October 21, 2022

Chiquita Brooks-LaSure
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is writing in response to the Center for Medicare and Medicaid Services' (CMS) proposed rule, Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting [CMS–2440–P].

As CMS implements mandatory annual Core Set reporting, in accordance with section 50102 of the Bipartisan Budget Act of 2018 and section 5001 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), it will be important to provide State Medicaid Agencies with technical assistance, systems resources, and phased-in implementation timelines. This will ensure that State Medicaid Agencies can report accurate baseline data, while building their system capacity to report on additional populations and to stratify data on demographic variables.

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Mandatory Reporting and Alternative Data Sources

In the proposed rule, CMS discusses issuing annual guidance that would specify the measures on which states would be required to report, any required data stratification, and standardized formats and procedures for reporting this data. NAMD encourages CMS to release this annual guidance as far in advance as possible, as small changes in measure definitions can require states to make significant changes to systems and technical specifications. States report that it can take well over a year to come into compliance with new data specifications, so CMS should consider phasing in new or changed measures.

CMS should also align technical specifications for the Core Set measures with other commonly used measure sets when possible. States note, for example, that past CMS Core Set specifications have differed slightly from the standard HEDIS specifications.

Many states require their managed care organizations to report plan-level HEDIS data, so different Core Set specifications would cause significant operational challenges.

In the proposed rule, CMS references exploring the use of alternate data sources, including T-MSIS, to generate specific measures. Although states appreciate CMS' intent to reduce reporting burden on states, they also cite concerns about the accuracy of the T-MSIS Analytic File (TAF) calculated rates, which often substantially differed from state-calculated rates in the pilot evaluation. Some states also noted that they are currently not capable of reporting on all of the required fields in the T-MSIS file, which would be a barrier to using T-MSIS for Core Set reporting. If CMS does pursue the use of alternate data sources like T-MSIS, it should be at state option to ensure reporting is both feasible and accurate.

Data Stratification by Demographic Variables and Delivery System

In the proposed rule, CMS discusses phasing in data stratification requirements on the basis of demographic data (including race, ethnicity, sex, age, rural/urban status, disability, and language) over the course of five years. NAMD supports this phased-in approach and encourages CMS to consider an even longer implementation timeline. CMS should also give states the flexibility to decide the measures and factors for which they will submit stratified data each year. Many states have reported challenges collecting robust demographic data and this phased-in approach would help states build up their infrastructure for collecting data, along with member trust that data will not be used for discriminatory purposes.

Given the challenges with collecting complete demographic data, CMS should provide technical assistance on the level of data completeness required for a stratified rate to be considered valid. At this time, the National Committee for Quality Assurance does not require a minimum level of data completeness on HEDIS measures to ensure that at least some stratified data can be reported; CMS should consider aligning with the HEDIS specifications. CMS could also allow states to count unknown, missing, or non-responses on demographic variables as a stratification category with its own associated measure rate.

NAMD also requests clarification on the stratified reporting by delivery system and population subgroup discussed in the rule. In some states, fee-for-service (FFS) enrollment is temporary until the member selects a managed care plan or comprises a very small percentage of total Medicaid enrollment. This creates challenges in reporting on FFS members and limits the utility of stratified data. Reporting on FFS members who are dually eligible for Medicare and Medicaid would be extremely challenging, as it would require access to Medicare claims data; this issue is discussed in greater detail below.

Phased-In Reporting for Certain Measures and Populations

In the proposed rule, CMS seeks comment on phasing in reporting for certain measures, including health outcome and survey measures. These measures are more administratively burdensome than claims-based measures and require additional time and resources to collect. Clinical data collection may also require providers to change workflows and data collection practices and to implement EHR updates; the Fast Healthcare Interoperability Resource standard has the potential to improve quality reporting, but its benefits remain theoretical, particularly on the scale of national Core Set reporting. Because of these considerations, NAMD supports biennial reporting on these measures. NAMD also supports phased-in implementation of reporting on these measures; states report very long implementation timelines (over five years) to come into compliance with non-claims-based measures.

In the proposed rule, CMS highlights potential barriers to state reporting on: 1) members who are dually eligible for Medicare and Medicaid; (2) members served by the Indian Health Service (IHS), Tribes and Tribal Organizations, or Urban Indian Organizations; (3) members served by Federally Qualified Health Centers (FQHCs), and (4) members receiving services on a fee-for-service basis in states where most members are enrolled in managed care plans. NAMD affirms that reporting on these groups would be very challenging and strongly supports phased-in implementation. With respect to (2), any CMS rules about data completeness must respect Tribal sovereignty; CMS should engage in consultation with Tribes and Tribal Organizations.

States note significant challenges reporting on dually eligible members, with specific challenges reporting on dually eligible members who are not enrolled in integrated managed care plans, as this would require accessing Medicare FFS claims data. Reporting on these members would require extensive resources, technical assistance, and lead time. States expressed particular interest in joining the Medicare-Medicaid Data Sharing Program discussed in the proposed rule; CMS should facilitate state participation in this program.

As discussed above, states with primarily managed care delivery systems also note challenges reporting on members receiving services through fee-for-service (FFS). In many states, members are only temporarily enrolled in FFS (e.g., until they select a managed care plan or for retroactive coverage) or only enrolled in FFS if they have another primary payer (e.g., Medicare or commercial insurance). Members who are temporarily enrolled in FFS may not meet length-of-enrollment requirements for quality measures; for example, many HEDIS measures only use data from members who have been enrolled for at least 12 months. States report that it would take significant resources and lead time to develop the infrastructure to report on this group. Given the size of this population, CMS should consider whether this is an appropriate use of state resources.

States note that reporting on members who also have commercial insurance (i.e., members who receive Medicaid for premium assistance) would not be possible as states do not have access to commercial claims data. CMS should clarify that these populations would be exempt from Core Set reporting.

Resources and Technical Assistance

In order to assure accurate and timely Core Set reporting, CMS must provide states with sufficient resources and robust technical assistance (TA). States report that it is hard to predict exactly what TA would be needed before seeing the measure specifications, but that written guidance, standard templates, FAQs, measure specification and coding assistance, one-on-one state specific TA, and instructional webinars that allow for questions would all be helpful. States also report that being able to directly communicate with CMS' technical assistance contractor has been very helpful in the past, as have learning collaboratives where states can learn from each other.

CMS should consider enhanced TA for specific measures and populations. As discussed above, states note significant challenges reporting on dually eligible members enrolled in FFS Medicaid, collecting complete demographic data, and reporting on measures that require a hybrid or non-claims-based approach. CMS should develop specialized TA under these focus areas, including sharing promising practices and lessons learned across states.

CMS should also work to ensure parity in resources between states with primarily managed care delivery systems and primarily fee-for-service delivery systems. External Quality Review Organizations (EQROs) play an important role in quality and outcome measurement, with many states leveraging EQROs for Core Set reporting. Per guidance released in 2016, mandatory and optional EQR activities for managed care organizations are eligible for a 75 percent federal match rate. In contrast, EQR activities for fee-for-service delivery systems are matched at the typical 50 percent administrative federal match rate. This disparity in match rates disadvantages states with fee-for-service delivery systems; states should receive the 75 percent match rate for all EQR activities. These enhanced federal resources would support states in building out robust systems for quality and outcome measurement, including Core Set reporting.

Considerations for Separate CHIPs

In the rule, CMS proposes to require states with a separate CHIP to report on the Child Core Set in three categories: Medicaid and CHIP combined; Medicaid inclusive of CHIP-funded Medicaid expansion; and separate CHIP. Some states currently report Child Core Set measures at the aggregate level, inclusive of children in Medicaid and CHIP, and some states have worked to align benefits and provider networks across Medicaid and CHIP. NAMD encourages CMS to allow aggregate reporting to align with existing state practices and to reflect general alignment of benefits and provider

networks across Medicaid and CHIP. If CMS does move forward with the proposal for reporting in separate CHIPs, states would need additional TA.

NAMD appreciates the opportunity to provide these comments. Annual Core Set reporting will represent a major operational lift for states, but phased-in implementation timelines, robust technical assistance, and adequate systems resources will help ensure accurate baseline data and timely reporting. We look forward to working together to improve quality reporting in Medicaid.

Sincerely,

Allison Taylor
NAMD Board President
Director of Medicaid
Indiana Family and Social Services Administration

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NAMD Board President-Elect
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