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HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

January 14, 2019

Timothy Hill
Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Proposed Rule: CMS-2408-P. Medicaid Program; Medicaid and Children's Health Insurance Program Managed Care

Dear Acting Director Hill:

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule that would further streamline Medicaid and Children's Health Insurance Program (CHIP) managed care regulations. CHA supports reducing federal regulatory barriers for state Medicaid agencies and appreciates CMS' ongoing commitment to improving its oversight of Medicaid managed care programs.

California has made it clear that the delivery system of choice is the managed care delivery system available through Medi-Cal, California's Medicaid program. The largest Medicaid program in the nation, Medi-Cal serves more than 13 million Californians, including approximately one-half of the state's children. Nearly one in three Californians depends on the Medi-Cal program for all of their health care needs. Since 2012, enrollment in Medi-Cal's managed care delivery system has increased from 55 percent to more than 80 percent of total Medi-Cal beneficiaries. This growth is a result of expanding the Medi-Cal managed care delivery system statewide, further expanding the program to almost 4 million beneficiaries under the Affordable Care Act and implementing the Coordinated Care Initiative.

Now, more than 10 million beneficiaries are part of the Medi-Cal managed care delivery system. As such, the state must administer a very complicated program that includes more than 60 direct contracts with 24 unique managed care plans (MCPs), requiring actuaries to certify more than 1,400 individual rate cells per contract period. Since CMS released the final Medicaid managed care regulations on May 6, 2016, California's Department of Health Care Services (DHCS), MCPs and the hospital stakeholder community have worked diligently to ensure compliance with the new requirements, while simultaneously ensuring sufficient access and capacity in the Medi-Cal managed care delivery system. Through this collaborative process, we have learned many lessons and identified further challenges that must be overcome; both inform our comments below.

CHA supports the proposed rule as yet another important step to promote flexibility and reduce regulatory barriers created by the final rule. However, based on the lessons we have learned to date, we do not believe the proposed streamlined policies go far enough. To fully achieve its goals, we urge that CMS:

1. **Allow directed payments approved under §438.6(c)(1)(iii) to be used for payment periods covering multiple years.**
2. **Carefully review the network provider provision for additional flexibility.**
3. **Build upon the exception process to established time and distance standards under existing §438.206 and §438.207.**

In its 2016 final rule, CMS implemented a series of significant changes that forced many states, including California, to completely overhaul long-standing supplemental payment programs to comply with the allowable directed payment circumstances enumerated in §438.6(c)(1)(i) through §438.6(c)(1)(iii). The final rule prohibits a state from directing expenditures by a managed care organization (MCO)ⁱ, prepaid inpatient health plan (PIHP)ⁱⁱ or prepaid ambulatory health plan (PAHP)ⁱⁱⁱ. However, the rule lists a few exceptions, including value-based purchasing models, delivery system reform or performance improvement initiatives, or directed payments to network providers. **CMS has proposed a number of changes to §438.6(a) and (c) in its effort to promote flexibility; specifically, it proposes to streamline the process for directed payment arrangements linked to the state plan approved rates, codify an existing CMS Informational Bulletin released subsequent to the final rule, and remove specific provisions that may have created unintended barriers. However, these proposed changes do little to decrease unnecessary administrative burdens or promote flexibility — particularly with respect to California’s directed payment programs, which are structured in accordance with §438.6(c)(1)(iii).**

CMS — through its decision to codify existing guidance that limits multi-year approvals to only state-directed value-based purchasing models, in accordance with §438.6(c)(1)(i) and (ii) — misses an opportunity to reduce the administrative burden on state Medicaid agencies and promote additional flexibility. As currently proposed, only one of California’s directed payment programs would benefit from this multi-year approval flexibility.

1. **Allow directed payments approved under §438.6(c)(1)(iii) to be used for payment periods covering multiple years.**

State fiscal year 2017-18 marked California’s first contract year under the new directed payment programs and subject to CMS advance approval. In that year, the process to receive CMS approval for the PHDP Program took more than nine months; in that case, the program was not approved until [March 6, 2018](#). As of January 14, 2019, the state is still awaiting approvals for the state fiscal year 2018-19 proposals. **CHA urges CMS to revisit the requirement that directed payments structured as state-directed fee schedules (§438.6(c)(1)(iii)) be approved annually — especially when there are very minimal changes from one contract year to the next, as is the case with the state fiscal year 2018-19 programs. Delayed CMS approval of directed payment programs only creates uncertainty for the state, MCPs and the provider community.** It does not expedite the state’s rate development timeline, but instead delays the entire rate review and approval process. CMS proposes, under §438.7(e), to issue annual guidance to help expedite the rate review process. However, that would do little to accelerate the process because California already provides, with each rate package, a “Medicaid Managed Care Rate Development Guide” document — exactly what CMS proposes to issue.

While CHA is aware of — and very much appreciates — CMS’ efforts to review and approve State Plan Amendments within 90 days, we are not aware of any such effort on the managed care rate side. For example, one of California’s rate packages has been under CMS review since 2017, and is for a contract

period dating back to state fiscal year 2015-16. These unnecessary administrative burdens placed on the state directly impact the majority of California's directed payment programs and, we believe, run contrary to CMS' goals as specified in this proposed rule. **CHA urges CMS to allow for a similar process through which directed payments approved in accordance with §438.6(c)(1)(iii) can cover multi-year periods.**

2. Carefully review the network provider provision for additional flexibility.

As detailed in our letter to Administrator Verma dated January 30, 2018, **CHA remains concerned with the requirement that only network providers can receive supplemental Medicaid managed care payments using one of the permissible payment mechanisms. This "one size fits all" approach is not practical in a state as large and diverse as California, and it creates significant barriers to smooth implementation — particularly given available policy alternatives the agency could recognize that achieve the same goals.** As discussed above, California has 24 MCOs, 58 counties and more than 400 hospitals that historically have received supplemental Medicaid managed care payments. Due to California's geography, it is impossible for every county to have specialty or tertiary services in close proximity. Therefore, patients in need of critical care are commonly transferred to a hospital several counties away. In certain counties, Medi-Cal managed care is operated by a single County Organized Health System health plan. Other counties utilize a Two-Plan model in which there are two managed care plans, and still others operate under a Geographic Managed Care model that involves a plurality of plans. As a result of this framework, two contiguous counties could — and often do — have vastly different models for delivering managed health care to the Medi-Cal population. Additionally, while the delivery system may appear to be consistent between counties, there are specific nuances between each county and model type related to which populations are enrolled in managed care and which services are actually covered by the plan^{iv}. Therefore, the foundation for managed care contracting cannot be universally applied as a "one contract fits all" scenario. Contracts are highly regionalized — sometimes by arbitrary county-line boundaries, but often by the natural delineation of regions by geographic occurrence such as mountain ranges, expansive desert areas, rivers or hundreds of miles between urban areas. The areas within California are not homogenous; instead, they require care delivery that meets each unique community's diverse needs. Assuming that these diverse models can be viewed as an overall singular system of care creates complexity and concern as we continue to find ways to implement the rule's provisions. **We believe strongly that, due to the complexity of California's geography and diverse health care system, CMS should utilize its discretionary authority to recognize the need for flexibility under this provision. We urge CMS to recognize exceptions to the rule and expand flexibility to include patients receiving emergency care as well as those transferred to other hospitals for medical reasons. Our concerns are detailed below for further consideration.**

Credentialing and Recredentialing

The administrative burden on hospitals that has resulted from the final rule is significant. The final rule requires the state to establish a uniform credentialing and recredentialing policy that plans must follow. Under §438.214, each Medicaid managed care plan must follow a documented process for credentialing and recredentialing network providers — in addition to the requirement that all network providers be enrolled and screened by the state.^v

While these standards appear relatively simple, the credentialing and recredentialing process is anything but. The process — which can often take a substantial amount of time (e.g., six months), during which

providers have limited access to patients — creates a significant administrative burden for many providers. In addition, this process can be further drawn out when the plan misplaces paperwork or determines that the submitted application is incomplete. The credentialing/re-credentialing process is further complicated in counties with value-based arrangements as required by CMS and DHCS through the implementation of Attachment R of the Medi-Cal 2020 Waiver^{vi}. Historically, the plans in these counties have utilized the “delegated model” of managed care, which involves contracting with numerous parties. For example, Medicaid managed care plans in Los Angeles County delegate financial risk for Medi-Cal enrollees to other MCOs and medical groups, each of which may further delegate the population to another MCO or medical group, and then eventually to the hospital. In these situations, separate credentialing is often required for each plan and each subcontracted entity. These delegated models are promoted by — and have increased since — the promulgation of Attachment R, which intends to set goals for hospitals to move to a more sustainable model that promotes value over volume. **However, the unintended consequence of these arrangements is a significant administrative burden for hospitals. Further, delays in credentialing and recredentialing decisions can impact whether providers are considered network providers for the purposes of directed payments.**

Contractual Terms

Requiring hospitals to be network providers for the purposes of receiving supplemental payments for care already provided to a Medi-Cal beneficiary creates an inappropriate advantage for MCOs in contract negotiations, and we are seeing the unintended consequences play out in the marketplace. For example, plans may impose additional requirements on hospitals by contract. In some instances, plans have tried to limit the scope of services payable under their contracts with providers by defining “medical necessity,” “covered services” or “emergency services” in a manner more limited than is permitted by DHCS. Plans also often impose unrealistic billing or other one-sided terms in contracts, or insist upon rates that are far below the average Medi-Cal reimbursement amounts. Further, populations travel throughout the state; it is unrealistic to assume the Medi-Cal enrollee will only need access to emergency services in his or her managed care contracted service area. **Again, Medi-Cal managed care plans now have all the leverage in contract negotiations with hospitals, because hospitals must have a contract in place to receive the directed payment. These unintended consequences of well-intended policies create misaligned incentives in the market.**

3. Build upon the exception process to established time and distance standards under existing §438.206 and §438.207.

CHA does not support CMS’ proposal to replace the required time and distance standards with more flexible quantitative network adequacy standards. We are concerned that additional flexibility — without additional federal and state oversight — will 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.

As CMS stated in the preamble to the final rule, time and distance standards — which are common in the private market and many state Medicaid managed care programs, including California’s — present a more accurate measure of an enrollee’s ability to have timely access to covered services, as compared to provider-to-enrollee ratios. Appreciating that provider networks can vary between a state’s geographic areas and that states have different geographic areas covered by managed care contracts, the final rule permits states to vary those standards in different geographic areas to account for the

number of providers practicing in a particular area. In addition, the final rule requires states to take into account a number of factors when setting their time and distance standards, including the number and types (in terms of specialization, training and experience) of network providers, geographic location of network providers, and use of telemedicine or similar technologies. §438.68(d) already permits that states develop an exceptions process for MCOs, PIHPs and PAHPs that are unable to meet the network standards established in §438.68(a).

Instead of replacing the required time and distance standards with more flexible quantitative network adequacy standards, **CHA recommends that CMS build upon best practices from states that currently have a process for seeking exceptions to established time and distance standards, under the state standards imposed on a managed care entity by existing §438.206 and §438.207.** CHA requests that CMS clarify that — upon request of a MCO, PIHP or PAHP — states may allow alternative access standards for the time and distance standards only if the requestor has exhausted all other reasonable options to contract with enough providers to meet the applicable standard, or the state determines that the requestor has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access. If an MCO, PIHP or PAHP cannot meet the time and distance standards established by the state, it should submit a request for alternative access standards to the state for approval. The MCO, PIHP or PAHP should also describe the reasons justifying the alternative access standards. **CHA encourages CMS to remind states that they may allow the use of clinically appropriate telecommunications technology — including telehealth, e-visits or other evolving and innovative technological solutions that are used to provide care from a distance — to determine annual compliance with established time and distance standards. Lastly, states should be required to post any approved alternative access standards on their websites.**

CHA appreciates the opportunity to comment on the proposed rule. If you have any questions, please do not hesitate to contact me at akeefe@calhospital.org or (202) 488-4688; or my colleague Ryan Witz, vice president, health care financing initiatives, at rwitz@calhospital.org or (916) 552-7642.

Sincerely,

/s/

Alyssa Keefe

Vice President Federal Regulatory Affairs

ⁱ An MCO is defined as “a managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.” 42 C.F.R. § 438.2. We are informed and believe that the geographic managed care, two-plan model, and regional model plans are operated as MCOs.

ⁱⁱ A PIHP is defined as “an entity that – (1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates. (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.” 42 C.F.R. §438.2. We are informed and believe that the county mental health plans operate as PIHPs.

ⁱⁱⁱ A PAHP is defined as “an entity that – (1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates. (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.”

^{iv} Centers for Medicare & Medicaid Services, Medi-Cal 2020 Waiver, Waiver Number 11-W-00193/9, Attachment N, Amended April 5, 2018. Accessed January 10, 2019, at www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCsAmended060718.pdf.

^v 42 CFR §438.602(b).

^{vi} Centers for Medicare & Medicaid Services, Medi-Cal 2020 Waiver, Waiver Number 11-W-00193/9, Attachment R, Amended April 5, 2018. Accessed January 10, 2019, at www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCsAmended060718.pdf.