

Medicaid Access Regulations

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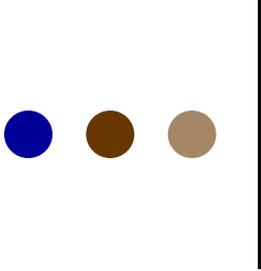
North Carolina Institute of Medicine

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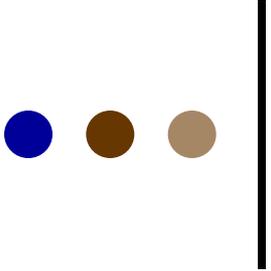
Medicaid: Assuring Access to Covered Medicaid Services (NPRM)

- CMS issued proposed regulations 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.”
 - Proposed regulations: 76 Fed. Reg. 26342-XXX (May 6, 2011), available at: <http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10681.pdf>
 - Comments due no later than July 5, 2011.



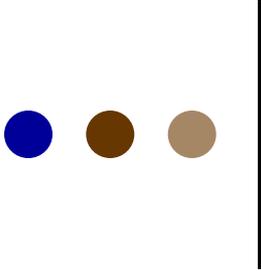
Assuring Access to Covered Medicaid Services

- States will be required to assure access based on Medicaid and CHIP Payment and Access Commission (MACPAC) 3-part framework:
 - Enrollee needs
 - Availability of care and providers
 - Utilization of services
- States have some flexibility in determining the appropriate data for these measures



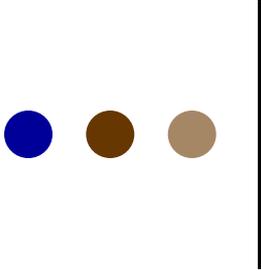
Measuring Enrollee Needs

- States can use different data sources to measure enrollee needs, including:
 - Extent of knowledge that a service is covered by Medicaid
 - Success in scheduling an appointment with a provider, including after hours
 - Satisfaction with the availability of services providers within a reasonable distance
 - Ability to obtain transportation to/from appointment
 - Number and reasons for emergency room services received in the year
 - Number and reasons for missed appointments and means
 - Ability to schedule an appointment or receive services in light of LEP proficiency
 - Turnover in providers (eg, personal care attendants)
 - Means and ability to seek help scheduling appointments



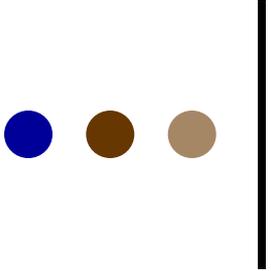
Availability of Care and Providers

- States can use a number of different data elements to measure availability of care and providers, including:
 - Availability of care and services through FFS as compared to access standards for Medicaid managed care, commercial managed care or other commercial insurance access standards
 - Number of providers with open panels who are accepting new Medicaid patients
 - Extent to which timely follow-up visits occur after ER visit or inpatient stay
 - Provider Medicaid enrollment (with open panels) compared to licensed providers in preceding rate year applicable to covered service



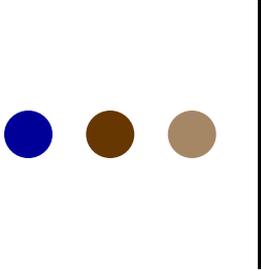
Availability of Care and Providers (cont'd)

- Provider Medicaid enrollment compared to actual provider Medicaid participation (as measured by claims submitted) in preceding rate year applicable to covered service
- Provider Medicaid enrollment (with open panels) compared to provider enrollment in one of the four largest commercial insurers in the state in preceding rate year applicable to covered service
- Provider loss and retention in preceding rate year applicable to each covered service
- Average amount of time from provider application for enrollment to approval of provider agreement
- Average amount of time from provider claim submission to payment of claim by Medicaid agency



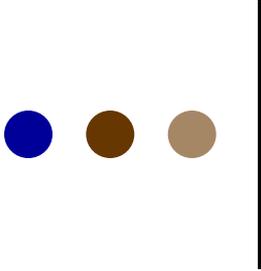
Utilization of Services

- States may review and monitor beneficiary utilization through:
 - Medicaid utilization of applicable services on per capita basis
 - Avoidable emergency room visits and hospital admissions



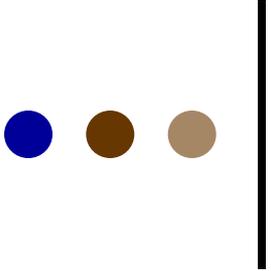
Medicaid Payment Data

- Review must *also* include:
 - 1) Estimate of the percentile which Medicaid payment represents of estimated average customary provider charges
 - 2) Estimate of percentile which Medicaid payment represents of one or more of: Medicare payment rates, average commercial payment rates, or applicable Medicaid allowable cost of services
 - 3) Estimate of the composite average percentage increase or decrease resulting from any proposed revision in payment rates.
- Data must be stratified for state government owned or operated providers, non-state governmental, or private providers



Assuring Access to Covered Medicaid Services

- Must conduct access reviews:
 - For a subset of services each calendar year and make data available publicly.
 - Every service must be reviewed at least once every five years.
- Special rules if the state wants to reduce or restructure provider payments
 - Must have conducted access review within prior 12 months, and review must have demonstrated sufficient access
 - Must have process to obtain input from beneficiaries and affected stakeholders
 - Must monitor access to demonstrate sustained service access



Corrective Action

- Corrective action plan will depend on specific circumstances. May include:
 - Steps to remove administrative burdens on providers
 - Help for beneficiaries in obtaining appointments
 - Incentivizing development or expansion of clinics in underserved areas
 - Change provider reimbursement rates to address geographic disparities or offer weekend or evening appointments
 - Modify or implement transportation, telemedicine or integrate care models to expand availability of care