NATIONAL HEALTH LAW PROGRAM

Protect Medicaid Funding

Access to Providers

Issue #9

Medicaid provides a long-term investment in health that helps people succeed. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, and reduces health care disparities.[1] Medicaid coverage is tailored to the unique needs of low-income individuals and families, but still costs less per enrollee than employer-based insurance.[2] Despite Medicaid's proven success and efficient use of funds, opponents repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the 97 million people who benefit from Medicaid each year.[3] Medicaid's core consumer protections make the program work for enrolled populations, including children, parents, pregnant women, low-income workers, older adults, and people with disabilities. This fact sheet examines why one such set of protections, Medicaid provider access rules, is so important to Medicaid enrollees and how it is threatened by spending caps.

Why Medicaid provider access protections are important:

- **Medicaid law includes provider payment rate requirements.** No health insurance can provide meaningful access to care if providers are paid so little that they do not participate. Medicaid includes specific rules to promote adequate provider payment rates. States must set payment rates high enough to ensure that access to care in Medicaid is equivalent to access for the general population in the geographic area.[4] In addition, payment rates for Medicaid managed care must be "actuarily sound."[5] While Medicaid does have some provider access problems, these are a function of two factors: (1) historically low enforcement of Medicaid's provider payment rate requirements; and (2) how little Medicaid spends, considering the size and needs of the covered population, compared to other sources of coverage.[6] Medicaid is extremely efficient with the dollars allocated to the program, spending less per enrollee than private insurance and maximizing coverage for approximately 97 million of the country's most vulnerable individuals.

- **Medicaid managed care has network adequacy requirements.** The Medicaid population includes a wide range of vulnerable individuals, including older adults, persons with disabilities, pregnant women, women with breast and cervical cancer, and children with behavioral health conditions. A robust network of providers is necessary to

effectively cover such a diverse and complex population. Each Medicaid managed care plan must maintain a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the enrollees in the service area.[7] Managed care plans must also follow state-established standards governing the amount of travel time and the distance between enrollees and providers.[8]

- **Medicaid requires coverage of community health clinic services**. Low-income individuals heavily depend on care from federally qualified health centers (FQHCs) and rural health clinics (RHCs) in their communities.[9] Medicaid requires states to cover FQHC and RHC clinic services, including for the Medicaid expansion population.[10] State managed care plans are also required to include FQHC services.[11] Medicaid law guarantees fair minimum payment rates for these providers, including payments made by managed care plans.[12]

How funding caps threaten Medicaid provider access protections:

- **Funding caps would lead to provider rate cuts.** Funding caps would reduce federal Medicaid funding and shift those costs onto states. Faced with less money to run the same Medicaid program, states would cut provider rates to save money. This would harm providers and health care infrastructure, reduce provider participation in Medicaid, and make it more difficult for Medicaid enrollees to access care. Rate cuts and related access problems would likely be most harmful in rural settings where providers are often scarce.

- **Funding caps would lead to restrictive provider networks.** States trying to make up for lost federal funding would also likely implement restrictive provider networks to save money. Enrollees in underserved areas, such as rural areas, would be seriously harmed. Enrollees with complex medical conditions, such as many older adults or children with developmental problems, would also be harmed by reduced access to specialists. States would likely reduce provider networks to the minimum legal limits and/or seek authority to ignore Medicaid standards for networks.

- **Spending caps would likely lead to reduced access to providers**. Another strategy states would likely use to save costs once their federal funding is reduced is to create barriers to accessing providers. For example, states may increase use of utilization controls such as prior authorization and referral requirements or treatment limits to reduce access to medical providers. Another tactic states may use is increasing cost sharing such as premiums and copayments, making it difficult for low-income individuals to afford health care visits. Policies like these would particularly harm individuals with chronic health conditions or disabilities who need regular medical care to stay healthy.

[1] Harvey W. Kaufman et al., *Surge in Newly Identified Diabetes among Medicaid Patients in 2015 within Medicaid Expansion States under the Affordable Care Act*, 38 DIABETES CARE 833 (2015) (Medicaid coverage improves diabetes screening and treatment initiation); DAVID W. BROWN ET AL., NAT'L BUREAU OF ECON. RESEARCH, MEDICAID AS AN INVESTMENT IN CHILDREN: WHAT IS THE LONG-TERM IMPACT ON TAX RECEIPTS? 20 (2015), http://www.nber.org/papers/w20835 (Medicaid improves long-term outcomes for children); Thomas C. Buchmeuller et al., *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage* 106 AM. J. PUB. HEALTH 1416, 1420 (2016) (Medicaid expansion reduced health care disparities).

[2] TERESA COUGHLIN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT DIFFERENCE DOES MEDICAID MAKE? 4, 7 (May 2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (employer-based coverage would cost 28% more than covering the same low-income individual with Medicaid).

[3] CONG. BUDGET OFFICE, DETAIL OF SPENDING AND ENROLLMENT FOR MEDICAID FOR CBO'S MARCH 2016 BASELINE (2016), https://www.cbo.gov/sites/default/files/51301-2016-03-Medicaid.pdf. Though 97 million individuals enrolled in Medicaid over the course of 2015, the average monthly enrollment was 76 million. *Id*. This underscores the importance of Medicaid as a source of coverage for individuals who temporarily lose coverage, such as individuals between jobs.

[4] 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.203 – 204.

[5] 42 U.S.C. § 1396b(m)(2)(A)(iii).

[6] *See* EDWIN PARK & MATT BROADDUS, CENTER ON BUDGET AND POLICY PRIORITIES, CORRECTING SEVEN MYTHS ABOUT MEDICAID (2014), http://www.cbpp.org/cms/?fa=view&id=4023.

[7] 42 C.F.R. § 438.207(b)(2).

[8] *Id*. § 438.68.

[9] Health centers provide services to one in three people living in poverty, and 72% of all health center patients are living in poverty. *See* NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, A SKETCH OF COMMUNITY HEALTH CENTERS (2014), http://www.nachc.com/client//Chartbook_2014.pdf.

[10] 42 U.S.C. §§ 1396d(a)(2)(B) and (C), 1396u-7(b)(4).

[11] *Id*. § 1396n(b).

[12] *Id.* §§ 1396a(bb), 1396b(m)(2)(A)(ix).