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Andrew M. Slavitt
Acting 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; Final Rule with Comment Period (CMS-2328-FC) and Medicaid Program; Request for Information-Data Metrics and Alternative Processes for Access to Care in the Medicaid Program (CMS-2328-NC)

Dear Acting Administrator Slavitt:

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 Final Rule with Comment Period, *Methods for Assuring Access to Covered Medicaid Services* (the "Rule"), and Request for Information (RFI), *Data Metrics and Alternative Processes for Access to Care in the Medicaid Program*.

We commend CMS for recognizing the impact that physician 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 healthcare 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." [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.

We are encouraged that the administration has turned its attention to addressing physician payment levels that prevent the promise of the equal access provision from being fully realized. We strongly support

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

CMS' effort to create a standardized and transparent process for states to comply with the equal access requirements. The Rule represents an important step toward ensuring state accountability and, ultimately, sufficient access to quality services for Medicaid beneficiaries. We also applaud CMS taking a more active oversight role of payment rates in light of the Supreme Court's ruling in *Armstrong v. Exceptional Child Center Inc.*, 135 S. Ct. 1378 (2015).

However, we are concerned that the Rule does not go far enough. First, we do not believe the Rule provides sufficient criteria for measuring access and urge that it be strengthened by requiring states to use specific and uniform data elements. Second, strong federal oversight of the process set forth in the Rule will be critical to ensuring its successful implementation. Third, we recommend development of an administrative pathway for physicians and other providers to challenge payment rates directly to CMS.

Access to care review elements, measures, and data

Requiring States to conduct an access review for services provided under the state plan is an important step toward ensuring Medicaid patients are able to access the medical care they need. However, we believe that all Medicaid beneficiaries are entitled to the protections afforded by the equal access provision. Access issues span Medicaid delivery systems and, therefore; access measures should be aligned across delivery systems. We believe that Medicaid beneficiaries would benefit from consistent standards against which access can be measured regardless of whether care is provided on a fee-for-service basis, through a managed care plan, or under a waiver program. To silo access standards is to create an uneven application of the equal access mandate. We, therefore, submit the following comments and recommendations for services provided under a state plan and across delivery systems.

We strongly support the creation of a transparent, standardized process for states to measure Medicaid beneficiaries' access to care and are encouraged that CMS will require states to define the specific measures in section 447.203(b)(4). With additional quantitative and measurable standards, regulators will be able to better assess whether Medicaid programs have the capacity to serve all beneficiaries and whether there is enough diversity in provider availability to meet the needs of beneficiaries. However, we urge CMS to establish a national framework and prescribe the measures, including those described in section 447.203(b)(4), that states must use as part of the access review rather than leaving states with discretion to determine the measures against which they will grade themselves. Further, we have maintained that states are best suited to establish the specific measurements within a national framework, and we continue to believe that states are in the best position to "plug" in those numbers. We caution against setting national thresholds that do not account for the variation in state circumstances.

Yet if a state only measured access to care using the eight measures suggested in section 447.203(b)(4), neither CMS, the state, nor stakeholders would view a complete picture as needed to determine true adequacy of access. In addition to the measures suggested in section 447.203(b)(4), we recommend that CMS require additional measures in this section:

- Patient-to-provider ratios, by provider type, and a comparison of patient-to-provider ratios to other public programs and private health plans;
- Wait times for appointments, by provider type; and
- Access to alternative office hours (e.g., evenings and weekends) by provider type.

Additionally, we suggest refining the eight suggested measures. Specifically, given the reliance of many beneficiaries on public transportation, we recommend that time and distance standards incorporate travel on public transportation if heavily utilized in a geographic region. We also recommend that analysis of service utilization patterns specifically address whether beneficiaries have a usual source of care and use of emergency department services because research has demonstrated that in areas with a limited supply of primary care physicians, Medicaid beneficiaries are more likely to seek care in an emergency department.

A strong, national framework to measure access is vital, but strong measures in no way negate the need for strong federal oversight, especially in the Medicaid program. The AMA encourages CMS to closely monitor states' development and implementation of these measurements, maintaining the possibility of establishing federal minimum requirements in the future, if needed.

We also urge CMS to require, under section 447.203(b)(3), an analysis of the percentage comparison of Medicaid payment rates to Medicaid managed care rates, instead of permitting states to exclude this information "as practical." Through the capitation rate setting process, states have or should have documentation of managed care payment rates and should not be given the opportunity to excuse themselves from this important analysis. Payment rates significantly weigh on physicians' decisions to participate in the Medicaid program, and the AMA believes that states should report and CMS should review physician payment rates under all Medicaid delivery systems. Not only are payment rates a certain determinant of access, but they are also taxpayer dollars, and the public deserves to know that these dollars are being spent in a manner that advances the core purpose and goals of the Medicaid program.

The AMA is pleased to see that CMS will require a complete analysis and measurable standards for services by specific provider types in section 447.203(b)(5)(ii). In addition to the provider types listed in the Rule, we ask that CMS include subspecialists, adult and pediatric, to ensure appropriate access to covered subspecialty care for Medicaid beneficiaries. Additionally, we encourage CMS to require states to distinguish between pediatric and adult services for primary care services, physician specialist services, and behavioral health services. We also urge CMS to include a separate analysis for family planning services because many Medicaid beneficiaries, including those who receive care through a managed care plan, receive family planning services on a fee-for-services basis under the freedom of choice for family planning provision at section 431.51. Finally, we recommend that the analysis of behavioral health services in section 477.203(b)(5)(ii)(B) include an assessment of compliance with the Mental Health Parity and Addiction Equity Act and implementing regulations.

Review and enforcement

The AMA is very supportive of the addition of new access monitoring requirements in the Rule and appreciates CMS' movement toward more meaningful requirements for access. However, given growing access concerns, we ask that CMS go even further than the changes proposed in this regulation.

We urge CMS to provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels sufficient to allow Medicaid patients access to necessary services in a timely manner. While the Rule provides, at section 447.204(c), that CMS may disapprove a proposed state plan amendment if it determines that Medicaid service payment rates are modified without the required

analysis set forth in the Rule, or take a compliance action using the authority and procedures set forth at section 430.35, we believe that CMS' oversight role in addressing and remediating access issues should be strengthened. The Rule should be modified to make it clear that CMS, in reviewing a state's submitted access rate reviews, can itself determine that the data indicate an access problem that needs corrective action. This should not be left solely to the state's discretion. Moreover, the Rule should specifically provide that if a deficiency is identified, by the state or CMS, the corrective action plan must be subject to CMS' approval.

We are also very concerned that, even after identifying access issues resulting from inadequate payment rates, states will not be required to increase those payment rates. Section 477.203(b)(8)(i) instructs that states have available a number of approaches, such as improving care coordination, which will allow states to avoid the addressing the source of the problem, e.g., low payment rates. We fear that these alternative approaches will provide the mere appearance of action. While we do not intend to detract from the importance of improving outreach to providers and reducing barriers to provider enrollment, for example, as key elements of a state's overall strategy to promote provider participation and achieve equal access, the reach of those activities is limited and too little to address the longstanding and severe access problems that are pervasive in Medicaid programs. Under the Rule, a state could "check the box" with these activities while keeping physician rates dismally low and, as a result, have no lasting impact on physician participation.

Finally, we are concerned that the decision to maintain the current regulatory framework, i.e., relying largely on state attestation and certification to verify compliance with the equal access requirements, will only perpetuate access inadequacies. The Rule leaves to states the responsibility for setting standards and access measures and also the discretion to determine whether they have met their chosen standards. Though, as the preamble notes, states are the ones who are ultimately responsible for ensuring compliance with statutory and regulatory requirements, they are not best suited to judge themselves on whether they have met that responsibility. We think it is critical to have an independent, objective third party as the primary arbiter of a state's compliance with the equal access mandate.

<u>Alternative processes for access concerns</u>

At the heart of the Rule is 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*., and we praise CMS for assuming a greater enforcement role. While the AMA continues to believe that a private enforcement right is permitted under the equal access provision, absent access to judicial review, we urge CMS to create an administrative pathway for providers to challenge payment rates directly to CMS. Recognizing that state reductions to reimbursement rates substantially hinder access to care, Medicaid providers have long 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 has 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 will go unfulfilled and it is, therefore, incumbent on CMS to preserve this important enforcement tool.

We commend CMS for requiring states to develop procedures to seek input from stakeholders and to consider feedback received from physicians. Leaving physicians only with a state-based avenue to challenge payments, however, is insufficient. As *Armstrong* petitioner and director of the Idaho Department of Health and Welfare expressed, the equal access provision "does not obligate the State to do *anything*."[2] (emphasis in original). 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.

Finally, to the extent that CMS develops a beneficiary complaint-driven appeals process as contemplated in the RFI, the AMA strongly urges CMS to make that appeals process available to physicians as well. Physicians have a unique perspective on patient access to care and are important stakeholders in the program.

Conclusion

The AMA appreciates the opportunity to provide our comments on the Final Rule and RFI. We applaud CMS' effort to create a standardized and transparent process for states to comply with the equal access provision of the Social Security Act. The Rule is particularly 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 Rule to require states to collect and report data that truly measures access to care. Equally important, we urge CMS to strengthen the enforcement and oversight mechanisms in the Rule to ensure state compliance with the equal access provision so that state Medicaid programs can remain sustainable safety net programs.

Thank you for the opportunity to comment. 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

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