NAMD 2021 Regulatory Priorities

This document presents 11 broad issue areas that the NAMD Board of Directors has identified for focused engagement with CMS. Within each issue area are discrete sets of sub-issues and a recommended course of action.

Medicaid Directors stand ready to partner with CMS to provide additional information and hope these documents, and ongoing state-federal conversation around these issues, will foster a strong federal/state partnership to further enhance the Medicaid program going forward.

Priority Areas

Advancing Equity in Medicaid

Equity is foundational to all of the issues outlined in this document. Whether we are discussing telehealth policies and addressing the digital divide or improving our data collection and analytics to identify solutions to populations experiencing disparate outcomes, the lens of improving equity and addressing longstanding inequities within the program should be brought to bear. NAMD is encouraged by the similar commitment to equity at the federal level. Equity work should include a focus on racial and ethnic minorities, rural populations, Tribal populations, and any other groups experiencing disparate health outcomes, with an understanding that inequities are multidimensional and often fall across multiple population characteristics or categories.

We also see discrete areas where focus would be beneficial, bearing in mind that the work to advance equity in Medicaid is holistic and branches across all issue domains.

Equity Issue	NAMD Recommendation
1. **Targeted Data Collection to Support Equity Initiatives:** NAMD recognizes that consistent collection of racial and ethnic data, primary language data, and other relevant information to provide an understanding of inequities in health care is not uniform or consistent. However, we also recognize that creating new reporting requirements for states imposes administrative burden and costs, which must be justified by the planned use of such data.	Work with states to consider a voluntary set of measures to support equity initiatives, such as race and ethnicity, primary language, rural/urban status, housing status, and other salient factors. Guidance and technical assistance for states interested in measuring these factors would also be helpful. States should have the explicit authority to collect any data they consider necessary for their equity initiatives.
2. **Supporting Equitable Access to Telehealth Opportunities:** Medicaid programs rapidly expanded telehealth modalities during the COVID-19 pandemic. NAMD anticipates many states will maintain some level of expanded telehealth post-pandemic. However, disparate access to Internet services and devices across	Explore flexibilities in existing Medicaid authorities to support states in increasing Medicaid member access to broadband Internet, technology, and counseling in the use of this technology to utilize telehealth services. Assist states in identifying and making use of other federal opportunities to increase member access to telehealth.

Medicaid populations inhibits the ability for all Medicaid members to receive the full benefits of telehealth.	
3. **Enhancing State Options for Use of Emergency Medicaid:** Emergency Medicaid is a tool states may use to provide coverage and services for populations not otherwise eligible for coverage. As we have seen during the pandemic, these populations are particularly vulnerable to COVID-19 complications and often do not have access to testing or treatment.	Provide more flexible interpretations of emergency Medicaid coverage to support states interested in providing more robust coverage to emergency Medicaid-eligible populations.

Addressing Social Determinants of Health

SDOH Issue	NAMD Recommendation
1. **Improve Data Sharing Mechanisms:** More streamlined and effective cross-sector data exchange is the foundation for targeting SDOH in a sustained way. Just as states work to foster inter-agency data exchange to support targeting housing insecurity, food insecurity, etc., so should CMS and federal partners work towards this goal. The Office of the National Coordinator (ONC) could play a specific role in this process.	Convene a cross-agency federal working group with state participation to explore streamlining cross-sector data exchange. ONC should play a role in ensuring that SDOH electronic referral platforms being developed maintain interoperability.
2. **Facilitate Braided Funding Approaches:** Medicaid is limited by statute in how it may directly support certain SDOH interventions. Leveraging other federal funding sources which may flow through different programs, grants, and to non-Medicaid state entities is often necessary to address SDOH holistically. However, navigating these various funding streams and creating a sustainable funding mechanism is challenging.	Develop guidance and technical assistance opportunities on leveraging braided funding sources to address common SDOH targets.
3. **Provide Additional Sub-Regulatory Flexibility to Target SDOH:** States appreciate CMS's existing guidance on Medicaid authorities that can target SDOH in certain ways and for certain members. As	Maintain dialogue with states on the utility of existing guidance and refine guidance based on state feedback. This refinement should be undertaken with the aim of providing additional opportunities for states to creatively

states continue to review this guidance, we encourage CMS to continue to refine its tools for states to support their initiatives. This should be undertaken with an eye towards maximum flexibility for states.	address social risk factors and provide services addressing those risk factors. A specific area of focus should be on broader interpretations of in lieu of services provided in managed care, which could provide additional non-demonstration flexibilities.

Long-Term Services and Supports (LTSS)

LTSS Issue	NAMD Recommendation
1. **Explore Approaches to Rebuild HCBS Workforce Post-COVID:** The COVID-19 pandemic's effects have been particularly acute among the home- and community-based services (HCBS) recipients and their caregivers. Throughout the early stages of the pandemic, HCBS providers were not consistently prioritized for PPE acquisition, essential worker designation, or receipt of Provider Relief Fund dollars. These factors have resulted in many states seeing a marked decline in HCBS workforce and overall HCBS system capacity, with serious ramifications for ongoing work to rebalance the provision of LTSS towards the community. HCBS workforce capacity was already a challenge, with aging populations of both members and caregivers straining state infrastructure pre-COVID.	Consider additional flexibility on funding, licensure requirements, and other pathways to support state efforts to expand HCBS infrastructure and capacity. CMS should continue working with states and stakeholders to ensure maximum flexibility of current federal HCBS enhancements under the American Rescue Plan and any future investments Congress may make.
2. **Support States in Right-Sizing Institutional Services Post-COVID:** The impact of COVID was acute for institutional settings like nursing homes and assisted living facilities. In many states, occupancy rates have not reverted to pre-COVID levels. While recognizing the need for some level of institutional capacity going	Work with states to explore new or alternate financing arrangements that support state strategic goals for the role of institutional care within their LTSS continuums, such as reserving institutional settings for the highest acuity members, ensuring more funding goes to providing care and paying frontline staff within facilities, providing incentives for person-centered care and keeping individuals in their homes, and fostering transitions into

forward, states have identified a need to improve outcomes and quality of life for those living in institutional settings.	the community. Bring Medicare partners to the table for cross-agency and cross-sector dialogue on duals integration and alignment, with a specific focus on addressing Medicare policies that incentivize institutionalization over community-based options.
3. Maintain Flexibility on HCBS Settings Rule Implementation Timeline: The 2014 HCBS rule created a federal definition for an HCBS setting and requires states to transition settings that do not meet this definition into compliance, or to prepare to no longer receive federal match for services provided in non-compliant settings. In recognition of the significance of this task, CMS provided a five-year transition period, which has since been extended twice. The current deadline for settings transitions is March 2023. States remain committed to the objectives of the rule and its promotion of robust community-based care. However, states remain challenged by the impact of the COVID-19 pandemic on HCBS infrastructure, workforce, and disruption to site visits and other transition activities necessary to comply with the rule.	Maintain current timelines for settings rule compliance, with consideration of additional extensions if states demonstrate ongoing difficulties with developing adequate HCBS capacity in the post-pandemic period.

Medicaid Financing

Financing Issue	NAMD Recommendation
1. 1115 Budget Neutrality and Rebasing: CMS has over the past two Administrations revised its approach to accumulated savings across 1115 demonstration waiver renewal cycles. While not opposed to reasonable approaches to rebasing these waivers, NAMD continues to be concerned that the current policy will pose unduly large challenges for states and threaten the viability of comprehensive 1115s in the future. This is particularly difficult given the likely utility of the 1115 waiver as a vehicle to advance	Partner with states to consider ongoing state concerns with the 1115 rebasing policy and how CMS goals can be met in this area while continuing to preserve the overall viability of the 1115 vehicle.

innovative initiatives targeting social determinants, payment reforms, and equity initiatives.	
2. **Supplemental Payment Reporting:** As part of its budget actions to fund the federal government for FY 2021, Congress included requirements for states to report on aspects of their supplemental payment programs starting October 1, 2021.	Engage early with states in the planning process for the reporting mechanisms required by Congress, working to ensure statutory requirements are met in the least burdensome manner possible.
3. **Enhanced Shared Savings Options for Medicaid Programs Serving Dual Eligibles:** An ongoing challenge for state investment in integrated care models for dually eligible Medicare-Medicaid members is that investments in Medicaid services often generate savings for the Medicare program, rather than for Medicaid. Currently only the Financial Alignment Initiative (FAI) demonstrations offer a mechanism for sharing these accrued savings with the states. An inability to share savings through other integration approaches creates a fiscal disincentive for states to invest in the long-term work necessary to promote duals integration.	Partner with states to explore shared savings mechanisms that can be applied outside of FAI demonstrations, with a focus on integrated Medicaid and Duals Special Needs Plan (D-SNP) models and Programs of All-Inclusive Care for the Elderly (PACE). Savings mechanisms could be modeled on those employed in the FAI demonstrations. The Medicare-Medicaid Coordination Office, Medicare, and the Center for Medicaid and CHIP Services should all be involved in this work.

Managed Care

Managed Care Issue	NAMD Recommendation
1. **Revisit Guidance on Directed Payments:** CMS issued new guidance on the use of managed care directed payments in January 2021, alongside a rework of the directed payment preprint. While NAMD recognizes the need for CMS to exercise proper oversight over these mechanisms, the revised approaches and preprint create onerous requirements that are out of step with processes to use other authorities. In particular, requirements	Revisit the directed payment guidance and work with states to strike a suitable balance between oversight and feasibility for states in using the directed payment mechanism.

around state provision of information on any written payment arrangement existing between the state and providers or amongst providers is not reasonable.	
2. Maintain Network Adequacy Flexibilities: CMS revised the managed care regulatory framework in November 2020. NAMD is supportive of many of the changes in the revision and encourage CMS to maintain them going forward. We are especially supportive of the flexibility in network adequacy standards to require states to have quantitative standards in place, rather than mandatory time and distance standards.	Maintain changes to managed care regulatory framework. If changes are anticipated, engage states early in the process.
3. Continue Rate and Contract Approval Process Improvements: NAMD appreciates the efforts in the past several years to address pain points in the managed care rate and contract approval processes. However, we continue to see opportunities for additional progress in this area.	Continue working with states to address discrete areas in these processes that contribute to delays in required approvals. Consider modification of timing for state contract submissions as a part of this work.

Behavioral Health

Behavioral Health Issue	NAMD Recommendation
1. Work with CBO to Accurately Score Cost of IMD Exclusion Repeal: CMS has gained a large amount of data and cost information on Medicaid coverage of services in Institutions for Mental Disease (IMDs) via 1115 waivers, managed care "in lieu of" services, and the SUPPORT Act state plan coverage option for SUD. This rich data set could be a useful tool for informing Congressional consideration of repeal of the outdated statutory IMD exclusion,	Work with the Congressional Budget Office (CBO) to incorporate data from the wide array of IMD coverage options in effect among the states into a revised score for repeal of the IMD exclusion.

which continues to pose barriers to providing appropriate intensive psychiatric care for Medicaid members.	
2. **Implement Regulatory Alignment Between 42 CFR Part 2 and HIPAA:** The CARES Act passed early in the COVID pandemic included language allowing substance use disorder (SUD) records to be used or disclosed by a Part 2 entity for purposes of treatment, payment, and health care operations as permitted by the HIPAA regulations. NAMD strongly supports this change and is eager to see it implemented in rulemaking from SAMHSA.	Coordinate closely with SAMHSA as regulatory work is undertaken to implement statutory alignment between 42 CFR Part 2 and HIPAA.
3. **Issue Guidance to Support Implementation of the 988 Crisis Hotline:** By July 16, 2022, all telecommunications carriers will have their networks support three-digit access to the national suicide prevention and mental health crisis hotlines. These can be billable services under Medicaid, but states need support to ensure provider enrollment and billing requirements are addressed to allow Medicaid coverage.	Develop guidance for states offering menus of options to ensure crisis hotlines may be enrolled in Medicaid programs and bill for crisis services.

Delivery System and Payment Reform (DSPR)

DSPR Issue	NAMD Recommendation
1. **Enhance Medicaid Partnership with CMMI:** The Center for Medicare and Medicaid Innovation (CMMI) and its models are key drivers of reform opportunities across the health care sector. However, Medicaid is not always at the forefront of CMMI model development, which produces downstream challenges for states. While CMMI has made efforts to incorporate Medicaid agencies into its processes, there is additional room for improvement.	Work with CMMI to incorporate more detailed Medicaid perspectives into model development and operationalization, including bringing state perspectives into CMMI's planning processes on the front end.

2. **Facilitate Equitable Access to Upfront Resources for DSPR:** Medicaid Directors maintain a long-standing focus on advancing DSPR in their programs. Time and experience have shown that this work requires significant investment of resources and agency capacity. While CMS has shown prior interest in providing states with the ability to invest in reform through mechanisms such as the State Innovation Model grants and Delivery System Reform Incentive Payment waivers, these approaches had their own challenges and have been phased out. However, the needs these programs met remain.	Work in partnership with states and CMMI to explore new vehicles for investing in state reform initiatives. This exploration should encompass leveraging 1115 waivers, more flexible and creative uses of non-waiver authorities, and incorporate equity initiatives. A guiding principle should also be to ensure equitable access to reform resources across the states, with the resources agnostic to the state's level of sophistication in previous DSPR work.

Prescription Drug Costs and Coverage

Prescription Drug Issue	NAMD Recommendation
1. **Provide Additional Tools to Strengthen State Negotiating Power:** Drug cost trends across the nation, including high-cost specialty drugs and inflating generic drug costs, are challenging the sustainability of the Medicaid drug rebate program (MDRP). Covering all Food and Drug Administration-approved drugs, regardless of comparative effectiveness with existing therapies, in exchange for a guaranteed rebate is not necessarily the appropriate mechanism for addressing these trends. Current interpretation of the MDRP suggests an all-or-nothing approach: either states accept mandatory rebates in exchange for mandatory coverage, or they are unable to provide prescription drug coverage in their programs.	Allow states to test new coverage and reimbursement approaches via 1115 demonstration waivers, including targeted exclusions from the MDRP for specific drug classes or therapeutic categories to allow selective product coverage within those categories, explicit use of cost effectiveness and comparative effectiveness analyses in setting coverage criteria, and developing alternative payment models for the Medicaid drug benefit, including outcomes-based contracts.

Telehealth Policy

Telehealth Issue	NAMD Recommendation
1. **Support Efforts to Assess Quality of Telehealth Services:** Telehealth utilization greatly increased during the pandemic. For providers able to adapt to telehealth modalities, this utilization allowed services to be maintained and revenues to remain sufficient to stay in operation. As with any new benefit, states are now seeking tools to gauge the quality of services rendered via telehealth and refine their policies accordingly.	Work with states and other stakeholders to identify effective practices to evaluate telehealth services for quality, including by modality, service type, and populations served. Opportunities to learn from Medicare's evaluation of its own telehealth expansion could be particularly useful.

Data and Systems

Data and Systems Issue	NAMD Recommendation
1. **Delay of Interoperability Rule Timelines:** In the past two years CMS finalized two separate interoperability rules creating new requirements for states, providers, and managed care plans. The first rule's effective date is subject to a discretionary enforcement period which delayed it to July 1, 2021. Unfortunately, given the timing of the rule's finalization and the onset of COVID, the majority of states do not have the resources – or in some instances, the budget authority – to accomplish the rule's activities. The second interoperability rule, while not effective until 2023, was open for comment for fewer than 30 days and fell across holidays, leading to inappropriately brief time for states to articulate their concerns with its proposals.	Further delay the first interoperability rule's implementation date by at least one year, with additional flexibilities for states demonstrating good faith effort towards compliance. Reopen the comment period on the second rule to solicit more detailed state input.

2. **Support States in Preparing for Mandatory Core Set Reporting in 2024:** The Bipartisan Budget Act of 2018 mandated states begin reporting on the full set of Medicaid and CHIP Child Core Set measures beginning in FY 2024. Congress also mandated that states report on all behavioral health measures in the Medicaid and CHIP Adult Core Set in FY 2024. While all states are reporting some of these measures on a voluntary basis, we anticipate several technical challenges to navigate to meet this reporting mandate.	Begin developing guidance for states on effective practices for meeting technical specifications of the Core Set measures and how to maximize enhanced systems match to support the reporting requirements. Provide ongoing technical assistance opportunities for states in this area. Consider how to promote parity in FMAP opportunities between FFS and managed care – in the latter case, eFMAP is available for External Quality Review that does not currently exist in FFS.
3. **Consistency in Approach to Systems Direction:** Medicaid systems projects are consistently some of the most expensive, lengthy, and administratively complex procurements states manage. Effectively instituting systems changes requires significant lead time, with limited ability to change direction mid-course. Unfortunately, states perceive that CMS's focus on Medicaid systems work has not reflected this reality. Over previous years, that focus shifted from MMIS modularity to T-MSIS data quality, undercutting state investments in the former and taxing the time of the same set of Medicaid systems staff and vendors. NAMD understands that federal leaders have the prerogative to emphasize work in specific program areas. That said, a more unified approach to systems prioritization and an interlinkage with policy work would create a more stable environment for state systems modernization.	Reconsider the overarching policy objectives of CMS systems priorities and ensure consistency in emphasis and direction for the next five years, at minimum. This will provide states with the certainty needed to plan their own systems initiatives within a stable federal policy environment. Consider convening a CMS-state working group to delve into these topics and offer recommendations for future directions.
4. **Clarity on Outcomes-Based Certification for APDs:** CMS recently adopted an outcomes-based certification approach for approval of Advanced Planning Documents for Medicaid systems work. Exactly how this process functions remains unclear to states, and there is concern that the process is inconsistently applied across regions.	Issue clarifying guidance to states on the outcomes-based systems certification process. Work to ensure the process is consistently followed with CMS regions, with a clear pathway for escalation if states face barriers to APD approvals.
5. **Reasonable Timeframes for Addressing T-MSIS Data Quality:** CMS is increasingly seeking to leverage T-MSIS to develop reports and	Provide states reasonable timeframes for executing on TPIs and otherwise addressing identified data quality issues in their T-MSIS submissions.

state data snapshots. It is aiming to further improve the quality of state T-MSIS submissions to support this work. However, the process to effectuate submission improvements through identifying T-MSIS Priority Items (TPIs) creates a significant amount of work for states, often resulting in backlogs as additional TPIs are added to previous ones.	
6. **Revisiting Definitions of Compliance with 21st Century Cures Electronic Visit Verification Requirements:** States are continuing to experience challenges with meeting the 21st Century Cures Act's requirements for electronic visit verification (EVV) systems for Medicaid personal care services (PCS) and home health services. NAMD recognizes that the statutory deadline for EVV in PCS has passed and CMS is required by statute to apply FMAP penalties to applicable waivers for non-compliant states. However, a more nuanced interpretation of compliance would provide states with additional leeway for meeting statutory requirements without removing resources from programs that are serving highly vulnerable Medicaid populations.	Work with NAMD and sister state associations to ensure CMS compliance expectations closely align with the statutory requirements of the 21st Century Cures EVV provisions.

Program Integrity

Program Integrity Issue	NAMD Recommendation
1. **COVID PHE Grace Period:** States had to act quickly at the onset of the COVID-19 pandemic to ensure their Medicaid members continued receiving services safely and that providers remained financially supported. In many instances, state actions preceded federal guidance, and CMS directed states not to wait on federal processes to take necessary action. States acted in good faith in	Recognize the uniquely challenging circumstances of the COVID-19 pandemic and the uncertain environment in which urgent policy modification took place. Work with audit entities to ensure that the timing of state actions compared to federal guidance is well understood. Encourage an approach focused on evaluation of state actions rather than generating findings.

this period of uncertainty, but there are instances where implementation did not align with subsequent federal parameters.	
2. Partner to Advance Common Framework for PI: States are increasingly seeing multiple simultaneous audit inquiries from a variety of federal oversight bodies – primarily GAO, HHS OIG, and CMS itself. These separate audits are generally treated as distinct efforts, with little coordination between each. This creates significant strain on state staff and resources to respond to each audit and diverts state resources away from other critical program operations.	Develop a joint working group consisting of states, CMCS, the Center for Program Integrity, and HHS OIG to discuss core principles for coordination and collaboration in program oversight. Consider using the PERM and MEQC processes as a starting point for this engagement, as these are issues that pose routine challenges for states.