Deadline: April 18, 2022

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

Re: Request for Information (2022) Access to Coverage and Care in Medicaid & CHIP
https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV_6EYj9eLS9b74Npk
(responses pasted at the above link)
(See comments on eligibility criteria and other issues from the CCD Long Term Services and Supports Task Force)

The following comments were submitted on behalf of the Consortium for Citizens with Disabilities (CCD) Employment and Training Task Force. The CCD is a coalition of more than 100 national disability organizations working together to advocate for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self- determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, as well as gender and gender identity discrimination.

There is no greater manifestation of inclusion than empowering more people with disabilities to enter the workforce. As such, the Employment and Training Task Force strives to review, understand, comment on, and influence those policy issues affecting over 22 million working-age people with disabilities.

- **Objective 1, Question 2 – Learning from successful State Implementation of Medicaid Buy-In Program:** The state-based adoption of market-based models for personal care services have had notable success in helping to eliminate some workplace barriers and allowing talented workers with disabilities to support themselves while contributing to the economy. Washington state is a good example of what can be accomplished through the thoughtful development and iterative evaluation of Medicaid Buy-In programs at the state level. At the same time, we recognize that significant implementation issues break down as states look to meet local circumstances. Critically,

CMS can provide a platform for convenes state partners, evaluating state efforts, and sharing organizational learning across state lines. Any such efforts should be public, transparent and offer opportunities for stakeholder engagement to develop solutions.

- **Objective 1, Question 3 – Support states in addressing barriers to enrollment and retention of eligible individuals among different groups:**
    - Build strong partnerships with state and community-based organizations that already serve these populations or have memberships that include these populations
    - Create effective communications campaigns and modes that are most effective for reaching these populations.
        - These populations may include those in underserved urban and rural in addition to those with limited English proficiency and limited literacy.
        - Communications must include augmentative assistive communication devices to achieve successful communication with and outreach to the disability community.

- **Objective 1, Question 3 – Supporting Greater Economic Mobility for People with Disabilities:** We must lift asset limits for people with disabilities in Medicaid programs across the country and disregard spousal income for eligibility of supports to allow for increased economic mobility, wealth generation and accumulation to facilitate empowerment and increased independence for greater participation in society.
    - This will lead to the opportunity for millions of Americans (1 in 4 Americans has a disability according to the Centers for Disease Control and Prevention) being able to get married, raise children and select their employment or profession and state of residence by choice and not be hampered by restrictive state regulations.
        - One mother of an adult son with a disability states her son is on Medicaid 4 years after earning a bachelor of arts degree because he is not able to find a position with health insurance. He continues to work at the part-time job at a grocery store he started when he started college.
        - After one individual with a physical disability left his full-time job for the state of New Jersey, he went back to work through the Ticket to Work Program. After 8 weeks of training, he went to work as a medical office assistant. He told his supervisors that he could only make so much an hour. As soon as he went over the limit of income, he lost his benefits and his job because he had to have 3 back surgeries and was not able to return to work until he completed his rehabilitation.
        - One attorney with a physical disability has been prohibited from obtaining a pay raise in almost a decade because he will lose his benefits. He is a father and is unable to get married to his fiancée due to income and asset limits. In many states, a spousal income is included for eligibility purposes – this should also be corrected to eliminate penalty for those who want to work.
        - Workers with disabilities are forced to stop working after the age of 64. Workers with disabilities should be allowed to work for as long as they want to work.

- **Objective 1, Question 3 – Disparities and Diversity within the Disability Community:** The CCD Employment and Training Task Force is very glad to see the attention and focus that CMS is bringing to critical issues around supporting states, addressing barriers to enrollment, and meeting the distinct needs of marginalized communities. This is especially important news for the Black, Indigenous and other People of Color (BIPOC) and those within such communities who live with disabilities. As well documented by researchers and advocates, the Medicaid program is absolutely critical for millions of people of color and other minority communities across the United States. The National Committee to Preserve Social Security and Medicare (NCPSSM) reported that in 2018 "African Americans accounted for 34 percent of Medicaid enrollees" The most recent iteration of the U.S. Census Bureau's American Community Survey found that there are 5,981,120 African Americans with disabilities, meaning that addressing barriers to accessing Medicaid will have positive impacts on those with multiple marginalized and intersectional identities. At the same time, given demographic change, improving Medicaid will also have important impacts in Hispanic/Latinx communities across the country. As also noted by NCPSSM, "Latinos have the highest uninsured rate among racial/ethnic groups at 37.1 percent" and that has major consequences for the 6,154,420 Hispanic/Latinx people with disabilities in America today. These are just a few data points that reflect the present disparities and diversity within the disability community itself. Our Task Force hopes that more focused attention, resources, and culturally competent work can be done to address equity, disparities and diversity via CMS' many different programs, policies, and sub-agencies.

- **Objective 1, Question 3 – Learning Lessons and Restoring the Good Work of the Medicaid Infrastructure Grant (MIG) program:** CMS should work with the Administration to seek a restoration and revitalization of the Medicaid Infrastructure Grant that had such an impact between 2009 and 2018. Such revitalization should reflect valuable lessons learned under MIG and reflect the economic needs present in an economy transformed by COVID.

- **Objective 2, Questions 1 and 2 – Medicaid eligibility redeterminations and Long COVID:** No current conversation around health, access, and public policy can ignore the stark realities created by the COVID-19 pandemic. Apart from the 1 million United States residents killed by this deadly plague, advocacy organizations estimate that more than 1.2 million Americans who survived COVID are now disabled. Even if many individuals living with Long COVID return to the workforce, many will not and as such, they will need to access the benefit system. This is an even more acute need as the Public Health Emergency is slated to end this month. As such, there needs to be clear guidance, public engagement, and active communications from CMS about how people with Long COVID can access Medicaid if they choose to do so but that those that need care but also want to continue earning an income can do so.

- **Objective 2, Question 2 – Beneficiaries at Risk of Disenrollment and Breaking the Cycle of Unemployment:** CMS should create a no-harm approach (grace period) in which beneficiaries have up to 12 months of increasing wages above the minimum before

signaling that their benefits may be discontinued. This change would offer beneficiaries the opportunity to build a savings and a year of work experience toward long-term financial independence. This is a critical opportunity and one that reflects the lived experience of many workers with disabilities who need a chance to hone their skills and succeed in the labor force. It would also help to break the vicious cycle where a worker with disabilities begins to work, earns a growing income only to lose their benefits because they earned too much, resulting in loss of access to care which will lead to them losing their jobs. Long term solutions around income-based eligibility depend on an antecedent short-term fix that ensures a change in earnings does not result in an immediate loss of mentions before a strategy using one of the current options, whether it's an ABLE account or a special needs trust can be addressed. In summary: immediate income changes should not result in the immediate loss of benefit. This is a major topic that merits greater attention, research, and action by CMS, working with the states.

- **Objective 2, Question 3 – Competitive Employment and Medicaid Buy-In Access for Transitioning Workers with Disabilities:** Of particular interest to our task force and the current state of disability employment policy is the status of workers who transition out of 14c subminimum wage programs and into competitive, integrated employment (CIE). As advocacy has moved forward, state laws have changed and the economy has begun to surge, more people with significant disabilities are working in the community at minimum wages or above. As documented early last year by the Government Accountability Office (GAO), there is a distinct risk that those transitioning workers might have earnings "too high to qualify for an SSI cash payment" but still need to "access health insurance through Medicaid buy-in." As such, CMS should look to those states where more workers are transitioning to CIE and provide further clarification to individuals and advocates.

- **Objective 3, Question 3 – Concepts of whole person care or care coordination:** Communicate clearly and often with state and local partners who work with and provide services to people with disabilities to ensure that the organizational staff understand the regs and guidance. Provide train-the-trainer opportunities to build staff expertise to then provide guidance to beneficiaries. Encourage and incentivize cross-system collaboration to provide holistic support services to individuals with disabilities.

- **Objective 2, Question 4 – Enhance eligibility and enrollment system capabilities:** Encourage and incentivize collaboration among state agencies to add Medicaid and other health data to existing statewide longitudinal data systems (SLDS).

- **Objective 3, Question 4 – Cultural Competency, Language Preferences and Diverse People with Disabilities:** The Task Force co-chairs are glad to see that CMS is actively soliciting input on how to ensure that minimum access standards reflect the need for cultural competency and language preferences. People with disabilities are diverse and part of all communities, including linguistic minorities, historically marginalized communities as well as other intersectional identities. For example, many organizations within the CCD coalition, other governmental agencies, and non-profit organizations have developed resources that address this specific need for Spanish language

resources/materials on disability. Similar resources are clearly needed to cover other cultural and linguistic groups. For example, Medi-Cal has had to develop resources for 17 different languages in order to meet the health needs of diverse Californians with disabilities. Recognizing the unique challenges facing each state Medicaid program, where possible CMS should share resources and create common materials in diverse languages.

Review U.S. Census demographic data to determine the diversity of populations and the communities in which they live. Compare to the beneficiaries served by U.S. Census Bureau's American Community Survey (ACS) Public Use Microdata Sample (PUMS) areas to determine who resides in unserved or underserved in communities. Conduct outreach campaigns that are linguistically and culturally appropriate; partner with local providers and membership organizations to assist in sharing that information more broadly. Regardless of the demographic groups, all materials, products, guidelines, and resources should be provided in plain language to ensure access by all audiences including providers as well as beneficiaries.

- **Objective 3, Question 5 – Increase and diversify the pool of available providers:** Provide multiple avenues for non-traditional audiences to participate in training to become service providers. Work with community colleges and adult education offices at the state and local levels to develop curricula and offer training.

- **Objective 4, Question 2 – Measures of potential access and robustness of provider networks across delivery systems:** As noted above, a number of states have invested in longitudinal data systems (SLDS) that tie together data from state agencies through data sharing agreements. Encourage or incentivize state Medicaid offices to connect with the SLDS in their state to ensure that data systems include CMS data.

- **Objective 4, Question 3 – LTSS, HCBS, and Prioritizing Employment Outcomes:** In looking at ways to monitor access to long-term services and supports (LTSS) within Medicaid, there is a continuing and critical need to how LTSS supports employment outcomes. The case management, supported employment, assistive technology and personal care supports that Medicaid pays for are crucial to the employment success of many people with disabilities. As such, CMS should examine LTSS data between states and cross reference that data in terms of employment outcomes. Further leadership, work, and guidance is needed to ensure that Medicaid can better support the range of economic opportunities open to people with disabilities who may need support funded through LTSS. Case management should always be about ascertaining the goals of a Medicaid recipient and determining the appropriate array of services to meet their needs. Medicaid reimbursement rates that incentivize competitive integrated employment is one critical need. "Conflict free" case management is a return to ensuring services are selected to meet recipient goals without pressure from agencies who fiscally benefit when certain options are chosen over others.

- **Objective 5, Question 4** – ***Some research suggests that, in additional to payment levels, administrative burdens that affect payment, such as claims denials and provider***

enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries. What actions could CMS take to encourage states to reduce unnecessary, administrative burdens that discourage provider participation in Medicaid and CHIP while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?

In an effort to streamline the application process, there is no need to require applicants to submit the same information as part of the application process from one year to the next unless there is a change in status.

Sincerely, CCD Employment and Training Task Force Co-Chairs:

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The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. The Employment and Training Task Force monitors federal legislation and regulations relevant to the employment of people with disabilities, particularly issues related to the programs and projects funded under the Rehabilitation Act of 1973, as amended.