FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

April 18, 2022

Dan Tsai
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP

Dear Deputy Administrator and Director Tsai:

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation — improvements that make a real difference in people's lives. In all of our work, we strive to elevate the interests of children and families in public policy to ensure that their health and well-being is foremost on the minds of policymakers. Thank you for putting out a Request for Information (2022) on Access to Coverage and Care in Medicaid & CHIP. We applaud the outstanding work by you and your staff to protect, strengthen and expand Medicaid and CHIP in a number of areas. We very much appreciate the agency's focus on Medicaid coverage as critical to advancing health equity for children and families.

Our comments follow the organizational structure set out in the RFI submission portal.

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

A. Automated enrollment: An uninsured person cannot receive Medicaid or CHIP until they learn about available assistance, figure out whether they are likely to qualify, complete application forms, and provide requested documentation. We do not impose these requirements on most people in our health care system, and this Medicaid/CHIP model often fails traditionally disadvantaged populations for whom challenging life conditions make administrative burdens particularly difficult to overcome. CMS should encourage state experimentation with automated enrollment, including through 1115 waivers. As noted by the Office of Management and Budget:

> "Research indicates that where there are administrative burdens, they do not fall equally on all entities and individuals, leading to disproportionate underutilization of critical services and programs, as well as unequal costs of access, often by the people and communities who need them the most. Burdens that seem minor when designing and implementing a program can have substantial negative effects for individuals already facing scarcity."

Benefit programs for seniors are structured very differently. Historically,[1] seniors were automatically enrolled into Medicare Part B coverage of physician and outpatient care when they turned 65, with premiums deducted automatically from Social Security checks. Seniors could opt-out of Part B, but very few did, while "everyone eligible receive[d] Part A no matter what." Eligibility for Medicare Part D low-income subsidies (LIS) is generally based on prior-year tax income.[2] However, if someone received Medicaid or Supplemental Security Income (SSI) in one calendar year, that person automatically qualifies for LIS the following year, without needing to submit a LIS application. That is true even in states where Medicaid eligibility is more generous than LIS eligibility. Federal and state agencies exchange data, identify seniors who qualify for LIS based on past receipt of Medicaid or SSI, and automatically enroll them into LIS. If they do not pick a Part D plan, one is selected for them.

CMS must go as far as possible in moving Medicaid and CHIP towards automated or default enrollment models like those that have succeeded in Medicare, models that better meet the needs of many struggling families. We would point to several mechanisms automating eligibility that are currently achievable without statutory change:

A. Automating eligibility based on SNAP receipt: Louisiana's initial implementation of Express Lane Eligibility (ELE) automatically qualified children for Medicaid based on their receipt of SNAP. Researchers[3] described the initial results as follows: "Only 1 percent of families whose children received SNAP but not Medicaid opted out of [data sharing between the two programs]. The remainder were sent Medicaid cards, which were automatically activated upon first use. Nearly 30,000 children received health coverage, further reducing the state's already low percentage of uninsured children." Focus groups[4] reported that families were delighted by this new and more automatic approach to enrollment, using words like, "blessing," and "gift from God." Eventually,[5] information technology limitations forced Louisiana to change its approach. Instead of consenting to enrollment by simply using their children's Medicaid card to seek care,

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[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447695/
[2] https://www.kff.org/wp-content/uploads/2013/01/8094.pdf
[3] https://www.healthaffairs.org/do/10.1377/forefront.20180501.141197
[4] http://www.statecoverage.org/files/UI-LouisianaCaseStudy_4.2012.pdf
[5] http://webarchive.urban.org/UploadedPDF/413272-CHIPRA-Express-Lane-Eligibility-Evaluation-Louisiana.pdf

parents had to opt in by checking a box on the SNAP application form. Adding that apparently modest requirement reduced enrollment by 62%. It is hard to imagine a clearer illustration of the need to change the basic model of enrollment for children and families so that, without families needing to take action, public agencies can and do determine their eligibility and, unless the family opts out, enroll them into coverage for which they qualify. CMS should list "consent through benefit use" as an approved method for consent[6] to auto-enrollment through ELE, both when a State Plan Amendment provides ELE to children and when an 1115 waiver provides it to adults. CMS should also make clear that third-party data sources and SNAP specifically verify MAGI-based financial eligibility whenever they establish a high likelihood of eligibility, even if those data sources are not framed in terms that precisely align with MAGI income definitions. For example, in 45 states and D.C., SNAP receipt establishes a 97% or greater likelihood[7] that children are financially eligible for Medicaid. CMS should require such states to consider SNAP receipt as sufficient verification of children's financial eligibility for Medicaid, unless other evidence shows ineligibility.

B. <u>Automating enrollment into Medicaid and CHIP based on state income-tax filing:</u> Seven states have enacted "Easy Enrollment" programs, through which uninsured tax-filers ask tax agencies to share their tax return information with health agencies to establish eligibility for health programs and enroll into coverage. Whether through formal guidance or otherwise, CMS should approve states' use of tax information to obviate the need for families to complete additional paperwork before enrolling—for example, by using identifying information on the return to verify citizenship by matching with Social Security Administration citizenship records, letting many eligible families avoid the need to complete paperwork attesting to citizenship or satisfactory immigration status. CMS should encourage 1115 waivers that adjust Medicaid eligibility procedures and criteria to permit automatic enrollment for all Medicaid-eligible uninsured consumers who consent to have their tax data shared with Medicaid.

C. <u>Clarifying CMS Requirements for Data Matching</u>: CMS must change regulations and guidance to require states to use all data sources listed in §1413(c)(3)(A) in establishing eligibility without requiring paperwork from consumers, unless the Secretary of HHS explicitly finds under §1413(c)(3)(B) that accessing a particular source would be excessively costly, relative to likely gains. CMS can and should also develop options, under ACA §1413(c)(2)(B)(ii)(II), through which people can seek coverage "by requesting a determination of eligibility and authorization of disclosure of … information" from third-party data sources.

D. <u>1115 Waivers:</u> CMS should release guidance encouraging waiver proposals that:
   a. Experiment with models for identifying eligible people based on data matches, enrolling them into Medicaid or CHIP unless they opt out, and using innovative methods to eliminate or obtain required affirmative consent (for example, by having community agencies or Managed Care Organizations obtain such consent

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[6] https://www.medicaid.gov/federal-policy-guidance/downloads/SHO10003.PDF

[7] https://www.urban.org/sites/default/files/publication/23566/412808-Using-SNAP-Receipt-to-Establish-Verify-and-Renew-Medicaid.PDF

soon after coverage begins, much as real-time eligibility determination began when states collected verification after finding families eligible).

b. Implement multi-year Continuous Eligibility: After years of advocacy support for the concept, Oregon has come forward with the first of what are likely to be multiple formal state proposals to extend Continuous Eligibility (CE) in Medicaid beyond 12 months. No other type of health insurance requires annual eligibility redeterminations. Multi-year CE will be a significant step toward aligning Medicaid eligibility determinations with what is typical of other kinds of health coverage. It will also be important in meeting children's developmental needs for continuous care during the critical, early years of life.
c. Continuous Eligibility for expansion adults: CMS should revisit its policy on waivers to provide CE to adults. Current policy requires states to accept reduced FMAP on the theory that some adults will maintain enrollment who are not expansion eligible. This policy has sharply limited state take-up and can be revisited on multiple legal and policy grounds and we urge CMS not to reduce FMAP for adults in expansion states.
d. Automate enrollment at birth: As with state income tax filing, birth is a time when significant components of Medicaid eligibility are known or relatively easily acquired. Moreover, getting to universal coverage of newborns is an important statement of principle. Multi-year CE from birth can and should be combined with an automated approach to enrolling in Medicaid eligibility following birth.

B. **Federal Enforcement:** For historically disadvantaged populations to gain equitable access to Medicaid and CHIP, CMS must hold every state accountable to maximize eligible people's coverage. CMS is currently in the middle of an historic response to the unique challenge of unwinding the Continuous Coverage requirement tied to the public health emergency and enhanced FMAP under the Families First Coronavirus Response Act (FFCRA). However, even before the pandemic, Medicaid and CHIP eligibility and enrollment policy was regressing in a number of states, an important driver for increasing uninsured rates for both children and adults during 2017-2019. These problems relate to limited state implementation of Medicaid regulations regarding the ACA's requirements for simplified eligibility determinations, especially with regard to "ex parte" renewals. CMS should set and enforce reasonable quantitative state minimums for ex parte renewals as well as real-time determinations of eligibility. Surveys show wide disparities among states on these metrics, even though many statutory and regulatory provisions require every state to maximize performance. [8]

C. Fully implementing the ACA's "no-wrong-door" requirements: CMS should return, as soon as possible, to the Obama administration's original proposed regulation requiring all marketplaces to determine, not just assess, applicants' Medicaid and CHIP eligibility. Over a longer time, the Administration should require each state to operate a single eligibility system or service for all insurance affordability programs.[9]

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[8] https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf

[9] https://www.familiesusa.org/wp-content/uploads/2021/12/COV-2021-67_No-Wrong-Door-Report.pdf

D. Barring states from misusing data matches to arbitrarily terminate eligibility: Millions of children and families lost Medicaid during the previous administration. Many unwarranted terminations took place when states initiated massive data matches with quarterly wage records and ended coverage whenever families failed to respond, within 10 days of the notice being sent, to state information requests triggered by a single quarter's wage spike, no matter how modestly above Medicaid eligibility thresholds, and whether or not such a modest spike would ultimately end the families' ongoing eligibility. Given the income fluctuations routinely experienced by low-income families, especially in communities of color, these practices are an easy way for states to evade the regulatory requirement for 12-month redetermination periods. This troubling history makes clear the need to bar eligibility terminations before regular renewal based on data matches initiated by the state, as part of forthcoming changes to Medicaid redetermination regulations.[10]

> *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 for monitoring 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?*

A. In the short-term, call center staffing is a critical tool for states and a critical resource for federal monitoring and public reporting. We would also reference our short-term Health Equity Fellow Navigator recommendations below in Objective 1 response #3.
B. First, the administration should implement Social Security Act §1942(a) and ACA §§1413(c)(2)(A) and (c)(3)(A)(ii), which give Medicaid and CHIP programs access to the National Directory of New Hires (NDNH). By providing information about people working for multi-state employers, federal employers, and people who work in one state but live in another, NDNH greatly increases the number of low-income people for whom Medicaid can access information about quarterly wages. Second, the administration should let Medicaid programs take advantage of the IRS data retrieval tool (DRT) used for college student aid applications, which often makes tax return information available within a few weeks of return filing—an order of magnitude faster than with current processes. Both of these steps will increase the number of people whose eligibility can be verified electronically, easing consumer burdens and improving access to coverage.

> *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+); people*

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[10] https://www.aspe.hhs.gov/sites/default/files/migrated_legacy_files/199881/medicaid-churning-ib.pdf

with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?

The following recommendations emerged from a meeting that Families USA held with navigators in communities of color, called "Health Equity Fellows", on March 17, 2022. The Health Equity Fellows[11] are a group of state and local health care advocates who help people of color navigate the Medicaid program and other health care services in a number of states and communities:

A. CMS should encourage or require states to increase the number and type of sites of care in which people can obtain presumptive eligibility. Although states have a number of options to provide presumptive Medicaid and CHIP eligibility to children, pregnant women, and other Medicaid eligible groups at a wide range of qualifying sites in addition to hospitals, most states do not exercise these options.[12] CMS should encourage states to, at a minimum, provide for presumptive coverage at community health centers, schools, hospitals, and WIC sites, and when people are leaving correctional facilities.
B. CMS should require or encourage states to not rely solely on web tools and phone lines for remote enrollment. It is critical that enrollment policies recognize and reflect that the digital divide makes it difficult for some people to enroll without in-person assistance.
C. As CMS has already provided through navigator grant awards in FFM states, CMS should use its authority under ACA §1311(i)(4) to set standards requiring navigators to include enrollment assisters who are from communities of color and who serve communities of color. Such steps are needed to ensure trusted and knowledgeable members of the community have the resources needed to overcome barriers and successfully achieve enrollment goals
D. CMS should allow and encourage states to retain flexibilities that have enabled enrollment assisters to help people with virtual Medicaid enrollments during the pandemic. Flexibilities such as permitting people to enroll without a "wet signature" were helpful and should be retained – especially critical for people in rural areas who were able to enroll in Medicaid without traveling to distant offices for help.
E. CMS should train and support community-based enrollment assisters who are bilingual to help with Medicaid and CHIP enrollment. CMS should provide sustainable federal funding for enrollment assistance: one-time grants, only available in some states, are not viable for some community groups who are equipped to assist. Both through targeted outreach regarding funding opportunities, and by helping groups submit joint proposals, CMS should ensure that funding reaches assisters who have relationships with linguistic groups that are uncommon in the United States. These include Pacific Islanders (entitled to Medicaid as part of U.S. obligations under the Compact of Free Association) and Mayan people, many of whom settled in California after the

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[11] https://familiesusa.org/our-work/health-equity-academy-in-system-transformation/

[12] https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/, table 12

Guatemalan Civil War.[13] CMS could help foster cross-state relationships with community-based organizations that have expertise in serving such linguistic populations. CMS could provide simple educational materials for assisters to use, including educational materials about "public charge" rules and regulations since assisters will also be reaching mixed status families.

F. If a state is sending a notice of disenrollment or a notice to provide more information, CMS should require or encourage notices and enrollee communications to be specific as to why people are being disenrolled. State and community advocates who serve people of color note that mass communications sent by several states are confusing to enrollees. CMS should develop model notices for states to use when people might be disenrolled due to a procedural reason, such as returned mail/unable to find new address. Further, CMS should develop a model message to display on notice envelopes when an enrollee's address is in question so that the post office or a neighbor who receives mis-delivered mail will be more likely to help. CMS should conduct national outreach and media campaigns in multiple languages advising people to update their addresses and be on the lookout for Medicaid, CHIP and marketplace notices.

G. CMS should encourage or require states to extend the appeal timeline for people who contest disenrollment during the unwinding. People with both MAGI and non-MAGI Medicaid may need longer timeframes to appeal. If they have not received or understood notices regarding a termination, they may not realize they have been disenrolled until they seek medical care.

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

Key indicators documenting state progress overcoming administrative burdens include:

1. Percentage of denials for both new applications and redeterminations;
2. Percentage of such denials, within each category, that are for procedural reasons; and
3. Percentage of applications granted in "real time" (i.e., within 24 hours).

It is important for states to differentially report those three metrics based on:

- Age (i.e., 0-18; 19-64; 65+)
- Whether disability is claimed

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 after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to

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[13] https://familiesusa.org/resources/community-voices-recommendations-to-state-policymakers-for-advancing-health-equity/

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?*

A. <u>Reporting</u>: In addition to our above comments in Objective #1 regarding permanent CMS oversight responsibilities, we urge CMS to make publicly available all state redetermination plans and state baseline and monthly redetermination reports. We were pleased to see the monthly reporting template, however; CMS should make clear that states must report all redetermination outcomes using the template. In addition, CMS must clarify that state should separately report redetermination outcomes for MAGI- and non-MAGI-based beneficiaries. Without those distinctions, it will be needlessly difficult for CMS to evaluate state compliance, since different redetermination duties attach to those separate populations. Finally, we urge CMS to add call-center metrics to monthly redetermination reports, since call-center problems are often an early warning signal of emerging problems.
B. <u>Enforcement</u>: CMS must be prepared to take effective action if state non-compliance threatens to end coverage for people eligible for insurance affordability programs. Such CMS action can include suspending procedural terminations pending satisfactory implementation of a corrective action plan, potentially as a condition of avoiding federal denial of matching funds that would otherwise result from state non-compliance.
C. <u>Maximize SNAP Option Under New Blanket e(14) Waivers</u>: Building on CMS's recent re-opening of (e)(14) waiver authorities, CMS should issue a finding that SNAP data are useful for every state's redetermination process and grant a blanket 1902(e)(14)(A) waiver allowing every state to auto-renew Medicaid beneficiaries under age 65 based on SNAP receipt. These steps reflect CMS's prior recognition that, for children and for adults in expansion states, SNAP receipt establishes a 97% likelihood of MAGI at Medicaid levels.[14]
D. <u>Additional e(14) Waiver Ideas:</u> Develop other options for 1902(e)(14)(A) waivers by commissioning research to identify beneficiary characteristics known to state Medicaid programs that are associated with a high likelihood of MAGI at Medicaid-qualifying levels. Examples of waiver policies to explore include:

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[14] https://familiesusa.org/wp-content/uploads/2022/03/MCD-2022-48_SNAP-Issue-Brief_final.pdf

- Basing renewal on adjusted gross income (AGI) reported on state income tax returns. In states that do not access federal income tax data because of IRS data security requirements, this could be a useful option, so long as research shows that the vast majority of beneficiaries whose AGI is at Medicaid-qualifying levels also have MAGI at such levels.
- Administrative renewal rules developed by states through data-mining beneficiaries' records. For example, before the ACA, Louisiana used specific business rules[15] to administratively renew children, based on household characteristics that made continued eligibility "reasonably certain," such as households where all past income has come from Social Security payments. Research could validate those rules, in the MAGI context, and suggest others.

E. Strengthening redetermination regulations. To fit regulations more closely to the rigorous standards set by ACA Section 1413(c), states should be required to connect with all third-party data sources referenced in that subsection, except where HHS specifically finds the cost of connection exceed the value added by the source; ex parte renewals, with beneficiary obligations to correct state notices, should be required whenever available data establishes a high likelihood of eligibility; beneficiaries should not be terminated based on failure to respond to a state notice unless the state has taken all feasible and effective steps to obtain current contact information; 30-day notice periods should be required whenever a beneficiary who has been covered for at least 12 months is subject to potential termination; and as noted above, states should be prohibited from redetermining eligibility before regular renewal based on data matches initiated by the state.

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?

A. It is essential for states to collect, maintain, and regularly update contact information for all beneficiaries that goes well beyond street address, along with asking beneficiaries for their preferred contact method. That information includes cell phone numbers for calling and texting, email addresses, social media contacts, or other channels authorized by the beneficiary. That way, when disenrollment risks emerge, state staff, contractors, and authorized community agencies will have many channels to reach out to beneficiaries, make sure they understand their situation, and help them do what is needed to retain coverage.

B. Another important step is to make sure that authorized representatives have back-end access to beneficiaries' case records sufficient to proactively identify and solve emerging eligibility problems. Such access can enable smooth problem resolution that both prevents termination of eligible families and limits administrative demands on states.

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[15] https://ccf.georgetown.edu/wp-content/uploads/2012/04/The-Louisiana-Experience.pdf

Obviously, such back-end data access must be accompanied by strong protections of privacy and data security.

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] qualified supports 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?

A. Medicaid and CHIP No Wrong Door: It is a long-overdue step for CMS to require all states that operate separate CHIP programs to integrate eligibility systems for Medicaid and CHIP, using common income definitions, standards and methodologies, so that either agency can determine eligibility for both programs. Florida illustrates[16] the problems that can result from bifurcated eligibility systems. Applications for children's coverage are frequently transferred back and forth between programs. Results can include delays and applications falling between the cracks, with eligible children remaining uninsured. Families have been forced to complete redundant applications for both programs, with resulting burdens and confusion that deter enrollment by children who clearly qualify for assistance. CMS should end that state of affairs as soon as possible, in Florida and other states.
    a. When children move from Medicaid to separate state CHIP programs, they should not be denied CHIP because of failure to make required premium payments. Rather, they should be given at least an interim period of coverage without premium charges, as they transition to a different form of coverage that requires monthly payments.

B. Medicaid and Marketplace No Wrong Door: Medicaid programs should be required to determine eligibility for Advance Premium Tax Credits (APTCs) and Cost-Sharing Reductions (CSRs), as provided by Social Security Act §1943(b)(1)(C). See also ACA §1413(b)(2). In most cases, states have already determined that beneficiaries are U.S. citizens or lawfully present non-citizens. Through statutorily-required third-party-liability databases,[17] states already have more information than exchanges about beneficiaries' access to employer-sponsored insurance. States are legally obliged, under ACA §1413(c), to access federal income tax data for verification purposes, and such data are the basis on which exchanges verify financial eligibility for APTCs and CSRs. Finally, states that terminate a beneficiary because of income above Medicaid thresholds should be required to ask such a beneficiary whether they expect that income to continue at similar levels, with the same household size, during the remainder of the calendar year. All of that information should suffice to establish APTC and

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[16] https://www.familiesusa.org/wp-content/uploads/2021/12/COV-2021-67_No-Wrong-Door-Report.pdf

[17] https://www.medicaid.gov/sites/default/files/2019-12/summaryoffederalstatutoryrequirements.pdf

CSR eligibility. For people losing Medicaid eligibility who qualify for exchange plans with zero-net premiums, CMS should encourage state-based marketplaces to implement default enrollment policies that give consumers a choice of qualified health plan, but enroll them into zero-net-premium coverage if it is available and if consumers do not pick a different option by the end of the applicable special enrollment period. States pursuing such efforts should be encouraged to test promising options for addressing the risk of tax-reconciliation "claw-back payments," such as through state indemnification or strong informed consent procedures.

C. Require state Medicaid programs, Medicare and marketplaces to notify transitioning individuals/families of differences in covered benefits between Medicaid, CHIP, Medicare and marketplace (e.g., differences in EPSDT vs pediatric EHB, lack of subsidized adult dental coverage in marketplace/its exclusion in Medicare, etc.). We recommend that CMS also require state agencies to notify beneficiaries of: 1) the upcoming change in their eligibility group at least 120 days in advance; 2) the services (categories and specific) for which they will no longer have coverage and the new service categories for which they will be newly covered; and 3) where and how to access information on finding health care providers in the networks for which they are eligible. We also urge CMS to consider how state Medicaid programs can ensure beneficiaries understand the variation in coverage of optional services across state lines, as well as across individual managed care plans within a state, and that they may lose or gain benefits such as dental when they move or change plans.

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

A. The administration should finally implement Social Security Act §1942(a) and ACA §§1413(c)(2)(A) and (c)(3)(A)(ii), which give Medicaid and CHIP programs access to the National Directory of New Hires (NDNH). By providing information about people working for multi-state employers, federal employers, and people who work in one state but live in another, NDNH substantially increases the number of low-income people for whom state benefit programs can access information[18] about quarterly wages. The Office of Child Support Enforcement, which administers NDNH, generally disregards data-access laws that do not specifically amend the NDNH statute. We urge the administration to make an exception to this policy so families eligible for Medicaid and CHIP do not needlessly remain uninsured.

B. The IRS data retrieval tool (DRT)[19] used for college student aid applications often makes tax return information available within a few weeks of return filing.[20] The administration should

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[18] https://www.acf.hhs.gov/archive/testimony/wade-f-horn-ndnh-and-tanf

[19] https://studentaid.gov/help-center/answers/article/what-is-irs-drt

[20] https://studentaid.gov/help/when-tax-info-irs-drt

make the DRT available to states through the federal data services hub, thereby providing more timely and useful income data to verify eligibility. Internal Revenue Code §6103 authorizes Medicaid programs to access the data elements supplied by the DRT, so long as they meet IRS requirements for data storage and security. States that follow such requirements should gain access to this tool.

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?

A. <u>The Need for Specific National Standards in Managed Care and Fee-for-Service</u>: Medicaid provider networks have long been narrower than those other coverage types and reliant on safety net hospitals and community health centers. As Medicaid has grown to become the largest health coverage program in the United States, these narrow networks are problematic. The issue comes up prominently in focus groups with beneficiaries and on the priority lists of consumers and grassroots social justice organizations like NAMI and Black Mamas Matter. However, oversight of network adequacy has actually weakened in the last several years, as the Supreme Court's *Armstrong* decision eliminated the ability of providers to sue in federal court regarding lack of access in Medicaid and passed oversight to CMS. Under both the Obama administration (in 2015-2016) and the Trump administration, CMS held off on regulating national minimum standards for network adequacy and focused instead on requiring states to announce their own standards and report on Medicaid networks. Mandatory public planning was the basic structure of both Medicaid managed care regulation and the fee-for-service Access regulation. This was not an impactful framework and essentially created empty paperwork obligations on states.

CMS should reinstate the time and distance standards that the Trump administration weakened and specify specific national time and distance minimums applicable in all states. States are now permitted significant latitude in making exceptions to the standards that increase enrollee travel distance and time. For example, following a loosening of the federal travel time and distance standards under the Trump administration, the California Department of Health Care Services (DHCS) approved nearly 10,000 new "alternative access standards" requests in 2019, and that number rose to 15,000 in 2020. OB/GYN primary care and other specialty providers including ophthalmologists and hematologists experienced the most significant changes in distance requirements under these approvals.[21] Research showed that most approvals increased the required travel distance to all types of providers by more than 20 miles. In the northern part of Los Angeles County, widely known for congested traffic, exceptions for travel distances of between 41-60 miles were granted.[22]

National standards should also apply to:

- Appointment wait times;
- Language access; and
- Availability of extended hours.

B. <u>An Incremental Regulatory Approach</u>: Networks are a core operational issue for state Medicaid agencies, and the Administration should regulate on network adequacy in close consultation with the National Association of Medicaid Directors. We support the approach suggested by the question: to take the key step of regulating national network adequacy standards, but to do so incrementally. Priority areas in which existing Medicaid access is poor in most states would be behavioral health providers (including both mental health and substance use) and pediatric sub-specialists—these could be part of a first phase of national network minimum standards.

C. <u>Alignment across Medicaid/CHIP, Medicare Advantage, and Marketplace:</u> CMS should have the long-term goal of creating a single national standard of network adequacy for provider types that are in common across its major health programs.

D. <u>Behavioral Health Standards</u>: CMS and states should implement several network adequacy standards to oversee compliance to ensure that families have adequate access to the mental health and substance use services to which they are legally entitled. We endorse the "Consensus Recommendations on Network Adequacy and Oversight for Advancing Equitable Access to Mental Health and Substance Use Care for Children and Youth," led by Mental Health America. Further, as we commented on CMS-4192-P with regard to Medicare Advantage, the below are additional key principles for network adequacy in behavioral health care.

    a. Require that plans have sufficiently available providers and treatment facilities for both substance use disorders and mental healthcare, and track compliance separately for those two conditions.

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[21] State of California Health and Human Services Agency. 2020 Annual network certification alternative access standards for Medi-Cal managed care health plans (contract years starting July 2020 and January 2021). In: Services DoHC, editor. 2020

[22] A. Coursolle, Health Equity Blog Series [Internet]: National Health Law Program, August 25, 2021, https://healthlaw.org/exceptions-to-network-adequacy-rules-may-exacerbate-health-disparities-in-medi-cal-managed-care/. Accessed on March 2, 2022.

   b. Determine that level of care assessment tools reflect generally accepted standards of care.[23]
   c. Ensure that care is available across the continuum, including for emergency and urgent, inpatient, residential, outpatient, and home- and community-based services.

Finally, it is important to note that some of these standards will be inadequate to ensure access while some critical health care services, like dental care for adults, remain optional for states to cover. While CMS cannot require states to cover these services without Congressional action, we encourage CMS to provide guidance and/or incentives to states encouraging them to take up options like covering comprehensive dental care of adults.

> *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?*

A. <u>Public access to state access reports</u>: The mandatory state reports on access in fee-for-service (described at § 447.203(b)(6), § 447.204(b), and § 447.204(c)) are currently only available to CMS. The public should also have access to these critical analyses. Public availability of this data and a public input process would provide stakeholders with more immediate insight into the potential impact and rationale for the provider rate change.
B. <u>Supplement Medicaid Claims/Administrative Data with Provider/Beneficiary Experience Data</u>: Much of the data required to comply with Medicaid Access Monitoring comes from claims or administrative sources. While it is administratively simpler for states to analyze their own data, claims and payment methodology data are not sufficient to provide a holistic picture of access. § 447.203(b)(4) primarily highlights the provider/beneficiary experience measures the state must analyze in their triennial Access Monitoring Review Plan. States should be required to establish systems to collect, analyze, and make public this information to contribute to our collective understanding of access in the Medicaid system. Additionally, these analyses should be stratified by race and ethnicity, as well as the provider types listed in § 447.203(b)(5)(ii), as well as other key providers of interest such as medication assisted treatment. CMS should modify universal billing forms to collect race and ethnicity data. For behavioral health, one of our priority areas for reporting, CMS should require reporting on timely access to care for inpatient and for outpatient mental health services and for substance use disorder services, both for children and youth and for

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[23] Comments on Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefits Programs (CMS-4192-P), submitted March 7, 2022 by Families USA, Inseparable, the Kennedy Forum, Legal Action Center, Mental Health America, and National Alliance on Mental Illness.

adults. CMS should also require reporting on available providers equipped to deliver those services, including the methods states used to verify the accuracy of provider directories.

3. How could CMS consider the concepts of whole person care 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?

A. Medicaid Waivers and Payment reform: Medicaid waivers continue to be an important opportunity to support investments in the care coordination capacity of safety net providers and negotiate state commitments to payment reform. In the next year, CMS will have the opportunity to negotiate large Medicaid waiver renewals with multiple states that have a history of driving safety net delivery system change using Medicaid waivers, including Arizona, Massachusetts, Oregon and New York—and this list could well grow with federal encouragement. Given the Biden administration's historic responsibility and opportunity to pursue racial justice by, in part, addressing disparities in social drivers of poor health, CMS should place health equity at the center of its Medicaid waiver strategy. This can take the form of:
    a. Medicaid pay for performance that holds the health care system accountable for reduced health disparities;
    b. Providing greater flexibility, incentives and resources for health care providers and plans to build and staff relationships with social service providers and community-based organizations;
    c. Moving to risk-based provider payment with strong quality incentives tied to population health can create strong incentives to build more holistic care delivery.

B. Oral health: In addition to the types of services mentioned in this question, oral health is part of whole person care. Infections in the mouth have known effects on diseases of other organs and on the outcomes of surgery. Medications commonly used for physical and mental illness can cause dry mouth and exacerbate oral health conditions if doctors fail to educate patients and mitigate this. When reviewing waiver requests, for example, we urge CMS to ask states how they plan to integrate oral health care and educate practitioners about disease linkages.

C. Parity Compliance: CMS could better equip state Medicaid agencies to monitor parity compliance and insist that states do so. For example, CMS could develop a common audit tool for Medicaid agencies' use in determining managed care organizations' parity compliance. CMS itself should include parity enforcement staff, just as the Department of Labor has staff overseeing the parity compliance of group plans. CMS should ensure that administrative law judges who preside over Medicaid fair hearings are aware of parity rules and assess behavioral health grievances and appeals with a parity lens (in addition to applying any other applicable rules).

D. Same-Day Billing: CMS should encourage or require states to eliminate policies that prohibit same day billing by behavioral and physical health providers.
E. Doulas for pregnant and post-partum women: CMS should leverage guidance to support states to reimburse culturally rooted doula care to assist pregnant and postpartum women. CMS should also encourage states to provide Medicaid reimbursement of culturally competent doula care. States often do not recognize indigenous, cultural and traditional knowledge. States and/or CMS should recruit an advisory council that includes doulas and people from indigenous and diverse communities to help inform certification requirements.[24]
F. Supporting culturally-concordant behavioral health care:
    a. Some states are working to increase diversity in the behavioral health workforce and have noted that working alliances between patients and clinicians are stronger when they are of the same ethnic background.[25]
    b. Additionally, some tribes and community-based organizations are urging state Medicaid programs and public health departments to fund traditional healing practices, which center on *community* healing and recognize historical trauma.[26]
    c. Working with HRSA and SAMHSA, CMS could help develop and disseminate an evidence-base for traditional health services. Some other important areas in need of improvement include the incorporation of language and cultural competency criteria into mental health care provider recruitment, reimbursement of traditional health workers and peer support workers, grants to tribes, and the employment of community-defined, evidence-based approaches to behavioral health care.[27]

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

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[24] Health Equity Fellows meeting, op cit.

[25] Mia Antezzo et al., "State Strategies to Increase Diversity in the Behavioral Health Workforce," National Academy for State Health Policy, December 13, 2021, https://www.nashp.org/state-strategies-to-increase-diversity-in-the-behavioral-health-workforce/#toggle-id-7.

[26] Michael Blanding, "Cultural Healing," T.H. Chan School of Public Health, Harvard University, November 30, 2021, https://www.hsph.harvard.edu/news/features/cultural-healing/.

[27] Susan Flores, *Medi-Cal Managed Care Plan Mental Health Services: An Unfulfilled Promise for Communities of Color* (Oakland and Sacramento, CA: California Pan-Ethnic Health Network, September 2021), https://cpehn.org/assets/uploads/2021/09/Medi-Cal-Managed-Care-Plan-Mental-Health-Services_September-2021-1.pdf; *Concept Paper: Policy Options for Community-Defined Evidence Practices (CDEPs)* (Oakland and Sacramento, CA: California Pan-Ethnic Health Network, April 2021), https://cpehn.org/publications/concept-paper-policy-options-for-community-defined-evidence-practices-cdeps/; *Tribal Behavioral Health Strategic Plan – 2019 to 2024* (Portland, OR: Oregon Health Authority, n.d.), https://www.oregon.gov/oha/HSD/AMH/docs/Tribal-BH-Strategic-Plan-2019-2024.pdf.

and other stakeholders found the most meaningful in identifying cultural and language gaps among providers that might impact access to care?

Community advocates in Oregon and Washington, two states that have worked to provide language access, note that certification requirements and low pay have been obstacles to recruiting a sufficient medical interpreter/translator workforce. For example, some programs have required people to submit proof of proficiency in English and in their respective languages through a high school diploma – but their countries of origin do not issue high school diplomas. Some certification programs were closed during the pandemic, increasing the shortage of available interpreters. Average pay for interpreters has been "embarrassingly low", two state-based advocates told us, and pay scales that are based on the length of time people have served as interpreters should recognize interpretation that people provided prior to certification. CMS could help states set requirements for a minimum number of interpreters. CMS should also encourage states and medical facilities to provide quick-access virtual interpretation, which has been extremely important for rare languages and in rural areas.[28]

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?

Long waiting lists for home- and community-based services have been problematic in a number of states, both because of caps on available slots and due to shortages of caregivers. Some states do not pay family members to provide care, even when doing so could alleviate burdens for many families. CMS should either mandate that states include family caregivers in their home- and community-based workforces, or at a minimum, make this the default option in state plan and waiver documents.

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 data sources (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)

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[28] The recommendations on language access came from a March 17 meeting of health Equity Fellow.

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?

Our primary response on this question is under Objective 3, with reference to access and network regulation.

CMS-wide Core Equity Measure Set: HHS should undergo a multi-stakeholder process to develop a core health equity measure set and require all Medicare and Medicaid payers and providers to report on those measures. This core equity set should be determined by a wide variety of stakeholders, including those with lived experience and individuals who identify as a part of underrepresented, marginalized or disenfranchised communities that most frequently experience health disparities. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), in conjunction with RAND Health Care, recently submitted a report to CMS that defines a health equity measurement approach. This approach was developed in response to Executive Order 13985 issued by President Joe Biden

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.)?

All of the measures listed above in our response to Objective 3 are important to monitor. Further, it is difficult for individuals covered by Medicaid managed care organizations to call a list of providers and identify one that has availability. States and CMS Regional Offices should monitor what actions the plan is taking to locate an available and appropriate provider, especially when services are urgent. For example, at a minimum, behavioral health professionals should provide help over the phone to callers who are experiencing emotional distress while they await appointment availability and to ensure that callers with urgent or emergent needs receive prompt service.

Federal managed care regulations should require performance improvement projects to measure and improve health equity as a central performance metric. As states and CMS identify disparities, they should create tools and clinical guidance reminders regarding disparate health conditions, ensure evidence-based practices, and address access barriers including transportation to medical appointments, hours of service, physical access, language, and availability.[29]

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?

[No response]

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?

Broadly, standardized appeals, grievance and fair hearing data should include whether the issue was eligibility or access to a service, the type of service in dispute, the resolution, and data on the time from the initial claims or eligibility denial to resolution. For prescription drugs, information about the class and drug denied prior authorization and the ultimate resolution should be included. For behavioral health cases, include information on parity claims and findings. CMS should consider collecting information that is comparable for both Medicaid and marketplace plans. (In marketplace plans, data will be from internal and external reviews.)

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.)?

[No response]

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 extent that such care and services are available to the general population in the geographic area." Section 1932 of the

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[29] Fish-Parcham, Measuring and Improving the Quality of Medicaid-Funded Care to Reduce Disparities in Health and Health Care Outcomes, Families USA, December 2020, https://familiesusa.org/wp-content/uploads/2020/12/HE-277_Technical-Assistance-Document.pdf.

Act 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 leveraging existing 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?

We believe that regulation of network adequacy and consumer access is the best mechanism for regulating provider payment adequacy. Minimum standards of access should apply to both mandatory and optional service categories where states have optional benefits in place (e.g., adult dental coverage in Medicaid). This is particularly important as a parent or caregiver's access to care directly influences a child's access to care in addition to the fact that, for adults, chronic conditions like diabetes and heart disease are complicated by lack of access to dental care

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?

The Growth of Community Health Workers in Medicaid Delivery:

When incorporated into health care teams, Community Health Workers, or CHWs, improve health outcomes and prevent unnecessary health care utilization by addressing social determinants of health (SDoH) and other upstream factors.[30] CHWs' inherent person-centered care model lends itself to the goals of the Medicaid and CHIP programs. CHWs represent a largely untapped and effective workforce asset that can and should be deployed as a part of regular care models.[31],[32] CMS should ensure that states are supported and encouraged to

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[30] Shannon Cosgrove et al. "Community Health Workers as an Integral Strategy in the REACH U.S. Program to Eliminate Health Inequities," *Health Promotion Practice* 15, no. 6 (July 25, 2014): 795-802, doi: https://doi.org/10.1177/1524839914541442.

[31] Emmett Ruff, Eliot Fishman, Raven Gomez, and Denisse Sanchez, "Advancing Health Equity Through Community Health Workers and Peer Providers: Mounting Evidence and Policy Recommendations," Families USA, November 2019, https://familiesusa.org/resources/advancing-health-equity-through-community-health-workers-and-peer-providers-mounting-evidence-and-policy-recommendations/

[32] Eliot Fishman and Denisse Sanchez, "Making Community Health Workers Fundamental: New Research Strengthens the Case for State Policymakers to Include CHWs in Care Delivery Teams," Families USA, December

integrate CHWs into their existing Medicaid payment structures. There are many different opportunities[33] available to states to integrate CHW services into existing payment models,[34] and into more innovative value-based purchasing models.[35] In order to fully support the breadth of services that CHWs are able to provide, CMS should expand the preventive services state plan option to include more reimbursable codes for CHW reimbursement, including payment for addressing things like SDoH.

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?

- As CMS is well aware, fee-for-service Medicare does not currently cover dental care in the majority of cases. Most importantly, we hope that CMS will work to strengthen Medicare by allowing for “medically necessary” dental services to be covered, meaning those that are incident and integral to a medically covered service, as allowable under current statute, and by continuing to work with Congress on a broader legislative solution. Moreover, sufficient payment rates in Medicaid do not result in access to care if a state’s program does not cover comprehensive dental for all Medicaid enrollees, or if the state ends or rolls back its coverage in difficult budget years. As previously stated, we urge CMS to encourage all states to implement comprehensive set of dental services for adults in addition to children, and to continue to work with Congress on a more permanent solution.
- We recommend several strategies to help in assessing the sufficiency of rates for both children and adults who rely on the Medicaid program for their dental care. As noted above, we believe the primary approach to Medicaid access standards should be to measure beneficiary access rather than provider rates. In the case of dental care, provider access has been particularly problematic, and CMS should consider measures of access and provider rate sufficiency that compare provider participation, the difference between current provider rates and average commercial rates, and utilization for primary care medical services to dental care access(e.g., percentage of children receiving well child visits compared to percentage receiving any dental or oral health services and related provider rates, percentage of adults receiving prenatal care with

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2019, https://familiesusa.org/resources/making-community-health-workers-fundamental-new-research-strengthens-the-case-for-state-policymakers-to-include-chws-in-care-delivery-teams/

[33] https://familiesusa.org/resources/at-a-glance-pathways-for-sustainably-funding-community-health-workers-in-medicaid/

[34] https://familiesusa.org/resources/how-states-can-fund-community-health-workers-through-medicaid-to-improve-peoples-health-decrease-costs-and-reduce-disparities/

[35] https://familiesusa.org/resources/community-health-workers-in-delivery-and-payment-transformation-how-new-delivery-and-payment-models-can-incentivize-and-support-the-use-of-chws/

percentage receiving any dental care and related provider rates).[36] We also suggest developing a cross-state study of states' dental rates paid, how they compare to average commercial rates in the state, dental care utilization, and reported barriers to access. However, dental care access and utilization hinges on far more than just provider rates. We suggest CMS also consider:

- Providing technical assistance and guidance to states on reimbursement of dental providers for vaccinations and other services aimed at managing other chronic conditions (e.g., screening for mental health conditions, substance use disorders, hemoglobin A1C levels, and diabetes management, etc.)
- Providing guidance and technical assistance to states in implementing telehealth and teledentistry services as well as the delivery and reimbursement for at-home care that parents/caregivers may be able to administer (e.g., fluoride varnish applications)
- Providing guidance and technical assistance to states in adopting alternative and community-based providers like community health workers, doulas, and dental therapists while also encouraging cross-state licensing; CMS could establish a model for cross-state licensing that states can adopt
- Assessing and addressing other concerns raised by dentists who are reluctant to enroll in Medicaid or treat Medicaid, including administrative burdens (credentialing processes, verifying eligibility, submission of prior authorization); compliance concerns; no-show rates; lack of clarity regarding benefits packages; unclear or infrequent communication from Medicaid or contractor about policy changes; fear of auditing; transportation barriers faced by patients; and language and cultural barriers.

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. 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?

We noted some of these barriers in earlier questions. They include state prohibitions on same day billing for physical and behavioral health services (though federal law no longer prohibits same day billing, some states do); inadequate payment levels and career advancement for community health workers and peer support workers.

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[36] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0417_1