AMERICAN ACADEMY OF FAMILY PHYSICIANS

April 30, 2024

The Honorable Brett Guthrie
Chairman
Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to express our appreciation for the Subcommittee's focus on Medicaid and ways to improve coverage and access for the millions of patients it serves with today's hearing titled "Legislative Proposals to Increase Medicaid Access and Improve Program Integrity."

As of December 2023, Medicaid is the single largest health care payer in the United States, covering essential health care services for nearly 78 million individuals of all ages. It covers many of our nation's most vulnerable populations, including children, pregnant women, low-income individuals and those with disabilities. Family physicians are often the first point of contact with the health care system for many of these patients and frequently provide care across the lifespan for Medicaid beneficiaries, developing longitudinal, trusting relationships.

As firm believers in access to affordable health care for all, the AAFP has long advocated for protecting and strengthening the Medicaid safety net. We maintain that Medicaid is essential to advancing health equity, increasing health coverage, and facilitating access to comprehensive, person-centered primary care. As you consider opportunities to improve access to and coverage of care for Medicaid beneficiaries during today's hearing, I would like to offer the following recommendations on behalf of family physicians and the patients we serve.

**Increasing Medicaid Payment for Primary Care**

Medicaid payment rates have a direct impact on patient access to primary care. Medicaid payment is on average 66 percent of the Medicare rate for primary care services, but it can be as low as 33 percent in some states.[i] These low rates have historically been a barrier to physicians accepting more Medicaid patients. Reports from the Medicaid and CHIP Payment and Access Commission (MACPAC) show that physician acceptance of new Medicaid patients worsens as the ratio of Medicaid payment rates to Medicare allowances decreases.[ii] Physicians cite low payment as the primary reason they were unable to accept additional Medicaid patients.[iii] Managed care plans report caps on clinicians' Medicaid patient panels and low physician participation in Medicaid are top challenges in ensuring access to care.[iv] Medicaid enrollees experience longer office wait times, more difficulty scheduling visits, and both low-income patients and their physicians report low payment rates lead to shorter, inadequate visit times.[v,vi,vii]



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Meanwhile, evidence indicates patient access improved when Congress raised Medicaid primary care payment rates to Medicare levels in 2013-2014. One study found that appointment availability increased during the "primary care fee bump" and decreased after it expired.[viii] Other studies found the fee bump did not significantly increase physicians' participation in the Medicaid program, likely due to the temporary nature of the payment increase.[ix] MACPAC surveyed physicians about the primary care fee bump and found that it modestly increased willingness to accept new Medicaid patients, though physicians reported early operational issues delaying the start of increased payments were a major challenge. Raising Medicaid payment for primary care services can improve access to care for Medicaid beneficiaries and in turn mitigate health disparities.

Last week, CMS finalized proposals to require Medicaid managed care plans to conduct payment analyses that compare Medicaid payment rates for primary care to Medicare payment rates, and in fee-for-service (FFS) Medicaid, requirements that state programs must publish the fee schedule so it is easier to compare Medicaid FFS payment to Medicare payment for the same services. **The AAFP submitted comments in strong support of these proposals and applauds their finalization.** These new requirements will make physician payment more transparent, allowing CMS, state agencies, physician practices, and other stakeholders to better understand Medicaid payment rates in each state and address issues that could be negatively impacting beneficiary access and clinician participation.

These requirements will also help highlight states where Medicaid payment falls short. AAFP policy states that Medicaid payment for services should be fair and adequate, and at least at Medicare rates, in compliance with the "equal access" provision of the Medicaid statute. Additionally, the AAFP believes 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.

To ensure all Medicaid beneficiaries can access high-quality primary care when they need it, Congress should support policies to help states raise Medicaid payment for primary care services to at least Medicare rates. **The Academy has endorsed the bipartisan Kids' Access to Primary Care Act (H.R. 952), which would apply a Medicare payment rate floor to Medicaid primary care services**. Advancing this policy is a necessary step toward addressing the unsustainably low payment rates that are exacerbating existing health disparities and undermining patient access to essential care. However, the AAFP also continues to emphasize that Medicare payment rates have failed to keep up with inflation and should not be considered adequate to ensure equitable, timely access to care. While Medicare is not a perfect comparator, we agree that it is a useful starting place because states continue to pay even lower Medicaid rates and Medicare rates are publicly available on a national basis.

## Continuous Eligibility and Expansion of Coverage

The AAFP believes that all Medicaid programs should provide continuous eligibility to beneficiaries for at least twelve months. Continuous, undisrupted coverage translates to improved access to preventive care, fewer disruptions in care, strengthened physician-patient relationships built on trust and continuity, and less costly emergency department visits.[x] Streamlining access to coverage and reducing churn helps improve access to high-quality, longitudinal primary care, which has been shown to reduce mortality rates, improve health outcomes, and lower health care expenditures. Ensuring continuous coverage in Medicaid will help reduce enrollment churn, which in turn reduces administrative burdens on physicians and their practices and helps physicians maintain continuity and trust in their relationships with their patients.

The AAFP applauded recently implemented requirements from the Consolidated Appropriations Act of 2023 that state Medicaid agencies must provide 12 months of continuous eligibility for all children. We also appreciate Congress permanently extending the voluntary option for states to extend postpartum Medicaid coverage for up to a year. However, a permanent solution across all states is needed to ensure access to continuous care for pregnant people throughout the full, one-year postpartum period.

Current law only requires states to provide Medicaid coverage based on pregnancy status up to 60 days postpartum. As the largest single payer of maternity care in the U.S., covering 41 percent of births nationwide, Medicaid has a critical role to play in ensuring healthy moms and babies.[xi] According to the Centers for Disease Control and Prevention, more than half (53 percent) of pregnancy-related deaths occur between one week and one year postpartum, during which time many postpartum individuals lose Medicaid coverage.[xii] **The AAFP therefore continues to advocate for requiring one year of postpartum Medicaid coverage as an important way to address the disparities in maternal health and improve outcomes.**

In alignment with our policy calling for 12 months of continuous coverage for all Medicaid beneficiaries, the **AAFP also supports the Stabilize Medicaid and CHIP Coverage Act (H.R. 5434 / S. 3138), which would require state Medicaid and Children's Health Insurance Programs (CHIP) to provide twelve months of continuous coverage for all enrolled individuals**, building upon the existing continuous coverage requirement for all children. This will have meaningful impacts on reducing administrative red tape, closing existing coverage gaps, and addressing health disparities.

Furthermore, the AAFP advocates for individuals who are incarcerated or detained to have access to comprehensive medical services, including mental health care and substance use disorder (SUD) treatment. We applaud Congress for taking recent steps to improve access to Medicaid coverage for SUD and justice-involved populations in the Consolidated Appropriations Act of 2024. This includes permanently requiring state Medicaid programs to cover medication-assisted treatment for opioid use disorders and authorizing grants to promote continuity of care for incarcerated individuals who are eligible for Medicaid or CHIP. **The Academy strongly urges Congress to build upon these recent actions by advancing additional policies to improve access for justice-involved populations.**

Specifically, **we support the Reentry Act (S. 1165 / H.R. 2400), which allows Medicaid coverage for incarcerated individuals to automatically begin 30 days prior to their release.** This will facilitate better care continuity as part of community reentry, including for those with SUD and mental health needs. **The Academy also supports the Due Process Continuity of Care Act (H.R. 3074), which would amend the Medicaid Inmate Exclusion Policy (MIEP) and ensure eligible individuals being detained pre-trial are able to continue receiving SUD treatment**. The impact of incarceration can begin prior to sentencing as people living in poverty are often incarcerated while pending trial due to their inability to pay the cash bond, regardless of their potential threat to society or severity of their alleged crime. In 2019, 65 percent of people who were incarcerated were awaiting trial.[xiii] Pre-trial incarceration can last weeks, and sometimes months to years, often disrupting an individual's ongoing SUD treatment and access to care.

Finally, **Congress should address billing restrictions by some state Medicaid agencies that impede patients' ability to access mental and primary care services together**. Currently, some state Medicaid agencies prohibit billing for activities by two different clinicians on the same day; for example, one primary care visit and one mental health visit. This undermines one of the strengths of the collaborative care model: the "warm handoff," in which the primary care physician brings the behavioral health clinician into the exam room. These are two distinct visits by two distinct

practitioners, but if they are billed by the same practice, the second is frequently denied. This restriction creates difficulties for patients who cluster their medical visits and for clinicians who may not be paid for providing services to these patients.

Therefore, **the Academy strongly supports the bipartisan Improving Coordination and Access to Resources Equitably (CARE) for Youth Act (H.R. 7996 / S. 2556).** This bill would address this financial and coverage barrier by ensuring Medicaid coverage of mental health and primary care services furnished on the same day, aligning federal statute with laws in 27 states.

**Denials and Appeals in Medicaid Managed Care**

Nearly three-quarters of Medicaid beneficiaries are enrolled in managed care.[xiv] Managed care organizations (MCOs), which contract with state Medicaid agencies to provide coverage, often deny or limit services for patients using utilization management processes, such as prior authorization, which they describe as a cost-control mechanism. However, repeated evidence has shown that many MCOs use prior authorization inappropriately, causing care delays and worsening patient outcomes and satisfaction.

In 2022, California-based L.A. Care, which administers Medicaid and other types of coverage, failed to address a backlog of more than 9,000 prior authorization requests and more than 67,000 complaints or appeals.[xv] Meanwhile, an Office of the Inspector General (OIG) report published in July 2023 found that **Medicaid MCOs denied one out of every eight (12.5 percent) prior authorization requests in 2019 – a rate even higher than in Medicare Advantage (5.7 percent)**. Approximately 2.7 million Medicaid beneficiaries were enrolled in MCOs with prior authorization denial rates greater than 25 percent.[xvi] However, minimal data collection on and oversight of these practices is being done by state Medicaid agencies. This is largely because current federal rules do not require states to collect and monitor data needed to assess access to care, monitor the clinical appropriateness of denials, or require that states publicly report information on plan denials and appeals outcomes.

In March, MACPAC convened to discuss denials and appeals within Medicaid managed care. In their research, they noted the lack of federal requirements for collecting key data as described above. They also identified some of the challenges and barriers impeding the ability for individuals to pursue denials and appeals in Medicaid; for example, MCOs are required to mail denial notices, but beneficiaries do not always receive these denial notices in time to pursue an appeal within the allotted time frames. In light of these findings, MACPAC put forward seven recommendations to improve the appeals and denials process for individuals enrolled in Medicaid:

- States should be required to establish an independent, external medical review process that can be accessed at the beneficiary's choice;
- CMS should issue guidance to improve the clarity and content of denial notices and clarify how Medicaid funding may be used to support external entities, such as ombudsperson services;
- MCOs should be required to provide beneficiaries with the option to receive electronic denial notices in addition to mailed notices;
- CMS should extend the timeline for beneficiaries to request continuation of benefits and issue guidance to improve beneficiary awareness of their rights to continue receiving services while an appeal is pending;
- CMS should require states collect and report data on denials, use of continuation of benefits, and appeals outcomes, and use the data to improve delivery of care to patients;

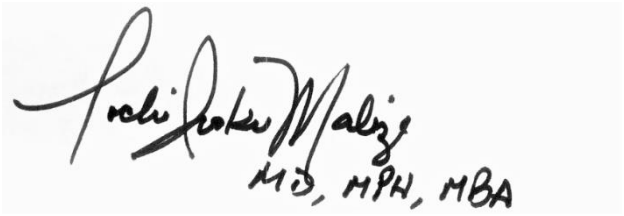
- States should be required to conduct routine clinical appropriateness audits of managed care denials and ensure access to medically necessary care; and
- CMS should publicly post all state Managed Care Program Annual Reports and require states to include denials and appeals data on their quality rating system websites to ensure beneficiaries can access this information when selecting a plan.

**The AAFP strongly urges Congress to act upon these MACPAC recommendations to improve the denials and appeals processes for Medicaid beneficiaries and ensure patients have timely access to medically necessary care as recommended by their physician**.

Additionally, the AAFP applauded CMS for finalizing a regulation earlier this year that will streamline prior authorization processes, implement electronic prior authorization, and improve transparency across all of its payers, including Medicaid MCOs, as well as address inappropriate coverage denials. However, **we continue to advocate for the passage of legislation to enshrine these necessary reforms into statute, including for Medicaid managed care, and ensure they are not undone**.

Thank you for your commitment to strengthen and improve the Medicaid program. Family physicians look forward to working with you to advance policies that increase access to high-quality care for the patients we serve. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,



Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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[i] Zuckerman, S., Skopec, L., Aarons, J. (2021, February 01). Medicaid physician fees remained substantially Below fees paid by Medicare in 2019. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611

[ii] Medicaid and CHIP Payment and Access Commission, "Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey." June 2021. Accessed online at: https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf

[iii] Decker SL. In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. Health Aff (Millwood). 2012 Aug;31(8):1673-9. doi: 10.1377/hlthaff.2012.0294. PMID: 22869644; PMCID: PMC6292513.

[iv] Garfield R, Hinton E, Cornachione E, Hall C. Medicaid managed care plans and access to care. Kaiser Family Foundation. 2018. Retrieved from: http://files.kff.org/attachment/Report-Medicaid-Managed-Care-MarchPlansand-Access-to-Care

[v] Oostrom, T., Einav, L., & Finkelstein, A. (2017). Outpatient office wait times and quality of care for Medicaid patients. Health Affairs, 36(5), 826-832. doi:10.1377/hlthaff.2016.1478. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5812017/

[vi] Hsiang WR, Lukasiewicz A, Gentry M, Kim CY, Leslie MP, Pelker R, Forman HP, Wiznia DH. Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance

Patients: A Meta-Analysis. Inquiry. 2019 Jan-Dec;56:46958019838118. doi: 10.1177/0046958019838118. PMID: 30947608; PMCID: PMC6452575.
[vii] Lewis C, Zephyrin L, Abrams MK, Seervai S. (2019). Listening to low-income patients and their physicians: Solutions for improving access and quality in primary care. The Commonwealth Fund. https://www.commonwealthfund.org/blog/2019/listening-low-income-patients-and-their-physicians--improvingaccess-and-quality
[viii] Candon M, Zuckerman S, Wissoker D, et al. Declining Medicaid Fees and Primary Care Appointment Availability for New Medicaid Patients. JAMA Intern Med. 2018;178(1):145–146. doi:10.1001/jamainternmed.2017.6302
[ix] Decker S. (2018). No Association Found Between The Medicaid Primary Care Fee Bump And Physician Reported Participation In Medicaid. Health Affairs. https://doi.org/10.1377/hlthaff.2018.0078
[x] American Hospital Association. Report: The Importance of Health Coverage. https://www.aha.org/guidesreports/report-importance-health-coverage
[xi] National Center for Health Statistics, "Birth Data." Last reviewed April 4, 2024. Accessed online at: https://www.cdc.gov/nchs/nvss/births.htm.
[xii] Trost S et al. "Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019," Centers for Disease Control and Prevention. Accessed online at: https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html.
[xiii] Zeng Z and Minton TD. "Jail Inmates in 2019," U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics. March 2021. Accessed online: https://bjs.ojp.gov/content/pub/pdf/ji19.pdf.
[xiv] Medicaid and CHIP Payment and Access Commission, "Denials and Appeals in Medicaid Managed Care." March 2024. Accessed online at: https://www.macpac.gov/wp-content/uploads/2024/03/Chapter-2-Denials-and-Appeals-in-Medicaid-Managed-Care.pdf.accreport.pdf.
[xv] Liss S. 2022. L.A. Care fined $55M after members faced barriers to timely care. Healthcare Dive. https://www.healthcaredive.com/news/la-care-55m-fine-membersbarrierstimelycare/619925/#:%7E:text=L.A.%20Care%2C%20the%20nation%27s%20largest,Managed%20Health%20 Care% 20announced%20Friday.
[xvi] Grimm CA, "High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care." Office of Inspector General, U.S. Department of Health and Human Services. Published July 2023. Available online at: https://oig.hhs.gov/oei/reports/OEI-0919-00350.asp.