Ensuring Access to Medicaid Services (CMS-2442)
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OMB/OIRA Meeting, March 1, 2024

Attendees on Behalf of Modivcare

- Jody Kepler, Chief Compliance Officer
- Katie Dotto, Esq., Director, Government Affairs
- Amy Krieg, Manager, Government Affairs
- Karen Late, Sr. Director, Simon&Co.

MODIVCARE COMMENTS

Presenter: Jody Kepler

Good afternoon. Thank you for having Modivcare with you today.

I'm Jody Kepler, the Chief Compliance Officer for Modivcare. Also on the phone is Katie Dotto, Director of Government Affairs, Amy Krieg, Manager of Government Affairs, and Karen Late, our external advisor from MJ Simon and Company. Modivcare is here today to provide important information about CMS's Ensure Access to Medicaid Final Rule, or in its short form, The Access Rule.

Modivcare, formerly known as LogistiCare, provides supportive care and personal care services to Medicaid and other government health care programs. Specifically, Modivcare provides non-emergency medical transportation, remote patient monitoring, and personal care services to vulnerable people. Our services allow people to be in their homes and with their families, rather than more expensive venues such as nursing homes and emergency rooms.

I will now turn it over to Katie Dotto so that she can provide more detail on the impact of the Access Rule to the home and community-based services space. Katie -

Presenter: Katie Dotto

Thank you, Jody.

Good afternoon. My name is Katie Dotto and I serve as the Director of Government Affairs for Modivcare. I would like to start by thanking you for providing us with an opportunity to share our concerns with the CMS proposed rule, known as the Access Rule. You should be in

receipt of our Comments that were submitted to Administrator Brooks-LaSure, as well as a one-pager that outlines the industry's concerns with a specific portion of the rule, which has come to be known as the "80/20 Rule."

As mentioned in our comments, Modivcare is in favor of any effort that thoughtfully advances transparency in reporting, data analytics and quality of care across our industry. CMS's proposed rule hits that mark in many regards. The new HCBS transparency and reporting requirements establish reporting standards and require stakeholder engagement in the rate setting process. Provisions to stratify HCBS quality measures and standardize reporting for those individuals who remain unable to access HCBS will allow states to analyze and improve population-level outcomes that will inform responsiveness and innovation at the provider and system levels. The implementation of a grievance system and new requirements for incident management systems will certainly result in enhanced quality as well as patient safety and experience.

These are all goals that we can support. Unfortunately, the 80/20 provision of the rule, while well-intended, must be given additional consideration before it can be finalized. As you know, the rule requires that 80% of Medicaid dollars received be passed through in wages to the direct care worker or caregiver. It is well known throughout the industry that providers want to pay our caregivers more competitive wages. Many would if they were given the resources to do so and would do so without a directive – the market dictates it.

Anecdotally, we know that caregivers leave the homecare sector for opportunities with other health care providers or better wages in other industries. A survey conducted in Pennsylvania by the state homecare association noted the top reason employees gave for leaving the homecare industry was low wages. Providers can't survive without the necessary workforce to provide the care. However, we have been stretched thin by systemic underfunding and ever-increasing fixed, operational costs, which this provision does not take into account.

For example, this past December, West Virginia Bureau for Medical Services Commissioner, Cindy Beane, testified before the Legislative Oversight Commission on Health and Human Resources Accountability regarding a rate study that reviewed reimbursement rates for a variety of HCBS services. In her testimony, she noted that the study recommended personal care hourly reimbursements be increased to $25.42 from $18.92. I should note that West Virginia has the lowest reimbursement of any market that we operate in; some states are reimbursing twice the West Virginia rate.

The study used the rate 'build' approach, a common, CMS-accepted HCBS rate setting methodology which adds together each component of cost necessary to deliver a service. Any provider will tell you that the cost of care has increased dramatically over the past several years and that cost is attributed to increases in both employee costs and operations costs. An aggressive wage pass-through rule such as the 80/20 rule would be detrimental in a state like West Virginia, especially, if the legislature does not enact a budget that includes the recommended increase in reimbursements.

Many states, like West Virginia, are facing a grim reality when COVID-era American Rescue Plan Act funds are no longer available. Some states will see those funds exhausted at the end of next month, but funding is slated to run out for all states on March 31, 2025.

Additionally, the 80/20 Rule does not make accommodations for the uniqueness of each state's HCBS waiver programs. Each state designs their HCBS programs to meet their constituents' distinct needs and sets rates reflective of budget priorities and realities. If you have seen one Medicaid program, you have seen one Medicaid program. Given the unique nature of each state program, it comes as a shock that a comprehensive study was not done before proposing a blanket rule that could have a variety of impacts on a variety of states with a variety of waivers and regulations.

For instance, New York State has a rule called "Spread of Hours," that requires an employer to pay the caregiver an extra hour of pay at the minimum wage rate if the total workday lasted longer than ten hours, even if the ten hours were not consecutive. This means that a caregiver in New York City who works a three-hour shift in the morning and has a three-hour break before their next four-hour shift that afternoon would be paid for eight hours, not seven at a rate of $18.55. I should note that the minimum wage in New York is set to increase over the next two years. The compounding effects of the 80/20 rule in a scenario like this means that finite dollars are being diverted away from patient care even when patient care is not being provided.

In Pennsylvania's HCBS waiver program, providers are not reimbursed for overtime hours worked. Given the workforce shortage and challenge to staff cases, many caregivers are working more than forty-hours a week. This means that providers are left to absorb the time and a half overtime cost. Applying the 80/20 rule to this scenario makes it increasingly difficult to meet the demand for HCBS, creating an access to care issue. The irony in this case is that the proposed rule contains a provision that would require states to report on HCBS waiting lists. In this situation, I imagine that this new report would paint a dire picture.

Again, a comprehensive study has not been done to illustrate the impacts across various markets. The CMS proposal also lacks the data necessary to support the proposed wage threshold rule. The proposed rule cites two states – Illinois and Minnesota – that have implemented somewhat similar but lower threshold requirements in a relatively small number of HCBS waiver programs. To suggest that the implementation of those wage thresholds could be scaled across the nation, given the variety of unique waiver programs, seems unlikely. For example, in 2022 Massachusetts passed their own threshold law that would direct 75% of Medicaid dollars to direct care worker wages. It is now 2024 and this rule has yet to be implemented. The legislation did not set a target wage nor did it define what was to be included in the definition of wage. My understanding is that with 27 Aging Services Access Points and Area Agencies on Aging each with their own negotiated personal care services rate, it has been difficult to pare down what will ultimately be included in this definition, similar to the challenge we see CMS facing nationally.

If we are going to increase caregiver wages, it must be done by increasing the financial resources dedicated to the Medicaid program. There are only two ways that this can be done, through an increase in the federal matching funds or through increases in individual states' budgets. Neither option is within the control of CMS. Without truly understanding the financial needs driven by operational and fixed costs of HCBS, we risk compromising important components associated with the provision of care. Training and career development ensure that caregivers are equipped with knowledge and know-how to provide the highest quality care to Medicaid participants. The retention of office staff – schedulers, care coordinators, supervising nurses, etc. – ensures that caregivers, participants, and their families have the supports required to maintain access to the care that many individuals consider a critical lifeline. Investments in quality initiatives and innovation translate to better patient outcomes and overall cost of care management, but this will go by the wayside if providers are forced to comply with an 80% threshold.

I would also mention compliance – this alone is a major cost driver. Numerous state and federal regulatory requirements are necessary to provide HCBS to diverse populations across the country. Imposing aggressive wage thresholds neither considers nor respects the cost of compliance associated with these requirements. In fact, it requires the reallocation of resources away from the necessary investments required to protect the quality and continued access to these services.

As our Chief Compliance Officer, I would like to give Jody the floor to discuss the nature and extent of Modivcare's compliance program and how it could be compromised by the 80/20 Rule.

Finally, I would just like to reiterate the importance of data collection. When Modivcare was still LogistiCare and our sole line of business was non-emergency medical transportation, we saw the value in collecting data. Eventually, our data would be used by the Kaiser Family Foundation in a study that showed the positive impact that NEMT services had on the Medicaid population's health care outcomes. What we have learned from data has helped to drive informed policymaking and cemented the value of the NEMT program and helped to establish it as codified Medicaid benefit.

I urge you to set aside the 80/20 provision of the Medicaid Access Rule until a time that data is collected, and a comprehensive study is done to determine what detrimental impacts this rule could have on our most vulnerable populations.

Again, thank you for your time, and please let us know if there is any additional information that you would like for us to provide.

Presenter: Jody Kepler

We know we are not the first company to speak with you about the 80/20 portion of the Access Rule. However, Modivcare may be the only company that is presenting its Chief

Compliance Officer to the OMB to discuss it. You may have already heard that leaving home and community-based service providers with 20% of their reimbursement for overhead will impact quality initiatives and innovation. Of course, I share their concern. But I also worry about the impact on fraud, waste, and abuse.

As I am sure you know, HHS's Office of the Inspector General expects to recover over 3 billion dollars from its 2023 fraud enforcement and investigation activities. For some reason, I can't even fathom, our government health care system is a target for nefarious actors.

As you likely also know from the OIG's annual workplans, home care is a frequent target of such activities. In response, CMS, the Department of Justice, and health plans expect that health care providers maintain a robust compliance program to support the integrity of government health care services.

Great compliance programs require experienced professionals in the areas of law, government, data science, data analytics, investigating and – very important – internal auditing and monitoring. In addition, companies have to maintain operating systems or vendors for OIG-SAM exclusions screens, ethics hotline services and required training activities.

We already know that some personal care providers are saying that they won't be able to stay in business under an 80/20 rule, or will need to scale back services. You have my commitment that Modivcare is committed to compliance under all circumstances.

However, I worry that the smaller and less sophisticated providers who find their overhead dictated will not be able to keep up with the compliance that is required to oversee these programs. They won't have resources for data professionals - data analytics is one of the most effective ways to catch fraud. They won't have budget for an internal monitoring program to catch issues early. All of the eight elements of an effective compliance program could suffer. Nefarious opportunists will quickly perceive the limitations on supportive services, such as compliance, in a strained environment. The industry may become a bigger target for fraud.

We don't want to enable a system that can't stand up to fraud. We want home and community-based services to have a reputation of integrity, where people are proud to work and want to work.

It is never too late in a process to pump the breaks to preserve integrity, or to pause to consider compliance. We simply do not understand enough about how 80/20 will impact fraud, waste and abuse in the personal care space to proceed with it.

Thank you for your time.