



Questions included in the Request for Information: Access to Coverage and Care in Medicaid & CHIP February 2022

https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV_6EYj9eLS9b74Npk. Note that responses to each question are limited to 20,000 characters. The public comment period is open for 60 days from February 17, 2022 through April 18, 2022.

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.*

The National Rural Health Association encourages CMS to enhance efforts to reach the more than 61 million individuals living in rural areas. While uninsured rates among non-elderly adults in rural areas have fallen substantially since 2010, rural uninsurance continues to be about 2-3% higher than urban areas.¹ Further, many rural communities face challenges that contribute to persistent health disparities, when compared to urban areas, including geographic distances, infrastructure limitations, and provider shortages. As such, certain supports may be required to assist rural individuals with equitable coverage.

Outreach and Enrollment: Targeted efforts should be made to support and expand permanent Navigator programs, such as eligibility workers in State Marketplaces, the State Marketplace Modernization Grants, and Connecting Kids to Coverage Outreach. In addition to provide sustainable federal funding for enrollment assistance, targeted outreach regarding funding opportunities should be provided to ensure that funding reaches assisters who have relationships with rural populations. It is critical that enrollment policies recognize and reflect that the digital divide experience in rural areas makes it difficult for some people to enroll without in-person assistance. Further, these programs should recruit and train outreach and enrollment workers, including community health workers, who have specific knowledge of and expertise in working with diverse rural populations.

Simplified and Automated Processes: CMS should create incentives for states to pursue opportunities to simplify optional eligibility and enrollment processes for non-MAGI populations. While Medicaid and CHIP enrollees have kept their insurance due to the maintenance of effort (MOE) requirement, many states simplified their Medicaid application process due to the pandemic.¹ CMS should allow states to continue this flexibility post-PHE. These include: 1) automated enrollment policies through 1115 waivers, 2) automatic redeterminations and renewals for individuals and families utilizing state administrative agencies, 3) automatically confer benefits and redeterminations for applicants with no source of income, 4) simplify the process for

¹ Turrini, G. et. All. "Access to Affordable Care in Rural America: Current Trends and Key Challenges." (July, 2021) HHS ASPE Office of Health Policy. Report HP-2021-16.

beneficiaries to update their information, 5) make redetermination data information widely available, and 6) pre-populating the renewal form.

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?*

Financing new or expanded infrastructure and technology can be a challenge for rural states and rural providers given resource limitations. As such, CMS should support enrollment and eligibility processes improve capabilities through the following mechanisms.

- Align enrollment and eligibility process with existing federal grant programs (e.g., Health Resources and Services Administration and CMMI) to maximize resources providing technical assistance to rural providers ready to transition to new payment systems.
- Provide support through resources such as outreach and enrollment workers (as mentioned above) and call center support.
- Extend federal data infrastructure to increase electronic verification by Medicaid and CHIP, preventing paperwork-driven denials and terminations, including access to resources such as the IRS's Data Retrieval Tool (DRT) and the National Directory of New Hires (NDNH).
- Develop easy-to-use systems that contain clear requirements and instructions with system capability enhancements including: 1) site and the patient to electronically submit all applications, 2) interoperability across EHR vendors on insurance status and eligibility, and 3) development of a single system for all program data submissions.
- Support for multiple languages, beneficiaries with limited health literacy and patients with limited digital resources.
- Encourage use of Enhanced Funding for Eligibility and Enrollment Systems to help support population health management and financial risk management technologies and staff training.
- Encourage use of the Medicaid Innovation Accelerator Program to support states in four function areas: payment modeling and financial simulations, data analytics, performance improvement, and quality measurement.

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?*

Medicaid plays a central role helping to fill gaps in private coverage in rural areas. Private insurance accounts for the largest share of health coverage among individuals in rural areas. However, nonelderly individuals in rural areas have a lower rate of private coverage compared to those in urban and other areas, reflecting greater employment in jobs that do not offer employer-

sponsored health insurance and the lower labor force participation rate in rural areas. Medicaid helps fill this gap in private coverage.²

Since rural recipients are more likely to rely on Medicaid as their source of insurance coverage, any changes in eligibility or simplify the application process could positively affect rural communities. CMS and state governments should analyze the impact of eligibility changes on rural communities prior to implementation. CMS should encourage or require states to increase the number and type of sites of care in which people can obtain presumptive eligibility, including community health centers, rural health clinics, and rural hospitals.

It is important to understand that barriers to enrollment and retention are not the same across each community. CMS should assess unique access and retention barriers for each prioritized group using available data. Specifically, CMS should create more incentives for States, Managed Care Organizations, and providers to adopt strategies and care models to address SDOH and support the whole-person model approach. Rural Medicaid recipients must be treated equitably by managed care and consumer-choice programs. Further, given the size and poverty level of the rural elderly and disabled populations, coordination of benefits and enrollment into available programs for dual-eligible beneficiaries should be given greater priority.

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?

The National Rural Health Association recommends the following monitoring actions to better help understand enrollment trends:

- **Critical analysis of those who are not enrolled.** Given the higher rates of uninsurance in rural, versus urban, areas CMS should work with state to analyze data for who is eligible and who is enrolled and do targeted outreach to those who are not enrolled in rural areas. This should include geo-mapping of where eligible-yet-unenrolled populations live and direct targeted outreach and resources to those communities.
- **Equity issue:** CMS should require states to track and report disaggregated data by race/ethnicity, geographic location, and gender identity, to include reasons for and rate of denials, timeliness of application re/determination, and methods of contact/application. States should also report on location and quality of enrollment center and enrollment assisters/outreach efforts.

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.

² <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>

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?*

The Need for Specific National Standards in Managed Care and Fee-for-Service. Medicaid provider networks have long been narrower than those other coverage types and reliant on rural safety net hospitals, rural community health centers, and rural health clinics. As Medicaid has grown to become the largest health coverage program in the United States, these narrow networks are problematic. CMS should reinstate the time and distance standards weakened in the last administration and specify specific national time and distance minimums applicable in all states to ensure adequate access for rural beneficiaries. As a first step, National Rural Health Association suggests that CMS begin to measure rural primary care access and investment for each state Medicaid program. When determining adequate access to care, the assessment should include travel time and actual geographic access. It should also be structured to reflect whether the area is urban or rural, the cost and availability of transportation, and provider capacity. Each of these considerations factors into whether the patient can access services from the provider within a certain amount of time, which may vary depending on the services the patient needs and the patient's condition.

Equity for Services. There should be equity of Medicaid benefits across medical, oral health, and behavioral health benefits. Particular attention needs to be given to the disparities in health that affect rural populations and often Medicaid beneficiaries most specifically. CMS and states should implement several network adequacy standards to oversee compliance to ensure that families have adequate access to the mental health and substance use services to which they are legally entitled, including the following key principles for network adequacy in behavioral health care.

- Require that plans have sufficiently available providers and treatment facilities for both substance use disorders and mental healthcare, and track compliance separately for those two conditions.
- Ensure that care is available across the continuum, including for emergency and urgent, inpatient, residential, outpatient, and home- and community-based services.

Support for Access. Where standards are inadequate, CMS should work to ensure access while some critical health care services, like dental care for adults, remain optional for states to cover. While CMS cannot require states to cover these services without Congressional action, we encourage CMS to provide guidance and/or incentives to states encouraging them to take up options like covering comprehensive dental care of adults.

- Federal policies should continue to support advances in telemedicine as a tool to expand access and ensure adequate reimbursement for telemedicine services.
- In order to promote improvements in rural transportation for Medicaid beneficiaries, CMS should assess whether states are adequately addressing the requirements of the Medicaid program to provide non-emergency medical transportation benefits.

3. *How could CMS consider the concepts of whole person care or care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS*

and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?

Adequate Medicaid access provided at sustainable state and federal costs will require reductions in waste, redundancies, and inadequate community level collaboration. To ensure improvements in rural systems of care for children, coordination should be improved between Medicaid and the State Children's Health Insurance Program (SCHIP). Further, expanded multi-organizational collaboration should be encouraged, if not required, to advance the development of sustainable, integrated community health strategies for Medicaid populations. Additional support may be needed for public health and other initiatives that will foster the expansion of preventive services to rural Medicaid populations. Reimbursement structures need to adequately compensate providers for these services and collaboration between public health entities and providers needs to be fostered.

Oral health. In addition to the types of services mentioned in this question, oral health is part of whole person care. Poor oral health has known effects on chronic conditions, other diseases, the outcomes of surgery, pregnancy outcomes, a child's ability to learn, a person's ability to find work, and more. In addition, medications commonly used for physical and mental illness can cause dry mouth and exacerbate oral health conditions if doctors fail to educate patients and mitigate this. When reviewing waiver requests, for example, we urge CMS to ask states how they plan to integrate oral health care and educate practitioners about disease linkages.

Same-Day Billing. CMS should encourage or require states to eliminate policies that prohibit same day billing by behavioral and physical health providers.

Full Range of Maternal Health Providers for pregnant and post-partum women. CMS should leverage guidance to support states to reimburse culturally rooted certified nurse midwife (CNM) and doula care to assist pregnant and postpartum people. CMS should also encourage states to provide full Medicaid reimbursement of culturally competent CNM. States and/or CMS should recruit an advisory council that includes people from rural, indigenous, and diverse communities to help inform how these providers are best supported.

Chronic Disease Management. Medicaid reimbursement should support chronic disease management and case management programs for Medicaid beneficiaries that improve quality and continuity of care while achieving cost savings. Issues that may be unique to rural populations need more focused assessment. Case management can be particularly beneficial to rural beneficiaries who may need additional assistance identifying providers and in obtaining medically necessary transportation.

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?

Given the profound challenges of recruiting to rural communities, the definition of eligible providers should be expanded to cover all types of primary care, mental health, and oral health providers and to include general surgery (an increasing critical shortage category). Given the need for more rural providers to ensure adequate Medicaid access, training programs for physicians, dentists, advanced practice nurses, registered dental hygienists, and pharmacists should be expanded. There should be particular attention to coordination with educational programs that commit to expanding rural training in settings that provide care to Medicaid recipients and the uninsured, and that demonstrate success in achieving additional rural placements in proportion to funding.

Support for Primary Care. The training of primary care professionals is focused on the health of the whole person, rather than one aspect of health, disease state or bodily system. This makes primary care teams uniquely positioned to coordinate across physical health, mental health services, substance use disorder care, and social care. However, neither the current level of primary care payment for primary care nor the predominant fee-based payment methodology adequately supports this sort of coordination. To ensure primary care practices have the necessary resources to support whole-person care, Medicaid, working in tandem with other payers, should change both how and how much primary care is reimbursed.

Home- and Community-based Services. Long waiting lists for home- and community-based services have been problematic in many rural areas, both because of caps on available slots and due to shortages of caregivers. Some states do not pay family members to provide care, even when doing so could alleviate burdens for many families. CMS should either mandate that states include family caregivers in their home- and community-based workforces, or at a minimum, make this the default option in state plan and waiver documents.

Community Health Workers (CHWs) and Case Managers: CHWs are frontline public health workers who are trusted members of and/or have an unusually close understanding of the rural community served. This trusting relationship enables a CHW to facilitate access to services and improve the quality and cultural competence of service delivery by serving as an intermediary between health and social services and the rural community. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, informal counseling, social support, and advocacy. Case managers perform a similar function, such as making referrals and providing follow-up, facilitating transportation to services and helping to address other barriers to services, and informing people and systems about community assets and challenges. To promote whole-person care and achieve health equity, CMS should better support the full range of services provided by community health workers (CHWs). Medicaid policy should provide adequate funding, meaningful quality guardrails, and assurance that CHW roles and identities are preserved and not over-medicalized.

Pharmacists: Pharmacists are currently not recognized as providers and thus, their services are not reimbursed. Pharmacists help enhance patients' health literacy through providing clinical medication management assistance and support on chronic disease management, especially in rural areas where access to providers may be limited. Adding them to the providers list would allow them to serve as better partners with health centers to fill gaps in care.

Allied Health Providers: CMS should encourage states to reimburse for more allied health professional to increase the available number of health care professionals available to serve

Medicaid and CHIP patients. This includes nurse practitioners, medical assistants, dental therapists, and other critical roles that serve safety-net patients.

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?*

Medicaid helps sustain rural hospitals and other providers. Medicaid provides economic stability for hospitals and other rural health care providers, which have unique challenges delivering care in sparsely populated areas. The Medicaid expansion substantially reduced hospital uncompensated care costs: such costs as a share of hospital operating budgets fell by about half between 2013 and 2015 in expansion states. Rural hospitals are also more likely to turn a profit if located in an expansion state. Conversely, uninsured rates among rural residents are disproportionately higher in states that have not expanded Medicaid, with the rural uninsured rate twice as high in non-expansion states in 2019 (21.5% vs. 11.8%).

Low payments in Medicaid increases demands on safety net providers, including rural hospitals. Poor federal Medicaid revenues increase fiscal strains on these providers who already face a range of challenges that have contributed to increases in closures among rural hospitals in recent years. Provider payments in rural areas must be adequate to assure Medicaid beneficiaries of financial access to services as well as to support recruitment and retention of providers. Specific protections should be implemented for rural providers, requiring state Medicaid plans to set payment rates that would reimburse the allowable cost appropriate to “economically and efficiently operated” rural providers, as defined by the states subject to approval by CMS. This approach should require that providers receiving such cost-based reimbursement receive no less when participating in managed Medicaid programs. This approach should also recognize that Medicaid programs should in some cases reimburse at a higher rate for services in rural areas than in non-rural settings to support the recruitment, operation, and retention of providers.

The vital link between adequate reimbursement for Medicaid providers and access to care for beneficiaries cannot be overstated. When rates fall, many providers either cannot afford or choose

not to treat Medicaid patients. Those that do often are forced to shift the unreimbursed Medicaid costs onto other payers or provide care at a loss. The need for and benefit of increased rural provider payment rates in the Medicaid program cannot be overstated. Studies have shown that increased Medicaid reimbursement rates expand access to care.

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

Federal policy changes and regulatory requirements often have significant and problematic consequences for rural providers. The National Rural Health Association encourages CMS to consider the administrative burden and cost associated may impact rural provider participation in Medicaid. Too often, Federal rules fail to consider the unique circumstances of small or rural community hospitals, including smaller size and limited staff capacity. Throughout 2020, rural hospitals were on the front lines of the COVID-19 pandemic that has impacted rural America disproportionately. These hospitals did not have the time nor the resources they needed to comply with onerous regulations and processes. Rather it pulls limited staff and financial resources in directions that could be better used providing health care to patients, especially in rural areas.

The need for payment policy and other reforms is even more significant in the wake of the COVID-19 pandemic. The health care industry has experienced severe and worsening workforce shortages that are negatively impacting their ability to provide care to vulnerable populations. In order to ensure access to care for rural Medicaid beneficiaries, the National Rural Health Association encourages the Administration to consider promoting any Congressional efforts aimed at reforming the current Medicaid financing framework to increase Medicaid payments to health providers and facilities. This may include legislation to increase investments to support the recruitment, training, retention, and professional development of a diverse clinical and non-clinical workforce, including new incentives and opportunities to practice in rural and underserved areas, additional measures to incentivize more individuals to enter the field, and increasing reimbursement rates. We also urge CMS to use its regulatory authority more immediately to increase provider payment rates and alleviate these staffing shortages.

Other Feedback: At the end of the RFI, there is an opportunity to provide any additional comments you have for this Request for Information that does not apply to one of the previous questions.

ⁱ <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-instructions.pdf>