



**ELECTRONICALLY DELIVERED VIA REGULATIONS.GOV**

Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2406-P2  
Mail Stop C4-26-05  
7500 Security Blvd.  
Baltimore, MD 21244-1850

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

Dear Administrator Verma:

The American Association for Home Care (AAHomecare), the national trade association representing the home medical equipment industry, appreciates the opportunity to comment on the above-captioned proposed rule (Proposed Rule). AAHomecare writes in opposition of the proposed rescission of 42 C.F.R. § 447.203(b), (c) and (d) as described in the Proposed Rule and urges the agency to withdraw it. Although we understand concerns over regulatory burden expressed by state Medicaid agencies, we are deeply concerned that the Proposed Rule will negatively impact safety-net providers and reduce access to medically necessary services by some of the most vulnerable patient populations.

**The Access Monitoring Review Plan Regulation Was Intended to Address the Lack of Private Enforcement Of Section 1902(a)(30)(A) of the Social Security Act**

CMS begins its discussion of 42 C.F.R. § 447.203 by describing section 1902(a)(30)(A) of the Social Security Act (the Act). As CMS points out, section 1902(a)(30)(A) of the Act, also known as the “equal access provision,” requires that state plans for medical assistance assure that payments under the plan are “sufficient to enlist enough providers so that care and services under the plan are available under the plan at least to the extent that such care and services are available to the general population.”

What CMS omits from its discussion, however, is the fact that the ability of health care providers and Medicaid beneficiaries to enforce state compliance with the equal access provision has been eroded to the point of irrelevance over the past 30 years. In 1990, the Supreme Court ruled that the then-existing Boren Amendment at section 1902(a)(13)(A) of the

Social Security Act – which at the time contained language that is virtually identical to today’s section 1902(a)(30)(A) – was enforceable in the federal court system through the use of the Federal Civil Rights Statute. See *Wilder Virginia Hospital Association*, 496 U.S. 498 (1990). But over the succeeding three decades, the *Wilder* decision has gradually been eroded. Today, virtually every appellate court in the United States agrees that section 1902(a)(30)(A) is not enforceable via the federal courts. See *Douglas v. Independent Living Center of Southern California*, 565 U.S. 606, 617 (2012) (Roberts, C.J. dissenting) (noting that this is the law “in virtually every ... circuit”) (citing *Sanchez v. Johnson*, 416 F.3d 1051 (9<sup>th</sup> Cir. 2005) (“[T]he flexible, administrative standards embodied in [§ 1902(a)(30)(A)] do not reflect a Congressional intent to provide a private right of action for their violation”). See also *Long-Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50 (1<sup>st</sup> Cir. 2014). And in *Armstrong v. Exceptional Child Center*, 575 U.S. \_\_\_, 135 S. Ct. 1378 (2015), the Supreme Court ruled that section 1902(a)(30)(A) is not enforceable in the federal court system via the Supremacy Clause of United States Constitution, Art. VI. Para. 2.

The equal access provision’s history in federal courts bears directly on the importance of CMS’ promulgation of the access monitoring review plan (AMRP) regulation. The *Armstrong* decision prompted CMS to propose the current access monitoring review plan regulation that CMS now proposes to effectively repeal, see 80 Fed. Reg. 67576, 67577 – 78 (Nov. 2, 2015) and 81 Fed. Reg. 21479 (Apr. 12, 2016). Thus, if CMS is successful in rescinding the regulation, section 1902(a)(30)(A) is completely unenforceable by providers and beneficiaries that are affected by the inadequacy of state Medicaid reimbursement rates.

It is of course true, as CMS notes, that “states would still be obligated by the statute to ensure Medicaid payment rates are sufficient to enlist enough providers to assure that beneficiary access to covered care and services” are adequately available under the state plan. 84 Fed. Reg. at 33724. But CMS neglects to mention that this “obligation” is effectively unenforceable if states do not provide adequate information to CMS for the agency to be able to assess the adequacy of access to services by Medicaid beneficiaries. CMS enforcement through the access monitoring review plan is the only means of ensuring compliance with § 1902(a)(30)(A), and we urge the agency to maintain this requirement to protect beneficiary access to care.

### **The AMRP Is an Important Oversight Mechanism to Ensure Compliance with the Statute**

Absent the current monitoring requirement, AAHomecare fails to see how CMS will ensure consistent enforcement of § 1902(a)(30)(A) across the United States and that the rights of beneficiaries to equal access to services will be protected. Contrary to the assertion that underlies the proposed rule, the AMRP does not eliminate or even hinder a state’s ability to administer its plan for medical assistance. The AMRP is simply providing oversight into how states are assuring they have adequate rates and a program that ensures access. If CMS is interested in achieving a reduction in regulatory burden, it could limit the number of years of tracking rate adjustments or benefit redesign to two years.

## **Absent the AMRP Requirement, CMS Will Have Insufficient Information to Enforce Compliance with the Equal Access Requirements**

If a state elects to change its rate structure or benefit design, it must submit a state plan amendment to CMS that describes the proposed changes. Our experience, however, is that SPAs typically contain only basic, general language that do not give CMS sufficient information to describe the effect of the proposed rate change or benefit design. Although CMS notes that it will, concurrently with issuance of a final rule, issue guidance to states about the types of information that it must maintain to ensure compliance with the equal access requirements, the fact of the matter is that the SPA is the operative legal document that is submitted to CMS. And CMS does not “approve” a SPA; rather, a SPA is deemed approved if it is not rejected. 42 C.F.R. § 430.16(a)(1). Accordingly, we do not think that, absent the AMRP, CMS will have enough information to effectively enforce the equal access requirements of the statute.

## **The Ongoing Transition to Managed Care is Not an Appropriate Reason to Effectively Excuse Compliance with Section 1902(a)(30)(A) of the Act**

CMS spends much time in the Proposed Rule suggesting that the current AMRP requirement is unnecessary because much of the Medicaid population receives benefits through managed care. Indeed, the prevalence of managed care in Medicaid was the reasoning that CMS articulated for its earlier March 23, 2018 proposed rule to exempt states with 85% managed care penetration from many of the requirements of 42 C.F.R. § 447.203.

But even assuming, for the sake of argument, that Medicaid managed care plans adequately compensate providers and adequately ensure access to services, there is still a role for fee-for-service (FFS) Medicaid even for managed care enrollees. First, the majority of Medicaid spending still occurs in the fee-for-service program because individuals enrolled in FFS constitute the highest-need beneficiaries in the program.<sup>1</sup> This is in spite of Medicaid payments already being notoriously low.<sup>2</sup> Second, according to MACPAC, over 40 percent of Medicaid beneficiaries receive at least some, if not all, care through the FFS system.<sup>3</sup> In part this is because if a managed care plan excludes a benefit that constitutes medical assistance from coverage, the state plan must provide that benefit through the fee-for-service program. 42 C.F.R. § 438.206(a). Thus, MCO plans need specific oversight by the state Medicaid program to ensure the federal dollars being spent on this program give patients access to care. Medical loss ratio tracking, in and of itself, does not ensure access to care for the MCO plans.

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<sup>1</sup> Rosenbaum S. “The Medicaid Access Proposed Rule Would Undermine Access, Not Promote It.” Health Affairs (April 2, 2018).

<sup>2</sup> On average, Medicaid paid just 72% of what Medicare paid in 2016. Zuckerman S, Skopec L, Epstein M. “Medicaid Physician Fees after the ACA Primary Care Fee Bump,” Urban Institute (March 2017).

<sup>3</sup> Sommers A. “Final Rule for Assuring Access in Fee-for-Service Medicaid,” MACPAC (December 10, 2015).

## **Assessing Rate Reductions by a Flat Percentage Amount Does Not Adequately Reflect the Effect that those Rate Reductions Would Have on Access to Services**

In the Proposed Rule, CMS states that it has abandoned the concept of exempting from the AMRP proposed rate reductions that are less than a specified threshold (4% per service category). 84 Fed. Reg. at 33723. Although CMS states that it believes those thresholds were supportable, it has decided “not to finalize the proposed exemptions.” We agree with CMS’s decision to abandon this proposal. In the case of home medical equipment, any percentage “safe harbor” could negatively impact patients who rely on these services because home medical equipment is such a small percentage of a state’s overall Medicaid budget. Depending upon how broadly a state defined the “service category” into which home medical equipment is placed, a 4% reduction could be devastating to patients. We agree with the agency’s decision to abandon this proposal.

## **T-MSIS Data is Not Transparent and Should Not Be a Data Source Unless and Until it is Publicly Available**

In the Proposed Rule, CMS notes that the public was generally supportive of standardized access measures across states and delivery systems in response to a request for information (RFI) that the agency issued in 2015. 84 Fed. Reg. at 33724. CMS never advanced this concept because the agency did not have “the necessary data at the federal level to move forward with developing such measures.” *Id.* Now, according to CMS, the availability of data via the Transformed Medicaid Statistical Information System (T-MSIS) gives the agency access to more robust data such that CMS can “better understand[ ] ... how such data can be used to monitor access in Medicaid.” *Id.*

While T-MSIS may be helpful for CMS to better monitor access in Medicaid, as a statistical tool it is not helpful to the public because T-MSIS data is not available to the public. If CMS intends to move forward with using T-MSIS to monitor access in Medicaid, we recommend that the data that resides in that system be made available to the public, either as a matter of right or via Freedom of Information Act (FOIA) requests.

## **CMS Should Institute a Complaint Process if it Chooses to Move Forward with the Proposed Rescission of the AMRP Regulation**

To reiterate what we have said earlier, AAHomecare opposes the proposed regulation. If, however, CMS moves forward with its proposal to rescind 42 C.F.R. § 447.203(b) – (d), at the very least, there should be a process for the public (Medicaid beneficiaries, their caregivers and their providers) to complain to CMS if a state’s proposed rate reductions or modifications to benefit design could potentially violate section 1902(a)(30)(A). This is the very least that CMS could do, in light of the fact that state violations of the equal access requirement cannot be

challenged in the federal court system. The Supreme Court, in *Douglas v. Independent Living Centers of Southern California*, 565 U.S. 606, 614 (2012), observed that aggrieved beneficiaries or providers may have a cause of action against CMS under the Administrative Procedure Act (APA) for approving a state plan amendment that violates § 1902(a)(30)(A). Surely, CMS would find it more preferable to establish a complaint process for aggrieved parties to challenge state action than to be hauled into court each time a state imposes a rate reduction or a change in benefit design in its Medicaid program.

## **Conclusion**

In conclusion, AAHomecare urges CMS to withdraw the proposed rescission of 42 C.F.R 447.203(b) – (d) and retain the current language. If CMS feels that it is compelled to reduce regulatory burden on states, there are other means of achieving that goal short of repealing the entire AMRP. AAHomecare is concerned that, in light of the inability of beneficiaries and providers to challenge state compliance with § 1902(a)(30)(A) in the federal court system, rescission of the AMRP leaves beneficiaries and providers with little or no recourse to challenge state non-compliance with a duly-enacted federal statute.

Sincerely,

A handwritten signature in black ink that reads "Thomas Ryan". The signature is fluid and cursive, with the first name "Thomas" and last name "Ryan" clearly distinguishable.

Thomas Ryan  
President & CEO  
American Association for Homecare