

July 5, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-2328-P

Dear Administrator Berwick:

On behalf of the undersigned physician organizations, thank you for the opportunity to provide the Centers for Medicare and Medicaid Services (CMS) with comments and recommendations in response to the proposed Rule, *Methods for Assuring Access to Covered Medicaid Services* (hereinafter, “the Rule”), published in the Federal Register on May 6, 2011. We strongly support CMS’ effort to create a standardized and transparent process for states to comply with section 1902(a)(30)(A) of the Social Security Act, also known as the “equal access” provision of Medicaid. We applaud CMS for recognizing the need for states to measure beneficiaries’ access to care when reducing provider payment rates and adjusting payment methodologies under Medicaid. The Rule is an important step toward ensuring state transparency and accountability so that there is sufficient access to quality services for Medicaid beneficiaries.

We are concerned, however, that the Rule does not go far enough. First, we do not believe the Rule provides sufficiently clear criteria for measuring access and urge that it be strengthened by requiring states to use uniform data elements, especially cost studies. Adequate payment rates to physicians and other providers are essential to ensuring that Medicaid patients have actual access to medically-necessary care and services. Second, strong federal oversight of the process set forth in the Rule will be critical to ensuring its successful implementation. Third, we are concerned that the Rule does not apply to Medicaid managed care plans. These points are discussed in further detail below.

Standardized and Transparent Process

We commend CMS for creating a transparent, standardized process for states to measure Medicaid beneficiaries’ access to care, particularly when a state changes the provider payment rate or adjusts the payment methodologies under Medicaid. We support the idea of a standardized template and appreciate that a state Medicaid program’s data analysis will be available to the public. This data is important to help identify and understand any issues in access to care and will be helpful as stakeholders work with state Medicaid programs to address problematic areas.

Required Data Elements

We are concerned that the three-part framework adopted in the Rule based on recommendations from the Medicaid and CHIP Payment and Access Commission (MACPAC) is not adequate and will not give sufficient guidance to states. While we understand the need for some flexibility in how states measure access, we are concerned that without requiring certain data elements, access reviews conducted by states may fail to measure whether Medicaid beneficiaries truly have access to care. For this reason and in response to CMS' request for public comments on whether specific data elements should be required, we urge CMS to require the following data elements in state access reviews: 1) cost studies; 2) the number of physicians accepting *new* Medicaid patients; 3) emergency room utilization among Medicaid beneficiaries; and 4) the patient/physician ratio in Medicaid versus private health plans. These data elements should also be included in the standardized template. Each of these data elements is discussed in detail below.

First, as part of a state access review, we strongly believe states should provide data demonstrating the impact that cuts to provider payment rates will have on access to care. Cost studies are the most important piece of information measuring access to care. In many states, Medicaid payments are woefully inadequate, with physicians receiving on average 28 percent less than the physician would receive for providing the exact same service to a Medicare patient.¹ While physicians have a strong sense of responsibility to provide care for Medicaid beneficiaries, physician practices cannot remain economically viable if they lose money on the care they provide. Without adequate payment rates, Medicaid beneficiaries may have coverage but not real access to care. **We strongly urge CMS to require states to submit cost studies as part of their access review.**

We also believe data on the number of physicians accepting *new* Medicaid patients is important to demonstrate access to care. In many states, the number of physicians who accept Medicaid patients is considerably more than the number willing to accept new patients. Many physicians find they cannot afford to accept new Medicaid patients or must limit the number of Medicaid patients they treat in order to keep their doors open for all patients. In short, the number of physicians participating in Medicaid is not as accurate an indicator of access to care compared to the number of physicians accepting *new* Medicaid patients. The latter number will become even more important as the Medicaid program expands in 2014.

Emergency room utilization is also an important indicator of access to care and should be included in a state's access review. Studies have shown that Medicaid patients who lack access to providers are more likely to use the emergency room. A study by the Robert Wood Johnson Foundation found higher rates of emergency department utilization in areas with limited supply

¹ Kaiser Family Foundation, State Health Facts, Medicare to Medicaid Fee Index (2008).
<http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4>

of primary care providers.² Requiring this information as part of the state's access review will help identify access problems in a state or in certain geographic areas.

Finally, as part of an access review, states should provide data on the patient/physician ratio in Medicaid compared to private insurance plans. This comparison data is necessary for state compliance with the statutory language of the equal access provision, which mandates "that payments are...sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area." 42 U.S.C. 1902(a)(30)(A)

Stakeholder Input & Enforcing State Compliance

We commend CMS for requiring states to develop procedures to seek input from stakeholders prior to submission of a state plan amendment that proposes to reduce or restructure payment rates, and to monitor access to services after a change in payment rates has been implemented. The Rule also requires states to have ongoing mechanisms for beneficiary input on access to care. However, physicians and other providers are important stakeholders in this process, and states should be required to seek their ongoing input as well. This is particularly important because providers have a unique perspective on patient access to care, such as whether primary care physicians can find specialists willing to accept a Medicaid patient. Therefore, we urge that Section 447.203(b)(4) of the Rule be amended to specifically include ongoing provider input, in addition to beneficiary input, and that Section 447.204(a)(2) be amended to specifically include input from "providers." Moreover, we believe it is important that physicians and other stakeholders be given sufficient notice and opportunity to provide meaningful input into the process, and therefore, the Rule should be modified to specify a minimum time period of at least 60 days during which input from stakeholders will be solicited.

While we believe a private enforcement right is already permitted under the equal access provision, we recognize that this private right of action is at risk due to the U.S. Supreme Court's pending review next term of the *Douglas v. Independent Living* case from the 9th Circuit. Regardless of the Supreme Court's ruling, it is important that CMS provide strong oversight and enforcement of Medicaid rate-setting by the states. We urge CMS to provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure that there is sufficient physician/provider participation so that Medicaid patients can actually access necessary services in a timely manner. While the Rule provides, at Section 447.204(b), that CMS may disapprove a proposed state plan amendment if it determines that Medicaid service payment rates are modified without the required analysis set forth in the Rule, or take a compliance action using the authority and procedures set forth at Section 430.35, we believe that CMS' oversight role in addressing and remediating access issues should be strengthened. The Rule should be modified to make it clear that CMS, in reviewing a state's submitted access rate reviews, can itself determine that the data indicates an access problem that needs correction action. This should not be left solely to the state's discretion. Moreover, the Rule should

² The Robert Wood Johnson Foundation. (Research Synthesis Report No. 17, 2009). Emergency Department Utilization and Capacity.

specifically provide that if CMS determines there is an access problem, the state should be required to develop a corrective action plan within a specific deadline, such as within 90 days of notice of CMS' determination. Any corrective action plan should be subject to CMS' approval.

Managed Care

Finally, we are concerned that the Rule does not apply to Medicaid managed care even though the majority of Medicaid beneficiaries receive at least a portion of their health care through a managed care plan. According to the Kaiser Family Foundation, about 70 percent of Medicaid beneficiaries receive some or all of their services through a Medicaid managed care plan.³ Since the purpose of the Rule is to ensure *all* Medicaid beneficiaries have access to care, failing to include plans that cover a majority of Medicaid beneficiaries weakens the impact and diminishes the effectiveness of this Rule. This is especially critical in light of problems that the General Accountability Office (GAO) found in CMS' oversight of Medicaid managed care plans: in its 2010 report, the GAO found that CMS' oversight in reviewing the actuarial soundness of states' managed care rates needed improvement.⁴ CMS indicates in the Rule's Preamble that it is currently undertaking a review of state managed care access standards and are considering future proposals to address access issues under managed care delivery systems. **We urge CMS to develop a rule for Medicaid managed care as expeditiously as possible.**

Public Notice

In response to CMS' request for public comment on whether the term "significant" should be removed from the statutory language, thereby requiring public notice for any changes in rates, methods and standards, we agree with CMS' logic that this change would be consistent with current CMS policy. This change also reflects the overall spirit of the Rule which encourages a transparent process and collaboration with stakeholders. Any reduction in rates should trigger the public notice requirements.

Conclusion

The undersigned organizations appreciate the opportunity to provide our comments on the Rule. We applaud CMS' effort to create a standardized and transparent process for states to comply with the equal access provision of the Social Security Act. The Rule is particularly important as states move forward to implement the Affordable Care Act (ACA), including the expansion of Medicaid. For health care reform to be a success and meet its goals to improve access to care while reducing overall health care costs, state Medicaid programs must remain viable and build their physician capacity. Health system reform can only be a reality when patients not only have coverage, but also timely access to a physician. For this reason, it is critically important that CMS strengthen the Rule to require states to collect and report data that truly measures access to

³ Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Managed Care: Key Data, Trends, and Issues* February 2010.

⁴ GAO Report, *Medicaid Managed Care: CMS' Oversight of States' Rate Setting Needs Improvement* (August 2010).

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care, including cost studies. Equally important, we urge CMS to strengthen the enforcement and oversight mechanisms in the Rule to ensure state compliance with the equal access provision so that state Medicaid programs can remain viable.

Thank you for the opportunity to provide our input and concerns. Please contact Margaret Garikes, Director Federal Affairs, American Medical Association, at margaret.garikes@ama-assn.org if you should have any further questions about this letter.

Sincerely,

American Academy of Family Physicians
American Academy of Home Care Physicians
American Academy of Ophthalmology
American Association of Clinical Endocrinologists
American Association of Neuromuscular & Electrodiagnostic Medicine
American College of Chest Physicians
American College of Emergency Physicians
American College of Osteopathic Surgeons
American College of Physicians
American Congress of Obstetricians and Gynecologists
American Medical Association
American Osteopathic Academy of Orthopedics
American Psychiatric Association
American Society for Surgery of the Hand
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society of Pediatric Nephrology
Infectious Diseases Society of America
Medical Group Management Association
Society for Cardiovascular Angiography and Interventions
Society for Maternal-Fetal Medicine

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Medical Association of Georgia
Hawaii Medical Association

Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society