



December 24, 2015

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

**Attention: CMS-2328-NC
Medicaid Program; Request for Information (RFI) – Data Metrics and Alternative
Processes for Access to Care in the Medicaid Program**

Dear Sir/Madam:

Thank you for the opportunity to comment on CMS–2328–NC, “Medicaid Program; Request for Information (RFI) – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program,” hereinafter referred to as the Request for Information (RFI).

The Center for Children and Families is based at Georgetown University’s Health Policy Institute with the mission of improving access to health care coverage among the nation’s children and families, particularly those with low and moderate incomes. Much of our work relates to access to services in public programs.

In 2014, the full implementation of the Affordable Care Act (ACA) resulted in the largest single-year reductions in the number and percentage of uninsured Americans on record. The number of uninsured fell by 8.8 million from 2013 to 2014, resulting in a decline in the uninsured rate from 13.3 to 10.4 percent. Though the bulk of the coverage provisions in the ACA focused on adults, just as earlier research suggested, children have benefited as well. The uninsured rate among children dropped to a historic low of 6.3 percent in 2014, and those states that expanded Medicaid to cover more uninsured adults saw nearly double the rate of decline in uninsured children as compared to states that did not expand. Some coverage gaps remain, particularly among 26- to 34-year olds, Hispanics, residents of the South and West, the un- and under-employed and people living in low-income households, especially in states that have not implemented the Medicaid expansion.

Access Framework

As more and more children and families gain health coverage, the question of how to measure and improve access to affordable and effective health care is of increasing

importance. Monitoring access in Medicaid has been a challenge for decades, but fortunately the increased attention to access concerns in recent years has moved the dialogue forward with respect to measuring and monitoring access over time. Drawing from several useful resources¹, we suggest following the four-point framework below for monitoring access with relevant data sources and measures in Appendix A. These measures should be evaluated across Medicaid delivery systems within a state and should allow for comparisons between Medicaid and the general population in the geographic area as well as between Medicaid programs in different states. Additionally, we suggest that access be separately monitored for children, as was done in the development of the access indices in Colorado², because there may be significant differences in access today that will dictate different strategies for improvement. Finally, the measures listed in Appendix A are simply an illustrative example of some of the measures that are available from existing data sources that could be used to monitor access. Other data sources and other measures from these data sources should also be considered.

- (1) Potential Access: Adequate insurance coverage and a sufficient number of local providers make it more likely that beneficiaries will get the care they need. Potential access measures include the number of participating providers in the geographic area and the number of participating providers who are accepting new patients, relative to the number of beneficiaries.
- (2) Barriers to Access: Many obstacles make it hard for beneficiaries to get needed health care, even if they have insurance and there are providers available. Barriers to access measures include delaying care due to cost and lack of a medical home.
- (3) Realized Access: Use of appropriate health services is a good indication of adequate access to care. Realized access measures include good indicators, like a preventive or well-child visit and poor indicators, like multiple emergency department visits.
- (4) Patient Satisfaction and Health Outcomes: Consistent receipt of appropriate care results in improved health outcomes. Health outcome measures include beneficiaries reporting good or excellent health and full-term deliveries among other things.

Federal Core Set

We suggest that HHS review the possible measures and data sources available, including the sample measures identified in Appendix A, and establish a core set of access measures that states must include in their access monitoring review plans. As with the pediatric and adult core measure sets for quality, establishing a federal core set helps states prioritize data collection and allows for longitudinal and national analyses. Initially, HHS could

¹ See for example: [Monitoring Access: Measures to Ensure Medi-Cal Enrollees Get the Care They Need](#) by Marsha Gold and Genevieve Kenney; [Recommendations for Monitoring Access to Care among Medicaid Beneficiaries at the State-level](#) by NORC at the University of Chicago; the [Colorado Access to Care Index](#) by the Colorado Health Institute and the Colorado Coalition for the Medically Underserved; and [Examining Access to Care in Medicaid and CHIP](#) by MACPAC.

² See the [Colorado Access to Care Indices](#) for the General Population and Children.

simply collect and monitor the core set measures from each state, but over time, HHS should set specific thresholds to ensure beneficiaries across the country have equal access to care as the statute requires. The thresholds should be set realistically, but adjusted over time to ensure continual improvement. Continual monitoring of a core set of measures will allow HHS to set national goals and identify successful strategies to promote as models to all states.

Measures and Data Sources

Each of the measures identified in Appendix A was selected with the goal of minimizing administrative burden, while still allowing for a robust set of measures to evaluate access in Medicaid and draw comparisons to other coverage sources. The identified data sources are: the Transformed Medicaid Statistical Information System (TMSIS), the National Health Interview Survey (NHIS), the National Ambulatory Medical Care Survey (NAMCS), the Consumer Assessment of Health Plans Survey (CAHPS), the Health Plan Employer Data and Information Set (HEDIS), the Behavioral Risk Factor Surveillance System (BRFSS) and birth and death records. However, each of these data sources has limitations that would need to be addressed over time in order to ensure the accuracy and precision of the data. For example, sample sizes for many of the surveys would need to be increased in order to allow for state-specific analysis of Medicaid beneficiaries. Meanwhile, HHS could use the responses from multiple years to gain a more robust data set.

Other data sources have more specific limitations that would need to be accounted for, like the time needed for states to fully implement TMSIS with integrated claims and encounter data and the need to expand surveys like BRFSS to include children. Finally, certain measures that would help evaluate health outcomes (i.e., hospital admission for uncontrolled diabetes or asthma) were not included because not all states participate in the Healthcare Cost and Utilization Project (HCUP), but claims and encounter data may be available that would help monitor these ambulatory-sensitive conditions. Despite these limitations, the data sources identified would allow for some stratification by key variables such as race, ethnicity, age, gender, income and type of insurance coverage.

Process for Beneficiaries, Providers and other Stakeholders to Raise Access Concerns

HHS should also establish a process that would allow applicants, enrollees, providers, and other stakeholders to raise and seek resolution of concerns about access. In the final rule with comment period that HHS issued concurrently with this RFI (CMS-2328-FC), HHS requires an access review when the state or CMS has received a significantly higher than usual volume of access complaints (§447.203(b)(5)(G)). We support this provision, but believe that additional clarification is required. States may include different processes in their access monitoring review plans that would allow beneficiaries, providers and other stakeholders to raise access concerns, but the central repository that Louisiana has created

for all complaints, grievances, and appeals for managed care could serve as a model that could be adapted to capture all access related complaints and concerns.³

However, individual state processes may not be sufficient to ensure access, which points to the need for HHS to also establish a federal process. As HHS notes in the background section of the RFI, the Supreme Court's decision in *Armstrong v. Exceptional Child Center, Inc.*, "plac[es] greater importance on CMS review to ensure that rates are 'consistent with efficiency, economy and quality of care' and ensure sufficient beneficiary access to care under the program."⁴ In order for this review to adequately address access issues, beneficiaries, providers and other stakeholders must have a clear mechanism to trigger federal oversight.

It should be noted that in addition to measuring access to services once enrolled, we must have a better understanding of access to the program itself. Eligibility requirements are complex and vary by state. Discontinuous eligibility and program churn create gaps in coverage that limit access to care more than many of the factors identified above. Therefore, we recommend that HHS also monitor the percent of eligible individuals who are enrolled by state and subpopulation and the rate of churn.

Specifically, CMS should collect and publish all performance indicators listed in its February 4, 2014 release of the "Medicaid and CHIP Eligibility and Enrollment Performance Indicators and Sub-indicators." Additionally, we recommend that CMS propose, offer for public comments, and finalize Phase 2 of the performance indicators to include more detailed information on renewals by type (e.g., ex parte, prepopulated form) and channel (e.g., online, telephone, etc.) and to include additional measures needed to accurately establish a churn rate both within Medicaid and between Medicaid and other insurance affordability programs. Phase 2 should include standardized denial and disenrollment codes that are more detailed than simply distinguishing between ineligibility and eligibility could not be established. A good model for these standardized reasons was developed and published as part of the Maximizing Enrollment project.⁵

³ Here's a link to Louisiana's [centralized complaint repository](#). The state refers each incident to the appropriate managed care plan, which is expected to report the resolution. Louisiana publishes and posts a [routine transparency report](#), which includes summary information about complaints, grievances and appeals, including fair hearings. Louisiana's [enabling legislation Act 212](#) provides additional information about this process.

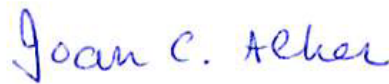
⁴ We noted inconsistent descriptions of the holding in *Armstrong* in the RFI and the accompanying final rule with comment period, CMS-2328-FC. HHS should clarify that the holding in *Armstrong* is that described at 80 FR 67577 (November 2, 2015), which reads: "Earlier this year, the Supreme Court decided in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015) that the Medicaid statute does not provide a private right of action to **providers** to enforce state compliance **with section 1902(a)(30)(A) of the Act** in federal court." (Emphasis added.)

⁵ Harrington, M., et al, "New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance, National Academy of State Health Policy and the Robert Wood

In addition to tracking these measures, HHS should continually monitor and document state eligibility rules and procedures to ensure compliance with federal regulations and to identify ways to improve the process, like increasing the share of renewals determined ex parte.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Kelly Whitener (kdw29@georgetown.edu).

Sincerely,

A handwritten signature in blue ink that reads "Joan C. Alker". The signature is written in a cursive style and is positioned to the left of a vertical line.

Joan Alker

Appendix A: Access to Care Measures

MEASURE	DATA SOURCE
POTENTIAL ACCESS	
Number of participating providers, including dentists, by provider type	TMSIS
Number and range of beneficiaries served per provider	TMSIS
Beneficiaries reporting usual source of care	NHIS
Physicians accepting any/new patients	NAMCS
Physicians accepting any/new patients in practices with midlevel providers by primary care providers and specialists	NAMCS
Percentage of physician patient population with Medicaid coverage by primary care providers and specialists	NAMCS
BARRIERS TO ACCESS	
Beneficiaries reporting delayed care and reason for delay	NHIS
Beneficiaries that delayed medical care due to cost	NHIS
Beneficiaries who experienced trouble finding a general doctor or provider	NHIS
Beneficiaries who were not accepted as new patients	NHIS
Beneficiaries who visited doctors' offices that did not accept their form of health insurance	NHIS
Beneficiaries who delayed medical care because they could not get an appointment soon enough	NHIS
Unmet need for specialty care, primary care, follow-up care, dental care, prescription drugs, therapies, mental health counseling, eyeglasses due to cost concerns	NHIS
If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?	NHIS
Physicians experiencing difficulties referring patients for specialty care	NAMCS
In the last 6 months, when your child needed care right away, how often did your child get the care as soon as he or she needed?	CAHPS
In the last 6 months, how often did you get an appointment for a check-up or routine care for your child at a doctor's office or clinic as soon as your child needed?	CAHPS
In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?	CAHPS
REALIZED ACCESS	
At least one physician visit in prior year	NHIS, TMSIS
Primary care visit in prior year, including care from mid-levels	NHIS, HEDIS, TMSIS

Preventive child/adult checkup in the prior year	NHIS, BRFSS, HEDIS, TMSIS
Dental visit in prior year	NHIS, TMSIS
Specialty visit in prior year	NHIS, TMSIS
Mental health visit in prior year	NHIS, TMSIS
Beneficiaries with chronic conditions with visit to specialist or mental health provider	NHIS, TMSIS
Women receiving a pap smear	NHIS
Women receiving a mammogram	NHIS
Beneficiaries receiving a flu shot	NHIS
Children/adolescents receiving appropriate immunizations	HEDIS
One/multiple emergency department visit	NHIS, TMSIS
Women receiving adequate prenatal care	Birth Records, TMSIS
Beneficiaries getting needed care	CAHPS
Beneficiaries getting care quickly	CAHPS
PATIENT SATISFACTION AND HEALTH OUTCOMES	
Beneficiaries in good or excellent health	NHIS
Preterm births, low and very low birth weight births, neonatal mortality	Birth and death records, TMSIS
For individuals with specific chronic conditions, control of blood pressure, blood sugar, cholesterol, etc.	TMSIS
Beneficiaries with one/multiple poor mental health days in the past month	NHIS, BRFSS
Beneficiaries that are current smokers	NHIS
Beneficiaries that are obese/overweight	NHIS
How well do doctors communicate?	CAHPS
In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?	CAHPS
In the last 6 months, how often did your child's personal doctor listen carefully to you?	CAHPS
In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?	CAHPS
In the last 6 months, how often did your child's personal doctor spend enough time with your child?	CAHPS
In the last 6 months, how often did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?	CAHPS