



DRAFT FACT SHEET

Assuring Access to Covered Medicaid Services Final Rule

Background:

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 services are available to the general population in the geographic area.*" The rule, published in the federal register on Monday, November 2, 2015 (<http://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27697.pdf>) creates a standardized, transparent process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services.

What the rule requires:

- States must develop an Access Monitoring Review Plan that includes the following
 - Data elements that will support the state's analysis of whether beneficiaries have sufficient access to care
 - Analysis of the data elements to determine if beneficiary needs are met across different geographic regions, services and beneficiary populations
 - Actual or estimated levels of provider payments available from other payers by provider type and site of service
 - Beneficiary and provider input
 - Comparison of Medicaid payment rates to other public and private payments rates



- The Access Monitoring Review Plan must include analysis for
 - Primary care services
 - Physician specialist services
 - Behavioral health services
 - Pre- and post-natal obstetric services, including labor and delivery
 - Home health services
 - Additional services for which the state or CMS has received a significant higher volume of access complaints
 - Additional types of services selected by the state
- The plan must be published and made available for public review and comment for no less than 30 days prior to being finalized
- The plan must be submitted to the Center for Medicare and Medicaid Services for review by July 1, 2016 and updated by July 1 of each subsequent review period
- States must have mechanisms for ongoing beneficiary and provider input
- If it is determined that there is inadequate access states must submit a corrective action plan to the Center for Medicare and Medicaid Services within 90 days of identifying access issues that includes specific steps and timelines to address the issue within 12 months

Special Provisions:

- The rule includes special provisions for proposed provider rate reductions or restructuring
- States must submit an Access Review with an State Plan Amendment that reduces or restructures provider rates
- The Access Review must demonstrate sufficient access for services impacted by the rate reduction and include the most recent Access Review Monitoring Plan for the affected services, an analysis of the effect of the change in payment rates on access, and a specific analysis of the information and concerns expressed by affected stakeholders
- States must establish procedures for at least three years following the effective date of the State Plan Amendment to monitor access after implementation of a rate reduction

