NAMD
National Association of Medicaid Directors

September 9, 2024

Chiquita Brooks-LaSure
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is writing in response to the Centers for Medicare and Medicaid Services' (CMS) proposed rule, 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 [CMS-1809-P].

NAMD is supportive of the proposed exceptions to the "four walls" requirement for Medicaid clinic services. These exceptions would help increase access to care for Tribal members, individuals living in rural communities, and individuals with mental health or substance use conditions. NAMD is also supportive of the proposed changes to streamline Medicare coverage for individuals reentering from incarceration. These changes align with Medicaid agencies' efforts to improve outcomes during reentry.

NAMD is a professional community of state and territory leaders who provide health insurance to more than 80 million individuals and families through Medicaid and the Children's Health Insurance Program (CHIP) in each of the 50 states, the District of Columbia and the U.S. territories. NAMD elevates thought leadership on core and emerging policy matters, amplifies the experience and expertise of Medicaid and CHIP directors, supports state programs in continuous improvement and innovation, and optimizes federal-state partnerships to help millions live their healthiest lives.

Medicaid Clinic Services Four Walls Exceptions

Under 42 C.F.R. § 440.90(a), Medicaid clinic services are required to be physically provided at the clinic – or within the "four walls" of the clinic facility – with an exception for services provided outside of the clinic to people who are experiencing homelessness. Under CMS's current policy, there is a grace period (currently set to end

in February 2025) for Indian Health Service (IHS) and Tribal facilities; during this time, IHS and Tribal clinics can continue to claim Medicaid reimbursement for services delivered outside the four walls of the facility.

In this rule, CMS proposes three new exceptions to the four walls requirement. As of the effective date of the final rule, CMS would create a mandatory exception to the four walls requirement for IHS and Tribal clinics, and optional exceptions for behavioral health clinics and clinics located in rural areas.

NAMD is supportive of these proposed exceptions to the four walls requirement. The proposed exception for IHS and Tribal clinics would help increase access to care for Tribal members, as it would allow clinics to provide services to members within their homes and communities. Medicaid agencies report that this change would have a significant impact on access to services for older adults and for Tribal members who need transportation to clinics. More broadly, this change would support Medicaid agencies' efforts to reduce health disparities for American Indian and Alaska Native (AI/AN) individuals.

Some Medicaid agencies report that the proposed mandatory exception to the four walls requirement for IHS and Tribal clinics may have short-term budgetary impacts and necessitate changes, in collaboration with Tribal partners, to state plan services. For states that can demonstrate these impacts, CMS could consider an extended implementation timeline on a case-by-case basis.

NAMD is supportive of the proposed optional exceptions for behavioral health and rural clinics. Medicaid agencies report that the optional exception for behavioral health services would help increase access to community mental health and substance use care. For some individuals seeking behavioral health services, it is challenging to regularly travel to community mental health centers or other behavioral health clinics. This also creates sustainability challenges for clinic providers, who may be obligated to provide care to these patients but cannot currently receive Medicaid reimbursement for services delivered outside the four walls of the facility. The optional exception would give Medicaid agencies flexibility to reimburse for services provided outside of the clinic, significantly increasing access to care and improving continuity.

Similarly, the proposed optional exception for clinics in rural areas would help reduce barriers to care. Individuals in rural communities often travel long distances to access wellness visits, preventive services, and other essential health care. Enabling clinic reimbursement at locations outside of the facility would help increase access for these individuals.

CMS seeks comment on how they should define "rural" for the proposed four walls exception. **NAMD supports the fourth option, under which CMS would not specifically define "rural" in regulation and instead allow states/territories to**

choose any definition of rural that can be linked to the four criteria described in the proposed rule and that meets their program needs. This option would give Medicaid agencies the flexibility to use any definition of "rural" that best meets the unique geographical and service access needs of their state or territory. For example, one state with large frontier populations reports that they have a small city that cannot be accessed by road but is designated as urban by the Census Bureau. If CMS were to use the Census Bureau definition of "rural," individuals in this community could not access services outside the four walls of their primary care clinic, even though a high percentage of the population meets CMS's criteria for exceptions. If CMS does elect to use a federal agency definition of "rural," they should consider revising the behavioral health exception to include primary care clinics that provide behavioral health services, even if they are not "primarily organized for the care and treatment of outpatients with behavioral health disorders." This would help ensure that individuals in remote communities can access clinic services, even if they do not meet the federal definition of "rural."

Individuals Currently or Formerly in the Custody of Penal Authorities

In this rule, CMS proposes changes to streamline Medicare eligibility for individuals leaving correctional facilities. Specifically, CMS proposes to narrow the Medicare definition of "custody" to no longer include individuals who are on parole, probation, bail, or supervised release, and to change the "triggering event" for the Incarcerated Medicare Beneficiaries Special Enrollment Period (SEP) to streamline access to coverage.

NAMD strongly supports these proposed changes. As of August 2024, eleven states have approved Section 1115 waivers to provide Medicaid-covered services up to 90 days before release from incarceration, and another thirteen states have applied for Section 1115 waivers. However, some incarcerated individuals are eligible for Medicare, not Medicaid, or are dually eligible for both programs; as of 2022, 4.3% of individuals incarcerated in state or federal prisons and 1.7% of individuals held in local jails were ages 65 or older. This represents a significant increase in the percentage of incarcerated individuals who are older adults, a trend that is projected to continue as the United States' population ages. As Medicaid agencies work to improve health outcomes during the reentry period, it is crucial that other payers also take action. The changes proposed in this rule would support continuity of care by removing barriers to Medicare coverage during reentry.

Thank you for the opportunity to provide comments on this proposed rule. NAMD looks forward to continuing to work with CMS to improve access to care.

Sincerely,

Lisa Lee
NAMD Board President
Commissioner
Kentucky Department for Medicaid Services

Melisa Byrd
NAMD Board President Elect
Medicaid Director
DC Department of Health Care Finance