

**Summary of Public Comments in response to the
Centers for Medicare & Medicaid Services (CMS) 2022
Request for Information (RFI): *Access to Coverage and
Care in Medicaid and CHIP***

December 2022

Contents

Executive Summary	v
I. Background on the Request for Information and Summary of Methods.....	1
II. Summary of Public Comment Themes	3
A. Counts of public comments by objective and respondent type	3
B. Counts of top themes by respondent type	5
C. RFI Objective Themes.....	7
1. Summary of Objective 1 themes: Eligibility and enrollment.....	7
2. Summary of Objective 2 themes: Ensuring consistent coverage	14
3. Summary of Objective 3 themes: Standards for access to care.....	18
4. Summary of Objective 4 themes: Data and measurement-related comments.....	22
5. Summary of Objective 5 themes: Ensuring Medicaid and CHIP payments are sufficient to enlist and retain enough providers so that services are accessible	28
D. Cross-Cutting Themes	34
1. HBCS: Themes across all RFI objectives	34
2. Maternal and child health: Themes across RFI objectives	37
3. Behavioral health: Themes from all RFI objectives	41
4. COVID-19 PHE: Themes across all RFI questions	45
5. Equity: Themes across all RFI questions.....	48
6. Engagement: Themes across all RFI questions	49
7. Oral health coverage and payment: Themes across all RFI questions	50
E. Summary of Findings	52
References	54

Tables¹

ES.1	Summary.....	vii
II.1	Frequency of themes by objective and cross-cutting themes.....	4
II.2	Top themes by respondent type	5
II.3	Summary of Objective 1 themes: Eligibility and enrollment.....	9
II.4	Summary of Objective 2 themes: Ensuring consistent coverage	16
II.5	Summary of Objective 3 themes: Standards for access to care	20
II.6a	Summary of Objective 4 themes: Data and measurement.....	24
II.6b	Summary of data and measurement themes from other objectives	26
II.7	Summary of Objective 5 themes: Payment and provider participation	29
II.8	Home and community-based services themes	35
II.9	Maternal and child health themes	39
II.10	Behavioral health themes	43
II.11	COVID-19 PHE themes.....	46

¹ Tables are not presented in the following cross-cutting theme sections: Equity (II.D.5), Engagement (II.D.6), and Oral Health (II.D.7).

Figures²

ES.1	RFI responses by respondent type	viii
I.1	Access to Medicaid and CHIP: A person-centered framework.....	1
II.1	Objective 1 public comments by respondent type.....	8
II.2	Objective 2 public comments by respondent type.....	15
II.3	Objective 3 public comments by respondent type.....	19
II.4	Objective 4 public comments by respondent type.....	23
II.5	Objective 5 public comments by respondent type.....	29
II.6	HCBS-related public comments by respondent type.....	34
II.7	MCH-related public comments by respondent type.....	38
II.8	Behavioral health-related public comments by respondent type	42

² A figure is not presented in the COVID-19 section (II.D.4).

Executive Summary

Medicaid and the Children’s Health Insurance Program (CHIP) provide health care coverage for 90.5 million people, including individuals and families with low-income, pregnant women, children, older adults, and people with disabilities (CMS, August 2022). CMS is committed to ensuring eligible people can enroll in the appropriate programs, retain their coverage, and access high-quality health care services. Using regulations, guidance, and other tools, CMS is developing a multifaceted strategy to help ensure equitable access to health care for people that are eligible and enrolled in Medicaid and CHIP across all care delivery systems. To inform the development of this work, CMS released Request for Information (RFI): Access to Coverage and Care in Medicaid & CHIP (referred to as 2022 Access RFI) with a public comment period from February 17, 2022, through April 18, 2022.³ The 2022 RFI was structured around five objectives described below and framed across three dimensions of health care access: (1) enrolling in coverage, (2) maintaining coverage, and (3) accessing services and supports.

- **Objective 1:** Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage.
- **Objective 2:** Medicaid and CHIP beneficiaries experience consistent coverage.
- **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.
- **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).
- **Objective 5:** Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible.

This report is a summary of public comments, as worded by RFI respondents. As a result, certain suggestions or feedback provided through public comments in response to the RFI may already be allowable under current law, regulations or guidance.

The report takes the following steps to summarize the findings and key themes:

- Breaks down the top themes observed in the public comments by respondent type
- Summarizes the public comment themes by RFI objective or priority topic (for example, maternal and child health (MCH) and home and community-based services (HCBS))
- Identifies finding and key takeaways across objectives

³ To request a copy of the submitted comments, e-mail medicaidaccess@mathematica-mpr.com

Key findings from the analysis of the 2022 RFI public comments include the following:

- Out of 796 RFI respondents⁴ and 7,125 comments,⁵ 181 respondents and 1,975 comments were excluded from the analysis because their content was unclear, blank, or were testimonials⁶ without suggestions. 5,150 comments were included in the analysis that is reflected in this report. Of the remaining 615 respondents whose comments were used in this report, a majority (74 percent) of the respondents were organizations, and nonprofits were the most common organization type.
- The most common themes were related to the following areas:
 - Addressing equity and cultural competence, including suggestions to collect and analyze outcomes by sociodemographic data, to establish minimum standards that take cultural competence and language preferences into account, and to improve provider cultural competence
 - Reimbursement rates as a key driver of provider participation in Medicaid and CHIP programs
 - Aligning approaches and setting minimum standards for payment regulations and compliance across Medicaid and CHIP delivery systems, services, and benefits to ensure beneficiaries' access to services is as similar as possible across beneficiary groups, delivery systems, and programs
- Comments from individuals (versus comments from an organization) who responded to the RFI often focused on improving communications to and with people seeking coverage (in initial application eligibility determinations and renewal redeterminations), including using multiple modes of communication and establishing best practices for outreach and enrollment communications.
- As depicted in Table ES.1, most comments were related to the RFI questions on access to care (Objective 3; 32 percent), enrollment in Medicaid and CHIP (Objective 1; 22 percent), and maintenance of coverage for Medicaid and CHIP beneficiaries (Objective 2; 18 percent).

Other key findings across objectives included suggestions for CMS to consider in the following areas:

- **Data, systems, and information technology (IT).** Respondents stressed the need for coordination across systems or agencies and compatibility of data, and the importance of facilitating accessible communication to and with people enrolled in Medicaid and CHIP through applications and systems.
- **Provider availability and network adequacy.** Respondents commonly called for establishing national minimum standards for network adequacy, as well as measures of provider availability, appointment wait times, provider network robustness, and realized access to care (for example, receiving needed services in an appropriate setting).
- **Sufficiency of payments to providers.** Respondents often suggested addressing low reimbursement rates to improve the sufficiency of provider payments.

⁴ Respondent = an individual or organization that submitted comments to the 2022 RFI.

⁵ Comment = an individual's or organization's response to the 2022 RFI.

⁶ Testimonial —a description of personal experience with Medicaid or CHIP programs, services, or benefits. Testimonial comments that represented only testimonial feedback or requests for assistance without policy recommendations were excluded from the analysis and re-routed for support from CMS if they included a request for assistance.

Summary of Public Comments: CMS 2022 Request for Information
Access to Coverage and Care in Medicaid and CHIP

Table ES.1. Summary ^{a,b}

Number of Respondents	Count	%
Respondents included the analysis	615	77
Excluded respondent	181	23
Unclear	98	12
Blank	11	1
Testimonial	72	9
Total number of respondents	796	100
Comment overview	Count	%
Comments included in the analysis	5,150	72
Excluded comments	1,975	28
Unclear	1,515	21
Testimonial	271	4
Blank	189	3
Total number of comments across all RFI questions submitted	7,125	100
Comments by objective and cross-cutting themes	Count	%
Objective 1	1,112	22
Objective 2	927	18
Objective 3	1,653	32
Objective 4	667	13
Objective 5	672	13
Other feedback	206	4
HCBS	455	9
Maternal and child health	517	10
Behavioral health	498	10
Total number of comments included in analysis	5,150	100
Responses by type of respondent (included in analysis)	Count	%
Individual	213	35
Enrolled in Medicaid	14	2
Organization	402	65
Nonprofit	168	27
Advocacy	59	10
Other	49	8
Provider	45	7
State	40	7
Health plan	15	2
Research	12	2
Federal	8	1
Local	4	1
Tribal	1	<1
Regional	1	<1
Total number of respondents included in analysis	615	100

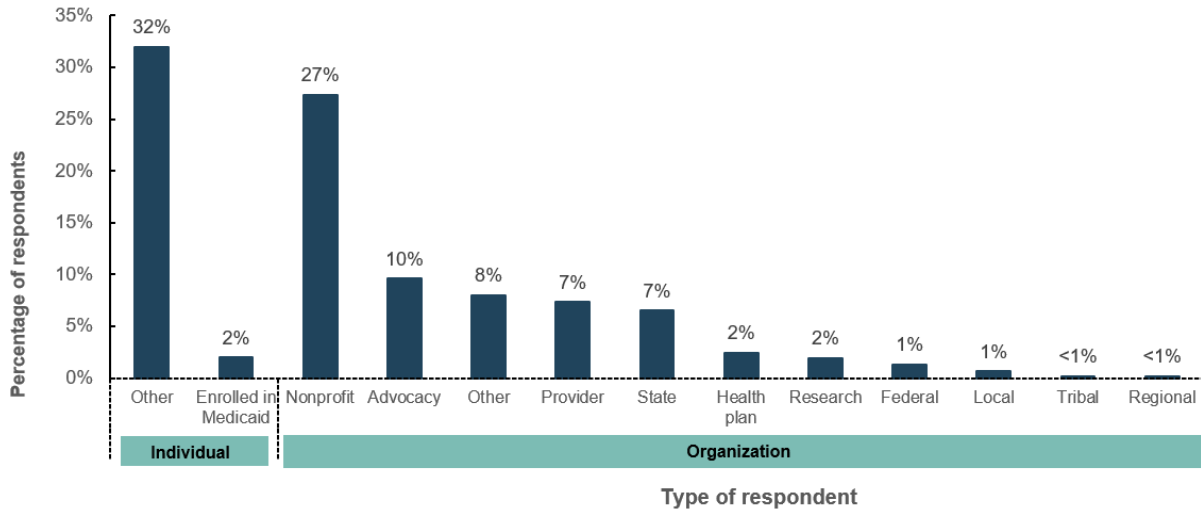
Summary of Public Comments: CMS 2022 Request for Information
Access to Coverage and Care in Medicaid and CHIP

Comments by type of respondent	Count	%
Individual	1,360	26
Enrolled in Medicaid	144	3
Organization	3,790	74
Nonprofit	1,583	31
Advocacy	516	10
Other	446	9
State	420	8
Provider	401	8
Health plan	165	3
Federal	119	2
Research	81	2
Local	30	1
Tribal	21	<1
Regional	8	<1
Total number of comments included in analysis	5,150	100

^a HCBS = home and community-based services.

^b Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

Figure ES.1. RFI responses by respondent type ^a



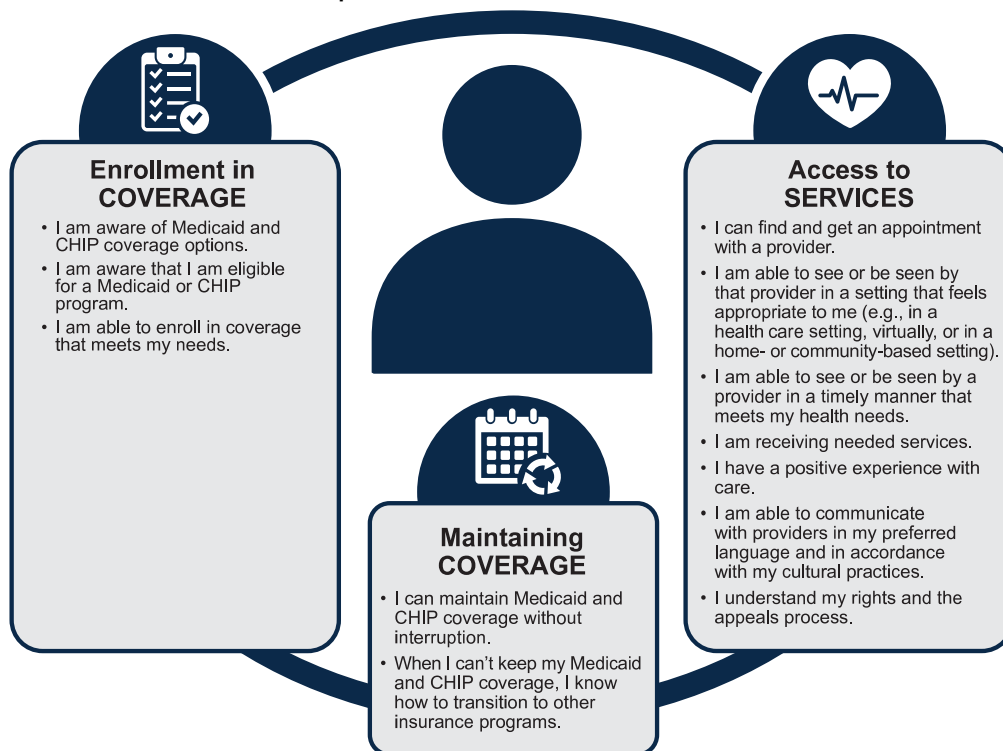
^a Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

I. Background on the Request for Information and Summary of Methods

Medicaid and the Children’s Health Insurance Program (CHIP) provide health care coverage for 90.5 million people, including individuals and families with low-income, pregnant women, children, older adults, and people with disabilities (CMS, August 2022). CMS is committed to ensuring that eligible people can enroll in the appropriate programs, retain their coverage, and access high-quality health care services. Using regulations and guidance, along with other tools, CMS is developing a multifaceted strategy to help ensure equitable access to health care for people enrolled in Medicaid and CHIP across all care delivery systems. To inform the development of this work, CMS released a Request for Information (RFI), open for comments from February 17, 2022, through April 18, 2022, related to access to coverage and care in Medicaid and CHIP (referred to as 2022 Access RFI).

The 2022 RFI sought feedback from a diverse set of stakeholders and aligned with CMS’s strategic vision for Medicaid and CHIP that focuses on three key areas: (1) coverage and access, (2) equity, and (3) innovation and whole person care (CMS.gov 2021; Brooks-LaSure and Tsai 2021). For the 2022 Access RFI, CMS framed the continuum of health care access across three dimensions: (1) enrolling in coverage, (2) maintaining coverage, and (3) accessing services and supports (Figure I.1). For access to services and supports, CMS assessed multiple domains of access that span: (1) potential access (provider availability and accessibility); (2) beneficiary utilization (realized access and access-related outcomes); and (3) beneficiaries’ perceptions and experiences with care. These terms and definitions build upon previous CMS efforts to examine how best to monitor access (Kenney et al. 2016).

Figure I.1. Access to Medicaid and CHIP: A person-centered framework



Note: “I” represents a potential or current Medicaid or CHIP beneficiary, even though in many circumstances a caregiver might perform or assist the beneficiary with many of these tasks or functions. The term “provider” refers to those providing health care services of all kinds, including physical health care services, mental health services, substance use services, long-term care services and supports, etc.

In this report, we use “I” to refer to people who are potentially or currently enrolled in Medicaid or CHIP, even though caregivers sometimes perform or help with many of these tasks. We use “provider” to refer to those providing health care of all kinds, including physical health care, mental health care, substance use treatment services, and long-term services and supports (LTSS).

Within each dimension of access, accompanying regulatory, monitoring, or compliance actions might be needed to ensure beneficiaries achieve and maintain access to health care. To gather feedback on these three dimensions, while taking into account its strategic vision for Medicaid and CHIP, CMS structured the RFI around five objectives:

- **Objective 1:** Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage.
- **Objective 2:** Medicaid and CHIP beneficiaries experience consistent coverage.
- **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.
- **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).
- **Objective 5:** Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible.

This report summarizes the findings and key themes from the public comments submitted in response to the 2022 RFI. For the analysis, CMS’s contractor, Mathematica created a comment coding workbook with codes specific to each RFI objective.

The remaining sections of this report are composed of counts of comments and types of respondents, summaries of common themes within and across objectives, cross-cutting findings, and key takeaway messages. The detailed description of the methods can be found in a separate appendices report. Raw comments are also available from CMS upon request.

This report is a summary of public comments, as worded by RFI respondents. As a result, certain suggestions or feedback provided through public comments in response to the RFI may already be allowable under current law, regulations or guidance.

II. Summary of Public Comment Themes

A. Counts of public comments by objective and respondent type

A total of 796 RFI respondents participated in and submitted 7,125 comments to the RFI. From these, 181 respondents and 1,975 comments were excluded from the analysis because their content was unclear, blank, or were testimonials without suggestions. As a result, this report reflects an analysis of 615 respondents' submissions representing 5,150 comments (see Table ES.1). Table II.1 summarizes the frequency of comments by objective or cross-cutting theme and respondent type. Across all objectives, the overwhelming majority (75–90 percent) of comments came from organizations, with the minority (11–16 percent) coming from individuals.⁷ Among the organizations, nonprofit organizations provided the most comments (31–40 percent). Individuals who identified themselves as enrolled in Medicaid represented approximately 1–3 percent of comments for each objective.

Individuals and organizations provided comments mostly related to Objectives 1, 2, and 3. As seen in Table II.2, the most common themes for all respondent types related to (1) equity, (2) reimbursement rates, and (3) opportunities to align approaches and set minimum standards for payment regulations and compliance across Medicaid and CHIP delivery systems, services, and benefits.

However, the focus of comments differed between comments provided by individuals and those submitted by organizations. Comments that came from organizations mirrored the three most common themes described above. Of those three themes, most types of organizations (health plan; provider; federal, state, and local; advocacy groups; nonprofit; and other) provided comments related to equity. In contrast, individuals' comments focused primarily on (1) concepts of whole person care or care coordination, (2) standards for communications to beneficiaries, and (3) family members as paid caregivers. These were the most common themes among all individuals, regardless of whether the individual identified themselves as enrolled in Medicaid. All of these themes are described in greater detail later in this chapter.

⁷ The survey allowed respondents to select their characterization as individual or organization. If the respondent selected to submit their comments as an individual, but their text-based response indicated they were submitting on behalf of an organization, the comment was re-coded to indicate it came from an organization.

Summary of Public Comments: 2022 CMS Request for Information
 Access to Coverage and Care in Medicaid and CHIP

Table II.1. Frequency of themes by objective and cross-cutting themes ^{a, b, c}

Category	RFI objectives										Cross-cutting themes						Total frequency by respondent
	Objective 1		Objective 2		Objective 3		Objective 4		Objective 5		HCBS		Maternal and child health		Behavioral health		
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	
Individuals	419	13%	359	16%	629	14%	196	12%	228	13%	88	11%	66	12%	77	13%	2,062
Enrolled in Medicaid	25	1%	43	2%	64	1%	24	2%	19	1%	16	2%	5	1%	5	1%	201
Organizations	2,757	87%	1,845	84%	4,006	86%	1,373	88%	1,531	87%	715	89%	465	88%	518	87%	13,210
Nonprofit	1,267	40%	819	37%	1,794	39%	562	36%	668	38%	297	37%	192	36%	236	40%	5,835
Advocacy	364	11%	216	10%	473	10%	156	10%	215	12%	147	18%	49	9%	68	11%	1,688
Other	295	9%	189	9%	475	10%	188	12%	184	10%	90	11%	52	10%	42	7%	1,515
State	254	8%	183	8%	316	7%	123	8%	117	7%	46	6%	32	6%	47	8%	1,118
Provider	241	8%	182	8%	492	11%	127	8%	187	11%	40	5%	82	15%	85	14%	1,436
Health Plan	132	4%	106	5%	176	4%	89	6%	89	5%	50	6%	20	4%	15	3%	677
Federal	91	3%	89	4%	91	2%	58	4%	33	2%	13	2%	11	2%	10	2%	396
Research	74	2%	42	2%	97	2%	52	3%	12	1%	22	3%	15	3%	8	1%	322
Local	26	1%	14	1%	56	1%	9	1%	14	1%	3	0%	11	2%	5	1%	138
Tribal	12	0%	5	0%	17	0%	7	0%	8	0%	6	1%	0	0%	2	0%	57
Regional	1	0%	0	0%	19	0%	2	0%	4	0%	1	0%	1	0%	0	0%	28
Total frequency of objective themes	3,176		2,204		4,635		1,569		1,759		803		531		595		15,272

^a HCBS = home and community-based services.

^b Percentages are the frequency of themes noted for the objective and respondent type, divided by the total frequency of themes noted for the objective.

^c Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

B. Counts of top themes by respondent type

Table II.2. Top themes by respondent type ^{a, b}

Theme	Count	Percentage of comments from respondent type
All		
0.2.10 Comment relating to equity	337	7
3.5.1 Reimbursement rates	293	6
5.1.1 Opportunities to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems, services, and benefits	236	5
		Denominator: 5115
Individuals		
3.3.10 "Other" comment relating to concepts of whole person care or care coordination	42	3
2.2.1 Standards for communications	41	3
3.5.7 Family members as paid caregivers	39	3
		Denominator: 1360
Enrolled in Medicaid		
3.5.7 Family members as paid caregivers	7	5
3.3.10 "Other" comment relating to concepts of whole person care or care coordination	6	4
2.2.1 Standards for communications	6	4
		Denominator: 144
Organizations		
0.2.10 Comment relating to equity	319	9
3.5.1 Reimbursement rates	258	7
5.1.1 Opportunities to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems, services, and benefits	202	5
		Denominator: 3755
Nonprofit organization		
0.2.10 Comment relating to equity	162	10
3.5.1 Reimbursement rates	116	7
3.1.1 Developing standards for potential access	80	5
		Denominator: 1583
Advocacy organization		
3.5.1 Reimbursement rates	40	8
0.2.10 Comment relating to equity	35	7
5.1.1 Opportunities to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems, services, and benefits	30	6
		Denominator: 500
Other organization		
0.2.10 Comment relating to equity	39	9
3.5.1 Reimbursement rates	33	8
5.1.1 Opportunities to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems, services, and benefits	25	6
		Denominator: 439

Summary of Public Comments: 2022 CMS Request for Information
Access to Coverage and Care in Medicaid and CHIP

Theme	Count	Percentage of comments from respondent type
State organization		
5.1.1 Opportunities to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems, services, and benefits	20	5
5.3.7 "Other" comment relating to DATA OR MEASUREMENT for assessing the sufficiency of rates for services which are not generally covered by Medicare	19	5
5.3.1 Potential data sources, methods, or benchmarks to assess the sufficiency of Medicaid and CHIP payment rates	19	5
		Denominator: 420
Provider organization		
0.2.10 Comment relating to equity	40	10
3.5.1 Reimbursement rates	31	8
5.1.1 Opportunities to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems, services, and benefits	28	7
		Denominator: 401
Health plan organization		
0.2.10 Comment relating to equity	15	9
5.2.4 Recommendations for specific payment policies	13	8
5.1.1 Opportunities to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems, services, and benefits	12	7
		Denominator: 165
Federal organization		
0.2.10 Comment relating to equity	11	10
3.5.2 Telehealth	7	7
2.2.1 Standards for communications	6	6
		Denominator: 107
Research organization		
3.3.10 "Other" comment relating to concepts of whole person care or care coordination	7	9
3.4.12 "Other" comment relating to cultural competency and language preferences	5	6
3.5.3 Licensure	5	6
		Denominator: 81
Local organization		
0.2.10 Comment relating to equity	4	13
3.3.6 Comment relating to behavioral health	3	10
3.4.12 "Other" comment relating to cultural competency and language preferences	3	10
		Denominator: 30
Tribal organization		
0.2.1 Support for additional engagement activities with Medicaid and CHIP stakeholders to inform strategy	2	10
5.1.1 Opportunities to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems, services, and benefits	2	10
1.1.11 "Other" comment relating to supporting states in achieving timely eligibility determination, timely redetermination and timely enrollment	1	5
		Denominator: 21
Regional organization		

Summary of Public Comments: 2022 CMS Request for Information
Access to Coverage and Care in Medicaid and CHIP

Theme	Count	Percentage of comments from respondent type
3.5.1 Reimbursement rates	2	25
3.5.2 Telehealth	1	13
5.4.1 Opportunities to reduce administrative burdens for providers	1	13
Denominator: 8		

^a This table presents the top three themes for each respondent type, with the count of comments for the theme and percentage of all analyzed comments for each respondent type. The following residual themes may apply to the analyzed comments but are not listed in this table: comment related to a different question, other (other theme not coded elsewhere), testimonial.

^b Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

C. RFI Objective Themes

1. Summary of Objective 1 themes: Eligibility and enrollment

The first RFI objective focused on soliciting feedback on approaches to ensuring that eligible people are aware of Medicaid and CHIP coverage options and their ability to apply for coverage, and that state agencies conduct timely eligibility determinations and enrollment. The types of respondents for Objective 1 mirrored those for the RFI overall (Figure II.1).

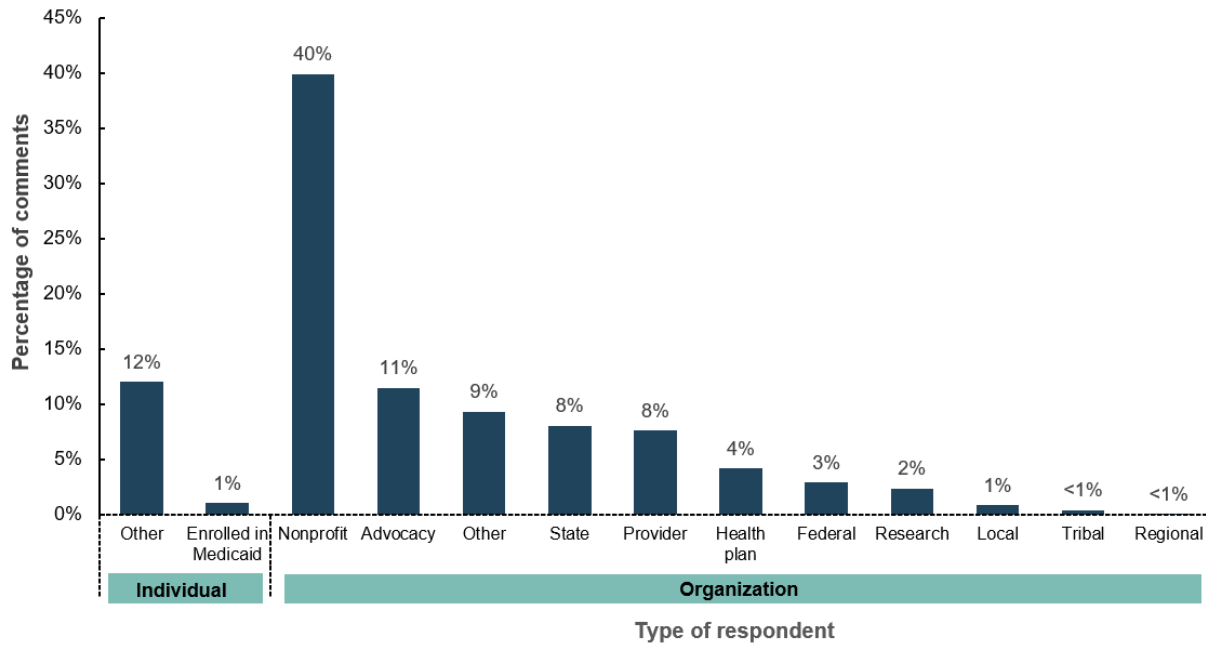
Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage.

This objective included several RFI questions to better understand concepts such as:

1. **Ways to support states in achieving timely eligibility determination and timely enrollment** for both modified adjusted gross income (MAGI) and non-MAGI-based eligibility determinations
2. **Additional capabilities needed by states to improve timeliness for determinations and enrollment or eligibility processes** to identify and facilitate enrollment for eligible individuals
3. **Ways to Support states in addressing barriers to enrollment and retention of eligible individuals among different groups**
4. **Examples of Key indicators of enrollment in coverage**

A total of 921 comments addressed at least one Objective 1 theme, which represents 18 percent of analyzed comments. The most common themes among these comments focused on (1) streamlining applications for eligibility determinations, (2) providing support to states to improve eligibility and enrollment processes and systems, (3) identifying and spreading best practices for outreach and enrollment, and (4) monitoring reasons for denial of eligibility (Table II.3).

Figure II.1. Objective 1 public comments by respondent type ^a



^a Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

Table II.3. Summary of Objective 1 themes: Eligibility and enrollment ^{a, b}

Theme	Count	Percentage of Objective 1 comments
Q1.1 themes		
Provide state funding or other support	108	12
Ex parte redeterminations	68	7
Initial enrollment in Medicaid and CHIP	66	7
Streamlining applications for eligibility determinations	143	16
Streamlining applications for non-MAGI based determinations	35	4
Streamlining applications for MAGI based determinations	20	2
Automatic eligibility	72	8
Express lane eligibility	38	4
Improper enrollment denials	19	2
HCBS enrollment	11	1
Enrollment in MCOs	39	4
Actions to prioritize relating to supporting states in achieving timely eligibility determination, timely redetermination, and timely enrollment	34	4
Q1.2 themes		
Systems and IT capabilities	153	17
Tools for monitoring waiting lists	22	2
Coordination and data system compatibility between state systems and Healthcare.gov	16	2
Tools for monitoring waiting times	7	1
Waivers and demonstrations	79	9
Automatic eligibility	16	2
Modified state staffing arrangements	68	7
Actions to prioritize relating to additional capabilities states need to improve timeliness for determinations and enrollment or eligibility	11	1
Q1.3 themes		
Outreach and enrollment communications best practices	140	15
Addressing barriers to enrollment among people whose primary language is not English	77	8
Addressing barriers to enrollment among people with disabilities	70	8
Addressing barriers to enrollment among people who are from communities of color	51	6
Addressing barriers to enrollment for people who are experiencing homelessness	49	5
12 month continuous enrollment	47	5
Addressing barriers to enrollment among people who identify as LGBTQ+	40	4
Addressing barriers to enrollment among people with mental health and substance use disorders	38	4
Addressing barriers to enrollment in rural regions	38	4
Non-emergency transport	14	2
Actions to prioritize relating to CMS supporting states in addressing barriers to enrollment and retention among different groups	31	3
Provide state funding or resources	26	3
Provide state funding for healthcare enrollment navigators and innovative communication methods	75	8
Provide federal funding for states to develop health IT infrastructure	7	1
Support states studying barriers to enrollment	13	1
Enrollment communications on federal websites	12	1
Q1.4 themes		
Monitoring reasons for denial	75	8
Monitoring eligibility determination denial rates	39	4
Application processing times	25	3
Disenrollment rates	22	2

Summary of Public Comments: 2022 CMS Request for Information
Access to Coverage and Care in Medicaid and CHIP

Theme	Count	Percentage of Objective 1 comments
Key indicators that are more readily available based on existing data and systems	12	1
Participation rates of eligible beneficiaries who are enrolled	10	1
Actions to prioritize relating to CMS monitoring of key indicators of enrollment in coverage	10	1
Timeliness of follow-up communication to beneficiaries	7	1
Key indicators that are less readily available based on existing data and systems	7	1
Total Medicaid beneficiary counts	5	1
Percentage of enrollees that received follow-up communication after application	4	<1
Include questions about enrollment in coverage in CAHPS survey	3	<1
Total number of comments analyzed with any Objective 1 theme(s) coded		Denominator: 920

^a The coding framework included both parent (main) themes and subthemes, which are specific themes categorized under a parent theme. Themes are organized in descending percentage order by parent theme.

^b CHIP = Children's Health Insurance Program; MAGI = modified adjusted gross income; HCBS = home and community-based services; MCO = managed care organization; IT = Information Technology; CMS = Centers for Medicare & Medicaid Services; CAHPS = Consumer Assessment of Healthcare Providers & Systems.

Streamlining applications for eligibility determinations. Many respondents emphasized the importance of streamlining the application process for Medicaid and CHIP to ensure timely, accurate, and equitable eligibility determinations. Respondents encouraged CMS to leverage the Section 1115 demonstration waiver submissions and renewal processes to incentivize states to implement policies to streamline eligibility determinations and enrollment. Some of the most common suggestions to CMS included the following:

- **Incentivize ex parte determinations and Express Lane Eligibility.** Many comments suggested incentivizing states to maximize their use of ex parte eligibility determination processes, leveraging other existing state and federal data sources for core eligibility criteria, including income and disability status. More specifically, respondents noted that few states use the **Express Lane Eligibility** option for children, which grants Medicaid eligibility without the need for additional documentation when children are eligible for the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). The respondents emphasized the opportunity to encourage more states to use this approach for children and, potentially, expand it to parents and other adults.

“These recommendations include: automatically granting Medicaid eligibility when children or adults participate in SNAP or TANF; incentivizing states to take up Express Lane Eligibility to expedite and simplify enrollment in Medicaid and CHIP by relying on findings from other agencies’ eligibility determinations; adjusting eligibility determination periods to facilitate automatic enrollment when people file their tax returns” [The Arizona Chapter of the American Academy of Pediatrics, Comment ID: R_1EgJ2mR7iOO9Xqx_Q1.1].

- **Clarify the “reasonably compatible” policy regarding income and resources.** Respondents noted inconsistency in states’ interpretation of the policy and opportunities for clarification to support ex parte determinations.

“CMS guidance should address confusion about reasonable compatibility policy and set clear standards for state compliance. The guidance should also encourage states to maximize the use of self-attestation for eligibility factors when allowable and minimize verification requests by increasing their reliance on electronic data sources” [Center on Budget and Policy Priorities, Comment ID: R_3G9S9xXj649bfOa_Q1.1].

- **Expand presumptive eligibility.** Respondents described the value of expanding the type and number of sites allowed to determine presumptive eligibility for Medicaid and CHIP.

“CMS should encourage or require states to increase the number and type of sites of care in which people can obtain presumptive eligibility. CMS should encourage states to, at a minimum, provide for presumptive coverage at community health centers, schools, hospitals, and WIC sites, and when people are leaving correctional facilities” [Association of Maternal & Child Health Programs, Comment ID: R_1hRUeUr9HNNScN4_Q1.1].

“Once people have a verified ID/A [intellectual disability or autism] diagnosis, they should not be required to re-qualify for that diagnosis. Rather, those with a verified ID/A diagnosis should be considered presumptively ID/A” [Pennsylvania Advocates and Resources for Autism and Intellectual Disabilities, Comment ID: R_1GVsv3eFiMrKDqs_Q1.1].

- **Maintain flexibilities enacted during the COVID-19 public health emergency (PHE).** Respondents referred to multiple flexibilities enacted during the PHE that have helped support enrollment and should be maintained, including expanded options for verbal consent, self-attestation, electronic signatures, and waiving requirements for in-person meetings.

- **Employ a “no wrong door” policy.** Several comments referenced the potential benefits of promulgating and implementing regulation requiring state and federal marketplaces to determine eligibility for all relevant forms of health insurance coverage, including Medicaid and CHIP eligibility.

Support to states to improve eligibility and enrollment processes and systems. Many respondents for Objective 1 advocated for CMS support to improve states’ eligibility and enrollment systems, including IT. These suggestions focused on a range of direct technical assistance and expert guidance:

- **Technical assistance and state-to-state learning.**

“CMS can support states by facilitating peer to peer learning among states with high ex parte rates and those with low ex parte rates. CMS can also provide one-on-one help to states to help identify the reason that more redeterminations are not completed using the ex parte process” [Center for Law and Social Policy, Comment ID: R_1DN11ERx15LjuHQ_Q1.1].

- **Coordination between state systems and Healthcare.gov.**

“While the account transfer process between the state Medicaid and CHIP agencies and the Exchange is intended to help prevent churning between programs and directly connect recently denied consumers to the Exchange, ... it is unclear whether consumers have their eligibility reviewed by the state when the Exchange finds them potentially eligible for Medicaid or CHIP. Because of this, CMS should work with states to ensure that they are consistently using the account transfer process to share information between the state agencies and the Exchange” [Maximus, Inc., Comment ID: R_2cvz1OiBgJU3wsr_Q1.1].

- **Promotion of modern approaches for consumer support and assessments of usability.**

“CMS could support states’ use of Artificial Intelligence or Chat Bots to help applicants navigate issues with the application process ... expressly allowing plans to text members directly with a pre-populated application form and electronically attach a state approved document highlighting the most important information that be provided” [Ascension, Comment ID: R_3NEXesviHQa7wr1_Q1.1].

“When approving 90/10 FMAP [Federal Medical Assistance Percentage] for IT Medicaid systems design, implementation, and enhancements, require states use a third-party assessment of consumer usability of the proposed application or system changes as a condition of payment to their IT systems vendor so that resources are used in ways that truly improve the consumer experience” [National Health Law Program, Comment ID: R_2YrCCQ20hbHx90U_Q1.1].

Outreach and enrollment communications best practices. Many respondents emphasized the importance of promulgating, and requiring, the use of best practices for states to communicate with potentially eligible people, especially those who face major challenges with communication, including people experiencing homelessness, those who speak a non-English primary language, and individuals with disabilities. These approaches included the following:

- **Centering approaches around where potential enrollees are located.**

“We believe states should streamline Medicaid/CHIP enrollment processes by, for example, developing shorter applications, coordinating Medicaid and TANF application processes, and placing eligibility workers where potential enrollees work, go to school, and receive medical care” [American Medical Association, Comment ID: R_1jNHrFW2n7Fa3AG_Q1.3].

- **Using multimodal outreach and enrollment processes.**

“Sending reminder notices via mail, phone, text, and/or email can increase response rates and keep eligible consumers enrolled. This will also ease redetermination efforts as consumers’ addresses will already be known and up to date, minimizing no contact denials” [Maximus, Inc., Comment ID: R_2cvz1OiBgJU3wsr_Q1.1].

- **Ensuring understandable and respectful outreach and enrollment processes.**

“CMS should require each state to provide a language access plan as part of their state plan for Medicaid (and actually a broader communication plan, see answer to Objective 3 Question 4), which CMS should carefully review and require states to publicly post and update regularly.... We encourage CMS to strengthen the requirement of plain language on all public-facing materials in its programs and projects as well as state-based materials for Medicaid and CHIP” [National Health Law Program, Comment ID: R_2YrCCQ20hbHx90U_Q1.1].

“Staff assisting individuals with Medicaid enrollment should receive training to ensure they can communicate and work with a diverse range of enrollees in a manner that is respectful of individual identity, free from bias, and that combats stigma associated with Medicaid. Additionally, we encourage states to hire Medicaid enrollment support staff who reflect the diversity of the communities they serve so that they can better understand and meet the needs of individuals seeking Medicaid enrollment support” [Blue Cross Blue Shield Association, Comment ID: R_25TKN2s9pNhEQ9A_Q1.3].

Monitoring application denial. Several respondents emphasized the importance of monitoring reasons for denial for Medicaid and CHIP and assessing any differences in denials across applicants’ characteristics as a means of assessing the quality and equity of eligibility determinations.

- **Monitoring reasons for denial.** The Center for Law and Social Policy suggested capturing several data points, including application denials and reasons for denial, disaggregated by several applicant characteristics, such as race and ethnicity:

“Without better data collection it will be impossible to make true progress on Medicaid access. CLASP recommends the following data points be collected by each state, reported to CMS, and posted publicly. Each data point should be disaggregated by race, ethnicity, age, gender, geography, and eligibility category, in order to understand where the greatest gaps or disparities exist....

- Application denials per month, including how many were found ineligible and how many were denied for procedural reasons.
- Top five procedural reasons for denial of application” [Center for Law and Social Policy, Comment ID: R_1DN11ERx15LjuHQ_Q1.4].

- **Assessing denials across applicant characteristics.**

“Additionally, CMS must enforce requirements that all populations are treated equitably by ... collecting and analyzing data on applicant race and ethnicity, preferred language, housing status, and disability status to identify groups that are disproportionately being denied or terminated from coverage” [Virginia Poverty Law Center, Comment ID: R_2Ram9jHZPXpsLuY_Q1.3].

2. Summary of Objective 2 themes: Ensuring consistent coverage

Objective 2 of the RFI focuses on better understanding the ability of people enrolled in Medicaid and CHIP to maintain consistent coverage, including identifying strategies to prevent inappropriate disenrollment and to minimize enrollment gaps resulting from transitions between programs. Continuity of coverage is particularly critical during and after the COVID-19 PHE, when people need to renew their coverage or when they might make a transition between eligibility categories or programs. The expiration of the continuous coverage required by the Families First Coronavirus Response Act (P.L. 116-127; enacted March 18, 2020) along with the expiration of the temporary authorities adopted by many states during the PHE, could likely represent the largest health coverage transition since the first open-enrollment period of the Affordable Care Act. The types of respondents for Objective 2 were similar to those for the RFI overall (Figure II.2).

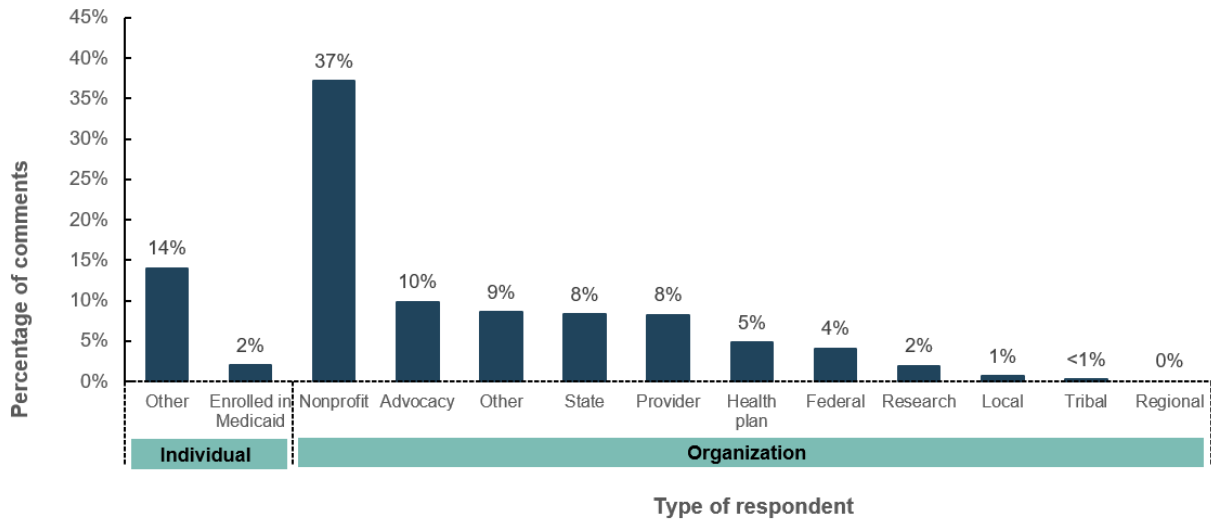
Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage.

This objective included several RFI questions to better understand concepts such as:

1. Ways to monitor **eligibility redeterminations** and improving the process
 2. Suggestions for setting standards for how states communicate with **beneficiaries at-risk of disenrollment** and intervene prior to a gap in coverage
 3. Methods 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
 4. Strategies to support states that need to enhance their **eligibility and enrollment system capabilities**
-

A total of 813 comments addressed at least one Objective 2 theme, which represents 16 percent of analyzed comments. Many of the themes in Objective 2 comments were similar to those in Objective 1. The most common themes among respondents' comments specific to Objective 2 focused on: (1) communication standards with beneficiaries at-risk of disenrollment, (2) improved renewal processes, and (3) 12-month continuous enrollment (Table II.4). Across all the themes of Objective 2, respondents frequently suggested that CMS identify states that had exemplary performance in the areas of consistent coverage and work with those states to develop standards that other states could implement.

Figure II.2. Objective 2 public comments by respondent type



^a Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

Table II.4. Summary of Objective 2 themes: Ensuring consistent coverage ^{a, b}

Theme	Count	Percentage of Objective 2 comments
Q2.1 themes		
12 month continuous enrollment	97	12
Information requests and communications with beneficiaries	90	11
Enrollment navigation efforts	98	12
Leveraging enrollment broker organizations for information requests and communication	14	2
Leveraging managed care organizations for information requests and communication	44	5
Streamline the renewal process	55	7
Ex parte redeterminations	64	8
Express lane eligibility	41	5
Enhancing state eligibility systems to improve monitoring of redeterminations	29	4
Modifying eligibility requirements	120	2
Periodic eligibility checks	16	2
Actions to prioritize relating to state monitoring of eligibility redeterminations	8	1
Q2.2 themes		
Standards for communications	192	24
Notice letters	48	6
Accessibility and readability of notice letters	39	5
Federal resources to help identify beneficiaries at-risk of disenrollment	23	3
Compatibility between states' data systems	17	2
Actions to prioritize relating to communication with beneficiaries at risk of disenrollment	10	1
Compatibility of federal data systems with state systems	8	1
Pregnant women/new mothers	7	1
Q2.3 themes		
Continuity of coverage for beneficiaries moving between programs	87	11
Enrollment navigation efforts	77	9
Continuity of coverage for beneficiaries moving between eligibility groups	58	7
Continuity of coverage for beneficiaries moving out-of-state	44	5
Continuity of coverage for beneficiaries transitioning between Medicare and Medicaid	36	4
12 month continuous enrollment	19	2
Ex parte redeterminations	18	2
Engagement with social workers	17	2
Actions to prioritize relating to continuity of coverage for beneficiaries transitioning between Medicaid or CHIP services and programs	11	1
Q2.4 themes		
Enhance state eligibility and enrollment systems	56	7
State tracking reasons for denial or eligibility status change	37	5
Compatibility between states' data systems	26	3
Eligibility workforce	25	3
Compatibility of federal data systems with state systems	17	2
Minimize eligibility verification requirements	15	2

Theme	Count	Percentage of Objective 2 comments
Actions to prioritize relating to CMS support for state enhancement of state eligibility and enrollment systems	8	1
Federal renewal and redetermination verification	6	1
Total number of comments analyzed with any Objective 2 theme(s) coded		Denominator: 813

^a The coding framework included both parent (main) themes and subthemes, which are specific themes categorized under a parent theme. Themes are organized in descending percentage order by parent theme.

^b CHIP = Children's Health Insurance Program, CMS = Centers for Medicare & Medicaid Services.

Communication standards with beneficiaries at risk of disenrollment. By far, standards for communications with beneficiaries were the most highly discussed theme. There was a clear consensus from the comments that respondents suggest CMS consider requiring, or at least urging, states to communicate with beneficiaries frequently and through various modalities.

- **Frequent communication in various modes.**

“CMS should consider setting not only frequency standards for communicating with enrollees at risk of disenrollment, but also mode of communication standards. We encourage CMS to work with states to set standards for sending communications via SMS text, email, and website notifications” [Planned Parenthood Federation of America, Comment ID: R_2CUhrYex6mXqB2Z_Q2.2].

Improved renewal processes. Echoing many of the suggestions in Objective 1, respondents suggested improvements to the renewal process to make it easier to understand, more accessible, and standardized. Some suggestions on how the process should be improved:

- **Plain language.**

“Materials should all be written at no more than a fourth grade reading level and in multiple languages” [American Psychiatric Association, Comment ID: R_2RZZM1AW9GbThZx_Q2.1].

- **Resources to assist with renewal.**

“CMS needs to provide states with technology resources to be able to requalify patients that live in remote and/or urban areas that do not have the means to update an application in person.... Is there a way to provide a community fair that would bring the workers out to the urban or remote areas and/or homeless shelters to assist patients with completion of applications?” [Valleywise Health, Comment ID: R_2YigSYyEeyezXzQ_Q2.1].

- **Technology to streamline process.**

“A national or state omnichannel consumer engagement platform would allow for more streamlined consumer outreach in addition to more efficient document uploading and processing. This strategy would create a unified consumer experience, ensuring consumers are not deemed ineligible for coverage due to lack of response or administrative errors. CMS and states can leverage enrollment broker relationships to help facilitate redeterminations, including outreach and communication methods.... A more intentional and proactive beneficiary engagement and outreach model would mitigate the potential for coverage losses post the redetermination process” [Maximus, Inc., Comment ID: R_2cvz1OiBgJU3wsr_Q2.1].

12-month continuous enrollment. Similarly, respondents stressed the importance of 12-month continuous enrollment. There were many comments that specifically detailed the need for continuous enrollment as well as the potential impacts from adopting that option nationally:

- **Minimum floor of 12 months**

“As CMS considers strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs, continuous eligibility policies that reduce administrative churn should be prioritized. Almost half of the states have taken up the option to provide 12-month continuous eligibility for children, but progress at the state level has stalled. Building a minimum floor of at least 12 months of continuous eligibility nationwide would help children maintain coverage and reduce churn.... If Congress were to permanently expand this provision to all states for both Medicaid and CHIP, administrative costs for states would be reduced and health providers and plans would more readily maintain continuity of care management” [Texas Pediatric Society, Comment ID: R_2Ui71CdkzKeHv49_Q2.1].

- **Continuous coverage extension**

“Continuous enrollment can mitigate churn and allow members to access their providers for care without disruption. We are encouraged and supportive of efforts such as the proposal in Oregon’s Section 1115 Demonstration to extend continuous coverage for children from ages 0 to 6, and to allow adults to stay continuously covered for two years” [Kaiser Permanente, Comment ID: R_2bUis2WXc9BscqF_Q2.1].

- **Regulatory guidance on continuous eligibility**

“CMS should provide regulatory guidance to states that individuals eligible for Medicare and Medicaid should be certified as eligible for 24 months instead of the usual 12” [Molina Healthcare, Comment ID: R_2f9ie6z9yyQct8i_Q2.1].

- **Appropriate use of period verification data matching**

“Barring states from misusing data matches to arbitrarily terminate eligibility.... Many unwarranted terminations took place when states initiated massive data matches with quarterly wage records and ended coverage whenever families failed to respond to state information requests triggered by a single quarter’s wage spike, no matter how modestly above Medicaid eligibility thresholds, and whether or not the spike ultimately affects the families’ ongoing eligibility. Given income fluctuations routinely experienced by families with low-income, especially in communities of color, these practices are an easy way for states to evade the regulatory requirement for 12-month redetermination periods. This troubling history makes clear the need to bar eligibility terminations before regular renewal based on data matches initiated by the state, as part of forthcoming changes to Medicaid redetermination regulations” [American Network for Oral Health Coalitions, Comment ID: R_3izjX0hjjXlb5dp_Q1.1].

3. Summary of Objective 3 themes: Standards for access to care

Objective 3 of the RFI centers on ensuring access to timely, high-quality, and appropriate care and people’s care with their needs as a whole person, regardless of the payment system (that is, fee-for-service or managed care). The types of respondents for Objective 3 were similar to those for the RFI overall (Figure II.3).

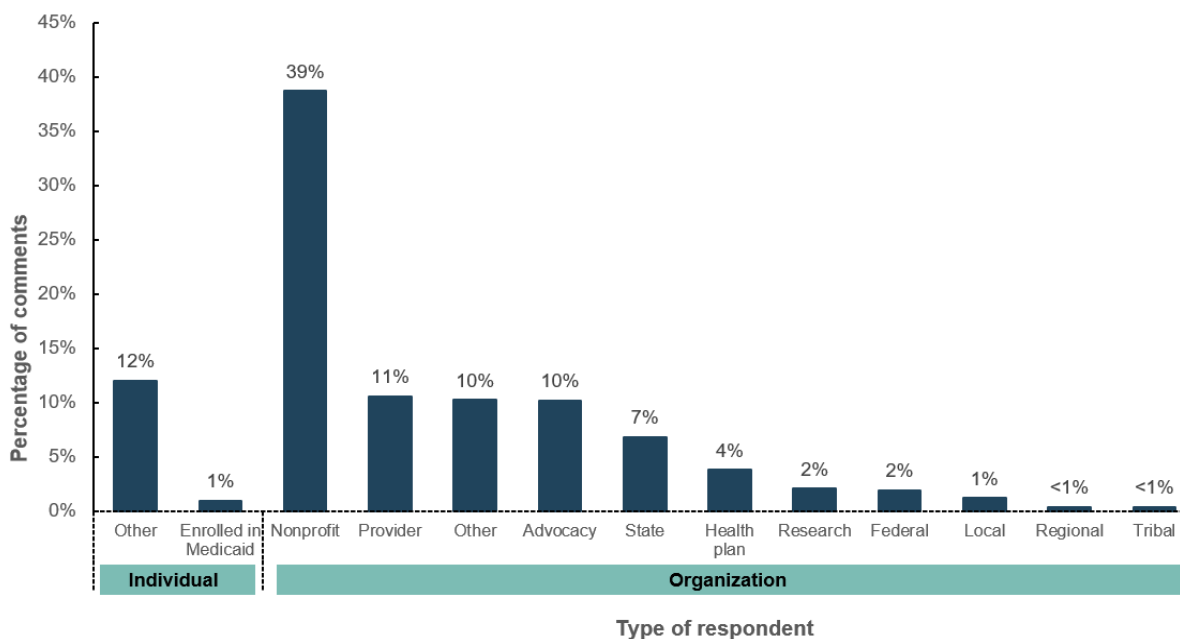
Objective 3: Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary’s needs as a whole person.

This objective included several RFI questions to better understand concepts such as:

1. **Develop minimum standards** for Medicaid and CHIP programs related to access to services
2. **Monitor states’ performance against those minimum standards**
3. **Concepts of whole person care or care coordination** across physical health, behavioral health, LTSS, and health-related social needs when establishing minimum standards for access to services
4. Address **cultural competency and language preferences** in establishing minimum access standards
5. **Increase and diversify the pool of available providers** for Medicaid and CHIP

A total of 1,402 comments addressed at least one Objective 3 theme, which represents 27 percent of analyzed comments. The questions related to Objective 3 focus on collecting information about developing and monitoring these minimum standards, with specific considerations for whole-person care and care coordination across physical health, behavioral health, LTSS, health-related social needs, cultural competency, and language preferences. The RFI questions posed also addressed increasing and diversifying the pool of available Medicaid and CHIP providers.

Figure II.3. Objective 3 public comments by respondent type ^a



^a Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response

Table II.5 shows the most common themes among comments for Objective 3 focused on (1) payment rates, (2) developing standards for potential access, (3) monitoring minimum standards, and (4) diversifying the workforce. Due to the focus on payment rates in Objective 5, themes related to payment are listed in that section. In this section, the report focuses on the other two main themes.

Table II.5. Summary of Objective 3 themes: Standards for access to care ^a

Theme	Count	Percentage of Objective 3 comments
Q3.1 themes		
Developing standards for potential access	190	14
Standards focusing at the national level	76	5
Standards focusing at the state level	50	4
Standards focusing at both state and national levels	67	5
Developing standards for realized access	91	6
Developing standards applicable across delivery systems	38	3
Developing standards for beneficiary experience	31	2
Standards by program eligibility	14	1
Standards based on geography	72	5
Standards based on provider types or specialties	75	5
Standards based on value-based payment arrangements	46	3
Actions to prioritize relating to developing standards for access to Medicaid and CHIP services	10	1
Q3.2 themes		
CMS monitoring of measures of state access	94	7
Compliance actions against states	67	5
Incentives for states	57	4
Standardized reporting on minimum standards	129	9
Actions to prioritize relating to monitoring state performance against minimum standards for access to Medicaid and CHIP	35	3
Q3.3 themes		
Administrative alignment across types of care	133	9
Actions to prioritize relating to concepts of whole person care or care coordination	131	9
Payment models	123	9
Health IT and care coordination	64	5
Q3.4 themes		
Access to care in preferred language	93	7
Barriers to using or accessing interpreters and translators	54	4
Provider training on cultural competency and language preference	50	4
Actions to prioritize relating to cultural competency and language preferences	39	3
CLAS standards	36	3
Digital translation services	29	2
Q3.5 themes		
Reimbursement rates	296	21
Telehealth	176	13
Licensure	135	10
Family members as paid caregivers	96	7
Provider incentive programs	65	5
Administrative burdens for providers	61	4
Value-based payment	56	4
Supplemental payments to providers	22	2
Actions to prioritize relating to increasing the pool of available providers	15	1
Total number of comments analyzed with any Objective 3 theme(s) coded		Denominator: 1402

^a. CHIP = Children's Health Insurance Program, CMS = Centers for Medicare & Medicaid Services, IT = information technology, CLAS = Culturally and Linguistically Appropriate Services.

Developing standards for potential access. Within themes around developing standards for potential access (which represents the factors necessary to access care, such as provider availability and accessibility), comments included unifying standards across payer types, incorporating social risk factors and social determinants of health, and travel time. Comments under Objective 4 (described below) also commonly suggest measures of provider availability, appointment wait times, robustness of provider networks, and realized access to care would be most helpful in measuring access. Suggestions for developing potential standards of access include the following:

- **Establish minimum standards for network adequacy.** Many of the respondents agreed with the concept of establishing minimum standards for network adequacy. However, respondents varied on whether they should be established at a national or state level. Some respondents suggested states should be given flexibility on establishing network adequacy “give states flexibility to tailor standards to unique program features, populations, and services” [Blue Cross Blue Shield Association, Comment ID: R_25TKN2s9pNhEQ9A_Q3.1.]. Common suggestions regarding network adequacy included the following:
 - Develop different minimum network adequacy standards for different provider types and services, including pediatric care, mental health, substance use disorders, LTSS including HCBS providers, audiology and speech-language pathology, and dentists.
 - Align Medicaid managed care organization (MCO) network adequacy standards with different delivery systems and programs, such as Medicaid fee-for-service (FFS), the federal marketplace, and Medicare Advantage.
 - Expand how network adequacy is measured to include factors beyond geographic distance, such as wait times, provider capacity, appointment availability, access transportation, and language services.
 - Evaluate provider networks to ensure network adequacy, including reviewing provider directory data to assess accuracy of information and availability of the provider.
- **Establish minimum standards for serving communities in ways that address cultural competency and language preferences.**

“CMS should require states to make widely available directories of providers who are able to provide services in-language as well as those who have received cultural competency training” [Asian & Pacific Islander American Health Forum, Comment ID: R_1hW6v5GkJgIbXAx_Q3.5].
- **Incorporate telehealth into new access standards.**

“Incorporating telehealth into new access standards, especially when care is not otherwise available, would address several of the access barriers outlined in this section. This is especially true in geographically isolated and underserved areas where provider availability is limited” [AmeriHealth Caritas, Comment: R_yR7VI7ICFcYiIo1_Q3.1].

Monitoring minimum standards. Respondents shared several ways in which minimum standards could be monitored and benchmarked, although several respondents asked that CMS consider keeping administrative burden low. Others expressed the importance of transparency in monitoring minimum standards and suggested compliance actions and/or financial incentives. Common suggestions regarding the monitoring of minimum standards included the following:

- Use state dashboards to share information and allow for analysis of trends over time.

- Set national minimum thresholds to “to assess areas where state Medicaid programs are experiencing access gaps, as benchmarks for states to improve performance, and as the basis for compliance action for states that fail to meet the thresholds” [The Robert Wood Johnson Foundation, Comment ID: R_3e2Wy7m1QrGWI82_Q3.2].
- Use standards that promote equity, value-based care models, cultural competence, availability of services that promote access, including travel times and geographic concerns, transportation, language services, and telehealth.

Increasing and diversifying the pool of available providers. Within increasing and diversifying available providers, telehealth was a common theme. Respondents particularly felt that telehealth should extend beyond the PHE and be covered on a permanent basis. Common suggestions related to telehealth included the following:

- Reduce barriers for cross-state licensing and/or instituting a universal standard for participation.
- Increase telehealth for mental health services, especially in remote areas.
- Build language access into telehealth workflows.

One respondent noted that CMS can support increased diversity by allowing providers to cross state boundaries, especially via telehealth:

“Language barriers in one state could be overcome by telehealth services in another state with a more diverse population” [Individual, R_qDURc4TVMIFeuAN_Q3.5].

Paying family members as caregivers. Respondents were also supportive of the concept of family members as paid caregivers noting, this “should be made permanent within the Medicaid Program. By making paid family caregivers permanent, the pool of culturally competent providers from diverse racial and ethnic communities could be increased” [Tennessee Disability Coalition, Comment ID: R_06Av4OagOEngqf7_Q3.5]. Other respondents noted paying caregivers would help with the shortage of in-home care workers.

Objective 4: CMS has data available to measure, monitor, and support improvement efforts related to access to services (that is, potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations).

This objective included several RFI questions to better understand concepts such as:

1. **Implement an access monitoring approach that is as similar as possible** across Medicaid and CHIP delivery systems and programs and across services/benefits
2. **Identify measures of potential access**
3. Promote a more standardized effort to **monitor access in LTSS, including HCBS, programs**
4. Require 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
5. Leverage Transformed Medicaid Statistical Information System (T-MSIS) **data to monitor access** broadly and to help assess potential inequities in access

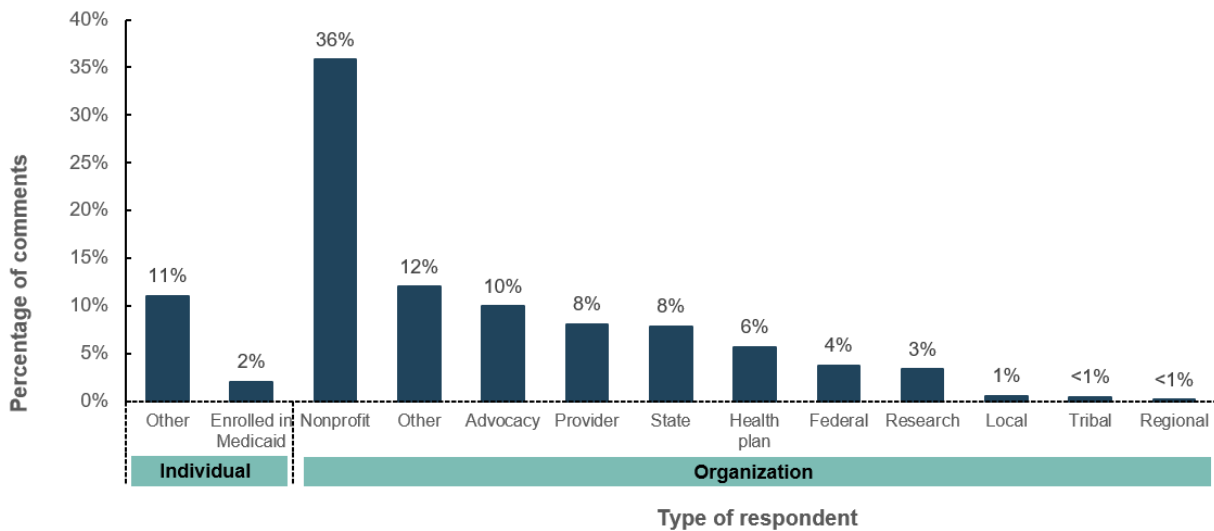
4. Summary of Objective 4 themes: Data and measurement-related comments

Data to measure, monitor, and support efforts to improve access and the availability of these data are the focus of Objective 4, which cuts across the dimensions of health care access. The types of respondents for Objective 4 were similar to those for the other objectives and RFI overall (Figure II.4).

A total of 552 comments addressed at least one Objective 4 theme, which represents 11 percent of analyzed comments. The most common Objective 4 themes were (1) measures of provider availability, (2) technical assistance or other resources to support states in standardized monitoring and reporting, (3) suggested data sources, and (4) streamlining reporting across systems and reports and methods to reduce state reporting burden (Table II.6a). Other common themes included reporting requirements for fair hearings, CHIP reviews, appeals, and grievances; additional data or specific variables; assessing inequities; data to monitor in LTSS, including HCBS; and measures of access in LTSS, including HCBS.

Within these themes, comments centered on potential access measures; how to address inequities, streamline reporting systems, and care for LTSS including HCBS populations; and state capacity for monitoring access.

Figure II.4. Objective 4 public comments by respondent type ^a



^a Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

Summary of Public Comments: 2022 CMS Request for Information
Access to Coverage and Care in Medicaid and CHIP

Table II.6a. Summary of Objective 4 themes: Data and measurement ^a

Theme	Count	Percentage of Objective 4 comments
Q4.1 themes		
Technical assistance or other resources to support states in standardized monitoring and reporting	91	16
Data sources	80	14
Streamline reporting across systems/reports and methods to reduce state reporting burden	71	13
Support for states to conduct secret shoppers or bene surveys	14	3
Actions to prioritize relating to monitoring comparability across delivery systems	10	2
Provide federal funding for states to develop health IT infrastructure	8	1
Q4.2 themes		
Measures of provider availability	103	19
Appointment wait times	70	13
Robustness of provider networks across delivery systems	69	13
Accessibility of transportation	46	8
Measures specific to managed care	32	6
Grievances and appeals	27	5
Availability of language-accessible and culturally competent services	23	4
Actions to prioritize relating to measures of potential access	7	1
Q4.3 themes		
Data to monitor access in LTSS including HCBS	38	7
Measures of access in LTSS including HCBS	28	5
Specify standards that states must meet	25	5
Grievances and appeals	18	3
HCBS measure set	13	2
Person-centered care plan	9	2
Actions to prioritize relating to monitoring access in LTSS and HCBS	5	1
Monitor availability of language-accessible and culturally competent services	4	1
Q4.4 themes		
Reporting requirements for fair hearings, CHIP reviews, appeals, and grievances (including through existing or new reporting requirements)	57	10
CMS guidance on fair hearings, CHIP reviews, appeals, and grievances	16	3
Actions to prioritize relating to monitoring Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes	2	<1
Q4.5 themes		
Additional data or specific variables	43	8
Assessing inequities	39	7
Technical assistance or other types of support to aid states in standardized monitoring and reporting	34	6
Actions to prioritize relating to leveraging T-MSIS data to monitor access	3	1
Total number of comments analyzed with any Objective 4 theme(s) coded		Denominator: 552

^a IT = information technology, LTSS = long-term services and supports, HCBS = home and community-based services, CHIP = Children's Health Insurance Program, CMS = Centers for Medicare & Medicaid Services, T-MSIS = Transformed Medicaid Statistical Information System.

Measures of provider availability, data sources, and appointment wait times. Respondents noted that assessing access could include measures of provider availability, appointment wait times, robustness of provider networks, realized access to care, and social determinants of health. Respondents also emphasized the importance of capturing information related to service utilization, transportation, access to medication, characteristics of the workforce, and health disparities. Other suggestions included measures relating to oral health, Medicaid fair hearings and CHIP reviews, application denials, and managed care appeals and grievances. Several comments emphasized a need for increased quality and reporting of child data.

Technical assistance and resources that support standardized monitoring and reporting, streamline reporting across systems and reports, and reduce state reporting burden. While increased measures are necessary to improve access monitoring, many states have limited capacity to implement new measures. Instead, several respondents suggested using existing framework or measure sets to minimize burden.

“[A]ny federal framework or state strategy focus on a finite number of high-value measures—relying on those that are already utilized for access monitoring, quality assessment, accreditation, or other uses—rather than create a list of new measures or requirements to be stacked on top of what states and plans are already doing” [Association for Community Affiliated Plans, Comment ID: R_23TVuoTPjGgTOGo_Q3.1].

- Respondents suggested that states streamline reporting systems to increase data accessibility, which will require technical assistance. This applies to all data, but especially to race and ethnicity data.

“[S]tates need both direct funding and hands-on technical assistance to support this work ... based on our work with states, we think this needs to go beyond documentation and uniform measure specifications. To do this well, states should have access to experts who can provide practical, hands-on advice that is responsive to their specific needs. The type of assistance needed will vary and needs to be flexible.... We would also recommend that any TA [technical assistance] effort include a forum for states to discuss implementation challenges with their peers” [Whitman-Walker Health and Whitman-Walker Institute, Comment ID: R_2dW0Nng1NJta6aY_Q4.1].

- As noted above, comments advocated for minimum standards that include appointment wait times, access to critical therapies and services, mental health care, travel times, distance, and overall network adequacy. Comments suggested CMS provide technical assistance to states to help develop and improve existing monitoring systems.

Data monitoring and access in LTSS, including HCBS populations. In incorporating changes to data sources and measures to assess access to LTSS care which includes HCBS, respondents suggested CMS consider specifying standards that states must meet to ensure data quality and usability. Some comments expressed concern about data being reported in a timely manner, as some LTSS providers do not reliably report data to Medicaid agencies. While many respondents were supportive of CMS’s efforts to develop a standard set of HCBS measures, several respondents felt additional field testing may be needed to understand feasibility.

Table II.6b. Summary of data and measurement themes from other objectives ^{a, b}

Question ID	Theme	Count	Percentage of data and measurement comments
5.3	"Other" comment relating to data or measurement for assessing the sufficiency of rates for services which are not generally covered by Medicare	186	16
3.2	"Other" comment relating to data or measurement for monitoring state performance against minimum standards for access to Medicaid and CHIP	118	10
1.4	"Other" comment relating to data or measurement for CMS monitoring of key indicators of enrollment in coverage	114	10
4.1	"Other" comment relating to data or measurement for monitoring comparability across delivery systems	106	9
1.1	"Other" comment relating to data or measurement for supporting states in achieving timely eligibility determination, timely redetermination, and timely enrollment	75	7
2.1	"Other" comment relating to data or measurement for state monitoring of eligibility redeterminations	69	6
4.3	"Other" comment relating to data or measurement for monitoring access in LTSS, including HCBS	58	5
1.2	"Other" comment relating to data or measurement for additional capabilities states need to improve timeliness for determinations and enrollment or eligibility	56	5
2.4	"Other" comment relating to data or measurement for continuity of coverage for CMS support for state enhancement of eligibility and enrollment system capabilities	47	4
3.3	"Other" comment relating to data or measurement for concepts of whole person care or care coordination	47	4
2.3	"Other" comment relating to data or measurement for continuity of coverage for beneficiaries transitioning between Medicaid or CHIP services and programs	40	3
2.2	"Other" comment relating to data or measurement for communication with beneficiaries at risk of disenrollment	36	3
4.4	"Other" comment relating to data or measurement for monitoring Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes	36	3
3.1	"Other" comment relating to data or measurement for developing standards for access to Medicaid and CHIP services	31	3
4.2	"Other" comment relating to data or measurement for measures of potential access	31	3
1.3	"Other" comment relating to data or measurement for CMS supporting states in addressing barriers to enrollment among different groups	30	3
3.4	"Other" comment relating to data or measurement for cultural competency and language preferences	29	3
5.1	"Other" comment relating to data or measurement for aligning approaches and set minimum standards for payment regulation and compliance	29	3
5.4	"Other" comment relating to data or measurement for reducing administrative burdens that discourage provider participation in Medicaid and CHIP	26	2
4.5	"Other" comment relating to data or measurement for leveraging T-MSIS data to monitor access	18	2

Summary of Public Comments: 2022 CMS Request for Information
Access to Coverage and Care in Medicaid and CHIP

Question ID	Theme	Count	Percentage of data and measurement comments
5.2	"Other" comment relating to data or measurement for assessing the effect of and promoting state payment policies and contracting arrangements that are unique to the Medicaid program on access	11	1
3.5	"Other" comment relating to data or measurement for increasing the pool of available providers	9	1
Total comments received with any "other" data and measurement theme(s) coded			Denominator: 1145

^a CHIP = Children's Health Insurance Program, LTSS = long-term services and supports, HCBS = home and community-based services, TMSIS = Transformed Medicaid Statistical Information System.

^b Each row represents data from the "other" comment relating to data or measurement theme for that objective and question.

A total of 1,145 comments addressed at least one data and measurement-related theme, which represents 22 percent of analyzed comments. As shown in Table.II.6b, the most common data and measurement themes from other objectives included (1) assessing the sufficiency of rates for services not generally covered by Medicare; (2) monitoring state performance against minimum standards for access; (3) monitoring key indicators of enrollment in coverage; (4) monitoring comparability across data systems; and (5) supporting states in timely eligibility determination, redetermination, and enrollment.

Assessing the sufficiency of rates for services that are not generally covered by Medicare compared with other payers such as private coverage. Many comments expressed concern that providers, especially dentists, often do not accept Medicaid because payment drives provider participation. This concern was also shared for mental health services. Comments provided suggestions to address issues caused by Medicaid rates, such as comparing Medicaid rates with private sector rates. CMS could also compare Medicaid reimbursement rates with Medicare and TRICARE reimbursement rates.

Monitoring state performance against minimum standards for access. Comments suggested that CMS should consider setting reporting standards for states and act when states fall out of compliance.

Monitoring key indicators of beneficiary and provider participation in Medicaid and CHIP. Respondents noted that enrollment data could be standardized to better understand key indicators of enrollment in coverage. Key indicators of coverage highlighted in the comments include state turnaround time for applications, denial rates and reasoning, provider satisfaction, and measures specific to HCBS.

Monitoring comparability across data systems. Respondents also emphasized a need for efforts to increase data sharing and standardization. Data standardization can improve the ability to share data across states and make comparisons. Interoperability between state systems for state exchanges and Medicaid and CHIP programs was highlighted in the comments.

Data transparency. Respondents called for data timeliness, suggesting states' data should be publicly reported more frequently and focusing on states' monthly performance indicator data and application processing time. Many comments emphasized the need for more data sharing.

“Enhanced data sharing with state departments of revenue, unemployment and other social services could be integrated to better identify individuals whose income qualify them or if they have experienced a qualifying event (for example, loss of employment). If state-data systems were better integrated, they could trigger workflows for enrollment navigators to outreach or State Medicaid authorities to send communications re: potential enrollment. These integrated data systems could automate redeterminations based on state income tax payments” [Individual, Comment ID: R_aXfesrxUCDxssWB_Q1.1].

5. Summary of Objective 5 themes: Ensuring Medicaid and CHIP payments are sufficient to enlist and retain enough providers so that services are accessible

Objective 5 of the RFI focuses on the relationship between Medicaid and CHIP payment rates and provider participation, especially as required by Sections 1902(a)(30)(A), Section 1932, and Section 2101(a) of the Social Security Act. The types of respondents for Objective 5 were similar to those for the other objectives and RFI overall (Figure II.5).

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible.

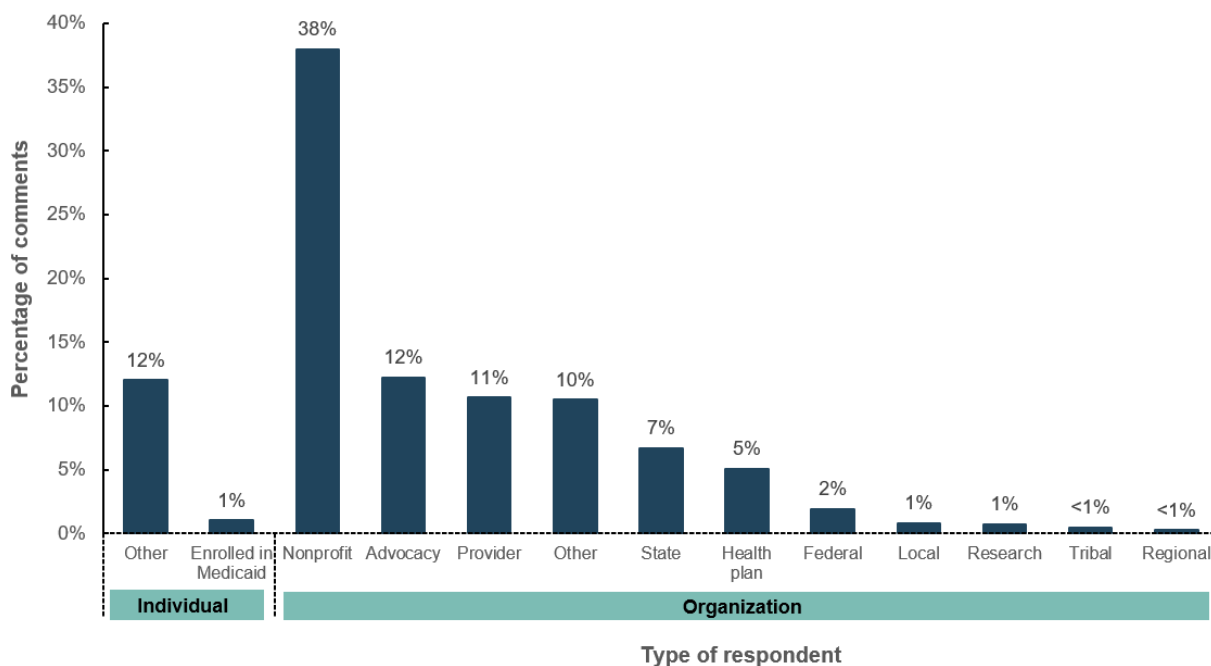
This objective included several RFI questions to better understand concepts such as:

- 1. Align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems and across services/benefits**
- 2. Assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access**
- 3. Assess the sufficiency of rates for services that are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare**
- 4. Reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP while balancing the need for program integrity**

While Objective 5 focused on specific opportunities to align and assess payment policies and regulations, respondents frequently raised recommendations across all objectives about addressing payment rates. These comments frequently centered around CMS ensuring that state programs are compliant with Section 1902(a)(30)(A) of the Social Security Act. This section summarizes comments to Objective 5 and comments across other objectives related to payment.

A total of 651 comments addressed at least one Objective 5 theme, which represents 13 percent of analyzed comments. The most common themes related to payment focused on (1) payment regulation and compliance; (2) assessments of the effect of state payment policies and contracting arrangements; (3) data sources, methods, or benchmarks to assess the sufficiency of Medicaid and CHIP payment rates; and (4) opportunities to reduce administrative burdens for providers (Table II.7).

Figure II.5. Objective 5 public comments by respondent type ^a



^a Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

Table II.7. Summary of Objective 5 themes: Payment and provider participation ^a

Theme	Count	Percentage of Objective 5 comments
Q5.1 themes		
Opportunities to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems, services, and benefits	236	36
Payment rates for HCBS	52	8
HCBS workforce capacity	43	7
Actions to prioritize relating to aligning approaches and set minimum standards for payment regulation and compliance	17	3
Q5.2 themes		
Recommendations for specific payment policies	137	21
Opportunities to assess the effect of state payment policies and contracting arrangements	122	19
Opportunities to promote payment policies that have a positive impact on access	61	9
Opportunities to promote contracting arrangements that have a positive impact on access	47	7
Actions to prioritize relating to promoting and assessing the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access	6	1
Q5.3 themes		
Potential data sources, methods, or benchmarks to assess the sufficiency of Medicaid and CHIP payment rates	185	28
Actions to prioritize relating to assessing the sufficiency of rates for services which are not generally covered by Medicare	3	<1
Q5.4 themes		
Opportunities to reduce administrative burdens for providers	177	27

Summary of Public Comments: 2022 CMS Request for Information
Access to Coverage and Care in Medicaid and CHIP

Theme	Count	Percentage of Objective 5 comments
Actions to prioritize relating to reducing administrative burdens that discourage provider participation in Medicaid and CHIP	27	4
Garnering ongoing/continuous feedback from providers	24	4
Lessons learned from changes in provider enrollment processes stemming from the COVID-19 PHE	11	2
Total number of comments analyzed with any Objective 5 theme(s) coded		Denominator: 651

^a CHIP = Children's Health Insurance Program, HCBS = home and community-based services; PHE = public health emergency.

Opportunities to align approaches and set minimum standards for payment regulations and compliance across Medicaid and CHIP delivery systems, services, and benefits. A large proportion of respondents suggested prioritizing policies to address what they viewed as low payment for services in Medicaid and CHIP and its role as a primary driver of insufficient provider participation and network adequacy. Respondents also described the opportunity to expand reimbursement to a broader range of providers to meet the goals of Medicaid and CHIP, including nonclinical providers, such as doulas, community health workers, and family members.

Sufficiency of payment rates and access to care. One respondent summarized:

“The clear link between adequate reimbursement for Medicaid providers and availability of enough providers to ensure access to care for beneficiaries cannot be overstated. When Medicaid payment rates fall, many providers either cannot afford or choose not to treat Medicaid patients. Those that do often are forced to shift the unreimbursed Medicaid costs onto other payers and/or to cut services and programs low-income beneficiaries need” [America's Essential Hospitals, Comment ID: R_1FqA3unARTjq4Rh_Q1.1].

Common suggestions regarding payment policies to promote access included the following:

- Develop standards on minimum reimbursement rates.
- Require states to perform rate reviews on a regular cycle, including comparing Medicaid and CHIP payments with payments from other payers (for example, Medicare, commercial, and TRICARE) in the same market in access and network adequacy reviews, across provider and service types.
- Streamline CMS’s approval process for state directed payments and allowing improved access as a specific rationale.
- Modify current Section 1115 demonstration waiver budget neutrality calculations to exclude rate increases to improve access, especially when the rate increase would not require a waiver on its own.
- Develop state and MCO reimbursement standards for translation and interpretation services utilized by providers, including increasing reimbursement for visits shown to be more time intensive, such as with those with limited English proficiency (LEP) to recognize the additional time it takes for providers to communicate with patients through an interpreter.
- Permanently authorize the continuation of the current telehealth waivers allowing reimbursement parity for telehealth visits, including audio-only.
- Expand reimbursement for additional types of providers, such as community health workers, case managers, patient navigators, dental hygienists and therapists, doulas, and midwives.
- Enhance reimbursement for specific types of services including vaccines, emerging therapeutics, and out-of-state services.
- Increase opportunities for alternative payment methods that include people enrolled in Medicaid and CHIP and are aligned across payers.

- Implement an “any willing provider” regulation to avoid limits on provider enrollment in managed care.

Medicaid payment and direct service workers. Some respondents also noted the role of payment rates in overlap between the population of direct service workers and people enrolled in Medicaid:

“Many direct service workers (DSWs) are themselves eligible for Medicaid benefits by virtue of their low wages. In fact, more than 40 percent of direct care workers live in households that rely on some form of public assistance, such as food stamps, cash assistance, and Medicaid. Through its efforts to encourage community-based care, CMS should consider options that will encourage states to provide living wages to DSWs” [UnitedHealthcare Community & State, Comment ID: R_114qvjdU3YNUL6A_Q3.3].

Medicaid financing and workforce development. In addition to direct payment, several respondents made suggestions about opportunities to leverage Medicaid and CHIP financing to support the training of clinicians who might be more likely to serve people enrolled in Medicaid and CHIP. Suggestions included the following:

- Promote and collaborate with workforce incentive programs that encourage participation in Medicaid, including loan repayment or forgiveness, tax credits for malpractice insurance costs, and other Health Resources and Services Administration (HRSA)-funded programs.
- Consider opportunities through Section 1115 demonstration waivers to promote the training of clinicians likely to serve people enrolled in Medicaid and CHIP.

Opportunities to assess the effects of state payment policies and contracting arrangements on access. Respondents frequently advocated for several approaches for CMS to assess the effects of state payment policies and contracting arrangements on access to care. Broadly, many suggested restarting the access monitoring review plan process described at 42 CFR 447.203 and 447.204 for FFS programs, and some proposed a similar approach for managed care. Specific approaches from multiple respondents included the following:

- **Develop processes for providers and people enrolled in Medicaid to submit direct complaints to CMS regarding access.** Respondents noted that there are no consistent mechanisms for providers and people enrolled in Medicaid programs to make direct complaints to CMS despite the Supreme Court’s decision in *Armstrong v. Exception Child Center, Inc.*, 135 S. Ct. 1378 (2015), which placed the oversight of payment policies and their effect on access on CMS.

“Unfortunately, there are few means for providers and beneficiaries to connect with CMS directly to raise access concerns in their state. CMS should open a designated access complaint process with required steps of review and provide periodic outreach to states ensuring stakeholders have a forum to voice concerns about inadequate payment” [Autism Society of America, Comment ID: R_2EtRDxglDa0KqPa_Q5.2].

- **Monitor states’ implementation and enforcement of policies.** Several respondents noted the importance of CMS moving beyond the assessment of the presence of policies and monitoring the implementation and enforcement of those policies by states.

“With respect to Medicaid managed care, CMS must go beyond reviewing states’ managed care contracts and verify that managed care contract requirements are actually enforced” [Missouri Hospital Association, Comment ID: R_1rNOS5ow8GSLFXG_Q5.1].

“States should be required to assess the adequacy of not only their reimbursement for dental procedures but also the appropriateness of their methodology for setting those rates. CMS should

incentivize states that regularly adjust fees to keep up with inflation” [Texas Academy of Pediatric Dentistry, Comment ID: R_24wr0drODpsgfgO_Q5.1].

- **Identify and spread best practices in monitoring and promoting access.** Respondents described the limited capacity for states to identify best practices from other states and suggested a role for CMS in identifying and spreading these practices.

“[W]e encourage CMS to work with states in a learning collaborative to identify best practices that have led to increased access to Medicaid providers. A learning collaborative could help identify states that have been able to successfully incentivize specific types of providers (for example, behavioral health providers) to participate in Medicaid” [CVS Health, Comment ID: R_1Cd30c8YeX3ixVk_Q5.2].

Potential data sources, methods, or benchmarks to assess the sufficiency of Medicaid payment and CHIP rates. Suggestions from respondents for data sources, methods, and benchmarks included the following:

- **Benchmark Medicaid and CHIP payments compared with Medicare, TRICARE, and commercial rates.** Respondents frequently described the importance of using Medicare, TRICARE, and commercial rates in the same regions as comparisons for Medicaid and CHIP in implementing section 1902(a)(30)(A) of the Social Security Act. The respondents suggested a range of sources for commercial data, most of which are proprietary to professional organizations or data aggregation firms. Several respondents noted that comparisons of one state’s Medicaid rates to surrounding states’ rates are inadequate for assessing sufficiency because of the historical low rates across all Medicaid programs. Respondents also noted several caveats for comparisons with Medicare, TRICARE, and commercial rates for services that (1) also have historically low rates from those payers, such as behavioral health services; (2) other payers typically do not reimburse, such as community health workers; and (3) are included in value-based payment models.

“CMS could consider creating a national Medicaid data warehouse that would gather states’ information on rates and payments from existing data sources such as T-MSIS. This would allow MCEs [managed care entities] and others to compare with peer entities. This data warehouse could also include Medicare information and average commercial rate information where available” [MassHealth-Commonwealth of Massachusetts, Comment ID: R_OIL9yMor9ccDeXT_Q5.2].

- **Collect information on perspectives of those enrolled in Medicaid on access.** Respondents suggested CMS require states to use several methods for collecting perspectives of those enrolled in Medicaid on access, including direct surveys and audit surveys of providers’ acceptance of Medicaid and CHIP and wait times for visits, also known as “secret shopper studies.”
- **Use the Transformed Medicaid Statistical Information System (T-MSIS) to assess provider availability.** A few respondents noted the potential to use T-MSIS to monitor metrics of provider availability, such as ratios of people enrolled in Medicaid to providers, across provider types and specialties.
- **Require state reporting on the direct care workforce.** Several respondents noted the importance of monitoring methods that are specific to the direct care workforce.

“At minimum, states should be collecting and reporting to CMS a description of the characteristics of the direct care workforce that provides home and community-based services, including the number of full- and part-time direct care workers, the average and range of direct care worker wages, the benefits provided to direct care workers, and the turnover and vacancy rates of direct care worker positions. The state should also collect and submit demographic data related to the workforce to

identify disparate impacts and ensure equity” [Autism Society of America, Comment ID: R_2EtRDxglDa0KqPa_Q5.3].

“[E]stablishing minimum state standards and measures for the following areas related to HCBS programs and a state’s regional HCBS capacity:

- Provider rate-setting methodologies, including based on outcomes to specific quality measures
- Provider reimbursement levels
- Rapid access to reimbursement (for example, payments are processed in thirty calendar days or less)
- HCBS workforce capacity monitoring, recruitment, retention, turnover, training programs, and qualitative surveys to indicate worker satisfaction, perhaps weaving results into a formula or index that impacts provider reimbursement. We note these may look different in FFS and managed LTSS programs” [American Association of Retired Persons (AARP), Comment: R_2PiZsNw1xwjlWY_Q5.2].

Opportunities to reduce administrative burdens for providers. Many respondents described how administrative burdens for providers can be strong disincentives for participation in Medicaid and CHIP. Opportunities for policy improvements noted by respondents included the following:

- **Reduce the burden of provider enrollment.** Many respondents described the complex and often redundant credentialing and enrollment processes within and across state Medicaid and CHIP programs as burdensome. Respondents encouraged states to consider the following potential solutions:
 - Create a single process to allow enrollment in FFS and all managed care plans.
 - Accept home state enrollment in Medicaid and CHIP as sufficient for out-of-state enrollment.
 - Participate in existing common credentialing services and new cross-state credentialing agreements.
 - Participate in learning collaboratives on best practices for streamlining provider enrollment.

To help monitor these processes, several respondents suggested that CMS consider requiring states to submit information on how many providers are denied enrollment in Medicaid programs and the reasons.

- **Limit prior authorization, claims denials, and other forms of utilization management.** Many respondents noted that utilization management by state FFS and managed care plans can be a substantial deterrent to provider participation and can delay important patient care. They noted opportunities to identify and reduce practices that provide limited benefit for detecting fraud and abuse. Potential approaches described by respondents included the following:
 - Limiting or eliminating prior authorization for procedures and treatments that have high historical approval rates
 - Establishing uniform standards for electronic prior authorization
 - Implementing an efficient and immediate appeals system for prescribing/ordering physicians
 - Continuing to cover a drug or medical service that is removed from a plan’s formulary or subject to new coverage limitations for the duration of a patient’s benefit plan year to minimize disruption
 - Leveraging prepayment claims reviews in lieu of prior authorization services or separately as part of its Medicaid recovery audit program
 - Removing prior authorization for all FDA-approved medications to treat substance use disorder

D. Cross-Cutting Themes

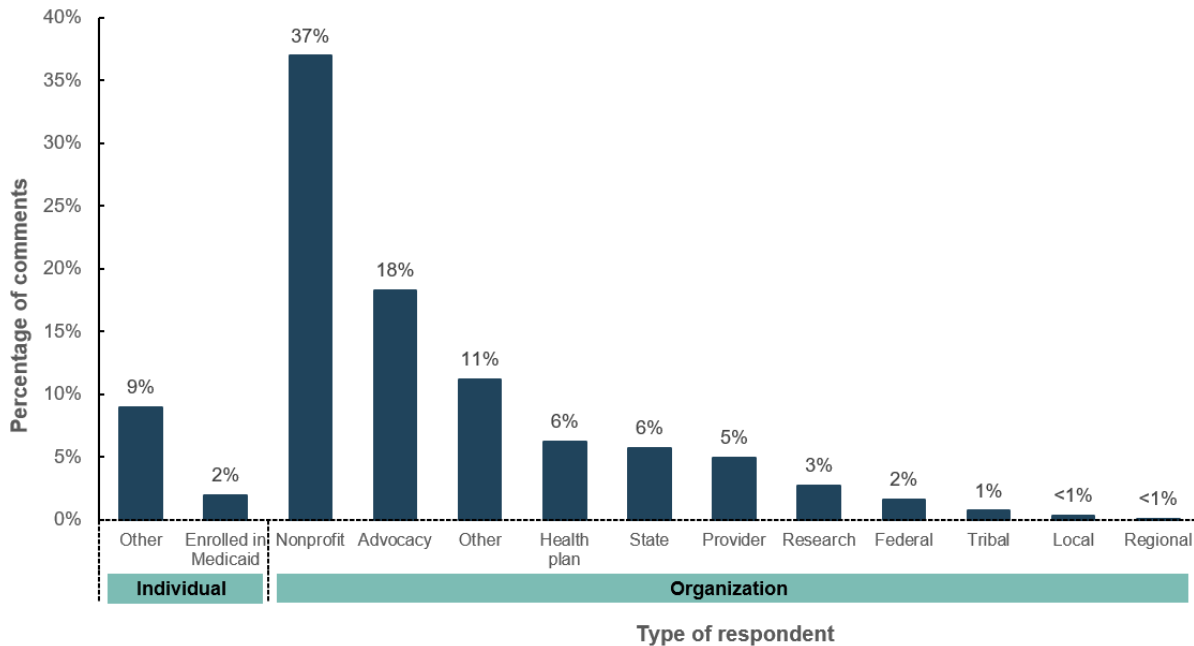
There were several topics that were prevalent across respondents' comments to all RFI questions. The following cross-cutting themes are summarized in this section of the report: (1) HCBS, (2) maternal and child health, (3) behavioral health, (4) COVID-19 PHE, (5) equity, (6) engagement, and (7) oral health coverage and payment.

1. HCBS: Themes across all RFI objectives

Although the RFI did not have an objective dedicated to HCBS, CMS prioritizes gathering information related to enhancing access in HCBS. The RFI asked for feedback on HCBS as it relates to eligibility, monitoring, and payment rates. This section pulls information across all of the RFI objectives and summarizes HCBS-related themes. The most prevalent comments related to HCBS addressed increasing the pool of available providers, aligning approaches and setting minimum standards for payment regulation and compliance, and expanding concepts of whole person care or care coordination (Table II.8).

Figure II.6 shows the distribution of respondent types for HCBS-related public comments.

Figure II.6. HCBS-related public comments by respondent type ^a



^a Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

Table II.8. Home and community-based services themes ^a

Question ID	Theme	Count	Percentage of HCBS comments
3.5	Increasing the pool of available providers in HCBS	80	18
3.3	Concepts of whole person care or care coordination in HCBS	67	15
5.1	Aligning approaches and setting minimum standards for payment regulation and compliance in HCBS	63	14
3.1	Developing standards for access to HCBS	40	9
4.3	Monitoring access in LTSS including HCBS	39	9
4.1	Monitoring comparability across delivery systems in HCBS	30	7
5.3	Assessing the sufficiency of rates for services which are not generally covered by Medicare in HCBS program and/or delivery	27	6
1.1	Timely eligibility determination, timely redetermination, and timely enrollment for HCBS	25	6
5.2	Assessing the effect of and promoting state payment policies and contracting arrangements that are unique to the Medicaid program on access to HCBS	24	5
1.2	Additional capabilities states need to improve timeliness for determinations and enrollment or eligibility for HCBS	22	5
4.2	Measures of potential access to HCBS program and/or delivery	17	4
1.3	Addressing barriers to enrollment among different groups in HCBS	16	4
1.4	CMS monitoring of key indicators of enrollment in coverage for HCBS program and/or delivery	14	3
3.4	Cultural competency and language preferences in HCBS	14	3
2.3	Continuity of coverage for HCBS beneficiaries transitioning between Medicaid or CHIP services and programs	12	3
3.2	Monitoring state performance against minimum standards for access to HCBS program and/or delivery	12	3
5.4	Reducing administrative burdens that discourage provider participation in HCBS program and/or delivery	13	3
4.5	Leveraging T-MSIS data to monitor access to HCBS	5	1
2.2	Communication with beneficiaries at risk of disenrollment from HCBS program and/or delivery	5	1
2.4	State enhancement of eligibility and enrollment system capabilities for HCBS	4	1
2.1	CMS monitoring of eligibility redeterminations for HCBS program and/or delivery	3	1
4.4	Monitoring Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes in HCBS	2	<1
Total number of comments analyzed with any HCBS theme(s) coded			Denominator: 453

^a. HCBS = home and community-based services; CMS = Centers for Medicare & Medicaid Services; CHIP = Children's Health Insurance Program; LTSS = long-term services and supports; T-MSIS = Transformed Medicaid Statistical Information System.

Reimbursement rates and wages for direct care workers. Many respondents indicated that addressing low reimbursement rates and increasing wages for direct care workers are critical to increase the pool of available providers due to the current workforce shortages that most states are facing for HCBS.

“[T]he key role of the workforce, along with the current workforce crisis, suggests that assessments of rate adequacy should include attention to wage levels needed to attract a sufficient number of direct care workers, and especially home care workers, to participate in Medicaid HCBS programs. . . . At the same time, agency employers of workers providing HCBS often cite low Medicaid rates as a barrier to raising wages. All of these issues point to the need for greater

CMS scrutiny of state Medicaid payment policies in this area, and for a process that is specific to HCBS” [Service Employees International Union, Comment ID: R_2pRJpzGhsa60qlG_Q5.3].

Respondents provided a range of suggestions to address the issues of low reimbursement rates and wages for direct care workers in HCBS:

- Implement workforce and care delivery pilot programs and invest in training programs, career pathways, and increased technology use for direct care workers in HCBS.
- Require minimum floors for wages, wage pass-through policies, and annual cost of living adjustments for HCBS rates.
- Consider the use of supplemental payments for LTSS.
- Incorporate value-based payment strategies for HCBS.
- Reduce administrative burdens for HCBS providers.
- Review the rate-setting methodology to develop approaches that incorporate unique aspects of HCBS care delivery, such as incorporating transportation into provider reimbursement, adding worker travel time into rates, or developing tiered rates based on acuity and other factors.

Paid family caregivers and self-directed models. Respondents also noted that expanding the use of paid family caregivers and self-directed models across all state HCBS programs could be an strategy to increase the pool of available providers.

“CMS should either mandate that states include family caregivers in their home- and community-based workforces, or at a minimum, make this the default option in state plan and waiver documents” [Shriver Center on Poverty Law, Comment ID: R_2f4UftgovhGeAxz_Q3.5].

“Self-directed services can be a useful tool to expand the provider pool, as it permits individuals to recruit and hire employees from their own social and community networks. Although many states have self-direction available, it may only be available under one waiver authority and not under another or is available for those who receive FFS but not those in MLTSS. It should be available throughout the Medicaid program. Even when it is available, the function of fiscal management agencies can cause access problems” [LTSS Task Forces of the Consortium for Citizens with Disabilities, Comment ID: R_2wHPjSyhWjZf6UF_Q3.5].

Rate-setting process and minimum standards for HCBS. Respondents expressed strong support for CMS to provide guidance on the rate-setting process and minimum standards for HCBS. Suggestions for HCBS rate processes included the following:

- Establish an advisory board to help determine rates and requiring that the rate-setting process be transparent, reviewed regularly, and designed to incorporate inflation adjustment.
- Require a comment period when states submit rates to CMS.
- Set caps on administrative fees in rates.
- Conduct studies to determine adequate rates, including comparing rates with those in the Veterans Health Administration program, and conduct workforce studies in conjunction with other federal agencies to establish pay ranges for different classifications of HCBS workers.

Methods and measures to assess the adequacy of HCBS. Respondents noted that there is a need for methods and measures to assess the adequacy of HCBS, such as by comparing eligibility for services and services received, to address whole person care.

Whole person care. Several respondents also provided suggestions for improving whole person care:

- Standardize and improve the assessment process for HCBS, through strategies such as timeliness standards and including direct care workers in the process.
- Use integrated care models to improve care coordination for people eligible for both Medicare and Medicaid.

Many respondents also posed that it is important to screen individuals for social determinants of health and to have flexible payment methods to address medical and nonmedical needs. Respondents also noted that HCBS providers should have access to electronic health records and other data sharing methods to be able to address whole person needs.

Other comments that addressed HCBS included the following topics:

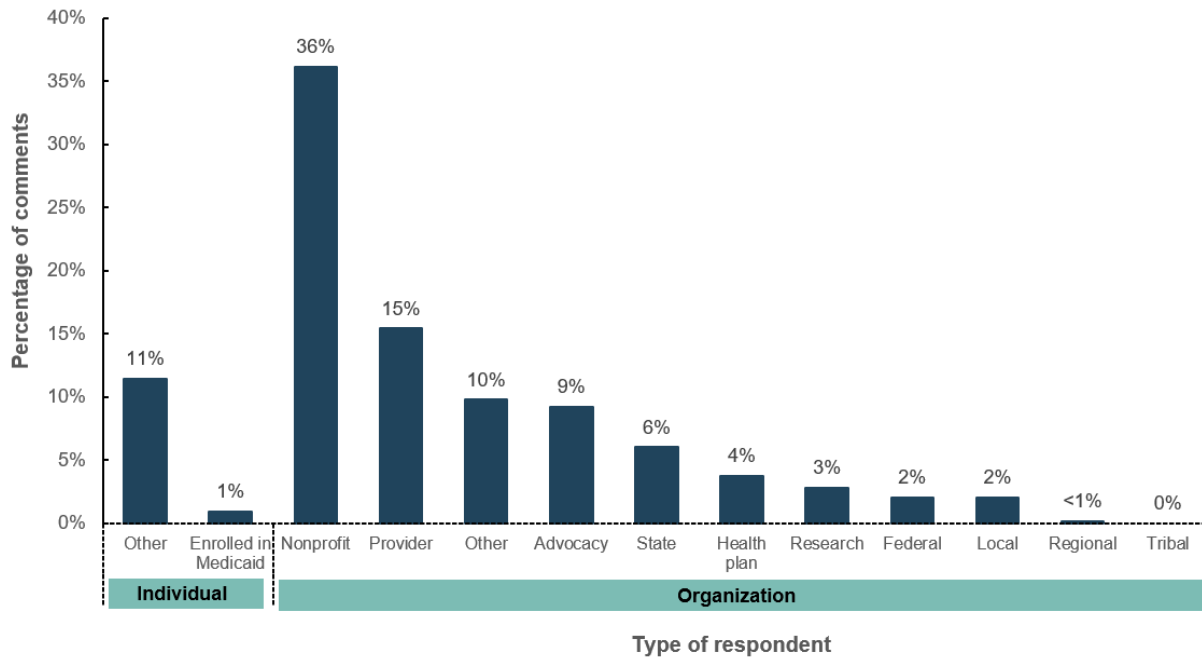
- Implementing presumptive eligibility for HCBS for people with relevant inpatient or residential treatment stays
- Improving data collection and reporting, particularly related to the HCBS workforce
- Improving transparency and processes around HCBS waiting lists
- Importance of addressing payment rates and workforce issues for nursing facilities in addition to HCBS.

2. Maternal and child health: Themes across RFI objectives

Medicaid and CHIP play major roles in access to coverage and care for women, especially mothers, and children. Medicaid covers more than one-third of women during pregnancy and more than 42 percent of live births (CMS 2020). More than 44 percent of children ages 0 to 17 have public insurance, predominantly Medicaid and CHIP (Cohen et al. 2022). Although the RFI did not ask questions specific to maternal and child health (MCH), all the objectives and questions are relevant to women's and children's ability to access coverage and care in Medicaid and CHIP. This section summarizes MCH-related themes that cut across the public comments for all objectives. These comments focused on care coordination, increasing the pool of available providers, and CMS monitoring key indicators of enrollment in coverage for mothers and children (Table II.9).

Figure II.7 shows the distribution of respondent types for MCH-related comments.

Figure II.7. MCH-related public comments by respondent type ^a



^a Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

Table II.9. Maternal and child health themes ^a

Question ID	Theme	Count	Percentage of maternal and child health comments
3.3	Concepts of whole person care or care coordination in maternal and child health	90	17
3.5	Increasing the pool of available providers for maternal and child health care	76	15
2.1	CMS monitoring of eligibility redeterminations for mothers and children	72	14
1.1	Timely eligibility determination, timely redetermination, and timely enrollment for mothers and children	41	8
1.3	Addressing barriers to enrollment and retention among different groups of mothers and children	39	8
5.1	Aligning approaches and setting minimum standards for payment regulation and compliance in maternal and child health care	37	7
2.3	Continuity of coverage for mothers and children transitioning between Medicaid or CHIP services and programs	36	7
3.1	Developing standards for access to Medicaid and CHIP services for mothers and children	35	7
5.4	Reducing administrative burdens that discourage maternal and child health provider participation in Medicaid and CHIP	25	5
1.2	Additional capabilities states need to improve timeliness for determinations and enrollment or eligibility for mothers and children	24	5
4.2	Measures of potential access to maternal and child health care	18	3
5.3	Assessing the sufficiency of rates for maternal and child health services which are not generally covered by Medicare	17	3
4.1	Monitoring comparability across delivery systems for maternal and child health care	14	3
2.2	Communication with mothers and children at risk of disenrollment	12	2
3.2	Monitoring state performance against minimum standards for access to Medicaid and CHIP for mothers and children	11	2
3.4	Cultural competency and language preferences in maternal and child health care	11	2
1.4	CMS monitoring of key indicators of enrollment in coverage for mothers and children	10	2
5.2	Promoting and assessing the effect of state payment policies and contracting arrangements related to access to maternal and child health care that are unique to the Medicaid program	10	2
2.4	Improved retention of mothers and children through state enhancements of state eligibility and enrollment systems	5	1
4.4	Monitoring Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes for maternal and child health care	5	1
4.5	Leveraging T-MSIS data to monitor access to maternal and child health care	4	1
4.3	Monitoring access to maternal and child health care in LTSS and HCBS programs	3	1
Total number of comments analyzed with any Maternal and Child Health theme(s) coded			Denominator: 516

^a CMS = Centers for Medicare & Medicaid Services; CHIP = Children's Health Insurance Program; LTSS = long-term services and supports; HCBS = home and community-based services; T-MSIS = Transformed Medicaid Statistical Information System.

Whole person and whole family care. Respondents suggest that CMS foster interagency collaboration and coordination to promote whole person care. They also asked that CMS consider establishing standards and disseminating best practices for strengthening whole family care and care coordination models for people enrolled in Medicaid programs. Respondents also emphasized the importance of services and programs that take a whole family approach, and that care coordination must integrate medical and nonmedical resources, such as housing, food security, and mental health services. Whole person care was identified as being particularly important for families at-risk of entering foster care, pregnant and postpartum women living with substance use disorder, and children with complex medical needs.

“We ask CMS to consider coordinating with the [Administration for Children and Families (ACF)] and other departments within [United States Department of Health and Human Services (HHS)] to maximize access to physical and mental health and substance use supports for children and families at risk of entering foster care to:

- Publish guidance and provide technical assistance on efficient integration, coordination, and access to services.
- Ensure the availability of a robust array of eligible evidence-based mental health programs that have demonstrated improved outcomes in communities, including those with demonstrated outcomes for populations overrepresented in the child welfare system.
- Support engagement of youth, parents, kinship caregivers, foster/resource parents and other community stakeholders in the development and implementation of any coordination engaged in by CMS and ACF to ensure the services and supports most needed by community members are included” [Casey Family Programs, Comment ID: R_1DAQuhp4CuNiiid_Q3.3].

Broadening the numbers and types of providers involved in delivering maternal and child health care. Many respondents focused on means to increase the pool of available care provider types, such as doulas and community health workers.

“Investments in the perinatal workforce can significantly improve maternal health outcomes, including maternal mental health outcomes. For example, women who give birth with a doula present were four times less likely to have a low-birth-weight baby, two times less likely to experience birth complications, and significantly more likely to initiate breastfeeding. [Organization name] recommends expanding the list of billable providers to include positions in the perinatal workforce such as doulas and midwives to help meet the maternal health needs of pregnant individuals” [Pennsylvania Association of Community Health Centers, Comment ID: R_33g9eHiWRLRt55O_Q3.5].

Other respondents suggested including providers in federally qualified health centers who provide care coordination and other services that are currently not billable across all states, such as certified asthma educators and community health workers. Respondents asked CMS to consider promoting telehealth to increase the available pool of Medicaid providers and creating loan repayment programs for pediatric subspecialty providers that incentivize the provision of telehealth services to rural and underserved areas.

Monitoring of eligibility redeterminations, especially for children. Respondents expressed concerns about people enrolled in Medicaid and CHIP losing coverage during redeterminations, especially due to administrative barriers. Several respondents noted that monitoring eligibility redeterminations will be particularly important at the end of the COVID-19 PHE and suggested that CMS particularly monitor, and try to reduce, the churn rate for children.

Timely eligibility determination, redetermination, and enrollment for pregnant women and children, especially for racial and ethnic minority groups and people with special needs.

Respondents identified numerous steps CMS could take to help states ensure timely eligibility determination, redetermination, and enrollments:

- Encourage states to use a single streamlined application for all health insurance programs.
- Encourage states to coordinate Medicaid and TANF application processes.
- Use enrollment information in the Special Supplemental Nutrition Program for Women, Infants, and Children and the federal school lunch assistance program as documentation for CHIP eligibility.
- Work with states to allow for the presumptive assessment of eligibility and retroactive coverage to the time at which eligible children and pregnant women seek medical care.
- Work with states to adopt policies to streamline eligibility determinations, such as utilizing express lane eligibility determinations and expanding the number and type of data sources used for ex parte renewals.
- Facilitate state options to extend eligibility periods, especially 12-month continuous eligibility for children.
- Remove the sunset on the Medicaid postpartum extension option.
- Remove the five-year waiting period for eligible children and pregnant women lawfully residing in the United States.
- Explore options to transfer Medicaid eligibility between states for children with disabilities.

Respondents suggested that CMS work with states to specifically reduce barriers to enrollment and retention for racial and ethnic minority groups, children with special health care needs, pregnant women, and children regardless of immigration status.

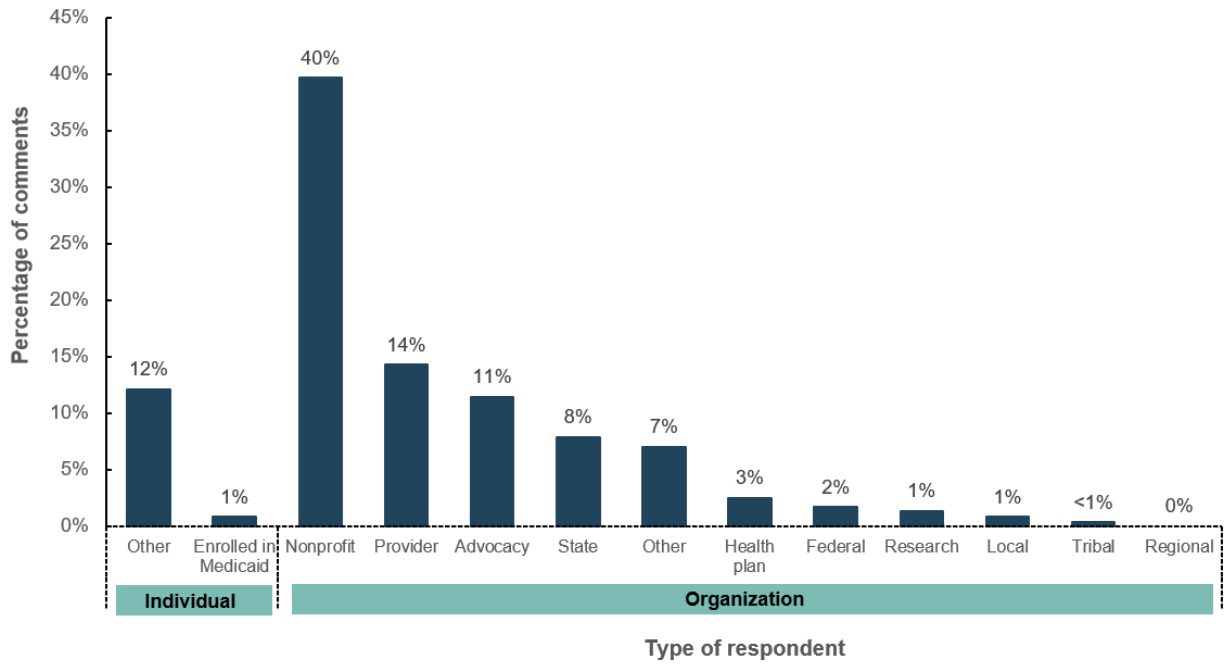
3. Behavioral health: Themes from all RFI objectives

Medicaid, as the single largest payer for behavioral health services, plays a key role in access to these services (Soni 2022). Of people enrolled in Medicaid ages 18 to 64, 27.6 percent reported a mental health condition in 2018 (MACPAC 2021). Additionally, about 8 percent of people ages 12 years and older enrolled in Medicaid were treated for a substance use disorder in 2019, the most recent year of data reported to Congress (U.S. Department of Health and Human Services 2022). Several objectives in the RFI included questions related to behavioral health. This section summarizes themes related to behavioral health that cut across the public comments.

The most common behavioral health themes were concepts of whole person care or care coordination in behavioral health (34 percent), increasing the pool of providers for behavioral health (17 percent), developing standards for access to behavioral health services (11 percent), addressing barriers to enrollment among different groups of individuals who need behavioral health care (9 percent), aligning approaches and setting minimum standards for payment regulation and compliance in behavioral health (6 percent), and cultural competency and language preferences in behavioral health (4 percent) (Table II.10).

Figure II.8 shows the distribution of respondent types for behavioral health-related public comments.

Figure II.8. Behavioral health-related public comments by respondent type ^a



^a Enrolled in Medicaid = self-identified as enrolled in Medicaid as part of RFI response.

Table II.10. Behavioral health themes ^a

Question ID	Theme	Count	Percentage of behavioral health comments
3.3	Concepts of whole person care or care coordination in behavioral health	165	34
3.5	Increasing the pool of available providers for behavioral health	85	17
3.1	Developing standards for access to behavioral health services	55	11
1.3	Addressing barriers to enrollment among different groups of individuals who need behavioral health care	43	9
5.1	Aligning approaches and setting minimum standards for payment regulation and compliance in behavioral health	29	6
3.4	Cultural competency and language preferences in behavioral health	21	4
3.2	Monitoring state performance against minimum standards for access to behavioral health	20	4
4.2	Measures of potential access to behavioral health	20	4
5.4	Reducing administrative burdens that discourage behavioral health provider participation in Medicaid and CHIP	20	4
1.1	Timely eligibility determination, timely redetermination, and timely enrollment for individuals who need behavioral health care	9	2
2.3	Continuity of coverage for individuals who need behavioral health care transitioning between Medicaid or CHIP services and programs	9	2
5.2	Assessing the effect of and promoting state payment policies and contracting arrangements that are unique to the Medicaid program on access to behavioral health	9	2
4.1	Monitoring comparability across delivery systems for behavioral health	8	2
5.3	Assessing the sufficiency of rates for services which are not generally covered by Medicare in behavioral health	8	2
2.1	CMS monitoring of eligibility redeterminations for individuals who need behavioral health care	7	1
1.4	CMS monitoring of key indicators of enrollment in coverage for individuals who need behavioral health care	5	1
4.4	Monitoring Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes for behavioral health	5	1
1.2	Additional capabilities states need to improve timeliness for determinations and enrollment or eligibility impacts for individuals who need behavioral health care	4	1
2.2	Communication with individuals who need behavioral health care at risk of disenrollment	3	1
2.4	Improved retention of mothers and children through state enhancement of state eligibility and enrollment systems	2	<1
4.3	Monitoring behavioral health access in LTSS including HCBS	2	<1
4.5	Leveraging T-MSIS data to monitor access to behavioral health	2	<1
Total number of comments analyzed with any Behavioral Health theme(s) coded			Denominator: 487

^a CMS = Centers for Medicare & Medicaid Services; CHIP = Children’s Health Insurance Program; LTSS = long-term services and supports; HCBS = home and community-based services; T-MSIS = Transformed Medicaid Statistical Information System.

Whole person care or care coordination in behavioral health. Respondents often suggested that CMS could consider exploring ways to address whole person care by expanding coverage of care coordination and integration of behavioral health with primary care and services to address “health-related social needs” [United States of Care, Comment ID: R_1cZcjzma6kbc8ST_Q3.3].

Respondents suggested the following strategies:

- Expand billable social and behavioral health care.
- Promote collaborative care models and integrated care (for example, allowing different types of providers to bill for the same patient for the same diagnosis on the same day, even if the providers are co-located).
- Issue joint guidance with appropriate agencies, such as the Substance Abuse and Mental Health Services Administration to support access to substance use disorder treatment.
- Cover comprehensive services for people with behavioral health needs, including crisis-related services and residential care.
- Require data sharing and coordination elements in provider contracts.

One respondent said:

“It’s important that physical health and behavioral health payment models are coordinated and managed together. When these benefits are managed separately, an inherent conflict is created on how the patient’s care is paid for.... CMS can require that states include data sharing and coordination elements in their contracts between physical health, behavioral health, oral health, and LTSS providers to support transparency and encourage collective impact on population health....”
[Legacy Health, Comment ID: R_1jOGgQTIDJJF1AV_Q3.3].

Developing standards for access to behavioral health services. Respondents often emphasized that standards specific to behavioral health providers and services are vital to ensuring network adequacy. Respondents suggested that CMS consider developing standards in the following areas, with some respondents specifically recommending thresholds for these standards:

- Number of providers
- Appointment wait times for emergency, urgent, and nonurgent services
- Time and distance to a behavioral health provider
- Prior authorization processes
- Denial rates
- Managed care plan reliance on out-of-network providers
- Inclusion of essential community providers of both mental health and substance use disorder services
- Network adequacy for the full breadth of substance use disorder and mental health services that is consistent with national criteria, such as the American Society of Addiction Medicine or Level of Care Utilization System, and aligns with Medicare and marketplace plans
- Culturally appropriate care

Increasing the pool of providers for behavioral health, aligning approaches, and setting minimum standards for payment regulation and compliance in behavioral health. Increasing the pool of behavioral health providers and minimum standards for payment regulation are intertwined. Several respondents suggested a need to provide more competitive reimbursement rates for behavioral health providers to increase the provider pool. Respondents also provided the following suggestions:

- Allow people enrolled in Medicaid to receive behavioral health care through telehealth when clinically appropriate after the PHE is lifted.
- Diversify types of behavioral health providers that provide care to enrolled populations.

“We recommend CMS work with states to better understand how MCOs have increased and diversified providers in their networks to ensure appropriate access. [In] Louisiana, our Medicaid segment identified that lack of access to behavioral health providers was a barrier for our members in a specific region of the state. Our network team was able to add 133 behavioral health intensive outpatient programs throughout Louisiana since 2019 to address this issue” [CVS Health, Comment ID: R_1Cd30c8YeX3ixVk_Q3.5].

- Invest in training programs and loan forgiveness for behavioral health providers.
- Implement a bid system.

“We recommend piloting a bid system for selecting provider types. Let the providers bid for Medicaid business like MCOs bid for Medicaid managed care contracts. Then establish payment rates based on a blend of bid amounts and quality metrics” [Virginia Hospital and Healthcare Association, Comment ID: R_1JLqVANRcV7NALH_Q5.1].

Addressing barriers to enrollment for individuals who need behavioral health care. Respondents often cited the importance of addressing social factors, such as transportation, housing, and accessibility of enrollment materials as barriers to enrollment, along with regulatory limitations. Several respondents offered suggestions for how to reduce barriers to enrollment for different groups of individuals who need behavioral health care, such as individuals experiencing homelessness or housing insecurity, justice-involved individuals, and youth with behavioral health needs. Suggestions included the following:

- Eliminate address requirements on enrollment forms and increasing flexibility in modes of enrollment, renewal, and communications (for example, in-person or online as opposed to by mail).
- Encourage states to pursue Section 1115 demonstration waivers and expanding demonstration waiver flexibilities (for example, by authorizing federal Medicaid matching funds for services provided to eligible justice-involved populations or for covering room and board).
- Work with states to consider how to best support schools and community-based organizations in enrolling eligible youth in Medicaid.
- Provide funding for care coordinators or navigators who help families navigate the mental health care system.
- Eliminate limitations on federal funding for institutions for mental disease (IMD) or increase the threshold for number of beds in an IMD facility.
- Eliminate the Medicaid Inmate Exclusion policy.

4. COVID-19 PHE: Themes across all RFI questions

The COVID-19 PHE created new access challenges for people enrolled in Medicaid and CHIP. To address these challenges, the federal government, as part of the Families First Coronavirus Response Act, required continuous coverage of people enrolled in Medicaid. CMS approved several temporary authorities, including Section 1135 waivers or new state plan amendments. In addition, many states added or enhanced Medicaid benefits, including expanding coverage for telehealth services (CMS 2021b). Several questions in the RFI prompted respondents to consider the effect of the PHE on coverage, provider enrollment, and access more broadly. This section summarizes the themes related to the COVID-19 PHE from all public comments.

Table II.11. COVID-19 PHE themes ^{a, 1}

Question ID	Theme	Count	Percentage of PHE impacts comments
2.1	CMS monitoring of eligibility redeterminations	84	22
3.5	Increasing the pool of available providers	52	14
1.1	Timely eligibility determination, timely redetermination, and timely enrollment	47	12
1.2	Additional capabilities states need to improve timeliness for determinations and enrollment or eligibility	25	7
3.3	Concepts of whole person care or care coordination	24	6
5.1	Aligning approaches and setting minimum standards for payment regulation and compliance	22	6
5.4	Reducing administrative burdens that discourage provider participation in Medicaid and CHIP	22	6
2.2	Communication with beneficiaries at risk of disenrollment	20	5
1.3	Addressing barriers to enrollment and retention among different groups	19	5
2.3	Continuity of coverage for beneficiaries transitioning between Medicaid or CHIP services and programs	19	5
3.1	Developing standards for access to Medicaid and CHIP	18	5
3.4	Cultural competency and language preferences	11	3
2.4	State enhancement of state eligibility and enrollment systems	7	2
5.2	Promoting and assessing the effect of state payment policies and contracting arrangements that are unique to the Medicaid program	7	2
4.1	Monitoring comparability across delivery systems	5	1
1.4	CMS monitoring of key indicators of enrollment in coverage	3	1
3.2	Monitoring state performance against minimum standards for access to Medicaid and CHIP	3	1
4.2	Measures of potential access to Medicaid and CHIP	3	1
5.3	Assessing the sufficiency of rates for services which are not generally covered by Medicare	3	1
4.3	Monitoring access in LTSS and HCBS	2	1
4.5	Leveraging T-MSIS data to monitor access to Medicaid and CHIP	1	<1

Total number of comments analyzed with any COVID-19 PHE theme(s) coded Denominator: 380

^a PHE = public health emergency; CMS = Centers for Medicare & Medicaid Services; CHIP = Children's Health Insurance Program; LTSS = long-term services and supports; HCBS = home and community-based services; T-MSIS = Transformed Medicaid Statistical Information.

¹ An accompanying figure is not presented in this section.

Robust state monitoring. Of the respondents who mentioned Medicaid access in the context of the PHE, the most common topic was CMS monitoring of eligibility determinations after the PHE (Table II.11). These comments ranged from simply encouraging CMS to engage in robust state monitoring to providing

monitoring strategy suggestions. For instance, UnitedHealthcare Community & State offered the following suggestion:

“[S]tates develop and maintain a dashboard indicating the progress of eligibility redeterminations and sharing real-time information with MCOs to facilitate communications to beneficiaries who may be at risk of losing coverage...and monthly retention rates should be made available to CMS for review and analysis” [Comment ID: R_114qvjdU3YNUL6A_Q2.1].

Facilitating the use of community health centers. The Geiger Gibson Program in Community Health Policy at the George Washington University Milken Institute School of Public Health similarly encouraged CMS to closely monitor state eligibility determinations efforts post-PHE and added that CMS should ensure that states facilitate the use of community health centers for people enrolled in Medicaid losing coverage in the following ways:

- Provide outstationed enrollment and determination support at all safety net provider sites.
- Train safety net providers regarding community resources that supplement their services.
- Integrate safety net providers’ onsite enrollment and renewals into their states’ main eligibility systems.

Ex parte renewals. Many respondents highlighted the role of the ex parte renewal process once the PHE ends and the potential of enhanced CMS oversight to improve the eligibility redetermination process. For example, the Ann & Robert H. Lurie Children’s Hospital of Chicago made the following suggestion:

“CMS should issue ex parte processing standards ... and pursue corrective action plans for states that do not meet the standard. CMS should require states to routinely test their systems to assure ex parte processing is possible and could incentivize states to achieve specific performance standards on renewal related data, such as a specified threshold of ex parte and data-driven renewals” [Comment ID: R_2bH6gNLIbhY222p_Q2.1].

Best practices for redeterminations. In addition to its oversight role, respondents suggested that CMS could improve the redetermination process by promoting best practices:

“We encourage CMS to issue guidance, share best practices and develop tool kits for states on conducting ex parte renewals ... guidance should highlight opportunities for states to include additional data sources or types of data in their ex parte renewals to increase the likelihood of successfully redetermining eligibility through the ex parte process ... and outline strategies for making IT system updates to allow data platforms to access and retrieve data from these different sources” [The Blue Cross Blue Shield Association, Comment ID: R_25TKN2s9pNhEQ9A_Q1.1].

Additional capabilities states need to improve timeliness for determinations and enrollments.

Respondents on this issue often noted the volume of redeterminations that must take place after the PHE and advocated for infrastructure and systems-based solutions. For example, the SAS Institute said states are likely to experience unanticipated difficulties with the redetermination process and recommended that CMS help states streamline enrollment and redetermination processes, for instance by configuring a secure bidirectional data exchange between state and federal programs for MAGI-based eligibility determinations. It also proposed that CMS explore whether states may be able to use existing commercial off-the-shelf capabilities in the marketplace to help agencies prioritize redeterminations by identifying and focusing on those who are mostly likely still eligible and in need of services.

Pool of available Medicaid providers. Respondents frequently discussed how the PHE highlights the need to increase the pool of available providers participating in Medicaid, particularly through the use of telehealth. Many of those respondents advocated for continuing some of the provider flexibilities employed during the PHE to increase the Medicaid provider pool. For example, one respondent said:

“During earlier COVID period, cross-state licensure of providers requirement was waived so that telehealth could be utilized a lot more. This was a great benefit for Alaska. Once that was no longer waived and the providers had to look at state licensure in each place, the telehealth ended. For Alaska that often meant we need to travel the patient out of state for a visit that could be telehealth but the provider does not want to go through the process of licensure” [Individual, Comment ID: R_0uf9xQIAYJEaL8R_Q3.5].

PHE flexibilities. Other respondents raised the possibility of making flexibilities allowed during the PHE permanent, such as allowing family members to be paid caregivers within Medicaid programs (which has an added benefit of increasing the pool of culturally competent providers from diverse racial and ethnic communities) and allowing cross-state provider licensure.

5. Equity: Themes across all RFI questions

Health equity focuses on the attainment of optimal health for everyone, regardless of race, ethnicity, disability, and other factors that affect access to care and health outcomes (CMS.gov n.d.). Although there were no specific questions that addressed equity in the RFI, respondents prioritized the consideration of equity in potential targeted solutions to improve access in Medicaid and CHIP.

Across objectives, respondents most frequently illuminated barriers to and suggested solutions related to equity in enrollment in coverage and standards for access to services and supports of health care. Additionally, comments recommend consideration of equity in monitoring, data, and measurement to ensure equity is being maintained across dimensions of access.

Equity in enrolling in coverage. Respondents recommended ensuring equity in enrolling in coverage through leverage of navigation programs and monitoring reasons for denials, illustrated in these comments from Comagine Health and the Virginia Poverty Law Center:

“Addressing barriers to enrollment is critical to supporting underserved populations and ensuring health equity. Comagine Health’s state partners have demonstrated success engaging [communities of color] through navigation programs that are embedded within the communities” [Comment ID: R_1QsXMzfxivou7Vp_Q1.3].

“Additionally, CMS must enforce requirements that all populations are treated equitably by ... collecting and analyzing data on applicant race and ethnicity, preferred language, housing status, and disability status to identify groups that are disproportionately being denied or terminated from coverage” [Comment ID: R_2Ram9jHZPXpsLuY_Q1.3].

Equity in data and monitoring. Respondents suggested that CMS consider improving equity in Medicaid and CHIP through identifying, examining, and monitoring existing health inequities by taking the following steps:

- Improving data quality on race, ethnicity, and other demographic information
 - Examples of measures mentioned across public comments included race, ethnicity, gender, language, housing status, food access, physical and mental health conditions, disabilities, and safety and psychosocial factors. Many comments also called for the incorporation of perspectives of people enrolled in Medicaid into data to identify access issues people experience.
 - Planned Parenthood Federation of America commented:

“CMS should work with other federal and state agencies to ensure that they effectively and ethically collect socio-demographic data across race/ethnicity (including disaggregating data among racial groups like Asian Americans and middle eastern patients), sexual orientation, sex, gender identity, and income in addition to tracking data from people with disabilities and their experiences across Medicaid and CHIP delivery systems, services and programs. This data will not only expose concerning health disparities, but once it is collected and studied, it can be used to inform policy solutions to target the underlying causes of health inequities among Medicaid beneficiaries” [Comment ID: R_2CUhrYex6mXqB2Z_Q4.1].

- Developing access standards that promote equity and monitor the existing Medicaid network against those standards

“Rather than varying access standards by state, geography, or delivery system, MPCA supports consistent standards with an emphasis on health equity. Unifying standards across payer types—Medicaid, Medicare, commercial, and HRSA Section 330 grants for the uninsured—would lower the administrative burden for low-resource safety net providers such as health centers. The standards should consider the special needs of the most vulnerable groups, including racial and ethnic minorities, people with disabilities, people experiencing homelessness, and people in need of language and translation services. Access standards that incorporate social risk factors and the social determinants of health can improve access in more equitable ways. For example, health centers dedicate more staff time to preserve access to care for individuals who may face housing instability and food insecurity. The work to guarantee access in harder-to-reach populations must be acknowledged when establishing standards, making comparisons, and evaluating performance” [Montana Primary Care Association, Comment ID: R_1LZhqiVqmIPTHP].

Cultural competency and language preferences across services, including in behavioral health.

Some respondents posited that allowing tribes direct access to Medicaid funds could increase services that are more culturally specific. Public comments noted there is a need for more multilingual behavioral health providers, as well as those from communities of color. There is also a need for more accessible communication materials. One respondent described:

“CMS should ... go beyond recommending a language access plan by recommending state agencies, grantees and contractors develop a broader ‘access plan.’ This should include, for example, how the entity will provide foreign language interpreters, translated materials, sign language interpreters, large print/Braille documents or audio/video formats of materials, auxiliary aids and services for effective communication, and a range of other communication assistance. An access plan will help agencies, grantees and contractors be better prepared to meet the needs of LEP and individuals with disabilities by planning how to provide communication assistance and ensure accessibility” [National Health Law Program, Comment ID: R_2YrCCQ20hbHx90U_Q3.4].

6. Engagement: Themes across all RFI questions

The RFI respondents recommended engagement with a diverse group of Medicaid and CHIP stakeholders, including those enrolled in the programs, to best understand how to address access across noted challenges.

Additional engagement. Respondents frequently expressed support for additional engagement activities with Medicaid and CHIP stakeholders to inform the development of the CMS access strategy. Respondents encouraged CMS to reach out to specific groups and populations to garner deep understanding of Medicaid and CHIP access challenges and possible solutions.

- The National Association of Counties, for instance, asked that CMS gather input from county health departments, as they are often on the front lines of Medicaid enrollment and service delivery:

“The National Association of Counties urges CMS to seek input from counties in conjunction with our state partners to identify possible improvements in eligibility redetermination. Broadly, county health and human services agencies have the closest proximity to residents seeking care and can directly assist with efforts to promote continuity of coverage through eligibility redeterminations” [Comment ID: R_0dpTRzhprw7cLi9].

- The Georgetown University Center for Children and Families similarly recommended that CMS consult states about Medicaid access strategies and suggested several topics for discussion:

“States’ processes and systems vary. We encourage CMS to engage with individual states to understand their unique challenges with eligibility determinations and enrollment. We recommend CMS explore opportunities to incentivize states to incorporate more automated processes and systems that allow for eligibility determinations to occur more quickly and with less paperwork. There may be opportunities to streamline some processes across states while still accounting for individual state programs and systems. We also recommend CMS consider how to work with states to streamline eligibility processes for MAGI and non-MAGI populations to align the two processes more closely” [Comment ID: R_1Cd30c8YeX3ixVk].

- Rather than solicit feedback from state and local governments, the National Health Law Program posited that by partnering with advocacy organizations people enrolled in Medicaid could offer CMS a strong understanding of Medicaid and CHIP access barriers and facilitators:

“While CMS regularly engages with states, we recommend CMS set up formal mechanisms to actively engage with health advocates, including legal services providers, reproductive health and justice organizations, as well as national partners, to help identify issues occurring in states and hold state Medicaid and CHIP programs accountable for their obligations to enrollees. CMS should use every tool ranging from greater transparency, data reporting, and state compliance scorecards to civil monetary penalties and sanctions, to ensure that state Medicaid programs best serve the needs of enrollees” [Comment ID: R_2YrCCQ20hbHx90U].

- The Centers for Social Policy said that CMS may benefit from undertaking shared decision making with people enrolled in Medicaid, specifically arguing that partnering with these participants could generate strategies for addressing Medicaid and CHIP access, systemic racism, and producing better health outcomes:

“CMS should prioritize hearing from beneficiaries directly and encouraging states to do likewise. This requires more than user experience studies or focus groups that address the application process, but more fundamental efforts to shift power and allow for shared decision-making. Partnering with individuals with lived expertise at every step of policy, implementation, and evaluation is needed to ensure that Medicaid and CHIP not only meet the immediate health care needs of the people they are intended to serve, but also interrupt practices that uphold systemic racism and perpetuate disparities. As recommended by the [Biden] Administration’s equity plan, trusted community intermediaries and accessible, relevant channels of communication are critical part of stakeholder engagement with underserved populations” [Comment ID: R_1DN11ERx15LjuHQ].

7. Oral health coverage and payment: Themes across all RFI questions

The RFI did not include any questions specifically about oral health, but the analysis of the public comments showed that oral health came up frequently from a variety of respondent types. Individual

respondents commonly cited long wait times or long distances to travel for dental appointments. One respondent noted, “I found it extremely difficult to find a dentist who would take Medicaid and had to drive 45 minutes to get to him” [Individual, Comment ID: R_114UeGB6Xu8VBqa_Q3.1]. This section summarizes the themes related to oral health from all public comments.

Enhanced oral health coverage and reimbursement. Many respondents suggested that CMS could consider expanding and standardizing dental coverage and mandatory benefits across beneficiary populations enrolled in Medicaid and CHIP.

“Establishing a base threshold of dental coverage beyond beneficiaries classified as children would support a mechanism to establish and monitor minimum standards for payment regulation and compliance across Medicaid and CHIP, regardless of administration type (e.g., fee-for-service or managed care) and beneficiary group designation” [CareQuest Institute for Oral Health, Comment ID: R_24pUNJy5g1qjW9F_Q5.1].

Suggestions from respondents included the following:

- Use Early Periodic Screening, Diagnostic and Treatment (EPSDT) as a benchmark for dental coverage for children enrolled in Medicaid and CHIP and as a model to develop minimum standards for adults enrolled in Medicaid and CHIP.
- Establish a standard definition or timeline for people enrolled in Medicaid and CHIP who are “aging out” of dental coverage.
- Create dental periodicity schedules or base threshold guidelines of dental coverage for groups not qualifying as a child.
- Encourage states to adopt optional adult Medicaid dental coverage by providing guidance, technical assistance, and other data-sharing opportunities.

Reimbursement for oral health providers. Respondents often cited low reimbursement rates as a primary driver for oral health providers not accepting Medicaid.

Respondents offered the following thoughts on this topic:

- Require states to conduct regular assessment of dental reimbursement rates.
- Establish a payment floor for states that includes a mechanism to account for an annual increase and geographic adjustment.
- Establish a new facility billing code for dental rehabilitation surgery to increase access to dental care in operating room settings for Medicaid populations with significant needs.
- Expand coverage or incentivize states to cover certain dental disease management services and services for high-need patients, such as case management, behavior management, motivational interviewing, care coordination, nutritional counseling, application of dental caries arresting, or preventive medicaments.

The role and reimbursement of dental hygienists and therapists. To help address the limited pool of available dentists, some respondents recommended that CMS consider expanding reimbursement for non-dentist providers.

- Allowing dental hygienists and dental therapists to bill directly to Medicaid for services rendered
- Updating EPSDT regulations to recognize non-dentist providers who provide dental services directly to patients:

“States and others desiring to improve access to dental services have creatively sought Medicaid reimbursement for non-dentist providers under a different, more general, EPSDT regulation, 42 CFR § 440.60, relating to ‘Medical or other remedial care provided by licensed practitioners’.... Unfortunately, the characterization of services provided by dental hygienists as ‘remedial’ has caused numerous issues, including ADHA members being told with respect to certain Head Start children on Medicaid that Medicaid reimbursement to dental hygienists is available only for ‘remedial care,’ not for dental services” [American Dental Hygienists’ Association, Comment ID: R_3KJB9Lau5KgHU4T_Q3.5].

The role of teledentistry in improving access to oral health care. Respondents who raised suggestions on oral health access often mentioned teledentistry and services delivered at home or in schools as means for addressing disparities and distance barriers in oral health services and advocated for increased reimbursement for these services. Respondents suggested the following approaches:

- Improve reimbursement of services delivered via teledentistry and ensure payment parity compared to in-person services.
“We recommend the following.... Support payment parity for services delivered via teledentistry. Provide guidance to states on the importance of recognizing and paying for teledentistry CDT codes, D9996-7” [American Dental Association, Comment ID: R_wLtn5T5YIZvf8it_Q3.5].
- Expand reimbursement of dental services to include at-home care that parents and caregivers may be able to administer, such as fluoride varnish applications, and educational or preventive services delivered at schools, child development centers, community centers, senior centers, nursing homes, home health visits, and well-child visits.

E. Summary of Findings

The public comments submitted in response to this RFI reflect a wish for more equitable access to health care for people enrolled in Medicaid and CHIP. Respondents shared feedback across the three dimensions defined in the RFI: (1) enrolling in coverage, (2) maintaining coverage, and (3) accessing services and supports. In addition to the following topics, many respondents expressed support for CMS’s continued engagement with Medicaid and CHIP stakeholders as it defines next steps.

- Across objectives, respondents suggested improving **equity and cultural competence** in Medicaid and CHIP by capturing key sociodemographic data, applying a health equity lens to all metrics, and increasing cultural competence among providers and staff working with people enrolled in Medicaid. Specifically, respondents suggested establishing minimum standards for cultural competency and language preferences, increasing race and ethnicity data quality and standardizing the same data in Medicaid and CHIP data systems, and reducing barriers to enrollment and retention for racial and ethnic minority groups.
- Individual respondents commonly advocated for making improvements in **communications to and with people enrolled in Medicaid and CHIP** in eligibility determinations and redeterminations. Respondents suggested using multiple modes of communication, establishing communications best practices and standards, utilizing enrollment broker relationships and navigation efforts to help facilitate communication, and improving the accessibility and usability of written materials and websites.
- Comments provided across several objectives and cross-cutting themes related to Medicaid and CHIP **data, systems, and IT**, particularly regarding coordination across systems or agencies. Comments proposed coordination between state Medicaid and CHIP systems and Healthcare.gov, as well as other program systems to streamline eligibility determinations and redeterminations during regular program

operations in addition to unwinding from the PHE. Coordination and compatibility of data was also commonly suggested to promote whole person care and care coordination, especially within the cross-cutting topics of maternal child health, HCBS, and behavioral health.

- Feedback on the RFI also reflected a need to **assess the sufficiency of payments to providers and the pool of available providers**. Respondents suggested using Medicare, TRICARE, and commercial rates to benchmark payments to providers, as well as increasing wages for direct care workers. Comments within HCBS and MCH cross-cutting themes suggested reimbursing more types of providers, including family caregivers and doulas. Respondents also suggested enhanced oral and behavioral health coverage and reimbursement.

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