May 22, 2018

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2406-P, P.O. Box 8016
Baltimore, MD 21244-1850

Re: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services – Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold

To Whom It May Concern:

I am writing to you today on behalf of the Home Care Association of New York State (HCA), which is a statewide not-for-profit organization representing nearly 300 health care providers, allied organizations, managed care plans and individuals committed to the availability and advancement of quality home care services and supports in New York State and nationally.

In representation of our certified home health agency (CHHA) members serving over 200,000 Medicaid fee-for-service (FFS) and Medicaid Managed Care home health beneficiaries annually, we appreciate the opportunity to comment on the U.S. Centers for Medicare and Medicaid Services’ (CMS’s) proposals to exempt states from most federal access-monitoring requirements for services provided through the Medicaid FFS program in cases where states rely heavily on managed care and/or impose only a “nominal” Medicaid rate cut (CMS-2406-P).

Background on the Current Law and Proposed Rule

Under current law, states are required to set Medicaid FFS rates at a level that would ensure access to services for Medicaid beneficiaries at a comparable level to non-Medicaid FFS insured individuals. This rule, known as the equal access provision, enables patients and providers to hold state Medicaid programs accountable for keeping competitive rates, and it acts as a deterrent against rate stagnation.

In 2015, CMS issued a rule intended to hold states accountable to the equal access provision. As part of this rule, states are required to develop and submit to CMS an access monitoring review plan (AMRP) every three years for a variety of Medicaid FFS services (including home health) or when Medicaid rate changes pose a threat to access to care.
However, in November 2017, CMS issued a letter stating that “nominal” reductions in reimbursement rates made to the Medicaid program were not likely to impact access, and would not warrant an AMRP analysis, a contention that we feel ignores other policy overhauls not directly classifiable as “reimbursement cuts,” including a host of major licensure, certificate of need and eligibility changes now in motion or being considered in New York State under both Medicaid FFS and Medicaid managed care, both of which are under the umbrella of New York’s Medicaid program. In the March 2018 proposed rule, CMS defines a “nominal” rate reduction as being up to four percent for one year, or six percent for two years. Such percentages could hardly be called “nominal,” especially in combination with other non-rate changes which have a fundamental impact on access-to-care, magnifying the effect of even seemingly slight reductions.

Also, in its current rulemaking, CMS has proposed exempting states from the detailed AMRP analysis if the state has a Medicaid population where 85 percent of its beneficiaries are covered by a managed care organization. However, HCA would argue, based on the experience in New York State, that an equal-access provision and related transparency protections are all the more important in assessing states with diverse payment, enrollment and eligibility systems that may very well include a high volume of managed care and may likewise have involved dramatic structural and marketplace changes to arrive at that volume.

HCA Urges Continuation of the Current, Needed Regulation for State Medicaid Programs and CMS’s Rejection of Proposed Exemptions for State AMRP Submissions

HCA believes the current regulation [42 CFR 447.203(b)] on AMRP submissions is critical and should be maintained. It requires states to submit to CMS an AMRP every three years to document whether Medicaid payments in the FFS systems are sufficient to enlist providers and to assure that beneficiary access to covered care and services is adequate.

HCA also does not support either of CMS’s two proposed AMRP exemptions, the first of which would exempt states with at least 85 percent of their Medicaid population in managed care from having to submit the AMRP every three years, and the second of which would exempt states from conducting an AMRP analysis for any Medicaid payment rate reduction to providers of less than 4 percent annually or less than 6 percent over two years, which CMS considers to be “nominal” and unlikely to affect access to care.

HCA bases this position on the actual Medicaid home health FFS and managed care experience and history in New York from 2010 to 2018, for both providers and Medicaid beneficiaries. We would like to share with you that experience to better convey why we do not support either of CMS’s proposals to exempt states from submitting this important AMRP analysis in certain cases.
New York State’s Medicaid Policy Changes Between 2010-2018 and Their Impact on Home Health Providers and FFS Beneficiaries

Over the past eight years, New York State’s Medicaid program has undergone unprecedented change. The vast majority of these changes emanated from the state’s Medicaid Redesign Team (MRT), authorized by the 2011-12 State Budget, and later implemented, on a rolling basis, under a policy framework overseen by the state Department of Health (DOH).

If viewed as a multi-prong process, the MRT actions affecting New York’s home care system first involved constrictions to the existing FFS home care system. This included major payment changes such as a global cap on aggregate Medicaid spending that still applies to virtually all sectors of health care and provider-specific spending caps for CHHAs in 2011, which reduced state annual home health Medicaid FFS expenditures by approximately $200 million.

The state’s cap on CHHA expenditures was a one-year spending limitation in advance of an entirely new CHHA reimbursement system for Medicaid FFS services. This new reimbursement system, now in effect, is modeled closely after the Medicare home health prospective payment system (HHPPS). Like Medicare HHPPS, New York’s Medicaid episodic payment system (EPS), which went live on May 1, 2012, reimburses CHHAs with a single risk-adjusted rate that— with certain exceptions— covers a 60-day “episode” of care, regardless of how many times the provider visits a patient or how much care the patient ultimately requires. Importantly, the EPS methodology is in effect only for Medicaid patients needing fewer than 120 days of care. (Certain populations, like children, are exempted from EPS, too.)

This first phase of CHHA program reductions was followed by a second phase of initiatives involving structural changes to the home care system as a whole: i.e., the management and authorization of home care services and the placement of patients in new service models, and other changes as the state now pursues near-universal Medicaid managed care plan enrollment for its long-term care populations and many other service levels.

The policy change requires all FFS long term Medicaid home care services (for cases needing 120 days of care or more) to be provided through home care agency contracts with a Medicaid Managed Long Term Care (MLTC) plan. The change presents a fundamental shift in service delivery, payment and regulation. It has included the state’s reshuffling of billions of dollars in reimbursement, a succession of new regulatory mandates, and transitioning nearly a hundred-thousand CHHA and other home care patients from their existing community service arrangements into different service settings.

The vast majority of these “longer-term” patients have now been moved and are continuing to be moved to Medicaid MLTC plans under a process called “mandatory enrollment.”

A chart on the next page shows how the FFS home health benefit has dramatically changed from 2010 to 2018. In 2010, CHHAs in New York provided services to over 80,000 Medicaid FFS
beneficiaries and received approximately $1.35 billion in Medicaid FFS revenues for services provided. At the time, the state DOH reimbursed CHHAs on a per-visit basis that was cost-based using two-year-old Medicaid Cost Reports. By 2011, DOH had initiated CHHA spending caps within this cost-based system, followed by the aforementioned roll-out of the new EPS in May 2012 and the ongoing migration of longer term CHHA cases to managed care and away from cost-based FFS arrangements. In 2015, DOH implemented a process called rebasing within the dwindling volume of FFS cases, which is essentially a series of adjustments intended to update the EPS rates for CHHAs. However, for most providers, the rebasing process was simply another payment cut, contributing to operational losses for many CHHAs. (In fact, the average percentage rate cut attributable to CHHA Medicaid EPS rebasing was a 19.6% reduction between 2015 and 2016 – which resulted in $80 million less in CHHA Medicaid FFS expenditures between December 2015 and December 2016.) As a result of these substantial changes over a period of less than ten years, the CHHA FFS amounts have dropped from 80,000 to 13,787 beneficiaries and from $1.35 billion to $122.3 million in revenues from 2010 to 2018 – a substantial rebalancing of the managed care and FFS relative volumes which has had a profound impact on care delivery in both sectors and which continues to demand scrutiny by both the state and federal governments regarding access to care and equity of care.

**Impact of NYS Medicaid Policy Changes on FFS Home Care from 2010 to 2018**

<table>
<thead>
<tr>
<th>Time Period</th>
<th>MLTC Plan Enrollment</th>
<th># of FFS CHHA Beneficiaries</th>
<th>CHHA Medicaid FFS Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2010</td>
<td>28,951</td>
<td>80,025</td>
<td>$1.35 Billion</td>
</tr>
<tr>
<td>Jan 2011</td>
<td>32,602</td>
<td>77,063</td>
<td>$1.25 Billion</td>
</tr>
<tr>
<td>Jan 2012</td>
<td>45,487</td>
<td>74,500</td>
<td>$1.18 Billion</td>
</tr>
<tr>
<td>May 2013</td>
<td>87,419</td>
<td>31,724</td>
<td>$465 million</td>
</tr>
<tr>
<td>Dec 2013</td>
<td>128,841</td>
<td>29,013</td>
<td>$385.4 million</td>
</tr>
<tr>
<td>Dec 2014</td>
<td>163,179</td>
<td>22,904</td>
<td>$354.4 million</td>
</tr>
<tr>
<td>Dec 2015</td>
<td>175,788</td>
<td>20,785</td>
<td>$231.7 million</td>
</tr>
<tr>
<td>Dec 2016</td>
<td>205,687</td>
<td>17,355</td>
<td>$151.3 million</td>
</tr>
<tr>
<td>Jan 2018</td>
<td>205,175</td>
<td>13,787</td>
<td>$122.3 million</td>
</tr>
</tbody>
</table>

**NYS Medicaid Policy Changes and Its Impact on CHHAs Financially**

These Medicaid policy changes have adversely affected home health agencies financially. This financial toll is also coupled with rate inadequacies to managed care plans, which has a downstream effect on home care providers and their operating margins. Indeed, approximately 75% of a CHHA’s Medicaid revenue now comes from Medicaid Managed Care (MLTCs and mainstream managed care) contracts, compared to only 25% directly from the state through EPS billing. (In 2010, over 90% of CHHA’s Medicaid revenue came from direct FFS billing to the state.) Today, CHHAs are substantially negotiating with MLTCs under the state’s Medicaid global cap, inadequate premium payments to MLTC plans, and other constraints.
In late 2017 to early 2018, HCA conducted a comprehensive review of the financial status of CHHAs in New York. HCA specifically reviewed the latest available collection of state-mandated and independently certified Medicaid Cost reports and found that approximately 70% of New York’s CHHAs were operating at a loss across all payors in 2016. This is due in large part to a similar financial strain placed on MLTC plans, specifically premium payments from the state that also do not meet MLTC plan costs. According to our review, approximately 62% of all MLTC plans had negative premium incomes in 2016, up from 42% in 2012 (a 39% increase since 2012). A negative premium income means that the state’s payment to the plan is less than the plan’s costs and adversely affects its capacity to reimburse services delivered by downstream CHHAs and other providers.

These FFS utilization trends and financial realities within home care are all occurring within the context of universal managed care enrollment. CMS’s proposal to exempt AMRP reporting for states with high managed care thresholds ignores the reality that these thresholds are reached over a period of time, with a rolling impact on home care program finances and viability that are all the more necessary to examine in the context of massive migrations of patients and resources. New York State is very close to reaching the 85 percent threshold of Medicaid beneficiaries being enrolled in a managed care plan that CMS has proposed as a condition for exempting AMRP reporting by New York State. (As of February 2018, 78 percent of Medicaid beneficiaries were enrolled in a Medicaid Managed Care plan, according to the February 2018 state Department of Health Medicaid Global Cap Report.)

The FFS and managed care payment systems do not exist in silos. All of these services exist in Medicaid and, therefore, warrant monitoring by states and CMS for assuring equal access regardless of managed care volume. This is especially important given new limits that New York State is placing on home care provider contracting and licensure, as well as certificate of need changes, which altogether create an even more immediate threshold for duly examining network and provider adequacy, especially in rural regions of the state. As such, HCA believes it is very important for CMS to keep the current regulations in place and not move forward with the two proposals that would exempt State Medicaid programs from conducting the necessary AMRP analysis every three years (or when Medicaid rate reductions occur). Keeping the current regulation in place will help ensure that access to care is adequate for both the Medicaid FFS beneficiary and managed care enrollee, so that these issues are understood holistically and with an eye toward equity across payment lines.

Due to the current financial condition of CHHAs in New York, HCA also strongly believes that any rate reduction of less than 4 percent in one year and 6 percent over two years is certainly not “nominal,” especially given the accumulation of reductions in past years that magnify the financial impact of even slight proposed cuts, coupled with regulatory, enrollment, contracting, labor, and other state policy impacts that do not necessarily classify as cuts but would nevertheless result in more CHHAs experiencing operating losses, some CHHAs closing, and threatening access to skilled home health services throughout the state.
We thank CMS for this opportunity to submit comments and respectfully request CMS’s consideration of our concerns and recommendations.

I would be pleased to answer any questions or assist CMS staff in any way going forward. I can be contacted at pconole@hcany.org or 518.810.0661.

Sincerely,

Patrick Conole
Vice President of Finance & Management
Home Care Association of NYS