



Medicaid Network Adequacy (ACE Kids 2019-20)

Today. The ACE Kids bill did not create or expand Medicaid benefits or the set of providers eligible to provide services to Medicaid patients -- Medicaid programs are already required to cover care from out-of-state providers in specific circumstances, including when the patient needs care that is not available through in-state providers. There is a multi-part determination for out-of-state care: 1) the patient must need a specific item or service; 2) the care the patient requires is unavailable in-state or more readily available out-of-state; and 3) the out-of-state provider is enrolled or otherwise qualified to treat the patient and submit claims to the patient's state Medicaid program. Prior to the COVID-19 pandemic, states had wide variability on the burden associated with qualification of out-of-state providers, with some states requiring full enrollment processes that significantly burdened providers and created care delays due to review and approval processes. The regulatory flexibilities encouraged by CMS throughout the pandemic promoted a pragmatic approach – streamlined qualification of out-of-state providers based on enrollment in their home state Medicaid program or participation in Medicare.

Provider Burden and the Age 18 Restriction. Haystack's redline edits relate to the burden the provider has to contend with. The bill addresses this, but its ambiguous whether the provider enrolled under this provision is *only able to treat* "qualifying individuals." This would create a very odd situation where a hospital may be able to treat some Medicaid patients but not others, and there could even be confusion on whether a specific individual is a "qualifying individual." For example, a 20-year-old patient with a disorder that is childhood-onset would probably be a qualifying individual. What if they were not diagnosed until age 19 so that "onset" was not clearly documented? Essentially, any patient over age 18 that the provider had not treated before age 18 could present confusion. Given that the inherent purpose of out-of-state provider enrollment requirements is to ensure that Medicaid beneficiaries receive care from providers qualified to deliver that care, there does not appear to be a programmatic rationale for requiring a provider qualified to treat a 23-year-old with condition X and documented onset before age 18 to submit full documentation and enrollment materials to treat an individual of the same age and condition without clear onset before the age 18 cut-off. Importantly, the COVID PHE blanket waivers that are already permitting what this bill hopes to do – are doing it without this age distinction.

Solution. Removal of the age 18 restriction would be simplest. However, the redline attempts to work within the confines of the bill, and clarifies that once a provider is enrolled under this provision (i.e., treats a five year old patient, let's say), the provider will be able to treat any rare disease patient regardless of their age if that patient needs out of state care. In other words, once enrolled per the age barrier, they can treat anyone at any age, so long as the patient fits within parameters (detailed below) designed to address the narrow subset of patients for whom out-of-state care is clearly appropriate.

Patient Barrier. The bill does not address this second determination that is critical to getting the

Jim Caro
CEO
Haystack Project
Jim.caro@haystackproject.org

www.haystackproject.org



patient to the appropriate provider. Recent years have brought an increasing number of treatments for which FDA sets forth specific requirements, limited sets of facilities eligible to provide the treatment, etc., within REMS. Emerging treatments addressing very rare conditions are particularly likely to be available only in select Centers of Excellence. It is imperative that Medicaid beneficiaries are not denied access to needed treatments due to burdensome enrollment processes imposed on out-of-state care.

Solution. Haystack added a new section that sets out four criteria to identify the relatively narrow set of patients and circumstances for which out-of-state care may be the only treatment option. The criteria limit the types of patients that will be presumed to be entitled to out-of-state care to address scoring and plan concerns. Haystack urges the Congress to ensure that scoring is informed by actual experience throughout the COVID PHE, and based on cost increases, if any, due to the out-of-state nature of the care rather than to reflect savings accrued through lack of in-state providers able to deliver emerging, potentially life-saving therapies.

Technical Edit. Finally, just to make the bill operationally correct – not a policy issue – we edited a circular reference in the bill that makes the HHS determination difficult to operationalize. It basically requires HHS/CMS implementation before any provider can be enrolled under this bill b/c the HHS determination is one of the requirements.