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NAHC Files Comments Opposing Medicaid Changes that Restrict Access to Care *(from NAHC Report)*

The National Association for Home Care and Hospice (NAHC) strongly opposes proposed rules changes regarding state analysis of access to care, public reporting, and application of requirements for an access monitoring review plan of Medicaid programs, wrote NAHC President William A. Dombi in comments submitted to the Department of Health and Human Services and Centers (HHS) for Medicare & Medicaid Services (CMS) on May 22, 2018.

HHS and CMS have proposed a number of reforms in the requirements state Medicaid programs must follow in set payment rates in fee-for-service Medicaid benefits, in a March 23 Notice of Proposed Rulemaking (NPRM). Unfortunately, the proposed changes would significantly dilute the protections that existing rules provide relative to ensuring that payment rates are sufficient to secure access to care.

It must be emphasized and understood that Medicaid payment rates generally are lower than the cost of care. At the same time, some states have reduced payment rates over the years purely for budgetary reasons, without analysis or evaluation of the impact of rates on care access. Other states have left payment rates unchanged for years as care costs have increased, jeopardizing continued access to care. Essentially, providers of care have to use revenues from other payer sources to subsidize Medicaid. However, the margins from other payer sources are shrinking, deteriorating any continued subsidization potential. Diminishing the protections found in the existing rules now creates higher risk than ever that care access will be reduced or lost entirely.

The risks are acute in home care given changes in minimum wage and overtime obligations under federal and state laws. Further, the risks have been heightened in home care as providers compete for staff with institutional care providers who have the benefit of reasonable payment rates from commercial; payers while home care providers rely on Medicare, Medicaid, VA and other government program-based payment sources.

NAHC's objections to the proposed rules and our reasoning are, as follows:

1. CMS proposes to exempt states where at least 85 percent of Medicaid beneficiaries are enrolled in a Medicaid managed care plan. However, **Medicaid beneficiaries receiving services under the traditional fee-for-service benefit model deserve the protections afforded by the existing rules whether those beneficiaries represent more or less than 15 percent of the state's Medicaid beneficiaries and CMS has provided no evidence that rate reductions in states with 85 percent or more management care enrollment have less impact on access for fee-for-service beneficiaries than in states with less than 85 percent managed care enrollment.** Entire populations of Medicaid beneficiaries could very well be put at risk if the CMS proposal comes to pass. This is particularly true with respect to home care, since many states have not created Managed Long-Term Services and Supports (MLTSS) programs while enrolling non-MLTSS beneficiaries entirely in managed care. Medicaid home and community based care on a fee for service basis can represent the majority of long term care spending in a given state at an amount that exceeds the total Medicaid spending for managed care enrollees.
2. CMS proposes to exempt rate reductions that are four percent or lower in one year or six percent over two years based on a classification of such rate reductions as "nominal," but provides no evidence to substantiate its claims. **Since the average profit margin for a free-standing home health agency (HHA) participating in Medicare was less than two percent in 2016, a four percent rate reduction in Medicaid payments would likely bring the average HHA into insolvency.** Clearly, if the average HHA is insolvent, access to care for its Medicaid patients would be at risk.
3. **CMS should take steps to strengthen the reporting responsibilities of states and the process for protecting access to care in Medicaid rate setting.** NAHC recommends that CMS establish a uniform reporting tool that requires a reasonable analysis of existing Medicaid rates along with a structure process for evaluating rate reductions. The process should include an analysis of current Medicare, VA, commercial insurance, managed care and private pay rates for the services. In addition, the process should involve an evaluation of the provider marketplace that includes such factors as market saturation or shortages of providers. It is also important that states conduct the rate sufficiency evaluations no less than annually to improve the chances of continuing care access. Annual reviews are conducted by the Medicare Payment Advisory Commission (MedPAC) in Medicare. Medicaid beneficiaries deserve the same level of protection.
4. **The value of an effective rate evaluation system far outweighs any burden on the states.** CMS calculates that its proposed modifications in the Medicaid access rule would save less than $1.7 million per year. In a program of over $300 billion in annual spending, less than $1.7 million is a very small price to pay to protect access to care for some of America's most needy and vulnerable citizens.

NAHC respectfully urges CMS to withdraw its proposal and instead work to strengthen the rate setting protections instituted in 2016.