

Issue brief: Assuring access to Medicaid services

Background

Federal Medicaid law requires states to ensure Medicaid beneficiaries are able to access the healthcare providers they need through what is known as the “equal access requirement.” Under the equal access requirement, states are required to have methods and procedures to ensure that provider payment rates 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.”¹ The Centers for Medicare and Medicaid Services (CMS) had not previously defined an approach for states to meet this statutory requirement.

Despite the equal access requirement, Medicaid reimbursement rates are too often woefully inadequate. A physician who treats a Medicaid patient can expect to be paid about 33 percent less than the physician would receive for providing the exact same services to a Medicare patient.² For primary care services it is even lower – about 41 percent less than the physician would receive for treating a Medicare patient. Low reimbursement rates contribute to insufficient numbers of physicians participating in Medicaid. Nearly a third of office-based physicians do not accept Medicaid patients,³ and physicians are less likely to accept Medicaid patients than to accept patients covered by Medicare or private insurance.⁴ As a result, some Medicaid beneficiaries have trouble accessing the care they need.

In the past, Medicaid providers sometimes sued to enforce the equal access requirement. However, in March 2015, the Supreme Court ruled in *Armstrong v. Exceptional Child Center Inc.* that the Medicaid statute does not provide a private right of action for providers to enforce state compliance in federal court.⁵ The Court said, instead, that enforcement of the law falls to CMS. The ruling underscored the need for stronger federal oversight to ensure access. In response, CMS issued the final rule “[Medicaid Program: Methods for Assuring Access to Covered Medicaid Services](#)” in November 2015 that outlined a standardized, transparent, and data-driven process for states to document that provider payment rates are sufficient to enlist enough providers to serve the Medicaid population. The final rule incorporates many of the [comments](#) made in 2011 on the proposed rule by the AMA, along with 48 state medical associations and 20 national specialty associations.

State advocacy

In the final rule, CMS lays out the parameters for how states can show compliance with federal Medicaid law’s equal access requirement. Though some specific requirements must be met, CMS purposefully left

¹ Section 1902(a)(30)(A) of the Social Security Act

² The Henry J. Kaiser Family Foundation, Medicaid-to-Medicare Fee Index, available at <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>

³ Sandra L. Decker, *Two-Thirds of Primary Care Physicians Accepted New Medicaid Patients in 2011–12: a Baseline to Measure Future Acceptance Rates*, Health Affairs (July 2013)

⁴ Sandra L. Decker, *In 2011 Nearly One-Third of Physicians Said they Would Not Accept New Medicaid Patients, But Rising Fees May Help*, Health Affairs (August 2012)

⁵ 135 S. Ct. 1378 (2015)

states with some flexibility in designing appropriate approaches to demonstrate and monitor access to care, particularly given the evolving state of health care delivery models used by Medicaid programs.

The AMA believes state-level advocacy is important to further improve state Medicaid programs. While the AMA achieved significant wins in this final rule, more safeguards are needed to further ensure all Medicaid beneficiaries are able to access the care they need. Through ongoing discussions with state Medicaid directors and legislative and regulatory action, state advocates should build upon the provisions in the final rule and implement additional protections not provided by federal law.

Summary of the final rule

The final rule sets out a more consistent and transparent way for states to collect and analyze the necessary information to support CMS's review of State Plan Amendments (SPAs). It does not require states to adjust their payment rates or methodologies. Rather, it requires each state to develop and implement an access monitoring review plan and new procedures following a payment rate reduction or restructuring.

Though states will be required to consider beneficiary access when setting or modifying payment rates, CMS instructs that access issues can be addressed in other ways than increasing payment, such as redesigning service delivery strategies or improving provider enrollment and retention strategies. Moreover, the review plan is only required for services provided under the state plan, the fee-for-service model of Medicaid. The final rule does not apply to Medicaid services provided by managed care organizations or under a state waiver program.

Access monitoring review plan requirements

The state access monitoring review plan and analysis must consider:

- The extent to which beneficiary needs are fully met;
- Availability of care through enrolled providers to beneficiaries by geographic area, provider type, and site of service;
- Changes in beneficiary utilization of covered services in each geographic area;
- Characteristics of the beneficiary population, including considerations for care, service and payment variations for pediatric and adult populations and for individuals with disabilities; and
- Actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service.

Data requirements

The plan must include an access and monitoring analysis that includes the data sources, methodologies, baselines, assumptions, trends and factors, and thresholds that analyze and inform determinations of the sufficiency of access to care.

Beneficiary and provider input

The plan analysis must consider relevant provider and beneficiary information which describes access to care concerns or suggestions for improvement in access to care. Such information includes information from the rate-setting process, the medical advisory committee, the state's ongoing mechanisms for beneficiary and provider input (described below), and other mechanisms such as letters from providers and beneficiaries to state or federal officials. The state must also consult with the state medical advisory committee in developing

the plan and must publish and make publically available for comment the plan for at least 30 days prior to being finalized.

Comparative payment rate review

The plan must include an analysis of the percentage comparison of Medicaid payment rates to other public (including Medicaid managed care, as practical) and private health insurer payments. The comparison must be done for each service, by provider type and site of service.

Standards and methodologies

The plan must include specific measures to analyze access, including but not limited to:

- Time and distance standards;
- Providers participating in the Medicaid program;
- Providers with open panels;
- Providers accepting new Medicaid patients;
- Service utilization patterns;
- Identified beneficiary needs;
- Data on beneficiary and provider feedback and suggestions for improvement; and
- The availability of telemedicine and telehealth.

The plan must also include information on how the measures relate to access, the baseline and updated data associated with the measures, any issues with access that are discovered as a result of the review, and the state agency's recommendations on the sufficiency of access to care based on the review. The state must also have procedures to monitor access for at least 3 years after a provider rate reduction or restructuring (described below).

Timeframe

Beginning July 1, 2016, states must develop an access monitoring review plan and update the plan annually. Every 3 years, states will conduct a separate analysis, by provider type and site of service, for each of the following core services: primary care services, physician specialist services, behavioral health services, pre- and post-natal obstetric services (including labor and delivery), and home health services. States must include any additional services for which the state or CMS has received a significantly higher than usual volume of access complaints and may opt to include additional types of services in the analysis.

Special provisions for proposed provider rate reductions or restructuring

When a state submits a SPA that includes a provider payment reduction or restructuring that could result in diminished access, the state must conduct an access review – in accordance with the state's access monitoring review plan – for each service affected by the SPA. The access review must include an analysis of the effect of the change in payment rates on access and demonstrate sufficient access for any service for which payment will be reduced or restructured. The SPA's access review must also contain a specific analysis of the information and concerns expressed by affected beneficiaries, providers, and other affected stakeholders. The state should maintain a record of input and responses.

In addition, states must establish procedures to monitor access to the affected services annually for three years. Procedures must include clearly defined measures, baseline data, and thresholds that will demonstrate sustained service access, consistent with efficiency, economy, and access to care.

CMS may disapprove a SPA for failure to comply with the statutory access requirements. To remedy an access deficiency, CMS may withhold federal matching funds.

Mechanisms for ongoing beneficiary and provider input

States must have mechanisms for ongoing beneficiary and provider input via hotlines, surveys, ombudsman, review of grievance and appeals data, or another equivalent mechanism. States must promptly respond to public input with appropriate investigation, analysis, and response and maintain a record of data on public input and how states responded to this input. The record must be made available to CMS upon request.

Addressing access questions and remediation of inadequate access to care

When deficiencies are identified, the state must, within 90 days after discovery, submit a corrective action plan with specific steps and timelines to address those issues. Remediation of the access deficiency should take place within 12 months.

Corrective action may include increasing payment rates, improving outreach to providers, reducing barriers to provider enrollment, providing additional transportation to services, providing for telemedicine delivery and telehealth, and improving care coordination. Resulting improvements must be measured and sustainable.

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