



Protect Medicaid Funding Issue #4: Access to Providers (Updated September 2024)

Michelle Yiu and [David Machledt](#)

Access to Providers

Medicaid helps people live healthier and more economically secure lives. It increases the diagnosis and early treatment of chronic conditions, enhances educational achievement and future earnings for covered children, reduces health care inequities, and provides comprehensive, high-quality, and cost-effective care.¹ Medicaid coverage is tailored to the unique needs of individuals and families with low incomes but still costs less per beneficiary than private insurance.² Medicaid's core beneficiary protections make the program work for enrolled populations, including children, parents, pregnant people, low-income workers, older adults, and people with disabilities.

Despite Medicaid's proven success and efficient use of funds, detractors repeatedly seek to cut or cap funding for the program. These proposals seriously jeopardize the health and financial security of the over 80 million people who benefit from Medicaid and CHIP.³ This fact sheet examines why access to Medicaid providers is important to Medicaid beneficiaries and how they are threatened by funding 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 requirements 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 Payment rates for Medicaid managed care must be "actuarially 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 Still, Medicaid is

efficient with the dollars allocated to the program, spending less per beneficiary than private insurance and maximizing coverage for the country's most underserved individuals.

Medicaid managed care has network adequacy requirements. The Medicaid population includes a wide range of underserved individuals with various health needs, including older adults, people with disabilities, pregnant people, people 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 quantitative network adequacy standards for particular kinds of providers.⁸ Recently finalized rules set maximum wait times for making appointments for key services and will require states to verify those standards with annual independent secret shopper surveys.⁹

Medicaid requires coverage of community health clinic services. Individuals with low incomes heavily depend on care from federally qualified health centers (FQHCs) and rural health clinics (RHCs) in their communities.¹⁰ Medicaid requires states to cover FQHC and RHC clinic services, including for the Medicaid expansion population.¹¹ Managed care plans must also ensure that FQHC services are accessible to their enrollees to the same extent as such under Medicaid fee-for-service.¹² Medicaid law guarantees fair minimum payment rates for FQHCs, with state Medicaid agencies paying the difference when total managed care plan payments to an FQHC do not meet the minimum standard.¹³

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 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 beneficiaries 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. Beneficiaries in underserved areas, such as rural areas, would be seriously harmed. Beneficiaries with complex medical conditions, such as many older adults or children with developmental disabilities, 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 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, making it difficult for individuals with low incomes to afford health care visits. Policies like these would particularly harm individuals with chronic health conditions or disabilities who need regular care to stay healthy.

ENDNOTES

- ¹ Robin Rudowitz et al., Kaiser Fam. Found., *10 Things to Know about Medicaid* (Jun. 30, 2023), <https://www.kff.org/mental-health/issue-brief/10-things-to-know-about-medicaid/>; MACPAC, *Access in Brief: Children’s Experience in Accessing Medical Care* (Nov. 2021), <https://www.macpac.gov/wp-content/uploads/2016/06/Access-in-Brief-Childrens-Experiences-in-Accessing-Medical-Care.pdf>.
- ² Heidi Allen et al., *Comparison of Utilization, Costs and Quality of Medicaid vs. Subsidized Private Health Insurance for Low-Income Adults*, 4 JAMA NETWORK OPEN (2021), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774583> (“ . . . overall health care spending was more than 80% higher among Marketplace-eligible adults than among Medicaid-eligible adults. This difference was no longer significant when claims were adjusted to Medicaid prices, indicating that the cost differences were driven by higher prices for the same services in the Marketplace compared with Medicaid.”). See also Hannah Katch et al., Ctr. on Budget & Pol’y Priorities, *Frequently Asked Questions About Medicaid* (Nov. 22, 2019), <https://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid> (Private insurance costs twenty-two percent more than covering the same low-income individual with Medicaid).
- ³ CMS, *May 2024 Medicaid & CHIP Enrollment Data Highlights* (Aug. 30, 2024), <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.
- 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). 42 C.F.R. Part 438.
- ⁶ See Hannah Katch, *supra* note 2; Molly O’Malley Watts et al., Kaiser Fam. Found., *State Medicaid Home & Community-Based Services (HCBS) Programs Respond to COVID-19: Early Findings from a 50-State Survey* (Aug. 10, 2021), <https://www.kff.org/coronavirus-covid-19/issue-brief/state-medicaid-home-community-based-services-hcbs-programs-respond-to-covid-19-early-findings-from-a-50-state-survey/>; 42 C.F.R. § 447.203. There is ongoing work to address provider access problems. CMS recently finalized regulations that will increase transparency and accountability on Medicaid rates and Medicaid provider access. CMS, *Ensuring Access to Medicaid Services*, 89 Fed. Reg. 40542 (May 10, 2024); CMS, *Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*, 89 Fed. Reg. 41002 (May 10, 2024).
- ⁷ 42 C.F.R. § 438.207(a), (b)(2).
- ⁸ *Id.* § 438.68.
- ⁹ 42 C.F.R. § 438.68(f).
- ¹⁰ Health centers provide services to one in three people living in poverty, and 91% of all community health center patients are living in or near poverty. See Nat’l Assn. of Cmty. Health Cts., *Community Health Center Chartbook 2024* (March 2024), <https://www.nachc.org/resource/community-health-center-chartbook/>.
- ¹¹ 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(2)(B) and (C), 1396u-7(b)(4).
- ¹² *Id.* § 1396n(b); See Medicaid & CHIP Payment & Access Comm’n, *Medicaid Payment Policy for Federally Qualified Health Centers* (Dec. 2017), <https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf>.

¹³ *Id.* §§ 1396n(b), 1396a(bb), 1396b(m)(2)(A)(ix).