

Legal Challenges to Medicaid Rate Reductions Frustrated by Proposed Federal Rules

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Providers who participate in Medicaid should familiarize themselves with proposed federal regulations published on May 6, 2011 that, if adopted, would substantially impede their ability to challenge Medicaid rate reductions in court. Interested parties may submit comments to the proposed rules, which must be received by the Centers for Medicare and Medicaid Services (“CMS”) no later than 5 pm EST on July 5, 2011.¹

The proposed rules interpret a federal Medicaid law that limits how state Medicaid programs can set

payment rates. That law, known as “Section 30(A)” of the Medicaid Act, requires state Medicaid Plans to utilize “methods and procedures” that “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 same extent that such care and service are available to the general population in the geographic area.”² These payment-related requirements are known as the “quality” and “access” standards.

In recent years, various types of providers have brought successful legal challenges to Medicaid rate cuts that do not comply with Section 30(A) quality and access requirements. While providers cannot get money damages in these lawsuits, they have been able to block state Medicaid programs from implementing rate cuts that violate Section 30(A).

Since 1997, federal courts in Washington and elsewhere in the Ninth Circuit have required states, in order to comply with Section 30(A), to conduct “responsible cost studies” to ensure Medicaid rates will be “reasonably related” to provider costs, and to conduct

such cost studies prior to setting the new rates. *Orthopedic Hosp. v. Belshe*, 103 F.3d 1491, 1497 (9th Cir. 1997).³ Based on this requirement, many health care providers have successfully challenged budget-driven Medicaid rate reductions on the basis that the state did not conduct a responsible cost study prior to developing a new rate (or that the study itself was inadequate), and that the providers would be financially harmed if such rate went into effect.

The proposed rules would substantially alter this legal standard. Rather than require cost studies, the rules would allow states to conduct a more flexible access analysis that examines three factors: (1) enrollee needs; (2) availability of care and providers; and (3) utilization of services. Clarifying that the relationship of rates to provider costs is no longer the primary focus of an “access” analysis, CMS noted: “Depending on State circumstances, cost-based studies may not always be informative or necessary. In addition, because many State payment rates are not specifically calculated based on provider cost considerations, it can be burdensome and not particularly productive to rely solely on that one factor as a measure of ac-

cess.”²⁴ Going a step further, CMS suggests that a Medicaid rate can satisfy Section 30(A) requirements irrespective of the payment level: “If beneficiaries are able to gain access to care . . . then clearly the standards of the Act have been met regardless of other factors, including payment levels.”²⁵

The singular focus on “access” to Medicaid services is problematic for providers such as hospitals, which must provide some measure of treatment to all who come to the emergency department regardless of insurance status or payment rates. Indeed, the framework in the proposed rules was developed based on a study that focused on primary and specialty care providers and services, and did not specifically address hospital, ancillary, and long-term care services.⁶ The rules also do not address Section 30(A)’s second requirement that states must ensure “that payments are consistent with efficiency, economy, and quality of care,”

in addition to ensuring access to services.

Finally, the proposed rules would make it difficult for providers to establish that a state failed to satisfy Section 30(A) access requirements, as the rules give CMS discretion to deny a State Plan Amendment only where a state fails to conduct an access analysis altogether and not where the access review is methodologically unsound or reveals deficiencies.⁷ For example, if a state’s access review identifies access issues, instead of denying the State Plan Amendment, the proposed rules permit the state to submit a corrective action plan, and take up to twelve months to remediate the deficiency.

Given these issues, Medicaid providers should critically examine the proposed rules and consider submitting comments to ensure that the final rules provide meaningful protections against budget-driven rate cuts.

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1. The proposed rules are available at <http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10681.pdf> (76 Fed. Reg. 26342 (May 6, 2011)).
2. 42 U.S.C. § 1396a(a)(30)(A).
3. Holding reaffirmed in *Indep. Living Ctr. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009).
4. 76 Fed. Reg. at 26344.
5. *Id.* at 26350.
6. Medicaid and CHIP Payment and Access Commission (MACPAC), Report to Congress on Medicaid and CHIP (March 2011), Ch. 4, p.126, available at http://www.macpac.gov/reports/MACPAC_March2011_web.pdf?attredirects=0&d=1.
7. Proposed 42 C.F.R. § 447.204(b).

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