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CENTERS FOR MEDICARE & MEDICAID SERVICES
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Access Rule Implementation
Frequently Asked Questions (FAQs)
Issued: March 16, 2016

This is one of a series of FAQs CMS will post regarding implementation of the final rule with comment period: Method for Assuring Access to Covered Medicaid Service; CMS 2328-FC.

Access Monitoring Review Plans

1. Which services must states monitor through the access monitoring review plans?

Every three years, states must review access to care for:

1. Primary care services (including those provided by a physician, FQHC, clinic, or dental care);
2. Physician specialist services (for example, cardiology, urology, radiology);
3. Behavioral health services (including mental health and substance use disorder);
4. Pre- and post-natal obstetric services including labor and delivery; and
5. Home health services.

States must add services to the access monitoring review plans when they reduce payment rates or restructure rates when the changes could result in diminished access and monitor access to those services for at least three years after the effective date of the change.

Additionally, if a state or CMS receives a significantly higher than usual volume of beneficiary, provider or other stakeholder access complaints regarding a particular type of care for a geographic area, the state must add those services to its review procedures. States may also select additional services to review.

2. What do states need to include in the access monitoring review plans?

The access monitoring review plans must identify a data-driven procedure to review access to care. Specifically, the access monitoring review plan must include an access monitoring analysis describing: data sources, methodologies, baselines, assumptions, trends, factors, and thresholds. States must use this information to determine the sufficiency of access to care which may vary by geographic location within the state.

The access monitoring review plan must identify data elements that will address:

- the extent to which beneficiary needs are fully met,
- the availability of care through enrolled providers, and
- changes in beneficiary service utilization.

The access monitoring review plan must also show aggregate comparisons between Medicaid rates and rates paid by other public and private payers. Finally, the reviews must consider real-time information from providers and beneficiaries that states gather through ongoing feedback mechanisms.

3. How can CMS expect states to develop access monitoring review plans within the timeframe?

The regulation provides states flexibility to determine the measures and data sources that will be used to analyze access to care. We expect state access monitoring review plans will be evolving documents and will become more sophisticated over time. CMS is also available to provide technical assistance to any state needing assistance in understanding the requirements of the final rule and will work to identify models for states to use when developing the access monitoring review plans.

4. How should states submit the access monitoring review plan to CMS?

States should submit the access monitoring review plan to: MedicaidAccesstoCare@cms.hhs.gov and include a cc' to their CMS Regional Office Medicaid Associate Regional Administrator (ARA).

5. What will CMS do with the access monitoring review plans?

CMS will review the access monitoring review plans for completeness and to determine if the state has addressed all of the required elements in a reasonable manner. CMS will work with the state if we determine changes are necessary to the state's submission, or if access issues are identified as part of the review. Ultimately, we intend to post each state's access review monitoring plan on Medicaid.gov.

6. Will CMS formally approve the access monitoring review plan?

States are required to submit the access monitoring review plans to CMS and we will review the plans to ensure that they comply with the requirements of 42 CFR 447.203. We do not intend to issue formal approval letters or disapprove a state's access monitoring review plan. As needed, we will work with the state if we determine that changes are necessary to the state's submission, or when access issues are identified as part of the review. However, we may take compliance actions if the access monitoring review plans do not consider public input or are insufficient to measure access to care and the state does not make the changes necessary to be in compliance with the requirements.

7. How will states know if the access monitoring review plan is acceptable to CMS?

CMS will provide feedback to each state on the access monitoring review plans. The access monitoring review plans should be living documents and we expect them to evolve over time as the approaches to reviewing access become more sophisticated and data improves.

8. Do states need to make the access monitoring review plans public?

Yes, states are required to publish and make the access monitoring review plans publicly available on an ongoing basis. In addition, the plans must be available for review and comment at least 30 days prior to be being finalized and submitted to CMS for review. CMS intends to publish the finalized plans on Medicaid.gov.

9. What does CMS expect states to do with the comments they receive on the access monitoring review plans?

To the extent that states receive comments that offer recommendations to improve the access monitoring review plans and could feasibly be incorporated by the state, CMS expects the state to modify the review plans accordingly. Similarly, to the extent the comments raise concerns about the access monitoring review plans CMS expects states to explain how it will address the concerns through the access reviews.

10. If a state expands Medicaid after submitting its plan will the state have to complete a new access monitoring review plan?

CMS will not immediately require states that newly expand Medicaid coverage to low income adults to complete an access monitoring review plan, as we do not believe a newly expanding state would have the necessary data on the expansion population readily available to conduct a meaningful access analysis. We encourage states to plan for sufficient access to care for the expansion population and will review a revised plan from any state that wishes to update its current plan to reflect the anticipated needs of the expansion population. However, CMS does expect the state to incorporate the expansion population into subsequent access reviews both for ongoing service reviews and for payment changes that require service additions to access monitoring review plans. In the interim, we also expect states to be vigilant in monitoring their beneficiary and provider feedback mechanisms to identify potential access concerns. If access issues are identified, states will need to take necessary actions to remedy the issues and may ultimately need to add services to the access monitoring review plans.

11. Has CMS identified data sets that are already in existence that states may use to complete the access monitoring review plans?

The final rule allows states broad discretion in identifying data sets and other information that may be used to conduct the analysis required in the access monitoring review plans. To the extent possible, states should use data and information that is available to them. Some potential resources states' should consider are: MMIS data sets, data from service utilization review activities, provider rosters, available federal data sets (such as data available from: CMS, US Census Bureau, HRSA, SAMSHA, AHRQ, ASPE and other pertinent data sets available at: www.healthdata.gov), beneficiary call center logs, provider call center logs, Medicare fee schedules, and recommendations from the state medical care advisory committees.

12. What if states have difficulty collecting the data that is required in the access monitoring review plan?

The regulations at 42 CFR 447.203 provide significant flexibility for states to determine the data and sources that they use to analyze access to care through the access monitoring review plans. States must address: the extent to which beneficiary needs are met, the availability of care and providers, changes in beneficiary service utilization, and compare Medicaid rates to rates paid by public or private payers. Within those parameters, states may choose the types of information they will use to analyze access to care. The final rule includes examples of the types of information that states may analyze in the review plans (such as, but not limited to: time and distance standards, providers participating in the Medicaid program, providers with open panels, providers accepting new Medicaid beneficiaries, service utilization patterns, identified beneficiary needs, data on beneficiary and provider feedback and suggestions for improvement, the availability of telemedicine and telehealth, and other similar measures). We will also provide technical assistance to states as needed on the development of the access monitoring review plans.

13. Are there requirements about the timeliness of the data that is used in the access review monitoring plans?

Generally, states should use the most recent available and reliable data. While we understand there is often a lag associated with certain data sets, we would expect that the lag be no more than two years, so that states are able to more accurately evaluate access to care. For other types of data, such as beneficiary and provider feedback, service utilization and Medicaid provider enrollment data, CMS would expect the lag time to be minimal.

14. Are states required to conduct cost studies as part of the access monitoring review plan?

No, the regulation does not require states to conduct cost studies.

15. How does CMS suggest states collect commercial carrier/private payer payment information within the access monitoring review plan?

States may compare Medicaid payment rates to the rates paid by other public and private health payers in the same geographic area. For many services, Medicare payment rates or the rates paid by the state employee health insurance may be options that are most available for such comparisons. For private pay comparisons, states may also consider rates paid by state-based exchanges, private pay information from third party vendors, survey information, and all-payer databases. Some of these resources are in development and we expect more resources to be available as payment transparency improves. If a state is not able to make comparisons to private health payer rates because the data are not available for a particular service, we expect the state to explain this as part of its analysis and conduct other appropriate reviews of Medicaid rates.

We note the comparison is an aggregate percentage comparison and states are not required to make comparisons at the individual code level.

16. What happens if a state chooses not to develop and update the access monitoring review plan?

The regulation, at 42 CFR 447.204(c), states that CMS may disapprove a proposed state plan amendment affecting payment rates if the state does not include in its submission the most recent access review monitoring plan for the services impacted, an analysis of the effect the change in payment rates will have on access, and a specific analysis of the information and concerns expressed from affected stakeholders. CMS may also take a compliance action in accordance with 42 CFR 430.35 if a state fails to remedy an access deficiency or fails to comply with federal regulatory requirements or fails to comply with federal regulatory requirements, including submitting a current, complete access monitoring review plan.

17. Provisions at 42 CFR 447.203(b)(5)(ii)(G) state that other services must be added to the access monitoring review procedures when a state or CMS has received a significantly higher than usual volume of beneficiary, provider or other stakeholder access complaints for a geographic area. What does this mean?

States must have mechanisms for obtaining ongoing beneficiary, provider, and other stakeholder input on access to care and must maintain a record of public input and the state's response. CMS also frequently receives correspondence from providers and other stakeholders describing access to care concerns. If a state determines that it has received a significantly higher than usual volume of access complaints for a geographic area, it should investigate the nature of the complaints and consider adding services to the access monitoring review plan and analyze whether access to care is sufficient. In cases when states receive high complaint volume, we will review the situation with the state, and review available data to inform a determination of whether the access concerns are substantiated, before determining whether a service should be added to the access monitoring review plan. We understand there could be efforts to raise concerns to the Medicaid agency that are not based on diminished access to care and do not necessarily warrant an addition to the access monitoring review plan. For this reason, it is important that states obtain and provide the best available data with respect to access for such services. CMS will work with states that receive a higher than normal volume of access complaints to validate the concerns and help determine if adding service categories to the review plan is warranted.

18. Why did CMS only identify specific services to be included in the access monitoring review plan? What about services that are not subject to rate reductions and not included in the ongoing review?

CMS identified specific services (i.e., primary care, physician specialist, behavioral health, pre- and post-natal obstetric care, and home health) that states must include in the access monitoring review plans because these services are frequently used by Medicaid beneficiaries and access to these services generally indicates that individuals have sources of care. In addition to the listed services, additional services may be added to the access monitoring review plans if the state or CMS receives a significantly higher than usual volume of complaints about access to care within geographic areas or if states choose to incorporate additional services for review. All other services must be reviewed for sufficient access to

care and monitored for sustained access as states reduce rates or restructure payments in ways that may diminish sufficient access to care.

19. How will workforce shortages be considered in the access monitoring review plan?

The state should acknowledge within its access monitoring review plan any significant workforce shortages that impact Medicaid beneficiaries' access to care. While we understand that such workforce shortages are generally not within the state Medicaid agency's control, such shortages should nonetheless be noted in the access review monitoring plan. When there are significant workforce shortages in a geographic area, often access will be impacted for not only Medicaid beneficiaries, but also for the general population.

20. What if a state's fee-for-service population is small and includes individuals with unusual need so that access is difficult to measure?

The final rule with comment period does not provide for exceptions based on the composition of a state's fee-for-service population. We understand state fee-for-service systems may be limited to serving individuals with complex needs that are dissimilar to other individuals within state geographic areas. This may mean that care delivery and access to services are particularly challenging. States should consider the care needs of the individuals who receive care in their systems and factor that into their access to care analysis when determining whether access is sufficient consistent with the statutory requirements. Specifically, a state should discuss challenges related to care delivery that may or may not be unique to the Medicaid program and how the state addresses the challenges. We are interested in working with states to better understand these issues and developing monitoring plans that consider population care needs, state delivery systems, and transitions between delivery systems.

21. Will CMS withhold federal financial participation (FFP) if there are access to care problems identified in states?

CMS intends to work with states to remedy access to care issues. 42 CFR 447.203(b)(8) requires states to submit a corrective action plan with specific steps and timelines to address access issues they identify within 90 days. The regulation also requires states to remediate the access deficiency within 12 months. If a state is unwilling to develop and implement a corrective action plan, CMS may take a compliance action using the procedures described at 42 CFR 430.35, which may result in CMS withholding FFP.

Special Procedures for Provider Payment Rate Reductions

22. Are states required to set Medicaid provider payment rates at a certain level?

No, the regulations do not directly require states to set Medicaid payment rates at a specific level. Rather, the state must ensure that its Medicaid payments are consistent with efficiency, economy and quality of care and sufficient to ensure access. However, if a state

determines that low rates are a cause of, or significant contributor to, access deficiencies it should consider the feasibility of increasing rates as a means to improve access to care.

23. What happens when a state proposes to reduce rates for services?

Prior to submitting the state plan amendment to CMS for approval, a state must analyze whether there is sufficient access to the services through the access monitoring review plans. States must also follow the procedures described in 42 CFR 447.204, Medicaid provider participation and public process to inform access to care.

24. What does CMS mean by payment restructuring?

States make payments to providers through a variety of ways. For instance, many states make supplemental payments to institutions, facilities, physicians and other providers that are paid as lump sum adjustments rather than through rate schedules. States also often make multiple adjustments to provider payments at once that may be budget neutral in the aggregate, but have significant effects on individual providers or access in geographic areas. To the extent states restructure supplemental or other payments made outside of rate schedules and those changes may result in circumstances detrimental to access to care, the procedures of the final rule apply. Where it is not apparent whether payment changes will affect access to care, states should work with stakeholders to better understand how access to care will be affected before determining whether to conduct the access analysis and other procedures described in the regulation.

25. Some rates have inflation built into rate methodologies and some do not. If states modify inflation increases, will that be considered a rate reduction subject to an access analysis?

To the extent that the provider payment rates are lowered based on the state's adjustment to an inflation index in the approved state plan methodology, or a state removes an expected inflation adjustment from that methodology, it would be considered a methodology change that is subject to an access analysis. CMS will work with states on an individual basis to determine if a proposed modification to inflation would require an access analysis.

26. How will CMS handle SPAs submitted between January 1, 2016 and July 1, 2016 when the first plan is due? States won't have the documentation required in 447.204(b) complete and available for inclusion with the SPA submittal.

Section 1902(a)(30)(A) of the Act requires that State plan payment rates must be consistent with efficiency, economy and quality of care and sufficient to enlist providers to assure sufficient beneficiary access to covered care and services. Before issuing the final rule, CMS requested that states document that access to care is sufficient when proposing to reduce Medicaid payment rates. While we understand states may not be able to fully review and analyze access to care consistent with the requirements described in the access monitoring review plan provisions of final rule prior to July 1, 2016, states must submit information and data to demonstrate that access is consistent with the statute before CMS approves rate

reduction SPAs. CMS will also expect states to monitor access to care after rate reduction SPAs are approved and follow the procedures for public process consistent with the requirements of the final rule for SPAs submitted after January 1, 2016.

27. Are the access monitoring review plan data requirements different for services subject to ongoing reviews and services affected by rate reductions or payment restructuring?

When reducing rates or restructuring payments, states must add the service affected by the changes to the access monitoring review plans. Prior to submitting a state plan amendment to CMS for review, the state must conduct the access analysis described under the review plan procedures and determine whether access is sufficient. The data requirements are the same for ongoing access reviews and for reviews conducted due to methodology changes. States are also required to periodically (at least annually) monitor data to ensure continued access to care after the changes for at least three years.

28. The rule says that states need to periodically monitor data for services affected by rate reductions or payment restructuring. How frequently should they monitor the data?

42 CFR 447.203(b)(6)(ii) requires states to monitor the data periodically and at least annually. States may determine a more frequent monitoring period based on the nature of the state plan change or concerns raised through the public input processes.

29. How long does the monitoring last for services affected by rate reductions or payment restructuring?

42 CFR 447.203(b)(6)(ii) requires states to conduct monitoring for at least 3 years after the effective date of the payment rate reduction or restructuring.

30. Do states have to submit access monitoring review plans if they increase rates? Or only if the state is decreasing rates?

The access monitoring review plan is required to accompany the submission of a state plan amendment that proposes to reduce or restructure payment rates in accordance with 42 CFR 447.203(b)(6). CMS will only require states add services to the access monitoring review plans if a state is decreasing rates or otherwise restructuring payments in ways that could diminish access to care. States do have discretion to monitor the impact of rate increases on access by adding services to their access monitoring review plans, and CMS would review that data if a state submits it.

31. What types of mechanisms for ongoing beneficiary and provider input can states use to meet the regulatory requirement?

States have flexibility regarding the types of mechanisms for ongoing beneficiary and provider feedback. Examples of acceptable mechanisms include, but are not limited to: beneficiary or provider hotlines, ombudsman programs, medical care advisory committees, and grievance and appeals data. CMS encourages states to use mechanisms, such as call

centers, that work to identify and address real-time beneficiary and provider related access-to-care concerns.

32. How will CMS enforce this requirement if states are not adequately soliciting or including the views of beneficiaries and providers?

The regulation requires ongoing beneficiary and provider feedback mechanisms and consideration of access concerns raised by stakeholders when Medicaid payments are changed through the SPA process. While there is no threshold for whether state adequately solicit and consider stakeholder feedback, the requirements intend to help CMS and states understand issues with access to care and we expect stakeholders will raise concerns if a state's processes are insufficient. The beneficiary and provider feedback mechanisms are intended to identify and address access concerns in real-time. States are required to keep records of the concerns that are raised through the mechanisms and how the state addressed the concerns. CMS will review these records when considering state payment proposals that could affect access to care as well as when considering whether additional services must be added to the access review monitoring plan.

CMS does have enforcement mechanisms for states to fail to implement any feedback mechanism, which are described in the regulation. CMS has standard and formal compliance action processes which could lead to deferral of federal Medicaid funds if states do not comply with the provisions of the final rule or fail to correct access to care deficiencies. In addition, CMS may disapprove a state plan amendment that proposes rate reductions or restructures payments in ways that may diminish access to care if a state does not follow the procedures described in the final rule and demonstrate compliance with section 1902(a)(30)(A) of the Act.

33. What does CMS expect states to do with the information?

CMS expects states to use public input to identify and address access issues. States can demonstrate that they have done this by responding to public input that identifies specific access problems, with an appropriate investigation, analysis and response. They must also maintain a record of the input and how the state responded.

Medicaid Provider Participation and Public Process to Inform Access to Care:

34. What is the purpose of this process?

The purpose of the process described in 42 CFR 447.204 is to increase transparency and have states consider information and concerns raised by stakeholders over payment changes that may affect access to care. Prior to the issuance of the final rule, states were only required to notify the public of changes to payment methodologies one day prior to the effective date of making those changes and conduct a public process for payment changes associated with inpatient hospital and long term care facility services. Now states must provide the public with an opportunity to submit comments, and must analyze the information and concerns expressed in those comments.

35. What must states consider as part of the process?

Prior to the submitting to CMS any state plan amendment that proposes to reduce or restructure Medicaid service payment rates, states must consider the data and analysis performed through the access monitoring review plans, as well as input from beneficiaries, providers and other affected stakeholders on beneficiary access to the affected services and the impact that the proposed rate change will have, if any, on continued service access. The state must submit to CMS with such proposed state plan amendments affecting payment rates, the most recent access monitoring review plan, an analysis of the effect of the change in payment rates on access, and a specific analysis of the information and concerns expressed in input from affected stakeholders.

36. What are some examples of how a state could comply with the public input requirement?

The final rule does not require states to have a particular process for receiving input from beneficiaries, providers and other affected stakeholders. States could do so through mechanisms similar to those they use to accept public input to meet the public process requirements for rate-setting for certain institutions described in section 1902(a)(13) or through public forums, web-based systems, or similar mechanisms that are already used by states to receive information from stakeholders.