June 30, 2023

Submitted Electronically via *www.regulations.gov*

Re: **Comments on CMS Proposed Rule: Medicaid Program; Ensuring Access to Medicaid Services (CMS 2442-P, 88 *Fed. Reg*. 27960, May 3, 2023)**

Introduction

The American Association for Homecare (AAHomecare) is the national association representing durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare community. Our members are proud to be part of the continuum of care that assures beneficiaries and other patients receive cost effective, safe, and reliable home care products and services. AAHomecare is submitting comments on the above-captioned proposed rule.

Key Home and Community-Based Services (HCBS) Provisions

According to the Centers for Medicare & Medicaid Services (CMS), ensuring beneficiaries can access covered services is a critical function of the Medicaid program and a top priority of CMS. The proposed rule, *Ensuring Access to Medicaid Services,* includes both proposed changes to current requirements and newly proposed requirements that would improve access to care, quality, and health outcomes, and better promote health equity for Medicaid beneficiaries across fee-for-service (FFS) and managed care delivery systems, including for home and community-based services (HCBS) provided through those delivery systems.

In its proposed rule, CMS seeks to:

- Establish a new strategy for oversight, monitoring, quality assurance, and quality improvement for HCBS programs;
- Strengthen person-centered service planning and incident management systems in HCBS;
- Require states to establish grievance systems in FFS HCBS programs;
- Require that at least 80% of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation for the direct care workforce (as opposed to administrative overhead or profit);
- Require states to publish the average hourly rate paid to direct care workers delivering personal care, home health aide, and homemaker services;
- Require states to establish an advisory group for interested parties to advise and consult on provider payment rates and direct compensation for direct care workers;
- Require states to report on waiting lists in section 1915(c) waiver programs; service delivery timeliness for personal care, homemaker and home health aide services; and a standardized set of HCBS quality measures; and

- Promote public transparency related to the administration of Medicaid-covered HCBS through public reporting of quality, performance, and compliance measures.

CMS also explains that, if finalized, these provisions would:

- Require states to make all FFS Medicaid payment rates public and accessible on a state website.
- Require states to report on their state Medicaid rates relative to comparable Medicare FFS rates.
- Establish an interested parties advisory group comprised of beneficiaries, providers, and other interests partis to advise on current or proposed payment rates.
- Rescind and replace the current AMRP requirements for states with a tiered approach to data submission for determining whether states' rate change proposals comply with section 1902(a)(30)(A) of the Social Security Act. The tiered approach would include a comparison of Medicaid payments as an important basis for understanding whether Medicaid rates are likely to be sufficient.

Comments

Overall, AAHomecare generally supports CMS' goals for its proposed rule and provisions that would increase transparency, promote accountability, and better assure appropriate access. Given the importance that DME and medical supplies play in ensuring that many patients can actually receive health care in their homes, it is important for CMS to ensure that state HCBS programs include DME and medical supplies as a standard benefit in HCBS program. Access to DME items and services should be recognized as an integral part of the HCBS benefit.

Home health care services have been broadly interpreted by CMS to encompass durable medical equipment, among other medical supplies and equipment. CMS implemented its interpretation of section 1905(a)(7) at 42 C.F.R. § 440.70(b) wherein the agency defined "home health services" to include "medical supplies, equipment, and appliances for use in any setting in which normal life activities take place…."[i] The regulations define "supplies" as health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual….".[ii] As for defining "equipment," the regulations borrow from the definition of DME applicable to Medicare, but clarify that "State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program."[iii]

Request for Clarification: We understand that CMS defines HCBS as possibly including DME, (see Home- and Community-Based Services | CMS), but this proposed rule makes only one reference to DME (see page 28000) where DMEPOS payment is used as an example of the proposed payment rate transparency publication requirement. AAHomecare therefore requests that CMS clarify that the provisions of this proposed rule, if finalized, would apply to DME and medical supplies services/benefits.

HCBS Grievance System for FFS care delivery

- AAHomecare fully supports CMS' proposed requirement to establish a grievance system in FFS HCBS programs.

- CMS should require states to submit their grievance systems for review, not just require states to have them on file for CMS to review upon request. We recommend that CMS establish and maintain a process for an annual or regular review of the summary of issues and the states' resolution of the issues.

HCBS Payment Adequacy and Transparency

- CMS should require MCOs to mirror the process that FFS Medicaid plans have in place to ensure there are minimum amounts that state plans pay for covered services (rate floors).

- CMS should consider not just provider enrollment to ensure appropriate access, but should also review the DMEPOS rates set by the MCO plans to ensure the rate covers the costs of the items and services being provided. As CMS acknowledged in the proposed rule, Medicaid covers a large number of individuals throughout the country and providers are often forced to accept the low MCO payments rates or else face complete isolation from the program. Often, Medicaid rates do not cover the cost of providing DME and they operate at a loss for every life served.

- The State Medicaid populations, especially in non-expansion states, are often sicker and require a higher level of care than standard covered populations. This makes it even more important for provider rates to have a minimum to cover the cost of care so that enrollees can have adequate service coverage.

- Standardizing the FFS and MCO payments rates would lessen the administrative burden and allow states to use the same data sets to submit to CMS for approval. Whether a state is FFS or MCO does not change the needs of the Medicaid population served.

- DME providers serve individuals in HCBS settings, institutional settings and also traditional covered populations. Therefore, particular attention should be paid to these provider rates to ensure proper access and not just whether providers are enrolled in provider networks.

- DME providers are often unable to challenge rates proposed by MCO plans as these types of providers often are smaller, independent providers who do not have the ability, the size, nor the resources to be able to dispute rates. In addition, if they dispute the proposed rates they are likely to risk losing the contract.

- AAHomecare supports requiring MCOs to publish their payment rates, similar to that of FFS, to ensure all can see if they are adequate and give DME providers the ability to see what has been offered to others in the same service area.

- CMS noted that "commenters also commonly shared that they viewed *reimbursement rates as a key driver of provider participation in Medicaid and CHIP programs*. Further, commenters noted that aligning payment approaches and *setting minimum standards for payment regulations and compliance across Medicaid and CHIP delivery systems, services, and benefits could help ensure that beneficiaries' access to services"*

- AAHomecare fully agrees with these comments and wishes to stress the importance of setting minimum payment standards for DME reimbursement in both FFS and managed care networks.

- We support CMS' comments that (1) an "insufficient supply of HCBS providers can prevent individuals from transitioning from institutions to home and community-based settings" and can therefore prevent consumers from receiving HCBS that can prevent institutionalization, and (2) "limits on the availability of HCBS lessen the ability for State Medicaid programs to deliver LTSS in a cost-effective, beneficiary friendly manner." These comments underscore the need for greater CMS oversight of state HCBS programs to ensure appropriate access.

Access Reporting

- CMS should require FFS and managed care programs to establish clear network adequacy criteria by DMEPOS product category and geographic area to ensure there is real patient choice. For example, some DMEPOS suppliers only provide respiratory items and services while others only provide complex rehabilitation technology (CRT) items and services. There should be multiple DMEPOS suppliers providing the same product category in a geographic area. CMS and/or the Medicaid programs should establish metrics to determine when network adequacy has been met for each product category in the DMEPOS space. CMS currently has established time and distance requirements for many other provider types (e.g., hospitals, skilled nursing facilities, physicians and home health agencies). AAHomecare would be happy to work with CMS to develop metrics that would ensure access to care. These metrics must exist for DMEPOS suppliers.

- CMS should ensure there is a clear channel within CMS for DMEPOS suppliers to escalate concerns when access issues are identified. This results in (i) access issues for beneficiaries due to a lack of competition, (ii) lack of access standards by DMEPOS product category, and (iii) a lack of patient choice for beneficiaries.

- CMS should ensure that Medicaid programs establish and maintain a "same and similar" portal for DMEPOS suppliers to verify if a recipient is eligible for a specific DMEPOS items(s). This is consistent with traditional Medicare practices and would enable suppliers to ensure a beneficiary has not previously received a similar DMEPOS items(s) recently that would not allow for coverage of a newly ordered item.

- Our members have grave concerns about certain vertical integration arrangements that are becoming increasingly common in the market. For example, when a managed care contractor has common ownership in a DMEPOS supplier, it creates a conflict of interest where the health plan benefits financially with larger market share and higher healthcare cost and could create access to care issues. This type of vertical integration (i) restricts access to care, (ii) restricts patient choice, and (iii) results in other DMEPOS suppliers being frozen out of servicing the Medicaid recipients.

Standardization of HCBS Reporting Requirements and Transparency

- AAHomecare recommends that CMS require the states to make encounter and similar types of claims data (e.g., plan specific claims submitted, claims paid - by CPT/HCPCS codes) available to

the public via FOIA requests. This should apply to managed care plans as well as fee for service data.

Conclusion

Thank you for the opportunity to submit comments. Please contact us if you would like us to provide any further information.

Sincerely,

Tom Ryan
President and CEO
American Association for Homecare

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[i] 42 C.F.R. § 440.70(b)(3).

[ii] *Id.* at § 440.70(b)(3)(i).

[iii] *Id.* at § 440.70(b)(3)(ii).