CMS' Medicaid and Children's Health Insurance Program (CHIP) RIF Questions

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The Centers for Medicare & Medicaid Services (CMS) released an RFI seeking feedback on topics related to health care access, such as enrolling in and maintaining coverage, accessing health care services and supports, and ensuring adequate provider payment rates to encourage provider availability and quality. Feedback obtained from the RFI will aid in CMS' understanding of barriers to enrolling in and maintaining coverage and accessing needed health care services. The RFI submissions will also inform CMS' work to ensure timely access to critical services, such as behavioral health care and home and community-based services.

Below is a list of the objectives and questions included in this RFI.

Objective 1: Identify strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage.

1. How can CMS support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI-based eligibility determinations?
2. What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes? Which is most important, and how can CMS help states improve these capabilities?
3. How can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups? Which would you prioritize first?
4. What key indicators of enrollment in coverage should CMS consider monitoring? Which indicators are more or less readily available based on existing data and systems, and which indicators would you prioritize?

Objective 2: Offer input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs.

1. How should states monitor eligibility redeterminations, and what is needed to improve the process?
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? 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?
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? Which of these actions would you prioritize first?
4. What are the specific ways that CMS can support states that need to enhance their eligibility and enrollment system capabilities? What barriers to eligibility and enrollment system performance can CMS help states address?

Objective 3: Feedback on how to establish minimum standards for equitable and timely access to providers and services.

1. What are the most important areas CMS should focus on to develop minimum standards for Medicaid and CHIP programs related to access to services? How should the standards vary by delivery system, value-based payment arrangements, geography, program eligibility, and provider types or specialties?
2. How could CMS monitor states' performance against those minimum standards? 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? Which would you prioritize as most important?
3. How could CMS consider the concepts of whole person care 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? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders?
4. How should CMS address cultural competency and language preferences in establishing minimum access standards? What activities have states and other stakeholders found the most meaningful in identifying gaps that might impact access to care?
5. How can CMS support states to increase and diversify the pool of available providers for Medicaid and CHIP? Which are most important?

Objective 4: New data sources, existing data sources, and additional analyses that can be used to monitor and encourage equitable access within Medicaid and CHIP programs.

1. What should CMS consider when developing an access monitoring approach that is as similar as possible across Medicaid and CHIP delivery systems and programs and across services/benefits? Would including additional levels of data reporting and analyses make access monitoring more effective? 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?
2. What measures of potential access, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor? How could CMS use data to monitor the robustness of provider networks across delivery systems?
3. How can CMS promote a more standardized effort to monitor access in long-term services and supports (LTSS), including HCBS, programs? Which activities would you prioritize first?
4. How should CMS consider requiring states to report standardized data on Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes that address enrollment in coverage and access to services? How could these data be used to meaningfully monitor access?
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?

Objective 5: Enlist and retain enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs.

1. What opportunities are available for CMS to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?
2. How can CMS assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?
3. What data sources, methods, or benchmarks might CMS consider to assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?
4. How can CMS encourage states to reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?

Covered California Comment: Objective 2, 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? Which of these actions would you prioritize first?

In an ongoing effort to make it easier for Californians to keep coverage, avoid gaps, and continue to receive critical financial assistance, Covered California is implementing two key programs aimed at assisting individuals transitioning between Medi-Cal (California's Medicaid program) and individual market coverage through Covered California. Specifically, Covered California's autoenrollment initiative aims to facilitate continued coverage for those who become ineligible for Medi-Cal. Additionally, the Carry Forward Status program, done in partnership with the Department of Health Care Services (the agency responsible for administering Medi-Cal), ensures individuals transitioning from individual market coverage through Covered California to Medi-Cal will not have a lapse in coverage. Covered California is prioritizing both programs and encourages CMS to work with states to eliminate barriers that may exist in implementing these types of programs.

Under the autoenrollment program, established through state legislation, beginning in June 2022, Covered California will automatically enroll individuals losing their Medi-Cal eligibility into the lowest-cost silver health plan available to them through Covered California while granting them maximum advanced premium tax credits (APTC) and cost-sharing support (CSR). Individuals being automatically enrolled will need to take an affirmative step to effectuate their coverage to ensure they are willing to accept liability for APTC. If an individual fails to effectuate their coverage through Covered California, their plan will be canceled; however, consumers will still have their 60-day loss of coverage special enrollment period option to select a plan on their own.

Once consumers have effectuated their coverage, Covered California will send notices to auto-enrolled consumers to explain their plan enrollment and financial assistance amounts, create a dedicated website landing page to efficiently direct consumers to their account information, and set up specialized phone support, including an interactive voice response menu with automated opt-in and opt-out options. This ensures that individuals losing Medi-Cal will not experience a gap in coverage if they effectuate their coverage through Covered California within a month of their disenrollment from Medi-Cal.

Covered California utilized consumer research to inform the implementation of the autoenrollment program. Through consumer research, Covered California made informed policy decisions with the goal of increasing consumer understanding and awareness. Specifically, Covered California designed communication material to help consumers understand that their autoenrollment into a silver plan is just the starting point and that they have options, such as opting-out or canceling their enrollment. Covered California also understands the trust consumers have in Medi-Cal and that co-branded material with Medi-Cal and Covered California logos will help consumers understand the relationship between the two programs. Through consumer research, it is clear that many consumers who will be automatically enrolled in coverage through Covered California will be new to private health insurance, which is why Covered California created a new Eligibility Determination Notice for the transition population to ensure that consumers have the information they need to understand their options and next steps. Covered California is also designing educational consumer information including an education flyer that will be sent to consumer with their Eligibility Determination Notice that will provide

them with information about Covered California, financial help available, health insurance terminology, and an overview of plan out-of-network costs.

Similarly, the Carry Forward Status program places individuals who become potentially eligible for Medi-Cal in a special status while the responsible county completes its review of the individual's eligibility determination. During this review process, the individuals placed in Carry Forward Status will continue both their enrollment and eligibility for APTC and CSR, reducing the potential for a coverage gap and financial consequences. When an individual is placed in this status, they receive a notice from Covered California informing them that they may continue to pay their monthly premium to avoid a gap in coverage, and their coverage through Covered California will continue until their local county office completes its Medi-Cal eligibility determination and that they should respond to all requests for additional information to assist in this process.