



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

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DC Department of Health Care Finance
441 4th Street, NW, 900S
Washington, DC 20001

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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.