



April 18, 2022

Chiquita Brooks-LaSure
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is pleased to offer responses to CMS's Request for Information on access to care in the Medicaid and CHIP programs. Medicaid Directors and their teams honor the mission of Medicaid, working tirelessly to provide high-quality care to the members they serve while balancing state-level dynamics and resource constraints. As CMS considers how to enhance access in the program, NAMD urges CMS to maintain the equity partnership between states and the federal government and work to streamline existing processes, data sources, and initiatives before contemplating additional, potentially burdensome regulatory processes.

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Medicaid Leads the Way in Building Services for the Most Vulnerable

Medicaid and CHIP are crucial programs that provide comprehensive services to a wide array of members. These programs cover the most complex populations in the nation – many of whom would not receive the same types of benefits from other payers. In many instances, Medicaid provides wholly unique services that are simply not available from commercial payers or Medicare.

For example, Medicaid is the primary payer of home- and community-based services (HCBS) that allow individuals with long-term services and supports (LTSS) needs to reside in their communities, rather than institutions. Whether an individual is living with a lifelong intellectual or developmental disability or is aging and needs assistance with activities they could do on their own when younger, Medicaid is there to support HCBS populations in living their most fulfilling lives. No other payer plays the role that Medicaid does for these populations.

The same holds true for mental health services, substance use disorder services, maternal and child health services, and many other service categories. Medicaid is a

major payer, and often the predominant payer, in each of these areas. Medicaid provides a robust set of benefits to its members, with minimal or no cost sharing. Private insurance does not offer – or would impose prohibitively high cost sharing – for many of the populations that Medicaid covers as a matter of course.

That is not to say that there is no room for improvement in how Medicaid’s delivery systems are structured and how access to covered services are delivered on the ground. Medicaid agencies are keenly aware of opportunities to strengthen access to the vital services members need. However, as CMS considers stakeholder responses to this RFI and charts its future course on strengthening access in Medicaid, it should not lose sight of the good work that states do every day in their Medicaid programs.

COVID Impacts on the Delivery System Will Take Time to Address

Any conversation about strengthening access in Medicaid must reckon with the impacts of the COVID-19 pandemic on the nation’s health care infrastructure. For over two years, the pandemic has taken its toll on health care systems and the communities they serve. The distinct phases of the pandemic, from its initial onset through the Delta and Omicron variant surges, further impacted the ability of systems of care to continue meeting the needs of their communities.

Medicaid was on the front line of the nation’s response to the pandemic, providing coverage of critical physical and behavioral health services. Medicaid agencies and our federal partners at CMS and across the federal government admirably stepped up to the challenge of COVID. The partnership and collaboration throughout these unprecedented circumstances produced tangible results, such as the rapid expansion of telehealth to maintain Medicaid service availability during the early stages of the pandemic.

While these actions were vital, the duration of the COVID emergency is negatively impacting provider availability across service arrays and across payers. Care sectors where existing shortages were already felt, [such as the availability of mental health services](#), have been further exacerbated by the pandemic. In other sectors, such as the availability of sufficient skilled nursing to [support hospitals](#) and [nursing homes](#), the provider workforce challenges take on a new tenor that did not necessarily exist prior to the onset of COVID.

The fundamental challenge the nation faces in addressing the frayed health care workforce in the face of increasing service demand requires a long-term national strategy. Medicaid is a part of the solution, but it is not the only part. [NAMD identified short-term and medium-term strategies states can employ through our Medicaid Forward project](#) to address behavioral health needs, children’s health needs, and LTSS needs. But Medicaid cannot solve the long-term impacts of COVID alone, nor can

Medicaid be expected to provide robust access to services in sectors where every payer is struggling to meet service demand.

Responses to RFI's Specific Objectives

Objective One: Medicaid and CHIP Reaches People Who Are Eligible and Can Benefit from Coverage

Ensuring that eligible individuals apply for and enroll in Medicaid is an essential component of access. States have undertaken significant efforts – including developing integrated eligibility systems, launching communications campaigns, and building relationships with community partners – to make sure that eligible individuals understand their coverage options through Medicaid and CHIP. To support these efforts, CMS and other federal agencies should create additional flexibilities around application requirements, provide resources for data and systems enhancements, and streamline data sharing across the federal government. CMS should also allow states to remove barriers to enrollment for special populations.

Make Application Processes Clearer and More Accessible

Medicaid eligibility is complex, with different criteria across eligibility categories and complicated interactions with other benefits. CMS should consider simplifying application processes for MAGI and non-MAGI populations. Specifically, CMS could:

- Re-evaluate federal noticing requirements, with the goal of giving states new flexibilities to create clear and accessible application language.
- Consider aligning eligibility standards (including household composition, countable income, income disregards, and countable resources), change reporting requirements, and verification policies across Medicaid eligibility groups.
- Work with states and across HHS to align eligibility-related definitions and rules (e.g. income counting methodologies) across public assistance programs (e.g. Medicaid, SNAP, TANF, etc.). This would greatly enhance states' efforts to offer integrated and streamlined eligibility processes.
- Evaluate options to streamline non-MAGI eligibility processes. Specifically, CMS could:
 - Expand presumptive eligibility to the Aged, Blind, and Disabled (ABD) pathway and LTSS.
 - Allow states to accept self-attestation for applicants with post-enrollment verification, including self-attestation of disability.
 - Allow states to apply simplified disability determination requirements for categories of eligibility that require a disability determination. States report that SSI methodologies are difficult to implement.

- Simplify eligibility LTSS, including by giving states the option to remove estate recovery and post-eligibility cost of care.
- Consider making permanent COVID-related flexibilities that created alternatives (like verbal consent and electronic signatures) to the “wet signature” requirement for HCBS person-centered care plans.

Support Systems and Data Enhancements

CMS should also support states in modernizing their eligibility and enrollment systems. Updating these systems is costly and time-consuming, and states report that enhanced federal resources, including dedicated funding streams for integrated eligibility systems, would greatly support state efforts. In many states, Medicaid agencies do not directly oversee eligibility and enrollment processes, which complicates efforts to improve processes; in these states, CMS could consider financial incentives for better performance. Finally, States also report that the administrative claiming process for No Wrong Door systems and Aging and Disability Resource Centers is cumbersome and could be simplified.

CMS should also work to streamline data sharing across federal agencies. Specifically, CMS should:

- Develop streamlined eligibility processes for individuals who are dually-eligible for Medicare and Medicaid.
- Work with the Social Security Administration to provide state agencies with timely information on SSI payment histories and disability determinations.
- Build stronger data sharing processes between the U.S. Department of Veterans Affairs (VA) and state Medicaid agencies, as incomplete information about veterans’ benefits can delay eligibility determinations.

Address Barriers Specific to Certain Communities

States have also noted barriers to enrollment for specific populations, which can lead to inequities in access. CMS should consider policy changes to remove barriers to coverage:

- The Social Security Act’s “inmate exclusion” policy prohibits Medicaid coverage of people who are incarcerated. Although a statutory fix to the inmate exclusion would require Congressional action, CMS could release guidance on 1115 waiver flexibilities to allow pre-release coverage; this would help prevent gaps in enrollment during the re-entry process.
- The streamlined federal application for Medicaid includes a question on gender with potential answers of “male” and “female.” Similarly, Medicaid claims require binary identification of gender. This may be a barrier to enrollment for transgender and non-binary applicants.

- People with serious mental illness or substance use often experience challenges responding promptly to requests from state Medicaid agencies. CMS could allow an alternative contact or advocate to be copied on all communications; this may help facilitate enrollments and renewals.
- People experiencing homelessness experience additional barriers to enrollment. CMS should remove the signature requirement and consider streamlined pathways to enrollment for this population.

States report that navigators and application assistors are effective at increasing the number of individuals who successfully apply for Medicaid coverage. However, states have seen [large swings](#) in the availability of funding for navigators over the past several years, which makes efforts to provide and advertise consistent programming difficult. CMS should consider strategies for ensuring sustainable funding for these programs, including broadening the types of outreach and eligibility assistance that can qualify for the administrative match.

Objective Two: Medicaid and CHIP Members Experience Consistent Coverage

Make Renewal Processes Clearer and More Accessible

Ensuring that Medicaid members can access consistent, uninterrupted coverage is an important goal. It is, however, also important to recognize the legal constraints under which state Medicaid programs operate. By statute, Medicaid programs are [required to conduct renewals](#) for most members every 12 months, and have legal obligations if a member does not provide information that is needed to complete the renewal. Members may not report changes in addresses or respond to renewal notices for a variety of reasons –unstable housing, unreported transitions to other coverage, lack of access to a computer or phone, challenges understanding renewal notices and instructions – and Medicaid agencies alone cannot address all of these barriers.

However, there are steps CMS could take to reduce barriers to completing renewals. Specifically, CMS could:

- Conduct a re-evaluation of notice requirements, with the goal of giving states additional flexibility to make letters more member-friendly and putting legally required language on websites instead. States report that simplifying language in renewal notices would likely help members renew coverage.
- Align renewal requirements and timelines between Medicaid, SNAP, TANF, and other public assistance programs to prevent member confusion.
- Fund the development of streamlined online application and renewal portals. CMS should also consider flexibilities around Medicaid coverage of internet; this would ensure that all Medicaid members can access online renewal options.
- Fund the State Health Insurance Assistance Program (SHIP) to launch programming with counselors who specialize in dually eligible members. CMS could also allow states to claim administrative match on counseling to duals.

- For LTSS populations, give states flexibility to allow for longer durations of time between level of care evaluations (which are currently required annually). Some Medicaid members have conditions that are unlikely to improve, and annual level of care evaluations can delay the renewal process.

Maximize Use of Available Data for Renewals

States have launched broad ex parte processes to utilize existing data sources for renewals. However, state Medicaid programs cannot access the full breadth of data that is available to the federal government and would be useful for Medicaid eligibility determinations. There are also significant challenges with data sharing between states, which can make continuity of coverage challenging when members move across state lines.

We recommend that CMS:

- Work with states to improve the Federal Data Services Hub (FDSH) and Renewal and Redetermination Verification (RRV) service. Specifically, states suggest integrating additional income verification services, dates of death, national foster care placement information, and residency information (PARIS and/or managed care data) into the hub.
- Expand access to electronic income verification sources that include out-of-state verification of income. States also recommend building stronger connections with the Treasury Department to make data on federal benefits amounts paid through Direct Express and lookback period histories available to state Medicaid agencies.
- Consider making permanent COVID-19 related flexibilities that allow states to automatically renew a household whose zero-dollar income was verified within the last 12 months at application or renewal, when no new information is returned from a financial data source at the time of renewal and the members are otherwise still eligible.
- Allow presumptive eligibility for Medicaid members who move across state lines, while eligibility is being determined in the new state.
- Allow states to use in-state forwarding addresses from the National Change of Address (NCOA) database without taking additional steps to independently confirm address changes with members. The NCOA has implemented robust strategies to mitigate errors, including sending two confirmation letters to the new and old address and making submission of an unauthorized change of address request a federal offense, and the requirement to verify addresses places significant burden on states.

Support States in Adopting Systems and Policies that Encourage Continuity of Care

State Medicaid spending has [grown consistently](#) over the past two decades, and will likely jump this year when the Families First Coronavirus Response Act's FMAP

enhancement ends. These fiscal pressures limit states' ability to take up policy options that promote continuous coverage, like 12-month continuous eligibility for children. Similarly, updating data systems can be time-consuming and expensive.

To address these challenges, CMS could:

- Allow states to draw federal match if a member receives services after being found presumptively eligible, but then is ultimately determined ineligible after a full determination is completed.
- Provide enhanced federal match for states who elect policy options (like 12-month continuous coverage for children) that increase state spending.
- Provide planning and implementation grants for systems changes, or revisit using waiver authority to enact a Medicaid 90/10 systems match to fund integrated systems.
- Providing additional grant opportunities and technical assistance, similar to the [recent grant program](#) to reduce the number of uninsured children.

Objective Three: Access to Timely, High-Quality, and Appropriate Care in All Payment Systems That Aligns with the Member's Whole-Person Needs

Minimum Standards are Not Operationally Feasible

CMS is specifically seeking feedback on “how to establish minimum standards or federal floors for equitable and timely access to providers and services.” Although NAMD supports CMS' goal of ensuring timely, high-quality, and appropriate care, we strongly believe that establishing minimum access standards is not operationally feasible.

There are immense comparability challenges across regions, states, provider types, payers, and eligibility groups that would make establishing minimum standards very difficult. Services have different definitions and eligibility criteria across states and payers. For example, in Medicaid home health programs are often used for chronic conditions, while in private insurance they are used for acute conditions. Further, rural regions and frontier states have significant and unique challenges with provider availability in comparison to more urban areas. Service demand and availability trends also change rapidly (as illustrated by the COVID-19 pandemic and related workforce shortages) which would make keeping these minimum standards up-to-date incredibly challenging.

It is also important to underscore that there are many access challenges that cannot be solved by state Medicaid programs in a vacuum. In many regions and specialties, there are provider shortages that meaningfully impact access to care across payers. Medicaid cannot be expected to provide better access to care than Medicare or private payers in these markets.

Imposing minimum standards may also have unintended consequences that reduce access to care for Medicaid members. States note that requiring providers to track and report additional data (such as the time between when a patient requested a service and received a service) would result in large increases in administrative burden. This may further reduce the number of providers who are willing to participate in the Medicaid program.

Supporting Whole-Person Care

Although establishing minimum standards is not operationally feasible, states have identified a number of policy changes that would increase access to high-quality, whole-person care. These approaches focus on removing regulatory barriers to providing coordinated care and countering economic incentives that discourage providers from taking on patients with intersecting needs.

Specifically, CMS could:

- Provide a match or incentive payment for providers who treat patients with additional care coordination needs. For example, states report that inpatient substance use disorder providers face significant financial incentives to take on lower medical acuity, non-pregnant, and childless patients. CMS could consider providing additional reimbursement or value-based care arrangements to counter this effect.
- Examine existing regulatory practices that restrict duplication of services in the SPA and waiver review process. For some individuals, multiple providers should be reimbursed for their unique roles in a coordinated care team. Current restrictions that aim to prevent duplicative services (such as the one payment rule for Section 2703 Health Home Services) often limit access to well-coordinated care.
- Consider extending the Section 2703 Health Home framework, which uses team-based approaches for comprehensive care coordination, to other populations. For example, this approach could be used with pregnant and postpartum members.
- Support providers in launching health information exchanges and other electronic health record integration efforts. This would support whole-person care for individuals who have physical health, behavioral health, and LTSS-related needs.
- Provide funding to states to support care coordination for fee-for-service populations, including Alien Emergency Medical clients and non-DSNP-eligible Medicare clients.

Cultural Competency, Language Access, and Provider Diversity

Ensuring that Medicaid members can access care that is culturally competent and linguistically appropriate is important, given the high number of Medicaid members who have limited English proficiency. Per federal law, Medicaid must provide access to linguistically appropriate care, and states have launched broad initiatives to ensure

access to culturally competent care. However, it is important to recognize the industry-wide challenges (including shortages of bilingual providers) and historic inequities that Medicaid alone cannot address.

There are steps CMS could take to promote more equitable care:

- States report that leveraging trusted community-based organizations for interpreter and community health worker services is often an effective approach. CMS should offer enhanced match or other financial incentives to fund these types of community-based partnerships.
- Remove the prohibition on, or create waiver flexibilities to allow, family members to deliver personal care services. Families typically bring a level of cultural and linguistic competence that may otherwise be hard to fill in HCBS.
- Support states in implementing more rigorous managed care contracting requirements, including CLAS standards and expanded requirements for search/filtering functionality on provider portals (by language, race, and ethnicity).
- Support the adoption of telehealth by offering financial support to providers to obtain telehealth equipment, particularly behavioral health and social services providers who may not have been prioritized in previous telehealth infrastructure initiatives. Allow state investments in such provider technological infrastructure to be federally matched
- Remove any regulatory barriers to offering e-consults to expand client access to linguistically and culturally appropriate specialty care.
- Consider technical assistance or national provider credentialing data bases to facilitate cross-state licensure of providers. This can help stretch the existing supply of providers to meet regional needs.

Objective Four: Data to Measure, Monitor, and Support Improvement Efforts Related to Access

Maximize Utility of Existing Data Reporting

Before considering any new reporting requirements for Medicaid programs, CMS should first seek to maximize the impact of existing state reporting. Medicaid programs are already subject to a wide array of required reporting in both fee-for-service and managed care – much of which is geared towards assessing access. Indeed, Medicaid stands apart from other payers in the existing rigor surrounding its access evaluations. These current requirements include, but are not limited to:

- The fee-for-service access monitoring rule, which requires states to develop access monitoring plans for five specific service categories and for any service category that is subject to a rate reduction or significant rate restructure.
 - Since its finalization, [NAMD has noted challenges with this rule and the significant administrative burden it puts on states](#). NAMD encourages

CMS to jettison this regulatory framework and seek more holistic methods of supporting states in strengthening access in their Medicaid programs.

- Collecting documentation from contracted managed care plans on plan compliance with availability and accessibility of services, inclusive of compliance with network adequacy standards.
- Annual managed care program reports assessing program operations, including availability and accessibility of covered services inclusive of network adequacy standards.
- As part of the annual managed care external quality review process, states are required to hire external organizations to validate each contracted managed care plan's network adequacy.
- States operating managed care programs must have a monitoring system in place addressing all aspects of the program, including availability and accessibility of covered services. States must also use data from other monitoring activities, including grievance and appeals data, to identify potential issues and make program improvements.

These requirements pose significant administrative burdens on states, particularly the fee-for-service access monitoring rule. To the extent that such requirements are not meeting states' and CMS's needs, these requirements should be modified to better address mutual policy goals around access. If current requirements are not effective, then they should be eliminated concurrently with the creation of new requirements, paired with appropriate implementation timelines and support for state systems modification to meet new reporting expectations. The overall aim should be to maximize the impact of data collection, reporting, and analysis for both states and CMS.

CMS Can Facilitate Use of Validated Tools and Measures, But Must be Mindful of Where Cross-State Comparisons are Challenging

Cross-state and cross-system data comparisons are challenging, due to nuances of state policy, program design, service definitions, and other factors. However, when such comparisons are possible, they can be helpful for states as they evaluate their own policies and program requirements.

CMS can support states in conducting meaningful comparisons with their peers by serving as a hub for effective analytical practices, validated measure sets, and validated comparison tools. Some examples of what could be helpful include:

- Providing enhanced federal match for state development and implementation of certified measure reporting using nationally recognized measures that facilitate comparability with other state programs.

- Promoting alignment across program measurement frameworks (the Child and Adult Core Measure Sets, waiver monitoring requirements, etc.).
- Centralizing in a user-friendly format information on state Medicaid coverage policies to facilitate state comparison of such policies.
- Funding additional national and state health care access surveys to support evaluation of access.
- Enhancing the capabilities of Transformed Medicaid Statistical Information System (T-MSIS) data to allow states to include local provider taxonomy codes and additional data elements for providers that are not required to have a billing provider taxonomy or National Provider Identifier, both of which would allow states to better assess access to services provided by non-medical or atypical providers.
- Identifying the array of state practices to gauge potential access, such as provider network assessments, provider/enrollee ratios, geo-mapping of providers to assess travel times for members, appointment wait times and availability, grievances and appeals data, etc.
 - NAMD notes that not all states anticipate value in comparing grievances and appeals data with other Medicaid programs, given the fact-specific nature of the outcomes of such processes and their intrinsic link to state laws and regulations governing their function.

Not every Medicaid-funded service array lends itself to this type of clear comparison. Areas where states have significant discretion to define the service array, such as within HCBS programs, are particularly difficult to compare across states. As such, data and measures that address these types of services must consider and honor the uniqueness of state policy decisions and regional variation. The utility of any new reporting requirements must also be appropriately balanced against the administrative burden for states and providers of meeting such requirements, with specific consideration given to not creating disincentives for providers to participate in Medicaid due to increased reporting expectations.

Unique Considerations for LTSS and HCBS Data

As noted above and within the RFI itself, LTSS (particularly HCBS) presents a unique challenge for cross-state comparisons. State variation in service definitions, program design, and the role of self-direction complicates potential standardized analytical frameworks.

As a first step in promoting consistency in state approaches to monitoring these programs, CMS could consider creating a set of baseline recommended performance measures across LTSS and HCBS systems, which could reduce state need to develop bespoke measures. This set could incorporate existing validated measures already developed by entities such as the National Quality Forum and the National Committee

for Quality Assurance, alongside measures assessing member experience of care from the National Core Indicators survey, National Core Indicators – Aging and Disability survey, and the HCBS Customer Assessment of Healthcare Providers and Systems survey. States should continue to retain the authority to develop more specialized or unique measures to assess areas of their programs not reflected in CMS’s recommended measure set.

Objective Five: Ensuring Payment Rates are Sufficient to Enlist and Retain Providers Such that Services are Accessible

States Are the Appropriate Determiners of Medicaid Payment Sufficiency

States have a core responsibility under federal Medicaid statute to set payment rates that ensure access to care and that are consistent with efficiency, economy, and quality of care. Each state does so through its own processes in consultation with its provider community, state legislature, member advocates, and other important stakeholders. State rate-setting strategies also reflect state policy objectives and priorities, including delivery system and payment reform goals. This discretion to states in payment approaches must continue to be respected by CMS, as it is a core component of the Medicaid’s equity partnership between states and the federal government. It is not feasible or appropriate for CMS to determine the sufficiency of state Medicaid rates.

Provide Tools and Data to Streamline State Payment Decisions

An appropriate role for CMS in state rate development is providing states with data, resources, and other tools to inform state processes and setting reasonable expectations for the frequency with which states review and update rate structures. CMS can also work to align payment rules and authorities across fee-for-service and managed care, which will promote more streamlined pathways for states to advance value-based payment reforms.

Some specific areas where CMS could support states include:

- Creating a Medicaid rate data warehouse for states to access to support state rate comparisons with their peers, to the extent that states determine such comparisons are meaningful and valuable. This data warehouse could also include Medicare rate information and average commercial rate information where available to support benchmark analyses.
- Provide guidance to states on common approaches to data-driven rate development and the role of benchmarking to other payers, considering wage amounts, inflation, fringe benefits, and other factors.
- Provide guidance to states on effective evaluation approaches to understand the impact of rate changes on access, such as effects on provider participation and network robustness.

- Conduct or make available to states economic analyses of provider markets to assist states in understanding cross-payer subsidization of certain service categories or provider types.
- Conduct cost analyses for non-Medicare provider types to understand their margins for Medicaid-funded services compared to commercial payers.
- Guidance on how to account for telehealth services in access assessments.
- Partnering with the Department of Labor to create more specific job classifications that address direct support workers providing LTSS, which would facilitate the collection and analysis of more granular federal wage data for these workers that can inform rate development.

Streamline Approvals for Managed Care Directed Payments

CMS can also make policy changes to facilitate more direct comparability between fee-for-service and managed care payment structures. Specifically, CMS could significantly streamline state use of directed payment authority when the state is setting minimum fee schedules. Minimum fee schedules, which are often linked to state fee-for-service fee schedules, are straightforward policy levers that can promote consistency in payment across delivery systems. Yet despite this relative simplicity compared to more advanced value-based purchasing arrangements, CMS's approval process requires extensive review under its directed payment rules and often leads to significant delays in approvals. Further, CMS requires states to tie their directed payments to a goal in the state's managed care quality improvement strategy, but enhancing access to services is not considered sufficient rationale to approve a directed payment – even if strengthening access is a clearly articulated goal of the state. CMS should adjust its approach to directed payments such that burdensome approval processes are not required for adoption of minimum fee schedules.

Enhance the Viability of 1115 Waivers to Promote Payment Innovation

Section 1115 demonstration waivers provide states with significant flexibility to pilot innovative programs in alignment with CMS's strategic objectives and to increase access to high quality care and services. However, while enabling innovation, 1115 waivers have some significant administrative barriers which reduce the ability of states to utilize the waiver structure to implement new approaches to health and health care by constraining allowable costs. Specifically, current budget neutrality calculations require states to include increases in payment rates regardless of whether the rate increase itself requires waiver authority. This requirement is too restrictive, limiting states' ability to correct for historic underinvestment in certain provider categories and creating unnecessary barriers to innovation. Requiring inclusion of these increases in budget neutrality calculations penalizes states aiming to meet market demands and incentivize broader access to often under-represented provider groups, resulting in limited provider networks for vulnerable populations.

In order to address these administrative barriers to access, CMS should consider modifying current 1115 waiver budget neutrality calculations to exclude appropriate rate increases used to increase access or improve health outcomes. CMS should enable states to align rate increases with program priorities and initiatives within their 1115 waivers. Payment rate increases rarely require a federal waiver, and therefore, should not be included as part of the budget neutrality estimate for waiver authority. This rule needlessly limits states' ability to successfully implement demonstrations, address access concerns for critical services and providers, and improve health and health care for Medicaid members.

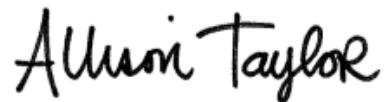
Tools to Streamline Provider Enrollment and Participation in Medicaid

Federal requirements around provider enrollment in Medicaid can pose barriers to more widespread provider participation in the program. CMS can help mitigate these barriers by considering the following:

- Creating a clearinghouse for providers to submit all necessary documentation for enrollment in multiple state Medicaid agencies and managed care organizations. This strategy could be particularly helpful for providers that serve Medicaid members across state lines.
- Provide guidance and technical assistance to states on effective practices to streamline provider enrollment processes.
- Develop guidance on permissible exceptions processes to full provider enrollment requirements to support provision of nontraditional Medicaid services that address social determinants of health, such as pest control, deep cleaning, and home modifications.
- To the extent permissible under federal statute, ease requirements for states to recoup Medicaid payments made to providers who serve individuals who become retroactively eligible for other coverage, such as Medicare or disability. This requirement creates administrative burden for states and frustration for providers who served eligible Medicaid clients in good faith.
- Revise or withdraw the Electronic Visit Verification (EVV) outcomes-based certification process. EVV requirements have created significant burden on personal care providers and are further complicated by inconsistent EVV applications, lack of access to cell phone and/or internet services in rural areas, and uncertainty around potential revisions to EVV statutory requirements. CMS's current approach to EVV creates pressure for states to strictly enforce the EVV requirement and deny claims for provided personal care services that do not meet EVV requirements, which negatively impacts member access to care and supports. CMS must provide a pathway for states to meet EVV expectations without denying claims for personal care services.

We appreciate CMS's consideration of state Medicaid agency perspectives on these critical questions around improving access to care in Medicaid and CHIP. We encourage CMS to continue its strong collaboration with states to inform any future changes to regulatory requirements and expectations for Medicaid agencies and to ensure such changes are feasible and of maximal value.

Sincerely,



Allison Taylor
NAMD Board President
Director of Medicaid
Indiana Family and Social
Services Administration



Cindy Beane
NAMD Board President-Elect
Commissioner
West Virginia Department of Health
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