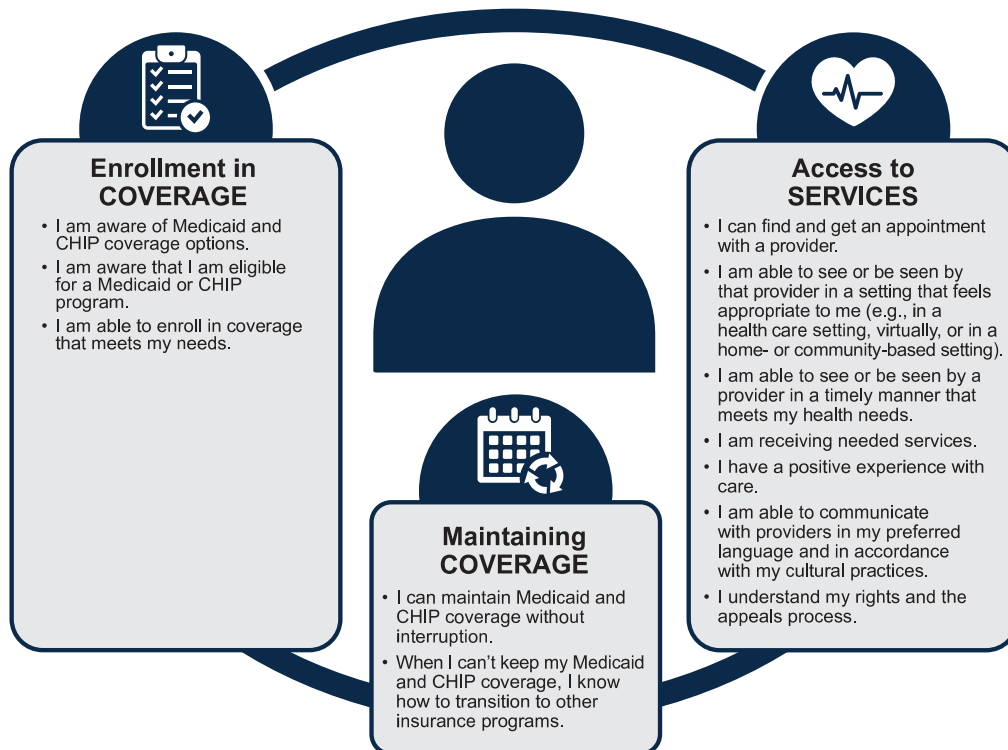


Summary of Public Comments from CMS’s 2022 Request for Information: Access to Coverage and Care in Medicaid and CHIP

At-a-glance 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.¹ The Centers for Medicare & Medicaid Services (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 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. 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 1).

Figure 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.

¹ CMS “Medicaid and CHIP Enrollment Trend Snapshot.” August 2022. Available at <https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html>.

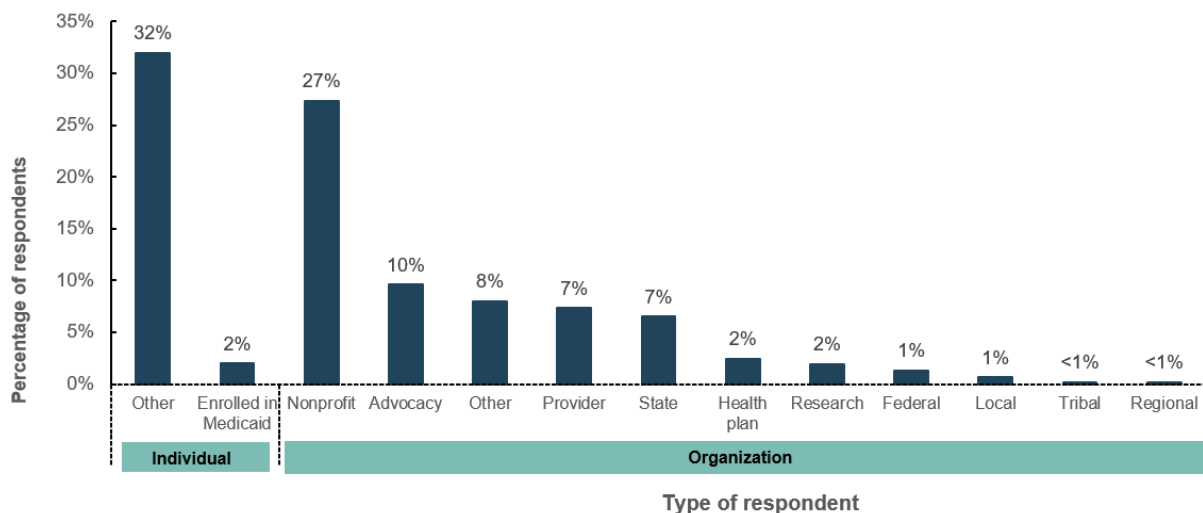
Within each dimension of access, accompanying regulatory, monitoring, or compliance actions might be needed to ensure beneficiaries achieve and maintain access to health care. To gather feedback on these three dimensions, while taking into account its strategic vision for Medicaid and CHIP, CMS structured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

- **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.

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

- Out of 796 RFI respondents² and 7,125 comments³, 181 respondents and 1,975 comments were excluded from the analysis because their content was unclear, blank, or were testimonials⁴ without suggestions. Of the remaining 615 respondents, a majority (74 percent) of the respondents were organizations, and nonprofits were the most common organization type (Figure 2).

Figure 2. RFI responses by respondent type



² Respondent = an individual or organization that submitted comments to the 2022 RFI.

³ Comment = an individual’s or organization’s response to the 2022 RFI.

⁴ 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.

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- The most common themes were related to:
 - Addressing equity and cultural competence, including suggestions to collect and analyze outcomes by sociodemographic data, to establish minimum standards that take into account cultural competence and language preferences, 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.

Public comments by objective: Examples of suggestions and feedback from RFI respondents

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.

Objective 1. Eligibility and enrollment

- **Applications for eligibility determinations.** Maximize use of ex parte determinations and express lane eligibility; clarify the policy regarding income and resources; expand presumptive eligibility; maintain public health emergency (PHE) flexibilities; implement a “no wrong door” policy.
- **Eligibility and enrollment processes and systems.** Provide states with technical assistance; facilitate state-to-state learning for states with high and low ex parte rates; coordinate between states and Healthcare.gov; promote modern approaches for consumer support and usability assessment.
- **Best practices for outreach and enrollment.** Focus on areas where potential enrollees are (school, work, doctor’s offices); use multimodal outreach and enrollment; ensure respectful outreach and enrollment processes.

Objective 2. Ensuring consistent coverage

- **Communication standards with beneficiaries at-risk of disenrollment.** Communicate frequently via multiple modes (letters and email).
- **Renewal processes.** Use plain language in materials; provide resources, such as technology, to assist with renewal applications; use technology to streamline consumer outreach.
- **Continuous enrollment periods of 12 months.** Set a minimum of 12 months of continuous eligibility; extend continuous coverage; provide states with regulatory guidance on continuous eligibility; ensure appropriate use of data matching for period verification issues.

Objective 3. Standards for access to care

- **Standards for potential access.**⁵ Establish minimum standards for network adequacy; establish minimum standards for cultural competency when serving communities; incorporate telehealth into access standards.
- **Minimum standards.** Keep administrative burden low; use standards that promote equity, value-based care models, cultural competence, and availability of services.
- **Available provider pool.** Expand and diversify provider pool; expand telehealth permanently; reduce barriers for cross-state licensing; expand language access in telehealth; expand telehealth for mental health.

Objective 4. Data and measurement

- **Measures of provider availability.** Use measures of provider availability, such as appointment wait times, robustness of provider networks, potential and realized access to care,⁶ and social determinants of health. For example, stratify measures by social determinants of health as a proxy for provider availability.
- **Technical assistance or other resources to support states in standardized monitoring and reporting.** Streamline reporting across systems and reports; reduce state reporting burden; recognize limited state capacity and provide support to implement new measures.
- **Data to measure and monitor.** Use data that address topics such as service utilization, transportation, access to medication, workforce characteristics, health disparities, oral health, Medicaid fair hearings and CHIP reviews, application denials, managed care appeals and grievances.

Objective 5. Ensuring Medicaid and CHIP payments are sufficient

- **Payment regulation and compliance.** Expand reimbursement to more types of providers; increase payment to providers; increase wages to direct service workers; invest in workforce development.
- **State payment policies and contracting arrangements.** Facilitate processes for providers and enrollees to submit complaints; monitor states' implementation and enforcement of policies; identify and spread best practices.
- **Data sources, methods, or benchmarks for Medicaid payments and CHIP rates.** Compare Medicaid and CHIP payments with Medicare, TRICARE, and commercial rates; collect enrollees' perspectives; use data from the Transformed Medicaid Statistical Information System (T-MSIS) to assess provider availability; require state reporting on the direct care workforce.
- **Administrative burdens for providers.** Reduce the burden of provider enrollment; limit prior authorization, claims denials, and other forms of utilization management.

⁵ Beneficiaries' potential to access providers and services, regardless of whether the providers or services are used, including provider availability and accessibility.

⁶ Realized access represents beneficiaries receiving needed care.

Themes that cut across objectives: Examples of suggestions and feedback from RFI respondents

- **Home and community-based services (HCBS).** Address low reimbursement rates and wages for direct care workers; pay family caregivers and implement self-directed models; establish a rate-setting process and minimum standards; develop methods and measures to assess adequacy of HCBS.
- **Maternal and child health.** Assess key indicators of enrollment in coverage for mothers and children; ensure timely eligibility determination, redetermination, and enrollment for pregnant women and children, especially for racial/ethnic minority groups with special needs.
- **Behavioral health.** Implement standards for access to behavioral health services; develop approaches and minimum standards for payment regulation and compliance in behavioral health; assess barriers to enrollment for individuals who need behavioral health care.
- **COVID-19 PHE.** Ensure states facilitate the use of community health centers for people enrolled in Medicaid losing coverage; monitor eligibility determinations after the PHE.
- **Equity and engagement with beneficiaries.** Assess equity in data and monitoring; infuse cultural competency and language preferences across services, including in behavioral health; conduct additional engagement with beneficiaries.
- **Oral health coverage and payment.** Enhance oral health and reimbursement; reimburse oral health providers; update regulations to allow non-dentists (dental hygienists and therapists) to bill for services they provide directly to patients; incorporate teledentistry into access to oral health care.

To view the full report, visit: <https://www.medicaid.gov/medicaid/access-care/index.html>