Medicaid Program: Ensuring Access to Medicaid Services

Talking Points:

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

- CMS acknowledges the Supreme Court's outcome in Armstrong v. Exceptional Child Care Center, Inc. that CMS has the 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.
- 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 not changed in over a decade, while 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.
- 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:

- 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.
- It is likely that states will not increase total Medicaid rates, rather implementing requirements that 80% of the current payment be spent on direct care compensation.
- 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% for non-direct care compensation is 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.

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    - 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.
- 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.
- 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.

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).

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 individual's services 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.

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 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.
    - For services not utilizing a cost-based methodology, 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.).
- 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.

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