

**HEALTHY  
MOMS.  
STRONG  
BABIES.**



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Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, D.C. 20201

**RE: Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP  
(Submitted by Web Form)**

March of Dimes, the nation's leading nonprofit organization fighting for the health of all moms and babies, is pleased to have the opportunity to provide the following comments to the February 17<sup>th</sup> CMS request for information titled "Access to Care and Coverage for People Enrolled in Medicaid and CHIP."

We began that fight more than 80 years ago as an organization dedicated to eradicating polio in the U.S., a goal that we achieved. We continue that fight today as we work to address some of the biggest threats to moms and babies, such as premature birth and maternal mortality, through research, education, programs and advocacy.

March of Dimes' ongoing work to improve maternal and infant health is more important than ever as our nation is in the midst of a dire maternal and infant health crisis. Rates of preterm birth are increasing, the U.S. is one of the most dangerous places to give birth in the developed world, and there are unacceptable disparities in birth outcomes between women and infants of color and their White peers. An estimated 700 women die from complications related to pregnancy each year and more than 60,000 other women experience life-threatening complications due to labor and delivery.

Additionally, one in five women are affected by anxiety, depression, and other maternal mental health conditions during the postpartum period. It is well documented that the threat of maternal mortality and morbidity is especially acute for women of color. Furthermore, Black and American Indian/Alaskan native babies being twice as likely as White babies to die before their first birthday. We also know, the health and well-being of mothers and infants are inextricably linked. By improving the health of, and conditions for, women before, during and between pregnancies, we can improve outcomes for both them and their infants. But we have many challenges before us.

According to our 2020 report, *Nowhere to Go: Maternity Care Deserts Across the U.S.*, 7 million women of childbearing age live in counties without access or with limited access to maternity care and give birth to more than 500,000 babies per year. Of those, 2.2 million in 1,095 counties live in maternity care deserts that have no hospital offering obstetric care, no birth center and no obstetric provider. Maternity care deserts have a higher poverty rate and lower median household income than counties with access to maternity care. Since 2010, there has been an increase in the percentage of rural obstetric units that have closed their doors and currently only 8 percent of obstetric providers report practicing in rural areas. While the focus of maternity care deserts is often in rural areas, this problem

also occurs in urban areas and areas adjacent to urban centers. 1 in 3 live women of childbearing age in a maternity care desert reside in a large metropolitan area or urban setting.<sup>1</sup>

Each year, approximately 40% of births in the U.S. are covered by Medicaid. It covers a greater share of births in rural areas, among minority women, young women (under age 19), and women with lower levels of educational attainment. Given its disproportionate role in covering these births, Medicaid will play a key role in addressing concerns about rising pregnancy-related mortality and morbidity and significant racial and ethnic disparities in maternal outcomes.<sup>2</sup>

Over two-thirds of women whose births were financed by Medicaid (68.3 percent) started prenatal care during the first trimester and more than three-quarters (76.3 percent) received nine or more prenatal care visits. While women on Medicaid are more likely to receive treatment, these women are also less likely to both receive prenatal care in the first trimester and receive adequate prenatal care compared to privately insured women.<sup>3</sup>

Because of the state of maternal and infant health care in the U.S., March of Dimes urges CMS to work more closely with states to ensure that their Medicaid programs are provided the guidance and resources necessary to improve care while the public health emergency (PHE) unwinds.

Thank you again for this opportunity to provide feedback on ways CMS can improve access to coverage and care for those eligible for Medicaid and CHIP. We look forward to continuing to work together to improve our maternal and infant health care to the preeminence that our nation's moms and infants deserve.

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<sup>1</sup> Maternity Care Deserts Report. (n.d.). Retrieved April 10, 2022, from <https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx#:~:text=Maternity%20care%20deserts%20are%20counties,ability%20to%20access%20that%20care.>

<sup>2</sup> Medicaid's role in Financing Maternity Care - macpac.gov. (n.d.). Retrieved April 11, 2022, from <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf>

<sup>3</sup> Ibid.

***Response to Objective 1.1: What are the specific ways that CMS can support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI-based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan, when applicable.***

March of Dimes believes that all women, pregnant and postpartum, as well as their infants should be covered by affordable and high quality health insurance regardless of external factors. Like other patient populations, many mothers do not receive the coverage that they are entitled to because they do not know that assistance is available for them and their infant, or doubt they will qualify. Adequate enrollment policies and outreach to educate moms and infants is essential to improving access to adequate care. When mothers have health insurance, their infants are more likely to get the care they need to start life healthy. Broadly, studies have shown that interventions to enroll children based on eligibility in other means-tested assistance programs would capture 70% of those children who are eligible but are not otherwise currently enrolled in Medicaid or CHIP.<sup>4</sup>

March of Dimes highly recommends that CMS support the state plan amendment process (SPA) outlined in the American Rescue Plan Act by expediting the acceptance of state 1115 waiver requests to extend postpartum care coverage to 12 months of continuous eligibility for mothers and infants enrolled in Medicaid and CHIP. Medicaid should also strongly encourage those states that have not submitted a waiver request to do so. To date, CMS has only Louisiana, Virginia, New Jersey and Illinois. 11 other states, and DC, are waiting for approval to extend postpartum coverage to 12 months, as outlined in their SPAs.

With 40% of births in the U.S. covered by Medicaid, this alone could have enormous impact on eligibility and coverage of moms and infants. Based on HHS estimates, approximately 720,000 people would benefit if all states were to adopt the American Rescue Plan's new option to extend post-partum Medicaid and CHIP coverage for a full 12 months. Extending this coverage will bring the peace of mind of health coverage to parents and children during the vulnerable post-partum period.

Additionally, March of Dimes strongly supports the permanent expansion of presumptive eligibility to ensure patient care is provided. This should include encouraging states to modify requirements to virtual and in-person interviews. This authority was provided by CMS as part of the public health emergency (PHE) and allows hospitals to make Medicaid coverage determinations in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, if they are capable of such determinations. This policy has been proven to increase utilization of prenatal care and the increased likelihood of obtaining care in the first trimester, and guarantee that providers are reimbursed prior to a final determination.<sup>5</sup>

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<sup>4</sup> Crocetti, Michael et al. "Characteristics of children eligible for public health insurance but uninsured: data from the 2007 National Survey of Children's Health." *Maternal and child health journal* vol. 16 Suppl 1,0 1 (2012): S61-9. doi:10.1007/s10995-012-0995-x

<sup>5</sup> Eckert, E., & Yinger, M. (2020, April 2). *Five Things State Medicaid agencies should do now to improve care for pregnant and postpartum women amid the COVID-19 pandemic: Health Affairs Forefront*. Health Affairs. Retrieved April 10, 2022, from <https://www.healthaffairs.org/doi/10.1377/forefront.20200330.454590>

CMS should provide guidance and technical assistance for states on appropriate strategies for easing and improving the redetermination process, which could include using pre-printed, pre-populated, renewal forms for non-MAGI populations, allowing renewals by phone and internet, accepting self-attestations and conducting post-enrollment verification of specific eligibility requirements in a timely manner, and extending the timeframe for returning renewals forms from 30 days to 60 days, as well as extending timeframes for resolving discrepancies arising from a change in circumstances.

Managed Care Organizations (MCOs) are another key enrollment and redeterminations partner for states. CMS should continue to encourage states to share individual renewal data and fully utilize MCO support capabilities to provide outreach and communications to members undergoing redeterminations, including via text and email, prior to and post-disenrollment. CMS can additionally develop an 1115 demonstration waiver template to streamline state applications for a Facilitated Enrollment and Renewal program allowance.

***Response to Objective 1.2: What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?***

CMS should consider working with states to encourage them to update their Medicaid address information proactively before the end of the PHE utilizing public databases, including through utilizing the U.S. Postal Service National Change of Address Database or contracting with vendors to achieve this. States can also be encouraged to set up or improve upon existing online account services designed to make it easier for enrollees to update their personal information.

CMS should re-issue a previous exception to the cost allocation requirements set forth in the Office of Management and Budget (OMB) Circular A-87<sup>6</sup> to allow Federally-funded health and human services programs to benefit from investments in the design and development of State eligibility-determination systems for State-operated Exchanges, Medicaid, and the Children’s Health Insurance Program (CHIP). In 2011, HHS and the U.S. Department of Agriculture issued this exception to encourage states to leverage the technology investments and advances in streamlined enrollment required under the Affordable Care Act (ACA) for modernizing eligibility and enrollment for other safety-net benefits.

HHS can also use the A-87 exception to encourage states to integrate all safety-net programs, regardless of state agency. Given the millions of Americans who faced unemployment during the public health emergency and the technology challenges state unemployment agencies faced to meet the unprecedented demand, states will be looking to improve their unemployment IT systems. This presents an opportunity for HHS to partner with the U.S. Department of Labor to leverage federal technology investments that will be made to improve access to unemployment to also improve access to health and social services. For example, creating more direct linkages between unemployment

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<sup>6</sup> “OMB CIRCULAR A-87 REVISED,” The White House – President Barack Obama Archive, 5/10/2004, [https://obamawhitehouse.archives.gov/omb/circulars\\_a087\\_2004](https://obamawhitehouse.archives.gov/omb/circulars_a087_2004)

Insurance benefits and Medicaid, CHIP, and ACA-exchange plans could help consumers who may have lost employer-based coverage avoid a gap in coverage and disruption in treatment.

***Response to Objective 1.3: In what ways can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups, which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?***

March of Dimes strongly urges CMS to ensure that any waivers received do not create barriers to care or insurance coverage for pregnant and postpartum mothers or their infants. We also highly recommend that all states be allowed, and encouraged to utilize this authority, to permanently grant presumptive eligibility authority to qualified providers to treat pregnant women when they first seek treatment rather than waiting to begin treatment after a final eligibility determination has been made by the state. This policy has been proven to increase utilization of prenatal care and the increased likelihood of obtaining care in the first trimester, and guarantee that providers are reimbursed prior to a final determination.<sup>7</sup>

Outreach to mothers is critically important, especially for hard-to-reach communities. CMS should equip states with resources to initiate targeted outreach through community partnerships to notify enrollees of potential coverage changes, obtain updated contact information, and assist with applications or renewals. We know that plain language notices, particularly surrounding requests for information and the appeals process, will go a long way in helping enrollees maintain their coverage and furthering our joint desire for improving health literacy. These outreach strategies should be conducted with established community leaders and key stakeholders to ensure messaging is culturally competent and appropriately tailored to the above-listed groups, so it is well-received and understood by enrollees. CMS should also consider providing funding to community-based organizations that are connected with populations that may face additional barriers to enrollment. CMS could create educational materials that can be posted at health care facilities and distributed to patients directing them to update their contact information and prepare for renewals or enrollment in QHPs.

The Telephone Consumer Protection Act (TCPA) also continues to be a barrier to reaching vulnerable Americans through their preferred communication methods. Guidance is needed from CMS and the Federal Communications Commission (FCC) to ensure health care entities can effectively communicate with Medicaid-eligible individuals and enrollees, improving individuals' health care access and reducing

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<sup>7</sup> Eckert, E., & Yinger, M. (2020, April 2). *Five Things State Medicaid agencies should do now to improve care for pregnant and postpartum women amid the COVID-19 pandemic: Health Affairs Forefront*. Health Affairs. Retrieved April 10, 2022, from <https://www.healthaffairs.org/doi/10.1377/forefront.20200330.454590>

inequities. For example, when used to remind enrollees of renewal requirements and health care appointments, provide assistance with navigating plan benefits, and provide fundamental health education, text messaging can be an effective method of communication for individuals with Medicaid. Culturally and linguistically appropriate text messaging can also reduce health disparities and improve health outcomes and reduce churn in Medicaid and CHIP.

***Response to Objective 1.4: What key indicators of enrollment in coverage should CMS consider monitoring? For example, how can CMS use indicators to monitor eligibility determination denial rates and the reasons for denial? Which indicators are more or less readily available based on existing data and systems? Which indicators would you prioritize?***

March of Dimes recommends that CMS improve state Medicaid offices' access to race and ethnicity data. Because this information is in claims data protected by HIPAA Medicaid programs cannot access this information, hindering research and analysis vital to improving the care given to those who are most in need.

***Response to Objective 2.1: How should states monitor eligibility redeterminations, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?***

Health coverage for children must be reliable, stable and consistent to prevent abrupt terminations, transitions or waiting periods that could leave children with inadequate or no coverage. Accessible health insurance coverage should pose minimal enrollment and renewal burdens, commence with the minimal waiting period needed to verify eligibility, offer continuous eligibility for a minimum of 12 months, and be portable across states. Pregnant women should have continuous coverage throughout their pregnancy, and 12 months postpartum, with consistent access to their maternity care providers. If a change in coverage is necessary, transitions must be seamless and allow for a continuation of needed services and providers to maintain existing provider-patient relationships and ensure children and pregnant women have timely access to needed care in their medical and dental home.<sup>8</sup>

Research also demonstrates the high rates of churn among postpartum individuals, particularly Black and Latinos, which in turn can drive the increasing rates of maternal morbidity and mortality.<sup>9</sup> The extension of Medicaid coverage of postpartum care to 12 months can help address these poor outcomes. To date, nearly half of the states have passed extensions of postpartum coverage or are

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<sup>8</sup> Principles of Child Health Care Financing. Mark L. Hudak, Mark E. Helm, Patience H. White, Committee on Child Health Financing. Pediatrics Sep 2017, 140 (3) e20172098; DOI: 10.1542/peds.2017-2098 <https://pediatrics.aappublications.org/content/140/3/e20172098>

<sup>9</sup> Daw JR, Kozhimannil KB, Admon LK. High Rates of Perinatal Insurance Churn Persist After the ACA. Health Affairs Forefront. September 2019

submitting 1115 waivers to seek permission from Medicaid.<sup>10</sup> These include the following states that are still awaiting approval of their SPAs: California, District of Columbia, Indiana, Kentucky, Maine, Michigan, Minnesota, Oregon, New Mexico, South Carolina, Tennessee, and West Virginia. However, CMS can do more to urge non-expansion states to extend coverage for postpartum moms.

CMS should also consider extending the special enrollment period for individuals that lose Medicaid or CHIP coverage during the redeterminations process. This could facilitate enrollment in a QHP and avoid coverage losses.

With respect to managed Medicaid, managed care regulations do not prohibit health plans from providing information on a qualified health plan to enrollees who could potentially enroll due to a loss of eligibility, and this type of outreach is likewise not considered marketing. States should be encouraged to amend any administrative regulations or internal procedures which may prohibit the sharing of disenrollment information of members with their MCO. To enable timely and accurate communication from MCOs in tandem with states, states should provide members and MCOs with awareness of at least 60 days advance notice prior to when a redetermination will begin.

***Response to Objective 2.3: 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?***

March of Dimes believes that postpartum care should extend to all mothers and infants in the U.S. When new mothers are dropped from Medicaid 60-days after giving birth this results in a new mother possessing no continuity of coverage. State postpartum Medicaid benefits should be extended to all women who are initially covered under Medicaid and CHIP. This is an unacceptable barrier to postpartum coverage that puts both the lives of a new mother and infant at risk.

CMS should consider how to help interested states leverage navigators and other qualified partners to ensure continuous coverage of mothers and infants. For example, CMS can encourage states to develop “Community Enrollment Partnerships” where qualified partners assist in directly enrolling eligible individuals into qualified health plans. CMS could also provide funding to navigators to assist enrollees with renewing coverage or enrolling in QHP coverage, if they are no longer eligible for Medicaid.

CMS should also continue to support states in preparing IT systems for eligibility redeterminations, including the implementation of electronic health record (EHR) reminder messages for patients. CMS

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<sup>10</sup> Published: Apr 12, 2022. (2022, April 12). Medicaid postpartum coverage extension tracker. KFF. Retrieved April 13, 2022, from <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>

could partner with EHR developers to facilitate the implementation of automated EHR alerts at the point of care. These alerts could equip physicians with information on how to discuss eligibility changes and coverage renewals with their patients. Alerts for patients in their EHRs can reiterate what was discussed in visits with their physicians and can include guidance and information on how to renew or transition to alternative coverage.

March of Dimes also encourages CMS to work with states to streamline the ex-parte renewal process to help ensure an enrollee's coverage is automatically renewed based on information in the enrollee's EHR and a patient isn't required to fill out additional paperwork or take any action to maintain health insurance coverage.

***Response to Objective 3.1: What would be the most important areas to focus on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?***

In our annual report, *Nowhere to Go: Maternity Care Deserts Across the U.S.*, March of Dimes shines a light on the unequal access to maternity care found throughout the U.S. Access to quality maternity care is a critical component of maternal health and positive birth outcomes, especially in light of the high rates of maternal mortality and severe maternal morbidity in the U.S.

Families should not have to travel hours to seek the care they need to ensure a safe birth and the best start for their child's life. Each year, over 2.2 million women, and 150,000 babies, face the prospect of childbirth without the help of a hospital offering obstetrics, a birth center or OB provider in their community. In total, 7 million women of childbearing age live in counties without access or with limited access to maternity care. These women are giving birth to more than 500,000 babies a year and this is putting them at risk of serious health complications. For these women and babies, maternity care deserts are an all-too-common reality in the U.S., where unequal access to healthcare is contributing to a maternal and infant health crisis.<sup>11</sup>

In light of the declining access to maternal and infant care, CMS needs to continue to focus on ensuring access to a sufficient range of providers with the training and expertise to provide appropriate, high-quality, and cost-effective care including mental and behavioral health care prior to and following birth. As approximately 40% of births in the U.S. are covered by Medicaid, CMS is in a unique place to ensure that mothers and infants are able to access the quality care they need by ensuring provider networks are expanded in maternity care deserts and providers are encouraged to practice in these underserved areas through new incentives and care models.

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<sup>11</sup> Maternity Care Deserts Report. (n.d.). Retrieved April 10, 2022, from <https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx#:~:text=Maternity%20care%20deserts%20are%20counties,ability%20to%20access%20that%20care.>

March of Dimes encourages payment parity for telehealth services to ensure providers continue providing services following the conclusion of the PHE. These services have provided crucial medical services to millions of patients during the pandemic, including hundreds of thousands of new mothers, and their newborns. Additionally, we encourage CMS to support care models that encourage whole person care and that conduct routine screenings for both mother and infant. This includes newborn screenings that are essential to ensuring a baby receives the care from the start of life and mental health screenings are available for postpartum mothers. This also includes ensuring that all mothers are provided virtual and in-person access to translated materials and interpreter services when providers do not speak their language.

March of Dimes also requests that CMS standardize monitoring of, and improve reimbursement for, providers who take high-risk women and account for the number of unique beneficiaries they serve. It is not uncommon for specialists, such as OB-GYNs to take limited numbers of Medicaid patients, resulting in a maternity care shortfall with limited numbers of providers that Medicaid patients can access care through.

***Response to Objective 3.4: 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?***

March of Dimes strongly encourages CMS to work with state Medicaid programs to ensure that all materials can be provided in other languages and that translator services are available, in-person or virtually, when the provider does not speak the patient's language. Such services will help ensure quality of care and that a mother fully understand the medical advice they are being given. This also allows the provider to fully understand the patient's medical history and symptoms so that they can properly document and treat the patient with minimal opportunities for medical error.