BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

OFFICE OF THE EXECUTIVE VICE PRESIDENT
UC HEALTH

OFFICE OF THE PRESIDENT
1111 Broadway, Suite 1400
Oakland, California 94607-5200
(510) 987-9071 Fax (510) 835-2346

January 31, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2393-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS Docket No. CMS-2019-0169, RIN 0938-AT50, Comments in Response to Proposed Rulemaking: Medicaid Fiscal Accountability Regulation

Submitted via www.regulations.gov.

Dear Administrator Verma:

The University of California Health system ("UC Health") appreciates this opportunity to express our serious concerns that the new restrictions and requirements put forth by the Centers for Medicare & Medicaid Services ("CMS") in the proposed Medicaid Fiscal Accountability Regulation ("MFAR")[1] would severely undermine the long-standing financial foundation of the California Medicaid program (known as "Medi-Cal"), jeopardizing coverage and access to care for millions of our most vulnerable patients. CMS has woefully underestimated the impact of the proposed MFAR and the administrative burdens it will add to state Medicaid programs and providers.

The UC Health system has always maintained an unwavering commitment to caring for all Californians regardless of their ability to pay. UC Health has also been a long-standing partner of the State and CMS in effectuating the well-articulated goals of prompt access, cost effectiveness, efficiency and quality in the delivery of Medi-Cal services. As one of the nation's largest academic health systems, we combine teaching, research and public service to provide high quality care to millions of patients each year and to drive the innovative research and medical advances that save lives.

[1] 84 Fed. Reg. 63,722 (Nov. 18, 2019).

UC Health is therefore deeply concerned about the potentially devastating impact of the proposed MFAR on our Medi-Cal patients and the communities we serve, as well as on the providers that serve them. We therefore urge CMS to withdraw this proposed rule in its entirety.

UC Health's Commitment to Access to Care for Medi-Cal Patients

The UC Health system includes five top-ranked academic medical centers located at the Davis, Irvine, Los Angeles, San Diego, and San Francisco campuses, which serve as the principal teaching sites for the Schools of Medicine, Nursing, Pharmacy and Dentistry at those locations. In addition, UCSF School of Medicine operates a branch campus in Fresno and UC Riverside School of Medicine trains students and residents at a number of community hospitals throughout Riverside County. UC also operates a School of Veterinary Medicine at Davis, a School of Optometry at Berkeley, and two schools of public health located at Berkeley and Los Angeles. In September 2019, the Regents approved establishing a new school of public health at UC San Diego to bring together a variety of existing teaching and research programs previously dispersed across the campus.

The UC Health system provides tertiary and quaternary specialty services to patients from across California and beyond. Our general acute care hospitals include three American Burn Association verified Regional Burn Centers, three Level I Trauma Centers, three Level I or Level II Pediatric Trauma Centers and five Transplant Centers offering solid organ transplants and four offering bone marrow transplantation. The UC Health system campuses are also home to five National Cancer Institute-designated Comprehensive Cancer Centers, providing access to cutting edge care and clinical trials not available elsewhere. Although we represent less than six percent of the acute care hospital beds in California, the UC Health system is one of the largest providers of inpatient services and hospital-based outpatient visits for Medi-Cal enrollees. More than 35 percent of our systemwide inpatient days are associated with Medi-Cal, and at some of our health systems, the percentage is even higher. For example, at UC Irvine Health, 41 percent of total inpatient days are for Medi-Cal patients.

The University of California also operates the largest health sciences instructional program in the nation, and is currently training nearly 14,500 health care professionals. The majority of these students remain in California after they complete their programs. All of UC Health's schools emphasize public service and caring for the underserved. For example, the UCSF Fresno branch campus and the UC Riverside School of Medicine were established with the support of the state legislature to help address physician shortages in underserved and rural areas in the state. UC's six medical schools participate in Programs in Medical Education, a program that supplements standard training with additional curriculum tailored to meet the needs of various underserved

populations. In 2018-2019, there were 354 students enrolled in the program, 64 percent of whom come from groups that historically have been underrepresented in medicine.

The reach of the UC Health System in caring for Medi-Cal patients also extends far beyond the walls of our hospitals and clinics. UC Health has invested heavily in building care delivery systems that extend beyond hospital care, such as by developing comprehensive lower-cost community based ambulatory networks to improve access and help ensure patients are seen in the most cost-effective setting. For example, in October 2018, UC Davis Health and Sacramento County created a new partnership to expand primary care services for up to thousands of additional Medi-Cal patients at the Sacramento County Primary Care Center, and UC Davis Health primary care and specialty care physicians, residents, and medical students also serve patients at other federally-qualified health centers in Sacramento, Yolo, and San Joaquin counties. At the same time, UC Health maintains services that are often unavailable elsewhere such as esoteric specialty ambulatory services, particularly for vulnerable populations such as children, and psychiatric services.

As a governmental provider, UC Health and other public health care systems in California offer critical support to the Medi-Cal program. The vital funding UC Health receives from Medi-Cal helps support our education and public service missions. More specifically, Medi-Cal funding has enabled us undertake innovative projects focused on outpatient delivery system transformation and preventive services, high-risk or high-cost populations, and resource utilization efficiency, all of which are intended to drive the transition of our hospitals to value-based care. The proposed changes would eliminate these payments, reverse decades of long-standing CMS policy, and could force our state to restructure its program, restrict eligibility or benefits, or reduce payments to providers if the state is unable to find alternate sources of funding. By severely restricting UC Health's ability to contribute to the Medi-Cal program, the proposed MFAR threatens the state's health care safety net and access to care for the most vulnerable patients in our communities.

CALIFORNIA RELIES ON MULTIPLE PUBLIC FUND SOURCES OF NON-FEDERAL SHARE

Since the beginning of the Medicaid program, Congress has consistently recognized the important role that state and local sources of funds serve to help states finance the non-federal share of Medicaid expenditures.[2] In fact, other than the specific circumstances set forth in Section 1903(w) of the Social Security Act regarding non-bona fide provider-related donations and certain health care-related taxes, Congress generally has allowed states significant flexibility to determine the funding sources used to finance the non-federal share.[3] Under longstanding CMS regulations,

[2] *See* Social Security Act § 1902(a)(2).

[3] *See* Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. Law 102-234, 102nd Cong. (1991); Social Security Act § 1903(w)(6)(A) (prohibiting the Secretary from restricting states' use of funds

states have been permitted to rely on the use of "public funds" from "public agencies" to support the non-federal share in claiming federal financial participation (FFP).[4] And for decades, CMS has authorized arrangements that rely on public funds transferred to the State or local Medicaid agency via intergovernmental transfers (IGTs) or certified public expenditures (CPEs) from local units of government or other units of state government. For example, in California, the last three Section 1115 Demonstration Project Special Terms & Conditions have clearly authorized the use of a variety of sources of public funds for IGTs, including patient care revenue received as payment for health care services.[5]

These sources of financing have brought significant benefits to the Medicaid program. For example, California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, which is part of California's current Section 1115 Demonstration Project called "Medi-Cal 2020," is locally designed and financed, including by UC Health systems, to improve care delivery and efficient utilization of resources for the most complex and vulnerable patients that we serve. The PRIME program projects are organized into three domains, and within each domain, there are one to three required projects for public health care systems and at least one additional optional project. The three domains are: (1) outpatient delivery system transformation and prevention; (2) targeted high-risk or high-cost populations; and (3) resource utilization efficiency.

To highlight just a few of the significant efforts that have been made possible through the PRIME program, five of our UC Health systems, along with many other hospitals across California, are collaborating with the California Maternal Quality Care Collaborative (CMQCC), an organization working to end preventable morbidity, mortality, and racial disparities in California maternity care.[6] Through this collaboration, the UC Health systems have positively affected thousands of families through our collective work in preventing maternal hemorrhage, reducing C-section rates, and increasing breast milk feeding among newborns.

Another example is that at UC Davis Health, the PRIME program has facilitated the implementation of an evidence-based population health model to treat common psychiatric conditions within primary care, which has led to improvements in screening for depression and follow-up plans behavioral health services. Similarly, UCSD Health improved the rate of

---

derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government with a State as the non-Federal share of expenditures … unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under the section); House Report No. 102-310 (1991).

[4] 42 C.F.R. § 433.51 (2010).

[5] *See, e.g.*, CMS Special Terms & Conditions, 11-W-00193/9, California Medi-Cal 2020 Demonstration.

[6] https://www.cmqcc.org/about-cmqcc/what-we-do (last visited Jan. 27, 2020).

screening for depression and follow up care by 19%,[7] which means that in the current rolling twelve-month period, 12,700 more patients were screened for depression and provided follow up services as compared to fiscal year 2017-2018. UCLA Health tripled the number of patients to whom it provided such screening and follow-up (representing some 51,000 Californians).

The UC Health systems also have achieved significant improvements in other screening and preventive care metrics. For example, UC Davis Health created the UC Quits hotline to provide tobacco cessation counseling by phone, leading to dramatic improvements in the rates of tobacco assessment and provision of counseling services since the beginning of PRIME. UCSF Health screened and counseled 10% more patients against tobacco use.[8] UCLA Health also increased its rate of screening and counseling against tobacco use, to reach nearly 117,000 patients each year.

Consistent with these examples, the Interim Evaluation of the PRIME Program prepared for the California Department of Health Care Services based on data available through June 2018 (also called demonstration year or "DY" 2013) indicates that overall, hospitals participating in PRIME made greater improvements in process of care measures within the outpatient delivery and prevention and targeted high-risk/high-cost populations domains compared to their comparison hospital groups.[9] The program evaluation report also observed progress in process measures in the resource utilization efficiency domain, but that progress was statistically similar between PRIME and comparison hospital groups.

The care delivery and process improvements achieved through PRIME projects have also contributed to better health outcomes for UC Health patients. For example, as a result of PRIME projects, UC Davis Health helped 17% more patients achieve blood pressure control; UC Irvine Health lowered its 30-day readmission rate by 28%; and UCLA Health helped 30% more patients achieve better blood sugar control.[10]

PRIME certainly is not the only program that the proposed MFAR would undermine. Indeed, the PRIME program builds on the innovative programs that have driven improvements in quality and access through the Delivery System Reform Incentive Program (DSRIP) that was part of California's previous Section 1115 Demonstration Project. The proposed MFAR threatens to undermine the success of these types of innovative, system transformation projects, putting at risk many of the improved patient outcomes that UC Health systems have achieved and maintained

[7] https://caph.org/wp-content/uploads/2019/02/prime-final-2.21.19.pdf
[8] https://caph.org/wp-content/uploads/2019/02/prime-final-2.21.19.pdf
[9] UCLA Center for Health Policy Research, PRIME Interim Evaluation, p. 43 & Exhibit 376 (Aug. 2019), available at http://healthpolicy.ucla.edu/publications/Documents/PDF/2019/PRIME-Interim-Report-aug2019.pdf
[10] https://caph.org/wp-content/uploads/2019/02/prime-final-2.21.19.pdf

over the years and jeopardizing access to care for patients in our communities. As governmental providers, each of the UC Health systems plays a critical role in contributing to the non-federal share. UC Health is concerned that its ability to continue to contribute to the Medi-Cal would be severely limited if the MFAR is finalized as proposed.

Specifically, the proposed MFAR would inappropriately restrict permissible sources of non-federal share to "state general fund dollars appropriated by the state legislature directly to the state or local Medicaid agency"; "intergovernmental transfer of funds from units of government within a State (including Indian tribes), derived from state or local taxes (or funds appropriated to state university teaching hospitals), to the State Medicaid agency and under its administrative control"; or "Certified Public Expenditures," which are certified by a unit of government within a State as representing expenditures eligible for federal financial participation" and which meet the new requirements set forth in the proposed § 447.206.[11] Among the new limitations on CPEs, CMS incorporates by reference its proposals to re-define "State government provider" and "non-State government providers." [12] The proposed new definition of "State government provider" includes a State university teaching hospital only if it "has access to and exercises administrative control over State-appropriated funds from the legislature or State tax revenue, including the ability to dispense such funds" and gives CMS expansive discretion to consider the "totality of the circumstances" to determine whether a provider is a "State government provider."[13]

UC Health believes that these new restrictions on states' use of funds raise significant legal issues in that the restrictions exceed what is authorized in the Medicaid statute, they are arbitrary and capricious, they are ill-defined and fail to provide adequate guidance, and they create significant uncertainty for state Medicaid programs that have necessarily relied on a variety of state and local sources of funds in order to finance their programs. And as noted above, UC Health is especially concerned that the proposed MFAR will undermine our efforts, together with other public health systems, to help transform the Medi-Cal system and will adversely impact our Medi-Cal patients.

CMS HAS WOEFULLY UNDERESTIMATED THE IMPACT OF THE PROPOSED MFAR

Despite the potentially broad reaching impact of the proposed MFAR, CMS inexplicably declined to assess the impact of the proposed rule on Medicaid patients and the providers that serve them, stating only that the "fiscal impact on the Medicaid program from the implementation of the policies in the proposed rule is unknown."[14] CMS cites its rulemaking obligations under the Regulatory Flexibility Act, Social Security Act, Unfunded Mandates Reform Act, Executive Order 13132, and Executive Order 13771, but in each case claims that costs imposed by the rule would

[11] *See* Proposed § 433.51(b); § 447.206.
[12] Proposed § 447.206(a).
[13] Proposed § 447.286.
[14] 84 Fed. Reg. at 63,773.

not meet the threshold for analysis in these respective authorities. To the contrary, we believe the impacts would be very substantial to governmental providers and state and local governments here in California, including UC Health. We do not believe that CMS can or should finalize a rule such as the proposed MFAR without a robust impact analysis of the many proposed provisions and a full understanding and appreciation of the scale and scope of the adverse impacts it will have on patients in California and in nearly every state across the nation.

CMS SHOULD CONSIDER SUPPLEMENTAL PAYMENTS IN CONTEXT, AS A CRITICAL COMPONENT OF TOTAL MEDICAID REIMBURSEMENT NECESSARY TO PRESERVE ACCESS TO CARE

Medicaid supplemental payments are an integral component of total Medicaid reimbursement for health care services furnished by a variety of types of providers and clinicians and are critical to preserve access to safety net services. While we understand CMS's concern about the growth of supplemental payments over the years and the desire to exercise appropriate oversight over states' uses of those supplemental payments, we respectfully recommend that any evaluation of states' Medicaid reimbursement methodologies should consider both base payments and supplemental payments together.

According to a nationwide analysis by MACPAC, supplemental payments represented more than 25% of total Medicaid payments to hospitals in fiscal year 2016.[15] Consistent with this analysis, supplemental payments are critical for a variety of health care providers and clinicians in California as well. The fact that supplemental payments represent such a significant share of Medicaid reimbursement underscores the need for a comprehensive assessment of the adequacy of reimbursement rates that considers total provider payments. Looking at only supplemental payments in isolation, and proposing significant new additional administrative burdens and reporting requirements related to supplemental payments alone, could result in serious disruptions in Medicaid reimbursement to health care providers that are not financially sustainable. Restrictions on supplemental payments must be weighed against the adequacy of base payments and any corresponding adjustments to base payments.

UC Health is especially troubled that CMS is proposing new administrative burdens and barriers to supplemental payments at the same time that CMS has proposed, under a separate rulemaking, to rescind a rule requiring states to document whether Medicaid payments are sufficient to enlist enough providers to assure beneficiary access to covered services.[16] Proposing to reduce oversight

[15] https://www.macpac.gov/wp-content/uploads/2016/03/Medicaid-Inpatient-Hospital-Services-Feefor-Service-Payment-Policy.pdf.

[16] *See* 84 Fed. Reg. 33,723 (July 15, 2019).

of the impact of overall Medicaid rates on access while adding new limits to supplemental payments will lead to significant new pressures for health care providers to sustain their operations on decreasing levels of reimbursement. And those providers who cannot sustain such financial losses could be forced to stop participating in the Medicaid program, thereby increasing the strain on the remaining providers and jeopardizing beneficiary access to care.

THE PROPOSED RESTRICTIONS ON PHYSICIAN AND OTHER PRACTITIONER SUPPLEMENTAL PAYMENTS JEOPARDIZE ACCESS TO CARE

Ensuring adequate physician access is foundational to the success of the Medicaid program. CMS proposes to limit supplemental payments for services provided by physicians and other licensed professionals to 50 percent of Medicaid fee-for-service (FFS) base payments,[17] without any regard for the levels of payment that are necessary to ensure adequate access to primary care, specialty services, and other critical services for Medicaid patients. By contrast, under current CMS policy, issued through subregulatory guidance, supplemental professional services payments are limited to no more than the average commercial rate for specific medical services.

Supplemental payments to physicians and other clinicians are a critical safeguard to retaining Medicaid providers and maintaining access to professional services for Medicaid patients. For example, in California, the Department of Health Care Services has used revenue generated from an excise tax imposed on tobacco and tobacco-related products by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) to make supplemental payments to clinicians for new and established patient office/outpatient visits, psychiatric diagnostic evaluations, psychiatric diagnostic evaluation with medical services, and psychiatric pharmacological management services.[18] These types of supplemental payments are especially important as provider shortages in primary care and certain specialties such as psychiatry are prevalent and growing.[19] An April 2019 study by the Association of American Medical Colleges estimates a potential shortage of up to nearly 122,000 primary and specialty physicians in 2032, as demand continues to outpace the number of practitioners.[20]

---

[17] Proposed 42 C.F.R. § 447.406. For physicians providing services within geographic health professional shortage areas (as designated by the Health Resources and Services Administration) or Medicare-defined rural areas, the limit would be 75 percent of Medicaid FFS base payments.

[18] California State Plan Amendment 17-030, available at https://www.dhcs.ca.gov/formsandpubs/laws/Documents/17-030Apv.pdf.

[19] *See* California Future Health Workforce Commission Final Report (Feb. 2019), https://futurehealthworkforce.org/our-work/finalreport/ (last accessed Jan. 27, 2020).

[20] Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections from 2017 to 2032 (April 2019), available at https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf

The proposed limitations on supplemental payments to physicians are arbitrary, risk narrowing access to Medicaid providers, and undervalue critical physician services. For all of these reasons, we oppose the new payment limitations. Instead, we ask CMS to affirm the essential role

physicians and non-physician practitioners have in the effective management and delivery of services to Medicaid beneficiaries and to develop more comprehensive methodologies for

evaluating whether payments to such practitioners meet Medicaid requirements. While we understand the concerns expressed in the proposed MFAR regarding the calculation of rates based on proprietary commercial rates, we encourage CMS to allow states the flexibility to develop appropriate methodologies to approximate such rates or to reference commercial benchmarks as a tool for evaluating payment levels. Commercial rates represent the best available estimates of the fair market value of furnished services. Commercial rates are also closely connected with the requirement in the Medicaid statute that rates be sufficient to enlist enough providers to ensure that care and services are available "at least to the extent that such care and services are available to the general population in the geographic area."[21] Payment of average commercial rates in a geographic area, or a reasonable approximation thereof, straightforwardly meets this standard.

THE PROPOSED MFAR ADDS SIGNIFICANT ADMINISTRATIVE BURDENS TO PROVIDERS

UC Health, along with other providers, generally supports efforts to increase transparency and to promote the integrity of the Medicaid program. However, UC Health is concerned that the numerous new reporting requirements contained in the proposed MFAR do not strike the right balance between transparency and the costs to states—and providers—associated with such reporting requirements in the form of decreased flexibility to develop and test innovative payment methodologies and increased administrative burden.

UC Health appreciates that CMS has consistently attempted to reduce regulatory and administrative burden to providers through initiatives such as Patients over Paperwork, trying to increase efficiency in the delivery system by allowing providers to focus their time and resources on patient care.[22] But we believe that many of the proposed provisions related state- and provider-level reporting in the proposed MFAR would run counter to the goals of that initiative, adding administrative burdens for states and providers, without improving care or lowering program costs. Indeed, CMS's estimates of the time, cost, and difficulty associated with implementing the proposed MFAR's new reporting requirements are far too low. Moreover, the data that CMS proposes to require are unlikely to meaningfully increase the transparency related to these programs. UC Health therefore urges CMS to thoughtfully and comprehensively evaluate the

[21] SSA § 1902(a)(30)(A), 42 U.S.C. § 1396a(a)(30)(A).
[22] Patients Over Paperwork, https://www.cms.gov/About-CMS/Story-Page/patients-over-paperwork (last visited Jan. 27, 2020).

regulatory burdens associated with these proposals before finalizing any of the new reporting requirements.

CONCLUSION

For all of these reasons, UC Health urges CMS to withdraw this harmful proposed rule so that we can continue to effectively operate, provide care to our Medi-Cal patients, and fulfill our mission to serve the public and our communities. Thank you again for the opportunity to submit comments and for your consideration of our concerns.

Sincerely,

DocuSigned by:
Carrie Byington
0E849F9639EA49A...

Carrie Byington, M.D.

Executive Vice President—UC Health