



July 3, 2023

Chiquita Brooks-LaSure
Administrator
The Center 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, [Ensuring Access to Medicaid Services \[CMS-2442-P\]](#).

Together, CMS's proposed access and managed care rules seek to ensure Medicaid members have timely access to high-quality services. Medicaid agencies share CMS's commitment to these goals. Independently, many of CMS's proposals are strong policy ideas. However, Medicaid agencies report serious concerns about their ability to implement the volume of policies proposed in these two rules, along with other ongoing state and federal priorities. CMS should consider additional flexibilities, extended implementation timelines, and enhanced resources.

NAMD is a professional community of state leaders who provide health insurance to more than 93 million individuals and families through Medicaid and the Children's Health Insurance Program in each of the 50 states, the District of Columbia and the U.S. territories. NAMD elevates thought leadership on core and emerging policy matters, amplifies the experience and expertise of Medicaid and CHIP directors, supports state programs in continuous improvement and innovation, and optimizes federal-state partnerships to help millions live their healthiest lives.

Key Messages

NAMD offers four overarching areas for consideration as CMS advances this rule. These broad areas inform the more specific operational feedback we offer on the rule's policy proposals.

Medicaid Agencies Support the Aims of These Rules

Together, CMS's proposed managed care and access rules seek to improve access to care for Medicaid members. Medicaid Directors share these aims. Medicaid is a critical connection to health care for over 90 million people, including low-income families, pregnant people, children with complex health care needs, individuals living with disabilities, older adults, and single adults below certain incomes. [Research shows](#) that

access to Medicaid coverage improves health outcomes, with particularly strong effects for children.

These rules come at a watershed moment for the program, as our country moves out of the most acute phase of the COVID-19 pandemic. During the pandemic, Medicaid programs served as a crucial lifeline, providing access to COVID-19 vaccinations and treatment, rapidly expanding access to telehealth, and enrolling millions of new members through Congress' continuous coverage requirement. However, the pandemic also exposed fundamental challenges in our country's health care system, including disparities in access to care, provider shortages, and lack of access to housing and other social needs.

Medicaid agencies are currently going through the process, as required by federal law, of redetermining eligibility for all Medicaid members. Medicaid Directors are laser-focused on ensuring that all people who remain eligible for the program maintain eligibility, and those who are no longer eligible find their way to other sources of coverage. Medicaid agencies are engaging in unprecedented levels of outreach to Medicaid members about the steps they need to take to renew coverage, and this "unwinding" process will undoubtedly yield important insights into the most effective strategies to help people enroll in Medicaid and renew their coverage.

As we emerge from the pandemic and the corresponding unwinding process, Medicaid has opportunities to strengthen access to care for members. Many of the proposed policies in these rules – including strengthening the role of Medicaid members in the policymaking process, utilizing secret shopper surveys and other instruments to measure access, strengthening home and community-based services, and using enrollee experience surveys to gauge quality of care – have been pioneered at the state level. Other proposed policies – including the 80 percent wage pass-through in HCBS, rate comparisons to Medicare, and the Medicaid and CHIP Quality Rating System – represent interesting policy directions and merit careful consideration.

Medicaid leaders' deep interest in these policies was evident throughout NAMD's comment development process. We held over a dozen calls on the proposed rules, many of which had over 100 attendees, and received written feedback from many states. The overwhelming sentiment of our members is that the policy goals in these rules – including ensuring that member voice is heard, that HCBS are safe and accessible, that Medicaid members can access high quality care when they need it, and that Medicaid agencies have the data they need to identify and resolve access issues – are shared state and federal priorities. As discussed in our comments below, navigating the complexities of how to move our current system closer to these aims is challenging and some proposed policies may not represent the most effective path. However, we applaud CMS's commitment to Medicaid members and the Medicaid program.

The Proposed Rules Include Significant Systems Lift and Cost

As articulated above, Medicaid agencies share CMS's commitment to the aims of this rule. However, NAMD urges caution around the effort, cost, timing, and complexity of the systems changes necessary to implement the rule as written.

Medicaid agencies appreciate the significant financial contribution that CMS makes to systems changes, in the form of 90 percent match. It is also important to note that CMS has invested considerable effort and time in simplifying and accelerating the administrative processes associated with qualifying for that match.

However, the numerous, interrelated, and overlapping obligations that Medicaid agencies will have to undertake if all of the elements of both rules are adopted as proposed will cost exponentially more than CMS has estimated, require extensive new Medicaid agency staffing and large-scale vendor contracts, intersect with numerous systems obligations that are already in the pipeline as well as those that are anticipated under various pieces of federal legislation, and require staging and more time than is anticipated by CMS's proposed implementation deadlines.

States and territories must go through a lengthy process to implement new systems, including:

- **Appropriations & Enabling Legislation:** Before starting systems work, Medicaid agencies generally must seek appropriations from their legislatures to fund the state component of the match. Dependent on state law, Medicaid agencies may also need to seek enabling legislation to allow for policy implementation, even when federal regulations mandate certain policy changes. This can take significant time, as most state legislatures only convene during certain months and some state legislatures convene every other year.
- **Advance Planning Document Approval:** The Advance Planning Document (APD) process that Medicaid agencies must fulfill for any project involves extensive up-front framing of project plans and anticipated outcomes, documentation of the required ten percent state match, and numerous process steps. The latest reported data in the [Federal Administrative Accountability section of the Medicaid and CHIP Scorecard](#) indicates that as of Q1 2021 it took CMS an average of 43 days to approve Medicaid agency requests for APDs. Typically, Medicaid agencies must receive CMS approval of their APD and Request for Proposal for any project anticipated to cost \$500,000 or more (which includes most projects) before moving ahead with procurement.
- **Formal Procurement Process:** The formal procurement process is lengthy, complex, and iterative. Bidders who are not selected to enter contracts often mount time-consuming challenges, which can significantly add to procurement timelines.

- **Systems Design, Testing, and Implementation:** After a vendor is contracted, there are numerous stages of systems development and testing that must occur before final implementation. Depending on the nature of the project, these timelines can take five years or more, particularly if testing identifies unanticipated challenges in design or if implementation does not go smoothly.

States and territories never have the luxury of focusing exclusively on one systems initiative at a time. Any new federal obligation that requires systems work necessitates re-prioritization and staging of the many other systems obligations that are already in the pipeline. CMS's proposed access and managed care rules include at least six elements that will require extensive systems work: 1) a new HCBS FFS grievance process; 2) a new HCBS incident management system; 3) significant new reporting obligations, including on the new HCBS provisions, the HCBS Quality Measure Set, access data, payment adequacy data, and a direct care worker wage pass-through policy; 4) new website requirements; 5) new requirements for comparative analysis of FFS rates; and 6) a managed care Quality Rating System meeting federal requirements for interactivity. These will layer on both existing projects in the pipeline (e.g., continuing compliance work related to eligibility systems, implementation of Asset Verification Systems and Electronic Visit Verification, etc.) and upcoming obligations associated with the Consolidated Appropriations Act (e.g., continuous eligibility for children).

For all of the above reasons, while in general CMS has proposed one- to four-year time frames for implementation of various components of both rules – and some of these are in their own right not unreasonable – CMS must be conscious of and account for the entirety of the systems obligations that states and territories are facing within that time period (as well as the impacts on program structures and the political scrutiny that may accompany such impacts) and scale implementation timeframes accordingly.

The Proposed Rules Would Create Reporting and Evaluation Burden

Throughout both rules, CMS proposes significant new reporting and evaluation requirements, including the HCBS quality measure set, rate reporting and comparative analyses, new evaluations for state-directed payments and in lieu of services, and the Medicaid and CHIP Quality Rating System. Taken together, Medicaid agencies have serious concerns about their ability to comply with this level of reporting and questions about the overall utility of this data.

Medicaid agencies raise concerns about operationalizing this breadth of reporting. As discussed above, implementing the systems changes required to gather many of these new data sets will be costly and time consuming, and in many agencies will fall on the same set of staff experts. Many of the proposed evaluations will necessitate the hiring of additional FTEs or contracting with vendors.

If Medicaid agencies were confident these new data would drive meaningful improvements in care, they may be worth the associated costs. However, Medicaid

agencies report serious questions over the utility of this reporting. More data is not always better; without state and federal infrastructure to analyze data and, more importantly, act on data, we risk Medicaid agencies and the federal government expending significant resources without seeing associated improvements in access.

Given these concerns, NAMD urges CMS to prioritize these reporting requirements, based on which data is most operationally feasible to collect and act on. CMS should also consider phasing in reporting requirements over time wherever possible; this runway gives Medicaid agencies time to make needed systems changes, address data quality issues, and meaningfully integrate the results of these analyses into policy and programmatic decisions. This is especially true in areas where CMS seeks stratification of data.

Additional Flexibilities, Implementation Time, and Resources are Needed

To increase the feasibility of these proposals, NAMD urges CMS to consider additional flexibilities, implementation time, and resources.

Many of CMS's policy proposals are quite prescriptive. Throughout these rules, CMS establishes detailed policies for Medical Care Advisory Committees, sets appointment wait time standards, mandates a wage pass-through threshold for HCBS direct care workers, and creates new specifications for websites, among many other proposals. These standards fail to acknowledge the diverse contexts – including provider landscapes, system constraints, existing processes and initiatives, and legislative environments – in which states and territories operate.

While CMS may see value in bringing more standardization across Medicaid programs, NAMD cautions against being overly prescriptive in federal regulation, which would inhibit Medicaid agencies' flexibility to account for these diverse contexts. If CMS inadvertently codifies processes that prove burdensome or have unintended consequences for states or Medicaid members, correcting them would require additional federal rulemaking. Instead, CMS should identify its goals and provide a regulatory framework, iterated upon via sub-regulatory guidance, which gives Medicaid agencies the flexibility necessary to design solutions that work in local contexts.

If CMS moves forward with these proposals, NAMD urges CMS to provide extended implementation time. Although some of our suggested timelines may seem unreasonably long, NAMD encourages CMS to consider the time needed to issue necessary sub-regulatory guidance, for legislatures to pass appropriations and enabling legislation, and for Medicaid agencies to procure vendors and hire staff. Together, these steps may take several years before Medicaid agencies can actually enact policy changes. Extended implementation time will also allow Medicaid agencies to thoughtfully stage their many competing priorities, including the unwinding, implementation of new 2023 Consolidated Appropriations Act policies, and the long-term compliance with eligibility and renewal process requirements.

Specific Feedback

A. Medical Care Advisory Committees

NAMD supports CMS's goals for incorporating the lived experience of Medicaid members, their families, and their caregivers into the Medicaid policymaking process. We recognize the power differentials at play in the current MCAC process, which may not lend itself to authentic member engagement. Indeed, several Medicaid agencies have taken proactive steps to effectively solicit the valuable perspectives of their Medicaid members through diverse member engagement strategies. That being said, the specific proposals CMS contemplates around a dedicated Beneficiary Advisory Group (BAG), with a component of its members serving on a larger Medicaid Advisory Committee (MAC), may pose operational difficulties that could impede this larger goal. Legislative, regulatory, and process changes within the states and territories may also be necessary; as such **NAMD requests at least two years to implement changes to current committee structures** and note some of our members would benefit from even more lead time.

Medicaid agencies indicate that the life circumstances of individuals with lived Medicaid experience can lead to inconsistent participation in existing advisory committees. The lack of available resources to compensate members of these committees, alongside the need to address issues such as transportation, childcare, or caregiving responsibilities (particularly among the adult expansion population), can lead to variable participation rates. CMS's proposal for a subset of the BAG to also serve on the MAC would double demands for specific individuals' time and would be difficult for most Medicaid agencies to meet. **NAMD recommends that CMS consider alternatives to the proposed 25 percent membership crossover between the BAG and the MAC, such as 10 or 15 percent and/or a more graduated approach for committee crossover. CMS should also provide technical assistance and best practices for committee retention.**

We recognize that part of CMS's goal in its 25 percent committee crossover proposal is to ensure robust and diverse input into the larger MAC and to ensure the Medicaid member perspective is reflected in MAC recommendations. However, the variability in covered Medicaid populations and the programs that serve them means that even a 25 percent requirement would not necessarily capture all the perspectives necessary to maximize member input. Several Medicaid agencies have already taken steps to solicit member input from specific areas of their programs, such as specific subcommittees structured around individuals with physical disabilities or intellectual and developmental disabilities. Depending on the nature of the conversation at hand, these more specific subgroups can generate more relevant feedback for policymaking than what could be surfaced in a broader BAG.

Additionally, some Medicaid agencies note that beneficiary input can be more effective when it is provided in a less formal environment. There are concerns that overtly formal committee structures and meetings, including formal reports, may inhibit the type of

input that is most meaningful for policymakers. **CMS should allow Medicaid agencies which have existing, effective membership solicitation processes, and are able to demonstrate such processes to CMS, to continue employing current practices. Further, Medicaid agencies should have the ability to structure specific beneficiary subcommittees and meet CMS's expectations, so long as those subcommittees are providing meaningful and documented input to the broader MAC.**

From an administrative perspective, states and territories have concerns with executing CMS's vision for the MAC and BAG. As noted above, Medicaid members and individuals with lived Medicaid experience may need supports to facilitate consistent participation. Not all Medicaid agencies have the resources, or even the authority, to provide such supports, though **when agencies are able to provide compensation or other supports, CMS should allow such supports to be disregarded for purposes of Medicaid eligibility to ensure there are no unintended impacts on eligibility as a result of participation in advisory groups.** Coordination of hybrid in-person and virtual meetings with multiple languages will also be challenging to consistently realize. Further, CMS's proposed requirements for bi-annual public meetings and annual reports with incorporated recommendations from the BAG create additional administrative and resource burdens on Medicaid agencies and on the members of the committees. **We recommend CMS consider a good-faith effort exceptions process to allow Medicaid agencies to alter the cadence of meetings and reports in a manner that matches their administrative resources and program goals.** CMS should also consider altering its proposed language to stipulate that it is the Single State Agency that has committee appointment authority, and not another state authority.

NAMD appreciates the option for the MAC and BAG to also serve as the interested party advisory group on rates for HCBS required elsewhere in this rule. Several Medicaid agencies expressed interest in using the committees for this purpose.

On a final note, several NAMD members indicated that the naming of the BAG could have negative connotations, and recommended an alternative name for this committee, such as Beneficiary Advisory Committee, Board, or Council.

B. Home and Community-Based Services

Person-Centered Care Plans

In this rule, CMS proposes to replace the current 1915(c) assurances framework with a requirement that states annually reassess functional needs, and correspondingly revise person-centered service plans, of at least 90 percent of all individuals who are continually enrolled in a waiver for at least 365 days. NAMD supports these enhancements to the person-centered planning requirements and appreciates the recognition of the centrality of person-centered planning to the provision of high quality

HCBS. Medicaid agencies generally report that the 90 percent threshold is appropriate, although some states report that 85 percent may be more feasible.

To strengthen this proposal, CMS should clarify the annual reassessment requirement: is a complete reassessment required through the proposed rule, or would ensuring current assessment results are still valid qualify as compliant? Medicaid members report that assessments can be rigorous and sometimes feel intrusive. **To minimize burden on individuals receiving HCBS, NAMD recommends that CMS only require a full reassessment when the individual's circumstances or needs change significantly or at the member's request, while allowing states and territories to conduct more frequent assessments if desired.**

To strengthen this proposal, CMS should also offer a good-cause exception to the 90 percent threshold. Medicaid agencies report there are sometimes extenuating circumstances such as medical emergencies/hospitalizations, assessment delays at member request, and access issues in rural areas that would merit a good-cause exception. CMS should also provide an extended implementation timeline of up to five years for states who need to make major systems changes or contractual changes with their managed care organizations.

Fee-For-Service Grievance Systems

In this rule, CMS proposes to require states to implement new grievance systems for 1915(c) waivers and 1915(l), (j), and (k) State Plan authorities in FFS delivery systems. In general, Medicaid agencies support CMS's proposal to provide Medicaid members in FFS delivery systems with the same grievance rights as are currently afforded to members served in managed care delivery systems. This is an effective means of ensuring procedural protections for people who receive HCBS. For Medicaid agencies with a small percentage of their population enrolled in FFS, however, this will represent a significant administrative lift for a small number of Medicaid members. **CMS should consider an exceptions process in these circumstances.** We also encourage CMS to provide states with the flexibility to hire vendors to administer the grievances process if state staffing resources do not easily support taking on this function. **In either scenario, CMS should offer enhanced funding opportunities for such functions,** such as by amending the definition of Skilled Professional Medical Personnel to allow the designation to apply to staff administering the grievance process and be eligible for 75 percent match. This would equalize financial supports across FFS and managed care.

NAMD also supports:

- CMS's decision not to apply these standards to state plan services, recognizing that those services are not subject to the requirements of the HCBS Settings Rule.

- CMS’s decision not to expand the scope of its proposal to include changes to fair hearing rights in FFS delivery systems. These rights are well articulated and longstanding, and there are already means in place to notify beneficiaries of those protections and also pathways to judicial review, as necessary, in the event that a beneficiary exhausts their administrative remedies.

In the rule, CMS proposes timelines for grievance resolution (within 90 calendar days for non-expedited grievances and within 14 calendar days for expedited grievances, with the option for a 14-calendar day extension). Although the timeline for non-expedited grievances is feasible, Medicaid agencies report concerns with the 14-day timeline for expedited grievances. Grievances are serious situations that require complete and thorough investigations. These investigations take time, and if any party provides incomplete information or is delayed in responding to requests for information, the timeline is impacted. While appropriate timely action is imperative, it is equally important that accurate information is gathered prior to grievance resolution. **NAMD suggests 30 calendar days for resolution of expedited grievances, with the option for a 14-calendar day extension, recognizing states may choose to set shorter timelines where they feel feasible and appropriate.** Medicaid agencies also report concerns on how they would implement expedited vs. non-expedited grievances; CMS should provide TA on how to define which grievances fall into each category and how to manage situations when Medicaid members disagree with the agency’s determination of an expedited vs. non-expedited grievance.

CMS proposes an implementation time frame of two years from the effective date of the final rule. Medicaid agencies highlight significant concerns with this proposed timeline, as they would need to make changes in state code, hire and train staff, and procure or redesign IT systems. **CMS should consider an extended implementation timeline of at least four years following the effective date of the final rule.**

Incident Management Systems

CMS proposes to require states to operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. NAMD fully supports CMS’s aim of ensuring critical incidents are appropriately monitored to ensure member health and safety and believes that electronic incident management systems are crucial to achieving this aim. NAMD also supports CMS proposal to not include 1905(a) services in this system, given varying degrees of such services provided in the HCBS landscape and differential data reporting infrastructure for 1905(a) services versus waiver programs.

Many states already have electronic critical incident management systems and report that CMS’s proposal is feasible. However, states that do not currently have these systems in place report that implementation will require significant time and effort, including substantial coordination across state agencies and managed care entities and significant systems cost and time. **To address these concerns, CMS should provide**

at least five years of implementation time. Further, we propose that the timeframe for implementation be based on the provision of sub-regulatory guidance, rather than the effective date of the rule, as states will likely need to wait for sub-regulatory guidance to begin implementing the required systems changes.

In this rule, CMS proposes a universal minimum definition of “critical incident.” **CMS seeks comment on expanding the definition of “critical incident” beyond the current proposal; NAMD recommends against this expansion.** Some states report concerns that the proposed definition is overly broad, which may impede coordination with other agencies and stakeholders; in contrast, others note that a consistent definition of “critical incident” may support standardization efforts across state agencies. Expansion of the definition beyond the current proposal would create additional burden on states to implement, as state statute and agency regulation amendments would likely be required. We specifically recommend that CMS not expand the definition to include identify theft or fraud, as this would create duplication of existing investigative and reporting processes.

If CMS finalizes the definition as proposed, guidance on specific protocols for incident substantiation will be necessary. This should include clarity around the exact definition of medication errors, including consideration of removing this element of the definition entirely or at least removing those “resulting in a telephone call or visit to a poison control center” as this cannot be as readily tracked as visits to health care providers. CMS must also be mindful of how this proposed definition may not align with existing state and local government regulations and the confusion that may result.

CMS also proposes to require states to use claims, Medicaid Fraud Control Unit (MFCU), and Adult Protective/Child Protective Services data to identify unreported critical incidents. Medicaid agencies report serious concerns about this proposal, as implementation will require significant time, cost, and staffing resources. States report that they are unlikely to glean substantial information from claims data, given the delay between service delivery and billing and general challenges determining which claims may indicate an unreported critical incident. **NAMD recommends that CMS start by requiring Medicaid agencies to use existing data for incident identification and verification; CMS should phase in expansion to other data sources over time, after better understanding the potential utility of these additional data sets.** States also note confusion over what data sharing is allowable between Medicaid and Adult Protective Services/Child Protective Services under current federal law; CMS should clarify this.

In this rule, CMS proposes new reporting requirements around critical incidents. **NAMD recommends that CMS provides a definition of the term “provider” for purposes of critical incident reporting in self-directed service models, as well as guidance on the reporting process for self-direction.** As the beneficiary or a family member is often the employer of record and responsible for overseeing their service providers, it is

unclear whether the self-directed employee should be responsible for critical incident reporting or if that responsibility would fall to the beneficiary. CMS should also consider reporting requirements for entities that have no reported incidents to ensure robust oversight; Medicaid agencies report concerns that the proposed structure could inadvertently incentivize underreporting.

Further, **we recommend CMS remove the requirement for reporting on the failure to deliver services.** While many states already have robust mechanisms to collect and report on critical incidents when the incident occurs during the provision of HCBS, states reported concerns with proposed requirement to report incidents that occur because of a failure to deliver services, as this criterion is too broad for states to operationalize effectively and consistently. It is unclear how providers and states would objectively correlate a failure to deliver services with a critical incident.

In this rule, CMS proposes to create federal minimum performance standards, such that an investigation is initiated and completed within state-specified timeframes for no less than 90 percent of critical incidents, and corrective action is completed within state-specified timeframes for no less than 90 percent of critical incidents that require corrective action. NAMD appreciates CMS's proposal to defer to state-identified timelines on incident resolution. Medicaid agencies report mixed views on the feasibility of the proposed 90 percent target; while some states report that this is feasible, others would prefer an 85 percent target. Regardless of the final threshold, **NAMD recommends that CMS create a good-cause exception to account for resource challenges or when the investigating agency requests that the Medicaid agency refrain from contact due to an ongoing and active investigation.**

Medicaid agencies report serious concerns around the proposed requirement that they separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within state-specified timelines. Although Medicaid agencies recognize the importance of cross-agency collaboration, this requirement may actually hinder the formation of these partnerships. Agencies have different processes and timelines for investigations, and bridging these differences will require long-term work and deep understanding of each other's current processes. States also cite conflicts with state statute that clearly dictates which agency is in charge of investigations in which circumstances. Finally, Medicaid agencies express concern that this provision may impede active investigations; for example, if a police department is investigating an assault that impacted an HCBS member, requiring the Medicaid agency to launch a separate investigation may actively hinder the police investigation. **NAMD strongly recommends that CMS not finalize this provision and instead encourage (e.g., through grant funding and technical assistance) cross-agency coordination on critical incidents.**

HCBS Payment Adequacy

CMS proposes that at least 80 percent of all Medicaid payments for homemaker, home health aide, and personal care services, including but not limited to base payments and supplemental payments, be spent on compensation to direct care workers (DCWs). NAMD supports the intent of this pass-through requirement as a strategy to improve recruitment, retention and economic security of the HCBS direct care workforce. This is a critical workforce for provision of HCBS across Medicaid programs, and Medicaid agencies and their sister agencies with operational oversight of waiver programs consistently identify the DCW shortage as a fundamental challenge to strengthening HCBS.

That said, Medicaid agencies report:

- a considerable range of opinions as to whether the proposed, uniform standard of 80 percent is the correct threshold;
- need for greater clarity in definition of terms;
- need for uniform, federally-produced enabling tools including sub-regulatory guidance and an HCBS cost report template; and
- concern about the cost and effort of implementing, monitoring, and ensuring compliance with this requirement.

While this proposal may help improve pay for people who do this work, Medicaid agencies reinforce that solving the workforce challenge will also require other strategies, including specialized training to support retention and meaningful career ladders for growth. Addressing wages is a necessary aspect of resolving this crisis, but by itself is not sufficient. CMS should continue to actively partner with the Administration for Community Living and other sister federal agencies to promote a comprehensive, integrated campaign that addresses the multiple facets (promotion of and improvement of social valuation of this work, workforce pipelines, immigration policy, wages, benefits, training, vehicles for retirement savings) of the direct workforce crisis.

With respect to CMS's definition of terms and selection of the 80 percent threshold:

- **Definition of the term "personal care."** Medicaid programs and the sister state agencies that are responsible on a day-to-day basis for administering HCBS LTSS would benefit from more specific detail on the definition of "personal care", particularly as that may implicate constituent parts of other services (e.g., residential habilitation). It is notable that while CMS's definition of "direct care worker" (DCW) specifically includes reference to job roles that provide services for individuals with intellectual and developmental disabilities, the definition of personal care substantially excludes the habilitative services on which those people rely.
- **Definition of the term "DCW".** NAMD's members are generally supportive of the broad, functionally-based definition of DCW that has been adopted by CMS and of including both agency-based and self-directed DCW. One state notes that it may be helpful for CMS to specify which employees are *excluded* from the

definition for ease of provider education. It is important to note, however, that typical definitions of DCWs have focused on unlicensed, non-clinical providers of personal care services and have not typically included nurses. NAMD understands this to be an intentional expansion, but some Medicaid agencies note that, by including nurses in the definition of DCWs, services that are reliant on nursing will have an easier time meeting the 80 percent requirement due to the higher levels of compensation for nurses. CMS should also clarify how some administrative functions falling within a DCW's scope of work impacts the applicability of this policy, and whether the portion of time spent on administrative tasks should be excluded.

- **Definition of the term “compensation”.** While CMS does provide helpful detail about what it considers to be included in the term “compensation”, NAMD's membership would benefit from further clarification, such as whether travel time is included. Some states recommend including paid time off for vacation, continuing education, and worker's comp in the definition of compensation, along with a defined training cost per FTE.
- **80 percent threshold.** Some states have expressed concern about solely relying on the methodology used by states that have been early adopters of this strategy and would prefer to have the opportunity to establish their own evidence base. Many, however, generally support the use of an identified threshold and are also supportive of expanding the requirement to other services and settings, both as a means of addressing broader workforce needs and also to promote consistency and standardize the approach from a systems standpoint. That said, states expressed concern that CMS's decision not to permit exceptions to the 80 percent threshold will likely disfavor 1) small and new providers as compared to larger/established providers; and 2) rural and frontier providers, who often have fewer options to optimize administrative costs and higher costs of recruiting and maintaining staff. Of specific concern is that a uniform standard may unintentionally disfavor or crowd out small Black, Indigenous, and Persons of Color (BIPOC) providers and exacerbate the degree to which large agencies that are well-established and have economies of scale with proportionately higher administrative costs. **CMS should consider alternative approaches, such as a scaling threshold based on provider size, rural/urban status, risk of closure, and/or an exceptions process for small providers.** We note that not all states and territories may avail themselves of such flexibilities, either out of preference for more universal application of a base wage strategy for their DCW workforce or out of administrative ease compared to the scaled approach. Nonetheless, a policy that is flexible enough to advance the underlying goals of enhancing DCW rates while being sensitive to unique local realities is appropriate in NAMD's view.

Medicaid agencies have also identified the following as significant challenges associated with implementing the pass-through requirement:

- **Lack of current mechanism for cost reporting.** Providers of direct care, whether agency-based or self-directed, have not historically been required to submit cost reports to Medicaid programs. If CMS finalizes this proposal, NAMD urges CMS to develop and disseminate a standard cost report template and guidelines for reporting, to enable consistent state adoption and implementation of the pass-through requirement. Some states would prefer an attestation and audit approach, whereby providers attest to their compliance with the pass-through requirement and states conduct periodic retrospective audits. However, other states note that non-state agency audit processes may still require cost-reporting data for their own work.
- **Lack of capacity, staffing and systems for monitoring and compliance.** NAMD's members underscored that there are large numbers of providers who fall within the proposed definition of DCW, and that many lack experience and sophistication with respect to documentation of cost structures and reporting. Related, NAMD members identified that they would need to socialize and support provider literacy around these requirements, design and implement cost mechanisms and provider documentation of compliance, engage with managed care plans on implementation, and expand staffing to enable monitoring and audit functions. Expanding staff for this purpose will, in many states, be challenging due to resource constraints and an overall direction towards reducing the number of state employees. If CMS finalizes this provision, they should provide clear direction on enforcement mechanisms, including recommended approaches for remediation.
- **Concurrent obligations.** A number of states identified that it will be challenging to implement due to concurrent obligations including, but not limited to, management and sustainability work around the ARPA HCBS funds as well as continuing to fully implement the HCBS Settings Rule.
- **Unintended consequences for providers.** Some Medicaid agencies, as noted above, are concerned about the unintended consequences for providers of this policy. Lack of familiarity and resources to produce cost reports would disproportionately impact smaller providers and may lead to lower overall provider availability for critical Medicaid HCBS. It is also unclear what the remedy is for providers that are not able to comply with the pass-through requirement – and it clearly should not be terminating a non-compliant agency, as that would exacerbate shortages.

CMS proposes a four-year implementation timeline. Medicaid agencies report concerns about the feasibility of this timeline. Implementing this policy would require: 1) legislative changes; 2) system development for reporting and oversight, including developing cost reporting systems; 3) partnering with providers for initial implementation; and 4) provider remediation for violations. **Due to the volume of this work, CMS should consider up to six years for implementation.**

Concurrently, CMS proposes new annual reporting requirements on the aggregate percent of payments for homemaker, home health aide, and personal care services, that are spent on compensation for direct care workers, separately by each of the three services and for self-directed services. NAMD supports this proposal as a positive strategy to improve transparency and facilitate meaningful comparisons across programs. While this will require additional effort and resources to fulfill, Medicaid agencies feel that:

- it would be useful for CMS to consider expanding the reporting obligations for other DCW services (e.g. residential habilitation services, day habilitation services, and home-based habilitation services), with consideration for how the cost profiles – particularly cost of living associated with residential services – informs the pass-through threshold and the cadence with which broader services are adopted to allow states and providers to become familiar with this new process;
- an optional self-attestation process would be helpful to Medicaid programs, although some Medicaid agencies note that they would need to collect at least some provider-level data to ensure compliance;
- aggregate reporting is preferable to a more granular approach (e.g. reporting on the percent of payments for certain HCBS that are spent on compensation for direct care workers at the delivery system, HCBS waiver program, or population level; report on median hourly wage and on compensation by category);
- it would be useful and appropriate to permit Medicaid agencies to exclude from their reporting to CMS payments to providers of agency directed services that have low Medicaid revenues or serve a small number of Medicaid beneficiaries; and
- focusing this reporting requirement on HCBS waiver, as opposed to State Plan, authorities is appropriate.

Medicaid agencies would prefer less frequent reporting (i.e., every other year) to reduce administrative burden. Collecting provider-level data is time consuming and can require significant follow-up to ensure all providers have submitted data. **In addition, CMS should extend the implementation timeline to five years to increase feasibility.**

Reporting Requirements: Timeliness of Access and Waiver Waitlists

CMS proposes new reporting requirements around waiver waitlists and the amount of time from when certain HCBS are initially approved to when service delivery begins. NAMD supports CMS's intent and agrees that stronger data collection is an important step in improving access for Medicaid members. However, states report some concerns over the proposed requirements and recommendations to improve the utility of this data.

States report broad concerns that the amount of new data collection required may not translate into meaningful policy action. The data collection proposed would require

significant investments at the state level, so CMS should provide clarification on how this data will be used to drive improvements in access.

On the wait list reporting requirements, states agree that collection of wait list data is valuable and that the proposed 3-year implementation timeline is feasible. **CMS should, however, consider a 2-year reporting cycle instead of annual reporting to reduce administrative burden.** States also note that waiting list definitions and processes vary widely among states and even among individual state programs, making it difficult to directly compare waitlists. Additionally, states report broad concerns about how this data will be contextualized. Workforce availability is a significant driver of waitlists and addressing provider capacity is a long-term challenge that can sit outside of the Medicaid agency's direct control. CMS could consider identification of reasons for delays in service delivery and/or being put on a waitlist to properly contextualize this data.

On the timeliness of access requirements, states report that the proposed changes would require substantial policy and systems changes, as states would need to be able to capture the date of any HCBS service referral or authorization and capture the date that services were initiated. The proposed data collection would also not reflect individual circumstances that may contribute to delays in service initiation, such as when a member is hospitalized, changes providers, is traveling or unavailable for service delivery, or otherwise declines services. There may also be instances where a beneficiary is receiving another service that meets their needs prior to initiation of personal care, homemaker, or home health aide service. These circumstances could delay service initiation but may not be due to true access issues.

To address these concerns, NAMD recommends that CMS allow states the option to choose one of the proposed criteria on which to report, or to propose a different metric on which to report. State flexibility to determine the most appropriate metrics for their programs is essential to ensuring meaningful data collection and evaluation, and subsequent action steps. NAMD also recommends that CMS engage with states on how these reporting requirements would apply to self-directed services as they develop any corresponding sub-regulatory guidance.

HCBS Quality Measure Set

In this rule, CMS proposes to require states to report every year on a mandatory HCBS Quality Measure Set. The HCBS Quality Measure Set is the product of thoughtful collaboration with states and the selected measures are largely relevant, useful, and feasible. Overall, NAMD believes that the proposed changes to quality expectations will focus work on meaningful, outcome-based measures. We especially appreciate the inclusion of National Core Indicator (NCI) measures as 48 states and DC have used these measures for quality improvement for some time. States report that the NCI measures have been especially helpful for understanding members' and caregivers' experiences of services and supports.

NAMD also appreciates and strongly supports CMS's commitment to ensuring that all measures included in the HCBS Quality measure set "reflect an evidence-based process including testing, validation, and consensus among interested parties; are meaningful for States; [and] are feasible for State-level, program-level, or provider-level reporting as appropriate." These are the correct standards. We also appreciate that CMS emphasizes consultation with states in this process.

To strengthen this proposal, CMS should consider modifying their proposed biannual cadence for updates to the mandatory measure set. While we appreciate the anticipated need for future revisions to the brand new HCBS quality measure set, we are concerned that the biennial cadence does not allow time for real world implementation and testing to determine if a measure yields useful results. Although CMS could choose to make no updates at any given biennial, establishing these timeframes will create expectations among stakeholders and uncertainty among states. This is especially true as the process for updating appears to include re-identifying the specific measures for which reporting is mandatory and for which stratification is required. **NAMD recommends that CMS instead consider updating the measure set every five years, while retaining the right to make updates in the interim when needed.**

NAMD strongly recommends that CMS phase-in implementation of the new reporting requirements over an extended timeframe. Medicaid agencies report that the timeline contemplated by the proposed rule is not realistic or attainable, especially in the context of all of the new requirements in the proposed rule. Adopting new measures would take an almost complete retooling of their quality systems infrastructures and will cost significantly more than CMS's estimate. To ensure effective implementation, CMS should find a way to provide states additional funding.

Medicaid agencies also report concerns about the proposed stratification requirements. States report long-standing challenges collecting complete demographic data on Medicaid members. They also report concerns around sample size requirements for complete stratification and corresponding concerns around staff capacity, survey fatigue, and challenges identifying baseline demographics. **NAMD appreciates CMS's proposal to phase-in stratification requirements and use imputed models to address incomplete demographic data but would encourage even longer implementation timelines, ideally an extra two years for each phase of stratification.**

Website Transparency

CMS proposes to require Medicaid agencies to operate websites that meet certain requirements on reporting, available data, accessibility, and centralization, including new requirements to include incident management, critical incidents, person centered planning, and service provision compliance data; data on the HCBS Quality Measure Set; access data; and payment adequacy data. NAMD supports CMS's aims around member/stakeholder engagement and transparency, and acknowledges that

streamlining access to this data would be helpful. Medicaid agencies, however, report concerns over the prescriptiveness of the proposed policies.

As noted above, with respect to the payment adequacy provisions, NAMD's membership generally support consideration of expanding the reporting over time to include a broader array of services. That said, some states support exclusion of providers that have low Medicaid revenues or serve a small number of Medicaid beneficiaries.

As far as CMS's proposed procedural requirements for these websites, Medicaid agencies report that they are overly prescriptive and may create unintended consequences. For example, CMS seeks to limit how often websites redirect to other sources of information. While improving the usability of these websites is a worthy aim, Medicaid agencies are concerned that including a large volume of information on one webpage may actually decrease ease of use. This provision would also create operational challenges associated with keeping the Medicaid website updated given multiple "sources of truth" (e.g., MCO sites).

Overall, NAMD's membership has identified that meeting these requirements will necessitate:

- significant effort, resources and time, which may be especially challenging for small, resource-constrained states as well as, by contrast, states that have large, integrated web platforms of which Medicaid reporting is only one part;
- internal or vendor advice and support on complying with CMS's extensive accessibility standards, design and implementation of the new website format; and
- planning and stakeholder engagement to define the purpose of and distinguish the use of the required toll-free telephone number from the typical numbers used for eligibility and information & referral.

All of the above will affect the feasibility of CMS's proposed time frames for implementation. CMS should consider an extended timeline of five years, a phased approach for posting required metrics, and enhanced resources (i.e., 75 percent systems maintenance match), and streamlined approval processes for necessary systems work.

C. Documentation of Access to Care and Service Payment Rates

Fully Fee-for-Service States

CMS seeks comment on if they should mirror aspects of the managed care rule in applying appointment wait time standards, secret shopper survey requirements, and reporting requirements to fully fee-for-service states. NAMD opposes this proposal.

As discussed in our response to the managed care rule, Medicaid agencies have serious concerns about implementing these provisions in managed care. It is arguably simpler to implement appointment wait time standards, secret shopper surveys, and reporting in managed care than in FFS, as Medicaid agencies can write these requirements into their managed care contracts. In fully fee-for-service programs, Medicaid agencies would need to bring on additional staff and vendors to implement these provisions. FFS programs also do not have access to the enhanced match associated with capitation and managed care External Quality Review, and so would be at a financial disadvantage in comparison to managed care programs. Further, these provisions (depending on CMS's expectations for state enforcement of these requirements, particularly termination of non-compliant providers) could chill future provider participation in the program.

NAMD recognizes CMS's goal of promoting uniformity across FFS and managed care to ensure Medicaid members have a consistent experience. **However, due to the significant operational challenges with designing and implementing appointment wait time standards, secret shopper surveys, and reporting in fully FFS programs, NAMD recommends that CMS not move forward with these standards at this time.** CMS should consider providing targeted technical assistance for those FFS states that see value in adopting such strategies and aligning with managed care expectations, but we do not consider mandating these approaches as the appropriate path forward.

Payment Rate Transparency

CMS proposes to require Medicaid agencies to publish Medicaid fee schedule payment rates on their websites using a standardized format. Agencies would also be required to conduct a payment rate analysis comparing their Medicaid rates to Medicare rates for certain services and disclose average hourly payment rates for personal care, home health aides, and homemaker services.

NAMD supports the overall premise of improving public transparency of Medicaid FFS rates and enabling comparison of those rates to an identified benchmark. However, Medicaid agencies report serious concerns around both capacity and methodology.

First, Medicaid agencies are concerned about the effort, systems lift, and time needed to catalogue and publish all FFS rates. Medicaid agencies report that they would need to hire additional staff or expand their actuary contracts to implement this rule. CMS should be mindful that it can take as long as 36 months to complete the legislative process, procurement process, process to obtain position authority for hiring, and actual recruitment, hiring and training for new employees. **To reduce burden, some agencies propose that CMS instead pilot this requirement with a more limited set of E/M CPT/HCPCS codes; CMS could align this subset of codes with those proposed in the comparative payment analysis and payment rate disclosure sections.**

Medicaid agencies also express concerns around methodological challenges associated with the comparative rate analysis, specifically:

- challenges of comparability between Medicare and Medicaid, especially for services like behavioral health where coverage is significantly more extensive in Medicaid and where Medicare may not be a prominent or effective payer;
- interpretive questions about how to handle 1) individually negotiated rates; 2) bundled payments; 3) rates set via cost reports; 4) statutorily established rate methodologies; 5) supplemental payments; and 6) rates with a component tied to quality performance; and
- the significant challenges associated with stratifying data consistent with CMS's proposed requirements.

NAMD recommends that CMS consider, instead, requiring states and territories to submit their fee schedules to CMS. CMS could then conduct the required comparative rate analyses and publish the rates themselves, reducing burden on Medicaid agencies and ensuring uniformity. In taking on this analytical responsibility, CMS should offer opportunities for state input on its methodology and analytical framework to account for the many factors that inform rate development. We also note that while this step will alleviate analytic burden on states and territories, there remain some fundamental tensions in rate comparisons between Medicaid and Medicare.

In HCBS, CMS proposes to require Medicaid agencies to convene an "HCBS Interested Parties Advisory Group" to advise and consult on rates for identified FFS HCBS. Although NAMD supports CMS's intention of ensuring DCW voice in the rate setting process, Medicaid agencies express concerns over convening another distinct advisory committee. CMS helpfully clarifies that the MAC could serve this function and some Medicaid agencies indicate they would pursue this approach. However, other agencies warn that requiring a formal HCBS Interested Parties Advisory Group would duplicate existing stakeholder engagement and add burden without yielding additional insights.

If CMS finalizes the proposal as written, the proposed January 1, 2026 implementation deadline would not be feasible, given the up to two-year time frame for claims run-out and adjustment. **NAMD requests a longer implementation timeframe of at least four years and ideally five years.** Medicaid agencies also express serious concerns over CMS's proposal to withhold administrative FFP as a means of ensuring compliance with the payment rate transparency, comparative analysis, and rate disclosure requirements. States and territories rely on federal match to sustain services and withholding FFP would negatively impact access for Medicaid members.

State Analysis Procedures for Rate Reduction or Restructuring

In the rule, CMS proposes to formally rescind Access Monitoring Review Plan (AMRP) requirements and replace them with a two-tiered process to evaluate SPAs that would reduce or restructure a rate. For the first tier, CMS would require a streamlined set of

data when the SPA would result in no more than a four percent reduction in aggregate FFS expenditures for each benefit category, would result in a rate at or above 80% of the comparable Medicare rate, and when public comment does not result in significant access concerns. If the rate reduction does not meet the three criteria described above, states would be required to submit additional data.

NAMD supports the proposed rescission of AMRP requirements. Since this framework was finalized, [NAMD has noted challenges with AMRPs](#) and the significant administrative burden they place on states. NAMD also appreciates CMS's expressed commitment to achieving the right balance between its interest in understanding the potential implications of reduction or restructuring of Medicaid rates on member access and administrative burdens at the state level.

NAMD is concerned, however, that the proposed two-tiered process for rate reductions would pose significant challenges to Medicaid agencies and limit their capacity to timely and flexibly respond to changed program needs and/or legislative mandates for Medicaid cost savings. This is an important example of the need for attention to an appropriate calibration of the level of oversight and regulation that is embedded within the federal-state/territory partnership under which Medicaid operates. In brief, this policy does not feel like the appropriate balance of federal and state/territory interests.

Unlike the federal government, almost every state and territory has balanced budget requirements. This means that, during times of economic contraction, Medicaid agencies are often asked to cut expenditures quickly. Medicaid agencies have a [limited number of levers to reduce spend](#): they can cut eligibility groups, reduce benefits, or lower rates. CMS should seriously consider the access implications if its regulations make it more difficult to reduce or restructure rates during lean budget cycles. If Medicaid agencies do not have the option to reduce rates, they may be forced to cut benefits or eligibility groups to comply with legislative mandates.

More specifically, Medicaid agencies express the following concerns about the three criteria used to determine the level of review:

- For the second criteria, Medicare may not be the right basis of comparison as it is not a significant payor of certain Medicaid-covered services (e.g., behavioral health) and serves a significantly different population. We also recognize that, while imperfect as a point of comparison, Medicare is at least a reliable source of data that utilizes cost studies and other factors in its own rate setting processes. If Medicare is retained as the benchmark, Medicaid agencies endorse use of an aggregate, as opposed to code-by-code, comparison with Medicaid rates. A code-by-code analysis would be extremely difficult as CMS would need to define a methodology to determine if there is a one-to-one match between service descriptions and procedural codes in Medicare and Medicaid; Medicaid agencies report significant variation in codes and service descriptions.

- Medicaid agencies have significant concerns over the third strand of the analysis. Rate reductions are almost always opposed by affected providers, who have strong incentive to and will allege access concerns during the public comment process. In practice, this means that agencies will almost always have to go through the more intensive, second-tier process. Collecting the data required for this second tier will be time-intensive and costly. **If CMS finalizes this provision, NAMD strongly encourages CMS to remove the third criteria from the threshold analysis.**

Further, NAMD recommends that CMS adopt a streamlined review for a) reductions necessary to implement CMS Federal Medicaid payment requirements; b) reductions that will be implemented as a decrease to all codes within a service category or targeted to certain codes, but for services where the payment rates continue to be at or above Medicare and/or average commercial rates; and c) reductions that result from changes implemented through the Medicare program, where a Medicaid agency's service payment methodology adheres to the Medicare methodology. Additionally, CMS should adopt a streamlined review for scenarios in which rate adjustments reflect adoption of withholds in value-based payment arrangements, as opposed to reductions.

Conclusion

We appreciate CMS's consideration of state and territory perspectives on these important issues. NAMD and our members look forward to continued collaboration with our federal partners to ensure Medicaid members have access to high-quality care. We encourage CMS to pursue policy interventions that meaningfully improve access, acknowledge the on-the-ground realities of Medicaid agency administrative capacity and systems, and can be flexibly tailored to local contexts.

Sincerely,

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