RUPRI Rural Health Panel
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Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201
By electronic submission at http://www.regulations.gov

RE: CMS-2328-P, Proposed Rule: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services

Dear Dr. Berwick:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments regarding the Centers for Medicare and Medicaid Services' (CMS) Notice of Proposed Rulemaking to create a standardized, transparent process for States to follow as part of their broader efforts to "assure that payments are consistent with efficiency, quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area" as required by §1902(a)(30)(A) of the Social Security Act (hereinafter §30A).

The Panel understands that CMS will receive comprehensive comments from a wide variety of sources. Thus we will limit our comments to rural-specific issues.

#1. Clarifying that §30A Requires States to Assure that Medicaid Services are Available in Rural Areas within A State.

PROPOSED RULE: Section 30A mandates that States have an obligation to assure that Medicaid "payments ...are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population *in the geographic area.*" (emphasis added) The comments to the proposed rule repeatedly acknowledge that §30A requires States to assess the sufficiency of access in various geographic areas within a State, proposes that States review access measures by "State designated geographic location," and notes that

States have legal authority to "tailor their access strategies to take into account local conditions including geographic disparities in the availability of providers and demand for particular services."[1]

COMMENT: The process the proposed rule creates for States to assess access fails to specify that such reviews must take into account the needs of different geographic areas requiring only that access reviews "may vary by geographic location with the State." This proposed standard is, at best, unclear and, at worst, misstates the clear statutory requirements of §30A by failing to require the States assess access by geographic area.

The RUPRI Panel is especially concerned that the proposed rule provides for the use of "State designated geographic location" with no guidance on how the State is to designate geographic locations. We are concerned that without further guidance States may designate geographic areas in a way that merges rural and urban areas together so that access problems in smaller, more remote locations are not apparent. For example, if an access standard is set such that percent of the population in a designated have proximate access (defined in miles and/or minutes) to essential services, the standard could be met in a merged rural/urban area without being met for any of the rural residents.

The RUPRI Panel suggests that CMS explicitly require States to assess Medicaid beneficiary access in geographic locations of the State designated as rural. Further, and with respect to defining the rural and non-rural parts of States, CMS should indicate that States use one of the following recognized methods/systems for classifying rural and urban places:

- The Department of Agriculture, Economic Research Service's *Rural Urban Commuting Areas* or
- The Department of Agriculture, *Urban Influence Codes*

Both classification systems disaggregate rural places into smaller, more remote places. Such detail is often needed to understand differences in access across different types of rural communities and areas.

SUGGESTED CHANGES:

(1) The third sentence of Section 447.203(b) should be revised to include the following italized language: "The access reviews must include the items specified in this section *by State-designated geographic location within the State*, as well as trends and factors, which may vary by geographic location within the State..."

(2) A new subsection (iv) should be added to §447.203(b)(1) providing that the State access review must document, at a minimum, *"The process and standards the State used for designating geographic locations within the State for assessing enrollee needs, availability of care and beneficiary utilization.*

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[1] Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. at 26342, 26343 (May 6, 2011) (to be codified at 42 C.F.R. pt. 447). See also, "The required statutory test is a comparison between Medicaid beneficiary access and access to medical services by the general population in the geographic area." Id. at 26345. "We are confident that the Medicaid data will implicitly address general access standards in the geographic area." Id.

In designating geographic locations, States are to assess access in geographic locations designated as rural by either The Department of Agriculture, Economic Research Service's Rural Urban Commuting Areas or The Department of Agriculture's Urban Influence Codes."

#2 Limitations in Existing Data Sets Ability to Assess Access to Care for Medicaid Beneficiaries by Geographic Location within a State

REQUEST FOR PUBLIC COMMENT: CMS requests public comment on the extent to which existing sources of data can provide States with sufficient data to ensure that they are fulfilling their responsibilities pursuant to §30A. CMS specifically requests public comment on a list of existing data sources that includes the HRSA Uniform Data System; HRSA Health Areas Shortage Designation website; AHRQ Medical Expenditures Panel Survey; CDC National, Ambulatory Medical Care Survey; CDC National Health Interview Survey; Medicare and Medicaid, Data Assistance Center, Medicare Current Beneficiary Survey; U.S. Census Bureau's Current Population Survey, and State Health Access Data Assistance Center (SHADAC) website. Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. at 26350.

COMMENT: The RURPI Panel notes that the data sources listed at Fed. Reg. 26350 cannot be used to assess local access or geographic differences in access to care for Medicaid beneficiaries. Unfortunately, national health survey data sets such as the National Health Interview Survey and the Medical Expenditure Panel Survey cannot support sub-state analysis of health access.

To our knowledge the only dataset available to the States that can support sub-state, local analysis is the Behavioral Risk Factor Surveillance System (BRFSS) survey. Conducted by the States with funding from the Centers for Disease Control and Prevention, BRFSS is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, data are collected monthly in all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. In most if not all States, survey sampling is done to allow for sub-state analysis, including rural and urban analysis. The BRFSS survey has a core module on healthcare access that includes standard questions that would allow States to measure Medicaid beneficiaries' access to care.

In addition to the BRFSS data, many States conduct surveys of their Medicaid and CHIP populations. To the extent possible States should be encouraged to generate samples for these surveys that allow for analysis of geographic differences across rural and urban areas.

Finally, States can use their claims data to examine certain access measures for specific sub-populations or chronic conditions. So, for example, access to preventive services tends to be a larger problem in rural areas; these differences can be measured using Medicaid claims. Likewise analyses of patterns of care for specific conditions, such as depression or other mental disorders, can be used to assess geographic differences in access to specialty services.

Thank you for your consideration of these comments. Please do not hesitate to contact us with questions.

Sincerely,

Sidney D. Watson and Andrew F. Coburn on behalf of
The Rural Policy Research Institute Health Panel

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