



District of Columbia Fee-for-Service Medicaid: Access Monitoring Review Plan

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I. Executive Summary

A. Overview

The District of Columbia (the District) provided Medicaid benefits to more than 266,207 individuals in fiscal year 2015 (FY 2015). The majority of these individuals—219,865—received services primarily through managed care plans, while the remainder—46,342—received services primarily through the Medicaid fee-for-service (FFS) program. More than 80 percent of the 46,342 individuals in the FFS program were elderly or adults with disabilities.

Under section 1902(a)(30)(A) of the Social Security Act, the District must ensure that payment rates to health care providers treating Medicaid beneficiaries are “sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general populations in the geographic area.” The Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicaid, issued a final rule in November 2015 (the Rule) setting forth how states must comply with this statutory requirement for the FFS program.¹ In accordance with this rule, states are now required, among other things, to develop an Access Monitoring Review Plan (Access Plan) that evaluates whether beneficiaries have sufficient access to services provided under FFS Medicaid, and to submit this plan to CMS once every three years.

As the single state agency that administers Medicaid, the Department of Health Care Finance (DHCF) undertook the Access Plan analysis using a variety of available data sources and methods to analyze payment and access to FFS services in six required categories:

1. primary care (including primary care providers, dental services, and FQHCs),
2. physician specialist services,
3. behavioral health services,
4. pre- and post-natal obstetric services,
5. home health services,
6. and other services selected by the DHCF because stakeholders identified them as having potential access issues.

This report provides the findings from this analysis and constitutes the District’s first Access Plan submission.

B. Methodological Approach

To support the development of a baseline for future analyses, the District opted to report available data from two timeframes: the most recent fiscal year, FY 2015, and over the most recent five-year period, FY 2011 through FY 2015.² For each of the six required categories of FFS services, DHCF undertook an analysis of three primary components to determine FFS beneficiary access: (1) payment rate comparison; (2) provider participation and experience and (3) beneficiary utilization and experience.

¹ See 80 FR 67575 (CMS-2328-FC).

² The District’s fiscal year runs from October 1 of each year to September 30 of the following year.

This Access Plan organizes findings into a discussion of FFS payment rates, followed by a discussion of provider participation and beneficiary utilization in each of the six FFS service categories. The report also provides recommended next steps for improving DHCF's ability to measure access in future Access Plans and monitor access over time.

In developing this report, DHCF discovered a number of important limitations in the available data. First, because private payer data are proprietary and the District does not host an all-payer claims database or have other means for private payer data collection, the District did not have readily available private payer data to inform this report. In addition, the seven (7) month timeframe between the promulgation of the Access Rule and the initial deadline for submission of the report did not allow the District sufficient time to contract with a vendor to provide this data. As a result, this report only includes comparisons to Medicare and Medicaid MCO rates and not those of private payers.

Second, the District has not historically or routinely surveyed FFS providers or beneficiaries on access issues and was unable to develop and field a comprehensive survey given the limited time available for the analysis, which was originally due to CMS on July 1, 2016. While DHCF did create and field a survey of members of the District's Medical Care Advisory Committee (MCAC), responses were limited.

Finally, DHCF's ability to analyze claims data for federally qualified health centers (FQHCs) was limited. During the FY 2011 through FY 2015 study period, FQHCs billed using a single encounter code regardless of service provided, whether it was a primary care non-dental service—the type most commonly furnished by FQHCs—a behavioral health service, or primary care dental service. Because DHCF could not distinguish between visit types, DHCF categorized all FQHC claims as primary care non-dental services. This had the effect of inflating the utilization figures for primary care, and underreporting the utilization figures for behavioral health and dental services. An additional limitation with FQHC claims data during the study period is that claims do not always identify individual providers. If an FQHC does not identify providers in its claims, and one of those providers does not also bill FFS Medicaid through his or her own separate practice, DHCF would not have identified that provider as one that bills Medicaid. Though the number of such providers is comparatively small,³ this nevertheless results in an understatement of provider participation. For all of these reasons, this first Access Plan analysis does not present a complete picture of FFS beneficiary access to care, but instead offers an initial set of baseline data and impressions from which future Access Plans can build.⁴

DHCF conducted the work for this Access Plan during the months of December 2015 through September 2016. An internal workgroup formed, bridging agency expertise in clinical care, provider relations, service delivery for both the FFS and managed care programs, and quality monitoring. Workgroup members identified available data, constructed access measures, and coordinated the analyses. The Workgroup informed the MCAC about this initiative in the Spring of 2016 and requested participation in

³ In FY2015, for example, 885 primary care primary care physicians who were licensed in DC and based in the DC metropolitan area (within 20 miles of the geographic center of the District) billed Medicaid. Another 49 did not bill Medicaid but according to their licensure information were based at FQHCs. Due to the populations FQHCs tend to serve, it is highly likely that many of these 49 primary care physicians furnish services to Medicaid beneficiaries. Therefore, our figures may underestimate primary care physician participation by as much as 5%.

⁴ Upcoming changes to the FQHCs payment policy and billings procedures will improve DHCF's ability to capture participation by FQHC-based providers. For example, FQHCs will bill with separate encounter codes for primary care, dental, and behavioral health services. These changes are slated to go into effect on October 1, 2016.

a survey to solicit stakeholder experience with the program and incorporated findings into the report. Initial findings from the Access Plan analysis were presented at the July 27, 2016 meeting of the MCAC. The workgroup incorporated MCAC comments and posted the draft Access Plan on the agency's website and announced the availability of the report for 30 days of public comment in the DC Register on August 19, 2016. The draft report was also circulated via email to MCAC members; officials at other District government agencies that deliver services to FFS Medicaid beneficiaries, including the Department of Behavioral Health (DBH), Department of Health (DOH), and the Department on Disabilities Services (DDS); and other advocacy groups.

DHCF received eight (8) sets of comments from interested stakeholders, including three advocacy groups representing beneficiaries and providers, and two Medicaid beneficiaries. Many of the comments focused on the need for additional measures of beneficiary and provider experience with access issues. DHCF concurs with the need for additional measures and plans a variety of initiatives to increase beneficiary and provider inputs. These initiatives are discussed in greater detail in the conclusions section of this report. Other comments contained corrections or clarifications to text in various sections of the report. DHCF incorporated these changes wherever appropriate. Finally, some comments focused on access to home- and community-based services offered under the District's waiver program for the Elderly and Persons with Physical Disabilities (EPD). Per CMS regulations, this report is focused exclusively on analyzing access to FFS, non-waiver programs, and the EPD waiver comments are therefore outside the scope of this report. These comments were provided to the agency's Long Term Care Administration, which administers the EPD waiver program, and are under consideration.

C. Summary of Initial Findings and Conclusions

FFS Medicaid Payment Rate Analysis

DHCF compared FFS Medicaid payment rates for the six service categories—primary care, physician specialist services, behavioral health services, pre- and post-natal obstetric services, home health services, and other services selected by DHCF—to Medicare and Medicaid managed care organizations. DHCF was unable to obtain private payer data for comparison. The District's Medicaid rates for physicians are tied to the Medicare physician fee schedule; these rates were either equal to Medicare rates—in the case of qualifying primary care physicians (PCPs), obstetricians and gynecologists (OB/GYNs), psychiatrists, and advanced practice registered nurses (APRNs)—or 80 percent of Medicare rates—in the case of all other physicians. A comparison of Medicaid with Medicare for the non-physician categories of services (e.g., home health, dentists, or behavioral health) was not possible since Medicare does not provide comparable coverage. Medicaid FFS rates tend to be equal to or less than Medicaid MCO rates, although there was considerable variation by category of service, provider type, and individual MCO. Limited data made it impossible to quantify the difference. Based on this analysis, FFS Medicaid payment rates appear comparable to other public program payers.

FFS Medicaid Access Analysis

DHCF's analysis of access to the six categories of FFS services over the five-year baseline period, FY 2011 through FY 2015, offered varied information. In three of the six categories, the access analysis yielded favorable results. Specifically, for primary care services, behavioral health services, and other services about which DHCF had access concerns—dermatology, oncology, and ophthalmology—the

preponderance of indicators demonstrated overall beneficiary access as either remaining stable or improving. Despite these indicators, anecdotal evidence suggests additional research is needed to determine whether there is an access barrier for psychiatrists and dermatologists. Utilization of dental services by children and youth under age 21, which decreased slightly during the five-year period, also warrants future monitoring. DHCF was already aware of the issue, and has put in place a monitoring and outreach plan to increase access and utilization in future years.

DHCF's analysis of access to care for two other service categories—physician specialty services and pre- and post-natal obstetrics services—appeared to have mixed and inconclusive results. For physician specialty services, available indicators for nephrology and pulmonology showed stable or improving access, while indicators for cardiology, endocrinology, and podiatry showed varied results. Indicators for pre- and post-natal obstetric services also showed varied results. The adequacy of the FFS provider network in FY 2015, the most recent year available, well exceeded the National Committee for Quality Assurance (NCQA's) minimum standards. However, the total number of pre- and post-natal obstetrics providers billing FFS Medicaid has declined slightly since FY 2011, a trend that DHCF will continue to monitor. It is noteworthy that the majority of Medicaid beneficiaries of child-bearing age (15-44 years) are enrolled in managed care. Women of child-bearing age in the FFS program accounted for 25 percent of live births for all Medicaid-insured women in FY 2015. Two other types of services, durable medical equipment and non-emergency transportation, were flagged as having increased Ombudsman complaints among FFS beneficiaries during the study period, but due to methodological challenges and time constraints, these service areas were not analyzed in this report. DHCF plans to include these in future Access Plans.

DHCF's analysis of access to care for the sixth category of service, home health services, consistently showed a decline in provider participation and beneficiary utilization. The specific home health services DHCF examined were personal care assistance (PCA) services and skilled nursing services. The decline in these services is related to the efforts of DHCF and law enforcement to reduce the high incidence of fraud, waste and abuse in the District's PCA benefit. Over the course of several years, DHCF worked to reduce fraud, waste, and abuse by referring cases for prosecution and instituting policy changes. These policy changes include the requirement that all new and existing beneficiaries be assessed in person for ongoing PCA services by nurses who are independent of the providers. DHCF began instituting these conflict-free, face-to-face assessments of need in November, 2013, and experienced an immediate reduction in new beneficiaries who were eligible for PCA services. In February, 2014, based upon referrals initially made by DHCF, the U.S. Federal Bureau of Investigations (FBI) raided and shuttered four large licensed home care agencies contracting with licensed nursing staffing agencies. DHCF reached out to all the approximately 4,000 beneficiaries served by these agencies, assigned them to other home health providers and conducted assessments to ensure that every beneficiary had a legitimate need for services. In the end, some 567 beneficiaries either did not respond to repeated efforts to contact them, declined services or were found ineligible. By FY 2015, payments for PCA services had decreased drastically, from \$25,204,428 per month in FY2013 to approximately \$18,330,415 million per month in FY 2015.

Overall, after completing assessments on all beneficiaries who were receiving PCA services from all home care agencies, approximately 40 percent were disenrolled because they did not complete the process or failed to meet the minimum level of need to qualify for services. These actions had the effect of reducing utilization of PCA services and—concomitantly—skilled nursing services, as supervisory skilled visits are required monthly to maintain the PCA benefit. According to our analysis, while provider participation and utilization dipped substantially in 2014; it has grown slightly since the initial decline.

For these reasons, DHCF is confident that much of the decline represents an appropriate adjustment in services.

Conclusions

Using available measures and data sources DHCF did not identify any obvious access deficits or precipitous declines in access with any of the services in the six required categories. However, because the scope of available data was limited, and the results were varied, DHCF is unable to draw any reliable conclusions about access to care experience from the findings in this report. Instead, DHCF believes this first Access Plan provides a reasonable baseline from which to conduct future monitoring, not a conclusive assessment of the sufficiency of payment and access in the District's FFS Medicaid program.

With a goal of strengthening future Access Plans and monitoring, DHCF is planning a variety of initiatives to improve its ability to measure and monitor access to care, both for the next triennial Access Plan and on an ongoing basis. Examples include the implementation of a new beneficiary and provider complaints tracking system, an annual provider survey, a "secret shopper" initiative for the Medicaid FFS program, requiring Medicaid MCOs to submit rate data upon request, and the purchase of private insurer payment rate data. In addition, DHCF plans to recommend that the Medical Care Advisory Committee establish an Access Monitoring Subcommittee to provide the Agency with on-going input on access issues.

II. Background

A. The District's Medicaid Program

Under the Medicaid program, the District provides coverage for a broad range of health care services to individuals with low income and individuals with disabilities. These include the following statutorily required services, as well as optional services. (See Table 1 below.)

Table 1: Examples of Mandatory and Optional Medicaid-Covered Services

Examples of Mandatory Services	Examples of Optional Services
Inpatient/Outpatient Hospital	Dental
Non-Emergency Transportation	Prescribed Drugs
Lab & X-Ray	Durable Medical Equipment
Health Clinics	Medical Supplies
Federal Qualified Health Centers	Optometry/Eye Glasses
Physician Services	Psychiatric Residential Treatment Facilities
Early Periodic Screening Diagnosis & Treatment	Personal Care
Nursing Facilities	Hospice, Adult Day Health Programs
Emergency Ambulance	Home and Community Based Services (State Plan, 1915(i))
Home Health	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

The District provides additional services, such as case management, respite care and expanded PCA services, to individuals enrolled in its two home and community-based services (HCBS) waiver programs: the EPD waiver program and the Individuals with Intellectual and Developmental Disabilities (IDD) waiver program.

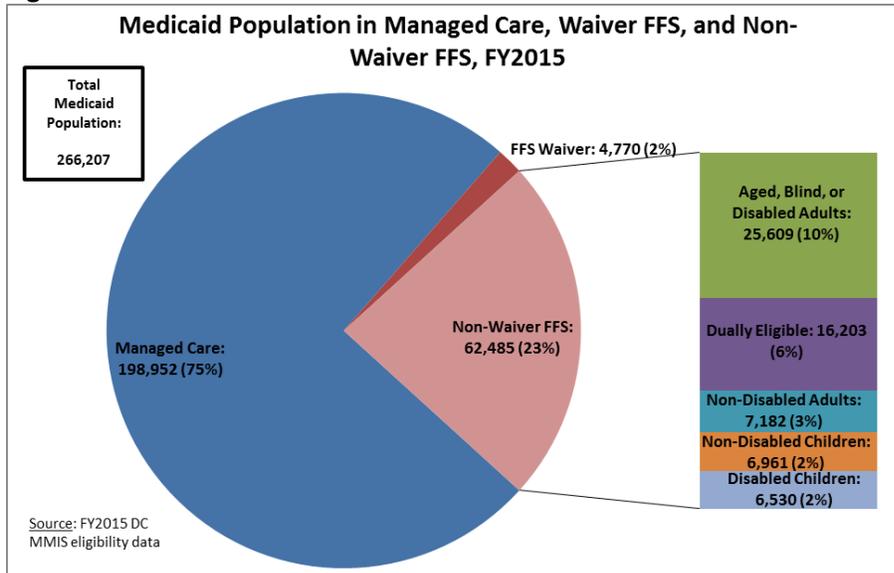
The District provides these covered services to various categories of individuals allowed under federal law. Notably, the District has been a leader in using the flexibility in federal law to expand health care coverage for its residents. For example, when the Affordable Care Act (ACA) allowed states to expand Medicaid to childless adults with household incomes up to 133 percent of FPL beginning in FY2014, the District not only adopted this expansion, but was one of only a few states exercising the early expansion option in 2010. In addition, also in 2010, the District secured a waiver to expand coverage to childless adults up to 200 percent FPL. Childless adult eligibility levels were expanded once the District's eligibility levels were converted under the ACA's MAGI methodology and were increased to 210 percent of FPL under the District's State Plan Amendment approved in 2015. The District's Medicaid coverage for childless adults is the highest Medicaid eligibility level for adults in any state. As a result of the District's efforts, its Medicaid program covers more than 266,000 of the 678,000 District residents, or more than one in three. With this high Medicaid enrollment, as well as the District's locally-funded Alliance program for individuals with low incomes who do not qualify for Medicaid coverage, the District has one of the lowest uninsured rates in the nation. According to U.S. Census data, in 2015 only 3.8 percent of

District residents were uninsured, making the District the second leading state in the nation in providing insurance coverage for its residents.⁵

The District provides Medicaid benefits to its beneficiaries through two primary models for healthcare delivery: (1) managed care, which is administered under contracts with four managed care plans, and (2) the FFS program, which is administered under enrollment agreements with individual health care providers. Over the last 10 years the managed care model has overtaken FFS as the predominant healthcare delivery model for DC Medicaid beneficiaries. Of the roughly 266,207 Medicaid beneficiaries who were enrolled in Medicaid at any point in FY 2015, 198,925, or about 75 percent, were in the managed care program. (See Figure 1.) The remaining 62,485 individuals, or 23 percent, were in non-waiver FFS, and another 4,770 individuals, or 2 percent, were in FFS and one of the two HCBS waiver programs. The majority of the individuals enrolled in non-waiver FFS were aged, blind or disabled adults or dually eligible for both Medicaid and Medicare. Consequently, certain types of services, such as pre- and post-natal obstetrics services, are less frequently utilized for the FFS population than by beneficiaries enrolled in managed care plans.

⁵Source: U.S. Census Bureau, 2013, 2014, and 2015 1-Year American Community Surveys. 2015. Available at <http://www2.census.gov/programs-surveys/demo/tables/p60/257/tableA1.pdf>.

Figure 1



B. FFS Population Characteristics

While DHCF identified 62,485 beneficiaries who were enrolled in the FFS program at some point during FY 2015, only a subset of these individuals, 46,342, relied on the FFS program as their primary model of health care delivery. The other 16,143 beneficiaries were individuals newly enrolled in Medicaid who were in the process of joining managed care plans. (All newly enrolled beneficiaries spend their first month in FFS Medicaid until those required to join a managed care plan do so in their second month.) The 46,342 beneficiaries who were enrolled solely in the FFS program during FY 2015 are referred to in this report as the “core” FFS population.

FFS population: program eligibility and demographics Of the 46,342 beneficiaries in the core FFS population in FY 2015, the majority were elderly, blind or disabled, and smaller numbers qualified as non-elderly adults and children. (See Figure 2.) Most were African-American (about 85 percent) and non-elderly adults age 21 to 64 (60 percent). (See Figures 3 and 4.) They were evenly split between females and males (50 percent each).

Figure 2

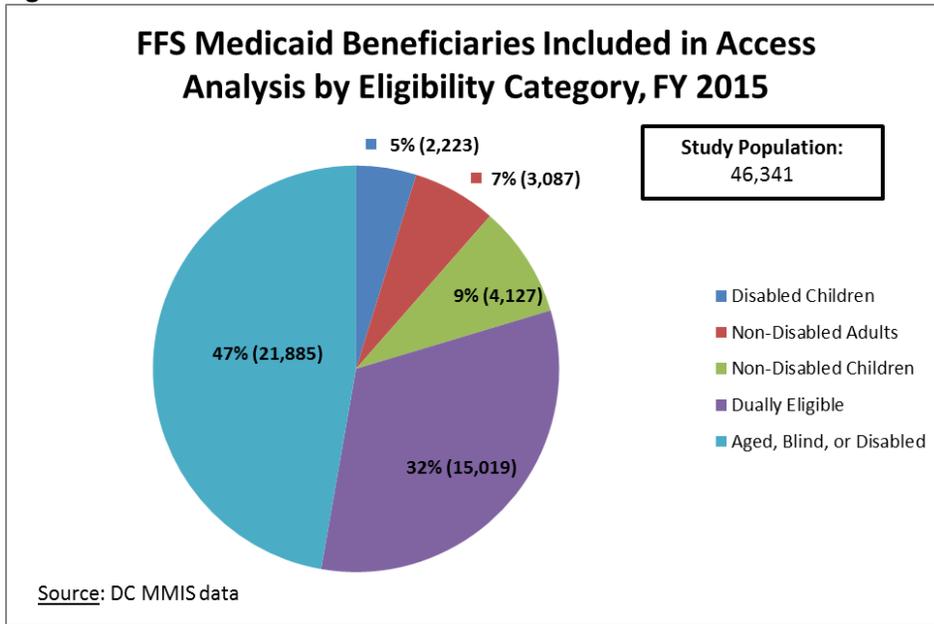


Figure 3

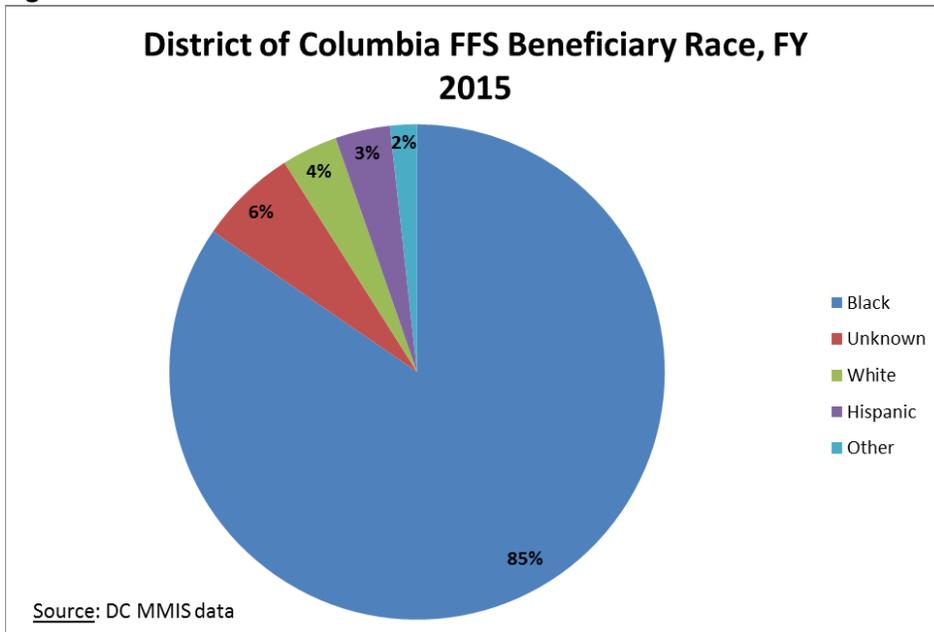
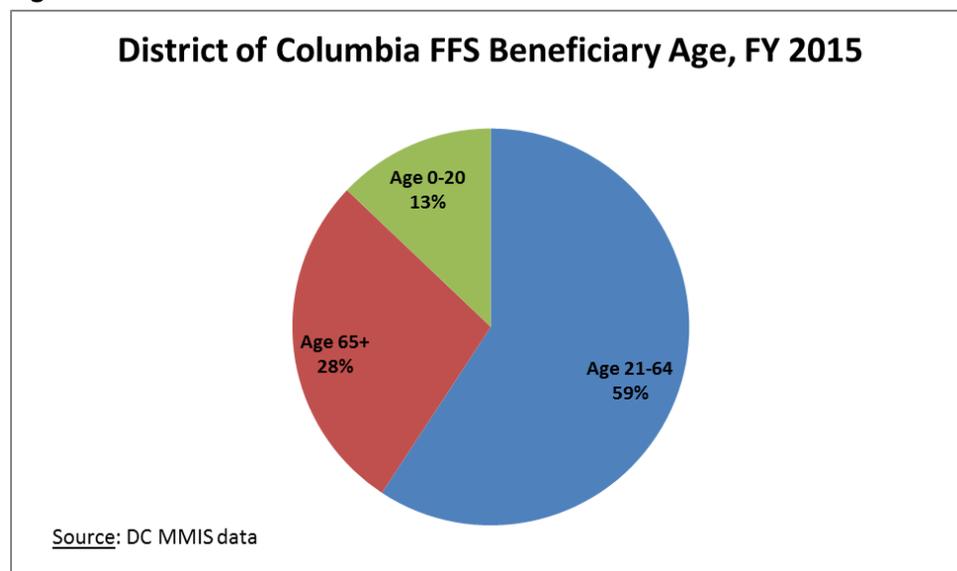


Figure 4



FFS population: health status Of the 46,342 beneficiaries in the core FFS population in FY 2015, the most common chronic conditions were hypertension (51 percent prevalence in the study group), hyperlipidemia (28 percent), diabetes (27 percent), depression (22 percent), and asthma (21 percent).

FFS population: comparison with MCO population Compared to beneficiaries enrolled in the Medicaid managed care program, individuals in the general FFS population are more likely to have complex, costly health care needs. In FY 2015, beneficiaries in the general FFS population cost more on average to treat (\$26,399 per person for FFS compared to \$6,781 for MCO members). They were also more likely to have an inpatient visit; in 2015, 11 percent had an inpatient visit compared to seven percent of MCO beneficiaries. In addition, the average length of stay for hospital admissions for beneficiaries in the general FFS population was 20 days, compared to five days for MCO members. In terms of prescription medication utilization, beneficiaries in the general FFS population had an average of 32 prescriptions in FY15, compared to 14 prescriptions for MCO members. They also are disproportionately burdened with chronic health conditions; 71 percent had at least one chronic condition, and 32 percent had five or more chronic conditions. By comparison, 41 percent of MCO members had at least one chronic condition, and 4 percent had five or more chronic conditions.

Given that FFS beneficiaries tend to have more complex health care needs than individuals in MCOs, they may require significant care coordination services. In January, 2016, the District implemented a health home program targeted to serve individuals with serious mental illness and designed to integrate behavioral and physical health care to improve their experience and outcomes. The District is also developing a second health home program for implementation in 2017, *My Health GPS*, which will target individuals with multiple chronic health conditions. These health home programs will generate new data to allow for deeper analysis of FFS claims to determine impact of better care management on outcomes for beneficiaries with chronic diseases for future access monitoring efforts.

III. Methodology

A. Selection of FFS Study Population

To identify the core FFS population in each year, DHCF applied a conservative selection method that applied two specific restrictions. First, only beneficiaries for whom DHCF paid three or more medical transportation capitation payments were included, as these payments indicate that the beneficiary was enrolled in FFS Medicaid for at least 90 days in each study year. Second, DHCF excluded any beneficiary for whom DHCF paid a managed care capitation payment in the year of interest. This restriction was applied to account for beneficiaries who were assigned to a Medicaid managed care organization after initially entering the Medicaid program, as all beneficiaries are covered under FFS during their first month of eligibility. In addition, beneficiaries can opt out of managed care coverage, which further demonstrates how beneficiaries can transition between FFS and managed care even within a certain year. DHCF employed the study selection method outlined above to attempt to ensure that the study group was restricted to only beneficiaries who were only enrolled in the FFS program during each year. Finally, Qualified Medicare Beneficiaries, who have limited Medicaid benefits and for whom Medicare is the primary insurer, were also excluded from the analysis. The District opted to review the entire FFS population, except to the extent that only subpopulations utilized a particular provider or service (e.g., children, elderly, women of childbearing age for pre- and post-natal services).

B. Selection of FFS Providers by Category of Service

Under the final Access Rule, DHCF was mandated to review six service areas: primary care providers, physician specialty services, behavioral health providers, pre- and post-natal obstetrics including labor and delivery, home health services, and any other service areas for which provider rates had been reduced or restructured or there were concerns about access. For some categories of services, such as primary care, CMS directed states to review specific types of providers within that category. For other categories of services, such as physician specialists and other providers, CMS allowed states discretion to choose the types of providers for whom they had particular interest or concern.

After reviewing available data on primary diagnoses and volume of services for FFS beneficiaries, consulting internal subject matter experts, analyzing complaints to the DC Office of the Health Care Ombudsman and Bill of Rights (Ombudsman), and surveying the MCAC, DHCF selected the following list of provider types that fit into the sixth service categories outlined by CMS:

- **Primary Care:** Primary care encompasses a wide range of provider types. Where possible, DHCF analyzed as many as five different provider types, although not all were feasible to include in every analysis.
 1. Primary care physicians (PCPs; defined as physicians with a specialty of general internal medicine, obstetrics and gynecology, family medicine, general pediatrics, geriatrics, or general practice),
 2. Dentists
 3. FQHCs
 4. Advanced Practice Registered Nurses (APRNs)
 5. Psychiatrists

- Physician Specialists: DHCF analyzed five types of physician specialists that either treat the District’s most common chronic conditions or otherwise bill the District for a high volume of service. These specialists include:
 1. Endocrinologists, who treat diabetes, one of the DC Medicaid program’s most common chronic conditions;
 2. Cardiologists, who treat hyperlipidemia and hypertension, two of the DC Medicaid program’s most common chronic conditions;
 3. Nephrologists, who treat kidney disorders and bill the DC Medicaid program at a high volume;
 4. Podiatrists, who treat foot and ankle-related ailments and bill the DC Medicaid program at a high volume; and
 5. Pulmonologists, who treat asthma, one of the DC Medicaid program’s most common chronic conditions.

- Behavioral Health: DHCF analyzed access to two types of providers of behavioral health services:
 1. Psychiatrists and
 2. Other behavioral health providers, which included the following
 - a. Mental Health Rehabilitation Services (MHRS) providers: MHRS services are provided by psychiatrists, psychologists, APRNs with psychiatry as an area of practice, Registered Nurses (RNs), Licensed Professional Counselors (LPCs), licensed social workers, and addiction counselors.
 - b. Adult substance abuse rehabilitative services (ASARS) providers: ASARS services are provided by physicians, psychologists, licensed clinical social workers, LPCs, licensed marriage and family therapists; and APRNs.
 - c. Free Standing Mental Clinics (FSMHCs): psychiatrists oversee all FSMHC services, including those by psychologists, licensed clinical social workers, and counselors.
 - d. Behavioral supports providers
 - e. Public and private psychiatric hospitals

To streamline the results, DHCF elected to analyze and report on these five provider types together in one provider type, “other behavioral health providers.”

- Pre- and Post-Natal Obstetrics: DHCF identified OB/GYNs and neonatologists as providers of pre- and post-natal obstetrics services.

- Home Health: DHCF analyzed two types of providers that deliver care to Medicaid FFS beneficiaries in the home setting: skilled nursing and/or personal care aide (PCA) services. Some of these providers furnished these services directly with their own staff, while others did so indirectly through contracts with nurse staffing agencies. In order to provide skilled nursing and PCA services in the home, providers must be licensed as “home care agencies” by DOH. While FFS beneficiaries may receive other types of home health services, including occupational therapy, physical therapy, speech therapy, audiology, durable medical equipment prosthetics, orthotics and supplies (DMEPOS), and home health aide services, these additional services are less frequently utilized and were not included in the scope of this report. DHCF plans to include analysis of these services in future Access Plans and monitoring.

- Other Providers⁶: DHCF identified three types of physician specialists for which access concerns were raised based on an analysis of feedback from internal stakeholders, MCAC provider representatives and other stakeholders, and complaints to the Ombudsman:
 1. Dermatologists
 2. Oncologists
 3. Ophthalmologists

C. Comparing Payment Rates

Once DHCF identified the list of provider types, DHCF conducted its “comparative payment review.” required under the final Access Rule. The Rule charged state Medicaid agencies with comparing Medicaid rates with other public and private payers operating within the state, including Medicare and private insurers. Because the District does not collect or have access to private insurance data, the analysis in the Access Plan was limited to comparisons with Medicaid MCO and Medicare rates.

Medicare and Medicaid Managed Care Plan Comparison: To compare Medicaid payment rates with those of other public insurers, DHCF first selected a list of CPT codes relevant to each provider type. The specific codes were identified as representative of the full range of services providers in each provider type could bill on a claim. DHCF then obtained the corresponding payment rates for those codes from the Medicare program and the four managed care plans participating in the District’s Medicaid program. One managed care plan only provided information about whether their rates were higher or lower than Medicaid’s for the requested codes, making it impossible for the District to calculate an average MCO payment rate for each type of provider. As a result, DHCF cannot report on whether the Medicaid payment rate is above or below the average of the four MCO plan rates. However, DHCF was able to determine if each plan’s rates were higher, lower, or about the same as Medicaid FFS.

Private Payer Comparison: A comparison with private health insurers operating in the District by the October 1, 2016 deadline was not feasible. Private health insurance payment rates are proprietary and not readily publicly accessible. At this time, the District does not operate an All Payer Claims Database (APCD). DHCF investigated the possibility of obtaining private payer rate data from an APCD in a neighboring state. However, none of the neighboring states had a major metropolitan area with demographic characteristics and a health insurance market similar to the District, so the District lacked confidence that the rates would be truly comparable. Finally, DHCF explored the possibility of procuring private payer rates from private third-party data vendors, but in the seven month timeframe between the promulgation of the Access Rule and the required submission of the first Access Plan, the District did not have sufficient time to procure services and was unable to identify any whose data contained a sufficient level of service detail and/or rates specific to private payers in the District.⁷ DHCF is exploring the possibility of procuring such data for future analysis.

⁶ For this final category of services, CMS requires states to include services for which either (1) states have requested a payment rate reduction or restructuring, or (2) they have received a higher than usual volume of access complaints. Because DHCF had not requested payment reductions or restructurings at the time the analysis was being conducted, DHCF focused on services in the latter category.

⁷ The final Access Rule originally required submission of state Access Monitoring Review Plans by July 1, 2016. It was revised to allow states to submit by October 1, 2016.

D. Measuring Access

DHCF developed a set of access measures to gauge provider and beneficiary participation and experience in compliance with the final Access Rule. Specifically, CMS directed states to consider a variety of different measures and data sources in analyzing access, among them available sources of provider and beneficiary input. In response, DHCF finalized a set of measures and organized them into two categories: those that reflected the provider perspective and experience, and those that focused on the utilization and experience of beneficiaries. Not all measures were available or appropriate for each provider type.

Part A: Provider Participation and Experience

- Rate of Participation by DC-Licensed, Metropolitan-Area Providers

This measure of access focuses on the extent to which the provider population in the DC metropolitan area participates in the District's Medicaid program. To develop this measure, DHCF obtained a dataset of all physicians and dentists licensed by the D.C. Department of Health (DOH) Health Regulation and Licensing Administration (HRLA) Board of Medicine (BOM), Board of Dentistry (BOD), and Board of Podiatry (BOP) from FY 2011 and FY 2015. DHCF then merged this dataset with provider enrollment and claims data housed in the Medicaid Management Information System (MMIS) to determine which providers were enrolled in and billed Medicaid for each of the five years between FY 2011 and FY 2015. Once DHCF had identified the subset of providers, DHCF removed those with practice addresses that were more than 20 miles from the District's geographic center. While DHCF preferred to define the DC Metropolitan area as equal to the Medicaid FFS program's service area—which extends farther than 20 miles from the epicenter, including all contiguous Virginia and Maryland counties and also Baltimore—this was not possible given the time allowed. However, future reports will examine providers within the entire FFS service area. DHCF was able to conduct this analysis for FY 2011 through FY 2015 for all physician provider types, but not those licensed or certified by entities other than the Board of Medicine, Board of Dentistry, or Board of Pharmacy, such as home health agencies and behavioral health organizations other than psychiatrists.

While DHCF measured rates of enrollment and claims submission for each provider type, and presents the results of both measures, the claims submission rate serves as the overall indicator of provider participation in this report. It should be noted that some providers who enroll in Medicaid, but never submit claims for services, still play an important role in beneficiary care as ordering and referring providers. For example, a provider who treats dual-eligible beneficiaries may only bill Medicare, but in order to issue orders and referrals for certain Medicaid-covered services, the providers must be enrolled with Medicaid; otherwise, MMIS cannot process the orders and referrals. While the ordering and referring role is a significant one, this applies only to some providers who enroll but do not submit claims. For this Access Plan, DHCF used claims submission as the indicator of provider participation in Medicaid; for future Access Plans, DHCF will define participation as those who submit claims and/or order and refer. DHCF conducted Z-tests to determine whether the difference in billing rates from year to year was statistically significant at the 95 percent significance level, indicating whether the difference in rates was likely due to chance. The corresponding p-value was reported for each provider type.

- Number of Metropolitan-Area Providers Who Submit Medicaid Claims Each Year

Another measure focuses not on the rate of participation, but on the total number of metropolitan-area providers participating in Medicaid each year. This approach is advantageous because it counts providers who are licensed outside of the District but still operate close enough to its borders to provide access to DC Medicaid beneficiaries. DHCF constructed this measure based on MMIS data for each of the five years between FY 2011 and FY 2015; again limiting the identified providers to those whose address in MMIS showed they were located within 20 miles of the District's city center. Again however, the FFS service is actually broader and future reports will take this into consideration.

Another caveat to the data is how services provided to physicians who practice within FQHCs are counted. The District has eight FQHCs including several with multiple provider sites. Collectively, these FQHCs provide primary care to 36% of Medicaid beneficiaries in the District. Although DHCF accounted for the number of individual Medicaid-enrolled primary care physicians who render care at FQHCs, DHCF was unable to fully capture the total number of FQHC-based primary care providers who have billed Medicaid. When FQHCs submit a claim to Medicaid, the rendering provider field is often populated by the name of the clinic and not the provider who rendered the service. As a result, the number of individual primary care physicians who billed Medicaid may be underrepresented.

- Comparing Provider Ratios with Available Standards

While the rate of provider participation and the number of billing providers are useful measures, they do not factor in the size of the beneficiary population, and do not contain an objective measure of access against which the FFS program can be compared. To offer a standard by which to compare available access, DHCF calculated a provider-beneficiary ratio and compared this against available standards, including the actual provider-beneficiary ratios for Medicaid MCOs (where available), MCO contract network adequacy standards, and NCQA provider-beneficiary ratios for standard health plan accreditation for psychiatrists and OB/GYNs. There were limited provider-beneficiary ratio standards for home health services – MCOs typically do not provide these and NCQA does not have provider to beneficiary ratios for home health providers or the other types of physician specialists DHCF analyzes in the Plan.

- Provider Input (Qualitative)

DHCF currently does not conduct regular surveys of Medicaid providers, although such a survey is under development for future monitoring and for the next Access Plan. For this Plan, DHCF conducted an online survey of members of its MCAC in February 2016. The survey was short and only offered respondents a brief period in which to respond in consideration of the initial July 1 deadline for completion of the Access Plan. As a result, only four MCAC members responded. The respondents addressed access to a variety of different provider types. DHCF also fielded a provider survey as part of the State Innovation Model planning grant that was ongoing during the research period in the Spring of 2016. Unfortunately, provider responses were very limited and the survey did not yield useable data.

- Timely Payment Data

DHCF collected and analyzed data for each of the five years between FY 2011 and 2015 to determine whether the timeliness of payment was a factor that might influence a provider's decision to participate in the Medicaid FFS program. DHCF is required to pay all "clean claims" within 30 days of receipt. A clean claim is defined under federal Medicaid regulations as one that can be processed without

obtaining additional information from the provider of the service or from a third party.⁸ DHCF analyzed the proportion of clean claims that were paid within that timeframe. This analysis was conducted for fourteen provider types, including behavioral health, cardiology, dental, dermatology, endocrinology, home health, nephrology, pre- and post-natal obstetrics, oncology, ophthalmology, podiatry, primary care, psychiatry, and pulmonology.

Part B: Beneficiary Utilization and Experience

- Utilization of Services

DHCF also used MMIS data to measure the rate at which the beneficiary population utilized services. Specifically, DHCF identified the number of beneficiaries who received services from providers in each provider type each fiscal year and divided that by the total beneficiary population applicable to that provider type by year. For most provider types, the denominator was either the core Medicaid FFS beneficiary population or, for utilization measures that focused on children or the elderly, the core FFS Medicaid population under age 21 or 65 and older, respectively. However, for the utilization rate for pre- and post-natal obstetric services, the denominator was all women of child-bearing age (ages 15 to 44) in the core FFS population. DHCF calculated the Z-test and corresponding p-value to test the statistical significance of the difference in the utilization rates between each provider type for each year under review. Statistical significance was calculated at the 95% significance level, and was included as an indicator for whether the difference in rates was likely due to chance. DHCF reports on utilization of services for each provider type for each category of service each of the five years between FY 2011 and FY 2015.

The manner in which FQHCs bill the Medicaid FFS program presented challenges for accurately measuring utilization. From FY 2011 to FY 2015, FQHCs billed under a single CPT code at an all-inclusive rate regardless of whether primary care non-dental (PCPs or APRNs), dental, or behavioral health services were provided during each encounter. Because the majority of services provided by FQHCs are primary care non-dental, DHCF considered all FQHC claims to be for primary care non-dental services. This overstates utilization of these services and understates utilization of dental and behavioral health services, a significant limitation to the analysis. DHCF recently completed approval of a new FQHC payment methodology, which will be implemented upon approval by CMS. The new methodology will give DHCF greater insight into FQHC billing that will help inform this analysis in future years.

- Beneficiary Complaint Data

The Ombudsman records and categorizes complaints received from Medicaid beneficiaries on a wide range of issues. Using these categories, DHCF isolated those complaints related to access and identified the relevant provider types. DHCF identified 1,056 complaints regarding access between FY 2011 and 2015. Access complaints were defined as in those in which a beneficiary, caregiver, or other beneficiary representative stated that a beneficiary could not obtain a needed service or was experiencing a delay

⁸ Federal regulations also specify that claims containing errors originating in a State's claims system are considered clean, and therefore must be paid within the District's 30-day timeframe, and that claims from a provider who is under investigation for fraud or abuse or those under review for medical necessity are not considered clean. See 42 CFR § 447.45.

with obtaining a needed service. DHCF reports on the number of complaints by category of service and provider type as appropriate for each of the five years between FY 2011 through FY 2015.

- Beneficiary Surveys

DHCF does not regularly survey FFS beneficiaries, although launching such an effort (e.g., by expanding the annual CAHPS survey to include beneficiaries in FFS program, using online surveys or focus groups) is under consideration for the next Access Plan. DHCF conducted in-person emergency room interviews of 100 Medicaid beneficiaries for the State Innovation Model (SIM) planning grant during the Spring of 2016. Some of the information discussed in the interview, which mostly focused on identifying health care needs and access to services for high-users of care, is relevant to the discussion of access and the findings are being incorporated into this report. However, it is important to note that respondents included both FFS and MCO Medicaid beneficiaries.

- Map of Beneficiary/Provider Addresses

A final indicator relevant to sufficiency of access to services is providers' geographic location relative to where beneficiaries live. Because the District occupies a relatively small geographic area (68 square miles), the usual time and distance standards for network adequacy of providers are less applicable to the District. Still, it proved useful to construct a heat map showing the areas where beneficiaries reside in the District relative to the locations of primary care providers and hospitals. The heat map divides the District into its eight wards, each ward having its own political representation and organization of services. The wards are linked by a variety of means of public transportation, including the Metrorail subway system, buses and a streetcar line, and taxicabs are readily available. The District also provides non-emergency transportation to beneficiaries to enable them to attend medical appointments. The DC Office of the Chief Technology Officer (OCTO) constructed the heat map based on FY2014 data retrieved from MMIS and HRLA by DHCF. Notably, the heat map does not capture Medicaid enrolled providers who are outside the physical boundaries of the District. The District will look to expand the heat map to incorporate providers within the entire FFS service area for the next Access Plan.

IV. Payment Rate Comparison Initial Findings

DHCF compared Medicaid FFS payment rates to Medicare and MCO plan payment rates for the six provider categories: primary care, physician specialists, behavioral health, home health, pre- and post-natal obstetrics, and other providers selected due to suspected access issues. The initial findings are below.

A. Comparison with Medicare

Medicaid payment rates are generally 80 percent of, or equal to Medicare payment rates or are not comparable due to differences in covered services or payment methodologies. For certain primary care services, the Medicaid payment rate is 100 percent of the Medicare rate for qualifying physicians, psychiatrists, OB/GYNs, and APRNs. To qualify, physicians must attest to DHCF that they have a specialty designation of family medicine, general internal medicine, pediatric medicine, obstetrics and gynecology or psychiatry by showing either that they that are Board-certified in that specialty or that they bill 60 percent of their Medicaid services for eligible Evaluation and Management (E&M) codes. APRNs must bill 60 percent of their Medicaid services for eligible E&M codes and submit an attestation

form. The rate for qualifying primary care services has been set at 100 percent since January 1, 2013, when the District implemented the physician rate increase under Affordable Care Act requirements. In 2016, the District made the rate increase permanent and extended it to psychiatrists, OB/GYNs, and APRNs based upon an analysis that looked at which provider types most frequently billed for the eligible evaluation and management codes associated with primary care.

For non-qualifying primary care services and for physician specialist services, the District typically pays 80 percent of the Medicare physician fee schedule. This includes all the physician provider types included in this report: cardiologists, dermatologists, endocrinologists, OB/GYNs, nephrologists, neonatologists, oncologists, ophthalmologists, podiatrists, psychiatrists, and pulmonologists (except for OB/GYNs or psychiatrists eligible to receive the primary care provider rate increase noted in the paragraph above). Effective May 1, 2016, the District increased the rate paid to oncologists for physician-administered chemotherapy drugs from 80 percent to 100 percent of the Medicare fee schedule

Comparing Medicaid and Medicare rates for many of the other services, such as home health, dental, and behavioral health services other than psychiatry, failed to yield results because many of the specific services in those categories are not covered or are covered on a limited basis by Medicare. Other types of services, such as primary care services provided by FQHCs, were paid under different payment methodologies, making a straightforward, quantifiable comparison difficult.⁹ Therefore, while Medicare serves as a useful benchmark for physician services, it is less informative generally than our comparison with Medicaid MCOs.

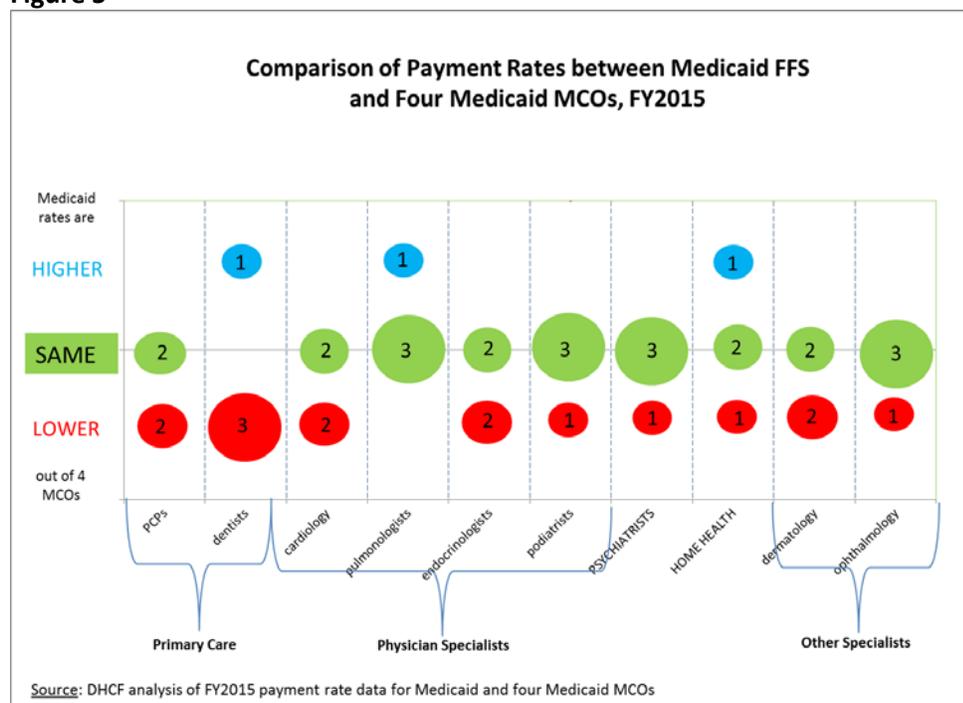
B. Comparison with Medicaid MCOs

DHCF was unable to calculate an average MCO payment rate for each provider type and compare it to Medicaid FFS. However, DHCF was able to determine whether Medicaid FFS tended to be higher, lower, or about the same as each MCO's rates. Although there was considerable variation by MCO, FFS payment rates tend to be either on par or lower. (See Figure 5.) For seven provider types—PCPs, cardiologists, endocrinologists, podiatrists, psychiatrists, dermatologists, and ophthalmologists—MCOs paid rates that were either higher than Medicaid FFS or about the same. For three other provider types—dentists, pulmonologists, and home health providers—Medicaid FFS paid higher rates than one MCO but about the same or lower than the other three.

A comparison between Medicaid FFS and Medicaid MCOs for oncology and nephrology services was inconclusive. Due to wide variation in rates for these services within and between MCOs, there was no clear pattern of payment.

⁹ In 2015, FQHCs received a single encounter rate for medical and behavioral health visits. In contrast, Medicare pays FQHCs the lesser of (1) their charges or (2) a single national rate which is adjusted based on the location of where the services are furnished.

Figure 5



C. Conclusions about Payment Adequacy

In comparing Medicaid FFS payment rates to Medicare and to Medicaid MCO plan payment rates, Medicaid appears comparable to other payers. Medicaid’s payment for FFS services is typically 80 percent of Medicare for most providers and is equal to Medicare in some cases. Medicaid FFS also appears to pay comparable rates to most Medicaid MCO plans operating in the District for many services. Although DHCF was unable to determine actual rates from all four MCOs and therefore are unable to quantify the magnitude of the difference in payment across plans, DHCF was able to determine if each plan’s rates were higher, lower, or about the same as Medicaid FFS. According to our analysis, Medicaid pays the same rate as most Medicaid MCOs for pulmonologists, podiatrists, psychiatrists, and ophthalmologists. However, Medicaid is paying on par or less than at least half of MCO plans for primary care services, cardiologists, endocrinologists, and dermatologists, and paying less than most Medicaid MCOs for dentists.

Our payment rate comparison had several limitations. First, because DHCF did not receive actual rates from all four MCOs participating in Medicaid, DHCF was unable to calculate an average rate across MCOs, and therefore could not quantify any overall differences with Medicaid FFS. Second, DHCF was unable to obtain payment rate information for private payers, which left a crucial point of comparison out of our analysis. Consequently, the results of our payment rate comparison should be considered an initial, or baseline set of findings. For the next Access Plan, DHCF will require rate information from all four participating Medicaid MCOs to address this information deficit and contract with a vendor to obtain private payer rate data. As a result, DHCF expects the payment analysis to be more sophisticated and results more definitive over time.

V. Access Measurement Analysis Initial Findings

A. Primary Care

DHCF's analysis of access to primary care services in the Medicaid FFS program had two components: (1) provider participation and experience and (2) beneficiary utilization. The provider participation and experience component analyzed provider licensure, enrollment and billing trends, compared current provider network adequacy ratios between the FFS program and Medicaid MCOs (measures of provider participation), and included qualitative data from a survey of MCAC members (a measure of provider experience). The beneficiary utilization and experience component analyzed trends in service utilization rates (a measure of beneficiary utilization) and reviewed ombudsman complaints, SIM survey results, and a heat map showing location of beneficiary residences relative to primary care providers (measures of beneficiary experience).

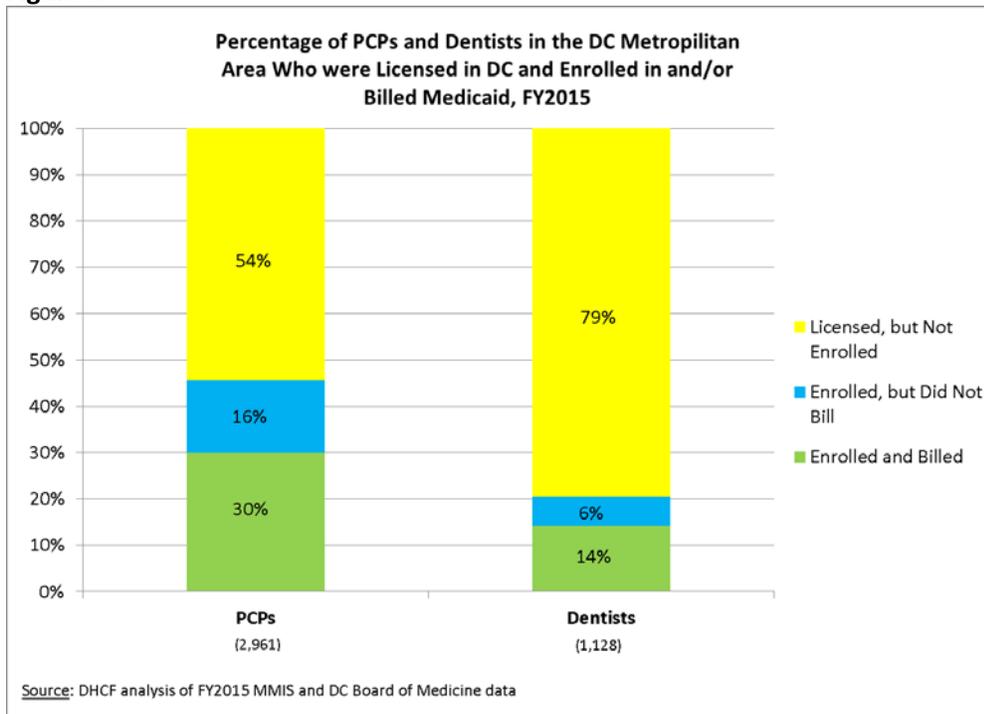
Primary Care Provider Participation and Experience

Rate of Participation by DC-Licensed, Metropolitan-Area Primary Care Providers Appears to Have Increased

To determine participation, DHCF created FY 2015 snapshot and five-year trend analyses of PCP and dental providers, included calculations of total providers licensed in the District, those enrolled who did not bill, and those who enrolled and billed for services. Providers who enrolled but did not bill may be ordering and referring providers, so this number may represent providers who are seeing Medicaid beneficiaries to refer for treatment by other providers.

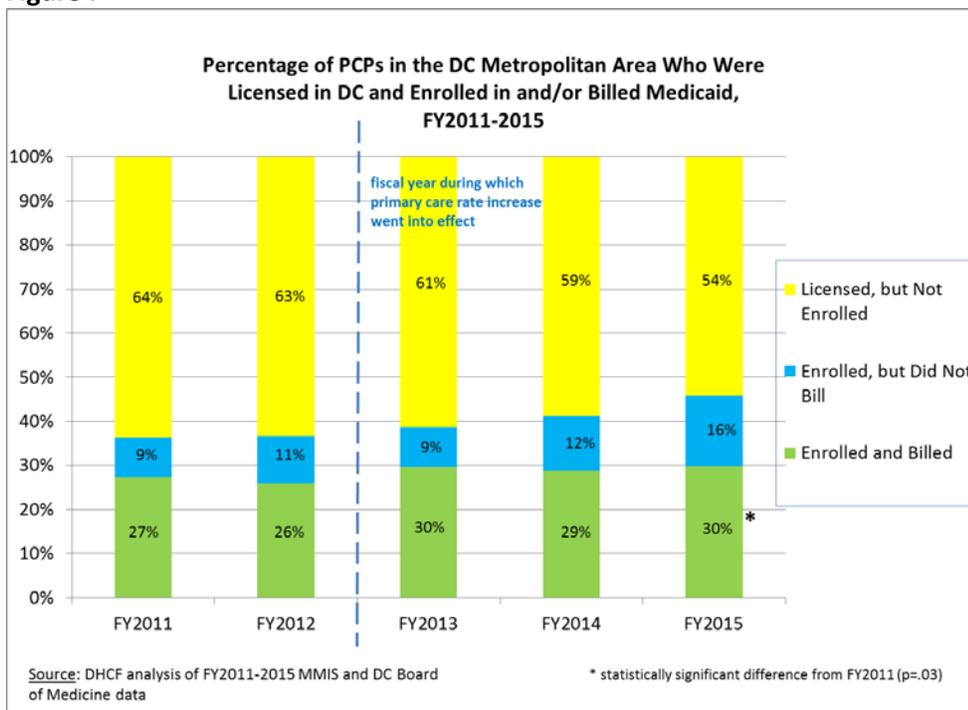
FY 2015 Snapshot: Of the 2,961 PCPs that are either licensed in the District or based in the DC Metropolitan Area in FY 2015, 46 percent were enrolled in Medicaid, and 30 percent billed for at least one primary care service for a Medicaid beneficiary that year (See Figure 6). Of the 1,128 dentists licensed in DC and based in the DC metropolitan area, 20 percent were enrolled in Medicaid, and 14 percent billed for at least one primary care service for a Medicaid beneficiary.

Figure 6



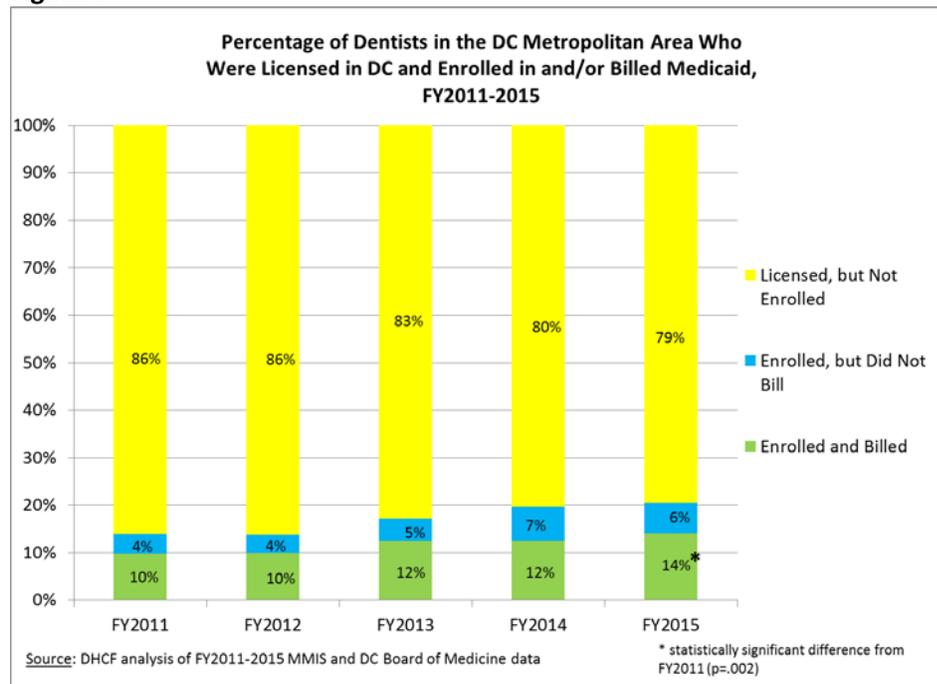
Five-Year Trend: Between FY 2011 and FY 2015, the percentage of DC-licensed, metropolitan-area PCPs who billed Medicaid fluctuated, but the rate of participation grew by 11 percent, from 27 percent in FY 2011 to 30 percent in FY 2015. (See Figure 7.) This increase was statistically significant. It is important to note that FY2013 was the year the primary care rate increase went into effect.

Figure 7



Dental providers' rate of participation also appears to be increasing. Between FY 2011 and FY 2015, the rate of participation by DC-licensed, Metropolitan-Area dentists in Medicaid increased 40 percent, from 10 percent in FY 2011 to 14 percent in FY 2015. (See Figure 8.) This increase was statistically significant. Even given this increase, the data indicates that a relatively small percentage of licensed dentists in the District participate in the Medicaid program. One stakeholder commented that low participation rates by dentists is an issue that is affecting access for beneficiaries and recommended that DHCF discuss this with dental providers to better understand the reasons for this disparity in participation. DHCF agrees that more information regarding factors influencing participation in Medicaid will be useful and plans to implement new outreach strategies in the future to better understand this trend.

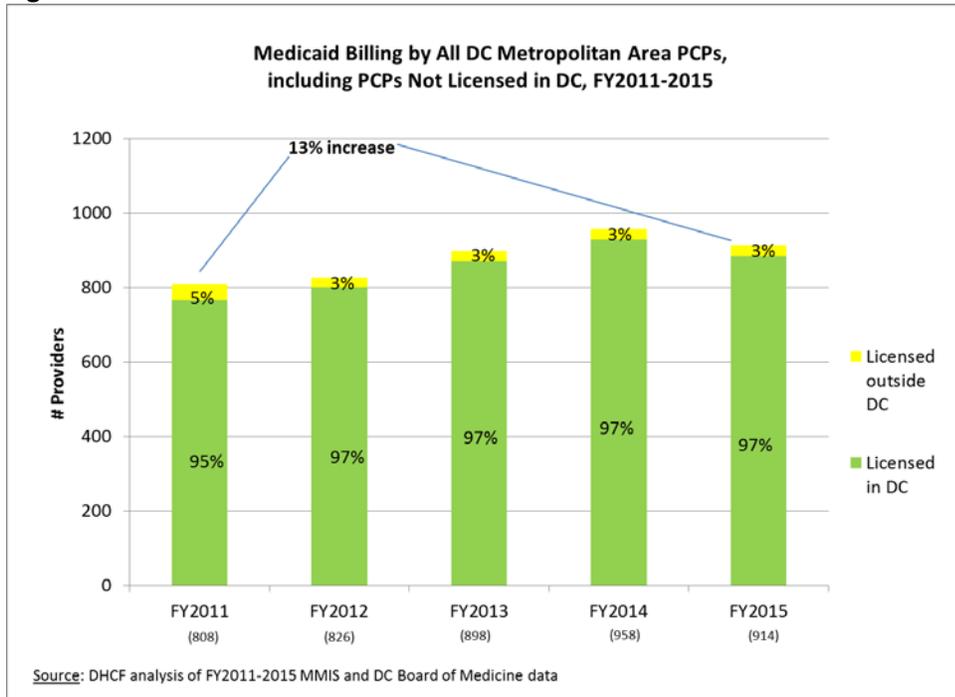
Figure 8



Total Number of Metropolitan Area PCPs and Dentists Billing Medicaid Appears to Have Increased

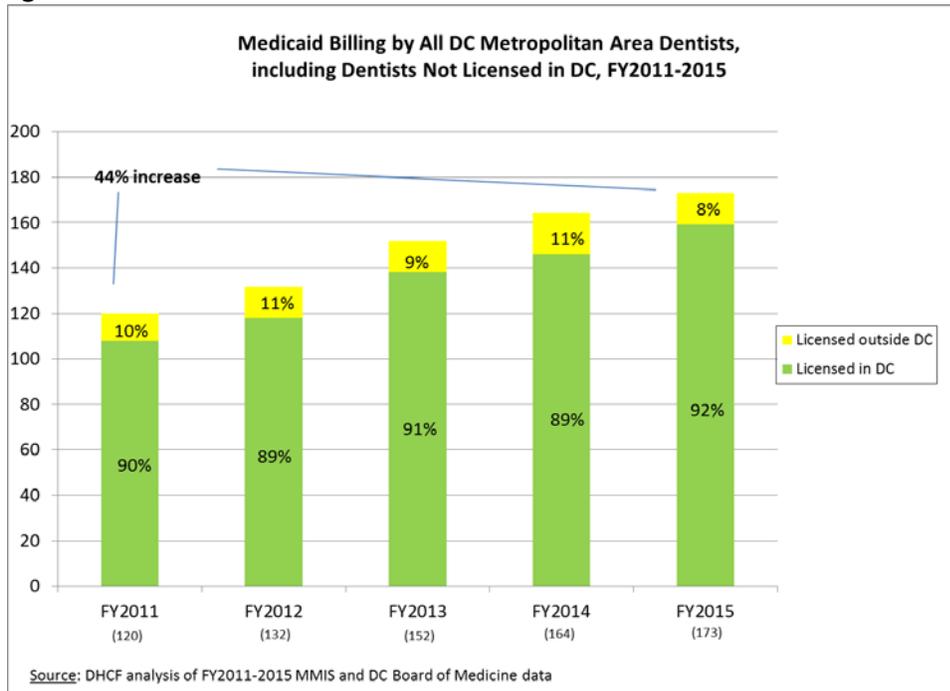
Between FY 2011 and FY 2015, the total number of metropolitan-area PCPs that billed Medicaid for at least one primary care service annually rose 13%, from 808 to 914. (See Figure 9.) Providers licensed outside DC played a small role, representing only about 3% of PCPs in FY 2015.

Figure 9



Between FY 2011 and FY 2015, the number of DC Metropolitan Area dentists who billed Medicaid for at least on dental service annually rose 44%, from 120 to 173. (See Figure 10.) A small but significant percentage (averaging 10 percent) were licensed outside of DC during each year under review.

Figure 10



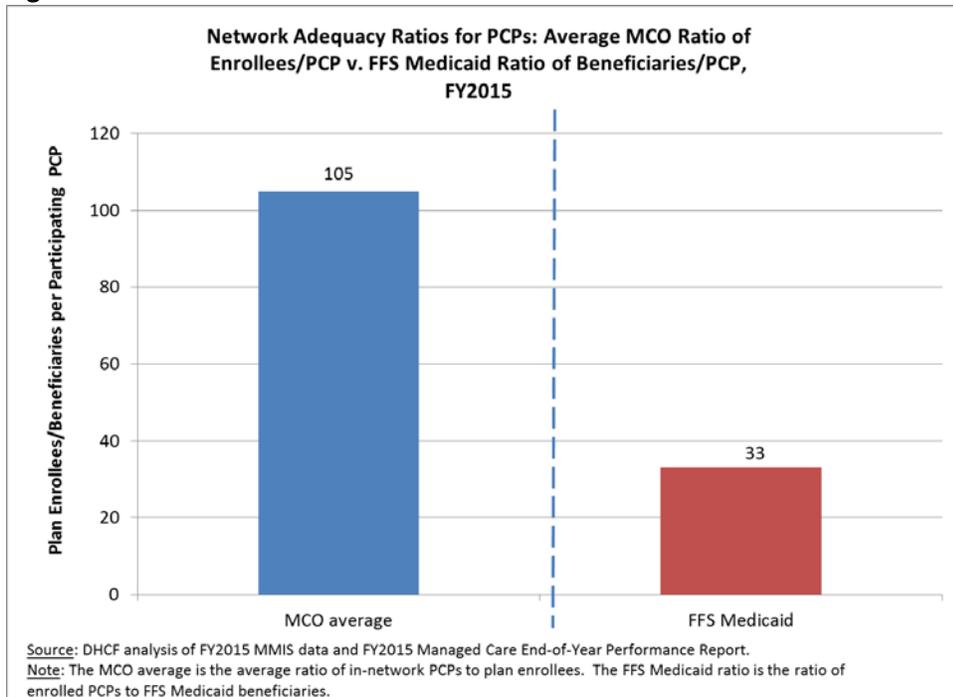
Participation by FQHCs appears stable

FQHCs provide comprehensive primary care, behavioral health services, and dental care. There are eight FQHCs participating in the District Medicaid program, including some with multiple provider sites. The number of Medicaid-enrolled FQHC providers has remained consistent throughout the study period, although the number of sites at participating providers has grown. In FY 2015 FQHC offered services at sites in each of the District’s eight Wards (See Map in Figure 21, below)..

FFS Provider/Patient Ratios Appear to Compare Favorably to Medicaid MCOs

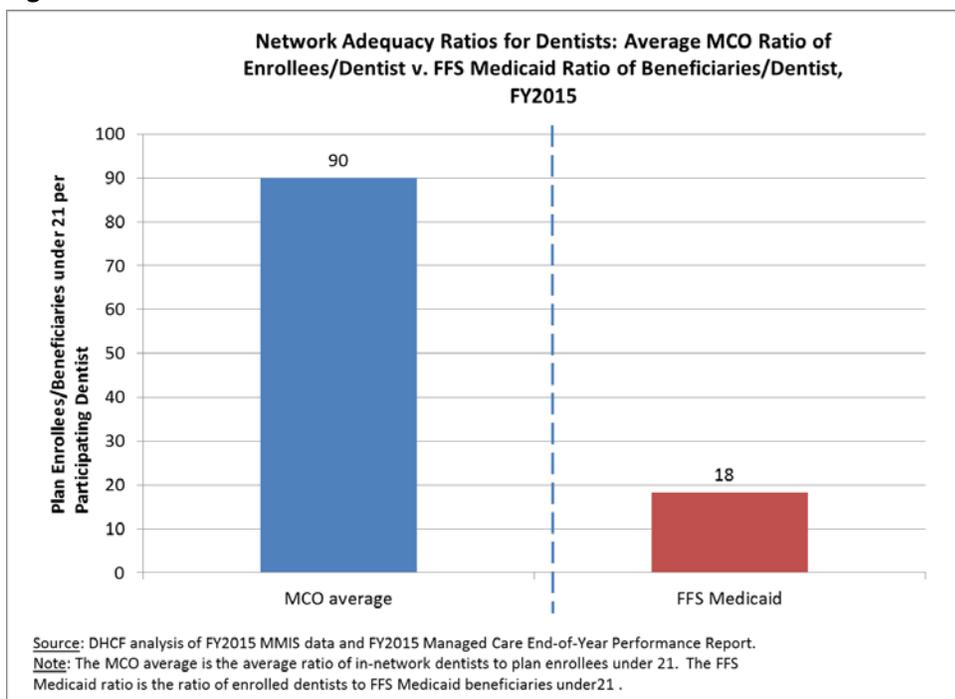
In FY 2015, the ratio of DC Metropolitan Area PCPs enrolled in Medicaid to FFS Medicaid beneficiaries was 1:33. (See Figure 11.) This compares favorably with the average of the actual operational ratios of PCPs to plan members reported by MCOs in FY 2015, 1:105.

Figure 11



In FY 2015, the ratio of DC Metropolitan Area dental providers to FFS Medicaid beneficiaries under 21 was 1:18. (See Figure 12.) This compares favorably with the average of the actual operational ratios of PCPs to plan members under 21 reported by MCOs in FY 2015, 1:90.

Figure 12



MCAC Survey Respondents Raised Concerns about Long Wait Times and Lack of Medical Dentistry Options

In the MCAC Access Survey, three MCAC members responded with concerns regarding access to primary care in the FFS program. They highlighted long wait times to schedule an appointment for PCPs, lack of medical dentistry options, and concerns about geographic proximity of providers. Due to the relatively low response rate of the MCAC survey, it is not possible to draw conclusions regarding the general applicability of these concerns. With additional time, DHCF intends to expand the reach of the Access Survey for the next Access Plan.

The three members responded with the following:

- “The provision of medical dentistry is currently at bare minimum and only very few dentists are available in southeast only. DC should expand their options to allow greater reimbursement so more dentist are incentivized in each neighborhood throughout the city.”
- “PCPs - long wait times to get new patient appointments”
- “Very few dentists who will do restorative dental work”

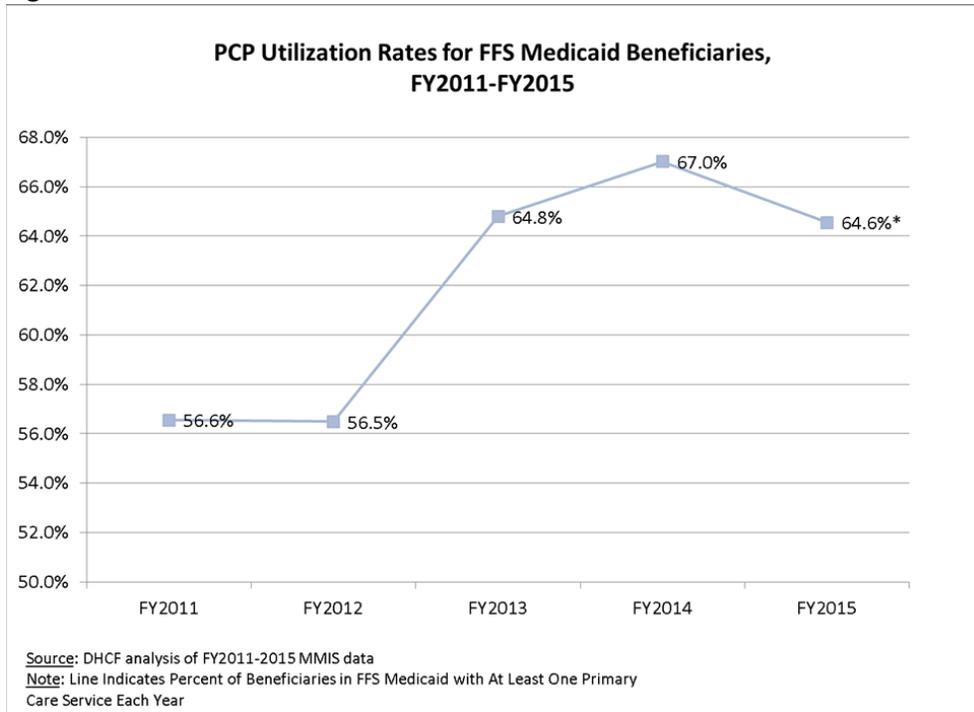
Beneficiary Utilization and Experience with Primary Care Services

Utilization of Primary Care Services Appears to Have Increased Over Time

Overall FFS Beneficiary Population: As primary care provider participation increased, the rate of utilization of primary care services for the FFS beneficiary population increased between FY 2011 and FY 2015. (See Figure 13.) In FY 2011, 56.6 percent of FFS beneficiaries received at least one primary care

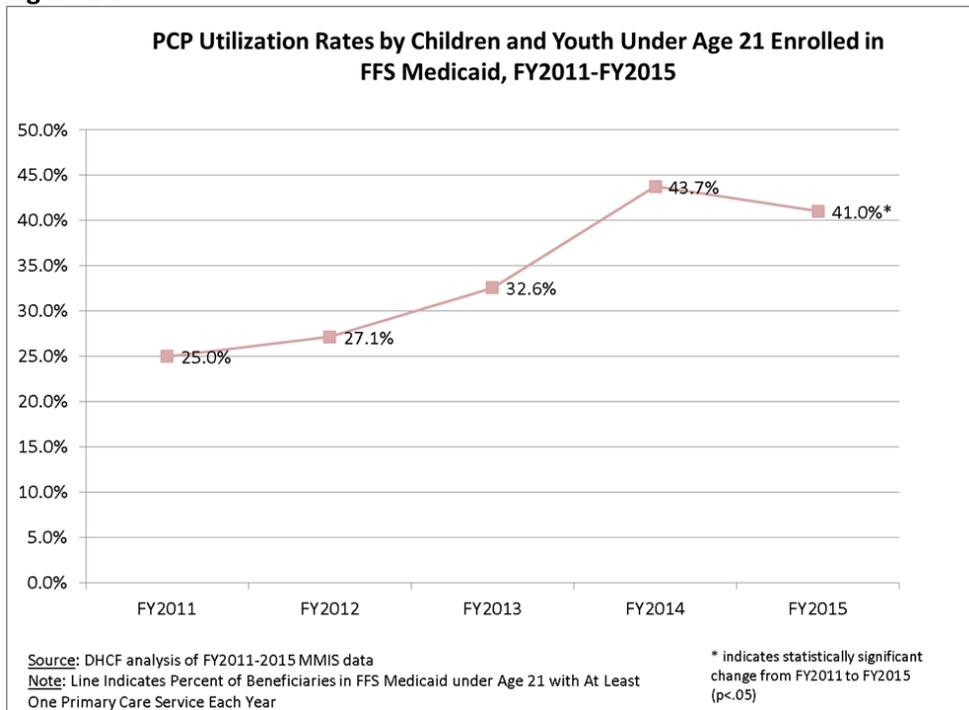
service from a PCP. By FY 2015, the number had risen to 64.6 percent. This 14.1 percent increase was statistically significant.

Figure 13



Children and Youth: The increased utilization trend for PCP services was consistent for children and youth under 21 years of age. In FY 2011, 25 percent of the FFS beneficiaries under age 21 received at least one primary care service from a PCP, but by FY 2015 that percentage had increased to 41 percent. (See Figure 14.) This 64 percent increase in the utilization rate was statistically significant.

Figure 14



Despite these important gains in utilization over time, this analysis indicates that PCP service utilization may be lower than is medically indicated for the FFS population, especially for medically vulnerable beneficiaries and children.¹⁰ One challenge in assessing the service needs for children and youth, for example, is that they may be receiving intensive non-medical social services through other programs that are not currently well-aligned or coordinated with Medicaid. To address this concern, the District is committed to implementing more coordinated oversight of the early and periodic screening, diagnostic, and treatment (EPSDT) services benefit, including well-child visits, dental services, and lead screens regarding FFS children. The target population for FFS-enrolled children includes:

1. Children with disabilities living at home;
2. Children in a long-term care institutional setting;
3. Children in foster care or in custody of child welfare agency;
4. Adopted and permanently placed children; and
5. Juvenile justice involved children and youth.

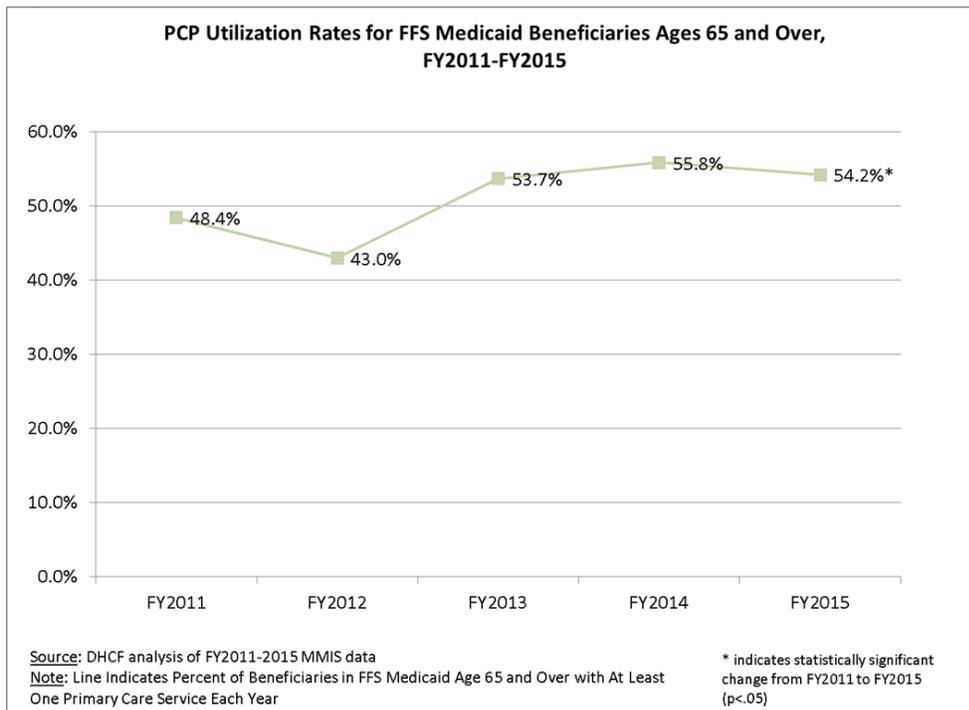
Recognizing the different needs of these sub-populations, the District is undertaking a targeted approach specific to each. For example, DHCF is developing a memorandum of agreement (MOA) with DC Child and Family Services Agency (CFSA) to ensure that CFSA has more accurate records of foster care children in their custody who are due and overdue for needed primary care services, including dental services and lead screens. In addition, DHCF is developing an MOA with the Department of Youth Rehabilitative Services (DYRS) to ensure more accurate recordkeeping for children in the juvenile justice system. DHCF received comments from one external stakeholder that they were not aware of DHCF's

¹⁰ In FY2015, there were 6,350 children and youth under 21 in the core Medicaid FFS population, according to DHCF estimates of FY 2015 MMIS claims.

outreach initiative. In response, DHCF plans to present this targeted outreach initiative at an upcoming MCAC meeting, and welcomes input and participation from all stakeholders.

Elderly Individuals: Individuals aged 65 or older also experienced a trend of increased utilization of PCP services during the study period. In FY 2011, 48.4 percent of elderly beneficiaries received at least one primary care service from a PCP, while in FY 2015, 54.2 percent received at least one primary care service from a PCP. (See Figure 15.) This 11.9 percent increase in the utilization rate was statistically significant. It is worth noting that some of these beneficiaries may be dually eligible for Medicare and Medicaid and their utilization of primary care services may not be well-documented in Medicaid claims because it was fully or partially covered under Medicare.

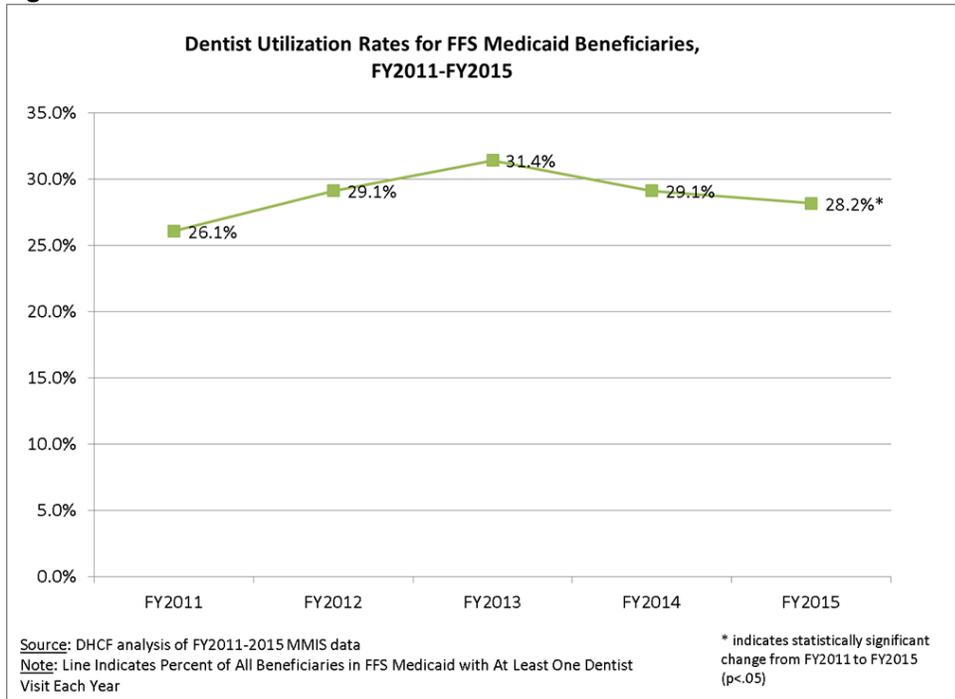
Figure 15



Utilization of Dental Services Appears to Have Increased Over Time

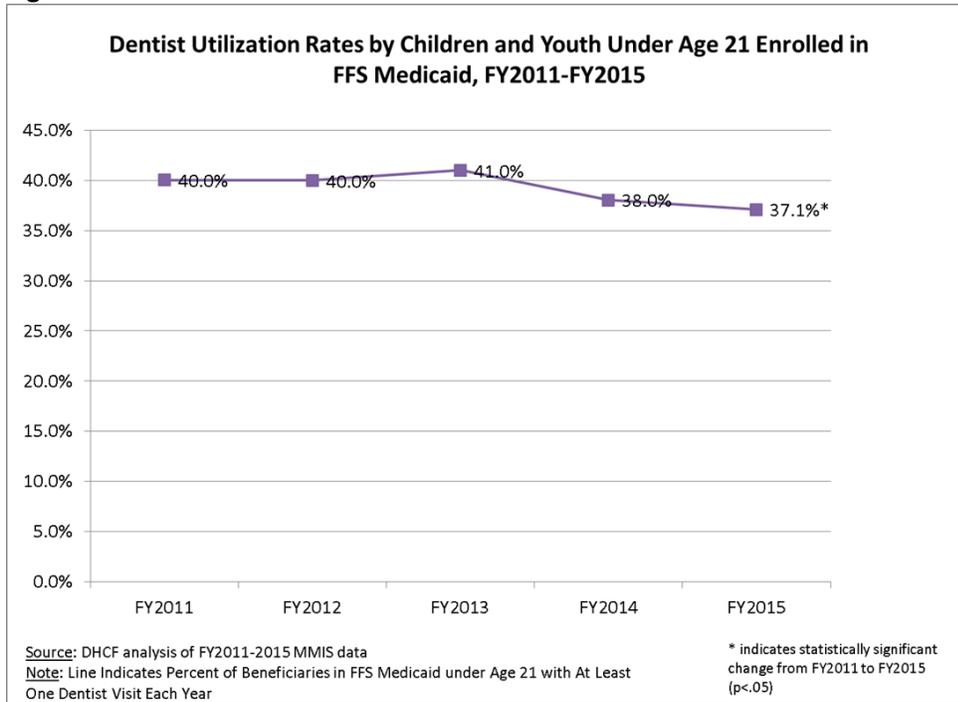
Overall FFS Beneficiary Population: The dental services utilization rate by FFS beneficiaries, which was calculated using the number of unique beneficiaries divided by all FFS beneficiaries enrolled in each year, increased between FY 2011 and FY 2015. In FY 2011, 26.1 percent of FFS beneficiaries received services from a dental provider and in FY 2015, 28.2 percent received services from a dental provider, representing an 8.0 percent increase over the five year period. (See Figure 16.) This increase was statistically significant.

Figure 16



Children and Youth: In contrast to the core FFS population generally, core Medicaid FFS beneficiaries under age 21 appear to have experienced a decrease in utilization of dental providers. In FY 2011, 40.0 percent of the 7,678 beneficiaries under age 21 received at least one service from a dentist, and in FY 2015, 37.1 percent of the 5,987 beneficiaries under age 21 received at least one service from a dentist. (See Figure 17.) This 7.25 percent decrease in the utilization rate was statistically significant. It is important to note that the utilization rates for dental services for beneficiaries under 21 did not include dental services rendered by FQHCs. Thus, the data may not accurately represent utilization of dental services by children.

Figure 17

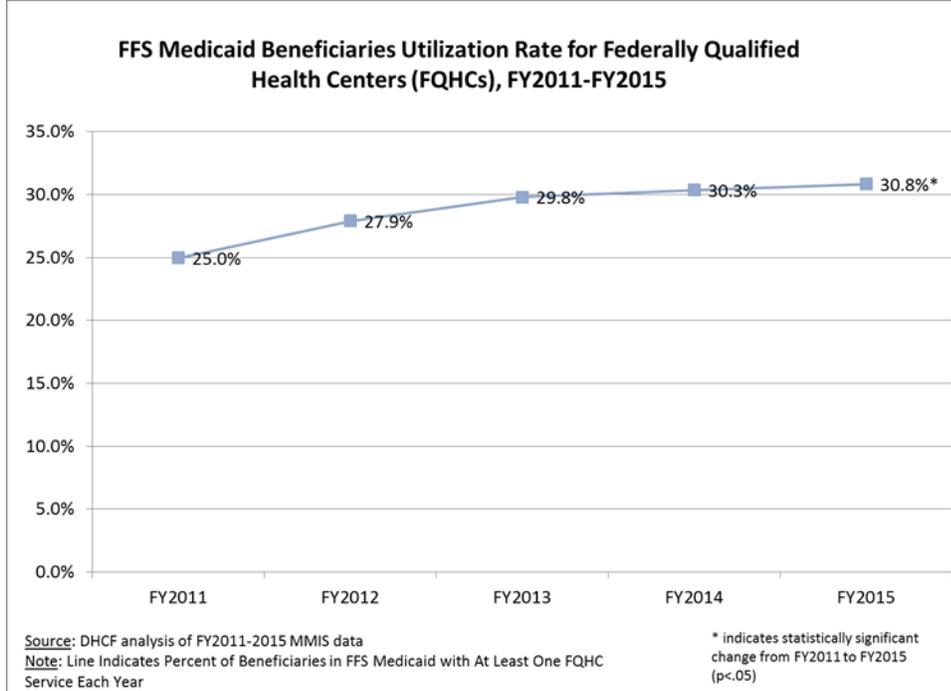


DHCF is monitoring recent decreases in utilization rates for children and is using the same outreach and monitoring strategies for dental utilization as those described above for PCPs. (DHCF plans on presenting the package of targeted outreach strategies at an upcoming MCAC meeting, and will welcome input from all stakeholders.) Further, once the new payment methodology is implemented for FQHCs, DHCF will have more accurate data on utilization of dental services provided by FQHCs.

Beneficiaries Continue to Rely on FQHCs Heavily for Primary Care Services

Beneficiary utilization of FQHC services was calculated using the number of unique FFS beneficiaries who received at least one FQHC service in each study year, divided by all FFS beneficiaries who were eligible in that year. As shown in Figure 18 below, the utilization rate increased from 25.0% in FY 2011 to 30.8% in FY 2015; this 23.2 percent increase was statistically significant. It is important to note that because FQHC providers bill the District's Medicaid program and the Medicaid managed care organizations using a single encounter code, it was not possible to determine from the claims data exactly which type of services were rendered; some of the District's FQHCs provide dental and behavioral health services in addition to primary care. However, the majority of services rendered by FQHCs are primary care services.

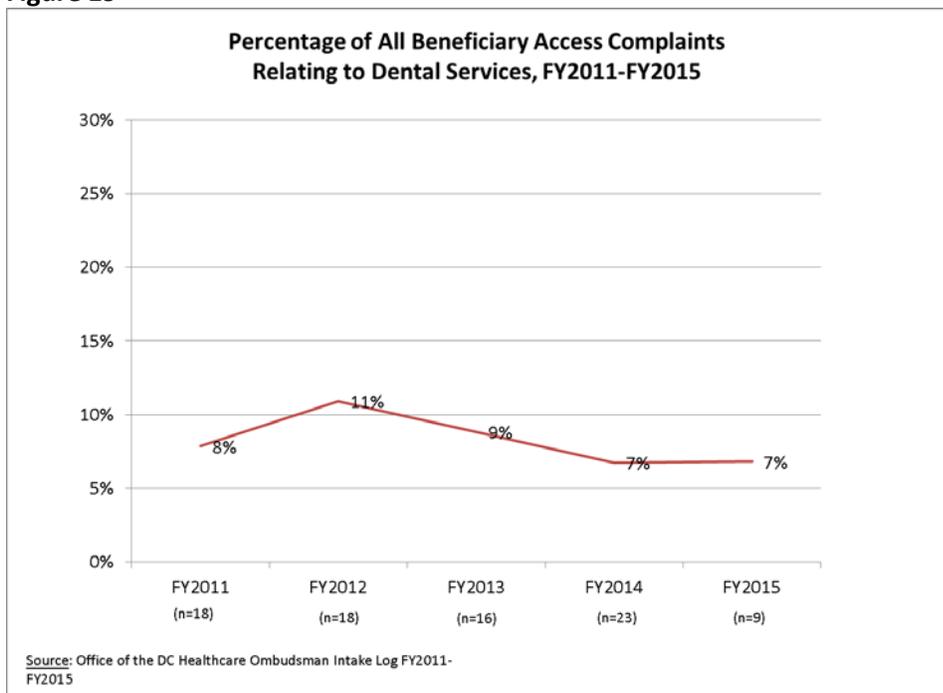
Figure 18



Beneficiary Access Complaints Relating to Primary Care Services Focused on Dental Care

The District’s Health Care Ombudsman Office received very few beneficiary complaints related to access concerns for PCPs. However, complaints about access to dental services comprised between 7 to 11 percent of all access-related complaints each year. FY 2011(See Figure 19.) FY 2011These complaints mainly arose from beneficiaries not being able to see a dentist or receive certain services like dentures.

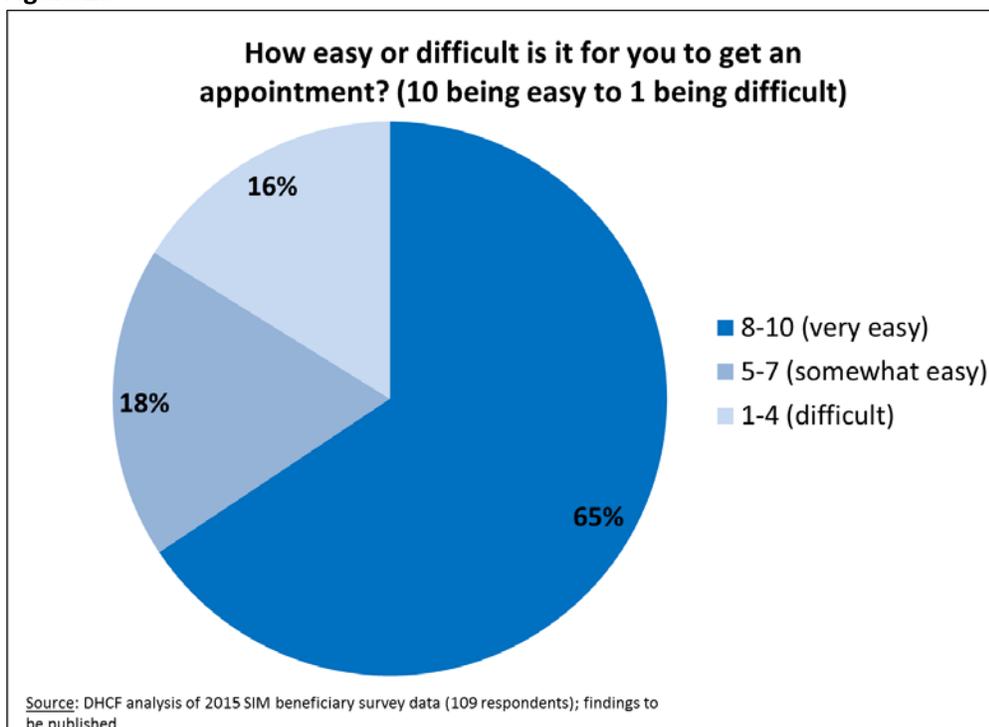
Figure 19



SIM Survey Findings Suggest General Ease in Securing Appointments, But Results Not Specific to FFS

An analysis of interview data from a State Innovations Model (SIM)- funded survey of Medicaid beneficiaries in the emergency room found that 84% of the Medicaid beneficiaries interviewed reported having a primary care physician. In addition, 65% rated their experience in obtaining an appointment at an 8 or above on a scale of 1 (difficult) to 10 (easy). (See Figure 20) An additional 18 percent of beneficiaries rated their experience as “somewhat easy” with a score of 5-7 out of 10. While this data may indicate that beneficiaries with higher care needs may perceive having sufficient access to care, it’s important to note a few limitations in applying this data more broadly. First, this study involved both FFS and MCO beneficiaries, so the findings may not accurately represent the actual FFS beneficiary experience. In addition, the beneficiaries presenting in the emergency room may have more acute care needs and as a result may not offer a proportional representation of FFS beneficiary experience. Finally, these findings appear to conflict with anecdotal stakeholder inputs on the difficulty of scheduling appointments with PCPs. For these reasons, more data is needed to confirm actual FFS beneficiary experience in obtaining appointments and securing treatment from a PCP.

Figure 20



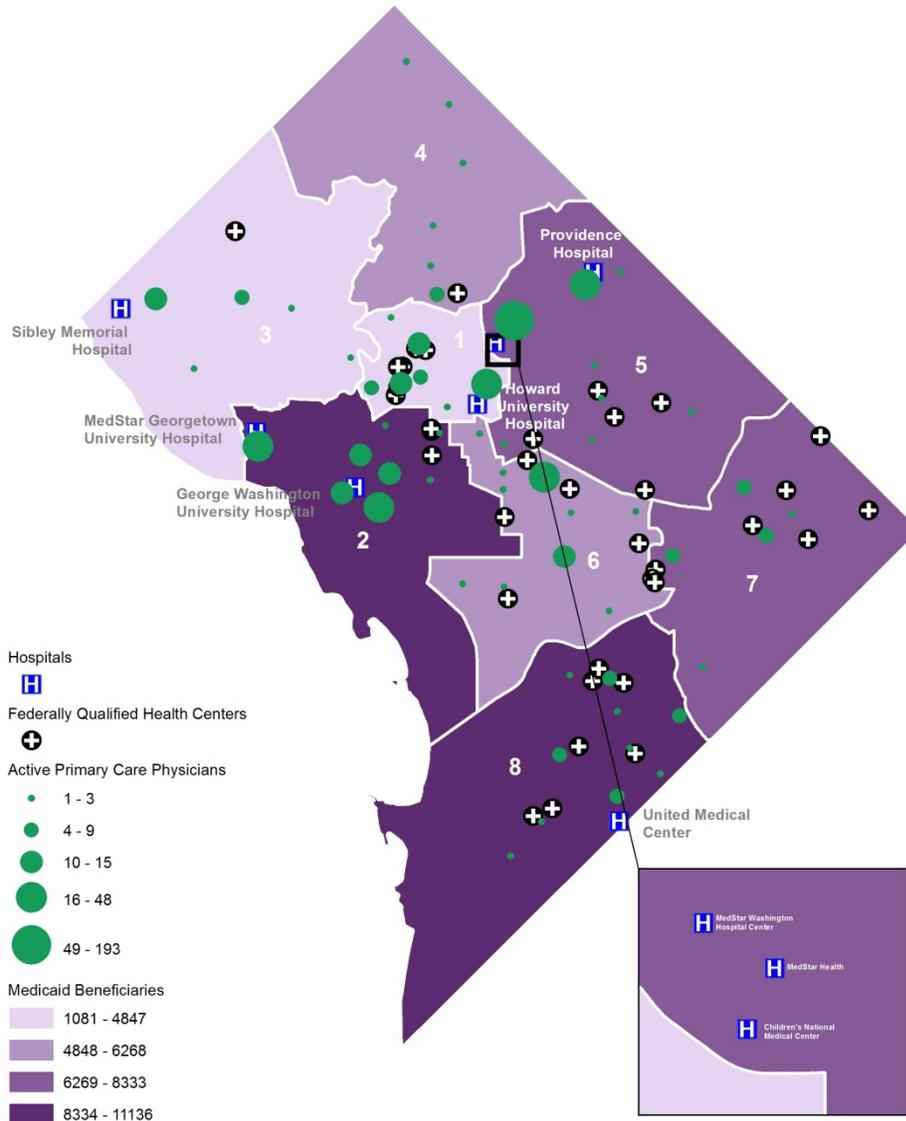
Geographic Location of Beneficiaries and PCPs Among District Wards Suggests Disparity Between Beneficiary and Provider Density

Using data gathered by DHCF, OCTO created a heat map that demonstrates where Medicaid FFS beneficiaries live among the Districts’ eight wards compared to the location and density of PCPs, hospitals and FQHCs. (See Figure 21.) As the map demonstrates, Medicaid FFS beneficiaries are concentrated into Wards 2, 5, 7 and 8, with the highest concentration in Wards 2 and 8. By contrast, the greatest concentration of enrolled Medicaid provider density is in Wards 1, 2, 5, and 6, with many of those providers practicing at area hospitals. FQHCs have sites throughout the city, and tailor their services to fit the special needs and priorities of their communities, providing services in a linguistically and culturally appropriate setting. FQHC sites often offer different services or providers, serve target populations (e.g. homeless individuals, pregnant women, individuals with HIV/AIDS, or Latinos), or have different hours of operation. Therefore, some of the sites reflected on the map may not be used by all Medicaid-enrolled FFS beneficiaries. For example, while the map appears to indicate a significant density of FQHCs in Ward 8 and fewer in Ward 2, the two wards with highest concentration of Medicaid FFS beneficiaries, additional research is needed to determine to what extent these sites are filling the need for access to PCPs and the scope of population being served.

It is also important to note that this map does not reflect Medicaid FFS providers who are located outside of the geographic boundaries of the District. For example, many residents in Ward 7 and 8 seek health care services from DC Medicaid-enrolled providers located in adjacent Prince Georges County, MD, but these providers are not reflected on the current map.

Figure 21

**Location of Medicaid FFS Population Residences
Relative to Provider Practice Locations, FY2014**



Source: DC Office of the Chief Technology Officer (OCTO) analysis of FY 2015 MMIS data and DC Department of Health Primary Care Provider sites, analyzed for DHCF June, 2016.

As discussed above, this map may indicate some disparities between the beneficiary demand for PCPs near where beneficiaries live and where PCPs are generally located. However, additional data is needed to better understand beneficiary experience. The need for additional PCP access points for Medicaid beneficiaries where they live has been reinforced anecdotally by beneficiary advocates and other stakeholders. This potential disparity will be an area of focus for future monitoring and improvement efforts and will be evaluated in the next Access Plan.

Conclusions about Access to Primary Care Services

Based on DHCF's analysis, beneficiary access to primary care services in the FFS program appears generally to have increased over the past five years. The percentage of DC-licensed, metropolitan area PCPs and dentists billing Medicaid increased from FY 2011 through FY2015, and the total number of DC Metropolitan area providers that billed Medicaid in those years also increased. The FFS program also compared favorably with Medicaid managed care plans in terms of network adequacy. Overall beneficiary utilization of primary care and dental services increased, as did utilization of primary care services for children and youth under age 21 and adults age 65 and older. Even given the mostly increasing rates, primary care utilization overall still appears low, especially for children. In fact, findings show the utilization of dental services by children and youth actually decreased slightly during the five-year study period. The District has been aware of this issue, is already pursuing a plan for enhanced outreach and monitoring to address it and will continue these efforts.

Participation rates by dentists are small compared to the number of licensed dentists in the District as noted by one commenter, which may be a factor influencing low utilization. DHCF plans to engage providers to gain insights into the factors influencing dentists to participate in Medicaid. DHCF will also want to compare these rates to participation rates in other state Medicaid programs since private dentist participation is typically low in Medicaid generally due to a variety of factors including many dentists' decision to decline insurance or Medicaid coverage participation.¹¹ DHCF also notes that dental provider participation rates may be under-represented in this report due to the inability to accurately collect and report on dental utilization within FQHCs under the current PPS reimbursement model. As noted earlier, the District is seeking CMS approval to move to a new alternative payment methodology (APM) which will reimburse FQHCs a different rate for primary care, behavioral health and dental services and allow FQHCs to bill for one of each of these types of encounters in a single day. As a result, DHCF expects that future data will more accurately report the frequency of dental service utilization and volume of dental provider participation.

The findings also indicate the need for additional research to determine whether there is a disparity in access points for PCP services where Medicaid FFS beneficiaries live. DHCF plans to do further research to assess beneficiary experience and availability of existing PCP provider sites to support

DHCF's analysis of access to primary care services in the FFS program had significant limitations. Specifically, the measures DHCF used for provider participation and beneficiary utilization and experience relied upon Medicaid claims data. Input from providers and beneficiaries—in the form of the MCAC survey and Ombudsman complaint data, respectively—was limited and inconclusive. Consequently, the results of this analysis of access to primary care services should be considered an initial, or baseline set of findings from which future analyses and monitoring can build. For the next Access Plan, DHCF will have in place more robust beneficiary and provider feedback, and therefore DHCF expects this analysis to be more sophisticated and results more definitive over ti

¹¹ Hinton, Elizabeth and Julia Paradise, *Access to Dental Care in Medicaid: Spotlight on Nonelderly Adults*, Kaiser Family Foundation Issue Brief (Washington, DC, March 17, 2016), accessed on September 22, 2016 at <http://kff.org/medicaid/issue-brief/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults/>.

B. Physician Specialists

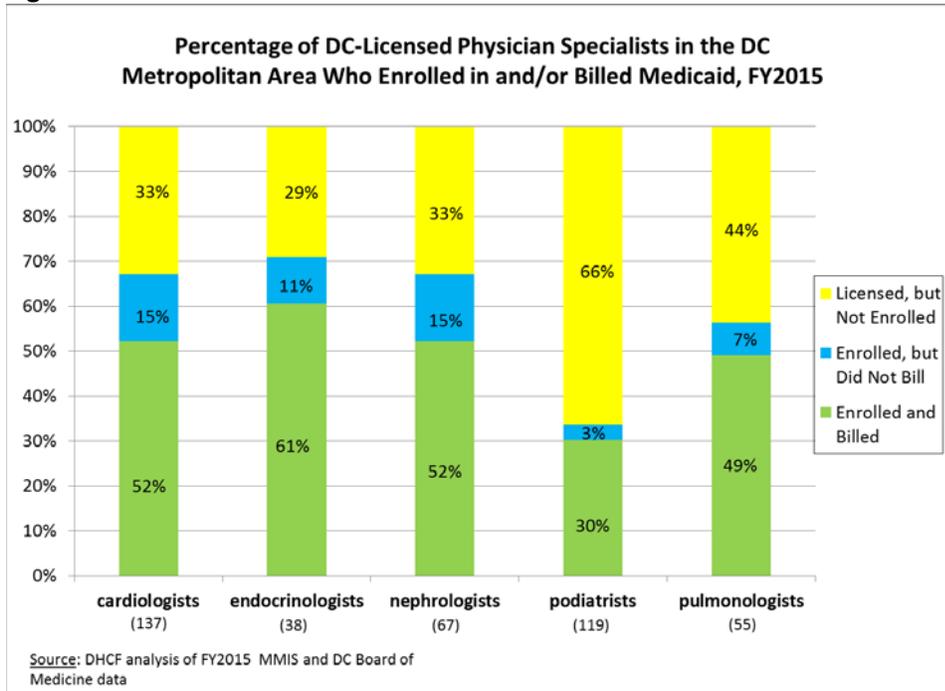
DHCF's analysis of access to physician specialist services in the Medicaid FFS program had two components: (1) provider participation and experience; and (2) beneficiary utilization and experience. The provider participation and experience component relied on an analysis of provider licensure, enrollment and billing trends (a measure of provider participation) and a survey of MCAC members (a measure of provider experience). The beneficiary utilization and experience component relied on an analysis of trends in service utilization rates (a measure of beneficiary utilization) and review of ombudsman complaints (a measure of beneficiary experience).

Physician Specialist Participation and Experience

Rate of Participation by DC-Licensed, Metropolitan-Area Physician Specialists Has Been Stable Over Time

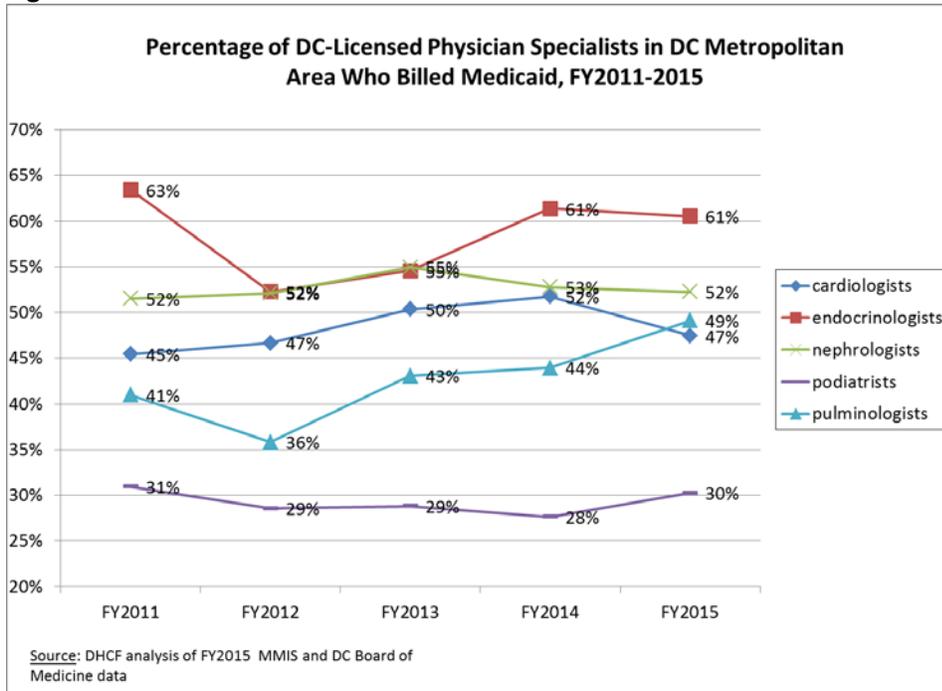
FY 2015 Snapshot: Participation levels varied among DC-licensed physician specialists in the DC metropolitan area. Endocrinologists had the highest level of participation in FY 2015, with 72 percent enrolled in Medicaid, and 61 percent billing for at least one endocrinology service for a Medicaid beneficiary. (See Figure 22.) The percentage of cardiologists and nephrologists enrolling and billing for services were also higher, with 67 percent of each enrolled and 52 percent billing Medicaid. Pulmonologist participation was lower, with 56 percent enrolled and 49 percent billing Medicaid. Podiatrists had the lowest levels of participation, with 33 percent enrolled in Medicaid, and 30 percent billing for at least one podiatry service for a Medicaid beneficiary.

Figure 22



Five-Year Trend: Between FY 2011 and FY 2015, the percentage of DC-licensed, metropolitan-area physician specialists who billed Medicaid was relatively constant, with mostly small changes from year to year that were not statistically significant. (See Figure 23.) The most substantial change over that period was in participation of pulmonologists, whose participation increased by 20 percent, from 41 percent participating in FY 2011 to 49 percent participating in FY 2015; however the change was not statistically significant.

Figure 23



Number of DC Metropolitan Area Specialists Billing Medicaid Over Time Varied by Type of Specialist

Between FY 2011 and FY 2015, the total number of physicians in the District metropolitan-area who billed varied depending on the type of specialist. The number of cardiologists, nephrologists, and pulmonologists increased (by 6, 13, and 23 percent respectively). (See Figures 24, 25, and 26.) For nephrologists and pulmonologists, this increase was largely due to an increase in participation by non-DC-licensed physicians. During the same period, the number of podiatrists and endocrinologists in the metropolitan area who billed Medicaid decreased (by 4 percent and 12 percent, respectively). (See Figures 27 and 28.) Participation by non-DC-licensed specialists did not change much for either type of specialist over time; the decreases were primarily in DC-licensed specialists.

Figure 24

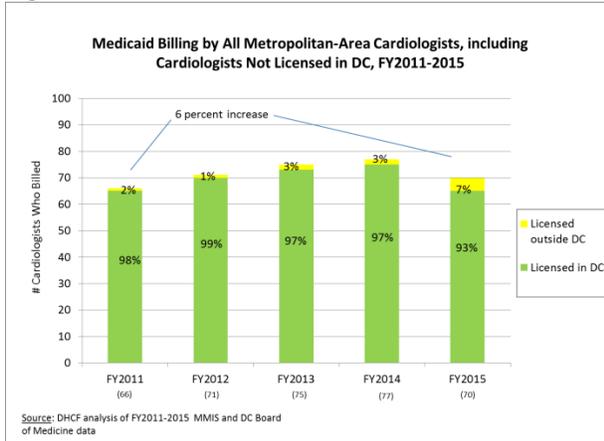


Figure 25

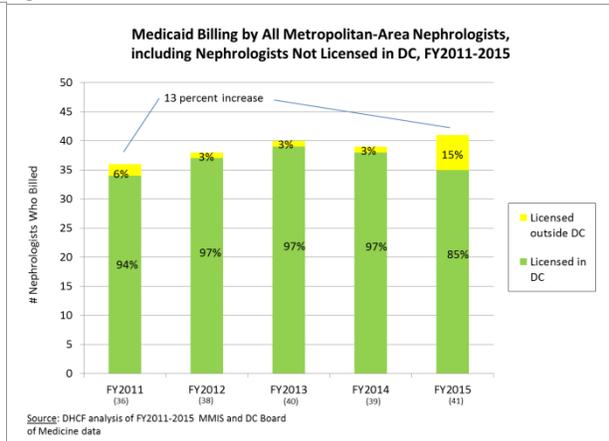


Figure 26

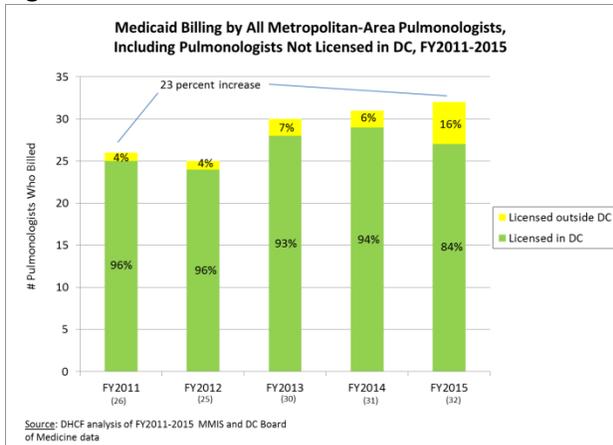


Figure 27

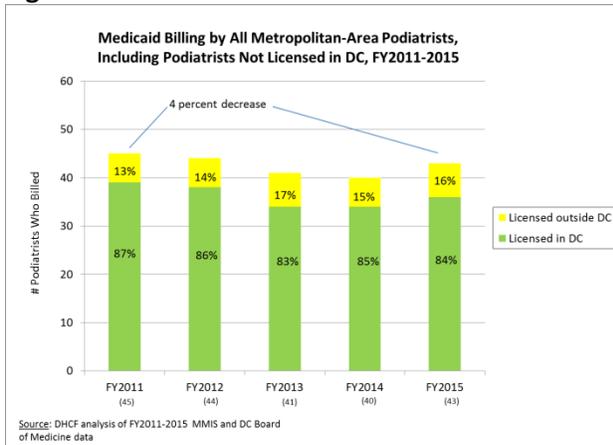
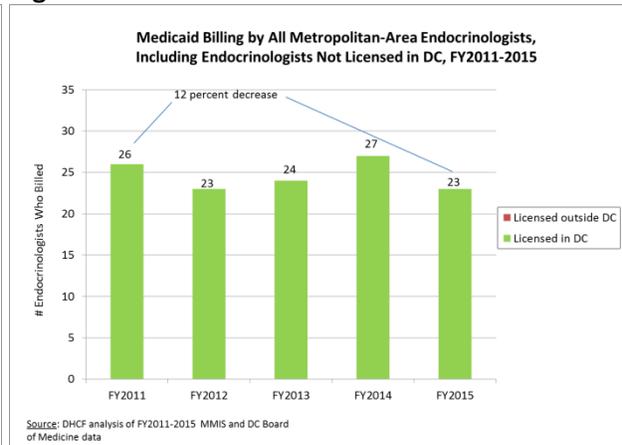


Figure 28



MCAC Survey Respondents Raised a Variety of Concerns

Three MCAC members responded to the MCAC Access Survey noting concerns about access to physician specialists. They highlighted shortages of, and long wait times for certain specialists, and lack of access to surgeons performing gender-affirming surgeries for transgender individuals. Due to the relatively

low response rate of the MCAC survey, as noted previously, it is not possible to know if these were widespread perceptions among the stakeholder population.

The three stakeholders responding to the MCAC survey provided the following comments:

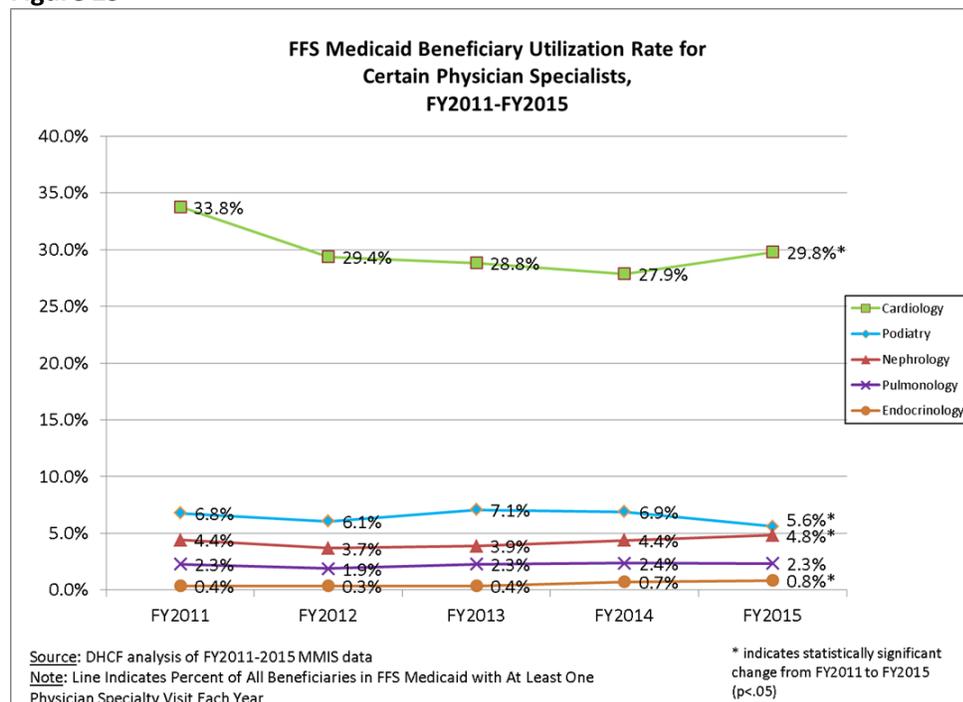
- “Accessing specialists continues to be a challenge for FFS Medicaid beneficiaries in the district. Typically, appointments for common issues that require specialists such as colonoscopies can take 3-6 months. The issue is also present with endocrinology, psychiatry, and cardiology. To some extent, the issue of access for certain specialties is national. As diseases such as diabetes and heart disease rise, the demand for specialists also increases.”
- “Orthopedic/Physical therapy, hematology, Neuropsych [sic] testing, and dermatology very difficult to find providers.”
- “Surgeons performing gender affirming surgeries – No identified providers who will do Vaginoplasty, Metoidioplasty, Phalloplasty. MedStar MCO has no providers for orchiectomy and some other surgeries.”

Beneficiary Utilization and Experience with Physician Specialist Services

Trends in Beneficiary Utilization of Specialists Varied Over Time

DHCF calculated the specialty utilization rates using all FFS beneficiaries as the denominator, and the number of unique beneficiaries who received each service as the numerator. According to DHCF’s analysis, utilization trends varied by type of specialist between 2011 and 2015. (See Figure 29.) Rates for endocrinology, pulmonology, and nephrology services increased between FY 2011 and FY 2015, while rates for cardiology and podiatry decreased over the same time period. The changes for endocrinology, nephrology, cardiology, and podiatry were all statistically significant.

Figure 29



Virtually No Beneficiary Ombudsman Complaints Identified Access to Physician Specialists

From FY 2011 to FY 2015, virtually none of the 1,143 complaints received by the Ombudsman about access to care related to these physician specialists. During the study period, the Ombudsman received two complaints regarding access to dermatologists and one complaint regarding access to oncologists. Given the concerns expressed by three MCAC members, and the mixed results in the beneficiary utilization analysis, it is not possible to draw conclusions from this data.

Conclusions about Access to Physician Specialist Services

DHCF's analysis of FFS beneficiary access to physician specialty services produced mixed results. The percentage of DC Metropolitan Area providers billing Medicaid for services was relatively constant for all five specialty groups—cardiologists, endocrinologists, nephrologists, podiatrists, and pulmonologists—for the five year study period between 2011 and 2015. The total number of DC Metropolitan Area specialists billing Medicaid increased over that period for all specialty groups except podiatrists and endocrinologists which both decreased. Beneficiary utilization of specialists was also mixed over the study period: beneficiary utilization of endocrinology and nephrology increased significantly, but utilization decreased significantly for cardiology and podiatry, and did not significantly change for pulmonology. Despite this significant decline in beneficiary utilization of cardiology and podiatry providers, the District Ombudsman received few complaints relating to access to specialists, so it is difficult to draw conclusions about the causes or impact of these declines. For example, a decline in utilization of podiatrists could indicate improvement in treatment of diseases or conditions requiring treatment, including diabetes, or it could indicate a barrier in access. Additional data is needed to better understand how to interpret this baseline data and what it might indicate about access to care.

DHCF's analysis of access to physician specialists in the FFS program included significant limitations. Input from providers and beneficiaries—in the form of the MCAC survey and Ombudsman complaint data, respectively—was limited and inconclusive. Consequently, the results of our analysis of access to primary care services should be considered an initial, or baseline set of findings. For the next Access Plan, DHCF expects to have more robust beneficiary and provider feedback, and therefore expect the analysis to be more sophisticated and results more definitive over time.

C. Behavioral health

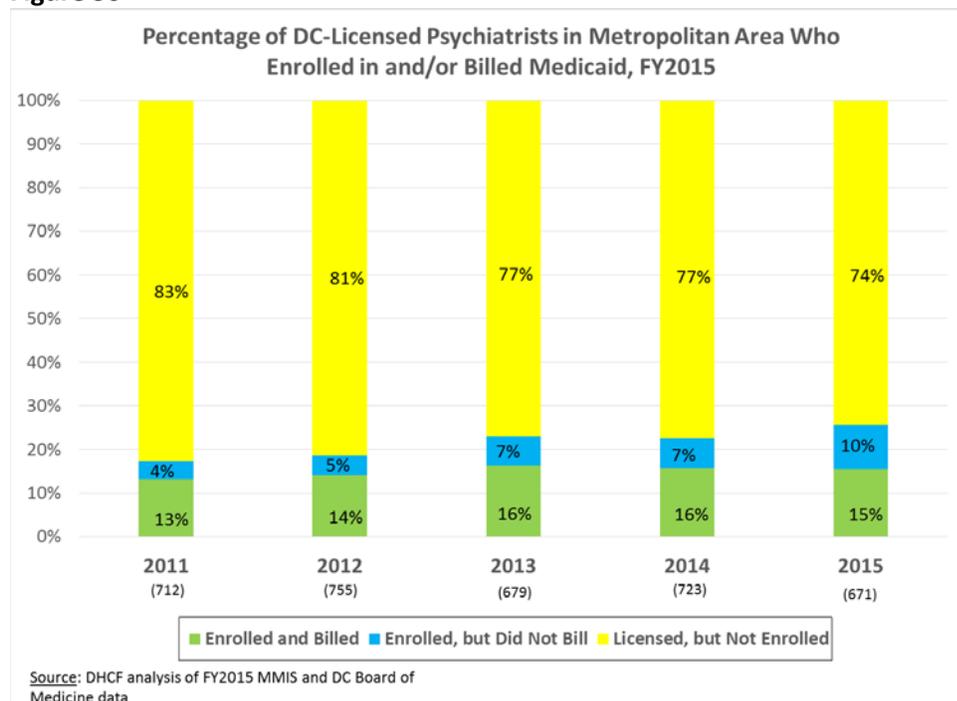
DHCF's analysis of access to behavioral health services in the Medicaid FFS program had two components: (1) provider participation and experience; and (2) beneficiary utilization and experience. The provider participation and experience component analyzed provider licensure, enrollment and billing trends, compared the FFS program's network adequacy ratio for psychiatrists against NCQA standards (measures of provider participation) and used a survey of MCAC members and free-standing mental health clinic (FSMHC) provider site visits (measures of provider experience). The beneficiary utilization and experience component analyzed trends in service utilization rates (a measure of beneficiary utilization) and reviewed ombudsman complaints (a measure of beneficiary experience).

Behavioral Health Provider Participation and Experience

Rate of Participation by DC-licensed, Metropolitan-Area Psychiatrists Appears Stable over Time

From FY 2011 to FY 2015, the percentage of psychiatrists licensed in DC and based in the metropolitan area participating in Medicaid did not appear to change over time. (See Figure 30.) In FY 2011, 17 percent of these psychiatrists were enrolled in Medicaid, and 13 percent billed for at least one psychiatric service for a Medicaid beneficiary. In FY 2015, 25 percent of these psychiatrists were enrolled in Medicaid, and 15 percent billed for at least one psychiatric service for a Medicaid beneficiary. The increase in the percentage of psychiatrists who billed Medicaid between the two years was not statistically significant.

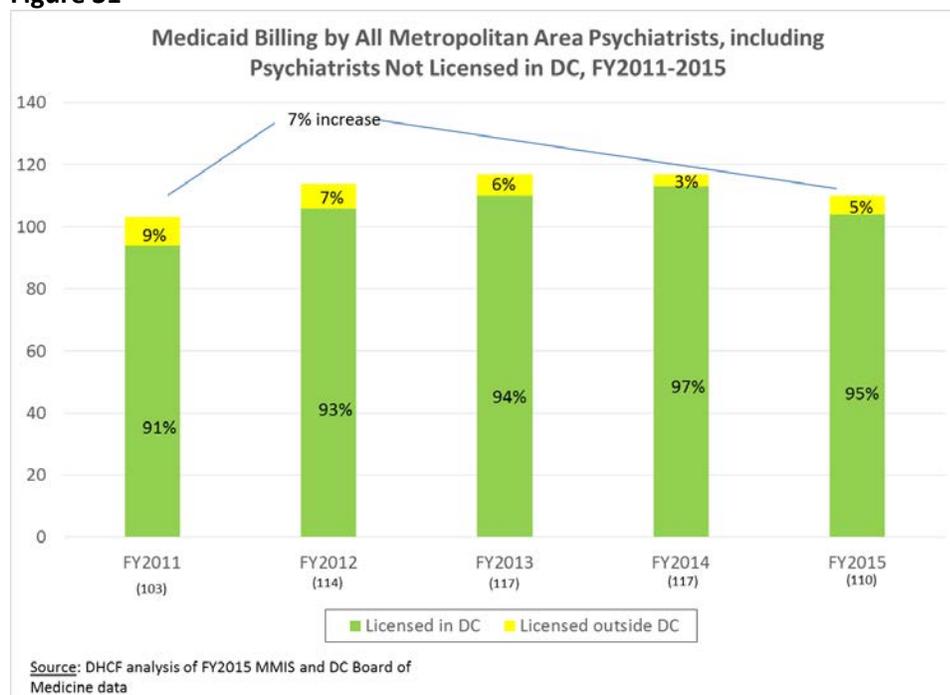
Figure 30



Number of Metropolitan-Area Psychiatrists and Other Behavioral Health Providers Billing Medicaid Also Appears to Have Increased

Between FY 2011 and FY 2015, total billing by psychiatrists and other behavioral health providers based in the District metropolitan area increased. (See Figure 31.) The total number of District metropolitan area psychiatrists—including those not licensed in DC—who billed Medicaid for at least one psychiatric service every year increased from 103 in FY 2011 to 110 in FY 2015, an increase of 7 percent. Providers licensed outside of DC played a relatively smaller role in FY 2015 (5 percent) than FY 2011 (9 percent).

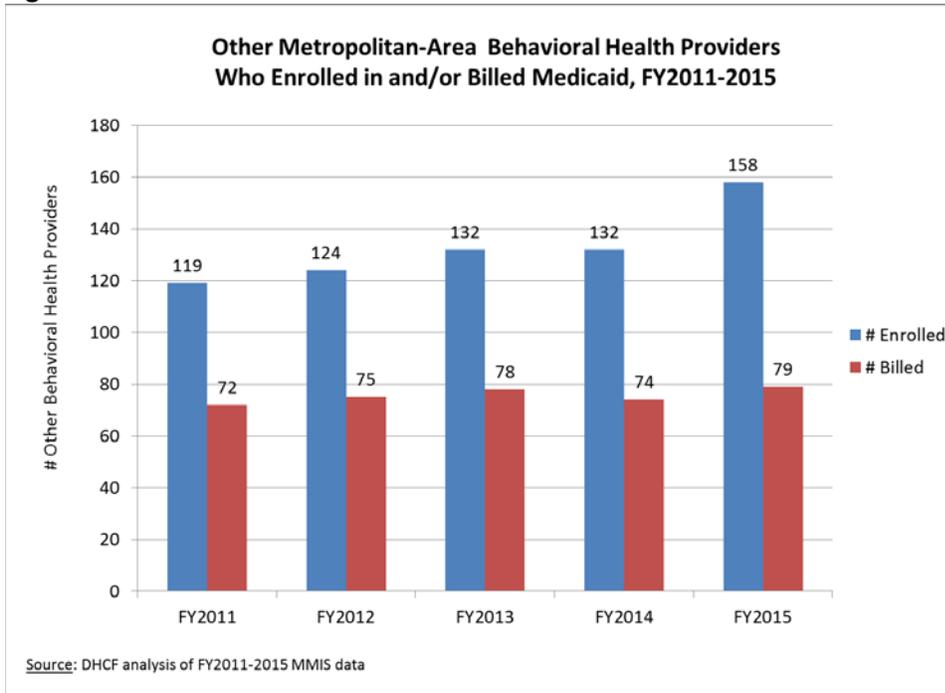
Figure 31



Similarly, the total number of other behavioral health providers (various types of behavioral health providers furnishing services under Medicaid behavioral health benefits, including MHRS, FSMHCs, and ASARS) also increased, beginning at 119 in FY 2011 and rising to 158 in FY 2015, an increase of 32 percent. (See Figure 32.) (Notably, the “other behavioral health provider” category did not include FQHCs, some of whom provide behavioral health services, because the specific providers offering these services could not be identified as such due to the current PPS payment methodology resulting in claims data without sufficient specificity, as discussed in the Methodology Section, above.) Despite the increase in overall number of other behavioral health providers’ participation in Medicaid, the percentage billing Medicaid annually dropped, from 60 to 50 percent.

One possible factor that may have impacted participation is the provider certification moratorium that the Department of Behavioral Health (DBH) put into effect in 2012 for core service agencies (CSAs), the providers that are certified to provide most behavioral health services covered under Medicaid. DBH instituted the moratorium as a way of managing provider entry due to concern about the need to regulate the number of providers participating given the absence of condition of need requirements. Although the moratorium has been lifted briefly for limited enrollment during the study period, DHCF heard from one FSMHC behavioral health provider during unrelated site visits in the Spring of 2016 that the provider moratorium has limited their ability to participate and bill for more substantial behavioral health treatment under Medicaid. It is unclear whether this is a widespread issue and subsequent DHCF research indicated that overall Medicaid utilization of behavioral health services under MHRS, the benefit for which CSA certification is required, has doubled over the past five years. This suggests that provider supply may be ample to address beneficiary needs. Additional research is needed to further investigate how provider participation is impacting access.

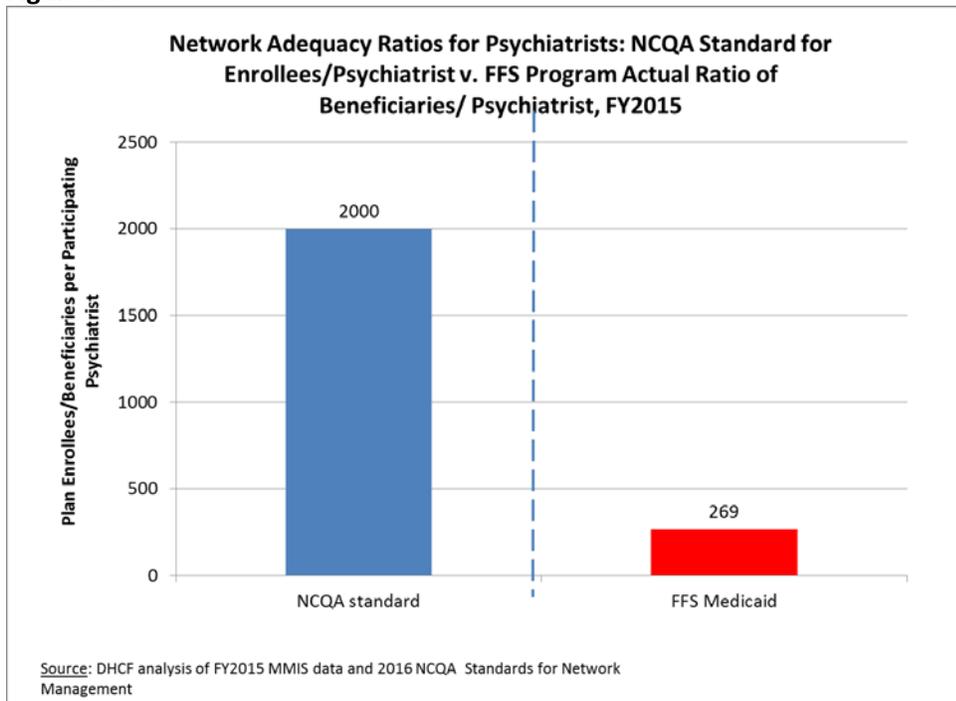
Figure 32



Provider/Beneficiary Ratios for FFS Program Compare Favorably with NCQA Standards

NCQA requires a ratio no greater than one psychiatrist for every 2,000 plan members for every psychiatrist. FFS Medicaid compares favorably, with the ratio of psychiatrists enrolled in Medicaid to Medicaid FFS beneficiaries at 1:269 (See Figure 33.) NCQA does not have a standard ratio for other behavioral health providers. While this comparison is very favorable, prevalence rates of mental disorders and serious mental illness among Medicaid FFS beneficiaries are higher than in the general population. Therefore, it is unclear whether the NCQA ratio provides a useful standard of comparison. Participation standards targeted to the Medicaid population are needed to support a more accurate analysis of provider ratios.

Figure 33



Some Providers Raised Concerns about Access

Providers have expressed concerns about beneficiary access to behavioral health services. One MCAC survey respondent stated that there is a “lack of mental health therapists and psychiatrists and suboxone providers - long wait times and not enough providers.” However, the overall lack of responses to the MCAC survey limited the generalizability of the results. One provider commenting on the Access Plan reported that a number of providers seeking psychiatric referrals for their patients often did not receive responses from participating core service agencies, had heard their patients complain about the quality of psychiatric treatment, or encouraged their patients to change their medication regimen due to lack of access to a prescribing psychiatrist, which adversely impacted treatment. Additional research is needed to determine whether this experience is widespread and whether it indicates an access barrier due to low psychiatrist participation.

Providers also expressed concerns during a series of site visits with 5 of the 23 FSMHCs in Spring of 2016. DHCF conducted these site visits to inform coordination with DBH regarding the benefit and through that process obtained anecdotal information about these providers’ experience with participation, payment rates, and how benefit structures may be impacting beneficiary access to care. Some providers expressed concern that reimbursement mechanisms and associated administrative burdens were not conducive to serving beneficiaries based on their treatment needs. For example, some MHRS providers that were also FSMHCs raised concerns that requiring beneficiaries with a serious mental illness to undergo an initial three hour assessment before receiving treatment posed a barrier to entry for some beneficiaries, either because beneficiaries couldn’t stay for the full assessment or because it was challenging getting them back into care after the initial assessment. More in depth research is needed with providers to determine the scope and nature of provider concerns.

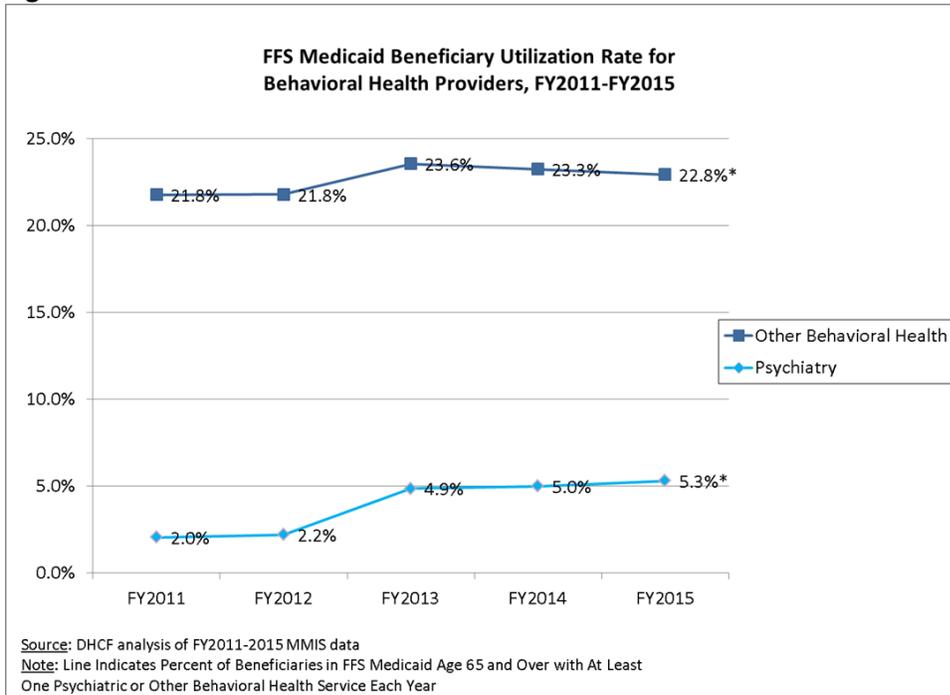
Beneficiary Utilization and Experience with Behavioral Health Services

Utilization of Psychiatric Services Appears to Have Increased, While Utilization of Other Behavioral Health Providers Appears Unchanged Over Time

Utilization rates for both psychiatrists and other behavioral health providers, including ASARS, behavioral supports, FSMHCs, MHRS, and public and private psychiatric hospitals, was calculated by dividing the number of unique beneficiaries receiving services from each of the two provider types by the total number of enrolled FFS beneficiaries in each study year. The utilization rate for psychiatrists increased significantly over time. (See Figure 34.) In FY 2011, only 2.0 percent of beneficiaries received a service from a psychiatrist, but that rate had more than doubled by FY 2015 to 5.3 percent. The utilization rate for other behavioral health services also increased, from 21.8 percent in FY 2011 to 22.8 percent in FY2015. (Notably, the “other behavioral health provider” category did not include FQHCs, some of whom provide behavioral health services, but could not be identified as such due to the PPS payment methodology and resulting limitations in claims data, as discussed in the Methodology section, above.) This increase was also statistically significant.

While the utilization rate for psychiatrists more than doubled during the study period, the overall utilization rate appears low. Additional research is needed to determine whether the five percent utilization rate represents an access barrier or merely reflects the appropriate demand for care. Recent DHCF research looking at Medicaid beneficiary utilization of behavioral health services shows that utilization more than doubled in the District Medicaid program (FFS, MCO and waiver programs combined) during the study period. This suggests that more beneficiaries are seeking and using services. Given the high rates of serious mental illness and behavioral health disorders among District Medicaid beneficiaries, further analysis is needed to understand how to interpret provider participation and utilization in the context of access to care.

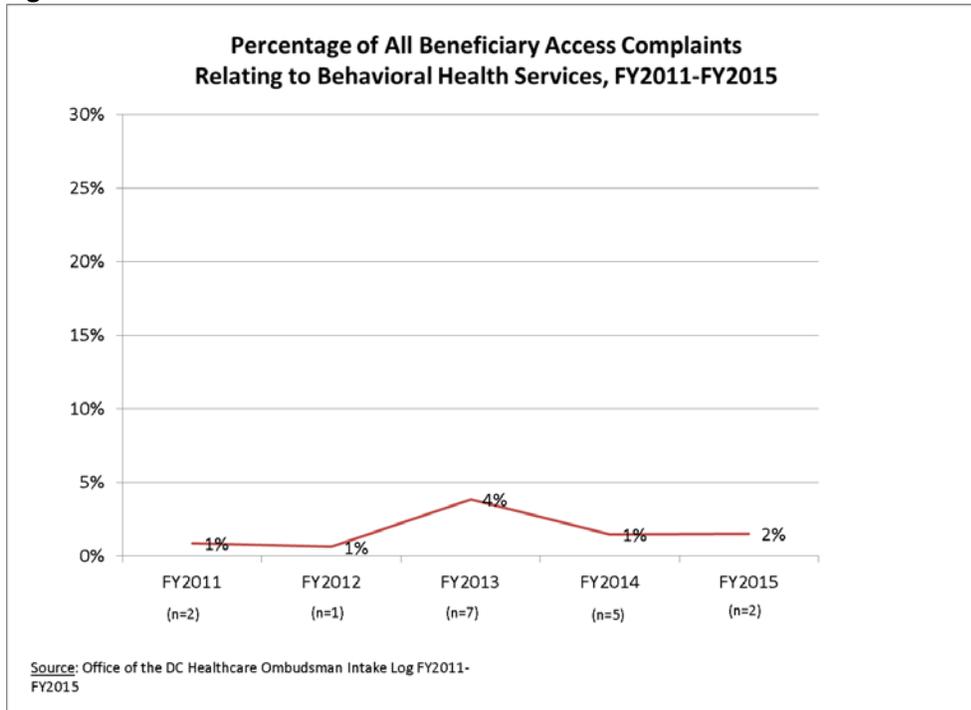
Figure 34



Relatively Few Beneficiary Complaints about Access to Behavioral Health Services

The Ombudsman received proportionally few complaints about access to behavioral health services between FY 2011 and FY 2015. (See Figure 35.) Other than FY2013, when complaints related to behavioral health were 4 percent of all access-related complaints, the volume of complaints was relatively low and consistently in the 1 to 2 percent range.

Figure 35



Conclusions about Access to Behavioral Health Services

Access to behavioral health providers in the FFS program generally appeared stable over the five-year study period, and appears to have increased somewhat for psychiatrists. The percentage of DC-licensed psychiatrists billing Medicaid for a behavioral health service remained stable between FY 2011 and FY 2015. The total number of billing DC Metropolitan Area providers, including the numbers of psychiatrists and other behavioral health providers, increased. DHCF obtained NCQA network adequacy standards for psychiatrists, and found the District's ratio of Medicaid FFS providers to beneficiaries was far more favorable than the NCQA standard, although DHCF understands that this population will have a higher demand for services than a typical private coverage population for which NCQA standards are typically used. Anecdotal information gathered as part of a review of free-standing mental health clinics in the Spring of 2016 suggests that providers are concerned about barriers to entry to provide most behavioral health services and have concerns about overly prescriptive and rigid structures in delivering behavioral health services. Beneficiary utilization of behavioral health providers overall was relatively consistent, but utilization of psychiatrists doubled during the study period. Even with increased utilization, beneficiary utilization of psychiatrists is low but it is unclear whether that represents an access concern. Beneficiary complaints about access to behavioral health care represented a very small portion of all access complaints received by the Ombudsman over the five-year period (between 1 and 2 percent in most years).

DHCF's analysis of access to behavioral health providers in the FFS program included significant limitations. The measures DHCF used for provider participation and beneficiary utilization and experience relied upon Medicaid claims data. However, DHCF was not able to identify behavioral health services provided by FQHCs in the claims data, so DHCF did not capture an important source of

beneficiary behavioral health care. Input from providers and beneficiaries—in the form of the MCAC survey, site visits with a handful of free-standing mental health clinics and Ombudsman complaint data, respectively—was limited and generally not generalizable. Consequently, the results of our analysis of access to behavioral health services should be considered an initial, or baseline set of findings. For the next Access Plan, DHCF will have more robust beneficiary and provider feedback, and therefore expect the analysis to be more sophisticated and results more definitive over time.

D. Home Health

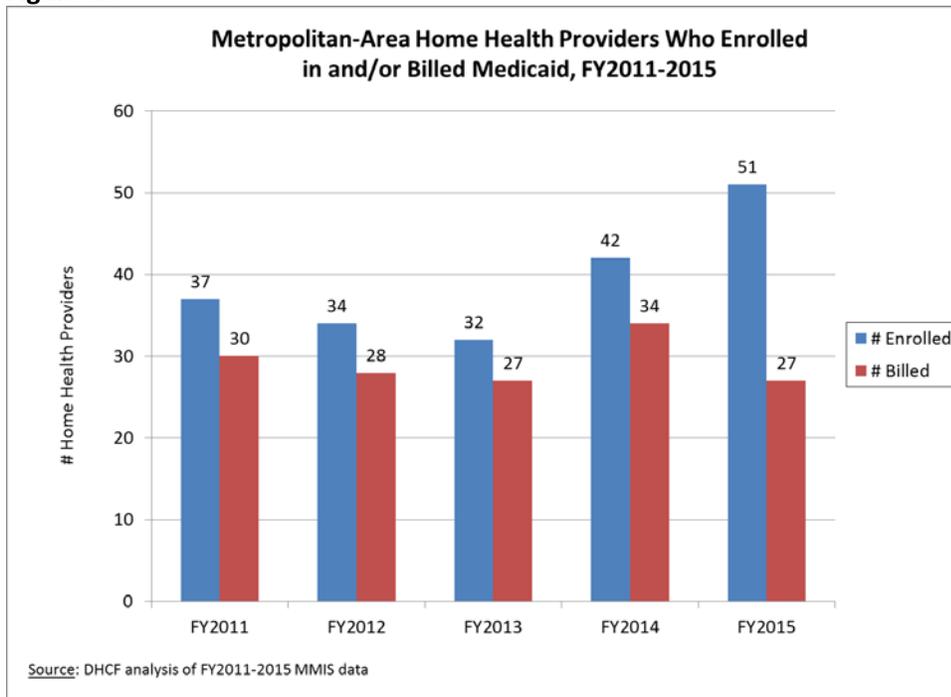
DHCF's analysis of access to home health services in the Medicaid FFS program—specifically, PCA and skilled nursing services— included two components: (1) provider participation and experience and (2) beneficiary utilization and experience. The provider participation and experience component analyzed provider enrollment and billing trends (a measure of provider participation). The beneficiary utilization and experience component analyzed trends in service utilization rates (a measure of beneficiary utilization) and ombudsman complaints (a measure of beneficiary experience).

Home Health Services Provider Participation and Experience

Number and Percentage of Home Health Providers Billing Medicaid has Decreased over Time

Between FY 2011 and FY 2015, the number of home health providers billing Medicaid for PCA and/or skilled nursing services each year fluctuated, but was smaller in FY 2015 than FY 2011. (See Figure 36.) Specifically, 30 home health providers billed Medicaid for PCA and/or skilled nursing services in FY 2011 out of 37 enrolled, while in FY 2015, 27 billed Medicaid out of 51 enrolled. While the number of providers declined by 10 percent, it is noteworthy that the percentage of billing providers of all enrolled providers declined substantially, from 81 percent of enrolled providers billing in FY 2011 to 52 percent of enrolled providers billing in FY 2015, representing a decline in percentage billing of 36 percent.

Figure 36

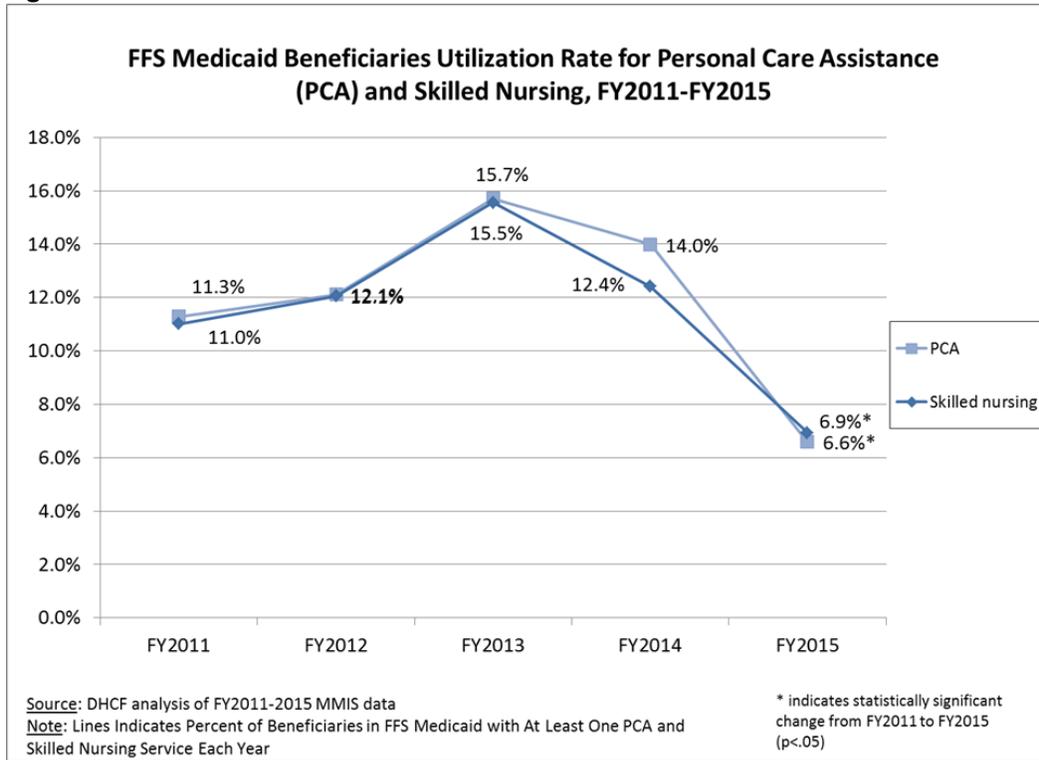


Beneficiary Utilization and Experience with Home Health Services

Utilization of Home Health Services Has Decreased Over Time

Between FY 2011 and FY 2015, the percentage of Medicaid beneficiaries who received either PCA or skilled nursing home health services decreased. (See Figure 37.) In FY 2011, 11.3 percent of FFS beneficiaries received PCA, and 11.0 percent received skilled nursing. Utilization rates peaked in FY2013, increasing to 15.7 percent for PCA and 15.5 percent for skilled nursing, but decreased to 6.6 and 6.9 percent, respectively, in FY 2015. This approximately 40 percent decrease in the utilization rate was statistically significant, but is likely directly tied to the aggressive efforts by DHCF to reduce fraud, waste and abuse in the program. As noted below, as a result of the discovery and prosecution of significant fraud among home health agencies and Medicaid beneficiaries, DHCF implemented conflict-free assessments that reduced PCA service utilization in cases where services weren't medically necessary. With the decline in PCA service utilization, there was a concurrent decline in utilization of skilled nursing services; monthly supervisory skilled nursing visits are typically required for beneficiaries receiving PCA services.

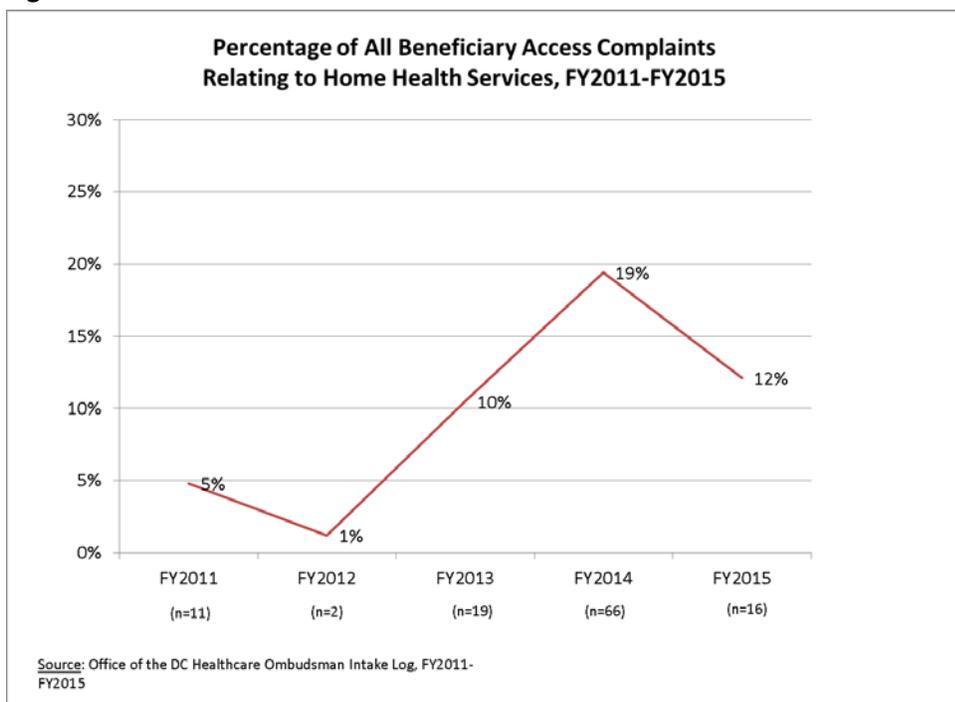
Figure 37



Beneficiary Complaints to Ombudsman Spiked in FY2014

From FY 2011 to FY 2015, the percentage of access-related beneficiary complaints about home health services fluctuated, rising precipitously in FY2014, the year of the FBI raids, and then falling again. (See Figure 38). In other years, many of the issues were requesting a fair hearing due to reduction in benefits or hours. Other complaints included personnel not being assigned to a beneficiary in a timely manner or absenteeism of the home health aide.

Figure 38



Significant Home Health Provider Fraud in FY2014, Impacting Both Provider Participation and Beneficiary Utilization

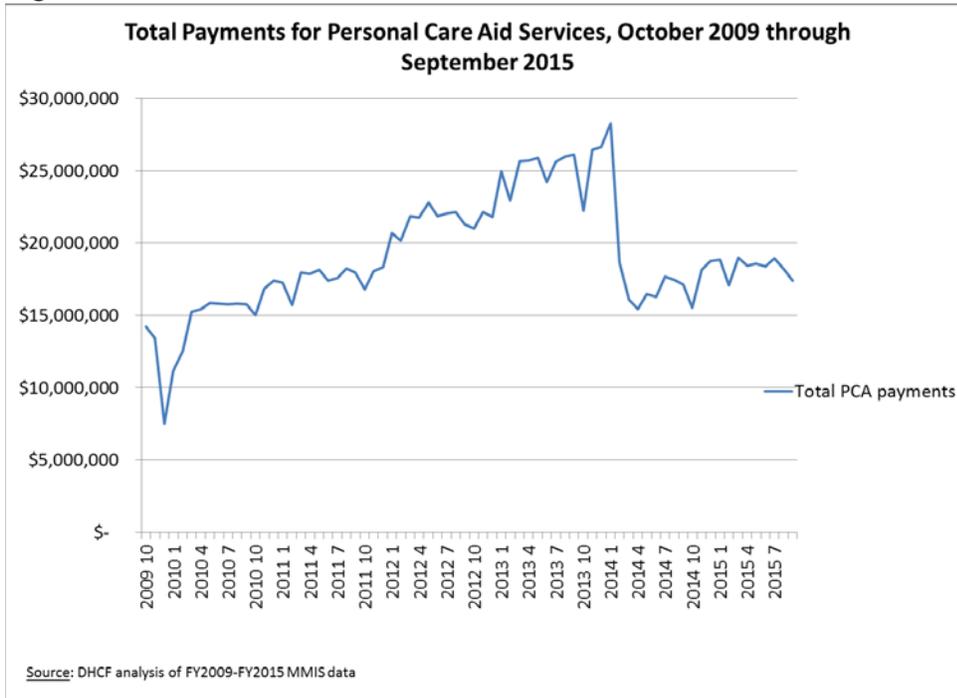
In assessing the District’s experience with access to PCA and skilled nursing services, it is important to understand recent history with provider and beneficiary fraud and its’ impact on provider participation and beneficiary utilization. Beginning in 2009, DHCF referred a number of cases to law enforcement involving fraudulent billing by home health providers. Allegations involved providers billing for services not rendered and beneficiaries who were being recruiting to accept kickback payments in exchange for enrolling in the program and routinely falsifying timesheets. In February, 2014, based upon referrals initially made by DHCF, the FBI raided and shuttered four large licensed home care agencies contracting with licensed nursing staffing agencies. DHCF reached out to all the approximately 4,000 beneficiaries served by these agencies, assigned them to other home health providers and conducted assessments to ensure that every beneficiary had a legitimate need for services. In the end, some 567 beneficiaries either did not respond to repeated efforts to contact them, declined services or were found ineligible.

In addition to engaging law enforcement, DHCF also worked to reduce fraud, waste, and abuse by instituting policy changes. Among these changes were a requirement that all new and existing beneficiaries be assessed in person by nurses who are independent of the providers; DHCF began instituting these conflict-free, face-to-face assessments in November 2013 and saw an immediate reduction in new beneficiaries who were eligible for services.¹² DHCF also instituted new edits in claims processing to help identify aides who were billing multiple agencies for excessive hours.

¹² DHCF continues to work to improve the assessment process. For example, the agency is modifying its current long term care services and supports assessment contract to include requirements to provide oral interpretation

Together, the law enforcement actions and policy changes had the effect of reducing utilization of personal care aide (PCA) services by approximately 40 percent. Figure 39, below, documents the growth, spike and subsequent reduction in spending for PCA services after the FBI raids and DHCF reviews during the past five years of the study period.

Figure 39



Conclusions about Access to Home Health Services

In the analysis of certain home health services—specifically, skilled nursing and PCA services— DHCF found that the number of providers who furnished these services and the number of beneficiaries who received them rose from FY 2011 to FY2014 and then fell in FY 2015. The number of home health-related complaints to the Ombudsman followed a similar trend—peaking in FY2014 and then dropping again. These trends track closely with DHCF’s efforts to address fraud in home health services, and subsequent adjustment of the program. Based on available data and DHCF’s understanding of the transition in the program, there is not sufficient evidence to identify an access deficiency at this time. One stakeholder raised concerns in comments on the Access Plan about access to PCA services due to what they said was a low number of home care agencies and high turnover rate among staff. DHCF plans to do additional survey research with beneficiaries and providers to better understand how to interpret current provider participation and beneficiary utilization to determine whether access challenges exist. For this report, the provider participation and beneficiary utilization findings for FY 2015 probably best reflect an initial, or baseline level of access from which to assess future trends and

services free of charge utilizing the AT&T Language Access Line (or a comparable service) or through on-site interpretation services, regardless of language spoken. The oral interpretation services will have to be provided using a professional and qualified interpreter.

experience. For the next Access Plan, DHCF will continue to track provider participation and beneficiary utilization measures as well as add mechanisms for beneficiary and provider feedback. DHCF expects its analysis to be more sophisticated and results more definitive over time.

E. Pre- and Post-Natal Obstetrics

DHCF's analysis of access to pre- and post-natal obstetrics services in the Medicaid FFS program had two components: (1) provider participation and experience and (2) beneficiary utilization and experience. The provider participation and experience component analyzed provider licensure, enrollment and billing trends and compared the FFS program's network adequacy ratio for OB/GYNs against NCQA standards (measures of provider participation) and reviewed a survey of MCAC members (measures of provider experience). The beneficiary utilization and experience component analyzed trends in service utilization rates (a measure of beneficiary utilization) and reviewed ombudsman complaints (a measure of beneficiary experience).

Pre- and Post-Natal Obstetric Services Provider Participation and Experience

Rate of Participation by DC-Licensed, Metropolitan-Area Specialists Who Can Provide Obstetrics Services Appears to Have Remained Stable

In FY 2015, the percentage of DC-licensed, metropolitan-area physician specialists who can provide pre and post-natal obstetrics services—specifically, OB/GYNs and neonatologists—did not appear to change. In FY 2011, the percentage of DC-licensed, metropolitan-area OB/GYNs who billed Medicaid was 24 percent, and by FY 2015, the percentage had fallen slightly to 23 percent. (See Figure 40.) In FY 2011, the percentage of DC-licensed, metropolitan-area neonatologists who billed Medicaid was 46 percent, and by FY 2015, the percentage had fallen to 42 percent. (See Figure 41.) Neither of these changes were statistically significant.

Figure 40

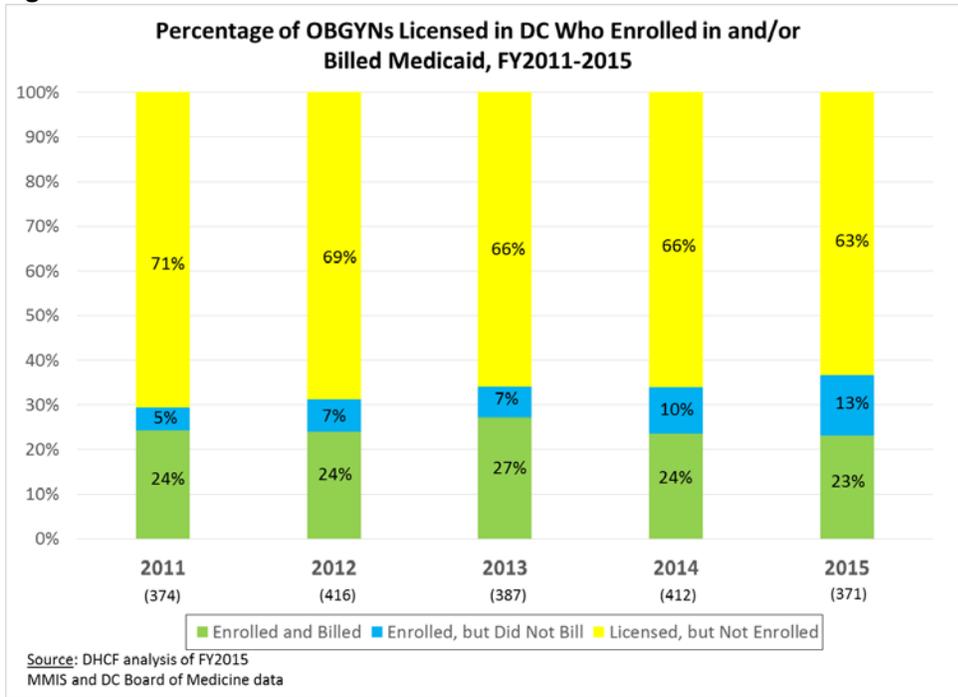
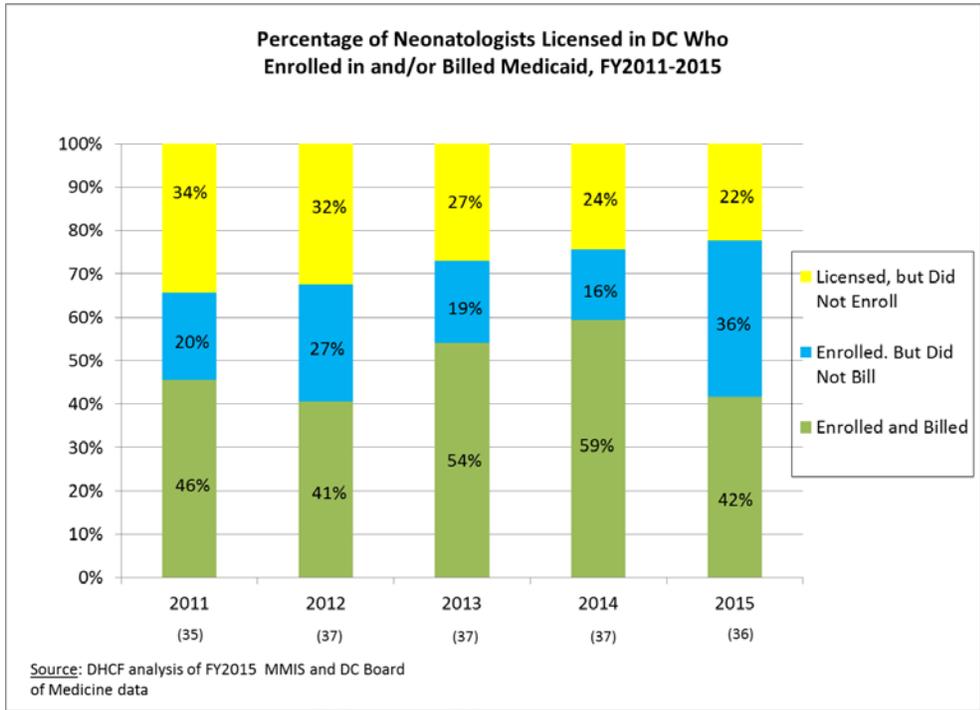


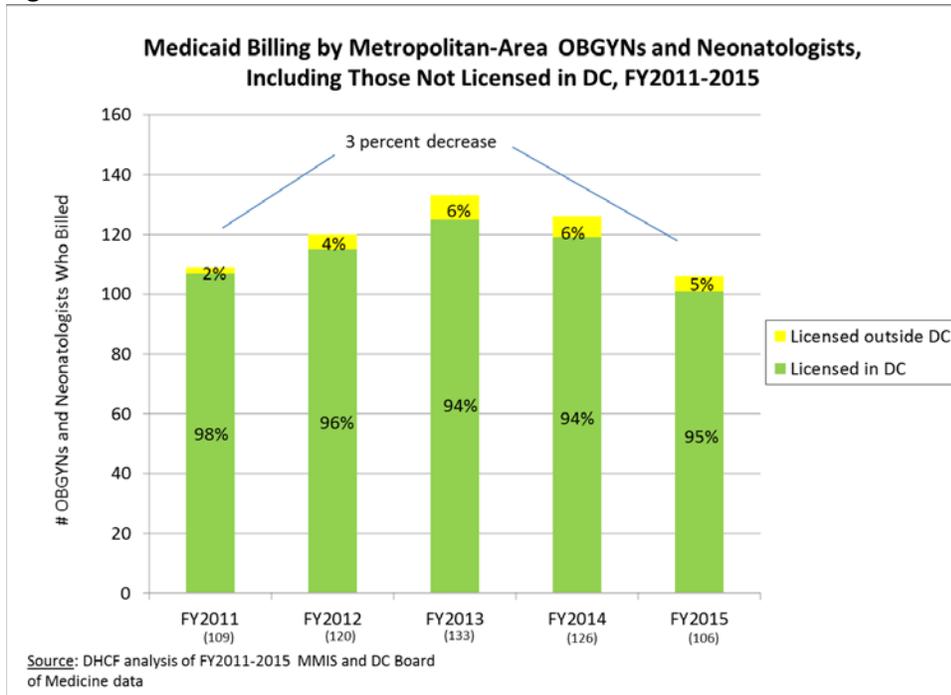
Figure 41



From FY 2011 through FY 2015, the combined number of metropolitan-area OB/GYNs and neonatologists who billed Medicaid rose from 109 to 133 and then fell again to 106, with a net decrease

of 3 percent across the five-year period. (See Figure 42.) The vast majority of these providers were DC-licensed.

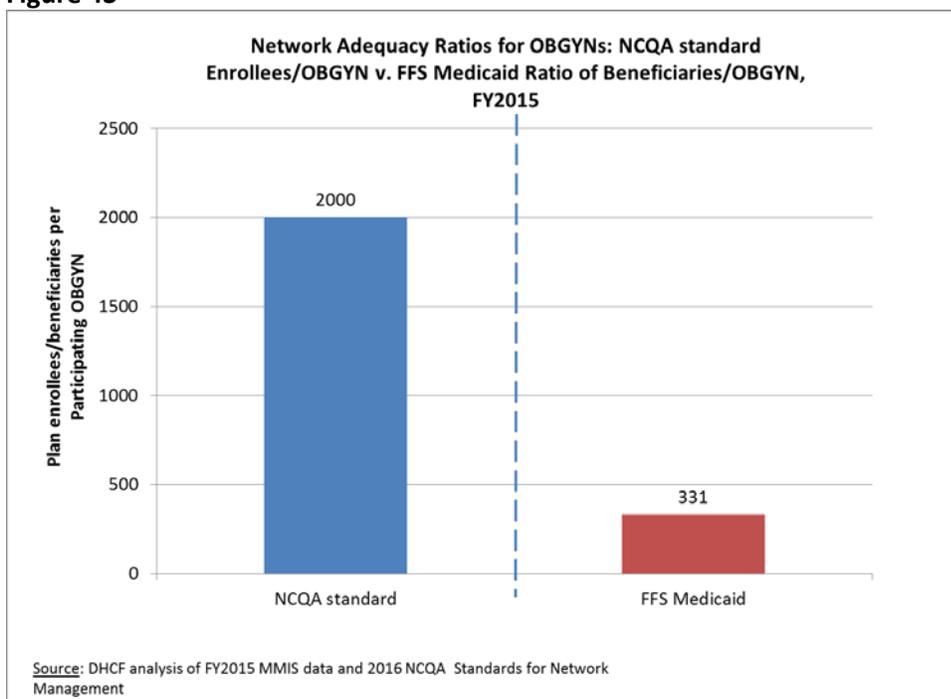
Figure 42



Provider/Beneficiary Ratios for FFS Program Compare Favorably with NCQA Standards

Although NCQA does not have network adequacy standards specific to pre- and post-natal obstetrics, NCQA does have network adequacy standards for OB/GYNs. NCQA requires a ratio of at least one OB/GYN for every 2,000 plan members. FFS Medicaid compares favorably, with the ratio of enrolled DC Metropolitan Area OB/GYNs to Medicaid FFS beneficiaries at 1:331. (See Figure 43.)

Figure 43



The MCAC Survey Yielded No Feedback on Access to Obstetrics Services

None of the respondents to the survey of MCAC members commented on access to pre-or post-natal obstetrics services.

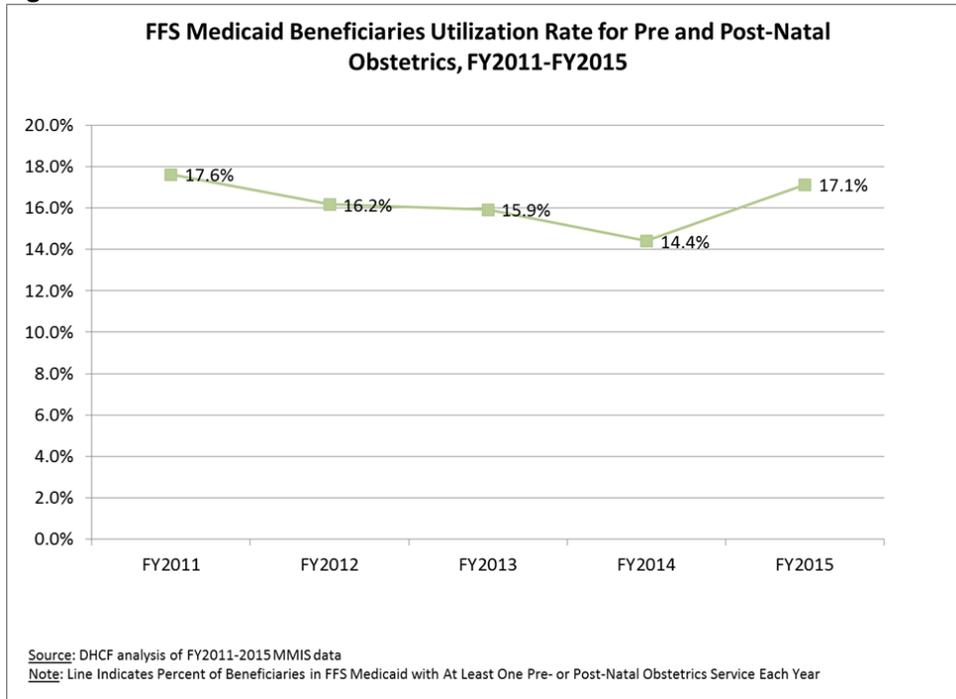
Beneficiary Utilization and Experience with Pre- and Post-Natal Obstetric Services

Utilization of Pre-and Post-Natal Obstetrics Has Remained Stable Over Time

Utilization of pre- and post-natal obstetric services was calculated using the number of unique beneficiaries receiving these services, divided by the number of women of child-bearing age (ages 15 to 44) in each study year. Women of child-bearing age were included in the numerator if they received pre- or post-natal services or had claims indicating pregnancy or successful delivery; in addition, women of child-bearing age with claims indicating an aborted pregnancy were also included if those women had claims for either pre- or post-natal services.

Based on this approach, between FY 2011 and FY 2015, utilization of pre- and post-natal obstetrics services by Medicaid beneficiaries held steady at approximately 17 percent. (See Figure 44.) In FY 2011, 17.6 percent of women ages 15 to 44 obtained at least one such service, compared to 17.1 percent in FY 2015. Utilization rates decreased to 14.4 percent in FY2014, echoing a drop in birth rates in the District and nationwide. Furthermore, live births among FFS women decreased from approximately 1,600 in FY 2012 to approximately 1,100 in FY 2015. While the utilization rate increased in FY 2015, this may be due to the District's implementation of APR-DRG codes in October 2014, which may have affected how providers bill for deliveries and other pregnancy-related services.

Figure 44



No Beneficiary Complaints for Pre- and Post-Natal Obstetrics Services

The Ombudsman received no complaints regarding access to pre- or post-natal obstetrics services from FY 2011 through FY 2015.

Conclusions about Access to Pre- and Post-Natal Obstetrics Services

Access to pre- and post-natal obstetrics services appeared stable over the five-year study period. The percentage of DC-licensed OB/GYNs and neonatologists in the DC Metropolitan Area who billed Medicaid for at least one pre- or post-natal obstetric service between FY 2011 and FY 2015 did not change. With respect to the total number of billing DC Metropolitan Area providers, the number decreased slightly over the five-year period. DHCF found the ratio of FFS providers to beneficiaries was far more favorable than the NCQA standard. Beneficiary utilization of pre- and post-natal obstetrics services during the five-year period held steady. Though utilization rates were low, this can be expected given the relatively small number of women of child-bearing age in the FFS population. The Ombudsman received no beneficiary complaints about pre- or post-natal obstetrics services.

The results of our analysis of access to pre and post-natal services should be considered an initial, or baseline set of findings. For the next Access Plan, DHCF will have more time to develop mechanisms for beneficiary and provider feedback. DHCF therefore expects our analysis to be more sophisticated and results more definitive over time.

F. Other Providers Selected due to Access Concerns

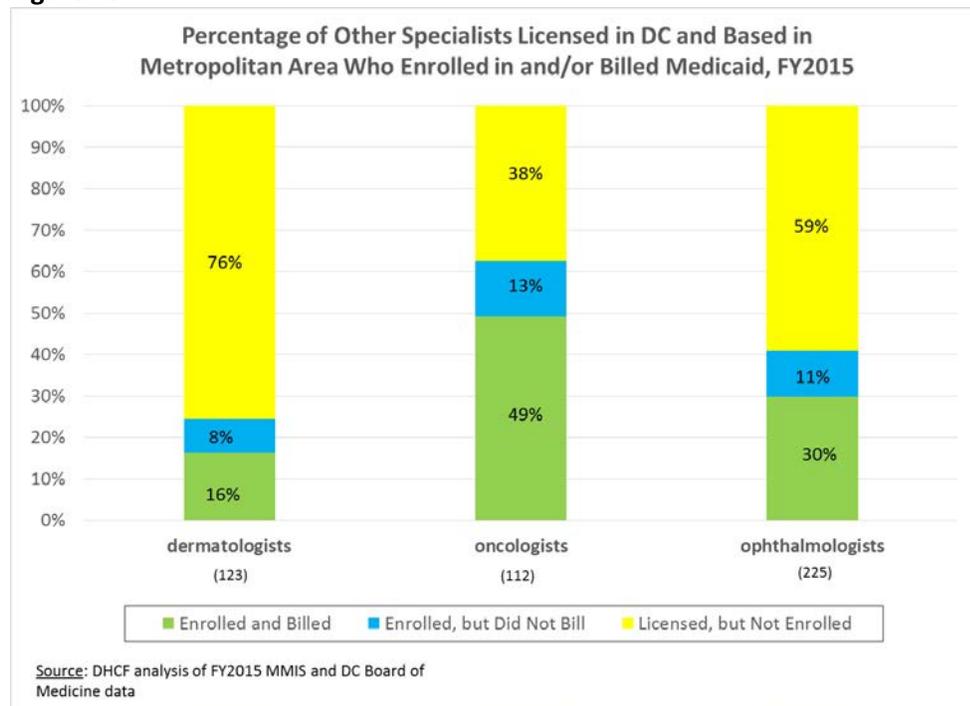
DHCF’s analysis of access to other FFS providers selected due to access concerns—oncologists, dermatologists, and ophthalmologists—had two components. The provider participation and experience component relied on an analysis of provider enrollment and billing trends (a measure of provider participation) and a survey of MCAC members (a measure of provider experience). The beneficiary utilization and experience component relied on an analysis of trends in service utilization rates (a measure of beneficiary utilization) and review of ombudsman complaints (a measure of beneficiary experience).

Other Provider Participation and Experience

Rate of Participation by DC-Licensed, Metropolitan-Area Primary Care Providers Has Been Stable

FY 2015 Snapshot: The rate of participation varied among oncologists, dermatologists, and ophthalmologists licensed in DC and based in the metropolitan-area. (See Figure 45.) Oncologists had the highest rate of participation of the three specialties, with 62 percent of the 112 providers enrolled in Medicaid, and 49 percent billing for at least one oncology service. Dermatologists had the lowest rate of participation of the three specialties, with 24 percent of the 123 providers enrolled in Medicaid, and 16% billing Medicaid for at least one dermatology service.

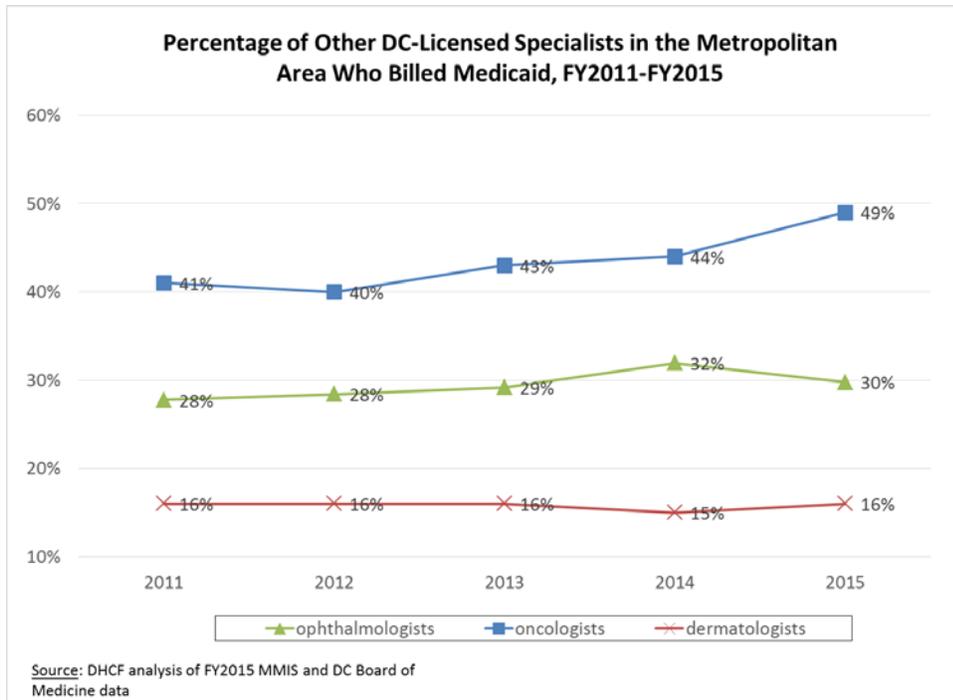
Figure 45



Between FY 2011 and FY 2015, the percentage of DC-licensed, metropolitan area oncologists, dermatologists, and ophthalmologists who billed Medicaid for one of their specialty services varied over time, with the largest change occurring with oncologists (from 41 percent in FY 2011 to 49 percent in FY

2015, an increase of 20 percent). (See Figure 46.) However, none of the variation was statistically significant ($p < .05$).

Figure 46



The Number of Metropolitan-Area Oncologists, Dermatologists, and Ophthalmologists Billing Medicaid Increased Over Time

Between FY 2011 and FY 2015, the number of metropolitan-area physicians with these three specialties billed Medicaid for their specialty services increased. (See Figures 47, 48, and 49.) The largest increase was in the number of dermatologists, which grew from 21 to 27, or by 29 percent. The number of oncologists and ophthalmologists both grew by 9 percent.

Figure 47

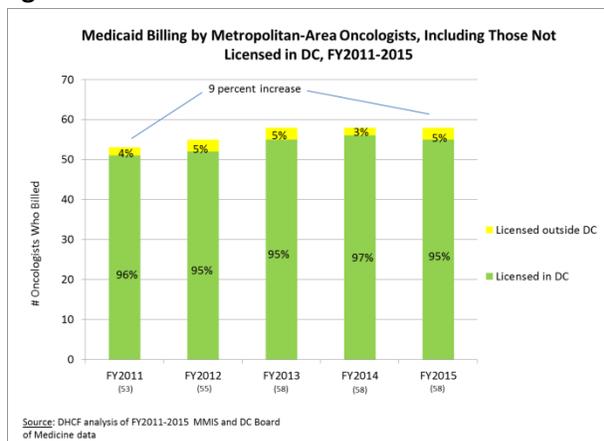


Figure 48

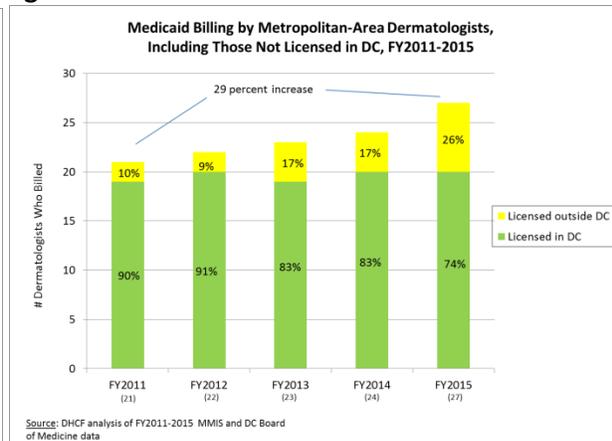
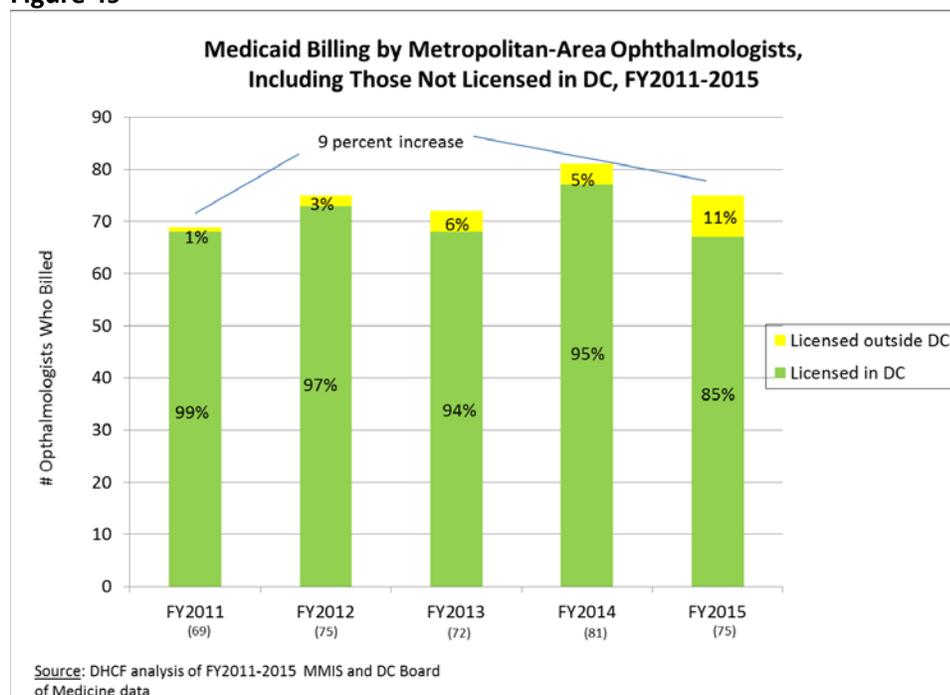


Figure 49



Provider Feedback on Access to Other Providers Has Been Limited

DHCF received limited feedback on access to this category of providers. Only one MCAC survey respondent commented on access to these three specialty groups. The respondent stated “...dermatology very difficult to find providers; lack of cancer treatment providers accepting Medicaid...” Another provider, a primary care physician, told DHCF that low participation rates among dermatologists was a problem resulting in low beneficiary utilization. Additional research is needed to verify this concern. Also, the George Washington University in the District of Columbia conducted an analysis of Oncology providers in the District, and found that among the 95 providers that are currently practicing in the District, a disproportionately low number of these providers actually accept FFS Medicaid.

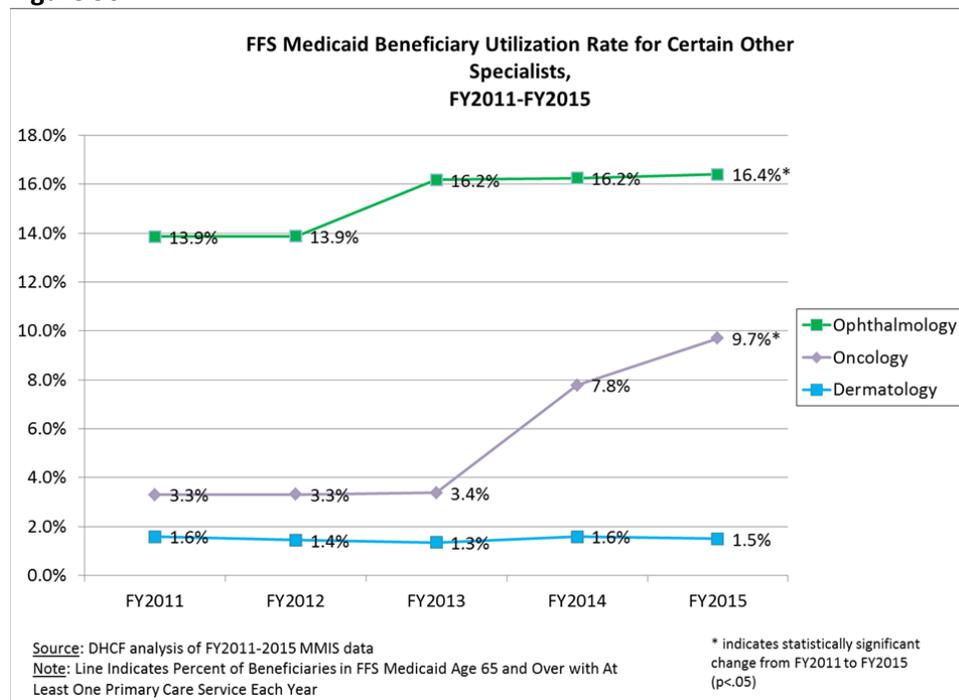
DHCF’s access analysis suggests that recent steps to increase access to oncology providers for its Medicaid beneficiaries have had some success. These efforts include raising the rate for Physician administered chemotherapy drugs from 80 percent to 100 percent of Medicare. The rate increase was well received by oncology provider community. According to a representative from one oncology group, “ultimately, this policy change will result in less fragmented care for cancer patients who often need to receive multiple treatment modalities for their best chance at survival.” In the months ahead, DHCF plans to increase the number of clinicians to accommodate this influx of new patients. DHCF is encouraged by the productive collaboration to best serve Medicaid patients in need of cancer care services and looks forward to continuing our work together on behalf of DC residents.

Beneficiary Utilization and Experience with Other Providers

Beneficiary utilization of other services from these other providers (oncologists, dermatologists and ophthalmologists) was calculated using the number of unique beneficiaries who received each service,

divided by the total number of enrolled FFS beneficiaries each year. The utilization rate for oncologists and ophthalmologists increased over the study period, while the rates for dermatologists remained virtually unchanged. (See Figure 50) Specifically, the rate for oncologists increased dramatically, from 3.3 in 2011 to 9.7 to percent in FY 2015, a 293 percent increase in the utilization rate. The rate for ophthalmologists rose from 13.9 percent in 2011 to 16.4 percent in 2015, an 18.0 percent increase in the utilization rate. The utilization rate for dermatologists fell from 1.6 percent in FY 2011 to 1.5 percent in FY 2015, a decrease of 6.4 percent in the utilization rate. The trends for ophthalmology and oncology were statistically significant.

Figure 50



Information from Beneficiary Complaints was Inconclusive

Between FY 2011 and FY 2015, the Ombudsman received only one complaint concerning access to dermatology services and one complaint concerning access to oncology services. The Ombudsman did receive a significant amount of complaints about “optical services” (6 percent of all complaints over the five-year period), but it was not possible to sub-divide those complaints between ophthalmologists and other providers of optical care.

Conclusions about Access to Other Provider Services

Access to other physician specialists with suspected access issues—dermatologists, oncologists, and ophthalmologists—appear to be stable overall, with participation remaining relatively constant and beneficiary utilization improving slightly over the study period. With respect to the rate of provider participation, the percentages of DC-licensed, metropolitan-area providers in all three specialty groups who billed Medicaid between FY 2011 and FY 2015 remained steady. With respect to the total number of billing metropolitan-area providers, the numbers increased for all three specialty groups. Beneficiary

utilization of oncology and ophthalmology increased, while utilization of dermatology did not change. Provider and beneficiary complaint information was limited and inconclusive. Although provider and beneficiary complaint information was limited and inconclusive, at least one provider's concerns about low dermatologist participation indicate that additional research may be needed to understand whether access barriers exist.

DHCF's analysis of access to dermatologists, oncologists, and ophthalmologists had significant limitations. The measures DHCF used for provider participation and beneficiary utilization and experience relied mostly upon Medicaid claims data. Input from providers and beneficiaries—in the form of the MCAC survey and Ombudsman complaint data, respectively—was limited and inconclusive. Consequently, the results of our analysis of access to these services should be considered an initial, or baseline set of findings. For the next Access Plan, DHCF plans to obtain more robust beneficiary and provider feedback, and therefore expect our analysis to be more sophisticated and results more definitive over time.

VI. Conclusions and Next Steps

DHCF's analysis of access to the six categories of FFS services over the five-year baseline period, FY 2011 through FY 2015, offered varied information. In three of the six categories, the access analysis did not appear to indicate access barriers. Specifically, for primary care services, behavioral health services, and other services about which DHCF had access concerns—dermatology, oncology, and ophthalmology—the preponderance of indicators for provider participation and experience and beneficiary utilization and experience appeared to indicate FFS beneficiary access as either remaining stable or improving. However, limited anecdotal evidence of access barriers for psychiatrists and dermatologists indicates a need for additional research and will be an area for future monitoring. DHCF's analysis of access to care for two other service categories—physician specialty services and pre- and post-natal obstetrics services—appeared to have mixed and inconclusive results. DHCF's analysis of access to care for the sixth category of service, home health services, consistently showed a decline in access—specifically to PCA services and skilled nursing. However, DHCF believes the decline in these services is appropriate given DHCF and law enforcement efforts over the past two years to reduce the high incidence of fraud, waste and abuse in the District's PCA benefit.

DHCF did not identify—using its available measures and data sources—any clear access deficits or precipitous declines in access with any of the services in the six required categories. However, because our results were varied, and did not reflect the desired levels of beneficiary and provider input, rate information from private payers, or other data that might shed additional light on access experience for providers and beneficiaries, DHCF is unable to draw definitive conclusions about the sufficiency of payment and access in the District's FFS Medicaid program from the findings of this report. Instead, DHCF believes the findings in this report establish a reasonable baseline from which to assess future trends and conduct future monitoring.

A. Strategies to Improve Access Monitoring and Analysis

With a goal of strengthening our comparison of Medicaid FFS payments with other payers, including additional sources of beneficiary and provider input, and addressing other limitations in our analysis, DHCF will pursue the following five strategies for future Access Plans.

#1: Obtain Additional Payment Rate Information

In the seven months available to develop this initial Access Plan, DHCF was unable to obtain data on payment rates from private insurers in the DC metropolitan area and had insufficient time to contract with a vendor to provide this information. As a result, DHCF's payment comparison review lacked an important comparator. DHCF will explore the possibility of securing funding and contracting with an outside entity that collects such data. DHCF will also collect payment rates from all participating Medicaid MCOs, so that they can be compared with FFS rates and any differences can be clearly observed and quantified.

#2: Broaden Beneficiary Input

DHCF's primary source for beneficiary input on access issues in this Access Plan was complaints data collected by the Ombudsman. While our analysis of this data shed light on access issues for some types of providers, such as dentists and home health providers, complaint data was less useful in identifying access issues for others. Several stakeholders commenting on this report underscored the importance of having more robust beneficiary input to assess experience in the program. DHCF agrees. To redress this challenge for future access monitoring, DHCF will undertake new initiatives to gather beneficiary input on access issues. One initiative, which the agency is already planning to implement, is a new agency-wide complaint tracking system. DHCF staff will use the system to log any complaints, questions, or other issues raised by beneficiaries over phone, email, or in person; assign the issue to a DHCF employee; and use reporting functionality to track their resolution and analyze trends to inform policy.

DHCF will pursue three other strategies to capture the beneficiary experience of accessing care. First, DHCF plans to expand the scope of its current Consumer Assessment of Health Care Providers and Systems (CAHPS) survey, from beneficiaries in Medicaid managed care programs to beneficiaries in FFS Medicaid. Second, DHCF plans to implement a "secret shopper" initiative for its FFS program, which would assess beneficiary experience in scheduling appointments with providers, provider availability, appointment wait times, and other factors, replicating a similar initiative DHCF already has for its Medicaid managed care program. Under this initiative, secret shoppers could contact providers who furnish services in the six required service categories and ask a variety of access-related questions—for example, identify if they currently accept FFS beneficiaries, or whether they provide translation services. Third, DHCF plans to develop and implement an access-to-care survey instrument that DHCF will use to assess FFS beneficiaries' experience and access to care. DHCF plans to use this survey at health fairs and other public events for beneficiaries and make available at DHCF offices on an ongoing basis. Finally, DHCF is planning to recommend implementing an Access Subcommittee as part of its MCAC as a means of obtaining beneficiary inputs on access issues systematically throughout the year. Through these new tools, DHCF hopes to increase and deepen its understanding of beneficiary access experience and any barriers beneficiaries may face, to inform ongoing monitoring and future Access Plans.

#3: Broaden Provider Input

DHCF's primary source of provider input on access issues in this report was an online survey of MCAC members that, due to the initial July 1 deadline for the Access Report submission to CMS, was distributed quickly with a tight deadline for recipients. As a result, provider response was very limited. To redress this data gap for future monitoring and Access Plans, DHCF is considering other methods to increase provider input, including an annual provider survey. DHCF could initiate a survey through its MCAC, or explore the possibility of contracting with an outside entity to conduct such a survey. DHCF is

also planning to recommend establishing an Access Subcommittee for the MCAC, which would create a venue where providers could highlight access concerns and identify recommendations.

During the time this Access Plan was being developed, DHCF lacked a system for tracking provider complaints. As stated above, the agency is in the process of implementing a new agency-wide complaint tracking system. Staff in DHCF's provider services or billing departments will be required to enter any complaints they receive from providers in the new system, and resolve them and close them out. DHCF will be able to quantify the number of complaints pertaining to payment adequacy issues or beneficiary access issues, and use reporting functionality to track their resolution and analyze trends to inform policy.

DHCF is also considering obtaining provider input through focus groups or stakeholder meetings. Focus groups allow for the intensive, interactive exploration of specific topics that are too complex for a survey. One example of a focus group topic would be why such a large majority of DC-licensed, Metropolitan Area dentists either do not participate in FFS Medicaid or are enrolled in the program but do not actually furnish services to beneficiaries. DHCF plans to explore the feasibility and cost of convening focus groups as a method for obtaining provider input.

Through these and other new tools, DHCF hopes to increase and deepen its understanding of provider access experience and any barriers faced, to inform ongoing monitoring and future Access Plans.

#4: Employ More Standards of Comparison for Network Adequacy and Geographic Availability

In developing this first Access Plan, DHCF had limited success identifying objective standards for network adequacy and geographic availability that could easily be applied to the FFS Medicaid population. While DHCF used several NCQA network adequacy standards in the comparison—specifically, for psychiatrists and OB-GYNs—several other NCQA standards were not as readily useable due to differences between how NQCA standards categorize providers and how providers are identified in Medicaid FFS claims. For the next Access Plan, DHCF will research and determine other options for understanding appropriate rates of provider participation, utilization and geographic availability that are targeted to the District's unique characteristics and demographic makeup. Examples of standards DHCF will review include the adequacy of the FFS network, such as provider-to-beneficiary ratios published by other states, and for geographic availability, such as time-and-distance standards published by NQCA and other accrediting bodies or clinical experts applicable to urban metropolitan areas like the District.

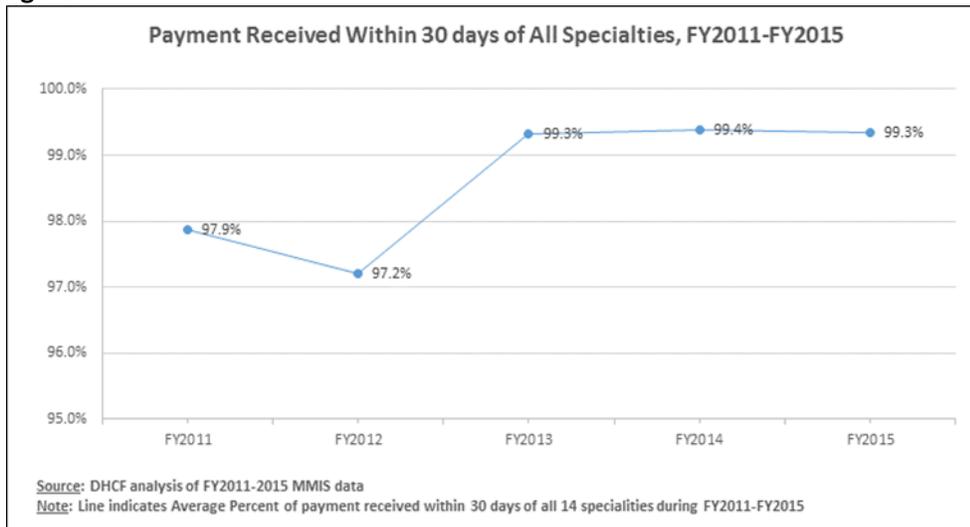
#5: Ensure Provider Participation and Utilization Measures Reflect FFS Medicaid Geographic Parameters

Due to the complexity of the analysis and the time constraints for creating the Access Plan, DHCF was unable to reflect in this report the full scope of providers operating in the District FFS Medicaid program, which includes all contiguous counties in Virginia and Maryland and extends to Baltimore City. Instead, this report limited analysis to providers located within 20 miles of the District's epicenter. As a result, the findings in this Access Plan may understate the true scope of provider participation and beneficiary utilization of services. DHCF intends to include these providers in future Access Plans, but is also cognizant of the importance of capturing beneficiary experience in using Medicaid Non-Emergency Medical Transportation as an indicator of accessibility of these providers in outlying areas. Future analyses will include providers located in these outlying areas, and also analyze the sufficiency of beneficiary to non-emergency transportation services that beneficiaries rely on to reach them.

B. Access-Related Outreach

Although DHCF did not identify any obvious access deficits or precipitous declines in access with any of the services studied in this report, the agency does recognize the need to improve provider participation in certain areas. For example, through its MCAC, DHCF plans to target recruitment efforts at physicians in the physician specialist and “other” categories. Much of this effort will focus on removing physician stereotypes about the operation of the program—in particular, misconceptions about barriers to enrollment or delays in receiving payment for services. Such outreach efforts could include dissemination of analysis like the one below (Figure 51), which shows the improvement in the timeliness of payment between FY 2011 and FY 2015.

Figure 51



DHCF will also work more closely with the MCAC to monitor access to care in the FFS program. Over the course of the next year, the agency will consult with, and report regularly to the MCAC as it pursues a variety of initiatives to improve access monitoring and reporting, such as additional beneficiary and provider input measures and data on private payer rates. DHCF will also recommend the MCAC form an access sub-committee to ensure a subset of MCAC members are identified to provide the agency with input on its access work.

DHCF also recognizes that FFS Medicaid beneficiaries would benefit from clearer expectations about their ability to access services, and how to report access issues when they arise. With this in mind, DHCF plans to update the FFS beneficiary handbook with a section on access to care. The section will include general timeframes under which beneficiaries should be able to expect to secure an appointment with a provider for a needed service, and what to do if they are unable to do so.

C. Looking Ahead

Developing and sharing this report has provided DHCF with valuable opportunities to assess FFS program experience in a comprehensive way for the first time. Doing so has offered useful information and insights and posed new questions that will inform our future efforts to improve care for beneficiaries served by this program. The report also offers an important window into the program for providers and beneficiaries participating in Medicaid and has begun a dialogue about ways to reimagine

how DHCF measures access and delivers services that will continue in our future work. Although the report did not generate conclusive findings about access, DHCF is confident that the information shared will provide a foundation on which to build a deeper understanding to support the agency's ability to continue administering the program in the best interests of District residents for years to come.

Appendix: Acknowledgements

This report is the product of contributions from many individuals within and outside of District government, under the leadership of DHCF. Yorick Uzes and Alice Weiss drafted the report, with analytic and narrative contributions from John Wedeles, Ellyon Bell, Deniz Soyer, DaShawn Groves, Amy Xing, Marie Dorelus, and An-Tsun Huang. Members of DHCF's Access Workgroup provided initial guidance and ongoing feedback on the methodology, analysis, and draft. Workgroup members included Amy Xing, Cavella Bishop, Andrea Clark, Claire DeJong, Marie Dorelus, Diane Fields, Lisa Fitzpatrick, Ieisha Gray, DaShawn Groves, Maude Holt, Carmencita Kinsey, Laurie Rowe, Colleen Sonosky, John Wedeles, Alice Weiss, Monique Willard, and Constance Yancy. DHCF Director Wayne Turnage, Senior Deputy Director and Medicaid Director Claudia Schlosberg, and Chief of Staff Melisa Byrd provided direction and feedback to inform the report. DHCF also appreciates the contributions from other District agencies, including DOH, DBH, and the District of Columbia Public Schools, the District's Medical Care Advisory Committee, and other interested stakeholders, which have greatly improved this report.