Via online submission

January 4, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

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

Dear Acting Administrator Slavitt:

The National Health Law Program (NHeLP) is a public interest law firm working to protect and advance the health rights of low-income and underserved individuals and families. Founded in 1969, NHeLP advocates, educates and litigates at the federal and state levels.

We appreciate the opportunity to comment on CMS's Request for Information on Data Metrics and Alternative Processes for Access to Care in the Medicaid Program. NHeLP offers its feedback, based on our considerable experience working with consumers and consumer advocates around the country to ensure that they have real access to the services they need. We respond, below, to each of the questions CMS has set forth in the RFI.

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A. Access to Care Data Collection and Methodology.

i. What do you perceive to be the advantages and disadvantages to requiring a national core set of access to care measures and metrics? Who do you believe should collect and analyze the national core set data?

We strongly recommend that CMS set a national core set of access to care measures and metrics. Under federal law, CMS is charged with the responsibility of enforcing the Medicaid Act; and core access measures will allow it to do so. While individual states could be responsible for collecting and analyzing state-level data to evaluate compliance with national standards set by CMS, we urge CMS to take a strong role in monitoring states' efforts and enforcing compliance if the data reveals access problems. National measures are needed to ensure that standards do not vary too widely from one state to another, and that oversight by CMS is not fragmented.[1]

ii. Do you believe there are specific access to care measures that could be universally applied across services? If so, please describe such measures.

In general, we believe that access measures must be specific to service categories. While we believe that CMS can use the same kinds of measures across different types of services, the precise standard used should often be different between primary care and specialty care, for example, or between behavioral health services and dental care. Differences are needed to capture Medicaid beneficiaries' need for different kinds of services, and the most clinically appropriate delivery of those services.

iii. What information and methods do you believe large health care programs use to measure access to care that could be used by the Medicaid program? What role can health information technology lay in measuring access to care?

Many state insurance agencies require licensed health plans to measure access and demonstrate compliance with state standards. Often, Medicaid Managed Care plans that operate in the state are required to meet the same standards as commercial plans. Thus, these state standards provide valuable information about access to care in Medicaid managed care compares to access in private insurance. There are several types of measures that are used in this context, including geographic access measures, timely access measures, quality measures, and patient experience measures that CMS could implement across the Medicaid

[1] *Cf.* SUZANNE MURRIN, DEPT. OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GENERAL, STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE 19 (2014) ("CMS and States need to do more to ensure that all States have adequate access standards and strategies for assessing compliance."), *available at* http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf.

program.[2] State Medicaid programs also employ measures to ensured enrollees get the care they need.[3]

In addition, CMS already has significant expertise in measuring access in Medicaid. In the 1990s, CMS routinely included access measures in its 1115 waivers including standards for geographic access, timely access, and provider-covered person ratios.[4] While these standards have typically been applied in a managed care context, CMS has experience and expertise with their monitoring and measuring that could be generalized to a FFS context.

We believe that Health Information technology has the potential to make measuring access easier for CMS and State Medicaid programs, and also to increase the reliability of data collected. For example, in California the state agency that licenses most health plans (including most Medicaid plans) launched a five-year process to improve monitoring of plans' compliance with long-standing timely access to care rules.[5] Through that process, the agency is working with plans and providers to implement appointment scheduling systems that can track the time a person requests an appointment and the date for which appointments are actually scheduled.[6] We commend this approach to CMS as a model for measuring timely access that could be adapted for use across the Medicaid program.

In the Medicaid managed care context, several states have recently moved to use one unified provider file both as the basis for plan provider directories, as well as a data input used to evaluate network adequacy.[7] This approach minimizes the burden on plans to produce the

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[2] *See* KAREN BRODSKY *ET AL.,* HEALTH MANAGEMENT ASSOCIATES, MAKING AFFORDABLE CARE ACT COVERAGE A REALITY: A NATIONAL EXAMINATION OF PROVIDER NETWORK MONITORING PRACTICES BY STATES AND HEALTH PLANS (2015) (comparing metrics used in the private market to those used in Medicaid), https://www.healthmanagement.com/assets/Publications/HMA-Final-Report-RWJF-Project-Provider-Network-Monitoring-Compliance-Survey-Oct-2015.pdf.

[3] *See, e.g., See* CAL. HEALTHCARE FOUND., MONITORING ACCESS: MEASURES TO ENSURE MEDI-CAL ENROLEES GET THE CARE THEY NEED App. A (2014) (listing access measures), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MonitoringAccessMediCal.pdf.

[4] *See, e.g.,* JANE PERKINS, MEDICAID MANAGED CARE UPDATE: SECTION 1115 WAIVER CHARTS (1997), http://www.healthlaw.org/publications/browse-all-publications/1115-waiver.

[5] Cal. Dept. Managed Health Care, Submit Health Plan Filings and Reporting, https://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings.aspx (last visited Dec. 15, 2015) (containing detailed templates and instructions for plans).

[6] CAL. DEPT. MANAGED HEALTH CARE, PROVIDER APPOINTMENT AUDIT METHODOLOGY (2015), https://www.dmhc.ca.gov/Portals/0/LicensingAndReporting/SubmittingHealthPlanFilings/ProviderAppointmentAuditMethodology.pdf.

[7] *See, e.g.,* CAL. DEPT. HEALTH CARE SERVS., NETWORK ADEQUACY MONITORING PROJECT 1 (2015), http://www.dhcs.ca.gov/services/Documents/MCAG/ V2_ NetworkAdequacyMonitoringProject.pdf; SHANNON M. MCMAHON, MARYLAND DEPT. HEALTH & MENTAL HYGIENE, MEDICAID NETWORK ADEQUACY STANDARDS AND VALUE OPTIONS MARYLAND CARVE OUT (2015), http://www.marylandhbe.com/wp-content/uploads/2015/08/ S.McMahon.Medicaid-NA-Standards.May2015.pdf; WISC. DEPT. HEALTH, CONTRACT FOR BADGERCARE PLUS AND/OR MEDICAID SSI 170-71 (2015).

same data multiple times and in multiple formats, and also streamlines the process for ensuring that both provider directories and network adequacy assessments are up-to-date. We recommend this approach to CMS, and urge the agency to explore implementing a unified provider file approach across the Medicaid program.

iv. What do you believe are the primary indicators of access to care in the Medicaid program? Is measured variance in these indicators based on differences in things such as: Provider participation and location, appointment times, waiting room times, call center times, prescription fill times, other?

Conceptually, access must be measured both in terms of potential, as well as realized access.[8] In Medicaid, salient indicators of potential access include: provider participation and provider location. Any measures of provider participation must account for the expected utilization of beneficiaries in the service area relative to: the specialization, experience, and expertise of participating providers; the extent to which providers are accepting new patients; and the scope of services provided by participating providers and facilities, including any limitations on service provision pursuant to religious or moral objections. Measures should also account for meaningful participation, as researchers have consistently done when they study Medicaid payments and provider participation, for example defining a participating provider as one who sees a certain number of patients or submits a certain amount of claims per year. Measures of provider location must account for the expected utilization of beneficiaries in the service area relative to: the distance of participating providers and facilities from beneficiaries' homes and workplaces; the means of transportation used by beneficiaries relative to provider sites (*i.e.*, if most beneficiaries rely on public transit, are participating providers proximate to major transit lines); and the extent of transportation assistance offered by the state. Salient measures of realized access include: the time it takes to schedule an appointment, the amount of time beneficiary's spend waiting to see a provider after the time of a scheduled appointment, the amount, duration, and scope of services received versus prescribed, the number of referrals received versus those made, and the proportion of Medicaid beneficiaries, including children, who receive recommended screenings and immunizations.

We emphasize that measures of realized access are particularly important, since too often, measures of potential access are not sufficiently nuanced to ensure that enrollees have access to all covered benefits. Measures that only count the numbers and locations of providers, for example, fail to account for whether providers are obligated to provide all covered services that fall within the scope of practice of their provider license. Enrollees may not be able to access needed care due to providers' unwillingness or protected refusal rights to provide a covered service. For example, if a state provides geographic access to OB/GYNs who provide prenatal care, but it does not contract with any providers who provide counselling and prescriptions for

[8] *See* GERALD F. KOMINSKY, UCLA CNTR. HEALTH POLICY RESEARCH, NARROW NETWORKS: DO WE KNOW WHEN NETWORKS HAVE BECOME TOO NARROW? 15 (2015).

family planning services in its service area, enrollees will not have adequate access to those services. Similarly, measures of potential access frequently do not account for the sub-specialization, particular expertise, or scope-of-practice of providers. For the parent of a child Medicaid beneficiary with leukemia, knowing that the state has contracts with many oncologists is little help if the state cannot provide her child access to a pediatric oncologist with experience treating childhood leukemia.

v. Do you believe a national core set of access measures or metrics should apply across all services, or is it more appropriate to target a core set of access measures by service?

We recommend that CMS adopt a core set of measures that would apply across all services. The specific metrics may need to be different for different services, but the overall methods and measures should be the same. In other words, we recommend that CMS, for example, adopt geographic access standards for all services. We encourage CMS to adopt a higher threshold for primary care than specialty care, however, in recognition of the importance of primary care to Medicaid beneficiaries, and acknowledging that there are often fewer specialists in any particular specialization area than there are primary care providers, and thus additional travel is sometimes required to obtain specialty care.

vi. Do you believe questions in provider and beneficiary surveys should be consistent for Medicaid and Medicare beneficiaries? If not, what differences do you believe should be accommodated for the Medicaid program, including differences in covered services?

In general, we favor consistency between the Medicaid and Medicare surveys—specifically, we recommend that CMS continue to work with the Agency for Healthcare Research and Quality to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey in both programs. In addition, we suggest that CMS consider adapting the Medicare Current Beneficiary Survey (MCBS) for use in Medicaid. The MCBS is a far more comprehensive survey than CAHPS and includes a number of survey sets that ask questions about particular patterns of access and service utilization. Adapting the MCBS for use in Medicaid would allow CMS to use consistent survey questions to better facilitate comparison of access between the two programs. We recommend, however, that for Medicaid the MCBS be supplemented to include certain areas where the MCBS does not adequately encompass the services and provider types in the Medicaid program. For example, Medicaid programs cover a broad range of rehabilitative, preventive, mental health, substance use disorder, and reproductive health services beyond what are provided for in Medicare. In addition, because Medicaid covers many children, adolescents, and women of childbearing age, it must contract with providers who have pediatric and reproductive expertise who may not typically serve the Medicare population.

For example, the MCBS survey set on Medical Providers and Utilization lacks categories for midwives and providers of Intensive Behavioral Services for children with autism spectrum disorder. Since these provider types are common in Medicaid, they should be reflected in this survey if it is adapted to Medicaid. Similarly, if used in Medicaid, the MCBS survey set on Health Status and Functionality should be expanded to include questions about reproductive health, including pregnancy and family planning services; child health, including screenings and immunizations recommended by the Bright Futures periodicity schedule, and common childhood illnesses and conditions. Moreover, the MCBS survey set on Usual Sources of Care only allows respondents to identify doctors and clinics as their usual sources of care, but not other provider types, like Nurse Practitioners, Physician Assistants, Midwives, or Behavioral Health providers. In Medicaid, non-Physician providers frequently serve as beneficiary's usual source of care. If used in Medicaid, this survey module must be adapted to include other provider types.

Thus, while we suggest that CMS use the MCBS as a starting point to survey Medicaid beneficiaries and qualitatively analyze their access and utilization of services, we recommend that CMS review the MCBS before implementing it in Medicaid to ensure that the survey tools accurately and adequately capture the scope of services used by Medicaid beneficiaries.

vii. What do you believe we should consider in undertaking access to care data collection in areas related to: Differences between fee-for-service (FFS) and managed care delivery, variations in services such as acute and long-term care, community and institutional settings for long-term care delivery, behavioral health, variations in access for pediatric and adult populations and individuals with disabilities, and variations in access for rural and urban areas? Consider also individuals with chronic conditions who may have limited functional support needs related to activities of daily living but nonetheless require more intensive care than other Medicaid beneficiaries, such as persons living with HIV/AIDS.

We do not see any reason to collect data differently in FFS Medicaid than in managed care. The needs of beneficiaries are the same, regardless of the delivery system through which they receive services. In addition, using the same methods of collecting and analyzing data across delivery systems will better facilitate comparisons of the performance of state and managed care plans. That said there may be a very few areas where some differences are dictated by the delivery system. For example, given the different process for appeals in managed care compared to FFS, CMS may need to tailor its collection and analysis of data in different delivery systems. On the whole, however, because the same legal requirements concerning access apply in both a FFS and managed care settings, we urge CMS to collect data as consistently as possible. . In addition, in *both* FFS and managed care systems there is a strong and equivalent structural need to monitor access:

- In FFS, there may be no entity responsible for creating networks, so the random formation of the network may leave gaps.
- In managed care, there is an entity coordinating the network, however that entity relies on restrictive networks to control costs, and this too may lead to gaps.

We do think it is generally appropriate to apply different measures for different types of services. As described in more detail below, we believe that most measures of access should differentiate between service types. Even where the metric used is the same, we recommend disaggregating service types to allow CMS and states to identify areas where there are particular problems or gaps. If the state only collects information about the distance of all Medicaid providers compared to beneficiary's homes, for example, it will not be able to determine if there are particular gaps in coverage of primary care, or behavioral health, or in other areas. We also recommend separately measuring adult and pediatric services in many categories. Since child beneficiaries generally need to see providers with pediatric expertise, disaggregation is necessary to measure any access differences between providers for adults and providers for children. CMS should also consider separating measures for geriatric and disability specialization, as well as health conditions that may require more specialized provides (such as HIV).

viii. Specific to long-term services and supports, including home and community based services, what factors do you believe we should consider in measuring access to care? Do you believe we should incorporate into reviews of access to care for these services economic factors and significant policy factors such as: Minimum wage and overtime requirements, direct service worker shortages, training and professional development costs, or other factors?

Measuring access to long-term services and supports (LTSS) and home and community based services (HCBS) is different from measuring access to other clinical services and states are significantly "behind the curve" when it comes to measuring access in these areas due to a dearth of metrics to measure access. To begin with, the most frequently used access criteria such as time and distance standards are generally inapposite to services provided in a fixed home, community, or institutional location. Additionally, LTSS and HCBS services have (1) a wider range of amount, duration, and scope variations (for example, home attendant services that may be prescribed for 7 hours per week, or 17 hours, or 27 hours, etc.) and (2) a wide range of unique conditions that may complicate provision of services (such as travel time to an individual's home or very particular skills needed for at-home care for a specific individual). Given these factors, access to care has been less reliable. As described in greater detail below, in the context of LTSS and HCBS, CMS will need to:

- Develop metrics to evaluate if needed care is being prescribed. For example, in the context of LTSS and HCBS it is all too common to evaluate need based on available

treatments, as opposed to prescribing treatments based on need. In this process individuals in many locations are routinely pressured into accepting insufficient treatment plans.

- Develop metrics to evaluate if provider capacity is sufficient. (The more typical network adequacy analysis).

- Develop metrics to evaluate what proportion of prescribed hours is *actually* being filled. One of the most pervasive problems in LTSS and HCBS care is that many individuals only receive a fraction of the care they need even though they *have* an approved prescription for the care (for example, they may receive only 20 of their 40 hours of prescribed home care).

- Develop metrics to evaluate how assessed "need" is being inappropriately influenced (i.e., assessed to low) based on extraordinary supports from friends or family, or unreasonable expectations on service recipients themselves.

- Develop methods to stratify metric data to identify how aggregate access data may mask serious access difference among the extremely diverse population relying on these services.

Currently, there are no well-established factors or methodology to assess access to LTSS and HCBS.[9] CMS has set forth important principles of access for these services, but has identified few metrics that states can use to evaluate whether their programs comply with those principles.[10] Some states, such as Minnesota, have attempted to measure access and have encountered difficulty in establishing measures and methodology that will accurately reflect access issues.[11] In a study on the effect of rates on access, the results showed the difficulties in measuring access and highlighted that while practical experience confirms that decreased rates affect access, this trend was not always easily identifiable through statistical measure.[12] Also, the report noted that the measures used can only show associations, not causation; that it is very difficult to control for policy or programmatic changes; and that other factors, such as

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[9] *See, e.g.,* H. Stephen Kaye & Charlene Harrington, *Long-term Services and Supports in the Community: Toward a Research Agenda*, 8 HEALTH & DISABILITY J. 3 (2015) (identifying research gaps in LTSS access); DISABILITY RIGHTS EDUCATION & DEFENSE FUND & NAT'L SENIOR CITIZENS LAW CNTR., IDENTIFYING AND SELECTING LONG-TERM SERVICES AND SUPPORTS OUTCOME MEASURES (2013) [hereinafter LTSS OUTCOME MEASURES REPORT] (discussing potential measures and their limitations), http://dredf.org/2013-documents/Guide-LTSS-Outcome-Measures.pdf.

[10] *See* CNTRS. MEDICARE & MEDICAID SERVS., GUIDANCE TO STATES USING 1115 DEMONSTRATIONS OR 1915(B) WAIVERS FOR MANAGED LONG TERM SERVICES AND SUPPORTS PROGRAMS (2013), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf.

[11] JESSICA KASTEN & REBECCA WOODWARD, TRUVEN ANALYTICS, MINNESOTA LTSS SERVICE ACCESS STUDY: FINDINGS FROM YEARS 1 AND 2 (2014), http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_189962.pdf.

[12] *See id.*at 23.

the presence of an informal caregiver, were not part of the study.[13] A significant finding from the Minnesota reports is that provider supply has an independent effect on HCBS access, both for service planning and service receipt.[14] Therefore, measuring access for LTSS and HCBS has the compounding factor that it will be difficult to find some access problems because services are not requested. Other states, such as Rhode Island, have measures some aspects of access, including LTSS, but such studies have largely focused on geographic location and whether providers are currently accepting new patients.[15] While such factors, which are commonly used for measuring access to other services, are helpful, assessing access for LTSS and HCBS has proven to be much more complex.

Moreover, for LTSS and HCBS, access to services is greatly affected by employment issues. The ability of providers to pay reasonable wages out of the rate received for the services is significant. Wage is a driving force in the availability, skill, reliability, and longevity of workers.[16] This is especially true when the services are for those individuals who are more medically complex or have significant behaviors and thus more skill is needed and longevity, such that the worker is familiar with the needs of the individual, is very important to access to services. For many individuals who use LTSS/HCBS, consistency and reliability in workers is critical to successful community living. Many people experience service disruption and access issues when there is a change in workers or they have to change providers because the provider no longer has workers that will meet the needs of the individual. In addition to wage, other factors that could be measured would include gaps in service, both length of time and frequency, as well as frequency of provider changes. Possible measures of access related to direct care workers would include comparing units of service authorized to those used to measure, which should reflect access to providers and reliability of providers; average number of unique participating providers by types compared to those found in individual claims; the number of providers licensed to practice in a particular geographic area from year to year; and the ratio of unique recipients to the number of unique participating providers per county.
Services provided by natural supports, both paid and unpaid, would also be relevant to questions of access as would assessments of the care providers.[17] For example, if a parent of an adult child is providing a significant number of hours, both paid and unpaid, this could be an indicator that the family cannot find a qualified provider for the services. In addition, an assessment of that parent's well-being could indicate that providing the services is not ideal

[13] *Id.*
[14] *Id.* at 19-20.
[15] *See* RHODE ISLAND DEPT. HEALTH, 2015 STATEWIDE HEALTH INVENTORY UTILIZATION AND CAPACITY STUDY 58-79 (2015), http://www.health.ri.gov/publications/reports/2015HealthInventory.pdf.
[16] *See, e.g.,* CNTRS. MEDICARE & MEDICAID SERVS., COVERAGE OF DIRECT SERVICE WORKFORCE CONTINUING EDUCATION AND TRAINING WITHIN MEDICAID POLICY AND RATE SETTING: A TOOLKIT FOR STATE MEDICAID AGENCIES 18 (2013), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Workforce/Downloads/DSW-Training-rates-toolkit.pdf.
[17] *See* LTSS OUTCOME MEASURES REPORT at 28.

and is impacting the parent's ability to otherwise support the individual and continue to provide services in the future. Additional access issues could be identified by surveying LTSS/HCBS participants and their support systems as they would be able to identify with the most specificity the access issues and the perceived cause of such problems.

Related to wage, the requirements for ongoing training and development costs as well as other factors that can affect provider availability, such as overtime requirements and whether or not travel is reimbursed as part of the service, should be factored in when considering access issues.[18] The overtime requirements are particularly relevant in the immediate future as many LTSS/HCBS providers are facing major changes as they come into compliance with the changes to the home care rule, which may create more direct care worker shortages.[19] Ongoing training and development of workers is important to quality of care and ensuring direct care workers have the tools they need to both provide good care and to continue in the profession. The costs associated with development of the workforce may also be exacerbated by high worker turnover and could be relevant, depending on how it is measured, to access to provider issues. It is not clear if these factors need to be measured, but availability of data could help in the analysis of access issues. As discussed above, access to LTSS and HCBS is difficult to analyze and many factors are likely important in understanding what is contributing to access issues. The potential factors to be measured that are discussed in these comments are certainly not an exhaustive list. We firmly believe that measuring access for LTSS and HCBS will require thinking outside the current measurements for access used for other services and will take the knowledge of multiple groups.

ix. Do you believe measuring access to Home and Community Based Services (HCBS) differs from measuring access to acute medical care? Please describe.

NHeLP believes that measuring access to HCBS and LTSS will require the use of different measures than those used to measure access to acute care. As described in more detail above, attempts to measure access for LTSS and HCBS thus far seem to be overly general for the needs of the population, such as whether there are facilities currently taking residents. Such measures are helpful to the extent it will show major problems, but access to LTSS and HCBS is much more complex. For example, collecting data on whether there are openings at ICFs/IDD may provide general information about demand for such institutional placements, but it does not tell the state that the openings are for a certain population type, such as young women with moderate intellectual disabilities, and that access for the aging ID/DD population is a serious problem. Measuring access to more community-based problems can sometimes be even more complex about what types of individuals, in terms of diagnoses, demographics, or behavioral issues, a provider has capacity to serve.

[18] *Cf.* CNTRS. MEDICARE & MEDICAID SERVS., *supra* note 16 at 38.
[19] *See* Rachel B. Morgan, Nat'l Conf. State Leg., *Fair Wage and Labor Standards for In-Home Direct Care Workers Goes Into Effect November 12, 2015*, http://www.ncsl.org/research/health/fair-wage-and-labor-standards-extended-to-in-home-direct-care-workers635503487.aspx.

x. Do you believe access to HCBS should be tracked in FFS and in managed care delivery systems? Do you perceive any differences between tracking HCBS in each system?

We do not believe that there should be significant inherent differences in measurement of access for LTSS and HCBS under FFS versus managed care and recommend that any standards be usable under commonly used delivery systems. However, we do urge CMS to pay special attention to MLTSS access given the large-scale transitions of LTSS and HCBS populations to managed care currently underway in the health care system. This transition is disrupting some long-standing LTSS and HCBS infrastructure, while at the same time transitioning individuals into managed care entities that in some cases have less experience with LTSS and HCBS networks. Under these circumstances, CMS must prioritize metrics that may identify problems related to these transitions (such as disruptions in case management or service plans). In any event, there must be standards for measuring LTSS and HCBS, but because these standards are not currently well-established, we recommend convening stakeholders so that the standards that will be set are meaningful and effective. Such standards could be set forth in sub-regulatory guidance, much like CMS sets out network adequacy standards for Medicare Advantage plans.

In the context of implementing the recent HCBS settings regulation, CMS has begun to analyze some factors that may inform metrics and thresholds for access to LTSS and HCBS. We urge CMS to use the information it collects in the HCBS settings rule implementation process to its larger access measurement goals, both in a managed care and a FFS context. Moreover, we disagree that HCBS waiver programs should be exempted from the access rules. Exempting waiver programs is inconsistent with CMS's own technical guidance.[20] We urge CMS to review all HCBS delivery using the same criteria in order to ensure that beneficiaries have uniform access to care.

xi. Do you believe there are additional metrics that need to be tracked related to HCBS?

The few studies that exist seem to show that measuring access for HCBS does not yet have well-established practices.[21] Therefore, we strongly recommend that CMS take the comments received into consideration, but focus on creating a working group or similar collaboration of stakeholders such to formulate specific standards and methodology for measuring access to LTSS and HCBS. Merely establishing that states have to measure access for LTSS and HCBS without further information or standards does little to actually ensure access for services that

[20] CNTRS. MEDICARE & MEDICAID SERVS., INSTRUCTIONS, TECHNICAL GUIDE, AND REVIEW CRITERIA FOR 1915(C) HOME AND COMMUNITY-BASED WAIVER 266 (2015), https://www.medicaid.gov/medicaid-chip-program-information/bytopics/waivers/downloads/technical-guidance.pdf.
[21] *See* sources cited *supra* note 9.

are critical to community living. Membership of such a group should include representatives from the federal Health and Human Services Agency, including CMS, Substance Abuse and Mental Health Services Administration (SAMHSA), Administration for Community Living (ACL), and the Office for Civil Rights (OCR); state Medicaid agencies; Medicaid managed care plans; Medicaid beneficiaries; Medicaid beneficiary advocates; and academics.

B. Access to Care Thresholds/Goals

i. Do you believe we should set thresholds for Medicaid access to care? If so, do you believe such thresholds should be set at the national, state or local levels? Why?

NHeLP strongly urges CMS to set national thresholds for Medicaid access to care. Doing so will allow CMS to evaluate access across states and identify best practices. Allowing states to set thresholds at the state or local level, will also result in standards that vary too widely from one state or locality to another. While it is inevitable that some Medicaid beneficiaries will have to wait longer than others to see doctors, or travel further, CMS should play the role of setting maximum wait times that state Medicaid programs may not exceed. There is no reason for beneficiaries to be subject to different *maximum* waits simply because they live in different states or regions—the clinical standards for timely access do not vary based on region. Moreover, it will be difficult for CMS to oversee and monitor states' performance if it must enforce 50 or more different standards.[22] Moreover, a national standard can be sufficiently flexible to account for geographic and demographic differences around the country. For example, all state-licensed managed care plans in California—a large diverse state, with both large urban cities, and many sparsely populated, rural areas—are subject to the same access thresholds, subject to limited exceptions on a case-by-case basis.[23] It uniform standards that have been tested and work in a large state like California, there is no reason CMS cannot similarly adopt a national minimum threshold for all state Medicaid programs.

If it permits a proliferation of thresholds, CMS's oversight of access problems will likely continue to be fragmented and ineffective.[24] Setting a national floor which all states must meet will allow CMS to more easily ensure that all Medicaid beneficiaries are receiving a minimally acceptable level of access through uniform data collection and analysis. CMS should permit

[22] *See* MURRIN, *supra* note 1 at 8-9 (describing various state standards for travel time and distance in the Medicaid managed care context, ranging from 5 miles in two states, to 100 miles in two other states); *see also* BRODSKY, *supra* note 2 at 12-19 (describing the range of various state standards network sufficiency in the Medicaid and private insurance markets).
[23] *See* CAL. HEALTH & SAFETY CODE §§ 1368, 1368.01, 1374.30 (access provisions of California's Knox-Keene Act); CAL. CODE REGS., tit. 28, §§ 1300.51(c)(H), 1300.67, 1300.67.2.2(c) (regulations implementing Knox-Keene access provisions).
[24] *See* MURRIN, *supra* note 1 at 19 ((“CMS and States need to do more to ensure that all States have adequate access standards and strategies for assessing compliance.”).

states to use their own access thresholds at the state or local level only when those thresholds are more protective of beneficiaries that the national standards set by CMS.

ii. If we set Medicaid access thresholds, how do you believe they should be used? For instance: For issuing compliance actions to states that do not meet the thresholds, as benchmarks for state improvement, for use in appeals processes for beneficiaries that have trouble accessing services, or in other ways?

NHeLP recommends that CMS use national Medicaid access thresholds in the following ways: (1) as the basis for beneficiary appeals and state corrective action on an individual basis where the state fails to meet an access threshold with respect to an individual beneficiary; (2) to assess areas where state Medicaid programs are experiencing access gaps; (3) as benchmarks for states to improve performance and address identified gaps; (4) as the basis for compliance action when states fail to address identified gaps; (5) as the basis for sanctions for states that repeatedly fail to correct or address identified gaps. In other words, we suggest that CMS use thresholds as benchmarks with respect to both individual beneficiaries, but also as a tool to identify and address systemic problems. By using national thresholds, CMS will also be more easily able to compare states to one another, and identify national access problems as well as local or regional ones.

C. Alternative Processes for Access Concerns

i. Do you believe there are existing and effective processes to resolve consumers' concerns regarding health care access issues that might be useful for all state Medicaid programs?

We are not aware of any state Medicaid program that has a statewide system of addressing access concerns in a FFS program. In some states, beneficiaries may occasionally find someone at their state or local Medicaid office who will assist them in finding a provider who accepts FFS Medicaid, but frequently beneficiaries are simply referred to the phone book.[25] Even the beneficiaries who do get help may be given a provider list that is full of inaccuracies. Many states resolve these issues—if at all—through their fair hearing processes, or through litigation in state or federal court. Neither process is well-suited to addressing systemic problems in a timely or efficient manner. By contrast, Medicaid managed care plans are required by regulation to accept enrollee grievances and appeals, which do provide enrollees a forum to raise address most access complaints.[26] Medicaid plans must resolve enrollee

[25] *See, e.g.,* Eric Steele, Medicaid patients face limited access, Bangor Daily News (Jan. 27, 1998), http://archive.bangordailynews.com/1998/01/27/medicaid-patients-face-limited-access/.
[26] *See* 42 C.F.R. §§ 438.400-402 (depending on how an access problem presents, it could be classified as an action, which entitles an enrollee to an appeal, including a state fair hearing; or as a non-action, which only allows the enrollee to pursue an internal grievance with his or her plan).

grievances and appeals within 90 and 45 days, respectively; appeals must be handled within three working days when the "time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function."[27] There is no comparable right to expedited resolution for FFS beneficiaries.

We also note that the federal regulations require Medicaid plans to collect and report grievance and appeal data that includes information about access problems.[28] Some states include several categories in the reports that contracted plans fill out and return to the state aimed at collecting information about access problems.[29] We commend these examples to CMS as a model of how it might collect and monitor complaint data to understand what it reveals about access problems in state Medicaid programs.

Ultimately, we recommend that CMS require all states to have a dedicated informal process for addressing access problems, such as an access hotline or ombuds program. Through various forms of notice, this centralized contact point should be known to consumers, consumer advocates and case workers, providers, health plan member services representatives, and state and county Medicaid agency staff. The staff who run the program should have standardized information to share with consumers, including up-to-date provider lists, information about filing appeals, etc. This informal process must first and foremost help consumers troubleshoot specific problems, but it should *also* serve a systemic role by recording, compiling, and reporting complaints to identify patterns in access problems and help the state develop responses. More specifically, we recommend that this contact point be established to fulfill the functions required in recently proposed regulations 42 C.F.R. §§ 447.203(b)(5)(ii)(G) and (b)(7). A well-known and centralized access problem contact point is a critical component for resolving individual problems and monitoring access at the systemic level.

ii. What do you believe are the advantages and disadvantages of either a complaint resolution process or a formal appeals hearing for access to care concerns?

We urge CMS, consistent with the principles of due process, to continue to require states to offer fair hearings to beneficiaries who do not have adequate access to care. In contrast to performance measures, such as HEDIS, which provide information about how a program was working years before, a well-functioning complaint process provides government officials with real-time information about how the Medicaid program is working. Thus, the complaint process is an absolutely essential (yet often times despised) component for states to implement. CMS

[27] *Id.* § 438.410(a); *see also id.* § 438.408(b).
[28] *See* 42 C.F.R. § 438.416.
[29] *See, e.g.,* LOUISIANA MEDICAID MANAGED CARE, MEMBER GRIEVANCES OPERATIONAL GUIDE 6 (2015), http://www.dhh.state.la.us/assets/docs/BayouHealth/MCO_Templates/Grievance/LA_Medicaid_Managed_Care_Member_Grievances_Operational_Guide_Rev_8-2015.pdf.

should clarify in written guidance that, when a state fails to provide reasonable access to a covered service, such that individuals experience delays in obtaining the service, this is a violation of 42 USC 1396a(a)(3), which guarantees beneficiaries the right to a fair hearing when claims for assistance are not acted on with reasonable promptness. CMS should also clarify in regulation that FFS Medicaid beneficiaries have a right to an expedited fair hearing in urgent cases. But even with these improvements to the existing fair hearing process, we urge CMS to establish an informal process through which states can actually resolve and address individual access complaints, by providing assistance to beneficiaries in finding providers, making appointments, and locating facilities.

Another straightforward solution to some of the access barriers that Medicaid beneficiaries face would be to require states to use and regularly update uniform provider listings for all Medicaid providers. Medicaid managed care plans are required to make directories of their contracted providers available, but there is no comparable mandate for FFS Medicaid.[30] Several states already voluntarily compile provider information for their FFS programs. CMS should explore requiring states to compile provider listings that include both FFS and managed care providers, where applicable, and delineate the provider's specialization, scope of services provided, location, contact information, and office hours; whether the provider is accepting new patients; whether the provider refuses to provide covered services within the provider's scope of practice; what languages are spoken by the provider and staff; and an assessment of the accessibility of the provider's office or facility to beneficiaries with disabilities. By ensuring states provide a uniform directory of Medicaid-participating providers, CMS would reduce many access barriers by simply ensuring that beneficiaries have sufficient information to find providers of covered services, especially for FFS beneficiaries who cannot rely on a managed care plan to help them coordinate their care and locate providers.

iii. Who do you believe should be the responsible party (for example, the state or federal government, an independent third party, a civil servant, an administrative law judge, etc.) to hear beneficiary access to care complaints and/or appeals?

As described above, NHeLP urges CMS to strengthen the fair hearing process to ensure that states use it to address access concerns. But we also suggest that CMS work with states to establish informal process for resolving access problems, which could be run by civil servants or perhaps contracted to third parties, to more quickly and efficiently resolve delays that individuals are experiencing.

[30] *See* 42 C.F.R. § 438.10(f)(6).

iv. For an access to care appeal, what criteria do you believe should be used to help determine: Whether an appeal should be heard? Whether an appeal merits recommendations to the state Medicaid agency?

As described in more detail below, NHeLP suggests that CMS establish access thresholds in terms of appointment timeliness and geographic proximity. We recommend that these thresholds could also be used to determine whether an appeal should be heard, and whether it is meritorious. For example, consider that CMS establishes a threshold that requires states to provide access to primary care within 15 days of request, and within 30 minutes or 15 miles of the beneficiary's home. If a beneficiary alleges to the state that it has not been able to obtain an appointment within 15 days, or within 15 miles of his home, the state should permit the beneficiary to appeal. If the beneficiary's appeal goes forward, the state would bear the burden of proof of showing that an appointment was actually available to the beneficiary within the specified time or distance. If the state is not able to make the required showing, the beneficiary's appeal would succeed, and the state would be required to make remediation to the beneficiary.

v. Which access to care areas of measurement or specific metrics may be useful in setting thresholds that would help hearings officers assess appeals and determine access to care remedies?

NHeLP suggests that CMS set particular thresholds for access in terms of appointment timeliness and geographic access. As described above, hearing officers should use those thresholds to assess appeals and determine appropriate remedies. We set forth our specific recommendations as to thresholds in our response to part D, below.

vi. Lack of timeliness of an appeal could undermine the time sensitive efforts associated with remediating an individual's access to medical services. You may want to consider providing information on the following: How could appeals be expedited? What outcomes could an appeals officer offer if services are unavailable to Medicaid beneficiaries? Are there other non-appeal based processes that could be used instead?

NHeLP shares the concern that formal appeals are frequently not sufficiently timely to actually address access issues. For this reason, we recommend that CMS require states to establish informal access complaint processes for FFS Medicaid, and clarify that Medicaid managed care plans should resolve access problems through their internal grievance and appeals processes. The timeline for these informal processes should be quite swift, and should not preclude beneficiaries from pursuing a formal appeal, but could provide much needed assistance to beneficiaries in resolving access problems that are presenting barriers to care.

In terms of formal appeals, we recommend that CMS clarify that FFS appeals can be expedited when "taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function."[31] Such clarification would provide parity between FFS Medicaid and Medicaid managed care. It also creates a commonsense standard to allow truly urgent cases to be triaged and handled quickly.

In terms of remedies that appeals officers could provide to beneficiaries, we suggest that the remedies will differ for timely access problems than for geographic access problems. When the state has failed to make services available in a timely manner, we believe that in most cases, an appeal officer will not have the power to make the beneficiary whole, as the time for the needed service will already have passed. In some cases, a beneficiary may receive care from a non-Medicaid provider in order to obtain timely care, and in such cases, CMS should make clear that the state must reimburse the beneficiary or provider. Moreover, where there is time to do so, CMS should require states to enter into single-case agreements with non-Medicaid providers as needed to ensure beneficiaries' timely access to care. However, in other cases, where the beneficiary has simply received care after an unreasonable delay, we suggest that the state's FFP be reduced or eliminated for the service, even though this kind of penalty cannot be expected to make the beneficiary whole. In cases involving geographic access barriers, CMS should clarify that states must either provide or reimburse for transportation expenses (including lodging and any other ancillary expenses) necessary to facilitate the beneficiary's receiving care an unreasonable distance from home, or must enter into single-case agreements, when possible, to permit a beneficiary to see a provider nearer to home rather than to travel.

Finally, federal law requires states to make fair hearing decisions available to the public.[32] We are aware that some states do not adhere to this requirement. CMS should enforce it, and also require public access to decisions at the managed care plan level.

D. Access to Care Measures

NHeLP has outlined our recommendations in this area in the chart attached as Appendix A. Note that we recommend that CMS measure all metrics at the county or service area level so that it and the states can best monitor local access patterns and identify gaps at the local level. CMS has requested comments on several types of measures with which we lack expertise to make specific recommendations, but which we agree warrant further exploration. Specifically, we urge CMS to collect more information on potential measures of the availability of direct support workforce for home health and home and community-based services; call-center capability standards to support providing beneficiaries with information that can improve their

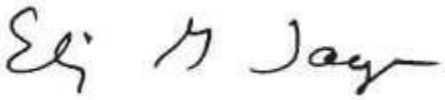
[31] 42 C.F.R. § 438.410(a).
[32] *Id.* § 431.244(g).

access, and produce useful metrics for monitoring; call-center metrics that reveal issues with beneficiary access and their resolution; beneficiaries able to access long-term services and supports in institutional settings; beneficiaries able to access home and community based services; length of delays in accessing long term services and supports in community setting due to direct service worker shortages and/or lack of adequate training; trends in emergency room utilization relative to primary and mental health and substance abuse treatment care utilization; and acquisition costs compared to Medicaid payments for pharmaceuticals.

Conclusion

Thank you again for the opportunity to provide feedback. If you have any questions or need any further information, please contact Abbi Coursolle (coursolle@healthlaw.org; (310) 736-1652), Staff Attorney, at the National Health Law Program.

Sincerely,



Elizabeth G. Taylor,
Executive Director

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
1. Measures for Availability of Care and Providers	1 PCP per 1200 adult enrolles	Calculation based on existing data	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Eligible providers determined by federal licensure lists.	Adults	Sets a baseline for provider participation to ensure that the state or plan contracts with sufficient providers to ensure access.	
	1 Pediatric PCP per 1000 child enrollees	Calculation based on existing data	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Eligible providers determined by federal licensure lists.	Children	Sets a baseline for provider participation to ensure that the state or plan contracts with sufficient providers to ensure access.	
	At least 70% of PCPs offer office hours during evenings or weekends.	Would require CMS to develop survey.	Participating providers determined by provider directories and provider contracts maintained by the state or MCO.	All	Sets a baseline to ensure that beneficiaries who work during the traditional business day have access to primary care without taking time off of work.	We are not aware of any studies that suggest a particular threshold for the proportion of PCPs that offer "after hours" office hours. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers is needed to provide adequate access to working beneficiaries.

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	***Recommended Threshold***	***Feasibility of Collection***	***Data Sources and stewards***	***Applicable Groups or Subpop-ulations***	***Indicators***	***Advantages and notes***
	At least 90% of eligible FQHCs participate	Calculation based on existing data	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Eligible providers determined by federal licensure lists.	All	Sets a baseline for provider participation to ensure that the state or plan contracts with sufficient providers to ensure access.	90% threshold is used in Medicare Advantage.
	At least 90% of eligible RHCs participate	Calculation based on existing data	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Eligible providers determined by federal licensure lists.	All	Sets a baseline for provider participation to ensure that the state or plan contracts with sufficient providers to ensure access.	90% threshold is used in Medicare Advantage.
	At least 90% of Title X Family Planning Clinics participate	Calculation based on existing data	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Eligible providers determined by federal licensure lists.	Beneficiaries of reproductive age	Sets a baseline for provider participation to ensure that the state or plan contracts with sufficient providers to ensure access.	90% threshold is used in Medicare Advantage.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 90% of eligible Free Standing Birth Centers participate	Calculation based on existing data	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Eligible providers determined by federal or state licensure lists.	Pregnant women	Sets a baseline for provider participation to ensure that the state or plan contracts with sufficient providers to ensure access.	90% threshold is used in Medicare Advantage.
	At least 90% of eligible Indian Health Care providers participate	Calculation based on existing data	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Eligible providers determined by federal or state licensure lists.	Native Americans and Alaska Natives	Sets a baseline for provider participation to ensure that the state or plan contracts with sufficient providers to ensure access.	90% threshold is used in Medicare Advantage.
	At least 90% of eligible community mental health centers participate	Calculation based on existing data	Participating community mental health centers determined by provider directories and provider contracts maintained by the state or MCO. Eligible mental health centers determined by federal or state licensure lists.	All	Sets a baseline for provider participation to ensure that the state or plan contracts with sufficient providers to ensure access.	90% threshold is used in Medicare Advantage.

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 50% of eligible retail pharmacies participate	Calculation based on existing data	Participating retail pharmacies determined by provider directories and provider contracts maintained by the state or MCO. Eligible pharmacies determined by federal or state licensure lists.	All	Sets a baseline for provider participation to ensure that the state or plan contracts with sufficient providers to ensure access.	We are not aware of any studies that suggest a particular threshold for the proportion ofparticipating retail pharmacies. We believe that 50% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers is needed to provide adequate access to beneficiaries.
	For all threshold languages, at least 25% of providers or provider offices speak the threshold language	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Proportion of providers speaking threshold languages determined by provider survey.	LEP beneficiaries	Will establish whether sufficient numbers of providers are actually available to provide needed care to LEP beneficiaries.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that speak other languages. We believe that 25% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers is needed to provide adequate access to LEP beneficiaries.
	At least 25% of providers or provider offices are proficient in American Sign Language.	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Proportion of providers proficient in ASL determined by provider survey.	Deaf beneficiaries	Will establish whether sufficient numbers of providers are actually available to provide needed care to deaf beneficiaries.	We are not aware of any studies that suggest a particular threshold for the proportion of providers proficient in ASL. We believe that 25% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers is needed to provide adequate access to deaf beneficiaries.

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 70% of participating adult primary care providers are accepting new Medicaid patients.	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Secret shopper survey to determine number of contracted providers accepting new patients.	Adults	Will establish whether sufficient numbers of providers are actually available to provide needed care.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.
	At least 70% of participating pediatric primary care providers are accepting new Medicaid patients.	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Secret shopper survey to determine number of contracted providers accepting new patients.	Children	Will establish whether sufficient numbers of providers are actually available to provide needed care.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.
	At least 70% of participating women's health providers are accepting new Medicaid patients.	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Secret shopper survey to determine number of contracted providers accepting new patients.	Women	Will establish whether sufficient numbers of providers are actually available to provide needed care.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 70% of participating adult behavioral health providers are accepting new Medicaid patients.	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Secret shopper survey to determine number of contracted providers accepting new patients.	Adults	Will establish whether sufficient numbers of providers are actually available to provide needed care.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.
	At least 70% of participating pediatric behavioral health providers are accepting new Medicaid patients.	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Secret shopper survey to determine number of contracted providers accepting new patients.	Children	Will establish whether sufficient numbers of providers are actually available to provide needed care.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.
	At least 70% of participating adult specialists are accepting new Medicaid patients.	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Secret shopper survey to determine number of contracted providers accepting new patients.	Adults	Will establish whether sufficient numbers of providers are actually available to provide needed care.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 70% of participating pediatric specialists are accepting new Medicaid patients.	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Secret shopper survey to determine number of contracted providers accepting new patients.	Children	Will establish whether sufficient numbers of providers are actually available to provide needed care.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.
	At least 70% of participating adult dentists are accepting new Medicaid patients. (When state covers adult dental.)	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Secret shopper survey to determine number of contracted providers accepting new patients.	Adults	Will establish whether sufficient numbers of providers are actually available to provide needed care.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.
	At least 70% of participating pediatric dentists are accepting new Medicaid patients.	Requires provider survey	Participating providers determined by provider directories and provider contracts maintained by the state or MCO. Secret shopper survey to determine number of contracted providers accepting new patients.	Children	Will establish whether sufficient numbers of providers are actually available to provide needed care.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.

Metric	***Recommended Threshold***	***Feasibility of Collection***	***Data Sources and stewards***	***Applicable Groups or Subpop-ulations***	***Indicators***	***Advantages and notes***
	At least 70% of referrals by PCPs to specialists are fulfilled.	May require provider survey or audit.	Number of referrals made must be counted or collected by PCP offices; number of specialist appointments made may be available in existing encounter data.	All	Will establish whether sufficient numbers of specialists are available to fulfill PCP referrals.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.
	At least 70% of referrals by behavioral health providers to PCPs for beneficiaries with severe mental illness are fulfilled.	May require provider survey or audit.	Number of referrals made must be counted or collected by behavioral health provider offices; number of PCP appointments made may be available in existing encounter data.	Beneficiaries with severe mental illness	Will establish whether there are sufficient PCPs with capacity to serve beneficiaries with severe mental illness.	We are not aware of any studies that suggest a particular threshold for the proportion of providers that are accepting new patients. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of providers accepting new patients needed to provide adequate access to beneficiaries.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 70% of PCP offices meet accessibility standards for beneficiaries with disabilities.	Develop and implement accessibility evaluation tool. California uses a comprehensive accessibility tool in its Medicaid managed care program.	States or plans to implement accessibility tool and collect and report data.	Beneficiaries with disabilities	Will establish whether there are sufficient PCPs with capacity to serve beneficiaries with disabilities.	We are not aware of any studies that suggest a particular threshold for the proportion of PCP offices that are accessible to people with disabilities. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has assessed what level of providers accepting new patients needed to provide adequate access to beneficiaries with disabilities, and states have had the chance to work with providers to invest in infrastructure necessary to provide full accessibility, including programmatic accessibility for beneficiaries with intellectual disabilities.
	At least 50% of other, non-PCP offices meet accessibility standards for beneficiaries with disabilities.	Develop and implement accessibility evaluation tool. California uses a comprehensive accessibility tool in its Medicaid managed care program.	States or plans to implement accessibility tool and collect and report data.	Beneficiaries with disabilities	Will establish whether there are sufficient non-PCP providers with capacity to serve beneficiaries with disabilities.	We are not aware of any studies that suggest a particular threshold for the proportion of non-PCP offices that are accessible to people with disabilities. We believe that 50% is a reasonable starting threshold, which could be adjusted after CMS has assessed what level of providers accepting new patients needed to provide adequate access to beneficiaries with disabilities, and states have had the chance to work with providers to invest in infrastructure necessary to provide full accessibility, including programmatic accessibility for beneficiaries with intellectual disabilities.

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 70% of hospitals meet accessibility standards for beneficiaries with disabilities.	Develop and implement accessibility evaluation tool. California uses a comprehensive accessibility tool in its Medicaid managed care program.	States or plans to implement accessibility tool and collect and report data.	Beneficiaries with disabilities	Will establish whether there are sufficient hospitals with capacity to serve beneficiaries with disabilities.	We are not aware of any studies that suggest a particular threshold for the proportion of hospitals that are accessible to people with disabilities. We believe that 70% is a reasonable starting threshold, which could be adjusted after CMS has assessed what level of providers accepting new patients needed to provide adequate access to beneficiaries with disabilities, and states have had the chance to work with providers to invest in infrastructure necessary to provide full accessibility, including programmatic accessibility for beneficiaries with intellectual disabilities.
	At least 50% of ancillary service locations meet accessibility standards for beneficiaries with disabilities.	Develop and implement accessibility evaluation tool. California uses a comprehensive accessibility tool in its Medicaid managed care program.	States or plans to implement accessibility tool and collect and report data.	Beneficiaries with disabilities	Will establish whether there are sufficient ancillary service locations with capacity to serve beneficiaries with disabilities.	We are not aware of any studies that suggest a particular threshold for the proportion of ancillary service locations that are accessible to people with disabilities. We believe that 50% is a reasonable starting threshold, which could be adjusted after CMS assessed what level of providers accepting new patients needed to provide adequate access to beneficiaries with disabilities, and states have had the chance to work with providers to invest in infrastructure necessary to provide full accessibility, including programmatic accessibility for beneficiaries with intellectual disabilities.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 90% of adult beneficiaries have access to a participating adult primary care provider within 30 minutes or 10 miles.	Mapping based on existing provider participation data.	Participating providers and provider locations determined by provider directories and provider contracts maintained by the state or MCO.	Adults	Will establish that there are sufficient PCPs to serve adult beneficiaries within a reasonable geographic area.	90% threshold is used in Medicare Advantage.
	At least 90% of child beneficiaries have access to a participating pediatric primary care provider within 30 minutes or 10 miles.	Mapping based on existing provider participation data.	Participating providers and provider locations determined by provider directories and provider contracts maintained by the state or MCO.	Children	Will establish that there are sufficient providers of pediatric primary care to serve child beneficiaries within a reasonable geographic area.	90% threshold is used in Medicare Advantage.
	At least 90% of female beneficiaries have access to a participating provider of women's health services within 30 minutes or 10 miles.	Mapping based on existing provider participation data.	Participating providers and provider locations determined by provider directories and provider contracts maintained by the state or MCO.	Women	Will establish that there are sufficient providers of women's health services to serve female beneficiaries within a reasonable geographic area.	90% threshold is used in Medicare Advantage.

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	***Recommended Threshold***	***Feasibility of Collection***	***Data Sources and stewards***	***Applicable Groups or Subpop-ulations***	***Indicators***	***Advantages and notes***
	At least 90% of adult beneficiaries have access to a participating behavioral health provider within 30 minutes or 10 miles.	Mapping based on existing provider participation data.	Participating providers and provider locations determined by provider directories and provider contracts maintained by the state or MCO.	Beneficiaries with mental illness	Will establish that there are sufficient providers of pediatric behavioral health services to serve child beneficiaries within a reasonable geographic area.	90% threshold is used in Medicare Advantage.
	At least 90% of child beneficiaries have access to a participating pediatric behavioral health provider within 30 minutes or 10 miles.	Mapping based on existing provider participation data.	Participating providers and provider locations determined by provider directories and provider contracts maintained by the state or MCO.	Children	Will establish that there are sufficient providers of behavioral health services to serve adult beneficiaries within a reasonable geographic area.	90% threshold is used in Medicare Advantage.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 90% of beneficiaries have access to a participating hospital which has a capacity to serve the entire beneficiary population based on normal utilization, and, if separate from such hospital, a provider of all emergency health care services within 60 minutes or 30 miles.	Mapping based on existing provider participation data.	Participating providers and provider locations determined by provider directories and provider contracts maintained by the state or MCO.	All	Will establish that there are sufficient hospitals and emergency departments to serve beneficiaries within a reasonable geographic area.	90% threshold is used in Medicare Advantage.
	At least 90% of beneficiaries have access to a participating retail pharmacy within 30 minutes or 10 miles.	Mapping based on existing provider participation data.	Participating providers and provider locations determined by provider directories and provider contracts maintained by the state or MCO.	All	Will establish that there are sufficient retail pharmacies to serve beneficiaries within a reasonable geographic area.	90% threshold is used in Medicare Advantage.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 90% of beneficiaries have access to a participating laboratory within 60 minutes or 30 miles.	Mapping based on existing provider participation data.	Participating providers and provider locations determined by provider directories and provider contracts maintained by the state or MCO.	All	Will establish that there are sufficient laboratories to serve beneficiaries within a reasonable geographic area.	90% threshold is used in Medicare Advantage.
	At least 90% of adult beneficiaries have access to a participating dentist within 30 minutes or 10 miles (where the state covers adult dental).	Mapping based on existing provider participation data.	Participating providers and provider locations determined by provider directories and provider contracts maintained by the state or MCO.	Adults	Will establish that there are sufficient dentists to serve adult beneficiaries within a reasonable geographic area.	90% threshold is used in Medicare Advantage.
	At least 90% of child beneficiaries have access to a participating pediatric dentist within 30 minutes or 10 miles.	Mapping based on existing provider participation data.	Participating providers and provider locations determined by provider directories and provider contracts maintained by the state or MCO.	Children	Will establish that there are sufficient pediatric dentists to serve child beneficiaries within a reasonable geographic area.	90% threshold is used in Medicare Advantage.

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	At least 60% of primary care doctors report they are notified when a patient is discharged from the hospital or emergency room.	Would require provider survey	Providers, hospitals	All	Are patients receiving coordinated care?	This threshold would measure whether PCPs are aware of and coordinating with other providers, especially after acute incidents.
2. Measures for Beneficiary Reported Access:	80% of beneficiaries report having a usual source of primary care.	CAPHS or survey instrument similar to MEPS or MCBS.	Beneficiary survey to be administered by CMS or states.	All	Will evaluate whether most beneficiaries have a place to receive primary care.	This is a common beneficiary survey question. We recommend an 80% threshold as a starting point, which could be adjusted by CMS.
	80% of adult beneficiaries report timely access to primary care	CAPHS or survey instrument similar to MEPS or MCBS.	Beneficiary survey to be administered by CMS or states.	Adults	Do beneficiaries perceive timely access to primary care?	This is a common beneficiary survey question. We recommend an 80% threshold as a starting point, which could be adjusted by CMS.
	80% of beneficiaries report timely access to specialty care.	CAPHS or survey instrument similar to MEPS or MCBS.	Beneficiary survey to be administered by CMS or states.	All	Do beneficiaries perceive timely access to specialty care?	This is a common beneficiary survey question. We recommend an 80% threshold as a starting point, which could be adjusted by CMS.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	80% of child beneficiaries report timely access to primary care.	CAPHS or survey instrument similar to MEPS or MCBS.	Beneficiary survey to be administered by CMS or states.	Children	Do beneficiaries perceive timely access to specialty care?	This is a common beneficiary survey question. We recommend an 80% threshold as a starting point, which could be adjusted by CMS.
	80% of beneficiaries report timely access to urgent care.	CAPHS or survey instrument similar to MEPS or MCBS.	Beneficiary survey to be administered by CMS or states.	All	Do beneficiaries perceive timely access to urgent care?	This is a common beneficiary survey question. We recommend an 80% threshold as a starting point, which could be adjusted by CMS.
	80% of beneficiaries report timely access to emergency care.	CAPHS or survey instrument similar to MEPS or MCBS.	Beneficiary survey to be administered by CMS or states.	All	Do beneficiaries perceive timely access to emergency care?	This is a common beneficiary survey question. We recommend an 80% threshold as a starting point, which could be adjusted by CMS.
	Less than 10% of beneficiaries reporting difficulty finding a specialist/general clinician.	CAPHS or survey instrument similar to MEPS or MCBS.	Beneficiary survey to be administered by CMS or states.	All	Can identify trends in lack of specialty access.	This is a common beneficiary survey question. We recommend an 10% threshold as a starting point, which could be adjusted by CMS.
	80% of adults with DSM major depression criteria received treatment	Survey instrument similar to National Comorbidity Survey II.	Beneficiary survey to be administered by CMS or states.	Adults with serious mental illness	Sets a baseline for treatment access for one of the most common mental health conditions.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries with major depression to receive treatment. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	80% of children with DSM major depression criteria received treatment	Survey instrument similar to National Comorbidity Survey II.	Beneficiary survey to be administered by CMS or states.	Children with serious mental illness	Sets a baseline for treatment access for one of the most common mental health conditions.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries with major depression to receive treatment. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.
	80% of adults with DSM generalized anxiety disorder criteria received treatment	Survey instrument similar to National Comorbidity Survey II.	Beneficiary survey to be administered by CMS or states.	Adults with serious mental illness	Sets a baseline for treatment access for one of the most common mental health conditions.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries with generalized anxiety disorder to receive treatment. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.
	80% of children with DSM generalized anxiety disorder criteria received treatment	Survey instrument similar to National Comorbidity Survey II.	Beneficiary survey to be administered by CMS or states.	Children with serious mental illness	Sets a baseline for treatment access for one of the most common mental health conditions.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries with generalized anxiety disorder to receive treatment. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	80% of adults with DSM substance use disorder criteria received treatment	Survey instrument similar to National Comorbidity Survey II.	Beneficiary survey to be administered by CMS or states.	Adults with substance use disorder.	Sets a baseline for treatment access for beneficiaries with substance use disorder.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries with substance use disorder to receive treatment. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.
	80% of children with DSM substance use disorder criteria received treatment	Survey instrument similar to National Comorbidity Survey II.	Beneficiary survey to be administered by CMS or states.	Children with substance use disorder.	Sets a baseline for treatment access for beneficiaries with substance use disorder.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries with substance use disorder to receive treatment. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.
	80% of beneficiaries diagnosed with heart disease received treatment in the preceeding 12 months	Would require CMS to develop survey.	Beneficiary survey to be administered by CMS or states.	All	Sets a baseline for treatment access for one of the most common chronic health conditions.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries with heart disease to receive treatment. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	80% of beneficiaries diagnosed with cancer received treatment in the preceeding 12 months	Would require CMS to develop survey.	Beneficiary survey to be administered by CMS or states.	All	Sets a baseline for treatment access for one of the most common chronic health conditions.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries with cancer to receive treatment. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.
	80% of beneficiaries diagnosed with chronic obstructive pulmonary disease received treatment in the preceeding 12 months	Would require CMS to develop survey.	Beneficiary survey to be administered by CMS or states.	All	Sets a baseline for treatment access for one of the most common chronic health conditions.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries with COPD to receive treatment. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.
	80% of beneficiaries who experienced a stroke received treatment in the preceeding 12 months	Would require CMS to develop survey.	Beneficiary survey to be administered by CMS or states.	All	Sets a baseline for treatment access for one of the most common chronic health conditions.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries with strokes to receive treatment. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
3. Measures regarding Service Utilization	80 % of beneficiaries referred to a specialist by a PCP obtained a specialty visit within 6 months.	May require provider survey or use of encounter data.	Provider survey or encounter data.	All	Tracks actual utilization of follow-up on specialty referrals to assess whether beneficiaries have appropriate access to specialty care.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries referred to specialty care to see a specialist. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.
	80% of beneficiaries referred to receive prenatal care have a prenatal visit within 4 weeks.	May require provider survey or use of encounter data.	Provider survey or encounter data.	Pregnant women	Tracks actual utilization of follow-up on prenatal referrals to assess whether beneficiaries have appropriate access to prenatal care.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries referred to prenatal care to see a specialist. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.
	80% of beneficiaries referred to a behavioral health provider by a PCP obtained a behavioral health visit within 6 months.	May require provider survey or use of encounter data.	Provider survey or encounter data.	All	Tracks actual utilization of follow-up on behavioral health referrals to assess whether beneficiaries have appropriate access to behavioral health care.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries referred to behavioral health care to see a specialist. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	80% of prescriptions written for Medicaid beneficiaries are filled within 4 weeks.	May require provider survey or use of encounter data.	Provider survey or encounter data.	All	Tracks actual utilization of follow-up on prescriptions written to assess whether beneficiaries have appropriate access to prescription drugs.	We are not aware of any studies that suggest a particular threshold for the proportion beneficiaries who fill their prescriptions. We believe that 80% is a reasonable starting threshold, which could be adjusted after CMS has had time to assess what level of treatment utilization is reasonable.
	Women able to access: Pap smears, breast cancer screenings, chlamydia screenings, etc. based on most recent HEDIS median scores.	Existing HEDIS data.	NCQA	Female beneficiaries	Will help establish whether female beneficiaries have appropriate access to recommended screenings.	Thresholds to be based on current medians.
	Children able to access appropriate immunizations and/or seasonal vaccines based on most recent HEDIS median scores and CMS Form 416.	Existing HEDIS and CMS data.	NCQA and CMS	Child beneficiaries	Will help establish whether child beneficiaries have appropriate access to recommended immunizations.	Thresholds to be based on current medians and state performance.

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	***Recommended Threshold***	***Feasibility of Collection***	***Data Sources and stewards***	***Applicable Groups or Subpop-ulations***	***Indicators***	***Advantages and notes***
	Adults able to access appropriate immunizations and/or seasonal vaccines based on most recent HEDIS median scores.	Existing HEDIS data.	NCQA	Adult beneficiaries	Will help establish whether adult beneficiaries have appropriate access to recommended immunizations.	Thresholds to be based on current medians.
	Adults able to access appropriate interventions for chronic conditions including heart disease, diabetes, etc. based on most recent HEDIS median scores.	Existing HEDIS data.	NCQA	Adult beneficiaries	Will help establish whether adult beneficiaries have appropriate access to recommended immunizations.	Thresholds to be based on current medians.
	Urgent care appointments for medical or dental services are available within 48 hours of request.	Will require survey of providers or audit of appointment scheduling systems.	Medicaid providers	All	Do beneficiaries have timely access to urgent care. Based on California's Knox-Keene Act.	CMS could work with states and providers to develop appointment scheduling systems that automatically track the request for an appointment relative to the date it is scheduled.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	Non-urgent appointments for primary and specialty care are available within 15 business days of request.	Will require survey of providers or audit of appointment scheduling systems.	Medicaid providers	All	Do beneficiaries have timely access to non-urgent care. Based on California's Knox-Keene Act.	CMS could work with states and providers to develop appointment scheduling systems that automatically track the request for an appointment relative to the date it is scheduled.
	Non-urgent appointments with a non-physician mental health care provider are available within 10 business days of request .	Will require survey of providers or audit of appointment scheduling systems.	Medicaid providers	All	Do beneficiaries have timely access to behavioral health care. Based on California's Knox-Keene Act.	CMS could work with states and providers to develop appointment scheduling systems that automatically track the request for an appointment relative to the date it is scheduled.
	Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition are available within 15 business days of request.	Will require survey of providers or audit of appointment scheduling systems.	Medicaid providers	All	Do beneficiaries have timely access to ancillary care. Based on California's Knox-Keene Act.	CMS could work with states and providers to develop appointment scheduling systems that automatically track the request for an appointment relative to the date it is scheduled.

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	Non-urgent dental appointments are offered within 30 business days of request.	Will require survey of providers or audit of appointment scheduling systems.	Medicaid providers	All	Do beneficiaries have timely access to non-urgent dental care. Based on California's Knox-Keene Act.	CMS could work with states and providers to develop appointment scheduling systems that automatically track the request for an appointment relative to the date it is scheduled.
4. Comparison of Payments:	Provider payment rates for primary care are set at least 95% of the Medicare or commercial rate, and exceed actual costs.	Based on existing provider payment rate data.	CMS (Medicare rates), DOIs (commercial rates), provider organizations (actual costs), states (Medicaid rates)	All	Are primary care providers paid a sufficient rate to provide services to Medicaid beneficiaries? CMS would presume that a rate that meet or exceeds 90% of Medicare is sufficient, and would require proof of sufficiency.	We recommend a 95% threshold as a long-term goal. CMS should use this benchmark to set a presumption of compliance such that, states whose payment rates meet or exceed the benchmark are presumed to be in compliance with (a)(30)(A) and face a less burdensome process to demonstrate equal access. This approach will reward high performing states and create an incentive for all states to become high performers.
	Provider payment rates for specialty care are set at least 95% of the Medicare or commercial rate, and exceed actual costs.	Based on existing provider payment rate data.	CMS (Medicare rates), DOIs (commercial rates), provider organizations (actual costs), states (Medicaid rates)	All	Are specialty care providers paid a sufficient rate to provide services to Medicaid beneficiaries? CMS would presume that a rate that meet or exceeds 90% of Medicare is sufficient, and would require proof of sufficiency.	We recommend a 95% threshold as a long-term goal. CMS should use this benchmark to set a presumption of compliance such that, states whose payment rates meet or exceed the benchmark are presumed to be in compliance with (a)(30)(A) and face a less burdensome process to demonstrate equal access. This approach will reward high performing states and create an incentive for all states to become high performers.

Appendix A: NHeLP's Proposed Metrics for D. Access to Care Measures - CMS-2328-NC RFI

Metric	*Recommended Threshold*	*Feasibility of Collection*	*Data Sources and stewards*	*Applicable Groups or Subpop-ulations*	*Indicators*	*Advantages and notes*
	Provider payment rates for behavioral health care are set at least 95% of the Medicare or commercial rate, and exceed actual costs.	Based on existing provider payment rate data.	CMS (Medicare rates), DOIs (commercial rates), provider organizations (actual costs), states (Medicaid rates)	All	Are behavioral health providers paid a sufficient rate to provide services to Medicaid beneficiaries? CMS would presume that a rate that meet or exceeds 90% of Medicare is sufficient, and would require proof of sufficiency.	We recommend a 95% threshold as a long-term goal. CMS should use this benchmark to set a presumption of compliance such that, states whose payment rates meet or exceed the benchmark are presumed to be in compliance with (a)(30)(A) and face a less burdensome process to demonstrate equal access. This approach will reward high performing states and create an incentive for all states to become high performers.
	Provider payment rates for ancillary services are set at least 95% of the Medicare or commercial rate, and exceed actual costs.	Based on existing provider payment rate data.	CMS (Medicare rates), DOIs (commercial rates), provider organizations (actual costs), states (Medicaid rates)	All	Are ancillary care providers paid a sufficient rate to provide services to Medicaid beneficiaries? CMS would presume that a rate that meet or exceeds 90% of Medicare is sufficient, and would require proof of sufficiency.	We recommend a 95% threshold as a long-term goal. CMS should use this benchmark to set a presumption of compliance such that, states whose payment rates meet or exceed the benchmark are presumed to be in compliance with (a)(30)(A) and face a less burdensome process to demonstrate equal access. This approach will reward high performing states and create an incentive for all states to become high performers.

Metric	***Recommended Threshold***	***Feasibility of Collection***	***Data Sources and stewards***	***Applicable Groups or Subpop-ulations***	***Indicators***	***Advantages and notes***
	Provider payment rates for hospital-based services are set at least 95% of the Medicare or commercial rate, and exceed actual costs.	Based on existing provider payment rate data.	CMS (Medicare rates), DOIs (commercial rates), provider organizations (actual costs), states (Medicaid rates)	All	Are hospital-based providers paid a sufficient rate to provide services to Medicaid beneficiaries? CMS would presume that a rate that meet or exceeds 90% of Medicare is sufficient, and would require proof of sufficiency.	We recommend a 95% threshold as a long-term goal. CMS should use this benchmark to set a presumption of compliance such that, states whose payment rates meet or exceed the benchmark are presumed to be in compliance with (a)(30)(A) and face a less burdensome process to demonstrate equal access. This approach will reward high performing states and create an incentive for all states to become high performers.