



National Health Law Program's Responses to

CMS Request for Information: Access to Coverage and Care in Medicaid & CHIP

Submitted April 18, 2022

Objective 1 of 5

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

- 1. What are the specific ways that CMS can support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan when applicable.**

Eligibility and Enrollment Application Process

Federal regulations at 42 C.F.R. § 435.907 require states to establish processes that enable individuals to submit a single streamlined application for Medicaid, CHIP and Marketplace coverage by telephone, by mail, or in-person. There is wide variation across states with respect to consumer application usability across multiple modalities. To ensure more standardized consumer experiences within states, CMS should:

Standardized Metrics Across Modality. Establish standardized metrics and public facing reporting requirements that would allow for oversight and transparency with respect to application experiences by modality and by eligibility group. Metrics should be based on accepted industry standards and could include, for example, call center wait and drop times, abandoned and completed online applications, and appointment wait times for in-person application and renewal assistance.

Online-Specific Application Processes. Despite the federal and state investments in establishing online application pathways, many online applications continue to be difficult to navigate for individuals seeking to apply for or renew their coverage. For example, in 2018 only [34 states](#) have functionality to allow individuals to scan and upload documents, which impedes application processing timeframes. In 2021, only [32 states](#) had functionality that enables individuals to complete and submit an application using a mobile device. As such, CMS should:

- Issue regulations establishing that in order to meet the online application submission requirement, states must have functionality for individuals to upload and submit documents and to submit applications using a mobile device.
- Conduct a review of states' online applications to ensure they are: (1) dynamic – so that individuals are only answering questions that are relevant to their circumstances; and (2) meet basic expectations with respect to usability and compliance with individuals with Limited English Proficiency.
- When approving 90/10 FMAP for IT Medicaid systems design, implementation, and enhancements, require states use a third party assessment of consumer usability of the proposed application or system changes as a condition of payment to their IT systems vendor so that resources are used in ways that truly improve the consumer experience.
- Conduct consumer user experience assessments of the HealthCare.gov application process to ensure that the application process is not creating undue barriers.
- Require states with state based marketplaces (SBMs) to conduct consumer user experiences assessments of eligibility applications through third party vendors (independent of the vendors implementing the SBM systems technology) and to provide a report to CMS.

Verification Processes at Application and Renewal

As states continue to improve upon ex-parte renewal and retention rates, CMS has an opportunity to issue verification-specific guidance and regulations that would help to enhance continuity of coverage. Such guidance and regulations could include:

Reasonable Compatibility. Federal regulations allow for states to use a reasonable compatibility process at both application and renewal, though the regulations are not clear on how to apply reasonable compatibility at renewal. The operating principle behind the reasonable compatibility construct is the comparison of data sources against an attestation, either on an application or renewal form. Per 42 C.F.R. § 435.952, “if information provided by



or on behalf of an individual (on an application or renewal form or otherwise) is reasonable compatibility with information obtained by the agency...the agency must determine or renew eligibility based on such information.” While CMS has not put forth guidance on this issue, the expectation is that a state’s ex-parte renewal process needs to be based on comparing data sources against income eligibility levels and not against information in the eligibility system. To that end, CMS should issue new guidance that clearly allows for the use of a reasonable compatibility threshold at renewal whereby a state may compare data sources against information in the eligibility system renewal.

Zero Income. CMS should issue guidance that when an individual attests to zero income at application or renewal and no data sources are returned that indicate otherwise, the state may accept the lack of data from available sources as reasonably compatible with the attestation of no income and no further information or documentation is required.

Individuals Unlikely to Experience a Change In Circumstances. CMS should issue guidance that outlines specific categories of individuals who are highly unlikely to experience a change in circumstances and for whom a state may automatically renew coverage unless the individual reports a change in circumstances. Such individuals could include SSI recipients, former foster care youth, and adults in skilled nursing facilities.

Periodic Data Checks. States routinely use routine data checks that seek to identify changes or discrepancies in eligibility data between regularly scheduled renewals. These checks often uncover data discrepancies that escalate churn (*i.e.*, eligible members falling off Medicaid due to missed paperwork deadlines and re-enrolling) and increase administrative costs. Particularly because states often require a ten day response time to confirm or correct data, routine data checks can make it difficult for low-income families to maintain continuity of coverage and access to health care. CMS should discourage periodic checks by clarifying that states will not be subject to eligibility errors or oversight if they do not conduct such checks; CMS also could encourage states that do undertake periodic data checks to give people more time (*e.g.*, thirty days) to respond to requests for information and to conduct outreach via multiple modalities (*e.g.*, telephone and email) if there is no response to the consumer notice so that periodic checks do not lead to procedural/administrative coverage losses.

States With Integrated Eligibility Systems. Some states with integrated eligibility systems are not conducting Medicaid ex-parte renewals for individuals enrolled in both Medicaid and SNAP, which is contrary to CMS regulations. CMS should issue guidance clarifying that states with integrated eligibility systems must conduct ex parte Medicaid renewals consistent with



Medicaid rules for all individuals, including those enrolled in SNAP. CMS should also conduct monitoring and oversight on the IT system capacity to ensure ex-parte renewal processes are being conducted.

Leverage Federal Tax Filing to Streamline Eligibility. Current regulations require states to obtain consent to review IRS data for verifying income at application and renewal when determining eligibility for an Advance Premium Tax Credit for a Qualified Health Plan. After the five years have passed, states must re-obtain consent. CMS should issue regulations that remove the five year limit on IRS tax data consents.

Some states [continue to experience delays](#) in application processing and are having glitches in the Medicaid renewal process, to the [detriment of many Medicaid applicants and beneficiaries](#). Such delays are particularly problematic for applicants who need in-home services to stay safely at home as opposed to moving to a more segregated congregate placement, such as a nursing home. Similarly, individuals who have been receiving Medicaid waiver services or other in-home services who receive notices that they have been terminated from Medicaid are facing problems. The Affordable Care Act (ACA) changed the Medicaid application and renewal process in ways that should streamline the Medicaid application and renewal process, thereby decreasing the burden on individuals. However, many states have failed to effectively implement these regulations, resulting in problems for applicants and beneficiaries. This has resulted in litigation to enforce applicants' right to have their applications processed timely. *See, e.g., Wilson v. Gordon*, No. 3-14-1492, 2014 WL 4347807 (M.D. Tenn. Sept. 2, 2014); *Rivera et al. v. Douglas*, No. RG14740911, Alameda Sup. Ct. Jan. 20, 2015 (order granting preliminary injunction).

Beneficiaries should not have to sue their states to have their applications acted upon in a timely manner. This is an area where CMS can do more to monitor and enforce existing protections. CMS should ensure that states permit applicants to address Medicaid application delays and improper terminations directly through the fair hearing process through clearly available processes and no undue administrative burdens. If an application is delayed, states must allow an individual to file a request for a fair hearing on the basis that the state has failed to make a determination in a reasonably prompt manner. CMS should clarify that states cannot force applicants to rely solely on the Marketplace appeal mechanisms. CMS should make it clear to states an appropriate remedy for a failure to determine applications in a timely manner is enrolling the individual pending the state's final determination and that FFP would be available in such circumstances. *See, e.g., Rivera*.



Many of the eligibility computer systems created in the wake of the ACA rely heavily on automated processes, centralized document processing, and separated workflows. Eligibility workers have little direct interaction with applicants or have knowledge of their case such that they can catch processing errors. The eligibility systems are rarely programmed to create audit trails or otherwise generate reports to identify errors in eligibility determinations or trends in who is getting denied to identify disparate impact. For example, some eligibility categories are fairly stagnant, such as Disabled Adult Children (DAC), and a sudden uptick in denials of DAC-eligible beneficiaries should generate alarms in the system for review by eligibility staff. Another red flag would be if a high number of beneficiaries in a certain geographic area, disability, race, or language preference disparately lose or are denied eligibility. States need to do more to identify problems in a system as opposed to what many do, which is wait for beneficiaries to complain to the State or through constituent services with their legislative representative. Such a technique does not adequately meet the state's obligations under the Medicaid Act and U.S. Constitution, and overly relies on individuals knowing they should be eligible when the State is telling them they are not.

The increased automation of the eligibility processes often relies on a level of technological sophistication regarding information and document requests and related submissions, communications, and notices that exceeds the technological knowledge, literacy, access, and skill level of the Medicaid population. This is particularly true in areas where access to internet and technology is more limited. Medicaid eligibility systems, including the systems themselves and associated document management processes, are notorious for losing documents and repeatedly asking for the same or unnecessary documents or information. States also fail to provide information on a pre-populated form as required, and generate notices that are [wrong](#), [incomplete](#), or otherwise fail to meet due process requirements. CMS should do more to audit states' systems and also enforce the requirement that eligibility policies and procedures be "consistent with simplicity of administration and *the best interests of the applicant or beneficiary*." 42 C.F.R. § 435.02 (emphasis added). Renewal packets should not be [nearly 100 pages](#), ask repeatedly for the same information, request unnecessary information, or otherwise be confusing. Similarly, application processes that require additional information must avoid similar issues. Too often these eligibility systems are designed for business workflow purposes and fail to fully consider the impact on beneficiaries and fulfilling their actual purpose of timely and *accurately* determining eligibility.

CMS must also do all it can to reinforce the rights of people with disabilities, people with limited English proficiency (LEP), and older adults in the eligibility and redetermination processes. Too often, applicants and beneficiaries in these protected groups lose eligibility because states do not provide the necessary assistance in what can be complicated application and redetermination processes. Complicated eligibility systems, insufficient notices, reliance on technology, and complicated workflow processes can mean eligibility workers are rarely able to fully and helpfully answer an applicant or beneficiary's questions. This violates the requirement that a State provide application assistance and ensure the accessibility of their eligibility processes. However, most states fail to fulfill their assistance obligations, due process obligations, and non-discrimination requirements under federal civil rights laws including Title VI of the Civil Rights Act, § 504 of the Rehabilitation Act, the Age Discrimination Act, and §1557 of the Affordable Care Act. CMS should offer clearer guidance on the level of assistance that states must provide to meet Medicaid, non-discrimination, and Due Process Clause requirements.

Support Eligibility Protections for Limited English Proficient (LEP) Individuals

LEP individuals are more likely to require assistance at enrollment and more likely to face barriers in accessing the application, which can greatly impact the accessibility and timing of enrollment. (See Feinberg, Emily, Katherine Swartz, et al, Language Proficiency and the Enrollment of Medicaid-eligible Children in Publicly Funded Health Insurance Program, Maternal Child Health J. (2002)).

CMS can support states by providing better language access infrastructure and resources for outreach to LEP communities. CMS should require each state to provide a language access plan as part of their state plan for Medicaid (and actually a broader communication plan, see answer to Objective 3 Question 4), which CMS should carefully review and require states to publicly post and update regularly. We recommend that CMS create an Office of Language Access in order to oversee the administration and monitoring of state language access plans and services across programs. An Office of Language Access would also be able to provide technical support and resources to states and plans to facilitate language access and compliance with language access requirements.

Despite HHS language access guidance and regulations, many states still fail to implement or effectively monitor language access for LEP enrollees. CMS should require and review language access plans for states in order to encourage states to proactively improve language



access, as opposed to relying on stakeholders and community advocates to bring language access issues to the attention of states and CMS through the complaint process.

Provide Resources and Heighten Enforcement of Plain Language Requirement

Use of plain language is a critical tool in improving timely application processing and enrollment. According to [Healthy People 2020](#), uninsured and publicly insured (e.g., Medicaid) individuals are at higher risk of having low health literacy. (See Kutner M, Greenburg E, Jin Y, Paulsen C. The health literacy of America's adults: results from the 2003 national assessment of adult literacy. National Center for Education Statistics; 2006. Report No.: NCES 2006-483.) Further, people with low health literacy and limited English proficiency are twice as likely as individuals without these barriers to report poor health status. (Sentell T, Braun KL. Low health literacy, limited English proficiency, and health status in Asians, Latinos, and other racial/ethnic groups in California. *J Health Commun.* 2012;17 Suppl 3:82–99. doi: 10.1080/10810730.2012.712621). One study found that 74% of Spanish-speaking patients have less-than-adequate health literacy as compared to 7% of English-speaking patients. (Brice JH, Travers D, Cowden CS, Young MD, Sanhueza A, Dunston Y. Health literacy among Spanish-speaking patients in the emergency department. *J Natl Med Assoc.* 2008;100(11):1326–32.).

Research has shown that both English and non-English speakers alike demonstrate higher understanding of materials that are written in plain language. (See e.g., [Kimble, Joseph, The Proof is in the Reading: Solid Evidence that Plain Language Works Best, Mich. Bar J. \(Oct. 2016\)](#)). Further, use of plain language is especially important for accessibility by people with intellectual disabilities and people who speak limited English. Use of plain language has been required since Congress passed the PLAIN Act in 2010, but still many states lag behind in implementing plain language principles on public-facing materials.

We encourage CMS to strengthen the requirement of plain language on all public-facing materials in its programs and projects as well as state-based materials for Medicaid and CHIP. First, CMS should provide financial and technical resources for states who are not consistently using plain language principles in their public-facing materials. Second, CMS should ensure the plain language requirement applies to important materials that reach enrollees. Although CMS monitors use of plain language on information that CMS produces, CMS does not monitor states' use of plain language on Medicaid applications and due process notices among other publications. Proactive encouragement and enforcement can improve timeliness of the enrollment process by reducing the need for applicants and enrollees to rely on in-person



assistance with applications. It may also reduce the churn that results from disenrollment of individuals who misunderstand renewal notices that are not written in plain language.

Use of plain language benefits all enrollees, but particularly those who need assistance to have meaningful access these programs, such as people with disabilities and LEP individuals. Encouraging and enforcing the use of plain language only strengthens the likelihood that state programs meet the civil rights requirements given by § 504, § 508, Title VI, and § 1557. Therefore, plain language is also an important and necessary tool to advance health equity in Medicaid and CHIP.

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?

(Not answered)

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?

Establish Robust Outreach Standards and Support States in Adopting Them

The lack of information about eligibility for Medicaid, CHIP and subsidized Marketplace coverage continues to be an issue that significantly impedes enrollment of eligible but uninsured individuals. Few states engage in sustained, effective outreach, often relying only on their websites and generally deferring more focused and purposeful outreach efforts to community-based organizations. To truly address access issues, CMS should use its authority to establish robust outreach standards, identify resources to support states in adopting them, and oversee compliance with outreach standards. CMS should clarify in guidance that federal regulations at 42 C.F.R. § 431.15, which require states to provide for methods of administration that are necessary for the proper and efficient operation of the state Medicaid plan, encompass robust outreach to ensure that individuals can access



coverage. Based on that authority, CMS should establish minimum expectations for outreach and education and hold states responsible for conducting outreach directly or through trusted community-based partners as a core administrative function of state Medicaid agencies.

CMS could also take the following steps to support states in implementing strengthened priorities.

- Elevate promising practices, toolkits, and other resources to help states implement/strengthen their outreach efforts.
- Continued federally-funded navigator-type money with focus on key populations. Develop “off the shelf” outreach campaigns that can be customized by states (as CMS is doing with PHE unwinding).
- Share Healthcare.gov annual messaging and outreach strategy, and work with state Medicaid agencies and SBMs to align and amplify consistent messaging on Medicaid, CHIP and Marketplace eligibility.
- Support (via grants or learning collaboratives) for states messaging strategies and education about culturally and linguistically appropriate communications.

Data Collection

CMS must adopt standardized comprehensive demographic data collection in its programs in order to effectuate its commitment to health equity. The [Biden-Harris Administration's Executive Order on Advancing Racial Equity and Support for Underserved Communities](#), [HHS's Strategic Goals 1 and 3](#), and [CMS's recently identified Health Equity Challenges](#) all identify the need for standardized demographic data collection. We recommend that CMS require collection of enrollee's race, ethnicity, primary language, sexual orientation, gender identity, variations in sex characteristics, and disabilities upon enrollment in Medicaid and CHIP. We also encourage CMS to regularly make demographic information accessible to stakeholders to promote transparency and accountability.

Although CMS does collect race and ethnicity information from enrollees, CMS must expand its information collection to other demographic characteristics. Without collecting demographic information about sexual orientation, gender identity, disabilities, primary language, and variations in sex characteristics, CMS cannot identify where disparities exist in these populations and target interventions to address disparities. For example, CMS needs the capability to compare the baseline eligible population and the enrolled population for each of



these demographic categories in order to identify disparities in enrollment before CMS can identify the barriers causing those disparities. With access to enrollees' demographic information at enrollment, CMS and states can better target population-specific interventions to assure equity in CHIP and Medicaid access and address any identified disparities.

As stated in NHeLP's prior [comments](#), CMS should require states collect comprehensive data about enrollees' race, ethnicity, primary language, disabilities, sex, gender identity, and sexual orientation. CMS should also require sufficient data categories to capture subpopulations and then adopt rules for aggregating that data. For example, states should collect race data using more than the five categories adopted by OMB; for Asian and Pacific islanders, states should include fields for individuals to self-identify whether they are Japanese, Chinese, Indonesian, Korean, etc. As noted by the [Institutes of Medicine](#), "important variations in health and health care that may be masked when data are analyzed using only the OMB race and Hispanic ethnicity categories."

Collection of this demographic information should be mandatory for states to include on Medicaid and CHIP applications, but it should be voluntary for enrollees to report. CMS should continue to provide technical assistance to states to ensure that enrollees understand that providing demographic information on the application or at enrollment will not affect eligibility or benefits. CMS should also provide states with supporting materials, training, and resources that can improve voluntary reporting and response rates. For example, message testing shows that response rates on demographic questions improve when the individuals being surveyed understand why the information is being collected. (See [Baker DW, Cameron KA, Feinglass J, Georgas P, Foster S, Pierce D, et al., Patients' attitudes toward health care providers collecting information about their race and ethnicity, J. Gen. Intern. Med. \(2005\)](#)). Education and support of providers and frontline staff also improves response rate. (See [Vega Perez, Ruben D., Hayden, Lyndia, Mesa, Jefri, Bickell, Nina, Abner, Pamela, Richardson, Lynne D., and Kai, Nya Ming, Improving Patient Race and Ethnicity Data Capture to Address Health Disparities: A Case Study from a Large Urban Health System, 14 Cureus \(2022\)](#)).

Following these recommendations, CMS should provide states with specific evidence-based text to use on applications, in call centers, and for staff who assist with applications. The sample language should explain why the information is being collected, that the information is voluntary to report and does not affect eligibility, and what privacy protections are in place to protect disclosure of the information. Further, CMS should require states to explicitly train (and document the training) of call center staff and eligibility workers on these issues. CMS should develop these training and technical assistance materials building on the work of existing



research, such as the studies cited above and the American Hospital Association's [Health Research and Educational Trust Toolkit](#).

We urge CMS to require states to collect this information using standardized demographic questions on Medicaid and CHIP applications. Standardized questions and terminology ensures that information can be compared across states. If states continue to each decide themselves how to collect this data, CMS will remain unable to identify trends and issues between and amongst states. For example, the [State Health Access Data Assistance Center \(SHADAC\)](#) found significant differences in state applications: some states use more granular racial categories, some do not; some states combine the race and ethnicity questions, some do not; and some collect demographic information on primary language, some do not. [SHADAC](#) found that states also differ greatly in the collection of information on sex and gender, with some collecting both assigned sex at birth and gender identity and some conflating the two. Recognizing that standardizing the fields may take time, CMS could develop a timetable for implementation. For example, CMS could first require states to begin collecting new data (e.g. SOGISC data) and later update their fields for collecting race and ethnicity or vice versa. And CMS should remind states of the availability of enhanced [FMAP \(90%\)](#) to upgrade their eligibility and enrollment IT systems. (See also GAO, [Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist](#) (Dec. 2014)).

For sample language, CMS can look to the [2011 HHS Data Collection standards](#), which address race, ethnicity, and disability , and the recently released [National Academies of Sciences, Engineering, and Medicine \(NASEM\) report](#), which provides expert consensus on questions regarding sexual orientation, gender identity, and variations in sex characteristics. Collecting this information on applications enables tracking of applications by and enrollment trends by demographic characteristics. States can compare the demographic makeup of applicants to the overall Medicaid-eligible population using population-level data from national surveys such as the Census or the American Community Survey. This comparison allows CMS and states to track disparities and identify barriers to enrollment that are population-specific. It also allows CMS to monitor trends in utilization and retention across the period of enrollment and identify changes in enrollment that may result from structural disenfranchisement. Collecting enrollees' demographic data at the application stage enables CMS to address barriers that already exist as well as to monitor enrollment for protection of all enrollees' civil rights. Further, collecting demographic data and sharing it with healthcare providers can assist them in preparing for the needs of LEP individuals and persons with disabilities at points of care by knowing – in advance of appointments or treatment -- what languages their patients speak so they can have appropriate language services in place or



what the communication needs of individuals with disabilities and having appropriate auxiliary aids and services or meeting their physical accessibility needs..

Emergency Medicaid

CMS should provide formal guidance to states: (1) explaining that pre-enrollment for emergency Medicaid is the preferred method of determining eligibility and enrolling individuals into the program (or at least that it is an option available to states); and (2) providing operational support to states to implement pre-enrollment, including specifically explaining the availability of an enhanced federal match (i.e., 90%) for IT changes necessary to make this work. Many states require emergency Medicaid-eligible individuals to apply for emergency Medicaid to reimburse their provider after receiving emergency care. After qualifying for reimbursement through emergency Medicaid, such individuals are not necessarily enrolled in the program – they are required to apply for reimbursement through the program after each subsequent emergency.

Providing clarity to states on pre-enrollment for their emergency Medicaid programs will not only help them reduce administrative burdens for their agencies and providers, it will also assist states in designing programs that expand health care coverage to state residents who do not qualify for Medicaid or Exchange coverage due to their immigration status. If residents ineligible for Medicaid or Exchange coverage are pre-enrolled in emergency Medicaid, states could more easily connect and transition them to new coverage programs and could better identify enrollees in their new programs as individuals whose emergency services should receive federal funding through emergency Medicaid.

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?

Knowing the demographic information of enrollees is critical for CMS to be able to monitor whether states are upholding civil rights requirements and improving outcomes for historically underserved communities. A program that routinely denies enrollment or services to individuals of a particular class could be in violation of civil rights laws, but CMS cannot be aware of such violation without measuring the demographic makeup of applicants and enrollees.



Requiring such demographic data collection is highly feasible for CMS. CMS already requires states to report the race and ethnicity of enrollees through the T-MSIS database. Although many states still fail to report complete and accurate race and ethnicity data, CMS has seen improvement over time and with the development of accountability standards. (See [SHADAC, Collection of Race, Ethnicity, Language \(REL\) Data in Medicaid Applications \(2021\)](#), CMS should continue to improve and expand demographic data reporting through the T-MSIS database. See our response to Objective 4, Question 5 for more recommendations on this issue.

As noted in Objective 1, Question 3, CMS can improve its monitoring of equity in enrollment denials by requiring states to add Sexual Orientation, Gender Identity, and Sex Characteristics (SOGISC) and disability status questions to their applications, providing additional technical and financial resources to states, and engaging in regular analysis and reporting of data. CMS should require states to collect information on the Medicaid and CHIP application about SOGISC and disability. This requirement should come with additional technical and financial resources to support the modification of applications and reporting systems (such as T-MSIS) both on the federal and state level and to support interoperability. CMS should also be prepared to provide states with recommended practices and guidelines for collection of this data, including messaging and training for frontline staff. Finally, CMS should adopt accountability measures to improve completeness and quality of data. We recommend that CMS provide resources to support data collection in the first years of this requirement and phase in mandates.

Objective 2 of 5

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?

Ex-Parte Renewal Processes

Federal regulations at 42 C.F.R. § 435.916 require states to first conduct ex-parte renewals using available data sources prior to requesting additional information or documentation. Unfortunately, most states are not able to process a large portion of their redetermination using ex-parte processes. [Of the 42 states processing ex parte renewals, only 11 states report completing 50 percent or more of renewals using ex parte processes. Twenty-two states complete less than 50 percent of renewals on an ex parte basis, including 11 states where less than 25 percent of renewals are completed using ex parte processes.](#) In states with county-based eligibility systems, ex parte rates may also widely by county. In order to improve ex-parte rates and consistent with Social Security Act § 1902(a)(19) requirements that states must “provide such safeguards as may be necessary to assure that eligibility” will be determined “in a manner that is consistent with the simplicity of administration and the best interests of recipients,” CMS should:

- Issue ex-parte processing standards (e.g., at a minimum, 60 percent of all redeterminations should be processed ex-parte) and pursue corrective action plans for states that do not meet those standards, including holding back 75% enhanced match for IT improvements if states systems are not able to meet these standards.
- CMS should require states to routinely test their systems to assure ex parte processing is possible and that states meet minimum processing standards. CMS should require states to achieve specific performance standards on renewal related data, such as a specified threshold of ex parte and data-driven renewals.
- Update regulations to require ex parte renewals for non-MAGI populations and continue providing technical assistance to states to help implement this requirement.

Targeted Enrollment Strategy State Plan Authority

Very few states have taken up the [Targeted Enrollment Strategy State Plan](#) authority to leverage SNAP or other means tested eligibility information to enroll/renew adults into Medicaid coverage. This is largely due to the State Plan required operational processes that require state Medicaid agencies to reach out to individuals and obtain additional information in order to align the SNAP income information, for example, with a Medicaid MAGI determination. In order to increase states' utilization of the Targeted Enrollment Strategy State Plan Authority, CMS should:

- Work with states to develop a more streamlined and accessible Targeted Enrollment Strategy State Plan option and update the State Plan template;
- Allow states to use § 1902(e)(14) waiver authority on a permanent basis to allow for the use of SNAP income to be used without conducting a separate Medicaid MAGI income determination. CMS is currently approving these waivers to support states' federal continuous coverage unwinding processes and could develop a § 1902(e)(14) waiver template for states to complete that could include program integrity assurances.

Continuous Enrollment

CMS has recently implemented a special enrollment periods (SEP) for individuals with income under 150% FPL. CMS should advance regulations to provide such enrollees with a continuous 12-month enrollment period, rather than requiring them to re-enroll during the standard open enrollment period, which could come soon after initial enrollment.

States with Integrated Social Service Benefit Program IT systems

States that use integrated eligibility systems have unique opportunities to streamline eligibility and enrollment processes and promote coverage and retention by minimizing requests to applicants and enrollees for additional information and reducing administrative burden for states. That said, state agencies administering multiple social service programs too often do not regularly share information to enhance eligibility and enrollment processes for Medicaid enrollees. As such, CMS should issue guidance to states encouraging collaboration and information sharing among state agencies and provide technical assistance to states that are unable to meet federal Medicaid requirements because of their use of integrated eligibility systems.



State Audits

State auditors create additional and unnecessary eligibility and enrollment audit work for states, which is particularly onerous to states during the public health emergency. As such, CMS should:

- Issue guidance, clarification, and/or education for state auditors regarding what is required of states with respect to Medicaid eligibility and enrollment.
- Release an Office of Inspector General (OIG) circular that articulates state auditor parameters on eligibility and enrollment audits.
- Issue guidance that state auditors should “hold harmless” state Medicaid agencies on audits and oversight penalties as states work to address PHE-related backlogs.

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?

Outreach as Part of Redetermination Processes

Most states do not have a formal outreach process via telephone, email or online account when it receives returned mail from a current enrollee or when an individual does not respond to a request for information. Rather, states usually send a follow-up paper notice that often times goes unanswered. To ensure states are taking meaningful steps to conduct outreach when paper processes are not effective, CMS should:

- Clarify that states: (1) are required to make at least two outreach attempts in a modality that is not paper when the state receives returned mail or does not get a response to a request for information; (2) may update enrollee contact information based on information provided by their contracted Medicaid managed care plans.
- CMS could also develop new policy on returned mail; current standards are loose and states do not actively follow up. CMS could require that individuals cannot be terminated unless the state first conducts a review of available residency data sources and conducts at least one follow-up via an alternative modality (e.g., telephone or email) requesting updated contact information.



- CMS could identify additional federal data sources that would be incorporated into the HUB for updating contact information including addresses. CMS could also provide technical assistance to states on how to access state data sources that may contain more recent address information such as from Immunization Information Systems, Health Information Exchanges and the Department of Motor Vehicles.

Children in the Juvenile Justice System At Risk of Disenrollment

Children in the juvenile justice system are particularly at risk of disenrollment, because states may not claim federal funds for benefits provided to incarcerated children and adults. However, most children spend less than 6 months in such settings. This means that unless states take proactive steps to ensure that children's benefits are only temporarily suspended and are active upon release, brief stays in carceral settings can lead to long-term disruptions in access to care.

The 2018 SUPPORT Act took an important step to protecting incarcerated youths' access to Medicaid by prohibiting states from terminating youths' Medicaid eligibility upon incarceration. Instead, states must now suspend eligibility or benefits for the period of incarceration and then to lift that suspension upon release. See Jennifer Lav, [New Omnibus Opioid Law Contains Medicaid Fix for Justice-Involved Children and Youth](#), *Nat'l Health Law Prog.* (Jan. 30, 2019). This allows for youth leaving the juvenile justice system to more quickly and seamlessly receive behavioral health care they need upon release, including counseling, case management, substance use disorder treatment, and other supports. In addition, the SUPPORT Act requires states to conduct a redetermination of eligibility before youth are released from custody *without* requiring them to submit a new application. Finally, the law mandates that states process applications from eligible youth who apply for Medicaid prior to their release.

We are concerned, however, that the promises of the SUPPORT Act have not been fully realized. In late 2020, a bipartisan group of Senators and Representatives noted that [the full implementation of these provisions has been delayed in states](#) across the country. CMS released guidance on implementation of this provision in January 2021, and additional technical assistance in March 2022, but state advocates continue to report circumstances where youth who are currently in juvenile justice settings face barriers to accessing Medicaid-funded alternative settings. Furthermore, public information is difficult to locate regarding state status of implementation of these reforms and youth rights to access care upon release or transfer to a hospital.



We suggest that CMS separately track, update, and share publicly information about implementation of the SUPPORT Act, including the methodology used by states to suspend either benefits or eligibility. We also recommend that CMS provide training and information—including state examples—of processes states have adopted to increase the rate of Medicaid enrollment of youth released from juvenile facilities.

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?

Integrated Eligibility and Enrollment Systems Within State Based Marketplaces

Eight State Based Marketplace (SBM) states have not integrated their Medicaid and CHIP into their Marketplace eligibility system which creates barriers with facilitating transitions of coverage across Insurance Affordability Programs. Even states that have “integrated” E&E systems do not have a seamless eligibility and enrollment consumer experience in all cases. As such, CMS should issue guidance to state based marketplace regarding expectations for ensuring smooth transfers across Medicaid and Marketplace that includes, but is not limited to, requirements that:

- Individuals may not be required to provide additional information/take additional steps for their eligibility determination; ensure visibility into the reason for the eligibility determination (e.g., whether an individual was procedurally denied for Medicaid);
- Account transfer information shall include all available contact information; and
- SBMs pre-populate Advance Premium Tax Credit applications based on available information.

Strengthening the Federally Facilitated Marketplace

CMS should continue its work to assure that account transfers between Medicaid and the FFM work smoothly and that accounts contain all information needed to make an eligibility



determination without requesting additional information from the applicant. CMS should also provide robust monitoring and reporting data on Healthcare.gov inbound account transfers from states, including: take-up/QHP enrollment by income level; number and percentage of consumers who never applied through the FFM; number and percentage of consumers who applied and were determined ineligible for APTC coverage; denial reasons; number and percentage of consumers referred back to state Medicaid agencies for determination, number and percentage of consumers who “loop” between the FFM and Medicaid.

CMS should work with states to innovate and enhance the consumer planning shopping experience for individuals transitioning from Medicaid to the Federally Facilitated Marketplace. For example, CMS could issue guidance to states on the opportunities and necessary guardrails of leveraging enhanced direct enrollment technology to enable individuals to more seamlessly transition from Medicaid to QHP coverage. CMS could also issue improve the consumer experience by tailoring the shopping experience for individuals by offering QHPs with: the same provider networks that were in the consumer’s previously enrolled Medicaid plan; frequently used providers; and lowest deductibles/cost sharing obligations.

Increasing Affordability and Smoothing Transitions Across Insurance Affordability Programs

Based on lessons learned from the American Rescue Plan’s lower premiums, CMS should issue regulations that require issuers to offer standardized, zero deductible and low premium Qualified Health Plan options on both the Federally Facilitated Marketplace and State Based Marketplaces. As more states explore the option of the Basic Health Plan (BHP), CMS should share lessons learned and best practices from other BHP states and identify additional flexibilities that states can leverage to encourage more adoption. CMS should work in partnership with states to identify existing barriers to leveraging § 1332 Waivers and issue guidance on available flexibilities and solutions in order to maximize innovation.

CMS should recognize that even a seamless transition between insurance affordability programs or providers (e.g., Medicaid to Marketplace coverage, or transitions within Medicaid, especially between managed care plans or fee-for-service to managed care) can lead to disruptions in care. Continuity of care is especially important for persons with disabilities or chronic illness, for which access to services such as outpatient prescription drugs is crucial.

CMS should encourage states to extend flexibilities adopted in response to the COVID-19 pandemic. These include extending refills and eliminating quantity limits on the number of pills



Medicaid enrollees may obtain. States should prevent managed care plans from requiring burdensome prior authorization and other utilization controls that only serve as barriers for Medicaid enrollees seeking care.

CMS should also require states to provide transition planning for persons facing transitions in coverage and care, including for young adults who age out of EPSDT. States with managed care can require transition planning in their managed care contracts. However, both states and CMS should conduct compliance monitoring to ensure that Medicaid enrollees actually receive these services.

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?

Twelve years after enactment of the Affordable Care Act (ACA), in which Congress provided significant funding to states to upgrade legacy computer systems, many of the same problems exist as pre-ACA. As unwinding the Public Health Emergency (PHE) approaches, states are still using outdated or poorly functioning computer systems that result in significant numbers of enrollees losing coverage or making transitions to the Marketplaces. All states must take the time and spend the necessary resources to modernize their computer systems to ensure that they can meet the needs of enrollees.

For example, we have recently learned that account transfers have not improved since the early days of Marketplaces, and that many states will not be able to forward sufficient consumer information to Marketplaces so they can contact individuals who may be eligible for coverage if terminated from Medicaid. We urge CMS to hold states accountable for enhanced funding they received to upgrade eligibility systems and continue to work so that states can fully modernize their eligibility and enrollment systems. CMS should also use this opportunity to mandate standardized fields for certain activities, such as collecting demographic data as well as procedural codes (see our response to Objective 1, Question 3).

Currently, CMS does not require states to all use the same fields for race, ethnicity and other demographic data collection. This makes it impossible to accurately ascertain similarities and differences across states with regard to health disparities and health equity. We also strongly

recommend that CMS require all states to collect comprehensive SOGISC and disability status data.

CMS should also standardize demographic data codes/fields so that they can be meaningfully analyzed and used to identify any issues or problems that may need to be addressed. This should include codes for eligibility determinations so that CMS can audit states' activities, monitor eligibility and termination rates. Having these types of standardized codes would be exceptionally useful for unwinding the PHE so that CMS could more easily monitor states' redetermination activities and identify any potential problems.

Objective 3 of 5

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?**

CMS should set national minimum access to care standards

We strongly recommend that CMS set a national core set of access to care measures and metrics. Under federal law, CMS is charged with the responsibility of enforcing the Medicaid Act; and core access measures will allow it to do so. (To balance the need for a national standard and state flexibility, CMS could allow states to use their own standards for network adequacy as long as both the standards and review process are at least as stringent as the



established federal standards.) These measures should encompass managed care delivery systems, fee-for-service, as well as Medicaid waiver programs. While individual states could be responsible for collecting and analyzing state-level data to evaluate compliance with national standards set by CMS, we urge CMS to take a strong role in monitoring states' efforts and enforcing compliance if the data reveals access problems. National measures will help ensure that standards do not vary too widely from one state to another, and that oversight by CMS is not fragmented.

NHeLP has previously outlined [our recommendations](#) of specific access measures we encourage CMS to employ, and we again commend them to CMS. We recommend that CMS measure all metrics at the county or service area level so that it and the states can best monitor local access patterns and identify gaps.

- 2. It is often appropriate to apply different measures for different types of services. As described in more detail below, we believe that most measures of access should differentiate between service types. Even where the metric used is the same, we recommend disaggregating service types to allow CMS and states to identify areas where there are particular problems or gaps. If the state only collects information about the distance of all Medicaid providers compared to beneficiary's homes, for example, it will not be able to determine if there are particular gaps in coverage of primary care, or behavioral health, oras.**

We also recommend separately measuring adult and pediatric services in many categories. Since child beneficiaries generally need to see providers with pediatric expertise, disaggregation is necessary to measure any access differences between providers for adults and providers for children. Given states' obligations to ensure that child enrollees have access to a comprehensive range of services pursuant to EPSDT, CMS will better be able to monitor compliance if they measure pediatric specialists separate from those who only serve adults.

CMS should also consider separating measures for geriatric and disability specialization, as well as health conditions that may require more specialized providers (such as HIV). We discuss other considerations below.

Network adequacy monitoring and enforcement is key

We emphasize that setting rigorous standards for access must be paired with a robust plan for ongoing monitoring and enforcement. Experience from both federal and state programs has demonstrated that a [layered approach to network adequacy](#) – one that accounts for both



potential and realized measures of access, and that employs multiple strategies to monitor and enforce compliance with network standards – is the most effective way to ensure that people can actually get the right care in the right place at the right time. Moreover, all stakeholders benefit when the standards are clear and easy to measure. Specific standards are important so that beneficiaries and advocates know whether access problems they experience warrant a complaint.

CMS should also set standards for the provision of language services, cultural competency certification, auxiliary aids and services for people with disabilities, and the accessibility of services and facilities. Such standards are necessary to account for the capacity of providers to serve limited English proficient (LEP) individuals and persons with disabilities. While Title VI of the Civil Rights Act of 1964, § 504 of the Rehabilitation Act, and § 1557 of the Affordable Care Act apply to Medicaid programs and CHIPs, explicit standards will help ensure that states and participating providers provide effective language services for LEP individuals. CMS should adopt more explicit standards to ensure the provision of sign language interpreters as well as other auxiliary aids and services for people with communication needs.

At a minimum, CMS must emphasize that Medicaid and CHIPs have an obligation to identify the linguistic and communication needs of enrollees and provide free language assistance services and auxiliary aids and services at all points of contact. For example, California plans have a long standing requirement to provide enrollees with no-cost language assistance. See Cal. Code Regs., tit. 28 § 1300.67.04(c). NHeLP encourages CMS to adopt additional standards to ensure that LEP enrollees and enrollees with disabilities have meaningful access to care, by adopting stronger standards to ensure that enrollees have access to oral interpreting, sign language interpreting and auxiliary aids and services and by requiring plans to report on qualified bilingual providers and staff. CMS should explicitly require Medicaid and CHIPs to directly pay for interpreting services (both foreign language and sign language as needed) and auxiliary aids and services for their contracted providers and not bundle these costs into reimbursement rates which results in a failure to provide language and communication services because the actual costs are not reimbursed but rather amount to minimal amounts spread across all providers who may not need to provide these services. For example, if the costs of interpreters are directly paid, these costs will not be borne by any particular provider. If the costs are included in the regular reimbursement rate, every provider of that service – and not merely those who need to hire interpreters -- may get a minimal bump. But those providers who actually need to provide interpreters will pay the full cost of hiring them which can often cost more than the reimbursement for the actual out-patient service. This negative incentive leaves many LEP individuals without language services. A



[number of states](#) already provide direct reimbursement and CMS must take action to ensure more states do so.

Additionally, CMS should work with states and other stakeholders to encourage more integrated and comprehensive models of physical and behavioral health care in community-based settings. This should include co-located primary care and behavioral health practitioners, use of consulting psychiatrists to advise primary care practitioners on appropriate treatment, and use of peer support services. We urge CMS to begin collecting data about use of these approaches in Medicaid and CHIP programs, enabling the agency to develop future standards and payment models that encourage integrated treatment in community-based settings.

CMS must develop ways to monitor access to LTSS and HCBS

Measuring access to long-term services and supports (LTSS) and home and community based services (HCBS) is [different from measuring access to other clinical services and states are significantly “behind the curve”](#) when it comes to measuring access due to a dearth of metrics. The most frequently used access criteria such as time and distance standards are generally inappropriate to services provided in a fixed home, community, or institutional location. Additionally, LTSS and HCBS services have (1) a wider range of amount, duration, and scope variations (for example, home attendant services that may be prescribed for 7 hours per week, or 17 hours, or 27 hours, etc.) and (2) a wide range of unique conditions that may complicate providing services (such as travel time to an individual’s home or very particular skills needed for at-home care for a specific individual). Given these factors, access to care has been less reliable. To help ensure access to LTSS and HCBS, CMS should develop metrics to evaluate:

- if needed care is being prescribed. For example, in LTSS and HCBS, it is all too common to evaluate need based on available treatments, as opposed to prescribing treatments based on need. In this process, individuals are routinely pressured into accepting insufficient treatment plans.
- if provider capacity is sufficient. (The more typical network adequacy analysis).
- what proportion of prescribed hours is *actually* being filled. One of the most pervasive problems in LTSS and HCBS care is that many individuals only receive a fraction of the care they need even, though they *have* an approved prescription for the care (for example, they may receive only 20 of their 40 hours of prescribed home care), especially due to provider shortages.

- the number of providers identified during the planning process/provider change period who were actually willing to accept the beneficiary for all needed services.
 - how assessed “need” is being inappropriately influenced , for example, basing need on extraordinary supports from friends or family, or unreasonable expectations on service recipients themselves.

CMS should also develop methods to stratify metric data to identify how aggregated access data may mask serious access differences among the extremely diverse population relying on these services.

For LTSS and HCBS, employment issues greatly affect access to services. Providers often struggle to pay reasonable wages out of the rate received for the services. Wages are a driving force in the availability, skill, reliability, and longevity of workers. This is especially true when the services are for individuals who are more medically complex or have significant behaviors, and thus more skill is needed and longevity, such that the worker is familiar with the needs of the individual, is very important to access to services. For many individuals who use LTSS/HCBS, consistency and reliability of workers is critical to successful community living. Many people experience service disruption and access issues when there is a change in workers, or they have to change providers because the provider no longer has workers that will meet the needs of the individual. In addition to wages, other factors that could be measured would include gaps in service, both length of time and frequency, as well as frequency of provider changes. Possible measures of access related to direct care workers would include comparing units of service authorized to those used to measure, which should reflect access to providers and reliability of providers; average number of unique participating providers by types compared to those found in individual claims; the number of providers licensed to practice in a particular geographic area from year to year; and the ratio of unique recipients to the number of unique participating providers per county

Services provided by family members and other caregivers, both paid and unpaid, would also be relevant to questions of access, as would assessments of the care providers. For example, if a parent of an adult child is providing a significant number of hours, both paid and unpaid, this could indicate that the family cannot find a qualified provider for the services. In addition, an assessment of that parent’s well-being could show that providing the services is not ideal and is impacting the parent’s ability to otherwise support the individual and continue to provide services in the future. State’s should also be asked to measure how natural supports are factored into the evaluation of need for services, such as in budgeting and assessments, because reliance on natural supports put pressure using those supports as paid providers and



the availability of those individuals to step in for missing providers. State Medicaid programs could identify additional access issues by surveying LTSS/HCBS participants and their support systems as they would be able to identify with the most specificity the access issues and the perceived cause of such problems.

Ongoing training and development costs, as well as other factors that can affect provider availability such as overtime requirements and whether or not travel is reimbursed as part of the service, are also a factor considering access issues. Ongoing training and development of workers is important to quality of care and ensuring direct care workers have the tools they need to both provide good care and to continue in the profession. The costs associated with development of the workforce may also be exacerbated by high worker turnover and could be relevant, depending on how it is measured, to access to provider issues. It is not clear if these factors need to be measured, but availability of data could help in the analysis of access issues.

We appreciate that CMS has spent time over the last few years [investigating and promoting different ways to create payment structures](#) to deliver HCBS and LTSS to beneficiaries with complex care needs. Unfortunately, few states have implemented these policies. CMS should work more closely with states to ensure that their payment structures for these services are designed in a way that ensures that beneficiaries are able to actually receive the services they need, in all areas of the state, for beneficiaries with all levels of need.

Currently, states are performing [HCBS rate studies pursuant to ARPA](#), which may provide information to CMS about how such data could be measured and monitored in the future. CMS should particularly look at rate studies that measure, given the type of services and amounts of services authorized in a given state (include duration of services--like eight hour shifts, twenty-four hour care, etc.), what rate would it take to ensure those services are filled in all areas of the state for all levels of need.

CMS should ensure abortion access

As abortion access is rapidly decreasing, CMS should focus on leveraging its authority to ensure states fulfill their legal obligation to provide abortion coverage as required by the Hyde amendment, which limits the use of federal funds for abortion coverage to cases of rape, incest, and life endangerment. The Hyde amendment often functions as a [de facto ban](#) and disproportionately impacts Black, Indigenous, and all people of color; LGBTQ+ people; young people; immigrants; and people with disabilities. It deepens already dire intergenerational health inequities. Rectifying states' failure to adequately cover abortions



even in these limited cases is necessary to achieve the administration's public commitments to addressing racial, gender, and other health inequities.

Multiple reports, including one from a [2019 U.S. Government Accountability Office](#) (GAO), have documented numerous violations of federal legal requirements to cover abortions. These coverage violations generally fall into two categories: failure to cover abortion within the Hyde amendment's exceptions, and failure to cover medication abortion as required by federal law. For example, South Dakota has long refused to cover abortions in cases of rape or incest. In [Iowa](#), the Governor must sign off on every Medicaid-eligible abortion before the state will cover the service. As a result, the University of Iowa Hospitals and Clinics, the state's primary abortion provider, has stopped billing the state for Medicaid-eligible abortions.

The 2019 GAO report also documented significant failures to comply with the Medicaid Act's prescription drug coverage requirements, as it found that thirteen states and the District of Columbia do not cover Mifeprex (or its generic version, called mifepristone), which (in combination with misoprostol) is the only FDA-approved medication for medication abortions in the United States. While some of these states clarified their policies after this report, severe gaps still remain in ensuring Medicaid enrollees access to care. CMS should reiterate states' legal obligations to cover all abortions within the Hyde amendment exceptions including different service types (e.g., medication, procedural, and surgical) and delivery formats (in person; telehealth; mailing or delivery) required within Hyde Amendment exceptions.

Outside of states' failures to cover all abortions within Hyde exceptions, a myriad of social barriers impede or block Medicaid enrollees' access to abortion care, with significant consequences for financial and health outcomes. We are concerned that states may not be providing or adequately informing Medicaid enrollees of their rights to non-emergency medical transportation (NEMT) for covered abortions and other reproductive health, undermining the purpose of the Medicaid program to provide medical assistance. Without transportation-related services, many enrollees [have](#) no other way to get to health care appointments. Additionally, because of stigma related to abortion and the additional cost and risk associated with abortions later in pregnancy, enforcement of timeliness and confidentiality requirements is extremely important. CMS can alleviate some of these barriers by leveraging existing policy related to NEMT to ensure states with the optional NEMT benefit cover the full range of these services to the full extent required under federal law.



Behavioral health minimum access standards

For specialty behavioral health, any minimum standards developed related to access to services must be measured by more specific categories than simply “behavioral health.” Simply measuring access to “inpatient” and “outpatient” behavioral health care is insufficient. Instead, access to sub-specialty behavioral health services should be monitored separately.

As a starting point, it is important to disaggregate SUD providers and mental health providers, to avoid situations where a plan meets the defined access standard by only providing mental health but not SUD services, or vice versa. A mental health provider that does not provide support for SUD treatment does little to nothing for the individual with only SUD. Further, certain core services essential for individuals with high support needs to live in the community should be measured separately. These include Medication Assisted Treatment (MAT), Assertive Community Treatment (ACT), Supported Housing, Supported Employment, and [Mobile Response Services](#). This group of behavioral health services require separate minimum access standards and tracking for two reasons.

First, they are more akin to HCBS waiver services than traditional office-based outpatient services in how they operate, and therefore are not adequately measured via office or facility-focused measurements. However, these behavioral health services are rarely delivered via HCBS waivers, and therefore not subject to the same HCBS waiver monitoring and oversight that non-behavioral health HCBS services are subject to.

Second, many of these services are extremely time-sensitive. For example, mobile crisis access should be measured in a matter of minutes or hours, not days. Because delays in accessing these interventions can wholly defeat the effectiveness of the intervention itself, separate monitoring and measures are required.

CMS should end clinically inappropriate utilization management

Medical management techniques are insurer-imposed conditions under which a provider’s drug or service order can be covered. They include step-therapy – where a patient has to try one method and “fail” (which could include pregnancy or medical complications) before the insurer will authorize what may be a more expensive method – or prior authorization by the insurer. When medical management practices align with standards of care, they can improve efficiency without sacrificing quality of care or patient wellbeing. For example, if a patient complains of mild headaches, it may be reasonable for an insurance company to deny coverage of narcotic pain medication as a first-line treatment absent some showing of medical



necessity. But when medical management techniques ignore or override standards of care and are driven solely by insurers' desire to control costs, they can prevent or delay access to necessary treatments and services that are preferred or recommended for particular enrollees.

While federal regulations acknowledge that Medicaid MCOs may adopt methods and procedures to safeguard against unnecessary use of services, physicians may experience these procedures as administrative hurdles that conflict with providers' clinical judgment. The National Bureau of Economic Research found that the cost of haggling with insurers and lost revenue results in physicians losing seventeen percent of Medicaid revenue and some physicians refusing to accept Medicaid patients. See [Abe Dunn et al., *A Denial a Day Keeps the Doctor Away*, Nat'l Bureau Econ. Rsch. \(July 2021\)](#).

Many states have now created their own laws or policies to prevent insurers from using medical management techniques, including cost-sharing, prior authorization, prescription requirements, gender restrictions, or quantity limitations, for time-sensitive services such as contraception, abortion, and pre- and post-exposure prophylaxis. See [Evaluating the Impact of Prior Authorization Requirements for PrEP and PEP in California](#); [Insurance Coverage of Contraception](#); [DHCS APL 15-020](#). CMS could take actions to encourage states to eliminate medical management and prior authorization when it conflicts with the standard of care.

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?

In recent years, CMS has focused heavily on quantitative oversight. This information is certainly valuable, but it can be difficult to locate, requires expertise to use it, and often is describing a point in time that is over a year old. Moreover, CMS has not taken enforcement actions when the quantitative data repeatedly reveals deficiencies with the state program.

In the past, CMS oversight and enforcement included program/site reviews, audits, and similar qualitative investigative activities. See 42 C.F.R. § 440.32. For example, in the EPSDT context, CMS staff were assigned to and had state-based EPSDT program knowledge (and states were expected to have a designated EPSDT coordinator on staff). Enforcement activities included specific identification of improper practices and monitoring and corrective action plans to



address them. These activities are no longer occurring to any great extent; however, they are invaluable to children and child health advocates. Quantitative oversight cannot replace them.

We urge CMS to revisit the critical role of quantitative oversight. We are urging CMS to re-introduce some focus on what is not happening—on directly addressing weak points in EPSDT implementation (while organizations like CHCS, NASHP, Manatt provide the public with helpful information on best practices).

Network adequacy monitoring and oversight

We urge CMS to establish uniform methods for evaluating compliance with time and distance standards. Time and distance standards are a key measure of enrollees' potential access to care. After all, if a Medicaid program can only offer a beneficiary appointments with providers who are hundreds of miles away, it has not provided access to covered services. Ensuring that care is available within a reasonable distance from where beneficiaries are is crucial. CMS can easily track compliance with time and distance standards by having Medicaid programs submit address information for Medicaid enrolled providers and facilities, and beneficiaries. CMS can then use mapping software to determine whether Medicaid programs comply with these standards.

We also encourage CMS to work with states to develop standard approaches to monitoring appointment wait times. A standard that only evaluates the types and locations of providers may not be enough to ensure that beneficiaries have access to all covered Medicaid benefits, since in most states, providers are not obligated to provide all covered services that fall within the scope of practice of their provider license. Further, beneficiaries may not be able to access needed care due to providers' protected refusal rights. For example, if a Medicaid program provides geographic access to OB/GYNs who provide prenatal care, but it does not contract with any providers who provide counseling and prescriptions for family planning services in its service area, enrollees will not have adequate access to those services. Similarly, in many states, Medicaid enrolled providers may limit the number of Medicaid beneficiaries they accept in their practice as patients. The fact that a primary care provider is available a few blocks from a beneficiary's home is little comfort to that beneficiary if the primary care provider is not accepting new patients.

To appropriately monitor and enforce appointment wait time standards, CMS must employ direct testing. As the [Office of Inspector General has recognized](#), direct testing is an important and reliable way to measure network adequacy. Secret shopper surveys are useful because



they not only capture the wait time for appointments, but can also reveal inaccuracies and limitations in provider directories or listings.

Another direct testing option is to employ a standardized audit methodology that would allow Medicaid programs to audit providers to determine whether enrollees were able to schedule appointments within the required time elapsed standards. Rather than call providers to ask about the next available appointment, Medicaid programs would need to have a system to collect data about both when an individual requested an appointment and when the actual appointment was made. California has [currently employed this methodology](#) to track appointment wait times for Medicaid specialty mental health services.

Both survey and audit methodologies will capture data for a single point in time, which could be skewed by seasonal variations or other temporary factors. Thus, in the long run, we encourage the CMS to work with states, managed care plans, and providers to put into place data systems and mechanisms to track the date of an appointment request relative to the date for which the appointment is made, so that plans can audit the data on an ongoing basis to capture variations in seasonal availability, or calculate an average for the entire year. In addition, we encourage CMS to explore ways of tracking the sex, gender identity, race, ethnicity, sexual orientation, sex characteristics, disability status/specific disability, and primary language of those requesting appointments as a way to identify health disparities.

CMS should also develop methods of monitoring compliance with standards for the provision of language services and auxiliary aids and services for people with disabilities, cultural competency certification, and the accessibility of services and facilities. CMS should explicitly require Medicaid programs to pay for interpreting services (both foreign language and sign language as needed) and auxiliary aids and services for their contracted providers. (See our response to Objective 3 Question 1).

For states that use managed care delivery systems, we urge CMS to require contracted plans to arrange in their provider contracts to pay for these services directly, even in interactions between provider and patient, to ensure the availability of communication services and improve compliance by providers who often do not have the resources to evaluate or pay for competent communication services. Each Medicaid program should be required to set forth in detail its process for paying for and guaranteeing timely communication services, both for its own customer service functions and whenever necessary to facilitate communication between enrollees and providers. These communication policies should be made available to the public on each Medicaid program's website. CMS can monitor compliance by reviewing state



policies, including state policies for monitoring and enforcing compliance. In addition, either the survey or audit methodology for testing appointment wait times could incorporate a component to track wait times for LEP beneficiaries and people who request communication assistance, such as an interpreter, for their appointments.

We recommend that CMS adopt a standard accessibility tool to aid Medicaid programs in assessing the accessibility of their providers to enrollees with disabilities. California has used [such a tool](#) in its Medicaid managed care program for more than a decade, and has refined the tool through multiple iterations. We recommend this tool to CMS as a starting point for evaluating and reporting on the accessibility of Medicaid enrolled providers to beneficiaries with disabilities.

Requiring states to report provider ratios is a straightforward way to determine whether a Medicaid program contracts with a sufficient number of providers to meet the needs of beneficiaries. Ratios must account for the expected utilization of beneficiaries in the service area relative to: the specialization, experience, and expertise of participating providers; the extent to which providers are accepting new patients; and the scope of services provided by participating providers and facilities, including any limitations on service provision pursuant to religious or moral objections. CMS should require states to report on ratios for a range of provider types by specialty, and report separately for adults and pediatric services. Ratios should also account for meaningful participation, as researchers have consistently done when they study Medicaid payments and provider participation, for example defining a participating provider as one who sees a certain number of patients or submits a certain amount of claims per year.

As discussed in more detail below, CMS must require states to regularly report on provider payment rates, including rates paid to providers who participate in Medicaid managed care or other capitated arrangements. At minimum, this data will allow CMS to identify outliers among states for particular services, and begin to correlate payment rates with other access measures. Over time, this will allow CMS to track ways in which rate increases can address access gaps.

We also urge CMS to require states to report on the availability of direct support workforce for home health and home and community-based services; and produce useful metrics for monitoring; call-center metrics that reveal issues with beneficiary access and their resolution; beneficiaries able to access long-term services and supports in institutional settings; beneficiaries able to access home and community based services; length of delays in



accessing long term services and supports in community setting due to direct service worker shortages and/or lack of adequate training; trends in emergency room utilization relative to primary and mental health and substance abuse treatment care utilization; and acquisition costs compared to Medicaid payments for pharmaceuticals.

The quality standards adopted by CMS must be capable of demographic stratification and analysis in order to realize CMS' goal of advancing health equity. Measuring only the average performance of all groups on quality standards masks lack of improvement or even deterioration in how separate populations of Medicaid- and CHIP-eligible individuals access services, especially those populations that are historically underserved.

CMS acknowledges that it must collect information about applicants' and enrollees' race, ethnicity, sexual orientation, gender identity, sex characteristics, and disabilities to understand disparities in access. CMS should take this opportunity to standardize demographic data reporting across Medicaid and CHIP by requiring states to collect this information on their applications (See our answer to Objective 1 Question 3). Only then can CMS gain an accurate picture of performance on quality standards and set expectations that reflect a commitment to health equity.

Access standards for family planning services

The Medicaid Act sets standards for family planning services, including the legal right to receive family planning services from a Medicaid enrollee's provider of choice. Several states have successfully undertaken efforts to undermine those standards. On Feb. 24, 2022, Missouri Governor Mike Parson signed a supplemental budget bill that excludes abortion providers from the state's Medicaid program, and this exclusion went into effect on March 11, 2022. We strongly urge CMS to fulfill its duty to ensure health care access for people with low incomes — who are disproportionately Black and Latinx— and use standardized reporting and compliance plans immediately to enforce Medicaid's free choice of provider requirement. This action can guarantee people access to care in Missouri and other states undermining the freedom choice provision (e.g., Texas, Arkansas, Mississippi, Louisiana, and South Carolina), and send a strong signal that CMS will not tolerate similar actions by other states that are targeting Medicaid enrollees.

CMS should also require minimum set of demographic data that includes race, ethnicity, sex assigned at birth, sexual orientation, gender identity, primary language, disability status (See our answer to Objective 1 Question 3); require and provide states resources to ensure data can be stratified by these demographic identifiers. CMS should take corrective action where



states fail to report above a certain percent of this information.

- 3. How could CMS consider the concepts of whole person care^[5] 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?**

^[5] Under a “whole-person” philosophy, individuals with chronic physical and/or behavioral health conditions are provided linkages to long-term community care services and supports, social services, and family services, as needed. State Medicaid Director Letter #10-024. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd10024.pdf>

While CMS regularly engages with states, we recommend CMS set up formal mechanisms to actively engage with health advocates, including legal services providers, reproductive health and justice organizations, as well as national partners, to help identify issues occurring in states and hold state Medicaid and CHIP programs accountable for their obligations to enrollees. CMS should use every tool ranging from greater transparency, data reporting, and state compliance scorecards to civil monetary penalties and sanctions, to ensure that state Medicaid programs best serve the needs of enrollees.

Enhancing compliance with the Mental Health Parity and Addictions Equity Act

Medicaid is the [largest payer](#) of mental health services in the United States and plays a vital role in ensuring access to behavioral health services for Medicaid’s more than eighty million low-income enrollees. Current federal parity protections apply only to Medicaid Managed Care Organizations (MCOs), Medicaid Alternative Benefit Plans (ABPs) and the Children’s Health Insurance Program (CHIP), but not to fee-for-service Medicaid. To truly strengthen behavioral health coverage in Medicaid, federal parity protections should also extend to fee-for-service Medicaid. CMS should work with Congress to extend parity requirements.

Beyond this, however, much work remains to truly enforce the existing promises of the Mental Health Parity and Addictions Equity Act (MHPAEA) within Medicaid and CHIP. Despite significant efforts by both Congress and CMS, parity noncompliance within Medicaid and CHIP remains a problem. A 2021 [issue brief](#) by MACPAC indicated that the federal parity law has



not improved access to behavioral health coverage for people enrolled in Medicaid or CHIP. Enforcing behavioral health parity is a significant challenge. The current system of parity compliance relies almost entirely on consumer complaints, placing the burden on an individual seeking behavioral health services to be able to identify that their denial, increased costs, or additional administrative burdens are a parity violation, and then walk through a convoluted web of paperwork, appeals, and agency enforcement mechanisms. Additionally, analysis of parity complaints is [complex](#), requiring evaluation of both quantitative treatment limits (QTLs) (e.g., limits on the number of visits to a provider or the length of a specified treatment) and non-quantitative treatment limits (NQTLs) (e.g., medical necessity criteria used to deny treatments or prescription drug formulary designs). Often, this analysis cannot be completed because of [a lack of disclosure from the plans](#) of the information necessary to identify parity issues. Even if plans disclose some level of information, the findings in the *Wit v. United Behavioral Health* decision show [how ingrained](#) some of the unlawful limits to behavioral health care may be, as well as the difficulty of appealing denials of care deemed necessary by treating clinicians. While some progress has been made in identifying and eliminating quantitative treatment limits, addressing NQTLs has remained [challenging as has the existence of treatment exclusions](#).

To improve parity compliance, CMS must take a more proactive role in enforcing MHPAEA. Under current regulations, parity analysis is left primarily to states or MCOs (42 C.F.R. § 438.920). In particular, we remain concerned about MCO's willingness to perform a comprehensive analysis of NQTLs, and even less confidence that plans will disclose the type of information truly necessary to perform this comparison or that they will disclose the information at a level that allows identification of parity violations.. Plans have every disincentive to identify parity violations, as such violations allow them to deny care and save costs. States also need support and guidance from federal enforcement agencies to be able to conduct thorough parity analysis. CMS should mandate disclosure and transparency requirements for all health plans that enables ready analysis. In addition, we ask that CMS require states to demonstrate compliance with EPSDT through a valid analysis rather than simply attesting to EPSDT compliance for parity purposes. [Numerous court cases](#) have found states in violation of the basic EPSDT requirements of informing, screening, and providing and arranging for behavioral health treatment a child needs. Finally, we suggest that any regulations issued going forward explicitly affirm that parity protections can be privately enforced by Medicaid and CHIP beneficiaries.

Additionally, as we noted above, our parity enforcement system remains largely complaint driven, with the onus placed on individuals to file appropriate appeals and complaints, and



there is no clear way to file a complaint for Medicaid or CHIP. Navigating this patchwork system of enforcement is confusing and overwhelming. To improve this, CMS should coordinate with other parity enforcement agencies to create a centralized, easily accessible, public complaint process. (See, e.g., the centralized [complaint portal](#) implemented under the No Surprises Act). Further enforcement agencies should work together to produce easy-to-understand educational materials for the general public. These materials should include clear examples of what parity violations look like and should be part of an ongoing outreach campaign to provide up-to-date support, information, and resources on behavioral health parity.

Advancing maternal health equity

The CMS Innovation Center (CMMI) can support states in promoting maternal health equity by designing, selecting, and scaling payment and service delivery models to address related issues. For example, CMMI should work with advocates, doulas, doula collectives, and doula groups, particularly Black individuals and Black-led groups, to test Medicaid global payment, bundled payment, and salary based models for antepartum, birth, and postpartum doula services, particularly community-based doula services. Doulas, and particularly community-based doulas, can provide individually tailored and person-centered social, emotional, and physical support and information for people before, during, and after labor and birth. Extensive research demonstrates how prenatal, birth, and postpartum doula care can improve maternal and child health outcomes, such as fewer cesarean births, fewer low birthweight babies, and higher rates of breastfeeding initiation. Having the support of a doula can help pregnant and birthing people of color [mitigate the impacts of racism and white supremacy](#) in the health care system. Doula support during the perinatal period can also provide support to help pregnant and birthing people access the care they need to address chronic conditions, behavioral health, substance use disorder, and other health needs.

Current efforts focused on expanding access to doula care for Medicaid enrollees have illuminated a number of common challenges across states. For example, states have struggled to find effective billing and payment strategies that balance state administrative needs while not overburdening individual doulas who seek to become Medicaid providers. States have also tried various approaches to the requirements doulas must meet in order to be eligible for Medicaid reimbursement. CMS should encourage states to take a broader and more flexible approach to billing/payment and credentialing requirements, so as to not create additional barriers for those seeking to join the doula Medicaid workforce. CMS should also provide support for states and state Medicaid Agencies to help ensure a sustainable wage for the



doulas providing care to Medicaid enrollees, as low reimbursement rate has been a key reason why some of the [earlier doula Medicaid programs](#) in the country have faltered. More broadly, CMS can provide greater guidance to states, particularly in lifting up best practices and those approaches that best achieve the goals of equity, inclusion, and sustainability in the design of doula Medicaid programs.

When selecting models for testing, CMMI should consider a set of additional factors beyond what is listed at 42 U.S.C. § 1315a(b)(2)(C). The following additional factors are specifically focused on promoting health equity include whether the model:

- includes or requires that awardees develop a regular process for ensuring culturally and linguistically appropriate services;
- will deliver services that are tailored to community health and health-related social needs and provided by community-based and –led providers (e.g., community-based doulas);
- is designed to mitigate harmful effects of racism, particularly anti-blackness, and other forms of discrimination;
- was designed by or with significant input from the populations the model aims to serve;
- includes a regular process for collecting comprehensive demographic data collection of patients and providers including race, ethnicity, language, disability status, sex characteristics, sexual orientation and gender identity; or
- requires States and other entities participating in the testing of models to develop nondiscrimination plans that identify how they will prevent discrimination on the basis of race, ethnicity, language, disability, age, sex, sexual orientation, gender identity, and sex characteristics.

CMMI should also consider these factors when selecting model participants.

4. In addition to existing legal obligations, how should CMS address cultural competency and language preferences in establishing minimum access standards? What activities have states and other stakeholders found the most meaningful in identifying cultural and language gaps among providers that might impact access to care?

We believe the federal government has an obligation to ensure accessible and meaningful engagement with underserved communities. This should not stop with agency engagement but also agencies should require it of their grantees and contractors.



We recommend that CMS add specific requirements regarding communication with and accessibility for people with disabilities to all contracts with state agencies and all grant agreements to ensure the agencies also undertake these actions themselves. We believe an entity should plan for the communication and access needs of underserved communities, including people with limited English proficiency (LEP) and people with disabilities. This can be accomplished through requiring an “access plan”.

As an example, HHS has long recognized the benefit of creating a language access plan. [HHS’ 2003 LEP Guidance](#) included elements of an effective language access plan. And as noted in 2016 § 1557 NPRM’s preamble, many organizations already develop such plans based on the model described in HHS LEP Guidance. Doing so ensures that covered entities understand the scope of the populations they serve, the prevalence of specific language groups in their service areas, the likelihood of those language groups coming in contact with or eligible to be served by the program, activity or service, the nature and importance of the communications provided and the cost and resources available. Depending on an entity’s size and scope, advance planning need not be exhaustive but is used to balance meaningful access with the obligations on the entity. The size and scope of the plan may vary depending on whether the covered entity is a small provider or a larger entity. OMH has also developed a [reference guide](#) for developing language access plans. Further, CMS can better monitor compliance of entities that have a language access plan (or develop one in response to a complaint).

Our experience shows that entities are in a better position to meet their obligations to provide language assistance services in a timely manner when those entities identify, in advance, the types and levels of services available in each of the contexts in which the covered entity encounters individuals who are LEP. It is important to emphasize that such a plan should not be limited to servicing LEP populations but also people with disabilities.

CMS should, however, go beyond recommending a language access plan by recommending state agencies, grantees and contractors develop a broader “access plan.” This should include, for example, how the entity will provide foreign language interpreters, translated materials, sign language interpreters, large print/Braille documents or audio/video formats of materials, auxiliary aids and services for effective communication, and a range of other communication assistance. An access plan will help agencies, grantees and contractors be better prepared to meet the needs of LEP and individuals with disabilities by planning how to provide communication assistance and ensure accessibility. As one example, HHS has developed a checklist “[Ensuring Language Access and Effective Communication During](#)



[Response and Recovery: A Checklist for Emergency Responders](#) and many of the issues included would be relevant for a broader access plan for covered entities.

In addition to communication issues, state agencies, grantees and contractors should plan to ensure accessibility for individuals with physical and/or behavioral health disabilities. This should include compliance with the [Medical Diagnostic Equipment Accessibility Standards](#) that were finalized by the Access Board in 2016. There are still too many physical locations that are inaccessible for many people with disabilities.

Further, grantees and contractors should designate an office or “point person” whose contact information is readily available on websites and in materials to provide assistance to individuals who are LEP and/or have disabilities.

Budgets

Another way to evaluate whether state agencies, grantees and contractors are adequately prepared to ensure effective communication with individuals with LEP or people with disabilities that impact their communication is to ensure funding for these purposes. Agencies should be required to delineate specific funding in their budgets to ensure language access for LEP individuals, TTD/TTY and other communication mechanisms for deaf and hard of hearing individuals, and other communication assistance needed by people with disabilities. Along with access plans, analyzing budgets to ensure inclusion of the funding essential to provide language access should be a step in CMS’s review of agencies’ reimbursement reports as well as a requirement for agencies to undertake in reviewing budgets of grantees and contractors.

We also would recommend CMS to encourage more states to directly pay the costs of language services and require states to ensure that MCOs pay for the costs of language services for their network providers. Only approximately fifteen states pay directly for the costs of language services. While states may say they consider the costs of language services when setting reimbursement rates, the reality is that if language services are not separately paid for – in addition to the reimbursement rate for the service – the cost is a barrier and many providers still fail to provide competent language services. Further, bundling the costs of language services in with the total reimbursement means that providers who may see a large number of LEP patients – either because of location, access, or other reasons – bear a higher financial cost as compared to providers who do not see many LEP patients. Targeting the reimbursement at the actual costs rather than spreading out the costs to all providers would likely assist in ensuring effective communication.



Further, many MCOs fail to pay for language services needed in their network providers' settings, shifting the cost and responsibility of paying for language services directly onto the network providers. States should require that managed care plans pay for the services as part of the capitated rate, both to ensure compliance with federal civil rights laws and relieve the providers of the costs of doing so.

While federal and some state laws require language access, the costs of actually providing such services remain a significant barrier to ensuring compliance with these laws.

Notice and Comment Processes

To ensure that all individuals can participate in public notice-and-comment processes, CMS should adopt requirements that all agencies undertake comprehensive outreach activities during state comment processes (*e.g.*, for Medicaid § 1115 waivers) and accept comments in any language. When states are required to hold hearings or publish notices about their activities, these hearings and notices should also be accessible to LEP. Participatory democracy is a foundational element of our country. Everyone should be afforded an equal opportunity to participate, regardless of the language they speak. CMS should ensure that everyone can provide comments and have input into the policymaking done by Medicaid and CHIP agencies as well as the federal government.

CMS should require, for each state notice-and-comment period, a designated state agency contact for individuals who are LEP or have disabilities in case they need assistance in determining how to respond and participating in the public comment process. Notices should be published in multiple languages with clear information about how to request language services at public meetings and/or translated materials. CMS should also do the same for its own rulemaking.

Government Forms

One way to engage underserved communities is to provide accessible information. When a state agency or contractor develops materials or forms that will be used by consumers – for example, applications, educational materials, outreach materials – the agency/contractor should have a standardized process by which information is made available in low literacy formats, alternative languages and formats. As but one example, this RFI was only available in English and the format on the website would make it difficult to navigate for those with low health literacy. CMS materials on unwinding the Public Health Emergency (PHE) have generally only been available in English and sometimes Spanish.



CMS should adopt specific standards for when states must translate consumer-facing materials such as applications, notices, outreach materials, etc. into multiple languages. These standards should include not only the number of languages but also the timeframe within which new materials are translated. For example, we would recommend that any consumer-facing material developed by the agency would have to be translated within fourteen business days of the release of the English version. And to have clearly identified mechanisms for ensuring that LEP and PWD have meaningful access. Requiring each Medicaid/CHIP agency to have a language access plan – and update that plan at least once a year – would help with this process.

CMS should develop a roadmap, checklist or technical guidance that all state Medicaid/CHIP agencies should follow. The first part should address readability. CMS should adopt requirements that consumer-facing materials be produced at a low literacy level such that the vast majority of individuals can access and understand them. If an agency can justify the need for a higher literacy level, there should be an approval process for an exemption for low literacy requirements and the agency should then be required to produce a summary or alternative format for individuals with low literacy.

Secondly, CMS should require the automatic translation of all materials or forms used by consumers into the top fifteen non-English languages as well as large print and Braille within fourteen business days of agency release or approval of a form. Far too often, forms, applications, and informational materials are only available in English and perhaps one or two additional languages. Economies of scale make it much more efficient and cost-effective if the federal government engages in translation on a routine basis. Making translation routine and required will ensure a better ability to engage underserved populations.

Translation Glossaries

With eight percent of the U.S. population identified as LEP, it is critical that the federal government ensure effective communication to ensure community engagement. Access to standardized definitions of the new terms that will be critical to ensuring all eligible individuals enroll in the program that is right for them. CMS can assist by creating (or requiring affected agencies to create) translation “glossaries” for standardizing the terminology used when developing materials in non-English languages. These glossaries, which should be available in multiple languages, will ensure consistency throughout an LEP individual’s interactions with varying entities/agencies.



Since translation costs are often based on the number of words needing translation, creating translation glossaries also saves money by preventing translators from having to continually translate the same terms. As examples of translation glossaries, the [IRS](#) has translation glossaries for tax words and phrases in multiple languages.

In addition to the cost-savings, having standardized translations will result in consistent use of terminology which will assist LEP individuals and those assisting them to effectively communicate and engage with federal agencies, grantees and contractors. For example, an LEP individual may apply to the Medicaid agency for health insurance, receive assistance from a community based organization with that application, get mail from a Medicaid managed care organization (MCO) upon enrollment, and interact with many different health care providers. Having consistent terminology will ease understanding since the same term will have the same translation across all points of contact. Otherwise, a state agency may use one translation of a term while a MCO uses another translation and a hospital yet a third.

According to the Robert Wood Johnson Foundation's Hablamos Juntos project:

The absence of a standardized vocabulary for translating in the health care industry adds greatly to the inconsistency and inaccuracy often seen in translations. To avoid these and related difficulties, each organization should ideally create its own:

- Standardized glossary of commonly used words, standard phrases and descriptions used in various health care texts.
- Conventions and guides for translating. . . name(s), business titles, proper names, frequently used acronyms and abbreviations, etc.
- Conventions and practices for translating medical terms and health care nomenclature (e.g., “managed care”, “health care provider”) in easy-to-read translations for readers with varying literacy and familiarity with health care environments. For example, an adopted standard might say that English terms will be used once, defined and given a common replacement in the target language. Then the replacement term will be used throughout. See Hablamos Juntos, a project of the Robert Wood Johnson Foundation, *Tool 1: Getting Started with Translations in Health Care*, available at <https://www.yumpu.com/en/document/view/36969694/getting-started-with-translations-in-health-care-hablamos-juntos>.



Creating translation glossaries will benefit all entities engaged in enrollment, outreach and education. The steps needed to create translation glossaries will include the following:

- Identify needed terms with no equivalents;
- Create the equivalent terms; and
- Disseminate the terms (in formats easily usable by other entities).

In identifying programs or activities for which translation glossaries would be required, CMS should certainly require them as new activities begin. For example, translation glossaries would have been useful during the early months of COVID.

Further, CMS should work with competent translators and linguists to ensure that the translated terms are correct, have equivalent (or near-equivalent) meaning, and are understandable if a language has multiple variations (e.g., Spanish from Mexico versus Guatemala versus Spain). These terms should be field-tested. In some cases, it may be most useful to keep the original term and provide a translation of the explanation in the target language. For example, proper names may not need translation but an explanation.

We recommend that CMS develop translation glossaries in multiple languages in a timely manner and in a format accessible to all the potential users. This will ensure the benefits accrue before many of these entities have to embark on their own translation projects, increasing costs and decreasing standardization.

Detailed Implementation “How-To” Guides

While we are hopeful that most Medicaid/CHIP agencies and Medicaid providers know about their obligations under federal civil rights laws, including Title VI of the Civil Rights Act of 1964 and § 1557 of the Affordable Care Act, we know that the actual mechanics of providing language services are elusive for many of them. For example, we filed [a complaint](#) with the HHS Office for Civil Rights outlining significant problems with state websites created during the pandemic. Similar issues arise with Medicaid and CHIP websites.

CMS should work to create detailed guides that apply to its programs and activities that would supplement agency-wide regulations and guidance. For example, when must language services be provided in nursing homes or in conjunction with the provision of home and community based services? How can a state ensure that its offices are accessible to LEP and people with disabilities (PWD)? How can a state ensure that its integrated voice prompt



systems do not deter LEP individuals from getting assistance when the prompts are only provided in English and perhaps one other language? We believe that providing more specific information about particular services and settings would increase understanding of **how** to provide language services beyond the legal requirements.

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?

As noted in our response to Objective 5, Question 3, for home and community based services (HCBS), including community-based behavioral health services, there is a workforce crisis that is directly related to insufficient rates, leading to *de facto* denials of services. People approved to receive HCBS often struggle to find staff to support them, because low Medicaid rates lead to [systemic staffing shortages, high turnover rates, and inadequate training](#). The essential workers who provide HCBS services—primarily women and people of color—are [among the lowest paid health care workers in the United States](#), which perpetuates more racial and economic injustices.

While Medicaid requires states to ensure that payments are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population, there is often no identifiable comparison in Medicare or private insurance for these services. Access standards for HCBS are underdeveloped.

To address inadequate rates, we recommend that CMS amend the equal access rule to expressly include HCBS waivers and managed care. Specifically, CMS' distinction between state plan services and services provided via HCBS waivers makes little sense as a matter of statutory interpretation, and it is bad policy. Nothing in 42 U.S.C. § 1396a (a)(30)(A) restricts its application to a narrow set of “state plan services.”

While states are required to report on their rate methodology when they request a new HCBS waiver, CMS could add additional safeguards to ensure that this analysis of rates will meet the needs of participants. This look-behind could include any number of factors that would inform the sufficiency of rates, including an analysis of individuals who had hours of waiver services



approved but unstaffed or understaffed, a requirement that states analyze direct service provider turnover and capacity, and that states explain if their rates are adjusted for inflation, and if not, how that impacts availability of services. We also recommend including additional factors to ensure that rates are sufficient to meet the needs of people who may need staff with special training or skills, such as the ability to use assistive technology; ASL or other language skills; the training and skills to handle complex behavior needs without abuse, neglect, or over medication; and other needed cultural competency skills. If such needs are not part of the rate planning, people with complex needs will continue to be denied care or have limited access and disparities in access to HCBS will worsen.

We additionally recommend that CMS [reiterate training](#) and guidance, and [continue to lift up](#) helpful strategies regarding rate sufficiency and methodology for HCBS. One example of this includes incorporating transportation (including gas and mileage) into the rate paid for providers, or including personal care aides' travel costs between individuals' homes. This approach can help increase rate-sufficiency and the supply of providers in rural areas, where the time and distance providers have to travel can create barriers to services. Other examples include moving away from a straight fee schedule for all services in one category, and instead using tiered rates based on acuity or other factors to account for individuals who have more intense needs or face other barriers to obtaining services. States can also use geographic variation to ensure that services are equally available across the state, or make supplemental or enhanced payments to providers to help workforce retention or other quality initiatives for specific services. While many states already utilize some combination of these tools, to a varying extent, additional guidance and technical assistance from CMS could help advocates understand how they can engage to urge states to use all the tools at their disposal to help ensure that those who need HCBS are actually able to receive it.

We also encourage CMS to address how states use individualized budgeting and the impact on access to services, including rates. Budgeting is often used by states and MCOs as a hard and fast limit on services, despite these budgets often being based on [assessment tools that are difficult to understand, secretive, and often based on biased data or assumptions](#). These budgets are also typically based on complex statistical aggregations of population data. They include significant outliers, but often exceptions are either not available, difficult to get, not appealable, or all of the above. Person-centered planning with such budgets becomes an exercise in how to make a person's needs fit what is available rather than how they may receive what they need according to their personal preferences, unless there is [clear guidance](#) otherwise and even then budget tools can limit access to what people need. The impact of assessments and budgets has been the subject of litigation and complaints throughout the



country, often involving claims related to their impact on HCBS recipients' community integration or risk of institutionalization. Low assessed budgets frequently limit a person's ability to pay adequate rates to pay for services, such as in the *Waskul*, 979 F.3d 426 (6th Cir. 2020) or *Belancio*, No. 17-CV-1180-EFM, 2018 WL 2538451 (D. Kan. Sept. 21, 2018) cases. There should be clear guidance setting standards and expectations for the use of budgetary tools that protects the right of HCBS participants to access the services they need as well as increased transparency, look behind methods, and accountability for when such tools are used.

CMS should also address self-directed services.. As mentioned above, a budgeting process can significantly impact the rates available to pay providers, such as in the *Waskul* case where a change in the budgeting process meant that the plaintiffs in Michigan no longer had sufficient funds to meet their service goals or pay the necessary providers. There are also access issues around the function of fiscal management agencies. These entities are responsible for helping people in self-direction programs handle employee payment and other important functions. But these agencies are often causing problems for people through slow payment, administrative burdens in hiring employees, and other issues that limit payment to and processing of employees. Such problems directly influence access to care and there are often very few mechanisms that HCBS participants using self-direction can use to correct such malfunctions. There is usually limited or no choice in fiscal management agencies and states often provide very little, if any, problem solving assistance. Because self-direction itself can improve or resolve some access to care barriers, any guidance on access to HCBS should promote self-directed services and at least consider any potential harm on self-directed HCBS.

Further, encouraging states to continue some of the initiatives they have undertaken during the public health emergency (PHE) beyond the end of the PHE could help expand the pool of providers. For example, during the PHE states have permitted qualified providers from other states; allowed family caregivers to become paid caregivers while still ensuring participant choice of providers; increased payment rates for direct care workers; expanded coverage of telehealth in terms of services, providers, and modalities. All of these strategies present a fairly low risk to participants, and can generally improve the direct care workforce stability and improve access to services. CMS could provide additional public-facing guidance related to this opportunity,

While actively encouraging states to retain certain measures post-PHE, and share publicly their plans for doing so.



Diversifying doula workforce

To increase and diversify the doula workforce, CMS must encourage states to find a balance between ensuring that doulas are sufficiently trained to serve Medicaid enrollees, while also ensuring the barriers to access are not too high for the potential doula workforce. Any training requirements should be flexible and not necessarily tied to specific certification at specific certifying doula organizations. Alternative methods for meeting the training requirements must also be allowed, such as legacy pathways for experienced doulas who have been practicing for some time but may not have specific proof of the training, certification, apprenticeship, or other program they underwent many years prior.

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?**

We strongly recommend that CMS set a national core set of access to care measures and metrics. These measures should encompass managed care delivery systems, fee-for-service, as well as Medicaid waiver programs. Currently, Medicaid has one set of access rules (network adequacy) for Medicaid managed care, see 42 C.F.R. § 438.68, and a separate set of rules for fee-for-services Medicaid, see 42 C.F.R. §§ 200-205. Access to services provided



through waivers, which include many LTSS and HCBS, may be measured and monitored in yet other ways. Thus, we urge CMS to look at the Medicaid program as a whole and apply a uniform national approach throughout the program, regardless of delivery system. While individual states could be responsible for collecting and analyzing state-level data to evaluate compliance with national standards set by CMS, we urge CMS to take a strong role in monitoring states' efforts and enforcing compliance if the data reveals access problems. National measures are needed to ensure that standards do not vary too widely from one state to another, and that oversight by CMS is not fragmented. We recommend that CMS measure all metrics at the county or service area level so that it and the states can best monitor local access patterns and identify gaps at the local level.

It is often appropriate to apply different measures for different types of services. As described in more detail below, we believe that most measures of access should differentiate between service types. Even where the metric used is the same, we recommend disaggregating service types to allow CMS and states to identify areas where there are particular problems or gaps. If the state only collects information about the distance of all Medicaid providers compared to beneficiary's homes, for example, it will not be able to determine if there are particular gaps in coverage of primary care, or behavioral health, or in other areas. Again, we commend the [list of measures we have previously shared with CMS](#).

The federal government has the unique ability to standardize demographic data collection across all Medicaid and CHIP programs—and should not wait any longer to do so (see our answer to Objective 1 Question 3). Demographic data collection is broadly supported by stakeholder groups, insurance associations, insurance plans, and the public. For example, in its [comments](#) on the 2023 Medicare MA and PDP Model Enrollment form, Anthem, Inc. encouraged CMS to go further in standardizing demographic data collection for all Medicare programs and include questions that capture Sexual Orientation, Gender Identity, and Sex Characteristics (SOGISC) data. A recent [MACPAC report](#) also found that inconsistent reporting of demographic information can be attributed to the lack of standardized categories of reporting. These groups recognize that standardized demographic data collection is necessary to monitor access to care as well as plan for better quality of care for various populations.

To ensure data quality, CMS should explore and adopt additional levels of demographic data reporting where feasible. CMS already allows states to report race and ethnicity data to T-MSIS through claims data and enrollment in additional services like HCBS. Collecting data at multiple points improves data quality because it allows for better validation of the data at



multiple levels. We encourage CMS to adopt this practice for validation of SOGISC, primary language, and disability data as well.

CMS must provide financial and technical resources to states to ensure the success of demographic data collection requirements. States must be able to implement, and where already implemented, improve demographic data collection. A recent NCQA-Grantmakers in Health [report](#) on data quality recommends that the federal government provide resources in the form of ensuring interoperability of local, state, and private systems, data systems enhancement, and reporting capacity. CMS must develop materials for states to provide training to frontline staff on data collection, including how to talk to stakeholders about demographic data collection, ensure privacy protections are appropriately explained, and engage stakeholder feedback in demographic data collection. It may be helpful for CMS to issue new guidance on privacy protections in demographic data collection activities to help clarify the appropriate uses and safekeeping of demographic data. CMS support must also include financial resources for staff time to engage in demographic data collection activities.

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.)?

We strongly recommend that CMS set a national core set of access to care measures and metrics, as explained more fully in our answer to question 1 above.

We also emphasize that access must be measured and monitored [not only in terms of potential, but also realized access](#). In Medicaid, salient indicators of potential access include: provider participation and provider location. Any measures of provider participation must account for the expected utilization of beneficiaries in the service area relative to: the specialization, experience, and expertise of participating providers; the extent to which providers are accepting new patients; and the scope of services provided by participating providers and facilities, including any limitations on service provision pursuant to religious or moral objections. Measures should also account for meaningful participation, as researchers have consistently done when they study Medicaid payments and provider participation, for example defining a participating provider as one who sees a certain number of patients or



submits a certain amount of claims per year. Measures of provider location must account for the expected utilization of beneficiaries in the service area relative to: the distance of participating providers and facilities from beneficiaries' homes and workplaces; the means of transportation used by beneficiaries relative to provider sites (*i.e.*, if most beneficiaries rely on public transit, are participating providers proximate to major transit lines); and the extent of transportation assistance offered by the state.

Salient measures of realized access include: the time it takes to schedule an appointment; the amount of time beneficiary's spend waiting to see a provider after the time of a scheduled appointment; the amount, duration, and scope of services received versus prescribed; the number of referrals received versus those made; and the proportion of Medicaid beneficiaries, including children, who receive recommended screenings and immunizations.

We emphasize that measures of realized access are particularly important since too often, measures of potential access are not sufficiently nuanced to ensure that enrollees have access to all covered benefits. Measures that only count the numbers and locations of providers, for example, fail to account for whether providers are obligated to provide all covered services that fall within the scope of practice of their provider license. Enrollees may not be able to access needed care due to providers' unwillingness or protected refusal rights to provide a covered service. For example, if a state provides geographic access to OB/GYNs who provide prenatal care, but it does not contract with any providers who provide counseling and prescriptions for family planning services in its service area, enrollees will not have adequate access to those services. Similarly, measures of potential access frequently do not account for the sub-specialization, particular expertise, or scope-of-practice of providers. For the parent of a child Medicaid beneficiary with leukemia, knowing that the state has contracts with many oncologists is little help if the state cannot provide her child access to a pediatric oncologist with experience treating childhood leukemia.

Care availability in Medicaid managed care

The 2016 Managed Care rule update created a new mandatory External Quality Review (EQR) activity to validate network adequacy, and the preamble to that rule suggested that CMS was looking at increasing direct testing of provider networks. The protocol laying out how states should conduct this new required activity has not yet been released, but evidence collected in the intervening years has continued to accumulate reinforcing the importance of actively auditing MCO's assurances about their provider networks and directories.



In 2014, HHS Office of the Inspector General conducted direct testing of Medicaid plans and found over half the provider directory entries were incorrect or not available for appointments. Since then, a number of states have also found that direct testing of networks and provider directories through mechanisms like secret shopper surveys helps identify consumer access barriers. States including Texas, Maryland, Missouri, New Hampshire, and Ohio have conducted surveys that revealed massive error rates in provider directories and documented long wait times to obtain a scheduled appointment. Maryland's [extensive survey of on-line and paper provider directories](#) led to nine corrective action plans for MCOs in 2019. Texas' [EQRO study](#), which only successfully contacted fifty-two percent of providers in 2018, includes a list of best practices for more accurate provider directories.

Ohio's EQRO compared secret shopper against revealed caller surveys. When the caller identified themselves as an evaluator, 81.7% of primary care providers reported appointment wait times under thirty days for new patient well-check visits. Ohio's [secret shopper survey](#), using the same sampling, found only 69.5% of PCPs reported wait times under thirty days. This discrepancy shows the value of anonymous direct testing for accurately identifying access barriers. New Hampshire has worked with its EQRO to conduct both [secret shopper](#) and revealed caller provider surveys, with each finding substantial errors in provider directories and identifying specific challenges setting up appointments in specialty services and primary care.

Until CMS releases a detailed protocol for this activity, states that do not validate network adequacy face no penalties. Enhanced match for activities related to required network adequacy validation is also contingent on the new protocol. States may be able to classify direct testing of this kind under existing optional EQR activities that qualify for enhanced match. CMS should promote these active auditing activities with states, including through technical assistance that reminds states that can obtain higher 75% FMAP for conducting MCO provider network availability surveys through EQR. CMS should also provide technical assistance that details common problems designing and conducting these surveys to ensure that data collected is actionable.

CMS should also recommend how states should design these surveys to account for potential differences in accessibility for medically underserved groups, including people with disabilities, people with limited English proficiency, and people of color. For example, many people with disabilities still struggle when network providers lack the equipment necessary to provide services that accommodate their unique needs. One [Connecticut Medicaid secret shopper survey](#) found that callers using a "multicultural" name when seeking a Medicaid appointment were told more often that providers were not accepting new patients.



Beneficiaries spend untold hours searching for providers to provide needed services, and many give up after fruitlessly wading through wrong numbers, outdated listings, and providers who are not accepting new patients. Others end up with surprise bills for out-of-network services due to errors in provider directories.

States must work to eliminate the burden of this bureaucratic red tape, and one of the best ways to do that is transparency. CMS could build on some of the provider directory accuracy provisions from the 2021 Consolidated Appropriations Act and require states to update MCO and FFS provider directories at least every quarter, respond to consumer network questions promptly, and hold Medicaid beneficiaries harmless if they obtain services from an out-of-network provider listed as in-network. CMS could require states to publish periodic (at least annual) scorecards for accuracy and typical appointment wait times for different services in FFS and MCO networks. Such scorecards would need to include benchmarks with [enforceable standards](#) to incentivize states and plans to comply.

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?

(Not answered)

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?

We recommend that CMS require all states to have dedicated centralcontact point addressing access problems. Through various forms of notice, this centralized contact point – be it an access hotline, an ombuds program, or some other entity – should be known to consumers, consumer advocates and case workers, providers, health plan member services representatives, and state and county Medicaid agency staff. The staff who run the program should have standardized information to share with consumers, including up-to-date provider lists, information about filing appeals, contact information for other support resources, etc. This informal process must first and foremost help consumers troubleshoot specific problems, but it should *also* serve a systemic role by recording, compiling, and reporting complaints to identify

patterns in access problems quickly and help the state develop responses. A well-known and centralized access problem contact point is a critical component for resolving individual problems and monitoring access at the systemic level in real time.

We urge CMS, consistent with the principles of due process, to continue to require states to offer fair hearings to beneficiaries who do not have adequate access to care. In contrast to performance measures, such as HEDIS, which provide information about how a program was working years before, a well-functioning complaint process provides government officials with real-time information about how the Medicaid program is working. Thus, the complaint process is an absolutely essential component for states to implement. CMS should clarify in written guidance that when a state fails to provide reasonable access to a covered service, such that individuals experience delays in obtaining the service, this is a violation of 42 U.S.C. § 1396a(a)(3), which guarantees beneficiaries the right to a fair hearing when claims for assistance are not acted on with reasonable promptness. CMS should also clarify in regulation that FFS Medicaid beneficiaries have a right to an expedited fair hearing in urgent cases. But even with these improvements to the existing fair hearing process, we urge CMS to establish an informal process through which states can actually resolve and address individual access complaints, by providing assistance to beneficiaries in finding providers, making appointments, and locating facilities.

CMS must ensure that any data reported can be stratified by demographic information given by the enrollee at the time of application. Demographic stratification will enable CMS to make the promise of health equity real by exposing patterns and disparities in access. Only then can states and CMS have any meaningful way to address inequities in enrollment and access.

CMS issued July 2021 guidance that implements provisions in the 2016 managed care final rule requiring annual reports of each state-contracted Medicaid MCO. These reports will have to include specific data on appeals, grievances, and fair hearings in each program. Tracking appeals and grievances can be an effective oversight tool to complement other quantitative approaches to measuring access to care, but only if that data is complete enough to allow for detailed analysis, including the patterns of resolutions of the complaints, grievances, and state fair hearings.

We know of several instances where the compilation of fair hearings data helped make a compelling case for MCO malpractice. For example, a [2016 report](#) by non-governmental organizations of fair hearing appeals in New York found that in the six-month period after managed care plans took over the needs assessment process from the counties, the number



of decisions involving home care reductions increased six-fold. Three plans accounted for the vast majority of all appeals, and the total proposed reductions would have cut the aggregate hours by some forty-three percent. In the end, fully ninety percent of the proposed reductions were prevented – partly due to court opinions in the state and partly due to MCOs that either failed to show up or withdrew their request at the hearings sixty-four percent of the time.

The report was powerful and effective because the data included the outcomes of fair hearings. But it took substantial resources to compile that data, and in many states a lack of transparency would preclude compiling similar data. CMS and the states are uniquely situated to collect and publish detailed complaint, grievance, and fair hearing data as a system check on managed care and state FFS programs. The new Medicaid managed care annual reports will improve transparency, but are not likely to include the detail necessary to identify this type of pattern. They should.

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., 4 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.)?

We strongly encourage CMS to make use of the existing T-MSIS system to measure, analyze, and report on access to care.

Our primary recommendation is for CMS to ensure that states not only collect but also report information about enrollees' race, ethnicity, primary language, sexual orientation, gender identity, sex characteristics, and disabilities at multiple points in T-MSIS. We recommend that CMS use the [National Academies of Sciences Engineering and Medicine report on Measuring Sex, Gender Identity, and Sexual Orientation](#) and the [2011 HHS Data Collection Standards](#) to determine what demographic information fields should be added to T-MSIS. Where CMS requires reporting of demographic information, CMS must ensure that the terminology used within data systems match the terminology used in reporting requirements. Appropriate fields must be added to T-MSIS to ensure standardization of the reporting process and ease of use for states.



Our secondary recommendations consider the potential of T-MSIS as a tool for health equity. Not only must CMS collect information about Medicaid and CHIP-enrolled populations, it must make use of this information to correct inequities within the health system.

Where possible, CMS must ensure that enrollment, claims, utilization, and expenditure information can be stratified by demographic characteristics. Only when this is possible can CMS and states truly understand what issues in access needs interventions and what those interventions should be.

CMS must enable better public access to T-MSIS records. Currently, T-MSIS files are not available for public use, and researchers must pay to obtain detailed information from T-MSIS. We join the [many expert recommendations](#) that demographic data and analysis must be made accessible to stakeholder groups in order to improve trust in data collection and accountability to underserved populations. Public oversight of data is critical to ensure that equity issues are swiftly addressed. Further, it may enable quicker and more robust analysis of data as it becomes available. Ensuring access to publicly-available, de-identified data can increase stakeholder engagement in addressing the access issues that are identified.

Finally, CMS must improve compliance monitoring on data collection through T-MSIS - first by providing states with more resources to implement data-gathering technology, then by initiating reporting mandates. As discussed above, CMS should require demographic data collection as part of the Medicaid and CHIP application (see our answer to Objective 1 Question 3). CMS should provide states with resources to implement this requirement and explore making this data collection a condition for participation in certain Medicaid and CHIP programs. However, even when it is required, CMS must do more to support states in collecting and reporting this data. In 2019, CMS's DQ Atlas found that 18 states were still missing race/ethnicity data for over a quarter of Medicaid beneficiaries, while 28 states showed discrepancies with comparison data from the American Community Survey on more than 10 percent of their records. Race/ethnicity reporting was required as of 2014. Although CMS instituted a plan to improve completeness of data, CMS should take additional steps to hold states to account. As one example, [New York](#) recently piloted changes to collecting race and ethnicity on its marketplace application that resulted in increased response rates. Multiple avenues of reporting give more opportunities for demographic data reporting and can improve data quality by providing multiple points to validate the data. Technical and financial resources to support data collection efforts may be necessary for states who need to update data systems. For states that repeatedly report unusable data, CMS must take initiative to institute corrective action, withhold payment, or deny participation in programs if necessary.



CMS expects T-MSIS demographic data quality to improve as states fine-tune their systems, but progress has been slow. According to the [DQ Data Atlas](#), in 2019 (the most recent data year evaluated), only fifteen states achieved the “low concern” category for race/ethnicity, meaning that fewer than ten percent of files were missing and fewer than ten percent of the entries had discrepancies after cross-checking against the American Community Survey (ACS). Seventeen states exhibited “high concern” and five had “unusable” data problems related to race/ethnicity. This represents almost seven states with no improvement over 2016, when fifteen states had “high concerns” and seven submitted unusable race/ethnicity data.

The COVID pandemic highlighted the huge demographic data gaps in healthcare and how those gaps hindered a targeted response to certain groups that were especially affected – including Black, Latinx, and Native American communities as well as people with disabilities in a variety of community-based settings. While the exigencies of pandemic response may have drawn attention and resources away from fixing data systems like T-MSIS, the urgency for improving demographic data quality and completeness has never been more clear. This data underlies many of the health equity goals this administration has set.

At the very least, CMS should examine best practices in demographic data collection in the states that are doing relatively well (either in Medicaid and CHIP or other programs such as New York’s pilot with marketplace applications mentioned above) and share those lessons with the other states. CMS should also identify gold standards for how to successfully ask for demographic data and encourage states to train their frontline staff to use those best practices.

Objective 5 of 5

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?

Regularly beset by budget pressures, many states have cut Medicaid provider reimbursement rates significantly, leaving providers a thin profit margin and [making it difficult for those Medicaid programs to attract a sufficient number and mix of providers](#) to ensure that beneficiaries can access needed services. As a result, providers and beneficiaries filed numerous lawsuits over the years alleging violations of the equal access provision. See, e.g., *Visiting Nurse Ass'n of North Shore v. Bullen*, 93 F. 3d 997 (1st Cir. 1996); *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F. 3d 908 (5th Cir. 2000); *Arkansas Medical Soc., v. Reynolds*, 6 F. 3d 519 (8th Cir. 1993); *Clark v. Coye*, 60 F. 3d 600 (9th Cir. 1995).

In 2011, recognizing the need for additional oversight and guidance, CMS promulgated regulations to implement the Medicaid Act's equal access provision. While the proposed rule was pending, on March 31, 2015, the Supreme Court ruled 5-4 in *Armstrong v. Exceptional Child Care Ctr.* that providers do not have a right to sue state Medicaid programs in federal court to enforce the equal access provision. 135 S. Ct. 1378, 1388 (2015). After the Supreme Court's decision, there is little recourse to address reimbursement rate and access shortcomings in federal court, even where there is a clear violation of the Medicaid Act. The Court admonished the parties in the case to seek administrative recourse from CMS instead.

Following the Court's decision in *Armstrong*, on November 2, 2015, CMS issued a final rule implementing the regulations. In addition, CMS issued a separate Request for Information (RFI) seeking input on development of standards for beneficiary access to covered services. In the preamble to the Access Rule, CMS acknowledged that the *Armstrong* case "underscored the primacy of CMS's role in ensuring access." Then in 2019, CMS proposed to rescind the 2015 final rule, but to date, the rule has not been rescinded.



The time is ripe to revisit the 2015 rule, along with the network adequacy provisions of the 2016 Medicaid Managed Care final rule, and to think about access to services in Medicaid holistically, across the program and delivery systems.

Provider payment rates are not the only determinant of access to care. But the research confirms what common sense tells us, and what the Medicaid statute requires: payment rates do matter, so much so that they must be “sufficient to enlist enough providers so that care and services are available under the [state Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area.” 42 U.S.C. § 1396a(a)(30)(A).

Numerous studies have linked reductions in Medicaid provider payment rates to diminished access. One study [found that provider payment reductions led to a significant increase](#) in the likelihood that a Medicaid enrollee had no provider visits in the last year. In addition, the study found that payment reductions resulted in Medicaid enrollees seeking more care in hospital outpatient departments than physicians’ offices. Decreases in payment significantly increase the likelihood that Medicaid enrollees are diagnosed with pregnancy complications, asthma, hypertension, abdominal pain, and urinary tract infection in an emergency department instead of a physician’s office. From our own experiences working with advocates in fifty states and the District of Columbia, we know that low-income people can experience particular barriers to obtaining specialty care, including orthopedic and psychiatric care.

There is also evidence that increases in Medicaid provider payments result in improved access. The increase in Medicaid payment rates for primary care providers to Medicare levels in 2013 and 2014 improved some measures of access to care. A “secret shopper” study in ten states [found that the availability of Medicaid primary care appointments increased by 7.7 percentage points](#) after the reimbursement increase. The study also found that states with larger reimbursement increases tended to have larger increases in appointment availability. Research also shows that this primary care “bump” was particularly important for children. After the payment increase, [office-based primary care pediatricians increased their rates](#) of Medicaid participation.

Thus, it is crucial that CMS 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. As a starting point, CMS



should require states to pay at least ninety percent of the applicable Medicare rate for services that are covered by both Medicare and Medicaid. CMS should establish payment benchmarks for services for which there is no Medicare rate. In addition, CMS should develop a methodology to be able to compare payment rates to other access measures, to help it determine how increases and decreases in rates are impacting access.

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?

(Not answered)

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?

For home and community based services (HCBS), including community-based behavioral health services, there is a workforce crisis that is directly related to insufficient rates, leading to de facto denials of services. People approved to receive HCBS often struggle to find staff to support them, because low Medicaid rates lead to [systemic staffing shortages, high turnover rates, and inadequate training](#). The essential workers who provide HCBS services—primarily women and people of color—are [among the lowest paid health care workers in the United States](#), which perpetuates more racial and economic injustices.

While Medicaid requires states to ensure that payments are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population, there is often no identifiable comparison in Medicare or private insurance for these services. Access standards for HCBS are underdeveloped.

To address inadequate rates, we recommend that CMS expressly include HCBS waivers and managed care in future rulemaking about access to care measurement and metrics. Specifically, CMS' distinction between state plan services and services provided via HCBS waivers in its current fee-for-service access monitoring regulations makes little sense as a



matter of statutory interpretation, and it is bad policy. Nothing in 42 U.S.C. § 1396a(a)(30)(A) restricts its application to a narrow set of “state plan services.”

While states are required to report on their rate methodology when they request a new HCBS waiver, CMS could add additional safeguards to ensure that this analysis of rates will meet the needs of participants. This look-behind could include any number of factors that would inform the sufficiency of rates, including an analysis of individuals who had hours of waiver services approved but unstaffed or understaffed, a requirement that states analyze direct service provider turnover and capacity, and that states explain if their rates are adjusted for inflation, and if not, how that impacts availability of services. We also recommend including additional factors to ensure that rates are sufficient to meet the needs of people who may need staff with special training or skills, such as the ability to use assistive technology; ASL or other language skills; the training and skills to handle complex behavior needs without abuse, neglect, or over medication; and other needed cultural competency skills. If such needs are not part of the rate planning, people with complex needs will continue to be denied care or have limited access and disparities in access to HCBS will worsen.

We additionally recommend that CMS [reiterate training](#) and guidance, and [continue to lift up](#) helpful strategies regarding rate sufficiency and methodology for HCBS. One example of this includes incorporating transportation (including gas and mileage) into the rate paid for providers, or including personal care aides’ travel costs between individuals’ homes. This approach can help increase rate-sufficiency and the supply of providers in rural areas, where the time and distance providers have to travel can create barriers to services. Other examples include moving away from a straight fee schedule for all services in one category, and instead using tiered rates based on acuity or other factors to account for individuals who have more intense needs or face other barriers to obtaining services. States can also use geographic variation to ensure that services are equally available across the state, or make supplemental or enhanced payments to providers to help workforce retention or other quality initiatives for specific services. While many states already utilize some combination of these tools, to varying extents, additional guidance and technical assistance from CMS could help advocates understand how they can engage to urge states to use all the tools at their disposal to help ensure that those who need HCBS are actually able to receive it.

We also encourage CMS to address how states use individualized budgeting and the impact on access to services, including rates. Budgeting is often used by states and MCOs as a hard and fast limit on services, despite these budgets often being based on [assessment tools that are difficult to understand, secretive, and often based on biased data or assumptions](#). These



budgets are also typically based on complex statistical aggregations of population data. They include significant outliers, but often exceptions are either not available, difficult to get, not appealable, or all of the above. Person-centered planning with such budgets becomes an exercise in how to make a person's needs fit what is available rather than how they may receive what they need according to their personal preferences, unless there is [clear guidance](#) otherwise and even then budget tools can limit access to what people need. The impact of assessments and budgets has been the subject of litigation and complaints throughout the country, often involving claims related to their impact on HCBS recipients' community integration or risk of institutionalization. Low assessed budgets frequently limit a person's ability to pay adequate rates to pay for services, such as in the *Waskul*, 979 F.3d 426 (6th Cir. 2020) or *Belancio*, No. 17-CV-1180-EFM, 2018 WL 2538451 (D. Kan. Sept. 21, 2018) cases. There should be clear guidance setting standards and expectations for the use of budgetary tools that protects the right of HCBS participants to access the services they need as well as increased transparency, look behind methods, and accountability for when such tools are used.

Self-directed services also need to be addressed in access to care guidance and regulations. As mentioned above, a budgeting process can significantly impact the rates available to pay providers, such as in the *Waskul* case where a change in the budgeting process meant that the plaintiffs in Michigan no longer had sufficient funds to meet their service goals or pay the necessary providers. There are also access issues around the function of fiscal management agencies. These entities are responsible for helping people in self-direction programs handle employee payment and other important functions. But these agencies are often causing problems for people through slow payment, administrative burdens in hiring employees, and other issues that limit payment to and processing of employees. Such problems directly influence access to care and there are often very few mechanisms that HCBS participants using self-direction can use to correct such malfunctions. There is usually limited or no choice in fiscal management agencies and states often provide very little, if any, problem solving assistance. Because self-direction itself can improve or resolve some access to care barriers, any guidance on access to HCBS should promote self-directed services and at least consider any potential harm on self-directed HCBS.

Further, encouraging states to continue some of the initiatives they have undertaken during the public health emergency (PHE) beyond the end of the PHE could help expand the pool of providers. For example, during the PHE states have permitted qualified providers from other states; allowed family caregivers to become paid caregivers while still ensuring participant choice of providers; increased payment rates for direct care workers; expanded coverage of



telehealth in terms of services, providers, and modalities. All of these strategies present a fairly low risk to participants, and can generally improve the direct care workforce stability and improve access to services. CMS could provide additional public-facing guidance related to this opportunity,

While actively encouraging states to retain certain measures post-PHE, and share publicly their plans for doing so.

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.^[6] 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?

As we mentioned in response to Objective 3 Question 1, medical management techniques are insurer-imposed conditions under which a provider's drug or service order can be covered. They include step-therapy – where a patient has to try one method and “fail” (which could include pregnancy or medical complications) before the insurer will authorize what may be a more expensive method – or prior authorization by the insurer. When medical management practices align with standards of care, they can improve efficiency without sacrificing quality of care or patient wellbeing. For example, if a patient complains of mild headaches, it may be reasonable for an insurance company to deny coverage of narcotic pain medication as a first-line treatment absent some showing of medical necessity. But when medical management techniques ignore or override standards of care and are driven solely by insurers' desire to control costs, they can prevent or delay access to necessary treatments and services that are preferred or recommended for particular enrollees.

While federal regulations acknowledge that Medicaid MCOs may adopt methods and procedures to safeguard against unnecessary use of services, physicians may experience these procedures as administrative hurdles that conflict with providers' clinical judgment. The [National Bureau of Economic Research found](#) that the cost of haggling with insurers and lost revenue results in physicians losing seventeen percent of Medicaid revenue and some physicians refusing to accept Medicaid patients. Many states have now created their own laws or policies to prevent insurers from using medical management techniques, like cost-sharing,



prior authorization, prescription requirements, gender restrictions, or quantity limitations, for time-sensitive services such as [contraception](#), [abortion](#), and [pre- and post-exposure prophylaxis](#). CMS could take actions to encourage states to eliminate medical management and prior authorization when it conflicts with the standard of care.

Reducing Administrative Burdens for New Medicaid Providers such as Doulas

State Medicaid Agencies are increasingly reimbursing new types of Medicaid providers, such as doulas, community health workers, peer support counselors, and others. Some of these new providers will have existing mechanisms of support built up around them to help with the administrative burdens that come with becoming Medicaid providers. However, other new Medicaid providers, such as doulas, may not.

CMS can provide guidance to states on how to ensure that the provider enrollment process for new Medicaid providers is simple, straightforward, and streamlined. Clear step-by-step instructions should be widely available on a publicly accessible website. There should also be a mechanism for people to ask questions and get support navigating provider enrollment, and receive a response on a timely basis.

CMS can also provide guidance to states on how to support the administrative tasks of billing, payment, documentation, reimbursement, and other tasks associated with being a Medicaid provider. In some cases, doulas and other new Medicaid providers may want to affiliate with a group, organization, or third party agency to help facilitate some of these administrative tasks. CMS can help support these efforts by providing guidance to states on how individual Medicaid providers might be able to affiliate with such groups to benefit from such support. This could also address concerns we have heard from some providers that Medicaid billing is too difficult and thus they just do not participate in Medicaid.

