AMERICAN ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

July 5, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn. CMS-2328-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Methods for Assuring Access to Covered Medicaid Services, CMS-2328-P

Dear Dr. Berwick,

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 100,300 family physicians and medical students nationwide, I am writing in response to the proposed rule, "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services" (CMS-2328-P) proposed rule as published in the May 6, 2011 *Federal Register*.

The *Children's Health Insurance Program Reauthorization Act* (CHIPRA, PL 111-3) created the Medicaid and CHIP Payment and Access Commission (MACPAC) to review federal and state policies that affect provider reimbursement and beneficiary access in Title XIX and Title XXI programs. In its first report to Congress in March 2011, MACPAC noted the need for an improvement in the collection and analysis of Medicaid data. The AAFP believes this proposed rule takes an important step forward in collecting the data needed to accurately understand the needs of this vulnerable population.

The AAFP appreciates the opportunity to comment on the proposed rule and appreciates efforts to clarify how states set payment rates in Medicaid fee-for-service. The AAFP recommends CMS develop a consistent national approach to measuring access to care through use of specific data elements proposed by CMS, some of which we suggest may be more helpful than others, while also encouraging CMS to provide clear guidance to states on available data sets and analytic tools. Additionally, AAFP recommends CMS partner with Medicaid agencies on outreach efforts and urge states to develop electronic feedback mechanisms for beneficiaries and providers. The AAFP also concurs with the proposal to revise the public notice rule and recommends deletion of the currently undefined term "significant" from the section addressing the scope of rate changes for which states must post a notice to prevent further confusion on the part of states.

The proposed regulation aims to strengthen the requirements of section 1902(a)(30)(A) of the Social Security Act that directs states:

> *to provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan… as may be necessary to safeguard against unnecessary utilization of*

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such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

In the past, this section has been controversial for CMS, states, and providers, resulting in legal actions and uncertainty about specific requirements under the statute. As stated, "only a few States indicated that they relied upon actual data," to determine compliance with these access requirements.

The *Affordable Care Act* (PL 111-148) requires that beneficiaries have meaningful access to the health care services that are within the scope of the covered benefits. The AAFP agrees with the agency's assertion that, "States lack the guidance that they need to understand the types of information that they are expected to analyze and monitor in determining compliance with statutory access requirements." The proposed rule offers states flexibility to determine appropriate data elements that focus on MACPAC's recommended three-part framework: enrollee needs, availability of care and providers, and utilization of services. The AAFP believes CMS should allow states to develop alternative approaches to demonstrate consistency with the access requirement using a standardized, transparent process. While CMS should provide guidance that sets a consistent national approach, states ought to consider additional factors such as local market conditions, variable provider costs, administrative burden for providers and demographic differences.

As part of the amendments to section 447.203, CMS suggests 10 data elements for measuring the availability of care and services through Medicaid fee-for-service. The AAFP suggests four of these are most critical to gauging provider participation:

- The availability of care and services through Medicaid fee-for-service as compared to access standards established under Medicaid managed care.
- The availability of care and services through Medicaid fee-for-service as compared to commercial managed care or other commercial insurance access standards.
- Average amount of time from provider application for enrollment to the approval of the provider agreement.
- The average amount of time from provider claim submission to payment of the claim by the Medicaid agency.

The AAFP perceives the final data element as the most critical, given reports that family physicians wait six months or longer for payment in some states. Primary care practices, particularly solo, small and medium-sized practices, operate as small businesses and often on narrower financial margins than other providers. Prompt payment for services rendered to Medicaid patients is vital to these practices' ability to continue participating in the program.

Many of the 10 data elements for assessment of how well beneficiaries' needs are met also would be indicative of provider experience. Given the Medicaid administrative hassles reported by family physicians—including, onerous enrollment processes, opaque reimbursement procedures and delays in payment—such data could be indicative of needed state action. These data elements include:

- Extent of knowledge that a service, including transportation services, is covered by the Medicaid program.
- Number of and reasons for missed appointments.
- Ability to schedule interpreter services for patients with limited proficiency in English.
- Means and ability to seek help in scheduling appointments with specialty care providers.

We find it helpful that CMS encourages states to examine existing data sources rather than attempt to create a new data set. While the proposed rule mentions data available from the Research Data Assistance Center, the AAFP encourages CMS to specifically direct states' attention to the Medicaid Analytic Extract

(MAX). While the AAFP recognizes the limitations in use of claims data for quality analysis, such data can prove useful in measuring access to care. MAX data can provide a solid basis for comparison of data within and among states. As MAX data provides state, county and zip code level data, analysis may help states determine geographic areas where a single, statewide payment rate may need adjustment. Widespread usage of MAX data would assist in creating a consistent national approach to the analysis and documentation of access to Medicaid services that allows states to formulate their own processes and metrics in light of local factors and circumstances influencing access in their state.

In response to the economic downturn, states reduced staffing levels of most government agencies and Medicaid programs often were no exception. This downsizing reduced states' capacities for research and analysis. In the final regulation, the AAFP encourages CMS to provide additional guidance on data analysis to states, as well. We believe providing off-the-shelf tools, such as the algorithm for measuring unnecessary hospitalizations developed by the Agency for Healthcare Research and Quality, will be helpful to states in complying with policy changes required in the final rule.

The regulation would require states, prior to submission of a State Plan Amendment (SPA) that requests reducing rates or altering the structure of provider payment rates, to submit information from an access review. The underlying data analysis also must be available to the public and furnished to CMS for any SPA that restructures provider payments in a way that could result in access issues. Further, CMS proposes to require states to conduct access reviews for a subset of services each calendar year and for the agency to release the results through public records or a web site by January 1 of each year, while allowing states to determine the services that they will review, provided that each service is reviewed at least once every five years. While the AAFP appreciates flexibility for states to determine the timeline and the organization of the review and to prioritize their reviews, additional guidance would be helpful. States that do not currently undertake robust access reviews will require technical assistance in the implementation of the process proposed by the regulation. Additional guidance should include a recommendation that states pay particular attention to Medicaid patients' access to critical primary care services.

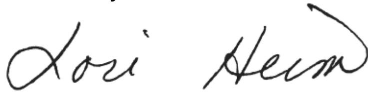
CMS also proposes to require states to submit corrective action plans to CMS with specific steps and timelines to address non-compliance with the statute. The rule proposes that corrective action plans must be submitted within 90 days of discovery of the issue with a goal for remediation of the access issue to take no longer than 12 months. While the AAFP generally supports this proposal, concerns with the provision that the corrective action plan may include longer-term measures remain. If not carefully monitored and limited in the scope of what longer-term measures states may use, this provision could have an adverse effect on provider participation and access to care.

CMS also proposes changes to the public process and public notice (Sections 447.204 and 447.205). The AAFP agrees with the conclusion that clarification and modernization of these regulations are necessary. Often, public hearings on coming rate changes are perfunctory in nature and serve little purpose. To address potential access issues, the proposal allows states to implement an ongoing mechanism that encourages beneficiary feedback. The AAFP concurs with this proposal, but suggests permitting providers to offer feedback, as well. An ongoing mechanism should combine periodic, well-advertised public hearings with electronic reporting mechanisms, such as a feedback form readily available on the state Medicaid website. CMS should urge states to develop online feedback forms for beneficiaries, providers and advocates to help continuously monitor access. The AAFP feels an ongoing feedback system of this nature would enhance the public process amendments CMS proposes to section 447.204. Additionally, this would be, a positive first step in the development of the access "early warning system" discussed by MACPAC. The AAFP also encourages CMS to partner with states on outreach initiatives to ensure that beneficiaries and providers are aware of and understand the feedback mechanism.

The AAFP supports the proposed changes to section 447.205 that require that: (1) notices are published on the state Medicaid agency's web site on a regular basis, (2) the issued notice include the date released to the public on the web site, and (3) the content of the notice is not altered after the initial publication. In regards to section 447.205(a), CMS specifically requests comment on whether it is advisable to delete the term "significant," because the term is not defined and the impact of payment changes is not always objectively clear. The lack of clarity leaves states confused on when it is appropriate to notify the public of changes to rate-setting methods and standards. The AAFP supports the deletion of the term from the regulation as states should be explicitly required to notify the public and providers of any rate change. The inclusion of additional filters to determine what constitutes a "significant" change to payment rates would further complicate a regulation states find confusing.

Thank you for the opportunity to comment on this proposed regulation and we are happy to respond to questions. Please contact Robert Bennett, Regulatory Affairs Manager, at 202-232-9033 or rbennett@aafp.org. The American Academy of Family Physicians appreciates your efforts to bring greater attention to the need for adequate payment to ensure ongoing access to essential services for Medicaid patients.

Sincerely,



Lori J. Heim, MD, FAAFP
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