PolicyLab

April 18, 2022

Re: Centers for Medicare and Medicaid Services Request for Information on Access to Coverage and Care in Medicaid and CHIP

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

- ***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?***

  As CMS considers how to support states in addressing barriers to enrollment and retention of eligible individuals in Medicaid and CHIP, we would urge consideration of the family unit. We know that children are more likely to be insured if their parents are also insured, so aligning enrollment policies between children and parents can help families obtain ongoing and coordinated access to health care. To ensure the whole family has coverage, we encourage policies that support a 'no wrong door' approach, through which families are connected to Medicaid and CHIP regardless of where they interface with public services. This may require close collaboration with agencies that provide other services such as nutrition supports, or incentives to states to encourage cross-systems linkages in implementation. Also, in data from 2018, more than half of uninsured children nationally were eligible for Medicaid or CHIP but not enrolled, highlighting the importance of investing in outreach efforts to families and addressing barriers to enrollment and coverage renewal.

  We would highlight the following priorities to specifically address barriers to enrollment and retention of eligible individuals in different population groups:

- **Ensuring coverage for youth with mental health or substance use disorders -** With the burgeoning behavioral health crisis among youth, it is critical that we ensure that youth have access to coverage that will meet their needs and offers care in accessible settings. Prior to the COVID-19 pandemic, 35% of youth who received behavioral health services did so in schools, illustrating the key role schools play in supporting positive youth behavioral health. In some states, schools may also utilize and receive Medicaid funding (administrative claims) to dedicate resources and capacity to enrolling students in Medicaid. We would encourage CMS to work with states to consider how to best support schools in enrolling eligible youth in Medicaid. More recommendations on how to meet the behavioral health needs of youth are included in responses within Objective 3 of this request for information as well as in CHOP PolicyLab's response to the U.S. Senate Committee on Finance's Request for Information on Addressing Unmet Mental Health Needs.

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- **Addressing needs of immigrant and limited English proficiency communities** – In a CHOP PolicyLab led survey of immigrant community leaders and other stakeholders working with immigrant communities and those with limited English proficiency (LEP) in Pennsylvania during the COVID-19 pandemic, respondents emphasized the importance of working with thoughtfully selected messengers, including formal or informal community leaders, to share information. This is also essential as it relates to supporting enrollment in public safety net programs, including Medicaid and CHIP. States should invest in navigators and enrollment supports for those with LEP specifically. Furthermore, the Public Charge Rule has caused a 'chilling effect' in terms of immigrant community uptake of public programs. Thawing this chill will require investment in outreach strategies to immigrant communities to communicate about recent changes to the Rule. We encourage CMS to work closely with the Department of Homeland Security as that agency undertakes rulemaking efforts to codify an equitable definition of public charge – see CHOP PolicyLab's comment on that rulemaking process here. We also recommend that CMS continue its outreach to states to encourage them to clarify current public charge policy.

- **Meeting the needs of pregnant and parenting people, including those with substance use disorder -** While the flexibility afforded states in the American Rescue Plan Act to extend pregnancy eligibility for Medicaid to one year following birth is an important step, it will be important to ensure broad uptake of this option by states. CMS should consider how to further incentivize all states to do so and continue to work with Congress to mandate and make permanent the extension of Medicaid coverage in the postpartum period. CMS should also support states with outreach strategies that reach pregnant and postpartum individuals, including through pediatric health care providers, so that the full benefit of this policy change can be realized. In addition, CMS should work with states to support workforce investments such as Medicaid payment for doulas, peer support specialists, home visitors, and community health workers that can help families navigate health care and coverage decisions in the perinatal period.

Objective 2: Medicaid and CHIP beneficiaries experience consistent 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 Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualified supports who transitions to other Medicaid services such as home and community based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the Marketplace); or across state boundaries? Which of these actions would you prioritize first?***

CMS should work with and incentivize states take up the option of Medicaid continuous enrollment for all children, allowing children to remain eligible and enrolled in Medicaid or CHIP for 12 months (or more) regardless of changes in family income. CMS should also encourage and incentivize states to implement policies that further streamline children's enrollment in Medicaid and CHIP, such as presumptive eligibility and express lane determinations. The response to this request for information from the Children's Hospital Association, which CHOP contributed to, offers further details on how CMS and HHS leadership can support state-based legislative changes that could help streamline eligibility and enrollment of children in Medicaid and CHIP.

State agencies often do not communicate well with each other, leaving state Medicaid agencies without access to relevant income or address information that other agencies have. CMS should continue to encourage collaboration among state agencies and the aligning of public assistance data systems. This is especially true for states that continue to rely on outdated and burdensome paperwork processes for Medicaid and CHIP eligibility and enrollment processes, and we would encourage CMS to work with states to modernize and streamline these processes. As is they create undue administrative burden for families that results in application delays and coverage disruptions, as well as unnecessary churning on and off Medicaid and CHIP. For example, an estimated 50,000 children in Texas lose Medicaid each year because families do not file eligibility paperwork on time, but one in three of these children re-enrolls within the year.

The continuous enrollment in Medicaid during the course of the COVID-19 Public Health Emergency has been essential for protecting against this churn. However, with states facing a mass re-enrollment event as early as summer 2022, protecting against unnecessary disenrollment from Medicaid is essential. As part of this, consideration must be given to the fact that minorities were more likely than others to have moved during the COVID-19 pandemic. CMS should work with states to develop plans that are responsive to this in order to protect worsening disparities in health care coverage. CMS should support states to take proactive steps to keep mailing addresses current using the USPS National Change of Address Database or contracting with an external vendor.

Furthermore, it will be essential for state Medicaid agencies to partner with community-based organizations to communicate information about re-enrollment processes to support hard-to-reach populations, using a range of channels. CMS can support these partnerships by providing tools and guidance to help states implement additional opportunities for enrollment in all services (Medicaid, CHIP, SNAP) through community-based services and Federal and state tax filing. CMS should also encourage states to leverage community non-profits that are already engaging with the potentially eligible population, e.g. food pantries, housing assistance, to support enrollment efforts.

CMS should also encourage and support states to implement a 'no wrong door' approach between Medicaid, CHIP, and the state's health insurance marketplace. Such an approach to benefits education and enrollment by state agencies would ensure that all relevant agencies can screen and help individuals to enroll in these essential programs. The ACA health insurance marketplace enrollment processes should direct families to Medicaid and CHIP when eligible. This is especially important in the states, such as Pennsylvania, that have a CHIP 'buy-in' option, as CHIP offers a much more comprehensive and robust set of pediatric benefits than plans on the exchanges, with limited cost-sharing.

Finally, we would note that teens and young adults with intellectual and developmental disabilities face unique challenges as they transition to adult coverage, services and medical care. CMS should work with states to ensure that these individuals do not face a gap in their Medicaid coverage or access to services as they make this transition, and consider investments in programs that coordinate support for these individuals and their families, such as this one run by CHOP.

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

- ***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?***

We have seen the limits of delegating questions of network adequacy, essential health benefits, and physical and behavioral health parity to states. It would be an important step for CMS to develop minimum standards AND to have enforcement mechanisms at both the federal and state levels.

Furthermore, CMS should specifically consider pediatric network adequacy standards, including as it relates to behavioral health. As CMS and state partners explore quantitative standards for network adequacy, it is important to watch that these standards ensure access to pediatric specialty care. Several states have adopted time and distance standards for health plans, based on those used in Medicare Advantage. However, research has shown that nearly half of all pediatric specialty hospitalizations would be beyond the distance requirements, including standards specific to the rurality of the child's home county.

Determining network adequacy is a complex challenge that must reflect the makeup of the available providers as well as beneficiaries' needs, and increasingly the potential use of telehealth. Access to providers should be assessed in terms of proximity, but should also consider availability of providers that are accepting new enrollees, availability of providers that offer specific expertise (e.g., child-focused) and time-to-service. Equally important are measures of how well the network meets beneficiaries' needs, including perceived needs. To measure beneficiaries' perceived access, it is important to consider meaningful indicators related to who is offering the services (e.g. racial/ethnic backgrounds, gender identity, sexual orientation), the languages in which services are offered, and availability of follow-up care. Network adequacy determinations may need to take the needs of different populations into account. Mental Health America has been leading a coalition effort, to which CHOP PolicyLab is contributing, to form a set of principles specific to pediatric network adequacy for behavioral health. There is more detail in their response to this request for information.

Finally, the issue of network adequacy is especially important for children with medical complexities. These children and their families have unique care needs and often navigate

multiple health care providers. To this end, CHOP supported legislation recently passed in New Jersey that redefined network adequacy for pediatric primary and specialty care and allows for Medicaid patients to be treated at out-of-state specialty hospitals. The legislation stipulates that Medicaid managed care plans must allow children with medical complexity appropriate access to both specialty care and pediatric-specific case management. It also established pediatric network adequacy requirements, outlining the full range of services, through quaternary care, which each managed care entity must have within its regular network. Stipulating these parameters as requirements addresses concerns voiced by Medicaid managed care organizations that having the full spectrum of pediatric specialty services available in-network can be a significant competitive disadvantage, i.e. result in adverse selection, when not all Medicaid MCOs are required to do the same.

In addition to measurement, CMS should prioritize oversight of the network adequacy standards. To do this, CMS should establish national quality measures of care adequacy that reflect the points above and ensure dedicated funding is available at the federal and state level to carry out this oversight.

- ***How could CMS consider the concepts of whole person 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?***

A commitment to whole person care requires investments in the workforce that supports care coordination and addressing health-related social needs, including community health workers, home visitors, and peer support specialists. Furthermore, it requires removing payment-related barriers to the integration of behavioral and physical health care services.

In order to support access to care for pregnant and postpartum people with behavioral health needs, including substance use disorder, CMS should first and foremost encourage states to take up the option of extending postpartum Medicaid coverage to 12 months after delivery. To serve the postpartum population, and especially as it relates to behavioral health, CMS should also consider further payment flexibility and incentives to states to adopt the options that already exists related to dyadic and integrated care delivery. CHOP PolicyLab's work highlights the opportunity of the pediatric setting to identify caregiver mental health needs and support connection to care, but that to do so requires innovation by state Medicaid programs, which CMS could bolster and incentivize. It is also important to address barriers to care for specific populations, such as parenting teens.

As it relates to the behavioral health needs of children and youth, fewer than 50% of children referred to mental health services access them, in part because it can be complicated and confusing for families to navigate the mental health care system. Care navigators, who may be social workers, community health workers, or other non-clinical professionals, support the

patient and their family in connecting with mental health care providers and resources. While care navigator models vary, families who have worked with care navigators are more likely to complete assessments and stay engaged in care. In addition, providers are identifying many more patients who need mental health services with the increasing mandates for mental health screening in the primary care setting. This underscores the need for investing in care coordination to link these youth to services, as well as payment policies to support these coordination efforts. CMS should take steps to facilitate state payment policies that support care coordination services for clinical and nonclinical mental health workers.

Integrating mental health care in primary care settings for both children and their caregivers will improve children's overall well-being. The primary care setting offers a critical opportunity to identify mental health needs. Most children see a primary care provider at least once per year and pediatricians are often the first to identify a mental health condition. Integrating mental health providers into primary care settings substantially improves treatment initiation and allows for a "warm handoff" between a pediatrician and a specialist.

Health care payment policy is a powerful lever to drive changes in care delivery and should support and incentivize integrated and coordinated mental health care, including preventive services in physical health care settings. As essential groundwork for this, reimbursement rates for behavioral health providers need to be consistent with physical health reimbursement.

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

CMS should encourage states to collect data on preferred language in CHIP and Medicaid applications, and also support states to disaggregate their available data related to issues such as the availability of services in non-English languages. This information could be used to both better connect with families, and to gather data that can be used to monitor disparities. While interpretation services must be available and reimbursed, providers and staff should also be trained on how to effectively use telephonic and in-person interpretation services. Any efforts to study and improve language access should carefully consider the role of intake and non-clinical staff, who are often the first point of contact for patients. Finally, CMS should ensure that health systems address lesser-spoken languages, as opposed to focusing merely on the most commonly spoken non-English languages in a region.

- ***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 should encourage and support higher reimbursement rates for Medicaid providers, and particularly Medicaid behavioral health providers. Historically low Medicaid reimbursement rates make it exceedingly difficult for these safety net providers, who are already operating on thin margins, to weather any kind of financial downturn, and this further limited much-needed behavioral health services during the COVID-19 pandemic.

Even as we emerge from the COVID-19 pandemic, CMS should encourage states to promote telehealth access and work with states to ensure that Medicaid programs continue to cover telehealth services. These services have proven particularly important for supporting access to care in rural areas or in specialties with pronounced workforce shortages, e.g. adolescent behavioral health. To reach the underserved, we also recommend the inclusion of audio-only services. Increased reimbursement rates for telehealth services supported the rapid expansion of these services during the pandemic and should be continued at an appropriate level to maintain children's access to telehealth services. Telehealth across state lines is also an important way to improve access to pediatric specialty care providers, particularly in states where these specialists are in short supply.

State can also increase and diversify the pool of available providers for Medicaid and CHIP by considering how they support and finance service delivery in a diversity of settings, including community and school-based services. As it relates to youth behavioral health needs, investing in evidence-based prevention programs that can be delivered in the community will reduce the burden in secondary and tertiary care settings and enable child psychiatrists and psychologists to serve those who need them most. CMS should work with states to explore payment models for supporting staff that deliver preventive services in community settings, such as schools, primary care practices, child care settings and afterschool programs. This creates the opportunity to leverage embedded staff and trusted relationships, while also maximizing reach and impact, particularly for communities of color and other underserved populations.

Specific to the school setting, CMS can better support payment for school-based health services. While CMS allowed states to permit schools to bill Medicaid for school-based health services for all Medicaid-enrolled students, not just those with an Individualized Educational Program, most states need to update their Medicaid plans to access these funds. Many school districts report challenges and barriers in accessing these funds, and CMS can improve its guidance to support states and schools to navigate the processes. One important barrier is misalignment between the licensing requirements of the different agencies involved in school-based health services. Several state entities (e.g., state Medicaid plans, departments of education, state licensing boards) may be involved in determining what provider types may treat youth in a school setting and if the provider is eligible for Medicaid reimbursement. CMS should work with and support states to consider how to align licensing so that a many different provider types can offer services in the school setting and be eligible for reimbursement.

Youth spend most of their time in school and schools are a key setting for them to receive mental and behavioral health services. Prior to the COVID-19 pandemic, 35% of youth who received behavioral health services did so in schools. Schools need additional resources to provide behavioral health services to their students, including sustainable funding for preventive services. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is one such opportunity. While EPSDT includes behavioral health screening and treatment, there are limited examples of Medicaid funds supporting behavioral health care (e.g., preventive) for youth that do not have a behavioral health diagnosis. CMS can more clearly provide guidance on

the EPSDT benefits such that they can apply to preventive behavioral health services in clinical and community settings, such as schools.

Sincerely,

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