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WHA Comments on Medicaid Proposed Rules on Access, Transparency and Managed Care

Commenting this week on two major proposed rules related to access, finance and quality in the Medicaid managed care and fee-for-service (FFS) delivery systems, WHA supported enhanced transparency in Medicaid provider payment rates, encouraged greater oversight into the adequacy of provider networks for post-acute care services, and urged CMS to set clear guardrails around insurer utilization management programs and consider requiring states to collect data on Medicaid managed care plans use of prior authorization and claims denials.

The proposed regulations would require states to publish Medicaid FFS rates in a format such that the public could clearly understand the amount Medicaid would pay different provider types for pediatric and adult services. In addition, the rule would require that states publish a comparison of Medicaid FFS rates for a select set of acute, routine and preventive services to rates under the Medicare fee schedule. While supportive of the increase in transparency, WHA expressed concern that such a comparison could imply that Medicare rates are adequate when, instead, Medicare also underpays providers and thus any such comparison should be viewed with some caution.

CMS proposes several new network adequacy provisions including wait times. Recognizing that differences in geography must be considered for network standards, WHA urged flexibility. However, for post-acute care services in particular, WHA suggested the need for more rigorous network adequacy standards and greater oversight of health plan practices related to prior authorization and denial of service. This is particularly important given that the decrease in available nursing home beds and other post-acute care settings has continued to constrain health care capacity across the entire health care system.

For Medicaid managed care, WHA suggested that states be required to collect data on prior authorizations and claims denials more broadly and that CMS set clear guardrails around when such utilization management activities can be categorized as quality improvement activities for purposes of the medical loss ratio. Finally, WHA encouraged CMS to maintain state flexibility in tying certain payments to utilization, and opposed restrictive upper payment approaches that could limit such flexibility.

Comments on both rules were due to CMS by July 3.

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