Access Monitoring Review - 2016

State of Idaho

Idaho Department of Health & Welfare

Division of Medicaid

Overview

New Federal Rules for Monitoring Access

As a result of new federal rules published by the Centers for Medicare and Medicaid Services (CMS), Idaho Medicaid developed a plan to measure and monitor participants' access to fee-for-service care. The plan follows CMS's guidance for defining and measuring access using paid claims data that is available to state Medicaid programs. When states use the same measures, there is common ground for understanding access across the nation.

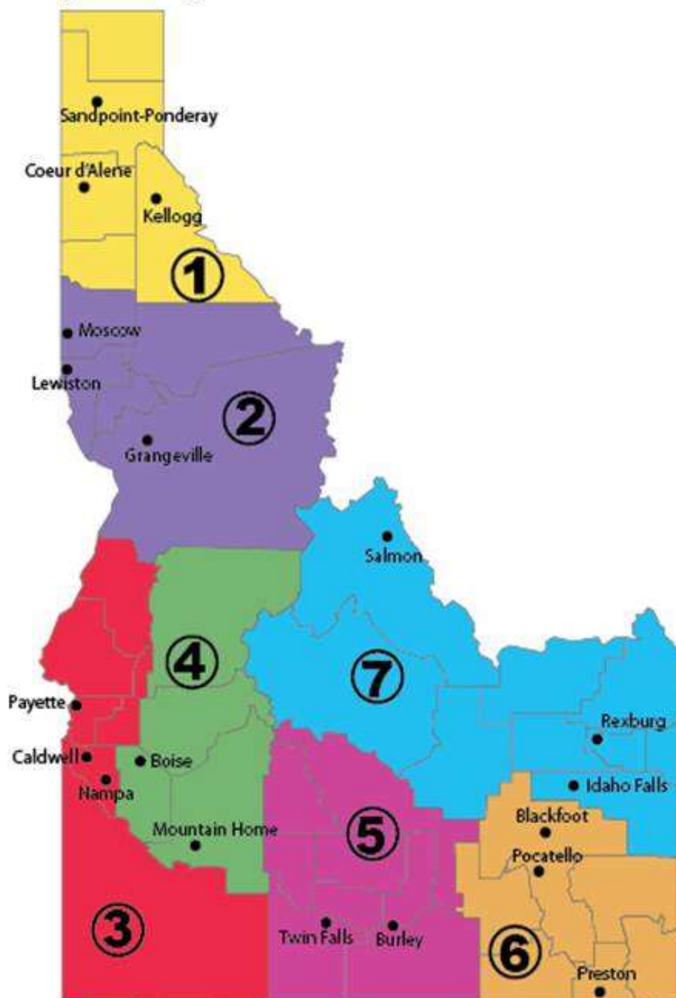
As part of the plan, Idaho Medicaid must submit an Access Monitoring Review report to CMS at least every three years. Idaho Medicaid plans to seek feedback about access from participants and providers in order to identify emerging access issues and to inform the results of future reports.

This report, the Access Monitoring Review - 2016, describes the methods that were used to measure access and what the first review results using these methods have revealed about access to fee-for-service care. In future reports, which will be available for public review and comment, the findings for these measures will be compared to those from the previous year in order to analyze and monitor trends, which will inform how access to services changes for participants over time.

Idaho Medicaid

In accordance with Titles XIX and XXI of the Social Security Act and state statute, Idaho's Medicaid program administers comprehensive healthcare coverage for low-income families including children, pregnant women, the elderly, and people with disabilities. The Medicaid program is operated through the Idaho Department of Health and Welfare's (IDHW) Division of Medicaid. The program served approximately 280,000 participants per month during calendar year 2014. The total amount of money spent on fee-for-service claims during 2014 was approximately $1.5 billion. To facilitate program operations, Idaho Medicaid operates on a regional level. The state is organized into seven regions, as shown in Figure 1 below.

Figure 1: Idaho Department of Health & Welfare: Regional Map



The state of Idaho is a northwestern, rural state. Census estimates for 2014 place Idaho's total population at 1.6 million[1] and 2010 Census data placed Idaho at 46th in the nation for population density, with approximately 19 people per square mile[2].

The Association of American Medical Colleges ranked Idaho 49th in the nation for active physicians for every 100,000 people and 46th for active primary care physicians for every 100,000 people[3]. The U.S. has approximately 265.5 physicians and 91.1 primary care physicians for every 100,000 people. By comparison, Idaho had 189.6 (71% of the national average) active physicians and 72.1 (79% of the national average) active primary care physicians per 100,000 people[3].

According to the U.S. Department of Health & Human Services' Health Resources and Providers Administration, Idaho has 256 health professional shortage areas and 44 medically underserved areas/populations[4]. Figure 2 below shows a map of the primary care health professional shortage areas in Idaho. The map is produced by the IDHW Bureau of Rural Health & Primary Care in the Division of Public Health[5].

Figure 2: Idaho Primary Care Health Professional Shortage Areas

Methods for the Access Monitoring Review 2016

In accordance with 42 CFR 447.203, Idaho Medicaid developed an access monitoring review plan to measure and monitor indicators of healthcare access to ensure that its participants have access to care that is comparable to the general population. The plan considers the availability of Medicaid providers, use of Medicaid services, and the extent to which Medicaid participants' healthcare needs are fully met. The information includes descriptions of the data, measures, and methods used.

The data analysis was conducted for the following service categories provided under a fee-for-service arrangement:

- Primary care
- Physician specialists
- Pre-/postnatal obstetrics
- Home health

Although behavioral health services are also covered in 42 CFR 447.203, Idaho Medicaid delivers outpatient behavioral health services through a managed-care contract. Managed care is not covered in 42 CFR 447.203; therefore, those services are not included in the access monitoring plan and review.

Idaho Medicaid chose to conduct its access monitoring review using provider specialty, which categorizes providers into service categories, to define the service groups. This is not a perfect method of categorization because a provider may treat more than one condition. For example, some participants may have been seen for pregnancy by their primary care provider (PCP), while other participants may choose to have their OB/GYN act as their PCP. However, Idaho Medicaid believes these types of instances are the exception rather than the rule and that using provider specialty is the most accurate method of classifying claims and providers into such service groups.

This Access Monitoring Review report was developed in collaboration with the Medical Care Advisory Committee between March and August of 2016. It will be posted on the IDHW website for public comment from August 18, 2016 through September 17, 2016. Unless otherwise noted, all data comes from the Medicaid Management Information System (MMIS). Idaho Medicaid contracts with Truven Health Analytics to provide Data Warehouse and Decision Support System reporting services. Data was analyzed for 2014 which is the most recent year that Idaho Medicaid had complete data (all claims were paid). Therefore, this report reflects the availability of Medicaid providers, use of Medicaid services, and the extent to which Medicaid participants' healthcare needs were fully met in 2014.

High Level Summary of Results

Analysis of available measures that compared Idaho Medicaid to overall Medicaid and U.S. benchmarks (including private payers), suggest that Idaho Medicaid participants are able to access medical care at a rate similar to or greater than other Medicaid and private payer organizations.

Data was not available to make direct comparisons of utilization between Idaho Medicaid and private Idaho payer organizations.

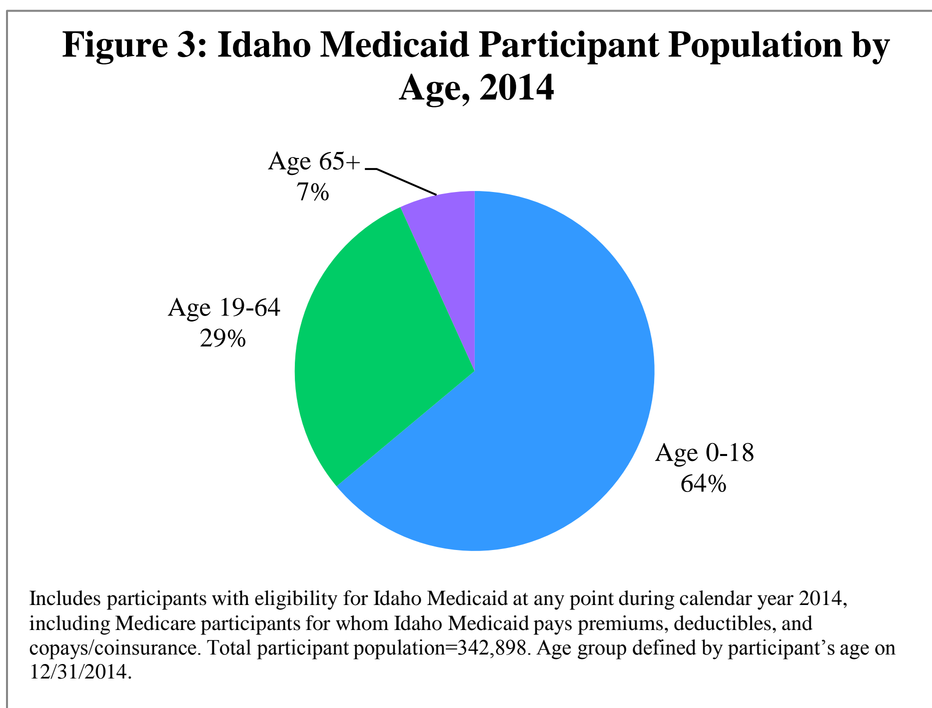
In gauging Idaho Medicaid participants' perceptions about access to care, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey conducted for the Children's Health Insurance Program population suggests most participants were able to access care when needed. In fact, nearly half of respondents ranked Idaho Medicaid as the "Best Health Plan Possible" on a scale from 0-10, and over 80% reported their child was "Usually" or "Always" able to get primary or specialist care as quickly as needed. Because Idaho Medicaid operates a Primary Care Case Management (PCCM) Program, only a very small percentage (2%) of PCP-disenrollments were related to access problems. When such access concerns did result in a PCP-disenrollment, the participant was enrolled with a new PCP without any lapse in PCCM coverage in over 70% of cases. In the participant reported data available to Idaho Medicaid access problems were not substantially reported.

Analysis of the Participant Population

Participant Population

During 2014, the Idaho Medicaid program served approximately 280,000 participants each month and a total of 342,898 unique participants throughout the year. The participants served included all individuals eligible for Medicaid or the Children's Health Insurance Program (CHIP) at any point during 2014. Also included were Medicare participants for whom Idaho Medicaid paid Medicare premiums, deductibles, and copays/coinsurance. Figure 3 shows the age breakout of Idaho Medicaid participants. Age was defined as the participant's age as of December 31, 2014. The majority (64%) of Idaho Medicaid participants were children ages 0-18 and over 90% were under the age of 65.

Figure 3: Idaho Medicaid Participant Population by Age, 2014



Includes participants with eligibility for Idaho Medicaid at any point during calendar year 2014, including Medicare participants for whom Idaho Medicaid pays premiums, deductibles, and copays/coinsurance. Total participant population=342,898. Age group defined by participant's age on 12/31/2014.

Figure 4 shows the distribution of Idaho Medicaid participants by region during 2014. Region was determined by the residence address reported by the participant. Forty percent of Idaho Medicaid participants reported a residence address in Region 3 or Region 4. Region 2 had the smallest proportion of participants, and 5% of participants reported a current residence address out of the state. The reporting system only captures the most recent address for a participant; therefore, the 5% may represent participants who had moved since their eligibility in 2014.

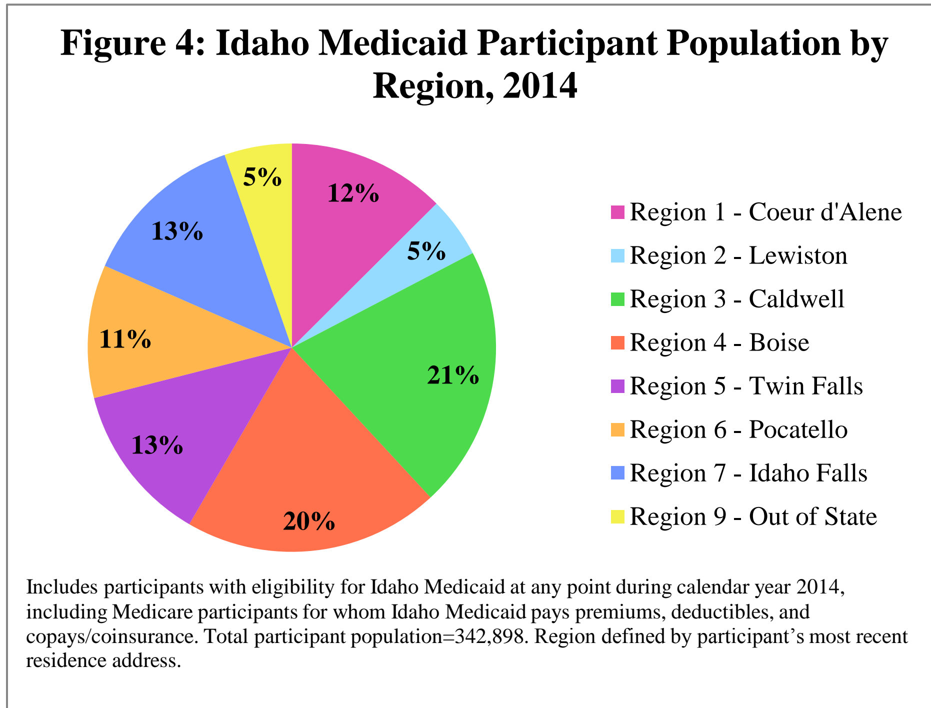
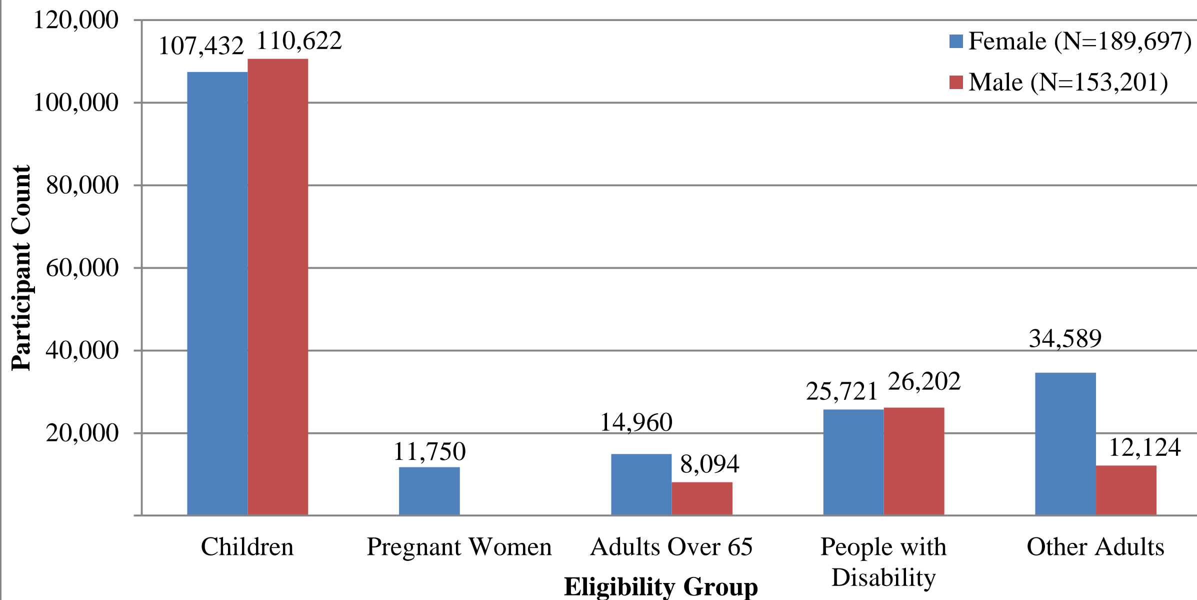


Figure 4: Idaho Medicaid Participant Population by Region, 2014

Includes participants with eligibility for Idaho Medicaid at any point during calendar year 2014, including Medicare participants for whom Idaho Medicaid pays premiums, deductibles, and copays/coinsurance. Total participant population=342,898. Region defined by participant's most recent residence address.

Figure 5 shows the gender and eligibility breakdown of Idaho Medicaid participants during 2014. Eligibility groups were defined by the Idaho Medicaid aid codes used to determine the basis of eligibility. Slightly more Idaho Medicaid participants were female (55%) than male (45%). The largest differences in gender by eligibility group were seen in the "Other Adults" category and for those above the age of 65 (excluding the female-only, pregnant women category).

Figure 5: Idaho Medicaid Participants by Gender & Eligibility Group, 2014



Includes participants with eligibility for Idaho Medicaid at any point during calendar year 2014. Total participant population=342,898. Eligibility groups were defined by the state aid categories. Participants may have had more than one eligibility category during the year and will appear in every category for which they had eligibility. The sums of the eligibility groups may not equal the total participant population during the year.

Utilization of Services by Participants

Figure 6 shows the number of Idaho Medicaid participants who accessed primary care, physician specialist, pre-/postnatal obstetric, and home health providers (defined by Idaho Medicaid provider specialties) throughout 2014. Participants were only counted once for each provider group each month, regardless of the number of times they accessed care during the month. Participants were also counted for every month in which they accessed care. The number of participants accessing primary care and obstetric providers followed very similar trends, and use of both provider groups peaked in October 2014. The number of participants accessing physician specialist providers remained fairly consistent during 2014, and the number of participants accessing home health providers decreased slightly through the year.

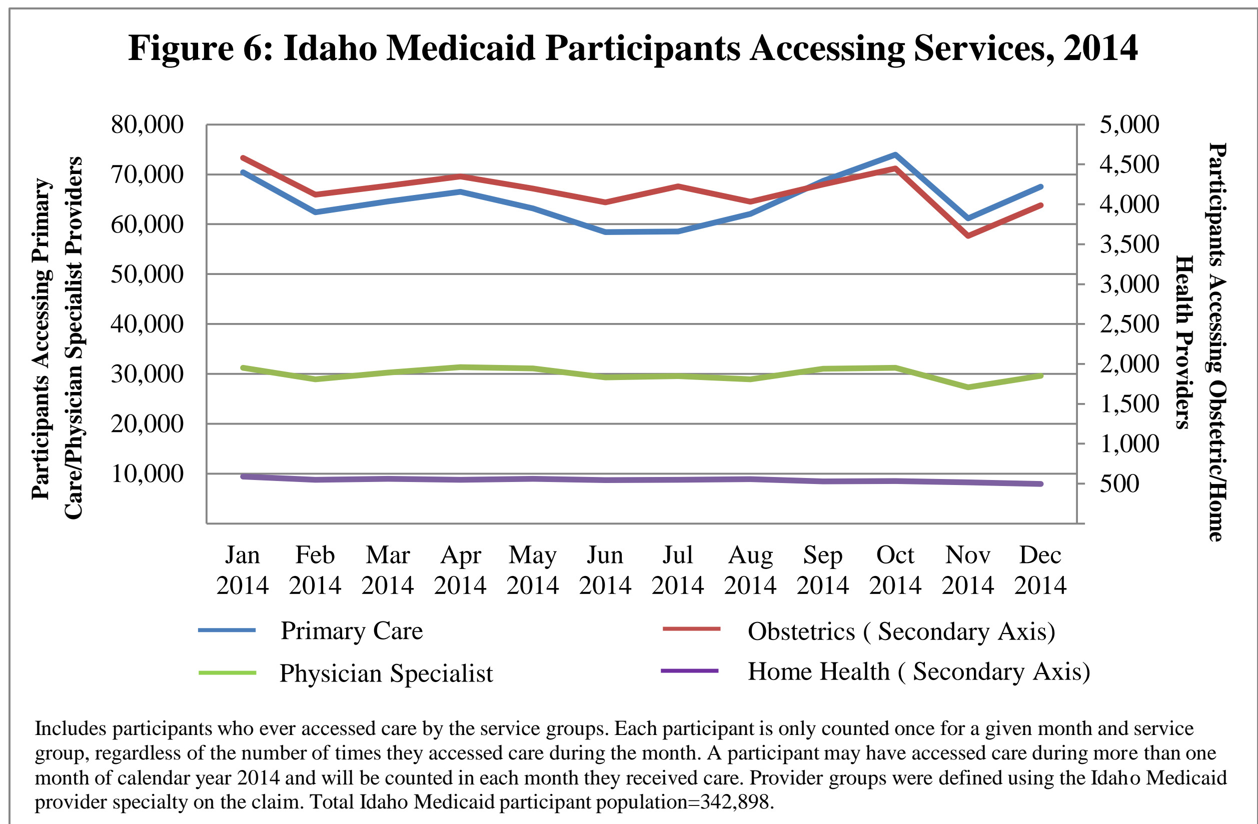


Figure 6: Idaho Medicaid Participants Accessing Services, 2014

Includes participants who ever accessed care by the service groups. Each participant is only counted once for a given month and service group, regardless of the number of times they accessed care during the month. A participant may have accessed care during more than one month of calendar year 2014 and will be counted in each month they received care. Provider groups were defined using the Idaho Medicaid provider specialty on the claim. Total Idaho Medicaid participant population=342,898.

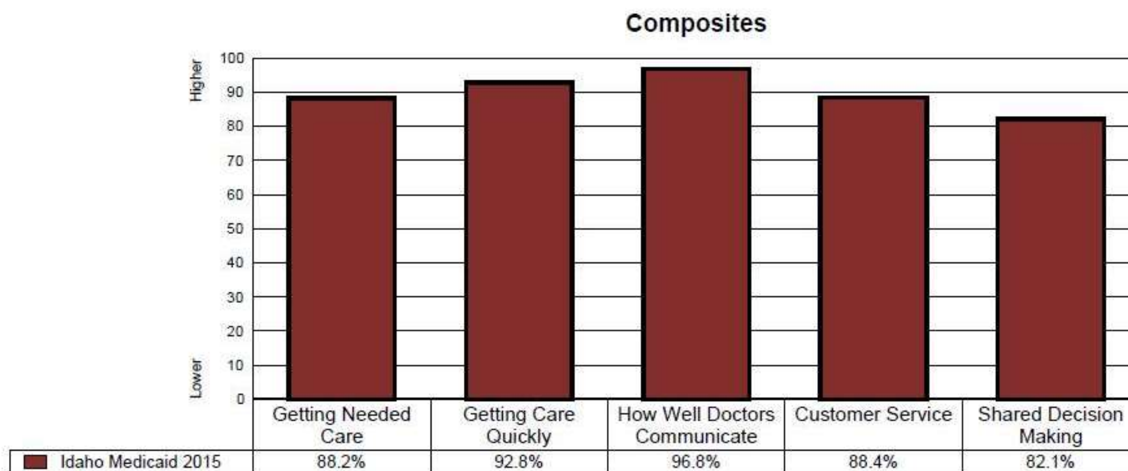
Participant Perceptions of Access to Care

Idaho Medicaid conducts a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey of the state's CHIP population. While the CHIP program does not represent the entire Idaho Medicaid participant population, given the nature of the Idaho Medicaid age distribution (i.e., heavily weighted toward children) and the alignment of Idaho's CHIP state plan services with Medicaid state plan services, the CHIP participants' experiences likely reflect the majority of Idaho Medicaid participants.

The CAHPS® survey was conducted from July 13, 2015, through September 8, 2015. Children enrolled for at least six months as of December 31, 2014, with a gap in enrollment of no more than 45 days, were eligible for the survey. Idaho Medicaid selected a random sample of 1,650 cases and, ultimately, 615 responses were collected.

The composite scores for all five domains shown below (Figure 7) were greater than 82%. The composite for "Getting Needed Care" was 88.2%, and the composite for "Getting Care Quickly" was 92.8%.

Figure 7: Composite Scores from 2015 CAHPS® Survey of Idaho CHIP Population



On individual CAHPS® survey questions, 85% of respondents reported their child had a personal doctor, 95% reported their child was "Always" or "Usually" able to get care when their child needed care right away, and 93% reported their child was "Always" or "Usually" able to get the care, test, or treatment their child needed. For questions regarding specialist care, 17% of respondents reported their child had seen a specialist, and 83% of those respondents reported their child was able to get an appointment with the specialist as soon as they needed one. Overall, nearly half (49%) of respondents ranked Idaho Medicaid as the "Best Health Plan Possible" on a scale from 0-10, and 82.7% ranked Idaho Medicaid as at least an 8 on the 0-10 scale.

Comparing Utilization and Cost of Medical Services to other Medicaid and Private Payer Organizations

In the Decision Support System reporting tool used by Idaho Medicaid, Truven Health Analytics has pre-defined Market Scan benchmark measures. These benchmarks are calculated for Idaho Medicaid data in addition to other state and private insurance organizations that contract with Truven. These benchmarks allow Idaho Medicaid to compare certain usage trends, at the participant level, to an overall Medicaid and U.S. total (which includes private payers) benchmark. The benchmark measures are proprietary to Truven Health Analytics and the number or identity of specific insurance organizations included in them is not available to Medicaid. Nevertheless, they allow Idaho Medicaid to make some comparisons and conclusions.

Table 1 shows the number of participants that accessed any medical care during 2014 per 1,000 total participants with coverage, and the average net payment for medical services for each participant each year. Idaho Medicaid totals are shown along with the most recently available Medicaid and U.S. total benchmarks.

Idaho Medicaid had more participants accessing medical care per 1,000 total participants than the overall Medicaid and U.S. total benchmarks for participants 64 years of age and younger. For participants above the age of 65, Idaho Medicaid had more participants accessing medical services than the Medicaid Benchmark, slightly less than the U.S. total benchmark.

Table 1: Utilization and Net Payment for Idaho Medicaid Participants Compared to Other Medicaid and Private Payer Organizations, 2014.

	Participants Accessing Medical Care per 1,000 Total Participants with Medical Coverage			Net Payment per Participant per Year for Medical Services		
Age Group	Idaho Medicaid	Medicaid Benchmark	U.S. Total Benchmark	Idaho Medicaid	Medicaid Benchmark	U.S. Total Benchmark
0-18	819.1	771.3	755.3	$1,827.15	$3,611.99	$2,095.25
19-64	774.3	705.9	713.8	$7,025.84	$9,142.79	$3,433.03
65 Plus	710.4	465.7	770.4	$9,621.73	$10,012.55	$3,455.30

Medicaid Expenditures

Idaho Medicaid spent less on medical services for participants of all ages than the Medicaid benchmark and less than the U.S. total benchmark for participants under the age of 18. The U.S. total benchmark for medical expenditures for adults, especially adults above the age of 65, was much lower than the Idaho Medicaid or overall Medicaid benchmark expenditures. It is likely this difference was due to the variance in services covered by Medicaid versus private insurance. For adults over the age of 65, Medicare would be the primary payer and was not represented in the U.S. total expenditures benchmark.

Although Idaho Medicaid spent less on medical services for each participant than the Medicaid benchmark, this did not appear to negatively impact Idaho Medicaid participants' access to medical care, as evidenced by the fact that more Idaho Medicaid participants were accessing care

than the Medicaid benchmark. The difference in expenditures may have been due to regional differences in payment amounts. As noted before, Idaho Medicaid does not know which Medicaid organizations were included in the benchmark, so regional differences in the payment amount cannot be confirmed or limited to Medicaid organizations in Idaho or with similar demographics to Idaho.

The following sections include separate analyses for each service category: primary care, physician specialists, pre-/postnatal obstetrics, and home health. Data reported in Tables 2-9 below was based on paid claims data. The Decision Support System's Market Scan benchmark measures available to Idaho Medicaid cannot be stratified by claims measures, so Idaho Medicaid was unable to compare Medicaid's data to that of other payers.

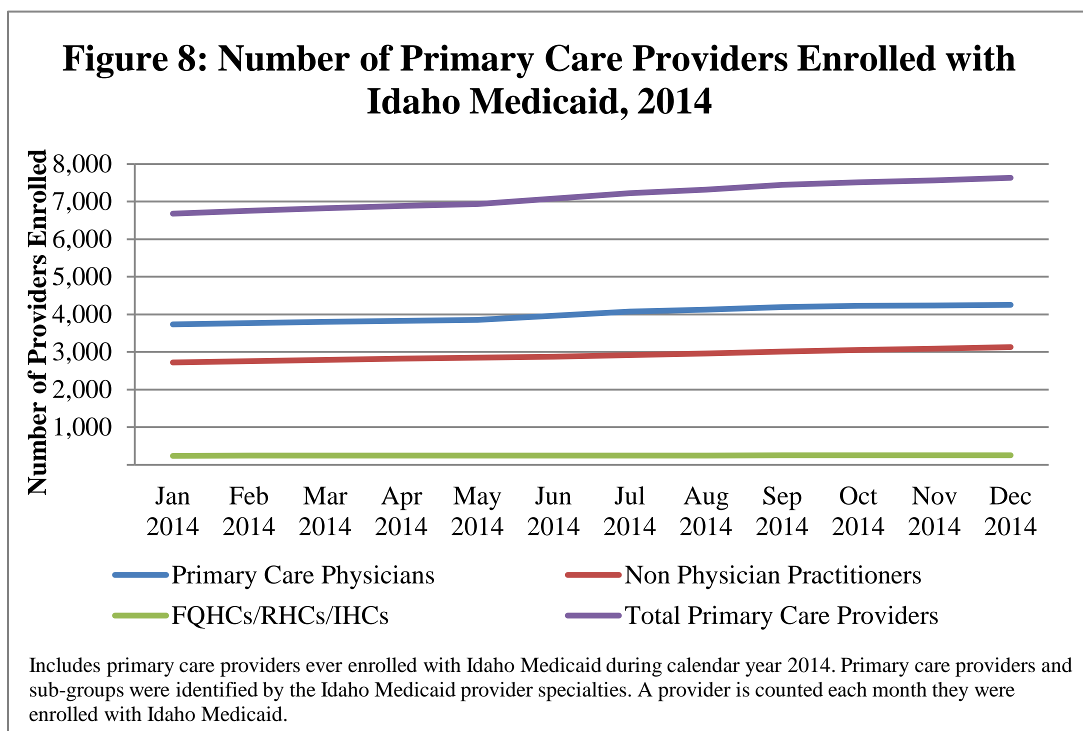
Analysis for Primary Care Providers

Availability

Primary care providers (PCPs) were defined by Idaho Medicaid provider specialties. Specialties considered to be primary care included:

- Physicians with specialties such as family medicine, general medicine, pediatrics, etc.
- Nurse practitioners, including those with focuses in areas such as primary care, family health, pediatrics, etc.
- Physician assistants
- Federally-qualified health centers (FQHCs)
- Rural health clinics (RHCs)
- Indian health services clinics (IHCs)

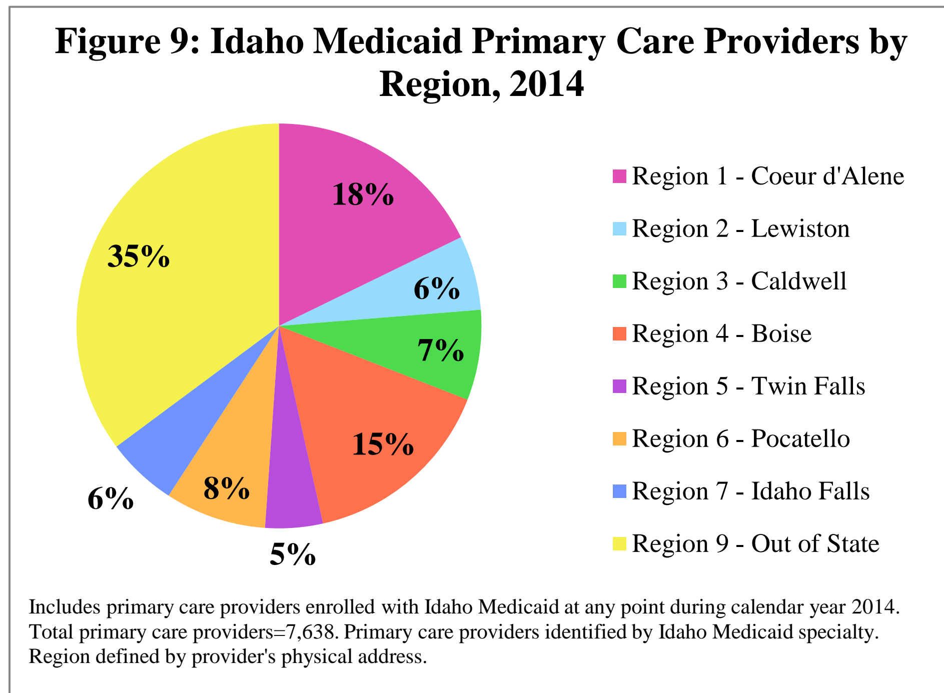
Figure 8 shows the number of PCPs enrolled with Idaho Medicaid each month during 2014.



Includes primary care providers ever enrolled with Idaho Medicaid during calendar year 2014. Primary care providers and sub-groups were identified by the Idaho Medicaid provider specialties. A provider is counted each month they were enrolled with Idaho Medicaid.

The number of PCPs enrolled with Idaho Medicaid increased during 2014. There were slightly more non-physician practitioners than physicians enrolled with Idaho Medicaid as PCPs. The number of FQHCs, RHCs, and IHCs remained at the same level through the year. Approximately 7,000 PCPs were enrolled each month with Idaho Medicaid during 2014.

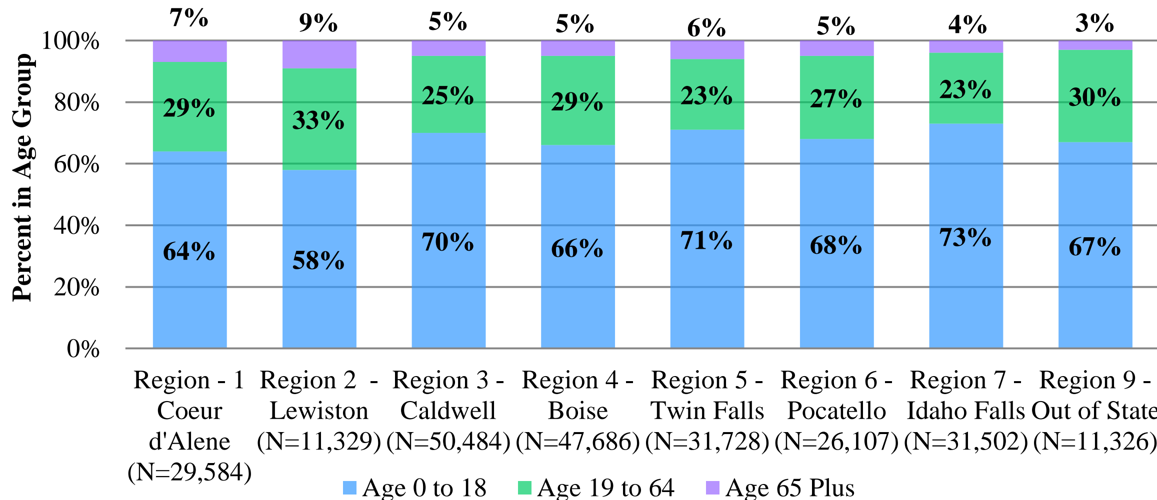
Figure 9 shows that most PCPs in Idaho during 2014 reported a physical address in Region 1 or Region 4. One third of enrolled PCPs were not located in the state of Idaho. The majority of out-of-state PCPs enrolled with Idaho Medicaid were physicians located in major metropolitan areas of surrounding states such as Portland, Salt Lake City, and Seattle.



Utilization Rates

Figure 10 indicates there was not a substantial variation in the age of participants accessing PCPs by the participant's most recent region of residence during 2014. The distribution fairly closely followed the overall distribution of Idaho Medicaid participants' ages; however, there is a slight skew toward children accessing PCPs compared to adults 65 years of age and older. The number of participants accessing care by region also followed the distribution of participants in the state. The largest numbers of participants accessing care were from Region 3 and Region 4.

Figure 10: Idaho Medicaid Participants Accessing Primary Care Services, by Age & Region, 2014



Includes Idaho Medicaid participants who ever accessed a primary care provider during calendar year 2014 (Total N=239,746). Age groups defined by participant's age on 12/31/2014. Region defined by participant's most recent residence address. Primary care providers identified by Idaho Medicaid provider specialty on the claim.

Table 2 shows Idaho Medicaid's utilization rates for PCPs during 2014 based on paid claims data. Nearly 70% of participants enrolled with Idaho Medicaid during 2014 accessed PCPs at least once during the year. The percentage of participants accessing PCPs was greatest among children (74% of children aged 0-18 years) and decreased with the age of participants (56% of participants aged 65 years and older). Participants accessing PCPs had, on average, 4.7 primary care claims during 2014.

Table 2: Idaho Medicaid Utilization of Primary Care Providers, 2014.

Age Group	Total Participants	Participants Accessing Primary Care Providers	% of Participants Accessing Primary Care Providers	Average Claims per Participant
0-18	219,214	163,086	74.4%	3.9
19-64	100,457	63,600	63.3%	6.4
65 Plus	23,227	13,057	56.2%	7.3
Total	342,898	239,743	69.9%	4.7

*Primary care providers identified by Idaho Medicaid provider specialty on the claim. Average claims per participant included only participants who accessed primary care providers during calendar year 2014.

Medicaid Expenditures

Table 3 shows Idaho Medicaid's expenditures for PCPs during 2014 based on paid claims data. Idaho Medicaid spent $88.8 million on over 1 million claims to PCPs in 2014. On average, Idaho Medicaid spent $78.03 per primary care claim, with the highest reimbursement among children 0-18 years ($87.95 per claim). Idaho Medicaid spent approximately $370.43 per participant for PCPs during 2014. The lower reimbursement among participants aged 65 years and older was likely due to Medicare being the primary payer on these claims.

Table 3: Idaho Medicaid Expenditures for Primary Care Providers, 2014.

Age Group	Total Expenditures	Average Expenditures per Claim	Average Expenditures per Participant
0-18	$55,959,023.64	$87.95	$343.13
19-64	$30,204,833.51	$74.18	$474.92
65 Plus	$2,644,236.58	$27.92	$202.51
Total	$88,808,093.73	$78.03	$370.43

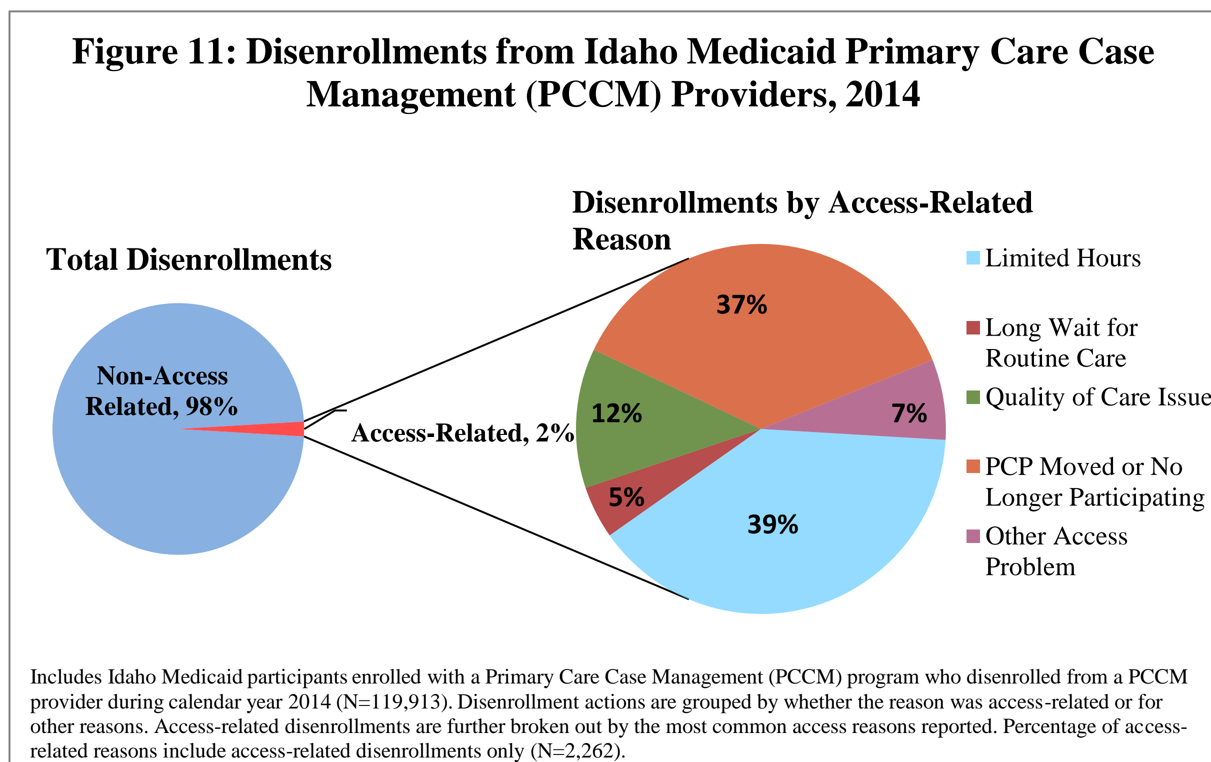
*Primary care providers identified by Idaho Medicaid provider specialty on the claim. Average expenditures per participant included only participants who accessed primary care providers during calendar year 2014.

Disenrollment Data

Idaho Medicaid operates a Primary Care Case Management (PCCM) program where participants are enrolled with a PCP, and the PCCM clinic is paid a monthly case management payment to coordinate the participant's care. Enrollment in the PCCM program is mandatory for most Idaho Medicaid participants. Exemption reasons include participants enrolled in other care coordination programs (such as the Medicare-Medicaid Coordinated Plan), participants who have a PCP that is not participating in the PCCM program, and participants who do not have participating PCPs in close proximity to their residence. Whenever a participant leaves a PCP (including to transition care to a new PCP), Idaho Medicaid records a disenrollment action and reason. Disenrollment reasons are self-reported by the participant. In 2014 there were 119,913 disenrollment actions.

Figure 11 shows the distribution of access-related disenrollments. Disenrollment reasons were categorized as access-related by the PCCM program and data analytics staff. Access-related reasons included limited hours, long wait periods, quality of care issues, clinics closing, or a provider leaving the clinic or program. Non-access-related reasons included participants aging out of a provider type (e.g., a pediatrician), a participant moving to a different provider at the same clinic, a participant transitioning to a different Idaho Medicaid program, etc. Only 2% of disenrollments were due to access-related reasons. The vast majority of those access-related disenrollments were due to limited hours or a PCP moving or no longer participating in the PCCM program. Ninety eight percent of disenrollments were not related to access—70% of these disenrollments were from a participant moving from one PCP at a clinic to a different PCP at the same clinic.

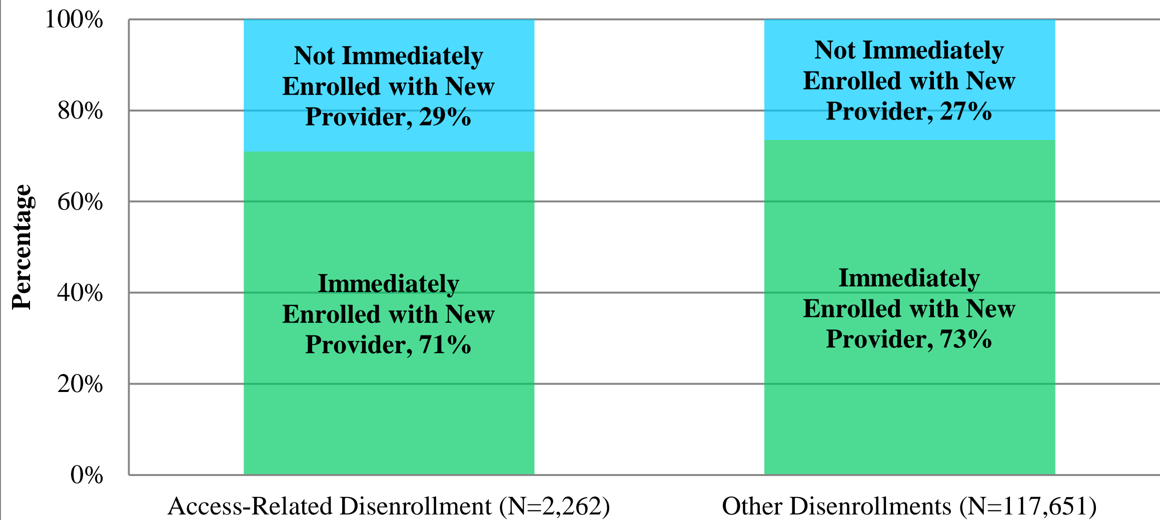
Figure 11: Disenrollments from Idaho Medicaid Primary Care Case Management (PCCM) Providers, 2014



Includes Idaho Medicaid participants enrolled with a Primary Care Case Management (PCCM) program who disenrolled from a PCCM provider during calendar year 2014 (N=119,913). Disenrollment actions are grouped by whether the reason was access-related or for other reasons. Access-related disenrollments are further broken out by the most common access reasons reported. Percentage of access-related reasons include access-related disenrollments only (N=2,262).

Figure 12 shows that in over 70% of disenrollment actions, participants were enrolled with a different PCP with no gap in coverage during 2014 (i.e., a participant's enrollment with a PCP was terminated and their enrollment with a new PCP started the following day). The re-enrollment rate was similar for both access-related and non-access-related disenrollments. Some of the delays in re-enrollments were due to system limitations that required a new enrollment to begin on the first day of the following month.

Figure 12: Disenrollment from Primary Care Provider by Re-Enrollment Status, 2014



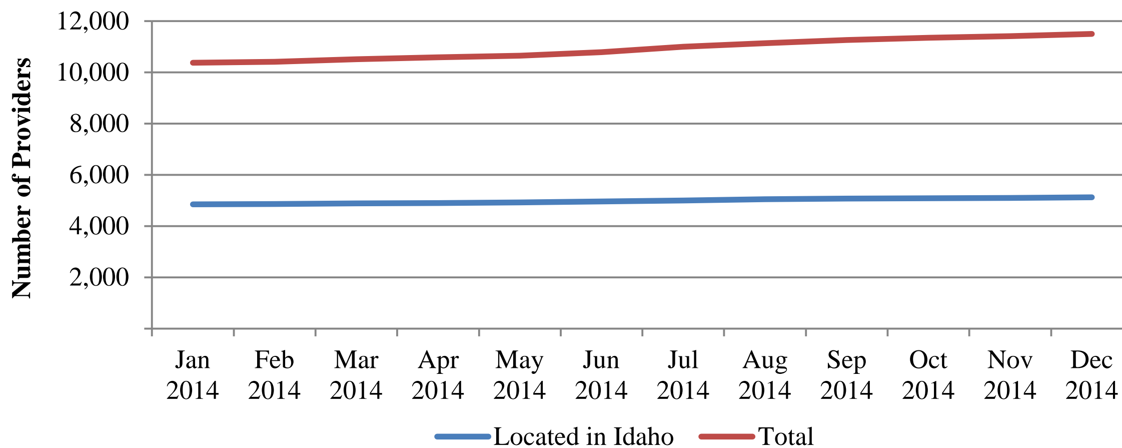
Includes Idaho Medicaid participants enrolled with a Primary Care Case Management (PCCM) program who disenrolled from a PCCM provider during calendar year 2014 (N=119,913). Immediate enrollment with a new provider was defined as no gap between enrollments with a PCCM provider (the new enrollment segment started the day after the previous segment ended). Participants may have had more than one disenrollment action during a year and each disenrollment is counted separately based on whether the participant was immediately enrolled with a new provider.

Analysis of Measures for Physician Specialist Providers

Availability

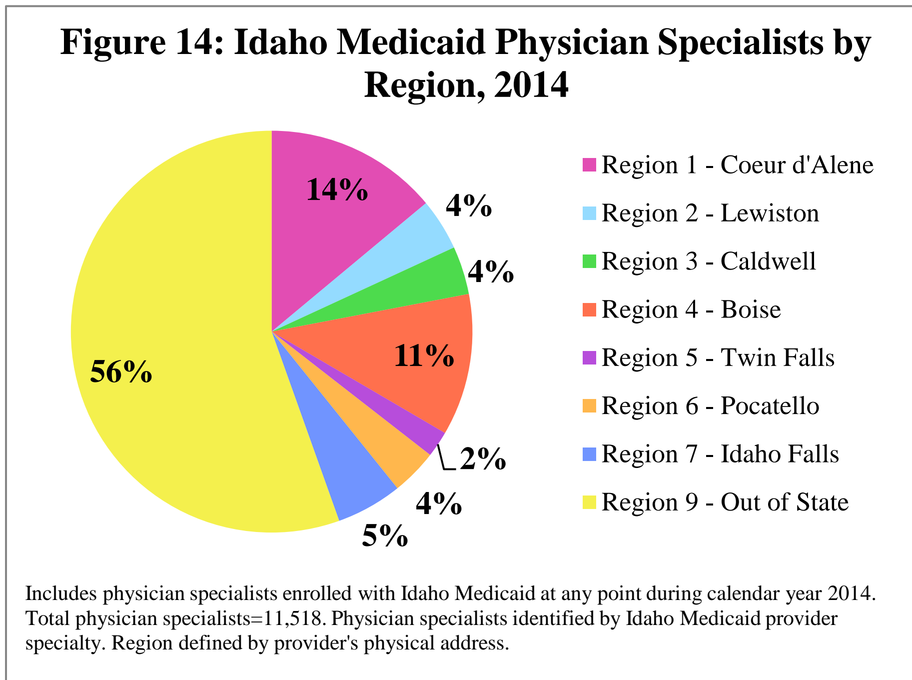
Physician specialist providers were defined by Idaho Medicaid provider specialties. Specialties considered physician specialists are anesthesiology, cardiology, endocrinology and neurology, etc. Figure 13 shows the number of physician specialist providers enrolled with Idaho Medicaid each month during 2014. The total number of physician specialists enrolled with Idaho Medicaid increased slightly over 2014. There were approximately 10,900 physician specialists enrolled with Idaho Medicaid in any given month during 2014. The number of physician specialists enrolled with Idaho Medicaid and located in the state of Idaho remained largely consistent through 2014, at approximately 5,000 providers in any given month.

Figure 13: Number of Physician Specialists Enrolled with Idaho Medicaid, 2014



Includes physician specialists ever enrolled with Idaho Medicaid during calendar year 2014. Physician specialists with a physical address in Idaho are shown in addition to the total number of physician specialists enrolled with Idaho Medicaid. Physician specialists were identified by the Idaho Medicaid provider specialties. A provider is counted each month they were enrolled with Idaho Medicaid.

Figure 14 shows that the majority (56%) of physician specialists enrolled with Idaho Medicaid during 2014 reported an out-of-state address. As with PCPs, the majority of out-of-state physician specialists were located in Portland, Salt Lake City, and Seattle. Within Idaho, physician specialists enrolled with Idaho Medicaid were concentrated in Region 1 and Region 4.

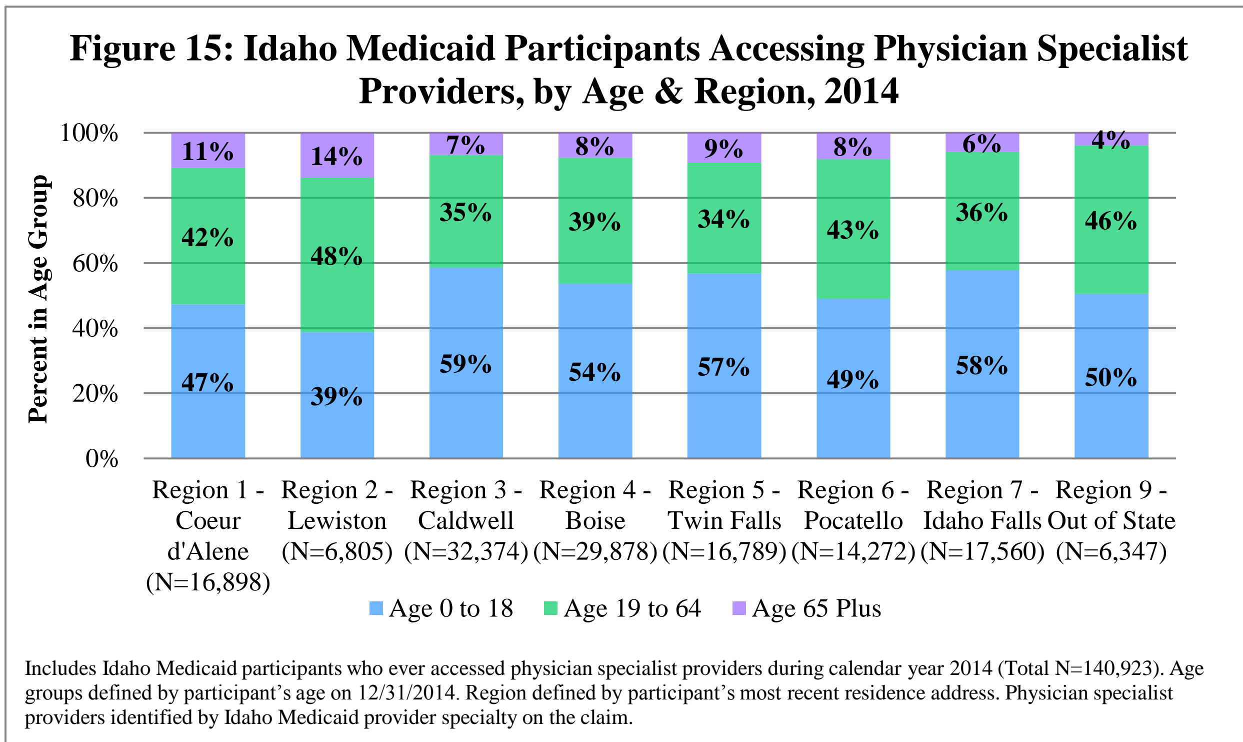


Includes physician specialists enrolled with Idaho Medicaid at any point during calendar year 2014. Total physician specialists=11,518. Physician specialists identified by Idaho Medicaid provider specialty. Region defined by provider's physical address.

Utilization Rates

Figure 15 indicates that the distribution of ages of Idaho Medicaid participants accessing physician specialists during 2014 was weighted to adults compared to the overall age distribution of Idaho Medicaid participants. This weighting, combined with the age demographics of Idaho Medicaid participants accessing PCPs, suggests children on Idaho Medicaid may have been more likely to access care with a PCP while the adult population may have been more likely to access care through a physician specialist.

Figure 15: Idaho Medicaid Participants Accessing Physician Specialist Providers, by Age & Region, 2014



Includes Idaho Medicaid participants who ever accessed physician specialist providers during calendar year 2014 (Total N=140,923). Age groups defined by participant's age on 12/31/2014. Region defined by participant's most recent residence address. Physician specialist providers identified by Idaho Medicaid provider specialty on the claim.

Table 4 shows Idaho Medicaid's utilization rates for physician specialist providers during 2014. Forty one percent of participants ever enrolled with Idaho Medicaid during 2014 accessed physician specialist providers at least once during the year. The percentage of participants accessing physician specialist providers was greatest among adults aged 19-64 years (54%) and was lowest among children 0-18 years (35%). Participants accessing physician specialist providers had, on average, 5.3 physician specialist claims during 2014. Adults 65 years of age and older had the greatest number of physician specialist claims at 8.2 claims for each participant.

Table 4: Idaho Medicaid Utilization of Physician Specialist Providers, 2014.

Age Group	Total Participants	Participants Accessing Physician Specialist Providers	% of Participants Accessing Physician Specialist Providers	Average Claims per Participant
0-18	219,214	75,530	34.5%	3.4
19-64	100,457	54,147	53.9%	7.2
65 Plus	23,227	11,244	48.4%	8.2
Total	342,898	140,921	41.1%	5.3

*Physician specialist services identified by Idaho Medicaid provider specialty on the claim. Average claims per participant included only participants who accessed physician specialist services during 2014.

Medicaid Expenditures

Table 5 shows Idaho Medicaid's expenditures for physician specialist services during 2014. Idaho Medicaid spent $60 million for over 740,000 claims to physician specialists in 2014. On average, Idaho Medicaid spent $81.12 per physician specialist claim and $426.13 per participant for physician specialists. Lower expenditures were seen among adults 65 years of age and older, just like with primary care. It is again likely that Medicare was the primary payer on the physician specialist claims for this age group.

Table 5: Idaho Medicaid Expenditures for Physician Specialist Providers, 2014.

Age Group	Total Expenditures	Average Expenditures per Claim	Average Expenditures per Participant
0-18	$25,224,394.45	$97.33	$333.97
19-64	$32,274,618.84	$82.92	$596.06
65 Plus	$2,552,079.64	$27.77	$226.97
Total	$60,051,092.93	$81.12	$426.13

*Primary care services identified by Idaho Medicaid provider specialty on the claim. Average expenditures per participant included only participants who accessed primary care services during 2014.

Analysis of Measures for Pre-/Postnatal Obstetric Providers

Availability

Pre-/postnatal obstetric ("obstetric") providers were defined by Idaho Medicaid provider specialties. Specialties considered obstetrics included obstetrics and gynecology physicians (OB/GYN) and midwives. Hospital claims for births were not included in this access monitoring review because it is difficult to track and group an entire pregnancy because of the variety of providers and services a participant may access over the course of a pregnancy. Figure 16 shows the number of obstetric providers enrolled with Idaho Medicaid each month during 2014. On average, 745 obstetric providers were enrolled with Idaho Medicaid in any given month during 2014.

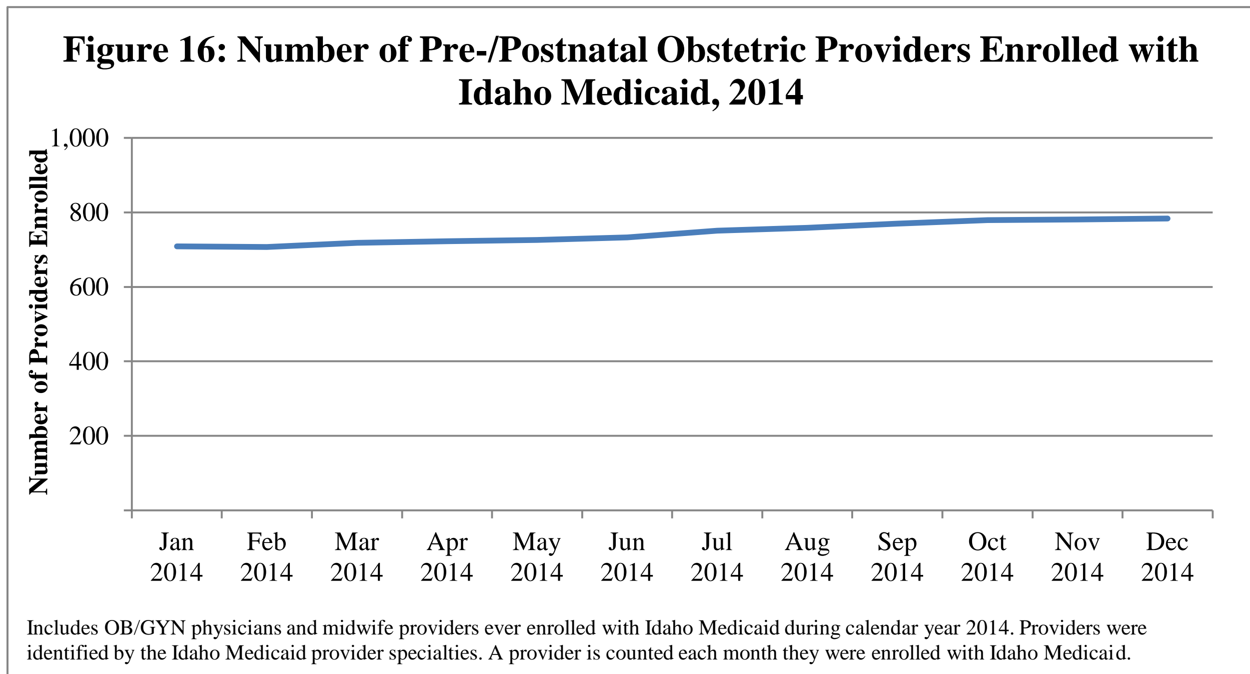
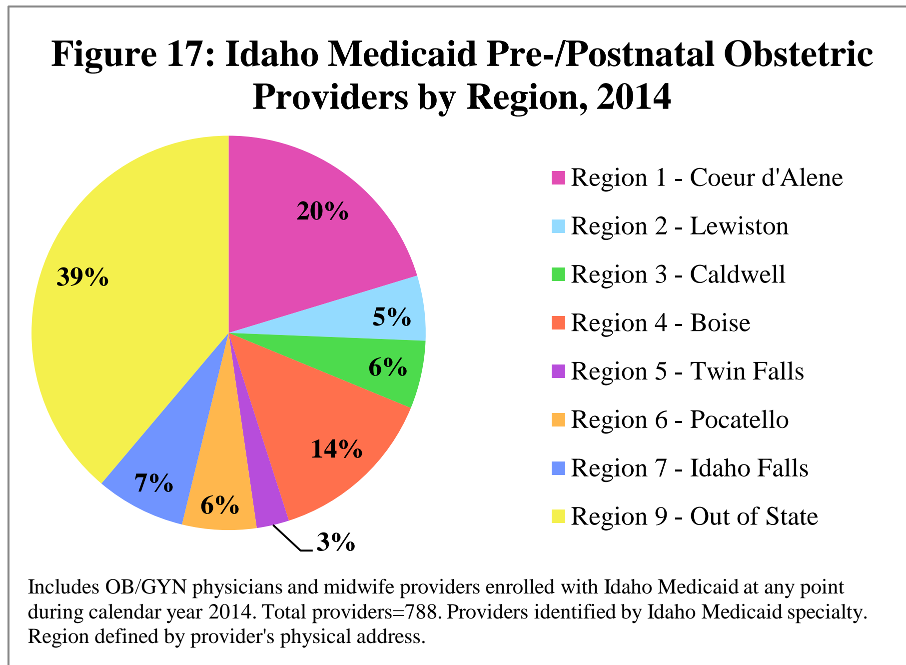


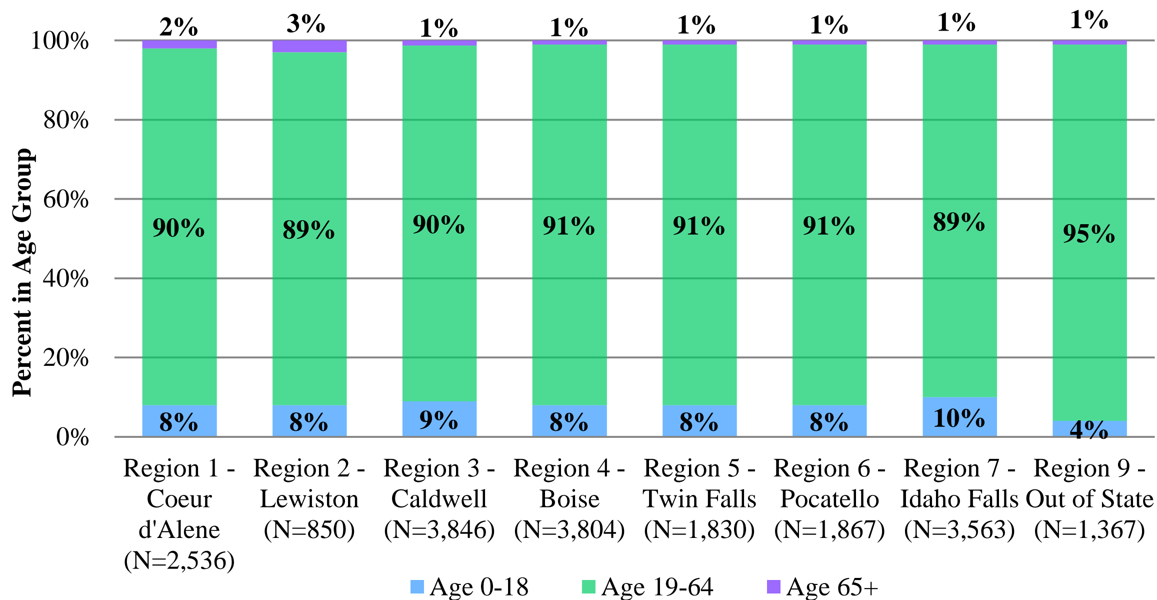
Figure 17 shows (similar to other provider groupings) that a substantial proportion of obstetric providers enrolled with Idaho Medicaid reported an out-of-state address during 2014. Again, these out-of-state providers were largely OB/GYN physicians in neighboring metropolitan areas. Within the state, obstetric providers were concentrated in Region 1 and Region 4.



Utilization Rates

Figure 18 indicates that nearly all the participants accessing obstetric providers during 2014 were adults aged 19 to 64. It is possible that some of the children counted as accessing obstetric providers were infants accessing services through the mother's eligibility, and adults over the age of 65 may have been accessing obstetric providers for services other than pre-/postnatal care. However, given the small number of outliers (~1% over the age of 65), Idaho Medicaid believes that using provider specialty still gave an accurate representation of access to pre-/postnatal obstetrics services.

Figure 18: Idaho Medicaid Participants Accessing Pre-/Postnatal Obstetric Providers, by Age & Region, 2014



Includes Idaho Medicaid participants who ever accessed OB/GYN physicians or midwife providers during calendar year 2014 (Total N=19,663). Age groups defined by the participant's age on 12/31/2014. Region defined by participant's most recent residence address. Providers identified by Idaho Medicaid provider specialty on the claim.

Table 6 shows Idaho Medicaid utilization rates for pre-/postnatal obstetric providers during 2014. Percentage of participants accessing obstetric providers was limited to female participants. As expected, the percentage of participants accessing obstetric providers was greatest among female adults 19-64 years (27%). On average, participants accessing obstetric providers had 4.0 claims to OB/GYN or midwife providers during 2014.

Table 6: Idaho Medicaid Utilization of Pre-/Postnatal Obstetric Providers, 2014.

Age Group	Total Participants	Participants Accessing Pre-/Postnatal Obstetric Providers	% of Participants Accessing Pre-/Postnatal Obstetric Providers	Average Claims per Participant
0-18	106,632	1,618	1.52%	2.9
19-64	65,900	17,770	26.97%	4.2
65 Plus	15,059	275	1.83%	2.1
Total	187,591	19,663	10.48%	4.0

*Obstetric providers identified by Idaho Medicaid specialty on the claim. Only claims for OB/GYN physicians and midwife providers were included. Average claims per participant included only participants who accessed obstetrics providers during calendar year 2014.

Medicaid Expenditures

Table 7 shows Idaho Medicaid expenditures for obstetric providers during 2014. Expenditures included only expenditures for OB/GYN or midwife services (hospital billings were not included). Additionally, since infants can be billed using the mother's eligibility, these expenditures may be included in the numbers below. Idaho Medicaid spent $17.7 million on nearly 80,000 claims to obstetric providers. On average, Idaho Medicaid spent $223.43 per claim for an OB/GYN or midwife provider. Idaho Medicaid spent approximately $902.47 per participant to obstetric providers during 2014.

Table 7: Idaho Medicaid Expenditures for Pre-/Postnatal Obstetric Providers, 2014.

Age Group	Total Expenditures	Average Expenditures per Claim	Average Expenditures per Participant
0-18	$898,772.57	$191.02	$555.48
19-64	$16,824,717.38	$226.92	$946.80
65 Plus	$21,837.28	$38.11	$79.41
Total	$17,745,327.23	$223.43	$902.47

*Obstetric providers identified by Idaho Medicaid specialty on the claim. Only claims for OB/GYN physicians and midwife providers were included. Average expenditures per participant included only participants who accessed obstetric providers during calendar year 2014. Infants can be billed on the initial claims after delivery and these expenditures may be included in the above numbers. Among participants aged 65 years and older, Medicare was likely the primary payer resulting in lower average expenditures by Idaho Medicaid.

Analysis of Measures for Home Health Providers

Availability

Home health providers were defined by an Idaho Medicaid provider specialty of home health. Figure 19 shows the number of home health providers enrolled with Idaho Medicaid each month during 2014. The number of home health providers enrolled with Idaho Medicaid during 2014 remained fairly constant at approximately 114 providers in any given month.

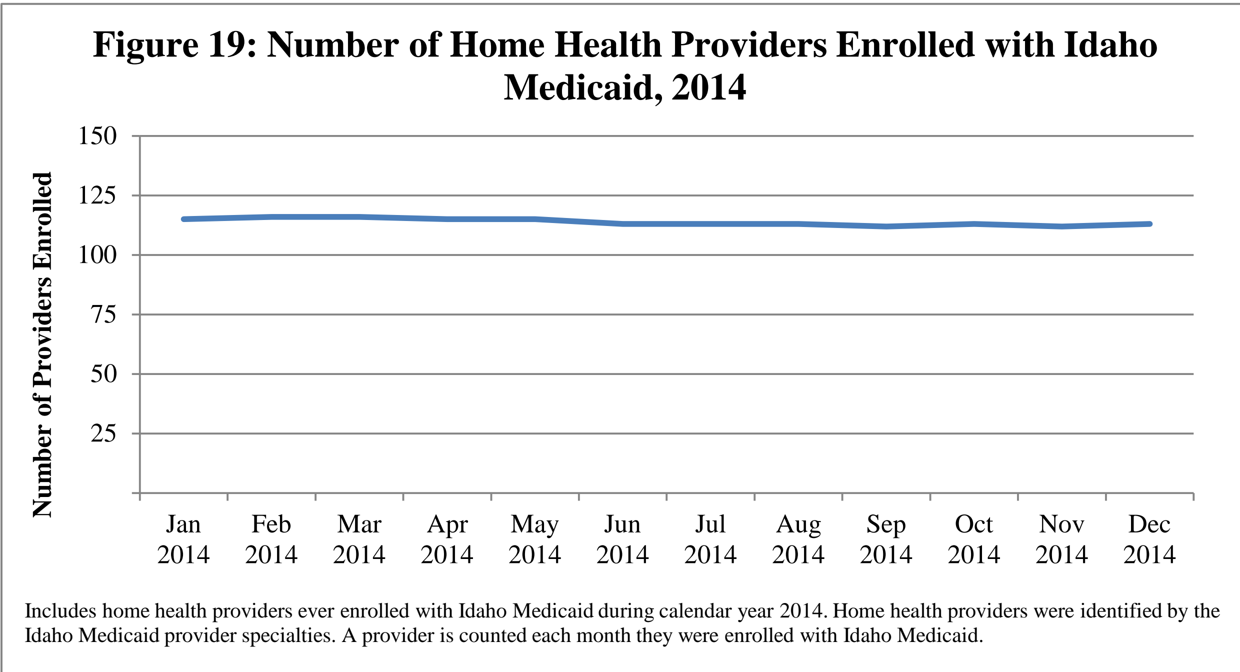


Figure 19: Number of Home Health Providers Enrolled with Idaho Medicaid, 2014

Includes home health providers ever enrolled with Idaho Medicaid during calendar year 2014. Home health providers were identified by the Idaho Medicaid provider specialties. A provider is counted each month they were enrolled with Idaho Medicaid.

Figure 20 shows, unlike other provider groupings considered, that home health providers were mostly located in the state of Idaho during 2014. Only 7% of providers reported an out-of-state address. The distribution of providers across the state largely mirrored the distribution of participants in the state—although the distribution of home health providers between Regions 3 and 7 differed slightly from the Idaho Medicaid participant distribution.

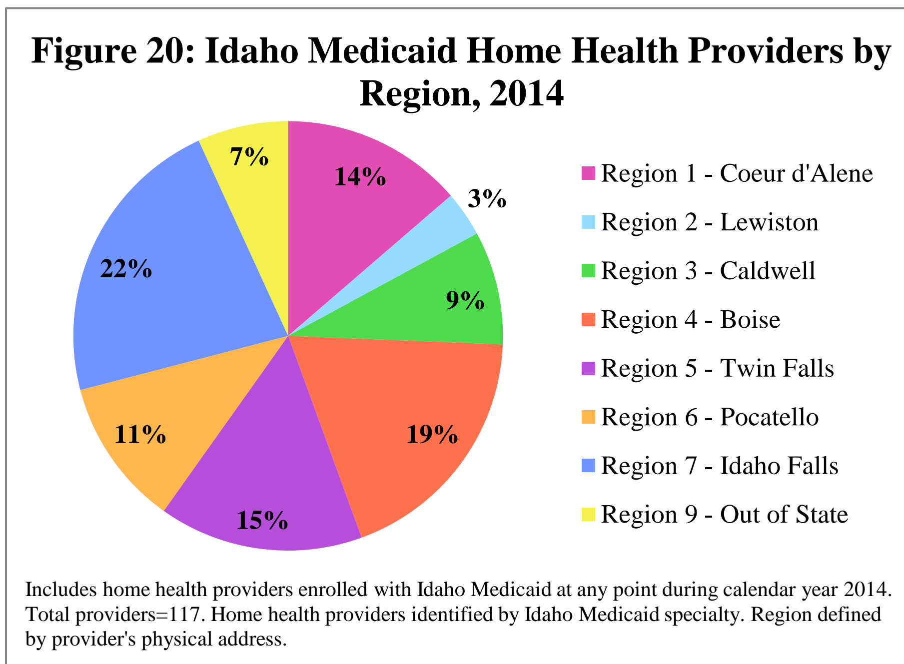
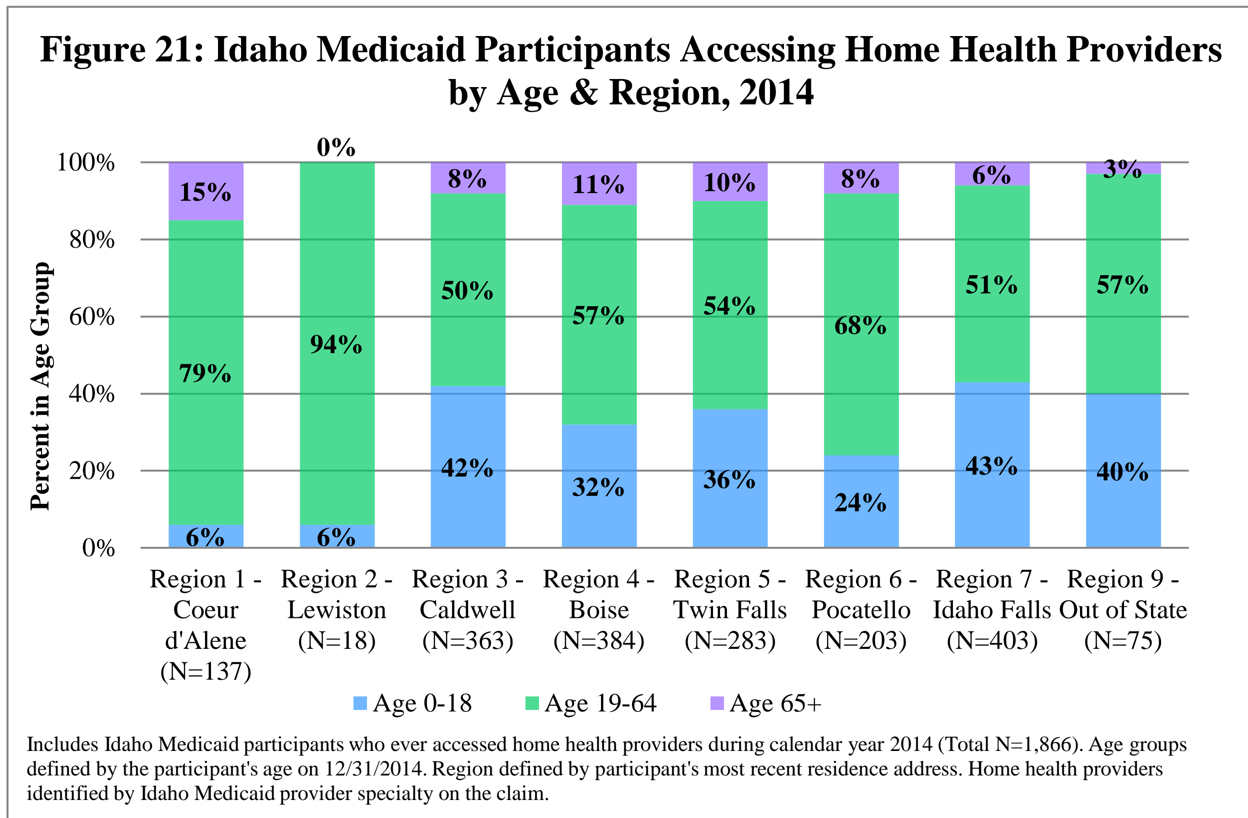


Figure 20: Idaho Medicaid Home Health Providers by Region, 2014

Includes home health providers enrolled with Idaho Medicaid at any point during calendar year 2014. Total providers=117. Home health providers identified by Idaho Medicaid specialty. Region defined by provider's physical address.

Utilization Rates

Figure 21 shows that Idaho Medicaid participants accessing home health providers during 2014 were largely adults from Region 3 and Region 4. Overall, the number of participants accessing home health providers (1,866) was much lower than the number of participants accessing other provider groupings. Therefore, there was more substantial variation in the ages of participants across regions than has been previously seen.



Includes Idaho Medicaid participants who ever accessed home health providers during calendar year 2014 (Total N=1,866). Age groups defined by the participant's age on 12/31/2014. Region defined by participant's most recent residence address. Home health providers identified by Idaho Medicaid provider specialty on the claim.

Table 8 shows Idaho Medicaid utilization rates for home health providers during 2014. The greatest percentage of Idaho Medicaid participants accessing home health providers was adults 19-64 years (1%). It is expected that home health providers would primarily serve adult participants. On average, participants who accessed home health providers had 5.2 home health claims during 2014.

Table 8: Idaho Medicaid Utilization of Home Health Providers, 2014.

Age Group	Total Participants	Participants Accessing Home Health Providers	% of Participants Accessing Home Health Providers	Average Claims per Participant
0-18	219,214	639	0.29%	5.7
19-64	100,457	1,066	1.06%	5.1
65 Plus	23,227	161	0.69%	3.9
Total	342,898	1,866	0.54%	5.2

*Home health providers identified by Idaho Medicaid provider specialty on the claim. Average claims per participant included only participants who accessed home health providers during calendar year 2014.

Medicaid Expenditures

Table 9 shows Idaho Medicaid expenditures for home health providers during 2014. Idaho Medicaid spent $4.1 million for home health providers, representing over 9,700 claims. On average, Idaho Medicaid spent $426.15 per home health claim. Idaho Medicaid spent approximately $2,219.15 per participant for home health providers during 2014.

Table 9: Idaho Medicaid Expenditures for Home Health Providers, 2014.

Age Group	Total Expenditures	Average Expenditures per Claim	Average Expenditures per Participant
0-18	$1,306,408.54	$355.68	$2,044.46
19-64	$2,538,984.08	$468.36	$2,381.79
65 Plus	$295,532.68	$474.37	$1,835.61
Total	$4,140,925.30	$426.15	$2,219.15

*Home health providers identified by Idaho Medicaid provider specialty on the claim. Average claims per participant included only participants who accessed home health providers during calendar year 2014.

Summary of Results

Idaho Medicaid works to provide quality healthcare coverage for the over 370,000 unique participants who are enrolled each year. In ensuring access for its participants, Idaho Medicaid faces the challenge of the availability of providers because much of the state is rural and numerous health professional shortage areas and medically underserved areas/populations exist[2]. In an attempt to increase access given the relatively few providers available in Idaho, Idaho Medicaid enrolls providers from neighboring metropolitan areas such as Portland, Seattle, and Salt Lake City. Additionally, Idaho Medicaid allows Telehealth delivery of specific services in order to increase access to care in rural areas of the state. Starting February 1, 2016, Idaho Medicaid allows reimbursement of primary care services delivered via Telehealth. Idaho Medicaid believed this expansion of the Telehealth policy will further increase access to services within the state.

During 2014, nearly 70% of participants ever enrolled with Idaho Medicaid accessed PCPs, 40% of all participants accessed physician specialist providers, 27% of female participants 19-64 years of age accessed OB/GYN or midwife providers, and 0.5% of all participants accessed home health providers. This distribution of access to care by participants was not unexpected given that 64% of Idaho Medicaid participants were 0-18 years of age, and over 90% were under the age of 65.

Idaho Medicaid's Data Warehouse and Decision Support System vendor, Truven Health Analytics, has Market Scan benchmark measures that allow Idaho Medicaid to compare participant-level measures to overall Medicaid and U.S. totals (including private payers). Due to the proprietary nature of the measures, Idaho Medicaid is not permitted to know the specific organizations that are included in the benchmarks. Nevertheless, these benchmark measures do allow Idaho Medicaid to make the following comparisons and conclusions.

Comparisons and Conclusions

Idaho Medicaid has lower average expenditures for medical services per participant than the Medicaid benchmark. However, the number of participants accessing medical providers per 1,000 total participants for Idaho Medicaid was greater than or similar to the rates of the Medicaid total and U.S. total benchmarks. This suggests that although Idaho Medicaid may reimburse at a lower level than other state Medicaid or private payers, Idaho Medicaid participants are able to access medical care at a rate similar to or greater than other Medicaid and private payer organizations.

In gauging Idaho Medicaid participants' perceptions about access to care, the CAHPS® survey conducted for the CHIP population suggests most participants are able to access care when needed. In fact, nearly half of respondents ranked Idaho Medicaid as the "Best Health Plan Possible" on a scale from 0-10, and over 80% reported their child was "Usually" or "Always" able to get primary or specialist care as quickly as needed. Additionally, because Idaho Medicaid operates a PCCM program, a very small percentage (2%) of PCP-disenrollments is related to access problems. When such access concerns do result in a PCP-disenrollment, the participant is enrolled with a new PCP without any lapse in PCCM coverage in over 70% of cases. In participant reported data available to Idaho Medicaid, access problems are not substantially reported.

Moving forward, Idaho Medicaid will continue to monitor participants' access to care in order to ensure a quality healthcare plan is offered and that the requirements outlined in 42 CFR 447.203 are met. The measures defined above will be tracked at least every three years to monitor the changes in provider availability and utilization rates. Additionally, participant and provider feedback will be sought through a variety of mechanisms in order to identify, analyze, and resolve any access issues or gaps that may arise. Idaho Medicaid is committed to working to promote and improve the health of Idahoans by providing access to care that fully meets participants' needs.

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5. Idaho Department of Health and Welfare. *Rural Health and Primary Care: Shortage Designations.* http://healthandwelfare.idaho.gov/Health/RuralHealthandPrimaryCare/ShortageDesignations/tabid/415/Default.aspx. Accessed May 5, 2016.

APPENDIX A

Medical Care Advisory Committee Feedback on the Report

Two MCAC members participated on the project team responsible for implementing the rules. At the quarterly meeting of the MCAC, the Project Manager opened discussion with basic requirements of the new Rule and next steps. Three data summary slides were presented by the Research Analyst in order to get the discussion going (15 minutes allotted). Membership had access to and opportunity to review entire report for over 30 days. The full report was also open during discussion. No changes were made to the report as a result of the discussion and subsequent research.

Questions about Figure 6: Idaho Medicaid Beneficiaries Accessing Services, 2014:

Question: How is access to Ob-Gyn services measured month to month?

- Comment: Typically, physicians either bill prenatal services and the delivery separately, or they bill one global rate at delivery, which includes the monthly prenatal visits. These beneficiaries are likely being seen every month, but these visits won't be billed. Since this is based on paid claims data, these visits will not be represented.
- Comment: Some people can access care just for delivery (there would be one global bill, but it would not reflect the absence of monthly prenatal visits). It would not be known if a doctor is not available (access issue) or if the member is just not going in. Would have to access your Electronic Health Records (EHR) to determine whether a member is going in prior to delivery.

Response: Paid claims data does have some limitations.

- The measure does not track the individual, showing how many dates of service an individual had. It shows the number of unique individuals who had a visit in any given month.
- Since births occur each month of the year, those whose monthly visits are not billed separately are captured at the birth visit. This is worth noting in the report.
- Medicaid does not have access to EHR data for reports.

Action Item: Can these measurement limitations be further addressed for the report? Share in next meeting.

- Applicability of pre-/post-natal obstetric provider grouping (per research analyst).
    - On average, there are 4 claims per patient accessing our OB/GYN provider grouping. It is possible that the Pre-/Postnatal Access metrics include beneficiaries who were only seen for delivery. However, from the average number of claims per beneficiary, it does not appear that this would be substantial in our data.

Question: Enrollment does not automatically imply access; are we measuring access?

Response: We look at both enrollment and access to services month to month to get a picture of access for the population.

Questions about Table 1: Utilization and Net Payment for Idaho Medicaid Members Compared to Other Medicaid and Private Payer Organizations, 2014.

Question: Is this only looking at those Medicaid beneficiaries who have the same eligibility criteria?

- Comment: Different states' Medicaid programs have different eligibility criteria; some are very broad (ours is fairly narrow & largely children) which could impact accessibility or eligibility – different populations with different utilization rates. For example, a broader, healthy population versus a more limited, less healthy population. There could be very different denominators; different services available to those beneficiaries.

Response: The TRUVEN resource we have available to us limits our ability to stratify to member characteristics. We do not have access to the number of benchmark payers, nor their identities.

- This data is limited to beneficiaries with medical coverage. Therefore the numbers are in the same family; beyond that we don't know what that looks like for each benchmark. We don't know if this is an "apples to apples" comparison.
- The TRUVEN resource is nice to have when there aren't other options in light of CMS' request for comparisons with commercial payers. We are not able to request utilization data directly from those payers. This data gives us some gauge, although with limitations, suggesting we are not an outlier.

Question: Please explain the 819 figure in Table 1.

Response: Looking across the year, on average, 819 beneficiaries per 1000 are accessing services in the year.

- Because the measure tracks the number of unique individuals who had a visit during the year, it does not differentiate how many visits an individual had.
- As discussed above, some utilization differences between us and US Medicaid and US benchmarks might be explained in part by different definitions for enrollment. Alternatively, we may be getting more people in, and not spending a lot of money on them. Kids 0 -18 are probably our healthiest kids.
- Comment: In the commercial market, *services per thousand* is commonly used for utilization (Yvonne).
- Response: We can't get that through our contractor; this is only thing we can get to fulfill request for some commercial comparisons.

Action Item: Additional post-meeting analysis to determine if TRUVEN could provide services per thousand.

- Availability of a visits or services benchmark (per research analyst)
  The Decision Support System (DSS) does not have an overall visits measure for which benchmarks are available. The services measure available is based off of units and appears to be heavily influence by variation in the way services are provided between payers. The services measure was not deemed to be a valid comparison, so beneficiaries accessing care per 1,000 appears to be the most valid comparison available in the DSS used by Idaho Medicaid.

Question: Can the comparison states be listed out?

Response: Kara – Truven can't break it out for us because the benchmarks are proprietary. They cannot provide the number of insurance organizations in the list either, or the provider types

Comment: Yvonne: They have the biggest payers in there. Blue Cross used TRUVEN. There is a big commercial dump in there for Idaho.

- Kara – there are out of state organizations as well, and those states may have cost-of-living differences that can impact costs.

Question: Does Truven provide regional benchmarks?

Response: Kara – I don't believe so, but can check.

- Comment: Yvonne – even right now, providers get their cost comparisons at the regional level. Not asking to re-run the analysis; some of this is available elsewhere. This is a great application great to see you using it.
- Matt – good to look at this; at least it tells us we're not an outlier.

Action Item: Additional research on regional benchmarks (checked by research analyst).

- Regional benchmarks
  - Regional benchmarks are not available for the benchmarks included in the analysis.

General Questions:

Question: What was the conclusion? How are we doing with access?

Response: This is our baseline for comparisons with future data as we gather additional information.

- There was little direct information about access from beneficiaries, but we were able to collect some data from the CAHPS survey that shows on a scale from 1 to 10 that we're pretty good. CAHPS data is not all of Medicaid, but since Medicaid is child heavy, it provides some information about the population and what they think about access. We also brought in some beneficiary feedback information from the Healthy Connections program reports on disenrollment. All in all, there is nothing indicating that our beneficiaries are telling us we have an access issue. We will continue to monitor these and will be able to compare these measures over time to look at trends.
- Matt: We have the best handle on primary care; we track closely who is assigned, who is attributed and who is accepting new Medicaid patients. We work with physicians to accept new members (95% of primary care is enrolled with Medicaid).
- Not seeing any red flags for specialists or Home health. Within the limits of the data, the access picture appears to be pretty good.
- This is the first time we've taken a look in such depth; might find we have new capabilities in the future.

- Julie. CFR also requires we establish mechanisms for ongoing feedback from providers and participants. This committee could help a great deal with this aspect of the work.

Question: If you look back to what pushed CMS to do this, it was a law suit that we brought against the state. The Access Review is not looking at any DD services. It is hard to believe CMS does not want to include these services in what they are measuring and tracking.

Response: Matt – the regulations were in part prompted by the Supreme Court decision around DD individuals.

- Regulations were promulgated back in 2011 in draft form. For this access rule, CMS finalized those. The rules are directed at Fee-for-Service Services. They don't apply to waivers – CMS has been very specific about that.
- CMS has separate requirements around managed care that have a big focus on access and access standards. Under waiver authorities, quality assurance reports and tracking success in different ways is a focus for CMS. It's a big and important question.