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*Via Electronic Submission ([www.regulations.gov](http://www.regulations.gov))*

July 5, 2011

Donald Berwick, M.D., M.P.P.  
Administrator  
Centers for Medicare & Medicaid Services  
ATTN: CMS 2328-P  
7500 Security Blvd.  
Baltimore, MD 21244-8013

***Re: CMS 2328-P: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, Proposed Rule (Federal Register, Vol. 76, No. 88, May 6, 2011).***

Dear Dr. Berwick:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "*Medicaid Program; Methods for Assuring Access to Covered Medicaid Services.*" The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises approximately 300 nonfederal teaching hospitals and health systems. The Association also represents all 135 accredited U.S. medical schools and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 114,000 clinical faculty members, 5,000 medical students, and 106,000 resident physicians who deliver over one-fifth of all clinical care in the nation.

The nation's major teaching hospitals and medical school faculty physicians are an integral and vital part of communities, and provide a disproportionate amount of health care services for Medicaid beneficiaries. While the country's 273 COTH institutions represent just six percent of all hospitals and 23 percent of all hospital admissions, they account for over one-quarter of all Medicaid discharges and 40 percent of all hospital charity care. Additionally, Medicaid patients on average account for approximately 15 - 17 percent of healthcare services provided by physician faculty practice groups over the past few years. This rate is over 50 percent higher than the average for community-based multi-specialty groups.

The economic downturn has triggered increased demand for Medicaid services at teaching hospitals and from faculty physicians. Medicaid services provided by the academic medical community will further increase as Medicaid enrollment grows as a result of the Affordable Care Act (ACA). Consequently, Medicaid payment reductions have a direct and acute impact on the financial stability of teaching hospitals and physicians, as well as all providers. While we recognize the budgetary strains placed upon the states, it is critical that any cuts to the Medicaid program be carefully analyzed so that access to high quality care for beneficiaries is not compromised.

Section 1902 (a)(30)(A) of the Social Security Act (“Section (30)(A)”) requires states to “assure that [Medicaid] payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” The AAMC is pleased that, through this proposed rule, CMS has taken an important and necessary step to implementing Section (30)(A) and to address the access issues affecting Medicaid beneficiaries. We appreciate the difficulty of promulgating a rule that balances the priorities and concerns of all interested parties. The AAMC supports the concepts underlying many of the requirements in the proposed rule, including the state-level access and payment reviews, and the mechanism for greater beneficiary input. While we believe the Agency is moving in the right direction, the final rule must be strengthened in a number of areas and generally be more explicit to ensure appropriate federal oversight of this important program.

Specially, CMS should adopt the following changes in the final rule to ensure that Medicaid beneficiary access to quality care is protected:

- Modify the Framework for Demonstrating Sufficient Access to Care,
- Exclude Disproportionate Share Hospital (DSH) Payments from the Payment Analysis,
- Require States to Conduct Access Reviews for All Medicaid Services Every Three Years,
- Extend Access and Payment Requirements to Medicaid Managed Care Organizations,
- Include Mechanisms to Allow All Stakeholders to Raise Concerns Regarding Payment and Access and Issues,
- Incorporate Additional Changes to Access Reviews and Corrective Action Plans,
- Expand Oversight of Access Reviews and State Plan Amendments, and
- Require Public Notice for All Payment Rate Changes.

### **Modify the Framework for Demonstrating Sufficient Access to Care**

The AAMC has serious concerns with CMS’ reliance on the Medicaid and CHIP Payment and Access Commission’s (MACPAC) self-described “initial” three-part framework to assess care for Medicaid beneficiaries (published March 2011). In particular, we believe there must be a more direct link to the relationship between provider payments and costs.

Under the proposed rule, states must utilize the MACPAC framework to assess whether they are meeting the access requirements of Section (30)(A) in their state-level access reviews. The three-part framework includes three key areas of examination:

- The extent to which the enrollee’s needs are met,
- The availability of care and providers, and
- The enrollee’s utilization of covered services.

At the outset, we note that MACPAC specifically stated in its March report that the Commission’s three-part framework was primarily intended to assess access to physician and

primary care services, and does not specifically address hospital, ancillary or long-term care services. Relying on MACPAC's preliminary access framework is especially problematic for hospital services because the *Emergency Medical Treatment and Labor Act* (EMTALA) requires hospitals participating in the Medicare program and operating an emergency department to screen and treat emergency patients regardless of their ability to pay. Because hospital services are generally available to Medicaid beneficiaries, the access review issues of beneficiary need and provider availability are less relevant.

In order for states to show compliance with the requirements of Section (30)(A), the AAMC urges CMS to expand MACPAC's three-part framework to include an examination of cost studies. This "4<sup>th</sup> prong" to the framework would be used to determine whether provider payment rates are reasonably related to the cost of providing quality services. The use of cost studies to determine whether rates are reasonably related to the cost of care was articulated in *Orthopedic Hospital v. Belshe* (102 F. 3d 1481, 1496 (1997), cert denied, 533 U.S. 1044 (1998)). The United States Court of Appeals for the Ninth Circuit concluded in this case that California must:

*"undertake responsible cost studies that will provide reliable data as to the hospitals' costs in providing outpatient services to the end that it determine the cost to an efficient hospital economically providing quality care. The state must set rates that have some reasonable relation to costs, the state bearing the burden of justifying any rate that substantially deviates from such determined costs."*

We also believe that as part of the cost studies, states should be required to examine how Medicaid provider payments compare to payments made by other payers, such as commercial insurers and Medicare.

### **Exclude DSH Payments from the Payment Analysis**

The AAMC asks CMS to clarify in the final rule that Medicaid DSH payments are excluded from the state's payment analysis. These supplemental payments are not solely calculated for the care of Medicaid beneficiaries, but also include support for a hospital's uncompensated costs of care to the uninsured. Since DSH payments support these additional costs, they should be excluded from the Medicaid payment analysis.

### **Require States to Conduct Access Reviews for All Medicaid Services Every Three Years**

The AAMC agrees with CMS that states should conduct periodic access reviews for all Medicaid services. CMS has proposed that each Medicaid service be reviewed at least once every five years. We urge CMS to reduce the access review timeline for each Medicaid service so that the review is conducted every three years in order to allow for a proper assessment of a state's compliance with the federal requirements of Section (30)(A). As the proposed rule is written, the earliest that all Medicaid services would be reviewed is CY 2018, which is far too long to ensure that access concerns are addressed.

In addition, the proposed rule requires the results of these access reviews be made public. The AAMC is pleased with CMS' decision to require greater transparency. We also ask that the full access review be posted on the state's Medicaid website. Placing the review on this website would reduce the burden of time and money that would result from public requests for this information.

### **Extend Access and Payment Requirements to Medicaid Managed Care Organizations**

CMS states in the preamble that the requirements of the proposed rule only apply to Medicaid fee-for-service (FFS) payments, and therefore do not include services that are provided through Medicaid managed care. This interpretation would exclude the examination of access to over 70 percent of Medicaid's enrollees who participate in some form of Medicaid managed care arrangement. The AAMC urges CMS to specify in the final rule that the access review requirements apply to Medicaid managed care payments to providers.

### **Include Mechanisms to Allow All Stakeholders to Raise Concerns Regarding Payment and Access Issues**

As proposed, CMS would require states to implement a mechanism for beneficiary feedback as part of the state access review process. CMS has said that this could be accomplished through the implementation of a survey, hotline, Medicaid ombudsman, or additional actions. The AAMC supports this requirement and also urges CMS to expand the input mechanism to allow providers and other interested parties the opportunity to raise concerns regarding access and payment issues. Most importantly, the AAMC asks that these stakeholders have the ability to communicate their concerns both to the states and directly to CMS.

All stakeholders should have a means to relay access and payment concerns on an ongoing basis directly with CMS during the federal review process. This input mechanism should also be separate from the normal rule making process. Before, during, and after the implementation of a state plan amendment (SPA), stakeholders should have the means to voice concerns to CMS and the state regarding access issues that are uncovered.

Finally, under the proposed rule, before a state can submit an SPA to implement a provider rate restructuring or reduction, it would be required to discuss these changes with stakeholders. The AAMC is pleased this communication requirement was included but believes it should be more robust. For example, CMS should require states to share their complete analysis of the access review and provider payment data with stakeholders and the public prior to the implementation of an SPA.

### **Incorporate Additional Changes to Access Reviews and Corrective Action Plans**

The AAMC generally supports the state-level access review and corrective action plan as outlined in the proposed rule. As proposed, before a provider payment restructuring or reduction could be implemented, states would be required to submit an access review completed from the

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previous 12 months. If the review process uncovers an access issue, the state would have 90 days to correct the problem.

The AAMC asks that CMS implement a mechanism to fast-track any substantive access concerns that are uncovered during the state-level access review. The state should be required to immediately report to CMS these issues with a timeline on when it will be resolved. States should not be permitted to wait until the start of the next calendar year to fix an immediate and substantive problem.

Additionally, if the state implements a provider payment cut, we request that it conduct an additional access review on the affected services within 12 months. This would be in addition to the monitoring steps that are included in the proposed rule. Without an immediate, follow-up review, we may not fully know how a service is affected until years later.

### **Expand Oversight of Access Reviews and State Plan Amendments**

The AAMC urges CMS to definitively state in the final rule that the Agency will disallow any SPAs that seek to reduce or restructure provider payments without complying with the state-level review requirements outlined in the proposed rule. We ask that the final rule include language that clarifies that CMS has the authority to review the state's access and payment analysis to ensure that it fully meets the equal access requirements.

The AAMC also urges CMS to delay any provider payment rate reduction or restructuring if an access problem is uncovered. Payment reductions should not be implemented until the state takes corrective action to fix the access problem. CMS should also state in the final rule that payment rate changes may not be applied retroactively, and may only be implemented once the corrective action changes are in place.

### **Require Public Notice for All Payment Rate Changes**

Under the current regulations, states are required to announce all "significant" changes in Medicaid payment rates. However, there is no specification of a threshold or additional clarification as to what "significant" entails. CMS has requested public comment on the removal of this word for future provider payment rate changes. The AAMC urges CMS to remove "significant" and public notice should be given when a payment rate change is proposed. A notification on the state's Medicaid website could be sufficient for public notice purposes.

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Thank you for considering these comments. If you have any questions or issues regarding our comments, please feel free to contact me at 202-862-6140 or [kfisher@aamc.org](mailto:kfisher@aamc.org), or Scott Wetzel at [swetzel@aamc.org](mailto:swetzel@aamc.org)

Sincerely,



Karen S. Fisher, JD  
Senior Director and Senior Policy Counsel

cc: Scott Wetzel, AAMC  
cc: Joanne Conroy, MD, AAMC