

Utah's Access Monitoring Review Plan

2016

Key Dates

Publish for public comment	<i>7/5/2016</i>
Present draft plan to MCAC	<i>7/21/2016</i>
Public comment ends	<i>8/5/2016</i>
Submit to CMS	<i>9/30/2016</i>

Fee-For Service Population

- The Access to Care regulation only applies to a state's Fee-For-Service Population
- In SFY15, Utah's Fee-For-Service population was just above 40,000
- Managed Care currently represents 80% of the State Medicaid population and 100% of the CHIP population, all of the state's Urban counties are part of mandatory Managed Care
- There are 29 counties total in Utah, 13 counties are mandatory Managed Care Counties
- Managed Care Counties were removed from the access to care analysis.
- 95% of Medicaid recipients receive behavioral health care through a prepaid mental health plan. Therefore, this category was not analyzed for the purpose of this plan.
- The Access Monitoring Review Plan excludes waiver programs Section 1902(a)(30)(A) of the Social Security Act is the section the Access to Care Rule is based on. That section only applies to services available under the state plan not services beyond the state plan.
- Separate CMS initiatives have addressed the framework for Medicaid managed care and HCBS programs.
- The remaining 16 FFS counties are divided into two categories
 - Frontier Counties
 - Rural Counties

Data Sources

- Data for Utah's Access Monitoring Review Plan comes from multiple sources including the Medicaid data warehouse.
- Data pertaining to rate comparisons and providers was obtained from the All Payers Claims Database provided by the Utah Office of Health Statistics.
- The APCD data is collected from commercial health insurance carriers as well as Medicaid and covers approximately 90% of Utah's non-Medicare population.
- In *Gobeille v. Liberty Mutual Insurance Co.* the U.S. Supreme Court 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.
- In the event that data becomes unavailable or statistically questionable, an alternative baseline data structure and accompanying survey instrument are being considered

Data Model

- An access to care composite index was constructed to establish a baseline and to measure potential changes in access to care. Geographic regions are broken into two categories, frontier counties and rural counties.
- The index is composed of four elements which are broken down into each, geographic region and by area of service.
- Included in the equation are the respective universes for each population
- The four elements are:
 - Provider ratio (Medicaid to Commercial)
 - Utilization ratio (claims) (Medicaid to Commercial)
 - CAHPS response to the question of how often members received care as quickly as they wanted, respectively. Weighted Medicaid and weighted commercially covered child and adult percent of survey respondents who replied “usually” or “always”.
 - CAHPS response to the question of how often they received care they needed. Weighted Medicaid and weighted commercially covered child and adult percent of survey respondents who replied “usually” or “always”.
- For the baseline, each one of these components is weighted equally and the baseline is set equal to 100.
- The threshold for flagging a potential access issue occurs in the event the access index differential becomes greater than 25%.

Baseline Data Model Example

Location	Service Type	Provider Ratio (PR)	Utilization Ratio (UR)	Needed Care (NC)	Getting Care Quickly (GCQ)	Base Index
Frontier	Home Health	0.7500	0.7500	0.9900	0.9900	100.00
Rural	Home Health	0.7500	0.7500	0.9900	0.9900	100.00

- $\text{Base Index} = \text{PR}/\text{PR} \times 25 + \text{UR}/\text{UR} \times 25 + \text{NC}/\text{NC} \times 25 + \text{GCQ}/\text{GCQ} \times 25$
- The threshold, which is monitored for access issues, is then derived from the access to care index formed in the baseline data.
- The threshold for flagging a potential access to care issue occurs in the event the access index differential becomes greater than 25%.

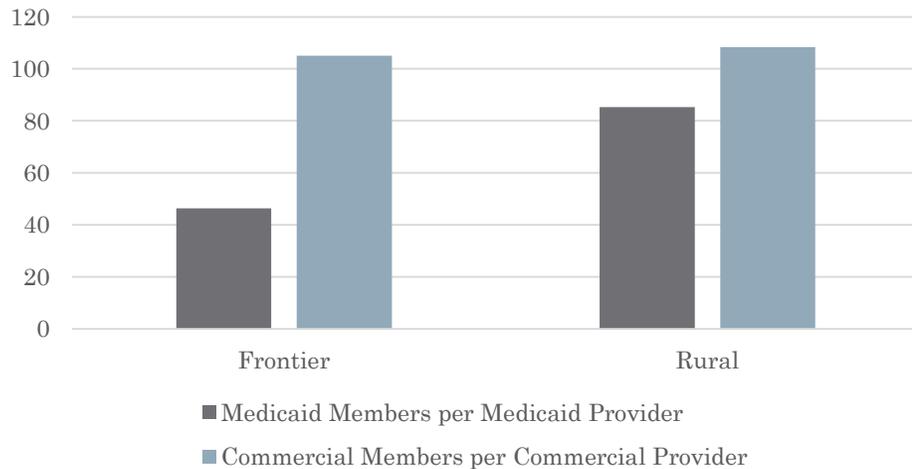
Baseline Index Raw Data 2013-2014

Table 4: Baseline Index Raw Data 2013-2014

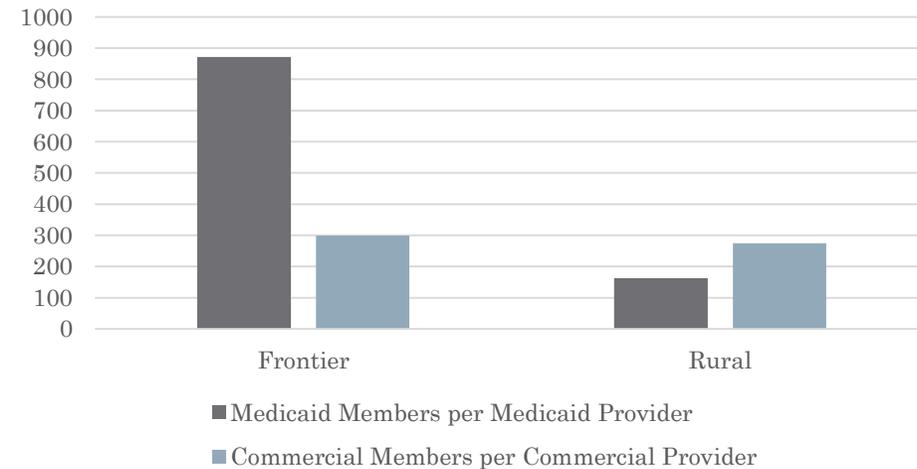
Location	Service Type	Medicaid Members per Medicaid Provider	Commercial Members per Commercial Provider	Medicaid Claims per Medicaid Provider	Commercial Claims per Commercial Provider
Frontier	Home Health	233	2268	38	25
Frontier	Obstetrics	26133	15124	0	451
Frontier	Physician Specialist	871	298	375	78
Frontier	Primary Care	46	105	258	138
Rural	Home Health	171	3843	80	16
Rural	Obstetrics	1411	3843	356	43
Rural	Physician Specialist	163	275	220	82
Rural	Primary Care	85	108	241	109

Provider Ratios

Primary Care

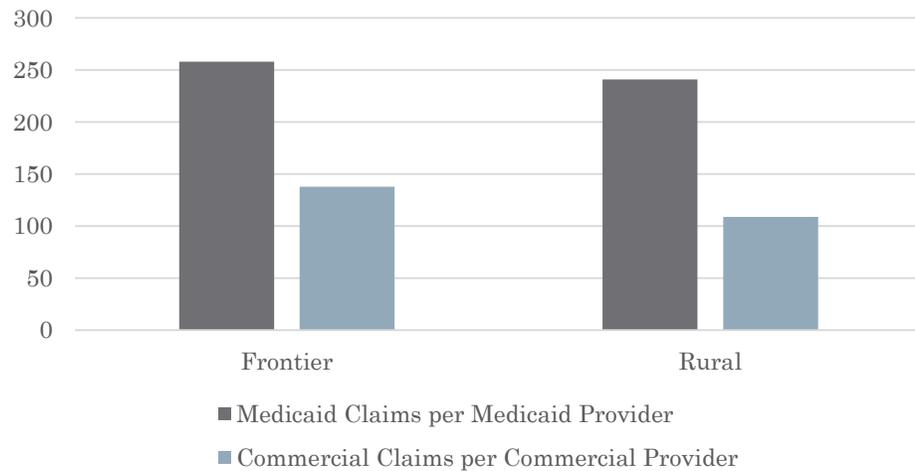


Physician Specialists

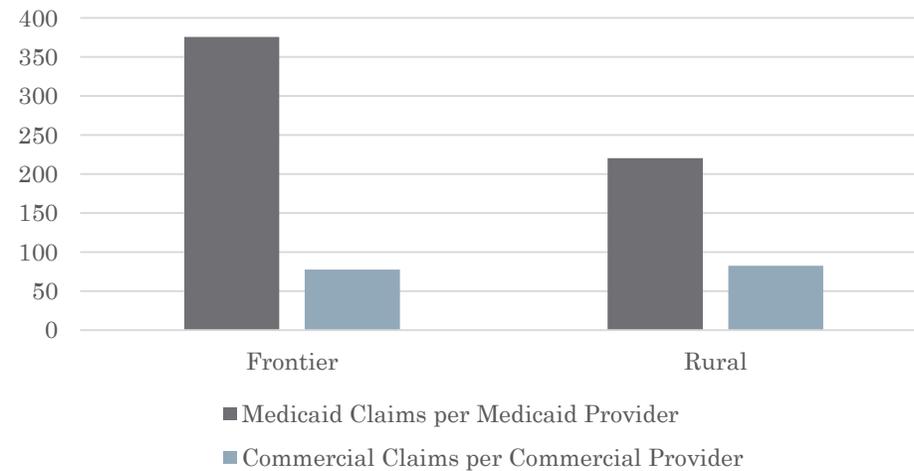


Utilization Ratios

Primary Care



Physician Specialists



Cost Comparison

Table 6: Medicaid to Commercial Cost Comparison

Service Type	Average Commercial reimbursement per claim	Average Medicaid Reimbursement per Claim	Medicaid to Average Commercial Ratio
Home Health	\$726.39	\$323.22	0.44
Obstetrics	\$312.53	\$249.40	0.80
Physician Specialist	\$158.47	\$71.55	0.45
Primary Care	\$325.29	\$166.80	0.51

Other Components Included in the AMRP

- Mechanisms for Beneficiary (Member) and Provider Feedback
- Other Department Programs That Ensure Access to Care, examples include:
 - Transportation services
 - Physician and dental rate enhancements in rural areas
 - Telehealth
 - Local health department contracts
- Resources such as FQHCs, RHCs, and Safety Net Clinics
- Description of monitoring procedures
- Data limitations