

RESEARCH REPORT

Proposed Medicaid Access Measurement and Monitoring Plan

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August 2016



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Submitted to:

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Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Contractor:
The Urban Institute

Contract:
Improving Quality of Care in Medicaid and CHIP
Through Increased Access to Preventive Services

Task 12: Measuring and Monitoring Access to Care

HHSM-500-2010-00024I/HHSM-500-T0005

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The authors would like to thank Kelly Devers and Jennifer Edwards of the Lewin Group for their early work in helping to conceptualize this project while they were at the Urban Institute and HMA, respectively; Stephen Zuckerman of the Urban Institute and Karen Brodsky of HMA for their review and helpful suggestions on this report; all of the experts and stakeholders who provided their time and insights toward this effort; and project officers Deirdra Stockmann and Mary Beth Hance as well as their colleagues at the Centers for Medicare & Medicaid Services for their guidance and insights.

This report was funded by the Centers for Medicare & Medicaid Services contract number HHSM-500-2010-00024I/HHSM-500-T0005. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine our research findings or the insights and recommendations of our experts. Further information on the Urban Institute's funding principles is available at www.urban.org/support.

Executive Summary

Background and Purpose

Medicaid provides health insurance to millions of Americans and has been expanding rapidly in number of people served and spending.¹ The program is required under Section 1902(a)(30)(A) of the Social Security Act [42 USC § 1396a(a)(30)(A)] to ensure that provider payments are “consistent with efficiency, economy, and quality of care and . . . 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.”²

In recent years, the Centers for Medicare & Medicaid Services’ (CMS’s) approaches to monitoring access have evolved. This document outlines current efforts to measure and monitor access and quality within Medicaid, describes existing regulatory approaches CMS is using for monitoring access, and proposes a Medicaid Access Measurement and Monitoring Plan based on these efforts to further enable CMS to monitor Medicaid enrollees’ access to care. The plan includes a proposed access framework, an initial core set of access measures, and strategies for implementation and evolution of the plan over time. The foundation for the plan was the November 2015 request for information (RFI), which solicited input on how CMS can develop systems and standards for monitoring access to care in Medicaid across delivery systems in the context of regulatory changes.³ **The goal of this Access Measurement and Monitoring Plan is to allow CMS to track access to care in Medicaid at the state level, with the hope that it will ultimately help identify priority areas for access improvement, as well as particular policies and practices that contribute to high levels of access.**

Note that while this document focuses on measuring and monitoring access within Medicaid, components of the plan pertaining to pediatric services could also be applied to monitoring access for children and adolescents covered by the Children’s Health Insurance Program (CHIP).

Access Measurement and Monitoring Plan

Proposed Access Framework

Our definition of *access* is consistent with that of the National Academy of Medicine (formerly the Institute of Medicine)—the “timely use of personal health services to achieve the best possible

outcomes,”⁴ and we further define *personal health services* to include long-term services and supports (LTSS). Our proposed access domains and measures draw on established frameworks and reflect input from CMS, key informant interviews, responses to the RFI, and the literature. We propose that CMS monitor access in three domains—**provider availability and accessibility, beneficiary utilization, and beneficiary perceptions and experiences**—building primarily on the framework put forth by the Medicaid and CHIP Payment and Access Commission (MACPAC) (2011)⁵ and operationalized for California by Gold and Kenney (2014).⁶ Our first two domains are similar to those proposed by MACPAC and Gold/Kenney, and based on input from CMS, we also explicitly include beneficiary perceptions and experiences as a third domain, rather than subsuming it under beneficiary utilization (as in the MACPAC and Gold/Kenney frameworks). Including beneficiary perceptions of access as a separate domain for state-level monitoring of access to care among Medicaid enrollees is also consistent with the recommendations included in a 2013 report on monitoring access to care in Medicaid that was funded by the US Department of Health and Human Services.⁷ Our three domains of access, described in more detail in the body of the report, are summarized here:

- **Provider availability and accessibility** (potential access): This domain measures potential access to providers and services, whether or not the providers or services are used.
- **Beneficiary utilization** (realized access and access-related outcomes): This domain addresses beneficiaries’ use of the providers and services available to them, thus “realized,” as opposed to “potential,” access. We also propose that this domain explicitly address the outcomes of utilization, not just whether care was received.
- **Beneficiary perceptions and experiences**: These measures, based on consumer surveys and program complaints and grievances, provide insights about foregone or delayed care and provider-consumer interactions that cannot be detected in the claims and encounter data on which many beneficiary utilization measures are based.

Selection Criteria for Measures, Services, and Population Groups

We developed an initial core set of access measures across the three domains of our framework, taking into consideration concerns that were expressed by CMS or that surfaced in conducting the key informant interviews and reviewing the comments provided in response to the RFI. **We recommend a Medicaid Access Measurement and Monitoring Plan that would:**

- Include an initial core set of measures of provider availability and accessibility, beneficiary utilization and access-related outcomes, and beneficiary perceptions and experiences;

- Align with and primarily leverage existing monitoring and data collection activities, building on the existing CMS Core Sets of Adult and Child Health Care Quality Measures for Medicaid and the Children’s Health Insurance Program (CHIP) (“Adult and Child Core Sets”), the Transformed Medicaid Statistical Information System (T-MSIS), and the Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and also relying on a new “secret shopper” audit;
- Rely on continued investments in T-MSIS and the Nationwide CAHPS, allowing CMS to monitor Medicaid access at the state level without introducing excessive new burdens on states;
- Track access to different services and providers using existing measures;
- Prioritize developing valid access measures for long term services and supports, including both institutionally based services and home and community-based services (HCBS);
- Monitor access at the state level for specific Medicaid subpopulations, including aligning with the data collection standards that can help CMS and states measure disparities (as developed under Section 4302 of the Affordable Care Act)⁸ and assessing geographic patterns of access within states;
- Use a common approach to access monitoring across both managed care and fee-for-service delivery systems;
- Provide a robust assessment of access which takes into account important state-specific contextual factors and considers patterns found across and within the access domains (i.e., triangulation);
- Include feedback loops between CMS and state Medicaid programs to ensure that (1) the measures are constructed, implemented, and interpreted correctly, (2) both CMS and states become aware of particular states that are consistently high or low performers or where access is either improving or deteriorating, and (3) the underlying reasons are probed and appropriate policy and programmatic responses are identified, particularly when access is falling far short of national norms or declining precipitously;
- Determine the appropriate role of thresholds in monitoring access within Medicaid, assess the pros and cons of alternative methodologies for setting access thresholds or state-specific guard rails, evaluate the uses of thresholds in access monitoring (e.g., as part of public reporting on

state-level access in Medicaid or as triggers for follow-up actions by CMS and states), and implement the proposed approach;

- Assess the extent to which variability in access across states and over time is sensitive to differences and changes in the characteristics of the Medicaid population being served;
- Provide, where possible, comparable estimates to other (non-Medicaid) populations;
- Build capacity for states to collect and report on more rapid-turnaround information on a few key metrics to complement the proposed core access measures set and produce a real-time assessment of access to care; and
- Expand and revise the access measures set over time to include targeted outcome measures and to incorporate new measures that are developed and new data sources that become available, particularly those designed to capture access to home and community-based services and other types of long-term care, and to specialty care.

Recommended Initial Core Set of Access Measures

The proposed initial core set of access measures includes 22 measures across the three access domains in our framework:

- **Four provider availability and accessibility measures**, reflecting provider-to-enrollee ratios by provider type, the timeliness of appointment availability for different types of services, the availability of appointments and information outside traditional business hours (e.g., evenings, weekends, and holidays), and the availability of language-accessible services (e.g., multilingual services or translation/interpretation services).
- **Fifteen beneficiary utilization and outcomes measures**, reflecting receipt of care in (1) outpatient settings (physician visits including well-child visits, follow-up care after hospitalizations for mental health issues, preventive dental care, and prenatal and postpartum care), (2) the emergency room (visits overall as well as those potentially avoidable), and (3) inpatient settings (ambulatory care sensitive admissions).
- **Three measures that reflect beneficiaries' experiences and perceptions**, namely, frequency and ease of getting needed care, having a usual source of care, and receipt of culturally competent care (e.g., how well providers communicate with their patients).⁹

Nearly half the measures in this proposed initial access core set are from the Core Sets of Health Care Quality Measures for Adults and Children, which are already being reported by most states. Beyond these, the proposed access core set includes measures that could be constructed from T-MSIS and from the Nationwide CAHPS, as well as several that would be derived from new “secret shopper” audits. The initial access core set includes measures for nearly all categories of services and providers identified in the November 2015 RFI as priorities, including primary and preventive care; pediatric care; specialty care; and oral, behavioral, and maternal health care. The proposed core set includes several measures that can be assessed at the state level for key geographic units and population subgroups. Appendix A provides more detail about each proposed measure. As much as possible, we suggest that CMS “triangulate” across measures (i.e., consider them collectively, not in isolation) to develop inferences about how access compares across states and is changing over time and to assess whether follow-up is advisable in a particular state or service area.

Execution and Evolution of the Access Measurement and Monitoring Plan

Execution of the Access Measurement and Monitoring Plan

The number of health care quality measures has grown substantially over the last two decades, reflecting a consensus that measuring and monitoring quality—which includes access to care as a critical first step—is essential to improving health outcomes. The proposed framework and components of the Access Measurement and Monitoring Plan described above are therefore designed to use and build on existing measures and be aligned with the National Quality Strategy (NQS) and the related CMS Quality Strategy. Additional resource investments will be needed, however, to develop, refine, test and implement the proposed measures.

PROVIDER AVAILABILITY AND ACCESSIBILITY MEASURES (POTENTIAL ACCESS)

We propose four measures for assessing provider availability and accessibility, one that we assume could be centrally calculated by CMS from T-MSIS data (i.e., provider-to-enrollee ratios) and three that would require states or CMS to field a new “secret shopper” audit initiative to assess the timeliness of appointment availability, the availability of appointments and information outside traditional business hours, and the availability of language-accessible services.

For this and the other T-MSIS measures in the initial core access set, CMS would need to implement uniform measure specifications, provide guidance to states on how T-MSIS fields are used in the measure calculations, and ensure that the validity of the data for state-to-state comparisons is rigorously tested. Measure specifications would also need to account for variations by state in provider billing types, licensure categories, and delivery systems. For example, some states may rely more heavily on nurse practitioners and nurse-managed clinics to meet demand for primary care than states with more restrictive scope of practice laws.

Recognizing that CMS will face challenges in defining these provider availability measures,^{10,11} that the quality of state-submitted T-MSIS data is likely to improve and become more comprehensive as states gain greater experience with reporting, and that new resources will be needed to conduct “secret shopper” audits, CMS may wish to consider a phased-in implementation of these measures.

We have identified several states currently reporting on our proposed provider availability measures. For example, Pennsylvania included a provider-to-enrollee ratio in its access monitoring plan mandated by the 2015 Medicaid final rule on the equal access provision,¹² Georgia listed Days to Appointment as a measure to monitor in its 2016 “Quality Strategic Plan for Georgia Families (Medicaid)” but has not yet reported on it,¹³ and New York reports provider participation rates by measurement year as part of its Quality Incentive Report.¹⁴

BENEFICIARY UTILIZATION MEASURES (REALIZED ACCESS AND ACCESS-RELATED OUTCOMES)

Nine of our proposed measures for realized access are already part of the Adult and Child Core Sets, and all that are not from the Adult and Child Core Sets are already being used to monitor access in some states. For example, California, Colorado, and New Hampshire measure whether adults received at least one ambulatory service in the prior year; Texas, Florida, and Georgia also include a variation of this measure (Access to Preventative/Ambulatory Services) for adults.¹⁵ In its draft access monitoring plan, Pennsylvania has included Adults Receiving at Least One Dental Service in the Prior Year as a measure.¹⁶ New Hampshire, Texas, and Georgia all include Emergency Visits that were Potentially Preventable or Avoidable or that Potentially Could Have Been Treated in a Primary Care Setting, in their access monitoring, quality improvement, or strategic plans.¹⁷ We found less evidence that states are measuring pediatric hospital admissions for ambulatory care sensitive conditions (e.g., diabetes complications, asthma), but New Hampshire has been monitoring Hospital Admissions for Ambulatory Care Sensitive Conditions for Children.¹⁸

One measure proposed in this domain is from the Nationwide CAHPS survey. Otherwise, we are proposing that CMS would compute measures from both the Core Sets and other sources, to the extent

possible, using T-MSIS data; implement uniform measure specifications as necessary; and test the measures to assure comparability across states and over time.

BENEFICIARY PERCEPTIONS AND EXPERIENCE MEASURES

We are proposing that these three measures be centrally calculated by CMS using results from a Nationwide CAHPS survey, provided the survey could be structured to produce timely, state-level results (similar to what state-sponsored CAHPS surveys currently achieve) and avoid duplication with state-level CAHPS survey efforts.

We also recommend that the Nationwide CAHPS survey be expanded to include children and that CMS consider enhancing it to include content on additional areas of access (e.g., unmet need for substance use treatment or prescription drugs, the availability of language-accessible services, and the availability of appointments and information outside traditional business hours). In addition, we suggest that information from Medicaid (and potentially Medicare) claims/encounter and enrollment files be included in the CAHPS data files, making the survey function more like the Medicare Current Beneficiary survey has.

We also believe it will be important for CMS to survey persons receiving Medicaid home and community-based services and their family caregivers to assess access for these services, building on the efforts underway (as described in Section II) to develop and implement HCBS experience of care surveys. We recommend that CMS consider how access-sensitive measures from HCBS experience of care surveys could be incorporated into the Access Measurement and Monitoring Plan in the future or, if feasible, how access-sensitive elements of the Experience of Care survey could be incorporated into the Nationwide CAHPS.

Strategies and Approaches for Operationalizing the Plan

We recommend that the Access Measurement and Monitoring Plan implementation timeline be structured to allow states sufficient time to align their policies, procedures, and IT systems; to consider state staffing additions, reassignments, and necessary training; and to implement managed care organization (MCO) or other contract revisions that will ensure the plan's success and to reduce duplication of effort. To increase states' flexibility to adapt current processes and systems, CMS could consider a phased-in implementation that would allow a state to defer reporting on measures requiring more significant program changes.

We further recommend that CMS (1) develop a formalized process for consulting with states during implementation to address and respond to emerging questions, issues, and challenges; (2) provide states initial and ongoing staff training resources and other technical assistance to assure consistent application and reporting of the access measures and standards; and (3) advise states on the availability of an enhanced administrative federal medical assistance percentage (FMAP) for system changes and other administrative costs related to compliance with the Access Measurement and Monitoring Plan under Section 1903(a) or other available authorities.

Finally, we recommend that CMS work jointly with states to analyze and interpret the data collected, as states are well positioned to understand and interpret the various Medicaid factors (e.g., delivery systems, covered services, reimbursement, telemedicine utilization) and non-Medicaid factors (e.g., rural/urban differences, scope of practice laws, employer-based coverage levels) that may be affecting their measure results. Meanwhile, CMS is well positioned to identify policy weaknesses and strengths and to help identify promising practices and resources for states that fall well below national norms or where access is deteriorating. Therefore, we recommend that the format, content, and scope of the analysis and public reporting—including the identification of high- or low-performing states, places where access is improving or deteriorating, and policy and programmatic responses to identified access issues—be determined by CMS in consultation with states and other stakeholders.

Evolution of the Access Measurement and Monitoring Plan

The access plan and its specific measures will need to evolve and be supplemented and revised as more data become available and as new measures are developed. We therefore address strategies to (1) identify and develop new data sources for access measures; (2) study, analyze, refine, and supplement access measures, including by addressing aspirational measures (such as HCBS) and the role of national thresholds; and (3) promote all of these efforts through a coordinated effort to build on the numerous regulatory changes and new systems that will emerge from the final rules on equal access and managed care.

I. Introduction

A. Background

Medicaid provides health insurance coverage to more than 57 million nonelderly adults and children, as well as long-term services and supports (LTSS) and services that supplement Medicare coverage to more than 9 million elderly and disabled nonelderly adults and children covered by Medicare.^{19,20}

Medicaid is jointly administered and financed by states and the federal government, recently surpassing Medicare in the number of people served and in spending growth.²¹ Under the Medicaid “equal access provision,” Section 1902(a)(30)(A) of the Social Security Act [42 USC § 1396a(a)(30)(A)], Medicaid is required to ensure that provider payments be “consistent with efficiency, economy, and quality of care and . . . 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.”²²

In recent years, the Centers for Medicare & Medicaid Services (CMS) has proposed new regulatory approaches for monitoring access to care in both fee-for-service (FFS) and managed care Medicaid programs. These are summarized here and further discussed in Section III below.

- In 2011, CMS issued a notice of proposed rulemaking (NPRM) that outlined a consistent approach under the equal access provision for considering and monitoring state plan amendments (SPAs) that affect enrollees’ access to covered services. Relevant SPAs include proposed provider payment reductions in FFS programs.²³
- In June 2015, CMS issued an NPRM on Medicaid managed care that included several elements that strengthen and provide information on enrollees’ access to care, including changes in quality assessment and performance improvement program provisions, the collection and submission of performance measurement data, and new minimum network adequacy standards.²⁴
- In November 2015, CMS finalized the proposed 2011 equal access rule to create “a standardized, transparent, data-driven process for states to document that provider payment rates are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available . . . at least to the extent [they] are available to the general population in the geographic area.”²⁵

- At that time, CMS also released a request for information (RFI) soliciting input on how CMS could develop systems and, potentially, standards for monitoring access to care across both FFS and managed care in the context of these other regulatory changes.²⁶
- And in May 2016, CMS issued its Medicaid managed care rule that finalized numerous standards and monitoring and reporting requirements relating to enrollees' access to care.²⁷

Also in recent years, CMS has shepherded the development and implementation of two core sets of quality measures, one monitoring care for adults and another monitoring care for children, covering those enrolled in Medicaid and the Children's Health Insurance Program (CHIP). These Adult and Child Core Sets of Health Care Quality Measures, which include access-sensitive measures, are a starting point for any other efforts to monitor access and quality of care in Medicaid. They are further discussed in Section II below.

B. Purpose of this Report

The goal of this Access Measurement and Monitoring Plan is to provide CMS with an operational framework for nationwide monitoring of access to care in Medicaid at the state level. Over time, the plan can also enable CMS to identify priority areas for access improvements, as well as policies and practices that contribute to widespread access. This document is the primary deliverable under Task 12 of the project, "Improving Quality of Care in Medicaid and CHIP through Increased Access to Preventive Services." In that task, CMS requested a plan for measuring and monitoring Medicaid enrollees' access to care, emphasizing strategies for developing an initial core set of Medicaid access to care metrics and national thresholds and goals based on the metrics.

Note that while this document focuses on measuring and monitoring access within Medicaid, components of the plan pertaining to pediatric services could also be applied to monitoring access for children and adolescents covered by the Children's Health Insurance Program (CHIP).

Following the National Academy of Medicine (formerly the Institute of Medicine), we characterize access as the "timely use of personal health services to achieve the best possible outcomes,"²⁸ and we further define *personal health services* to include LTSS. Our charge was to provide a roadmap for CMS to monitor access to care uniformly across and within states for key services and populations covered by Medicaid, irrespective of whether services are provided through waivers or under FFS or managed care delivery systems. We placed a premium on two goals: (1) leveraging and aligning with existing CMS access and quality monitoring and improvement initiatives—particularly

CMS's Adult and Child Core Sets—and (2) developing a plan that could be operationalized primarily with existing data sources and metrics, but that would also be sufficiently flexible to encompass advances in practice, data, and measures.

To design the plan, we conducted (1) a comprehensive review of the public comments provided in response to the November 2015 RFI; (2) a targeted literature review of existing access monitoring frameworks and efforts; and (3) key informant interviews with representatives from state Medicaid agencies, federal agencies, professional organizations, a multistate Medicaid health plan, and experts in monitoring Medicaid access and developing access measures; as well as additional background discussions with experts on complaints, grievance and appeals systems, and quality measures. We have also consulted regularly with CMS and have incorporated their feedback into this plan. See appendix B for a description of our research methods.

The following sections provide contextual information on current efforts to measure and monitor access and quality within Medicaid and describe CMS's existing regulatory approaches for monitoring access. Subsequent sections describe a framework for monitoring access and propose an initial core set of access measures for CMS to consider for monitoring state-level access to care in Medicaid. The final sections consider how the plan could best be executed, what ongoing data and infrastructure investments would be needed, and how the plan could evolve over time, including whether and how thresholds and guidelines could be used to identify areas for improvement.

II. Current Efforts to Measure and Monitor Access and Quality in Medicaid

Current initiatives to measure and monitor quality and access to care in state Medicaid programs are built on decades of work by multiple public and private entities, most notably, the organizations listed in box 1. This work has resulted in a continuously evolving landscape of hundreds of performance measures used by state Medicaid programs to assess quality. Recent quality measurement initiatives have also been informed by the National Quality Strategy (NQS), required by the Affordable Care Act (ACA), and prompted by CMS's efforts to align its quality measurement programs with the NQS priorities, as further described below.

A. National Quality Strategy and the CMS Quality Strategy

Despite having the highest per capita health care expenditures in the world, the United States has shorter life expectancies and poorer health outcomes than other developed countries. To address this problem, the ACA required the Department of Health and Human Services (HHS) to establish the NQS. The NQS, first released in 2011, is led by the Agency for Healthcare Research and Quality (AHRQ) and includes three overarching aims that build on the Institute for Healthcare Improvement's Triple Aim: better care, healthy people/healthy communities, and affordable care. These aims are advanced through six priorities:

- Making care safer by reducing harm caused in the delivery of care;
- Ensuring that each person and family is engaged as partners in their care;
- Promoting effective communication and coordination of care;
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
- Working with communities to promote wide use of best practices to enable healthy living; and
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Box 1

Selected Key Health Care Quality Measurement Organizations

The Joint Commission, a nonprofit that accredits and certifies more than 20,000 hospitals and other health care organizations and programs.

National Academy of Medicine (formerly the Institute of Medicine), a division of the private, nonprofit National Academy of Sciences that provides evidence-based research and makes recommendations concerning health policy.

Agency for Healthcare Research and Quality (AHRQ), an agency within the Department of Health and Human Services (HHS) that produces evidence to make health care safer, higher quality, more accessible, equitable, and affordable. AHRQ also funds and oversees the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools and leads the ACA-required National Quality Strategy initiative.

National Committee for Quality Assurance (NCQA), a nonprofit that accredits health plans, provider organizations, and other care and disease management organizations. NCQA also produces the Healthcare Effectiveness Data and Information Set (HEDIS).

National Quality Forum (NQF), a private sector standard-setting organization that evaluates and endorses tools for standardized performance measurement. NQF is widely viewed as the gold standard for health care performance measures.

Measures Applications Partnership (MAP), a multi-stakeholder partnership (convened by NQF) comprised of health care leaders and experts representing consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers. Since 2011, HHS has called upon the MAP to recommend performance measures for federal health care programs, including Medicaid.

For the first time in 2016, AHRQ issued an integrated report combining its annual *National Healthcare Quality and Disparities Report* with its NQS update.²⁹ The combined report draws from more than 250 measures of quality and disparities, covering a broad range of health care services and settings to provide national-level statistics and trends within three main focus areas: access to health care, quality of health care and the NQS priorities.

CMS has aligned its own quality strategy with the NQS: each NQS priority is a goal in the CMS Quality Strategy with associated strategic results, specific objectives and desired outcomes.³⁰ CMS uses quality measurement to drive improvement and has mapped the NQS priorities to the measure domains of patient safety, patient and family engagement, care coordination, clinical process/effectiveness, population/public health, and efficient use of health care resources.³¹ CMS has also set a strategic objective to strengthen alignment of quality measures and their associated public reporting with the NQS to both improve patient outcomes and reduce the burden of measure reporting. As of December 31, 2013, 822 unique measures were in use or finalized for use in 25 CMS quality measurement programs spanning hospital, ambulatory, and post-acute care settings.³² (For a list of the 25 CMS quality measurement programs, see appendix C.)

B. Selected CMS Initiatives to Measure Quality and Access in Medicaid

i. CMS Core Sets of Health Care Quality Measures

As required by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the ACA, CMS has worked with stakeholders to identify two core sets of measures to assess the quality of health care provided to children and adults enrolled in Medicaid and CHIP. The Adult and Child Core Sets of Health Care Quality Measures are both updated annually by CMS, informed by recommendations from the National Quality Forum's (NQF's) Measure Applications Partnership (MAP). States voluntarily report on these measures and CMS analyzes, synthesizes, and publishes reports on them. CMS's stated goals are to increase (1) the number of states reporting Core Set measures, (2) the number of measures reported by each state, and (3) the number of states using Core Set measures to drive quality improvement.³³

A. CHILD CORE SET

Development of the Child Core Set was required by CHIPRA in 2009. It includes measures relevant to pediatric services across several service categories, including preventive health, behavioral health, care of acute and chronic conditions, oral health, and maternal and perinatal health (which was included in part because it was not known at the time whether there would be an Adult Core Set).

The number of Child Core Set measures voluntarily reported by states has grown since the measure set's inception in 2010. In FFY 2010, 43 states (including the District of Columbia [DC]) reported at least one of that year's 24 Core Set measures; the median number reported was seven. For FFY 2014, all states (including DC) reported at least one Child Core Set measure to CMS, and 41 states reported at least 11 of the 22 FFY 2014 measures. Two states (Georgia and South Carolina) reported on all 22 measures and eight states reported on 21 of the 22 measures. The most frequently reported measures for FFY 2014 were the two dental measures (51 states reporting), the well-child visit and access to primary care practitioner (PCP) measures (42 to 46 states reporting), and the childhood immunization status and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures (39 states reporting). The median number of measures reported in FFY 2014 was 16.^{34, 35}

In FFY 2016, the Child Core Set includes 26 measures, which are a mix of process, outcome, and experience of care measures (although most are process measures). Approximately two-thirds are HEDIS measures. Many Child Core Set measures are access sensitive.³⁶ For a complete list of the Child Core Set measures for FFY 2016, see appendix D.

B. ADULT CORE SET

The ACA mandated the Adult Core Set, which addresses the diverse populations served by Medicaid, including women of child-bearing age, the elderly, and people with disabilities. It covers several of the same service categories that the Child Core Set does, such as preventive services and behavioral health care, but it does not address oral health. In the case of maternal and perinatal health, some measures appear in both the Child and Adult Core Sets. Like the Child Core Set, the adult version includes a mix of process, outcome, and experience of care measures (although most are process measures). Two-thirds are HEDIS measures, and several are access sensitive.³⁷

States voluntarily reported Adult Core Set measures for the first time for FFY 2013. In the second year of reporting (for FFY 2014), the total reporting at least one measure grew from 30 to 34 states. For FFY 2014, 31 states reported data on at least half of all 26 measures and seven states reported on 21 or more measures, including one state (Georgia) that reported on 25 measures. The most frequently

reported measures (reported by at least 25 states) focused on diabetes care management, postpartum care visits, and women's preventive health care.^{38, 39}

In FFY 2016, the Adult Core Set includes 28 measures. For a complete list of the Adult Core Set measures, see appendix E.

ii. **Nationwide CAHPS Survey**

In 2014 and 2015, the Center for Medicaid and CHIP Services (CMCS) conducted a Nationwide CAHPS survey of adult Medicaid enrollees ("Nationwide CAHPS") to attain national and state-by-state measures of access, barriers to care, and satisfaction with care across financing and delivery models (e.g., managed care and FFS) and population groups (e.g., individuals with disabilities and persons dually eligible for Medicare and Medicaid). This first-of-its-kind survey was intended to help CMS and states improve the quality of care for Medicaid enrollees, and also to provide baseline information on the experiences of low-income adults covered by Medicaid during the early stages of ACA implementation.

The sampling methodology for the survey captures four subgroups of adult Medicaid enrollees in each state:

- Dually eligible individuals,
- Persons with disabilities (non-duals),
- Medicaid managed care (non-duals, nondisabled) enrollees, and
- FFS (traditional) Medicaid (non-duals, nondisabled) enrollees.

In total, 46 states plus DC provided CMS's survey contractor with a sample of more than 1.2 million cases, averaging 29,000 enrollees per state. After adjusting for different expected response rates by subgroup, the target sample size per state was 5,556 each for the dually eligible and the persons with disabilities subgroups, 11,110 for the Medicaid managed care subgroup, and 7,407 for the FFS subgroup. Four survey waves between December 2014 and July 2015 resulted in 272,679 completed surveys (reflecting an overall response rate of 23.6 percent).⁴⁰

The Nationwide CAHPS survey instrument used a modified version of the Adult Medicaid CAHPS 5.0H. Five questions were removed, 21 new questions were added, and other changes were made to use the updated HHS data collection standards for race, ethnicity, and disability status. Most of the new questions were designed to assess potential access barriers more broadly and were based on previously validated questions, including questions used in national surveys like the surveys like the Medical

Expenditure Survey (MEPS 2011), the National Health Interview Survey (NHIS 2013), and the National Health and Aging Trends Survey (NHATS). Other new questions were adapted from the Dental Plan and Health Plan CAHPS surveys. CMS's survey contractor reported plans to launch the Nationwide Adult Medicaid CAHPS Data Repository, an interactive website, in "Spring 2016."⁴¹

iii. Health Home Quality Reporting

Section 2703 of the ACA created the Medicaid "health home" state plan option. Under this option, which builds on the patient-centered medical home concept, states target beneficiaries who have or are at risk of having two or more chronic conditions, including a serious and persistent mental health condition. States are required to provide a person-centered system of care that facilitates access to and coordination of the full array of primary and acute physical health services, behavioral health care, and community-based long-term services and supports. States with an approved health home SPA receive a 90 percent federal match rate for qualified health home service expenditures for eight quarters.

CMS has established a Core Set of Health Care Quality Measures for Medicaid Health Home Programs (containing eight quality measures and three utilization measures⁴²) that states are expected to report in addition to state-specific goals and measures. These Health Home Core Set measures reflect key priority areas (e.g., behavioral health and preventive care) and align with the Adult Core Set measures, the electronic health record (EHR) incentive "Meaningful Use" program measures, and the NQS.⁴³ (For a complete list of the Health Home Core Set measures for 2013–2015, see appendix F.)

iv. Quality Measures for Medicaid Home and Community-Based Services

Long term services and supports (LTSS) include both institutional care (e.g., nursing homes) and home and community-based services (e.g., respite, homemaker, and personal care services). While nursing homes and other institutionally based LTSS have long been subject to quality-based certification requirements as conditions of participation in Medicare and Medicaid, quality measures for home and community-based services (HCBS) are less advanced and vary by state. Further, there are no well-established methodologies for assessing HCBS access, which presents different complexities and challenges when compared to evaluating acute and preventive care. For example, time and distance standards are not relevant for services provided at the beneficiary's home. Similarly, the definition of service "need" can differ dramatically across HCBS subpopulations (i.e., frail elders, persons under age 65 with physical disabilities, persons with intellectual/developmental disabilities, and persons with traumatic brain injuries). This has prompted a variety of efforts to develop a core set of quality measures for both LTSS and HCBS. Several of these efforts are described below.

A. NQF HCBS QUALITY MEASUREMENT RECOMMENDATIONS PROJECT

Under a two-year contract with HHS, the NQF has undertaken a project relating to the development of HCBS quality measures. The multi-stakeholder process will accomplish the following goals:

- Create a conceptual framework for measurement, including an operational definition of HCBS;
- Synthesize evidence and carry out an environmental scan for HCBS measures and measure concepts;
- Identify gaps in quality measurement based on the framework and then scan; and
- Recommend priorities for measurement.⁴⁴

All people who could, and do, use HCBS will be considered. The project will also build upon previous and ongoing work to provide a unified picture of HCBS quality measurement and to identify opportunities for measure development. NQF has already released three interim project reports (July 2015, December 2015, and June 2016).⁴⁵ In the second, NQF identified 261 measures, 394 measure concepts, and 75 instruments; the majority were found in the domains of service delivery, system performance, effectiveness/quality of services, choice and control, and health and well-being. Other domains considered (consumer voice, equity, community inclusion, and caregiver support) had fewer or no measures, measure concepts, or instruments.⁴⁶ As defined in the report, several of the 11 domains address access, including workforce, system performance, caregiver support, service delivery, and equity. (See appendix G for a description of each HCBS quality domain.) The NQF will submit a final report to HHS in September 2016.

B. EXPERIENCE OF CARE (EOC) SURVEY

In 2014, CMS awarded four-year TEFT grants (“Testing Experience and Functional Tools”) to nine states to test quality measurement tools and demonstrate e-health in Medicaid community-based long-term services and supports (CB-LTSS). One component of the TEFT grant program is a field test of a cross-disability experience of care survey to elicit feedback from beneficiaries enrolled in Medicaid CB-LTSS programs, including frail elderly individuals, persons with a physical disability, persons with an intellectual or developmental disability, persons with an acquired brain injury, and persons with severe mental illness. CMS will use the field test to seek a CAHPS trademark and an NQF endorsement.

C. NATIONAL CORE INDICATORS (NCI)

The National Core Indicators (NCI) program is a voluntary, collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human

Services Research Institute (HSRI), which also receives grant funding from the Administration on Intellectual and Developmental Disabilities within HHS. The purpose of the NCI is to support state member agencies in gathering standard performance and outcome measures relating to services for individuals with intellectual and developmental disabilities (ID/DD) and their families. The measures can be used to track agency performance, compare results across states, and establish national benchmarks. State participation has grown from seven states in 1997, to 38 states, 22 sub-state agencies, and DC in 2013–14.

The “Core Indicators” address key areas of concern for persons with ID/DD across five broad domains: individual outcomes; health, welfare, and rights; staff stability and competency; family outcomes; and system performance. The system performance domain includes an “access” subdomain with three indicators designed to assess whether publicly funded services are readily available to individuals who need and qualify for them: (1) the rate at which people report that they get the services they need, (2) the proportion of people who report having adequate transportation when they want to go somewhere, and (3) the proportion of people who feel their support staff have been appropriately trained to meet their needs. Three data sources are used to assess outcomes: an adult consumer survey, three family surveys, and a provider survey (e.g., addressing staff turnover).

Over time, NCI has grown to become an integral piece of most states’ quality management systems and aligns with basic requirements for assuring quality in Medicaid HCBS waivers.

D. NATIONAL CORE INDICATORS—AGING AND DISABILITIES (NCI-AD)

A recent outgrowth of the NCI project, the NCI-AD is a collaborative effort between the National Association of States United for Aging and Disabilities, (NASUAD), NASDDDS, and HSRI; the initiative also received tool development funding from the Administration for Community Living. NCI-AD assesses the performance of state programs for older adults and persons with disabilities by collecting and maintaining data on participants’ quality of life and outcomes. After pilots in Georgia, Minnesota, and Ohio in 2014, the NCI-AD Consumer Survey was officially launched in June 2015 with 13 participating states. State agencies administer in-person surveys to a sample of at least 400 older adults and individuals with physical disabilities who access publicly funded services in skilled nursing facilities, Medicaid waivers, Medicaid State Plan Amendment services, state-funded programs, and Older Americans Act programs. Survey questions address access-sensitive indicators for HCBS, including the proportion of people who receive the services they need, whose support workers come when they are supposed to, who have adequate transportation, and who get needed equipment and assistive devices (e.g., wheelchairs, grab bars, home modifications).⁴⁷

C. Other Federal Data and Collection and Monitoring Initiatives

Other federal health care surveys and initiatives, if enhanced to provide state or local estimates, provide information that could be used for measuring and monitoring access to care for Medicaid enrollees. Two of these efforts, the NHIS and the National Ambulatory Medical Care Survey (NAMCS), are described in appendix H. Currently, however, we are not aware of any federal survey efforts that can support ongoing state-level Medicaid access measurement.

D. National Estimates of Medicaid Enrollees' Access to Care

While we are aware of individual states that produce or maintain state Medicaid access-related reports or data,⁴⁸ our research found few recent examples of national efforts to compare Medicaid-access-related performance across states or with performance in the commercial insurance market. A few examples are described below.

i. State Performance on Core Set Measures

CMS produces annual reports summarizing and analyzing the performance data reported by states for the Adult and Child Core Sets.

Appendices I and J present state performance data on selected Child and Adult Core Set measures associated with or potentially indicative of access.^{49,50} States reported having relatively high performance rates on children's primary care access measures, but reported fewer well-child visits than recommended by the American Academy of Pediatrics. The results also indicate that most pregnant women had a prenatal care visit in the first trimester or within 42 days of enrolling in Medicaid/CHIP (the median rate among 24 states reporting was 81 percent). Performance on the access-related behavioral health and oral health measures, however, was lower. For example, among the 34 states reporting Follow-up after Hospitalization for Mental Illness (for ages 6–20), the median rate was 43.9 percent. The median rate among the 51 states reporting Preventive Dental Services for ages 1–20 years was 47.6 percent.

ii. Comparison of Medicaid and Commercial Performance

The Medicaid and CHIP Payment and Access Commission (MACPAC) has analyzed national household survey data to compare health care access for Medicaid recipients to that of uninsured and commercially insured nonelderly adults. The MACPAC analysis recognizes that the Medicaid

population's characteristics (i.e., health demographic and socioeconomic) differ significantly from those of the uninsured and adults with employer-sponsored insurance. After applying standard statistical methods to control for these differences, the MACPAC analysis found that Medicaid enrollees reported substantially better access to care than the uninsured for almost every measure analyzed. Comparisons with commercially insured adults, however, produced mixed results:

For example, adults with Medicaid report delaying care at rates comparable to adults with employer-sponsored insurance but report different reasons for delayed care. Adults with employer-sponsored insurance are more likely to report delayed medical care because of concerns about out-of-pocket costs, whereas adults with Medicaid are more likely to report delayed care because of difficulty obtaining appointments or because they do not have transportation.⁵¹

A 2014 report for CMS compared Medicaid managed care performance on a regional basis for 16 HEDIS measures included in the Medicaid Adult Core Set, with results for the same measures reported by commercial health plans in 43 states, DC, Guam and Puerto Rico (the "2014 HEDIS Comparison Report"). The comparison, presented on a regional basis (rather than state by state) and covering data from 2010–2012, showed commercial plans having higher median rates for most measures with a few exceptions. In particular, the Medicaid plan median for the CAHPS Rating of Health Plan measure was 17 points higher than the commercial plan median, indicating Medicaid members were more satisfied with their health plans than commercial plan members. Medicaid median performance was 10 or more percentage points lower, however, on the measures for breast cancer screening, postpartum care, antidepressant medication management, and follow-up after hospitalization for a mental illness.⁵² Unlike the MACPAC analysis, however, the 2014 HEDIS Comparison Report did not control for differences in enrollee characteristics. Instead, the report notes that various limitations must be considered when analyzing the comparative results (e.g., differences between Medicaid and commercial plan case mixes, data collection methods, payment and delivery systems). The report nevertheless concludes that the comparison provides an important resource for benchmarking the quality of care in Medicaid.

III. Regulatory Context for Developing the Access Measurement and Monitoring Plan

Two significant recent developments in the Medicaid regulatory landscape have and will affect the design, evolution, and implementation of this plan: CMS's 2015 final rule on the Medicaid equal access

provision (equal access rule) and its 2016 final rule on Medicaid managed care. Under these new rules, states will be required to monitor and report to CMS on key access issues for both FFS and managed care. Underscoring the significance of these regulatory changes, CMS also issued an RFI in November 2015 seeking public input on measuring access to care across both FFS and managed care. In this section, we summarize the major legal and regulatory actions relevant to the development, implementation, and evolution of our Access Measurement and Monitoring Plan under both the equal access and the managed care final rules. (See table 1 below for a timeline of relevant regulatory actions related to measuring and monitoring access to care.)

A. Equal Access Final Rule

The equal access rule requires states to develop an access monitoring review plan that identifies the specific measures they will use to analyze access to care. States must also analyze the data collected, by provider type and by site of service furnishing each type of service, at least once every three years.⁵³ States must submit their initial access monitoring review plans by October 1, 2016.

B. Medicaid Managed Care Final Rule

Although the November 2015 equal access final rule only addressed FFS programs, CMS issued an NPRM earlier in 2015 to significantly revise current Medicaid managed care regulations.⁵⁴ As CMS explained in the RFI, “the proposed managed care rule . . . would apply the same principles in determining access in the managed care environment as are contained in the fee-for-service environment.”⁵⁵ CMS published the final rule on Medicaid managed care on May 6, 2016.⁵⁶

TABLE 1

Regulatory Actions Related to Measuring and Monitoring Access to Care

Date	Regulatory or Legal Action	Description
1978	Payments for services ⁵⁷	Federal regulation required that “the agency’s payments must be to enlist enough providers so that services under the sufficient plan are available to recipients at least to the extent that those services are available to the general population.” This provision was a recodification of earlier Medicaid policy dating back to the enactment of the program. ⁵⁸
1989	Medicaid equal access statutory provision adopted ⁵⁹	Federal Medicaid statutory requirement that Medicaid reimbursements be <i>sufficient to enlist enough providers so that care and services are available</i> (emphasis added) under the plan at least to the extent that such care and services are available to the general population in the geographic area. ⁶⁰
May 2011	Notice of Proposed Rulemaking: Methods for Assuring Access to Covered Medicaid Services ⁶¹	Proposed federal rule outlining a consistent approach for considering and monitoring SPAs that affect enrollees’ access to covered services, including proposed provider payment reductions under fee-for-service.
June 2015	Notice of Proposed Rulemaking: Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third-Party Liability ⁶²	Proposed federal rule significantly revising current Medicaid managed care regulations including changes in quality assessment and performance improvement program provisions and the collection and submission of performance measurement data and new provisions on ensuring access to care, including network adequacy standards.
Nov. 2015	Final Rule: Methods for Assuring Access to Covered Medicaid Services ⁶³	Final federal rule prescribing “a standardized, transparent, data-driven process” for states to document that provider payment rates are consistent with the Medicaid equal access provision; requiring states to develop an access monitoring review plan for their fee-for-service programs. ⁶⁴
Nov. 2015	Request for Information: Data Metrics and Alternative Processes for Access to Care in the Medicaid Program ⁶⁵	Request for information (issued along with Nov. 2015 equal access final rule) seeking input on how CMS can develop systems and potentially standards for monitoring access to care across both fee-for-service and managed care in the context of these other regulatory changes.
May 2016	Final Rule: Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third-Party Liability ⁶⁶	Final federal Medicaid managed care rule. Four specific areas ⁶⁷ are particularly relevant to this plan: (i) standards relating to ensuring access to care (e.g., network adequacy); (ii) standards and requirements for reporting encounter data; (iii) new quality improvement measures; and (iv) new monitoring and reporting requirements for states that include all of these areas (ensuring access to care, encounter data and quality measures).

Numerous interrelated provisions of the final rule that address beneficiaries' access to care will be implemented over the next several years; this will create more opportunities to develop access measures and data in the future. Except for the standard approach to reporting encounter data, the provisions also reflect CMS's approach to give states significant discretion in developing their own standards, approaches, and measures within broad federal guidelines.

i. Ensuring Adequate Access to Care: 42 CFR §§ 438.68, 438.206, and 438.207

The final managed care rule implements new network adequacy standards relating to **provider participation and availability**, requiring states to develop time and distance standards for several specific provider types. States with managed care plans which cover LTSS must develop time and distance standards for LTSS provider types to which an enrollee must travel to receive services, and other network adequacy standards for LTSS provider types that travel to the enrollee to deliver services. Each managed care entity will be required to submit documentation to the state at least annually to show it is maintaining a network sufficient to provide access to covered services for all beneficiaries under the state's standards. CMS did not prescribe the documentation managed care entities should provide, nor did it mandate "provider to enrollee ratios, appointment and office wait times, beneficiary complaint tracking, and other [quantitative] network adequacy standards" for any services.⁶⁸

ii. Encounter Data Requirements: 42 CFR §§ 438.242 and 438.818

The managed care final rule adds more detailed requirements regarding the encounter data (**beneficiary utilization**) each managed care entity must provide the state. And perhaps most importantly, the rule implements an ACA provision that conditions federal financial participation (FFP) for a managed care entity contract upon compliance with the new encounter data requirements. The future availability of encounter data should create opportunities for CMS and states to develop core access measures that are not currently feasible to implement.

iii. Quality Measurement and Improvement: Subpart E 42 CFR §§ 438.310, 438.320, 438.330, 438.334, and 438.340

The final rule includes specifications for three quality initiatives: (1) a quality assessment and performance improvement (QAPI) program (42 CFR § 438.330);⁶⁹ (2) a managed care quality rating system (QRS) (42 CFR § 438.334);⁷⁰ and (3) a comprehensive state-managed care quality strategy (42

CFR § 438.340).⁷¹ Each provides an opportunity for CMS and the states to further develop access measurement and monitoring strategies.

iv. **Monitoring and Reporting Requirements and External Quality Review: 42 CFR § 438.66 (State Monitoring Requirements) and 42 CFR § 438.358 (EQR)**

CMS has significantly revised the requirements related to state monitoring of managed care. CMS is requiring states to develop monitoring systems to “address all aspects of the managed care program” and to address the performance of each managed care entity in several areas including availability and accessibility of services, quality improvement, and utilization and case management. The state’s annual report must include an assessment of encounter data reporting by each managed care entity; the availability and accessibility of covered services, including network adequacy standards; and “[e]valuation of MCO, PIHP [prepaid inpatient health plan], or PAHP [prepaid ambulatory health plan] performance on quality measures, including as applicable, consumer report cards, surveys, or other reasonable measures of performance.” The final rule adds a new mandatory element to external quality review (EQR): validation of a managed care entity’s network adequacy over the preceding 12 months to comply with the state’s network adequacy standards.

C. Design of an Access Measurement and Monitoring Plan to Fit this Regulatory Framework

Both the equal access and managed care final rules have launched new processes and systems to strengthen measurement and monitoring of access in FFS and managed care. Appendix K provides further detail on related key provisions of the equal access and managed care final rules. These provisions will provide numerous opportunities for states and CMS to implement, assess, and evolve this Access Measurement and Monitoring Plan and identify new access measures. To be consistent with the principles behind this plan, we recommend that CMS begin with a set of access measures that can be implemented using existing data systems. In Section VI, we also recommend how CMS can develop a more robust access measuring and monitoring program by building on the new processes and systems that will evolve as these final rules are implemented.

IV. Access Measurement and Monitoring Plan

This section proposes a framework for monitoring access in Medicaid and a set of criteria for selecting measures, services, and population groups. It culminates in a description of the initial core set of access measures proposed for Medicaid.

A. Access Framework

i. Prior Access Frameworks

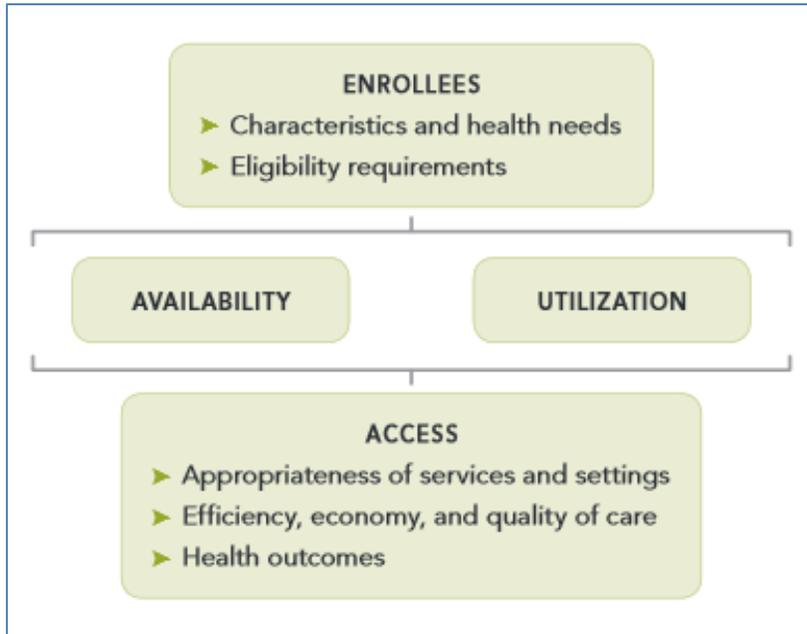
Our proposed access domains and specific access measures draw heavily on the 2011 MACPAC access framework⁷² operationalized for the State of California by Gold and Kenney in 2014.⁷³ MACPAC's access framework includes three dimensions: enrollees and their distinct characteristics, availability of providers, and utilization of services (figure 1). In this framework, **availability** and **utilization** are the main access dimensions measured, each taking into account and informed by **enrollee characteristics**. Ultimately, the goal is not simply to count the number of providers available or services used, but to evaluate the appropriateness of services and settings; the efficiency, economy, and quality of care; and health outcomes.

Gold and Kenney recommend including additional considerations within these domains. For example, their framework emphasizes the importance of selecting outcome measures (like ambulatory care sensitive admissions) that are particularly sensitive to access and of risk-adjusting comparisons, since these outcomes can be affected by other factors, such as underlying health needs and economic circumstances, beyond availability and utilization of services.

Two articles reviewed in our targeted literature scan also informed our framework: Penchansky and Thomas's 1981 examination of access using a patient satisfaction lens⁷⁴ (which was referenced in Mathematica Policy Research's comments to the November 2015 RFI) and Levesque, Harris, and Russell's 2013 analysis of various conceptualizations of access,⁷⁵ both of which drew on the seminal contributions of Aday and Anderson.⁷⁶

FIGURE 1

MACPAC Access Framework



Source: MACPAC, “Report to the Congress on Medicaid and CHIP” (Washington, DC: US GPO, 2011), https://www.macpac.gov/wp-content/uploads/2015/01/MACPAC_March2011_web.pdf.

Penchansky identified five dimensions of access—**availability, accessibility, accommodation, affordability, and acceptability**—that generally fit within the MACPAC framing, while offering additional factors to consider within them. After reviewing numerous definitions and frameworks of access described in the literature between 1971 and 2008, Levesque also proposed five dimensions of accessibility, which closely relate to Penchansky’s: **approachability, acceptability, availability and accommodation, affordability, and appropriateness**. He further described five corresponding “abilities of populations to interact with the dimensions of *accessibility* to generate *access*” (emphasis added): the abilities to **perceive, seek, reach, pay, and engage**. These generally support MACPAC’s recommendation to consider enrollee characteristics when assessing access to care, while underscoring the importance of capturing beneficiary experiences and perceptions.

Finally, we drew on the framework included in a 2013 report on monitoring access to care in Medicaid at the state level, prepared by NORC at the University of Chicago and funded by the Office of the Assistant Secretary for Planning and Evaluation in HHS. The report also includes beneficiaries’ perceptions of access as a separate domain for state-level monitoring of access to care among Medicaid enrollees.⁷⁷

ii. Proposed Access Framework

Our proposed access framework is provided in a schematic form below (figure 2). Like the MACPAC and Gold/Kenney frameworks, ours includes two domains that focus on **provider availability** and **beneficiary utilization**. As we discuss below, we also explicitly include **beneficiary perceptions and experiences** as a third domain, rather than subsuming them under beneficiary utilization (as in the MACPAC and Gold/Kenney frameworks).

The dimension of the MACPAC framework that focused on **enrollee characteristics** was not designed to produce specific measures for access, but rather to draw attention to considerations for interpreting and assessing access, taking into account the unique needs and circumstances of the populations served by Medicaid. Characteristics specifically identified by MACPAC include “lower incomes and assets; discontinuous eligibility; geographic location; complex health care needs; cultural diversity; and level of health literacy.” Therefore, we are not explicitly including “enrollee characteristics” as a domain in our own framework, but we acknowledge the importance of understanding and considering them, particularly when making comparisons to other population groups and when assessing variation across and within states. As noted below, we place particular emphasis on the characteristics (race, ethnicity, sex, primary language and disability status) addressed by Section 4302 of the ACA.

Our three domains of access are as follows:

- **Provider availability and accessibility (potential access):** This domain measures potential access to providers and services, whether or not the providers or services are used. Like MACPAC and Gold/Kenney, we conceptualize this domain as reflecting both provider and service availability. **Provider availability** addresses the distribution of providers and facilities in terms of geography, travel distance or time (including via public transportation), or the number or share of providers in an area or population who participate in Medicaid/CHIP (either on an FFS basis or within a managed care plan). It also includes the number or share of such providers who are actually willing to accept Medicaid/CHIP patients. **Service availability** reflects the timeliness of appointments available to Medicaid enrollees for different types of care. Gold and Kenney emphasized that the measures in this domain must reflect not just an adequate number of any providers, but an appropriate and accessible mix of the *right types* of providers to meet beneficiaries’ needs.

We also propose that CMS consider other factors, namely **provider accommodation** as described by Penchansky (e.g., whether evening and weekend appointments are available, the

accessibility and usability of appointment-making systems, and the physical accessibility of facilities for people with disabilities)⁷⁸ and **provider approachability**, as described by Levesque (e.g., transparency and outreach regarding the availability of services; beneficiaries’ awareness that health providers and services exist to meet their needs and are aware of how to reach them).⁷⁹ While some of these concepts may be difficult to operationalize at this time, they represent potential goals for future measure development. In addition, states’ coverage of optional benefits and potential out-of-pocket costs (e.g., monthly premiums for Medicaid populations in some states) could be considered as affordability factors that reflect access to care.

Although our focus is on tracking access to care within Medicaid, it will also be important to identify whether people can get access to the program itself. This would mean tracking changes in enrollment among the target population while controlling for underlying eligibility changes, though that is not within the scope of our plan here.

- **Beneficiary utilization (realized access and access-related outcomes):** This domain addresses beneficiaries’ use of the providers and services available to them, thus “realized,” as opposed to “potential,” access. MACPAC included three factors in this domain: (1) which services are used, including appropriate use of services; (2) the affordability of services; and (3) beneficiaries’ experiences navigating the system and their experiences with their care. In our framework, the first category—**which services are used, including appropriate use of services**—encompasses measures such as getting recommended preventive checkups, as well as emergency department visits and hospital stays for conditions that could have been prevented had more effective ambulatory care been provided.

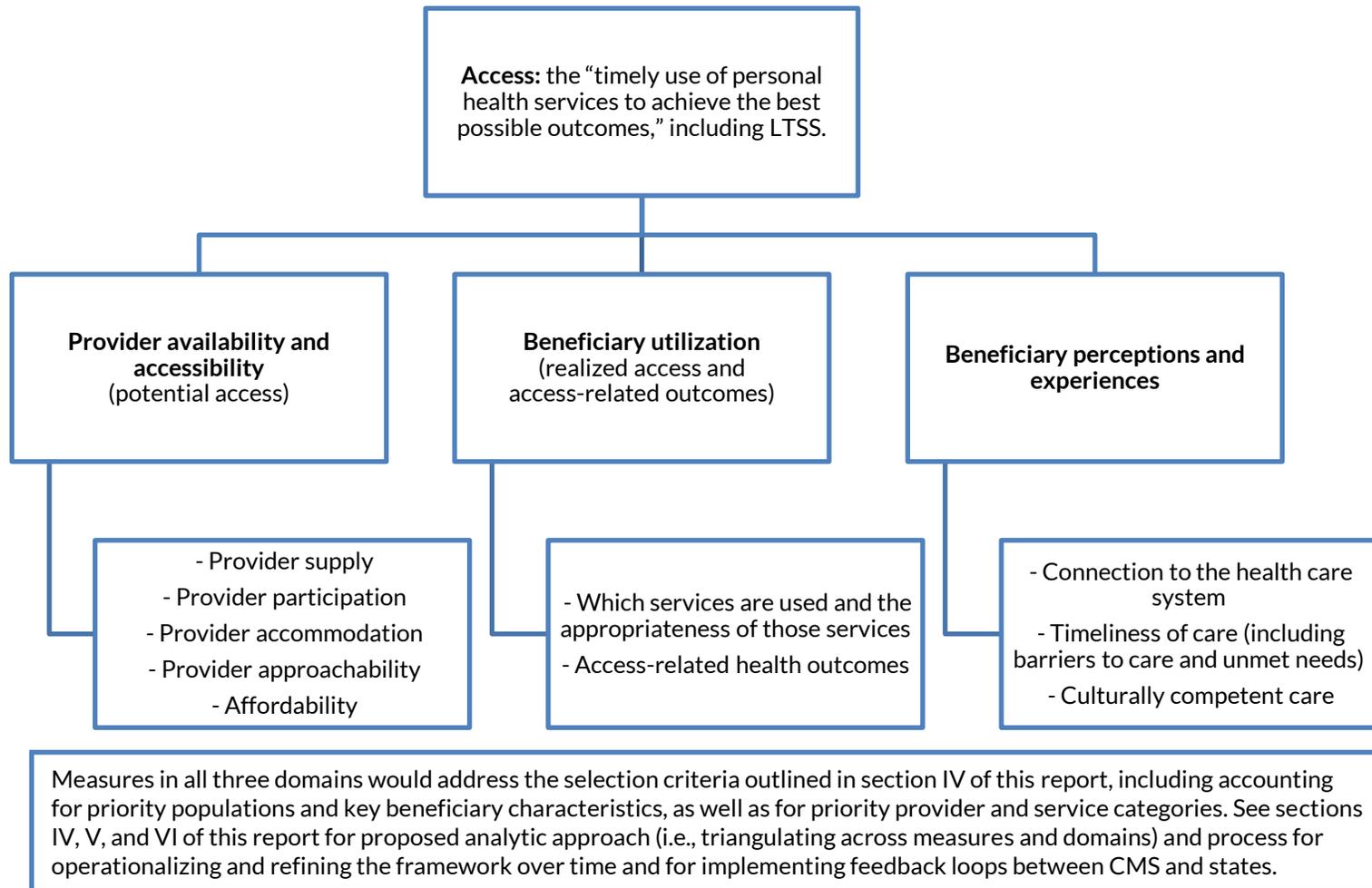
We also propose that this domain explicitly address the **outcomes** of utilization, not just whether care was received. Whereas outcomes were highlighted as part of the ultimate goal of assessing access under MACPAC’s framework, we propose that they be a specific focus of measurement and monitoring, and that CMS include access-sensitive measures in the initial core set. Examples of potential access-sensitive outcomes measures are hospital admission for short-term diabetes complications, heart failure, asthma, and chronic obstructive pulmonary disease (COPD).

The other two dimensions MACPAC suggested here are included in our other domains—we include MACPAC’s **affordability of services** factor in our potential access domain above, and its **beneficiary experience** factor as its own domain below.

- **Beneficiary perceptions and experiences:** As indicated above, we propose this as a separate domain within our framework, rather than including it within the beneficiary utilization domain. Including beneficiary experiences and perceptions as its own domain is consistent with the framework proposed for monitoring access to care in Medicaid in NORC's report prepared for HHS.⁸⁰ Whereas utilization measures are largely based on claims and encounter data, these measures, which focus on beneficiaries' perceptions of their needs, their access barriers and unmet needs, and their care experiences, are based on consumer surveys and program complaints and grievances. Such measures can provide insights about foregone or delayed care and provider-consumer interactions that cannot be detected in claims and encounter data. Relevant concepts suggested by Gold/Kenney include **connection to the health care system** (e.g., beneficiaries reporting a usual source of care other than the emergency department); **timeliness of care** (e.g., beneficiaries reporting delays to care and reason for delay, or beneficiaries reporting getting care quickly); and **culturally competent care** (e.g., how well providers communicate with their patients).⁸¹ The timeliness of care concept is particularly important when measuring **barriers to access and unmet needs for care** caused by factors including cost concerns (which relates back to the affordability issues mentioned in the first domain), lack of provider availability, or lack of transportation.

FIGURE 2

Proposed Medicaid Access Measurement and Monitoring Framework



Notes: CMS = Centers for Medicare & Medicaid Services; LTSS = long-term services and supports. Our definition of *access* is consistent with that of the 1993 National Academy of Medicine (then the Institute of Medicine) access framework, and we further define personal health services to include LTSS. **NAM (IOM) access framework source:** Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services, *Access to Health Care in America* (Washington, DC: National Academy Press, 1993).

B. Selection Criteria for Measures, Services, and Population Groups

This section describes the key issues we considered in developing the initial core set of access measures recommended for CMS to use in measuring and monitoring access to Medicaid, across the three domains of our access monitoring framework. In selecting the specific measures and data sources, providers and services, and population groups to be assessed under this initial core set, and in proposing a process for implementing the plan, we sought to ensure that the core set addressed concerns that were expressed by CMS or that surfaced in conducting the key informant interviews and reviewing the comments provided in response to the RFI. **As a consequence, we recommend a Medicaid Access Measurement and Monitoring Plan that would:**

- Include an initial core set of measures of provider availability and accessibility, beneficiary utilization and access-related outcomes, and beneficiary perceptions and experiences.
- **Align with and primarily leverage existing monitoring and data collection activities.** As a starting point, we propose measures used in current Medicaid monitoring efforts to minimize new data collection costs and reporting burdens on states and plans, leverage existing investments, and align with other ongoing access monitoring efforts. **In particular, we recommend using a number of measures included in the current CMS Core Sets of Adult and Child Health Care Quality Measures for Medicaid and CHIP**, such as well visits for children and adolescents, follow-up after hospitalization for mental illness for children and adults, percentage of eligible children that receive preventive dental services, postpartum care rate, timeliness of prenatal care, and hospital admissions for ambulatory care sensitive conditions, partly because they fit within the access domains we are proposing but also because substantial state and federal investments have already been made to support Adult and Child Core Set reporting by a growing number of states.

For several proposed provider availability and accessibility measures, we propose that CMS conduct “**secret shopper**” audits to assess the availability of care. The other proposed measures for the initial core set of access measures are ones we expect could be derived from either **the Nationwide CAHPS survey (described in Section II) or from enrollment, claims and encounter data reported by states to CMS via the Transformed Medicaid Statistical Information System (T-MSIS)**. T-MSIS is a replacement for, and upgrade of, the previous MSIS system. Because T-MSIS is still being implemented across the states and because of differences

in states' payment methods and other factors, at this point it is uncertain how T-MSIS could be used to support this plan. In proposing specific measures, we have also noted reporting requirements in the final access and managed care rules and the extent to which states were using these measures as part of quality and access monitoring efforts.⁸²

- **Rely on continued investments in T-MSIS and the Nationwide CAHPS, allowing CMS to monitor Medicaid access at the state level without introducing excessive new burdens on states.** Being mindful of time and funding constraints facing most states and the benefits associated with using a uniform approach in each state, most measures we recommend as part of the core access set could be derived by CMS from either T-MSIS or the Nationwide CAHPS survey (though the Nationwide CAHPS would have to be expanded to include state-level samples of children). We specifically recommend that CMS commit to fielding and producing timely results from the Nationwide CAHPS survey annually or biannually and that CMS expand the Nationwide CAHPS to include state-level samples of children.
- **Track access to different services and providers using existing measures.** Based on the scope of work provided for the task, the final rule, and the recommendations derived from the key informant interviews and comments submitted in response to the RFI, we sought to include measures that reflected access to (1) primary and preventive care, including pediatric care; (2) physician specialist services; (3) dental and oral health care; (4) behavioral health care, including substance use disorder services; and (5) maternal health care, including pre- and postnatal obstetric services. Given the state of measure development and data constraints, our proposed initial core set does not include multiple measures in each of these areas, nor does it include LTSS measures. However, our proposed evolution of the plan is designed to address these gaps over time.
- **Prioritize developing valid access measures for LTSS, including both institutionally based services and HCBS.** As explained above, several efforts are underway to develop quality and access measures for LTSS. Such care has unique elements, and measuring access to HCBS presents particular challenges, both in terms of provider availability and beneficiary utilization. Measures that take into account adherence to individualized care plans, availability of qualified providers, and state flexibility around LTSS eligibility may be needed. Adopting state-specific goals that show progress from a baseline may be one approach to consider.
- **Monitor access at the state level for specific Medicaid subpopulations,** including aligning with the data collection standards for race, ethnicity, sex, primary language, and disability status

developed under Section 4302 of the ACA⁸³ and assessing geographic patterns of access within states. We propose that CMS separately monitor access for the disabled and nondisabled children and nonelderly adults who are not dually enrolled in Medicare and for elderly and nonelderly adults who are dually enrolled in Medicare and Medicaid. Where state-level assessment is not possible, we recommend that CMS use existing data sources to assess potential access differentials at a **national** level for groups defined by race, ethnicity, sex, primary language, and disability status and that CMS assess (or build capacity for assessing) geographic patterns of access across and within states.

- **Use a common approach to access monitoring across both managed care and FFS delivery systems.** Despite the many differences between Medicaid FFS and managed care delivery systems, particularly with respect to reporting requirements, we propose that CMS use the same measures for assessing access across systems of care. This might require additional state-level improvements and investments in encounter data collection and reporting to improve comparability across states. However, changes in encounter data reporting are already required under the 2016 Medicaid managed care rule.⁸⁴
- **Provide a robust assessment of access, which takes into account state-specific contextual factors and considers patterns found across and within the access domains (i.e., triangulation).** To capture the multifaceted nature of access, we propose that CMS monitor measures across each of the three overarching domains of access (provider/service availability, beneficiary utilization, and beneficiary perceptions) in conjunction with each other. With the possible exception of proposed measures designed to capture the timeliness of appointment availability for Medicaid enrollees, we recommend that CMS not focus on any one particular measure in isolation but instead “triangulate” them to provide a coherent picture of access.
- **Include feedback loops between CMS and state Medicaid programs** to ensure that (1) the measures are constructed, implemented, and interpreted correctly, (2) both CMS and states become aware of particular states that are consistently high or low performers or where access is either improving or deteriorating, and (3) the underlying reasons are probed and appropriate policy and programmatic responses are identified, particularly when access is falling far short of national norms or declining precipitously. We anticipate that analysis of access patterns and state-specific trends would be just the starting point and that it would reveal areas where follow-up by states and CMS is necessary. Ideally, follow-up would be used to understand the factors that contribute to better or improved access, as well as to identify policies that can improve access to care in states where access is problematic or deteriorating.

- **Determine the appropriate role of thresholds in monitoring access within Medicaid**, assess the pros and cons of alternative methodologies for setting access thresholds or state-specific guard rails, evaluate the uses of thresholds in access monitoring (e.g., as part of public reporting on state-level access in Medicaid or as triggers for follow-up actions by CMS and states), and implement the proposed approach. As discussed below, we anticipate that over time CMS would develop thresholds or guardrails for identifying services and states that appear to be outliers in terms of access levels or changes in access. Initially, thresholds could primarily be for feedback between CMS and the states about improving access, but thresholds may ultimately be used for public reporting on states' performance.
- **Assess the extent to which variability in Medicaid across states and over time is sensitive to differences and changes in the characteristics of the Medicaid population being served.** We recommend that over time, CMS assess how comparisons across states at a particular point in time and changes in access within a state over time vary, when accounting for differences over time and across states in the demographic, socioeconomic, geographic, and health status composition of the Medicaid population. Recognizing that states differ in ways unrelated to Medicaid policy that can affect estimated access to care, we propose that CMS assess the differences that emerge when adjusting for demographic, geographic, and socioeconomic factors outside a state's control.
- **Provide, where possible, comparable estimates to other (non-Medicaid) populations.** We did not identify existing data sources capable of producing comparable state-level access measures for both Medicaid and non-Medicaid populations for all the proposed core measures. Therefore, we recommend that CMS seek over time to develop comparable estimates for the general population (we return to this issue in Section VI below). It should be noted that our proposed "secret shopper" auditing to assess appointment availability in Medicaid could also be done to provide parallel estimates for the general population with commercial coverage.
- **Build capacity for states to collect and report on more rapid-turnaround information on a few key metrics to complement the proposed core access measures set and produce a real-time assessment of access to care.** Of all the measures proposed as part of the core access measures set, only the "secret shopper" measures and, potentially, those related to emergency room use and hospital stays could realistically provide a more timely assessment of access. We recommend that CMS develop a systematic, robust approach to real-time monitoring so that Medicaid can promptly identify and address serious access issues. Information sources for CMS to consider include complaints, appeals, and grievance data to identify patterns of access

deficiencies. Also, CMS might use sentinel providers to report regularly on access experiences, with respect to referrals for specialty care or to other types of follow-up care (e.g., mental health services in the community, home-based care).

- **Expand and revise the access measures set over time** to include targeted outcome measures and to incorporate new measures and new data sources that become available, particularly (1) those that capture access to home and community-based services and other types of long-term care, (2) those that focus on access to specialty care, (3) those that can increase measurement of outcomes and experience of care over process, (4) those that take advantage of new data sources as they mature, such as electronic health records, and (5) those that account for evolving changes in service delivery to include telehealth services, online portals, the use of self-directed care for HCBS, and more. Revising the core access set would also include retiring measures as needed.

C. Recommended Initial Core Set of Access Measures

Below is a high-level list of our recommended initial core set of access measures, according to the three domains of our access monitoring framework. Appendix A provides more detail about each proposed measure, including whether it is from the current Adult and Child Core Sets and its data sources.

TABLE 2

Overview of Proposed Initial Core Set of Access Measures^a

	Measure ^b	Source
Provider Availability and Accessibility (Potential Access)	Participating providers by provider type (e.g., primary care providers, pediatric providers, mental/behavioral health providers, other specialists, community health centers and federally qualified health centers, OB/GYNs, acute care hospitals, dental providers)	T-MSIS
	Days to appointment (e.g., for routine care, urgent care, medical/behavioral health problems, and maternity care)	“Secret shopper” audits
	Availability of appointments and advice outside traditional business hours (e.g., evenings, weekends, and holidays)	“Secret shopper” audits
	Availability of language-accessible services (e.g., multilingual services or translation/interpretation services)	“Secret shopper” audits
Beneficiary Utilization (Realized Access and Access-Related Outcomes)	Adults receiving at least one ambulatory service visit in prior year	T-MSIS
	Adults receiving a routine checkup in prior year	Nationwide CAHPS
	<i>Child and Adolescents’ Access to Primary Care Practitioners</i>	<i>Child Core Set</i>
	<i>Well Visits (i.e., in the First 15 Months of Life; in the 3rd, 4th, 5th and 6th years of Life; and for Adolescents)</i>	<i>Child Core Set</i>
	<i>Follow-up After Hospitalization for Mental Illness (i.e., for ages 6-20 and for ages 21 and older, both 7 day and 30 day follow up rates)</i>	<i>Child, Adult Core Sets</i>
	<i>Percentage of Eligibles Who Received Preventive Dental Services</i>	<i>Child Core Set</i>
	<i>Prevention: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk</i>	<i>Child Core Set</i>
	Adults receiving at least one dental service in prior year for states covering nonemergency dental services for adults in that year	T-MSIS
	<i>Prenatal & Postpartum Care: Postpartum Care Rate</i>	<i>Adult Core Set</i>
	<i>Prenatal & Postpartum Care: Timeliness of Prenatal Care</i>	<i>Child Core Set</i>
	Adult emergency department visits	T-MSIS
	<i>Ambulatory Care – Emergency Department Visits</i>	<i>Child Core Set</i>
	Adult and pediatric emergency visits that were potentially preventable/avoidable or that potentially could have been treated in a primary care setting (e.g., asthma, diabetes, heart failure)	T-MSIS
<i>Hospital Admissions for Ambulatory Care Sensitive Conditions (e.g., diabetes complication, heart failure, asthma, COPD)</i>	<i>Adult Core Set</i>	
Pediatric hospital admissions for ambulatory care sensitive conditions (e.g., diabetes complications, asthma)	T-MSIS	
Beneficiary Perceptions and Experiences	Frequency and ease of getting needed care (i.e., routine care, specialty care, tests/treatment, special medical equipment, mental health or behavioral health services, dental services)	Nationwide CAHPS
	Having a “personal doctor” or a place to go for care and advice (other than the emergency department)	Nationwide CAHPS
	Culturally competent care (e.g., beneficiaries reporting that their provider explained things in an understandable way, listened carefully to them, showed them respect, and spent enough time with them)	Nationwide CAHPS

^a A more detailed table is provided in appendix A.^b Measures from the Adult and Child Core Sets are listed in italics.

Following are some key features of the proposed initial core set of access measures:

Access domains. The initial core access measure set includes 22 measures across the three domains of access in our framework: four provider availability measures, 15 beneficiary utilization and outcomes measures, and three measures that reflect beneficiaries' experiences and perceptions. Note that some of these 22 measures include several variations based on population or provider type. For example, we listed well visits as one measure, but this includes three measures from the Child Core Set: well visits for infants, children, and adolescents. So, the actual number of access core set measures will depend on the number of specifications CMS chooses to include for each proposed measure.

Alignment with current Core Sets. Of the proposed measures in the access core set, nine are also part of the current Adult and Child Core Sets: pediatric well visits, children's and adolescents' access to primary care practitioners (PCPs), follow-up after hospitalization for mental illness (for both adults and children), two maternal health measures, two oral health measures, adult hospitalization for ambulatory-sensitive conditions, and children's emergency department visits. The measures selected are among the most frequently reported performance measures. In FFY 2014, 51 states reported on the percentage of eligibles who received preventive dental services, between 40 and 44 states reported on the various well-child visit measures, and 36 states reported on the timeliness of prenatal care.⁸⁵ Both follow-up after hospitalization for mental illness and the postpartum care rate were also frequently reported—30 and 34 states reported these measures in FFY 2014, respectively.⁸⁶

As indicated below in Section V, to the extent possible, we recommend that CMS consider producing any core access set measures that are part of the Adult and Child Core Sets with T-MSIS.

Data sources. In addition to the proposed measures from the current Adult and Child Core sets, the recommended access core set includes measures we anticipate could be constructed from three sources:

- **T-MSIS:** participating providers by provider type, adult ambulatory visits, adult dental visits (although this may present some challenges as discussed below), adult emergency department visits, potentially avoidable emergency department visits for adults and children, and pediatric ambulatory-sensitive hospital admissions;
- **The Nationwide CAHPS survey:** adults' receipt of routine checkups in prior year, receipt of routine visits, frequency and ease of getting needed care, having a usual source of care, and receipt of culturally competent care; and

- “Secret shopper” audits of the timeliness of appointment availability for different types of care, the availability of appointments and information outside traditional business hours, and the availability of language-accessible services.

Providers and services. The initial access core set includes measures for nearly all the categories of services and providers the RFI identified as priorities. Although an exact count of measures per service or provider category is difficult, given the options CMS has for specifying some proposed measures, approximate counts based on the potential specifications listed in table 2 are as follows:

- 12 measures reflect access to primary and preventive care, including pediatric care;
- 5 assess access to dental and oral health care;
- 4 assess access to behavioral health care;
- 6 assess access to other specialty services; and
- 4 assess access to maternal health care, including prenatal and postpartum obstetric services.

The measures reflect receipt of care in (1) outpatient settings (physician visits including well-child visits, follow-up care after hospitalizations for mental health issues, preventive dental care, and prenatal and postpartum care), (2) the emergency room (visits overall as well as those potentially avoidable), and (3) inpatient settings (ambulatory care sensitive admissions). As we discuss in Section VI, we propose that CMS prioritize developing valid access measures for LTSS, so access to those critical services can similarly be tracked.

Populations. Given that Nationwide CAHPS and T-MSIS use information from the enrollment files, it would be possible to develop separate state-level estimates for adults and children, as well as estimates by gender and disability status (and dual status, where appropriate) for those measures. Moreover, it would be possible to assess racial and ethnic patterns of access, and possibly access based on primary language, based on the CAHPS survey nationally and in some states. In addition, T-MSIS and the “secret shopper” audits, and possibly Nationwide CAHPS, could also support sub-state analyses.

Triangulation. Respondents in our key informant interviews agreed that no single measure or type of measure can be used to definitively identify states with Medicaid access problems. It was also clear from our interviews and other research that inherent limitations exist for all access-related metrics. For example, surveys depend on the accuracy of patient recollections, claims data often lack critical clinical detail or are incomplete, and health outcomes data are influenced by many non-Medicaid factors. Therefore, to get a more complete picture of access in a state, as much as possible we suggest that CMS

triangulate across measures to develop inferences about how access is changing or whether follow-up is needed in a particular state or service area. In particular, we suggest the following actions:

- Combining information from *multiple data sources* on access to a given provider or service—such as reviewing “secret shopper”, T-MSIS, and Nationwide CAHPS data on provider and appointment availability, emergency room use, hospital stays, and post-hospital follow-up—to create a multifaceted assessment of access to mental health care.
- Comparing data and trends on access to *different services* in relation to each other, and within the state’s broader context, to better understand the access “story.” For example, reductions in or lower than average ambulatory care visits alone would not necessarily indicate that access is deteriorating or problematic in a particular state. But if reductions were occurring in combination with higher rates of emergency room visits or ambulatory care sensitive admissions, the pattern could suggest an access problem. Conversely, an increase in emergency department visits alone could either indicate a lack of access to primary care providers or simply relate to an infectious disease outbreak. Thus, it will be important to look at emergency visit rates overall in conjunction with potentially avoidable emergency visits, ambulatory visit rates, and beneficiaries’ reports of unmet need.
- Considering several types of *provider availability* measures in concert with each other, and alongside *beneficiary experience* measures. For example, Sommers and Kronick⁸⁷ point out that a measure focusing on the percentage of physicians accepting new Medicaid patients fails to account for whether they already care for Medicaid patients, and how many; in addition, focusing only on physicians may ignore beneficiaries’ need for or utilization of services by other providers, such as nurse practitioners, or facilities, such as Federally Qualified Health Centers. It is similarly important to track access to specialists, mental/behavioral health providers, and other types of providers—not just primary care and emergency room data. And several respondents to the November 2015 RFI noted that time and distance standards may be a floor to consider, but they do not address providers’ capacity or willingness to accept Medicaid patients, nor beneficiaries’ experience in trying to make appointments. These and other recommendations are why we did not propose that CMS use time and distance standards in this measure set, and why we propose measuring appointment wait times in addition to provider-to-enrollee ratios, alongside beneficiary reports of the frequency and ease with which they get care and advice (via the Nationwide CAHPS survey, which can in turn be triangulated with results from the “secret shopper” audits).

- Cross-referencing *other data*, beyond the measures in the core access set, to provide further context. For example, information on *reasons* for emergency room visits provided from the Nationwide CAHPS could provide insights on barriers to access when interpreting T-MSIS data on emergency room visits that are classified as avoidable.

Feedback loops. We recommend that CMS develop feedback loops with states. These would be used to follow up with states performing consistently below or above others, and when access is deteriorating or improving. When the measures point to significant deterioration or performance consistently below national norms, CMS could work with the state to implement practices and policies that could remedy the problem and continue monitoring until access improves. When the measures point to significant improvements or to performance above national norms, CMS could work with the state to identify the policies and practices contributing to those positive outcomes and then disseminate that information to other states. In addition, feedback loops between CMS and states can help ensure that initial and future measures are constructed, implemented, and interpreted correctly.

Rapid turnaround monitoring. The initial core access set incorporates measures that could assess the timeliness of appointment availability for primary, urgent, routine, follow-up, maternity, and behavioral health care, and that could be produced quickly.⁸⁸ Such measures would require a new data collection effort that would use the “secret shopper” audit approach to assessing appointment timeliness, the availability of after-hours and weekend care and advice, and the availability of language-accessible services (e.g., translation and interpretation). We propose that such an investment be made because secret shopper audits can generate real-time indicators of access for children, pregnant women, and other adults. Such indicators would complement other measures based on the Nationwide CAHPS that provide information on access experiences in previous years.

V. Execution of the Access Measurement and Monitoring Plan

A. Initial Development of the Core Access Measure Set

Over the past two decades, the number of health care quality measures has increased substantially, reflecting a consensus among health care payers (including CMS and states) and others that the use of meaningful quality measures can help drive high-quality, cost-effective health care and improved health

outcomes. Since the ACA initiated the National Quality Strategy for Quality Improvement in Health Care in 2011, CMS has worked to strengthen the alignment of its quality measures with the NQS to both improve patient outcomes and reduce the growing burden of measure reporting.⁸⁹ This strategic objective is consistent with widespread consensus from our key informant interviews: initially, that the Access Measurement and Monitoring Plan should comprise or build on validated measures and standards that already exist.

The proposed framework and components of the Access Measurement and Monitoring Plan described above are therefore designed to use and build on existing validated measures while being fully aligned with the NQS and the CMS Quality Strategy (which also inform and guide all other CMS quality measurement programs). **Additional resource investments will be needed, however, to refine, test, and implement the proposed measures, as further described below.**

i. Provider Availability and Accessibility Measures (Potential Access)

As illustrated above and in appendix A, we propose four measures for assessing provider availability and accessibility, one measuring participating providers that we assume could be centrally calculated by CMS from T-MSIS data (which include monthly submissions for both FFS and managed care), and three that would require states or CMS to field a new “secret shopper” audit initiative.

For this and the other T-MSIS measures in the initial core access set, CMS would need to implement uniform measure specifications (ideally in consultation with states and other stakeholders), provide guidance to states on how T-MSIS fields are used in the measure calculations, and ensure that the validity of the data for state-to-state comparisons is rigorously tested.

It will be important for CMS to consider challenges associated with defining measures of provider availability (e.g., how to define denominators and numerators), which are discussed in detail by Sommers and Kronick⁹⁰ and Coffman.⁹¹ In addition, measure specifications would need to account for variations across states in provider billing types, licensure categories, and delivery systems. For example, some states may rely more heavily on nurse practitioners and nurse-managed clinics to meet demand for primary care than states with more restrictive scope of practice laws. We also understand that the quality of state-submitted T-MSIS data is likely to improve and become more comprehensive over time as states gain experience with this relatively new reporting requirement.

Finally, new resources will be needed to conduct “secret shopper” audits of the timeliness of appointment availability, the availability of appointments and information outside traditional business hours, and the availability of language-accessible services in each state. If CMS carries out the audits, it

will need to devote new administrative resources to this effort, but will likely need to rely on states to supply provider lists and contact information (much like states provide CMS the beneficiary samples for the Nationwide CAHPS). If states carry out the audits, we recommend that CMS advise states on the availability of enhanced administrative matching funds to support this effort (as further discussed below). To the extent some states may already be conducting “secret shopper” audits for their managed care programs, states and CMS may be able to coordinate to minimize overlap and new costs. Therefore, we recommend that CMS confer with states on the type and frequency of the audits. For example, CMS may wish to conduct a statewide audit once per year to understand overall Medicaid provider capacity, while the state rotates health-plan-specific audits throughout the year. For these reasons, CMS may consider phasing in implementation of these measures (as further described below).

Several states are already reporting on our proposed provider availability measures. For example, Pennsylvania included a provider-to-enrollee ratio in its initial access monitoring plan,⁹² and similar to our “secret shopper” measure to assess timely availability of providers, Georgia has listed Days to Appointment as a measure to monitor in its 2016 “Quality Strategic Plan for Georgia Families (Medicaid)” but has not yet reported on it.⁹³ New York reports provider participation rates by measurement year as part of its Quality Incentive Report.⁹⁴

ii. **Beneficiary Utilization Measures (Realized Access and Access-Related Outcomes)**

Nine of the fifteen proposed measures for realized access are from the Adult and Child Core Sets. For all measures in this domain (with the exception of the one derived from the Nationwide CAHPS survey), we propose that CMS would compute the measures, to the extent possible,⁹⁵ using T-MSIS data, implement uniform measure specifications as necessary (ideally in consultation with states and other stakeholders) and test each measure to assure reliable results that are comparable across states.

For the five proposed T-MSIS utilization measures not from the Adult and Child Core Sets, we found evidence of current use and reporting in several states. For example, California, Colorado, and New Hampshire all measure whether adults have received at least one ambulatory service in the prior year; Texas, Florida, and Georgia also report a variation of this measure (Access to Preventative/Ambulatory Services) for adults.⁹⁶ New Hampshire, Texas, and Georgia have been reporting on the measure Emergency Visits that were Potentially Preventable or Avoidable or that Potentially Could Have Been Treated in a Primary Care Setting in their access monitoring, quality improvement, or strategic plans.⁹⁷ We found limited evidence of states measuring pediatric hospital admissions for ambulatory care sensitive conditions (e.g., diabetes complications, asthma), but New

Hampshire has been monitoring Hospital Admissions for Ambulatory Care Sensitive Conditions for Children.⁹⁸ This measure may not have as much value for reporting, however, due to low prevalence, which introduces challenges in some states and years. Pennsylvania has included an adult dental measure (Adults Receiving at Least One Dental Service in the Prior Year) as part of its draft access monitoring plan for 2016.⁹⁹ Consistently tracking the adult dental measure may be difficult—states can choose whether or not to track that and other optional services each year, and since coverage can vary by eligibility group, tracking trends through T-MSIS would be difficult.

iii. **Beneficiary Perceptions and Experiences Measures**

We propose that the three measures for assessing beneficiary perceptions and experiences—and one from the beneficiary utilization domain discussed above—be centrally calculated by CMS using results from the Nationwide CAHPS survey. This would entail an ongoing federal commitment to field the survey annually or biannually, along with ongoing state support for providing the survey samples. This also assumes that state-level results can be produced promptly (similar to what state-sponsored CAHPS surveys currently achieve) and that the Nationwide CAHPS could be structured to avoid duplication with state-level CAHPS survey efforts.

Besides assuming an ongoing federal commitment to continuing the Nationwide CAHPS survey, we recommend that CMS expand it to include children and enhance it to include content on additional areas of access (e.g., unmet need for substance use treatment or prescription drugs, the availability of language-accessible services, and the availability of services and advice on nights and weekends), some of which could be triangulated with “secret shopper” data).

We further recommend that information from Medicaid (and potentially Medicare) claims and encounter and enrollment files be included in the Nationwide CAHPS data files, making CAHPS function more like the Medicare Current Beneficiary survey has over the years. The latter extension is feasible given how the Nationwide CAHPS sample frame is developed, and doing so would open up the potential for many new policy-relevant analyses.

We also believe it is important to survey persons receiving Medicaid HCBS and their family caregivers to assess access for these services, recognizing that current efforts are underway (as described in Section II) to develop and implement HCBS experience of care surveys. We recommend that CMS consider how access-sensitive measures from HCBS experience of care surveys could be incorporated into the Access Measurement and Monitoring Plan in the future or, if feasible, how access-sensitive elements of the Experience of Care survey could be incorporated into the Nationwide CAHPS.

As discussed in Section II, the 2014 Nationwide CAHPS survey was fielded to 1.2 million adult Medicaid enrollees across 46 states and DC.¹⁰⁰

B. Analysis and Public Reporting of Access Measurement and Monitoring Plan Results

As noted above, getting a complete picture of access in a state will require that the measure results be analyzed together (i.e., “triangulated”), rather than viewed individually. Also, transparent public reporting of state performance results can promote Medicaid access improvements and can be a powerful supplement to other tools (i.e., technical assistance or enhanced administrative federal funding). States are well positioned to understand and interpret the various Medicaid factors (e.g., delivery systems, covered services, reimbursement, telemedicine utilization) and non-Medicaid factors (e.g., rural/urban differences, scope of practice laws, employer-based coverage levels) that may affect the measure results. Meanwhile, CMS is well positioned to identify policy strengths and weaknesses and to help identify promising practices and resources for states that fall well below national norms or where access is deteriorating. Therefore, we recommend that the format, content, and scope of the analysis and public reporting—including the identification of high- or low-performing states, places where access is improving or deteriorating, and policy and programmatic responses to identified access issues—be determined by CMS in consultation with states and other stakeholders. This recommendation is also consistent with concerns expressed by the National Governors’ Association¹⁰¹ and the National Association of Medicaid Directors¹⁰² regarding the public release of state T-MSIS data.

We also recommend that, at least initially, the access analysis be focused on changes in access compared to access at baseline, rather than on assessing the “adequacy” of access in the baseline period. To accomplish the latter, we believe 51 in-depth case studies would be needed to appropriately capture and analyze all Medicaid and non-Medicaid factors potentially affecting access—seemingly a much heavier lift for both CMS and the states compared to a focus on change. Over time, as experience develops with monitoring these measures and with developing thresholds, we recommend that CMS and states focus increasing attention on access levels in order to rectify problems and identify strategies producing successful results.

Finally, we recommend that, to the extent available, analysis of individual state results take into account HEDIS results reported by commercial plans as points of comparison for Medicaid. As described above, a 2014 report prepared for CMS compared Medicaid managed care performance results on 16 HEDIS measures included in the Adult Core Set, with results for the same measures

reported by 43 commercial health plans in 43 states, DC, Guam, and Puerto Rico.¹⁰³ The results (calculated by the National Committee for Quality Assurance [NCQA]), however, were reported on a regional basis (rather than state by state). In some regions, sample sizes for certain measures were insufficient to produce a reliable comparison. Also, HEDIS reporting by commercial plans to NCQA is voluntary, limiting the CMS's ability to rely on this potential data source for all states. If available, however, this comparative data could add another dimension to the access analysis for a particular state.

C. Other Strategies for Operationalizing the Access Measurement and Monitoring Plan

i. Implementation Timeline

Some components of the Access Measurement and Monitoring Plan rely on data already collected by states and CMS. To the extent other components require new investments and data (e.g., the state-produced provider files required to conduct the “secret shopper” audits), we recommend that the Access Measurement and Monitoring Plan implementation timeline be structured to allow sufficient time for states to align their policies, procedures, and IT systems; and to consider state staffing additions or reassignments and the training necessary to produce the required information and avoid duplication of efforts. In some cases, implementing the plan may require vendor contract amendments, regulatory changes, and possibly new state legislation, especially if additional state administrative funding is required. To increase states' flexibility to adapt current processes and systems, we recommend that CMS consider a phased-in implementation that would allow states to defer reporting on measures requiring significant program changes.

ii. State Consultation and Technical Assistance

We recommend that CMS develop a formalized process for consulting with states during implementation to address and respond to emerging questions, issues, and challenges. We also recommend that CMS provide initial and ongoing staff training resources and other technical assistance to states when and if necessary to assure consistent application and reporting of access measures and standards (e.g., uniform reporting templates and identification of best practices). These resources could be especially important for states with constrained administrative resources (which is the norm). Since, however, the proposed Access Measurement and Monitoring Plan relies primarily on CMS calculations

using T-MSIS data and continued CMS administration of the Nationwide CAHPS survey, states' need for technical assistance may be mitigated.

iii. **Enhanced Administrative Financial Support**

Subject to a few exceptions, states receive a 50 percent federal matching rate—the Federal Medical Assistance Percentages (FMAP)—for their costs to administer the Medicaid program. Section 1903(a) of the Social Security Act, however, provides for a higher Medicaid administrative FMAP under certain circumstances. These include a 90 percent FMAP for the design, development, and installation of a Medicaid- Management Information System (MMIS); a 75 percent match for MMIS management and operations, and 75 percent for a medical and utilization review performed by a quality improvement organization or QIO-like entity. To promote more rapid and complete state reporting, in addition to the “in-kind” training and technical assistance resources described above, we recommend that CMS advise states on the availability of an enhanced administrative FMAP. States may use such funding for system changes and other administrative costs related to compliance with the Access Measurement and Monitoring Plan under Section 1903(a) or other available authorities.

VI. Evolution of the Access Measurement and Monitoring Plan

Our proposed initial access core set is limited because it reflects the current state of measurement and is based on data sources we believe are feasible for CMS and states to use today. These systems, however, are not static. Several key data sources are not yet ready to be used in a nationwide access measurement and monitoring system. They may, however, be available in the future, particularly if there are focused efforts to develop them for this purpose. Access measures will also need to account for a changing health care delivery system, which currently focuses primarily on face-to-face encounters between patients and providers but may rely increasingly on care management and less traditional sources of care, such as telehealth, e-mail, text, and telephonic communications.

Additionally, more recent initiatives to develop nuanced approaches to measuring access to care among diverse populations—particularly measuring access to LTSS, including institutionally-based care and HCBS; and access to specialty services—are not yet ready to be included in a national core set. However, we recommend these topics be prioritized in the future.

Thus, the access measures CMS and the states develop will need to evolve and be supplemented and revised as more data become available and as new measures are developed. CMS has significant opportunities to promote the collection of better and more varied access data and to study, analyze, refine, and supplement the initial proposed core set of access measures. We therefore recommend that the Access Measurement and Monitoring Plan include key elements that will promote the evolution of the plan. Specifically, this section of the plan addresses strategies to (1) identify and develop new data sources for access measures; (2) study, analyze, refine, and supplement access measures, including by addressing aspirational measures (such as HCBS) and the role, if any, of national thresholds; and (3) promote all these efforts through a coordinated effort to build on the numerous regulatory changes and new systems that will emerge from the final rules on the equal access provision and managed care.

A. Identifying and Developing New Data Sources for Access Measures

The availability of high-quality data sources to measure access is impacted by cost, administrative complexity, and policy. We recommend that CMS do the following:

- **Analyze existing databases that include information relevant to measuring access to determine whether they could be used to measure access to care in Medicaid.** Several databases have the potential to be used to monitor access. For example:
 - » Birth and vital records data, combined with information from Medicaid enrollment files, could be used to track birth outcomes and related measures;
 - » Cancer registries,¹⁰⁴ combined with information from Medicaid enrollment files, could be used to track changes in timeliness of cancer diagnoses;
 - » Immunization registries or immunization information systems could be used to track immunization rates;
 - » The National Health Interview Survey (NHIS), National Ambulatory Medical Care Survey (NAMCS), and the Behavioral Risk Factor Surveillance System (BRFSS) all provide valuable national data that could be integrated into a Medicaid access monitoring system. However, using these surveys for state level monitoring would require enhanced state samples, consistent information on type of coverage to identify Medicaid enrollees, or both.
- **Prioritize the study and eventual development of systems that will enable CMS to compare access across coverage systems.** Several approaches could be pursued. As marketplaces implement new network adequacy and quality standards, it may be desirable to replicate at

least some of those measures in Medicaid in order to compare access in Medicaid and Qualified Health Plans (QHPs). This will be important given that many people are expected to move between those coverage systems as their income changes. Mathematica’s report to CMS, comparing Medicaid managed care and certain commercial health plans’ performance on selected HEDIS measures, is one approach that could be assessed for adaption to this access measurement and monitoring plan.¹⁰⁵ All payer claims databases could help CMS compare data across coverage systems, but may now require federal initiatives to develop.¹⁰⁶ While there are significant differences between Medicare and Medicaid populations and between the services provided under those programs for dual eligibles, we recommend that CMS continue to explore where access measures and data collected in Medicare might be used to compare access in Medicaid. Conversely, a 2015 report prepared for CMS described the results of two studies – one qualitative and one quantitative – suggesting that Medicaid reimbursement policies on cross-over claims (when Medicaid is responsible for Medicare cost-sharing amounts for dual eligibles) can impact access to *Medicare* services for dual eligibles.¹⁰⁷ CMS may wish to replicate this type of study on an ongoing basis to supplement the access information for dual eligibles derived from Medicaid data.

- **Develop guidance to help states compile and analyze complaint, grievance, and appeals data to identify access issues in both FFS and managed care.** Commenters to the RFI and several experts we interviewed believe that complaints, grievances, and appeals data¹⁰⁸ are a good source of “real-time” information on access issues and could serve as an early warning system for access problems within a Medicaid program. Louisiana has developed a fairly detailed system for collecting data on grievances and appeals in its managed care program; it requires MCOs to use standard templates and classifications for tracking grievances and appeals and it reviews the data manually.¹⁰⁹ Pennsylvania monitors the volume of calls to its statewide beneficiary call center. If there is an unexplained increase in calls, the state categorizes the reasons for the calls to determine whether access issues have increased and to identify which types of beneficiaries or providers are involved. The state then investigates, decides how to resolve the access issues, and monitors changes in response to those actions.¹¹⁰ Pennsylvania described these efforts in its draft Access Monitoring Review Plan for 2016 under the equal access rule; other states may identify other systems for monitoring access issues through complaints, grievances, appeals, and call center inquiries. We have not identified any state that has developed a database to analyze aggregate complaints, grievances, and appeals data to identify patterns of access issues. We recommend that CMS prioritize this as a potentially significant method to use *beneficiary perceptions and experiences* to measure and monitor access

and that CMS provide guidance to the states on collecting and analyzing enrollee grievance and appeal logs and provider complaint and appeal logs (which is included in the managed care state monitoring requirements). CMS might also identify states willing to pilot a more sophisticated data collection and analysis system to test whether aggregate complaints, grievances and appeals data can be used to identify access issues.

B. Evaluating, Refining, and Supplementing the Initial Proposed Access Core Set

As described in Section II.B, currently there are numerous national efforts to explore and analyze potential access measures. These include measures specifically for LTSS, encompassing institutionally based access and HCBS. Additionally, the new equal access rule requires states to submit their initial access monitoring and review plans to CMS for FFS programs in late 2016. States are required to identify the specific measures they will use to analyze access to care, then analyze the data collected “with a separate analysis for each provider type and site of service furnishing the type of service” for certain provider types at least once every three years.¹¹¹ The equal access rule’s monitoring program allows states to explore a variety of approaches to measuring access and CMS to study and analyze those approaches.

Similarly, the new managed care rule will require states to monitor, document, and report information relating to access, including data in connection with new quality initiatives. Under both these systems, some states may develop methods for measuring and monitoring access that might be appropriate to include in a national core access set. The new access plans required under the equal access final rule and the new data collection and reporting requirements in managed care—including for encounter data (42 CFR § 438.242) and for the documentation of adequate capacity and services (42 CFR § 438.207)—provide opportunities to learn about data limitations and to refine monitoring and reporting efforts. With respect to measuring *provider availability and accessibility*, new network adequacy standards in the managed care rule include the following:

- Their applicability to LTSS,
- The mandatory documentation of compliance with those standards,
- The addition of network adequacy validation as a mandatory element of EQR, and
- The annual monitoring report each state must provide to CMS.

These adequacy standards all provide opportunities to analyze how the states are evaluating access and whether there are opportunities to develop access measures based on this new documentation and information.

These new systems and information on access at the state level will also enable CMS to consider the possibility of developing **national thresholds**. The RFI raised this issue, but we recommend that CMS not adopt national thresholds initially. Once there has been experience with the equal access measurement systems developed by the states, and after reporting begins under the managed care rule, there will be opportunities to assess whether and how to implement national thresholds and how to use them. If CMS adopts a national access core set, CMS can begin to assess variation in patterns of access across states. Simple unadjusted differences across states and patterns in those unadjusted estimates would need to be complemented with an assessment of how well these patterns hold up when controlling for observed differences. This is particularly true for the target population, which could affect the measures. CMS could use this to assess whether states are consistent outliers—both good and bad—and develop procedures for providing states feedback on their performance. Whether CMS eventually adopts thresholds, or implements more of a “guardrail” system such as that proposed by Mathematica in its comments to the RFI,¹¹² we recommend that the Access Measurement and Monitoring Plan include consideration of how to improve access outcomes in the states.

We therefore recommend that CMS take the following actions:

- **Develop access measures for LTSS and HCBS based on the work of the NQF HCBS Quality Measurement Recommendations Project, the Experience of Care Survey and the National Core Indicators, including the adult and disability outgrowth.** Measuring and monitoring access to LTSS, including institutionally based access and HCBS, is a high priority for CMS that raises unique issues requiring specific expertise. We believe a targeted effort to identify access measures for these services will be necessary. We recommend that this effort address adherence to individualized care plans, availability of qualified providers, and state flexibility around eligibility for such services (including state adoption of state-specific goals that show progress from a baseline).
- **Monitor and integrate into this Access Measurement and Monitoring Plan as appropriate any other new access measures developed as part of ongoing efforts to develop other quality measures.** Whether as part of the NQS and the NQF Measure Applications Partnership or of other multi-stakeholder efforts, we recommend that CMS identify measures that could be included in an access core set.

- **Continue to scan performance measures used in private and government programs to identify those that might be appropriate for measuring access in Medicaid.** In addition to Medicare and individual states' Medicaid performance measurement efforts, other government initiatives may also provide useful models. An illustrative example is the Health Resources and Services Administration's National Performance Measures under the Title V Maternal and Child Health Block Grant program.¹¹³ A systematic analysis of performance measures and the data used to report on them may reveal new measures or approaches to incorporate into the Access Measurement and Monitoring Plan over time.

C. Using New Regulatory Requirements to Promote the Collection of Access Data and the Analysis and Further Development of an Access Core Set

As reflected in appendix K, the new equal access and managed care rules provide both CMS and the states numerous opportunities to develop systems for measuring and monitoring access to care. With respect to the access measurement and monitoring plans states develop *under the equal access rule*, we recommend that CMS take the following actions:

- **Conduct an analysis of the specific measures identified by each state** in their initial monitoring review plans and identify common measures and data sources, if any, as well as less common and unique measures that CMS can monitor during the first three-year cycle the rule is in effect.
- **Prepare a database that can be updated** as states complete analyses of specific access measures and services, seek provider payment rate reductions or payment restructuring, identify any access issues that emerge, and take corrective actions as appropriate.
- **After each three-year state reporting period, prepare a cross-state analysis of these data**, including comparing access measures and findings related to specific services or arising from specific data sources.

Similarly, under the new Medicaid managed care rule, states will be required to monitor and report annually on a wide variety of new data, including data that address access issues.¹¹⁴ States' experiences developing and monitoring new network adequacy standards, monitoring member grievance and appeal logs and provider complaint and appeal logs, and monitoring and reporting on overall availability and accessibility of covered services in their managed care programs will provide additional

opportunities for CMS to promote exploration of data sources and monitoring practices that could lead to changes in the core access set.

Finally, to promote common approaches and processes across both FFS and managed care delivery systems, we recommend that CMS coordinate its guidance to states for monitoring and reporting access under both systems and develop approaches to be implemented in both systems. A coordinator within CMS, who has the ability to work across FFS and managed care and across elements of managed care (ranging from encounter data, to quality measures and quality improvement, to network adequacy, state monitoring, and EQR), could identify opportunities to promote and develop the Access Measurement and Monitoring Plan. A coordinator could help develop a plan for CMS to systemically address access issues at numerous stages of implementation of the equal access and managed care final rules. Similarly, states could benefit from having a coordinator working across their FFS and managed care Medicaid programs and with CMS's coordinator on developing and implementing the Access Measurement and Monitoring Plan over time.

Appendix A. Proposed Initial Core Set of Access Measures: Key Details

Access Domain	Measure Name ^a	Data Source	Services/Providers Addressed
Provider Availability and Accessibility (Potential Access)	Participating provider by provider type (e.g., primary care providers, pediatric providers, mental/behavioral health providers, other specialists, community health centers and federally qualified health centers, OB/GYNs, acute care hospitals, dental providers)	T-MSIS	Primary care, urgent care, oral health, mental/behavioral health, other specialty care, maternal health
	Days to appointment (e.g., for routine care, urgent care, medical/behavioral health problems, and maternity care)	“Secret shopper” audit	Primary care, urgent care, mental/behavioral health, maternal health
	Availability of appointments and advice outside traditional business hours (e.g., evenings, weekends, and holidays)	“Secret shopper” audit	Primary care, urgent care, mental/behavioral health, maternal health
	Availability of language-accessible services (e.g., multilingual services or translation/interpretation services)	“Secret shopper” audit	Primary care, urgent care, mental/behavioral health, maternal health
Beneficiary Utilization (Realized Access and Access-Related Outcomes)	Adults receiving at least one ambulatory service visit in prior year	T-MSIS	Primary care, specialty care
	Adults receiving a routine checkup in prior year	Nationwide CAHPS	Primary care
	<i>Child and Adolescents’ Access to Primary Care Practitioners</i>	<i>Child Core Set</i>	<i>Primary care</i>
	<i>Well Visits (i.e., in the First 15 Months of Life; in the 3rd, 4th, 5th and 6th Years of Life; and for Adolescents)</i>	<i>Child Core Set</i>	<i>Primary care</i>
	<i>Follow-up After Hospitalization for Mental Illness (i.e., for ages 6-20 and for ages 21 and older, both 7 day and 30 day follow-up rates)</i>	<i>Child, Adult Core Sets</i>	<i>Primary care, behavioral health</i>
	<i>Percentage of Eligibles Who Received Preventive Dental Services</i>	<i>Child Core Set</i>	<i>Oral health</i>
	<i>Prevention: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk</i>	<i>Child Core Set</i>	<i>Oral health</i>
	Adults receiving at least one dental service in prior year for states covering nonemergency dental services for adults in that year	T-MSIS	Oral health

Access Domain	Measure Name ^a	Data Source	Services/Providers Addressed
	<i>Prenatal & Postpartum Care: Postpartum Care Rate</i>	<i>Adult Core Set</i>	<i>Maternal health</i>
	<i>Prenatal & Postpartum Care: Timeliness of Prenatal Care</i>	<i>Child Core Set</i>	<i>Maternal health</i>
	Adult emergency department visits	T-MSIS	Emergency care
	<i>Ambulatory Care – Emergency Department Visits</i>	<i>Child Core Set</i>	<i>Emergency care</i>
	Adult and pediatric emergency visits that were potentially preventable/ avoidable or that could have been treated in a primary care setting (e.g., asthma, diabetes, heart failure)	T-MSIS ^b	Emergency care, primary care
	<i>Hospital Admissions for Ambulatory Care Sensitive Conditions (e.g., diabetes complication, heart failure, asthma, COPD)</i>	<i>Adult Core Set</i>	<i>Emergency care, primary care</i>
	Pediatric hospital admissions for ambulatory-sensitive conditions (e.g., diabetes complications, asthma)	T-MSIS	Emergency care, primary care
Beneficiary Perceptions and Experiences	Frequency and ease of getting needed care (i.e., routine care, specialty care, tests/treatment, special medical equipment, mental health or behavioral health services, dental services)	Nationwide CAHPS	Primary care, specialty care, mental/behavioral health, oral health
	Having a “personal doctor” or a place to go for care and advice (other than the emergency department)	Nationwide CAHPS	Primary care
	Culturally competent care (e.g., beneficiaries reporting that their provider explained things in an understandable way, listened carefully to them, showed them respect, and spent enough time with them)	Nationwide CAHPS	Primary care

Note:

^a Measures from the Adult and Child Core Sets are listed in italics.

^b Measure derived using NYU algorithm to help classify emergency department utilization (<http://wagner.nyu.edu/faculty/billings/nyued-background>).

Appendix B. Methods

To inform the development of the Access Measurement and Monitoring Plan, the Urban Institute team reviewed and analyzed public comments received in response to the CMS Request for Information (RFI) on Measuring Access to Care in the Medicaid Program (N=100), conducted key informant interviews (N=12) and background discussions (N=4), and performed a targeted literature review (N=110).

A. Review of Comments

The Urban Institute team received 103 comments from CMS to review, three of which were duplicates or replacements for other comments. We used the qualitative data software NVivo to code the comments based on major topics in the RFI and on type of commenter (table B.1). The list of codes was revised iteratively, based on pilot-coding a sample of comments. Once the final codebook was established, three researchers coded all comments and ran numerous queries to facilitate analysis.

We organized our analysis and this summary around several key issues and questions raised by CMS in the RFI. For each such issue or question, we summarized responses to those questions, noted any identifiable patterns among the categories of commenters, and offered examples. In some cases, we also identified significant “exceptions”—comments that varied from the reported pattern. Finally, because there were many detailed comments about several issues (including numerous minor exceptions to general patterns), we relied on appendices to capture specific comments to use as resources in preparing our Access Measurement and Monitoring Plan.

B. Key Informant Interviews

The research team held interviews with twelve key informants representing state Medicaid agencies federal agencies, professional organizations, a multistate Medicaid health plan, and experts in monitoring Medicaid access and developing access measures. We developed several tailored semi-structured discussion guides based on respondent type to elicit information about approaches to measuring provider availability, realized access or utilization, and beneficiaries’ experiences. Five additional background discussions were held with experts on complaints, grievance and appeals systems, and quality measures.

TABLE B.1

Number of Commenters on RFI, by Type

Commenter Type	# of Sources
Providers^a	49
Hospital associations	5
LTSS, LTC, or HCBS provider associations	25
Other providers or associations ^b	19
Health plans^a	10
Health plans ^b	4
Health plan association	6
Consumer advocates	11
Researchers, academics, or consultants	6
State or city government agencies and associations^a	14
State Medicaid agencies ^b	12
Other state or local government agencies	2
Other	10
Sum	100

Notes:

^a Sum of sub-categories

^b Count includes a duplicate value; three organizations submitted duplicate comments. There were 100 unique commenters from the 103 total comments submitted.

C. Literature Review

The Urban Institute team conducted a focused search for the most relevant peer-reviewed and grey literature to augment what we learned from public comments in response to the RFI and from the key informant interviews. We used a systematic approach to identify and synthesize current literature (peer reviewed and gray) on the current measurement landscape, conceptual frameworks and goals for measuring and monitoring access, proposed metrics and data sources, and strategies and approaches for operationalizing the plan. Table B.2 shows the total counts and a description of the team’s review process.

TABLE B.2

Literature Review Resources

	Initial counts of resources	Counts after our abstract review, resources for full review
Resources recommended by team and CMS	Approximately 50	76 for full review, including team’s resources plus RFI sources
Resources cited by RFI comments that we flagged in our RFI review	Approximately 75	
Additional online search for peer and grey articles		
Search terms: Medicaid + Access + Measure	137	34 (some culled because they duplicated existing resources)
Time period: since 2013		

D. Systematic Review of Measure Reporting

To document current use of the access measures we have proposed by individual states (as referenced in the plan), we reviewed available access and quality measurement reports for 10 states:

- [Arizona](#)
- [California](#)
- [Colorado](#)
- [Florida](#)
- [Georgia](#)
- [Minnesota](#)
- [New Hampshire](#)
- [New York](#)
- [Oregon](#)
- [Pennsylvania](#)

These states are diverse in terms of region, population size, level of urbanization, demographic composition, and Medicaid delivery systems. For five states (Arizona, California, Colorado, New Hampshire, and Pennsylvania), we were able to identify an access monitoring report that considered access separately from quality, including one state that had submitted a draft equal access rule access review monitoring plan. For the states for which we were not able to identify a specific access report, we reviewed external quality review reports, quality reports, reporting on quality incentives, and other documents to identify use of our proposed measures.

Appendix C. CMS Quality Measurement Programs

Setting	Program
Hospital	Hospital Inpatient Quality Reporting Program
	Hospital Value-Based Purchasing Program
	Hospital Readmissions Reduction Program
	Hospital-Acquired Condition Reduction Program
	Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Eligible Hospitals and Critical Access Hospitals
	Hospital Outpatient Quality Reporting Program
	Ambulatory Surgical Center Quality Reporting Program
	Inpatient Psychiatric Facility Quality Reporting Program
Prospective Payment System–Exempt Cancer Hospitals Quality Reporting Program	
Ambulatory	Physician Quality Reporting System
	Medicare Electronic Prescribing Incentive Program
	Physician Feedback Program
	Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Eligible Professionals
	Medicare Shared Savings Program
	Physician Compare
	Medicare Part C (Display or Star Ratings)
	Medicare Part D (Display or Star Ratings)
Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set)	
Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set)	
Postacute	Nursing Home Quality Initiative
	Home Health Quality Reporting Program
	End-Stage Renal Disease Quality Incentive Program
	Hospice Quality Reporting Program
	Inpatient Rehabilitation Facilities Quality Reporting Program
	Long-Term Care Hospitals Quality Reporting Program

Source: Centers for Medicare & Medicaid Services, “National Impact Assessment of the CMS Quality Measures Report” (Baltimore: CMS, 2015), <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualitymeasures/downloads/2015-national-impact-assessment-report.pdf>.

Appendix D. Child Core Set

2016 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)		
NQF #	Measure Steward	Measure Name
Access to Care		
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP)
Preventive Care		
0033	NCQA	Chlamydia Screening in Women (CHL)
0038	NCQA	Childhood Immunization Status (CIS)
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15)
1407	NCQA	Immunizations for Adolescents (IMA)
1448	OHSU	Developmental Screening in the First Three Years of Life (DEV)
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV)
NA	NCQA	Adolescent Well-Care Visit (AWC)
Maternal and Perinatal Health		
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI)
0471	TJC	PC-02: Cesarean Section (PC02)
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW)
1391	NCQA	Frequency of Ongoing Prenatal Care (FPC)
1517	NCQA	Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)
1380	CDC	Audiological Evaluation No Later Than 3 Months of Age (AUD)*
NA	AMA-PCPI	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)
Behavioral Health		
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)
1365	AMA-PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)
NA	AHRQ-CMS CHIPRA NCINQ	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*
Care of Acute and Chronic Conditions		
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC)
1799	NCQA	Medication Management for People with Asthma (MMA)
NA	NCQA	Ambulatory Care – Emergency Department (ED) Visits (AMB)
Oral Health		
2508	DQA (ADA)	Prevention: Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL)
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT)
Experience of Care^a		
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items) (CPC)

^a The Centers for Medicare & Medicaid Services will pilot a reporting process for the Child Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (NQF # 2548) to determine whether to include the HCAHPS measure in a future Child Core Set.

* This measure was added to the 2016 Child Core Set.

AHRQ – Agency for Healthcare Research and Quality; AMA-PCPI – American Medical Association-Physician Consortium for Performance Improvement; CDC – Centers for Disease Control and Prevention; CHIPRA – Children's Health Insurance Program Reauthorization Act; CMS – Centers for Medicare & Medicaid Services; DQA (ADA) – Dental Quality Alliance (American Dental Association); NA – Measure is not NQF endorsed; NCINQ – National Collaborative for Innovation in Quality Measurement; NCQA – National Committee for Quality Assurance; NQF – National Quality Forum; OHSU – Oregon Health and Science University.

Source: Centers for Medicare & Medicaid Services, "2016 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)," <https://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2016-child-core-set.pdf>.

Appendix E. Adult Core Set

2016 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)		
NQF #	Measure Steward	Measure Name
Preventive Care		
0032	NCQA	Cervical Cancer Screening (CCS)
0033	NCQA	Chlamydia Screening in Women (CHL)
0039	NCQA	Flu Vaccinations for Adults Age 18 and Older (FVA)
0418	CMS	Screening for Clinical Depression and Follow-Up Plan (CDF)
2372	NCQA	Breast Cancer Screening (BCS)
NA	NCQA	Adult Body Mass Index Assessment (ABA)
Maternal and Perinatal Health		
0469	TJC	PC-01: Elective Delivery (PC01)
0476	TJC	PC-03: Antenatal Steroids (PC03)
1517	NCQA	Prenatal & Postpartum Care: Postpartum Care Rate (PPC)
Behavioral Health and Substance Use		
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)
0105	NCQA	Antidepressant Medication Management (AMM)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
NA	NCQA	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA)
NA	PQA	Use of Opioids at High Dosage (OHD)*
Care of Acute and Chronic Conditions		
0018	NCQA	Controlling High Blood Pressure (CBP)
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01)
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08)
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05)
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15)
1768	NCQA	Plan All-Cause Readmissions (PCR)
2082	HRSA	HIV Viral Load Suppression (HVL)
2371	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM)
Care Coordination		
0648	AMA-PCPI	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR)
Experience of Care		
0006	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, Version 5.0 (Medicaid) (CPA)

* This measure was added to the 2016 Medicaid Adult Core Set.

AHRQ = Agency for Healthcare Research & Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CMS = Centers for Medicare & Medicaid Services; HRSA = Health Resources and Services Administration; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

Source: Centers for Medicare & Medicaid Services, "2016 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)," <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2016-adult-core-set.pdf>.

Appendix F. Health Home Core Set

2013–2015 Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set)		
NQF #	Measure Steward	Measure Name
Core Set Measures		
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
0018	NCQA	Controlling High Blood Pressure (CBP)
0418	CMS	Screening for Clinical Depression and Follow-Up Plan (CDF)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)
0648	AMA-PCPI	Care Transition – Timely Transmission of Transition Record (CTR)
1768	NCQA	Plan All-Cause Readmission Rate (PCR)
NA	NCQA	Adult Body Mass Index Assessment (ABA)
NA	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92)
Utilization Measures		
NA	NCQA	Ambulatory Care – Emergency Department Visits (AMB)
NA	CMS	Inpatient Utilization (IU)
NA	CMS	Nursing Facility Utilization (NFU)

AHRQ = Agency for Healthcare Research & Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CMS = Centers for Medicare & Medicaid Services; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.

Source: Centers for Medicare & Medicaid Services, “2013–2015 Core Set of Health Care Quality Measures for Medicaid Health Home Programs: (Health Home Core Set),” <https://www.medicare.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2013-2015-health-home-core-set.pdf>.

Appendix G. Draft Subdomains of HCBS Quality Measurement

Domains for Measurement	Subdomains Corresponding to Each Domain
Workforce/Providers	Sufficient numbers and appropriately dispersed; dependability; respect for boundaries, privacy, consumer preferences, and values; skilled; demonstrated competencies when appropriate; culturally competent, sensitive, and mindful; adequately compensated, with benefits; safety of the worker; teamwork, good communications, and value-based leadership
Consumer Voice	Meaningful mechanism for input (e.g., design, implementation, evaluation); consumer-driven system; breadth and depth of consumer participation; level of commitment to consumer involvement; diversity of consumer and workforce engagement; and outreach to promote accessible consumer engagement
Choice and Control	Choice of program delivery models and provider(s) including self-direction, agency, particular worker(s), and setting(s); personal freedoms and dignity of risk; achieving individual goals and preferences (i.e., individuality, person-centered planning); self-direction; shared accountability
Human and Legal Rights	Delivery system promotes dignity and respect; privacy; informed consent; freedom from abuse and neglect; optimizing the preservation of legal and human rights; sense of safety; system responsiveness
System Performance	Consumer engagement; participatory program design; reliability; publicly available data; appropriate and fair resource allocation based on need; primarily judged by the aggregate of individual outcomes; waiting lists; backlog; financing and service delivery structures; availability of services; efficiency and evidence based practices; data integrity
Full Community Inclusion	Enjoyment or fun; employment, education, or productivity; social connectedness and relationships; social participation; resources to facilitate inclusion; choice of setting; accessibly built environment
Caregiver Support	Training and skill-building; access to resources (e.g., respite, crisis support); caregiver well-being (e.g., stress reduction, coping); caregiver and/or family assessment and planning; compensation
Effectiveness/Quality of Services	Goals and needs realized; preferences met; health outcomes achieved; technical skills assessed and monitored; technical services delivered; team performance; rebalancing
Service Delivery	Accessibility (e.g., geographic, economic, physical, and public and private awareness or linkage); appropriate (e.g., services aligned with needs and preferences, whether goals are assessed); sufficiency (e.g., scope of services, capacity to meet existing and future demands); dependable (e.g., coverage, timeliness, workforce continuity, knowledge of needs and preferences, and competency); timely initiation of services; coordination (e.g., comprehensive assessment, development of a plan, information exchange between all members of the care team, implementation of the plan, and evaluation of the plan)
Equity	Reduction in health and service disparities; transparency of resource allocation; access or waiting list; safe, accessible, and affordable housing; availability; timeliness; consistency across jurisdictions
Health and Well-Being	Physical, emotional, and cognitive functioning; social well-being, spirituality; safety and risk as defined by the consumer; freedom from abuse, neglect, and exploitation; health status and wellness (e.g., prevention, management of multiple chronic conditions); behavioral health

Source: National Quality Forum, “Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Synthesis of Evidence and Environmental Scan—Interim Report,” (Washington, DC: National Quality Forum, 2015), <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=81346>.

Appendix H. Summary of Selected Federal Data Collection Initiatives

Survey	Summary and Relevance to Measuring/Monitoring Medicaid Enrollees' Access to Care	Limitations
National Health Interview Survey (NHIS)	The principal source of information on the health of the civilian noninstitutionalized population of the United States. The data are also used by the public health research community for policy analysis of such timely issues as determining barriers to accessing and using appropriate health care. ^a Following passage of the ACA, the survey's access content was expanded to better capture the ACA's effects on access to health care services for adults and children.	The sample frame is not large enough to create annual population-based estimates for all states, and even fewer states have sufficient numbers to support Medicaid-specific estimates.
National Ambulatory Medical Care Survey (NAMCS)	A national survey that meets the need for objective, reliable information about the provision and use of ambulatory medical care services in the United States. ^b This survey was expanded in 2010 to provide state-specific estimates of payer mix for individual physicians, including Medicaid.	State estimates were supported with special funding, which has not been maintained.

Source: Unless otherwise noted, information is cited from Marsha Gold and Genevieve M. Kenney, "Monitoring Access: Measures to Ensure Medi-Cal Enrollees Get the Care They Need" (Oakland: California HealthCare Foundation, 2014), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MonitoringAccessMediCal.pdf>.

^a Centers for Disease Control and Prevention, "About the National Health Interview Survey," October 8, 2015, http://www.cdc.gov/nchs/nhis/about_nhis.htm.

^b Centers for Disease Control and Prevention, "Ambulatory Health Care Data," 2015, <http://www.cdc.gov/nchs/ahcd.htm>.

Appendix I. Selected Medicaid/CHIP Child Core Set Measures: State Reporting, FFY 2014

Measure	No. of States Reporting	Mean	Median	25th Percentile	75th Percentile
Primary Care Access and Preventive Care					
Access to Primary Care: 12–24 Mos ^a	41	95.8	96.4	94.3	97.3
Access to Primary Care: 25 Mos–6 Yrs ^a	43	87.1	88.6	84.3	91.6
Access to Primary Care: 7–11 Yrs ^a	42	88.9	91.2	86.1	94.0
Access to Primary Care: 12–19 Yrs ^a	42	88.0	90.6	85.7	92.1
Well-Child Visits: First 15 Mos	40	61.7	62.1	56.2	68.7
Well-Child Visits: 3–6 Yrs	46	67.1	67.4	60.6	75.9
Well Care Visits: 12–21 Yrs	44	45.5	43.5	38.0	56.2
Maternal and Perinatal Health					
Timeliness of Prenatal Care	34	77.1	81.4	69.7	86.4
Frequency of Ongoing Prenatal Care	27	56.6	65.8	43.1	72.8
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness: 6–20 Yrs:					
7 days	34	44.8	43.9	32.0	62.9
30 days	34	64.2	65.2	51.9	78.3
Follow-Up Care for Children Prescribed ADHD Meds: 6–12 Yrs:					
Initiation phase	34	44.2	44.1	35.3	53.3
Continuation phase	31	53.9	56.5	45.3	63.1
Dental and Oral Health Services					
Preventive Dental Services: 1–20 Yrs	51	45.6	47.6	42.5	50.6

Source: US Department of Health and Human Services, “2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP” (Washington, DC: US DHHS, 2016), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-sec-rept.pdf>.

Notes:

^a As measured by participating provider by provider type.

Appendix J. Selected Medicaid Adult Core Set Measures: State Reporting, FFY 2014

Measure	No. of States Reporting	Mean	Median	25th Percentile	75th Percentile
Primary Care Access and Preventive Care					
Body Mass Index (BMI) Assessment	26	52.6	69.3	7.7	81.2
Maternal and Perinatal Health					
Postpartum Care Rate	34	54.4	58.2	42.5	63.9
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7 days	30	39.0	37.0	25.5	54.7
30 days	30	56.7	57.3	45.0	71.9

Source: US Department of Health and Human Services, "2015 Annual Report on the Quality of Care for Adults in Medicaid" (Washington, DC: US DHHS, 2016), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-adult-sec-rept.pdf>.

Appendix K. New Regulatory Requirements Relevant to Measuring Access to Care in Medicaid

Source	Reference	Summary of Requirement	FFS or Mgd Care	Timeline ^a	Connection to Implementation/Evolution of the Proposed CMS AMMP
Equal access final rule		States must develop an “ Access Monitoring Review Plan ” (State AMRP) that considers numerous factors and specifies the data elements and measures states will use to determine whether beneficiaries have adequate access to care.			Each state will develop its own data sources, methodologies, baselines, assumptions, trends and factors, and thresholds to analyze the sufficiency of enrollees’ access to care, including for specified services. Although only applicable to FFS, these State AMRPs will provide the first opportunity under the regulations for CMS to monitor and study different state approaches and strategies to measuring access to care. Given that some states have moved most of their Medicaid population into managed care, however, approaches and strategies used by states with limited FFS enrollment may be less useful to other states or to informing development of approaches across both FFS and managed care.
	42 CFR § 447.203	Among other requirements, states must consider the extent to which enrollee needs are met, the availability of care through enrolled providers in each geographic area of the state by provider type and site of service, the utilization of services, and characteristics of the beneficiary population.	Fee-for-Service (FFS)	10/1/16: States submit initial State AMRP to CMS and update it at least every three years.	
		The final rule stated: “The experiences of beneficiaries should be a primary determinant of whether access is sufficient.” 80 FR 67576, 67580 (November 2, 2015)			
	42 CFR § 447.203(b)(5)	States must analyze the data collected for specific services , including: primary care; physician specialists; behavioral health, pre- and post-natal obstetric, including labor and delivery; home health; and any other services states decide to review. (Other	FFS	In addition to updating the State AMRP, states must also analyze data related to these specific services at least every 3 years following submission of	See above comments about State AMRP.

Source	Reference	Summary of Requirement	FFS or Mgd Care	Timeline ^a	Connection to Implementation/Evolution of the Proposed CMS AMMP
		categories of services that require an analysis of data are addressed in the next two rows below.)		the initial State AMRP on 10/1/16.	
	42 CFR § 447.203(b)(5) and (b)(7)	Complaints about access: States must have “ongoing mechanisms for beneficiary and provider input on access to care (through hotlines, surveys, ombudsman, review of grievance and appeals data, or another equivalent mechanisms [sic])” and must “promptly respond” to public input regarding access problems “with an appropriate investigation, analysis, and response.” States must maintain a record of data on this public input and how they responded, and make the record available to CMS upon request.	FFS	10/1/16 to the extent the complaint mechanisms are part of the State AMRP. At least every 3 years to address complaints relating to types of services for which there has been a significantly higher than usual volume.	This process (along with the state monitoring requirements in managed care, 42 CFR § 438.66) could provide an opportunity for CMS to conduct an analysis of “real time” complaints regarding access, identify best practices for collecting and responding to such complaints and exploring how such data could be aggregated to identify patterns of access issues.
	42 CFR § 447.203(b)(6)	States must submit an access review (consistent with the State AMRP) for each service affected by any proposed state plan amendment (SPA) that proposes to reduce provider payment rates or restructure payments “when the changes could result in diminished access.”	FFS	Access review submitted with the proposed SPA to reduce or restructure provider payments. Monitoring procedures at least annually for 3 years following the effective date of the SPA.	See above comments about State AMRP. The access review documents submitted by states with these payment SPAs provide additional opportunities to analyze state strategies to monitor and address access to care issues.
Managed care final rule: Access to care standards	42 CFR § 438.68	Network adequacy standards: With respect to each managed care plan, ^b each state must develop and enforce its own network adequacy standards, including time and distance standards for specific provider types: primary care (adult and pediatric); OBY/GYN, behavioral health (adult and pediatric); specialist (adult and pediatric), hospital; pharmacy; pediatric dental; and additional provider types that may be identified by CMS. States with managed care plans which cover LTSS must develop time and distance standards for LTSS provider types to which an enrollee must travel to	Managed care	No later than the rating period for contracts starting on or after 7/1/18.	These new network adequacy standards will be implemented in the context of related access to care regulations (438.206 and 438.207) and must be addressed in the new state monitoring requirements (438.66) and external quality review requirements (438.358).

Source	Reference	Summary of Requirement	FFS or Mgd Care	Timeline ^a	Connection to Implementation/Evolution of the Proposed CMS AMMP
		<p>receive services, and other network adequacy standards for LTSS provider types that travel to the enrollee to deliver services. In developing all of these standards, states must consider numerous factors. For LTSS, states must also consider additional factors.</p> <p>States must publish these network adequacy standards on their public websites.</p>			
	42 CFR § 438.206	Availability of services: States must ensure that all services covered under the State plan are available and accessible to enrollees of managed care plans in a timely manner.	Managed care	No later than the rating period for contracts starting on or after 7/1/18.	These access standards are related to network adequacy standards (438.68) and access to care requirements (438.207) and must be addressed in the new state monitoring requirements (438.66).
	42CFR § 438.207	<p>Assurance of adequacy capacity and services. States must require each managed care plan to assure the state, and to provide documentation that demonstrates, it has the capacity to serve the expected enrollment in its service area (including that it is complying with the network adequacy and availability of services standards in 438.68 and 438.206).</p> <p>States must publish the documentation received from the managed care plans on their public websites. <i>See</i> 42 CFR § 438.602(g)(2); 42 CFR § 438.604(a)(5).</p>	Managed care	No later than the rating period for contracts starting on or after 7/1/18. Managed care plans must provide the documentation at least annually.	States have discretion to specify the format for the documentation required from managed care plans. This provides an opportunity for CMS to analyze states' documentation requirements and work with states to identify best practices. This provision is related to network adequacy standards (438.68) and access to care requirements (438.207) and must be addressed in the new state monitoring requirements (438.66).
Managed care final rule:		Quality Assessment and Performance Improvement (QAPI) Program (general):			
Quality measurement and improvement	42 CFR § 438.330	<p>Sets forth basic requirements regarding managed care plans' "ongoing comprehensive quality assessment and performance improvement program[s]."</p> <p>States must identify standard performance measures and each managed care plan must report on them annually. Performance improvement projects must include specific</p>	Managed care	Annually, beginning no later than the rating period for contracts starting on or after 7/1/17.	Numerous elements of QAPI programs could address access issues. Therefore, analysis of these programs to identify standards and mechanisms used by states to assess and improve performance related to access could help inform the evolution of the accompanying proposed CMS AMMP. As one example, QAPI programs must include "mechanisms to detect both underutilization and overutilization of services"—which may

Source	Reference	Summary of Requirement	FFS or Mgd Care	Timeline ^a	Connection to Implementation/Evolution of the Proposed CMS AMMP
		elements including “implementation of interventions to achieve improvement in the access to and quality of care.” States must review annually the impact and effectiveness of each managed care plan’s QAPI.			be indicators of access issues.
	42 CFR § 438.330(b)(5)	Quality Assessment and Performance Improvement (QAPI) Program (LTSS): QAPI applies to LTSS and must include “assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee’s treatment/service plan, if applicable.”	Managed care	Annually, beginning no later than the rating period for contracts starting on or after 7/1/17.	These QAPI programs provide an opportunity for CMS and states to analyze how to most effectively measure whether persons needing LTSS are receiving services consistent with their individualized treatment plans.
	42 CFR § 438.330(a)(2)	Quality Assessment and Performance Improvement (QAPI) Program (mechanism for adopting federal performance measures): This provision of the regulation provides CMS the legal authority to adopt national performance measures and performance improvement projects (PIPs). States must require managed care plans to include these in their QAPI programs and report on them annually. The regulations also establish a process for states to receive an exemption from a measure or a PIP.	Managed care	Only after consulting with states and other stakeholders and going through a public notice and comment period, may CMS specify performance measures and performance improvement plans which must be included in state QAPI programs.	This is a mechanism by which CMS could adopt national access measures and performance improvement projects (which perhaps could include national thresholds) that are consistent with these provisions. In the final rule, CMS said it would provide states with further guidance if it identified national performance measures for QAPI.
	42 CFR § 438.334	Managed care quality rating system. CMS will identify performance measures and a methodology for a Medicaid managed care quality rating system. States must either adopt the framework developed by CMS or adopt and implement an alternative quality rating system subject to CMS approval. Every year the state must collect data from each managed care plan and issue (and publish) a quality rating for each plan.	Managed care	No later than 3 years from the date of a final notice published in the Federal Register.	CMS will develop a quality rating system, using a methodology that aligns with the summary indicators in the quality rating system for qualified health plans. This could present an opportunity to address access issues.
	42 CFR § 438.340	Managed care state quality strategy. Each state must draft and implement a written quality strategy for “assessing and improving” the quality of health care and	Managed care	Beginning 7/1/18.	The state quality strategies integrate standards related to network adequacy, timely access to services, and the performance measures states adopt

Source	Reference	Summary of Requirement	FFS or Mgd Care	Timeline ^a	Connection to Implementation/Evolution of the Proposed CMS AMMP
		services provided by each managed care plan. The quality strategy <i>must</i> include the state's network adequacy and availability of services standards (438.68 and 438.206) and a description of the state's performance measures reported for QAPI programs (438.330).			(including those that CMS may later adopt) for QAPI programs. This is an example of how different regulatory requirements could come together to help focus states and CMS on how best to measure access to care.
Managed care final rule:	42 CFR §§ 438.66(a) through (d)	State monitoring requirements: States must have a system for monitoring all managed care programs in numerous areas, including availability and accessibility of services, quality improvement, and medical management (including utilization and case management). States must use data collected from monitoring activities to improve performance of their managed care programs, including member grievance and appeal logs and provider complaint and appeal logs, findings from the external quality review (EQR) process, results from enrollee or provider surveys, and performance on required quality measures.	Managed care	No later than the rating period for contracts starting on or after July 1, 2017.	These new state monitoring requirements and the related annual report described below provide an opportunity to further develop data collection and measurement efforts related to access. The monitoring provisions relating to complaints and grievances provide opportunities like those addressed above with respect to the equal access rule.
State monitoring requirements	42 CFR § 438.66(e)	State monitoring requirements: annual report to CMS. In connection with the state monitoring requirements, states must submit an annual report to CMS with information on an assessment of the managed care program in several areas including: encounter data reporting by each managed care plan; grievance, appeals and state fair hearings for the managed care program; availability and accessibility of covered services, including network adequacy standards; and evaluation of plan performance on quality measures (including surveys).	Managed care	Annual report due no later than 180 days after each contract year, beginning with the rating period for contracts that start after CMS releases guidance on the content of the reports.	CMS will issue guidance to states on the form and content of the annual program reports, which provides another opportunity to address specific issues relating to access. CMS could consider aligning some reporting around access issues under 438.66 to the approaches taken under the equal access rule and through the State AMRPs.
Managed care final rule:	42 CFR § 438.358	Activities related to external quality review. The final rule added a new mandatory EQR-related activity: validation of each managed care plan's network	Managed care	States will be required to begin to conduct the mandatory EQR-related activity of validation of	The validation of network adequacy standards will provide an opportunity to assess the different standards states develop under the network adequacy

Source	Reference	Summary of Requirement	FFS or Mgd Care	Timeline ^a	Connection to Implementation/Evolution of the Proposed CMS AMMP
External quality review		adequacy during the preceding 12 months to comply with network adequacy requirements in 438.68 and, if the plan enrolls Indians in the managed care plan, § 438.14(b)(1).		network adequacy “no later than one year from the issuance of the associated EQR protocol.” 81 FR at 27499.	provisions in 438.68. CMS’s EQR protocol can also further address implementation of these new standards. For states that have an entity perform optional EQR-related activities—including validation of encounter data, administration or validation of consumer or provider services, calculation of performance measures, conduct of performance improvement projects—these activities may also enable CMS and the states to assess different approaches to access measurement, monitoring, and reporting under the interrelated provisions of the final rule on managed care.
Managed care final rule: Encounter data	42 CFR § 438.242 and 42 CFR § 438.818	Health information systems, including encounter data: The final rule adds more detailed requirements relating to managed care plans’ reporting of enrollee encounter data, including requiring the states to use quality assurance protocols to ensure submitted data are complete and accurate. The final rule also provides that states that fail to meet the requirements for providing CMS enrollee encounter data may lose their federal Medicaid funds for all or part of the relevant managed care contract.	Managed care	No later than the rating period for contracts starting on or after 7/1/18 is the effective date for the provision conditioning federal funding on compliance with requirements for encounter data.	CMS emphasized the importance of receiving complete and accurate encounter data from states. Encounter data are a critical element of the proposed CMS AMMP and improvements in the data should provide opportunities for CMS and the states to more effectively measure access to care.

Notes:

^a To identify timelines, the authors relied on: (1) the equal access final rule, 80 FR § 67576 (November 2, 2015); (2) the Extension of the Deadline for Access Monitoring Review Plan Submissions, 81 FR 21479 (April 12, 2016); and (3) on CMS’s April 25, 2016 table summarizing Implementation dates for the Medicaid and CHIP Managed Care Final Rule. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/implementation-dates.pdf>.

^b The managed care final rule addresses several different types of managed care entities: managed care organizations (MCOs); prepaid inpatient health plans (PIHPs); prepaid ambulatory health plans (PAHPs); and primary care case management entities (PCCM entities). Different provisions of the managed care regulations apply to different entities. This table uses the term “managed care plans” to refer collectively to MCOs, PIHPs, and PAHPs, all of which are included in the specific regulatory provisions addressed in the table. In certain cases (e.g., certain quality measurement and improvement requirements), the regulatory provision may also apply in part to certain PCCM entities, but each regulatory provision should be reviewed to determine which types of managed care entities are addressed.

Notes

- 1 Centers for Medicare & Medicaid Services, "Medicare Enrollment Dashboard," <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/EnrollmentDashboard.html>.
- 2 Sara Rosenbaum, "Medicaid and Access to Care: The CMS Equal Access Rule," *Health Affairs* (blog), November 19, 2015, <http://healthaffairs.org/blog/2015/11/19/medicaid-and-access-to-care-the-cms-equal-access-rule/>.
- 3 Centers for Medicare & Medicaid Services, "Medicaid Program; Request for Information- Data Metrics and Alternative Processes for Access to Care in the Medicaid Program," 80 Fed. Reg. 67377 (November 2, 2015), <https://federalregister.gov/a/2015-27696>.
- 4 Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services, *Access to Health Care in America* (Washington, DC: National Academy Press, 1993).
- 5 MACPAC, "Report to Congress on Medicaid and CHIP" (Washington, DC: MACPAC, 2011), <https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-311/>.
- 6 Marsha Gold and Genevieve Kenney, "Monitoring Access: Measures to Ensure Medi-Cal Enrollees Get the Care They Need" (Oakland: California HealthCare Foundation, 2014), [http://www.chcf.org/~media/MEDIA_LIBRARY/Files/PDF/PDF M/PDF MonitoringAccessMediCal.pdf](http://www.chcf.org/~media/MEDIA_LIBRARY/Files/PDF/PDF%20M/PDF%20MonitoringAccessMediCal.pdf).
- 7 Mike Davern, "Recommendations for Monitoring Access to Care among Medicaid Beneficiaries at the State Level" (Chicago: NORC, 2013), <https://aspe.hhs.gov/pdf-report/recommendations-monitoring-access-care-among-medicaid-beneficiaries-state-level>.
- 8 Centers for Medicare & Medicaid Services, "Quality of Care Health Disparities," <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-health-disparities.html>; US Department of Health and Human Services, Office of Minority Health, "Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status," <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=23>.
- 9 Johnson R. "The Changing Face of Patient Care: Delivering Patient-Centered and Culturally Competent Care in an Evolving World." *Delaware Medical Journal* [serial online]. March 2015;87(3):85-87.
- 10 Benjamin D. Sommers and Richard Kronick, "Measuring Medicaid Physician Participation Rates and Implications for Policy," *Journal of Health Politics, Policy and Law*, January 5, 2016, <http://jhppl.dukejournals.org/content/early/2015/12/22/03616878-3476117>.
- 11 Janet M. Coffman, Denis Huett, Margaret Fix, and Andrew B. Bindman, "Physician Participation in Medi-Cal: Ready for the Enrollment Boom?" (Oakland: California HealthCare Foundation, 2014), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20P/PDF%20PhysicianParticipationMediCalEnrollmentBoom.pdf>.
- 12 Pennsylvania Department of Human Services, "Pennsylvania Access Monitoring Draft Review Plan" (Harrisburg: Pennsylvania Department of Human Services, 2016), http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_230992.pdf.
- 13 Georgia Families, "Quality Strategic Plan for Georgia Families" (Atlanta: Department of Community Health, 2016), <https://dch.georgia.gov/medicaid-quality-reporting>.
- 14 New York State Department of Health, "Quality Incentive for Medicaid Managed Care Plans" (Albany: New York State Department of Health, 2015), https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2015/docs/quality_incentive.pdf.

- 15 California Department of Healthcare Services, “Monitoring Access to Medi-Cal Covered Healthcare Services”; Colorado Trust and Colorado Health Institute, “A New Day in Colorado: Health Insurance Reaches Record High” (Denver, Colorado Health Institute: 2015), http://www.coloradohealthinstitute.org/uploads/downloads/2015_CHAS_for_Web_.pdf; Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services, “Monitoring Access to Care in New Hampshire’s Medicaid Program” (Concord: Department of Health and Human Services, 2012), <http://www.dhhs.nh.gov/ombp/documents/nhmedicaidaccesstocareinformationreportnovember2012.pdf>.
- 16 Pennsylvania Department of Human Services, “Pennsylvania Access Monitoring Draft Review Plan.”
- 17 Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services, “Monitoring Access to Care in New Hampshire’s Medicaid Program”; Georgia Families, “Quality Strategic Plan for Georgia Families”; Texas Health and Human Services Commission, “Annual Report: Medicaid and CHIP Quality-Based Initiatives and Recommendations by the Medicaid and CHIP Quality-Based Payment Advisory Committee” (Austin: Health and Human Services Commission, 2014), <http://www.hhsc.state.tx.us/reports/2014/SB7-MCDQBI-QBIPAC-Recommendations-102014.pdf>.
- 18 Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services, “Monitoring Access to Care in New Hampshire’s Medicaid Program.”
- 19 According to CMS, the number was 59,337,953 as of July 2015. See Medicaid, “Total Medicaid Enrollees: VIII Group Break-Out Report July 2015” (Baltimore: CMS, 2016), <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/cms-64-enrollment-report-july-sept-2015.pdf>.
- 20 According to CMS, the number was 56,459,538 as of April 2016. See Kaiser Family Foundation, “Featured Dual Eligible Resources” (Washington, DC: Kaiser Family Foundation), <http://kff.org/tag/dual-eligible/>.
- 21 Centers for Medicare & Medicaid Services, “CMS Program Statistics,” <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/EnrollmentDashboard.html>.
- 22 Rosenbaum, “Medicaid and Access to Care”
- 23 Centers for Medicare & Medicaid Services, “Medicaid Program; Methods for Assuring Access to Covered Services,” 42 CFR § 447 (May 6, 2011), <https://federalregister.gov/a/2011-10681>.
- 24 Centers for Medicare & Medicaid Services, “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability,” 42 CFR §§ 431, 433, 438, 440, 457, 495 (June 1, 2015), <https://federalregister.gov/a/2015-12965>.
- 25 Centers for Medicare & Medicaid Services, “Medicaid Program: Request for Information—Data Metrics and Alternative Processes for Access to Care in the Medicaid Program,” 80 FR 67377, and “Medicaid Program: Methods for Assuring Access to Covered Medicaid Services,” 80 FR 67576 (November 2, 2015), <https://federalregister.gov/a/2015-27696>.
- 26 80 FR 67377.
- 27 Centers for Medicare & Medicaid Services, Medicaid, and Children’s Health Insurance Program, “Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability,” 81 FR 27498 (May 6, 2016), <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.
- 28 Note quality measurement often subsumes access measures. See Jeanne Mandelblatt, K. Robin Yabroff, and Jon Kerner, “Access to Quality Cancer Care: Evaluating and Ensuring Equitable Services, Quality of Life, and Survival,” (Washington, DC: National Academy of Sciences, no date), [https://www.nationalacademies.org/hmd/~media/Files/Activity%20Files/Disease/NCPF/mandle.pdf](https://www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Disease/NCPF/mandle.pdf).

- 29 Agency for Healthcare Quality and Research, “2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy,” (Rockville, MD: AHRQ, 2016), <http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/nhqdr15/2015nhqdr.pdf>.
- 30 Centers for Medicare & Medicaid Services. “CMS Quality Strategy”, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html>
- 31 Centers for Medicare & Medicaid Services, “2015 National Impact Assessment of the CMS Quality Measures Report, March 2, 2015” (Baltimore: CMS, 2015), <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualitymeasures/downloads/2015-national-impact-assessment-report.pdf>.
- 32 Ibid.
- 33 Measure Applications Partnership, “MAP Medicaid Adult and Child Task Forces In-Person Meeting,” May 2016, <http://www.qualityforum.org/ProjectMaterials.aspx?projectID=75335>.
- 34 US Department of Health and Human Services, “2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP” (Washington, DC: US DHHS, 2016), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-sec-rept.pdf>.
- 35 However, eight states reported on fewer than 10 measures in FFY 2014, and five of those states reported on fewer than five measures. The least frequently reported measures were Behavioral Risk Assessment for Pregnant Women (4 states reporting), Cesarean Section for Nulliparous Singleton Vertex (16 states reporting), and Developmental Screening in the First Three Years of Life (20 states reporting).
- 36 As an exercise in reviewing the Core Set measures, the NQF MAP recently mapped all measures to the National Academy of Medicine’s Vital Metrics framework, and thus identified some Core Set measures as relating to access. For example, these included Child and Adolescents’ Access to Primary Care, Well Child Visits (in the first 15 months; and in the 3rd, 4th, 5th, and 6th years of life), and Follow-Up after Hospitalization for Mental Illness (ages 6-20). In doing so, the MAP noted that the Core Set measures did not map perfectly to the NAM Vital Metrics domains due to overlapping concepts. Indeed, some measures mapped to other domains could also have been considered measures of access.
- 37 Again, the NQF MAP has linked some of them to the National Academy of Medicine’s Vital Metrics access domain. Among the Adult Core Set, all measures the NQF MAP identified as related to access pertain to behavioral health, including Follow-Up After Hospitalization for Mental Illness: Age 21 and Older, Antidepressant Medication Management, and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.
- 38 US Department of Health and Human Services, “2015 Annual Report on the Quality of Care for Adults in Medicaid” (Washington, DC: US DHHS, 2016), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-adult-sec-rept.pdf>.
- 39 Only one state reported on fewer than 10 measures, but 14 states reported on 15 or fewer measures. The least frequently reported measures were HIV Viral Load Suppression (3 states reporting), Antenatal Steroids (3 states reporting), Care Transition—Timely Transmission of Transaction Record (4 states reporting), and Screening for Clinical Depression and Follow-up Plan (5 states reporting).
- 40 NORC, “Methodology Report: 2014–2015 Nationwide Medicaid CAHPS Survey” (Chicago: NORC, 2015), http://www.norc.org/pdfs/CAHPS/CAHPS_methodsfinalreport508.pdf.
- 41 NORC, “Nationwide Adult Medicaid CAHPS,” <http://www.norc.org/Research/Projects/Pages/nationwide-adult-medicaid-cahps.aspx>.
- 42 Medicaid.gov, “Health Home Information Resource Center,” <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2013-2015-health-home-core-set.pdf>.

- 43 Cindy Mann to State Medicaid Directors, Letter 13-001: Health Home Core Quality Measures, January 15, 2013, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-001.pdf>.
- 44 National Quality Forum, “Measuring HCBS Quality,” http://www.qualityforum.org/Measuring_HCBS_Quality.aspx.
- 45 National Quality Forum, “Home and Community-Based Services Quality,” <http://www.qualityforum.org/projectmaterials.aspx?Projectid=77692>.
- 46 National Quality Forum, “Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living: Synthesis of Evidence and Environmental Scan,” Interim Report (Washington, DC: National Quality Forum, 2015), <http://nqf.informz.net/z/cjUucD9taT01Mjk2NDc2JnA9MSZ1PTEwNTk2NTkyMzEmbGk9MzI5MTY4MTE/index.html>.
- 47 National Core Indicators: Aging and Disabilities, “Adult and Disability Adult Consumer Survey, 2015–2016 Mid-Year Results,” (Washington, DC: National Association of States United for Aging and Disabilities and Human Services Research Institute), http://nci-ad.org/upload/reports/NCI-AD_2015-2016_Six_State_Mid-Year_Report_FINAL.pdf.
- 48 See California Department of Health Care Services, “Healthcare Access Monitoring Reports,” http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Healthcare_Access_Report.aspx, and Arizona Health Care Cost Containment System, “Access to Care 2015 Projection for FFY 2016” (Phoenix: AHCCCS, 2015), https://www.azahcccs.gov/plansproviders/Downloads/ffsrates/accesstocare2015_Web.pdf.
- 49 US Department of Health and Human Services, “2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP.”
- 50 US Department of Health and Human Services, “2015 Annual Report on the Quality of Care for Adults in Medicaid.”
- 51 MACPAC, “Key Findings on Access to Care,” <http://www.macpac.gov/subtopic/measuring-and-monitoring-access/>.
- 52 Karen Onstad, Aisha Khan, Alyssa Hart, Rich Mierzejewski, Faye Xia, Kate Stewart, and Margo Rosenbach, “Benchmarks for Medicaid Adult Health Care Quality Measures” (Cambridge, MA: Mathematica Policy Research, 2014), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/adultbenchmarkreport.pdf>.
- 53 Services that must be analyzed at least every three years include primary care services, physician specialist services, behavioral health services, pre- and postnatal obstetric services including labor and delivery, and home health services.
- 54 Centers for Medicare & Medicaid Services, “Notice of Proposed Rulemaking: Medicaid and Children’s Health Insurance Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third-Party Liability,” 80 FR § 31098 (June 1, 2015), <https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicoid-managed-care-chip-delivered>.
- 55 Centers for Medicare & Medicaid Services, “Medicaid Program and Children’s Health Insurance Program (CHIP) Programs,” RFI, 80 FR § 67378 (November 2, 2015).
- 56 Centers for Medicare and Medicaid Services, Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 FR § 27498 (May 6, 2016).
- 57 Centers for Medicare and Medicaid Services, Medicaid Program and Children’s Health Insurance Program (CHIP) Programs. 42 CFR § 447.204 (1978).
- 58 A version of this requirement has been part of Medicaid policy since the law’s enactment. See Rosenbaum, S, *Medicaid Payment Rate Lawsuits: Evolving Court Views Mean Uncertain Future for Medi-Cal*. California HealthCare Foundation (October 2009). <http://www.chcf.org/publications/2009/10/medicaid-payment-rate-lawsuits->

evolving-court-views-mean-uncertain-future-for-medical. The quoted text was found in the 1978 version of 42 CFR § 447.204, which re-codified, without substantive policy changes, earlier versions of Medicaid regulations. See 43 FR 45176 (September 29, 1978) (addressing Medicaid recodification effort).

59 Section 1902(a)(30)(A) of the Social Security Act [42 U.S.C. § 1396a(a)(30)(A)].

60 Note: Historically, this applied only to FFS programs.

61 Centers for Medicare and Medicaid Services. Medicaid Program and Children’s Health Insurance Program (CHIP) Programs; Methods for Assuring Access to Covered Services. May 2011. 42 CFR 447. <https://federalregister.gov/a/2011-10681>.

62 Centers for Medicare and Medicaid Services, Notice of Proposed Rulemaking: Medicaid and Children’s Health Insurance Programs; Medicaid Managed Care, CHIP Delivered in managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, 80 FR § 31098 (June 1, 2015).

63 Centers for Medicare and Medicaid Services, Medicaid Program and Children’s Health Insurance Program (CHIP) Programs; Methods for Assuring Access to Covered Medicaid Services, Final Rule, 80 FR § 67576 (Nov. 2, 2015).

64 The services that must be analyzed at least every three years include: primary care services, physician specialist services, behavioral health services, pre- and post-natal obstetric services including labor and delivery, and home health services.

65 Centers for Medicare and Medicaid Services, Medicaid Program and Children’s Health Insurance Program (CHIP) Programs. RFI, 80 FR § 67378 (Nov. 2, 2015).

66 Centers for Medicare and Medicaid Services, Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 FR § 27498 (May 6, 2016), . <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.

67 Other provisions are also relevant to access monitoring and measurement and, in the future, could be incorporated into a robust access monitoring plan, such as standards addressing cultural competency, coordination and continuity of care, and access to LTSS.

68 Centers for Medicare & Medicaid Services, “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third-Party Liability, Final Rule,” 81 FR § 27661.

69 The final rule amends existing quality assessment and performance improvement (QAPI) requirements to add “specialized mechanisms to assess the quality and appropriateness of care furnished to enrollees receiving LTSS” (81 FR 27676). It also sets forth a process for CMS to develop national performance measures that all states would report on (42 CFR § 438.330(a)(2)). This new regulatory authority provides a mechanism for CMS to adopt in the future—following public notice and comment—mandatory national access measures.

70 CMS will identify performance measures and a methodology for a Medicaid managed care quality rating system. States must either adopt the framework developed by CMS or adopt and implement an alternative quality rating system subject to CMS approval. Every year the state must collect data from each managed care plan and issue (and publish) a quality rating for each plan.

71 States’ managed care quality strategies will be required to include their network adequacy and availability of services standards (42 CFR § 438.340(b)(1)). A state’s managed care quality strategy must identify its performance improvement projects, “including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP [prepaid inpatient health plan], or PAHP [prepaid ambulatory health plan].” (42 CFR § 438.340(b)(3)(ii)). The final rule also includes new requirements to address health care disparities in Medicaid managed care. CMS declined, however, to require states to include FFS in their state quality strategies (81 FR 27692).

- 72 MACPAC, “Report to the Congress on Medicaid and CHIP.”
- 73 Marsha Gold and Genevieve Kenney, “Monitoring Access: Measures to Ensure Medi-Cal Enrollees Get the Care They Need.” (Oakland: California HealthCare Foundation, 2014), http://www.chcf.org/~media/MEDIA_LIBRARY/Files/PDF/PDF M/PDF MonitoringAccessMediCal.pdf.
- 74 Roy Penchansky and J. William Thomas, “The Concept of Access: Definition and Relationship to Consumer Satisfaction,” *Medical Care* 19, no. 2 (1981): 127–40.
- 75 Jean-Frederic Levesque, Mark Harris, and Grant Russell, “Patient-Centered Access to Health Care: Conceptualising Access at the Interface of Health Systems and Populations,” *International Journal for Equity in Health* 12, no. 18 (2013), <http://equityhealth.biomedcentral.com/articles/10.1186/1475-9276-12-18>.
- 76 Lu Ann Aday and Ronald Andersen, “A Framework for the Study of Access to Medical Care,” *Health Services Research* 9, no. 3 (1974): 208–20.
- 77 Davern, “Recommendations for Monitoring Access to Care among Medicaid Beneficiaries at the State Level.”
- 78 Penchansky and Thomas, “The Concept of Access.”
- 79 Levesque et al. “Patient-Centered Access to Health Care.”
- 80 Davern, “Recommendations for Monitoring Access to Care among Medicaid Beneficiaries at the State Level.”
- 81 Johnson R. The changing face of patient care: delivering patient-centered and culturally competent care in an evolving world. *Delaware Medical Journal* [serial online]. March 2015;87(3):85-87.
- 82 For measures not included in the Core Sets, we sought to identify examples of use in a sample of diverse states. To do so, we systematically reviewed relevant access and quality measurement reports as well as strategic plans (depending on availability). The 10 states included in our review were Arizona, California, Colorado, Florida, Georgia, Minnesota, New Hampshire, New York, Oregon, and Pennsylvania; they represent a wide range of geographies, populations, and Medicaid delivery systems. We found at least one example of current reporting on (or in the case of quality strategic plans, plans to report on) every measure in our list, including those not part of the current Adult and Child Core Sets. Many of our measures were being collected in several states. These examples are incorporated throughout the report where appropriate.
- 83 Centers for Medicare and Medicaid Services, “Quality of Care Health Disparities,” <https://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-health-disparities.html>; US Department of Health and Human Services, Office of Minority Health, “Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status,” <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=23>.
- 84 42 CFR § 438.242; Suzanne Martin, “Not All States Reported Medicaid Encounter Data as Required,” Office of the Inspector General Report # OEI-07-13-00120 (Washington, DC: US DHHS, 2015), <http://oig.hhs.gov/oei/reports/oei-07-13-00120.pdf>.
- 85 Sylvia Burwell, “2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP” (Washington, DC: US DHHS, 2016), <https://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-sec-rept.pdf>.
- 86 Ibid.
- 87 Sommers and Kronick, “Measuring Medicaid Physician Participation Rates and Implications for Policy.”
- 88 Georgia has developed standards for Timely Access to Care and Services that measure appointment availability for primary, maternity, vision, dental, and behavioral health providers as part of their Quality Strategic Plan for 2016. The state has not published specifications or collected this measure yet. One example of specification of such measures is found in Missouri’s Medicaid managed care program.

- 89 Department of Health and Human Services. Report to Congress. March 2011. “National Strategy for Quality Improvement in Health Care”, <http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf>
- 90 Sommers and Kronick, “Measuring Medicaid Physician Participation Rates and Implications for Policy.”
- 91 Coffman et al., “Physician Participation in Medi-Cal.”
- 92 Pennsylvania Department of Human Services, “Pennsylvania Access Monitoring Draft Review Plan.”
- 93 Georgia Families, “Quality Strategic Plan for Georgia Families.”
- 94 New York State Department of Health, “Quality Incentive for Medicaid Managed Care Plans.”
- 95 For example, in terms of our proposed access measures from the Child and Adult Core Sets, T-MSIS would likely support construction of the measure of children’s receipt of dental services, but would not support construction of the prenatal and postpartum measures, given that many states rely on global maternity payments.
- 96 California Department of Health Care Services, “Monitoring Access to Medi-Cal Covered Health Care Services”; Colorado Trust and Colorado Health Institute, “A New Day in Colorado: Health Insurance Reaches Record High”; Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services, “Monitoring Access to Care in New Hampshire’s Medicaid Program.”
- 97 Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services, “Monitoring Access to Care in New Hampshire’s Medicaid Program”; Texas Health and Human Services Commission, “Annual Report: Medicaid and CHIP Quality-Based Initiatives and Recommendations by the Medicaid and CHIP Quality-Based Payment Advisory Committee”; Georgia Families, “Quality Strategic Plan for Georgia Families.”
- 98 Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services, “Monitoring Access to Care in New Hampshire’s Medicaid Program.”
- 99 Pennsylvania Department of Human Services, “Pennsylvania Access Monitoring Draft Review Plan.”
- 100 NORC, “Methodology Report.”
- 101 NGA letter to the Honorable Orrin Hatch and the Honorable Ron Wyden, January 8, 2016 (<http://www.nga.org/cms/home/federal-relations/nga-letters/health--human-services-committee/col2-content/main-content-list/medicaid-data-and-reporting.html>), stating, “For this reason, CMS should make aggregate, non-aggregate and analyzed data available confidentially to states for the purposes of benchmarking, quality improvement, and measuring efficiency.”
- 102 NAMD letter to the Honorable Orrin Hatch and the Honorable Ron Wyden, January 8, 2016 (<http://medicaiddirectors.org/wp-content/uploads/2016/01/NAMD-Response-to-SFC-data-request-160108-1.pdf>), stating, “Due to the issues discussed above, states remain concerned about the public availability of the data they submit through T-MSIS. We believe states must have a role in prioritizing the audiences and focus of data releases.”
- 103 Onstad et al., “Benchmarks for Medicaid Adult Health Care Quality Measures.”
- 104 Arti Parikh-Patel, Cyllene R. Morris, Robert Martinsen, and Kenneth Kizer, “Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance” (Davis: UC Davis Institute for Population Health Improvement, 2015), https://www.ucdmc.ucdavis.edu/iphi/resources/1117737_cancerhi_100615.pdf. This analysis did not use information from Medicaid administrative data, so it was not possible to assess the information in the cancer registry in combination with information on Medicaid enrollment history and duration.
- 105 Onstad et al., “Benchmarks for Medicaid Adult Health Care Quality Measures.”
- 106 All-payer claims databases may take the longest time to develop, but we recommend that CMS continue to explore the possibilities. In *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016), the Supreme Court ruled that

states do not have the legal authority to require self-insured, self-funded health insurance plans (i.e., ERISA plans) to participate in all-payer claims databases. The full impact of the decision is not yet known. See William Sage, “Out of Many, One: ERISA Preemption, State All-Payer Claims Database Laws, and the Goals of Transparency.” *Health Affairs* (blog), March 10, 2016, <http://healthaffairs.org/blog/2016/03/10/out-of-many-one-erisa-preemption-state-all-payer-claims-database-laws-and-the-goals-of-transparency/>.

- 107 Centers for Medicare & Medicaid Services, “Access to Care Issues among Qualified Medicare Beneficiaries” (Baltimore: CMS, 2015), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.
- 108 Grievances are unique to the managed care system but when we refer to *grievances* or *appeals*, we intend to capture both formal and informal concerns raised by enrollees. Such concerns might be raised through grievances and appeals or state fair hearings in managed care, or state fair hearings in FFS, or through informal inquiries or expressions of concern by phone or otherwise for either managed care or FFS.
- 109 Grievance and appeals data include office wait time; length of time to get appointment; inability to find provider/time and distance to provider; inability to obtain requested service other than pharmacy or extra benefit (i.e., provider inaction); inability to obtain listed extra benefit; involuntary discharge by provider; provider administrative barriers to access; administrative barrier to access (plan ID card, incorrect third party liability(TPL) information, provider requiring payment by member, or health plan eligibility); and “other” access to care issues.
- 110 Pennsylvania Department of Human Services, “Pennsylvania Access Monitoring Draft Review Plan.”
- 111 Services that must be analyzed at least every three years include primary care services, physician specialist services, behavioral health services, pre- and postnatal obstetric services including labor and delivery, and home health services.
- 112 Mathematica Policy Research, comments submitted to Nov. 2015 RFI, <https://www.regulations.gov/document?D=CMS-2011-0062-0362>.
- 113 Health Resources and Services Administration, “Explore the Title V Federal-State Partnership,” <https://mchb.tvisdata.hrsa.gov/>.
- 114 The new monitoring requirements will go into effect for contracts starting on or after July 1, 2017 (42 CFR § 438.66(f)). The initial reports will be due “after the contract year following the release of CMS guidance on the content and form of the report” (42 CFR § 438.66(e)(1)(i)). Annual reports will be due 180 days after each contract year.