AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of
American Academy of Family Physicians
Submitted for the Record

House Energy and Commerce Committee
Subcommittee on Health Hearing

Strengthening Medicaid and
Prioritizing the Most Vulnerable

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The American Academy of Family Physicians (AAFP), the largest primary care organization in the United States with a membership representing 124,900 family physicians and medical students, appreciates the opportunity to submit testimony for the record regarding ways to improve the Medicaid program and protect the most vulnerable.

Family physicians are dedicated to treating the whole person, providing a wide variety of clinical services. They treat babies with ear infections, adolescents with hypertension, adults with depression and seniors with multiple chronic illnesses. And because of their focus on prevention, primary care and overall care coordination, they are able to treat illnesses early and, when necessary, refer their patients to the right specialist and advocate for them.

Medicaid and Primary Care

The Medicaid program finances essential primary and preventive services for patients. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.[1] Primary care physicians are specifically trained for and skilled in comprehensive first contact and continuing care for persons whose conditions are undifferentiated upon arrival and not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.[2]

Primary care medicine achieves better health outcomes and increase cost savings. This is particularly important for rural communities and for vulnerable populations who depend on Medicaid to a larger degree than other populations.[3]

The benefits also translate into healthier communities.[4] For instance, U.S. states with higher ratios of primary care physicians-to-population ratios have better health outcomes, including lower rates of all causes of mortality: mortality from heart disease, cancer, or stroke; infant mortality; low birth weight; and poor self-reported health, even after controlling for sociodemographic measures (percentages of elderly, urban, and minority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and smoking).[5]

The dose of primary care can even be measured -- an increase of one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3 percent, or 49 fewer deaths per 100,000 per year.[6] In addition, high quality primary care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering per capita costs.[7]

Medicaid's Programmatic Strengths

We understand that policy makers are reviewing proposals to reform the Medicaid program. We believe this is an important opportunity to identify the program's strengths.

Patient Health Care Coverage. A key Medicaid program strength is in its coverage for populations who have no other source of care, namely children, the low-income, and persons with disabilities. Under the *Affordable Care Act* (ACA) childless adults were able to access these benefits for the first time in 31 expansion states and District of Columbia.

Medicaid provides coverage for low-income people and helps ensure that patients enjoy a consistent source of high quality care. According to a 2017 report from Centers for Medicaid and

Medicare (CMS), the Medicaid program provides coverage for over 70 million people. The coverage population includes 32 million low-income children, seven million elderly, 20 million non-elderly adults, and 10 million persons with disabilities.[8] Since passage of the ACA, the Medicaid population grew by 17 million because of expansion efforts. Many of these "expansion population" patients were previously uninsured and are individuals who family physicians treat on a regular basis.

One important, but often overlooked dimension is that Medicaid assists the most vulnerable patients who are members of minority groups, homeless, formerly incarcerated, foster and former foster youth, mentally ill, addicted, and military families. Insurance coverage rates among minorities are lower than rates among the non-Hispanic white population.[9] Minorities experience disproportionate rates of illness, premature death, and disability compared to the general population.[10] In addition, virtually all of the estimated individuals nationally who are homeless could be eligible for Medicaid. Many in this population would benefit from the mental health and addiction treatment requirement included under the law.[11] Forty percent of our nation's veterans who are under 65 years of age have incomes that could qualify them for Medicaid under the ACA's expanded coverage.[12] In general, family members of veterans are not covered by the Veteran's Administration, but may seek coverage through Medicaid or the marketplace.[13] Many patients in this category are unaware that they qualify for health benefits. Experts recommend more robust awareness raising efforts.

Full Scope of Benefits. States that provide Medicaid services have always been required to provide a full array of benefits. Historically, patients are entitled to any benefit that is "medically necessary," which includes hospital care, nursing home care, physician services, lab and x-ray services, immunizations and early, periodic, screening, diagnostic, and treatment (EPSDT) for those under the age of 21, family planning, and other maternal health services.[14] The program also allows states to cover optional benefits such as case management.

Under the ACA, Medicaid must cover preventive services that we believe represent a program improvement. For example, the program covers reproductive health care for men and women, including new requirements to screen for intimate partner violence and to cover contraceptives with no co-sharing. Thanks to the Medicaid expansion, in many states Medicaid also offers unencumbered access to affordable, evidence-based health care for women across their lifespan.

Other preventive care benefits worth highlighting include vaccine coverage, smoking cessation, mental health care, addiction treatment, and obesity screening. New Medicaid expansion benefits have helped increase chronic disease screenings and improved patient's ability to access a consistent source of care. Research published by the Commonwealth Fund notes that 88 percent of Medicaid patients enrolled in 2016 were "satisfied" with the care that they received.[15] More than half of those surveyed (51 percent) were highly satisfied, a much higher rate than under Marketplace coverage (38 percent).[16]

Health Care Savings. One important Medicaid program strength is that increasing access has produced an important return on investment in the form of state health care savings. Data from a Robert Wood Johnson Foundation report indicates that 11 states: Arkansas, California, Colorado, Kentucky, Michigan, New Mexico, Oregon, Pennsylvania, Washington, West Virginia, and the District of Columbia showed health system savings. These expansion areas saw significant financial benefits through lower spending on the uninsured, job growth, and reduced hospital uncompensated care costs.[17]

Expansion had significant fiscal effects on state budgets with savings ranging from $25 million in Kentucky to over $100 million in Washington State.[18]

Family physicians also have observed reductions in uncompensated care, especially for those operating in rural and other underserved areas. For example, a January 17, 2017 *CNN Money* story presented a common reality shared among family physicians. John Cullen, a family physician who works in Valdez, Alaska said, “At this medical practice, it's rare for someone to be turned away. We've done it for things like forging prescriptions, but never for not being able to pay." Before Obamacare passed in 2010, one out of every five patients seen at Cullen's clinic was uninsured. "We were losing $250,000 a year," he said. Seven years later, many of the town's residents have gained coverage through the exchanges or through Medicaid and uncompensated care at the clinic has fallen by 70 percent he says.[19]

AAFP’s Core Principles for Medicaid Program Review

The AAFP supports innovation and flexibility, but believes that access cannot be achieved without adequate financial investment that is predictable, consistent, and equitable for all regardless of their geographic location. New policies should keep Medicaid coverage strong as well as center on patients’ ability to access affordable care and the program’s ability to improve health outcomes. Program efficiency is important, but patient outcomes should be well-researched and prioritized. As the Committee examines Medicaid improvements, we urge you to consider the following AAFP principles[20]:

- The federal share should be increased if Medicaid enrollment is increased by federal legislation;
- Payment for primary care services should be at least equal to Medicare's payment rate for those services when provided by a primary care physician;
- The patient-centered medical home model of care with appropriate payment for case management and chronic care coordination should be implemented broadly and should include collaboration between the physician's practice and Medicaid case management programs;
- A benefit profile should be required that includes first dollar coverage of primary care visits and preventive services;
- Cost-containment should be determined by evidence-based research;
- Medicaid programs should use a clear definition of medical necessity that is based on evidence;
- Medicaid should support health information exchange through adequate infrastructure investment and electronic medical records by means of adequate payment for electronic visits and related services;
- Pay for performance and other quality improvement activities should be rooted in evidence-based research;
- Current pharmaceutical benefits for dual eligibles should be maintained if those benefits cover more drug costs than Medicare does;
- Coverage of tobacco cessation counseling, pharmaceuticals and other assistive methods should be included;
- Coverage should be mandatory for pharmaceuticals, counseling and treatment for substance abuse, and oral and mental health measures;
- Federal financial participation in territorial assistance programs should be equitable;
- Medicaid programs should provide continuous eligibility for at least twelve months; and

- A clearly defined appeals process should facilitate fair and prompt resolution of disputed claims and administrative issues, e.g., determinations of meaningful use and pay-for-performance decisions.

In addition, Medicaid Managed Care Organizations should be held accountable for:

- Adequacy of primary care and specialist networks (especially with regard to the number of available physicians and geographic availability).
- Assignment of beneficiaries to a primary care physician who is geographically proximate.
- Assurance of continuity of care for Medicaid patients from the primary care physicians of their choice.
- Beneficiaries' access to all allowable and covered services under federal and state law.

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