Q&A

Adequacy of Medicaid Fee-For-Service Payments: Final Rule[1]

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Q: I hear that the federal government has recently issued regulations related to Medicaid provider payments. What do these regulations do?

A: The federal Centers for Medicare & Medicaid Services (CMS) have issued final regulations establishing a process for states to comply with the Medicaid Act's requirements that payments be sufficient to ensure adequate provider participation in the program. While these regulations provide additional direction and focus to states, they do not require as much CMS oversight as advocates had hoped. Moreover, the regulations state that the statutory requirement and therefore the regulations do not apply to managed care rates.

Discussion

The Medicaid program is a vendor payment program in which providers choosing to participate in Medicaid receive reimbursement for services they provide to beneficiaries. States have flexibility to determine reimbursement rates, but must assure that payment rates are sufficient to attract 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

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general population in the geographic area.[2] This requirement is commonly known as the "equal access" provision. In addition, payments must safeguard against unnecessary utilization of care.[3]

Despite the equal access requirement, beneficiaries have often had difficulty finding providers that accept Medicaid, particularly with certain types of services. Advocates and providers have long complained of states' failure to comply with the equal access provision and that CMS has failed to provide the oversight and enforcement necessary to ensure compliance.

As a result, providers and beneficiaries have filed numerous lawsuits over the years alleging violations of the equal access provision.[4] Last year, however, the Supreme Court held that providers do not have the right to enforce the equal access provision in court.[5] While the Court did not address the right of beneficiaries to enforce the requirement, it is very doubtful that such enforcement is possible.[6] Accordingly, more than ever, beneficiaries, providers, and advocates are looking to CMS to ensure that states comply with the equal access requirement.

Federal Regulatory Action

In 2011, recognizing the need for additional oversight and guidance from the Department of Health and Human Services promulgated regulations to implement § 1396a(a)(30)(A), including the equal access provision.[7] On May 6, 2011, CMS issued a proposed rule prescribing methods to comply with the provision and, in particular, to assure access to services.[8] While advocates and providers welcomed CMS' efforts to ensure that beneficiaries had access to services, particularly the requirements for public

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[2] 42 U.S.C. § 1396a(a)(30)(A).

[3] *Id.*

[4] *See* NHELP, AN ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM, Sec. 4.14(T), fn. 244.

[5] *Armstrong v. Exceptional Child Care Ctr.,* 135 S. Ct. 1378 (2015). For further discussion of this decision, *see* Jane Perkins, *Q&A: Armstrong v. Exceptional Child Ctr.* (Apr. 23, 2015); Jane Perkins, *Update on Private Enforcement of the Medicaid Act: The Supremacy Claus and 42 U.S.C. § 1983* (Sept. 29, 2015), both available from TASC and NHeLP.

[6] CMS has opined that neither providers nor beneficiaries can enforce the provision. *See* p. 5, *infra.*

[7] *See also* Memorandum from Byron Gross and Jane Perkins, NHeLP, *et al.*, to Cndy Mann, Director, Centers for Medicare & Medicaid Services, *Suggestions for Development of Proposed Regulations Implementing 42 U.S.C. § 1396a(a)(30)(A)* (Feb. 11, 2011).

[8] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *Medicaid Program: Methods for Assuring Access to Covered Medicaid Services,* 76 Fed. Reg. 26,342 (May 6, 2011).

notice and input into proposed rate reductions, many opined that the regulations were not strong enough and failed to provide sufficient criteria to establish a robust enforcement scheme. Along with other stakeholders, NHeLP complained that CMS has not specified that the equal access requirement applied to managed care rates.[9]

After more than four years, on November 2, 2015, CMS finally issued a final rule implementing the regulations.[10] Although the rule is final and the regulations scheduled to become effective on January 4, 2016, CMS will be accepting further comments and information. First, comments may be submitted on whether to adjust the new requirements for ongoing state review of beneficiary access.[11] In addition, CMS issued a separate Request for Information (RFI) seeking input on development of standards for beneficiary access to covered services.[12] Additional comments and information must be submitted by January 4.[13] The final rule and the RFI are discussed below.

Final Regulations

In the final rule, rather than providing for a standardized federal enforcement scheme, as NHeLP and other advocates had urged, CMS chose to "provid[e] increased state flexibility within a framework to document measures supporting beneficiary access to services."[14] Specifically, CMS requires each state Medicaid agency to develop a **medical assistance monitoring review plan** (review plan) to be published and available for public review and comment at least 30 days before finalization and submission to CMS. The agency must also consult with the state's Medical Care Advisory Committee (MCAC) when developing the plan.[15]

The regulations require that the review plan include the following elements:

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[9] *See, e.g.,* National Health Law Program, *Comments on Regulation Providing Methods for Assuring Access to Covered Services* (June 17, 2011), available at http://www.healthlaw.org/component/jsfsubmit/showAttachment?tmpl=raw&id=00Pd0000006EySJEA0.

[10] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs, *Medicaid Program: Methods for Assuring Access to Covered Medicaid Services,* 80 Fed. Reg. 67,575 (Final Rule) (Nov. 2, 2015).

[11] 80 Fed. Reg. at 67,576.

[12] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs, *Medicaid Program: Request for Information (RFI) – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program*, 80 Fed. Reg. 67,377 (Nov. 2, 2015).

[13] 80 Fed. Reg. at 67,576 (Final Rule); 80 Fed. Reg. at 67,377 (RFI).

[14] 80 Fed. Reg. at 67,577.

[15] For discussion of the MCAC, *see* NHELP, A GUIDE TO OVERSIGHT, TRANSPARENCY, AND ACCOUNTABILITY IN MEDICAID MANAGED CARE, p. 14 (March 2015).

1. **Analysis,** including data sources, methodologies, baselines and other elements to determine the sufficiency of access to care, as well as specification of necessary data elements. The analysis must consider (a) whether beneficiary needs are fully met; (b) availability of care by provider type and site; (c) changes in utilization; (d) characteristics of beneficiary population, including people with disabilities; (e) actual or estimated levels of provider payments to non-Medicaid providers;
2. **Beneficiary and provider input** obtained through public rate-setting processes, MCACs or other mechanisms;
3. **Comparative payment rate review,** including a percentage comparison of Medicaid fee-for-service rates with other public and private rates, including Medicaid managed care rates;
4. **Standards and methodologies**, meaning the specific measures that the state uses to analyze access to care, including time and distance standards, providers accepting new Medicaid patients, availability of telehealth, and numerous others.

States must start developing its review plan in July 1, 2016 and develop it by July 1 of the first review year and update it by July 1 of each subsequent review period.[16] For certain services, the state must analyze provider access at least once every three years: (1) primary care services, including FQHC; (2) physician specialist services; (3) behavioral health services; (4) pre- and post-natal obstetric services, including labor and delivery; (5) home health services; (6) services for which a rate reduction or restructuring is scheduled; (7) additional types of services for which CMS or the state has received a higher than usual volume of complaints; and (8) additional services prescribed by the states.[17]

When states are submitting a state plan amendment to reduce provider rates or restructure them where the changes could result in diminished access, the state must submit an **access review** for each service. The access review "must demonstrate sufficient access" for all services for which the rate reduction or restructuring is proposed.[18] In addition, the state must establish procedures to monitor continuing access to care. The monitoring must be conducted at least annually and be in place for at least three years. The regulation requires that the state establish "clearly defined

[16] 80 Fed. Reg. 67,611 (to be codified at 42 C.F.R. § 447.203(b)(1)-(5)).
[17] *Id.* (to be codified at 42 C.F.R. § 447.203(b)(5)(ii)).
[18] 80 Fed. Reg. 67,612 (to be codified at 42 C.F.R. § 447.203(b)(6)(i)).

measures" but does not specify what those methods should be. States must also maintain a record of public input.[19]

When a state review identifies access deficiencies, the state must submit a corrective action plan within 90 days and remediation should generally be done within 12 months. The state may, but is not required to, address deficiencies through increased payment rates, outreach, additional transportation or telemedicine, care coordination, or reduction of barriers to provider enrollment.[20] States must provide public notice of changes in statewide methods and standards for submitting payment rates through a web site accessible to the general public, in addition to the other methods of publication already prescribed in the existing regulations.[21]

The regulations specify that CMS may disapprove a state plan amendment affecting payments rates if the required documentation is not included. Moreover, the rule specifies that CMS may withhold payments to a state in whole or part to remedy an access deficiency, as it is empowered to do for other violations of Medicaid requirements.[22]

Request for Information

CMS also issued a request for information "to inform the potential development of standards" for beneficiary access to covered services. This includes both fee-for-service and managed care delivery systems because, CMS states, § 1396a(a)(30)(A) does not govern managed care plans.[23] For this reason, CMS wants to align the measures and methods used to review and analyze access to care in both fee-for-service and managed care.[24]

CMS further states that the Supreme Court's decision in *Armstrong* holding that providers and beneficiaries do not have a private right of action to challenge Medicaid payment rates in federal courts, "plac[es] greater importance on CMS review to ensure that rates" comply with the equal access requirement. CMS is therefore "working to strengthen the framework for CMS review . . ." Accordingly, CMS requests public input

[19] *Id.* (to be codified at 42 C.F.R. § 447.203(b)(7)).
[20] *Id.* (to be codified at 42 C.F.R. § 447.203(b)(8)).
[21] *Id.* (to be codified at 42 C.F.R. § 447.205(d)(iv)).
[22] *Id.* (to be codified at 42 C.F.R. § 447.204)); *see also* 42 C.F.R. § 430.35.
[23] 80 Fed. Reg. at 67,378.
[24] *Id.*

on the additional data sources and approaches that could help determine whether access to care is sufficient.[25]

CMS seeks input on a variety of questions. The agency is considering four different approaches to measuring access, while seeking input on any other actions that could be taken, specifically:

- Developing a core set of measures for all states to use;
- Measuring access to LTC and HCBS;
- Setting national access to care thresholds;
- Establishing a process for access to care that would allow beneficiaries to raise and seek resolution of concerns about access.[26]

CMS asks more than sixty questions under four general topics: (1) access to care data collection and methodology; (2) access to care thresholds and goals; (3) alternative processes for access concerns: and (4) access to care measures. In general, CMS asks a number of questions about the feasibility of and desirability of national standards and thresholds. Its questions also show concern about financial and administrative burdens on the states in implementing the equal access regulations. In addition, a number of these questions relate to people with disabilities, including the following:

- What do you believe we should consider in undertaking access to care data collection in areas related to . . . community and institutional settings for long term care deliver, behavioral health, . . . people with disabilities, . . . [and]] individuals with chronic conditions who may have limited functional support needs related to activities of daily living but nonetheless require more intensive care than other Medicaid beneficiaries, such as persons living with HIV/AIDS?
- Specific to LTSS, including HCBS, what factors do you believe we should consider in measuring access to care?
- Do you believe access to HCBS differs from measuring access to acute medical care?27

With regard to access to care, CMS also asks for input on the availability of certain types of care, including:

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[25] 80 Fed. Reg. at 67,387. While *Armstrong* did not directly address the rights of beneficiaries to enforce the equal access provision, the reasoning of the decision appears to apply equally to beneficiary suits.

[26] *Id.*at 67,379.

[27] *Id.* at 67,380.

- Specialty care (including HCBS, addiction, and psychiatry services);
- Direct support workforce for home health and HCBS;
- Psychiatric and substance abuse clinicians;
- Behavioral health clinics or community mental health centers.[28]

Further, the agency asks for input about sources of care, service utilization, and comparison payments.[29]

Conclusion and Advocacy Recommendations

While the regulations do provide some additional direction and focus to states, it is disappointing that CMS did not do more to establish a federal enforcement scheme. Moreover, despite acknowledging the issues created by the *Armstrong* decision, the regulations fail to address the oversight role that CMS should be playing. It is particularly important to clarify how beneficiaries and providers could address problems with access to services. The rule fails to do this.

Moreover, the regulations do not address many concerns that NHeLP raised in 2011 in its comments on the proposed rule. For example, there are no clear criteria or procedure for measuring access. CMS simply provides states with a few benchmarks and then leaves it to them. While CMS does ask for comments and suggestions in a separate request for information on access measures and metrics, it provides a very short period of time for advocates to submit comments and there is no indication of when and in what form such measures and metrics may be issued. In addition, without any statutory authority to do so, the regulation excludes Medicaid managed care from the scope of § 1396a(a)(30). Given that nearly 70 % of beneficiaries are enrolled in managed care, this raises the question of how much of an impact these regulations will actually have.

Advocates should provide input to CMS on at least some of these questions, if time allows. Unfortunately, CMS only allowed 60 days to respond to the RFI, which means that comments are due on **January 4, 2016**. Once the regulations become final, however, advocates should engage with their state's MCAC and provide information and direction to that body to influence the development and monitoring of the access review plan. They should also engage with providers of specific services and monitor their state's plan amendment process. Finally, advocates should watch for further information from NHeLP about this issue.

[28] *Id.*
[29] *Id.*