California Association of
Public Hospitals and Health Systems

July 27, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Subject: CMS–2390–P: Medicaid and Children's Health Insurance Program (CHIP); Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

Dear Mr. Slavitt:

The California Association of Public Hospitals and Health Systems (CAPH) appreciates the opportunity to submit comments on the proposed regulation on Medicaid/CHIP Managed Care and Medicaid/CHIP Comprehensive Quality Strategies.[1] As core safety net providers to California's Medicaid population and leaders in quality improvement in both our state and the nation, California's public health care systems support efforts to ensure the Medicaid program fulfills the promise of high quality care to California's lowest income residents. As such, CAPH is deeply concerned that the scope and methods by which CMS is proposing to alter Medicaid managed care will serve to severely destabilize, rather than improve, the Medicaid delivery system in California – especially California's public health care systems.

In order to understand the potential adverse impact of CMS's proposed rule on California's public health care systems, it is important to understand the vital role they play in the state's safety net and health care landscape. California's 21 public health care systems (PHS) deliver care to all who need it, regardless of ability to pay or circumstance. Though just six percent of all California hospitals statewide, they serve 2.85 million Californians each year and provide nearly 30 percent of all hospital care to the state's Medicaid population, including over half a million newly eligible Medicaid beneficiaries. Public health care systems also operate more than half of the state's top-level trauma centers and more than two-thirds of the state's burn centers, and train over half of the new doctors in the state. To a large extent, their patient population has complex and multiple medical needs. PHS take pride in providing a high level of cultural competence, which they achieve through services such as language access programs, patient advisory councils, community health navigators, and other individualized methods of building bridges between health care systems and the patients they serve in each

[1] Notice of Proposed Rulemaking ("NPRM"), 80 Fed. Reg. 31098 (June 1, 2015).

community. In light of their significant and multiple roles, PHS and their delivery system improvements have a profound impact on the health care and health of millions of Californians. They are at the very heart of the Medicaid delivery system.

County-operated public health care systems in California also have a legal obligation to treat the indigent, regardless of reimbursement, and do so as part of their core mission as public entities. This mission is reflected in the unique payer mix of public health care systems, with over half of their costs, and for some systems over 90% of costs, attributable to care provided to Medicaid and uninsured individuals, compared to an average of 27% for other hospitals in the state. Recognizing the critical nature of the role and mission of public health care systems, the state appropriately targets additional support to public health care systems through locally-financed payments to ensure patients have access to high quality, culturally competent care.

CAPH recognizes and appreciates CMS's desire to modernize Medicaid managed care and better align the regulations with existing standards for commercial plans, health insurance marketplace plans, and Medicare Advantage plans. As CMS engages in policymaking of the scope reflected in these proposed regulations, it is imperative that the impact on California's public health care systems and the patients they serve be thoughtfully considered. CMS's goal of providing meaningful access to care for Medicaid patients cannot be achieved without these critical safety net providers remaining viable sources of care to low income patients across California. In that spirit, we urge the agency to consider the following comments.

1. **The Proposed Regulations Should Explicitly Support Continuation of State Flexibility to Set and Achieve Medicaid Program and Delivery System Objectives, Consistent with CMS's Preamble Statements.**

In the Notice of Proposed Rulemaking (NPRM),[2] CMS identifies the many areas in which the health care delivery landscape has changed, which prompts the need to modernize the Medicaid managed care regulatory structure. It is essential that these efforts do not overlook key distinctions that are inherent in the Medicaid delivery system and the populations who are served. We are encouraged by CMS's acknowledgement of the need "to tak[e] into consideration the unique aspects of delivering services through Medicaid managed care."[3]

One aspect of critical importance to California providers is reflected in CMS's underlying desire for "*states* to be able, at their discretion, to incentivize and retain certain types of providers to participate in the delivery of care to Medicaid beneficiaries under a managed care arrangement."[4] In California, public health care systems are required by law and their missions to treat low-income patients, including Medicaid patients, without regard to their ability to pay. These systems, as most safety net providers do, serve high volumes of

[2] Notice of Proposed Rulemaking ("NPRM"), 80 Fed. Reg. 31098 (June 1, 2015).
[3] NPRM at 31108.
[4] NPRM at 31124 (emphasis added).

Medicaid and other low-income and indigent populations, and did so even before the Medicaid expansion under the Affordable Care Act. As a result, California's PHS have limited commercial, exchange, or Medicare payer volume, and face base payment rates from managed care plans for Medicaid enrollees that are well below commercial rates. Because public health care systems look to the Medicaid program as a primary source of revenue, they rely on predictable and adequate payments from the Medicaid program for the financial stability to remain available and viable for all who need them. In turn, the Medicaid program looks to safety net providers to provide critical and unwavering access for the Medicaid delivery system.

States have traditionally used the flexibility of supplemental payments to support their core Medicaid providers. These payments are subject to federal fiscal oversight through federal limitations, including upper payment limits, actuarial soundness, and other limitations on Medicaid payments. Within these limitations, targeted supplemental payment programs exist in many states because they are needed investments, for which the Medicaid program, its beneficiaries, and the health care delivery system as a whole receives considerable return. In California, public health care systems provide access to services to the community as a whole and offer specialty services or services to particularly high-risk patients that are essential to the local delivery system, such as trauma, burn unit, and pediatric specialty services. They also serve as the key training grounds for medical education programs. In providing all these essential services while primarily relying on Medicaid for revenues, base payments for patient services are far below the costs for providing these services. For these reasons, states like California have concluded that targeted supplemental payments are necessary to adequately compensate safety net providers for the central role they play in the Medicaid program and in the overall health care delivery system. These CMS-approved arrangements have been developed through extensive negotiation with stakeholders and leaders at the local and state level, consistent with federal limitations on payment.

For safety net providers, Medicaid does not act primarily as a *purchaser* of services for Medicaid beneficiaries. Since its inception, Medicaid has functioned as an important *guarantor* that core safety net providers will receive minimum levels of payment for the services they make accessible to and provide to Medicaid beneficiaries. The predictability and adequacy of Medicaid funding for public health care systems enables them to remain in operation, and to ensure minimum access and quality levels for the broader population. These broader health care delivery objectives are well within a state's purview. Medicaid program costs comprise a significant portion of states' budgets, and there has been a rapid rise in the percentage of residents covered by Medicaid in states electing to implement Medicaid expansion under the Affordable Care Act. In California, more than 12 million people, or nearly one third of the state's population, is now enrolled in Medicaid. As such, states regard and use their Medicaid programs as the primary lever to shape the overall health care delivery system.

Attempts to align Medicaid with Medicare and commercial insurance should not undermine the states' basic and historical commitments to its lowest income residents and the providers who serve them. These commitments have been shaped over time through their respective legislative and stakeholder processes. As Medicaid is a publically financed program,

states should neither be required nor expected to cede their public policy role to private entities. This is especially important given the significant consolidation activity among health care plans, which may serve to insulate contracted Medicaid plans from local concerns. Moreover, in the absence of a commitment to ensure that commercial rates are paid for all Medicaid services, there is a pressing need for health care providers that work primarily with Medicaid and indigent populations to be able to receive targeted supplemental payments to ensure their financial viability and their ability to provide critical services to Medicaid beneficiaries and the broader community.

In considering the policy changes it will include in the final rule, we encourage CMS to preserve sufficient flexibility to allow states to structure and utilize supplemental payment structures, consistent with federal limitations, that will allow the state to ensure a robust Medicaid program that meets the needs of its beneficiaries.

2. **CMS Policy on Directing Plan Expenditures (proposed subsection 438.6(c))**

CAPH has significant concerns regarding proposed subsection 438.6(c) of the NPRM, which would codify a new requirement prohibiting states from "directing" plan expenditures, and with CMS's proposal to continue its policy in section 438.60 that prohibits states from directly paying providers for services included in a managed care contract. Taken together, these two policies could prevent states from exercising essential oversight over payments that are made for Medicaid managed care enrollees. In particular, the policies as proposed could impact essential payment streams that have been developed over many years – with CMS approval – and which are built into the fabric of California's Medicaid program. Disrupting or requiring material modifications to these payment streams would jeopardize essential financial support for California's core safety net providers. ***CAPH urges CMS to withdraw the language in subsection 438.6(c), in light of the specific comments below.***

A. **States should not be prohibited from establishing requirements or parameters on Medicaid plan payments to providers, including requirements for plans to support essential Medicaid providers.**

The intended scope of proposed subsection 438.6(c) is not evident from its text or from CMS's discussion in the preamble, and, as written, could be interpreted to undermine long-standing financial arrangements. The proposed regulations include a general prohibition on states directing the expenditures of a Medicaid managed care plan under its contract. As described in further detail below, CAPH is concerned that this concept is difficult, if not impossible, to apply in the context of the heavily regulated and negotiated contracts and arrangements between states and Medicaid managed care plans.

The manner in which some states and plans develop Medicaid managed care supplemental payments may help illustrate the difficulty CMS faces in applying the proposed language. As discussed above in section 1, states seek to achieve dynamic and far-reaching goals in establishing Medicaid policy and requirements, including the long-term impact on the availability of services through the delivery system, and the adequacy of payment rates to

particular providers that are essential to the Medicaid program. States may have significant concerns that, without state involvement, Medicaid plans would inadequately compensate or hinder the participation of essential health care providers who rely on Medicaid reimbursement, and who are essential to the long-term stability and success of the Medicaid delivery system. In this context, and subject to federal parameters, state laws or policies may establish minimum payment requirements or expectations for payments from a Medicaid plan to specific providers of services. These requirements are comparable to federal statutes that establish floors on payments from Medicaid plans to federally qualified health centers or for primary care services.[5] Such payment requirements are consistent with the undisputed authority of a state to oversee and regulate all aspects of the managed entities operating with its jurisdiction. Indeed it is difficult to understand, in light of a state's overarching responsibility to establish and ensure "through its contracts" that plans meet service availability, service adequacy, and service coordination and continuity of care standards,[6] why CMS would seek to take away such an important aspect of the Medicaid program from states.

Payment requirements established by states in law or policy, and the plan's willingness and ability to meet them, are considered in the contract bid and/or approval process and are built into the development of capitation rates for contracting plans. Contracting Medicaid managed care plans are at risk for providing the full array of mandated services under the contract consistent with state law, including any minimum payment requirements or other requirements on plan arrangements with providers. The plans retain administrative control over the use of their capitation rates, and are independent parties responsible for fulfilling their obligations under law and contract.

In these circumstances, it is unclear when – and under what conditions – a state would be considered to be directing the plan's actions. CAPH is concerned that the NPRM's subsection 438.6(c) represents an undefined and under-conceived policy that could implicate a wide variety of long-standing arrangements essential to ensuring the stability of the Medicaid delivery system. If the prohibition is applied broadly, it could have the effect of stripping state authority over Medicaid payment rates in favor of a model that guarantees to plans unlimited discretion to determine how Medicaid funds are allocated among local providers and services. This possibility represents a significant threat to those safety net providers, including CAPH's members, that currently rely on state payment policies. It would also represent a significant transfer of authority from state policymakers to Medicaid plans, which may be less responsive to public policy concerns or to the interests of the local community.

The discussion of subsection 438.6(c) in the NPRM does not indicate that CMS intends such a broad disruption to state policies. To the contrary, CMS's concern appears to be specifically with arrangements where the state effectively makes payments directly to a provider in violation of the prohibition in section 438.60, or in a manner that effectively undermines a plan's status as an at-risk contractor.[7] These concerns appear to only call into

[5] Social Security Act § 1903(m)(2)(A)(ix)), Social Security Act § 1932(f)(C).
[6] 42 C.F.R. §§ 438.206, 438.207, 438.208.
[7] NPRM at 31123-24.

questions those arrangements where states usurp a certain degree of plan discretion. Other arrangements, in which a state exercises its oversight function by establishing minimum payment requirements or other parameters for how plans reimburse providers of service, seem to fall outside of these concerns. We are concerned that CMS lacks a clear policy or guidelines to distinguish between the two situations.

Given the importance of state policies in California and other states that regulate payments between Medicaid plans and providers, CAPH urges CMS to ***ensure that the revised regulations will not restrict the ability of states to target supplemental payments, by contract, policy or otherwise, to achieve states' goals, including the support for public health care systems***. ***CAPH urges CMS to withdraw the language in subsection 438.6(c), in light of the specific comments below.***

B. **Should CMS seek to impose restrictions on state direction of payments, it should revise the proposed exceptions, and the exception process, in proposed subsection 438.6(c) to grant states greater flexibility.**

As discussed above, CAPH believes a broadly applied prohibition on states directing plan expenditures is both unwarranted and impractical, and should be deleted in its entirety. If CMS chooses not to remove this part of the proposed regulation, CAPH is concerned that the exceptions to the general prohibition set forth in Section 438.6(c) are overly narrow. CMS has proposed three limited categories of potential exceptions to the general prohibition in 438.6(c), where states would be permitted to direct plan expenditures. In the preamble, CMS states that the goal of these exceptions are to "encourage states to use health plans as partners to assist the states in achieving overall delivery system and payment reform and performance improvements."[8] CMS goes on to say that it wants states to be able, at its discretion, to incentivize and retain certain types of providers to participate in Medicaid managed care.[9]

However, the exceptions CMS has proposed are far too narrowly circumscribed to allow states to achieve the goals articulated by CMS. If finalized, section 438.6(c) will limit state innovation in the Medicaid managed care delivery system to narrow, pre-designated categories, undermining the ability to implement new payment, delivery system, or performance incentive models. ***If CMS does not strike subsection 438.6(c) entirely, CAPH urges CMS to withdraw, revise, and reissue for comment both the enumerated exceptions and the exception process, to afford states substantially greater flexibility.*** This flexibility will help ensure that the regulations remain viable in the present environment and for years to come.

The proposed exceptions in subsection 438.6(c) would materially impair and restrain state flexibility to achieve reform in each of the areas CMS identifies – payment reform, delivery system reform, and specific performance initiatives. For example, permitted state "payment reform" models would be limited to "value-based purchasing models." While CAPH supports efforts to transition away from traditional fee-for-service payments, flexibility as to

[8] NPRM at 31124.
[9] NPRM at 31124.

how Medicaid plans reimburse providers should be encouraged, not limited. Moreover, many current models of value-based purchasing may not meet the requirements set forth by CMS. The NPRM would require states to demonstrate that the arrangement is based on the "utilization and delivery of services." This requirement undermines the goals of value-based purchasing; in the Medicare program, CMS has expressly stated a policy goal of moving away from volume (e.g. utilization and delivery of services) to value, and to see plans and providers held accountable based on outcomes, rather than the utilization of services.[10] To ensure that the regulations reflect current thinking around quality and incentive payments in placing increased importance on outcomes, *CMS should affirm that state payment reform efforts may include arrangements where Medicaid plans pay in ways that are not solely based on the utilization and delivery of services, including but not limited to payments based on outcomes or other value-based criteria proposed by the state.*

Similarly, the language of subsection 438.6(c) would seemingly restrict state delivery system reform or performance improvement initiatives to only those arrangements that involve multiple payers. (Proposed 438.6(c)(1)(ii)). This limitation serves no conceivable federal purpose. The Medi-Cal program in California serves over 12 million beneficiaries, approximately 75% of whom are enrolled in managed care. Delivery system reform or performance improvement initiatives that focus solely on the Medicaid population would have a positive impact on the Medicaid delivery system, which features many providers that look to Medicaid as a primary source of revenue. Moreover, as described above, Medicaid programs have goals that are not necessarily shared by other payers, including Medicaid's long-standing commitments and obligations to support safety net providers and the disproportionate amount of care they deliver to low-income populations. Given Medicaid's size and unique role, *states should not be required to seek buy-in from other payers prior to initiating efforts at delivery system reform*.

We also question the rationale behind requiring state minimum fee schedules to be available to all providers who provide a particular service, and for delivery system and performance improvement initiatives to be available to both public and private providers equally, under the same terms of service. As described above, many states have adopted minimum payment requirements targeted to specific providers, in order to implement key state priorities. These requirements enhance the value of the Medicaid program, and strengthen the delivery system for the patients who rely on it. CMS expressly recognizes the validity of such payments, when it states that its goal in issuing the exceptions to subsection 438.6(c) is to allow *states* "to incentivize and retain certain types of providers."[11] The exceptions offered in the NPRM would directly prevent states from achieving this goal, as they would block states from targeting incentives or financial guarantees to those providers the state wishes to support. ***CMS should revise the proposed regulatory language to recognize states' interests in***

[10] A January 26, 2015 press release from HHS explained the new Medicare policy goal of moving "toward paying providers based on the quality, rather than the quantity of care they give patients." Available at http://www.hhs.gov/news/press/2015pres/01/20150126a.html. Accessed July 21, 2015.
[11] NPRM at 31124.

targeting payment requirements and programs to specific providers as designated by the states.

CAPH has similar concerns about other proposed provisions under subsection 438.6(c), including the attempt to limit the use of IGTs that are recognized as appropriate sources of nonfederal share,[12] or to prevent states from recouping funds if state goals are not met. CAPH urges CMS to withdraw and reconsider the exception process for determining when a state can direct plan payments. Rather than prohibiting all models that do not fit a pre-determined exception, CMS should develop a significantly more flexible process that allows states to implement arrangements that more broadly meet the goals of Medicaid program, including recognizing states' interests in targeting payment requirements and programs to specific providers as designated by the states.

In finalizing this policy, CAPH urges CMS to promote and maintain the ability of states to ensure consistency between the use of fee-for-service and managed care arrangements. State fee-for-service supplemental payment programs are not restricted in the ability of the state to target payments to identified providers, so long as the amounts paid to the provider are appropriate, and the aggregate amount expended is within federal parameters. Similar flexibility must be afforded for arrangements done through Medicaid managed care, to preserve consistency and to avoid creating a new and unnecessary barrier to states' use of managed care. To that end, if CMS fails to delete section 438.6(c) in its entirety as requested above, CAPH urges CMS *to consider amendments to section 438.6(c) to allow states to establish policies requiring plans to make supplemental payments consistent with fee-for-service programs, to the extent those payments are built into their capitation rates.*

If CMS does not strike subsection 438.6(c) entirely, CAPH urges CMS to withdraw and reconsider the exception process for determining when a state can direct plan payments. Rather than prohibiting all models that do not fit a pre-determined exception, CMS should develop a significantly more flexible process that allows states to implement arrangements that more broadly meet the goals of Medicaid program, including recognizing states' interests in targeting payment requirements and programs to specific providers as designated by the states.

C. **If CMS intends for states to discontinue, or to materially modify, existing managed care supplemental payment arrangements, CMS should properly identify these changes as a change in law with the intent and the scope of the new requirements clearly specified. CMS should initiate a new comment period and include an appropriate regulatory impact analysis of the new policy to allow stakeholders to address the potential impacts prior to finalizing the changes.**

We are particularly concerned by CMS's assertion that the language represents a formalization of long-standing policy on the extent to which a state may direct a Medicaid

[12] Social Security Act §1903(w)(6); 42 C.F.R. §433.51.

plan's expenditures under a risk contract.[13] This characterization is inaccurate, given that CMS has approved Medicaid plan arrangements that involve requirements for plans to make minimum payments for designated providers. Moreover, just days after issuing the NPRM, CMS issued its *Draft 2016 Medicaid Managed Care Rate Development Guide*, which included specific guidance addressing the review and documentation of Medicaid plan contracts that include "pass-through" arrangements.[14] Nowhere in this guide does CMS articulate any policy restricting the use of such arrangements.

California's public health care systems rely on supplemental payment programs, some of which are paid through Medicaid managed care, for a significant proportion of their revenue. These programs have been developed over many years, with the support and approval of CMS. CAPH urges CMS to ***revise and reissue for comment section 438.6(c), its policy rationale, and regulatory impact analysis, with sufficient clarity to allow affected stakeholders to understand what the policy would prohibit, and what alternatives would be permissible prior to finalizing such a proposal.*** As currently drafted, the intended scope of CMS's policy is fundamentally uncertain. Such uncertainty is contrary to the goals of the Administrative Procedure Act, particularly when the issues hold such significant potential financial impact.

In the event that CMS does finalize subsection 438.6(c) in a manner that requires significant restructuring of current Medicaid payment arrangements, it is imperative that CMS provide lead time of at least 3 to 5 years to allow the state, public health care systems, and other stakeholders to develop alternatives to current financing arrangements that would comply with CMS's new policy.

D. **Should CMS prohibit states from making supplemental payments through Medicaid plans to designated Medicaid providers, CMS should revise section 438.60 to allow a state to make direct payments to those providers.**

If, in finalizing the NPRM, CMS prohibits states from targeting supplemental payments for designated providers through Medicaid managed care plans, then it is imperative that CMS also revisit its policy expressed in section 438.60 that prohibits states from making direct payment to providers for services covered under a managed care contract. CMS has carved out exceptions to the prohibition in section 438.60 previously, to allow the state to make payments for Medicaid Disproportionate Share Hospital payment (DSH), Federally Qualified Health Center (FQHC) wrap-around, Graduate Medical Education (GME) payments, and primary care provider payment increases. In each case, there are assurances that the Medicaid program is not authorizing a duplicate payment because the costs of the

[13] NPRM at 31123.

[14] *Draft 2016 Medicaid Managed Care Rate Development Guide* (June 5, 2015), pp. 7-8, available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/draft-2016-managed-care-rate-guidance.pdf. Accessed July 21, 2015.

supplemental payments are excluded from plan capitation rates, rendering the payments outside the scope of the plan contract. ***CMS should modify section 438.60 to allow states to make direct payment of supplemental payments to providers for services provided to Medicaid managed care enrollees, when any obligations to pay such supplemental amounts are excluded from plan contracts and plan capitation rates.***

3. **Comments on CMS's Proposal Regarding Use of Rate Ranges and Requirements for States to Justify Final Rates; proposed section 438.3(c), 438.4(b)(4)**

CMS has requested comment on a proposed approach that would require states to provide to CMS specific data, assumptions, and methodologies behind each contracted rate for each rate cell.[15] This approach is specifically contrasted with the current ability of states to have actuaries certify a range of acceptable rates, and then have the state select a point within that range through either state policy determinations or through negotiations with contracted plans. CMS proposes that states would be able to continue to rely on actuarially-determined "rate ranges," but proposes to have states provide details documenting how the final capitation rates are selected.

CAPH appreciates CMS's recognition of rate ranges as an appropriate actuarial tool, as well as CMS's recognition that states may enter into negotiations with plans to determine the specific rate within a range. Current actuarial guidelines support the use of rate ranges, with the understanding that states and plans will contract somewhere within the certified range. Once an actuary has provided its certification, the actuary's role in the rate development process should be resolved; actuaries have no professional ability to verify the accuracy or appropriateness of an amount that results from a negotiation between two parties, so long as it does not fall outside the range the actuary has certified. ***CMS should clarify that states may rely on an actuary's certification of its final rates, so long as those final rates are submitted to CMS and fall within the range certified by an actuary.*** Requiring actuaries to revisit rates after specific rates are established would significantly increase administrative burdens by requiring a duplicate review to be conducted. This second review would need to be conducted in accordance with the actuary's professional standards.

Furthermore, CAPH urges CMS to ***clarify that states have discretion to establish plan capitation rates anywhere within a certified rate range***. If CMS finalizes a requirement for states to "justify" how rates were selected within an approved rate range, CMS should confirm that states have discretion to pursue state policy goals in the negotiation and establishment of capitation rates, consistent with specifically detailed federal policies, including the requirements that rates be actuarially sound.

4. **CAPH supports CMS's actions to provide whole-person care to patients through policies that create flexibility to cover services in an IMD setting, "in lieu of" services, and expanded care coordination.**

[15] NPRM at 31120.

In serving some of California's most vulnerable residents, California's public health care systems recognize the importance of having flexibility to provide alternatives to the services and settings of care explicitly authorized in the State Plan in order to best meet a patient's needs. Often these alternatives provide more efficient and patient-centered care that helps avoid unnecessary and costly ER or inpatient stays. CAPH appreciates CMS's acknowledgement of the ability to account for "in lieu of" services, including IMD services, in the rate-setting process, as well as taking an expansive view of care coordination services plans can and should provide. CAPH recommends that CMS provide some additional clarity, described below, to ensure the policies are well utilized.

A. **CMS should finalize its proposal at 438.3(u) to address managed care plan flexibility in the context of patient stays in an institution of mental disease (IMD).**

CAPH supports CMS's proposal to permit plans to receive a capitation payment from the state for enrollees ages 21 to 64 that spend no more than 15 days during a month in an IMD.[16] California faces a more acute shortage of inpatient psychiatric beds than many other states in the country.[17] Public health care systems that provide inpatient psychiatric services experience this shortage on a daily basis. The IMD exclusion has created increased pressure on existing beds and on local governments to step in to provide additional necessary services. CMS's proposal would clarify the ability of plans to cover IMD stays and to ensure that expenditures for the avoided State Plan services are included in the rate-setting process.

California operates a county-based specialty mental health system pursuant to a section 1915(b) waiver that is carved out of the Medicaid managed care benefit. The plans operated pursuant to this waiver are not capitated, but manage a network of providers and are subject to CMS's Medicaid managed care regulations as Prepaid Inpatient Health Plans (PIHPs). CAPH urges CMS to clarify that the flexibility offered in section 438.3(u) also applies to Medicaid managed care plans that are not capitated.

As one of the states participating in the Medicaid Emergency Psychiatric Demonstration project, CAPH encourages CMS to continue examining whether eliminating or restricting the scope of the IMD exclusion can improve access to care and help reduce costs.

B. **CMS should formalize and clarify its rate-setting policy regarding "in lieu of services."**

CAPH strongly supports CMS's clear statement in the preamble to the NPRM that Medicaid plans may cover medically necessary alternative services or services in a setting that are not covered under the State Plan "in lieu of" covered State Plan services.[18] Today, such services in California are often provided by local systems that are seeking to relieve pressure on their ERs or, in some isolated cases, by Medicaid plans that opt to provide these additional

[16] Proposed 438.3(u).
[17] California's Acute Psychiatric Bed Loss," California Hospital Association, http://www.calhospital.org/sites/main/files/file-attachments/psych_bed_data_14.pdf. Accessed July 27, 2015.
[18] NPRM at 31117.

services. In order to ensure that CMS's policy with regard to "in lieu of" services is uniformly available, ***CAPH recommends that CMS clarify plan authority to offer "in lieu of" services in regulation***.

Public health care systems in many cases invest local dollars to provide services that are not covered by Medicaid to relieve pressure on the hospital. For example, San Francisco operates a sobering center to allow for safe, medically monitored detoxification and recovery in a non-hospital setting at a much lower cost.[19] Patients who are relying on the sobering center services would have otherwise been seen at the hospital. Even in cases when local investments have been possible, the ability to offer these services is not necessarily consistent, and access to such critical services has often been reduced in lean years.

Medicaid plans have sometimes made similar investments in alternative "in lieu of" services, but in California such investments have historically been based on individual plan decisions, not as a result of a broader unified policy. For example, in years when the state has restricted the scope of benefits, some plans continued to provide optional benefits that were removed from the State Plan, such as podiatry, as a cost-effective alternative to likely ER and inpatient visits for diabetic patients. For plans that chose to continue to offer such services, there was no formal policy to ensure that their expenditures for the non-covered services would not negatively impact their rate-setting process. Plans should have the assurance that, when they make sound policy choices that help ensure the economical use of Medicaid program resources, they will not be financially penalized, due to the lack of formal CMS guidance.

Current Medicaid managed care regulations do not acknowledge the ability of plans to offer "in lieu of" or "substitute" services, making the existence of this policy challenging to identify without further accessing sub-regulatory guidance. Existing regulations state, at 42 CFR 438.6(c)(1)(i), that actuarially sound capitation rates are defined as those that, among other requirements, meet the practice standards established by the Actuarial Standards Board (ASB). ASB Actuarial Standard of Practice (ASOP) 49 on Medicaid Managed Care Capitation Rate Development and Certification states, under "3.2.5 Covered Services," that "[w]hen developing capitation rates under 42 CFR 438.6(c), the actuary should reflect covered services for Medicaid beneficiaries, as defined in the contract between the state and the MCOs, *which may include cost effective services provided in lieu of (State Plan) services*."[20] In CMS's *Draft 2016 Medicaid Managed Care Rate Development Guide* released on June 5, 2015, CMS also acknowledges the ability to include "in lieu of" services in the rate-setting process.[21] Paragraph 3.C. of that guidance describes how actuaries should build the cost of such services into plan rates.

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[19] See https://www.sfdph.org/dph/comupg/oprograms/HUH/medrespite.asp. Accessed July 27, 2015.
[20] Available at http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/#325-covered-services (emphasis added). Accessed July 20, 2015.
[21] *Draft 2016 Medicaid Managed Care Rate Development Guide* (June 5, 2015), pp. 7-8, available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/draft-2016-managed-care-rate-guidance.pdf. Accessed July 21, 2015.

Despite this sub-regulatory guidance, states and Medicaid plans may not be aware of the ability to substitute services and/or settings for State Plan services due to the lack of explicit regulatory language. Boilerplate contract language for Medicaid plans in California does not include any language on "in lieu of" or substitute services.[22] Some plans in California believe they do not have the authority to provide alternative services to Medicaid beneficiaries. Moreover, some plans have cited the CMS regulation that limits plan capitation rates to services offered under the State Plan[23] to indicate that they may not offer such services, or that the offering of non-covered services as substitutes for State Plan services would lead to a reduction in their capitation rates.

CAPH is encouraged to see CMS's clear affirmation for the use of "in lieu of" services in the preamble to the NPRM. In the preamble, CMS defines "in lieu of" services as "alternative services or services in a setting that are not included in the State Plan or otherwise covered by the contract but are medically appropriate, cost effective substitutes for State Plan services included within the contract…"[24] The proposed regulation also alludes to CMS's intention to clarify the existing "in lieu of" policy, saying in the preamble that "[w]e aim to propose rules on substitute providers under Medicaid managed care programs for CMS's 'in lieu of' policy in particular."[25] However, the actual proposed rule contains no reference to "in lieu of" or substitute services and does not address how those services can be accounted for in the rate setting process.

CAPH is concerned that this continued lack of clarity does not make the policy option clear to states or policy stakeholders, and recommends that CMS formalize its "in lieu of" policy in regulation. CAPH recommends that CMS include the following components:

- Definition: Section 438.2 should define "in lieu of" services as "alternative services or services in a setting that are not included in the State Plan or otherwise covered by the contract but are medically appropriate, cost effective substitutes for State Plan services included within the contract," consistent with the definition offered in the preamble.

- Voluntary Nature: Proposed 438.3(e) should be amended to recognize that Medicaid plans may cover additional or "in lieu of" services. Currently, the proposed language does not reference "in lieu of" services. In addition, the language suggests that alternative services may only be provided "voluntarily" by the plan; this language should be revised to reflect that states may require plans, as part of their contracts, to offer additional or alternative benefits. This is consistent with federal statute, including section 1915(a)(1)(A) of the Social Security Act. CAPH agrees that the final decision about whether to receive alternative or additional services should rest with the patient.

[22] Medi-Cal Managed Care Boilerplate Contracts. California Department of Healthcare Services. Available at http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. Accessed July 20, 2015.
[23] Current 42 C.F.R. 438.6(e)(1), as re-designated by the NPRM as 438.3(e)(1).
[24] NPRM at 31117.
[25] NPRM at 31116.

- Standard Contract Requirement Regarding "In Lieu of" Services: CMS should include a new requirement in section 438.3 that requires states to include language in contracts with plans describing the "in lieu of" policy. This will ensure that plans are uniformly and explicitly aware of their ability to provide "in lieu of" services and are reassured that such expenditures will be accounted for in the rate setting process.

- Rate Development Standards: Section 438.5 should reference the ability to account for "in lieu of" services in the rate setting process. This should include direction on principles to follow when accounting for the coverage of "in lieu of" services in the development of capitation rates, consistent with CMS's *Draft 2016 Medicaid Managed Care Rate Development Guide*, including a requirement that the cost of avoided State Plan services may be included in the development of the rate. For reference, the 2016 Draft Guidance requires information on:

    - The categories of service that contain "in lieu of" services;

    - the percentage of cost that "in lieu of" services represent in each category of service; and

    - how the "in lieu of" services were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.

  In particular, CAPH urges CMS to permit an accounting of cost that reflects the cost of the avoided State Plan service, so that plans have a clear incentive to seek more economical but appropriate alternatives to costly services. Plans are discouraged from thinking openly about providing "in lieu of" services if policies would result in rates being reduced once cost efficiencies are gained.

- Medical Loss Ratio (MLR): In section 438.8, CMS should expressly include plan expenditures for "in lieu of" services in the numerator of the MLR calculation.

C. **CMS should clarify that plans can and should coordinate "a full range of community based support services to provide services in the most integrated setting to enrollees."**

CMS states in the preamble that in 438.208(b) and (b)(1) it was removing the words "'health care' to explicitly recognize that MCOs, PIHPs, and PAHPs may coordinate not only health care services but a full range of community based support services to provide services in the most integrated setting to enrollees."[26] It also describes its intention to allow for coordination of services provided outside the Medicaid plan. CAPH supports this guidance, but is concerned that the slight word changes do not sufficiently notify stakeholders of the changed scope of a plan's obligations to coordinate with the full range of support services. CAPH

[26] NPRM at 31140.

requests that CMS clarify its intent ***by adding a new 438.208(b)(2)(iv) "with services the enrollee accesses, including housing and other social supports, to improve health and reduce unnecessary health care utilization."***

5. **Partial Disallowance Authority (section 438.807)**

Proposed section 438.807 would give CMS authority to defer or disallow federal financial participation (FFP) for capitation payment amounts on a service-by-service basis, if CMS determines those components of the rate do not meet actuarial soundness requirements. CMS bases this proposal upon a reinterpretation of Section 1903(m)(2)(A) of the Social Security Act, which conditions FFP for state expenditures for services under managed care contracts upon compliance with several enumerated requirements.[27] CMS's preamble explanation of its analysis in this regard is not entirely clear. It is difficult to see how the statutory condition in section 1903(m)(2)(A)(iii) requiring that "services are provided … in accordance with a contract between the State and the [MCO] entity under which prepaid payments to the entity are made on an actuarially sound basis…" can be interpreted to allow CMS to pick and choose among rate cells and among portions of rates that it will approve.

As a practical matter, CAPH questions whether rates that have been certified as actuarially sound can remain so after CMS carves out those elements it "determines" are not actuarially sound. Additionally, while the proposed rule references the administrative processes for deferrals and disallowances identified in sections 430.40 and 430.42, it is not clear how and when disputes involving actuarial standards and determinations would be substantively resolved.

CMS states the proposed rule would result in "more fair and measured penalties for violations, and lead to more expedient resolution of compliance actions."[28] CAPH believes, however, that the effect of a partial deferral or disallowance of rates would be just as disruptive to plans and providers as a complete deferral or disallowance. This is because plans and providers would still be obligated to provide services, but without knowing how and whether they would be paid. Currently, CMS often works with states to resolve issues concerning rates prior to a deferment or disallowance action, in order to avoid the significant disruption caused by uncertainty around plan rates. To the extent the NPRM leads to an increase in CMS's use of the deferral or disallowance process, the result would be greater disruption. We note that the NPRM contains no assurances to resolve rate issues in a timely manner. Further, by delaying approval of certain components of the rate, this could ultimately result in the imposition of additional retroactive adjustments to rates paid to plans, something CMS has indicated they seek to minimize. ***CAPH is concerned that the proposal will result in more deferrals and disallowances, rather than timely resolution of rate issues, and urges CMS to withdraw proposed section 438.807.***

[27] NPRM at 31132.
[28] NPRM at 31133.

6. **CAPH supports CMS's proposal for plans and states to measure and report on quality improvement efforts (Part 431 Subpart I and Part 438 Subpart E).**

CAPH appreciates CMS's efforts to unify quality measurement and reporting for state Medicaid programs in the proposed amendments to Part 431 Subpart I and Part 438 Subpart E. Public health care systems in California have extensive experience working on improving quality through our first-in-the-nation Delivery System Reform Improvement Program (DSRIP), which has involved 21 PHS working simultaneously on hundreds of quality improvement goals over the last five years. Lessons from this and other experiences inform CAPH's comments on CMS's desired quality structure within this regulation:

A. **CAPH supports the principle of incorporating the entire Medicaid population in the Statewide Comprehensive Quality Strategy, as well as the inclusion of statewide goals and metrics related to the strategy, under Part 431, Subpart I.**

CAPH supports having a Statewide Comprehensive Quality Strategy that encompasses the entire Medicaid population. Though California has enrolled approximately three-quarters of its Medicaid population in managed care, there are still a significant number of individuals and services in fee-for-service. A statewide strategy for Medicaid that seeks to improve the health of the entire population should include all of these individuals and services, not just those in managed care.

In addition, CAPH supports the inclusion of measurable goals and objectives in the Statewide Comprehensive Quality Strategy as described in 431.502(b)(1) and (b)(2). California's existing statewide strategy[29] includes goals and priority focus areas, but lacks metrics to demonstrate measurable results of these quality strategies. CAPH's experience with the DSRIP shows the motivating effect that measuring quality and evaluating progress with data can have on the delivery system. CMS's proposal to add metrics will help California strengthen its quality improvement efforts for the entire Medicaid population.

B. **CAPH supports the ability of states to modify federal quality improvement topics and/or metrics by requesting an exemption under 438.330(a)(2)(ii), and recommends that CMS provide guidelines within which states can modify such requirements.**

CAPH appreciates the need to offer comparability among states and plans for the Managed Care Quality Rating System and individual plan Quality Assessment and Performance Improvement Programs. Strong guidelines and criteria across health care systems (and in the context of this rule, Medicaid plans) will help ensure that all entities are collectively working towards shared goals. Because states may need to account for wide geographic variation within a state or compared to other states, CAPH supports CMS's proposal to allow states to

[29] "DHCS Strategy for Quality Improvement in Health Care," California Department of Health Care Services, December 2014. Available at http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2014.pdf. Accessed July 21, 2015.

apply for an exemption from the federally established measures and performance improvement projects under 438.330(a)(2)(ii).

States that request an exemption should still be required to gather data and report on quality metrics, and CAPH recommends that states requesting an exemption still follow certain guidelines. For example, states should still ensure that any metrics selected align with existing recommended metrics from national quality bodies and other required reporting, to avoid unnecessary duplication of effort. The option for states to develop metrics with these types of specific guidelines, as opposed to reporting on federally-mandated metrics, will allow the states to build on existing efforts, and the opportunity for local input, creating the potential for stronger buy-in from local plans and providers.

C. **CAPH supports a robust stakeholder process for selecting quality improvement metrics.**

Throughout the rule, CMS acknowledges the importance of a public stakeholder process for developing quality metrics. CAPH agrees and supports this public process, both in the case of federally determined metrics described in 438.330(a)(2) as well as for any state alternative that could be proposed under 438.330(a)(2)(ii).

D. **CAPH recommends that future notice and comment on quality include discussions on setting improvement targets, not simply focus on selecting metrics.**

CAPH's DSRIP experience has revealed that selecting an appropriate target to achieve on a given metric is as important as the choice of the metric itself. While encouraging reporting can be an important first step in getting a quality improvement apparatus in motion, ultimately real improvement requires targets that are ambitious enough to stimulate innovation but not so aggressive that they are impossible to achieve. Those tasked with setting targets will have to balance this need with the need to compare against other benchmarks such as national and statewide averages, or clinically appropriate targets. CMS implicitly points to the need for targets in the Statewide Comprehensive Quality Strategy by requiring states to have goals and objectives. Similarly, in order to award stars in a QRS, a decision will need to be made about what merits three versus four stars, for example, which would presumably require some comparison to a target or benchmark. CAPH looks forward to discussion on this topic in future rulemaking.

E. **CAPH supports a five-year timeline for CMS and states to fully develop and implement a Statewide Comprehensive Quality Strategy, a Medicaid Managed Care Quality Rating System (QRS), and Quality Assessment and Performance Improvement Programs (QAPI).**

CMS has rightly proposed to include a more comprehensive quality structure for the Medicaid program. Developing this structure with appropriate stakeholder input will take time for adequate public input and refinement. ***CAPH recommends that states be required to***

comply with the statewide strategy, the QRS, and the QAPIs no sooner than 5 years after the finalization of the managed care rule.

CAPH appreciates the opportunity to submit these comments and looks forward continuing to work with CMS to improve the long-term quality and sustainability of the Medicaid program.

Sincerely,

Erica Murray
President and CEO