mhpa Medicaid Health Plans of America

September 9, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1809-P,
P.O. Box 8010, Baltimore, MD 21244-8010

Re: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities (CY 2025 OPPS Proposed Rule)

Dear Administrator Brooks-LaSure,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to provide input on the CY 2025 OPPS Proposed Rule.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 150 MCOs serving nearly 47 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries. Below you will find our comments in response to this proposed rule.

Continuous eligibility for Medicaid and CHIP

MHPA expresses strong support for the codification of the requirement to provide 12 months continuous eligibility for children under the age of 19 enrolled in Medicaid and CHIP. Individuals with continuous eligibility are more likely to have access to preventative care, experience fewer unmet health care needs, and are in better health than those who cycle on and off coverage.[1] Fewer disruptions in coverage would allow children to access critical preventative health services and necessary treatments to support their healthy development, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Continuous coverage is also a valuable approach for addressing health disparities and supporting health equity. Notably, "Black, Hispanic, and Indigenous individuals and families are more likely to live in poverty

[1] Sarah Sugar, Christie Peters, Nancy De Lew, Benjamin D. Sommers, Assistant Secretary for Planning and Evaluation (ASPE), Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic, (ASPE Issue Brief, April 12, 2021).
https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf (accessed September 2024).

and therefore have higher rates of income volatility than Whites"[2] and are at increased risk for experiencing churn. Based on data from states that have provided continuous eligibility to children prior to this requirement, average monthly eligibility for Medicaid and CHIP is expected to increase by 3.5% in affected states, with over one million children estimated to gain at least one month of eligibility.[3]

MHPA supports continuous eligibility for postpartum individuals, children, and has recently published an issue brief[4] in support of continuous eligibility for populations receiving long-term services and supports through Medicaid.

Medicaid reimbursement for certain services outside of a clinic.

MHPA expresses strong support for the authorization of federal reimbursement for services furnished outside the "four walls" of a freestanding clinic by Indian Health Service (IHS)/Tribal Clinics, behavioral health clinics, and clinics located in rural areas.

The COVID-19 pandemic demonstrated the critical need for behavioral health services, and evidence has demonstrated that telemedicine provides opportunities to create robust access for them.[5] Further, research demonstrates the efficacy of telehealth for behavioral health conditions at the system, provider, and patient level.[6] Telehealth can reduce barriers to care for at-risk populations, including limited transportation and housing instability, by allowing flexibility for the patient. In rural and suburban areas in Pennsylvania for example, where several of our member plans operate, public transportation is often limited and Medicaid funded transportation services have limited hours and/or days of operation and people must travel long distances to attend appointments.

We also support efforts to expand access to health care for rural communities given the well-documented challenges that individuals living in rural areas face when it comes to receiving health care. In some rural areas, travel to and from a one-hour therapy appointment may take four to six hours. A lack of access to telehealth is a major barrier for working parents, parents of very young children, families of school age children or anyone who has other obligations during the day. For families, telehealth access can facilitate access to care when the enrollee needs to secure childcare or take time off of school or work. We support an expansive definition of rural for the purposes of this section, that is, whatever definition has the highest population and/or encompasses the largest service area in order for the exception to be available to as many clinics and individuals as possible. We also question why this exception must be limited to rural areas at the exclusion of other underserved areas that may have access challenges related to transportation as well. We encourage CMS to work with Congress to lift the four walls requirement entirely with telehealth being widely accepted as an avenue to improve access for Medicaid enrollees.

---

[2] Tricia Brooks, Allexa Gardner, Continuous Coverage in Medicaid and CHIP, (Georgetown University Health Policy Institute, Center for Children and Families, July 2021), https://ccf.georgetown.edu/2021/07/19/continuous-coverage-in-medicaid-and-chip (accessed September 2024)

[3] Caroline Hogan et al, ASPE, New Federal 12-Month Continuous Eligibility Expansion, (ASPE Issue Brief, March 27, 2024). https://aspe.hhs.gov/sites/default/files/documents/5b52fb410eb22517d4fc1bc4cac834bd/aspe-childrens-continuous-eligibility.pdf (accessed September 2024).

[4] Medicaid Health Plans of America. Continuous Eligibility. https://medicaidplans.org/wp-content/uploads/2024/06/ContinuousEligibility_newformat.pdf

[5] Palmer CS, Brown Levey SM, Kostiuk M, Zisner AR, Tolle LW, Richey RM, Callan S. Virtual Care for Behavioral Health Conditions. Prim Care. 2022 Dec;49(4):641-657. doi: 10.1016/j.pop.2022.04.008. Epub 2022 Oct 20. PMID: 36357068; PMCID: PMC9581698. https://pubmed.ncbi.nlm.nih.gov/36357068 (accessed September 2024)

[6] *Id.*

Regarding this exception for IHS and Tribal Clinics, we have several clarifying questions and remarks which we believe should be addressed in the final rule:

- Would the exception in this proposed rule apply to Tribal Health Clinics also operating at FQHCs?

- Would the proposed "four walls" exception also apply to services rendered to non-native members who receive care at Tribal clinics? We recommend that it does.
    - It is difficult for plans to identify native status among members who receive care at Tribal Health Clinics, especially for dual eligibles – when a member turns 65+ and becomes a dual, the state eligibility file defaults to their Medicare eligibility, which does not designate Native American as an ethnicity (everyone is listed as Caucasian).
    - Expanding the "four walls" exception to non-native members who receive care at Tribal clinics would simplify processes for clinics and plans.

- We would like to know if this proposed exception will cover services like traditional healing, which will be reimbursable by Medicaid in the near future.

- We believe that CMS should expand the definition of "IHS Tribal Clinics" to include non-profit clinics operating on Tribal lands and include them in the "four walls" exception.

As CMS implements this requirement, we recommend they assess the impacts of this proposal to state and federal budgets, particularly because this policy is designed to increase provider payment rates. As CMS makes annual revisions to the Medicaid Managed Care Rate Development Guide, we recommend acknowledging that states may have to adjust rates initially and mid-year to account for this new authorization in order to remain compliant with statutory requirements for actuarial soundness.

Creating a Minimum Standard for Hospital Obstetrical Services

We appreciate CMS' commitment to maternal health in proposing new standards for Hospitals and Critical Access Hospitals (CAHs) for obstetrical services, including quality initiatives, data reporting, minimum standards, and annual training. MHPA remains committed to improving the lives of pregnant and postpartum individuals by ensuring they receive high quality services. However, we are concerned that these rules will result in a large and unattainable financial burden for labor and delivery (L&D) units caring for the most vulnerable patients in geographic areas already seeing access challenges, especially units serving a high volume of Medicaid patients. These requirements have the potential to lead to result in the closure of some L&D units, further worsening access to maternal health for Medicaid enrollees. Hospitals in rural and underserved areas are likely to have less funding than other hospitals, meaning hospitals serving populations in rural areas may be penalized due to these new requirements.

We recommend that CMS focus on alternatives to address the maternal health crisis, such as implementing value-based payments to reward quality, supporting facilities with additional programs and resources for capacity improvement, providing loan reimbursement programs or grants to expand obstetric care teams in rural or underserved areas, promoting alternative delivery sites like birthing centers for low-risk pregnancies, and incorporating midwives, doulas, and other perinatal personnel into obstetric care programs.

Should CMS choose to finalize these requirements regardless of public feedback, we recommend providing clear definitions for criteria in the rule, such as defining training that is "suboptimal" and "well

mhpa Medicaid Health Plans of America

organized" services. Further, we recommend the development of guidance for maternity providers that may not have specified maternity training noted in the proposed rule (Nurse Practitioners and Physician Assistants without specific additional maternity training specific to the location of care they are supporting; direct entry midwives without formal educational training). Finally, we are concerned about the lack of solutions addressing racial/ethnic inequities in maternal and neonatal outcomes, and recommend CMS integrate health equity into their standards.

Once again, thank you for the opportunity to provide comments on the CY 2025 OPPS Proposed Rule (CMS-1809-P). Supporting access to care and services for Medicaid beneficiaries is of paramount importance to MHPA. We appreciate the opportunity to share our perspective to address access challenges and barriers and look forward to continuing to work with CMS and our state partners to make a meaningful difference in the lives of Medicaid beneficiaries.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Senior Vice President, Government Relations and Advocacy