May 22, 2018

VIA ELECTRONIC SUBMISSION

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2406-P; Proposed Rule: Methods for Assuring Access to Covered Medicaid Services-Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold

Dear Administrator Verma:

On behalf of the more than 560,000 physicians and medical students represented by the combined memberships of the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Osteopathic Association, and the American Psychiatric Association, we write to submit comments on the proposed rule referenced above. We read the proposed rule with great interest, as it will have far-reaching effects on patients who are enrolled in Medicaid FFS.

We believe the proposed rule would greatly reduce transparency regarding access in Medicaid fee-for-service (FFS), which continues to serve some of the most vulnerable populations in the Medicaid program. Additionally, the rule would erode the federal government's responsibility to ensure equal access in the Medicaid program, which could make it easier for states to cut provider payment rates in FFS. We are concerned that this will lead to less physician participation in the program as Medicaid already pays chronically low fees (recent surveys show Medicaid pays, on average, at 72 percent of Medicare rates).[1] Further cuts enabled by the proposed rule could leave our patients, particularly those with serious, chronic, or complex medical needs, with reduced access to the care they need. We urge CMS to withdraw the proposed rule, and to instead work with us to strengthen access monitoring and ensure adequate payment rates. Our specific comments are below.

The Proposed Rule Relinquishes the Federal Government's Responsibility to Monitor Equal Access

The Supreme Court's 2015 decision in *Armstrong v. Exceptional Child Center, Inc.* held that Medicaid providers do not have a cause of action to challenge a state's Medicaid payment rates. As such, the Supreme Court resolved it is the responsibility of the federal government to enforce the equal access provision found in 42 U.S.C. §1396a(a)(30)(A), which requires that state Medicaid provider payments be "sufficient to enlist enough providers so that care and services are available …at least to the extent that such care and services are available to the general population in the geographic area."

CMS developed regulations to enforce this provision, effective April 2016, that require states to develop and submit to CMS an Access Monitoring Review Plan (AMRP) that specifies the data elements the state will use in assessing beneficiary access to care in a Medicaid fee-for-service delivery system. The recently released proposed rule diminishes the federal government's responsibility to monitor access to care for patients enrolled in Medicaid. As such, we cannot support its implementation.

[1] https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

If the proposed rule were to be finalized, CMS would have less information to determine whether a state complies with the statutory equal access requirement. The same would be true for agencies and program stakeholders at the state level, who rely on data to assess whether patients enrolled in Medicaid have adequate access to the care they need. Additionally, the initial AMRPs were submitted to CMS on October 1, 2016, meaning that the current structure used to monitor and enforce the equal access provision has been functioning for just over 18 months. Deviating from this reporting process so early into its implementation is in direct contradiction to the evaluation framework. Stakeholders, like states, the federal government, providers, and patients, need more information to evaluate whether there is acceptable access in the Medicaid program, not less.

Exemption for States with High Managed Care Enrollment

The current regulations specify that states' AMRPs must include specific access reviews for primary care, physician specialist services, behavioral health services, pre- and post-natal obstetric services including labor and delivery, and home health services, all services essential to our patients. All states were required to submit these plans by October 2016 and update them every three years, regardless of the makeup of the state's Medicaid delivery system. Although the comprehensiveness of the initial state plans varies, many plans include data on beneficiary need, provider availability, use of care, and geographic-specific comparative payment information. While the comprehensiveness of the initial state plans varies, there are some exemplary plans among the high managed care states that could be used as examples for future guidance to states to comply with current requirements, such as the plans submitted by Nebraska and the District of Columbia.

The proposed rule amends § 447.203(b) to establish a comprehensive, risk-based managed care enrollment rate threshold. States above the threshold would be exempt from meeting the requirements of § 447.203(b)(1) through (6), including data requirements, comparative rate reviews, and mandatory beneficiary and provider input. Specifically, states with a managed care enrollment rate of 85 percent or greater would not be required to develop an AMRP, conduct an access analysis, or add services to the AMRP when reducing or restructuring provider payment rates. While CMS proposes that these exempt states submit an alternative analysis with supporting data to comply with the regulatory requirement, we are concerned that these alternative mechanisms could lead to less robust oversight that is insufficient, obscuring the state's responsibility to monitor access to care.

We believe that there is no substantive justification for the proposed 85 percent threshold in the proposed rule and request that CMS provide data and analysis to justify this seemingly arbitrary rate, which exempts at least 18 states from the requirement to develop and submit an AMRP.[2] The total Medicaid FFS enrollment these 18 states is about 4 million, including more than half a million children. The result would be far less transparency into the accessibility of services for our patients who are not enrolled in Managed Care Organizations (MCO) in these states. As providers, we know firsthand that beneficiaries remaining in Medicaid FFS are often more likely to be members of vulnerable populations, such as those who are dually eligible, Native Americans, and individuals with intellectual disabilities or rare diseases. Access to care for these individuals is critical to optimal health status but can also be more challenging given the special needs of these populations. Further, many states also carve services out of managed care contracts, so that even individuals enrolled in MCOs may access services through fee-for-service, such as prescription drugs, mental health, and long-term services and supports. Any rollback of reporting requirements could undermine access to these services for beneficiaries who receive care through both FFS and MCOs.

[2] https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Population%22,%22sort%22:%22desc%22%7D

It is important to note that while the NPRM specifically addresses access monitoring and exemption for payment rate changes in Medicaid FFS delivery systems, this rule has implications for Medicaid Managed Care. Under a circumstance where states and MCOs utilize FFS payments as a benchmark for their own payments, this proposed rule could justify similar cuts to MCO provider rates. Specifically, lower FFS rates could support lower actuarially sound capitation payments to MCOs, and lower FFS rates could enable MCOs to lower their network provider payment rates correspondingly. The resulting impact will be felt not just by states that qualify for exemption under the arbitrary 85 percent threshold in the proposed rule, but by all states. Furthermore, if CMS chooses to amend the 2016 Managed Care rules in a similar way to this proposed rule, the consequences for beneficiary access to care could be even more problematic.

Exemption for Payment Rate Changes

Under the current regulations, before proposing to reduce or restructure Medicaid service payment rates, states are required to submit to CMS an analysis of the effect of the change in payment rates on access, in addition to a specific analysis of the concerns expressed in input from affected stakeholders. The NPRM proposes to amend §§ 447.203(b)(6) and 447.204 to set a threshold for "nominal" payment rate changes that are below 4 percent for a Medicaid service category in total within a single State Fiscal Year (SFY). Additionally, since states may make rate changes in consecutive years, CMS proposes to limit the exemption threshold to a 6 percent reduction in spending for a Medicaid service category over 2 consecutive SFYs. Under the proposed rule, any state making a "nominal" payment cut would be exempt from meeting the requirement to submit an impact analysis on access to care.

States often set payment rates for Medicaid services at significantly lower amounts than Medicare. Especially when considering rising medical costs and adjusting for inflation, a 4 percent payment cut should not be considered nominal. Furthermore, the accumulating effect of yearly cuts to provider payments, which could still meet the exemption requirements of the proposed rule, would be detrimental to access for beneficiaries in the Medicaid program and could harm our members' ability to sufficiently provide these essential services. Moreover, as shown in some of the more comprehensive AMRPs submitted in October of 2016, all states have different payment rates for each procedure code. Because the baseline is variable, setting a threshold of a 4 percent payment cut (or 6 percent over two years) is arbitrary and will likely not guarantee access equivalent to that for individuals in the general population.

In addition, because we interpret service categories to include multiple kinds of services (for example, 1905(a)(4) of the Social Security Act includes nursing facility services, EPSDT, family planning services and supplies, and tobacco cessation counseling and pharmacotherapy for pregnant women), a rate cut to any of these individual services of a magnitude higher than 4 percent or 6 percent may not violate the exemption included in the proposed rule, leading to even deeper cuts than perhaps envisioned by the proposal. Multiple data sources show that payment is the primary driver in determining physician participation in the Medicaid program, and the proposed rule could lead to increasingly insufficient Medicaid payment rates, seriously jeopardizing patients' ability to access health services.

Additionally, when submitting such "nominal" payment rate reductions, the proposed rule would no longer require states to undertake a public process that solicits input on the potential impact of the proposed rate reductions. This process is key to understanding access in the Medicaid program. Importantly, the current regulations include safeguards that encourage providers, beneficiaries, and other stakeholders to provide input regarding any significant proposed change in methods and standards for setting payment rates for services. The current regulations also mandate states, in addition to the 5 services categories included in their AMRPs, to monitor additional services for which the state or CMS

has received a significantly higher than usual call volume of access complaints from beneficiaries, providers, or other stakeholders.[3]

Together, these safeguards give physicians and patients an outlet to participate in the access monitoring process. Removing the requirement to undertake a public process would deny providers the right to comment on state rate reviews or payment rate adjustments. In addition to removing the patient and provider voice from the decision-making process, such a change could eliminate essential qualitative data and testimonials from providers and beneficiaries that inform which services need to be monitored.

Our members are the foundation of the U.S. health system and include the front-line physicians who care for families, adults, adolescents, women, and children in rural, urban, wealthy, and low-income communities. Our groups are unified in urging CMS to withdraw the proposed rule, and to instead strengthen the current access monitoring regulations.

Sincerely,

American Academy of Family Physicians
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American College of Physicians
American Osteopathic Association
American Psychiatric Association

[3] https://www.macpac.gov/wp-content/uploads/2017/03/Monitoring-Access-to-Care-in-Medicaid.pdf