

MEMORANDUM

TO: Joint Budget Committee

FROM: Melodie Beck, JBC Staff

SUBJECT: CMS Proposed Rule to Ensure Payments Comply with Section 1902 (a) (30) (A) of the Social Security Act

DATE: June 20, 2011

On May 6, 2011 the Centers for Medicare and Medicaid Services (CMS) released a proposed rule that could substantially impact the State's autonomy and flexibility in setting provider reimbursement rates. CMS is considering comments on the proposed rule until July 5, 2011. The Executive Branch, through the Department of Health Care Policy and Financing, will be providing Colorado's comments on the rule. Because this rule has the potential to significantly impact future budgeting for the State, staff wanted to inform the Committee of this issue.

Background

Title XIX of the Social Security Act (Title XIX) provides the federal legal framework for the Medicaid program. Details concerning the scope of Medicaid services and the payment methodologies for services are set forth in the Medicaid State plan and must be approved by CMS. Under section 1902 (a) (30) (A) of Title XIX, states must ensure that beneficiaries have access to the health care services provided in the State plan. In the new rule proposed by CMS, CMS is expressing concern that payment rate changes made for budgetary reasons may result in states being out-of-compliance with the access requirements for the Medicaid program. Specifically, CMS states that "budget-driven payment changes have led to confusion about the analysis required to demonstrate compliance with Medicaid access requirements states attempting to reduce Medicaid costs through payment rate changes have increasingly been faced with litigationThese decisions have left states without clear and consistent guidelines." In addition, CMS cited the *Orthopedic Hospital v. Belshe* (1997) Ninth Circuit Court decision that requires states to set provider payment rates that "bear a reasonable relationship" to provider costs, based on "responsible cost studies." This ruling was reaffirmed by the Ninth Circuit in *Independent Living v. Maxwell-Jolly* (2009) [this case (joined by other cases filed in CA) is scheduled for hearing before the United States Supreme Court during the term beginning October 2011].

The CMS proposed rules are an attempt to provide additional guidance and regulation in order to create a standardized, transparent process for states to follow in order to prove and assure payments are consistent with the Medicaid access requirements. In fact, the U.S. Solicitor General's office, advised the Supreme Court in their brief to not take up the *Independent Living v. Maxwell-Jolly*

(2009) case because:

"The Secretary of Health and Human Services is planning to issue rules within the year explaining how federal law applies to state Medicaid ratesThe Secretary's rulemaking may well resolve the disagreement among the circuits on these issues, making this Court's review unnecessary." [however, as stated earlier the U.S. Supreme Court has decided to hear this case].

The proposed rule released by CMS in May 2011 is the Administration's attempt to provide direction on how states can show that provider payments are adequate enough to ensure access to care.

CMS Proposed Rule

- (1) The proposed rule impacts the fee-for-service program (managed care plans are already regulated under 42 CFR part 438).
- (2) The proposed rule would impact states that are not changing provider payment rates and those who are (i.e. all states will have to comply with the data gathering).
- (3) Under the proposed rule, the states will be required to collect and analyze certain data elements that include information on: (a) enrollee needs; (b) availability of care and providers; and (c) utilization of services. The data collection will allow the states to determine if Medicaid clients have the same access to care as the general population in a geographic area. This data will need to be collected on an ongoing basis and specifically with respect to any affected service prior to submitting a Medicaid SPA that proposes service payment rate reductions.
- (4) The data and analysis will be available to the public and furnished to CMS as required in the context of any SPA that reduces provider rates or restructures provider payments in circumstances that could result in access issues. The rule will require a public process that solicits input on the potential impact of the proposed reduction of Medicaid service payment rates on beneficiary access to care. The rule will also address the requirements for the state regarding public notice of payment changes to clarify existing requirements.
- (5) The administrative costs associated with implementing the rule will receive a 50 percent federal match (same as other administrative costs under the Medicaid program).

Colorado's Response

The Department of Health Care Policy and Financing is in the process of reviewing and determining the State's response to the proposed CMS rule. It is staff's understanding that the Department's comments will be submitted to CMS prior to the July 5, 2011 deadline. In discussing this issue with the Department, staff was informed that the Department's comments will highlight the following:

- (1) The rule seems to emphasize that access to care is primarily a function of payment rates and rate methodologies. This view isn't in line with value-based purchasing initiatives that many states are investigating and implementing.
- (2) The rule's language is over broad and ambiguous. While CMS is attempting to set national guidelines in order to lessen litigation (and solve different court opinions from different circuits), the new proposed rule could result in even greater litigation risks for the states.
- (3) The rule is administrative burdensome. The rule will create major limitations for states in trying to balance budgets in a timely way. Currently, federal law limits states ability to adjust eligibility -- this rule will limit the ability of states to adjust provider rates. The only area left for short-term savings will be to cut benefits or impose utilization restrictions (which are not as timely as rate changes).

Please note that staff anticipates that major organizations representing the states will also comment on the rule (NASBO, NCSL, NAMD). Prior to issuance of the proposed rule, NAMD (National Association of Medicaid Directors) urged that any rule proposed by CMS consider the following:

- (1) cost studies should not be required to demonstrate compliance with the access issue;
- (2) an attestation of compliance by the state should suffice at the time of a rate change;
- (3) states can use a variety of methods to monitor the impacts of rate changes;
- (4) states are responsible for ensuring efficiency, economy, quality of care, access, which is a much broader responsibility than simply the sufficiency of payment rates;
- (5) the difference between payment rates and actual payments; and
- (6) access to care is a relative standard where Medicaid should not be held to a higher standard than that available to the general public.

Specifically, the NAMD urged CMS to make sure the regulation:

"acknowledges that states may set or adjust payment rates (or decline to adjust them) based on available funds under the state's budget, as long a they are able to provide the required assurance in support of any payment rate adjustment. This is

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particularly important, because of the tendency of providers to contend that any time a payment rate adjustment is influenced in any way by a state's budget circumstances the adjustment is necessarily violative of the federal statute. Some court rulings seem to accept this contention. Yet, it is unrealistic to believe that in a program as costly as Medicaid that the federal law requires reimbursement decisions to be made without regard to the available state resources." (NAMD letter to Cindy Mann on April 4, 2011).

In staff's opinion, the current proposed rule does not adequately address the concern mentioned above in the NAMD letter.

Staff would also note one other major concern with the proposed rule -- CMS focuses entirely on the Executive Branch's role in the rate making process (such as requiring stakeholder input at the state Medicaid agencies). However, state legislatures play a significant role in setting the state policy and budgets for such rates. It is at the state legislature where different public policies, including both those related and unrelated to Medicaid, must be balanced.

JBC Staff Recommendation

At this time staff does not recommend any action from the Committee. This memo is informative only. After the comment phase of the rule-making process is complete, CMS will make revisions. After the rule has been published and if there appears to be significant budget concerns or items that could result in costly litigation in the State, a political or legislative solution may need to be pursued by involving the Colorado Congressional delegation.

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JOINT BUDGET COMMITTEE

200 East 14th Avenue, 3rd Floor
LEGISLATIVE SERVICES BUILDING
Denver, CO 80203
Telephone 303-866-2061
www.state.co.us/gov_dir/leg_dir/jbc/jbchome.htm

June 20, 2011

Sue Birch
Director, Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Dear Ms. Birch:

As you are aware, when balancing the State budget for FY 2011-12, the Executive and Legislative Branches had to make many difficult choices. Specifically, for the Department of Health Care Policy and Financing, health care providers have had their Medicaid reimbursement rates reduced repeatedly over the last several years.

It has recently come to our attention that the calculations for the FY 2011-12 provider rate reduction approved by the General Assembly included pharmacy reimbursements. This rate reduction would be in addition to the efforts that the Department has taken to include more drugs on the State Maximum Allowable Cost (SMAC) program. At this time, the Committee believes that implementing both rate reduction for pharmacy and SMAC program would severely impact the ability of pharmacies to provide the prescription drug benefit to Medicaid recipients. Therefore, the Joint Budget Committee respectfully asks the Department to not implement the provider rate reduction for pharmacies. However, the Department should move forward with efforts to implement the SMAC program.

We understand that this request may result in the need for a future supplemental issue if the Department is unable to achieve the targeted General Fund savings of \$544,874 that was included in the Long Bill calculations for the pharmacy reimbursement rate reduction. If you have any questions about this letter, please contact Melodie Beck, our staff analyst for the Colorado Medicaid program, at 303-866-4549.

Sincerely,

Senator Mary Hodge
Chair

cc: Henry Sobanet, Office of State Planning and Budgeting
John Bartholomew, Colorado Department of Health Care Policy and Financing