AMA AMERICAN MEDICAL ASSOCIATION

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September 12, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services–Rescission (CMS-2406-P2)

Dear Administrator Verma:

On behalf of the American Medical Association (AMA) and our physician and medical student members, thank you for the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with comments and recommendations in response to the Proposed Rule with Comment Period, Methods for Assuring Access to Covered Medicaid Services (the "Proposed Rule").

The regulations that CMS proposes to rescind were promulgated to implement the equal access mandate in section 1902(a)(30)(A) of the Social Security Act, which requires states to ensure 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. When enacting the equal access provision, Congress recognized that, "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program."[1] While physicians have a strong sense of responsibility to provide care for Medicaid beneficiaries, physician practices cannot remain economically viable if they lose money on the care they provide. Without an adequate supply of participating physicians, Medicaid patients may have coverage but not real access to care. Too often beneficiaries must wait for unreasonable periods of time to receive needed care, travel long distances to find Medicaid participating physicians, or go without care altogether. Lack of access to participating physicians puts beneficiaries at risk of harm or even death and is contrary to the intent of Congress and the overriding purpose of the Medicaid Act. Despite the Congressional mandate, Medicaid reimbursement rates lag behind private insurance and Medicare, participating physicians remain sparse in many areas of the country, and access to health care services remains unequal.

The AMA was encouraged when CMS issued the Final Rule with Comment Period: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services ("Access Rule") in 2015. At the time, the AMA praised the Access Rule but cautioned that the modest protections it afforded did not go far enough. Though the Access Rule was not perfect, repealing it in its entirety is not the solution. We fear that

[1] H.R. Rep. No. 101–247 at 390 (1989)

rescinding CMS's administrative oversight of state fee-for-service (FFS) systems will worsen disparities in access to care that too many vulnerable beneficiaries already experience.

Rescission of the Access Rule would eliminate the only standardized, evidence-based methodology to prospectively review and retrospectively monitor potentially injurious payment policies and return instead to a regulatory framework that is entirely state-driven. Yet, history has demonstrated that states cannot meet the standards set by the equal access mandate without oversight. Because Medicaid accounts for an increasingly large portion of state budgets, states often cut physician rates for purely budgetary reasons and without consideration for the impact payment rates have on beneficiaries' ability to obtain health care services. And, as many managed care rates are based on FFS rates, a rate cut in FFS is often effectively an across-the-board rate cut regardless of the delivery model. Yet, as the petitioner in *Armstrong v. Exceptional Child Center Inc.*, 135 S. Ct. 1378 (2015) and director of the Idaho Department of Health and Welfare expressed, the equal access mandate "does not obligate the State to do *anything*."[2] (emphasis in original). Though both beneficiaries and physicians alike frequently appeal to state policymakers to address unequal access caused by low Medicaid reimbursement, we continually see payment rates cut even while the number of Medicaid beneficiaries increases and demand for services soars. While state-level engagement is crucial, it cannot be the only way to ensure the federal protection guaranteed by Section 1902(a)(30)(A) is properly granted. Though the preamble to the Proposed Rule promises to publish subregulatory guidance to states, we do not think that guidance to "remind" states of their ongoing obligation is sufficient to enforce a federal protection that is so determinative of the health of low-income patients.

Instead of rescission we urge CMS to improve upon the Access Rule. While we agree with CMS that siloing access standards creates an uneven regulatory framework and we are sympathetic to the administrative burden on states that accompanies development of Access Monitoring Review Plans (AMRPs), we think that the review and monitoring process created by the Access Rule – including evidence-based methodology, stakeholder and public comment periods, and data-driven evidence requirements – is of great value and ought to be expanded. If states find the administrative resources necessary to produce AMRPs incongruent with the small population covered by FFS, then they would benefit from economies of scale that would be created by expanding AMRPs to analyze access for all Medicaid populations, not just those covered by FFS. As the AMA commented in 2016, the equal access mandate should apply equally to all Medicaid patients, regardless of the delivery model through which they receive care.

Accordingly, as we urged in 2016, AMRPs should monitor access for beneficiaries enrolled in managed care and other delivery models, in addition to FFS. Access issues span Medicaid delivery systems and beneficiaries would benefit from consistent standards against which access can be measured regardless of whether care is provided on an FFS basis, through a managed care plan, or under a waiver program.

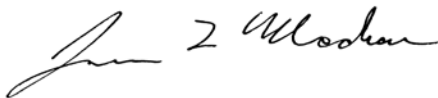
Finally, we cannot consider the Proposed Rule without taking into account the procedural history that led to the promulgation of the Access Rule in 2015. At the heart of the Access Rule was CMS' recognition that the agency must do more to ensure adequate access to care after the Supreme Court's ruling in *Armstrong v. Exceptional Child Center Inc*. In that case, the Supreme Court held that the equal access mandate does not create a private right of action for providers to challenge Medicaid payment rates and halted private enforcement in the courts. Instead, the Court said that enforcement falls exclusively to

[2] Brief for Petitioners at 52 *Armstrong v. Exceptional Child Center Inc.*, 135 S. Ct. 1378 (2015) (No. 14-15).

CMS. That is why, in addition to strong prospective federal oversight of payment changes, we continue to urge CMS to create an administrative pathway for providers to challenge payment rates directly to CMS. Prior to the Supreme Court's ruling in *Exceptional Child*, recognizing that state reductions to reimbursement rates substantially hinder access to care, Medicaid providers relied on private lawsuits to remedy states' non-compliance with the equal access mandate. Those private actions succeeded in bridging the access gap. Private enforcement spurred improvement in states, including increased reimbursement rates, greater provider participation, and ultimately improved access to care. Undoubtedly, private enforcement saved lives and improved the health of those who need it most, including low income children and people with disabilities. Absent provider-initiated challenges, the promise of equal access goes unfulfilled and it is, therefore, incumbent upon CMS to revive this important enforcement tool. Without federal judicial review, it is essential for physicians and other providers to have a means to alert administrative authorities to violations of the equal access mandate, and we urge CMS to create a process for providers to bring complaints directly to the administration in addition to robust, prospective federal oversight of state activities.

The AMA appreciates the opportunity to provide our comments on the Proposed Rule. The Access Rule is vitally important as Medicaid programs grow and account for increasingly large portions of state budgets. To effectuate the core purpose of the Medicaid Act and improve the quality of care while reducing health care costs, state Medicaid programs must remain viable and build their physician capacity. For this reason, it is critically important that CMS strengthen the Access Rule, not rescind it, to ensure state compliance with the equal access mandate. Please contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409 with any questions.

Sincerely,



James L. Madara, MD