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Centers for Medicare & Medicaid Services  
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## *CMCS Informational Bulletin*

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**DATE:** July 11, 2019

**FROM:** Calder Lynch  
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**SUBJECT:** Comprehensive Strategy for Monitoring Access in Medicaid

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that we are initiating a strategy to measure and monitor beneficiary access to care across Medicaid. We are committed to develop a new data-driven strategy to understand access to care in the Medicaid program across fee-for-service and managed care delivery systems, as well as in home and community-based services (HCBS) waiver programs. This new strategy will focus on a more uniform and comprehensive methodology for analyzing Medicaid access data for all states and will be led by CMS working in partnership with states.

### **Background:**

Section 1902(a)(30)(A) of the 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.” In the November 2, 2015 **Federal Register** (80 FR 67576) we published the “Methods for Assuring Access to Covered Medicaid Services” final rule with comment period that outlined a data-driven process for states to document their compliance with section 1902(a)(30)(A) of the Act. Among other requirements, the 2015 final rule with comment period required states to develop and submit to CMS an access monitoring review plan (AMRP) for certain Medicaid services that is updated at least every three years. Additionally, the rule required that when states submit a State plan amendment (SPA) to reduce or restructure provider payment rates, they must consider the data collected through the AMRP and undertake a public process that solicits input on the potential impact of the proposed reduction or restructuring of Medicaid payment rates on beneficiary access to care.

Numerous states expressed concern regarding the administrative burden associated with the November 2015 regulatory requirements, especially those states with high rates of beneficiary enrollment in managed care. States have also questioned whether the AMRP process is the most effective or accurate reflection of access to care in a state’s Medicaid program. In

attempt to address some of the states' concerns regarding unnecessary administrative burden, in the March 23, 2018 **Federal Register** (83 FR 12696), we published a proposed rule that would have exempted states from requirements to analyze certain data or monitor access when the vast majority of their covered beneficiaries receive services through managed care plans and would have provided similar flexibility to all states when they make nominal rate reductions to fee-for-service payment rates. Based on the responses we received during the public comment period, we have decided not to finalize the proposed exemptions and instead are setting out a new approach to understanding access and ensuring statutory compliance while eliminating unnecessary burden on states.

Please note that CMS' intent is to improve access to care and will continue to ask states how they are meeting the statutory requirements, and address access to care concerns expressed by beneficiaries and other stakeholders.

While CMS believes the AMRPs can be useful to guide states overall process to monitor beneficiary access, because they are generally limited to access in fee-for-service delivery systems and focused on targeted payment rate changes rather than the availability of care or population health outcomes, we have decided a more comprehensive approach is warranted. Concurrently with this Informational Bulletin, we are publishing a Notice of Proposed Rulemaking (NPRM) in the **Federal Register** that proposes to rescind the requirements of the 2015 final rule with comment period while we develop a more comprehensive approach to monitoring access across delivery systems. Through the NPRM, we are seeking comments and feedback from our stakeholders regarding both the rescission of the current regulatory requirements and our approach moving forward.

It is important to note, that until such point that the NPRM is finalized, the current regulatory requirements are still applicable. And, although the NPRM would remove the regulatory process requirements for states to develop and update an AMRP and to submit certain access analysis when proposing to reduce or restructure provider payment rates, states still are obligated by the statute **to ensure Medicaid payment rates are sufficient to enlist enough providers to assure that beneficiary access to covered care and services is at least consistent with that of the general population in the same geographic area, particularly when reducing or restructuring Medicaid payment rates through SPAs.** If the regulatory amendments in this proposed rule are finalized, we would utilize existing CMS authority concurrently with the publication of the final rule through a letter to State Medicaid Directors to provide information on data and analysis that states may submit with SPAs to support compliance with section 1902(a)(30)(A) of the Act. Such data might include: rate comparisons; ratios of participating providers to total providers in the geographic area; ratios of participating providers to beneficiaries in the geographic area; available transportation in the geographic area; direct comparisons of access for Medicaid beneficiaries to that of the general population in the geographic area; and provider, beneficiary, and other stakeholder complaints and recommendations for resolution of such complaints.

### **Developing a New Access Strategy:**

We want to work collaboratively with states and other stakeholders to develop a streamlined, comprehensive approach to monitoring access across Medicaid delivery systems by identifying uniform access indicators that may be measured through available data. To accomplish this, we

will convene workgroups and technical expert panels that include key state and federal stakeholders in the upcoming months. The workgroup will focus on identifying: 1) how the current requirements could be improved; 2) the most effective approach to ensuring beneficiary access to care; 3) how can CMS best ensure states comply with the statutory access requirements; and 4) the best way to align access monitoring across fee-for-service and managed care delivery systems. The workgroups will also identify data that could be available to conduct access reviews at the federal level and the types of analyses that would be beneficial.

**Next Steps:**

In the coming weeks, CMS will be working with the National Association of Medicaid Directors (NAMMD) to identify states that would be interested in partnering with us on this important initiative by participating in technical expert panels and ongoing working groups. Our focus will be to identify measures and benchmarks and data that may be used as common access indicators across fee-for-service, managed care and home and community based waivers. Throughout the process, we will be soliciting feedback and input on the strategy and will work collaboratively with our state partners and other stakeholders to determine a comprehensive access measurement approach.

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