



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, [Medicaid and CHIP Managed Care Access, Finance, and Quality \[CMS-2439-P\]](#).

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, implementation timelines, and 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

1. Access

Enrollee Experience Surveys

In this rule, CMS proposes to require states and territories to conduct an annual enrollee experience survey for Medicaid managed care entities. **In general, NAMD supports this proposal.** Medicaid agencies report that enrollee experience surveys are a valuable tool to inform program administration and assess access challenges. Many Medicaid agencies already administer annual experience surveys (e.g., CAHPS, NCI-AD, and NCI) as part of their broader strategies to monitor access, though agencies acknowledge that these instruments may not be individually representative of all demographic groups.

NAMD recommends that CMS give states and territories discretion to choose the specific survey instrument used. Some agencies have tailored their enrollee experience surveys to their local contexts and managed care markets. For example, one state reports using the Mental Health Statistical Improvement Program survey for their behavioral health MCOs to align with SAMHSA reporting. Additionally, if CMS requires agencies to change their current survey to align with a uniform standard, states and territories may lose valuable longitudinal data to track access and quality improvement efforts over time. Finally, Medicaid agencies report additional administrative burden (e.g., staff training) associated with implementing a new enrollee experience survey. Instead of mandating a specific instrument, CMS should offer technical assistance to interested Medicaid agencies.

NAMD also recommends that CMS give states discretion to tailor their enrollee experience by populations. One state notes that they alternate child and adult surveys by year to avoid parents potentially receiving two surveys in one year. Allowing states to tailor their annual survey by population will help address local factors and prevent survey fatigue. States also request clarification on exemptions for states with small percentages of enrollees in managed care; what definition would CMS use for this exemption?

CMS proposes an implementation deadline of the first rating period on or after three years following the final rule effective date. Medicaid agencies believe this timeline is feasible. Medicaid agencies would be required to evaluate the enrollee experience data as part of their Managed Care Program Annual Reports; agencies recommend adding this into the MCPAR template.

CMS proposes to require Medicaid agencies to use the existing CHIP CAHPS survey data to evaluate network adequacy in CHIP. Agencies would be required to post comparative summary results of CHIP CAHPS surveys by plan on their website annually. NAMD recommends extending the implementation deadline for posting CHIP survey results and comparative summaries on websites. Some states with combined

Medicaid and CHIP programs aggregate Medicaid and CHIP-enrolled children in their data; disaggregating this data would take more lead time and have limited return on investment.

Appointment Wait Time Standards

In this rule, CMS proposes establishing maximum appointment wait times for routine appointments for outpatient mental health and substance use providers, OB/GYN providers, and primary care. States would also establish a wait time standard for a fourth provider type, as identified by the state. Medicaid agencies agree with CMS that long appointment wait times create access challenges for members but have serious concerns about CMS's proposal.

Medicaid agencies are deeply concerned that CMS's proposed maximum wait times – 10 days for behavioral health, 15 days for primary care, and 15 days for OB/GYN – are not realistic. Long appointment wait times are a common challenge across Medicaid, Medicare, and private insurance. A [2022 secret shopper survey from AMN/Merritt Hawkins](#) of appointment wait times in major metropolitan areas found an average wait time of 31.4 days for OB/GYN services and 20.6 days for family medicine across insurers. The [National Council for Mental Wellbeing estimates](#) the average wait time for behavioral health services is 48 days nationally, and a [2015 secret shopper survey](#) found a median wait time for adolescent psychiatry appointments of 50 days, with average wait times of up to 75.1 days in some regions.

These findings are mirrored in Medicaid agencies' experiences implementing appointment wait time standards in managed care. [The majority of states currently include wait time standards in their managed care contracts](#), although the maximum wait times vary significantly across programs, provider types, and appointment types (e.g., routine vs. urgent). One state reports that their MCOs currently struggle to meet a 45-day limit for routine services, and that meeting appointment wait time standards is particularly challenging in rural and frontier regions and health professional shortage areas.

[Researchers commonly cite](#) provider shortages and maldistribution as important drivers of long appointment wait times. These shortages were exacerbated by the impacts of the pandemic on providers, increased demand for behavioral health services, and an aging population. Appointment wait time standards fail to address these underlying causes of long wait times. CMS should work with the Health Resources and Services Administration and other federal entities to strengthen provider workforces, address maldistribution issues, and encourage providers to use [open-access scheduling and other evidence-based strategies](#) to reduce wait times.

More fundamentally, Medicaid Directors are concerned that, if finalized, CMS's proposed maximum appointment wait time standards will lead to unintended consequences. If MCOs routinely cannot meet appointment wait time standards,

Medicaid agencies may need to implement a large number of remedy plans, leading to intense administrative burden on both agencies and plans. Additionally, if data shows that Medicaid MCOs struggle to meet wait time standards that are unrealistic for any payer – *without showing average wait times for these other payers* – it could drive an inaccurate narrative that Medicaid coverage is inferior. This perception contributes to the stigmatization of the program and may [reduce enrollment in the program](#) and [utilization of services](#), thus reducing access.

CMS cites alignment with the Plan Year 2024 appointment wait time standards for Qualified Health Plans (QHPs) as a reason for the specific maximum wait times. However, given that these wait times are not in effect until 2024, it is currently unclear if QHPs will be able to meet these standards. **Given the lack of data on feasibility of these provisions, NAMD strongly recommends that CMS not finalize the proposed appointment wait time standards at this time.**

Instead, CMS could consider:

- Conducting studies to assess current wait times in Medicaid and other payers. Wait time standards should be based off data and CMS should set access goals that are achievable.
- Allowing Medicaid agencies to define their own appointment wait time standards based off local data and conditions.
- Aligning with the significantly longer appointment wait time standards in Medicare Advantage (30-45 days).
- Phasing in appointment wait time standards over time (either by phasing down the maximum number of days or phasing up the percent of appointments that must be compliant).

If CMS does move forward with this provision, CMS should consider:

- Creating an exception process for rural and frontier regions and healthcare workforce shortage areas. As noted above, many states do not think that these wait times will be met 90 percent of the time in many parts of their state.
- Providing guidance and flexibility on the definition of “routine” as many states have their own definitions in managed care contracts.
- Providing technical assistance on how states should identify the fourth provider type.
- Phasing in the appointment standards over time, starting with two categories and introducing others in subsequent years to allow time for states and plans to familiarize themselves with CMS’s expectations and implement strategies to meet them.

CMS seeks comment on how telehealth should be treated when determining compliance with appointment wait time standards. **Instead of CMS’s proposal, which would only count telehealth availability towards compliance if the provider also**

offers in-person appointments, NAMD supports using the Medicare Advantage approach, which gives plans a ten-percentage point credit if the plan has telehealth appointment availability for the applicable provider type. Medicaid agencies note that, for some members, telehealth is the preferred service delivery model and should be credited appropriately alongside in-person appointments.

Secret Shopper Surveys

In this rule, CMS proposes to require Medicaid agencies to use secret shopper surveys as part of their monitoring activities. States/territories would be required to use independent entities to conduct annual secret shopper surveys of managed care plans to 1) monitor compliance with proposed appointment wait time standards and 2) assess the accuracy of provider directory data.

Medicaid agencies report mixed experiences using secret shopper surveys. Although some states report that secret shopper surveys return useful data, other states have abandoned the use of these surveys due to low utility of data. Additionally, some states note that secret shopper surveys are much better at identifying provider directory errors than measuring appointment wait times. Overall, Medicaid agencies agree that while secret shopper surveys are one important tool to measure access, they should be administered at the discretion of Medicaid agencies and not mandated.

Medicaid agencies report that secret shopper surveys can disadvantage smaller plans. Because smaller, local plans have less name recognition than larger, national brands, provider office staff may incorrectly say the provider is not in-network. Additionally, Medicaid agencies note that secret shopper surveys inherently measure access at a single point in time, among a sample of providers. Agencies report that they have found more success with multimodal approaches to measure access, such as using claims data analysis to identify Medicaid-enrolled providers who are not actually billing Medicaid, looking at the number of hours authorized vs. received under a care plan, using larger practices' and/or health systems' centralized scheduling and appointment systems to assess appointment availability and how it changes over time, and direct feedback from members.

NAMD is concerned that CMS is requiring Medicaid agencies to use one tool that may not be the best fit for all local contexts. **Instead of finalizing mandatory use of secret shopper surveys, CMS should engage further with Medicaid agencies to inform a thoughtful, multi-modal managed care access framework.** The collaboration that produced the 2017 network adequacy toolkit can serve as a model for this process.

Medicaid agencies who do not currently use secret shopper surveys would appreciate technical assistance on survey design and implementation, including on methods of data collection, strategies in survey question design to ensure accuracy, and how to generate fake Medicaid ID numbers. States note particular challenges with how to

identify the secret shopper; providers will often refuse to offer an appointment time if the name of the “Medicaid member” is not in their system as an enrollee, and some states’ systems are not capable of generating fake Medicaid ID numbers. Agencies appreciate that they can leverage EQRO for elements of these surveys, as this will relieve fiscal burden.

In the rule, CMS proposes timelines for communicating errors in provider directories identified via secret shopper. Medicaid agencies must receive information on provider directory errors identified by the secret shopper surveys no later than three business days from the date the independent entity identifies the error. Agencies must then send this data to the applicable managed care plan within three business days of receipt. Some Medicaid agencies report concerns that this timeline is not feasible, and that **CMS should allow seven days for states to report errors to managed care plans.**

CMS proposes a compliance date for these provisions of no later than the first rating period on or after three years following the effective date of the final rule. Medicaid agencies report that this is feasible.

Payment Analysis & Reporting

In this rule, CMS proposes to require managed care plans to submit an annual payment analysis to their Medicaid agency including: 1) payment and comparisons to Medicare rates for primary care, OB/GYN, and outpatient behavioral health services; and 2) payment and fee-for-service comparisons for homemaker services, home health aides, and personal care services. Although Medicaid agencies support CMS’s aim of transparency, they report concerns over the utility of the data and the operational lift associated with implementing this provision.

First, Medicaid agencies report concerns over whether Medicare is an appropriate benchmark. Medicare and Medicaid serve very different populations; this may be most relevant for OB/GYN rate comparisons, as the majority of Medicare members are past childbearing age. Medicaid also covers a more expansive set of behavioral health services than Medicare. This can make comparisons to Medicare operationally challenging, as discussed below, and of questionable meaningfulness.

Second, Medicaid Directors raise concerns about the usefulness of this data. Several states report that they have good line of sight into managed care rates and profitability but less data on other provider types, including hospitals and long-term care providers. Another state reports skepticism that the partial comparative analysis against Medicare rates will provide meaningful insights. Medicaid agencies also report concerns over uniformity of data; because codes can vary across MCOs and states or the underlying benefit designs differ, it may be difficult to draw meaningful national comparisons. CMS should consider developing clear guidelines on how to conduct these comparisons to inform this work.

Finally, Medicaid agencies express concerns around operationalizing this proposal. MCOs use different codes for similar services and some codes may not be on the Medicare or Medicaid FFS fee schedule. These different coding methodologies can result in very different estimates of payments, based on how codes are cross-walked. Agencies report that, to properly implement this provision, they would need to be much more involved in indicating which codes MCOs should include in their analyses. This would necessitate using actuarial contractors to evaluate past encounter data to define which codes would need to be reported by each MCO.

To address these challenges, NAMD recommends that CMS pilot MCO rate reporting and comparisons with a small subset of E/M CPT and HCPCS codes. This would allow CMS to address key implementation challenges before requiring national reporting on the broader subset of codes.

If CMS does move forward with these provisions as written, Medicaid agencies would need substantial technical assistance with identifying specific codes for MCO reporting and establishing systems for data collection. CMS's proposal to incorporate this reporting into existing reporting frameworks like MCPAR is appreciated, although some agencies report challenges with the usability of MCPAR. CMS should also provide extended implementation time. **At minimum, CMS should provide at least two years following the release of any relevant sub-regulatory guidance for compliance.**

As discussed in NAMD's comments on the proposed access rule, we strongly recommend against applying similar requirements to fully FFS Medicaid programs.

Remedy Plans

CMS proposes a "remedy plan" framework with the goal of strengthening states' monitoring of access requirements in managed care. Medicaid agencies have serious concerns about this proposal, including on the overall policy direction and on implementation. **NAMD strongly recommends that CMS not finalize this provision.**

Managed care contracts – including contractual requirements related to access and network adequacy – are managed by Medicaid agencies. Medicaid agencies report using a wide range of strategies to ensure MCOs comply with contractual requirements, including corrective action plans, performance improvement plans, monetary damages, and other intermediate sanctions. If provisions in the rule (like appointment wait time standards and secret shopper surveys) are finalized, Medicaid agencies would work these requirements into their contracts and use these existing strategies to ensure compliance. **Medicaid agencies do not think it is the appropriate division of state and federal responsibility to have CMS prescribe contract oversight processes.**

Medicaid agencies are also concerned about specific operational details of the remedy plan proposal. First, agencies note that **the proposal is vague on what access issues would merit a remedy plan.** The rule states that remedy plans would be used to

enforce the proposed appointment wait time standards, secret shopper survey, and provider directory provisions, along with any time the Medicaid agency, plan, or CMS identifies an area in which a plan's performance "under the access standards... could be improved." To properly evaluate this proposal, CMS would need to provide additional detail on what access issues would rise to the level of needing a remedy plan. Medicaid agencies also request clarification on how, and within what timelines, MCOs and CMS would be expected to report access issues to the agency.

As discussed above and in light of workforce constraints extending well beyond the Medicaid program, Medicaid agencies have serious concerns about the ability of their managed care plans to meet the proposed appointment wait time standards. If this rule is finalized, **Medicaid agencies would expect to complete a very high number of remedy plans which would generate substantial administrative burden, likely without driving meaningful improvements in access.** Again, because agencies already leverage corrective action plans, sanctions, liquidated damages, and other enforcement mechanisms with managed care plans, this effort would create significant administrative burden with unclear benefits.

Medicaid agencies also express serious concerns over the proposed 12-month timeline for remedy plans. Not every (or arguably, most) access challenge can be effectively addressed within 12 months. Medicaid agencies also report concerns that the strategies referenced by CMS – increasing rates, conducting more provider outreach, lowering credentialing barriers, and addressing prior authorization issues – are often: 1) inadequate to resolve access challenges that result from provider shortages; and 2) not under the control of the Medicaid agency or MCO. Addressing scope-of-practice and credentialing barriers, for example, often requires action by the state licensing agency and/or state legislature. Medicaid agencies also note that, under the state-directed payment provisions proposed in this rule, neither CMS nor Medicaid agencies would have the authority to require MCOs to modify their reimbursement rates on access-related considerations alone.

States report that provider shortages are at the root of many of their access challenges. Medicaid agencies and MCOs cannot create more providers or force existing providers to accept Medicaid patients. Given these dynamics, **it is inappropriate for CMS to disallow FFP based off failure to adequately conform with a remedy plan.** Enforcement discretion should be left with states, who have the best understanding of what is achievable for managed care plans within their unique local markets.

Website Transparency

Most Medicaid agencies do not foresee challenges in meeting CMS's requirements around website transparency. However, there are some minor concerns with general website redesign and administrative burden associated with developing a chat feature. States also report that providing multilingual content "in each prevalent non-English

language” would be challenging and costly, dependent on the number of languages that could be considered “prevalent” in the state; for example, one state reports recently translating their materials into 20 languages. CMS should provide guidance on resources available to support this function. Lastly, some of the documents and reports CMS proposes to be published on the website, such as MLR reports and rate comparisons, are highly technical and it will be challenging to ensure this information is presented in a manner that is understandable to a layperson.

2. State Directed Payments

State Directed Payments (SDPs) are an essential lever for Medicaid agencies to advance quality, access, and value-based payment in managed care. Further, many states with managed care delivery systems report that SDPs are their *primary mechanism* to address access concerns. Medicaid leaders share CMS’s desire to ensure that all SDPs meaningfully advance these goals, that there are appropriate fiscal and program integrity guardrails in place, and that state/territory and federal taxpayer dollars are used effectively.

While there are some SDP proposals that Medicaid agencies support, on the whole, we believe this section of the proposed rule places undue administrative and reporting burden on our members. This will increase administrative costs for Medicaid agencies and the federal government, especially for contracted actuarial services. In addition, the cumulative burden of the proposed requirements may discourage states and territories from using SDPs to advance access, quality, and value-based payment objectives. We are particularly concerned about approval delays that could result from these proposals impacting cash flow for critical safety net providers.

To address these overarching concerns, **CMS should create a two-tiered structure for SDPs, minimizing reporting on low-risk arrangements that are clearly linked to existing fee schedules and applying more oversight and reporting to higher risk or more novel arrangements.** It is particularly troubling that CMS appears to apply the same regulatory framework to most SDPs, despite the fact that not all SDPs present the same level of risk to the federal government. A two-tiered structure would alleviate the administrative burden on Medicaid agencies and allow CMS to focus its limited oversight resources on those arrangements that potentially pose greater risk to the federal government.

In addition to this overarching proposal for a two-tiered structure, we have identified specific recommendations on this section of the rule. These comments are as follows.

Medicaid leaders support proposed changes that would provide more state flexibility around the use of SDPs. This includes:

- Permitting SDPs for non-network providers.

- CMS could further enhance the utility of this option by permitting SDP constructs that reward in-network providers with higher payments.
- Providing additional flexibility for SDPs to advance value-based purchasing, such as removing the prohibition on recouping unspent funds.
- Exempting from the pre-print process SDPs that set the fee schedule at 100 percent of Medicare.
 - CMS should clarify whether SDP methodologies that rely on calculating a uniform percentage increase tied to Medicare rates can take advantage of this pre-print exemption. NAMD believes it would be appropriate to do so.
- Allowing agencies to have up to 90 days before the end of the rating period to submit the pre-print, rather than having to submit before the rating period begins.
- Clarification that broad contract requirements that direct plans to move a set percent of provider payments into value-based arrangements do not trigger SDP provisions. **NAMD encourages CMS to consider formally including this clarification in the regulation.**

Regulatory Limit on SDPs

We urge CMS not to cap SDPs as a share of program costs. Capping SDPs as a percentage of total program costs, such as 1.5 percent or 2.5 percent, would severely limit Medicaid agencies' ability to advance access, quality, and value-based purchasing goals through managed care. For example, it could take away a key tool for agencies to ensure network adequacy standards are met by cutting off the ability to direct MCOs to raise rates to the level required to ensure network adequacy and access. Any limit would be arbitrary and would prevent new provider types from being included in these arrangements in the future. For example, agencies that are at or near the global limit for SDPs with current provider types (e.g., hospitals and nursing facilities) would not be able to advance new SDPs with other providers, like behavioral health or HCBS providers. Advancing access, quality, and value-based purchasing are going to be critically important for these additional provider types ongoing, and CMS should not discourage Medicaid agencies from using SDPs as a mechanism to meet these goals.

States and territories are comfortable with the proposed regulatory limit of the Average Commercial Rate (ACR) with a few recommended changes. ACR is preferable to an overall cap on SDPs as a percentage of program costs. It is also preferable to setting Medicare as the limit. ACR better balances the goals of sustainability of the Medicaid program while preserving the ability to use financial mechanisms to enhance access in the four provider types. However, we recommend the following amendments to make this policy more feasible and appropriate to implement:

- **The ACR regulatory limit should only apply to inpatient, outpatient, and qualified practitioner services at academic medical centers.** Medicaid leaders agree with CMS's decision not to apply ACR to other provider types where commercial rate is not appropriate comparison. As CMS notes in the

proposed rule, commercial insurance and Medicare do not provide the same scope of behavioral health services, for example, as Medicaid. However, CMS has identified nursing facilities as subject to ACR analysis. Medicaid is the primary payer for nursing facilities, not commercial insurance. In addition, Medicare is not a reasonable benchmark for nursing facilities since Medicare adopted the Patient-Driven Payment Model reimbursement methodology, as CMS acknowledged in [SMD #22-005](#). As such, we suggest removing nursing facilities from the ACR limit.

- **Provide technical assistance to Medicaid agencies for developing ACR analyses.** Medicaid agency leaders are unclear on whether data in national hospital databases are collected in such a way to clearly identify non-Medicaid covered services in commercial payments or third party liability (TPL) amounts. In addition, agencies are unclear on how ACR requirements could be met using Medicare cost reports or through additional data sources. CMS could support states and territories in meeting the objectives of this section and ensure efficiencies in administrative processes by providing technical assistance and training for agency finance staff.
- **Allow Medicaid agencies to increase the ACR level between demonstrations to account for inflation.** Allowing for three years between ACR demonstrations is a welcome proposal to reduce state/territory burden. However, while the ACR is static between demonstrations, medical trends are not. CMS should allow Medicaid agencies to account for medical inflation within their jurisdictions in their ACR over the three-year period without redoing the ACR demonstration.

CMS should exempt SDPs that set a minimum fee schedule between the Medicaid FFS fee schedule and 105% of Medicare from the pre-print process, and consider alternative bases of comparison when SDPs are targeting provider types not represented in Medicare. Medicaid leaders support CMS's proposal to exempt SDPs that set a minimum fee schedule at 100% of Medicare from the pre-print process. We believe that CMS's policy rationale (that the Medicaid and Medicare fee schedules have been approved through a separate process) should be extended further. Medicaid agencies commonly use minimum fee schedules based on percentages of Medicare. By definition, these payment arrangements cannot pose more risk than payment arrangements based on 100 percent of Medicare rates. Exempting minimum fee schedules based on percentages of Medicare payment rates from prior approval will reduce administrative burden for both Medicaid agencies and CMS, allow agencies to set a meaningful "floor" for payment for certain types of providers in order to support access, and allow CMS to focus its limited oversight resources on payment arrangements that pose more significant levels of risk. In addition, we encourage CMS to provide an upper bound to this pathway at 105 percent of Medicare, which may include incentive arrangements. Any arrangements within that bound should also be exempt from the pre-print process.

Interim Payments

Medicaid agencies should continue to have the option to make interim payments in SDPs based on historical utilization – or at a minimum, interim payments based on current contract period utilization. Interim payments, which are reconciled to actual utilization, are an important vehicle through which SDPs can be made to providers. Interim payments can be important to mitigate cash flow challenges that safety-net providers often face, given their thin operating margins. Medicaid leaders understand CMS’s desire to ensure these arrangements do not undercut the value of prospective risk-based capitation payments to plans. However, we believe CMS can still protect that goal without eliminating the use of interim payments altogether. At a minimum, CMS should at least permit the Medicaid agency to make interim payments based on current contract period utilization and reconcile to actual utilization as the contract year progresses.

Including SDPs in Contracts

CMS should allow Medicaid agencies to include SDPs in contracts by making formal reference to approved SDP pre-prints. Medicaid leaders acknowledge the importance of ensuring that MCOs have enough detail to implement SDPs correctly. However, we are concerned that the proposed rule eliminates the option to make reference to approved 438.6(c) arrangements in the contract. CMS’s proposal, which would require all details about SDPs to be included in the contract, would increase the administrative burden on states/territories and CMS. In particular, it would require contract amendments to be made whenever a pre-print is approved, or it would delay contract approvals if the SDP has not been approved prior to the contract review. This would increase the burden on Medicaid agency staff and CMS. It is also duplicative of the review and approval that CMS will be doing of the pre-print.

Separate Payment Terms

CMS should continue to permit states/territories to use separate payment terms for SDPs. This is an important flexibility that ensures Medicaid agencies can use SDPs to increase access, improve quality, and advance value-based payment. Separate payment terms can afford greater flexibility and less administrative burden, which can ensure payments are made quickly. One state notes they often use separate payment terms for rural providers and Critical Access Hospitals. Another state notes that they use separate payment terms for pools of funds from their state legislature that are set aside for certain goals; without the ability to use separate payment terms, they would need to seek additional legislative approval to draw down these funds.

Medicaid agencies also note that requiring SDPs to be included in capitation rates instead of separate payment terms puts states and CMS at greater financial risk if program enrollment is greater than projected. This financial risk extends to providers; if utilization is lower than projected, providers are at risk for underpayments. Allowing Medicaid agencies to include SDPs in separate payment terms helps promote fiscal

stability, especially in times when program enrollment or service utilization is significantly different than anticipated (e.g., a pandemic or recession).

In addition, CMS should not limit the use of separate payment terms to VBP-related SDPs. There are other times when it is most appropriate and effective to use separate payment terms outside of a VBP context.

SDPs for Value-Based Payment

NAMD is broadly supportive of CMS's proposals to streamline the use of SDPs to achieve VBP goals. CMS should ensure policies around VBP SDPs provide enough flexibility so that Medicaid agencies can meaningfully use this lever for a variety of populations and provider types. Specifically, there are a few areas where agencies urge caution and/or additional clarification around CMS's proposals for SDPs for VBP.

- **The requirement that Medicaid agencies use only metrics for which baseline data is available.** The requirement at 438.6(c)(2)(vi)(4) appears to require agencies to only use metrics for which baseline information is available. This may not be possible for some services for which the measure for the payment strategy isn't currently collected.
- **Operationalizing condition-specific or population-based payments.** CMS notes that the condition-specific or population-based payments would replace the contractor negotiated rate. However, it is unclear if CMS would require these payments to always represent a fee or APM-based service payment. CMS should also provide guidance on how to include actual cost of services in capitation rate setting in scenarios where a plan pays providers a prospective sub-capitation payment without subsequent reconciliation.
- **Additional reporting burden.** CMS should ensure that any reporting requirements, including around SDPs that advance VBP, could be met through the broader reporting at 438.6(c)(4). Any additional reporting around SDPs that advance VBP would disincentivize Medicaid agencies from using this important tool to transform payment and care delivery.
- **Ensure that SDPs to advance VBP can be used for dually eligible individuals.** CMS should ensure that the SDP requirements for VBP take into account shared or coordinated VBP for the dual eligible population through aligned D-SNPs.

SDP Evaluation

CMS should permit an access measure to be the sole performance objective of an SDP. The proposed rule would require SDP evaluation plans to advance both access and at least one other performance measure. This runs counter to CMS's goal in the proposed rule of advancing access as a primary objective. We believe CMS should permit SDPs for which improving access is the primary and sole objective.

The threshold for SDP evaluation should be higher and should be data-informed.

Medicaid agencies are concerned about the administrative burden the proposed 1.5 percent threshold for evaluation would create. The administrative burden of the proposed evaluation requirements could discourage agencies from using SDPs to advance quality, access, and value-based payment goals. In particular, the proposed policy is not sufficiently tailored to focus evaluation on those arrangements that are novel or present greater risk to the federal government. We encourage CMS to consider a higher threshold for evaluation that is informed by analysis of current SDPs that are most novel or present the most risk to the federal government.

CMS’s proposal to consider SDP performance in the approval process will disincentivize Medicaid agencies from using SDPs to drive meaningful quality and access initiatives. We share CMS’s desire to ensure SDPs advance quality, access, and value-based payment goals. But the proposed evaluation requirements are likely to disincentivize Medicaid agencies from using SDPs to drive meaningful performance improvement for the reasons outlined below. CMS should work with NAMD to develop a more feasible system for taking performance into account when considering whether to approve or disapprove SDP arrangements.

- Under the language proposed for 42 CFR § 438.6(c)(2)(ii)(F), it appears that CMS intends to disapprove (or at least give itself the authority to disapprove) any SDP arrangement that fails to produce an improvement in the stated measure in any individual year. CMS proposes that all SDPs must result in achieving the goals and objectives outlined in the evaluation plan during the period of the pre-print approval. Clinical quality improvement initiatives are complex and often not linear; it is common for outcome measures to fluctuate from year to year, even as trends improve over time. This is likely to disincentivize Medicaid agencies from setting meaningful performance targets.
- The requirement that at least one measure must always demonstrate improvement jeopardizes even successful performance improvement initiatives. Under the proposed rule, a performance improvement initiative would be discontinued if it does not continue to exhibit indefinite year-over-year improvement. Such an approach is counterproductive and does not align with how clinical quality improvement initiatives function.
- CMS proposes to look at each managed care plan separately for SDP performance evaluation. This is extremely problematic for Medicaid agencies that carve out certain services, such as behavioral health, even though the overall benefits provided are the same. This is likely to disincentivize programs from using SDPs to advance quality improvement and access in behavioral health or LTSS delivered in a carve-out environment.
- CMS’s proposed evaluation requirements appear to operate on multi-year timelines. While this aligns with approved multi-year SDPs, it is unclear how they would be operationalized for SDP arrangements that are approved annually and subsequently renewed with potential modifications. Technical assistance will be

necessary to clarify expectations here. It is unclear how CMS would operationalize the evaluation requirement.

Medicaid leaders appreciate the option to use EQROs for SDP evaluation, and would appreciate the additional flexibility of being able to conduct the evaluation themselves. EQROs are ideally positioned to support the work of SDP evaluation, and most agencies are likely to adopt this approach. The enhanced federal match for EQROs helps to facilitate these activities and it is operationally straightforward to integrate these activities into the current contractual arrangement with EQROs. While most programs would leverage their EQROs, it would be helpful for agencies to have the option to conduct the evaluation internally, if they choose. If an agency chooses to leverage their EQRO, CMS should **not** require a new competitive procurement to amend the scope of an EQRO contract or other contract vehicle that complies with state procurement requirements.

SDP Financing

NAMD is concerned with CMS's views on states' obligations to identify indirect hold harmless arrangements among providers and recommends against creating new oversight obligations for Medicaid agencies on these matters. Medicaid leaders share CMS's desire to ensure all SDPs are financed by legitimate sources of the state share. However, CMS takes a new expansive policy position in the NPRM by postulating that indirect arrangements between two providers can violate the "hold harmless" prohibition. This definition is ambiguous, and it fails to recognize the limits of a Medicaid agency's authority. Broadly speaking, states do not have the authority to access general ledgers of hospital systems to identify indirect arrangements that may exist, nor do states have the internal capacity to assess such information and identify these arrangements. Further, it is not uncommon for one hospital to own a minority ownership stake in another hospital and for funds to flow between these providers, or for two or more providers to have agreements in place to contract for services at a rate that is above market value. Medicaid does not have authority to oversee these types of arrangements between private providers. Due to these realities, CMS should revisit its proposed policy and only apply the harmless prohibition to direct arrangements between providers. **NAMD believes that to the extent CMS wishes to conduct oversight on indirect arrangements among providers, it should do so itself and not impose an unrealistic obligation on states.**

CMS should clarify its expectations for Medicaid agency enforcement of hold harmless provider attestations. Under the proposed rule, it is unclear how Medicaid agencies would proceed if one or more providers participating in a provider tax and SDP refuse to submit an attestation. Medicaid leaders would need clarity on whether this would put the whole SDP at risk, or if agencies and their contracted plans could withhold the SDP from those targeted providers. Further, it is important to ensure that providers who refuse to sign the attestation are not able to avoid the tax but still benefit

from the SDP that is being financed by said tax. Policies that permit this type of provider behavior would undermine provider taxes as a core and legitimate source of state share. In addition, for certain classes of providers (e.g., ambulance providers), the administrative lift of gathering provider attestations will be significant. CMS should consider ways to facilitate and streamline Medicaid agency efforts to collect these attestations.

SDP Reporting

Medicaid leaders agree with using T-MSIS for reporting on SDPs but urge close federal/state partnership to finalize the elements and approach for this reporting.

Medicaid leaders recognize CMS's desire to increase public transparency around SDPs, and they believe that T-MSIS will provide enough information for CMS to report on SDPs. Medicaid agencies would appreciate close, collaborative engagement with CMS around the elements for T-MSIS reporting and how data elements would be captured in T-MSIS. For example, agencies have concerns about CMS's proposed plan to include enrollee identifiers or allowed amounts by plan. CMS should also clarify if this reporting requirement applies to SDPs implemented via separate payment terms.

Medicaid leaders are unsure about the value of using MLR reporting as a short-term solution. Using MLR as a short-term strategy would necessitate a notable operational lift for both CMS and Medicaid agencies. For example, CMS would need to issue timely guidance on the changes and address questions around specific calculation of the SDP percentage via MLR, including how VBP arrangements via SDP are accounted within the MLR. Then, agencies would have to operationalize these changes in their MLR reporting forms and in guidance to MCOs. Medicaid agencies have already struggled to get MCOs to follow longstanding MLR reporting guidance. These challenges and the time it will take to get accurate reporting through the MLR may mean that it is not worth it to stand up this temporary solution.

SDP Appeals

Medicaid leaders agree with the need for a pathway to appeal CMS decisions on SDPs disapprovals but would prefer the Office of Hearings and Inquiries (OHI) appeal pathway, rather than the Department Appeals Board (DAB) pathway. Some Medicaid leaders believe that the OHI appeals process (currently used for SPA disapprovals) would be preferable to the proposed DAB appeals process. This is because SDPs are more akin to SPA approvals or disapprovals than disallowance-related issues, which are typically the focus of the DAB. In addition, Medicaid agencies have found that OHI appeals are often resolved more quickly than DAB processes.

Regardless of the pathway, CMS should consider ways to promote resolution in an efficient and expedited way. This is important, given the interplay between SDPs, managed care contracts, and managed care rates. We encourage CMS to ensure it has the capacity to resolve all Medicaid agency appeals in a timely manner, whether through the OHI or DAB.

If CMS ultimately decides to use the DAB, it would be helpful for CMS to articulate the remedy CMS will permit if the DAB sides with the Medicaid agency. This is particularly important if the contract year is already over. For example, CMS could permit the approval to be retroactively allowed for the contract period that has ended.

SDP Compliance Dates

CMS should have the earliest compliance dates be the first rating period of contracts beginning on or after one year following the effective date of the rule. Medicaid leaders appreciate CMS's proposed phased approach to compliance of this section. However, we urge CMS to provide at least one year after the effective date of the rule for any proposed changes to go into effect. This will better reflect the reality that SDPs are started before the rating period, due to needing prior approval by CMS. It will also give Medicaid agencies needed time to adjust to the appeals process for workflow purposes.

Other SDP Issues

CMS should provide technical assistance and support to help Medicaid agencies meet the numerous new SDP requirements, if finalized. CMS's process for review and approval of SDPs has grown in complexity, challenging agency staff and requiring more time and resources. Some Medicaid agencies have needed to designate FTEs and, in some cases, a whole unit of staff to submit SDP documentation and reporting. CMS could help reduce the administrative burden on Medicaid agencies by providing training for fiscal, managed care, and analytics staff on how to comply with SDP reporting. CMS could provide these staff with training through a technical assistance institute, like the CMS-sponsored Medicaid Integrity Institute at the University of South Carolina. In addition, CMS could consider adopting a software solution to make it simpler for states to complete SDP reporting.

3. Medical Loss Ratio Standards

NAMD is broadly supportive of CMS's proposals to enhance the accuracy of medical loss ratio (MLR) reporting by contracted managed care plans. We agree that clarification of elements underlying the MLR calculation can address potentially inaccurate or inflationary MLR calculations and produce more reliable reports. However, CMS's proposed effective date of 60 days after the publication of the rule is not sufficient to make the contract changes and conduct the legal reviews necessary to effectuate these proposals. **NAMD recommends a one-year implementation timeframe for MLR changes.**

Medicaid agencies see mixed value in CMS's proposals on accounting for SDPs in MLR reporting. Some agencies appreciate the overall approach to transparency in MLR reporting inclusive of the proposed SDP policies, while others feel that the SDP elements will complicate an already complex reporting function that plans struggle to meet. These agencies question the value of including the SDP elements, particularly

when the agency does not have a remittance requirement for plans that do not meet MLR targets. It is also unclear to some Medicaid agencies as to how the agency would report VBP arrangements that are specific to SDPs in the MLR.

Medicaid agencies offer the following suggestions to enhance MLR reporting:

- Provide a consistent definition of what constitutes quality improvement activity overhead for purposes of MLR calculations, and provide guidance for available recourse for Medicaid agencies if the plan does not or cannot break out overhead or indirect expenses.
- Allow community health worker quality improvement activities to be a permissible element of the numerator. This will incentivize managed care plans to invest in these workers to address a variety of clinical and non-clinical Medicaid member needs, including health-related social needs.
- Offer a point of view on preferred expense allocation methodologies plans should use in their MLR calculations. While the proposed rule increases the detail of what is reported on in these methodologies, it does not indicate a preference for a given methodological approach. Taking this step could promote more consistency in MLR calculations, particularly in allocation factors between MLR reporting periods or across liens of business.
- Allow a 30-day or monthly period for reporting of identified overpayments instead of the proposed 10-day period. A monthly cadence will better align with existing Medicaid agency and plan processes while still meeting goals around routine reporting of identified overpayments.

4. In Lieu of Services and Settings

CMS proposes to largely codify its [January 2023 guidance on managed care in lieu of services \(ILOS\)](#) into regulation. For Medicaid agencies with limited current utilization of ILOS outside of short-term stays in Institutions for Mental Diseases (which are not impacted by CMS's proposed changes), CMS's proposals would have minimal impact. However, for Medicaid agencies with significant ILOS utilization today or where future ILOS utilization is anticipated, there are significant concerns with what CMS proposes. While NAMD recognizes CMS's intention in taking this step is to promote ILOS as a pathway for addressing health-related social needs and providing consistency in ILOS documentation, reporting, and evaluation, the degree of proposed prescriptiveness in ILOS substantially departs from current practice, creates major administrative burden, and will significantly inhibit use of such services in the future.

CMS proposes that ILOS must be services otherwise coverable under the state plan or 1915(c) waivers. Medicaid agencies have mixed views on the appropriateness of this limitation. It is understandable that CMS wants appropriate guardrails in place around ILOS and there is substantial leeway under this definition to provide services such as supportive housing. However, some Medicaid agencies are concerned that this provision may inadvertently limit managed care plans' ability to innovate and provide timely, medically effective, and cost effective substitutions. Though NAMD does not

have a specific recommendation to make on this proposal, we do want to surface these views for CMS's consideration.

Of more significant concern are CMS's proposals to require that: 1) ILOS be documented in managed care contracts with specific populations identified via clinical criteria; and 2) plans utilize specific codes to track ILOS in encounter data. When the projected ILOS cost percentage exceeds 1.5 percent, more substantive documentation requirements attach (discussed further below). While these requirements would, in theory, allow more granular assessments of ILOS, embedding such a level of detail into contracts – and requiring states to proactively identify target populations for ILOS and the nature of the ILOS for the population to receive – will substantially inhibit ILOS use in the future. Medicaid agencies already have reservations about the level of documentation required in CMS's contract approval processes, which can take extensive time and are often subject to delays. CMS requiring additional ILOS documentation will likely exacerbate these difficulties.

More fundamentally, the proposed level of documentation in the contract for ILOS removes the flexibility managed care plans have to make informed judgments on medically appropriate and cost effective service substitutions for their enrollees. The ability for plans to customize ILOS to meet a specific member's needs, based on sound clinical judgement, is an enabling feature of CMS's current regulations. For example, some plans use ILOS to provide individualized services to members with complex health and social needs who are awaiting a discharge from a hospital. Under the proposed rule, a Medicaid agency would need to proactively identify the universe of potential ILOSs and embed them within a contract in order to replicate what plans can currently do today. It is difficult to envision how an agency would replicate the personalized or one-off nature of ILOSs in each plan contract, given variability in enrollee needs and the inability to foresee all potential future needs.

To address these concerns, NAMD recommends CMS consider a grandfathering approach to maintain current ILOS practice in extant contract constructs that do not substantially change from year to year. If CMS does move forward with its proposed documentation requirements, NAMD recommends only requiring documentation updates every five years when ILOSs are medically appropriate, cost effective, and not changing on an annual basis.

These challenges become even more acute under CMS's proposals for projected and final ILOS costs and the requirements that attach to these cost calculations. CMS proposes to limit ILOS to five percent of total managed care program costs and require Medicaid agencies to calculate projected ILOS costs and final ILOS costs within two years of the end of the rating period. When the projected ILOS cost percentage exceeds 1.5 percent, CMS will require extensive additional documentation from the Medicaid agency and a mandatory evaluation of all ILOS within the given contract.

While most Medicaid agencies indicate that their current managed care programs are under the proposed five percent ILOS cap, they consider this cap to be a significant deterrent to the adoption of future ILOS. CMS believes the five percent cap is appropriate given the permissible level of incentive payments in contracts under current regulations. However, ILOSs are wholly distinct from incentive payment programs. Applying such a cap will stifle innovation among Medicaid managed care programs, particularly in programs which utilize specialty plans to serve complex Medicaid populations such as those with significant behavioral health or HCBS needs. Notably, some states indicate that their specialty plans' use of ILOS is substantially above the proposed five percent cap, and application of the cap would significantly impact current Medicaid members. For example, one state notes that they would have to stop providing certain individualized HCBS services under the proposed policy. A one-size-fits-all approach to capping ILOS that is not sensitive to the nature and intent of the ILOSs within a program would have significant unintended consequences on effective strategies that are in place today.

To address these challenges, NAMD recommends that CMS not apply a cap to ILOS. However, if CMS does proceed with a cap, it should consider 1) distinguishing between ILOSs intended to provide HCBS using accepted or established clinical and cost-effectiveness standards from ILOSs to address HRSNs, and exempt the former from any cap; and 2) applying this cap in aggregate across all of a Medicaid agency's managed care programs to mitigate undue impact on specialty plans.

Finally, the documentation and evaluation requirements triggered by projected ILOS cost percentages above 1.5 percent create major disincentives for continued or expanded use of ILOS. Once this threshold is crossed, CMS's evaluation requirements would apply universally to all ILOSs within the rating period, regardless of the relative scope or scale of any one ILOS. This could lead to scenarios where Medicaid agencies would need to perform complex evaluations on small numbers of services that are not significant contributors to the overall cost percentage. Depending on the nature of these services, the cost of evaluation could exceed the cost of providing the service. **NAMD recommends that CMS consider 1) exempting services already demonstrated as medically appropriate and cost effective, such as HCBS, from the threshold calculation; 2) raising the projected ILOS cost percentage threshold for additional documentation and evaluation from 1.5 percent to three percent; 3) allow Medicaid agencies to aggregate small services up to a threshold that is appropriate for the program, as determined by the agency's actuary; and 4) applying a risk-based evaluation process, such that only ILOSs that individually comprise at least 0.1 percent of the capitation rate are subject to evaluation when the applicable projected cost threshold is exceeded in order to focus evaluative efforts on services with more significant costs.**

5. Quality Assessment and Performance Improvement Programs, State Quality Strategies, and External Quality Review

CMS proposes to require Medicaid agencies to make their managed care quality strategies available for public comment at each three-year renewal and whenever significant changes are made to the strategy, to post the results of this three-year review on their website, and to submit their revised/renewed strategy to CMS at minimum every three years. In general, Medicaid agencies agree with this proposal and believe the proposed one-year implementation deadline is feasible.

CMS discusses stratifying EQR performance measures (for EQR technical reports, under the performance measure validation activity) to monitor disparities. Although Medicaid agencies agree with CMS's goal of measuring disparities, they report ongoing challenges collecting enough demographic data to be able to accurately report measures on demographic groups. Medicaid agencies and plans would need significant time and TA to collect this data. Some states currently contractually require their plans to achieve NCQA Health Equity Accreditation; CMS should consider modifying or waiving stratification requirements when this accreditation is required by the state.

CMS proposes to change the due date for annual EQR technical reports from April 30 to December 31, so that EQR performance measurement can follow the annual HEDIS audit. If this represents additional time (i.e., if annual technical reports were due December 31, 2023 instead of April 30, 2023), Medicaid agencies are supportive of this change. However, if this change represents reduced time (i.e., if annual technical reports were due December 31, 2022 instead of April 30, 2023), Medicaid agencies oppose this change and indicate that it would be extremely challenging to complete mandatory EQR activities.

Medicaid agencies are strongly supportive of the proposed optional EQR activity in which agencies could use their EQRs to assist with certain evaluation activities related to quality, SDPs, and ILOS. This would help states and territories leverage the expertise of their EQROs and generate additional resources through the enhanced match.

CMS proposes to require that Medicaid agencies maintain at least the past five years of EQR technical reports on their websites. Medicaid agencies do not report concerns about this proposal. If CMS finalizes this provision, they should provide clarification on how agencies are expected to display this data.

6. Quality Rating Systems

In this rule, CMS proposes new requirements for Medicaid and CHIP Quality Rating Systems (MAC QRS). Medicaid agencies report some concerns over the feasibility of implementing interactive websites, CMS's proposed MAC QRS methodology, and the overall cost of the MAC QRS. CMS should consider if the MAC QRS is the best use of

limited Medicaid resources, especially in states/territories with small numbers of managed care plans or plans that do not compete for enrollees.

Mandatory Measure Set & Proposed Sub-regulatory Process

In this rule, CMS proposes an initial set of 18 mandatory measures for the MAC QRS. Although Medicaid agencies appreciate that these measures align with the Adult and Child Core Set, some states report ongoing challenges collecting this data, including specific challenges collecting supplemental data, contracting with vendors, and conducting medical records review. Medicaid agencies report that collecting the proposed LTSS measures will be particularly challenging.

In this rule, CMS proposes three standards, including six measure inclusion criteria, to evaluate whether measures should be added or removed for the mandatory measure set. Medicaid agencies generally support these standards; some agencies report interest in also including measures related to child lead screenings, preventive care for adults, and immunizations. In general, Medicaid agencies report that targeting 15-20 mandatory measures overall is reasonable. We also note that in circumstances where a measure is no longer endorsed by its primary body, it should not be included in the QRS.

Medicaid agencies report ongoing concerns around their ability to stratify measures on race, ethnicity, language, and other similar variables. States and territories will need significant time to develop their data infrastructure, along with member trust that data will not be used for discriminatory purposes. NAMD discusses these challenges in our [formal comments on CMS's Mandatory Medicaid and CHIP Core Set Reporting rule](#).

CMS proposes a sub-regulatory process to modify the mandatory measure set. Medicaid agencies support the use of a sub-regulatory process, as the rulemaking process would be far too slow to ensure the measure set is updated and believe the proposed process would allow for adequate stakeholder engagement. Medicaid agencies request, however, that the sub-regulatory process engages the existing Adult and Child Core Set workgroups. Medicaid agencies have diverging views on the proposed biennial cadence for updates; some agencies report this timeline is appropriate, while others express concern that biennial updates to the Mandatory Measure Set would impose significant administrative burden if there are large changes to the set. CMS seeks comment on if they should allow Medicaid agencies until the end of the second calendar year following mandatory measure updates to display the updated ratings; agencies support this proposal, which allow sufficient time for the policy, systems, and operational changes required for measure collection.

CMS proposes to release an annual technical resource manual. Medicaid agencies would like this manual to include data specifications, resources on data collection and validation, and free source coding materials. CMS proposes to release the manual at least five months prior to the measurement period for which the updates would apply.

States would prefer more lead time, with the technical resource manual being released at least twelve months prior to the rating period in which the changes would apply.

MAC QRS Methodology

Medicaid agencies have serious concerns over CMS's proposal to incorporate data from Medicare and fee-for-service (FFS) Medicaid when required to calculate certain measures. Medicaid agencies indicate that it can take several years to obtain Medicare encounter and claims data, which would not be feasible with the proposed timelines. Agencies also raise concerns over how they would validate Medicare Advantage data. **If CMS moves forward with this proposal, they should provide a standardized data set of Medicare quality data to Medicaid agencies, along with TA on how to use this data to calculate MAC QRS measures.** Medicaid agencies also report that they lack staffing and systems to capture quality data in their FFS programs. NAMD appreciates that CMS included an "undue burden" standard for these provisions and urges CMS to consider Medicaid agency administrative capacity and systems burden when evaluating what would qualify as an undue burden.

More broadly, Medicaid agencies have concerns with assigning ratings to plans for services for which they are not the responsible party. Because these ratings are public, plans may be held accountable by stakeholders, even if the plan is not ultimately responsible for delivering the service.

CMS seeks comment on the use of plan-level and program-level ratings, the future use of domain-level ratings, and the 500-member enrollment threshold for managed care organizations, by which states would not need to collect data from plans with less than 500 members. Medicaid agencies support the 500-member threshold and the use of by-plan and by-program ratings. Medicaid agencies are not opposed to the eventual use of domain-level ratings, although they note that too many ratings may be confusing for Medicaid members and other stakeholders. If CMS proposes domain-level ratings in future rulemaking, Medicaid agencies request additional details on the specific measures included in each domain, along with weighting criteria and other technical details.

MAC QRS Website

CMS proposes a phased approach for development of MAC QRS websites. In phase one, Medicaid agencies would need to develop a site with quality ratings (stratified by sex, race, ethnicity, and dual status) and information on or links to provider directories and formularies. In phase two, the website would need to be interactive, such that users can tailor the display and search for plans that cover specific providers and medications.

Medicaid agencies report that this website would require significant time and resources to develop. Agencies would need additional funding, staff, and contractors to implement the website as envisioned, with an especially high level of resources required for the

interactive elements. As discussed below, our members raise questions over if this is the best use of limited Medicaid resources.

If CMS does move forward with this proposal, it should consider extending the implementation deadline for phase one to five years following the effective date of the final rule, with an optional extension for Medicaid agencies who face significant barriers during implementation. For phase two, CMS should allow, at minimum, an additional three years for implementation with an optional extension. Medicaid agencies request significant technical assistance, including sample file layouts and examples of existing interactive websites in states. CMS should also work with Medicaid agencies and NAMD to help ensure vendors supporting this work operate in good faith given the common challenges to be solved in the states and territories, including encouraging the use of shared contract vehicles to support multi-state streamlined procurements of qualified sets of contractors.

In the rule, CMS proposes to require states and territories to use their existing beneficiary support systems to help Medicaid members understand how to use the MAC QRS to select a managed care plan. Medicaid agencies report that this may be helpful to members but would require additional investments in training. These training needs would be particularly acute if CMS moves forward with requirements to include provider directories and drug formularies on websites, as this content is technical and beyond the existing scope of most beneficiary support systems. CMS should consider funding to offset these costs.

Alternative QRS

In the rule, CMS seeks comment on the process for alternative QRS. Some Medicaid agencies report interest in developing an alternative QRS but would need technical assistance or guidance from CMS on minimum expectations to demonstrate substantial comparability. **Medicaid agencies report that they would need approval of their alternative QRS within the first year after the effective date of the final rule, to allow sufficient implementation time.**

Implementation Considerations

Medicaid agencies raise questions about the overall utility of the MAC QRS. In comparison to Medicaid, [where most states have five or fewer comprehensive managed care plans](#), Medicare offers a wide variety of plans, with the average member being able to choose from among 39 Medicare Advantage plans in 2022. However, a [2022 study by KFF](#) found that only 29 percent of Medicare beneficiaries compared their current plan to other available plans. This finding raises questions about how many Medicaid members would utilize the MAC QRS to compare plans, and if the resources that Medicaid agencies would need to expend to implement the MAC QRS would offer a strong return on investment. **NAMD encourages CMS to consider if an interactive MAC QRS website is the best use of Medicaid resources (e.g., funds, staff time, etc.) at this time.**

If CMS moves forward with the proposal as envisioned, CMS should consider scaled expectations for states and territories with small numbers of managed care plans. [KFF's analysis of CMS's 2020 Managed Care Enrollment Summary](#) found that, of the 40 states with comprehensive MCOs, 15 states have three or fewer managed care plans and 25 states have five or fewer plans. In some states, managed care plans only serve specific regions or populations. This means that, in many states, the MAC QRS may not provide valuable information on plan comparisons, as there are not many, or any, plans to compare. **CMS should consider an exception process or scaled scope for states with a small number of managed care plans.**

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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