Advocacy Action Guide for AAP Chapters

The Centers for Medicare and Medicaid Services (CMS) Methods for Assuring Access to Covered Medicaid Services final rule details how state Medicaid programs must document compliance with the “equal access” provision of federal Medicaid law. The “access rule” gives states significant flexibility to demonstrate that Medicaid enrollees have meaningful access to care. The rule applies only to care delivered via Medicaid fee-for-service payment; it does not apply to Medicaid managed care payment or payment through a waiver program.

The access rule creates an entirely new paradigm for Medicaid both at the state and federal levels. CMS has indicated that it expects the newly required state access monitoring review plans to be “evolving documents [that] will become more sophisticated over time.”

Although questions remain about the strength of the oversight created by the rule, it represents an opportunity for AAP chapters to influence how states study and document access to care, and to raise concerns about access issues in the Medicaid program.

Overview

- A longstanding provision of federal Medicaid law, the equal access provision requires state Medicaid provider payments to be “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” (42 U.S.C. §1396a(a)(30)(A)).

- This is the first time since the provision’s 1989 addition to Medicaid statute that CMS has issued a final rule to implement the equal access provision.

- The access rule follows the 2015 US Supreme Court Armstrong decision that the equal access provision does not create a private right of action for providers to seek its enforcement. The ruling, therefore, prohibits pediatricians and other physicians from suing state Medicaid programs under the Supremacy Clause of the US Constitution to seek enforcement of the “equal access” provision—a legal strategy previously undertaken by advocates, including AAP chapters, seeking higher Medicaid payment rates.
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- The US Supreme Court asserted that the correct arbiter of whether a state appropriately meets the equal access requirement is the US Department of Health and Human Services (HHS), which has the authority to withhold federal Medicaid dollars from states out of compliance with federal standards.

- Despite AAP advocacy efforts to ensure the rule would apply to all Medicaid services, it only governs care provided via fee-for-service Medicaid payment.

- The access rule gives states considerable flexibility with regard to documenting access to care. However, CMS expressly indicates that the access rule does not require states to adjust existing Medicaid payment rates.

What does the access rule require?

- The heart of the access rule is a requirement for states to create an access monitoring review plan. This plan is to be developed in consultation with the state Medicaid program’s Medical Care Advisory Committee (MCAC), be updated on a regular basis, and follow specific steps when conducted after a payment rate reduction or other restructuring that could result in diminished access to care.

- The access monitoring review plan must include an access monitoring analysis, which considers:
  - The extent to which beneficiary needs are met.
  - Availability of care through enrolled providers in each geographic area, by provider type and site of service.
  - Changes in utilization of covered services in each geographic area.
  - Characteristics of the beneficiary population.
  - Actual or estimated levels of provider payment (including considerations for care, service and payment variations for pediatric and adult populations and for those with disabilities).
  - Actual or estimated levels of provider payment available from other payers, both public and private, and by provider type and site of service.

- The access monitoring review plan must also include an analysis of percentage comparison of Medicaid payment rates to other public (including, as practical, Medicaid managed care) and private rates in the geographic area.

- The access rule does not dictate the specific measures states must use to analyze and document access to care. However, the rule does require the access monitoring review plan to include the data sources, methodologies, baselines, assumptions, trends and factors, and thresholds used when conducting the analysis.

- While states are given considerable latitude to determine the specific measures used to document access to care, CMS offers sample measures that might be used, such as:
  - Time/distance standards.
  - Providers participating in Medicaid.
  - Providers with open panels.
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✓ Providers accepting new Medicaid patients.
✓ Service utilization patterns.
✓ Identified beneficiary needs.
✓ Data on provider/beneficiary feedback and suggestions for improvement.
✓ Availability of telehealth care.

• CMS has set October 1, 2016 as the deadline for states to develop their access monitoring review plans. State plans must be updated annually by October 1.

• As part of the access monitoring review plan, states are to conduct a separate analysis every 3 years for each of the following provider types:
  ✓ Primary care (physician, federally qualified health center (FQHC), clinic, dental).
  ✓ Physician specialists.
  ✓ Behavioral health.
  ✓ Pre- and postnatal obstetric services, including labor/delivery.
  ✓ Home health.
  ✓ Additional types of services for which either the state or CMS has received a significantly higher percentage of complaints in a geographic region.

In addition, states may choose to include other types of services in this analysis.

• States must also submit an access review analysis with any Medicaid state plan amendment (SPA) that is intended to lower payment rates and could result in diminished access to care. This analysis must include each service affected by the SPA.
  ✓ This review must demonstrate sufficient access for any service for which the state agency proposes to reduce or restructure payment rates, and must be completed within the prior 12 months.
  ✓ The access review is to contain a specific analysis of the information and concerns raised by beneficiaries, providers, and other stakeholders regarding the payment reduction or restructuring.
  ✓ States must establish procedures in the access monitoring review plan to monitor continued access to care at least annually for 3 additional years after implementation of the rate reduction/restructuring.
  ✓ States must provide public notice of changes in methods/standards for setting payment rates.

• The rule requires states to have ongoing mechanisms for beneficiary and provider input on access to care—examples include hotlines, surveys, ombudsmen, review of grievances/appeals, etc. States must respond “promptly” to public input of access problems with an appropriate investigation, analysis, and response. States must maintain data on public input and state responses. This information must be available to CMS upon request.

• When a deficiency is identified, states must submit a corrective action plan within 90 days with steps and timelines to address identified issues. Remediation of the deficiency must take place within 12
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months, and could include any number of actions, including raising payment rates, improving outreach, reducing barriers, providing transportation, etc.

What does this mean for states and AAP chapters?

- The access rule creates a new framework for states to monitor access to care in the Medicaid fee-for-service environment. This is an opportunity for chapters to identify and highlight concerns with access to care caused by inadequate Medicaid payment.

- The rule establishes processes and procedures that can be used to objectively document access issues, and provide ongoing provider and beneficiary feedback on access issues as they arise.

- Because the rule requires a specific analysis for several types of providers, AAP chapters can advocate that states look specifically at pediatric primary, medical subspecialty, and surgical specialty care.

- CMS has indicated that it will not formally approve or disapprove access monitoring review plans, but will, as part of its review, work with states if changes are needed or when access issues are identified. CMS reserves the authority to take corrective action if public input is not considered, the plans are insufficient to measure access, or the state does not make changes necessary to come into compliance.

What can AAP chapters do?

- State Medicaid programs are charged with developing an access monitoring review plan by October 1, 2016. The plan must be developed with input from the state Medicaid program’s Medical Care Advisory Committee (MCAC)—pediatricians and other physicians sit on MCACs in many states. Chapters can work with state Medicaid programs and advocate for pediatrician expertise into this process.

- Chapters can advocate that measures of access must include the pediatric population and document known access issues for children in the state.

- Chapters also have the opportunity to work with patients, families, and other advocacy groups to raise the profile of the access review plan and to ensure it appropriately documents any access issues in Medicaid.

- Chapters can work to ensure that the plan includes a separate analysis for pediatric primary, medical subspecialty, and surgical specialty care every 3 years, and can work with the state to ensure ongoing mechanisms to include beneficiary/provider input on access issues are appropriate for pediatrics.

- The requirement that states conduct specific analyses when they propose Medicaid payment cuts that could negatively impact access to care presents additional advocacy opportunities. Since states will
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have to show how access can be maintained even with payment cuts, AAP chapters can take specific actions during this time, including:

✓ Providing input into methods state will use to document access to care with such a cut.
✓ Surveying members/other physicians to document any potential harm caused by cuts.
✓ Partnering with other physician and child advocacy groups to raise concerns about proposed cuts.
✓ Filing comments during all comment periods.
✓ Offering written complaints through provider complaint processes; engaging with families to do the same.
✓ Ensuring that AAP chapter positions on proposed cuts are included in any analysis sent to CMS to implement the payment cut.

• Chapters can also use the access rule to support ongoing state advocacy efforts related to increasing Medicaid payment.

• Chapters are encouraged to use the following guidance summary of various aspects of the access rule in your state advocacy activities. Please contact the Division of State Government Affairs at 800-433-9016, x7799 or stgov@aap.org for consultation and technical assistance.

Additional Resources

• CMS | Medicaid Access Final Rule
• CMS | Access Rule Implementation Frequently Asked Questions (FAQs) – March 16, 2016
• Health Affairs | Medicaid and Access to Care: The CMS Equal Access Rule
• AAP | Medicaid Reimbursement Reports
GUIDANCE SUMMARY

Creation of Medical Assistance Review Plan

- States are required to consult with their Medicaid program’s medical care advisory committee (MCAC) in creating the access monitoring review plan. Chapters should seek pediatric involvement in the MCAC to offer expertise in the development of plan.
- Although the plan only applies to Medicaid fee-for-service care, chapters can advocate that states also require an analysis of access to care in Medicaid managed care as well as any waiver demonstration program.
- The plan must be made publically available for 30 days for review and comment. Chapters should be aware of the review period, publicize it widely for other child health advocates, and formally file comments.

Access Monitoring Analysis

- The access monitoring review plan must contain an access monitoring analysis, which will consider a number of measures of access to care. Chapters should review and make recommendations on these measures, including data elements and sources used, methodologies, baselines, assumptions, trends, factors, and thresholds that inform access to care documentation.
- Chapters can work to add other considerations to the access monitoring analysis, such as:
  - Specific attention to the extent to which the needs of children with special health care needs (CSHCN) are met.
  - Programmatic administrative barriers/hassles that might impede access.
  - Delays in provider payment.

Payment Analysis

- The access rule does not dictate exactly how states are to conduct the required comparison of Medicaid payment rates to other payments. States should establish a baseline payment level for this rate comparison. Chapters can advocate that the baseline for pediatric primary care be the Medicaid rates for evaluation and management (E&M) services in place during 2014. These rates were raised during 2013-2014 by the Affordable Care Act (ACA) to Medicare levels; using these as the baseline will help many states document any subsequent reduction in payment.
- Chapters can advocate that this analysis be required to include Medicaid managed care and any payment in a demonstration program. Such an analysis may show a disparity in payment from Medicaid fee-for-service and/or private payment.
- Chapters might use payment data from the AAP Medicaid Reimbursement Survey reports (available above under Additional Resources) in this analysis, which provide fee-for-service payment rates for pediatric services by CPT code as reported by state Medicaid programs.

Access Measures Generally

- Any metrics used by the state to measure access to care should capture children's access to pediatric primary, specialty, and subspecialty care. Metrics for adults should be separate from those for children so that the state can appropriately capture access issues facing children in the Medicaid program.
- Such measures must meaningfully demonstrate true access to care, including whether the physician is accepting new patients, or has capped Medicaid participation. Measures must incorporate the ability of physicians to actually see and care for patients, not simply whether one is a Medicaid provider.
- Access measures must also be compared to those in private sector to document differences and any issues with children obtaining necessary care.
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Access Measures

• States might select any number of measures to study access to care in the Medicaid fee-for-service environment, in comparing access in Medicaid with that of other payers. Examples of measures states might use include:
  • Number/ratio/percent of children reporting an ongoing relationship with a pediatric medical home.
  • Number/ratio/percent of pediatricians, pediatric medical subspecialists, and pediatric surgical specialists accepting any and new Medicaid patients, by specialty/subspecialty.
  • Number/ratio/percent of primary care pediatricians offering evening/weekend hours.
  • Number/ratio/percent of children and youth utilizing the emergency department (ED) in the past 12 months.
  • Number/ratio/percent of primary care pediatricians reporting ability/difficulty referring to pediatric medical subspecialists and pediatric surgical specialists.
  • Number/ratio/percent of home health, pediatric dentist, durable medical equipment (DME), mental/behavioral health facilities, pharmacy, and other services to any Medicaid patients, by type and specialty.
  • Time/distance standards for children's access to a pediatric primary care medical home as well as needed pediatric medical subspecialists and surgical specialists.
  • Average wait times for children's appointments to pediatric specialists or subspecialists from initial request.
  • Average wait time for authorization of services from initial request.
  • Percentage of children and youth by age group who have had 1 or more visits to a pediatric medical home in the last 12 months.
  • Percentage of children and youth by age group who have had recommended Bright Futures well-baby and well-child visits in past 12 months.
  • Percentage of children and youth by age group who are up-to-date in ACIP/Bright Futures recommended immunizations.
  • Number of complaints by Medicaid-insured children or their parents/guardians about difficulty obtaining recommended care from a pediatric medical home, pediatric medical subspecialist or surgical specialist, pediatric dentist, pediatric behavioral/mental health or substance use disorder specialist, pediatric DME or home health agency, pharmacy, or other services.

Required Triennial Review

• Every 3 years, states must conduct a separate analysis for a list of enumerated provider types. At each state's discretion, other providers may be added to the list for specific review.
• AAP chapters should advocate that, in addition to the above services, states specifically examine children's access to primary care pediatricians, as well as pediatric medical subspecialists and pediatric surgical specialists every 3 years.

Specific Review in Case of Payment Cut

• The requirement that states conduct a specific analysis of access to care when proposing a payment cut or restructuring may be one area where the access rule has significant effect. AAP chapters should work to document the impact of a Medicaid payment cut and use every opportunity to raise concerns with the cut will have on the ability of children to access appropriate care.
• Chapters can:
  • Provide input into methods the state will use to document access to care with such a cut.
  • Survey members/other physicians to document any potential harm caused by the cut.
  • Partner with other physician and child advocacy groups to raise concerns about the cut.
  • File complaints during all comment periods and through monitoring mechanisms; engage with families to do the same.
  • Ensure that AAP chapter positions on the cut are included in any analysis sent to CMS to implement it.
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Ongoing Monitoring Mechanisms

• The requirement that states have ongoing mechanisms for beneficiary and provider input on access to care is another area where the access rule provides AAP chapters with an opportunity to proactively bring identified access issues to the forefront.
• AAP chapters should be involved in state planning to create access monitoring mechanisms. Chapters should be sure that such mechanisms are robust and do not rely solely on 1 method.
• Chapters should ensure that data related to reported access issues is made public, and that state responses to identified issues are timely and truly address identified needs.
• Chapters should also highlight the access monitoring mechanisms and publicize them widely among other providers and patient families, so that access issues can be reported to the state and appropriately addressed.
• Finally, chapters should vocally use the established monitoring mechanisms to report issues with access to care, and ensure that the state takes appropriate steps—including raising Medicaid payment when necessary—to address identified access issues.