



College of Public Health – N232A
 105 River Street
 Iowa City, IA 52242
 (319)-384-3832
<http://www.rupri.org/panelandnetworkviewer.php?id=9>
Keith-mueller@uiowa.edu

Rural Health Panel

Keith J. Mueller, PhD., Chair
 Andrew F. Coburn, Ph.D.
 Jennifer P. Lundblad, Ph.D., M.B.A.
 A. Clinton MacKinney, M.D., M.S.
 Timothy D. McBride, Ph.D.
 Charlie Alfero

January 4, 2016
 Centers for Medicare and Medicaid Services Department of Health and Human Services
 Attention: CMS–2328–NC
 P.O. Box 8012
 Baltimore, MD 21244-8016
 By electronic submission at <http://www.regulations.gov>

Re: 40 CFR Part 447 [CMS–2328–NC] Medicaid Program; Request for Information (RFI) – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program

To Whom It May Concern:

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 offer comments regarding the RFI regarding Data Metrics and Alternative Processes for Access to Care in the Medicaid Program.

The Panel has consolidated the questions from CMS in order to address the broad issues raised in the RFI. The Panel understands that CMS will receive comprehensive comments from a wide variety of sources. Thus we will limit our comment to rural-specific issues.

Question: *Access to care data collection and methodology:* What access measures, if any, could be universally applied across services, settings (such as long term or community based care), delivery systems, geographic locations, or acuity levels?

Comment: The Panel encourages CMS to consider more than just the geographic presence of a provider in assessing a beneficiary’s access to services. Ideally, access measures will account for a variety of factors. In 2014, the Panel suggested a four-dimensional approach to access measures in a paper entitled: RUPRI Access to Rural Health Care – A Literature Review and New Synthesis (http://www.rupri.org/Forms/HealthPanel_Access_August2014.pdf). The following table suggests access measures within these four dimensions.

People	Place	Provider	Payment
Health care visit within the last year	Travel time to health care	Primary care professional availability	Health insurance options available

Utilization rate of preventive services	Travel distance to health care	Practice patient-centeredness	Premiums, co-pay, and deductible rates
Culturally sensitive care available	Geographic barriers to health care access	After-hours care available	Payment consideration for low-volume services
Ambulatory care sensitive conditions rate	Transportation to health care options	Care coordinator and coordination availability	Primary versus specialty care payment rates
Skipped recommended test or follow-up	Electronic connectivity to health care options	Age- and gender-sensitive care available	Public program payment rates

Question: *Access to care thresholds/goals:* Should thresholds for access be set at all, and if so, at what level?

Comment: The Panel recommends setting a national baseline threshold for Medicaid access that can be used to guide specific state actions. If thresholds were set at a state or local level, it would be possible for rural states to argue for a lower threshold, which would not be in the best interest of beneficiaries. States should set access standards that meet or exceed national standards. Thresholds are important for ensuring access to providers in rural areas. However, there can be tension between thresholds that ensure broad access to providers and services, and thresholds that restrict the Medicaid program or its proxies in delivering services efficiently. Therefore, it is important to strike a balance in setting thresholds that will provide access to rural providers without decreasing program efficiency.

Question: *Access to care thresholds/goals:* Once thresholds are established, how should they be used?

Comment: The Panel recommends using thresholds for issuing compliance actions to states that do not meet thresholds. The Panel is concerned that using thresholds as benchmarks will not create sufficient incentives for states to provide access to beneficiaries. Further, CMS should not allow thresholds to be used simply in administrative appeals processes. Administrative appeals can be time consuming and difficult to navigate, particularly for individuals of low socioeconomic status that may not have the resources to take full advantage of this process. The best way to assure compliance with thresholds is to place the burden of compliance on states rather than beneficiaries.

Question: *Access to care measures:* What access to care measures should be prioritized?

Comment: The Panel is concerned that prioritization will exclude some essential access measurements and therefore not address the needs of many rural beneficiaries. Instead, CMS should focus on integrating different access measures such as utilization rates, travel times, provider availability, and affordability of care. All these different access measures should be used in setting a minimum national threshold for access.

Question: *Measures for availability of care providers:* How should “geographic areas” be defined in the context of access to providers?

Comment: The Panel recommends a statewide plan that considers multiple access measures. Access measures should have a beneficiary nexus rather than a geographical nexus. There is currently not an effective method for implementing geographical measures other than at a statewide level. A statewide is the best option as there are not sufficient data at a more local level.

Question: *Measures for availability of care and providers:* What providers should be factored into assessments of availability of care?

Comment: The Panel appreciates the list of providers CMS has included in the RFI. CMS should also consider whether providers are accepting new Medicaid patients in determining the number of available providers. Further, CMS should consider the use of both telehealth as a supplement to access and beneficiary reports of availability of providers as discussed in the following comment.

Question: *Measures for beneficiary reported access:* What measures of beneficiary reported access should be considered?

Comment: The Panel agrees with the beneficiary reported access measurement areas listed in the RFI, but proposes the following additions: (1) beneficiaries able to access after-hours care, (2) beneficiaries able to access care coordination services, (3) beneficiaries able to access care through telehealth services and other remote care provision, and (4) beneficiaries able to access culturally sensitive care.

The Rural Policy Research Institute Health Panel

Keith J. Mueller, PhD – Chair

Andrew F. Coburn, PhD

Jennifer P. Lundblad, PhD, MBA

A. Clinton MacKinney, MD, MS

Timothy D. McBride, PhD

Charlie Alfero