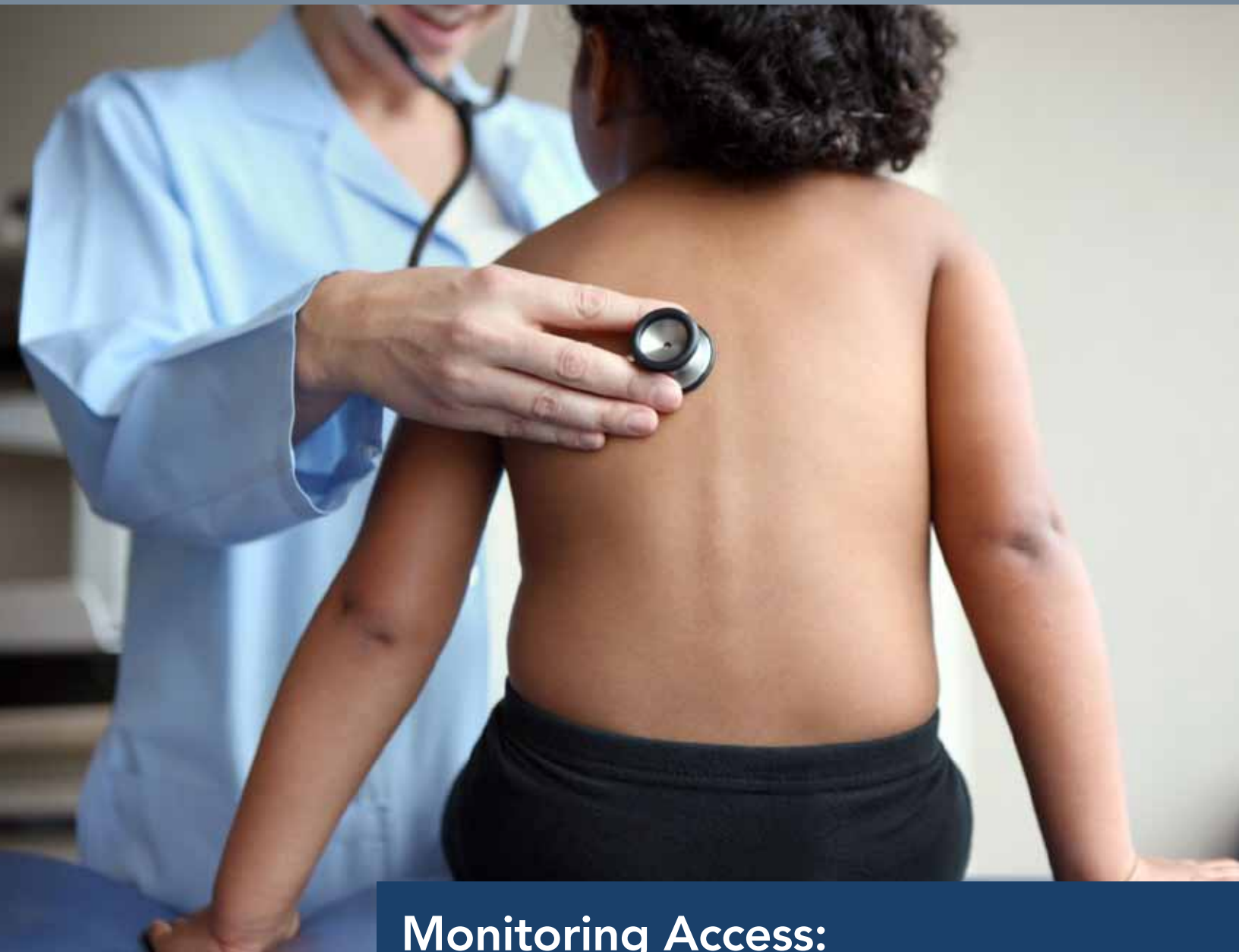




CALIFORNIA HEALTHCARE FOUNDATION



**Monitoring Access:**  
Measures to Ensure Medi-Cal  
Enrollees Get the Care They Need

MAY 2014

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## Introduction

This report offers a framework and a targeted set of measures for monitoring access to ambulatory care for individuals enrolled in the Medi-Cal program. It is intended as an actionable starting point for elected leaders, state and federal program officials, and other stakeholders, to help them monitor changes in access to care over time, to identify disparities in access to care across subgroups or geographic regions, and to compare access between Medi-Cal enrollees and other insured populations in California and nationally.

Such monitoring assumes that the state will employ a strong system of oversight and enforcement to assure that both federal and state access requirements are met. However, some stakeholders and others who have studied this issue have pointed out what they believe are areas of weakness, inconsistency, or lack of coordination in Medi-Cal's existing access monitoring, some of which the present framework is intended to address.

The conceptual core of this framework reflects established concepts of access that have long guided policymakers and is sensitive to the unique characteristics and needs of Medi-Cal beneficiaries. As discussed fully below, the framework focuses on providing metrics that can be used to determine the extent to which Medi-Cal provides beneficiaries with appropriate access to health services. The metrics provide a way to assess:

- ▶ Availability of services (potential access to care that connects individuals to the health care system, and participation by a sufficient number of appropriately located providers to meet their needs)
- ▶ Use and receipt of appropriate care (realized access, as reflected in beneficiaries receiving services and appropriate care in a timely, affordable, and culturally appropriate manner)
- ▶ Health outcomes, including health status, limitations, and health behaviors

The framework suggests that outcomes be assessed program-wide, by beneficiary subgroup, and by locale, to support benchmarking both internal to the program and to other populations and state programs.

Most of the proposed measures applied in the framework's analysis are widely used in California and elsewhere

and require data that already exist in California or are likely to be available soon. The framework would align its efforts to measure Medi-Cal access with federal initiatives and national standards while taking advantage of the rich data in California that many other states do not have available. This approach should also limit the costs of implementing the framework.

### Why Monitoring Medi-Cal Access Is Important

With the enactment of the Patient Protection and Affordable Care Act of 2010 (ACA), the nation has taken a major step to address coverage gaps and other financial barriers that may limit access to health care. Millions of low- to moderate-income individuals will have improved access to health coverage as Medicaid expands and new health insurance marketplaces are implemented.

Yet, while the lack of health insurance is a major barrier to health care access, it is well established that access can also be a problem even for those who have coverage.<sup>1</sup> Barriers to access are particularly likely to be encountered by those who are most vulnerable, because of low income, race or ethnicity, language, geography, or disabilities or chronic conditions that generate high and often special needs for care. Among insured populations, those on Medicaid and similar public insurance programs for low-income populations are particularly vulnerable. In part because of such vulnerability, monitoring access to health care among those covered by public insurance is a long-standing concern nationally and an important reason why Congress created the Medicaid and CHIP Payment and Access Commission (MACPAC).<sup>2</sup>

Monitoring access to care is particularly important when coverage rules change and health systems evolve, as is now occurring with coverage expansions under the ACA, and as public and private sector payers alter the way health care is organized and paid for, such as through the spread of capitated managed care and the creation of accountable care organizations. When systems change, there are increased risks that some people will fall through the cracks.<sup>3</sup> Monitoring performance as systems change generates feedback on the results of change so that stakeholders can take steps to maximize the yield and value of change, including access to care.

Although designed for use in California, this framework and set of measures can be adapted for use in other states. In many cases, the same or similar measures could be constructed there. The largest gap would likely be for the access measures that reflect the beneficiary perspective, particularly for smaller states that lack large sample sizes in national surveys.

## Current Landscape of Monitoring Access

### California Efforts

California has a solid base of work upon which to build a Medi-Cal program-wide access monitoring effort. At the core are three distinct activities led by the Department of Health Care Services (DHCS):

- ▶ In response to Assembly Bill 97 (2011), which included a 10% payment reduction to many types of Medi-Cal fee-for-service (FFS) providers, the state developed a set of 23 metrics to monitor access to care for FFS Medi-Cal enrollees (see Appendix A). The importance of this initiative has somewhat diminished, however, as the population of Medi-Cal enrollees who get their care predominantly through an FFS arrangement has declined following the recently completed statewide expansion of Medi-Cal managed care.
- ▶ For Medi-Cal managed care enrollees, DHCS regularly reports results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Healthcare Effectiveness Data and Information Set (HEDIS).<sup>4</sup> CAHPS includes several measures of access to care but is currently conducted only every three years. Conducting CAHPS annually would improve its usefulness for monitoring access to care. HEDIS measures are reported annually, but they are generally more relevant to in-depth quality monitoring than to a broad-based assessment of access.
- ▶ As part of California's Bridge to Reform federal Medicaid waiver, the state was required to develop an overall monitoring strategy for measuring access to Medi-Cal services.<sup>5</sup> It relied primarily on public data that are reported for each of the major program segments: FFS, managed care, and the low-income health program. Unfortunately, the information and measures available from each program is limited and

is inconsistent across segments. So, from a population or programmatic point of view, the plan does not provide an aggregate profile of performance across beneficiaries cared for in diverse parts of the program. Nevertheless, the access monitoring that has been published by DHCS provides a valuable starting point for understanding current data challenges and identifying additional work that would be required to monitor performance of the Medi-Cal program overall.<sup>6</sup>

Other support for access monitoring in California includes:

- ▶ **Robust population and health care data.** Public funds have long supported the collection of critical data that are invaluable in monitoring access. These include a well-established California Health Interview Survey (CHIS), an all-payer database of hospital discharges and emergency room data managed by the Office of Statewide Health Planning and Development (OSHPD), a well-developed vital statistics system, and extensive Medi-Cal administrative data.
- ▶ **Performance standards.** California has enacted the nation's first specific, enforceable standards that set benchmarks that can be used for monitoring access to care.<sup>7</sup> The standards apply to products overseen by the Department of Managed Health Care (DMHC). For example, they include being seen by a primary care physician for a routine visit within 10 business days of a request (within 48 hours for an urgent visit) and being referred to a specialist for a routine service within 10 business days (within 96 hours for an urgent visit). Telephone triage and screening services also must be available 24/7 from a health professional. DMHC (which shares jurisdiction with DHCS for oversight of managed care plans that contract with Medi-Cal) is responsible for enforcing these standards. Unfortunately, data upon which to assess compliance are still limited. Further, DMHC so far has examined compliance only for products overall (such as health maintenance organizations), not for specific populations (e.g., Medi-Cal, commercial, Medicare contracted enrollees).<sup>8</sup> However, should these limitations be addressed, the standards could provide important benchmarks for future efforts to monitor access in Medi-Cal.

► **Private support.** Private foundations, purchasers, and other organizations have contributed to the goal of access monitoring and provided resources to enhance this effort. For example, several California foundations help fund CHIS, and the California HealthCare Foundation has supported a long history of work to conceptualize and measure access in California’s Medi-Cal program.<sup>9</sup> California also is well served by a variety of other external funders that complement state investments in monitoring access and also serve a valuable convening function across public and private interests.

## Emerging Federal Initiatives

Federal data collections have long been an important source of information for states and localities seeking to monitor health care, and federal investment supports metrics and national data with which to set benchmarks for state performance. Large states like California also benefit from federal data collection efforts that can produce reliable state-level estimates. Certain federal sources are even designed to provide state or local estimates. Some of the emerging federal initiatives that may benefit California, either on their own or as a complement to California data, include both broad national monitoring efforts and those focused specifically on Medicaid. Since there is much work underway, this section focuses on those initiatives which are in more advanced stages and are directly relevant to California. (Appendix B provides additional information about these and other selected federal initiatives.)

**Department of Health and Human Services (HHS).** To better position itself to monitor the ACA nationwide, the federal government has expanded the access-related content on its National Health Interview Survey (NHIS) to capture effects of the ACA on access to health care services for adults and children.<sup>10</sup> Such data, together with information from CHIS, provide a rich source of information on patient-reported metrics regarding access. Also, the National Ambulatory Medical Care Survey (NAMCS) has been expanded, at least temporarily, to provide state-specific estimates of payer mix for individual physicians, a valuable adjunct for monitoring Medi-Cal participation statewide that will help put in context California’s licensure survey results on participation. In addition, to support its overall health system tracking, the Assistant Secretary for Planning and Evaluation of HHS has identified and posted five core access measures

with estimates for various subgroups. While these are not available on a payer-specific basis by state, they provide valuable benchmarks for monitoring state data, including information on hospitalization for conditions where hospitalization might be avoided if appropriate ambulatory care is received (“ambulatory care sensitive conditions”).

**Centers for Medicare & Medicaid Services (CMS).** In its most direct effort to expand data for monitoring Medicaid access nationwide, CMS is contracting for a Medicaid Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey (version 5.0).<sup>11</sup> While CAHPS surveys are common, this one will be unique in its design to generate population-based CAHPS measures by

### CAHPS as a Tool for Monitoring Work for the Disabled

Under grants from the National Institute for Disability and Rehabilitation Research, the Center for Health Care Strategies, and the California HealthCare Foundation, Susan Palsbo adapted the CAHPS instrument to capture “Assessment of Health Plans and Providers by People with Activity Limitations.” English and Spanish versions are provided, along with a dashboard with a case mix adjustment that was developed in conjunction with stakeholders.<sup>12</sup>

The two-page AHPPAL Dashboard is designed for comparisons of plans and providers on six sets of metrics: (1) overall ratings (personal physician, specialists, case manager, counselors); (2) talking to personal doctor (“enough time, respected what I said, shared decisionmaking, gave advice on healthy living”); (3) ease of getting care (routine appointment, specialty appointment, urgent appointment, mental health counseling, physical or occupational therapy), prescription medications, and medical supplies (e.g., mobility or breathing equipment); (4) health information from any doctor or nurse (e.g., how to manage disabling pain or fatigue, family planning, preventing SID); (5) access to care by people who have trouble walking (how often waited, able to get exam table, vehicle arranged by health plan on time; ability to get into the vehicle that arrives); and (6) communication when people have trouble seeing, reading, hearing, or speaking (“received non-printed formats when I needed it that way, easy to speak with doctor when I use sign language, easy to talk to doctor even if I have trouble speaking because of a Medi-Cal condition”).

subgroup for the nation and for individual states. From the sample it will be possible to generate state-specific estimates for four subgroups of the Medicaid population: dual eligibles (Medicare and Medicaid), disabled adults who are not dual eligibles, adults in managed care who are not disabled or dually eligible, and adults in an FFS setting who are not disabled or dually eligible. While some details remain to be clarified, CMS's goal is to field the survey in 2014 and 2016. These data will provide valuable access estimates for subgroups of California's Medi-Cal population that may be underrepresented in plan-level and population surveys. There also has been some innovative work using CAHPS to monitor certain population subgroups, such as the disabled (see sidebar on page 6). Other initiatives to monitor access have also been explored.<sup>13</sup>

## Conceptual Core of the Framework

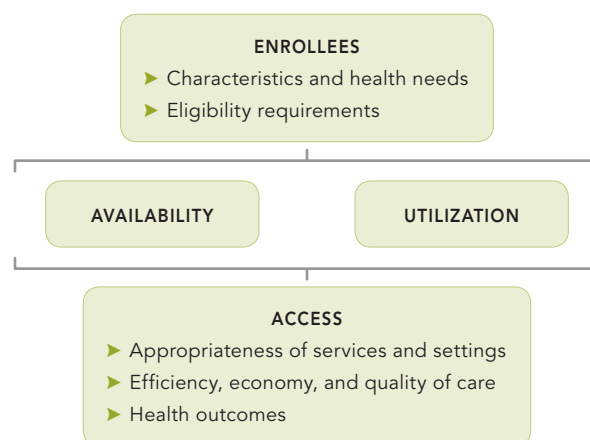
The conceptual core of the framework offered in this report is the framework for monitoring access nationally, established by the Medicaid and CHIP Payment and Access Commission (MACPAC) in its first Annual Report to Congress in March 2011 (see Figure 1).<sup>14</sup> MACPAC's framework reflects established concepts of access that have long guided policymaker activity (see Appendix C) in ways sensitive to the unique characteristics and needs of Medicaid beneficiaries.<sup>15</sup>

Key dimensions of this framework are aligned to long-standing concepts of access, as discussed below.

### Enrollees

This element of the framework reinforces the importance of using metrics that reflect the target population and the diversity of its needs. From the point of view of access monitoring, it is important to identify whether people can get access to the program itself (a separate matter from access to care within the program), which means tracking changes in enrollment among the target population, controlled for underlying eligibility changes. In terms of population characteristics, it is crucial that access measures be developed in ways that reflect a good understanding of the people served by the program and the particular needs of diverse subpopulations. The metrics also should support comparisons across

Figure 1. MACPAC's Access Framework



Source: Medicaid and CHIP Payment and Access Commission (2011).

subgroups, so that disparities in access can be identified and addressed. The proposed framework incorporates the development of distinct metrics for specific subgroups within the Medicaid population, such as children and adults in Medi-Cal, as well as for those located in different areas within the state. It also uses available data, to the extent feasible, to incorporate metrics relevant to the range of conditions and needs brought by all those who are eligible for Medi-Cal services.

### Availability

Availability metrics include indicators that reflect what traditionally has been referred to as "potential access" — that is, whether resources exist and are available to Medi-Cal enrollees (whether or not they are used) to meet their needs. An important element is provider adequacy — whether a sufficient number of the right types of providers are available for Medicaid beneficiaries. Key variables that influence availability include: (1) the overall supply and distribution of providers of diverse types by specialty/type and geography; (2) the extent to which these providers participate in FFS Medicaid or in available health plans such as Medicaid managed care; (3) whether the providers are taking new patients (especially for primary care) or appointments (specialists); and (4) travel time and convenience, which must take into account accessibility of public transportation, an issue of particular import for low-income Medicaid enrollees.

Beyond provider availability, potential access also depends on other features of available providers, such as medical practices' capabilities in terms of language and interpretive services. Patients also are more likely to contact providers with whom they have some ongoing relationship. Therefore, having a "usual source of care" acceptable to the patient is an intermediate variable that is likely to help convert potential access to actual use. While there are challenges in developing consistent and meaningful metrics that apply both to traditional FFS Medicaid and to Medicaid managed care, the aim of the framework is to allow Medi-Cal performance to be analyzed across all program sectors.

## Use and Access

Historically, access has been regarded as "realized" when enrollees used care, regardless of the need for care or the quality of the care interaction. However, with a growing emphasis on evidence-based care, there is a concern that access measures become more sophisticated to reflect whether the care being received is appropriate and timely. In this regard, MACPAC emphasized that access means the obtaining of needed care in a timely manner and that the care reflects appropriate use of health care services.

Some measures of this more nuanced notion of access can be developed from transaction data on use of services, but such data must also reflect measures that take into account what care is deemed appropriate and benchmarks by which to assess whether it is received. Clinical standards can provide some of these benchmarks (e.g., making at least one visit over some appropriate time frame, receiving preventive services called for in guidelines). Another source of benchmarks can be provided by research identifying use patterns that are harmful or unnecessarily costly and that could have been avoided with appropriate access to earlier services (e.g., avoidable/preventable emergency department visits, ambulatory care sensitive hospitalizations, avoidable hospital readmissions). A third set of benchmarks reflects the extent to which the care received matches well-accepted standards for appropriate access, such as timeliness, continuity of care, and met versus unmet needs. For a Medicaid population, cultural appropriateness, patient-provider communication, provider knowledge about the patient's condition, and beneficiary experience regarding the physical accessibility of services within facilities are important additional measures of realized access.

## Health Outcomes

A fundamental goal of health care is that people's health improves, or where that is not feasible, that health is maintained, with as high a quality of life and functional status as possible. Clinical outcomes for some subgroups can be measured with a certain degree of precision (such as pregnancy outcomes, glucose control for diabetics), but for most subgroups, outcomes are more difficult to ascertain and categorize. Many factors, beyond the receipt of care itself, affect health outcomes. So, in monitoring outcomes, it is particularly important to focus on outcome measures that are designed to be sensitive to differential access to care. It also is important to risk-adjust comparisons to the extent possible. Doing so may help avoid unintentionally discouraging providers from caring for patients with more challenging needs, and may also permit more meaningful comparisons.

## Proposed Access Framework

### Principles for Choosing Access Measures

While scores of access measures have been developed over the years, this framework focuses on a subset of key metrics and data sources for monitoring access to ambulatory care under the Medi-Cal program.<sup>16</sup> A principal objective is to make it relatively easy and low-cost to report results on a regular basis, but several other factors were also considered when selecting measures. The array of measures should:

- ▶ **Address each of the framework's three key dimensions: potential access, realized access, and health outcomes.** The potential access measures, which reflect provider willingness to serve Medicaid beneficiaries and the extent to which care will be available when needed, are designed to indicate the ease with which beneficiaries can get the care they need. Realized access measures reflect the extent to which beneficiaries are receiving timely, appropriate health care — whether they are receiving recommended screenings and preventive care, whether the care they receive is consistent with the prevailing standard of care, how beneficiaries perceive the care they are receiving, etc. The third dimension — health outcomes — includes measures such as self-reported



health status and health behaviors which, it is hoped, are improved as a consequence of the greater access to health care that results from enrollment in Medi-Cal (as compared with having no coverage). Regarding these two latter categories, the framework proposes some measures that reflect beneficiaries' perspectives on their access to care.

- ▶ **Reflect the range of population subgroups and services covered by Medi-Cal.** It is important to include not only general-purpose measures that apply to the overall child and adult populations covered by Medi-Cal but also to designate measures appropriate for subgroups with high or unique needs, and for services where historically there has been evidence of unmet needs. For example, given the large number of pregnancies covered by Medi-Cal, measures unique to that group are included. Likewise, given the disproportionate costs and unique service needs of the disabled population, particularly those with behavioral health problems, it will be important to report measures for that population and to incorporate evolving measures that reflect how their health care needs are being met.<sup>17</sup>
- ▶ **Reveal variation in access across subgroups and geographies.** Where possible, access should be monitored for subgroups with particular needs and access concerns (e.g., those in deep poverty and individuals whose primary language is not English). Likewise, given the variation in the service delivery systems within the state, it will also be important to assess the extent to which access to care in Medi-Cal varies across regions and local communities.
- ▶ **Widely accepted and used.** Designating widely accepted measures means they can be benchmarked against national and state sources so that the Medi-Cal experience can be compared to other programs and population groups.
- ▶ **Built on measures historically used to monitor access in Medi-Cal.** As discussed earlier in this report, California has a long history of access monitoring, including three current initiatives. While there is considerable overlap between the measures Medi-Cal currently reports and the recommended measures in this proposed framework, the proposed measures seek to better align with the selection criteria outlined here. Of particular note, no measures are proposed that provide information solely on the FFS

Medi-Cal population, since that population is steadily shrinking.<sup>18</sup>

- ▶ **Constructed from existing data sources but revised as new data sources become available.** The proposed framework draws on existing data from both California-specific sources, including CHIS, the California Physician Licensure Survey, and OSHPD, and national sources, such as NHIS and NAMCS. Potentially important new data sources and measures expected to become available in the coming years include the new Medicaid Adult CAHPS survey that the federal government is slated to field in 2014 and 2016 and the core quality measures that have been proposed for adults and children on Medicaid (see Appendix B). Medi-Cal administrative data currently do not permit population-based estimates that combine the experience of beneficiaries in FFS and capitated managed care. The measures for the entire Medi-Cal population that are most likely to be feasible to report in the near-term from Medi-Cal data sources are those from the initial proposed core list of health care quality measures for children and adults, of which Medi-Cal is reportedly developing a subset.<sup>19</sup> These core measures have the virtue of offering estimates from other states as a point of comparison to Medi-Cal. Currently, CAHPS and HEDIS measures periodically report for the entire population of managed care enrollees in California. Once the expansion of Medi-Cal managed care is complete, only a small fraction of Medi-Cal enrollees who receive a comprehensive set of benefits will be enrolled in FFS, which will make CAHPS and HEDIS measures more representative of the program as a whole.
- ▶ **Provide timely information so that the findings can better feed into policy choices and lead to corrective actions.** Most of the proposed measures will provide information that reflects a relatively current picture of experience under Medi-Cal. However, some measures are proposed because they address access issues for a key population subgroup covered by Medicaid (e.g., those relating to pregnancy and birth outcomes) despite the most recent data available being several years old. Likewise, included is a subset of CAHPS and HEDIS measures that were collected for the Medi-Cal population in prior years, despite uncertainty whether those same estimates will be available on a timely basis in future years.

To maximize the utility of the framework, it will be important to explore ways to speed up the timeliness of the data that are used to support the measures.

- **Updated annually and complemented with real-time reporting on access through other mechanisms.** Annual reporting seems to strike an appropriate balance between the need for timely information and the burden associated with constructing and interpreting the measures. To complement annual reporting, it is important to build in some more rapid-turnaround information on a smaller number of key metrics for Medi-Cal through the use of ongoing data collection efforts like OSHPD's. For example, such sources could be used to produce select statistics on emergency department use and hospital admissions on a much more timely basis, or new data collection efforts could produce real-time results (such as Internet surveys) reporting on access by sentinel providers as part of

some sort of systematic early warning system. This type of information could put Medi-Cal in a position to identify and address emerging access issues in something close to real time.

## Recommended Data Sources and Measures

Table 1 presents this framework's proposed metrics and data sources for measuring and monitoring access to care in Medi-Cal. The table groups the measures into three components of the access framework — potential access, realized access, and health outcomes. Within these three components, each proposed metric is described in conceptual terms in the first column and the associated empirical representation and data source is listed in the second column. The potential Medi-Cal universes (e.g., children, pregnant women, nonelderly adults) and comparison groups available for each metric and data source are provided in the last two columns, respectively.

**Table 1. Proposed Metrics and Data Sources, by Population Group and Available Comparison Group, for Annual Monitoring of Access to Ambulatory Medi-Cal Services**

CONCEPTUAL MEASURE	EMPIRICAL MEASURE (data source)	POTENTIAL MEDI-CAL UNIVERSES (data source)	POTENTIAL COMPARISON GROUPS (data source)
<b>Potential Access</b>			
Connection to the health care system	<ul style="list-style-type: none"> <li>► Beneficiaries reporting a usual source of care (other than the emergency department) (CHIS, NHIS)*</li> </ul>	<ul style="list-style-type: none"> <li>► Children</li> <li>► Nonelderly adults</li> <li>► Sub-state geographies (CHIS)</li> </ul>	<ul style="list-style-type: none"> <li>► Private/ESI and uninsured in CA (CHIS, NHIS)</li> <li>► Medicaid population outside of CA (NHIS)</li> </ul>
Provider availability for Medi-Cal beneficiaries <sup>†</sup>	<ul style="list-style-type: none"> <li>► Primary care physicians (excluding pediatricians) accepting any/new patients (CA licensure survey)<sup>‡</sup></li> <li>► Primary care pediatricians accepting any/new patients (CA licensure survey)<sup>‡</sup></li> <li>► Specialists accepting any/new patients (CA licensure survey)<sup>‡</sup></li> <li>► Physicians accepting any/new patients (NAMCS)<sup>‡</sup></li> <li>► Physicians experiencing difficulties referring patients for specialty care (NAMCS)<sup>§</sup></li> <li>► Dentists accepting any/new patients<sup>#</sup></li> <li>► Mid-levels accepting any/new patients<sup>#</sup></li> <li>► Beneficiaries reporting difficulty finding a specialist (CHIS) / general doctor, not taking new patients / your insurance (CHIS, NHIS)</li> </ul>	<ul style="list-style-type: none"> <li>► Physicians, overall and by specialty (NAMCS, CA licensure survey)</li> <li>► Children and nonelderly adults (CHIS, NHIS)</li> <li>► Sub-state geographies (CHIS)</li> </ul>	<ul style="list-style-type: none"> <li>► Private/ESI in CA (CHIS, NHIS, CA licensure survey)</li> <li>► Medicaid population outside of CA (NHIS, NAMCS)</li> </ul>

\*Also proposed by Medi-Cal in its September 2011 report, as discussed in Appendix A.

<sup>†</sup>It may be important to also track capacity specifically at FQHCs.

<sup>‡</sup>Similar in concept but draw on different data sources for the measure.

<sup>§</sup>It will be necessary to assess whether the NAMCS data available for California can support this measure.

<sup>#</sup>It is not clear that data are available for California to support this measure at this time.

Note: Where possible, metrics would be computed annually, and release schedules for data sources would support "current" estimates with minimal lags.

**Table 1. Proposed Metrics and Data Sources, by Population Group and Available Comparison Group, for Annual Monitoring of Access to Ambulatory Medi-Cal Services, *continued***

CONCEPTUAL MEASURE	EMPIRICAL MEASURE (data source)	POTENTIAL MEDI-CAL UNIVERSES (data source)	POTENTIAL COMPARISON GROUPS (data source)
<b>Realized Access</b>			
Beneficiary receipt of services	<ul style="list-style-type: none"> <li>▶ At least one physician visit in prior year (CHIS, NHIS, Medi-Cal claims and encounter data)*</li> <li>▶ Primary care visit in prior year, including care from mid-levels (NHIS, HEDIS, Medi-Cal claims and encounter data)</li> <li>▶ Preventive child/adult checkup in the prior year (NHIS, BRFSS, HEDIS, Medi-Cal claims and encounter data)</li> <li>▶ Dental visit in the prior year (CHIS, NHIS, Medi-Cal claims and encounter data)*</li> <li>▶ Specialty visit in the prior year (CHIS, NHIS, Medi-Cal claims and encounter data)</li> <li>▶ Mental health visit in the prior year (CHIS, NHIS, Medi-Cal claims and encounter data)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Children (CHIS, NHIS, HEDIS)</li> <li>▶ Nonelderly adults (BRFSS, CHIS, NHIS, HEDIS)</li> <li>▶ Sub-state geographies (CHIS)</li> <li>▶ Medi-Cal enrollee subgroups (Medi-Cal encounter and claims data)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Private/ESI and uninsured in CA (CHIS, NHIS, BRFSS)</li> <li>▶ Medicaid population outside of CA (NHIS, HEDIS)</li> </ul>
Receipt of appropriate care**	<ul style="list-style-type: none"> <li>▶ Beneficiaries with chronic conditions (asthma, diabetes, heart disease, mental health issues, etc.) with visit to specialist or mental health provider (NHIS and CHIS [sample permitting, which is more likely as Medicaid enrollment grows], Medi-Cal claims and encounter data)</li> <li>▶ Women receiving a pap smear (NHIS)</li> <li>▶ Women receiving a mammogram (NHIS)</li> <li>▶ Beneficiaries receiving a flu shot (NHIS)</li> <li>▶ Children/adolescents receiving appropriate immunizations (HEDIS)</li> <li>▶ Hospital discharges with a readmission within 30, 60 days (OSHPD data merged with Medi-Cal administrative files)</li> <li>▶ Hospital admissions for ambulatory care sensitive conditions (OSHPD data merged with Medi-Cal administrative files)*</li> <li>▶ Emergency visits that were potentially preventable/avoidable or that could have been treated in a primary care setting (OSHPD data merged with Medi-Cal administrative files)</li> <li>▶ One/multiple emergency department visits (CHIS, NHIS, Medi-Cal claims and encounter data)</li> <li>▶ Women receiving adequate prenatal care (birth records merged with Medi-Cal)††</li> </ul>	<ul style="list-style-type: none"> <li>▶ Children and nonelderly adults (CHIS, NHIS)</li> <li>▶ Sub-state geographies (CHIS)</li> <li>▶ Children and nonelderly adults (OSHPD)</li> <li>▶ Children/adolescents (HEDIS)</li> <li>▶ Pregnant women (birth/Medi-Cal records)††</li> </ul>	<ul style="list-style-type: none"> <li>▶ Private/ESI and uninsured in CA (CHIS, NHIS)</li> <li>▶ Medicaid population outside of CA (NHIS)</li> <li>▶ Private/ESI and uninsured population in CA (OSHPD)</li> <li>▶ Non-Medicaid in CA (CHIS, NHIS)</li> <li>▶ Medicaid population outside of CA (CAHPS, HEDIS)</li> <li>▶ Private/ESI and uninsured in California (birth/Medi-Cal records)††</li> </ul>

\*Also proposed by Medi-Cal in its September 2011 report, as discussed in Appendix A.

\*\*This component should be updated to incorporate measures from the Initial Core set of Health Care Quality Measures for Medicaid-Eligible Adults and Children as they become available for California and to include any additional specialty access measures that are developed.

††It will be important for access monitoring in Medi-Cal on prenatal care and birth outcomes to account for Medi-Cal enrollment timing and to define appropriate comparison populations.

Note: Where possible, metrics would be computed annually, and release schedules for data sources would support “current” estimates with minimal lags.

**Table 1. Proposed Metrics and Data Sources, by Population Group and Available Comparison Group, for Annual Monitoring of Access to Ambulatory Medi-Cal Services, continued**

CONCEPTUAL MEASURE	EMPIRICAL MEASURE (data source)	POTENTIAL MEDI-CAL UNIVERSES (data source)	POTENTIAL COMPARISON GROUPS (data source)
Receipt of timely, affordable, and culturally appropriate care <sup>††</sup>	<ul style="list-style-type: none"> <li>▶ Beneficiaries reporting delayed care and reason for delay (CHIS and NHIS)*</li> <li>▶ Unmet need for specialty care, primary care, follow-up care, dental care, prescription drugs, therapies, mental health counseling, eyeglasses due to cost concerns (NHIS, CHIS<sup>††§§</sup>)</li> <li>▶ Beneficiaries getting needed care (CAHPS)</li> <li>▶ Beneficiaries getting care quickly (CAHPS)</li> <li>▶ If you get sick or have an accident, how worried are you that you will be able to pay your medical bills? Are you very worried, somewhat worried, or not at all worried? (NHIS)</li> <li>▶ Women receiving timely prenatal care (birth records merged with Medi-Cal administrative files)<sup>*††</sup></li> <li>▶ How often does your doctor or Medi-Cal provider listen carefully to you? (CHIS)</li> <li>▶ How often does your doctor or Medi-Cal provider explain clearly what you need to do to take care of your health? (CHIS)</li> <li>▶ Beneficiaries having a hard time understanding the doctor? (CHIS)</li> <li>▶ How well do doctors communicate? (CAHPS)</li> <li>▶ Did you need assistance with understanding your doctor due to a language barrier? (CHIS)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Children and nonelderly adults (CHIS, NHIS, CAHPS)</li> <li>▶ Sub-state geographies (CHIS)</li> <li>▶ Pregnant women (birth/Medi-Cal records)<sup>††</sup></li> <li>▶ Overall and by racial/ethnic/language groups and education level (CHIS, NHIS)</li> <li>▶ Sub-state geographies (CHIS)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Private/ESI and uninsured in CA (CHIS, NHIS)</li> <li>▶ Medicaid population outside of CA (NHIS, CAHPS)</li> <li>▶ Non-Medicaid pregnant women in California (birth/Medi-Cal records)<sup>††</sup></li> </ul>
<b>Health Outcomes</b>			
Health status	<ul style="list-style-type: none"> <li>▶ Preterm births, low and very low birth weight births, neonatal mortality (natality and mortality files merged with Medi-Cal administrative files)*</li> <li>▶ Beneficiaries in very good or excellent health (CHIS, NHIS)</li> <li>▶ For individuals with specific chronic conditions, control of blood pressure, blood sugar, cholesterol, etc. (Medi-Cal claims and encounter data)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Newborns/infants</li> <li>▶ Children and nonelderly adults (CHIS, NHIS)</li> <li>▶ Subgroups in Medi-Cal (claims and encounter data)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Non-Medicaid in CA (natality/mortality/Medi-Cal)</li> <li>▶ Private/ESI and uninsured in CA (CHIS, NHIS)</li> <li>▶ Medicaid population outside of CA (NHIS)</li> </ul>
Health limitations	<ul style="list-style-type: none"> <li>▶ Beneficiaries with one/multiple poor mental health days in the past month (NHIS, CHIS, BRFSS)</li> <li>▶ Beneficiaries with one/multiple poor physical health days in the past month (BRFSS)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Children (CHIS, NHIS)</li> <li>▶ Nonelderly adults (CHIS, NHIS, BRFSS)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Private/ESI and uninsured in CA (CHIS, NHIS)</li> <li>▶ Medicaid population outside of CA (NHIS)</li> </ul>
Health behaviors	<ul style="list-style-type: none"> <li>▶ Beneficiaries that are current smokers (NHIS, CHIS)</li> <li>▶ Beneficiaries that are obese/overweight (NHIS, CHIS)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Nonelderly adults</li> </ul>	<ul style="list-style-type: none"> <li>▶ Private/ESI and uninsured in CA (CHIS, NHIS)</li> <li>▶ Medicaid population outside of CA (NHIS)</li> </ul>

\*Also proposed by Medi-Cal in its September 2011 report, as discussed in Appendix A.

<sup>††</sup>It will be important for access monitoring in Medi-Cal on prenatal care and birth outcomes to account for Medicaid enrollment timing and to define appropriate comparison populations.

<sup>†††</sup>This measure should be updated when content for the new federal Medicaid CAHPS survey is established.

<sup>§§</sup>Additional analysis is needed to home in on the key access measures for the Medi-Cal population that are available from CHIS.

Note: Where possible, metrics would be computed annually, and release schedules for data sources would support “current” estimates with minimal lags.

## Application of the Proposed Measures

This framework's proposed metrics reflect key dimensions of access, including multiple measures in each of the three domains — potential access, realized access, and health outcomes.<sup>20</sup> Most of the measures that capture beneficiary perceptions about their access to care can be computed only for the Medi-Cal populations of children and nonelderly adults (due to sample size constraints in existing data sources). However, other measures based on provider databases, such as OSHPD, when combined with Medi-Cal enrollment data or measures that draw on Medi-Cal claims and encounter data, can support meaningful estimates for particular subgroups (such as the disabled). In addition, in-depth analyses on particular subgroups, where needed, could be done by combining multiple years of data.

Most of the metrics can be derived from a limited number of existing data sources and measures:<sup>21</sup>

- ▶ **Household surveys.** NHIS, CHIS, and possibly the Behavioral Risk Factors Surveillance System (BRFSS), provided that analytic work is conducted with that survey which demonstrates the validity of BRFSS estimates for California
- ▶ **Information on physicians.** The California licensure survey and possibly NAMCS, provided analytic work is conducted that demonstrates the accuracy of the NAMCS estimates for California, over time and across specialty
- ▶ **Appropriateness of care.** OSHPD and the natality files, which ideally would be merged with Medi-Cal administrative data, to support key measures on this dimension

As indicated above, since most Medi-Cal enrollees are being transitioned into managed care, the framework also proposes to tap existing CAHPS and HEDIS measures, and where possible, Medi-Cal claims and encounter data. However, it will be important to consider making the CAHPS and HEDIS measures more robust. CAHPS data, based on samples of Medicaid managed care enrollees in a particular plan, typically come from surveys whose sample structure was not developed with the aim of supporting measures of performance across all plans. CAHPS surveys also tend to be supported

by limited resources and so have very low response rates. HEDIS metrics are aggregate measures for plans; because payers do not have access to the individual patient data upon which they are based, and because these data themselves reflect a small sample, there are limits to the risk adjustments that can be derived from them. In addition, both these measures — because they were developed to assess plan, rather than program, performance — are based on individuals continually enrolled in the same plan. As a result, they provide limited insight into enrollees who may switch plans frequently or who fall in or out of eligibility.

Both state and national comparison groups are proposed as points of reference for Medi-Cal performance, each of which has advantages and disadvantages. As outlined in MACPAC's reports from March and June 2011, a key question is what standard should be used to judge performance under Medicaid. For the measures proposed in this framework, experience under Medi-Cal can be compared to that of other groups in California, in particular to the privately insured and those who are uninsured, and to the Medicaid population in other states. Also, changes in the Medi-Cal program over time can be tracked to detect significant improvements or declines in access.

When making such access comparisons, it will be important to take into account differences in underlying health care needs and other factors that can affect access to care. Medi-Cal, like other Medicaid programs around the country, disproportionately covers people who have higher than average health care needs. And for Medi-Cal enrollees living under or near the poverty line, where they live may affect the provider base available to serve them. Medicaid populations in other states may be more similar to the Medi-Cal population than to the privately insured population in California in terms of income and health care needs, but they may differ significantly on other dimensions (e.g., race and ethnicity, urbanicity) and face very different service delivery systems that shape their access experiences. In addition, the needs of the population served by Medi-Cal may change over time in ways that distort comparisons. Thus, when comparing access to care under Medi-Cal with that for other populations, it will be important to assess the role that differences in other attributes play in affecting observed differences in access to care. (See Considerations for Assessing Access in Medi-Cal on page 14.)

## Considerations for Assessing Access in Medi-Cal

One of the key considerations in assessing access to care in Medi-Cal and in Medicaid more generally is the standard of care to be used as the point of comparison. The “equal access provision” in the federal Medicaid statute requires that Medicaid enrollees have the same access to care as the general population. However, this provision does not indicate whether and how such comparisons should account for differences in underlying need for care, nor even describe how access is to be defined. Following the approach developed by the Institute of Medicine for assessing access across different groups, the framework presented here proposes using two sets of adjustment factors for making comparisons.<sup>22</sup>

Each set of adjustments is intended to capture particular types of characteristics. The first set, which is designed to make the population in the comparison group (whether non-Medi-Cal in California or a Medicaid population in another state) more comparable to the Medi-Cal population in terms of observed health needs, is made up of factors that should reasonably affect the need for health care, such as age, health status, and functional limitation. The second set of adjustments includes factors that should not directly affect individuals’ need for health care but that may affect access nonetheless, such as income, race/ethnicity, and household structure. The use of both sets of adjustments together is designed not only to reveal factors that might contribute to observed differences in access to care between Medi-Cal and other population groups but also to help identify subgroups that are systematically experiencing access problems.

It should be noted here that the proposed framework and its related metrics are not without limitations. In particular, measures based on household surveys depend on the completeness and accuracy of patient recollections as well as potential biases if interviewees feel some answers are more socially desirable than others, and that influences their response. Moreover, measures of unmet and delayed care as self-reported by beneficiaries in household surveys may not reflect the extent to which beneficiaries are going without or not receiving timely care as judged by clinicians or various clinical guidelines. On the other hand, administrative data on these issues

also are flawed because they lack critical clinical detail or may otherwise be incomplete, and often provide information only on those who seek care, rather than on the entire population in a program. Lastly, the health outcome measures, while critical, are influenced by many social, economic, and genetic factors that are not directly affected by the receipt of health care, and thus warrant cautious interpretation.

## Conclusion

The Medi-Cal program has recently undergone a series of major transformations, including shifts of populations from FFS into capitated managed care, the transfer of children from Healthy Families (California’s CHIP program) into Medi-Cal, and a major eligibility expansion under the ACA to include new groups of nondisabled adults. With such dramatic changes, this is a critical time to track the extent to which access to care among Medi-Cal enrollees is improving or deteriorating and to assess whether access issues are more pressing for some groups or in certain areas of the state. However, these changes will also make it difficult to assess access to care over time without a population-wide focus that supports subgroup comparisons and that takes into account changes in the case mix served by Medi-Cal.

During critical times of change in Medi-Cal, it will be important that other oversight mechanisms be implemented to track changes in access over time, especially for enrollee groups that have disproportionate numbers with complex physical and behavioral health issues, such as the disabled. Even during times of more stability in the program, changes in the underlying economy or in other factors outside of the direct control of the program could affect access to care and make it difficult to gauge the performance of the program. Therefore, to the extent possible, the measures computed at different times and for groups with different health care needs should take into account such other differences.<sup>23</sup>

The measures and accompanying data sources of the framework proposed here have been selected to provide actionable information that stakeholders can use on a timely basis to measure performance. As a consequence, the framework largely reflects data sources and metrics currently available to support estimates on the Medi-Cal population. It will be important to reassess and update

the framework as new data sources become available. For example:

- ▶ As the CAHPS survey instrument, which the federal government is planning to field in 2014 and 2016, is finalized for the Medicaid population in all 50 states, consideration should be given to expanding the framework to incorporate high-priority measures for dual eligibles, disabled adults who are not dual eligibles, adults in managed care who are not disabled or dually eligible, and adults in an FFS setting who are not disabled or dually eligible.
- ▶ To the extent that the Medi-Cal program develops the analytic capacity to support estimates for the entire population it serves (i.e., both FFS and managed care enrollees) based on its claims and encounter data, consideration should be given to expanding the framework to incorporate additional measures that make use of that information.
- ▶ The framework should also be revisited if and when California establishes consistent and reliable mechanisms for measuring timely access to care across managed care plans, particularly if results can be stratified by source of coverage (e.g., private, Medi-Cal, Medicare).
- ▶ In addition, it will be important to consider more intensive monitoring efforts for particular subgroups or service areas, such as the disabled or individuals with behavioral health problems, where there is heightened concern about the adequacy of access to care.

Finally, the measures used to monitor access to care should evolve to reflect changes in health care delivery. As more health care organizations adopt and embrace the concept of team-based care, access metrics should reflect care provided by nurses and by other clinical and nonclinical staff. Similarly, many health care organizations are leveraging technology to expand access beyond in-person visits, such as through telemedicine, phone or email consultations, patient self-care, and remote monitoring. Access metrics that reflect only in-person visits with a physician may be misleading or, worse, may discourage the type of cost-effective innovations that are needed to make significant gains in access to care.

## Appendix A. Medi-Cal Fee-for-Service Access Measures

The following are the Medi-Cal FFS indicators presented by DHCS in its Plan for Monitoring Access to Medi-Cal Covered Health Care Service.<sup>24</sup> The information in parentheses following each indicator is the source from which the data, reported quarterly, are drawn. An <sup>X</sup> following an entry indicates that the measure was not included among the set proposed in the framework presented in this paper. An <sup>NA</sup> following an entry indicates that the proposed measure is outside of this acute care framework's scope.

### Beneficiary Measures

Percentage Change in Medi-Cal Enrollment<sup>X</sup>  
(Monthly Medi-Cal Eligibility File [MMEF] administration data quarterly trends)

Percentage Change in Dental Enrollment<sup>X</sup>  
(MMEF administration data quarterly trends)

### Provider Availability

Primary Care Practitioner Supply Ratio  
(MMEF, Provider Master File [PMF] yearly versus the Health Resources and Services Administration [HRSA] statewide ratio)

Provider Participation Rate  
(Medi-Cal Provider Master File [PM], claims, quarterly trends)

Concentration of Medi-Cal Beneficiaries Among Providers  
(PM, claims, quarterly trends)

Dental Provider Ratios<sup>X</sup>  
(MMEF, PMF quarterly trends)

Pharmacy Participation Rates<sup>X</sup>  
(claims, licensure data, yearly trends)

Long Term Care (LTC) Provider Participation Rates<sup>NA</sup>  
(licensure, certification program data, yearly trends)

Ratio of Medi-Cal LTC Occupied Bed Days to Statewide LTC Occupied Bed Days<sup>NA</sup>  
(OSHDP, audit data yearly trends)

Medi-Cal LTC Bed Vacancy Rates<sup>NA</sup>  
(OSHDP, audit data yearly trends)

Medi-Cal Beneficiaries with a Usual Source of Care  
(CHIS biannual compared to CHIS, NHIS, Medical Expenditure Panel Survey [MEPS])

Medi-Cal Beneficiary with Provider Language Discordance  
(CHIS biannual compared to CHIS other insurance)

### Service Use and Outcomes

Percentage of Enrollees with at Least One Physician Visit During Past 12 Months  
(MMEF, claims yearly compared to CHIS, NHIS, MEPS)

Mean Number of Physician Visits During Past 12 Months<sup>X</sup>  
(MMEF, claims yearly compared to NHIS)

Percentage of Children with at Least One Dental Visit During Last 12 Months  
(MMEF, claims yearly compared to CHIS, NHIS, MEPS)

Service Rates per 1,000 Member Months  
(MMEF, claims quarterly trends)

Emergency Department Visits per 1,000 Member Months<sup>X</sup>  
(MMEF, claims yearly trends)

Medi-Cal Beneficiary Perceived Timely Access to Care  
(CHIS biannual versus CHIS with other insurance)

Timely Prenatal Care  
(claims, vital stats yearly versus trends, statewide rates)

Preventable/Avoidable Hospitalization Rates  
(claims, OSPHD yearly trends, statewide rates)

Rate of Low Birthweight to Full-Term Births  
(claims, vital stats yearly versus trends, statewide rates)

Percentage of Low Preterm Birth Rates  
(claims, vital stats yearly versus trends, statewide rates)

Help Line Calls Categorized by Reason for Call and Geographic Location<sup>X</sup>  
(call center data, quarterly trends)



## Appendix B. Selected Federal Data Collection Initiatives

### National Ambulatory Medical Care Survey (NAMCS)

While NAMCS was originally developed to describe the content of office visits in ambulatory practices of different types, the induction form has also been used in recent years to provide national data on characteristics of physicians and their practices. The survey also asks about the share of revenue from various payers, including Medicaid.<sup>25</sup> Starting in 2010, the sample was expanded to provide state as well as national estimates on physicians' use of electronic medical records in their offices. This data source produced 2011 estimates on whether physicians were accepting new patients, including specific items on Medicaid.<sup>26</sup> The Centers for Medicare & Medicaid Services (CMS) wants to link these reports to claims data to assess their quality, though the claims data themselves have the problem that not all states code providers consistently. The state estimates were provided with special funding, and the long-term commitment of HHS to producing them annually is uncertain.

### National Health Interview Survey (NHIS)

NHIS is the largest ongoing national survey that asks about access to health care for nonelderly adults and children. NHIS includes content on usual source of care, use of health services, unmet need for health care services, barriers to obtaining care, and health care cost.<sup>27</sup> The sample frame for the survey is not large enough to create estimates for all states, but the most recent release includes estimates for the 20 largest, which includes California. However, these estimates are for the population as a whole; few states have sufficient numbers to support Medicaid-specific estimates.

NHIS has expanded its content on access. The changes are summarized in a 2013 report by the State Health Access Data Assistance Center called "NHIS Questionnaire Changes Addressing the Patient Protection and Affordable Care Act." (The latest publicly available instrument can be accessed at [www.cdc.gov](http://www.cdc.gov).)

NHIS changes include:

- ▶ **Coverage.** Makes it easier to understand whether someone was uninsured the year before. (There are many other coverage questions, but they are less directly relevant unless analysis of subgroups gaining coverage is the goal.)

- ▶ **Potential access.** Addition of reasons for the lack of a usual source of care, whether the most recent emergency department visit was at night or on a weekend, and why the patient went there (both adult and child).
- ▶ **Provider access.** Additional information on whether a person was told that a clinic or provider was not accepting new patients or that their health insurance was not accepted by the provider, whether they had trouble finding a general doctor, and wait times for appointment, including time in the waiting room. Asks about use of new technology for various health tasks (both adult and child).
- ▶ **Affordability of care.** Additional information on whether individuals needed but could not find affordable follow-up care or specialist visits, were worried about paying medical bills, asked their doctor to lower the cost of medical bills, or did certain things to save on the costs of prescriptions. Also asks about worry over paying medical bills or having trouble with medical bills (as well as about affordability of insurance).
- ▶ **Preventive care.** Preventive care questions were expanded to eight items and cover the previous 12 months.
- ▶ **Disability.** As part of a battery of questions on long term care, asks about met needs for assistance with activities of daily living (ADLs) and if person will need help with ADLs soon. (Existing survey asked about use or unmet need.)

### Health System Tracking Project

For purposes of national monitoring, HHS has identified a subset of measures from national data on access to care.<sup>28</sup> The specific measures are:

- ▶ Percentage with usual source of medical care (NHIS)
- ▶ Percentage reporting difficulty seeing a specialist, among those who self-report needing one (MEPS)
- ▶ Percentage (two-plus years old) reporting use of oral health system in past 12 months (MEPS)
- ▶ Ambulatory care sensitive conditions rate of hospitalization for adults (age 18 and over), as

measured by the Ambulatory Preventive Quality Indicator Project (H-CUP data)

- ▶ Ambulatory care sensitive conditions rate of hospitalization for children (age 6 to 17), as measured by the Pediatric Quality Indicator Composite (H-CUP data)

Unfortunately, none of these variables is available at the state level by payer.

### **Adult Health Care Quality Measures**

HHS is in the process of exploring core quality measures for adults on Medicaid, consistent with the ACA.<sup>29</sup> In 2012, HHS developed a grant program to assist states in collecting data to evaluate the core quality measures defined by the ACA. CMS is awarding first-year grants to 26 states, including California. With this grant, DHCS will test and evaluate a subset of the initial set of core adult quality measures (states must report on at least 15 of the 26 measures, but it is not clear which measures California plans to evaluate). DHCS will base its analyses on administrative and clinical data such as the HEDIS measures and self-reported data such as the CAHPS surveys.

## Appendix C. Background on Evolving Concepts Regarding Medicaid Access Monitoring

Approaches to monitoring access have evolved over time as needs changed and issues emerged. Early work on defining access to care was developed to support research on utilization of health services, with a focus on its determinants.<sup>30</sup> Access was defined as “those dimensions which describe the potential and actual entry of a given population group to the health services delivery system.”<sup>31</sup> Researchers distinguished three kinds of variables that influence utilization: (1) health needs both clinically defined and self-perceived; (2) predisposing variables such as age, sex, personal characteristics, and health care preferences related to those needs; and (3) enabling variables like provider availability, transportation, income, and health insurance status that determine whether potential need is translated into “realized access” — the actual use of health services.

A second body of early research was developed at the University of Michigan. Berki and Ashcraft (1979) identified “usual source of care” as critical to using health care effectively, a concept that has become important in measuring access to care and providing an early precedent for current interest in whether a patient has a particular point of contact with the health care system, such as a “medical home.”<sup>32</sup> More broadly, Penchansky and Thomas (1981) distinguished what they call the “5 A’s” in access: (1) availability — sufficient resources in personnel and technology to meet the needs of the patient; (2) accessibility — geographically, how easily the patient can reach the physician’s office; (3) accommodation — whether care is organized in ways that meet the patient’s needs (e.g., office hours, appointments, telephone access); (4) affordability, as it relates to the patient’s willingness and ability to pay; and (5) acceptability — whether the patient is comfortable with the characteristics of the provider.<sup>33</sup> As McLaughlin and Wyszewianski describe it, this research views access based on “the fit between the characteristics and expectations of providers and clients.”<sup>34</sup> Such concepts form a foundation for current interest in patient-centered care and reinforce the point that insurance coverage alone (as Medicaid and CHIP provide) does not guarantee access if other essential ingredients are missing. The unique characteristics of patients served by Medicaid and CHIP have important implications for the way access measures are conceived for these programs.

In the early 1990s, the Institute of Medicine (IOM) sought to refine measures to more fully address concerns about

the implications of resource constraints on the ability to secure adequate care. IOM expressed concern that receipt of needed services was persistently below recommended levels and also highly uneven across subgroups. IOM’s analysis of access was tied not just to use of services but to use of the “right” services — that is, those likely to achieve desired outcomes and goals.

IOM defined access as the “timely use of personal health services to achieve the best possible outcomes.” In its revised access framework, IOM distinguished three kinds of barriers: (1) structural barriers related to supply and organization of care, and transport to that care; (2) financial barriers related to insurance coverage and continuity, provider payments, and benefits/cost sharing; and (3) personal barriers that arise as a result of patient characteristics such as culture, language, attitudes, education, and income, which may influence the care they find acceptable. The first two are most susceptible to policy intervention, although the third can be influenced by the way health care systems are designed to accommodate patients’ characteristics and preferences.

The major emphasis of IOM’s work, however, was not barriers to use of care but links between use and outcomes, to support more nuanced measures of access not just to care but to appropriate care. In particular, IOM proposed that access measurement should include a focus on how concepts such as appropriateness, efficiency, provider quality, and patient adherence mediate between use and the ability to achieve desired health outcomes across populations on an equitable basis. That is, the goal was not merely the use of services but use of appropriate services as a means to enhance the impact of health care on outcomes. To support monitoring consistent with this definition, IOM identified and recommended a series of measures to monitor access in ways that better reflected health care goals as manifested in desired outcomes.

These various lines of research subsequently informed and were refined by national efforts to monitor quality and the performance of the health care system.<sup>35</sup> Equity and disparities in access and health outcomes have been a strong focus in the IOM research, but its work has paid more attention to developing new insights on whether access was ultimately achieved rather than to monitoring barriers such as provider availability and affordability.

## Endnotes

1. Institute of Medicine, *Access to Health Care in America* (Washington, DC: National Academy Press, 1993).
2. Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, DC: MACPAC, 2011). CHIP is the Children's Health Insurance Program.
3. These concerns, for example, were behind the Medicaid access monitoring requirements that California has agreed to as a condition of its five-year section 1115 Bridge to Reform demonstration waiver from the federal government.
4. CAHPS and HEDIS include a variety of measures, some of which are more relevant to critical concepts of access to health care than others; HEDIS, in particular, was designed to monitor quality of care within individual plans. CAHPS and HEDIS data are available at [www.dhcs.ca.gov](http://www.dhcs.ca.gov). CAHPS data reported are for 2010. HEDIS data reported are for 2012. These data are for Medi-Cal health plans (specific information is available at [www.dhcs.ca.gov](http://www.dhcs.ca.gov)). These sources produce estimates relevant to subgroups of patients, such as health plan enrollees or users at a particular practice, rather than to the entire population in a given geographic area (e.g., all Medi-Cal beneficiaries in a county), in contrast to population-based indicators that capture care to all people (whether or not they are tied to a particular health care system). However, weighted averages of CAHPS (and HEDIS) measures can be created to support monitoring access at a geographic level, albeit only for populations that are captured by the metrics. With the increased use of managed care in Medi-Cal, CAHPS and HEDIS are growing in importance as monitoring tools.  
  
Network adequacy requirements, which are highly relevant to monitoring access, still are relatively crude and unstandardized across states, which lessen their ease of use and applicability in a broad-based monitoring program.
5. California Department of Health Care Services (DHCS), *Monitoring Access to Medi-Cal Covered Health Care Services: A Plan to Monitor Healthcare Access for Medi-Cal Beneficiaries* (Sacramento, CA: DHCS, 2011); California Department of Health Care Services, *1115 Bridge to Reform Demonstration: Access Report and Plan* (Sacramento, CA: DHCS, January 1, 2013).
6. Medi-Cal also collects encounter data for health plans. Since none of the state reports published to date uses these data, the authors of this report are uncertain as to their quality and whether they can be meaningfully combined with claims data to provide aggregated estimates of access for all Medi-Cal enrollees. If they can, it might be possible for these data to complement survey metrics with claims/encounter-based metrics that might be more timely and could support more subgroup comparisons than are supported by surveys.
7. DMHC, *Timely Access*, accessed December 15, 2013, [www.dmhc.ca.gov](http://www.dmhc.ca.gov).
8. DMHC, *Summary of Health and Mental Health Plan Compliance with the Timely Access Regulation, Measurement Year 2011* (Sacramento, CA: DMHC, August 2013), [www.dmhc.ca.gov](http://www.dmhc.ca.gov).
9. See, for example, Mathematica Policy Research, Inc., *Access to Physician Services in California's Public Insurance Programs* (Oakland, CA: California HealthCare Foundation, 2004), [www.chcf.org](http://www.chcf.org) and University of California, San Francisco, *Physician Participation in Medi-Cal, 2008* (Oakland, CA: California HealthCare Foundation, 2010), [www.chcf.org](http://www.chcf.org).
10. State Health Access Data Assistance Center, *NHIS Questionnaire Changes Addressing the Patient Protection and Affordable Care Act* (Minneapolis, MN: University of Minnesota, 2013), [www.shadac.org](http://www.shadac.org).
11. For the Federal Register notice eliciting comments on this initiative, see "CMS Notice CMS-10493, Nationwide Consumer Assessment of Healthcare Providers and Systems (DCAHPS) Survey for Adults in Medicaid," 78 Fed. Reg. 43887 (July 22, 2013), [www.federalregister.gov](http://www.federalregister.gov).
12. See S. E. Palsbo, G. Diao, and G. A. Palsbo, "Case Mix Adjustment and Enabled Reporting of the Health Care Experiences of Adults with Disabilities," *Archives of Physical Medicine and Rehabilitation* 91 (September 2010): 1,339–46. The instrument is available at: [www.chcs.org](http://www.chcs.org).
13. With funding from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services (HHS), ASPE and the National Opinion Research Center produced "Recommendations for Monitoring Access to Care Among Medicaid Beneficiaries at the State Level" (Michael Davern, February 15, 2013), which assessed the strengths and weaknesses of existing data sources for monitoring access under Medicaid but did not include data analysis.
14. Medicaid and MACPAC, *Report to the Congress*.
15. Ron Andersen and Lu Ann Aday, "Access to Medi-Cal Care in the United States: A Conceptual and Empirical Overview," *Medi-Cal Care* 16, no. 7 (1978): 533–46; Lu Ann Aday and Ronald Andersen, "Equity of Access to Medi-Cal Care: A Conceptual and Empirical Overview," *Medi-Cal Care* 19, no. 12 (1981): 4–27, Supplement; Lu Ann Aday, Ronald Andersen, and Gretchen V. Fleming, *Health Care in the US: Equitable for Whom?* (Beverly Hills, CA: Sage Publications, 1980): 26; and Institute of Medicine, *Access to Health Care in America* (Washington, DC: National Academy Press, 1993).
16. Future iterations of the framework could be expanded to focus on other types of services provided by Medi-Cal, such as long term care services, or to include targeted access measures for particular groups of enrollees, such as the disabled, for whom the general purpose access measures may not capture the most critical elements of access.
17. It is expected that the Medicaid CAHPS that will be fielded for the disabled will include content that is tailored to their needs.

18. As discussed earlier, if encounter data from the managed care sector are of sufficient quality, it could be feasible to use these data to replicate and expand upon the proposed metrics from surveys, especially if they can be combined with claims from the FFS sector. However, while this would add depth, by permitting assessments for more subgroups and local geographies and by providing more measures of the appropriateness of the care provided, the survey-based estimates would continue to be critical in providing unbiased, rigorous estimates for the population as a whole and in reflecting patient perspectives of their access experiences.
19. See *Quality Measurement and Reporting*, DHCS, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).
20. As the health care delivery system evolves, it will be important to adapt the framework to accommodate new ways (e.g., through email and phone contacts, telemedicine) that individuals access and receive care.
21. For example, the proposed framework includes measures on the availability of midlevel providers and dentists to Medi-Cal enrollees, but those data are not readily available from existing sources.
22. See Kenney and Coyer 2012 and Long et al. 2012 for examples of this approach.
23. Given the methodological complexities involved, it will be desirable to develop a straightforward, easy-to-implement adjustment approach and to involve multiple teams working with different data sets.
24. DHCS, *Monitoring Access to Medi-Cal Covered Healthcare Services: A Plan to Monitor Healthcare Access for Medi-Cal Beneficiaries* (Sacramento, CA: DHCS, 2011), [www.dhcs.ca.gov](http://www.dhcs.ca.gov).

Of the 21 metrics that DHCS proposed under provider availability, service use, and access outcomes (which correspond to the framework's three domains of potential access, realized access, and health outcomes and behaviors), 12 overlap with the metrics proposed in the framework. However, in some instances, such as physician participation, the framework proposes a different data source to address measurement concerns. Table 1 flags the measures that overlap with what Medi-Cal has proposed. Other metrics proposed by Medi-Cal but not included here are (1) three long term care measures that were out of scope given the framework's focus on ambulatory care services; (2) pharmacy participation statistics, which were not included because pharmacy access did not seem to be a high-priority concern for access under Medi-Cal; (3) alternative formulations of the service use indicators — the focus of this framework is on any receipt of a particular service, not on the mean number of visits, and in the case of emergency department use, on the extent of frequent use and whether the emergency department use was avoidable (that is, if care could have been provided in a primary care setting); and (4) help line calls reporting access problems, which was not included here since it is not known how well publicized and well staffed these lines are, which could affect interpretation of the findings.

Such findings may be better included in a targeted plan to produce real-time monitoring of access to care, which may be especially critical during times of major change in the program, such as the current period.

25. The survey can be accessed at [www.cdc.gov/nchs](http://www.cdc.gov/nchs).
26. Sandra L. Decker, "In 2011, Nearly One-Third of Physicians Said They 'Would Not Accept New Medicaid Patients,' but Rising Fees May Help," *Health Affairs* 31, no. 8 (2012): 1673–1679.
27. State Health Access Data Assistance Center, *Monitoring the Impacts of Health Reform at the State Level: Using Federal Survey Data* (Minneapolis, MN: University of Minnesota, 2011).
28. US Department of Health & Human Services, *Access to Care*, [healthmeasures.aspe.hhs.gov](http://healthmeasures.aspe.hhs.gov).
29. Centers for Medicare & Medicaid Services, *Quality of Care – PM - Adult Health Care Quality Measures*, [www.medicaid.gov](http://www.medicaid.gov).
30. Andersen and Aday, "Access to Medi-Cal Care"; Aday and Andersen, "Equity of Access to Medical Care."
31. Aday, Andersen, and Fleming, *Health Care in the US*, 26.
32. Sy Berki and Marie Ashcraft, "On the Analysis of Ambulatory Utilization: An Investigation of the Roles of Need, Access, and Price as Predictors of Illness and Preventive Services," *Medi-Cal Care* 17, no. 12 (1979): 1,163–81.
33. Roy Penchansky and J. William Thomas, "The Concept of Access: Definition and Relationship to Consumer Satisfaction," *Medi-Cal Care* 19, no. 2 (1981): 127–140.
34. Catherine G. McLaughlin and Leon Wyszewianski, "Editorial — Access to Care: Remembering Old Lessons," *Health Services Research* 37, no. 6 (2002): 1,441.
35. See, for example, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academy of Sciences, 2001); Institute of Medicine, *Envisioning the National Health Care Quality Report* (Washington, DC: National Academy of Sciences, 2001); and Chris Fleming, "Don Berwick's Vision: The Triple Aim," *Health Affairs Blog*, April 20, 2010, [www.healthaffairs.org/blog](http://www.healthaffairs.org/blog).