



On April 18, 2022, 25 patient and consumer organizations submitted the following recommendations to the Centers for Medicare and Medicaid Services (CMS) in response to the Request for Information: Access to Coverage and Care in Medicaid and CHIP.

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.

Question 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.

Our organizations encourage CMS to work with states to use information from other programs to simplify the eligibility process for beneficiaries to the greatest extent possible. This could include urging states to adopt the Express Lane Eligibility (ELE) option for children, allowing states to use information from approved agencies like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Head Start to facilitate enrollment in healthcare coverage, as well as outlining a pathway to apply ELE processes to adults and facilitating data system coordination between Medicaid, Supplemental Nutrition Assistance Program (SNAP), and other public programs. For example, only 30 states use Supplemental Nutrition Assistance Program data to verify income and even fewer are using ELE for children. CMS should also publicize the cost and labor efficiency of ELE determinations to educate states about these benefits of these processes. CMS could also create a learning collaborative

focused on best practices when sharing data between systems and help states write data-sharing memorandums of understanding.

The patients we represent rely on many different pathways to enroll in Medicaid coverage. CMS should ensure that beneficiaries can submit applications by telephone in all states and encourage states to implement mobile-friendly formatting. While states are required to accept applications online, in person, by mail, or by telephone, only 49 states accept telephone applications and 32 states have mobile-friendly formatting on their online application. [1] Patients with chronic conditions can face barriers traveling in-person to agency offices. Further, comfort with technology and accessibility of stable internet varies widely among beneficiaries. In order to ensure timely receipt of information, it is vital that patients have as many ways to submit their application and renewal information as possible.

Finally, transparency is important to hold states accountable for processing applications in a timely manner. CMS should publicly report states' monthly performance indicator data more frequently. States are currently required to report on application processing time and CMS should be commended for including this data in their Medicaid and CHIP Scorecard. However, there is a lag of approximately a year and only three months of data are released, masking issues such as Missouri's current application wait times. Improving the timeliness and frequency of this public reporting could lead to greater accountability for states.

[1] Tricia Brooks et al., "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey," Kaiser Family Foundation and Georgetown Center for Children and Families, March 2022, <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/>.

Question 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?

Robust outreach and enrollment efforts are critical to addressing barriers to enrollment. Our organizations have supported increased funding for these efforts and urged HHS to focus resources on addressing disparities in coverage. To that end, our organizations recommend that CMS:

- **Work with states to maximize their outreach and enrollment funding using CHIP administrative dollars.** 42 U.S.C. §1397bb (2018) and 42 C.F.R. §457.90 (2001) require that states use CHIP administrative funds to conduct outreach targeted towards children who are likely to be eligible for Medicaid or CHIP. The only limitation on using CHIP-matched funds for outreach is that a state's total administrative expenses (including outreach) not exceed 10 percent of total CHIP expenditures. An analysis by the Georgetown University Center for Children and Families shows that in 2019, only four states had administrative expenditures greater than 7.5 percent of total administrative funds—meaning that the vast majority of states have ample room to increase their spending on outreach and enrollment backed by the higher CHIP match. [2]

- **Ensure that states report outreach activities in the state plan and CHIP annual reports.** When states publicly report their outreach activities, it makes it easier for community-based organizations and advocacy groups like ours to coordinate their efforts with the state. Our groups can provide input on the state’s outreach strategy and help the state reach sometimes hard-to-reach populations.
- **Prioritize investment in targeted, community-based outreach and enrollment assistance programs.** CMS should catalog which states have certified application counselor programs (CACs) and assess where there are geographic, cultural, linguistic, and accessibility gaps. Then, CMS could work closely with states to ensure federal funding is supporting the expansion of CAC programs and other community-based assistance where it is needed most.
- **Ensure that all notices, forms, and program materials meet plain language requirements and language assistance is readily available.** CMS should support states in reviewing the accessibility of notices that require action by the enrollee or applicant and ensuring that all materials include taglines informing beneficiaries of their right to free language assistance and auxiliary aides. When states choose not to use the single streamlined application template released by CMS, CMS should ensure that the alternative application does not include extraneous questions and still meets plain language requirements. CMS could track if states are following accessibility requirements on the Medicaid and CHIP Scorecard.
- **Support states as they customize non-English language outreach and consumer assistance tools.** To reach immigrant families, it is essential that CMS help states distribute official (and accessible) materials explaining that applying for Medicaid coverage will not count against an individual when applying for citizenship. We also recommend that CMS inventory the availability of non-English language materials and support states in creating consumer assistance resources such as instructional videos and online chat support tools.
- **Assess cultural and language barriers to Medicaid enrollment and redetermination.** An Illinois survey conducted by academic researchers and non-profit organizations found that limited English proficiency (LEP) Medicaid beneficiaries were at heightened risk of losing their benefits at redetermination and that language barriers played a role in this loss. [3] This survey design employed bilingual staff at community agencies whose services targeted Arabic, Chinese, Korean, and Vietnamese populations. Staff called individuals in these populations who were or had recently been receiving Medicaid benefits and asked them about their experience with the redetermination process. CMS should encourage state governments, academic institutions, and NGOs to replicate these surveys to identify cultural and language gaps.
- **Encourage state Medicaid and CHIP agencies to invest in community-based organizations or qualified oral interpreters.** Linguistically accessible paperwork, while helpful, is not sufficient for eliminating linguistic and cultural barriers to coverage for LEP individuals. Research, including the Illinois survey described above, indicates that these populations are turning to community-based organizations for assistance filling out redetermination paperwork. CMS should encourage state agencies to contract with community-based organizations, application assisters, and providers to assist LEP individuals with enrollment and redetermination processes.
- **Develop a model full-service assister portal.** While portals like Kynect, which serve both the Marketplace and Medicaid eligibility system, give assisters valuable tools to keep track of and support their clients, many states do not have the technology capability to implement such portals. CMS could work with a technology vendor to create a model system or code states could use.
- **Support the implementation and simplification of multi-program applications.** Multi-program applications that integrate health and non-health eligibility systems cut down on the “time tax”

and administrative red tape that individuals face. They can also help address the social drivers of health by connecting individuals to more resources. Ideally, applications should be person-centered and responsive to an applicant's answers so that they do not have to answer more questions than required. For example, in 2019, Michigan redesigned and shortened its social assistance application, cutting average application time in half. [4]

CMS can also reduce barriers to enrollment through changes to Section 1115 demonstration waivers. CMS should rescind the authority for waivers included in section 1115 demonstrations that chill enrollment and increase churn, such as premiums and cost-sharing beyond the limits allowed in the statute. We applaud CMS for its decision to phase down premiums in Arkansas and Montana as well as deny Georgia's request for premiums. Currently, premiums are still approved as part of the Iowa Wellness Plan demonstration (expiring 12/31/2024); the Healthy Indiana Plan demonstration (expiring 12/31/2030); the Healthy Michigan demonstration (expiring 12/31/2023); and the Wisconsin BadgerCare Reform demonstration (expiring 12/31/2023). We urge CMS to withdraw these states' authority to impose premiums beyond those allowed under statute. CMS should also end approvals of 1115 waivers that limit retroactive coverage, which put patients at risk for additional medical debt and may lead to additional delays in accessing care.

Additionally, our organizations encourage CMS to craft guardrails to ensure that future section 1115 demonstrations and state plan amendments (SPAs) will improve enrollment and retention. We urge CMS to require that states submit a coverage impact and equity analysis with any proposed changes, similar to the guardrails that states follow for 1332 waivers. The analysis should include the number of coverage months that would be gained or lost, the benefits that would be increased or decreased, and which populations the proposed change would most likely impact. All projections should be disaggregated by race and ethnicity. CMS should post the coverage impact and equity analysis publicly with the SPA or 1115 application.

[2] Joan Alker and Tricia Brooks, "Millions of Children May Lose Medicaid: What Can be Done to Help Prevent them from Becoming Uninsured?" Georgetown University Center for Children and Families, February 2022, <https://ccf.georgetown.edu/2022/02/17/millions-of-children-may-lose-medicaid-what-can-be-done-to-help-prevent-them-from-becoming-uninsured/>.

[3] Mansha Mirza et al., "Medicaid Redetermination and Renewal Experiences of Limited English Proficient Beneficiaries in Illinois," *Journal of Immigrant and Minority Health* 24, no. 2, February 2022 (pg. 146-147), <https://pubmed.ncbi.nlm.nih.gov/33755840/>.

[4] See "Project re:form: Removing Barriers to Benefits by Transforming the Longest Assistance Application in America" Available at: <https://civilla.org/work/project-reform>.

Question 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?

Data are crucial for identifying disparities and where policy interventions are needed to address inequities. CMS should work to improve collection and reporting of race/ethnicity/language, sexual orientation and gender information, disability status (beyond eligibility category), and other enrollment data. CMS should study and lift up the examples of states that have worked to improve their data collection and reporting. For example, although race/ethnicity is an optional question on Medicaid applications, there are many improvements that states could make to increase response rates and

accuracy, including adding more subgroups (such as Middle Eastern/North African) and training navigators and assisters on the importance of answering this question.

Comprehensive, transparent and timely data on key indicators of enrollment is critical for CMS, states and other stakeholders to monitor enrollment and identity concerns. CMS should require states to report the total number of pending applications/renewals, the number of renewals determined *ex parte*, the number of applications renewed using a pre-populated form, the number of applications/renewals found ineligible, the number of applications terminated for procedural reasons, and the number of fair hearings pending more than 90 days. The data should be reported both throughout and after the unwinding of the COVID-19 public health emergency (PHE) continuous eligibility period. CMS should post the data within 30 days after it receives the data from the states, meaning that the data is no more than two months old.

Call center statistics and, if applicable, online assistance data are also important indicators of patients' experience with the enrollment process. Call center statistics should include call volume, average wait time, and call abandonment rate. Online assistance data should include the number of online chat requests initiated, the number completed, and the share that are deemed successfully resolved. We recommend states be required to disaggregate the statistics at a minimum by eligibility group and age and, where possible, by race/ethnicity. The data should be reported on a monthly basis no more than 30 days after the end of the month both throughout and after the unwinding of COVID-19 PHE continuous eligibility period. CMS should post the data within 30 days after it receives the data from the states, meaning that the data is no more than two months old.

Finally, CMS should increase oversight in states where the share of procedural disenrollments exceeds the national median. States that conduct frequent periodic data checks may be erroneously disenrolling beneficiaries who are not able to respond to requests for information in the limited timeframe they are given. In order to minimize these disenrollments, CMS should calculate the median based on the reporting described above. For the states that exceed the median, CMS should undertake additional federal oversight of state eligibility and enrollment processes and enforce corrective action plans if necessary.

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).

Question 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?

Patients with serious and chronic conditions cannot afford gaps in coverage. While monitoring eligibility redeterminations will be particularly important at the end of the COVID-19 PHE, strong monitoring and oversight of the eligibility redetermination process is important to ensure access to care for the patients we represent at any time. In addition to the recommendations under Objective 1 regarding important data points for CMS and states to monitor and publicly report on, our organizations also urge CMS to require states to monitor rates of re-enrollment after disenrollment (“churn.”) States should track the share of individuals who reenroll within three months, within six months, and within a year of losing coverage as well as average length of time between disenrollment and reapplication. All data should be stratified by eligibility group, age, income, and to the extent possible race/ethnicity. Disenrollment data should also be sorted by reason for disenrollment, including full determination of ineligibility, procedural determination (and its subcategories explained in Objective 1, Question 4), and if there was a successful account transfer to the Marketplace.

Our organizations strongly support the expansion of continuous eligibility to ease the administrative burden on patients and help them keep their healthcare coverage. We urge CMS to publish a template for section 1115 demonstrations that test the benefits of continuous eligibility for adults and issue a state Medicaid director letter encouraging states to submit such proposals. The 1115 demonstration template should include guidance on how states can incorporate the administrative cost savings that come with continuous eligibility into their budget neutrality analyses. Further, CMS should allow states to implement multi-year continuous eligibility for young children on Medicaid. The evidence is clear that continual access to coverage leads to better outcomes, high quality of life, and cost savings for people with chronic conditions. CMS could also incorporate continuous eligibility into the Medicaid and CHIP scorecard as a measure of state health system performance. States may be incentivized to adopt continuous eligibility when it is contextualized as a measure of system performance and efficiency.

Finally, our organizations urge CMS to release the guidance required under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. The guidance should outline how states can use section 1115 demonstrations to request authority to facilitate Medicaid enrollment and provide healthcare services to incarcerated individuals 30 days prior to their return to the community.

Question 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?

CMS should develop best practices for states to identify predictable risks for disenrollment and conduct targeted outreach to assist with transitions that minimize gaps in coverage. Medicaid enrollees are at risk for disenrollment at certain milestones. All enrollees are at risk of disenrollment (usually) at their annual renewal. Additionally, several categories of eligibility have predictable risks of disenrollment at known life events: children when aging out of coverage categories, pregnant individuals after postpartum coverage, parents when children age out, and adults when aging out of Medicaid expansion eligibility. CMS should develop best practices for targeted outreach to beneficiaries in such circumstances, including the use of text messages, emails, and phone calls in addition to regular mail.

This outreach should occur multiple times — for example, three months, one month, and one week prior to sending renewal materials for predictable life events.

Additionally, CMS should develop best practices for states to leverage health plan and provider information to improve renewal success rates. Plans and providers could remind beneficiaries to renew, share records including addresses, collect and share required paperwork, or help with other renewal-related tasks. CMS should work with states to have managed care plans and assisters supplement a state's communications efforts (regular mail, email, text messages, phone calls) with text reminders, document scanning, and other renewal-related tasks.

Question 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 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?

One third of adults who lose Medicaid eligibility at the end of the COVID-19 PHE are estimated to be eligible for Marketplace coverage, and our patients in particular need a smooth transition between sources of coverage to appropriately manage their health conditions. [5] The extension of the American Rescue Plan's enhanced premium tax credits will be essential to ensure that these patients have access to quality, affordable coverage. In addition, during the unwinding of the COVID-19 related continuous coverage period, we recommend that CMS and CCIIO work together to:

- **Use existing flexibilities to allow people disenrolled from Medicaid ample time to enroll in marketplace coverage.** This should include allowing for a Special Enrollment Period (SEP) for those previously enrolled in Medicaid—an appropriate and logical policy following the Administration's COVID SEP that resulted in historic gains in enrollment. Additionally, CMS could generously interpret the SEP for those who were not timely aware of their loss of Medicaid eligibility during this transition period. This may include allowing an individual to attest to failure to receive timely notice and count 60 days from the date the individual learned of their disenrollment from Medicaid.
- **Facilitate enrollment through Navigators by sharing lists of individuals disenrolled from Medicaid with Navigators so they can better target their outreach and enrollment efforts.** While state Medicaid agencies are supposed to transfer an individual's information to the Marketplace when they are determined ineligible for Medicaid, individuals will likely require additional guidance completing the application process. CMS and CCIIO should encourage states to provide Navigators with information about individuals who have been disenrolled to increase the likelihood of a warm handoff.
- **Ensure Navigators have sufficient funding, resources, and information to help facilitate enrollment of individuals previously covered by Medicaid.** CCIIO should be commended for restoring funding to Navigators. However, individuals transitioning from Medicaid may require greater assistance picking a plan than their peers. And, given the anticipated increase in the caseload on top of post-enrollment duties from the SEP's historic gains, programs may be stretched beyond capacity without additional resources.

- **Prohibit enhanced direct enrollment sites (EDEs) and brokers from selling non-ACA compliant plans.** EDEs and brokers traditionally receive higher compensation for non-ACA products and may be more likely to steer individuals to short-term plans—which are particularly inadequate for people with chronic conditions. To ensure that individuals are getting appropriate products for their needs when they lose the relatively comprehensive benefits of Medicaid coverage, CMS and CCIIO should change short-term plan rules to prohibit EDEs’ and brokers’ sale of these plans during the unwinding period.
- **Encourage regulators and Marketplace plans to stay in communication about network capacity as enrollment increases during the unwinding of the continuous eligibility period related to the public health emergency.** CCIIO should work with states to collect real-time Marketplace plan enrollment data and consider various mitigation strategies if enrollment exceeds network capacity. Strategies CCIIO could suggest include shutting off further enrollment in a plan; extending continuity of care protections to enrollees unable to access providers and facilities within the quantitative network adequacy requirements; and allowing individuals to change Marketplace plans.

The need for smooth transitions between Medicaid and the Marketplace will not end with the COVID-19 PHE. Generally, to ensure successful transitions between Medicaid and the Marketplace, we recommend that CMS and CCIIO work together to:

- **Ensure that Marketplace plan coverage is effective on the first day of the month after a person losing Medicaid coverage enrolls, even if that person enrolls after the 15th of the month.** Completing the application process for Marketplace coverage can be burdensome and result in gaps in coverage as individuals collect needed paperwork. CMS and CCIIO can support continuity of coverage—which is of utmost importance to individuals with chronic conditions—by ensuring coverage is retroactive to the first day of the month in which an individual starts the application process.
- **Use every available opportunity to facilitate enrollment with applications pre-populated with information included in the file transfers.** In addition to just transferring data from Medicaid to the Marketplace, the Marketplace should use the data to pre-populate an application and ask the individual to verify the information included. CMS could provide technical and IT assistance in this endeavor.
- **Consider possibilities for auto-enrollment in \$0 premium plans.** CMS should work with federal and state legislators as well as IT vendors to craft an option allowing individuals to consent to enrollment in a \$0 premium plan. The agencies should consider appropriate guardrails, such as allowing individuals to change plans within a set timeframe if they face issues related to network access or prescription drug coverage.
- **Ensure that outreach and advertising during the transition directs people to silver level plans in order to obtain the cost-sharing assistance, if applicable.** For those who are eligible for cost-sharing reductions but who enroll in a bronze plan, healthcare.gov can send a notice of the availability of cost-sharing help and the opportunity to change plans if the enrollee is still within their SEP window and hasn’t effectuated coverage.
- **Recognize challenges of transitioning to new coverage, particularly for those who transition mid-plan-year and who have substantial health care needs.** This would include allowing enrollees to maintain access to their provider with in-network cost-sharing under the new plan, having pro-rated cost-sharing for the partial-year coverage, and carrying over or guaranteeing expedited approvals for treatments covered under their Medicaid plan.

- **Require a minimal level of commissions for enhanced direct enrollment sites and brokers during special enrollment periods.** This change could help shift the incentives for EDEs and brokers who often push non-ACA compliant products which provide poorer coverage for the patient, but are more lucrative for the EDE or broker.

Finally, there are important steps that CMS could take to improve individual transitions between eligibility groups within Medicaid and/or between MCOs. For these individuals, we recommend:

- **Encourage state Medicaid agencies to require MCOs to be more proactive in assisting with transitions within Medicaid.** CMS regulations at 42 C.F.R. §438.208 require MCOs to implement procedures that meet state requirements for delivery and coordination of services to enrollees and to conduct initial screenings for enrollees. CMS should encourage states to require MCOs to assist individuals with predictable life events (aging out of children’s coverage, aging out of Medicaid expansion, etc.) to ensure continuity of providers after transition. CMS should also encourage states to require MCOs to move quickly to conduct initial assessments after transitions for existing enrollees and, in the case of changes in eligibility groups by existing enrollees, to conduct a review of related changes in benefits and develop a plan for addressing those changes.
- **Develop standards for MCOs to allow individuals to complete courses of treatment and prescriptions and honor prior authorization requirements after new transitions.** Specifically, CMS should implement policy requiring that, when individuals are involuntarily transitioned outside of normal or annual enrollment periods, or when an MCO alters a provider contract or coverage policy, enrollees have a transition period where they can still access the providers, treatments or services in question. Ideally, such a transition period would be long enough to allow an enrollee to select a new MCO, if they so choose. Medicaid enrollees should not be forced to remain in a managed care plan while the plan is allowed to materially change their coverage or providers.

[5] Matthew Buettgens and Andrew Green. What Will Happen to Medicaid Enrollees’ Health Coverage after the Public Health Emergency? March 2022. Available at: https://www.urban.org/sites/default/files/2022-03/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency_1_1.pdf.

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.

Question 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?

Our organizations strongly support the development of minimum quantitative standards for network adequacy in Medicaid managed care. CMS regulations at 42 CFR 438.206(b) require that states develop a “quantitative network adequacy standard” for each of seven different provider types (if covered under the state’s contracts with MCOs). The purpose of these standards is to ensure that MCO provider networks are sufficient to provide access for all enrollees to all services covered under the state’s contract with the MCO. CMS should develop minimum quantitative standards, including time-and-distance and appointment wait time, and revise its regulations to require that states enrolling beneficiaries in MCOs require those MCOs to meet or exceed the CMS minimum standards. The CMS minimum standards for Medicaid network adequacy should be at least as protective of beneficiary access as those developed for QHPs in the Marketplace under the January 5, 2022 Notice of Benefit and Payment Parameters. CMS should also revise its regulations to expressly require that, in conducting readiness reviews, states determine whether an MCO’s provider network meets the minimum quantitative standards (or, if more protective of beneficiaries, the state’s quantitative standards) for network adequacy.

Many of our patient communities have experienced problems accessing needed medications through state Medicaid programs. Our organizations urge CMS to develop minimum standards for access to prescription drugs for all Medicaid and CHIP beneficiaries in both managed care and FFS states. This will require collecting data not currently available from other sources to understand drug access issues. For example, in the area of Medicaid prior authorization, this would include: (1) the process for setting preferred drug lists; (2) the process for setting clinical criteria used for coverage of non-preferred drugs requiring prior authorization; (3) information on the effect of the prior authorization process on access to needed medications; and (4) the adequacy of pharmacy networks, including the availability of 24-hour pharmacies and pharmacies with translation services and cultural competencies. (For additional detail on prior authorization processes, see the recommendation in Objective 4, Question 4). We also urge CMS to collect data on the impact of monthly limits on prescriptions for drugs and, if the evidence shows that such limits impair access, prohibit the imposition of such limits, regardless of whether the beneficiary has a right to seek an exception on a case-by-case basis. Even in cases where the state allows exceptions to the limits on a case-by-case basis, beneficiaries may be deterred by the appeals procedures from seeking an exception.

Question 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?

Our organizations have urged HHS to prioritize access to culturally and linguistically competent care when evaluating network adequacy in the Marketplace, and we are pleased to see a similar focus in this RFI. First, we urge CMS to set digital accessibility standards for state Medicaid websites and MCO websites consistent with the Department of Justice’s recommended strategies for developing multilingual digital services. These strategies include ensuring websites have tagline notices in non-English languages directing people with LEP to translated materials and informing them of access to language assistance services, as well as ensuring websites are accessible to people with disabilities. If not all important information is translated online, such as language in footers and disclaimers, websites should indicate this to people with LEP and direct them to where they can find that information. Any

telephone numbers provided for assisting beneficiaries should offer non-English voicemail menus, and customer service representatives answering the phone should have access to qualified interpreters. Additionally, managed care provider directories should be accessible to people with LEP and indicate which providers have multi-cultural competencies.

CMS should also encourage states to adopt language access policies that explicitly require translation and interpretation services for LEP and disability populations. Under Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act, states are required to ensure LEP individuals can meaningfully access Medicaid and CHIP benefits. While all states have passed laws protecting language accessibility for health care services, only a limited number of states require the comprehensive translation and interpretation services that would be necessary for meaningful access to care. Comprehensive language access laws have increased Medicaid enrollment in states where they are enacted, and CMS's guidance should strongly recommend their use.

Finally, CMS should recommend cultural competency training for interpreters and providers. At least six states—California, Connecticut, Iowa, New Mexico, Oklahoma, and Oregon—have passed language access laws addressing the need for cultural competency in health care or mandating cultural competency training for translators and some health professionals. CMS should promote these policies as ways to expand access and improve care for LEP and immigrant Medicaid beneficiaries. CMS can leverage the managed care contract review process to accomplish this.

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.

Question 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) 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?

As a starting principle, our organizations urge CMS to develop an access monitoring approach that includes fee-for-service AND all waiver programs (including managed care and HCBS programs). Patients need access to comprehensive, timely treatment regardless of the delivery system.

Transparency is fundamental to monitoring access. However, the current version of the Medicaid & CHIP Scorecard contains only some access metrics, does not include any equity metrics, does not break down access on a population-specific basis (children, maternal health, individuals with behavioral health needs, etc.), and does not post MCO-specific performance data. Our organizations therefore recommend that over the next year, CMS establish a new access monitoring dashboard on Medicaid.gov

to post all access information currently reported to CMS by all states, both FFS and managed care, as well as the access metrics in the Child and Adult Core sets, on a state- and MCO-specific basis. Over time, CMS could also supplement this state-reported information with its own analyses of access patterns by race/ethnicity derived from the T-MSIS database and rank states and MCOs by performance on access metrics for different populations and services (well-child care, behavioral health, HCBS, etc.).

*Question 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.)?*

Our organizations urge CMS to adopt a multi-pronged approach to monitoring the robustness of provider participation across delivery systems. CMS should require all states to collect data on time and distance standards, appointment wait times, share of providers accepting new patients, share of providers equipped to serve beneficiaries with limited English proficiency, share of providers trained in serving LGBTQ+ populations, and share of providers whose offices are accessible to people with disabilities. These metrics should be reported annually to CMS on a statewide and, in managed care states, on an MCO-specific basis. Additionally, CMS should conduct “surveillance testing,” including secret shopper surveys and provider directory audits which measure both accuracy and accessibility. The targeting of these surveys and audits should be informed by the state reporting of standard access metrics, above.

Our organizations also urge CMS to clarify that MCO provider directories must be user-friendly and equipped with the appropriate functions. 42 CFR 438.10(h) requires that each MCO make available to enrollees and potential enrollees a provider directory containing specified information. CMS should clarify in guidance that provider directories should be able to search and/or filter results, are accessible using adaptive technology, and list all relevant features of a practice (i.e., language, LGBTQ+ affirming, physical and programmatic accessibility, and if a provider offers non-standard hours).

*Question 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?*

CMS should require all states to report, on an annual basis, standardized data on appeals and grievances and Medicaid fair hearings. Data should be disaggregated by demographic factors, provider type, service type, reason for denial, access to aid paid pending appeal, whether consumer was represented in the appeal, and disposition of grievance or appeal, including time to resolution and outcome. States contracting with MCOs should report information on an MCO-specific basis. States and CMS should review the data to identify and remediate potential access problems.

Our organizations also urge CMS to require all states to report, on an annual basis, information on the effect of prior authorization requirements on access to care. This information should include prior authorizations requested and prior authorizations approved and denied, disaggregated by type of service and race and ethnicity of the beneficiary. In the case of managed care states, the information

should be specific to each MCO. With respect to prescription drugs, the information should include: (1) the percentage of prior authorization requests that were denied; (2) the percent of prior authorization requests for which there was no response within the required 24 hours; (3) the percentage of emergency situation prescriptions that were not dispensed within 72 hours while a prior authorization request was being resolved; (4) the percentage of prior authorization denials that were appealed; and (5) the procedures/paperwork that are required to obtain prior authorization. States and CMS should review the data to identify and remediate problematic prior authorization regimes, with particular focus on access to needed medications.

Question 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.)?

Our organizations urge CMS to continue using T-MSIS data to analyze treatment accessibility for conditions. CMS's January 2021 Medicaid and CHIP Sickle Cell Disease Report created using T-MSIS files was a laudable first step in using the data to study access to treatment. [6] CMS should continue to use T-MSIS in this way to study access to care for Medicaid and CHIP beneficiaries with other conditions and create a library of resources. When conducting these studies, CMS should engage the patient community and relevant experts for the condition which they are examining to better understand what type of information would be useful.

[6] Wilson-Frederick, S., et al., "Medicaid and CHIP Sickle Cell Disease Report, T-MSIS Analytic Files (TAF) 2017," Center for Medicaid and CHIP Services, Division of Quality and Health Outcomes, January 2021, <https://www.medicaid.gov/medicaid/quality-of-care/downloads/scd-rpt-jan-2021.pdf>.

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 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.

Question 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?

In determining whether capitation rates paid to MCOs are actuarially sound, CMS should ensure that the rates it approves are sufficient to support payments to providers that will enable an MCO to recruit and maintain a provider network that meets minimum CMS quantitative network adequacy standards. CMS regulations at 42 CFR 438.4(b)(3) require that, in order to be approved by CMS, capitation rates must be “adequate to meet the requirements on MCOs” relating to network adequacy—i.e., that the MCO’s provider network is sufficient to provide adequate access to all services covered under the risk contract with the state Medicaid agency. In response to Objective 3, Question 1, we recommend that CMS require states to adopt minimum quantitative standards for network adequacy that are at least as protective of Medicaid enrollees as the standards that CMS has proposed to apply to QHPs for the protection of consumers in the Marketplace. CMS should align the review and approval of capitation rates with the adoption of these minimum quantitative standards.

Recommendations submitted by:

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
American Kidney Fund
Asthma and Allergy Foundation of America
ALS Association
Cancer Support Community
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Lupus Foundation of America
Muscular Dystrophy Association
National Coalition for Cancer Survivorship
National Eczema Association
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National MS Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society