



July 27, 2015

Hon. Sylvia Burwell
Secretary
U.S. Department of Health and Human Services
Attn: CMS-2390-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: 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 (CMS-2390-P)

Dear Secretary Burwell:

On behalf of the American College of Physicians (ACP), I appreciate the opportunity to comment on the Medicaid Managed Care proposed rule. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 143,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The College supports efforts to modernize and streamline Medicaid managed care regulations as the program expands in the wake of the Affordable Care Act. As more states contract with managed care organizations to cover patient populations with complex needs, it is important that the Centers for Medicare and Medicaid Services (CMS) provide strong oversight to ensure that our most vulnerable patients receive the care to which they are entitled. In general, ACP urges the federal government to work with states and other stakeholders so that Medicaid remains the coverage foundation for low-income children, adults, and families; physicians are reimbursed at adequate rates; resources are allocated in a manner that emphasizes team-based, evidence-supported care; and reforms are implemented to reduce administrative burdens encountered by patients and physicians and other health care professionals.ⁱ

ACP supports the proposed rule's aim to align Medicaid managed care with the Medicare program and commercial health insurance plans where applicable and offers the following recommendations:

438.104: Marketing

ACP supports strong regulations on aggressive marketing and promotion of Medicaid managed

care and other plans. College policy recommends that state and federal standards for marketing health benefits plans must ensure that marketing materials not include false or materially misleading information and that sales agents do not partake in abusive enrollment procedures. Rules related to marketing by Medicaid managed care plans should prohibit door-to-door canvassing in low-income areas, marketing at Supplemental Nutrition Assistance Program offices, and offering gifts as incentives to join a plan, among other protections. The College recognizes that the proposed changes intend to clarify that certain Medicaid marketing regulations do not apply to qualified health plans and seek to mitigate care disruptions as enrollees transition to qualified health plans. We urge CMS to maintain the requirements that states closely monitor relevant Medicaid managed care organization (MCO) and other health plan marketing materials to prevent false or misleading claims and unethical sales tactics, whether delivered via social media, email, or other means.

438.400, 438.402, etc.: Appeals and Grievances

The College supports an easily accessible, transparent, and prompt appeals system for MCO and other health plans. Additionally, ACP policy recommends that states establish a statewide grievance system for their Medicaid managed care program for use by enrollees and providers to report instances of fraud and abuse or unreasonable denials of care. The College concurs with language that limits MCO and other plans to a single level of appeal for enrollees. This will ensure that barriers to necessary care are minimized. We also support providing enrollees an opportunity to receive a State Fair Hearing following an adverse benefit determination.

Regarding 438.406(b)(2), ACP policy recommends that regulations mandate that the managed care plan physician ultimately denying medical necessity decisions needs to be licensed in the state in which the patient is being treated and needs to be in a specialty relevant to the medical problem. Additionally, an appeal of the managed care plan physician's decision needs to be heard by the managed care plan Medical Director in a time frame as determined by the urgency of the medical condition.

We support revisions to 438.408 that would require that standard, non-expedited appeals decisions be made within a maximum of 30 days of receipt of appeal as well as the revised timeframe for expedited appeals (i.e., 72 hours after the MCO receives appeals notice).

438.4, 438.5, etc.: Medical Loss Ratio

ACP supports the establishment of a medical loss ratio for MCOs and other plans. This requirement would further align Medicaid managed care plans with Medicare Advantage and commercial plans, promote plan efficiency, enable more accurate rate setting, and promote value and high-quality care.

438.3: Standard Contract Requirements

ACP supports the language in 438.3(a) that directs CMS to review and approve MCO and other

plan contracts on the basis of their value. In the case of risk contracts, all health plans must assume responsibility to assure that financial risk-sharing methods do not lead to compromised patient care, which capitation and other risk-sharing methods may do. The rate-setting process must be robust and follow actuarial guidelines to ensure initial rates are sufficient to minimize the need for future adjustments. The plans need to be open to proposals from physicians to restructure their capitation arrangements to reduce any potential adverse impact on patients. It is not sufficient for health plans to argue that the responsibility for assuring that appropriate care is given falls solely on the physician, when it is the health plan that determines the financial arrangement under which medical care is provided. Further, ACP supports inclusion of paragraph (l), stating that a contract must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

Prior Authorization and Utilization Review Recommendations

ACP asserts that drug utilization review policies should never place physician financial incentives in conflict with patient welfare. ACP guidelines on utilization review and management are provided in the Appendix.

Prior authorization procedures should only be required of practices with a documented history of overuse or inappropriate use of services. Doing so will decrease the administrative burden and cost on practices that provide necessary and efficient care. By targeting outliers, Medicaid can enable physicians to direct more time to patient care rather than paperwork. Further, ACP believes regulations should require MCOs and other health plans or the entities that perform prior authorization review to track and regularly publish, in a form accessible to the public and physicians and of worth to health services researchers, information about the numbers and rates of denials of health care services, rates of denial of payment for services, and of rates of reversal of denials on appeal.

Managed care plans should require prior authorization only for services for a specified procedure if there is clear evidence that: (1) routine use of prior authorization substantially reduces the number of medically unnecessary services; and (2) the costs of conducting the prior authorization—including costs incurred by the physician's office in complying with the prior authorization requirements—do not exceed the potential savings.

State contracts with Medicaid managed care plans should include standards for accountability and management of the health plan and should include review of a health plan's medical necessity standards and prior authorization rules to ensure that the health plan's standards of care are consistent with those in the medical community.

Further, to ensure that services are provided in a timely manner, ACP supports rules that would require MCOs and other plans to review an adverse prior authorization determination upon request of the enrollee, enrollee's family, or enrollee's physician within specified time frames that would allow for a rapid determination of denials for urgent and emergency care. ACP proposes the following time frames:

- For urgent care services, within one hour after the time of the request for such review; and
- For services other than emergency and urgent care, within 24 hours after the time of a request for such review.

The College strongly believes that the optimal solution is not only to make prior authorizations easier to resolve, but also to avoid them whenever possible. The preferred approach, which utilizes technology to bring transparent, accurate, and actionable cost and insurance coverage information to patient and clinician before and at the point-of-care, not only reduces administrative burden but also facilitates informed value-based shared decisions about treatments and testing.

Paragraph (u) proposes to permit federal payments to MCOs and Pre-paid Inpatient Health Plans (PIHPs) for enrollees that are a patient in an institution for mental disease. ACP supports this language and believes that this revision to the program will help broaden access to inpatient facilities for enrollees with short-term needs. ACP recently released a position paper on the integration of behavioral health into the primary care setting.ⁱⁱ Because of the sharp decline in the availability of inpatient psychiatric beds over the last few decades, prisons, jails, and emergency departments have become the de facto inpatient behavioral health setting for vulnerable patients. This provision is a promising step to improve necessary access and help achieve true mental health parity.

438.4: Actuarial Soundness; 438.5: Rate Development Standards; 438.6: Special Contract Provisions Related to Payment

ACP believes that risk adjustment should be used to ensure that vulnerable patients, including those with multiple chronic diseases, are able to maintain a regular source of care from the physician they trust. To help achieve this, payments to managed care plans should not create incentives for plans to discriminate against patients with complex illnesses and capitation payments to providers should reflect the risk level of the patient population. College policy recommends that capitated payments should be actuarially based on analysis of utilization and enrollment expectations of the covered population. ACP concurs with the proposed language that capitation payments should be sufficient to cover reasonable, appropriate, and attainable costs in providing services to Medicaid enrollees and be adequate to meet network adequacy, availability of services, and coordination and continuity of care requirements. Health plans should modify the methods they use to determine capitation payments to include several factors, in addition to age and gender, that can predict use of medical care resources. ACP recommends that health plans incorporate measures of health status and prior-year utilization and be required to provide necessary documentation to support their evidence that rates comply with Medicaid stipulations.

We encourage CMS to work with states to certify that MCO and other plans' capitation rates are sufficient to meet these requirements and direct plans to amend their rates if they prove to have a negative effect on enrollee access, provider participation, etc. It is important that CMS and state regulators closely evaluate the MCO and other plans' rates to ensure that they are actuarially

sound. A 2010 GAO report found serious gaps in CMS's efforts to review rates in Tennessee, Nebraska and other states.ⁱⁱⁱ The agency must require states to use up-to-date, relevant, and appropriate data so that rates are accurate and sufficient.

With regards to team-based care models, payment systems that require the clinical care team to accept financial risk must account for differences in the risk and complexity of the patient population being treated, including adequate risk adjustment.

The College agrees with the intent of paragraph 438.6(c) that would allow states to require MCOs and other programs to implement value-based purchasing models for provider reimbursement. ACP supports efforts to tie physician payment to performance assessment if the intent is to achieve improved patient health and encourages systems-based reform. ACP believes that performance assessment-based payment efforts should:

- Be integrated into innovative delivery system reforms such as the patient-centered medical home and other payment reform efforts that promote systems-based collaboration and health care delivery;
- Demonstrate improved quality patient care that is safer and more effective as the result of program implementation;
- Support an environment where all physicians—in both primary care and specialty practices—are supported in their efforts to perform better, continually raising the bar on quality;
- Develop, or link closely to, technical assistance efforts and learning collaboratives so that physicians and other health professionals are motivated and helped to improve their performance;
- Engage physicians in all aspects of program development including determination of standard measure sets, attribution methods, and incentive formulas; and
- Reflect national priorities for strengthened preventive health care, quality improvement, quality measurement, and reducing health disparities.

Further, the reward framework should be incorporated into systems-based payment reforms designed to permit and facilitate broad-scale positive behavior change and achievement of performance goals within targeted time periods.

ACP strongly supports the Patient-Centered Medical Home (PCMH) model, a team-based model that emphasizes care coordination, a strong physician-patient relationship, and preventive care. According to the National Academy for State Health Policy, 46 states have worked to advance medical homes in their Medicaid or CHIP programs.^{iv} Wider implementation of the PCMH model may encourage delivery of care based on value rather than volume and improved patient experience as well as achieve other important goals such as the integration of behavioral health into the primary care setting.

The College appreciates proposed paragraph (c)(iii), which would allow states to continue vital and effective payment incentives including continuation of Medicaid-Medicare pay parity for primary care services under section 1202 of the Affordable Care Act. Early evidence shows that the primary

care pay parity program was having its intended impact prior to its expiration. A study released in January 2015 found that appointment availability for Medicaid-participating primary care clinicians increased by 7.7 percent during the period that pay parity was in effect, demonstrating that higher reimbursements are related to improved access for Medicaid patients.^v

ACP supports the safeguards described in paragraph (c)(2), including written assurances that the quality improvement program is based on utilization and delivery of high-quality services and prohibitions on automatic renewal to ensure proper evaluation and oversight. The College also believes programs will operate more efficiently and reduce administrative burdens by using a common set of performance measures across all of the payers and providers, as described in (c)(2)(ii)(B).

438.600, 438.602, etc. Program Integrity/State Responsibilities

ACP agrees with the spirit of 438.602(b), which would require the state to screen, enroll, and revalidate MCO and other plan-participating providers. This process may help to maintain the integrity of the Medicaid program and ensure that negligent providers are removed from the system. However, we are concerned that allowing MCOs and other programs to conduct an additional layer of screening would place an unnecessary administrative burden on providers. We suggest that if this is implemented, it be limited only to “high-risk” providers. This process should be streamlined to ensure maximum compliance and limited administrative burden, such as through an electronic database with prepopulated form, and limited only to those providers that give cause to concern for fraud and abuse or inappropriate care. We urge that the final rule codify language that establishes protections for physicians and other health care professionals that treat high-risk populations or specialize in high-cost, medically necessary treatments so they are not unjustifiably targeted by MCOs and other plans for treating vulnerable patients.

438.54: Managed Care Enrollment

Patients must have a choice of health plans and the opportunity to voluntarily choose plans that best meet their health needs. The College believes that automatic enrollment policies that force patients into an MCO or other arrangement with which they are unfamiliar are not ideal and threaten patient choice and the patient-provider relationship. To avoid confusion on the part of recipients and providers created by automatic enrollment policies, states should be required to notify enrollees concerning any health plans to which they may be assigned and the need to use a health plan’s network of providers. ACP believes that enrollees should be given at least 60 days to enroll in a different plan without cause during a plan year. Policies should be constructed with the goal of educating enrollees and providers of expectations and ensuring seamless continuity of care during any transition.

438.62, 438.208: Continued Services to Beneficiaries and Coordination and Continuity of Care

We strongly urge CMS to include in the final rule a requirement for states to ensure MCOs and other plans establish care transition policies to provide for uninterrupted service for enrollees such

as for when a contract is terminated or an enrollee switches plans. ACP agrees that such policies need to be expanded beyond circumstances related to rural-area managed care organizations. To facilitate care transition, the final rule may provide clinically integrated information systems to improve communication between providers during patient handoffs and allow temporary in-network coverage of the patient's previous provider during the transitional period.

Regarding 438.208, the College strongly believes that MCOs and other plans should establish protocols that enable and encourage enrollees' primary care physicians, specialists, and other health care professionals to work together in a team-based care model across settings. The College has developed a High-Value Care Coordination Toolkit to provide resources to facilitate more effective and patient-centered communication between primary care and subspecialist physicians.^{vi} ACP agrees that a patient should have access to the provider who can best furnish necessary services. However, we urge the final rule to underscore the importance that all Medicaid enrollees have access to a regular source of primary care in addition to other types of care. In the event of a contract termination between a physician and MCO or other model plan, we believe it is important that enrollees have sufficient time to transition to another primary care provider. We urge that the final rule require that Medicaid enrollees be quickly informed of their primary care physician's contract termination and any assistance available to help the enrollee find another primary care physician.

Additionally, the maturity of a health IT standard is unrelated to its value or usefulness in delivering care. Before considering a health IT standard for inclusion in rulemaking or guidance, CMS must determine that there is at least one documented use case where the standard has proven its value in enhancing care delivery.

438.10: Information Requirements

Since many enrollees may not be familiar with health insurance and managed care concepts, it is important that the final rule require that MCOs, other model plans, brokers, and other relevant parties provide clear, understandable, and accessible plan information. College policy recommends that states conduct appropriate education and outreach programs to their Medicaid populations to familiarize them with the rules of managed care. Information should be provided in a manner that is accessible and understandable to those with disabilities and limited English proficiency. Medicaid MCOs and other model plans should be required to make patients aware of formulary utilization and any cost sharing requirements. Patient information should describe how a formulary functions and how cost sharing may affect the pharmacy benefit. Enrollees should be clearly informed in advance of any restrictions on their access to specialists that may result from their choice of alternative delivery systems and have clear explanations of prior authorization mandates. We further recommend that CMS require that utilization review criteria be disclosed to patients.

MCOs and other plans should be required to maintain accurate provider directories and update directories on at least a monthly basis. A June 2015 report from the California State Auditor^{vii} found that the three Medi-Cal managed care plans studied had inaccurate provider directories and

included listings for inactive providers, incorrect contact information, and other mistakes. The report noted, “when errors occur in the providers’ directories, Medi-Cal beneficiaries could experience delays in their access to care.” Similarly, an HHS Office of Inspector General report found that 51 percent of providers listed in directories were not participating at the listed location or not accepting enrolled patients. This information must be accurate if maximum distance standards and other measures are going to be used to determine network adequacy and whether enrollees can access needed care. ACP supports the requirement that provider directories be updated at least monthly and that electronic provider directories be updated within 3 days of receipt of updated provider information.

ACP also supports language in 438.10(g) that would require the MCO and other plans to ensure that all enrollees receive written information about the appeals and grievance procedures at the time of enrollment. ACP recommends that CMS and state regulators closely monitor plan information and impose sanctions on MCOs and other plans that fail to abide by this section.

438.68, 438.206, 438.207: Requirements for the Network Adequacy Standards Set by the State for a Specified Set of Providers

ACP appreciates the proposed rule’s attention to robust provider network adequacy rules to ensure that Medicaid enrollees are able to access their preferred physician in a timely manner. As more states elect to expand their Medicaid programs to childless adults, it is essential that MCOs and other models are required to include an adequate range of high-quality primary care physicians and specialists in plan networks. ACP appreciates that the proposed rule would require states to apply travel time and distance standards for primary care providers and other provider categories. We encourage CMS to codify this language in the final rule and emphasize that enrollees should have access to a regular source of care preferably delivered through a patient-centered medical home. The College also recommends that the final rule include standards to ensure that Medicaid enrollees are able to access high-quality specialists and subspecialists. ACP policy recommends that access could be improved by permitting internal medicine subspecialists to participate with managed care plans as primary care physicians, principal care physicians, and/or consultants based on their preference if they meet the requisite credentialing criteria for each role.

The College believes CMS should consider additional network adequacy criteria such as provider-to-patient ratios, maximum appointment wait times, and provider capacity and availability that will help provide a more accurate evaluation of provider access. The final rule should allow states to use additional network adequacy measures. ACP also supports language in paragraph 438.68(c) that would require particular attention be given to addressing access to care in geographically underserved areas and among medically underserved populations including racial and ethnic minorities and those with limited English proficiency. The College also agrees with the inclusion of network adequacy standards that consider the care needs of chronically ill patients. Further, MCOs and other models should be required to disclose their network development criteria in a manner that is readily accessible to patients, physicians and other health care providers, and other stakeholders.

Regarding the related network adequacy language in 438.206, ACP appreciates the inclusion of language requiring that patients be given the opportunity to seek a second opinion from a qualified health professional if needed as well as language requiring maintenance and monitoring of networks to provide all services for all enrollees including those with limited English proficiency or physical and mental disabilities. The College supports and encourages the concept of internists being considered as one of the consultants in any second opinion program, whether medical or surgical. ACP also supports language in paragraph (b) providing that if a patient is unable to access medically necessary services from a network physician or other health care professional, the service be made available to the patient through an out-of-network provider. Additionally, the College strongly believes that all patients, regardless of race, ethnic origin, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion, deserve high-quality health care and concurs with paragraph (c)(2), ensuring that MCOs and other plans participate in programs to deliver culturally competent services to enrollees.

CMS should collaborate with states to provide ongoing monitoring, oversight, and enforcement to ensure timely access to services and providers. The College recommends that if CMS and states are to rely on health plan attestations and documentation (i.e., under 438.207) to evaluate network adequacy and access to services, it is imperative that regulators verify the accuracy of information submitted by health plans. ACP recommends that states conduct audits, conduct consumer complaint tracking, and collect use-of-out-of-network provider information and other activities to determine if a plan's network is adequate. Evaluations should be conducted in a manner that is not administratively burdensome to physicians and other health care professionals. If it is determined that an MCO or other model plan does not have adequate network capacity to assure reasonable access to benefits and services under the contract, the health plan should be required to take corrective action, address the deficiency, and ensure timely access to necessary services.

While ACP recognizes that some states permit exceptions to network adequacy standards, we strongly encourage close oversight and monitoring of network changes to ensure they do not negatively affect patient access to care.

Subpart E: Quality Measurement and Improvement; External Quality Review

ACP supports the intent of the proposed quality of care language. College policy provides general guidance toward ensuring managed care organizations deliver high-quality, high-value care to patients and achieve contract goals in a fiscally responsible manner. Managed care plans should be required to:

- Establish mechanisms to incorporate the recommendations, suggestions, and views of enrollees and participating physicians and providers that improve quality of care into:
 - Medical policies of the plan (such as policies relating to coverage of new technologies, treatments, and procedures);
 - Quality and credentialing criteria of the plan; and
 - Medical management procedures of the plan.

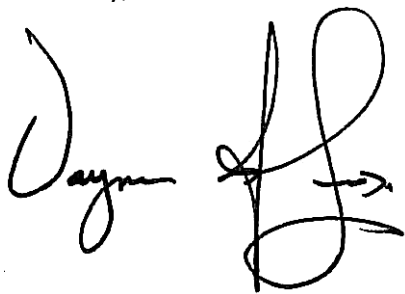
- Monitor and evaluate high-volume and high-risk services and the care of acute and chronic conditions.
- Evaluate the continuity and coordination of care that enrollees receive.
- Have mechanisms to detect both underutilization and overutilization of services.
- Use systematic data collection of performance and patient results, provide interpretation of these data to their practitioners, and make needed changes.
- Make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate).

Conclusion

Medicaid is the largest single source of health coverage and the program continues to grow as more states choose to expand eligibility under the Affordable Care Act. Managed care's reach is also growing and is delivering services to more vulnerable populations. While managed care can encourage coordination among providers and may tamp down inefficiencies, it is extremely important that states and CMS provide strong oversight to ensure that Medicaid enrollees receive the care they need from the providers they trust. The evidence shows that gaps in oversight can lead to gaps in care and compromised patient health. ACP urges strong requirements on network adequacy, administrative efficiencies, comprehensive benefits, accessible enrollee education and information, and consistent and constant quality improvement to ensure that patients are able to receive the care they need from the physicians they prefer.

The College appreciates the opportunity to provide comments on the Agency's proposed changes to the Medicaid managed care policies. Please contact ACP's Ryan Crowley at rcrowley@acponline.org or (202) 261-4521 if you have any questions or need anything further.

Sincerely,

A handwritten signature in black ink, appearing to read "Wayne J. Riley". The signature is fluid and cursive, with a large initial "W" and "R".

Wayne J. Riley, MD, MPH, MBA, MACP
President
American College of Physicians

Appendix: Utilization Review/Utilization Management Guidelines

1. Physicians' adherence to evidence-based, scientifically supported practice guidelines should result in payment without excessive demands for documentation and without filing appeals. If the patient care does not comply with these guidelines, the physician should provide information to justify the claim.
2. Utilization review (UR) appeals should provide physicians with due process including the right to review the material used to make the claims denial with the actual personnel responsible for the review.
3. Managed care plans should reveal UR criteria—such as computer algorithms, screening criteria, and weighting elements—to physicians and their patients upon request.
4. Managed care plans should require preauthorization only for services for a specified procedure if there is clear evidence that: (1) routine use of preauthorization substantially reduces the number of medically unnecessary services; and (2) the costs of conducting the preauthorization—including costs incurred by the physician's office in complying with the preauthorization requirements—do not exceed the potential savings.
5. Managed care plans should require that UR/Utilization management (UM) personnel and processes focus on medical procedures that have a consistent pattern of overutilization, pose significant medical or financial risk to the patient, or for which there are no clear medical indications for use.
6. Managed care plans should apply uniformly the UR/UM criteria established or endorsed by a UR/UM organization or the medical community based on sound scientific principles and the most recent medical evidence
7. Managed care plans should ensure that the UR/UM process is educational. Instead of punishing physicians or preventing appropriate care, the process should alert physicians to practices that may not be cost-effective and efficient. UR/UM should encourage physicians to examine methods for altering practices and procedures while viewing high quality patient care as their priority.
8. Managed care plans should not exclude physicians who have served as patient advocates in appealing UR/UM decisions.
9. Managed care plans should not initiate UR/UM contracts intended to deny medically necessary services.
10. Managed care plans should not base the compensation of individuals who conduct UR/UM on the number or monetary value of care denials.
11. Managed care plans should accept a prudent layperson's assessment of an emergency condition in determining when to pay for initial screening and stabilization in the emergency room. Managed care plans should base the determination on what the patient knows at the time of seeking the emergency care, rather than on what the emergency department visit reveals.

12. With input from practicing physicians, the managed care plan industry should standardize utilization review authorization processes.
13. All insurers requiring pre-approval for the provision of medical services (diagnostic and/or therapeutic) must provide an approval mechanism 24 hours a day, and a physician must be available on-call 24 hours a day to review and adjudicate any denials. All insurers rejecting the provision of medical services (diagnostic and/or therapeutic) must provide the specific reason for said action at the time of rejection).

ⁱ American College of Physicians. Medicaid and Health Care Reform. Philadelphia: American College of Physicians; 2011: Policy Paper. Accessed at http://www.acponline.org/acp_policy/policies/medicaid_healthcare_reform_2011.pdf on July 20, 2015.

ⁱⁱ Crowley RA and Kirschner N. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. *Ann Intern Med.* 2015. doi:10.7326/M15-0510 Accessed at <http://annals.org/article.aspx?articleid=2362310#r4-0510> on July 20, 2015.

ⁱⁱⁱ U.S. Government Accountability Office. Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement. August 2010. Accessed at <http://www.gao.gov/new.items/d10810.pdf> on July 20, 2015.

^{iv} NASHP Staff. Medical Homes & Patient-Centered Care. National Academy for State Health Policy. January 12, 2015. Accessed at <http://www.nashp.org/medical-homes-map/> on July 20, 2015.

^v Polsky D, Richards M, Basseyn, Wissoker D, Kenney GM, Zuckerman S, Rhodes KV. Appointment Availability after Increases in Medicaid Payments for Primary Care. *N Engl J Med.* 2015; 372:537-545. Accessed at <http://www.nejm.org/doi/full/10.1056/NEJMsa1413299> on July 20, 2015.

^{vi} American College of Physicians. High Value Care Coordination (HVCC) Toolkit. Accessed at https://hvc.acponline.org/physres_care_coordination.html on July 20, 2015.

^{vii} California State Auditor. California Department of Health Care Services: Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care. Report 2014-134. Accessed at <https://www.auditor.ca.gov/pdfs/reports/2014-134.pdf> on July 20, 2015.