AHLA Practice Groups
email alert

Date: December 3, 2015

CMS Issues Rule Requiring States to Measure Access in the Medicaid Program

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The Centers for Medicare & Medicaid Services (CMS) has finalized a Medicaid regulation, first proposed in 2011, that requires state Medicaid agencies to document and review access to care and service payment rates with respect to specified Medicaid-covered services.[1] These requirements are being imposed as part of states' broader efforts to ensure that Medicaid payments be "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 extent that such care and services are available to the general population in the geographic area."[2]

The final rule does not identify a national access standard. Instead, the rule specifies procedural requirements that states must follow to support their determination that beneficiaries have sufficient access to care.

The new rule would require states to submit to CMS a formal "access monitoring review plan" demonstrating sufficient access any time it proposes an action, including proposed reductions or restructuring of payment rates, that could reduce access to care, and would authorize CMS to deny a proposed change if the state fails to meet this standard. In addition, each state must develop an access monitoring review plan that analyzes access to the following services, for each provider type and each applicable site of service: primary care services; physician specialist services (for example, cardiology, urology, radiology); behavioral health services (including both mental health and substance abuse disorder treatment services); pre- and post-natal obstetric services (including labor and delivery); and home health services. States have discretion to review access to additional categories of services, and must review additional types of service for which they receive a higher-than-usual volume of access complaints.

The access monitoring review plans must be updated at least every three years. The plan must include the specific measures the state uses to analyze access, which may include time and distance standards, analysis of

participating providers, providers with open panels, providers accepting new Medicaid beneficiaries, service utilization patterns, identified beneficiary needs, data on beneficiary and provider feedback and suggestions for improvements, and the availability of telehealth/telemedicine. A state must include its analysis of the sufficiency of access to care in geographic locations within the state, including the data sources, methodologies, baselines, assumptions, trends and factors, and thresholds used in the analysis. The access plan 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, and the characteristics of the beneficiary population. In addition, for each service reviewed, the state must document the actual or estimated levels of provider payments available from other payers (including public and private payers) and a percentage comparison of the Medicaid payments rates to those other provider payments for the geographic area.

States are required to have mechanisms for beneficiaries and providers to offer input on access to care, to maintain a record of such input and the state's response, and to promptly respond to input citing specific access problems.

If access deficiencies are identified, states are required to submit a corrective action plan within 90 days after discovery. Examples of methodologies states may use to address the deficiencies include increasing payment rates, improving provider outreach, reducing barriers to provider enrollment, providing additional transportation to services, expanding telemedicine or telehealth services, or improving care coordination.

While the CMS final rule has immediate legal effect, CMS has requested comments on certain aspects of the rule, which could lead to modifications or changes. Specifically, CMS has requested comments on: (1) whether adjustments to the access review requirements would be warranted in the absence of a triggering circumstance; and (2) whether exemptions based on state program characteristics (for example, high managed care enrollment) are warranted. In addition, CMS also has issued a register for information soliciting feedback on which access measures, thresholds, and appeal processes would be useful to ensure Medicaid beneficiaries' access to care. Comments on these areas are due by January 4, 2016.

**We would like to thank Anil Shankar and Diane Ung (Foley & Lardner LLP, Los Angeles, CA) for providing this email alert.*

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[1] 80 Fed. Reg. 67576 (Nov. 2, 2015).
[2] Social Security Act 1902(a)(30)(A), 42 U.S.C. 1396a(a)(30)(A).