

## Medicaid Payment Reform: What Policymakers Need to Know About Federal Law

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### Foreword

CHCS is pleased to publish the 2nd (and 3rd) in its series on reforming Medicaid payment. Having made a compelling case for an initial focus on the fundamentals of payment methodologies, our senior program consultant, Deborah Bachrach, produced an insightful paper on Medicaid payment statutes, regulations, and court rulings. This paper, *Medicaid Payment Reform: What Policymakers Need to Know About Federal Law*, is intended to provide federal and state government officials and other Medicaid stakeholders with an accessible legal context for understanding Medicaid payment as we know it.

The third paper in our series, *Sound Practices in Medicaid Payment for Hospital Care*, by Kevin Quinn and Connie Courts of ACS, again with Ms. Bachrach's guiding hand, scans current state practices in hospital inpatient and outpatient payment and suggests approaches for incentivizing improvements in quality and reductions in unnecessary expenditures. Taken together with Ms. Bachrach's initial paper, *Payment Reform: Creating a Sustainable Future for Medicaid*, CHCS hopes that it is helping federal and state policymakers take fuller advantage of Medicaid's ever-increasing purchasing power. By getting its payment fundamentals in order, Medicaid will be able to take its rightful seat at the payment reform table with Medicare and commercial purchasers.

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Since its enactment in 1965, Medicaid has been jointly administered and financed by the state and federal governments. Under overarching federal rules and federal oversight, states have considerable flexibility to define the operating details of their respective state Medicaid programs including eligibility standards, covered services and supplies, and provider payments and networks.

The recent federal health care reform legislation alters the federal-state Medicaid partnership in a number of important ways. For example, the Patient Protection and Affordable Care Act (ACA): (1) establishes, for the first time, national eligibility levels and enrollment standards; (2) provides additional requirements with respect to covered benefits; and (3) significantly increases federal matching dollars for the cost of care for childless adults and many parents as well as for some services. To improve the quality of care and contain Medicare and Medicaid expenditures, the ACA establishes and funds a Center for Medicare and Medicaid Innovation and authorizes more than 30 demonstrations to test new payment strategies across all payers. Specifically with respect to Medicaid payment policies, the ACA reduces Medicaid funding for hospitals that serve disproportionately large numbers of Medicaid and uninsured patients; requires and funds increases in Medicaid payment for primary care services; and bars Medicaid from reimbursing for health care-acquired conditions resulting from hospital treatment. However, while payment and delivery system reform are central goals of the ACA, it does not fundamentally alter the statutory scheme governing state Medicaid payment policies.

This brief examines federal Medicaid law, regulations, and court decisions that govern Medicaid payment practices in both fee-for-service (FFS) and managed care. This is the lens through which state payment policies must be evaluated in the first instance. Accordingly, this brief starts with a short review of how states and the federal government have historically approached rate setting and reflects on the

## IN BRIEF...

As Medicaid transitions from a welfare program to the nation's largest health insurer, it is critical that payment policies support high-quality, cost-effective care. This analysis examines the requirements of federal law that govern Medicaid payment practices. In sum:

- Federal law requires states to adopt Medicaid payment practices that: (a) safeguard against unnecessary utilization; (b) reinforce efficiency, economy, and quality of care; and (c) assure that beneficiaries have the same access as others in the geographic area.
- To date, the Centers for Medicare & Medicaid Services (CMS) has provided limited additional guidance, leaving states, and in some instances the courts, with the task of developing the standards or methodologies that give meaning to the statutory requirements.
- Federal regulations or standards would provide states with a much-needed roadmap for establishing sound payment fundamentals and a sound base upon which to build the payment reforms called for in the Patient Protection and Affordable Care Act.

implications of federal health reform. It then discusses the statutory and regulatory boundaries that states must consider in crafting, and the federal government must apply in approving, state payment choices. The final section focuses on the implications of these rules (or lack thereof) as states and the federal government seek to ensure that Medicaid purchases cost-effective, quality care. With Medicaid slated to become the nation's single largest insurer covering 25 percent of all Americans, getting Medicaid payment right is critical. Getting it right begins with an understanding of the legal framework.

### Background

Under federal Medicaid law, as interpreted by CMS, states have significant freedom to determine payment methods and amounts. Federal law provides broad parameters and lays out few specifics. With the exception of payment mandates for certain provider categories such as Disproportionate Share Hospitals (DSH hospitals) and Federally Qualified Health Centers (FQHC), federal law generally addresses payment standards

that: guard against unnecessary utilization; are consistent with efficiency, economy and quality of care; and assure that Medicaid beneficiaries have the same access to care as others in the community.<sup>1</sup> Regulations establish “upper payment limits” for Medicaid rates to institutional providers.<sup>2</sup> Because CMS has provided only limited regulatory guidance, stakeholders are increasingly turning to the courts, which have further interpreted the federal statutory mandates. Finally, Congress and CMS have stepped in to constrain state payment and financing strategies intended to maximize federal Medicaid dollars without the required state match.

Historically, little attention has been paid to Medicaid's payment policies or the impact of these policies on access, quality, and efficiency. Each state develops its own payment methods and amounts and each CMS regional office, overseen by central office staff, leads its own review and approval process. CMS review tends to focus on states' compliance with public process requirements and upper payment limit (UPL) demonstrations,<sup>3</sup> while states seek to juggle budget constraints and provider demands. Indeed, earlier this year, when this author Googled the phrase “Medicaid Payment Policy,” Google responded: “Did you mean Medicare Payment Policy?” The fact is whether due to generally vague federal payment rules, Medicaid's genesis as a welfare program, its 50-state structure and bifurcated administration, or diminished state revenues and staffing shortages, Medicaid generally has not been a sophisticated purchaser. Programs often fail to effectively leverage Medicaid's market position to buy cost-effective, quality care. But that is rapidly changing.

Medicaid payment policies influence whether beneficiaries have access to care and the amount, type, and quality of care they receive. And, all of this determines how much the state and federal governments spend on Medicaid. Under

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health care reform, roughly 20 million more people will become eligible to enroll in Medicaid in 2014.<sup>4</sup> And, every new enrollee will need access to effective and efficient care. That is just one reason why states and their federal partners are rethinking Medicaid payment policies to ensure that they are supporting access to quality care at the lowest total cost.

Also triggering this new attention are: national discussions on retooling payment policies to bring down costs, enhance quality, and improve outcomes; the ACA's substantial investment in payment reform; the creation of the Medicaid and CHIP Payment and Access Commission (MACPAC); and, last but certainly not least, mounting state budget deficits. While the key federal statute governing Medicaid payment policies was enacted in 1989, its roots date back to Medicaid's enactment in 1965.<sup>5</sup> The principles it advances are no different than those espoused by today's payment experts and embraced by the ACA. In the sections that follow, this brief explores: (1) how these broad principles have been translated into operating rules by CMS and the courts and effectuated by states; (2) where specific payment provisions dictate state payment rules; and, (3) where additional federal guidance is needed.

## Overview of Federal Legal Framework

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The tie that binds state and federal government in Medicaid is the statutory provision noting that "The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance."<sup>6</sup> The "State Plan" is the mechanism by which a state administers Medicaid while adhering to federal requirements. There are 71 statutory requirements that a State Plan must meet before it is approved by CMS, including setting appropriate payment rates for each

type of service covered in the State Plan, describing the methodology by which the rates were established, and providing a public notice and comment period for determining payment rates for hospitals, nursing homes and intermediate care facilities for the mentally retarded (ICFs/MR.)<sup>7</sup>

For the most part, federal payment laws are broad with only limited additional detail in regulations. Accordingly, states have considerable freedom to establish their own payment methods and amounts. The overarching federal substantive requirement with respect to state payment policies is found at Section 1902 (a)(30)(A) of the Social Security Act<sup>8</sup> and provides that:

"A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments 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."

While Section 1902(a)(30)(A) cited above is often referred to as the "Equal Access Provision," in actuality it imposes three requirements on state payment policies and "equal access" is the third. (Accordingly, this brief refers to this provision as "Section (30)(A)").

As discussed below, the limited regulatory guidance under Section (30)(A) tends to focus on the second requirement with respect to "efficiency and economy." Court decisions tend to focus on both the "efficiency, economy and quality of care" language of the second requirement and even more on the "equal access provisions"

of the third requirement. And both the regulations and the judicial decisions focus almost exclusively on payment levels, not on payment methods. There is no regulatory or judicial guidance with respect to the unnecessary utilization requirement.

### ***CMS Interpretation of Section (30)(A)***

Federal law speaks broadly to rates that: (a) discourage unnecessary utilization; (b) are consistent with economy, efficiency, and quality; and (c) assure equal access. However, it is the UPL regulations that have become a central focus of federal review of Medicaid payments under Section 30(A), providing little more than a blunt tool to contain Medicaid spending.<sup>9</sup>

More than any other, the implementing regulations that give meaning to and are derived from Section (30)(A) are the UPL regulations.<sup>10</sup> These regulations are intended “to ensure State Medicaid payment systems promote economy and efficiency.”<sup>11</sup> They do so by limiting the amount that states can pay in the aggregate for services provided by three classes of hospitals, nursing homes, and ICFs/MR, and for outpatient services provided by three classes of hospitals and clinics. The three classes are: state-owned; non-state-owned, public; and private entities. Generally for each class of provider, UPLs are tied to Medicare reimbursement rates or provider costs or charges. To secure CMS approval of the rate provisions of State Plans, states must demonstrate, with exacting detail, that aggregate payments to each provider group do not exceed either provider costs or what Medicare would have paid for the same services. The federal focus on payment amounts is understandable, but it is notable how little federal attention has been paid to other aspects of Section (30)(A).

### ***Judicial Interpretations of Section (30)(A)***

While, and to some extent because, CMS has provided limited guidance regarding the meaning of Section (30)(A), numerous

federal courts have examined the provision in response to lawsuits, which are almost always brought by providers challenging state payment levels.<sup>12,13</sup> As a result, the facts and the legal findings are generally provider-centric. That is, the law is about the beneficiaries, but the lawsuits are about the providers. Complicating it further for states seeking guidance from court decisions is the fact that the federal appellate courts are split as to whether Section (30)(A) requires a certain *process* (“provide such methods and procedures . . . to assure that payments are consistent with efficiency, economy, and quality of care”) or whether it requires certain *results* (“assure that payments . . . are sufficient to enlist enough providers”).

In 1996, in the case of *Methodist Hospitals v. Sullivan*, the Seventh Circuit Court of Appeals<sup>14</sup> found that Section (30)(A) allows states to “behave like other buyers of goods and services in the marketplace: they may say what they are willing to pay and see whether this brings forth an adequate supply. If not, the state may (and under § 1396a(a)(30), must) raise the price until the market clears.”<sup>15</sup> The Court found that Section (30)(A) does not require states to conduct studies in advance of modifying their rates. The question is whether the new prices “elicited enough medical care.”<sup>16</sup>

The Seventh Circuit’s decision in *Methodist Hospitals* prioritized access over any procedural requirements that Section (30)(A) could be read to require. This decision remains good law and was cited as recently as June 2010 when the United States District Court for the District of Connecticut rejected a provider association’s challenge to nursing home rates, finding that Section (30)(A) “does not contain a procedural requirement, it mandates only a substantive outcome.”<sup>17</sup>

In 1999, the Third Circuit<sup>18</sup> reached a similar conclusion to *Methodist Hospitals* in *Rite Aid v. Houstoun* holding that the Equal

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Access Provision only dictated a result, not a process:

We agree with the Court of Appeals for the Seventh Circuit that section 30(A) requires the state to achieve a certain result but does not impose any particular method or process for getting to that result. *Id.* Thus, section 30(A) does not require any "particular methodology" for satisfying its substantive requirements as to modifications of state plans. However, we will not go as far as did that court as to say that the Department literally may act like any other buyer of health care by offering a certain price, and seeing what response or result that price brings forth; that is, that the "states may behave like other buyers of goods and services in the market: they may say what they are willing to pay and see whether this brings forth an adequate supply." We decline to adopt that approach because ordinarily, at least, a state may not act arbitrarily and capriciously, although other actors in the market may do so if they so choose.<sup>19</sup>

The courts of appeals' split thus arises from the question whether section 30(A) demands a process which will ensure future results, or merely the result itself. In reaching our result we will not read procedural criteria into section 30(A). That section requires that the state "assure" certain outcomes, including efficiency, economy, etc., but it does not call explicitly for any particular findings. Thus, it is up to a state to determine how it will "assure" the outcomes. We reiterate that section 30(A) does not specify a particular process for a state agency to follow in establishing rates.<sup>20</sup>

Interestingly, while the *Rite Aid* Court chooses results over process, it does hold that the process cannot be "arbitrary and capricious" and noted that "although budgetary provisions may not be the sole basis for a rate revision, they may be considered given that section 30(A)

mandates an economical result."<sup>21</sup> While the Court does not outline the required "results," presumably such results include rates that: (a) safeguard against unnecessary utilization; (b) are consistent with efficiency, economy, and quality of care; and (c) are sufficient to enlist enough providers so that Medicaid beneficiaries have the same access to care as others in the geographic area.

The Ninth Circuit<sup>22</sup> reached a different decision from *Methodist Hospitals and Rite Aid* when it reached the merits of Section 30(A) in 1997. The Court in *Orthopaedic Hospital v. Belshe* found that Section 30(A) specifically requires that state payment rates "bear a reasonable relationship" to the cost of providing service and that states cannot set payment rates without "responsible cost studies." The Court's reasoning follows:

Whether the statute requires the Department to consider the costs hospitals incur in delivering services when setting specific payment rates under Section 1396a(a)(30)(A) is the issue. We conclude that the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', which provide reliable data as a basis for its rate setting...<sup>23</sup>

The Ninth Circuit rejected the State's argument that so long as access is adequate, the State's payment policies are legal under Section 30(A) finding that "De facto access produced by factors totally unrelated to reimbursement levels [such as Medicare requirements or mission], does not satisfy the requirement of Section 1396a(a)(30)(A) that payments must be sufficient to enlist enough providers."<sup>24</sup>

By fixing payment rates in relation to provider cost, the Court read a requirement into the language of Section (30)(A) that is not expressly in the words. The Court further read a procedural requirement into Section (30)(A) in that a state cannot set a payment rate without a study of provider costs. The *Orthopaedic Hospital* ruling is cited frequently by other courts, most notably in cases where a state tries to close budget shortfalls with across-the-board cuts to payment rates. And, the Ninth Circuit itself expressly confirmed the reasoning in *Orthopaedic Hospital* just last year in the case of *Independent Living Center of Southern California v. Maxwell-Jolly*.<sup>25</sup> In doing so, the Ninth Circuit in *Independent Living Center* notes that even were it to focus on results, rather than process, the state's 10 percent rate cut might conflict with the "quality of care and access" requirements of Section (30)(A) because "at least some providers" stopped treating Medi-Cal (Medicaid) beneficiaries. The Court does not explore whether there are sufficient providers without the loss of these providers or whether Medi-Cal beneficiaries have the same access as others in the geographic area; nor does it discuss the relationship between "quality" and the number of providers available to serve Medi-Cal beneficiaries.

*Orthopaedic Hospital* built upon an earlier decision in the Eighth Circuit.<sup>26</sup> In *Arkansas Medical Society v. Reynolds*, the Eighth Circuit confronted a situation in which the Arkansas Department of Human Services (DHS) issued an emergency rule cutting reimbursement rates to non-institutional Medicaid providers by 20 percent to close a shortfall in the Medicaid budget.

The Court in *Arkansas Medical Society* held:

[T]he equal access provision provides an unambiguous and compulsory framework to guide substantive agency decisions regarding reimbursement rates for noninstitutional providers.... The purpose of this subsection is to ensure adequate access and quality of care in the

context of non-institutional Medicaid providers . . . Accordingly, DHS must consider the relevant factors of equal access, efficiency, economy, and quality of care as designated in the statute when setting reimbursement rates.<sup>27</sup>

Referring to the adequacy of DHS' findings, the Court noted:

DHS admitted in a letter dated July 6, 1992, that "any studies in regard to the cuts on providers that goes into effect July 1 for example, the effect cuts will have on accessibility . . . [do] not exist according to our records." The only evidence offered during the hearings regarding the rate cuts' effect on accessibility was purely speculative and could only be confirmed by historical data accumulated after the cuts were made . . . Indeed, there is ample evidence suggesting that the reimbursement rate reductions were overwhelmingly based on budgetary concerns . . . Abundant persuasive precedent supports the proposition that budgetary considerations cannot be the conclusive factor in decisions regarding Medicaid.<sup>28</sup>

The Court in *Arkansas Medical Society* found that the lack of any procedural safeguards (i.e., cost studies) combined with the fact that the only apparent justification for the cuts was budgetary, meant that the Arkansas DHS was in violation of Section (30)(A). This analysis by the court was concerned only with the steps taken prior to a payment change, and did not concern itself with the actual impact on access (or quality, efficiency, or utilization) after the rate change.

In sum, the federal appellate courts that have addressed the merits of Section (30)(A) are split as to the requirements of the statute, with the Eighth and Ninth Circuits concerned with the procedures a state undertakes before setting rates, and the

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Third and Seventh Circuits concerned with the effects of a state's payment rate, independent of any procedures followed or ignored as the case may be. However, it is fair to say that states act at their peril if they can offer nothing to defend the challenged payment policy beyond the state's fiscal constraints.

### **Specific Federal Payment Provisions**

While Section (30)(A) provides the overarching framework for state rate setting, there are several areas where federal law dictates specific payment standards and methods for state Medicaid programs. Examples follow and Appendix A contains a complete list of federal payment laws and regulations.

- ***Disproportionate Share Hospitals.*** State payment policies must “take into account” the situation of DSH hospitals.<sup>29</sup> In practice this requirement has meant supplemental Medicaid payments to hospitals, with states generally determining the amount of payments and the hospitals eligible for such payments subject to minimum federal requirements. Aggregate DSH payments are capped by Section 1902(a)(13)(A)(iv) of the Social Security Act and any individual hospital's DSH payments are capped at the difference between its costs of serving Medicaid and uninsured patients and its Medicaid compensation. The federal share of Medicaid DSH payments totaled more than \$11 billion in 2009. Anticipating decreased numbers of uninsured with implementation of federal health reform, the ACA in Section 1203 makes significant reductions to DSH allotments from 2014 to 2020. The largest reductions will be applied to states that: (a) have the lowest uninsured rates; (b) have the lowest levels of uncompensated care (excluding bad debts); and (c) do not

target DSH payments to hospitals with high volumes of Medicaid patients.

- ***Medicaid Managed Care Plans.*** Section 1903(m)(2)(A) of the Social Security Act provides the statutory basis for the payment regulations applicable to Medicaid managed care (MMC). The specific rate-setting requirements are laid out, in some detail, in regulations.<sup>30</sup> The overarching requirements provide that MMC rates must be: (a) actuarially sound; (b) developed in accordance with actuarial principles appropriate for the population and services; and (c) certified by actuaries. The regulations also specify the documentation states must submit to demonstrate compliance with these requirements, including a description of the rate-setting methodology and the underlying data on which the state relied. The regulations of MMC rates provide more specifics as to the rate-setting process than do the FFS regulations.<sup>7</sup> However, as with FFS rates, there are no precise standards to judge the reasonableness or adequacy of the rates.

With enrollment in Medicaid managed care plans expected to increase significantly as a result of both cost containment efforts and anticipated federal reforms, Congress, in the Children's Health Insurance Program Act of 2009, required the Government Accountability Office (GAO) to assess the extent to which state payments to fully capitated managed care organizations were in fact actuarially sound. In its August 2010 report, the GAO found that federal oversight of the rates varied depending on the CMS regional office involved and that CMS generally did not take steps to assure the quality of data used to set managed care rates.<sup>31</sup>

- ***Federally Qualified Health Centers.*** Federal law establishes minimum

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facility-specific payment rates based on each facility's cost trended forward.<sup>32</sup> These rates must be paid using a per-visit payment method unless the FQHC agrees to an alternate method that must generate at least as much revenue as the per-visit methodology. The FQHC payment mandates are among the most prescriptive in federal law, detailing the payment method as well as the payment levels states must use in setting rates for FQHCs.

- **Lab Fees.** Section 1903(i)(7) of the Social Security Act provides that state Medicaid agencies may not pay more for diagnostic laboratory tests than Medicare would have paid. This standard can be problematic for states seeking to package ancillary services, including lab, into a single outpatient payment to encourage providers to use ancillary services more efficiently. Notably, Medicare's failure to package ancillaries has been criticized by the Medicare Payment Advisory Commission and others and is often cited as the cause of the growth in spending for Medicare outpatient services.<sup>33</sup>

The ACA added two additional Medicaid payment mandates to federal law as follows:

- **Primary Care Services.** Section 1202 of the ACA requires that states pay 100 percent of the Medicare payment rate for primary care services provided by physicians participating in Medicaid during calendar years 2013 and 2014. The law provides 100 percent federal matching dollars for the difference between a state's current reimbursement level and the Medicare amount during those two years. Medicaid managed care plans must make payments to physicians consistent with the new minimum payment rates.
- **Health Care-Acquired Conditions.** Effective July 1, 2011, section 2702 of

the ACA prohibits state Medicaid agencies from paying for services that relate to health care-acquired conditions (HACs) – preventable conditions resulting from treatment in a hospital. The Secretary is charged with promulgating regulations that define HACs based on Medicare definitions and state provisions.

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## Health Care-Related Provider Fees and Taxes

While the federal law governing the circumstances under which states may use provider taxes and fees to cover the non-federal share of Medicaid expenditures does not speak directly to state payment policies, it in fact has an enormous impact. Section 1903(w) of the Social Security Act and federal regulations permit states to cover the state share of Medicaid payments with revenue raised from health care-related taxes on 19 classes of providers, including hospitals and nursing homes, provided the tax meets the requirements detailed in federal law and regulations. In short, the taxes must be broad-based, treating all providers in the class the same, and the provider may not be guaranteed return of the tax through provider payments. As a general matter, provider taxes may not exceed 5.5 percent of aggregate net patient revenue.

With states facing increasing fiscal pressures, provider taxes are an important source of revenue, often enabling states to maintain or even increase Medicaid provider payments while maintaining eligibility levels and benefits. Today over 40 states have some form of a provider tax.<sup>34</sup> However, provider taxes have a downside; namely, securing legislative approval generally requires the agreement of the affected providers. Providers then wield significant (one might say, disproportionate) influence over how the tax dollars are incorporated into rates or supplemental UPL and DSH payments. This almost inevitably weakens state and federal



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Federal rules can facilitate state payment reform initiatives, providing guidance on how and when states may bundle Medicaid payments, share savings, and pay bonuses to providers – the linchpins of the ACA’s payment reform provisions.

governments' ability to assure that state payment policies assure access, discourage over-utilization and promote efficiency, economy, and quality of care.

### **Implications and Recommendations**

This review of the laws, regulations, and court cases demonstrates the complexity of any effort to draft a road map for states seeking to implement sound payment strategies. The three requirements for Medicaid payment rates found in the Social Security Act are compelling, requiring states to adopt payment methods and procedures that: (a) safeguard against unnecessary utilization; (b) are consistent with efficiency, economy, and quality of care; and (c) are sufficient to ensure that Medicaid beneficiaries have access to care that is comparable to others in the geographic area. The problem is not with the wording of the statute; it is on target. The problem is how to operationalize these requirements and here neither CMS nor the courts provide adequate guidance.

UPL rules focus on aggregate payments to classes of providers ensuring that states do not pay “too much” for hospital inpatient and outpatient services, nursing home, and ICF/MR services. It is a gross mechanism for controlling costs. A state’s compliance with the UPL requirement does not mean that the state’s payment methods and levels are sufficient to ensure equal access; discourage over-utilization; or encourage quality, efficiency, or economy.

While providers are increasingly turning to the courts to challenge payment levels and budget-driven rate cuts, only a limited number of courts reach the merits and even then court decisions are split as to how states should proceed. Some rulings require cost studies before rates are set; others require only that states evaluate the outcomes of the rate policy; and, none look beyond payment levels in any case.

The judicial process is cumbersome, lengthy, and expensive. Moreover, courts are ill-equipped to tackle thorny questions as to the relationship between Medicaid payment policies and Medicaid beneficiaries’ access to quality care that is provided in an efficient and effective manner or whether those policies guard against unnecessary utilization of services. Even the issue of equal access for Medicaid beneficiaries is a knotty one, implicating more than just FFS payment levels, and including the provider enrollment process, timeliness of state Medicaid payments, audit rules as well as socioeconomic factors. And, how does one balance the need to assure access with the mandate to guard against unnecessary utilization. Health policy experts and payers – including federal and state governments – continue to grapple with all these issues. Indeed, one of the priorities of the new Center for Medicare and Medicaid Innovation is to test the impact of different payment policies on access, quality, and efficiency.

Both state and federal governments have strong incentives to ensure that Medicaid dollars are spent on care that is accessible, efficient, and high-quality. Medicaid enrollment is growing and will increase dramatically in 2014, with adults making up most of the 15 to 20 million newly eligible beneficiaries. States are facing enormous budget pressures. And, federal Medicaid spending in both relative and absolute terms will jump in 2014 under federal health reform.

As this brief illustrates, Section (30)(A) provides the statutory underpinning for sound Medicaid rates. Notably missing are federal regulations or guidance that define the requirements of Section (30)(A) through the lens of all stakeholders, including the beneficiaries that depend on Medicaid and the taxpayers that underwrite its costs. The guidance needs to be in terms that states may act upon with some assurance that CMS approval will be forthcoming expeditiously and with some

confidence that courts will accept. These regulations should identify the elements of sound payment methods that discourage over-utilization, encourage efficient and effective care, and provide guidance on how states can meet the equal access requirements. Finally, federal rules can facilitate state payment reform initiatives, providing guidance on how and when states may bundle Medicaid payments, share savings and pay bonuses to providers – the linchpins of the ACA’s payment reform provisions.

More than 60 million people depended on Medicaid last year and the federal and state government spent more than \$400 billion purchasing services to maintain and improve their health. By 2016, Medicaid is expected to be the nation’s single largest insurer, both in terms of people covered and dollars expended.<sup>35</sup> Medicaid must become a smart purchaser of care. Now more than ever states need a national framework to guide their payment policies, ensuring Medicaid beneficiaries access to quality care that is provided in an efficient and effective manner.

### **About the Center for Health Care Strategies**

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. Its program priorities are: improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity.

For more information and additional resources on payment reform, visit [www.chcs.org](http://www.chcs.org).

## Appendix A: Federal Medicaid Payment Laws and Regulations

Statute ( <i>Social Security Act section in bold</i> )	Regulation
<b>1902(a)(13)(A)</b> – <i>Public Process</i> (42 USC 1396a(a)(13)(A))	42 CFR 447.205 - Public notice of changes in Statewide methods and standards for setting payment rates Section 4711 of BBA 97 repealed the Boren amendment and nullified its requirements outlined in the regulations at: 42 CFR 447.252 (ref. 430.10 and 413.30) - State Plan Requirements; and 42 CFR 447.250 - Reasonable and Adequate Rates
<b>1902(a)(13)(B)</b> - <i>Hospice</i> (42 USC 1396a(a)(13)(B))	No Medicaid specific regulations
<b>1902(a)(28)(C)</b> – <i>Nursing Facilities</i> (42 USC 1396a(a)(28)(C))	42 CFR 447 Subpart C - Payment for Inpatient Hospital and Long-Term Care Facility Services
<b>1902(a)(30)(A)</b> – <i>Efficiency, Economy, Quality of Care; Sufficient Participation; Upper Payment Limits</i> (42 USC 1396a(a)(3)(A))	42 CFR 447.40 - Payments for reserving beds in institutions 42 CFR 447.57 - Restrictions on payments to providers for bad debts 42 CFR 447.204 - Access to Care 42 CFR 447.205 - Public Notice 42 CFR 447.206 - Cost limit for providers operated by units of government 42 CFR 447.253 - Other requirements 42 CFR 447.271 - Upper limits based on customary charges 42 CFR 447.272 - Inpatient UPL 42 CFR 447.304 - Adherence to UPL 42 CFR 447.321 - Outpatient and clinic UPL 42 CFR 447.325 - Prevailing Charges Limit
<b>1902(a)(32)</b> - <i>Assignment of Payments</i> (42 USC 1396a(a)(32))	42 CFR 447.10 - Prohibition against reassignment of provider claims
<b>1902(bb)</b> - <i>FQHC/RHC</i> (42 USC 1396a(bb))	<b>There are no existing regulations related to this Statutory provision.</b> The existing regulation at 42 CFR 447.371- <i>Services Furnished by Rural Health Clinics</i> refers to the previous provisions at 1902(bb) and are obsolete.
<b>1902(s)</b> - <i>Adjustment in payment for hospital services furnished to low-income children under age of 6 years</i> (42 USC 1396a(s))	None
<b>1903(e)</b> - <i>Hospitals</i> (42 USC 1396b(e))	This provision is self-implementing.
<b>1903(i)</b> - <i>Customary Charge Limits for Hospitals, Practitioners, DSH</i> (42 USC 1396b(i))	42 CFR 447.271 - Upper limits based on customary charges
<b>1903(i)(7)</b> - <i>Clinical Diagnostic Laboratory Services payment ceiling</i> (42 USC 1396b(i)(7))	None
<b>1903(m)</b> - <i>Medicaid Managed Care Organizations</i> (42 USC 1396b(m)) and (42 USC 1396u-2)	42 CFR Part 438 - Managed Care 42 CFR 438.6 - Contract requirements 42 CFR 438.50 - State Plan requirements
<b>1905(a)(28)(A)</b> - <i>Wards of the State</i> (42 USC 1396d(a)(28)(A))	42 CFR 435.1009 - Institutionalized individuals 42 CFR 435.1010 - Definitions relating to institutional status

## Appendix A: Federal Medicaid Payment Laws and Regulations

Statute <i>(Social Security Act section in bold)</i>	Regulation
<b>1905 (a)</b> - <i>IMD, IMD Exclusion</i> (42 USC 1396d(a)(16))	42 CFR 435.1009 - Institutionalized individuals 42 CFR 435.1009 - Definitions relating to institutional status 42 CFR 440.140 - Inpatient hospital services, nursing facility services, and intermediate care facility services for individuals age 65 or older in institutions for mental diseases 42 CFR 440.160 - Inpatient psychiatric services for individuals under age 21.
<b>1911</b> - <i>IHS</i> (42 USC 1396j)	42 CFR Part 136 - Indian Health
<b>1913</b> - <i>Nursing Facility Services Provided by a Hospital</i> (42 USC 1396l)	42 CFR 447.280 - Swing Bed Hospitals
<b>1915(a)(1)(B)</b> - <i>Exception to Freedom of Choice for Laboratory Services and Medical Devices</i> (42 USC 1396n(a)(1)(B))	42 CFR 431.54(d) - Special procedures for purchase of medical devices and laboratory and X-ray tests
<b>1923</b> - <i>Disproportionate Share Hospitals</i> (42 USC 1396r-4)	42 CFR 447 Subpart E - Payment Adjustments for Hospitals that Serve a Disproportionate Number of Low-Income Patients 42 CFR 455 Subpart D - Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments
<b>1886 (h)</b> - <i>Payments for Direct Graduate Medical Education Costs</i> (42 USC 1395ww(h))	42 CFR 438.6 (c)(5)(v) - Contract requirements 438.60 - Limit on payment to other Providers
<b>Health Care and Education Reconciliation Act § 1202</b> - <i>Payments to Primary Care Physicians</i>	None
<b>Affordable Care Act § 2702(b)</b> - <i>Payment Adjustment for Health Care Acquired Conditions</i>	CMS required to promulgate regulations.

## Endnotes

<sup>1</sup> 42 U.S.C. 1396(a)(30)(A).

<sup>2</sup> 42 C.F.R. Sec.s 447.206; 447.321; 447.271; 447.272; 447.325.

<sup>3</sup> Recently, CMS reviewers have asked states seeking to reduce rates to describe the impact, if any, that the rate reduction will have on the availability and access to services.

<sup>4</sup> M. Sisko, C.J. Truffer, S.P. Keehan, J.A. Poisal et al., "National Health Spending Projections: The Estimated Impact of Reform Through 2019," *Health Affairs* (October 2010, Web First): 1937.

<sup>5</sup> *Medicaid Payment Rate Lawsuits: Evolving Court Views Mean Uncertain Future for Medi-Cal*, California HealthCare Foundation, October 2009, page 3.

<sup>6</sup> 42 U.S.C. 1396(2).

<sup>7</sup> 42 U.S.C. 1396a(a).

<sup>8</sup> 42 U.S.C. 1396a(a)(30)(A).

<sup>9</sup> P. Thompson. *Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity*. Kaiser Commission on Medicaid and the Uninsured (February 2004).

<sup>10</sup> 42 C.F.R. Sec.s 447.206; 447.321; 447.271; 447.272; 447.325.

<sup>11</sup> Federal Register, January 12, 2001 at 3148.

<sup>12</sup> Many of the challenges under Section (30)(A) do not reach the merits of the plaintiffs' case with courts' finding that the provision does not create a privately enforceable claim. See e.g., *Gonzaga University v. Doe*, 576 U.S. 273 (2002) (limiting plaintiffs' cause of action under 42 U.S.C.1983); *Equal Access for El Paso v. Hawkins*, 509 F.3d 697 (5<sup>th</sup> Cir. 2007) (relying on *Gonzaga*); cert. den., 129 S. Ct. 32 (2008); *Sanchez v. Johnson*, 416 F.3d 1051 (9<sup>th</sup> Cir. 2005) (relying on *Gonzaga*). This brief discusses only federal appellate decisions that reach the merits and discuss the substantive requirements of Section (30)(A).

<sup>13</sup> The Section (30)(A) appellate challenges discussed here involve rates that are alleged to be too low. Section (30)(A) has also been invoked by CMS to defend its rejection of a rate increase. See, e.g., *Alaska Department of Health and Social Services v. Centers for Medicare and Medicaid Services*, 424 F.3d 931 (9<sup>th</sup> Cir. 2005).

<sup>14</sup> The Seventh Circuit covers the following states: Wisconsin, Illinois and Indiana.

<sup>15</sup> *Methodist Hospitals v. Sullivan*, 91 F.3d 1026 at 1030 (7th Cir. 1996).

<sup>16</sup> *Methodist Hospitals* at 1030.

<sup>17</sup> *Connecticut Association of Health Care Facilities v. Rell*, 2010 U.S. Dist. Lexis 54649 (D. Conn. June 3, 2010).

<sup>18</sup> The Third Circuit covers the following states: Pennsylvania and New Jersey.

<sup>19</sup> *Rite Aid v. Houstoun*, 171 F3d 842, 851-852 (3rd Cir. 1999).

<sup>20</sup> *Rite Aid v. Houstoun*, at 852.

<sup>21</sup> *Rite Aid v. Houstoun* at 856.

<sup>22</sup> The Ninth Circuit covers the following states: Washington, Oregon, Montana, Idaho, Nevada, California, Arizona, Hawaii and Alaska.

<sup>23</sup> *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997).

<sup>24</sup> *Orthopaedic Hospital* at 1498.

<sup>25</sup> 572 F.3<sup>rd</sup> 644 (9<sup>th</sup> Cir. 2009).

<sup>26</sup> The Eighth Circuit covers the following states: North Dakota, South Dakota, Nebraska, Minnesota, Iowa, Missouri and Arkansas.

<sup>27</sup> *Arkansas Medical Society v. Reynolds*, 6 F3d 519, 530 (8th Cir. 1993).

<sup>28</sup> *Arkansas Medical Society v. Reynolds*, at 531.

<sup>29</sup> 42 U.S.C. 1396a(a)(13)(A)(iv).

<sup>30</sup> 42 CFR 438.6.

<sup>31</sup> *Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement*. United States Government Accountability Office. Report to Congressional Committees. August 2010. Available at <http://www.gao.gov/products/GAO-10-810>.

<sup>32</sup> 42 U.S.C. 1396bb.

<sup>33</sup> Federal Register, August 2, 2007 at 42627.

<sup>34</sup> *Financing Medi-Cal's Future: The Growing Roles of Health Care-Related Provider Fees and Taxes*, California HealthCare Foundation, November 2009.

<sup>35</sup> See Centers for Medicare & Medicaid Services, *Updated NHE Historical and Projected 1965-2010*, at [www.cms.gov/NationalHealthExpendData/03\\_NationalHealthAccountsProjected.asp#TopOfPage](http://www.cms.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage).