United States of Care's Response to Promoting Efficiency and Equity Within CMS Programs Request for Information

On November 3rd, United States of Care (USofCare) submitted responses to a [Request for Information (RFI)](#) from the Centers for Medicare and Medicaid Services (CMS) on efficiency and health equity within CMS programs. CMS posed a series of questions to stakeholders focused on various topics related to health care access, health equity, and the impacts of the COVID-19 pandemic. These topics included health disparities, access to services and supports, and waivers and flexibilities. USofCare 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, increasing sustainable access to virtual care, and extending COVID-19 waivers and flexibilities.

Topic 1: Accessing Healthcare and Related Challenges

CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. We are interested in receiving public comment on personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, or utilizing healthcare services (including medication therapies) across CMS programs.

- *Prompt 1*
    - *Challenges accessing comprehensive and timely healthcare services and medication, including primary care, long-term care, home and community-based services, mental health and substance use disorder services*
    - *Challenges in accessing care in underserved areas, including rural areas*
    - *Challenges of accessing oral health services and the impact on overall health*
    - *Understanding coverage options, and/or technology to support access to coverage*

At United States of Care, listening to people's needs and experiences with the health care system is at the core of what we do, and too often we hear that many people face challenges in accessing comprehensive, timely health care services. During a recent listening tour in rural South Carolina, community members shared their experiences needing to travel long distances and experience long wait times to access primary, mental, and maternal health care due to a lack of providers, especially specialists, serving rural areas.

"Even if I want mental health services, it's a long wait." - African American male, Calhoun, SC

Similarly, many people face challenges in accessing oral health services, and enrollees in public programs like Medicare and Medicaid are not immune to these challenges. About fifty percent of Medicare beneficiaries lack dental coverage, and approximately two-thirds of all beneficiaries suffer from periodontal disease. Health disparities exist for low-income older adults and communities of color, such as Black and Hispanic populations, who are more likely to have untreated cavities and experience tooth loss. With insufficient dental coverage, many low-income, older individuals and communities of color are unable to seek oral health care, perpetuating many of these disparities. Oral health is closely linked to physical health, so coverage of oral health services is critical for preventing and alleviating the burden of oral health disparities.

"One of the things that we really struggled with was that Medicare and Medicaid doesn't cover dental care, unless it's, quote unquote, a life saving emergency." - White male, Chicago, IL

Moreover, across many types of health care services, virtual care – including telehealth – can be an important tool to expand access. Our listening work suggests that users have enjoyed virtual care services because of their convenience and ease of use:

"I liked [my experience with virtual care] a lot…and I hope they continue it after COVID is done. You know, for certain situations. Maybe one time a year you would go in for the physical and lab work, but the rest could be virtual. It's been a very good experience." - Asian woman living with a disability, MN

"Well, I liked it because [virtual providers] worked with my father during COVID. I didn't have to take him and they literally took the time. They weren't rushing - actually, at that time when my dad got sick, he was actually at home. [The provider] was calling his patient from home." - Black female, Vance, SC

However, without a strategic and thoughtful approach to virtual care, virtual care can exacerbate existing disparities: barriers continue to limit some people's ability to access care virtually, especially people belonging to underserved communities. About 35% of American Indian/Alaska Native students lack access to a computer at home compared to 10% of white students, and rural communities are 12-16% less likely to have broadband access than urban and suburban communities. There are also disparities in technological literacy as 26% of non-elderly adult Medicaid beneficiaries reported never having used a computer, 35% did not use the internet, and 40% did not use email. Similarly, 30% of Medicare Advantage beneficiaries reported that they were uncomfortable using virtual care to access medical care. Among racial and ethnic groups, communities of color have lower utilization of virtual care services due to shortcomings like limited non-English-speaking health providers.

"So I would love to be able to access my medical professionals virtually. But I have unreliable internet access. I have to wait until I have reliable internet." - 71 year old female, rural

"(Virtual care) ended up saving me time in terms of driving, parking, waiting in the waiting room, you know, that type of stuff. So, it was just real quick and easy, you don't have to really get dressed. I didn't have to worry about traffic. I didn't have to worry about finding a parking spot. I didn't think about that initially." - 67 year old female, urban

- ***Prompt 2:*** *Perspectives on how CMS can better communicate quality standards and accessibility information to individuals, particularly those with social risk factors.*

To communicate quality standards and accessibility to individuals with social risk factors, CMS should consider the injustices that many rural individuals and communities of color feel

when they interact with the health care system. In our community engagement and listening work, we have heard:

"It seems as if [the health care system] is based on color, or socio economic status. And then the fact that we're just in rural South Carolina, well, you can't keep a good physician." - Black female, Bamburg, SC

*"I'm sorry, these [health inequities] have always been things that I've been aware of. I have family members that have been lost in the struggle. And also, **it hasn't been fair for us for a long time.** So I don't know when it has ever been fair. I didn't need the pandemic to point out the obvious." - Black female, Chicago, IL*

● ***Question 3****: Recommendations for how CMS can address these challenges through our policies and programs.*

To address challenges through policies and programs, CMS should design models with equity and peoples' needs in mind. Achieving this requires cooperation from health plans and provider groups, who should regularly incorporate focus groups and activities that are demographically representative in their care models. CMS should also build on its [various collaborations](#) from the COVID-19 pandemic, including but not limited to demographic data sharing with the Health Resources and Services Administration and prescription drug data sharing with the Federal Drug Administration. Through data sharing, CMS can more easily collect robust data sets for underserved populations. CMS should also augment existing data collection practices to allow for parsing within aggregated data. The combination of representation and robust data collection ensures that CMS listens to - and better understands - the needs of underserved communities.

The implementation of the [Colorado Option](#) presents another opportunity: to build a more sustainable system around cultural responsiveness beyond existing network adequacy standards — which strives to validate, understand, and affirm the different cultures of a diverse population in decision making and implementation.

Additionally, the Center for Medicare and Medicaid Innovation should test new incentives in Medicaid to address health disparities. CMS, for instance, could test whether allowing Medicaid programs to reimburse providers at Medicare rates increases provider participation in Medicaid and improves patient outcomes. CMS can also encourage innovation through payments for social determinants of health as well as value-based payments (VBP), in which some states mandate managed care plans to place VBP requirements into their contracts. Better quantitative and qualitative data collection, like community health needs assessments, are also necessary to help Medicaid programs better understand people's health and social needs. Throughout these efforts, CMS can establish criteria for and address the needs of regions with the greatest health disparities.

Because there remain [disparities within and due to virtual care services](#), CMS should also improve its virtual care infrastructure. To promote participation in virtual care, CMS should consider and adopt a reimbursement model that pays for assistance of social workers, community health workers, personal digital assistants, telepresenters, and language interpreters. Many Medicare and Medicaid enrollees also struggle with technology, so CMS should increase the utilization of dual-use non-medical equipment (tablets, smartphones, Internet) in virtual care. [Rural populations, communities of color, and tribal nations](#) continue to be the most affected by virtual care disparities, so CMS should focus on addressing barriers and bolstering virtual care among these demographics.

Topic 3: Advancing Health Equity

CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

- *Prompt 1:*
  - *Identifying CMS policies that can be used to advance health equity*
  - *Recommendations for CMS focus areas to address health disparities and advance health equity, particularly policy and program requirements that may*

impose challenges to the individuals CMS serves and those who assist with delivering healthcare services

- *Input on how CMS might encourage mitigating potential bias in technologies or clinical tools that rely on algorithms, and how to determine that the necessary steps have been taken to mitigate bias.*
- *Feedback on enrollment and eligibility processes, including experiences with enrollment and opportunities to communicate with eligible but unenrolled populations.*
- *Recommendations for how CMS can promote efficiency and advance health equity through our policies and programs.*

The COVID-19 pandemic unmasked grave inequities in the American health care system as people of color, low-income people, people with a disability, people who are uninsured, and many others bore disproportionate burdens of disease, infections, hospitalizations, and deaths. The nation's health depends on the reduction of health disparities, so relieving community and individual burdens and meeting vulnerable communities' social needs are essential.

Virtual care, which includes telehealth in addition to other virtual services, can reduce disparities by enabling patients to interact with their providers virtually. This increased access to providers addresses inequities such as rural health care access, physician shortages, and transportation issues. Virtual care's benefits were evident throughout the COVID-19 pandemic, when virtual care accounted for 40% of mental health (MH) and substance use disorder (SUD) outpatient visits – compared to <1% pre-pandemic. One year later, 36% of MH and SUD outpatient visits are still conducted through virtual care, reflecting an overall increase in its use over the past few years.

To improve virtual care in the coming years, CMS should allow for the blending of in-person and virtual care. Virtual care cannot replace all in-person care, but people should have the option and flexibility to choose when and whether to choose in-person or virtual care, increasing their access to care. CMS may also maximize locations for patients receiving

virtual services. Barriers such as transportation or scheduling difficulties may discourage people from seeking in-person care, so they should have the ability to access virtual care through their homes, schools, and community centers. Moreover, it is vital to expand broadband in rural and underserved areas. Slower Internet speeds in rural, underserved areas impede patients' ability to use virtual care services and diminish their technical expertise of virtual care systems, leaving many of these patients behind and giving way to health disparities. To meet these patients' needs and eliminate barriers, CMS should allow audio-only care and remote device monitoring.

Nonetheless, it is important to acknowledge that virtual care can sometimes exacerbate inequities as some algorithms encode racial biases that can disproportionately [harm communities of color](). Many algorithms are built on biased or missing data or flawed algorithms like race-based adjustments, so Black patients often receive [worse care]() and [reduced access to additional care](). To address these inequities and flawed adjustments in virtual care, CMS should employ intentional design tactics and incorporate equitable frameworks & guardrails, oversight, and constant evaluation for bias or discrimination.

As the COVID-19 Public Health Emergency (PHE) ends, it will be essential to support the implementation of virtual care in state Medicaid programs because failing to invest in virtual care services could leave already underserved communities behind and worsen health disparities. As such, CMS should issue clarifying guidance to states and notify them that they can make telehealth flexibilities permanent in their Medicaid program through State Plan Amendments, templates, and other avenues. Moreover, CMS should conduct research and evaluate the return on investment of virtual care services to support and inform states' efforts to make telehealth flexibilities permanent.

Additionally, leveraging available technologies in order to more effectively communicate with people about their enrollment options can help address challenges in enrollment. Texting, for instance, may be a health equity issue that CMS can tackle. [76% of low-income Americans have smartphones]() on which they can receive text messages, and increasingly more individuals are using texting as their primary mode of communication. Texting has the potential to be a health equity tool by facilitating providers and health plans' communication

with patients and enrollees. When redetermination begins, many enrollees will be expected to lose coverage if they are unaware of necessary documents or steps to retain coverage, but texting can allow health plans to reach individuals and ensure that they have coverage as long as they remain eligible. By expanding texting services, CMS can provide a more equitable health care experience for low-income, underserved individuals who would then be more able to receive care and health care coverage.

Topic 4: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE. Example responses may include, but are not limited to

- ***Prompt 1***: *Impact of COVID-19 PHE waivers and flexibilities and preparation for future health emergencies (e.g., unintended consequences, disparities) on health care providers, suppliers, patients, and other stakeholders.*

The COVID-19 pandemic upended the nation and our entire health care system. The scope of the emergency has forced us to focus on the cracks in our system and how it is leaving many people behind. The COVID-19 pandemic has highlighted and exacerbated long-standing inequities in our health care system for people of color, low-income people, people with a disability, people who are uninsured, and many others. The pandemic, and resulting policy responses, has unleashed an unprecedented level of flexibility and innovation across our entire system. Many policy flexibilities created during the COVID-19 pandemic and public health emergency (PHE) helped people access health care services and made care more affordable, dependable, personalized, and easy to understand for people.

COVID-19 spurred innovation and flexibility, which fundamentally changed how people experience health care. The following areas are particularly notable, given our listening work and engagement with people for whom these policy flexibilities really matter.

The flexibilities that CMS adopted in response to the COVID-19 pandemic, including a relaxed enforcement of its prohibition on mid-year benefit enhancements (MYBE) and Medicare Advantage (MA) organizations, helped ensure access to important services. Many MA organizations were able to enhance benefit packages mid-year and meet more beneficiaries' social needs in the wake of COVID-19, including access to food and transportation services. Humana, for instance, increased its monthly Healthy Foods Card allowances for several dual-eligible special needs plans. Likewise, Independence Blue Cross collaborated with United by Blue to offer four weekly grocery deliveries for enrollees in HMO plans with chronic obstructive pulmonary disease.

As the COVID-19 Public Health Emergency (PHE) nears an end, however, the future of these flexibilities and requirements remains an important consideration. Current flexibilities for MYBE for MA plans are allowed only if they are associated with the COVID-19 pandemic, so they may stop once the COVID-19 PHE ends. As such, MA organizations will have a limited ability to respond to changing circumstances and meet the needs of their enrollees. Likewise, continuous coverage is required only during the pandemic, so millions of people may lose coverage following the COVID-19 PHE. Permanent approaches are necessary to address SDOH and continuous coverage; without them, historically marginalized communities will continue to disproportionately experience negative health outcomes as a result of not only the COVID-19 pandemic but also any future health emergencies.

- ***Prompt 2****: Recommendations for CMS policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE.*

CMS should utilize opportunities to build on lessons learned during the pandemic to address health disparities under Medicare and Medicaid.

Within Medicare, CMS can pursue an extension of SDOH flexibilities in MA plans. With benefit flexibilities like those during the COVID-19 Public Health Emergency (PHE), Medicare Advantage plans can meet the social needs of their enrollees, such as access to healthy food and transportation. However, it is important for CMS to set guardrails that limit changes to those that improve coverage or reduce cost-sharing. Moreover, benefits should not be limited or eliminated to offset the costs of increasing the generosity of other benefits. While extending SDOH flexibilities, CMS should also invest in efforts to both identify and address underlying systemic and environmental factors that impact health.

"In order to get transportation most of the time you got to be on Medicare. If you're not on Medicare you're not getting it because they're gonna tell you that you make too much." Black women, Vance, SC

Similarly, under Medicaid, CMS can reduce health inequities by supporting continuous eligibility and coverage. The continuous coverage requirement, which prohibits states from disenrolling Medicaid beneficiaries, will end at the end of the PHE, leaving millions of people without health insurance. An estimated [15 million people](#), including 9 million adults and 6 million children, will lose Medicaid coverage when the PHE – and the continuous care requirement – ends. States will face an FMAP cliff at the end of the PHE and may feel pressured to rush the unwinding process, which will disproportionately impact [Latinx and Black individuals](#) and [children of color](#).

Although CMS has begun working with [state Medicaid agencies, Marketplaces, navigators, health, plans, and others](#) to ensure that individuals remain connected to coverage, CMS can take some actions to encourage continuous coverage. CMS can support section 1115 waivers for continuous coverage. CMS can also approve state plan amendments for a 12-month continuous eligibility period for adults.

To encourage innovation, CMS may also provide states with funding to update their Medicaid

eligibility and enrollment systems. Streamlining eligibility and enrollment can help reduce disparities through processes like [ex-parte renewals](), which automatically review and renew eligible Medicaid enrollees' coverage every year. Administrative burdens often result in loss of coverage and adverse health outcomes, but ex-parte renewals ensure that people retain coverage for longer periods. Another option is tying an enhanced FMAP with equity goals like continuous coverage and benefits that reduce health disparities. This option, however, requires Congress to take legislative action on the enhanced FMAP, so CMS cannot achieve this on its own.