American Hospital Association

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Submitted Electronically

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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: CMS 2328-P: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services (Vol. 76, No. 88), May 6, 2011.

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to offer comments on the Centers for Medicare & Medicaid Services' (CMS) proposed regulation on methods for assuring access to covered services within the Medicaid program.

The proposed rule represents a good first step in giving CMS the tools necessary to hold states more accountable for paying providers adequately. As the federal agency overseeing the Medicaid program, CMS is responsible for reviewing how state governments set provider payment rates, and the implications those decisions have on access to services for the Medicaid population. We appreciate CMS setting forth a new standardized and transparent process for how state governments set provider payments, including a process to monitor rate changes and their impact on access. However, there are several areas where the rule should be strengthened; chief among them is a stronger link between payment rates and access to services.

The Medicaid program has long served as the nation's health care safety net. The federal Medicaid statute requires that states set provider payment levels that are consistent with efficiency, economy and quality of care and sufficient to ensure that the program's

beneficiaries have access to health care services available to the general population (42 U.S.C. § 1396a (a) (30) (A)). Hospitals play a vital role in ensuring access to health services for Medicaid beneficiaries and other vulnerable populations by providing care to patients who come through their doors, regardless of their ability to pay.

Notwithstanding the provision of the law, hospitals experience severe payment shortfalls when treating Medicaid patients. On a national level, the Medicaid payment shortfall amounted to $11.3 billion in 2009, the most recent year for which data are available. That meant Medicaid paid only 89 cents for every dollar spent treating Medicaid patients. This is in addition to the $39.1 billion of uncompensated hospital care provided that year to those without insurance. Stronger CMS oversight is needed to help ensure that changes to Medicaid payments to providers do not result in problems accessing care for this vulnerable population. Our detailed comments follow.

ACCESS REVIEW AND COST STUDY

DOCUMENTATION OF ACCESS TO CARE

The AHA finds CMS' reliance on the Medicaid and CHIP Payment and Access Commission's (MACPAC) three-part access review framework to be deficient because the framework fails to adequately address access issues for hospitals, longer term care facilities and other service providers. The AHA recommends that CMS expand the three-part framework to more directly link provider payment to beneficiary access by including a fourth section that requires states to conduct provider cost studies to determine if payment rates bear a reasonable relationship to provider costs. We further recommend that states, in conducting such cost studies, be required to include an examination of how Medicaid provider payments compare to payments made by other payers, such as commercial insurers and Medicare.

The proposed rule directs states to use the three-part framework for assessing access to care recommended by MACPAC in its March 2011 Report to Congress. States must apply the MACPAC framework to examine 1) an enrollee's health needs; 2) the availability of care and providers; and 3) an enrollee's utilization of covered services. States are required to document their review of access to care and must use Medicaid provider data trends and other factors to analyze whether access is sufficient. The proposed rule further directs states to make certain that the access review includes provider payment data that compare Medicaid payment rates to commercial rates, Medicare rates and Medicaid allowable costs.

However, the MACPAC report makes clear that the commission's framework is preliminary and limited to assessing access to physician and primary care services when it states: "The initial framework presented here focuses on primary and specialty care providers and services and does not specifically address hospital, ancillary, long-term

care or other services or supports. Access to care for these critical services will be addressed in future work." (MACPAC March 2011 Report to Congress, pp 126-127).

CMS' reliance 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. Therefore, the access review should include an examination of the adequacy of Medicaid provider payments. In the *Orthopedic Hospital v Belshe* (102 F. 3d 1481, 1496 (1997), cert denied, 533 U.S. 1044 (1998)), the U.S. Ninth Circuit Court of Appeals recognized this and commented that, in the case of the Medicaid program in California "…they cannot ensure access by relying on regulations requiring hospitals to treat patients in the emergency room, and then refuse to pay the cost of such treatment because theoretically it could be provided more efficiently elsewhere." The Ninth Circuit concluded that the state of California should be required to set provider rates that "bear a reasonable relationship" to provider costs, based on "responsible cost studies."

MEDICAID PROVIDER PAYMENT DATA

The AHA recommends that CMS clarify in the final rule that state Medicaid Disproportionate Share Hospital (DSH) payments are to be excluded when states look at Medicaid payment data in their access reviews. The proposed rule directs states to include all base and supplemental payments to providers described in a Medicaid State Plan when a state reviews payment data while performing the access review. Medicaid DSH payments, however, are made to compensate hospitals for more than the care provided to Medicaid beneficiaries. Medicaid DSH payments are calculated using Medicaid shortfalls and uncompensated care provided to uninsured patients and, as such, DSH payments partially offset the cost of non-Medicaid uninsured patients. Consequently, DSH payments should be excluded from any analyses of Medicaid access.

INTERVAL OF ACCESS REVIEW AND TRANSPARENCY

The AHA urges CMS to require states to conduct access reviews every three years. The proposed rule recommends that states conduct periodic access reviews for each Medicaid service. This ongoing review process is important to ensure state compliance with the federal statutory requirements on "equal access" (42 U.S.C. § 1396a (a) (30) (A)). The rule recommends that each service undergo an access review every five years and that states make public their findings. States also should make their findings available to the public on the state's Medicaid website. For many state Medicaid programs, the base Medicaid payment rates, particularly for hospitals, have not changed for many years, and a lengthy interval between reviews would not uncover potential access problems resulting from low reimbursement rates.

APPLICATION OF ACCESS REVIEW FOR MANAGED CARE PAYMENTS

The AHA recommends that CMS apply the access review requirements to all payments between managed care organizations (MCOs) and the provider. The preamble of the proposed rule states that the access review requirements stipulated in the regulation would not apply to services provided through managed care arrangements because the federal "equal access" statutory requirement only applies to fee-for-service payments. According to MACPAC's June 2011 Report to Congress on Medicaid Managed Care, more than 70 percent of Medicaid enrollees receive their care through some form of managed care. While the federal statute requires that capitation payments paid by the state MCOs be "actuarially sound," many MCOs pay their providers, in particular hospitals, on a fee-for-service basis rather than on a capitated basis. There is nothing in the federal statute or regulation suggesting that the federal "equal access" requirement cannot or should not also apply in managed care payment arrangements. At the very least, it should apply to both fee-for-service payments and capitated when those types of payments occur between the MCO and the provider.

PUBLIC PROCESS, MONITORING, COMPLIANCE AND NOTIFICATION

MECHANISM TO DIRECTLY SHARE CONCERNS WITH CMS

The AHA urges CMS to establish a mechanism to allow beneficiaries and stakeholders to raise concerns and issues regarding access and provider payments directly with the agency. The proposed rule requires states to have ongoing mechanisms for beneficiary input on access to care. Such mechanisms could include surveys, an ombudsman or hotlines. While the AHA supports the need for an ongoing process to allow beneficiaries the opportunity to raise concerns with state Medicaid programs, we believe this requirement should be expanded in two ways. First, the beneficiary input mechanism should include stakeholders such as hospitals and beneficiary advocates. Second, the mechanism for input should not stop with the state Medicaid program.

Beneficiaries, providers, beneficiary advocates and other stakeholders should have a formal mechanism to share directly with CMS their concerns about payment rates and the implications of such payment rates on access to services, including during the CMS State Plan Amendment (SPA) review process. This formal mechanism should be separate from the normal rulemaking process and should be ongoing. Suggested approaches for this formal mechanism could include, but not be limited to, the formation of a technical advisory group, or the creation of an ombudsman within CMS. The creation of a direct communication mechanism between CMS and beneficiaries and stakeholders will help to guard against the possibility that an access issue exists but is masked because the access

review may look only at the categories of covered services, such as clinic or hospital services in the aggregate, and not at the service-delivery level.

CONSEQUENCES FOR FAILURE TO COMPLY WITH ACCESS REVIEW AND STATE LEGISLATIVE RATE SETTING

The AHA urges CMS to clearly hold that state Medicaid programs cannot implement provider payment reductions until they have complied with the new "equal access" regulatory standards and CMS has approved the state's SPA to reduce provider payments. Allowing state Medicaid programs to implement provider payment reductions prior to receiving CMS' approval could create entirely preventable access problems. Some state legislatures also are playing a more prominent role in terms of setting provider payment rates. The legislative process should not obviate the states' obligation to comply with the federal "equal access" statutory and regulatory requirements. Also, the rule should clarify that all state actions pertaining to provider payment rate setting, whether they are administratively or legislatively determined, fall under the federal "equal access" requirements. In addition, the rule should clearly state that CMS has authority to look behind the state's analysis to determine if it is credible to meet the "equal access" requirement.

MONITORING PROCESS FOR PROVIDER RATE REDUCTIONS

The AHA supports requiring states to establish a baseline access analysis prior to taking action to reduce provider rates, to require states to conduct an ongoing monitoring process to detect access problems, and to require corrective action when access problems are detected. The proposed rule requires states, when making provider payment reductions, to conduct an access review for the 12 months prior to the rate reduction and continuously monitor access while the rate reduction is being implemented. If the state access review process finds access is impaired, then a corrective action process is triggered and states have 90 days to correct the deficiency. The AHA recommends that, if an access problem is detected, any payment rate reduction be suspended until corrective measures are taken. CMS should clarify that once the corrective measure has been implemented, the payment rate reduction may not be applied retroactively.

PUBLIC NOTICE REQUIREMENTS, STAKEHOLDER INVOLVEMENT AND USE OF THE TERM "SIGNIFICANT"

The AHA supports CMS' proposal to require states to notify and consult with beneficiaries and stakeholders before making *any* provider payment reductions. The proposed rule requires that states consult with beneficiaries and stakeholders such as providers and advocates prior to the submission of an SPA. This consultation is critical to an open and transparent rate-setting process. But such consultations are meaningless if the beneficiaries and stakeholders do not have the benefit of the state's analysis of provider rates and determination of how access may or may not be affected. To make

this public process more meaningful, **we also urge CMS to require that detailed analysis of the access review and provider payment data be made public in the most accessible manner possible.**

In addition, CMS is asking for public comment on the use of the term "significant" as it applies to the requirement that states must notify the public of payment rate changes. The AHA agrees that the term "significant" is highly subjective. We strongly recommend that CMS require states to notify the public whenever the provider payment rate changes, without regard to whether the state believes the rate change is significant or not.

MACPAC reports that 67 million people rely on the Medicaid program for their health care, including our nation's most vulnerable children, poor, disabled and elderly. By 2019, the Medicaid program will add 16 million more to its rolls as a result of the expansions included in the *Patient Protection and Affordable Care Act*. In light of the continuing fiscal pressures and expanding numbers of people to serve, state governments will ultimately turn to reforms in provider payment and care delivery systems to address these pressures. Hospitals understand the need to provide patient care in a more accountable, more coordinated way and that they will be expected to improve outcomes for patients while lowering costs. That is why it is so crucial to get it right in terms of the necessary oversight tools that will allow CMS to hold states accountable in how they set their Medicaid provider payment rates and maintain beneficiary access to health care services. The proposed rule is a good starting point, but further refinements are needed to ensure sufficient access to services for the vulnerable populations served by the Medicaid program.

Thank you for your consideration of our comments. If you have any questions, please contact me or Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President