



NATIONAL HEALTH COUNCIL

## **National Health Council's (NHC's) responses to the CMS Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP**

The following are the National Health Council's (NHC's) responses to the CMS Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP. Only the questions that NHC responded to are included and each question is followed by the NHC's answer.

**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. Unfortunately, many people who remain uninsured are currently eligible for financial assistance for coverage either through Medicaid, CHIP, or the Marketplace. Seven million people who were uninsured in 2020 are eligible for Medicaid or CHIP, most of whom are people of color. We applaud the Administration's efforts to addressing timely eligibility determination and enrollment and support the Executive Order on "Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government" that strives to streamline eligibility and enrollment processes and increase efforts to reach uninsured individuals who are eligible for Medicaid, CHIP, or Marketplace coverage. We also support increased consumer education, awareness, and assistance with navigation. We support specific efforts that would help increase enrollment of individuals in Medicaid and CHIP. For example, Federal and State enrollment and eligibility should increase connections with other State and Federal programs so that there is a no-wrong door approach to enrollment. For instance, if someone is enrolling in a means-tested food assistance program, that should automatically trigger consideration of Medicaid enrollment at the same time and place. It would also be helpful if tax data was linked to Medicaid systems to proactively reach out to individuals eligible for Medicaid and not enrolled.

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. Medicaid and CHIP enrollment can be an arduous process. The system will also face a large wave of redeterminations when the COVID-19 public health emergency (PHE) ends. Efforts to increase States' capabilities to administer enrollment and determinations must be supported. This is a very appropriate role for the Federal government in the Medicaid Federal-State partnership. The NHC supports efforts to provide adequate resources to States to appropriately process eligibility and determinations in a timely manner. This includes increased personnel to assist individuals through the process. It also means additional education and marketing resources that are aimed at helping individuals navigate the system in clear, actionable, and understandable ways. Community-based organizations, including patient groups, are a vital partner in this as they often help eligible individuals navigate the system. These partners must be included in any efforts to improve Medicaid and CHIP processes.
  
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 with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?
  - A. As noted above, the NHC recommends that the Federal government and States work with community-based organizations and trusted voices to educate individuals about Medicaid and CHIP. This includes engaging those entities in the process of creating education, outreach and other informational materials and not just dissemination. It is critical that individuals from marginalized communities are consulted directly to create information that is appropriate, culturally competent, and actionable. The CMS should develop a patient engagement infrastructure that creates an ongoing dialogue about systemic issues with those most affected by them. We encourage CMS to do all it can to ensure that application and enrollment procedures are accessible, understandable, and in plain language.

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?
  - A. The NHC appreciates the focus on oversight in this RFI. It is important that CMS provide oversight of state denials. This oversight should be used to identify states with abnormally high denial or application abandonment rates. Anomalies should trigger Federal action including investigation and action plans for addressing issues.

**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 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. It is important to remember how vital continuous access to coverage is for people with acute or chronic conditions and those with disabilities. Medicaid is literally a lifeline for many—without access to hospital services, home health services, prescription drug benefits, and/or long-term services and supports, many would experience a significant decline in quality of life and in some instances. Losing Medicaid access puts lives in jeopardy. When the current PHE ends, states will have 14 months to undertake eligibility redeterminations that have been on hold through the PHE. States are currently planning for the large number of redeterminations they will undertake and are developing their plans for processing and prioritizing how they will approach the task. The Urban

Institute estimates roughly 15 million people will lose Medicaid coverage during this process. NHC asks CMS to provide oversight and monitoring of the rate and speed of eligibility redeterminations and their outcome. Most importantly, everyone determined ineligible should be immediately referred to resources to seek other sources of coverage in a timely and understandable way. This is another area where community-based and patient organizations can be of assistance. The NHC encourages CMS to develop educational resources for community-based organizations to help constituents navigate redetermination and seeking alternative coverage. As stated above, we encourage CMS to engage those entities in the process of creating education, outreach, and other informational materials and not just dissemination.

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. With the coming wave of redeterminations and likely disenrollment, it is critical that information is provided to those at risk of disenrollment with clear, direct, actionable language, and that information needs to be delivered in multiple ways. Individuals on Medicaid are some of the most vulnerable people in our society. Too often government adds to their burden by requiring unnecessary effort for them to get information or to understand information they receive from Medicaid. We need to make sure that they are proactively provided information in a way that is most accessible and useful to them. Engaging patients to help understand what the best information will be is a critical part of this. One thing that would be particularly helpful is information for consumers about what the redetermination process will look like, what information an individual will need to compile, and how to best get assistance navigating the process.
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. Times of transition are often fraught for individuals with acute or chronic conditions and disabilities. Questions of whether specific services, treatments, medications, and providers that a person has come to rely on will be covered in the same way can cause great stress and anxiety. Too often the answer is that the required change may put their health at risk. When transitions are coming, particularly ones that are predictable like aging out of a particular category of coverage, there must be communication and coordination between the programs long before the transition happens, and that information should be centered around the needs of the individual. A planful approach to transitions can help the individual prepare for coming changes, relieve stress, and help the systems best serve that individual and adapt when needed. In order to do this, CMS should identify ways to increase coordination and information exchange between programs.

**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. The NHC supports creating national standards that measure the ability of an individual to access services so that Medicaid recipients can expect basic care no matter where they live. Currently, many people must make decisions on what state they can live in if they depend on certain services. The essential health benefits under the ACA have shown that having national minimum standards creates stability for individuals and improves the coverage and care people receive. While we support national standards, it is important to view them as a minimum. Maintaining managed care incentives is particularly needed to provide additional value-based services while focusing the states' attention on assuring minimum standards.

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. Centralized reporting on performance standards by States to CMS would significantly improve the Medicaid program and increase accountability. These standards must be based on the true experience of patients and measure what patients identify as important. In addition, this reporting needs to be transparent and available to the public.
3. How could CMS consider the **concepts of whole person care<sup>51</sup> 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. One of the most important things CMS can do to make the promise of mental health parity a reality is to increase oversight and compliance. Too often parity is not fully implemented and there is not enough oversight and identification of non-compliance.

Care coordination and person-centric care needs to be required and built into all managed care contracts. Managed care organizations have resources and an interest in being more person-centric, but face implementation barriers from State regulations. Those barriers need to be identified and addressed with states incentivized to support coordinated care.

Finally, the NHC recommends that care coordination efforts be inclusive of those services that support social determinants of health. By only coordinating services in the health system, a significant factor in supporting health is being neglected.

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



- A. The NHC appreciates the focus on cultural competence and language preferences. This is an important part of making sure that people receive health care and information in appropriate ways. The NHC asks CMS to be sure that disability communication access is also a part of all efforts to address language and cultural barriers to care.
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?
- A. An important part of the care team that is often neglected are family members and other unpaid caregivers. Providing financial support, education, and other supports for caregivers, such as respite care, will help ensure that individuals with chronic conditions and disabilities get the quality care they need. The Veteran’s Administration has provided caregivers with assistance for many years, and it has proven to reduce caregiver burden and improve services. Telehealth is also an important component that can expand and diversify the provider pool. However, state licensing issues have proven to be a barrier to fulfilling that promise. Unless providers are allowed to operate via telehealth across state lines, the provider pool available to individuals will not increase dramatically. The NHC encourages safeguards to assure that providers are operating safely and ethically, but the barrier that state licensing presents must be addressed. Finally, continuing to assure that payment and administrative barriers for providers are identified and addressed is an important part of making sure that a diverse and vibrant provider workforce exists.

**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 **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.)?

- A. While access to care can be measured as the availability and clinical outcomes of care, it is important that the patient experience is also considered. The NHC encourages CMS to build measures that capture the true patient experience. Factors such as wait times, grievances, and appeals are often key measures of patient experience and satisfaction. We encourage CMS to build in measures that assess patient burden in accessing care and satisfaction with their experience.
2. 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?
    - A. One of the most important things CMS can do to assure access to LTSS and HCBS is to monitor access, usage, and waiting lists for services, both the waiting list for waiver services and the time it takes to initiate services once found eligible and off the waiting list. This will allow for comparing states and addressing states where there is limited access to LTSS for various reasons. One issue is that in many states, individuals don't have real Medicaid LTSS options because provider payment rates are set extremely low, resulting in extremely limited provider pools and quality concerns. CMS should review state LTSS provider rates, particularly for HCBS, and build incentives and penalties to address this issue.