

ACCESS MONITORING REVIEW PLAN – 2016

Ohio

To be submitted September 2016

DRAFT

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Ohio Access Monitoring Review Plan Overview

- The Ohio Medicaid program provides healthcare coverage for low-income individuals, including children, pregnant women, individuals with disabilities, elderly, parents and other adults. The Ohio Department of Medicaid (ODM) is the single state agency that administers the Medicaid program within the state. In state fiscal year (SFY) 2015, the ODM provided coverage to approximately 2.9 million¹ enrolled beneficiaries with total expenditures of approximately \$23.4 billion².
- Ohio's total population is 11.6 million³. With 230 hospitals actively certified by Medicare/Medicaid in the state⁴, a large network of 39 active rural health clinics⁵ and 41 federally qualified health centers throughout the state, there are numerous options for Medicaid beneficiaries to receive healthcare.
- Ohio measures and monitors indicators of healthcare access to ensure that its Medicaid beneficiaries have access to care that is comparable to the general population.
- In accordance with 42 CFR 447.203, Ohio developed an access review monitoring plan for the following service categories provided under a fee-for-service (FFS) arrangement:
 - Primary care services, including dental care
 - Physician specialist services
 - Behavioral health services
 - Pre- and post-natal obstetric services, including labor and delivery
 - Home health services
- The plan describes data that will be used to measure access to care for beneficiaries in FFS. The plan considers: the availability of Medicaid providers, utilization of Medicaid services and the extent to which Medicaid beneficiaries' healthcare needs are fully met.
- The plan was developed during the months of January – May 2016. It was presented to the Medical Care Advisory Committee on June 16, 2016 and posted on the state

¹ <http://www.medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/ODM-Annual-Report-SFY15.pdf>

² <http://www.medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/ODM-Annual-Report-SFY15.pdf>

³ <http://www.census.gov/quickfacts/table/PST045215/39>

⁴ http://publicapps.odh.ohio.gov/eid/Search_Results.aspx

⁵ http://publicapps.odh.ohio.gov/eid/Search_Results.aspx

Medicaid agency's website from July 6, 2016 – August 5, 2016 to allow for public inspection and feedback.

- Analysis of the data and information contained in this report show that Ohio Medicaid beneficiaries have access to healthcare that is similar to that of the general population in Ohio.

Overview of Ohio Medicaid Population

Description of Medicaid Fee for Service (FFS) Population

In calendar year (CY) 2015, the Ohio Medicaid program provided point-in-time coverage to approximately 2.9 million enrolled beneficiaries. At any point in time, approximately 80% of these beneficiaries are enrolled in managed care. The 20% receiving care through FFS primarily include individuals with disabilities and the elderly, although there are a small number of non-elderly or disabled adults and children not enrolled in managed care. Although the FFS program had 20% of all beneficiary months in CY 2015, this is not indicative of the actual population that remains in FFS since most beneficiaries are in FFS for only a transitory period. Exhibit 1 shows that, during CY 2015, 19.6% of ever enrolled beneficiaries were enrolled continuously for nine to 12 months. However, when considering all beneficiaries enrolled in Ohio Medicaid at some point during CY 2015, these 19.6% of FFS months represent only 2.1% of the total Medicaid child FFS population (age 0-18) and only 6.6% of the total adult FFS Medicaid population.

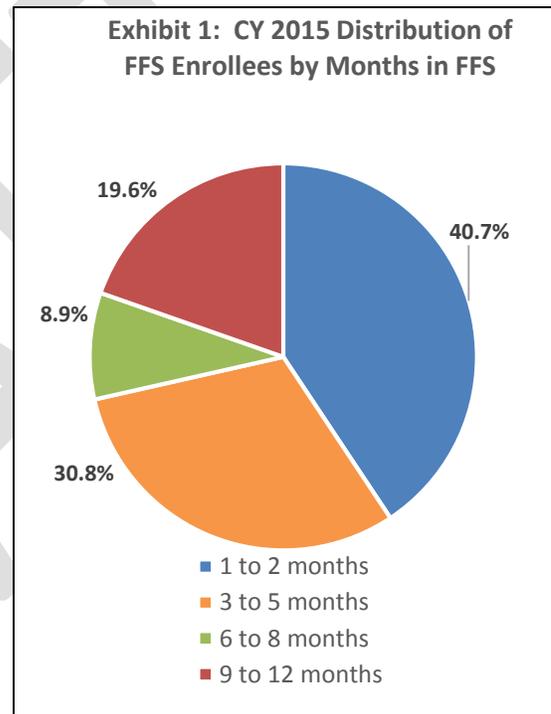


Exhibit 2 shows the SFY 2015 breakdown of FFS beneficiaries by aid category. Only 8% of enrolled beneficiaries have FFS as their delivery system.

Exhibit 2: State Fiscal Year 2015 Breakdown of Fee-For-Service Population

Population	Enrollees	% of Total Medicaid	Current Delivery System	% Transition to MCP
CFC/MAGI	161,901	5.5%	Managed Care	100.0%
Newly Eligible	130,471	4.4%	Managed Care	100.0%
MCR Premium Assistance	123,465	4.2%	FFS premiums, co-pays only	0.0%
Duals	119,249	4.0%	FFS	0.0%
Family Planning	50,004	1.7%	FFS	0.0%
ABD Adults	37,940	1.3%	FFS	0.0%
Presumptive, Alien, Refugee,	27,113	0.9%	FFS	0.0%
ABD Children	2,196	0.1%	FFS	0.0%
Total FFS Population				652,339
Actual FFS Population (less those going to managed care and MCR Premium Assistance)				236,502
SFY 2015 Average Medicaid Enrollment				2,963,816
Actual FFS as Percent of SFY 2015 Average Medicaid Enrollment				8.0%

The percent of enrolled beneficiaries in the FFS by delivery system continues to decline. When examining point-in-time member months, the percent of enrollees in FFS has declined from 29.4% in SFY 2013 to 20.6% in SFY 2015. Preliminary FFS enrollment for SFY 2016 is running at about 19.4%. The current full risk managed care program (MCP) has been in place in Ohio since 2005, although Ohio has had some form of managed care since the early 1990's. The MyCare program began in 2014 as the managed care program for Medicare/Medicaid dual eligibles.

Enrollment Maps

Exhibit 3 shows the Ohio Medicaid enrolled population density for CY 2014, including dually eligible Medicare/Medicaid beneficiaries, with total enrollment (FFS, MCP and MyCare). Exhibit 4 on the following page shows the same information but for the FFS enrollment exclusively.

Exhibit 3: Total CY 2014 Ohio Medicaid Enrollment in Thousands – Dual Eligibles Included

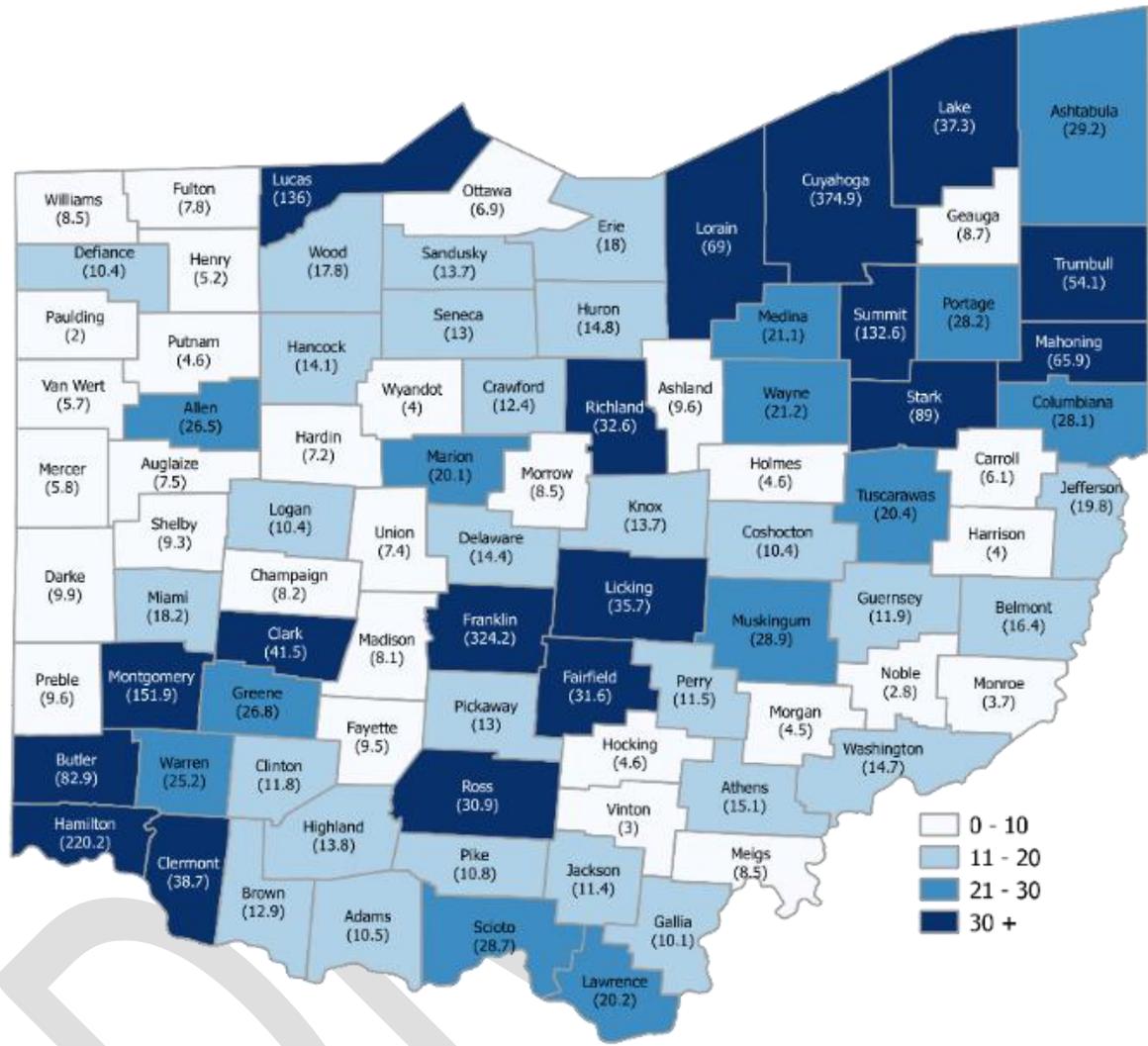
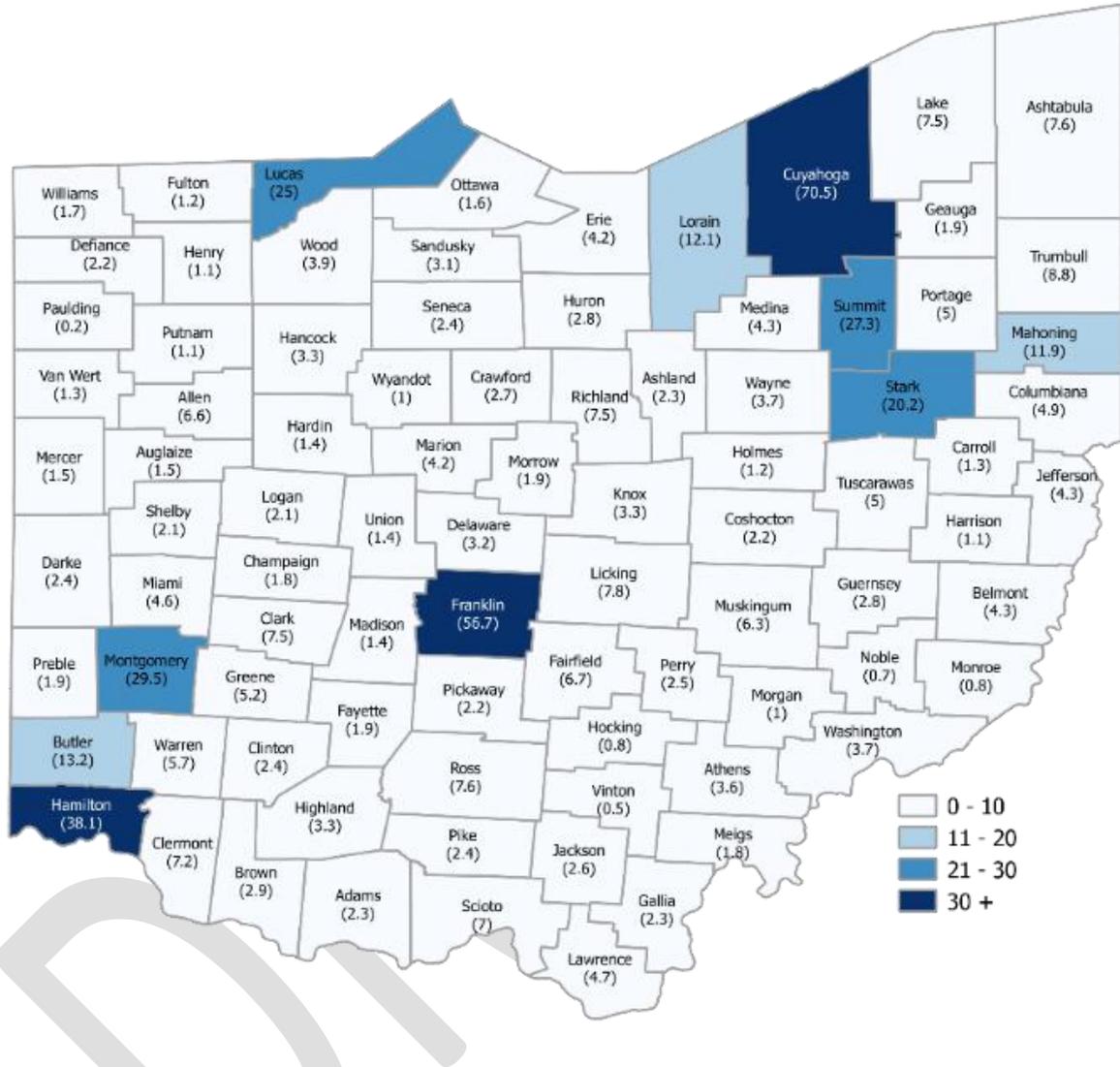


Exhibit 4: FFS CY 2014 Ohio Medicaid Enrollment in Thousands – Dual Eligibles Included



Similar to Exhibits 3 and 4 on the previous pages, Exhibits 5 and 6 show Ohio Medicaid enrolled population density for the total population and the FFS population only, but each exhibit excludes the dual eligible population. Since these individuals receive medical care through Medicare, they were removed from several categories of analysis as Medicaid is not the primary source of care.

Exhibit 5: Total CY 2014 Ohio Medicaid Enrollment in Thousands – Dual Eligibles Excluded

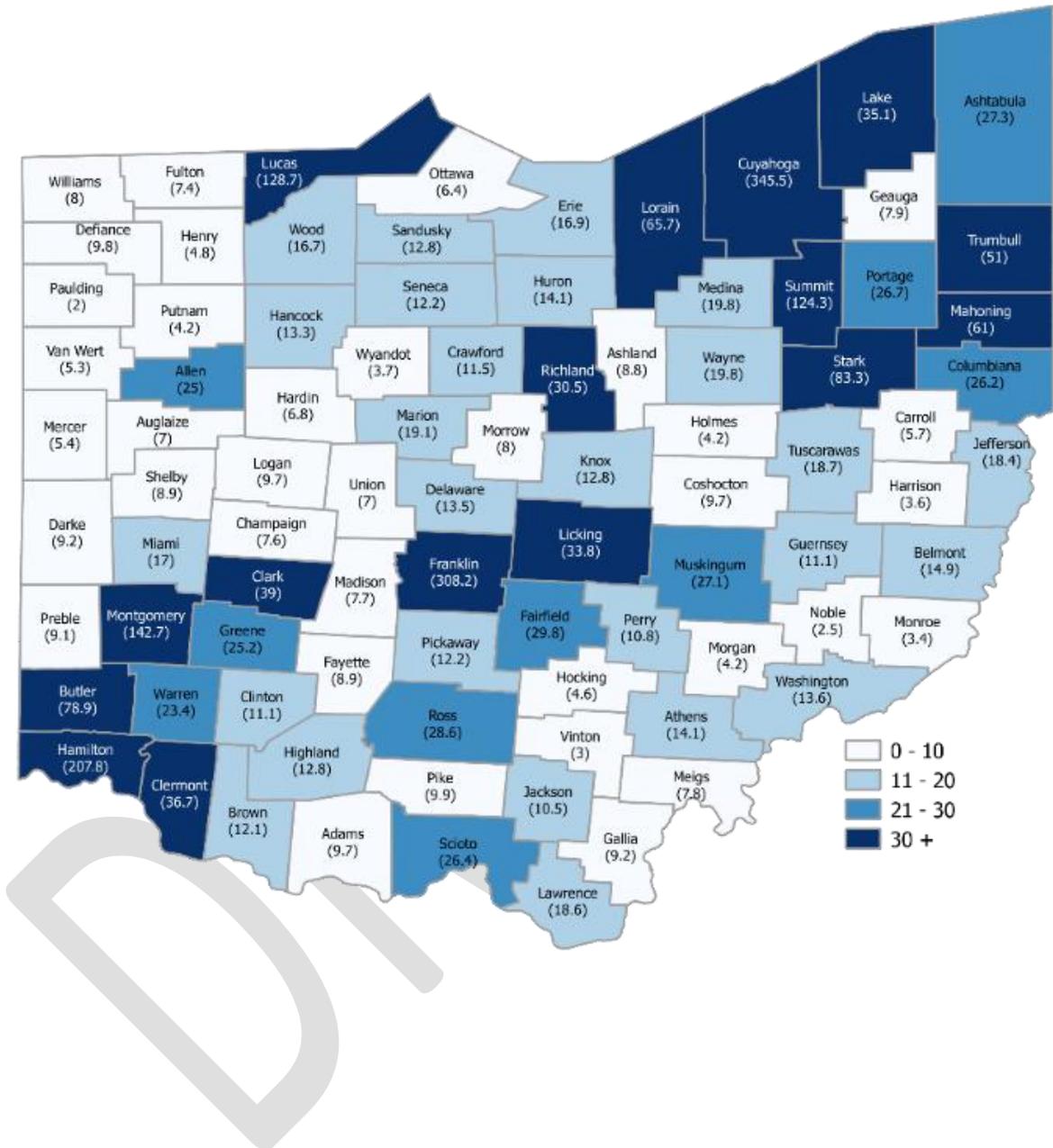
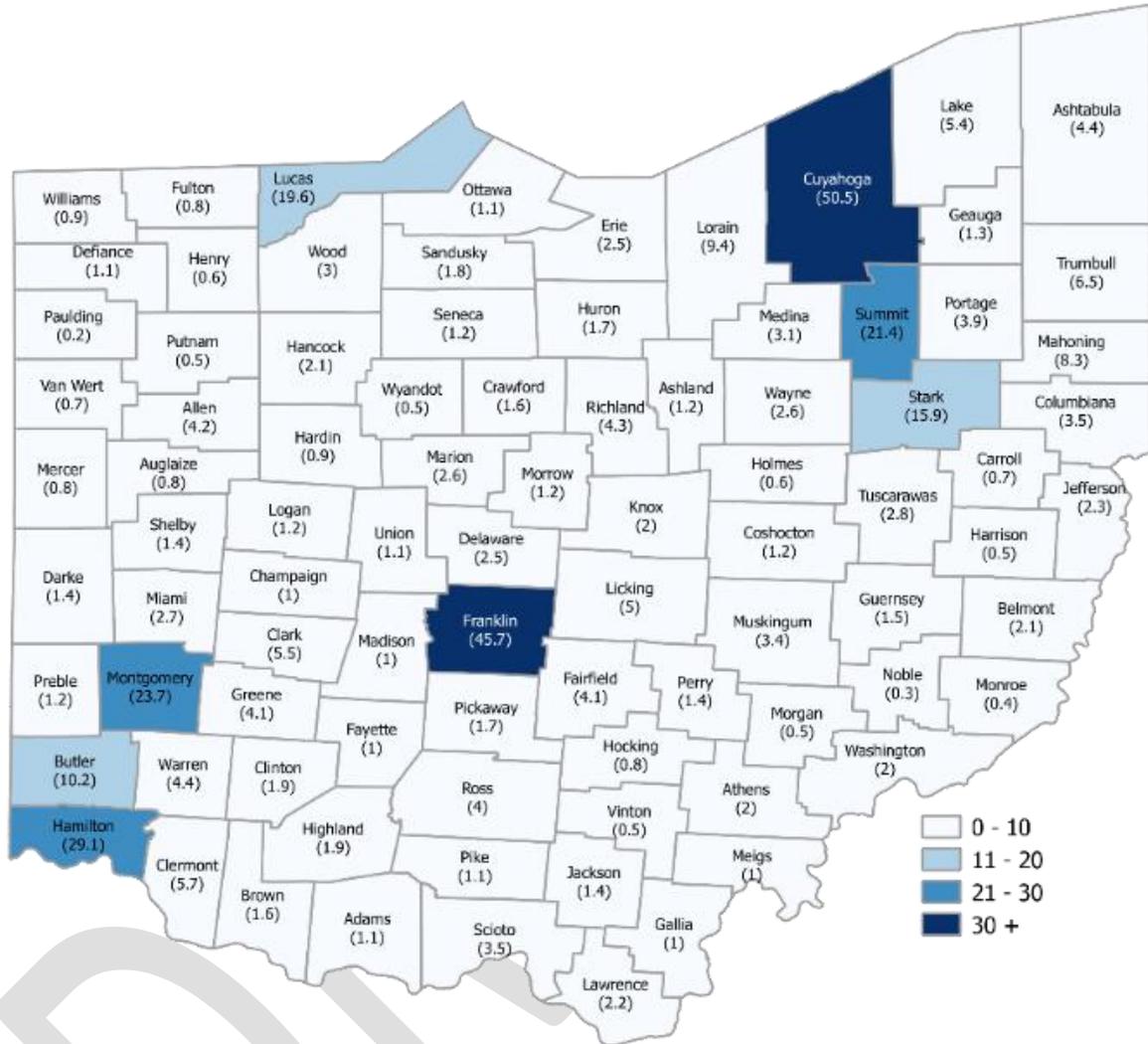


Exhibit 6: FFS CY 2014 Ohio Medicaid Enrollment in Thousands – Dual Eligibles Excluded



Ohio made a number of significant changes in Medicaid eligibility since January 1, 2014, which included:

- The method under which eligibility is determined when based on income by applying a new Modified Adjusted Gross Income (MAGI) budgeting methodology for children, pregnant women and parent/caretaker relatives;
- Extending eligibility to certain individuals with income at or below 138 percent of the federal poverty level (FPL) using MAGI budgeting;
- Presumptive eligibility for certain individuals with income at or below 138 percent FPL as well as former foster care adults and parent /caretaker relatives;
- Extending the eligibility age for former foster care adults to age 26;

- Establishing hospitals and the department of youth services (DYS) as qualified entities for presumptive eligibility; and
- Removing the five-year bar for children and pregnant women with qualified non-citizen status.

The most significant enrollment impact occurred among adults whose income is at or below 138 percent FPL. For many of these individuals, their enrollment into Medicaid was set retroactively due to challenges with the federal hub. This created a larger than usual denominator of individuals in FFS in CY 2014 as they had no ability to enroll in managed care during the retroactive period. Consequently, the larger denominator for CY 2014 impacted data used in the access to care analyses throughout this report. Enrollment monitoring reports indicate a more predictable and stable pattern of retroactive eligibility for CY 2015. Where this creates an aberrant pattern for the components of the access analysis, it will be noted in the report.

In addition to the Medicaid eligibility changes, ODM's SFY 2016 / 2017 biennial budget invests in moving additional populations into managed care so that they may benefit from access to better care coordination on day one of enrollment. Beginning January 1, 2017, Ohio will provide the option for approximately 40,000 individuals with intellectual disabilities to enroll in managed care and will also shift approximately 28,000 adopted and foster children into managed care.

In addition to the enrollment changes, the biennial budget requires ODM to direct its managed care plans to use community health workers who live in the most high-risk neighborhoods to assist with the outreach and identification of women, especially pregnant women, to make sure they are connected to ideal health care and other community supports.

Statewide Measures of Access

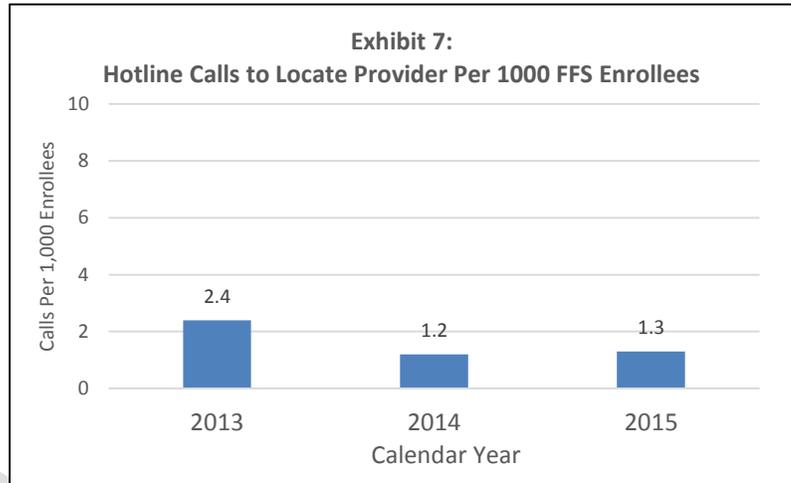
Access Concerns Raised by Beneficiaries

Ohio operates a beneficiary call center as a service to beneficiaries and as a way to engage beneficiaries and assist them with their needs. Each beneficiary's Medicaid card includes the toll-free number for the call center along with information about how to seek assistance if they have difficulty finding a provider or scheduling an appointment. The call center operates daily from Monday through Friday, 7am to 8 pm, and Saturday, 8 am to 5 pm, and utilizes a messaging service after hours. Calls into the call center are logged detailing the issues raised and the resolution. On a bi-weekly basis, a report is produced detailing the number of calls, the issues raised and the resolution of the issue, including the timeliness.

The majority of calls in which the beneficiary requests assistance with locating a provider are resolved immediately by call center staff. These calls are tracked and repeat callers seeking assistance in locating the same type of provider are flagged as this might indicate a potential access issue.

Exhibit 7 shows the number of hotline calls per 1,000 FFS enrollees from CY 2013 through CY 2015 that are specifically related to access questions.

Ohio has experienced a decrease in the number of calls per 1,000 enrollees to the consumer hotline to locate a provider from 2013 through 2015. This is in spite of the fact that Ohio experienced a significant increase in the number of enrollees in CY 2014 in particular.



Beneficiary Perceptions of Access to Care

Consumer Assessment of Healthcare Providers and Systems

Ohio collects and analyzes the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for those served by managed care population. Comparable data is not available for the FFS population, but ODM believes the results are indicative of what the FFS population experiences. Since the data is retrospective, it may not demonstrate current access, but it is an indicator of whether or not beneficiaries are able to access medical services when they are needed. For this report, Ohio is using SFY 2014 CAHPS survey data and specifically looked at access to primary care and specialists.

As shown in Exhibits 8 and 9 on the next page, over 80% of Ohio beneficiaries are satisfied that they are able to access needed care. Ohio Medicaid beneficiary satisfaction scores were at or above national average scores in 2014.

Additional CAHPS results appear in Appendix A (Overview of the Medicaid Program).

Exhibit 8: CAHPS Survey Results SFY 2013-2015, Adults

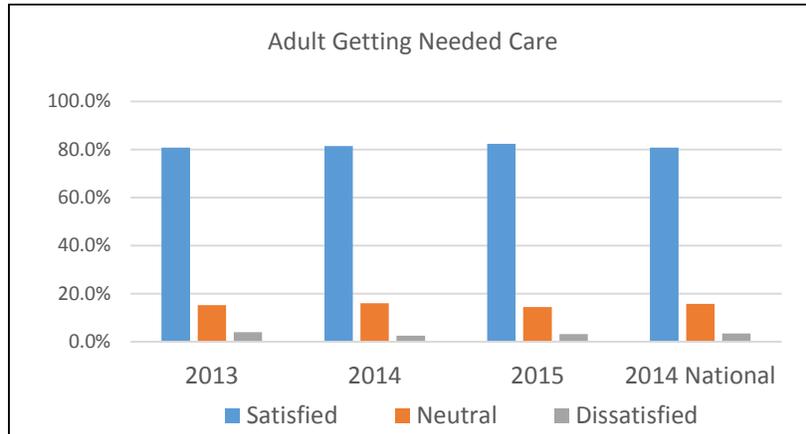
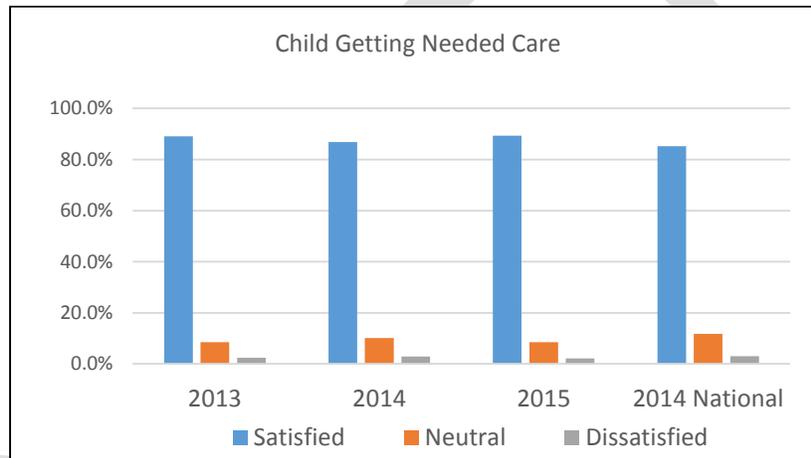


Exhibit 9: CAHPS –Survey Results SFY 2013-2015, Children



Ohio Medicaid Assessment Survey

The Ohio Medicaid Assessment Survey (OMAS) is a telephone survey that samples both landline and cell phones in Ohio. The survey examines access to the health system, health status, and health determinant characteristics of Ohio’s Medicaid, Medicaid eligible, and non-Medicaid populations. OMAS is an important tool to help the ODM and state agencies identify gaps in needed health services, develop strategies to increase service capacity, and monitor Ohioans’ health status and health risk.

Results from the 2015 OMAS show that 91% of adults and 96% of parents of children indicate they have a usual source of care as seen in Exhibits 10 and 11 on the next page.

Exhibit 10: OMAS Response Rate – Usual Source of Care – Adult

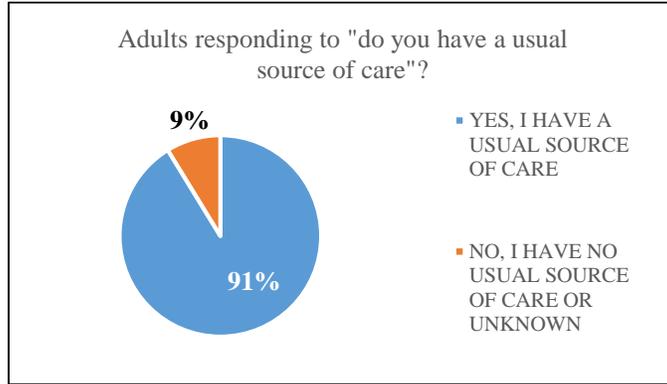
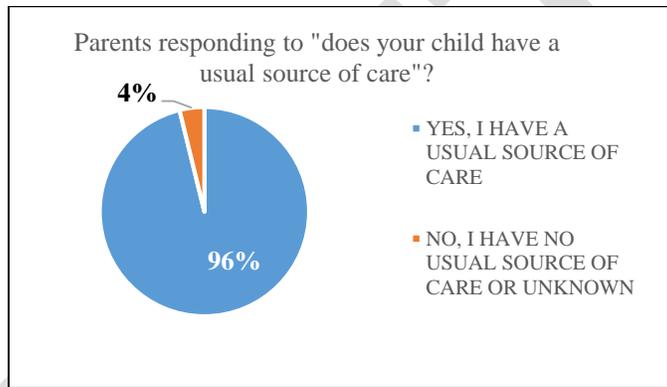


Exhibit 11: OMAS Response Rate – Usual Source of Care – Child



When asked about their ability to access care compared to three years ago, 83% of adults and 90% of parents with children responded that it was the same or easier to access care as seen in Exhibits 12 and 13. Additional OMAS information will be presented in Appendix A: Overview of the Medicaid Program.

Exhibit 12: OMAS Response Rate – Ability to get health care compared to 3 years ago - Adult

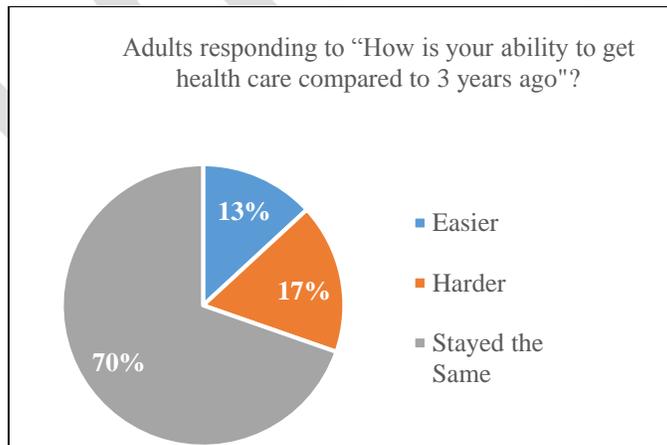
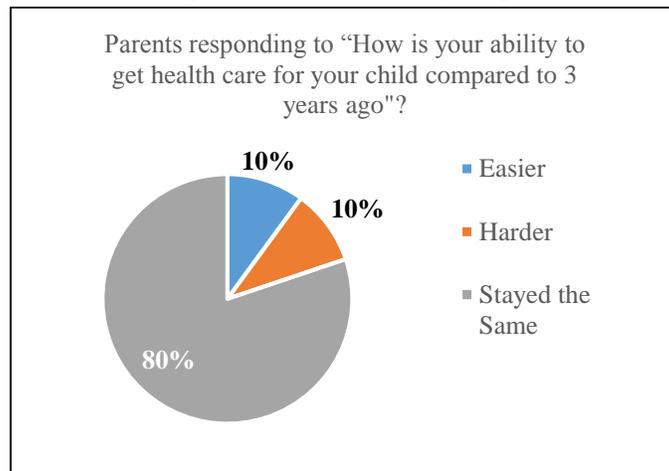


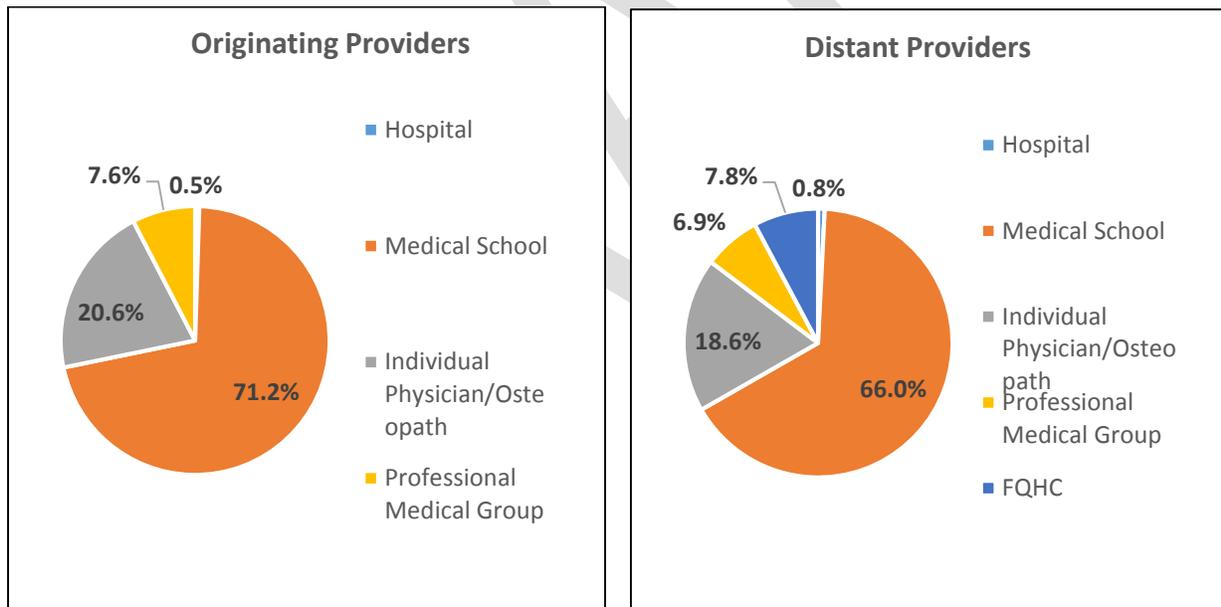
Exhibit 13: OMAS Response Rate – Ability to get health care – Child



Access to Telemedicine Services

ODM began offering telemedicine for the medical-surgical program in January 2015. Exhibit 14 shows the distribution of provider types among originating and distant sites for the first year this was offered. ODM will continue to monitor telemedicine utilization.

Exhibit 14: Distribution of Telemedicine Providers



Comparison of Medicaid Payment Rates to Medicare

Ohio is a Medicaid expansion state and does not have a separate SCHIP program, so rates do not differ for adult and pediatric populations. Specific procedure code payment rate comparisons were performed for each provider type listed in this report. Exhibit 15 provides a summary of the rates paid for non-facility evaluation and management codes for primary care compared to Medicare. Commercial rates are not available.

Figure 15: Comparison of Medicaid to Medicare Rates for Select Procedure Codes

Procedure Code	Office Visit Description	CY 2016 Ohio Medicaid Non-Facility Rate	CY 2016 Medicare Non-Facility Rate	Ohio Medicaid as Percent of Medicare Non-Facility Rate
99201	New patient, 10 minutes	\$23.55	\$42.33	56%
99202	New patient, 20 minutes	\$38.93	\$72.35	54%
99203	New patient, 30 minutes	\$57.76	\$104.89	55%
99204	New patient, 45 minutes	\$88.07	\$160.34	55%
99205	New patient, 60 minutes	\$110.67	\$201.51	55%
99211	Established patient, 5 minutes	\$14.50	\$18.97	76%
99212	Established patient, 10 minutes	\$26.73	\$41.97	64%
99213	Established patient, 15 minutes	\$43.61	\$70.46	62%
99214	Established patient, 25 minutes	\$66.14	\$104.00	64%
99215	Established patient, 40 minutes	\$89.63	\$140.46	64%

Additional payment rate comparisons can be found in the provider specific sections of the report appendices.

Methodology and Data Overview

The data sources used for this Access Monitoring Review Plan (AMRP) included Medicaid claims payment data and encounter submissions from managed care plans (tabulated from the State’s Medicaid Information Technology System, or MITS); Medicaid beneficiary enrollment system data (MITS); Medicaid provider enrollment file (MITS); results of CAHPS survey access-related questions; results of the in-state OMAS survey access-related questions; results from the Healthcare Effectiveness Data and Information Set (HEDIS) measures of access; Area Health Resource File (AHRF) data for general public provider availability; Medicare payment rate data; and other state Medicaid payment rate data, as applicable.

Data was organized and aggregated into beneficiary cohort populations, such as children, adults, dual eligibles, or persons with disabilities, for comparative purposes. A team of subject matter experts at ODM convened to define the attributes of the provider specialties that are presented in Appendices B through H. ODM used a team of analytics programmers that performed all analytics in the report to provide consistency in tabulation and reporting. An iterative process was convened with ODM subject matter experts within each provider specialty

reviewing results of the provider-specific analyses shown in Appendices B through H. The final versions of the analytics were presented to the Medical Care Advisory Committee and released for the 30-day public feedback period.

Provider Specific Analyses of Access to Care

The provider types for which specific analyses of access to care were performed include:

- Primary Care Providers – see Appendix B
- Dental Providers – see Appendix C
- Physician Specialists – see Appendix D. the following specialist categories had the highest utilization of all specialists:
 - Radiology providers
 - Cardiology
 - General Surgery
- Behavioral Health Providers
 - Traditional Medical Benefit Providers – see Appendix E
 - Community Behavioral Health Providers – see Appendix F
- Obstetrics/Gynecologist Providers – see Appendix G
- Home Health Providers – see Appendix H

Each provider-specific analysis of access to care includes comparisons of:⁶

- Availability
 - Unique number of providers serving beneficiaries, by county, in CY 2014
 - County comparison between the number of providers nationally compared to providers enrolled in Ohio Medicaid
- Utilization
 - All Beneficiaries
 - Utilization per 1,000 member months (MM), by county, CY 2014
 - Average statewide utilization per 1,000 MM for CY 2013-CY 2015
 - Comparison of selected counties to the statewide average utilization per 1,000 MM for CY 2013-CY 2015
 - Utilization among beneficiaries with disabilities
 - Utilization per 1,000 MM, by county, CY 2014
 - Average statewide utilization per 1,000 MM CY 2013-CY 2015
- Driving Distances

⁶ Some comparisons are excluded when not applicable to a particular provider type or where data limitations prevent reliable results.

- Average driving distance, by county, in CY 2014 for total beneficiaries and beneficiaries with disabilities specifically
- Regional comparison between Medicaid average driving distance and Medicare managed care maximum driving distances used for network adequacy
- HEDIS and CAHPS measures, if applicable
- Concerns/ issues raised by providers through provider feedback mechanisms
- Comparative analysis of Medicaid and Medicare payment rates

Summary of Key Findings From Provider Specific Analyses

Primary Care Providers

- Provider Access: Adults and children have sufficient access to primary care.
 - Servicing provider data shows that a wide variety of primary care providers are available to the Medicaid population with variations in the numbers of providers accessed largely varying along with population density across the state.
 - Comparative analysis with AHRF between primary care providers found no counties identified as having fewer providers than the general public which is consistent with the servicing provider data examined.
- Utilization:
 - Primary Care Utilization is high for both adults and children, for the total population and the FFS population alone.
 - This finding is also true for beneficiaries with disabilities.
 - Beneficiaries with disabilities utilized primary care at higher rates, however, than the total Medicaid population. More than 80% of beneficiaries with disabilities had at least one or more primary care visit in CY 2014.
 - For most counties examined in CY 2014, the vast majority showed primary care use among the adult and children population above 200 visits per 1,000 MM.
 - When utilization was examined for trends from CY 2013 to CY 2015:
 - All Beneficiaries
 - The average utilization/ 1,000 MM for all beneficiaries in total is stable across the years.
 - The average utilization/ 1,000 MM for FFS beneficiaries showed a slight decrease in CY 2014 compared to CY 2013 but appears to be rebounding in CY 2015.
 - Results from CY 2014 in particular for all FFS beneficiaries may, in part, be an artifact of the expansion population being added into

the FFS temporarily without sufficient time to seek a PCP visit before enrolling into managed care.

- Beneficiaries with Disabilities
 - Utilization remained stable when looking at beneficiaries with disabilities in total.
 - FFS beneficiaries with disabilities had an increase in utilization with a spike in average utilization occurring in CY 2014.
- Average Driving Distance: When the total population (FFS and managed care) was analyzed, only one county had an average driving distance in CY 2014 just above 30 miles.
 - When the FFS population was examined specifically, there were 16 counties with an average distance above 30 miles in CY 2014, but the maximum county value was 34.
 - The average driving distance statewide for the disabilities population (15.2 miles) was similar to the Medicaid population overall (14.6 miles).
 - Regional driving comparisons to Medicare managed care maximum distance standards for total beneficiaries show variability between regions.
 - Maximum difference between Medicare and Medicaid occurring in metro areas of 5.65 miles.
 - Medicaid had a shorter driving distance of 4.55 miles than the Medicare standard for rural areas.
- CAHPS Measures: CAHPS survey results suggest satisfaction among Ohio Medicaid members greater than Medicaid members nationally.
- HEDIS measures: HEDIS measures suggest there could be improvement in primary care access.
- Medicaid reforms underway during the SFY 2016/2017 biennium that impact primary care include:
 - Investment of \$41.6 million (state and federal funds combined) for a temporary increase in primary care rates from January 1, 2016 through June 30, 2017.
 - Statewide launch of patient centered medical homes began in January 2016 which will provide additional funding to incentivize practice transformation to promote high-quality, individualized, continuous and comprehensive care.

Dental Providers

- Provider Access: Adults and children have sufficient access to dental services in large urban and surrounding counties.

- Although rural counties have the lowest concentration of dental servicing providers, the county with the minimum number of providers is 84 and the median value statewide is 228 providers.
- Comparative analysis found that Ashtabula, Auglaize, Gallia, and Monroe counties were identified as having less providers available than compared to those available to the general public.
- **Utilization:** Compared to PCP service, utilization is low, although beneficiaries with disabilities utilized services at a much higher rate.
 - Utilization trends in CY 2014 (total population), expressed as visits per 1,000 member months
 - Total population (adults and children)- 64 /1,000; FFS only population- 33 /1,000
 - Total population (children only)- 79 /1,000; FFS children only- 48 /1,000
 - Total Medicaid population age 65 and older- 26 /1,000; FFS population 65 and over- 31 /1,000
 - Beneficiaries with Disabilities
 - Beneficiaries with disabilities utilized FFS dental services at double the rate of the FFS non-disabled population.
- **Average Driving Distance:** The vast majority of counties have driving distances under 40 miles.
 - 16 counties had average distance greater than 40 miles.
 - Three counties had an average distance greater than 50 miles.
 - For beneficiaries with disabilities, on average, the driving distance to dental servicing providers was 1.2 miles less statewide than the total Medicaid population.
- **HEDIS measures:** Ohio is below the national average in terms of access to dental care services for children age 2-21.
- Medicaid reforms are underway during the SFY 2016/2017 biennium that include an increase in dental fees by 1% effective January 1, 2016, with 5% being targeted to rural dental providers.

Physician Specialty Providers

- **Provider Access:** Medicaid beneficiaries have sufficient access to specialists.
 - Cardiologists, general surgeons and radiologists were examined specifically by examining the number of providers seen by members in a given county during CY 2014.
 - Radiologists: median value was 271; lowest county was 110.
 - General surgeons: median value was 112; lowest county was 29.

- Cardiologists: median value was 88; lowest county was 23.
 - Comparative analysis identified some counties with lower numbers of enrolled providers compared to those reported in the AHRF data.
 - Some of these counties have below average utilization and above average driving distance.
 - Hardin had both for radiology.
 - Seneca, Sandusky and Ottawa had both for cardiology.
 - Warren, Ottawa, Medina, Carroll had both for general surgery.
- **Utilization:** Data suggests consistent utilization over the three years analyzed.
 - An increase in utilization of some specialties, like radiology, in CY 2014 compared to CY 2013 may be attributable to pent-up demand by the expansion population.
- **Average Driving Distance:** Most regions and counties are below 40 miles driving distance.
 - Similar numbers of counties among specialists had average driving distances above 40 miles across all three specialties.
 - 11 in general surgery, 10 in cardiology and 10 in radiology.
 - Comparative analysis with Medicare managed care maximum distance thresholds shows that Medicaid has lower driving distances to cardiologists and radiologists than Medicare in micropolitan statistical areas and rural areas.
- **CAHPS:** Beneficiaries satisfaction with access to specialty care is at or above the national CAHPS average.
 - Adult satisfaction rose from 2013 to 2014 while children's satisfaction fell slightly.

Behavioral Health Medical Providers

- **Provider Access:** Medicaid beneficiaries overall are accessing small numbers of providers for this benefit.
 - Provider types include physicians, psychologists and mental health clinics with provider specialties of psychiatric, addiction medicine, psychology and other mental health clinic.
 - Median number of providers serving members in a county is 40. Eleven of the 88 counties in the state have less than 20, while two (Noble and Morgan counties) have less than 10.
- **Utilization:** Varies greatly by county, but some overall trends found.
 - Rates among beneficiaries with disabilities and on FFS are the highest statewide.
- **Average Driving Distance:** Most regions and counties are below 40 miles driving distance.
 - 19 counties are above 40 miles.

- Comparative data for Medicare managed care shows that Medicaid has lower driving distances for all regions except large metro.
- Average driving distance for total Medicaid population is 20.5; for disabled is 22.1 miles.

Behavioral Health Community Providers

- Provider Access: Adults and children appear to have sufficient access to behavioral health community servicing providers on a statewide basis.
 - Availability data and location mapping of satellite data suggests that beneficiaries have access to a variety of facilities.
 - The largest concentration of community servicing providers is located in large urban and surrounding counties.
 - 11 of the 88 counties have less than 50 community servicing providers, with the lowest at 30 providers in Noble County.
- Utilization: Is highest among adults and children with disabilities. FFS utilization is at slightly higher rates than the total population.
 - In CY 2014, utilization for beneficiaries with disabilities is near 800 visits /1,000 member months. This is 2.9 times higher than the mean utilization for the total beneficiary population.
 - Slight increase in utilization over three-year period for total population, but slight decrease among the FFS-only population and the disabled population specifically.
- Average driving distance: Could not be computed given the inability to map the multiple satellite locations of the servicing providers.
- Medicaid reforms underway during the SFY 2016/2017 biennium that impact behavioral health community providers include:
 - Medicaid in Schools Program (MSP) will be expanded to cover more services for children with special needs.
 - Restructure all Medicaid reimbursed behavioral health services under some form of managed care to improve care coordination and outcomes.

Obstetrics and Gynecology

- Provider Access: Medicaid beneficiaries have sufficient access to obstetrics/gynecology providers and midwives.
 - CY 2014 utilization data showed, at the county level, that enrolled Medicaid females saw a minimum of 23 OB/GYNs but the median value across counties was 88.
 - Comparative analysis identified some counties with lower numbers of enrolled providers compared to those reported in AHRF data.

- **Utilization:** Data confirmed that most prenatal and postnatal care occurs in managed care, since the utilization rate per 1,000 member months for women in FFS is approximately one-third the rate seen for women enrolled in managed care.
 - Median rate is 57 visits/1,000 for both programs, but FFS median is 18 visits /1,000.
 - Only one county, however, had utilization below 30/1,000 (Adams at 29) when FFS and managed care combined are considered.
 - This trend is an artifact of the enrollment pattern for pregnant women being almost exclusively in managed care except for a potential small transition period.
- **Average driving distance:** For the majority of counties, it is less than 40 miles and also less than the Medicare managed care region maximum.
 - 17 counties had average driving distances above 40 miles.
 - Comparative analysis identified all regions had lower driving distances for Medicaid than the Medicare managed care maximum standard.
- **HEDIS measures:** Results for timeliness of pre- and post- natal care, however, were well below the national average.

Home Health

- **Provider Access:** Beneficiaries have sufficient access to home health servicing providers on a statewide basis.
 - At the county level, median value was 21 providers serving members.
 - 10 counties had less than 10 providers, and the lowest was 4 in Paulding County.
- **Utilization:** Data suggests beneficiaries of all ages are using these services, but at different rates.
 - FFS enrollees use home health at higher rates than total population (FFS+MCP).
 - Age 65+ use home health services at rates more than double for all FFS enrollees.
 - In CY 2014, utilization for disabled members is the highest among all members.
 - 972 visits /1,000 (total population), or more than 4 times higher than all beneficiaries.
 - 3,915 visits /1,000 (FFS disabled only)
 - Utilization trends from CY 2013 to CY 2015 generally stable for all populations.
- **Average driving distance:** Could not be computed given that individual employees drive to beneficiary homes to provide service.
- In SFY 2015, \$23 M was invested to increase nursing and aide rates.
- Medicaid reforms underway during the SFY 2016/2017 biennium that impact home and community based providers include:
 - Provides “no wrong door” entry into long-term services and supports.

- Ensure care in home is done safely and honestly.
- Implement electronic verification for home visits.

Description and Outcome of Public Process

- Narrative in this section will be completed after public comment period is over.

Provider and Beneficiary Input

ODM offers multiple opportunities for providers and beneficiaries to provide input on access to care including:

- Ohio Medicaid Consumer Hotline
- Provider Hotline
- MCAC Committee Hearings
- Stakeholder meetings – ODM has regularly scheduled meetings with stakeholder groups that varies by provider type
- Administrative rule process – public notices are added to the department web site inviting comments on proposed rules
- Biennial budget process – opportunity to provide input to the legislature

Recent Provider and Beneficiary Input for Primary Care

Ohio implemented the Primary Care Rate Increase (PCRI) in accordance with the Affordable Care Act and reimbursed qualified providers for eligible primary care services at the Medicare rate during calendar years 2013 and 2014. The federal government funded 100% of the primary care fee increase. Stakeholder meetings focused on implementation of the fee increase.

As a result of the SFY 2016/2017 biennial budget, Ohio has implemented its own primary care rate increase for dates of service from January 1, 2016 to June 30, 2017. This investment added \$41.6 million to primary care services. During implementation, the Ohio State Medical Association requested that ODM include prenatal codes in the fee increase. As a result, these codes were included in the recently enacted primary care rate increase.

Ohio implemented a multiple procedure payment reduction January 1, 2014. ODM received correspondence from a gastroenterologist questioning how the reduction would be applied for services provided in an ambulatory surgery center. As a result of the input received, ODM subsequently modified the multiple procedure payment reduction effective July 31, 2014.

Recent Provider and Beneficiary Input for Dental Care

Quarterly meetings are held with the Ohio Dental Association (ODA) Council on Access to Care and Public Services; meetings of the ODA - Medicaid work group are called as needed. Some dentists are members of both groups. ODM and ODA staff members also get in contact periodically (in person or by telephone, e-mail, or surface mail) to discuss dental industry and provider issues, concerns, and opportunities. Individual dentists and oral health advocates also contact ODM regarding program coverage and reimbursement issues.

Oral health advocates emphasize that Ohio Medicaid dental reimbursement averages about 40% of fees while the typical dental office has an overhead of 60-65% of fees; meaning most dentists do not break even when treating Medicaid patients. They point out that the last significant fee increase was in 2000 and that fifteen years of no fee increases have placed Ohio Medicaid reimbursement for dental services among the bottom ten states.

Effective January 1, 2016, ODM implemented the equivalent of a 1% fee increase with a rural fee differential of 105% of the Medicaid fee schedule for dental services provided in a rural Ohio county, in addition to removing or relaxing prior authorization requirements. Ohio will continue to monitor utilization of dental services throughout the state.

Recent Provider and Beneficiary Input for Home Health

Effective July 1, 2015, home health rates were established using a market-based pricing methodology that took into account the key cost components of providing each service (e.g., labor market and licensure data). The nearly \$20 million investment resulting from the SFY 2012/2013 biennial budget was designated to: right-size the distribution of funding for nursing and aide services (i.e., modernize rates to reflect actual service delivered by provider/agency type); to differentiate between RN and LPN credentialed service payments; and to add two new distinct services (RN assessment and RN consultation) to Ohio's state plan.

The SFY 2016/2017 biennial budget required that payment rates for home health aide services that are provided by a provider, other than an independent provider, during the period beginning January 1, 2016, and ending June 30, 2017, shall be at least five per cent higher than the rate in effect on October 1, 2015, for those services. The new rates for home health aide services (agency provider only) went into effect on January 1, 2016.

ODM met monthly with stakeholders for 18 months during the rule drafting and review process, up until the release of the aforementioned rate updates. Multiple stakeholder meetings were held for the purpose of reviewing the changes proposed to home health administrative rules. In particular, representatives of two statewide associations, the Ohio Council for Home Care and Hospice and Midwest Care Alliance participated along with sister agency departments in the development of OAC 5160-12-08.

The Ohio Department of Medicaid also engaged various internal and external stakeholder groups for two years around the development of a rate methodology for nursing and aide services in both the home health and private duty nursing benefits. The Ohio Department of Medicaid spent over six months working with three associations (Midwest Care Alliance, Ohio Council for Home Care and Hospice, and Ohio Provider Resource Association) on finalizing rates and/or the drafting of rules relative to the services added to the Medicaid state plan (i.e., RN Assessment and RN Consultation). Stakeholder comments and input was taken under advisement during the process of amending and/or developing each home health rule in Chapter 12. Stakeholder input continues to play an integral part in drafting rules, policy implementation, and training related to home health and private duty nursing benefits.

Recent Provider and Beneficiary Input for Behavioral Health

Community Behavioral Health

ODM is currently in the process of re-designing the behavioral health Medicaid program. As part of this process, ODM has been working jointly since October 2014 with the Ohio Department of Mental Health and Addiction Services (ODMHAS) to formulate the new/revised services. In conjunction with ODMHAS, ODM has been working with a large stakeholder group representing both providers and advocacy groups for those needing behavioral health services. These bi-weekly meetings have been an opportunity for stakeholders to raise concerns about the program design, proposed payment rates, and impact on the individuals served.

Key Findings and Recommendations

- Ohio has very few Medicaid beneficiaries who consistently receive services through FFS.
 - In CY 2014, 5.6% of all ever enrolled beneficiaries were in FFS for 12 months (0.9% of children and 4.7% of adults).
 - In CY 2015, 4.7% of all ever enrolled beneficiaries were in FFS for 12 months (0.9% of children and 3.8% of adults).
- Overall, Ohio Medicaid has sufficient access to care in its FFS delivery system, although two services stand out that warrant further review.
 - Dental
 - While availability of dentists is largely sufficient, utilization for the FFS population is low compared to the total population.
 - This may be related to beneficiaries just not seeking care or not being in FFS long enough to arrange an appointment for dental care or set up the appointment and visit after transition to a managed care plan.
 - The total population includes enrollees who receive care through a managed care delivery system and the hypothesis is that analysis of

subsequent years with increased managed care enrollment and reduction in enrollment time to 45 days will only improve utilization.

- The state has increased rates overall by 1% beginning in January 2016, and specifically focused an additional 5% rate increase for dentists in rural areas to encourage dentists in those locations to accept Medicaid beneficiaries.
 - Further examination will be conducted on the “long term enrolled” FFS population (e.g., beneficiaries enrolled in FFS for more than nine months in a single year).
- Obstetrics and Gynecology
 - The analyses confirmed that most prenatal and post-natal services are being provided in managed care, as utilization rates for the total population versus FFS were much higher.
 - Since CY 2014, Ohio has reduced the time it takes to enroll in a managed care plan to 45 days. While this is an improvement, one recommendation would be to look for additional opportunities to further reduce the time enrollees spend in FFS.
 - Ohio has made a number of significant investments into improving care for moms and babies and it is recommended that Ohio update the access to care analysis using data from CY 2016. Investments in improving care for moms and babies include:
 - Presumptive eligibility for pregnant women.
 - Targeted improvement efforts – e.g., encourage use of progesterone to reduce preterm births.
 - Investment in identifying populations and locations most at risk for infant mortality.
 - While no particular access to care issue stood out in the review of behavioral health, there are efforts either recently enacted or in development that it is recommended that Ohio update the access to care analysis to evaluate the impact of:
 - In 2014, Medicaid eligibility expansion provided access to 400,000 residents with behavioral health needs who previously relied on county-funded services or went untreated.
 - Ohio recently added new behavioral health provider types that could bill directly for services, including licensed independent social workers.
 - Redesign of the behavioral health benefit package – this work is underway.
 - Future integration into some form of managed care for behavioral health.

- A highlight of the access to care analysis is that adults and children have sufficient access to primary care.
 - Availability of providers in Medicaid is greater than that of the general public.
 - Primary care utilization is high for both adults and children, for the total population and the FFS population alone.
 - HEDIS measures suggest there could be improvement in primary care access. However, CAHPS survey results suggest satisfaction among Ohio Medicaid members greater than Medicaid members nationally.
 - The average driving distance statewide to primary care providers was 14.6 miles, with the maximum driving distance of 34 miles in one county.

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