Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

April 18, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Washington, DC 20201

Daniel Tsai
Deputy Administrator and Director of the
Center for Medicaid and CHIP Services
Baltimore, MD 21244

Anne Marie Costello
Deputy Director of the Center for Medicaid
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Dear Administrator Brooks-LaSure, Director Tsai and Deputy Director Costello:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization representing more than 2,200 Catholic health care systems, hospitals, long-term care facilities, clinics, service providers and organizations, attached are our comments to the recent Request for Information (RFI) on Access to Coverage and Care in Medicaid & CHIP.

Medicaid and the Children's Health Insurance Program (CHIP) are the foundation of our nation's safety net and provide necessary health care services to working families, children, the elderly and the disabled, many of whom would be uninsured in the absence of a strong and vital Medicaid program. As the single largest health insurer in the United States, Medicaid funding is a critical support for America's safety net institutions, including many Catholic hospitals and nursing homes that serve a disproportionate share of the low-income, uninsured and underinsured in their communities every day.

For decades CHA and our members have carried the message that health care is a basic human right essential to human flourishing, and we have advocated policies to ensure that everyone has access to affordable health care. The first principle in our Vision for U.S. Health Care affirms our call to pay special attention to the needs of the poor and the vulnerable, those most likely to lack access to health care, in our journey towards affordable, accessible health care for all. This commitment is why the Catholic health ministry has strongly supported public health care programs like Medicaid and CHIP.

Our comments highlight the need for CMS to maintain important policies such as presumptive eligibility, retroactive eligibility, continuous coverage (especially for certain populations like mothers, babies, and children), and increased support for outreach programs. Additionally, we urge CMS to consider new policies that advance innovation, health equity and the need to increase Medicaid payments to combat the workforce challenges and rising costs of care.

Thank you for the opportunity provide feedback through this RFI on behalf of our members and the millions of beneficiaries we are privileged to serve.

Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. *CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are awareof coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.*

1. What are the specific ways that CMS can support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI-based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan, when applicable.

The Catholic Health Association (CHA) strongly supports policies and programs in Medicaid that connect individuals, children, and families to this important coverage. CHA is strongly committed to ensuring our nation's Medicaid program remains a viable, efficient, and effective program and through our national Medicaid Makes it Possible campaign, we continue to educate policy makers about how our more than 2,200 hospitals, systems, long-term care facilities, clinics and health care organizations are supported by Medicaid. Connecting eligible individuals to Medicaid coverage is a responsibility of our members and we ask that the Centers for Medicare and Medicaid Services (CMS) establish the following policies for the success of our longstanding partnership:

- CMS must encourage states to take full advantage of the fourteen-month period to unwind after the public health emergency ends as outlined by the State Health Official (SHO) letter issued on March 3, 2022.
- CMS must also understand the staffing issues at the state level, as outlined by a recent article from NPR that found the "nation is on course for a mass-scale disruption in people's benefits — even for those who still qualify for the insurance." We encourage CMS to provide for additional resources to states to help with this challenge, even temporarily, so that states can have the needed workforce once the public health emergency (PHE) ends.
- Expand Medicaid's *presumptive eligibility* policies by hospitals, with the ability to use phone and on-line portals beyond the PHE. This vital flexibility allowed patients and their families to become eligible for coverage when seeking care in healthcare settings.
- Additionally, we ask that the Medicaid *retroactive eligibility* provision which provides coverage for health care expenses three months prior to a beneficiary's application date, provided the beneficiary is eligible that period. We ask that CMS preserve this important tool that protects beneficiaries' access to needed services and treatment.
- We ask that CMS increase national marketing and education campaigns to help beneficiaries understand upcoming changes in coverage as a result of the PHE by letting them know what other coverage options (Medicaid, Marketplace, CHIP, Basic Health Program, Employer Sponsored Insurance) they may be eligible for.
- CMS should build on the success of their partnerships and work to increase the roles of navigators, community health workers and other organizations that can help with outreach, education and supporting enrollment. Many CHA members are trusted partners in their communities and have strongly supported the ACA Navigator program over the years.
- CMS should encourage and support state's efforts to implement a "no wrong door" integrated eligibility process that streamline application, determinations, and enrollment. We can look to New York's program that operate under this approach.

- We ask that CMS leverage all available data across systems and databases to process timely eligibility determinations and enrollment and implement auto-enrollment processes for non-MAGI populations by utilizing existing state databases like the Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI), Women, Infants and Children (WIC), Social Security Disability Insurance (SSDI), Motor Vehicle Department, homeless service agencies and other systems without the need for another application to reduce the impact of redeterminations.
- CMS should support and encourage states to implement other policies like express lane eligibility (ELE) or through the integration of eligibility and enrollment at certain sites of care, as when hospitals can reach patients during services or need immediate coverage, such as a pregnant woman delivering a baby. These policies will help catch eligible women, children and babies who represent a majority of Medicaid enrollees.

2. What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? How can CMS help states improve these capabilities?

As we have noted in the previous question, CHA believes that CMS must provide states with the necessary resources, flexibilities and partnerships to prepare for what the Urban Institute is projecting to be the "biggest coverage event since the Affordable Care Act." Specifically, we ask that:

- CMS work with states to develop systems that allow the site and the patient to electronically submit all applications alongside real-time updates with electronic applications that show eligibility and status updates on requests.
- CMS promote interoperability across electronic application vendors on insurance status and eligibility. This enhancement would prevent the rejections that happen during referrals for services after a patient's insurance status changes.
- CMS develop a single system for all program data submissions. Current integration tools often require launching separate systems to conduct eligibility verifications, which creates barriers for front desk staff.
- CMS provide for support for multiple languages, beneficiaries with limited health literacy and patients with limited digital resources.
- We ask that CMS increase national marketing and education campaigns to help beneficiaries understand upcoming changes in coverage as a result of the PHE by letting them know what other coverage options (Medicaid, Marketplace, CHIP, Basic Health Program, Employer Sponsored Insurance) they may be eligible for. This outreach should utilize social media campaigns, paid media buys, such as radio and TV to educate the public on redeterminations in the patient's preferred language.
- CMS should identify counties with the highest Medicaid enrollment and target outreach in those areas, using renewal data to conduct direct outreach to individuals the state has been unable to renew during the PHE. CHA has appreciated the centralized communication materials, resources, and websites should be used by Managed Care Organizations (MCOs), community organizations, and health care organizations to communicate changes with consumers like CMS' "Coverage to Care" resources and be available in 20+ languages. Additional resources dedicated to redetermination education will greatly improve accessibility.
- CMS should continue to work with providers who interact with patients and serve as trusted

partners.

3. In what ways can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups, which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders?

CHA understands that some Medicaid beneficiaries come from communities that require committed, trustworthy and specialized outreach. CMS can strengthen various policies through the approval of Section 1115 waivers and state plan amendments (SPAs) that support:

- Continuous eligibility for certain populations like children up to age 18, pregnant women (including through the new American Rescue Plan post-partum coverage) and waivers that address vulnerable individuals with mental health or substance use disorders through the Institutions for Mental Disease (IMD) exclusion.

CMS can support states in addressing barriers to enrollment and retention of eligible individuals among different groups by expanding places/access points where enrollment can take place in the community. CMS should consider expanding enrollment locations to libraries, Boys & Girls Clubs, Y's, schools, pharmacies, and WIC offices. It is also necessary to ensure that bilingual navigators are available to support individuals whose primary language is not English.

4. What key indicators of enrollment in coverage should CMS consider monitoring? For example, how can CMS use indicators to monitor eligibility determination denial rates and the reasons for denial? Which indicators are more or less readily available based on existing data and systems? Which indicators would you prioritize?

CHA asks that CMS focus on at-risk populations and carefully monitor coverage loss due to the redetermination process, specifically for those experiencing homelessness, who are currently enrolled and track the rate at which they lose coverage during the redetermination process for reasons other than “no longer eligible”. Many of our members engage in outreach to these populations as part of their indigent care clinics, mobile outreach and community service. These rates should be compared to the overall lost coverage rates of people enrolled in Medicaid.

We also applaud CMS commitment to health equity and ask that CMS require states to track and report disaggregated data by race and ethnicity, to include reasons for and rate of denials, timeliness of application re-determination, and methods of contact. CHA is strongly committed to health equity, through our We Are Called campaign, which has been adopted by nearly all our member organizations. We know that the Medicaid program can help advance health equity and close the coverage gaps for people of color.

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage. *CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs.*

1. How should states monitor eligibility redeterminations, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary?

CHA has long supported policies in Medicaid and CHIP that have prevented churn, which describes the process of beneficiary coverage loss due to income fluctuations. The PHE prevented this churn due to provisions in the Families First Coronavirus Response Act. As CMS works with states to prepare for the unwinding of the PHE, we ask that CMS work with states to:

- 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;
- 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.

As stated in our previous comments we also ask that CMS provide resources and policies for states to be able to bolster their ability to:

- Expand Call Center access, improve accessibility of online processes to ensure that applications can be easily accessed, ease the process of updating personal information on applications, utilize provers to communicate enrollment information and increase benefit enrollment support staff to address the millions of redetermination applications.

2. How should CMS consider setting standards for how states communicate with beneficiaries at-risk of disenrollment and intervene prior to a gap in coverage? For example, how should CMS consider setting standards for how often a state communicates with beneficiaries and what modes of communication they use? Are there specific resources that CMS can provide states to harness their data to identify eligible beneficiaries at-risk of disenrollment or of coverage gaps?

The recent article from NPR highlights the need for expanding the use of effective communication with beneficiaries, in this case the need for text messaging. While we understand the regulatory barriers in place that make this policy a challenge for state Medicaid programs, we encourage CMS to consider approaches to reducing burden for beneficiaries, for example, by considering ways to support text-based enrollment and eligibility determinations through sharing pertinent information (such as a beneficiaries Medicaid enrollment number) and links to forms via text.

We also recommend that CMS consider how to rely on critical members or a patient's care team to support communication, education, and potentially enrollment, among beneficiaries at risk of disenrollment. Many of our members are trusted partners for Medicaid beneficiaries and ask that CMS work with state Medicaid to be proactive communicating with beneficiaries at risk of disenrollment early on, along with informing health care providers or community health centers of the possible individual at risk of losing coverage.

3. What actions could CMS take to promote continuity of coverage for beneficiaries transitioning between Medicaid, CHIP, and other insurance affordability programs; between different types of Medicaid and CHIP services/benefits packages; or to a dual Medicaid-Medicare eligibility status?

When it comes to redetermination or notifying patients when they are transitioning between health coverages, communicating with enrollees in a variety of ways, including via email, text, a phone call, or a letter to ensure they know of the change coming is key. While states are obligated to provide both applicants and beneficiaries with adequate and timely written notice regarding eligibility decisions (42 CFR 435.917, CMS 2017a) which must be written in plain language for those with limited English proficiency and people with disabilities (42 CFR 435.905, 42 CFR 435.917(a)), the mode of communication can be limited depending on the state. Most states utilize paper notices to notify enrollees on enrollment and renewal items. As of a 2020 study, two states use mobile apps for their application and eight states allow apps for access to online accounts. Having myriad options to notify enrollees about their status or ask for updated information, to meet enrollees where they are, is crucial.

Additionally, it also will be necessary for community navigators to be educated on how to share redetermination information with those in their community and what various coverage options are available for those losing Medicaid or CHIP coverage. Navigators play an important role off ramping and reenrolling beneficiaries. Subsidies may also be offered to encourage people to reenroll in coverage that requires monthly premiums. Several of our member hospitals and health systems believe that monthly premiums may be a barrier for some people re-enrolling in coverage who no longer qualify for Medicaid and the most meaningful and predictable path forward is simplifying the process for individuals to enroll on the health insurance exchanges, that provide those under 200% FPL with coverage that is almost entirely subsidized.

4. What are the specific ways that CMS can support states that need to enhance their eligibility and enrollment system capabilities? For example, are there existing data sources that CMS could help states integrate into their eligibility system that would improve ex-parte redeterminations? What barriers to eligibility and enrollment system performance can CMS help states address at the system and eligibility worker levels? How can CMS support states in tracking denial reasons or codes for different eligibility groups?

As we discussed earlier, CHA believes that CMS must work with states to implement "no wrong door" integrated eligibility processes that streamline applications, determinations, and enrollment as this will help reduce duplication of efforts and burden across state agencies and beneficiaries. By having data interface with Medicaid systems across the country, state and federal systems can effectively work to assure seamless coverage when a person transitions between systems. Additionally, CMS must ease other challenges beneficiaries may experience as they transition between coverage options. For example, beneficiaries switching from Medicaid or CHIP to a marketplace plan, may no longer have access to care management services. It will be important to educate those supporting these

transitions—such as navigators, social workers, representative from health plans—and the beneficiaries themselves about differences in coverage.

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 carewill be aligned with the beneficiary's needs as a whole person. *CMS is seeking feedback on how to establish minimum standards or federal "floors" for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or "floors" would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., byspecific state regions and rural versus urban), language needs, and cultural practices.*

1. What would be the most important areas to focus on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value- based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?

We join with our colleagues at the American Hospital Association and ask that CMS examine the following areas: Medicaid managed care; behavioral health; maternal, pediatric, and adolescent access; and long-term care and long-term services and supports (LTSS).

- Medicaid Managed Care: Medicaid beneficiaries enrolled in some form of Medicaid managed care account for nearly 70% of total Medicaid enrollment. 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. Commercially administered Medicaid managed care plans often create unnecessary barriers to care and increased administrative burden. They typically have 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. Denials aren't the only problem, of course; delays in authorizations or claims adjudication also create barriers. 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 judgment could not wait any longer to begin care before the prior authorization process was completed. According to an 2019 survey by the American Hospital Association, 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. Enrollees, who are eligible for services, are experiencing inappropriate denials that limit access to needed care. To curb these practices, we recommend 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.

- We also urge CMS to create 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. In addition, we urge CMS to establish additional policies and oversight requirements regarding Medicaid managed care networks, including the updating and managing of provider directories. Changes to managed care regulations replaced time and distance standards for meeting provider network adequacy requirements with state-established quantitative network adequacy standards. We recommend 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. CMS also should 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 medical health needs and behavioral health patients.
- 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, CHA recommends that CMS look at behavioral health access barriers for Medicaid beneficiaries in the context of the current Institutions for Mental Disease (IMD) exclusion. CHA 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. CHA encourages CMS to 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 limited or no access to obstetric specialists. 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.

- Long Term Care and Long-term services and supports (LTSS): Many of our members operate health care organizations that serve those needing long-term care, and also populations who are elderly and/or disabled. We recommend that CMS consider access to these services and programs and monitor how insufficient reimbursement that causes post-acute and long-term care providers to delay or even reject Medicaid patients. We also encourage CMS to work with states to broadly adopt successful programs that are currently a state option. For example, the Program for All Inclusive Care for the Elderly (PACE) is an optional program that states may choose to offer. We strongly encourage CMS to work with states to implement this program as it would increase access to needed care for vulnerable beneficiaries.

2. How could CMS monitor states' performance against those minimum standards? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?

CHA recommends that CMS require public reporting by Medicaid agencies and Medicaid managed care organizations on metrics that include:

- Time and distance to both primary care and specialist providers (including behavioral health providers)
- Treatment authorization wait times for services
- Provider appeals and grievances
- Hospital administrative days/delayed discharges due to lack of post-acute care beds
- Managed care authorizations for out-of-network providers as a measure of network adequacy

This type of transparency will enable Medicaid agencies to better understand where there are gaps in accessible services and provide an opportunity to improve access for all beneficiaries. Additionally, we urge CMS to establish national minimum standards for the Medicaid program in Medicaid managed care and in Fee for Service (FFS). We also strongly recommend CMS work to align and make consistent network adequacy and access standards across qualified health plans and Medicaid—to the extent feasible. Consistency across states and programs will support uniformity in access across beneficiaries and reduce CMS and other stakeholders' burden.

Additionally, we recommend that CMS establish a system for access complaints. CMS could consider establishing an administrative access complaint system that allows interested parties to submit evidence that a state or MCO is failing to meet its federal access obligations, separate from the grievances/appeals filed by individual patients concerning individual issues. Ever since Supreme Court's 2015 decision in Armstrong v. Exceptional Child Center closed off the private right of action for providers and beneficiaries to enforce federal access standards, Medicaid stakeholders have not had a clear path to raise their access concerns and receive a response. CMS should fill this gap by creating a new system that would allow providers, provider associations, patient advocacy organizations and others to make states and CMS aware of significant access issues.

3. How could CMS consider the concepts of whole person care or care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?

CHA applauds CMS raising the issue of whole person care and care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs. CHA and our members have championed this knowing that coordinating health care, support services, and social services lead to better outcomes for our patients. Specifically, we recommend that CMS take all available steps to require state agencies and Medicaid managed care organizations (MCOs) to fully commit to parity in access, payment, and treatment by:

- Mandating identical treatment authorizations processes for emergency psychiatric services as for other emergency services. Similarly, CMS should require Medicaid agencies and Medicaid MCOs to maintain identical payment processes for behavioral and mental health services as compared to physical health.
- Requiring reimbursement for medical transportation to be provided for non-hospital destinations to allow for diversion from emergency rooms.
- Expanding the guidance on the provision of" in-lieu-of-services" (ILOS). While not specific to behavioral health care, 33 states have reported to Kaiser Family Foundation that they use ILOS authority for adults receiving inpatient treatment in an institution for mental disease (IMD). However, the guidance from CMS and states is thin. One example raised by our members in California show that there are significant differences in the adoption of the ILOS benefit across each county. Medically tailored meals might be available for one health plan in a county, but not another. We strongly urge CMS to provide more guidance for ILOS with an eye toward equity and parity.

CHA has also long championed how the social determinants of health impact a patient. CMS has also begun to see this linkages and issued a roadmap last year to address this issue. CMS must work with states to support access to supportive services. Based on the experience of one of our largest members, Medicaid beneficiaries may be eligible for additional programs including SNAP or Temporary Assistance for Needy Families (TANF), however, they may face barriers to enrollment into these programs or services. To help address this barrier, we recommend that CMS encourage and support state efforts to develop common applications, streamlined eligibility systems, and educate and train navigators to ensure these tools are available to support access to additional services. One example is Indiana where they have implemented a common application that is used for assessing eligibility for and facilitating enrollment into Medicaid, SNAP, TANF and that also includes a screener for social determinant of health needs.

4. In addition to existing legal obligations, how should CMS address cultural competency and language preferences in establishing minimum access standards? What activities have states and other stakeholders found the most meaningful in identifying cultural and language gaps among providers that might impact access to care?

CMS should require, standardize, and streamline Race, Ethnicity and Language Data Collection. Collecting and monitoring data on disparities by race, ethnicity, and language is a necessary precondition to any effort to reduce health disparities and address health equity. All state Medicaid agencies collect self-reported data on race, ethnicity, and language (REL) from applicants during the eligibility and enrollment process. However, the type and granularity of information collected varies considerably, and many states continue to face longstanding and persistent challenges in collecting complete, accurate, and consistent data on REL. CMS should require standardized data collection and should also implement requirements to assure that such information is kept on files so that beneficiaries are not repeatedly asked for such information.

5. What are specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

CHA encourages CMS to pursue variety of strategies to increase access to care and diversify the pool of available providers. These strategies include:

- Provide more slots and increase funding for Graduate Medical Education programs to expand the number of providers trained at teaching hospitals. We also recommend additional or separate funds for historically underrepresented groups and cultural competency and anti-bias education.
- Make permanent the COVID-19 waivers that expanded the use of telehealth for both mental and physical health. Included in this is the waiver to allow new behavioral health patients to use telehealth exclusively and not require an in-person visit.
- Promote value-based reimbursement that includes sufficient payment that will allow providers to address social determinants of health that negatively impact patient outcomes. An example of this might include a per beneficiary per month payment that can be used to address issues like transportation, food insecurity, housing insecurity, or connect patients with supportive services like legal aid or employment counseling.
- Eliminate the Medicaid DSH reductions.

We also recommend that CMS and states ensure coverage includes reimbursements for services provided by community health workers, peer support specialists and other members of a patient's care team. While there are no national accrediting bodies for community health workers and peer support specialists, some states (e.g., ID, MI, OH, OR) have accrediting boards, which supports the ability of these providers to bill.

Our members also urge CMS and state partners to consider making permanent, or at least extending, flexibilities permitted during the PHE which relaxed state licensure requirements and permitted providers to deliver care across state lines. This would support states' abilities to address workforce challenges and support beneficiary access to key providers regardless of whether they are in the same state. Second, we recommend CMS and states consider policies to support access to and reimbursement of remote patient monitoring (RPM) and telehealth, including audio only visits, which are critical in low-income communities or communities with limited broadband access. We

also recommend CMS and states consider allowing reimbursement for certain text-based services, including a crisis text line. Extending temporary flexibilities or implementing permanent policies that remove certain state licensure requirements and expand reimbursement for telehealth and RPM can help meet patients where they are and help states address workforce issues.

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). *CMS is interested in feedback about what new data sources, existing datasources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.*

1. What should CMS consider when developing an access monitoring approach that is as similar as possible across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care programs) and programs (e.g., HCBS programs and dual eligibility in Medicaid and Medicare) and across services/benefits? Would including additional levels of data reporting and analyses (e.g., by delivery system or by managed care plan, etc.) make access monitoring more effective? What type of information from CMS would be useful in helping states identify and prioritize resources to address access issues for their beneficiaries? What are the most significant gaps where CMS can provide technical or other types of assistance to support states in standardized monitoring and reporting across delivery systems in areas related to access?

CHA encourages CMS to prioritize data the agency already has through T-MSIS or other sources such as current provider payment and Medicaid Disproportionate Share Hospital (DSH) and non-DSH supplemental payment reporting to be used more efficiently and reduce administrative burden. CMS should require both states and managed care organizations to gather more data and set out standardized data requirements, which would then enable CMS to compile, compare, and analyze the data. CMS could then take action to ensure that enrollees nationwide are able to receive the services to which they are legally entitled. As appropriate, CMS should publish aggregated data to improve transparency and support public engagement and advocacy on access issues. CMS could consider a tiered system of access oversight, focusing heightened scrutiny on lower Medicaid reimbursement rates and as needed, work with states to implement corrective action plans.

Additionally, CHA and many of our large healthcare systems strongly support including additional levels of data reporting and analyses by delivery system, with a special focus on managed care plan performance. Of the 41 states that use Medicaid managed care organizations to provide care, 38 have enrolled more than 50% of their beneficiaries in MCOs and 15 have 90% or more MCO enrollment (according to Kaiser Family Foundation). Due to this overwhelming use of managed care programs, CMS must focus on the role MCOs play in access, enrollment, and equity. For example, CMS should replace the requirement for a Medicaid fee-for-service (FFS) access study with a comprehensive, MCO-inclusive access study. We believe the requirement for an FFS Access Study in states with very high managed care utilization is largely irrelevant and does not provide the agency with the information it needs to support the programs. We recommend that CMS monitor the number of hospital administrative days created for Medicaid and Medicaid managed care patients due to lack of safe place to discharge. As stated in response to prior questions, we believe that requiring managed care plans to reimburse hospitals for the costs associated with these days would reduce administrative days, increase access to care for Medicaid beneficiaries, and improve patient outcomes.

Lastly, CMS should standardize denial and termination Reason Codes for state monitoring and comparison nationwide. Public reporting of denial disenrollment reason codes could be used to identify

issues, monitor trends and pinpoint ways to improve coverage rates among eligible individuals. Currently, however, denial cods have become virtually useless for tracking why people are denied or terminated from Medicaid/CHIP in part because neither the federal government nor states use this data for any purpose. To make such reporting maximally efficient, CMS should work with states to standardize reason codes for denials and terminations to improve the quality of the data for in-state and cross state analyses.

2. In what ways can CMS promote a more standardized effort to monitor access in long-term services and supports (LTSS), including HCBS, programs? For example, how could CMS leverage the draft HCBS measure set, grievances and appeals, or states' comparisons of approved Person-Centered Service Plans to encounter or billing data in managed care or fee-for-service to ensure appropriate services are being received? Which activities would you prioritize first?

As we stated earlier, access to LTSS, including HCBS and other programs, such as PACE is critical for Medicaid beneficiaries. As such, CHA urges CMS to consider supporting expanded access to services and programs that are currently a state option. For example, PACE is an optional program states can choose to offer. We strongly encourage CMS to work with states to implement this program as it would increase access to needed care for vulnerable beneficiaries.

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible. *Section 1902(a)(30)(A) of the Social Security Act (the "Act") requires that Medicaid state plans "assure that payments are consistent with efficiency, economy, and quality of care and 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." Section 1932 of the Act includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States "in an effective and efficient manner…." CMS is interested in leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.*

1. What are the opportunities for CMS to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?

CHA has long advocated for increasing the Medicaid payments for our providers, many of whom service large numbers of Medicaid beneficiaries. The pandemic has exposed the rising costs of providing care because of workforce shortages, increased costs of supplies and other issues tied to inflation. 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. Overall, 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. 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. Added to this is the fact that 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.

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. 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.

More importantly, CMS must ensure sustainable financing for nursing home and other long-term care institutions which have been underfunded by Medicaid for many years. CMS must work with states to increase the current reimbursement rates to nursing home providers especially as Medicaid continues to be the largest payer of long-term care services. As CMS considers policies to implement proposals on nursing home safety, it is imperative that CMS also explore how low reimbursement rates affect workforce shortages and concerns, directly impacting patient safety, which the nationally renowned and independent nonprofit ECRI listed as their number one concern that healthcare leaders must address in 2022. Additionally, the Medicaid and CHIP Payment Advisory Commission (MACPAC) found that "low Medicaid payment rates may affect a facility's ability to pay for needed staff and may affect their willingness to accept new Medicaid patients." We ask that CMS prioritize this issue and work with states about their responsibilities to provide full reimbursement for the cost of care.

Medicaid beneficiaries look to hospitals, long-term care institutions 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.

We ask that CMS should pursue the following opportunities to ensure beneficiaries have access to services:

- Consider the implication of low payment rates on hospitals and long-term care institutions' ability to provide a broad variety of care, including access to specialists.
- 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
- Require health plans to pay for administrative hospital days as a result of a health plan's lack of engagement in discharge planning and/or inability to secure an appropriate setting of care for the patient to be discharged to after acute care.
- Allow for directed payments to be paid for utilization of out-of-network providers.
- Allow for greater flexibility in determining actuarial soundness and benchmarking to commercial rates.
- Establish reasonable rate floors for Medicaid reimbursement levels to ensure reimbursement levels allow for access on par with the general public as required by the Social Security Act. Unsustainably low rates of Medicaid payment limit access to services for Medicaid beneficiary services. This is particularly true for certain specialist services and mental health services.
- Continue to work with states to implement value-based purchasing (VBP) models and

arrangements that support population health and accountability for care. To this end, we urge CMS to continue to approve Section 1115 waivers or work with the Center for Medicare and Medicaid Innovation (CMMI) to test models that aim to improve outcomes, quality, and control costs.

- Work to incentivize Medicaid MCOs to implement models that allow providers to share in risk. Similarly, we recommend CMS to consider ways to clarify best practices or promising approaches for how MCOs and providers share risk for managing total cost of care (TCOC). We also recommend that CMS establish minimum MLR requirements for managed care plans across all states and urge states with MLR requirements to enforce them.