Methods for Assuring Access to Covered Medicaid Services

Access Monitoring Review Plan (AMRP) Development

2/25/16

Medicaid Access Requirement

The Social Security Act requires states to:

"…*assure that payments are consistent with efficiency, economy, and quality of care and are 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;"*

What is the access monitoring review plan (AMRP)?

- The final rule requires states to develop and publish a medical assistance access monitoring review plan.
- The AMRP is **only** required for services covered and paid through the Medicaid state plan on a fee-for-service basis.
- The AMRP must include a methodology to analyze access to care consistent with 1902(a)(30)(A) of the Act using data and other available information.
- The AMRP must also include the data and information the state relies upon to conclude whether access is sufficient.
- Certain categories of services are reviewed every three years, while others are reviewed based on access concerns and monitored for three years.

AMRP Basics

Basic Requirements:

- Plans must be developed in consultation with the medical care advisory committee.
- The plan must be published and made available for public review and comment for no less than 30 days prior to it being finalized.
- The plan must be submitted to CMS for review.

AMRP Timeframes (Required Services)

Timeframes for the required service categories:

- First plans are due July 1, 2016 – this includes the methodology and analysis demonstrating compliance with 1902(a)(30)(A) for ongoing service categories.
- Plans must be updated by July 1 of each subsequent review period.
- Updated data and analysis must be incorporated into the review plan every 3 years.

Which services must be included?

Required Service Categories (every three years):

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

When are services added to the plan?

States may add services to the AMRPs if they choose to do so.

Additional services must be added to the plan based on:

- SPAs that reduce provider rates or restructure payments in ways that may harm access to care.
  - Access reviews must demonstrate sufficient access for services impacted by the rate reduction before CMS approves the SPA
  - State must establish procedures to monitor access after implementation of the rate reduction
    - Must include periodic review and have defined measures, baseline data and thresholds
    - Monitoring procedures must be in place for at least 3 years following the effective date of the SPA
- Significantly higher than usual volumes of beneficiary, provider or other stakeholder access complaints for a geographic area.

Required Review Elements

States must address the following in the AMRPs:

- The extent to which beneficiary needs are fully met;
- The availability of care through enrolled providers to beneficiaries in each geographic area, by provider type and site of service;
- Changes in beneficiary utilization of covered services in each geographic area.
- The characteristics of the beneficiary population (including considerations for care, service and payment variations for pediatric and adult populations and for individuals with disabilities); and
- Actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service.

Beneficiary and Provider Input

- The AMRP must consider relevant provider and beneficiary information, such as that obtained through public rate-setting processes, the medical advisory committee, beneficiary and provider feedback, and other mechanisms which describe access to care concerns or suggestions for improvement in access to care.

Standards and Methodologies

At a minimum, the AMRP must describe:

- The specific measures states use in the analysis.
- How the measures relate to the access monitoring review plan.
- Baseline and updated data associated with the measures.
- Any issues with access that are discovered as a result of the review.
- The state agency's recommendations on the sufficiency of access to care based on the review.

Payment Reductions

- For services subject to payment reductions states must:
  - Add the services to the AMRP and conduct an initial analysis demonstrating sufficient access.
  - Monitor access to care after the SPA is effective for at least three years.

Monitoring Procedures

- The AMRP should describe the defined measures, baseline data and thresholds used to monitor sustained access.
- The monitoring procedures must be in place for at least 3 years after the effective date of the SPA authorizing the payment changes.

Addressing State Questions

- CMS is available for technical assistance through the SOTA process.
- Frequent state questions:
  - Does the rule include waivers and demonstrations?
  - What if the private payment data is unavailable?
  - Are there requirements around data trending?
  - What if access varies based on changes states make their programs?
  - What if my state is nearly all managed care?
  - What if the populations served through fee-for-service have particular access to care needs that are not comparable to the general population?
  - How can we measure access in geographic areas where it is known that access is poor?
  - What if we have rate reductions in with CMS that predate January 4, 2016?
  - What will CMS's approval process of the AMRPs look like?
  - What does higher than usual access complaints mean?

Sample AMRP - Overview

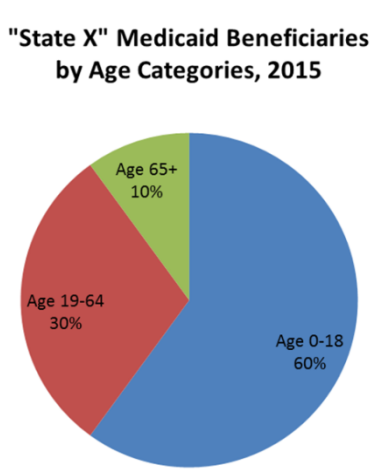
Overview

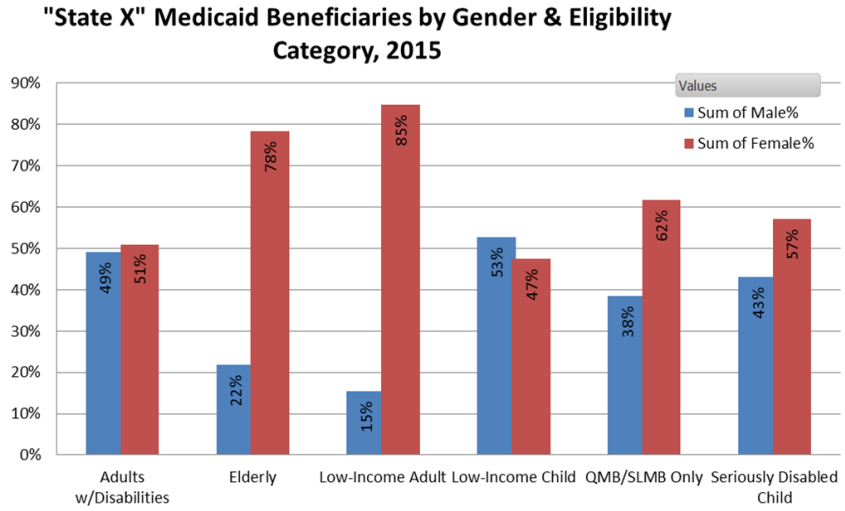
- State X Medicaid program provides healthcare coverage for low-income individuals, including children, pregnant women, individuals with disabilities, elderly, parents and other adults. The X Department of Human Services (DHS) is the single state agency that administers the Medicaid program within the state. In 2015, the X Medicaid program provided coverage to approximately 1.4 million enrolled beneficiaries with total expenditures of approximately $9.3 billion.
- State X is an average size state, with a total population of XX million. With 79 acute care hospitals and affiliated practices and a large network of rural health clinics and federally qualified health centers throughout the state, there are numerous options for Medicaid beneficiaries to receive healthcare.
- State X measures and monitors indicators of healthcare access to ensure that its Medicaid beneficiaries have access to care that is comparable to the general population.
- In accordance with 42 CFR 447.203, *state x* developed an access review monitoring plan for the following service categories provided under a fee-for-service (FFS) arrangement:
  - Primary care services
  - Physician specialist services
  - Behavioral health services
  - Pre- and post-natal obstetric services, including labor and delivery
  - Home health services
- The plan describes data that will be used to measure access to care for beneficiaries in FFS. The plan considers: the availability of Medicaid providers, utilization of Medicaid services and the extent to which Medicaid beneficiaries' healthcare needs are fully met.
- The plan was developed during the months of January – May 2016 and posted on the state Medicaid agency's website from May 15, 2016 – June 15, 2016 to allow for public inspection and feedback.
- Analysis of the data and information contained in this report show that state X Medicaid beneficiaries have access to healthcare that is similar to that of the general population in state X.

Characteristics of Population

Beneficiary Population

- In 2015, the X Medicaid program provided coverage to approximately 1.4 million enrolled beneficiaries. Approximately 62% of these beneficiaries are enrolled in managed care. The 48% receiving care through FFS primarily include individuals with disabilities and the elderly, although there are a small number of non-elderly or disabled adults and children not enrolled in managed care.

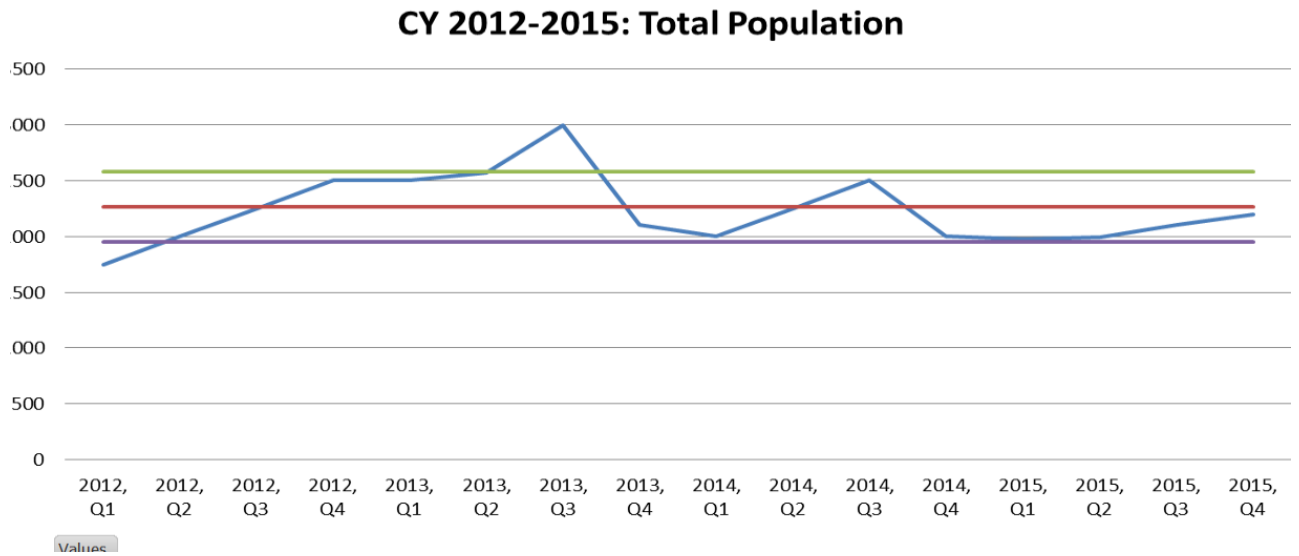




Describing Access Concerns

Access concerns raised by beneficiaries

- State X operates a beneficiary call center as a service to beneficiaries and as a way to engage beneficiaries and assist them with their needs. Each beneficiary's Medicaid card includes the toll-free number for the call center along with information about how to seek assistance if they have difficulty finding a provider or scheduling an appointment. The call center operates daily from 8am – 8pm and utilizes a messaging service after hours. Calls into the call center are logged detailing the issues raised and the resolution. On a bi-weekly basis, a report is produced detailing the number of calls, the issues raised and the resolution of the issue, including the timeliness.
- The majority of calls in which the beneficiary requests assistance with locating a provider are resolved immediately by call center staff. These calls are tracked and repeat callers seeking assistance in locating the same type of provider are flagged as this might indicate a potential access issue.
- Figure #3 shows the number of beneficiary calls identifying an access issue from 2012 – 2015

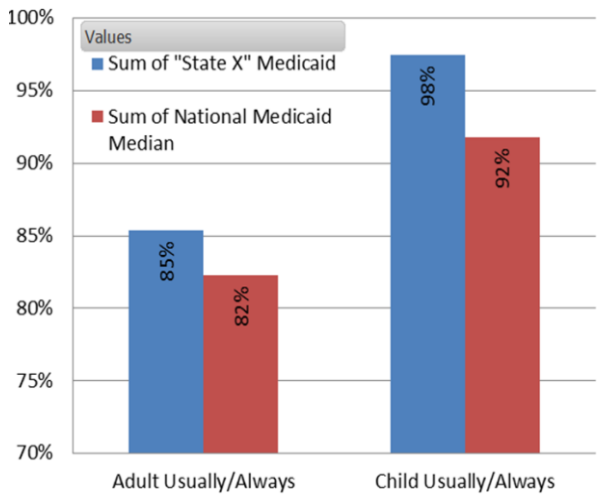


Identifying Beneficiary Needs

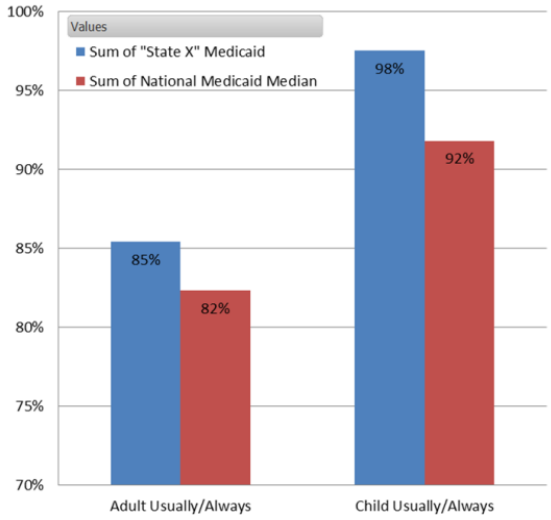
Beneficiary perceptions of access to care

- State X collects and analyzes the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys administered through CMS. Since the data is retrospective, it may not demonstrate current access, but it is an indicator for whether or not beneficiaries are able to access medical services when they are needed.
- As shown in Figure #4 and Figure #5, State X beneficiaries were able to access needed care in a timely manner and that those beneficiaries were highly satisfied with their child's personal doctor at a rate that exceeded the national averages.

Percent of CAHPS Survey Respondents Who Needed Care Right Away in the Last 6 months and Reported Getting it as Soon as Needed or Aways, CY 2014



Percent of CAHPS Survey Respondents Rating Their Or Their Child's Personal Doctor as an 8, 9, or 10 on a Scale of 0-10, CY 2014



Making the Payment Comparison

Comparison analysis of Medicaid payment rates to Medicare and other payers

- This data in Figure #6 shows that for the most recent period (2015) State X's payment rates are approximately 56% of the existing Medicare rates for the adult populations and approximately 72% of the existing Medicare rates for the pediatric population. By contrast, neighboring State A's Medicaid payment rates were equal to 80% of Medicare for the non-facility or physician office setting. While State X's rates are not as high as State A's, we acknowledge that our pediatric population is significantly higher than our non-pediatric population and the rates reflect that differential. Within each category of beneficiary (adult and pediatric), the state has not experienced any changes in provider enrollment and availability or any changes in the beneficiaries' ability to access services.

HCPCS	DESCRIPTION	2015 Medicare NonFac Rate (State X)	2015 State X Medicaid Rates (Adults)	% Difference	2015 Medicare NON FAC Rate (State X)	2015 State X Medicaid Rates (Pediatric)	% Difference	2015 Medicare NonFac Rate (State A)	2015 State A Medicaid Physician Rates	% Difference
99201	Office/outpatient visit new	47.79	25.94	**54%**	47.79	33.48	**70%**	43.63	34.74	**80%**
99202	Office/outpatient visit new	81.22	44.98	**55%**	81.22	58.05	**71%**	74.45	59.49	**80%**
99203	Office/outpatient visit new	117.92	66.40	**56%**	117.92	85.69	**73%**	107.56	86.37	**80%**
99204	Office/outpatient visit new	178.42	100.17	**56%**	178.42	129.27	**72%**	163.69	131.24	**80%**
99205	Office/outpatient visit new	223.83	125.34	**56%**	223.83	161.76	**72%**	205.49	164.52	**80%**
99211	Office/outpatient visit est	21.86	14.94	**68%**	21.86	19.27	**88%**	19.96	16.03	**80%**
99212	Office/outpatient visit est	47.79	26.83	**56%**	47.79	34.62	**72%**	43.63	34.74	**80%**
99213	Office/outpatient visit est	78.64	42.93	**55%**	78.64	55.41	**70%**	72.40	58.14	**80%**
99214	Office/outpatient visit est	116.64	64.99	**56%**	116.64	83.87	**72%**	107.40	85.76	**80%**
99215	Office/outpatient visit est	157.25	87.60	**56%**	157.25	113.06	**72%**	144.68	115.88	**80%**
Total Average Comparison		**$ 107.14**	**$ 60.01**	56%	**$ 107.14**	**$ 77.45**	72%	**$ 98.29**	**$ 78.69**	80%

Category Specific Information

Review Analysis of Primary Care Services

Data sources: Medicaid provider enrollment system
Medicaid claims payment data (MMIS)
Results of CAHPS survey (access-related questions)
Medicaid beneficiary enrollment system

Availability of primary care providers –
# of primary care physicians – trended over time
# of primary care non-physician practitioners – trended over time
# of FQHCs/ RHCs/ hospital-based clinics – trended over time
# of dentists – trended over time
Geographic distribution of the above
Ratio of primary care providers to beneficiaries (do we want to show a breakdown of rural/ urban or a few geographic areas?

Utilization data –

CAHPS data relevant to primary care/ beneficiary needs being met (are there any measures?)

Concerns/ issues raised by primary care providers through provider feedback mechanisms

Comparison analysis of Medicaid payment rates to Medicare and other payers

Category Specific Information (100% Managed Care)

Review Analysis of Pre- and Post-Natal Obstetric Services

- In State X, 100% of Medicaid covered pre- and post-natal obstetric services are paid for through a capitated managed care arrangement, including the costs associated with labor and delivery. Because these services are not paid through FFS, we are not including a review analysis of pre-and post- natal obstetric services as part of this access review monitoring plan submission.

State's Conclusion of Sufficient Access to Care

- Based on the data and information described in the access monitoring review plan, state X concludes that access to care is currently sufficient and consistent with section 1902(a)(30)(A) of the Act. State X has based this conclusion on:
  - ???

Wrap-up

The sample information provided in this presentation is for illustrative purposes. States are not bound to this information or any specific format. In addition, the sample offers states suggested data measures but does not fully describe all of the elements in the review plan "standards and methodologies" section of the rule. States are encouraged to review the final rule to ensure that all of the requirements are covered and to rely on their own available data to demonstrate compliance with 1902(a)(30)(A).

Questions?

Dedicated email address to send questions:

MedicaidAccesstoCare@cms.hhs.gov