OHCA
OHIO HEALTH CARE ASSOCIATION

9200 Worthington Road
Suite 110
Westerville, OH 43082
P: 614.436.4154 / F: 614.436.0939
www.ohca.org

OHCA Comments - Ensuring Access to Medicaid Services

The Ohio Health Care Association (OHCA) represents more than 1200 assisted living communities, home care and hospice service providers, providers of care and services to individuals with intellectual and developmental disabilities (ID/DD) and skilled nursing care facilities. OHCA is the only association in Ohio to represent this continuum of long-term care services and supports. We appreciate the opportunity to provide comments regarding the proposed regulation, Ensuring Access to Medicaid Services.

While CMS has included numerous provisions in this lengthy regulation, our comments will focus on the areas which we believe could have the greatest impact for ensuring access to all Medicaid services, but particularly those long-term services and supports our members provide. We were disappointed to see that CMS did not take this opportunity to ensure access to all Medicaid services, as the title of this regulation would imply, but rather put forth a package of proposed regulations that barely scratch the surface of measuring where access issues exist and in the one area which has the single greatest impact on access – Medicaid payment adequacy – not only limits the scope, but misses the mark altogether.

CMS Responsibility for ensuring Medicaid reimbursement rates are adequate to support access to services:

- 42 CFR 447.204 (a) requires "The agency's payments must be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population."
- CMS acknowledges the Supreme Court's outcome in Armstrong v. Exceptional Child Care Center, Inc. that CMS has the statutory responsibility to determine the sufficiency in Medicaid payment rates to ensure access to Medicaid services.
- We agree that payment rates have a direct relation to the accessibility of services, as well as quality of care.
- CMS does not address the requirement for Medicaid payment rates to ensure quality of care.
- While CMS is focusing on state proposals to reduce or restructure payment rates, it is also imperative that ongoing rate reviews are conducted. Many Medicaid payment rates have gone over a decade without changing, but inflation and other factors can lead to payment rates which were once adequate to become inadequate and lead to access issues.
- Additionally, CMS is limiting the scope of the payment adequacy requirement, and while we do not believe that the currently proposed method will actually ensure access, we believe that CMS has the responsibility to ensure payment adequacy for all Medicaid services, including home care, hospice, assisted living, home and community based services for people with intellectual and/or developmental disabilities, intermediate care facilities for individuals with intellectual disabilities and skilled nursing facilities.
- The purpose of the payment adequacy provision is to ensure rates support competitive wages to attract and retain a sufficient workforce to meet the assessed needs of Medicaid recipients.

80/20 Provision for payment adequacy:

- Any standard requiring a percentage of a Medicaid rate to be utilized for direct care compensation will not be beneficial for ensuring access without first implementing standards for determining that the Medicaid rate in total is sufficient to provide competitive wages, promote quality services and ensure compliance with all state and federal regulations.

- CMS did not present any data proving that requiring 80% of Medicaid reimbursement going to direct care compensation would either increase the number of direct care workers or improve access to services.
- While we agree with CMS that direct care workers historically earn low wages and have limited benefits, implementing a provision that 80% of the reimbursement received goes to direct care wages and benefits will not ensure Medicaid rates support competitive wages and may actually cause more access issues.
- CMS has done nothing to ensure that states increase rates instead of implementing requirements that 80% of the current payment be spent on direct care compensation. A requirement that a higher percentage of existing rates go to wages will do nothing but discourage providers from serving Medicaid beneficiaries, thereby decreasing access.
- It is unclear if the 80/20 provision will be applied to the state submitted reimbursement methodology or if States will be required to capture data from providers on how the funding is spent. If States need to collect data from providers, this would be a new regulation which would actually add to the administrative costs providers incur.
- The 20% to cover all costs except direct care compensation is grossly inadequate for a number of reasons, including:
    - The exclusion of supervisory or other clinical support staff. Given that many of these services are provided in locations where staff do not have other staff or supervision, it's important to fund these supervisory and clinical positions to ensure direct care staff have adequate support.
    - Medicaid providers are highly regulated at both the federal and state level. Ensuring compliance with these numerous regulations requires non-direct care staff to monitor regulations, train direct care staff, conduct background checks, complete compliance or other surveys, report and investigate incidents, respond to state, federal or other regulatory authorities, etc.
    - Quality assurance and quality improvement project costs would be included in the 20%. If these are reduced, there likely would be a reduction in the quality of care people receive.
    - Non-billable time for staff trainings/recertifications, travel time, person-centered planning meetings, service documentation, electronic visit verification (EVV) documentation, assistance in maintaining benefits, etc. need to be considered.
    - Costs of goods or services that are required for direct care workers to perform their job would all be included in the 20%. These costs include everything from personal protective equipment (masks, gloves, etc.) to the cost for direct care workers to accompany the person they are serving to community activities (ex. staff costs to enter zoo, attend sporting events, etc.).
- While CMS is proposing to apply the 80/20 provision to a limited number of services, there is a real concern that States will apply this requirement to additional services. State Medicaid agencies have often attempted to create parity across various services of similar nature, to prevent staff from moving from one type of service to another, which may be perceived as an environment with less regulatory requirements or greater pay. If CMS continues with this proposed 80/20 provision, OHCA opposes including any additional services, particularly ones that are delivered in a congregate setting that have even more non-wage costs.

OHCA proposes the following recommendations regarding how CMS could improve this regulation, by setting common criteria CMS could utilize during the review of state rate setting methodologies to determine if Medicaid payment rates are adequate to attract sufficient staffing and providers to ensure Medicaid recipients have access to medically necessary services.

Recommendations for Improvement:

- CMS is required to review and approve all State Plan Amendments, Waiver Amendments and Waiver renewals. CMS could build into those processes a review of payment rates and require adequate payment rates prior to approving these amendments and renewals. This review would apply to all amendments or

renewals and not just those recommending reductions or restructuring of rates. This would allow CMS to review rates more often and prevent years or decades passing without rates being reviewed or adjusted.

- CMS should require states to have a process for periodically reviewing and updating rates to reflect changes in costs and other relevant factors. CMS should approve the process as part of a SPA/waiver amendment. The period should be annually, or at most every two years.
- CMS could include a variety of factors in the determination of payment adequacy including, but not limited to:
    - Require states to include an average wage component to reimbursement methodologies for services provided by direct care workers.
    - Require the average wage component included in the reimbursement meets the following conditions:
        - Exceeds the maximum income standard (for a full-time employee) in that state for eligibility for a family of two (direct care worker plus one dependent) for the following benefits:
            - Medicaid coverage
            - SNAP benefits
            - Child care assistance
        - Meets or exceeds the statewide "Living wage" for 1 adult as calculated by MIT (https://livingwage.mit.edu/)
        - For services where the state provides similar services, meet or exceed the average wage paid to state employees performing similar duties.
        - For states that have an annual Cost of Living Adjustment (COLA) to the state's minimum wage, require the same COLA percentage to be applied reimbursement rates annually.
    - For Medicaid services which utilize a cost-based reimbursement methodology, require rates be no less than 80% of the reported costs, unless the services are 100% Medicaid funded such as habilitative services for individuals with developmental disabilities, which would require reimbursement methodologies to cover 100% of costs to provide services.
    - For services not utilizing a cost-based methodology, consider transitioning to a cost-based methodology or require Medicaid rates be no less than 80% of Medicare, private insurance, private payment, state run services or other comparable service rates.
    - Require states to submit a plan to address any waiting lists for services provided by direct care workers, including both state plan services and those provided via HCBS waivers. Address unrecognized waiting lists for services due to state limitations (for example, limiting the number of certified beds or limiting the number of providers of a specific service).
    - Require states to report utilization data, by service, for those services in which a person participates in a person-centered planning process and assessed to need a quantity of service. For any services where utilization is under 80%, require states to submit a plan to address any access issues which are leading to underutilization.
    - Require states to create a Medicaid recipient survey to collect information directly from Medicaid recipients regarding other types of services they are unable to access (ex. transportation, dental, etc.). Then CMS can review those rate methodologies as part of any SPA submission.
- If concerns are raised at CMS for any of the indicators above, require states to address the issues prior to approving the amendment or renewal.
- Create a public comment process, at the federal level, as part of CMS' review of state plan amendments, waiver applications or renewals. This would be beyond state level comment processes so CMS could hear directly from impacted stakeholders.

In addition to the comments and recommendations to ensure payment adequacy, OHCA submits the following comments regarding the rate transparency, quality measures and waiting list provisions of the proposed regulation.

Transparency of Rates:

- We appreciate CMS recognizing the lack of transparency regarding Medicaid rates as well as CMS' intent to increase transparency in how Medicaid rates compare to Medicare rates.
- However, there is a need for transparency for all Medicaid services and not just the limited services included in the proposed rule.
- To increase transparency, states should publish not only the Medicaid rate, but the methodology utilized to determine the rate. When the rate methodologies are not included, it's difficult to compare rates across services or for stakeholders to understand what is included in the rate and what is excluded.
- When Medicaid services are not funded by Medicare, states should publish other available rates including private insurance, private pay and state costs for comparable services provided directly by the state (example, state-run psychiatric hospitals or state-run ICFs-IID).
- Additionally, services that cannot be computed into an hourly service, such as adult day habilitation or assisted living waiver, should be reported as daily rates.

Quality Measure Development:

- CMS acknowledges in the rule making that the current QMs can be burdensome and costly to providers, and suggest that the Secretary undergo a comment period every other year on the development and applicability of current QMs. We suggest that CMS undergo a comment period of the current QMs before enacting any reporting requirements of those QMs.
- Suggested time periods for phased in approach of QM requirements related to a percentage of QMs reported. We suggest that QM requirements are phased in by reporting method. For example, CAHPS based reporting requirements phased in first, followed by consumer survey and then provider health record. This would enable a less disruptive transition and enable providers to plan for and evaluate administrative costs for any technology-based solutions needed to meet the reporting requirements.
- You propose to inform states of how to collect and calculate data on the measures and provide standardized reporting measures. We respectfully request a separate stakeholder process to evaluate current capabilities of HCBS providers to provide this data to be collected.

Waiting Lists/Access Reporting:

- We were happy to see CMS included some reporting requirements for states related to waiting lists as well as CMS' recognition that Medicaid recipients may have been granted a waiver slot, but are not receiving any services. Reporting and monitoring of this data can be a key task in monitoring access issues in a particular state or specific waiver.
- CMS acknowledges that states may be operating "unauthorized" waiting lists. While reporting on the number of people on these unauthorized waiting lists is a good first step, CMS should clarify what actions CMS will take when a state operates an unauthorized waiting list.
- However, CMS could improve upon this access reporting by requiring states to submit data related to utilization of services. Most people receiving services are required to complete a person-centered planning process which assesses individuals' service needs. State should report data related to the units of service authorized versus the units of service delivered (claims data). Many Medicaid recipients are receiving a drastically reduced quantity of services due to the lack of available direct care workers.

We appreciate your time reviewing these comments. Please feel free to contact Debbie Jenkins (DJenkins@ohca.org) with any questions.