ALERTS AND UPDATES

CMS: Proposed Rule for States on Medicaid Fee-for-Service Rate-Setting Procedures

May 12, 2011

The U.S. Centers for Medicare and Medicaid Services (CMS) published in the May 6, 2011, *Federal Register* (76 Fed. Reg. 26342) a proposed rule establishing a transparent process that states would be required to follow to change Medicaid payment rates, as well as procedures to ensure ongoing access to care for Medicaid beneficiaries. Under section 1902(a)(30)(A) of the Social Security Act, states are required to ensure that state payments for Medicaid 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 extent that such care and services are available to the general population in the geographic area." The proposed rule was prompted by states increasingly being subject to litigation challenging Medicaid payment rate reductions as conflicting with the quality-of-care and access provisions of section 1902(30)(A). This litigation has led to inconsistent opinions among the federal circuit courts; and therefore, has left states without consistent guidance on section 1902(a)(30)(A)'s requirements for Medicaid rate-setting. Moreover, CMS has noted "[t]ight State budgets coupled with increased demand for services during the recession have led many States to propose reductions in Medicaid provider payments, without clear Federal guidance on how to assure access."

CMS did not adopt the standard previously set forth by the U.S. Court of Appeals for the Ninth Circuit, which interpreted section 1902(a)(30)(A) to mean states are required to conduct cost studies before adjusting payment rates and provide proof that rates are reasonably related to provider costs. Rather, the rule proposes that states conduct periodic data reviews for all covered services using a three-part framework recommended by the Medicaid and CHIP Payment and Access Commission (MACPAC). The three-part framework consists of: (1) enrollee needs, (2) the availability of care and providers and (3) utilization of services. In acknowledging the need for flexibility, CMS proposes requiring states to establish appropriate data elements that focus on the MACPAC three-part framework rather than requiring states to adhere to a standardized methodology. CMS stated that "beneficiaries' experiences in receiving services are a primary driver in determining the sufficiency of service access." Thus, under the rule, states may want to first determine whether beneficiaries' needs are being met. CMS then proposes a range of data that states could use to evaluate the sufficiency of access to care and the impact of Medicaid payment rate reduction or changes in payment methodology.

To ensure ongoing access, states would be required to conduct access reviews for a sampling of Medicaid services each year. The states are permitted to choose the services it will review annually, as long as every Medicaid service is reviewed every five years. The results of the state's annual reviews would have to be published by January 1 each year. The reviews should include the specific measures that the state used to analyze access to care by geographic location, discuss its analysis within the three-part MACPAC framework, discuss any access-to-care issues found in its analysis and make recommendations about the state's compliance with the section 1902(a)(30)(A) requirements. The rule also recognizes, "as States have requested, electronic publication as an optional means of communicating State plan amendments (SPAs) proposed rate-setting policy changes to the public."

When proposing a reduction in Medicaid payment rates or a change in payment methodology, states would be required to submit information from an access review performed within the last year as part of any submission of an SPA that would reduce payment rates or alter the structure of payment rates. Moreover, states would be required to develop procedures to monitor beneficiaries' access to care after a payment rate reduction or change in payment methodology is implemented. The rule also would require states to develop: (1) an ongoing mechanism for beneficiary feedback, (2) a public process for stakeholder comments prior to payment rate reductions or changes in payment provider structure and (3) procedures to implement corrective action plans in the event states identify access issues during their periodic reviews.

Comments to the proposed rule are due, no later than 5 p.m., on July 5, 2011.

For Further Information

If you have any questions about this *Alert*, please contact Frederick (Rick) R. Ball, Erin M. Duffy, any member of the Pharmaceutical, Pharmacy & Food industry group, any member of the Health Law practice group or the attorney in the firm with whom you are regularly in contact.