601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
C 202.450.8218
ahip.org

Matthew Eyles
President & Chief Executive Officer

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Ms. Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via http://www.regulations.gov

RE: Medicaid Program; Ensuring Access to Medicaid Services Proposed Rule (CMS-2442-P) — AHIP Comments

Dear Administrator Brooks-LaSure:

On behalf of AHIP, the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans, we appreciate the opportunity to provide comments and feedback on the *Medicaid Program; Ensuring Access to Medicaid Services Proposed Rule (the "Proposed FFS[1] Rule").* AHIP members provide high-quality and affordable health care coverage for more than two-thirds of people with Medicaid in partnerships with more than 40 state Medicaid programs.

Under separate cover, we have submitted detailed comments and recommendations on the *Managed Care Access, Finance, and Quality Proposed Rule CMS-2439-P (the "Proposed Managed Care Rule").* In this letter, we offer feedback on four provisions of the Proposed FFS Rule that also apply to Medicaid managed care organizations (MCO).

- **Incident Management Systems.** We agree with CMS on the importance of effective systems that identify and track critical incidents that can harm Medicaid enrollees. We are concerned about potential operational challenges and recommend that CMS consider steps like developing a technical expert panel that could help establish uniform standards and best practices that states could adopt for their systems.
- **Home and Community-Based Services (HCBS) Payment Adequacy.** We strongly support initiatives to strengthen the supply of direct care service workers. However, we urge CMS to work with states and other stakeholders to address significant practical obstacles to implementing CMS' proposal that would require states to demonstrate that at least 80 percent of all Medicaid payments for certain covered services are spent on compensation to certain direct care workers.

[1] FFS: "fee for service"

- **Reporting on HCBS Quality Measure Set.** We appreciate CMS efforts to standardize and streamline HCBS quality measures. We encourage CMS to work with states to ensure the proposal on mandatory reporting is feasible, assess options for improving response rates on survey measures, and align with measure reporting in other programs, where possible.
- **Website Transparency.** We support the goals of the proposed website transparency provisions but note that states are faced with completing many information technology initiatives to stand up the systems that would provide data for the website, and that states will need additional time.

Following are our detailed comments and recommendations on these proposals.

1. Incident management systems (§§ 441.302(a)(6), 441.464(e), 441.570(e), and 441.745(a)(1)(v)).

CMS proposes to require states to provide assurances that they operate and maintain an incident management system that identifies, investigates, reports, triages, resolves, tracks, and trends critical incidents. The proposed rule would introduce a broad definition of critical incidents to include "at a minimum: verbal, physical, sexual, psychological, or emotional abuse; neglect; exploitation including financial exploitation; misuse or unauthorized use of restrictive interventions or seclusion; a medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death; or an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect." CMS also proposes minimum standards for electronic critical incident systems and other requirements to ensure incidents are reported and investigated. States would have to comply with the requirement no later than 3 years after the effective date of the final rule for FFS delivery systems or for managed care states, the first contract rating period beginning on or after 3 years after the effective date of the final rule.

We support efforts to ensure that critical incidents that can harm Medicaid enrollees are identified and referred to appropriate authorities as necessary. While CMS notes that it seeks to further detail its standards, several important components of the proposal are unclear or will be difficult to operationalize given the range of stakeholders involved and different kinds of incidents, management systems, coordinating activities, and data sharing that can be implicated.

a. **We recommend that CMS confirm the specific programs to which the incident management requirements are intended to apply.** It is unclear whether the proposed incident management reporting requirements apply only to home and community-based services (HCBS) 1915(c) waiver programs or to other programs as well.
b. **We recommend that CMS produce internally or convene a technical expert panel (TEP) to develop a best practices playbook that will provide states, MCOs, and other stakeholders with a standardized view of the systems CMS envisions for incident management.** Given the complexities involved in meeting the new standards, additional detailed sub-regulatory guidance from CMS on the desired characteristics of incident

management systems, and the respective roles and responsibilities of stakeholders, could help states implement compliant systems in the most cost-effective way. CMS may already have the internal resources to produce such guidance, or it might consider convening an interdisciplinary TEP comprising representatives of states, MCOs, and other stakeholders to provide such guidance, perhaps in the form of a best practices playbook.

c. **We recommend that CMS require states to provide annual progress reports on their incident management system programs beginning 1 year following the effective date of the final rule with a compliance date of at least 5 years after the effective date of the final rule.** The proposed definition of critical incidents encompasses a very broad range of incidents for which state incident management systems would be accountable. Given the range of local, county, state, and federal government agencies, managed care organizations (MCO), providers, and other stakeholders that potentially would be involved in identifying and exchanging information on such incidents, we believe it will take states more time to achieve compliance than is anticipated in the proposed rule. Moreover, as noted in our comments on the Proposed Managed Care Rule, the combined scope of changes in both proposed rules will present resource challenges for states and MCOs having to work with extended, multi-year development timelines that overlap with other initiatives at the same time they are devoting significant time and resources to Medicaid redeterminations.

2. HCBS Payment Adequacy (§§ 441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi)). CMS proposes to require that states provide assurances that their HCBS payment rates are adequate to ensure a direct care workforce that is sufficient to meet the needs of enrollees and provide access to services in the amount, duration, and scope specified in the person-centered service plan. States would be required to demonstrate that at least 80 percent of all Medicaid payments (base, supplemental, and other payments) for certain covered services are spent on compensation to direct care workers providing homemaker services, home health aide services, and personal care services. Compensation would include salary, wages, and other remuneration; benefits (such as health and dental benefits, sick leave, and tuition reimbursement); and the employer share of payroll taxes for direct care workers. Direct care workers would include workers who provide nursing services, assist with activities of daily living or instrumental activities of daily living, and provide behavioral supports, employment supports, or other services to promote community integration. Requirements would apply to services delivered under FFS or managed care delivery systems. States would have to comply with the requirements beginning 4 years after the effective date of the final rule; and in the case of states with managed care delivery systems, by the first managed care plan contract rating period beginning on or after 4 years following the effective date.

Along with CMS, states, and people receiving long-term services and supports (LTSS) and HCBS, MCOs share concerns with potential shortages of direct care workers providing those services and supports. Direct care workers are essential to ensuring the ability of LTSS recipients to live with the greatest degree of independence and engage with their families and communities.

We understand and agree with CMS' goal to potentially improve and sustain the supply of direct care workers. At the same time, we note several practical concerns with implementing this requirement and offer the following recommendations:

a. **We recommend that CMS not finalize this provision until it consults with states on the most effective way to ensure compensation information is available.** While MCOs know how much they pay an agency or facility for services, they do not have visibility into how providers then pay their employees. MCOs could begin to include contract requirements that LTSS facilities and home health agencies provide information on employee payment levels, but we are concerned that such requirements may not be effective or achieve the intended results. States could compel such reporting but likely only by changing licensure laws.
b. **We recommend that CMS not finalize the HCBS payment adequacy provision without further consultation with states to address their concerns and providing detailed guidance on this issue.** Under the proposed rule, the reporting and assurances would apply only to Medicaid. Many agencies and facilities also serve Medicare and commercial-plan patients. We are concerned about potential unintended consequences from this proposal, such as providers modifying payments to their employees for non-Medicaid patients to compensate for higher rates of employee pay for Medicaid patients.
c. **We urge CMS to confer with states on the ways that people with mental health disabilities could benefit from the opportunities and protections contemplated in the NPRM to the same extent as people with other forms of disabilities.** While the HCBS payment adequacy provisions and other proposals in this NPRM clearly apply to HCBS programs, we are aware of concerns that the proposals would not apply to mental health rehabilitative services, a form of HCBS that help people with significant mental health disabilities live independently in their communities. Medicaid HCBS play a critical role in supporting people with all kinds of disabilities to maintain independence in the least restrictive settings.

3. Reporting on the Home and Community-Based Services (HCBS) Quality Measure Set § 441.311(c).

CMS proposes to require that states report every other year on the HCBS Quality Measure Set identified by the Department of Health and Human Services (HHS). States with FFS delivery systems would be required to comply 3 years following the effective date of the final rule; states using managed care delivery systems would be required to comply by the first managed care plan contract rating period beginning on or after 3 years after the effective date.

We appreciate CMS's efforts to standardize and streamline measurement while ensuring quality care for this vulnerable population. Enrollees who receive HCBS are entitled to safe and high-quality care that meets the most current evidence-based standards. A single national measurement set could streamline reporting for MCOs and increase the efficiency of states and

stakeholders in identifying, assessing, and implementing quality measures. To advance these goals, we offer the following recommendations:

a. **As CMS implements mandatory reporting for the HCBS measure set, we recommend that CMS work with MCOs and other stakeholders to ensure reporting is feasible and the response burden is minimal.** We note the HCBS Quality Measure Set includes a number of survey-based measures. While we agree with the importance of patient reported data, we urge the agency to be cognizant of the response burden on participants.
b. **We also recommend that CMS work with stakeholders to ensure enrollees without an available advocate can effectively respond.** We note that survey response rates have been declining across markets and recommend CMS work with measure developers, MCOs, and other stakeholders to streamline these measures to encourage higher response rates. For example, the surveys should be fielded in a way that people with intellectual disabilities, limited health literacy, or limited English proficiency can effectively respond.
c. **CMS should also consider ways to align the measures in the HCBS Quality Measures set and the Medicaid Managed Care Quality Rating System mandatory measure set.**

4. Website Transparency (§§ 441.313, 441.486, 441.595, and 441.750).

CMS proposes to require states to operate websites that are available and accessible to Medicaid enrollees and provide results of the new reporting requirements under newly proposed § 441.311, specifically incident management, critical incident, person centered planning, and service provision compliance data; data on the HCBS Quality Measure Set; access data; and payment adequacy data. States would be required to have their websites in place 3 years following the effective date of the final rule for states with FFS delivery systems, or by the first managed care plan contract rating period beginning on or after 3 years after the effective date for state using managed care delivery systems for HCBS.

a. **We recommend that CMS set a much later compliance date, at least 5 years after the effective date of the final rule.** We support the goal of providing Medicaid enrollees with a range of useful HCBS program information. However, between this Medicaid Access proposed rule and the Medicaid managed care proposed rule, states will be faced with information system development and implementation projects that will require very significant resources and many years to complete. Given the other initiatives that states are pursuing, including Medicaid redeterminations and implementing new requirements of federal legislation, CMS should defer implementation of this initiative until other information system initiatives are first completed.
b. **We recommend that CMS convene a technical expert panel of relevant stakeholders that would create a set of guidelines and best practices that state could leverage to produce the kinds and levels of functionality that CMS envisions in meeting the website transparency requirement.** There are many technical issues that would need to be resolved to implement this proposal. For example, CMS would require that the data and information that States are required to report under § 441.311 be provided on one web page, either directly or by linking to the web pages of the managed care entity that is

authorized to provide services. CMS should leverage a TEP of key stakeholders rather than have each state invest time and resources thinking through how those requirements should be operationalized and run the risk of producing a website that does not meet requirements.

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In closing, we appreciate the opportunity to provide comments and look forward to continued partnership with CMS to ensure affordable, quality, equitable coverage and care is accessible to everyone. If you have any questions, please contact Rhys Jones at rjones@ahip.org or 202-861-1446.

Sincerely,

Matthew Eyles

Matthew Eyles
President & Chief Executive Officer