



January 14, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2408–P
P.O. Box 8013
Baltimore, MD 21244–1813

RE: CMS–2408–P – Medicaid Program; Medicaid and Children’s Health Insurance Plan (CHIP) Managed Care; published at Federal Register, Vol. 83, No. 220, November 14, 2018.

Submitted electronically via www.regulations.gov

Dear Administrator Verma,

UnityPoint Health (“UPH”) appreciates this opportunity to provide feedback on the proposed rule. UPH is one of the nation’s most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 38 hospitals in metropolitan and rural communities and 15 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits.

UPH appreciates the time and effort of CMS in developing and proposing this rule. We respectfully offer both general input on opportunities to improve Medicaid managed care as well as comments related to select provisions of the proposed rule.

GENERAL COMMENTS

The growth of Medicaid managed care is well documented. We believe that this trend has generally resulted in states turning over their regulatory keys concerning some of their most vulnerable residents to private health plans with little accountability and virtually no avenue for public input. As a large integrated health system, our providers are responsible for providing high-quality direct care across settings. Despite the intimate relationship and trust we have built with our patients, by instituting Medicaid managed care, healthcare providers have effectively lost our voice with state Medicaid agencies and have been relegated to a vendor role for the various Medicaid managed care organizations. As currently structured, providers can no longer go directly to states with widespread grievances or opportunities for improvement. When we do, our concerns are characterized as contractual and our

recourse is to address our concerns with each health plan individually. As a multi-state provider, these issues are compounded and administrative burden exponentially increased. Although UnityPoint Health is usually in support of additional flexibility for states to address local issues, we have significant concerns that loosening federal parameters for Medicaid managed care will usurp decision-making authority that should appropriately lie with, and be maintained by, taxpayers and the federal and state governments. We do not believe that CMS should erode Medicaid oversight and basic standards, but instead should set clear guidelines that assure stakeholder input, including input from consumers and providers.

Among the areas that we would encourage CMS to consider for adoption as uniform guidelines for Medicaid managed care include:

- Establish a Medicaid Managed Care Steering Committee. We urge CMS to highly encourage states with Medicaid managed care to embed a collaborative approach to managed care through the creation of a steering committee. This would provide a forum for stakeholders to discuss Medicaid program implementation, improvement and policy and to identify system issues and offer collaborative approaches to solve problems. Suggested composition would include CEOs/designees of the managed care companies and the state’s largest health systems or provider organizations, Director/designee of the state Medicaid agency, consumers and other stakeholders representing the healthcare community. We would also suggest that CMS recommend a limited committee size (i.e. not to exceed 10 members), meeting frequency (i.e. at least quarterly) and deliverables (i.e. biannual written recommendations).
- Create a Third-Party Appeal Process for Providers. We urge CMS to require states to have a neutral third-party appeal process for providers. This process would have the authority to resolve disputed claims and set precedence for future claims with similar circumstances. Although providers may currently appeal denied claims to managed care plans, if the denial is upheld by the plan, providers in most cases do not have another recourse to appeal the claim.
- Improve the Prior Authorization Process. Patients are experiencing delays in treatment due to the current system of prior authorizations and are frustrated by administrative burdens and inconsistent application. We encourage CMS to establish uniform authorization criteria across managed care plans to standardize the process, reduce administrative inefficiencies and reduce fragmentation within the delivery system. We also request that CMS prohibit the practice of retrospective downgrades of services that had been approved via the established prior authorization process. Both practices would support a focus on patient-centered outcomes.
- Mandate Timely Data Sharing. With the advent population health management, providers need timely, relevant and accurate data to manage and improve the health of individuals in our care. While CMS has established stringent data collection, reporting and interoperability standards for Medicare providers, data exchange standards for Medicaid managed care plans has not kept pace. We urge CMS to set minimum standards for data provided to Accountable Care Organizations and other providers in value-based arrangements by Medicaid managed care plans.

- Enforce Contractual Obligations. Many of the frustrations of healthcare providers related to Medicaid managed care are due to the lack of enforcement of current contract requirements included in the managed care plans' contracts with the states. Issues include denying covered services, delaying reimbursements and providing inaccurate information to patients and providers. We recommend CMS consider requiring improved executive oversight of managed care contracts, particularly when violations have been identified by providers, and establishing guidelines for timely and transparent resolution.
- Institute a Centralized Credentialing Process. In many states, no centralized credentialing system exists or, if one does, managed care plans are often allowed to require additional or different credentialing information. This creates duplication, administrative burden and unnecessary delays. We encourage CMS to require that credentialing requirements remain within the purview of the states and to prohibit managed care plan from varying these requirements.

We believe that setting guidelines for states related to the above items would retain regulatory authority within state government, help assure minimum processes are being followed and reduce duplicative and even contrary practices from being adopted by managed care plans. Ultimately, these suggestions would improve patient access to Medicaid services.

In addition to emphasizing the need for certain standard guidelines, we would also like to reiterate the need for CMS to continue its prioritization of value-based arrangements for Medicaid. Through MACRA, Congress has established participation thresholds (revenue and patient count) required to earn Advanced Alternative Payment Model (A-APM) status. Certain Medicaid value-based arrangements are eligible for inclusion as an "Other Payer" A-APM. Unfortunately, many Medicaid managed care plans have not been willing to enter into qualifying arrangements, despite state contractual obligations and/or incentives. We urge CMS to revisit how Medicaid managed care plans should be encouraged to include value-based arrangements with providers.

MEDICAID MANAGED CARE

The following UnityPoint Health comments relate to specific provisions of the proposed rule.

B2. ACTUARIAL SOUNDNESS STANDARDS

CMS is proposing to permit states to develop and certify a rate range of 5 percent per rate cell within set parameters. In addition, CMS is clarifying that any differences in capitation rates development practices must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations and must not vary with the rate of Federal Financial Participation (FFP) associated with the covered populations in a manner that increases federal costs.

- **Comment:** We are concerned that rate ranges do not promote rate transparency and obscure healthcare pricing. The inclusion of rate ranges prolongs rate negotiations between the states and managed care plans and, instead of being based on the cost of services, resulting negotiations may selectively target rate cells without additional public notice or CMS approval. During a period when CMS is demanding price transparency for hospital prices and prescriptions drugs, we are puzzled by

this backward step for Medicaid rate setting and pricing.

B5. RATE CERTIFICATION SUBMISSION

CMS is clarifying that states may adjust capitation rates within a permissible 1.5 percent range without requiring a revised rate certification or justification to CMS. CMS is also proposing to issue annual sub-regulatory guidance to help streamline rate review processes and allow for an accelerated rate review.

- **Comment:** We are supportive of a streamlined and accelerated process for rate certification and that CMS intends to issue an annual sub-regulatory guidance addressing the review process. We would request that CMS embed sufficient time for managed care plans to negotiate rates with providers. In addition, we would generally oppose any accelerated process that may shorten timeframes related to the public notice and comment period.

B10. NETWORK ADEQUACY STANDARDS

CMS is proposing to replace the requirement for states to establish time and distance standards with a more flexible requirement that states establish quantitative network adequacy standards. CMS is also clarifying that states have the authority to define “specialists” in the most appropriate way for their programs.

- **Comment:** UnityPoint Health supports alternative means to meet access requirements outside the traditional time and distance standards. As a provider organization whose service area largely encompasses rural areas, time and distance standards alone do not necessarily equate to access. At minimum, we believe that access requirements should include telehealth and Centers of Excellence (common practices for service delivery within ACOs). While we generally agree that quantitative standards may include “minimum provider-to-enrollee ratios; maximum travel time or distance to providers; a minimum percentage of contracted providers that are accepting new patients; maximum wait times for an appointment; hours of operation requirements (for example, extended evening or weekend hours); and combinations of these quantitative measures,” we want to assure that these requirements are set by the States and may not be further restricted by managed care plans.

B12. ENROLLEE ENCOUNTER DATA

To clarify an existing requirement that managed care plans provide for the submission of all enrollee encounter data that the state is required to submit to CMS under § 438.818, CMS is proposing to explicitly state that required data elements include “allowed amount and paid amount.” CMS also commits to treating this data as trade secret when the requirements for such a classification are met.

- **Comment:** We support efforts by CMS to obtain robust encounter data from Medicaid managed care plans. In addition, UnityPoint Health does not want to miss this opportunity to again advocate for greater data transparency and the timely sharing of data, not just with CMS, but with providers.

B13. MEDICAID MANAGED CARE QUALITY RATING SYSTEM (QRS)

CMS is proposing develop a minimum set of mandatory performance measures that will apply equally to the federal QRS and alternative QRS and committing to consult with states and other stakeholders in developing the QRS, including sub-regulatory guidance on the “substantially comparable” standard for an alternative QRS. Lastly, CMS is proposing to eliminate the requirement that a state receive approval from CMS prior to implementation of an alternative QRS while maintaining CMS oversight authority.

- **Comment:** We are generally supportive of this proposal, which seems to align with our recommendation under “General Comments” in which we advocate for certain uniform guidelines. In terms of quality measures, our organization collects and tracks more than 200 measures to comply with various public and private contractual obligations. Not all these measures can be collected electronically, and there are many measures that purport to measure the same concept but differ in definition and therefore must be collected and reported separately. In prior comment letters, we have repeatedly applauded the CMS Meaningful Measures initiative and its attempt to streamline data collection and reporting. We also are encouraged at CMS’s movement towards outcome-based measures instead of outputs and process measures. In terms of Medicaid, we would generally encourage that performance measures follow Meaningful Measure guidelines and transition to outcome measures when possible. In addition, we have two other recommendations / observations:
 - Alternative QRS. We are concerned that this proposal would lead to more divergent measures instead of streamlining QRS. We will reserve further comment until CMS releases its sub-regulatory guidance on the “substantially comparable” standard. Overall, we believe that uniform standards would ease the collection and reporting burden for providers, allow consistency for quality initiatives, and permit like comparisons of performance across geographies.
 - Other Payer Measures. We believe that this proposed rule presents an opportunity to align Medicaid quality measure sets and ratings with traditional fee-for-service Medicare as well as Medicare Advantage. At minimum, we would suggest that Medicaid, Fee-for-Service Medicare and Medicare Advantage strive to use the same measurement domains and to include roughly an equivalent number of measures within each domain. We also encourage the total number of measures within sets to be small (i.e. less than 20 measures). As for individual measures, while we understand that the Medicaid population may warrant some targeted measures, we believe that measures should be instituted that adopt a more holistic, population health framework when possible. For instance, appropriate measures should be expanded to include broader age ranges without altering other definitional parameters. Efforts to streamline measures across payers would not only support provider compliance but also enhance public perception and consumer and caregiver understanding.

We are pleased to provide comments to the proposed rule and its impact on our patients, communities and integrated healthcare system. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,



Sabra Rosener
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