



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

July 15, 2015

The Honorable Sylvia Mathews Burwell
Secretary of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
Attention: CMS-2390-P
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Burwell:

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I write in response to the [proposed rule](#) titled, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability" that was published by the Centers for Medicare & Medicaid Services (CMS) in the June 1, 2015 *Federal Register*.

Over the past four years, enrollment in Medicaid managed care plans has increased by 48 percent and now 46 million beneficiaries receive coverage through these plans. The AAFP applauds CMS and the U.S. Department of Health and Human Services (HHS) for these steps in modernizing and strengthening the Medicaid and CHIP managed care programs by aligning their rules and requirements with other major sources of coverage, such as Qualified Health Plans operating in the Marketplaces and Medicare Advantage plans. The AAFP supports consistency across public and private health plans as a means to promote accountability by the plans, improve care provided to beneficiaries, and reduce administrative hassles for medical practices.

Medical Loss Ratio

The AAFP fully supports applying the Medical Loss Ratio (MLR) requirement to Medicaid managed care and CHIP health plans for contracts beginning on or after January 1, 2017. The MLR is expressed as a percentage, generally representing the percentage of revenue used for patient care, rather than for other items such as administrative expenses or profit. Over several years, we have commented in strong support of applying the MLR to Medicare Advantage plans (Part C), Medicare Prescription Drug Benefit plans (Part D), and Marketplace plans.

When calculating a health plan's MLR, the AAFP believes that expenses must be taken into consideration if they provide physician practices with actionable clinical data that help achieve the goal of improving the quality of care. The AAFP also believes that incentive-based expenditures for meeting nationally recognized quality-of-care benchmarks and performance improvement also must be included in the calculation. Innovative ideas for changes to the delivery of primary care are costly, such as care coordination and disease management efforts that directly impact clinical outcomes, and these efforts must

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be incorporated in the medical expense portion of the calculation of the MLR. We believe the MLR is intended to require issuers to spend most of their funds on actual health care, not administrative costs or profits. However, in the context of managed care, where an emphasis is placed on care management to prevent beneficiaries from accumulating medical bills, the line between value-based care and administrative costs may be less clear. Accordingly, there may be many Medicaid beneficiaries who require auxiliary services, such as transportation and social services, in order to improve care management, coordination, and outcomes. We offer our [policy](#) on care management fees as an example of core activities within the context of a patient-centered medical home:

- Non-physician staff time dedicated to care management
- Patient education
- Use of advanced technology to support care management
- Physician time dedicated to care management
- Medication management
- Population risk stratification and management
- Integrated, coordinated care across the health care system
- Care planning.

We feel many of the innovative ideas for changes to the delivery of primary care, such as care coordination and disease management efforts embedded in physician practices, directly impact clinical outcomes and, thus, should be included in the calculation of the medical expense portion of the MLR calculation. We would like to see that work remain impactful and intact. While we support applying the MLR onto Medicaid managed care and CHIP health plans, the AAFP also believes managed care plans should invest at minimum 15 percent of their total spending on primary care services by primary care physicians. This would greatly help increase access to preventative and primary care services to the Medicaid managed care and CHIP population.

The AAFP continues to support implementation of MLR requirements, because it will ensure that health care finances are focused on patient care. A June 2014 [report](#) from the Milliman actuarial firm looked at managed care plans with at least \$10 million in annual revenue across 35 states from 2009 to 2013 and found average MLRs of at least 85 percent each year. In addition, the average MLR was 85 percent or higher in 28 of the 38 states that used Medicaid managed care, according to a 2013 Kaiser Family Foundation [study](#). The AAFP believes healthcare funds should be used for actual clinical care; thus, we believe CMS properly established the proposed minimum MLR of 85 percent, and we encourage states to set even higher rates to improve patient care.

Setting Actuarially Sound Capitation Rates for Medicaid Managed Care Programs

The AAFP agrees with the proposed regulation's requirement for greater transparency in how states determine whether the rates they pay plans are actuarially sound. Since 26 states and the District of Columbia currently certify ranges of rates instead of specific rates for their managed care programs, this proposal could be challenging for them. However, requiring states to provide CMS enough detail for the agency to understand the specific data, assumptions, and methodologies behind the rates will help ensure payments are sufficient to cover the services required under the contract.

CMS has created a proposed minimum for standard contract terms for how Medicaid managed care and CHIP plans' capitation rates are judged to be actuarially sound and risk-adjusted. The AAFP understands

the need for CMS and states to calculate accurately the plans' capitation rates. However, our experience with rate setting and risk adjustment under the Medicare Advantage program is that it quickly results in the constant harassment of physicians for medical records to support the plans' claims about the health acuity of their enrollees. The plans constantly mine those records for diagnoses to support their contentions that their members are the sickest of the sick and, thus, the plans deserve more money from CMS. Meanwhile, the physicians and practices that are caring for those individuals must divert precious time and effort toward this paper chase, which only serves to benefit the plans and not the patients. We strongly encourage CMS to avoid a repetition of this farce by implementing its proposed standards for Medicaid managed care plans. CMS needs to minimize, as best it can, any frequent or needless contacts with the medical practice by Medicaid managed care plans. The AAFP does not believe managed care plans should interfere with medical practices through unnecessary and burdensome documentation requests desired by the health plan in attempts to justify their capitation rate.

Special Contract Provisions Related to Payment

The AAFP appreciates the agency's reiteration, through this proposed rule, that states have the flexibility to require managed care plan participation in a broad-range of delivery system reforms or performance improvement initiatives. We particularly appreciate the proposed rule's inclusion of the patient-centered medical home (PCMH) in a list of delivery system reform projects that are designed to improve access to services. We equally appreciate the regulation's recognition that states have the flexibility to make available incentive payments for the use of technology that supports interoperable health information exchange.

We urge CMS and states to strongly consider increased payments for practices that are a PCMH, since it is a model that transitions away from a focus on symptoms and illnesses toward a more realistic system providing comprehensive and coordinated primary care. Family physicians practicing in a PCMH are responsible for the patient's coordination of care across all health care systems, which is facilitated by registries, information technology, health information exchanges, and other means to ensure the patient receives care when and where it is needed. With a commitment to continuous quality improvement, care teams utilize evidence-based medicine and clinical decision support tools that guide decision making as well as ensure that patients and their families have the education and support to actively participate in their own care. The AAFP believes payment for such high quality services should appropriately recognize and incorporate the value of the care teams, non-direct patient care, and quality improvement provided in PCMHs.

However, notwithstanding this proposed flexibility for delivery system and provider payment initiatives, the AAFP also notes that the agency proposes, in Section 438.6(c)(1)(iii)(A), to allow state Medicaid programs to require a Managed Care Organization (MCO), Pre-paid Inpatient Health Plan (PIHP), or Pre-paid Ambulatory Health Plan (PAHP) to "adopt a minimum fee schedule for all providers that provide a particular service under the contract." The AAFP is grateful for the explicit recognition that state Medicaid programs that set minimum payment rates in primary care must contractually require participating MCOs, PIHPs, and PAHPs to pay such rates to primary-care providers. However primary-care rates across the states now vary widely, and in many states, they are not sufficient to enlist enough providers so that care and services are available to the extent that they are to the general population in the geographic area—despite the fact that state Medicaid programs are required to ensure sufficient provider capacity under Section 1902(a)(30)(A) of the *Social Security Act*. The AAFP believes it is critical that payment rates for primary

care physicians must be at or above Medicare rates for all primary care services provided to Medicaid managed care and CHIP enrollees.

Meanwhile, under the Supreme Court decision *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015), family physicians and all other Medicaid providers may no longer seek review of compliance with Medicaid access requirements in federal court. Accordingly, because enforcement of Medicaid's equal-access requirement is now solely the responsibility of CMS, the AAFP urges CMS to finalize its proposed rulemaking from May 6, 2011, on Medicaid access as expeditiously as possible. Without private enforcement, CMS must aggressively act to ensure Medicaid beneficiaries' right to access to care, including primary care. In addition, the AAFP reiterates that CMS should require states to submit specific data as part of their access review, including cost studies, the number of physicians accepting new Medicaid patients, emergency-department utilization, and the physician/patient ratio in Medicaid compared to private insurance plans. The AAFP adamantly believes equal access to primary care services in the Medicaid managed care and CHIP population will not be accomplished if the plans pay for primary care services at a rate less than the reasonable Medicare allowance.

In regard to contract provisions related to payment, the AAFP reminds the agency and health plans that effective January 1, 2015, Medicare began paying for chronic care management (CCM) services. The AAFP continues to appreciate that CMS identifies the importance of CCM services, since it recognizes the value of complicated clinical oversight that requires significant clinical time outside the exam room. The AAFP urges CMS to specify in this final rule that all Medicaid managed care and CHIP plans recognize and provide full payment for the CCM. Further, we recommend the full elimination of the beneficiary's copayment for chronic disease management. CCM services do not currently fall under the Medicare preventive services umbrella, even though management also serves to prevent chronic conditions from worsening. Under the CCM code, the beneficiary is potentially responsible for coinsurance of about \$8 a month, whether or not the patient sees the doctor in a separate face-to-face encounter. This has led to beneficiary confusion and to the administrative difficulty of collecting the beneficiary's share of the payment. Given the high value of this service, the AAFP believes that chronic-care management should be available without beneficiary cost sharing.

Provider Enrollment, Network Adequacy, and Program Integrity

In the current system, physicians and providers may furnish services to Medicaid managed care and CHIP patients, but not order subsequent items or services for them without having to enroll as Medicaid providers. Some health plans depend on this policy to improperly inflate their provider network. CMS is proposing that all providers who furnish services to Medicaid managed care and CHIP beneficiaries must enroll in Medicaid and thus be subject to the screening and disclosure requirements arising from enrollment.

The AAFP is concerned that this proposal creates further administrative hassles for physicians and could ultimately limit the number of physicians treating patients from Medicaid managed care and CHIP plans. However, we also appreciate the efforts to improve the accuracy of provider information available to beneficiaries of Medicaid managed care and CHIP plans. Inaccurate and out-of-date provider directories are the foundation of many accessibility concerns. Without accurate provider directories, beneficiaries face unfair, costly, and protracted obstacles to their receiving the care, treatment, and follow-up they need. In the case of family medicine and primary care, accurate and up-to-date physician directories ensure that health care's main entry point stays open and easily accessible for patients.

The AAFP acknowledges that physicians have a role in contributing to the accuracy of provider directories, but we would urge CMS to place responsibility mainly on the health plans. When health plans generate their provider directories, they should work with the information technology infrastructure to avoid an additional and overly burdensome reporting requirement for providers. For example, the regular communications by plans to physicians to ascertain whether they are accepting new patients should be communicated electronically, by mobile phone texting, and through regular mail. Furthermore, electronic communications should have an embedded hyperlink to the plan's provider directory for the physician to access. Any changes or updates the physician makes on that webpage, regarding contact information and availability, should update the health plan's online provider directory instantaneously.

Since there are so many Medicaid managed care and CHIP plans, the AAFP urges CMS to require that provider information for directories be standardized and that each plan should collect only:

- Provider name;
- Practice street address, city, state, zip code, phone number, website;
- Practice office hours and other information that could affect availability;
- Notice of whether the provider is taking new Medicaid patients; and
- The anticipated time period for accepting or not accepting new Medicaid patients.

The plan's webpage that physicians use to change or update their information should be pre-populated with the insurance products and networks in which the physician is currently participating. This will serve to remind the physician of his or her plan participation. The webpage's user interface should be easy for physicians to understand and navigate. Lastly, the AAFP believes yearly communications are a reasonable time period for communications between CMS, plans, and physicians.

The proposed regulation requires that, in assessing network adequacy, states must account for a number of factors. The AAFP is pleased with the time and distance network adequacy requirements proposed by CMS and would ask that standards be set for appointment wait times as well. A [study](#) last year by HHS' Inspector General found only half the doctors listed in official plan directories were taking new Medicaid patients. Among those doctors who were, one-fourth could not see patients for a month. Standards on appointment wait times would add an additional beneficiary protection that would ensure health care's main entry point stays open and easily accessible for patients.

Also in regard to network adequacy, the proposed regulation allows wide flexibility for states by requiring them to develop and enforce their own specific network adequacy standards. As we have interpreted the regulation, states would not be required to set specific provider-beneficiary ratios, but rather must develop time and distance standards for primary care and other provider types. While we recognize this approach is consistent with CMS' general approach for the Medicaid program, we are concerned with the states' previous lackluster performance and enforcement of network adequacy standards, especially when it's unclear how financially strapped state Medicaid programs will respond.

Finally, we are equally concerned with the practice of patient churning among health plans. A 2012 Urban Institute [study](#) concluded 6.9 million people will move from Medicaid to subsidized coverage in the state or federal Health Insurance Marketplaces or vice versa. In addition, 19.5 million people will move between Medicaid and ineligibility for all insurance subsidy programs, typically because of having income over 138

percent of the federal poverty level and affordable employer-sponsored insurance offers. Continuity of care is a primary objective of family medicine and is consistent with quality patient care. The AAFP urges CMS to be mindful of the importance of continuity of care while developing network adequacy and patient enrollment policies and to strive to minimize the effect of patient churn between various plans.

Quality Measures and Ratings

It would appear from the proposed regulation that states would have the option to include additional quality measures. If so, the process for including additional quality measures is not yet clear, and family physicians are already fatigued from dealing with too much variation between quality reporting systems. We respectfully ask CMS to ensure a high level of standardization and harmonization of quality measures and methodologies across reporting programs to ease compliance and allow more focus on meaningful quality improvement efforts.

In regard to quality measures, the AAFP calls on the agency to take into account the inherent nature of Medicaid beneficiaries tending to be sicker and having more health care needs. Therefore, the ratings system should be different than the star ratings system used for Medicare Advantage plans. The current Medicare Advantage Star Ratings system does not adequately consider the unique and extensive needs of Medicaid beneficiaries when making these assessments. The Medicaid managed care ratings system should weigh the variables of overall health disparities, diminished health literacy, socioeconomic risk factors, and higher occurrence of comorbidities in this population.

Regulatory Compliance Committee

CMS proposes the establishment of a Regulatory Compliance Committee on the Board of Directors for each Medicaid managed care and CHIP plan as a management procedure designed to guard against fraud and abuse. The AAFP supports such oversight; we encourage CMS to require that the health plans include local, practicing family physicians on the committee. We believe the inclusion of family physicians will support the committee's mission due to family physicians' expertise and leadership in many areas, including the critical evaluation of research published in peer-reviewed literature, clinical prevention, health promotion, and primary team-based care.

Primary Care Case Management

CMS proposes to distinguish traditional Primary Care Case Managers (PCCMs), such as physicians, from larger and more complex primary care case management entities with ties to a health plan. CMS also proposes increased oversight of these larger entities.

While the AAFP generally supports the proposed direction, since it increases the distinction between individual primary care case managers and larger primary care case management entities, we believe the best case management in terms of value and quality for the patient comes from case managers embedded in a family medicine practice. We support separate payment for the care management services provided by family physicians and their practices and urge CMS and health plans to consider payment to practices for care management services.

Third Party Liability

The AAFP has reviewed and understands the proposed rule's assertion that Medicaid should be the health payer of last resort and that other available resources must be used before Medicaid pays for the care and services of a Medicaid-eligible individual. We understand Medicaid will be the payer of last resort in third

Secretary Burwell

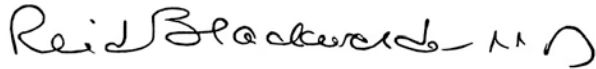
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party liability situations. However, we believe all payers involved have a responsibility to promptly coordinate and process claims, so physicians and other health care providers can address the medical condition of the patient with some assurance of timely compensation for their services and no fear of going broke while the payers in question haggle over who is the primary payer.

For any questions you might have please contact Shannon Morey, State Government Relations Manager, at 202-232-9033 or smorey@aafp.org.

Sincerely,

A handwritten signature in black ink that reads "Reid B. Blackwelder MD". The signature is written in a cursive style with a large, stylized "R" and "B".

Reid B. Blackwelder, MD, FAAFP
Board Chair

CC:

Andrew M. Slavitt, Centers for Medicare & Medicaid Services