Oregon Health Authority

2016

Oregon Access Monitoring Review Plan

Actuarial Services Unit

Health Systems Division

Health Policy and Analytics Division

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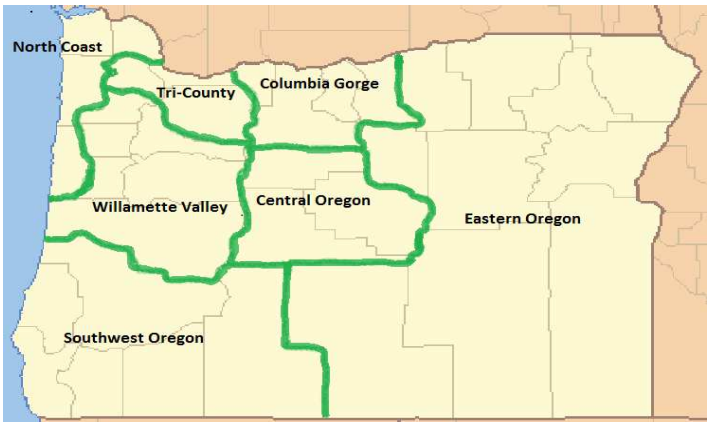
1 EXECUTIVE SUMMARY

The Oregon Health Authority has established an Access Monitoring Review Plan to determine the sufficiency of access to care for fee-for-service (FFS) members. This summary captures the findings from the first iteration of the FFS Access Monitoring Plan, and steps to be taken to monitor and improve access to care for FFS members. FFS members represent approximately 15% of the OHP population. The FFS population primarily consists of members with other private health insurance, dual-eligible (Medicare and Medicaid) members, non-citizens with the CAWEM benefit package, and American Indian/Alaskan Native tribal members who are not mandatorily enrolled in managed care plans.

The plan reviews beneficiary utilization and access complaint rates for the following regions:



A baseline of FFS beneficiary complaint rates was established based on the average rate (per 1000 FFS members) of quarterly complaints logged at the department in calendar year 2015.

For each region, the threshold that triggers investigation and potential corrective action is when quarterly complaint rates surpass two standard deviations of the 2015 baseline:

Region	North Coast	Tri-County	Columbia Gorge	Eastern Oregon	Willamette Valley	Southwest Oregon	Central Oregon
Complaint Baseline	3.90	4.27	2.77	2.60	3.49	3.20	3.23
Threshold	**6.10**	**5.68**	**3.54**	**4.43**	**4.63**	**4.75**	**4.59**
Q1 2016 Rate	2.33	4.69	**3.57**	2.51	3.65	3.31	3.12
Q2 2016 Rate	3.05	4.27	2.14	2.07	3.44	2.69	3.21

In Q1 2016, the complaint rate in the Columbia Gorge region surpassed the threshold; however in Q2 2016 the complaint rate was significantly reduced below the baseline.

A similar method for monitoring beneficiary utilization rates will be used when criteria for counting raw primary care, physician specialty, behavioral health, obstetric, dental, and home health claims is established. OHA will establish baseline utilization rates for each of the required service categories, and thresholds based on two standard deviations below the baseline for each region by October 2017. This primary monitoring function will also capture utilization rates separately for adults, children, and American Indian/Alaskan Native (AI/AN) FFS members. *Primary Monitoring Activities* such as complaint rates and utilization rates will be refreshed every quarter.

Other *Secondary Monitoring Activities* include the FFS Reimbursement Rate Study and the Access to Care Measures captured in sections 5 and 6. The functions will be refreshed annually.

FFS members, through the CAHPS survey, generally report similar or better experiences with accessing care as their CCO counterparts. The primary care and behavioral health utilization measures in section 6 show that FFS members utilize fewer services than CCO members. OHA will begin investigating whether an access issue specific to Oregon Medicaid exists due to the low rates of utilization for the FFS population on the *Adolescent Well-Care Visit* and *Well-Child Visits* measures. For Adolescent Well Care Visits, FFS children and young adults are utilizing at about 22 percentage points below their CCO counterparts at 13.8% compared to 35.7%. This FFS rate is also significantly lower than the 2014 national Medicaid 75th percentile of 62%. For Well-Child Visits (six visits with their care provider in the first 15 months of life), less than a third of FFS children meet the six visit threshold. This is 33.6 percentage points below CCOs, and 47.7 below the 2014 national Medicaid 90th percentile.[1]

The FFS Reimbursement Rate Study shows actual average FFS reimbursement amounts are less than CCO and Medicare reimbursements. Generally this disparity between FFS and CCO reimbursements is most pronounced for primary care and dental services.

Within the 2015 Oregon Physician Workforce Survey (PWS), 88% of practitioners reported they are accepting new OHP members. Of the 12% who reported not accepting new Medicaid recipients, the top reason was the “reimbursement rate” at 83%. Physicians surveyed report very low levels of ease in referring OHP recipients to inpatient and outpatient behavioral health services. On average, only 25% of physicians surveyed in 2015 reported ease in referring members to behavioral health services. 64% reported ease in referring Medicaid recipients to specialists.

OHA must devote resources to monitoring and assuring access to services for the FFS population. For any measures showing poor performance, OHA will develop and implement specific improvement plans.

[1] Oregon's Health System Transformation: CCO Metrics 2015 Final Report – June 2016
https://www.oregon.gov/oha/Metrics/Documents/2015_Performance_Report.pdf

2 Overview

The Oregon Medicaid program, known as the Oregon Health Plan (OHP), provides healthcare coverage for low-income individuals including children, pregnant women, people with disabilities, elderly, parents and non-citizens. The Oregon Health Authority (OHA) is designated as the single state Medicaid agency. Oregon expanded access to Medicaid through the Affordable Care Act Medicaid Expansion in 2014, and by 2015, provided coverage to approximately 1.1 million enrolled beneficiaries.

The Oregon Health Plan is a demonstration project authorized under section 1115 of the Social Security Act (the Act), which is funded through titles XIX and XXI of the Act. Under the demonstration, Oregon strives to promote the following objectives:

- Providing a health benefit package
- Insuring broad participation by health care providers
- Implementing a clinical effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians
- Structuring benefits using a prioritized list of health care conditions and treatments
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries that:
    - Improve the individual experience of care
    - Improve the health of populations, and
    - Reduce the per capita costs of care

OHA has developed an Access Monitoring Review Plan for the following service categories provided under a fee-for-service (FFS) coverage plan:

- Primary care services, including oral health access
- Physician specialist services
- Behavioral health services
- Pre-natal and post-partum obstetric services, including labor and delivery
- Home health services

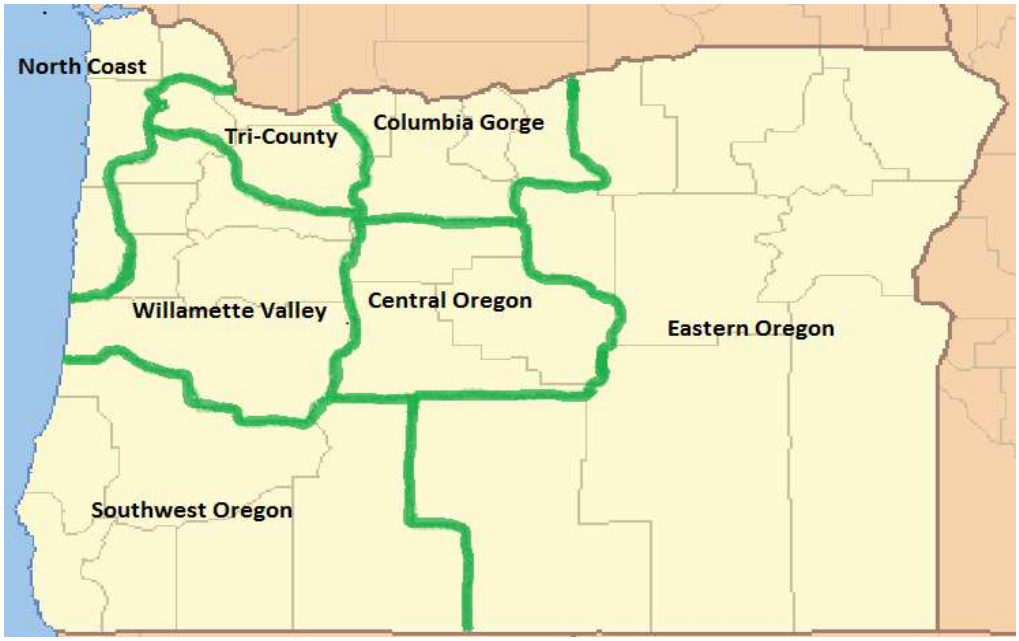
2.1 Oregon Regions

Regional analysis was conducted based on seven groups of Oregon counties. These regions were determined based on the unique characteristics and culture of each area. Within the Tri-County region is the major metropolitan Portland area, with the more rural North Coast and Columbia Gorge regions on each side. The lower Willamette Valley hosts a mixture of rural areas and small to mid-sized cities like the capital Salem, and college towns Eugene and Corvallis. The Southwest and Central Oregon regions are predominantly rural each with one small to mid-sized

city in Medford and Bend, respectively. The Eastern Oregon frontier region is a large, sparsely populated area of the state (see Figure 1):

- **Columbia Gorge** - Hood River, Wasco, Sherman and Gilliam counties
- **Tri-County** - Washington, Multnomah, Clackamas counties
- **Willamette Valley** - Marion, Polk, Yamhill, Benton, Lane, Linn counties
- **North Coast** - Clatsop, Columbia, Tillamook, Lincoln counties
- **Central Oregon** - Jefferson, Crook, Deschutes counties
- **Southwest Oregon** - Coos, Douglas, Curry, Josephine, Jackson, Klamath counties
- **Eastern Oregon** - Morrow, Umatilla, Union, Wallowa, Wheeler, Grant, Baker, Harney, Malheuer, Lake counties

Figure 1: Seven Regions for the FFS Access Monitoring Plan



There are variations in the regions in Sections 5 (FFS Reimbursement Rate Study) due to a small total number of claims. Certain regions were combined with others for more accurate analysis.

2.2 Structure of Monitoring Activities: Primary and Secondary Operations

The FFS Access Monitoring Plan will produce data and analysis that informs determinations of the sufficiency of access to care for the service categories outlined above. Through regional analysis of beneficiary feedback and utilization trends, OHA will create baseline data, and set thresholds for investigation of access issues at two standard deviations from the baseline. Other

data analyses the impact and implications of provider availability, population characteristics, and FFS reimbursements compared to other regional healthcare payers.

The structure of the FFS Access Monitoring Plan is to use primary data from beneficiary feedback and rates of service utilization to inform whether access is sufficient. These are considered to be *Primary Monitoring Activities* because they draw a direct correlation, from member generated data, to the ability to access services. *Secondary Monitoring Activities* also use primary data, but do not provide a direct correlation to access. Secondary measures and analysis, like the FFS Reimbursement Rate Study, will be utilized as factors that may influence access and the availability of services. Primary Monitoring Activities include: (1) reviewing beneficiary access complaint rates, and (2) beneficiary utilization rates against their respective baselines, for each region. A threshold for department investigation of an access issue (and potentially creating a corrective action plan) will be set at two standard deviations above the baseline for beneficiary complaints, and two standard deviations below the baseline for utilization rates. CCO performance metrics adopted for the FFS population, related to utilization, are also used as primary monitoring functions. These metrics are shown in Section 6.1.

The baseline for beneficiary complaints was established based on access complaints logged in calendar year 2015. From the 2015 complaint data, regional access complaint rates were established for each quarter by dividing the number of complaints by the total FFS members in the region, and multiplying by 1000. This established the access complaint per 1000 FFS members rate. The regional baselines for access complaints were then calculated based on the average of quarterly complaint rates (see Figure 2). A similar method will be used for monitoring utilization rates in each region. Utilization rates will also be broken down by select populations, including by adults, children, and American Indian/Alaskan Natives (AI/AN) given the large proportion of AI/AN members who are FFS.

Figure 2: Beneficiary Complaint Monitoring Methodology

Beneficiary Complaint Monitoring Method							
Region	Central Oregon	Columbia Gorge	Eastern Oregon	North Coast	Southwest Oregon	Tri-County	Willamette Valley
FFS Members	10900	2802	11135	5581	27511	53686	50641
2015Q1 Rate	4.22	2.86	4.13	4.84	4.51	5.10	4.46
2015Q2 Rate	2.75	3.21	1.71	2.33	2.47	3.54	3.08
2015Q3 Rate	3.49	2.86	2.33	5.02	2.84	3.61	3.32
2015Q4 Rate	2.48	2.14	2.25	3.40	2.98	4.84	3.08
Complaint Rate Baseline (2015 Average)	3.23	2.77	2.60	3.90	3.20	4.27	3.49
Standard Deviation	0.68	0.39	0.91	1.10	0.78	0.71	0.57
Complaint Rate Threshold (Baseline + 2 std. dev.)	4.59	3.54	4.43	6.10	4.75	5.68	4.63

Secondary Monitoring Activities will be refreshed annually, and include survey results from the Physician Workforce Survey (PWS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Mental Health Services surveys to supplement our understanding of beneficiary experience and provider availability. Also, a FFS Reimbursement Rate Study will be refreshed annually comparing actual average FFS reimbursement amounts to other regional payers.

3 Characteristics of the OHP FFS Population

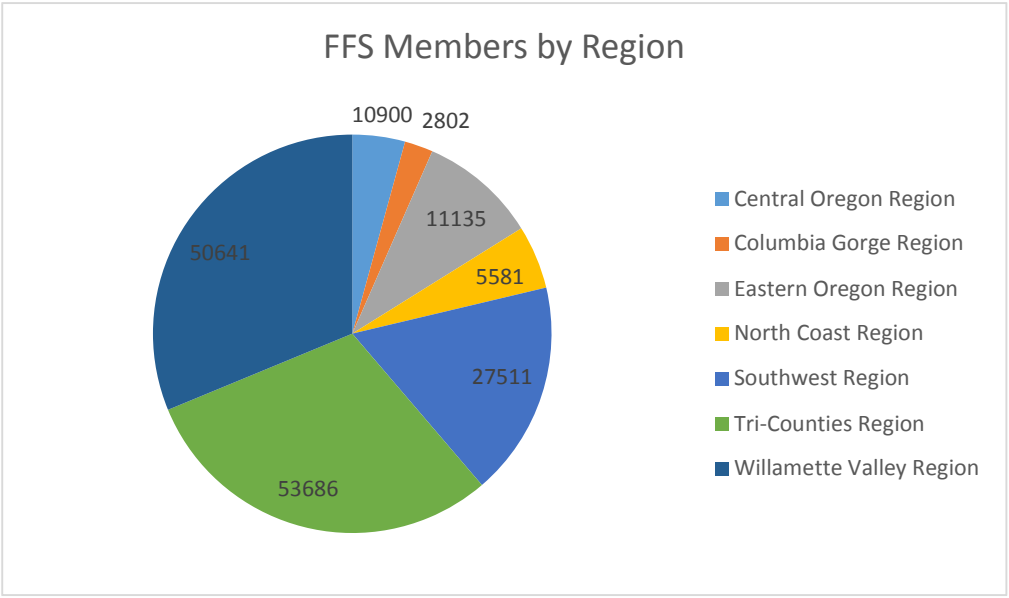
Members on the Oregon Health Plan who are not enrolled in a Coordinated Care Organization (CCO) or other managed care entity are considered to be FFS. Some FFS OHP members may only be FFS for a specific service category, and have managed care enrollment for others.

Below are the options for managed care coverage for OHP members:

- CCO-A: physical, mental, and dental health services
- CCO-B: physical and mental health
- CCO-E: mental health only
- CCO-G: mental health and dental
- DCO: dental care organization
- MHO: mental health organization

Figure 3: FFS Members (no physical health plan), by Region, May 2016

Regions	Total FFS Members
Central Oregon Region	10900
Columbia Gorge Region	2802
Eastern Oregon Region	11135
North Coast Region	5581
Southwest Region	27511
Tri-Counties Region	53686
Willamette Valley Region	50641
Grand Total	**162256**



3.1 How Members Become FFS on the Oregon Health Plan

When members are determined to be eligible for the Oregon Health Plan, most are required to join a CCO. Through the coordinated care organizations, members gain access to a comprehensive network of providers, and receive highly coordinated care. Dual-eligible (Medicare and Medicaid) members must opt-in to join a CCO. American Indian & Alaska Natives have the ability to join and leave a CCO as they choose. Children in the legal custody of the Department of Human Services or where the child is expected to be in a substitute care placement for less than 30 calendar days are also exempted from mandatory CCO enrollment.[2]

People who are non-citizens and eligible for the Citizen/Alien Waivered-Emergency Medical (CAWEM) program (for pre-natal, labor and delivery services or emergency treatment services) may not be enrolled with a CCO for any health care coverage[3]. Newly eligible members who are admitted as an inpatient at a hospital may not be enrolled with a CCO, but may be enrolled with a dental care organization. A significant portion of FFS members on the Oregon Health Plan are covered under a private major medical insurance policy or other third party resource (TPR) that covers the cost of services to be provided by a CCO. These members are not allowed to enroll with a CCO, however they are required to enroll with a DCO regardless of having oral health TPR.

Other members (or their health providers) may request that they be exempted from CCO enrollment on a case-by-case basis, based on the following scenarios[4]:

- Children under 19 years of age who are medically fragile and who have special health care needs
- Pregnant OHP members
- Newly eligible clients who are diagnosed and under the treatment protocol for an organ transplant
- Other members that the OHA determines just cause for, including enrollment would cause a serious health risk, and/or the OHA finds no reasonable alternatives

A high proportion of FFS members have other private health insurance, or are dual eligible (Medicare and Medicaid).[5] Dual-eligible members account for 20% of the total FFS population without a physical health plan[6], while those with private health insurance account for 29%. 11%

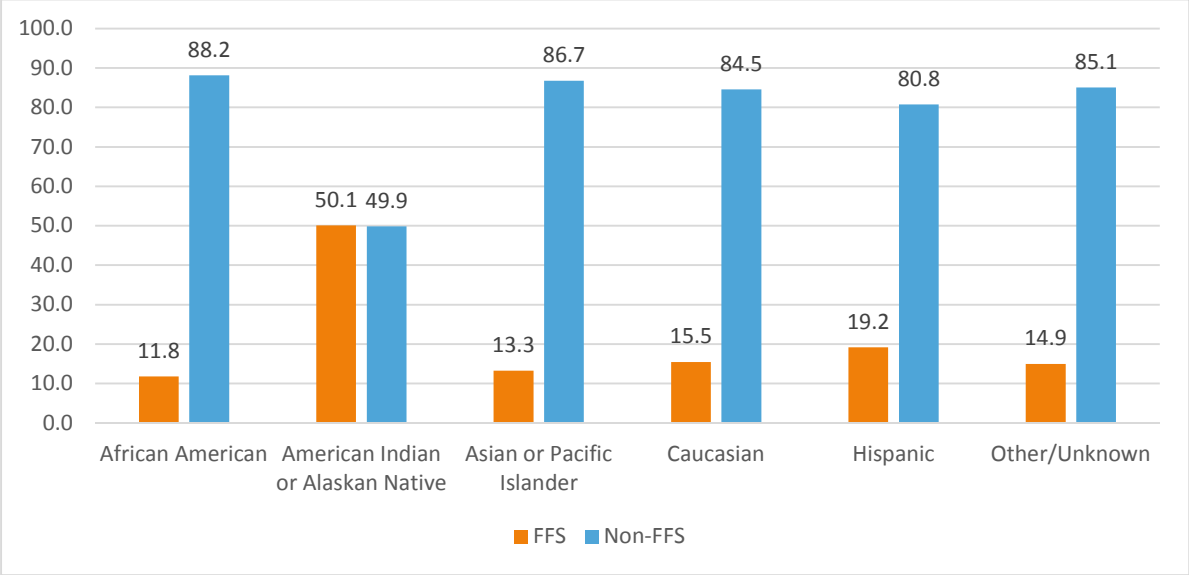
[2] Oregon Administrative Rule 410-141-3060(2) – Enrollment Requirements in a CCO
[3] Oregon Administrative Rule 410-141-3060(2) – Enrollment Requirements in a CCO
[4] The Oregon Health Plan Handbook references the FFS exemptions on page 9 - *https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he9035.pdf; OAR 410-141-3060 (6)(d)(A-B) also covers the continuity of care exemption*
[5] Datasource: DHS/OHA DSS warehouse; May 16th, 2016 Current Eligibles Tables.
[6] Initial figures produced for FFS members account of members not enrolled in a physical health plan (CCO-A or CCO-B)

of FFS members have the HNA indicator due to Tribal membership, and are not mandatorily enrolled in CCOs.

3.2 Demographics with a Higher Proportion of FFS Members

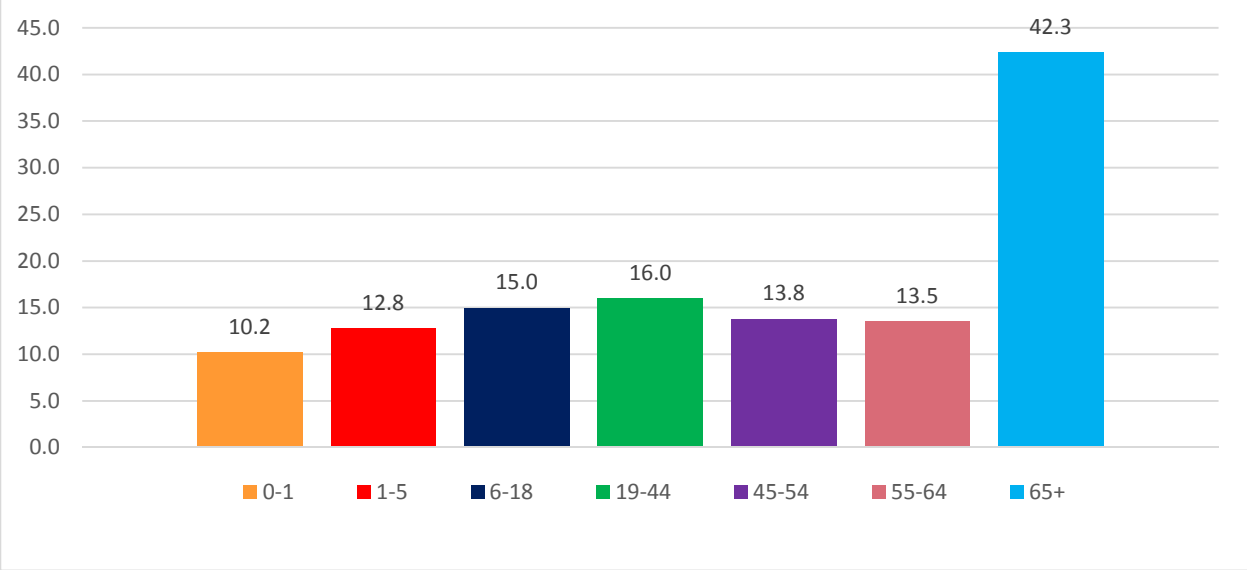
About half of all American Indian & Alaskan Natives on the Oregon Health Plan are FFS due to their ability to opt-out of the coordinated care model. There is also a larger proportion of Hispanic members who are FFS. Documented and undocumented immigrants are able to attain the CAWEM benefit package; however even pregnant non-citizens who qualify for the CAWEM-plus benefit package are prohibited from enrollment in a CCO (see Figure 4).

Figure 4: Percent of Oregon Health Plan Population on FFS by Race and Ethnicity, May 2016



Our population analysis also found that 42.3% of OHP members over the age of 65 are not enrolled with a CCO. This is not surprising considering dual-eligible (Medicare and Medicaid) members must opt-in to join the coordinated care model, and are not mandatorily enrolled. Roughly 16% of individuals between the ages of 19 – 44 are not enrolled in a CCO. This may be representative of the large bracket of FFS members with other private health insurance (see Figure 5).

Figure 5: Percent of OHP Population on FFS, by Age Group, May 2016



Regional analysis of the distribution of FFS members across the state found that there is not much variation between the seven regions in the percentage of FFS members, except in the Tri-County region (see Figure 6). Eastern Oregon has a slightly higher proportion (19%) of FFS members. This region is a large frontier area, consisting of an older population. On the contrary, the major metropolitan Tri-County region has a much lower percentage of OHP members who are FFS. Large CCOs which cover Portland and surrounding areas appear to have had more success in enrolling a more centrally located urban population, when compared to other regional CCOs.

Figure 6: Percent of OHP Population on FFS, by Region, May 2016

Central Oregon	***Eastern Oregon***	*Columbia Gorge*	North Coast	Southwest Oregon	**Tri-County**	Willamette Valley	State Avg.
18%	**19%**	17%	18%	18%	**14%**	17%	16%
10900	11135	2802	5581	27511	53686	50641	162256

4 Review of FFS Member Complaints

Data compiled for this trend analysis was generated through in-coming calls and written complaint forms (form 3001)[7] received by the Client Services Unit (CSU). Although CSU fields calls and receives 3001 forms from both FFS and CCO beneficiaries, the primary function of CSU is to serve as the customer service contact for the FFS population. While this monitoring plan will demonstrate how OHA analyzes complaint trends in retrospect, CSU and the OHA Complaints, Hearings, and Grievances Unit actively work to resolve complaints in real-time.[8] Staff take complaints over the telephone and record in a database, or upon the member's request, a complaint form is mailed or e-mailed to the member. Complaints are resolved by OHP member services, and escalated to the Health Systems Division's Complaint Unit, if necessary, for resolution.

4.1 FFS Member Complaints: January 2015 – May 2016

Several categories from the total complaint volumes were selected to compile the data. When the call is received, the client's enrollment status is reviewed based on the service category of the complaint (i.e., dental access, physical health). If the client is receiving the service as FFS, the complaint will be logged as FFS, even if the client is enrolled with a CCO for a different service category unrelated to the complaint[9]. The data and analysis in this section is based only on FFS complaints.

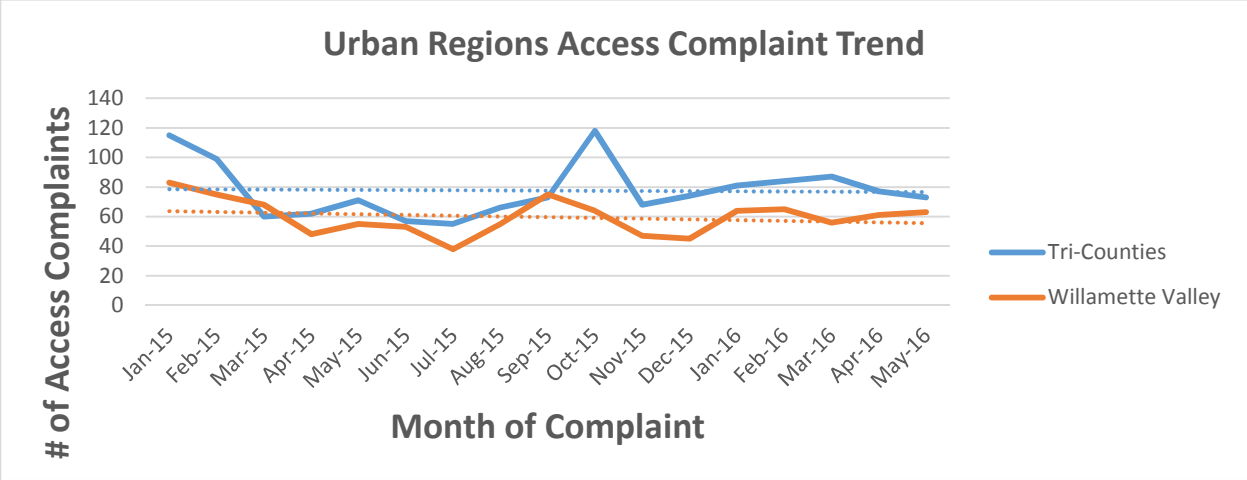
There is consistent trending across the regional service areas with the *Access to Services* and *Billing* categories receiving the highest volume of complaints. The majority of client complaints in the billing category are related to FFS members being charged directly for services rather than OHP covering the costs. When this occurs, OHP staff work directly with members and providers to verify OHP coverage, and resolve billing issues. Statewide, complaints received from FFS members overwhelmingly fell into these two categories (see Figures 7 and 8). Access to Service complaints made up 58% of total FFS complaints, while Billing complaints were 41%. The other two categories, *Quality of Service* and *Consumer Rights*, each accounted for less than one percent of total complaints statewide.

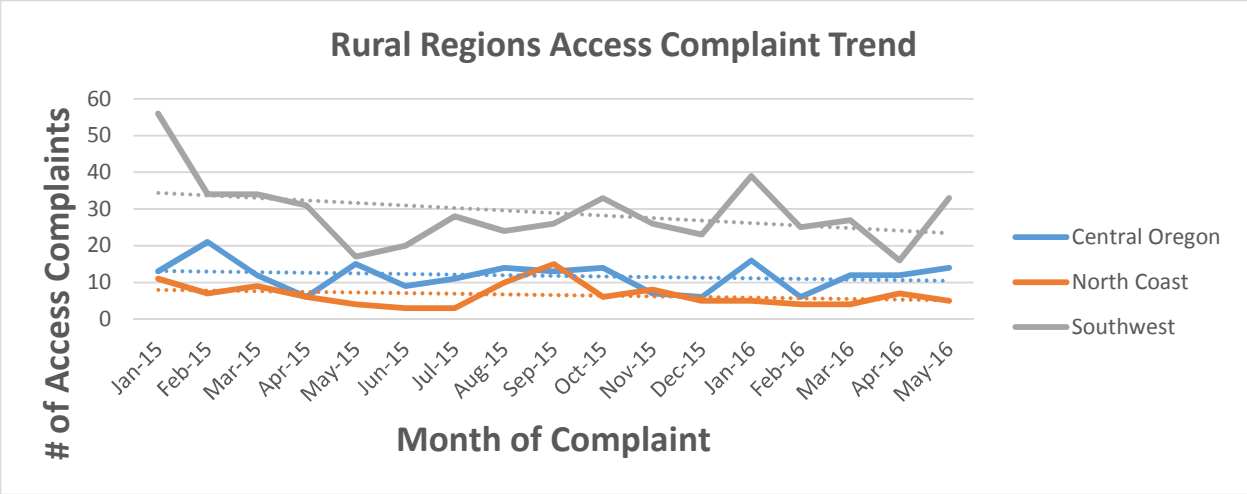
[7] Oregon Health Plan Client Complaints and Appeals webpage - *https://www.oregon.gov/oha/healthplan/Pages/complaints-appeals.aspx*
[8] Oregon Health Plan, Section 1115 Quarterly Report – Complaints and Grievances *http://www.oregon.gov/oha/healthplan/DataReportsDocs/First%20Quarter%202016.pdf*
[9] Managed Care Plan Service Cross-walk *https://www.oregon.gov/oha/healthplan/tools/Plan%20Codes%20Crosswalk.pdf*

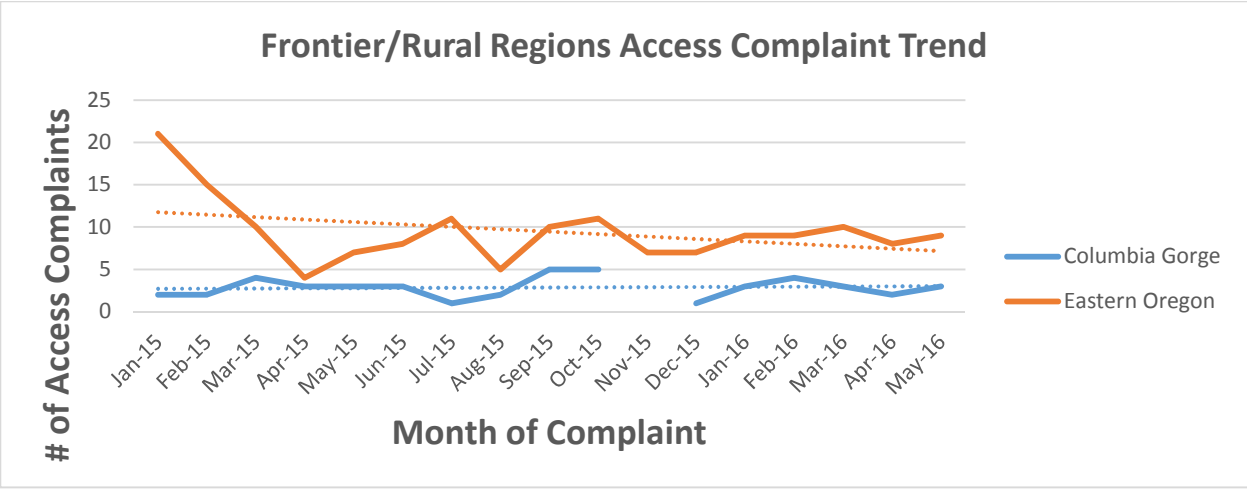
Figure 7: Aggregate FFS member complaints, by region

FFS Client Complaints January 2015 - May 2016						
Columbia Gorge	Tri-County	Willamette Valley	North Coast	Central Oregon	Southern Oregon	Eastern Oregon
Adult 57	Adult 1611	Adult 1266	Adult 156	Adult 275	Adult 631	Adult 264
Minor 27	Minor 491	Minor 408	Minor 51	Minor 84	Minor 172	Minor 73
Total 84	Total 2102	Total 1674	Total 207	Total 359	Total 803	Total 337
Consumer Rights	Consumer Rights	Consumer Rights	Consumer Rights	Consumer Rights	Consumer Rights	Consumer Rights
0 0%	2 0%	1 0%	0 0%	0 0%	1 0%	0 0%
Quality of Service	Quality of Service	Quality of Service	Quality of Service	Quality of Service	Quality of Service	Quality of Services
0 0%	2 0%	4 0%	0 0%	0 0%	0 0%	1 0%
Billing	Billing	Billing	Billing	Billing	Billing	Billing
40 48%	708 34%	613 37%	90 43%	149 42%	286 36%	168 50%
Access to Service	Access to Service	Access to Service	Access to Service	Access to Service	Access to Service	Access to Service
44 52%	1390 66%	1056 63%	117 57%	210 58%	516 64%	168 50%

Figure 8a, 8b, 8c: Trended FFS access complaints, January 2015 - May 2016




Rural Regions Access Complaint Trend
# of Access Complaints
60
50
40
30
20
10
0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Month of Complaint
Central Oregon
North Coast
Southwest


Frontier/Rural Regions Access Complaint Trend
# of Access Complaints
25
20
15
10
5
0
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Month of Complaint
Columbia Gorge
Eastern Oregon

5 OHP FFS Reimbursement Rate Study

The Oregon Health Authority's (OHA) Actuarial Services Unit (ASU) is assisting the Oregon Health Plan in developing an access monitoring plan for Fee-For-Service (FFS) Medicaid members. FFS access monitoring and review is required by federal regulation as stipulated in 42 CFR §447.203(b), and detailed by CMS guidelines published in November 2015.

The *2014 Oregon Physician Workforce Survey* shows that FFS reimbursement rates have a direct impact on the availability of care for Medicaid recipients[10]. It's important to quantitatively measure and compare FFS reimbursement rates to other payers, such as Medicare, and Oregon's Coordinated Care Organizations (CCOs), or MCOs, on an ongoing basis.

The first phase of the study compares primary care services and specialty care services provided by physicians and practitioners paid on the Medicaid's fee schedule and compares the reimbursement level to other payers. Under the Medicaid fee schedule methodology, professional services are adjudicated based on Relative Value Units (RVU) and a conversion factor that results in certain level of payment for each coded procedures. Preventative services is a target area for improvement in Oregon's health system transformation and is broken out in this reimbursement study for analysis purposes. We compare rates to the same professional services provided by CCOs and the current 2016 Medicare national fee schedule. Obstetrics and neonatal services, and dental services are also broken out in the reimbursement study.

In October 2017, the second phase of the study will include hospital claims and professional services provided in a hospital, or outpatient facility setting. Please note, OHA relies on cost to charge ratio method for most rural hospital claims (A/B hospitals), and therefore some services cannot be directly compared with Medicare payment systems (DRG or APC payments).

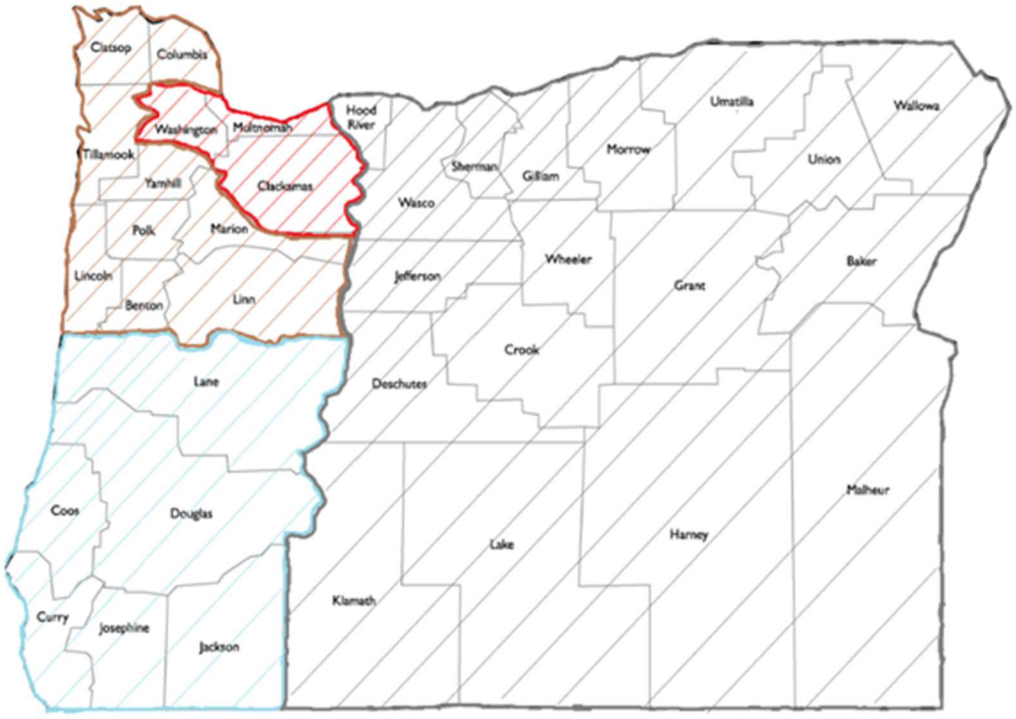
5.1 Regions

Regions were used to group the FFS data for the rate study for OHA's review. Regions allow for a relatively large data set to be analyzed while retaining the regional characteristics that might influence different payment levels, such as rural vs. urban. Several regional options were reviewed for the FFS reimbursement study; however, the limited members in FFS reduced the data credibility when more than four regions were selected. ASU aligned with the regions used for CCO rate setting regions and used the following four-region approach. This approach was appropriate in terms of member enrollment, geographic location and alignment with existing CCOs.

[10] 2014 Oregon Physician Workforce Survey
https://www.oregon.gov/oha/analytics/Documents/2014PhysicianWorkforceSurvey.pdf

Figure 9a, 9b: Regions for FFS Reimbursement Study

Region	2015 FFS FFS Members	CCOs in Region	2015 CCO Members
Tri County	57,532	2	350,208
Willamette/North Coast	37,654	5	204,703
Central/Eastern Oregon	26,118	4	129,241
Southwest Oregon	31,164	5	223,861
Total	**152,468**	**16**	**908,013**



5.2 Data Sources

Claims data for OHP FFS members, with dates of service in calendar year 2015, were used for the reimbursement study. FFS claims were processed through the Oregon MMIS, and extracted into the MMIS data warehouse for analytics. The MMIS data warehouse is the source for this reimbursement study.

5.3 FFS Data Exclusion and CCO Limitations

Services provided by federally qualified health centers (FQHC), rural health clinics (RHC), Tribal 638 clinics, and Indian Health Services (IHS) clinics have cost-based or all-inclusive reimbursement structures. Due to reimbursement differences, these provider types were excluded

from the analysis. In addition, members who were eligible for other coverage outside of Medicaid are not included in the comparison, such as dual-eligible members (Medicaid & Medicare), and TPL covered members. These exclusions were necessary to isolate the actual average FFS reimbursement rate on OHP, and compare to other regional payers. Not excluding these claims would result in the average FFS rate being skewed downward due to reported Medicare and TPL payments reducing FFS paid amounts on claims.

CCO reimbursement reflected in the encounter data is limited and may not capture the full level of reimbursement to providers. CCOs may make additional payments to their network providers through risk sharing, incentive or other alternative arrangements, including sub-capitation. Therefore, the comparison between OHP FFS and CCO reimbursement is limited to paid amounts reported on CCO encounter data. If CCO paid amounts are not available, either due to sub-capitation or third party liability, then encounters were excluded from the analysis.

5.4 Primary Care Services Definitions and Oregon Health Groups (OHG)

The Oregon Health Grouper (OHG) is a health service classification system adopted by OHA for analyzing claims and measuring utilization of services. It has over 100 groups for inpatient, outpatient, physician, Rx, mental health and dental services. OHGs provide a grouping methodology for claims, such as primary care services. In the FFS reimbursement study, primary care OHGs were used to group provider and procedure codes at a summary level.

OHA defines the following providers and procedure codes as primary care. Please note, FFS members can access primary care services from eligible providers who are reimbursed according to applicable OHA policies at the time of services.

Figure 10: Primary Care Groupers, Oregon Health Groups

Primary Care Providers	
Physician	Adolescent Medicine
	Clinic
	Family Practitioner
	General Practitioner
	Geriatric Practitioner
	Gynecology
	Internist
	Obstetrics
	Obstetrics & Gynecology
	Osteopathic Physician
	Pediatrics
	Preventive Medicine
	Public Health
	Advance Practice Nurse

Primary Care Procedure Codes				
90460	99231	99324	99363	99406
90471	99232	99325	99374	99407
90472	99233	99326	99375	99408
90473	99234	99327	99377	99409
90474	99235	99328	99378	99411
99201	99236	99334	99379	99412
99202	99238	99335	99380	99420
99203	99239	99336	99381	99441
99204	99281	99337	99382	99442
99205	99282	99339	99383	99443
99211	99283	99340	99384	99460
99212	99284	99341	99385	99461
99213	99285	99342	99386	99462
99214	99291	99343	99387	99463

Primary Care Providers	
Advance Practice Nurse	Certified Nurse Midwife
	Family Nurse Practitioner
	Nurse Practitioner
	Nurse Practitioner Clinic
	Obstetric Nurse Practitioner
	Pediatric Nurse Practitioner
	Public Clinic
	Physician Assistants
	Midwife Maternity
	Naturopath
	Family Planning Clinic

Primary Care Procedure Codes				
99215	99292	99344	99391	99464
99217	99304	99345	99392	99465
99218	99305	99347	99393	99487
99219	99306	99348	99394	99489
99220	99307	99349	99395	99490
99221	99308	99350	99396	99495
99222	99309	99354	99397	99496
99223	99310	99355	99401	G0396
99224	99315	99356	99402	G0397
99225	99316	99357	99403	
99226	99318	99360	99404	

5.5 Primary Care Reimbursement Rate Comparisons

2015 FFS primary care reimbursement rates were compared to CCOs and the updated 2016 Medicare fee schedule. The reimbursement rates by CCOs are actual reported paid amounts in the CCO encounter data report for services provided in 2015. The Medicare fee schedule used was current as of February 2016 published by CMS. Prevalent Medicare modifiers were incorporated in the comparison; however, regional labor adjustments were not applied in the analysis.

Findings: FFS primary care reimbursement rates are lower overall than CCO reimbursement by about 24.2%, and lower than Medicare reimbursement rate by about 29.8%. In the Tri-County urban region, FFS primary care reimbursement rates are lower by 34.6% than CCOs. In the Central/Eastern Oregon region, FFS primary care reimbursement rates are lower by 8.2% than CCOs.

Figure 11: Primary Care Services Reimbursement Rate Comparison

	Tri-County	Willamette/ North Coast	Central/ Eastern	South west	All Regions
FFS vs CCO – Adult	-35.3%	-24.8%	-10.1%	-17.0%	**-24.5%**
FFS vs Medicare – Adult	-31.8%	-30.9%	-30.9%	-29.4%	**-30.7%**
FFS vs CCO – Children	-32.7%	-23.3%	-2.3%	-20.2%	**-23.4%**
FFS vs Medicare - Children	-27.7%	-27.0%	-28.0%	-26.5%	**-27.2%**
FFS vs CCO	-34.6%	-24.3%	-8.2%	-17.9%	**-24.2%**
FFS vs Medicare	-30.7%	-29.6%	-30.2%	-28.7%	**-29.8%**

Comparison Notes:

CCO reimbursement comparison is limited to paid amounts on CCO encounter data. CCOs may provide additional payments through risk sharing, incentive and other alternative payment arrangements with providers not reflected in this comparison. In the event that paid amounts are not available, either due to sub-capitation or third party liability, the encounters were excluded from the analysis.

Medicare fee schedule used in the comparison is the current 2016 national fee schedule.

FQHC, RHC, Tribal 638, and IHS clinic claims are excluded in this study.

5.6 Specialty Service Reimbursement Rate Comparison

2015 FFS specialty service reimbursement rates were compared to CCOs and the 2016 Medicare fee schedule. The reimbursement rates by CCOs are actual reported paid amounts in the CCO encounter data report for services provided in 2015. The Medicare fee schedule was current as of February 2016 published by CMS. Prevalent Medicare modifiers were incorporated in the comparison; however, regional labor adjustments were not applied in the analysis.

Findings: FFS reimbursement rates for specialty services are lower overall than CCO reimbursement by 7.1% and 12.1% lower than Medicare reimbursement. In the Tri-County region, FFS specialty reimbursement rates are lower by 14% than CCOs. In the Willamette/North Coast region, FFS specialty reimbursement rates are higher by 3.5% than CCOs.

Outpatient Note: For specialty services, some of FFS claims are outpatient facility claims that are paid at a higher cost to charge ratios, e.g. for A/B hospital outpatient facilities. Therefore, comparisons would be lower for FFS if those A/B hospital outpatient claims were to be excluded. This has a more significant impact in the rural regions (i.e. Central/Eastern, Willamette/North Coast)

Figure 12: Specialty Services Reimbursement Rate Comparison

	Tri-County	Willamette/ North Coast	Central/ Eastern	South west	All Regions
FFS vs CCO – Adult	-9.3%	3.3%	-4.8%	-15.3%	**-5.8%**
FFS vs Medicare – Adult	-11.9%	6.5%	-12.2%	-25.6%	**-10.3%**
FFS vs CCO – Children	-26.8%	4.2%	-6.1%	-17.6%	**-13.3%**
FFS vs Medicare - Children	-29.8%	-8.5%	-11.3%	-28.3%	**-20.4%**
FFS vs CCO	-14.0%	3.5%	-5.0%	-15.3%	**-7.1%**

FFS vs Medicare	-16.7%	3.8%	-12.1%	-25.6%	**-12.1%**

Comparison Notes:

CCO reimbursement comparison is limited to paid amounts on CCO encounter data. CCOs may provide additional payments through risk sharing, incentive and other alternative payment arrangements with providers not reflected in this comparison. In the event that paid amounts are not available, either due to sub-capitation or third party liability, then encounters were excluded from the analysis.

Medicare fee schedule used in the comparison is the current 2016 national fee schedule.

FQHC, RHC, Tribal 638, and IHS clinic claims are excluded in this study.

5.7 Obstetrical and Neonatal Reimbursement Rate Comparisons

2015 FFS Obstetric and Neonatal reimbursement rates were compared to CCOs and the updated 2016 Medicare fee schedule. The reimbursement rates by CCOs are actual reported paid amounts in the CCO encounter data report for services provided in 2015. The Medicare fee schedule used was current as of February 2016 published by CMS. Prevalent Medicare modifiers were incorporated in the comparison; however, regional labor adjustments were not applied in the analysis.

Findings: FFS Obstetric and Neonatal reimbursement rates are lower than CCOs by about 11.6% and lower than Medicare reimbursement rate by about 7%. In the Tri-County region, FFS reimbursement rates are lower by 14.1% than CCOs. In the Willamette/North Coast region, FFS Obstetric and Neonatal reimbursement rates are lower by 14.8% than CCOs.

Figure 13: Obstetric and Neonatal Services Reimbursement Rate Comparison

	Tri-County	Willamette/ North Coast	Central/ Eastern	South west	All Regions
FFS vs CCO – Adult	-10.0%	-12.5%	-6.2%	-1.4%	**-8.6%**
FFS vs Medicare - Adult	3.5%	3.4%	2.7%	-1.7%	**2.4%**
FFS vs CCO - Children	-26.7%	-21.4%	-4.7%	-14.9%	**-19.8%**
FFS vs Medicare - Children	-28.4%	-28.8%	-28.1%	-28.8%	**-28.5%**
FFS vs CCO	-14.1%	-14.8%	-5.8%	-5.5%	**-11.6%**
FFS vs Medicare	-5.3%	-6.6%	-8.2%	-11.0%	**-7.2%**

Comparison Notes:

CCO reimbursement comparison is limited to paid amounts on CCO encounter data. CCOs may provide additional payments through risk sharing, incentive and other alternative payment arrangements with providers not reflected in this comparison. In the event that paid amounts are not available, either due to sub-capitation or third party liability, then encounters were excluded from the analysis.

Medicare fee schedule used in the comparison is the current 2016 national fee schedule.

FQHC, RHC, Tribal 638, and IHS clinic claims are excluded in this study.

5.8 Dental Reimbursement Rate Comparisons

2015 FFS dental reimbursement rates were compared to CCOs and the fee schedules of three western states with similar dental delivery systems to Oregon. The states are Alaska, California, and Washington. The reimbursement rates by CCOs are actual reported paid amounts in the CCO encounter data report for services provided in 2015.

Findings: FFS dental reimbursement rates are lower than CCOs by about 32.4% and lower than the western states by an average of 30.1%. In the Tri-County region, FFS dental reimbursement rates are lower by 35.2% than CCOs. In the Southwest region, FFS dental reimbursement rates are lower than CCOs by 37.1%.

Figure 14: Dental Services Reimbursement Rate Comparison

	Tri-County	Willamette/ North Coast	Central/ Eastern	South west	All Regions
FFS vs CCO – Adult	-33.3%	-28.7%	-26.8%	-30.7%	**-29.0%**
FFS vs CCO - Children	-37.6%	-38.1%	-27.3%	-44.4%	**-38.1%**
FFS vs CCO	-35.2%	-32.7%	-26.9%	-37.1%	**-32.4%**
FFS vs Western States					**-30.1%**

Comparison Notes:

CCO reimbursement comparison is limited to paid amounts on CCO encounter data. CCOs may provide additional payments through risk sharing, incentive and other alternative payment arrangements with providers not reflected in this comparison. In the event that paid amounts are not available, either due to sub-capitation or third party liability, then encounters were excluded from the CCO reimbursement analysis. Please note, dental services are commonly paid through sub-capitation arrangements.

FQHC, RHC, Tribal 638 and IHS clinic claims are excluded in this study.

6 Access to Care Measures

Quality and access measures are used by OHA to determine whether CCOs are effectively and adequately improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations that they serve. Recent efforts by OHA have expanded tracking of these measurements to the FFS population. The FFS Access Monitoring Plan accelerated this work to produce actionable data to ensure that those members outside of the coordinated care model also have access to high quality care. For the FFS Access Monitoring Plan, the Health Policy and Analytics (HPA) Division utilized the existing framework and infrastructure used to produce CCO performance metrics, Consumer Assessment of Health Providers and Systems (CAHPS) surveys, Mental Health Services surveys, and Physician Workforce Surveys (PWS) to derive the results for the FFS population listed below.

6.1 Utilization Metrics for Access

The following table shows utilization rates from calendar year 2015. The FFS population varies greatly from CCO enrolled individuals for all metrics except Initiation and Engagement for SUD Treatment. Separate from these existing utilization metrics (in Figure 15), Oregon will also establish primary monitoring of utilization rates for each service category by October 2017. More information related to the timing and specification of primary utilization monitoring can be found in Section 7.2.

Figure 15: Utilization Metrics for Access, 2015

Metric	CCO results	FFS results
Adolescent Well-Care Visits	**35.7%**	**13.8%**
Child/Adolescent Access to Primary Care		
All ages	**89.5%**	**72.9%**
12 to 24 months	**94.8%**	**79.3%**
25 months to 6 years	**86.7%**	**66.7%**
7 to 11 years	**90.1%**	**73.9%**
12 to 19 years	**90.6%**	**75.7%**
Well-Child Visits (first 15 months of life)	**62.8%**	**29.2%**
Follow-up after MH hospitalization	**87.7%**	**66.0%**
Follow-up ADHD meds		
Initiation phase	**61.0%**	**42.3%**
Continuation and maintenance phase	**68.9%**	**45.1%**
Initiation and Engagement for SUD Treatment		
Initiation phase	**37.7%**	**35.4%**
Engagement phase	**18.8%**	**15.8%**

Figure 15 shows that a significantly lower proportion of FFS children are receiving well-child or well-care visits when compared to children in CCOs. The *Adolescent Well-Care Visit* is based on the percentage of members between the ages of 12-21 who received one well-care visit in the measurement year. The *Well-Child Visits* measure is the percentage of children who visited their health care provider at least six times in the first 15 months of life. FFS members may also experience difficulty accessing follow-up behavioral health services after hospitalizations for mental illness.

6.2 Patient Experience Measures for Access

The FFS population surveyed shows similar experience with self-reported access to physical health and mental health services. Adults in particular report difficulty accessing dental services across the board, including the FFS population.

Figure 16: Patient Experience Measures for Access, 2015

	Medicaid Total		FFS		Source
	Adult	Child	Adult	Child	
Access to emergency and urgent care	84%	92%	89%	94%	CAHPS Health Plan Survey
Access to Routine Care	77%	84%	80%	88%	CAHPS Health Plan Survey
Access to Specialist	75%	88%	82%	89%	CAHPS Health Plan Survey
Access to Personal Doctor	80%	88%	79%	92%	CAHPS Health Plan Survey
Access to urgent Dental Care	44%	52%	41%	52%	CAHPS Health Plan Survey
Access to a Regular Dentist	57%	79%	57%	79%	CAHPS Health Plan Survey
Access to timely MH services	74%	82%	78%	79%	Mental health Services Survey, 2015

6.3 Provider Availability Measures

Provider availability measures specifically pertaining to the FFS population will be introduced in the 2016 Physician Workforce Survey. The providers included in the Physician Workforce Survey are all physicians with an active DO or MD license and primary practice location in Oregon. Amongst dental specialties, only oral surgery is included. Starting in the 2016 survey, dentists will be included.

Figure 17: Provider Acceptance of Medicaid Patients and Referral to Service, 2015

Measure	Population	Source
Providers accepting new Medicaid patients	88% (Adult + Child)	Physician workforce Survey, 2015
Provider currently with Medicaid patients under their care	90% (Adult + Child)	Physician workforce Survey, 2015
Reasons providers are not accepting new Medicaid patients		
Reimbursement rate	83%	
Balancing payers	77%	
Administrative requirements	77%	
Patient load	74%	
Liability insurance	23%	
Complex needs of patients	64%	
Non-compliance of patients	69%	

Source: Physician Workforce Survey, 2015

Ease of referral for Medicaid patients by providers ***Percentage of providers who reported 'usually' or 'always' being able to refer Medicaid patients to these services***	
Specialist	64%
Ancillary services	45%
Non-emergency hospital services	59%
Diagnostic imaging	77%
Inpatient mental health services	27%
Outpatient mental health services	31%
Inpatient substance use disorder services	18%
Outpatient substance use disorder services	24%

Source: Physician Workforce Survey, 2015

7 FFS Access to Care Review

Although OHA devotes resources to resolve access deficiencies and complaints in real-time, the FFS Access Monitoring Plan provides information on the data, analysis, assumptions, baselines, and thresholds used to inform determinations of the sufficiency of access to care. In this section, we outline the primary monitoring functions such as analysis of trends in beneficiary complaints, and utilization reviews for the required service categories. We then discuss our findings from secondary monitoring operations such as the *FFS Reimbursement Rate Study* and the *Access to Care Measures*. Secondary analysis will be refreshed and updated annually, while primary monitoring activities will be refreshed for monitoring every quarter.

7.1 Beneficiary Complaint Monitoring

Beneficiary complaint rates related to access will be reviewed every quarter to determine if the threshold has been crossed, and if further investigation is warranted. When a threshold is crossed, OHA will review complaint narrations logged by the Client Service Unit to determine the specific service category (i.e. primary care, dental, behavioral health).

To determine the baseline and threshold for beneficiary complaints, we used complaints logged in calendar year 2015. We developed a quarterly rate of complaints, per 1000 FFS beneficiaries, for each region. Our regional complaint **baselines** are the average quarterly complaint rate for 2015 (see Figure 18). The regional thresholds for department intervention is then set at two standard deviations above the mean (baseline).

Figure 18: Beneficiary Complaint Monitoring Methodology

Beneficiary Complaint Monitoring Method							
Region	Central Oregon	Columbia Gorge	Eastern Oregon	North Coast	Southwest Oregon	Tri-County	Willamette Valley
FFS Members	10900	2802	11135	5581	27511	53686	50641
2015Q1 Rate	4.22	2.86	4.13	4.84	4.51	5.10	4.46
2015Q2 Rate	2.75	3.21	1.71	2.33	2.47	3.54	3.08
2015Q3 Rate	3.49	2.86	2.33	5.02	2.84	3.61	3.32
2015Q4 Rate	2.48	2.14	2.25	3.40	2.98	4.84	3.08
Complaint Rate Baseline (2015 Average)	3.23	2.77	2.60	3.90	3.20	4.27	3.49
Standard Deviation	0.68	0.39	0.91	1.10	0.78	0.71	0.57
Complaint Rate Threshold (Baseline + 2 std. dev.)	**4.59**	**3.54**	**4.43**	**6.10**	**4.75**	**5.68**	**4.63**

A review of the baseline and threshold will occur in the second half of 2017 when calendar year 2016 complaints are logged. The determination to set the threshold at two standard deviations above the baseline for quarterly complaint rates was made to ensure that the threshold would

accurately identify access issues within the Oregon Medicaid delivery system. In determining changes to the threshold, we will consider what occurred with this primary monitoring function in 2016. With this being the first iteration of a quantitative approach to access monitoring, we anticipate the baselines and thresholds will evolve when new information becomes available.

The regional complaint rates for Q1 and Q2 2016 are shown in Figure 19 below. The Columbia Gorge region crossed the threshold for department investigation in Q1, but reverted back below even the baseline in Q2 2016:

Figure 19: Beneficiary Complaint Monitoring, September 2016

Beneficiary Complaint Monitoring - 2016							
Region	Central Oregon	Columbia Gorge	Eastern Oregon	North Coast	Southwest Oregon	Tri-County	Willamette Valley
Complaint Rate Threshold (Avg. + 2 std. dev.)	4.59	3.54	4.43	6.10	4.75	5.68	4.63
2016Q1 Rate	3.12	**3.57**	2.51	2.33	3.31	4.69	3.65
2016Q2 Rate	3.21	2.14	2.07	3.05	2.69	4.27	3.44
2016Q3 Rate							
2016Q4 Rate							

7.2 Beneficiary Utilization Monitoring

By October 2017, OHA will establish and begin monitoring utilization rates for each of the required service categories. OHA will establish baseline (average) utilization rates, using a similar methodology used for monitoring complaint rates, and thresholds based on two standard deviations below the baseline for each region. This primary monitoring function will capture utilization rates separately for adults, children, and American Indian/Alaskan Native (AI/AN) FFS members. Approximately 50% of AI/AN OHP members are FFS.

OHA intends for this primary monitoring function to capture and monitor basic service utilization for each of the service categories required within §447.203(b). OHA will determine what constitutes a primary care, physician specialty, behavioral health, obstetric, dental, and home health claim within the Oregon MMIS, and use those criteria to establish utilization rates, baselines, and thresholds for department investigation. OHA will consider using only claims data with dates of service back to January 2015 given the systemic shift in the Oregon Medicaid delivery system from the ACA expansion in January 2014.[11]

[11] https://www.oregon.gov/oha/Documents/MedicaidExpansion-EstimatedFinancialEffects.pdf

7.3 Secondary Monitoring Activities

Other access monitoring activities captured throughout the plan, including the *Reimbursement Rate Study* and the *Access to Care Measures* captured in sections 5 and 6 respectively, will be refreshed and updated on an annual basis. Secondary monitoring activities will be used to supplement department investigation of access issues that are discovered through primary monitoring functions.

FFS members, through the CAHPS survey, generally report similar or better experiences with accessing care as their CCO counterparts, however the primary care and behavioral health utilization measures in Figure 16 show that FFS members utilize less services than CCO members. For FFS and CCO members, substance use disorder services appear to be under-utilized when needed by members. OHA will begin investigating whether an access issue specific to Oregon Medicaid exists due to the FFS population utilization rates on SUD services, *Adolescent Well-Care Visit* and *Well-Child Visits* measures. For Adolescent Well Care Visits, FFS children and young adults are utilizing at about 22 percentage points below their CCO counterparts, and significantly lower than the 2014 national Medicaid 75th percentile of 62%. For FFS children receiving at least six visits with their care provider in the first 15 months of life, less than a third meet the six visit threshold. This is 33.6 percentage points below CCOs, and 47.7 below the 2014 national Medicaid 90th percentile.[12]

The FFS Reimbursement Rate Study illuminated the fact that actual average FFS reimbursement amounts are much less than CCO and Medicare reimbursements. Generally this disparity between FFS and CCO reimbursements is most pronounced for primary care and dental services. Overall, for physician specialty services, the disparity is much less pronounced (-7% overall), but in regions such as the Willamette Valley and North Coast, FFS is generally paying more than the area CCOs and Medicare. Survey results show that reimbursement rates are the top reason for physicians who are not accepting new OHP members.

Within the 2015 Oregon Physician Workforce Survey (PWS), 88% of practitioners reported they are accepting new OHP members. Of the 12% who reported not accepting new Medicaid recipients, the top reason was the “reimbursement rate” at 83%. 77% of these practitioners also reported “administrative requirements” and “balancing payers” as reason for not accepting Medicaid recipients.

Also within the PWS, physicians report difficulties referring Medicaid recipients to other service categories. The categories of particular concern are inpatient and outpatient behavioral health services. On average, only 25% of physicians reported ease in referring Medicaid recipients to the behavioral health services. 64% reported ease in referring Medicaid recipients to specialists.

[12] Oregon's Health System Transformation: CCO Metrics 2015 Final Report – June 2016
https://www.oregon.gov/oha/Metrics/Documents/2015_Performance_Report.pdf

7.4 CONCLUSIONS

OHA must devote resources to monitoring and assuring access to services for the FFS population. As described in Section 3, many FFS members are dual-eligible with Medicare coverage, immigrants covered on CAWEM, or American Indian/Alaska Native. For any measures showing poor performance, OHA will develop and implement specific improvement plans.

OHA looks forward to finalizing and refreshing Primary Monitoring Activities related to utilization and complaint rates, and believes that a quantitative approach to these functions will allows the department to accurately determine access issues throughout the seven regions of the state. Through Tribal consultations and analysis of the AI/AN population showing a high proportion are FFS members, we determined it is necessary to give special consideration for the AI/AN population when monitoring utilization rates and access to specialty care. Utilization rates, baselines, and thresholds for the seven regions are expected to be finalized by October 2017.

8 Public Comment and Tribal Consultation

8.1 Tribal Consultations

OHA Tribal Consultation, May 5th 2016	
Comment	**OHA Response**
Concerned about data analysis methods related to determining who the FFS population is because many Tribal members move in and out of CCOs to gain access to specialty services	All claims data denotes whether the member is FFS or enrolled with a managed care plan on the date of service. Population analysis is based on OHP members without a physical health managed care enrollment within May 2016
Access to specialty services for Tribal FFS members is a big concern	Agree. OHA anticipates that the FFS Access Monitoring Plan will assist in identifying specific regions with specialty care access issues.
OHA Tribal Monthly Meeting, May 26th 2016	
Comment	**OHA Response**
Incorporate qualitative data and analysis from the Tribes in the Access Monitoring Review Plan	Qualitative data not received; however OHA will monitor utilization rates specifically for AI/AN members
Continue to meet with and work on the access plan with the Tribes	Agree.
Pharmacy access may be a concern	OHA will determine if pharmacy access is an issue for FFS OHP members
OHA Tribal Monthly Meeting, June 15th 2016	
Comment	**OHA Response**
Improve access by requiring all Medicaid enrolled providers to accept FFS members, as well as their contracted CCO's members	Outside of scope of FFS Access Monitoring Plan; tactic may be used to remediate access issues and will be considered separate from the FFS Access Monitoring Plan
Reference was made to the CCO metric "Assessments for Children in DHS Custody". Participant mentioned that CCOs completed these assessments despite many of the children being FFS. Participant indicated that state may be able to use this method as a framework for CCOs to be held accountable for their regional FFS members as well	OHA intends to monitor access for the FFS population and not delegate this function to CCOs
For FFS rate comparisons, participant indicated that it is important for Actuarial Services to account not only for rates, but also the various APMs being offered at CCOs	The Actuarial Services Unit used the actual average reimbursement amount on claims data rather than FFS rates from the published fee schedule
Requested presentation of draft plan at July 13th Tribal Monthly Meeting	Agree.
OHA Tribal Monthly Meeting, July 13th 2016	
Comment	**OHA Response**
How does OHA plan to advertise the complaint process for OHP members?	Included link to OHP complaint process with *Request for Public Comment* for the FFS Access Monitoring Plan; OHP members will continue to receive materials when determined eligible for OHP that detail how to submit complaints
Would like the access plan to breakdown dual eligible population by Tribal members who are dual eligible AND AI/AN members who are dual eligible	Unable to acquire this data for first iteration of FFS Access Monitoring Plan; will explore options for plan refresh in 2017

8.2 Medicaid Advisory Committee

Medicaid Advisory Committee, June 22nd 2016	
Comment	**OHA Response**
When we think about this population think about pregnant women (CAWEM and women who make more than Medicaid income level)	Agree. OHA will consider producing utilization measure for obstetrics broken out by CAWEM mothers
Interested in outcomes and reducing or eliminating disparities among African American/Black community. How can we develop a plan without primary data? Who are the partnerships with CCOs and other providers? What results have already been determined from interventions in the last several years?	Current FFS Access Monitoring Plan includes significant amount of primary data including complaint totals and claims data. The percentage of African American OHP members who are FFS is the lowest amongst all race classifications, indicating that CCOs have succeeded in bring African American individuals into the coordinated care model
Will the written report be publicly available with rate comparisons?	Yes, the plan is available for public comment until September 30th at http://www.oregon.gov/oha/healthplan/Pages/Announcements.aspx
On a task force for people with development and intellectual disabilities and most are on FFS. When looking at access in these surveys, are you looking at access to a prescriber or access to specific therapies? Is there that kind of separation in the provider services therapy?	We do ask about specialized counseling and specialized therapies. We also ask about chronic conditions, including those associated with mental health issues. In the Physician Workforce Survey, a specific question inquires about how easy it is to refer patients to inpatient and outpatient mental health services
Comment – assume in group we are looking at, dental is probably a much larger percent than ~19%. Having dental under the bucket of primary care is concerning (CMS issue). There isn't anything dental related on utilization page – would be a shame not to have something dental related right from the start. Even a straight up utilization measure would be important.straight up utilization is not a controversial measure. Recommend looking at CCO Oregon measures.	Agree. Dental care is now treated as it's own separate service category within the FFS Access Monitoring Plan. OHA plans to incorporate basic utilization measures for all service categories by October 2017

Medicaid Advisory Committee, July 27th 2016	
Comment	**OHA Response**
Is this data also looking at the country level or only at the regional level?	Both. Regional for access measures and primary monitoring functions. The rate study includes data from other state Medicaid fee schedules. The Medicare fee schedule is also used
How do you break down areas that cross multiple counties?	The FFS Access Monitoring Plan does not subdivide counties. Each county is grouped within a single region
This plan to monitor access not to act on it?	If access issues are discovered, OHA must submit a corrective action plan to CMS within 90 days of discovery, and remediate the access issue within 12 months
Who will act on this information?	The Oregon Health Authority with key stakeholders and partners with interest in improving access
Is terms of thresholds and triggers, can we look at what we provide CCOs in incentives and levers?	This plan is specific to the FFS OHP population; although it utilizes certain metrics from the CCO Performance Reports

Do people know the differences between having an open card access versus going through a CCO? For example, a FFS person does not get non-emergency transportation, how does a person know that when looking at this data?	If there are deficiencies related to FFS access for services categories outside of what is capture in this plan, OHA will include the service category for monitoring in future iterations of the plan
How do you plan to approach the goals of trying to address the shortfalls of this plan?	Further engagement with stakeholders and tribal governments; additional data and analysis. We intend for the FFS Access Monitoring Review Plan to evolve over time
There is a barrier for individuals in not getting non-emergency transportation with FFS. How is this pulled out in the report?	NEMT services are not monitored within this iteration of the plan; however we will consider adding the service category for future monitoring if OHA determines there is an access issue for FFS members
Are you able to separate out providers who are FFS versus Medicaid providers contracted with CCO/DCO's?	Yes, every claim in the Oregon MMIS denotes whether the member is FFS or enrolled with a managed care plan. Claims data can be used to determine the providers serving FFS members.
To what degree do you find legislation impacting services especially for the mental health population who have guardians making medical decisions for them?	Not relevant to the FFS Access Monitoring Plan
Where does Oregon rank with other states when looking at reimbursement and medical fee schedules?	For the states included in this iteration (AK, CA, WA), Oregon ranks 2nd among the four for dental reimbursements. Alaska has the highest dental reimbursement rate. Other service categories did not include state-by-state rate comparisons.
Support wider dental information and workforce survey data for 2016	Agree. OHA plans to include dentists in 2016 Physician Workforce Survey.
Recommend that this report and data be publicly available so that agencies can use it	Plan is available for public comment until September 30th at http://www.oregon.gov/oha/healthplan/Pages/Announcements.aspx
Future comparison data should include Medicaid dental data rates rather than commercial ADA FFS rates	Confirmed. FFS Access Monitoring Plan now compares Oregon dental reimbursement amounts to other state Medicaid fee schedules

8.3 Medicaid Advisory Committee, Letter of Support

Division of Health Policy and Analytics

Kate Brown, Governor

Oregon Health Authority

500 Summer Street, NE
Salem, OR 97301

August 29, 2016

Dear Ms. Coyner:

On behalf of Oregon's Medicaid Advisory Committee, we are writing in support of the Oregon Access Monitoring Review Plan (the Plan). We applaud state efforts to assess and, ultimately, to improve access to care for the fee-for-service (FFS) population, which includes some of the most vulnerable populations in the Oregon Health Plan: low-income aging adults, pregnant women not eligible to enroll in Coordinated Care Organizations (CCO), many of Oregon's tribal OHP members, medically fragile children, and others.

In general, we support the Oregon Health Authority's (OHA) approach in building the Plan from the monitoring and performance improvement measurements used for CCOs. We applaud this efficient use of existing systems and resources, and encourage OHA to continue to look for opportunities to leverage its resources for broad impact. While enrollment in a CCO offers greater opportunities to coordinate and integrate care to further improve health, we agree with the goal of ensuring Oregonians inside and outside of the coordinated care system have access to high quality care.

The Medicaid Advisory Committee is currently developing a framework for oral health access in OHP overall. As such, we take a particular interest in the dental access sections of this plan and offer the following comments and recommendations:

- We encourage OHA to identify a utilization measure for dental access and to incorporate this measure into the plan as soon as practicable. OHA could look to the work of recent stakeholder groups, such as the Dental Quality Metrics Work Group and the CCO Oregon Dental Work Group for recommended measures.
- We support OHA's plans to include dentists and dental hygienists in the Provider Workforce Survey starting in 2016. This data will shed additional light on the availability of dental providers within Medicaid, as well as barriers to Medicaid acceptance, such as reimbursement rates or administrative requirements.
- We recommend that OHA benchmark FFS dental rates to Medicaid rates in selected comparison states or to a national average of Medicaid FFS dental. Benchmarking to national Medicaid dental rates may provide the state with more actionable data than benchmarking against the American Dental Association (ADA) dental fee survey, which includes commercial carriers. It is notable, however, that Oregon FFS dental rates are significantly lower than CCO rates.
- We support OHA's work to strengthen access to dental care for pregnant women in the FFS population and encourage OHA to incorporate information gained from the Plan into that ongoing work.
- More broadly, the MAC recommends that OHA take steps to fully integrate dental care into the Patient-Centered Primary Care Home (PCPCH) model with explicit inclusion of dental providers in the care management team. This could improve access to care for both the FFS and managed care populations when they see providers practicing in a PCPCH.

We urge OHA to share not only the Plan, but also its underlying data, with stakeholder groups and fellow state agencies. We believe the data and analysis will have broad and valuable applications. Further, we request OHA develop and share a defined strategy for addressing access deficiencies or shortfalls revealed by the Plan no later than spring of 2017. We believe the Plan and companion strategy assessment will provide OHA a clear opportunity to make evidence-based decisions to improve care for OHP members, and therefore encourage the state to develop a plan of action even if federal regulations do not specifically require one. We are happy to support this effort if we can be helpful.

The Oregon Access Monitoring Plan is a positive step toward improving access to care for OHP FFS members, many of whom cannot or choose not to enroll in CCOs. We support Oregon's continued efforts to monitor, understand, and improve health care delivery for all members of OHP.

Sincerely,

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