United States of Care's Response to CMS Access to Coverage and Care in Medicaid & CHIP 2022 Request for Information

On April 18, United States of Care (USofCare) submitted responses to a Request for Information (RFI) from the Centers for Medicare and Medicaid Services (CMS) on access to coverage and care in the Medicaid and CHIP programs. CMS posed a series of questions to stakeholders focused on various topics related to health care access, including: enrollment policies, maintaining coverage, and access to services and supports. USofCare selected a handful of these questions and submitted the following responses to CMS, based on our people-centered work to increase access to high-quality, affordable health care coverage and services. We focused our responses on supporting enrollment and eligibility practices, promoting consistent coverage, and increasing sustainable access to whole-person care.

Objective 1 (Eligibility): 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 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?*

We appreciate the focus on improving enrollment and retention for those enrolled in Medicaid, as we know barriers to enrolling and maintaining coverage affect the continuity of care and costs states and the federal government money. To ensure eligible people can enroll and stay enrolled in Medicaid, the federal government should continue providing states with funding for improving and further building out their eligibility and enrollment systems and should explore ways to incentivize states with outdated eligibility and enrollment systems to update their systems. For example, CMS should continue to provide support to states that want to better build out their Medicaid eligibility systems in a way that leverages other assistance programs, such as the Supplemental Nutrition Assistance Program (SNAP), which only 28 states currently do.

Special priority should be given to states directly tackling disparities in enrollment, such as providing states with funding to improve the enrollment processes for individuals with limited English proficiency (LEP) or providing specific training to customer service representatives who assist people with enrollment in Medicaid coverage. For example, Colorado currently requires full Medicaid beneficiary correspondence to be translated into the second most commonly spoken language as well as the inclusion of translated "taglines" for the top 15 languages by speakers in the state. Tennessee enables extensions on all Medicaid paperwork for those who require translation services. CMS could provide incentives for additional states to invest in actions such as these that promote enrollment for individuals with LEP.

Additionally, CMS could encourage states to utilize Section 1115 waivers as a way to achieve targeted expanded eligibility for specific populations and invest resources in the enrollment and retention of coverage for these specific populations. CMS should work with states to include these policies as they apply for or renew 1115 waivers. Some states have pursued 1115 waivers to create population-specific eligibility expansions for people who have historically faced barriers to accessing care, including individuals with mental health and substance use disorders, and those and other models can be highlighted by CMS as states apply for and renew 1115 waivers.

CMS should also create incentives for states pursuing certain policies geared at increasing enrollment and retention, similar to how CMS created options for states to implement targeted enrollment strategies in the past. These tools can also protect the coverage gains made since the Public Health Emergency (PHE) began, providing people with a dependable source of coverage.

CMS also has the opportunity to clarify guidance on how state agencies and contractors, such as MCOs, can utilize text messaging to communicate with beneficiaries. Text messaging can ease redeterminations and promote continuity of coverage for beneficiaries by sending renewal reminders and updates through the communication method that is most comfortable for them. For example, in December 2020, Montana began sending one-way text and email messages to beneficiaries when it received returned mail asking enrollees to update their mailing addresses, and about 25% of individuals who received a text message responded to update their address. Clarification on the utilization of text messaging as a form of communication with beneficiaries is needed for state Medicaid agencies, MCOs, and third-party contractors to use all tools available to them.

Objective 2 (Consistent Coverage): 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?*

CMS should identify policies that states can enact to improve enrollment and retention and create incentives for states pursuing them. Given the anticipated end of the Public Health Emergency (PHE), there is now an even greater opportunity to not only preserve the coverage gains made to date but to expand on those across all coverage options. States are currently exploring options through 1115 waivers and other mechanisms to ease the impact of the end of the PHE and continuous coverage requirements, and CMS can learn from these approaches when approving other state waivers and in thinking about longer-term federal policy change.

For example, the continuous coverage provisions included in the American Rescue Plan Act (ARPA) made it clear that there are benefits to easing the Medicaid renewal process, and CMS should identify and assess the impacts of offering states the ability to utilize similar approaches, weighing the benefit to beneficiaries, the cost savings for state eligibility and enrollment systems, and the potential costs to the state and federal government. CMS should explore whether some policy options for states can be more targeted or temporary in nature in order to address a state's acute needs while not necessarily requiring funds over multiple years, such as creating continuous coverage policies for certain children. Given that states will be more likely to take up these policy options if they are provided financial incentives for doing so, CMS should explore whether the federal government should provide enhanced federal funding to states that enact certain policies (as was done with targeted enrollment strategies offered to states in the past and through ARPA).

We commend the federal government's recognition of the importance of continuous coverage for pregnant and postpartum people, as there is growing evidence that a number of postpartum deaths occur after the current 60-day Medicaid postpartum coverage window. The provision in the ARPA that authorized states to pursue a state plan amendment for 12-month postpartum coverage for 5 years went into effect on April 1, 2022, and several states have begun to take up this option. We encourage CMS to provide incentives for states to continue to offer 12-month postpartum coverage after the 5-year period allowed under the ARPA to improve outcomes for pregnant persons and their families.

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?*

States need to have the flexibility needed to communicate with beneficiaries in the most effective way to promote continuous coverage and prevent avoidable disenrollment. These flexibilities include flexibility in the mode of communication, targeted outreach and enrollment assistance for people with limited English proficiency, the ability to partner with third-party contractors and other state agencies to obtain up to date contact information, and additional assistance for those most at risk of losing coverage through life's changes.

Mode of communication: As text messaging is rapidly becoming the prominent form of communication for a majority of the population, it has emerged as an alternative way for providers and patients to communicate, easing barriers to accessing care. However, text messaging is not currently utilized to its full potential. Although state Medicaid and CHIP agencies can communicate via text messaging, according to the Federal Communications Commission's (FCC) interpretation of the Telephone Consumer and Protection Act (TCPA), managed care organizations (MCOs) and third-party contractors are unable to communicate with their beneficiaries through text messaging. By allowing MCOs to communicate with their beneficiaries, they can inform beneficiaries at-risk of disenrollment about necessary steps needed for these members to stay insured and reduce gaps in coverage. CMS, along with the FCC, can clarify or issue new guidance on how text messaging can and should be used by state Medicaid agency contractors, including MCOs.

Assistance for individuals with LEP: CMS could encourage states to expand outreach and targeted interventions for beneficiaries with Limited English Proficiency (LEP). One study found that beneficiaries with LEP are drastically more likely to lose their coverage than those who are proficient in English. As mentioned previously, to address these barriers to consistent coverage, Colorado and Tennessee have both worked to ease the burden on beneficiaries with LEP through translation services and extensions on paperwork to accommodate translation needs. CMS could recommend that all states form relationships with community partners who may be able to conduct outreach, as well as other guidelines for translation services and access to information.

Partnering with MCOs: Further, In 2020, it was estimated that nearly 10% of Medicaid enrollees experienced a change in address. This can negatively impact their Medicaid eligibility during renewal periods if their information is not up to date. To address this issue, Arizona implemented messaging toolkits with best practices and directions to contact enrollees and make system updates. CMS could suggest or provide incentives for states to utilize the CMS messaging toolkit and actively collaborate with MCOs in their respective state to conduct outreach and mailing address updates before Medicaid renewal periods. CMS could propose that states specify in their contracts with MCOs that they must proactively engage with

Medicaid state agencies to update and maintain mailing address data to mitigate churn that occurs from procedural delays. We recommend CMS provide template language for states to include in MCO contract language to address this issue.

Coordinating with state agencies: Currently, some Medicaid enrollees are at risk of losing coverage due to mail that is returned with no forwarding address. To address this issue, 44 states already use a non-health program to help locate and or verify a current mailing address for enrollees, such as the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). In addition to coordinating with other state agencies, CMS could also recommend that state Medicaid agencies also collaborate with MCOs or other providers to identify the most current addresses of beneficiaries.

Addressing churn: Additionally, every year during health insurance enrollment periods, there are a number of individuals who fall in and out of coverage, known as the 'churn population'. When the Public Health Emergency (PHE) ends and Medicaid redeterminations resume, 15 states plan to utilize electronic data to proactively contact state residents who may no longer be eligible for Medicaid so they can be enrolled in an alternative plan to support continuity of coverage as they churn between coverage options. We recommend that CMS include this proactive approach to contacting at-risk Medicaid enrollees in all Medicaid programming guidance permanently.

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 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?*

We know that people want the security and freedom that dependable health coverage can provide as life changes. To that end, we appreciate CMS seeking input on how to promote continuity of coverage, as we know there are harmful effects when people churn off or churn between coverage programs. CMS should ensure states have the tools they need to ensure people maintain coverage, including by approving waivers that specifically focus on continuity of coverage between insurance affordability programs. Given the tremendous coverage gains

made since the emergence of the COVID-19 pandemic, it is also critical that CMS prioritize preserving those gains, and we encourage CMS to also approve temporary waivers that address states' more immediate needs. Many states are already submitting such waivers, such as Oregon's recent 1115 waiver submission that includes temporary provisions focused on extending the continuous coverage period for children and adults.

More broadly, however, CMS should work with states that wish to implement innovative proposals that support continuity of coverage across coverage options through all available authorities. For example, Oregon's legislature approved the creation of a task force to develop a "Bridge Plan" focused on those with incomes between 138-200% FPL, understanding they are at the greatest risk of churning between Medicaid and marketplace coverage, which is a greater risk as the end of the Public Health Emergency and the continuous coverage requirement is imminent. The task force will determine which federal waiver to pursue and was granted authority to submit an 1115, 1331, or 1332 waiver depending on what the task force recommends. We encourage CMS to work with Oregon and other states to approve proposals that allow for the maximum amount of flexibility to support as many people as possible through coverage transitions.

Objective 3 (Access to Care): 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 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?

Care coordination is critical to support continuity of care and limit fragmentation in the health care system. We encourage CMS to explore opportunities to address the care of the whole person through care integration and allow coverage of health-related social needs.

Behavioral Health Integration: CMS can explore opportunities to leverage telehealth technology to support care integration, particularly between primary care and behavioral health care services. However, there is often not a clear referral path to providers due to a lack of behavioral health providers and other barriers to access. Several existing models can potentially be expanded or replicated to promote sustainable reimbursement for virtual consultation services between primary care and behavioral health providers. Examples include the Collaborative Care Model to promote integrated care and HRSA's Pediatric Mental Health Care Access Program, which was expanded to provide grant opportunities to all 50 states under the American Rescue Plan Act. We recommend that CMS explore opportunities to incentivize state Medicaid programs to adopt the collaborative care model to promote care coordination and provide technical assistance guidance for states on how to submit the proper waiver application and/or state plan amendment to stand up the Collaborative Care Model.

We commend the Administration's commitment to primary and behavioral health integration, as was demonstrated by the increase in funding for care integration included in the President's fiscal year 2023 budget. We encourage CMS to work with other agencies within HHS to use this momentum to test payment models that support whole-person care through integration. In addition, we recommend that CMS authorize Medicaid reimbursement for inter-professional consultations so that primary care providers can consult with a specialist, such as a behavioral health provider, to ensure all care needs are addressed. United States of Care also released a set of policy recommendations that explore how virtual care technology can be leveraged to address barriers to accessing behavioral health services and support care integration.

Health-related social needs: We encourage CMS to provide technical assistance and incentives to state Medicaid programs to leverage existing Medicaid authorities to increase access to health-related social needs, further supporting whole-person care. These needs could include transportation services, housing-related supports, and more. CMS can build on existing guidance focused on opportunities in Medicaid and CHIP to address social

determinants of health. Technical assistance could include promoting opportunities to highlight existing state efforts to address care coordination and promote whole-person care, including the Coordinated Care Organization (CCO) model in Oregon, which not only promotes care coordination but also requires all CCOs to create a health equity plan to ensure that all beneficiaries in their service areas have equitable access to necessary services. States are also leveraging Section 1115 waivers to address health-related social needs, including North Carolina through the development of the Healthy Opportunities Pilot Program. We encourage CMS to work with states that express interest in developing innovative programs to address whole-person care by providing technical assistance on the best mechanism to implement such programs.

Collaboration with CMMI: We encourage CMS to work with the CMS Innovation Center (CMMI) to create payment incentives and design models based on the needs of people to promote whole-person care and advance care coordination in Medicaid. United States of Care shared a list of recommendations for CMMI to explore new incentives in Medicaid to promote care coordination and increase equitable health outcomes. These recommendations include opportunities to improve care for people with disabilities and multiple or complex health conditions enrolled in Medicaid, promote parity between mental health and physical health care, and test virtual care models to optimize quality and access for people.

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?*

We appreciate CMS's request for information on opportunities to address cultural competency and language preferences to promote equitable access to care. People continue to highlight barriers to accessing care which reveal inequities in the current system that need to be addressed, including insufficient distribution of providers, transportation barriers, language access challenges, communication barriers due to hearing loss, and a lack of flexible provider hours, among others. As an illustrative example, in several areas of the country, large portions of the uninsured population (up to 69%) reside in households with limited English proficiency (LEP), which has been linked to lower health literacy and worse health outcomes.

Because of these barriers, CMS efforts to improve equitable access should include tailoring provider networks to the specific needs of enrollees, learning from states that are leading in these efforts. Colorado and California are making strides in advancing equitable

access to care through provider network requirements and we encourage CMS to explore opportunities to leverage these or other efforts to continue investing in advancing equitable access to providers.

Colorado has made great strides in addressing cultural competency and advancing health equity in the development of the Colorado Option, a public health insurance option set to launch in 2023. As part of the Colorado Option, the state must develop culturally responsive health care provider networks, which are required to be informed by and be responsive to the unique cultural needs of diverse populations. This first-in-the-nation approach provides a real opportunity to reduce health disparities and champion health equity within the system. As part of the implementation, Colorado must develop specific criteria for issuer network access plans, including a description of their efforts to construct diverse, culturally responsive networks. One strategy to increase access to necessary providers and accompanying information is the requirement for Colorado Option carriers to include additional information in provider directories, particularly related to language access and accessibility. The information must include the availability of translation and interpreter services for people with LEP and the accessibility of services for people with disabilities.

California has comprehensive language access provisions for both providers and issuers to support effective communication and increased health literacy. Language access provisions are critical to increasing access to care and the quality of health care encounters.

Question 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?*

Telehealth: The telehealth flexibilities granted during the COVID-19 Public Health Emergency (PHE) allowed for care continuity and the ability for access to be sustained during periods of quarantine and stay-at-home orders when access to in-person care was severely limited. There is an opportunity to leverage these PHE flexibilities to create sustainable policies that can increase access to the pool of providers available to Medicaid and CHIP enrollees. However, it will be imperative to ensure that expanded telehealth access does not create

additional barriers or enhance inequities for already underserved communities. Opportunities CMS could explore to enhance access to providers via virtual care technology include:

Create sustainable Medicaid and CHIP reimbursement for provider-to-provider consultation via telehealth, particularly for virtual consultations between primary care and specialty care providers. For example, provider-to-provider consultation between primary care and behavioral health providers can promote care integration and help address the existing behavioral health provider workforce shortage that exacerbates access issues. Several existing models can potentially be expanded or replicated to promote sustainable reimbursement for virtual consultation services between primary care and behavioral health providers. Examples include the Collaborative Care Model to promote integrated care and HRSA's Pediatric Mental Health Care Access Program, which was expanded to provide grant opportunities to all 50 states under the American Rescue Plan Act.

Explore opportunities to retain or modify Medicaid provider enrollment flexibilities granted during the COVID-19 PHE to allow for cross-state licensure, while ensuring the efficacy of provider certification standards across states.

Caregiving: Currently, there are 53 million caregivers in the US–64% of whom are boomers or Gen-X. Among caregivers, 61% have another job and more recently, 70% of caregivers have noted experiencing at least one symptom of negative mental health impacts since the beginning of the COVID-19 pandemic. Not only are there more caregivers now than five years ago (as the US population ages), but the general well-being of caregivers is deteriorating as well. One of the biggest strains on caregivers is the financial burden. Not only are caregivers expected to cover general care and health care costs for the individual(s) in need of support, but they may also work fewer hours or take valuable paid, or unpaid, time off from their job. States have been able to help ease this burden by reimbursing caregivers through self-directed Medicaid home and community-based services (HCBS) authorized through 1915 waivers or state plan options.

During the COVID-19 pandemic, some states have allowed more family members to be paid caregivers using PHE-related flexibilities. Since the COVID-19 pandemic, federal policymakers in Congress have recognized the importance of increasing access to HCBS by increasing the HCBS federal medical assistance percentage (FMAP) by 10% for one year in the American Rescue Plan Act. This FMAP increase offers additional funds to help build infrastructure and support family caregivers.

We recommend that CMS explore opportunities to make these PHE flexibilities permanent, benefit new caregivers, and assist individuals who are already acting as unpaid caregivers. We also encourage CMS to explore opportunities to incentivize states to increase Medicaid HCBS payment rates and/or the number of HCBS waiver slots. We also encourage CMS to work with CMMI to explore opportunities to develop payment models that incentivize the provision of HCBS.

If you have questions about our response, please reach out to Rachel Bonesteel, Policy Manager, at rbonesteel@usofcare.org.