Chapter 4:

Monitoring Access to Care in Medicaid

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Key Points

- Federal and state policymakers alike want to ensure that Medicaid beneficiaries have sufficient access to necessary care. That is, are providers available, to what extent do beneficiaries receive appropriate care, and what are the barriers to receiving services.
- Efforts to monitor access can inform assessment of the program's value, serve as a means of accountability, help identify problems, and guide program improvement.
- MACPAC and others have found that Medicaid beneficiaries have much better access to care and higher health care utilization than those without insurance, particularly when controlling for socioeconomic characteristics and health status. Medicaid beneficiaries fare as well, or better, on some access measures as individuals with private insurance, but they often experience more difficulty obtaining health care.
- There is no single federally mandated method for states to monitor and evaluate access to Medicaid-covered services. However, rules promulgated in 2015 and 2016 require states to monitor access for certain types of services provided under fee for service (FFS) and to include network adequacy requirements in their managed care contracts.
- MACPAC reviewed state access monitoring review plans and found that current monitoring approaches rely primarily on complaint hotlines and advisory committees. Most plans did not define adequate access. However, some states shared information on past efforts to demonstrate that when a problem is identified, the state works to address it.
- MACPAC also surveyed states to learn about their access monitoring activities in FFS Medicaid. Twenty-nine of 37 responding states reported collecting data for one or more of the measures of beneficiary experience accessing covered services; 29 reported collecting data for measures of beneficiary utilization of covered services; and 21 collected data on provider supply measures.
- New network adequacy standards for managed care will apply beginning July 1, 2018. States are now starting to set up their newly required standards and practices.
- States and the federal government face many challenges in monitoring access, including data limitations, inconsistent use of measures, lack of benchmarks for what is considered adequate access, and administrative capacity. States and the Centers for Medicare & Medicaid Services are also interested in learning more about what initiatives work best for improving access across different populations and for different services.

CHAPTER 4: Monitoring Access to Care in Medicaid

As enrollment and spending in Medicaid grow, federal and state governments want to ensure that they are paying appropriately for care and that beneficiaries have sufficient access to necessary care. One of the key tests of the effectiveness of a health care coverage program like Medicaid is whether it provides access to appropriate and high-quality health care services in a timely manner. That is, are providers available to Medicaid beneficiaries, to what extent do they receive high-quality and efficient care, and what are the barriers to the receipt of such services. Monitoring access to care for Medicaid beneficiaries is a requirement under both fee-for-service (FFS) and managed care programs. And while different strategies may be needed to monitor access under the different delivery systems, findings from both can be used to support assessment of program value, act as a mechanism for accountability, and help identify problems and guide program improvement efforts.

The fundamental purpose of Medicaid is to provide medical assistance, and thus access is central to its purpose. This is seen in multiple provisions of the law including the definition of covered services and design of delivery systems. The key element of the Medicaid statute that created an obligation to ensure access is the so-called equal access provision. Enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239), the equal access provision focuses on the adequacy of provider payments in assuring access, requiring that they be “consistent with efficiency, economy, and quality of care and ... sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area” (§ 6402(a) of OBRA 89). Historically, the requirement to “enlist enough providers” had been assessed primarily through the adequacy of provider payment rates. With increased use of managed care, under which plans, rather than states, pay providers, the focus of ensuring access has shifted from adequate state payments to providers to state contracts with managed care plans. In addition, questions have been raised about meeting the standard of “the extent that such care and services are available to the general population in the geographic area,” given Medicaid’s role in covering services and populations that have no corollary in the private market.

Measuring Medicaid access is not a simple task for both conceptual and practical reasons. First, as discussed in more detail below, access is a multidimensional concept incorporating the need for care, the ability to obtain that care, and the value of the services obtained or not received (MACPAC 2011). Second, there are separate regulatory requirements that specify how access must be monitored under FFS and managed care arrangements. Even so, many beneficiaries receive services under both types of arrangements. Third, the tools needed to monitor patterns of use and barriers to care—timely and complete data, validated measures, and metrics—are not always available. Despite these challenges, sustained and consistent efforts to measure and monitor access can help policymakers understand whether they are in fact providing appropriate access to Medicaid enrollees, if there are particular access issues that should be addressed, and which populations are at risk of access problems.

Because there is no single mandated method for monitoring and evaluating access to services for Medicaid beneficiaries, MACPAC has chosen in this chapter to focus on how states are monitoring access in both their FFS and managed care populations, and how they propose to monitor access in the future. States and managed care plans are currently using multiple datasets and measures to monitor access; new regulations will require many states to expand their efforts to report on access to services they currently do not monitor. The chapter looks at the monitoring systems themselves and not the findings of those systems; it is not intended to evaluate whether access is adequate or how access affects outcomes of care.

The chapter begins by defining what is meant by access, referencing the framework MACPAC developed in 2011, and the measures and data that can be used to monitor differences over time, across states, and within states. This is followed by a brief review of what is known about access to care in Medicaid, based primarily on recent findings from MACPAC's work comparing access in Medicaid and privately insured populations. The chapter then explains the different federal monitoring requirements and current state practices under FFS and managed care. It concludes with a discussion of key challenges to monitoring and evaluating access.

Defining Access

As one of its first undertakings in 2011, the Commission developed a framework for examining access to care for enrollees in Medicaid and the State Children's Health Insurance Program (CHIP). This framework was built on many years of research into defining and measuring access to care and was designed to reflect the program policies and special characteristics of enrollee populations, as well as the barriers to receipt of appropriate and necessary care that these populations may face. The framework, which focuses on both primary and specialty care providers and services, has three main elements:

- characteristics of enrollees that affect their need for care and their propensity to seek and use services (such as health status and conditions, geographic location, income, cultural beliefs and practices, and continuity of their insurance coverage);
- availability of providers and services as measured by overall supply of providers and facilities and the willingness of those providers to serve Medicaid enrollees; and
- use of health care services, including whether and how services are used, affordability of services, and how easily enrollees can navigate the health system (MACPAC 2011).

Andersen and Davidson (2007) described four types of access: potential, realized, equitable, and efficient. Potential access includes factors that are necessary, but not sufficient, to obtain care, such as the ability of patients to find providers who will see them, the availability of transportation to the site of care, and the ability of patients to pay for services. Realized access refers to actual receipt of services. Equitable access means that utilization rates are similar to others with similar need. Efficient access is achieved when equitable access is achieved at the lowest possible cost (Andersen and Davidson 2007). Access may differ by geographic area as a function of the health care infrastructure and medical practice patterns, as well as an individual's clinical and perceived need for services. Furthermore, care may be ultimately received but with different levels of difficulty, such as requiring multiple phone calls to schedule an appointment, or long travel times to providers. Quality is a construct separate from access and is related to the achievement of positive outcomes associated with utilization, not whether health care use occurs at all or the difficulties experienced when obtaining care. The analysis in this chapter touches on, but does not consider mechanisms for ensuring quality of care.

Measuring Access

Assessing the adequacy of access requires specific measures and data. Over the years, numerous access measures have been developed to quantify provider supply, utilization of services, and perceived difficulty or ease of obtaining services. National surveys collect measures of utilization for specific services; these measures allow the experience of Medicaid beneficiaries to be compared with that of individuals who have private insurance or who are uninsured. Such surveys also gather information on respondents' perceptions of whether they delayed care or did not receive needed care and the reasons respondents did not receive timely services. Administrative datasets are commonly used to compare utilization rates, often for specific services such as preventive care or ongoing treatment for chronic conditions. Provider licensing data and provider association surveys are commonly used to identify the number of providers by geographic area and whether they participate in Medicaid. Access to providers is most commonly measured using the number of health care providers in a geographic area relative to the population in that area.

Although clinical and perceived need, timeliness, difficulty obtaining specific health services, and utilization rates are all subject to variation, standards do exist. Validated metrics can be used to assess access and barriers to access at the population level. Comparisons can be made to other populations, such as privately insured individuals, or to other time periods, such as utilization rates from prior years. Definitions of acceptable access can be based on clinical factors or other benchmarks, such as setting the maximum acceptable travel time to a provider or the minimal number of providers in a managed care network available to see patients.

Different data sources can be used to provide information on the different dimensions of access but all have certain limitations (MACPAC 2012a). Administrative and claims data can be used to measure care that is received but not care that is needed or desired. These data do not usually include measures of social determinants of health such as income, health literacy, race and ethnicity, language spoken, or education that are associated with both the need for health care and the ability to obtain it. Surveys, which are more likely to contain data on social determinants, typically have smaller sample sizes, provide less detail about the services that are obtained, and are based on self-reports. Information from beneficiary complaint hotlines may identify real and pressing problems but may not be representative of the entire enrollee population.

Data from health plans on their provider networks may accurately represent capacity but may not reflect actual services provided. For example, provider-to-enrollee ratios measure the number of providers from which a beneficiary could theoretically receive health care services. However, if the directories that enrollees use to identify potential providers are not accurate, or if providers in the directory do not accept new patients, then the actual provider-to-enrollee ratio may not be meaningful. One study of Medicaid managed care providers conducted by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services found that about 33 percent of contracted providers could not be found at the location listed by the plan; another 8 percent said that they were not participating in the plan; and an additional 8 percent were not accepting new patients (OIG 2014a).

There are few datasets that track measures over time that can be used to correlate access with specific clinical outcomes. In addition, the existing measures typically focus on medical care (for example, physician visits) and there are far fewer measures for other types of services, such as long-term services and supports, which are disproportionately important in Medicaid. In theory, access should be measured in terms of achievement of specific metrics (did individuals receive the care they needed with improved health outcomes); in practice, access is primarily monitored using process and outcome measures, and whether they are similar to other populations and if they change over time.

What Do We Know About Access to Care in Medicaid?

In keeping with its statutory authority to review access policies under Medicaid and CHIP, MACPAC has conducted literature reviews, analyzed survey and claims data, and assessed the potential impact of federal and state legislation and regulations on access to care among Medicaid beneficiaries. For example, a chapter in the June 2013 report discussed what is known about access to care among people with disabilities enrolled in Medicaid coverage (MACPAC 2013). We have analyzed data from large federal household surveys to compare access to care by adults under age 65 and children enrolled in Medicaid to those same age groups that have private insurance and who are uninsured, and have reported our results in *MACStats* and a series of issue briefs (MACPAC 2016a, 2016b, 2016c, 2016d, 2016e, 2016f, 2016g). We have also conducted original analyses using Medicaid administrative data to assess the effect of state Medicaid policies for paying Medicare cost sharing on beneficiary use of services (MACPAC 2015a).

The body of work to date by MACPAC and others shows that Medicaid beneficiaries have much better access to care, and much higher health care utilization, than individuals without insurance, particularly when controlling for socioeconomic characteristics and health status (MACPAC 2012b, 2012c). Medicaid beneficiaries also fare as well as or better than individuals with private insurance on some access measures. Adults with Medicaid are as likely to have a usual source of medical care as those with private coverage. They are also as likely as privately insured individuals to have a physician visit in a given year and to receive some important health care services, such as Pap tests (MACPAC 2016a, 2016b, 2016c, 2016d, 2016e, 2016f, 2016g, NCHS 2016). Low-income adults under age 65 with Medicaid coverage are actually less likely to worry about paying for medical bills than those with private coverage (MACPAC 2016e). Children enrolled in Medicaid or CHIP are more likely to receive behavioral health care services than those with private insurance.[1]

Although utilization rates for many services are comparable, Medicaid enrollees often experience more difficulty obtaining health care. For example, our analyses show that adults and children with Medicaid coverage have more problems than privately insured individuals in obtaining care, that is, they experience longer wait times for appointments, have more difficulty finding a provider who will treat them, have more trouble obtaining transportation, or have to wait longer at the provider's site of care (MACPAC 2016b, 2016e). Adult Medicaid beneficiaries are less likely to receive mammograms and colorectal tests than the privately insured (MACPAC 2016f). The rates of people with a dental care visit in the past year, an optional benefit for adults but a mandatory benefit for children, are also lower for adults and children covered by Medicaid than for those with private health insurance (MACPAC 2016d, 2016g).

Medicaid beneficiaries, like other low-income individuals, may have lower health literacy, more transportation and child care difficulties, and other factors that affect their ability to access health care. Some of the differences in access between Medicaid-enrolled and privately insured populations may be due to these factors rather than to specific features of Medicaid, such as low provider payment rates or lack of coverage for certain types of services. However, even when comparing similarly situated individuals, some differences remain. For example, Medicaid enrollees have more difficulty than low-income privately insured individuals in finding a doctor who accepts their insurance and making an appointment; Medicaid enrollees also have more difficulty finding a specialist physician who will treat them. Other differences narrow when controlling for income, such as rates of dental visits for children and rates of mammography for women age 50–64 (MACPAC 2016d, 2016f).

People with disabilities, who are represented in the Medicaid population at higher rates than in the general population, have particular barriers to care, including access to specialist services. Children with special health care needs enrolled in Medicaid or CHIP have more problems obtaining an appointment and finding a doctor who accepts their health insurance than those with special health care needs covered by private insurance (MACPAC 2016b).[2] Adults under age 65 with a disability who are covered by Medicaid are more likely than their privately insured counterparts to report having trouble finding a general doctor, having trouble finding a doctor who would accept their health insurance, and being unable to obtain needed medical care due to cost (MACPAC 2016e).

Monitoring Access in Fee-for-Service Medicaid

Although managed care is now the dominant delivery system in Medicaid, monitoring access under FFS remains important for several reasons. First, a substantial portion (55 percent) of national Medicaid spending was for services provided under FFS arrangements in fiscal year 2015 (MACPAC 2016a).[3] The use of FFS varies by state—Tennessee and Vermont operate exclusively in a managed care environment, but other states, such as Connecticut and Oklahoma, operate mainly under FFS. Still, even FFS states may use features similar to managed care, such as medical homes and case management services.

Second, the populations that remain in FFS Medicaid, such as children and adults with disabilities, are among the most vulnerable beneficiaries, and ensuring their access to services is particularly important given their high health needs. For example, in Arizona, two-thirds of individuals with disabilities are enrolled in comprehensive managed care, but in West Virginia, less than 2 percent of beneficiaries with disabilities receive services through managed care arrangements.

Third, even in states with high managed care penetration, some services, such as long-term services and supports, dental services, and behavioral health services, are carved out of managed care contracts and provided through FFS arrangements. As a result, many enrollees receive some care under both types of arrangements, and the data needed to monitor access are captured separately for care provided under FFS and managed care.

Access requirements in FFS Medicaid

Efforts to monitor access to care in FFS Medicaid stem from the provision of the Social Security Act (the Act) requiring that states set Medicaid provider payment rates so that they are "consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area" (§ 1902(a)(30)(A) of the Act). As such, the focus under FFS has primarily been on how changes in payment rates might affect provider participation, as well as on monitoring whether beneficiaries enrolled in FFS have a level of access that is similar to others in their geographic area. Although FFS enrollees may see any participating Medicaid provider who will treat them, payment rates that are too low may discourage providers from treating Medicaid-enrolled individuals, thus impairing these individuals' access to services.

Until recently, there were no federal regulations to guide states in meeting the equal access provision. This absence of federal guidance led to substantial variation in the processes and standards used by states to monitor and ensure access to care in FFS Medicaid. In some instances, payment rates were determined to be too low to ensure equal access to Medicaid services primarily as the result of lawsuits filed by providers and beneficiaries. On March 31, 2015, in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015), the Supreme Court decided that Medicaid providers and beneficiaries do not have a private right of action to contest state-determined Medicaid payment rates in federal courts, making federal enforcement of the equal access provision that much more important.

On November 2, 2015, the Centers for Medicare & Medicaid Services (CMS) published a final rule describing how states should monitor and report on access to care under FFS Medicaid (CMS 2015a). CMS noted that the goal was to provide a more transparent process for monitoring access to services paid for under FFS arrangements and to allow CMS to make and document informed, data-driven decisions when considering proposed rate reductions and other payment or state program changes that could reduce beneficiaries' abilities to receive needed care. The monitoring requirements also apply to populations receiving services paid on a FFS basis when carved out of managed care as well as those in primary care case management arrangements.

Access monitoring review plans. CMS's final 2015 rule required states to submit an access monitoring review plan by October 1, 2016.[4] This plan was to have been developed with the state's medical care advisory committee, as well as provider and beneficiary input, and made available for public comment for at least 30 days. CMS reviewed state plans for compliance with the requirements, but did not formally approve those plans.

The access monitoring review plan applies to five categories of services: primary care services, physician specialist services, behavioral health services, prenatal and postnatal obstetric services, and home health services. The state must also monitor additional services for which the state or CMS has received a significantly higher than usual call volume of access complaints from beneficiaries, providers, or other stakeholders. In addition, states must submit a recent access review with any state plan amendment proposing a reduction or restructuring of payment rates that could result in diminished access. The plans must also include procedures to periodically monitor access for at least three years after the implementation of a provider rate reduction or restructuring.

The rule includes additional parameters for such plans. For example, they must include the measures, data sources, methods, and thresholds used to analyze access. This analysis must also take into account state-specific delivery systems, beneficiary characteristics, and geography. In making a determination of whether access is sufficient, the plan must consider the following:

- the extent to which beneficiary needs are fully met;
- the availability of care through enrolled providers (by geographic area, provider type, and site of service);
- changes in beneficiary utilization;
- characteristics of the beneficiary population; and
- actual or estimated provider payments from other payers.

When problems with access are identified, states must submit, within 90 days, a plan of corrective action listing specific steps and timelines to address the issues within 12 months. Corrective actions can take a variety of forms, including, but not limited to, increasing provider rates, improving provider outreach, reducing barriers to provider enrollment, providing additional transportation or telehealth services, and improving care coordination (Kvedar et al. 2014).

Initial review of draft state access monitoring plans in FFS

An initial review of the draft state access monitoring review plans from 49 states shows that the approach to monitoring access varies across states; nevertheless, some common themes emerged, as noted below.[5] Some states noted in their draft plans that the vast majority of enrollees in their state receive services through managed care entities and commented on the administrative burden of monitoring access for what was sometimes perceived as the small and idiosyncratic population enrolled in FFS Medicaid. It is likely that the approaches outlined in the drafts will change as state access monitoring review plans are finalized and ongoing state efforts to monitor access evolve.

Existing state approaches to monitoring access. Current state approaches to monitoring access primarily rely on consumer complaint hotlines and advisory committee meetings. Some states also discussed their efforts to address access issues as an indication that once a problem is identified, the state works to address it. For example, a number of states have initiatives designed to improve access through delivery system reforms, such as accountable care organizations and telehealth, or through provider incentives, such as loan repayment programs.

Baseline data. Most states reported baseline data across the five required service areas, and some states included data pertaining to additional service areas for which access issues had been identified, such as dental and transportation services. Some states deliver all prenatal and postnatal care or behavioral health services through managed care arrangements, so baseline data for these services were not presented. Baseline data were reported from a variety of sources, such as utilization data from claims, self-reported access measures from beneficiary surveys, and provider enrollment figures. States also differed in the extent to which they included demographic or other enrollee characteristics that would allow them to identify the populations served through FFS arrangements.

Standards or benchmarks. Although some states provided trend data or made regional comparisons as part of their baseline reporting, they typically did not provide a standard for what would be considered adequate access. Overall, only a handful of states included explicit standards or benchmarks for comparisons. For example, a few states set a provider-to-enrollee ratio and others used the ratios in managed care network adequacy requirements. In assessing utilization, a few states compared utilization to individuals with private insurance coverage.

Provider rate comparison. A majority of states made comparisons to Medicare payment rates, while a smaller number looked at the rates paid by Medicaid in other, typically neighboring, states. In making the comparison to other states, a number relied on the Medicaid-to-Medicare physician fee index published by researchers at the Urban Institute (Zuckerman et al. 2014). Few states had available private payer data, although those with access to exchange plan data or all-payer claims databases included such comparisons.

Corrective action plan. Most states reported little in terms of concrete steps to address access issues when they are discovered, although the plans typically declared the state's intent to work with CMS to address issues within the required time frame. A number acknowledged that any potential access issue would likely require investigation to determine the most appropriate response. For example, one state described the use of a response team to determine the cause of the access issue and to develop a corrective action plan. A few states identified areas for improvement in their review and highlighted the particular steps they would take to investigate and address the issue.

Current access monitoring practices in FFS

To gain a better understanding of the approaches that states take to monitor, assess, and improve access for populations covered under FFS Medicaid, MACPAC contracted with RTI International to conduct a survey of state Medicaid programs. The survey provides MACPAC and others with additional details beyond those available in the state plans, for example, the types of measures used, the frequency of data collection, and how states use the measures.

The survey asked about state practices that were in effect on May 1, 2016. First, a screener determined which populations were receiving services under FFS Medicaid in the state. The remainder of the survey focused on three aspects of access that states might measure: beneficiary experience accessing covered services, beneficiary utilization of covered services, and provider supply. If applicable, states were asked to report the populations (such as children or adults with disabilities, the elderly, or pregnant women) for which these data were collected. They were also asked whether they were collecting data for specific types of services and providers. These additional details were sought in part to understand where existing efforts align with the requirements of the new rule. (For a full list of the populations, services, and providers included in the survey, see Appendix 4A, Table 4A-1.) The survey also asked about the types of data collected, the frequency of data collection, and how states used the measures. The survey was fielded from August 8 through September 20, 2016, and 37 states responded.

Survey findings. All of the 37 states that responded to the survey provided services on a FFS basis to at least 4 of the 10 populations listed, and 27 of the states provided services on a FFS basis to all of the populations (Table 4-1).

Of the three general types of access measures, 29 of the 37 responding states reported collecting data for one or more of the measure types related to beneficiary experience accessing covered services; 29 responding states reported collecting data for measures of beneficiary utilization of

TABLE 4-1. Number of States Serving Specific Populations in Fee-for-Service Medicaid, 2016

Population	Number of states
Non-disabled children	34
Non-disabled adults	32
Individuals age 65 and older	34
Children with physical disabilities	35
Adults with physical disabilities	34
Children with intellectual or developmental disabilities	36
Adults with intellectual or developmental disabilities	35
Children with severe emotional disturbance or substance use disorders	34
Adults with severe mental illness or substance use disorders	33
Pregnant women	30

Notes: Data are shown for the 37 responding states.
Source: RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid fee-for-service beneficiaries' access to care.

TABLE 4-2. Number of States Collecting Category-Specific Access Measures, 2016

Access measure	Number of states
Beneficiary experiences accessing covered services	29
Receipt of covered services	26
Receipt of timely covered services	20
Specific barriers to covered services	19
Utilization of covered services	29
Provider supply	21

Note: Data are shown for the 37 responding states.
Source: RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid fee-for-service beneficiaries' access to care.

covered services; and 21 responding states collected data related to provider supply measures (Table 4-2). Thirteen responding states collected data across all five of these areas. (See Appendix 4A, Table 4A-2 for a breakdown of the access measures collected by each state.)[6]

Populations, services, and providers. In most areas of measurement, there was little variation in the number of states collecting data for particular populations. In terms of services and providers, states most often collected measures related to primary and specialty care, behavioral health, and dental health. Given prior analyses suggesting that these are areas where access to services may be an issue in FFS Medicaid, monitoring efforts targeting these specific areas would be expected. (See Appendix 4A,Tables 4A-3, 4A-4, and 4A-5 for specific populations, services, and providers for which measures are collected.)

Beneficiary experience. Of the 29 states that reported collecting data on beneficiary experience accessing covered services, 26 collected data relating to beneficiary receipt of covered services. Twenty states collected data on the timely receipt of covered services, such as whether enrollees were able to obtain an appointment or find a provider that accepted Medicaid. Nineteen states collected data on the specific barriers to covered services, for example, the lack of transportation to a provider. Sixteen states collected data for all three beneficiary experience measures.

Across the types of beneficiary experience measures, states focused their efforts on specialty services, primary care, and behavioral health services. Regarding timely receipt of services, states most often collected data on the ability to find a provider and the ability to find one that accepted Medicaid. States were also more likely to collect data related to an individual's inability to secure a usual source of care and the lack of transportation to providers than data related to other potential access barriers.

Beneficiary utilization of covered services. Twenty-nine of the 37 responding states reported that they collected measures of beneficiary utilization. Sixteen collected data for all of the survey populations, 19 collected data for all provider types, and 11 collected data for all service types.

Provider supply. Twenty-one states collected provider supply measures for either the state overall or Medicaid FFS populations specifically.

States most commonly collected data on the ratio of participating providers to the population (16 states); provider participation in Medicaid (15 states); and the overall number of providers in the state, but not necessarily those serving Medicaid beneficiaries (15 states). States also tended to focus their efforts on primary care providers and specialty care providers, followed by behavioral health and dental providers.

Data sources and comparisons. Across the measures of beneficiary experience and utilization, states most often used claims data, beneficiary surveys, complaint hotline caller logs, and stakeholder meetings to assess the adequacy of enrollee access. In making these assessments, states compared the data to trends from previous years and national Medicaid averages. A number of states also reported these data publicly, while smaller numbers used them to provide feedback to providers or guide corrective action. To assess provider supply in Medicaid and across the state, states most often used provider enrollment data, comparing them to trends from previous years. States used these data to assess the adequacy of access and report publicly, as well as to guide state policy to increase provider supply. (See Appendix 4A, Tables 4A-6, 4A-7, and 4A-8 for sources, uses, and comparisons of the data collected.)

Monitoring Access in Medicaid Managed Care

Unlike FFS arrangements, in which states pay providers directly and are solely responsible for monitoring access, managed care arrangements involve states contracting with managed care organizations (MCOs), which in turn contract with providers and monitor and enforce access and quality standards. State Medicaid programs approve contracts that describe how access will be monitored and deficiencies corrected, but in most cases do not pay or interact with providers directly. Managed care offers states the opportunity to provide access to appropriate services and coordinate care for Medicaid enrollees—linking each enrollee with a regular source of primary care, arranging access to a contracted network of providers, and providing support services such as health education. Because managed care plans are paid on a capitated basis, there are risks that these arrangements will incentivize plans to contain costs through limited provider networks or inadequate payment rates that could negate some of the positive aspects of ensuring access to care. States maintain contractual oversight of the plans and have an obligation to ensure that beneficiaries receive the appropriate services and that capitation payments are actuarially sound and made to entities that can provide these services.

Access requirements in Medicaid managed care

Access to Medicaid services for enrollees in managed care are covered under Sections 1903(m) and 1932 of the Act. MCOs must show the state and the Secretary of the U.S. Department of Health and Human Services (the Secretary) that they have the capacity to serve the expected number of enrollees and provide evidence that the plan offers an appropriate range of services, including access to preventive and primary care services, and maintains a sufficient number, mix, and geographic distribution of providers. The statute also requires that MCOs have procedures in place for monitoring and evaluating the quality and appropriateness of care and services to beneficiaries and that these services reflect the full spectrum of the needs of the populations enrolled under the contract. Medicaid MCOs must also document standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care, adequate primary care, and specialized services capacity (§1932 of the Act).

On May 6, 2016, CMS issued a final rule that amended previous provisions governing network adequacy and access monitoring in MCOs (CMS

2015b). Specifically, the final Medicaid managed care rule includes provisions regarding network adequacy standards for both the state and the MCOs. Under the final rule, states are required to develop—and make publicly available—time and distance network adequacy standards for providers, including primary and specialty care providers (adult and pediatric), obstetrician/gynecologists, behavioral health providers, hospitals, pharmacies, pediatric dental providers, and additional provider types as determined by CMS (42 CFR 438.68). The rule applies to services provided to beneficiaries who are enrolled in managed care, including those who receive some carved-out services, such as behavioral health and dental services, in FFS arrangements.

The Medicaid managed care final rule also lists factors that states must consider in setting standards, including the ability of providers to communicate with limited English proficient enrollees and to accommodate enrollees with disabilities. States should also consider the availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and other evolving and innovative technological solutions (42 CFR 438.68).

States must develop standards for all geographic areas of the state covered by the managed care program, but may allow capitated plans to meet different standards in different parts of the state. For example, a state could require plans to provide primary care within 10 miles or 15 minutes in urban areas of the state, but within 30 miles or 45 minutes in rural areas. States may grant exceptions to its time and distance standards, as long as the exceptions process is set forth in the plan contract and is based on the number of providers in the relevant specialty area who are practicing in the plan's service area. State time and distance standards must be published on the state's website and be provided in hard copy and accessible formats upon request. If states create exceptions to network adequacy standards, they must monitor enrollee access on an ongoing basis (42 CFR 438.68).

The rule also has more specific requirements, such as ensuring that female beneficiaries have direct access to women's health specialists and timely access to family planning services. Enrollees must also be able to get second opinions from an in-network or out-of-network provider, if necessary. Furthermore, beneficiaries must be permitted to obtain medically necessary services out of network, and out-of-network providers must coordinate with MCOs to ensure that enrollees do not have to pay more for these out-of-network services. Network providers must offer hours of operation no less than those offered to commercial beneficiaries or comparable to Medicaid FFS, and must offer around-the-clock services when medically necessary (42 CFR 438.206).

The provisions of the new managed care final rule will be phased in over a period of time. The new network adequacy standards will apply to plan years beginning on or after July 1, 2018, and states are now starting to set up their newly required standards and practices.

Current access monitoring practices in managed care

Managed care plans may be in a better position than state officials to monitor beneficiary access to care; their defined population of enrollees and providers provides a ready source for data collection. Furthermore, 33 states either require or recognize health plan accreditation from the National Committee for Quality Assurance (NCQA), which includes consistent data collection and reporting across states and plans. NCQA accreditation requires annual submission of data collected by the Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. HEDIS is a set of state-level quality, access, and effectiveness-of-care measures for selected conditions, including measures related to the receipt of certain cancer screenings and child immunization rates; CAHPS is a set of beneficiary surveys designed for children and adults that covers a range of topics, including access to care (Toppe 2016).

Because federal regulations did not require specific network adequacy or other access standards before the May 2016 rule, and the new standards are not yet in effect, states vary considerably in what they require in MCO contracts and how the state monitors access once the contracts are in place. Many states have a standard for the maximum distance or travel time allowed to travel to a primary care provider; fewer specify these distances or travel time maximums to specialists (KFF 2016a; KFF 2016b). Standards range from requiring 1 primary care provider for every 100 enrollees to 1 primary care provider for every 2,500 beneficiaries. Additionally, standards are often not specific to certain types of providers or to areas of the state.

States also use different strategies to assess compliance with the access standards established in their managed care contracts. They typically do not use what are called direct tests, such as making calls to providers. A review by the OIG found that most states did not identify any violations of their access standards over a five-year period; the states that found the most violations were those that conducted direct tests of compliance. Among the states that identified violations, most relied on corrective action plans to address the violations, and only six imposed sanctions. Finally, the study found that CMS provided limited oversight of state access standards (OIG 2014b).

Challenges to Monitoring and Ensuring Access in Medicaid

States monitor access to ensure that Medicaid beneficiaries have adequate access to care and to provide feedback on where their programs are succeeding and where there are problems requiring attention. These activities also help the federal government assess whether states are using their federal funds in an appropriate manner and make comparisons across states. However, limitations in available and timely data, standard and validated access measures and benchmarks, and administrative capacity are major challenges for states and CMS in monitoring access. In addition, states and the federal government may have different priorities for access monitoring: while CMS may be focused on the need for standard access measures that can be compared across states, states may value measures tailored to their populations and local circumstances that can provide information for program improvement.

Data limitations

Consistent and detailed data across states and programs are lacking. Many sources of data are available to characterize access at the national level, but far fewer are available at the state level. For example, national household surveys have limited sample sizes at the state level, so few can be used to produce state-level estimates. Administrative or claims data do not contain information on care that is needed but not obtained. In addition, race and ethnicity are not well reported in administrative datasets and often not collected by plans, although the percentage of plans collecting these data is increasing (Escarce et al. 2011). Administrative data also cannot be used to compare measures across payers because the data are generally payer-specific.

The completeness of data may also be a function of delivery system design. States that continue to pay predominantly under FFS may have standardized data that can be used to monitor access for all enrollees. In states with high managed care penetration, contracts with plans may allow states to get more specific data for use in monitoring access. However, plans may collect those data differently, so while states may have data from all plans, the data are not necessarily comparable, making it difficult to make comparisons across plans, as well as across states.

It is also difficult to assess the sufficiency of Medicaid payment rates without payment data from other states or payers. Private payer data are often considered proprietary and states may not have ready access to them. Furthermore, although Medicare rates may be available for comparison, Medicare providers might not provide services that can be compared to, for example, pediatric dentistry under Medicaid plans.

All-payer claims databases are beginning to become more common, and have the potential to be used to compare Medicaid to privately insured populations. States are also using these databases to compare patterns of care across payers, including the use of emergency department services and differences in specific services for specific conditions by geographic area, race and ethnicity, and other available characteristics of beneficiaries (APCD Council 2017). However, these datasets do not capture the experience of uninsured populations and, like other administrative datasets, they do not contain much information on social determinants of health or need for services (Porter et al. 2014).

Available measures

Access to care has been studied for decades, and well-established measures that can be used to compare access across states are available, for example, HEDIS measures quality, access, and the effectiveness-of-care measures and the CAHPS beneficiary surveys include data on access to care and satisfaction with providers. Some state Medicaid agencies use CAHPS and similar measures to gauge member satisfaction with Medicaid managed care arrangements and many require participating MCOs to collect and report HEDIS data. These standard measures are useful in comparing broad-based measures, such as whether individuals saw a physician in the past year, whether they had a usual source of medical care, or whether they reported receiving needed medical care, across states and programs.

However, states vary in their adoption of these measures, in part because there is no federal mandate on their use and in part because their populations and monitoring needs differ. For example, some states have focused on particular populations, such as children, in their use of the CAHPS, while others have adopted the measures more broadly. This inconsistent use of standard measures makes it difficult to compare access across state Medicaid programs. A recent report commissioned by CMS proposed measures that could be used to monitor access in FFS populations across states in compliance with the FFS access rule, primarily using existing data sources and validated measures. The report recommended that states use measures that align with existing data collection activities, including the CMS Core Sets of Adult and Child Health Care Quality Measures for Medicaid and CHIP (otherwise known as the Adult and Child Core Sets), the Transformed Medicaid Statistical Information System (T-MSIS), and the Nationwide Adult CAHPS survey. The report also recommended that states add some new measures based on secret shopper audits as part of their monitoring and contract compliance activities (Kenney et al. 2016).

These broad-based measures, however, may not be sufficient for monitoring Medicaid access for specific services and populations, and in many cases local conditions affect comparisons of even commonly used standard measures. Ideally both types of measures would be used to collect data: standard measures in national data collection activities to identify broad-brush differences in access, but also more specific measures tailored to the needs of specific populations, services, and localities.

CMS acknowledged the need for better and possibly more measures when it issued the equal access rule, issuing at the same time a request for information, due January 4, 2016, that asked interested parties to share measures and methods to take into account differences in delivery system designs, populations served, and provider networks. For example, CMS noted the need for measures to address the many factors that affect access to Medicaid services, including the following: “level of payment, geographic location, time and distance to the closest provider, workforce, numbers of specialists and other types of providers within the state, lack of knowledge of available resources by beneficiaries, insufficient provider outreach, scope of practice approaches, and other economic and policy factors” (CMS 2015b).

More specific access measures are needed that are relevant to specific localities, populations, and services. Transportation may be more of a barrier to access in some areas, whereas finding a provider willing to treat the beneficiary may be of greater concern in another location. States that allow telehealth may have different distance standards than those that do not. Physical barriers to access, such as width of elevator doors, lack of ramps, or specialized exam tables, may be problematic for people with disabilities but not for other populations. Development of measures of access for services that are not usually covered by other insurers, such as home and community-based services and enhanced behavioral health services, like applied behavioral analysis for autism spectrum disorder, lags behind development of measures of access to more commonly used medical services.

Lack of benchmarks

A key question in assessing access to care in Medicaid is defining an appropriate comparison. The FFS standard established in the statute—that access be comparable to the general public—is problematic for several reasons. First, many of the populations served by Medicaid are not covered by other insurers, meaning that there is no true comparison group. Even within Medicaid, given the diverse specific needs of Medicaid enrollees, the large number of services they use, and the wide range of available providers across locations, collecting information on the numerous potential barriers to access may differ across states and programs and therefore not readily allow comparisons.

Second, given the trend in private coverage towards more high-deductible, limited network plans with lower actuarial value, it is not clear that a comparison to this standard would be a measure of sufficient access to care for Medicaid beneficiaries, because many services that are covered by Medicaid are not covered by private insurers or may be available only after high copayments. In addition, state regulations differ with regard to private plans and mandated benefits. As such, private plans in one state may not be similar to those in other states, much less Medicaid programs. Further complicating access monitoring in Medicaid programs is the fact that different Medicaid programs and plans cover different optional services with different restrictions and eligibility rules. For example, state plan dental and behavioral health services differ considerably by state, and the benefits offered in MCOs and waiver services vary even more (MACPAC 2015b, 2015c).

Administrative capacity constraints

Medicaid agencies at both the state and federal level are often expected to manage a large and diverse set of responsibilities but continue to face staff shortages and resource constraints. In a 2017 survey of state Medicaid agencies, 31 states cited budgetary constraints at the administrative, agency, or state level as an overall issue, with particular inability to fully address program reforms (NAMD 2016). CMS also faces budget constraints, staff attrition, and the changing nature of health care program oversight (MACPAC 2014). For example, the new managed care and access rules described earlier create new obligations for agency staff to review all state Medicaid access monitoring plans, evaluate whether any proposed payment changes will affect access, and review managed care contracts to ensure that capitation rates are actuarially sound.

State and federal Medicaid agencies are also constrained in their ability to collect, analyze, and report data, important functions for monitoring access in Medicaid. A number of states with large managed care populations have also voiced their concerns regarding the burden of monitoring the typically small and sometimes unique populations that continue to receive services in FFS. State capacity to review managed care contracts and ensure that measures of access are appropriate may also be an issue because of competing priorities with other oversight responsibilities and staff expertise with data analysis, access measurement, and managed care contracting.

Lack of data on effectiveness of interventions to increase access

States and CMS would benefit from greater understanding of effective strategies to increase access to care in Medicaid, yet the outcomes associated with past and ongoing interventions are largely unknown. Many states have worked to improve provider participation by increasing payment rates, reducing paperwork, and creating loan repayment programs. Others have focused on expanding the pool of available providers for certain services, for example, dental hygienists and nurse practitioners, and by expanding use of telehealth. Other access initiatives have focused on increasing office hours and after-hours access, promoting use of non-emergency medical transportation, and providing enabling services such as translation and interpretation (Bodenheimer and Pham 2010, Rowland and Salganicoff 1994).

Some barriers, such as overall provider supply, may be beyond the purview of the Medicaid program, although agencies may be able to work with others to lessen these barriers. For example, Medicaid programs have collaborated with state licensing boards to change licensing laws or scope of practice regulations to increase overall provider supply, which may also increase the number of providers participating in Medicaid. Medicaid can also work collaboratively to target access barriers for specific populations served through other agencies. For example, Medicaid programs in several states are working with criminal justice systems to enroll individuals prior to their release so they can continue needed health services without interruption (CMS 2016b).

As discussed above, states have undertaken a variety of approaches to increase provider supply; however, little is known as to which approaches are successful, and whether their success differs by provider type or service location. As such, it is difficult for Medicaid administrators to determine which intervention is most appropriate. Sharing information across programs—including the associated costs and outcomes—could help to spread the adoption of successful approaches to improving access.

Conclusion

States vary considerably in their approaches to monitoring access to care, and these efforts will likely evolve in response to the final rules issued by CMS in 2015 and 2016. But despite measurement and capacity constraints, states and the federal government have an obligation to ensure that Medicaid beneficiaries have sufficient access to services. Increasing the ability to monitor access to care, and increased attention to doing so, also increases transparency and accountability for program spending. This oversight, both by CMS and by state agencies, can and should be further strengthened with more timely and consistent data collection and program evaluation.

Given its statutory charge, MACPAC will continue its work to assess the performance of Medicaid and CHIP relative to the fundamental goal of providing access to appropriate and effective services that lead to better health at a reasonable cost. The Commission will continue to follow state activities that put FFS monitoring plans into action and work with MCOs to implement the managed care rule. We will also monitor developments to improve data collection and analysis that have the potential to provide timely and important information and are consistent with the administrative resources of the states and federal government, such as the implementation of the T-MSIS. We will continue our examination of areas within the Medicaid program for which there are no obvious benchmarks to commercial insurance and where traditional measures of access are not easily applied. And as states develop and implement new value-based delivery system models in their Medicaid and CHIP programs, the Commission will consider their impact on access to care.

Endnotes

[1] This analysis does not control for need for services.

[2] Children with special health care needs are identified through a series of questions that ask about the following: the need for or use of medicines prescribed by a doctor; the need for or use of more medical care, mental health, or education services than is usual for most children; being limited in or prevented from doing things most children can do; the need for or use of special therapy, such as physical, occupational, or speech therapy; and the need for or use of treatment or counseling for emotional, developmental, or behavioral problems. Parents or other respondents who responded yes to any of the initial questions in the sequence were then asked to respond to up to two follow-up questions about whether the health consequence was attributable to a medical, behavioral, or other health condition lasting or expected to last at least 12 months. Children with positive responses to all of the follow-up questions for at least one of the five health consequences were identified as having a special health care need.

[3] This figure represents spending in managed care and premium assistance, and includes comprehensive and limited-benefit managed care plans, primary care case management, employer-sponsored premium assistance programs, and Programs of All-Inclusive Care for the Elderly. Comprehensive plans account for over 90 percent of spending in the managed care category. Managed care also includes rebates for drugs provided by managed care plans and managed care payments associated with the primary care physician payment increase, Community First Choice option, and preventive services with U.S. Preventive Services Task Force Grade A or B, and Advisory Committee on Immunization Practices vaccines.

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

[5] Two states—Vermont and Tennessee—were exempt from developing plans because they have no FFS enrollment in their Medicaid programs. The basis for exemption is for states to confirm that 100 percent of the population is enrolled in managed care and that they have no FFS volume

for the services subject to ongoing review. Only Tennessee and Vermont were able to provide confirmation of this (Silanskis 2016).

[6] Five states (Alaska, New Jersey, New Mexico, Vermont, and West Virginia) did not report collecting any of these types of measures. It may be that because the reference date for our survey was prior to the requirement for the development of an access monitoring review plan, these states were not yet doing anything specific to monitor access in their FFS Medicaid programs. It may also be that the survey questions did not adequately capture their existing monitoring efforts. As discussed above, each of these states (except for Vermont, which was exempt based on its high level of managed care-like enrollment) submitted an access monitoring review plan to CMS outlining its approach to ongoing access monitoring.

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APPENDIX 4A: Summary Tables from State Survey on Measuring Access to Care in Fee-for-Service Medicaid

TABLE 4A-1. Categories of Populations, Services, and Provider Types Used in Access-to-Care Survey, 2016

Populations	Services	Provider types
• Non-disabled children • Non-disabled adults • Individuals age 65 and older • Children with physical disabilities • Adults with physical disabilities • Children with intellectual or developmental disabilities • Adults with intellectual or developmental disabilities • Children with severe emotional disturbance or substance use disorders • Adults with severe mental illness or substance use disorders • Pregnant women	• Primary care • Specialty care • Child developmental screening • Behavioral health • Prenatal and postpartum care and services • Home health services • Long-term services and supports • Dental care and services • Emergency department services • Pharmacy services • Any covered service (specific service(s) not measured) • Other services	• All providers • Primary care providers • Specialty care providers • Behavioral health providers • OB/GYN providers • Home health providers • Dental care providers • Other providers
Applies to following questions:	**Applies to following questions:**	**Applies to following questions:**
• Screener for populations served by fee for service • Beneficiary receipt of covered services • Beneficiary receipt of timely services • Specific barriers to obtaining services • Beneficiary utilization • Provider supply	• Beneficiary receipt of covered services • Beneficiary receipt of timely services • Specific barriers to obtaining services • Beneficiary utilization	• Beneficiary receipt of timely services • Specific barriers to obtaining services • Beneficiary utilization • Provider supply

Notes: To gain a better understanding of the approaches that states take to monitor, assess, and improve access for populations covered under fee-for-service Medicaid, MACPAC contracted with RTI International to conduct a survey of state Medicaid programs. The survey asked about state practices that were in effect on May 1, 2016. The survey also asked about the types of data collected, the frequency of data collection, and how states used the measures. The survey was conducted from August 8 through September 20, 2016, and 37 states responded.
Source: RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid fee-for-service beneficiaries' access to care.

TABLE 4A-2. Specific Access-to-Care Measures, by Category, Collected by Each State in FFS Medicaid, May 1, 2016

State (N = 37)[1]	Total number of access measures collected per state	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply	Other types of access measures[2]
		Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services			
States collecting any measure of access in category	N/A	26	20	19	29	21	12
Alabama	6	✓	✓	✓	✓	✓	✓
Alaska[3]	N/A						
Arkansas	1				✓		
California	3		✓		✓	✓	
Colorado	5	✓	✓	✓	✓	✓	
Connecticut	6	✓	✓	✓	✓	✓	✓
Delaware	2	✓			✓		
District of Columbia	4	✓			✓	✓	✓
Georgia	4	✓	✓	✓	✓		
Idaho	5	✓	✓	✓	✓	✓	
Indiana	4		✓	✓	✓	✓	
Iowa	6	✓	✓	✓	✓	✓	✓
Kentucky	4			✓	✓	✓	✓
Louisiana	2	✓		✓			
Maine	5	✓	✓	✓	✓	✓	
Maryland	3	✓			✓		✓
Michigan	4	✓	✓	✓	✓		
Minnesota	2				✓	✓	
Missouri	2	✓			✓		
Montana	6	✓	✓	✓	✓	✓	✓
Nevada	2	✓					✓
New Hampshire	2				✓	✓	
New Jersey[3]	N/A						
New Mexico[3]	N/A						
New York	4	✓			✓	✓	✓
North Carolina	3	✓	✓	✓			

TABLE 4A-2. (continued)

State (N = 37)[1]	Total number of access measures collected per state	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply	Other types of access measures[2]
		Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services			
Oklahoma	5	✓	✓	✓	✓	✓	
Oregon	5	✓	✓	✓	✓		✓
Rhode Island	2	✓			✓		
South Carolina	6	✓	✓	✓	✓	✓	✓
South Dakota	5	✓	✓	✓	✓	✓	
Utah	4	✓	✓		✓	✓	
Vermont[3]	N/A						
Virginia	4	✓	✓		✓	✓	
Washington	6	✓	✓	✓	✓	✓	✓
West Virginia[3]	N/A						
Wyoming	5	✓	✓	✓	✓	✓	

Notes: FFS is fee for service. N/A is not applicable. A blank cell indicates that the state does not collect data for the access measure type in question.

[1] The table excludes the 14 states that did not participate in the survey.

[2] These states provided varying levels of detail about other types of access measures they collected. Many indicated sources of data (e.g., member surveys, call centers) rather than types of measures. In some cases, the measure provided might fit within one of the categories specified in the survey, for example, measures of cultural competency could be considered a type of barrier to covered care. However, lacking information about how the measures were defined, we did not attempt to categorize them according to our standard survey categories, but rather entered them in the "other" category.

[3] State did not report collecting any of these types of measures.

Source: RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

TABLE 4A-3. Number of States Measuring Access to Care, by Category, for Specific FFS Medicaid Population, May 1, 2016

State (N = 37)[1]	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply
	Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services		
States collecting any measure of access in category	**26**	**20**	**19**	**29**	**21**
Non-disabled children	22	15	10	25	17
Non-disabled adults	19	14	10	23	18
Individuals age 65 and older	20	16	13	25	16
Children with physical disabilities	20	15	11	26	16
Adults with physical disabilities	21	16	13	25	17
Children with intellectual or developmental disabilities	21	17	13	25	16
Adults with intellectual or developmental disabilities	21	15	13	24	16
Children with severe emotional disturbance or substance use disorders	20	16	12	24	15
Adults with severe mental illness or substance use disorders	20	15	12	24	16
Pregnant women	21	14	11	23	17
Other populations[2]	7	4	4	4	4

Notes: FFS is fee for service.

[1] The table excludes the 14 states that did not participate in the survey.

[2] States reported collecting measures for the following other populations: all populations; all enrolled participants; populations that varied by the specific measure type; a random sample of beneficiaries enrolled in primary care case management; all Consumer Assessment of Healthcare Providers and Systems survey respondents; all populations eligible for integrated care management and patient centered medical homes; and pregnant women.

Source: RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

TABLE 4A-4. Number of States Measuring Access to Care under FFS Medicaid, by Category, for Specific Type of Service, May 1, 2016

Type of service (N = 37)[1]	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply[2]
	Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services		
States collecting any measure of access in category	**26**	**20**	**19**	**29**	**21**
Primary care	17	12	9	24	N/A
Specialty care	18	13	8	23	N/A
Child developmental screenings	12	6	2	15	N/A
Behavioral health, including mental health, and alcohol and other substance use disorder treatment services	16	10	7	22	N/A
Prenatal and postpartum care and services	12	7	5	16	N/A
Home health services	11	5	5	19	N/A
Long-term services and supports	13	5	6	16	N/A
Dental care and services	16	9	6	22	N/A
Emergency Department services	10	4	4	15	N/A
Pharmacy services	10	4	4	14	N/A
Any covered services (not specified)	6	3	4	10	N/A
Other covered services[3]	5	2	0	2	N/A

Notes: FFS is fee for service. N/A is not applicable.

[1] The table excludes the 14 states that did not participate in the survey.

[2] States were not asked what type of services for which they collected provider supply measures.

[3] States reported the following other service types: categories as reported in HEDIS; measures specific to a category of service or a provider type related to an access concern or compliant; and data on the utilization of inpatient hospitals and all services on an as-needed basis.

Source: RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

TABLE 4A-5. Number of States Measuring Access to Care under FFS Medicaid, by Category, for Specific Provider Type, May 1, 2016

Provider type (N = 37)[1]	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply
	Receipt of covered services[2]	Receipt of timely covered services	Specific barriers to covered services		
States collecting any measure of access in category	**26**	**20**	**19**	**29**	**21**
All provider types	N/A	12	12	19	8
Primary care providers	N/A	17	15	27	18
Specialty care providers	N/A	17	14	26	18
Behavioral health, including mental health and alcohol and other substance use treatment providers	N/A	16	14	26	16
OB/GYN providers	N/A	14	13	24	14
Home health providers	N/A	14	13	23	15
Dental care providers	N/A	16	13	26	16
Other provider types[3]	N/A	1	0	2	3

Notes: FFS is fee for service. N/A is not applicable.

[1] The table excludes the 14 states that did not participate in the survey.

[2] States were not asked what type of services for which they collected measures of receipt of covered services.

[3] States reported collecting measures on the following other provider types: pediatricians and maternity providers; all providers as needed; and information for health homes.

Source: RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

TABLE 4A-6. Number of States Using Specific Data Source to Collect Information about Access-to-Care Measures under FFS Medicaid, by Category, May 1, 2016

Data source (N = 37)[1]	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply
	Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services		
States collecting any measure of access in category	**26**	**20**	**19**	**29**	**21**
Claims and administrative data	25	15	7	28	N/A
Provider surveys[2]	7	4	4	6	7
Beneficiary surveys	17	14	10	7	N/A
Complaint hotline call logs	14	10	7	N/A	N/A
Stakeholder advisory meetings	17	12	8	N/A	N/A
LTSS ombudsman data	8	5	1	N/A	N/A
Other ombudsman data	5	4	1	N/A	N/A
Registries[3]	N/A	N/A	N/A	8	N/A
Provider enrollment data	N/A	N/A	N/A	N/A	20

Notes: FFS is fee for service. N/A is not applicable. LTSS is long-term services and supports.

[1] The table excludes the 14 states that did not participate in the survey.

[2] Provider surveys include state-conducted provider survey data.

[3] The registries category includes data from vaccination and cancer registries.

Source: RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

TABLE 4A-7. Number of States Measuring Access to Care under FFS Medicaid, by Category, for Specific Purpose, May 1, 2016

Purpose Total (N = 37)[1]	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply
	Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services		
States collecting any measure of access in category	**26**	**20**	**19**	**29**	**21**
To assess adequacy of access	19	16	15	23	15
To report information publicly	15	11	8	14	11
To provide feedback to providers	9	8	9	11	5
To make decisions about provider payment incentives	8	4	4	8	3
To guide corrective actions	11	7	7	11	9
Other uses	9	4	2	6	3

Notes: FFS is fee for service.

[1] The table excludes the 14 states that did not participate in the survey.

Source: RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

TABLE 4A-8. Number of States Reporting Measures Used to Assess Adequacy of Access to Care under FFS Medicaid, by Access-to-Care Measure Category, May 1, 2016

Purpose Total (N = 37)[1]	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply
	Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services		
States collecting any measure of access in category	**26**	**20**	**19**	**29**	**21**
Trends from previous year[2]	16	13	10	20	12
Regional comparisons[3]	7	8	4	11	6
Managed care comparisons[4]	7	5	2	8	1
National Medicaid averages[5]	12	10	6	11	1
Other states	6	4	4	4	2
Other comparisons[6]	1	0	1	1	0
No comparisons made	2	2	2	1	6

Notes: FFS is fee for service.

[1] The table excludes the 14 states that did not participate in the survey.

[2] Same state, same population, different years of data.

[3] Comparing regions within the state, such as urban vs. rural, or different zip codes.

[4] Comparing FFS populations with Medicaid managed care populations.

[5] Comparing data to national Medicaid averages.

[6] Types of comparisons reported included using Southeastern benchmarks as a comparison for assessment, data from Truven to determine comparison groups, and subpopulations as comparison groups.

Source: RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.