November 4, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Request for information: Make your voice heard—Promoting efficiency and equity within CMS programs

Dear Administrator Brooks-LaSure:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am submitting these comments in response to the request for information (RFI), Make your voice heard—Promoting efficiency and equity within Centers for Medicare & Medicaid Services (CMS) programs (CMS 2022a). We appreciate the opportunity to comment and share the views of the Commission, as well as highlight key findings from our prior work.

Our comments focus on two of the four topics described in the RFI, advancing health equity and the impact of the COVID-19 public health emergency (PHE) waivers and flexibilities. As you may be aware, MACPAC has committed to examining how it can best contribute to combating structural racism and addressing racial disparities in health care and health outcomes by embedding a health equity lens across all of its work. The Commission has also closely followed federal and state developments related to the COVID-19 PHE, particularly related to the unwinding of the continuous coverage requirement.

We appreciate the opportunity to comment on this RFI and commend CMS's commitment to engaging stakeholders as the agency seeks to ensure that beneficiaries can access the care they need and that the program operates as equitably and efficiently as possible. In addition to sending you this letter, we have submitted our comments through the online portal.

Advancing Health Equity

The Commission is encouraged by the steps CMS and states are taking to advance health equity, but note the need for ongoing work to identify and implement specific steps to ensure that all Medicaid beneficiaries, particularly those that have been historically marginalized, have opportunities to be as healthy and independent as possible. Below we note some particular areas within the subtopics identified in the RFI where CMS's ongoing work and commitment are warranted.

Recommendations for CMS focus on areas to address health disparities and advance health equity, particularly policy and program requirements that may impose challenges to the individuals CMS serves and those who assist with delivering healthcare services

Below we note three areas where CMS focus is needed to address health equity among beneficiaries.

Collecting and reporting race and ethnicity data

Addressing concerns with the quality of race and ethnicity data across state-level data sources is needed to ensure that CMS and states have a complete and accurate understanding of racial and ethnic health disparities among Medicaid beneficiaries and can identify opportunities to address them (MACPAC 2022a). In 2020, 15 states had data of low concern, 17 had data of medium concern, 16 had data of high concern, and 4 states had unusable data (CMS 2022b).

Recent MACPAC work has identified several challenges for collecting and reporting race and ethnicity data. These issues can prevent beneficiaries from self-reporting their race and ethnicity, which would typically happen as part of the application process and is voluntary. Self-reported data are considered the gold standard because individuals select the identity that best reflect themselves. Challenges include beneficiaries' discomfort providing sensitive information because of concern about how the information may be used or because they are unsure how to answer race and ethnicity questions, particularly if their identities are not included among the response choices. For example, individuals from Middle Eastern and North African (MENA) populations may check "other" and write-in their country of origin.

We also learned that some states have designed Medicaid applications to collect multiple race and ethnicity categories but that they have difficulties aggregating the data to meet the federal reporting requirements. Federal reporting only allows for the reporting of one race and one ethnicity, which may affect data accuracy and completeness. One state that collects multiple race and ethnicity categories said that they select the first choice alphabetically when processing multi-racial and multi-ethnicity information for submission to the Transformed Medicaid Statistical Information System (T-MSIS). Another state's application allows for multi-race or multi-ethnicity responses, but the Medicaid Management Information System does not, and defaults them to null values. These null values are then categorized as missing when the state submits to T-MSIS, contributing to the state's high rate of missing data.

In addition, MACPAC has recommended that CMS further standardize and improve T-MSIS data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity (MACPAC 2022b). T-MSIS is the only federal Medicaid data source with person-level information on eligibility, demographics, service use, and spending. However, quality concerns and coding inconsistencies make state- and population-level comparisons difficult. Additional consistency in variable definitions would allow for a more accurate and complete assessment of the services people are using and the providers they are seeing.

Improving the collection of race and ethnicity data is important for supporting other state and federal efforts, such as measuring quality of care using the core set measures. The Commission supports CMS's efforts to collect the child core set, adult behavioral health core set, and health home core set measures stratified by factors such as race and ethnicity (MACPAC 2022c). Such reporting will provide standardized data on state performance on a uniform set of measures, which will help to identify disparities and help states target quality improvement efforts. MACPAC urges HHS and CMS to expedite specific guidance for states on which measures will be required for reporting as well as the expectations for stratification (MACPAC 2022c). Delaying such guidance could hinder

states' ability to prepare for core set reporting, which in turn would delay the availability of this data. The rule proposes to require a phase in of stratified reporting over five years to provide states time to develop the capability for such reporting given the known challenges with collecting and reporting race and ethnicity data. The Commission urges CMS and HHS to work with states now and during the phase in period to improve data collection and other technical capacities needed for stratifying core set measures (MACPAC 2022c).

The Commission recognizes the need to address inequities and disparities experienced by beneficiaries who are too often marginalized for other reasons, such as their age, disability, sex, gender identity, sexual orientation, and geography. Ongoing work to address data gaps and improve collection of these demographic characteristics of Medicaid beneficiaries is needed. These data can be used to understand how intersectionality (that is, how an individual's multiple social identities that have been affected by oppression (Crenshaw 1989)) may be affecting access to and quality of care for Medicaid beneficiaries, and for developing approaches to address concerns. For example, it is important that data identify inequities and disparities for persons with disabilities in ethnic and minority populations. In addition, historically, few national data sources have included questions about sexual and gender identity and those that do collect these data do not consistently use the research validated instruments for asking about sexual orientation and gender identity, which can limit the comparability and accuracy of the data (NASEM 2020, SHADAC 2021, Badgett 2009, Herman 2014).

Monitoring access to care

In June 2022, MACPAC recommended that CMS develop an ongoing and robust access monitoring system consisting of measures for a broad range of services that are comparable across states and delivery systems. (MACPAC 2022b). The Commission stated that an access monitoring system should examine potential and realized access and beneficiary perceptions and experiences, and that it should prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities. These include, for example, children with special health care needs, people with disabilities, sexual and gender minorities, individuals involved in the justice system, and people of color, as well as those who may be marginalized for other reasons. MACPAC also recommended that CMS field an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care, an area where data currently are lacking (MACPAC 2022b).

It is the Commission's view that an access monitoring system should examine access for all Medicaid beneficiaries, but should prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities. For example, we note that recent MACPAC analysis found that in 2015-2019, lesbian, gay, and bisexual (LGB) adults with Medicaid were significantly more likely than heterosexual adults to report having a mental illness or substance use disorder and to not receive needed treatment in the past 12 months. In 2015, transgender and gender diverse (TGD) adults covered by Medicaid were more likely to report not being able to find in-network providers to provide gender-affirming surgery (MACPAC 2022d).

Individuals eligible for Medicaid who are involved in the criminal justice system experience delays in getting coverage, and once covered can have unmet health needs. For example, from 2015–2019, nearly one in three Medicaid beneficiaries (31 percent) under community supervision reported that they needed mental health treatment or counseling and did not receive it, and Black beneficiaries (42 percent) with mental illness were significantly less likely than their white counterparts (62 percent) to report receiving treatment (MACPAC 2021a). In addition, Medicaid and the State Children's Health Insurance Program (CHIP) cover 60.4 percent of children or youth who had stayed overnight in jail or juvenile detention. About one-in-five (21.7 percent) of these youth reported experiencing a major depressive episode at some point in their lifetime, and approximately 16.4 percent reported experiencing one in the past year (MACPAC 2021b). Finally, monitoring access to long-term services and supports (LTSS), particularly home- and community-based services (HCBS), is especially important given the

predominant role of Medicaid in funding these services, and racial and ethnic disparities in outcomes and use of services among HCBS users (Georges et al. 2019, Fabius et al. 2018, MACPAC 2022e). In addition, barriers to accessing HCBS, such as workforce shortages, may further exacerbate these disparities.

The Commission has also said that as part of its role in monitoring access to care, CMS should be responsible for setting standards or benchmarks for access to care with state involvement to ensure the feasibility and meaningfulness of measures. For example, CMS could calculate baseline measures for states over a multi-year period. These data would provide a range of state-level results to determine reasonable minimum thresholds of access to care and benchmarks for improved access over time (MACPAC 2022b).

We note that a potential source of information for measuring access to care is data on complaints, grievances, and appeals, but these are not consistently captured by states or plans, and are not always shared with states and CMS. In considering how these data can be used for access monitoring, it will be important to understand which beneficiaries (e.g., English speakers vs. those with limited English proficiency) are or are not likely to have complained, or filed grievances and appeals (MACPAC 2022b).

Individuals dually eligible for Medicare and Medicaid

It is the Commission's strongly held view that furthering integration has the potential to improve beneficiary outcomes and promote more effective and efficient coordination between Medicaid and Medicare, potentially reducing spending and promoting equity (MACPAC 2022f). MACPAC has recommended requiring states to develop strategies to integrate Medicaid and Medicare (MACPAC 2022g). Among dually eligible beneficiaries, there were proportionately more Black (21 percent) and Hispanic (17 percent) beneficiaries than among the non-dual Medicare population (9 percent and 6 percent, respectively) (MACPAC and MedPAC 2022). Additionally, dually eligible beneficiaries have more health care needs and report worse health status than Medicare-only beneficiaries. For example, among dually eligible beneficiaries, 25 percent report three or more limitations in activities of daily living, compared to 7 percent of Medicare-only beneficiaries (MACPAC and MedPAC 2022). They are also more likely to qualify for Medicare based on disability (51 percent) than Medicare-only beneficiaries (15 percent) and less likely to self-report excellent or very good health than Medicare-only beneficiaries (20 percent versus 50 percent) (MACPAC and MedPAC 2022).

Pregnant individuals

We are encouraged by the number of states expanding postpartum coverage to 12 months and appreciate CMS's ongoing efforts to work with states seeking to expand this coverage. Given the ongoing disparities in maternal outcomes, MACPAC previously recommended extending postpartum coverage for individuals eligible for Medicaid and CHIP to 12 months regardless of changes in income. The Commission also recommended requiring states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways. Inadequate postpartum care may contribute to persistent racial and ethnic disparities in maternal and infant health outcomes. Black, non-Hispanic women and Indigenous women have higher risks of maternal morbidity and mortality (MACPAC 2021c).

Recommendations on how CMS can better promote and support accommodations, including those from providers and health plans, for people with disabilities and/or language needs or preferences

MACPAC's recent work on beneficiary communication preferences identified the need to ensure that beneficiaries with disabilities or with language needs or preferences are able to access services. Multiple modes of communication are needed to reach beneficiaries with different communication preferences and comfort levels with technology. Having multiple methods to apply for Medicaid, as well as to receive and access information, is

necessary to reach everyone. Beneficiaries have noted the importance of having different communications options available (MACPAC 2022h). This includes American Sign Language (ASL) for persons who are deaf and hard of hearing. Although states have worked on ensuring accessibility of communications, challenges persist, including for example, issues logging into and using online accounts. MACPAC has learned that some beneficiaries with disabilities who use assistive technology, such as screen readers, face difficulty using state online systems. In addition, lack of access to high-speed broadband service at home and the affordability of internet service or devices limit their use by applicants and enrollees (MACPAC 2022h). Finally, our past work has found that many beneficiaries would like to receive text messages and some automated phone calls from the state regarding their coverage. However, HHS and CMS noted that concerns about violating the Telephone Consumer Protection Act (TCPA, P.L. 102-243) has hindered efforts by states and their partners in using text messages and automated, prerecorded calls (MACPAC 2022h).

Medicaid beneficiaries may also face transportation barriers to accessing care. States must ensure necessary transportation for beneficiaries to and from providers. However, beneficiaries have expressed concerns such as late pickups, ill-equipped vehicles, and long call center wait times. The most frequent users of Non-Emergency Medical Transportation (NEMT) include beneficiaries who are eligible for Medicaid on the basis of disability or age and those with certain conditions, including end-stage renal disease, intellectual or developmental disabilities, and behavioral health conditions. The extent to which NEMT programs meet the needs of beneficiaries appears to vary widely across and within states. Racial and ethnic disparities in the conditions present among frequent NEMT users are well documented, including disparities in disease prevalence, access to care, quality of care, and outcomes (MACPAC 2021d). More data and research are needed to understand whether there are racial and ethnic disparities in access to and use of NEMT (MACPAC 2021d).

Feedback on enrollment and eligibility processes, including experiences with enrollment and opportunities to communicate with eligible but unenrolled populations

CMS and states have been working to streamline eligibility and enrollment process, particularly since the enactment of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). MACPAC's work has described the outcomes of such efforts as well as identified ongoing opportunities for continued focus.

Streamlining processes

MACPAC's response to the April 2022 RFI on access to care provided extensive information about findings from our past work on the effects of simplification and streamlining of enrollment processes with a focus on state approaches for prioritizing real time enrollment and renewal for certain beneficiaries, and the effect of using combined online applications on beneficiary access to programs and reduced beneficiary burden. We highlighted beneficiaries' need for clear and easy to understand notices about the steps they need to take to enroll or renew their coverage, and the need for ensuring accurate and current beneficiary contact information (MACPAC 2022e). States have historically grappled with these issues, but the COVID-19 pandemic has laid bare the need to address them.

MACPAC also plans to comment on the recently proposed rule making changes to Medicaid application, enrollment, and renewal processes. Several of these proposed changes are consistent with MACPAC's prior work and support of efforts to streamline application and enrollment processes to facilitate the enrollment of eligible individuals and to reduce individual and state burden (MACPAC 2022 nd).

Given the high level of focus by CMS and states on the unwinding of the continuous coverage requirements of the PHE, and the renewed focus on ex parte renewal processes, the Commission notes the need to address

challenges with using this process. States are already required to use ex parte processes, which may reduce administrative burden associated with renewals for beneficiaries and state and county eligibility staff. However, the share of renewals completed using the ex parte process varies by state, including 22 states completing less than 50 percent of renewals using ex parte. States have identified challenges to their ability to use ex parte; these include for example, connecting to data sources, resource constraints for making needed systems changes, and with respect to the non-MAGI population, interaction with the electronic asset verification systems that states are required to use (MACPAC 2022e). Greater use of ex parte processes may be helpful in reducing the level of churn among Medicaid beneficiaries. MACPAC found that in 2018, about 8 percent of Medicaid beneficiaries churned on and off Medicaid within 12 months, with higher rates of churn among Black and Hispanic beneficiaries compared to white beneficiaries (MACPAC 2021e). Overall, 9.4 percent of non-Hispanic, Black beneficiaries and 8.4 percent of Hispanic beneficiaries disenrolled and re-enrolled within 12 months, which was higher than the rate for non-Hispanic, white beneficiaries (8.0 percent) (MACPAC 2021e).

Individuals dually eligible for Medicare and Medicaid

Over the last several years, the Commission has spent considerable time examining coverage and care for individuals who are dually enrolled in Medicare and Medicaid, including issues related to Medicare Savings Programs (MSP) and dual eligible special needs plans (D-SNPs).

MSP. It is the Commission's view that more work is needed to streamline eligibility determinations for MSPs, which have historically had low enrollment. Low enrollment in the MSPs has been an ongoing concern for policymakers because cost-sharing assistance can affect beneficiary use of services. A 2017 MACPAC analysis found that 15–53 percent of eligible individuals were enrolled in MSPs, depending on the program (MACPAC 2017). One of the key factors contributing to low take up of MSPs is conflicting enrollment and eligibility requirements between the MSPs and related federal programs such as the Part D Low-Income Subsidy (LIS) program, which is administered by the Social Security Administration (SSA) and CMS (MACPAC 2020a).

Congress and CMS have acted to streamline eligibility and enrollment for MSPs but program participation remains low. Congress has previously aligned MSP and LIS asset limits and required eligibility data transfer from LIS to MSP. We also note that CMS has previously issued guidance and provides technical assistance to states on simplifying the eligibility determination process in the MSPs. However, many states still use asset counting rules that differ from those used by SSA for the LIS program (MACPAC 2020a). This can prevent states from using the SSA data to assess eligibility for the MSPs and may require beneficiaries to submit additional documentation (MACPAC 2020a).

In September, CMS proposed a number of regulatory changes to streamline enrollment in MSPs. The Commission will be submitting detailed comments regarding the MSP and several other provisions in response to CMS's proposed rule making changes to Medicaid application, enrollment, and renewal processes. The Commission supports changes that would increase enrollment in MSPs and streamline eligibility determinations. For example, policies in the proposed rules to require states to accept and treat verified electronic data regarding eligibility for the Part D Low-Income Subsidy program from SSA as an application for Medicaid without requiring further documentation from beneficiaries are consistent with previous MACPAC recommendations. The Commission also supports a requirement that states accept the attestation of the value of certain types of income and assets, and adopt the LIS definition of family size for purposes of MSP eligibility.

D-SNPs. The Commission has previously expressed concerns regarding processes and assistance for beneficiaries in enrolling in D-SNPs (MACPAC 2022g). In a January 2022 proposed rule, CMS suggested that states convert Medicare-Medicaid plans (MMPs) to D-SNPs. MACPAC's comments noted the importance of individualized benefit counseling as well as a dedicated ombudsman program, which were required under the Financial Alignment Initiative and received dedicated funding. MACPAC views ombudsman programs as valuable

in protecting beneficiaries in two distinct ways: educating them about their coverage and investigating and resolving their complaints (MACPAC 2022g). Given that dually eligible beneficiaries often lack access to a single, impartial advisor to help them compare a complex set of coverage options, the Commission has expressed concern about the loss of these important consumer protections and the resources that support them in moving from MMPs to D-SNPs.

MACPAC previously described the need for CMS to provide guidance to states on implementing default enrollment into D-SNPs. Certain states can use default enrollment to allow D-SNPs to automatically enroll a Medicaid member becoming eligible for Medicare if the D-SNP is of the same parent company as the beneficiary's current Medicaid plan. Default enrollment may facilitate enrollment and retention in D-SNPs similar to the way passive enrollment does for MMPs (MACPAC 2019). However, not all states can use default enrollment, and for states that can, it may be challenging to implement. This is particularly true for states whose staff have limited Medicare expertise.

Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

Through the RFI, CMS seeks to understand the impact of waivers and flexibilities issued during the PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

Examining the effects of PHE waivers and flexibilities on access to care, health equity, and reducing provider and beneficiary burden may be instructive to state and federal policy and programmatic efforts to address these issues. For example, there may be opportunities to streamline provider enrollment policies and processes for providers who routinely serve patients from different states. A MACPAC analysis of out-of-state hospital use found that on average, children's hospitals served beneficiaries enrolled in more than six states (MACPAC 2020b). MACPAC has also highlighted provider shortages in certain regions of the country (e.g., rural areas) or certain provider types (e.g., behavioral health, oral health) (MACPAC 2021f, 2021g, 2015).

Reviewing pandemic waivers and flexibilities would also be consistent with MACPAC's recommendation that the Secretary of HHS (in collaboration with the states) create feedback loops to simplify and streamline regulatory requirements; determine which current federal program integrity activities are most effective; and take steps to eliminate programs that are redundant, outdated, or not cost-effective (MACPAC 2022c).

The Commission highlights the need to examine the effects of telehealth in Medicaid given its increased use during the COVID-19 pandemic and the likelihood of its ongoing use. CMS and states should now have more experience and data for understanding the effects of telehealth on access, cost, outcomes, quality, and beneficiary and provider satisfaction than before the PHE. In addition, research is needed to examine the extent to which disparities exist in Medicaid beneficiaries' ability to use telehealth, the causes, and solutions. Such research should examine whether there are disparities across racial and ethnic groups, eligibility pathways, and geographic areas (MACPAC 2020c). Finally, the Commission notes that the increased use of telehealth raises potential program integrity considerations that need to be understood and monitored (GAO 2022).

Transparency

Lastly, the Commission's view remains that the RFI process should be as transparent as possible, which we originally expressed in our response to the April 2022 access RFI (MACPAC 2022e). This RFI on making stakeholder voices heard uses the same online submission process as was used for the April RFI. Because the RFI directs respondents to submit written comments only through the portal, options that are typically available through the formal rulemaking process (i.e., email, mail, hand delivery) do not appear to be available. As such, the ability to respond may not be available to all interested parties. The RFI webpage does not specify whether comments will be made public.

Thank you again for the opportunity to comment on this RFI. We hope these comments are helpful to your ongoing work to improve the equity and efficiency of the Medicaid program. Should you have any questions, please contact Commission staff member, Joanne Jee (joanne.jee@macpac.gov).

Thank you,

Melanie Bella

Chair

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