



**CENTER *for* HEALTH LAW
and POLICY INNOVATION**
HARVARD LAW SCHOOL

The Center for Health Law and Policy Innovation (CHLPI) advocates for legal, regulatory, and policy reforms in health and food systems, with a focus on the health, public health, and food needs of systemically marginalized individuals. The following comments were submitted to the [Access to Coverage and Care in Medicaid & CHIP Request for Information](#) on April 18, 2022.

Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such 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.

Timely and accurate eligibility determinations are always critical to ensure appropriate access to care for Medicaid enrollees, but they are even more imperative now, as states are about to undertake a monumentally challenging and intensive redetermination process following the end of the COVID-19 Public Health Emergency (PHE).

Because health care access for millions of people hangs in the balance of this process, it is important that CMS and state Medicaid programs take every precaution to ensure that this process is done thoroughly and with consideration of the needs of vulnerable communities and those with intensive health care needs. For example, for individuals living with HIV and other chronic illnesses, disenrollment and gaps in coverage have the potential to greatly disrupt access to care and complex treatment regimens, leading to avoidable negative health outcomes.

We are encouraged that CMS has issued guidance to states about managing the PHE unwinding, and that CMS has placed guardrails around disenrollment timelines. However, we recommend that CMS additionally consider the following proposals:

- (1) Require states to engage in a robust stakeholder engagement process to shape their unwinding processes.** States are currently adopting many different approaches to the coming redetermination period, each of which may have different potential impacts on enrollees. See KFF, *States Are Planning for the End of the Continuous Enrollment Requirement in Medicaid After the COVID-19 Public Health Emergency Expires, But Many Have Not Made Key Decisions*, March 16, 2022: <https://www.kff.org/medicaid/press-release/states-are-planning-for-the-end-of-the-continuous-enrollment-requirement-in-medicaid-after-the-covid-19-public-health-emergency-expires-but-many-have-not-made-key-decisions/>. For states to effectively gauge the impact of their strategy, including any unintended consequences, states should be required to solicit input from stakeholders, including patient advocacy groups, providers, and, most importantly, current Medicaid

enrollees. We recommend that CMS require states to hold key stakeholder listening sessions as well as to provide open comment periods on state PHE unwinding plans.

(2) Require states to consider medical need as part of a disenrollment strategy. CMS currently recommends that states take a staggered and strategic approach to prioritizing outstanding eligibility and renewal determinations during the PHE unwinding. However, CMS does not explicitly address how states should consider medical need, including chronic illness or disability status, as part of an enrollment process. Individuals with intensive health care needs, including people living with HIV, are at increased risk for negative health outcomes related to disruptions in care as a result of the PHE unwinding process. Therefore, we encourage CMS to require that states consider medical need as part of any disenrollment process, such as by deprioritizing those enrollee determinations in order to provide as much time as possible for those members to (1) ensure that they are not inappropriately disenrolled or (2) otherwise engage in another health insurance option.

(3) Require states to engage in a robust information campaign to connect newly disenrolled individuals with resources. While we support CMS' guidance to states to address the harms associated with churn and inappropriate disenrollment, we believe that insufficient emphasis has been placed on the need for a robust consumer education campaign, both from CMS and the states. In addition to regular communications to enrollees about the redetermination process, both state and federal agencies should be prioritizing mass media campaigns to inform Medicaid enrollees about the end of the PHE, their rights, and what steps they can take to prevent inappropriate disenrollment. Further, we encourage CMS to begin a federal information campaign as soon as the end of the PHE is determined.

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?

CMS has the opportunity to address churn and improve enrollment retention of Medicaid-eligible people through a number of key policy levers.

First, we recommend that CMS provide additional pathways for states to adopt and implement continuous eligibility provisions. Research shows that continuous eligibility reduces unnecessary churn, improves continuity of care, reduces administrative burden on states, and improves health equity. See Georgetown University Health Policy Institute, Center for Children and Families, *Continuous Coverage in Medicaid and CHIP*, July 2021: <https://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf>. This tool is all the more important as we approach the end of the Public Health Emergency (PHE), where the risk of Medicaid churn and inappropriate disenrollment due to overburdened state administrative systems is particularly high. CMS has helped to create pathways for these provisions by allowing states to implement these provisions with state plan amendments for certain key populations, including children and post-partum adults. But otherwise, states must propose continuous enrollment provisions

through the waiver process. We encourage CMS to offer states the opportunity to provide 24-month continuous eligibility to all Medicaid members through a state plan amendment option.

Second, we recommend that CMS review its policy of allowing states to waive retroactive eligibility through the waiver process. Although 1115 waivers to curtail federal requirements to provide retroactive coverage are relatively common, they are incompatible with both the purposes of the Medicaid program and the purpose of 1115 waivers. Retroactive eligibility helps protect individuals against unforeseen medical expenses immediately prior to their formal enrollment in the Medicaid program. This is most important for individuals who are switching insurance providers or who experience gaps in care due to administrative errors – exactly the kind of challenges that are likely to result as part of the PHE unwinding process. These waivers neither serve to provide coverage to Medicaid-eligible people, which is the goal of the Medicaid program, nor do they constitute a valid “experiment” under Section 1115. Therefore, CMS should revise its policy of approving these types of waivers and waiver renewals.

Third, we encourage CMS to improve pathways for states to provide coverage to individuals transitioning out of correctional settings. As part of the SUPPORT Act, passed in 2018, Congress directed the HHS Secretary, through CMS, to issue a State Medicaid Director letter regarding “opportunities to design demonstration projects under section 1115 of the Social Security Act... the improve care transitions for certain individuals who are soon-to-be former inmates of a public institution,” including through the provision of Medicaid coverage 30 days prior to release. As far as we understand, CMS has not yet released such a letter, although a number of states have expressed interest in providing care pre-release to people in prisons and jails through 1115 waiver proposals, in order to improve the provision of care to people transitioning back into the community. We strongly encourage CMS to issue this legislatively-mandated letter and to provide opportunities to states to facilitate transitions of care and Medicaid enrollment for people reentering society, in order to avoid facilitate enrollment and avoid churn for this high-risk population.

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.

*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 develop minimum standards for Medicaid and CHIP programs that promote high-quality HIV prevention and care, including ensuring beneficiaries have timely access to HIV prevention (i.e., Pre-exposure Prophylaxis and ancillary services) and treatment. Such standards would align with the Administration’s commitment to End the HIV Epidemic, to support the management of chronic medical conditions, and to implement the National HIV/AIDS Strategy.

CMS should also develop clear standards that limit inappropriate utilization management techniques employed by state Medicaid programs and their contracted managed care organizations (MCOs) in the provision of life-saving hepatitis C treatment. Specifically, CMS should reemphasize the agency’s 2015 guidance, which makes clear that the states may not impose

discriminatory UM practices that limit treatment on the basis of disease severity, sobriety, or prescriber type. Additionally, we recommend that CMS also provide guidance to states about the importance of limiting administrative barriers to care, such as overly burdensome reporting requirements as part of the prior authorization process, and advise states on the value of eliminating prior authorization in order to improve access to care, especially for vulnerable populations.

*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?*

To monitor states' performance against minimum standards for high-quality HIV prevention and care, CMS should implement evidence-based quality measures and require states to report on key HIV-related standards, such as viral load suppression and retention in care measures. To support states' compliance with these standards, CMS should update the Joint Informational Bulletin "Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries," last issued in 2016. Significant changes in federal guidance and HIV prevention biotechnology warrants updated recommendations to ensure appropriate access for all Medicaid and CHIP beneficiaries. Where states fail to meet minimum standards, CMS should work with states to leverage policies that can address systemic barriers to HIV prevention and care.

*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?*

CMS should devote increased attention to the rate and network adequacy of mental health coverage in managed care plans. CMS should review plans' internal comparative analysis of non-quantitative treatment limitations. (See <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/faq-38/00018.pdf>) Congress required insurers to create such comparative analysis in the Consolidated Appropriations Act of 2021, to improve enforcement of Mental Health Parity and Addiction Equity Act (MHPAEA), Pub. L. 116-260 (Dec. 27, 2020). Despite an effective date in February 2021, the agencies' recent report to Congress observed that managed care plans are largely ignoring this requirement. (See <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf>) Requiring managed care plans to live up to the requirements of MHPAEA by creating these analyses, and to work together with state partners to improve mental health coverage where the analysis reveals shortcomings is a key step in overcoming the mental health access crisis. CMS could also require publication of these internal analyses to improve transparency and improve understanding of coverage and plan design.

*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?

CMS can support states in increasing and diversifying the pool of available providers by encouraging state Medicaid and CHIP programs to incorporate Community Health Workers (CHWs) into their covered services. CHWs are trained frontline staff who act as a crucial bridge between communities, patients, and health care providers.

By providing support in homes and communities, CHWs allow patients to better manage chronic health conditions, resulting in improved health outcomes and reduced health care costs.

CHWs often reflect the diversity of communities served and can serve as a key component in outreach to underserved communities. As states incorporate CHW services into covered benefits, policymakers should actively solicit engagement from CHW stakeholders to ensure that overly burdensome requirements do not exclude a diverse workforce.

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).

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.)?

CMS should measure potential access to gender affirming care, including but not limited to hormone therapy, facial reconstruction surgery, durable medical equipment (e.g., binders), breast/chest surgery, genital surgery, voice therapy, hair removal, and body contouring. Measures of potential access should include availability of coverage and timeliness of care. CMS should pay particular attention to addressing categorical exclusions of gender-affirming care and ensuring provider networks are broad enough to include providers with low appointment wait times. CMS should also consider grievance, appeals, and denial overturn rates within Medicaid programs to measure whether beneficiaries have practical access to these services or whether prior authorization requirements present unworkable or overly burdensome pathways to care.

Other Feedback

Using this text box, please provide any additional feedback you have for this Request for Information that does not apply to one of the previous questions.

We applaud CMS for providing this opportunity for comment on issues related to access to care and coverage for people enrolled in Medicaid and CHIP. As a final point, we would like to encourage CMS to engage in a similar data-gathering effort to better understand current barriers

and best practices in state efforts to address social determinants of health and health-related social needs (HRSNs) for individuals enrolled in these programs.

Social needs, such as food insecurity, housing insecurity, and lack of transportation, have a tremendous impact on health outcomes and health care costs. As a result, many states are working to integrate responses to these issues into their Medicaid programs through waivers, managed care authorities, and other pathways. By circulating a request for information, CMS could gather valuable information on common barriers and best practices and use that information to provide guidance and technical assistance to better support these efforts. In particular, we recommend that CMS request information from relevant stakeholders, including states, plans, and advocacy organizations, on:

- (1) **Payment:** Current use of (and questions regarding) policy pathways to cover/pay for HRSN interventions in Medicaid;
- (2) **Infrastructure:** Infrastructural gaps creating barriers to partnership between social service organizations and Medicaid programs/plans (e.g., gaps in infrastructure for billing, coding, referrals); and
- (3) **Regulation:** Common questions regarding how core health care compliance frameworks (e.g., HIPAA, Civil Monetary Penalties, and Anti-Kickback statute) impact partnerships between social service organizations and Medicaid programs/plans.

We recognize that some of these issues may implicate a wider array of offices/departments within HHS. We therefore encourage CMS to also use information gathered through this RFI to inform cross-agency planning and technical assistance.