



December 24, 2015

Sylvia M. Burwell, Secretary
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

RE: Methods for Assuring Access to Covered Medicaid Services and Data Metrics and Alternative Processes for Access to Care in the Medicaid Program (CMS–2328–FC)

Dear Secretary Burwell and Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I am responding to the [final rule with comment period](#) titled, “Methods for Assuring Access to Covered Medicaid Services” and the related [request for information](#) titled “Data Metrics and Alternative Processes for Access to Care in the Medicaid Program” that were both published in the in the November 2, 2015 *Federal Register*.

The final rule with comment period calls for a transparent and data-driven process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services. It recognizes electronic publication as an optional means of providing public notice of proposed changes in rates or rate-setting methodologies. The request for information seeks to inform the potential development of standards with regard to Medicaid beneficiaries’ access to covered services and CMS is interested in information on core access to care measures and metrics that could be used to measure access to care for beneficiaries in the Medicaid program including managed care delivery systems.

AAFP Reaction

In our July 5, 2011, [comment letter](#) to CMS in response to the proposed version of this regulation, the AAFP acknowledged the Medicaid and CHIP Payment and Access Commission (MACPAC) recommendation that the agency improve the collection and analysis of Medicaid data. While we believe that the transparent and data-driven process specified in the final rule takes an initial step towards fulfilling that recommendation, the AAFP is nevertheless very

www.aafp.org

President Wanda Filer, MD <i>York, PA</i>	President-elect John Meigs, Jr., MD <i>Brent, AL</i>	Board Chair Robert L. Wergin, MD <i>Milford, NE</i>	Directors Yushu “Jack” Chou, MD, <i>Baldwin Park, CA</i> Robert A. Lee, MD, <i>Johnston, IA</i> Michael Munger, MD, <i>Overland Park, KS</i> Mott Blair, IV, MD, <i>Wallace, NC</i> John Cullen, MD, <i>Valdez, AK</i> Lynne Lillie, MD, <i>Woodbury, MN</i>	John Bender, MD, <i>Fort Collins, CO</i> Gary LeRoy, MD, <i>Dayton, OH</i> Carl Olden, MD, <i>Yakima, WA</i> Marie-Elizabeth Ramas, MD, (New Physician Member), <i>Mount Shasta, CA</i> Richard Bruno, MD, (Resident Member), <i>Baltimore, MD</i> Tiffany Ho (Student Member), <i>Baltimore, MD</i>
Speaker Javette C. Orgain, MD <i>Chicago, IL</i>	Vice Speaker Alan Schwartzstein, MD <i>Oregon, WI</i>	Executive Vice President Douglas E. Henley, MD <i>Leawood, KS</i>		

disappointed that the final rule does not follow the AAFP's recommendation to develop a consistent national approach to measuring access to care. Instead, after more than 4 years, CMS merely requests further feedback on how to measure access to care. This lack of progress is a major concern. We believe CMS should do more to implement methods and procedures relating to the utilization of, and the payment for, care and services available under Medicaid fee-for-service and Medicaid managed care plans. The AAFP appreciates that the agency is establishing new procedures at the state level for CMS to approve provider rate reductions or restructuring. Nonetheless, we believe CMS needs to exert oversight that will prevent reductions in access to care—especially for Medicaid beneficiaries to their primary care physicians.

The AAFP believes Medicaid beneficiaries deserve meaningful access to the health care services that are within the scope of covered benefits. Though primary care practices experienced short-term relief from inadequate Medicaid payments via Section 1202 of the *Affordable Care Act*, that two-year program expired in 2015. According to a [study](#), the availability of primary care appointments in the Medicaid group increased during these two years and states with the largest increases in availability tended to be those with the largest increases in reimbursements. In 2016, the Medicare Primary Care Incentive Program also will expire reducing payment to primary care practices. Furthermore, the 2 percent sequestration cut took effect in 2013 further reducing primary care payments for Medicare beneficiaries. Though the AAFP continues to support healthcare coverage for all, this threefold punch to Medicare payment rates has and will continue to severely impact beneficiaries' access to primary care physicians, who already operate on narrower financial margins. This is particularly true for solo, small and medium sized practices. We are, therefore, concerned about the long-term sustainability of primary care practices whose Medicaid payment is less than that of Medicare and commercial plans.

Due to these issues, the AAFP believes that the final rule does not sufficiently ensure effective methods to measure Medicaid beneficiaries' access to care. While measuring and publicly reporting provider payment rates and transparently adjusting payment methodologies under Medicaid are important, the AAFP believes only adequate payment rates (matching at least the Medicare rates for primary care physicians) is the principal factor in ensuring that Medicaid fee-for-service and managed care patients have access to medically necessary care and services. We call on CMS to mandate that states use a baseline of 2014 for primary care payments. This will help illustrate what states have done after the end of the two-year implementation of Section 1202 and reward those states that kept rates at least at the level of Medicare.

CMS issued the final rule with comment period in part to provide the opportunity for stakeholders to explain whether CMS should allow exemptions based on state program characteristics. Since the AAFP calls for a consistent national approach to measuring access to care, we do not believe CMS should offer exemptions -- with one exception. If states reimburse primary care service at or above Medicare rates, then in these favorable circumstances, CMS should offer states the opportunity to bypass further reporting requirements.

The AAFP provides the following feedback in response to the request for information:

A. Access to Care Data Collection and Methodologies:

1- What do you perceive to be the advantages and disadvantages to requiring a national core set of access to care measures and metrics? Who do you believe should collect and analyze the national core set data?

The advantages of requiring a national core set of measures and metrics for access to care are that we would have a settled standard for beneficiaries and reduced administrative burden for providers. Furthermore, this core set should be harmonized among Medicaid managed care plans and other lines of coverage. This information would help the states and health plans discern whether Medicaid patients are well served and have adequate access, compared to those with other coverage, and could ultimately help inform the state's decision making. Cost and quality improve when access to primary care physicians are in a position to deliver, manage, and coordinate care effectively.

2-Do you believe there are specific measures on access to care that could be universally applied across services? If so, please describe such measures.

Certain measures that could be universally applied include:

- Percent of people with a specific source of ongoing primary care
- Emergency department and urgent care utilization rates that are risk-adjusted based upon patient health status, as well as demographic, socioeconomic, and geographic factors.
- Percent of patients without a designated family physician or primary care physician; and
- Primary care physician and specialist visits per thousand lives.

3- What do you believe are the primary indicators of access to care in the Medicaid program? Is measured variance in these indicators based on differences in things such as: Provider participation and location, appointment times, waiting room times, call center times, prescription fill times, other?

In general, access to care is very complex and difficult to measure. Different populations face a myriad of challenges that are independent of the physician and/or health plan (i.e., social determinants of health). The AAFP believes primary indicators of access to care in the Medicaid program are:

- Number of providers, including their full-time equivalent status
- Percent of patients using urgent care and emergency departments instead of a primary care provider;
- Waiting room times;
- Distance to nearest primary and specialist care providers;
- The length of time to get a first appointment;
- Access to transportation services; and
- 24/7 access to a provider with access to an electronic health record.

The AAFP believes measured variance in these indicators is based on differences in provider participation and location, wait room times, call center times, and prescription fill times. In addition, there are a number of levers outside of physician performance that the state can utilize to improve access, such as higher reimbursement rates, higher reimbursement rates for Patient-Centered Medical Homes, which provide same-day appointments and reimbursement for telehealth services, such as e-visits, remote monitoring, and home health care.

B. Access to Care Thresholds/Goals

1- Do you believe CMS should set thresholds for Medicaid access to care? If so, do you believe such thresholds should be set at the national, state or local levels? Why?

Yes, the AAFP encourages CMS to set minimum thresholds for Medicaid access to care. States should measure access by actual patient visits and outcomes, rather than number of providers since some providers limit their Medicaid patient panel.

Thresholds should be set at a county level, which could be based on demographics, prevalence of physicians and population needs. If the threshold is set at the county level, the needs of the communities would be better understood and reflected.

2- If CMS sets Medicaid access thresholds, how do you believe they should be used? For instance: For issuing compliance actions to states that do not meet the thresholds, as benchmarks for state improvement, for use in appeals processes for beneficiaries that have trouble accessing services, or in other ways?

Any thresholds should be used as a guideline or benchmarks for the first few years of implementation and should not be punitive. Comparability is especially critical to physicians, who practice in solo, small, or independent practice environments, rural settings, and in health professional shortage areas, since they may not have access to supporting services available to physicians who do practice in other settings. However, once the state has been given sufficient time to understand and implement this reporting program, potential penalties could be implemented. For example, states that are able to reimburse physicians at Medicare or higher rates should receive additional federal funds.

C. Alternative Processes for Access

1- What do you believe are the advantages and disadvantages of either a complaint resolution process or a formal appeals hearing for access to care concerns?

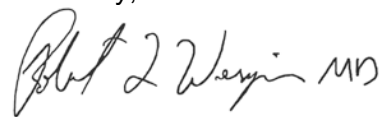
It would be useful to have a formal process for complaints and appeals when access to care is impaired. If a physician chooses to not participate with certain Medicaid managed care plans and when these plans only provide limited benefits, CMS should allow patients to change plans so that beneficiaries are not held captive in poorly administered plans for an entire year. Beneficiaries that are locked into such plans are therefore not allowed to remain with their primary care physician which would erode an ongoing relationship with their primary care physician. In addition, a complaint resolution process would give patients an avenue to highlight undue delays and burdens to access care. The disadvantage is that the process adds a level of cost.

2- Who do you believe should be the responsible party (for example, the state or federal government, an independent third party, a civil servant, or an administrative law judge) to hear beneficiary access to care complaints and/or appeals?

A responsible party could be a state ombudsman (or similar office) or an independent third-party who could be contacted in cases when patients need help in getting needed care.

We appreciate the opportunity to provide these comments. For any questions you might have, please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,



Robert L. Wergin, MD, FAAFP
Board Chair