CHAPTER 4

Examining Access to Care in Medicaid and CHIP

Section 1900(b)(1) of the Social Security Act: MACPAC shall – (A) review policies of the Medicaid program established under this title (in this section referred to as 'Medicaid') and the State Children's Health Insurance Program established under title XXI (in this section referred to as 'CHIP') affecting access to covered items and services, including topics described in paragraph (2).

Chapter Summary

Drawing on earlier research and ongoing efforts to measure access to care, the Commission has developed an initial framework for examining access that takes into account the characteristics and complex health needs of Medicaid and CHIP populations, as well as program variability across states. Our approach aims to help shape our future work on monitoring and evaluating access to services for Medicaid and CHIP enrollees. This framework will also serve as the basis for our work to develop an early-warning system (EWS) to identify areas with provider shortages and other factors that adversely affect, or could potentially adversely affect, access to care for, or the health status of, Medicaid and CHIP enrollees.

The Commission's framework, which focuses initially on primary and specialty care providers and services, has three main elements: enrollees and their unique characteristics, availability of providers, and utilization. Factors associated with enrollee characteristics such as geographic location, cultural diversity, and program eligibility should be accounted for along with income levels and health care needs. Availability of providers is also a significant factor affecting access and is influenced by overall supply and provider participation. Utilization encompasses whether and how services are used, the affordability of services, and how easily enrollees can navigate the health care system. In addition, the Commission will evaluate overall access in terms of the appropriateness of services and settings for care; efficiency, economy, and quality of care; and overall health outcomes.

Using this initial framework, a set of measures will be identified and monitored to provide an understanding of where access levels exist today and allow the Commission to track trends moving forward. We also intend to identify federal and state policies relevant to Medicaid and CHIP that provide promising opportunities for enhancing appropriate access. We expect our access framework to evolve to address new health care practice patterns, changing program needs, and new Commission priorities.

CHAPTER 4

Examining Access to Care in Medicaid and CHIP

One of the key tests of the effectiveness of a health care coverage program is whether it provides access to appropriate health care services in a timely manner and whether those services promote health improvements. The Commission is charged with examining access to care and services for Medicaid and CHIP enrollees. As a first step in undertaking this effort, the Commission has reviewed research to measure and assess access to care for Medicaid and CHIP enrollees.

In order to fulfill its charge, the Commission needs an approach for evaluating access to health care services that considers the complex characteristics and health needs of the Medicaid and CHIP populations, as well as program variability across states. Based on a review of the literature on measuring access, the Commission has tailored its approach to take into account the needs of the Medicaid and CHIP populations, the distinct features of the Medicaid and CHIP programs, and the priorities inherent in the Commission's statutory charge. This chapter lays out how the Commission will start to assemble the data and analyses necessary to examine access to care.

While addressing access to care within Medicaid and CHIP is a primary charge of the Commission, there are a number of other important reasons for monitoring health care access, including understanding whether providers are available to enrollees as well as whether or not enrollees appropriately use and receive high-quality and efficient care. Examining access will help the Commission determine whether or not the programs are positively affecting the health outcomes of enrollees.

Federal and state governments want and expect to purchase high-quality and appropriate care for their Medicaid and CHIP enrollees. Section 1902(a)(30)(A) of the Medicaid statute directs that, "A State plan for medical assistance must…provide such methods

and procedures related to the utilization of, and payment for, care and services under the plan… as may be necessary…to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." A common definition for access has yet to be adopted by states or the federal government for evaluating access to services for Medicaid and CHIP enrollees. A monitoring system could help policymakers understand whether they are purchasing value in the form of efficient and high-quality care for their enrollees.

Lastly, the framework will also serve as the basis for the Commission's charge to create an early-warning system (EWS) to identify areas with provider shortages and other factors that adversely affect, or that could potentially adversely affect, access to care for, or the health status of, Medicaid and CHIP enrollees.

The Commission's Framework for Examining Access to Care for Medicaid and CHIP Enrollees

Drawing on earlier work and ongoing efforts to examine access to care in the overall health system, the Commission has developed its initial framework to help shape our future work on access. The Annex to this chapter provides a historical overview of 30 years of research on defining and measuring access to care. The framework takes into account the important developments in defining and measuring access achieved by health services researchers and leading health policy organizations. The framework incorporates notions of appropriate services in appropriate settings to maximize the value and quality of care received. The impact of services received, namely the health outcomes of care, is also included in the Commission's approach. Finally, the Commission intends for its measures of access to be useful in diagnosing reasons for poor access and to assist state and federal policymakers in evaluating policy choices while being responsive to the programmatic needs of Medicaid and CHIP.

The framework is also tailored to reflect Medicaid and CHIP policies, special characteristics of the programs' enrollees, and factors these populations may face when seeking and obtaining appropriate care. For example, transportation and translation services are important supports for Medicaid enrollees and should be considered when examining access for these populations. Sensitive to the wide variability in state programs and their enrolled populations, the framework considers state and subgroup estimates in important areas where state policies or population needs are likely to differ substantially. At the same time, the Commission must be realistic about resource constraints and data limitations, and focus on measures likely to be most revealing of important barriers to access and shortfalls in program performance. Finally, the Commission's framework will seek to address access questions from both the federal and state perspectives.

The initial framework presented here focuses on primary and specialty care providers and services and does not specifically address hospital, ancillary, long-term care or other services and supports.

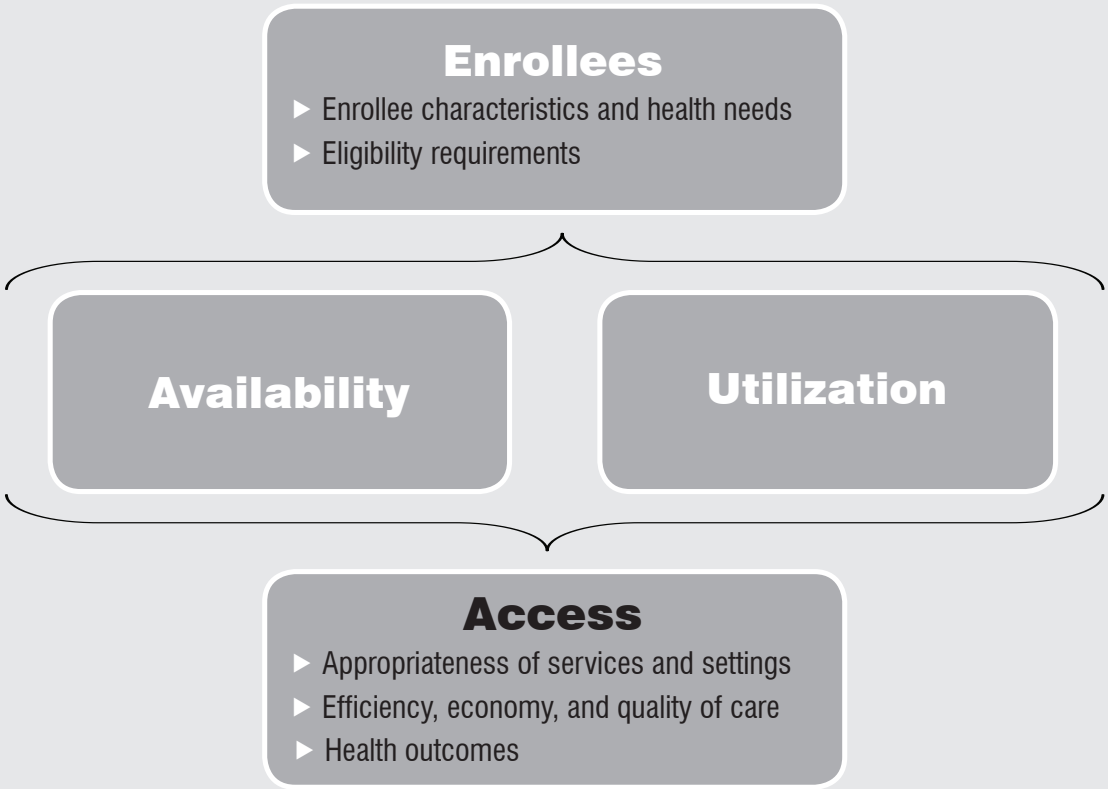
Access to care for these critical services will be addressed in future work.

As Figure 4-1 shows, the Commission's access framework has three main elements: enrollees and their unique characteristics, availability, and utilization.

- **Enrollees.** Medicaid and CHIP enrollees differ from the general population in terms of their demographic characteristics, health needs, and how they qualify for coverage.
- **Availability.** Provider availability for Medicaid and CHIP populations is influenced by a community's health care delivery system and the distribution of providers (its health care workforce and institutional resources), as well as state policies and providers' responses to those policies (provider payment, provider participation rates, willingness to accept Medicaid, and workforce issues such as scope of practice).
- **Utilization.** Realizing that insurance coverage may not guarantee the use of services, utilization focuses on whether available services are used, the affordability of these services for the enrollee, the enrollee's ability to navigate the health care system (including wait times and transportation), and the enrollee's experiences with the health care system.

Analysis incorporating these three components will serve as the basis for evaluating access, allowing the Commission to determine whether Medicaid and CHIP enrollees have adequate access to health care services that are economical and produce positive outcomes.

FIGURE 4-1. The Commission's Access Framework



The remainder of this section addresses each of the elements of the Commission's framework in turn: Medicaid and CHIP enrollees' distinctive characteristics; availability of providers; and aspects of utilization. This section concludes with a discussion on evaluating access in terms of appropriateness, efficiency, quality, and health outcomes.

Unique Characteristics of Enrollees

Medicaid and CHIP serve an important role in the health insurance market. As discussed in earlier chapters, these programs serve low-income populations who would otherwise experience considerable financial barriers to obtaining health services. Characteristics of Medicaid and CHIP enrollees that should be accounted for in monitoring access include:

- lower incomes and assets;
- discontinuous eligibility;
- geographic location;
- complex health care needs;
- cultural diversity;
- level of health literacy; and
- state variation in composition of enrollees.

Each of these considerations is reviewed immediately following.

Lower incomes and assets

Eligibility requirements for Medicaid and CHIP are complex and vary across state programs and subgroups covered. Those eligible for Medicaid and CHIP must meet income and, in some cases, asset tests that vary by state. Forty-eight percent of Medicaid enrollees have incomes at or below 100 percent of poverty—a much higher share than for the population covered by private insurance.[1] Approximately 90 percent of children enrolled in CHIP are at or below 200 percent federal poverty level (FPL) ($37,060 for a family of three in 2011).[2] Medicaid and CHIP enhance financial accessibility to health care for those enrolled and limit the financial burden of high health care costs on enrollees. Even though enrollment in Medicaid and CHIP provides coverage, limits on covered services and cost-sharing requirements may still create financial barriers to access for these low-income individuals. Additional research is needed to determine the impact that service and cost-sharing limits may have on limiting access to care or encouraging inappropriate use of services by enrollees.

Discontinuous eligibility

Turnover in eligibility status within enrolled populations has been an issue historically for both Medicaid and CHIP. One study, using data from the Medical Expenditure Panel Survey, found that nationwide, 20 percent of adults on Medicaid disenrolled within six months of initial enrollment and 43 percent of adults disenrolled within 12

[1] Analysis of 2010 National Health Interview Survey (NHIS) by the National Center for Health Statistics (NCHS) for MACPAC. NHIS uses poverty thresholds as calculated by the Census Bureau. One hundred percent of poverty was $11,136 income for an individual and $17,378 for a family of three in 2010.

[2] MACPAC analysis as of February 2011 of CHIP Statistical Enrollment Data System (SEDS), as reported by states.

months (Sommers 2009). Turnover can be a function of changes in enrollee income levels that can affect eligibility or issues with renewal. This has important effects on timeliness and continuity of care that should be considered when assessing access within Medicaid and CHIP. Medicaid also accepts enrollment when care is needed and retroactively covers some services, unlike private insurance.

Geographic location

Studies have shown that individuals and families with lower incomes and providers tend to be unevenly distributed within inner city areas (Adams 2001). In addition, Medicaid and CHIP enrollees are somewhat more likely to live in rural areas: 20 percent of Medicaid and CHIP enrollees live outside metropolitan statistical areas (MSAs), compared to 15 percent of the general population, as shown in Table 18 of MACStats. Provider supply has been shown to be a particular issue in areas where many enrollees reside and one compounded by other factors that make providers less likely to participate in Medicaid and CHIP.

Complex health care needs

Medicaid enrollees are more likely to report fair or poor general health and mental health status than individuals with private insurance, as shown in Figure 4-2 for adults at or below 138 percent of FPL. These results may be compounded by the fact that even among adults at or below 138 percent FPL, a greater proportion of Medicaid and CHIP enrollees have lower incomes than the privately insured (Holahan et al. 2010). Therefore, the needs associated with chronic illness, behavioral health needs, cognitive impairment, physical or intellectual disabilities—and other special needs that require access to services that are less common within the general population—must be accounted for in monitoring access to services within Medicaid and CHIP. Because children constitute half of all Medicaid enrollees and most CHIP enrollees, access measures specific to the health care needs of children also are critical, including measures targeted to unique program benefits like Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) for children under age 21. Forty-one percent of U.S. births are covered by Medicaid; thus measures of access to appropriate prenatal care are also important (CHCS 2010).

Cultural diversity

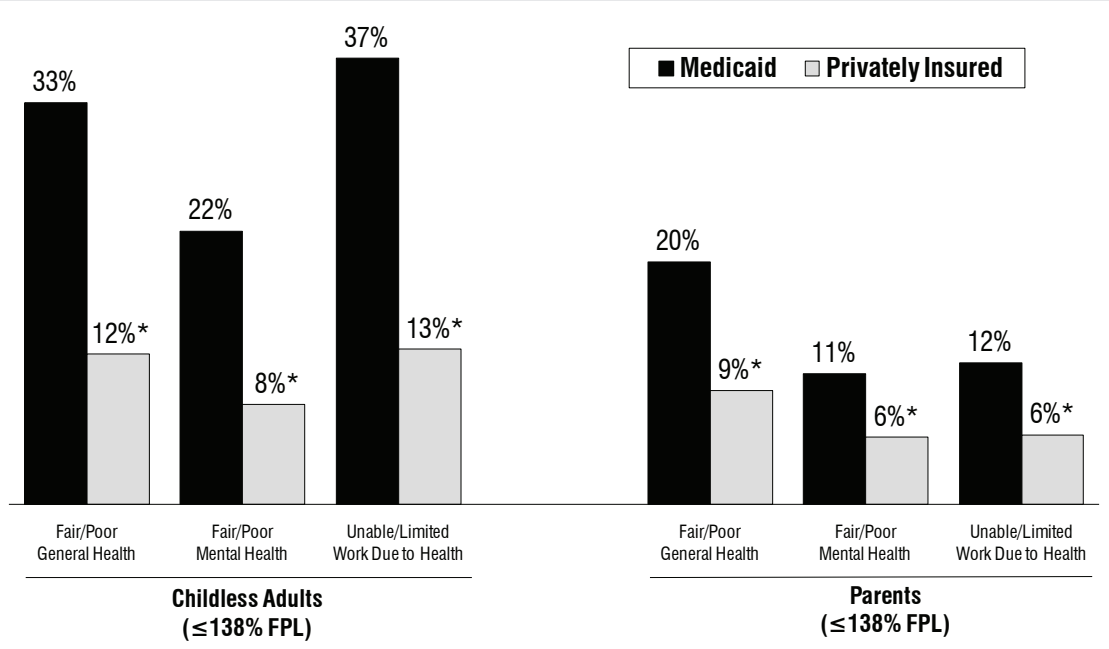
Medicaid and CHIP enrollees are culturally and ethnically diverse. As shown in Table 18 of MACStats, among Medicaid and CHIP enrollees, Whites account for 42 percent of all eligible individuals, Hispanics 29 percent, African Americans 23 percent, and "other races" 7 percent.[3] In addition, many speak English as a second language. These characteristics make access to culturally competent care and translation services particularly important for ensuring effective access.

Level of health literacy

Health literacy—the ability to read, understand and act on health care information—is likely to be a challenge for Medicaid and CHIP enrollees, as it has been found to be more problematic among those with low incomes, nonwhites, individuals over 60, and those with chronic disease. Individuals

[3] Whites, African Americans, and "other races" shown here are Non-Hispanic. Hispanics may be of any race.

FIGURE 4-2. Health Status of Low-Income Adults: Medicaid Enrollees Compared to Persons with Private Insurance, 2005–2006



*p<0.05, statistical significance denotes difference with Medicaid.

Note: FPL is federal poverty level. In 2011, 138% of FPL is $15,028 for an individual. Adults are 19-64 years of age.

Source: Holahan et al. 2010

with low health literacy are less likely to understand written and oral information given by providers and insurers; act upon necessary procedures and directions such as medication and appointment schedules; and navigate the health system to obtain needed services (Potter and Martin 2005a, b).

State variation in composition of enrollees

Subject to federal standards and requirements, both Medicaid and CHIP are state-administered, with substantial flexibility granted to states in program design and administration. Because of program differences across states, national statistics on access may obscure important variations across states. Variability among eligibility categories further complicates monitoring because health care needs and spending likely vary in systematic ways across different eligibility groups.

Availability

Availability focuses on whether care and providers are accessible to the Medicaid and CHIP populations. There are two key factors that influence the availability of providers: provider supply and provider participation. Overall, the availability of providers is greatly influenced by a community's health care delivery system and the distribution of providers (its health care workforce and institutional resources), as well as state policies and providers' responses to those policies

(provider payment, provider participation rates, willingness to accept Medicaid, and workforce issues such as scope of practice). Each of these factors is explained in more detail below, including commonly used measures for quantifying impact on access. Key questions about provider availability that the Commission intends to explore include:

- How many and what kinds of health professionals and institutional providers practice in areas where Medicaid and CHIP enrollees reside?
- How many of these providers participate in the programs and what does this mean in terms of whether there are sufficient providers available to deliver the services Medicaid and CHIP enrollees require?
- What settings are used by Medicaid and CHIP enrollees for receiving care (e.g., clinics, private physician offices, hospitals, emergency departments [EDs])?
- Does provider availability and the mix of participating providers differ between managed care and fee for service?
- What policies and practices exist at the federal and state levels to assure appropriate availability of providers, such as payment to providers and payment methodologies, and how well do they appear to work?

Provider supply

Providers, particularly physicians and other health care professionals, are unevenly distributed across the country. Research shows that physicians disproportionately locate in densely populated areas where incomes are high and demand for care is well financed by existing levels of coverage (Brasure 1999, Fossett and Perloff 1999). Although providers move to some areas with lower (but not the lowest) provider-to-population ratios, they have a tendency to go to areas with higher per capita income and lower unemployment (Ricketts and Randolph 2008). In addition, historical disincentives to choose primary care practice over other specialties are likely to continue, and thus increase the challenges in attracting primary care physicians to communities with limited economic resources (Steinwald 2008, Reinhardt 2002).

Provider-to-population ratios are often used as measures of provider supply. These ratios remain the measure most widely used to assess the supply of health professionals available to the general population. Within public insurance programs, participation rates help gauge provider supply relative to that which is available to the general population. More refined calculations take into account not just physical distance to providers' offices but also travel time given major travel routes, the availability of public transportation, and service needs of the underlying population. Analysis of data from 2005 to 2007 suggests that adults under age 65 enrolled in Medicaid disproportionately live in geographic Health Professional Shortage Areas (HPSAs) compared to other areas. (Hoffman et al. 2011).[4] Located in HPSAs, federally qualified health centers (FQHCs)

[4] The Health Resources and Services Administration (HRSA) defines HPSAs as areas with shortages of primary medical care, dental or mental health providers which may be geographic (a county or service area), demographic (low-income population) or institutional (comprehensive health center, FQHC or other public facility). However, as required by the Patient Protection and Affordable Care Act of 2010 (PPACA), HRSA is currently engaged in negotiated rulemaking to develop a new approach to the HPSA designation, with a target date of July 1, 2011 for the release of the negotiated rulemaking committee's report.

play an important "safety net" role by providing primary care services in these underserved urban and rural communities.

Provider participation

Medicaid enrollees disproportionately rely on providers at community health centers (CHCs) and hospital outpatient departments (OPDs) for primary care services; on a national level, patients with Medicaid or CHIP accounted for a higher percentage of primary care visits to CHCs (44 percent) and OPDs (31 percent) than to physician offices (13 percent) (Hing and Uddin 2008). Safety-net hospitals are also an important source of care for Medicaid enrollees; more than a third of discharges (36 percent) and a quarter of outpatient visits (26 percent) were for Medicaid patients (Cummings et al. 2009).

Of office-based primary care physicians in 2009, only 65 percent were accepting new Medicaid patients, as compared to 74 percent and 88 percent for Medicare and private insurance patients, respectively.[5] Physicians report greater difficulties referring Medicaid patients for specialty consultation than they do for patients with Medicare or private insurance. A 2006 survey indicated that 49 percent of office-based physicians reported difficulties with referring Medicaid patients for specialty consultations, compared with 13 percent reporting such difficulties for patients with Medicare and 16 percent for privately insured patients.[6]

In a 2004-2005 Community Tracking Study Physician Survey, physicians reported that inadequate payment was the most common reason for providers not to accept Medicaid patients, followed by the administrative burden of billing Medicaid, delays in payment, capacity constraints, and high clinical burden (Cunningham and May 2006). Physicians also voice concerns about malpractice. Although there is little research on this issue, studies have not found that people with Medicaid or CHIP coverage are more likely to sue than others (Baldwin et al. 1992, Mussman et al. 1991).

Measures of provider participation typically reflect the share of available providers who agree to participate in the program (potentially collected through surveys and claims-based analyses) and the concentration of patients across providers. Several surveys currently collect physician participation rates in Medicaid and CHIP across the country. Table 4A-1 in the Chapter Annex summarizes several examples of these surveys, as well as their respective definitions for "participating," survey purpose and design, periodicity, and response rates.

Provider participation measures often fail to distinguish between providers who may treat a few Medicaid enrollees and those who treat a substantial number (PPRC 1991). Further, the types of health professionals included in measures differ (e.g., how obstetricians/gynecologists who provide primary care to some women are counted). These inconsistencies can limit the validity of comparisons of provider participation across studies.

States often require managed care plans that participate in Medicaid and CHIP to meet formal

[5] Analysis of 2009 National Ambulatory Medical Care Survey (NAMCS) by the National Center for Health Statistics (NCHS) for MACPAC.
[6] Analysis of 2006 NAMCS by NCHS for MACPAC.

standards of network adequacy for their provider panels. Most states have established minimum ratios for primary care practitioners to enrollees, including some that require plans to demonstrate provider-to-population ratios equivalent to those observed in the fee-for-service sector. States are also requiring plans to meet certain standards with regard to the distance or travel time to reach services, both for urban and rural areas. Such standards are more developed for primary care physicians than for specialists; plans and providers report greater difficulty developing adequate specialty care networks and making successful referrals for specialty care (Gold et al. 2003).

Table 4-1 summarizes potential measures of availability of providers that the Commission intends to explore further.

Utilization of Services

The third component of the Commission's evolving framework on access focuses on the way enrollees use services when available and how they perceive their experiences with obtaining care and interacting with their providers. Utilization is "realized access" or how services are actually used by individuals. Our framework includes three factors that encompass utilization of services by Medicaid and CHIP enrollees: (1) what services are used, (2) the affordability of services, and (3) how easily enrollees can navigate the health system and their experiences. Each of the three factors is discussed in a subsection below. Key questions regarding utilization of services by Medicaid and CHIP that the Commission intends to explore include:

- Do enrollees have a usual source of care?
- How do patterns of service use differ for different subpopulations?
- Are the services needed by Medicaid and CHIP enrollees affordable?
- How do enrollees perceive the quality of care they receive and their providers' ability to communicate with them?
- What policies and procedures exist at the federal and state levels that can ensure that utilization is appropriate and prevent the over, under, and misuse of health services?

TABLE 4-1. Potential Measures of Provider Availability

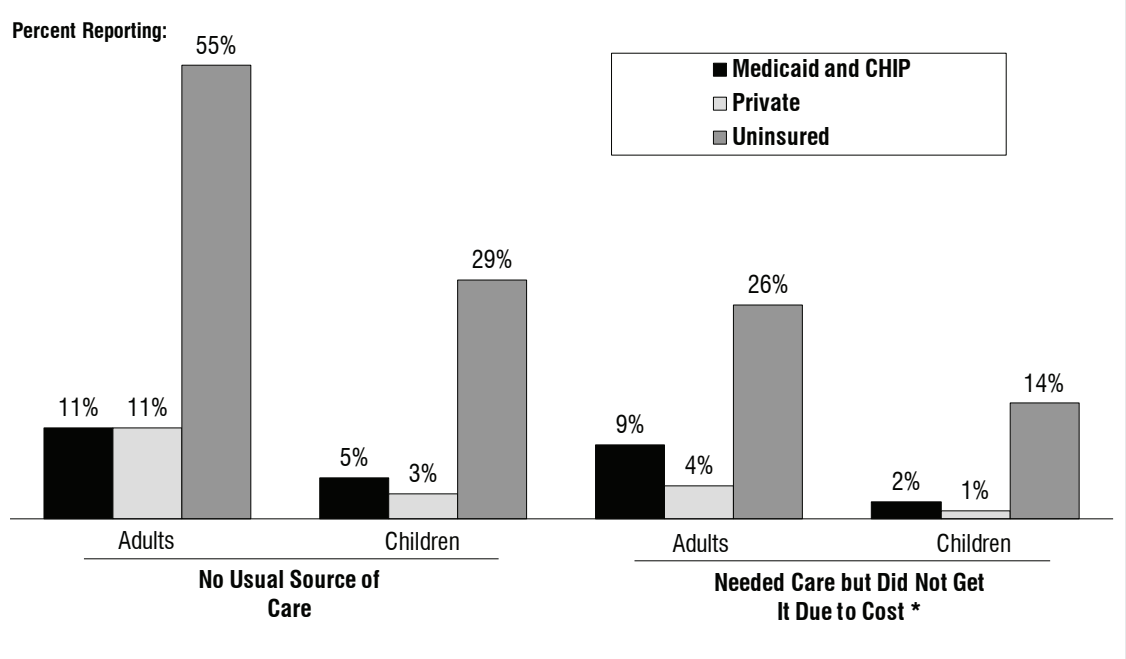
Availability Factors	Potential Measures
Provider Supply	▶ Medically underserved area (MUA) and HPSA designations ▶ Area provider-to-population ratios ▶ Providers available within standard travel time and distance
Provider Participation	▶ Share of providers participating, by specialty ▶ Providers accepting new patients ▶ Provider entry/exit from the program ▶ Patient load per provider

Interpreting measures of utilization from the perspective of access is a challenge because use is affected by many factors, only some of which policymakers and program administrators can control. Utilization measures can take the form of absolute standards such as prenatal care, relative performance (how do Medicaid and CHIP enrollees compare with the general population?), trend analysis (is performance getting worse or better?), or subgroup analysis (which groups within Medicaid and CHIP have more difficulty than others using services and, therefore, warrant special attention?).

Services used

As already discussed, access to health services traditionally is defined by measures that include having a usual source of care and whether any services are used. Figure 4-3 shows that children and adults with Medicaid and CHIP are equally likely as those with private insurance to report no usual source of care. More than half of the uninsured adults (55 percent), however, reported not having a usual source of care compared to 11 percent of adults with Medicaid and CHIP or private insurance. Results were similar for those who reported that they did not get needed care because of cost (KCMU 2011). These averages do not take into consideration differences in the health needs and use of services by various subpopulations or variations by state. Although the differences in these types of measures may not be sufficient on their own, such measures create signals that a particular geographic or population group may experience problems accessing health care.

FIGURE 4-3. Access to Care: Medicaid and CHIP Enrollees Compared to Persons with Private Insurance, 2009



* In the past 12 months

Note: Respondents who said their usual source of care was the emergency room were included among those not having a usual source of care.

Source: KCMU 2011, data from 2009 NHIS

Affordability of services

Health insurance coverage is an important factor in reducing financial barriers to using health care. Insured individuals generally and those in public programs like Medicaid and CHIP have substantially better access to care than those without insurance (IOM 2009). Still, affordability remains a potential problem for Medicaid and CHIP enrollees because of their health needs and relatively low incomes. Out-of-pocket costs due to cost-sharing requirements and restrictions on benefits can be important influences on receipt of health care (Newhouse 2001). For people with low incomes, even limited cost-sharing has been shown to reduce use of services (Hudman and O'Malley 2003). One recent study examined increases in prescription drug copayments for privately insured patients and found that individuals living in low-income areas were less likely to continue taking their medications than people in high-income areas (Chernew et al. 2008).

Measures that define affordability within the context of Medicaid and CHIP should be program-specific, reflecting federal benefit requirements, cost-sharing limits, and areas of state discretion. Under Medicaid, cost-sharing historically has been very limited due to the very low incomes of enrollees as well the promotion of early access to primary and preventive services; thus, financial barriers have tended to be associated with whether, and to what degree, states cover benefits that are optional (e.g., dental services for adults). Developing affordability measures that capture cost-sharing burdens and the coverage of optional benefits, particularly for enrollees with potentially high health care needs for whom "nominal" copays can result in a large total obligation, is particularly important (Selden et al. 2009).

System navigation and patient experiences

System navigation relates to the "fit" between the patient and service delivery. Whether or not available services are well-targeted is important for all users of the health care system. For example, available office hours (including night and weekend coverage) and appointment scheduling policies (same day appointments) are important features of the delivery system that have been shown to influence access to care and the inappropriate use of emergency rooms (MASG 1994). Availability of transportation can also affect receipt of care, particularly for those without cars or who live in areas less well served by public transportation. Given the racial and ethnic diversity of Medicaid and CHIP enrollees, access to providers that patients believe understand their needs is important. Language facility and translation services are also important for reaching subgroups of Medicaid and CHIP enrollees. The experience of moving large numbers of people into Medicaid managed care reinforced the importance of educating enrollees in the program about their choices, how they can obtain services, and the providers available to them; not providing this information impedes access to care (Coughlin et al. 2008, Gold and Mittler 2000, Ku et al. 2000, Gold et al. 1996, Rowland and Lyons 1987).

Many of these types of measures are captured in patient surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), in which adults are asked to report on the care they and/or their children receive. Some state Medicaid

agencies use CAHPS and CAHPS-like measures to gauge member satisfaction with both managed care and fee-for-service arrangements. For example, Medicaid HMO enrollees reported that they usually or always got care without long waits (80 percent) compared to privately insured (86 percent) or Medicare (87 percent) patients (Table 4-2). Medicaid HMO enrollees also gave their health plan a higher overall rating (59 percent) compared to privately insured (38 percent) or Medicare (53 percent) patients.

Surveys can also inform policymakers on how well enrollees with particular health problems (e.g., chronic conditions) understand how to manage their conditions and other questions regarding aspects of care that relate to their specific needs. Administrative records on complaints are another source for measuring patient experiences. "Secret shopper" studies can provide other information, such as the wait time for an available appointment and flexibility to accommodate patient needs. Table 4-3 provides examples of measures for the three utilization factors.

The final discussion in this presentation of the Commission's access framework addresses evaluation criteria.

Evaluating Access

The Commission's framework provides a foundation for our future efforts to monitor access to care for Medicaid and CHIP enrollees. Yet provider availability and use of services by themselves do not necessarily result in optimal enrollee access—or more importantly—optimal

TABLE 4-2. Select CAHPS Health Maintenance Organization (HMO) Member Satisfaction Measures, 2009

Measure	Commercial	Medicare	Medicaid
Consumer and Patient Engagement and Experience			
Rating of Health Plan: Rating of 9 or 10	38.3%	59.0%	52.5%
Rating of Health Care: Rating of 9 or 10	48.7	56.2	47.0
Getting Needed Care: Usually or Always	85.4	89.1	75.0
Getting Care Quickly: Usually or Always	86.4	86.7	79.5
How Well Doctors Communicate: Usually or Always	93.4	93.5	87.0
Personal Doctor: Rating of 9 or 10	63.2	73.3	60.1
Specialist: Rating of 9 or 10	61.8	69.3	60.5
Customer Service: Usually or Always	84.5	86.5	79.5

Note: The data reported to and by National Committee for Quality Assurance (NCQA) only includes data collected from managed care plans. Comparisons among the populations need to be viewed with caution because important differences between the commercial, Medicare and Medicaid populations may affect the results (i.e., health status and benefit designs of the different programs).

Source: NCQA 2010

TABLE 4-3. Potential Measures of Utilization

Utilization Factors	Potential Measures
Services Used	▶ Percentage of enrollees receiving a particular service (e.g., specialty care, pharmacy services, well child visits, prenatal care) ▶ Percentage of enrollees with a usual source of care
Affordability of Services	▶ Coverage of optional benefits ▶ Actuarial measures of benefit package design and potential out-of-pocket costs
System Navigation and Patient Experiences	▶ Appointment waiting times ▶ Complaints ▶ Percentage of enrollees experiencing delays in getting care ▶ Rate of managed care plan selection vs. auto-assignment ▶ Enrollee reports on provider communication with patients: ▷ Clarity of instructions ▷ Language ▷ Understanding of care management (if chronically ill)

health outcomes for an individual or for the program population overall. Even with health coverage, positive outcomes are not guaranteed and the potential for overuse, underuse, and misuse of services still exists. In its work on access, the Institute of Medicine (IOM) emphasized that use of services is not the ultimate goal but instead that the appropriate use of services enhances the impact of health care on outcomes. This focus ultimately on health outcomes has been articulated in national efforts over the past decade to monitor quality and the performance of the health care system (Berwick et al. 2008, IOM 2001).

To reflect this orientation in evaluating access to health services, the Commission has identified three key evaluative components: (1) the appropriateness of services and settings, (2) efficiency, economy, and quality of care, and (3) impact on health outcomes. Our overall analysis of access to care within Medicaid and CHIP will incorporate these three components. Each is discussed below.

Appropriateness of services and settings

Appropriateness of services focuses specifically on the use or nonuse of services that are well accepted as indicative of health care quality. Overuse and misuse of services are also important factors when examining appropriate use of services. In addition, if health care services are not used, it could reflect lack of availability, but it also could indicate a lack of care-seeking behavior by enrollees or that care is misdirected towards less

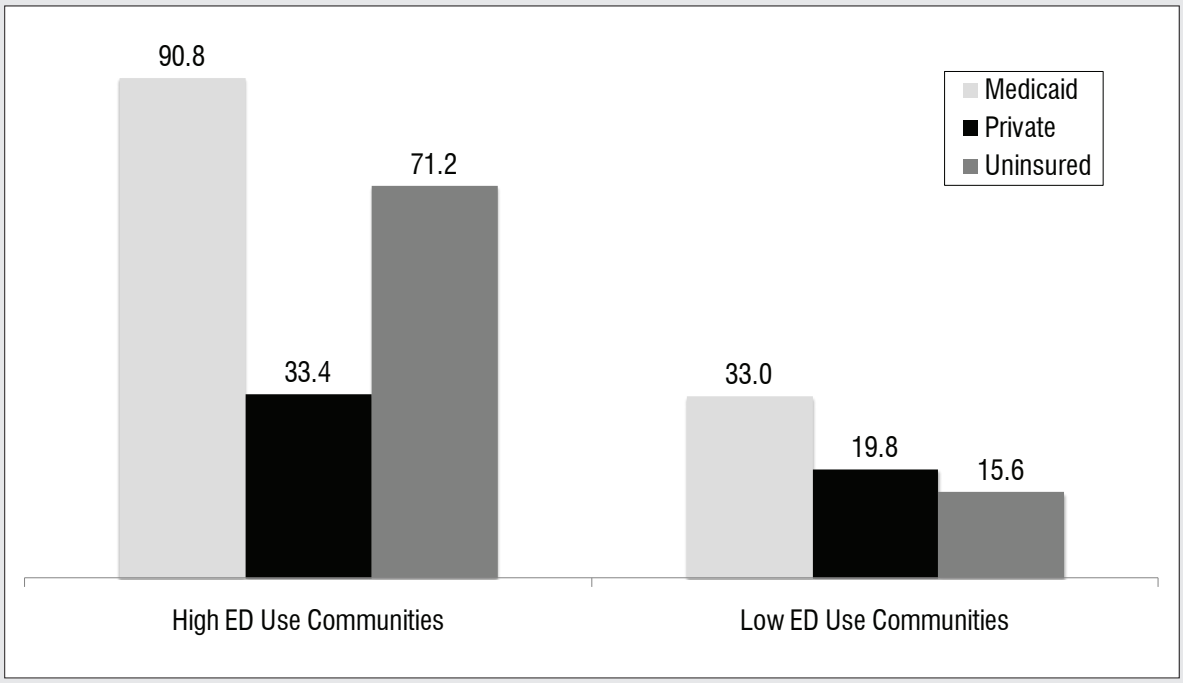
effective modes of care. Personal responsibility also must be considered, as effective care may be available but not sought or overused by enrollees. Indicators of appropriateness of services and settings may include examining rates of use for recommended preventive services; hospitalization rates for conditions that are viewed as avoidable with adequate access to primary care; hospital readmission rates for conditions potentially avoidable with appropriate ambulatory care; and adequacy of prenatal care.

ED visits are a prime example of care that may not always be delivered in the most appropriate setting. Figure 4-4 shows that, after adjusting for self-reported health status, demographics, and the capacity of local EDs and primary care providers, Medicaid enrollees had a greater number of ED visits per 100 persons than did those with private insurance or no coverage (Cunningham 2006). Unmeasured health and related factors may be part of the explanation for the differences in ED use among Medicaid enrollees compared to the uninsured and those privately insured. More research is needed to determine what is driving these patterns of different ED utilization rates and whether its use was appropriate.

Efficiency, economy, and quality of care

As discussed in Chapter 5, there are many definitions of efficiency in health care and little agreement about which is preferable. There is limited additional guidance on this language, particularly the meaning of efficiency, economy, and quality of care, leaving states with the task of developing the standards or methodologies

FIGURE 4-4. Emergency Department (ED) Visit Rates by Coverage Type, 2003



Note: High ED use communities are defined as the 25 percent of Community Tracking Study (CTS) communities with the highest number of ED visits per 100 people. Low ED use communities are defined as the 25 percent of CTS communities with the lowest number of ED visits per 100.

Source: Cunningham 2006

that give meaning to the statutory requirements. Further, because Medicaid continues to be one of the nation's largest payers of health coverage, it is critical that payment policies support high-quality, efficient care (Bachrach 2010).

Regarding quality, over the past decade there have been many concerted efforts to expand the use of standardized measures for quality improvement (Lipson et al. 2009). The National Committee for Quality Assurance (NCQA) has created a set of state-level quality measures for selected conditions called the Healthcare Effectiveness Data and Information Set (HEDIS). These data are collected voluntarily from more than 1,000 health plans across the country and many state Medicaid agencies require managed care plans that serve Medicaid enrollees to report the data. However, these quality measures are not collected for individuals who receive their care in non-managed-care settings, such as fee for service, making comparisons across delivery systems difficult. At a national level, the Medical Expenditure Panel Survey (MEPS) contains select quality-of-care measures that can be used to draw comparisons among individuals with private coverage, public coverage, and individuals without coverage. Select MEPS quality-of-care measures are included in Table 4-4 below.

Health outcomes

Purchasers of health care services want to be assured that they are paying for high-quality care that will produce positive health outcomes. This concept is applicable to all purchasers of health services, whether in the private or public sectors. State and federal governments also have a vested interest in obtaining the best possible outcomes for their enrollees. While

TABLE 4-4. Select Medical Expenditure Panel Survey Quality-of-Care Measures, 2008

Measure	<65, Public Insurance Only	< 65, Any Private Insurance	<65, Uninsured
Percent of adults age 18 and over with diabetes who reported having a hemoglobin A1C measurement at least once in past year	63.5	75.4*	57.1
Percent of adults advised to quit smoking	65.1	62.9	51.1*
Percent of children age 2 – 17 with a dental visit in the past year	40.5	56.5*	25.9*

* $p < .05$, Statistical significance denotes difference with <65, Public Insurance Only population.

Note: Uninsured refers to persons uninsured during the entire year. Public and private health insurance categories refer to individuals with public or private insurance at any time during the period; individuals with both public and private insurance and those with Tricare (Armed Forces-related coverage) are classified as having private insurance.

Comparisons among the populations need to be viewed with caution because there are important differences between individuals with private and public coverage and those with no coverage that may affect the results (i.e., health status and benefit designs of the different programs).

Source: Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey, 2008

everyone can agree that health outcomes are an important output of health-related services, it is more difficult to reach agreement as to which outcomes are most important and how best to obtain them. Recognizing the complexity of this undertaking, the Commission intends to examine the impact of access on health outcomes for Medicaid and CHIP enrollees more closely in the future.

Looking Forward

The development of a framework for examining access to care in Medicaid and CHIP is the Commission's first step towards fulfilling its charge related to access. Using this initial framework, adapted as needed, we will first identify a set of measures that are feasible to collect and monitor over time. This set of measures should incorporate a combination of availability and utilization measures. Further, we will start to assemble data and information to examine what is known about access to care in the Medicaid and CHIP programs. After understanding where access levels exist today on both the national and state levels, we will have the ability to monitor the impact of future changes identified either through the EWS or broader Commission analysis.

We are well aware that limitations in available and timely data are a major challenge for conducting realistic and appropriate monitoring of access in Medicaid and CHIP. Although many sources of data are available at the national level, far fewer sources are available at the state level and these are often inconsistent or out of date. Because analysis at the state level is important, given the wide variation of Medicaid and CHIP programs across the country, the Commission's ongoing plans are to work with states and learn from their experiences and best practices.

The Commission will also assess policy interventions available at the state and federal levels with the potential to affect access for Medicaid and CHIP enrollees. For example, in terms of provider supply and availability, the supply and distribution of health professionals are not within the direct control of most Medicaid and CHIP programs but both have a significant effect on how well the programs function. Changing the number, mix, and geographic distribution of health professionals is a major challenge facing these programs.[7] The Commission plans to examine the interplay of supply and overall participation of providers and track the recent efforts to increase and reshape the health care workforce in undersupplied areas. This research will help us to identify opportunities for enhancing access within Medicaid and CHIP. Closely related to provider supply, the Commission intends to examine payment policies as well as interventions to reduce administrative burdens that can discourage provider participation, as discussed in Chapter 5.

Regarding use of services, the Commission plans to gain a better understanding of differences that exist between services used by Medicaid and CHIP child and adult enrollees, their counterparts who are uninsured, and those with private insurance.

[7] PPACA mandated the development of a multi-stakeholder Workforce Advisory Committee charged with recommending a national workforce strategy with an emphasis on primary care and location in MUAs. Commission members were appointed on September 30, 2010, although the Commission has not yet received funding.

Our examination of service use will extend to unique subgroups such as persons with disabilities and dual eligibles, and our analyses will take into account differences in need and use that may exist because of health status and socioeconomic status and delivery system (e.g., fee for service vs. managed care). We also plan to review data about the availability of recommended levels of care (e.g., recommended preventive services, appropriate use of ED) as one aspect of understanding the appropriateness of services and settings.

Medicaid and CHIP managed care is also an area that the Commission intends to examine. As shown in Table 2 of MACStats, in FY 2008, almost half of all Medicaid enrollees (and a higher portion of CHIP enrollees) were in a risk-based health plan. Given the important role of managed care in Medicaid and CHIP, the Commission plans to employ access measures and approaches that will examine this in the future. We aim to develop a monitoring system on access that reflects the full range of how enrollees get their health care in Medicaid and CHIP and how federal and state policies relevant to Medicaid and CHIP may create positive or negative outcomes in both fee for service and managed care environments.

Realizing that policies available to influence enrollee access may differ across Medicaid and CHIP programs, particularly within managed care, the Commission will work with states and provide guidance on efforts for improving access.

Possible areas for in-depth analysis include:

- how benefits are designed or modified at the state level, including cost-sharing, and their potential impacts on access to care;
- use of EDs, including the impact of patient characteristics and behaviors, provider office hours and locations, appropriateness of use, and comparisons of use by Medicaid and CHIP enrollees with uninsured and privately insured individuals;
- differences between providers who participate in Medicaid and CHIP and those who do not;
- access to specialty services and whether differences exist between individuals in managed care and fee-for-service arrangements; and
- the types of resources available to states to address access to care in managed care settings.

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Chapter 4 Annex

Defining Access: Evolution of Research Approaches

To better understand key issues in monitoring access, the Commission reviewed 30 years of work related to the topic. This review indicated that over time the concept of access has been adapted and enlarged to answer new questions and concerns as health care practice patterns and individuals' health care needs have changed. While initial work on access was developed to support research on utilization of health care services, definitions and frameworks on access have evolved and become multi-dimensional. Over time, aspects such as the fit between providers and patients, the appropriateness of services used, and health outcomes have been incorporated into access frameworks. Today greater emphasis is placed on the link between the use of the right services to achieve desired outcomes and the factors that support or hinder access than envisioned in earlier definitions. The Commission's framework takes into consideration these important elements.

Utilization as a Measure of Access

The first definitions of access to care were developed to analyze the use of health services, with a focus on its determinants (Aday and Andersen 1981, Andersen and Aday 1978). Access was defined as "those dimensions which describe the potential and actual entry of a given population group to the health services delivery system" (Aday et al. 1980, p. 26). Researchers distinguished three kinds of factors that influence utilization: (1) health needs both clinically defined and self-perceived; (2) predisposing variables such as age, sex, personal characteristics, and health care preferences as related to those needs; and (3) enabling variables like provider availability, transportation, income, and health insurance status, which determine whether potential need (as defined by the first two) is translated into "realized access"—the actual use of health services.

A second body of early research identified "usual source of care" as critical to using health care effectively, anticipating the current concept of "medical homes," that is, a designated point of contact within the health care system to help patients coordinate their care (Berki and Ashcraft 1979). Penchansky and Thomas elaborated on the concept by distinguishing "5 As" in access: (1) *availability*, sufficient personnel and

technology resources to meet the needs of the client; (2) *accessibility*, the geographic ease with which the client can reach the physician's office; (3) *accommodation*, whether care is organized in ways that meet the client's needs (e.g., office hours, appointments, telephone access); (4) *affordability*, as it relates to the client's willingness and ability to pay; and (5) *acceptability*, whether the client is comfortable with the characteristics of the provider (Penchansky and Thomas 1981). This conceptualization characterized access as a function of "the fit between characteristics and expectations of the providers and the clients" (McLaughlin and Wyszewianski 2002). Such concepts form a foundation for current interest in patient-centered care and reinforce the point that insurance coverage (as Medicaid and CHIP provides) enables but does not guarantee access to care if other essential ingredients are missing.

Adding Appropriate Use and Outcomes to the Definition

In the early 1990s the Institute of Medicine (IOM) sought to refine the definition of access to care to address more fully concerns related to the implications of resource constraints on the ability to secure an adequate level of care. IOM expressed concern that receipt of needed health care services was persistently below recommended levels and also highly uneven across population subgroups. Analysis of access was tied not just to use of services but to use of the "right" services, that is, those likely to achieve desired goals and outcomes.

IOM defined access as the: "Timely use of personal health services to achieve the best possible health outcomes" (IOM 1993). IOM identified three kinds of barriers to access: (1) *structural barriers* related to supply and organization of care (and transport to that care); (2) *financial barriers* related to insurance coverage and continuity, provider payments, and benefits and cost-sharing; and (3) *personal barriers* such as acceptability, culture, language, attitudes, education and income. The first two barriers are most susceptible to policy intervention, although the third can be influenced by the way health care systems are designed to accommodate the characteristics and preferences of patients.

The major emphasis in IOM's work focused on elaborating the links between use and outcomes, which could support more nuanced measures of access to appropriate services. In particular, IOM proposed that access measurement should include a focus on how appropriateness, efficiency, provider quality, and patient adherence mediate between use and the ability to achieve desired health goals across populations on an equitable basis. The mere use of services was no longer a sufficient endpoint. More and different kinds of information were needed to determine whether these services used improved health. Health outcomes have now become a strong focus in IOM's investigations.

Including Quality and System Performance in Evaluating Access

More recently, work on access by IOM and others has emphasized looking more broadly at quality and the performance of the health care system (Berwick et al. 2008, IOM 2001). That health care services may be overused, underused, and misused is now widely recognized (McGlynn et al. 2003). Further, there are wide variations in practice patterns across geographic areas. (NHPF 2010,

MedPAC 2009, Fisher et al. 2003, Wennberg 1984). It is unclear how much of this variation can be explained by differences in health status or shifting costs across payers (Zuckerman et al. 2010, Gold 2004).

In the 1990s the Physician Payment Review Commission (PPRC) monitored access for Medicare and Medicaid beneficiaries using a multi-dimensional framework that included measures to assess potential barriers to provider participation; the way health plans structured provider networks and delivery of services; appropriate use of care; and patient experiences (PPRC 1996, Docteur et al. 1996). Similarly, Gold and colleagues developed a framework linking different kinds of access measures to potentially relevant policy interventions (Gold et al. 2006, Gold et al. 2004).

TABLE 4A-1. Selected Surveys Examining Provider Participation in Medicaid and CHIP

Survey and Administering Organization	Variables Related to Participation	Purpose	Design, Response Rate, and Periodicity
National Ambulatory Medical Care Survey(NAMCS) National Center for Health Statistics	Physician accepting new Medicaid patients Percent of patient care revenue from Medicaid Physician reporting difficulty referring patients for specialty consultation (2003-2006, and 2012)	To collect information about office-based physician practices, patient visits, and the adoption of electronic medical records in ambulatory care settings	Nationally representative probability sample of physicians In-person survey with 59 percent response rate[1] Conducted annually In 2011 a question on acceptance of new Medicaid patients will be added to the NAMCS Electronic Medical Record Supplement, a mail survey which has complemented the core in-person NAMCS survey since 2008. Sample size for the mail survey (approximately 10,000 physicians) will support state-level estimates of Medicaid participation for all physicians. Response rate is expected to be comparable to the 68 percent response rate observed for the 2010 mail survey.
Health Tracking Physician Survey 2008 Center for Studying Health System Change	Physician accepting all, most, some, or no new Medicaid patients Percent of patient care revenue from Medicaid Reasons why physician accepting only some or no new Medicaid patients ▶ Billing Requirements ▶ Delayed Payment ▶ Inadequate Payment ▶ Practice has enough patients ▶ High clinical burden Scored as Very, Moderately, Not Very, or Not At All Important	To track a variety of physician and practice dimensions, from basic demographic characteristics, practice organization and career satisfaction to insurance acceptance, compensation arrangements and charity care provision	Nationally representative probability sample of physicians Mail survey 62 percent response rate[2]

TABLE 4A-1, Continued

Survey and Administering Organization	Variables Related to Participation	Purpose	Design, Response Rate, and Periodicity
Population Group HPSA Designation Surveys State Primary Care Offices under guidance from Health Resources and Services Administration, HHS	Physician accepts Medicaid patients Percent of practice patients insured by Medicaid Percent of practice patients offering self-payment using a sliding fee scale based on income or ability to pay Usual elapsed time between request and appointment for ▶ a new patient ▶ established patient	To request HPSA designation for primary care, dental, or mental health services	100 percent sample of physicians in candidate service areas Survey methods vary across states 67 percent response rate or higher required by HRSA Designated areas are required to field survey every three years
Group Practice Survey American Medical Association	Percent of practice patients insured by Medicaid ▶ 0-25 percent ▶ 26-50 ▶ 51-75 ▶ 76-100	To track general demographic and administrative data on group practices of three or more physicians	100 percent sample of all group practices Telephone survey ~100 percent response rate[3] with ~45 percent completion rate for Medicaid participation variable Updated annually
Survey of Physician Participation in Medi-Cal 2008 Bindman et al., University of California San Francisco, sponsored by The California HealthCare Foundation	Practice accepting: ▶ Any new FFS Medi-Cal patient ▶ Any new Medi-Cal managed care (HMO) patient Percent of practice patients insured by Medi-Cal	To determine the level of physician participation in Medi-Cal	Probability sample representative of California physicians Survey mailed in conjunction with licensure renewal applications through the Medical Board of California 60 percent response rate

TABLE 4A-1, Continued

Survey and Administering Organization	Variables Related to Participation	Purpose	Design, Response Rate, and Periodicity
Texas Physician Survey Texas Medical Association	Physician accepting: ▶ All new: ▶ A limited number of new: ▶ No new: ▷ Medicaid patients ▷ CHIP patients	To identify emerging issues, track the impact of practice and economic changes, assess physician priorities, and develop data to support Texas Medicaid Association advocacy efforts	100 percent sample of all physicians in Texas 2010 survey conducted in a series of email modules ~ 20 percent response rate Conducted biennially
Secret Shopper Survey of Primary Care Physicians NORC at the University of Chicago sponsored by Office of the Assistant Secretary for Planning and Evaluation, HHS	Physician accepting new Medicaid patients Wait time for appointment	To monitor provider participation in different insurance programs and assess access differences by insurance status	Probability sample of primary care physicians in 9 states Sample sizes allow state-level estimates On-going study, response rates not yet available One-time study

Notes:

1 Based on proportion of eligible physicians who responded to the survey in 2008 (1,334). Eligible physicians (2,229) defined as office based, principally engaged in patient care, non-federal. Excludes anesthesiologists, pathologists, and radiologists. Eligible physicians were screened from an initial sample of 3,319.

2 Based on proportion of eligible physicians who responded to the survey in 2008 (4,720). Eligible physicians (7,642) defined as providing patient care at least 20 hours per week, non-federal, and excluding: specialists not involved in patient care; physicians in training; and graduates of foreign medical schools with temporary licenses to practice in U.S. Screened from an initial sample of 10,250.

3 Approximately 105,000 practice locations representing 370,000 affiliated physicians.