District of Columbia FFS Medicaid Program:

Access Monitoring Review Plan

October 1, 2016

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DRAFT FOR PUBLIC COMMENT

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I. Executive Summary

A. Overview

The District of Columbia (the District) provides Medicaid benefits to more than 266,207 individuals in 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. In FY 2015, more than 80 percent of FFS program enrollees 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 population 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 (AMRP) that evaluates whether beneficiaries have sufficient access to services provided under FFS Medicaid and 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 AMRP 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, and
6. 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 AMRP 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, FY2011 through FY2015.[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. This AMRP 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

[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.

also provides recommended next steps for improving DHCF's ability to measures access in future AMRPs and monitor access over time.

DHCF conducted the work for this draft AMRP during the months of December 2015 through July 2016 in consultation with sister 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). In addition, DHCF sought feedback from the District's Medical Care Advisory Committee (MCAC), and will be soliciting input from stakeholders by providing a period for public comment. The AMRP will be announced in the DC Register and posted on DHCF's website for a 30-day period beginning in August 2016, to allow for public review and comment. The final report will incorporate any comments received.

In developing this report, DHCF discovered a number of important limitations in the available data. First, because private payer data is proprietary, the District does not have an available means to obtain such data to inform this report. Thus, 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 stakeholder survey of MCAC members, responses were limited. Finally, DHCF's ability to analyze claims data for federally qualified health centers (FQHCs) was limited. During the FY2011 through FY2015 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. DHCF addressed this by assuming all FQHC claims were for primary care non-dental services, which inflates the utilization figures for that type of service, and underreports the utilization figures for behavioral health and primary care dental services. An additional limitation with FQHC claims data is that they 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 relatively small, this nevertheless suggests that the provider participation figures in this report are understated. For all of the reasons above, this first AMRP 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 AMRPs can be built.

C. Summary of Initial Findings

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 (i.e., home health, dentists, or behavioral health) was not possible since

Medicare does not typically cover the same set of services. 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. Based on this data, 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, FY2011 though FY2015, 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 for provider participation and experience and beneficiary utilization and experience demonstrated overall beneficiary access as either remaining stable or improving. The exception was utilization of dental services by children and youth under age 21, which decreased slightly during the five-year period. 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 even 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 FY2015, 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 FY2011, a trend that DHCF will continue to monitor. It is noteworthy that the vast 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 only 25% of live births for all Medicaid-insured women in fiscal year 2015. Two other types of services, durable medical equipment and non-emergency transportation, were flagged as having increased 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 will plan to include these in future monitoring 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 aide (PCA) and skilled nursing services. The decline in these services is appropriate given DHCF and law enforcement efforts 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, including 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 saw 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 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. 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 [DHCF will add after review of public comments]

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	Residential Treatment facilities
Early Periodic Screening Diagnosis & Treatment	IFC/MR & Day treatment
Nursing Facilities	Personal Care, Hospice
Emergency Ambulance	Home Health, Case Management

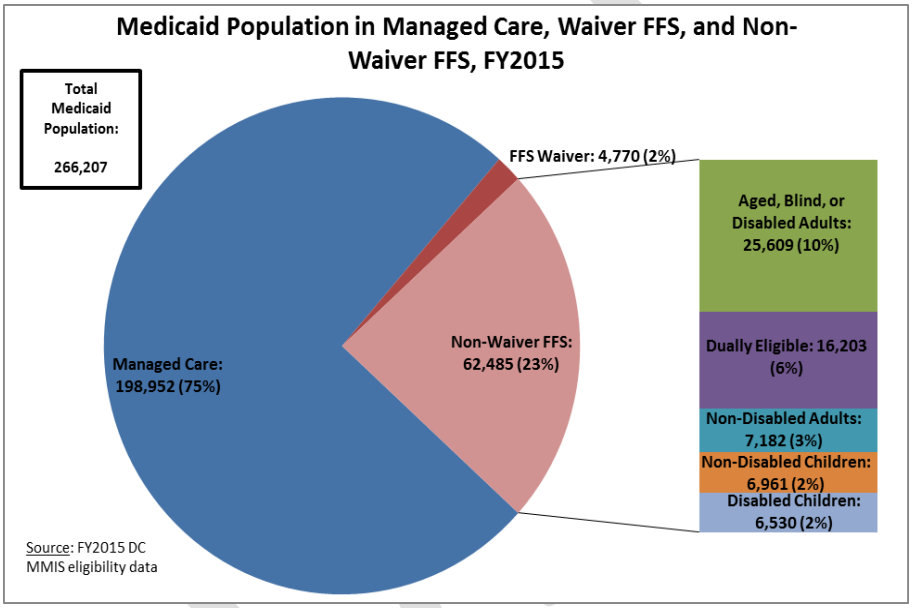
The District provides additional services, such as respite care and expanded PCA services, to individuals enrolled in its two home and community-based waiver programs: the Individuals with Intellectual and Developmental Disabilities (IDD) waiver and the Elderly and persons with Physical Disabilities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

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 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% FPL. 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 residents of DC, 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 income who

do not qualify for Medicaid coverage, the District has one of the lowest uninsured rates in the nation. According to 2014 U.S. Census data, only five percent of District residents are uninsured.[3]

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) FFS, which is administered under enrollment agreements with individual health care providers.[4] 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 FY2015, 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 of less relevance for the FFS population than for those enrolled in managed care.

Figure 1



B. FFS Population Characteristics

While DHCF identified 62,485 beneficiaries who were enrolled in the FFS program at some point during FY2015, only a subset of these individuals, 46,342, relied on the FFS program as their primary model of

[3] United States Census Bureau, Health Insurance Coverage in the United States: 2014. Available here: https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf..

[4] Two programs to provide home- and community-based services (HCBS) under Medicaid, the Elderly and Individuals with Physical Disabilities (EPD) and Individuals with Intellectual and Developmental Disabilities (IDD) waivers, are not a separate model of health delivery, but serve as a supplement to the FFS program for the small number of waiver-enrolled individuals. However, neither of these waiver-based programs are included in the FFS study group, per direction under federal Access rules.

healthcare 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 FY2015 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 FY2015, 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

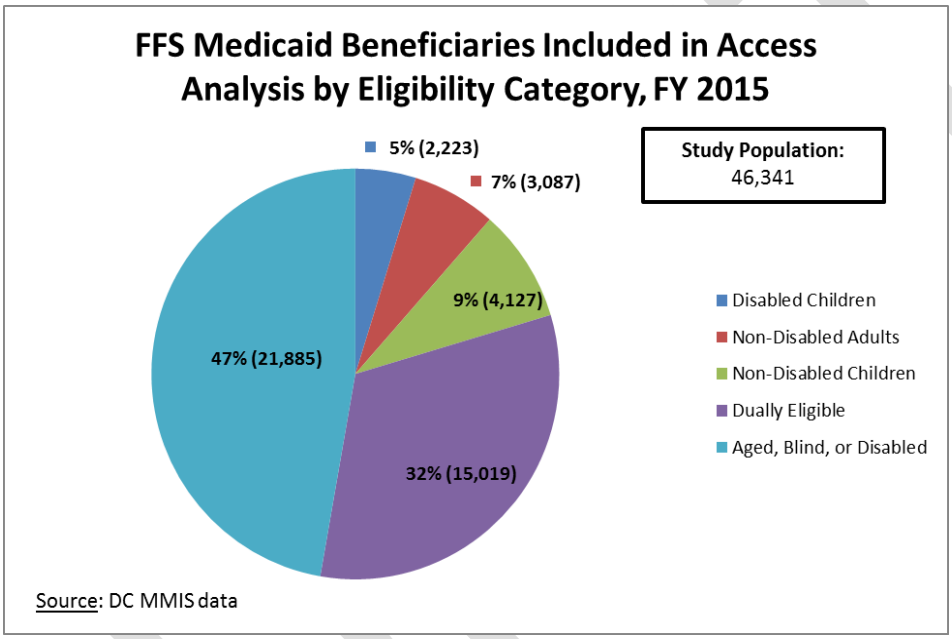


Figure 3

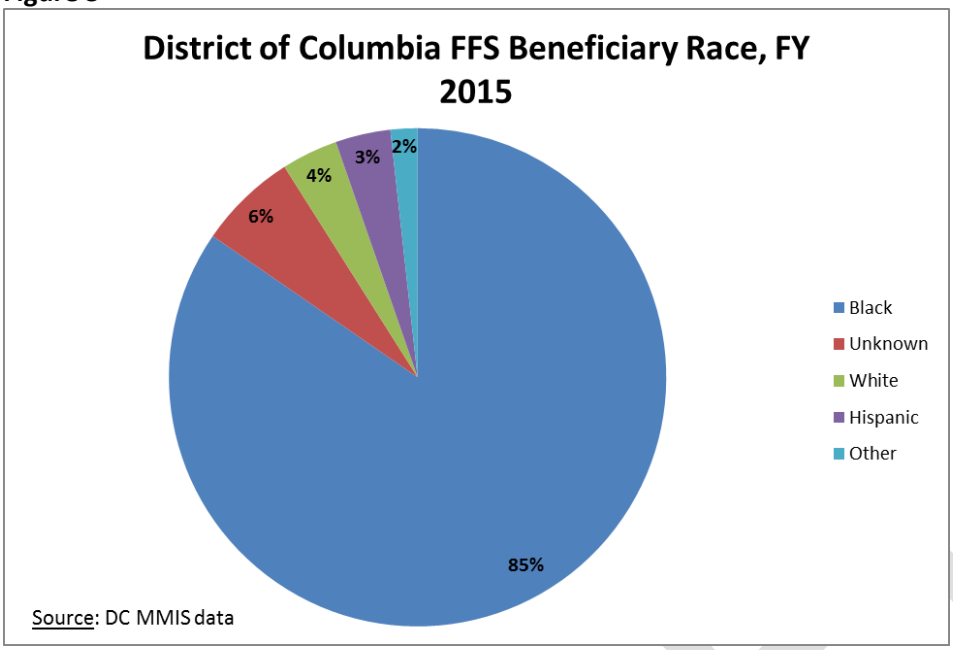
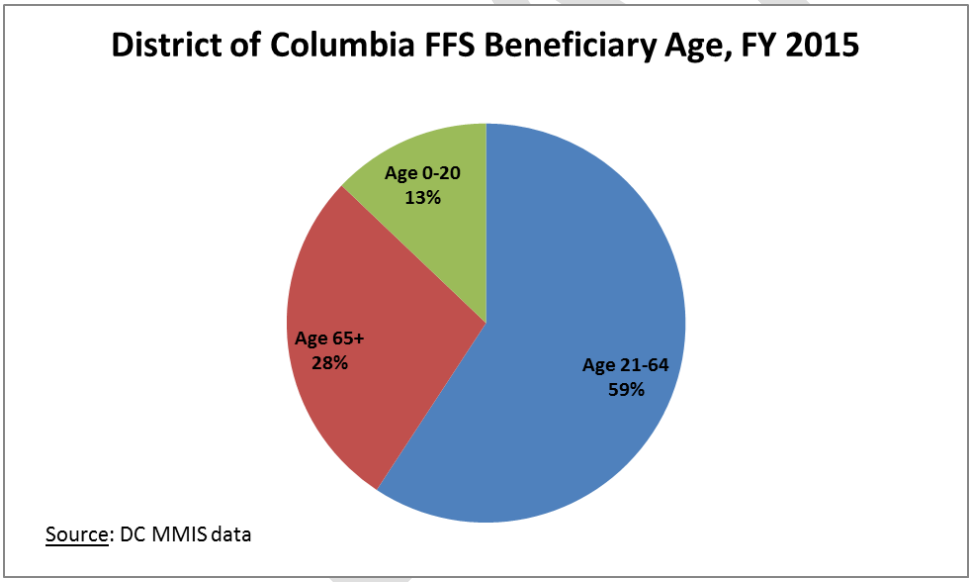


Figure 4



FFS population: health status. Of the 46,342 beneficiaries solely enrolled in the FFS program in FY2015, the most common chronic conditions were hypertension (51% prevalence in the study group), hyperlipidemia (28%), diabetes (27%), depression (22%), and asthma (21%).

FFS population: comparison with MCO population. Compared to beneficiaries enrolled in the Medicaid managed care program, individuals in the FFS population are more likely to have complex, costly health care needs. In FY 2015, FFS beneficiaries on average cost more to treat on a per-person basis ($26,399 per person for FFS compared to $6,781 for MCO members). FFS beneficiaries were also more likely to

have an inpatient visit; in 2015, 11 percent of the FFS population had an inpatient visit as compared to seven percent of MCO beneficiaries. In addition, the average length of stay for hospital admissions for FFS beneficiaries was 20 days, compared to five days for MCO members. In terms of prescription medication utilization, FFS beneficiaries had an average of 32 prescriptions in FY15, compared to 14 prescriptions for MCO members. FFS beneficiaries 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 beneficiary experience and outcomes. The District is also developing a second health homes program that will target individuals with multiple chronic health conditions, which will be implemented in 2017.

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.

B. Selection of FFS Providers by Category of Service

Under the final Access Rule CMS-2328 FC, 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 three 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 providers who furnished two types of services 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 medical 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 beneficiaries may receive other types of services at home, such as occupational therapy, physical therapy, speech therapy, and home health aide services, these additional services were not included in the scope of this report. They will be analyzed in future AMRPs.

- Other Providers: 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[5]

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 AMRP 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

[5] 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 has not requested payment reductions or restructurings from CMS since the New Rule was implemented, DHCF focused on services in the latter category.

(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 timeframe initially available, the District was unable to identify any whose data contained a sufficient level of service detail and/or rates specific to private payers in the District.[6] DHCF is exploring the possibility of procuring such data for future analysis.

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 data set of all physicians and dentists licensed by the D.C. Department of Health's (DOH) Health Regulation and Licensing Administration (HRLA), Board of Medicine (BOM), Board of Dentistry (BOD), and Board of Podiatry (BOP) from FY 2011 and FY2015. 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 FY2011 and FY2015. 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 FY2011 through FY2015 for all physician provider types, but not for providers 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 billing for each provider type, and presents the results of both measures, the billing 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 bill for services, still play an

[6] 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.

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 bill. For this AMRP, DHCF used billing as the indicator of provider participation in Medicaid; for future AMRPs, DHCF will define participation as those who bill 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% 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 Bill Medicaid 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 FY2011 and FY2015; 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 Federally Qualified Health Centers (FQHCs) are counted. Currently, there are eight FQHCS operating in the District, 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 AMRP. 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 AMRP. 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's policy is to pay all clean claims within 30 days of receipt. DHCF analyzed the proportion of 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. Adjusted and denied claims were not included in the analysis.

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). 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 FY2011 and FY2015.

The manner in which FQHCs bill the Medicaid FFS program presented challenges for accurately measuring utilization. From FY2011 to FY2015, 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 identify

the relevant provider types. DHCF identified 1,056 complaints regarding access between FY2011 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 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 FY2011 through FY2015.

- 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 AMRP. 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 AMRP.

IV. Payment Rate Comparison Initial Findings

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, including reimbursement for primary care providers services provided by primary care physicians, psychiatrists, OB/GYNs and APRNS and for physician-administered chemotherapy prescription drugs. Medicaid FFS also appears to pay comparable rates to most Medicaid MCO plans operating in the District for many services. Although we were unable to determine actual rates from all four MCOs, we were 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.

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. The District later extended the rate increase 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. DHCF percentage increase permanent in 2016.

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). In June 2016, CMS approved a State Plan Amendment (SPA) to allow the District to reimburse oncologists at 100 percent of the Medicare fee schedule for physician-administered chemotherapy drugs.

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 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.[7] 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

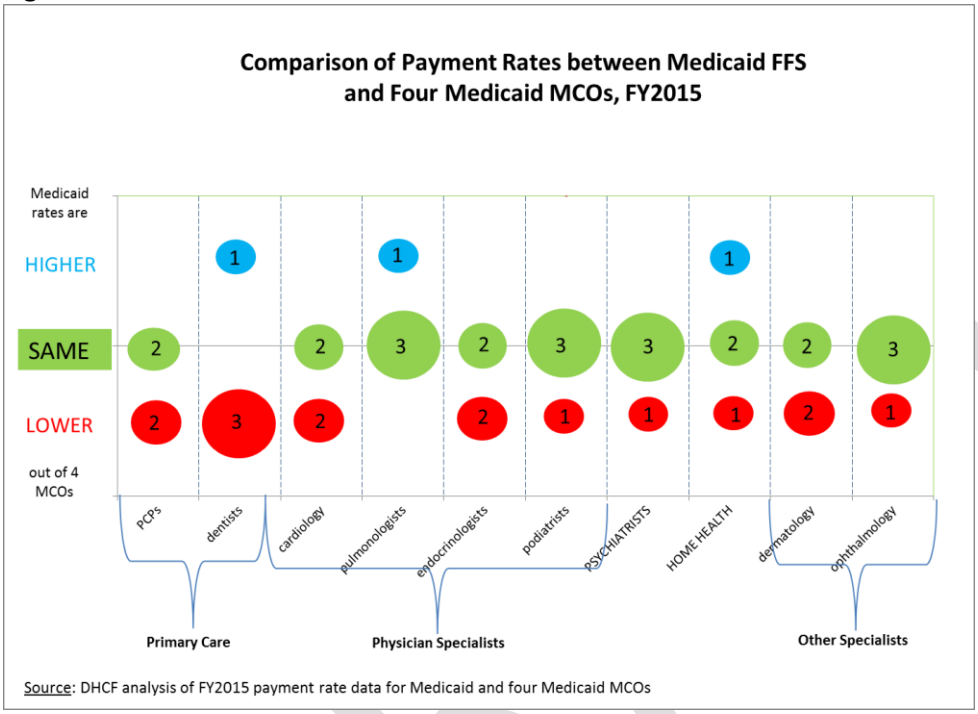
DHCF was unable to calculate an average MCO payment rate for each provider type and compare it to Medicaid FFS. However, DHCF was able to determine whether Medicaid FFS tended to be higher, lower, or about the same as each MCO's rates. Although there was considerable variation by MCO, FFS payment rates 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

[7] 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.

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.

Figure 5



Source: DHCF analysis of FY2015 payment rate data for Medicaid and four Medicaid MCOs

C. Conclusions about Payment Adequacy

[Placeholder]

V. Access Measurement Analysis Initial Findings

A. Primary Care

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 that billed Medicaid increased from FY2011 through FY2015, and the total number of DC Metropolitan area providers that billed Medicaid in those years also increased. The FFS program compared favorably with Medicaid managed care plans in terms of network adequacy; specifically, for both PCPs and dentists, the ratios of FFS providers to FFS beneficiaries was far more favorable than the ratios of plan network providers to plan members averaged across the three MCO plans. 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, utilization still appears low, especially for children, and the utilization of dental services by children and youth actually decreased slightly during the five-year period. The District is aware of this issue and is already pursuing a plan for enhanced outreach and monitoring to address it. Provider and beneficiary survey information was limited, but yielded some potential issues for future monitoring.

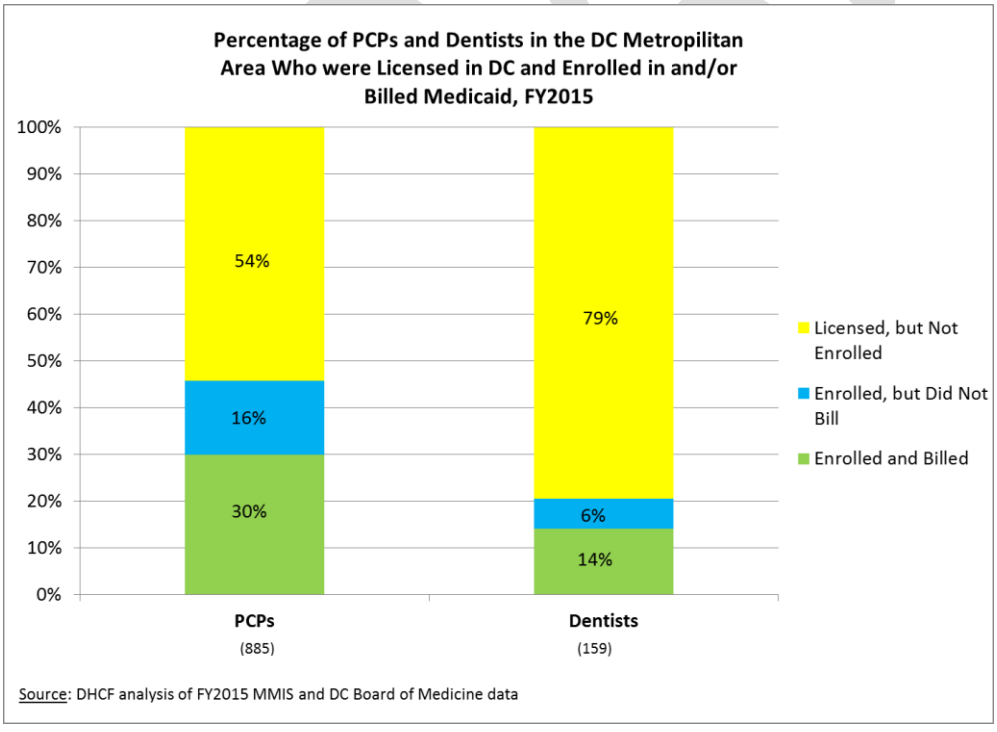
Primary Care Provider Participation and Experience

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

To determine participation, DHCF created FY2015 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.

FY2015 Snapshot: Of the 885 PCPs licensed in the District and based in the DC Metropolitan Area in FY2015, 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 159 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.

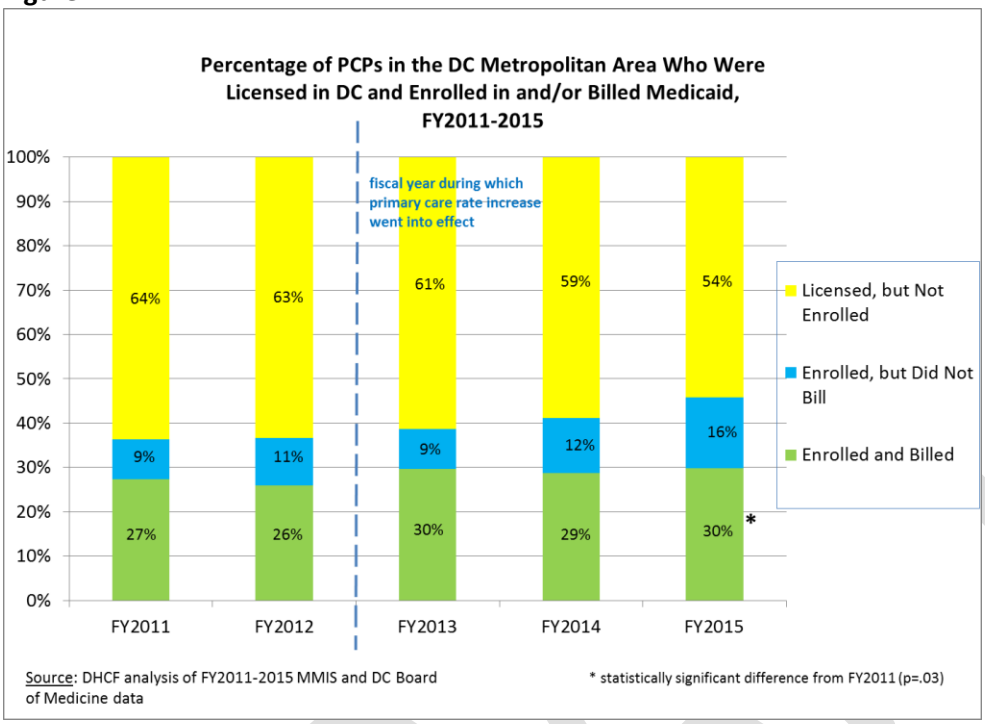
Figure 6



Five-Year Trend: Between FY2011 and FY2015, the percentage of DC-licensed, metropolitan-area PCPs who billed Medicaid fluctuated, but increased 11 percent, from 27 percent in FY 2011 to 30 percent in

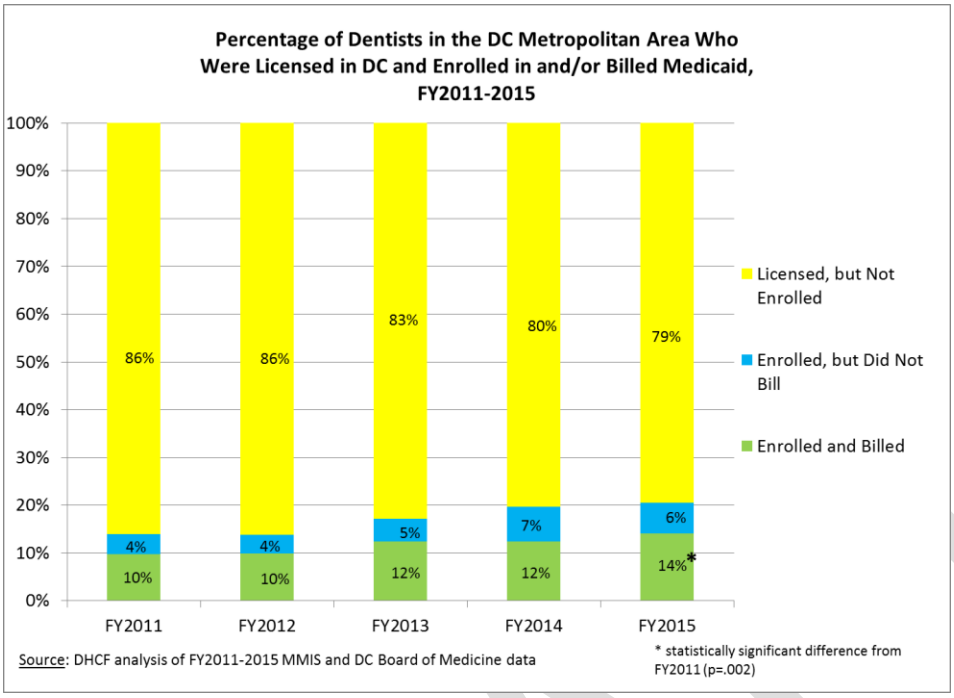
FY 2015. (See Figure 7.) This increase was statistically significant. It is important to note that FY2013 was the year the primary care rate increase went into effect.

Figure 7



Dental providers' rate of participation also appears to be increasing as more dentists billed Medicaid services over the past five years. Between FY2011 and FY2015, the percentage of DC-licensed, metropolitan-area dentists that billed Medicaid increased 40 percent, from 10 percent in FY 2011 to 14 percent in FY 2015. (See Figure 8.) This increase was statistically significant.

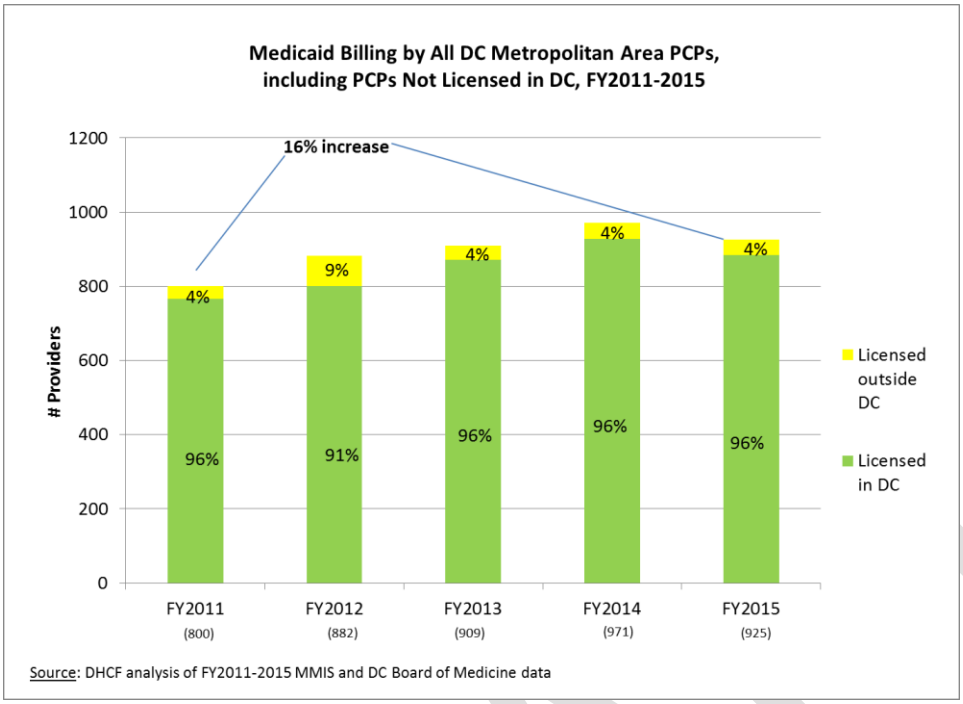
Figure 8



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

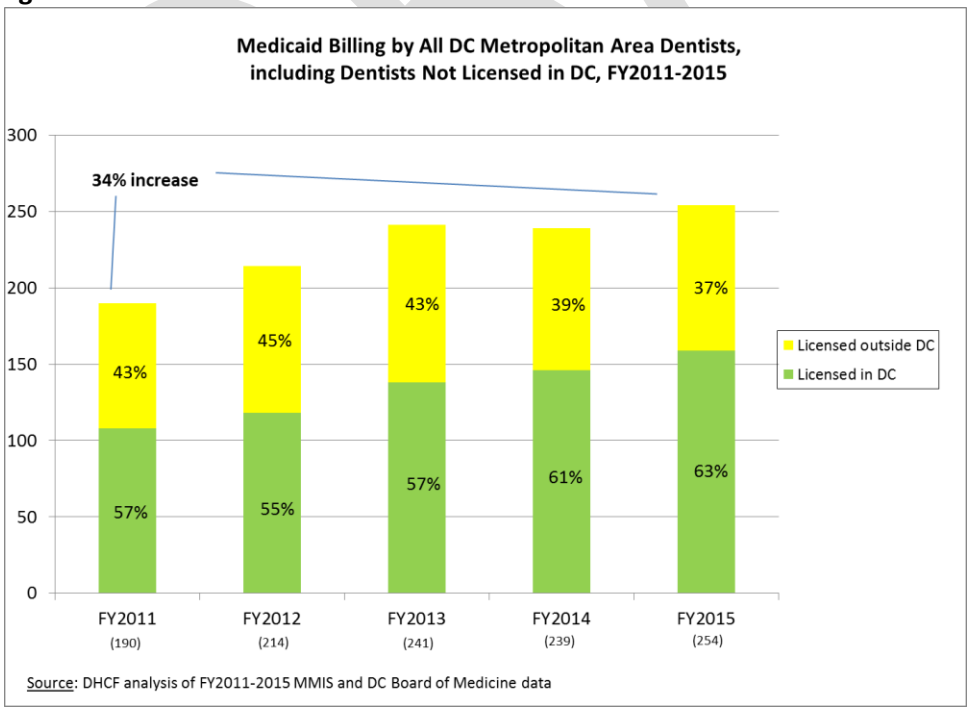
Between FY2011 and FY2015, the total number of metropolitan-area PCPs that billed Medicaid for at least one primary care service annually rose 16%, from 800 to 925. (See Figure 9.) Out-of-state providers played a small but constant role, representing about 4% of PCPs in FY2015.

Figure 9



Between FY2011 and FY2015, the number of DC Metropolitan Area dentists who billed Medicaid for at least on dental service annually rose 34%, from 190 to 254. (See Figure 10.) Many billing dentists were licensed outside of DC during each year under review, with more than a third of billing dentists licensed outside of DC in FY 2015.

Figure 10



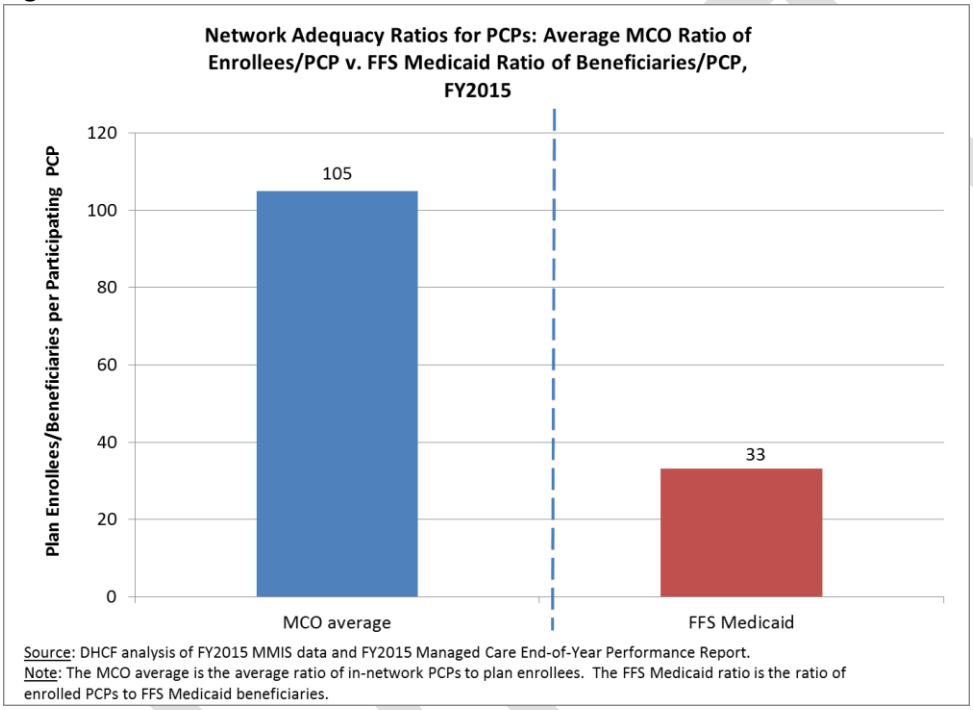
Participation by FQHCs Appears Stable

FQHCs provide comprehensive primary care, behavioral health services, and dental care. Eight FQHCS, including several with multiple provider sites, participated in the District Medicaid program between FY2011 and FY2015. The number of FQHCs has remained consistent throughout the study period.

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 FY2015, 1:105.

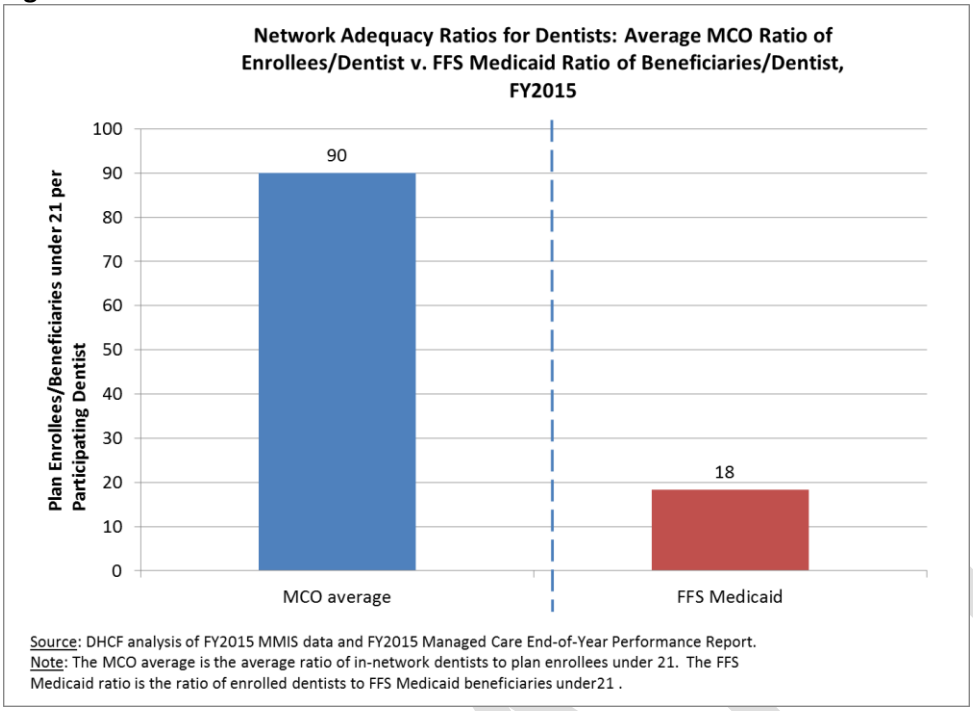
Figure 11



Source: DHCF analysis of FY2015 MMIS data and FY2015 Managed Care End-of-Year Performance Report.
Note: The MCO average is the average ratio of in-network PCPs to plan enrollees. The FFS Medicaid ratio is the ratio of enrolled PCPs to FFS Medicaid beneficiaries.

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 FY2015, 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. 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 AMRP.

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"

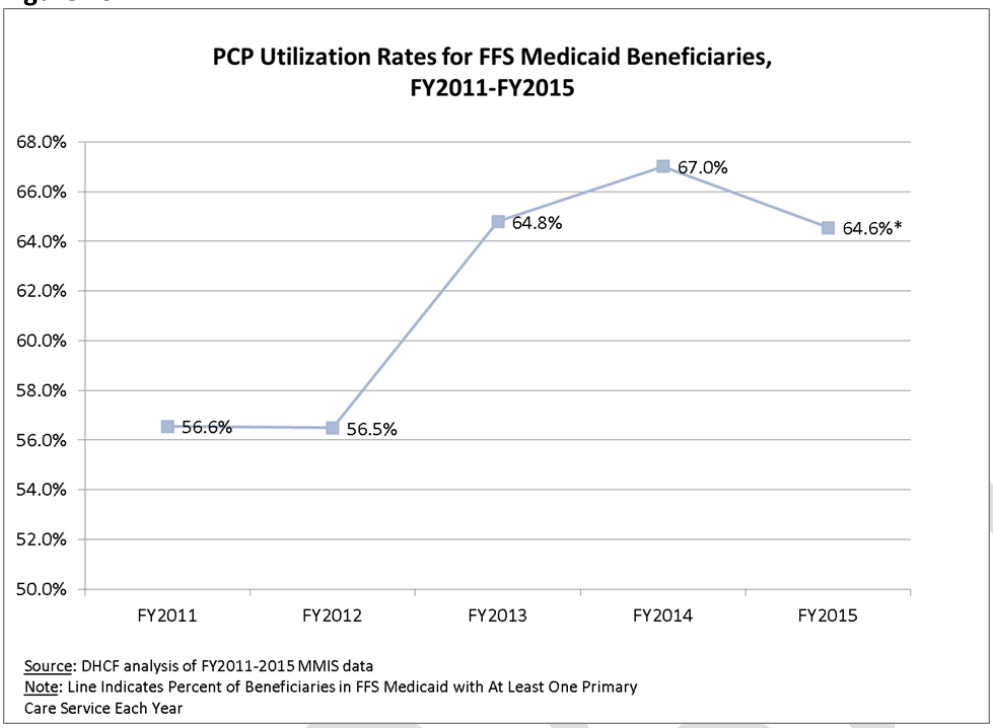
Beneficiary Utilization and Experience with Primary Care Services

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 FY2011 and FY2015. (See Figure 13.) In FY2011, 56.6 percent of FFS beneficiaries received at least one primary care

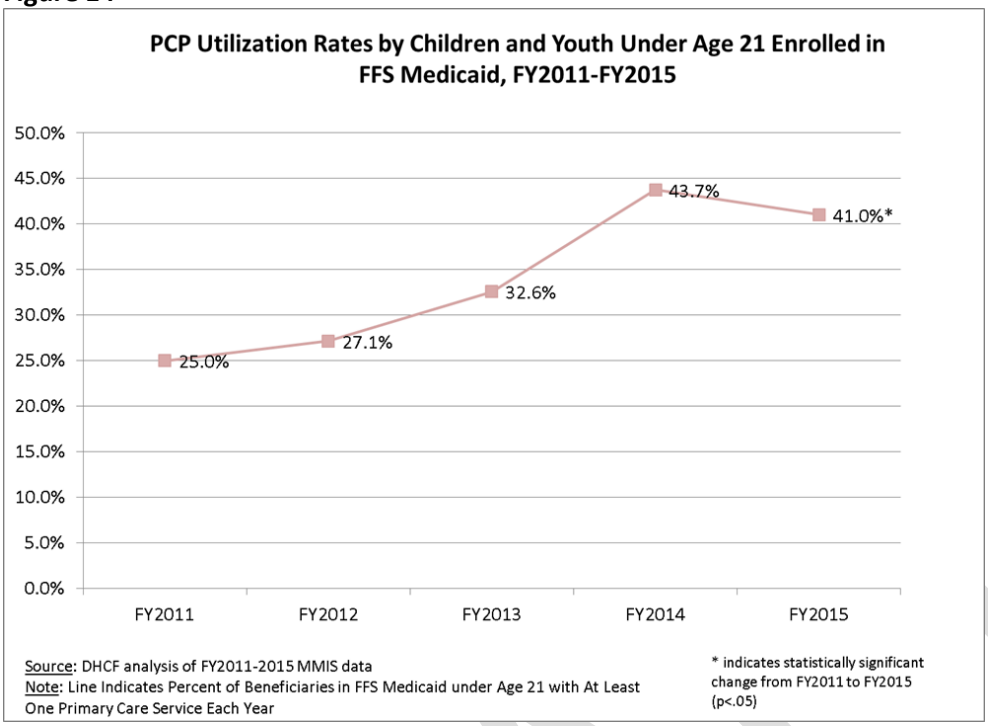
service from a PCP. By FY2015, the number had risen to 64.6 percent. This 14.1 percent increase was statistically significant.

Figure 13



Children and Youth: The trend of increased utilization of PCP services was consistent for children and youth under 21 years of age. In FY2011, 25.0 percent of the FFS beneficiaries under age 21 received at least one primary care service from a PCP, while by FY2015, the number had risen to 41.0 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 utilization of PCPs may be lower than is medically indicated for the FFS population, especially for medically vulnerable beneficiaries and children. Part of the explanation for children and youth, for example, is that they may be receive intensive non-medical services through other child-serving systems that do not coordinate well with the Medicaid program. (In FY2015, there were 6,350 children and youth under 21 in the study Medicaid FFS population.) To address this concern, the District is committed to implementing more coordinated oversight of early periodic screening, diagnostic, and treatment (EPSDT) services, including well-child visits and lead screens regarding FFS children. The target population for FFS-enrolled children includes:

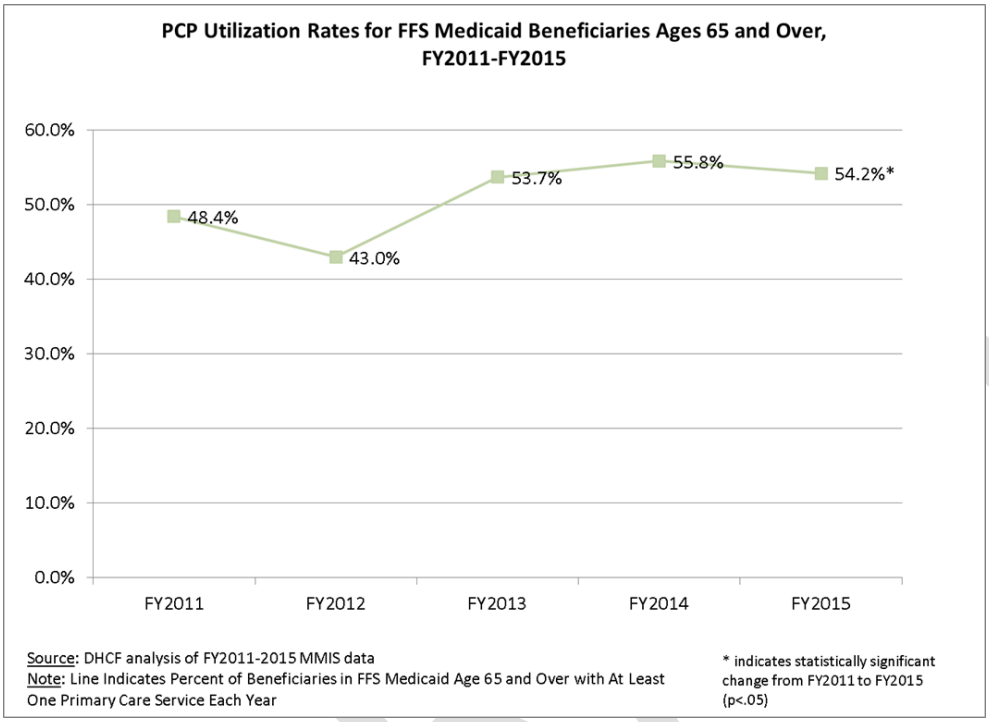
1. children with disabilities living at home;
2. children residing in a nursing facility or other institutional setting;
3. children in foster care or in custody of child welfare agency;
4. adopted and permanently placed children; and
5. juvenile justice involved children and youth.

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.

Elderly: The trend of increased utilization of PCP services held for individuals ages 65 and above. In FY2011, 48.4 percent of this beneficiary subpopulation received at least primary care service from a PCP,

while in FY2015, 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.

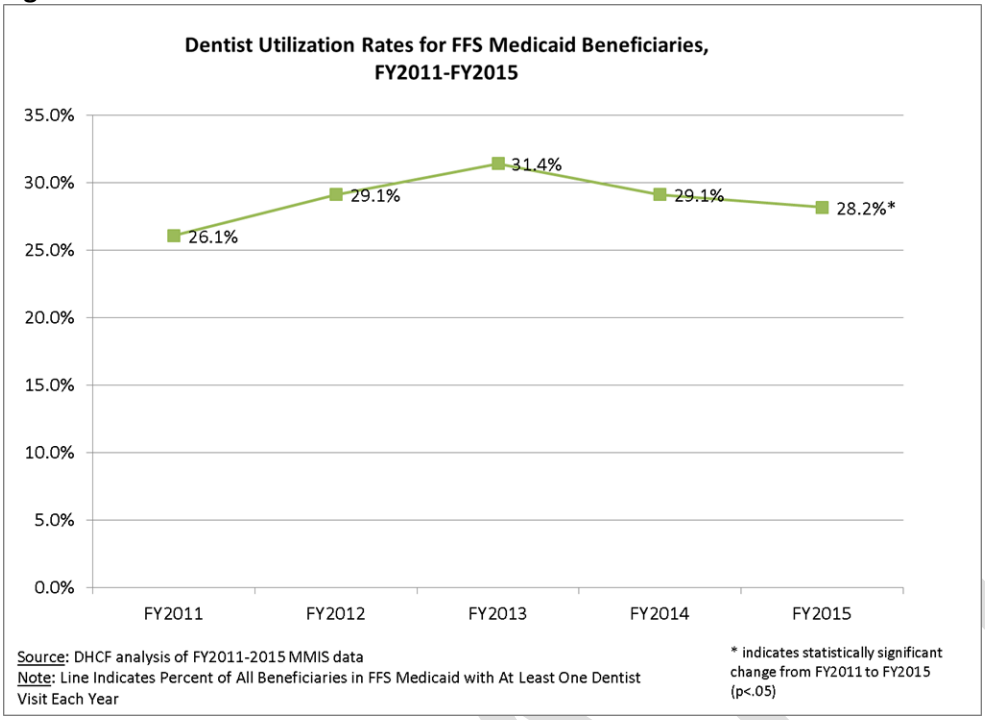
Figure 15



Utilization of Dental Services Appears to Have Increased Over Time

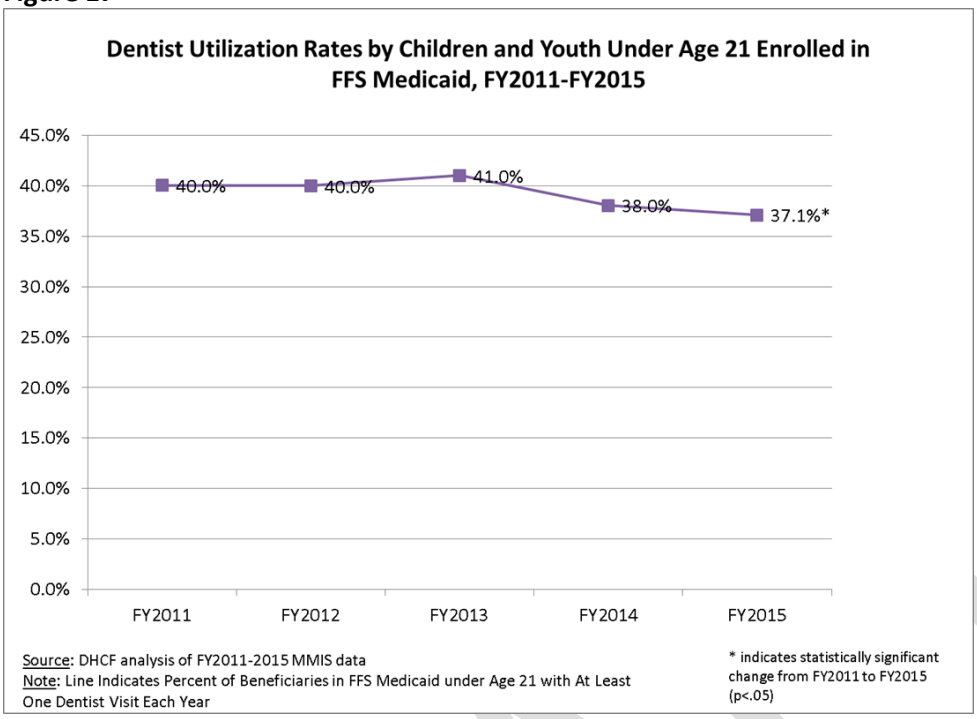
Overall FFS Beneficiary Population: The dental services utilization rate by FFS beneficiaries, which was calculated using the number of unique beneficiaries divided by all FFS beneficiaries enrolled in each year, increased between FY2011 and FY2015. In FY2011, 26.1 percent of FFS beneficiaries received services from a dental provider and in FY2015, 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 (p=0.00).

Figure 16



Children and Youth: In contrast to the FFS population generally, Medicaid FFS beneficiaries under age 21 appear to have experienced a decrease in utilization of dental providers. In FY2011, 40.0 percent of the 7,678 beneficiaries in that age range received at least one service from a dentist, and in FY2015, 37.1 percent of the 5,987 beneficiaries in that age range 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

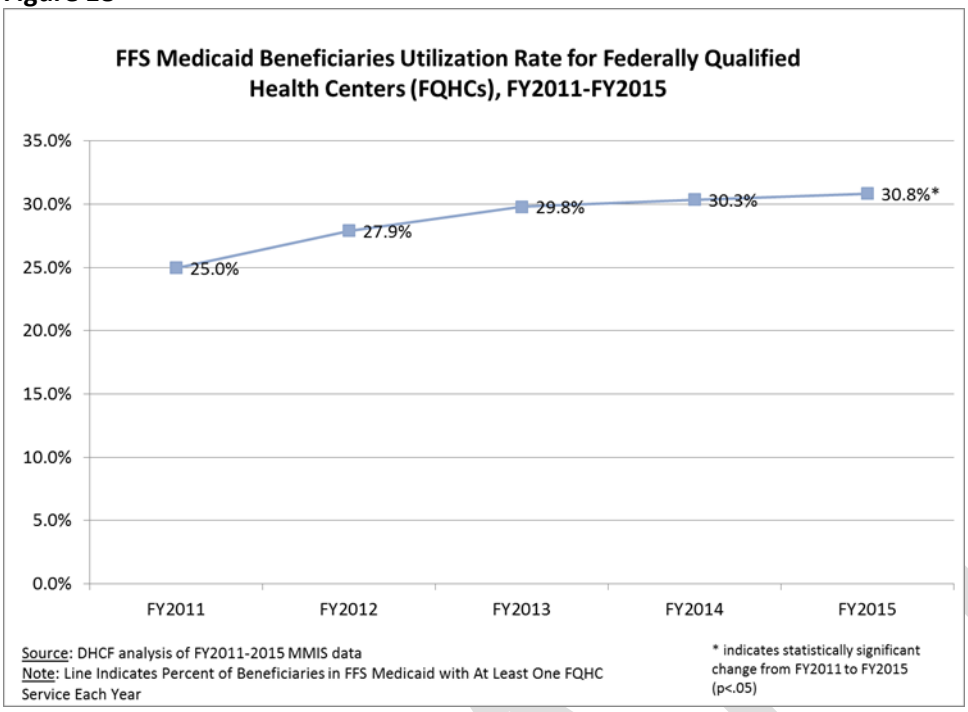


DHCF is monitoring recent decreases in utilization rates for children and is using the same outreach and monitoring strategies for dental utilization as those described above for PCPs. Further, once the new payment methodology is implemented for FQHCs, DHCF will have more accurate data on utilization 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 FY2011 to 30.8% in FY2015; 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.

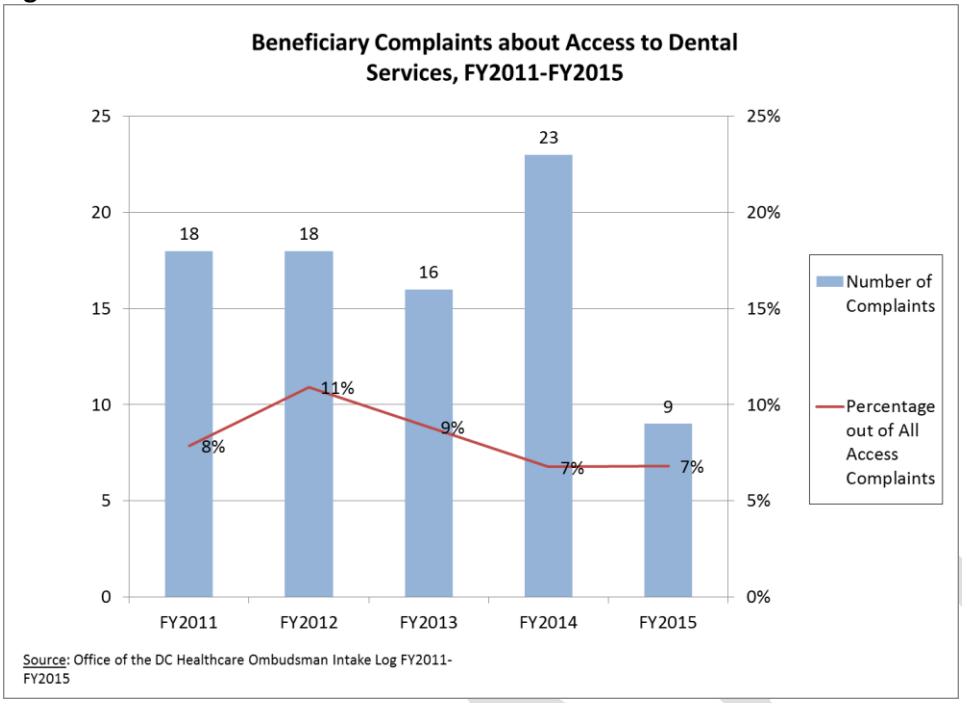
Figure 18



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

Very few complaints made to the District's Health Care Ombudsman Office related to access concerns regarding PCPs. However, complaints about access to dental service comprised between 7 to 11 percent of all access-related complaints each year. The number of dental service access-related complaints fluctuated between 18 in FY2011 and 9 in FY2015, with higher rates in the intervening years. (See Figure 19.) Compared to FY2011, there were 50 percent fewer complaints in FY2015. These complaints mainly arose from beneficiaries not being able to see a dentist or receive certain services like dentures.

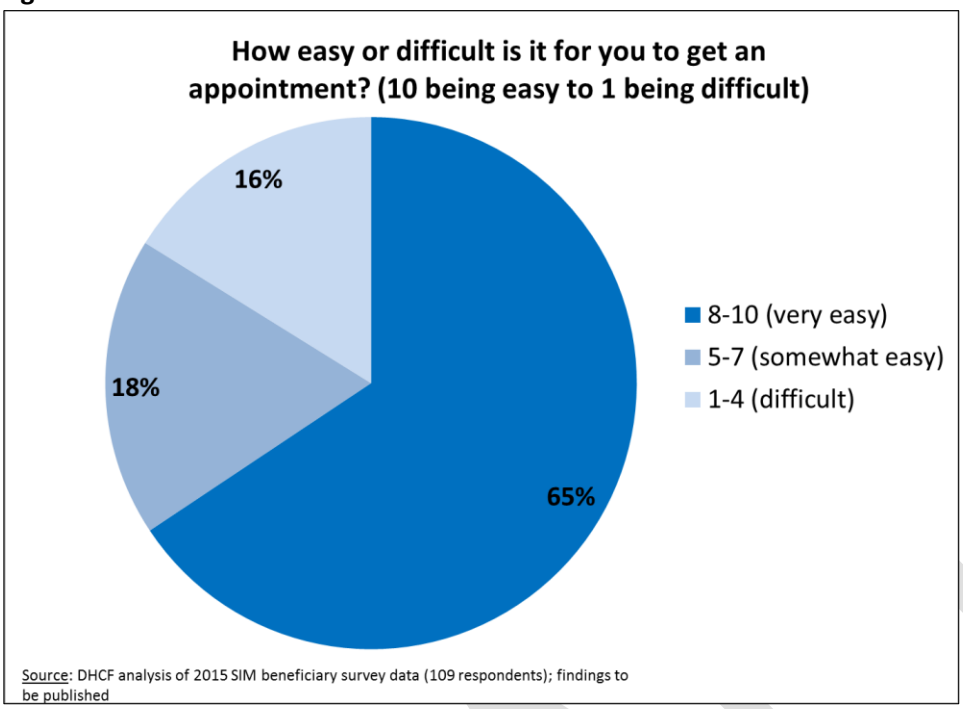
Figure 19



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

An analysis of interview data from a State Innovations Model- 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 the ease/difficulty of obtaining an appointment at an 8 or above on a scale of 1 (difficult) to 10 (easy). (See Figure 20.) 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 be a higher needs population and may not offer a proportional representation of FFS beneficiary experience. Finally, these findings appear to conflict with stakeholder inputs on the difficulty of scheduling appointments with PCPs. For these reasons, more data is needed to confirm actual beneficiary experience, including representative surveys or focus groups.

Figure 20

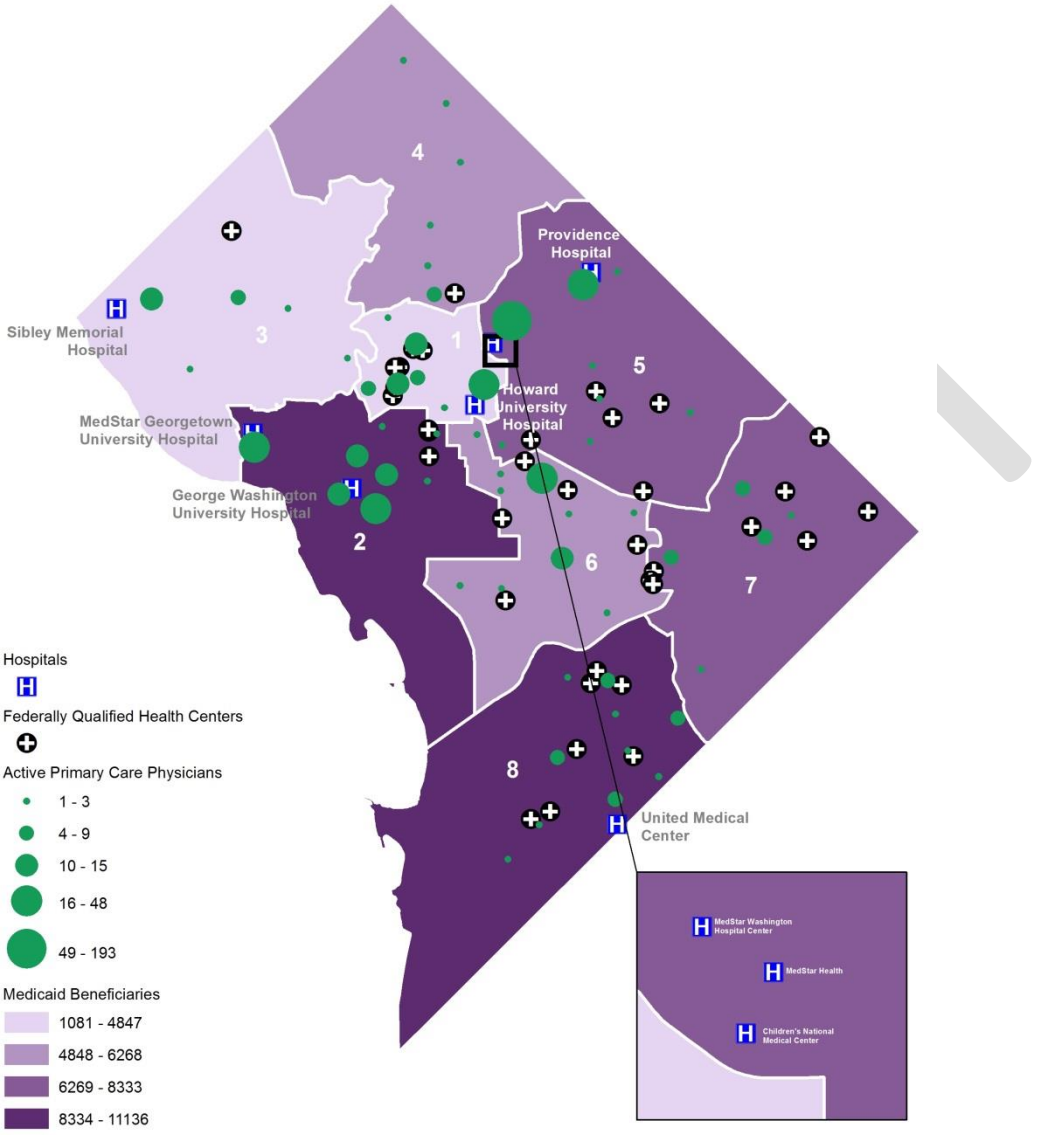


Geographic Location of Beneficiaries and PCPs Among District Wards Suggests Disparity Between Beneficiary and Provider Density

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. 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. While FQHCs have sites throughout the city, their placement in Wards 7 and 8, the two with the highest concentration of beneficiaries, is less dense. Notably, this map does not reflect Medicaid FFS providers who are located outside of the physically boundaries of the District. For residents in Ward 7 and 8, for example, many seek health care services from DC Medicaid enrolled providers located in adjacent Prince Georges County. Nevertheless Wards 7 and 8 are designated as medically underserved areas.

Figure 21

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



Source: OCTO analysis of FY2015 MMIS data

This map appears to indicate a disparity between the beneficiary demand for PCPs near where beneficiaries live and where PCPs are generally located. This idea has been reinforced anecdotally by beneficiary advocates and other stakeholders. This disparity will be an area of focus for future monitoring and improvement efforts and will be evaluated in the next AMRP.

Conclusions about Access to Primary Care Services

[Placeholder]

B. Physician Specialists

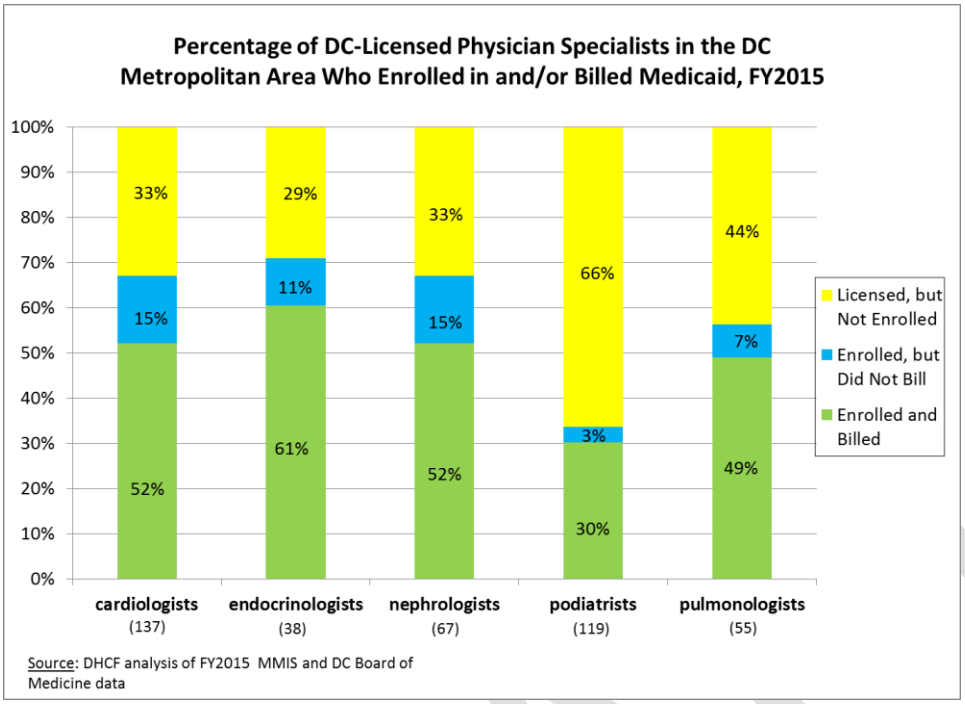
Measuring FFS beneficiary access to physician specialty services produced mixed results, and will require future monitoring and better data sources to better understand actual experience. The percentage of DC Metropolitan Area providers billing Medicaid for services was relatively constant for all five 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, decreased significantly for cardiology and podiatry, and did not significantly change for pulmonology. Despite this beneficiary utilization experience with cardiology and podiatry, the District Ombudsman received few complaints relating to access to specialists.

Physician Specialist Participation and Experience

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

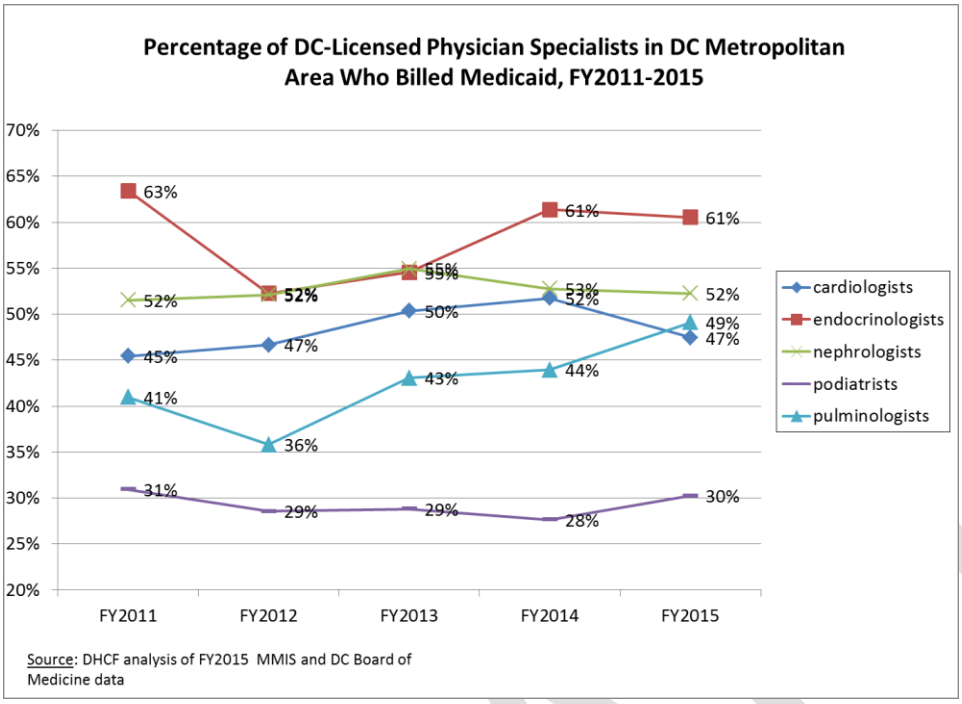
FY2015 Snapshot: Participation levels varied among DC-licensed physician specialists in the DC metropolitan area. Endocrinologists had the highest level of participation in FY2015, with 72 percent enrolled in Medicaid, and 61 percent billing for at least one endocrinology service for a Medicaid beneficiary. (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 FY2011 and FY2015, 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 FY2011 and FY2015, the total number of physicians in the 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

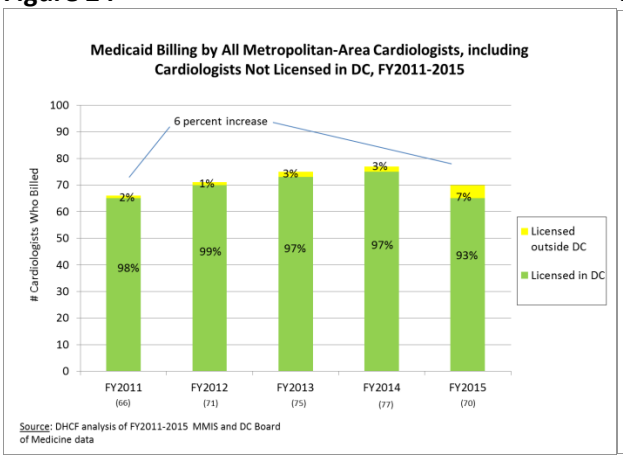


Figure 25

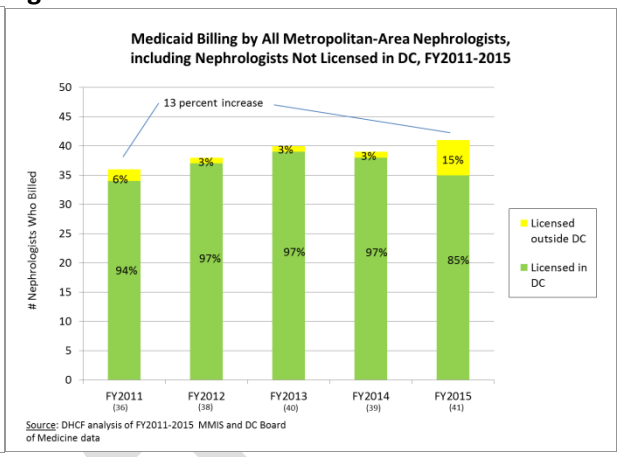


Figure 26

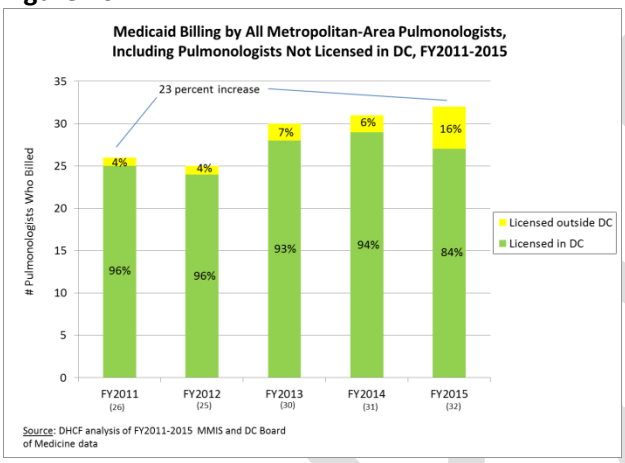


Figure 27

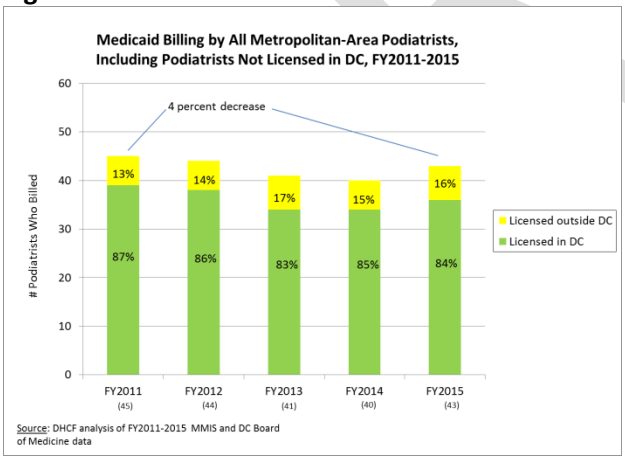
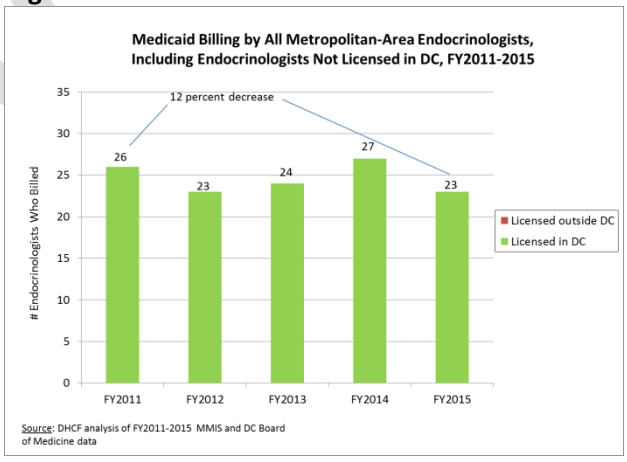


Figure 28



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 members responded with the following:

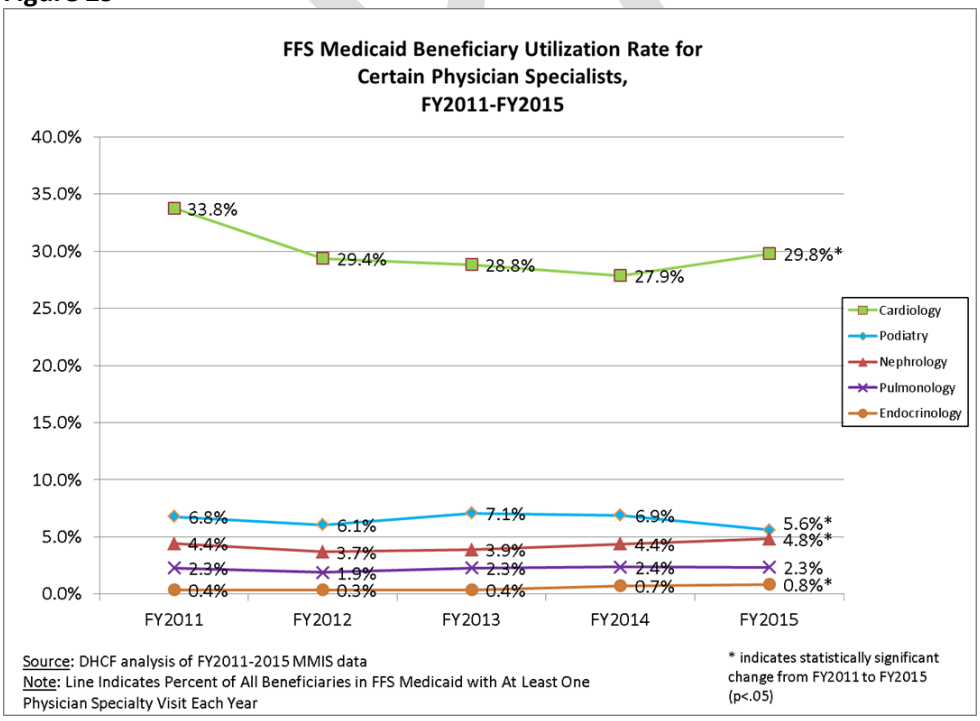
- "Accessing specialists continues to be a challenge for FFS Medicaid beneficiaries in the district. Typically, appointments for common issues that require a specialists such as colonoscopies can take 3-6 months. The issue is also present with endocrinology, psychiatry, and cardiology. To some extent, 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 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 FY2011 and FY2015, 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 FY2011 to FY2015, of the 1,143 complaints received by the Ombudsman about access to care, two were about access to dermatologists and one was about 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

[Placeholder]

C. Behavioral health

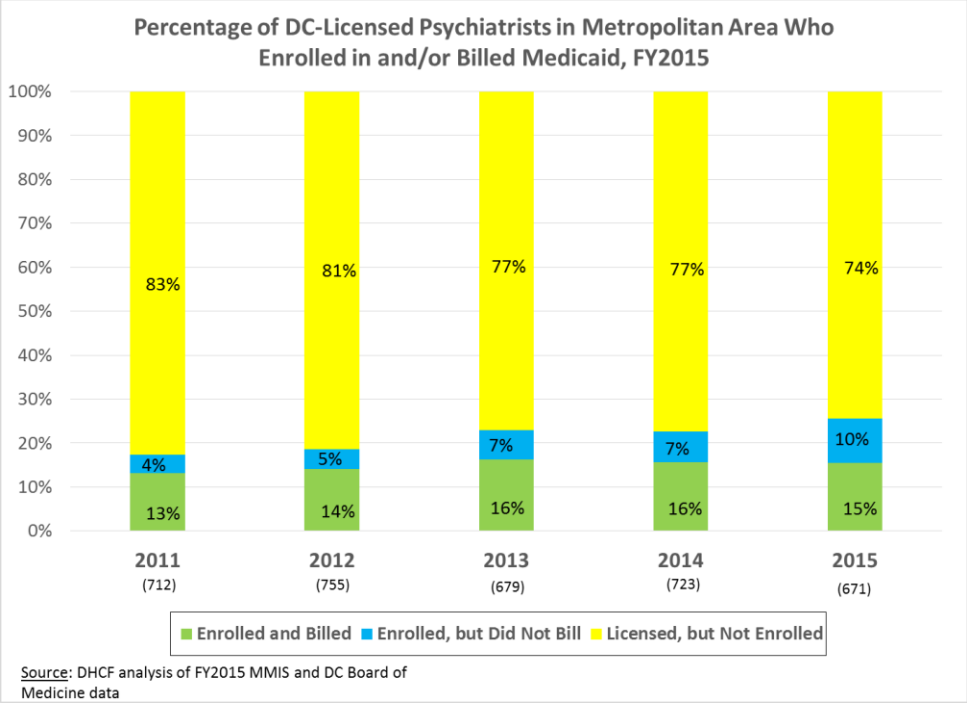
Access to behavioral health providers in the FFS program generally appeared stable over the five-year study period, and appears to have increased somewhat for psychiatrists. The percentage of DC-licensed psychiatrists billing Medicaid for a behavioral health service remained stable between FY2011 and FY2015. The total number of billing DC Metropolitan Area providers, including the numbers of psychiatrists and other behavioral health providers, increased. (Notably, this analysis did not include FQHCs, some of which provide behavioral health services, but could not be identified as such due to limitations in claims data.) 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. 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 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).

Behavioral Health Provider Participation and Experience

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

From FY2011 to FY2015, 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 FY2011, 17 percent of these psychiatrists were enrolled in Medicaid, and 13 percent billed for at least one psychiatric service for a Medicaid beneficiary. In FY2015, 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

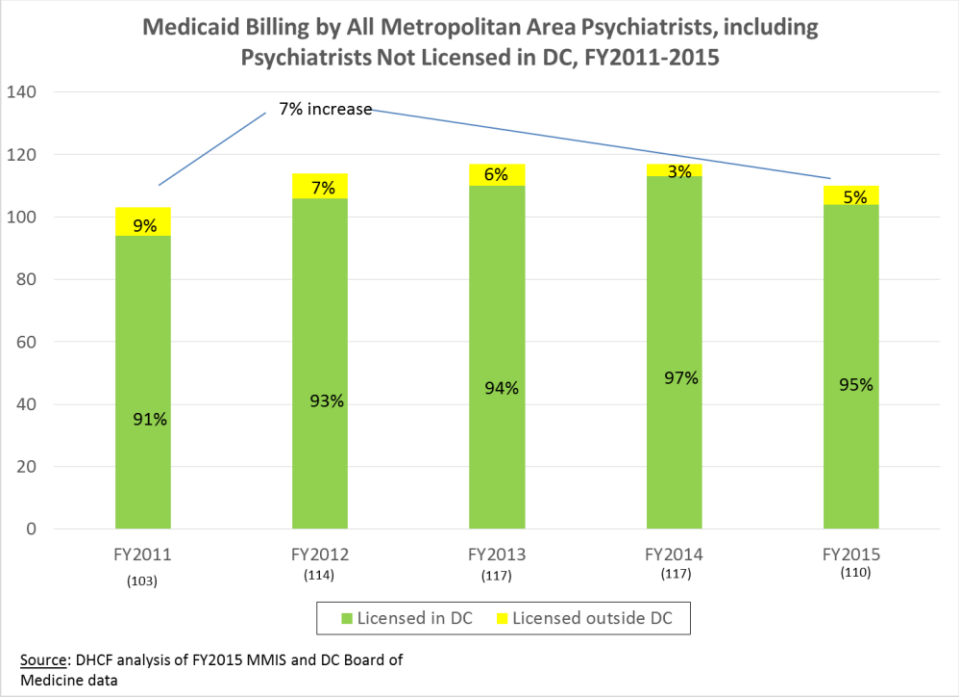


Source: DHCF analysis of FY2015 MMIS and DC Board of Medicine data

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

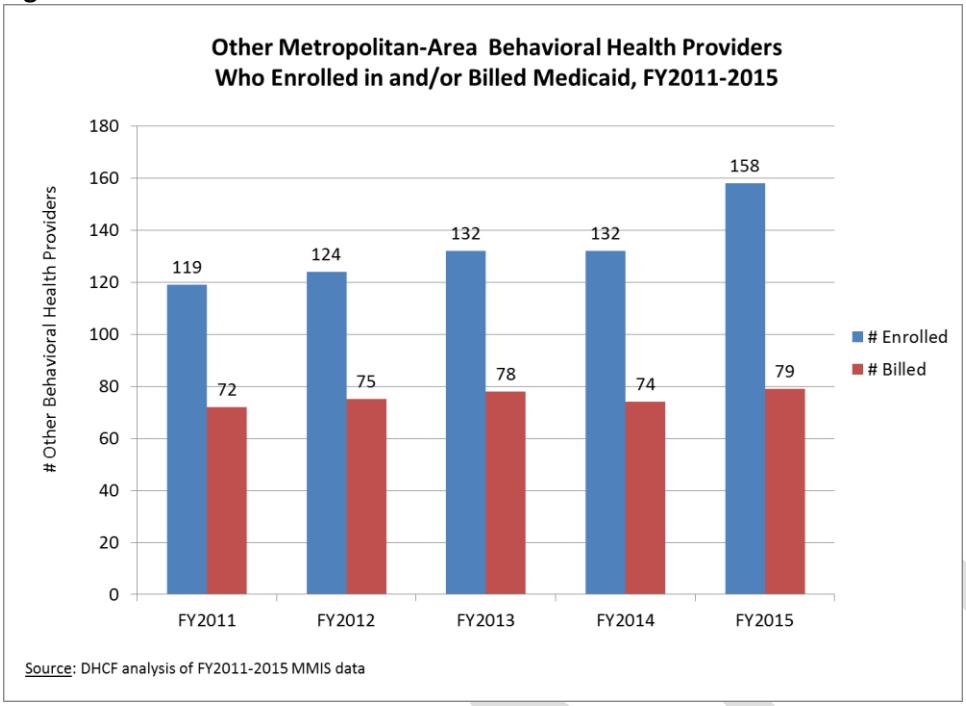
Between FY2011 and FY2015, total billing by psychiatrists and other behavioral health providers based in the DC-metropolitan area increased. (See Figure 31.) The total number of metropolitan-area psychiatrists billing Medicaid for at least one psychiatric service every year increased from 103 in FY2011 to 110 in FY2015, an increase of 7 percent. Providers licensed outside of DC played a relatively smaller role in FY2015 (5 percent) than FY2011 (9 percent).

Figure 31



Similarly, the total number of other behavioral health providers (various types of behavioral health providers providing services under Medicaid behavioral health benefits, including MHRS, FSMHCs, and ASARS also increased, beginning at 119 in FY2011 and rising to 158 in FY2015, 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, but could not be identified as such due to limitations in claims data.) 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 has had in effect for community service agencies (CSAs), the providers that are certified to provide most behavioral health services covered under Medicaid. Although the moratorium has been lifted briefly for limited enrollment during the study period, DHCF heard from behavioral health providers 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.

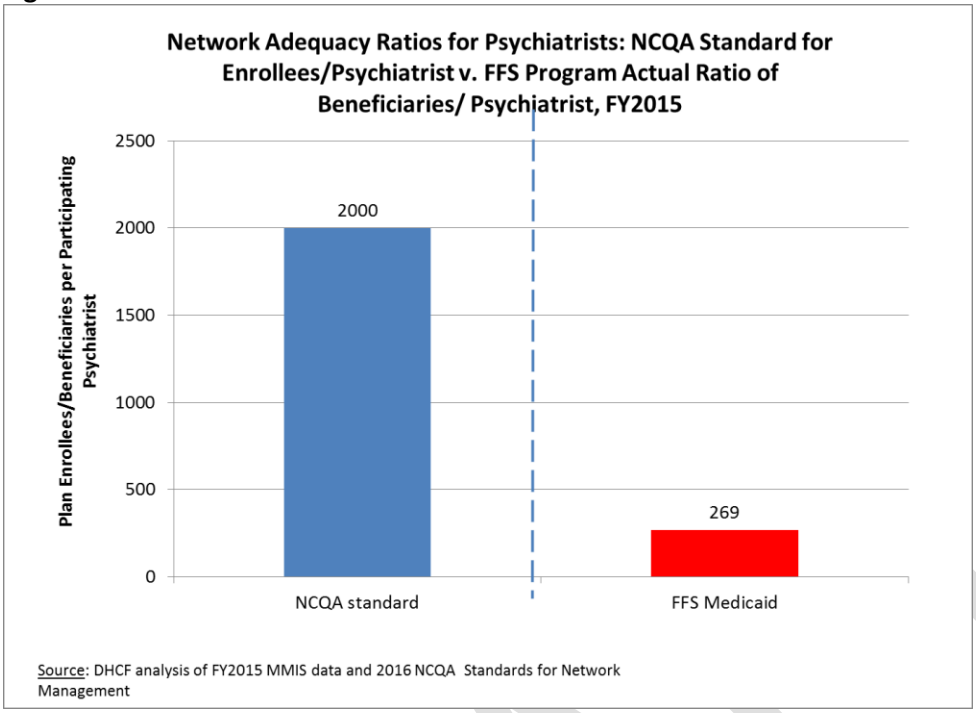
Figure 32



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, it's important to note that Medicaid FFS beneficiary needs may be disproportionately higher than the general population, due to the greater incidence of diagnoses of mental illness in the population. Therefore, it is likely appropriate that Medicaid ratios would be significantly higher than the recommended NCQA standard.

Figure 33



Source: DHCF analysis of FY2015 MMIS data and 2016 NCQA Standards for Network Management

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.

Providers also expressed concerns during a series of site visits with free-standing mental health clinic benefit 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. Providers expressed concern that reimbursement mechanisms and associated administrative burdens were not conducive to serving beneficiaries where they are; they need to fit beneficiary needs into the payment infrastructure instead of the payment infrastructure reflecting beneficiary needs. For instance, in general, MHRS services are designed to meet intensive mental health needs while FSMHC services are designed for beneficiaries with a lower acuity. Most mental health services providers in the District are only certified as one or the other, so beneficiaries must switch providers when their level of acuity changes.

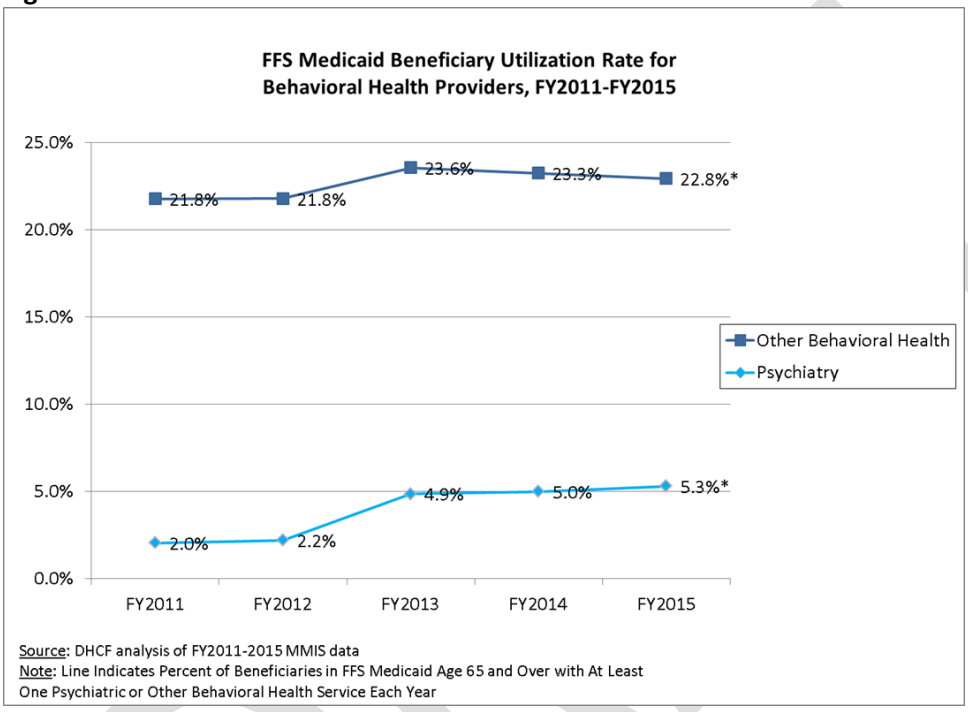
Beneficiary Utilization and Experience with Behavioral Health Services

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 FY2011, 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 limitations in claims data.) This increase was also statistically significant.

Figure 34

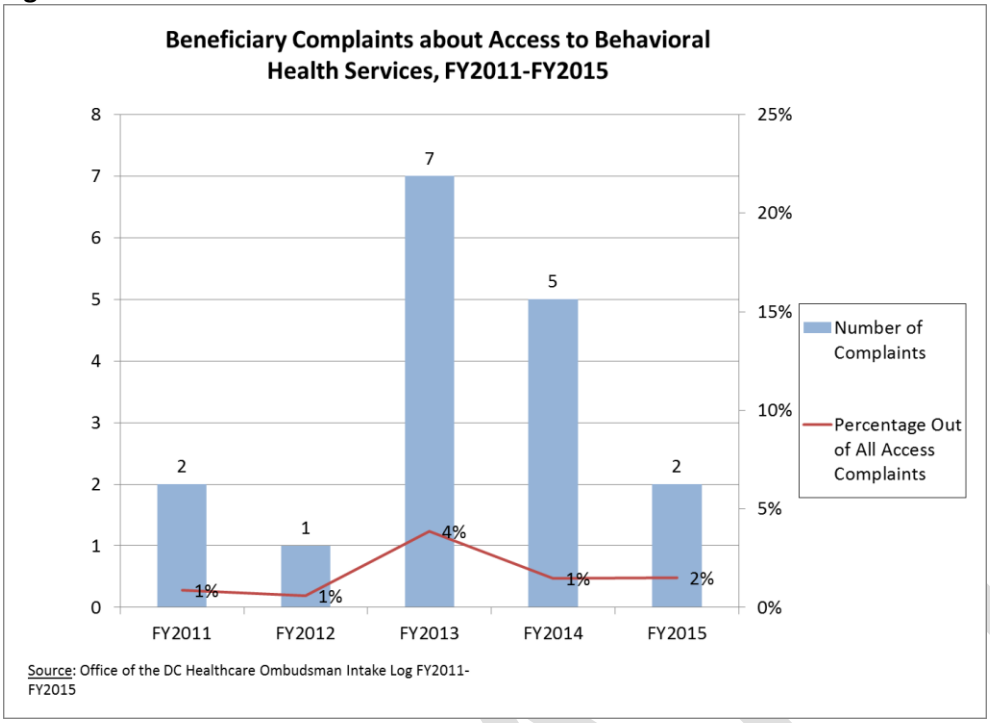


Source: DHCF analysis of FY2011-2015 MMIS data
Note: Line Indicates Percent of Beneficiaries in FFS Medicaid Age 65 and Over with At Least One Psychiatric or Other Behavioral Health Service Each Year

Relatively Few Beneficiary Complaints about Access to Behavioral Health Services

The Ombudsman received relatively few complaints about access to behavioral health services between FY2011 and FY2015. (See Figure 35.) The number of complaints began at 2 in FY2011, rose to 7 in FY2013, and fell to 2 in FY2015. 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



Source: Office of the DC Healthcare Ombudsman Intake Log FY2011-FY2015

Conclusions about Access to Behavioral Health Services

[Placeholder]

D. Home Health

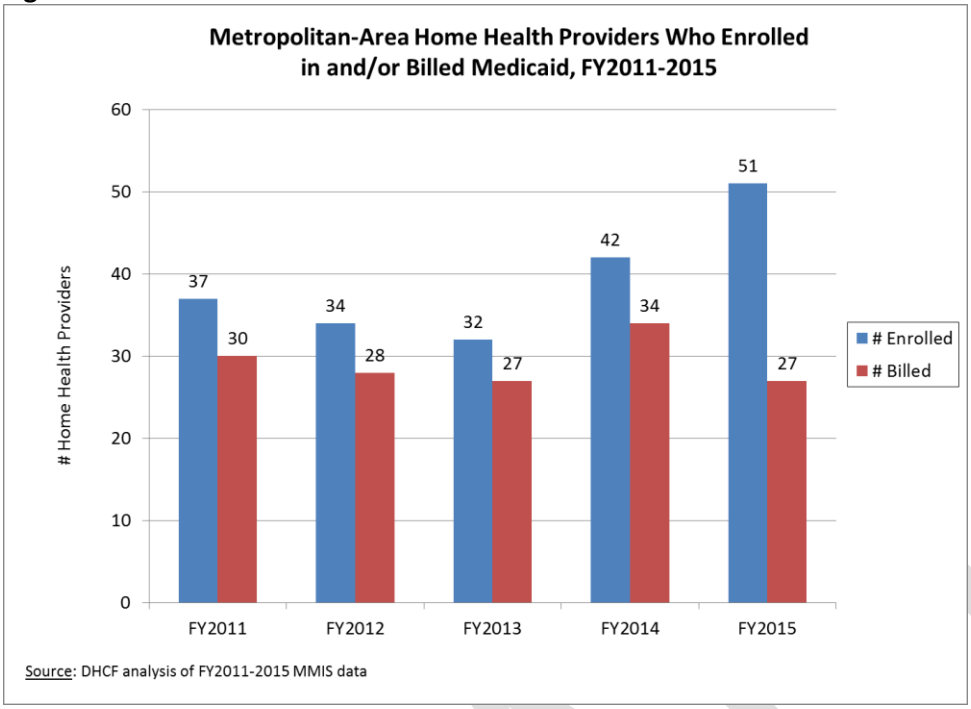
Results from both provider and beneficiary-related access measures suggest that access to certain home health services—specifically, skilled nursing and PCA services—decreased, although in fact, these results reflect a right sizing of services due to fraud—not insufficient provision of care to beneficiaries. In February, 2014, based upon referrals initially made by DHCF, the FBI raided and shuttered four large staffing agencies that were contracting with licensed home care agencies. DHCF reached out to all the approximately 4,000 beneficiaries served by these agencies, assigned them to other 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. These actions had the effect of reducing utilization of personal care aide (PCA) 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.

Home Health Services Provider Participation and Experience

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

Between FY2011 and FY2015, the number of home health providers billing Medicaid for PCA and/or skilled nursing services each year fluctuated, but was smaller in FY2015 than FY2011. (See Figure 36.) Specifically, 30 home health providers billed Medicaid for PCA and/or skilled nursing services in FY2011 out of 37 enrolled, while in FY2015, 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

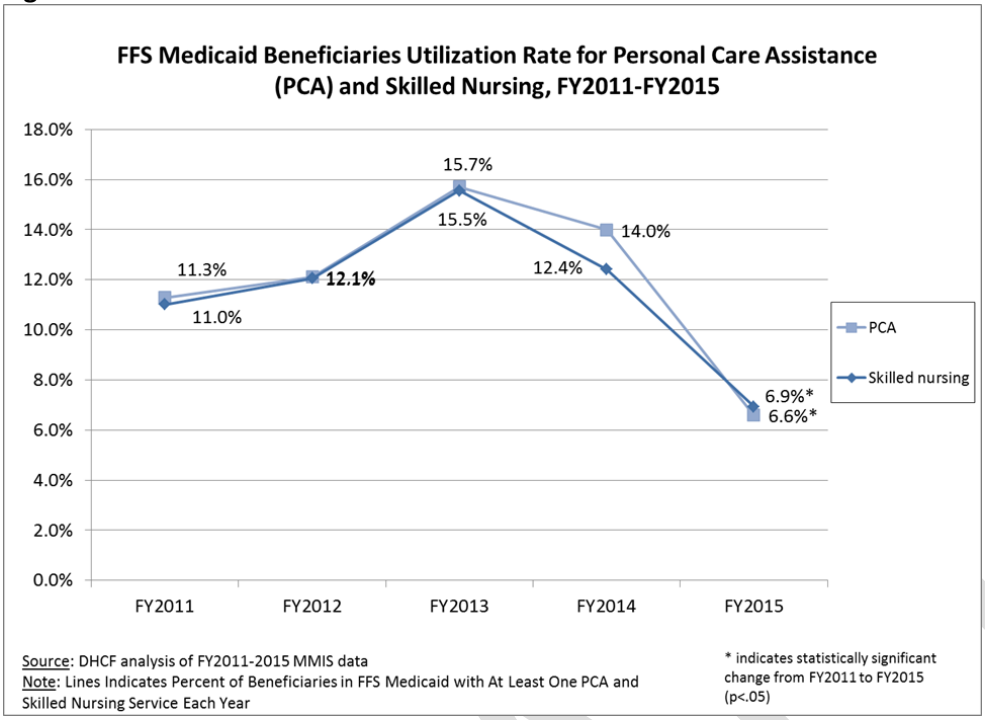


Beneficiary Utilization and Experience with Home Health Services

Utilization of Home Health Services Has Decreased Over Time

Between FY2011 and FY2015, the percentage of Medicaid beneficiaries who received either PCA or skilled nursing home health services decreased. (See Figure 37.) In FY2011, 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 FY2015. 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.

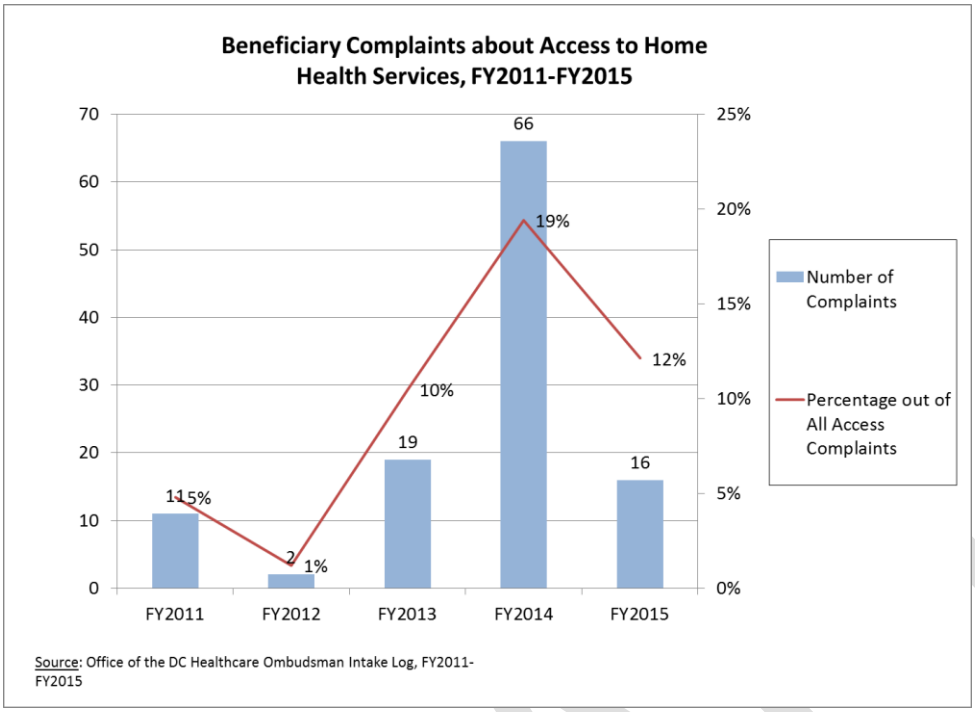
Figure 37



Beneficiary Complaints to Ombudsman Spiked in FY2014

From FY2011 to FY2015, the number 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

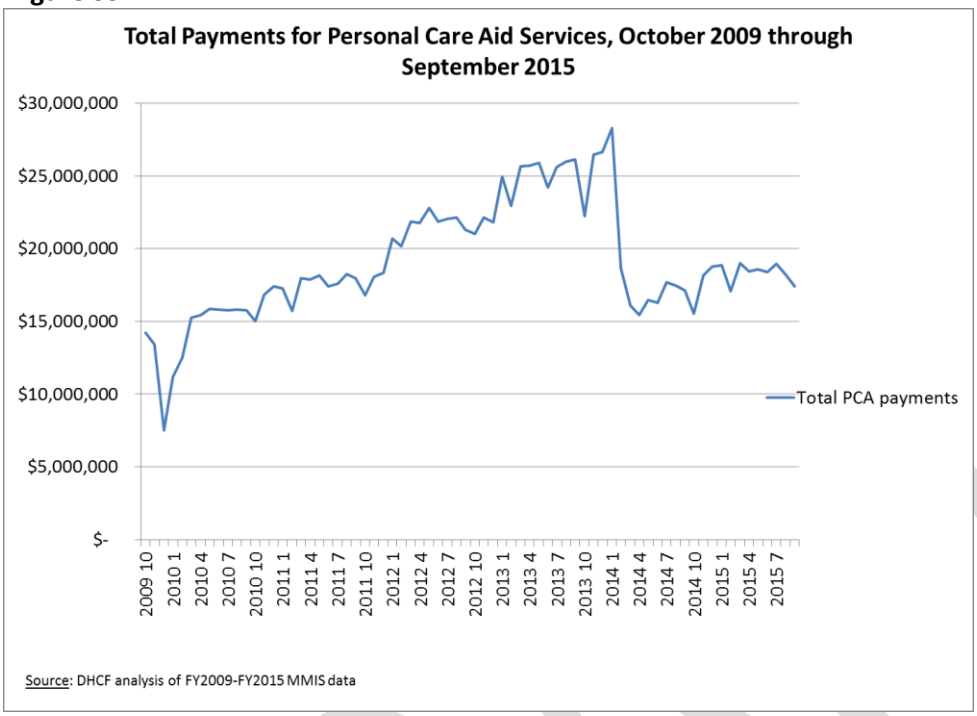
In assessing the District's experience with access to PCA and skilled nursing services, it is important to understand recent history with provider and beneficiary fraud and its' impact on provider participation and beneficiary utilization. Beginning in 2009, DHCF referred a number of cases to law enforcement 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 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. DHCF also instituted new edits in claims processing to help identify aides who were billing multiple agencies for excessive hours.

Together, the law enforcement actions and policy changes had the effect of reducing utilization of personal care aide (PCA) services. 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

Placeholder

E. Pre- and Post-Natal Obstetrics

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 FY2011 and FY2015 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 obtained NCQA network adequacy standards for OB/GYNs, and 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. The Ombudsman received no beneficiary complaints about pre- or post-natal obstetrics services. Notably, the number of FFS beneficiaries of child bearing age (ages 15 to 44) was approximately 5,200 throughout the study period. This group accounted for only ten percent of the total study group, the majority of whom were aged, blind or disabled. By comparison, a total of 53,260 women of child-bearing age were enrolled in a managed care organization at any point in FY 2015. For these reasons, the low utilization rate reported below does is not an area of concern at this time.

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 FY2015, 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 FY2011, the percentage of DC-licensed, metropolitan-area OB/GYNs who billed Medicaid was 24 percent, and by FY2015, the percentage had fallen slightly to 23 percent. (See Figure 40.) In FY2011, the percentage of DC-licensed, metropolitan-area neonatologists who billed Medicaid was 46 percent, and by FY2015, the percentage had fallen to 42 percent. (See Figure 41.) Neither of these changes were statistically significant.

Figure 40

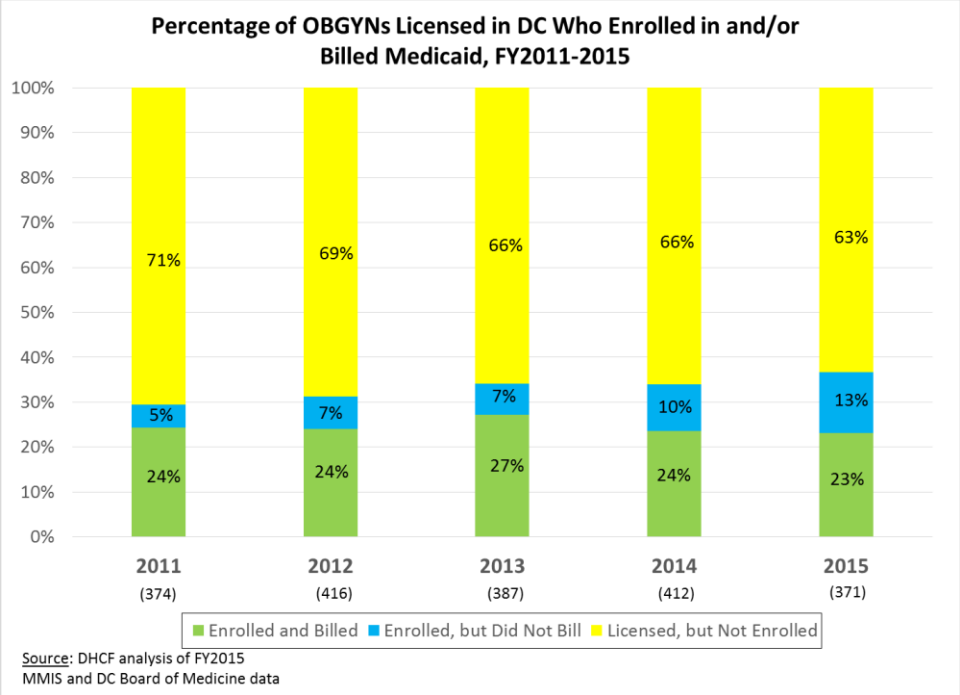
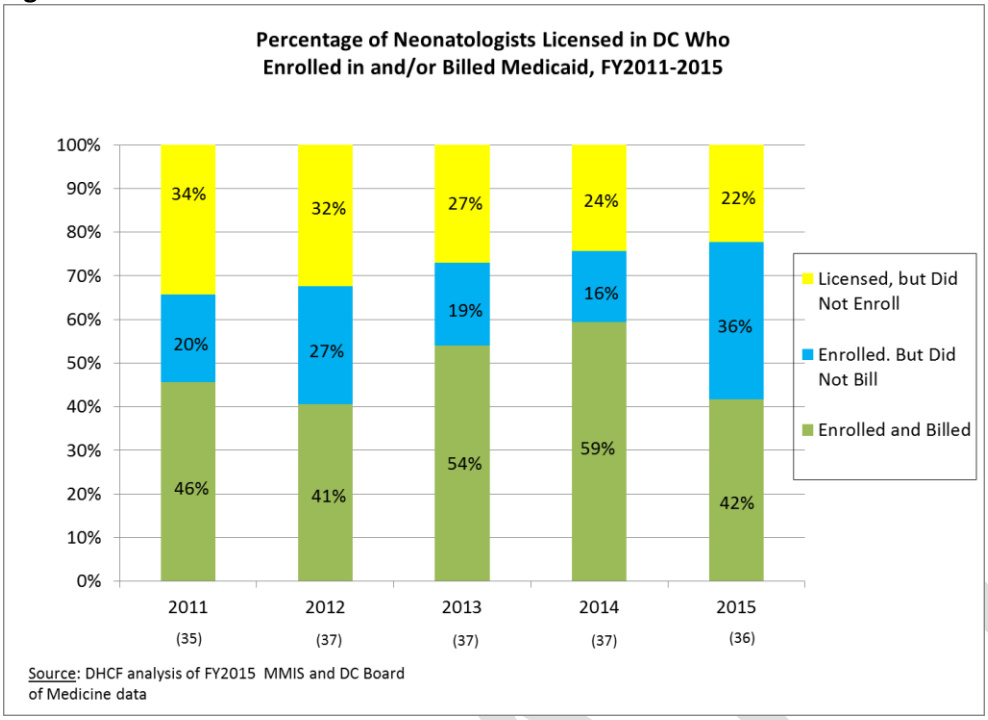
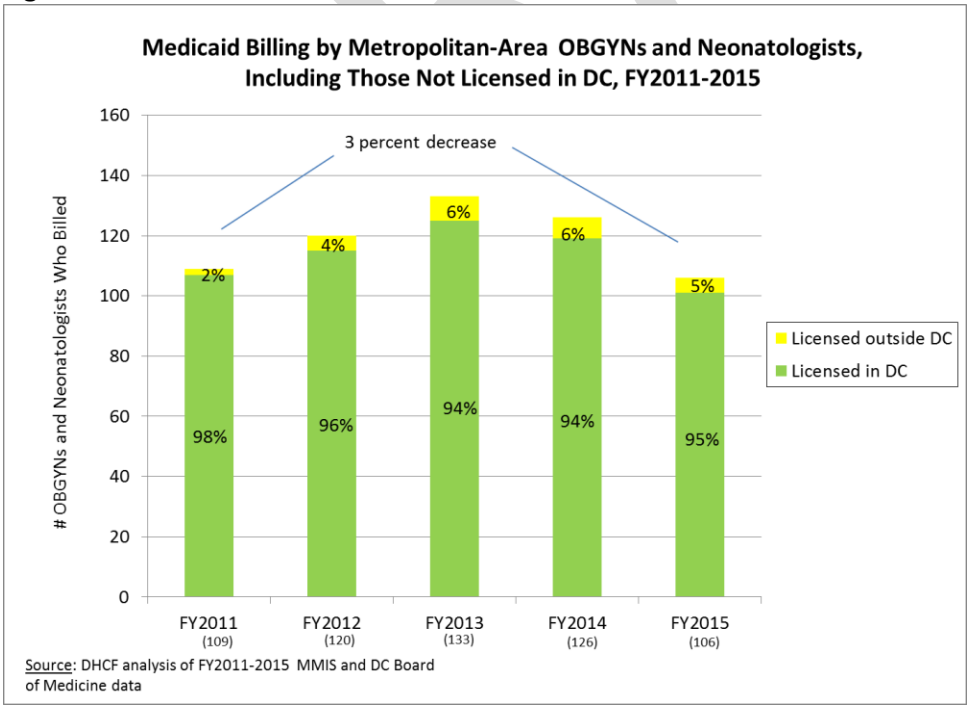


Figure 41



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

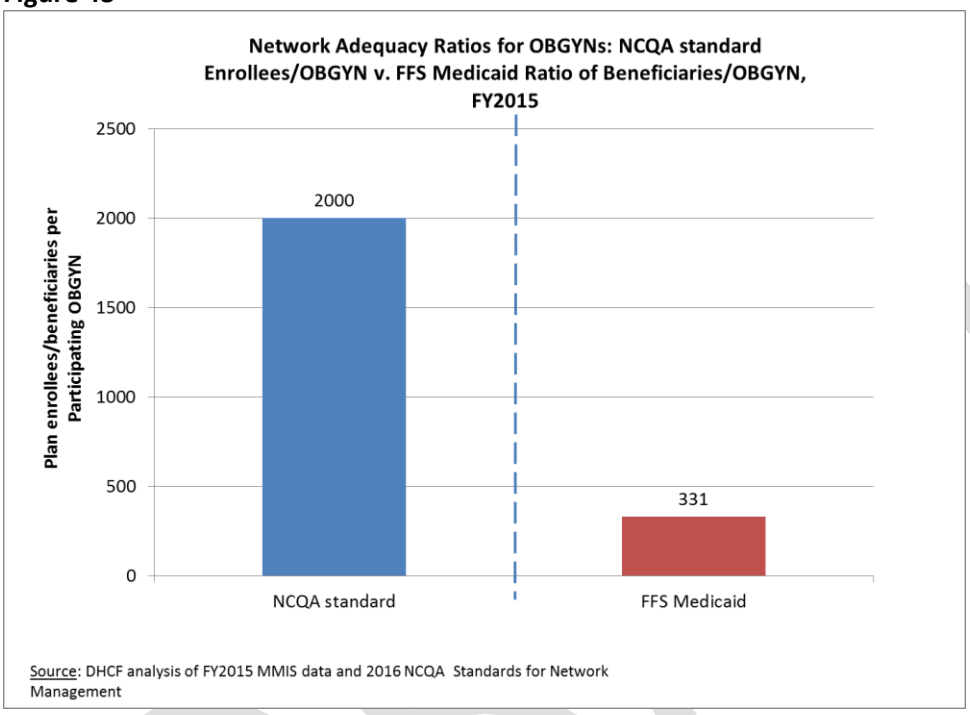
Figure 42



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.

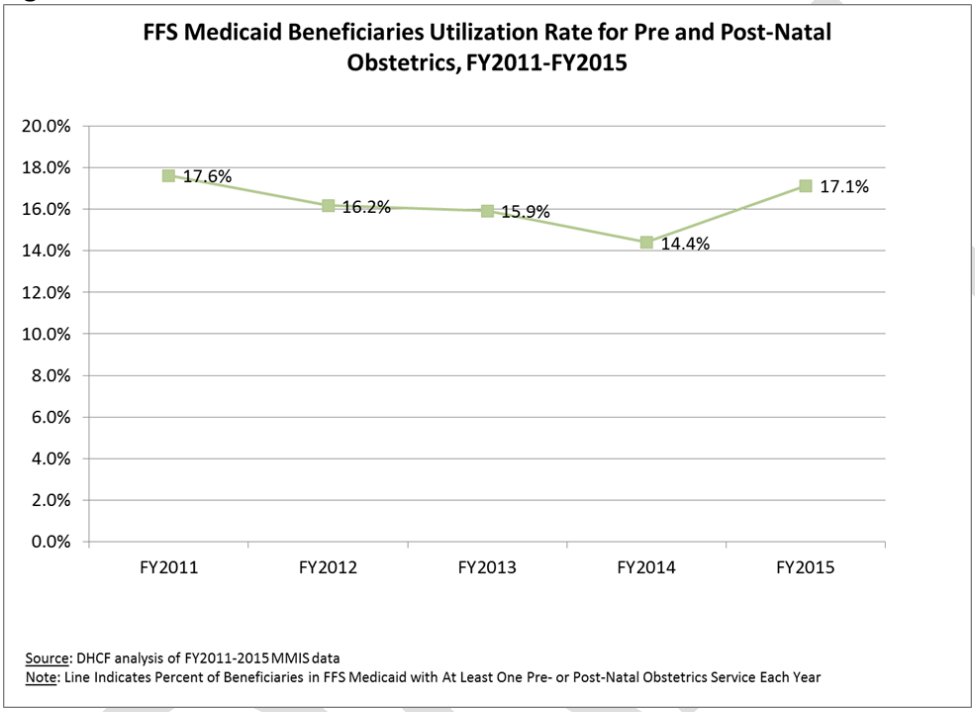
Beneficiary Utilization and Experience with Pre- and Post-Natal Obstetric Services

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 FY2011 and FY2015, utilization of pre- and post-natal obstetrics services by Medicaid beneficiaries held steady at approximately 17 percent. (See Figure 44.) In FY2011, 17.6 percent of women ages 15 to 44 obtained at least one such service, compared to 17.1 percent in FY2015. 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 FY2015, 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 FY2011 though FY2015.

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

[Placeholder]

F. Other Providers Selected due to Access Concerns

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 FY2011 and FY2015 remained steady. With respect to the total number of

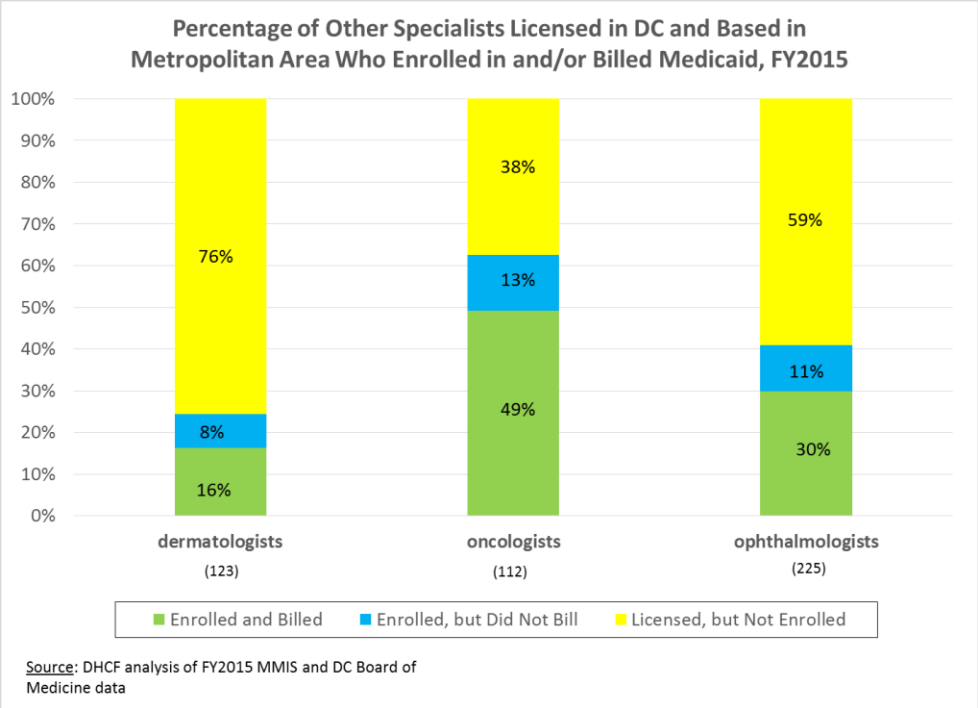
billing metropolitan-area providers, the numbers increased for all three specialty groups. Beneficiary utilization of oncology and ophthalmology increased, while utilization of dermatology did not change. Provider and beneficiary complaint information was limited and inconclusive.

Other Provider Participation and Experience

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

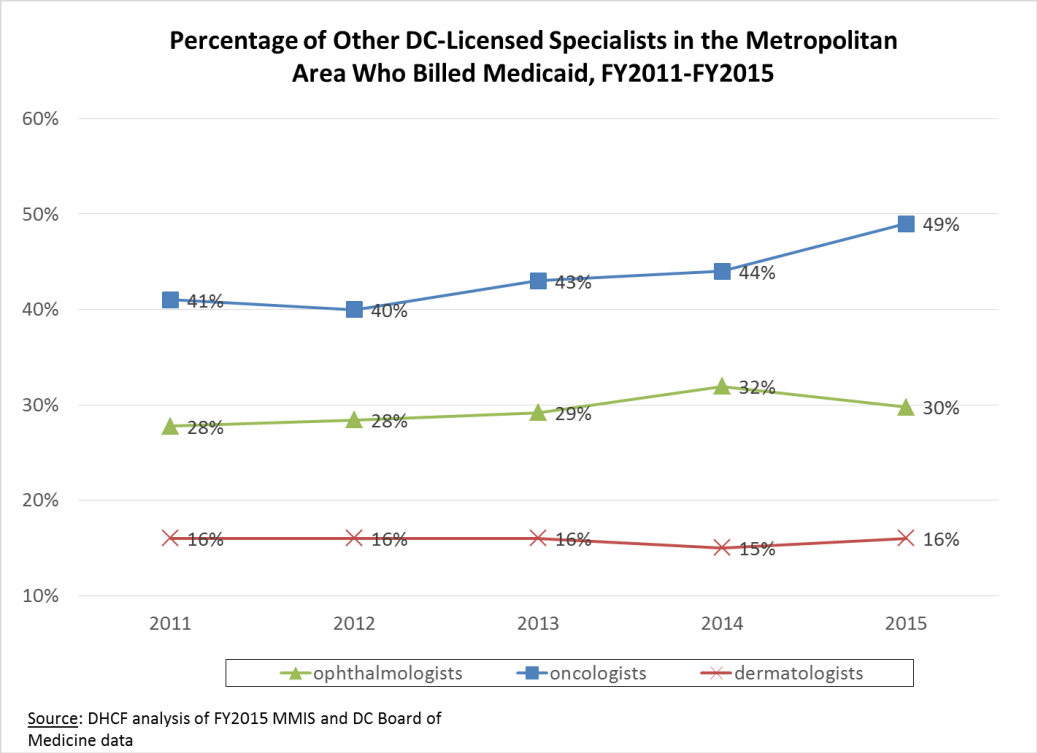
FY2015 Snapshot: The rate of participation varied among oncologists, dermatologists, and ophthalmologists licensed in DC and based in the metropolitan-area. (See Figure 45.) Oncologists had the highest rate of participation of the three specialties, with 62 percent of the 112 providers enrolled in Medicaid, 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 FY2011 and FY2015, 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 FY2011 to 49 percent in FY2015, an increase of 20%). (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 FY2011 and FY2015, 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

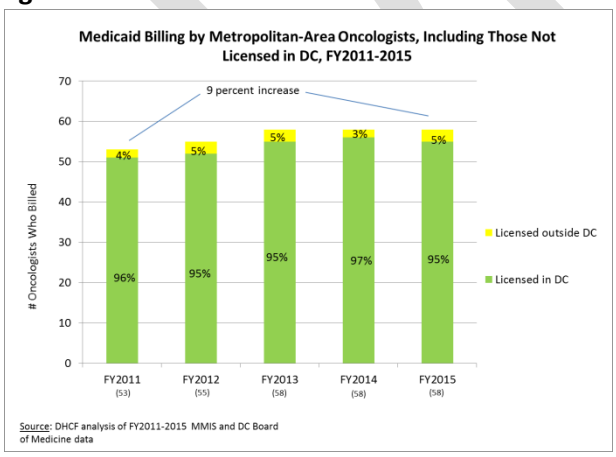


Figure 48

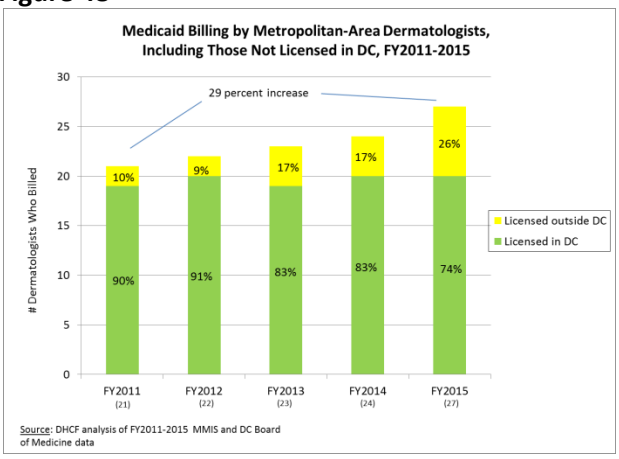
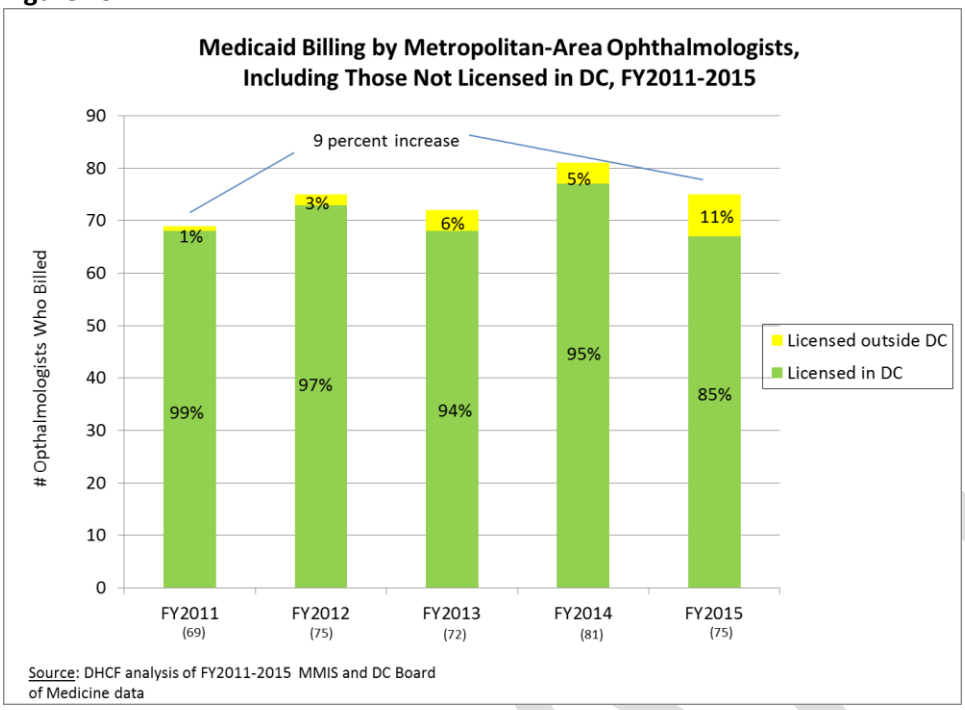


Figure 49



Provider Feedback on Access to Other Providers Has Been Limited and Mixed for Oncologists

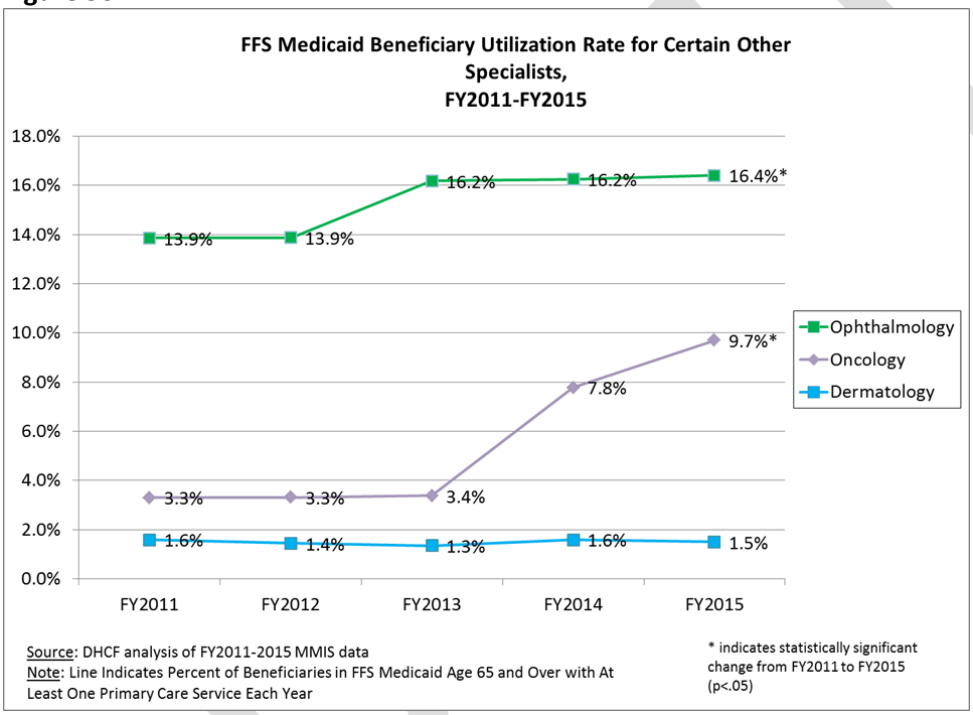
Providers have expressed concerns about beneficiary access to oncology services. Only one MCAC survey respondent commented on access to these three specialty groups. The respondent stated "…dermatology very difficult to find providers; lack of cancer treatment providers accepting Medicaid…." Also, the 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 disproportionally 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% to 100% 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, we plan to increase the number of clinicians . . . . to accommodate this influx of new patients. We are encouraged by our productive collaboration to best serve Medicaid patients in need of cancer care services and look forward to continuing our work together on behalf of DC residents."

Beneficiary Utilization and Experience with Other Providers

Utilization for 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, while the rates for dermatologists remained virtually unchanged. (See Figure 50.) Specifically, the rate for oncologists increased dramatically from 3.3 to 9.7 to percent in FY2015, a 293 percent increase. The rate for ophthalmologists rose from 13.9 percent to 16.4 percent, an 18.0 percent increase. The utilization rate for dermatologists fell from 1.6 percent in FY2011 to 1.5 percent in FY2015, a decrease of 6.4 percent. The trends for ophthalmology and oncology were statistically significant.

Figure 50



Information from Beneficiary Complaints was Inconclusive

Between FY2011 and FY2015, 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

[Placeholder]

VI. Conclusions and Next Steps

[Placeholder]