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July 3, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
SUBMITTED VIA REGULATIONS.GOV

Re: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P)

Dear Administrator Brooks-LaSure,

University of California Health ("UCH") is pleased to submit the following comments regarding the Center for Medicare and Medicaid Services (CMS) proposed rule on Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality.

UCH includes six academic health centers located at the Davis, Irvine, Los Angeles, Riverside, San Diego, and San Francisco campuses and 20 health professional schools. Together, UCH programs are the nation's largest health sciences and medical education training programs, the leading provider of certain specialty services and medical procedures, world leaders in clinical discoveries, and the second largest provider of Medicaid inpatient services in California.

UCH supports many of the comments raised by the California Association of Public Hospitals and America's Essential Hospitals. In addition, we respectfully request that CMS consider the following comments:

1. Any limit imposed by CMS on state directed payments should not be lower than the "Average Commercial Rate."

The size and importance of State Directed Payments ("SDPs") to safety net hospitals, including the UC hospitals, have steadily increased since CMS' adoption of the 2016 final rule. SDPs have become an important means of financial support for UC hospitals, enabling them to invest in value-based care, such as the California Quality Incentive Program (QIP), promoting health equity, and other innovations in care delivery.

SDPs to date have not been subject to an explicit payment limit. CMS proposes to establish limits equal to the Average Commercial Rate ("ACR") for (1) inpatient hospital services, (2) outpatient hospital services, (3) qualified practitioner services at academic medical centers, and (4) nursing facility services. CMS notes that these four services represent the vast majority of SDPs that are currently paying up to the ACR, and that it believes the ACR is an appropriate limit to allow managed care plans to compete with commercial plans for providers to participate in-network.

UCH strongly supports allowing states to require managed care plans to pay at commercial-equivalent rates. The ACR represents the fair market value for the services provided, and any restriction on paying market rates for Medicaid beneficiaries would undervalue the services provided to this important and vulnerable patient population. UCH respectfully requests that CMS use the ACR to assess the benchmark for measuring the reasonableness of SDP rates, rather than a limit on SDP payments.

However, if CMS insists on establishing an upper payment limit for SDPs, UCH believes that the ACR is a more appropriate limit. CMS should not impose a Medicare-based upper payment limit for SDPs.

a. CMS should leave flexibility to states to determine how to demonstrate ACR.

CMS will require states to submit (1) an ACR demonstration and (2) a total payment rate comparison to the ACR for the four services subject to the ACR limit. The ACR demonstration would be submitted with the initial preprint submission and then updated at least every three years. CMS proposes to allow states elect to provide a demonstration of the ACR at both the service and provider class level or just at the service level. We urge CMS to maintain flexibility for how states demonstrate ACR, so states may design their SDPs to advance their policy goals and promote access to care based on the needs of their particular state.

b. CMS should not impose SDP expenditure limits.

CMS indicates that it is considering imposing a limit on the amount of expenditures for SDPs to 10 to 25 percent of total costs. However, CMS acknowledges that a limit could have negative impacts on access to care.

UCH, like other safety net providers, incurs significant uncompensated costs while treating Medicaid patients and relies on SDPs as an additional source of Medicaid reimbursement. UCH is deeply concerned that an expenditure limit on SDPs could indeed impact access to care and urges CMS not to impose SDP expenditures limits and allow states the flexibility to design their Medicaid managed care programs to best serve beneficiaries.

2. CMS should expand directed payments for non-network providers.

CMS proposes removing the term “network” from the descriptions of SDP arrangements. Existing regulations specify that fee schedules and uniform rate increases are authorized for “network providers” providing services under the MCO contract.

UCH supports expanding directed payments to non-network providers. Removing this requirement will require MCOs to pay non-network providers at a minimum level and expand access to quality care for Medicaid beneficiaries. For example, UC hospitals provide highly specialized, tertiary and quaternary services to Medicaid patients from across the state of California and even other states, and therefore may not always be a network provider for Medicaid managed care plans that provide coverage in only some regions in California. Removing the “network” provider requirement will increase access to specialty care services and out-of-state providers for Medicaid beneficiaries. Therefore, UCH encourages CMS to expand directed payments to non-network providers to maintain access to care at essential hospitals.

3. Standards for access to care should include hospital and specialty services.

CMS proposes new standards to improve state monitoring of access of care through managed care organizations, including a requirement for managed care plans to conduct a payment analysis to submit to the state, which would review it and submit it to CMS. The annual report would analyze the managed care organization’s level of payment for services using paid claims data from the immediate prior rating period in comparison to Medicare rates and would be required for evaluation and management codes for primary care, obstetrics and gynecology (OB/GYN), mental health and substance use disorder services. However, there is no proposed requirement with respect to analyzing hospital rates.

UCH supports the implementation of access standards that would require managed care organizations to

provide analysis of reimbursement levels and maximum wait times. CMS notes significant evidence that Medicaid payment rates are lower on average than Medicare and commercial rates. CMS also notes that provider payment rates influence access by affecting the number of providers willing to accept Medicaid patients and the limited capacity of those who do participate.

For that reason, UCH encourages CMS to include hospital services beyond OB/GYN and behavioral health services—namely, hospital and specialty professional services—in the required managed care organization's provider payment analysis to assess access to care for these services. Monitoring of these rates is important for ensuring provider participation and access to hospital and specialty services.

Thank you again for the opportunity to submit these comments. Should you have any questions about our comments, please contact me at tam.ma@ucop.edu.

Sincerely,

Tam Ma

Tam Ma
Associate Vice President
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