Insights

CMS Issues Final Rule: "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services"

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On November 2, 2015, the Centers for Medicare and Medicaid Services ("CMS") issued a Final Rule titled "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services" following the recent Supreme Court case, Armstrong v. Exceptional Child Care Center, where the Court held that a provider does not have a private right of action to enforce compliance with section 1902(a)(30)(A) of the Social Security Act ("the Act").[1] The result of this case led CMS to issue this Final Rule as a strategy to improve CMS's review and enforcement capabilities of section 1902(a)(30)(A) of the Act through the implementation of state review plans that evaluate access to care for Medicaid covered services.[2] Additionally, the Final Rule increases the flow of information to CMS so that CMS can ensure that payment rates are "sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area," and that access improvement strategies are efficiently improving delivery of care, where necessary.[3]

The Final Rule is the final version of the 2011 proposed rule and contains many provisions of the proposed rule but also contains some significant changes. Under the Final Rule, states are required to establish a medical assistance access monitoring review plan ("Plan") that is developed in consultation with the state's medical care advisory committee and submitted to CMS for review.[4] Before the Plan is submitted to CMS for review, it must be available for public review and comment for at least 30 days.[5]

The Plan must meet data requirements and include certain standards and methodologies. The data requirements mandate that the Plan must include an access monitoring analysis equipped with data sources, methodologies, baselines, assumptions, trends and factors, and thresholds that all analyze how sufficient the access to care is in certain geographical areas of the state, as well as influence other state policies for access to Medicaid services, such as provider payment rates.[6] Additionally, the Plan must compare Medicaid payment rates to other public and private health insurer payment rates in the same geographic areas of the state.[7]

The Plan must also contain, at a minimum, the following standards and methodologies:

- "the specific measures used to analyze access to care,
- how those measures relate to the Plan,
- baseline and updated data associated with those measures,
- any issues with access discovered as a result of the review, and

- the state's recommendations on the sufficiency of access to care based on the review."[8]

States must develop and implement the Plans by July 1 of the review year, beginning with July 1, 2016, and review and analyze the data collected in the Plan at least once every three years for primary care, physician specialist, behavioral health, pre- and post-natal obstetric, and home health services.[9] Additionally, if a state submits a State Plan Amendment ("SPA") to modify provider payment rates in a way that could lead to decreased access to care, the state must include an access review completed within the previous twelve months for each service affected.[10] Following a state service plan rate reduction, the state must implement annual procedures for monitoring access to care, to be completed for at least three years after the rate reduction.[11]

CMS clarified in the commentary that this Final Rule applies to payments for care and services available under the state plan, which CMS has interpreted to refer to payments to providers and not to capitated payments to MCEs. CMS specifically states that it is not addressing access to care under managed care arrangements in this rulemaking effort.

Although this was issued as a Final Rule, CMS provided a comment period through January 4, 2016 to solicit public comments on the time frame for development and implementation of the Plans and whether additional adjustments to the access review requirements should be made.[12] The regulations of the Final Rule are codified at 42 C.F.R. Part 447 and become effective on January 4, 2016.[13]

[1] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67576, 67577 (Nov. 2, 2015)(codified at 42 C.F.R. pt. 447).

[2] Id. at 67576.

[3] *Id*.

[4] *Id*. at 67611.

[5] *Id*.

[6] *Id*.

[7] *Id*.

[8] *Id*.

[9] *Id*.

[10] *Id*.

[11] *Id*. at 67612.

[12] *Id*. at 67576.

[13] *Id*.