AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

May 16, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2406–P
P.O. Box 8016
Baltimore, MD 21244–8016

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I write in response to the proposed rule titled, "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services—Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold" as published by the Centers for Medicare & Medicaid Services (CMS) in the March 23, 2018, *Federal Register*. The proposed rule amends the process for states to document whether Medicaid payments in fee-for-service (FFS) systems are sufficient to enlist physicians and other providers to assure beneficiary access to covered care and services.

Background
Payment rates in Medicaid are seriously low, especially for primary care, and the Medicaid bureaucracy impedes timely, adequate payment. In anticipation of an increase in the number of individuals enrolled under Medicaid expansion, the *Affordable Care Act* introduced a two-year Medicaid fee increase to boost Medicaid payment rates to at least 100% of Medicare payment rates for primary care services. While Congress allowed this increase to lapse in 2014, 21 states continued the fee increase, either partially or in full.

A 2015 study in the *New England Journal of Medicine* showed that the availability of primary care appointments for Medicaid patients increased by 7.7 percent between 2012 and 2014 following the introduction of the pay increase. The study also found that the largest increases in appointment availability correlated with states with the largest pay increases. Similarly, a 2017 study in the *Journal of the American Medical Association Internal Medicine* found that between 2012 and 2016 – a period that included the Medicaid primary care funding increase – appointment availability for Medicaid patients increased, while availability for private insurers remained constant. This result reflects the importance of the fee increase in expanding access to primary care financed by Medicaid. Conversely, a 2018 *JAMA Internal Medicine* study concluded that "reductions in Medicaid funding have led to states lowering their Medicaid fees" to physicians, jeopardizing access to care and reinforcing the importance of the Medicaid pay increase to physicians, patient care, and positive health outcomes.

Today, Medicaid payment rates range from a low of 33 percent of Medicare rates for primary care services in Rhode Island to 127 percent of Medicare rates in Alaska. Nationwide, Medicaid payment

is 66 percent that of Medicare for primary care services. **If CMS strives to ensure access to Medicaid covered services, the AAFP calls for urgent state and federal efforts to raise Medicaid physician payment levels to at least Medicare rates for services rendered by a primary care physician.** Lack of parity between these rates has historically created a demonstrable barrier to health care access for low-income, disabled, and elderly Medicaid enrollees, as many physicians are unable to afford new Medicaid patients due to low payment rates and significant administrative burden.

Beyond the low payments provided by states under Medicaid, fee-for-service Medicaid is the most challenging type of insurer to bill. This is because the Medicaid claim denial rate is shockingly high: 17.8 percentage points higher than that for fee-for-service Medicare. Family physicians with significant Medicaid populations are doing a service for their communities, yet Medicaid red tape makes even low Medicaid payments hard to access. In fact, the denial rate for Medicaid managed care was 6 percentage points higher than that for fee-for-service Medicare. These realities should be factored in whenever any policy like the proposed rule is contemplated, as States with FFS Medicaid and Medicaid Managed Care organizations should be held to a higher standard than the current regime is producing. States and MCOs should not make it harder to care for the lowest resourced and most vulnerable members of family physician patient panels.

Exemption for States with High Managed Care Enrollment
States that are considered to have a high MCO penetration according to CMS include 17 states that currently have a comprehensive, risk-based managed care enrollment rate of 85 percent or greater. If implemented, the proposed rule would allow these states to forego an access monitoring review plan (AMRP). In addition, adding services to the AMRP when reducing or restructuring payment rates would also not trigger a new AMRP for states with high MCO penetration. To provide some level of access monitoring in these instances, however, when proposing to reduce or restructure Medicaid payment rates in circumstances that may diminish access, the proposed rule would still require states to present alternative data and analysis, determined at the discretion of the state.

The AAFP opposes this proposal since it will almost certainly lower the level of access monitoring in those states. While we understand that the Medicaid recipients in question are a small portion of the total recipients in their respective states (i.e. 15% or less of the state's total Medicaid population), all Medicaid beneficiaries deserve access to high quality care as guaranteed by the Medicaid statute. Since this proposed rule impedes the federal government from confirming compliance with access to care for patients enrolled in Medicaid, the AAFP cannot support it.

Indeed, the potential impact of this change could be significant for the most complex care populations and services. For example, adults and children with severe disabilities often receive home and community-based care under fee for service structures outside of or supplemental to a state's Medicaid managed care population. Under the proposed rule, however, a state would be excused from monitoring access conditions for these populations—the highest-need and most costly beneficiaries—simply because 85 percent of the total Medicaid population might be enrolled with managed care organizations (MCOs). Similarly, even if long term nursing home services are not included in MCO contracts, a state would no longer have to monitor the adequacy of nursing home access if its MCO enrollment meets the 85 percent access threshold. Furthermore, the proposed rule would also hamper efforts by CMS to monitor the effects of payment rates on access to laboratory services and could require a state to take remedial action in the event of inadequate access.

We believe that there is no substantive justification for the proposed 85 percent threshold in the proposed rule and request that CMS provide data and analysis to justify this seemingly arbitrary rate. If implemented, the proposed rule would result in far less transparency for patients not enrolled in MCOs in these states. Any rollback of reporting requirements could undermine access to important services for beneficiaries who receive care through FFS alone or within MCO structures supplemented with FFS-paid benefits.

This concern is only exacerbated by the phrase "determined at the discretion of the state" in regard to alternative data and analysis. The proposed rule offers no guidance regarding which information is acceptable and why.

Exemption for Payment Rate Changes
CMS also proposes to exempt states from the analysis and monitoring procedures associated with payment rate changes for specific rate reductions over a period of years. Any FFS rate reductions to a service category that are below 4 percent for a state's fiscal year, and below 6 percent across two consecutive state fiscal years would qualify for this safe harbor. These states would still be required to present alternative data and analysis, but this information would be determined at the discretion of the state.

The AAFP opposes this proposed exemption in monitoring since it will not guarantee access equivalent to individuals in the general population. Furthermore, it seems to ignore the thin margins at which primary care physicians operate – especially in Medicaid. Those margins are typically below the 4 percent for one year or 6 percent for two years proposed by CMS, such that cuts of those magnitude could have a devastating impact on access to primary care in a community. **Especially given the value that primary care brings to Medicaid and the rest of the health care system, we urge CMS to limit this proposal to those service categories other than primary care while maintaining the current level of access analysis and monitoring for the primary care service category, regardless of the size of payment rate changes.**

Another reason we oppose this proposal is that the percentages in question apply to an "overall service category." As such, a state could target any narrow but important sub-category of medical care services for deep rate reductions without establishing an access evidence base to justify such reductions to CMS, so long as, in the aggregate, its reductions remain below the 1-year or 2-year percentage cap across the entire service class.

We appreciate the opportunity to provide these comments. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org with any questions or concerns.

Sincerely,

John Meigs, Jr., MD, FAAFP
Board Chair