Children's Hospital Association Responses to CMS RFI
April 18, 2022

Objective 1. Enrollment

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 eligibilitydeterminations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan, when applicable.

BACKGROUND ON CHA AND CHILDREN'S HOSPITALS

On behalf of over 220 children's hospitals across the country, CHA appreciates the opportunity to provide comments on the CMS' Request for Information (RFI) on Access to Coverage and Care in Medicaid & CHIP.

Medicaid is the single largest health insurer for children in the United States and serves as the backbone of children's health care. Children are about half of all Medicaid beneficiaries, but they account for less than 20 percent of program spending. The program provides affordable coverage with pediatric appropriate benefits for children in low-income families and children with special health care needs and chronic or complex conditions.

Children's hospitals are a vital safety net for all children, treating children across the country who are uninsured, underinsured, and enrolled in Medicaid. Though children's hospitals account for only 5 percent of hospitals in the United States, they provide 47 percent of the inpatient hospital care required by children covered by Medicaid. Children's hospitals are regional centers for children's health, providing care across large geographic areas and serving Medicaid children across state lines. Children's hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services. In addition, children's hospitals are engaged in efforts to promote delivery system changes, efficiency and cost savings in Medicaid.

We appreciate CMS's focus on identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. We agree with CMS' perspective that eligible individuals should be able to apply, enroll in and receive benefits in a timely and streamlined manner that promotes equitable coverage. We applaud your efforts to consider ways to improve the Medicaid and CHIP eligibility determination processes to ensure that eligible individuals are able to enroll in and access coverage.

STREAMLINED ELIGIBILITY PROCESSES ARE A CRITICAL FIRST STEP TO ASSURING ACCESS TO CARE

We believe that ensuring access to care is critical for children, especially for children with special health care needs or serious, chronic or complex medical conditions. Children’s need for timely access to pediatric primary, specialty and subspeciality providers is particularly acute given their continuous growth and development. It is imperative children receive timely preventive care, well-child visits and developmentally appropriate screenings to identify challenges early and that they continue to access needed treatment services to achieve and maintain their highest level of functioning. Longer lag times between symptoms onset and treatment due to challenges enrolling in Medicaid or CHIP and accessing needed services may not only result in poorer outcomes, but also in greater costs to families and the health care system.

Multiple solutions are necessary to ensure that children have access to the care they need; in this section of our RFI response, we share suggestions about steps CMS can take to streamline eligibility determination processes, a critical first step in assuring access.

REDEFINE AND REQUIRE TIMELY DETERMINATIONS OF ELIGIBILITY

In addition to continuing its work with states to streamline eligibility paperwork and, wherever possible, encourage states to apply presumptive eligibility to children, CMS should issue new regulations setting forth clear expectations for timely processing.

Current regulations at 42 C.F.R. 435.912 require states to process applications “promptly and without undue delay.” Despite the time-intensive and financial investments that states have made in upgrading eligibility and enrollment IT systems, based on the most recently released Medicaid Modified Adjusted Gross Income (MAGI) processing timeframes, many states are still not able to determine eligibility in real or near to real time (e.g., in under 24 hours).[1]

Children’s hospitals report various challenges in their own states that impede efficient application processing and enrollment. For example, in Ohio, the county can't see the signature page on the application and applicants need to send additional documentation to prove they signed the application, limiting the ability of the state to process applications in a timely manner. Robust federal standards and monitoring could help identify and address these issues.

While CMS has defined 45 days for MAGI applications and 90 days for non-MAGI as maximum timelines for processing applications, the norm should be much less to ensure access and continuity of coverage. Therefore, CMS should issue new regulations to set out timeliness and performance standards for processing Medicaid MAGI and non-MAGI applications and pursue corrective action plans for states that do not meet those standards. For example, CMS could establish a range for processing times, e.g., that a certain percentage of applications be processed in 24 hours, under 7 days, etc.

Because many processing delays are likely due to health information technology and policy issues that require a human touch to complete a determination, CMS also could issue new rules to specify that the enhanced Medicaid matching rates for IT systems are conditioned on being able to conduct automated real or near to real time eligibility determinations without eligibility worker intervention. Such an expectation would complement, not replace, stronger processing timeline standards.

STREAMLINE NON-MAGI ELIGIBILITY RULES

Children with disabilities may have their income determined using non-MAGI eligibility rules. While many of the regulatory changes implemented because of the Affordable Care Act apply to both MAGI and non-MAGI populations, states have varied practices in implementing and operationalizing these enrollment and verification processes for non-MAGI populations. With federal funding available to support states in modernizing their eligibility systems, CMS should conduct the following to enable alignment across MAGI and non-MAGI populations:

Release guidance on expectations that states should be implementing required enrollment and verification processes for its non-MAGI populations. These regulatory requirements include, but are not limited to, the following: ensure application submission across all modalities including telephone, online and in-person; use of electronic data sources if available and request documentation only if electronic data is not available; apply reasonable compatibility principles; and utilize ex-parte renewals processes.

Update regulations to require states to apply current optional eligibility and enrollment simplifications for its non-MAGI populations. These include but are not limited to: allowing for self-attestation of all non-financial eligibility criteria except for citizenship and immigration status; accepting self-attestation with post-eligibility verification; accepting reasonable explanations of discrepancies between attested information and electronic data; removing in-person interviews; pre-populating the renewal form; treat age, blindness and disability as a continuing eligibility factor without requiring re-verification at renewal.

STREAMLINE ENROLLMENT AND CARE TRANSITIONS FOR NEWBORNS

Children’s hospitals see various challenges with assuring that newborns receive care and providers are reimbursed for such care in a timely manner. For example, while some states rely on Medicaid managed care plans to report births and automatically enroll a child into the mother’s managed care plan (with voluntary changes possible), this practice varies across states and in some states individuals need to take action, including choosing a plan. CMS should develop best practices for, and monitor states with respect to, connecting newborns to coverage and care. These processes should be seamless, given the importance of this time period for well-being checks, vaccinations and care.

The Deemed Newborns eligibility group under 42 C.F.R. §435.117 consolidates the statutory requirements described in sections 1902(e)(4) and 2112(e) of the Social Security Act (the Act) to assure that children born to women covered by Medicaid or CHIP (as targeted low-income pregnant women) are automatically enrolled in Medicaid or CHIP for their first year of life. A child is now eligible based on the birth mother’s coverage for the date of birth, even if the child does not return home with her (e.g., because the child is adopted), does not remain in her household the whole year (e.g., because the child lives with someone else), or the birth mother does not remain Medicaid eligible. Families cannot be required to complete an application for Medicaid deemed newborn coverage, including if the birth mother was covered under CHIP. While deemed newborn coverage is mandatory for some newborns, CMS should encourage states to adopt optional deemed newborn coverage as well.

Given the longstanding challenges in this area, we recommend that CMS identify newborn eligibility issues as a key area for state improvement, conduct data analysis to better understand gaps in coverage and establish an improvement group of states at the bottom of the list with an expectation that they shall improve and if not pursue corrective action. The learning from these efforts could inform widespread guidance, which CMS could couple with its managed care contract oversight authority to help assure that newborns are enrolled in managed care seamlessly.

CMS should issue guidance with best practices regarding auto enrollment and billing and then use its contract oversight authority to ensure that automatic assignment rules are in effect so that newborns are automatically assigned to the same plan as the mother or siblings to assure continuity of care. Standardizing state practices will have the added benefit of helping to assure that T-MSIS data about births and newborn care is as consistent as possible across states; T-MSIS FAQs urge caution in comparing some data related to maternal delivery and newborn care given the many ways that states permit hospitals and other providers to bill for care.

Finally, states/MCOs should ensure that parents of newborns are connected with a pediatrician or a pediatric medical home. CMS currently measures well-child visits within the first 15 months of life,[2] and results show a great deal of variation across states, some of which is likely attributable to newborns and infants not having a regular primary care physician or source of care. To help move the needle, CMS could develop metrics to measure the extent to which Medicaid works to connect Medicaid-eligible families with a primary care physician and/or to ensure that managed care plans monitor well-baby visits and other essential services to assure that care is delivered as recommended. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey currently asks questions about whether children have a regular source of care, but CMS could encourage the Agency for Health Care Research and Quality to develop additional questions related to maternal and infant care to help identify gaps.

ENFORCE TIMELY ENROLLMENT INTO MANAGED CARE PLANS

To avoid gaps in coverage after eligibility is determined, CMS should require that managed care enrollment be effectuated no longer than 30 days after active coverage is set up, with an option to opt out and change plans.

SUPPORT LEGISLATIVE CHANGES TO STREAMLINE ELIGIBILITY & ACCESS

In addition to developing regulations and guidance consistent with the recommendations above, we urge CMS and HHS leadership to support legislative changes that could help streamline eligibility and enrollment activities, as well as access to services. For example, legislative changes to require at least 12-month continuous coverage for children, permit 24-month continuous eligibility for children or adults, extend presumptive eligibility and to permit auto-enrollment in Medicaid based on tax filing information could all help assure that individuals who are eligible are seamlessly enrolled in coverage. To take another example, Emergency Medicaid could be expanded to cover mild to moderate behavioral health issues for children not otherwise eligible for Medicaid.

NOTES

[1] CMS, Medicaid MAGI and CHIP Application Processing Times, https://www.medicaid.gov/state-overviews/scorecard/medicaid-magi-and-chip-application-processing-times/index.html.
[2] CMS, Well-Child Visits in the First 15 Months of Life, https://www.medicaid.gov/state-overviews/scorecard/well-child-visits-first-15-months-of-life/index.html.

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 formonitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?

We support efforts to provide states the tools they need to support improvements in timeliness for determinations and enrollment or eligibility processes. CMS should do all it can to support these efforts in states. We recommend a focus on the following policies that could help streamline and reduce the burden on states.

ALIGN PUBLIC ASSISTANCE DATA SYSTEMS

State agencies too often do not communicate with each other, meaning that the Medicaid agency may not have access to relevant income or address information that other state agencies have.

CMS should continue to encourage collaboration among state agencies. Aligning public assistance data systems would reduce administrative burden to Medicaid members and providers by aligning public assistance data systems and potentially reduce state staff time.

Similarly, CMS could provide tools and guidance to help states implement additional opportunities for enrollment in all services (Medicaid, CHIP, SNAP) through community-based services, i.e., DMV, school registration, libraries, community centers, federal and state tax filing. For example, CMS could clarify in guidance that helping people enroll in SNAP is a Medicaid objective to enable data sharing between state Medicaid and SNAP agencies.

IMPROVE ONLINE APPLICATIONS AND CONTINUED INVESTMENTS IN ENHANCED SYSTEM CAPACITIES

Federal regulations at 42 C.F.R. 435.907 require states to establish processes that enable individuals to submit applications by telephone, by mail or in-person. Despite federal and state investments in establishing online application pathways, as of 2018 an estimated 34 states had functionality to allow individuals to scan and upload documents which impedes application processing timeframes and 32 states had functionality that enables individuals to complete and submit an application using a mobile device.[1] Given the advances in technology since CMS last updated its Medicaid eligibility, as well as the proliferation in use of mobile devices, CMS should update its regulations to facilitate access, automating enrollment via website or mobile apps (with a backup manual system for those without access to technology).

CMS should issue regulations establishing that to meet the online application submission requirement, states must have functionality for individuals to upload and submit documents and to submit applications using a mobile device.

Relatedly, CMS should work with states to ensure ongoing updates are made to state eligibility systems to assure that they are user-friendly and dependable. Children’s hospitals report experiences with families submitting necessary paperwork through the electronic platform only to be later told that the paperwork has not been received.

CLARIFY ONGOING RETURNED MAIL STANDARDS

As part of its recent PHE "unwinding" guidance, CMS recently provided guidance to states about strategies they can use to verify addresses, including in the case of returned mail. During the unwinding period and beyond, states should be required to take steps to keep mailing addresses up-to-date and to locate individuals through other means (e.g., electronic communications or phone call) when mail is returned.

CMS should also clarify that states should provide enrollees 30 days to verify their new address, provide online forms or interactive voice response systems to simplify reporting of address changes, engage MCOs in keeping addresses current and identify changes through the U.S. Postal Service Change of Address Database (USPS NCOA).

ENHANCE SUPPORT FOR MEDICAID APPLICATION ASSISTERS

We recommend support for more staffing to answer questions and guide families through the application as well as modified staffing arrangements, including extended hours, to help assure access. States also need more resources to hire navigators, with skills in different languages, to help with enrollment, plan selection and even selection of providers. In addition to providing additional funding for such assistance, CMS could set standards for Medicaid agency staffing and/or devote resources to outreach and enrollment efforts, building on the successes of Marketplace Navigator funding, for example.

NOTES

[1] Tricia Brooks et al., Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey, KFF (March 2018), https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-Enrollment-Renewal-and-Cost-Sharing-Policies-as-of-January-2018; Tricia Brooks et al., Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey, KFF (March 2022), https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/.

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+); peoplewith disabilities; and people with mental health or substance use disorders? Which activities would youprioritize first?

ENHANCE CONTINUOUS ENROLLMENT POLICIES

Building on the benefits of the federal public health emergency continuous coverage requirements in ensuring continuity of coverage and care, as well as the state plan authority for 12-months continuous coverage for children, CMS should continue to advance continuous enrollment policies in a number of ways.

CMS should continue its efforts to encourage states to take up the option for children if they have not yet done so. Extending eligibility timelines is a proven strategy to maintain coverage and should be encouraged.

Particularly at a moment when individuals are at risk of losing coverage due to the end of the public health emergency, CMS should move quickly to approve pending continuous enrollment requests, including waiver requests to facilitate continuous coverage for adults, and work to streamline consideration of new requests. Aligning enrollment policies between children and parents is important to help families obtain the full benefit of ongoing and coordinated access to health care.

As part of its data-driven focus, CMS also could require states to track administrative denials to identify the frequency of individuals losing coverage even if they remain eligible and use that information to work with states to implement 12-month continuous eligibility as a remediation approach.

ELIMINATE OR DISALLOW PERIODIC DATA CHECKS

States use routine data checks that seek to identify changes or discrepancies in eligibility data between regularly scheduled renewals. These checks often uncover data discrepancies that inevitably increase administrative costs and escalate churn (i.e., members falling on and off Medicaid due to missed paperwork deadlines and not because they aren’t eligible).

Particularly because states often require a 10-day response time to correct data, routine data checks can make it difficult for low-income families to maintain continuity of coverage and access to health care. At a minimum, CMS should encourage states to run data checks every quarter or twice annually, instead of monthly.

EXPAND THE USE OF ROLLING DETERMINATIONS

Rolling redeterminations would allow for providers to assist health plans in getting patients’ redetermination information ready leading up to the patient being disenrolled. Such interventions could help avoid lapses in coverage.

SUPPORT AND FUND ENHANCED OUTREACH

CMS—and states—should support more outreach via Community Health Workers, social workers and certified application counselors to help connect people to coverage. For example, CMS should encourage states to leverage community non-profits that are already engaging with the potentially eligible population (food pantries, housing assistance) to support enrollment efforts.

Outreach strategies are particularly necessary for people with disabilities, non-English speakers and patients with mental health needs. Members of these groups may not be aware of the support available. CMS could encourage states to more actively collaborate with community-based organizations to ensure that targeted messages reach key populations.

This support could take the form of additional navigator funding and/or off-the-shelf communication templates that CMS could issue and states could adapt and publish, meeting their unique needs.

UPDATE POLICIES ON CHIP PREMIUMS

CMS should issue regulations permitting/requiring a premium grace period for individuals newly enrolled in CHIP. For many individuals who transition to CHIP from Medicaid, payment of premiums is new and unexpected. To mitigate coverage losses during these transition periods, CMS should require states to provide a premium grace period to help ensure that enrollees are not cut off of coverage for non-payment; a premium grace period will enable enrollees to receive multiple notices prior to termination and creates opportunity for enrollees to begin paying.

4. What **key indicators of enrollment in coverage** should CMS consider monitoring? For example, howcan 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?

STANDARDIZE DENIAL REASON CODES AND MONITOR RESULTS

Public reporting of disenrollment reason codes could be used to monitor trends and pinpoint ways to improve retention. To make such reporting maximally efficient, CMS should standardize reason codes for denials to facilitate comparison across states.

Public reporting of standardized codes for denials will enable CMS and states to identify if states are, for example, outliers on procedural denials (i.e., failure to return paperwork, returned mail). Meaningful reporting of the reasons that applications are denied will enable states to take corrective actions (either voluntarily or as required by CMS) if trends are identified that suggest procedural or other administrative barriers to enrollment.

Standardized measures also are needed to assess the extent to which churn drives up administrative costs and undermines access to timely and appropriate health care for eligible beneficiaries. Data also should be stratified by race/ethnicity to assess equity implications and be reported by age.

Finally, disenrollment rate data should be used to develop corrective action plans as needed. For example, if disenrollment rates differ across different racial, ethnic or linguistic or age groups, community groups that specialize in working with those groups should be empowered to facilitate enrollment.

ELIGIBILITY ERROR REPORTING

CMS should monitor disenrollment and denial rates to assure that individuals are not erroneously being denied coverage.

CMS has authority (under 42 C.F.R. 431.15) to ensure that states provide for methods of administration that are necessary for the proper and efficient operation of the state Medicaid plan. Properly enrolling eligible individuals is a core function of state Medicaid programs and CMS should regularly audit eligibility terminations to determine accuracy. Disenrolling an eligible individual as well as denying new applicants erroneously should be monitored and reported so that corrective action plans can be pursued where issues are identified.

Today, CMS payment error rate measurement (PERM) reviews focus on improper payments, such as payments for individuals erroneously determined to be eligible for Medicaid. To encourage states to take care to avoid erroneous denials of eligibility, CMS could expand the definition of an eligibility error to include state disenrollment of eligible individuals. Disenrolling an eligible individual as well as denying new applicants erroneously should be monitored and reported so that corrective action plans can be pursued where issues are identified.

ADDITIONAL DATA MONITORING SUGGESTIONS

CMS should utilize data to see if eligible individuals in different groups enroll in Medicaid and CHIP at the same levels as the general population.

CMS should utilize tax filing data to correlate income trends with insurance coverage data and use such data that services are available in proximity to those with greatest need.

Objective 2. Redeterminations

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 afterthe 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 (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income (SSI)/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).*

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? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?

Given the importance of continuity of care for all beneficiaries—and most especially for children—we appreciate CMS’ request for input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. We agree with CMS that these strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE). We offer the following recommendations to help advance these goals.

ESTABLISH RENEWAL PERFORMANCE STANDARDS

Federal regulations at 42 C.F.R. 435.916 require states to first conduct ex parte renewals using available data sources prior to requesting additional information or documentation. However, most states are not able to process a large portion of their redetermination using ex parte processes. To improve ex-parte rates and consistent with Social Security Act 1902(a)(19) requirements that states must “provide such safeguards as may be necessary to assure that eligibility” will be determined “in a manner that is consistent with the simplicity of administration and the best interests of recipients.”

According to the Kaiser Family Foundation, of the 42 states processing ex parte renewals, only 11 states report completing 50% or more of renewals using ex parte processes. Twenty-two states complete less than 50% of renewals on an ex parte basis, including 11 states where less than 25% of renewals are completed using ex parte processes.[1]

CMS should issue ex parte processing standards (e.g., at a minimum, 60% of all redeterminations should be processed ex parte) and pursue corrective action plans for states that do not meet the standard. CMS should require states to routinely test their systems to assure ex parte processing is possible and could incentivize states to achieve specific performance standards on renewal related data, such as a specified threshold of ex parte and data-driven renewals.

CMS should also continue to work with states to encourage and facilitate ex-parte processing for non-MAGI populations.

ENCOURAGE STATES TO EXPAND STAFFING TO ASSIST WITH REDETERMINATIONS

At all or most disproportionate share hospitals and FQHCs, states are required to post eligibility workers to assist with applications. No such requirement applies to renewals, but Medicaid beneficiaries often need assistance complete renewals as well. CMS should encourage states to expand staffing to include assistance with renewals. CMS could also encourage states to create a redetermination Hot Line that only deals with redeterminations.

NOTES

[1] Tricia Brooks et al., Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey, KFF (March 2022), https://files.kff.org/attachment/REPORT-Medicaid-and-CHIP-Eligibility-and-Enrollment-Policies-as-of-January-2022.pdf.

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?

ENHANCE NOTICE REQUIREMENTS, INCLUDING MULTIPLE COMMUNICATION MODALITIES

To improve the redetermination process, CMS could update regulations to increase the notification time frame and require states to send more than one notification in the mail. CMS also should encourage/require states to move towards text, call and online notification options in addition to relying on mail.

Most states do not have a formal outreach process via telephone, email or online account when it receives returned mail from a current enrollee or when an individual does not respond to a request for information. Rather, states usually send a follow-up paper notice that oftentimes goes unanswered.

To ensure states are taking meaningful steps to conduct outreach when paper processes are not effective, CMS should clarify in its regulations that states are required to make at least two outreach attempts in a modality that is not paper when the state receives returned mail or does not get a response to a request for information. Providing multiple notices in the form of text, calls and online communications would also give members time to seek guidance from a trusted third party, like children's hospitals, with any questions they might have about the renewal process.

CMS also should encourage states to build capacity into their eligibility and enrollment websites and mobile apps to send automatic notifications about deadlines.

EASE THE TRANSITION FROM MEDICAID TO MARKETPLACE PLANS

The ACA requires a single streamlined application across Medicaid, CHIP and the Marketplace such that people may apply for enrollment in, receive a determination of eligibility for participation in and continue participation in, applicable state health subsidy programs. The ACA also requires that if an individual applying through the Marketplace is found through screening to be eligible for Medicaid or CHIP, the individual must be enrolled using secure data interfaces (Affordable Care Act, Section 1413(a) and (c)(1)). However, eight State Based Marketplace (SBM) states have not integrated their Medicaid and CHIP into their Marketplace eligibility system, which creates barriers with facilitating transitions of coverage across Insurance Affordability Programs.

CMS should continue its efforts to help ease the transition from Medicaid to Marketplace plans by reviewing account transfer requirements and operations and providing guidance—if not performance standards—to assure that moving from Medicaid to Marketplace coverage does not lead to gaps in coverage.

CMS guidance for SBMs should reinforce expectations for ensuring smooth transfers across Medicaid and Marketplace, including but not limited to, requirements that:

– Individuals may not be required to provide additional information/take additional steps for their eligibility determination; ensure visibility into the reason for the eligibility determination (e.g., whether an individual was procedurally denied for Medicaid);
– Account Transfer information shall include all available contact information; and
– SBMs pre-populate Advance Premium Tax Credit applications based on available information.

ENCOURAGE INCREASED COORDINATION ACROSS STATE AGENCIES

CMS should encourage increased coordination across state agencies to proactively work with members at risk of disenrollment. For example, the state Medicaid agency should collaborate with Title V Maternal and Child Health (MCH) agencies who are more likely to have up-to-date contact information with Medicaid enrollees and/or may be in more frequent communication with these members. Leveraging existing connections at the local level (via MCH or other entities) could increase the rate of successful communication with Medicaid members.

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? For example, how can CMS promote coverage continuity for beneficiaries moving between eligibility groups (e.g., a child receiving Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualifiedsupports who transitions to other Medicaid services such as home and community based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the Marketplace); or across state boundaries? Which of these actions would you prioritize first?

STREAMLINE ENROLLMENT AND CARE TRANSITIONS FOR NEWBORNS, as described in response to Objective 1, Question 1.

DEVELOP EDUCATIONAL MATERIALS RELATED TO AGE-BASED TRANSITIONS

Parents and caregivers have many questions about guardianship or conservatorship options as their children near transition age. CMS could provide or direct states to provide more comprehensive educational tools summarizing options for caregivers and young adults to navigate the decision.

TRACK DISENROLLMENT DATA

As noted above under Q.1.4, states should be required to adopt standardized reason codes to identify when and why people are losing benefits, especially if they are still eligible or eligible to transition to CHIP or the Marketplace.

ENHANCE TRANSITION OF CARE POLICIES

CMS Medicaid regulations at 42 C.F.R. § 438.62 establish protections for people when delivery system changes occur during a course of treatment. We encourage CMS to continue refining these regulations to better meet the needs of children by requiring transition of care policies for enrollees when a disruption of services will impact the enrollee's health and well-being, development, ability to maintain their level of functioning or otherwise impact anticipated health outcomes. Special attention to children in foster care, juvenile justice system and those with special health care needs is warranted; CMS should also enhance protections for children transitioning from FFS to managed care and vice-versa, as for children aging out of coverage and into eligibility groups with different benefits.[1] Timely approval of continuity of care plans is essential and states should be required to streamline their approaches to approving continuity of care services.

NOTES

[1] From 2015 CHA comment letter on managed care proposed rule: We also recommend §438.62(b) be modified to better meet the needs of children by requiring transition of care policies for enrollees when a disruption of services will impact the enrollee's health and well-being, development, ability to maintain their level of functioning or otherwise impact anticipated health outcomes. We are particularly concerned the proposed §438.62(b) to require transition of care policies for circumstances when "in the absence of continued services, [the enrollee] would suffer serious detriment to their health or be at risk of hospitalization or institutionalization" is too limiting

and may not appropriately protect children who may transition between providers, managed care plans or delivery systems. This language does not account for children who are in a course of treatment during the transition where disruption could impact or delay the expected outcome or those at risk of prolonged hospitalization and institutionalization. In addition, children with chronic conditions often have long-term relationships with their provider and could physically and mentally benefit from a transition of care policy even though they are not at risk of suffering a “serious detriment to their health.”

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 systemand eligibility worker levels? How can CMS support states in tracking denial reasons or codes for different eligibility groups?

Align Public Assistance Data Systems, as described above under Objective 1, Question 2.

Support and Fund Enhanced Outreach, as described above under Objective 1, Question 3.

Standardize denial reason codes and monitor results, as described above under Objective 1, Question 4.

Objective 3. Access—Federal Standards

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. *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., by specific 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?

For millions of children, Medicaid and CHIP play a vital role in supporting healthy development. Unfortunately, too many of those children face barriers that prevent them from accessing the right care in the right setting at the right time. These barriers are particularly acute for children and youth with serious or complex medical needs, including systemic issues regarding access to pediatric specialty services and behavioral health care.

We urge CMS to strengthen and align the access standards for pediatric care across programs and delivery systems to ensure that all covered children can access the services they need to thrive. As described in our response to this and other RFI questions in Objectives 3 through 5, we request that CMS:

– Require managed care organizations (MCOs) to contract with one or more children's hospitals in each geographic service area and maintain comprehensive pediatric specialty services, as described below. (A qualifying children's hospital may be a standalone entity or may be part of a larger health system.)

– Move toward more data-driven oversight of enrollee access at both the state and federal level, as described in responses to Objective 4.

– Ensure that states and MCOs are adequately reimbursing providers for services furnished to Medicaid and CHIP beneficiaries, including with respect to the high-cost drugs and therapies used in many types of specialty care.

– Take action to reduce the unnecessary administrative burdens associated with prior authorizations, as well as the processes through which patients request and receive services from providers who are outside of an MCO’s network and/or located outside the patient’s home state, which impede patient access to timely care and increase provider costs. These concerns, and proposed solutions, are discussed in response to Objective 5, Question 4.

In addition, we urge CMS to proceed with implementation of the Advancing Care for Exceptional (ACE) Kids Act, including by establishing a national definition for eligible children as described in prior Children’s Hospital Association communications. A standardized federal approach will help to assess access for this population of high-needs children, identify any gaps in care, and inform the design of payment models to support the highest quality of care for children with multiple complex needs.

FEDERAL ACTION IS NEEDED TO ENSURE THAT CHILDREN HAVE TIMELY ACCESS TO APPROPRIATE HEALTHCARE SERVICES

We see significant access barriers for children enrolled in Medicaid and CHIP, especially children who have serious or complex conditions. These barriers are briefly listed below. We outline proposed policy solutions to address these barriers.

BARRIERS THAT PREVENT MANAGED CARE ENROLLEES FROM ACCESSING THE RIGHT PROVIDER
– Narrow MCO networks that do not include adequate pediatric capacity, particularly specialty care (which is often hospital-based) and outpatient behavioral health services.
– MCO gatekeeping and utilization management practices that steer patients away from specialized children’s hospitals, even when they are in-network.

BURDENSOME ADMINISTRATIVE PROCEDURES that can result in delayed or denied care for children, in addition to needlessly increasing costs for providers. These access-threatening administrative burdens include:
– Excessive and burdensome prior authorization procedures.
– Frequent service denials that are overturned on appeal, including issues related to medically necessary EPSDT coverage, as well as denied access to out-of-network or out-of-state providers.
– The over-use of single case agreements in place of an adequate network and the process for negotiating MCO single case agreements for out-of-network care when needed.
– Ensuring in-network coverage for out-of-state care.

INADEQUATE PAYMENT RATES. Medicaid rates are known to be lower than other payers’, and this issue is particularly acute for certain classes of pediatric services, such as behavioral health (as discussed below), and outpatient pediatric services. With respect to outpatient services:
– Aside from FQHCs, which receive a form of cost-based reimbursement, reimbursement rates for outpatient primary care are frequently too low to attract providers. As a result, we increasingly see a two-track system, in which commercially insured children and Medicaid children are seeing two different sets of outpatient providers.
– Outpatient reimbursement for pediatric specialty care (e.g., endocrine services for diabetic children) is so low that providers must ration visits, leading to long wait times for outpatient care that FQHCs are unable to provide.

NATIONAL EMERGENCY FOR CHILDREN’S MENTAL HEALTH. CHA, together with the American Academy of Pediatrics (AAP) and the American Academy of Child and Adolescent Psychiatry (AACAP), declared a national emergency in October 2021 in light of rapidly rising rates of suicide attempts and other behavioral health ED visits among America’s children.[1] More support is needed for behavioral health (BH) services all along the continuum of care, from more support in pediatricians’ offices through more intensive treatments for children with more severe needs. Low payments under Medicaid for these services is directly impacting access for kids.

– The Senate Finance Committee’s March 2022 report on mental health concludes that “accessing outpatient psychiatric appointments has presented longstanding challenges, as many children wait an average of one month before being seen by a psychiatrist, in part due to low participation rates by these providers in Medicaid.”[2]

– In EDs and inpatient units, BH services often demand additional staff, such as “sitters,” to prevent self-harm or security and clinical staff trained to mitigate violent behavior.

– The lack of intermediate level of care between the physician office and the hospital is a huge issue for children who need intensive outpatient behavioral health services, partial hospitalization and other step-down services. High-acuity BH patients may end up stuck in the hospital setting because, for a Medicaid patient with significant BH needs, there is no available option for step-down programs. Intensive outpatient programs can help prevent hospitalizations, but also help the child transition back to home. Some of these programs currently do not take Medicaid at all or limit the placements for children covered by Medicaid.

INCONSISTENT IMPLEMENTATION OF EPSDT: Children’s hospitals and other pediatric providers report inconsistent implementation of this critical benefit for children. Gaps in access to services are particularly acute when looking at mental health services and ensuring early identification and prevention all the way through treatment. Children’s hospitals report lack of access to the intermediate level of care, such as intensive outpatient, day programs and partial hospitalization, that can prevent hospitalizations and help children transition back home after more intensive treatment.

ACCESS STANDARDS MUST RECOGNIZE CRUCIAL DIFFERENCES BETWEEN CHILDREN AND ADULTS

THE OUTSIZE IMPORTANCE OF MEDICAID AND CHIP FOR CHILDREN. These programs cover nearly 40% of children/youth age 18 and under, as compared to less than 15% for non-elderly adults.[3] Medicaid rates and administrative processes thus have an outsize impact in the pediatric space, both in terms of ensuring timely access to high-quality services for children, and in terms of ensuring the sustainability of pediatric providers.

THE NATURE OF CHILDREN’S HEALTH CARE NEEDS. For children, a lack of timely and adequate access can impede healthy development, with lifelong consequences. It is imperative that children receive timely preventive care, well-child visits and developmentally appropriate screenings to identify challenges early, and that they continue to access needed treatment services to achieve and maintain their highest level of functioning. Moreover, children with special health care needs require a network that can support an appropriate transition to adult care providers. The network must include adult providers who are able to provide for their unique needs or pediatric and/or adolescent specialists who are able to provide specialized care through young adulthood and possibly beyond.

THE NEED FOR PEDIATRIC EXPERTISE. Children are not “little adults.” Providers who specialize in treating adults may not have the expertise—or the equipment—that is needed to appropriately treat children. Children, particularly those with serious, chronic or complex conditions, represent a unique cohort of covered patients and must have access to practitioners with the unique training and experience—and the appropriately sized equipment—to meet their needs.

THE REGIONAL NATURE OF CHILDREN'S HEALTH CARE. While all children's hospitals provide local care, they also excel in specialty care, meaning that children throughout large geographic regions have access to trained pediatric specialists, specialized services and technology not found in community or adult hospitals. It is crucial that states and MCOs support children in identifying and traveling to an appropriate site of care, which may be a children's hospital in another state.

MCO PROVIDER NETWORKS MUST INCLUDE FULL RANGE OF PEDIATRIC SPECIALTY SERVICES

To serve children adequately, MCO provider networks must assure that all children have in-network access to the full range of pediatric subspecialty services, including one or more pediatric hospital providers in each of the MCO's geographic service areas that maintain comprehensive pediatric specialty services. We urge CMS to revise the network adequacy standards to include this requirement, in addition to implementing the monitoring, rate adequacy and administrative reforms described elsewhere in our RFI response.

We encourage CMS to develop multi-faceted pediatric-specific network adequacy standards, but caution that the use of travel time and distance standards, particularly those developed for the Medicare Advantage program, are not appropriate metrics to determine network adequacy for children in need of specialty care. While the use of time and distance metrics as a generally appropriate measure of a network's pediatric primary care capacity, time and distance cannot account for the many children who travel long distances and across state lines to receive necessary care from appropriate pediatric specialty providers, including children's hospitals equipped to meet their unique tertiary and quaternary medical needs. A study in the June 2018 issue of Health Affairs[4] found that nearly half of pediatric specialty hospitalizations took place outside of adult-focused distance standards. Similarly, an earlier CHA analysis found that approximately 50% of children nationwide would not have access to the services of an acute care children's hospital if adult Medicare Advantage time and distance standards are used. The use of time and distance standards as the sole metric for network adequacy would place children at risk of delayed services or may lead them to care in settings ill-equipped to address their pediatric service needs.

Rather than a sole reliance on time and distance, we recommend a comprehensive, multi-faceted set of quantitative standards specific to pediatric, including but not limited to wait times; enrollee ratios by specialty; geographic accessibility; geographic population dispersion; and minimum appropriate providers available to meet the needs of children with special health care needs, including those with limited English proficiency, and diverse cultural and ethnic backgrounds. The standards should limit plans' opportunities to provide a justification for an inadequate network in lieu of assuring an adequate network. Justifications or exceptions, along with single case agreements, should only be accepted in very rare circumstances and for very rare health conditions.

CHILDREN'S HOSPITALS PROVIDE COMPREHENSIVE PEDIATRIC SERVICES. A network that does not include one or more children's hospitals to ensure children access to comprehensive pediatric specialty services will not have adequate capacity or the capability to provide the complete spectrum of specialty care that children may need. When a network includes providers without the requisite pediatric training and expertise, families may be referred to inappropriate providers who, by their own admission, do not have the experience to provide the needed services. Pediatricians, family practice physicians and adult community hospitals refer their patients to children's hospitals for treatment of everything from complicated fractures to complex congenital heart conditions because of the expertise of those working in the hospital.

At a minimum, plans must ensure that children have access to an in-network children's hospital with the capacity to provide:

- Pediatric specialty services including neonatal services, pediatric critical and intensive care, cardiology, neurology, nephrology, developmental medicine, psychiatry, gastroenterology, orthopedics, pulmonology, oncology and radiology.
- Pediatric surgical and anesthesia services.
- Pediatric emergency/trauma services.
- The relevant range of ancillary supports, such as pediatric occupational, physical and speech therapy services.
- Specialized pediatric pharmacies.
- Durable medical equipment.

In general, plans should demonstrate that the specialists in question have been trained and credentialed with substantial experience and expertise treating children. In addition, plans must ensure the availability of linguistically and culturally responsive providers/services.

It may be necessary for children to travel significant distances and to other states to receive treatment. Therefore, if an appropriate pediatric specialty hospital with the expertise to provide the needed care is not available in the immediate geographic area, the network should include access to an appropriate in-network facility in another region, which may be out-of-state. Referral arrangements should not impede timely access to those specialty providers that are outside the geographic area.

CURRENTLY, MCOs RELY EXCESSIVELY ON OUT-OF-NETWORK PROVIDERS FOR OUT-OF-STATE CARE. Health plans should be required to include a sufficient number of pediatric specialty providers in their provider network even if they are outside of the geographic region or in another state. CMS could also have states identify services that are not available in-state as part of their state plan to identify where out-of-state care will be required.

We emphasize the importance of meeting all the needs of covered children through in-network access to services provided through the EPSDT benefit. To meet the standard under this section, states must review plan networks for their full range of trained and experienced pediatric providers and only allow the use of out-of-network arrangements or procedures, including single case agreements under very rare or unanticipated circumstances. A reliance on, or over-use of, out-of-network providers impedes timely and appropriate care, which could be catastrophic for a child's long-term development and health.

We ask CMS to look at the use of single case agreements to ensure that they are not used as a way to fill gaps in MCO's networks rather than developing an adequate network. The single case agreement process is burdensome for patients, providers and plans alike. As an interim step, CMS could develop a template "single case agreement" that could be used across states and MCOs to help streamline the process.

An MCO that relies on an excessive number of single case agreements is likely to be failing to meet its federal obligation to "maintain a sufficient number, mix, and geographic distribution of providers" in its provider network, as required under Social Security Act (SSA) section 1932(b)(5)(B). Moreover, these burdensome and time-intensive processes, when relied on excessively, are in tension with Congress's directive that Medicaid services "be furnished with reasonable promptness to all eligible individuals" and provided "in a manner consistent with simplicity of administration and the best interests of the recipients," as required under SSA sections 1902(a)(8) and (19).

NOTES

[1] Children's Hospitals Declare National Emergency in Children's Mental Health (Oct. 19, 2021), https://www.childrenshospitals.org/news/newsroom/2021/10/childrens-hospitals-declare-national-emergency-in-childrens-mental-health.

[2] Committee on Finance, U.S. Senate, Mental Health Care in the United States: The Case For Federal Action, p.12 (March 2022), https://www.finance.senate.gov/imo/media/doc/SFC%20Mental%20Health%20Report%20March%202022.pdf.

[3] KFF, Health Insurance Coverage of Children 0-18 (2019), https://www.kff.org/other/state-indicator/children-0-18/; KFF, Health Insurance Coverage of Adults 19-64 (2019), https://www.kff.org/other/state-indicator/adults-19-64/.

[4] See Children's Hospital Association. Implications of adult network adequacy standards on children's access to pediatric specialty care, June 2018.

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?

CMS SHOULD ENHANCE ACCESS DATA COLLECTION AND REPORTING

We have access to better tools than ever before for data collection and data management. CMS’ June 2021 enhancements to the Annual Managed Care Program Report are a welcome step toward greater oversight and accountability in the Medicaid and CHIP programs, and we encourage CMS to move in a similar direction with respect to access monitoring, reporting and enforcement across delivery systems.

States and MCOs should be gathering more data in a more standardized fashion, and CMS should aggregate, review and act on that data to ensure that enrollees nationwide are actually able to receive the services to which they are legally entitled. In addition, CMS should (as appropriate) publish aggregated data to improve transparency and support public engagement and advocacy on access issues.

CMS has the authority to require additional reporting pursuant to statutes such as:

– SSA section 1902(a)(6), which directs states to “make such reports, in such form and containing such information, as [CMS] may from time to time require and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports.”

– SSA section 1932(c)(1)(iii), which provides that a state’s managed care quality strategy must define “procedures for monitoring and evaluating the quality and appropriateness of care and services,” including “requirements for provision of quality assurance data to the State using the data and information set that the Secretary has specified for use under [Medicare Advantage] or such alternative data as the Secretary approves, in consultation with the State.”

THE ACCESS STANDARDS MUST HAVE TEETH

Under today’s somewhat vague access standards, it may be challenging for CMS to determine when an access problem becomes so severe as to violate federal standards. Clearer measures and more robust reporting will give CMS and states better visibility into access, thereby supporting more robust oversight—and enforcement—of the access standards.

With respect to states, we urge CMS to monitor for access problems for children and, as needed, work with states to implement corrective action plans. Although CMS has the authority to withhold FFP, the loss of federal funding may make it challenging for states to address access problems, not least because access problems can often be addressed by raising provider reimbursement rates. By defining objective access measures and standardizing reporting across states, CMS would be able to identify access problems and cite a definitive legal basis for imposing a corrective action plan, compliance with which would spare the state from financial penalties.

With respect to MCOs, CMS should:

- Ensure that access measures are included in MCO quality assessment and performance improvement programs.
- Ensure that states are vigilant in monitoring for network changes that may reduce access during the contract term.
- Revise the rules on MCO sanctions (42 C.F.R. 438.700) to ensure that states define specific access-related bases for sanctions in their MCO contracts.

These steps would encourage states to consider specific access thresholds and signals each time they amend their MCO contracts, an exercise that may support additional access-related efforts such as directed payments or MCO performance incentives. Along those lines, CMS should also encourage states to incentivize robust access through value-based purchasing arrangements.

3. How could CMS consider the **concepts of whole person care[1] 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?

ENSURE THAT METHODOLOGIES AND PROTOCOLS REFLECT PEDIATRIC NEEDS

CMS should encourage states, and provide guidance and technical assistance as needed, to ensure that risk stratification methodologies and care coordination protocols are designed for children as well as adults. Specialized care coordination for children requires specialized skills that current MCO care coordinators may not have. States should require MCOs to measure care coordination for children separately from adults using robust tools such as Family Experience with Care Coordination or Peds QL.

ENCOURAGE INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH

CMS should support states in eliminating the bifurcation in delivery systems and funding between behavioral health and physical health. Relevant policy levers could include payment models, managed care contract arrangements, and state licensure standards.

OVERSIGHT OF EPSDT

CMS should provide more oversight of EPSDT and encourage state best practices that meet the needs of children all along the continuum. Guidance on what states should be doing to implement these requirements and how ESPDT can help ensure access to mental health services for children during this national crisis. Many states have improved EPSDT for kids after legal action. We should not have to wait for legal action to ensure this important benefit for children is provided. CMS could examine T-MSIS data to see which states are doing well and which are lagging behind and support improvements in consistently applying this critical benefit for children.

NOTES

[1] Under a "whole-person" philosophy, individuals with chronic physical and/or behavioral health conditions are provided linkages to long-term community care services and supports, social services, and family services, as needed. State Medicaid Director Letter #10-024. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd10024.pdf

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?

TO BETTER SUPPORT PEOPLE WITH LIMITED ENGLISH PROFICIENCY (LEP), CMS should encourage states and MCOs to:
– Establish centralized translation services. Smaller providers may not have the resources to fund robust translation services. Providing a centralized resource would support efficiency through economies of scale and would ensure access for patients and families with LEP.
– Increase reimbursement for visits with an LEP patient. Visits take significantly longer when the provider and the patient must speak through an interpreter. Reimbursement rates should reflect the additional time and effort for providers.

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?

PROMOTE TELEHEALTH ACCESS

To relax some of the constraints that patients face based on geography—particularly in rural and other underserved areas—CMS should encourage states to promote telehealth access. Helpful policies include parity of telehealth coverage and parity of telehealth reimbursement, including telehealth facility fees for clinical support services and infrastructure. Telehealth has been particularly helpful connecting children to needed behavioral health care. These policies should be supported and encouraged even as we transition out of the PHE.

RECOGNIZE THE VALUE OF MID-LEVEL PROVIDERS

In recent decades, many states have significantly expanded the scope of practice for clinicians such as nurse practitioners, physician's assistants and pharmacists. We urge CMS to ensure that federal law does not limit these clinicians' ability to work at the top of their license under state law.
– CMS could undertake a review of Medicaid's service delivery standards, as well as the Conditions of Participation, to identify and address instances in which federal law may require the presence of a physician, regardless of whether another practitioner may be licensed and competent to provide the service independently, or without in-person physician supervision.
– CMS could, in addition, evaluate the relationship between mid-level practitioners and access, which may generate helpful insights for states as they reconsider their licensure laws. Scope of practice could be one of many inputs into better or worse access in certain areas for certain services.

Objective 4. Access—Federal Monitoring

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 urges CMS to:

– Align access measures across FFS and managed care, to the extent possible. All children and youth deserve robust access to medically necessary services, regardless of the delivery system their state has chosen to adopt.

– Require MCO-specific reporting so that states can identify problematic plans, and so that CMS can identify problematic plan *families.*

– Issue guidance requiring states to implement MCO quality rating systems (QRS), as envisioned under 42 CFR 438.334. A QRS should include scoring specific to pediatric access and care quality so that families can make an informed choice about enrollment. Aggregate ratings that do not address critical sub-populations and quality domains may result in insufficient information to guide the choice of plans and prioritization of quality improvement efforts by plans. In addition, the information needs to be clear and useable for a range of consumers who will value certain services and quality improvement efforts differently. For example, a low-income, childless adult will search for a different plan than a parent of a child with severe asthma.

– Enhance transparency by publishing standardized data to facilitate cross-state comparisons.

– Provide technical assistance to states to improve the completeness and accuracy of data on enrollee race/ethnicity. If a state is not routinely and accurately capturing race/ethnicity data—and some states are not—the state will be limited in its ability to pursue health equity reforms.

These proposals flow from our recommendation for CMS to move toward a more data-driven approach to access monitoring and oversight at both the state and federal level. For additional details, see Objective 3, Question 2.

2. What **measures of potential access**, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor (e.g., provider networks, availability of service providers such as direct service workers, appointment wait times, grievances and appeals based on the inability to access services, etc.)? How could CMS use data to monitor the **robustness of provider networks across delivery systems** (e.g., counting a provider based on a threshold of unique beneficiaries served, counting providers enrolled in multiple networks, providers taking new patients, etc.)?

We urge CMS to adopt the access measures described below, which should be:
– Captured across both FFS and managed care.
– Broken down by age cohort (children, non-elderly adults, elderly adults), as well as by race/ethnicity, to identify population-specific access challenges.

IDENTIFYING DISEASES/SPECIALTIES WITH CHRONIC ACCESS PROBLEMS

TRACKING APPEALS, GRIEVANCES, AND FAIR HEARINGS. Different types of access problems are likely to be more or less prevalent in different states and under different plans. We thus urge CMS to drill down, asking states and MCOs to identify the diagnoses and specialties that are most commonly associated with grievances, appeals and fair hearings regarding delayed or denied access, including:
– Denied, limited or delayed authorization of a service; or
– Denied, limited or delayed authorization of a patient's request to receive services from an out-of-network provider (including under 42 C.F.R. 438.206(b)(3) (addressing second opinions) and 438.206(b)(4) (addressing scenarios in which a medically necessary covered service is not reasonably available in-network).
– Denied, limited or delayed authorization of a patient's request to receive services from an out-of-state provider.

States should be required to report these data to CMS (broken down by age cohort and race/ethnicity, as noted above), and to identify outlier conditions and specialties—namely, those well above the average on metrics such as frequency of appeals and grievances, the proportion of appeals that result in ultimate approvals and the average timeline for appeal resolution. For these outliers, states should be required to offer an explanation for the discrepancies and a proposed strategy to mitigate the discrepancies.

We respectfully remind CMS that simply including a pediatric specialist, subspecialist or hospital in a network does not guarantee that a child will have access to the services promised through EPSDT if a plan denies the referral to those providers. A high number of appeals and grievances to specialty care reflects an inadequate network, which should not be approved by the state. When the state identifies a pattern of denials that may impede a child's access to appropriate care, corrective action with supplemental documentation should be required immediately.

TRACKING THE OUTCOMES OF APPEALS. In addition, CMS should probe the outcome of appeals. Some states and MCOs routinely deny authorizations for certain services, and routinely overturn those denials in response to an appeal, sometimes even dismissing the appeal before the scheduled hearing date. Perversely, the state or plan may then issue a new denial when the same service comes up for reauthorization shortly thereafter, triggering the cycle to begin anew. Requiring beneficiaries to needlessly go through the appeals process can delay access to specialized pediatric care for children, create unnecessary stress for families and result in less than optimal health outcomes. Meanwhile, patients who do not file an appeal are denied care entirely, despite having a likely meritorious claim.

These practices can easily transition from effective plan oversight to tools that deny or delay care, which is counterintuitive to Medicaid’s responsibility to provide timely access to medically necessary services to children. Furthermore, it increases administrative costs for providers, plans and states. We urge CMS to establish additional guidance to limit unnecessary administrative denials and ensure providers are paid upon approval of an appeal if the only reason for that appeal was due to an administrative denial.

IDENTIFYING MCO NETWORK GAPS

MCOs should be required to report on the diagnoses, specialties and individual providers that are most commonly involved in out-of-network service authorizations, also known as single case agreements. And as noted above, MCOs should also be required to report on denials and appeals regarding such requests.

Although out-of-network access provides an important safety valve in rare cases when needed care is not reasonably available in-network, MCOs should not be permitted to rely on this safety valve as an alternative to maintaining an adequate provider network. For a discussion of the delays and other harms associated with excessive reliance on single case agreements, see response to Objective 3, Question 1.

We ask that CMS require plans to take corrective actions when there is a consistent pattern of referrals to, and utilization of, out-of-network specialty providers. Because a pattern of referrals to out-of-network providers indicates an inadequate network, plans must be required to supplement their networks in a timely manner. Under these circumstances, plans should be required to submit interim reports to the state to demonstrate that they have taken the appropriate steps to strengthen their networks.

OTHER ACCESS MEASURES

WAIT TIMES FOR PEDIATRIC REFERRALS to (1) outpatient mental health; (2) specialty care; (3) key therapies (e.g., ABA for autism); or (4) home nursing following hospitalization. As noted in a JAMA systematic review, “time to third-next-available appointment is a widely used metric for appointment availability. It is preferred over the time to the next available appointment because it does not give the false impression of schedule availability if there is a last-minute cancellation.”[1] It would be valuable to collect data on wait times from:
– Secret shopper surveys.
– Patient surveys.
– Primary care providers who perceive these referral delays across their Medicaid patient population.

CHECKING FOR CORRELATIONS TO IDENTIFY MISSED UPSTREAM OPPORTUNITIES. For example, CMS could interrogate the relationships between:
– Medicaid-covered births vs. well-baby checks, to ensure that eligible newborns are promptly enrolled in Medicaid and connected with appropriate pediatric services. For additional discussion of strategies to streamline care transitions after birth, see response to Objective 1, Question 1.
– Wait times for outpatient mental health visits vs. BH-related ED visits. Assessing these metrics together may help to establish minimally adequate measures for outpatient access, as well as

meaningful signals in ED visit rates that may require further investigation and a swift response.

– Utilization of routine well-baby/well-child visits vs. pediatric ED visits, for the same reasons described above regarding BH ED visits.

– Utilization of, and wait times for, non-emergency medical transportation vs. provider no-shows.

CARE COORDINATION MEASURES FOR MENTAL HEALTH, including the following HEDIS measures:

– Follow-up After Hospitalization for Mental Illness (FUH).

– Follow-up After Emergency Department Visit for Mental Illness (FUM).

NOTES

[1] Rose KD, Ross JS, Horwitz LI. Advanced Access Scheduling Outcomes: A Systematic Review. *Arch Intern Med.* 2011;171(13):1150–1159. doi:10.1001/archinternmed.2011.168

3. 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?

4. How should CMS consider requiring states to report standardized data on **Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes** that address enrollment in coverage and access to services? How could these data be used to meaningfully monitor access?

USING APPEAL DATA

SEE OUR RESPONSE TO OBJECTIVE 4, QUESTION 2 for proposed measures to track grievances, appeals and fair hearings related to denied, limited or delayed authorization of a service, including an out-of-network service or an out-of-state service, as well as potential responses if CMS or states identify conditions or specialties that account for a disproportionate share of such grievances and appeals.

APPEAL DATA PROVIDES AN INCOMPLETE PICTURE, AND APPEALS REPRESENT A BANDAID SOLUTION. Many more children face barriers to care than will ever file a grievance. Moreover, although a successful appeal results in access, that access may come later, and at a greater cost to patients and providers, than seamless access in the first instance. Plans must be required to design networks that ensure access to appropriate in-network providers for all covered services and must not be allowed to rely on vigorous appellate efforts from beneficiaries, out-of-network arrangements and other measures that create barriers and burdens for sick children in need of care.

ESTABLISHING A SYSTEM FOR ACCESS COMPLAINTS

Grievances and appeals originate out of the case of a single patient and are typically dropped if the patient is ultimately granted access to the requested service. Moreover, as noted above, it is our experience that many patients are disinclined to pursue grievances and appeals, even when they have legitimate access problems. An additional mechanism is needed for broader, more systemic access complaints that pertain to an entire population of patients or class of services, such as children being unable to secure timely behavioral health services in the community following discharge from a hospital. We urge CMS to 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.

This approach would essentially create an administrative "private right of action," similar to the lawsuits through which providers and beneficiaries previously enforced the federal access standards. As CMS is aware, the Supreme Court closed off that enforcement avenue with its 2015 decision in Armstrong v. Exceptional Child Center, leaving Medicaid stakeholders without a clear forum to raise their access concerns and receive a response. It would fill a significant gap and allow CMS and states greater insight into access issues.

This new system would allow providers, provider associations and patient advocacy organizations to bring salient information directly to state regulators and to CMS if they have evidence of significant access issues. For example:

– Some states have gone a decade or more without updating some of their pediatric provider rates, with attendant impacts on patient access and provider solvency.

– Some states and MCOs have a troubling track record of failing to pay timely—or at all—for services that are rendered out-of-state or out-of-network.

Beneficiaries and providers on the ground are in the best position to identify such issues. Any credible allegations of inadequate access would require a state investigation and, if necessary, corrective action.

While we believe this type of administrative complaint mechanism is sorely needed, we recognize that this policy would require new systems and processes. To reduce state burden and preserve state flexibility, CMS could adopt an approach similar to the Health Insurance Marketplaces. Each state would be invited to establish its own system, subject to federal requirements, including reports on access complaints and the state's responses. States would also have the option to allow CMS to step in with a federally operated model, including the ability to refer complaints to states for investigation and responsive action. Under either model, CMS could bring to bear its toolkit of information-gathering and enforcement powers, including the ability to impose a corrective action plan upon identifying serious violations of the federal access standards.

5. How can CMS best leverage **T-MSIS data to monitor access** broadly and to help assess potential inequities in access? What additional data or specific variables would need to be collected through T-MSIS to better assess access across states and delivery systems (e.g., provider taxonomy code set requirements to identify provider specialties, reporting of National Provider Identifiers [NPIs] for billing and servicing providers, uniform managed care plan ID submissions across all states, adding unique IDs for beneficiaries or for managed care corporations, etc.)?

We request that CMS consider including the following data fields in T-MSIS, and require states and MCOs to track patients accordingly:

– Consistent patient IDs across programs and delivery systems. In some states, a single patient may have multiple Medicaid/CHIP IDs, including different IDs for MCOs. MCOs should use a state-given Medicaid ID number.

– Geographic identifier(s), like census tract ID, to facilitate for geography-based population assessments.

Objective 5. Access—Provider Rates & Provider Burden

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 extentthat such care and services are available to the general population in the geographic area." Section 1932 of theAct 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 leveragingexisting 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?

ADEQUATE REIMBURSEMENT IS NECESSARY TO ENSURE ADEQUATE ACCESS TO SERVICES

In the short term, appropriate payment rates support access by increasing provider participation in the Medicaid program. Appropriate rates also support long-term financial stability and quality of care for providers—like children's hospitals—that serve a large number of patients covered by Medicaid and CHIP. Notably, although children's hospitals account for only 5% of hospitals in the United States, they provide nearly half of all pediatric hospital care covered under Medicaid.

Sadly, Medicaid rates generally fall below those of other payers. The Medicaid program cannot expect to ensure meaningful and timely access to high-quality services while paying substantially less than other payers, so much so that providers must take a financial loss with every Medicaid patient they serve.

An area of noteworthy financial hardship for providers concerns high-cost provider-administered drugs and biologics. Some state Medicaid programs do not adequately compensate providers for these costs, either by paying a flat fee for a hospitalization that fails to take drug costs into account, or by reimbursing for the product itself well below acquisition cost.

EXPLORE APPROPRIATE BENCHMARKS FOR PEDIATRIC SERVICES THAT COULD BE USED IN ACCESS MONITORING

We ask CMS to explore different rate benchmarks that could be used in access monitoring of pediatric services. Possible benchmarks to examine include cost-based reimbursement, which recognizes technology and other ongoing, long term infrastructure costs, Medicare parity with consideration of outliers and supplemental payments, commercial rates and their impact on access to pediatric services.

STATES MUST COVER THE COSTS OF HIGH-COST DRUGS AND THERAPIES. Currently, some state Medicaid programs are requiring providers to bear a large portion of the costs associated with acquiring and administering drugs and biologics as part of specialized treatment regimens. CMS should examine these practices and access the impact on the access to these life-saving drugs.

STATES MUST FAIRLY REIMBURSE FOR OUT-OF-STATE SERVICES. We discuss this issue below under Objective 5, Question 4.

URGE CAUTION ON REFORMS THAT MAY REDUCE ACCESS, INCLUDING CHANGES TO SUPPLEMENTAL PAYMENTS

We appreciate CMS's attention to questions related to provider reimbursement and patient access. We understand that CMS is also exploring current practices and potential reforms regarding supplemental payments, which vary across states in terms of both size and allocation methodology.

We are acutely aware of the crucial role that supplemental payments currently play in supporting fiscal sustainability for Medicaid providers. We support a vision for achieving adequate base rates for pediatric services, thereby ensuring that all providers are fairly compensated for their services. In such a world, supplemental payments may potentially diminish in importance. In today's world, however, supplemental payments are often not "supplemental" at all, and operate instead as a necessary counterbalance to inadequate base rates.

We fully support any CMS efforts that would increase base rates for Medicaid providers. At the same time, we urge caution in any payment reforms that may reduce any current payment streams, such as supplemental payments. We request that, before implementing any such reforms, CMS undertake a full analysis of the potential impacts on access and quality, in both the short and the longer term.

2. How can CMS **assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access** and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?

3. Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community based services (HCBS). What data sources, methods, or benchmarks might CMS consider to **assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?**

Please see our comments under Objective 5, Question 1.

PROVIDER PARTICIPATION RATES. The proportion of pediatric providers who participate in Medicaid can serve as a helpful proxy for rate adequacy, especially for services that lack a clear and accurate Medicare comparator. By examining participation rates region by region and service by service, CMS and states can identify access barriers that may flow from inadequate reimbursement.

SCHOOL-BASED HEALTH CENTERS (SBHC). We urge CMS to undertake an examination of state policies on reimbursement for SBHC programs. Notably, SBHCs operated by hospitals cannot recover the facility fee that is available for hospital services. CMS should, in addition, support funding to expand access to school-based services (mental, primary care, dental, vision), including planning and implementation grants.

4. Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries.[1] What actions could CMS take to encourage states to **reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP** while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?

In this section, we propose policy solutions to address four areas of administrative burden that consistently plague our members, driving up provider costs and impeding access to services for children and families:

- Barriers to out-of-state care
- Excessive and burdensome prior authorization procedures
- Frequent service denials that are overturned on appeal
- The process for negotiating MCO single case agreements for out-of-network care

REDUCING BURDENS ASSOCIATED WITH OUT-OF-STATE CARE

OUT-OF-STATE ACCESS IS CRUCIAL FOR PEDIATRIC SERVICES. As you know, children with serious or medically complex conditions often require out-of-state care. This care is often provided by children's hospitals, which serve as regional hubs for pediatric specialty services. According to MACPAC, in FY 2013, nearly 90% of children's hospitals serviced out-of-state patients. MACPAC found that the average hospital received payment from 3 states, while the average children's hospital received payment from 6 states, with some children's hospitals receiving payment from more than 25 states.[2] These data demonstrate that children's hospitals are serving much larger geographic regions due to the unique and specialized services they provide.

Sadly, there are many challenges and barriers to receiving and coordinating out-of-state care for children with medically complex conditions, which we outlined in our March 23, 2020, response to CMS' RFI on Coordinating Care from Out-of-State Providers (CMS-2324-NC).[3] CMS provided helpful guidance in its October 20, 2021, CMCS Informational Bulletin (CIB). Additional action is needed, however, to fulfill the promise of out-of-state access.

CMS has the authority to regulate in this area pursuant to SSA section 1902(a)(16), which directs states to "provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions … with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom."

COVERAGE FOR OUT-OF-STATE SERVICES. We urge states and CMS to monitor for troublingly high rates of denials and appeals regarding out-of-state access, as discussed above under Objective 4, Question 2. These data may reveal instances in which states or MCOs are not complying with, or dragging their feet with respect to, their federal obligations to cover out-of-state services in certain contexts, including when appropriate specialty services are more readily available in another state or in areas where it is common for patients to travel across state lines for care, as described in 42 C.F.R. 431.52.

Under Objective 3, Question 1, we proposed a requirement for MCOs to contract with an appropriate number of pediatric specialty services providers to serve their patients.

STREAMLINING PROVIDER ENROLLMENT. As CMS noted in the October 2021 CIB, “providers commented that they spend significant time and resources to overcome the administrative burdens related to enrolling in Medicaid across state lines, due to complex enrollment processes and requirements that can vary significantly across states” (p.4). Our members commonly experience the frustrations and delays that come with enrolling in another state’s Medicaid program, despite being a longstanding provider in good standing in both their home state’s Medicaid program and the Medicare program. States may require, for example, the submission of Social Security Numbers for all board members, as well as background checks for all C-level employees.

In the CIB, CMS recommended that states “consider an expedited screening and enrollment process with respect to out-of-state providers” (p.6). We urge CMS to promulgate regulations that define federal parameters for streamlined enrollment processes for out-of-state providers that have already undergone full vetting in connection with federal health care programs.

We urge CMS, in addition, to support passage of the Accelerating Kids Access to Care Act (S.1544/H.R. 3089), which would require states to establish a streamlined pathway for “eligible out-of-state providers.”

PROHIBITING DISCRIMINATORY PAYMENT. Despite the importance of out-of-state services, some states reimburse out-of-state providers significantly less than in-state providers. Compounding the financial impact, out-of-state providers are shut out of supplemental payment methodologies, even if they are located near a state border and commonly treat Medicaid patients from the neighboring state.

CMS should prohibit states from applying discriminatory rate penalties in scenarios where a patient qualifies for mandatory coverage of out-of-state care, as described in 42 C.F.R. 431.52.

ADDITIONAL STEPS TO IMPROVE ACCESS TO OUT-OF-STATE SERVICES.

- Guidance on coverage of travel, lodging and related support services. 42 C.F.R. § 440.170 sets forth requirements related to covering the cost of travel, lodging and meals, as well as attendant expenses, if states chose to cover transportation under their medical benefit (as opposed to as an administrative expense). Guidance could address minimum requirements for what must be covered by states as well as options for what may be covered (e.g., support for childcare costs).
- Guidance for MCOs regarding allocation of similar supports as medical vs. administrative expenses for purposes of calculating the medical loss ratio (MLR).
- Encourage states to authorize cross-state telehealth practice and cover virtual inter-professional consultations.
- Implementation of the ACE Kids Act would help with coordination of out-of-state services for children with medically complex needs. We urge CMS to establish a national definition for eligible children as described in prior Children’s Hospital Association communications. A standardized federal approach will help to assess access for this population of high-needs children, identify any gaps in care and inform the design of payment models to support the highest quality of care for children with multiple complex needs.
- Establishing a regional benefit package that includes the same standards for highly complex children (as defined by the region) to alleviate interstate barriers that sometimes arise when states cover a

different benefit package. Any such recommendations must be crafted in a manner that reinforces EPSDT requirements.

OTHER ADMINISTRATIVE BURDENS THAT DELAY CARE AND INCREASE PROVIDER COSTS

FREQUENT SERVICE DENIALS THAT ARE OVERTURNED ON APPEAL. In response to Objective 4, Question 2, we requested more robust monitoring of grievances and appeals regarding prior authorization (PA) denials, including the rates at which such appeals result in the original decision being overturned. States should be required to identify outlier conditions and specialties and respond accordingly.

BURDENSOME PRIOR AUTHORIZATION PROCEDURES. We urge CMS to move forward with its proposals (CMS-9123-P) to require standardized, streamlined and digitized PA procedures for Medicaid MCOs and other payers. CHA's comment letter on CMS's December 2020 proposed rule expresses our enthusiasm for reforms that would enhance transparency, reduce provider burdens, and reduce PA decision timelines.[4]

EXCESSIVE RELIANCE ON SINGLE CASE AGREEMENTS FOR OUT-OF-NETWORK CARE. If a given provider is out-of-network but treating a significant number of MCO patients every year, that inefficient arrangement may be causing delays in patient care and imposing unnecessary administrative burden on the provider. Moreover, the MCO may be failing to maintain an adequate network. For additional discussion of the problem and potential monitoring solutions, see Objective 3, Question 1, and Objective 4, Question 2.

NOTES
[1] Dunn, B, et al. "A denial a day keeps the doctor away." National Bureau of Economic Research. Available at https://www.nber.org/papers/w29010
[2] MACPAC, Medicaid Payment Policy for Out-of-State Hospital Services (Jan. 2020), https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid-Payment-Policy-for-Out-of-State-Hospital-Services.pdf.
[3] CHA's comment letter to the 2020 RFI on Coordinating Care from Out-of-State Providers is available here: https://www.regulations.gov/comment/CMS-2020-0006-0046.
[4] CHA's comment letter is available here: https://www.regulations.gov/comment/CMS-2020-0157-0194.

Other Feedback

At the end of the RFI, there is an opportunity to provide any additional comments you have for this Request for Information that does not apply to one of the previous questions.