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MEDICAID FEE-FOR-SERVICE

State Resources Vary for Helping Beneficiaries Find Providers

Accessible Version

MEDICAID FEE-FOR-SERVICE

State Resources Vary for Helping Beneficiaries Find Providers

Why GAO Did This Study

Medicaid is the federal and state health care program for low-income and medically needy individuals including certain children, adults, and aged and disabled individuals. As states transition more Medicaid enrollees and services to managed care, stakeholders have raised questions about populations that remain in FFS arrangements and the resources they can use to find health care providers. GAO was asked to provide information about Medicaid beneficiaries in FFS arrangements.

This report examines (1) the proportion and characteristics of Medicaid beneficiaries served in FFS arrangements, and (2) the federal and state resources available to help Medicaid beneficiaries in FFS arrangements find participating providers and report related challenges. GAO analyzed 2014 CMS data, the most recent available, on the proportion of Medicaid beneficiaries in different service delivery arrangements by state, and a 2015 survey of state Medicaid agencies by the Kaiser Commission on Medicaid and the Uninsured. GAO catalogued online, publicly available information from the 23 states having at least 30 percent of their Medicaid population in FFS arrangements, and confirmed the information via email or interview. GAO interviewed Medicaid officials and advocates in 6 of the 23 states and CMS officials. These states were selected, in part, based on the diversity of delivery system arrangements and resources. GAO also reviewed federal and state resources.

HHS provided technical comments on a draft of this report, which GAO incorporated as appropriate.

What GAO Found

According to the Centers for Medicare & Medicaid Services (CMS), as of July 2014, over 40 percent of nearly 71 million Medicaid beneficiaries were in fee-for-service (FFS) arrangements—traditional FFS and primary care case management—in which participating providers are paid for each delivered service (e.g., an office visit, test, or procedure). The percentage of beneficiaries in FFS arrangements varied widely among states—22 states served between 50 and 100 percent of beneficiaries, almost 16 million people, in FFS arrangements. A recent survey of states suggests that millions remained in FFS arrangements as of July 1, 2015. The survey also suggests that the proportion of beneficiaries in FFS arrangements is declining as states move more populations into risk-based managed care. Aged and disabled beneficiaries and children with special health care needs were the most likely of different Medicaid populations to be served through FFS arrangements instead of managed care.

CMS, the federal agency that oversees Medicaid, and states consider the development of resources to help beneficiaries find a provider to be a state role. CMS supports a federal resource for pediatric dental care and has provided guidance to states related to resources. The 23 states GAO reviewed have 4 common types of resources to help beneficiaries: searchable provider directories; nonsearchable provider lists; beneficiary helplines; and beneficiary handbooks. These resources vary with respect to the scope of information, availability, and states' adaptations to address beneficiary needs. Of the 23 states, GAO found the following:

- 17 had online, searchable provider directories; 16 of these included provider information on specialty care physicians and 4 indicated whether primary or specialty care providers were accepting new patients.

- 23 operated a helpline; 6 operated these outside of regular business hours.

- 9 included a mapping or location feature with their directories or lists.

Helplines are the primary resource that beneficiaries use to report issues finding a provider, according to Medicaid officials in 4 of 6 selected states and half of the advocacy group representatives GAO interviewed. When beneficiaries contact helplines, they can be directed to additional resources—beyond those listed above—to address their complaint.

United States Government Accountability Office

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GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

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The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
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The Honorable Joseph R. Pitts
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Subcommittee on Health
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Medicaid, the largest health insurance program by enrollment in the United States, covered approximately 76 million low-income and medically needy individuals as of July 2015.[1] This enrollee population is a diverse group that includes children, low-income adults, aged individuals, and those who are disabled. However, research has shown that enrollment in Medicaid does not ensure a beneficiary can obtain needed services. Access to health care services in Medicaid is affected by a number of different factors such as physician participation, availability of appointments, and proximity to participating providers.

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[1]This estimate of enrollees in the Medicaid program was provided by the Centers for Medicare & Medicaid Services' Office of the Actuary and is based on state-reported enrollment data in the Medicaid and State Children's Health Insurance Program (CHIP) Budget and Expenditure Systems as of July 2015.

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Medicaid was designed as a federal-state partnership that allows states significant flexibility to design and implement their Medicaid programs. Medicaid is financed jointly by the federal government and states; the federal government matches state Medicaid expenditures according to a statutory formula. The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), provides oversight and technical assistance for the Medicaid program, but states are primarily responsible for administering their respective Medicaid program's day-to-day operations, such as setting payment rates, within broad federal requirements.

The inherent flexibility in the program has resulted in variability across states in how Medicaid services are delivered, ranging from traditional fee-for-service (FFS) to comprehensive risk-based managed care. In traditional fee-for-service, states pay participating providers for each delivered service (e.g., an office visit, test, or procedure). Primary care case management (PCCM) is another FFS delivery arrangement in which providers are reimbursed on a FFS basis for each service delivered. However, in PCCM a primary care provider also receives a small case management fee per patient for monitoring, coordinating, and authorizing patient care, including referrals to specialty care. For the purposes of this report we generally consider both traditional FFS and PCCM as FFS arrangements, because the providers serving a beneficiary are reimbursed on a FFS basis for medical services provided to the patient.[2] In contrast, under comprehensive, risk-based managed care, states contract with managed care organizations to provide all or most Medicaid-covered services for beneficiaries and are at financial risk if spending on services and administration exceeds payments from the state.[3]

States have been transitioning greater numbers of Medicaid enrollees to managed care in recent years as a way to enhance care and control costs. For example, according to CMS data, between 2010 and 2014 managed care enrollment grew by over 16 million enrollees. As this transition continues, stakeholders have raised questions about the

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[2]Although the Social Security Act defines PCCM arrangements as a form of managed care, we treated PCCM arrangements as a form of FFS because providers are reimbursed on a FFS basis.

[3]For the purposes of this report, we will be referring to comprehensive, risk-based managed care as "managed care."

populations that remain in FFS arrangements and the resources, such as provider directories or hotlines, beneficiaries can use to find health care providers. We have reported that some Medicaid enrollees may face challenges accessing needed health care services—for example, obtaining specialty care (such as mental health care) or dental care.[4] There are no federal statutory requirements that mandate what resources states must provide to beneficiaries to assist them in finding available providers in FFS arrangements.[5]

You asked us to provide information about Medicaid beneficiaries who are served in FFS arrangements. This report describes

1. the proportion and characteristics of Medicaid beneficiaries served in fee-for-service arrangements; and

2. the federal and state resources available to help Medicaid beneficiaries in fee-for-service arrangements find participating providers and report related challenges.

To describe the proportion of Medicaid beneficiaries served through FFS arrangements at the national and state levels, we analyzed two data sets that varied in timeliness and completeness. Our primary source was data collected directly from states by CMS showing the number of Medicaid beneficiaries in various service delivery arrangements as of July 1, 2014.[6] We considered beneficiaries served through either PCCM or traditional

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[4]See GAO, *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care*, GAO-13-15 (Washington, D.C.: Dec. 10, 2012) and GAO, *Dental Services: Information on Coverage, Payments, and Fee Variation*, GAO-13-754 (Washington, D.C.: Sept. 6, 2013).

[5]In March 2016, the U. S. House of Representatives referred to the Senate a bill that, if enacted, would require states to make a directory of participating Medicaid providers available to beneficiaries served in FFS and PCCM. Ensuring Access to Quality Medicaid Providers Act, H.R. 3716, 114th Cong. § 3 (2016).

[6]The CMS data show enrollment in PCCM and two forms of managed care: care provided through managed care organizations and care provided through Programs of All-Inclusive Care for the Elderly (PACE). PACE is a provider-based program that serves frail, elderly individuals with the goal of keeping them in the community rather than in long-term care institutions as long as medically and socially feasible. In 2014, PACE programs served very few beneficiaries (fewer than .003 in any state).

FFS to be in a FFS arrangement.[7] Because the CMS data, the most recent available from the agency, were over 1 year old, we also examined more recent but less complete data from a second source: the 2015 survey of state Medicaid officials conducted by Health Management Associates and the Kaiser Commission on Medicaid and the Uninsured in collaboration with the National Association of Medicaid Directors, (hereafter called the Medicaid Survey).[8] In the Medicaid Survey, states reported the percentages of beneficiaries in different service delivery arrangements as of July 1, 2015, but not the number of beneficiaries.[9] We were able to use these data to assess whether the reported percentage of beneficiaries in FFS arrangements had changed in any given state since 2014, but not whether the percentage had changed nationally, as it is not possible to determine from statewide percentages either the number or percentage of beneficiaries in FFS arrangements nationwide. We also reviewed information on selected state Medicaid websites accessed in March through July 2016 to identify additional changes in service delivery arrangements that states have planned or made since July 2015. To describe the characteristics of Medicaid beneficiaries in FFS arrangements, we analyzed data from two sources: (1) Medicaid Survey data showing the percentage of beneficiaries in each of four eligibility groups—children; newly eligible adults in states that opted to expand Medicaid as authorized by the Patient Protection and Affordable Care Act (PPACA); other low-income adults; and individuals who were aged or had

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[7]Although the CMS data do not show the number of beneficiaries served through traditional FFS, we were able to determine the number in each state by subtracting the number enrolled in either PCCM or managed care from total enrollment. Beneficiaries should not be enrolled in PCCM and comprehensive risk-based managed care simultaneously, so subtracting the number enrolled in each from total enrollment yields an estimate of the number enrolled in neither—that is, the number in traditional FFS.

[8]Vernon K. Smith, Kathleen Gifford, and Eileen Ellis, Health Management Associates; Robin Rudowitz, Laura Snyder, and Elizabeth Hinton, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, Oct. 15, 2015).

[9]The Medicaid Survey data show the percentage of beneficiaries in traditional FFS, PCCM, and risk-based managed care. Although four states did not report any enrollment data, they did not include managed care among their service delivery arrangements, thus indicating that 100 percent of their beneficiaries were in some type of FFS arrangement.

disabilities—who were enrolled in managed care as of July 1, 2015;[10] and (2) CMS data showing whether states enrolled selected populations in managed care in 2014, from which we were able to determine whether these populations were served through FFS arrangements instead.[11] We assessed the reliability of the CMS and Medicaid survey data by comparing these data to data from other sources and other years and determined that they were sufficiently reliable for the purposes of our reporting objectives.

To provide information on the federal and state resources available to help Medicaid beneficiaries in FFS arrangements find participating providers and report challenges accessing care, we examined resources in 23 of the 25 states that use FFS arrangements to deliver care to at least 30 percent of their Medicaid population as of July 2015, based on the 2015 Medicaid Survey data.[12] We reviewed and catalogued online, publicly available resources that assist beneficiaries in finding primary and specialty care physicians in these 23 states. We confirmed the resources we identified with all 23 states through either email or phone

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[10]Under PPACA, states may opt to expand eligibility under their state Medicaid plans to non-pregnant, non-elderly adults who are not eligible for Medicare and whose income does not exceed 133 percent of the federal poverty level, with additional federal funding available for this expansion population beginning January 2014. PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the federal poverty level. See Pub. L. No. 111-148, §§ 2001, 10201(c),124, Stat. 119, 271, 918 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, § 1201, 124 Stat. 1029, 1051 (2010). For purposes of this report, references to PPACA include the amendments made by HCERA.

[11]The populations specified in the CMS data included adults newly eligible under PPACA; adults not otherwise eligible and covered prior to 2014 under a waiver or other authority; aged, blind or disabled children or adults; non-disabled children (excluding children in foster care or receiving adoption assistance); individuals receiving limited benefits; individuals dually eligible for Medicaid and Medicare; children with special health care needs; Native Americans/Alaska Natives; and children in foster care or adoption assistance.

[12]See Smith et al., *Medicaid Reforms to Expand Coverage, Control Costs and Improve Care*. We excluded Iowa because it was in the process of transitioning to a managed care delivery arrangement. We excluded Vermont because it operates a publicly sponsored managed care delivery system through the Vermont Agency for Human Services. We included 3 states (Idaho, Maine and North Carolina) that did not report what share of their Medicaid populations were covered under different delivery systems as of July 2015, but were reported as not having managed care enrollment in 2015. We confirmed this by checking CMS information on states with managed care.

interviews. We checked the functionality of the online directories but did not evaluate the accuracy of the information provided.[13] The information on state resources that we identified in these 23 states is not generalizable to other states. From this sample of 23, we interviewed state Medicaid officials as well as representatives from advocacy groups that work with Medicaid beneficiaries from 6 states. We chose these states because of geographic diversity; variation in the proportion of individuals served through managed care and FFS arrangements; and variation in types of resources offered to beneficiaries. The selected states were Alabama, Colorado, Connecticut, Oklahoma, Utah, and Wisconsin. We used these interviews to better understand the resources available to beneficiaries, the process for tracking and reporting beneficiary issues with locating a provider, and any access to care issues in FFS populations in these states. The experiences of the Medicaid officials in these 6 states are not generalizable to other states. In addition to our state interviews, we also interviewed CMS officials and representatives from a national advocacy group, examined federal statutes and regulations, and reviewed available federal resources—such as information on CMS's website—that are intended to assist either beneficiaries or states.

We conducted this performance audit from July 2015 to August 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Historically, Medicaid eligibility has been limited to certain categories of low-income individuals—such as children, parents, pregnant women,

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[13]To check the functionality of the online, searchable provider information (also called directories) we performed three searches (one for a general primary care provider and two for specialty care providers) in the general geographic area of the state's Medicaid office. We noted any error messages received when following the instructions provided on the website. We also checked the search results for persistent missing fields of information (more than two fields in the information of multiple providers) and for multiple listings of identical provider information. We accessed these directories in January 2016.

persons with disabilities, and individuals age 65 and older.[14] In addition to these traditional eligibility categories, PPACA, which was enacted on March, 23, 2010, permitted states to expand their Medicaid programs to cover non-elderly, non-pregnant adults with incomes at or below 138 percent of the federal poverty level, with additional funding available for this expansion population beginning in January 2014.[15]

Health Care Delivery Arrangements

State Medicaid programs are required to offer a minimum, comprehensive set of services, including services provided by primary care and specialty care physicians and services provided in hospitals, clinics, and other settings and are permitted to cover additional services at their option. Within that framework, states often use a variety of arrangements to deliver services to their Medicaid populations, including traditional FFS, PCCM and managed care. The state Medicaid agency is responsible for administering the program, and the structure of how Medicaid services are coordinated, administered, and delivered varies by state and arrangement.[16]

In traditional FFS, beneficiaries can visit any provider that accepts Medicaid patients. Some states that use both FFS arrangements and managed care restrict certain populations to traditional FFS to ensure they have access to all participating Medicaid providers. Certain states also use PCCM to enhance care coordination and reduce unnecessary and duplicative costs. PCCM structures vary across the states. While all PCCM programs feature a primary care case manager that coordinates beneficiary care, some states have adopted a more enhanced model that can incorporate provider network management and performance and quality reporting. To comply with federal regulations, a state's contract with a PCCM must include certain provisions, including a requirement to provide 24-hour availability of information, referral, and treatment for emergency medical conditions as well as arrangements with, or referrals

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[14]Among these traditional enrollees, persons with disabilities and individuals age 65 and over may be enrolled in Medicare as well and are referred to as dual-eligible enrollees.

[15]See Pub. L. No. 111-148, §§ 2001, 10201(c),124 Stat. 119, 271, 918 (2010), as amended by HCERA, Pub. L. No. 111-152, § 1201, 124 Stat. 1029, 1051 (2010).

[16]For example, Connecticut operates a FFS arrangement through the state's Department of Social Services but also contracts with an administrative service organization for certain functions including member services, provider enrollment, and case management, among other things.

to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.[17] Additionally, federal regulations require states to give beneficiaries enrolled in PCCM arrangements contact information for nearby providers.[18]

Medicaid managed care has become more prevalent over the past decade as states look to provide health care services in a cost-effective manner. Under managed care, state agencies typically contract with organizations to provide a specific set of Medicaid-covered services to beneficiaries, paying those organizations a set amount per beneficiary, per month to provide services. States vary in terms of the populations and services included in managed care. For example, states may have mandatory enrollment in managed care for some populations, voluntary enrollment for others, and may also exclude certain populations from managed care.[19] States or their managed care contractors are required to provide information to enrolled beneficiaries about primary care providers, specialists, and hospitals included in their provider network, including names, locations, telephone numbers, languages spoken, and whether the provider is accepting new patients.[20]

Federal Access to Care Requirements

Federal law establishes that state Medicaid payments to providers must be sufficient to enlist enough providers so that care and services are available to beneficiaries to at least the extent that they are available to the general population in the same geographic area.[21] This part of the Medicaid statute, which is sometimes referred to as the "equal access provision," has been previously used by providers and beneficiaries to

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[17]42 C.F.R. § 438.6(k)(1),(3) (2015).

[18]42 C.F.R. § 438.10(f)(6)(i) (2015). This includes names, locations, telephone numbers of, and non-English languages spoken by current contracted providers and identification of providers that are not accepting new patients.

[19]For example, some states exclude persons with disabilities, children with special needs, foster children, and medically needy enrollees from managed care. There are a variety of reasons states may exclude certain populations and CMS officials noted that capitation rate setting challenges and administrative simplicity, among other things, are potential reasons.

[20]42 C.F.R. § 438.10(f)(6)(i)(2015).

[21]42 U.S.C. § 1396a(a)(30)(A).

challenge state reimbursement rates to providers on the grounds that the rates are insufficient to attract enough providers and are, therefore, not in compliance with the law. In March 2015, however, the U.S. Supreme Court ruled in *Armstrong v. Exceptional Child Center, Inc.,* that the equal access provision does not provide a cause of action for providers to challenge a state's reimbursement rates.[22]

Subsequent to the *Armstrong* decision, CMS published a final rule on Medicaid access to care, *Medicaid Program: Methods for Assuring Access to Covered Medicaid Services.*[23] One purpose of the rule is to provide CMS with the necessary information to ensure that state reimbursement rates meet the requirements of the equal access provision. The rule outlines a process for states to document their approach to monitoring access, especially when proposed rate reductions or other changes that may reduce beneficiaries' abilities to access care. Under the rule, states are required to develop access monitoring review plans—which must contain specific data sources to support a finding of sufficient access—that cover at a minimum primary care and physician specialist services, behavioral health services, pre- and post-natal obstetric care, including labor and delivery, home health services, and any services for which the state or CMS has received a higher than usual volume of complaints. The data collected for these services through the access monitoring review plan must be analyzed every 3 years by states. States proposing to reduce or restructure provider payments that could result in diminished access to care must also submit an access review with the state plan amendment proposing such changes. In addition, states must monitor access to care after the implementation of the rate reduction or payment restructuring, at a minimum, annually over a 3-year period. States must submit their initial access monitoring review plans to CMS by October 1, 2016. Additionally, the rule requires that states have ongoing mechanisms for beneficiaries and providers to comment on access to care (through hotlines, surveys, ombudsman, review of grievance and appeals data, or another equivalent mechanism). States are required to maintain a record of the input they receive and how they

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[22]135 S. Ct. 1378 (2015).

[23]In November 2015, CMS published a final rule with comment period. 80 Fed. Reg. 67,576 (Nov. 2, 2015). In April 2016, CMS published a final rule that addressed comments and provided for a 3-month delay of an earlier state implementation deadline. 81 Fed. Reg. 21,479 (April 12, 2016). For purposes of this report, we collectively refer to these documents as CMS's "rule," the provisions of which will be codified in 42 C.F.R. §§ 447.203—447.205.

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responded. States must also provide this information to CMS upon request.

Medicaid Access to Care

We have previously reported on Medicaid access to care issues that different Medicaid populations have faced.[24] By some measures, access to care for Medicaid enrollees is comparable to that of privately insured individuals and better than that of uninsured individuals. In a national survey, for example, less than 4 percent of beneficiaries who had Medicaid coverage for a full year reported difficulty obtaining medical care, which was similar to individuals with full-year private insurance.[25] At the same time, however, Medicaid beneficiaries may have greater health care needs; for example, higher rates of obesity and other health conditions, and greater difficulty accessing specialty and dental care.[26] Certain groups of Medicaid enrollees have reported difficulty obtaining necessary care relative to others. For example, in 2012, about 7.8 percent of working-age adults with full-year Medicaid reported difficulty obtaining care compared with 3.3 percent of similar adults with private insurance—a statistically significant difference.[27] Medicaid enrollees also were more likely than individuals with private insurance to report factors such as lack of transportation and long wait times as reasons for delaying medical care.[28]

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[24]See GAO, *Medicaid: Key Issues Facing the Program,* GAO-15-677 (Washington, D.C.: July 30, 2015).

[25]See GAO, *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance,* GAO-13-55 (Washington, D.C.: Nov. 15, 2012).

[26]See GAO-13-55, GAO, *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care,* GAO-13-15 (Washington, D.C.: Dec. 10, 2012), GAO, *Oral Health: Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns,* GAO-11-96 (Washington, D.C.: Nov. 30, 2010), GAO, *Medicaid and CHIP: Information on Children's Access to Care,* GAO-11-293R (Washington, D.C.: Apr. 5, 2011), and GAO, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, GAO-11-624 (Washington, D.C.: Jun. 30, 2011).

[27]GAO-13-55.

[28]GAO-13-55.

We also have found that both Medicaid-covered adults and children may face challenges obtaining mental health and other specialty services.[29] For example, while Medicaid expansion under PPACA has increased the availability of mental health treatment for newly eligible adults, states have reported access concerns for new beneficiaries due to shortages of Medicaid-participating psychiatrists and psychiatric drug prescribers.[30] Even though Medicaid beneficiaries' use of dental services has increased, states have found it particularly challenging to ensure a sufficient number of dental providers for Medicaid enrollees, and Medicaid and other low-income beneficiaries, particularly children, visit the dentist less often than those with private insurance.[31]

Over 40 Percent of Medicaid Beneficiaries, Including Many with Disabilities, Were in Fee-for-Service Arrangements in 2014

CMS data show 41 percent of Medicaid beneficiaries nationwide were in FFS arrangements in 2014, with wide variation among states; more recent 2015 Medicaid Survey data suggest that millions remain in these arrangements. Disabled beneficiaries were among the most likely to be served through FFS arrangements.

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[29]GAO, *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States,* GAO-15-449 (Washington, D.C.: June 19, 2015) and GAO-13-55.

[30]GAO-15-449.

[31]GAO, *Dental Services: Information on Coverage, Payments, and Fee Variation,* GAO-13-754 (Washington, D.C.: Sept. 6, 2013) and GAO-13-55.

2014 Federal Data Show 41 Percent of Beneficiaries in Fee-for-Service, with Wide Variation among States; 2015 Medicaid Survey Data Suggest Millions Remain in These Arrangements

The most recent CMS data available show that 41 percent of about 71 million beneficiaries nationwide were served through FFS arrangements as of July 1, 2014.[32] About 21 million of the almost 29 million beneficiaries in these arrangements were served through traditional FFS, while another 7 million were enrolled in PCCM.

Among states, the percentage of beneficiaries in FFS arrangements varied widely, ranging from 0 to 100 percent (fig.1). In 22 states, the majority of Medicaid beneficiaries were served through FFS arrangements. Together, these states accounted for 55 percent, or almost 16 million, of all beneficiaries in FFS nationwide. The 22 states were evenly divided between those in which all or nearly all beneficiaries were in some type of FFS arrangement and those in which some beneficiaries were enrolled in managed care.[33] For a few of the latter states, enrollment of beneficiaries in managed care was relatively recent. For example, both Iowa and Louisiana began enrolling beneficiaries in managed care in 2012, and North Dakota began doing so in January 2014.

[32]The enrollment figures reported here are for the 51 states; for the purposes of this report, we refer to the District of Columbia as a state. These figures do not include enrollment in the five U.S. territories. Of the five, only Puerto Rico reported enrollment data, showing 1.5 million beneficiaries, all of whom were enrolled in risk-based managed care. Florida reported enrollment as of August 1, 2014. Washington reported the numbers of beneficiaries enrolled at any time during July 2014.

[33]We characterized 5 of the 22 states as having nearly all beneficiaries in FFS arrangements because these states served more than 99 percent of beneficiaries through these arrangements and less than .001 through PACE.

Figure 1: Percentage of Medicaid Beneficiaries in Fee-for-Service (FFS) Arrangements, by State, as of July 1, 2014

Map legend:
- Group 1
- Group 2
- Group 3
- Group 4
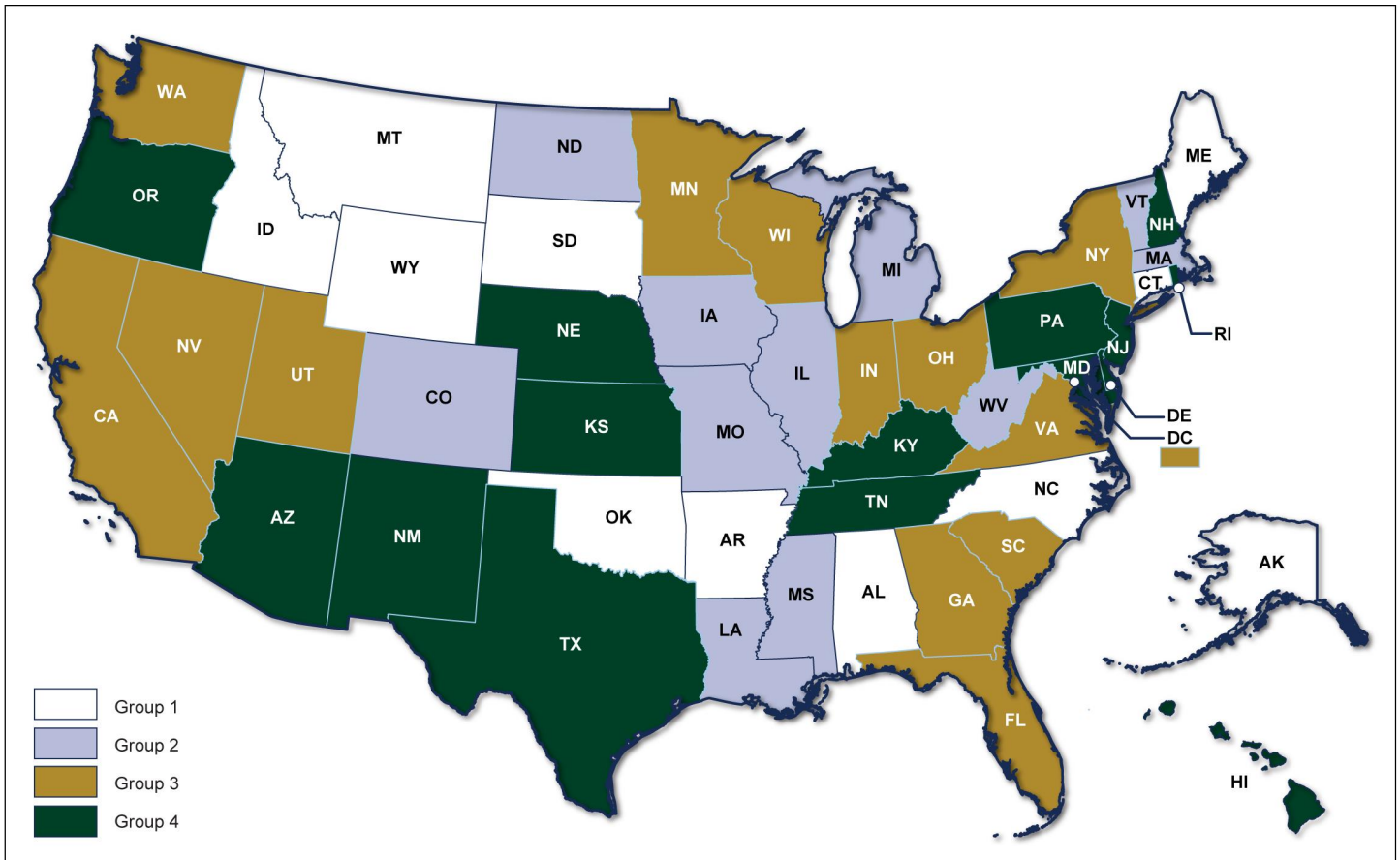
Predominately FFS arrangements (>50% of beneficiaries in FFS)		Predominately managed care (<50% of beneficiaries in FFS)	
Group 1 100% FFSa	**Group 2** 53-94% FFS	**Group 3** 25-45% FFS	**Group 4** 0-24% FFS
• 11 states	• 11 states	• 14 states	• 15 states
• 5.9 million beneficiaries in FFS arrangements	• 9.8 million beneficiaries in FFS arrangements	• 10.3 million beneficiaries in FFS arrangements	• 2.8 million beneficiaries in FFS arrangements
• 8 states serving most beneficiaries through primary care case management (PCCM)	• 7 states with widely varying enrollment in PCCM	• 3 states serving a small fraction of beneficiaries through PCCM	• 1 state serving a small fraction of beneficiaries through PCCM
• 3 states with all or nearly all beneficiaries in traditional FFS			• 2 states with all or nearly all beneficiaries in managed care

Source: GAO analysis of CMS and Washington state Medicaid data. Map Resources (map). | GAO-16-809

Notes: FFS arrangements include both traditional FFS and PCCM. Managed care refers to comprehensive risk-based managed care and includes care provided through managed care organizations and Programs of All-Inclusive Care for the Elderly (PACE). PACE is a provider-based

program that serves frail, elderly individuals with the goal of keeping them in the community rather than in long-term care institutions as long as medically and socially feasible. Florida reported enrollment as of August 1, 2014. Washington reported the numbers of beneficiaries enrolled at any time during July 2014.

[a]Five of the 11 states shown as having 100 percent of beneficiaries in FFS arrangements operated PACE programs, serving less than .001 of beneficiaries.

In the remaining 29 states, the majority of Medicaid beneficiaries were enrolled in managed care. But in many of these states, the percentage of beneficiaries in FFS or PCCM was still sizeable—more than 20 percent in 19 states and more than 30 percent in 9. Beneficiaries not enrolled in managed care in these states were primarily in traditional FFS, rather than PCCM.

The Medicaid Survey data suggest that millions of beneficiaries were still in FFS arrangements as of July 1, 2015. Although exact enrollment is unknown, all 11 states that reported serving all or nearly all beneficiaries through FFS arrangements in 2014—and which together accounted for 5.9 million beneficiaries at that time—reported the same in 2015.[34] In addition, 27 other states reported that at least 20 percent of beneficiaries were receiving services through some type of FFS arrangement in 2015.[35]

However, the Medicaid Survey data also suggest that the proportion of beneficiaries in FFS arrangements is declining, as states continue to move populations from a FFS delivery model into managed care. These data show 15 states with FFS as the predominant service delivery arrangement, compared with the 22 states reported in the 2014 CMS data.[36] A few states reported significantly lower percentages of beneficiaries in FFS arrangements than previously. For example, Louisiana, which eliminated PCCM in early 2015, reported 29 percent of beneficiaries in FFS arrangements as of July 1, 2015, compared with 68 percent a year earlier. At least 5 states, including Iowa and North Carolina, have expanded or begun managed care enrollment since the Medicaid Survey was conducted in 2015 or planned to do so within the next few years.

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[34]In the Medicaid Survey, states reported only the percentages of beneficiaries in different service delivery arrangements as of July 1, 2015, not the number of beneficiaries.

[35]These 27 states accounted for more than 50 million beneficiaries as of July 1, 2014.

[36]In addition, the Medicaid Survey data show 20 states with fewer than 25 percent of beneficiaries enrolled in FFS, compared with the 15 states in the 2014 CMS data.

Beneficiaries with Disabilities Were among Those Most Likely to Be Served Through FFS Arrangements

The 2015 Medicaid Survey data indicate that individuals with disabilities and aged individuals, who were reported together as one group, were the most likely to be served through FFS arrangements.[37] While the vast majority of aged beneficiaries likely had both Medicare and Medicaid coverage, beneficiaries with disabilities were much more likely to rely solely on Medicaid for coverage of acute care services.[38] Historically, many states have served beneficiaries with disabilities through FFS arrangements rather than managed care, in part to ensure that these vulnerable beneficiaries have access to a range of providers (some of whom might not have participated in managed care). While this trend is changing and states are increasingly enrolling individuals with disabilities in managed care, along with those whose complex health care needs require long-term services and supports, some states with managed care still serve all or most individuals with disabilities through FFS arrangements. According to Medicaid Survey data, of the 39 states with managed care as of July 1, 2015, 6 had enrolled no aged or disabled beneficiaries in managed care, and another 7 had enrolled fewer than one-third of these beneficiaries.

Children with special health care needs and certain other populations also were more likely to be served through FFS arrangements, because states were less likely to require or permit these populations to enroll in managed care. For instance, 9 of the 41 states with managed care in 2014 did not require or permit children with special health care needs to enroll in managed care, and another 9 states made enrollment voluntary for this group, according to CMS data. Other populations that some states served through FFS arrangements rather than managed care included children in foster care or adoption assistance, Native Americans and

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[37]Although disabled and aged beneficiaries were disproportionately in FFS arrangements, they likely constituted a minority of beneficiaries in these arrangements because they were a minority of Medicaid beneficiaries (an estimated 25 percent in fiscal year 2014).

[38]In 2012, about 90 percent of aged Medicaid beneficiaries were dually eligible for Medicare, compared with about 40 percent of Medicaid beneficiaries with disabilities. Dual-eligible beneficiaries are covered under Medicare for most acute care services and may be covered under Medicaid for long-term nursing facility care and home and community-based services. These beneficiaries may also qualify for payment of Medicare premiums and cost sharing.

Alaska Natives, and individuals who were eligible for only partial benefits, such as family planning services.[39]

In contrast, the 2015 Medicaid Survey data indicate that adults newly eligible under the Medicaid expansion made possible by PPACA were among the least likely to be in FFS arrangements. Twenty-nine states had exercised the option to expand Medicaid eligibility as of July 1, 2015. In 23 of those expansion states, fewer than 25 percent of adults newly eligible under the expansion were in FFS arrangements.[40] In states with managed care, the only beneficiaries as unlikely to be in FFS arrangements as expansion adults were non-disabled children.[41]

A Few Federal Resources Exist to Help Fee-For-Service Beneficiaries Find Providers; Selected States' Resources Vary

Although CMS and states consider the provision of resources to help beneficiaries locate a provider to be primarily a state role, CMS has provided a few resources to help beneficiaries. While most states generally have developed common resources, the scope of information that these resources provide, and the availability of resources among states, varies. Telephone helplines are the primary resource that beneficiaries use to report challenges in finding a provider.

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[39]Other beneficiaries who continue to be served through FFS arrangements in states with managed care include beneficiaries in rural or other geographic areas where managed care organizations do not operate; beneficiaries in areas where enrollment is voluntary because only one managed care plan is offered; beneficiaries residing in institutions; and individuals who qualify as "medically needy."

[40]Of the other six states, three were entirely FFS.

[41]Of the 39 states with managed care as of July 1, 2015, 32 served fewer than 25 percent of children through FFS arrangements.

Although States Play a Primary Role in Helping Fee-For-Service Beneficiaries Find Providers, CMS Has Provided a Few Resources

The development of resources to help Medicaid beneficiaries find a provider is primarily a state role, according to federal and state officials. CMS officials told us that states have the flexibility to operationalize resources as they see fit to meet state-specific needs and that resources are likely to vary among states as a result of this flexibility. Medicaid officials we interviewed from the six selected states agreed with CMS's view and noted that none of their states had requested assistance from CMS around developing resources for beneficiaries to help them find a provider.

The Dentist Locator on the Insure Kids Now website is the only federal resource that aims to directly assist Medicaid beneficiaries in locating a provider. CMS developed the Dentist Locator in partnership with the Health Resources and Services Administration to meet a requirement of the Children's Health Insurance Program Reauthorization Act of 2009.[42] The web-based tool allows beneficiaries to locate nearby dentists that treat children in Medicaid and the State Children's Health Insurance Program and to identify which providers are accepting new patients, speak languages other than English, and are able to provide support for patients with special health care needs.[43]

In addition to the Dentist Locator, CMS also provides state Medicaid agencies with a few suggested outreach messages through its "Helping Connect Enrollees to Care" initiative.[44] The initiative does not give detailed information on developing resources to help beneficiaries find a provider; instead, it provides general messaging for use on state Medicaid websites or in materials given to new enrollees to (1) help new enrollees establish a regular source of health care and (2) promote use of

[42]Pub. L. No. 111-3, § 501(f), 123 Stat. 8, 88 (2009). The Health Resources and Services Administration also runs the Insure Kids Now telephone hotline.

[43]Prior GAO work has identified incomplete or inaccurate provider information in the Dentist Locator. See GAO-11-96. Since our report, CMS has taken some steps to improve the information in the Dentist Locator including testing the accuracy of the data and modifying state reporting processes to ensure updated provider information is captured. GAO made several recommendations to CMS regarding the Dentist Locator and CMS has addressed most of them.

[44]Centers for Medicare & Medicaid Services, "Helping Connect Enrollees to Care," accessed June 17, 2016, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-tools/helping-connect-enrollees-to-care/helping-connect-enrollees-to-care.html.

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preventive health care services. Specifically, CMS's suggested outreach messages instruct beneficiaries to ask their provider if they accept Medicaid, visit their state's Medicaid website, or call their state Medicaid agency for information on finding a doctor. The initiative also directs beneficiaries looking for a pediatric dentist to visit the Insure Kids Now Dentist Locator.

States Generally Have Resources to Help Beneficiaries Find a Provider, but Scope of Information and Availability of the Resources Varies

The 23 states we reviewed generally offered four common types of resources—searchable provider directories, nonsearchable provider lists, handbooks, and telephone helplines—to help beneficiaries in FFS arrangements find a provider, with variation across states in the scope of information they provided and how they addressed the needs of specific Medicaid populations through their resources.[45] Twenty-one of the 23 states provided searchable provider directories or nonsearchable provider lists that contain contact information for providers who see Medicaid beneficiaries (see fig. 2).[46] All of the 23 selected states had a publicly available beneficiary handbook or brochure containing information about the Medicaid program and operated a statewide telephone helpline that allows beneficiaries to contact a Medicaid representative by telephone—either at the state Medicaid office or through a contractor—who can answer questions and provide information on a variety of topics.[47] Officials from all 6 state Medicaid agencies we interviewed told us they generally developed resources as a way to help beneficiaries access covered Medicaid services.

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[45]We examined resources in 23 of the 25 states that use FFS arrangements to deliver care to at least 30 percent of their Medicaid population as of July 2015, based on the 2015 Medicaid Survey data.

[46]A provider directory is considered searchable if a beneficiary can input data into a search field to yield related results. Nonsearchable provider lists are posted on (or downloadable from) a state's Medicaid website and do not allow the user to input search data.

[47]For the purposes of this report we will refer to all statewide telephone helplines as helplines.

Figure 2: Provider Information and Helplines in 23 Selected State Fee-for-Service (FFS) Medicaid Arrangements

	Provider information				Beneficiary helplines	
	Searchable provider directory	Non-searchable provider list	Information on specialty providers	Indicates if providers are accepting new patients	Indicates it can help beneficiaries find providers	Operates outside of business hours
Alabama	No	Yes	No	No	Yes	No
Alaska	Yes	No	No	No	Yes	No
Arkansas	Yes	No	Yes	No	Yes	No
Colorado	Yes	No	Yes	No	Yes	Yes
Connecticut	Yes	No	Yes	Yes	Yes	Yes
Georgia	Yes	No	Yes	Yes	No	No
Idaho	Yes	Yes	Yes	Yes[a]	Yes	No
Illinois	Yes	No	Yes	Yes	Yes	Yes
Maine	Yes	No	Yes	No	Yes	No
Massachusetts[b]	No	No	No	No	Yes	No
Mississippi	Yes	No	Yes	No	No	No
Missouri	Yes	Yes	Yes	No	Yes	No
Montana	Yes	No	Yes	No	Yes	Yes
Nevada	Yes	No	Yes	No	No	Yes[c]
North Carolina	No	Yes	Yes	Yes	No	No
North Dakota	Yes	No	Yes	No	No	No
Oklahoma	No	Yes	No	No	Yes	No
South Dakota	No	Yes	No	No	Yes	No
Utah	No	No	No	No	Yes	No
Virginia	Yes	No	Yes	No	Yes	No
West Virginia	Yes	No	Yes	Yes	Yes[d]	No
Wisconsin	Yes	No	Yes	No	Yes	No
Wyoming[e]	Yes	No	Yes	No	No	Yes

State had primary care case management (PCCM), in addition to traditional FFS, as of August 2014 — Yes

State had traditional FFS only — No

Source: GAO analysis. | GAO-16-809

[a]Only Idaho's nonsearchable provider list indicates if the provider is accepting new patients.

[b]Massachusetts does not have a searchable directory that includes primary or specialty care physicians, but it does have a searchable directory listing Medicaid dental providers.

[c]Nevada operates a nurse helpline outside of business hours for PCCM beneficiaries only. There is not an after-hours helpline for beneficiaries served exclusively through traditional FFS.

[d]West Virginia operates a general helpline for FFS beneficiaries and a separate helpline for beneficiaries enrolled in a PCCM or managed care arrangement. The general helpline for FFS beneficiaries did not have a listed purpose of helping beneficiaries find a provider and may not serve this function; only the helpline for beneficiaries in PCCM and managed care arrangements listed this purpose.

[e]Wyoming received approval to operate PCCM in September 2014. The resources listed in the table, including the provider directory, are for general Medicaid providers in the traditional FFS arrangement.

The scope of information offered and the functionality of these common resources varied:

- **Searchable provider directories:** Seventeen of the 23 selected states had online, searchable provider directories, and 16 of these included provider information on specialty care physicians. Four of the 23 selected states' searchable directories indicated whether providers (primary or specialty care) were accepting new patients. Additionally, of the 15 states with PCCM, 10 offered provider information (primary and specialty care) to beneficiaries through searchable provider directories. Although we did not evaluate the accuracy of the provider information itself, we identified errors in 8 of the 16 provider directories from our 23 selected states. These errors included duplication errors where identical provider information appeared more than once in a page of search results, functionality errors where the search tool did not work as indicated in the instructions, and missing data errors where multiple provider listings had more than two fields of data missing.[48]

- **Nonsearchable provider lists:** Six of the 23 selected states had nonsearchable lists containing provider contact information, and 2 of these included contact information for participating specialty care physicians. Provider lists from 2 of these states indicated whether a provider was accepting new Medicaid patients.[49] Additionally, of the 15 states with PCCM, 5 offered primary care information to beneficiaries through nonsearchable provider lists and 1 of these lists also provided information on specialty care providers. Beneficiaries in PCCM gain access to specialty care physicians through referrals from their primary care physician.[50]

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[48]We considered a directory as having a duplicate error if the same provider was listed more than once at the same address on the first page of search results. We considered a directory as having a functionality error if the search function did not work correctly (e.g., the instructions state a user can search using just zip code or city/state, but searching using those fields results in an error message to complete more fields). We considered a directory as having persistent missing data fields if multiple individual listings in a search had more than two missing fields of information (e.g., hours of operation, accepting new patients, accepted age ranges).

[49]Massachusetts and Utah have neither searchable directories nor nonsearchable provider lists.

[50]State Medicaid agencies or states' PCCMs are required to give beneficiaries enrolled in PCCM arrangements contact information for nearby providers, but online provider directories or lists are not required. 42 C.F.R. § 438.10(f)(6)(i) (2015).

- **Beneficiary telephone helplines:** All states operated a helpline and six operated outside of regular business hours.[51] Seventeen of the 23 states explicitly stated that the helplines could assist beneficiaries in finding or changing providers on the state's Medicaid website or in the beneficiary handbook. For example, the Connecticut handbook notes that beneficiaries can call member services for help with finding a provider, making appointments, and choosing or changing a primary care provider. Without such an explicit statement from the states, beneficiaries may not know they can use the helpline to get assistance in finding a provider.

States may face challenges maintaining accurate provider information within the resources developed. Medicaid officials in four states, along with three beneficiary advocacy groups, told us that resources—mainly directories and lists—are not useful if the provider information in them is not accurate. Officials from one state commented that provider information is only a "snapshot in time" and that maintaining accuracy is challenging because, in their directory, providers are responsible for updating their own information. An official from another state attributed that state's decision not to create a provider list for FFS beneficiaries to the challenging process of determining if a provider will accept new Medicaid patients.

Many of the 23 states we reviewed adapted existing resources, or developed additional resources, to target specific beneficiary needs. For example, 9 of the 23 states include a mapping or location feature with their provider directories or lists to help beneficiaries determine the travel distance to a provider. In addition, 8 of the 23 states include information on languages spoken by providers in their provider directories or lists to assist non-English speaking beneficiaries. Some of the 6 states we interviewed have added elements to existing resources to improve them, others have developed new resources to address specific population needs and make resources easier to use, as the following examples illustrate:

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[51]This number does not include the contracted primary care physicians receiving a monthly case management fee that are required to provide 24/7 telephone services to beneficiaries in states with PCCM.

Mobile application

In Colorado, the state Medicaid agency developed a mobile application for Medicaid beneficiaries that contains the same searchable provider directory as the Medicaid website as well as additional information about Medicaid benefits. State Medicaid officials told us they developed the application as a communication tool to reach young adults, the beneficiary population that grew the most following Colorado's decision to expand Medicaid eligibility under PPACA.[52]

Source: GAO-16-809

Figure 3: Medicaid Mobile Application
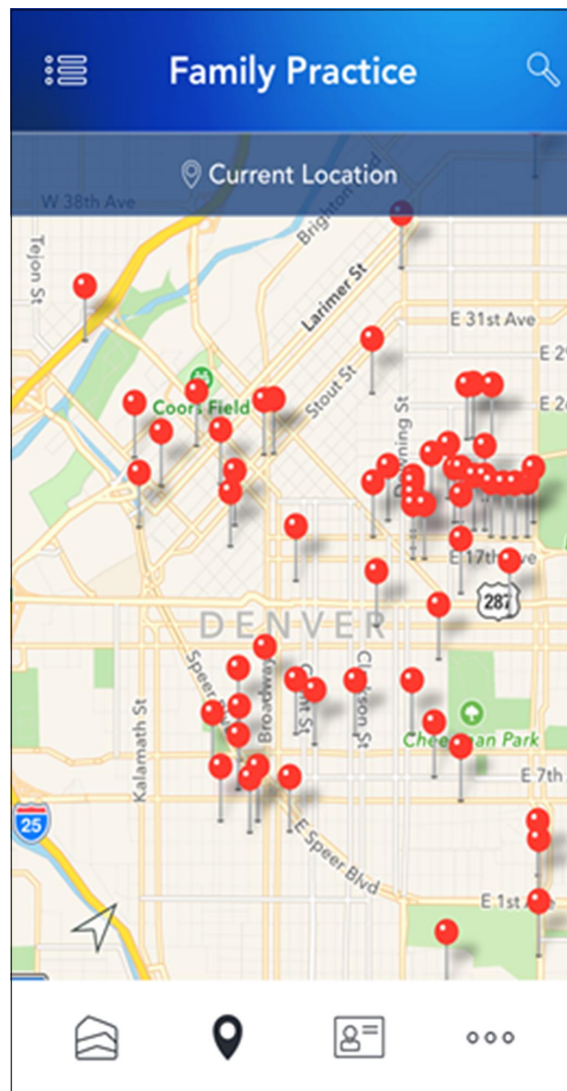
Source: Colorado Department of Health Care Policy and Financing. | GAO-16-809

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[52]As mentioned before, under PPACA, states may opt to expand eligibility for Medicaid to individuals at or below 138 percent of the federal poverty level, with additional federal funding available for this expansion population beginning in January 2014.

Figure 4: After-Hours Medicaid Provider Locator

After-Hours locator

In Oklahoma, the state Medicaid agency developed an after-hours provider locator to help beneficiaries locate Medicaid providers in their area who are available outside of business hours. Oklahoma Medicaid officials told us all providers listed on the site have agreed to see Medicaid patients after hours. They noted that providers receive a higher reimbursement for services provided after-hours.

Source: GAO-16-809

Oklahoma HealthCare Authority   AFTER HOURS PROVIDER LOCATOR

Zip code:

Age:

Radius: 20 miles

Source: Oklahoma Health Care Authority. | GAO-16-809

Figure 5: Covered Services Quick Guide

HUSKY Health Program Covered Services

Medical Services:
Your doctor is the first stop for all your medical needs, such as:
- Medical check-ups
- When you are sick
- Immunizations or "shots"
- Laboratory tests, including blood tests, and X-rays

Find a primary care provider (PCP) in the Provider Directory at www.huskyhealth.com.

Behavioral Health Services: www.ctbhp.com
The Connecticut Behavioral Health Partnership (CT BHP) can help you find the mental health and/or substance abuse services you need.

CT BHP Phone Number:
- 1.877.552.8247 Monday through Friday, 9 a.m. to 7 p.m.
- The number if you are deaf or hard of hearing is 711 or 1.866.218.0525.

Pharmacy:
Pharmacy services and medicines that need a prescription are covered under the HUSKY Health program.

Connecticut Pharmacy Assistance Program phone number:
- 1.866.409.8430 Monday through Friday, 8 a.m. to 5 p.m.
- The number if you are deaf or hard of hearing is 711 or 1.866.604.3470.

Translation and American Sign Language Services:
Our Member Services staff can:
- Call an interpreter line
- Translate any written material into the language you speak
- Print materials in a larger font
- Copy materials into Braille

Contact Member Services for assistance regarding interpretation services:
- 1.800.859.9889 Monday through Friday, 8 a.m. to 6 p.m.
- The number if you are deaf or hard of hearing is 711.

Vision:
Services include medical equipment/supplies, eye exams, and eyeglasses.

Find an eye doctor in the Provider Directory at www.huskyhealth.com.

Dental: www.ctdhp.com
The Connecticut Dental Health Partnership (CTDHP) can help you find a dentist to provide dental services.

CTDHP Phone Number:
- 1.855.283.3682 Monday through Friday, 8 a.m. to 5 p.m.
- The number if you are deaf or hard of hearing is 711.

Non-Emergency Medical Transportation:
https://memberinfo.logisticare.com/ctmember/Home.aspx
If you do not have transportation, LogistiCare is the company that arranges transportation to HUSKY members who need help getting to their medical appointments. You must request assistance in advance of your appointment.

LogistiCare Phone Number:
- 1.888.248.9895 Monday through Friday, 8 a.m. to 6 p.m.
- The number if you are deaf or hard of hearing is 711.

To view your handbook online or find a doctor/provider for any service:
Go to www.huskyhealth.com ➡ For Members
or
Call Member Services at 1.800.859.9889 Monday through Friday, 8 a.m. to 6 p.m.
The number if you are deaf or hard of hearing is 711.

The HUSKY Health Program Has Gone Social
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Source: Connecticut Department of Social Services. | GAO-16-809

Telephone Helplines Are the Primary Resource for Beneficiaries to Report Challenges Finding a Provider

Medicaid officials we interviewed in four of the six states and representatives from advocacy groups in three of the six states noted that helplines are the primary resource beneficiaries use to report issues finding a provider. When beneficiaries contact helplines, they can be directed to additional resources—beyond those listed in the above sections—to address their complaint. Other resources and approaches to address beneficiary complaints about finding a provider vary by state. These resources include using on-staff providers (nurses, psychiatrists, and dentists) to make referral requests to their peers in the medical community and escalating complaints to an ombudsman for one-on-one-service.[53]

States used different approaches to document and track the beneficiary complaints they received about finding a provider and access challenges more broadly.[54] While state approaches varied, all state Medicaid officials in the six states where we conducted interviews told us they track beneficiary complaint data in some way. In one state, officials told us the data were tracked in a spreadsheet and that one administrative employee typically handles calls about access challenges. Another state collected trend data from a statewide helpline and several more specialized call centers.[55] Medicaid officials in all six states told us they had not established a number, or threshold, of complaints that triggered state action (state actions could include providing incentives to recruit providers, creating an ombudsman service, developing a telemedicine program, etc.) on specific access issues. An official from one state told us that the process of identifying a widespread access issue (e.g., a shortage of dental providers) can be subjective due to the variety of ways complaints are classified. Under CMS's rule, states must have ongoing mechanisms for beneficiary and provider input on access to care (through

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[53]An ombudsman acts as a fair and impartial party to help Medicaid beneficiaries understand their rights and responsibilities, represent beneficiary rights with the state Medicaid agency, and to help research and resolve beneficiary grievances about the care or services provided.

[54]Access challenges include not only locating a provider willing to accept new Medicaid patients but also being able to make an appointment and travel to the provider in a reasonable amount of time. See appendix I for a discussion of additional state actions that address other access challenges such as provider shortages. For previous GAO work on access to care in the Medicaid program, see GAO-15-677 and GAO-13-55.

[55]The other call centers included 7 regional organizations that administer Medicaid and a statewide medical advice help line operated by nurses.

hotlines, surveys, ombudsman, review of grievance and appeals data, or other equivalent mechanism). States are required to maintain a record of the input they receive and how they responded. They must also provide this information to CMS upon request. Medicaid officials in the six states told us that they were still determining how they will adjust their approaches to identifying and responding to access to care challenges—such as issues locating a provider—to comply with CMS's rule.

Agency Comments

We provided a draft of this report to HHS for comment. The department provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of the report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of the report. GAO staff who made key contributions to this report are listed in appendix II.

Katherine M. Iritani
Director, Health Care

Appendix I: Additional State Actions to Address Access Challenges

Consistent with our prior work, which noted that over two-thirds of states reported challenges to ensuring enough Medicaid providers to serve beneficiaries, state Medicaid officials and beneficiary advocacy groups we interviewed identified specific state actions that attempt to address certain access challenges.[1] Several state Medicaid officials and advocacy groups noted that provider shortages, proximity to participating providers, and transportation, among other things, were more directly related to access challenges than resources for finding a provider. Several states have initiated efforts to address these challenges, including the following examples:

- In Oklahoma, Medicaid officials have started using telemedicine to help address the shortage of child and adolescent psychiatrists in the state.[2]

- In Connecticut, Medicaid officials require the administrative service organizations to perform and present annual geo-access analyses. A geo-access analysis is a visual mapping of provider locations to help identify potential access issues due to remoteness of beneficiaries.

- Utah's state legislature passed a law in 2016 to create state income tax credits for psychiatrists and psychiatric mental health nurse practitioners, under certain circumstances, to help recruit those providers to the state.[3]

While some states are addressing access challenges with statewide efforts, several state Medicaid officials and advocates in the 6 states we interviewed commented that challenges locating a provider can be community-specific at the county or city level and noted that federally qualified health centers, local health departments, or community health workers are points for both disseminating information about resources

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[1]GAO, *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance,* GAO-13-55 (Washington, D.C.: Nov. 15, 2012

[2]Telemedicine is the use of medical information exchanged from one site to another via electronic communications (such as video or e-mail) to improve a patient's clinical health status through, for example, provision of health care services or clinical monitoring.

[3]The law, Mental Health Practitioner Amendments (H.B. 265), takes effect for a taxable year beginning on or after January 1, 2017.

and for identifying and mitigating local access challenges. Additionally, some communities are developing resources to tackle specific access challenges in their area. For example, an alliance of health care stakeholder organizations in Denver is preparing to pilot the use of a specialty care referral network to address the difficulties underserved residents in the area face in finding specialty care physicians. The proposed network will help streamline referrals from primary care physicians to specialists and will allow for electronic consultation between the two about a patient's treatment.[4]

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[4]Electronic consultations are electronic, medical consultations that allow primary care and specialty care providers to quickly exchange clinical questions, messages, and share patient medical records through a secure online telemedicine system.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Katherine M. Iritani, (202) 512-7114 or iritanik@gao.gov

Staff Acknowledgments

In addition to the contact named above, Leslie V. Gordon, Assistant Director; Dan Klabunde, Analyst-in-Charge; Summar Corley; Christine Davis; Nancy Fasciano; Laurie Pachter; and Emily Wilson made key contributions to this report.

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