Overview of Connecticut Medicaid Access Plan and Medicaid Medical Care Advisory Committee

Medical Assistance Program Oversight Council

Friday, March 11, 2016

HUSKY Health is accountable to ensure access to services, and also to document that reimbursement is "economic and efficient".

- On behalf of the Department, the ASOs perform regular **geo-access analyses** of the provider network

- Through the ASOs, the Department also uses other tools and strategies; including **mystery shopper, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and evaluation of grievances**; to assess Medicaid member experience

- The DSS Division of Health Services is responsible for **assessing and documenting the reimbursement that the Department makes to providers**

- In recent years, the **U.S. Centers for Medicare and Medicaid Services (CMS) has more rigorously scrutinized, and required a much greater level of detail**, in the sections of Medicaid State Plans that address reimbursement

- The Kaiser Foundation annually produces a Medicare-to-Medicaid Fee Index (http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/). The most recent index is based on 2012 data. Note that this predates the ACA increase in primary care rates to 100% of Medicare rates.

Location	All Services	Primary Care	Obstetric Care	Other Services
U.S.	0.66	0.59	0.78	0.70
Connecticut	0.87	0.71	1.23	0.79

- Over SFY'15, HUSKY Health:
  - **increased the number of Primary Care Providers (PCPs)** enrolled in Medicaid by 7.49% and specialists by 19.34%
  - **recruited and enrolled 22 new practices into DSS' Person-Centered Medical Home (PCMH) program**, which now includes over 100 practices (affiliated with 366 sites and 1,332 providers)
- CMS has recognized HUSKY Health as having the **best access to dental care of any Medicaid program in the country**

Connecticut Medicaid Access Plan

Federal Rule

- CMS published a final rule entitled, Medicaid Program; Methods for Ensuring Access to Covered Medicaid Services, on November 2, 2015

- The rule can be accessed at this link:

https://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27697.pdf

- Federal law at section 1902(a)(30)(A) of the Social Security Act requires Medicaid programs to: "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and 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 . . ."

Statement of Intent

- In its summary of the rule, CMS indicates that it, "provides for a transparent data-driven process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with section 1902(a)(30)(A) of the Social Security Act (the Act)"

Statement of Intent (cont.)

- In explaining the rule, CMS also acknowledges:
  - "the Supreme Court decided in *Armstrong* v. *Exceptional Child Center, Inc.,* 135 S. Ct. 1378 (2015) that the Medicaid statute does not provide a private right of action to providers to enforce state compliance with section 1902(a)(30)(A) of the Act in federal court."
  - "To strengthen CMS review and enforcement capabilities [the rule] provides for the development of needed information to monitor and measure Medicaid access to care."

Applicability

- The rule applies to fee-for-service Medicaid programs
- The rule does not apply to:
  - managed care arrangements (covered by separate federal rules)
  - Medicaid waivers

Overview

- The rule requires that Connecticut (and all other states with fee-for-service Medicaid programs):
  - develop and submit an **access monitoring review plan** (after a public comment period) on several categories of service every 3 years (plus services with rate reductions)
  - Submit an **access analysis** with each State Plan Amendment (SPA) that reduces rates
  - develop and implement a **public input process** for providers, members, and the public to raise access issues
  - if applicable, develop and implement **corrective action plans** to resolve any access problems

Access Plan

- The purpose of the Access Plan is to assure that access is available to Medicaid beneficiaries to the extent that care is available to the general population in a geographic area

- The rule does not define standards for assessing the availability of care to the general population, but instead directs states to, “analyze access issues within broad parameters in a manner that appropriately reflects the local health care delivery system of each state”

Access Plan (cont.)

- The Access Plan must consider:
  - beneficiary needs
  - availability of providers in each geographic area
  - changes in utilization
  - characteristics of population
  - comparison to other payers
- Neither provider cost nor charges is a required review element, but the Department must compare its rates to Medicare or private payers

Access Plan (cont.)

- Although rates must be compared, CMS has indicated that this, “will only serve as an indicator of whether low rates may be a source of access issues. A better determination of whether the rates are sufficient to enlist providers into the Medicaid program will be the analysis of enrollee needs, the availability of providers and utilization trends, as well as beneficiary and stakeholder feedback.”

Access Plan (cont.)

- The Access Plan must include the following categories of service, and a separate analysis must be conducted for "each provider type and site of service":
  - Primary care services (including primary care provided by physician, FQHC, clinic, or dental care)
  - Physician specialist services (ex. 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
  - Services where rates are reduced or restructured in a way that may impair access
  - Additional types of services "for which the state or CMS has received a significantly higher than usual volume of beneficiary, provider or other stakeholder access complaints for a geographic area"
  - Additional types of services selected by the state

Access Plan (cont.)

- States must:
  - develop the access monitoring plan in consultation with a medical care advisory committee
  - publish a draft Access Plan and analysis for public comment at least 30 days before plan is finalized and submitted to CMS
  - consider analysis and public input

Access Plan (cont.)

- submit the first Access Plan to CMS by **July 1, 2016**
- submit successive Access Plans every three years thereafter, plus updates as necessary if there are unusual complaints or problems

SPA Requirements

- For all State Plan Amendments (SPAs) that include rate cuts and other restructuring of reimbursement that might affect access, states are required:
  - to analyze access before setting and adjusting payments that might affect access
  - before submitting these SPAs, to conduct a public process that solicits feedback from stakeholders
  - monitor access to affected services for at least three years after the effective date of the SPA

Public Input Process

- States must establish ongoing beneficiary and provider access input procedures on access to care "through hotlines, surveys, ombudsman, review of grievance and appeals data, or another equivalent mechanisms"

- Advocates for beneficiaries must have access to the beneficiary feedback procedures

Public Input Process (cont.)

- States must "promptly respond to public input" through those procedures "with an appropriate investigation, analysis, and response"

- States must maintain a record of public input and the state's response and make this record available to CMS on request

Corrective Action Plans

- Where an access deficiency is discovered, States must submit a plan to CMS within 90 days and aim to remediate the deficiency within 12 months

- Corrective actions may include “a variety of approaches, including, but not limited to: Increasing payment rates, improving outreach to providers, reducing barriers to provider enrollment, proving additional transportation to services, providing for telemedicine delivery and telehealth, or improving care coordination.”

Corrective Action Plans (cont.)

- Improvements in access "must be measured and sustainable."

Connecticut Medicaid
Medical Care Advisory Committee

Consistent with federal regulations, the Department is planning to convene a Medicaid Medical Care Advisory Committee (MCAC). The Committee will:

- advise the Department about health and medical care services, including quality of care and access to services
- contribute to development of policy and comment on program administration

Overview (cont.)

- The MCAC will meet quarterly, and will include 15 members

- Consistent with federal regulations, membership will include:
  - Medicaid members
  - Representatives of consumer organizations
  - Physicians and other health care professionals
  - Representatives of DSS and DPH

42 C.F.R. § 431.12 Medical care advisory committee.

(d) *Committee membership.* The committee must include—

(1) Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care;

(2) Members of consumers' groups, including Medicaid beneficiaries, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and

(3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency.

Overview (cont.)

- The Department will soon be publicly inviting interested parties to submit applications for membership
- Applications will be reviewed by a small nominating committee that will develop criteria for selection and on that basis make recommendations to the DSS Commissioner for appointments
- The Department is committed to ensuring that membership on the MCAC reflects many perspectives relevant to the Medicaid program

Questions?