Medicaid Access Technical Assistance Brief

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Leveraging Benchmarks, Advisory Groups, and Experts to Understand Access in Medicaid

This brief presents a process that staff in state Medicaid agencies can use to engage resources—such as benchmarks, subject matter experts, and advisory groups—in the development of their access monitoring review plans. The brief discusses each resource, discusses how and when states might use it, and includes links to supporting documents and additional information.

A. Introduction

Through access monitoring review plans (AMRPs), state Medicaid agencies are expected to monitor access to care for beneficiaries in fee-for-service (FFS) and track changes in access over time. States submitted their first round of AMRPs in October 2016 and will submit their second round in 2019. In their 2016 AMRPs, many states described plans to add additional measures and more sophisticated analyses to future AMRPs. CMS has also stated that it expects AMRPs to "become more sophisticated over time."[1]

Given the need to continually improve AMRPs, this brief presents three key resources that state Medicaid staff might leverage to help strengthen the comprehensiveness, methodological rigor, and overall usefulness of AMRPs. These resources include benchmarks for measures of access, enrollee and provider advisory groups, and subject matter experts. States may use these three resources at different times and for different purposes. To this end, the brief also provides considerations and options for states deciding how and when to engage each resource.

About this series: The Medicaid Access Technical Assistance brief series is intended to serve as a resource to state Medicaid agencies by providing options and strategies for completing their access monitoring review plans (AMRPs). In November 2015, CMS released a final rule directing states to use a data-driven approach to examine access for beneficiaries in fee-for-service (FFS) Medicaid (Methods for Assuring Access to Covered Medicaid Services, CMS-2328-FC). The final rule requires that, starting in October 2016 and every three years thereafter, states submit an AMRP to report data on access to care, and compare their Medicaid rates with rates paid by Medicare and private payers (commercial insurers) for services that are covered on a FFS basis.

B. Planning to engage resources for AMRPs

The process of developing and revising AMRPs can be broken down into four phases (Figure 1). In the first phase, **planning,** Medicaid agency staff review their prior AMRP, decide whether to make any changes—such as adding more measures or consulting other data sources—and form a plan to conduct the work. In the second phase, **data gathering,** staff identify data sources and collect the data required to calculate their selected measures. During the third phase, **measure calculation and analysis,** staff com-

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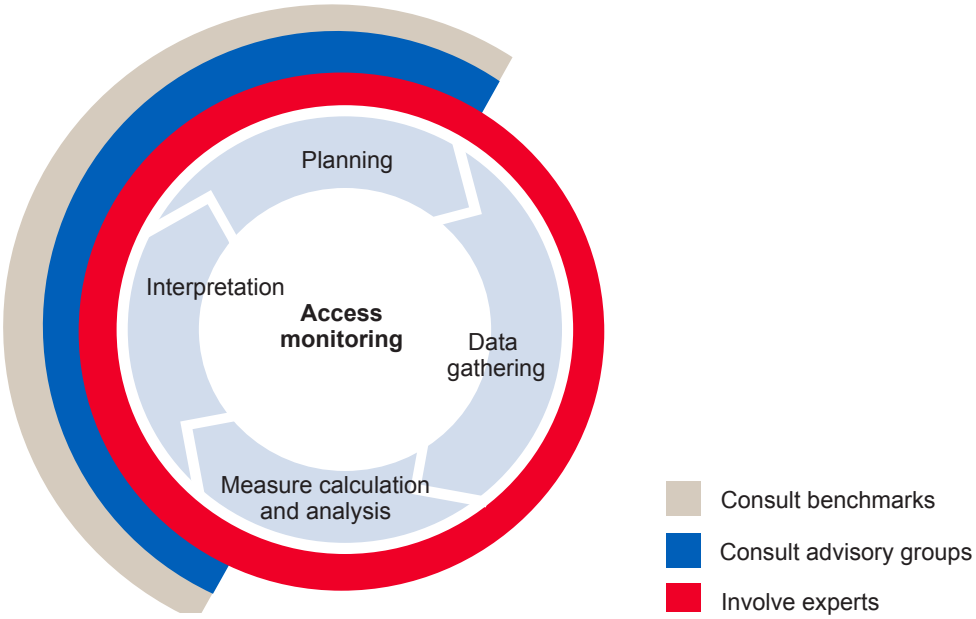
pute the selected measures. In this phase, states may also decide to conduct new analyses, such as comparing their measures to those of other populations or tracking changes in access over time. And in the fourth phase, **interpretation,** staff interpret their results, share them with administrators, and assess what the results mean about beneficiary access to care.

Depending on their specific needs, state Medicaid agencies might find it useful to tap resources such as benchmarks, advisory groups, and experts during one or more phases (Figure 1). Even if states do not involve these resources during the planning phase, any level of involvement during other phases could strengthen the findings and interpretation of beneficiary access. The rest of this brief describes these resources in detail, provides links to supporting documents, and discusses special considerations for engaging each resource.

Figure 1. Phases of the AMRP process and when to engage resources



WHEN TO USE BENCHMARKS

States may want to use benchmarks in the **planning phase,** while selecting measures to include in their AMRPs, and in the **interpretation phase,** once they have calculated their measures and are starting to assess what they mean about access to care.

C. Benchmarks

Benchmarks provide values or ranges of values representing access among other populations that states can use to compare to measures of access for their Medicaid FFS beneficiaries. Benchmarks can be (1) internal, reflecting access to care for other populations within a state, such as Medicaid managed care or commercial populations; or (2) external, reflecting populations in other states or at the national level.

State staff could leverage existing internal benchmarks or create new ones. These could include existing measures of access reported by Medicaid managed care or commercial managed care plans. It could also include using an all-payer claims database (APCDs) to construct access measures for populations with Medicare or commercial insurance. Though we did not find examples of states that leveraged APCDs to create in-state benchmarks for access measures in their 2016 AMRPs, a few states used APCDs for other aspects of their 2016 AMRPs. For example, four states used data from their state's APCD to conduct payment rate comparisons, and a few others mentioned that their states are in the process of developing an APCD.[2]

States might also consider using external benchmarks to compare measures of access in

FFS Medicaid in their state to that of other states or to national averages. Annual cross-state and national estimates are published for the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Health Care Providers and Systems (CAHPS) (Box 1). CMS also publishes results for a variety of measure sets, including the Child Core Set and Adult Core Set, which include some HEDIS and CAHPS-like measures of access.

In the 2016 AMRPs, several states incorporated comparisons to national benchmarks. For example, Iowa compared results from its CAHPS survey of FFS beneficiaries to the national CAHPS benchmark and to the state's managed care populations. Likewise, Massachusetts compared the frequency of ongoing prenatal care, a HEDIS measure, against Medicaid national benchmarks.

Box 1. National data sources for benchmarking

HEDIS: Current and historical benchmarks for commercial HMO and PPO Medicaid HMO, and Medicare HMO and PPO enrollees are available at http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2017-table-of-contents.

CAHPS: Percentile top-box scores for health plan and clinician/group surveys are available in the CAHPS Database Online Reporting System: https://cahpsdatabase.ahrq.gov/cahpsidb/.

CMS Quality of Care Performance Measurement: Results from the Child Core Set, Adult Core Set, and Nationwide Adult CAHPS are available on the CMS Medicaid website: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/.

Tips for implementation: Though they serve as useful points of comparison, benchmark values may reflect different populations or measurement methods than a state's own FFS access measures, and state staff should consider those differences in interpreting any comparisons. For example, even within a state, Medicaid FFS beneficiaries are likely to have a different composition of age or health needs than those in commercial insurance or even Medicaid managed care beneficiaries, which may exclude certain high-need groups. States may use a different survey collection modality for their FFS beneficiaries than what is used for data in the national benchmarking database (for example, internet-only collection rather than mail, telephone, or mixed-mode collection). National benchmarks may also use different risk-adjustment methodologies to reflect variation in health needs among the population.

States are encouraged to read the technical documentation that accompanies benchmarks reports to identify any relevant differences in national benchmarks and consider ways in which the differences could influence interpretation of the comparisons. States should also consider reading this documentation in the planning phase of their 2019 and subsequent AMRPs and prior to conducting new data collection and analysis. Doing so will allow states to design their methods to be consistent with those of benchmarks, and therefore, to make more meaningful comparisons of access in the interpretation phase.

WHEN TO ENGAGE ADVISORY GROUPS

States may want to engage enrollee and provider advisory groups in the **planning phase,** while selecting measures to include in their AMRPs, and in the **interpretation phase,** once states have calculated the measures and are starting to assess what they mean about access to care.

D. Beneficiary and provider advisory groups

Medicaid advisory groups can provide states with access to input from clinicians and beneficiaries, both of whom have lived experiences of access to care. States may consider leveraging one or more advisory groups to inform the design of their AMRPs and interpretation of the results.

The strongest opportunity to engage advisory groups is likely to be in the interpretation phase. After states calculate measures, advisory groups can help put findings in context and compare results to their lived experience (Box 2). For example, patients with disabilities might provide insights about how aggregate trends intersect with their lived experiences of accessing care—such as the ease or difficulty of finding specialists

who accept Medicaid patients. Similarly, clinicians can provide insights into experiences with finding other specialty clinicians to refer their Medicaid enrolled patients or challenges with providing greater access.

States can also engage advisory groups during the planning phase, especially in assessing the importance and face validity of measures of access. For example, states can ask representatives from advisory groups to help state staff prioritize a list of potential measures to include in the AMRP or measures that could be dropped from a prior AMRP (Box 2), understanding that doing so can prevent states from being able to track changes in access over time. An additional benefit of engaging stakeholders in measures selection is that it can help ensure stakeholder buy-in for a state's choice of measures in the AMRP.

Tips for implementation: Advisory groups may be readily accessible in states. For example, as required by federal regulations, all states have Medical Care Advisory Committees made up of provider, enrollee, and government representatives (42 CFR 431.12). These members help develop Medicaid policy and weigh in on aspects of program administration.

Depending on the composition of existing advisory groups, states may consider drawing on the input of special enrollee populations, such as patients with complex health care needs, who regularly seek care from a wide range of clinicians. States may also consider seeking input from providers across the service categories required in the AMRP—primary care, physician specialists, obstetrics, behavioral health, and home health. These providers could help provide insight into the potential causes and implications of changes in access to specific groups of providers or services.

Box 2. Potential discussion questions for advisory groups

- Do the proposed measures in the AMRP reflect aspects of care that are important to you or to the people you serve? If not, what is missing, and what can be removed?
- Do the results reflect your experience of access? Why or why not?
- What is not reflected in the results?

WHEN TO ENGAGE EXPERTS

States can engage subject matter experts throughout the AMRP process, from initial planning and measure selection through interpretation of results.

E. Subject matter experts

Experts in Medicaid delivery systems and statistical methods can expand the analytic capacity of state staff who are monitoring access in Medicaid FFS. Such experts might be found in Medicaid agencies, other health and human services agencies, academic institutions, consultant firms, or external quality review organizations (EQROs) (Box 3). Though EQROs tend to focus on access among managed care beneficiaries, states can contract with them for other forms of research support, including measuring access among the FFS population.

Our review of 2016 AMRPs showed that many states engaged a range of internal and external experts to complete their AMRPs; states can build on those existing relationships and engage additional experts where needed. For example, in interviews with Medicaid agency staff about their experience completing the 2016 AMRPs, many staff reported having worked with a range of internal experts—including financial experts, policy analysts, regulators, legal experts, data analysts, clinicians, and coding experts. Staff in several states said they partnered with experts in other agencies and state offices who specialized in health insurance, Medicaid eligibility, home health, and behavioral health. These experts helped identify data sources, guide the methodology, and conduct analyses.[3] Several states engaged experts from universities or other organizations to help conduct rate comparisons for their AMRPs.

Depending on specific needs, states could engage experts at any point in the AMRP process. For example, as part of the planning phase, experts in statistical methods or delivery systems could help states select new measures or refine existing ones, suggest measure specifications, or suggest data collection and analysis strategies that take into account state-specific data and challenges. During the measure calculation phases, experts

in data collection and statistical analysis can advise on methodology or act as staff extenders to accomplish measurement more efficiently. Once agency staff begin to interpret results, experts can provide professional guidance for assessing whether changes in access over time or differences across populations are meaningful.

Box 3. Where to find experts on measuring Medicaid access

- Other Medicaid departments
- Other state agencies (for example, a department of public health or behavioral health, if separate from Medicaid)
- Local universities
- External quality review organizations
- Consultants

Tips for implementation: Seeking guidance or direct assistance from experts – particularly in statistics and research methods – can help states quickly acquire technical capacity without requiring existing staff to learn new methods. However, states may need to invest some time to identify experts with the right expertise and develop a process for engaging them. States should also consider how to manage expert input before seeking it. While external experts can be a valuable asset, Medicaid agencies should make final decisions and communicate that they are seeking input from experts to inform their decisions rather than asking experts to make final decisions on methods, measures, or thresholds.

F. Discussion

As states begin working on their second round of AMRPs, due in 2019, they will face new challenges in building on their 2016 AMRP to understand trends in access. The resources described in this brief can strengthen a state's approach to the 2019 AMRP and help identify meaningful changes or deficits in access—ultimately improving the value of AMRPs for states and CMS alike.

Endnotes

[1] CMS. "Access Rule Implementation Frequently Asked Questions (FAQs)." March 2016. Available at https://www.medicaid.gov/medicaid/access-to-care/downloads/faq-31616.pdf. Accessed February 9, 2018.

[2] Chollet, Deborah, Amanda Lechner, Rivka Weiser, and Genna Cohen. "State Access Monitoring Review Plans: Rate Comparison Needs Assessment." Submitted to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Washington, DC: Mathematica Policy Research, March 31, 2017.

[3] Researchers from Mathematica interviewed staff from several states at various times in 2017 to discuss their experiences completing the 2016 AMRPs.

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