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July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445–G 200
Independence Avenue, SW
Washington, DC 20201

Re: Medicaid Program; Ensuring Access to Medicaid Services [CMS-2442-P]

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments in response to the Centers for Medicare & Medicaid Services (CMS) Proposed Rule on Ensuring Access to Medicaid Services [CMS-2442-P].

The AMA believes that health care is a basic human right and providing health care services is an ethical obligation of a civil society. Advancing health equity and access are major priorities of the AMA because it is both the right thing to do and fiscally sound policy. We know that access to health coverage improves population health, reducing downstream costs. We remain committed to advocating for expanded health insurance coverage for all and amplifying the voices of individuals from historically marginalized and minoritized communities.

When we talk about expanding Medicaid access, we are talking about improving the health of some of our nation's most historically marginalized and minoritized communities. As the rule notes, in addition to serving as America's single largest payer covering more than 85 million Americans, Medicaid also pays for 42 percent of all U.S. births and serves as the single largest payer of Long-Term Services & Supports, Substance Use Disorder Treatment (SUD), and human immunodeficiency virus (HIV) treatment and prevention services.

Overall, the AMA is strongly supportive of the policies in this rule and would like to express its thanks to CMS for the groundbreaking nature of several of the proposals, many of which are in direct response to past feedback from the AMA. These policies aim to increase pricing transparency, standardize pricing and quality information to facilitate comparisons, and ensure future policies are informed by those with direct experience with the program. Taken together, we are hopeful these proposals will accomplish the laudable goal of expanding access to critical health care services for millions of Medicaid beneficiaries. We also welcome the complementary policies advanced in CMS' accompanying managed care rule, which we have commented on separately here.

We appreciate that CMS recognizes in the rule the unique challenges that state Medicaid agencies are facing at this particular moment, not the least of which is resuming enrollment verifications following the expiration of the continuous enrollment provision on March 31, 2023. We appreciate that many of the proposed policies have a multi-year implementation plan to allow states time to adapt to changes. In the comments that follow, we include several items for consideration and constructive recommendations

intended to further mitigate potential adverse consequences or otherwise improve the proposals informed by the collective knowledge and experience of the nation's physicians who treat these populations.

Below we summarize several key recommendations, which we expand on in the letter.

- Finalize proposals to enhance payment rate transparency by posting fee-for-service (FFS) Medicaid rates and Medicaid-Medicare rate comparisons for certain core service lines to a public facing website and include specialty services.
- Finalize proposals to disaggregate payment rate data by key subpopulations to derive additional data insights and advance equitable access.
- Work towards establishing a Medicaid payment floor at a minimum of 100 percent of Medicare rates.
- Standardize processes for medical care advisory committees (MCACs) to facilitate more robust and consistent public input in Medicaid policy development across states while ensuring the physician perspective continues to be represented.
- Create an administrative pathway for providers to challenge payment rates directly to CMS.

I. Payment Rate Transparency Provisions

We commend CMS for recognizing the impact that payment rates have on access to care. 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. Yet in enacting the equal access provision in section 1902(a)(30)(A) of the Social Security Act, Congress recognized that, "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program." Despite the Congressional mandate, Medicaid reimbursement rates vary widely across states and consistently lag behind private insurance and Medicare. Medicaid pays 30 percent below Medicare rates, which themselves are around 30 percent below commercial rates. The differential is even larger for primary care and inpatient services.[1]

While physicians have a strong sense of responsibility to provide care for Medicaid beneficiaries, physician practices cannot afford to keep their doors open and continue to serve their communities if they consistently do not make enough on the care they provide to keep up with the rising costs of running a medical practice. Unfortunately, this means low Medicaid payment rates often limit the number of Medicaid beneficiaries that practices are able to accept and remain financially viable.

Without an adequate supply of practices, Medicaid patients may have coverage but not real access to care in many areas of the country. Too often, beneficiaries must wait for unreasonable periods of time to receive needed care, travel long distances to find Medicaid participating physicians, seek non-emergency care in the emergency department, or go without care altogether. Lack of access to participating physician practices can put beneficiaries at risk of harm or even death and is contrary to the intent of Congress and the overriding purpose of the Medicaid Act.

Furthermore, safety net providers that do have a higher proportion of their patient populations comprised of Medicaid populations operate at razor thin margins and are forced to do more with less. They do not have the same financial resources to be able to compete with other practices for staff or invest in new

[1] https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact

technologies or quality improvement strategies, all of which directly impacts quality of care and patient outcomes for Medicaid and safety net populations.

In the past, the AMA has called on CMS to strengthen transparency of Medicaid payment rates because we agree that a fundamental element of ensuring access to covered services is the sufficiency of a provider network, and that payment rates are a key driver of provider participation in the Medicaid program. Accordingly, the AMA supports several policies in this rule intended to improve Medicaid pricing transparency and requiring comparative rate analyses of Medicaid and Medicare rates for certain core service lines.

Payment rate transparency

The AMA has strongly supported the development of Access Monitoring Review Plans (AMRPs), praised CMS' movement toward more meaningful requirements for access, and previously called on CMS to more fully leverage and expand AMRPs. We also understand that AMRPs proved burdensome to states and failed to provide the kind of information needed to truly assess beneficiaries' access to care.

Requiring further rate transparency is a step in the right direction and the **AMA strongly supports CMS' proposal to require states to publish their FFS Medicaid payment rates on a public facing website.** We similarly support proposals to ensure rates are kept up to date by requiring states to indicate the date the payment rates were last updated and to update payment information within one month of rate change approvals. While we support these updates, we also urge CMS to retain some of the access measures currently required in AMRPs that are valuable, such as time and distance standards and the number of providers accepting new patients. Though disclosure of payment rates is important, transparency alone does not solve payment inadequacy, nor does it provide a complete picture of access. It is imperative that states continue to actively analyze the cumulative impact of payment rates and other proposed changes on access.

Comparative rate analyses of Medicaid and Medicare rates for certain services

The AMA strongly supports requiring states to develop and publish a comparative payment rate analysis of Medicaid and Medicare payment rates for primary care, obstetrical and gynecological, and outpatient behavioral health services. We agree this is an important step to ensuring Medicaid payment rates are sufficient to ensure appropriate access to health care services for Medicaid beneficiaries. **We further strongly support requiring states to disaggregate this pricing comparison data by adult or pediatric population, provider type, and geographic area,** which the AMA has specifically advocated for in the past because it yields important insights about these specific populations. We would also encourage any publicly reported pricing information to be provided with appropriate contextual information about what those prices include and do not include, particularly on a public-facing website. For example, out-of-pockets costs should be clearly delineated from total cost of care. This will be especially important if inpatient services are added in the future.

The AMA agrees that the proposed service categories of primary care, obstetrical and gynecological, and outpatient behavioral health are important to include because they are of critical importance to overall beneficiary health and can serve as connectors to other care services. However, **we believe it is equally important that specialty services also be included in Medicare-Medicaid comparative rate analyses.** Access to specialty care is a perennial issue faced by Medicaid beneficiaries that is often worse in rural areas, with specialists commonly citing low payment rates as a primary reason for not participating in the Medicaid program. Medicaid patients often have more complex health needs than other populations and

effective disease management by specialists can be extremely important to improving care outcomes, so we highly encourage specialty services be included as well in order to improve Medicaid beneficiary access to these critical, potentially lifesaving services.

Regarding inpatient services including behavioral health services, we understand that more complex payment methodologies common to inpatient settings could make it more difficult to isolate or compare the cost of an individual service. However, inpatient settings can be a critical way for rural beneficiaries to access care, so excluding them could cause CMS to disproportionately underrepresent data from rural communities, which could create access disparities. It is our hope that CMS will gain additional insights into the cost of inpatient services from this rulemaking that could facilitate adding them in the future.

We agree with CMS' decision not to propose that states identify the number of unique Medicaid-paid claims and the number of unique Medicaid enrolled beneficiaries who received a relevant service because we agree it would add unnecessary burden and unnecessarily jeopardize the security and privacy of patient data. However, we do feel it could be worthwhile for states to identify the total Medicaid-enrolled population that was eligible to receive (but did not receive) a relevant service within a calendar year. We believe this aggregate number would introduce minimal additional burden but would add a valuable additional lens through which to analyze trends in access. We suggest the data be disaggregated by relevant geographic, demographic, and social variables to provide further insights into any access inequities for certain subpopulations while carefully considering the additional burden of collecting this data on safety net practices and directing states to collect this data directly using alternative data sources whenever possible.

The AMA strongly supports requiring states to post Medicaid FFS payment rates and comparative payment rate analyses on a centralized webpage. We believe housing all of this information in a state central webpage will make it easier for patients, providers, and other interested parties to access this valuable information, as well as streamline costs and administrative processes for states. We also appreciate CMS reiterating states' obligations under existing federal law to effectively communicate to individuals with disabilities and take reasonable steps to accommodate English language learners to ensure all individuals are equally able to access this critical information regardless of disability or language barriers.

In addition to informing care decision making by individual beneficiaries and their providers, we believe this data will be valuable for cross state comparisons and research purposes. We appreciate that CMS encourages states to advance the interoperable exchange of data by adopting standards in 45 CFR, part 170 and other relevant standards identified in the Interoperability Standards Advisory (ISA) and the reminder of the enhanced federal match rate for the design, development, or installation of improvements of mechanized claims processing and information retrieval systems. In addition to this, we believe CMS should take an active role in facilitating states' participation in and adoption of these processes through technical support and other methods. Additionally, CMS should play an active role in working with states to ensure that posted data is appropriately de-identified and secured to ensure patient privacy is protected, which will also help to enhance patients' trust in the data and process.

While enhanced transparency is important progress towards addressing access problems that stem from inadequate Medicaid payment rates, it alone will not solve the Medicaid access problem. **Accordingly, we strongly encourage CMS to work towards establishing a Medicaid payment floor at a minimum of 100 percent of Medicare rates.** Countless studies have shown that physician payment rates are directly linked to a physician's willingness to accept Medicaid patients, including several cited by the rule. Yet, Medicaid payment rates remain inadequate in many parts of the country and are highly variable

state-to-state. As noted earlier, Medicare rates are 30 percent below Medicare, and as much as 60 percent lower than average commercial rates, and this gap is even larger for certain service categories such as primary care and hospital inpatient care. Until Medicaid rates close this gap, beneficiaries will unfortunately continue to experience barriers to care.

Rate reduction or restructuring

The AMA appreciates CMS' continued efforts to monitor the impact of state proposed payment rate reductions or restructuring. We also understand that the current state plan amendment process makes it difficult for CMS and others to derive useful information to estimate the true impact of potential changes to plans.

We generally support CMS' two-tiered approach that features a streamlined process for more nominal changes, and more robust information requirements for changes that would exceed certain de minimis requirements to reduce burden on state Medicaid agencies. The AMA appreciates that meeting the proposed three criteria does not guarantee approval, nor does failing to meet them automatically equal denial. Rather, this two-tiered approach is intended to strike a balance between mitigating unnecessary administrative burden on states proposing nominal changes while requiring sufficient information to reasonably ensure that Medicaid patient access is protected and providing states with an opportunity to make their case.

The AMA recommends that the threshold for the first criterion in § 447.203(c)(1)(i) be set at 100 percent of Medicare payment rates to solidify access to health care services for Medicaid beneficiaries. In addition to addressing the aforementioned wide discrepancies between Medicaid versus Medicare and commercial rates, this would also be consistent with CMS' November 2017 State Medicaid Director Letter which stated that "circumstances where a state's Medicaid FFS payment rates remain at least as high as the Medicare rates ... for the same specific service after the reduction is implemented would be unlikely to result in diminished access."

We similarly caution regarding the proposed second threshold of a four percent cumulative reduction in Medicaid FFS expenditures that it likely underestimates the significant impact that seemingly small rate changes can have on access to care. We further recommend that if CMS proceeds with a threshold based on aggregate FFS expenditures, the timeframe be expanded beyond one state fiscal year to capture the cumulative impact of rate reductions over sequential years. Absent changes to these criteria, we are concerned about the potential negative impact on Medicaid beneficiaries' access to care and strongly believe that any rate reduction or restructuring that could result in further diminished access warrants thorough investigation.

The AMA agrees that requiring states to provide supported assurance that the proposed changes have not yielded any significant concerns from interested parties, or that the state has reasonably responded to and mitigated these concerns (and kept a record of this) should be required. In addition, states should have to demonstrate that they actively solicited feedback from interested parties and record how they responded to all feedback, not only significant concerns. The AMA believes that input from patients, physicians, and other critical industry voices is critical to informed policymaking, particularly when it concerns physician reimbursement, and we support mechanisms that would incorporate public input for potential Medicaid reimbursement changes.

Regarding the more in-depth analysis required by (c)(2), if proposals do not meet all of the criteria to qualify for the streamlined review process, we appreciate that CMS aligned criteria with current

requirements where possible and generally believe that the proposed data elements would provide value insights, particularly trending the data over a period of three years and providing additional information about the specific beneficiary populations that would be impacted. We recommend disaggregating utilization data by race, medical condition, and other key clinical, social, and demographic variables as appropriate to better understand the potential impact on specific subpopulations, and directing states and plans to collect this information directly or use alternative data sources whenever possible to mitigate any additional burden on safety net practices. We support requirements to include total Medicaid payment rates before and after the proposed change with a comparison to Medicare rates.

II. Home and Community-Based Services (HCBS)

The AMA agrees that HCBSs can serve an integral role in fulfilling beneficiaries' preferences to remain in their homes and offer high-needs beneficiary subpopulations the support they need to remain independent, including those with disabilities, as part of a physician-led care strategy. The AMA understands CMS concerns regarding the national shortage and high turnover of HCBS providers that has been exacerbated by the COVID–19 pandemic, which can directly affect access to and quality of HCBS and can shift services to more expensive institution-based settings. We also acknowledge the challenges currently faced by the HCBS industry, including workforce shortages, which have been exacerbated by the pandemic.

Overall, we commend CMS for taking steps to better monitor and improve access, quality, outcomes, and oversight, as well as advance health equity and support more standardized metrics and pricing transparency to advance quality of and access to care, particularly for specific subpopulations. At the same time, we urge CMS to evaluate the impact of enhanced HCBSs reporting on state Medicaid agency resources to ensure it does not inhibit other important proposals advanced in this rule including pricing transparency and standardized wait times, which affect all Medicaid beneficiaries. The AMA strongly supports the fact that the HCBS proposals would generally apply to FFS and managed care plans to promote consistent standards and protections for all Medicaid beneficiaries regardless of coverage type.

III. Medical Care Advisory Committee (MCAC) Process

The AMA is highly concerned by CMS' proposal to replace the requirement that board-certified physicians participate in the process with a broad requirement that "clinical providers or administrators" be represented. While we agree that a range of clinical, administrator, care navigator, and community health perspectives provide valuable perspectives, physicians are highly trained professionals with a unique expertise on the practice of medicine and an understanding of the clinical complexities and needs of the patients they serve. For these reasons, **the physician perspective needs to continue to be required on each state's MCAC**. We would further recommend CMS consider more robust provider requirements to reflect the range of skills and expertise that are relevant to treating Medicaid populations, including physicians with expertise in primary care, chronic disease management, emergency medicine, etc. Importantly, states should specifically make an attempt to include specialties where there are current shortages in Medicaid networks, such as nephrology and cardiology, to better understand and address these gaps.

The AMA agrees that the beneficiary and caregiver perspective is important to consider because it leads to more effective policy solutions, helps overcome previously unknown challenges, and avoids further marginalizing disenfranchised groups. We also appreciate CMS' recognition that optimal outcomes require an intentional and continuous effort to engage and represent diverse voices. At the same time, we recognize that state Medicaid agencies are resource challenged, particularly now given the unwinding of

the Medicaid continuous enrollment provisions. CMS should be responsive to feedback from state Medicaid agencies on the feasibility of standing up a beneficiary advisory group and be open to providing additional assistance to states as needed. Nevertheless, the AMA supports the formation of a beneficiary advisory group overall and urges CMS to finalize proposals for standardizing the existing MCAC process, which we agree will help create a more robust and uniform feedback process across states, including the requirement that at least 25 percent of members are from the beneficiary or caregiver perspective.

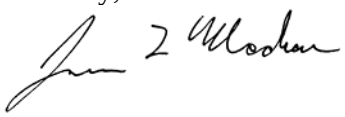
We support proposals to expand the scope of committees' feedback to include administration of the Medicaid program, as well as social determinants of health while leaving the specific topics for discussion up to each state, which we agree is important to ensure each state has the latitude to address whatever issues are most relevant considering the unique needs and challenges of its own program and population. We appreciate CMS directing state Medicaid agencies to keep in mind the demographics of the Medicaid population in their state. We agree diverse representation is critical. Likewise, we appreciate the agency's point about needing to devote resources to ensure beneficiaries of varying backgrounds can participate, and we urge CMS to make additional resources available to this end through federal grants or other means.

Lastly, we commend CMS for requiring states to develop procedures to seek input from interested parties and to consider feedback received from physicians, but as we have advocated in the past, the AMA strongly urges CMS to create an administrative pathway for providers to challenge payment rates directly to CMS. Leaving physicians only with state-based avenues to provide feedback about payment is insufficient. Physicians frequently appeal to state lawmakers and policymakers about unequal access, but 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. 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 Conclusion

Thank you for this opportunity to comment on these impactful proposals that collectively stand to improve access to health care services for millions of Medicaid beneficiaries. Please contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409 with any questions.

Sincerely,



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