

MACStats Appendix

Five new tables (Tables 23–27) presenting measures of access to care have been added to the March 2014 edition of MACStats. Measures reflect the conceptual framework for access to care that MACPAC first presented in its March 2011 report to Congress, which stresses timely receipt of care in an appropriate setting.¹ Each measure in Tables 23–27 is assigned a measure number that corresponds to a detailed description in the table (MACStats Appendix Table) contained in this appendix.

Access Domains. A total of 54 measures were selected to represent 5 access domains: provider availability, connection to the health care system, contact with health care professionals, timeliness of care, and receipt of appropriate care.

Populations. Table 23 presents data on provider availability for Medicaid/CHIP beneficiaries. Tables 24 and 26 present data for children and adults under age 65, respectively, and compare access measures for these individuals based on insurance status. Table 25 presents data on children with special health care needs (CSHCN) and compares access measures for these children based on insurance status. Table 27 presents data for adult Medicaid beneficiaries under age 65 and compares access measures for these individuals based on receipt of Supplemental Security Income (SSI). The SSI population is comprised of individuals with little or no income and assets whose ability to work is limited by a physical or mental disability that can be expected to result in death or last for at least 12 months. Although this definition does not capture all individuals with disabilities, receipt of SSI is used as a proxy to identify individuals with a diverse range of severe disabilities and complex needs.

Data Sources. Measures are drawn from four federal surveys with the broadest available scope of access measures. The surveys and years of data presented in this report are:

- ▶ National Ambulatory Medical Care Survey-National Electronic Health Records Survey (2012 NAMCS-NEHR);²
- ▶ National Health Interview Survey (2012 NHIS, and pooled 2009–2011 NHIS data);³
- ▶ National Survey of Children’s Health (2011–2012 NSCH);⁴ and
- ▶ National Survey of Children with Special Health Care Needs (2009–2010 NS-CSHCN).⁵

Measurement Approach. All measures represent national estimates. The data are drawn from surveys that apply different sampling methods, are collected from different time periods, and have different questions on health insurance coverage. For these reasons, measures from different surveys should not be directly compared.

Limitations. Interpretation of measures should consider the limitations of survey data. Particular weaknesses associated with household survey data include:

- ▶ Survey data are based on a respondent’s recall of events, which tend to omit some health care encounters documented by other sources such as medical records or administrative data.

- ▶ Parents reporting experiences for their children may feel pressure to provide answers that are socially desirable rather than factually accurate.
- ▶ Survey data are based on subjective perceptions that might not align with objective criteria (for example, individuals may not be aware of services they or their children need).

Moreover, interpretation of measures should consider the definition of each population and its characteristics:

- ▶ Responses about recent experiences with access to care and service use are based on the previous 12 months, during which some individuals had a different source of coverage than that shown in the table.
- ▶ Comparison of measures are unadjusted for differences between populations in age, health, income, ethnicity, race, family and household characteristics known to explain much but not all differences in access and use observed between individuals with different insurance experience.⁶
- ▶ Finally, measures might be interpreted differently based on the needs of each population. For example, people with severe disabilities need more help with transportation than other individuals, so one might expect that Medicaid beneficiaries receiving SSI would report more problems getting timely care because they did not have transportation.

Endnotes

¹ Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP*, March 2011 (Washington, DC: MACPAC, 2011). <http://www.macpac.gov/reports>.

² National Center for Health Statistics, *Ambulatory health care data* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). http://www.cdc.gov/nchs/ahcd/new_ahcd.htm.

³ National Center for Health Statistics, *National Health Interview Survey: About the National Health Interview Survey* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). http://www.cdc.gov/nchs/nhis/about_nhis.htm.

⁴ National Center for Health Statistics, *State and Local Area Telephone Integrated Survey: 2011–2012 National Survey of Children's Health quick facts* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). <http://www.cdc.gov/nchs/slait/nsch.htm>.

⁵ National Center for Health Statistics, *State and Local Area Telephone Integrated Survey: 2009–2010 National Survey of Children with Special Health Care Needs quick facts and additions* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). <http://www.cdc.gov/nchs/slait/cshcn.htm>.

⁶ Kenney, G.M., and Coyer, C., *National findings on access to health care and service use for children enrolled in Medicaid or CHIP* (MACPAC Contractor Report No. 1) (Washington, DC: MACPAC, 2012). <http://www.macpac.gov/publications>; Long, S.K., Stockley, K., Grimm, E., and C. Coyer. *National findings on access to health care and service use for non-elderly adults enrolled in Medicaid* (MACPAC Contractor Report No.2) (Washington, DC: MACPAC, 2012). <http://www.macpac.gov/publications>.

MACStats APPENDIX TABLE. Index of Access Measures in March 2014 MACStats Tables 23–27

Provider Availability			
Measures	Population Subgroups	Data Source	Rationale for Measure Selection
<p>P1. Primary care physician acceptance of new patients by source of payment</p> <p>Percentage of office-based physicians who reported currently accepting new patients into their practice with a type of payment of Medicaid/CHIP, Medicare, and private insurance, respectively.</p>	Pediatricians and other primary care physicians	NAMCS-NEHRS 2012	This measure is one method of identifying physicians participating in Medicaid or CHIP. Change in the proportion accepting new Medicaid/CHIP patients could indicate a change in Medicaid workforce capacity.
<p>P2. Percentage of the primary care physician's patient care revenue that comes from Medicaid/CHIP</p> <p>This measure shows the distribution of responses for Medicaid/CHIP by office-based physicians to the question: "Roughly, what percent of your patient care revenue at the reporting location comes from the following: Medicare? Medicaid/CHIP? Private insurance? All other sources?"</p>	Pediatricians and other primary care physicians	NAMCS-NEHRS 2012	Because many physicians see only a small number of Medicaid or CHIP patients, this alternative measure of physician participation in Medicaid/CHIP is based on the amount of revenue they receive from Medicaid/CHIP. A change in this revenue distribution could indicate a change in Medicaid/CHIP workforce capacity.

Connection to the Health Care System — Children			
Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
<p>S1. Has a usual source of care when sick or needs advice</p> <p>Percentage of children whose parents report that child had a usual place to go when sick or needs health advice (not the emergency department).</p>	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	Having a usual source of care is a common measure of potential access to health care and represents the interim step between provider availability and utilization with potential for timely access.
<p>S2. Had same usual source of medical care 12 months ago</p> <p>Percentage of children whose parents report that child had the same usual place of care 12 months ago. Denominator is all children.</p>	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	The foundation of a medical home is having an ongoing source of care. Having an ongoing source of care is Objective AHS-5.2 of Healthy People 2020 (HP2020). The HP2020 target is 100 percent of all children ages 17 and under. ¹
<p>S3. Has a personal doctor or nurse</p> <p>Percentage of children whose parents reported having one or more persons they think of as the child's personal doctor or nurse.</p>	Children and CSHCN ² with Medicaid/CHIP, private insurance, and uninsured	NSCH 2011–2012	This measure is a higher bar for potential access than having a usual source of care. Having a personal doctor or nurse is one of the criteria for receiving care in a medical home. See measure A4.
<p>S4. Access barrier is reason for having no usual source of care</p> <p>Percentage of children whose parents reported child had no usual source of medical care for reasons: too expensive, no insurance, or cost; doesn't know where to go; previous doctor not available/moved; or speaks a different language.</p>	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	When children have no usual source of care, primary and preventive care may be missed. Measure is limited to reasons for having no usual source of care that can be affected by health plan supports or other program features. This percentage is expected to be small, but reflects a gap in outreach for children enrolled the full year.
<p>S5. Had trouble finding a doctor</p> <p>Percentage of children whose parents reported one of three barriers during the past 12 months: trouble finding general doctor/provider who would see them; doctor's office/clinic would not accept child as new patient; doctor's office/clinic did not accept child's health care coverage.</p>	Children with Medicaid/CHIP, private insurance, uninsured	NHIS 2012	This is an alternative measure for barriers to access. Problems finding a doctor can be affected by provider behavior, plan recruitment of providers, payment, and other factors.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Connection to the Health Care System — Children, Continued

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
<p>S6. Had usual source of care barrier or trouble finding a doctor Composite of children facing barriers in S4 or S5.</p>	Children with Medicaid/CHIP, private insurance, uninsured	NHIS 2012	This measure captures the extent to which children experience barriers to connecting to the health system across measures.
<p>S7. Receipt of effective care coordination³ Children were classified as needing care coordination if the child received two or more services or the parent reported they needed help coordinating care.³ The criteria for “received all care coordination needed” were that the family has some type of help with care coordination and was very satisfied with doctors’ communication with other health care providers, school or other programs, if those services were needed. Otherwise children were classified as “did not receive all care coordination needed.”</p>	Children and CSHCN with Medicaid/CHIP, private insurance, uninsured	NSCH 2011–2012	Effective care coordination is one component of the medical home summary measure reported as A4. CSHCN often require care coordination among multiple providers. Lack of coordination may result in duplication of services and missed opportunities for better care.
<p>S8. Family had one or more unmet needs for support services Percentage of children whose parents reported that their family needed one or more family supports (respite care, genetic counseling, or family mental health care or counseling) but did not receive them.</p>	CSHCN with Medicaid/CHIP, children with private insurance, uninsured children	NS-CSHCN 2009–2010	These three specific family support services are services a family member of CSHCN might need because of the child’s medical, behavioral, or other conditions.

Connection to the Health Care System — Adults

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
<p>S9. Has a usual source of care when sick or needs advice Percentage of adults who reported currently having a place they usually go when they are sick or need advice about their health (not the emergency department).</p>	Adults with Medicaid, private insurance, uninsured; Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	Having a usual source of care is a common measure of potential access to health care and represents the interim step between provider availability and utilization with potential for timely access.
<p>S10. Had same usual source of medical care 12 months ago Percentage of adults who reported having the same usual place of care 12 months ago.</p>	Medicaid SSI-related and non-SSI-related adults	NHIS 2009–2011	A higher bar for potential access than having a usual source of care, this measure indicates an established relationship with a provider important for patient-centered, quality care.
<p>S11. Access barrier is reason for having no usual source of care Percentage of adults who reported one of the access-related reasons for having no usual place of medical care as listed in S4.</p>	Adults with Medicaid, private insurance, uninsured	NHIS 2012	Problems navigating the provider network, lack of consumer information, language barriers, cost and distance all are barriers to providers with factors that can be addressed by health plan outreach, payment, and other factors.
<p>S12. Had trouble finding a doctor Percentage of adults who reported facing one of three barriers during the past 12 months as listed in S5.</p>	Adults with Medicaid, private insurance, uninsured	NHIS 2012	This is an alternative measure of barriers to access. Trouble finding a doctor can be addressed by provider behavior, health plan recruitment of providers, payment, and other factors.
<p>S13. Had usual source of care barrier or trouble finding doctor Composite of adults who reported barriers in S11 or S12.</p>	Adults with Medicaid, private insurance, uninsured	NHIS 2012	Captures extent to which adults experienced barriers to connecting to the health system across measures.

MACStats APPENDIX TABLE, Continued

Contact with Health Professionals — Children			
Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
<p>C1. Had at least one office visit</p> <p>Percentage of children whose parent reported they had seen a doctor or other health care professional at a doctor's office, clinic, or other place (not including hospitalization, ER visits, dental visits, or telephone calls) during the past 12 months.</p>	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	This measure is commonly used to ascertain a minimal threshold of contact in an office or clinic setting and allows comparison between populations and data sources.
<p>C2. Saw a general doctor</p> <p>Percentage of children whose parent reported they had seen or talked to a general doctor who treats a variety of illnesses (a doctor in general practice, pediatrics, family medicine, or internal medicine) during the past 12 months.</p>	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	Contact with a general doctor is commonly used to ascertain a minimal threshold of contact with a physician and allows comparison between populations.
<p>C3. Saw a general doctor, nurse practitioner, PA, midwife, or Ob-Gyn</p> <p>Percentage of children whose parent reported the child had seen a general doctor, nurse practitioner, physician assistant (PA), midwife, or obstetrician-gynecologist (Ob-Gyn) during the past 12 months. Ob-Gyn encounters are limited to females age 15–18.</p>	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	This measure contributes to the interpretation of C2 by including mid-level clinicians and obstetrician-gynecologists. C3 more accurately gauges primary care contact that Medicaid enrollees may have at community clinics and through reproductive health care for adolescents.
<p>C4. Received at least one preventive dental visit</p> <p>Percentage of children whose parent reported that child had seen a dentist for preventive care, such as check-ups and dental cleanings, during the past 12 months.</p>	Children and CSHCN with Medicaid/CHIP, private insurance, and uninsured	NSCH 2011–2012	This measure monitors contact with the oral health care system and also is a measure of receipt of appropriate care. This question is not asked of children in the NHIS.
<p>C5. Received care from a specialist doctor</p> <p>Percentage of CSHCN whose parent reported that child received care from a specialist doctor during the past 12 months.</p>	CSHCN with Medicaid/CHIP, private insurance, and uninsured	NS-CSHCN 2009–2010	Specialists can play a critical role in the care of CSHCN.

Contact with Health Professionals — Adults			
Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
<p>C6. Had at least one office visit</p> <p>Percentage of adults who reported seeing a doctor or other health care professional at a doctor's office, clinic, or other place (not including hospitalization, ER visits, dental visits, or telephone calls) during the past 12 months.</p>	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012	This measure is commonly used to ascertain a minimal threshold of contact in an office or clinic setting and allows comparison between populations and data sources. Survey respondents may recall having an office visit but not know or recall which type of professional they saw.
<p>C7. Saw a nurse practitioner (NP), physician assistant (PA), or midwife</p> <p>Percentage of adults who reported seeing a nurse practitioner, physician assistant, or midwife in any setting during the past 12 months.</p>	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012	Mid-level clinicians are expected to play a role in expanding access to health care for Medicaid enrollees, yet little is known about the degree to which adults encounter these clinicians.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Contact with Health Professionals — Adults, Continued

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
<p>C8. Saw a medical doctor, nurse practitioner, PA, or midwife</p> <p>Percentage of adults who reported seeing or talking to any of these selected practitioners during the past 12 months: medical doctor, nurse practitioner, physician assistant (PA), midwife, and includes obstetrician-gynecologist, specialist, or eye doctor. For Medicaid adults with and without SSI, obstetrician-gynecologists and other specialists are presented separately in C13 and C14.</p>	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012	This measure emphasizes contact with a medical doctor or advanced practice clinician in any setting. Counting mid-level clinicians may increase contact levels observed in shortage areas.
<p>C9. Saw a mental health professional (individuals with SMI)⁴</p> <p>Percentage of adults with serious mental illness (SMI) who reported seeing or talking to a mental health professional (psychiatrist, psychologist, psychiatric nurse, or clinical social worker) during the past 12 months.</p>	Adults with Medicaid, private insurance, and uninsured, Medicaid adults with and without SSI	NHIS 2012	This measure monitors contact with the mental health system. The denominator for this measure is based partly on active symptoms and will miss some adults who no longer have symptoms because they are receiving successful treatment.
<p>C10. Saw a dental professional</p> <p>Percentage of adults who reported at least one visit to a dentist, dental specialist, or dental hygienist during the past 12 months.</p>	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	This measure monitors contact with the oral health care system.
<p>C11. Saw any health professional, excluding dental</p> <p>Percentage of adults who reported at least one visit in C8 or reported seeing a mental health professional (not limited to just those with SMI as in C9). The measure also includes encounters with health professionals not captured elsewhere (e.g. chiropractor, podiatrist or foot doctor, or physical therapist).</p>	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	Expands C8 to include mental health professionals, a major source of care for adults, and other health professionals to provide a global measure of contact. This percentage may not align with reported office visits in C6 due to differences in question wording, respondent interpretation, and recall.
<p>C12. Saw any health professional, including dental</p> <p>Composite measure of adults with at least one visit in C11 or C10, including visits to a dental professional.</p>	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	Much of the difference in contact between Medicaid and private patients is due to dental visits, so the summary measure is reported with and without visits to dental professionals in C12 and C11, respectively. Dental services are an optional Medicaid benefit.
<p>C13. Saw an obstetrician-gynecologist</p> <p>Percentage of Medicaid adults who reported seeing or talking with an obstetrician-gynecologist during the past 12 months. Limited to women.</p>	Medicaid adults with and without SSI	NHIS 2012	This measure is a subset of C8 that highlights specialists, who can play a critical role in the care of individuals with disabilities.
<p>C14. Saw other specialist, not an obstetrician-gynecologist</p> <p>Percentage of Medicaid adults who reported seeing or talking with a specialist other than an obstetrician-gynecologist during the past 12 months.</p>	Medicaid adults with and without SSI	NHIS 2012	This measure is a subset of C8 that highlights specialists, who can play a critical role in the care of individuals with disabilities.

MACStats APPENDIX TABLE, Continued

Timeliness of Care — Children			
Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
<p>T1. Delayed medical care due to an access barrier</p> <p>Percentage of all children whose parents reported the child needed health care during the past 12 months that was delayed due to a cost barrier, transportation, or provider-related reasons (couldn't get appointment, had to wait too long to see doctor, couldn't go when open or get through on phone, and speaks a different language). Each barrier is separately reported.</p>	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	Delayed care is a common measure, but this measure limits the definition to delays for reasons that could reasonably be influenced by providers, health plans, and program services and supports. Delays for reasons that primarily reflect parents' motivation (i.e., "put it off") are excluded.
<p>T2. Selected types of care were delayed or not received</p> <p>Percentage of all children whose parents reported child needed but delayed or did not receive a service during the past 12 months. Medical care, mental health care, dental care, and vision are separately reported.</p>	Children with Medicaid/CHIP, private insurance, and uninsured	NSCH 2011–2012	This measure provides information on specific services for which parents are reporting delayed or unmet needs. The measure does not capture reasons for delay or unmet need. Question wording is not comparable to NHIS measure of delayed care (T1).
<p>T3. Unmet need for selected types of care due to cost</p> <p>Percentage of all children whose parents reported a time in the past 12 months when their child needed a service but didn't get it because they couldn't afford it: medical care, mental health care or counseling, dental care, prescription drugs, eyeglasses. Services are separately reported.</p>	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	These measures track access to service domains in the mandatory Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid benefit for children, but not unmet need due to barriers other than cost that can impact Medicaid disproportionately. Other barriers are presumably captured in measure T2.
<p>T4. Had a problem getting referrals (children needing referrals)³</p> <p>Percentage of children whose parents reported that getting referrals was a big or small problem. The denominator of this measure is children whose parents reported that the child needed a referral to see a doctor or receive services during the past 12 months.</p>	Children with Medicaid/CHIP, private insurance, and uninsured	NSCH 2011–2012	Difficulty getting referrals from primary care providers or health plans can lead to delays obtaining timely diagnosis and treatment critical to child development.
<p>T5. Unmet need for selected types of care</p> <p>Percentage of children whose parents reported needing the service and did not receive all the care needed or received no care. The six types of care are: specialist; prescription drugs; mental health care; non-preventive dental; physical, occupational or speech therapy; vision care or eyeglasses.</p>	CSHCN with Medicaid/CHIP, private insurance, and uninsured	NS-CSHCN 2009–2010	The NS-CSHCN provides measures of unmet need for a wide array of services that are needed by children with severe mobility, cognitive, and sensory disabilities. All of these services fall under the EPSDT benefit. Unmet need for many of these services is not collected in the NHIS or the NSCH.
<p>T6. Had 2 or more unmet needs for 14 specific services</p> <p>In addition to types of care in T5, this measure captures unmet need for dental, mobility aids or devices, communication aids or devices, home health care, substance abuse treatment or counseling, durable medical equipment, genetic counseling, and respite care.</p>	CSHCN with Medicaid/CHIP, private insurance, and uninsured	NS-CSHCN 2009–2010	By measuring unmet need for particular services, this measure helps determine if unmet need is a significant problem for a small proportion of CSHCN with particular service needs.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Timeliness of Care — Adults			
Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
<p>T7. Delayed medical care due to an access barrier Percentage of adults who reported they needed medical care during the past 12 months and that it was delayed because of selected reasons as listed in T1.</p>	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	Medicaid beneficiaries primarily report barriers to care other than cost. Reasons for these delays are segmented to help identify where in the health care system the barriers exist.
<p>T8. Unmet need for selected types of care due to cost Percentage of adults who reported a time in the past 12 months when they needed a type of care but didn't get it because they couldn't afford it. For all adults, this measure reports on unmet need for medical care and mental health care or counseling. Other services reported for Medicaid adults with and without SSI are dental care, prescription drugs, and eyeglasses.</p>	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	These measures track access to two mandatory service groups for adult beneficiaries, but do not capture barriers to service unrelated to cost.
<p>T9. Did not take medication as prescribed to save money Percentage of adults who reported one of the following in past 12 months: unmet need for prescription medicines because of cost; skipped medication doses to save money; took less medicine to save money; or delayed filling a prescription to save money.</p>	Adults with Medicaid, private insurance, uninsured	NHIS 2012	This measure expands the well-known definition of “unmet need for prescriptions due to cost” to include individuals who took specific actions to save money. Some actions, such as “asked for a generic drug” were not included.
<p>T10. Reported any barriers to care, delayed care, or unmet need Composite of adults who reported any barriers in measures in measure S13 (had usual source of care barrier or trouble finding doctor), T7–T9 (delayed care due to an access barrier, unmet need due to cost, reported not taking medication as prescribed to save money).</p>	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	Provides a gauge for the overall reach and potential impact of all barriers to timely care in the population. Unmet need for dental care and eyeglasses are excluded due to the very limited Medicaid benefit available.

MACStats APPENDIX TABLE, Continued

Receipt of Appropriate Care — Children			
Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
<p>A1. Doctors and other providers spend enough time with child</p> <p>Percentage of children whose parents reported doctors or other health care providers usually or always spend enough time with the child.</p>	Children with Medicaid/CHIP, private insurance, uninsured	NSCH 2011–2012	This measure is one of the criteria for receiving care in a medical home.
<p>A2. Received at least one preventive medical visit</p> <p>Percentage of children whose parents reported that child saw a doctor, nurse, or other provider for preventive medical care such as a physical exam or well-child checkup during the past 12 months. Presented for selected age ranges.</p>	Children and CSHCN with Medicaid/CHIP, private insurance, uninsured	NHIS 2012 NSCH 2011–2012	The EPSDT benefit in Medicaid states that children should receive one or more preventive or well-child visits, dependent on the age group. This measure sets a low bar well below the number of preventive visits recommended for 0–3 year olds.
<p>A3. Received selected EPSDT services (children needing services)</p> <p>Among children whose parents reported that their child needed a specific type of EPSDT service, the percentage who received it: mental health services (children age 2–17 with a problem needing treatment), therapy services (children with autism or developmental delay), and vision screening (age 2–17).</p>	Children with Medicaid/CHIP, private insurance, uninsured	NSCH 2011–2012	These measures capture receipt of appropriate care for common EPSDT services. The denominator for each measure is limited to children needing the service based on parent-reported condition and/or eligible for screening based on age.
<p>A4. Received coordinated, ongoing, comprehensive care within a medical home^{3, 5}</p> <p>Percentage of children who have met all criteria for receiving care in a medical home based on a series of questions.</p>	CSHCN with Medicaid/CHIP, private insurance, uninsured	NS-CSHCN 2009–2010	This measure reflects a core outcome chosen by the Maternal and Child Health Bureau for the community-based system of services required for all CSHCN under Title V of the Social Security Act. ⁶ Increasing the proportion of CSHCN receiving care in a medical home is an HP2020 objective. The HP2020 target is 51.8 percent. ⁷
<p>A5. Had an ER visit in past 12 months and most recent ER visit was related to a serious health problem or an access barrier</p> <p>Percentage of children whose parents reported the child had an ER visit in the past 12 months, and the most recent ER visit is related to either serious health problem⁸ (e.g., admitted to hospital) or an access barrier, excluding serious health problems.</p>	Children with Medicaid/CHIP, private insurance, uninsured	NHIS 2012	ER visits due to access barriers (e.g. doctor's office wasn't open) may reflect poor access to primary care or a need for more education about the importance of using primary care providers when possible, rather than the ER.
<p>A6. Had 2 or more ER visits during the past 12 months</p> <p>Percentage of children whose parents reported that the child went to a hospital ER 2 or more times in past 12 months.</p>	Children and CSHCN with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012 NS-CSHCN 2009–2010	High use of ER services may signify complex health needs, poor access to primary care, or a need for parent education.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Receipt of Appropriate Care — Adults

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
<p>A7. Received any preventive visit or counseling Percentage of adult beneficiaries who reported receipt of prevention services, including any service in measures A8–A12, talking with a health professional about diet, having blood pressure checked by health professional, or screening for breast cancer. Includes individuals not in a high-risk group or of a recommended age who received the preventive service.</p>	Adults age 19–49, 50–64, pregnant or have chronic condition with Medicaid, private insurance, and uninsured	NHIS 2012	This measure is a global indicator that adults received some aspect of recommended prevention services. Physicians and patients may prioritize preventive services based on a patient’s risk of complications or a patient’s health goals and care preferences.
<p>A8. Had cholesterol checked by health professional (at-risk groups) Percentage of adults at high-risk for coronary heart disease who reported having their blood cholesterol checked by a doctor, nurse, or other professional during the past 12 months.</p>	Selected at-risk groups with Medicaid, private insurance, and uninsured	NHIS 2012	The U.S. Preventive Services Task Force (USPSTF) recommends routine screening for men ages 35 and over for lipid disorders, and others at increased risk of coronary heart disease. ⁹ The HP2020 target for the proportion of adults who have their blood cholesterol checked within preceding 5 years is 82.1 percent. ¹⁰
<p>A9. Had an influenza vaccine or flu shot Percentage of adults who reported having an influenza shot in the past 12 months is presented for all individuals and for three vaccination priority groups whose percentages should be higher as the result of flu shot campaigns.</p>	Selected high-risk groups with Medicaid, private insurance, and uninsured	NHIS 2012	The Centers for Disease Control and Prevention (CDC) recommends annual vaccination of persons at risk of severe complications from influenza. Priority is given to these high-risk groups when supply is short. Vaccination rates of wider populations will fluctuate with supply. ¹¹
<p>A10. Had professional counseling about smoking (current smokers) Percentage of currently smoking adults who reported that a doctor or other health professional talked to them about their smoking during the past 12 months.</p>	Current smokers with Medicaid, private insurance, and uninsured	NHIS 2012	This measure captures preventive counseling for smoking for a targeted population but will miss persons who reported using tobacco products other than cigarettes or who quit during the past 12 months, possibly as the result of counseling.
<p>A11. Had any test for colorectal cancer (CRC) Percentage of adults who reported having any test done for colon cancer during the past 12 months using a single item. Limited to individuals in the recommended age group 50–64.</p>	Men and women age 50 to 64 with Medicaid, private insurance, and uninsured	NHIS 2012	The HP2020 target for the proportion of adults age 50 to 75 receiving regular CRC screening is 70.5 percent. ¹² Because the periodicity of screening recommended by USPSTF has been increased to 5 years, ¹³ the proportion in annual surveys will be lower than the HP2020 target.
<p>A12. Had Pap smear or test for cervical cancer (women age 21 to 60)¹⁴ Percentage of women who reported having a Pap smear or Pap test during the past 12 months. This measure omits women over age 60 who are least likely to be eligible for screening.</p>	Women age 21–60 with Medicaid, private insurance, and uninsured	NHIS 2012	Because screening is recommended every 3 or 5 years, the proportion in annual surveys will be lower than the HP2020 target (93 percent for women age 21 to 64). ¹⁵
<p>A13. Had more than 15 office visits Percentage of adults who reported more than 15 office visits as defined in C6.</p>	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	Individuals with over 15 office visits may have very high needs or high use may be a sign of opportunities for improved clinical management.
<p>A14. Had an ER visit in past 12 months and most recent ER visit was related to a serious health problem or an access barrier⁸ Percentage of adults as defined in A5.</p>	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	See A5. If physicians are unable to meet demand from the new Medicaid expansion population, ER use related to access problems could increase.
<p>A15. Reported 4 or more ER visits Percentage of adults who reported having gone to a hospital ER 4 or more times in the past 12 months.</p>	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	High use of the ER relative to others may signify complex health needs, poor access to primary care, or a need for patient education.

MACStats APPENDIX TABLE, Continued

Notes: NAMCS-NEHS is the 2012 National Ambulatory Medical Care Survey-National Electronic Health Records Survey. NSCH is the National Survey of Children's Health. NHIS is the National Health Interview Survey. NS-CSHCN is the National Survey of Children with Special Health Care Needs.

HP2020 is Healthy People 2020. SSI is Supplemental Security Income. EPSDT is the Medicaid early and periodic screening, diagnostic, and treatment benefit. USPSTF is the U.S. Preventive Services Task Force. CDC is the Centers for Disease Control and Prevention. ER is hospital emergency room or emergency department. CSHCN is children with special health care needs.

Recommendations by the USPSTF are based on a rigorous review of existing peer-reviewed evidence; see U.S. Preventive Services Task Force (USPSTF), *About the USPSTF* (Washington, DC: USPSTF). <http://www.uspreventiveservicestaskforce.org/about.htm>.

Surveys from which the measures are drawn use different methods to sample individuals, and data are collected from different time periods. In addition, the surveys have different questions about health insurance and different reference periods. As a result, the population sampled and subsequently classified as Medicaid, privately insured, or uninsured differs based on the data source. See additional notes in MACStats Tables 23–27 for detailed definitions of populations and insurance coverage.

- 1 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). <http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=AHS-5.2>.
- 2 CSHCN is children with special health care needs. CSHCN are identified in the NSCH and NS-CSHCN using a 5-item, parent-reported tool that identifies children across the range and diversity of childhood chronic conditions and special needs who currently experience 1 or more of 5 common health consequences due to a physical, mental, behavioral, or other type of health condition lasting or expected to last at least 12 months. For more on how children are categorized as CSHCN, see Child and Adolescent Health Measurement Initiative (CAHMI), *Fast facts: Children with special health care needs screener* (Portland, OR: CAHMI, 2007). <http://childhealthdata.org/docs/cshcn/cshcn-screener-cahmi-quickguide-pdf.pdf>.
- 3 Measures S7, T4, and A4 are child quality measures developed by the Maternal and Child Health Bureau, Health Resources and Services Administration through the Child & Adolescent Health Measurement Initiative (CAHMI). For details on these measure definitions, see Data Resource Center for Child & Adolescent Health (DRC), CAHMI, *Indicator 4.9d: Medical home component: Effective care coordination*. <http://www.nschdata.org/browse/survey/results?q=2512&r=1> [for S7]; DRC, CAHMI, *Problems getting referrals, only children who needed referrals*. <http://www.nschdata.org/browse/survey/results?q=2549&r=1> [for T4]; DRC, CAHMI, *Indicator 4.8: Children who receive coordinated, ongoing, comprehensive care within a medical home*. <http://www.nschdata.org/browse/survey/results?q=2507&r=1> [for A4].
- 4 Individuals were defined as having serious mental illness if they reported an activity limitation due to depression, anxiety, or emotional problem; feelings interfered with life a lot in the past 30 days; or received a score of 13 or over (out of 24) on the Kessler Psychological Distress Scale (K6) in the NHIS. See R.C. Kessler, P.R. Barker, L.J. Colpe, et al., Screening for serious mental illness in the general population, *Archives of General Psychiatry* 60, no. 2 (2003): 184–189.
- 5 NS-CSHCN survey questions from which this measure is constructed are whether the child has a personal doctor or nurse, has a usual source of sick and well-child care, or has no problems obtaining needed referrals; family is satisfied with doctors' communication, or gets help coordinating the child's care if needed; doctor spends enough time with the child, listens carefully to the parent, is sensitive to the family's customs, or provides enough information; and the parent feels like a partner in care.
- 6 Maternal and Child Health Bureau, *The national survey of children with special health care needs chartbook 2009–2010* (Rockville, MD: Health Resources and Services Administration, U.S. Department of Health and Human Services, 2013). <http://mchb.hrsa.gov/cshcn0910/>.
- 7 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). <http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=MICH-30.2>.
- 8 The ER visit is classified as a serious health problem if it resulted in a hospital admission, a health provider advised the person to go, the problem was too serious for a doctor's office, or they arrived by ambulance. The ER visit is classified as an access-related problem if it happened either at night or on the weekend, or when their doctor's office or clinic was not open, and excludes individuals reporting a serious health problem.
- 9 M. Helfand, and S. Carson, Screening for lipid disorders in adults: Selective update of 2001 U.S. Preventive Services Task Force review, *Evidence Syntheses* 49 (Rockville, MD: Agency for Healthcare Research and Quality, 2008). <http://www.ncbi.nlm.nih.gov/books/NBK33500/>.
- 10 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). <http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=HDS-6>.
- 11 Over time and geographically, vaccination rates fluctuate based on supply of the vaccine and flu activity, reducing the utility of monitoring changes for the entire population. When vaccine supply is limited, health professionals are instructed to focus vaccination efforts on older adults and people with conditions that place them at high risk of developing complications from influenza. See L.A. Krosskopf, et al., Prevention and control of influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2013–2014, *Morbidity and Mortality Weekly Review* 62, no. RR07 (2013): 1–43. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6207a1.htm?s_cid=rr6207a1_w#PersonsAtRiskMedicalComplicationsAttributableSevereInfluenza.
- 12 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). <http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=C-16>.
- 13 The USPSTF recommends screening adults beginning at age 50 and continuing until age 75 for colorectal cancer using fecal occult blood testing every year, sigmoidoscopy in the past 5 years and blood test in the past 3 years, or colonoscopy in the past 10 years. See U.S. Preventive Services Task Force (USPSTF), *USPSTF A and B Recommendations* (Washington, DC: USPSTF). <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.
- 14 The USPSTF recommends against cervical cancer screening for women who have had a hysterectomy with removal of the cervix and who do not have a history of cervical abnormalities or cancer, but the 2012 NHIS removed the survey item capturing this history. Women over age 60 are not included in measure A12 to minimize overcounting of older women not eligible for screening. The USPSTF recommends screening for cervical cancer in women age 21 to 65 with cytology (Pap smear) every 3 years, and provides an alternative recommendation of screening every 5 years for women age 30 to 65 who want to lengthen the screening interval. See U.S. Preventive Services Task Force (USPSTF), *USPSTF A and B Recommendations* (Washington, DC: USPSTF). <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.
- 15 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC 2013). <http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=C-15>.

Source: MACPAC analysis.