mhpa Medicaid Health Plans of America

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Medicaid Health Plans of America Response to CMS Medicaid and CHIP Reform Request for Information

Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.

1. *What are the specific ways that CMS can support states 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.*

Thank you for the opportunity to respond to this Request for Information (RFI) regarding access to care and health equity for individuals enrolled in the Medicaid program. Medicaid Health Plans of America (MHPA) is the only national trade association with a sole focus on Medicaid, representing more than 130 managed care organizations (MCOs) serving more than 43 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non- profit, national and regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs.

We applaud this effort to consider the Medicaid program through a health equity lens to ensure that health coverage is both accessible and equitable for Medicaid beneficiaries. We believe the Medicaid program **is** a health equity program designed to support individuals who are underserved and face complex socioeconomic and clinical circumstances; we are pleased to have this opportunity to provide recommendations to support and improve efforts to meet the needs of this vulnerable population.

MHPA supports efforts by the Centers for Medicare & Medicaid Services (CMS) to help ensure that individuals who are eligible for Medicaid and CHIP are able to apply for and retain coverage. We also appreciate the guidance and support provided by CMS throughout the COVID-19 pandemic and ongoing efforts to facilitate a smooth transition from the COVID-19 policies that provided flexibilities during the public health emergency (PHE) that focused on preventing or minimizing any potential disruption in the continued delivery of quality health care for Medicaid beneficiaries. Our member plans are uniquely positioned to support states and beneficiaries throughout this process, and we would request that CMS continue to highlight to states how they can best partner with plans.

We encourage CMS to engage with individual states to understand their unique challenges with eligibility determinations and enrollment. Each state's processes and systems are different, which make it difficult to recommend uniform strategies. In addition to providing best practices and technical

assistance, we also encourage CMS to customize support on an individual state basis, identifying specific barriers in each geographic area and provider type and tailoring strategies to address those barriers.

We provide the following recommendations to help ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and know how to apply for and retain coverage:

Eligibility and Enrollment Policies

- **Continuous eligibility**. CMS should encourage or incentivize states to adopt 12 months of continuous eligibility for children and adults.
- **Express Lane Eligibility**. CMS should encourage or incentivize states to adopt Express Lane Eligibility (ELE) for beneficiaries under age 21 if they have not done so. CMS should also consider ways to promote expansion of ELE to additional populations.
- **Presumptive Eligibility.** CMS should encourage or incentivize states to expand presumptive eligibility authority to a broader range of providers and populations to facilitate real-time enrollment into Medicaid at the site of care.
- **Links to Other Programs.** CMS should encourage or incentivize states to link Medicaid program eligibility standards with other state programs often utilized by Medicaid beneficiaries (e.g., TANF, SNAP, WIC) and develop a clear hierarchy for resolving data source discrepancies.

Data Collection

Standardize and Improve 834 Data Collection. CMS should promote state standardization of 834 application form data collection that includes capture of an email address, identification of whether the phone number is a cell or land line, the renewal date for that member, income, and demographic data, and identified disenrollment reason for a member (i.e., moved to another plan, no longer eligible or did not complete renewal form).

Contact Information

Implement Processes to Update Contact Information. Maintaining current contact information for Medicaid beneficiaries is crucial to ensure beneficiary retention within the Medicaid program. CMS should encourage states to share the most recent member contact information available with MCOs. States can also leverage relationships with providers, health systems, and community-based organizations to improve information sharing capabilities and system interoperability.

Allowing MCOs to Update Beneficiary Contact Information. Because the Medicaid population is more transient than the general population, documents including those related to redetermination are often mailed to obsolete beneficiary addresses. MCOs are sometimes aware of a beneficiary's current address and/or telephone number but are not permitted to update that information. In some states, the MCO's only available response when becoming aware of outdated contact information is to advise the beneficiary to update that information with the state Medicaid agency, a process that may be confusing to beneficiaries. Allowing MCOs to update beneficiary contact information would significantly reduce beneficiary retention issues related to the redetermination process.

Technological Improvements

Online Portals. CMS should encourage or incentivize states to expand the availability of online portals for determinations, enrollment, redeterminations, and other beneficiary communications in addition to allowing for the submission of information in-person and via mail.

Modernize Technology for Eligibility Determinations and Renewals. An investment in online verification platforms would improve the efficiency and accuracy of eligibility determinations and renewals. CMS should consider incentivizing modernization of state IT systems to allow for enhanced data collection, standardization, and integration

__Communications and Outreach__

Beneficiaries and Preferred Methods of Communication. The ability of MCOs to communicate with their members in the way the members prefer (mobile/text, email, mail) presents an opportunity to support and reinforce state eligibility determination and redetermination outreach efforts. Educating, engaging, and empowering Medicaid beneficiaries is key to ensuring uninterrupted health coverage and access to care. Importantly, effective member education and communication can additionally help us solve health equity challenges related to accessing care for vulnerable and underserved populations. MHPA recommends that states empower MCOs to reach enrollees across more channels with communications related to redeterminations.

Provide Flexibility for Health Plans to Modernize Timely Communication with Members. CMS should encourage states that currently require explicit member opt-in for health plans to text and email members to assume member implied consent with opt-out ability. Implied consent, with opt-out ability, ensures all members have access to the most timely and pertinent information and have control the flow of text and email touch-points. Additionally, allowing health plan communication at least 30 days prior to a member's renewal date and up to 60 days following a member's renewal date would support member continuity of coverage. CMS should also work with states to allow for the expedition or fast-tracking of the approval of health plan marketing materials related to redeterminations and potential coverage transitions and that CMS should provide states with pre-approved template materials to ensure members receive timely outreach.

Launch State-Specific Awareness Campaigns. Some states have rebranded their Medicaid programs contributing to confusion for some individuals who may be eligible for Medicaid. Messaging around what Medicaid is and the program's benefits would be more effective when tailored to each state's terminology.

Special populations. Medicaid and CHIP are sometimes available to but not utilized by our American Indian (AI) populations. Potential AI beneficiaries may not be aware of their eligibility for these programs or may not understand the value in enrolling. This is because many tribal populations are served at no charge by tribal health clinics funded by Indian Health Services (IHS). However, tribal health clinics funded by IHS would absolutely benefit if AI patients seeking treatment had some form of health insurance coverage, including Medicaid or CHIP coverage. In addition, when a potential AI beneficiary requires medical services that can only be provided outside of the tribal health clinic, the AI beneficiary may be left uninsured. We believe that funding should be made available to help educate and enroll eligible members of the AI population.

2. *What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?*

MHPA supports efforts to improve timeliness for determinations and enrollment or eligibility processes and would encourage CMS to engage with individual states to best understand their needs. Specifically, we would encourage CMS to customize support on an individual state basis, identifying specific barriers in each geographic area and provider type and tailoring strategies to address those barriers. We provide the following considerations to assist states seeking additional or improved capabilities:

Ex Parte Renewals

Additional Data Sources. MHPA recommends allowing for states to leverage additional data sources to facilitate and expedite the determination of modified adjusted gross income (MAGI) eligibility and avoid lapses in coverage due to the inability to identify income for a member. We would also support the permanent authorization of Section 1902(e)(14)(A) waivers to facilitate the use of external data to support renewals, including through ex-parte processes. 1902(e)(14)(A) waivers allow for the use of data from the Supplemental Nutrition Assistance Program (SNAP) to support Medicaid eligibility determinations and redeterminations. In the absence of SNAP data, ex-parte processes can be leveraged to allow for renewals for households whose attestation of zero-dollar income was verified within the last 12 months when no information is returned through data sources.

Infrastructure Support. We recommend that CMS continue to make grants available to states to allow for ex-parte process enhancement and to improve infrastructure for agencies as they look to process redeterminations after the conclusion of the PHE.

Technical Assistance

Enhanced FMAP. CMS can provide states with technical assistance to receive enhanced FMAP for investments in eligibility systems and infrastructure, which could also assist with transitions between Medicaid and other health coverage sources, where applicable.

Advance Data Sharing. States should work with MCOs to develop a data exchange system, that may include improving the 834 file exchange. For example, whether the MCO or state obtains new or updated contact information for a beneficiary (e.g., email address, phone number, etc.) either one should be able to update the beneficiary's file. IT system updates often are needed to allow data platforms to access/receive data; federal level support could promote improvements.

Communications

Improve Alignment of Communications to Beneficiaries. States should work with MCOs to align communication. In some cases, a state may direct plans to reach out to members about upcoming redetermination or other changes but fail to update their beneficiary communication or publicly facing materials to ensure consistent messaging. For example, communication about when renewals are being processed should be consistent across MCO and state websites and materials.

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?*

MHPA believes that CMS and states can work together to address challenges among different groups related to enrollment and retention in Medicaid and we encourage CMS to partner with states on these efforts. To effectively identify and engage hard-to-reach groups, we recommend that CMS and states identify these vulnerable populations and develop a strategy intended to build up trust within these different communities through direct and culturally appropriate outreach and partnerships and support policies that make it easy to enroll and stay covered. We provide the following considerations to support states in addressing barriers to enrollment and retention in the Medicaid program:

Policies

Continuous Coverage. CMS should accelerate approvals of state options to extend coverage for certain populations such as children and postpartum women to 12 months, and should prioritize review/approval of waiver requests to promote continuous coverage of other populations.

Enrollment policy. CMS should promote and support the implementation of passive enrollment for former foster youth, contingent on meeting Medicaid eligibility requirements

Collaborative Care Models: CMS should promote collaborative care models that are effective at addressing needs of populations in need of mental health/substance use disorder (MH/SUD) services.

Communications

Communications Regarding Policy Changes Post-PHE. States should strengthen communications and referral processes for enrollees with questions regarding the impacts of eligibility, enrollment, and redetermination changes following the PHE on their coverage and enrollment by:

- Strengthening any available case management or outreach programs,
- Developing educational materials with local resource and contact lists (available in prevalent languages), and
- Conducting state staff trainings on new coverage decisions for alignment with MCO communications.

Culturally Sensitive and Inclusive Communications Methods. States should drive targeted communications based not only on reading level, but also on typical behaviors and capabilities of different groups of people.

Training

School-Based Training. A LGBTQ Health study demonstrates the positive impact that implementing school policies and practices supportive of LGBTQ+ youth has on the psychosocial health of youth who

identify as lesbian, gay, or bisexual (LGB) *and* on their heterosexual peers. CMS should encourage states to promote policies and programs that provide such support.

High-Risk Youth Groups. CMS, in conjunction with federal agency partners, should continue to develop programs for high-risk youth groups, including American Indian and Alaska Natives; individuals in rural communities; and, increasingly, Black youth.

Managed Care Organizations

Medicaid MCOs. Medicaid MCOs can play a critical role assisting CMS and their state partners with initiatives that reduce barriers to enrollment and retention of eligible individuals in Medicaid and CHIP. For example, we recommend that CMS work with states to allow MCOs to reach out to family or household members of already-enrolled Medicaid and CHIP members to ascertain eligibility status. We believe this type of outreach should already be allowed within the context of the federal marketing regulations and would encourage CMS to provide clear guidance and technical assistance to states who are willing to allow their MCOs to make this type of outreach to likely eligible but unenrolled individuals. We also recommend CMS issue guidance that clarifies that outreach conducted for the purposes of reaching eligible but unenrolled individuals in Medicaid and CHIP can be counted in the numerator of MCO Medical Loss Ratio (MLR) calculation.

Community-Based Organizations

Community-Based Organizations. Community-based organizations (CBOs) often serve hard-to-reach and vulnerable groups as part of their mission and daily work. CBOs can include, but are not limited to, schools, food pantries, and housing agencies. In communities of color and communities where English is a second language, CBOs can serve as a bridge connecting health plans with Medicaid enrollees. We recommend CMS work with states to leverage CBOs to assist with enrollment and outreach to groups, while also recognizing and addressing the limited capacity of these organizations. CBOs likely need financial support to increase their focus on Medicaid and CHIP enrollment and renewal efforts.

Clinical Providers

Hospitals and Other Critical Access Providers. For uninsured individuals, critical providers such as hospitals and federally qualified health centers (FQHCs) often act as the front door to the health care system. To increase enrollment of eligible individuals and defray these providers' costs of hiring insurance screeners, we encourage CMS to provide guidance on how a state can access enhanced federal dollars to fund kick payments for these providers targeted at enrolling eligible individuals in Medicaid and CHIP.

Pharmacists. Pharmacists can be a valuable resource for reaching individuals related to Medicaid eligibility and retention and can also be important partners for care planning with Medicaid enrollees. For pharmacists to be effective in reaching certain groups with Medicaid eligibility and renewal information, we encourage CMS to incorporate solutions within the pharmacy workflow that will allow for improved transparency of Medicaid beneficiary eligibility information.

Non-clinical providers

Non-Clinical Health Workers. Non-clinical health care workers such as community health workers (CHWs), doulas, and peer support specialists are vital in reaching hard-to-reach populations. These

groups are trusted members of the communities they help and serve as a link between health/social services and the population served by the community.

Doulas also offer a unique opportunity to reach populations that may be hesitant to trust the health care establishment and to reach women of childbearing age, pregnant and postpartum women, and children.

Certified peer support specialists can be vital in providing support to people living with mental health conditions and SUDs. These paraprofessionals are individuals with a lived experience of recovery from a mental health disorder or substance use disorder. This evidence-based practice helps individuals navigate the often-confusing health care system, get the most out of treatment, identify community resources, and develop resiliency. Due to the COVID-19 pandemic, engagement with treatment and care has been disrupted, but finding and utilizing support, such as peer services, in a timely manner can help mitigate negative health outcomes associated with this disruption. Peer support specialists could help reach populations struggling with mental health and substance use issues about Medicaid coverage.

Given the high value of these non-clinical providers who are embedded in these communities, we recommend that CMS develop a sustainable mechanism for states and MCOs to pay nonclinical health workers for "outreach" functions that involve education and enrollment assistance in Medicaid and CHIP. An enhanced federal match or specific pool of funds dedicated to outreach could help promote this option.

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?*

MHPA appreciates that CMS has provided states guidance to centralize tracking of emerging issues related to redeterminations and has encouraged states to implement tracking tools, reports, and dashboards to monitor and track procedural errors and mitigate inappropriate coverage loss. We urge CMS to continue working with states to improve disenrollment reason data, providing a clear distinction between denials based on income versus denials based on missing or incomplete applications and recommend that CMS monitor the State average turnaround time for processing measured by the time from when the application is submitted to when a final eligibility determination is issued. We would also encourage CMS to monitor the following indicators and use the data as a basis for CMS to work with states to streamline and improve the redetermination process:

- % of renewals completed using an ex parte process
- % of renewals completed using a pre-populated form
- % of individuals terminated for procedural reasons
- % of individuals terminated due to being determined ineligible
- % of individuals terminated who are reinstated within 90 days of losing coverage

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage. CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income SSI/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).

1. *How should states monitor eligibility redeterminations, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?*

Nearly three-quarters of the people covered by Medicaid receive health care provided by Managed Care Organizations (MCOs). Representing over 130-member health plans which serve more than 40 million Medicaid enrollees in 40 states, the District of Columbia and Puerto Rico, MHPA is committed to promoting and expanding meaningful health care coverage, which is critical to health equity, and includes support for polices that protect and improve the Medicaid program for the vulnerable populations that rely on this critical safety net program.

Since the beginning of the COVID-19 pandemic and the declaration of the PHE, MHPA has been working with CMS to facilitate continued access to health care services for Medicaid beneficiaries. As we now look ahead to the expiration of the PHE, MHPA continues to work with CMS on COVID-19 transition planning to ensure that the health care needs of Medicaid beneficiaries will continue to be met in an appropriate and timely manner.

MHPA appreciates the guidance and materials provided by CMS related to eligibility redeterminations after the federal PHE ends. We believe the guidance and materials will help states improve their redetermination processes beyond the unwinding period. The open and ongoing dialog between CMS, health plans, and states has been extremely beneficial as we engage in discussions and planning with states on redeterminations.

We are pleased that CMS noted in recent guidance that "It has been a top priority…to ensure, when the PHE eventually ends and states resume routine operations, including terminations of eligibility, that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage." (https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf) While CMS has provided states with immense flexibility to work closely with health plans on eligibility redeterminations following the end of the federal PHE, we have concerns that when permitted to conduct redeterminations of eligibility and transition individuals off the program, both states and eligible beneficiaries will face barriers to the efficient and successful renewal of coverage.

Our recommendations below include actions that CMS can take to encourage states to adopt policy options that improve the redeterminations process and mitigate the process barriers, state administrative burden, and PHE-related volume increases that compound to create Medicaid beneficiary churn detrimental to health care access for the nation's most vulnerable populations.

COVID-19 PHE Flexibilities

CMS should continue to educate and encourage states to take advantage of the flexibilities outlined in CMS guidance and materials, including:

- Allowing MCOs to provide verified updated contact information to states,
- Providing MCOs with lists of members in advance of their redetermination dates,
- Allowing MCOs to reach out to members about their redeterminations, and
- Allowing MCOs to directly assist members in completing their redetermination.

Policies

Multiple Channels. States should allow redeterminations to be completed through many channels: mail, phone, online, and in-person.

Continuous Coverage. CMS should continue to encourage states to provide 12-month continuous eligibility for children (via State Plan Amendment), adults (via 1115 waiver), and individuals enrolled in BHP (via Blueprint revision); and additionally provide 12-month postpartum coverage via State Plan Amendment. CMS can support states implementing continuous coverage provisions for groups of beneficiaries by making review/approval of these requests simpler and timely.

Express Lane Eligibility. CMS should encourage states to adopt an Express Lane Eligibility (ELE) option, which enables states to expedite and simplify enrollment for eligible children by relying on determinations from other agencies' eligibility processes. States could also opt to adopt ELE for certain adult populations (i.e., non-disabled, non-elderly) through the state plan amendment process. Current express lane agencies that states may utilize to streamline eligibility include Supplemental Nutrition Assistance Program (SNAP); School Lunch, Temporary Assistance for Needy Families (TANF); Head Start, National School Lunch Program (NSLP); and Women, Infants, and Children (WIC); among others.

Presumptive Eligibility. CMS should encourage or incentivize states to expand presumptive eligibility authority to a broader range of providers and populations to facilitate real-time enrollment into Medicaid at the site of care.

Contact Information

We appreciate guidance CMS has recently offered states to encourage information sharing and partnership with MCOs. We recommend CMS work to ensure states are following the guidance and allowing MCOs to provide direct member assistance to update contact information with the state agency. Partner organizations can provide valuable assistance to states to maintain coverage of eligible Medicaid beneficiaries both during the PHE unwinding and in the long-term. Medicaid MCOs often have access to beneficiary contact information that is more current than state Medicaid agencies. Some considerations for validation of enrollee contact information could include:

- States engaging CBOs, navigators, and providers to remind enrollees of renewals to provide updated contact information
- Requiring MCOs to regularly report on our best contact information for each enrollee
- On a regular schedule (such as every 6 months), states engaging enrollees through mail, texts, and emails to remind enrollees to update their contact information with the state to avoid losing coverage.

Mid-Year Income Checks

CMS should take all measures available to encourage states to reduce or eliminate periodic data matching for mid-year income changes.

MCO partnerships

Data-Sharing. CMS should encourage states to share data with MCOs on their enrolled members who are due for redetermination, which would better allow MCOs to assist with mitigating loss of coverage and ensure individuals are covered with the most appropriate form of coverage for their eligibility status. MCOs can assist states with identifying members or member populations who frequently require targeted renewal assistance. States should be prompted and encouraged to amend any administrative regulations or internal procedures which may prohibit the sharing of disenrollment information of members with their MCO. To enable timely and accurate communication from MCOs in tandem with states, states should provide members and MCOs with awareness of at least 60 days advance notice prior to when a redetermination will begin.

Empowerment to Support Renewals. CMS could encourage states to work with their MCO partners by:

- Requiring all states to allow MCOs to support renewals (e.g., renewal reminders; outreach to answer questions and help enrollees through the process; follow-up after disenrollment to help with submitting missing documentation)
- Providing fast-track reviews for member communications related to supporting renewals
- Giving MCOs accurate renewal dates and renewal files several months in advance of their redetermination dates
- Sharing information related to enrollees terminated for failure to return renewal documentation enabling MCO support for outreach and re-enrollment during the 90-day reconsideration period

Standardized Forms

We recommend CMS work with states to standardize and expand the use of 834 enrollment files. Currently, enrollment forms vary across states including the format and type of file used and the level of information provided. Standardizing 834 enrollment files across states will help them improve their own processes and help MCOs effectively assist with member redeterminations. A key area of opportunity is for states to include the reason for enrollee termination on 834 files. This information will help states identify trends in reasons for disenrollment and course correct as needed.

Ex Parte Renewals

We recommend that CMS work with states to increase the proportion of ex parte renewals by:

- Expanding data sources to include IRS reported wages, unemployment, SNAP, and TANF

- Issuing detailed guidance on data source hierarchy can be used to prioritize the most recent and reliable data for ex parte renewals
- Setting a minimum "reasonable compatibility threshold" for income that allows enrollees to maintain Medicaid eligibility when data from other sources (e.g., SNAP) suggests income is marginally higher than income reported by an enrollee and potentially disqualifying
- Providing detailed technical guidance and advisory support on synching ex parte data sources may help some states
- Establishing a minimum required proportion of ex parte renewals, and measure whether states meet it

Assistance with Forms

CMS should continue to offer grant funding and encourage federal financial participation for states pursuing navigator support and education for redeterminations, particularly for prioritized, complex, and vulnerable populations (e.g., LTSS or Dual Eligible members) where navigators can engage through individualized assistance. Support can also include guidance and technical assistance to leverage community-based organizations and health plans to assist members with renewal information submission and processing.

Cultural Competency

CMS should encourage states to regularly verify enrollees' language preferences and ensure that renewal documents are translated into multiple languages and reviewed for cultural competency; promoting access free language services and oral interpretation could include updating websites with taglines in non-English languages.

Waivers

Streamlined waivers. CMS should create and promote to states a streamlined 1115 demonstration waiver template to encourage the adoption of facilitated enrollment and renewal models. This model, currently approved via waiver in New York state, allows MCOs and Community-Based Organizations the ability to partner with states and offer guided, personalized assistance to beneficiaries, while the state retains control over eligibility determinations.

Transition to Other Medicaid Eligibility Groups

We also encourage CMS to allow states additional flexibilities for beneficiaries to smoothly transition to other Medicaid eligibility groups when there is a change in their health and/or work status.

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?*

During the PHE unwinding and beyond, state communication and proper outreach to beneficiaries undergoing redeterminations is essential. With proper communication and outreach allowances, MCOs can be a valued and trusted state partner to share information with members through modern methods, alleviate state burden, and mitigate risk for coverage loss. Additionally, MCOs can help states prioritize

populations for redeterminations and various criteria, such as stratifying individuals with certain physical or behavioral health conditions that would have adverse reactions to a disruption in care.

In addition to challenges with initial contact, Medicaid beneficiaries may also face challenges when trying to complete required actions during Medicaid renewals such as not knowing they need to submit information to the state agency for their Medicaid coverage to continue. In addition, beneficiaries may not be able to understand or interpret notices received by the state, and if they do, they may need additional time to secure and submit the requested information. We also recognize that states may have limited financial and staffing capacity to implement new processes.

MHPA provides the following considerations and recommendations for policies and strategies to modernize and enhance the redeterminations outreach and communications process:

Standardize Forms

To enhance the quality of beneficiary contact information captured by states, CMS should publish a standard 834 file form template for state adoption, including the requirement of data fields for: email address, phone number, phone type, date of renewal, and identified disenrollment reason for a member (i.e., no longer eligible or did not complete renewal form).

Contact information

First, if a state has inaccurate contact information for a beneficiary, the beneficiary will likely not receive state notices. We believe CMS should work with states to develop new processes for obtaining updated contact information from beneficiaries and should set standards that reflect state efforts to obtain updated contact information from members regularly. We recommend that CMS work with states to develop consistent and streamlined processes to accept verified updated contact information for Medicaid beneficiaries from Medicaid MCOs. Although some states currently allow MCOs to provide updated contact information to states, we believe the process can be improved and expanded to other states.

Communications

Advanced Communication. Lack of advanced communication between a state and an MCO about upcoming eligibility redeterminations can lead to disruptions in care and unnecessary churn. States should communicate with contracted MCOs early and often so that MCOs can serve as partners in notifying their enrollees of any potential changes to their benefit package and provide assistance.

Multiple Channels. We recommend CMS require states to contact beneficiaries using all modes of communication including mail, phone, text, and email. We recommend CMS consider standards that would encourage states to obtain cell phone numbers for beneficiaries and use phone calls and text messages to communicate with beneficiaries about renewing their Medicaid coverage.

Texting. To provide flexibility for health plans to modernize communications with members and assist states with timely outreach, CMS should continue to recommend that texting is a viable modality and continue to reiterate that the federal regulations broadly allow states and health plans to assume member implied consent for texting communications with the general provision of a member’s phone number to the health plan. CMS should work with the Federal Communications Commission to clarify

interpretations of the Telephone Consumer Protection Act that may produce barriers to member outreach through electronic means,

Outreach and Response Period

We encourage CMS to remind states that individuals must be provided renewal forms and given at least 30 days from the date of the renewal form to respond and provide any necessary information. We recommend CMS require states to make at least three different attempts to contact the beneficiary prior to initiating termination. We encourage CMS to require states to partner with MCOs to reach out to their members at risk of disenrollment at least once within the 30-day period and prior to termination.

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?*

MHPA supports efforts to promote continuity of coverage for beneficiaries transitioning between types of coverage or between different benefit packages or eligibility status. We believe MCOs can play pivotal roles to minimize disruptions in care and to help streamline the process; we urge CMS to educate states about opportunities to partner with MCOs. Our specific considerations and recommendations to promote continuity of coverage for beneficiaries who may no longer be eligible for Medicaid coverage are as follows:

Disenrollment Policies

Outreach. We recommend that CMS allow MCOs to reach out to members up to at least 60 days post-disenrollment to provide assistance.

Data sharing. We recommend that CMS encourage states to allow MCOs to share information with members post-disenrollment about other coverage options (i.e., QHPs, Medicare). Flexibility to provide this information prior to disenrollment may be appropriate on a state-by-state basis and if there is sufficient advance information about why the member may lose eligibility (e.g., income-related). CMS should also monitor ongoing state engagement with health plans and offer guidance and assistance to individual states to promote the sharing of timely information.

Navigators and Brokers

Navigators and brokers can assist with transition efforts by engaging with individuals who are deemed no longer eligible for Medicaid to educate and inform them regarding options for coverage. To support this approach, CMS should conduct and promote large-scale trainings for navigators and brokers on the impacts of losing Medicaid coverage, the potential to transition individuals into Medicare and/or the Marketplace, and how to educate consumers on the differences between the various coverage options

compared to Medicaid, including cost-sharing and terminology. We encourage CMS to establish a safe harbor for navigators and MCOs to allow for collaboration on how to ensure this population receives the best possible assistance during this time, including allowing navigators to leverage any MCO educational resources and trainings.

Mid-Year Income Checks

Given the potential month-by-month fluctuations of a Medicaid beneficiary's income, we encourage CMS to limit the state's ability to conduct periodic data checks throughout the year. Periodic data checks by states may increase coverage gaps, causing people to move on and off of coverage due to a temporary or small increase in income, such as overtime or seasonal work. While eligibility checks may help to ensure that some people who are no longer eligible for Medicaid are disenrolled, this approach also creates procedural barriers to maintaining coverage for people who are eligible. Previous research and experience show that increased requirements associated with eligibility determinations and renewals can lead to decreases in coverage among eligible people due to difficulties completing processes and providing documentation.[1]

Technology

A real-time comprehensive eligibility verification process would reduce point of care confusion as to what is covered and by who, as well as retrospective costly processes related to subrogation. We encourage CMS to consider developing a Medicaid and other health insurance eligibility verification system that would be developed with input from all stakeholders including Medicaid beneficiaries.

4. *What are the specific ways that CMS can support states that need to enhance their eligibility and enrollment system capabilities? For example, are there existing data sources that CMS could help states integrate into their eligibility system that would improve ex-parte redeterminations? What barriers to eligibility and enrollment system performance can CMS help states address at the system and eligibility worker levels? How can CMS support states in tracking denial reasons or codes for different eligibility groups?*

MHPA supports efforts by CMS to help states enhance their eligibility and enrollment system capabilities. As many states are continuing to address pandemic-related issues related to eligibility and enrollment as well as workforce and staffing, the need for robust, federally-compliant ex parte data verification and renewal systems remains. Although states can use multiple health and non-health data sources to verify individuals' income for ex parte renewals, states vary on which and how many data sources they include in ex parte reviews. We believe CMS should work with states individually to improve their ex parte processes and that may require additional resources for IT infrastructure to review and process data. States may also need assistance in developing hierarchies to help determine which data source to use when a match is found for an individual from more than one data source.

Some specific considerations and recommendations to support states seeking to enhance their eligibility and enrollment system capabilities include:

1 https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/

Training and Best Practices

CMS should host trainings and educational opportunities to reiterate to states the data sources required to be utilized under federal law, as well as share best practices discovered through ongoing CMS information-gathering efforts.

Data Sources

CMS should publish a list of additional data sources that states should be expected (when possible) to utilize during ex parte reviews, including but not limited to: data from the state Immunization Information Systems, Department of Motor Vehicles, and other means-tested programs like Unemployment Insurance, TANF, and SNAP where not currently in use.

Design and Programming Structure

CMS should conduct reviews of state design and the programming structure of eligibility and enrollment systems and meet individually with states to offer recommendations for improvement, such as the use of data source hierarchies and reasonable compatibility thresholds for income verification.

Objective 3: Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary's needs as a whole person. CMS is seeking feedback on how to establish minimum standards or federal "floors" for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or "floors" would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices.

1. *What would be the most important areas to focus on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?*

MHPA supports CMS' goal of ensuring Medicaid and CHIP beneficiaries have equitable access to health care. We strongly recommend that CMS consider the individual state environments and challenges that impact access to Medicaid providers and services. The Medicaid program was intentionally created to serve individual needs of states, and therefore, we believe access standards should be developed at the state level. We appreciate CMS taking steps to ensure access to Medicaid and CHIP services and we encourage the Administration to continue to provide states and plans with the flexibility to develop high quality provider networks that meet the needs of members. Our recommended considerations related to the development of minimum standards related to access to services are as follows:

Access Indicators

Factors like provider participation and location, appointment times, and call center times, physician-to-enrollee ratios, and time and distance measures are relevant, but often fail to reflect important factors

such as connecting members with care managers to facilitate appointments, providing transportation, or enhancing network access through telehealth. Plans have limited control over appointment wait times; patients interact with providers for appointments, not health plans. Plans also do not control patient schedules or provider capacity for patients. We encourage CMS to account for these approaches in its assessments.

Time and Distance Standards

MHPA supports nuanced approaches to network adequacy rather than minimum standards or a one-size-fits-all strategy. We continue to support the changes CMS promulgated in the 2020 Medicaid managed care rule, which replaced rigid time and distance standards with the ability of states to implement their own quantitative network adequacy standards. We believe that flexibility in network adequacy is crucial, particularly as we monitor access across a variety of geographic regions (rural, urban, suburban), provider types (primary care, specialists, LTSS, behavioral health), and delivery systems (carve outs, fee for service, managed care). Every state has varying conditions which necessitate a targeted approach, from population density to average income. Time and distance standards, which may solely promote access to a high quantity of providers, may not reflect the quality of the providers who are contracting with states and plans, nor do they necessarily accurately reflect the scarcity of providers. In other words, access thresholds are more appropriately established at the state level to reflect provider capacity and variations within a given state, and not strictly set at a national level. Therefore, we recommend that CMS take a measured approach by providing states with best practices and technical assistance to implement the state's own network requirements or access standards that could be based, for example, on individual county-level data. This approach would help CMS to better understand where state-identified gaps in access exist and work with individual states to address those barriers.

Telemedicine

Telemedicine does not easily fit into rigid time and distance standards. Especially during the COVID-19 pandemic, we have seen the value of incorporating telemedicine as part of health care delivery to ensure enrollees can access needed care. Given the increased utilization of telemedicine, CMS should consider that states use different definitions for provider types and therefore, minimum standards would not effectively crosswalk provider types across states.

Workforce Shortage

As CMS considers minimum standards in network adequacy, we encourage CMS to factor in the workforce shortage, particularly as the COVID-19 pandemic enters its third year. While the severity varies by state and discipline, the impact is strongly felt with high need specialties such as primary care and behavioral health as well as in rural areas and tribal communities. We recommend that efforts to monitor network adequacy be paired with training and grants to address workforce issues.

Unique Program Features, Populations and Services

Some specific points for consideration related to standard setting for unique program features, populations, and services include:

Long-Term Services and Supports (LTSS). CMS and states should consider LTSS standards centered on ensuring that the beneficiary has a choice of providers, services and settings instead of strict standards, such as time/distance standards; this is especially important for the managed LTSS (MLTSS) population, a majority of which receive services in their home or a community-based setting. Standards centered on beneficiary choice and self-determination also promote self-direction by supporting members in need of MLTSS in determining important aspects of their individualized care and service plan and selecting individuals to participate on their interdisciplinary care team.

Mental Health (MH) and Substance Use Disorder (SUD) Services. CMS should account for the variety of ways that individuals can access MH/SUD services and who is accountable, including an individual's primary care provider. Furthermore, access to integrated physical and MH/SUD is critical to ensuring individuals receive treatment for chronic conditions in a coordinated and effective manner.

Maternal and Pediatric Health. Access measures should account for the non-traditional services important to maternal and child health. CMS should look at how best to ensure individuals that deliver these services are accessible and of high quality when examining provider access measures. Furthermore, states should consider services that address health-related social needs of pregnant and parenting people.

2. *How could CMS monitor states' performance against those minimum standards? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?*

MHPA recognizes the important role that CMS plays in monitoring access and quality of state Medicaid programs. We recommend CMS work with states to develop tailored action plans, specific to each state, and we provide the following considerations:

<u>Access Measures</u>

Collection and Analysis of Any Core Set of Access Measures We recommend that CMS encourage states to rely on independent recognized accreditation organizations, such as National Committee for Quality Assurance (NCQA), the National Quality Forum (NQF), or the Utilization Review Accreditation Commission (URAC), to help define the measures most appropriate for states health care access goals.

Disadvantages of a National Core Set of Access Measures. We discourage CMS from applying a national core set of standardized access measures across all states and services. In evaluating access, CMS should consider the following:

Evaluate Existing Access Measures. CMS should first evaluate existing access measures, and then consider enhancements or develop any new needed measures, rather than establishing inflexible, quantitative, one-size-fits all standards.

Recognize Program and Population Variation. Geographic variation, local characteristics, healthcare market variation, and distinct population differences, such as demographics, must be factored into access measurement.

Account for Delivery System Differences. CMS should account for the broad range of differences between Medicaid managed care coverage and the fee-for-service delivery systems, especially as MCOs may cover different populations, utilize unique contracting mechanisms, provide tools to increase access, and offer services that focus on prevention and may extend beyond state requirements.

Waivers

We recommend that CMS play a stronger oversight role in its review of state waiver applications and Medicaid MCO contract reviews. We think CMS should ensure that all state-requested waivers and MCO contract changes will facilitate equitable access to care for Medicaid enrollees and not unintentionally reduce access. Any changes that seek to limit or fragment benefits for certain populations will likely result in decreased access to care, which should be considered in CMS' approval of certain waivers and MCO contracts.

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?*

The diverse and often complex needs of a state's Medicaid population make it difficult to apply minimum access standards across all states, particularly when considering the "whole person" approach to care. In other words, access standards in a state should reflect the characteristics of their unique geographic and beneficiary demographics. This is particularly important in considering the need for Medicaid enrollees to be able to access care that addresses their holistic needs and for coordination of care across types of need. We provide the following considerations and recommendations:

Carve-Outs

Access to care delays can occur when a product and/or associated services are divided across different programs. We recommend that CMS consider the impact of states carving certain benefits out of managed care on whole-person care and care coordination. When states carve-out some benefits such as pharmacy or behavioral health from managed care, it creates a fragmented system. It can also be confusing for beneficiaries to receive one set of benefits through their Medicaid MCO, another set of benefits through the state, and yet a different set through a different entity. Although MCOs provide integrated care management programs to Medicaid enrollees, we are limited in our ability to provide holistic care coordination when we do not manage all Medicaid benefits our members are eligible for. Given this, we encourage CMS to incentivize managed care states to carve all medical, pharmacy and behavioral health benefits into MCO contracts. This would improve care coordination for members and help MCOs create more opportunities to work with different provider types, such as primary care and behavioral health providers, to co-locate or coordinate services.

Provider Participation

Flexibility. We support CMS' increasing focus on promoting whole-person care. We encourage CMS to allow health plans to retain flexibility over network development and discourage policies, such as "any willing provider" requirements, that hinder the ability of MCOs to negotiate and contract effectively with providers. Strict quotas or other metrics based on provider specialty does not align with the ultimate goal to provide quality access to care for members. Health plan flexibility allows MCOs to negotiate constructive and quality-focused arrangements with network providers.

Behavioral Health

Parity Compliance. As MACPAC recently highlighted, the Mental Health Parity and Addiction Equity Act (MHPAEA) has not substantially increased access to behavioral health services.[2] While MHPAEA is aimed at reducing inequities in coverage between behavioral and physical health services, it does not require that Medicaid cover behavioral health services. In addition, the parity analysis requirement in MHPAEA focuses on a set of barriers that may limit access to care (e.g., prior authorization, step therapy) and ultimately has not resulted in significant changes to behavioral health benefits. States and MCOs have found the required parity analyses, particularly for non-quantitative treatment limitations, to be complex and time consuming. In addition, parity law addresses the issue of comparable medical and behavioral health coverage, not necessarily access to care – for example, a Medicaid program may cover services in compliance with parity laws, but the individual can still experience challenges accessing care because of issues like provider shortages. Therefore, we would recommend CMS take steps to provide clarity and ease the administrative burden on states and MCOs to complete parity analysis. We also recommend CMS explore other ways to increase access to needed behavioral health treatment.

Facilitating access to services. Allowing Medicaid to be billed for services provided by a wider range of providers could help address workforce shortage issues and help minimize long waits for care and services. For example, Federally Qualified Health Centers (FQHCs) could be allowed to bill Medicaid for visits beneficiaries have with a marriage and family therapist, licensed professional counselor, or a licensed addiction counselor. Another consideration to better facilitate access to care and to improve the beneficiary experience could allow for a medical visit to be billed the same day as a behavioral health and/or oral health visit. We would also support increased funding to address workforce availability and retention (e.g., financing for behavioral health degreed programs) and refer to the National Council for Mental Wellbeing/Health Management Associates study available at: https://www.healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf for more information on capacity issues related to the behavioral workforce and potential state policy actions.

Pregnant women and post-partum access. To support states in ensuring pregnant and postpartum women have access to needed behavioral health services, we believe the new state option to extend Medicaid coverage to 12 months postpartum will increase access to needed behavioral health care. Other options for increasing access to needed behavioral health services for pregnant and postpartum women include the utilization of doulas and telemedicine.

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2 https://www.macpac.gov/wp-content/uploads/2021/07/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf

Collaborative Care Models (CoCM): As COVID-19 catalyzes an increase in behavioral health needs, the case for implementing a Collaborative Care Model is only growing clearer and more urgent. That is especially true for the people of color and with lower incomes being hit hardest by COVID-19 and the underlying inequities that have exacerbated this pandemic.

Social Determinants of Health

Payment to Address Health-Related Social Needs (HRSN):

- CMS should explicitly allow costs of activities related to HRSN, or Social Determinants of Health (SDoH), to be included in the numerator of the MLR calculation.
- Additionally, CMS could clarify what SDoH investments are allowed as covered benefits, and/or able to be captured in rate development, by plans (captured in rate section as well)
- CMS should publish guidance encouraging states to include SDoH activities within their State Plan Amendments to assist in building of capitation rates.

Demographic Data Collection

We believe CMS can promote whole person care and care coordination by working with states to increase demographic data collection and analysis of Medicaid beneficiaries to better understand the needs of the population.

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?*

MHPA believes that culturally competent care and language preference are vital components of access. MCOs ensure network providers deliver culturally competent and linguistically appropriate care through various approaches such as providing cultural competency/humility trainings to all providers. We recommend that CMS explore opportunities to identify and promote best practices the range of initiatives taken by state Medicaid agencies, MCOs, and providers in support of culturally competent care delivery. We also encourage CMS to include health plans in these conversations related to cultural competency as we can offer several best practices that include, but are not limited to: providing written, culturally competent translations of our key documents and communications into multiple languages; providing access to free language services; enhancing access to qualified oral interpreters and hiring multilingual staff in call centers; and communicating information about language services in both written and digital materials

In order to improve access to culturally competent services that are receptive to language preferences, we provide the following considerations:

Translation Services. Medicaid plans are required to use a certified translation vendor, who is in turn required to use an exact translation when communicating with members. In some instances, an exact translation is not appropriate in the context of the communication with the member. Additional flexibility for translators to communicate in a manner that is pragmatic and appropriate for that language would be helpful.

Cultural Competency Training. While we strive to make our provider networks as inclusive as possible, it can be difficult to get information from providers on the status of their cultural competency training. Rather than having plans each individually collect this information, we recommend that providers be required to submit cultural competency training certifications to the state, who can in turn make this available to plans. This would reduce the administrative burden for providers, who would only be required to report this one time, and for plans, who could obtain this information from one source.

Language Preference. Language preference is not always captured in the member's enrollment information. We recommend that CMS provide guidance to encourage states to capture language preference when individuals first enroll in Medicaid and share this information with plans. This will reduce member confusion, as plans will be able to conduct initial outreach in the member's preferred language.

Education and awareness. Education and community awareness of behavioral health issues and treatment is an essential step to addressing the issue of diversity in the behavioral health care workforce. Mental health literacy is the basis for prevention, stigma reduction, and increased awareness to both behavioral health issues and available treatment options. Understanding and placing an emphasis on addressing cultural norms is essential to increasing diversity in the behavioral health care workforce. Improving mental health literacy should be a focus of policymakers in order to educate, engage, and encourage community awareness of the importance of behavioral health and well-being.

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?*

MHPA applauds CMS for taking steps to address the provider workforce shortage by seeking strategies to increase and diversify the pool of providers for Medicaid and CHIP. We recommend CMS consider several strategies for increasing the number and types of providers serving the Medicaid population. Provider shortages pose a significant challenge to meeting population health needs. CMS and states must work with Medicaid health plans to mitigate the effects of provider shortages, invest in the health care workforce, incentivize provider participation in high-quality programs designed for Medicaid populations, and augment the provider workforce. Below are our recommendations on ways to increase access by addressing workforce issues and demonstrating support for telehealth.

<u>Workforce Issues</u>

Cross-state Licensure. Throughout the COVID-19 pandemic, most states authorized immediate or expedited licensure reciprocity for healthcare professionals to bolster workforce capacity and sustain access to care for patients. Notably, licensure reciprocity played a critical role in the delivery of virtual care services for patients, particularly those with chronic illnesses, living in rural areas, or geographic regions where there is a dearth of specialty providers. CMS can promote cross-state licensure by releasing guidance and best practices.

Multi-state Licensure Compacts. Moving beyond the pandemic, MHPA believes that multi-state licensure compacts for providers that harmonize state licensure requirements can be an important boost for telehealth care delivery, as well as for providers that operate near state borders. Such compacts can help facilitate access to care and are particularly important for areas, both geographic and by type of practice, that are experiencing provider shortages.

Non-Clinical Workers. Many states are looking for ways to expand the Medicaid provider workforce to include non-clinical health care workers such as community health workers (CHWs), doulas, and peer support specialists. MCOs often cover the costs of these workers through administrative dollars unless a state explicitly allows reimbursement of non-clinical health care workers to be counted as a medical expense. This can be challenging for MCOs that are required to reach a specific MLR. In addition, challenges to credentialing non-clinical workers exist including education and training, certification, and scope of practice. We recommend that CMS work with states to create simple and uniform credentialing processes for non-clinical health care workers.

Out-of-State Provider Billing. Providers that live in bordering states can help increase the pool of available providers to serve Medicaid beneficiaries in a state, especially when a larger town or city is located right across a state border. An individual case agreement is a means of contracting with an out-of-state provider; however, we believe a streamlined process for out-of-state providers that live close to a state border to participate in the bordering state's Medicaid program would be administratively efficient and increase the availability of providers, enhancing access to care. To support this approach, we recommend CMS consider how to incentivize states to recognize licenses from bordering states and to not require providers to be physically located in the state where they are billing. Medicaid MCOs could more easily contract with bordering state providers if states adopted these policies. This would increase access to providers for Medicaid enrollees we recommend CMS work with states to ease access for out-of-state providers to bill for Medicaid, particularly those that live near state borders.

<u>Telemedicine</u>

Telehealth and Network Adequacy Standards in Medicaid. During the pandemic, all 50 states have used emergency authority to waive some aspect(s) of state licensure laws providing widespread access to care. We propose convening a task force of federal and state leaders to examine this issue and outline recommendations on changes that would increase access to telehealth services beyond the pandemic. We also encourage state efforts to foster cross state licensure reciprocity for all provider types to support increased access to services. Cross state licensure could be a solution to existing provider shortages and can reduce barriers to treatment. Moreover, allowing specialty providers to treat across state lines can fill the gap for communities that are lacking such providers. We commend CMS for allowing states to include and measure telehealth access in their network adequacy standards and determinations for Medicaid MCOs. We encourage CMS to provide technical assistance to states seeking to implement this approach by sharing best practices and outcomes from states that currently incorporate telehealth access into their network adequacy standards.

Telehealth and Behavioral Health: The COVID-19 pandemic exacerbated the pre-existing behavioral health workforce shortage, one that is especially severe in rural and underserved areas. Rural and underserved areas face unique challenges in recruiting and retaining health professionals. TeleBehavioral Health (TeleBH) allows members to continue behavioral health treatment safely and in the comfort of their own homes, which is particularly important in rural, and other under-served areas.

Virtual appointments also provide greater access to care for those who are homebound or have a disability. TeleBH connects members with providers who can meet their unique cultural needs and improve access to specialists, giving all members an equal opportunity to obtain specialized care. Additionally, TeleBH removes barriers that can be present with in-person care including SDoH (for example, access to reliable transportation), stigma, and time away from work. We recommend that CMS continue to encourage states to embrace telehealth and promote mutual recognition compacts. Moreover, we recommend that CMS continue to emphasize to states the flexibility they have in determining how telehealth services are delivered.

Telemedicine Support and Expansion. During the COVID-19 pandemic, we saw firsthand the value of telemedicine in ensuring access to care. We appreciate the telemedicine guidance provided by CMS to states during the pandemic, and we recognize that states already have broad flexibility to implement robust telemedicine coverage policies. We recommend CMS consider the following specific actions to increase access to providers through telemedicine:

Provider's Physical Location. CMS should not allow states to place restrictions on telemedicine providers who are physically located out-of-state if the providers are licensed and enroll with the state in which they are billing. Restrictions related to a provider's physical location or address create unnecessary barriers for providers, especially those who provide their services entirely through telemedicine (e.g., certain behavioral health providers).

Licensing. We support state flexibility to allow providers to practice across state lines when they hold the appropriate medical licensure. We also support promotion of interstate licensure compacts that recognize out-of-state licenses. This will increase access to services and address areas that may face provider shortages.

Standards. States should be encouraged to explore and make additional modifications to standards around provider networks, service types, and the range of technologies that can be used to expand access to telehealth.

Remote Patient Monitoring Programs. CMS should incentivize states to expand remote patient monitoring (RPM) programs, when appropriate, that could improve healthcare access for Medicaid beneficiaries and medically underserved communities

Quality of Care. CMS should consider how to ensure Medicaid enrollees are receiving high quality and clinically appropriate care whether the services are provided in-person or through telemedicine.

Technology Support. We encourage CMS to work across agencies to find solutions for increasing access to broadband internet services and smart-enabled devices. We support building off this to remove barriers to broadband and provide Medicaid beneficiaries with smart-enabled devices. Improving access to broadband services can help address the digital divide and increase health equity.

Objective 4: CMS has data available to measure, monitor, and support improvement efforts related to access to services (i.e., potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations). CMS is interested in feedback about what new data sources, existing data sources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community based services (HCBS) measure set),

and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

1. *What should CMS consider when developing an access monitoring approach that is as similar as possible across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care programs) and programs (e.g., HCBS programs and dual eligibility in Medicaid and Medicare) 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?*

MHPA understands CMS' interest in standardizing monitoring and reporting across delivery systems in areas related to Medicaid access. Medicaid is not only the largest payer of health care in the United States, but it also serves the most diverse population including children, adults, individuals with disabilities and the elderly. Further, states differ on how benefits are covered (waivers versus state plan) and delivery system (state-administered versus managed care). Given this complexity, we are concerned that monitoring approaches that try to standardize access measures across populations, coverage policies, and delivery systems will not appropriately account for the variation in state programs and beneficiaries. CMS mentions how to best help states identify and prioritize resources to address access issues; we believe the best approach would be for CMS to provide hands-on support to states to help them address individual state challenges to Medicaid access. To do so, we would recommend that CMS take the steps needed to ensure the quality of patient data that is available as well as to identify the current gaps (e.g., COVID-19 vaccination status) in data that, if addressed, would help inform how to improve issues of access and equity in the Medicaid program. While MCOs collect demographic and SDoH data through some channels, challenges such as a lack of interoperable data infrastructure and inconsistent data standards, as well as low consumer response rates, make it difficult to obtain and utilize the data to readily identify how these inequities are impacting our most vulnerable members.

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.)?*

MHPA supports CMS providing states and plans with the flexibility to develop high quality provider networks that meet the needs of their Medicaid beneficiaries. We believe measures of potential access should be analyzed from the perspective of the Medicaid beneficiary and overlayed with the strategies states and MCOs are using to increase access to care. We would encourage CMS to consider working with states and health plans to collect qualitative feedback on care availability from the perspective of the beneficiary. We believe this information would be most helpful for CMS in considering how to standardize and streamline monitoring of care availability. We provide the following considerations for CMS as they seek metrics that capture meaningful data on access:

Service Utilization

Data which measures service utilization could be helpful for measuring access. In designing any data collection, CMS should account for utilization trends varying by population, given populations' differing service needs. An aged, blind, and disabled (ABD) beneficiary, for example, may be expected to have higher emergency room (ER) use than a non-ABD beneficiary.

Network Adequacy Standards

CMS should take a measured approach by providing states with best practices and technical assistance on developing nuanced network adequacy standards that take into account varying time and distance standards.

Appointments/Wait Times

Appointment wait times surveys are often ineffective in changing provider behaviors and are administratively burdensome for plans and states to monitor. Moreover, plans have limited control over appointment wait times - patients interact with providers for appointments, not health plans. Plans also do not control patient schedules or provider capacity for patients. We support alternate metrics that more accurately capture the robustness of provider networks without imposing additional administrative burdens into the system.

Non-Medical Needs

Consideration should be given to addressing non-medical needs such as transportation, childcare, and after-hours availability so they can attend health care appointments.

Provider Fit

Health care is not one-sized fits all and sometimes a provider is not the right fit for a beneficiary who then needs assistance finding a new provider.

3. *In what ways can CMS promote a more standardized effort to monitor access in long-term services and supports (LTSS), including HCBS programs? For example, how could CMS leverage the draft HCBS measure set, grievances and appeals, or states' comparisons of approved Person-Centered Service Plans to encounter or billing data in managed care or fee-for-service to ensure appropriate services are being received? Which activities would you prioritize first?*

MHPA appreciates CMS taking steps to monitor meaningful access for the LTSS population, including through HCBS delivery systems. States offer different types of coverage of State LTSS and HCBS through state plans and waivers, making standardized approaches to monitoring access across states difficult. We have a few considerations and recommendations:

Network Adequacy

Traditional time and distance measures are not always accurate measures for assuring network adequacy in an LTSS program. Access is a crucial issue, particularly in the context of a shift towards HCBS services which allow plans to meet the need of members in their communities. We would encourage CMS to consider access with an emphasis on the availability of high-quality providers who drive the best outcomes for our members, rather than solely focusing on metrics such as the number of

providers in a geographic area. Access to care in the LTSS space must be considered in the context of workforce shortages, and we recommend that CMS pair increased monitoring with grants and technical assistance that promote training, hiring, and retention of direct care workers who provide care in the community. We believe this approach is aligned with an increasing use of value-based arrangements, which reward providers who provide this high quality of care.

Demographic Data

We appreciate CMS approaching access through the lens of health equity and recommend that CMS take steps to stratify data on access by demographic group so that gaps can be identified and addressed. Stratified data will help plans to implement targeted approaches to meet the needs of individual subpopulations of our members. This approach will help plans and states to identify gaps in the social needs of our members for both LTSS and Medicaid members more broadly.

Appeals and Grievance Indicators

A state-by-state comparison of person-centered planning with claims and grievances and appeals would reflect service usage across the nation and potentially identify areas for improvement.

Patient Experience

We recommend CMS and states evaluate member satisfaction using the current draft quality measures of person-centered planning.

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?*

There is great variability among Medicaid plans that can make it difficult to compare data between state Medicaid programs. For example, states create their own appeals and grievances reports with different categories. Grievances and appeals (G&A) policies and procedures are in place in all state Medicaid programs, many of which are rooted in NCQA accreditation requirements and are supplemented with each state's own expectations for access standards. NCQA accreditation requires not only measurement of access and availability of providers, but also member experience, which includes gathering member perspectives on how care-delivery may be improved.

We believe there are existing and effective processes in place that are useful for assessing and resolving consumers' access concerns, and these processes serve as a starting point for building any industry standards. To meaningfully monitor access, we would recommend establishing a standard list of appeal and grievance reasons like those established for Medicare to help CMS and states better understand how appeals and grievances reflect access to services in Medicaid.

We note that there is opportunity for improvement and refinement around how member feedback is incorporated into an access assessment. For example, consideration could be given to how certain service categories, which are accessed by different populations, may result in a wide variation in feedback (e.g., medical care compared to supportive services provided to an MLTSS member).

In many states, MCOs use member feedback in concert with state Medicaid programs to monitor state or regional access problems and develop solutions. MCOs can work together with states and providers to assess various measures in place for collecting and addressing member feedback and concerns and then utilize the information to look holistically at larger regional service or provider access trends that may be addressed.

5. *How can CMS best leverage T-MSIS data to monitor access broadly and to help assess potential inequities in access? What additional data or specific variables would need to be collected through T-MSIS to better assess access across states and delivery systems (e.g., provider taxonomy code set requirements to identify provider specialties, reporting of National Provider Identifiers [NPIs] for billing and servicing providers, uniform managed care plan ID submissions across all states, adding unique IDs for beneficiaries or for managed care corporations, etc.)?*

No response.

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible. Section 1902(a)(30)(A) of the Social Security Act (the "Act") requires that Medicaid state plans "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Section 1932 of the Act includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States "in an effective and efficient manner…." CMS is interested in leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.

1. *What are the opportunities for CMS to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?*

MHPA encourages CMS to consider the impact that minimum standards for payment, such as minimum fee schedules to be applied across all states, would have on state Medicaid programs. States have limited dollars for the Medicaid program, and, unlike the federal government, states must balance their budgets. Therefore, we would urge CMS to address how proposed floors or minimum payment policies would be supported with federal funding. Specific to managed care, CMS would need to ensure compliance with actuarial soundness principles for any mandated payment policies. Medicare fee schedules vary by state to account for local provider costs and prices. Given that Medicaid is a state-managed program, we encourage CMS to continue to allow states to set payment standards that are appropriate for their state given local costs, availability of providers, and state budgets.

Provider Reimbursement Change Impacts

We note that changes to provider reimbursement rates will likely have an impact to the overall Medicaid program costs. Given this impact, we believe any changes must be appropriately considered and documented in managed care capitation rate development and that capitation rates must reflect the impact of these changes and remain actuarially sound. Ensuring that rates are actuarially sound and reflect of underlaying provider payment rates is critical to maintaining access. We provide the following considerations and recommendations:

- **Procurement process.** States should provide more comprehensive data during procurement processes, including 3 years of historical cost and utilization data by rate cell, region, population group, and detailed categories of service.
- **Rate certification**. State actuaries should certify the rates prior to receiving any bids. This recommendation would help ensure an independent and sound process, since it requires the state actuaries to develop the rates prior to being influenced by any bids from an MCO.
- **Rate ranges.** State should provide the rate range to the bidders, prior to when MCOs would need to submit a bid.
- **Timelines.** States should allow for a reasonable amount of time (e.g., 30 days) to review and discuss the draft methodology with the state and state actuaries, prior to the rate certification being submitted to CMS.
- **Rate certification package.** States should share the same rate certification package (including follow-up questions/answers regarding the package) provided to CMS with the MCOs (with any confidential information redacted). In some states, very limited rate development data and explanation is provided to the MCOs. Enhanced transparency at no extra cost will help ensure actuarially sound rates.
- **Comment period.** States should provide for a "comment period" during which stakeholders (e.g., patient advocacy groups, MCOs, providers, etc.) could share high priority concerns so that the CMS and CMS Office of the Actuary could take them into account as part of their approval process. This as an opportunity for stakeholders to help the federal government better understand the complexities of each state's rate development process and could be designed to be similar to the 1115 comment process, whereby CMS collects input from all stakeholders prior to approval of these waivers.
- **Dispute resolution.** States should consider having a process available when there is no agreement between parties with regard to rates.

CMS Technical Assistance

As it relates to payment regulation and compliance, we encourage CMS to continue to offer and provide technical assistance to the states to ensure compliance. We believe that by assisting states in compliance with the new reporting requirements will work to increase transparency in Medicaid and aid in identifying where barriers and discrepancies exist in supplemental payments. This will ensure all providers are receiving the appropriate reimbursement for their services and encourage a fair, competitive payment structure in Medicaid.

Priority Recommendations

Ensure Sound Payment Policies that support payment for services that address Health-related Social Needs (HRSN):

- CMS should explicitly allow costs of activities related to HRSN, or Social Determinants of Health (SDoH to be included in the numerator of the MLR calculation.
- Additionally, CMS could clarify what SDoH investments are allowed as covered benefits, and/or able to be captured in rate development, by plans (captured in rate section as well)
- CMS should publish guidance encouraging states to include SDoH activities within their State Plan Amendments to assist in building capitation rates.
- CMS should encourage community reinvestment that builds from consultations with stakeholders to explore and encourage strategies to allow states and Medicaid managed care plans to flexibly reinvest Medicaid program savings and surpluses in community health projects that include SDOH activities.

2. *How can CMS assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?*

MHPA would encourage CMS to work with states in a learning collaborative to identify best practices that have led to increased access to Medicaid providers. These best practices could serve as models for other states as they consider their own approaches. For example, initiatives that consider access to CHWs, doulas, and peer support providers as Medicaid providers or a policy that allows for family members to be paid as caregivers provide opportunities to assess the impact of these approaches on access to care.

3. *Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community based services (HCBS). What data sources, methods, or benchmarks might CMS consider to assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?*

No response.

4. *Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries. What actions could CMS take to encourage states to reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?*

MHPA appreciates the need to reduce unnecessary administrative burdens that may discourage provider participation in Medicaid and CHIP and potentially impact time spent on patient care. We focus our response on two areas: provider credentialing/licensure and prior authorization.

Provider Credentialing/Licensure

MHPA appreciates the flexibilities granted to state Medicaid programs during the COVID-19 PHE to allow providers to practice across state lines when they hold the appropriate medical licensure. We believe this flexibility, along with the promotion of interstate licensure compacts that recognize out-of-state licenses, are beneficial approaches and would recommend continuation of this flexibility.

Prior Authorization

During the COVID PHE, we appreciated the need to work with our state Medicaid partners to ease restrictions on prior authorization. However, as we prepare to transition from the PHE, utilization management tools, such as prior authorization, allow for MCOs to work with providers to ensure the best quality treatment and options for our beneficiaries, and also ensure the long-term financial sustainability of state Medicaid programs. The lifting of prior authorization requirements and other utilization management tools can result in inefficient utilization of services and a higher total cost of care. Further, utilization management can help reduce the risk of fraud, waste, and abuse in telehealth, and is a necessary tool for MCOs to utilize. As the PHE ends and states begin to move back to normal operations, it is important for prior authorization to also return to normal in order to ensure the integrity and financial sustainability of state Medicaid programs.

Other Feedback:

No response