Medicaid Program; Ensuring Access to Medicaid Services (CMS-2442): Summary of Comments on the Proposed Rule

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Executive Summary

On April 27, 2023, the Centers for Medicare & Medicaid Services (CMS) released for public inspection a notice of proposed rulemaking, "Medicaid Program; Ensuring Access to Medicaid Services." The proposed rule was published in the Federal Register on May 3, 2023. The rule expands on CMS' previous rulemaking around access to care, transparency, and HCBS quality of care. Also of note, CMS simultaneously released a companion proposed rule, "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality," addressing topics specific to managed care delivery systems, including new requirements around medical loss ratio, state-directed payments, and rate transparency.

Twenty-eight state agencies commented on the Access NPRM, including Arizona, California, Florida, Massachusetts, Oregon, Pennsylvania, Tennessee, and Texas among others. Fifteen trade associations are included in this report, such as AMA, AAP, MHPA, AHIP, AEH, NAMD, and other HCBS organizations. For this analysis, Sellers Dorsey focused on a select number of state hospital associations and large-scale health systems including AHA, Florida Hospital Association, California Hospital Association, CommonSpirit Health System, and others which totaled twelve organizations representing this industry. Three large advocacy organizations are included as well: National Disability Rights Network, The Arc, and the Disability and Aging Collaborative. Finally, Centene and Blue Cross provided comments on the proposed rule and are included here. Though these groups represent a wide range of perspectives, all were supportive of improving services and supports for beneficiaries receiving HCBS. Please see Appendix 1 at the end of this report for a full list of commenters included.

Despite being supportive of the overarching goals, states were largely concerned with their ability to accomplish all new provisions in the time allotted by CMS. Many states also referred to the new provisions set out in the Managed Care Proposed Rule, which adds additional administrative burden on state agencies. Throughout the comments, states requested additional time, resources, and assistance to reach compliance with these provisions. Other groups were less likely to recommend longer timelines, such as advocacy organizations, which emphasized consumer access over states' concerns. However, despite these differences, most commenters reviewed in this report were either hesitant to support the 80% threshold for direct care worker payments or outright opposed the provision. Repeatedly, commenters asked CMS to consider the potentially harmful impacts of this requirement. Some suggested other ways to support the direct care workforce while others recommended that CMS spend more time analyzing the potential impact.

MEDICAID ADVISORY COMMITTEE AND BENEFICIARY ADVISORY GROUP (§ 431.12)

Twenty-one state agencies commented on this provision, the majority of which were in support of the changes. Some states were more hesitant to fully support the proposed changes to the MCAC structure. Throughout all of the comments, including those in support, states noted several challenges to implementing the BAG and MAC. Notably, states requested that any compensation given to participants be excluded from eligibility determinations; raised concerns about privacy with the publication of membership lists and meeting notes; and were uncertain about achieving the percentage of BAG and MAC crossover, given the significant time commitment required for participants. States such as Indiana and Maine requested that the authority to appoint members remain with the Medicaid Director. Overwhelmingly, states requested that CMS consider renaming the BAG to avoid negative connotations.

Trade associations were similarly supportive of the provision, and each urged CMS to ensure that a diverse range of voices and perspectives were represented on the MAC. NAMD stood in contrast to other trade agencies, voicing the concerns raised by state agencies of the burden of implementation while still maintaining support for the goals set out by CMS. Large advocacy groups such as The Arc and the Disability and Aging Collaborative were supportive of the provision and recommended that CMS ensure that these groups include the voices of those receiving HCBS.

Blue Cross did not comment on MAC and BAG, while Centene briefly commented in support of the changes.

Four hospital associations and one health system provided comments on the MAC and BAG requirements. The Children's Hospital Association (CHA) recommends that CMS include families of children currently enrolled in Medicaid, especially those with disabilities or medical complexity on each MAC and BAG. The California Health Association recommends that states be required or at least have the flexibility to establish standing and permanent membership and representation from certain provider types. The Ohio Hospital Association encourages CMS to provide states with best practices and technical assistance to ensure optimal engagement from members of these important advisory committees. The New Jersey Hospital Association recommends that CMS stipulate what must be included in the MAC's annual report to the state and urge

CMS to include recommendations made by the MAC throughout the year and actions taken by the State in response to those recommendations.

Trinity Health System strongly recommended that CMS include hospital and safety net provider representatives (specifically, safety net hospital providers, primary care providers and maternity care providers) in proposed MACs.

The Texas "coalition letter" (representing the Texas Medical Association, the Texas Pediatric Society, the Texas Academy of Family Physicians, the Texas Association of Obstetricians and Gynecologists, and the American College of Physicians, Texas Services Chapter) supported the proposed recommendations as stated.

HOME AND COMMUNITY-BASED SERVICES (HCBS)

Person-Centered Service Plans

(§§ 42 CFR 441.301(c), 441.450(c), 441.540(c), and 441.725(c))

Nine state agencies commented on this provision. Overall, states were supportive of the goals but concerned about the administrative burden and short timeline for implementation. Iowa and Maine requested "good cause exemptions" for certain circumstances such as end-of-life care and short-term institutional stays.

Eight trade associations commented on this provision, largely in support but requesting some modifications to the requirements for a full assessment. AMA noted that they wanted to ensure that CMS evaluates the impact of increased HCBS reporting on state agency resources to ensure that other proposals or programs are not being shelved due to resource constraints.

The Arc and the Disability and Aging Collaborative were supportive of these provisions, noting that these were important to people receiving HCBS services. Centene was also supportive of these provisions, as was Blue Cross. However, Blue Cross requested additional clarification on how reassessments would function with care planning/reassessments for dual eligibles.

Grievance System

(§§ 441.301(c)(7), 441.464(d)(2)(v), 441.555(b)(2)(iv), and 441.745(a)(1)(iii))

Eighteen state agencies commented on this provision and voiced significant concerns about the financial and administrative burden. Overwhelmingly, states requested additional time to implement this provision. States also requested that CMS increase the timeframe for expedited grievances. Some states wanted the timeframe extended to 90 days while others suggested 30 days. Other requests included additional funding for implementation. Most states were not supportive of establishing these requirements for state plan services, with the exception of New Mexico.

Fewer trade associations commented on this provision (5 out of 15), with general support for the grievance system. In contrast to the state agencies, the advocacy groups strongly recommended that the timeframe for responses be shortened from 90 days to 45 days. Centene commented in support of the grievance system.

Incident Management System

(§§ 441.302(a)(6), 441.464(e), 441.570(e), and 441.745(a)(1)(v))

This provision, similar to the grievance management system, had comments from twenty-five out of twenty-eight state agencies. State agencies asked CMS to increase the timeline for implementation and allow for "good cause exemptions," especially for states that do not already have the infrastructure to support this provision. Consistently, states commented on the definition of "critical incident." Louisiana was concerned about the lack of specificity in the definition along with Maine, Minnesota, North Dakota, and others. Some states requested that they be able to retain the flexibility to define "critical incident" in a way that best aligns with their current Medicaid managed care structure and state legislation (Missouri and Wisconsin).

NAMD strongly urged CMS to not finalize this provision, in contrast to the other trade associations. The remaining six trade associations were supportive with recommendations to strengthen the provision. NACDD recommended that CMS include state plan services and allow any person to report a critical incident directly to the state. Similarly, all advocacy groups commented in support of this provision and The Arc also recommended that any person be allowed to report a critical incident to the state. Centene was supportive of this provision.

Trinity Health was generally supportive of the goals of a critical incident reporting system and asked that CMS establish state requirements for incident reporting systems. Specifically, they "urge CMS to request state agencies ensure that the correct entity is both subject to the proposed investigation around a critical incident and responsible for implementing corrective actions."

Reporting
(§ 441.302(h))

There were few comments about this provision alone, states and other interested parties commented on the reporting requirements in their respective sections. New Mexico made a comment requesting that CMS issue a streamlined reporting template. Otherwise, comments made about the reporting requirements will be included in their respective sections (incident management, HCBS measure set, etc.)

NJHA supported the notion of critical incident reporting but urged CMS to "work with a group of stakeholders, including consumers, providers, and state regulators" to ensure that implementation does not result in confusion and the use of resources that would duplicate existing systems.

HCBS Payment Adequacy
(§§ 441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi))

Twenty-five state agencies commented on this provision, eight of which explicitly opposed the implementation of an 80% threshold for direct care worker payments. The remaining states urged CMS to consider the harmful unintended consequences of this provision if implemented as written. There were considerable concerns about shrinking the provider workforce willing to accept Medicaid, the challenges in collecting this data, and the potential of being considered an employer by the state and the legal ramifications that may come with that designation. Rural and frontier states such as Alaska and Maine noted that non-direct costs are likely to be higher than other states. Consistently, states were concerned about their ability to implement this and the potential detriment to recipients of HCBS services.

Twelve trade associations commented on this provision, with nine not supporting the 80% threshold, citing many of the same reasons as the state agencies. Many trade associations commented about what CMS considers to be "compensation," and felt that this provision would have harmful consequences. Three trade associations, NACDD, AAP, and AOTA, were supportive of this provision. The advocacy groups were

generally supportive of increasing supports for direct care workers. However, The Arc was not supportive of the 80% threshold. The National Disability Rights Network is supportive of a "state-level requirement" for payment but did not specify 80%. Similarly, the Disability and Aging Collaborative is supportive of a federal standard for payment. Finally, Centene and Blue Cross were both concerned about the harmful unintended consequences of this provision.

CHA urged CMS to ensure underlying HCBS payment rates are sufficient to ensure meaningful access. CHA is concerned that the provision requiring 80% to be spent on compensation is too limiting and should also allow the inclusion of costs related to information technology and training.

WHA and CHA (but not FHA) also voiced support for CMS' proposal to improve oversight of the HCBS programs and improve safeguards for HCBS beneficiaries and the HCBS workforce. But cautioned that additional requirements could burden smaller HCBS organizations. For example, the requirement that at least 80% of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation is likely to help bolster the HCBS workforce through improved wages. However, for some HCBS organizations, especially those that are smaller and/or rural, that requirement may be difficult to initially meet. These hospital associations suggested that CMS could consider giving states additional flexibility regarding this compensation requirement if these organizations meet certain criteria supportive of the HCBS workforce.

Supporting Documentation Required

(§ 441.303(f)(6))

Fewer state agencies commented on this provision (3 out of 28), generally in support of the additional documentation for waiting lists but noted that this would be an increased administrative burden on states. Trade associations were likewise supportive of this provision as well as all three advocacy groups (4 out of 15). Centene also commented in support of this provision.

Reporting Requirements
(§§ 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

While state agencies were generally supportive of the overall goals set by CMS (14 out of 28), they expressed serious concerns over the burden of increased reporting requirements. States noted the increased cost associated with reporting and sought to increase the timeline for implementation. Many states also commented on the reporting cadence, suggesting that the biennial reporting would not be enough time to capture relevant data. States recommended various timeframes, but generally three to five years. Trade associations also commented on the potential of overwhelming state agencies with increased reporting requirements and made recommendations to reduce the burden and avoid duplicative activity. The American Occupational Therapy Association stood in contrast to the other three trade associations in that they recommended a shorter timeframe for implementation. Only one advocacy group commented directly on this provision in support of the reporting requirements. Centene supported as well.

Home and Community-Based Services (HCBS) Quality Measure Set
(§§ 441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v)

Nineteen state agencies commented on this provision with concerns about the timeline for implementation and the additional burden of reporting. Arizona and the Missouri Department of Mental Health both opposed this provision due to the financial and administrative burden. Other states, while generally supportive, also voiced concerns about the requirement to stratify data given the potential for small sample sizes within certain waivers.

Trade associations also were supportive but submitted recommendations to CMS to reduce burden, increase accessibility, and retain flexibility. The Disability and Aging Collaborative commented in support of the measure set and requested that these apply to all Medicaid HCBS recipients, including the State Plan services. They were also supportive of data stratification. Both Blue Cross and Centene commented on this provision and were generally supportive. Centene requested that MCOs explicitly be included to better share data and information while Blue Cross requested that CMS clarify the relationship between the current, optional HCBS measure set and the new mandatory measures. Blue Cross also requested that CMS ensure the survey is accessible and equitable for all HCBS recipients.

CHA encouraged CMS to include pediatric-specific measures in the HCBS quality measure set. NJHA supported the proposed timeframe for measures and the proposed process for updating the measure set but asked CMS to provide more detail on how findings from the measures will be publicly shared. Finally, the "Texas coalition" requested that CMS create a pediatric care-specific quality measure set for HCBS.

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

Ten state agencies commented on this provision with concerns about the burden of implementation, although supportive of increased transparency. States noted that they needed additional time and resources to facilitate this provision. Texas felt that CMS should not enforce specific website display formats and Colorado felt that these requirements were "overly prescriptive." Very few trade associations commented on this provision. NAMD and AHIP aligned with state agencies over their concerns and NCAL was supportive. The advocacy groups and health plans did not comment on this provision.

NJHA asserted that CMS "must engage with the beneficiary community to identify the best ways to offer access" to information that will be presented on the website. The organization also believes that transparency concerning how states are using the data to improve HCBS and the progress being made is critical.

DOCUMENTATION OF ACCESS TO CARE AND SERVICE PAYMENT RATES (§ 447.203)

Fully Fee-For-Service States

Five states commented on this provision: Alaska, Colorado, Maine, North Dakota, and South Dakota. Alaska and Colorado commented with concerns about the extreme administrative lift on state agencies to reach compliance with this provision. Maine, North Dakota, and South Dakota all commented in opposition, citing the resources it would take to operationalize this provision. Maine commented that it would take the state over a decade to overhaul their program as described in the provision.

Few trade associations commented on this provision. NAMD aligned with the states in opposing the provision whereas AAP was supportive. The remaining organizations did not comment on this section of the proposed rule.

CHA urged CMS to apply access standards noted in the proposed Managed Care Rule, including wait times, secret shoppers, and enrollee experience surveys to FFS as well. They also encouraged CMS to explore other access gap areas, and to include marketplace specialty care wait time requirement of 30 days for non-urgent appointments for children. CHA also requested more focus on Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits for children.

FFS Payment Rate Transparency
(§ 447.203(b))

Twenty-one state agencies commented on this provision with reservations about the technical capabilities to support this analysis and the usefulness of the data. Many states commented on how the differences between Medicare and Medicaid billing and utilization would make it difficult to compare rates. California also noted that having to provide a "crosswalk" of the bundled rates would be an undue burden on states to provide. Some states such as Texas, Missouri, and Massachusetts noted that, while supportive of the goal of increased transparency, the information presented as required by the provision would likely be difficult for the public to understand. Massachusetts recommended that the state be allowed to disclose rate differentials as a global percentage where applicable.

NAMD aligned with state agencies in voicing their concerns about the burden of implementation. However, the seven other trade associations that commented did so in support of the provision, including the AMA, AAP, and AEH. The Arc commented in support of the provision, but the remaining organizations did not provide comments.

All hospital associations and health systems reviewed for this analysis supported CMS' proposal to require that states evaluate and disclose how rates for certain critical services compare to Medicare FFS rates, and to expand the rate disclosure to include physician specialty services. Respondents also urge caution in assuming that Medicare FFS rates are adequate, as Medicare also underpays providers, suggesting that the rate analysis should view Medicare comparisons as one piece of information as policymakers and stakeholders evaluate the impact of provider payment on beneficiary access to care. CHA further asserted

that "Medicare is not a perfect benchmark," particularly for pediatric services, and that more support is needed for children's behavioral health services along the entire continuum of care. Some cited the shortfall experienced by hospitals and other providers in their Medicaid rates, providing statistics such as Medicaid as a percentage of cost ($0.80 to $0.88 on the dollar) and Medicaid compared to Medicare (citing national data for this – average being about 78%). All supported CMS' proposal to update the agency's regulatory framework to improve transparency for stakeholders, beneficiaries, and the public.

All hospital associations and health systems reviewed for this analysis supported CMS' proposal to require states to routinely publish FFS rates in a format accessible to the public and display rates by population, provider type, and geography. CHA strongly supported the requirement for states to publicly report all FFS rates for Medicaid services and strongly suggests that "any new regulatory text changes not noticed in the immediate rule are subject to subsequent rulemaking, where the public may respond to full fiscal and impact analyses and afford a meaningful opportunity for public comment as to the actual regulatory language prior to finalizing." FHA also encouraged CMS to align the agency's access to care strategy across the FFS and managed care delivery systems and believes provider rate transparency will support that objective.

State Analysis Procedures for Rate Reduction or Restructuring
(§ 447.203(c))

Eleven state agencies commented, speaking about the reservations they had regarding the proposed requirements for rate restructuring. States commented about the detailed process and expressed reservations about the second-tier review. (Arizona, Alaska, California, Maine, Massachusetts, and South Dakota). Overall, states recommended various ways to streamline this process and maintain the integrity of the Medicaid program. Alaska noted that CMS should not require the state to review rate reductions if the Medicaid rate is set at the Medicare rate. Most states also commented that the timeline for implementation was not sufficient.

Like other provisions of the proposed rule, NAMD aligned with the state agencies and recommended ways for CMS to reduce the administrative burden of this analysis. Other trade associations including the AMA, AAP, NAHC, HCAOA, AHIP, AHCA, and NCAL were supportive. AMA and AAP requested that Medicaid rates be set at 100% of Medicare payment rates. Advocacy groups and health plans did not provide comments.

All hospital associations and health systems reviewed for this analysis support the requirement for states to conduct a "threshold access analysis," but urge CMS to establish a threshold above 80% of the Medicare rate (vs. the 80% proposed). Select associations, including WHA, HANYS, AHA, OHA, and the "Texas provider coalition" also raised concerns with the criteria that looks at no more than a 4% reduction in aggregate FFS expenditures and describes such a rate change as nominal and urges CMS to reexamine the appropriateness of a 4% rate reduction as a criterion in the "threshold access analysis." CommonSpirit requested that CMS include skilled nursing facilities and other long-term providers in the enhanced payment analysis in the final rule.

Medicaid Provider Participation and Public Process to Inform Access to Care
(§ 447.204)

No comments from the organizations included in this report.

APPENDIX 1: LIST OF COMMENTERS REVIEWED

Organization Name	Organization Category
Disability and Aging Collaborative	Advocacy Group
National Disability Rights Network	Advocacy Group
The Arc	Advocacy Group
Blue Cross	Health Plan
Centene	Health Plan
CommonSpirit	Health System
Trinity Health	Health System
California Hospital Association	Hospital Association
Children's Hospital Association	Hospital Association
Florida Hospital Association	Hospital Association
Healthcare Association of New York State	Hospital Association
NJ Hospital Association	Hospital Association
Ohio Hospital Association	Hospital Association
Texas coalition letter	Hospital Association
Wisconsin Hospital Association	Hospital Association
AHCCCS	State Agency
Alaska Dept of Health	State Agency
California Dept of Health Care Services	State Agency
Colorado Dept of Health Care Policy & Financing	State Agency
CT Dept of Developmental Services	State Agency
FL Agency for Health Care Administration	State Agency
Indiana FSSA	State Agency
Iowa Medicaid	State Agency
Kentucky Medicaid	State Agency
Louisiana Medicaid	State Agency
Maine DHHS	State Agency
MassHealth	State Agency
Michigan DHHS	State Agency
Minnesota DHS	State Agency
Missouri Dept of Mental Health	State Agency
MO Dept of Health and Senior Services	State Agency
NC Medicaid	State Agency
New Mexico Dept of Human Services	State Agency
NH DHHS	State Agency

North Dakota DHHS	State Agency
Oregon Health Authority	State Agency
PA Dept of Human Services	State Agency
Rhode Island EOHHS	State Agency
South Dakota Dept of Social Services	State Agency
TennCare	State Agency
Texas HHSC	State Agency
Vermont Agency of Human Services	State Agency
Wisconsin Dept of Health Services	State Agency
AAP	Trade Association
ACAP	Trade Association
AEH	Trade Association
AHIP	Trade Association
AMA	Trade Association
American Health Care Association + National Center for Assisted Living (AHCA + NCAL)	Trade Association
American Hospital Association (AHA)	Trade Association
American Occupational Therapy Association	Trade Association
ANCOR	Trade Association
GA Association of Community Care Providers	Trade Association
MHPA	Trade Association
MLTSS Association	Trade Association
NAMD	Trade Association
National Association for Home Care and Hospice + Home Care Association of America (NAHC + HCAOA)	Trade Association
National Association of Councils on Developmental Disabilities (NACDD)	Trade Association
National Center for Assisted Living (NCAL)	Trade Association
SNP Alliance	Trade Association