Emergency Department EDPMA Practice Management Association

February 5, 2015

Diane Rowland, Chair
Medicaid and CHIP Payment and Access Commission
1800 M Street, NW
Suite 650 South
Washington, DC 20036

RE: Ensuring MACPAC Findings on Medicaid Enhanced Primary Care Payments Are Based on Comprehensive Analysis

Dear Ms. Rowland:

We write to share with you some important perspective and considerations from stakeholders regarding the effectiveness of Medicaid enhanced primary care payments. As Congress considers whether to reauthorize the enhanced primary care payments and in what form, the March MACPAC report chapter on the enhanced primary care payments will carry significant weight with Congress, the Centers for Medicare and Medicaid Services ("CMS"), and the many states actively contemplating extending their own enhanced payments.

We are grateful that MACPAC is addressing the enhanced primary care payments, both in terms of the management and execution of the program and the overall effectiveness of the policy. However, after reviewing presentation material and transcripts from MACPAC's discussion of enhanced payments during its October 30, 2014 and January 22, 2015 public meetings, we have concerns over the limited range of data that this being reviewed and the conclusions MACPAC may draw from it. Therefore, it is imperative that any conclusions in MACPAC's ultimate March Report Chapter on primary care are fully supported by evidence and informed by input from affected stakeholders.

I. About EDPMA

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest trade associations supporting the delivery of emergency medical care to all Americans. EDPMA's members deliver (or directly support) health care for more than half of the 136 million patients who visit U.S. emergency departments ("EDs") each year. Our members include physician groups, billing and coding companies, and others who support health care provided in the ED and work collectively to deliver essential services often unmet elsewhere.

Our members are often the first point of access for individuals in need of acute and primary care services, handling 28 percent of first-contact care while utilizing only five percent of the physician workforce. ED patients include millions of indigent individuals and Medicaid beneficiaries with little or no access to timely primary care. Ensuring the ongoing availability of quality emergency services is an important part of maintaining a safety net for all patients including Medicaid beneficiaries, under both traditional fee-for-service as well as managed care arrangements. Our position at the nexus of care provides us with a unique perspective on how Medicaid beneficiaries receive not just emergency medical services but health care services in general, including their ability to access the primary care delivery system.

II. ACA Origins of Enhanced Primary Care Payment Policy

Recognizing that Medicaid populations would grow under the Medicaid expansion provision offered under the Patient Protection and Affordable Care Act ("ACA"), Congress implemented amendment Section 1202 to increase primary care capacity to meet that need. The two year program covering 2013 and 2014 incentivized physicians to participate in state Medicaid programs by requiring state agencies to reimburse qualifying providers at rates equal to Medicare payment rates for select services primary care providers. The federal government fully funded the difference between the states' prevailing rates on July 1, 2009, and the Medicare rates in 2013 and 2014.

Board certified physicians with a specialty designation in family, pediatric, or general internal medicine, or certain recognized Board certified subspecialists who met minimum Medicaid billing thresholds, became eligible for enhanced payment for evaluation and management and vaccine services provided to Medicaid patients. The enhanced rates were paid for services delivered between January 1, 2013, and December 31, 2014.

III. Public Meeting Presentations on Effectiveness of Primary Care Payment Increase

We appreciate that MACPAC discussions at public meetings are simply deliberations that are one step in the process of developing report content. Nevertheless, based on publicly available information from the October 30, 2014 and January 22, 2015 presentations on the enhanced primary care payments, we urge MACPAC that any of its conclusions or recommendations regarding the effectiveness of the policy be fully supported by data or analysis, or at the very least, that publicly-released material from MACAPAC make clear the extent of analysis underlying any final statements.

We highlight below some elements of the discussions at recent meetings that warrant closer analysis. We do this to inform your further work towards a March Report chapter on the enhanced payment policy and any recommendations concerning reauthorization. Also, we wish to urge that any further publicly-released material makes clear what is an official MACPAC position on the enhanced payment program, and what is instead, internal deliberation and the differing views and opinions of its membership.

a. *Seeming MACPAC Conclusion on Effectiveness of Policy*

A key element of any consideration of reauthorization of the Medicaid enhanced primary care payments is whether the program has been effective in its goal of recruiting primary care providers to take on new or expanded numbers of Medicaid patients. Publicly-released material from MACPAC at the October 30, 2014 public meeting states that the "payment increase had at best, a modest effect on provider participation according to states and MCOs. Most states reported that the provision had no effect on the use of primary care services."[1]

We are concerned that Congressional members, federal health policy officials, or other parities weighing the reauthorization of the program may be left with the impression that MACPAC stands behind a conclusion on the effectiveness of the program when, in fact, the substance of the discussion at the public meeting does not support such a conclusion.

b. Very Limited Scope of Informal Analysis

In conducting an evaluation of the impact of the enhanced payment policy, MACPAC staff spoke to officials in only eight states.[2] Surely, more states should be assessed in order to properly support a conclusion on the effectiveness of a program affecting 50 states. The eight state sample represents only 16 percent of all states. The sample is additionally limited in value as "Nearly all respondents reported that they had *no plans to evaluate the primary care payment increase,* nor had states been asked to provide data to CMS."[3] Therefore, the information collected from interviews is based merely on the impressions of state officials as opposed to a formal, data-based evaluation of the policy.

Later in the public discussion, a report by the Ohio State Medical Association ("OSMA") is considered. The OSMA report found that Medicaid primary care providers did increase their patient load. MACPAC staff suggested that the OSMA report findings should be qualified "because their response rate to their survey was 8 percent."[4] Yet, the eight percent response rate in the OSMA report is only marginally smaller than the 16 percent sample size conducted by the MACPAC staff survey.

The MACPAC staff survey is further qualified in that the evaluation of the eight states was based on "*semi-structured interviews*."[5] It is unclear from the meeting discussion exactly what level of formality was used in the state interviews and why MACPAC staff felt the need to qualify them. Perhaps at this initial stage of conversation with states, MACPAC staff allowed for wide-ranging conversations to provide opportunity for states to raise new issues of concern. It is conceivable that at the time of the semi-structured interviews with MACPAC staff, states had yet to complete formal analysis or develop considered positions on the program. At the very least, the

[1] "An Update on the Medicaid Primary Care Payment Increase," presentation by Ben Finder to MACPAC, pg. 7, (Oct. 30, 2014).
[2] See MACPAC, Public Meeting Transcript, pg. 151 (Oct. 30, 2014).
[3] B. Finder October presentation, slide 8 (emphasis added).
[4] October Meeting Transcript, pg. 155.
[5] Id. at pg. 151 (emphasis added).

implication is that more structured interviews are possible and should be undertaken on a comprehensive basis to generate consistent inputs to inform any ultimate MACPAC recommendation.

c. *Evidence of Provider Participation*

It is unclear how MACPAC staff are assessing or characterizing effectiveness of the program in its limited interviews with the eight states. At one point in the transcript, MACPAC staff offers, "Three of the states reported a modest increase, and three of the states said that anecdotally they believed it helped, but they didn't have the data to support that. Two of the states said that it didn't have any effect."[6] So, of the eight states interviewed, only two states claim that the policy had no effect on provider participation. The results in those two states should arguably not even be considered in the assessment sample because "provider participation in their networks was already high."[7]

In spite of this, the MACPAC meeting presentation characterizes the impact as "*at best*, a modest effect on provider participation according."[8] It is unclear how such a limited survey can justify the characterization, "at best," considering the 46 states for which no data is here offered and the wide variation in baseline payment rates in those states. Rather, of the eight states reviewed, two had participation rates so high as to not be affected by the policy, two reported increases, and two lacked data to support their conclusion of effectiveness. These results would tend to indicate effectiveness in increasing provider participation, but call for a more comprehensive assessment.

Fortunately, at the January 22, 2015 Public Meeting session, there was acknowledgement of the new University of Pennsylvania/Urban Institute study on the effects of the enhanced payments on Medicaid primary care availability released on January 21, 2015.[9] This study, funded by the independent Robert Wood Johnson Foundation, found a 7.7 percent increase in the availability of primary care appointments for Medicaid patients associated with the enhanced payments policy.[10] While the study was released immediately before the January 22, 2015 Public Meeting, we are grateful that it is available in time to inform MACPAC's March Report. The study's results warrant that MACPAC assessment of the effectiveness of the payment policy be stronger than it had been during the October Public Meeting.

d. *Limited Evaluation on Use of Primary Care Services*

As noted, the publicly released October materials indicated that "Most states reported that the provision had no effect on the use of primary care services."[11] In fact, as indicated by MACPAC

[6] Id. at pg. 154-155.
[7] Id. at pg. 155.
[8] B. Finder October presentation, slide 7 (emphasis added); "An Update on the Medicaid Primary Care Payment Increase," presentation by Ben Finder to MACPAC, pg. 4, (Jan. 22, 2015) (emphasis added).
[9] "Appointment Availability after Increases in Medicaid Payments for Primary Care," Polsky, Richards, et. al., New England Journal of Medicine (Jan. 21, 2015).
[10] Id.
[11] B. Finder October presentation, slide 7.

staff, this is the report of six of the only eight states surveyed by MACPAC.[12] Therefore, only 12 percent of states have told MACPAC that the enhanced payment policy had no effect on the use of primary care services.

The October meeting discussion and public material do not indicate how the states arrived at their conclusions and whether the conclusions are anecdotal or based on analysis. MACPAC staff note these state reports lack any adjustment for other factors in the states that may impact utilization.[13] It is not clear if the states considered whether participation or utilization of primary care services would have *decreased* without the payment policy. Further, as the states reported "they didn't have plans to evaluate the primary care payment increase," their conclusions seem to be based solely on anecdotal observation and impression as opposed to analysis.[14]

There seems to be little support for a conclusion that the policy had "no effect on the use of primary care services."[15] Rather, it seems that because CMS did not require an evaluation of the effectiveness of the policy, and the states did not initiate such evaluations, the appropriate conclusion may be to emphasize that the states are not in a position to see an impact on the use of primary care services.

We are pleased that during the January 22, 2015, Public Meeting MACPAC seems to have improved its assessment of the policy's impact on access to services, moving from "no effect on the use of primary care services,"[16] to "research is mixed on whether the primary care payment increase affected access to primary care."[17] However, as evidence of the "mixed" findings, the public materials state "some evidence that providers may not have been aware of the provision, few physicians completing attestation were new to Medicaid."[18] First, the enrollment status of physicians completing attestations would seem to inform an assessment of provider participation as opposed to increasing access to services. Second, if providers were unaware of the enhanced payments, this would indicate that the program was ineffectually implemented in a particular state, which is distinct from an assessment of whether enhanced payments motivate more physicians to participate and take on a greater Medicaid patient load.

IV. Recommending Reauthorization with Assessment and Advertisement

In considering a position on reauthorization of the enhanced primary care payments, we hope that MACPAC will consider stakeholder input and all sources of available data addressing Medicaid primary care access and the impact on beneficiaries of the end of the policy. The Urban Institute estimates the expiration of the payment policy results in an average 42.8 percent

[12] Id.
[13] October Meeting Transcript, pg. 155.
[14] Id. at pg. 157. For example, while MACPAC conducted its informal survey from July to September 2014, states like Maine were still initiating surveys to collect information as of October 23. See "Calling All Independent Primary Care Providers," MaineQualityCounts.org (Oct. 23, 2014), available at http://www.mainequalitycounts.org/articles/46-738/calling-all-independent-primary-care/4.
[15] B. Finder October presentation, slide 7.
[16] Id.
[17] B. Finder January presentation, slide 5.
[18] Id.

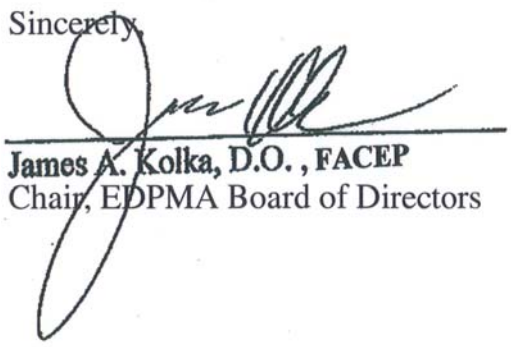
reduction in fees for primary care services.[19] MACPAC should consider the impact this will have in light of a growing Medicaid population and ongoing deficiencies in access to care.[20]

MACPAC certainly faces a challenge in analyzing and commenting on the effectiveness of a policy that was implemented without formal means to assess its effectiveness. Whatever the actual effectiveness of the enhanced primary care payment policy on provider participation and utilization of primary care services, it could have been better. MACPAC has thoroughly documented the implementation challenges that led payments in some states to be delayed until five to ten months following implementation. MACPAC has also documented that provider enrollment was limited by the fact that state outreach and notification "efforts were generally limited to those providers who were *already participating* in Medicaid."[21]

In conclusion, we hope that MACPAC will consider and make clear that the failure of CMS or the states to collect data measuring the effectiveness of a particular policy does not support a conclusion that the policy has been ineffectual. We believe that a need for the enhanced payments still exists to meet the primary care needs of a growing Medicaid population. Reauthorization of the program is an opportunity to continue upon the infrastructure that has been already built by the states and make improvements upon prior errors and deficiencies. We urge MACPAC to recommend that the enhanced payment program be reauthorized with new provisions requiring states to conduct outreach to non-participating providers and to collect data to assess effectiveness.

Thank you for your consideration. We are happy to serve a resource for any questions you may have for providers.

Sincerely,



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Sen. Ron Wyden, Ranking Member, U.S. Senate Finance Committee
Rep. Paul Ryan, Chairman, U.S. House Committee on Ways and Means
Rep. Sander Levin, Ranking Member, U.S. House Committee on Ways and Means

[19] See "Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015?: Evidence from a 2014 Survey of Medicaid Physician Fees," Urban Institute (Dec. 10, 2014).
[20] See "State Standards for Access to Care in Medicaid Managed Care," HHS Office of the Inspector General, OEI-02-11-00320 (Sept. 2014).
[21] October Meeting Transcript, pg. 153.

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