Ohio | Department of Medicaid

Medical Care Advisory Committee

Briefing on Ohio's Draft 2019 Access Monitoring Review Plan (AMRP)

August 29, 2019

What we will cover today

- Federal Regulations and Guidance
- Required Elements for CMS Submission
- Summary of Analytic Process Used
- Composite Dashboard
- Average Distance Dashboard
- Analysis of Payment Rates
- Public Process
- Key Findings
- Conclusions
- Recommended Next Steps

Federal Regulations and Guidance

- 42 CFR 477.203
  - » Fee for Service (FFS) only
  - » Initial reports due October 1, 2016 and every three years thereafter, OR if a state reduces FFS rates on a particular service, then report on this
- For 2019 submissions, CMS engaged Mathematica to develop tools to assist states in reporting
  - » Core Access and Optional Metrics
  - » While the deliverable is FFS only, many of the metrics suggested by CMS cross populations and some are specifically captured for managed care delivery systems
- CMS released proposed rule to eliminate the AMRP requirement but issued guidance that would replace it with a “Comprehensive Strategy for Monitoring Access in Medicaid”.
  - » States still required to submit 2019 AMRP

Required Elements for CMS Submission

- Provider Types
  - » Primary care services – physician, FQHC, clinic, dental care;
  - » Pre- and post-natal obstetric services including labor and delivery;
  - » Home health services;
  - » Behavioral Health Services – includes MH and SUD; and
  - » Physician specialist services – e.g., cardiology, urology, radiology.
- Data shown must address:
  - » Extent to which beneficiary needs met;
  - » Availability of care through enrolled providers; and
  - » Changes in beneficiary utilization.
- Analyses must show aggregate comparisons between Medicaid rates and rates paid by other payers.
- Stakeholder feedback must be completed prior to submission.

Summary of Analytic Process Used

- All claims, beneficiary and provider enrollment data originated from the Ohio Department of Medicaid Information Technology System (MITS) BIAR Data Warehouse as of March 2019.
- Study population
  - » Medicaid FFS beneficiaries who are not dually eligible for Medicare
  - » Are under age 65
  - » Enrolled during CY 2016, 2017 and 2018
- Services Reviewed
  - » Primary Care Services – includes physicians, FQHC, RHC
  - » Dental Care Services
  - » Prenatal and Postpartum obstetric services, including labor and delivery
  - » Home Health Services
  - » Behavioral Health Services – breakouts for SUD, SED and SMI (SED and SMI presented together as they share common set of diagnoses)
  - » Physician Specialist Services – Radiology (adult and pediatric); Surgery (adult only); Ear, Nose and Throat (pediatric only)
  - » Durable Medical Equipment

Summary of Analytic Process Used

- What was analyzed for each service reviewed?
  - » Section A: Count of Users – number of unique beneficiaries with at least nine months enrollment in FFS who used the service were counted for each study year.
  - » Section B: Utilization per 1000 Member Months – rates for each service category and population cohort (total, adult/pediatric, male/female, and disabled/non-disabled) for each study year.
  - » Section C: Average Driving Distances – calculated for unique member-to-rendering provider trips for CY 2018 utilization, using the latitude and longitude of each user member's home and each rendering provider's location in the study.
  - » Section D: Provider Availability – unique count of enrolled, licensed and billing providers for CY 2018, computed for the total population as well as for adult and pediatric cohorts.

Composite Dashboard

- Using CY 2018 data, summary of information from service specific dashboards presented on a regional basis
- Three key metrics of access to care
  - » Utilization per 1000 member months (FFS data only)
  - » Provider-to-Member Ratio
    - Provider availability per 1000 members in total (FFS and managed care).
    - Results benchmarked, where possible against Area Health Resource File (AHRF) provider availability to the general public
  - » Average Driving Distance
    - Weighted average of distance traveled by region
    - Counts unique trips between beneficiary and provider
    - Results benchmarked against service specific driving distance thresholds and are color coded as described on the next slide.

Average Distance Dashboard

- Presents average driving distances from Composite Dashboard at a more granular level to access care based on the beneficiaries' county of residence
- Results are color-coded to compare against service-specific driving distance thresholds of:
  - » 20 miles or less (except Radiology and Surgery which are set at 30 miles or less)
  - » More than 20 but less than 30 miles (except Radiology and Surgery which are set at more than 30 but less than 50 miles)
  - » More than 30 miles (except Radiology and Surgery which are set at more than 50 miles)
  - » Low sample size (which is set at less than 25 trips, except Prenatal/Postpartum and Ear, Nose and Throat which have no minimum threshold)

Analysis of Payment Rates

- Used CY 2018 FFS professional claims data and included 4,297 procedure codes that had any FFS claims volume. The included procedure codes range from CPT codes 10021 through 99483 and HCPCS codes G0396 and G0397.
- Using CY 2018 volume, Medicaid 2019 FFS rates were compared to 2019 Medicare rates, and Medicaid 2016 FFS rates and 2016 Medicare rates.
- Identify the top ten codes by volume for specific payment rate comparisons.

Public Process

- Public process begins with a notice and link to the draft 2019 AMRP on the department's website for 30 days at: https://medicaid.ohio.gov/RESOURCES/Public-Notices.
- Present the draft AMRP at the August 29, 2019 MCAC meeting.
- AMRP narrative in this section will be completed after the public comment period is over in order to include a summary of the public comments received as required by federal regulation.
- Ohio received no comments in 2016 when the first AMRP was released for public comment.

Key Findings

- Ohio has very few Medicaid beneficiaries who consistently receive services through FFS.
- Ohio Medicaid beneficiaries have better or equal access compared to the general public for most service specific providers, except Radiology which has provider availability ratios that are less than the AHRF benchmark value in all regions.
- With few exceptions, Ohio Medicaid FFS beneficiaries travel 30 miles or less to seek services.
  - » Greater challenges in Northwest and Southeast regions.
  - » Selected counties where driving distances pose greater challenges.
    - Coshocton – the driving distance average exceeded the established threshold for 7 out of 8 services studied.
    - Adams and Highland – the driving distance average exceeded the threshold in 6 out of 8 services studied.
    - Holmes, Noble, Pike, and Wyandot – the driving distance average exceeded the threshold in 5 out of 8 services studied.
  - » Within service categories, dental care has the most counties (37) that are above the 30-mile established threshold.

Key Findings

- Service Specific Findings
  - » *Count of Users*. In general the percentage of users for most services increased, with the exception of dental and prenatal and postpartum care.
  - » *Utilization per 1000, by different demographic cohorts*. In general, downward trends were observed with the exception of Home Health, DME, Radiology and Surgery.
  - » *Average driving distance*. In comparison to the 2016 AMRP:
    - Dental and Prenatal and Postpartum Care is better in 2019
    - Primary Care, Radiology and Surgery is worse in 2019
  - » *Provider availability*. In comparison to the 2016 AMRP:
    - Billing provider count has increased since 2016
    - Dental and Prenatal and Postpartum Care on a per 1000 basis is not as good as 2016.
    - Compared to AHRF, Radiology is not as good as in 2016.
- Other Measures. Most notable finding is the increase in use of Telehealth services, specifically in CY 2018 for behavioral health services.
- Payment Comparison. Overall, Medicaid payment rates in comparison to Medicare rates experienced slight declines from those observed in the 2016 AMRP.

Conclusions

- Overall, Ohio Medicaid has sufficient access to care in its FFS delivery system, even with the decline of FFS enrollment and a decline in the amount of time spent in FFS both contributing to the findings in this report.
  - » This made analysis and comparisons to the 2016 AMRP findings challenging given the small sample sizes, the most notable being Prenatal and Postpartum Care services which are largely provided to Medicaid beneficiaries through managed care.
- While overall access is sufficient, Dental, Prenatal and Postpartum Care, and Radiology are areas that may merit further examination.

Recommended Next Steps

- Ohio continues to enroll a larger proportion of the total Medicaid population into managed care. As such, monitoring access on a declining FFS population is challenging and is not representative of access to care in total for Medicaid. With this in mind, the following are recommended next steps to improve measuring and monitoring access to care for Ohio's Medicaid beneficiaries.
  - » Expand the analysis to include managed care encounter data when calculating utilization per 1000-member month rates. This would alleviate small sample size issues observed in preparation of this report.
  - » Add ongoing managed care metrics and monitoring efforts to create a complete picture of Ohio's efforts to measure and monitor access to care.
  - » Consider establishing a static set of core access questions in the state's Ohio Medicaid Assessment Survey that will allow for ongoing trend analysis.