2016

Access Monitoring Review Plan - 2016

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Overview

Michigan Medicaid provides healthcare coverage for low-income individuals, including children, pregnant women, elderly, parents, adults, and individuals with disabilities. The Michigan Department of Health and Human Services (MDHHS) is the agency responsible for administering the Medicaid program within the state.

With a total population of 10 million individuals, Michigan is the 10th most populous state. Michigan's Medicaid program currently provides coverage for approximately 2.2 million enrolled beneficiaries with total expenditures of approximately $16 billion annually. Of the 2.2 million beneficiaries, approximately 1.7 million are continuously enrolled in one of the 11 managed care health plans. There were 280,000 individuals enrolled in the fee-for-service program (FFS) for at least 11 months of fiscal year 2015. The remaining 200,000 individuals moved between FFS and the health plan, either because they were beneficiaries in the process of choosing a health plan or because their choice to enroll in a health plan was voluntary. Most of these beneficiaries end up enrolled in a health plan full time.

In accordance with 42 CFR 447.203, Michigan developed this Access Monitoring Review Plan (AMRP) for the following service categories provided under a FFS arrangement:

- Primary care services
- Physician specialist services – Orthopedics/Otolaryngology/General Surgery
- Behavioral health services
- Pre- and post-natal obstetric services, including labor and delivery
- Home health services

This AMRP was created to ensure Medicaid beneficiaries have access to care that is comparable to Michigan's general population. The plan considers the availability of enrolled Medicaid providers, utilization of Medicaid services, characteristics of the beneficiary population, provider payments available from other payers, and the extent to which beneficiary needs are fully met.

This plan was developed in collaboration with the Medicaid provider community and FFS Medicaid beneficiaries.

A thorough analysis of the data contained in this report shows that Michigan Medicaid FFS beneficiaries have access to care that is comparable to the general population of Michigan. The access to care is sufficient and in accordance with section 1902(a)(30)9A) of the Social Security Act. Michigan Medicaid rates are sufficient to enlist enough providers so that care and services are available to Medicaid beneficiaries at least to the extent they are available to the general public.

Characteristics of Beneficiary Population

Michigan Medicaid currently enrolls 2.2 million beneficiaries. This number includes roughly 600,000 beneficiaries enrolled in the Healthy Michigan Plan, which is Michigan's Medicaid expansion program for individuals 19-64 years of age with income at or below 133% of the federal poverty level. Healthy Michigan Plan began April 1, 2014.

With the exception of the following group of individuals, all Medicaid beneficiaries are required to enroll in one of the 11 managed care health plans.

Group #1 - Excluded from managed care – these individuals are continuously enrolled in FFS, and include beneficiaries who:

- Do not have full Medicaid coverage (e.g., coverage for emergency services only).
- Medicaid is purchasing Medicare coverage.
- Have Medicaid and reside in an intermediate care facility for individuals with intellectual disabilities or a state psychiatric hospital.
- Are residing in a nursing facility.
- Have been diagnosed with inborn errors of metabolism that have been authorized for and use metabolic formulas.
- Are served under the MIChoice Waiver.
- Are enrolled in the Children's Special Health Care Services Program and do not have full Medicaid coverage.
- Have a deductible.
- Have commercial managed care coverage, including beneficiaries enrolled in a Medicare health plan that is not approved to provide Medicaid service in their county of residence.
- Are in child caring institutions.
- Are in the Refugee Assistance Program.
- Are in the Repatriate Assistance Program.
- Have been dis-enrolled from a Medicaid health plan.
- Are receiving private duty nursing services.

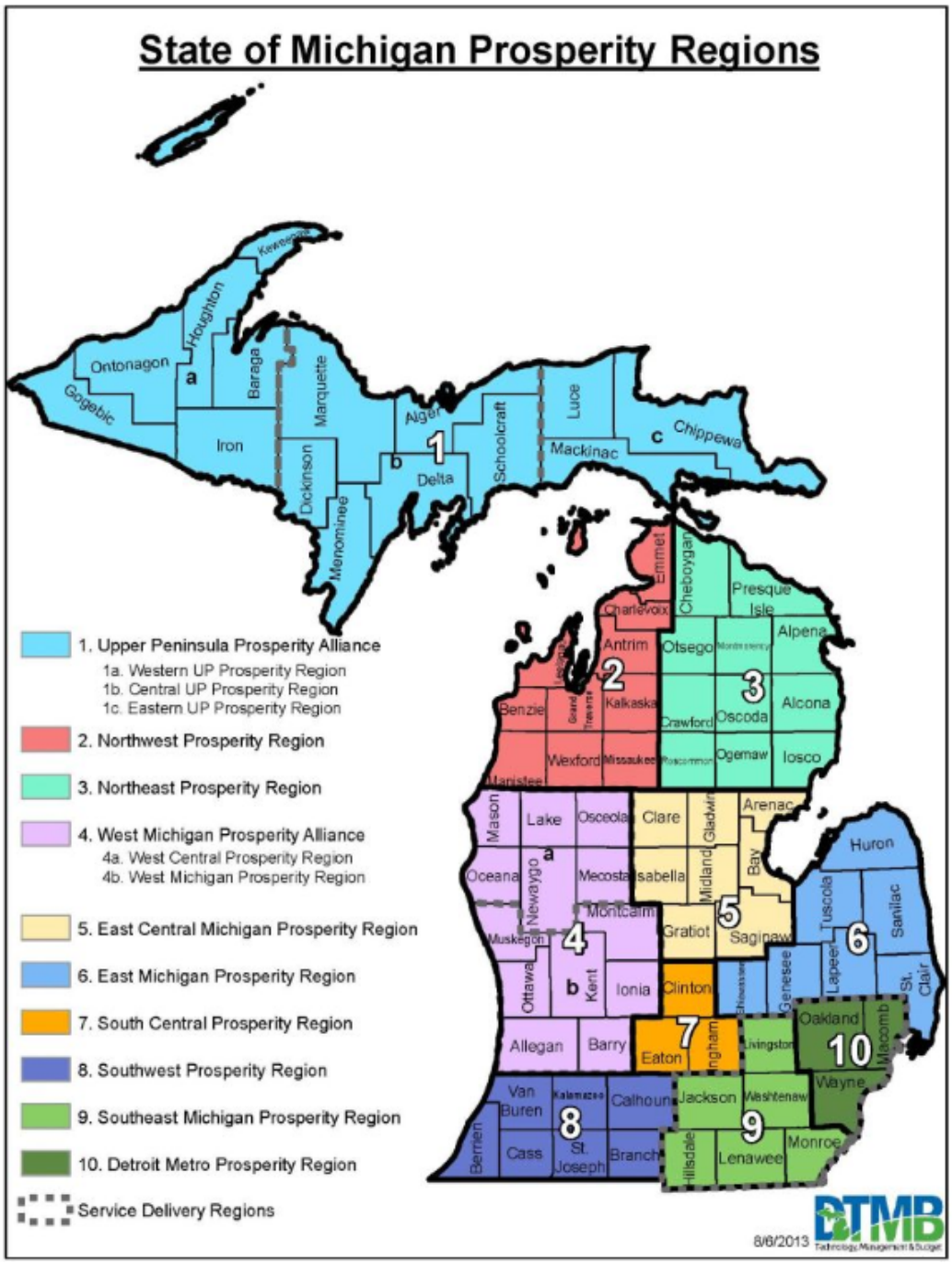
Group #2 – Voluntary enrollment group – these individuals have a choice of enrolling in a health plan or remaining in the FFS population:

- Migrants
- Native American Indians of federally recognized tribes
- Most Medicare/Medicaid dual eligibles

Population by Geographic Region

The following 10 Michigan Prosperity Regions were used for analysis:

1. Upper Peninsula Prosperity Alliance
2. Northwest Prosperity Region
3. Northeast Prosperity Region
4. West Michigan Prosperity Alliance
5. East Central Prosperity Region
6. East Michigan Prosperity Region
7. South Central Prosperity Region
8. Southwest Prosperity Region
9. Southeast Michigan Prosperity Region
10. Detroit Metro Prosperity Region


State of Michigan Prosperity Regions
1. Upper Peninsula Prosperity Alliance
1a. Western UP Prosperity Region
1b. Central UP Prosperity Region
1c. Eastern UP Prosperity Region
2. Northwest Prosperity Region
3. Northeast Prosperity Region
4. West Michigan Prosperity Alliance
4a. West Central Prosperity Region
4b. West Michigan Prosperity Region
5. East Central Michigan Prosperity Region
6. East Michigan Prosperity Region
7. South Central Prosperity Region
8. Southwest Prosperity Region
9. Southeast Michigan Prosperity Region
10. Detroit Metro Prosperity Region
Service Delivery Regions
Ontonagon
Houghton
Baraga
Gogebic
Iron
Marquette
Dickinson
Menominee
Alger
Delta
Schoolcraft
Luce
Mackinac
Chippewa
Emmet
Charlevoix
Cheboygan
Presque Isle
Antrim
Otsego
Alpena
Benzie
Kalkaska
Crawford
Oscoda
Alcona
Manistee
Wexford
Missaukee
Ogemaw
Iosco
Mason
Lake
Osceola
Clare
Gladwin
Arenac
Huron
Oceana
Newaygo
Mecosta
Isabella
Midland
Bay
Tuscola
Sanilac
Montcalm
Gratiot
Saginaw
Muskegon
Ottawa
Kent
Ionia
Clinton
Genesee
Lapeer
St. Clair
Allegan
Barry
Eaton
Ingham
Livingston
Oakland
Macomb
Van Buren
Kalamazoo
Calhoun
Jackson
Washtenaw
Wayne
Berrien
Cass
St. Joseph
Branch
Hillsdale
Lenawee
Monroe
8/6/2013
DTMB

Population Data

The data contained in the following charts consists of the Michigan Medicaid FFS population, calendar year 2015.

Prosperity Region	*Total Region Population*	*% of Total Population*
1	9,327	3.3%
2	9,919	3.5%
3	8,571	3.1%
4	48,287	17.3%
5	19,422	6.9%
6	27,304	9.8%
7	12,123	4.3%
8	19,989	7.1%
9	16,969	6.1%
10	107,867	38.6%
TOTAL	279,777	

Population by Age Group

Prosperity Region	*Ages 0-20*	*% of Region*	*Region % of Total Ages 0-20*
1	3,830	41.1%	4.5%
2	2,824	28.5%	3.3%
3	1,949	22.7%	2.3%
4	17,343	35.9%	20.2%
5	5,331	27.4%	6.2%
6	7,996	29.3%	9.3%
7	3,779	31.2%	4.4%
8	8,318	41.6%	9.7%
9	5,687	33.5%	6.6%
10	28,694	26.6%	33.5%
TOTAL	85,750	30.6%	

Prosperity Region	*Ages 21-44*	*% of Region*	*Region % of Total Ages 21-44*
1	2,316	24.8%	3.3%
2	2,463	24.8%	3.5%
3	2,017	23.5%	2.9%
4	12,345	25.6%	17.7%
5	4,850	25.0%	6.9%
6	7,037	25.8%	10.1%
7	3,179	26.2%	4.5%
8	5,204	26.0%	7.4%
9	4,315	25.4%	6.2%
10	26,156	24.2%	37.4%
TOTAL	69,882	25.0%	

Prosperity Region	*Ages 45-64*	*% of Region*	*Region % of Total Ages 45-64*
1	1,498	16.1%	2.4%
2	2,450	24.7%	4.0%
3	2,469	28.8%	4.0%
4	9,807	20.3%	15.9%
5	5,014	25.8%	8.1%
6	6,789	24.9%	11.0%
7	2,718	22.4%	4.4%
8	3,471	17.4%	5.6%
9	3,623	21.4%	5.9%
10	23,738	22.0%	38.6%
TOTAL	61,577	22.0%	

Prosperity Region	*Ages 65+*	*% of Region*	*Region % of Total Ages 65+*
1	1,682	18.0%	2.7%
2	2,182	22.0%	3.5%
3	2,137	24.9%	3.4%
4	8,792	18.2%	14.1%
5	4,226	21.8%	6.8%
6	5,483	20.1%	8.8%
7	2,447	20.2%	3.9%
8	2,995	15.0%	4.8%
9	3,344	19.7%	5.3%
10	29,279	27.1%	46.8%
TOTAL	62,568	22.4%	

Population by Gender

Prosperity Region	*Total*	*Female*	*Male*
1	9,327	5,374	3,953
2	9,919	5,742	4,177
3	8,571	4,829	3,742
4	48,287	27,680	20,607
5	19,422	11,005	8,417
6	27,304	15,663	11,641
7	12,123	6,857	5,266
8	19,989	11,456	8,533
9	16,969	9,391	7,578
10	107,867	63,170	44,697
TOTAL	279,777	161,167	118,610

Characteristics of Provider Population

Approximately 62,000 providers are actively enrolled in the Michigan Medicaid program. There are 47,031 individual providers, 7,839 group practices, and 7,143 facility agency organizations (FAOs). FAOs represent hospital and clinic type providers. Additionally, the provider enrollment application includes an optional field that allows a provider to indicate whether or not they are accepting new Medicaid patients. Currently, 85% of providers have indicated they are accepting new patients.

Below is a breakdown of the providers by the five service categories addressed in the AMRP. It should be noted that the totals below reflect the providers that have selected the specific specialty, they do not include providers that may have selected a different specialty but perform the services under multiple service categories. It should also be noted that the primary rate incentive that is currently being offered by Michigan Medicaid provides a strong incentive for providers to select a specialty designation of family practice, general internal medicine, and pediatric medicine rather than a more specific designation like ENT, general surgery, or orthopedics. The numbers below reflect the *individual providers* that are currently Medicaid-enrolled; they do not account for group practices, clinics, hospitals, ambulatory surgical centers, or mid-level practitioners who are providing many of these same services.

	Total Providers							
	Primary Care		***Specialists***			***OB*****	***Home Health***	
Prosperity Region	*PCP*	*Dental*	*ENT*	*Surgery*	*Orthopedic*	*OB***	*HHA*	*PDN*
1	62	14	3	2	5	33	14	18
2	62	14	2	7	6	25	9	5
3	60	6	-	1	4	18	11	7
4	135	52	1	7	9	85	34	18
5	117	15	5	9	10	26	15	2
6	111	31	1	8	1	47	33	16
7	45	17	-	2	1	28	6	4
8	72	21	5	10	3	37	19	8
9	119	35	1	15	6	50	22	15
10	436	308	16	55	34	195	125	42
OVERALL	**1,219**	**513**	**34**	**116**	**79**	**544**	**288**	**135**

*** OB total provider count includes those providers with specialty of Obstetrics/Gynecology or who have provided obstetric services based on claims data with dates of service between 10/1/2013 and present.*

Michigan has a large network of safety net providers including 195 Federally Qualified Health Centers, 190 Rural Health Centers, 18 Tribal Health Centers, and 45 Local Health Departments,

many of which have locations in multiple counties. In addition, several safety net providers operate mobile facilities that increase access to medical and dental services for beneficiaries residing in rural areas of the state. The Local Health Departments play an instrumental role in connecting Medicaid beneficiaries with providers in the community.

Behavioral health providers were not included in the chart above because Michigan Medicaid uses a contractor to manage and administer most of its behavioral health services. To expand access to these services, Michigan Medicaid recently opened enrollment to additional mental health professionals, including psychologists, social workers, professional counselors, and marriage and family therapists. MDHHS is confident the enrollment of these non-physician behavioral health provider types will adequately address access to care issues related to behavioral health services.

In addition to the face-to-face visits, telemedicine is also a payable service to Michigan Medicaid enrolled providers and is another avenue the state uses to help ensure access to care is available for all Medicaid beneficiaries. Telemedicine is particularly valuable for increasing access to specialists for beneficiaries who reside in rural areas of the state where specialty providers typically do not choose to open a practice.

Beneficiary and Provider Input

Michigan collects and analyzes the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data for individuals enrolled in managed care health plans. Michigan used FY 2015 CAHPS survey data to assist in its review of access to care. At this time, Michigan does not have an assessment survey in place that is dedicated specifically to FFS beneficiaries. While the CAHPS survey is designed for the managed care population, it was also sent to a sampling of Michigan's FFS beneficiaries. Survey results from 2015 indicated Michigan Medicaid FFS beneficiary satisfaction scores were above the national average.

[redacted] Total Number of Respondents and Response Rates				
Plan Name	**Sample Size**	**Completes**	**Ineligibles**	**Response Rates**
MDHHS Medicaid Program	**24,517**	**7,571**	**609**	**31.67%**
Fee-for-Service	1,350	430	99	34.37%
MDHHS Medicaid Managed Care Program	**23,167**	**7,141**	**510**	**31.52%**

Complete survey results can be found at: http://www.michigan.gov/documents/mdch/MI_CAHPS_Adult_Report_367057_7.pdf

Overall, 89% of Michigan FFS beneficiaries stated they were able to access the care they needed. The national average in this category was 81%. The survey results also showed that 90% of Michigan respondents stated they received the care they needed quickly, compared to the national average of 81%. These two statistics reinforce the stated findings that FFS beneficiaries are receiving the care they need and that their needs are being fully met.

Michigan operates a beneficiary call center as a way of engaging beneficiaries and assisting them with their needs. Each Medicaid card includes the toll-free number to the call center. The call center operates daily Monday through Friday, from 8 am to 7 pm. Calls into the call center are logged into Customer Relationship Management (CRM) software, detailing the issues raised and the resolution. On a monthly basis, a report is produced detailing the number of calls, the issues raised, and the resolution of the issue. Calls in which the beneficiary requests assistance with locating a provider are resolved immediately by call center staff. Since calls requesting assistance with locating a provider do not necessarily indicate an access to care issue, Michigan will be adding a couple of additional selectable options under the "reason" category in CRM that will make it easier for MDHHS to identify possible access issues.

The provider community has access to their own call center. Much like the beneficiary helpline, calls are logged in CRM with details of the issue raised and the resolution. Again, monthly reports are produced detailing number of calls, the issues raised, and the resolution. Michigan has created a provider support email address that allows providers to submit their questions and concerns via secured email. The emails are logged into CRM and providers are contacted directly with a resolution. Calls and emails regarding rates or payment methodology are forwarded to policy staff for consideration and resolution.

The state will continually monitor CRM for issues related to access to care, rates, and payment methodology. These numbers will serve as baselines should Michigan decide to reduce rates or change its payment methodology.

Payments available from other Public and Private Payers

Individual procedure codes from all five service categories were analyzed to determine how Michigan Medicaid rates compare to other carriers, including Medicare, commercial, and a neighboring state Medicaid plan that is comparable in size. A total of 53 rates covering 34 distinct procedure codes were analyzed. For each rate comparison the provider type and site of service were considered.

Primary Care - 99202, 99213, 99306, 99310, 99326, 99335, 99343, 99350

Physician Specialty Care – 99203, 99214, 99236, 99284, 99304, 20610, 73562, 31575, 92567, 47562, 35476

Behavioral Health Services – J0515, 90832, 90837, 90853, 96118

Pre- and Post Natal Obstetric Services including labor and delivery – 59400, 59510, 59425, 59426, 59430

Home Health Services – A6247, A4351, G0151, G0300, 99601

Michigan Medicaid rates are uniform across all Medicaid populations, with no payment variations between children and adults.

An average of all the procedure codes reviewed shows Michigan Medicaid's reimbursement rate is 79% of the Medicare fee schedule. Considering Medicare pays 80% of its fee schedule on Part B claims, Medicaid's reimbursement is essentially the same as Medicare's. However, the numbers vary by individual service category. For instance, under the Home Health category, Michigan Medicaid reimburses at 74% of Medicare's rate, while Pre- and Post Natal Obstetric services are paid at 95% of Medicare's rate.

In comparison, Michigan Medicaid's rates average about 54% of commercial rates. The highest percentage was 63% for Home Health and Pre- and Post Natal Obstetric services. A comparison of Medicare's rates to those of commercial rates shows that Medicare's rates are roughly 69% of private payers, on average.

Please note, the rate comparisons do not include Medicaid payments made under the cost based reimbursement model of the Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), and Tribal Health Centers (THC). The rates paid under cost based reimbursement model are traditionally higher than Medicare and commercial payer rates. The enhanced rate Michigan Medicaid is currently paying for Primary Care services was also excluded from this analysis.

Michigan also compared its reimbursement rates to those of a Medicaid program in a neighboring state. However, the neighboring state did not cover several of the procedure codes included in the analysis so the comparison between Michigan and the neighboring state only included codes covered by both states. The results of the comparison showed that, on average, the neighboring state's Medicaid rates were 72% of Michigan Medicaid's.

A comparison of the rates by site of service shows Michigan Medicaid pays, on average, 83% of Medicare rates for facility services. When Medicaid facility rates were compared to facility rates of commercial payers, it went down to 58%. A look at non-facility rates shows that, on average, Michigan Medicaid pays 70% of Medicare's rate and 47% of commercial rates. When we compared rates by site of service to another Medicaid program, the neighboring Medicaid program pays at 71% of Michigan Medicaid's non-facility rate and 81% of Michigan's facility rate. Again, the comparisons do not include Medicaid payments made under the cost based reimbursement model of the Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), and Tribal Health Centers (THC) or the enhanced primary care rate.

Since there was no utilization data available for Behavioral Health services, Michigan will include a these services in the rate comparison during the next AMRP review.

Analysis of Individual Service Categories

Primary Care Services

Extent to which beneficiary needs are fully met – Results from CAHPS survey and CRM inquiries show beneficiary needs are being met. The CAHPS survey shows a FFS beneficiary approval rate of around 90% for both having access to the care they need and receiving the care they need in a timely fashion.

Availability of care through enrolled providers – A review of Primary Care physicians shows an adequate number of enrolled providers in each prosperity region. An average of all the prosperity regions shows a ratio of 1 primary care physicians for every 229 beneficiaries. The best ratio was 1 physician to every 142 beneficiaries and the worst ratio was 1 physician for every 357 beneficiaries. Again, these numbers do not factor in LHDs or mid-level practitioners, many of whom act as primary care physicians.

Utilization – In 2015 primary care services had a utilization rate of 58.5%. When looking at the enrolled providers above, the average was figured by dividing the number of beneficiaries by the number of enrolled primary care physicians. If we refigure the provider to beneficiary ratio using the utilization rate, the ratio is 1 physician for every 134 beneficiaries. An overview of the prosperity regions shows utilization percentages ranging from 55 to 70 percent. These numbers only account for medical services. If we look at dental services the physician to beneficiary ratio is 1 to 575. This number will go down drastically beginning in October 2016 because children, located in Wayne, Oakland, and Kent counties will be enrolled in Healthy Kids Dental. The Healthy Kids Dental program is a managed care dental program that will be statewide beginning in October 2016.

Payment available from other payers – On average, Michigan Medicaid pays 57% of Medicare rate for primary care services. However, this percentage does not include the Michigan Medicaid enhanced rate for primary care services or the cost based reimbursement rates of the FQHCs, RHCs, and THCs. If the enhanced rate is considered, the percent of Medicare goes to 76%. The percentages are consistent across facility and non-facility sites of service. Michigan Medicaid's rates are currently 43% of local commercial rates and 118% of the neighboring Medicaid's rates.

Physician Specialists Services

Extent to which beneficiary needs are fully met – Results from CAHPS survey and CRM inquiries show beneficiary needs are being met. The CAHPS survey shows a FFS beneficiary approval rate of around 90% for both having access to the care they need and receiving the care they need in a timely fashion.

Availability of care through enrolled providers – A review of the three selected specialist categories shows a ratio of physicians to beneficiaries that is much lower than Primary Care services. An average of the three selected specialties, across all the prosperity regions shows 1 specialist for every 4,725 beneficiaries. This figure was derived by dividing the number of beneficiaries by the number of enrolled ENT, Orthopedic, and General Surgery specialists. The best ratio was 1 specialist for every 1,131 beneficiaries and the worst ratio was 1 specialist for every 27,304 beneficiaries. Again, these numbers do not factor in FQHCs, RHCs, THCs, hospitals, ambulatory surgical centers, or mid-level practitioners that are performing these services.

Utilization – In 2015 specialist services had a utilization rate of 6.2%. When looking at the enrolled providers above, the ratios were figured by dividing the number of beneficiaries by the number of enrolled specialists. If we refigure the provider to beneficiary ratio using the utilization rate, the ratio is 1 specialist for every 226 beneficiaries. An overview of the prosperity regions shows utilization percentages ranging from 2 to 10 percent.

Payment available from other payers – On average, Michigan Medicaid pays 58% of Medicare's rate for physician specialty services. However, many of the services under this category are also services that are eligible to receive the enhanced rate if the provider has the appropriate specialty on file. Again, these percentages do not include payments made under the cost based reimbursement model of the FQHCs, RHCs, and THCs or the enhanced rate. The percentages are consistent across facility and non-facility sites of service. Michigan Medicaid's rates are currently 45% of local commercial rates and 104% of the neighboring Medicaid's rates.

Behavioral Health Services

Behavioral Health services were not included in this analysis due to the structure of the behavioral health program in Michigan. While we have individuals who are covered under FFS Medicaid for most services, almost all of the behavioral health services are covered by a set of ten Prepaid Inpatient Health Plans (PIHPs). As a result, we have very few individuals who are not covered under managed care. Beginning on January 1, 2016, FFS Medicaid began covering some services for beneficiaries not enrolled with one of the PIHPs. If data is available, Michigan will include Behavioral Health services during the next plan review.

Pre- and Post-Natal Obstetric Services including Labor and Delivery

Extent to which beneficiary needs are fully met – Results from CAHPS survey and CRM inquiries show beneficiary needs are being met. The CAHPS survey shows a FFS beneficiary approval rate of around 90% for both having access to the care they need and receiving the care they need in a timely fashion.

Availability of care through enrolled providers – A review of the Obstetric services category shows the best ratio of providers to beneficiaries. An average of all the prosperity regions shows 1 OB provider for every 157 beneficiaries. The OB provider count includes those with specialty of obstetrics or gynecology, or those providers for whom we have claims data since October 2013 that indicates work in obstetrics. The best ratio was 1 OB provider to every 90 beneficiaries and the worst ratio was 1 OB provider for every 225 beneficiaries. It should be noted that ratios were based on the FFS population that is female and between the ages of 9 and 54.

Utilization – In 2015 OB services had a utilization rate of 16.6%. This rate uses females, ages 9 to 54 as the denominator. An overview of the prosperity regions shows utilization percentages ranging from 12 to 19 percent.

Payment available from other payers – On average, Michigan Medicaid pays 95% of Medicare's rate for OB services. The percentages are fairly consistent across facility and non-facility sites of service. Michigan Medicaid's rates are currently 63% of local commercial rates and 197% of the neighboring Medicaid's rates.

Home Health Services

Extent to which beneficiary needs are fully met – Results from CAHPS survey and CRM inquiries show beneficiary needs are being met. The CAHPS survey shows a FFS beneficiary approval rate of around 90% for both having access to the care they need and receiving the care they need in a timely fashion.

Availability of care through enrolled providers – A review of Home Health services shows an adequate number of enrolled providers in each prosperity region. An average of all the prosperity regions shows 1 home health agency for every 803 beneficiaries. These numbers reflect both Home Health Agencies and the Private Duty Nurses that service Medicaid beneficiaries under age 21. The numbers were derived by dividing the number of beneficiaries by the number of Home Health/PDN agencies. The best ratio was 1 home health/PDN agency for every 666 beneficiaries and the worst ratio was 1 home health/PDN agency for every 2,665 beneficiaries.

Utilization – In 2015 Home Health services had a utilization rate of .2%. If we refigure the provider to beneficiary ratio using the utilization rate, the ratio is 1 home health/PDN agency for every 3 beneficiaries. An overview of the prosperity regions shows percentages ranging from .1 to .3 percent.

Payment available from other payers – On average, Michigan Medicaid's pays 74% of Medicare's rate for Home Health Services. Michigan Medicaid's rates are 63% of local commercial rates and 111% of the neighboring Medicaid's rates.

Access Monitoring Review Plan Timeframe

The effective date of this AMRP is October 1, 2016. The entire plan will be updated by October 1 of each subsequent review period. If there are no rate reductions or restructuring, the plan will be updated every 3 years. The update will consist of a complete analysis of the data collected using the methodology specified in this plan, with a separate analysis for each provider type and the site of service. For rate reductions or restructuring, please see the section below titled: Special provisions for SPAs that reduce or restructure payments. The review will be completed for all of the following:

- Primary Care Services (including those provided by physician, FQHC, clinic, or dental care);
- Physician specialist services - Orthopedics/Otolaryngology/General Surgery;
- Behavioral health services (including mental health and substance use disorder);
- Pre- and post-natal obstetric services including labor and delivery;
- Home health services;
- Additional types of services for which the state or CMS has received significantly higher than usual volume of beneficiary, provider or other stakeholder access complaints for a geographic area, including complaints received through the mechanisms for beneficiary input, as described in the Mechanisms for ongoing beneficiary and provider input section below; and
- Additional types of services selected by the state.

Special Provisions for SPAs that Reduce or Restructure Payments

In the event the State of Michigan submits a State Plan Amendment (SPA) that proposes a provider payment rate reduction or restructures provider payments that could result in diminished access to care, the state will submit a new access review addressing each service affected. The review will be completed in accordance with the AMRP plan and will demonstrate compliance with the access requirements at section 1902(a)(30)(A) of the Social Security Act.

Once the payment rate reduction or restructuring is implemented, the State will annually monitor access for a period of three years from the effective date of the state plan amendment. The data gathered prior to the rate reduction or restructuring will be used as the baselines for the comparative analysis. The procedures for monitoring access will consist of:

- Comparing provider enrollment numbers pre- and post-implementation to determine if the rate change or restructure impacted the number of enrolled providers

- Monitoring beneficiary and provider input mechanisms, specifically looking for increased complaints regarding access to care and payment rates or methodologies
- Comparative rate reviews of Medicare and other public and private payers by provider type and site of service
- Comparing utilization of services data from before and after the rate reduction or restructuring

Mechanisms for ongoing Beneficiary and Provider Input

The State of Michigan has established the following mechanisms to monitor public input:

- Beneficiary helpline
- Provider helpline
- Children with disabilities helpline
- Beneficiary Pharmacy helpline
- Beneficiary enrollment helpline
- Healthy Kids dental helpline
- Beneficiary appeals process
- Provider appeals process
- Health facility complaint helpline
- Bureau of Community and Health Systems, allegation unit helpline
- Ombudsman

The state will continually monitor the above mechanisms for any issues related to access of care. Should any issues present, the state will take the following corrective action:

- Promptly respond to public input, citing specific access problems
- Conduct an investigation with a thorough analysis of the issue
- Maintain a record of public input data and how the state responded to the input. The record will be made available to CMS upon request.

Addressing Access Questions and Remediation of Inadequate Access to Care

For any access deficiencies that arise, the state will submit a corrective plan of action, within 90 days of discovery, with specific steps and timelines required to address the issue. The remediation of the access deficiency will take place within 12 months even though the plan may contain some longer-term objectives.

The state's corrective actions will address the access deficiencies with one or more of the following measureable and sustainable improvements:

- Increasing payments
- Improving outreach to providers
- Reducing barriers to provider enrollment
- Providing additional transportation to services
- Providing for additional telemedicine and telehealth services
- Improving care coordination
- Other resources as required to eliminate the access deficiency

Data Sources

- CHAMPS – Community Health Automated Medicaid Processing System
- CHAMPS Data Warehouse for historical claims data
- CRM
- CAHPS survey
- Medicare Fee Schedule
- Commercial Fee Schedule
- Neighboring State Medicaid Fee Schedule

Assumptions

A thorough analysis of the data contained in this report shows that Michigan Medicaid FFS beneficiaries have access to care that is comparable to the general population of Michigan. The access to care is sufficient and in accordance with section 1902(a)(30)9A) of the Social Security Act. Michigan Medicaid rates are sufficient to enlist enough providers so that care and services are available at least to the extent they are available to the general public.

Trends and Factors

An Executive Order in 2009 required the reduction of rates for many Medicaid services, but Michigan has not implemented any additional rate reductions since the 2009 Executive Order was issued. However, in the past five years there have been several factors that have had a potential positive impact on access to care for Michigan Medicaid beneficiaries, including the implementation of the Healthy Michigan Plan (Medicaid's expansion population) in April 2014, the enhanced primary care rate increase effective January 2013, and physician adjustor payments that began in October 2010. The primary care rate increase and physician adjuster program are still operational and have increased payments to physicians and hospitals.

The numbers supplied in the analysis above will service as baselines for any future comparisons. If appropriate, trending will be completed after the next rate or payment methodology change.

Key Findings

A thorough analysis of the data reviewed indicates that Michigan Medicaid beneficiaries do not encounter access to care issues and that access is consistent with that of Michigan's general population. When comparing the utilization of services to the number of providers enrolled in each service category, it clearly shows Medicaid beneficiaries are receiving care that is equal to that of the general population. The numbers also indicate that MDHHS rates are sufficient to enroll enough providers to service the Medicaid population. However, Michigan has identified a couple of reporting mechanisms that are being updated to assist the state in identifying access to care inquiries. Michigan continues to provide quality healthcare to its Medicaid population.