



Request for Information on Healthcare Access, Provider Experience, Health Equity, and Public Health Emergency Flexibilities

Topic 1: Accessing Healthcare and Related Challenges

Inadequate payment rates and ill-conceived utilization management efforts from Medicare, Medi-Cal, and the Children's Health Insurance Plan (CHIP) have long been presented as barriers to access. Unfortunately, and contrary to this administration's stated goals to reduce health outcome disparities, inadequate payment, and administrative barriers to access most impact those at greatest risk of experiencing negative health outcome disparities across all settings of care.

Access to Hospital Services: General Comments

One must only look at the recently announced closure of Atlanta Medical Center to see the deleterious impact of inadequate governmental payments on access in underserved areas. Kaufman Hall¹ estimates that even after federal support, California's hospitals lost more than \$12 billion in 2020 and 2021. As a result of COVID-19 and inadequate Medicare payment updates, 51% of California's hospitals had negative margins in 2021. These margins are unsustainable and jeopardize the stability of the hospitals that are essential to ensuring access to care for all who need it. If negative margins persist, hospitals will be forced to discontinue services needed by the community but that are financially unsustainable or cease all operations outright. To that end, CHA is aware of several California safety-net hospitals that are experiencing severe financial distress. Without a material improvement in revenue, they will be forced to discontinue operations.

CHA respectfully asks the Centers for Medicare and Medicaid Services (CMS) to use alternative sources of data that better reflect input price inflation to calculate the hospital market basket updates. Additionally, we respectfully ask CMS to use its existing authority to eliminate the productivity adjustment from the market basket update calculation for any year impacted by the COVID-19 public health emergency (PHE). Longer term, we ask the agency to work with Congress to repeal the productivity adjustment. CMS has acknowledged that hospitals are unable to achieve the productivity gains assumed by the general economy over the long run.² For additional details on these recommendations, please see CHA's comments³ on the federal fiscal year (FFY) 2023 inpatient prospective payment system (IPPS) proposed rule.

¹ www.kaufmanhall.com/sites/default/files/2022-04/KH_CHA-2021-Financial-Analysis-Ebook.pdf

² www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf

³ www.calhospital.org/cha-issues-draft-comments-on-ffy-2023-ipps-proposed-rule/

Access to Hospital Services: Rural Areas

Individuals under age 65 who live in rural areas are more likely to be uninsured than residents of urban areas. Approximately 12.3% of people in completely rural counties lacked health insurance compared to 10.1% for mostly urban counties.⁴ Further, those who are insured are less likely to have coverage through a commercial health plan. This is due in part to lower labor-force participation and greater employment in jobs that do not offer insurance.⁵ High rates of uninsured and coverage by governmental payers as part of a hospital's payer mix are frequently cited as key drivers of rural hospital closure.⁶ These demographics and socioeconomic factors drive the need for innovative models like the rural emergency hospital (REH) model to maintain access to high-quality health care in rural communities. Unfortunately, there are many issues with the REH model that CMS has not sufficiently addressed. This creates uncertainty about whether the model is financially sustainable, which limits interest in the model.

CHA again^{7,8} respectfully asks CMS to confirm that critical access hospitals (CAHs) that convert to an REH will still be able to use "Method II" to bill and receive payment for physician services provided at the REH. Additionally, we ask CMS to confirm that provider-based rural health clinics that meet the requirements under Section 130 of the Consolidated Appropriations Act will retain their grandfathered status after the hospital converts to an REH provider type. Without the retention of these important provider payment methodologies, CHA is concerned that converting to an REH will limit access to health care services instead of creating a sustainable platform from which to expand access.

Finally, CMS has not addressed an REH's eligibility for certain Medicaid safety-net payments. In California, the Medi-Cal global payment, federal disproportionate share hospital (DSH), and private DSH replacement programs play a vital role in ensuring the financial sustainability of hospital-based health care services in rural areas. CHA asks CMS to clarify that nothing in the REH regulations prevents these hospitals from receiving these crucial payments that support safety-net hospitals. If these payments are not preserved, it is unlikely that rural hospitals in California will be able to take advantage of the REH model to ensure access to services.

Beyond the new REH model, there are long-standing administrative barriers that continue to pose barriers to access to care in critical access hospitals. CAHs must maintain an annual average length of stay of 96 hours as a condition of participation in the Medicare program, yet some may offer certain critical medical services that have standard lengths of stay greater than 96 hours. In recent years, CMS enforced a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. This additional step and limitation drive CAHs to eliminate "96-hour-plus" services, reducing local access in rural areas and forcing patients to travel longer distances for care. CHA appreciates CMS' recognition that this condition of payment could stand in the way of promoting essential, and often lifesaving, health care services to rural America and we continue to recommend that CMS issue a permanent enforcement moratorium on the 96-hour condition of payment.

Access to Physician Services: General Comments

The situation for physicians is similar. Medicare payment updates to physicians have lost half of their value on an inflation-adjusted basis over the last 30 years. In 1994, the conversion factor was \$32.90. If

⁴ www.census.gov/library/stories/2019/04/health-insurance-rural-america.html

⁵ www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf

⁶ www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/

⁷ <https://calhospital.org/cha-issues-draft-comments-on-opps-proposed-rule/>

⁸ <https://calhospital.org/cha-comments-on-cy-2022-opps-proposed-rule/>

inflation-adjusted using the consumer price index, the conversion factor in today's dollars would be worth \$66.69. Instead, the proposed calendar year 2023 conversion factor is \$33.0775, which implies that it has lost half its purchasing power despite the increased compliance costs of running a practice (e.g., implementing and maintaining an electronic medical record, and reporting quality measures). In the short term, CHA asks CMS to work with Congress to address significant payment reductions to the proposed conversion factor and physician payments. Longer term, we ask the agency to work with Congress to develop and pass legislation that provides a sustainable conversion factor. This will ensure that all Medicare beneficiaries — particularly dually eligible beneficiaries — are able to access physician services in a timely manner.

Research related to primary care access for new Medi-Cal beneficiaries⁹ in eight Northern California counties spanning rural, urban, and suburban areas shows that appointment wait times are longer than those mandated by state regulations. Median wait times for a scheduled appointment with any available primary care physician by county could be as high as 32.5 days. Across the region, on average, only 34% of primary care clinics contacted had any appointment available, and only 19% had an appointment within the state-required 10 business days. Further, counties with reduced access to primary care also had higher emergency department usage by Medi-Cal enrollees.¹⁰

Given inadequate Medicare and Medi-Cal physician payment rates, hospital-based outpatient departments (HOPDs) provide services that are not otherwise available for vulnerable patient populations. For example, relative to Medicare beneficiaries seen in physician offices, beneficiaries seen in HOPDs are:¹¹

- 1.6 times more likely to be disabled, suffer from end-stage renal disease, or amyotrophic lateral sclerosis
- 1.8 times more likely to be dually eligible for Medicare and Medicaid
- 1.5 times more likely to be Black or Hispanic

Despite the crucial role that HOPDs play in providing access to individuals at higher risk of suffering inequitable outcomes, CMS has implemented site-neutral payment policies that make sustaining and/or expanding these much-needed services more precarious. As an example, one CHA member would like to expand an existing HOPD-based partial hospitalization program (PHP) program to a new, off-campus location to provide desperately needed mental health services and substance use disorder treatment to Medicare beneficiaries. However, given that this new location would be paid as a community mental health center (instead of at the HOPD PHP rate), the clinic is currently not financially sustainable due to CMS' site-neutral payment policies.

CMS takes a tentative step in the 2023 outpatient prospective payment system rule to ensure access for vulnerable populations in its proposal to exempt rural sole community hospital (SCH) off-campus, provider-based outpatient departments (PBDs) from the agency's site-neutral payment policy. While CHA supports this proposal, we encourage CMS to expand this to all rural hospitals and all safety-net hospitals (defined as eligible for Medicare disproportionate share payments).

⁹ CHA believes that access data for Medicaid beneficiaries is a reasonable proxy for both dually eligible Medicare beneficiaries and other individuals experiencing socioeconomic challenges accessing care.

¹⁰ www.annfam.org/content/annalsfm/18/3/210.full.pdf

¹¹ www.aha.org/system/files/media/file/2019/09/fact-sheet-site-neutral-0919.pdf

Based on documented improvements in access after the Affordable Care Act's temporary increase in Medicaid payment rates for primary care went into effect, CHA believes exempting safety-net providers from the site-neutral payment policy will reduce wait times for Medicare beneficiaries (particularly those who are dually eligible and most vulnerable). Research from 10 states (not including California) found that after the temporary increase in Medicaid primary care payments, there was a 7.7% increase in appointment availability and a decrease in median wait times for an appointment of six days.¹² The states with the largest increases in availability tended to be the ones with the largest increases in Medicaid payment for primary care services. Given the well-established link between payment levels and wait times, we believe expanding the exemption to the site-neutral payment policy would be a meaningful step toward realizing this administration's goal of increasing access to primary care for dually eligible Medicare beneficiaries and disadvantaged populations, thus reducing inequitable outcomes.

Related to PHPs, CHA asks that even after the COVID-19 PHE ends, CMS continues waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623 and the PBD requirements at 42 CFR §413.65. This would allow provider-based PHP to establish and operate, as part of the hospital, any location meeting the conditions of participation that continue to apply. Further, we ask that CMS continues to allow exempted, provider-based PHPs to relocate part of their exempted provider-based PHP to a new off-campus location while maintaining the original location. We believe providing this flexibility under the opioid PHE is necessary to ensure there is sufficient access to provide outpatient substance use disorder treatment and intensive mental health care services to all Medicare beneficiaries who need them.

Post-Acute Care: Medicare Advantage (MA) and Dual Special Needs Plan (D-SNP) Members

When Medicare — particularly dually eligible — beneficiaries require post-acute care (PAC), unnecessary delays in the prior authorization (PA) process negatively impact patient outcomes. These delays are driven by delayed responses to PA requests. Hospital case managers report difficulty reaching health plan personnel, lengthy hold times, no return calls, and other delays in responses to requests for PA. While hospitals care for patients 24/7, many plans do not have staff available to provide PA during weekends. Requests made from midday Friday until Monday are frequently not resolved until the following Tuesday, resulting in a spike in avoidable days.

Providers also report that plans make frequent and multiple requests for information and/or delay direct contact for additional discussion or review. These delayed determinations are often significant enough that the clinical condition changes and the discharge plan must be adjusted. Too often, for patients who need the more specialized treatment available in PAC settings, access delayed is access denied.

Additionally, CHA members report that some MA plans have limited understanding or knowledge of Medicare fee-for-service (FFS) benefits and criteria, leading to inappropriate denials. Many also report that when they pursue a peer-to-peer discussion of the request, the majority of the initial denials are reversed, calling into question the validity of the original determination. These observations were validated by a 2018 U.S. Health and Human Services Office of Inspector General report¹³ that found Medicare Advantage Organizations (MAOs) overturned 75% of their own denials. Often, these denials are related to PA requests for PAC services, particularly when a beneficiary needs access to hospital-level PAC settings such as admission to an inpatient rehabilitation facility or long-term care hospital.

¹² <https://pubmed.ncbi.nlm.nih.gov/25607243/>

¹³ <https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp>

California hospitals experienced these issues while working to better coordinate care for their dually eligible patients under CMS' financial alignment initiative, which was established in several counties, and enrolled these beneficiaries into Cal MediConnect plans for management of their Medicare and Medicaid benefits. During the demonstration, CHA members reported frequent instances when Cal MediConnect plans demonstrated a limited understanding of covered Medicare services and regulations, resulting in denied access to medically necessary care for vulnerable dually eligible patients. Addressing these access challenges is important for all MA plans. However, this need is heightened for D-SNPs, where the enrollees may be disproportionately impacted by these practices. In the aggregate, dually eligible beneficiaries have more chronic conditions and fewer resources than non-dual MA enrollees and may have a harder time challenging care denials or seeking alternatives. As a result, these beneficiaries are both more susceptible to inappropriate determinations and violations of MA policy. As California increasingly enrolls more older adults and persons with disabilities into MA plans and D-SNPs, it is imperative that MAOs ensure their enrollees maintain access to the same benefits available to Medicare FFS beneficiaries.

CHA encourages CMS to closely monitor the number of denials that are overturned at any stage of the appeals process as an indicator that MA plans (or their staff) do not have a comprehensive understanding of the benefits the member is entitled to and the criteria for those benefits. Further, we ask CMS to make these data publicly available on a CMS website so that beneficiaries can incorporate rates of overturned denials into their decision-making process when they are enrolling in an MA plan.

Beyond ensuring that MA plans continually demonstrate knowledge of the medical services Medicare beneficiaries are entitled to, we respectfully recommend that CMS implement a more robust appeals process for MA beneficiaries. This will allow MA members (or providers and/or hospitals working on their behalf) to access the medically necessary care they are entitled to when it has been wrongfully denied to them by an MA plan. CHA believes that, at a minimum, a robust appeals process should include access to real-time assistance from the plan to resolve concerns. This is crucial as it relates to time-sensitive, medically necessary services where delaying care will have detrimental effects on the quality of the patient's outcome. At a minimum, this could be similar to the current "important message from Medicare" process for appealing discharge decisions via a Quality Improvement Organization.

For D-SNPs, CHA believes they must establish a unified appeals process. Moreover, CHA urges CMS to establish additional requirements to streamline the PA process, including requirements for timely responses to requests for PA, particularly for services related to post-hospital care. We recommend that MA plans — including D-SNP plans — be required to respond to PA requests for services necessary for hospital discharge within a specified time frame. We encourage CMS to align specified time frames with state requirements for managed care contracts. For example, California's Department of Managed Health Care (DMHC) has established time frames for medical authorization, such as 30 minutes for post-stabilization services, five working days or fewer for concurrent review of authorization for a treatment regimen already in place, and 14 days for routine authorizations. DMHC also requires expedited authorization decisions within 72 hours when the patient's provider determines that following the standard time frame for PAs could seriously jeopardize the patient's life, health, or ability to attain, maintain, or regain maximum function. Aligning MA and D-SNP PA requirements would reduce the burden and confusion for patients and providers alike.

Medi-Cal Beneficiaries: General Comments

In California, the Medicaid program (Medi-Cal) provides important health coverage to one in three Californians, more than 40% of children, more than 50% of disabled people, and more than 1 million seniors. Together, Medi-Cal provides services to more than 15 million of California's most vulnerable populations. It serves as the largest part of California's safety-net program and is vital to California's overall health delivery system, providing coverage and financing for 50% of the state's births, and for 50% of the residents in many rural areas of the state.

We continue to have concerns that payment adequacy and administrative barriers are limiting access to high-quality services for Medi-Cal beneficiaries. Numerous studies have recognized a high correlation between the adequacy of Medicaid payments and access to quality care. For instance, the Medicaid and CHIP Payment and Access Commission¹⁴ recently found that higher Medicaid payments continue to be associated with higher rates of accepting Medicaid patients. This is consistent with prior research,¹⁵ which has similarly found that low Medicaid payments — relative to other payers — are consistently shown an important factor in a provider's decision to participate in Medicaid.

California has 24 managed care organizations (MCO), 58 counties and more than 400 hospitals that historically have received supplemental Medicaid managed care payments. Due to California's geography, it is impossible for every county to have specialty or tertiary services in close proximity. Therefore, patients in need of critical care are commonly transferred to a hospital several counties away. In certain counties, Medi-Cal managed care is operated by a single County Organized Health System health plan. Other counties utilize a Two-Plan model in which there are two managed care plans, and still others operate under a Geographic Managed Care model that involves a plurality of plans. As a result of this framework, two contiguous counties could — and often do — have vastly different models for delivering managed health care to the Medi-Cal population. Additionally, while the delivery system may appear to be consistent between counties, there are specific nuances between each county and model type related to which populations are enrolled in managed care and which services are covered by the plan.¹⁶ Therefore, the foundation for managed care contracting cannot be universally applied as a "one contract fits all" scenario. Contracts are highly regionalized — sometimes by arbitrary county-line boundaries, but often by the natural delineation of regions by geographic occurrence such as mountain ranges, expansive desert areas, rivers, or hundreds of miles between urban areas. The areas within California are not homogenous; instead, they require care delivery that meets each unique community's diverse needs. Assuming that these diverse models can be viewed as an overall singular system of care creates complexity and concern as we continue to find ways to implement the rule's provisions.

In this context, supplemental managed Medicare payments are an important component of the total payment that limits hospital losses on Medi-Cal patients and ensures continued access to high-quality care for those most at risk of inequitable outcomes. However, requiring hospitals to be network providers for the purposes of receiving supplemental payments for care already provided to a Medi-Cal beneficiary creates an inappropriate advantage for MCOs in contract negotiations and leads to unintended consequences that constrain access.

¹⁴ See MACPAC, *Physician Acceptance of New Medicaid Patients* (Jan. 24, 2019), available at: www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf

¹⁵ See e.g., Peter J. Cunningham & Len M. Nichols, *The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*, Medical Care Research and Review, Vol. 62, No. 6 (December 2005) (finding that low physician participation in Medicaid has been shown to negatively affect enrollee access to medical care.)

¹⁶ Centers for Medicare & Medicaid Services, *Medi-Cal 2020 Waiver, Waiver Number 11-W-00193/9, Attachment N, Amended April 5, 2018*. Accessed January 10, 2019, at www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCsAmended060718.pdf.

For example, plans may impose additional requirements on hospitals by contract. In some instances, plans have tried to limit the scope of services payable under their contracts with providers by defining “medical necessity,” “covered services,” or “emergency services” in a manner more limited than is permitted by DHCS. Plans also often impose unrealistic billing or other one-sided terms in contracts or insist upon rates that are far below the average Medi-Cal reimbursement amounts. Further, populations travel throughout the state; it is unrealistic to assume the Medi-Cal enrollee will only need access to emergency services in his or her managed care contracted service area.

This dynamic gives Medi-Cal managed care plans all the leverage in contract negotiations with hospitals because hospitals must have a contract in place to receive the directed payment. And in some instances, these Medi-Cal managed care plans have used this leverage to extract favorable pricing and contract term concessions from hospitals for the plans’ products in other lines of business. Health plans’ abuse of this leverage harms underserved individuals in two ways. First, it directly reduces coverage and payment for medically necessary services to Medi-Cal members, which reduces access to care for individuals who are at greater risk of experiencing inequitable outcomes. Second, it allows Medi-Cal managed care plans to artificially reduce payment to safety-net hospitals in their other lines of business, which exacerbates the considerable financial challenges facing these facilities. This only heightens the risk that these facilities will eliminate unprofitable services to remain open (or close altogether), further reducing access for underserved individuals.

We believe strongly that, due to the complexity of California’s geography and diverse health care system, CMS should utilize its discretionary authority to recognize the need for flexibility. We urge CMS to expand flexibility to include patients receiving emergency care as well as those transferred to other hospitals for medical reasons. This will create an equitable contracting dynamic between Medi-Cal managed care plans and the state’s hospitals, which will ensure coverage of and access to the full complement of services covered by Medi-Cal for individuals at risk of inequitable outcomes.

Beyond payment adequacy, certain administrative practices by Medi-Cal MCOs limit access to PAC for underserved individuals. Frequently, plans impose care management and coordination responsibilities on providers that should be handled by the health plan. For example, hospitals frequently must find in-network PAC providers who are accepting new Medi-Cal beneficiaries when they are ready to be discharged to the next appropriate setting of care. In this example, the plan provides little to no assistance in finding a post-acute provider with available beds and they do not provide payment for the administrative days incurred due to their lack of case management capabilities. This harms underserved individuals as it delays their transition to the next setting of care, which is crucial to their recovery. We strongly recommend that CMS requires states (and their managed care plan contractors) to pay for administrative days that result from delays in finding an appropriate PAC site for Medi-Cal beneficiaries. We believe this payment will incentivize the states and their managed care contractors to invest in sufficient care coordination resources.

Topic 2: Understanding Provider Experiences

Provider well-being and the challenges of a strained workforce have long been of concern to hospitals. In 2019, the National Academies of Medicine reported that burnout had reached “crisis” levels, with up to 54% of nurses and physicians, and up to 60% of medical students and residents, suffering from burnout. The COVID-19 pandemic has placed additional pressure on our caregivers, leading to an increase in

retirements and career changes that threaten to deplete an already burdened workforce and create additional access challenges for patients.

Numerous studies have demonstrated the impact of the COVID-19 PHE on physician and nurse burnout. In the earliest days of the pandemic, the health care workforce was severely challenged by limited resources, longer shifts, disruptions to sleep and to work-life balance, and occupational hazards associated with exposure to COVID-19, which contributed to increasing levels of physical and mental fatigue. Extreme levels of stress and anxiety were found across care settings, whether it be overwhelmed emergency department physicians, intensive care unit nurses afraid to bring home a COVID-19 infection to their families, or physicians under financial stress due to the cancellation of non-urgent procedures. It is estimated that in 2021, 333,942 health care providers dropped out of the workforce, citing burnout and other stressors related to the pandemic.

While rates of patients hospitalized with COVID-19 have decreased from the peak, health care workers continue to experience significant challenges. Capacity continues to be a concern in hospitals, with sicker patients who may have delayed care during the height of the pandemic. This is exacerbated as many hospitals have been forced to shutter services or reduce capacity due to inadequate staffing levels. Violence against health care workers is increasing, especially in emergency departments, where increasing numbers of individuals with mental health and substance use disorders await transfer to more appropriate levels of care. And staff turnover challenges those who remain on the job, as many hospitals must still rely on temporary nursing staff to meet demand, requiring a constant cycle of training by more experienced nurses. Staff shortages are only being exacerbated by these cycles — a report published in December 2021 surveyed a broad group of medical professionals and found that one in five doctors said they planned to leave the profession within the next two years, with even more planning to reduce the number of hours they work. Similarly, a survey from March 2022 found that more than a third of nurses plan to leave their current job by the end of the year.

CHA looks forward to the implementation of the Dr. Lorna Breen Health Care Provider Protection Act, which will provide grants and resources for programs that offer behavioral health services for front-line health care workers. The legislation also requires the Department of Health and Human Services to recommend strategies to facilitate health care provider well-being and launch a campaign encouraging health care workers to seek assistance when needed.

However, as noted earlier, provider burnout has been a concern even prior to the pandemic. Providers have long pointed to ever-increasing administrative tasks that keep them from direct-patient care as a major factor contributing to burnout. This includes certain documentation requirements, as well as proliferating data entry requirements for electronic health record systems. Another significant contributor to provider burnout is increasing PA requirements from insurers. For example, 79% of physician practices report PA requirements increased in the past 12 months.¹⁷ These requirements can delay and divert resources from patient care and frustrate physicians by complicating medical decision-making.

Topic 3: Advancing Health Equity

CHA shares CMS' ongoing commitment to addressing health equity, and we applaud the agency's continued prioritization of policies that work toward these goals. Hospitals continue to work with

¹⁷ www.mgma.com/data/data-stories/virtually-all-medical-groups-say-payer-prior-autho

organizations in their communities to eliminate health disparities. Disparate health outcomes for minorities, people experiencing homelessness, and other subsets of California's population are the result of historic and systemic inequalities that persist today, and it has risen to the level of a public health crisis in California. Unequal access to health care and health resources, as well as unequal and damaging environmental conditions due to race, socioeconomic status, and other factors are untenable in a just and healthy society.

Ensuring every Californian receives equitable, high-quality care requires long-term, systemic solutions. Research by the California Health Care Foundation has shown that Black Californians have the highest rates of new prostate, colorectal, and lung cancer cases, and the highest death rates for breast, colorectal, lung, and prostate cancer. In addition, about one in five Hispanic Californians report not having a usual source of care and difficulty finding a specialist. Californians who are Native American and Alaska Native, as well as Native Hawaiian and Pacific Islander, are less likely to report having a checkup within the past year than other racial/ethnic groups.

California's hospitals are on the front lines of mitigating health inequities. Within their communities, hospitals examine and address the social determinants of health — things like housing instability, access to healthy foods, and community violence — that significantly affect health risks and outcomes. And they continually work to improve the experience and outcomes for everyone in their care through a variety of initiatives, including a statewide maternal health quality collaborative; data collection and analysis on race, ethnicity, language preference, and other sociodemographic data; cultural competency training; increasing diversity in leadership and governance; and improving and strengthening community partnerships. But hospitals alone cannot eliminate health disparities. It will take systemic reform, paired with broad partnerships across all segments of California's communities, to break from the status quo.

As noted earlier in our comments, inadequate payment rates from Medicare and Medi-Cal are significant barriers to patient access, and access is most challenged in underserved areas of the state. These factors drive health disparities, as financially challenged safety-net hospitals may be required to reduce services or cease operations altogether, in communities with some of the most vulnerable populations. We refer CMS to our comments on Section 1 of this RFI that describe how inadequate and stagnant payment rates, along with policies such as site-neutral payment, impact hospitals and physicians' ability to provide care in underserved communities.

A key factor in advancing health equity is measuring disparities in outcomes and quality of care. To that end, CHA appreciates that CMS has focused on these topics in recent rulemaking. For example, in response to the FFY 2023 IPPS proposed rule, CHA supported the agency's thoughtful approach to measuring disparities across quality reporting programs. CHA agrees that providing information to hospitals and other health care providers on disparities in their quality data — including providing measure reports stratified by race, ethnicity, dually eligible status, or other factors — will be helpful in identifying where hospitals should focus their health equity improvement strategies. We also agree that both "within-provider" and "across-provider" reports are necessary to provide hospitals with the full picture of where health equity gaps within their facility and the broader community exist.

We also appreciate that CMS stated an intention to prioritize existing clinical quality measures with sufficient sample size and evidence of underlying disparities in treatment or outcomes for stratified measure reporting. While stratified measure reporting is useful, it may not be appropriate for every measure given the very small cell sizes that can result, and in the FFY 2023 IPPS proposed rule, CMS

outlined a set of principles that will help to ensure hospitals can focus their disparity reduction strategies in areas where they have the most quality improvement experience.

As CMS further considers its principles for social risk factors and demographic data, we urge the agency to consider how it can support hospitals and other providers in improving the collection of patient self-reported social risk factors and demographic data. Hospitals will soon begin reporting on new equity-focused quality measures under the inpatient quality reporting program, including a measure that assesses hospitals' commitment to health equity and measures related to screening patients for health-related social needs. It is important to ensure that these data are collected and reported in ways that will allow for comparison within and across hospitals in the future. We urge CMS to work closely with stakeholders to understand and promote best practices for the collection of self-reported patient demographic and social risk information.

California is also working to address health equity through its Medicaid program, known as Medi-Cal. The state is currently implementing an expansive set of reforms to expand, transform, and streamline Medi-Cal service delivery and financing, known as California Advancing and Innovating Medi-Cal (CalAIM). If successful, CalAIM will improve care coordination and delivery, particularly for Medi-Cal's most vulnerable beneficiaries. In doing so, CalAIM has the potential to have a significant positive impact on health equity.

Key components of CalAIM that relate to health equity include:

- Implementation of a statewide population health management program to identify beneficiaries' medical and nonmedical risks and needs and facilitate care coordination and referrals
- Establishment of an enhanced care management benefit to provide intensive case management and care coordination for the program's highest risk and need beneficiaries
- Provision of in lieu of services such as housing supports, medically tailored meals, recuperative care, and others to help address beneficiaries' social drivers of health and nonmedical needs
- Reforms to behavioral health services to improve access and integration, including seeking a waiver on the federal prohibition on funding for institutions for mental disease

CalAIM represents a major effort to improve health equity in California. We recommend CMS closely monitors CalAIM implementation to gain lessons learned from the reform effort and identify equity-related initiatives that might be scaled nationally and/or across health care programs. Questions to ask as CMS monitors CalAIM implementation could include:

- What kinds of enhanced oversight of Medicaid managed care plans could ensure they are successful in arranging and paying for enhanced care management and in lieu of services?
- How can providers be better utilized alongside community-based organizations for the purposes of intensive care coordination and the provision of nonmedical benefits?
- How does the voluntary nature of the in lieu of services provision, and their associated variation across the managed care plans, square with other programmatic imperatives such as the standardization of benefits?

Topic 4: Impact of the COVID-19 PHE Waivers and Flexibilities

Since the beginning of the COVID-19 PHE, the flexibilities provided by the federal government via regulatory waivers and congressional action have been essential to hospitals' ability to respond quickly and effectively to surging demand during uncertain times. Hospitals and health systems utilized these

newly authorized flexibilities to increase capacity, create separate areas of care for COVID-19 and non-COVID-19 patients, expand testing and telehealth capabilities, and mitigate workforce shortages.

As the pandemic enters a new phase, hospitals remain under considerable financial and operational strain and are focused on recovery and rebuilding, while continuing to provide high-quality care in their communities. Though the number of COVID-19 patients in hospitals has decreased, our members continue to report challenges with capacity and are preparing for potential winter surges with more contagious COVID-19 variants and flu season coinciding. With the timing of the end of the PHE uncertain (currently in place until Jan. 11, 2023), hospitals need certainty that they can continue to rely on flexibilities that support increased capacity. Further, as hospitals adapted and innovated under these waivers while responding to the pandemic, it is important to consider making certain flexibilities permanent.

We recognize that CMS is limited in its authority to continue waivers and flexibilities beyond the PHE. However, we urge the agency to work with Congress and recognize the immediate and potential long-term benefits of these flexibilities by making certain flexibilities permanent while supporting a post-COVID-19 PHE transition period for others.

Telehealth

CHA strongly supports expanded access to telehealth services, which have been proven to improve access to care and reduce barriers for some of our most vulnerable populations — including addressing health disparities experienced by people of color, as well as those living in rural and underserved communities — during the COVID-19 PHE. The regulatory flexibilities provided in response to the PHE have allowed hospitals to operationalize telehealth and other virtual services not as simply a replacement for in-person care, but as a new tool for improving care delivery. CHA appreciates that Congress has already recognized the need for a glide path to ending waivers related to telehealth by authorizing an additional 151 days of flexibilities beyond the duration of the PHE; however, we support making the following flexibilities permanent to ensure continued innovation through virtual care:

- Eliminate the originating and geographic site restrictions for all telehealth services
- Allow rural health clinics and federally qualified health centers to continue to serve as distant sites for all telehealth services beyond mental health services
- Expand telehealth eligibility to certain practitioners, such as respiratory, physical, occupational, and speech-language therapists
- Allow providers to deliver all Medicare telehealth services (beyond mental health services) via audio-only communications when medically appropriate
- Allow hospice and home health professionals to deliver telehealth services and qualify telehealth, including audio-only, visits to meet existing face-to-face requirements
- Allow direct supervision through telecommunications technology for specified services
- Allow HOPDs and CAHs to bill for telehealth services; or, alternatively, clarify the Health and Human Services Secretary's authority to enable hospitals to bill for outpatient psychiatry programs and other outpatient therapy services delivered through remote connection
- Allow hospitals to bill the originating site fee when hospital-based clinicians provide telehealth services to patients at home who would normally receive services at an HOPD
- Ensure remote patient monitoring is treated similarly to other existing telehealth flexibilities in terms of coverage
- Eliminate the current separate consent process for telehealth services and use the telehealth encounter as presumed consent

- Grant an exception for practitioners in states that have medical licensing reciprocity requirements to file separate Drug Enforcement Agency registration in any state where a provider practices to ensure appropriate prescribing for patients through telehealth services

Hospital Without Walls

During the PHE, CMS authorized several flexibilities that allowed hospitals to provide care beyond the traditional walls of the hospital. This has included the use of temporary expansion sites, which allowed hospitals to create surge capacity by allowing them to provide room and board, nursing, and other hospital services at remote locations, including the home of the patient in certain circumstances. These flexibilities have also allowed hospitals to screen patients outside of the emergency department, increasing capacity for those who need emergent care. We urge CMS to work with Congress to ensure that there is a glide path to ending these waivers after the termination of the PHE to ensure hospitals can maintain capacity in the event of a surge in demand due to COVID-19, the flu, respiratory syncytial virus (RSV), or other diseases. We also urge the agency to ensure that in the event of future PHEs, blanket waivers that increase capacity are issued swiftly.

The Acute Hospital Care at Home waiver has provided another opportunity for hospitals to innovate care for patients beyond the traditional walls of the hospital. The program has proven to be successful for both patients and hospitals and health systems by allowing for increased capacity while keeping patients safely in their own homes. We strongly support the Hospital Inpatient Services and Modernization Act, which would extend this important program for two years beyond the expiration date of the COVID-19 PHE. This would provide a necessary bridge for the development and implementation of a permanent hospital-at-home program.

CHA also supports permanently eliminating policy barriers that arbitrarily keep patients in the hospital when they could be placed in a more appropriate setting of care. Specifically, for the duration of the COVID-19 PHE, CMS has waived the requirement that Medicare beneficiaries have a three-day hospital stay prior to admission in a skilled-nursing facility. This would be done so that hospital capacity could be maintained for patients with COVID-19 and other conditions that require hospitalization. While we strongly support congressional action to repeal this statutory requirement, we also encourage CMS to consider applying this waiver beyond the PHE when hospitals experience capacity issues due to a surge in demand and workforce shortages.

Workforce

CHA supports making permanent policies that eliminate practice limitations that are more restrictive under CMS rules than under state licensure and permanently removing certain licensure requirements to allow out-of-state providers to perform telehealth services. CHA also urges CMS and Congress to support training the next generation of physicians by extending cap-building periods for new graduate medical education programs to account for COVID-19-related challenges, such as recruitment, resource availability, and program operations.