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RE: Access to Coverage and Care in Medicaid & CHIP

To Whom It May Concern:

The Rural Policy Research Institute Health Panel was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to the Access to Coverage and Care in Medicaid and CHIP request for information. Our comments are limited to rural-specific questions posed, or issues stated, in the draft rule.

The Panel underscores the importance of recognizing the variance in demand for Medicaid access and coverage across non-metro and metro areas. In 2019, the percent of Medicaid coverage in non-metro areas was 22.4 percent, whereas in metro areas the percent of Medicaid coverage was 19.1. The three percent difference signifies a need for a diverse subset of solutions to ensure resources are allocated equitably between non-metro and metro areas.

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

3. **What way can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups, including people living in rural and urban areas?**

   Preferred methods of communication vary between rural and urban communities due to cultural barriers, access to broadband, social determinants of health, and personal preferences. The Panel understands electronic access is a key method for enrollment but cautions the limitations it may have when aiming to connect with eligible individuals across cultural and geographic locations. The Panel recommends establishing a standardized enrollment opportunity at the point of service to reach those persons who are not registering in designated places such as agency offices due to factors such as

location of those offices and needing time off work. A "no wrong door" enrollment opportunity would enable all providers (e.g., primary care clinics including private practices, Rural Health Clinics and Federally Qualified Health Centers, and other clinical settings, including behavioral health clinics) to initiate the process by connecting eligible individuals with enrollment assisters or through other organizational partnerships.

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 system, and this care will be aligned with the beneficiary's needs as a whole person.

1. **What would be the most important area to focus on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services?**

   The Panel believes the most important focus area should surround network adequacy concerns within rural communities. Historic foci on time and distance to clinical providers, such as those use in certifying health insurance firms to offer plans in the designated marketplaces, are important and serve as a foundation, along with population-to-provider ratios. However, especially in the case of Medicaid and CHIP, a broader array of services is essential in assuring access to services contributing to health. The Panel encourages CMS to incorporate access standards for these services (not necessarily an exhaustive list of all that may important under the broad umbrella of Social Determinants of Health (SDOH)), some of which have been included as benefits in the Medicaid program:

   - Transportation (including use of local volunteer services in rural communities that lack any form or public transportation)
   - Housing assistance (i.e., agencies that assist in locating affordable housing, and agencies that might offer direct assistance)
   - Food services
   - Translation services, including outside of clinics
   - Assistance, including financial, for parents needing to accompany children to clinics
   - Human services agencies addressing other needs of low income families and families with special needs.

   In addition to the above list, we also recommend incorporate adequacy standards incorporate Home and Community Based Services (see question 3) and uses of standards related to cultural competency (see question 4).

2. **How could CMS monitor states' performance against those minimum standards?**

   The Panel supports issuing compliance actions to states that do not meet the minimum standards and believes aligning benchmarks to funding would create incentives for states to eliminate coverage gaps. The Panel cautions the process in which benchmarks are established, as benchmarks may be not as reliable in rural communities with small numbers.

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?**

   CMS can promote whole person care and care coordination through the inclusion of care management codes for payment. Reimbursement opportunities should be available for chronic care management, transitional care management, behavioral health, and palliative care services. Additionally, the Panel underscores the importance of Medicaid Home and Community-Based Services (HCBS) and believes

HCBS should be included in the minimum standards for access to services. Currently, thousands of individuals are on waitlists, which showcases the limited availability and access to the necessary services. Although HCBS Waivers are available, community members may be unaware of the opportunity to appeal or may not have the ability to fill out the form.

4. **In addition to existing legal obligations, how should CMS address cultural competency and language preferences in establishing minimum access standards?**

   The Panel believes placing a stronger emphasis on the 15 National Culturally and Linguistically Appropriate Services (CLAS) Standards would help CMS address cultural competency and advance health equity. The National CLAS Standards focus on communication and language assistance and provide examples of minimum access standards, such as offering language assistance to individuals with limited English proficiency, informing individuals of availability of language assistance, and providing easy-to-understand print and multimedia materials. The Panel also recommends funding community engagement conversations to support public health programs in their mission to better serve the holistic needs of the community.

   Additionally, the Panel believes CMS could impact access standards by providing guidelines for a broad-based course on the concept of cultural competency. Then on-site training needs to be tailored to the residents' specific community. Hospitals must take on the responsibility to increase awareness of patient demographics, identify solutions to increase cultural competency, language preferences, and allocate the necessary resources to educate residents.

5. **What are specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP?**

   The Panel agrees telehealth, cross-state licensure of providers, and providing reimbursement to family members who provide caregiving services are effective opportunities to increase and diversify the pool of available providers. We caution that using telehealth services should supplement services offered by local providers, not supplant them. Where services are available through local providers, that availability should be sustained.

   The Panel believes inter-agency partnerships can advance appropriate incorporation of new strategies for improving access, including telehealth. Three agencies, in addition to CMS, who are especially focused on access for rural residents are the Health Resources and Services Administration (HRSA), the Indian Health Service (HIS) and the Veterans Health Administration (VHA).

   Additionally, the Panel supports innovative programs which reduce barriers for health professionals born in other countries to become licensed and credentialed practitioners in the U.S. Such programs can include the development of clinical readiness assessments of eligible international medical graduates to serve in residency programs and awarding grants to support primary care residency positions designated for international medical graduates who are willing to serve in rural or underserved areas. This would build on CMS' funding of 1000 new residency slots for hospitals serving rural and underserved communities, which will become effective on July 1, 2023.

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 experiences with care across states, delivery systems, and populations).

1. **What should CMS consider when developing an access monitoring approach that is as similar as possible across Medicaid and CHIP delivery systems, programs, and across services/benefits?**

   The Panel suggests CMS develop a national template that each state can draw from, as part of the access monitoring approach. A standardized template would enhance the overall effectiveness of the approach and help states identify and prioritize resources to address access concerns, such as the challenges related to managed care organizations (MCOs) and network adequacy in rural areas.

2. **What measures of potential access, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor?**

   The Panel encourages states to measure care availability by analyzing provider networks, availability of service providers, and wait times. Measuring access based on the number of grievances and appeals may misrepresent the level of urgency regarding access concerns, as individuals may be unaware how or where to appeal. Alternative measures of access should be considered as well, such as: survey responses to questions about usual source of care for acute care, behavioral health services, and dental care; distance to care sites, and availability of services offered during the hours the patient can access them.

The Panel commends CMS's continued work on these critical issues and we thank you for the opportunity to submit comments prior to the finalization of this proposed rule.

Sincerely,

The Rural Policy Research Institute Health Panel

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