



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

January 8, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

SUBJECT: CMS-2328-NC; Medicaid Program; Request for Information (RFI) – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program, November 2, 2015

Dear Acting Administrator Slavitt:

On behalf of our nearly 400 hospital and health system members, the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services' (CMS) request for information for data metrics and alternative processes for assessing access to care in the Medicaid program.

CHA supports the recently released Medicaid Access final rule's goals to: (1) measure and link beneficiaries' needs and utilization of services with availability of care and providers; (2) increase beneficiaries' involvement through multiple feedback mechanisms; and (3) increase stakeholder, provider and beneficiary engagement when considering proposed changes to Medicaid fee-for-service payment rates that could potentially impact beneficiaries' ability to obtain care. To support these three goals, the final rule requires states to develop an access review plan outlining the data elements and other information to be used to ensure beneficiary access to mandatory and optional services; to establish new procedures to review the effects of proposed rate reductions and payment restructuring on beneficiary access; and to implement ongoing access monitoring reviews of key services, and additional services upon a state's discretion.

Key to successful implementation of the stated goals is an action plan with clear metrics for assessing progress toward each goal. CHA appreciates CMS' efforts to seek stakeholder input on core access to care measures and metrics for assessing Medicaid beneficiary access to care in both our Medicaid fee-for-service and managed care delivery systems. Our comments are informed by our experience in California state plan amendment proposals to reduce Medicaid payment rates to providers for a number of services, as well as the access studies conducted in support of those rate reductions. Through this process we have identified a number of areas in which both the metrics, and the lens through which they are viewed when assessing adequate access to care for Medicaid beneficiaries, could be improved. We offer the following comments for CMS' consideration.

1. A Multi-Stakeholder Approach for Defining Access to Care and a National Access Strategy

In reviewing CMS' request for information seeking stakeholder input on core metrics and goal-setting for access, we are reminded of the process that CMS undertook in developing the National Quality Strategy. **Notably, CHA believes an approach similar to that taken by CMS in developing the National**

Quality Strategy would prove to be a useful exercise creating an overall action plan for the development and implementation of an access strategy. The National Quality Strategy continues to be a multi-stakeholder and multi-agency effort led by the Department of Health and Human Services, in cooperation with a voluntary effort convened by the National Quality Forum and its National Priorities Partnership. The 51 organizations that voluntarily participate in this partnership continue to play a pivotal role in identifying national goals corresponding to the priorities put forth in the National Quality Strategy; providing input on measures for tracking national progress toward the goals; and offering guidance on strategic opportunities to accelerate improvement. CHA encourages CMS to consider a similar multi-stakeholder, multi-agency approach to developing a set of core metrics and goals for the access strategy. A common definition of “access” is as challenging to achieve as a common definition of “quality care” – and the two are inextricably linked. A national discussion on a consensus definition of access, as well as the important relationship between access and quality, should be a key objective for the agency and the nation going forward.

Developing measures of access in a silo, unrelated to the key goals and objectives of the National Quality Strategy, would only dilute the opportunity to accelerate our collective improvement efforts. As previously stated, the two are inseparable and must be considered together as we continue to advance our shared goals of a more integrated and efficient health care delivery system for our most vulnerable beneficiaries.

2. Evidence-Based Definitions of Access Metrics

In previous years, CHA challenged the adequacy of the access studies put forth by the California Health and Human Services Agency (CHHSA) in support of Medicaid payment rate reductions for a number of reasons. First, the access CHHSA studies traditionally submitted to CMS have focused on the number of licensed beds and utilization of services, rather than an assessment of patient and/or community need. The challenge with such an analysis is that it presents data through a narrow lens and leaves many issues unaddressed. For example, a licensed bed may be available in a community, but that facility may be miles away from other social supports the patient needs, such as family, friends and other care givers who would aid in recovery. Often, a bed may be available, but the facility may not have appropriate staff to meet the patient’s medical and behavioral health needs.

In addition, CHHSA has often looked at utilization trends in services, determining that if utilization remains constant or does not decline, there are no access challenges. However, utilization data only demonstrates use of services for those who have access, and is not in itself a measure of access — rather, it is a measure of current use of a service. CHA has long argued that CMS must assess patients’ unmet needs. In advocating for implementation delay of several state plan amendments, CHA has presented data about increased lengths of stay for patients who remain in the hospital because adequate placement for the patient is unattainable. To ensure a safe discharge, hospitals ascertain that not only is a bed available but that the facility has the appropriate staffing to meet the patient’s medical and behavioral health needs. This data, combined with data on the administrative days Medicaid has paid to hospitals when a patient exceeds the average length of stay but remains in the hospital on an administrative payment day rather than being discharged to the next appropriate level of care, paint a very different picture of access to care.

Moreover, while any payment of administrative days indicates discharge delay, the volume of reported paid administrative day claims significantly understates the actual number and length of extended hospital stays. The process of successfully billing administrative day claims can be cumbersome and time-consuming, and many hospitals will defer in favor of other critical clinical activities. Even more importantly, managed care plans do not routinely pay or report administrative days. As the number of Medi-Cal enrollees increases and more beneficiaries are transitioned to managed care from fee-for-

service, problems in access to post-hospital care have continued to increase — but that growth is masked as hospitals continue to care for non-acute patients without associated reimbursement.

Unfortunately, hospitals are often stuck between a rock and a hard place. Hospitals must ensure a safe discharge, but because the current indicators of access do not account for those who remain in the hospital unable to be discharged, we have successfully masked our most serious access issues. Moreover, while our most recent experience relates to care transitions to post-acute care and community based services, we are also seeing an increase in other areas of demand for hospital services, including emergency department use for non-urgent needs. California ED visits have increased by 20 percent between 2007 and 2012, while inpatient admissions and inpatient bed capacity have declined.¹ The greatest increase in volume has come from patients who visit the ED, but are not admitted. California EDs are providing more primary care, observation, procedural, occupational health, employee health and behavioral health services, and remain the safety net for indigent patients. Patients with behavioral health diagnoses make up a significant component of California's ED volume growth. Between 2006 and 2011, behavioral health diagnoses accounted for 21 percent of the increase in California ED volume.²

Increased emergency department utilization for non-urgent care is a symptom of a larger issue — lack of access to behavioral health services and primary care. CMS often considers the number of physicians participating in Medicaid on a geographic basis or the wait time for an appointment, but absent from this data is how many physicians are actually taking new patients and how that care is being managed across the continuum.

Traditionally, a face-to-face encounter with a physician has been a means to ensure a patient has access to care, but our delivery system is changing and we must look to other evidence-based measures of access that address both the ability to attain care and the outcome of that care. Another important area for consideration is telemedicine visits or ability to connect with a provider via other web-based applications or portals used by hospitals for chronic disease management. **CHA urges CMS to look beyond the traditional metrics of measurement and to use a multi-stakeholder process to identify new evidence-based areas for measure development as well as measurement gaps. A “one size fits all” approach will not meet our shared goals.**

CHA urges CMS to take a qualitative and quantitative look at development of evidence-based access measures. We also encourage CMS to revisit the National Quality Forum “episode of care” definition, which defines the preventative services needed to keep patients from moving to the acute episode, the episode of care itself, and the follow-up care needed to ensure the patient fully returns to being a productive member of the community and society as a whole. When access to a service is looked at through a narrow lens of only the acute episode (such as an inpatient hospital stay), rather than from a patient episode perspective, the needs of the beneficiary are understated, as is the definition of access. We must broaden this view so we can understand, measure and achieve access in the broadest sense.

3. Other Environmental Factors Impacting Access to Care

CHA believes that other environmental factors — including, but not limited to, sociodemographic factors — play a critical role in beneficiaries' access to care. Poverty, access to transportation, and affordable housing are just a few of the challenges the majority of our Medicaid beneficiaries face and are often the most difficult to overcome. Hospitals lead their communities in building networks of social and

¹ “Factors Associated with Closures of Emergency Departments in the United States”, Hsia, R., Kellerman, A, Shen, Y., JAMA, May 18, 2011-Vol 305, No. 19, June 7, 2011

² OSHPD EMS Utilization Trends

community supports to ensure patients safe transition post-hospital stay, but access to these services also impacts the health and well-being of patients and must be considered. The social determinants of health play a significant role in the health of our beneficiaries; as fundamental tenets of the Medicaid program, these should be looked at broadly.

4. Measures Addressing Payment Adequacy Should Reflect the Cost of Providing Care

CHA supports CMS' efforts to create a more equitable and efficient health care system, but in doing so we must also acknowledge the role hospitals play in providing 24-hour access to high-quality care. Stand-by capacity, as well as hospital contributions to the teaching and education of our health care professionals, must be fully reflected in provider payments. The cost of providing health care service is not linear. Providing health care services to our most vulnerable beneficiaries involves a complex delivery system in the midst of great transformation. CMS must ensure that payment rates adequately address the changing nature of health care delivery, and support those changes by recognizing the costs and burdens associated with asking providers to do more with less. Inadequate reimbursement will further deteriorate our fragile safety net; Steps must be taken to ensure providers have the resources required to make changes that will lead to more patient-centered, high-quality care.

CONCLUSION

CHA appreciates the opportunity to comment on CMS' request for information for data metrics and alternative processes for access to care in the Medicaid program. If you have any questions about our comments, please do not hesitate to contact me at akeefe@calhospital.org or (202) 488-4688.

Sincerely,

/s/

Alyssa Keefe
Vice President Federal Regulatory Affairs