May 13, 2016

Vikki Wachino
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: State Medicaid Payment Cuts

Dear Ms. Wachino:

On behalf of the American Academy of Pediatrics (AAP), a non-profit professional organization of 64,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, I write to express the AAP's deep concern over the disturbing trend of states cutting Medicaid payment rates in anticipation of the implementation of CMS's final Equal Access rule. We are joined by the American College of Physicians, American Medical Association and American Osteopathic Association.

Our respective organizations have long advocated the key role of adequate provider payment rates in ensuring equal access to necessary medical services. However, there has been regular conflict regarding the scope, impact, and enforceability of the equal access provision of federal law. After the Supreme Court ruled in *Armstrong* v. *Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015) that the Medicaid statute does not provide a private right of action to providers to enforce state compliance with §1902(a)(30)(A) of the Social Security Act (the "Equal Access provision") in federal court, we were encouraged to see CMS release the long awaited final Equal Access Rule. Our organizations hoped that the final rule would hold states accountable and enforce the Equal Access provision, as the Supreme Court noted in *Armstrong* that CMS has the authority to do.

We therefore call for, at a minimum, the adoption of the following three critical requirements: (1) that the payment rates in effect during 2014 constitute the baseline states must use to analyze access to care; (2) that the national immunization infrastructure be strengthened through appropriate VFC reforms including appropriate administration payments which should be included as components of every state's access to care analysis; and (3) that a federal ombudsman be empowered to field ongoing access challenges experienced by the pediatric and broader Medicaid community. Our first recommendation is critically important for CMS to adopt -- otherwise states have the incentive to cut Medicaid payments now, before their state access plans are due to CMS, thereby creating a new, much lower baseline.

Whether influenced by the October 1 Access Rule start date or not, in March and April of this year, Oklahoma and North Dakota proposed cutting Medicaid payment by over 25% and 47%, respectively, in order to close gaps in their state budgets. Drastic cuts such as these will harm children, adolescents and adults and almost certainly cause clinicians to stop accepting Medicaid enrollees into their practices.

We know Medicaid cuts hurt children and other patients enrolled in Medicaid. North Carolina payment rates were cut by 20% in 2015 as a result of the expiration of the Medicaid payment equity provision in the Affordable Care Act. State mandated cuts of an additional 3% went into effect at the same time. A 2015 survey of pediatricians conducted by the North Carolina Pediatric Society found that when the lower payment rates went into effect, about 25% of respondents began limiting the number of new Medicaid patients they would accept.[1] Some respondents noted that they were cutting services such as closing an asthma clinic. One-third of respondents laid off staff and left vacant positions open due to a lack of funds.

Alabama is also facing drastic cuts in Medicaid, with the state legislature approving a budget that cut Medicaid by $85 million (at time of writing April 28th, the Alabama House is considering legislation to fill in $50-$75 million of this shortfall with one-time settlement money). The Alabama Chapter of the American Academy of Pediatrics conducted an internal survey of its members on the effects of the cut combined with the end of the primary care payment increase from the ACA – the results are staggering. Almost half of the pediatricians in Alabama indicated they will stop accepting Medicaid or decrease the threshold of Medicaid patients in their practices, should it be implemented. One half of pediatricians in the state will have to lay off critical staff due to a lack of funds. Other pediatricians report that they will close their offices, retire early, or move out of state. 500,000 children in Alabama rely on Medicaid to finance their care. If the Medicaid payment cuts are implemented, the state will be failing these children by denying them access to critically important care.

CMS must use its enforcement authority, rooted in the Equal Access provision and the new final Access Rule, to ensure that these payment cuts are not implemented. CMS inaction will have a devastating impact on all patients enrolled in Medicaid but will have a particular adverse impact on already vulnerable children. Children comprise more than half of all Medicaid enrollees, and access to care and services is vital to their healthy growth and development. Ensuring that children enrolled in Medicaid have access to medically-necessary care and services depends on adequate payment rates to Medicaid physicians and other providers. Appropriate payment is associated with a greater likelihood of attachment to a medical home.[2] In turn, having a usual source of care is associated with lower health care costs. [3] Low payment, capitation, and paperwork concerns all relate to low Medicaid participation by pediatric health care providers.[4]

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[1] *Medicaid Rate Cuts in Excess of 20 Percent for NC Pediatricians Are Hurting Access to Care and Services Available to Children*, North Carolina Pediatric Society, Mar. 2015, http://c.ymcdn.com/sites/www.ncpeds.org/resource/resmgr/Impact_of_Medicaid_Rate_Cuts.pdf.

[2] See, Daniel Polsky, Ph.D., et al., "Appointment Availability after Increases in Medicaid Payments for Primary Care" N Engl J Med 2015; 372:537-545February 5, 2015DOI: 10.1056/NEJMsa1413299.
See also https://www.osma.org/Public-Affairs/News/Medicaid-Payment-Rate-Increases-for-Primary-Ca-%281%29.
See also Yoo BK, Berry A, Kasajima M, Szilagyi PG. Association between Medicaid reimbursement and child influenza vaccination rates. Pediatrics. 2010;126(5). Available at: http://pediatrics.aappublications.org/content/126/5/e998.
See also McInerny TK, Cull WL, Yudkowsky BK. Physician reimbursement levels and adherence to American Academy of Pediatrics well-visit and immunization recommendations. Pediatrics. 2005;115(4):833–838 Available at http://pediatrics.aappublications.org/content/115/4/833.

[3] See AHRQ National Healthcare Disparities Report, 2011, Chapter 9, Access to Health Care. http://archive.ahrq.gov/research/findings/nhqrdr/nhdr11/chap9.html.

[4] See Felland LE, Lechner A, Sommers A. Improving access to specialty care for Medicaid patients: policy issues

Addressing these factors will ensure sufficient capacity to appropriately serve children enrolled in Medicaid.

Medicaid payment matters for access to care and for the success of pediatricians, internists, family physicians, and other clinicians in smaller practices and in providing accessible care to their patients. This will especially be the case in– mainly rural – parts of the country where the great majority of children and youth are Medicaid beneficiaries. Our organizations find no rationale why Medicaid payments should systematically undervalue health care services for children and youth, as well as for adults. CMS should not allow states to game the system and drastically cut Medicaid payments before submitting their equal access plans to CMS. If CMS does not intervene, states will continue to have a perverse incentive to lower rates and clinicians will continue to stop accepting Medicaid.

Thank you for your attention to the views of our organizations. If you have questions regarding this issue, please contact Robert Hall at RHall@aap.org or 202/724-3309.

Sincerely,

American Academy of Pediatrics
American College of Physicians
American Medical Association
American Osteopathic Organization

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and options. New York: The Commonwealth Fund, 2013 (http://www.commonwealthfund.org/~/media/files/publications/fund-report/2013/jun/1691_felland_improving_access_specialty_care_medicaid_v2.pdf).
See also https://bus.wisc.edu/~/media/bus/knowledge-expertise/academic%20departments/asrmi/events/spring-2014/alice-chen-jm-paper.ashx.
See also Huffman LC, Brat GA, Chamberlain LJ, Wise PH. Impact of managed care on publicly insured children with special health care needs. Acad Pediatr. 2010;10(1):48–55.
See also Cunningham PJ, Nichols LM. The effects of medicaid reimbursement on the access to care of medicaid enrollees: a community perspective. Med Care Res Rev. 2005;62(6): 676–696.
See also Decker SL. Medicaid physician fees and the quality of medical care of Medicaid patients in the U.S.A. Rev Econ Househ. 2007;5(1):95–112.