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Advancing Health in America

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April 15, 2022

Daniel Tsai
Deputy Administrator and Director
Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Request for Information: Access to Coverage and Care in Medicaid & CHIP

Dear Mr. Tsai:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid (CMS) request for information (RFI) regarding access to coverage and care in the Medicaid and Children's Health Insurance Program (CHIP) programs.

The AHA applauds CMS's undertaking to conduct a comprehensive review of access and care challenges faced by Medicaid and CHIP beneficiaries and the agency's commitment to develop policies to address them. The AHA believes that the critical components for a comprehensive access and coverage strategy for Medicaid and CHIP should include:

- **Robust outreach and enrollment efforts to secure and maintain coverage for eligible individuals and families, as well as ensure beneficiary knowledge of how to use this coverage,**
- **Standards to ensure timely and equitable access to quality care, and**
- **Provider payments that are sufficient to enable beneficiaries' access to quality care.**

CMS plays a crucial role in enforcing the mandate established by Congress that reimbursement rates for health care providers are sufficient to ensure Medicaid beneficiaries enjoy the same access to health care services as the general

population.[1] In the wake of the U.S. Supreme Court's 2015 decision in *Armstrong v. Exceptional Child Center, Inc.*[2], which ended providers' and beneficiaries' right to challenge state Medicaid payment rates in federal court, CMS has become the final arbiter in determining if provider payments are adequate to ensure access under federal statute.[3] The safeguards embedded in the current regulatory requirements, established in 2015, are all that remain to hold federal and state governments accountable to ensure access for historically marginalized and special needs populations covered by Medicaid. State governments' chronic underfunding of the program, and the added pressure for states, hospitals and others providers in managing the ongoing COVID-19 pandemic, present significant challenges for CMS in developing comprehensive solutions to ensure access and coverage. **The AHA recommends that the agency convene stakeholder roundtables or workgroups to explore regulatory and legislative solutions to these access and coverage challenges and ensure that both beneficiaries and their hospital and health system providers are represented.**

AHA's specific comments to the request for information follow and focus on the agency's five objectives: enrollment, coverage, access standards, data for monitoring and provider payment and administrative burden.

Objective 1: Reaching and Enrolling those Eligible for Medicaid and CHIP

Patient and community access to health care coverage has long been a top priority for hospitals and health systems. As part of their mission and service to their communities, they work to connect their patients and community members to both public and private health care coverage options through enrollment fairs, public service announcements, social media campaigns, Marketplace assisters and other community-based outreach strategies. **The AHA encourages CMS to look to the hospital community as trusted voices as they build new community-based Medicaid and CHIP outreach and enrollment initiatives.**

The Affordable Care Act (ACA) provided additional muscle to hospitals' voluntary enrollment efforts by requiring states to allow for hospital presumptive eligibility (PE), which allows hospitals to provide temporary Medicaid coverage to individuals who are likely to qualify for Medicaid. The ACA provision allows hospitals to make PE determinations in every state for all individuals eligible for Medicaid based on modified adjusted gross income and at the state's discretion for other populations groups, including those covered by Section 1115 demonstration waivers. In addition, it allows hospital PE determinations to be extended to the patients' families and eligible individuals from the broader community.[4] The expansion of Medicaid PE policy, which is strongly supported by the AHA, has become an essential tool for states to ensure those

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[1] Microsoft Word - Armstrong - Amicus Pre-Filing Draft -- FINAL clean (aha.org)
[2] [2] https://www.supremecourt.gov/opinions/14pdf/14-15_d1oe.pdf
[3] Medicaid "Equal Access Standard" Soc. Sec. Act Se. 1902 (a) (30)(A)
[4] https://www.cdc.gov/phlp/docs/hospitalpe-brief.pdf

eligible for the program can begin the enrollment process when seeking care for themselves or their family members.

The COVID-19 pandemic only underscored hospitals' critical role in connecting their patients to coverage. For example, CMS extended considerable flexibility to states that allowed them to process hospital PE applications using phone and on-line portals, extend hospital PE to disabled and institutionalized individuals and relax certain hospital PE performance standards and metrics during the public health emergency (PHE).[5] **While CMS has encouraged states to consider adopting some of these policies once the PHE ends and states resume their redetermination processes, the AHA recommends that CMS standardize and make permanent these policies.** In particular, CMS should normalize the performance standards across states to ensure individual state policies do not become a barrier to a hospital's participation in PE programs.

In addition to hospital PE determinations, the Medicaid retroactive eligibility provision has also allowed hospitals to provide potential beneficiaries timely access to necessary health care services. This provision provides coverage for health care expenses three months prior to the beneficiaries' application date, provided the beneficiary is eligible during that period. Some states have moved to restrict the retroactive provision through Section 1115 demonstration Medicaid waivers. However, Medicaid retroactive eligibility has provided access to critical services for many individuals, particularly during downturns in the economy and is an important vehicle for ensuring that those who are eligible for enrollment have coverage.[6] **The AHA recommends that CMS preserve the Medicaid retroactive eligibility provision to protect access to needed services and treatment for Medicaid beneficiaries.**

Objective 2: Maintaining Coverage

Issues related to the continuity of coverage for Medicaid and CHIP populations have long been a concern for policymakers and stakeholders. Income fluctuations can result in beneficiaries dis-enrolling and re-enrolling in the programs multiple times over the course of a year, known as churn. Congress has attempted to address concerns about continuous eligibility and minimize churn for specific population groups such as children. Since 1997, states have had the option to extend continuous eligibility to children to provide a more stable source of coverage. As of January 2022, nearly half of the states have extended continuous eligibility for children in Medicaid or CHIP.[7] In response to the COVID-19 pandemic, Congress also required that states provide continuous coverage to Medicaid beneficiaries through the entirety of the PHE in order to be eligible for enhanced federal matching funds.

[5] COVID-19 FAQs for State Medicaid and CHIP Agencies
[6] Health Affairs https://www.healthaffairs.org/do/10.1377/forefront.20200506.111318/full/
[7] Kaiser Family Foundation, State Adoption of 12 Month Continuous Eligibility for Children, https://www.kff.org/statedata/, Jan. 2022.

The continuous coverage requirements also ensured continuous postpartum coverage since the start of the PHE. Relatedly, and also during the pandemic, Congress recently established a new state option to extend Medicaid postpartum coverage for five years beginning in April 2022 through a state plan amendment to help address disparities and inequities in maternal health. Prior to the new state option, states could establish postpartum coverage through a Section 1115 demonstration waiver. Over half of the states are in various stages of action through the new state plan amendment option or through 1115 waivers to establish postpartum coverage.[8] These efforts to ensure continuous coverage for Medicaid and CHIP enrollees, as well as for postpartum women, are important advances in expanding access to health care insurance coverage.

The AHA has supported and will continue to support legislative initiatives to provide continuous coverage for Medicaid beneficiaries. However, as the Medicaid and CHIP Payment and Access Commission (MACPAC) work in this area has highlighted, there are state policies and practices that could help address continuous coverage challenges and mitigate churn. MACPAC, in their examination, found that overall, 8% of Medicaid and CHIP beneficiaries in 2018 enrolled and re-enrolled within 12 months. The highest rates of churn were found in children enrolled in separate CHIP programs (16%) and adults enrolled in Medicaid through the modified adjusted gross income eligibility group (9%).[9] MACPAC highlighted two particular state practices that affected churn rates in Medicaid beneficiaries: (1) mid-year data checks for changes in circumstances; and (2) use of automated renewal processes.[10] The Commission found that states with mid-year data checks had a more significant share of beneficiaries with fewer than 12 months of continuous coverage and a higher churn rate of beneficiaries dis-enrolling and re-enrolling within 12 months. On the other hand, states with an increased use of automated renewals, which included the use of available electronic data sources and pre-populating renewal forms, showed a decrease in the average share of beneficiaries dis-enrolling and re-enrolling within 12 months.

As CMS and states begin the eligibility redetermination process once the COVID-19 PHE ends, state eligibility practices will be important in mitigating potential coverage losses. Toward that end, the AHA has provided tools and resources for our hospital members and state hospital associations to use as they work with their state Medicaid agencies to examine state policies to mitigate coverage losses when the continuous eligibility requirements end and eligibility redetermination resumes.[11] Recommendations include:

- Confirm eligibility using an ex parte process that looks at available data sources;
- Adopt an automated renewal process that pre-populates eligibility forms;
- Use self-attestation of income allowed during the PHE;

[8] https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/
[9] An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP (macpac.gov)
[10] Ibid.
[11] AHA. AHA PHE Unwinding Medicaid June, 2021.pdf

- Use data from other federal means test programs to streamline redeterminations and new enrollments;
- Partner with stakeholders to reach Medicaid beneficiaries; and
- Use hospital PE programs to assist with eligibility determinations.

The AHA recommends that CMS consider standardizing eligibility practices across states to promote continuous eligibility and minimize enrollment churn.

Objective 3: Establishing Standards for Equitable and Timely Access to Providers and Services

As CMS contemplates establishing standards for equitable and timely access to providers and services, examining where current policies and practices are subverting that objective is essential. We would recommend that the agency, in particular, examine the following areas: Medicaid managed care, behavioral health, and maternal. pediatric, and adolescent access.

Medicaid Managed Care. Medicaid beneficiaries enrolled in some form of Medicaid managed care account for nearly 70% of total Medicaid enrollment.[12] Medicaid managed care is heavily reliant on commercial health plans to administer benefits to enrollees. However, certain practices by commercial health plans are eroding Medicaid beneficiary access to care and services.

AHA's survey from 2019 found that commercially-administered Medicaid managed care plans had the highest prior authorization denial rate, and the highest rates of claims denial based on inaccurate enrollment files when compared to Medicare Advantage and other commercial health plan products outside of Medicaid and Medicare.[13] Providers at times must begin treatment or move a patient to a more appropriate site of care before obtaining a response to a prior authorization request to prevent harm and adequately care for patients. Some Medicaid managed health plans deny care that they acknowledge to be medically necessary because the provider in their clinical judgement could not wait any longer to begin care before prior authorization process was completed. According to an AHA 2019 survey, hospitals and health systems reported steep increases in short-stay denials, even when clinical indicators and the severity of illness meet the standards for inpatient admission. In these instances, the commercial Medicaid managed care plans downcode the inpatient claims to observation status and, in some instances, use the downcoding to deny the claim altogether by arguing that the provider did not seek prior authorization for observation status.

In addition, it is not uncommon for Medicaid managed care plans to deny claims based on coverage errors or inaccurate enrollment information. These problems occur most frequently in the first quarter of the year when insurers do not update membership files

[12] https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/
[13] addressing-commercial-health-plan-abuses-ensure-fair-coverage-patients-providers.pdf (aha.org)

on a timely basis. Enrollees, who are eligible for services, are experiencing inappropriate denials that limit access to needed care.

To curb these practices, the AHA recommends a number of solutions to standardize the prior authorization process and increase the oversight of Medicaid managed care plans including:

- **Standardizing the format for prior authorization requirements;**
- **Requiring plans have 24/7 capability to respond to requests for authorization;**
- **Standardizing the timeline for responses such as 72 hours for scheduled, non-urgent services and 24 hours for urgent services; and**
- **Standardizing the appeals process.**

In addition, the AHA recommends additional health plan oversight and performance measures, including: setting appropriate thresholds for prior authorization and payment denials; applying financial penalties for inappropriate denials; testing to demonstrate the adequacy of provider networks; and publishing performance data on prior authorization or other payment denials.[14]

It is also important to note that many states opted to waive Medicaid managed care prior authorization requirements to expedite patient access to services during the COVID-19 pandemic. This has been an important indicator of improved access to timely health care services during the PHE.

In addition, the AHA urges CMS to establish additional policies and oversight requirements regarding Medicaid managed care networks, including the updating and managing of provider directories. Current managed care regulations replaced time and distance standards for meeting provider network adequacy requirements with state-established quantitative network adequacy standards. **The AHA recommends that CMS return to time and distance standards as a measure of adequate provider networks and align such standards with those required for qualified health plans offered in the marketplaces.** Such quantifiable standards are particularly important in assessing the robustness of provider networks for adult and pediatric specialists or behavioral health providers to ensure vulnerable enrollees with complex medical conditions that need specialty care or behavioral health needs are met. We are deeply concerned that the lack of consistency in network adequacy standards that vary by state will fall short of ensuring equal access to health care services for all Medicaid beneficiaries.

The AHA further recommends that CMS look at how frequently managed care plan networks rely on out-of-network authorizations for care as a measure of network adequacy, particularly for adults and pediatric patients with complex

[14] Ibid

medical health needs and behavioral health patients. Up-to-date provider directories are also an essential tool for assessing provider networks. As a condition of their contract with the state, managed care plans should be required to frequently update their provider directories, proactively reach out to providers to confirm the accuracy of information and publicly share whether that provider is accepting new patients. Further, CMS should continue to push for standardization of provider directories using the most up-to-date interoperability standards.

Behavioral Health. Medicaid is the single largest payer for behavioral health services in the nation. As such, it is particularly important that CMS focus on the behavioral health needs of Medicaid beneficiaries when establishing access standards that promote the integration of behavioral health and physical health. When looking at Medicaid managed care, CMS should be focused on behavioral health measures for network adequacy, including time and distance standards, prior authorization practices that may impede timely access, denial rates and managed care plans' reliance on out of network providers. **In addition to evaluating behavioral health access in the managed care setting, the AHA recommends that CMS look at behavioral health access barriers for Medicaid beneficiaries in the context of the current Institutions for Mental Disease (IMD) exclusion.** While AHA advocates for the legislative repeal of the IMD exclusion, it also supports CMS's regulatory steps to make IMD services available in the Medicaid managed care setting, as well as implementing the state option to use IMDs for Substance Use Disorder treatment. CMS could further explore renewing the use of the Section 1115 demonstration waiver authority to promote access to IMD providers for Medicaid beneficiaries.

Maternal, Pediatric and Adolescent Services. The Medicaid program has a special obligation to ensure access to maternal, pediatric and adolescent services for the Medicaid and CHIP population. While expansion of coverage, continuous coverage, and access for these populations may require federal legislation, CMS can take actions to improve access and set standards.

For example, while states can use telehealth to improve access to care, the AHA encourages CMS to further explore how Medicaid telehealth coverage could specifically be used to improve maternal health through prenatal and postnatal care, recognizing this may require additional regulatory flexibility or waivers. This is particularly important for those rural and urban areas with no or limited access to obstetric providers. A small number of state Medicaid programs include obstetrical care in their telemedicine reimbursement and reimburse for telemedicine services delivered to the patient in their home but limit reimbursement of services, such as lactation assistance and in-home monitoring, during and after pregnancy.[15] A study in the CDC's Morbidity and Mortality Weekly Report examined work done by 13 state Maternal Mortality Review Committees to identify contributing factors and strategies to prevent future pregnancy-related

[15] Telemedicine and Pregnancy Care | KFF

deaths, which included addressing personnel issues at hospitals by providing telemedicine for facilities with no obstetric provider on-site.[16] In addition, telehealth services would give clinicians an opportunity to monitor and treat postpartum mothers for postpartum depression, the most common complication after pregnancy according to the American Psychological Association.

The COVID-19 pandemic has pushed pediatric and adolescent mental health to crisis levels. According to the CDC, from March to October 2020, hospitals saw a 24% increase in the proportion of mental health emergency department visits in kids ages 5 to 11 and a 31% increase for kids and teens ages 12 to 17 compared to 2019. In a follow-up study, the CDC found that beginning in May 2020, emergency department visits for suicide attempts began to increase among adolescents' ages 12 to 17, with visits 39% higher than during the same period in 2019.[17]

As behavioral health needs are increasing across the nation, we are seeing an alarming trend of decreasing behavioral health services in many communities, leading to severe challenges in providing inpatient psychiatric care to children and adolescents. Bed shortages lead to "boarding" in acute-care hospital emergency departments (EDs) and in non-psychiatric units as patients await available inpatient psychiatric beds. Although little data is available regarding boarding times for children and adolescents, our hospital members report untenable crowding in their EDs, with some describing a crisis in their communities.[18]

To amplify the call to address these urgent issues, the AHA has joined the Sound the Alarm for Kids initiative, which comprises more than 50 organizations united to raise awareness and urge immediate action to support the mental health of children, adolescents and their families. While Congressional action will be required to address some of these challenges, the Medicaid and CHIP programs can play a role in improving access. CMS could encourage states, through guidance and best practices, on the effective uses of telehealth mental health services for pediatric and adolescent populations. In addition, CMS could promote the integration of physical health and behavioral health for these populations by establishing access standards that would apply in the fee-for-service (FFS) as well as the managed care settings.

Objective 4: Data Sources to Monitor Access

Data will be critical for CMS and states to appropriately monitor access to coverage and services for the Medicaid and CHIP populations. The challenge for CMS is to balance existing data and reporting requirements with implementing new requirements. AHA encourages CMS to prioritize data the agency already has through T-MSIS or other sources such as current provider payment and Medicaid Disproportionate Share

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[16] Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017 | MMWR (cdc.gov)
[17] https://www.cdc.gov/mmwr/volumes/71/wr/mm7108e2.htm
[18] aha-senate-statement-protecting-youth-mental-health-part-ii-identifying-and-addressing-barriers-to-care-2-15-22.pdf

Hospital (DSH) and non-DSH supplemental payment reporting to be used more efficiently and reduce administrative burden.

In terms of additional reporting, we suggested in response to Objective 3 that CMS should require reporting and metrics on managed care plan prior authorization usage, claims denials and provider network adequacy. In other areas for reporting, CMS could consider more robust managed care plan reporting on beneficiaries' use of the appeals and grievances process. Appeals and grievances are critical access indicators but often are not aggregated in ways that are specific enough for state or CMS action. Low appeal and grievance numbers suggest that beneficiaries are either not aware of the extent of their coverage or their rights to raise concerns and objections to manage care plan actions. Lastly, CMS should put forward requirements that states report metrics that measure dis-enrollment and re-enrollment rates, such as churn rates, of Medicaid beneficiaries to identify possible barriers to maintaining Medicaid and CHIP coverage.

Objective 5: Ensuring Payment Rates Are Sufficient to Enlist and Retain Providers to Guarantee Access and Address Administrative Burden

With the *Armstrong*[19] case ending providers' and beneficiaries' rights to challenge state Medicaid payment rates in federal court, the current regulatory access safeguards are all that remain to hold federal and state governments accountable to ensure access for vulnerable populations covered by Medicaid. At the core of the Medicaid "equal access" standard is the sufficiency of provider payments to ensure access to services. Yet, the data reflects that total Medicaid payment falls far below hospitals' cost of caring for Medicaid patients.[20] According to data from the AHA's annual survey, hospitals received payment of only 88 cents for every dollar spent by hospitals caring for Medicaid patients in 2020. This underpayment resulted in a Medicaid shortfall of $24.8 billion in 2020.[21] In addition, MACPAC's analysis of Medicaid payments to hospitals shows that FFS rates are often far below Medicare payments for comparable services. For example, MACPAC reported that FFS Medicaid base payment rates were on average 78% of Medicare rates for the 18 Medicare Severity Diagnosis Related Groups studied using 2011 data.[22] And, states continue to look to cutting provider payments to address budget constraints. The Kaiser Commission on Medicaid and the Uninsured in its FY 2022 survey of state Medicaid programs notes that even amid the COVID-19 pandemic, 22 states adopted measures to restrict inpatient hospital payments by cutting or freezing payments.[23]

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[19] https://www.supremecourt.gov/opinions/14pdf/14-15_d1oe.pdf
[20] Total Medicaid payments include both Fee-For-Service and managed care payments, as well Disproportionate Share Hospital (DSH) payments, non-DSH supplemental payments, directed payments, and other adjustments, as reported by member hospitals.
[21] AHA. https://www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf.

[22] MACAPC.https://whttps://www.kff.org/report-section/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues-provider-rates-and-taxes/ww.macpac.gov/publication/medicaid-hospital-payment-a-comparison-across-states-and-to-medicare/.
[23] Kaiser. https://www.kff.org/report-section/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues-provider-rates-and-taxes/

Medicaid's historically low provider reimbursement rates have led to the growth of other enhanced payments to help providers such as DSH and non-DSH supplemental payments. According to MACPAC, supplemental payments account for a quarter of hospital payments, including hospital payments made by managed care organizations.[24] MACPAC further noted that hospital spending accounted for 34% of total Medicaid spending and Medicaid payments to hospitals accounted for 17% of all payments to hospitals in 2019.

While managed care rates are typically negotiated with health plans, the overall inadequacy of Medicaid payment rates has broadly substantiated the need for supplemental payments permitted by CMS's 2016 Medicaid managed care rule as directed payments. These additional payments have been critical in paying for services provided to Medicaid enrollees and offsetting Medicaid base rates that are often below hospital cost. Directed payments have helped to fill these payment gaps as more states have transitioned populations into managed care, resulting in an inability to continue making FFS supplemental payments to providers. In this way, directed payments are a necessary continuation of Medicaid providers' funding that ensures patient access to critical health care services and helps stabilize those hospitals who serve historically marginalized communities.

Medicaid beneficiaries look to hospitals and health systems to address a wide variety of complex health and social needs. A prevalent view of the "equal access" standard is that provider payment rates should be set at a level that balances efficiency and economy, while creating incentive for providers to participate. Financially distressed hospitals and health systems often are faced with reducing specialty care that can result in access challenges for Medicaid beneficiaries. While provider participation is critical, rates should also be set such that beneficiaries can continue to expect access to needed specialty care provided by hospitals. **CMS should consider the implication of low payment rates on hospitals' ability to provide a broad variety of care, including access to specialists.**

As CMS considers its access strategy and the role adequate provider payments play in ensuring access for Medicaid beneficiaries, the AHA recommends that CMS consider the totality of provider payments, including base rates and supplemental payments, and the role hospitals play in helping states finance their Medicaid programs. **AHA recommends CMS take steps to ensure that the totality of payment — whether reimbursed directly by the state or through a Medicaid managed care plan or some combination — are adequate to cover the costs of caring for beneficiaries and thereby support their access to health care services.**

Lastly, CMS examination of provider payments and access should include how payment rates impact physicians and behavioral health providers' participation in the Medicaid

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[24] https://www.macpac.gov/wp-content/uploads/2020/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf

and CHIP programs as well. A recent Urban Institute study found that Medicaid physician reimbursement is significantly lower than commercial payer and even Medicare payments for the same services despite growing enrollment in the public health care program.[25] Administrative burden for providers is another area for examination. Prior authorization denials not only contributed to negative clinical impact but to physician burnout issues as well.[26]

The AHA appreciates this opportunity to support CMS's endeavor to develop a comprehensive access and coverage strategy for the Medicaid and CHIP programs. We encourage CMS to consider roundtable sessions or workgroups of hospitals and other providers as the agency continues its work.

Please contact me if you have questions, or feel free to have a member of your team contact Molly Collins, director of policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

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[25] Health Affairs https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00611
[26] American Medical Association, "2018 AMA Prior Authorization (PA) Physician Survey"