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June 27, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure:

***Re: Medicaid Program: Medicaid and Children's Health Insurance Program (CHIP) managed Care Access, Finance, and Quality (RIN 0938-AU99)***

The Association of American Medical Colleges (AAMC or the Association) is pleased to submit comments to the proposed rule entitled "Medicaid Program: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality," 88 *Fed. Reg.* 28092 (May 3, 2023, issued by the Centers for Medicare & Medicaid Services (CMS or the Agency).

This letter responds to CMS' proposals to preserve states' ability to set Medicaid managed care payments at commercial-equivalent rates and implement new appointment wait time standards. We support CMS' proposals to ensure Medicaid reimbursement rates are sufficient and Medicaid managed care organizations (MCOs) maintain robust provider networks which are critical to safeguard access to care for Medicaid beneficiaries.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

***Ensure Medicaid Payment Rates are Sufficient to Ensure Beneficiaries' Access to Care***

Medicaid reimbursement rates are insufficient to maintain beneficiaries' access to care in comparison to other payers, including Medicare. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid fee-for-service (FFS) base payments are significantly below providers' costs of providing services to Medicaid enrollees. A MACPAC analysis showed that Medicaid

FFS base payment rates to hospitals were 78 percent of Medicare rates for the 18 MS-DRGs[1] the commission reviewed.[2] As more states turn to managed care to provide coverage for Medicaid beneficiaries and contain health care costs, the AAMC supports efforts to ensure that Medicaid managed care organizations (MCOs) payments are sufficient to protect beneficiaries' access to care and appropriately reimburse providers' providing this care.

As the proposed rule notes, more than 70 percent of Medicaid beneficiaries were enrolled in a Medicaid MCO in 2020. (p. 28092). However, payments by both Medicaid FFS and MCOs continue to be below the cost of providing care, negatively impacting providers that serve as safety-net providers for Medicaid beneficiaries. We are concerned that underpayment for services furnished to Medicaid beneficiaries relative to the reimbursement provided by other payers may significantly impede beneficiaries' access to care.

Teaching health systems and their associated providers are an important access point for care for many Medicaid beneficiaries. While only 5 percent of all U.S. hospitals, AAMC-member teaching hospitals accounted for almost 28 percent of all Medicaid inpatient days in 2021.[3] Moreover, they provided 32 percent of hospital charity care.[4] Ensuring that Medicaid reimbursement is adequate to maintain coverage must be a priority to achieve CMS' goal of improving timely access to care and addressing health equity issues for beneficiaries.

Lastly, we are concerned that comparing Medicare and Medicaid payment rates to determine payment adequacy in Medicaid fails to consider the significant differences in these populations. As CMS notes in the proposed rule, Medicare payment rates are developed for a population that differs dramatically from the Medicaid population. (p. 28124). The differences in these populations may require vastly different resources in order to meet the needs of the beneficiary population, and therefore, may not be a direct one to one match for creating adequate payment rates. We support CMS' proposal to continue to allow states to increase payment limits to safeguard Medicaid beneficiaries access to care; however, we urge CMS to recognize that Medicaid beneficiaries are distinctly different and, therefore Medicaid payment rates may not be comparable to Medicare.

**STATE DIRECTED PAYMENTS**

State Medicaid programs pay MCOs a capitated payment for a defined package of benefits for an enrolled population. Capitated rates must be actuarially sound to provide for reasonable, appropriate, and attainable costs under the required terms of the contract and for the operation of the MCO for the time period and the population covered under the terms of the contract. CMS reviews and approves capitation rates as actuarially sound.[5] MCOs, in turn, are responsible for paying providers for the services delivered to the enrolled beneficiaries. In general, states are not permitted to direct MCO payments to providers.[6] Understanding that access could still be an issue for beneficiaries enrolled in MCOs, in 2016 CMS issued

[1] Medicare Severity Diagnosis-Related Group
[2] Medicaid and CHIP Payment and Access Commission. Issue Brief: Medicaid Base and Supplemental Payments to Hospitals. March 2023.
[3] Source: AAMC analysis of American Hospital Association (AHA) Annual Survey Database, FY2021. Hospital counts reflect total number of hospitals in the database and excludes federal hospitals, long-term care hospitals, and specialty hospitals. Reflects AAMC membership as of 2022.
[4] Ibid.
[5] 42 CFR § 438.4
[6] U.S. Government Accountability Office, "Medicaid: State Directed Payments in Managed Care." June 28, 2022. GAO-22-105731

regulations establishing certain circumstances under which states may direct managed care payments to providers to improve patients access to care. These payments are known as state directed payments (SDPs).[7] SDPs must be tied to utilization and distributed to a defined class of providers with states having the flexibility to define the class. The proposed rule notes that since 2016, there has been a significant increase in the number of requests for SDPs. (p. 28122). This proposed rule seeks to provide additional clarification on SDPs.

*Proposed Payment Rate Limit for Inpatient and Outpatient Hospital Services and Qualified Practitioner Services at Academic Medical Centers*

CMS is proposing to define standards around what is a "reasonable, appropriate, and attainable" MCO payment rate for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers. Notably, CMS acknowledges that academic medical centers serve as an essential and important provider of these services for Medicaid beneficiaries. (p. 28121). Yet, Medicaid base reimbursement rates lag behind commercial rates and Medicare rates, respectively. (p. 28122). The proposed rule goes on to say that low MCO payment rates can be a barrier for MCOs to develop comprehensive provider networks. Therefore, CMS is proposing to use the average commercial rate (ACR) as the appropriate total payment rate limit for these services, which would provide states flexibility in pursuing provider payment initiatives and advance access and improve quality of care in Medicaid.

CMS notes that the most common services for which states utilize SDPs to raise total payment rates up to the ACR includes qualified practitioner services furnished at academic medical centers, inpatient hospital services, and outpatient hospital services. CMS is proposing to limit the payment rate increases to these three services to not disincentivize other providers' participation in MCOs and inadvertently negatively impacting beneficiaries' access to care. (p. 28123). Additionally, as noted in the proposed rule, because commercial plans typically pay the highest rates for these services, aligning payment rate limits with the ACR will allow the MCOs to raise reimbursement rates thereby improving Medicaid beneficiaries' access to medically necessary care.

Academic medical centers furnish a significant volume of services to Medicaid beneficiaries. AAMC-member teaching hospitals account for 26 percent of Medicaid hospitalizations.[8] Underpayments for these services further strains the financial stability of many hospitals that care for a disproportionate number of Medicaid beneficiaries. Increasing Medicaid reimbursement would maintain Medicaid beneficiaries' access to care, including specialty and sub-specialty care that is only provided at these institutions. The AAMC supports this proposal and appreciates CMS' acknowledgement that academic health systems and their associated providers are vital access points for Medicaid beneficiaries to obtain care.

CMS also discusses whether to consider alternatives to its proposal to use the ACR as the payment limits. The Agency outlines its concerns that setting the payment limit at the ACR may incentivize some states to raise their total payment rates based on the source of the non-Federal share rather than to further the state's MCO goals and objectives. To address this, CMS is considering adopting the Medicare payment rate as the total payment rate limit in the final rule. (p. 28123). The AAMC does not support this proposal. While Medicare rates are higher than Medicaid rates, they do not adequately reimburse providers for

[7] 81 FR 27498

services. According to the Medicare Payment Advisory Commission (MedPAC), Medicare payments to hospitals were below hospitals' costs in 2021. MedPAC also estimates that hospitals' Medicare margins in 2023 will be lower than in 2021.[9]

Moreover, Medicare rates do not compare to commercial rates. A 2020 study conducted by the Kaiser Family Foundation (KFF) found that, on average, private insurers' reimbursement was nearly double the Medicare rate for all hospital services.[10] In addition, because CMS has already treated the ACR as the payment limit for more than five years, codifying the SDP payment limit at Medicare rates would represent a substantial reduction to Medicaid payment levels compared to current rates and could undermine CMS' broader goals to address access and quality.

The Agency also proposes a third payment limit alternative that would limit the total payment rate for the four services listed to the ACR for value-based initiatives only and then use the Medicare rate as the limit for fee schedule arrangements related to these four services. (p. 28124). The AAMC does not support this proposal. We believe that the payment limit should be consistent across all states by utilizing one payment rate limit for these four services rather than having multiple payment rate limits. Different states may have different value-based initiatives, thereby putting providers that are not participating in these initiatives at a disadvantage. We urge CMS to finalize the proposal to utilize the ACR as the payment limit. We feel this proposal imposes the least amount of burden on states and providers and supports the Agency's goals to increase access for Medicaid beneficiaries, improve quality and advance health equity.

Lastly, any additional state reporting requirements related to the ACR calculation should not increase current reporting requirements on providers. CMS should continue to provide states with flexibility related to the data sources and methodologies used to calculate the ACR, comparable to flexibility provided under the current state.

*Definition of Academic Medical Center*

CMS is proposing to define the terms "academic medical centers" and "qualified practitioner services at an academic medical center" to clarify which SDP arrangements would be subject to the proposed limits. (p. 28123). An "academic medical center" would be defined as a facility that "includes a health professional school with an affiliated teaching hospital." We believe that this definition would exclude many AAMC-member academic medical centers that are affiliated with but do not include a health professional school. Therefore, we suggest that CMS define an academic medical center as a facility that ***"includes a teaching hospital and is affiliated with a health professional school."*** Many academic medical centers include clinical facilities (e.g., hospitals, clinics) that have clinical affiliations with medical schools (i.e., health professional schools). We urge CMS not to finalize this proposed definition; instead, CMS should adopt our suggested changes to ensure that all facilities associated with an academic medical center are included in the definition.

We support the proposed definition that ''qualified practitioner services at an academic medical center'' are professional services provided by physicians and non-physician practitioners affiliated with or employed by an academic medical center. We urge CMS to finalize this proposal.

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[9] Medicare Payment Advisory Commission. Report to Congress: Hospital Inpatient and Outpatient Services. Chapter 3. March 2023.

[10] Eric Lopez, Tricia Neuman, Gretchen Jacobson, Larry Levitt, How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature, KFF, (2020).

*Non-Network Providers*

CMS is proposing to remove the term "network" from the descriptions of SDP arrangements because it believes that limiting SDPs to in-network providers has created unintended barriers to access to quality care for beneficiaries. (p. 28115). The AAMC supports this proposal and asks CMS to finalize it. The expanded use of narrow networks negatively impacts beneficiaries' ability to access needed medical care, including access to specialty and sub-specialty care provided at AAMC-member teaching hospitals. This proposal supports states' and MCOs' ability to ensure access to non-network providers for beneficiaries and to utilize SDPs to adequately reimbursement for providers.

**APPOINTMENT WAIT TIMES**

CMS proposes a new network adequacy standard that requires states to establish appointment wait time standards for Medicaid and CHIP programs. Under the proposal, states would be required to develop and enforce wait time standards for routine appointments for four types of services covered under the MCO contract – outpatient mental health and substance abuse disorder, primary care, obstetrics and gynecology (OB/GYN), and one additional type of service determined by the state in an evidence-based manner. (p. 28098). Maximum appointment wait times must be no longer than 10 business days for routine outpatient mental health and substance use disorder appointments and no longer than 15 business days for routine primary care and OB/GYN appointments. CMS is not proposing a maximum appointment wait time for the state-selected provider type. (p. 28098). MCOs would be deemed compliant with the appointment wait time standards when secret shopper results show that appointment availability is met at least 90 percent of the time. (pp. 28101 – 28104).

The AAMC supports tracking appointment wait times as one indicator of network adequacy. For wait times to be a meaningful metric for Medicaid beneficiaries, however, they should be compared to wait times for commercially insured and Medicare patients for the same specialist and/or service within a defined area. For example, if average wait times for commercially insured patients and Medicare beneficiaries in a certain geographic area would be four weeks to get a non-urgent appointment with a primary care provider or specialist, then Medicaid wait times should be aligned.

We support efforts to ensure that Medicaid and CHIP beneficiaries have access to needed medical care in a timely manner. However, the use of narrow networks has expanded, often excluding teaching hospitals and their associated providers who furnish primary care, mental and behavioral health services, and specialty and sub-specialty care which limits the number of available providers directly impacting appointment wait times. We urge CMS to focus on network adequacy, specifically the number of providers of each specialty included in the network to achieve the goal of decreasing appointment wait times.

CMS should consider aligning Medicaid MCO network adequacy standards with the standards that govern plans in the federal Marketplace and Medicare Advantage. Those standards are designed to operate nationwide with sufficient flexibility to account for geographic differences, and so can appropriately be carried into the Medicaid program. In addition to supporting Medicaid and CHIP enrollees by establishing a federal floor for access, aligning standards across programs would create administrative efficiencies for insurance issuers and regulators, and would facilitate cross-program comparisons. CMS should enforce network adequacy standards for Medicaid MCOs and should require states and MCOs to identify and address access issues that are a direct result of inadequate networks. Further, we are concerned that providers currently within the MCOs' networks may feel added pressures

to meet the appointment wait times if networks do not contain an adequate number of providers to meet beneficiaries' demands.

Lastly, CMS should consider instituting minimum national access standards for both Medicaid FFS and MCOs to improve access for enrollees in both programs, while providing support for providers to meet these standards. These standards should encompass access to all providers, including specialty and sub-specialty providers. Currently, there is no unified national standard for network adequacy in Medicaid, resulting in significant variation across states, delivery systems, and types of services. Evaluation of health plan networks relies on plan provider directory data, which is often inaccurate or out of date. Medicaid MCOs should be required to maintain robust provider networks to ensure that Medicaid enrollees have access to needed medical care. Studies show that Medicaid provider networks for primary care and certain specialties are narrower on average than commercial plans in certain states. CMS must ensure that MCO provider directories are easily accessible to beneficiaries and are up to date to ensure timely access.

## CONCLUSION

Thank you for the opportunity to comment on this proposed rule. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic community. If you have questions regarding our comments, please feel free to contact my colleagues Mary Mullaney (mmullaney@aamc.org) and Katie Gaynor (kgaynor@aamc.org).

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer