January 11, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care [CMS-2408-P]

Dear Administrator Verma:

On behalf of the members of the California Association of Public Hospitals and Health Systems (CAPH) and the millions of patients they serve, we appreciate the opportunity to comment on this proposed rule to revise and refine the requirements in the Medicaid managed care program, especially related to directed payments and provider networks.

CAPH represents California's 21 county-operated public health care systems and the University of California medical centers who deliver care to all who need it, regardless of ability to pay or circumstance. These public health care systems (PHS) play a central role in the state's safety net and health care landscape: though just six percent of all California hospitals statewide, they serve 2.85 million Californians each year and provide 40 percent of all hospital care to the state's uninsured residents and 25 percent of all hospital care to the state's Medicaid population. They operate more than half of the state's top-level trauma centers and burn centers. To a large extent, their patient population has complex and multiple medical needs. 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.

We appreciate CMS' willingness to monitor the impact of the final managed care rule from June 5, 2016 ("the 2016 Managed Care Rule"), and to make modifications to CMS regulations based on states' and CMS' implementation experience. Many of the clarifications are helpful and will ease the ability of California's core safety net hospitals to continue providing high quality care to patients enrolled in Medicaid managed care plans. It is in this context that CAPH respectfully offers the comments below.

1. **Special contract provisions related to payment (§ 438.6)**

a. **CAPH strongly supports the new proposal to expand state flexibility to establish minimum payment requirements for classes of providers.**

Under the 2016 Managed Care Rule, the language in 42 C.F.R. § 438.6(c)(1)(iii) did not clearly allow states to direct Medicaid plans to reimburse providers using benchmarks such as Medicare, commercial rates, or cost, and may have unintentionally led states to narrowly construe the scope of permissible

"minimum fee schedules." We appreciate the proposed amendments to clarify that states may direct plans to reimburse a class of providers using these well-established benchmarks, and believe the amendments will reduce the administrative burden for states to establish payment methodologies that maintain continuity of services for patients receiving care from essential safety-net providers.

b. CAPH strongly supports exempting state plan approved rates from the directed payment approval process.

We appreciate the amendments to 42 C.F.R. § 438.6(c)(2), which would exempt directed payments that are based on "state plan approved rates" from the general requirement to receive prior written approval from CMS. We believe this proposal will further CMS' goals of streamlining managed care approvals by excluding those directed payment programs that are consistent with methodologies that CMS has already approved through the state plan amendment process. **CAPH strongly supports the proposal to not require pre-approval of state plan approved rates** in order to reduce the state's and CMS' administrative burden and to create greater flexibility for states to develop stable, long-term payment strategies that can be applied equally in both fee-for-service and managed care delivery systems. This flexibility can help the states and CMS focus on those payment methodologies that are truly unprecedented or novel, while bringing financial predictability to safety net providers who rely on Medicaid funding.

In connection with the proposed flexibility for state plan approved rates, **we seek confirmation that "state plan approved rates" as defined in proposed 42 C.F.R § 438.6(a) also includes state plan approved payments that are based on a provider's actual or projected cost.** Currently, the proposed definition refers to payments calculated on a "per unit" basis (the concept of "per unit" is not further defined). Many states utilize cost-based payment methodologies, particularly for publicly operated facilities, in lieu of paying a schedule of rates or a fee schedule. When these methodologies have been approved in the state plan as acceptable and appropriate for a class of providers, additional approval requirements are unnecessary and unwarranted.

In connection with this request for clarification regarding, it is critical to recognize that many cost-based payments are not structured as *supplemental* to another form of "per unit" payment but are the sole methodology by which the facility is reimbursed for Medicaid services. As a result, they appear to fall outside the new proposed definitions in 42 C.F.R. § 438.6(a) – it is not clear that they *are* "state plan approved rates," but they also clearly *are not* "supplemental payments." Moreover, cost-based rate methodologies are not "experimental" proposals that require annual CMS' oversight – states including but not limited to California have been using cost-based payments for decades, and have well-developed reporting processes to support these methodologies. **We urge CMS to amend the proposed definitions to clarify that state plan approved rates may include cost-based methodologies.**

Suggested modification (42 C.F.R. 438.6(a)).

> State plan approved rates means amounts ~~calculated as a per unit price of services~~ described under CMS-approved rate methodologies in the Medicaid State plan, *including but not limited to per unit rates or cost-based payments*.

2. CMS should allow multi-year approvals for all types of directed payments (§ 438.6(c)(3))

CAPH appreciates CMS' willingness to allow for multi-year approvals for directed payments. Indeed, creating, gaining federal approval, implementing, and realizing the impacts of these funding streams take significant time and effort on the part of providers, plans, the state, and the federal government.

This same effort is needed regardless of whether the directed payment is a value-based, delivery system reform, or fee-schedule payment program. Indeed, one of California's most recently approved directed payments under 42 C.F.R § 438.6(c)(1)(iii) took two years to develop, and currently is the subject of ongoing meetings between plans and providers to ensure data collection and exchange is occurring accurately under the new program. In order for these substantial efforts to be worthwhile, it is critical to know that they are in service of a program that will be in place for longer than a single year. Public health care systems' work on data collection, as well as the strengthening of the plan-provider partnership that is resulting from this work, is intended to be an ongoing endeavor with lasting effects on the delivery system. Under multi-year approvals, CMS would maintain its authority to approve or deny the request, and the approval would have to meet the requirements specified in the regulation, including ensuring that the program meets an objective of the state's quality strategy and that it is evaluated for its effectiveness. **Given these safeguards that would ensure the integrity of such a program, CAPH urges CMS to permit multi-year approvals for all types of directed payments, including those authorized under 42 C.F.R § 438.6(c)(1)(iii).**

3. **Network Adequacy Standards (§438.68): CMS should not finalize its network adequacy proposal to remove time and distance standards.**

CAPH does not support CMS' proposal to remove the requirement for states to set time and distance standards. CMS has proposed to eliminate this requirement to provide states with more flexibility in measuring network adequacy. While we support this general intent given the increased use of various forms of telemedicine and alternative means of accessing care other than a face-to-face visit, we are concerned that this flexibility, without additional federal guidance and oversight, could adversely impact patient access to care. In addition, states are already provided with considerable flexibility in developing their network adequacy standards under the final rule, where they can have a process for granting exceptions when warranted (as California does today). We are encouraged to see CMS reference a range of quantitative measures beyond time and distance that could be used to assess network adequacy and **request that CMS provide additional guidance and support to states in developing these types of measures that should build on existing standards.**

Access is a complex concept to measure and oversee, particularly in light of new innovations and technologies that are evolving traditional patient-provider interactions. We agree with CMS' assertion that, in some situations, time and distance may not be the most effective type of standard for determining network adequacy. It is our hope that CMS can partner with states, providers, managed care plans, and other stakeholders to develop and test new and better metrics that will give us more nuanced, reliable, and useful ways to measure access moving forward. At some point, it may be appropriate to move away from traditional means such as time and distance standards as we validate more appropriate and effective metrics, but more work remains before we reach that point; we may eventually find that the best strategy is to add measures rather than substitute. Assessing this critical issue from various angles, with a combination of metrics, will ultimately be the most meaningful way to measure access.

Linguistic and cultural competency is also a critical aspect of network adequacy. California's public health care systems have deep experience and a long history of providing culturally competent care, including interpretation, navigation, and other social services, to diverse, low-income populations. Like access in general, measuring linguistic and cultural competency is a complex and challenging aim. **We urge CMS to assist states in evaluating whether provider networks offer appropriate linguistic and cultural competence.**

4. **Medicaid Managed Care Quality Rating System (QRS) (§438.334): CMS should measure access as part of its assessment of health plan quality.**

As noted in a 2014 report by the Department of Health and Human Services Office of the Inspector General, access to care standards for Medicaid managed care enrollees vary widely by state and are often not specific to providers who are important to the Medicaid population (e.g., pediatricians, obstetricians, and high-demand specialists).[1] Access to health care services for enrollees in Medicaid managed care is essential. Without adequate access, enrollees would not receive preventive care and treatment necessary to achieve positive health outcomes. **CAPH urges CMS to recognize the importance of access to care as a summary indicator when developing a standardized Medicaid QRS.**

CAPH appreciates CMS' recognition of the flexibilities states need to ensure full access to Medicaid services and essential safety-net providers for a population with diverse needs. If you have questions, please contact Jackie Bender, Vice President of Policy, at jbender@caph.org or 510-874-3408.

Sincerely,

Erica Murray
President and CEO

[1] U.S. Department of Health and Human Services Office of the Inspector General. OEI-02-11-00320, State Standards for Access to Care in Medicaid Managed Care. September 2014. http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf. Accessed July 2, 2015.