MACPAC

Final Rule for Assuring Access in Fee-for-Service Medicaid

Final Rule and Request for Information

Medicaid and CHIP Payment and Access Commission
Anna Sommers

Final Rule with Comment Period

- On November 2, CMS published a final rule with comment period to assure access to covered services in fee-for-service Medicaid
- Proposed rule was issued in May 2011
  - MACPAC submitted comments
- CMS also issued a Request for Information (RFI) for access measures and methods
- The final rule becomes effective on January 4, 2016, after the comment period

Background

- Supreme Court decision in *Armstrong* removed provider's private right of action
- No external benchmark standards and no clear path to comply or enforce with the provision
- Over 40 percent of enrollees receive services under fee for service
- Final rule advances a data-driven framework and process for states to document payment adequacy and access to care

Scope of Access Rule

- Services covered under the state plan and payments made to providers through fee-for-service payment, including
  - Services under 1915(i) and 1915(k)
  - Value-based payments
- Does not apply to
  - Capitated payment to Medicaid managed care
  - Waiver or demonstration programs

Key Provisions

- Access monitoring review plan
  - Process
  - Documentation
  - Submission requirements
- Transparency of state process
  - Public and provider input
  - Public notice

Access Review Plan Content

- Rule leaves flexibility for states to select measures and define approach
- States must spell out details of the plan and results of analysis
  - Specific measures, methods, thresholds
  - Report baseline and trend data
  - Define geographic areas
- States must include in the report any access issues discovered as part of the review

Access Review Plan Content (continued)

- Extent to which beneficiary needs are fully met
- Availability of care through enrolled providers
- Changes in beneficiary utilization of covered services in each geographic area
- Characteristics of the beneficiary population
- Actual or estimated levels of provider payment available from other payers (public and private), by provider type and site of service

Periodic Review and Triggers

- By July 1, 2016, develop a review plan for five core services to be updated every three years
- Review other services in special circumstances:
  - SPA submission that proposes to reduce payment rates or restructure payment or services that would result in diminished access to care
  - High volume of complaints about access to a service in a geographic area received by state or CMS

Services Subject to Ongoing Review

- Primary care services
  - Physician, FQHC, dental care
- Physician specialist services
  - e.g. cardiology, urology, radiology
- Behavioral health
  - Mental health and substance abuse disorder
- Prenatal and postnatal obstetric services
  - Including labor and delivery
- Home health

Requirements for Public Input and State Response

- Public comment period for developing the plan
- Ongoing mechanisms for beneficiary and provider input and prompt response
- Maintain records on public input and state response to this input
- If a state website is used for public notice, certain accessibility requirements apply
- When access deficiencies are identified, submit a corrective action plan within 90 days and take remedial action within 12 months

Major Changes from Proposed Rule

- Reduces number of services subject to periodic review
- Specifies data elements of the access monitoring review plan
- Clarifies what states must do prior to submission of a SPA that would reduce or restructure payment, and CMS criteria for disapproval
- Added requirements for public notice, provider input, documentation for public and CMS.

Request for Information

- Data collection and methodology
  - Should there be core measures?
  - Who should collect data?
  - Should different measures and methodologies be used for different services?
- Thresholds/goals
  - Should there be any and who should set them?
  - How should they be used?
- Alternative processes for access concerns
  - Should CMS require a standard process for complaints?

Related MACPAC Work

- Contract to collect current monitoring activities in fee-for-service Medicaid
- Major tasks include:
  - Scan of state program documentation, data, measures
  - State survey of Medicaid agencies
  - State-by-state catalogue of monitoring practices
  - Summary report
- Provides richer information on state activity to compare to review plans due July 2016

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