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Submitted electronically via www.regulations.gov.

May 21, 2018

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2406-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold *(CMS-2406-P)*

Dear Ms. Verma:

The Association of American Medical Colleges ("the AAMC" or "Association") welcomes this opportunity to comment on the proposed rule entitled "Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold," 83 *Fed. Reg.* 12696 (March 23, 2018), issued by the Centers for Medicare & Medicaid Services (CMS).

AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 151 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Together, these institutions and individuals are the American academic medicine community.

The proposed rule seeks to introduce exemptions for states from the Medicaid equal access requirements,[1] which require states to submit an access monitoring review plan (AMRP) that analyzes the sufficiency of access to care for Medicaid fee-for-service (FFS) beneficiaries every three years. The AMRP functions in support of the federal Medicaid statute that requires payments to providers be "sufficient to enlist enough providers so that care and services are available under [each state's Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area."[2] Specifically, the AMRP is used by states to

[1] 42 CFR § 447.203(b)(1) – (b)(6); 42 CFR § 447.204(a) – (c).
[2] 42 U.S.C. 1396a(30)(A).

document their findings for a core set of services as to whether Medicaid FFS payments are sufficient to enlist providers. Also, if payment rates are reduced or restructured, states must add services to the AMRP if the changes could result in less access. CMS proposes two exemptions from the AMRP requirements for: (1) states with 85 percent or more managed care penetration, and (2) states that propose "nominal" amendments affecting payment rates, defined as those rate changes at 4 percent or less within the affected service category in a single state fiscal year (SFY) or 6 percent or less over two SFYs. CMS proposes these exemptions in an effort "to ease the administrative burden on states that are proposing certain payment rate reductions" (p.12697).

The AAMC agrees with CMS's objective to reduce administrative burden when practicable, but these proposals do so at the expense of vulnerable Medicaid populations and the providers that serve them. Specifically, the AAMC believes these exemptions expose Medicaid's most susceptible FFS populations, such as disabled or dual-eligible beneficiaries, to greater gaps in access to care, and allow for significant and less transparent payment cuts to providers, including hospitals, that service these populations. **Therefore, the AAMC strongly urges CMS to not finalize the rule as proposed.**

Do Not Finalize the Threshold for Managed Care Exemption

Many states have moved toward managed care to provide health coverage to their Medicaid populations, with Medicaid managed care enrollment near or above roughly 80 percent nationally as recently as 2016.[3] CMS is proposing an exemption from the AMRP requirements for states with managed care enrollment rates above 85 percent of its total Medicaid population. However, the beneficiaries that rely on FFS in those states are among the most vulnerable in the Medicaid program.[4]

CMS determined its proposed 85 percent threshold "based on comments received in response to the November 2, 2015 final rule with comment period in which states suggested thresholds ranging from 75 percent to 95 percent" (p. 12699). We believe this threshold must be viewed in light of *Armstrong v. Exceptional Child Center*, which denied providers and beneficiaries a private right of action to challenge state's Medicaid payment rates in federal courts under the federal access standard. This leaves CMS as the sole enforcer of this standard, and beneficiaries are left without any other avenue of redress or source of protection. The AAMC believes that CMS must exercise significant caution when reducing protections for Medicaid equal access and that the key consideration should be whether proposed changes are more likely or not to harm Medicaid beneficiaries. **Consequently, CMS's proposal to exempt states from vital access protections found in the current AMRP process should not be finalized.**

As of July 1, 2017, the proposed 85 percent threshold would exempt 18 states[5] from the AMRP requirements (p. 12701). In these cases, CMS proposes to require an alternative analysis, as determined by each exempt state, to prove compliance with the equal access rule. The AAMC is

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[3] https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf.
[4] https://www.macpac.gov/wp-content/uploads/2017/03/Monitoring-Access-to-Care-in-Medicaid.pdf.
[5] CMS assessed 17 states met the threshold as of July 1, 2016, but as of July 1, 2017, Washington state met the threshold bringing the total to 18 states. *See* https://www.kff.org/data-collection/medicaid-managed-care-market-tracker.

concerned with CMS's ability to ensure that all "alternative analyses" show meaningful evaluation of access to care. CMS proposes little, if any, insight or standard into how it plans to confirm that exempted states' alternative analyses are meaningful and comply with the Medicaid equal access requirements. States also would be required to submit an annual attestation that they meet the 85 percent threshold. Should this requirement be finalized, the AAMC asks that **CMS publish detailed standards by which the agency will review a state's alternative analysis.**

Additionally, the AAMC worries that exempting states from the "beneficiary and provider input" requirement[6] will further reduce the ability of those most affected by changes to provide meaningful information to the state - information that also should be evaluated by CMS. **If CMS finalizes the proposal, the agency should, at a minimum, revise the requirements to ensure states must continue to seek input from beneficiaries and providers.**

Remove the Threshold for the Nominal Payment Rate Amendment Exemption

Under the existing rule, when proposing state plan amendments (SPAs) affecting payment rates, states are required to submit their most recent AMRP and other analyses relating to access for the services at issue. The proposed rule seeks to exempt states from this requirement if the proposed rate reduction or restructuring is "nominal," which CMS has proposed to mean 4 percent or less over a single SFY, or 6 percent over two SFYs. Specifically, "states would not be required to consider the data collected through the AMRP and undertake a public process that solicits input on the potential impact of the proposed rate reduction or restructuring SPA, and accordingly, would not be required to include documentation supporting compliance with the AMRP review and public process otherwise required . . ." (p. 12699).

CMS claims that these "nominal" rate changes would be "unlikely to have adverse impacts on Medicaid beneficiaries' access to care" (p. 12699). It is unclear as to what data was used to determine the proposed 4 and 6 percent thresholds. The AAMC does not believe that such reductions should be labeled as "nominal" as they are likely to have a major impact on payment rates to providers and beneficiary access. Many states already have low FFS payment rates, and this proposal effectively permits states to reduce those rates by 4 percent each year in service areas with substandard access, without regard to need or analysis related to beneficiary concerns. If finalized, this rule would place even greater strain on providers that serve Medicaid FFS populations. Permitting these reductions without any meaningful analysis, public input, or supporting documentation may cause significant issues for beneficiaries in states with already-low FFS payment rates.[7] **The AAMC urges CMS not to finalize this proposal.**

In addition to its concerns about rate-reduction, the AAMC is also concerned that exempting states from the "beneficiary and provider input" requirement[8] will allow states to unilaterally make FFS rate reductions, without regard to any actual concerns from affected individuals and providers. As noted above, many vulnerable populations rely on Medicaid FFS payments and allowing these

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[6] 42 CFR §447.203(b)(2).
[7] https://www.kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief.
[8] 42 CFR §447.204(b)(3).

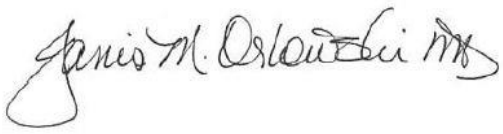
cuts without input from its intended beneficiaries and providers would run contrary to the purpose of the equal access rule. As proposed, this rule reduces transparency and payments at the expense of its most vulnerable populations. **If CMS finalizes the proposal, the agency should, at a minimum, revise the requirements to ensure states must continue to seek input from beneficiaries and providers.**

Finally, the proposed rule no longer requires SPA submissions to provide an analysis of the effect to the payment rate changes on access, and instead will propose that states make an "assurance" that access to care is sufficient paired with baseline data to show current access is adequate. CMS says that this proposal is being made because "having states provide an analysis of the effect that a proposed payment rate reduction might have on access is of limited usefulness due to many uncertainties inherent to such analyses" (p. 12700). This is a significant abdication of CMS's obligation under current Medicaid law to ensure that payments to providers are "sufficient to enlist enough providers so that care and services are available under [each state's Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area."[9] If CMS has determined that current state analyses are insufficient in demonstrating achievement of this core program requirement, CMS should support states in developing more useful analyses to improve oversight, rather than forgoing the statutory obligation to ensure access. **The AAMC asks that CMS not finalize this proposal.**

Conclusion

Thank you for the opportunity to comment on the "Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold" proposed rule. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at 202.909.2084 or mmullaney@aamc.org or Andrew Amari at 202.828.0554 or aamari@aamc.org.

Sincerely,



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cc: Ivy Baer, J.D., M.P.H, AAMC
Mary Mullaney, AAMC
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[9] 42 U.S.C. 1396a(30)(A).