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# CMS Issues Draft Regulations Linking Medicaid Payment Policies and Access

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**On Friday, April 29, 2011, the Centers for Medicare & Medicaid Services (CMS) issued draft regulations establishing a framework for states to apply in analyzing whether their Medicaid payment policies comply with federal access requirements. The proposed rules represent the first guidance from CMS with respect to how states should assess whether their payment policies provide sufficient access to care for beneficiaries under Section 1902(a)(30)(A) of the Social Security Act (Section (30)(A)).**

While federal law gives states considerable flexibility in establishing payment methods and levels, it does require states to ensure that their payment policies (1) safeguard against unnecessary utilization of care, (2) ensure that payments "are consistent with efficiency, economy, and quality of care," and (3) are sufficient to ensure that Medicaid beneficiaries have the same access to healthcare services as the general population. The proposed regulations focus on the third requirement, often referred to as the "equal access" provision.

Until CMS announced these proposed regulations, the only significant regulations under Section (30)(A) addressed the "efficiency and economy" language of the second requirement and provided that federal matching dollars would not be available for payments to classes of providers in excess of the upper payment limit (UPL), which is the maximum amount the providers would have received under Medicare for comparable services. The UPL provided a blunt tool to ensure that states did not pay too

much for Medicaid-covered services. The equal access provision focuses on the reverse —whether states are paying too little so that Medicaid beneficiaries do not have access to needed services. Recently, the equal access provision has received considerable attention for two reasons: first, as Medicaid enrollment has increased and state revenues have declined, states are increasingly relying on provider rate cuts to contain Medicaid costs; and, second, the expansion of Medicaid coverage under federal health reform has brought into question Medicaid payment policies and provider capacity.

Frustrated by across-the-board rate cuts, providers have increasingly looked to the courts, claiming that such cuts violate Section (30)(A). The federal Courts of Appeals that have reach the merits are split on whether the equal access provision requires states to follow a certain *process* before reducing payment rates or to demonstrate a certain *result* (namely that Medicaid beneficiaries have adequate access to care and services), with two Circuits in each camp. The Eighth Circuit and the Ninth Circuit have held that Section (30)(A) requires a certain process. The Third Circuit and the Seventh Circuit, however, have held that Section (30)(A) requires only a certain result.

The courts are consistent in finding that state budget constraints standing alone are insufficient to defend the challenged rate reductions. However, without clear federal guidance, states facing tight budgets have had no choice but to reduce Medicaid payment levels and hope that the revised rates hold up in court, if challenged. Ultimately, neither states nor stakeholders are well served by this level of ambiguity.

In 2009, Congress established the Medicaid and CHIP Payment and Access Commission (MACPAC) and required it to study and make recommendations on beneficiary access to care in Medicaid and the Children's Health Insurance Program (CHIP). MACPAC reviewed 30 years of research and consulted with stakeholders to develop recommendations on how to measure access to care for Medicaid beneficiaries. In its first report to Congress in March 2011, MACPAC recommended a three-part framework for analyzing access to care that considered (1) enrollee needs, (2) the availability of care and providers, and (3) the utilization of services.

**The Proposed Regulations**

In its draft rules, CMS adopts the MACPAC three-part framework, providing the first guidance to states on how to analyze beneficiary access to care in their Medicaid fee-

for-service programs. CMS stated that it is currently undertaking a review of Medicaid managed care access standards.

Recognizing that states vary in service delivery models and rate structures, CMS proposes flexible guidelines for states to demonstrate consistency with the Section (30)(A) access requirement. CMS notes that the required statutory test is a comparison between Medicaid beneficiary access and access to medical services by the general population. Under the proposed rules, states would each create a process to evaluate access that is tailored to the needs of that state while conforming with CMS's requirements, but states would not be required to meet specified access metrics. Specifically, states must conduct an access review and document that they applied the three-part framework articulated by MACPAC. A state's access review must set forth the specific measures it used to analyze access to care, how those measures relate to the MACPAC framework, and the state's assessment of the sufficiency of access to care based on the review.

In reviewing states' compliance with access requirements, CMS indicates that it intends "to focus on working with States to improve beneficiary access mindful of legitimate efforts to ensure that State policies are consistent with efficiency and economy, as well as the potential advantages of innovative methods of service delivery, provider payment and case management."

**Medicaid Payment Data**

States' reviews must include specific data on Medicaid payment levels, including an analysis of (1) Medicaid rates as a percentage of "average customary provider charges"; (2) Medicaid rates as a percentage of Medicare rates, average commercial payer rates, or the applicable Medicaid "allowable cost of the service"; and (3) an estimate of the average percentage increase or decrease resulting from any proposed change in payment rates. States' rate analyses must include all Medicaid payments to hospitals, both base payments and supplemental payments (e.g., disproportionate share payments and UPL payments). The payment data must be stratified by each of the following categories of providers: state-owned public, non-state-owned public, and private.

### Timing of Access Reviews and Monitoring

States must review a subset of Medicaid services each year by January 1, with all covered services undergoing a full review at least once every five years. If a state proposes reducing or restructuring provider rates, the state must submit, along with its state plan amendment, an access review that was completed within the prior 12 months. For example, if a state proposes to reduce inpatient rates, then the state would be required to submit an access review for inpatient rates that was completed in the prior 12 months. Presumably, if a state proposes reductions in provider rates in *all* service categories, then that state would need to submit access reviews for *all* services. Additionally, CMS proposes requiring that states develop a process to monitor continued access to care after implementing a rate reduction or payment restructuring.

In the proposed rule, CMS also requires that states regularly solicit input on access to care from beneficiaries. Specifically, states must establish ongoing mechanisms for beneficiary input, which may include hotlines, surveys, or an access ombudsman. Additionally, states considering rate reductions or payment restructuring would be required to solicit input from beneficiaries and affected stakeholders with respect to the likely impact of the proposed changes.

### Corrective Action Plans

If a state's access review or ongoing access monitoring reveals barriers to access, the state must submit a corrective action plan to CMS within 90 days. The corrective action plan must outline specific steps and timelines to address the access issues identified so that the state resolves the issues within 12 months. Again, CMS proposes granting states flexibility in crafting their corrective action plans so that states can tailor their corrective action plans to the unique dynamics of their state.

### Conclusion

Generally, the draft regulations encourage states to engage in a multifaceted analysis of issues potentially affecting access rather than to focus only on payment levels. Indeed, in the preamble to the proposed rule, CMS expressly rejects the Ninth Circuit's requirement that states must complete a provider cost study to ensure that payment rates bear a reasonable relationship to the provider's costs. CMS further states in the

preamble that if a state discovers access issues, "states may be able to resolve those issues through means other than increasing payment rates." CMS notes that states could improve access by, among other things, improving provider enrollment and retention, offering incentive payments for offering weekend or evening appointments, or structuring rates to encourage the development or expansion of clinics in underserved areas. That said, there is a disconnect between the preamble and the text of the proposed rule. While the preamble states that payment levels are only one factor states should consider when analyzing access, the draft rule requires states to collect specific information on Medicaid payment levels. In this way, the draft regulations implicitly signal that payment levels may be the most important factor in a state's access analysis, even though the preamble emphasizes that states should consider factors other than payment levels.