State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

July 24, 2015

RE: Proposed Rules on Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability (CMS-2390-P)

Submitted electronically via: http://www.regulations.gov/

The California Department of Health Care Services (DHCS) submits the enclosed comments for your consideration in response to the notice of proposed rulemaking (NPRM) published June 1, 2015, entitled "*Proposed Rules on Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability*."

DHCS shares the various goals and priorities cited by the Centers for Medicare and Medicaid Services (CMS) in modernizing the regulatory and financing frameworks for managed care, including alignment with other insurers; delivery system reform; payment and accountability improvements; and beneficiary protections. California has been at the forefront in adopting and expanding managed care delivery in the Medi-Cal program, in pursuit of promoting access to high quality coordinated care and cost efficiency. The transformation to managed care in California has been further reinforced in recent years through the implementation of the Affordable Care Act's (ACA) new adult group expansion, and the expansion of managed care to rural counties and additional Medi-Cal populations through the "Bridge to Reform" 1115 demonstration project. As a result, Medi-Cal managed care is now utilized in all 58 of California's counties and encompasses approximately 80% of Medi-Cal beneficiaries, up from 54% of the population just five years ago.

Given this level of commitment to managed care delivery system, the NPRM proposals are of utmost significance to DHCS and we appreciate this opportunity to participate in this rulemaking effort. However, while California has embraced these organized delivery systems in Medi-Cal, much of it has all been built upon a regulatory and financing structure which may be undermined upon finalization of the NPRM, which could result in unintended negative consequences for our more than 9 million beneficiaries enrolled in managed care and the safety net delivery system. With this in mind, we must stress the need for prioritizing state flexibility throughout the finalized rules and a reasonable multi-year timeframe for implementation, in order to assure a measured and sustainable transition to what CMS has envisioned.

We have included narrative comments in this letter touching upon overarching themes from the NPRM and key areas of concern from the California Medicaid perspective. Generally speaking, DHCS recommends that the final rule: provide sufficient time for states to overhaul programs, and build the necessary infrastructure and administrative capacity to assure sustainable compliance; prioritize state flexibility in restructuring the delivery, ratesetting, and contractual segments of managed care programs; and reinforce the well-established principle that ensuring and evaluating access to care is a multifaceted concept that cannot be measured on the basis of payment alone. As far as specific subject matters addressed, DHCS is particularly concerned with the following NPRM components: the elimination of the use of certified rate ranges; the restrictions on state direction of managed care plan expenditures; the centralized enrollment of all network providers; and the conditioning of Federal Financial Participation (FFP) in the reporting of enrollee encounter data. In addition, we have included various comments and recommendations in the enclosed chart which is organized according to the proposed regulatory sections.

NPRM's Expansive Scope and the Need for a Multi-Year, Phased Transition

The proposed rules represent a sweeping overhaul of nearly every facet of Medicaid managed care programs and the accompanying capitated ratesetting process. This includes not only heightened monitoring and documentation requirements on states and managed care plans (e.g., network adequacy, program integrity, rate development), but also the introduction of new and resource-intensive concepts into Medicaid (e.g., medical loss ratio) and significant shifts to what has been previously allowable under CMS policy (e.g., proposed restrictions on directing managed care plan expenditures). Within each of these various segments of managed care programs, there are a multitude of changes being proposed, all of which will require careful planning and implementation so as to not disrupt the continued delivery and financing of Medicaid services at the local level. Given the breadth of the proposals and the wide-ranging impact on programs, we feel it is unrealistic to expect state Medicaid agencies to be able to complete all that the proposed rules require on a simultaneous basis and within a turnaround time of what projects to be approximately 12 months from finalization.

The totality of these efforts will require substantial investment of time and resources in reshaping various programs in the front-end. The State will need sufficient time to plan for and effectuate the needed changes on multiple fronts, including but not limited to: overhaul of numerous State statutes, regulations and managed care and budgeting policies; amendments to approximately 100 managed care contracts; implementation of a new External Quality Review Organization (EQRO) contract which could take up to five years; and revision of various State Plan, waiver and demonstration authorities. This all comes at a time when state Medicaid resources are already stretched thin due to the ongoing task of ACA implementation and continued state budgetary constraints.

Because of this, DHCS strongly recommends that CMS provide for a phased implementation approach over the course of several years post publication of the final rule. This will better position California and other states to restructure their programs in accordance with the timing of our legislative, budgeting and administrative processes.

Just as important, states will also need the time to build the infrastructure and secure the administrative resources necessary to maintain compliance with the new framework in the years to come. We draw upon our recent experience in implementation of the ACA's primary care payment increase and health insurance provider fee to conclude that significant additional staff resources, time, and funding are needed to comply with the NPRM as written. This is particularly apparent when considering that these recent efforts are relatively narrow when compared to the ratesetting process requirements of the NPRM, and pale in comparison to the sum of the NPRM's components.

Need for State Flexibility in Modernizing and Repurposing Medicaid Managed Care

The prioritization of state flexibility is of the utmost importance to DHCS in modernizing the various aspects of Medi-Cal managed care in accordance with the revamped regulatory scheme.

We feel it is imperative that states are afforded sufficient latitude to build and repurpose programs in a manner that appropriately accounts for unique population demographics, existing initiatives and priorities of state Medicaid programs, and the varying market and political dynamics at hand for each state. With the medical loss ratio (MLR), for example, flexibility is warranted so that states may define the numerator components of the equation according to the specific policies employed in their respective Medicaid program. For DHCS, we would seek to include things such as utilization management and quality improvement activities to reflect how these activities are currently characterized in Medi-Cal. Likewise, flexibility is needed to align as much as possible with the principles and processes developed for regulation of the post-ACA commercial market here in California.

It also important that states are free to build upon and enhance existing policies and structures used in managed care programs, so long as these efforts are in alignment with the goals envisioned by CMS and are consistent with the spirit behind the proposed rules. By way of example, the NPRM requires the establishment of a comprehensive beneficiary support system (proposed §438.71) which mandates a number of features that are already existing in Medi-Cal managed care, albeit not under a single program or system. It would be duplicative and inefficient to require states to cast aside functioning elements of existing programs in order to meet this type of one-size-fits-all standard.

We also request clarification from CMS on the prospect for, and the parameters for obtaining approval of, waiver or expenditure authority for states to maintain existing programs or initiatives that may prove inconsistent with the proposed rules.

Recognition That Payment Rates Are Only One Component of Access

DHCS shares the view espoused by CMS that access to quality care is paramount in Medicaid, and we remain committed to strengthening current policies and integrating additional models for measuring and monitoring the beneficiary experience. We must stress that there can be no single, end-all metric for gauging access or evaluating the appropriateness of a payment rate, particularly with the complexities faced in managed care delivery in a state as large and diverse as California. Because of this, we caution against a regulatory approach that could be read to allow for a compartmentalized evaluation of access on the basis of payment rates alone, or one which dictates payment increases as the sole remedy for promoting access or quality in managed care delivery.

For example, we call your attention to two comment areas from the NPRM which could potentially further this oversimplified correlation between payment and access. First, there is concern with the introduction of ambiguous terms such as "adequate" and "sufficient" in connection with capitated payment requirements in both the proposed regulatory text (e.g., "adequate to meet the requirements on MCOs…" at §438.4(b)(3)), and in the preamble (e.g., "the review of the rate certification would explore whether the provider rates are sufficient to support the MCO's, PIHP's, or PAHP's obligations" at 80 FR 31098, 31120). We view this as potential reinforcement for the flawed notion that access can be maintained through actuarial practice alone. In addition, we are concerned that a disproportionate importance could be placed on the medical loss ratio in the determination of actuarially sound rates (e.g., "developed in such a way that the MCO…would reasonably achieve a medical loss ratio standard…of at least 85 percent for the rate year" at §438.4(b)(8)). DHCS requests that CMS make clear in the final rule that rate of payment is but one factor in a much larger context of network adequacy and service availability, and that use of tools such as the medical loss ratio shall be considered as but one component in the development of actuarially sound rates.

Proposed Restriction Against Use of Rate Ranges, and Certification of Each Individual Rate (proposed 42 CFR §438.3(b) and (c), §438.4(b), and §438.7(c))

DHCS is concerned with the proposal to eliminate the use of certified rate ranges, and instead require affirmative approval of the certification of each individual managed care plan rate. DHCS relies on the maneuverability that a certified rate range provides in adopting and adjusting rates in a dynamic and fluid funding environment. This loss of flexibility will introduce significant time, documentation, and cost burdens on states in

what stands to be an increasingly prescriptive regulatory framework for managed care ratesetting. While we appreciate the need for CMS to oversee material changes in managed care plan contracting, we believe this objective can still be served without requiring an approved certification upon each incremental adjustment, particularly when the use of range is an established, and in many ways optimal, actuarial practice. Within the development of an actuarially sound capitation rate range, an almost infinite combination of values is possible for each of the independent variables that go into creating the range. States utilize rate ranges for multiple reasons in paying different managed care plans varying capitation rates, including as a method to stabilize the safety net delivery system. There is no one actuarially sound capitation rate, and manipulating variable values to generate a specific rate in order to meet the NPRM standard is unnecessarily resource- and cost-intensive.

As an alternative, DHCS requests that the finalized rule allow for the certification and approval of rate ranges carrying a reasonably limited magnitude. We propose that states are permitted to employ a lower and upper bound of five percent from the targeted rate. In order to ensure proper federal oversight, states could be required to notify CMS of any adjustment within the certified range. We feel this alternative would more closely align with accepted principles of actuarial practice and would place states in a better position to adapt to changing conditions during a contract period. DHCS is also concerned with the 90-day prior submission requirement that would attach to each certified rate, given the frequency in which this requirement would be triggered in absence of rate range and the impact a prolonged approval period may have on the accuracy of rate development. As an alternative, DHCS requests that this time period is shortened to 45 days prior to the proposed effective date of the certified rate range being submitted.

Prohibition on Directing Managed Care Plan Expenditures (proposed 42 CFR §438.6(c))

The proposed “Special contract provisions related to payment” rule imposes new and expansive restrictions on the ability to employ payment initiatives in the managed care setting, by limiting the scenarios where states may direct managed care plan expenditures and imposing substantial pre-approval standards for the three allowable exceptions proposed. DHCS is concerned that this will narrow, and in some instances preclude, current practices which extend reimbursement to safety net providers in Medi-Cal managed care. This type of result would constrain exercise of longstanding state flexibility, pursuant to Sections 1902(a)(2) and 1903(w) of the Social Security Act, to draw upon a variety of state and local sources to fund the nonfederal share in furtherance of these initiatives in the managed care context. From our perspective, we do not see a rationale for imposing this for managed care when there are no such restrictions applied to supplemental payments in fee-for-service. Given the increasing

predominance of managed care in Medicaid, we recommend that the same customization in financing allowed in fee-for-service be preserved in the capitated environment, so that states may continue to pursue targeted payment strategies in the more cost-efficient and coordinated delivery setting.

Currently, the Medi-Cal program employs various payment initiatives in managed care which may fall under the proposed prohibition against directing managed care plan expenditures. For instance, the State uses hospital fee revenue to finance capitation payments to managed care plans, which in turn are to be used by managed care plans to support expenditures for Medi-Cal hospital services. In a similar fashion, California relies on voluntary local contributions to finance increased capitation to managed care plans, intended to target increased reimbursement to safety net providers. These various programs and funding streams are vital to the State in promoting access and quality objectives in a manner that can be readily tailored to local market dynamics and that can properly account for the differences between public and private providers within the same service category.

To the extent these are considered prohibited state direction of managed care plan payments, it will be nearly impossible in practice to repurpose these programs to comply with the requirements proposed in rule, particularly those calling for strict uniformity in provider participation and rate increases within each initiative of this type. As such, the State would be looking at a significant overhaul of its fiscal structure for Medi-Cal managed care, and a need for large-scale legislative, administrative and contractual changes. This fundamental change in policy would pose a substantial risk of destabilizing the Medi-Cal delivery system with particularly negative consequences for safety net providers.

With the above in mind, DHCS views the proposal at 438.6(c) as much more than a codification of existing federal policy, given the disruption to current financing initiatives employed in Medi-Cal managed care. As such, we urge CMS not to finalize the prohibition in subsection (c)(1) so as to allow for more targeted and flexible initiatives, beyond those which impose a uniform fee or increase for all providers of a particular service. States should be able to direct a fee-for-service floor for payment to certain provider-types within a service classification, without having to include all providers of that same service under a singular payment initiative. Likewise, states should not be held to unreasonable uniformity requirements when pursuing next-generation, value-based payment initiatives, because these programs are designed to target only certain providers within a category.

As an alternative to the pre-approval process in (c)(2), DHCS recommends that CMS require states to sufficiently document and support directed payment programs within the rate development and contract approval process. We believe that this will foster

continued state flexibility to pursue provider payment strategies within the bounds of actuarial soundness, while maintaining a strong commitment to transparency in ratesetting.

We also request clarification on the following: (1) the intended scope of the prohibition on directing managed care plan expenditures, including the difference between "direction" and "minimum payment expectations" (as used in the preamble at 80 FR 31098, 31120), and the level of discretion that must be afforded to managed care plans in disbursement of funds in order to be permissible under the rule. DHCS also request further clarification on the extent to which the prohibition against conditioning provider participation on Intergovernmental Transfer (IGT) arrangements would restrict increased capitation payment programs where the nonfederal share component is based entirely on voluntary local contributions.

Minimum Standards for Provider Screening and Enrollment (proposed 42 CFR §438.602)

DHCS believes that states should have the flexibility to determine how providers are credentialed and to delegate this responsibility to its managed care plan partners.

California currently delegates responsibility for credentialing to its managed care plan partners and sets minimum requirements in contracts and guidance for our managed care plans to meet. Compliance with these requirements is then measured through an annual medical audit and other monitoring mechanisms. DHCS has also recently developed new processes to oversee managed care plan compliance related to suspended providers and intends to extend these processes to other areas. Any deficiencies are resolved through corrective action and, if necessary, sanctions and/or penalties.

The requirement to have all Medi-Cal providers enroll through the fee-for-service (FFS) provider system is both burdensome and unnecessary. The same goals can be accomplished through a flexible system which allows states to delegate responsibility accordingly - program integrity is not improved under the proposed requirement. California's Medicaid program is comprised of over a hundred thousand providers. A requirement to credential all providers at the state level would impose significant and unnecessary administrative burden and could essentially halt expansion of the state's network. In addition, DHCS is concerned that current providers in our Medi-Cal managed care program that do not participate in Medi-Cal FFS, would choose to simply stop participating altogether rather than having to go through an additional credentialing and enrollment process. Given the rapid growth of California's program, this disruption could result in network adequacy issues which could impact State and managed care plan efforts to promote access to care.

Credentialing of all providers through a single system also is not appropriate for unique provider types. For example, many in-home providers of LTSS services are family members of beneficiaries who are delivering care. It would create an undue burden on these individuals, the State, and managed care plans to require all of these individuals to undergo a credentialing process. Similarly, other types of LTSS providers may be credentialed by other state agencies with expertise in the assessment of those provider types, and thus, a requirement to change the process of credentialing and enrollment would be duplicative and disruptive.

Given the significant expansion of the size of California's Medicaid program, it is necessary to maintain flexibility to expand provider networks in new ways. The proposed requirement would undermine that opportunity, and also undermine the ability of the State and managed care plans to leverage a range of new innovative provider types, which are likely to continue to emerge as states enhance their programs.

Submitting Enrollee Encounter Data and the Availability of FFP (proposed 42 CFR §438.818)

CMS should not withhold FFP for incomplete encounter data, and should instead collaborate with states in understanding and addressing key challenges in collecting and reporting encounter data. DHCS supports strong accountability for reporting of managed care plan encounter data and is committed to ensuring timely, accurate, and complete encounter data. DHCS implemented an Encounter Data Improvement Project three years ago which is focused on improving the completeness, accuracy, reasonability, and timeliness of encounter data by managed care plans. Since then significant improvements have been made in encounter data reporting. DHCS has also implemented the Quality Measures for Encounter Data (QMED) which measures managed care plan reporting on these four domains. The QMED is used to create a quarterly encounter data report card for each managed care plan. DHCS is actively monitoring managed care plan encounter data reporting and is working with managed care plans when deficiencies are identified by way of technical assistance and corrective action, when necessary. Given DHCS' commitment to encounter data, we are troubled by the proposal to withhold FFP for non-compliant encounter data, which would decrease resources to tackle the challenges in this area. A more effective and appropriate approach would be for CMS to partner with states to understand and help address the inherent challenges in obtaining and reporting compliant, high quality encounter data.

We are also concerned that the approach for operationalizing this policy is unclear in the NPRM. For instance, the rule does not specify whether states would receive full FFP once corrected data is accepted by CMS or if FFP would be disallowed permanently. It is also unclear whether FFP would be withheld if only some portion of the data are

deemed non-compliant or if states could achieve a reasonable threshold for the quality of encounter data and receive full FFP. These outstanding questions only underscore that collaboration with states is a more appropriate pathway to address encounter data challenges.

Should CMS impose this requirement, the proposal to condition FFP on "sufficient and timely" encounter data should recognize appropriate thresholds for completeness and accuracy, should be measured in the aggregate (and not by individual rate cell) and should recognize some of the inherent challenges with gathering encounter data that will be unique to certain programs, such as MLTSS. For example, certain HCBS encounters (particularly for environmental modifications), goods and services under self-direction, and services without a HIPAA standard HCPCS code are challenging and should be considered when determining what qualifies as "sufficient and timely."

Conclusion

DHCS appreciates the opportunity to comment and urges CMS to modify the proposed regulation to adjust for the aforementioned concerns and those noted in the attachment. Doing so will enable California to maintain a robust managed care delivery system for the over nine million Medicaid beneficiaries who rely on it to access critical health care services.

Sincerely,

Orginal signed by Mari Cantwell

Mari Cantwell
Chief Deputy Director, Health Care Programs
California State Medicaid Director

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
PART 438 – MANAGED CARE: SUBPART A – GENERAL PROVISIONS	
DEFINITIONS	
§438.2	DHCS urges the Centers for Medicare and Medicaid Services (CMS) to restrain from imposing a federal definition of LTSS for purposes of this regulation. DHCS is concerned that a federal definition of LTSS may not reflect the true scope of LTSS, especially in managed care programs. DHCS believes states should have the flexibility to set a definition of these services in the context of the structure of their program and managed care models. Furthermore, if imposed, CMS should only apply the definition for purposes of this regulation. Applying the definition outside of this regulation could have unintended consequences on many other elements of the Medicaid program, including on the appropriate application of parity requirements.
STANDARD CONTRACT PROVISIONS	
§438.3	(a) DHCS is committed to working with CMS to meet appropriate timeframes for rate and contract submissions to help ensure the process is more predictable with regard to the timing of approvals and effective dates. However, we are concerned about requiring rates and contracts to be submitted 90 days in advance of the effective date. The proposed 90 day requirement for rate and contract submissions, when coupled with the necessary time to develop the rates and contracts, would result in the use of less timely data, which raises concerns with accuracy of developed rates. Actuaries generally take 60 days or more to conduct their analysis and establish rates. To meet the proposed 90 day state submission deadline, the data used for rates will be almost six months old by the time of the contract effective date, at a minimum. DHCS believe 45 days is a more appropriate timeline for rate and contract submissions and would ensure that the data used to develop rates promotes accuracy and reflects current conditions. This alternative timeline for CMS review should be sufficient, given that CMS has sought to articulate its expectations for rate submissions in its 2016 Rate Development Guide and in this proposed rule. We believe extensive negotiations are unnecessary when all elements required by CMS have been considered, provided the necessary information on rate development, and received certification from the state's professionally trained and licensed actuary, as required. The increased transparency described in other parts of the regulation should mean that CMS' review process could be completed in the 45 day timeframe. Finally, some flexibility around the established timeline should be provided for both states and the federal government resulting in the ability to maintain services to beneficiaries. Instances will occur where meeting the proposed timeline is not feasible. (o) DHCS requests clarification that CMS is not requiring LTSS services authorized through an HCBS authority delivered through managed care to comply with the HCBS settings final rule until 2019, consistent with the overall timeline for state compliance with the HCBS settings final rule. (t) DHCS supports the use of coordination of benefit agreements and claims crossover process for managed care plans serving dually eligible population, but requests flexibility so that states can pursue alternative arrangements. Use of Medicare's automated claims crossover process may

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
	not be the only solution for every state. Because of this, states should have the option to require their managed care entities to sign Coordination of Benefits Agreements with Medicare or require alternative approaches for achieving care coordination and cross-over claims processing. (u) DHCS supports the flexibility to make capitation payments to managed care plans on behalf of enrollees aged 21-64 years of age who are short-term patients in institutions for mental disease (IMD). The interpretative scope of the IMD payment prohibition has limited the options available to states in building suitable capacity for providing mental health and substance use disorder (MHSUD) services to Medicaid populations. With the increased focus on these MHSUD segments accompanying implementation of the ACA and the federal Mental Health Parity and Addiction Equity Act, it is even more imperative now for states to be equipped with adequate flexibility to meet the MHSUD needs of Medicaid populations. We request that this proposal also be extended to non-capitated MHSUD carve-out arrangements, in recognition that states employ a variety of specialized delivery systems for this service category.
ACTUARIAL SOUNDNESS	
§438.4	DHCS is concerned that terms such as “adequate” and “sufficient” when used to describe capitation payments (for example, in §438.4(b)(3)) are too subjective, not consistent with the ASOP #49 and not consistent with the CMS Rate Setting Consultation guides to date. DHCS would support replacing the use of terms such as “adequate” and “sufficient” in describing capitation rates and payments with language consistent with the definition of actuarial soundness, i.e., “reasonable, appropriate and attainable.” These changes would ensure that the rule acknowledges that all capitation payments are risk payments and do not guarantee profitability for a particular plan. In addition, these changes would acknowledge the reality that payment rates are not themselves a measure of access, and that reimbursement is only one element of many that may impact access to services. (b)(1) DHCS would like CMS to confirm that capitation rates, with different Federal Financial Participation percentages attaching, may still vary by projected risk, and associated cost differences. This is necessary in order to be consistent with ASOP #49 requirements that capitation rates are appropriate for the populations to be covered and the services to be furnished under the contract. There may be a number of factors, unique to the costs of the population being served and unrelated to the applicable Federal Medical Assistance Percentages (FMAP) rate, which contribute to differences in payment levels across rate cells. We appreciate the need to properly guard against inappropriate federalization of State costs, but urge CMS to avoid applying a presumption that such a Federal Financial Participation (FFP) correlation is prima facie evidence of cost-shifting. We also request clarification regarding CMS statements outside of the NPRM which suggest that this prohibition is geared towards varied plan-to-provider payment, rather than capitation payments from the state to the plan. (b)(3) DHCS disagrees that it is the responsibility of the actuary, in developing actuarially sound capitation rates, to assess compliance with the access provisions at §438.206, §438.207 and §438.208. It is the responsibility of the state to assess and assure compliance with these provisions and the actuary should be able to rely on this assessment.

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
	(b)(4) CMS should confirm this would not prohibit blended rate structures. CMS has supported and previously approved such rate structures developed with actuarially sound principles and methodology.
RATE DEVELOPMENT STANDARDS	
§438.5	(c) CMS should clarify that not all base data need to be from "the three more recent and complete years prior to the rating period" if it is determined that more recent data is appropriate as determined by the actuary. In addition, we request clarification that three years of data not be required and that states have the flexibility to use one or two years of data if determined appropriate by the actuary. Further, DHCS is opposed to any requirement that all financial data reports be audited as long as it is in accordance with the actuarial standards for data quality and can be certified by the CEO/CFO as accurate and seeks clarification from CMS that no such requirement is imposed by this rule. DHCS currently supplements encounter and other data with ad-hoc and more detailed plan reporting, such as our Rate Development Template, which provide critical information and data to inform health plan rate setting. (d) DHCS requests CMS provide additional clarity at § 438.5(d) that historical population specific trend need not be the only source of trend data and information for rate development. Prospective trends may often differ materially from historical trend experience that should be considered. Examples include acceleration of Breakthrough Therapy Designation drugs that would increase costs and drugs moving from brand name to generic availability that would decrease costs.
SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT	
§ 438.6	The proposed restrictions and new requirements related to supplemental and directed payments in managed care of grave concern and a critical issue for DHCS. These changes appear to be fundamentally detrimental to California's existing programs, such as our hospital fee program, and could significantly destabilize our safety net system for Medicaid managed care in the state. We are concerned that it creates inequity in the use of supplemental payments in managed care, compared to FFS programs that have been allowed by CMS. We feel this change in policy unduly restricts longstanding State flexibility in financing Medicaid through use of a variety of State and local sources of funding. DHCS requests that the proposed prohibition at (c) is not finalized, and that the rule instead require states to provide suitable documentation and support for directed payment initiatives. DHCS appreciates the support for value-based purchasing and the important role that managed care plans play as our state partners. However, the capitation rate development provisions within the regulation text do not support "next generation" delivery system reform efforts by states, where substantial portions of payments by states to quality, cost efficient and effective managed care plans should be for providing better care (quality and patient satisfaction) and improved population health. Instead, the regulation appears to limit the flexibility within rate-setting for a state to pay

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
	quality, cost efficient and effective managed care plans for value or outcomes instead of volume. At a minimum, the rate setting and documentation specificity in the final rule should not inhibit such payment and delivery system reform and should not require that such efforts must be applied equally across all providers of a service, as that may not be the most effective use of available funding. CMS should clarify and provide for flexibility for the actuary to consider such value based purchasing strategies in the rate development and process requirements. DHCS recommends providing explicit linkage in the rate development provisions at §438.5 to allow for rate setting to be consistent with the value based purchasing provisions at § 438.6 (c) (i) and (ii).
RATE CERTIFICATION SUBMISSION	
§438.7	DHCS disagrees with the proposal to eliminate state flexibility to certify to a rate range by requiring submission of a certified rate. Instead, DHCS supports the requirement to identify that the final rate in the contract is within the certified rate range and submit to CMS for review and approval. The proposed elimination of the ability to certify to a rate range is unnecessarily restrictive and is of great concern to California, as it will reduce state flexibility, increase actuarial documentation (and state costs), and make it more difficult for the state to meet contract submission requirements for timely rate approval. Further, we believe it would exacerbate existing concerns around timely rate approvals. Within the development of an actuarially sound capitation rate range, an almost infinite combination of values is possible for those independent variables creating the range. States utilize rate ranges for multiple reasons in paying different managed care plans different capitation rates. There is no one actuarially sound capitation rate and manipulating variable values to generate a specific rate in order to meet this restrictive criteria related to MCO specific rates is unnecessarily resource and cost intensive. Instead, DHCS would support the use of a reasonable rate range of 5 percent above or below a midpoint. The use of a narrower rate range coupled with the requirement that the final rate must be specifically identified in the contract submitted to CMS for review and approval strikes a balance between preserving state flexibility, and assuring transparency and consistency with actuarial principles.
MEDICAL LOSS RATIO (MLR) STANDARDS	
§438.8	DHCS appreciates the flexibility provided in §438.8(c) to establish a minimum MLR that is higher than 85% and strongly supports retention of this provision in the final rule. The final rule should be clear that MLR is only a guide for evaluating appropriate deployment of federal and State funds, and only one potential factor out of many used in assessing actuarial soundness. We caution against placing a disproportionate value on MLR outcomes as this may impede states in efforts to improve quality and efficiency through rate setting. CMS should clarify in the final rule if and how the MLR applies at the sub-contracted level (including sub-contracted managed care plans.)

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
	The final rule should also retain enough flexibility for managed care plans, states, and actuaries to account for innovations in value based purchasing (VBP) and how related payments will be treated within the MLR formula. In addition, final rule should allow for state flexibility to determine and define the appropriate components of the numerator, including utilization management, quality and fraud prevention activities. CMS should clarify in the final rule that the MLR is to be calculated and reported in the aggregate for Medicaid, not by individual rate cell. Implementation in 2017 is not sufficient time for DHCS to implement the MLR in Medi-Cal. CMS should provide at least three years after publication of the final rule.
REQUIREMENTS THAT APPLY TO MCO, PIHP, PAHP, PCCM AND PCCM ENTITY CONTRACTS INVOLVING INDIANS, INDIAN HEALTH CARE PROVIDERS AND INDIAN MANAGED CARE ENTITIES	
§438.14	CMS should maintain current flexibilities for managed care plans pertaining to inclusion of Indian-Health clinics in network. Managed care plans are unable to force providers to join their networks when they are unwilling. CMS should replace the requirement in (b)(1) with a requirement to demonstrate a good faith effort to bring an Indian-health provider into its network. Such a revision coupled with the requirement in (b)(2) for managed care plans to provide access to services at and reimburse Indian-health providers for these services on an out of network basis, would provide the necessary protections without applying a potentially impossible standard.
PART 438 – MANAGED CARE: SUBPART B – STATE RESPONSIBILITIES	
MANAGED CARE ENROLLMENT	
§438.54	DHCS believes that the policy to require a period of 14-day fee-for-service (FFS) coverage would negatively impact quality of care for beneficiaries. In California, beneficiaries who do not actively pick a plan are assigned to and enrolled in a managed care plan. This assignment occurs after beneficiaries are noticed multiple times offering choice and a beneficiary support system is offered to assist the beneficiary during the decision making process. Following assignment, beneficiaries are able to change managed care plans monthly. Immediate assignment allows new beneficiaries to reap the benefits of care coordination provided by managed care plans. This is particularly important for pregnant women, individuals with behavioral health needs, and other high risk populations for whom it is vital to receive coordinated care as soon as possible. Many of these beneficiaries require immediate complex care. The proposed 14-day policy would limit access to care coordination and the full array of services in managed care during the period of initial enrollment. As long as beneficiaries are informed of their choice decision and provided the opportunity to change managed care plans, there is no need for an interim 14-day FFS enrollment period. DHCS also notes that in many cases, this period would end up being more than 14-days due to operational realities.

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
CONTINUED SERVICES TO ENROLLEES	
§438.62	DHCS supports the concept of continuity of care, and currently maintains robust continuity of care policies. However, we note that beneficiaries generally require continuity of services and only in limited circumstances continuity of providers. Continuity of providers should only be required when deleterious effects could be experienced by the beneficiary. The proposed rule should be modified to clarify this and to provide states with the flexibility and authority to determine whether continuity of services or continuity of provider is most appropriate. The proposed rule should also clarify that states be provided flexibility when establishing continuity of provider requirements. Eligible beneficiaries should be awarded continuity of providers when certain requirements are met. For example, a pre-existing relationship must be established (as defined by the state specific to the population); the provider must not have quality of care issues as this could be detrimental to the health of the beneficiary; and the provider and managed care plan must be able to agree to a rate with a base rate requirement of the managed care plan (such as the Medicaid FFS rate).
STATE MONITORING REQUIREMENTS	
§438.66	(d) DHCS believes that states should maintain the flexibility to outline their procedures for plan readiness reviews in their managed care authority, including the components of a plan readiness review, the changes that trigger a review, and the timing for conducting reviews. As the preamble of the rule acknowledges, states are already conducting a range of readiness reviews to ensure managed care plans can fulfill their obligations under their contract. These reviews are designed to match the scope of the contract and the responsibilities of the plan. For example, a comprehensive managed care plan will likely require a different review than a PIHP delivering behavioral health services. States develop their readiness reviews to capture this nuance and should continue to be able to do so. Therefore, DHCS urges CMS to permit states to determine the frequency of reviews, what events would trigger this analysis, and the timing for beginning them. CMS could require states to outline these procedures as part of their managed care authority, including Section 1115 or 1915(b) waivers or in in the state plan. (e) DHCS is concerned that the requirement for an annual program assessment would add to the vast array of reporting requirements under this rule and would be duplicative. CMS proposes this requirement in order to reduce fragmentation in the information it receives from states. However, this fails to streamline the array of reporting processes that states must complete under current regulations, as well as the provisions of the proposed rule. These include the submission of rates, quality strategies, contracts, External Quality Review Organization (EQRO) reports, data compliance plans, etc. The annual program assessment is also duplicative of many of these other reporting requirements. For instance, the program assessment would require states to report on plan performance on quality measures. This performance would already be captured through the quality rating system. In the event that CMS moves forward with this proposal, the agency should seek to minimize duplication and reduce other reporting requirements for states.

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
NETWORK ADEQUACY STANDARDS	
§438.68	DHCS currently maintains and monitors a set of robust network adequacy requirements for providers including time and distance standards, when appropriate. As such, DHCS supports the need for time and distance standards as one method of maintaining access; however, believes flexibility must be maintained to adjust for diversity amongst and within states. Such flexibility will also ensure that states are able to maintain similar standards for Medicaid populations as are applicable to commercial and other managed care populations; this is consistent with CMS' stated intent that the proposed regulation is an attempt to align Medicaid managed care with other non-Medicaid managed care. CMS should remove the specific identified providers in (b) and provide flexibilities to states in determining which categories of providers should be subject to time and distance standards as appropriate for the covered populations. In addition, CMS's proposal to impose time and distance standards for LTSS providers who travel to the beneficiary in (b)(2)(i) is not appropriate. Time and distance standards should be from the perspective of the beneficiary and not the provider.
BENEFICIARY SUPPORT SYSTEMS	
§438.71	DHCS supports the need to ensure that a robust beneficiary support system is in place, however, believes that states should be provided with flexibility when implementing the requirements as set forth under the proposed rule. States should be provided with flexibility to delegate certain beneficiary support system requirements, with oversight, to their managed care plan partners or other entities and should not be required to maintain a single "beneficiary support system" that would duplicate activities and responsibilities currently being provided within the state. The proposed requirements can be accomplished through a more flexible structure with no impact to the beneficiary.
PART 438 – MANAGED CARE: SUBPART D – MCO, PIHP AND PAHP STANDARDS	
ASSURANCES OF ADEQUATE CAPACITY AND SERVICES	
§438.207	DHCS supports transparency around network adequacy and the need to monitor availability of services to beneficiaries. However, states should not be required to certify provider networks annually. It is reasonable for states to certify provider networks when the plan enters a contract with the state or there are significant changes (as defined by the state), an annual certification requirement is duplicative and places a major administrative burden on states. In §438.358(b)(4), CMS includes a new mandatory EQR activity that would require the validation of network adequacy of MCOs, PIHPs, and PAHPs during the preceding 12 months. With this annual EQR activity in place, it is unnecessary to require states to annually certify the adequacy of provider networks. As such, this separate annual certification requirement would create an unnecessary administrative burden on states, without any benefit to quality or plan performance. As an alternative, DHCS suggests that CMS revise this annual certification requirement to a triennial certification requirement.

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
COVERAGE AND AUTHORIZATION SERVICES	
§438.210	A core premise of managed care is control of utilization management functions. The current managed care plan control of the utilization management process should not be disturbed. Managed care plans must continue to be allowed to determine and maintain their own utilization management processes, structures, and systems which provide care when services are medically necessary. Disallowing this core managed care function, would increase costs for the Medicaid program as a whole and remove the ability of managed care plans to best provide coordinated care for their beneficiaries. Therefore, CMS should revise the language in (a) so as to clarify that managed care plans are permitted to implement utilization management controls, whether the same or different as what is afforded in the State Plan, as long as such controls do not deny access to medically needed services.
PROVIDER SELECTION	
§438.214	DHCS believes that states should have the flexibility to determine how providers are credentialed and delegate this responsibility to its managed care plan partners or other appropriate entities as applicable. California currently delegates responsibility for credentialing to its managed care plan partners setting forth minimum requirements which must be met by contract and guidance. Compliance with these requirements is then measures through an annual medical audit and other monitoring efforts. DHCS has also recently developed new monthly processes to check plan compliance related to suspended providers and intends to extend these processes to other areas. Any deficiencies are resolved through corrective action and, if necessary, sanctions and/or penalties. The language in (b) requiring a "uniform credentialing and recredentialing policy" that applies to all providers is unnecessarily burdensome and fails to acknowledge the unique nature of different types of providers, particularly when considering LTSS services or services provided by non-licensed providers. The proposed requirement would also undermine the ability of the state and managed care plans to leverage a range of new innovative provider types, which are likely to continue to emerge as states enhance their programs. CMS should modify this proposed language to permit states the flexibility to set requirements for entities that are responsible for provider licensing and credentialing, such as managed care plans, which recognize the unique nature of various provider types. The requirement to have all Medi-Cal providers enroll through the FFS provider system is both burdensome and unnecessary. The same goals can be accomplished through a flexible system which allows states to delegate responsibility - program integrity is not improved under the proposed requirement. California's Medicaid program is comprised of more than 100,000 providers. A requirement to credential all providers at the state level would impose significant and unnecessary administrative burden and could essentially halt expansion of the state's network. Given the rapid population growth of Medi-Cal this could result in network adequacy issues, thus, limiting access, and disallowing the State from coming into compliance with other aspects of the proposed rule.

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
	Credentialing of all providers by a single entity also is not appropriate for unique providers. For example, many in-home providers of LTSS services are family members of beneficiaries who are delivering care. It would create an undue burden on these individuals, the state, and managed care plans to require all of these individuals to undergo a credentialing and enrollment process that is the same as the process for providers such as doctors or hospitals. Given the significant expansion of the size of California's Medicaid program, it is necessary to maintain flexibility to expand provider networks in new ways.
PROVIDER SELECTION	
§438.230	(c) DHCS is concerned regarding the 10 year audit requirement. Currently our mental health plans have a 5 year record keeping requirement. DHCS urges CMS to modify the duration to be 5 years. If CMS proceeds with a 10 year requirement, the implementation date must be far enough after finalization of the rule to account for prior years in which this was not a requirement.
PART 438 – MANAGED CARE: SUBPART E –QUALITY MEASUREMENT AND IMPROVEMENT; EXTERNAL QUALITY REVIEW	
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM	
§438.330	DHCS supports the need for quality assessment and improvement and the requirement for managed care plans to measure and report on standard metrics. We urge CMS, however, to recognize the need for making performance measurement manageable and allow states the flexibility to address variations in our particular populations and geographic regions. To that end, we request that in the implementation of the CMS developed measures as outlined in (a)(2) that CMS allow for approach in which CMS develops a set of minimum required measures from a larger menu of measures. This would still provide for consistency across states for the minimum measures while allowing for the necessary variation among states. We also urge CMS to limit the number of minimum required measures in order to allow for additional state variation and to ensure that the requirements are feasible and appropriate. In addition, we urge CMS to consult with states in the development of the minimum required measures and the menu of measures. This would ensure that the measures are relevant to states Medicaid programs and that the list of measures is more balanced and manageable for states and their health plan and provider partners.
STATE REVIEW AND APPROVAL OF MCOS, PIHPS, AND PAHPS	
§438.332	DHCS believes that states should maintain current flexibilities to determine accreditation requirements for their Medicaid managed care programs. We are concerned that the proposed rule creates a de-facto requirement for accreditation. The alternative to accreditation, which CMS outlines in the rule, is not a meaningful alternative because states must use the same standards as the accreditation entity. As the rule points out, states would

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
	have to purchase standards from one of the accrediting organizations for their own processes. We are troubled that this removes the current flexibility states are afforded to ensure that managed care plans meet the necessary standards to deliver care in Medicaid. The existing approach allows states to require accreditation or conduct a state-defined and state-specific review. It permits states to select and design a review approach that is tailored to the unique populations and risk-based programs they oversee. A national accreditation requirement, which the proposed rule effectively requires, is a one-size-fits-all approach that would not account for these differences. For example, behavioral health organizations serve unique populations in Medicaid managed care and often cannot meet national accreditation standards due to their specific focus and role.
MEDICAID MANAGED CARE QUALITY RATING SYSTEM	
§438.334	DHCS has established a managed care plan quality rating system and supports the idea for Medicaid managed care plans in concept. As such, DHCS believes that CMS should partner with states to develop a clear pathway and approval process for the use of alternative quality rating systems. Specifically, the final rule should articulate CMS' intent to partner with states to outline the criteria for approval of state-developed alternative systems and to outline the approval process for their use.
FEDERAL FINANCIAL PARTICIPATION	
§438.370	CMS should provide enhanced FFP for EQRO reviews of all managed care programs, as well as EQRO activities in FFS Medicaid. CMS's proposal to eliminate enhanced FFP for EQRs performed on PIHPs runs counter to the push to ensure quality under the proposed rule. It also does not align with the expanded requirements that CMS lays out under the rule. CMS' policy goals also appear to conflict with this provision. In many other portions of the regulation, CMS emphasizes its greater focus on safeguarding quality and promoting value in the program. Reducing this FFP would not only be a step backward from current policy, it would further exacerbate the lack of parity that exists in federal support for quality review activities today. Safeguarding quality is as vital an activity in FFS, PIHPs, and PAHPs as it is in MCOs. Therefore, it is troubling that enhanced FFP is not available for EQRO activities performed in all programs. For example, while states receive the enhanced FFP for having their EQRO conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey in MCOs, this funding is not available when the same organization assesses consumer satisfaction in FFS. In order to align with its goals of quality improvement and provide parity in its support for quality safeguards, CMS should build on its original interpretation of the statute and provide enhanced 75 percent match for EQRO providing EQR activities for PIHPs, PAHPs and PCCM entities. CMS should also provide the enhanced match for EQRO activities in FFS programs. The federal investment in these activities shows CMS' commitment to high quality care, and supports states in maximizing the use of EQR activities to drive quality in both their managed care and FFS programs. It also

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
	demonstrates the importance of ensuring quality care for the unique populations that continue to be served in FFS programs.
PART 438 – MANAGED CARE: SUBPART H – ADDITIONAL PROGRAM INTEGRITY SAFEGUARDS	
STATUTORY BASIS	
§438.600	DHCS requests that CMS provide a definition of the term "debarred" as this term is not regularly used in the state Medicaid program.
STATE RESPONSIBILITIES	
§438.602	(b) DHCS believes that states should have the flexibility to determine how providers are enrolled and revalidated and delegate this responsibility to its managed care plan partners or other appropriate entities as applicable. California currently delegates responsibility for enrolling network providers to its managed care plan partners setting forth minimum requirements which must be met by contract and guidance. Compliance with these requirements is then measures through an annual medical audit. DHCS has also recently developed new monthly processes to check plan compliance related to suspended providers and intends to extend these processes to other areas. Any deficiencies are resolved through corrective action and, if necessary, sanctions and/or penalties. (g) DHCS is committed to transparency and the working with stakeholders, advocates, and other entities external to the State. We currently share a myriad of information regularly including managed care plan contracts and rates, HEDIS and CAHPS reports, performance dashboards, medical audits/surveys, and other reports demonstrating overall performance of the program. Despite this, DHCS disagrees with the proposed requirements relating to information sharing. CMS should revise its approach to public information sharing, laying out a more rational and appropriate scope of information which promotes public understanding of the program. DHCS is most troubled by the requirement for states to report all of the data submitted under §438.604. This includes encounter data and other data submitted by the plan to the state, which the proposed rule does not require to be de-identified. This conflicts with the protections for health information under the Health Insurance Portability and Accountability Act. DHCS also strongly discourages requiring the posting of this information de-identified, as the burden of de-identifying the data coupled with the continued privacy risk to individuals would not be acceptable, nor would it result in increased understanding of the program by the public. In addition, the reporting requirements would not create meaningful transparency for the public and would result in an administrative burden for the State. Providing the public with an immense quantity of information keeps individuals from accessing the most pertinent and useful information. It would require stakeholders and consumers to sort through irrelevant documents, data and other information to identify the information they may be seeking. In order to achieve transparency that is both appropriate and meaningful, CMS should revise this section of the regulation to more specifically target only that data that is necessary and useful to the goals of this section. CMS should also consult with states to identify what information would promote transparency and be rational for the program to report.

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
SOURCE, CONTENT, AND TIMING OF CERTIFICATION	
§438.606	DHCS agrees that a plan's executive leadership should directly attest to its reasonably diligent review of the data, documentation and information it submits. However, the data certification and review process should not obstruct the regular transmission of data. DHCS frequently requests and collects adhoc data from managed care plans to support real time analyses of the program. Requiring certification of all data submitted is unreasonable. It is important to ensure this requirement does not impede the regular and efficient transmission of data, which enhances program integrity efforts. The final rule should clarify which transmissions require certification and still permit states and managed care plans to exchange information and data in a regular and efficient manner.
PROGRAM INTEGRITY REQUIREMENTS UNDER THE CONTRACT	
§438.608	(b) The requirement to have all Medi-Cal providers enroll through the FFS provider system is both burdensome and unnecessary. The same goals can be accomplished through a flexible system which allows states to delegate responsibility - program integrity is not improved under the proposed requirement. California's Medicaid program is comprised of over 100,000 providers. To the extent that non-traditional or non-licensed providers, particularly in the HCBS arena, such as in-home care workers, are also included in this requirement that would mean more than 400,000 additional providers would need to be enrolled. A requirement to enroll all providers in a single uniform system would impose significant and unnecessary administrative burden and could essentially halt expansion of the state's network and could result in providers choosing to not longer to participate in the program because of the additional administrative burden of going through the FFS enrollment system even though they will solely be a managed care provider. (d) DHCS agrees that managed care plans should report potential fraud and improper payments, but urges CMS to give states the explicit authority to articulate additional expectations for reporting, including defining improper payments. DHCS is working with our managed care plans to identify and reduce fraud, waste and abuse in the program. We seek to ensure there are clear expectations for reporting and support managed care plans in understanding the differences between potential fraud and improper payments. DHCS is developing pathways for managed care plans to communicate potential overpayments early in the process, prior to plan initiation of overpayment recoupment. This enables states to provide oversight of these efforts. CMS should allow states the option to articulate additional requirements for identifying and reporting on fraud and improper payments, in addition to the reporting required under the regulation. States should also be permitted, but not required, to define improper payments in the context of state program integrity efforts. These definitions can be useful to establish a common understanding of the differences between overpayment and fraud, which in turn can promote appropriate reporting.

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
PART 438 – MANAGED CARE: SUBPART J –CONDITIONS FOR FEDERAL FINANCIAL PARTICIPATION	
DEFERRAL AND/OR DISALLOWANCE OF FFP FOR NON-COMPLIANCE WITH FEDERAL REQUIREMENTS	
§438.807	DHCS strongly opposes this proposal to allow for targeted deferral/disallowance of payment amounts. We view this as inconsistent with a full-risk, capitated payment model and question how a piecemeal deferral/disallowance could be operationalized in the context of a comprehensive or near-comprehensive managed care contract. If finalized in this form, we urge CMS to provide for an intermediate, dispute resolution process which would allow for states to correct issues of noncompliance before FFP is jeopardized.
DEFERRAL AND/OR DISALLOWANCE OF FFP FOR NON-COMPLIANCE WITH FEDERAL REQUIREMENTS	
§438.818	(c) CMS should not withhold FFP for incomplete encounter data, and should instead collaborate with states in understanding and addressing key challenges in collecting and reporting encounter data. DHCS supports strong accountability for reporting of plan encounter data and is committed to ensuring timely, accurate, and complete encounter data. DHCS implemented an Encounter Data Improvement Project three years ago which is focused on the completeness, accuracy, reasonability, and timeliness of encounter data by managed care plans. Since then significant improvements have been made in relationship to encounter data reporting. DHCS has also implemented the Quality Measures for Encounter Data (QMED) which measures health plan reporting on these four domain areas. The QMED is used to create a quarterly encounter data report card for each health plan. Given DHCS' commitment to encounter data, we are troubled by the proposal to withhold FFP for non-compliant encounter data, which would decrease resources to tackle the challenges in this area. A more effective and appropriate approach would be for CMS to partner with states to understand and help address the inherent challenges in obtaining and reporting compliant, high quality encounter data. We are also concerned that the approach for operationalizing this policy is unclear in the NPRM. For instance, the rule does not specify whether states would receive full FFP once corrected data is accepted by CMS or if FFP would be disallowed completely. It is also unclear whether FFP would be withheld for all data deemed non-compliant or if states could achieve a reasonable threshold for the quality of encounter data and receive full FFP. These outstanding questions only emphasize that collaboration with states is a more appropriate pathway to address encounter data challenges. Should CMS impose this requirement, the proposal to condition FFP on "sufficient and timely" encounter data should recognize appropriate thresholds for completeness and accuracy, should be measured in the aggregate (and not by individual rate cell) and should recognize some of the inherent challenges with encounter data that will be unique to certain programs, such as MLTSS. For example, certain HCBS encounters (particularly for environmental modifications), goods and services under self-direction, and services without a HIPAA standard HCPCS code are challenging and should be considered when determining what qualifies as "sufficient and timely." (d) The timeframe for states to develop a detailed plan for meeting CMS requirements for encounter data should provide more than 90 days and

CA Department of Health Care Services - SPECIFIC COMMENTS/RESPONSES: Managed Care Proposed Rule [CMS-2390-P]	
Regulatory Reference	***Comments***
	reflect states' unique situations. States will need to conduct different levels of systems analysis to ensure submitted encounter data meets CMS expectations. DHCS will likely need to make changes to our contracts to come into compliance, which will require CMS review and approval. These changes will require much longer than 90 days. Therefore, we encourage CMS to provide a minimum of six-months for states to meet these requirements. States should also be permitted to seek an extension for meeting the new requirements around encounter data collection and validation processes.
PART 440 – SERVICES: GENERAL PROVISIONS	
§440.262	While DHCS supports the policy direction to evaluate access issues with a focus on cultural diversity, we are concerned with the level of ambiguity in this proposed regulation and view this as outside the scope of a Medicaid managed care rulemaking.