OFFICE OF LEGISLATIVE RESEARCH
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ResearchReport

Monitoring Medicaid Provider Rates

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Issue

This report provides an overview of federal equal access monitoring requirements that affect Medicaid provider rates and recent state requirements to conduct a new study of these rates. It updates, in part, OLR Report 2015-R-0291.

Summary

Generally, states have broad discretion to set Medicaid provider rates within federal rules. Federal law's "equal access provision" specifically requires that state Medicaid rates be (1) consistent with efficiency, economy, and quality of care and (2) sufficient to enlist enough providers so that covered benefits are available to Medicaid enrollees at least to the same extent they are available to the general population in the same geographic area (42 U.S.C. § 1396a(a)(30)(A)). In other words, federal law does not establish a minimum rate for specific provider types, but instead requires that rates be high enough to persuade providers to accept Medicaid as payment and thereby provide Medicaid enrollees with access to care.

Both federal and state law require reviews or studies of these rates and enrollees' access to care. For example, federal regulations require state Medicaid agencies to conduct an analysis at least once every three years using access monitoring review plans to assess whether access to care is sufficient. Additionally, federal law requires states to conduct and submit an access review when proposing to reduce or restructure provider rates in a way that could diminish access. In Connecticut, recently passed legislation requires the state's Medicaid agency, the Department of Social Services (DSS), to conduct a two-part study of its rates, due in 2024 and 2025.

Access Monitoring Review Plans

Federal regulations require state Medicaid agencies to develop and update medical assistance access monitoring review plans used to analyze and describe the status of their Medicaid programs (42 C.F.R. § 447.203(b)). As described by the Centers for Medicare and Medicaid Services (CMS), these review plans apply to services provided under fee-for-service delivery models.

By law, states had to produce their first review plans by October 1, 2016, and must update them by October 1 of each subsequent review period. States must publish their review plans for public comment for at least 30 days before finalizing and submitting them to CMS for review (42 C.F.R. § 447.203(b)).

DSS published Connecticut's first access monitoring review plan in 2016 and an update in 2019. Related documents are available on DSS's website. The next update must be submitted to CMS by October 1, 2024.

Plan Components

The review plans must include the following information, among other things:

1. an access monitoring analysis that includes data sources, methodologies, baselines, assumptions, trends, factors, and thresholds that the state will use to inform its policies on access to Medicaid services (e.g., provider rates);
2. the state's conclusion on whether access to care is sufficient, considering relevant provider and beneficiary information;
3. a comparative payment rate review that, for each reviewed service, compares Medicaid rates to other public and private health insurer payment rates for various geographic areas within the state;
4. specific measures the state uses to analyze access to care (e.g., providers participating in Medicaid or accepting new Medicaid enrollees);
5. any issues with access discovered during the review; and
6. the state agency's recommendations on access to care sufficiency based on the review (42 C.F.R. § 447.203(b)(1) to (4)).

Plan Timing and Additional Requirements

General Rule. CMS regulations require states to update their access monitoring review plans at least once every three years with separate analyses of the following services:

1. primary care services (including those provided by a physician, federally qualified health center, clinic, or dental care);
2. physician specialist services (e.g., cardiology, urology, and radiology);
3. behavioral health services, including mental health and substance use disorder;
4. pre- and post-natal obstetric services including labor and delivery;
5. home health services;
6. additional services for which the state submits a proposed state plan amendment to reduce rates (see below);
7. additional services for which the state or CMS has received significantly higher than usual volume of complaints from providers, beneficiaries, or other stakeholders on access in a geographic area; and
8. any other services the state selects (42 C.F.R. § 447.203(b)(5)).

Proposed Rate Reductions. When a state submits a state plan amendment (SPA) to CMS that proposes to reduce or restructure provider payments in a way that could diminish access, the regulations require the state to also submit an access review for the affected service. To demonstrate compliance with the equal access provision, the review must show sufficient access for any service for which the state proposes a reduced or restructured rate. The state must also establish procedures to monitor continued access to care for at least three years after reducing or restructuring rates (42 C.F.R. § 447.203(b)(6)).

For these SPAs, a state must submit the following to CMS:

1. its most recent access monitoring review plan performed for the service at issue,
2. an analysis of how the change in payment rates will affect access, and
3. a specific analysis of information and concerns expressed by affected stakeholders providing input.

CMS may disapprove a proposed SPA affecting payment rates if the state does not include this information (42 C.F.R. § 447.204).

Beneficiary and Provider Input. The regulations require states to have ongoing mechanisms for beneficiary and provider input on access to care (e.g., hotlines, surveys, ombudsman, and reviews of grievance and appeals data). They encourage states to promptly respond with an appropriate investigation, analysis, and response whenever public input provided through these

mechanisms cites specific access problems. States must maintain a record of this input and how they responded to it and make this record available to CMS upon request (42 C.F.R. § 447.203(b)(7)).

Remediating Inadequate Access. The regulations require states to submit a corrective action plan within 90 days of discovering or identifying an access deficiency. The plan must include specific steps and timeliness, such as:

1. increasing payment rates,
2. improving outreach to providers,
3. reducing barriers to provider enrollment,
4. providing additional transportation to services,
5. allowing telemedicine delivery and telehealth, or
6. improving care coordination.

While the plan may include long-term objections, it should aim to remediate the deficiency within 12 months (42 C.F.R. § 447.203(b)(8)).

Medicaid Reimbursement Rate Study in Connecticut

PA 23-186, § 1, requires DSS, within available appropriations, to conduct a two-part study of Medicaid reimbursement rates. The study must compare Connecticut's Medicaid rates to (1) Medicaid rates in neighboring states and (2) Medicare rates and cost-of-living increases.

The first part of the study must examine Medicaid rates for physician specialists, dentists, and behavioral health providers. The second part must cover the reimbursement system for all other aspects of the Medicaid program, including (1) ambulance services, (2) federally qualified health centers, (3) specialty hospitals, (4) complex nursing care, and (5) methadone maintenance.

The department must file interim reports with the Appropriations and Human Services committees on the first part by February 1, 2024, and on the second part by January 1, 2025.

The act specifies that it does not impact Medicaid reimbursement rates for FYs 24 or 25.

Relatedly, a separate bill considered earlier in the session (before PA 23-186 passed) would have raised Medicaid provider rates incrementally to 100% of the Medicare rate for the same services by FY 28 (HB 6885 (2023)). DSS submitted written testimony in opposition to the bill and instead suggested conducting a study. The department wrote:

> DSS currently lacks a systematic approach to assess rates across provider types on a consolidated or summarized document. As a managed fee-for-service state, Connecticut sets rates and fees for all its Medicaid providers. Often changes to the rates or fee schedules are reactive or situational in nature and rely upon appropriation or legislative changes engaged by the General Assembly, subject to the stakeholder input and feedback received. The result is an uneven rate setting process that leads to inequities between similarly situated providers and services. It is essential that DSS establish a framework for a more comprehensive and well-informed approach to provider rates and fee schedules.

The department advocated for using federal funds to "contract with a vendor to undertake a comprehensive Medicaid rate study." DSS described the project as follows:

> The consultant will also develop recommendations on payment reform methodologies and assist with prioritizing rate setting policies that are likely to reduce future costs and improve member outcomes. This is essential to comprehensively study this issue. There are roughly 430 separate provider types in the Medicaid program. Collecting and studying the rates across each of those provider types is a massive undertaking.

The Human Services Committee favorably reported the bill to the Appropriations Committee, which took no action on it.

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