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Via Electronic Submission (www.regulations.gov)

July 23, 2015

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-2390-P
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Medicaid and CHIP Managed Care Proposed Rule, File Code CMS-2390-P

Dear Acting Administrator Slavitt:

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's) proposed rule entitled, *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rule, 80 Fed Reg 31098 (July 2, 2015)*.

The AAMC's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers. The AAMC membership also includes all 144 accredited U.S. medical schools; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians. Among the missions of major teaching hospitals is the provision of care to large numbers of Medicaid and uninsured patients. Representing only five percent of all hospitals, major teaching hospitals are the sites for approximately a quarter of all Medicaid discharges. Indeed, our nation's teaching hospitals provide large amounts of ambulatory care in poor communities, often acting as the "family doctor" in areas where few individual practitioners exist.

As vital providers in the Medicaid health care delivery system, teaching hospitals are committed to participating in reforms aimed at improving access to timely care and effective quality improvement activities. Ensuring that teaching hospitals and their networks of physicians who work through their faculty practices are able to participate in Medicaid managed care networks is more important than ever to achieving these aims now that increasing numbers of Medicaid beneficiaries are enrolled in managed care. To that end, we welcome CMS' thoughtful engagement around ensuring network adequacy, appropriate and adequate payment rates, and a parsimonious quality measurement framework.

Our comments below focus on the following areas:

- Network Adequacy Standards
- Setting Actuarially Sound Capitation Rates for Managed Care Programs
- Graduate Medical Education (GME)
- Direct Payment Prohibition
- Quality of Care
- Program Integrity

NETWORK ADEQUACY STANDARDS

The AAMC appreciates and supports CMS' proposals to bring additional uniformity and rigor to network adequacy standards applied to Medicaid managed care plans. Meaningful network adequacy is vital to ensuring timely access to health care services, an all-too-frequent shortcoming of many Medicaid programs. Regardless of whether network adequacy is achieved by setting one national standard or through strong and enforceable federal guidance regarding the setting of individual state standards, the AAMC encourages CMS to be explicit about the all aspects of network adequacy, as discussed below.

Network Adequacy by Provider Type

CMS proposes to require states to establish network adequacy standards for broad categories of provider type: primary care (adult and pediatric), specialist (adult and pediatric), hospital, pharmacy, and pediatric dental. The AAMC requests that CMS establish further categories to ensure that access is available for additional essential provider types. In particular, the AAMC recommends that states set separate standards for, though not limited to, ACS Level I trauma centers, inpatient psychiatric units, mental and behavioral health providers, substance abuse services, providers that offer wrap-around social services, and specific specialty providers with known workforce shortages in the state.

CMS proposes to require states to separately examine pediatric primary, specialty, and dental network adequacy. As children represent large proportions of Medicaid beneficiaries in every state, in some instances the majority, and often have needs that are very different from adults, the AAMC supports this proposal.

CMS seeks comment on whether behavioral health should be a separate category for evaluation of pediatric network adequacy. The AAMC would find this a welcome addition. Further, the AAMC is aware of national workforce shortages in many pediatric subspecialties, such as pediatric rheumatology. Since only a few physicians or hospitals in a particular service area might provide subspecialty care, CMS should require states to set network adequacy standards for plans that assure access to these otherwise unavailable experts and facilities. Pediatric outcomes for tertiary and quaternary care are demonstrably better in specialized institutions that focus on children's

care.^{1,2} Pediatric network adequacy standards for acute care services should be specific to acute care settings with robust pediatric specialization. A pediatric network would be patently inadequate without inclusion of a specialized children's hospital or an acute care setting with specialized pediatric trauma services, surgeons, and other providers.

Inclusion of Appointment Wait Times in Access Standards

CMS proposes to require all states to establish time and distance standards for the provider types discussed above. While the AAMC agrees with CMS that time and distance standards, frequently used in Medicare Advantage and commercial contracts, are stronger measures of network adequacy than provider-to-enrollee ratios, these measures are insufficient indicators of adequate access. Medicaid beneficiaries often are plagued by long wait times. According to a 2014 report by the HHS Office of Inspector General (OIG), 32 states currently impose a wait time limitation on managed care plans as a measure of network adequacy.³ These standards vary widely, however, and are often very loosely enforced. The AAMC encourages CMS to require wait time standards in all Medicaid programs, and recommends that wait times be specific to the provider categories CMS recommends, plus those discussed in the prior section. Wait time standards also should vary by type of appointment; for example, urgent care appointments should be judged differently than routine, non-urgent appointments.

The AAMC recommends CMS require states to establish a process to address inadequate wait times for specialties or subspecialties that have been identified by external quality reviewers or state-led direct tests. Such a process could include setting wait time standards specifically for those specialties identified through these independent reviews.

Considerations for Setting Network Adequacy Standards

CMS proposes minimum factors that a state must consider in developing network adequacy standards, including anticipated enrollment, expected utilization of services, and characteristics and health needs of the covered population. Network adequacy requirements should include both quantitative and qualitative criteria. The qualitative criteria would take into account the differing abilities of hospitals and physician groups, such as faculty practice plans; for example, academic medical centers often are safety net providers that make large contributions to the provision of adequate access.

The AAMC encourages CMS to be more specific in addressing the characteristics and health needs of Medicaid populations by ensuring that managed care networks include providers best suited to meet those patients' needs. In particular, CMS should require states to address the needs of non-English speaking patients and those with severe physical/mental disabilities who may require

¹ Tilford J.M. et al (2000) Volume-outcome relationships in pediatric intensive care units. *Pediatrics*, 106 (2 Pt 1): 289-94.

² Phibbs C.S. et al (2007) Level and volume of neonatal intensive care and mortality in very-low-birth-weight infants. *New England Journal of Medicine*, 356 (21): 2165-2175.

³ U.S. Department of Health and Human Services, Office of the Inspector General. (2014). State Standards for Access to Care in Medicaid Managed Care. OEI-02-11-00320.

special access accommodations. We appreciate that CMS proposes to clarify that timeliness standards apply to all Medicaid beneficiaries including those with limited English proficiency, and encourage CMS to list linguistic and cultural competency as specific factors for determining network adequacy standards. Medicaid beneficiaries frequently cite limited hours - lack of evening or weekend appointments, for example - as a barrier to care. CMS should require states to include accessibility to providers that offer after-hours appointments and 24-hour access as an additional factor in determining network adequacy

Implementation and Oversight

The AAMC supports CMS' proposal to require managed care organizations to submit assurances of network adequacy on an annual basis and upon any substantive change to a plan's provider network. This regular review will be strengthened by CMS' additional proposal to require plans to submit detailed analysis to support network adequacy attestations. The AAMC requests that CMS require states to make these network adequacy analyses publicly available and in a timely way as another level of accountability and plan oversight.

The AAMC urges CMS to require each state to establish a clear and transparent process for patients, families, and stakeholders to raise network adequacy grievances. The process would include a timely review of complaints and provide a mechanism for addressing network adequacy problems that are identified through this process.

CMS seeks comment on enforcement standards for assuring timely access to primary, specialty, and urgent care services. Specifically, CMS offers a range of possible approaches including enrollee surveys, reviewing encounter data, reporting of HEDIS and other measures related to access, implementing secret shopper efforts, and evaluations of consumer service calls. The AAMC supports having CMS set strong federal standards for minimum state enforcement activities and encourages the Agency to apply the selected minimum activities to all specific provider types for which network adequacy standards are set, not merely the broad buckets of primary, specialty, and urgent care services.

More specifically, the AAMC supports requiring direct tests of timely access. The 2014 report by the HHS OIG concluded that most states found no violations of timely access standards over a 5-year period, suggesting widespread inadequate tracking and enforcement of existing standards.⁴ The report also found that three-quarters of all violations reported came from just three states, all of which used direct tests of timely access, such as secret shoppers or making calls to providers. Given that only robust evaluation of existing enforcement activities revealed network adequacy shortfalls, the AAMC requests that CMS set a direct test standard for overseeing network adequacy and timely access requirements.

In the event CMS opts not to require direct tests of timely access and network adequacy, the AAMC cautions against sole reliance upon HEDIS measures. HEDIS measures typically do not

⁴ U.S. Department of Health and Human Services, Office of the Inspector General. (2014). State Standards for Access to Care in Medicaid Managed Care. OEI-02-11-00320.

account for the additional measurement challenges of a transient population and would require modification before use for this purpose.

SETTING ACTUARIALLY SOUND CAPITATION RATES FOR MANAGED CARE PROGRAMS

Provider rates must be sufficient to maintain network adequacy. To achieve this goal, standards are needed to develop actuarially sound capitation rates.

While AAMC welcomes CMS' proposal to bring new transparency to the capitation rate setting process, the Association urges CMS to strengthen federal oversight of sufficiency of provider payments. The Supreme Court ruling in *Armstrong v. Exceptional Child Center*⁵ held that Medicaid providers cannot challenge a state's reimbursement rates. CMS has the responsibility to set minimum payment standards and establish a direct oversight process of provider rates.

CMS' definition of actuarially sound capitation rates requires that the rates must provide for "all reasonable, appropriate, and attainable costs that are required under the contract."⁶ The Agency clarifies that "the maintenance of an adequate network that provides timely access to services and ensures coordination and continuity of care is an obligation on the managed care plans..." CMS proposes that "in the event concerns in these areas arise, the review of the rate certification would explore whether provide rates are sufficient to support [the plan's] obligations."⁷ The AAMC appreciates CMS' stated willingness to engage in a review of sufficient provider rates but urges stronger standards regarding when a review would be warranted, what would constitute a review, and the transparency of such reviews.

As the sole enforcer of provider rate sufficiency in Medicaid managed care plans, CMS should make review of provider payments a standard element of capitation rate review. The process should include soliciting public comment on provider rate adequacy, and transparent sharing of the analysis submitted by managed care plans to support claims of payment adequacy. In this review CMS should also consider the *effective* payment rates paid to providers if some of the state-share of reimbursements is derived from taxes on providers themselves. Given the longstanding concern expressed by the provider community about underpayments in Medicaid, CMS should consider its "in the event concerns in these areas arise"⁸ already met and institute regular reviews as a standard course of business.

Alternatively, should CMS choose to finalize its proposal to only review provider payment rates upon indication of concern, the Agency should develop specific guidance regarding the process that would trigger a review when stakeholders or consumers raise such concerns about timely access and network adequacy. Stakeholders must have a clear understanding about the type of data and documentation needed. Further, states should explicitly link network adequacy oversight mechanisms with adequate provider rate reviews such that credible consumer complaints regarding

⁵ *Armstrong v. Exceptional Child Center*, 575 U.S. ____ (2015).

⁶ 80 Fed. Reg. 31120 (June 1, 2015)

⁷ *Ibid.*

⁸ 80 Fed. Reg. 31120 (June 1, 2015)

network adequacy will automatically prompt provider payment reviews in the plan's next capitation rate setting process.

Minimum Payment Rates to Providers

The AAMC appreciates CMS' clarification that States may dictate minimum payment rates to certain classes of providers paid through managed care plans in order to achieve state policy goals. While the Association understands CMS' interest in precluding such minimum payment rates from being based on relative federal financial participation (FFP) rates, other specifications within provider types may be necessary to achieve state policy goals around access and quality. The AAMC encourages CMS to clarify that States may set minimum payment rates for providers within a class that meet a certain criterion, such as the provision of particular types of services, especially those for which the state is concerned about access, or participation in new delivery reform models or public health initiatives.

POLICY-BASED PAYMENTS

Graduate Medical Education

Investments in graduate medical education (GME) through state Medicaid programs are vital to the training of our nation's physician workforce, and in aggregate represent the second largest source of funding (after Medicare) for physician training. As of 2012, 42 states and the District of Columbia provided GME payments through their Medicaid programs.⁹ As states work to implement the Affordable Care Act, including broad expansions of Medicaid eligibility, these investments in local physician training are essential to ensuring an adequate healthcare workforce to meet the needs of newly insured populations.

The AAMC appreciates CMS' affirmation in this proposed rule of GME's appropriate place as a State expenditure eligible for federal financial participation (FFP). The Association also lauds the Agency's decision to maintain State flexibility regarding how Medicaid GME programs are structured, allowing GME funding to be distributed to providers directly or through managed care capitation contracts. This flexibility allows each state to target its workforce training investments in the most effective manner for its unique Medicaid program and healthcare marketplace.

CMS proposes that "if a State makes payments to providers for graduate medical education (GME) costs under an approved State plan, the State must adjust the actuarially sound capitation rates to account for GME payments to be made on behalf of enrollees covered under the contract, not to exceed the aggregate amount that would have been paid under the approved State plan for FFS."¹⁰

While AAMC understands and supports the premise of this policy, we seek clarification regarding how CMS intends to implement the limitation on GME adjustments to capitation rates to the

⁹ Henderson, T.M. (2013) Medicaid Graduate Medical Education Payments: A 50-State Survey. *The Association of American Medical Colleges*.

¹⁰ 80 Fed. Reg. 31259 (June 1, 2015)

“aggregate amount that would have been paid... under FFS.”¹¹ The AAMC asks that CMS clarify whether this limitation will be applied on a provider-by-provider basis, or in the aggregate. The AAMC also requests that as CMS finalizes a transparent process for the development of actuarially sound capitation rates, the calculation of any GME adjustment likewise be transparent and open to feedback and review. Stakeholders should know which data sources and methodologies are being used to predict likely teaching hospital utilization. If teaching hospital utilization, and therefore GME payments that would have been paid under FFS, exceed predictions in a given plan year such that adjustments to capitation rates were too low, the state should have the flexibility to make up for this underpayment in the subsequent year – even if doing so would mean exceeding the subsequent year’s cap based on annual GME expenditures in FFS.

Direct Payment Prohibition

The AAMC is disappointed that CMS’ proposed rule not only does not modify the “direct pay prohibition” in 42 C.F.R § 438.60 but expands it, thus failing to allow states the ability to support vital missions through direct supplemental payments. The current prohibition forbids additional payments for services covered under managed care contracts, with exceptions for payments specifically required to be made by the State in statute or regulation or for graduate medical education payments. While the AAMC appreciates the importance of the existing exceptions to this standard, we urge CMS to modify the prohibition to permit certain policy-based direct payments that are part of a state’s approved State Plan.

The direct pay prohibition forces states to incorporate funding intended to support particular providers and achieve specific state policy goals into capitation rates paid to plans, thus diluting the intended impact of those payments and undermining the ability of states to address gaps in the market to ensure the needs of its citizens are met. States that have received CMS approval for policy-based supplemental payments in their Medicaid state plan could be required to carve those payments out of actuarially sound capitation rates and pay them directly to the intended providers. As with GME payments, states would be required to make corresponding adjustments to the capitated rates to the plans to reflect such direct payments. Through such required adjustments, CMS can be assured that overall payments will be consistent with economy and efficiency, as required by statute,¹² because the underlying state plan supplemental payments would have necessarily met that standard.

Of additional concern to AAMC, CMS proposes to expand the direct pay prohibition by adding a new section to the regulations (proposed 42 C.F.R. 438.6(c)) explicitly prohibiting states from directing plan expenditures under contracts, except under certain specified circumstances:

- requiring implementation of value-based purchasing models;
- mandating participation in a multi-payer delivery system reform or performance improvement initiative; or,
- requiring adoption of a minimum fee schedule or uniform rate increase for all providers of a particular service.

¹¹ Ibid.

¹² 42 U.S.C. §1396a(a)(30)(A).

The AAMC appreciates the value of these exceptions but believes they are too narrow. The policy itself would impair states' ability to ensure that their investments in Medicaid achieve additional worthy policy goals, and would dilute the impacts of scarce state resources intended to achieve a particular policy aim. For example, states may wish to focus additional support on providers with the largest, most complex, or most critically ill/injured Medicaid patient populations, acknowledging the extra burden they bear and their inability to cross-subsidize the low rates. Or, states may want to direct enhanced payments to providers that offer access to particular essential services, such as trauma, burn care, or disaster readiness. It appears that these forms of targeted payments would no longer be permitted under CMS' proposed rules. States would have to spread their scarce dollars across all providers, rather than targeting their support to those providers most in need. CMS could best address this issue by removing 438.6(c) from the final rule and adding a new paragraph (c)(iv) providing that the state may require plans to make enhanced payments to providers to account for CMS-approved, policy-based supplemental payments in their Medicaid state plan.

QUALITY OF CARE

National Standards for Quality Assessment and Performance Improvement Projects

CMS proposes to undertake an additional public notice and comment process to specify standardized performance measures and topics for performance improvement projects (PIPs) for inclusion in each state plan alongside state-specific measures and PIPs for managed care entities. The AAMC welcomes this step towards alignment of quality measurement and improvement activities across Medicaid delivery systems and state lines. The Association also appreciates the Agency's commitment to an additional public comment process and additional refinement over the coming years. In advance of that process, AAMC offers the following considerations and looks forward to having additional opportunities to comment.

- **National Quality Forum (NQF) and Measures Application Partnership (MAP).** In advance of proposing standardized measures for public comment, CMS should seek the counsel and approval of the NQF and MAP in developing measures appropriate to the Medicaid population and their application in this context. The guidance of the NQF and MAP should also be sought regarding gaps in appropriate measures, including for behavioral health care. All measures in the standardized set should be NQF-endorsed and implemented in a way that is consistent with that endorsement.
- **Parsimony.** In order to achieve the Agency's stated aim of standardized measurement, CMS should provide strict guidance to states regarding the removal of state-specific measures that overlap or conflict with federally mandated measures adopted through CMS' proposed public comment period. Adding new standardized measures without appropriately removing duplicative measures will add to administrative burden and confusion.

- **Risk Adjustment.** CMS should seek comment on risk adjustment factors and methodologies specific to the Medicaid population to ensure that there is a level playing field when comparing plans and providers caring for the sickest and most vulnerable beneficiaries. In Medicare patient populations, the proportion of Medicaid or dually-eligible patients often is used as a proxy for socioeconomic status (SES) and the often-related social and community-based barriers to care associated with SES disparities. When comparing Medicaid plans to each other the same considerations are relevant, but require the use of different measures. Especially in states that expanded Medicaid after enactment of the ACA, the populations served by Medicaid are more diverse. Any comparison of plans and providers that care for beneficiaries with social, economic, language, and functional limitations such as are found in a Medicaid population should take those and other relevant factors into account.

Medicaid Managed Care Quality Rating System

CMS proposes to require all States contracting with Medicaid managed care organizations to establish a public and transparent quality rating system to allow beneficiaries to consider quality when selecting a health plan. The AAMC looks forward to participating in CMS' anticipated stakeholder engagement efforts on this subject, as well as commenting on formally proposed measure sets and methodologies. In anticipation of this process, the AAMC encourages CMS to seek comment on the following issues of particular interest to academic medical centers.

- **Access to Specialty and Subspecialty Services.** Given the well-documented difficulties Medicaid beneficiaries often face accessing care,¹³ network adequacy and availability of timely appointments are likely to be among the most meaningful measures consumers consider. CMS should include Access to Care as a summary indicator in addition to the three domains included in the Qualified Health Plans' quality rating system. CMS should also seek comment on additional access measures that would be of specific value to Medicaid beneficiaries, including access to culturally competent care. Access measures should differentiate between primary, specialty, and behavioral health care and should break out specific specialties with known shortages. Pediatric access measures should be displayed separately from adult access measures. As recommended above, access measures should include wait times for appointments and procedures, in addition to travel times and adequate provider directories.
- **Risk Adjustment.** CMS should seek comment on risk adjustment factors and methodologies specific to the Medicaid population to ensure that plans and providers caring for the sickest and most vulnerable beneficiaries are compared on a level playing field. Please see additional detail in the preceding section.

¹³ U.S. Department of Health and Human Services, Office of the Inspector General. (2014). State Standards for Access to Care in Medicaid Managed Care. OEI-02-11-00320.

PROGRAM INTEGRITY

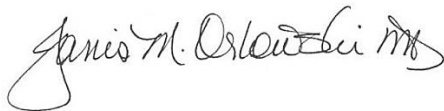
The AAMC appreciates and shares the Agency's commitment to responsible stewardship of Medicaid and CHIP resources. Academic medical centers often receive complicated medical cases from across state lines, creating the administrative burden of ensuring that their institutions, faculty physicians, residents, and other providers are appropriately enrolled in multiple Medicaid programs. In the case of some COTH members, this means complying with varying regulations across dozens of states. The Agency's proposals to bring additional uniformity to these state requirements are generally welcome.

The AAMC is concerned, however, that some of the Agency's proposals could impose barriers on medical residents who frequently provide care to Medicaid beneficiaries. It is essential that any requirements for providers take into account the fact that under the law in many states, medical residents in approved training programs have only limited licenses and may not be able to enroll in PECOS. Medicare has addressed this issue by allowing residents to register for the limited purposes of ordering, referring, and prescribing. The AAMC urges CMS to follow a similar path for the Medicaid program.

CONCLUSION

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic medical center community. If you have questions please feel free to contact Ivy Baer at 202-828-0499 or at ibaer@aamc.org.

Sincerely,

A handwritten signature in cursive script that reads "Janis M. Orłowski M.D." with a stylized flourish at the end.

Janis Orłowski, M.D.
Chief Health Care Officer

cc: Ivy Baer, J.D., AAMC
Christiane Mitchell, AAMC