MACPAC
Medicaid and CHIP Payment and Access Commission

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July 5, 2011

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-2328-P "Methods for Assuring Access to Covered Medicaid Services"

Dear Secretary Sebelius:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled "Methods for Assuring Access to Covered Medicaid Services." MACPAC is a non-partisan, independent congressionally established commission charged with reviewing state and federal Medicaid and CHIP access and payment policies and making recommendations to the Congress, the Secretary of Health and Human Services, and the states on a wide range of topics affecting Medicaid and CHIP populations.

The Commission is also charged with reviewing Medicaid and CHIP regulations that affect access, quality, and efficiency of health care. Our March and June 2011 reports to the Congress addressed access to care and payment issues for the Medicaid population in both fee for service and managed care. We support CMS' efforts to improve and monitor access to care for the Medicaid and CHIP populations, and we recognize that this proposed rule is a first step in developing guidance on assessing access to care for Medicaid and CHIP enrollees.

MACPAC's statutory charge includes analysis of access to appropriate, quality health care services for Medicaid and CHIP enrollees. As part of our charge, we developed an access framework in our March 2011 *Report to the Congress on Medicaid and CHIP* that considers the complex characteristics and health needs of the Medicaid and CHIP populations, as well as program variability across states. We expect the Commission's access framework to evolve to address new health care practice patterns and changing program needs.

The preamble to the proposed rule draws upon the Commission's initial framework for evaluating access to care for Medicaid and CHIP enrollees. CMS has recognized that the framework we developed for our Commission's work provides a useful mechanism to identify factors affecting access to care for low-income individuals.

We appreciate that CMS has drawn upon aspects of our framework in this rule, but note that we did not participate or consult with CMS on the content or development of the proposed rule. Recognizing the challenge of assessing access to care for the

low-income population and acknowledging the administrative, resource, and data constraints in such an undertaking, we offer the following comments to the proposed rule:

Linking access to quality, efficiency, and economy. The Commission encourages CMS to further consider all provisions of Section 1902(a)(30)(A) in the development of its final rule, including the requirements that Medicaid payments safeguard against unnecessary utilization and are consistent with efficiency, economy, and quality. The initial access framework in our March 2011 report includes three key evaluative components: (1) the appropriateness of services and settings, (2) efficiency, economy, and quality of care, and (3) impact on health outcomes. The Commission's March 2011 report also addresses the need for a broader view noting that payment levels alone are not the sole drivers of access. Payment methodologies and incentives to promote high quality and appropriate care should also be considered.

CMS acknowledges these same points in the preamble to the proposed rule; but the data required by the proposed regulatory language appear to only include indicators of provider availability, service utilization, and payment rates. The regulatory language omits data related to efficiency, economy, quality, and appropriateness of services, as well as comparisons to the general population. Further, the proposed rule's requirement to analyze payment data suggests a focus on payment levels as a primary determinant of access and links corrective action to address access issues to payment levels. However, as discussed in our March 2011 report, states use a variety of payment methodologies intended to align incentives in order to ensure access, appropriate utilization, and quality of care that should be considered. State payment methodologies, in addition to payment levels, may affect access to care, and they will be the subject of further examination by the Commission. The Commission recognizes that data regarding provider availability, utilization, and payment rates may be more readily available, but we believe that in order to monitor access effectively, all aspects of the framework and Section 1902(a)(30)(A) should be considered.

Data for measuring access and program accountability. As the Commission pointed out in our March and June 2011 reports, issues such as timeliness, consistency, and availability of Medicaid data have presented longstanding challenges to managing the program. In the preamble to the proposed rule, CMS indicates its intention to improve federal data collection and work with states to identify those data sources that are most useful to managing the program and assuring program integrity and accountability. We support CMS' efforts to collect and streamline appropriate data to assess access to health care for Medicaid and CHIP enrollees, particularly as these data are important for MACPAC's statutory charge to create an early-warning system to identify provider shortage areas and other factors that adversely affect access to care.

The Commission recognizes that data collection may be burdensome for states, but effective program operations and accountability necessitate some level of state data collection and monitoring. We continue to support the efforts of CMS in the development of a strategic plan for Medicaid and CHIP data that lessens burdens on states and other stakeholders while meeting program management needs. Further, we encourage CMS to explore ways in which federal data sources, including survey and administrative data, can be enhanced, linked, and shared with states to provide a more consistent and less burdensome source of information regarding access and allow data to be compared across states.

Comparisons to the general population. Section 1902(a)(30)(A) requires payment to be sufficient to enlist enough providers so that care and services are available at least to the extent that they are available to the general population in the geographic area. While consideration of access compared to the general population is not required in the proposed regulatory language, such a comparison is important to evaluating access because some access issues are not directly related to factors state Medicaid policies can address. Federal survey data and other sources could assist states in assessing access to care in their Medicaid program as compared to the general population. The Commission recognizes the challenge of determining appropriate data to address access for the broad population and notes that Medicare data may also be an important source of comparative information.

Addressing the roles of both managed care and fee for service. Assessing the adequacy of access to care is important regardless of whether an enrollee is in fee for service or managed care. In our March 2011 report we describe Section 1902(a)(30)(A) as applying to all services, regardless of whether they are provided through fee for service or managed care arrangements. Medicaid is a source of health coverage for 67 million people, and approximately 47 percent of Medicaid enrollees receive care through comprehensive risk-based managed care. Therefore, while we recognize that the proposed rule applies only to Medicaid services paid under fee for service, it is the Commission's view that efforts to evaluate Medicaid enrollee access to care should also consider risk-based managed care as a substantial number of enrollees receive their care through these types of managed care arrangements, as noted in the Commission's June 2011 *Report to the Congress: The Evolution of Managed Care in Medicaid.*

In sum, the Commission encourages CMS, in the final rule, to incorporate the principles of efficiency, economy, quality, and appropriateness of services; to consider the inclusion of services paid under risk-based managed care; and to the extent possible, minimize the administrative and data collection burden on states. We appreciate the opportunity to comment on the proposed rule, and we hope that our ongoing analyses will continue to be useful in informing the discussion. If you have any questions, please feel free to contact Lu Zawistowich, Executive Director of MACPAC.

Sincerely,

Diane Rowland

Diane Rowland, ScD
Chair

cc: Donald M. Berwick, MD