. Of these, over 77 percent have the capacity to accept new Medicaid patients. Further growth in the number of Medicaid and CHIP beneficiaries is expected as patients enroll during the health insurance marketplace open enrollment period which will increase the need for primary care physicians. To protect access to primary care services, CHIP and Medicaid should establish payment rates for physicians that are at least equal to Medicare rates for providing primary care to Medicaid and CHIP patients.

Because the 113th Congress failed to extend the Medicaid primary care payment program, starting in 2015 patients face even steeper barriers in accessing primary care[4],[5],[6]. Most AAFP members surveyed replied

[2] Cykert S, Kissling G, Layson R, Hansen C. "Health insurance does not guarantee access to primary care: a national study of physicians' acceptance of publically insured patients." *Journal of Internal Medicine*. Volume 10. Issue 6. (1995) : 345-8. Print.
[3] Decker SL. "Two-thirds of primary care physicians accepted new Medicaid patients in 2011-12: a baseline to measure future acceptance rates." *Health Affairs*. Volume 32. Issue 7. (July 2013) : 1183-1187. Print
[4] "Enhanced Medicaid Reimbursement Rates for Primary Care Services." *ACP Advocacy*. American College of Physicians, n.d. Web. 2014. Available at: http://www.acponline.org/advocacy/where_we_stand/assets/v1-enhanced-medicaid-reimbursement-rates.pdf

that they would be forced to stop seeing new Medicaid patients if Medicaid and CHIP payment rates were no longer at the same rate as Medicare, and they would likely have to limit or cut the number of current Medicaid patients they already treat. If Medicaid payments for primary care services are slashed to 2012 levels, primary care physicians will receive a significant pay cut for continuing to provide important primary care services to CHIP and Medicaid patients.

AAFP policy supports and encourages our members to provide appropriate, high quality, coordinated medical care to all, including the financially disadvantaged. We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have. Please contact Michelle Greenhalgh, State Government Relations Manager, at 202-232-9033 or mgreenhalgh@aafp.org.

Sincerely,

Reid B. Blackwelder, MD, FAAFP
Board Chair

[5] Decker SL. "Two-thirds of primary care physicians accepted new Medicaid patients in 2011-12: a baseline to measure future acceptance rates." *Health Affairs*. Volume 32. Issue 7. (July 2013) : 1183-1187. Print
[6] Decker SL. "In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help." *Health Affairs* Volume 31.Issue 8 (2012): 1673-1679. Print.