AMERICAN ACADEMY OF FAMILY PHYSICIANS

July 7, 2021

Daniel Tsai
Deputy Administrator and Director of the Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Deputy Administrator Tsai:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 133,500 family physicians and medical students across the country, I write to congratulate you on your appointment as Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS) and Director of the Center for Medicaid and CHIP Services (CMCS). The AAFP looks forward to working with you to ensure equitable access to high-quality, continuous primary care services for Medicaid and CHIP beneficiaries.

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 in achieving our shared goals of advancing health equity, increasing health coverage, and transitioning to a value-based health care system. As such, we made several recommendations for how to fortify Medicaid and CHIP when President Biden took office and have been pleased to see the administration take several steps to remove harmful regulations and waivers and support state efforts to expand coverage.

The AAFP stands ready to partner with you to continue this work, as well as tackle the unique challenges posed by continually growing Medicaid rolls due to the COVID-19 pandemic and its economic ramifications. We strongly supported the maintenance of effort (MOE) provisions enacted by the Family First Coronavirus Response Act as well as coverage expansions enacted by the American Rescue Plan Act. Below are our recommendations for ensuring that Medicaid coverage improvements also translate into improved access to comprehensive primary care.

Support Medicaid Payment Parity and Address Administrative Billing Challenges

Low Medicaid payment rates and significant administrative burdens associated with billing Medicaid continue to create barriersto accessing care for beneficiaries and exacerbate care inequities. **To ensure all Medicaid beneficiaries can access high-quality primary care when they need it, federal action is needed to improve Medicaid payment rates.**

In 2019, Medicaid payments remained significantly lower than Medicare and private insurance rates, as in prior years, despite growth in Medicaid enrollment since 2008.[1] On average, Medicaid pays 66 percent of the Medicare rate, with some states paying as low as 33 percent.[2] These inadequate rates

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have historically been a barrier to health care access for Medicaid enrollees. An internal analysis of the Medicaid and CHIP Payment and Access Commission (MACPAC) Report on Physician Acceptance of New Medicaid Patients from 2014-2017 revealed that physician acceptance worsens as the ratio of Medicaid payment rates to Medicare decreases. States with higher Medicaid-to-Medicare payment ratios typically had higher acceptance rates.[3] Physicians cite low payment as the primary reason they were unable to accept additional Medicaid patients.[4] Managed care plans report caps on clinician's Medicaid patient panels and low physician participation in Medicaid are top challenges in ensuring access to care.[5] Patients covered by Medicaid experience longer office wait times, and both low-income patients and their physicians report that low payment rates lead to shorter, inadequate visit times.[6,7] On the other hand, 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.[8] States with larger payment increases also had greater improvements in appointment availability and child health outcomes.[9,10] 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.[11] The Medicaid and CHIP Payment and Access Commission 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.[12,13] **Taken together, the available evidence indicates that, coupled with more rigorous oversight, enacting Medicaid payment parity for primary care for a longer period of time could meaningfully improve access for Medicaid enrollees.**

In addition to low payment rates, physicians experience significant administrative barriers when trying to receive Medicaid payments. These administrative issues come at a cost. A new study estimates physicians lose 16 percent of Medicaid payments to billing problems, compared with 7 percent for Medicare and 4 percent for commercial payers.[14] Since physician practices lose a significant portion of their already much lower Medicaid payments to billing issues, the researchers found many practices respond by refusing to accept Medicaid patients in states with worse billing hurdles.[15]

Primary care physicians form lasting relationships with their patients in order to provide comprehensive, continuous, coordinated primary and preventive care. While a temporary fee increase may help support physician practices operating on thin margins, a longer term or permanent solution would provide the necessary assurance that they will be paid adequately moving forward. Addressing the disproportionate burden of billing Medicaid may also improve physicians' willingness to accept new Medicaid patients.

Improving access to care for Medicaid beneficiaries can mitigate health disparities. Medicaid plays a particularly vital role in providing coverage to pregnant women, rural residents, individuals with disabilities, as well as Black, Indigenous, Hispanic, and other people of color. More than 30 percent of Black, Indigenous, and Hispanic adults and children have Medicaid coverage.[16] By improving coverage and affordability of primary care, the ACA significantly reduced racial and ethnic disparities in care utilization and access.[17] However, the odds of residing in a physician shortage area are much higher for predominantly Black neighborhoods.[18,19] Sixty-one percent of Primary Care Medical Health Professional Shortage Areas are also in rural areas, suggesting these populations may be impacted

most by changes in Medicaid physician participation.[20] Increasing Medicaid rates would help to further mitigate health inequities.

Given the significant growth in Medicaid eligibility and enrollment over the last year, federal action is needed to improve and secure long-term access to primary care for Medicaid beneficiaries. Federal financial support and oversight would help ensure primary care physicians can accept new Medicaid beneficiaries and spend as much time with the patient as they need without sacrificing the financial stability of their practice.

The AAFP further recommends that HHS provide guidance to state Medicaid programs and managed care plans to minimize billing disruptions. CMS could also conduct a study to determine whether billing disruptions are worse when billing Medicaid managed care plans.

Increase the Availability of Value-based Care Models that Include Medicaid Beneficiaries

The AAFP strongly advocates for the transitioning to value-based care, since the alternative payment models is essential to supporting comprehensive primary care. Unfortunately, there are currently few primary care models that incorporate Medicaid beneficiaries. To ensure that Medicaid beneficiaries are not left behind, a continuum of harmonized models should be implemented across payers, including Medicaid. This would encourage physician participation in alternative payment models, as well as enable them to move into more advanced models over time.

While all primary care payment models must include robust risk-adjustment to account for patients' social needs and a variety of risk factors, this will be particularly vital for models that incorporate Medicaid beneficiaries. Practices with a high proportion of Medicaid beneficiaries may also operate on slim margins and would likely benefit from models that are designed with "on ramps" to assist with making needed investments before taking on risk. Compared to Medicare, there may be limited opportunities for physician practices to achieve and share in savings for their Medicaid patient panels. These considerations should not prevent the adoption of models that include Medicaid patients, and the AAFP looks forward to partnering closely to facilitate this transition.

Restore Medicaid Managed Care Oversight

The lack of federal enforcement and oversight of managed care plans, as well as recent regulatory changes to weaken network adequacy requirements, may negatively impact beneficiaries' access to care.

We have previously recommended that CMS enforce the Medicaid Access Rule which requires states to issue Access Monitoring Review Plans (AMRP) to report Medicaid beneficiaries' accessto primary and other types of care every three years. The AAFP is pleased that CMS recently issued an Informational Bulletin outlining requirements and deadlines for states' Annual Managed Care Program Report, which will require states to report on network adequacy for various services, including primary care.[21]

The AAFP also urges CMS to reverse recently finalized regulations weakening network adequacy requirements for managed care plans. The Medicaid and Children's Health Insurance Program Managed Care rule, finalized in November of 2020, rescinds requirements for states to set time and

distance standards and instead requires that states set a "quantitative minimum" access standard for certain types of clinicians.[22] We understand that CMS plans to publish additional managed care oversight regulations, as indicated in the spring unified agenda, and look forward to partnering with the agency on this important work.

Implement the State Plan Option to Extend Medicaid Coverage to One Year Postpartum

The AAFP has supported efforts to extend postpartum Medicaid coverage, which currently ends just six weeks after delivery, to one year postpartum. This extension would help to mitigate racial inequities in postpartum health coverage and facilitate a smooth transition to primary care for postpartum patients.[23] With the passage of the American Rescue Plan Act, beginning April 1, 2022, states can elect to provide 12 months of coverage after the end of pregnancy to postpartum Medicaid beneficiaries. States that take up the option and provide coverage to lower-income pregnant individuals through CHIP must also provide a full year of postpartum coverage to individuals covered under the CHIP pathway.[24] Since the creation of the state plan option, and the recent CMS approval of several Section 1115 demonstration waivers to extend coverage, state interest in this policy has grown.[25] **CMS should issue guidance to the states on the parameters of this new option well in advance of the April 1, 2022 effective date, with a focus on addressing inequities in maternal health outcomes.**

Strengthen MOE Requirements for the Duration of the COVID-19 Public Health Emergency

The AAFP urges you to abandon the alternative interpretation of the MOE statutory requirement in the interim final rule entitled Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-9912-IFC) and restore the previous requirements, which are consistent with congressional intent. The AAFP opposed the alternative interpretation of MOE requirements, which requires states to move Medicaid beneficiaries between enrollment categories during the PHE and raised concerns that the alternative interpretation would lead to the loss of benefits.

Again, congratulations on your appointment. We look forward to partnering with you and would appreciate the opportunity to meet with you to discuss our shared goals for increasing equitable access to high-quality health care. To set up a meeting please contact Stephanie Quinn, Senior Vice President for Advocacy, Practice Advancement and Policy at squinn@aafp.org.

Sincerely,

Gary L. LeRoy, MD, FAAFP

Gary LeRoy, MD, FAAFP
Board Chair
American Academy of Family Physicians

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