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Via Electronic Submission (www.regulations.gov)

January 4, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS–2328—FC
7500 Security Blvd.
Baltimore, MD 21244-8013

Dear Mr. Slavitt:

Re: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services; Final Rule, File Code CMS–2328–FC

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) final rule, *Medicaid Program; Methods for Assuring Access to Covered Medicaid Service*, 80 *Fed. Reg*. 67576 (November 2, 2015). The AAMC is a not-for-profit association representing all 145 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, and 93 academic and professional societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC notes that it has been four years between the time the proposed rule was issued and the issuance of this final rule. Although the final rule is effective as of January 4, 2016, the AAMC appreciates that CMS has provided a comment period and hopes that with this new round of comments CMS will either make substantial changes in the final rule or will withdraw it and issue a re-proposed rule. The Association has the following overarching comments:

- Since the rule was proposed in 2011 the Supreme Courted decided Armstrong v. Exceptional Child Center Inc., 135 S.CT 1378 (2015), which found that Medicaid providers do not have a private right of action to contest state-determined Medicaid payment rates in federal court. That decision makes it all the more imperative that CMS forcefully exercise its regulatory authority to ensure that Medicaid beneficiaries have sufficient access to care, including that providers receive adequate payment for their services.
- Given that the Supreme Court decision leaves CMS with the sole authority to review and enforce the Medicaid program, the Association is disappointed that the Agency has stated that it "will not directly require states to adjust payment rates." (p. 67579), since access to care and adequate payment for necessary services go hand-in hand.

- The rule does not distinguish between adult and pediatric populations. It is essential that CMS ensure that states provide adequate access for both adults and children.

Comments related to select issues in the final rule follow.

Move to Triennial Review

CMS is requiring that the time for state reviews be at least once every 3 years rather than 5 years. The AAMC supports the shorter timeframe. However, CMS indicates its concern the burden on the states from this shortened timeframe and has made accommodations to the states even though these accommodations may weaken protections for beneficiaries and providers, as discussed below.

- **CMS must include hospital inpatient services in the list of core services**

In the final rule CMS requires that the triennial review include only a core set of services: primary care, physician specialist, behavioral health, pre- and post-natal obstetric care (including labor and delivery), and home health. The Agency states that the five services were selected because "we believe these services are both in high demand and commonly utilized by Medicaid beneficiaries." (p. 67584). Despite the importance of inpatient services to the Medicaid population, the only hospital service included in the score set is labor and delivery. The AAMC urges CMS to expand the list of core services to include inpatient services.

When CMS selected the proposed core services, the Agency considered only utilization data. It also is important for CMS to take into account Medicaid spending as an indicator of what should be included in cores services. For example, in the 2014 Medicaid spent a total of $54.3 billion inpatient services while spending about $26.2 billion on outpatient services[1]. Additionally, looking at AHRQ data from two early Medicaid expansion states, California and Oregon, inpatient utilization increased in the fourth quarter of 2014 compared to the fourth quarter of 2013 by approximately 25 percent and 70 percent, respectively.[2] These data points clearly highlight the importance of hospital services to Medicaid beneficiaries.

- **Other Hospital Services That Should be Included In the Triennial Review**

It is not only crucial inpatient services that hospitals provide to Medicaid beneficiaries. CMS should ensure that every state's Medicaid population has access to the different types of care provided by hospitals, including highly specialized surgeries and procedures, burn and trauma care, psychiatric care, and substance abuse treatment. Overall, federal oversight is needed to ensure that states are not able to continue to ignore patient needs and cut funds for hospital services that are necessary for the vulnerable Medicaid population.

- **Physician specialist services**

[1] http://kff.org/medicaid/state-indicator/spending-on-acute-care/

[2] http://hcup-us.ahrq.gov/faststats/statepayer/states.jsp

CMS includes physician specialist services among the core services and provides broad examples of specialties such as cardiology, urology, and radiology. The AAMC appreciates that CMS includes physician specialist services in the core set of services. However, in an age of specialization, "physician specialist services" is an overly broad category. CMS should acknowledge that Medicaid beneficiaries should have adequate access to all subspecialties. For example, an orthopedist who specializes in problems related to the spine is unlikely to accept a patient who needs care for a broken leg. Therefore, although an orthopedist, the spine specialist should not be counted when determining whether the availability of orthopedists is adequate. Pediatric patients also require their own set of specialists. An extensive list of subspecialists should be included in the state access review.

- **Rate reviews: rate reductions and restructuring; high volume of access concerns**

CMS also is requiring triennial reviews to include services where payment rates have been reduced or restructured, and services for which a higher than usual volume of beneficiaries, providers, or stakeholders have raised access to care issues. The AAMC urges CMS to be explicit in defining the terms "reduced rate" and "restructured rate." A standard national definition will ensure that there is consistency among the states regarding when rates are reviewed and will eliminate the ability of any state to avoid review by imposing definitions that will effectively provide a loophole.

Also included for rate reviews are services "for which a higher than usual volume of beneficiaries, providers or stakeholders have raised access to care issues." CMS should acknowledge that access issues may exist even for those services for which a higher than usual volume of concerns have not been raised. For instance, it is possible that access to some services has been limited for so long, and no action has been taken in response to complaints, that beneficiaries, stakeholders, and providers simply have stopped raising concerns. While it may not be possible to address this issue in the final rule, the AAMC hopes that the responses to the Request for Information (RFI) – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program (80 *Fed Reg* 67377) will provide CMS with data sources for uncovering these types of access problems and will inform thinking about how to deal with this situation.

The AAMC supports the comparison of Medicaid Rates to Other Payment Rates But the Requirement Should be Strengthened

CMS modified the proposed rule by requiring that as part of the triennial review states compare payments rates as a percentage of other public and private payment rates in the same geographic area, by provider types and sites of service. The Association supports the inclusion of this comparison believes that the original proposal that required a comparison to Medicare rates, average commercial rates, or Medicaid allowable costs would provide more useful information about rate adequacy and would reduce the chance that these changes could mask underpayments for services.

CMS Should Expand the Requirements to Include Medicaid Managed Care Plans, Waivers, and Demonstrations

The rule finalized access review requirements for only Medicaid FFS plans which eliminates nearly three-quarters of the Medicaid beneficiary population that receive their care through other arrangements including managed care or demonstration projects such as accountable care organizations (ACOs). CMS should not rely on the protocols for the demonstration waivers alone to ensure payments is sufficient to

ensure access. Instead, CMS should apply the final rule's access review requirements to all the aforementioned areas to monitor access to care for the entire Medicaid population.

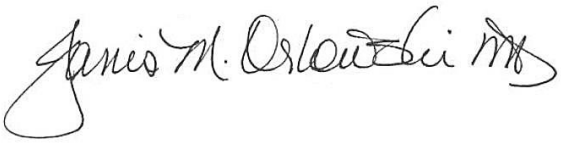
Ongoing Beneficiary and Provider Feedback

The AAMC supports the requirement for states to have mechanisms for obtaining ongoing beneficiary feedback and appreciates that CMS also is adding a requirement for ongoing provider feedback. The Association also is pleased that CMS is requiring states to maintain a record of the volume and nature of responses to the feedback. The AAMC believes that in addition CMS should require states to document their responses to this feedback. This is a way to ensure that this requirement does not merely become a record-keeping exercise as it will ensure accountability of the states.

Conclusion

The AAMC appreciates the Agency's consideration of the above comments. Should you have any questions, please contact Ivy Baer at ibaer@aamc.org or 202-828-0499.

Sincerely,



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