Questions included in the Request for Information: Access to Coverage and Care in Medicaid & CHIP

February 2022

The questions in the Access to Coverage and Care in Medicaid and CHIP RFI are presented below. In order for your comments to be received, please respond to the RFI at: https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV_6EYj9eLS9b74Npk. Note that responses to each question are limited to 20,000 characters. The public comment period is open for 60 days from February 17, 2022, through April 18, 2022.

Submit comments on the RFI via the survey response fields. Comments on the RFI may contain links to ***supplemental*** *or* ***supporting*** *materials, such as research articles, data, and/or visuals. When linking to supplemental materials in comments, describe the material in the question response field to which the material applies.*

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.

   CMS should increase the requirements for each state's oversight of eligibility determination timelines and increase public reporting of state performance against the requirement to provide greater transparency for all stakeholders. In California, the state delegates Medicaid and CHIP enrollment to the 58 counties. While the counties are required to process enrollment within 45 days, hospitals (and patients who meet the eligibility requirements) have experienced significant delays with these timelines. In many instances this can lead to delays in patient care. Even during the public health emergency (PHE), when counties are not required to perform redeterminations, new eligibility determinations are not being met within the 45-day window. These delays will be exacerbated once the PHE ends, and counties resume redeterminations.

   CMS should create a permanent extension of the Hospital Presumptive Eligibility (HPE) flexibilities authorized under the PHE. In California, Medicaid and CHIP enrollment has grown significantly since the expansion of coverage through the Affordable Care Act and further expanded temporarily through the PHE. One reason for this success has been HPE. At a time when county eligibility determinations remain a barrier to access to care, HPE has been a reliable pathway for many of the Medi-Cal beneficiaries to access medically necessary care in a timely manner.

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?

The California Hospital Association's (CHA) members believe that CMS should:

- *Allow greater flexibility for using other means-based government assistance programs to determine categorical eligibility for Medicaid.*
- *Support and encourage states' use of a single streamlined application process for all government assistance programs (e.g., Medi-Cal, CalFresh, CalWORKS, unemployment, etc.).*
- *Allow states to access other federal means-based government assistance programs to leverage data and information necessary for Medicaid eligibility determinations/redeterminations.*
- *Include a process with Medicare enrollment that validates eligibility for Medicaid and establishes a pathway for seamless enrollment for dually eligible beneficiaries.*

CHA believes that implementing these recommendations will reduce the administrative barriers that dissuade individuals from accessing programs for which they are eligible. Creating a "no wrong door" approach that increases access to multiple programs has the potential to significantly reduce inequality. It will also have the added benefit of reducing the administrative burden on states, thus reducing the cost to manage these programs.

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?

   CMS should allow greater flexibility and encourage increased use of presumptive eligibility pathways such as Hospital Presumptive Eligibility (HPE). One example of the flexibility that CMS should provide is eliminating limits on how frequently hospitals can use Presumptive Eligibility for an individual each year. The California Hospital Association's members also believe that CMS should eliminate barriers to access as result of limitation on federal financing support (e.g., Institutes to Mental Disease – IMD – exclusion, federal funding for non-emergency related services for pregnant beneficiaries).

   The IMD exclusion is particularly pernicious as it prevents individuals who need inpatient mental health care from accessing the services they need. This is the only part of federal Medicaid law that prohibits payment for the cost of providing medically necessary care because of the type of illness being treated. This discriminatory exclusion has been in place since Medicaid's enactment, and it has resulted in unequal coverage of mental health care. People with mental health conditions — just like people with any medical condition — need a range of care options from outpatient services to hospital care. Updating the IMD exclusion to allow for short-term stays in psychiatric hospitals helps strengthen the mental health system and provides those who rely on Medicaid with more treatment options.

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?

   The California Hospital Association's (CHA) members believe that CMS should take steps to improve transparency into the eligibility redetermination process. We strongly support increasing oversight and public reporting of eligibility redetermination timelines to improve performance, which will result in better access to care for Medi-Cal eligible individuals.

   Further, CMS should encourage states to adopt existing policy options through temporary enhanced federal funding. For example, in states that haven't adopted the "Express Lane Eligibility" (ELE) and/or 12-months of continuous eligibility, CMS could incentivize participation in these programs by temporarily providing enhanced FMAP percentages (similar to the 1% add-on for Screening, Brief Intervention, & Referral to Treatment – SBIRT – services, or Health Homes programs). Experience has shown that once a state implements these improvements, it becomes challenging to roll back these programs.

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?

   The California Hospital Association (CHA) strongly encourages CMS to allow health plans and providers to access an individual's redetermination date and provide outreach to enrolled members and patients prior to that date as a means to inform the individual of the importance of responding to redetermination efforts from counties. In particular, we believe that communications from providers or their care management team could be highly effective at reducing inappropriate disenrollment as patients are more likely to be attuned to and receptive of communications (both in person discussions at registration and written — letters, text, emails) from their caregivers. Further, CHA believes that any standards for how often a state communicates with beneficiaries must be differentiated for fee-for-service and managed care beneficiaries given that in many states these coverage vehicles serve different populations. For example, in California, Medi-Cal beneficiaries who receive coverage through the fee-for-service delivery system are more likely receiving coverage through presumptive eligibility, or temporary or restricted scope coverage, and it's critical to deploy strategies that are different than those beneficiaries enrolled in a managed care plan.

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?

   CMS should allow individuals transitioning between programs that have different benefit packages or levels of protection to continue and complete any treatment regimen they were on prior to transition. For instance, children aging out of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) have robust protections under EPSDT. Those protections should continue until their treatment is complete. Specific to California, we believe that enhanced requirements for increased coordination among the 58 counties would be more beneficial than increasing requirements on coordination across state boundaries given that eligibility determinations are the responsibility of each county.

   If CMS must prioritize transitions between programs, CHA believes it's important to ensure coordination of care occurs for the beneficiaries with the highest level of need: duals (Medicare), seniors or persons with disabilities, and other high utilizers.

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?

   The California Hospital Association believes that CMS should take the following steps related to standards to improve access to services:
   - *Require enhanced oversight of health plan access monitoring. Further, penalties for health plans that have insufficient networks or have imposed other barriers to access must be increased.*
   - *Increase the requirements on states before they can approve alternative access standards. For example, California's approved alternative access standards are nearly 350 pages long. In some cases, the state has approved plans' requests to require a beneficiary to travel two-and-a-half hours away just for primary care treatment. Even if the Medicaid population didn't struggle with transportation issues that present a barrier to care unto itself, this is not an adequate provider network.*
   - *Increase oversight and penalties of health plans for insufficient care coordination activities related to hospital discharge planning for lower levels of care — particularly to skilled nursing or post-hospital*

recuperative care. Delays in transitions of care not only harm patient outcomes but increase costs for hospitals. In instances where health plans are unable to provide placement at the appropriate lower level of care in a timely manner, CMS should require the plan to cover the hospital costs associated with the "administrative days."

- *Require oversight entities to have a direct and effective process for providers to escalate concerns about health plans that aren't fulfilling their contractual responsibilities. Currently, providers must fully exhaust administrative options with the health plan prior to raising concerns with the state. Based on the California Hospital Association's members' experience, this is time-consuming and ineffective as some health plans have an insufficient administrative appeals processes that result in lengthy delays in care, increased costs for hospitals, and poor patient outcomes.*
- *Remove health plan's ability to establish overly burdensome utilization management and treatment authorization requirements. For those processes that remain in place, CMS should require the plan to demonstrate a clear rationale — focused on the impact on patient outcomes of said administrative requirement — for policies. For instance, if prior authorization is required for procedures that are ultimately approved nearly every time, health plans should remove that policy as it only creates barriers to care and increases administrative costs for all stakeholders.*
- *Improve minimum standards for network adequacy. This must include access to inpatient psychiatric services. Today, California does not consider access to inpatient psychiatric services in their network adequacy determinations for their Prepaid Inpatient Health Plans.*

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?

   CMS must require public reporting on metrics of time and distance to both primary care (including mental health) and specialist providers, treatment authorization wait times for services, provider appeals and grievances, hospital administrative days/delayed discharges due to nowhere to discharge. Each state should be required to publicly post their performance against the minimum standards on their website — the performance should be transparent to all in real-time through a dashboard. Furthermore, CMS should require states to create and publicly post a plan of enforcement that details the escalating enforcement mechanisms they will use against plans for not meeting their contractual obligations.

3. How could CMS consider the **concepts of whole person care[1] 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?

   Based on feedback from its members, the California Hospital Association believes that CMS should take the following actions:

- *Require reimbursement for medical transportation to be provided for non-hospital destinations to allow for diversion from emergency rooms particularly. CHA's members believe this would be particularly beneficial for mental health and substance use.*
- *Specifically for parity, CMS should require the same standards for physical health and mental health. Currently, California has more restrictive requirements for accessing mental health services than physical health services (e.g., requiring treatment authorizations for emergency psychiatric services, denying payment for services).*
- *Expand the guidance on the provision of in-lieu-of-services. In California, since these benefits are considered optional from the federal perspective for the plans, there are significant differences in the adoption of the benefits. Medically tailored meals might be available for one health plan in the county, but not the other. If whole-person care is a focus, it should not be a restricted benefit that is only eligible if you live in one county and not the other, or for one health plan in the same county and not adopted by the other.*
- *Standardize the authorization requirements for whole-person-care services. Today in California, prior authorization for enhanced care management might be 72 hours with one plan, and five business days for another. The state has only issued guidance on the target populations but has not standardized the eligibility for those targeted populations. As a result, there are wide variations in the eligibility criteria for these whole-person-care services. A Medi-Cal beneficiary's eligibility will be predicated on the county they live in or the health plan they are enrolled in. Therefore, a Medi-Cal beneficiary might be eligible if they live in one county or are enrolled in one health plan, but not if they live in a neighboring county or are enrolled in a competing health plan. This variance in eligibility for whole-person-care services serves to increase health care inequality, not address it as is this administration's stated goal.*

4. 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?

   The California Hospital Association's members believe that CMS must use a variety of strategies to increase access to care and diversify the pool of available providers. These strategies include:

   - *Providing more slots and increasing funding for graduate medical education programs to expand the number of providers trained at teaching hospitals in the state of California.*
   - *Expanding the use of telehealth for both mental and physical health.*
   - *Promoting value-based reimbursement that includes sufficient payment that will allow providers to address social determinants of health that negatively impact patient outcomes. An example of this might include incentives for plans that enter into value-based arrangements with providers that include either incentive payments, or per beneficiary per month payments. These can be used to address issues like transportation, food insecurity, housing insecurity, or connect patients with supportive services like legal aid or employment counseling.*
   - *Eliminating the Medicaid DSH reductions.*
   - *Providing incentive funding for hiring diversity or cultural provider training.*

[1] 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

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?

   The California Hospital Association's members strongly support including additional levels of data reporting and analyses by delivery system. Given that California will soon have 99% of the Medi-Cal population enrolled in managed care, we believe that this additional data reporting and analysis should focus on managed care plan performance. Further, CHA's members believe CMS should replace the requirement for a fee-for-service (FFS) access study, with an overall access study by Medicaid agency. The requirement for an FFS access study in California is largely irrelevant given Medi-Cal's significant enrollment in managed care.

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.)?

   The California Hospital Association's members believe that metrics monitored to ensure adequate access and robustness of provider networks must include the following:

   - *Wait times for services*
   - *Average distance traveled for services*
   - *Treatment authorization timelines (and related denials) reporting*
   - *Volume of beneficiary and provider appeals and associated outcomes of the appeals process*

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?

The California Hospital Association's (CHA) members believe that CMS must monitor the number of hospital administrative days due to lack of safe place to discharge. As stated in response to prior questions, CHA's members believe that requiring managed care plans to reimburse hospitals for the costs associated with these days would reduce administrative days and increase access to post-acute care for Medi-Cal beneficiaries and thus improve patient outcomes.

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?

   The California Hospital Association's members believe that CMS should pursue the following opportunities to ensure beneficiaries have access to services:

   - *Require health plans to pay for administrative hospital days as a result of a health plan's lack of engagement in discharge planning and/or inability to secure an appropriate setting of care for the patient to be discharged to after acute care.*
   - *Allow for directed payments to be paid for utilization of out-of-network providers.*
   - *Streamline the capitated rate approval process. California is still waiting on CMS approval for state fiscal year 2017-18 rates. This has created a significant financial burden on the state and providers, which is negatively impacting the provider financials and risks triggering bond covenants. This unnecessary financial uncertainty has negatively impacted hospitals' ability to expand access to services for Medi-Cal beneficiaries.*
   - *Allow for greater flexibility in determining actuarial soundness and benchmarking to commercial rates.*
   - *Establish reasonable rate floors for Medicaid reimbursement levels to ensure reimbursement levels allow for access on par with the general public as required by the Social Security Act.*
   - *Reconsider how the level of non-Optional Expansion federal financial participation for a state is determined to take into consideration other factors like the cost of living and Medicaid eligibility rules to create incentives and provide greater federal support for states to expand Medicaid coverage.*

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?

   The California Hospital Association's members believe that CMS must require rate reviews and reporting that compares reimbursement levels to other payers (Commercial and Medicare).

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?**

   The California Hospital Association's (CHA) members believe that average commercial rates and other states' Medicaid programs are an appropriate comparator for payment rates for services that are not generally covered by Medicare. As discussed in response to Objective 5, Question 3 (above) CHA believes that all Medicaid services should be compared to commercial rates given that these rates "crowd out" Medicaid beneficiary access to providers as they are typically much higher than Medicaid rates.

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.[2] 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?

   The California Hospital Association's members believe that CMS should streamline the capitated rate approval process and allow greater flexibility of directed payments (such as to non-contracted providers). Further, we believe the agency must eliminate states' ability to assess administrative fees on intergovernmental transfers, provider taxes, etc. States have relied upon bona fide provider contributions to support Medicaid reimbursement in lieu of state general fund resources. These payments support the Medicaid programs across the country and should not be used as a revenue-generating option for states.

[2] Dunn, B, et al. "A denial a day keeps the doctor away." National Bureau of Economic Research. Available at https://www.nber.org/papers/w29010