



DISTRICT HOSPITAL LEADERSHIP FORUM



May 18, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Subject: Proposed Rule: CMS 2406-P/RIN 0938-AT41 Medicaid Program: Methods for Assuring Access to Covered Medicaid Services – Access to Covered Medicaid Services—Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold (Vol. 83, No. 57, March 23, 2018)

Dear Administrator Verma:

The California Hospital Association, the California Association of Public Hospitals and Health Systems, Private Essential Access Community Hospitals, Inc., the California Children's Hospital Association and the District Hospital Leadership Forum appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that would amend the process by which states document whether Medicaid payments in fee-for-service (FFS) systems are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with existing statute. This proposed rule aims to provide relief and address states' concerns over the administrative burden associated with current requirements, particularly for states with high rates of Medicaid managed care enrollment.

Our organizations respectfully oppose an exemption from the FFS access standards, regardless of the managed care penetration rate. Such an exemption eliminates safeguards that were put in place under the current rule to promote a more transparent data-driven process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered services, consistent with section 1902(a)(30)(A) of the Social Security Act. We have outlined below our concerns related to 1) the proposed exemption for states with high managed care enrollment, 2) the proposed exemptions for nominal rate reductions, 3) the proposed relief from public notice of rate reductions and 4) the need for greater CMS oversight of state Medicaid programs.

I. Exemption for States with High Managed Care Enrollment

We respectfully request that CMS not finalize the proposal to exempt from most access monitoring requirements states that have more than 85 percent of beneficiaries enrolled in Medicaid managed care organizations. California's Medicaid program, referred to as Medi-Cal, plays a significant role in providing health care coverage to Californians. As of May 2018, Medi-Cal provided health care coverage to approximately 13.3 million people, or roughly one-third of the state's population. Medi-Cal also finances 50 percent of the state's births, and provided coverage for 50 percent of California's children.

The number of individuals enrolled in Medi-Cal managed care has grown significantly under the Affordable Care Act. According to current California Department of Health Care Services (DHCS)

managed care enrollment [reports](#), enrollment increased from approximately 6 million people in December 2013 to nearly 10.8 million people in May 2018. California's current Medi-Cal managed care penetration rate is nearly 82 percent, meaning it could, in the near future, meet CMS' proposed 85 percent threshold for which states would be exempt from meeting the requirements of § 447.203(b)(1) through (6). It would certainly meet the threshold should CMS decide on a lower threshold of 80 percent, as our state Medicaid agency is requesting. Even with this high managed care penetration rate, 2.5 million Californians still receive care through the FFS system, including high-cost individuals who are enrolled in both Medi-Cal and Medicare (dually eligible individuals), individuals temporarily placed in FFS for approximately three months while they wait to receive informational materials and complete their Medi-Cal managed care health plan selection, and share-of-cost individuals.

The populations covered by Medi-Cal FFS in California are some of the most vulnerable, including children and adolescents with medically complex conditions and disabilities, individuals with breast and cervical cancer and tuberculosis, pregnant women and low-income seniors. DHCS [data](#) reveal:

- The distribution of ages in the FFS population is very different than that of the managed care population. The median age for Medi-Cal's FFS population (36) is 15 years older than for the Medi-Cal managed care population (21). Individuals participating in Medi-Cal's FFS delivery system had a slightly smaller proportion of children ages 0-18 and adults ages 19-64 compared to the managed care population. Conversely, FFS participants had a larger proportion of individuals ages 65 and older compared to their managed care counterparts.
- Dually eligible individuals — who comprise 88 percent of the aged eligibility group and 31 percent of the disabled eligibility group — represent 10 percent of the FFS population. In terms of spending, Medi-Cal's aged population represents 9 percent of the overall population, but accounts for 35 percent of total Medi-Cal spending. Similarly, Medi-Cal's disabled population constitutes 10 percent of the overall Medi-Cal population and accounts for 35 percent of overall spending, according to an October 2016 DHCS [report](#).
- When compared to Medi-Cal's managed care delivery system participants, Medi-Cal's FFS participants are more likely to be female.

Considering that California's FFS population is greater than the entire Medicaid program in many states — such as Colorado, Massachusetts, Oregon and Washington, to name a few — our organizations believe strongly that California's FFS population should be subject to an equal assurance of access and CMS oversight.

II. Exemption for Nominal Rate Reductions

We respectfully ask that CMS not finalize its proposal to allow states proposing to reduce Medicaid payment rates by less than 4 percent in overall service category spending during a state fiscal year (and 6 percent over two consecutive years) to be exempt from the current rule access requirements. California hospitals have historically been subjected to Medi-Cal rate reductions and limitations, especially in times of budget crises, with little to no supporting analysis. In the past, hospitals found themselves with no recourse other than to seek relief through the courts to ensure adequate rates. However, due to the Supreme Court's decision in *Armstrong v. Exceptional Child Center, Inc.*, California hospitals no longer have that ability. Instead, CMS is the only source of oversight — through the processes put in place by the current access rule data and public process requirements — that provides a venue for demonstrating the appropriateness of rate changes and ensuring that Medi-Cal beneficiaries

have access to vital health care services. The proposed exception would further diminish states' accountability for adequate provider reimbursement; we urge the agency not to finalize this provision.

Further, our organizations do not support the proposed 4 percent nominal threshold for two reasons. First, the rate of inflation continues to increase year over year. As labor and supply costs continue to increase at an even greater pace than the general inflation rate, any decrease in rate reimbursement would be extremely detrimental to the financial viability of all Medi-Cal providers. Secondly, the proposed rule does not include a cap or a specified time frame to exercise any rate reduction. For example, if a state implements a 4 percent reduction each year for five years, the compounded rate reduction at the end of the fifth year would be 15.1 percent.

III. Relief from Public Notice of Rate Reductions

Under the proposed rule, certain states with high Medicaid managed care penetration or states making nominal payment rate changes would be relieved of certain data analysis requirements, as well as the requirement to undertake a public process to solicit input on how proposed rate reductions could affect access to services. **Any process to restructure Medicaid payment rates should allow for the meaningful participation of Medicaid recipients, providers and other stakeholders — a critical component of enhancing transparency and assisting CMS in its review of proposed payment changes.**

IV. Need for Greater CMS Oversight of State Medicaid Programs

Our experience in California teaches us that it is extremely important for CMS to have effective tools to enforce its rules concerning state Medicaid programs. The California State Auditor has documented instances in which our state Medicaid agency provided ineffective program oversight, affecting access to care for Medi-Cal beneficiaries.

In a 2014 audit requested by the California Joint Legislative Audit Committee, the California State Auditor released a report concerning the California Department of Health Care Services' (DHCS) – California's state Medicaid agency – oversight of Medi-Cal managed care health plans. Titled, [*Improved Monitoring of Medi-Cal Managed Care Health Plans Is Necessary to Better Ensure Access to Care*](#), the report revealed:

- DHCS did not verify health plan data. Therefore, it could not ensure that the health plans had adequate provider networks to serve Medi-Cal beneficiaries.
- It cannot be certain the quarterly adequacy assessments of provider networks that the California Department of Managed Health Care (DMHC) performs on its behalf are based on accurate data.
- Provider directories for three health plans reviewed contained inaccurate information.
- DHCS needs to improve its processes for reviewing primary care provider directories.
- Thousands of calls from Medi-Cal beneficiaries to the Medi-Cal Managed Care Office of the Ombudsman, which was established to investigate and resolve complaints, went unanswered.
- DHCS did not consistently monitor health plans to ensure they met Medi-Cal beneficiaries' medical needs.
 - It did not perform statutorily required annual medical audits of all health plans.
 - It did not always ensure that DMHC had performed the required quarterly adequacy assessments.

We appreciate that the state has since taken steps to address many of the concerns brought to light by this report and believe that the current access monitoring review plan and public notice process offer the same opportunities to provide oversight and monitoring of the Medi-Cal FFS program and to identify opportunities to improve access to care for vulnerable populations.

Our organizations remain supportive of the goals of the current rule developed to: (1) measure and link beneficiaries' needs and utilization of services with availability of care and providers; (2) increase beneficiaries' involvement through multiple feedback mechanisms; and (3) increase stakeholder, provider and beneficiary engagement when considering proposed changes to Medicaid FFS payments rates that could potentially impact beneficiaries' ability to obtain care. The expansion of Medicaid and reliance on the Medi-Cal program to cover our most vulnerable magnify the importance of ensuring sufficient access and capacity in the broader delivery system and to maintain the health care safety net that is critical in serving all Californians, but particularly in supporting those with unmet health care needs.

We appreciate the opportunity to comment on the proposed rule. If you have any questions, please do not hesitate to contact Alyssa Keefe, vice president, federal regulatory affairs, California Hospital Association, at akeefe@calhospital.org or (202) 488-4688; or Amber Kemp, vice president, health care coverage, California Hospital Association, at akemp@calhospital.org or (916) 552-7543.

Sincerely,

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California Association of Public Hospitals & Health Systems
California Children's Hospital Association
District Hospital Leadership Forum
Private Essential Access Community Hospitals, Inc.