



<h1>ENERGYGUIDE</h1>	
<p>Estimated Yearly Energy Cost</p> <h2>\$15</h2>	<p>Airflow</p> <h2>5,109</h2> <p>Cubic Feet Per Minute</p>
 <p>Cost Range of Similar Models (49" – 60")</p> <ul style="list-style-type: none"> • Based on 12 cents per kWh and 6 hours use per day • Your cost depends on rates and use • Energy Use: 58 Watts 	<ul style="list-style-type: none"> • The higher the airflow, the more air the fan will move • Airflow Efficiency: 84 Cubic Feet Per Minute Per Watt 
<p>All estimates at high speed, excluding lights</p> <p style="text-align: right;">ftc.gov/energy</p>	

Sample Label 17 – Ceiling Fan

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By direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. 2015–27773 Filed 10–30–15; 8:45 am]

BILLING CODE 6750–01–C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS–2328–NC]

Medicaid Program; Request for Information (RFI)—Data Metrics and Alternative Processes for Access to Care in the Medicaid Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for information.

SUMMARY: In this request for information (RFI), we seek public input to inform the potential development of standards with regard to Medicaid beneficiaries' access to covered services under the Medicaid program. Specifically, we are interested in obtaining information on core access to care measures and metrics that could be used to measure access to care for beneficiaries in the Medicaid program (including in fee-for-service and managed care delivery systems) and used to develop local, state and national thresholds and goals to inform and improve access in the program. We are also interested in feedback on

approaches to using the metrics, which could include setting access goals and thresholds and formal processes for beneficiaries to raise access concerns.

DATES: *Comment Date:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 4, 2016.

ADDRESSES: In commenting, refer to file code CMS–2328–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2328–NC, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2328–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier)

your written comments ONLY to the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Jeremy Silanskis, (410) 786–1592.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of

the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

CMS and states have the responsibility under section 1902(a)(30)(A) of the Social Security Act (the Act) to assure that Medicaid payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the state plan at least to the extent that such care and services are available to the general population in the geographic area. We interpret this provision to mean rates and payments for Medicaid services are set at levels that ensure value, quality and provider participation. In the past, our oversight of this provision has primarily focused on ensuring that payment methodologies are economic and efficient, as well as consistent with upper payment limits for certain services. During the recent economic downturn, and in light of state proposals to dramatically reduce provider payments, we began requesting that states provide information to document that services are available and access remains after payment reductions go into effect. We found that state processes for documenting access were generally inconsistent and in many cases did not adequately document access.

To address this, on May 6, 2011, we published the proposed rule entitled "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services" (hereafter referred to as the "Access to Care" proposed rule) (76 FR 26342). In that rule, we proposed a specific process through which states would document that their payment rates provide access to care. The

proposed rule, which applies to services that states cover through the Medicaid state plan, is being finalized with comment period concurrent with the issuance of this request for information (RFI). Among other new processes, the rule requires states describe access monitoring review plans that address: The extent to which enrollee needs are fully met, the availability of care and qualified service providers, changes in service utilization and comparisons between Medicaid payments and payments made by other health payers for equivalent services. At a minimum, the access monitoring review plans apply to the following service categories: Primary care (including pediatric care), physician specialists, behavioral health (including substance use disorder services), pre- and post-natal obstetric services, and home health. If states reduce or restructure payments, or receive complaints about access to care for other services, they must add those services to the review plans and monitor access to those services over the ensuing 3 years. States, with public input from stakeholders, would determine measures and thresholds used to monitor access as the final rule does not require a core set of measures or describe national thresholds for Medicaid access to care.

We also recently proposed changes that promote access to care for beneficiaries who receive services through Medicaid managed care. On June 1, 2015, we issued a proposed rule entitled "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability (80 FR 31098), which proposed to modernize Medicaid and Children's Health Insurance Program (CHIP) managed care regulations to update the programs' rules and strengthen the delivery of quality care for beneficiaries. In that rule, we proposed: Minimum requirements for states when setting and monitoring network adequacy standards, certification of managed care plan networks at least on an annual basis, and annual reporting on the accessibility and availability of services. Similar to the "Access to Care" final rule with comment period that appears elsewhere in this issue of the **Federal Register**, the managed care proposed rule proposes to allow states the discretion to set the standards and measures for network adequacy and does not propose to require specific measures or thresholds for access to

care. The access requirements for managed care plans are not directly governed by section 1902(a)(30)(A) of the Act, but instead are governed by access requirements under sections 1903(m) and 1932 of the Act. The proposed managed care rule, however, would apply the same principles in determining access in the managed care environment as are contained in the fee-for-service environment.

We believe that, to the extent there are similarities in the methods and measures used to review and analyze network adequacy for managed care networks and access to care in fee-for-service, aligning such methods and measures would ease the administrative burden on states and ensure that all Medicaid beneficiaries receive the care that they need regardless of whether they are in fee-for-service, are enrolled with a managed care organization, or receive services through a Medicaid waiver program. We are undertaking this effort to review access to care across the entire program for all individuals enrolled in Medicaid regardless of the delivery system mechanism.

Importantly, earlier this year, the Supreme Court decided in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015) that Medicaid providers and beneficiaries do not have a private right of action to challenge state-determined Medicaid payment rates in federal courts, placing greater importance on CMS review to ensure that such rates are "consistent with efficiency, economy and quality of care" and ensure sufficient beneficiary access to care under the program. The Court concluded that federal administrative agencies are better suited than federal courts to make these determinations. Options for Medicaid providers and beneficiaries to pursue Medicaid rate-related issues in federal courts are now limited. As we note in the final rule with comment period, we are therefore working to strengthen the framework for CMS review to ensure that rates meet the requirements of section 1902(a)(30)(A) of the Act, including requiring access improvement strategies to improve care delivery where there are shortcomings. In this request for information, we are asking for public input on what additional data sources and approaches could be used to determine whether access to care is sufficient.

We recognize that many factors affect access to Medicaid services, including: Level of payment, geographic location, time and distance to the closest provider, workforce, numbers of specialists and other types of providers within the state, lack of knowledge of

available resources by beneficiaries, insufficient provider outreach, scope of practice approaches, and other economic and policy factors. Within state Medicaid programs, there are also considerable diversities in delivery system designs, populations served, and provider networks. We seek public input on what additional approaches we and states can take to understand, measure and improve Medicaid access more uniformly and in ways that account for these unique program features. This RFI solicits input from states, providers, beneficiaries and other members of the public on the feasibility of and methodologies related to the following four specific approaches:

- Developing a core set of measures of access that all states would monitor and publicly report on;
- Measuring access to long term care and home and community based services;
- Setting national access to care thresholds; and
- Establishing a process for access to care that would allow beneficiaries experiencing access issues to raise and seek resolution of their concerns.

We also invite input on additional actions that we or states may take to further measure and promote access to care in the Medicaid program.

In seeking this input, we recognize that we have not yet identified a clear, defined set of access measures that demonstrates whether access to care is sufficient. We are seeking input to identify a feasible set of measures and metrics that meaningfully demonstrate whether access to care is sufficient. We requested comments on potential core metrics and thresholds through the "Access to Care" proposed rule and received many suggestions. Generally, the responses suggested set levels of payment or access to providers consistent with Medicare or private insurance, without corresponding metrics and data sources to conduct a comparative analysis. Other health payers, such as Medicare, may be further along in measuring access through data collection tools. As any new data collection requirements would impose administrative burden on states and providers, we are particularly interested in how existing efforts, like the Medicare Current Beneficiary Survey and the Consumer Assessment of Healthcare Providers and Systems (and approved supplemental data sets), may be modified to apply to the Medicaid program.

We note that through this RFI, we are seeking comments on areas of measurement and metrics that may indicate sufficient access in Medicaid

programs regardless of delivery system. We are not attempting to develop areas of measurement that indicate causes of access deficiency, such as information on social determinants of health. While we appreciate the importance of understanding the reasons behind access problems and identifying those issues through data, our initial goal is to develop indicators of sufficient access that can be affected by Medicaid policy levers.

II. Provisions of the Request for Information

We are inviting states, beneficiaries, advocacy organizations, providers, managed care organizations, research and measurement communities, professional associations and other members of the public to share analyses and opinions related to the following topics: (1) Access to care data collection and methodology; (2) access to care thresholds and goals; (3) alternative processes for access concerns; and (4) access to care measures.

The terms: Measures, metrics, and thresholds, are used throughout this RFI. By measures, we mean concrete, quantifiable indicators that can be used to assess access to care in Medicaid. Measures have both a numerator and a denominator (for example, 500 Medicaid participating physicians in the state this year divided by the number of Medicaid enrollees this year, or the state received 50 beneficiary complaints this month divided by the number of beneficiaries enrolled). Metrics are used to examine measures relative to a baseline assessment (for example, there 10 percent more physicians participating in Medicaid this year than last year, or the state received 20 percent fewer complaints this month than last month). A threshold would be a minimum acceptable value for access to care that is based on the measures and metrics.

A. Access to Care Data Collection and Methodology

To better inform us on the nature and scope of access to care measures and metrics, we are requesting comments on how to focus our efforts to determine the best indicators of access in Medicaid across services and delivery systems. Consideration of the following questions may be helpful in providing us your ideas and suggestions.

- What do you perceive to be the advantages and disadvantages to requiring a national core set of access to care measures and metrics? Who do you believe should collect and analyze the national core set data?

- Do you believe there are specific access to care measures that could be universally applied across services? If so, please describe such measures.

- What information and methods do you believe large health care programs use to measure access to care that could be used by the Medicaid program? What role can health information technology lay in measuring access to care?

- What do you believe are the primary indicators of access to care in the Medicaid program? Is measured variance in these indicators based on differences in things such as: Provider participation and location, appointment times, waiting room times, call center times, prescription fill times, other?

- Do you believe a national core set of access measures or metrics should apply across all services, or is it more appropriate to target a core set of access measures by service?

- Do you believe questions in provider and beneficiary surveys should be consistent for Medicaid and Medicare beneficiaries? If not, what differences do you believe should be accommodated for the Medicaid program, including differences in covered services?

- What do you believe we should consider in undertaking access to care data collection in areas related to: Differences between fee-for-service (FFS) and managed care delivery, variations in services such as acute and long-term care, community and institutional settings for long-term care delivery, behavioral health, variations in access for pediatric and adult populations and individuals with disabilities, and variations in access for rural and urban areas? Consider also individuals with chronic conditions who may have limited functional support needs related to activities of daily living but nonetheless require more intensive care than other Medicaid beneficiaries, such as persons living with HIV/AIDS.

- Specific to long-term services and supports, including home and community based services, what factors do you believe we should consider in measuring access to care? Do you believe we should incorporate into reviews of access to care for these services economic factors and significant policy factors such as: Minimum wage and overtime requirements, direct service worker shortages, training and professional development costs, or other factors?

- Do you believe measuring access to Home and Community Based Services (HCBS) differs from measuring access to acute medical care? Please describe.

- Do you believe access to HCBS should be tracked in FFS and in managed care delivery systems? Do you perceive any differences between tracking HCBS in each system?

- Do you believe there are additional metrics that need to be tracked related to HCBS?

B. Access to Care Thresholds/Goals

To better inform us on how to interpret and use access to care metrics, we are requesting comments on setting access thresholds and how we might use the thresholds to improve access in the Medicaid program. Consideration of the following questions may be helpful in providing us your ideas and suggestions.

- Do you believe we should set thresholds for Medicaid access to care? If so, do you believe such thresholds should be set at the national, state or local levels? Why?

- If we set Medicaid access thresholds, how do you believe they should be used? For instance: For issuing compliance actions to states that do not meet the thresholds, as benchmarks for state improvement, for use in appeals processes for beneficiaries that have trouble accessing services, or in other ways?

C. Alternative Processes for Access Concerns

We are considering requiring standard access to care complaint driven processes to better ensure access and are interested in how data gathered and analyzed through a core set of measures might aid in resolving complaints, please consider the following questions:

- Do you believe there are existing and effective processes to resolve consumers' concerns regarding health care issues that might be useful for all state Medicaid programs?

- What do you believe are the advantages and disadvantages of either a complaint resolution process or a formal appeals hearing for access to care concerns?

- Who do you believe should be the responsible party (for example, the state or federal government, an independent third party, a civil servant, an administrative law judge, etc.) to hear beneficiary access to care complaints and/or appeals?

- For an access to care appeal, what criteria do you believe should be used to help determine:

- ++Whether an appeal should be heard?

- ++Whether an appeal merits recommendations to the state Medicaid agency?

- Which access to care areas of measurement or specific metrics may be useful in setting thresholds that would help hearings officers assess appeals and determine access to care remedies?

- Lack of timeliness of an appeal could undermine the time sensitive efforts associated with remediating an individual's access to medical services. You may want to consider providing information on the following:

- ++How could appeals be expedited?

- ++What outcomes could an appeals officer offer if services are unavailable to Medicaid beneficiaries?

- ++Are there other non-appeal based processes that could be used instead?

D. Access to Care Measures

In conjunction with this RFI, you may want to consider each of the topics listed below, and suggest what you believe we should prioritize. You are also welcome to provide additional metrics that are associated with measurement areas that are relevant indicators of access to care in the Medicaid program and feasible to collect and analyze.

For each suggested metric, you may consider describing the following:

- Suggested relevant data metrics,
- whether the metric is currently reported for Medicaid services,
- the feasibility of collecting the metric,
- the associated data sources/set(s) where the metrics are available,
- the financial cost (if any) of collecting the proposed metric,
- should including the metric in a more robust (or updated) Medicaid access policy be given priority;
- the party responsible/steward(s) of the metric data source,
- the metric validation process,
- whether the metric is relevant to all Medicaid populations or specific to particular groups, (for example, adults or pediatric populations, including children with special health care needs, or to people with disabilities or to dually eligible beneficiaries),
- whether the metric is applicable to FFS, managed care or both delivery systems,
- whether the metric is relevant for various subpopulations such as eligibility category, institutional status, or geographic region,
- whether the metric should be measured at the local, state or national level,
- as appropriate for Medicaid, thresholds associated with the metric,
- the challenges and advantages of the proposed metric, and how the metric is indicative to Medicaid access to care.

1. Measures for Availability of Care and Providers

We are soliciting public comment on the following availability of care and providers measurement areas within geographic areas. In addition to feedback on the proposed metrics below, we are also interested in your thoughts on how "geographic areas" should be defined.

- Primary care physicians (including pediatricians) and clinicians accepting any/new patients.

- Physician specialists accepting any/new patients.

- Specialty care (for example, addiction and psychiatric services,, home and community based services, specialty pharmacy) accepting any/new patients.

- Availability of direct support workforce for home health and home and community-based services.

- Dentists accepting any/new patients.

- Psychiatric and substance abuse clinicians such as psychiatrists, child psychiatrists, psychologists, and psychiatric social workers and mental health counselors accepting any/new patients.

- Physicians and clinicians experiencing difficulties referring patients to specialty care.

- Psychiatrists experiencing difficulties referring patients with serious mental illness to primary care.

- Available primary care clinics, federally qualified health centers or rural health clinics.

- Available retail community pharmacies.

- Available behavioral health clinics or community mental health centers.

- Available inpatient care.
- Other.

2. Measures for Beneficiary Reported Access

We are soliciting public comment on the following beneficiary reported access measurement areas:

- Beneficiaries reporting a usual source of primary care.

- Beneficiaries reporting difficulty finding a specialist/general clinician, not taking any new patients and/or the beneficiary's insurance.

- Beneficiaries able to access specialists or behavioral health care if they have: Chronic conditions, heart disease, behavioral health issues, etc.

- Beneficiaries able to access long-term services and supports in institutional settings.

- Beneficiaries able to access home and community based services.

- Women able to access: Pap smears, mammograms.

- Children and adults able to access appropriate immunizations and/or seasonal vaccines.
- Beneficiaries reporting delayed care and reason for delay.
- Unmet need for specialty, primary, follow-up, dental, prescriptions, and mental health and substance abuse treatment due to cost concerns.
- Beneficiaries getting needed care quickly.
- Wait times for appointments (for example, to primary care, urgent care, physician specialists, pre-natal care, behavioral health providers, and long-term services and supports in community settings).
- Length of delays in accessing long term services and supports in community setting due to direct service worker shortages and/or lack of adequate training.
- Call-center capability standards to support providing beneficiaries with information that can improve their access, and produce useful metrics for monitoring.
- Call-center metrics that reveal issues with beneficiary access and their resolution.
- Other.

3. Measures regarding Service Utilization—

We are soliciting public comment on the following service utilization measurement areas:

- Trends in service utilization by geographic regions within the state.
- Trends in emergency room utilization relative to primary and mental health and substance abuse treatment care utilization.
- Rates of utilization (for example, At least one of the following visits in the prior six months/year: Physician (including nurse practitioners and physician assistants), dental, specialty, behavioral health, and primary care/well-child.)
- Other.

4. Comparison of Payments

We are soliciting public comment on the following comparison of payment measurement areas:

- Payment rates for services set at a specific percentage of Medicare.
- Medicaid payment rates compared to surrounding states, Medicare, commercial payers.
- Acquisition costs compared to Medicaid payments for pharmaceuticals.
- Comparisons or measures that would inform managed care rate

adequacy (the payment managed care plans make to providers).

- Other.

We will evaluate the responses to this RFI, in addition to the findings from research that we are currently conducting, to inform whether it is advisable to collect and analyze core national measures at this time and the methods to conduct the collection. We may also use this information to help determine which measures could best inform understanding of access to care and to support the design of national or state and local thresholds.

III. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, if and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Dated: October 20, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

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