FAH Response to CMS' Request for Information on
Access to Coverage and Care in Medicaid & CHIP
April 18, 2022

On Feb. 17, 2022, CMS published on Medicaid.gov a Request for Information (RFI) regarding "Access to Coverage and Care in Medicaid & CHIP." Under each of the RFI's five objectives are four or five specific questions. CMS is collecting responses using an online submission tool where each objective is submitted separately.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH appreciates the opportunity to comment on the Agency's RFI and submitted the following comments using CMS' online submission tool.

CMS Objective 1*: "Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage."*

The Federation of American Hospitals (FAH) applauds the effort of the administration to "develop and implement a comprehensive access strategy for Medicaid and the Children's Health Insurance Program (CHIP)" using "regulations and guidance" and appreciates the opportunity to respond to this RFI. As detailed in the remainder of our comments, FAH supports CMS enhancing its regulations, guidance, and oversight of state Medicaid programs to ensure individuals can enroll in and maintain their coverage and can access needed health care services that are reimbursed at appropriate rates without undue burdens on beneficiaries or providers. Medicaid and CHIP are critically important programs that support the American economy, the workforce, and families' economic well-being. Thus, it is imperative that every state expand Medicaid to cover the uninsured and ensure that all Americans can obtain high-quality health care, and that CMS implement national standards to ensure adequate access is provided in Medicaid and CHIP.

Unfortunately, disparities exist in the health care system and have been further exposed during the COVID-19 Public Health Emergency (PHE). Everyone – particularly Medicaid and CHIP enrollees, who are more likely to live in disadvantaged communities – should have equal access and opportunity to obtain critical services, including behavioral health; the specialty care available in inpatient rehabilitation, psychiatric, long-term acute, and cancer hospitals; and other services and supports.

In 2020, approximately 7 million uninsured individuals were eligible for Medicaid or CHIP, nearly two-thirds of whom were people of color and three-fourths in working families (KFF 2021). CMS and states must take action to further enhance outreach activities and to streamline enrollment processes. In order to highlight the variation by state in the number of uninsured individuals who are eligible but not enrolled in Medicaid and CHIP, CMS should publish these state-specific estimates so states can be compelled to make improvements and the best-performing states can be highlighted for their performance and best practices.

Enrollment in Medicaid not only prevents uninsurance but also lowers families' out-of-pocket cost sharing and premiums. In fact, millions of Medicare beneficiaries are eligible for but not enrolled in Medicaid's Medicare Savings Program (MSP), which provides supplemental coverage that helps cover

Medicare cost-sharing and premiums (MACPAC 2017). By not obtaining this cost-sharing support, beneficiaries could face cost-related barriers to care. On the other hand, Medicaid agencies are not required to cover the full amount of the Medicare cost-sharing if the state's payment for services is lower than Medicare's – referred to as the "lesser-of" policy. For example, in states where the Medicaid rate for a doctor's visit is 80 percent or less of the Medicare rate, Medicaid would make no payments for the 20% Medicare Part B coinsurance for an MSP enrollee, and the amount would go unpaid and be absorbed by the provider. This results in providers not receiving payment for MSP enrollees' Medicare cost sharing and can also harm these beneficiaries' access to care (MACPAC 2020), while creating administrative burden and reduced payments for providers. Use of this lesser-of policy varies by state (MACPAC 2018). Congress and CMS should address this discriminatory, harmful "lesser-of" policy (FAH MAPD letter, 2022). At a minimum, CMS should track state use of the lesser-of policy and its effects on beneficiaries' access to care.

Some states have implemented "easy enrollment" programs so that individuals potentially eligible for Medicaid or subsidized exchange coverage can have their eligibility automatically determined and potentially be enrolled (Commonwealth Fund). These programs rely on the state tax-filing process. CMS should consider options for encouraging these programs and for states to automatically enroll individuals found eligible for no-cost Medicaid, CHIP, or subsidized exchange coverage.

CMS Objective 2*: "Medicaid and CHIP beneficiaries experience consistent coverage."*

Due to the COVID Public Health Emergency (PHE) and congressional action creating Medicaid's continuous coverage policy during the PHE, Medicaid enrollment is at historically high levels. As the PHE comes to an end, families will be facing the Medicaid/CHIP renewal process for the first time in years. Millions are likely to lose Medicaid coverage.

FAH appreciates CMS extending the timeframe for states to distribute their Medicaid renewal workload across 14 months post-PHE (CMS 2022), although additional months would ensure more stability in coverage. It is critical for states and CMS to effectively handle the PHE unwinding, including ensuring eligibility data can be seamlessly transferred between programs and that Medicaid managed care plans can support outreach efforts to beneficiaries, as described by CMS.

As states return to regular rules for eligibility and enrollment, many beneficiaries will be subject to coverage disruptions due to too frequent redeterminations – for example, based on purported changes in income flagged in state databases occurring between annual redeterminations (42 CFR 435.916(d)). Such activities cause confusion and disruption for beneficiaries, disincentivize work, and cause unnecessary administrative burden for enrollees, plans, and state Medicaid agencies. CMS should consider reversing these regulations so individuals have 12-month continuous eligibility between redeterminations.

Currently, states can choose to implement 12-month continuous eligibility for children via a state plan option and under Section 1115 demonstration authority for adults. Research has found 12-month continuous eligibility reduces coverage disruptions and improves health outcomes with a modest cost increase (RAND 2021). Other research indicates Medicaid enrollees with 12 months of consistent coverage have lower spending than those with partial-year coverage, not including the administrative costs to states and plans for churn (CBPP 2021). These higher costs can occur because individuals re-enroll in Medicaid for costly hospital care, which could have been avoided with adequate, consistent coverage and care coordination (Swartz 2015).

CMS should support policies to replace the outdated and too narrow Transitional Medical Assistance (TMA) with mandatory 12-month continuous eligibility for all MAGI populations (that is, Medicaid populations most likely to be in working families). This would end losses of coverage due to fluctuations

in working families' income changes during the 12-month enrollment period and would expand the provision proposed in the Build Back Better Act to require 12-month continuous eligibility for all children in Medicaid (H.R. 5376, Section 30724).

CMS Objective 3*: "Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary's needs as a whole person."*

As part of its new comprehensive access strategy, CMS should implement national access standards to ensure equity and eliminate inappropriate variation by state. Medicare Advantage provides a potential model of consistent federal access standards (time and distance) that reasonably take into account urban/rural characteristics and different provider types (42 CFR 422.116(d)). On the other hand, the Medicare Advantage network adequacy standards do not adequately address certain facilities such as inpatient rehabilitation facilities, long-term care hospitals, and inpatient psychiatric facilities. Network adequacy for Medicaid plans should include assessment of these services and facilities.

Mental health parity is a specific concern that should be addressed. As described in our March 7 comment letter, "These [Medicare Advantage] standards impose time and distance standards for inpatient psychiatric facility (IPF) services, but do not establish a minimum ratio of inpatient psychiatric beds to enrollees or establish access standards for other behavioral health care services like partial hospitalization programs or opioid treatment providers. … CMS' standards do not address network adequacy for other [non-psychiatrist] behavioral health professionals at all, even though behavioral health is offered along a continuum of care, and successful patient outcomes depend heavily on the full range of behavioral health care services, including partial hospitalization program services, outpatient treatment programs, and other community-based providers. Our members are concerned that MA plans often maintain an inadequate network of community-based behavioral health care providers." These issues apply to Medicaid access as well.

Standards should not vary depending on whether or not a beneficiary is enrolled in managed care. CMS should consider a regulatory framework that can address network adequacy and access to care consistently between managed care and fee-for-service (FFS). Under current regulations, FFS Medicaid has no time and distance standards for assessing access. In 2016, CMS finalized regulations requiring states to develop time and distance standards for specific provider types in managed care, but allowing states to define those standards (42 CFR 438.68 at 81 FR 27873-27874). In 2020, the previous administration eliminated the requirement for states to institute time-and-distance standards for their managed care plans (42 CFR 438.68 in current regulation, at 85 FR 72841). CMS should reinstitute this requirement and should strongly consider setting such standards, as is done in Medicare Advantage, so states are not permitting inadequate access to care through Medicaid managed care plans.

Medicaid and CHIP access standards need to address multiple types of providers, including behavioral health, inpatient rehabilitation, and long-term care hospitals. Such standards can help assure mental health parity.

However, standards alone are inadequate. Appropriate standards must be coupled with effective oversight of access to services. Without such oversight (and funding for such oversight), beneficiaries will still lack prompt access to needed care.

More action is necessary to ensure services at an institution for mental diseases (IMD) are available as necessary for 21- to 64-year-olds. While it is helpful that CMS and Congress intervened so that Medicaid managed care organizations (MCOs) can cover IMD services for up to 15 days for 21- to 64-year-olds, fee-for-service state Medicaid programs should also be able to obtain federal match for such services.

More generally, it is imperative to guarantee access to necessary services by eliminating this outdated IMD exclusion.

Any assessment of access should also measure and track MCOs' claims denial rates and their effects on beneficiary access, provider burden and payments. Plans often use denials as a tool to avoid or delay payment and restrict beneficiary access. Providers' administrative costs associated with denials (including those that are ultimately overturned) deter providers from accepting plan enrollees, further limiting access. Any assessment of access should also consider plans' use of prior authorization, utilization review, delayed patient transfers, and other strategies that could be abused as a tool to indirectly deny access while still appearing to meet certain standards.

CMS should encourage and collaborate with states to develop and promote state-based innovations to address whole-person care. Significant innovations are underway in many states, including efforts to address equity and reduce disparities. CMS should track these initiatives and share best practices.

States have the option to provide Medicaid targeted case management (TCM) services to directly fund care coordination. This is longstanding flexibility that predates newer bundled payment arrangements. Not all states provide TCM services (Kaiser Family Foundation). CMS should consider how to expand the use of TCM services for care coordination, which should result in lower overall costs, and share their use, effects and best practices in FFS, managed care, and alternative payment models (APMs).

Telehealth has proven critical to providing services during the COVID-19 PHE, and such flexibilities should be extended beyond the PHE. In Medicare, telehealth has enhanced use of behavioral health services and benefitted those beneficiaries in particular, due to that expanded access (OIG 2022). Prior to COVID-19, a congressionally mandated study found that telehealth improved children's access to substance use disorder (SUD) services in Medicaid at comparable quality and cost, with other advantages from providing these services via telehealth (HHS 2020). FAH appreciates CMS efforts to encourage states flexibility for use of telehealth in Medicaid before, during and looking ahead to the end of the PHE (CMS 2020, CMS 2021). CMS should consider how to incorporate telemedicine, remote patient monitoring and similar approaches in its comprehensive access strategy as vehicles that can enhance beneficiaries' access to care in Medicaid and CHIP.

During the PHE, states also have implemented flexibilities in providers' cross-state licensure that have expanded access, including long-term or permanent privileges (FSMB 2022a), particularly for telehealth (FSMB 2022b). Congress and CMS should consider how to ensure states can extend that flexibility and access post-PHE.

Providers often face challenges obtaining reimbursement for out-of-state Medicaid enrollees. For example, courts are allowing New Hampshire hospitals to move forward with a suit against the state of Vermont for alleged discriminatory Medicaid payment rates due to being out-of-state (Bloomberg 2022). CMS should ensure that providers near state borders, specialty hospitals, and other affected hospitals and providers are not harmed by practices to avoid payment for out-of-state beneficiaries or to pay significantly reduced rates, especially when those beneficiaries are seeking access to higher-quality, specialized care.

FAH continues to support federal and state efforts to eliminate barriers to access such as cost sharing, premiums, and work requirements that run counter to the objectives of Medicaid.

CMS Objective 4*: "CMS has data available to measure, monitor, and support improvement efforts related to access to services (i.e., potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations)."*

- [No comment]

CMS Objective 5*: "Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible."*

FAH applauds the efforts of the administration to ensure that requirements continue for state Medicaid programs' Access Monitoring Review Plans (AMRP) (9/12/19 comment letter), as well as this current effort to implement a comprehensive access strategy using the statutory and regulatory tools mentioned in this Objective.

As part of its plans to implement a comprehensive access strategy, CMS needs to broaden its requirements and oversight of states, to ensure they are fulfilling their statutory obligation that payments are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area" (1902(a)(30)(A) of the Social Security Act). As previously mentioned, access standards should not vary based on whether or not a beneficiary is enrolled in managed care. Adequate oversight must include adequate federal and state investment in monitoring, transparency around rate changes, and reviewing minimum standards.

Medicaid payments too often do not cover providers' costs. For hospitals, this is true even after accounting for supplemental payments, with Medicaid covering only 89.3% of hospital costs on average (AHA Table 4.4). For physicians, there is substantial variation in what Medicaid pays by state and by specialty, but in general remains "substantially below Medicare and private insurance fees"; in 2019, Medicaid physician payments were 28% lower than in Medicare and even lower compared to private insurance (Zuckerman 2021).

Besides inadequate payment rates, CMS should also monitor the effect on Medicaid beneficiaries' access to needed health care services and supports via inappropriate coverage limits, denials, prior authorization, utilization review, delayed patient transfers, and other strategies that could indirectly deny access while still appearing to meet certain standards. In addition, CMS should ensure providers are not burdened with additional claims submissions and unpaid cost-sharing amounts due to certain Medicaid plan practices and state policies (for example, MSP "lesser-of" policy).

As payment of Dual Eligible Cost Share is presently designed, State Medicaid agencies are only required to cover Cost Share for QMBs, not the Cost Share for all other types of Dual Eligibles. In addition, CMS permits State Medicaid agencies to apply the "lesser of" standard. This "lesser of" standard allows State Medicaid agencies not to pay Cost Share when the Medicare primary payment is greater than the Medicaid primary payment would have been. The "lesser of" calculation effectively results in providers not being reimbursed for Dual Eligible Cost Share on almost all QMBs, and in the limited circumstances where a State Medicaid agency has elected to cover other types of Dual Eligibles, the "lesser of" calculation also effectively results in providers not receiving the Cost Share amounts for those non-QMB Dual Eligibles. State Medicaid agencies should be prohibited from applying the "lesser of" calculation standard and Cost Share for all types of Dual Eligibles, not just QMBs, should be paid to providers in full.

Federal statute prohibits state Medicaid programs from setting limits on services' amount and duration and scope that are not "reasonable … to achieve their purpose" (1903(i) in first sentence after (27)). CMS' comprehensive access strategy needs to assess and consider regular oversight of states' limits on amount, duration, and scope. In terms of realized access and beneficiary experience, for example, Medicaid beneficiaries do not obtain cancer screenings at the same rate as the privately insured, and are significantly more likely to delay or not obtain needed care — as well as to have concerns with paying

medical bills (MACPAC 2021). The statutory standard for payment adequacy to ensure equal access to services "available to the general population in the geographic area" should use the privately insured as the benchmark.