

Access to Coverage and Care in Medicaid and CHIP RFI

Medicaid is an essential part of American health care. It helps improve the health and financial security of millions of Americans every day, including more than 2 million veterans. Health insurance providers are committed to ensuring that Medicaid is effective, affordable, and accountable.

Consistent with that commitment, AHIP responded to the Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on Access to Coverage and Care in Medicaid and CHIP (April 18, 2022). The RFI is among the first steps CMS is taking to develop a comprehensive strategy for Americans to access Medicaid and CHIP. The RFI asked questions about how to improve access through the enrollment process, help low-income families keep their coverage, and help people access services and support programs.

AHIP's comments reflected its perspectives on how to increase the stability of Medicaid enrollment, ensure that Americans continue to have access to health care coverage, improve health equity, and ensure stability in care and service access.

Health insurance providers know that Medicaid needs to work for those who depend on it, and the hardworking taxpayers who pay for it. We are committed to ensuring that Medicaid is effective and accountable.

Objective 1:

Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.

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.

Medicaid is an essential part of American health care. It helps improve the health and financial security of millions of Americans every day, including more than 2 million veterans. Medicaid is the largest health care program in the country, covering approximately 1 in 4 Americans. Health insurance providers are committed to ensuring that Medicaid is effective, affordable, and accountable.

On behalf of AHIP and its member managed care plans serving people enrolled in Medicaid and CHIP, we appreciate the opportunity to provide our views on the issues discussed in this Request for Information (RFI). With respect to this question, AHIP recommends several strategies that CMS should consider:

- a. **Ex parte usage.** We recommend that CMS continue to provide technical assistance and develop toolkits for states on strategies to leverage *ex parte* data resources, improve the *ex parte* renewal process and encourage states to auto-renew members prior to the renewal date. CMS should also continue to make grants available to states to allow for *ex parte* process

enhancement and to improve infrastructure for agencies as they look to process redeterminations after the conclusion of the public health emergency (PHE). We also request CMS explore options to incentivize states to increase their levels of *ex parte* determinations, e.g., by varying a state’s administrative FMAP based on the proportion of determinations and redeterminations completed using *ex parte* processes and data sources.

- b. **Timing of MCO enrollment.** Enrollment and other program timeframes should be the same for fee-for-service and managed care delivery systems. A person’s enrollment into an MCO should occur simultaneously with their enrollment into Medicaid. This would ensure that enrollees do not start with one set of rules that are effective for some days or months and then switch to a new delivery system with a different set of rules.

We recommend CMS provide technical assistance and best practices for states seeking to leverage the X12 834 electronic enrollment application to facilitate determinations of eligibility. We suggest CMS work with states to enhance the quality of member information received through the 834 enrollment application, allow for continued updates of existing contact information, and improve opportunity for plans to utilize this contact information to communicate with members regarding eligibility renewals and redeterminations.

- c. **Real-time and cross-program eligibility processes.** CMS should continue to support states’ capacity building for “no wrong door” eligibility and enrollment systems, real-time eligibility verification, and plan selection. These elements would have special importance for states relying on the federally facilitated marketplace (FFM). For example, most state-based marketplaces have developed or are in the process of improving integration with their Medicaid agencies and eligibility systems. We believe that efforts to develop similar “no wrong door” infrastructure for the FFM platform could help people in commercial coverage make seamless transitions due to changes in circumstances that make them eligible for Medicaid. Further, split family issues are more easily addressed with real-time eligibility and enrollment because people can plan selection for themselves as well as for their children at the same time.

CMS and federal agencies could also consider providing resources and planning to help states implement or improve an “express lane eligibility” (ELE) process using existing authority for children and explore development of a similar process for adults. CMS should marshal resources to focus on development of a one-step, automated process that does not require individuals to submit a separate Medicaid application when they enroll for programs with similar eligibility criteria (e.g., SNAP or WIC). In the same vein, federal legislation could standardize criteria across programs that provide benefits and/or services to similar populations. This could dramatically streamline and improve the speed of the determination and redetermination processes, as well as address barriers to enrollment for individuals as discussed below. Federal agencies could look to the education sector for successful examples, such as the Free Application for Federal Student Aid (FAFSA) and the Common Applications. Through one form, data is shared with and processed by various public and private entities, which have successfully expanded access to post-secondary education, particularly for first generation college students. Through any of these solutions, it is important that confidentiality, security, and privacy of individuals’ personally-identifiable health information remains protected.

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?

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?

- a. Every American deserves access to affordable, high-quality care and health coverage – regardless of the individual qualities that make us who we are, like our race, color, gender, disability, sexual orientation, or health status. Addressing the needs of diverse and minority populations requires collaboration between CMS, states, providers, and Medicaid plans. Consistent with AHIP’s

equity platform, we support public policies that affirm equal access to care and coverage regardless of race, color, national origin, sex, gender identity, sexual orientation, age, or disability. Reaching all populations is critically important to ensure that every single American has access to the affordable, high-quality coverage and care they deserve.

- b. **Enrollee materials.** Appropriately targeted, culturally sensitive and inclusive communications methods are critical to increasing enrollment and retention among these populations. CMS could create a workgroup with states to develop template communications materials that are designed to enhance clarity and comprehension for individuals based on factors such as reading level. Typical verbiage, use of technical/digital resources and style of communication can vary significantly across different groups of potential enrollees and eligible individuals.
- c. **Methods of communicating with enrollees.** MCOs can assist in cases where *ex parte* redeterminations are not possible, and information must be obtained from enrollees through direct outreach. Given MCOs' proximity to members, they are uniquely positioned to support states and enrollees with eligibility redeterminations. The ability of managed care plans to communicate with enrollees in the way the enrollees prefer (mobile/text, email, mail) presents an opportunity to support and reinforce state redetermination outreach efforts. Importantly, effective enrollee education and communication can help solve health equity challenges related to accessing care for underserved populations.

States should expand outreach efforts to Medicaid managed care plans, providers, and community organizations, as building and enhancing these partnerships will improve the effectiveness of long-term coverage retention efforts. MCO outreach to enrollees would be made more effective and timely with advance notices of specific enrollees who may be subject to adverse redeterminations. We recommend that CMS encourage states to provide advance monthly lists of members at risk of disenrollment as early as possible to MCOs and communicate the specific reason for potential disenrollment (e.g., due to income change), and encourage states to allow MCOs to assist members maintain coverage to the same extent as allowed by federal regulations. We also recommend that CMS encourage states to allow communications with enrollees to be conducted through multiple modalities, including voice and text messaging. CMS should also work across agencies to remove communications/privacy barriers to member outreach through electronic means, including the Telecommunications Consumer Protection Act (TCPA).

- **SDOH barriers.** Lack of access to the internet, computers, printers, scanners, childcare, and/or transportation are barriers to enrollment for many people. CMS could provide - or help states identify - resources and strategies for overcoming these barriers to facilitate enrollment. Examples can include programs bringing agency staff or navigators to underserved communities to help them sign up for eligible programs and services; providing transportation to locations with broadband internet services; and connecting enrollees with programs that make available smart-enabled devices to needy populations. Addressing the digital divide and other SDOH barriers can provide individuals with access to critical enrollment information faster and more effectively. CMS can also support states through policies that facilitate SDOH coverage and services offered through their contracted Medicaid managed care plans. For example:
 - To facilitate Medicaid MCOs' ability to address socioeconomic barriers to enrollment and care, we recommend that CMS enumerate a list of medically related SDOH services and interventions for which the federal government would provide federal matching funds. As with other optional services provided under a waiver or state plan, state Medicaid agencies would ultimately decide which medically related SDOH services to provide and to which populations and could incorporate those services as covered benefits within Medicaid managed care contracts. Costs of such medically related SDOH services should be counted in the numerator as "medically related" for purposes of calculating and reporting Medical Loss Ratio (MLR) in Medicaid managed care, given that they help reduce health disparities and unnecessary health care utilization, and improve patient experience and care outcomes. Considering medically related SDOH services medical expenses for purposes of calculating MLR would facilitate MMCOs' ability to scale and sustain efforts that address socioeconomic barriers to enrollment and to care.
 - We also recommend CMS consult with stakeholders to explore and encourage strategies to allow states and Medicaid managed care plans to flexibly reinvest Medicaid program savings and surpluses in community health projects that include the delivery of care and services to offset social factors that negatively impact the health of individuals and communities.

- d. **Continuous coverage.** To limit the need for redeterminations and potential enrollment churn among diverse and minority populations that historically have faced enrollment and retention barriers, CMS could further accelerate approvals of state options to extend coverage for certain populations like children and postpartum women to 12 months and prioritize review/approval of waiver requests to promote continuous coverage of other populations.
- e. **Data.** A key enabling factor that would support states in reducing barriers to enrollment and retention of specific demographic groups would be the development and adoption of a common standardized framework and interoperable codes for identifying the demographic characteristics and health-related social needs noted in the question. Implementing such a standard framework would then allow ongoing identification, monitoring, analysis, and apples-to-apples comparisons across state Medicaid agencies while allowing for customizable granular data collection at the local state level to focus on local needs. CMS could leverage ongoing public private partnerships working in this area. Three examples of this work include the Gravity Project, DaVinci Project and USCDI. The Gravity Project is a multi-stakeholder-driven process that identified and created standardized codes to promote interoperability of social determinants data (<https://www.hl7.org/gravity/>). The Da Vinci Project has developed technical standards and digital endpoints to facilitate interoperable data sharing on social determinants of health (SDOH). The United States Core Data for Interoperability (USCDI) included SDOH data in its version 2 that was released in July 2021 to support broader sharing of SDOH data and improved interoperability across systems. Leveraging both content and exchange standards would not only provide consistent, actionable information to states, plans and CMS, but would also enable information to be shared with providers, public health agencies and other key stakeholders to improve care more broadly.
- f. **Cross-program alignment.** A “whole person” approach that better aligns enrollment and retention strategies across federal programs could further help states to more effectively enroll and retain enrollees, including diverse and minority individuals in Medicaid and CHIP. For example, the “express lane eligibility” described in 1-d above that facilitates enrollment of children in multiple programs with similar eligibility criteria (e.g., SNAP or WIC) will clearly simplify processes and maximize coverage opportunities if made available to adults.
- g. **Verification requirements.** CMS could consider how to reduce variation of enrollment requirements and eligibility standards within Medicaid and CHIP that create barriers to enrollment. For example, some states require verification of enrollee eligibility only once a year, while other states require verification more frequently. Some states impose more stringent documentation requirements than others. Other examples of variation are shown in state eligibility verification plans at <https://www.medicaid.gov/medicaid/eligibility/medicaidchip-eligibility-verification-plans/index.html>.

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?

- a. CMS should monitor various eligibility and enrollment process measures, such as time from application to determination, approval rates, initial eligibility determination and redetermination denial rates and denial reasons, and percentage of determinations completed using *ex parte* data sources. Specific attention should be paid to applications for individuals with disabilities as well, who are more likely to have their applications pending for a long time due to manual process issues, even though these individuals are arguably more vulnerable and should be prioritized for faster processing. Such data from states could be used both to discern trends over time within a state and for comparison across states to identify performance outliers for purposes of targeting technical assistance and process improvement.
- b. In addition, CMS could monitor disparities in Medicaid enrollment by racial/ethnic demographics and by physical address (data that should be collected upon enrollment in Medicaid) to compare who is actually enrolling in Medicaid versus those who are eligible for Medicaid but who are not enrolled. Enrollment data could be compared to population-level datasets that show demographics and income levels, such as the Census, Current Population Survey, American Community Survey, Area Deprivation Index, and Social Deprivation Index, among others. This comparison could help inform outreach efforts to communities who are not enrolling in Medicaid.

Objective 2:

Medicaid and CHIP beneficiaries experience consistent coverage. CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income SSI/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).

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?

AHIP appreciates the significant amount of effort CMS has put into planning the resumption of normal operations when the PHE ends, including recognizing the important role health insurance providers, both MCOs and Qualified Health Plans (QHPs), can play in helping members through the redetermination process and transitioning to other coverage if determined ineligible for continued Medicaid coverage. AHIP incorporates by reference the several advocacy documents on the topic of redeterminations previously submitted to CMS.

- a. **Ex parte usage.** Perhaps the single most important step a state could take to minimize inappropriate disenrollments would be to significantly increase the use of *ex parte* information in processing renewals. See recommendations about supporting states in expanding use of *ex parte* renewals above. We also urge CMS to explore assisting states in obtaining enhanced federal matching funds for systems updates necessary to do *ex parte* determinations; e.g., a model Health Information Technology Implementation Advance Planning Document (HIT IAPD) template, and/or federal funding for technical assistance.
- b. **Leveraging managed care plans.** AHIP applauds recent CMS guidance providing clarity that the federal Medicaid MCO marketing rules do not apply in cases where an MCO is assisting an enrollee with an eligibility redetermination. CMS should continue meeting regularly with states and providing additional guidance, technical assistance, best practices, toolkits, and other resources that encourage states to work with MCOs as partners in obtaining up-to-date contact information for enrollees and helping enrollees with requests for information and completing renewals. In addition, we recommend CMS create and promote to states a streamlined 1115 demonstration waiver template to encourage the adoption of facilitated enrollment and renewal models. This model, currently approved via waiver in New York state, allows MCOs (and Community-Based Organizations) the ability to partner with states and offer guided, personalized assistance to enrollees, while the state retains control over eligibility determinations.
- c. **Federal funding for enrollee assistance.** CMS should continue to offer grant funding and encourage federal financial participation for states pursuing navigator support and education for redeterminations, particularly for prioritized, complex, and vulnerable populations (e.g., LTSS or Dual Eligible members) where navigators can engage through individualized assistance.
- d. **Continuous enrollment.** Consistent with our support of universal coverage, we applaud efforts to initiate continuous enrollment for children up to the age of 6. Options that CMS could explore to support states in providing continuous eligibility to this group include: technical assistance, education on the critical linkages between early childhood health coverage and educational attainment, and waiver or state plan amendment flexibilities. Continuous eligibility can keep people covered, mitigate churn, and allow members to access their providers for care without disruption. We have long supported access to coverage -- for example, subsidized coverage provided by Kaiser Permanente through its Charitable Health Coverage Programs -- and working to bridge care when families move between payers and types of health coverage.

CMS should also address churn by considering incentives for expanding continuous coverage to other population groups that have minimal fluctuations in eligibility, such as Medicare-Medicaid dual eligibles and enrollees with intellectual and development disabilities, through demonstration waivers. We also recommend CMS issue best practices that would be applicable to states with different political environments, and long term support (i.e., extended waiver approvals), since some states are hesitant to make programmatic changes if a future administration may not continue the financial support approved by the prior administration.

Please also see our comments in Objective 2, Question 3; we do not recommend basic health plans (BHP) as a viable strategy to address churn. It presents a significant risk to the state's existing exchange market, removing a segment of the population (i.e., below a certain income level) that has received marketplace coverage since 2014. This would be disruptive for those who are pulled out of marketplace coverage and moved to a basic health plan and detrimental to the individual market risk pool, potentially raising premiums for those remaining in the individual market. Further, a basic health plan does not resolve the issue of churn, it simply means people are churning between coverage types at a higher income threshold.

2. How should CMS consider setting standards for how states communicate with beneficiaries at-risk of disenrollment and intervene prior to a gap in coverage? For example, how should CMS consider setting standards for how often a state communicates with beneficiaries and what modes of communication they use? Are there specific resources that CMS can provide states to harness their data to identify eligible beneficiaries at-risk of disenrollment or of coverage gaps?

- a. **Standards for enrollee contact information.** As a corollary to prioritizing use of *ex parte* data sources to determine and redetermine eligibility, CMS should consider setting standards for obtaining current enrollee contact information when direct communication with enrollees is necessary to verify their ongoing eligibility. CMS could require states to have a process for integrating contact information from Medicaid plans, providers, local government agencies and other appropriate entities into state databases, as these sources are likely to have the most up to date information and can assist with outreach to enrollees at risk for losing coverage.
- b. **Modes of communication.** CMS could consider requiring states to utilize multiple methods for outreach to increase the likelihood of connecting with members. For example, outreach methods should include phone outreach (both cell phone and land lines), email, mail, and in-person visits. States could have flexibility to determine the primary mode(s) of engagement, but also could be required to periodically review and report to CMS on success rates and to implement additional/alternative modes as a regular practice based on the results of those reviews. And in conjunction with other federal agencies and stakeholders, CMS should consider how resource centers could be established in certain communities offering free public Wi-Fi and phones so that community members can more easily be reached and remain in communication.

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?

- a. **Achieving "No Wrong Door."** Ensuring people have uninterrupted care and coverage is critical to reaching the goal of universal coverage. States and CMS should focus on achieving the Affordable Care Act (ACA) principle of "no wrong door" is critical to promoting continuity of coverage and helping Americans avoid gaps in coverage when they face a change in circumstances. Disconnected Medicaid and marketplace eligibility systems created unnecessary barriers for consumers seeking to enroll in or maintain coverage.

States and CMS should invest in aligning eligibility systems to remove these administrative hurdles so consumers can apply for coverage through any pathway and be determined eligible for Medicaid or marketplace coverage and more seamlessly move between coverage when their circumstances change. Fully integrated eligibility systems is possible in states with a state-based marketplace, and at least 14 current state-based marketplaces already have fully integrated eligibility systems that

determine eligibility regardless for both programs.¹ Of the states using [healthcare.gov](https://www.healthcare.gov), only seven determine eligibility and enroll regardless of entry point.² One study found that children and people of color are disproportionately likely to be uninsured but eligible for Medicaid or CHIP.³ In states [healthcare.gov](https://www.healthcare.gov) states that do not have fully integrated eligibility systems, children of color are only 14% of the population but 32% of the uninsured population who qualify for Medicaid or CHIP, putting them at the most risk of remaining uninsured if their families seek coverage through [healthcare.gov](https://www.healthcare.gov).⁴ Investing in fully integrated eligibility systems to achieve the ACA's goal of "no wrong door" would significantly lower administrative barriers to accessing and maintaining coverage and improve access to coverage and promote health equity.

- b. **Frequency of redeterminations.** As we have indicated in past comments to CMS, we support a standard that limits Medicaid eligibility redeterminations to no more frequently than once a year. More frequent redeterminations lead to greater churn and loss of continuity of both coverage and care. When enrollees change Medicaid plans multiple times a year, it creates discontinuity of care and disrupts establishment of enrollee-provider relationships that support coordinated, whole person care. Churn also creates administrative and cost inefficiencies in the form of redundant new managed care plan enrollment and onboarding processes, such as issuance of new member information materials and duplicative mandatory health examinations.
- c. **Transfers of information to marketplace plans.** Mechanisms for plans and providers to get patient data to Medicaid or marketplaces are not linear; we appreciate the efforts outlined in State Health Official Letter [22-001](#) regarding pathways for updating of contact information. We are pleased to see CMS' efforts to demystify the process for consumers by centralizing communications and places where people can get enrollment assistance. Further efforts to allow state-to-state transfers of eligibility information would help individuals make coverage transitions more smoothly, particularly since so many people have transitioned their residence since the start of the PHE.
- d. **Interoperability.** CMS could also leverage interoperability to improve the flow of information among plans, providers, and states. In the Interoperability and Patient Access final rule, CMS required to exchange certain patient clinical data (specifically the U.S. Core Data for Interoperability (USCDI) version 1 data set) at the patient's request. AHIP recommends CMS refine the payer-to-payer data exchange to focus on a subset of key coverage, clinical, demographic, claims and encounter data that would support continuity of care as consumers transition from one payer to another. Furthermore, CMS could work with the Office of the Nation Coordinator for HIT (ONC) to expand policies to encourage providers to share data with plans to further support care coordination and to allow plans to take a more active role in promoting members' health. Finally, CMS and ONC could explore ways to use the Trusted Exchange Framework and Common Agreement (TEFCA) to facilitate data sharing among providers, plans, and states to support Medicaid enrollees.
- e. Regarding **Basic Health Programs (BHP)**, we do not recommend states adopting BHPs as a strategy to promote continuity of coverage. The use of BHPs is largely uncharted territory, as only two states, New York and Minnesota, have implemented BHPs to date. These two states had pre-ACA programs that were BHP predecessors that were built on Medicaid expansion waivers. These programs had expanded coverage into what has now become marketplace coverage in all other states.

Implementing a BHP in state that does not currently offer one presents a significant risk to the state's existing exchange market, removing a segment of the population (i.e., below a certain income level) that has received marketplace coverage since 2014. This would be disruptive for those who are pulled out of marketplace coverage and moved to a basic health plan and detrimental to the individual market risk pool, potentially raising premiums for those remaining in the individual market. Further, a basic health plan does not resolve the issue of churn, it simply means people are churning between coverage types at a higher income threshold.

For the immediate issue of Medicaid redeterminations at the end of the PHE, there is not sufficient time for states to set up a BHP and moving people into a BHP would not solve some of the current issues of identifying people losing Medicaid and moving to a BHP. The timeline for states to establish and certify a BHP makes that option an inelegant and potentially market-disrupting tool that would likely be inappropriate for individuals who may transition off Medicaid this year since the timing to implement will likely not align with the termination of the PHE and the initiation of redeterminations. The major challenge of identifying people who lose eligibility for Medicaid at the end of the PHE and helping them transition to new coverage still remains.

1 https://www.familiesusa.org/wp-content/uploads/2021/12/COV-2021-67_No-Wrong-Door-Report.pdf

2 *ibid*

3 *ibid*

4 *ibid*

Instead of creating additional coverage programs such as BHPs, we recommend that states focus instead on building mechanisms to leverage the existing coverage continuum in the most seamless way possible (see previous comments about seamless eligibility and “no wrong door” in Objective 1). One solution that has been used successfully in Massachusetts is subsidies for marketplace coverage for low-income enrollees, which smooths the transition for those who lose Medicaid coverage because the premiums and cost sharing are reduced and makes it more likely they will enroll and be able to afford the marketplace coverage. These types of coverage bridges that support continuity of care with existing plans and providers is critical for Medicaid members, since Medicaid serves high numbers of people in key vulnerable populations, such as women during childbearing years, children and adolescents with special needs, and individuals with mental health and substance use disorders.

4. What are the specific ways that CMS can support states that need to enhance their eligibility and enrollment system capabilities? For example, are there existing data sources that CMS could help states integrate into their eligibility system that would improve ex-parte redeterminations? What barriers to eligibility and enrollment system performance can CMS help states address at the system and eligibility worker levels? How can CMS support states in tracking denial reasons or codes for different eligibility groups?

- a. **Data sources to improve ex-parte redeterminations.** As mentioned above in greater detail, information resources that states can leverage for conducting *ex parte* redeterminations vary widely in terms of state information system infrastructure, Medicaid agency expertise, subcontractor relationships and other factors. CMS should consider compiling a playbook of options, solutions, and best practices that have been employed in states with high proportions of initial Medicaid eligibility determinations and renewals conducted using *ex parte* data resources.
- b. **Tracking denial reasons or codes for different eligibility groups.** We understand that currently there is not a standard code set available for eligibility, enrollment, and disenrollment processes across different enrollee groups. To enable better tracking by states, CMS could consider convening or designating a workgroup (for example, the Workgroup on Electronic Digital Interchange (WEDI) or Health Level 7) to develop a standardized set of eligibility and denial reason codes and require states to use them. CMS’ role in supporting development of the HIPAA transaction data sets 20 years ago could serve as a model.
- c. **Express lane eligibility and no wrong door.** Please see comments in Objective 1. Additionally, we urge CMS to help states obtain the enhanced administrative match through template IAPDs, technical expert TA to support implementation, and standardized data use agreements to speed the time to implementation.

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 systems, and this care will be aligned with the beneficiary’s needs as a whole person. CMS is seeking feedback on how to establish minimum standards or federal “floors” for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or “floors” would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices.

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?

- a. We support the goals articulated by CMS leadership in the 2021 article in *Health Affairs*, including the goal of having the majority of Medicaid enrollees covered through accountable care relationships by the year 2030. We recognize there are inherent challenges in achieving this goal, in part because such arrangements must incorporate value-based components

such as quality and performance measures, and risk and gainshare incentives. We also want to note that MCOs are accountable, and partner with providers to deliver on the vision outlined by CMS of increasing accountable care relationships. Of course, providers must be willing to participate in value-based arrangements and accept risk and other components of those arrangements. Development of federal access standards for Medicaid and CHIP should ensure consistency with risk-based principles and workability in value-based contracting arrangements. In addition, we oppose the development of minimum provider rates at the federal level and note that among the potential impacts is that federal minimum rates could reduce incentives for providers to participate in value-based arrangements. Therefore, if CMS were to develop minimum access standards that relate to provider payment levels, they should be conditioned on accepting explicit requirements for participation in value-based arrangements.

- b. **State/local flexibility.** Existing Medicaid managed care regulations require states to monitor the availability and accessibility of covered services, and to develop quantitative network adequacy standards that consider a variety of elements to ensure enrollee access. We believe that state regulators and Medicaid agencies are in the best position to determine the network adequacy standards that should apply to the insurance markets and Medicaid programs in their states. We are concerned that applying additional standards or review at the federal level creates additional burden and complexity without corresponding benefits for Medicaid enrollees.

Additionally, we are concerned that additional federal standards may conflict with standards developed by states over time, and not give appropriate consideration to each state's unique market dynamics and availability of providers and provider types, which can vary not only across states but within sub-state regions. Accordingly, we support retention of the existing regulatory structure for managed care plans. However, if CMS were to develop new minimum standards related to access to services, it should be done through a collaborative and negotiated process with key stakeholders -- states, Medicaid plans, providers, consumers, and national accrediting organizations -- that results in flexible standards that are based on clinical evidence and population needs and can be adapted by states to take into account the various ways that their residents access care.

- c. **Types of measures.** We urge CMS to avoid rigid national quantitative standards that rely on time and distance measures, as such measures are not appropriate for many geographic areas and do not actually ensure that enrollees will be able to receive care when they need it. Instead, we believe that access standards within each state should incorporate metrics that demonstrate Medicaid enrollees have timely access to appropriate, high-quality care such as enrollees' ability to receive care within a reasonable timeframe as determined by the state; plan performance on validated quality and patient satisfaction measures such as HEDIS and CAHPS; the availability of "24/7" access to clinical support through advice lines and telehealth; and whether plans engage in active monitoring of provider access.
- d. **Telehealth.** If CMS develops minimum access standards, we recommend that those standards recognize the critical role of telehealth, self-service, and digital care (software as a device) in broadening access to health services. This was true even before the COVID-19 pandemic, but it is especially relevant now as patients have increasingly turned to telehealth and other solutions to receive convenient, affordable, and high-quality care. Accordingly, any minimum access standards that CMS develops should include the availability of telehealth and other innovative service delivery mechanisms into the evaluation framework.

2. How could CMS monitor states' performance against those minimum standards? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?

Rather than impose compliance actions against states, CMS should consider using minimum standards to identify states that require additional support in expanding available provider capacity. This would allow the agency, working with other agencies like HRSA, to identify potential needs, grant opportunities, and other means to expand access to safety net providers in rural and underserved communities.

3. How could CMS consider the concepts of whole person care[5] 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? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination? [5] Under a “whole-person” philosophy, individuals with chronic physical and/or behavioral health conditions are provided linkages to long-term community care services and supports, social services, and family services, as needed. State Medicaid Director Letter #10-024. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd10024.pdf>

- a. **Flexibility.** We support CMS’ increasing focus on promoting whole person care. In line with our recommendations above, if CMS establishes minimum access standards, it should develop them in collaboration with states and allow the states to have the flexibility to adopt access standards that reflect the characteristics of their unique geographic and enrollee demographics. Access standards and measures should focus on how enrollees’ care needs are met, allowing states a degree of flexibility (including use of waivers) that reflects characteristics of local service areas, rather than on mandating arrangements with specific kinds of providers. Effective care coordination typically involves conducting a comprehensive assessment of an individual enrollee’s care needs, development of a care and services plan (CSP), and then execution on the elements of the plan. The CSP, together with provider claims and encounters processed for each of the CSPs’ elements, provide a framework for monitoring access.

Effective whole-person care requires engagement by providers who are committed to the delivery of high-quality care, and can coordinate with other providers, capture, analyze, and share data, and otherwise ensure delivery of the most effective and comprehensive set of services that meet all of a patient’s physical health, behavioral health, and social needs. Strict quotas or other metrics based on provider specialty does not align with the ultimate goal to provide quality access to care for members. Health plan flexibility allows plans to negotiate constructive and quality-focused arrangements with network providers. In addition, in line with our earlier comments, value-based arrangements are well-suited to supporting whole person care across the major dimensions of physical and behavioral health, LTSS, and social needs when such arrangements include performance measures of the extent to which the needs of individual enrollees are met through care management activities of providers and MCOs.

- b. **Addressing SDOH benefits through managed care.** Health-related social needs are cross-sectoral by nature and should be treated as such—assuring that programs and services are developed and delivered with a “whole person” approach rather than developed and delivered as specific to a particular product or federal program. A whole person approach could help provide needed services to Medicaid and CHIP enrollees more effectively.

To facilitate Medicaid managed care’s ability to address health-related social needs in a whole-person approach, CMS could enumerate a list of medically related SDOH services and interventions for which CMS would provide federal matching funds. State Medicaid agencies would ultimately decide which medically related SDOH services to provide and to which populations and could incorporate those services as covered benefits within Medicaid managed care contracts. These medically related SDOH services should be considered “medical services” for the purposes of calculating Medicaid managed care plans’ MLRs, given that they help lower costs by reducing unnecessary health care utilization, improve patient experience, reduce inequities, and improve outcomes. Having medically related SDOH services be considered medical expenses for purposes of calculating Medicaid plan MLRs would facilitate the ability of Medicaid plans to scale and sustain efforts that address socioeconomic barriers to enrollment and obtaining care.

- c. **Behavioral health.** There are several challenges to consider regarding increased access to behavioral health services that are coordinated with other patient needs. The challenges include longstanding shortages of behavioral health clinicians, which in many locations have been exacerbated by many behavioral health providers choosing not to participate in Medicaid managed care networks. Furthermore, there has been increased demand for behavioral health services during the COVID-19 pandemic. Together, these factors have resulted in the demand for behavioral health services exceeding the available supply. In addition, particularly given the short supply of behavioral health clinicians, it is also difficult to differentiate quality across clinicians or facilities. Strategies and policies that could help address these complex and multifaceted challenges include integrating

behavioral health into primary care settings, promoting the use of telehealth to increase access to care, creating centers of excellence to assist patients with complex needs such as pregnant and postpartum women with behavioral health conditions and/or substance use disorders, and extending Medicaid coverage for new mothers to 12 months *post-partum*. (See also AHIP brief on integrating behavioral health and primary care: <https://www.ahip.org/resources/issue-brief-integrating-behavioral-health-and-primary-care-2>. To support implementation of these strategies, we recommend CMS create waiver templates to expand SUD capacity, provide support for waivers that measure budget neutrality, taking into account other costs (social, criminal justice, etc.); and include evaluation metrics specific alternative modalities of delivering BH – telehealth, collaborative care, leveraging of non-licensed practitioners in evidence-based models, etc.

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?

- a. **Provider workforce diversity.** AHIP and its members support diverse provider networks that ensure access while reflecting the communities they serve so that enrollees can find providers that meet their preferences and needs to receive culturally competent and patient-centered care. This includes demographic diversity of providers and practitioners as well as diversity of staff and care team members. While managed care plans endeavor to develop provider networks that are diverse and reflect the demographic characteristics of the enrollees they serve, one should keep in mind that the characteristics of the provider infrastructure in a given geography are outside of the control of managed care plans. As part of our efforts, AHIP is advocating for more programs that promote health care workforce diversity, but health insurance providers are not in a position to implement these programs unilaterally (e.g., loan repayment and scholarship programs that help incentivize diverse providers to serve throughout the country and help address critical staffing shortages).
- b. **Data.** Health plans have not historically collected demographic data regarding providers and their staff. As with any aspect of provider data, these data are challenging to collect accurately and completely. While health insurance providers continue to explore solutions to obtain provider demographic data to help facilitate consumers’ abilities to find providers they feel comfortable seeing for care, AHIP strongly recommends that a centralized repository of this information be created to ensure that the data is collected and maintained accurately and consistently. We recommend CMS consider leveraging the National Provider and Plan Enumeration System (NPPES) for this purpose. This would ensure there is a “single source of truth” for provider demographics that health plans and health care organizations could use to help individuals find providers they feel comfortable seeing for care.
- c. **Training.** While racial or cultural harmony between providers and patients is important the large disparity between the number of physicians who are Black or African American (5%) or Hispanic/Latino (3-4%) versus the number of people who identify as Black or African American or Hispanic/Latina in the U.S. (13% and 19%, respectively)⁵ require a focus on enhanced training of providers and staff today delivering care. Areas of focus should include cultural competency and humility, anti-bias, and anti-racism to promote empathy, respect, and understanding between providers and patients. Medicaid MCOs in many states help ensure their contracted network providers deliver culturally competent and linguistically appropriate care through various approaches, including through provision of cultural competency and humility training. To this end, CMS should work with national accrediting organizations, licensure compacts and state health professional licensing boards to encourage cultural competency, anti-bias, and anti-racism training as conditions of licensure or license retention to support effective, standardized training and to reduce the administrative burden on health care providers from having to complete multiple trainings for each network in which they participate.

⁵ <https://www.ama-assn.org/education/medical-school-diversity/how-get-3000-more-black-people-physician-pipeline>

5. What are specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

- a. **Licensure.** Increasing and diversifying the total pool of available providers poses a significant challenge, particularly in the short term. Accordingly, CMS should prioritize actions that augment the reach of the existing provider workforce and thereby most quickly and effectively mitigate the impacts of provider shortages. CMS should strongly support efforts to allow providers to practice across state lines when they hold the appropriate medical licensure. We also support promotion of interstate licensure compacts that recognize out-of-state licenses. This will increase access to services and address areas that may face provider shortages.
- b. **Telehealth.** Please also see our recommendations on telehealth above. The experience of the pandemic has shown that telehealth, at least for services addressing particular conditions such as certain behavioral health care needs, can be an extremely effective means of enhancing access to care. In addition, telehealth can play an important role in value-based care arrangements. Further, we encourage CMS to convene a task force or technical expert panel of federal and state leaders with relevant expertise to consider the licensure issue and make recommendations on changes that would increase access to telehealth services beyond the COVID-19 pandemic.
- c. **Innovation.** CMS should leverage its Innovation Center to address innovative payment and care delivery arrangements in Medicaid to test benefit enhancements and greater integration of care teams for Medicaid enrollees. We encourage CMS to collaborate with health insurance providers to develop models that leverage the capabilities of Medicaid plans, which would facilitate multi-payer value-based initiatives and greater alignment across payers.

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 experience with care across states, delivery systems, and populations). CMS is interested in feedback about what new data sources, existing data sources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community-based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

1. What should CMS consider when developing an access monitoring approach that is as similar as possible across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care programs) and programs (e.g., HCBS programs and dual eligibility in Medicaid and Medicare) and across services/benefits? Would including additional levels of data reporting and analyses (e.g., by delivery system or by managed care plan, etc.) make access monitoring more effective? What type of information from CMS would be useful in helping states identify and prioritize resources to address access issues for their beneficiaries? What are the most significant gaps where CMS can provide technical or other types of assistance to support states in standardized monitoring and reporting across delivery systems in areas related to access?

- a. The Agency for Healthcare Research and Quality (AHRQ) defines access as the attainment of timely and appropriate health care.⁶ AHRQ further elaborates that access measures should be supported by evidence that an association exists between the measure and the outcome of or satisfaction with care. CMS should first consider leverage established performance measures to assess both access and quality in Medicaid, and then seek to develop new measures where there is consensus about the link between a concept and outcomes.

AHIP has partnered with CMS to convene the Core Quality Measures Collaborative (CQMC) to identify core sets of high-value, high-impact, evidence-based measures that could be aligned across public and private payers to improve health outcomes and provide consumers with actionable information to support their health care decision making. The CQMC membership includes

⁶ <https://www.ahrq.gov/gam/summaries/domain-definitions/index.html>

health insurance providers, medical associations, consumer groups, purchasers (including employer group representatives), and other quality collaboratives. Using broadly accepted, evidence-based measures such as those in the CQMC core sets could ensure access monitoring is feasible and provide actionable data. Moreover, these measures are standardized and can be used across public and private payers to minimize the burden of measurement. CMS has recently partnered with the CQMC to identify which of the measures in the CQMC Core Set could be most useful in identifying disparities in care as well measures that directly assess health equity. Adoption of these measures could promote alignment across Medicare, Medicaid, and commercial plans. Such alignment would ensure that equity is a consistent focus and minimize the resources required to report and calculate performance metrics.

- b. Similarly, CMS could work with the CQMC to advance use of measures based on T-MSIS across payers to further leverage this data to measure access broadly and advance equity for all patients.

2. What measures of potential access, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor (e.g., provider networks, availability of service providers such as direct service workers, appointment wait times, grievances and appeals based on the inability to access services, etc.)? How could CMS use data to monitor the robustness of provider networks across delivery systems (e.g., counting a provider based on a threshold of unique beneficiaries served, counting providers enrolled in multiple networks, providers taking new patients, etc.)?

- a. Flexibility and deference to state Medicaid programs is important in these areas. States are in the best position to monitor access based on their unique considerations: populations, programs, services, provider community characteristics, and geographic considerations. CMS should rely on existing data and not create any new data demands on states or plans. For example, the CQMC has developed core measure sets to assess quality in ten clinical specialty areas, including primary care, behavioral health, pediatrics, HIV, and Hepatitis C. The CQMC core sets include potential measures of access such as the receipt of recommended screenings and vaccinations, receipt of follow-up care, and receipt of well-child visits. As noted above, CMS could leverage these measures to assess access in a uniform manner across public and private payers to promote equity while avoiding adding additional administrative burden to providers.

Where there are gaps in measures, CMS should work with the CQMC Health Equity Workgroup to develop consensus about new measure concepts that are linked to outcomes.

- b. Also, AHIP has convened a Health Equity Measures for Value-Based Care Workgroup that is exploring measures to better to monitor the equitable provision of services and encourage organizations to invest in organizational equity structures and processes. We would be happy to share this work with CMS for consideration. An important finding of AHIP's work has been the value in focusing on measures of upstream prevention to promote health equity. For example, stratifying rates of colorectal or breast cancer screening supports the early identification of health care disparities and allows for interventions to close these gaps before disparities can have negative effects on patient health.

3. In what ways can CMS promote a more standardized effort to monitor access in long-term services and supports (LTSS), including HCBS programs? For example, how could CMS leverage the draft HCBS measure set, grievances and appeals, or states' comparisons of approved Person-Centered Service Plans to encounter or billing data in managed care or fee-for-service to ensure appropriate services are being received? Which activities would you prioritize first?

- a. **Complexity.** The nature of many LTSS and the locations in which they are provided differ fundamentally from services provided in traditional health care settings. Standardization is more complicated due to these factors, and because many LTSS involve a service provider traveling to the LTSS program enrollee's residence to assist with various activities of daily living (ADLs). Such services include personal attendant services (PAS), durable medical equipment/ supplies, medication administration, home-delivered meals, employment supports, home modifications, assistive technology, home health, and skilled nursing, among others. As noted in our earlier response on Question 3 of Objective 4, LTSS programs are based on a standardized approach to care management, consisting of a comprehensive assessment of the individual's services and supports needs, development of a care and services plan (CSP), and then execution on the elements of the plan. The CSP, together with service provider claims and encounters processed for each of the CSPs' elements, provide a basis for monitoring access.

- b. **Monitoring access for home-based LTSS.** If CMS were to implement new monitoring requirements for LTSS provided by LTSS providers traveling to the enrollee's residence, we believe different access measures for determining adequacy should apply in 1) pre "go-live" readiness reviews for new programs; and 2) post "go-live" steady state program operations.
- For purposes of pre-operational readiness reviews, we believe that LTSS network adequacy evaluation needs to draw on existing access measures, such as ensuring that plans have provider contracts covering the range of LTSS for the geographic service area and comparing the number of contracted providers for a service with the number of enrollees expected to use that service, based on historic service utilization levels.
 - For steady-state operations, CMS could encourage states to base LTSS access monitoring on a limited set of performance measures (see discussion below regarding time to placement, missed appointments, and late visits); and solicit feedback from enrollees receiving self-directed attendant services. LTSS monitoring standards should also take into account differences in the relative numbers of providers and enrollees in urban and rural areas, as well as differences in the nature of agency-directed vs. self-directed personal attendant services.
- c. **Monitoring access for LTSS outside the home.** For services that involve the enrollee traveling to a provider's location, we recommend that states develop separate network adequacy standards which may include provider-enrollee ratios or, if the state chooses, time/distance measures. Medicare time and distance standards could serve as a model. We also urge CMS to consider modern modalities of care delivery in developing network adequacy standards, recognizing evolving areas of innovation such as telehealth and remote monitoring. There should be flexibility in the standards, so Medicaid plans and states can quickly identify and account for new approaches that can help enrollees to connect with services and Medicaid plans to meet access requirements.
- d. **Specific measures.** With respect to access and service measures for LTSS programs that have stabilized and achieved a level of relative maturity, there are three principal measures that most directly correlate with positive outcomes: time to placement, missed visits, and late visits. Monitoring of these measures can be accomplished by comparing elements of the CSP with corresponding claims and encounters from the respective care and service providers, supplemented in some cases by electronic visit verification system (EVV) records.
- **Time to Placement** refers to how long it takes from the time a given service is requested by the health plan (based on the plan's assessment of the enrollee's needs and development of their person-centered CSP) to the time the enrollee receives the service at his or her location, commonly referred to as the "enrollee's placement." Faster times to placement correlate with stronger LTSS network access and adequacy. Note that for services to be received in the home, time to placement is more relevant than time and distance standards. The fact that a given provider is physically located near an enrollee is of little value if the provider is unable to provide the enrollee with services in their residence on a timely basis. This measure is also relevant for non-recurring services, such as home modifications.
 - **Missed Visits/Appointments** measures the percentage or number of scheduled visits or appointments that do not occur (excluding those cancelled by the enrollee). This measure is especially important for evaluating performance of recurring services. If an LTSS enrollee's personal attendant does not show up in the morning, for example, the enrollee likely is unable to complete essential ADLs, such as getting out of bed, eating, or going to work. Low numbers of missed visits are a second indicator of good LTSS network adequacy.
 - **Late Visits/Appointments** measures the percentage or number of scheduled visits or appointments that occur later than scheduled (excluding those for which the time is changed by the enrollee). Like missed visits, low numbers of late visits are a third indicator of good LTSS network access and adequacy for recurring services. The measure could be based on the number of scheduled visits or appointments that start more than a specific period of time after the scheduled time (the specific time could vary with the kind of service).
- We note that the **Missed Visits/Appointments** and **Late Visits/Appointments** measures are both very compatible with LTSS programs that utilize electronic visit verification system (EVV) or other similar monitoring systems.
- e. **Self-direction.** Personal care attendant services provided through self-directed programs shifts control over resources and staffing from service providers to the enrollee, allowing each enrollee to determine the role and extent that the provider will play in the enrollee's life. We believe that encouraging and supporting self-direction of services among people receiving LTSS is

an important goal. Standards should be centered on enrollee choice and self-determination, with enrollees deciding important aspects of their individualized care and service plans and selecting individuals to participate on their interdisciplinary care team. Access monitoring developed for agency-directed models may not be appropriate to use in self-directed models because enrollees may choose providers who are farther away or unable to visit the enrollee frequently. In developing standards for self-directed programs, CMS and states should focus monitoring via feedback solicited from enrollees regarding the personal attendant services they receive, and whether services are at the appropriate level, amount, time, and place. Depending on the structure of its MLTSS program, the state may look to the enrollee's MLTSS plan or the state's contracted fiscal management entity to survey enrollees for this information in these feedback areas.

- f. **Geographic differences.** As noted above, LTSS network adequacy standards should account for differences in provider supply between urban and rural areas. Primary and specialty physician supply varies significantly across urban and rural regions of the country; as a result, many states apply different network adequacy standards for urban and rural areas for traditional health care providers. Relative shortages of LTSS providers in rural areas suggest taking a similar approach. States should develop distinct network adequacy standards for rural areas that are less stringent than those in urban areas, which will allow health plans to build networks designed to provide reasonably prompt access to high quality LTSS while accounting for provider infrastructure.
- g. **Ad hoc contracts for certain services.** Some LTSS warrant an even more flexible approach. Most LTSS are not directly related to medical care, and some are required only occasionally. We recommend allowing states and LTSS plans to contract for certain services on an as-needed basis, such as home repairs, moving assistance, environmental technicians, and pest control, and that an access standard consider the existence of such contractual relationships in determining compliance. We also note that many states have developed their own solutions for certain services, like home meal deliveries. CMS should consider an exemption from MLTSS network adequacy standards for states and/or localities that have developed their own fee-for-service sole source networks. As discussed earlier, claims and encounters for care and services enumerated in an individual's CSP provide a basis for monitoring access for these kinds of services and supports.

4. How should CMS consider requiring states to report standardized data on Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes that address enrollment in coverage and access to services? How could these data be used to meaningfully monitor access?

While data from fair hearings, appeals and grievances could be leveraged as a component of access analyses, it's important that such data be viewed in the appropriate context. These kinds of data provide a retrospective view of care access as it existed in the past and may be most useful as high-level indicators for identifying general access issues in service categories or geographies, which are then subject to more detailed analysis. Another significant consideration is that different state Medicaid programs may apply different access and process standards and timelines to the matters subject to and being heard in fair hearings, appeals, and grievances. While CMS could require states to report data in a standardized format, that would not make the data comparable across programs unless the underlying access and process standards and timelines themselves were standardized as well. Otherwise, CMS could only evaluate the reported data in the context of the state submitting the data, perhaps for monitoring trends over time.

5. How can CMS best leverage T-MSIS data to monitor access broadly and to help assess potential inequities in access? What additional data or specific variables would need to be collected through T-MSIS to better assess access across states and delivery systems (e.g., provider taxonomy code set requirements to identify provider specialties, reporting of National Provider Identifiers [NPIs] for billing and servicing providers, uniform managed care plan ID submissions across all states, adding unique IDs for beneficiaries or for managed care corporations, etc.)?

Objective 5:

Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible. Section 1902(a)(30)(A) of the Social Security Act (the “Act”) requires that Medicaid state plans “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” Section 1932 of the Act includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States “in an effective and efficient manner...” CMS is interested in leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.

1. What are the opportunities for CMS to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?

- a. The standards of Section 1302(a)(30)(A) have implications for both Medicaid FFS and managed care programs, although with slightly different practical ramifications. In FFS, the requirement applies directly to the state’s provider fee schedules. In managed care, the requirement is two-fold:
 - i. Provider payment rates paid by Medicaid plans must be sufficient to attract enough providers to serve Medicaid enrollees and meet network adequacy requirements; and
 - ii. State capitation payments to Medicaid plans must be sufficient to ensure that Medicaid plans can comply with those requirements.

AHIP and its member Medicaid plans support provider payment rates that are adequate to ensure providers’ participation in Medicaid networks, and actuarial soundness requirements that ensure plans can meet access standards. Key to actuarial soundness is consistent and transparent documentation of data, projections, and assumptions in Medicaid rate setting. Most of the analysis, projections, assumptions, and calculations supporting Medicaid rates are shared only between a state Medicaid Agency and its contracted actuaries. We recommend CMS require states to meet an increased level of transparency by sharing such information with MCOs in the rate setting process.
- b. Generally, rate and risk assumptions need to vary to reflect the characteristics of different Medicaid eligibility groups and the programs in which those population are enrolled; in most cases it is not appropriate to apply the same assumptions for all populations. This is particularly true for complex populations in the Temporary Aid for Needy Families (TANF), Aged, Blind, and Disabled (ABD), and Long-Term Services and Supports (LTSS) eligibility groups. These payment and rate calculation principles and practices apply without regard to the level of federal financial participation (FFP) involved and differences in risk can apply between TANF, ABD, and LTSS populations, even though these populations may have the same level of FFP. Accordingly, we recommend that CMS allow states the flexibility to incorporate appropriate risk charges that reflect different levels of risk across the populations served by Medicaid.
- c. We support a federal Medicaid managed care rate setting framework that ensures the actuarial soundness of Medicaid capitation rates and their development in a consistent manner across state Medicaid programs. As applied to the objective of access to care and services, adjusting provider rates is one of several tools available in cases where a state identifies access issues in a certain specialty or geography. However, such analyses and identification of barriers is best done by states, given the state’s familiarity with local provider infrastructure and dynamics, and tools should be applied narrowly to specific access situations. We believe that access tools cannot be defined and implemented at the federal level for a program that has so many variations at the state level.

We also support efforts to bring more transparency to the rate setting process, including requiring that states, when requesting CMS certification of a rate range, document prior to the start of the rating period the rate range for each MCO by eligibility group. We also support CMS recertification of rates when there are changes during the rating period, even in cases where changes move rates within the approved rate range. Further, we recommend that states using rate ranges in competitive bidding should be required to provide MCOs with approved rate ranges, detailed trends, and historical cost data in advance of bidding, increasing the likelihood that bids will be in a range consistent with actuarially sound rates.

2. How can CMS assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?

- a. State and Medicaid plan investments in reducing socioeconomic barriers to care are upstream factors that help promote access to care. As one aspect of payment policies, we encourage CMS to affirm the positive impacts of such investments by permitting the inclusion of expenditures that mitigate impacts of socioeconomic barriers and SDOH in the numerator of the MLR calculation. To support Medicaid managed care plan initiatives that address socioeconomic barriers, CMS should consider enumerating a list of health-related SDOH services and interventions for which CMS would provide federal matching funds. State Medicaid agencies would ultimately decide which health-related SDOH services to provide through their programs and to which populations and could incorporate those services as covered benefits within Medicaid managed care contracts. These health-related SDOH services, as well as “value added” benefits offered by MCOs, should be considered “medical services” for the purposes of calculating Medicaid plan MLRS, given that they help lower costs by reducing unnecessary health care utilization, improve patient experience, reduce inequities, and improve outcomes. Including health-related SDOH services as medical expenses for purposes of calculating MLRs would facilitate MCOs’ ability to scale and sustain efforts that address socioeconomic barriers to enrollment and to care.
- b. To encourage Medicaid MCOs to invest in community-wide solutions that address social determinants of health not just of their individual members but of the wider community, CMS and state Medicaid agencies should look at rate adjustment methods that would prevent premium slide that could result from investments that improve community living conditions. Such rate adjustment methods have been explored in Oregon and California (<https://www.chcf.org/wp-content/uploads/2019/04/IntendedConsequencesMediCalRateSettings.pdf>) that would trigger a rate adjustment and shared savings mechanism between the State, the MMCO, and their provider and community-based partners if: (1) a state-approved community investment has been made by the MMCO; (2) certain quality targets are met; and (3) a certain amount of savings are generated. These types of rate adjustment methods incentivize MMCOs to invest in broader solutions that address SDOH and advance equity without being penalized in the process.⁷
- c. As we noted in our comments on Objective 3, increasing the adoption of value-based arrangements relies on the willingness of states, providers, and Medicaid plans to accept operating under a framework of value-based quality and performance measures, together with risk and gainshare incentives. We pointed out that the development of tactics like minimum provider rates at the federal level could reduce incentives for providers to participate in value-based arrangements. Similarly, at the federal level, broad encouragement of tactics such as directed payments to promote access runs the risk of reducing provider incentives to participate in value-based arrangements. States are best positioned to make decisions regarding the thoughtful and precise application of these kinds of tactics to specific service categories and geographies experiencing access issues. Therefore, assessment of the impacts of such tactics should not rely on measurement using a federal standard, but rather on analysis of how such tactics were applied, lessons learned, and best practices identified.

⁷ <https://www.chcf.org/wp-content/uploads/2019/04/IntendedConsequencesMediCalRateSettings.pdf>

3. Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community-based services (HCBS). What data sources, methods, or benchmarks might CMS consider to assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?

- a. As the question suggests, using Medicare rates as a pricing reference for Medicaid presents significant methodological problems. To start with, most Medicaid enrollee populations are very different than Medicare enrollees. The range of services and service settings covered by Medicaid is much broader than Medicare. In addition, Medicare rates are developed using a very complex process, and it is difficult to imagine how CMS could expand and replicate that process across 56 different Medicaid jurisdictions. We do not support the use of Medicare rates as a pricing reference in the context of assessing access in Medicaid
- b. For specific kinds of services where a state identifies payment rates in a specific area as a potential or contributing barrier to access, CMS could incentivize states to set minimum payment levels (on an actuarially sound basis reflected in capitation rates) and offer enhanced federal matching funds for those kinds of services.

4. Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries.[6] 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?

- a. Inconsistent and duplicative screening/health risk assessment requirements can create provider burden. While these types of screenings are an important aspect of person-centered planning, overly prescriptive regulation regarding their content and administration can create unnecessary burden for providers as they care for patients
- b. Inconsistent and duplicative provider credentialing requirements can create burden for Medicaid providers, particularly when contracting with multiple MCOs. CMS should encourage states to work with their MCOs to develop standardized uniform credentialing criteria and processes that permit the provider to file a single credentialing application with any of the state's contract MCOs.
- c. Expanding on our earlier response to Objective 4, reducing the administrative burden associated with quality measurement is another core goal of the CQMC. The CQMC aims to reduce administrative burden by aligning measures across public and private payers to minimize the effort by providers to collect and report quality data. By encouraging states to adopt the measures in the CQMC core sets and/or adopting the measures in the CQMC core sets CMS could reduce one potential source of administrative burden.
- d. States and Medicaid plans worked together during the COVID PHE to ease restrictions on prior authorization. As the country begins to emerge from the PHE, Medicaid plans will begin to apply appropriate utilization management tools to ensure that enrollees receive the right care in the right place at the right time, support the long-term financial sustainability of state Medicaid programs, and reduce instances of fraud, waste, and abuse. We recognize that providers may feel additional administrative burden as utilization management tools are reintroduced. We believe that burden can be reduced by adoption of electronic prior authorization (EPA) protocols. EPA supports evidence-based care, reducing duplicative and unnecessary services while promoting timely access to services and reducing provider burden. To implement EPA systems successfully, CMS and Medicaid agencies would need to foster collaborative programs across the range of Medicaid stakeholders, implementing proven standards that ensure functionality across payer and provider systems. But in the long run, Medicaid enrollees, states, and providers would see a reduction in administrative burden as well as other benefits.