

Chapter 1:

A New Medicaid Access Monitoring System

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Recommendations

1.1 The Centers for Medicare & Medicaid Services should develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems. These measures should:

- capture potential access, realized access, and beneficiary perceptions and experiences;
- prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities; and
- be adaptable to reflect changes in measurement, policy priorities, and care delivery.

CMS should issue public reports and data at the state and national level in a consumer-friendly and research-ready format in a timely manner.

1.2 The Centers for Medicare & Medicaid Services should involve stakeholders in the development and future modifications of a new system. The agency should actively solicit and incorporate input from key stakeholders, including, but not limited to, states, beneficiaries, consumer groups, health plans, providers, researchers, and other policy experts. The process for establishing a new access monitoring system should be public and transparent.

1.3 The Centers for Medicare & Medicaid Services should field an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care.

1.4 The Centers for Medicare & Medicaid Services should further standardize and improve the Transformed Medicaid Statistical Information System data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity.

1.5 To assist states in collecting and analyzing access measures, the Centers for Medicare & Medicaid Services should provide analytical support and technical assistance.

Key Points

- States and the federal government both have statutory obligations to ensure that Medicaid provides access to services. However, the current approach to monitoring access does not measure key domains of access or provide comparable or actionable data, which are needed to assess whether the program is meeting this obligation.
- A new access monitoring system should be developed with stakeholder involvement to ensure the inclusion of measures and services that are meaningful, promote health equity, and allow for changes over time.
- Public reporting of access data and assessments will provide the Centers for Medicare & Medicaid Services, states, and other key stakeholders with information to identify problems, guide program improvement, and serve as a means of accountability.
- Fielding a federal Medicaid beneficiary survey will serve as an important tool to measure beneficiary perceptions and experiences with care, a key area where measures are currently lacking.

CHAPTER 1: A New Medicaid Access Monitoring System

Medicaid provides coverage for health care and other related services to more than 82 million of the nation’s most economically disadvantaged people, including low-income children and their families, pregnant women, people over the age of 65, and people with disabilities (MACPAC 2021 a).¹ A key measure of the effectiveness of any health coverage program is whether it provides timely access to high-quality services. Given the effects of poverty and related socioeconomic factors on the health and ability of many Medicaid beneficiaries to obtain services, ensuring access to needed services is particularly important. Further, federal and state governments have a statutory obligation to ensure access. Thus, Medicaid should have a robust monitoring system both to ensure that these requirements are being met, as well as to help identify problems and guide program improvement.

However, the current systems to monitor access are insufficient to this task, due to their design, data availability, and state capacity constraints. Current monitoring requirements in fee for service (FFS) focus on a limited number of services, do not include key services such as long-term services and supports (LTSS), and are reported only every three years. In managed care, access requirements overly rely on structural measures (e.g., network adequacy) rather than direct measures of care. Neither captures information on care that was needed but not received nor information specific to particular subpopulations. Finally, the wide variation in the measures and standards used across states limits the ability to make meaningful comparisons.

In the Commission’s view, the Centers for Medicare & Medicaid Services (CMS) should establish a new regulatory structure to monitor access and address these inadequacies. A new access monitoring system should capture the three key domains

of access: provider availability and accessibility, service use, and beneficiary perceptions and experiences of care (MACPAC 2011, Kenney et al. 2016).² In building this system, CMS should develop the measures needed to capture these domains and take steps to improve the ability to collect, analyze, and respond to access monitoring data. Specifically, such a system should have consistent requirements and comparable measures across delivery systems and states, while allowing states to add measures to meet their priorities. Measures should be chosen to reflect the priorities of multiple stakeholders, including beneficiaries, and designed to capture disparities in access to care among historically marginalized populations. Additionally, given state concerns regarding administrative burden, data collection and analysis should be designed with clear roles and expectations for CMS, states, and managed care plans; capitalize on existing efforts; and adapt over time to reflect changes in care delivery and data availability. The data collected also should be timely and actionable, allowing CMS, states, and other stakeholders to assess and respond to access issues as they are identified.

To meet these goals, the Commission draws on prior research, comments on proposed and final rules, and key informant interviews to make a series of recommendations for a new access monitoring plan:

- 1.1 The Centers for Medicare & Medicaid Services should develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems. These measures should:
 - capture potential access, realized access, and beneficiary perceptions and experiences;
 - prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities; and

- be adaptable to reflect changes in measurement, policy priorities, and care delivery.

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- 1.3 The Centers for Medicare & Medicaid Services should field an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care.
- 1.4 The Centers for Medicare & Medicaid Services should further standardize and improve the Transformed Medicaid Statistical Information System data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity.
- 1.5 To assist states in collecting and analyzing access measures, the Centers for Medicare & Medicaid Services should provide analytical support and technical assistance.

This chapter begins by describing current requirements for monitoring access under FFS and managed care and the limitations with these approaches. It then describes the goals and key elements of a new access monitoring system, including stakeholder engagement, access

measures, data collection, and implementation. The chapter concludes with the Commission's recommendations and its rationale.

Current Approach for Monitoring Access

Monitoring access to care for Medicaid beneficiaries is a requirement under both FFS and managed care. However, there are separate statutory and regulatory requirements for how states and managed care plans must monitor and ensure access to care. Even so, CMS has acknowledged that the same principles for determining access, specifically that Medicaid beneficiaries have appropriate access to services and care, apply regardless of delivery system and expressed support for a more uniform and comprehensive strategy (CMS 2022a, 2019a, 2015a; OMB 2021).

Monitoring access under fee for service

The key requirement to ensure access to Medicaid services under FFS is commonly known as the equal access provision. Specifically, § 1902(a)(30)(A) of the Social Security Act (the Act) requires that Medicaid provider payment rates 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.”

Historically, compliance with the equal access provision requirement to “enlist enough providers” had been assessed primarily through the adequacy of provider payment rates. For many years, this was enforced as a result of lawsuits filed by providers and beneficiaries. Those rulings found that payment rates were too low to ensure equal access to Medicaid services. However, on March 31, 2015, in

Armstrong v. Exceptional Child Center, Inc., 135 S. Ct. 1378 (2015), the Supreme Court ruled that Medicaid providers and beneficiaries do not have a private right of action to contest state-determined Medicaid payment rates in federal courts. In response, both the Commission and CMS concluded that federal enforcement of the equal access provision is now the primary mechanism for ensuring that Medicaid beneficiaries have sufficient access to care. As such, CMS must play a leading role in establishing and administering an access monitoring system (MACPAC 2018; CMS 2015b).

Partially in response to the *Armstrong v. Exceptional Child Center, Inc.* ruling, CMS published a final rule with comment in November 2015, describing how states must monitor and report on access to care under FFS to comply with the equal access provision. Previously, there were no federal regulations to guide states in meeting the equal access provision.³ The final rule described the processes to review the effect of changes to provider payment rates on access (CMS 2015b).

The goal of the rule was to create a more systematic and transparent approach to monitoring access in FFS that would allow CMS and others to make informed, data-driven decisions (CMS 2015b).⁴ The rule required states to submit an access monitoring review plan (AMRP) by October 1, 2016, to be updated subsequently at least every three years. States were required to make the plan available for public review and comment prior to the initial submission.⁵ The rule also required that states submit a recent access review with any state plan amendment (SPA) proposing a reduction or restructuring of payment rates that could result in diminished access. States must monitor the effects of such changes for at least three years.

Despite the intention to create a more systematic approach to access monitoring, the lack of specific guidance led to wide variation across states. The original state AMRPs submitted in 2016 varied in how they approached the task and their benchmarks for sufficient access; lack of consistency in measures continues to make

it difficult to compare access across states.⁶ Although most states reported baseline data for the five required types of services (primary care, specialist care, behavioral health, pre- and postnatal obstetric services, and home health services), the scope of monitored services is limited. Some states reported on services for which access issues had been identified, such as oral health and transportation services. States used a variety of state-specific data sources, such as utilization data from claims, self-reported access measures from beneficiary surveys, and provider enrollment figures. States also differed in the extent to which they included demographic or other enrollee characteristics that would allow them to monitor access for different populations. Although most states collected data on similar types of services and access measures, the measures often relied on multiple state-specific data sources and so are often not comparable across states (MACPAC 2017). Updated AMRPs were submitted in 2019 but as of yet are not publicly available (Silanskis 2021). Given demands on Medicaid agencies during the COVID-19 public health emergency (PHE) and concerns regarding the representativeness of the data, CMS has delayed submission of updated AMRPs, initially due in 2022, until 2024 (CMS 2022b).

In comments on the final 2015 rule, many states, especially those with high managed care enrollment, expressed concerns about the administrative burden associated with monitoring access to care and analyzing the effect of payment rate changes affecting the relatively small number of Medicaid beneficiaries in FFS.⁷ In response to these comments, the Trump Administration proposed changes to the FFS monitoring rule, but these were never finalized. The first proposed rule would have established exemptions for states with high managed care enrollment and for those making payment rate changes below a threshold (CMS 2018). The second proposed rule would have rescinded all the state requirements established in the final 2015 rule, with the goal of instead developing a new rule with a more comprehensive

approach to monitoring access, reducing the burden on states (CMS 2019a).

Assessing access in managed care

Unlike in FFS, in which states are solely responsible for ensuring access, under managed care, states contract with managed care organizations (MCOs), which are responsible for monitoring and enforcing access and quality standards and contracting with providers. Provisions for ensuring access to Medicaid services for enrollees in managed care are governed under different statutory sections: §§ 1903(m) and 1932 of the Act. MCOs are required to demonstrate and document compliance that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity (§1932 of the Act). States approve contracts, determine the provider network adequacy standards, and have an obligation to ensure that beneficiaries receive appropriate services. State contracts with MCOs describe how access to providers will be monitored and deficiencies will be corrected.

On May 16, 2016, CMS issued a comprehensive managed care rule that established new requirements for how states should assess network adequacy and accessibility of services in MCOs (CMS 2016).⁸ The rule was updated in 2020 to require states to develop and publish quantitative network adequacy standards, which could include, but were not limited to, time and distance standards for primary and specialty care providers, obstetricians and gynecologists, behavioral health providers, hospitals, pharmacies, and pediatric dental providers (42 CFR 438.68, CMS 2020a).⁹ Additionally, the rule requires states to establish quality strategies. This includes developing performance improvement projects to assess the quality and appropriateness of care and improve access, and to have an external review of access, including network adequacy standards (CMS 2016).

MACPAC's 2018 review of Medicaid managed care contracts and quality strategies found wide variation in how states established, measured, and monitored provider network adequacy. Measures of network adequacy included provider-to-member ratios, appointment scheduling and appointment wait-time standards, requirements for after-hours access, and specifications for physical and communication accessibility. Several states had separate standards for rural and urban areas. Additionally, most states used multiple methods to monitor access, including review of periodic MCO provider network files and additional network reports. Many contracts also require MCOs to submit other information that could be used for access and network adequacy monitoring, such as grievances, surveys, and encounter data (MACPAC 2018).

Limitations of the Current Approach

In the Commission's view, the current approach has several limitations. The existing system does not measure key domains of access or provide comparable and actionable data. This limits the ability of CMS and states to compare access issues across states and populations, understand policies that affect access, and identify priority areas for improvement.

First, the existing system does not capture all the domains of access, most notably beneficiary experience. For example, many states rely on administrative data to monitor access and utilization of services, but this approach does not capture unmet health needs, barriers to care, beneficiary perceptions of care, or self-reported health status. Additionally, these data do not always capture all relevant demographic or socioeconomic measures. Further, measures of provider accessibility, such as availability of translation and interpretation services for beneficiaries with limited English proficiency and

accommodations for individuals with disabilities, are often lacking.

Second, the current approach does not monitor access to many services that are of high priority to Medicaid beneficiaries and states. For example, state AMRPs are only submitted every three years and only report on a limited set of services. Although states are required to report on home health services, they are not required to examine access to home- and community-based services (HCBS) more broadly, an integral and growing part of the Medicaid program.¹⁰

Further, the current approach often relies on structural or process measures rather than direct measures of access. For example, in states where the majority of the Medicaid population is enrolled in managed care, the structural measures reported by MCOs (such as time and distance standards) do not directly measure whether beneficiaries are receiving needed care. Additionally, provider directories, particularly paper versions, are often outdated and list providers who may no longer be accepting new patients or participating in the network, potentially overstating provider availability.

In addition, data issues limit the usefulness of this information for identifying problems and developing solutions. For example, there are concerns with the completeness and accuracy of administrative data that are used to assess utilization of care, as well as its timeliness. Survey data, although useful for monitoring beneficiary experience, are limited by their sample size and often cannot be used to compare access across states or subpopulations. Plans may be required to report grievance and appeals data to states, but these data are not consistently collected nor are they necessarily representative of the access and quality issues experienced by beneficiaries. Additionally, there is a lack of complete and reliable beneficiary demographic data, which limits the ability to monitor access across populations or detect disparities in access to care.

Finally, by design, the system allows for state variation and does not capture core measures uniformly across states and delivery systems. Further, finding comparable measures across states is challenging because of policy, health system, and geographic differences. For example, eligibility for particular services varies across states. In addition, states may define and report services and providers differently. This limits the ability of CMS, states, and other stakeholders to make meaningful comparisons, detect access issues, and identify priorities for improvement. It also makes it difficult for researchers and program evaluators to assess the effects of the many policy choices that states make in administering the program.

CMS repeatedly has expressed interest in a more consistent approach, acknowledging the need for a more unified data-driven approach that would align methods and measures used to monitor access across delivery systems (CMS 2019a, 2015a, 2015b). Most recently, CMS has indicated that it is developing a comprehensive access strategy which may involve a range of actions, such as regulations, guidance, and technical assistance. As an initial step, the agency released a request for information (RFI) in February 2022 (CMS 2022a).¹¹ A forthcoming rule is expected to support access monitoring across delivery systems, and be inclusive of HCBS. Publication of the rule is anticipated in October 2022 (OMB 2021).

Goals of a New Access Monitoring System

To address the concerns articulated above, CMS should develop a new regulatory framework for a new comprehensive access monitoring system. Such a system is needed to provide CMS, states, beneficiaries, and other stakeholders with information to assess the program's value, serve as a means of accountability, help identify problems, and guide program improvement. An effective access monitoring system should allow

for actionable and meaningful comparisons across states and delivery systems. The monitoring system should prioritize methods that are timely and minimize administrative burden, build on existing data collection and reporting wherever possible, and allow for updating over time. In addition, a new system should reflect the priorities of CMS, states, and beneficiaries, and incorporate considerations of equity in assessing and improving access.

Meaningful. The data collected should include measures that are meaningful to CMS, states, and beneficiaries, reflecting the services that are important to those served by the program. Further, an examination of access should account for the characteristics and complex health needs of Medicaid beneficiaries, as well as state-level programmatic, policy, and geographic differences.

Focused on equity. An access monitoring system should collect data that can be used to assess need, detect disparities, and identify areas of improvement for historically marginalized populations. This includes collecting and analyzing data by race and ethnicity, primary language, disability, sexual orientation, gender identity, and geography.

Comparable. The system should be based on a common set of access measures that are consistent and comparable across states, delivery systems, and populations. It also should allow for some flexibility for states to add additional measures to suit their unique circumstances and priorities.

Actionable. An effective access monitoring system should yield information that is actionable for CMS, states, and plans. The measures and data collected should be used to identify areas of concern, and guide program improvement.

Timely. A monitoring system should collect and report data in a timely enough fashion to detect problems so state and federal policymakers can intervene as quickly as possible.

Efficient. Given constraints on state and federal capacity, an access monitoring system should be efficient and minimize administrative burden for CMS, states, plans, and providers. It should build on existing systems and data wherever possible and prioritize which populations and services to monitor.

Adaptable. Access monitoring should allow for modification and updates to the system over time, including dropping measures that are no longer useful and adapting to changes in available data and the service delivery system.

Key Elements of a New Access Monitoring System

To inform the Commission's work on assessing the need for a new access monitoring system, MACPAC conducted a literature review, examined state and stakeholder comments on proposed and final federal rules, and conducted stakeholder interviews with CMS, states, plans, beneficiary advocates, and researchers. The interviews were designed to gain a better understanding of the stakeholder priorities, the challenges and potential solutions to monitoring access, and the design and implementation of a new access monitoring system.¹² MACPAC also convened experts including Medicaid researchers, beneficiary advocates, and representatives from CMS, states, and plans at public meetings to discuss data availability and implementation considerations in designing a new access monitoring system.

Below are the key elements of a new access monitoring system: stakeholder engagement, access measures, data collection and analysis, public reporting and oversight, and phased implementation.

Stakeholder engagement

Stakeholders with multiple perspectives should be engaged in the design and implementation

of a new access monitoring system. Public engagement with states, beneficiaries, consumer groups, plans, providers, researchers, and policy experts is critical to selecting access measures that are meaningful, feasible to collect, and actionable. Incorporating the beneficiary voice and experience in the design and implementation of the system is particularly important to understand their lived experience, the services they use, and the barriers they face.¹³ Similarly, collaborating with states in development and selection of access measures will help ensure that measures align with state priorities; complement, rather than duplicate, existing data collection efforts; and are practical and actionable. Although CMS has a primary responsibility to ensure access for Medicaid beneficiaries, states are equal partners in program design and administration and thus should be key partners in the development and implementation of a new access monitoring system.

In prior rulemaking, CMS engaged stakeholders formally through comment periods and requests for information. These formal comment mechanisms provided CMS with insight into stakeholder concerns, some of which were incorporated into regulations. For example, in response to state comments about use of uniform time and distance standards to measure network adequacy, CMS updated the requirements to allow states to develop their own quantitative standard tailored to their state (CMS 2020a). Similarly, in the final 2015 FFS rule, CMS addressed many of the comments submitted by states, researchers, and advocates in response to the proposed 2011 rule (CMS 2015b, 2011).

At times, CMS also has convened workgroups and technical expert panels, inviting key stakeholders to engage in designing and implementing a new approach to monitoring access. For example, in 2019, CMS announced plans to convene workgroups and technical expert panels with federal and state stakeholders that would focus on current requirements and identify data that could be used to conduct federal access reviews (CMS 2019a).¹⁴ However, CMS did not explicitly include

beneficiaries or specify how the beneficiary voice would be included in these processes.

As CMS designs and implements a new access monitoring system, it should take a more expansive approach to stakeholder engagement. The opportunities for contribution should be accessible to all stakeholder groups, including beneficiaries who represent the various populations covered by Medicaid, policy experts, advocates, and researchers. Further, the perspectives and concerns raised by these stakeholder groups should be incorporated into the design of the new access monitoring system.

CMS has successfully involved multiple stakeholder groups, and specifically beneficiaries, in formal structures for engagement with Medicaid. One example is the advisory council CMS convened to establish the Adult and Child Core Sets. This council (consisting of providers, beneficiary advocates, state officials, and policy experts) reviewed the core set measures, assessing validity and feasibility of the measures and alignment with federal priorities.¹⁵ If a similar process were used to develop access measures, it would be important also to incorporate direct input from beneficiaries and to provide assistance or resources in advance to promote their ability to contribute to the discussion (Stewart 2022).

Access measures

A new system should include a core set of standardized access measures that allow for comparison across states and delivery systems and are stratified by key demographic characteristics.

Beginning with the access framework described in MACPAC's inaugural report in March 2011, the Commission has highlighted the need to monitor access across multiple domains (MACPAC 2017, 2011). As identified by prior research and supported by stakeholders in MACPAC-conducted interviews, access measures should reflect three key domains: provider availability and accessibility

(i.e., potential access), use of services (i.e., realized access), and beneficiary perceptions and experiences (Kenney et al. 2016, NORC 2013).¹⁶ Gathering and analyzing data across these domains will require multiple sources of data, including claims and survey data.

Provider availability. Provider availability and accessibility measures capture potential access to providers and services, regardless of whether or not the services are used. Provider availability is a function of the presence of providers in the state or region (i.e., supply), as well as their participation in Medicaid and the Children’s Health Insurance Program (CHIP) (Kenney et al. 2016, MACPAC 2011). This domain should also include other measures of availability, such as timeliness of appointments, travel time, and accessibility for individuals with language barriers and disabilities.

States use various methods to measure and monitor provider availability and accessibility, including licensure data, provider directories, claims data, secret shopper audits, and surveys. However, each of these have shortcomings. For example, provider participation can be measured using health plan directories, but these are not always current and do not consider the size of a provider’s Medicaid case load. Secret shopper audits and provider surveys can measure provider accessibility, such as timeliness of appointments, but they are not used consistently across states or representative of all provider types.

The most feasible approach to improving provider availability data is to standardize the provider type definitions in the Transformed Medicaid Statistical Information System (T-MSIS) to improve consistency and identify active Medicaid providers across states. Additionally, a federal beneficiary survey could capture more consistent information on provider accessibility, such as wait times for appointments and transportation. Based on expert interviews, the Commission also considered expanding the use of secret shopper audits and provider surveys. However, given that these practices are not universal and often resource-

intensive for states and providers, the Commission did not pursue these as a necessary component of a new access monitoring system, understanding that states may continue to undertake such work for their own purposes.

Use of services. This domain measures realized access by examining use of services and in some cases, use of specific providers or settings. States typically rely on administrative data (reported by states to CMS in T-MSIS) to assess beneficiary utilization. Many states also require Medicaid managed care plans to report particular measures from the Healthcare Effectiveness Data and Information Set (HEDIS), a set of standardized performance measures.¹⁷ All states also voluntarily report some measures in the Adult and Child Core Sets, a set of standardized health care quality measures for beneficiaries in Medicaid and CHIP.¹⁸ However, existing measures typically focus on medical care; relatively few standardized measures are available for other types of services, particularly for LTSS (Box 1.1). Further, these measures typically focus on in-person services and do not capture telehealth services, which have expanded since the beginning of the PHE (Libersky et al. 2020). Stratifying these data by race and ethnicity and other important demographic characteristics is not required and may not be possible given the incompleteness and low quality of that information for many states (MACPAC 2022, Mathematica 2021, NCQA 2021).

T-MSIS is the most complete and consistent data source on utilization across states, and more attention to standardization would make it an even more useful source for access monitoring (MACPAC 2021b, Kenney et al. 2016). Over the past several years, significant investments have been made in T-MSIS to improve timeliness, reliability, and completeness of Medicaid data and in assessing and publishing data quality assessments of many T-MSIS measures (CMS 2021a, MACPAC 2019). Addressing the remaining quality issues would improve the availability of high-quality and timely data for access monitoring. Many researchers suggested that

BOX 1-1. Monitoring Access for Long-Term Services and Supports

Monitoring access to long-term services and supports (LTSS), particularly home- and community-based services (HCBS), is especially important given the predominant role of Medicaid in funding these services. Further, the Americans with Disabilities Act (ADA, P.L. 101-336, as amended) and subsequent Supreme Court decision *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999) require public programs such as Medicaid to ensure that people with disabilities have equal access to services and that services are provided in the community rather than institutions when community-based services are appropriate, desired by the beneficiary, and can be reasonably accommodated by the state. However, there are unique challenges to assessing access to HCBS and few established measures.

Monitoring provider availability in HCBS can be difficult because states typically contract with agencies rather than individual providers and often have no way to count the number of direct service workers providing care. Some states may require direct care workers to complete certifications, background checks, or join a registry, but these practices are not universal. In addition, provider network adequacy measures based on time and distance standards may not be applicable for providers who travel to a beneficiary's home or for self-directed care, which relies on an independent provider network (Ne'eman 2018).

Monitoring service use is challenging due to incomplete HCBS claims data in the Transformed Medicaid Statistical Information System (T-MSIS) and lack of consistency within and across states. In addition, personal care workers often do not have National Provider Identifiers and states use a variety of different procedure codes for these types of claims.²¹ Dates of services and units of service are often missing and there is variation in how specific services are reported (CMS 2022d). Further, CMS does not currently report assessments of the quality of HCBS data and completeness of elements of HCBS taxonomy in T-MSIS (CMS 2021a).²² Thus, significant expertise is required to ensure states are reporting data elements in the HCBS taxonomy correctly.

Monitoring unmet need and particular access goals for HCBS also can be a challenge. Service gaps, such as delivery of fewer HCBS hours than recommended in the treatment plan, are difficult to capture in administrative data, as recommended hours are not reported on claims. Further, many beneficiaries in need of HCBS may not be receiving any services at all given waiting lists for care.²³ Administrative data also cannot capture information on the key goals of HCBS, such as an individual's ability to live independently, see family and friends, and participate in community activities.

Beneficiary surveys could be used to address the limitations inherent in claims data. For example, CMS or states could use information from nationally accredited beneficiary surveys, including the National Core Indicators (NCI), the National Core Indicators of Aging and Disabilities (NCI-AD), and the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) to monitor access. However, these surveys are not administered in all states, often have small sample sizes, and beneficiaries may not have access to the support needed to complete these surveys.²⁴

CMS and policy experts are working to establish more standardized measures of access and quality in HCBS. For example, in 2020, CMS released a request for information to solicit feedback on a set of standardized HCBS quality measures, including those appropriate for states with managed LTSS (CMS 2020c).

further standardizing T-MSIS where there is lack of clarity in definitions and high rates of missing data is needed for greater comparability across states and populations. For example, efforts could focus on standardizing definitions of service and provider categories and improved collection of encounter data from managed care plans. Assessments of T-MSIS data by CMS, the U.S. Department of Health and Human Services Office of the Inspector General, and researchers also highlight the need for more complete and reliable beneficiary demographic data, particularly on race, ethnicity, and disability status (MACPAC 2022; CMS 2022a, 2021b; OIG 2021).¹⁹ Although CMS provides states with technical assistance to monitor and address specific data quality issues, several states and researchers noted that states likely will need additional technical assistance and resources to improve the quality of data reported to T-MSIS (CMS 2022c).

The Commission also discussed other data sources that could be used to construct access measures. For example, measures could be constructed based on chart reviews to compare treatment plans to actual utilization to identify any unmet need for sample populations. HEDIS measures and all-payer claims databases also could be used to compare access in private insurance and Medicaid. However, using these can be technically complex and would likely require many states to establish new systems.

Ideally, a monitoring system would capture key health outcomes and the appropriateness of services, although this is challenging in practice (Kenney et al. 2016). CMS may consider including some measures, particularly those already included in the Adult and Child Core Sets, in the initial set of access measures.²⁰ However, measures of access-related health outcomes and appropriate care are more challenging and resource-intensive to collect compared to utilization measures analyzed from claims data and may need to be developed over time. For example, determining the appropriateness of care for a child with developmental delays could require a chart review to assess whether

they received all the occupational therapy visits authorized in their treatment plan.

Beneficiary perceptions and experiences.

Beneficiaries' perceptions of their needs, barriers to care, and care experiences are important components of access. This includes connection to the health care system, timeliness of care, barriers to care and unmet needs, and culturally competent care (Kenney et al. 2016). It is also important to understand beneficiaries' perceptions of interactions with providers (including being treated with respect and without bias), beneficiary knowledge and understanding of benefits, stability of care, and perceived quality of care.

Current state activities to monitor beneficiary perceptions and experiences use data from surveys, consumer complaint hotlines, grievances and appeals, and other qualitative sources such as focus groups or interviews. However, there are comparability and generalizability limitations to these methods and collection of these data is not universal (MACPAC 2017). For example, a number of states use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey to assess access. However, these surveys only capture information about beneficiaries covered by managed care plans and data are only available from plans that voluntarily submit to the CAHPS database. Furthermore, response rates are low and the results are not representative of all Medicaid beneficiaries (AHRQ 2021b, 2019).²⁵ A few states conduct their own beneficiary surveys, but these are typically not comparable across states and are not generally reported to CMS (SHADAC 2021, UCLA 2021). Complaint data, including grievances and appeals, are not representative of general experience, in part because the process is complicated to navigate and may not be accessible to all beneficiaries (Myers 2018, Perkins 2016). States or plans may not consistently capture data and may not share those data with states and CMS.

In the Commission's view, access monitoring in Medicaid would be enhanced by fielding a survey of beneficiaries, much like CMS already does for Medicare beneficiaries. A Medicaid beneficiary survey would be particularly useful to measure unmet need, barriers to care, knowledge of benefits, and how beneficiaries perceive they are being treated.

The Commission discussed whether such a survey should be state or federally administered. A state-administered survey could include a core set of questions for consistency and comparability, but also allow for customization. This could promote cross-state comparisons, while also prioritizing measures that align with state needs and complement existing efforts. Such an approach is taken with other surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS).²⁶ Other researchers suggested that CMS could highlight certain access measures that states should include in their state surveys to promote consistency across state. However, as state-level beneficiary surveys are not universally

administered and do not use consistent and validated measures, such an approach would not address the need for gathering standardized information on beneficiary perceptions in all states (AHRQ 2021b).

A federal survey would provide consistent data across states and relieve some state administrative burden. It also could seek to address gaps in other domains of access, by including questions related to provider availability, service use, unmet need, and collect more complete demographic information. The survey should capture the experience of a wide range of beneficiaries, including children and people with disabilities, and allow for assessments among key demographic groups, such as by race and ethnicity. The survey should be designed to complement existing state survey efforts. Several researchers, including two panelists, told the Commission that the Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems (NAM CAHPS) specifically could serve as a starting point for a federal Medicaid beneficiary survey (Box 1.2).²⁷

BOX 1-2. Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems

The Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems (NAM CAHPS) was the only national Medicaid beneficiary survey conducted by the Centers for Medicare & Medicaid Services (CMS). The survey design, data collection, and analysis approach could serve as a starting point for a future Medicaid beneficiary survey.

Conducted in the fall of 2014, the NAM CAHPS was designed to inform the development of standard quality measures for the adult Medicaid population and provide baseline information on the experiences of low-income adults prior to implementation of the Patient Protection and Affordable Care Act ACA, (P.L. 111-148, as amended) (NORC n.d.). The survey allowed for national and state-level estimates of demographic and health characteristics, access to care, and barriers to care for adult Medicaid beneficiaries (NORC 2015, CMS 2014). The survey also allowed for direct comparisons between populations in fee for service (FFS) and managed care. It was not intended to interfere with ongoing survey efforts by states. For states that pursued their own CAHPS surveys, CMS developed standard procedures and coordinated with states to avoid duplication with existing survey efforts and prevent sampling any enrollee more than once (CMS 2014).

BOX 1-2. continued

The NAM CAHPS had a nationwide sampling frame of more than 1.2 million adult Medicaid enrollees.²⁸ Ultimately, more than 270,000 beneficiaries completed the survey, averaging approximately 5,800 adult Medicaid enrollees from each state. This represented a response rate of approximately 23.6 percent. The sample population was designed to capture four key subgroups: dually eligible individuals, individuals with a disability, individuals in Medicaid managed care, and individuals in FFS. The sampling frame was constructed from each state's Medicaid Statistical Information System (MSIS) eligibility file or internal eligibility system. States were given options for how this would be done, and most chose to have CMS's contractor extract eligibility data from MSIS, which the state then validated and appended enrollees' contact information. Participation in the survey was voluntary for beneficiaries (NORC 2015).

The NAM CAHPS was administered through the mail, with telephone follow-up as necessary, to collect information related to health care use, barriers to, and quality of care. The survey also captured data on race, ethnicity, sex, primary language, and disability status (NORC 2015). CMS spent approximately \$10.8 million over four years for administration and analysis of the NAM CAHPS (Costello 2021).²⁹

Prioritization. Given administrative capacity and data constraints, CMS will likely need to prioritize areas of focus. For example, it could focus on services for which Medicaid is a major payer, such as primary care, pediatrics, behavioral health, maternal health, and LTSS. CMS could concentrate efforts on services for which there are known access issues, such as behavioral health and oral health services, and known disparities. In establishing a new access monitoring system, CMS should seek to balance the need to assess access for specific populations and services, and feasibility in terms of data availability and state and federal capacity. For example, examining access for particularly small populations with significant but unique issues, such as children and youth with special health care needs and children involved in the child welfare system, may be especially difficult. CMS could consider whether such populations warrant specific state attention or should be examined on a rotating basis or through alternative means, such as targeted beneficiary surveys or focus groups.

Data collection and analysis

A new access monitoring system will require clearly defined roles for CMS, states, and plans in selecting measures, collecting and analyzing data, and setting benchmarks for adequate access. In the current approach, as described above, CMS laid out broad parameters and intentionally built in flexibility for states to design their own monitoring plan and measurement standards (CMS 2016, 2015b). Current regulations do not establish thresholds, benchmarks, or explicit goals for determining adequate access. This approach allows states to focus on state-level priorities, but the lack of standardization makes it difficult to make valid comparisons across states and delivery systems.

In the Commission's view, CMS should lead the design of a new access monitoring system, including establishing specific access measures that can be collected consistently across states and delivery systems and compared against benchmarks. However, there was less agreement

among the stakeholders interviewed about whether CMS or states should be responsible for data analysis and how CMS should determine benchmarks.

Collecting data. States, plans, and CMS should share responsibility for data collection activities, taking the lead on areas for which they are best suited, for example with CMS fielding an ongoing Medicaid beneficiary survey. States and plans are positioned to and already collect most of the data required for monitoring use of services

and provider availability.³⁰ However, resource constraints may limit states' ability to collect and analyze additional data, as demonstrated by the challenges states have faced in preparing to report on the mandatory core set of quality measures (MACPAC 2020). Bolstering and expanding existing data collection, such as through T-MSIS, would be an important first step in addressing existing data limitations and comparability across states and would provide continuity for states and plans while potentially easing the administrative burden on states.

BOX 1-3. Supporting Assessments of Access: The Role of Health Services Research

Health services researchers can be valuable partners in state monitoring efforts by collecting and analyzing data in partnership with state agencies. They independently can conduct analyses to identify access issues, underlying barriers to care, and health disparities that can help inform policy (Wasserman et al. 2019).

In many states, researchers at public universities work under contract or through other partnerships with their state Medicaid agency to provide analytic and technical expertise. For example, the University of Alabama has partnered with the Alabama Medicaid Agency to provide technical expertise to measure time and distance to provider locations using geographic information system mapping. Wisconsin partners with the Institute for Research on Poverty (IRP) at the University of Wisconsin-Madison, which developed an administrative database to evaluate state policies and outcomes across several of the state's health and human services agencies (IRP 2022). The State-University Partnership Learning Network (SUPLN), supported by AcademyHealth, has helped facilitate the development and growth of collaborations between state government and university researchers with the goal of supporting high-quality research and data analysis and improving the health and experience of the Medicaid population (AcademyHealth n.d.).

Independent research by health services researchers can provide insight into specific access issues or populations, and often focus on the effects of particular policy changes or interventions. While for many years researchers struggled to conduct multi-state or national studies due to difficulties in accessing high quality national and state-level Medicaid administrative data, the Transformed Medicaid Statistical Information System (T-MSIS) is changing this equation. Recent improvements to the data quality of T-MSIS and changes to the process of accessing the data with the launch of the Virtual Research Data Center (VRDC) have made the data more usable and accessible to researchers. Even so, there are still the ongoing data quality and cost concerns with T-MSIS. For example, although the cost for accessing Medicare and Medicaid data may be comparable, the cost of obtaining a sufficiently large Medicaid sample for state-level analyses may still limit the ability of many researchers to independently assess access (ResDAC 2022, CMS 2022d).

Calculating measures. Stakeholders interviewed offered differing opinions regarding who should be responsible for calculating and analyzing access measures. A few stakeholders suggested CMS should be responsible for calculating access measures at the national and state levels. However, others, including the states interviewed, preferred states to take the lead with CMS providing additional guidance on the analytical methods and support for dedicated analytical staff.³¹ Some researchers expressed concerns about limited state analytic capacity and suggested states contract out the data collection and analysis to universities and other research partners (Box 1.3).

Setting benchmarks. In our interviews, stakeholders commented that states should be involved in the process of determining the benchmarks so that they are feasible and meaningful, but CMS should be responsible for setting them. Several stakeholders suggested that CMS could start by calculating baseline measures for states over a multi-year period. These data could serve as minimum standards and a starting point to establish benchmarks for improved access overtime. However, others pointed out that expectations should account for factors that may affect access, such as provider shortages in certain regions or specialties, a pandemic, or other secular changes (e.g., a large increase or decrease in specific types of services).

CMS could determine benchmarks for adequate access in several ways, and there was no clear consensus from the stakeholders as to which method would be best. Policy experts and states noted that setting goals for relative improvement over time should be the focus of an access monitoring system. For example, given state variation, each state could have a different threshold, with expectations that access would not diminish or would see improvement over time against the state-specific baseline. In response to the 2015 RFI, the majority of states commented that CMS-established thresholds should both accommodate variation and be updated over

time to reflect changes in geography, state size, Medicaid populations, provider supply, and beneficiary demographics. Other states, policy experts, and beneficiary advocates interviewed said that it is important to have a national threshold for adequate access. Still others suggested a hybrid approach in which CMS could establish a minimum threshold or floor for states with the expectation for improvement over the state baseline.

Public reporting and oversight

Access monitoring can serve both a governmental oversight function and provide information directly to the public. CMS should publicly release the data collection and analytical methods, data, and results to promote transparency and accountability. For example, beneficiary advocacy groups would value having access to information in a timely and consumer friendly format in order to hold plans and states accountable for addressing access issues. States would value having information about how they compare to others. Additionally, details on the methods may help guide state data collection and improvement efforts. Health services researchers would value improved access to monitoring data to further research on access and quality in Medicaid.

Phased implementation

Changing Medicaid's approach to access monitoring with the elements described above would be a significant task. For that reason, a phased-in and iterative approach is needed to allow for sufficient time to engage stakeholders in the design and to provide states and plans ample time to establish processes to collect and analyze data.³² CMS, research experts, and provider groups suggested that CMS and states would first assess what they already do to measure access, and then determine necessary next steps to meet short-term and long-term monitoring goals. After establishing an initial set of measures using existing data, CMS could begin to assess

the gaps and determine whether states have the necessary infrastructure in place to collect data on the selected access measures and whether improved or new data sources are needed. States also should be provided with ongoing technical assistance to support implementation of the new access monitoring system.

Commission Recommendations

Recommendation 1.1

The Centers for Medicare & Medicaid Services should develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems. These measures should:

- capture potential access, realized access, and beneficiary perceptions and experiences;
- prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities; and
- be adaptable to reflect changes in measurement, policy priorities, and care delivery.

CMS should issue public reports and data at the state and national level in a consumer-friendly and research-ready format in a timely manner.

Rationale

The purpose of the Medicaid program is to provide access to services; states and the federal government have statutory obligations to ensure sufficient access. Yet there is insufficient information to assess whether the program is meeting this obligation. A core set of standardized access measures would allow for an assessment of access to care across states and delivery systems and represent both federal and state

priorities (MACPAC 2017, 2012). States should retain flexibility to monitor additional services, populations, and geographies that reflect their state-specific priorities.

In addition to being comparable, the core set of measures must be both timely and yield actionable information for CMS, states, and plans to detect access concerns and disparities and make improvements. To promote efficiency and reduce administrative burden, CMS should explore ways that existing data sources and data collection methods can be used.

A monitoring system should assess the full experience of Medicaid beneficiaries accessing care, including the availability of services, use of services, and experience with care. The selected measures should capture access to a range of services, including primary, preventive, and specialty care, and LTSS. The measures also should prioritize services for which Medicaid plays an outsized role and where there are known disparities or access concerns, such as oral health and behavioral health.

In addition, a monitoring system should allow for modifications to account for changes in CMS and state priorities, measurement, and care delivery (e.g., growth of services provided via telehealth, the introduction of new therapies). Finally, as the availability of data improves, or measures are no longer useful, measure sets should be updated to reflect these changes.

Data transparency and public reporting plays a critical role in ensuring accountability, identifying problems, and guiding program improvement. Reporting results in a timely, consumer-friendly, and accessible format can facilitate these efforts. Such reports should provide context for and additional information on state variation, such as geographic and programmatic differences, so that results can be interpreted accurately. In addition, to the extent possible with appropriate privacy protections, data should be available for use by outside researchers and stakeholders to assess access.

Implications

Federal spending. Increased data collection, standardization, and reporting could lead to increases in federal costs in the short term as a new approach is established. An approach that builds on what is currently in place and replaces duplicative process would help limit such increases.

States. There may be additional data collection and reporting associated with a new access monitoring system, particularly in the short term. To the extent that a new system builds on existing data collection and reporting infrastructure, the effect on states may be minimized.

Enrollees. To the degree that a new system identifies access barriers that lead to actions to change policies and practices, beneficiaries may experience improved access to services.

Plans and providers. To the extent that a new system capitalizes on existing data measures, the reporting burden on plans and providers may be minimized. Plans and providers may be affected to the extent that a new system changes reporting requirements.

Recommendation 1.2

The Centers for Medicare & Medicaid Services should involve stakeholders in the development and future modifications of a new system. The agency should actively solicit and incorporate input from key stakeholders, including, but not limited to, states, beneficiaries, consumer groups, health plans, providers, researchers, and other policy experts. The process for establishing a new access monitoring system should be public and transparent.

Rationale

Given the federal obligation to ensure access to services, CMS should take the primary role in defining the goals, requirements, and access measures for a new access monitoring system.

To ensure that the system is both meaningful and feasible, CMS should actively solicit input from states, beneficiaries, consumer groups that are representative of the people they serve, plans, providers, and other key stakeholders to design, update, and maintain a system that is meaningful for them and to secure their support. CMS also should make the process for modifying its approach to monitoring access public and transparent.

Meaningful stakeholder engagement goes beyond required public notice and comment periods in formal rulemaking, and should begin earlier in the process of developing a new approach to monitoring access. CMS should engage stakeholders through multiple avenues, such as requests for information, roundtables, and workgroups throughout the process. Actively working with a broad range of stakeholder groups can help ensure an access monitoring system that is designed with input from multiple perspectives, including from those who benefit from the services, and can facilitate stakeholder understanding of the standards and processes being used to monitor access.

Implications

Federal spending. Federal rulemaking already requires public notice and comment and CMS routinely seeks input from states and other key stakeholders. Costs to CMS may increase if additional staff time is necessary to ensure the process is meaningful for beneficiaries, states, and other stakeholders.

States. States routinely engage in the rulemaking and guidance process with CMS. The additional consultation process described in the recommendation may provide additional opportunities for engagement.

Enrollees. Beneficiaries and other key stakeholders often participate in the formal rulemaking process. To the extent that there are other avenues for stakeholder engagement,

beneficiaries may have additional opportunities to provide input.

Plans and providers. Plans and providers also routinely engage in the rulemaking process, and more informal opportunities may arise in the development of a new access monitoring system.

Recommendation 1.3

The Centers for Medicare & Medicaid Services should field an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care.

Rationale

Beneficiary perceptions and experiences are important components of monitoring access. These cannot be captured in administrative data, and grievances and appeals information may not be aggregated, transparent, or representative. A federal survey that allows for comparisons across states, subpopulations, and delivery systems will be an important tool to capture beneficiary perceptions and experiences with care, a key area where information is currently lacking. The Medicare Current Beneficiary Survey (MCBS) serves this function for the Medicare program, providing information on health outcomes, usual source of care, and satisfaction with care that are not available in administrative data (CMS 2021c).

A beneficiary survey also can be designed to address other data gaps. For example, existing measures of provider availability, such as time and distance standards, may not provide detail regarding the timeliness of appointments, drive-time or travel time via public transportation, or accessibility for individuals with disabilities or of limited English proficiency. A survey can ask beneficiaries directly about these barriers. A survey also can be designed to gather information on service use, unmet need, and more complete demographic information.

Any survey of Medicaid beneficiaries should be inclusive of the populations enrolled in Medicaid. While the NAM CAHPS examined care for adult Medicaid beneficiaries, including those with disabilities and individuals dually eligible for Medicare and Medicaid, it did not include children who currently comprise 40 percent of Medicaid enrollees (MACPAC 2021c). CMS could consider whether certain populations, such as pregnant women or individuals of a particular race or ethnicity, are examined or oversampled on a rotating basis.

In designing a beneficiary survey, CMS should not duplicate existing state survey efforts and work with states to ensure that the data gathered meet their needs. In doing so, CMS could consider how states could add customized questions or modules.

CMS also should consider ways of ensuring the usability of these data. This could include efforts to increase survey response rates, such as providing a wide array of survey modalities (e.g., in person, by mail, online, or by telephone) and to generate sufficient sample sizes to ensure reliable sub-group analyses. Additionally, CMS should develop the survey so that responses can be linked to claims data as is done with the MCBS and release data publicly in a timely fashion to facilitate broader analyses.

In developing a Medicaid beneficiary survey, CMS could draw on the agency's 30 years of experience conducting an annual survey of Medicare beneficiaries. The MCBS includes standard information on demographic characteristics, such as age, sex, and race and ethnicity, as well as information about health conditions and access to and satisfaction with care. CMS makes these data publicly available, including the linked survey responses and person-level utilization data (CMS 2021c).³³ CMS also can draw on federal experts at the Agency for Healthcare Research and Quality and their experience with the CAHPS survey, as well as experts at the Census Bureau and the National Center for Health Statistics.

Implications

Federal spending. CMS may need additional funds to mount such a survey and federal costs would increase in the amounts provided by Congress. The cost of the contractors to design, administer, and analyze the NAM CAHPS was \$10.8 million over four years. CMS staff were also dedicated to the project.

States. States could be asked to assist in the design of a federal beneficiary survey. States also may need to participate in certain validation activities when samples are drawn. For example, states could be asked to identify beneficiaries and provide address information.³⁴ To the extent that a federal survey replaces existing state survey efforts, states could see a reduction in costs and administrative efforts in collecting and analyzing data. However, some states may continue to field their own surveys in addition to the federal survey, in which case the cost to states may be unchanged.

Enrollees. An ongoing federal survey of beneficiaries would capture new information on unmet needs and other beneficiary experiences. Such information could be used to identify specific access barriers and result in improvements.

Plans and providers. Plans may play a role in some of the implementation pieces of the federal survey. As the survey would be directed to enrollees, it is unlikely that it would have any effect on providers.

Recommendation 1.4

The Centers for Medicare & Medicaid Services should further standardize and improve the Transformed Medicaid Statistical Information System data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity.

Rationale

T-MSIS is the only federal Medicaid data source with person-level information on eligibility, demographics, service use, and spending. However, quality concerns and coding inconsistencies make state- and population-level comparisons difficult. Additional consistency in variable definitions would allow for a more accurate and complete assessment of the services people are using and the providers they are seeing.

These efforts can build on existing work to improve the accuracy and completeness of T-MSIS data, focusing on standardizing definitions of service and provider categories most important to monitoring utilization and provider availability. CMS and its contractors are already working to improve the completeness and accuracy of T-MSIS data. These efforts may improve the usability of T-MSIS data for access monitoring purposes. For example, improving the ability to identify a specific provider associated with a claim could aid in assessing provider availability. Ensuring completeness of eligibility and demographic information will allow for comparisons across key groups of interest (CMS 2022d).

CMS should pay particular attention to creating consistent definitions and methods to identify HCBS providers, given the state variation in codes used for this type of provider claim. For example, CMS could assess the quality of the HCBS data and assist states in improving collection and reporting on these measures. Other efforts could focus on working with states to improve the collection of encounter data from managed care plans, provide consistent accounting of telehealth services, and collect more complete and accurate beneficiary-provided race and ethnicity information.

Implications

Federal spending. To the extent that efforts to improve T-MSIS align with existing work and the

timing of such efforts, the additional federal costs would be minimal.

States. States are working on improving the accuracy and completeness of the data they submit to T-MSIS. To the extent that changes for access monitoring purposes align with the ongoing improvement efforts, the additional effort for states may be minimal.

Enrollees. To the degree that a new system identifies access barriers and results in changes, beneficiaries may experience improved access to services.

Plans and providers. Depending on the extent of the standardization required, plans and providers may need to update or change how they report particular data to the state.

Recommendation 1.5

To assist states in collecting and analyzing access measures, the Centers for Medicare & Medicaid Services should provide analytical support and technical assistance.

Rationale

During the course of our interviews and the Commission's discussions, the need for state technical assistance came up repeatedly. Medicaid agencies often are expected to manage a large and diverse set of responsibilities while facing staff shortages and budget constraints. This may affect their capacity to collect, analyze, report, and act on access monitoring data. As such, states will likely need technical assistance and tools to improve the quality of data reported to T-MSIS and to construct and analyze additional access measures. For example, states may benefit from additional templates and data dictionaries to calculate core access measures consistently across states. CMS could provide states with guidance and highlight successful approaches for improving the completeness of certain types of data, such as race and ethnicity data. Interviewees commented

that states are in different places in terms of their analytical capabilities, partnerships with university researchers, and access to software and tools needed to monitor access. For some states, the administrative capacity to collect additional data, analyze and calculate new access measures, or report on new requirements, may be limited, and they could require more targeted assistance. Some states also said technical assistance from CMS would be important to help states address access issues identified through monitoring.

Implications

Federal spending. CMS routinely provides states technical and analytic support through efforts to improve T-MSIS data, as well as other initiatives. Although it is possible that the technical assistance necessary for an improved access monitoring system could be provided as part of these existing efforts, CMS would need to assess whether the current resources are sufficient or if additional funding should be requested.

States. Additional technical and analytic support from CMS could help states meet the obligation of collecting and reporting data to assess adequate access.

Beneficiaries. To the degree that technical assistance supports states to make improvements in monitoring and addressing access issues, beneficiaries may experience improved access to services.

Plans and providers. Plans and providers are unlikely to be directly affected by this recommendation.

Endnotes

¹ MACPAC uses the term pregnant women as this is the term used in the statute and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as women.

² CMS has noted that these three domains of access will be included in a forthcoming access strategy and were highlighted in the recent request for information (CMS, 2022a, LLanos 2021).

³ CMS proposed an access monitoring rule in 2011 that would have required states to conduct reviews of state-determined access measures, based on geographic location and on an established access framework, for a rotating subset of services. The 2015 rule provided states with more guidance and expanded on the 2011 proposed rule (CMS 2011).

⁴ Along with the final rule, CMS issued a separate request for information (RFI) on methodology and measures that could be used to monitor and assess access in the Medicaid program (CMS 2015a).

⁵ In the response to comments on the final rule, CMS recommended but did not require, that states publish the AMRPs and subsequent data collected through those plans on their websites. Approved plans submitted in 2016 are available on Medicaid.gov.

⁶ States were initially required to submit their access monitoring review plan, including the first review of the sufficiency of access, by July 1, 2016. A subsequent rule delayed the submission until October 1, 2016 (CMS 2016).

⁷ The 2015 final rule was issued with a comment period to determine whether further adjustments to the access review requirements would be warranted, including the scope of regular state access reviews. CMS also requested comment on whether there should be exemptions based on state program characteristics (CMS 2015b).

⁸ The 2016 rule required states to develop and make publicly available time and distance network adequacy standards for specific provider types. However, in 2020, a subsequent rule rescinded these standards and instead gave states flexibility to use other quantitative standards to determine network adequacy (CMS 2020a). Other provider network adequacy requirements in the final 2016 rule remain in place.

⁹ The 2020 managed care rule also requires states contracting with managed care plans for LTSS to have a quantitative network adequacy standard for LTSS providers.

¹⁰ Medicaid home health services include skilled nursing and home health aide services as described in 42 CFR § 440.70 and are only covered if they are medically necessary on a part-time basis (e.g., therapy following a hospitalization). This is different from HCBS which are non-medical services provided on a longer-term basis.

¹¹ The 2022 RFI used a broad definition of access and solicited feedback on enrolling in and maintaining coverage, in addition to accessing services. Specifically, it sought information on ensuring: Medicaid and CHIP reaches eligible people; beneficiaries experience consistent coverage; beneficiaries have access to timely, high-quality, and appropriate care in all payment systems; CMS has data available to measure, monitor, and support improvement efforts related to access to services; and payment rates are sufficient (CMS 2022a).

¹² Interviewees included federal officials from CMS; state officials from Alabama, Connecticut, Georgia, Oregon, and Wyoming; research and policy experts from Baruch College Health Policy Center, Center on Budget and Policy Priorities, Kaiser Family Foundation, Lurie Institute for Disability Policy, National Opinion Research Center at the University of Chicago, State Health Access Data Assistance Center at the University of Minnesota, UCLA Center on Health Policy Research, and Urban Institute; beneficiary advocates from The Arc, National Health Law Program, Kentucky Voices for Health, NC Child: The Voice for North Carolina's Children, and Shriver Center on Poverty Law; managed care organizations and health plan associations included Centene Corporation, Molina Healthcare, and Association for Community Affiliated Plans; and provider associations included American Academy of Family Physicians and American Academy of Pediatrics.

¹³ Lived experience is best understood through qualitative research in order to understand individuals' perceptions of their interactions with the health care system (de Casterle et al. 2011).

¹⁴ A CMS official shared that initial planning for creating workgroups began in late 2019, but the workgroups were paused due to the COVID-19 pandemic.

¹⁵ A committee continues to meet annually to provide input on measures (MACPAC 2020).

¹⁶ A 2016 report commissioned by CMS similarly describes three access domains: 1) provider availability and accessibility, 2) beneficiary utilization, and 3) beneficiary perceptions and experiences (Kenney et al. 2016). CMS has noted that the agency is using this report as a starting point for its most recent work on monitoring access to services (CMS 2022a).

¹⁷ HEDIS measures are developed by the National Committee on Quality Assurance (NCQA) and measure receipt of services such as certain cancer screenings and childhood immunizations using administrative data, medical chart reviews, and surveys collected from NCQA-certified health plans (MACPAC 2021d).

¹⁸ The core sets allow states, the public, and CMS to monitor trends in performance on standardized indicators of quality of care provided to Medicaid and CHIP beneficiaries under both FFS and managed care arrangements and examine performance across states (HHS 2011, CMS 2019b). CMS has developed core sets for pediatric and adult care, health homes, maternity care, and behavioral health services. Beginning in 2024, states will be required to report on the core set for children enrolled in Medicaid and CHIP and the core set of behavioral health measures for adults enrolled in Medicaid (MACPAC 2020).

¹⁹ T-MSIS includes questions on disability status but CMS has not assessed the extent to which states report on this information or the quality of this data.

²⁰ For adults and children, some access-related outcome measures are already included in the Adult and Child Core Sets (e.g. well-child visits, follow-up visits after hospitalization, preventive dental services, and hospital admissions due to ambulatory care sensitive conditions).

²¹ Until recently, personal care providers were not eligible to receive National Provider Identifiers (NPIs). In 2019, CMS issued guidance to clarify which Medicaid personal care attendants (PCAs) may obtain an NPI, although the guidance does not require states to assign unique identifiers to PCAs (CMS 2019c).

²² The HCBS taxonomy was developed by Truven Health Analytics and Mathematica Policy Research under contract with the CMS. The taxonomy maps state HCBS procedure

codes to 60 service types, which are then grouped into 18 taxonomy categories (Peebles and Bohl 2013).

²³ States differ in how they structure their waiting lists, and they may include individuals who are not eligible for Medicaid.

²⁴ The National Core Indicators survey is now included as an option to measure quality of care in the Medicaid Adult Core Set (CMS 2019b).

²⁵ CAHPS surveys include surveys on patient experience with providers, condition-specific care (e.g., cancer care), health plans, and facility-based care. This includes surveys on patient experience with hospital care, nursing home care, and HCBS (AHRQ 2021a).

²⁶ For example, the BRFSS is an ongoing, state-specific telephone survey that collects data about health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS consists of a standardized core questionnaire, optional modules, and state-added questions and is administered by state health departments. All health departments must ask the core component questions without modification. The questionnaire is designed and approved by a working group of state coordinators and staff at the Centers for Disease Control and Prevention (CDC 2021a, 2014). Similarly, the PRAMS also has core questions that are asked by all sites (i.e., states and cities). Additional questions can be chosen from a pretested list of standard questions developed by CDC or developed by sites on their own (CDC 2021b).

²⁷ The NAM CAHPS is different from the CAHPS health plan surveys discussed previously. The NAM CAHPS was a national Medicaid beneficiary survey conducted by CMS in the fall of 2014.

²⁸ Forty-six states plus the District of Columbia were included in the sampling frame, averaging approximately 29,000 adult Medicaid enrollees from each state.

²⁹ This amount included the survey contract, as well as other funds for IT and additional analysis. It does not include costs for CMS staff dedicated to the project.

³⁰ States collect the data on utilization and enrollment that they subsequently report to CMS in a standardized format to T-MSIS.

³¹ For example, in public comments and MACPAC interviews, states expressed concerns with existing CMS guidance on the AMRPs, particularly the need for additional clarity and specificity to help states calculate the measures consistently. Other stakeholders also pointed to the importance of specific guidance on how to collect and analyze data, as well as information on stratification by demographic characteristics and subpopulations. Similar comments were made in response to the 2015 RFI, with some states noting they lack the resources to collect and analyze certain data.

³² Prior efforts to monitor access and ensure network adequacy also have taken phased approaches. For example, under FFS, the first AMRP had to be submitted within a year after the publication of the final 2015 FFS rule. Even so, states reported that the process was burdensome. In comments submitted by states in response to the final 2015 FFS rule, most expressed concerns about this timeline, citing resource constraints and lack of state capacity to collect and analyze data that may not have been previously collected by some states. Under managed care, states had two years to implement network adequacy standards (CMS 2016).

³³ The historical target sample size for the MCBS is 11,500, although the sample size can fluctuate depending on the level of funding (CMS 2021b). The fiscal year 2021 total operational budget request for the MCBS was \$25.4 million (CMS 2020dc). However, the sample size for a federal Medicaid beneficiary survey may need to be larger to allow for state-level estimates. For example, the sample size for the NAM CAHPS survey of Medicaid beneficiaries was 270,000 (NORC 2015). Costs are also dependent on other factors such as how the data are collected.

³⁴ Based on the level of effort for the NAM CAHPS, this burden is likely to be minimal. On average, it took states nine hours to validate and append enrollee contact information to the sample file (NORC 2015).

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on April 8, 2022.

A New Medicaid Access Monitoring System

- 1.1 The Centers for Medicare & Medicaid Services should develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems. These measures should:
 - capture potential access, realized access, and beneficiary perceptions and experiences;
 - prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities; and
 - be adaptable to reflect changes in measurement, policy priorities, and care delivery.

CMS should issue public reports and data at the state and national level in a consumer-friendly and research-ready format in a timely manner.
- 1.2 The Centers for Medicare & Medicaid Services should involve stakeholders in the development and future modifications of a new system. The agency should actively solicit and incorporate input from key stakeholders, including, but not limited to, states, beneficiaries, consumer groups, health plans, providers, researchers, and other policy experts. The process for establishing a new access monitoring system should be public and transparent.
- 1.3 The Centers for Medicare & Medicaid Services should field an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care.
- 1.4 The Centers for Medicare & Medicaid Services should further standardize and improve the Transformed Medicaid Statistical Information System data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity.

1.5 To assist states in collecting and analyzing access measures, the Centers for Medicare & Medicaid Services should provide analytical support and technical assistance.

1.1-5 Voting Results	#	Commissioner
Yes	15	Allen, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, Duncan, Gordon, Heaphy, Johnson, Lampkin, Herrera Scott, Weno
Not Present	1	Scanlon