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PROVIDER PAYMENTS AND ACCESS TO MEDICAID SERVICES: A SUMMARY OF CMS' MAY 6 PROPOSED RULE

Introduction

The Medicaid program today provides health and long-term care coverage for about 60 million low-income Americans, including pregnant women, children and parents, people with disabilities, and seniors. Under the Affordable Care Act, beginning in 2014, Medicaid eligibility will expand to reach nearly everyone under age 65 with income below 133% of the federal poverty level ($14,500 for an individual in 2011), bringing an additional 16 million people, mostly uninsured adults, into the program. To help ensure that Medicaid connects enrollees with the care they need, federal Medicaid law establishes a standard for access to care in Medicaid. Specifically, the federal Medicaid statute requires that payments for covered care and services "are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area."[1]

On May 6, 2011, CMS issued a proposed rule [http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10681.pdf] that would, for the first time, provide federal regulatory guidance regarding what states must do to demonstrate their compliance with the access requirement. In the preamble to the rule, CMS makes an explicit linkage between Medicaid provider payment rates and access to care, stating: "We recognize that payment reductions or other adjustments to payment rates are legitimate tools to manage Medicaid program costs and achieve overall budget objectives. However,[…]Payment rate changes are not in compliance with Medicaid access requirements if they result in a denial of sufficient access to covered care and services."[2] CMS issued the proposed rule in part because of recent litigation by providers and beneficiaries challenging state efforts to reduce Medicaid costs by lowering provider payments. Inconsistent court rulings in these lawsuits have created uncertainty for states regarding how to comply with the access requirement. The purpose of the May 6 proposed rule is "to create a standardized, transparent process for States to follow as part of compliance with [the Medicaid access requirement]."[3] However, CMS notes, the rule "would not directly require States to adjust payment rates or take any steps that would not be consistent with efficiency, economy, and quality of care."[4]

This brief summarizes the major provisions of the proposed rule. The public comment period for the regulation closed July 5, 2011.

Scope and framework

The proposed rule would apply to fee-for-service Medicaid, but not to managed care arrangements, including managed care organizations (MCOs) and other risk-based plans and primary care case management (PCCM) programs, in which over 70% of Medicaid beneficiaries nationally receive at least some care.[5] In developing the proposed rule, CMS relied on the framework for assessing access to care that was articulated by the Medicaid and CHIP Payment and Access Commission (MACPAC) in its March 15, 2011 Report to Congress.[6] That framework considers enrollee needs, the availability of care and providers, and utilization of services.

Annual state-level access reviews, ongoing monitoring

Under the proposed rule, states would be required to conduct "medical assistance access reviews" for every covered Medicaid service. Such reviews are not currently required. The state Medicaid agency would have to review access to a subset of Medicaid-covered services every year, and review access to every Medicaid-covered service at least once every five years. Each state would have discretion as to the measures it uses to analyze access to care and the services it reviews in any given year.

In addition to an analysis of access to care in terms of the three factors in the MACPAC framework, the access reviews would have to include information on: 1) beneficiary input; 2) data comparing Medicaid payment rates to customary charges and to Medicare rates, commercial payment rates, and/or Medicaid allowable costs, and stratified by public versus private ownership of the provider; and 3) any access issues identified by the review and the state agency's recommendations. States would also be required to monitor access on an ongoing basis.

States would have to complete their annual reviews by January 1 of each year, with the first reviews due January 1 of the year beginning at least 12 months after the final rule takes effect. Thus, if the final regulations were published in the fall of 2011, the first annual reviews would be due January 1, 2013. States would have to make their reviews available to the public and CMS promptly.

Beneficiary input required

Under the proposed rule, states would be required to collect and document beneficiary input in connection with both annual access reviews and proposals to reduce provider payment rates. Access reviews would have to contain information from beneficiaries gathered through "ongoing mechanisms for beneficiary input on access to care," such as hotlines, surveys, or ombudsmen. If a state Medicaid agency seeks to reduce Medicaid payment rates, the agency would have to obtain input from beneficiaries (and other affected stakeholders) on the impact of the proposed rate changes on continued access to services. This input would have to be reflected in the agency's analysis of the sufficiency of the reduced payment rates.

No provider payment rate reductions without prior access reviews, beneficiary and stakeholder input, and ongoing monitoring

The proposed rule would significantly change the process for reducing Medicaid payments to fee-for-service providers.[7] As under current law, states would have to submit a state plan amendment (SPA) to CMS for approval when making a material change in provider payments. However, under the proposed rule, if a state Medicaid agency proposes to reduce Medicaid payment rates (or restructure them such that the changes could result in access issues), the agency would be required to submit along with the SPA an access review for the service in question that has been completed within the prior 12 months and that demonstrates sufficient access. The agency would also have to submit with the SPA an analysis reflecting its consideration of beneficiary and stakeholder input on the impact of the proposed rate change on continued access to the affected service. Finally, the agency would have to develop procedures to monitor continued access to care after implementation of the payment rate reduction or restructuring.

Current regulations require states to provide public notice of significant changes in Medicaid provider payment. The proposed rule would give states a new option to meet the requirement by posting the information on a state-run website.

Corrective action

If a state identifies access issues through a review or its ongoing monitoring, it would have to submit a corrective action plan to CMS within 90 days that specifies steps and timelines for addressing the issues. States would have discretion to determine their corrective action steps and timelines. However, the rule specifies that the goal for remediation of a deficiency should be no more than 12 months.

Federal funding and technical assistance

The data analysis activities required by the access rule would be reimbursable at the general 50% federal match rate for administrative expenditures. CMS indicates in the rule that it will offer states technical assistance to identify federal and state data resources, and that it will facilitate cross-state collaboration. The agency also plans to develop a standardized template for states to report and make publicly available the data analysis identified in the proposed rule.[8]

Looking ahead

The May 6 proposed rule on state requirements for ensuring access to care in Medicaid represents an important development, particularly in light of the approaching expansion of Medicaid in 2014. The proposed requirement that states seeking to reduce Medicaid provider payment rates take into account the impact of such reductions on beneficiary access to care explicitly recognizes the contribution of payment rates in the access equation.

Given the high level of interest in the proposed rule among states, providers, and advocates for beneficiaries, and the different perspectives they are likely to have on the approach laid out by CMS and whether it goes far enough or too far, it is difficult to anticipate what shape the final rule will take. It also remains to be seen how the Supreme Court will rule on *Independent Living Center v. Douglas*, which will determine whether beneficiaries and providers can sue states in federal court over Medicaid payment cuts that would reduce access. The case is scheduled to be heard on October 3, 2011. If the Supreme Court rules that the federal courts are not available to Medicaid beneficiaries and providers, the CMS rule, when finalized, will play an even more important role in shaping enforcement of state compliance with the federal Medicaid access requirement.

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[1] Section 1902(a)(30)(A) of the Social Security Act.
[2] 76 *Fed. Reg*. at 26343 (May 6, 2011).
[3] 76 *Fed. Reg*. at 26342 (May 6, 2011).
[4] 76 *Fed. Reg*. at 26344 (May 6, 2011).
[5] http://www.statehealthfacts.org/comparemaptable.jsp?ind=217&cat=4.
[6] MACPAC Report to Congress, March 2011 (www.macpac.gov).
[7] To the extent that a state bases its capitation rates for MCOs on the fee-for-service rates it pays for covered services, the procedures in the proposed rule could have an indirect effect on such rates over time, which could in turn affect MCO enrollees' access to care.
[8] *76 Fed. Reg.* at 26346 (May 6, 2011).

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