2016

Access Monitoring Review Plan

UTAH DEPARTMENT OF HEALTH DIVISION OF MEDICAID AND HEALTH FINANCING

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Executive Summary

The Utah Department of Health (DOH), Division of Medicaid and Health Financing (DMHF) administers Medicaid and the Children's Health Insurance Program (CHIP) to provide medical, dental, and behavioral health services to needy individuals and families throughout the state. DOH is designated as Utah's Single State Agency for Medicaid.

The administration of Medicaid and CHIP is accomplished through the Office of the Division Director and six bureaus. The Division Director administers and coordinates the program responsibilities delegated to develop, maintain, and administer the Medicaid program in compliance with Title XIX of the Social Security Act and CHIP in compliance with Title XXI of the Act, the laws of the state of Utah, and the appropriated budget.

In the State Fiscal Year (SFY) 2015 DMHF served an average of 307,901 members per month or 11% of the State population with total expenditures of approximately $2.5 billion.

In further efforts to provide comparable access to that which is provided to the non-Medicaid population, and in accordance with 42 CFR 447.203, DMHF has developed an Access Monitoring Review Plan (AMRP) for the following services categories provided under a fee-for-service (FFS) arrangement:

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

The AMRP describes a standardized, data-driven process by which DMHF documents and monitors access to care. The analysis will use baseline data to establish an access to care index that considers total provider data for Medicaid and the Utah market along with information from the Consumer Satisfaction Report of Utah Health Plans (CAHPS). A series of logistic regression models will examine the level of services provided to Medicaid members. Comparable reimbursement data from the All Payers Claims Database (APCD) will be included to contextualize reimbursement rates and their effect on access to care to Medicaid members. The estimated parameter from these models will be used subsequently to monitor and predict changes in access to care due to reimbursement rate changes.

The completed AMRP was drafted in consultation with the Medical Care Advisory Committee (MCAC) in accordance with 42 CFR 447.203(b). A number of additional stakeholder groups were identified and asked to provide feedback during development, including the Utah Indian Health Advisory Board (UIHAB), The Utah Hospital Association, The Utah Medical Association, The Office of Primary Care and Rural Health, The Utah Health Care Association, The Utah Academy of Physicians, and the Utah Association for Home Care. The stakeholder

groups were given an additional informal feedback period. Utah Medicaid member and public feedback was reviewed from the public rate-setting process in SFY13-15 and Medicaid Constituent Services. Input from these public notification periods, the MCAC, and identified stakeholder groups served as an integral influence to the final conclusions and recommendations going forward. Developed during the months of November 2015 and June 2016, the AMRP was posted from July 5, 2016 to August 5, 2016 to allow for public inspection and feedback.

Geographic Distribution

Utah is unique among the 50 states for having the youngest population in America, and one of the healthiest. Organized into 29 counties, only four of Utah's counties are classified as "urban", where 75% of the population resides. These contiguous counties comprise the "Wasatch Front." Twelve of Utah's counties qualify as "rural" with a population density between 6.1 and 99.9 persons per square mile. Thirteen of Utah counties qualify as "frontier" with the population density under 6.1 persons per square mile. Much of Utah is sparsely populated, with correspondingly limited infrastructure. (Utah Rural Health Plan, 2013)

Table 1: Utah County Information

County	Population	Area (Sq. mi)	Classification
Beaver County	6,629	2,590	Frontier
Box Elder County	49,975	5,746	Rural
Cache County	112,656	1,165	Rural
Carbon County	21,403	1,478	Rural
Dagget County	1,059	697	Frontier
Davis County	306,479	299	Urban
Duchesne County	18,607	3,241	Frontier
Emery County	10,976	4,462	Frontier
Garfield County	5,172	5,175	Frontier
Grand County	9,225	3,672	Frontier
Iron County	46,163	3,297	Rural
Juab County	10,246	3,392	Frontier

Kane County	7,125	3,990	Frontier
Millard County	12,503	6,572	Frontier
Morgan County	9,469	609	Rural
Piute County	1,556	758	Frontier
Rich County	2,264	1,029	Frontier
Salt Lake County	1,029,665	742	Urban
San Juan County	14,746	7,820	Frontier
Sanpete County	27,882	1,590	Rural
Sevier County	20,802	1,911	Rural
Summit County	36,324	1,872	Rural
Tooele County	58,218	6,941	Rural
Uintah County	32,588	4,480	Rural
Utah County	516,564	2,003	Urban
Wasatch County	23,530	1,176	Rural
Washington County	138,115	2,426	Rural
Wayne County	2,589	2,461	Frontier
Weber County	231,236	576	Urban

[1]

[1] Table 1. Population totals, 2010 US Census Bureau; County Area, Gazetteer of Utah Counties; National Center for Frontier Communities. This table represents all 29 counties in the State of Utah.

Managed Care

Managed care has been part of the Medicaid service delivery system since the 1990's. In a managed care delivery system, Medicaid members receive their health care through an organization under contract with DMHF to provide Medicaid covered services. DMHF uses waiver authority under Section 1915 (b) of the Social Security Act to implement managed care delivery systems.

Utah's 1915 (b) Choice of Health Care Delivery Program waiver grants authority to the Department to require Medicaid members living in certain counties to select a Managed Care plan and obtain their physical health benefits through a Managed Care plan. Since January 1, 2013, Medicaid members living in Weber, Davis, Salt Lake, and Utah counties are required to select a Managed Care plan. Starting on July 1, 2015, residents living in Box Elder, Cache, Wasatch, Morgan, Rich, Summit, Tooele, Washington, and Iron counties are required to select a Managed Care plan. Managed Care plans are responsible to provide Medicaid services through their provider network. Some Managed Care plans are available in other counties of the state. Enrollment in a health plan outside Weber, Davis, Salt Lake, Utah, Box Elder, Cache, Wasatch, Morgan, Rich, Summit, Tooele, Washington, or Iron County is voluntary.

Managed care currently represents 80% of the State Medicaid population and 100% of the CHIP population.

In September 2013, the DMHF implemented the 1915(b) Dental Choices waiver which requires Medicaid members eligible for full dental services, (pregnant women and children) to enroll in a dental Managed Care plan. Residents in Weber, Davis, Salt Lake, and Utah counties are required to enroll in a managed care dental plan.

Utah Behavioral Health Services

The 1915(b) Prepaid Mental Health Plan waiver allows Medicaid to enroll all Medicaid members in behavioral health plans statewide. Behavioral health services are provided under full risk capitated contracts administered under the statutory authority of the local county mental health and substance abuse authorities. Currently 95% of Medicaid members receive care through a prepaid mental health plan (PMHP), only a small portion of Medicaid clients receive Behavioral Health services via fee-for-service.

For the purposes of this report behavioral health will be analyzed independently of the other types of service. Wasatch County is currently the only county that does not participate in a PMHP, in addition substance abuse services in Cache, Rich, and Box Elder counties are provided FFS. These counties and the corresponding services will have a separate analysis and index.

Member Population Fee-For-Service

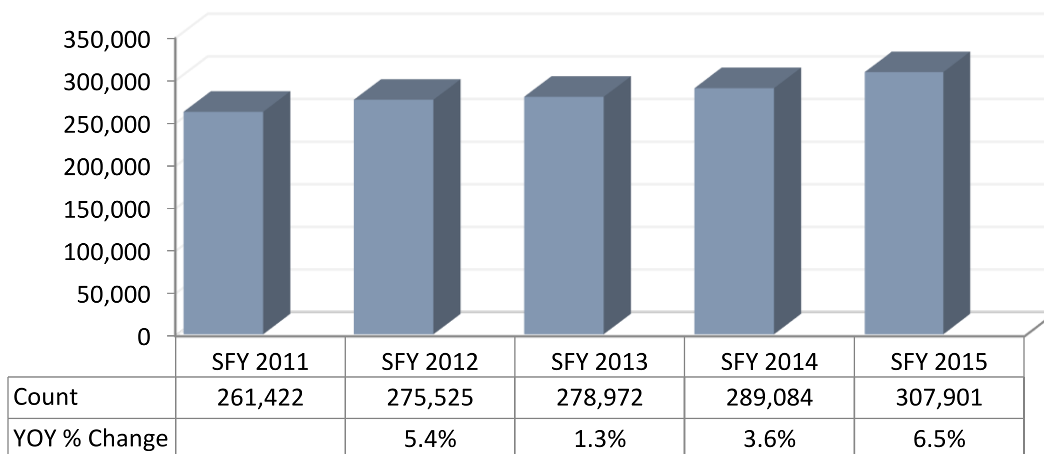
A Medicaid member is defined as an individual who meets the established eligibility criteria of the program, who has applied and has been approved by Medicaid to receive services, regardless of whether the member received any service or any claim has been filed on his or her behalf.

As of 2014, 29,070 Utah providers were enrolled to serve Medicaid clients. With 57 acute care hospitals, affiliated practices, and a network of Rural Health Clinics and Federally Qualified Health Centers throughout the state, there are numerous options for Medicaid beneficiaries to receive healthcare.

For this report, the Medicaid classifications are summarized in the following aid groups:

- Children (individuals under age 19)
- Adults (Ages 19-64)-Parents-adults in families with dependent children, not pregnant, not visually impaired, nor disabled.
- Pregnant women
- Elderly individuals (individuals aged 65 or older)
- Visually impaired individuals (individuals of any age who meet Social Security's criteria for statutory blindness) and People with Disabilities (individuals determined disabled by the state or Social Security)

Average Member Months: All Categories



	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Count	261,422	275,525	278,972	289,084	307,901
YOY % Change		5.4%	1.3%	3.6%	6.5%

Figure 1

"Member months" are defined as the number of Medicaid clients enrolled in each month over a fiscal year. Individuals, in this measure, can be counted multiple times depending on the

number of months they are eligible to receive Medicaid services. The average members per month (the average monthly enrollment) in a fiscal year is computed by dividing total member months by 12.

Utah Fee-For-Service Demographic Breakdown

In 2015, the Utah Medicaid program provided coverage to 415,843 enrolled beneficiaries. At the time, approximately 73% of these beneficiaries were enrolled in managed care. The 27% receiving care only through FFS reside in frontier and rural counties. The chart below illustrates the distribution of Medicaid enrollees classified as individuals with disabilities, adults, children, the elderly, and pregnant women between rural and frontier counties.

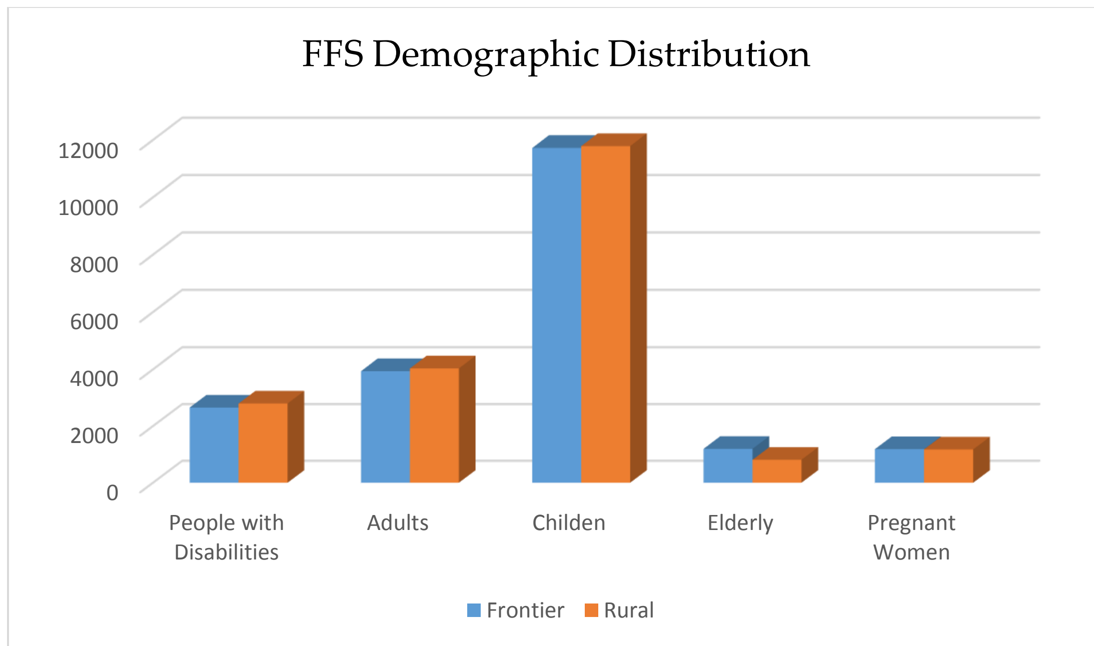


Figure 2

The expansion of managed care in SFY15 resulted in Accountable Care Organizations being responsible to provide Medicaid services through their provider network in 13 counties across the State. The remaining counties are divided into Frontier County and Rural County designations for the purposes of analyzing access to care for fee-for-service members. These groupings will be used to account for geographic consideration (fulfills 42 CFR 447.203(b)(1)(ii)). This is an important distinction because not all of Utah's remaining 16 counties offer all types of care, nor are their population densities the same, so analyzing the data on a county level would be misrepresentative of the actual condition of access.

Table 2: Utah Fee-For-Service Members by County

COUNTY NAME	TOTAL FFS MEMBERS SFY15	SFY 2013	SFY 2014	SFY 2015
	FRONTIER COUNTIES			
Daggett	72	4.50%	4.70%	3.70%
Duchesne	3674	11.00%	10.40%	11.80%
Emery	1806	11.10%	11.60%	12.10%
Grand	1793	11.60%	12.50%	13.90%
Wayne	422	7.90%	8.10%	11.10%
Piute	311	13.00%	14.00%	16.00%
Garfield	626	9.10%	9.00%	8.80%
Kane	1083	8.90%	8.50%	10.00%
San Juan	5088	23.80%	24.40%	25.50%
Juab	1828	11.10%	11.10%	12.20%
Millard	2277	11.70%	11.70%	13.40%
Beaver	1185	12.10%	11.80%	13.00%
Totals	20165	11.32%	11.48%	12.63%
	RURAL COUNTIES			
Uintah	5623	8.50%	8.80%	9.60%
Carbon	4708	15.30%	15.90%	16.80%
Sanpete	5294	11.80%	12.10%	13.50%
Sevier	4481	13.50%	14.10%	15.60%
Totals	20106	12.28%	12.73%	13.88%

[2]

[2] Table 2. Utah Medicaid Fee-For-Service Members by County, rural and frontier. Member population totals included as of State Fiscal Year 2015. Percentage of total population included for State Fiscal Years 2013, 2014, and 2015.

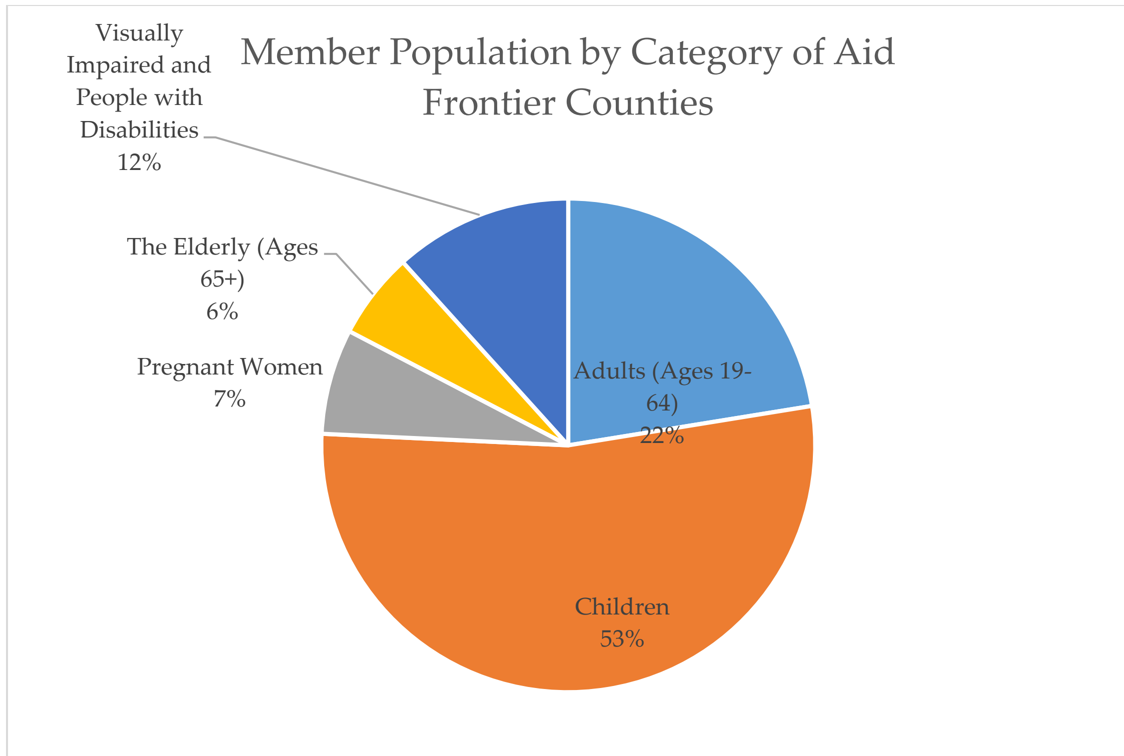


Figure 3

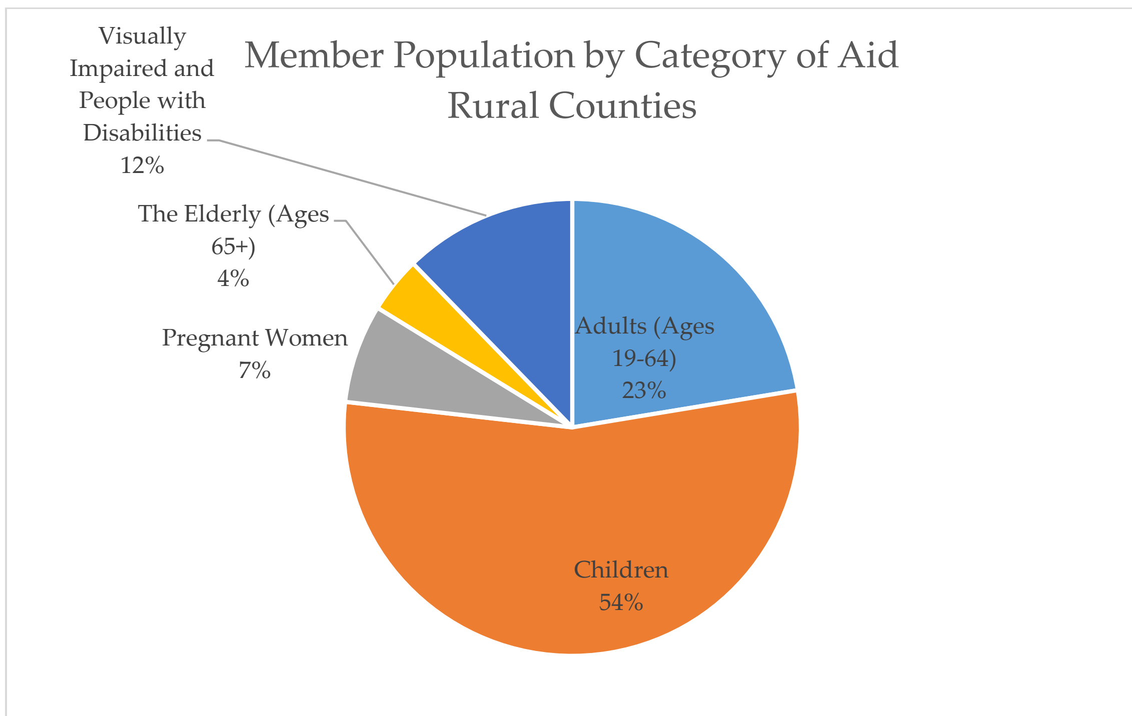


Figure 4

Office of Primary Care and Rural Health

Because the majority of Utah Medicaid FFS Members reside in rural and frontier counties DMHF staff is working with the Office of Primary Care and Rural Health Services to examine overlapping populations and resources. The Utah Department of Health's Office of Primary Care and Rural Health serves as Utah's Primary Care Office (PCO), and has done so since 1991. Utah's PCO partners with federal, state, and local agencies to serve the underserved and vulnerable populations of Utah by improving access to care and reducing health disparities. PCO activities include the designation of health professional shortage areas, coordination of workforce recruitment programs, provision of technical assistance to organizations and communities with similar goals, and the assessment of community needs, health workforce issues, and health disparities.

The Medicare Rural Hospital Flexibility Program (FLEX Program) aims to improve access to preventive and emergency health care services for rural populations. The FLEX Program requires development of a State Rural Health Plan and planning for improving rural health networks. The FLEX Program puts significant effort into designating Critical Access Hospitals (CAHs) and assists rural communities in integrating emergency medical services into the rural medical delivery systems, building rural hospital networks to exchange information, obtaining economies of scale and collective volume, and increasing cost efficiency and overall effectiveness by improving quality of care and overall organizational performance.

The State Office of Rural Health (SORH) provides assistance to help rural communities build their health care services through public and private partnerships and initiatives in rural health development. The State Primary Care Grants Program (SPCGP) provides financial resources to public and/or not-for-profit health organizations that offer primary care, mental health, and dental services to underserved populations. For more information on Utah's Office of Primary Care and Rural Health please visit the website www.health.utah.gov/primarycare/.

Safety Net Clinics and Resources

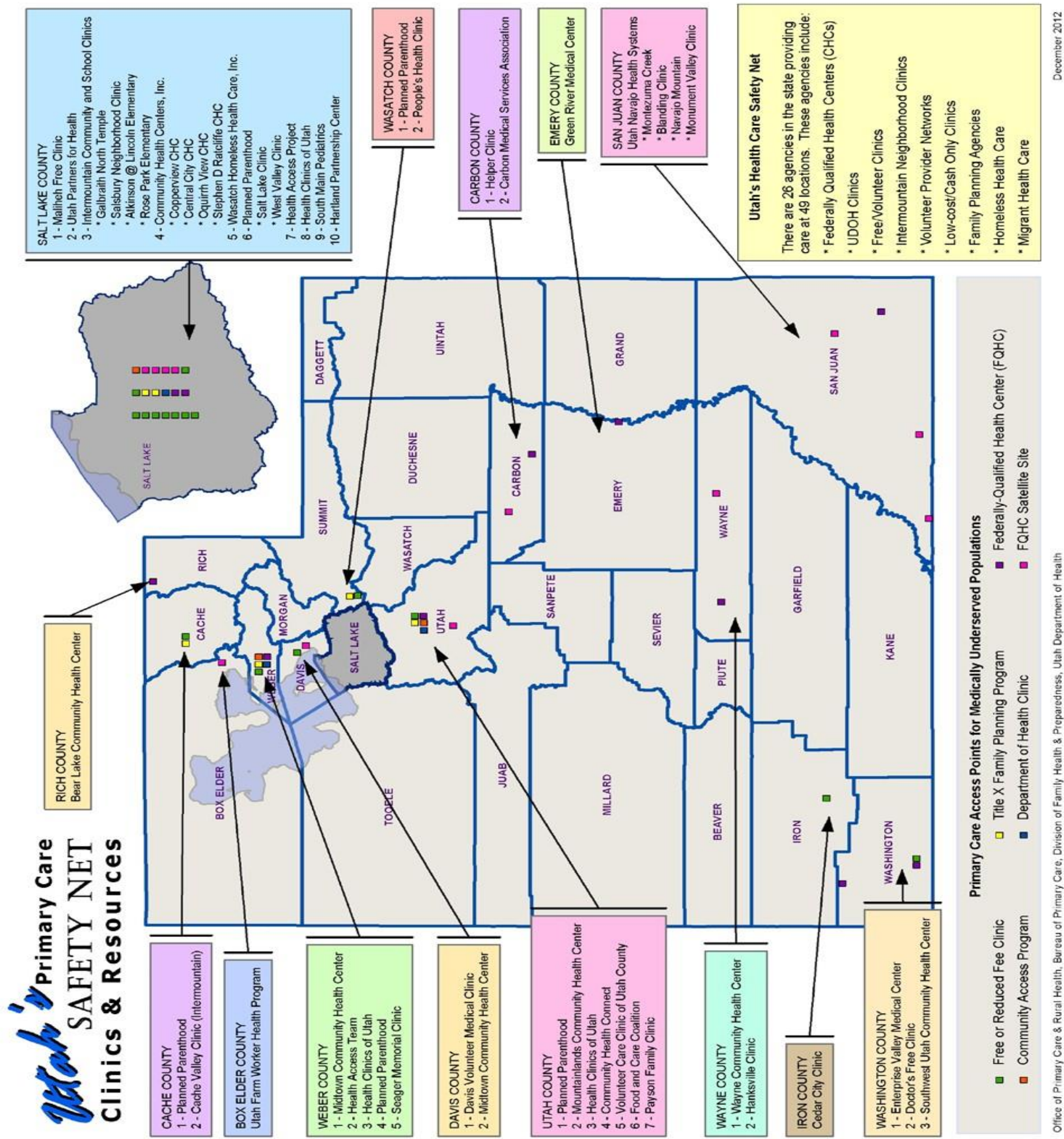


Figure 5 [3]

[3] Map Source: Utah Department of Health, Division of Family Health and Preparedness, Bureau of Primary Care, Office of Primary Care and Rural Health, 2012.

Utah Health Clinics

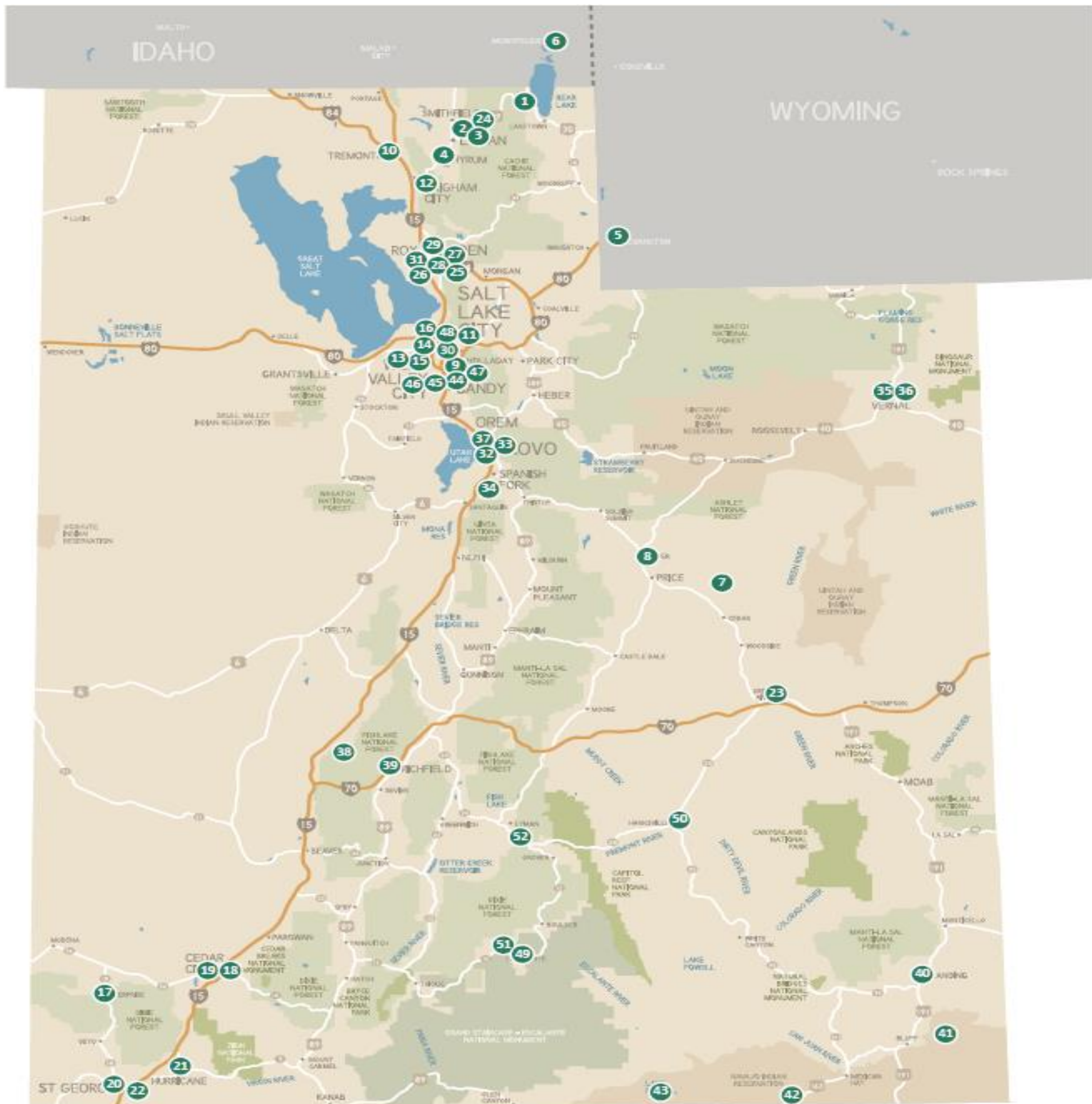


Figure 6[4]

[4] Map Source: Association for Utah Community Health

Table 3
Utah FEDERALLY QUALIFIED HEALTH CENTERS
Bear Lake Community Health Center
Carbon Medical Service Association, Inc.
Enterprise Valley Medical Clinic
Green River Medical Clinic
Southwest Utah Community Health Center (dba Family Healthcare)
Utah Navajo Health Systems
Utah Partners for Health
Wasatch Homeless Health Care
Wayne Community Health Center
Out of State FQHCs
Canyonlands Urgent FQHC (Page, AZ)
Community Health Clinic FQHC (Dove Creek, CO)
Valley Wide Health Service (Alamosa, CO)
Wendover Community Health FQHC (Wendover, NV)
Community Health Centers, Inc.
Midtown Community Health Center
Mountainlands Community Health Center
Utah MEDICAID RHC PROVIDERS
Emery Medical Center RHC
Beaver Med CLNC RHC
Beaver/Milford Med RHC
Parowan Medical RHC
Mountain Utah Family Med RHC
Garfield Memorial CLNC RHC
Bryce Valley Clinic RHC
Circleville Clinic RHC
Blanding Medical CLNC RHC
San Juan Clinic RHC
Gregory Iverson Fam Med RHC (Coalville)
Gregory Iverson Fam Med RHC (Kamas)[5]

[5] The list provided in table 3 includes umbrella clinics which can include other clinics, for example the Midtown Community Health Center, Inc includes 8 different clinic locations in Logan, Ogden, Clearfield, and Salt Lake City. For a complete list and map please visit AUCH.org at http://auch.org/images/CHC_Map__Listings_June_16.pdf

Access to Care Framework

Member perceptions of access to care

Utah collects and analyzes the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys administered through CMS. Since the data is retrospective, it may not demonstrate current access, but it is an indicator for whether or not beneficiaries are able to access medical services when they are needed.

The charts below show the percent of beneficiaries that were able to access needed care and that those beneficiaries were able to receive care in a timely manner. Both charts compare the national Medicaid and Utah commercial responses to Utah Medicaid fee-for-service responses.

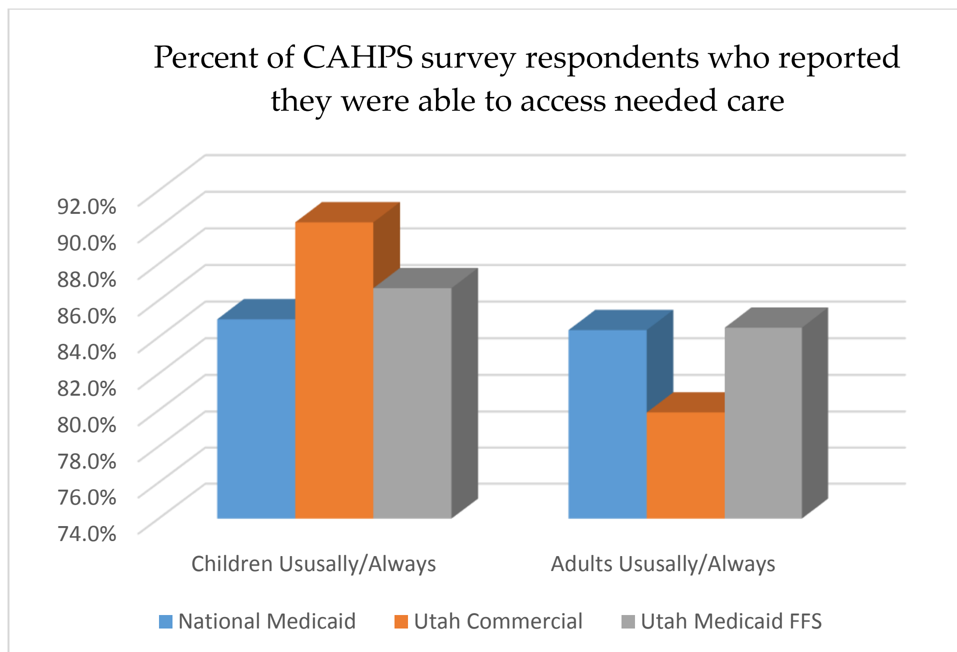


Figure 7

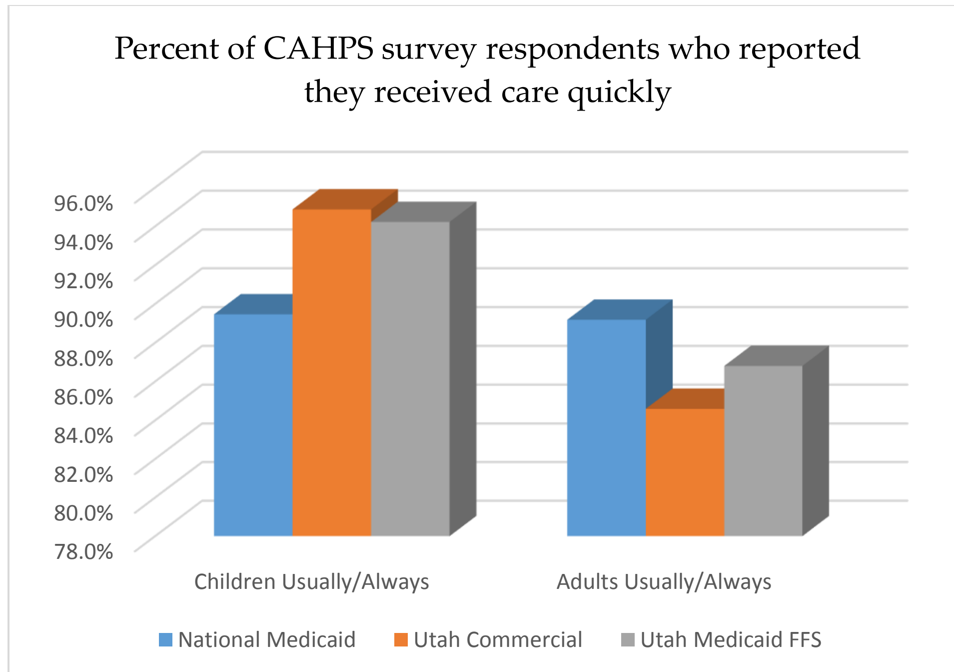


Figure 8

Mechanisms for Member and Provider Feedback on Access to Care

DMHF provides several options for members and providers to interact with the Division, to seek assistance regarding access to care, and provide feedback. Members have access to Division staff through the customer service and Health Program Representative (HPR) phone lines as well as Constituent Services. Although member interaction with Division staff is frequent, no formal tracking tool has been implemented to collect information regarding access to care. The Division is working now to build a tool to track and aggregate data so that member feedback can be better analyzed. Members are also given the opportunity to provide feedback regarding care through the CAHPS survey.

In addition to the formal public notice, public hearing, and hearing processes in place, both members and providers are represented through various stakeholder and advocacy groups that provide feedback to DMHF both informally and formally. In addition to the Medical Care Advisory Committee (MCAC) multiple stakeholder groups have been targeted to provide informal feedback to the Division regarding the AMRP.

Health Program Representatives and Customer Service

Health Program Representatives (HPRs) are housed in the Bureau of Managed Health Care, HPRs receive calls from both Medicaid managed care members and FFS members. The primary role of an HPR is to provide education and assistance that will aid members' understanding of their benefits and provider options. The Utah Medicaid website guides members to call an HPR

when they need help finding a provider. Also, each member's Medicaid card includes a toll-free number directing members to HPRs if they need assistance.

In addition to HPRs, Utah Medicaid operates a customer service line. The customer service line is managed by the Bureau of Medicaid Operations and functions weekdays from 8am – 5pm.

The majority of calls in which the member requests assistance with locating a provider are resolved quickly by HPRs or call center staff. Issues that are not immediately resolved are routed to appropriate staff and, when necessary, escalated to the Bureau Director level until resolution is found.

Constituent Services

The Utah Medicaid website makes available a page with additional information if a member has questions or concerns. A link is given if there is a concern or complaint; the link gives several options including the local phone number, toll-free phone number, and email address for the Medicaid Constituent Representative. The Constituent Service Representative (CSR) exists to answer everything from general medical coverage inquiries to case specific customer issues. While the CSR specializes in Medicaid and CHIP eligibility, this person is also connected across the Medicaid program to help facilitate a solution to any problem she encounters.

Calls to the Constituent Services Representative and to the HPRs are logged to detail the issues raised and the resolution. When the representative documents their interaction with a member, they translate the client's request into an equivalent ticket type and subtype. For each interaction, a log is created which identifies the "type" of call, and refines this further by identifying a "sub type" to describe the caller's concern(s) effectively. Calls regarding access to care concerns are first delineated into FFS or managed care clients and then logged under a subtype for access to care.

CAHPS Survey Questions Regarding Access

The current CAHPS survey tool asks members a number of questions designed to help analyze access to care. Responses from selected questions are employed in the baseline data for this plan. A sample of the access to care questions include:

1. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
2. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

3. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care in the last 6 months?
4. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
5. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

Department Workflow for Client Access Issues

Each point of contact with members initiates a workflow to address client access issues. When the normal workflows of addressing the issue with the HPRs, the customer service line, or constituent services are not sufficient, department staff are involved to investigate the root cause of the issue and take necessary actions. These actions include, but are not limited to:

- Policy analysis to determine if access gaps are present,
- Policy change if gaps can be addressed doing so,
- Manual intervention to correct a failed process (such as connecting two parties that can address the access issue), and
- Initiating rate evaluation if insufficient reimbursement is at cause.

As of April 2016 access to care issues have not been explicitly identified or documented. While calls are tracked to a certain extent by Constituent Services, there is an opportunity to collect valuable information during these calls. To address this opportunity FFS member calls will now be directed to HPRs or Constituent Services to handle. When Constituent Services or HPRs interact with client calls, each call will be tracked.

DMHF is working to develop an internal tool for tracking purposes. Calls would be tracked by FFS or Managed Care and zip code. Once the tool is in place the contact information available to members via the website and the Medicaid card will be updated accordingly.

Each call will be classified by 'type':

- Member
- Provider

Each call will be classified by 'issue':

- Eligibility
- Access to Care
- Claims
- Managed Care

- Other (specify)

Access to care calls will be further 'sub-typed' by the area of service:

- Primary Care
- Specialist
- Home Health Care
- Behavioral Health
- Obstetrics (pre- and post-labor delivery)
- Other (specify)

Access to care call will then be further 'sub-typed' by subject:

- Find a Provider
- Provider is too far (transportation)
- Taking too long to get into Provider (Over 1 month for primary care, over 3 months for specialist)

Calls will be tracked to resolution with close ended data points for aggregation.

See **Appendix A** for diagram of client access issue workflow.

Medical Care Advisory Committee

The role of the Medical Care Advisory Committee (MCAC) is to provide the State Medicaid Agency with recommendations on the operation and planning of Medicaid programs. This includes:

- input in the policy making process and program development
- oversight of the quality and quantity of services provided under Medicaid
- improving communication with provider and community stakeholders
- creating a public understanding and assurance that state services meet the needs of the people served at a reasonable cost to taxpayers
- planning for future programs, or aiding in decisions to end existing programs when appropriate

The committee membership includes medical professionals familiar with the needs of low-income population groups, consumer stakeholders and state department members.

In March 2016 DMHF provided the MCAC with a concept brief outlining the new Federal Regulations governing access to care and the Division's Access Monitoring Review Plan. The briefing included a solicitation for informal feedback during the developmental and formulation stage, noting formal feedback will be requested during the public notice and

comment period. In June 2016 an initial draft plan was submitted to the board for review and feedback. Subsequently the final draft was presented to the full committee in July 2016. Feedback received from the MCAC and other stakeholder groups has been incorporated into this plan.

Each time an updated version of the Access Monitoring Review Plan is submitted to CMS a corresponding report will be given to the MCAC for evaluation and input.

Utah Indian Health Advisory Board/Tribal Consultation

The Utah Indian Health Advisory Board (UIHAB) is comprised of tribally appointed health representatives with authority to maintain an open dialog with the Department of Health utilizing a formal consultation process to address policy and issues related to health and public health in Utah. There are eight (8) federally recognized tribes and one (1) Urban Indian Organization located in Utah. They are the *Confederated Tribes of the Goshute Reservation, Navajo Nation, Northwestern Band of Shoshone Nation, Paiute Indian Tribe of Utah, San Juan Southern Paiute, Skull Valley Band of Goshute, Ute Indian Tribe, and the Ute Mountain Ute Tribe.* There is a limited Indian Health Services (IHS) presence in Utah. The IHS operates one outpatient facility located on the Ute Indian Reservation in the northeastern part of the state. The State and Tribal relationship is based on a government-to-government relationship, not one based on race or ethnicity. Currently, three (3) of the eight (8) federally recognized Tribes operate their own Tribal 638 health facilities. Salt Lake City is home to one of the 32 Title V (Indian Health Care Improvement Act) Urban Indian Programs across the country; the Urban Indian Center of Salt Lake (UICSL). This is an outreach and referral center. The Center currently contracts with the Community Health Centers of Utah for referral of clients needing direct medical care. In addition, the Center provides access to direct services for Behavioral Health, Youth, Health Promotion and Disease Prevention, Emergency Preparedness and Diabetes programs, and servers as a cultural center for Salt Lake's urban Indian population.

According to the US Census, the average American Indian/Alaska Native (AI/AN) population in Utah is 48,538 (UDOH OHD 'Health Status by Race & Ethnicity, 2015). This is approximately 1.7 % of Utah's total population. According to the UICSL, there are approximately 16,000 AI/AN's living along Utah's Wasatch Front. Utah's AI/AN population is young, and very mobile, moving between reservations and urban centers several times a year for work, school, or even to access health care.

In April 2016 the AMRP project lead from DMHF met with the Department's Office of American Indian/Alaska Native Health Affairs. Subsequent to the initial meeting, DMHF initiated the Tribal Consultation process and provided the UIHAB with a concept brief outlining the new Federal Regulations governing access to care and the Division's Access Monitoring Review Plan. The briefing included solicitation for informal feedback during the developmental and formulation stage, noting formal feedback will be requested during the

subsequent July UIHAB meeting. There will also be opportunity for tribal and urban Indian community comment during the public notice and comment period.

Identified Stakeholder Groups

A number of additional stakeholder groups provide feedback to DMHF. For the purposes of the AMRP, specific organizations were identified. In addition to the MCAC, these groups were also asked to provide informal feedback during the developmental and formulation stage.

Public Notice Periods and Hearings

The DMHF regularly files rules and State Plan Amendments (SPAs) for public comment. These rules and SPAs are published in the Utah State Bulletin on the 1st and 15th of each month. On occasion, DMHF receives public comments on these rules and requests for public hearings. Upon receiving a request for a public hearing, DMHF will review the public hearing requirements found in Section 63G-3-302 of the Utah Code to determine whether the request warrants a public hearing.

DMHF may also hold a public hearing at its discretion, and schedule the hearing when it files a proposed rule through the e-rules system or when it creates a draft rule for public comment. The same preparation and procedures are followed.

When a public hearing takes place a final hearing record is compiled, which includes the minutes, a summary of the public comments received, and the DMHF responses. The final hearing record is submitted to the Division Director for approval.

Medicaid Restriction Program

The Medicaid Restriction Program allows providers such as physicians and pharmacists to provide quality care while assuring that Medicaid does not facilitate drug abuse or overutilization of Medicaid services. If a Medicaid member has utilized pharmacy services or emergency department services at a frequency or amount that is not medically necessary, that individual may be referred to and enrolled in the Medicaid Restriction Program.

Members are identified in the Restriction Program through on-going reviews of member profiles to identify excessive use of services; verbal and written reports of inappropriate use of services from one or more health providers; and referral from Medicaid staff, law enforcement, or other state agencies.

If a member calls in and is identified as part of the restriction program it will reflect in the resolution status of the tracking tool.

Summary

Information generated through reporting from HPRs and Constituent Services can allow insight into the Utah Medicaid Member experience, and help the Department form responses to the needs of our members. The refinements to standard operating procedures directing all staff to specifically identify access to care issues and document them appropriately using MMCS or the appropriate tracking tool should allow for improved identification of access to care issues reported to Utah Medicaid staff.

Future State with PRISM

PRISM, Provider Reimbursement Information System for Medicaid, is the name of the multi-year project to replace the current Medicaid Management Information System (MMIS). The contract was awarded to CNSI to work with Medicaid PRISM staff to develop the new system. The term "Release" is used for each component of software placed into production. There are four defined releases.

PRISM has designed the following as part of Release 4:

A member will be able to file a complaint or appeal in the Member Portal. No reports are currently designed.

The Bureau of Managed Health Care has designed a report for MCO Dis-enrollment which contains a dis-enrollment reason called "Access to Care". DMHF staff would also be able to view an online list page based on if a member has been exempted from Managed Care enrollment based on access to care.

Interactive Voice Response (IVR) when a member calls the IVR, they must authenticate who they are by entering either Member ID, OR SSN and DOB. Their address, including zip code is stored in Siebel (IVR product). If they are an unauthenticated caller, they can be entered into Siebel as a "Contact"...address can also be entered. However for "Contacts", there is not currently any type of flag to differentiate a provider from a member.

IVR will have options for Members like inquiring about "Current Member Health Plan", "All Available Health Plans", which are automated. They can also "Find or Locate HPR". Selecting these options in the IVR will create Activities in Siebel (e.g. tracking what options a caller selected in the IVR).

On the Siebel screens, a customer service representative can enter a Service Request and Activity types, sub-types, call types, etc. These are used to capture the types and purpose of the call.

Based on the list provided “Member Calls In”, the call types and sub types may need to be revised to better meet the CMS rule. The projected release implementation date is late 2019.

Other Department Programs and Activities That Ensure Access to Care

DMHF oversees a variety of programs and works with a significant number of stakeholder groups throughout Utah communities to ensure access to care is sufficient for our members.

Public Notice Periods and Hearings

As stated in a previous section The DMHF regularly files rules and State Plan Amendments (SPAs) for public comment. Beginning July 1, 2016 an analysis against Utah’s Access Monitoring Review Plan will be conducted anytime a SPA proposes a rate reduction or restructure to ensure members continue to have access to the care they need.

As with the AMRP itself, any review analysis and DMHF response to public comment regarding the AMRP will be posted on the Utah Medicaid Website.

Local Health Departments

DMHF contracts with seven Local Health Departments (LHD), representing the entire state, to provide education to providers and assistance for eligible clients in selecting a primary care physician and/or health plans.

The contracts mandate that LHDs contact local providers to promote participation in the Utah Medicaid and Primary Care Network (PCN) programs. The LHD is required to educate local providers who are interested in participation in the Utah Medicaid and PCN programs how they can enroll with the Department’s Provider Enrollment team. At the end of the State Fiscal

Year the LHD provides a report to DMHF with the names of local providers with whom they've conducted outreach.

Local Health Department contracts also include provisions regarding information dissemination and general education for inquiries by both providers and Members. Medicaid handbooks are given to LHDs in order to help facilitate these inquiries.

Telehealth

When provided by an authorized provider, Utah Medicaid covers physician and nurse practitioner services delivered via telemedicine. The services delivered must be covered by Medicaid.

- Telemedicine encounters must comply with HIPAA privacy and security measures to ensure that all patient communications and records, including recordings of telemedicine encounters, are secure and remain confidential. The provider is responsible for determining if the encounter is HIPAA compliant. Security measures for transmission may include password protection, encryption, and other reliable authentication techniques.

- Compliance with the Utah Health Information Network (UHIN) Standards for Telehealth must be maintained. These standards provide a uniform standard of billing for claims and encounters delivered via telehealth.

Transportation to Mental Health Services

Medicaid members who are not enrolled in a Prepaid Mental Health Plan may receive medically necessary transportation to any mental health service covered by Medicaid.

Transportation for Covered Medicaid Services

Medical transportation to obtain covered Medicaid services is a benefit for Medicaid members. Medical transportation benefits include the following types of transport:

- Personal transportation
- A UTA bus pass or bus services
- Special bus services (Flex Trans through UTA or Dial-A-Ride)
- Taxi cab service
- Non-specialized van services
- Specialized van services
- Ambulance transportation

Physician Home Visits Where Access is Limited

Utah Medicaid will consider coverage of a home visit by a primary care physician in certain situations. For example, the patient has a condition which makes travel very difficult and they live in a rural area where access to medical care is limited (i.e. they live 50 or more miles round trip from the physician's office).

Dental Incentive Programs

Effective July 1, 1997, Medicaid began new reimbursement programs for dentists. The programs are the result of an increase in funding from the 1997 legislature and recommendations made to Medicaid by a Dental Task Force composed of dentists, Medicaid staff, and client representatives. The intent of the programs are to increase access to dental service and reward dentists who treat a significant number of Medicaid clients.

If a provider has signed the Medicaid dental agreement, they will receive either 120% of the amount listed on the reimbursement schedule or the amount billed for the service provided.

Dentists outside of the Wasatch front (which includes all counties EXCEPT Salt Lake, Weber, Davis, and Utah Counties) automatically receive a 20% increase in reimbursement. This increase is to encourage dentists in rural areas to treat Medicaid clients and thereby improve access for clients residing outside of the Wasatch front areas.

Rural Area Enhanced Payment Rates

Physicians, including persons providing services under the direct supervision of a physician as allowed by state law, providing services in rural areas of the state are paid a rate differential equal to 112 percent of the physician fee schedule. Rural areas are defined as areas of the State of Utah outside of Weber, Davis, Salt Lake and Utah counties.

Rural Area Home Health Travel Enhancement

Medicaid provides enhancements to the home health reimbursement rate when travel distances to provide services are extensive.

The enhancement is available only in rural or frontier counties where round-trip travel distances from the care giver's base of operations are in excess of 50 miles. Rural counties are defined as counties other than Weber, Davis, Salt Lake, and Utah.

An enhancement factor is applied to home health services rendered for residents living in San Juan or Grand County. This enhancement is irrespective of the distances traveled and is in lieu of the rural area exceptions provided for other rural counties.

Neonatal Care and Mobile Ultrasounds for Rural Areas

CPT code 99464, Attendance at Delivery, is available for use by board certified neonatologists and board certified pediatricians in urban or rural areas. Family practice physicians trained in neonatal care who practice in rural areas will be recognized and included for reimbursement.

Some ultrasound codes will be open to mobile ultrasound facilities (Provider Type 71) to provide ultrasounds for rural areas with limited access requiring long distance travel. All FFS counties qualify for this service.

Licensed certified registered nurse-midwives who provide services in rural areas of the State will be paid the lower of usual and customary charges or rate equal to 112% of the established Medicaid fee schedule. Rural areas are defined as areas of the State outside of Weber, Davis, Salt Lake and Utah counties.

Utah Department of Health Family Dental Plan

Family Dental Plan (FDP) consists of three dental clinics and a mobile clinic operation which can be taken to various community locations throughout the state of Utah. Clinics are located in Salt Lake City and Ogden. The Family Dental Plan mission is to provide cost-effective, high quality dental services in a patient friendly environment for patients on Medicaid, PCN, CHIP, PEHP, and the uninsured on a fee-for-service (reduced rates) basis. Care is delivered by highly trained professional staff.

HOME Program

DMHF has a unique and specialized managed care organization, Healthy Outcomes Medical Excellence (HOME), which provides further access to care. Established in 2006, H.O.M.E. specializes in mental health and medical services for members who are dually diagnosed with a developmental disability and a mental illness. HOME supports the seven concepts of a medical home as outlined by the American Academy of Pediatrics: continuous care, comprehensive care, coordinated services, accessible, family centered, culturally sensitive and compassionate. HOME reports to DMHF on four quality measures to help ensure the delivery of quality care through their unique model to their members. These measures include Follow-Up After Hospitalization for Mental Illness, Provider Accessibility and Availability, Readmission Rate and a Provider Partnership measure.

Periodic 3-Year Monitoring

Every three years beginning July 1, 2016, Utah DMHF will submit to CMS an updated version of the Access Monitoring Review Plan by July 1 of that review period. DMHF will post the plan

in its most current form on the Utah Medicaid Website starting July 1, 2016, it will be updated by June 30 each subsequent year.

If provider rates are reduced or restructured, the associated service will be monitored and have an Access Review submitted to CMS by July 1 each year for three subsequent years in accordance with 42 CFR 447.203(b)(5)(i) and 42 CFR 447.203(b)(6)(ii).

Beginning in 2017 once a year, a report will be delivered to the MCAC on member and provider access to care data collected through feedback mechanisms. The MCAC will be asked to advise and provide input to DMHF based on the most recent AMRP and current member and provider feedback.

Monitoring Procedures

As part of the regular activities and procedures DMHF follows to ensure sufficient access to care for its members, the access to care index will be monitored annually in accordance with the baseline metrics and methodologies described in the Baseline Data section of this Plan.

When data analysis identifies an 'Access Issue', either through analysis of member call data or the threshold measure described in this plan, DMHF will initiate a process to examine the data in greater detail. After further data examination, DMHF will coordinate internally and with input from the MCAC to investigate the issue. If the issue is substantiated it will be escalated to an 'Access Deficiency' which triggers the requirements of 42 CFR 447.203(8).

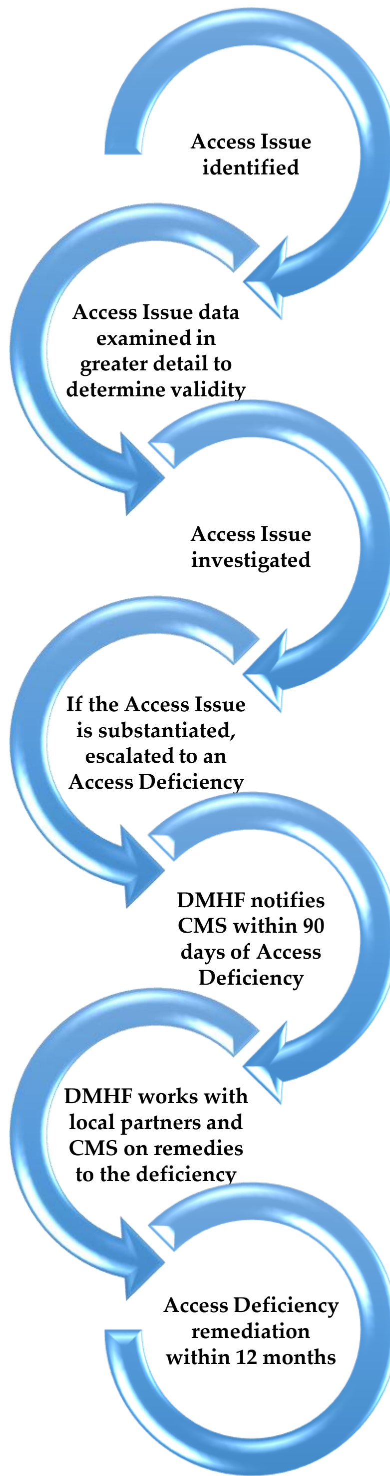


Figure 9

Access to Care Data Analysis

Data Sources

Data for Utah's Access Monitoring Review Plan comes from multiple sources including the Medicaid data warehouse and the All Payers Claims Database (APCD) provided by the Utah Office of Health Statistics. Member perception data comes from the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS). Data pertaining to rate comparisons and providers was obtained from the APCD

The baseline data will act as a thread throughout the analysis of each core area of service, primary care services, physician specialist services, pre- and post-natal obstetric services including labor and delivery, and home health services. Together with a series of logistic regression models and a comparison to commercial insurance rates, this data set will be used to analyze the extent to which Utah Medicaid member's needs are fully met; as well as the availability of care through enrolled providers to members, and changes in utilization of covered services in both rural and frontier counties.

As stated in previous sections of this document, currently 95% of Medicaid clients are eligible to receive care through a prepaid mental health plan. Only a small portion of Medicaid clients receive Behavioral Health services via fee-for-service so an analysis of these services will be represented on separate lines of the composite index.

Alternative Survey Instrument

In March of 2016 the Supreme Court of the United States held, as applied to Employee Retirement Income Security Act plans (ERISA), unconstitutional a Vermont law that requires certain entities, including health insurers, to report payments relating to health care claims and other information relating to health care services to a state agency for compilation in an all-inclusive healthcare database. (Kennedy, 2016)

At this time it is uncertain the extent to which this decision will affect the State's access to statistically valid data for the purposes of the AMRP. In preparation for the case that data becomes unavailable or statistically questionable, an alternative baseline data structure and accompanying survey instrument are being developed. Utah will work closely with CMS to construct an alternative data source and baseline data structure should it become necessary.

Data Limitations

The Consumer Assessment of Health Plans Study (CAHPS) surveys contribute two components of the composite index described in detail below. These surveys ask consumers and patients to evaluate their health care plans among other things. As such, the answers provide valuable

insight into access to care. However, adults and children are surveyed on alternate years, which means there will be overlap in producing an annual index. Another limitation is although the FFS structure is predominantly seen in Utah's rural and frontier counties, we are not able to discern responses in these areas with any semblance of statistical validity.

The commercial data represented in the individual core service analyses is not broken out by population segments. Therefore, while the Medicaid data will be broken out by category of aid segments the commercial data will be constant and represent the entire commercially insured population.

Baseline Data Structure

An access to care composite index was constructed to establish a baseline and to measure changes in access to care in accordance with 42 CFR 447.203(b)(1)(i) through (iii) and (447.203(b)(4). The index is composed of four elements which are broken down into each geographic region by area of service. The data used is compiled from 2013 and 2014.

1. Let C_{ig} = the number of commercial providers under service category i, M_{ig} = the number of Medicaid providers under service category i in geographical region g, E_g = the number of commercial members in geographical region g, F_g = the number of Medicaid members in geographical region g such that the commercial and Medicaid members per provider ratios are given by $W_{ig} = \frac{E_g}{C_{ig}}$ and
$Y_{ig} = \frac{F_g}{M_{ig}}$ and Z is a constant where Z > 1. For ease of computation we choose Z = 2. Thus the provider component (PC) is given by:

$$PC = \left(\frac{1}{Z(Y_{ig} - W_{ig})}\right)$$

equation 1

a) Where $q = \begin{cases} 0 : & Y_{ig} - W_{ig} = 0, \\ 1 : & Y_{ig} - W_{ig} < 0 \\ Y_{ig} - W_{ig} : & Y_{ig} - W_{ig} > 0 \end{cases}$

Specifying the calculation this way allows for $Y_{ig} = W_{ig}$ or $Y_{ig} - W_{ig} = 0$ so that $(0)^{(0)} = 1$.[6]

[6] In pure mathematical terms, for real numbers y such that $y \neq 0$, $y^0 = 1$ and indeterminate when y = 0. However we use use $\lim_{y \to 0} y^0 = 1$, which means that as y gets arbitrarily close to 0, y^0 stays at 1, for positive values of y.

b) The constant, Z, was included to prevent $Y_{ig} - W_{ig} = 1$ from yielding the same result as $Y_{ig} - W_{ig} = 0$. That is, we do not want $\frac{1}{(1)^{(1)}} = \frac{1}{(0)^{(0)}} = 1$.

c) Furthermore, $Y_{ig} - W_{ig} < 0$ is give a value of 1 because we are interested in whether Medicaid's access is at least equal to that of commercial plans.

2. Let A_{ig} = the number of commercial claims under service category *i* in geographical region *g*, B_{ig} = the number of Medicaid claims under service category *i* in geographical region *g*, such that the claims per provider ratios are given by $K_{ig} = \frac{A_{ig}}{C_{ig}}$ and $L_{ig} = \frac{B_{ig}}{M_{ig}}$ where C_{ig} and M_{ig} are from equation 1

   As such, the utilization component (UC) is calculated by:

$$UC = \left(\frac{1}{Z(L_{ig} - K_{ig})}\right) \quad \text{equation 2}$$

   a) Where $s = \begin{cases} 0 : L_{ig} - K_{ig} = 0, \\ 1 : L_{ig} - K_{ig} < 0 \\ L_{ig} - K_{ig} : L_{ig} - K_{ig} > 0 \end{cases}$

   These conditions hold for the same reasons given in a), b) and c) of equation 1

   b) Z is a constant which functions in the same way as in equation 1

3. Let S and T be defined as the weighted FFS Medicaid and weighted commercially covered child and adult percent of survey respondents who replied "usually" or "always" to the CAHPS question of how often they received care as quickly as they wanted, respectively. The ratio of Medicaid to commercial is given by $Q = \frac{S}{T}$, where Q is constrained such that $0 < Q \leq 1$.

4. Let U and V be defined as the weighted FFS Medicaid and weighted commercially covered child and adult percent of survey respondents who replied "usually" or "always" to the CAHPS question of how often they received care they needed, respectively. The ratio of Medicaid to commercial is given by $N = \frac{U}{V}$, where N is constrained such that $0 < N \leq 1$.

For the baseline, each one of these components will be set to 25 so that the total baseline will sum to 100. The measures will be recomputed every year, where every measure will be

compared to its specific baseline. For instance, let us suppose in the base year the difference between Medicaid and commercial providers is 4, which means PD = $\frac{1}{(2 \times 4)^1}$ = 0.125. That base amount is set to 25. In year two the difference is increases to 5, yielding a new PD of 0.1, which means the component value decreases from 25 to

$$\frac{0.1}{0.125} \text{ X } 25 = 20$$

This process will be repeated for all four components every year.

To determine sufficient access to care is present in the current baseline the first two data components were analyzed further to examine the current service penetration and provider penetration rates. The service penetration rate is calculated by dividing the number of service utilizers by the total number of members. The provider penetration rate is calculated by dividing the number of enrolled providers by the total number of members. These calculations are performed for both Medicaid and commercially insured populations for each type of service. The difference between the Medicaid penetration and provider rates and the commercial penetration and provider rates are then calculated to provide a determination in the difference between Medicaid members' ability to access services and providers versus the commercially insured population. The analysis looked for significant percentage point differences between Medicaid rates and rates for the commercial market. Commercial rates are not broken out by aid category the same way Medicaid member rates are since the commercially insured do not have the same designations. Therefore, comparisons are made between Medicaid member by aid category and the total commercial population rates.

A series of logistic regression models will be used to estimate access to care among Medicaid members. Specifically, these models will be used to examine the degree of services provided to Medicaid members and will be employed in the future when analyzing specific services related to rate changes as described in §447.203(6)(i). The estimated parameter from these models will be used to predict changes in access due to changes in reimbursement rates.

Logistic regression use dichotomous dependent variables, where the presence or absence of some behavior is indicated by a 1 or 0 respectively.

The dependent variable, Y_n, for each model is as follows:

Y_1: If any Medicaid patients are accepted then $Y_1 = 1$ if none then $Y_1=0$.

Y_2: If the ratio of the provider's Medicaid percent of total patient mix to the Medicaid enrollee percent of the county's population is greater than 0.50 then then Y_2= 1, if less than then Y_2 = 0.

Y_3: If the ratio of the provider's Medicaid percent of total patient mix is to the Medicaid enrollee percent of the county's population is greater than 1.00 then then Y_3= 1, if less than then Y_3 = 0.

Y_4: If the ratio of the provider's Medicaid percent of total patient mix is to the Medicaid enrollee percent of the county's population is greater than 1.50 then then Y_4= 1, if less than then Y_4 = 0.

Y_1 addresses whether the provider provides services to any Medicaid patients at all, while Y_2, Y_3 and Y_4 speaks to the degree of acceptance of Medicaid patients.

The independent variables used in these models are described in the table below.

Variable	**Variable Name**	**Measure**	**Data Source**	**Reference**
X_1	Differential paid amount to charged amount ratio per patient	Difference between Commercial and Medicaid per patient pay-to-charge ratio	Medicaid Medicaid data warehouse, APCD	(42 C.F.R. §447.203(b)(1)(1)), 2
X_2	Average ratio of Medicaid to commercial reimbursements	Medicaid per patient cost divided by commercial per patient cost, within each county	Medicaid Medicaid data warehouse, APCD	(42 C.F.R. §447.203(b)(1)(1)), 2

X_3	Provider Type Grouping	A value of 1 indicates each provider type and a 0 for not. That is, primary care (1, 0), dental care (1, 0), specialists (1, 0), behavioral health (1, 0), obstetrics (1, 0), home health (1, 0)	Medicaid Medicaid data warehouse, APCD	(42 C.F.R. §447.203(b)(4)), 2, 4, 5, 6, 8
X_4	Percentage of persons in county enrolled in Medicaid	County Medicaid beneficiaries divided by County population	Medicaid Medicaid data warehouse, US Census Population Data	(42 C.F.R. §447.203(b)(3)), 4, 14
X_5	County Medicaid managed care penetration rate	Number of ACO members divided by total members in each county	Medicaid Medicaid data warehouse	4, 6, 8
X_6	Practice/organization type	A value of 1 indicates each practice type and a 0 for not. That is, Solo or two-physician practice (0 ,1), group practice (1, 0),	Medicaid Medicaid data warehouse, APCD	4, 5, 6, 8, 10, 14

		ACO/MCO network (1, 0)		
X_7	Physicians per 1000 persons in each county	Number of physicians divided by population multiplied by 1,000 in each county	BLS, U. S. Census Bureau	4, 5, 14
X_8	Median family income in each county	Value as given	U. S. Census Bureau	(42 C.F.R. §447.203(b)(3))
X9	Percentage of AI/NA in each county	Number of AI/NA divided by population in each county	U.S. Census Data	(42 C.F.R. §447.203(b)(3))
X_{10}	Percent of uninsured in each county	Value as given	Rankings & Roadmaps (A Robert Wood Johnson Foundation Program)	(42 C.F.R. §447.203(b)(3)), 5
X_{11}	Percentage of individuals that are in fair or poor health in each county	Value as given	Rankings & Roadmaps (A Robert Wood Johnson Foundation Program)	(42 C.F.R. §447.203(b)(3))
X_{12}	Percent of county population under the age of 18	County individuals under age 18 divided by county population	U.S. Census Data	(42 C.F.R. §447.203(b)(3)), 4

X_{13}	Percentage of county population aged ≥ 65	County individuals ≥ 65 divided by county population	U.S. Census Data	(42 C.F.R. §447.203(b)(3)), 4
X14	Site of Service	A value of 1 indicates each site of service type and a 0 for not.	Medicaid data warehouse, APCD	4, 5, 6, 8, 10, 14
X15	County Population Density	County population divided by county square miles	U.S. Census Data	(42 C.F.R. §447.203(b)(4))
X16	County fixed effects	Each county is identified with a value of 1 and 0 when not that county. These values will be multiplied by the average ratio of Medicaid to commercial reimbursements.		

The general model to estimate the likelihood of Y1, Y2, Y_3 and Y_4 is as follows:

$$log\left(\frac{P(Y_n)}{1-P(Y_n)}\right) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + + \cdots + \beta_n X_n$$

where X_1, $X_2 \ldots X_n$ refer to the variables in the table above.

The above equation will be used to derive the probability of increased access given an increase in the in the reimbursement rates, such that

$$P = \frac{e^{\beta_0 + \beta_1 X_1 + \beta_2 X_2 + \cdots + \beta_n X_n}}{1 + e^{\beta_0 + \beta_1 X_1 + \beta_2 X_2 + \cdots + \beta_n X_n}}$$

Table 4 provides the raw data used to calculate the first two components of the access to care index.

Table 4: Baseline Index Raw Data 2013-2014

Location	Service Type	Medicaid Members per Medicaid Provider	Commercial Members per Commercial Provider	Medicaid Claims per Medicaid Provider	Commercial Claims per Commercial Provider
Frontier	Home Health	233.33	2,268.68	38.41	25.15
Frontier	Obstetrics	26,133.00	15,124.50	0.00	451.00
Frontier	Physician Specialist	871.10	298.51	375.53	77.63
Frontier	Primary Care	46.34	105.03	258.01	137.88
Rural	Home Health	171.71	3,843.12	80.64	16.38
Rural	Obstetrics	1411.83	3,843.12	356.00	42.85
Rural	Physician Specialist	162.90	274.51	220.45	82.41
Rural	Primary Care	85.28	108.37	240.83	108.66
Cache, Rich, Box Elder Counties	Substance Abuse	1,941.66	26,302.52	1,909.67	211.50
Wasatch County	Mental Health	203.37	415.92	136.25	374.15

CAHPS Component of Baseline

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are conducted once a year in the state of Utah. This survey measures what members thought about the health care and services they received from their health plan in the past year. Issues coved by the survey include whether the member had a problem getting care when needed, or if their customer service needs were met.

The survey is conducted for adults every other year and for children on the alternating years. For the purpose of the baseline in this plan a two year average was taken. In future analysis DMHF will readdress the baseline each year as CAHPS survey data becomes available.

The table below shows the CAHPS data used in the initial baseline calculations. The two questions considered in the baseline are:

1. Percent of survey respondents who replied "usually" or "always" to the CAHPS question of how often they received care they needed.

2. Percent of survey respondents who replied "usually" or "always" to the CAHPS question of how often they received care as quickly as they wanted.

Table 5: CAHPS Survey Data

	Medicaid Needed Care	Commercial Needed Care	Needed Care Mcaid/Comm	Medicaid Quick Care	Commercial Quick Care	Care Quickly Mcaid/Comm
Child	86.67%	90.35%	0.96	94.22%	95.18%	0.99
Adult	81.49%	87.48%	0.93	83.46%	84.24%	0.99
Total	84.08%	88.91%	0.95	88.84%	89.71%	0.99

Thresholds

The threshold is derived from the access to care index formed in the baseline data. The baseline data compares total providers, utilization, and CAHPS survey data between the commercially insured and Medicaid populations. The threshold for flagging a potential access issue occurs in the event the access index differential becomes greater than 25%. The baseline will be reset to 100 every 6 years in order to account for potential and uncontrollable external changes.

If such an increase in the gap were to occur, the Department will acknowledge as a possible access issue and initiate the investigation process described in this plan to determine whether access to care is indeed being impaired.

Comparison Analysis of Utah Medicaid Payment Rates to Commercial Payers

Utah Medicaid's physician fee schedule is based on relative value units (RVUs). The total RVUs for any procedure code is based on the Medicare formula for the specific calendar year. A corresponding conversion factor is also established such that total projected payments to physicians will not increase or decrease as a result of the annual rate update. The conversion factor may also include any changes established by the economic index discussed in Section 4.19-B Subsection 4 of the State Plan.

When a RVU value is either not available or not appropriate, an alternative method is used to establish the fee. In establishing alternative fees the following are given consideration:

a. Utah Medical payment history
b. Medicare fees
c. Practitioner fee schedules
d. Fee schedules from other states
e. Similar procedures with established fees
f. Medical determinations by physician consultants
g. Private insurance payments

In accordance with 42 CFR 447.203(b)(1)(v) and 447.203(b)(3) the data in table 6 compares the average commercial claim and the average claim for the Medicaid managed care organization, Molina Healthcare of Utah, to the average Medicaid FFS claim in each of the core service categories. The comparison is made using data provided by the APCD and internal encounter claims for all FFS counties in the calendar years of 2013 and 2014. After which, a Medicaid to commercial plan ratio and a Medicaid to Molina ratio is calculated. Rates are paid the same for both frontier and rural FFS counties so the geographies are combined in this table. The analysis as presented is the best comparison identified to date, however, due to limitations on commercial data such as payment policies, reimbursement methodologies, and the limitation on all data pertaining to varying case mixes, DMHF will review the available data periodically to determine if the comparison methodology is the most complete.

Table 6: Medicaid to Commercial and Public Payer Cost Comparison

Service Type	Average Commercial Reimbursement per claim	Average Medicaid Reimbursement per Claim	Medicaid to Commercial Ratio	Average Molina Reimbursement per Claim	Medicaid to Molina Ratio
Home Health	$726.39	$323.22	0.44	$284.26	1.14
Obstetrics	$312.53	$249.40	0.80	$462.15	0.54
Physician Specialist	$158.47	$71.55	0.45	$161.04	0.44

Primary Care	$325.29	$166.80	0.51	$149.55	1.12

Review Analysis Core Service Areas

The comparative analyses are based on Medicaid data extracted from the Medicaid data warehouse and commercial data provided by the APCD. The national provider identifier along with provider name and address were used to merge the data from the two sources.

Data regarding the four types of services are determined using provider specialty codes. Primary care include general preventive medicine, family practice, emergency medicine, student health, administrative medicine, and general practice. Furthermore, primary care providers have been active in providing obstetrics services particularly in frontier counties. Between 2013 and 2014 there were no obstetricians in these counties and, as such, primary care providers have filled in that service gap.

Physician specialists include providers with specialty code designations of:

- general surgery,
- allergy,
- cardiovascular diseases,
- dermatology,
- gastroenterology,
- proctology,
- diabetes,
- neurology,
- neurological surgery,
- endocrinology,
- ophthalmology,
- geriatrics,
- orthopedic Surgery,
- hematology,
- pathology,
- infectious diseases,
- plastic surgery,
- physical medicine and rehabilitation,
- colon & rectal surgery,
- pulmonary diseases,
- radiology,
- nephrology,
- pediatric neurology,
- thoracic surgery,
- urological surgery,
- nuclear medicine,
- clinical pathology,
- pediatric radiology,
- radiation oncology,
- rheumatology,
- abdominal surgery,
- occupational medicine,
- cardiovascular surgery,
- hand surgery,
- head and neck surgery,
- oncology surgery,
- pediatric surgery,
- neuropathology,
- oncology,
- cardiology,
- diagnostic radiology,
- immunology,
- neuroradiology,
- pediatric allergy,
- pediatric cardiology,
- respiratory diseases, and
- therapeutic radiology.

Obstetrics include obstetrics-gynecology, neonatology rehabilitation, and the provider type of certified nurse midwife.

Home health data was grouped using provider type designations including, licensed home health services, home health agency, and home delivered meals.

Below are figures and tables, broken out by geographic region type and category of aid that provide relevant information around the four core service areas of primary care, physician specialists, obstetrics, and home health. Figures titled 'Utilizer Groups' provide the demographic distribution of utilizers of the service which informs the member characteristic description. Additional figures, such as figure 12, show the number of providers for both Medicaid and commercial members relative to the total populations for each category. For example, the data shows that in frontier counties there are approximately 46 Medicaid members for every primary care provider that serves the Medicaid population, contemporaneously, there are approximately 105 commercially insured members for every primary care provider that serves the commercially insured population. Further figures, such as figure 13, show the number of claims for both Medicaid and commercial members relative to the total populations for each category. These figures represent the initial data used in the first two components of the baseline index of this plan, raw data for these figures is provided in the baseline data structure section.

Primary Care

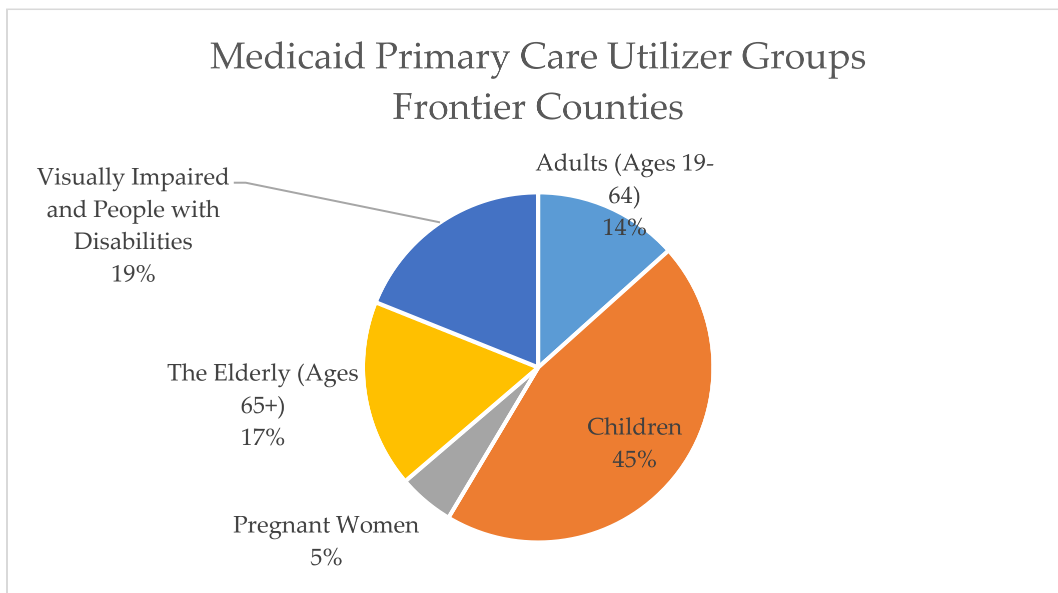


Figure 10

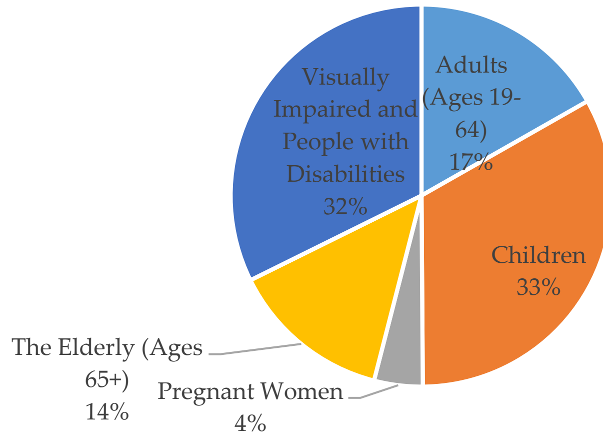


Figure 11

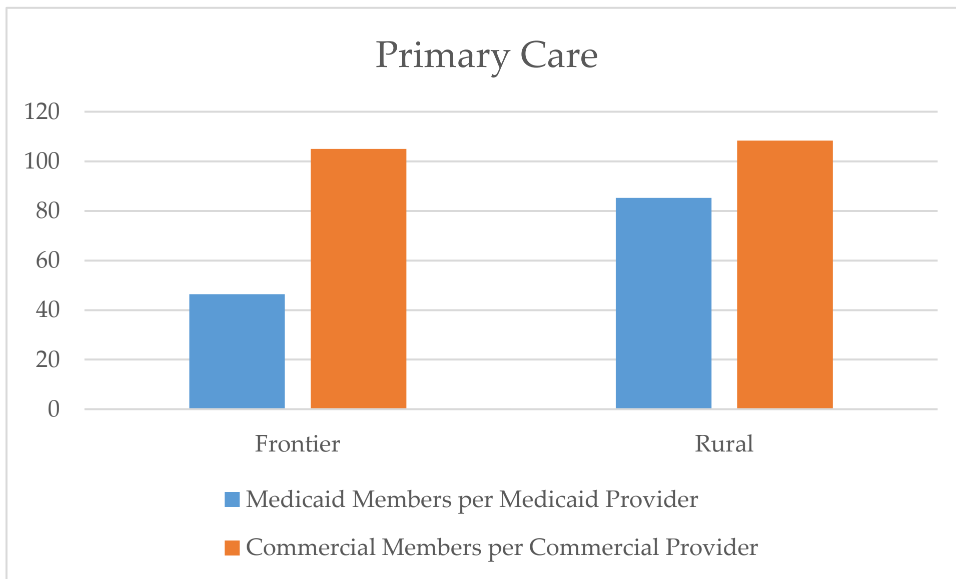


Figure 12

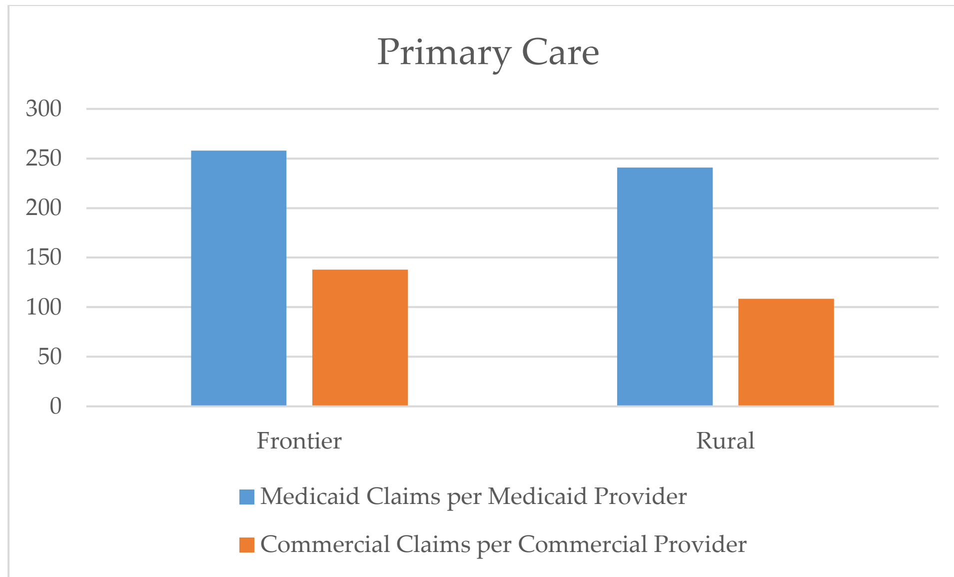


Figure 13

Table 7: Frontier Counties			
Category of Assistance	Medicaid Service Penetration Rates	Commercial Service Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	149%	66%	83%
Children	212%	66%	147%
Pregnant Women	187%	66%	122%
The Elderly (Ages 65+)	766%	66%	700%
Visually Impaired and People with Disabilities	406%	66%	340%
All	278%	66%	213%
Category of Assistance	Medicaid Provider Penetration Rates	Commercial Provider Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	3.75%	0.48%	3.28%
Children	0.92%	0.48%	0.45%
Pregnant Women	5.78%	0.48%	5.30%
The Elderly (Ages 65+)	13.35%	0.48%	12.87%
Visually Impaired and People with Disabilities	7.86%	0.48%	7.38%
All	1.08%	0.48%	0.60%

Table 8: Rural Counties			
Category of Assistance	Medicaid Service Penetration Rates	Commercial Service Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	94.16%	50%	44.03%
Children	76.54%	50%	26.40%
Pregnant Women	74.03%	50%	23.89%
The Elderly (Ages 65+)	433.62%	50%	383.49%
Visually Impaired and People with Disabilities	331.14%	50%	281.01%
All	141.20%	50%	91.07%
Category of Assistance	Medicaid Provider Penetration Rates	Commercial Provider Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	2.28%	0.46%	1.82%
Children	0.62%	0.46%	0.16%
Pregnant Women	2.91%	0.46%	2.45%
The Elderly (Ages 65+)	8.12%	0.46%	7.65%
Visually Impaired and People with Disabilities	4.00%	0.46%	3.54%
All	0.59%	0.46%	0.12%

Primary Care Services Access Issues Discovered As a Result of This Review

The analysis demonstrates that Medicaid Members as a whole, are accessing primary care services at a rate 213 percentage points higher in frontier counties and 91.07 percentage points higher in rural counties than the commercially insured population. The provider penetration for Medicaid is 0.6 percentage points higher in frontier counties and 0.12 percentage points higher than the commercial provider penetration.

The analysis demonstrates the State's compliance with the access standard in Section 1902(a)(30)(A).

Physician Specialists

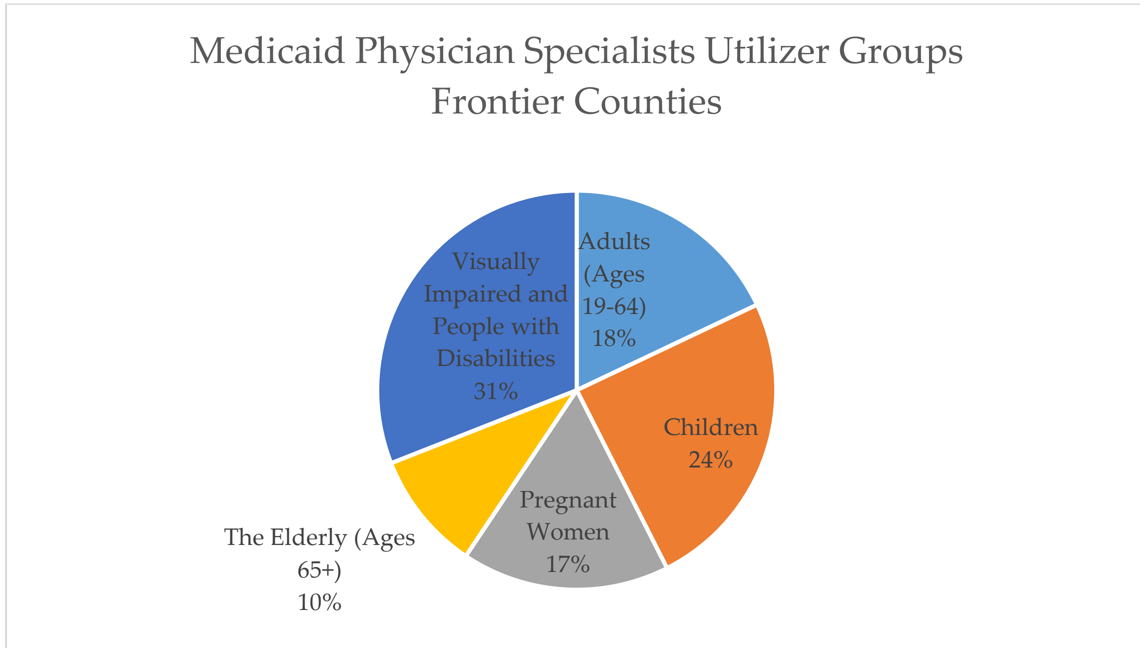


Figure 14

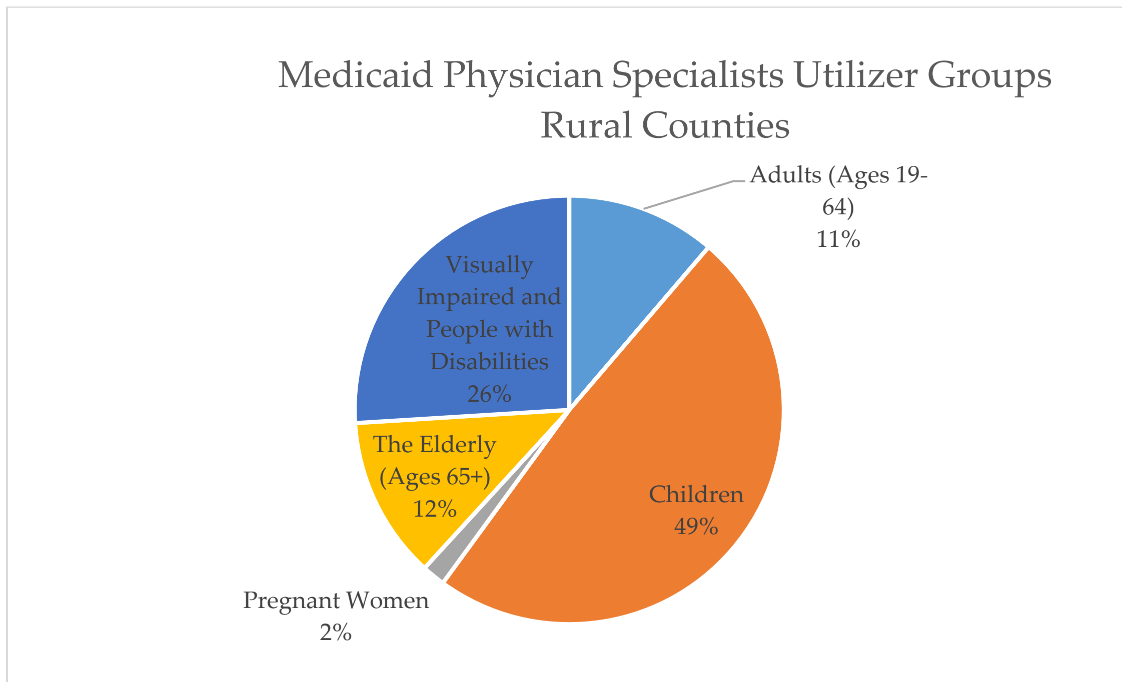


Figure 15

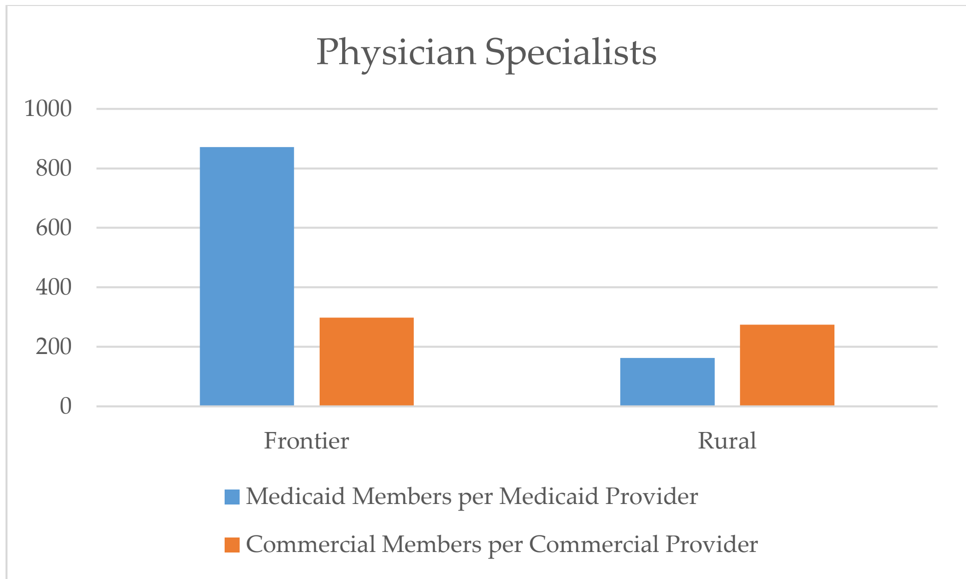


Figure 16

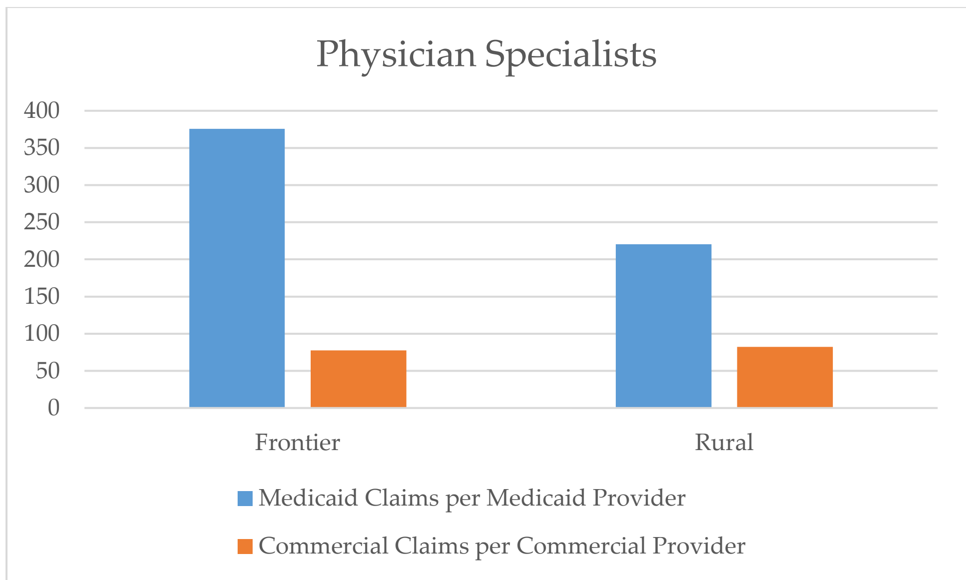


Figure 17

Table 9: Frontier Counties			
Category of Assistance	Medicaid Service Penetration Rates	Commercial Service Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	16.21%	13.00%	3.21%
Children	9.34%	13.00%	-3.66%
Pregnant Women	49.48%	13.00%	36.48%

The Elderly (Ages 65+)	34.53%	13.00%	21.53%
Visually Impaired and People with Disabilities	53.69%	13.00%	40.69%
All	21.56%	13.00%	8.55%
Category of Assistance	Medicaid Provider Penetration Rates	Commercial Provider Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	0.25%	0.17%	0.08%
Children	0.05%	0.17%	-0.12%
Pregnant Women	0.27%	0.17%	0.10%
The Elderly (Ages 65+)	0.80%	0.17%	0.63%
Visually Impaired and People with Disabilities	0.45%	0.17%	0.28%
All	0.06%	0.17%	-0.11%

Table 10: Rural Counties			
Category of Assistance	Medicaid Service Penetration Rates	Commercial Service Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	32.49%	15.01%	17.48%
Children	57.96%	15.01%	42.95%
Pregnant Women	16.25%	15.01%	1.24%
The Elderly (Ages 65+)	199.23%	15.01%	184.22%
Visually Impaired and People with Disabilities	136.93%	15.01%	121.92%
All	67.66%	15.01%	52.65%
Category of Assistance	Medicaid Provider Penetration Rates	Commercial Provider Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	1.30%	0.18%	1.12%
Children	0.32%	0.18%	0.14%
Pregnant Women	1.87%	0.18%	1.68%
The Elderly (Ages 65+)	5.60%	0.18%	5.42%
Visually Impaired and People with Disabilities	2.31%	0.18%	2.13%
All	0.31%	0.18%	0.12%

Physician Specialist Services Access Issues Discovered As a Result of This Review

The analysis demonstrates that Medicaid Members as a whole, are accessing physician specialist services at a rate 8.55 percentage points higher in frontier counties and 52.65 percentage points higher in rural counties than the commercially insured population. Staff has become aware of the service and provider penetration rates for children in Frontier Counties, although not statistically significant enough to indicate an access deficiency (both less than a 1 percentage point difference) they are currently lower than the commercially insured populations. Therefore these counties, and particularly children will be reviewed in our annual update.

Through this analysis this data has identified areas for additional review, language will be added to the Local Health Department (LHDs) contracts that specifically requires the LHDs to recruit these provider types in frontier counties. Overall the analysis demonstrates the State's compliance with the access standard in Section 1902(a)(30)(A).

Home Health

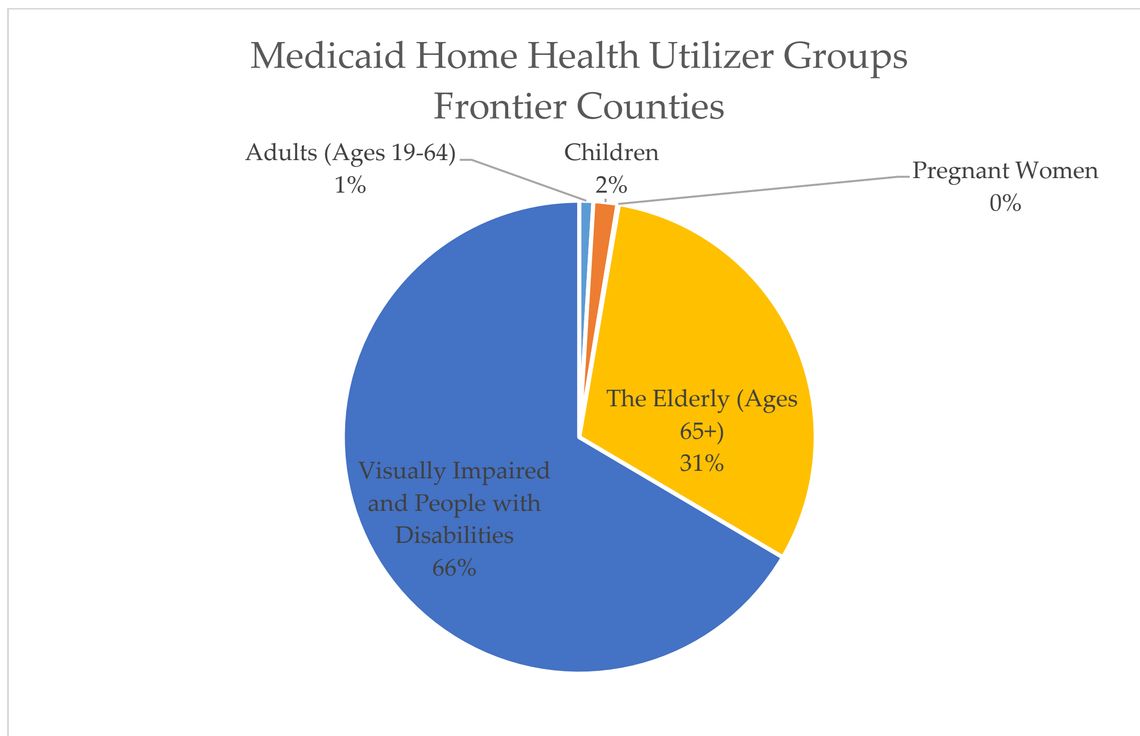


Figure 18

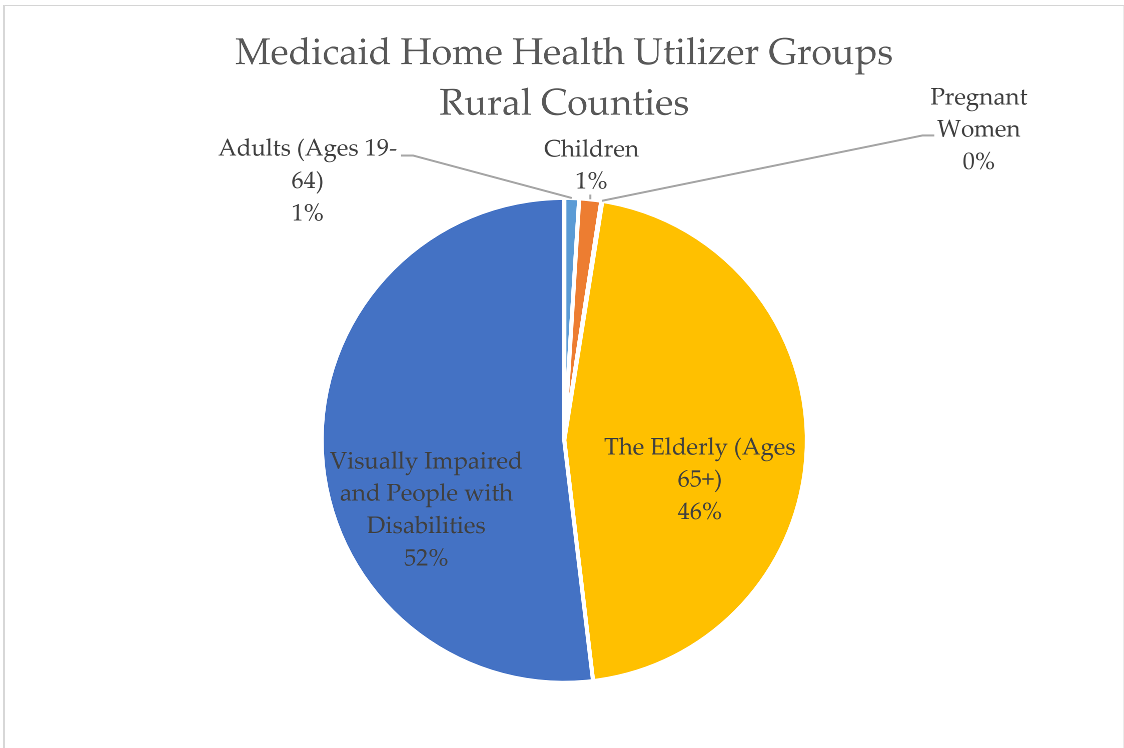


Figure 19

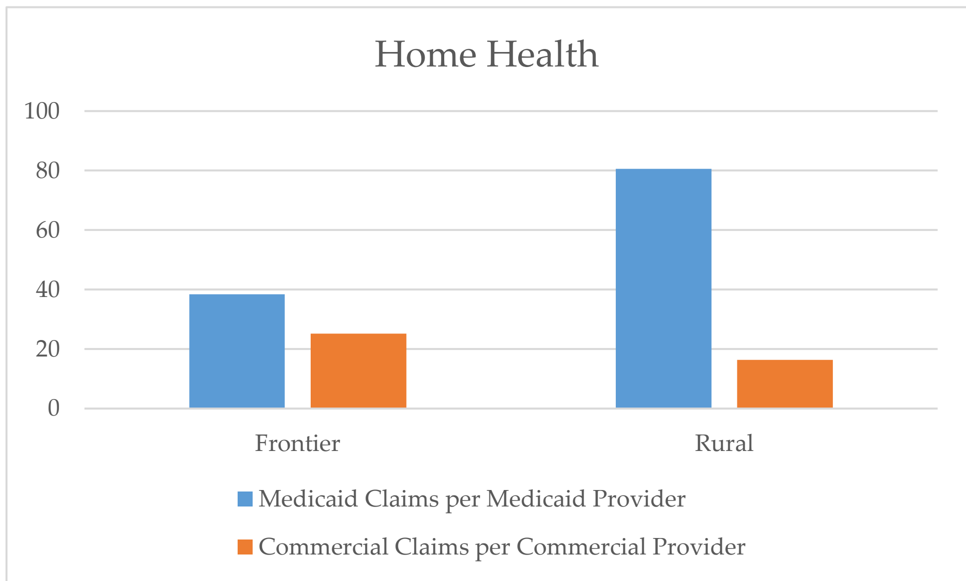


Figure 20

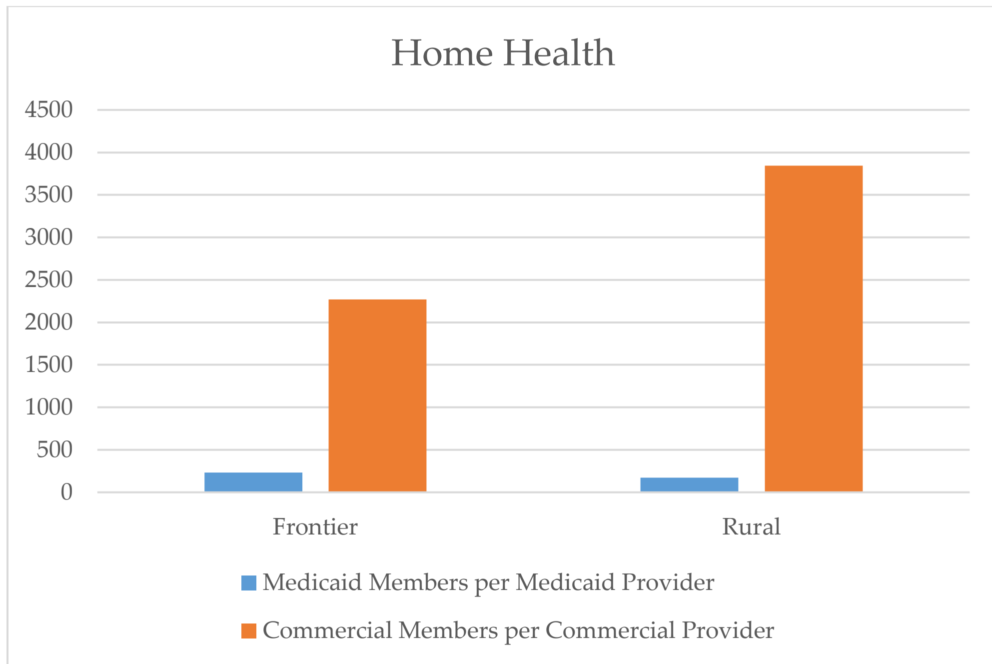


Figure 21

Table 11: Frontier Counties			
Category of Assistance	Medicaid Service Penetration Rates	Commercial Service Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	0.35%	0.55%	-0.20%
Children	0.25%	0.55%	-0.30%
Pregnant Women	0.11%	0.55%	-0.45%
The Elderly (Ages 65+)	44.89%	0.55%	44.33%
Visually Impaired and People with Disabilities	47.02%	0.55%	46.47%
All	8.23%	0.55%	7.68%
Category of Assistance	**Medicaid Provider Penetration Rates**	**Commercial Provider Penetration Rates**	**Percentage Point Difference Medicaid-Commercial**
Adults (Ages 19-64)	0.08%	0.02%	0.06%
Children	0.04%	0.02%	0.01%
Pregnant Women	0.11%	0.02%	0.09%
The Elderly (Ages 65+)	3.19%	0.02%	3.17%
Visually Impaired and People with Disabilities	1.48%	0.02%	1.46%
All	0.21%	0.02%	0.19%

Table 12: Rural Counties			
Category of Assistance	Medicaid Service Penetration Rates	Commercial Service Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	1.03%	0.21%	0.81%
Children	0.63%	0.21%	0.41%
Pregnant Women	0.22%	0.21%	0.01%
The Elderly (Ages 65+)	268.21%	0.21%	268.00%
Visually Impaired and People with Disabilities	98.81%	0.21%	98.60%
All	23.48%	0.21%	23.27%
Category of Assistance	Medicaid Provider Penetration Rates	Commercial Provider Penetration	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	0.09%	0.01%	0.07%
Children	0.04%	0.01%	0.02%
Pregnant Women	0.11%	0.01%	0.10%
The Elderly (Ages 65+)	7.15%	0.01%	7.14%
Visually Impaired and People with Disabilities	2.13%	0.01%	2.11%
All	0.29%	0.01%	0.28%

Home Health Services Access Issues Discovered As a Result of This Review

The analysis demonstrates that Medicaid Members as a whole, are accessing home health services at a rate 7.68 percentage points higher in frontier counties and 23.27 percentage points higher in rural counties than the commercially insured population. Staff has become aware of the service penetration rates for children, adults (ages 19-64), and pregnant women in Frontier Counties, although not statistically significant enough to indicate an access deficiency (all less than a 1 percentage point difference) they are currently lower than the commercially insured populations. This is most likely due to the data limitation that prevents comparable analysis to Medicaid aid category groups with commercial. Over 97%, of home health Medicaid utilizers fall into the aid categories of visually impaired and people with disabilities or the elderly. Provider penetration rates for Medicaid are higher in both Frontier and Rural counties.

The analysis demonstrates the State's compliance with the access standard in Section 1902(a)(30)(A).

Obstetrics – Pre and Post Labor Delivery

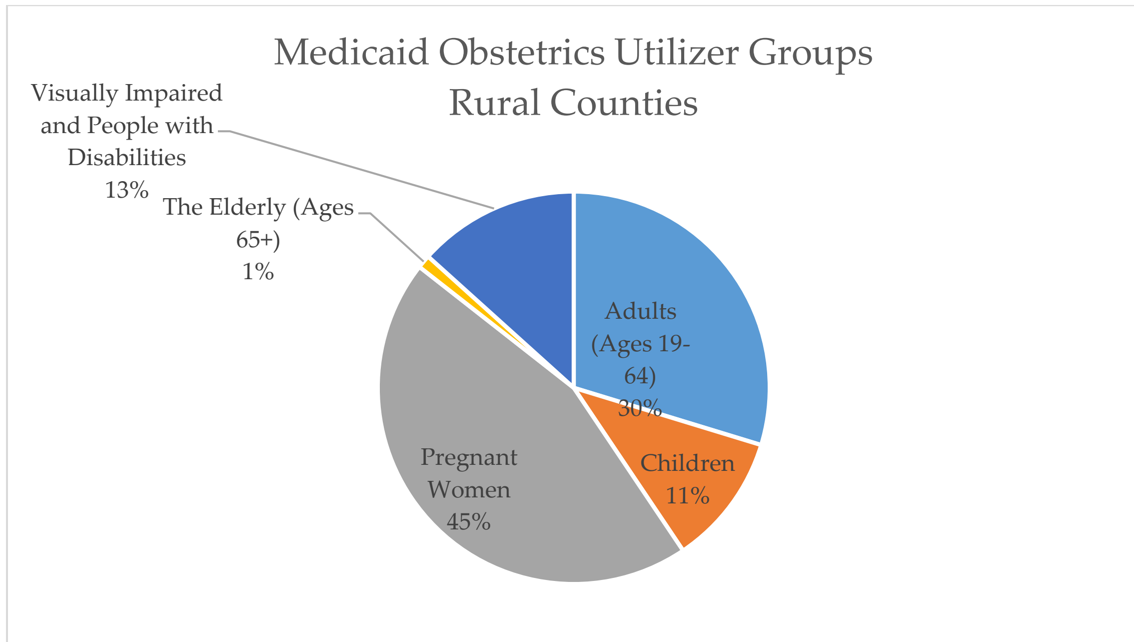
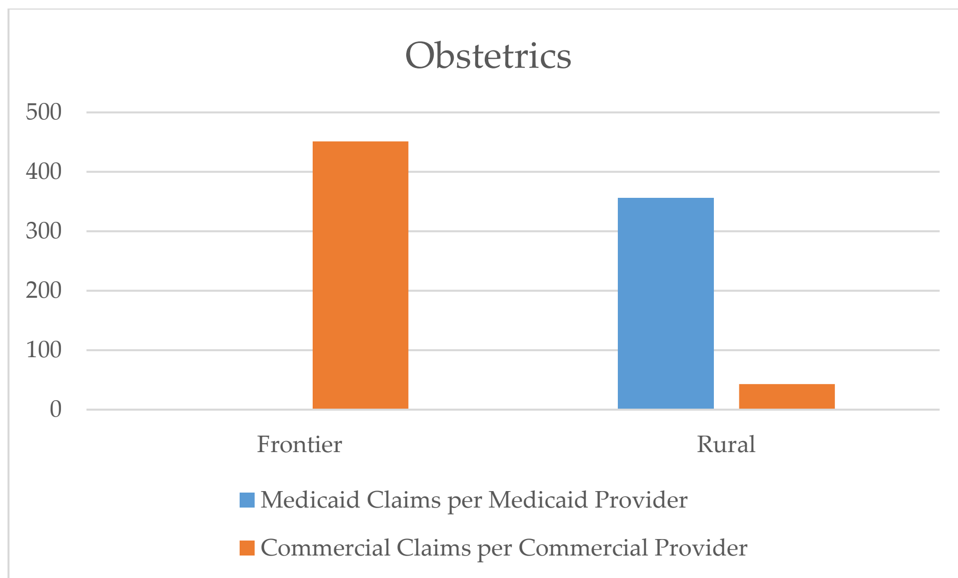


Figure 22



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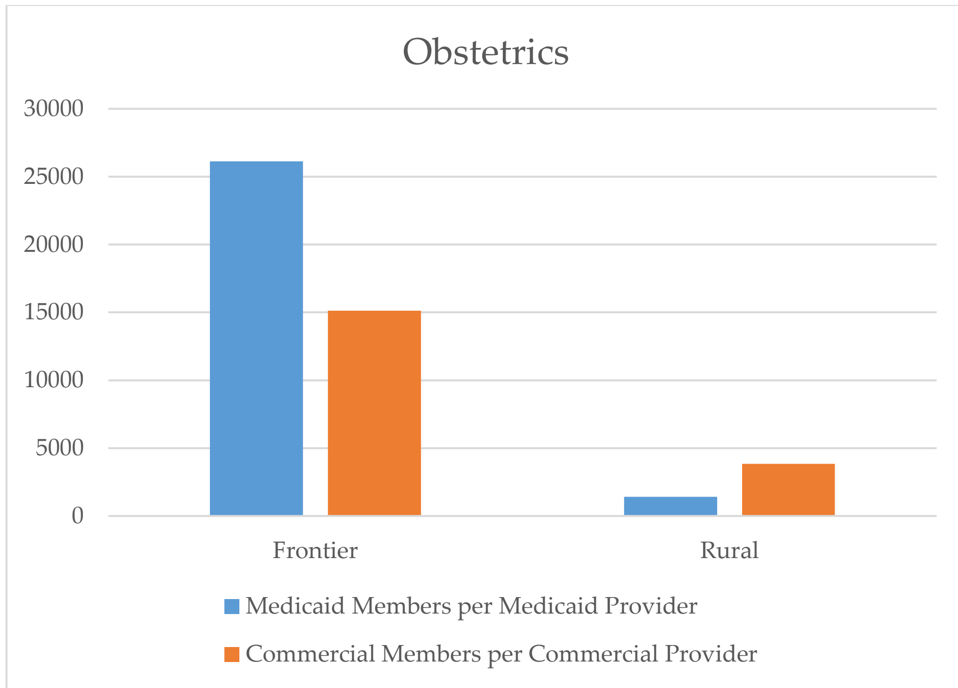

Figure 24

Table 13: Rural Counties			
Category of Assistance	Medicaid Service Penetration Rates	Commercial Service Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	15.68%	0.56%	15.12%
Children	2.36%	0.56%	1.80%
Pregnant Women	76.17%	0.56%	75.61%
The Elderly (Ages 65+)	3.29%	0.56%	2.73%
Visually Impaired and People with Disabilities	12.85%	0.56%	12.29%
All	12.61%	0.56%	12.05%
Category of Assistance	Medicaid Provider Penetration Rates	Commercial Provider Penetration	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	0.15%	0.01%	0.14%
Children	0.04%	0.01%	0.02%
Pregnant Women	0.38%	0.01%	0.37%
The Elderly (Ages 65+)	0.39%	0.01%	0.37%
Visually Impaired and People with Disabilities	0.28%	0.01%	0.27%
All	0.04%	0.01%	0.02%

Table 14: Frontier Counties			
Category of Assistance	Medicaid Service Penetration Rates	Commercial Service Penetration Rates	Percentage Point Difference Medicaid-Commercial
All	0.00%	0.56%	-0.56%
Category of Assistance	Medicaid Provider Penetration Rates	Commercial Provider Penetration	Percentage Point Difference Medicaid-Commercial
All	0.000%	0.003%	-0.003%

Obstetrics Services Access Issues Discovered As a Result of This Review

The analysis shows that Medicaid does not have any providers in Frontier Counties classified under obstetric specialty types, while the commercial market has 3. Further analysis indicates that the majority of obstetric services related to pre and post labor delivery are being performed through primary care services. Staff is aware that monitoring the provider rate in these counties will be necessary to determine if there are access issues related to the overall lack of providers in the market place. Since the number of total providers in these counties is low, at 3, the percentage point difference between Medicaid and commercial is not statistically significant at .003 percentage points. Analysis of rural counties demonstrate that Medicaid members are accessing services at a rate 12.05 percentage points higher than the commercially insured population. Through this analysis this data has identified areas for additional review, language will be added to the Local Health Department contracts that specifically indicates the need for these provider types to serve members frontier counties. Overall the analysis demonstrates the State's compliance with the access standard in Section 1902(a)(30)(A).

Behavioral Health

Data for the behavioral health analysis in this report comes from the same sources as the baseline data reported in earlier sections of this plan. The data includes behavioral health services in Wasatch County and substance abuse services in Box Elder, Cache, and Rich Counties.

For Medicaid provider category of service 'Alcohol and Drugs' was used for substance abuse and provider categories of service 'Mental Health Services' and 'Psychologist Services' were used for mental health. For the commercial population, the 'Substance Abuse Rehabilitation Facility' category was used for substance abuse, and all 'Behavioral Health' was used to analyze mental health.

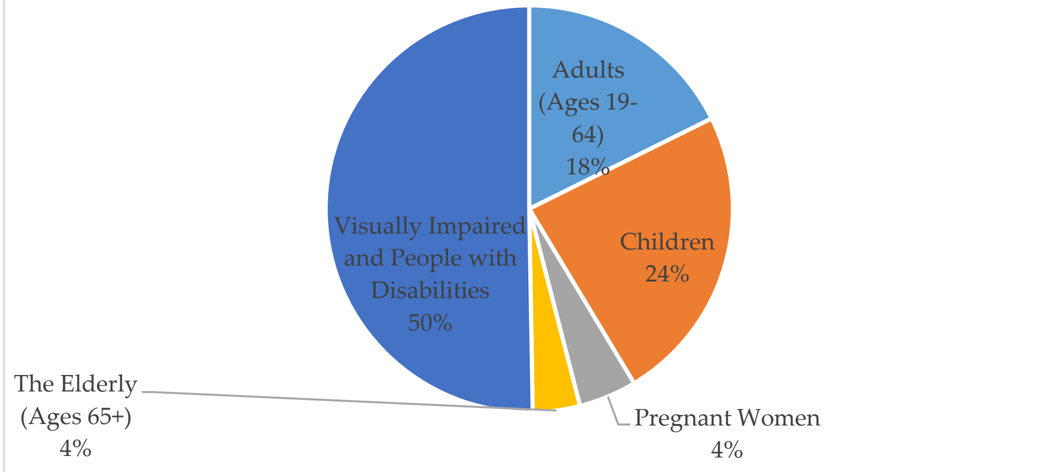

Figure 25

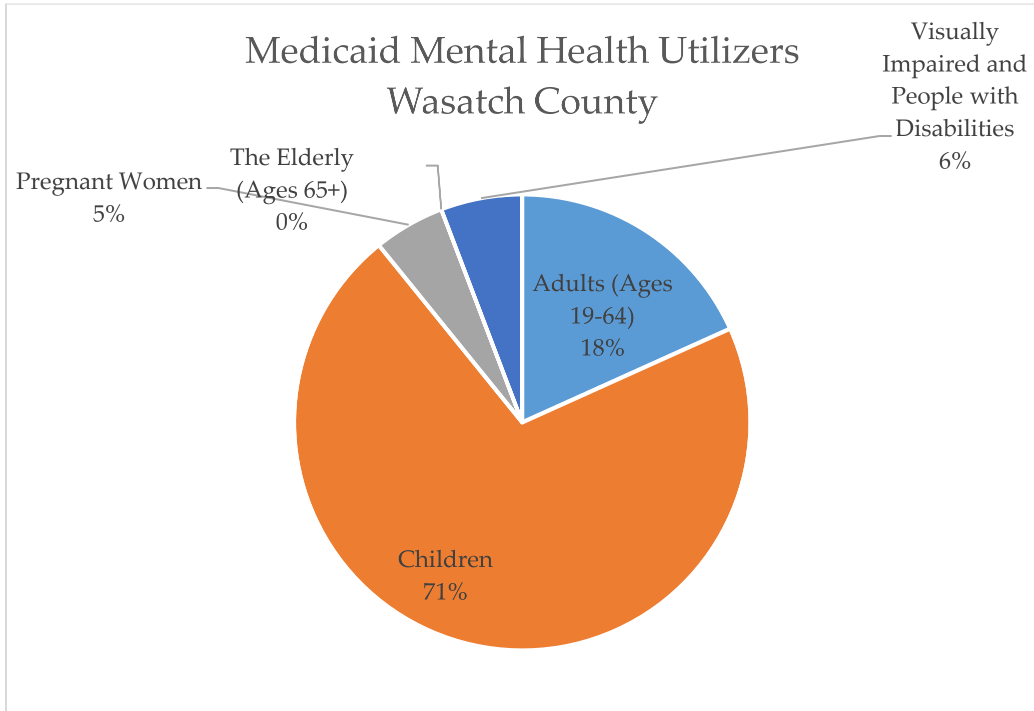

Figure 26

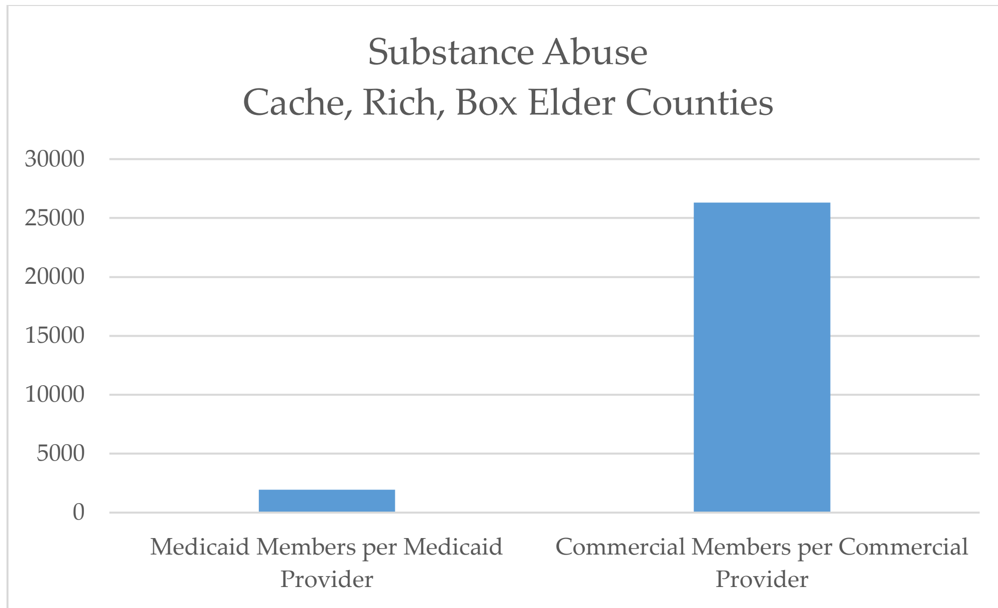

Figure 27

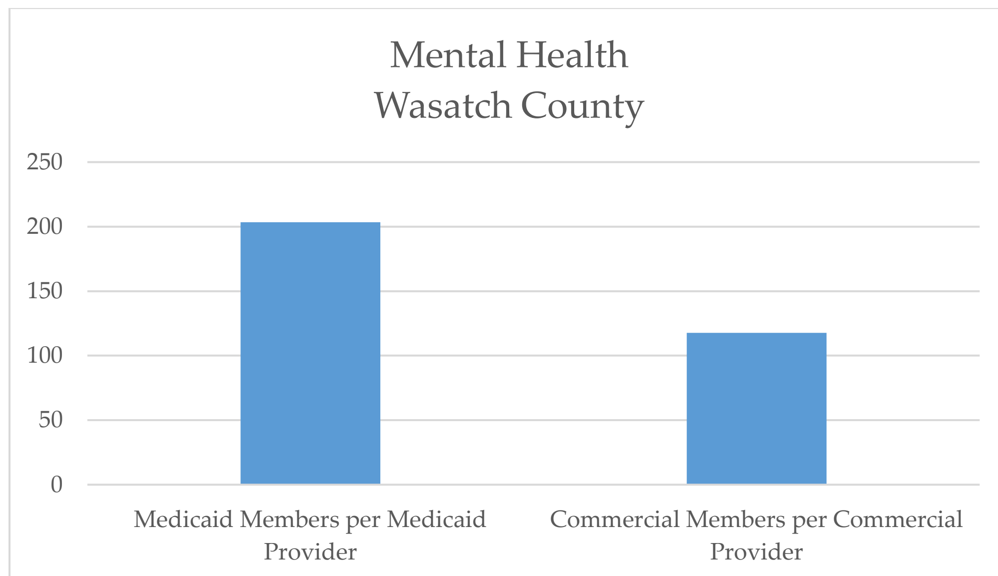

Figure 28

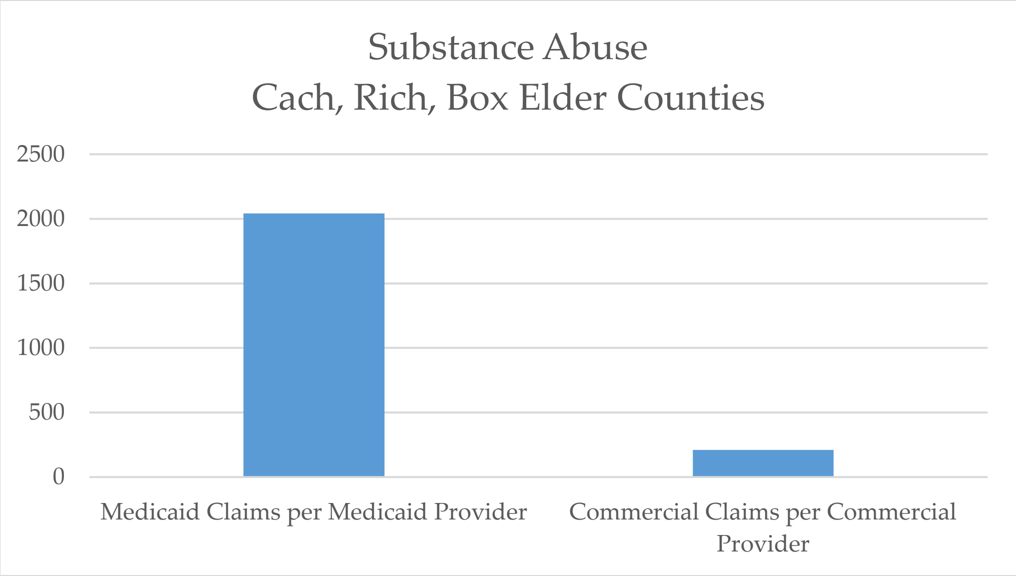

Figure 29

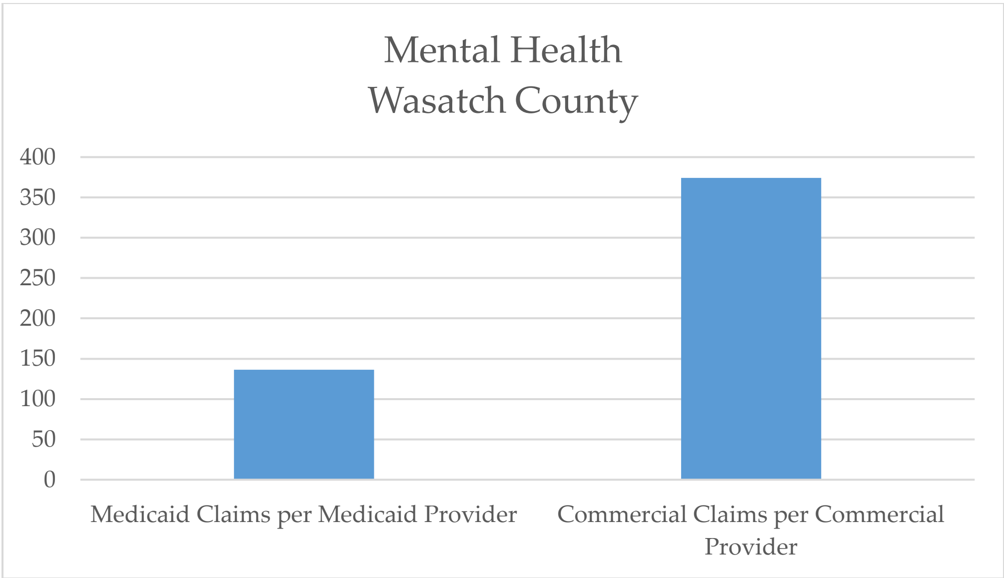

Figure 30

Table 15: Substance Abuse Cache, Rich, Box Elder Counties			
Category of Assistance	Medicaid Service Penetration Rates	Commercial Service Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	43.02%	0.40%	42%
Children	20.22%	0.40%	20%
Pregnant Women	23.01%	0.40%	23%
The Elderly (Ages 65+)	72.00%	0.40%	72%
Visually Impaired and People with Disabilities	256.03%	0.40%	255%
All	49.10%	0.40%	49%
Category of Assistance	Medicaid Provider Penetration Rates	Commercial Provider Penetration	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	0.112%	0.002%	0.110%
Children	0.050%	0.002%	0.048%
Pregnant Women	0.118%	0.002%	0.117%
The Elderly (Ages 65+)	0.225%	0.002%	0.223%
Visually Impaired and People with Disabilities	0.237%	0.002%	0.235%
All	0.026%	0.002%	0.024%

Table 16: Mental Health, Wasatch County			
Category of Assistance	Medicaid Service Penetration Rates	Commercial Service Penetration Rates	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	29%	45%	-16%
Children	32%	45%	-13%
Pregnant Women	17%	45%	-28%
The Elderly (Ages 65+)	0%	45%	-45%
Visually Impaired and People with Disabilities	21%	45%	-24%
All	33%	45%	-11%
Category of Assistance	Medicaid Provider Penetration Rates	Commercial Provider Penetration	Percentage Point Difference Medicaid-Commercial
Adults (Ages 19-64)	0.58%	0.12%	0.46%
Children	0.33%	0.12%	0.21%
Pregnant Women	0.61%	0.12%	0.49%
The Elderly (Ages 65+)	0.00%	0.12%	-0.12%
Visually Impaired and People with Disabilities	1.31%	0.12%	1.19%
All	0.25%	0.12%	0.13%

Mental Health/Substance Abuse Services Access Issues Discovered As a Result of This Review

The analysis demonstrates that Medicaid Members as a whole, are accessing substance abuse services in the three counties identified at a rate 49 percentage points higher than the commercially insured population. Staff has become aware of the service penetration rates for all Medicaid populations in Wasatch County are currently lower than the commercially insured population as a whole. Provider penetration rates for Medicaid are higher for both sets of services in the respective counties.

Through this analysis this data has identified areas for additional review. Wasatch Mental Health Center opened in the city of Heber, Utah in Wasatch County in 2013. Wasatch Mental Health provides mental health services to Medicaid FFS adults and children in Wasatch County. To analyze the impact of the Heber opening of Wasatch Mental Health on access to care, data from 2011 and 2012 was compared to the data used in this plan (2013-2014). The analysis shows a growth in Medicaid FFS providers from 2 in 2011 to 9 in 2015. The 2014-2015 data shows

Medicaid members accessing services at a rate of 52%. Wasatch Mental Health confirmed that as of September 2016 they provide evening appointments, average a week or less for an appointment, and do not cap the number of Medicaid members they accept. Further analysis will be conducted to determine if Medicaid members are seeking services in nearby counties. Wasatch County's proximity to Summit, Salt Lake, and Utah counties makes this a potential scenario. While the 2013-2014 data shows a gap in the service penetration rate, further analysis of available services demonstrates the State's compliance with the access standard in Section 1902(a)(30)(A).

Review Analysis Additional Services

In accordance with 42 CFR 447.203(b)(5)(ii)(F) and (G) if there are State Plan Amendments in the future that reduce or restructure rates in a way that requires a full access analysis[7], those services will be added to the access plan and monitored annually for 3 years. Additionally, if it is identified that the State or CMS has received a significantly higher than usual volume of member, provider, or other stakeholder access complaints for a geographic area than the identified service will be added to the access plan and monitored annually for 3 years.

[7] Exceptions to this are when Medicaid uses Medicare's rates. If Medicare were to reduce its rates, Utah would trust that access to care issues would have been resolved by CMS prior to implementation.

Feedback Chart (Appendix A)