



ACCESS TO MEDICAID SERVICES

By: Mary Fitzpatrick, Legislative Analyst I

Armstrong v. Exceptional Child Center, Inc.

In March 2015, the U.S. Supreme Court ruled that Medicaid's equal access provision does not provide a private right of action for providers and beneficiaries to challenge Medicaid payment rates in federal court ([135 S. Ct. 1378 \(2015\)](#)).

In its final rule, CMS argued that this decision underscored the need for stronger non-judicial processes to ensure access, including (1) developing beneficiary access data and (2) reviewing the effect of changes to payment methodologies on beneficiary access.

ISSUE

This report summarizes a new federal rule on access to Medicaid services ([80 FR 67575](#)).

SUMMARY

Federal law requires state Medicaid programs to establish methods and procedures to ensure that Medicaid beneficiaries can access services to at least the same extent as the general population in the same geographic area (i.e., the "equal access provision").

The federal Centers for Medicare and Medicaid Services (CMS) recently published a final rule implementing the equal access provision that requires state Medicaid agencies to develop a medical assistance access monitoring review plan. The review plan must consider:

1. the extent to which services meet beneficiaries' needs;
2. the availability of care through enrolled providers to beneficiaries by geographic area, provider type, and site of service;
3. changes in beneficiary use in each geographic area;
4. certain characteristics of the beneficiary population; and
5. actual or estimated levels of provider payment available from other public and private payers by provider type and site of service.

Effective January 4, 2016, the new rule requires states to develop review plans and update them periodically. States must make plans available to the public for at least 30 days, finalize them, and submit them to CMS for review. The first review plan is due July 1, 2016.

The rule also creates new requirements for certain Medicaid state plan amendments (SPA). When states submit a SPA to CMS to reduce or restructure provider payments, they must submit an access review for each service affected by the SPA and monitor access to each affected service for at least three years.

Connecticut's Department of Social Services (DSS) is currently in the early stages of developing its plan to comply with the new rule.

THE EQUAL ACCESS PROVISION

Federal Medicaid law requires states to reimburse health care providers at a rate that is low enough to ensure efficiency and economy yet high enough to attract a sufficient number of providers to ensure beneficiaries have access to health care services to the same extent they are available to the general public in the same geographic area ([42 U.S.C. § 1396a\(30\)\(A\)](#)).

In the past, providers and beneficiaries have challenged Medicaid reimbursement rates in court, arguing that low Medicaid rates discourage provider participation and thereby negatively impact beneficiaries' access to care. This year, the U.S. Supreme Court ruled that providers do not have a private right of action to challenge Medicaid payment rates in federal court ([135 S. Ct. 1378 \(2015\)](#)). The court held that the equal access provision cannot be privately enforced in the courts because the (1) law allows the U.S. Department of Health and Human Services to withhold funds from states that fail to meet Medicaid requirements and (2) equal access provision is broad enough to be "judicially unadministrable."

FINAL RULE ON EQUAL ACCESS

On November 2, 2015, CMS published a final rule implementing the equal access provision. (The agency issued a proposed rule in 2011 ([76 FR 26341](#)).) It applies to Medicaid state plan services paid for on a fee-for-service basis. It does not apply to services delivered (1) through managed care organizations or entities or (2) as part of a Medicaid waiver program. CMS also issued a request for information from the public on additional approaches to Medicaid's statutory access requirements that it should consider.

Medical Assistance Access Monitoring Review Plan

The rule requires state Medicaid agencies (e.g., DSS) to develop, update, publish, and submit to CMS a medical assistance access monitoring review plan. The plan must specify data elements that will support the state's analysis of whether beneficiaries have sufficient access to care. The analysis must include data sources, methodologies, baselines, assumptions, trends and factors, as well as thresholds to determine sufficient access to care and inform state policies. The review plan and analysis must at least include:

1. specific measures the state uses to analyze access to care, such as (a) time and distance standards, (b) participating providers, (c) providers accepting new Medicaid beneficiaries, (d) service use patterns, (e) beneficiary needs, (f) beneficiary and provider feedback, (g) availability of telemedicine and telehealth, and (h) other similar measures;
2. an explanation of how the measures relate to the review plan;
3. baseline and updated data associated with the measures;
4. any access issues discovered as a result of the review; and
5. state agency recommendations on access to care based on the review.

States must publish their review plans for public comment for at least 30 days before finalizing the plans and submitting them to CMS.

Services and Payment Comparison

The rule requires states to analyze data collected in accordance with their review plans at least once every three years, with a separate analysis for each of the following provider types or sites of service:

1. primary care services, including services provided by physicians, federally qualified health clinics, clinics, or dental care;
2. physician specialist services (e.g., cardiology, urology, or radiology);
3. behavioral health services, including mental health and substance use disorder;
4. pre- and post-natal obstetric services, including labor and delivery;
5. home health services;

6. any service subject to a higher than usual volume of complaints from providers, beneficiaries, or other stakeholders to either the state or CMS;
7. any service affected by a proposed SPA (see below); and
8. any additional type of service selected by the state.

For each included service, states must provide an analysis of the percentage comparison of Medicaid payment rates to other public and private health insurer payment rates within the geographic area.

SPA Requirements

Prior to submitting a proposed SPA seeking to reduce or restructure provider payment rates, a state must consider:

1. data collected and analyzed in its medical assistance access monitoring review plan, and
2. input from beneficiaries, providers, and other stakeholders on (a) beneficiary access to affected services and (b) the proposed rate change's impact on continued service access.

Additionally, a state's SPA application to CMS must include:

1. an access review, performed in the last 12 months, in accordance with its review plan for services affected by the SPA that demonstrates sufficient access for any service affected by the SPA;
2. an analysis of the rate change's effect on service access; and
3. a specific analysis of information and concerns expressed by affected stakeholders.

The rule allows CMS to disapprove a proposed SPA if it does not include the required reviews and analyses. In practice, unaffected by the rule, states may implement a rate change before CMS approves the SPA, but if the SPA is disapproved, the state must make corrective payments to affected providers.

The state's review plan must also include procedures to monitor continued access for the affected service for at least three years after the SPA's effective date. The procedures must include a review of measures, baseline data, and thresholds to demonstrate continued sustained service access, consistent with efficiency, economy, and quality of care. According to CMS, monitoring should occur at least annually.

Providers and Beneficiaries

The rule requires states to have ongoing mechanisms for provider and beneficiary input on access to care. Mechanisms may include hotlines, surveys, an ombudsman, or a review of grievance and appeals data. According to CMS, states should respond promptly to information on specific access problems received through these mechanisms with an appropriate investigation and analysis. States must maintain a record of this information and their response and make it available to CMS upon request.

Corrective Action Plan

The rule requires states to submit a corrective action plan within 90 days of discovering or identifying any access deficiency. The plan must include specific steps and timelines, such as:

1. increasing payment rates,
2. improving outreach to providers,
3. reducing barriers to provider enrollment,
4. providing additional transportation to services,
5. allowing telemedicine delivery and telehealth, or
6. improving care coordination.

While the plan may include long-term objectives, it should aim to remediate the deficiency within 12 months.

MF:cmg