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April 18, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1751–P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicaid Access to Care Request for Information

Dear Administrator Brooks-LaSure:

On behalf of ADvancing States, I am pleased to provide comments to CMS's Request for Information on access to care in the Medicaid and CHIP programs. ADvancing States is a nonpartisan association of state government agencies that represents the nation's 56 state and territorial agencies on aging and disabilities. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services (HCBS) for older adults and persons with disabilities. Our members administer a wide range of services and supports for older adults and people with disabilities, including overseeing Medicaid-funded long-term services and supports (LTSS) in many states. Together with our members, we work to design, improve, and sustain state systems delivering long-term services and supports for people who are older or have a disability and for their caregivers.

Due to the focus of our association and its work, we will limit our comments to issues that directly impact older adults and people with disabilities, with a specific focus on eligibility and access for individuals who do not qualify based on modified adjusted gross income (MAGI) as well as on HCBS and LTSS. Before addressing the individual questions in the RFI, we first want to stress that HCBS is a unique set of services and supports that differs from many of the other services in Medicaid. While there are inherent differences between Medicaid populations and those insured by private health plans or other coverage options, this distinction is particularly acute in LTSS settings where Medicaid is the primary payer. Thus access-related issues and strategies for older adults and people with disabilities may not align with strategies for other populations in the program.

Similarly, HCBS has historically been excluded from many Federal initiatives, incentives, and funding opportunities that were used to develop and enhance data collection, technology, and interoperability. As indicated in the RFI questions, much of the work regarding access

monitoring will rely on technology for data collection, aggregation, and analysis. This is particularly true in primary and acute settings where substantial investment has been made regarding electronic health records and interoperability. When developing strategies to monitor access across the Medicaid program, CMS must recognize the inherent difference in data that is available for HCBS compared to other covered services.

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.
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.

At the state level, non-MAGI financial eligibility processes are extremely burdensome on staff and applicants. This is particularly true for documentation related to the mandatory five-year look-back period for asset transfer penalties. We recognize that there are statutory constraints that limit CMS' ability to provide additional state flexibility on these processes but we do believe that there are some potential options to addresses challenges and expedite eligibility and enrollment for people with disabilities. We also recommend that CMS evaluate options for waiving the five-year look back period in states that are interested in expediting and simplifying LTSS eligibility.

We also suggest that CMS provide states with the option to accept self-attestation of income and/or disability status from applicants and then engage in post-enrollment verification. This is similar to, but distinct from, presumptive eligibility processes in statute. States that currently adopt this type of option for older adults are "at risk" of losing FFP if the individual is determined ineligible upon further review. We encourage CMS to provide FFP for services provided during this interim period of attestation. States would be responsible for tracking the error rates and mitigating future issues. Experience from WA state shows that this type of initiative can be done effectively and that states can implement quality process that result in low eligibility error rates. Alternatively, CMS could consider a "risk-based" approach to assessing the look-back period. Similar to the approach used for screening Medicare providers[1], CMS could give states the flexibility to limit review of the full five years of data for applicants that show no indication of prior asset transfer activity.

CMS should also evaluate ways to provide additional options for states to expand existing presumptive eligibility processes to include older adults and disability-related categories as well as LTSS applicants.

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[1] 42 CFR 424.518

Currently, 42 CFR 435.1103 limits the eligibility categories that states may include within presumptive eligibility. These limitations severely restrict the flexibility for states to streamline and expedite eligibility for individuals with the highest levels of need.

We also believe that there are opportunities to address timeliness of HCBS delivery. For example, current CMS rules require a full plan of care to be fully implemented prior to service delivery. In many cases, the plan of care is developed through a lengthy assessment and person-centered planning process. We stress that both person-centered planning as well as comprehensive service plans are important to ensure that HCBS participants can ensure that necessary services are provided in a manner that maximizes participant autonomy and community integration. However, the current requirements create an institutional bias, as participants can access facility-based care much more expediently than HCBS. We encourage CMS to clarify that states can develop a smaller menu of "basic" HCBS that is available immediately to HCBS applicants and that states may deliver these services under an interim plan-of-care pending the full person-centered planning process. This would provide significant opportunities for states and CMS to reach a mutual goal of 'rebalancing' the LTSS system.

Lastly, there are regulatory constraints that delay the delivery of HCBS. One such example is the "wet signature" requirement for plans of care. We believe that the Covid flexibilities implemented by states, such as verbal consent, electronic signatures, and other methods of participant sign-off, have demonstrated the value of these approaches both by providing alternative methods for participants with disabilities that may limit their ability to sign a paper, as well as by expediting the eligibility process. We also recommend allowing service delivery to begin prior to the signature being obtained, with a reasonable grace period to secure the signature.

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?

Through its partnership with ACL, CMS has supported state development of aging and disability resource centers (ADRCs) and no wrong door (NWD) systems. However, these networks are fragmented, vary significantly by state, and do not have adequate Federal funding. We commend CMS for developing the Administrative Claiming guide for ADRC/NWD networks; however, more support is needed to assist states actualize a robust, effective 'front door' for LTSS services. We also encourage CMS to be flexible and broad with the types of outreach, engagement, and eligibility assistance that can qualify for administrative funding. ADRC/NWDs are a crucial LTSS entry point that are not adequately funded around the country. Although CMS has worked to provide information on the administrative claiming process for ADRC/NWD systems, it remains cumbersome and we believe that it could be simplified.

We also believe that states should be able to better leverage outside entities to assist with level of care determinations. We recognize that statute requires a merit-based public employee to finalize eligibility determinations; however, there are significant challenges associated with data collection and verification, especially as it relates to the level of care (LOC) assessment that is required for many LTSS service options. Frequently, the type of clinical skills needed to perform effective LOC assessments makes it challenging for states to directly employ those individuals. We recommend that CMS explicitly allow states to use outside contractors to perform LOC verification validation even if state staff must ultimately process the eligibility determination.

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?

One of the most effective ways to engage with and inform individuals of programs is by partnering with community organizations that represent, are made up of, and/or are routinely and actively involved with these various diverse communities. We believe that states should be eligible for enhanced match when contracting with community organizations that are specifically focused on and close to different communities across the country. These contracts can be utilized to better educate individuals about the coverage options available to them as well as provide information, referral, and application assistance to those participants.

In addition to these types of community partners, we also want to highlight the availability of the broader information and referral networks that have footholds in communities across the country and are trusted, independent, providers of important assistance. Though many of these I&R providers are either housed in, or partner with, ADRCs, Medicaid could expand its partnership to include many other providers at the national, state, and local level. We recommend that CMS explicitly allow Medicaid administrative funding for the I&R entities in the alliance of information and referral specialist (AIRS) network.[2]

Another important barrier that CMS should address is access to technology. Over the past decade, CMS has encouraged states to expand the availability of online eligibility portals and to move towards centralized, integrated, systems that facilitate eligibility and enrollment. As more components of Medicaid eligibility move online, it eases the procedural burdens on many individuals but it also exacerbates the inequities associated with the "digital divide." Though it will not solve all these challenges, particularly for those individuals not yet eligible, allowing state Medicaid agencies to pay for internet access will lessen inequity across populations and provide more options for enrolled individuals to streamline their renewals.

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[2] https://www.airs.org/i4a/pages/index.cfm?pageid=1

We also want to stress that CMS must balance the different priorities and needs of various states regarding equity, particularly given that there is not an even distribution of different diverse populations across the country. States may have specific initiatives related to populations with the greatest unmet need in their communities, and CMS should support states as they identify and develop targeted initiatives rather than forcing states to adhere to a predetermined national standard or outreach strategy.

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).

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?

We believe that CMS and states can collaborate to make improvements to the institutional level of care (LOC) determination process for participants. We recognize that CMS has provided states with some flexibility regarding LOC redeterminations when a participant's condition is unlikely to change. However, CMS' waiver technical guide[3] requires that LOC be performed at least annually. Neither the statute at section 1915(c) of the Social Security Act nor the implementing regulations at 42 CFR §441.303(c)(4) specify a minimum duration for performing this redetermination. We recommend that CMS allow states the flexibility to identify participants with conditions that are unlikely to improve and allow for longer durations between level of care evaluations. We recognize that CMS must ensure the integrity of the functional eligibility requirements for LTSS. However, there are instances where it is extremely unlikely that a condition will either change or improve. Performing annual recertifications of these conditions is overly burdensome on participants and is also an unnecessary use of programmatic resources. CMS could potentially establish a minimum threshold and/or a listing of conditions for participants where states no longer need to redetermine LOC and/or could perform much more infrequent LOC determinations.

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[3] https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf

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?

In many cases, the required paperwork and associated non-responsiveness is a significant factor in disenrollment of participants. While states have made strides to simplify applications and provide participants with pre-filled applications and other resources to facilitate ongoing coverage, challenges remain for many participants. In most cases, these participants would benefit from proactive engagement and hands on assistance with the renewal application process. However, given the existing responsibilities of state eligibility staff, it is frequently not feasible for the caseworkers to provide this type of assistance.

Instead, CMS should provide states with financial resources as well as tools and other guidance that assists them engage with outside entities, such as managed care organizations (MCOs), ADRC/NWDs, and other community-based organizations to monitor the enrollment status and potential disenrollment of beneficiaries and to proactively assist with redeterminations. In fact, the PHE unwinding toolkit very explicitly lays out expanded flexibilities to use MCOs to assist with the backlog of redeterminations.[4] States would benefit from CMS resources and information on how to establish effective data sharing agreements, limitations and opportunities under HIPPA requirements, and allowable entities to perform these activities, as well as additional funding for this type of activity. Additionally, CMS should allow states to finance interoperable technology for partners using the 90-10 funds provided for eligibility systems. This technology would provide the partners with further resources and streamlined approaches to ensure that the trusted partners can provide individuals with timely assistance to prevent gaps in coverage.

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 EPSDT qualified supports who transitions to other Medicaid services such as 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?

The State Health Insurance Assistance Program (SHIP), created by sec 4360 of the Omnibus Budget Reconciliation Act of 1990, provides individuals with counseling on a variety of Medicare issues, including enrollment, benefits, and plan selection. Nationally, the SHIP program received $53 million in the most recent Federal appropriations, which is extremely insufficient to address all the needs of Medicare-only

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[4] https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html

participants let alone provide support for dual eligible and/or those transitioning from Medicaid to Medicare. We recommend that CMS develop policy and financing options to augment SHIP and allow it to provide additional support to individuals that are disenrolled from Medicaid upon their 65th birthday as they transition to Medicare. This is particularly impactful for participants in the ACA adult expansion group codified at 1902(a)(10)(A)(i)(VIII) but is also relevant to other groups with a statutory age limit, such as the Ticket to Work Medicaid Buy-in program established by 1902(a)(10)(A)(ii)(XV). We also recommend that CMS provide states with funding, guidance, and training to establish a cadre of SHIP counselors that specialize in dual eligible issues. This is a very complicated subset of Medicare enrollment issues, and knowledge about dual eligibility and opportunities for beneficiaries to access an integrated care program widely varies across the country.

In addition to the recommendations to expand CMS' support of SHIP, we believe that existing options could be better utilized to ensure that the SHIP programs are able to meet the needs of Medicaid enrollees. CMS should work to expand the availability of Medicaid administrative claiming for SHIP counselors that already help dual eligible enrollees. Today, SHIP counselors are often providing outreach, education, referrals, and application assistance to Medicare enrollees who may benefit from Medicaid. All these activities should qualify for Medicaid Administrative Claiming (MAC) based on current rules and regulations. We recommend that CMS create a MAC guide for SHIP that provides clear direction on how to draw down this funding and also reduce burdens and barriers that prevent states from maximizing MAC for eligible SHIP services.

Lastly, we note that HHS-funded navigator positions can be extremely valuable resources for information and assistance with Medicaid eligibility issues. However, funding for this program has varied significantly over the past few years and the inconsistencies have led to challenges with providing services on a continual basis. Application navigators require a specific skillset and knowledge base that is acquired over a long period of time. When drastic funding changes occur, experienced navigators may transition to a new role or new organization completely. This significantly limits the quality and consistency of services and also requires substantial training and resources to replace the skillset when new funding is provided. We encourage CMS to provide ongoing and predictable funding for these programs, including broadening the types of outreach and eligibility assistance that can qualify for MAC.

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.

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?

Although ADvancing States supports efforts to strengthen and expand the provider networks available to Medicaid participants, we need to stress that establishing minimum standards for access to services is not operationally feasible and that any comparisons or evaluations based on different states or alternate types of insurance will not be meaningful in any practical fashion. In the Medicaid program, states have wide latitude to establish service definitions, define the amount, duration, and scope of services, and clarify the types of qualified providers that can deliver services. Similarly, state licensing boards and legislative bodies can establish the scope of practice for different classes of health care professions, which can create wide variety in the types of services that are delivered by various providers. These factors, coupled with the inherent variation in population density, distances, and the characteristics of residents in different parts of the country, make it impossible to have any sort of meaningful national standards or requirements.

Though we recommend against trying to create standardized measures or access requirements, If CMS decides to address access issues, we encourage the agency to recognize the inherent differences between HCBS and primary/acute medical services. We believe that there is a robust process in place with assessment, plan of care development, service authorizations, and delivery. In HCBS, access should be determined based upon the delivery of those Medicaid-funded services contained within the plan of care and not based on time and distance standards. MLTSS contracts often include a 'time to service delivery' quality measure; our belief is that this is a more effective and person-centered way of measuring actual realized access of participants rather than trying to establish requirements related to provider enrollment measured access.   Another common approach in MLTSS is to monitor 'gaps in care' - that is, monitoring whether needed and authorized services in a person-centered care plan are delivered as dictated in the care plan.[5] Historic approaches related to time and distance focus on the concept of 'up-front' access, but realized access is more important in HCBS.

Similarly, any approach for access monitoring should have explicit distinctions related to rural, frontier, suburban, and urban localities. Not only does population density impact the availability of providers as well as demand for supports, but the characteristics of individuals who live in these various types of localities frequently differ as well. This can have an impact on cultural norms related to care, the need for different specialties, and accessibility as well. It would be inappropriate to try and establish any standards that do not account for the wide variation between these types of regions, as well as the variation in populations and associated health care dynamics between rural and urban areas in different parts of the country.

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[5] https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf, p. 412

Additionally, HCBS is very person-centered and the service needs and preferences can vary significantly amongst participants. Existing consumer surveys, such as the National Core Indicators In-Person Survey (NCI™) & the National Core Indicators – Aging and Disabilities (NCI-AD™) can provide valuable information about access to care. For example, NCI-AD™ addresses issues valuable to assess access such as:

•   Percentage of people whose services help them live the life they want

•   Percentage of people whose services meet their needs and goals

•   Percentage of people who have access to mental health services if they want them

•   Percentage of people who can get an appointment to see or talk to their primary care doctor when they need to

Hearing the voice of the participant is another key aspect of 'realized access'.

State agencies have made strides during recent decades to expand self-direction programs in their HCBS systems. These initiatives range from "agency with choice" models where a traditional company remains the Medicaid enrolled provider and participants have options to select the employee that actually provides care up to and including "cash and counseling" models where states establish prospective service budgets and provide participants with great flexibility to spend those funds on items and services that address their individualized needs. We encourage CMS to consider how self-direction expands available supports to participants and provide additional resources and support to assist states that are interested in further expanding this model.

We also note that access assumes that there are both providers enrolled in Medicaid as well as a sufficient an available workforce. Different states could have the same number of providers and less capacity due to external issues, such as enrollment increases that outpace provider enrollments, provider challenges with recruiting and retaining staff, as well as the intensity of service needs depending upon the current circumstances. Any realistic approach to address access issues must be multifaceted approach that engages multiple parts of the Federal government to support state and local initiatives. We request that CMS engage with other Federal partners to provide more assistance with workforce development, sustainability.

How could CMS consider the concepts of whole person care or care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?

We recognize and appreciate the effort CMS and other Federal agencies have made to incorporate social determinants of health into the overall scope of services and supports. We note that there is a substantial network of entities in the aging and disability networks that have existed for decades and can support and

enhance these initiatives. However, many of the existing SDOH initiatives have led to primary and acute providers building or attempting to build their own SDOH interventions rather than coordinating and collaborating with the existing networks. In many cases, these entities are making referrals to other parts of the system without any accompanying funding for the services requested. We strongly encourage CMS to bridge the divide between medical and LTSS/social services and to also ensure that there is adequate funding to support all needed interventions.

As discussed earlier, state ADRC/NWD systems coupled with I&R programs often offer a solid foundation for coordinating information, application assistance, and access to LTSS. We encourage CMS to use its visibility and authority through the Innovations Center to support states as they build out more robust ADRC/NWD systems and as they work to expand the use of technology in the LTSS programs. We would be particularly interested in initiatives that support technological enhancements, particularly at the HCBS provider and CBO level.

Many entities in the aging and disability networks have not been provided resources to establish robust technology, which can hinder their ability to integrate with the more robust technological ecosystem of the primary and acute industry partners. This creates further disconnects in the coordination of supports across the spectrum of participant needs and can exacerbate the development of duplicative information, referral, and documentation systems. This fragmented approach ultimately undermines efforts to establish whole person models of care. One example of an initiative underway that can be replicated in other areas is the value-based purchasing (VBP) initiative in Missouri's HCBS system. This initiative provides a valuable lesson in how strategic approaches to payment and technological integration can complement and connect the various parts of the health and human services systems and be leveraged to create incentives that promote better outcomes for participants.[6]

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?

One important change that can be made to expand the availability of providers is to remove the existing prohibition on family members delivering care for 1905(a)(24) personal care services. Other parts of the HCBS system, including 1915(c), (i), (j), and (k) allow participants to receive services from family members. Though there are other options for establishing these individuals as providers, the prohibition placed on 1905(a) state plan services creates challenges with service authorizations and delivery, as well as with complicated provider enrollment requirements, depending upon which part of the Medicaid program is paying for services. This is particularly challenging since CMS policy generally requires states to exhaust services available through the state plan before financing HCBS waiver services, and states must establish

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[6] https://dmh.mo.gov/media/pdf/stakeholder-update-value-based-payment-activities

complicated exception processes for individuals who receive PCS from family members and could not first use the 1905(a) supports. Given the intimate nature of the supports provided, the on-going nature of care, the provision of many services in individuals' homes, leveraging a family member to provide care is often a logical approach to ensure that the participant's needs are met.

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 HCBS measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

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 believe that there is value in looking holistically at access to ensure that individuals are not negatively impacted due to the service delivery system that they are enrolled in. Managed care delivery systems currently apply network adequacy standards that do not apply to fee-for-service; identifying opportunities to coordinate these access measures across Medicaid delivery systems would be welcomed. However, because of the different types of populations that are frequently included/excluded from MLTSS, we do not believe that it would be useful to compare access for fee-for-service vs. MLTSS programs. Many individuals with the most complex health and social needs are carved out of managed care and would likely have disparate access metrics due to the types of services and providers required. For example, a Mathematica analysis that looked at MLTSS vs FFS was unable to provide actionable information for states insofar as it did not highlight challenges related to the differences in populations and payment.[7]

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?

As addressed earlier, existing participant surveys could provide valuable insight into whether individuals are receiving necessary services and the underlying access issues inherent to their supports. Inclusion of these

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[7] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mltss-summeval-rep.pdf

measures in the HCBS measure set will be helpful, with the proviso that all programs and surveyed populations are not identical, which limits state-state comparisons.

We also encourage CMS to support state case management IT systems development through policy, financing, and technical assistance to ensure that necessary data is available that enables states to effectively and comprehensively compare service plan authorizations with encounter/claims data. Additionally, availability of comprehensive and timely information would be strengthened by the expansion of technology at the provider and CBO level with an emphasis on integration and interoperability between provider's IT, case management systems, and electronic health records and the state health information exchanges. Also noted earlier are examples of realized access in HCBS that effectuate the type of evaluation suggested in this question.

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?

It is important to note that managed care appeals and grievances tend to be more comprehensive and provide broader information that state fair hearings information. For example, in managed care, a participant may file a grievance based upon an inability to access services, rudeness or unresponsiveness of a care planner, or challenges with the types of support that are ultimately provided. In contrast, Medicaid appeals tend to provide information that focuses on more targeted and escalated issues, such as denials of payment or eligibility-related concerns. We do believe that this data can be monitored to show "early warnings" of access, particularly for managed care data; however, we caution CMS that it would not be feasible to create cross-state or cross-delivery system comparisons.

Additionally, particularly when it comes to fair hearings, the personalities and priorities of administrative law judges frequently impacts the ultimate decision as much as the rules of the program do. We are unsure if the information provided through the fair hearings data will result in data that can be used to make changes or address systemic issues in the Medicaid program.

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.

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?

Throughout the history of Medicaid, as embedded in the statute and regulations, states have been the entities with the responsibility to set payment rates. While the statute dictates that payment rates must ensure access to care and promote efficiency, economy, and quality of care, it does not provide CMS with the authority to mandate minimum reimbursement amounts or standards beyond this framework. Each Medicaid agency must follow the rules, requirements, and state laws by which it is bound. State legislatures, provider communities, advocates, members, and a wide range of stakeholders are also involved in the rate-setting process. This discretion to states in payment approaches must continue to be respected by CMS, as it is a core component of Medicaid's partnership between states and the federal government. It is not feasible or appropriate for CMS to determine the sufficiency of state Medicaid rates and instead the focus should be on working with states to ensure that their activities are consistent with the statutory requirements related to access, efficiency, economy, and quality.

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?

One area that CMS can assist is to work with other federal partners to ensure that there is sufficient information available to support the HCBS rate development process. A significant portion of HCBS rates are built on the wages of direct care worker (DCWs). However, states often do not have accurate and timeline information on what those wages are. We believe that increasing the formal recognition of DCWs as a job class and increasing the availability of information on these jobs, including the number of workers, wages, and other important information, would greatly enhance the ability of states to address rate setting activities. Right now there is not much information on HCBS/DCW providers; instead, information about these workers is wrapped up in broader job classifications for DOL. Better wage data availability will be crucial with state rate studies, which currently face struggles to identify accurate wage components when building them into the methodology.

Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of

Medicaid beneficiaries. What actions could CMS take to encourage states to reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID- 19 Public Health Emergency?

In HCBS, Medicaid programs frequently cover services that are not generally included in health insurance networks. This can include things such as pest control, mold abatement, home or vehicle modifications, and a wide range of other services and supports. However, despite these services being delivered by an entity that is unlikely to provide substantial Medicaid services on an ongoing basis, many states have interpreted CMS guidance to require standard screening and enrollment practices for these providers. We recommend that CMS develop clear guidance that allows exceptions processes to ensure that onerous enrollment requirements do not limit the availability of nontraditional providers.

Other Feedback – for responses that don't fit within the above.

We believe that CMS policy related to Electronic Visit Verification (EVV) exceeds the statutory requirements and results in further challenges with personal care provider shortages. For example, through the outcome-based certification for EVV systems, CMS is requiring states to implement pre-payment edits that deny reimbursement for claims without EVV. Similarly, CMS has provided guidance that curtails state use of alternative systems that were negotiated in concert with the provider and advocacy communities, such as electronic dual verification timesheets. The result of this guidance is pushing states to implement models of EVV with global positioning service (GPS) technology. Such technology has been opposed vehemently by many providers and participants, and feedback from advocacy and provider communities indicates that some DCWs have decided to stop providing these services due to the burdens with EVV, privacy concerns with GPS, and the CMS mandates that make EVV more onerous.

Conclusion

We recognize that access to care is an extremely challenging, nuanced, and complex issue to address in the Medicaid program. We appreciate CMS' approach to ask thoughtful questions prior to any formal regulatory activity, and we encourage you to continue dialogues with state agencies as we collaboratively work to improve access to services. We look forward to participating in this ongoing work together. If you have any questions regarding this letter, please feel free to contact Damon Terzaghi at dterzaghi@advancingstates.org.

Sincerely,

Martha Roherty
Executive Director
ADvancing States