MANUAL

Medicaid Access Resource Manual

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CONTENTS

TABLES

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LIST OF ACRONYMS AND ABBREVIATIONS

AMRP	Access Monitoring Review Plan
APNCU	Adequacy of Prenatal Care Utilization
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAM	Core Access Measure
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FFS	Fee-For-Service
GIS	Geographic Information System
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HPSA	Health Professional Shortage Areas
HRSA	Health Resources & Services Administration
MCO	Managed Care Organization
MEPS	Medical Expenditure Panel Survey
MMIS	Medicaid Management Information System
OCAM	Optional Core Access Measure
PRAMS	Pregnancy Risk Assessment Monitoring System

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I. INTRODUCTION

In November 2015, CMS released a final rule directing states to use a data-driven approach to examine access for enrollees in 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. The first AMRP submissions were delivered in 2016.

CMS directed states to prepare AMRPs that describe access to care in three domains and in five service categories. The domains are beneficiary needs, availability of care, and utilization. The service categories are primary care (including dental), physician specialist services, behavioral health, pre- and post-natal obstetric services, and home health services. Each state may choose which data sources and methods to use in its AMRP.

To assist states with reporting on access for Medicaid FFS beneficiaries, CMS created 10 templates that states can choose to complete in order to fulfill AMRP requirements.[1] The templates were developed by reviewing the AMRPs submitted by states in 2016 and compiling examples of meaningful measures.

This resource manual is intended to be a companion guide to the AMRP templates created by CMS, and the manual's organization mirrors that of the reporting templates. For each measure of access included in the templates, this manual provides guidance on commonly used data elements, potential data sources (including standardized data sets), and—when applicable—alternative methods of calculating the measure. Regardless of whether a state chooses to use the templates, the manual can be used as a guide to potential data elements, data sources, and analytic methods that states can use to create meaningful AMRPs.

A. Overview of AMRP measures described in the resource manual

There are 32 total measures described in this manual (Table 1). Of these, 11 are considered Core Access measures (CAM), or meaningful measurements of access that are relatively easy to report. Two measures are considered Optional Core Access measures (OCAM), because states may select between multiple distinct reporting options. There are also 19 Additional measures that may prove more challenging to report but are also strong measures of access.

Most measures in the templates belong to the three required access domains: (1) availability of care and providers, or measures that describe the number or convenience of health care access points; (2) utilization of services, or measures that describe use of health care resources; and (3) beneficiary needs, or measures that describe the health care needs of the Medicaid population. Measures in Template 1 describe the size of the beneficiary population but do not belong to an access domain.

[1] The templates can be accessed at (link forthcoming).

Table 1. AMRP Core Access and Additional measures by domain

Domain	Core Access measures	Additional measures
Not Applicable (N.A.)	• Total Medicaid Beneficiaries • Total Medicaid FFS Beneficiaries • Total MCO Beneficiaries • Medicaid FFS Beneficiaries in the Following Three Populations: Pediatric, Adult, Individuals with Disabilities*	
Beneficiary Needs	• Top Five Physical Clinical Conditions by Prevalence for the Pediatric, Adult, and Individuals with Disabilities Populations • Top Five Behavioral Health Clinical Conditions by Prevalence for the Pediatric, Adult, and Individuals with Disabilities Populations • Ability to Get Care	
Availability of Care	• Number of Providers Enrolled in Medicaid • Number of Licensed Providers • Participation Among Medicaid-Enrolled Providers* • Number of Beneficiaries Served • Number of Providers Who Billed CPT or Modifier Codes Indicating That They Saw New Clients for This Provider Type	• Composite Score for Getting Needed Care • Ease of Referral for Medicaid Patients • Number of Health Professional Shortage Areas • Average Distance (in Miles) to Reach Provider Among Beneficiaries • Average Driving Time (in Minutes) to Reach Provider Among Beneficiaries • Secret Shopper Measures
Utilization	• Number of Services Delivered to Medicaid Beneficiaries by Provider Type	• Number of Medicaid FFS Beneficiaries Who Use Telemedicine Services • Number of Telemedicine Services Provided to Medicaid FFS Beneficiaries • Top Five Originating Sites of Telemedicine Services Provided to Medicaid FFS Beneficiaries • Adults' Access to Preventive and Ambulatory Health Services • Breast Cancer Screening • Annual Dental Visits • Well-Child Visits in the First 15 Months of Life • Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life • Adolescent Well-Care Visits • Percentage of Deliveries That Had at Least One Timely Prenatal Visit • Frequency of Ongoing Prenatal Care • Percentage of Deliveries That Had at Least One Timely Postnatal Visit • Proportion of Women Who Received Early and Adequate Prenatal Care

* Indicates an Optional Core Access measure. States may select between multiple reporting options for Optional Core Access measures.

B. Reporting AMRP measures

The model templates assume that states will report AMRP measures by year for each of the past three years and by geographic area (as defined by the state). Some measures can also be stratified by three enrollment categories (pediatric,[2] adult, and individuals with disabilities) or by provider type (for example, family practice physician, licensed clinical social worker, or home health aide).

Reporting guidance for each template measure can be found in Chapters II–VI. Chapter VII offers guidance for reporting payment rate comparison data. Mechanisms for beneficiary and provider input on access to care are described in Chapter VIII.

Table 2 defines the elements included in the guidance for each measure described in Chapters II–VI.

Table 2. Elements included in measure guidance

Guidance element	Description
Template	The CMS reporting template to which the measure belongs.
Measure domain	Measures may belong to the Beneficiary Needs, Availability of Care and Providers, or Utilization of Services domains. Measures that do not belong to a domain are listed as Not Applicable (N.A.).
Measure tier	Describes whether the measure is a Core Access measure, Optional Core Access measure, or Additional measure.
Typical data type	Describes the typical type of data used to create the measure among states that reported the measure in their 2016 AMRPs.
Additional guidance	Any additional guidance for reporting this measure.
Count	When the measure is a count, this element describes the counted variable.
Measure set	When the measure is a rate, this element describes its originating measure set. For example, some measures originated as HEDIS measures or survey items in CAHPS.
Measure name	When the measure is a rate, this element describes the measure name in its originating measure set.
Numerator	When the measure is a rate, this element describes the numerator in the rate equation.
Denominator	When the measure is a rate, this element describes the denominator in the rate equation.
Data source	Describes the likely data source(s) used to report this measure.

[2] Here and throughout the resource manual, the pediatric enrollment category refers to the children eligibility group.

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II. TEMPLATE 1: BENEFICIARY POPULATION

This chapter provides guidance for reporting on the beneficiary population in Template 1. For each Template 1 measure, values may be reported for the past three years. These measures are as follows:

- Total Medicaid Beneficiaries
- Total Medicaid FFS Beneficiaries
- Total Medicaid MCO Beneficiaries
- Medicaid FFS Beneficiaries in the Following Three Populations:
  - Pediatric
  - Adult
  - Individuals with Disabilities

Total Medicaid Beneficiaries

This measure reports the number of unique Medicaid beneficiaries (de-duplicated total).

Template:	Template 1: Beneficiary population
Measure domain:	N.A.
Measure tier:	Core Access
Typical data type:	Medicaid enrollment
Additional guidance:	The number of unique Medicaid beneficiaries (de-duplicated total) reported for each year should match the sum of reported Medicaid FFS and MCO beneficiaries for those years

Reporting option 1

Count:	The number of unique beneficiaries (de-duplicated total) *with at least six months of enrollment during* the measurement year
Data source:	MMIS or data warehouse

Reporting option 2

Count:	The number of unique beneficiaries (de-duplicated total) *enrolled in Medicaid as of the last day of* the measurement year
Data source:	MMIS or data warehouse

Total Medicaid FFS Beneficiaries

This measure reports the number of unique Medicaid FFS beneficiaries (de-duplicated total).

Template:	Template 1: Beneficiary population
Measure domain:	N.A.
Measure tier:	Core Access
Typical data type:	Medicaid enrollment
Additional guidance:	Beneficiaries are considered Medicaid FFS beneficiaries if (1) they receive all services on an FFS basis or (2) they receive services in certain narrow categories—such as behavioral health, dental, or transportation—through a capitated payment structure, but their remaining services are FFS. Beneficiaries enrolled in a comprehensive MCO are considered MCO beneficiaries. For AMRP reporting purposes, individual beneficiaries may only be enrolled in one type of payment system (FFS or MCO).[3] The sum of Medicaid FFS and MCO beneficiaries reported for each year should match the total number of Medicaid beneficiaries reported for those years.

Reporting option 1

Count:	The number of unique beneficiaries (de-duplicated total) *with at least six months of enrollment and a last-known status of enrollment in any payment system other than* comprehensive MCO during the measurement year
Data source:	MMIS or data warehouse

Reporting option 2

Count:	The number of unique beneficiaries (de-duplicated total) *enrolled in Medicaid as of the last day of the measurement year who were never enrolled in* a comprehensive MCO during the measurement year
Data source:	MMIS or data warehouse

[3] More information on defining Medicaid FFS and MCO beneficiaries can be found in the Template 1 measures, Total Medicaid FFS Beneficiaries and Total Medicaid MCO Beneficiaries, respectively.

Total Medicaid MCO Beneficiaries

This measure reports the number of unique Medicaid MCO beneficiaries (de-duplicated total).

Template:	Template 1: Beneficiary population
Measure domain:	N.A.
Measure tier:	Core Access
Typical data type:	Medicaid enrollment
Additional guidance:	Beneficiaries who receive services from a comprehensive MCO are considered Medicaid MCO beneficiaries. States contract with comprehensive MCOs to cover all acute and primary medical services; some also cover behavioral health, dental, transportation, and long-term care. Entities that qualify as MCOs include health maintenance organizations and health insuring organizations (see 42 CFR 438.2).[4] For AMRP reporting purposes, individual beneficiaries may only be enrolled in one type of payment system (FFS or MCO).[5] The sum of the number of unique Medicaid FFS and MCO beneficiaries (de-duplicated total) reported for each year should match the number of unique Medicaid beneficiaries (de-duplicated total) reported for those years.

Reporting option 1

Count:	The number of unique beneficiaries (de-duplicated total) *with at least six months of enrollment and a last-known status of* comprehensive MCO enrollment during the measurement year
Data source:	MMIS or data warehouse

Reporting option 2

Count:	The number of unique beneficiaries (de-duplicated total) *enrolled in Medicaid as of the last day of the measurement year who were ever enrolled in* a comprehensive MCO during the measurement year
Data source:	MMIS or data warehouse

[4] The definition of comprehensive MCOs was adapted from *Medicaid Managed Care Data Collection System–2017 User Guide and Data Definitions*.

[5] Medicaid FFS beneficiaries are defined in the Template 1 measure, Total Medicaid FFS Beneficiaries.

Medicaid FFS Beneficiaries in the Following Three Populations: Pediatric, Adult, and Individuals with Disabilities

This measure reports the number of unique Medicaid FFS beneficiaries (de-duplicated total), separately for the pediatric, adult, and individuals with disabilities groups.

Template:	Template 1: Beneficiary population
Measure domain:	N.A.
Measure tier:	Optional Core Access
Typical data type:	Medicaid enrollment
Additional guidance:	States should report population totals for each of the following enrollment categories: • Pediatric • Adult • Individuals with disabilities In each enrollment category, reporting could be stratified by the following subcategories: • Age • Gender • Income groups relative to federal poverty level • Race/ethnicity • Primary language spoken • Other (defined by the state)

Reporting option 1

Count:	For each reported combination of enrollment category and subcategory, the number of unique FFS beneficiaries (de-duplicated total) *with at least six months of enrollment during* the measurement year
Data source:	MMIS or data warehouse

Reporting option 2

Count:	For each reported combination of enrollment category and subcategory, the number of unique FFS beneficiaries (de-duplicated total) *enrolled in Medicaid as of the last day of* the measurement year
Data source:	MMIS or data warehouse

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III. TEMPLATE 2: BENEFICIARY NEEDS

This chapter provides guidance for reporting measures of beneficiary needs in Template 2. For each Template 2 measure, values may be reported for the past three years. These measures are as follows:

- Top Five Physical Clinical Conditions by Prevalence in the Following Three Populations:
  - Pediatric
  - Adult
  - Individuals with Disabilities
- Top Five Behavioral Health Clinical Conditions by Prevalence in the Following Three Populations:
  - Pediatric
  - Adult
  - Individuals with Disabilities
- Ability to Get Care

Top Five Physical Clinical Conditions by Prevalence

This measure reports the five most prevalent physical clinical conditions for the Medicaid FFS beneficiaries, separately for the pediatric, adult, and individuals with disabilities groups.

Template:	Template 2: Beneficiary needs
Measure domain:	Beneficiary needs
Measure tier:	Core Access
Typical data type:	Medicaid enrollment and claims
Additional guidance:	Report physical clinical conditions at the three-digit ICD-10-CM level. Report the five most prevalent physical clinical conditions by ICD-10 category for each of the following enrollment categories: • Pediatric • Adult • Individuals with disabilities The template tool will automatically calculate the prevalence rate for each condition using the count of Medicaid FFS beneficiaries for each condition. The number of Medicaid FFS beneficiaries is reported in the Template 1 measure, Medicaid FFS Beneficiaries in the Following Three Populations: Pediatrics, Adult, and Individuals with Disabilities.

Reporting guidance

Count:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) with one or more paid claims with a primary diagnosis falling into the given ICD-10 category. List the five most prevalent ICD-10 categories and the number of unique Medicaid FFS beneficiaries (de-duplicated total) with at least one claim falling to the category.
Data source:	MMIS or data warehouse

Top Five Behavioral Health Clinical Conditions by Prevalence

This measure reports the five most prevalent behavioral health clinical conditions for the Medicaid FFS beneficiaries, separately for the pediatric, adult, and individuals with disabilities groups.

Template:	Template 2: Beneficiary needs
Measure domain:	Beneficiary needs
Measure tier:	Core Access
Typical data type:	Medicaid enrollment and claims
Additional guidance:	Report behavioral health clinical conditions at the three-digit ICD-10-CM level. Report the five most prevalent behavioral health clinical conditions by ICD-10 category for each of the following enrollment categories: • Pediatric • Adult • Individuals with disabilities The template tool will automatically calculate the prevalence rate for each condition using the count of Medicaid FFS beneficiaries for each condition. The number of Medicaid FFS beneficiaries is reported in the Template 1 measure, Medicaid FFS Beneficiaries in the Following Three Populations: Pediatrics, Adult, and Individuals with Disabilities.

Reporting guidance

Count:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) with one or more paid claims with a primary diagnosis falling into the given ICD-10 category. List the five most prevalent behavioral health ICD-10 categories and the number of unique Medicaid FFS beneficiaries (de-duplicated total) with at least one claim belonging to the category.
Data source:	MMIS or data warehouse

Ability to Get Care

This measure reports the ability of Medicaid FFS beneficiaries to get care in the last six months.

Template:	Template 2: Beneficiary needs
Measure domain:	Beneficiary needs
Measure tier:	Core Access
Typical data type:	Call center data, survey data, or other assessments
Additional guidance:	Any one of reporting options 1 through 5 could be used for this measure. These options represent questions from the CAHPS Adult and Child Medicaid Survey. Several other established surveys also collect information about ability to get care for adult and pediatric populations and could be used for this measure. These alternative survey questions include reporting options 6 through 8: • Reporting option 6 is similar to reporting option 1 • Reporting option 7 is similar to reporting option 2 • Reporting option 8 is similar to reporting option 5 State Medicaid beneficiary surveys that collect information about ability to get care for adult and pediatric populations could also be used for this measure.[6] See Appendix A for more information about CAHPS, NHIS, and MEPS.

Reporting option 1

Measure set:	CAHPS Health Plan Survey (Adult and Child Medicaid Survey Version 5.0)
Measure name:	In the last six months, when you needed care right away, how often did you get care as soon as you needed?
Numerator:	Count number of unique adults (de-duplicated total) who responded "Sometimes" and "Never" for the measure
Denominator:	Count number of unique adult survey respondents (de-duplicated total) for the measure
Data source:	Patient survey

[6] For example, Wyoming developed a Medicaid Beneficiary Survey and reported results in its 2016 AMRP. Similar to the CAHPS survey, the survey asked, "When care was needed right away, how often was care received as soon as needed?" The numerator was the total number of respondents responding "Always" or "Usually."

Ability to Get Care (continued)

Reporting option 2

Measure set:	CAHPS Health Plan Survey (Adult and Child Medicaid Survey Version 5.0)
Measure name:	In the last six months, when your child needed care right away, how often did your child get care as soon as you thought he or she needed?
Numerator:	Count number of unique children (parents/guardians) (de-duplicated total) who responded "Sometimes" and "Never" for the measure
Denominator:	Count number of unique child (parent/guardian) survey respondents (de-duplicated total) for the measure
Data source:	Patient survey

Reporting option 3

Measure set:	CAHPS Health Plan Survey (Adult and Child Medicaid Survey Version 5.0)
Measure name:	In the last six months, how often did you get an appointment for routine care at a doctor office or clinic as soon as you needed?
Numerator:	The number of unique adults (de-duplicated total) who responded "Always" and "Usually" for the measure
Denominator:	The number of unique adult survey respondents (de-duplicated total) for the measure
Data source:	Patient survey

Reporting option 4

Measure set:	CAHPS Health Plan Survey (Adult and Child Medicaid Survey Version 5.0)
Measure name:	In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
Numerator:	The number of unique adults (de-duplicated total) who responded "Always" and "Usually" for the measure
Denominator:	The number of unique adult survey respondents (de-duplicated total) for the measure
Data source:	Patient survey

Ability to Get Care (continued)

Reporting option 5

Measure set:	CAHPS Health Plan Survey (Adult and Child Medicaid Survey Version 5.0)
Measure names:	In the last six months, were you ever not able to get medical care, tests or treatments you or your doctor believed necessary?
Numerator:	The number of unique adults (de-duplicated total) who responded "Always" and "Usually" for the measure
Denominator:	The number of unique adult survey respondents (de-duplicated total) for the measure
Data source:	Patient survey

Reporting option 6

Measure set:	Adult Access to Health Care & Utilization
Measure name:	Have you delayed getting care for any of the following reasons in the past 12 months?
Numerator:	The number of unique Medicaid and CHIP respondents (de-duplicated total) who responded "Yes" for any reason for the assessment period
Denominator:	The number of unique Medicaid and CHIP respondents (de-duplicated total) for the measure for the assessment period
Data source:	National Health Interview Survey

Reporting option 7

Measure set:	Child Access to Health Care & Utilization
Measure name:	Have you delayed getting care for (child) for any of the following reasons in the past 12 months?
Numerator:	The number of unique Medicaid and CHIP respondents (de-duplicated total) who responded "Yes" for any reason for the assessment period
Denominator:	The number of unique Medicaid and CHIP respondents (de-duplicated total) for the measure for the assessment period
Data source:	National Health Interview Survey

Ability to Get Care (continued)

Reporting option 8

Measure set:	Access to Care
Measure name:	In the last 12 months, was anyone in the family unable to obtain medical care, tests, or treatments they or a doctor believed necessary?
Numerator:	Count the number of unique respondents (de-duplicated total) who responded "Yes"
Denominator:	The number of unique Medicaid and CHIP respondents (de-duplicated total) for the measure for the assessment period
Data source:	MEPS

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IV. TEMPLATES 3–8: MEASURES APPLICABLE TO MULTIPLE SERVICE TYPES

This chapter provides guidance for reporting Core Access measures (CAM) and Optional Core Access measures (OCAM) that are applicable to multiple service types. The service types are as follows:

- Template 3: Primary care
- Template 4: Physician Specialist
- Template 5: Pre- and Post-natal Obstetrics
- Template 6: Home Health Services
- Template 7: Behavioral Health
- Template 8: Other service

Each CAM and OCAM below may be reported for service types 1–7, in each of the past three years, in each geographic region defined by the state. If reporting an additional service category in Template 8, that measure would also be reported for the past three years and for each geographic region defined by the state.

- Number of Providers Enrolled in Medicaid
- Number of Licensed Providers
- Participation Among Medicaid-Enrolled Providers
- Number of Beneficiaries Served
- Number of Providers Who Billed CPT or Modifier Codes Indicating That They Saw New Clients for This Provider Type
- Composite Score for Getting Needed Care
- Ease of Referral for Medicaid Patients
- Number of Health Professional Shortage Areas
- Average Distance (in Miles) to Reach Provider Among Beneficiaries
- Average Driving Time (in Minutes) to Reach Provider Among Beneficiaries
- Secret Shopper Measures
- Number of Services Delivered to Medicaid Beneficiaries by Provider Type
- Number of Medicaid Beneficiaries Who Use Telemedicine Services
- Number of Telemedicine Services Provided to Medicaid Beneficiaries
- Top Five Originating Sites of Telemedicine Services Provided to Medicaid Beneficiaries

Number of Providers Enrolled in Medicaid

This measure reports the number of unique Medicaid-enrolled providers (de-duplicated total) by provider type.

Template:	Templates 3–8: All Service Types
Measure domain:	Availability of care and providers
Measure tier:	Core Access
Typical data type:	Provider enrollment
Additional guidance:	The template tool includes a list of suggested provider types for each service type. States may also define provider types for each service type. Provider types may be aggregated into rolled-up categories for reporting purposes. The template tool will automatically calculate the ratio of enrolled providers to licensed providers for each geographic region and service type. Information on licensed providers is reported in the Template 3–8 measure, Number of Licensed Providers for this Provider Type. The template tool will automatically calculate the ratio of Medicaid FFS beneficiaries to Medicaid-enrolled providers for each enrollment category, geographic region, and service type. Information on Medicaid FFS beneficiaries by provider type is reported in the measure, Number of Beneficiaries Served.

Reporting option 1

Count:	The number of unique providers (de-duplicated total) enrolled in Medicaid for a given provider type (for example, family practice physician, licensed clinical social worker, or home health aide) *at any time during* the measurement period.
Data source:	Provider enrollment

Reporting option 2

Count:	The number of unique providers (de-duplicated total) enrolled in Medicaid for a given provider type (for example, family practice physician, licensed clinical social worker, home health aide) *on the last day of* the measurement period.
Data source:	Provider enrollment

Number of Licensed Providers

This measure reports the number of unique licensed providers (de-duplicated total) by provider type.

Template:	Templates 3–8: All Service Types
Measure domain:	Availability of care and providers
Measure tier:	Core Access
Typical data type:	Area Health Resources Files, state database of licensed providers, state medical board, third-party data on licensed providers
Additional guidance:	This measure identifies the number of unique licensed providers (de-duplicated total) by provider type and region, regardless of Medicaid enrollment status. The template tool includes a list of suggested provider types for each service type. States may also define provider types for each service type. Provider types may be aggregated into rolled-up categories for reporting purposes. The template tool will automatically calculate the ratio of enrolled providers to licensed providers for each geographic region and service type. Information on enrolled providers by provider type is reported in the measure, Number of Providers Enrolled in Medicaid.

Reporting option 1

Count:	The number of unique licensed providers (de-duplicated total) for a given provider type (for example, family practice physician, licensed clinical social worker, home health aide) *at any time during* the measurement period.
Data source:	Area Health Resources Files, state database of licensed providers, state medical board, third-party data on licensed providers

Reporting option 2

Count:	The number of unique licensed providers (de-duplicated total) for a given provider type (for example, family practice physician, licensed clinical social worker, or home health aide) *on the last day of* the measurement period.
Data source:	Area Health Resources Files, state database of licensed providers, state medical board, third-party data on licensed providers

Participation Among Medicaid-Enrolled Providers 1: Number of Billing (Active) Medicaid-Enrolled Providers

This measure reports the number of unique active providers (de-duplicated total) – providers who billed at least one Medicaid claim – by provider type.

Template:	Templates 3–8: All Service Types
Measure domain:	Availability of care and providers
Measure tier:	Optional Core Access
Typical data type:	Medicaid claims
Additional guidance:	The template includes two alternative methods for reporting participation among Medicaid-enrolled providers. This guidance is for the first method, Number of Billing (Active) Medicaid-enrolled Providers. Guidance for the second method, Level of Participation Among Medicaid-Enrolled Providers, is found on page 23. States may choose to report this measure using one or both methods. Providers are considered active if they bill at least one Medicaid claim during the measurement period. The template tool includes a list of suggested provider types for each service type. States may also define provider types for each service type. Provider types may be aggregated into rolled-up categories for reporting purposes. For this measure, the template tool will automatically calculate the ratio of billing (active) providers to enrolled providers for each geographic region and provider type. Information on enrolled providers by provider type is reported in the measure, Number of Providers Enrolled in Medicaid. For this measure, the template tool will automatically calculate the ratio of providers accepting new Medicaid patients to the number of billing Medicaid-enrolled providers for each geographic region and provider type. Information on the number of providers accepting new Medicaid patients is reported in the measure, Number of Providers Who Billed CPT or Modifier Codes Indicating That They Saw New Clients for This Provider Type.

Reporting guidance

Count:	The number of unique providers (de-duplicated total) for a given provider type (for example, family practice physician, licensed clinical social worker, home health aide) that billed at least one Medicaid claim during the measurement period.
Data source:	MMIS or data warehouse, provider enrollment

Participation Among Medicaid-Enrolled Providers 2: Level of Participation Among Medicaid-Enrolled Providers

This measure reports the number of unique providers (de-duplicated total) – categorized by number of Medicaid beneficiaries served during the measurement year – by provider type.

Template:	Templates 3–8: All Service Types
Measure domain:	Availability of care and providers
Measure tier:	Optional Core Access
Typical data type:	Medicaid claims
Additional guidance:	The template includes two alternative methods for reporting participation among Medicaid-enrolled providers. This guidance is for the second method, Level of Participation Among Medicaid-Enrolled Providers. Guidance for the first method, Number of Billing (Active) Medicaid-enrolled Providers, is found on page 22. States may choose to report this measure using one or both methods. The template tool includes a list of suggested provider types for each service type. States may also define provider types for each service type. Provider types may be aggregated into rolled-up categories for reporting purposes. For this measure, the template tool will automatically calculate for each geographic region and provider type: (1) the ratio of inactive providers to Medicaid enrolled providers, (2) the ratio of limited-participation providers to Medicaid enrolled providers, and (3) the ratio of active providers to Medicaid enrolled providers. Information on enrolled providers by provider type is reported in the measure, Number of Providers Enrolled in Medicaid. For this measure, the template tool will automatically calculate the ratios of providers accepting new Medicaid patients to the number of active Medicaid-enrolled providers and to the number of limited-participation Medicaid-enrolled providers for each geographic region and provider type. Information on the number of providers accepting new Medicaid patients is reported in the measure, Number of Providers Who Billed CPT or Modifier Codes Indicating That They Saw New Clients for This Provider Type.

Participation Among Medicaid-Enrolled Providers 2: Level of Participation Among Medicaid-Enrolled Providers (continued)

Reporting guidance

Count:	The number of unique providers (de-duplicated total) for a given provider type (for example, family practice physician, licensed clinical social worker, home health aide) categorized by number of Medicaid FFS beneficiaries served during the measurement year: • Inactive: Providers who served no beneficiaries • Limited-participation: Providers who served between 1 and 25 beneficiaries • Active: Providers who served 26 or more beneficiaries
Data source:	MMIS or data warehouse, provider enrollment

Number of Beneficiaries Served

This measure reports the number of unique Medicaid FFS beneficiaries (de-duplicated total) served by provider type, separately for the pediatric, adult, and individuals with disabilities groups.

Template:	Templates 3–8: All Service Types
Measure domain:	Availability of care and providers
Measure tier:	Core Access
Typical data type:	Medicaid claims
Additional guidance:	The template tool includes a list of suggested provider types for each service type. States may also define provider types for each service type. Provider types may be aggregated into rolled-up categories for reporting purposes. Report population totals for each of the following enrollment categories: • Pediatric • Adult • Individuals with disabilities The template tool will automatically calculate the ratio of Medicaid FFS beneficiaries to Medicaid-enrolled providers for each enrollment category, geographic region, and service type. Information on enrolled providers by provider type is reported in the measure, Number of Providers Enrolled in Medicaid.

Reporting option 1

Count:	For each enrollment category, the number of unique Medicaid FFS beneficiaries (de-duplicated total) *with at least six months of enrollment during* the measurement year who received services from a provider, by provider type
Data source:	MMIS or data warehouse

Reporting option 2

Count:	For each enrollment category, the number of unique Medicaid FFS beneficiaries (de-duplicated total) *enrolled in Medicaid as of the last day of* the measurement year who received services from a provider, by provider type
Data source:	MMIS or data warehouse

Number of Providers Who Billed CPT or Modifier Codes Indicating That They Saw New Clients for This Provider Type

This measure reports the number of unique providers (de-duplicated total) who billed CPT or modifier codes indicating that they saw new Medicaid clients, by provider type.

Template:	Templates 3–8: All Service Types
Measure domain:	Availability of care and providers
Measure tier:	Core Access
Typical data type:	Medicaid claims
Additional guidance:	The template tool includes a list of suggested provider types for each service type. States may also define provider types for each service type. Provider types may be aggregated into rolled-up categories for reporting purposes. According to CMS, a patient is considered new if he or she has not seen the provider in three or more years.[7] CPT codes indicating that a provider saw a new Medicaid client include 99234–99238, 99341–99345, and 99201–99205. HCPCS codes indicating that a provider saw a new Medicaid client include G0466, G0469, G9481–G9485, S0610, and S0620. The CPT modifier 25 can be used in some circumstances to indicate treatment of a new patient. States are not restricted to using these codes to identify providers who saw new clients, and should replace or supplement these codes as appropriate. If states report the measure Participation Among Medicaid-Enrolled Providers 1: Number of Billing (Active) Medicaid-Enrolled Providers, the template tool will automatically calculate the ratio of providers accepting new Medicaid patients to the number of billing Medicaid-enrolled providers for each geographic region and provider type. If states report the measure Participation Among Medicaid-Enrolled Providers 2: Level of Participation Among Medicaid-Enrolled Providers, the template tool will automatically calculate the ratios of providers accepting new Medicaid patients to the number of active Medicaid-enrolled providers and to the number of limited participation Medicaid-enrolled providers, for each geographic region and provider type.

[7] The CMS definition of *new patient* is available in the CMS Medicare Claims Processing Manual, accessible at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf.

Number of Providers Who Billed CPT or Modifier Codes Indicating That They Saw New Clients for This Provider Type (continued)

Reporting guidance

Count:	The number of unique providers (de-duplicated total) for a given provider type (for example, family practice physician, licensed clinical social worker, home health aide) who billed at least one claim during the measurement period with a CPT or modifier code indicating that they saw new Medicaid clients.
Data source:	MMIS or data warehouse, provider enrollment

Composite Score for Getting Needed Care

This measure reports the percentage of beneficiaries that reported it was always, usually, sometimes, and never easy to get needed care.

Template:	Templates 3–8: All Service Types
Measure domain:	Availability of care
Measure tier:	Additional
Typical data type:	Survey of Medicaid FFS populations
Additional guidance:	The CAHPS Getting Care Quickly composite measure incorporates two CAHPS measures: • In the last six months, how often did you get an appointment to see a specialist as soon as you needed? • In the last six months, how often was it easy to get the care, tests, or treatment you needed? The template tool includes a list of provider types for each service type. States may also define provider types for each service type. Provider types may be aggregated into rolled-up categories for reporting purposes. See Appendix A for more information about CAHPS.

Reporting guidance

Measure set:	CAHPS Health Plan Survey (Adult and Child Medicaid Survey Version 5.0)
Measure name:	Getting Needed Care Composite
Numerator:	Count number of unique adults/children (de-duplicated total) who responded “Always” and “Usually” for both measures included in the composite
Denominator:	Count number of unique adult/child survey respondents (de-duplicated total) for both measures included in the composite
Data source:	Patient survey

Ease of referral for Medicaid patients

This measure reports the percentage of providers who reported "usually" or "always" being able to refer Medicaid patients for selected services.

Template:	Templates 4–8
Measure domain:	Availability of care
Measure tier:	Additional
Typical data type:	Provider survey
Additional guidance:	This measure can be reported for Templates 4–8. Do not report this measure for Template 3.

Reporting guidance

Measure set:	Physician Workforce Survey[8]
Measure name:	How often are you able to obtain access to the following for your Medicaid patients when you think it is medically necessary?
Numerator:	The number of unique providers (de-duplicated total) who reported "usually" or "always" being able to refer Medicaid patients for selected services.
Denominator:	The number of unique providers (de-duplicated total) who answered this survey question.
Data source:	Provider survey

[8] The 2015 Oregon Physician Workforce Survey Instrument and Report is are available at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Workforce-Survey.aspx.

Number of Health Professional Shortage Areas

The measures report the number of unique primary care, behavioral health, and dental HPSAs (de-duplicated total) by county.

Template:	Templates 3 and 7
Measure domain:	Availability of care
Measure tier:	Additional
Typical data types:	HRSA Data Warehouse[9]
Additional guidance:	The HRSA Data Warehouse is an interactive tool that produces information on HPSAs by county. This measure only applies to primary care, dental, and behavioral health services (Templates 3 and 7). It should not be used to measure access for other service types. The template tool includes a list of suggested provider types for each service type. States may also define provider types for each service type. Provider types may be aggregated into rolled-up categories for reporting purposes. See Appendix A for more information about the HRSA Data Warehouse.

Reporting guidance

Count:	The number of unique HPSAs (de-duplicated total) by county
Data source:	HRSA Data Warehouse

[9] The HRSA Data Warehouse is available at http://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx.

Average Distance to Reach Provider Among Beneficiaries

This measure reports the average driving distance in miles to reach providers among Medicaid FFS beneficiaries.

Template:	Template 3–8: All Service Types
Measure domain:	Availability of care
Measure tier:	Additional
Typical data type:	Medicaid enrollment and provider enrollment
Additional guidance:	States may employ commercial-off-the-shelf products or other software tools, such as GIS or Google's Application Programming Interface, to calculate average distance. In place of beneficiary home address, states may opt to use other geographical identifiers, such the centroid of a geographic area (for example, zip code, census district, or town centroid) or referral hospital to calculate distances to providers. States may also employ beneficiary surveys to collect information on average distance.

Reporting option 1

Measure set:	N.A.
Measure name:	N.A.
Numerator:	The sum of driving distances in miles from each beneficiary's home address to the nearest Medicaid-enrolled provider of a given service type
Denominator:	The number of unique Medicaid FFS beneficiaries (de-duplicated total)
Data source:	MMIS or data warehouse, provider enrollment

Reporting option 2

Measure set:	Washington State Health Care Consumer Survey[10]
Measure name:	How many miles is it to your <location>?
Numerator:	The total number of respondents who responded 1–4 miles, 5–9 miles, 10–19 miles, 20–29 miles, 30–39 miles, 40–49 miles and 50+ miles
Denominator:	The total number of survey respondents
Data source:	Beneficiary survey

[10] The Washington State Health Care Consumer Survey Data Report is available at https://www.ofm.wa.gov/sites/default/files/public/legacy/healthcare/pdf/health_care_data_report.pdf.

Average Driving Time to Reach Provider Among Beneficiaries

This measure reports the average driving time in minutes to reach providers among beneficiaries.

Template:	Template 3–8: All Service Types
Measure domain:	Availability of care
Measure tier:	Additional
Typical data type:	Medicaid enrollment and provider enrollment
Additional guidance:	States may employ commercial-off-the-shelf products or other software tools, such as GIS or Google's Application Programming Interface, to calculate average driving time. In place of beneficiary home address, states may opt to use other geographical identifiers, such the centroid of a geographic area (for example, zip code, census district, or town centroid) or referral hospital to calculate driving time to providers. States may also employ beneficiary surveys to collect information on average driving time.

Reporting option 1

Measure set:	N.A.
Measure name:	N.A.
Numerator:	The sum of driving times in minutes from each beneficiary's home address to the nearest Medicaid-enrolled provider of a given service type
Denominator:	The number of unique Medicaid FFS beneficiaries (de-duplicated total)
Data source:	MMIS or data warehouse, provider enrollment

Reporting option 2

Measure set:	Washington State Health Care Consumer Survey[11]
Measure name:	How long does it usually take you to get to your <location>?
Numerator:	The total number of respondents who responded 1–15 minutes, 16–30 minutes, 31–45 minutes, 46–60 minutes, and 61+ minutes
Denominator:	The total number of survey respondents
Data source:	Beneficiary survey

[11] The Washington State Health Care Consumer Survey Data Report is available at https://www.ofm.wa.gov/sites/default/files/public/legacy/healthcare/pdf/health_care_data_report.pdf.

Secret Shopper Measures

These measures report information about patient experiences with providers that was obtained through a secret shopper program.

Template:	Templates 3–8: All Service Types
Measure domain:	Availability of care and providers
Measure tier:	Additional
Typical data type:	Secret shopper survey
Additional guidance:	States could report one or all secret shopper measures listed as reporting options.
	Compliance thresholds are determined by the state and may differ by service type. If reporting the percentage of appointments within compliance standards, also report the threshold level. For example, compliance thresholds may be set at 30 days for routine appointments and 48 hours for urgent care.
	The template tool includes a list of suggested provider types for each service type. States may also define provider types for each service type. Provider types may be aggregated into rolled-up categories for reporting purposes.

Reporting option 1

Measure set:	N.A.
Measure name:	Able to schedule appointment by provider type
Numerator:	The total number of outreach calls to a provider that resulted in an appointment being scheduled
Denominator:	The total number of outreach calls to a provider
Data source:	Secret shopper survey

Reporting option 2

Measure set:	N.A.
Measure name:	Unable to schedule appointment by provider type
Numerator:	The total number of outreach calls to a provider that failed to secure an appointment
Denominator:	The total number of outreach calls to a provider
Data source:	Secret shopper survey

Secret Shopper Measures (continued)

Reporting option 3

Measure set:	N.A.
Measure name:	Appointments within compliance standards by provider type
Numerator:	The total number of outreach calls to a provider that secured an appointment within compliance standards
Denominator:	The total number of outreach calls to a provider
Data source:	Secret shopper survey

Reporting option 4

Measure set:	N.A.
Measure name:	Appointments within compliance standards for routine appointments by provider type
Numerator:	The total number of outreach calls for routine appointments to a provider that secured an appointment within compliance standards
Denominator:	The total number of outreach calls for routine appointments to a provider
Data source:	Secret shopper survey

Reporting option 5

Measure set:	N.A.
Measure name:	Appointments within compliance standards for urgent appointments by provider type
Numerator:	The total number of outreach calls for urgent appointments to a provider that secured an appointment within compliance standards
Denominator:	The total number of outreach calls for urgent appointments to a provider
Data source:	Secret shopper survey

Secret Shopper Measures (continued)

Reporting option 6

Measure set:	N.A.
Measure name:	Contact made by provider type for routine appointments
Numerator:	The total number of outreach calls for routine appointments to a provider that resulted in a telephone discussion with a provider or provider representative (such as a receptionist)
Denominator:	The total number of outreach calls for routine appointments to a provider
Data source:	Secret shopper survey

Reporting option 7

Measure set:	N.A.
Measure name:	Contact made by provider type for urgent appointments
Numerator:	The total number of outreach calls for urgent appointments to a provider that resulted in a telephone discussion with a provider or provider representative (such as a receptionist)
Denominator:	The total number of outreach calls for urgent appointments to a provider
Data source:	Secret shopper survey

Number of Services Delivered to Medicaid Beneficiaries by Provider Type

This measure reports the total number of Medicaid services delivered to beneficiaries by provider type, separately for the pediatric, adult, and individuals with disabilities groups.

Template:	Templates 3–8: All Service Types
Measure domain:	Utilization of services
Measure tier:	Core Access
Typical data type:	Medicaid enrollment and claims
Additional guidance:	Report the number of services delivered to Medicaid FFS beneficiaries for each of the following enrollment categories: • Pediatric • Adult • Individuals with disabilities The template tool will automatically calculate the ratio of services delivered to Medicaid FFS beneficiaries for each enrollment category, geographic region, and service type. Information on Medicaid FFS beneficiaries is reported in the measure, Medicaid FFS Beneficiaries in the Following Three Populations: Pediatric, Adult, and Individuals with Disabilities. The template tool includes a list of suggested provider types for each service type. States may also define provider types for each service type. Provider types may be aggregated into rolled-up categories for reporting purposes.

Reporting guidance

Count:	The total number of claims for a given provider type (for example, family practice physician, licensed clinical social worker, or home health aide)
Data source:	MMIS or data warehouse

Number of Medicaid Beneficiaries Who Use Telemedicine Services

This measure reports the number of Medicaid FFS beneficiaries who received telemedicine services.

Template:	Templates 3–8: All Service Types
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	Medicaid claims data
Additional guidance:	None

Reporting guidance

Count:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) who had a claim for telemedicine services during the measurement period
Data source:	MMIS or data warehouse

Number of Telemedicine Services Provided to Medicaid Beneficiaries

This measure reports the number of telemedicine services provided to Medicaid FFS beneficiaries.

Template:	Templates 3–8: All Service Types
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	Medicaid claims
Additional guidance:	None

Reporting option 1

Count:	The total number of claims paid to Medicaid-enrolled providers for telemedicine services delivered to Medicaid FFS beneficiaries
Data source:	MMIS or data warehouse

Top Five Originating Sites of Telemedicine Services Provided to Medicaid Beneficiaries

This measure reports the five most common originating sites for telemedicine services.

Template:	Templates 3–8: All Service Types
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	Medicaid claims
Additional guidance:	An originating site is the location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs. In many states, originating sites use HCPCS code Q3014 to bill for the facility fee. States may be able to use this code to identify originating sites.[12]

Reporting option 1

Count:	The number of unique Medicaid FFS claims for telemedicine services at each originating site. Report the name of the five most common originating sites of telemedicine services and the number of services provided at each of those sites.
Data source:	MMIS or data warehouse

[12] https://www.medicaid.gov/medicaid/benefits/telemed/index.html.

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V. TEMPLATE 3: PRIMARY CARE

This chapter provides guidance for reporting Additional measures that are applicable to Template 3. All Template 3 Additional measures may be reported for the past three years and for each geographic region defined by the state. These measures are as follows:

- Adults' Access to Preventive or Ambulatory Health Services
  - Adult
  - Individuals with Disabilities
- Breast Cancer Screening
- Annual Dental Visits
  - Pediatric
  - Adult
  - Individuals with Disabilities
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits

Adults' Access to Preventive or Ambulatory Care

This measure assesses the percentage of adult Medicaid FFS beneficiaries with access to preventive and/or ambulatory care.

Template:	Template 3: Primary Care
Measure domain:	Availability of care and providers Utilization of services
Measure tier:	Additional
Typical data type:	Medicaid claims, Medicaid enrollment
Additional guidance:	Report population totals for each of the following enrollment categories: • Adult • Individuals with disabilities See Appendix A for more information about HEDIS.

Reporting guidance

Measure set:	HEDIS
Measure name:	Adults' Access to Preventive/Ambulatory Health Services
Numerator:	Number of unique adult Medicaid FFS beneficiaries (de-duplicated total) with one or more ambulatory or preventative care visits during the measurement year.
Denominator:	Number of unique Medicaid FFS beneficiaries (de-duplicated total) ages 20 or older as of December 31 in the measurement year.
Data source:	MMIS or data warehouse

Breast Cancer Screening

This measure assesses the percentage of female Medicaid FFS beneficiaries ages 50–74 who had a breast cancer screening in the past two years.

Template:	Template 3: Primary Care
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	Medicaid claims
Additional guidance:	See Appendix A for more information about HEDIS and Healthy People 2020.
Reporting option 1	
Measure set:	HEDIS
Measure name:	Breast cancer screening
Numerator:	Number of unique female Medicaid FFS beneficiaries (de-duplicated total) ages 50 to 74 who had at least one mammogram to screen for breast cancer in the past two years
Denominator:	Number of unique female Medicaid FFS beneficiaries (de-duplicated total) ages 50 to 74 years without a bilateral mastectomy or two single mastectomies
Data source:	MMIS or data warehouse
Reporting option 2	
Measure set:	Healthy People 2020
Measure name:	C-17. Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines
Numerator:	Number of unique female Medicaid FFS beneficiaries (de-duplicated total) ages 50 to 74 years who have had a mammogram in the past two years
Denominator:	Number of unique female Medicaid FFS beneficiaries (de-duplicated total) ages 50 to 74 years
Data source:	MMIS or data warehouse

Annual Dental Visits

This measure reports the percentage of Medicaid FFS beneficiaries with at least one dental visit during the measurement year, separately for the pediatric, adults, and individuals with disabilities groups.

Template:	Template 3: Primary Care
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	Medicaid claims
Additional guidance:	Report population totals for each of the following enrollment categories: • Pediatric • Adult • Individuals with disabilities Under the EPSDT benefit, states are required to provide comprehensive and preventive health care services, including dental, for children under age 21 who are enrolled in Medicaid.[13] Therefore, for the pediatric population, report the percentage of beneficiaries under age 21 who had one or more dental visits with a dental practitioner. Note that the definitions for the pediatric and adult populations differ for this measure than other measures included in the template. See Appendix A for more information about form CMS-416, EPSDT, HEDIS, Health People 2020, and MEPS.

Reporting option 1

Measure set:	HEDIS
Measure name:	Annual Dental Visits
Numerator:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) with a claim for one or more dental visit with a dental practitioner
Denominator:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) as of the last day of the measurement year
Data source:	MMIS or data warehouse, CMS-416

[13] https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

Annual Dental Visits (continued)

Reporting option 2

Measure set:	Healthy People 2020
Measure name:	OH-7. Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year
Numerator:	Number of persons aged 2 years or older who report having had a dental visit in the past 12 months
Denominator:	Number of persons aged 2 years or older
Data source:	MEPS

Well-Child Visits in the First 15 Months of Life

This measure reports the percentage of Medicaid FFS beneficiaries ages 0–15 months with between zero and six well-child visits with a primary care physician.

Template:	Template 3: Primary Care
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	Medicaid claims
Additional guidance:	Seven separate numerators are calculated, corresponding to the number of beneficiaries who received 0, 1, 2, 3, 4, 5, or 6 or more well-child visits during their first 15 months of life. Under the EPSDT benefit, states are required to provide comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.[14] See Appendix A for more information about form CMS-416, EPSDT, and HEDIS.

Reporting guidance

Measure set:	HEDIS
Measure name:	Well-Child Visits in the First 15 Months of Life
Numerator:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) with 0, 1, 2, 3, 4, 5, or 6 or more paid claims for well-child visits with a primary care physician during the first 15 months of life
Denominator:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) ages 15 months or younger as of the last day of the measurement year
Data source:	MMIS or data warehouse, CMS-416

[14] https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

This measure reports the percentage of Medicaid FFS beneficiaries ages 3–6 years with at least one well-child visit with a primary care practitioner during the measurement year.

Template:	Template 3: Primary Care
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	Medicaid claims
Additional guidance:	Under the EPSDT benefit, states are required to provide comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.[15] See Appendix A for more information about form CMS-416, EPSDT, and HEDIS.

Reporting guidance

Measure set:	HEDIS
Measure name:	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Numerator:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) with at least one paid claim for a well-child visit with a primary care practitioner in the measurement year
Denominator:	The total unduplicated number of Medicaid FFS beneficiaries between ages 3–6 as of the last day of the measurement year
Data source:	MMIS or data warehouse, CMS-416

[15] https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

Adolescent Well-Care Visits

This measure reports the percentage of adolescent and young adult Medicaid FFS beneficiaries with at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Template:	Template 3: Primary Care
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	Medicaid claims
Additional guidance:	Under the EPSDT benefit, states are required to provide comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.[16] See Appendix A for more information about form CMS-416, EPSDT, and HEDIS.

Reporting guidance

Measure set:	HEDIS
Measure name:	Adolescent Well-Care Visits
Numerator:	The total number of Medicaid FFS beneficiaries with at least one paid claim for a comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner in the measurement year
Denominator:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) ages 12–21 as of the last day of the measurement year
Data source:	MMIS or data warehouse, CMS-416

[16] https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

VI. TEMPLATE 5: PRE- AND POST-NATAL OBSTETRICS

This chapter provides guidance for reporting Additional measures that are applicable to Template 5. All Template 5 Additional measures may be reported for the past three years and for each geographic region defined by the state. These measures are as follows:

- Percentage of Deliveries That Had One Timely Prenatal Visit
- Frequency of Ongoing Prenatal Care
- Percentage of Deliveries That Had One Timely Postnatal Visit
- Proportion of Women Who Received Early and Adequate Prenatal Care

Percentage of Deliveries That Had at Least One Timely Prenatal Visit

This measure reports the percent of deliveries to Medicaid FFS beneficiaries that had at least one timely prenatal visit.

Template:	Template 5: Pre- and Post-natal Obstetrics
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	HEDIS
Additional guidance:	PRAMS can be used to identify Medicaid beneficiaries but cannot differentiate Medicaid FFS and Medicaid MCO beneficiaries. See Appendix A for more information about HEDIS, Healthy People 2020, and PRAMS.

Reporting option 1

Measure set:	HEDIS
Measure name:	Timeliness of Prenatal Care
Numerator:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) who had at least one claim for a prenatal visit in the first trimester or within 42 days of enrollment in the organization
Denominator:	The number of unique of Medicaid FFS beneficiaries (de-duplicated total) who delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year
Data source:	MMIS or data warehouse

Reporting option 2

Measure set:	Healthy People 2020
Measure name:	MICH-10.1. Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester
Numerator:	The unique number of births to female Medicaid FFS beneficiaries receiving prenatal care in the first trimester (three months) of pregnancy in states that use the 2003 standard certificate of birth
Denominator:	Number of live births to female Medicaid FFS beneficiaries in states that use the 2003 standard certificate of birth.
Data source:	MMIS or data warehouse

Percentage of Deliveries That Had at Least One Timely Prenatal Visit
(continued)

Reporting option 3

Measure set:	PRAMS
Measure name:	Core Questionnaire, Question 13: How many weeks or months pregnant were you when you had your first visit for prenatal care?
Numerator:	Total number of unique Medicaid respondents (de-duplicated total) who had a visit for prenatal care in the first trimester
Denominator:	Total number of unique Medicaid respondents (de-duplicated total)
Data source:	Survey

Frequency of Ongoing Prenatal Care

This measure reports the frequency of prenatal care relative to the expected number of prenatal care visits.

Template:	Template 5: Pre- and Post-natal Obstetrics
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	Medicaid claims
Additional guidance:	Five separate numerators are calculated, corresponding to the number of Medicaid FFS beneficiaries who had different percentages of the number of expected prenatal visits. The National Committee for Quality Assurance retired this measure beginning with HEDIS 2018. However, states have the option to continue reporting on this measure. See Appendix A for more information about HEDIS.

Reporting guidance

Measure set:	HEDIS
Measure name:	Frequency of Ongoing Prenatal Care
Numerator:	Female Medicaid FFS beneficiaries who had an unduplicated count of < 21 percent, 21 percent through 40 percent, 41 percent through 60 percent, 61 percent through 80 percent or ≥ 81 percent of the number of expected prenatal visits, adjusted for the month of pregnancy at time of enrollment and gestational age
Denominator:	Total unduplicated count of Medicaid FFS beneficiaries who delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year
Data source:	MMIS or data warehouse

Percentage of Deliveries That Had at Least One Timely Postnatal Visit

This measure reports the percent of Medicaid FFS deliveries with timely postnatal care.

Template:	Template 5: Pre-and Post-natal Obstetrics
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	HEDIS
Additional guidance:	PRAMS can be used to identify Medicaid beneficiaries but cannot differentiate Medicaid FFS and Medicaid MCO beneficiaries. See Appendix A for more information about HEDIS, Healthy People 2020, and PRAMS.

Reporting option 1

Measure set:	HEDIS
Measure name:	Prenatal and Postpartum Care
Numerator:	The total number of Medicaid FFS beneficiaries with a claim for a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review
Denominator:	The number of unique Medicaid FFS beneficiaries (de-duplicated total) who delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year
Data source:	MMIS or data warehouse

Reporting option 2

Measure set:	Healthy People 2020
Measure name:	MICH-19. Increase the proportion of women giving birth who attend a postpartum care visit with a health care worker
Numerator:	The number of unique female Medicaid FFS beneficiaries (de-duplicated total) with a recent live birth who attended a postpartum care visit with a health care worker four to six weeks after the birth
Denominator:	The number of unique female Medicaid FFS beneficiaries with a recent live birth
Data source:	MMIS or data warehouse

Percentage of Deliveries That Had at Least One Timely Postnatal Visit (continued)

Reporting option 3

Measure set:	PRAMS
Measure name:	Core Questionnaire, Question 46: Since your new baby was born, have you had a postpartum checkup for yourself? A postpartum checkup is the regular checkup a woman has about four to six weeks after she gives birth.
Numerator:	The number of unique Medicaid respondents (de-duplicated total) who reported that they had a postpartum checkup
Denominator:	The number of unique Medicaid respondents
Data source:	Survey

Proportion of Women Who Received Early and Adequate Prenatal Care

This measure reports the proportion of female Medicaid FFS beneficiaries who received early and adequate prenatal care.

Template:	Template 5: Pre- and Post-natal Obstetrics
Measure domain:	Utilization of services
Measure tier:	Additional
Typical data type:	Certificate of Live Birth
Additional guidance:	This measure uses the APNCU Index, a prenatal care utilization measure that combines the month of pregnancy prenatal care begun with the number of prenatal visits. Rates can be classified as "intensive use," "adequate," "intermediate," or "less than adequate." For this measure, adequate prenatal care is defined as a score of either "adequate" or "intensive use." Prenatal care adequacy is determined by calculating from the date of the last menstrual period, date of the first prenatal visit, and number of visits, as entered on the 2003 version of the U.S. State Certificate of Live Birth.[17] See Appendix A for more information about Healthy People 2020.

Reporting option 1

Measure set:	Healthy People 2020
Measure name:	MICH-10.2. Increase the proportion of pregnant women who receive early adequate prenatal care
Numerator:	The number of births to female Medicaid FFS beneficiaries receiving adequate prenatal care by the APNCU Index in states that use the 2003 standard certificate of birth
Denominator:	The number of live births to female Medicaid FFS beneficiaries in states that use the 2003 standard certificate of birth
Data source:	State office of vital statistics or state register

[17] https://www.healthypeople.gov/node/4834/data_details.

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VII. TEMPLATE 9: MEDICAID PAYMENT RATE COMPARISON

This chapter provides guidance for reporting payment rate comparison data in Template 9. States submitting AMRPs must compare Medicaid payment rates to other public payment rates such as Medicaid managed care payment rates, Medicare payment rates, and payment rates for private health insurers.[18] For detailed guidance on reporting payment rate comparisons, please refer to the Payment Rate Resource Toolkit, which can be accessed at (link forthcoming).

Template 9 supports two options for Medicaid payment rate comparison reporting:

- **Option 1.** Import data from the Excel-based Medicaid Payment Rate Comparison Tool. This tool allows states to enter payment rate data from Medicaid, Medicare, and other payer sources and transform that data into percentage comparisons for reporting in Medicaid Access plans. This option is recommended for states that have not determined their own methodology for reporting payment rate comparisons. Follow the steps below to use the Medicaid Payment Rate Comparison Tool:
    1. Access the tool at (link forthcoming)
    2. Enter data into the Medicaid Payment Rate Comparison Tool, as described in the Medicaid Access Tool User Guide, available at (link forthcoming)
    3. Submit the data by clicking "Generate Aggregate Table and Charts" on the summary tab of the tool to produce the results file
    4. Save the data
    5. Import the Medicaid Access Tool results file into Template 9
- **Option 2.** States may elect to calculate payment rate comparisons using state-specific methodologies by manually entering payment rate comparison data into Template 9. The structure of the data entry form in Template 9 is identical to the structure of the results file generated by the Medicaid Payment Rate Comparison Tool (see Option 1 above).

[18] The final rule with comment period states that, because the statutory provisions in Section 1902(a)(30)(A) of the act refer to payment rates and comparisons to the general population, "it is necessary for states to compare Medicaid payment rates to the rates of Medicare or private payers" (*Federal Register*, vol. 80, no. 211, November 2, 2015, p. 67585; see https://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27697.pdf). Sections of the rule related to state reporting requirements were made final on April 8, 2016. See https://www.federalregister.gov/documents/2016/04/12/2016-08368/medicaid-program-deadline-for-access-monitoring-review-plan-submissions.

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VIII. TEMPLATE 10: MECHANISMS FOR BENEFICIARY AND PROVIDER INPUT ON ACCESS TO CARE

States are required to have a mechanism for obtaining ongoing feedback from beneficiaries and providers on access to care issues.[19] Template 10 provides a guide for how states might report on beneficiary and provider input on access to care by providing the following fields:

1. **Define mechanisms for receiving feedback.** States may employ one or more methods for obtaining feedback on access to care. These methods include the following:
    a. *Call centers for beneficiaries or providers.* In many states, beneficiaries and providers may contact a call center to ask questions about Medicaid eligibility or billing, file a complaint related to dissatisfaction with a plan or provider, or otherwise relay feedback about a Medicaid experience. States may be able to use data from these centers to track calls related to access to care and the specific nature of concerns regarding access.
    b. *Patient or provider experience surveys*. Patient experience surveys assess the state of access to care for beneficiaries by asking them to report their experience with obtaining care and treatment. For example, the CAHPS Health Plan Survey is a widely used patient experience survey that includes several questions about access to care. Surveys may also be used to collect information on provider experience with access to care for Medicaid beneficiaries.
    c. *Stakeholder advisory committees and meetings*. States may convene committees or meetings for stakeholders – including beneficiaries and providers – to discuss their experiences with Medicaid and make recommendations for improvements.
    d. *Online forms for provider or beneficiary input*. States may ask beneficiaries and providers to describe or rate their experience with access to care and other topics using online forms.
2. **Specify the types of provider and beneficiary feedback data the state collects or intends to collect.** The types of data states collect on beneficiary and provider input on access to care may vary across states. For example, some call centers group all beneficiary complaints about access under one heading, whereas others track these complaints by type (such as difficulties finding a provider, issues related to long appointment wait times, or inability to obtain a referral to a specialist). States can describe the specific types of data collected (or planned to be collected) in this text entry field.
3. **Define an analysis plan based on the data to be collected.** States can describe their plans to analyze data on beneficiary or provider input on access to care. Analysis plans may include, but are not limited to, details about the following:
    - The concepts to be monitored (such as beneficiary concerns about access or factors influencing appointment wait times)

[19] See 42 CFR 447.203(b)(7) for more on state requirements for obtaining beneficiary input.

- The use of baselines, thresholds, and methods for identifying meaningful changes
- Known data quality and data availability issues, if applicable

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APPENDIX A

DATA SOURCES

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This appendix includes additional information about selected data sources referenced in the resource manual.

Table A.1. Data sources

Data source	Description	Applicable templates and measures
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	CAHPS surveys collect data on topics important to consumers and focuses on aspects of quality that consumers are best qualified to assess, such as their experiences with health plans, providers, and health care facilities. Additional detail on CAHPS surveys and guidance is available on the Agency for Healthcare Research and Quality (AHRQ) website.	• Template 2: Ability to Get Care • Templates 3–8: Composite Score for Getting Needed Care • Template 10: Mechanisms for Beneficiary Input on Access to Care
Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report	The EPSDT report provides information on participation in the Medicaid child health program and the effectiveness of state EPSDT programs in the areas of child health screening services, referrals for corrective treatment, and receipt of dental services. Child health screening services are defined as initial or periodic screens provided according to the state's screening periodicity schedule. Additional detail is available in the Early and Periodic Screening, Diagnostic, and Treatment page and the Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report on Medicaid.gov.	• Template 3: Pediatric Annual Dental Visits • Template 3: Well-Child Visits in the First 15 Months of Life • Template 3: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life • Template 3: Adolescent Well-Care Visits
Healthy People 2020	Healthy People 2020 includes more than 1,200 objectives to monitor and improve the health of all Americans over the decade. The objectives are organized into 42 topic areas, each representing an important public health area. Additional detail on Healthy People data is available at HealthyPeople.gov.	• Template 3: Breast Cancer Screening • Template 3: Annual Dental Visits • Template 5: Percentage of Deliveries That Had at Least One Timely Prenatal Visit • Template 5: Percentage of Deliveries That Had at Least One Timely Postnatal Visit • Template 5: Proportion of Women Who Received Early and Adequate Prenatal Care

Table A.1. (continued)

Data source	Description	Applicable templates and measures
Healthcare Effectiveness Data and Information Set (HEDIS)	HEDIS collects data to support analysis on performance on important dimensions of care and service. It is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans. HEDIS and its associated tools enable users to conduct competitor analyses, examine quality improvement, and benchmark plan performance. Additional detail on HEDIS measures is available on the National Committee for Quality Assurance (NCQA) website.	• Template 3: Adults' Access to Preventive and Ambulatory Care • Template 3: Breast Cancer Screening • Template 3: Annual Dental Visits • Template 3: Well-Child Visits in the First 15 Months of Life • Template 3: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life • Template 3: Adolescent Well-Care Visits • Template 5: Percentage of Deliveries That Had at Least One Timely Prenatal Visit • Template 5: Frequency of Ongoing Prenatal Care • Template 5: Percentage of Deliveries That Had at Least One Timely Postnatal Visit
Health Resources and Services Administration (HRSA) Data Warehouse— Health Professional Shortage Areas (HPSA) Find Tool	The HRSA Data Warehouse includes data on areas with shortages of primary care, dental care, or mental health providers, known as HPSAs. HPSAs can be designated based on geographic area (a county or service area), population (for example, low-income or Medicaid-eligible), or facilities (for example, federally qualified health centers, or state or federal prisons). The HRSA Data Warehouse HPSA Find Tool enables users to search for HPSAs by state and/or county and other criteria. Additional information about shortage areas is available on the HRSA Bureau of Health Workforce's Shortage Designation page.	• Templates 3 and 7: Number of Health Professional Shortage Areas (HPSAs)

Table A.1. (continued)

Data source	Description	Applicable templates and measures
Medical Expenditure Panel Survey (MEPS)	MEPS is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States. MEPS collects data on the specific health services that Americans use, how frequently they use them, the cost of these services, and how they are paid for, as well as data on the cost, scope, and breadth of health insurance held by and available to U.S. workers. The Agency for Healthcare Research and Quality (AHRQ) website includes a MEPS Data Overview page, which outlines details of the survey methodology and the data available. MEPS provides data files, codebooks, and programming examples for SAS.	• Template 2: Ability to Get Care • Template 3: Annual Dental Visits
National Health Interview Survey (NHIS)	The National Health Interview Survey (NHIS) conducted by the Centers for Disease Control and Prevention (CDC) is a cross-sectional household interview survey. NHIS collects data relating to health status, health care access, and progress on national health objectives based on demographic and socioeconomic characteristics. These data are used to monitor trends in illness and disability and to support epidemiological and policy analyses. Details on the survey instruments, data, and additional documentation are available at the CDC's National Center for Health Statistics (NCHS) National Health Interview Survey page. NHIS also provides guidance on various methods to analyze data.	• Template 2: Ability to Get Care
Pregnancy Risk Assessment Monitoring System (PRAMS)	The CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) is a survey of new mothers about their pregnancies and their new babies. PRAMS collects data related to attitudes and feelings about the pregnancy, pregnancy and birth outcomes, barriers to and content of prenatal care, preconception care, health status, and health care access. These data enable comparison of state-specific data across states and support programs and policies aiming to improve the health of mothers and babies. Details on the survey methodology and questionnaires, and additional information, are available at the CDC's Pregnancy Risk Assessment Monitoring System (PRAMS)'s page.	• Template 5: Percentage of Deliveries That Had at Least One Timely Prenatal Visit • Template 5: Percentage of Deliveries That Had at Least One Timely Postnatal Visit

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