State advocacy roadmap: Medicaid access monitoring review plans

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 34 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. Research has consistently demonstrated that low reimbursement rates are a major reason why physicians decide not to accept Medicaid patients. Nearly a third of office-based physicians do not accept Medicaid patients, and physicians are less likely to accept Medicaid patients than to accept patients covered by Medicare or private insurance.[3] 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.[4] 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 process for states to document that provider payment rates are sufficient to enlist enough providers to serve the Medicaid population receiving benefits on a fee-for-service (FFS) basis.[5] The final rule does not apply to Medicaid services provided by managed care organizations (MCOs) or under a state waiver program, though CMS is expected to issue a final rule in 2016 to overhaul federal oversight of Medicaid managed care.

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[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] Esther Hing, Sandra Decker & Eric Jamoom, *Acceptance of New Patients With Public and Private Insurance by Office-based Physicians: United States, 2013*, NCHS Data Brief No. 195, U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics (Mar. 2015).
[4] 135 S. Ct. 1378 (2015).
[5] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Federal Register 211, 67576-612 (Nov. 2, 2015) (to be codified in 42 C.F.R. 447).

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

Never before have states been required to conduct a comprehensive review to determine the extent to which beneficiaries are able to access healthcare services. Not only will the findings from the states' analysis influence – positively or negatively – physician reimbursement rates in FFS programs, but they will likely impact rates paid under managed care arrangements as often a state's FFS fee schedule is the basis for reimbursement rates paid by MCOs.

However, the final rule lacks a strong federal enforcement mechanism. While the rule provides that CMS may disapprove a proposed state plan amendment (SPA) if it determines that Medicaid service payment rates are modified without the required analysis, the rule does not make it clear that CMS, in reviewing a state's submitted access rate reviews, can itself determine that the data indicate an access problem that needs corrective action. Instead states retain both the responsibility for setting standards and access measures as well as the discretion to determine whether they have met the chosen standards. Moreover, even after identifying access issues resulting from inadequate payment rates, states will not be required to increase those payment rates. Instead states have available a number of approaches, such as improving care coordination, which will allow states to avoid the addressing the source of the problem while keeping physician rates dismally low and, as a result, may have no lasting impact on physician participation.

State-level advocacy will be important as states design and implement access monitoring review plans. Though the final rule represents an important step forward, more safeguards are needed to further improve state Medicaid programs and 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.

Purpose of access monitoring review plans

The final rule sets out a more consistent and transparent way for states to collect and analyze the necessary information to document compliance with the equal access mandate and to support CMS's review of 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, update the plan on a regular basis, and follow specific 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 FFS model of Medicaid. The final rule does not apply to Medicaid services provided by MCOs or under a state waiver program. However, as noted above, often rates paid by MCOs are set according to the FFS fee schedule.

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CMS has said in guidance that, while it will review states' access monitoring review plans and provide feedback to states, the agency will not formally approve or disapprove the plans.[6] CMS plans to post each state plan on Medicaid.gov.

Provisions where states should seek additional protections

Access monitoring review plan

Beginning October 1, 2016, states must develop an access monitoring review plan and update the plan annually.[7] The plan and monitoring analysis must consider:

- The extent to which beneficiary needs are fully met;
- The availability of care through enrolled providers to beneficiaries in each geographic area, by provider type and site of service;
- Changes in beneficiary utilization of covered services in each geographic area;
- The 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.

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

Advocacy approach: States may want to consider requiring the access monitoring plan to address administrative barriers that delay provider payment and discourage provider participation.

Standards and methodologies

The plan must include specific measures to analyze access. CMS leaves states with discretion to determine the appropriate measures and offers that such measures may include:

- 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.

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[6] Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Access Rule Implementation Frequently Asked Questions (Mar. 16, 2016).
[7] CMS issued a final rule "Medicaid Program; Deadline for Access Monitoring Review Plan Submissions" on April 8, 2016 extending the deadline for states' access monitoring review plan submission to CMS from July 1, 2016 to October 1, 2016.

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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.

Advocacy approach: States should consider setting the specific standards that measure both potential and realized access, such as provider participation, geographic access measures, timely access measures, provider-to-patient ratios, quality measures, and patient experience measures. States should consider expanding upon those measures suggested in the rule with the following:

- Time and distance standards that take into account the availability of public transportation options;
- Service utilization patterns, including whether beneficiaries have a usual source of care, use of emergency departments, and access to inpatient hospital services;
- Patient-to-provider ratios, by provider type, and a comparison of patient-to-provider ratios to other public programs and private health plans;
- Wait times for appointments, by provider type; and
- Access to alternative office hours (e.g. evenings and weekends) by provider type.

When setting a methodology, states should carefully consider how measures capture Medicaid beneficiaries' need for different kinds of services. Though the same kinds of measures may be used across service categories, precise measures should account for the difference between primary care and specialty care, for example. States should also consider separately measuring adult and pediatric services in each category.

Comparative rate review

The access monitoring review plan must include an analysis of the percentage comparison of Medicaid payment rates to other public and private health insurer payments. The comparison must be done for each service, by provider type and site of service, but the comparison will be in aggregate. States are not required to make comparisons at the individual code level. The final rule instructs that the comparative rate review should consider rates paid by Medicaid managed care entities, *as practical*.

Advocacy approach: States should consider making a comparison of Medicaid rates mandatory across all delivery systems, including managed care. Further, the rule does not instruct states on how to incorporate the comparative rate review into their analysis of access. States should consider setting baseline payment levels, such as a percentage of Medicare rates, to serve as an access measure threshold.

Triennial review of specific services

Every three 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.

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Advocacy approach: States may want to consider requiring separate analyses for pediatric and adult providers for each of the service categories, as well as physician subspecialist services and family planning services. States may want to consider also requiring analysis for a certain number of adult subspecialties and pediatric subspecialties identified as being in high demands and presenting some degree of difficulty in access as reported through public input.

The rule does not state whether the Medicaid agency itself, CMS, or another entity is responsible for determining when "a significantly higher than usual volume of access complaints" warrants a separate analysis. States may want to consider assigning responsibility for that determination to an independent third party.

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.

Advocacy approach: The rule does not define under what circumstances a payment reduction or restructuring "could result in diminished access" and states should consider requiring a review for every payment reduction or restructuring.

Mechanisms for ongoing 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.

Advocacy approach: States should consider prescribing the specific means through which states must seek stakeholder input. States should consider developing a dedicated mechanism for providers and beneficiaries to report access issues and make such reporting publically available. States might also consider granting oversight authority of provider input mechanisms to the state medical care advisory committee or a legislative workgroup. States may also consider requiring outreach to the specific provider groups affected by a rate change. For example, a payment rate change for primary care services might warrant specific outreach to primary care physicians, pediatricians, and obstetricians and gynecologists.

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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 to CMS 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. In guidance, CMS advised that if a state is unwilling to develop and implement a corrective action plan, CMS may take a compliance action against the state and withhold federal matching funding. The rule does not require states to remediate access problems by increasing payment rates.

> **Advocacy approach:** States should consider making increased payment rates the default corrective action, as ample evidence has demonstrated payment rates are inextricably linked with provider participation rates in Medicaid. Other methods of improving access to care should be considered as complementary elements of a state's overall strategy to promote provider participation. States should also consider requiring remediation to take effect in a shorter timeframe, 90 days for example, to better address the contemporaneous healthcare needs of beneficiaries lacking access to care.

Provisions not included in the final rule

Enforcement mechanisms

As previously noted, the final rule lacks a strong federal enforcement mechanism. The rule provides that CMS may disapprove a SPA if it determines that Medicaid service payment rates are modified without the required analysis, but does not state CMS can itself identify an access problem and require corrective action. Moreover, even after identifying access issues resulting from inadequate payment rates, states will not be required to increase those payment rates.

> **Advocacy approach:** As noted above, states should consider making increased payment rates the default corrective action to remedy access problems in order to directly address provider participation rates in Medicaid.
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> In the absence of federal enforcement mechanisms, state policymakers should also consider enacting their own "equal access requirement" in state law to guarantee Medicaid patients can access needed health care services. Such a law might mirror the federal statute and require states to set Medicaid payments at levels "consistent with efficiency, economy, and quality of care" and "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." A state law should stand alone, independent of the federal equal access requirement and judicial review thereof. Further, states may want to consider explicitly authorizing judicial review as a mechanism for beneficiaries and providers to enforce the state's equal access law in state court. A private cause of action in the state would provide a substitute pathway in the absence of federal litigation precluded by US Supreme Court following the decision in *Armstrong v. Exceptional Child Center, Inc.*

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Independent review

The final rule relies largely on state attestation and certification to verify compliance with the equal access requirements, which is consistent with the existing regulatory framework that has failed to sufficiently address access inadequacies. The rule leaves to states the responsibility for setting standards and access measures and also the discretion to determine whether they have met those standards.

> **Advocacy approach:** States should consider requiring an independent, objective third party be the primary arbiter of a state's ability to provide adequate access to care.

Beneficiary assistance

> **Advocacy approach:** States should consider developing a centralized, informal process through which states can address specific access complaints and provide individualized assistance. For example, a state could create a dedicated hotline for beneficiaries or their providers to seek timely assistance with finding a participating provider, making an appointment, or filing an appeal, for example. In guidance, CMS encouraged states to use mechanisms, like call centers, to identify and address real-time access concerns.
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> States should also consider replicating across delivery systems the formal grievances and appeals processes federally mandated on Medicaid managed care plans. Medicaid managed care plans are required by federal regulation to accept enrollee grievances and appeals, resolve appeals within 30 days, and address complaints within 72 hours days when the "time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function," and report on grievance and appeal data.

Application to managed care

The rule does not apply to services provided by MCOs, yet the majority of Medicaid beneficiaries are enrolled in managed care plans, and access issues often span delivery systems.

> **Advocacy approach:** States should consider extending the scope of their access monitoring review plans to include managed care programs. States should also require consistent access measures, performance metrics, and analysis to be aligned across Medicaid delivery systems. At a minimum, states should compel Medicaid MCOs to disclose payments and access measures and metrics and open to the public those measures for study and review.

Provider directories

While managed care plans are required to make directories of contracted providers, states are not required to do so for FFS providers. Many states already compile provider listings for their FFS programs, but the level of detail included and the frequency with which the listings are updated are not regulated.

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Advocacy approach: States should consider requiring a regularly updated provider directory of all FFS Medicaid-participating providers. States may want to consider creating a uniform master provider directory that covers all Medicaid delivery systems. Directories should include information on a provider's specialty or subspecialty, geographic location, contact information, business hours, languages spoken, scope of services provided, and whether the provider is accepting new Medicaid patients. States should develop and make publically available procedures that directly test provider directories for accuracy of information, the ability of prospective patients to obtain an appointment, and the timeliness of appointments offered.

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