Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Access RFI Answers

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Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.

Question 1. What are the specific ways that CMS can **support states in achieving timely eligibility determination and timely enrollment** for both modified adjusted gross income (MAGI) and non-MAGI based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan when applicable.

- **Align non-MAGI-based eligibility policies and processes with MAGI policies enacted under the ACA**. Alignment will alleviate the burden of maintaining different processes within Medicaid systems and could advance the integration of non-MAGI eligibility into the MAGI system (according to the 2022 Kaiser 50-state survey only 36 states have MAGI systems that determine eligibility for non-MAGI Medicaid).
    - Tricia Brooks et al., “Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey,” Kaiser Family Foundation, March 16, 2022, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/.
- **Publish all timeliness data as required by the Performance Indicator Project monthly on an ongoing basis.** As a condition of eligibility for enhanced federal systems funding, states must meet certain requirements, including reporting performance indicator data. Since 2018, CMS has published a report on MAGI-processing times with state-level data for three months of data. States may be more inclined to take steps to improve timeliness if 50-state comparative data is published monthly on an ongoing basis.
    - Center for Medicaid and CHIP Services, “Training Materials for State Staff: Overview of the Medicaid and CHIP Eligibility and Enrollment Performance Indicators,” Centers for Medicare and Medicaid Services, September 2015, https://www.medicaid.gov/medicaid/downloads/overview-of-performance-indicator-project.pdf.
- **Review and assist states in ensuring that all notices meet plain language requirements and offer appropriate language assistance, as required.** Timeliness is impacted by consumer confusion and the need to provide documentation for eligibility criteria. A priority for notice review would be to focus on notices that require action by the applicant. While improving data-driven eligibility determinations will reduce the need for paper documentation, there will always be applicants whose eligibility cannot be verified through electronic sources.
- **Encourage states to adopt express lane eligibility (ELE) and allow states to apply the policy to parents, if not all adults, through an simplified Section 1115 waiver process similar to what the agency did to promote 12-month continuous eligibility for adults.** The 2013 evaluation of express lane eligibility found that states that invest in automated processes can add a meaningful number of children to Medicaid. Express lane eligibility also appears to find hard-to-reach children. Additionally, the evaluation findings

identified opportunities to improve ELE that should be incorporated into guidance or technical assistance to states.

  - Center for Medicaid and CHIP Services, "SHO #13-003: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014," Centers for Medicare and Medicaid Services, May 17, 2013, https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Express_Lane/ExpressLane-Letter2.pdf.
  - Sheila Hoag et al., "CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings," Mathematica Policy Research, Urban Institute, Health Management Associates, December 2013, https://www.urban.org/sites/default/files/publication/60916/2000283-CHIPRA-Mandated-Evaluation-of-Express-Lane-Eligibility-Final-Findings.pdf.

- **Ensure that states are offering enrollment and renewal online, over the telephone (with a telephonic signature), in-person, and through the mail.** States are required to provide opportunities for individuals to apply and renew eligibility through four modes: online, over the telephone (with a telephonic signature), in-person, and through the mail. CMS should enforce these requirements. While most states are in compliance, a handful of states are not according to the 2022 Kaiser 50-state survey.
  - Tricia Brooks et al., "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey," Kaiser Family Foundation, March 16, 2022, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/.

Question 2. **What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes**, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?

- **Provide technical assistance to fill gaps in state expertise, particularly relating to oversight of IT vendors.** In most states, the development and maintenance of eligibility systems is contracted to external vendors. Some states lack the in-depth IT expertise and contract management experience to effectively oversee complex IT contracts and hold vendors accountable. Billions of federal dollars are contracted to a handful of IT vendors that build different systems for different states that essentially handle the same processes based on the same basic rules, although some state customization is needed to provide for state flexibilities (ie, eligibility levels or self-attested eligibility criteria). CMS should take a closer look at the extent to which the federal government largely funds duplicative systems and assess vendor performance and cost-effectiveness.
- **Conduct oversight to ensure that systems produce the required performance indicator data and that states have the business analytic skills and expertise to collect and report data.** States must meet seven conditions required to qualify for enhanced eligibility system funding, including the ability to produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability. Systems should be able to produce electronically the accurate data that are necessary for oversight, administration, evaluation, integrity, and transparency, yet states struggle to report these data.
  - Centers for Medicare and Medicaid Services, "Medicaid IT Supplement (MITS-11-02-v1.0): Enhanced Funding Requirements: Seven Conditions and Standards," Department of Health and Human Services, April 2011, https://ccf.georgetown.edu/wp-content/uploads/2013/04/EFR-Seven-Conditions-and-Standards.pdf.

- **Provide technical assistance and systems support to states to maximize the use of reliable sources of eligibility data to advance real-time determinations.** CMS should create a technical advisory group (TAG) to determine best practices and assist states in increasing the share of applications processed in real time, as well as the share of renewals successfully completed via ex parte. Consider opportunities to incentivize states to improve their completion rate using data-driven determinations.

Question 3. In what ways can CMS **support states in addressing barriers to enrollment and retention of eligible individuals among different groups,** which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?

- **Ensure that states are reporting expenditures and activities for CHIP outreach as required.** States are required by statute and regulation to conduct outreach to families of children likely to be eligible for CHIP or other public or private health coverage and to assist them in enrolling their children. Only 11 states reported direct outreach expenditures in the 2019 CHIP financial management reports; it's unclear whether other states include outreach costs under administrative expenditures. CMS should require states to separately report outreach expenditures and ensure that states routinely update outreach activities in the state plan and CHIP annual reports.
- **Encourage states to adopt or expand certified application counselor (CAC) programs (42 C.F.R §435.908(c))**. In 2013, CMS finalized rules to set standards for states in certifying staff and volunteers of state-designated organizations to act as application assisters, and authorized to assist with applications and renewals. CMS should determine which states have CAC programs and gather information on best practices and outcomes. A special emphasis should be placed on identifying gaps in CAC geographic access as well as gaps in meeting the cultural, linguistic, and accessibility needs of targeted populations. CMS should provide guidance to states on ways they can use federal funding to support CAC programs.
- **Assess other ways states are supporting a community-based assistance network and promote best practices.** Some states, such as Massachusetts and New York, support a "hub and spoke" approach by working with one or a limited number of organizations to provide grants and support to a network of community-based assisters. These states collaborate with the network, providing training and updates and taking feedback from assisters on barriers to enrollment and renewals. Assisters are a valuable resource in trouble-shooting unforeseen glitches when states implement system changes among other things.
- **Encourage states to provide assister portals that include enhanced functions and features for assisters to assist applicants and enrollees.** Full-service portals like Kynect, Kentucky's combined Marketplace and Medicaid eligibility system, can empower assisters to better support applicants and enrollment with functions like providing alerts to assisters when one of their clients needs to take action. Portals also allow states to monitor the effectiveness of assisters.
- **Take a fresh look at outstationing strategies.** States are required to provide children and pregnant women with an opportunity to apply for Medicaid at non-government locations. Disproportionate Share Hospitals (DSH) and federally-qualified community health centers (FQHC) are specified in regulation but states may adopt "alternative" plans. Little data is available on outstation locations. It would be helpful to assess if outstation locations offer

reasonable access (i.e., travel distance or in-home assistance) and are able to meet the specific needs of the community (such as language assistance or accessibility supports).

- **Encourage states to adopt Express Lane Eligibility (ELE) which promotes continuity of coverage.** Similar to ex parte renewals, ELE promotes continuity of coverage when children's eligibility can be verified through ELE without the family completing a form or providing duplicative evidence of eligibility. As noted above, states should be encouraged to consider adoption of ELE to improve retention of eligible children.
- **Encourage the use of multi-benefits applications.** A joint application (preferably with dynamic questioning that tailors the application based on potential eligibility) simplifies the process for applicants and states. Generally, states that use multi-benefit applications have integrated Medicaid and non-health program eligibility systems. However, it is possible for states to offer a multi-benefit application that transfers the applicable information to separate eligibility systems. Multi-benefit applications also provide families with access to food assistance, child care, and other benefits, including supports for non-health drivers of health.
- **Conduct state-level surveys or expand the Medicaid CAHPS survey.** CMS should fund state-level surveys of people who recently applied or renewed coverage to better understand the barriers that individuals and families face. Such research should include a sufficient sample to produce state-level data stratified by demographics, including race, ethnicity, and primary language. The survey should oversample populations known to have more difficulty in maneuvering complex application or renewal processes. Alternatively, CMS could consider broadening the scope of the Consumer Assessment of Health Plan Performance (CAHPS) to help assess state performance on and consumer experience with enrollment and renewal processes.
- **CMS should provide formal guidance to states (1) explaining that pre-enrollment for emergency Medicaid is the preferred method of determining eligibility and enrolling individuals into the program (or at least that it is an option available to states); and (2) providing operational support to states to implement pre-enrollment, including specifically explaining the availability of an enhanced federal match (i.e., 90%) for IT chances necessary to make this work.** Many states require emergency Medicaid-eligible individuals to apply for emergency Medicaid to reimburse their provider after receiving emergency care. After qualifying for reimbursement through emergency Medicaid, such individuals are not necessarily enrolled in the program—they are required to apply for reimbursement through the program after each subsequent emergency. Providing clarity to states on pre-enrollment for their emergency Medicaid programs will not only help them reduce administrative burdens for their agencies and providers, it will also assist states in designing programs that expand healthcare coverage to state residents who do not qualify for Medicaid or Exchange coverage due to their immigration status. If residents ineligible for Medicaid or Exchange coverage are pre-enrolled in emergency Medicaid, states could more easily connect and transition them to new coverage programs and could better identify enrollees in their new programs as individuals whose emergency services should receive federal funding through emergency Medicaid.

Question 4. What **key indicators of enrollment in coverage** should CMS consider monitoring? For example, how can CMS use indicators to monitor eligibility determination denial rates and the reasons for denial? Which indicators are more or less readily available based on existing data and systems? Which indicators would you prioritize?

- **Update PERM requirements to classify inaccurate denials as an eligibility error.** Erroneously denying eligibility to an individual at application should be considered an eligibility error, just as enrolling an individual who is not eligible for coverage is.

- **Report all performance indicator data on a monthly and timely basis.** Data on the complete set of performance indicators has not been published, although states have been required to report such data as a condition of receiving enhanced federal funding for Medicaid systems development and operation since 2014. All data should be publicly reported on a routine and timely basis. We would suggest states submit within thirty days of the end of the month and CMS report publicly within 30 days of receiving the data. Disaggregation based on race/ethnicity is critical to addressing health disparities.
- **Complete the second phase of performance indicators.** A review of the indicators, including input from a cross-sector of external stakeholders, would be useful. Additional stratification of current indicators and inclusion of new performance indicators that address gaps in the data would be useful for pinpointing where and why there are problems. New indicators should include renewal timeliness standards, ex parte completion rates, and rates of disenrollment at renewal. In addition, determinations should be broken down by type (application, change, renewal), then by ineligibility versus procedural reasons.There should be breakouts for race/ethnicity for as many indicators as feasible based on the size of the dataset and ability to report reliable data.
- **Develop standardized reason codes for procedural denials.** To enhance the performance indicators, CMS should develop a set of standardized reason codes that will help assess actions that can be taken to avoid procedural denials. Mathematica, the National Academy of State Health Policy, and state participants in the Robert Wood Johnson Foundation-funded Maximizing Enrollment program developed a set of such standardized reason codes that could inform this effort. It is important to prioritize reasons that are actionable, such as taking steps to update contact information when mail is returned.
    - Mary Harrington et al., "New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance," Mathematica Policy Research, Inc. and National Academy for State Health Policy, October 2012, http://www.maxenroll.org/files/maxenroll/resources/new.denial.disenrollment.coding.strategies.pdf.

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage. CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income SSI/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).

Question 1. How should states monitor **eligibility redeterminations**, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?

- **Develop standardized reason codes for procedural disenrollments.** To enhance the performance indicators, CMS should develop a set of standardized reason codes that will help assess actions that can be taken to avoid procedural denials and disenrollments. Mathematica, the National Academy of State Health Policy, and state participants in the Robert Wood Johnson Foundation-funded Maximizing Enrollment program developed a set of such standardized reason codes that could inform this effort. It is important to prioritize reasons that are actionable—such as taking steps to update contact information when mail is returned.
    - Mary Harrington et al., "New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance," Mathematica Policy Research, Inc. and National Academy for State Health Policy, October 2012, http://www.maxenroll.org/files/maxenroll/resources/new.denial.disenrollment.coding.strategies.pdf.
- **Require states to report call center statistics during, and continuing after, the unwinding of the PHE-related continuous coverage protection.** During the initial year of enrollment under the ACA, some states did not adequately expand call center capacity, which contributed to long wait times and dropped calls. Unreasonable call wait times and high abandonment rates should be a trigger for assessing if a state's process and timeline need to be reviewed for potential mitigation strategies or corrective action plans.
- **Update PERM requirements to classify inaccurate disenrollments following a renewal or change in circumstance as an eligibility error.** Erroneously denying eligibility to an individual at renewal or when there is a change in circumstances should be considered an eligibility error, just as keeping an individual who is not eligible for coverage enrolled is.

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

- **Examine ways to promote or require follow-up between initial and closure notices when action is required to retain coverage.** States are not required to do more than send a renewal notice, followed by a termination notice if there is no response in 30 days. Reminders via different modes of communication can improve renewal response rates and decrease disenrollment for procedural reasons.
- **Ensure that states have implemented electronic notices as required (42 C.F.R. §435.918).** Electronic notices are cost-efficient and timely, and can provide key tracking data such as the open rate or alert the agency that the email address is no longer in use. States must allow enrollees to choose to receive notices electronically or by mail, but this option is not available in some states.
- **Clarify whether guidance on engaging managed care organizations (MCOs) during the PHE unwinding applies on an ongoing basis.** CMS has identified a number of roles that MCOs can play during the unwinding of the continuous coverage protection. CMS should clarify what MCO engagement strategies apply on an ongoing basis and encourage states to maintain the temporary processes they may have put in place.
- **Encourage states to use text messaging and telephone calls to share important information and remind enrollees if action is required to retain coverage.** Text messaging and automated calls can be low-cost and relatively straightforward to implement. Using these

modes can help improve the response rate when action is needed due to a change in circumstance or at renewal.

- **Encourage states to apply the 90-day reconsideration period following a loss of coverage due to income.** When individuals are disenrolled for procedural reasons, states must provide a period of 90 days for individuals to submit needed information and have their eligibility reviewed without completing a new application. This policy would also be helpful to individuals who lose coverage due to temporary changes. It would also reduce the state's administrative burden and cost in processing new applications associated with churn.
- **Assess opportunities to engage healthcare providers in assisting with outreach and retention.** CMS should consider granting the same flexibility for states to engage providers as it has for MCOs. Healthcare providers consistently update patient contact information and they are often first in line to inform an enrollee that they have lost coverage.

Question 3. What actions could CMS take to promote continuity of coverage for **beneficiaries transitioning** between Medicaid, CHIP, and other insurance affordability programs; between different types of Medicaid and CHIP services/benefits packages; or to a dual Medicaid-Medicare eligibility status? For example, how can CMS promote coverage continuity for beneficiaries moving between eligibility groups (e.g., a child receiving Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualified supports who transitions to other Medicaid services such as home and community based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the Marketplace); or across state boundaries? Which of these actions would you prioritize first?

- **Provide guidance to states on transitioning a state's separate CHIP program to a CHIP-funded Medicaid expansion.** There has been a steady stream over the past ten years of states switching from separate CHIP to M-CHIP programs. M-CHIP programs may be more administratively efficient to operate, while also providing EPSDT services and Medicaid's stronger child protections like prohibitions on premiums below 150% FPL. There can be glitches in transitioning children from Medicaid to separate CHIP programs, which is not an issue in states with M-CHIP programs. Guidance should include flexibilities states have to cover all children in Medicaid, while still allowing states to offer expanded pregnancy coverage through CHIP.
- **Provide technical assistance to states on policy options to smooth income fluctuations.** States may consider predictable changes in income, such as seasonal work, in determining eligibility. States may also project annual income through the end of the calendar year when processing a change in income. More technical assistance would help states apply and maximize the impact of these policies, and determine ways to program systems to flag situations that require manual review.
- **Ensure that periodic data checks are not resulting in enrollees losing coverage in error.** If states choose to conduct periodic data checks, they should be required to report procedural disenrollments resulting from those checks. CMS should also use its program integrity efforts to ensure that states are only acting on information that impacts eligibility.
- **Approve Section 1115 waiver proposals from states to cover young children for multiple years of continuous eligibility.** The evidence is clear that a healthy start in life sets children on a path to success in school and beyond. Multi-year continuous eligibility will promote continuity of coverage by eliminating gaps in enrollment due to temporary changes or renewal difficulties. The policy can support longer connections to medical homes which can improve health outcomes through higher rates of well-child visits and immunizations and use of other

preventive and routine care. Gaps in coverage are more likely to affect children of color. Even temporary gaps can result in substantial medical debt for families.

- **Support the development and stewardship of a continuity in coverage measure for future addition to the Child Core Set of healthcare quality measures.** Many healthcare quality measures require continuous periods of enrollment, and yet there is no measure for determining continuity in coverage. Healthcare quality measurement rates are incomplete when enrollees who experience churn are not included in the measurement.

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

- **Provide technical assistance and systems support to states to maximize the use of reliable sources of eligibility data to advance the share of renewals conducted on an administrative or *ex parte* basis.** CMS should create a technical advisory group (TAG) to determine best practices and assist states in increasing the share of renewals successfully completed via *ex parte*, as well as the share of applications processed in real time. Consider opportunities to incentivize states to improve their completion rate using data-driven determinations.
- **Conduct ongoing churn analysis using T-MSIS data.** T-MSIS data should be used to measure churn within various eligibility groups similar to the recent analysis conducted by MACPAC and Mathematica. CMS should examine churn patterns based on demographics, including race/ethnicity where feasible, and the amount of time the length of gaps in coverage (i.e., 30, 60, 90-days). Results should be publicly reported on an annual basis.
    - Medicaid and CHIP Payment and Access Commission, "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP," October 2021, https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

Objective 3: Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary's needs as a whole person. CMS is seeking feedback on how to establish minimum standards or federal "floors" for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or "floors" would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices.

Question 1. What would be the most important areas to focus on if CMS **develops minimum standards** for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?

- **Reaffirm that the minimum standard for access to services by children enrolled in Medicaid is compliance with the mandatory EPSDT benefit by all states and, in managed care states, by all MCOs**. In particular, the screening requirements of the EPSDT benefit are central to the access of children to preventive care and needed treatment services. Taking the following actions will focus state Medicaid programs and MCOs on these requirements, over time improving compliance and reducing health disparities:
    - ⇒ In 2022, CMS should not allow Oregon to condition access to "below the line" items or services on a case-by-case review or otherwise link the EPSDT benefit to the state's Prioritized List of Conditions and Treatments.
    - ⇒ In 2023, CMS should, through notice and comment rulemaking, clarify that waiving or otherwise modifying the EPSDT benefit is not likely to promote the objectives of the Medicaid program and is therefore an unlawful use of the Secretary's section 1115 demonstration authority.
    - ⇒ In 2024, CMS should begin posting on the State Health System Performance page of its Medicaid & CHIP Scorecard a comparison of the performance of each state in providing EPSDT screening services against a national *benchmark* derived from the American Academy of Pediatrics' *Bright Futures*. States would not be required to meet the national benchmark—the Medicaid statute holds them only to the periodicity schedules they adopt in consultation with relevant professional organizations in their state. Instead, their actual performance would be compared to the national benchmark in order *to make transparent the extent to which access to screening services differs* from the benchmark in each state, including those states that have adopted *Bright Futures* periodicity schedules.
- **Revise current regulations to specify minimum MCO network adequacy standards that are at least as protective of beneficiary access as those that CMS specifies for Qualified Health Plans in the Marketplace.** For beneficiaries who are mandatorily enrolled in an MCO, access to care depends largely on whether the numbers and types of providers in the MCO's network are sufficient to meet the needs of enrollees and whether those providers are geographically accessible to enrollees. CMS regulations at 42 C.F.R. §438.68(b) require states to develop a "quantitative network adequacy standard" for each of seven different provider types but they do not specify what those standards should, at a minimum, be (even though the CMS access regulations at 42 C.F.R. §447.203 exempt states from reporting on access for MCO enrollees on the assumption that the managed care regulations impose network adequacy requirements). As a result, there is wide variation in standards from state to state. To ensure a basic level of access for all MCO enrollees, regardless of the state in which they reside, CMS should develop MCO network adequacy standards for each of the seven provider types, starting with primary care (adult and pediatric), OB/GYN, behavioral health, and specialists (adult and pediatric). The standards should be at least as protective of beneficiary access as the standards that CMS adopts for Qualified Health Plans in the Marketplaces in the final Notice of Benefit and Payment Parameters for 2023, and they should be adjusted for geographic areas that HRSA designates as Health Professional Shortage Areas. The behavioral health standards should take particular account of the needs of pregnant and postpartum women and other high-risk populations. CMS should revise its current regulations to require that states contracting with MCOs apply and enforce compliance with standards that are at least as protective of beneficiary access as the standards that CMS specifies.
- **Develop minimum standards for access to prescription drugs for all Medicaid and CHIP beneficiaries.** This will require collecting data not currently available from other sources to understand drug access issues. For example, in the area of Medicaid prior

authorization, CMS should ask states for: (1) the percentage of prior authorization requests that were denied; (2) the percentage of prior authorization requests for which there was no response within the required 24 hours; (3) the percentage of emergency situation prescriptions that were not dispensed within 72 hours while a prior authorization request is being resolved; (4) the percentage of prior authorization denials that were appealed; and (5) the procedures/paperwork that are required to obtain prior authorization. Other prescription drug data that would help to assess access include: (1) the process for setting preferred drug lists; (2) the process for setting clinical criteria used for coverage of non-preferred drugs requiring prior authorization; (3) the adequacy of pharmacy networks, including the availability of 24-hour pharmacies and pharmacies with translation services and cultural competencies; and (4) the impact of monthly prescription drug limits.

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

- **Revise Form CMS-416 to better monitor the performance of states (and, in managed care states, MCOs) in meeting EPSDT screening requirements and post the revised metrics on a state- and MCO-specific basis.** The screening requirements of the EPSDT benefit are central to the access of children to preventive care and needed treatment services. The current version of the CMS-416 does not disaggregate screening data by type of screen (other than blood lead) or by race or ethnicity, making it impossible for CMS and the public to know whether there are racial disparities in access to screening services and if so, which ones. The following actions will help focus state Medicaid agencies and MCOs on reducing whatever disparities in access to screening services exist:
    - ⇒ In 2022, CMS should revise Form CMS-416 to require states to report screening ratios (expected number of screenings/total screens received) for the required comprehensive health and developmental screen for each of the seven currently reported age cohorts disaggregated by race and ethnicity.
    - ⇒ CMS should require that states collect information required by the revised CMS- 416 beginning in 2023.
    - ⇒ Also in 2023, CMS should expand the types of screenings for which states must report separate screening ratios for the seven age cohorts disaggregated by race and ethnicity to include vision, hearing, and dental. The collection of this separate screening data should begin in 2024, for inclusion in the CMS-461 submitted in 2025.
    - ⇒ In 2024, CMS should require that states begin using the revised CMS-416 to report their results for 2023. Until 2024, states should continue to report annually using the current version of the CMS-416.
    - ⇒ For a recommendation on MCO-specific EPSDT performance metrics, see the recommendation relating to the establishment of an MCO-specific child health dashboard in response to Objective 4, Question 1.
    - **Monitor and enforce state Medicaid agency compliance with current network adequacy requirements in 42 C.F.R. §438**. If the provider network of an MCO is not adequate, enrollees will not have access to the services they need and for which the

MCO is being paid. Regulatory responsibility for ensuring the adequacy of MCO provider networks rests with the state Medicaid agencies that contract with those MCOs. CMS should require state agencies to post documentation of the basis on which the state—not just the MCO—certifies the network adequacy for each MCO with which it contracts. CMS should also develop a measure of state Medicaid agency compliance with network adequacy requirements and post state-specific ratings in the State Administrative Performance pillar of the Medicaid & CHIP Scorecard. In addition, CMS should develop a methodology for analyzing the T-MSIS database of enrollee encounters with network providers to identify access problems in individual MCOs and periodically deploy this methodology to analyze data on a sample basis. If a problem is flagged, CMS should notify the state Medicaid agency of the need for corrective action.

Question 3. How could CMS consider the **concepts of whole person care[5] or care coordination** across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?

[5] Under a "whole-person" philosophy, individuals with chronic physical and/or behavioral health conditions are provided linkages to long-term community care services and supports, social services, and family services, as needed. State Medicaid Director Letter #10-024. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd10024.pdf

- **Use the full extent of CMS regulatory authority to ensure fee-for-service Medicaid beneficiaries receive the same Mental Health Parity and Addiction Equity Act parity protections as those in managed care.** Under current law and regulations, certain Medicaid beneficiaries receiving care through fee-for-service are not able to benefit from such protections. CMS should review its current regulations and authority to expand parity protections to all Medicaid beneficiaries to the fullest extent possible.
- **Take concrete steps to enhance parity compliance**. For example, in addition to requiring review and documentation of discrete barriers that may limit access to care such as prior authorization, step therapy, and day limits, CMS should also require states and MCOs to facilitate and document access to behavioral health services, especially those for which there have been historic or ongoing access barriers. Such data and documentation should be reported to CMS and made available to the public on a timely basis, including at the plan level.
- **Use the full scope of CMS authority to close gaps in state coverage of and access to behavioral health services.** As reiterated by CMS in SHO #21-008, the mandatory EPSDT benefit for children under 21 requires states to cover all 1905(a) benefits to treat or ameliorate health conditions, including mental health and substance use disorder conditions. Specifically, CMS should clarify the availability of mental health services for infants and toddlers under EPSDT.
    - Center for Medicaid and CHIP Services, "SHO #21-008: Medicaid Guidance on the Scope of Payments for Qualifying Community-Based mobile Crisis Intervention Services," Centers for Medicare and Medicaid Services, December 28, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.
- **Ensure access to maternal depression screening and treatment during the postpartum period by encouraging network adequacy standards that are specific to mental health**

providers who can support postpartum people. Mental health conditions are the underlying cause of nearly one in nine pregnancy-related deaths, and mental health disorders are the most common pregnancy complication. A growing body of research links maternal depression and anxiety with adverse child development that can extend into adolescence, including social-emotional, cognitive, motor, and other developmental outcomes. CMS can clarify in guidance that the requirement to develop quantitative network adequacy standards for behavioral health (mental health and substance use disorder) adult and pediatric" (42 C.F.R. §438.68(b)) applies to maternal mental health providers. CMS should highlight ways that Medicaid financing can support innovative, preventive maternal mental health care models, such as the "Mothers and Babies Program" or the "Reach Out, Stand Strong, Essentials for New Mothers (ROSE)" program.

- **Issue guidance jointly with HRSA on best practices to support improved access to substance use disorder treatment, including treatment provided via telehealth**. CMS has taken an important step in the creation of the Maternal Opioid Misuse Model grants to gather best practices and pilot new approaches to payment, but in the interim, joint guidance from CMS and HRSA could be effective in encouraging states to maximize access to substance use disorder treatment for pregnant and postpartum people, including preserving telehealth flexibilities put in place during the COVID-19 pandemic.
- **Issue updated guidance on Medicaid and school-based health services to encourage states to expand access to services, including behavioral health care.** The guidance should address opportunities under the 2014 reversal of the "free care" rule; streamlining administrative claiming, provider billing, and parental consent for billing; aligning licensure and provider requirements; coordination with and coverage under managed care; best practices for service delivery including the use of telehealth as a delivery mechanism; and blending Medicaid and other funding streams and programs including Elementary and Secondary School Emergency Relief (ESSER) funds and the Individuals with Disabilities Education Act (IDEA).
- **Issue informational bulletins or state learning opportunities on new ways to leverage federal programs for children engaged in multiple systems and at high risk for trauma or developmental delays, such as child welfare, special education and/or mental health.** IDEA Part C, the Department of Education's special education program for children under age three, offers one example. While a relatively small population may qualify for early intervention services, the overlapping federal requirements under Medicaid and IDEA Part C offer a specific focus population to illustrate opportunities and uncover challenges in ensuring the youngest children access needed care to prevent more costly delays before school entry. And while many low-income children served by Part C early intervention are also likely eligible for and/or enrolled in Medicaid, there is no uniform or consistent effort to track cross-enrollment, services utilization, or outcomes for children in both programs. This makes it difficult to fully understand the effectiveness of either program in reaching young children before preventable delays become more complex and costly to address.

Objective 4: CMS has data available to measure, monitor, and support improvement efforts related to access to services (i.e., potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations). CMS is interested in feedback about what new data sources, existing data sources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

Question 1. What should CMS consider when developing an **access monitoring approach that is as similar as possible across** Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care programs) and programs (e.g., HCBS programs and dual eligibility in Medicaid and

Medicare) and across services/benefits? Would including additional levels of data reporting and analyses (e.g., by delivery system or by managed care plan, etc.) make access monitoring more effective? What type of information from CMS would be useful in helping states identify and prioritize resources to address access issues for their beneficiaries? What are the most significant gaps where CMS can provide technical or other types of assistance to support states in standardized monitoring and reporting across delivery systems in areas related to access?

- **Create and maintain a Child Health Dashboard on Medicaid.gov that displays performance information for each MCO.** In 40 states and the District of Columbia, access to Medicaid-covered services for children is determined by the MCO in which they are enrolled. In many states, information about the performance of individual MCOs for children is not publicly available, so it is not possible to know whether children are able to access needed services or whether health disparities are being addressed. CMS can provide the necessary transparency by maintaining a child health dashboard using data already reported to it by state Medicaid agencies. Specifically:
    - ⇒ In 2022, CMS should stand up the first iteration of a child health dashboard that includes, for each MCO operating in 2021, the following data elements: (1) total number of children enrolled broken down by CMS-416 reporting age cohort; (2) total amount of capitation payments made to the MCO for the total number of enrolled children; (3) EPSDT screening ratio for each CMS-416 reporting age cohort; (4) Child Core Set metrics reported by the MCO.
    - ⇒ Also in 2022, CMS should issue subregulatory guidance clarifying that the federal False Claims Act applies to MCO reporting of encounter and other EPSDT-related data to the state Medicaid agency for purposes of the CMS-416 report.
    - ⇒ In 2023, CMS should update the child health dashboard for each MCO operating in 2022 and add a data element to capture the EPSDT participation ratio for each CMS-416 reporting age cohort.
    - ⇒ In 2024, CMS should continue to update the dashboard to include 2023 operating results and include EPSDT screening data disaggregated by race and ethnicity (see Recommended Action re EPSDT Screenings for Objective 3, Question 1) and, if available, T-MSIS encounter data (see Recommended Action re T-MSIS, below).

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

- **Continue providing technical assistance to states to improve and standardize data collection and include race/ethnicity breakdowns.** The most important way in which CMS can better leverage T-MSIS data to monitor access and related inequities is by working to improve data quality and making data publicly available. These data are already well poised to monitor enrollees' access to care, but vital components like race and ethnicity are incomplete in many states. CMS should highlight best practices from states where race/ethnicity data collection is advanced. It is not possible for CMS to get a data-informed assessment of inequities and disparities without complete and reliable data.
- **Make T-MSIS data publicly available on Medicaid.gov through a dashboard and data library to allow researchers and other stakeholders to assist in monitoring beneficiaries'**

access to care. Currently, T-MSIS is actually less transparent than the prior system; while the Medicaid and Statistical Information System (MSIS) was released publicly, access to T-MSIS is prohibitively costly. CMS recently published several T-MSIS data products, but they were difficult to interpret without an understanding of the underlying data. Compiling these data into a dashboard similar to the DQ Atlas with an option to download the underlying datasets would provide more visibility, accessibility, and transparency to monitor access to care. For example:

⇒ CMS could publish state-level enrollment and eligibility data by program (Medicaid, M-CHIP, and CHIP), age group, eligibility group, delivery system (i.e.: managed care vs. fee- for-service), and individual managed care organization.

⇒ To help encourage adoption of continuous eligibility (as discussed in Objective Two), CMS could also publish average length of enrollment, share of beneficiaries re-enrolled within three months, share of beneficiaries re-enrolled within six months, and share of beneficiaries re-enrolled within a year.

⇒ To help understand provider participation, CMS could also publish studies using T-MSIS on the share of providers participating in Medicaid and the distribution of patients among providers.