Washington State Health Care Authority

Fee for Service Access Monitoring Review Plan

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Fee for Service Access Monitoring Review Plan

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PURPOSE AND OVERVIEW

Recently the Centers for Medicare & Medicaid Services (CMS) published final rules designed to ensure that States' Fee for Service (FFS) Medicaid payments comply with the access standards in Section 1902(a)(30)(A) of the Social Security Act (SSA) (80 Fed. Reg. 67,576 (Nov. 2, 2015)). These rules added significant new procedural requirements for States.

These rules required States to develop "a medical assistance access monitoring review plan" to evaluate enrollees' access to certain Medicaid services. These access monitoring review plans, and all other requirements in the new rule, apply to FFS Medicaid rates only and they specifically excluded any managed care populations or populations covered by a federal waiver program. As specified in the rule, the first report is due to CMS by October 1, 2016. This report is based upon 2015 calendar year data and is being used to establish a baseline for future monitoring review plans which Washington will submit for ongoing regulatory compliance.

OVERVIEW OF APPLE HEALTH

In Washington State the Medicaid program is known as Apple Health (AH). It provides healthcare coverage for low-income individuals, including children, pregnant women, individuals with disabilities, the elderly, and other adults. The Washington State Health Care Authority (HCA) is the single state agency that administers the AH program within the state. In 2015, the AH Medicaid program provided coverage to approximately 1,876,642 enrolled beneficiaries. The vast majority of the Medicaid beneficiaries in Washington are enrolled in managed care, while only 4% are FFS clients. As mentioned above, the data and analysis in this report only applies to the FFS clients. One of the challenges we encountered while pulling together this report, was that data for this group alone is very limited.

Some additional information about the Apple Health program in Washington:

- Washington State has 116 hospitals representing over 13,395 available beds. These include 39 acute care hospitals and affiliated practices servicing rural communities.

- Washington also has a large network of 116 Rural Health Clinics (RHCs) and 26 FQHC organizations based in state. There are three FQHCs in Oregon and two in Idaho that are enrolled with Apple Health and bill for Washington Medicaid clients and some RHCs and FQHCs have multiple locations but are identified by a single National Provider Identifier (figure 1). For instance:
    - Sea Mar Community Clinics have over 50 locations in 12 counties in Western Washington; and
    - Yakima Valley Farm Worker's Clinics have 21 locations in Eastern Washington and an additional 8 clinics just across the border in Oregon.

- Whether a client receives services through a Managed Care Plan or FFS, or lives in an urban or rural community, there are numerous options for Medicaid beneficiaries to receive healthcare in Washington State.

- Washington measures and monitors indicators of healthcare access for AH managed care to ensure that beneficiaries have access to care that is comparable to the general population.

Figure 1 – Washington State FQHCs and RHCs by County

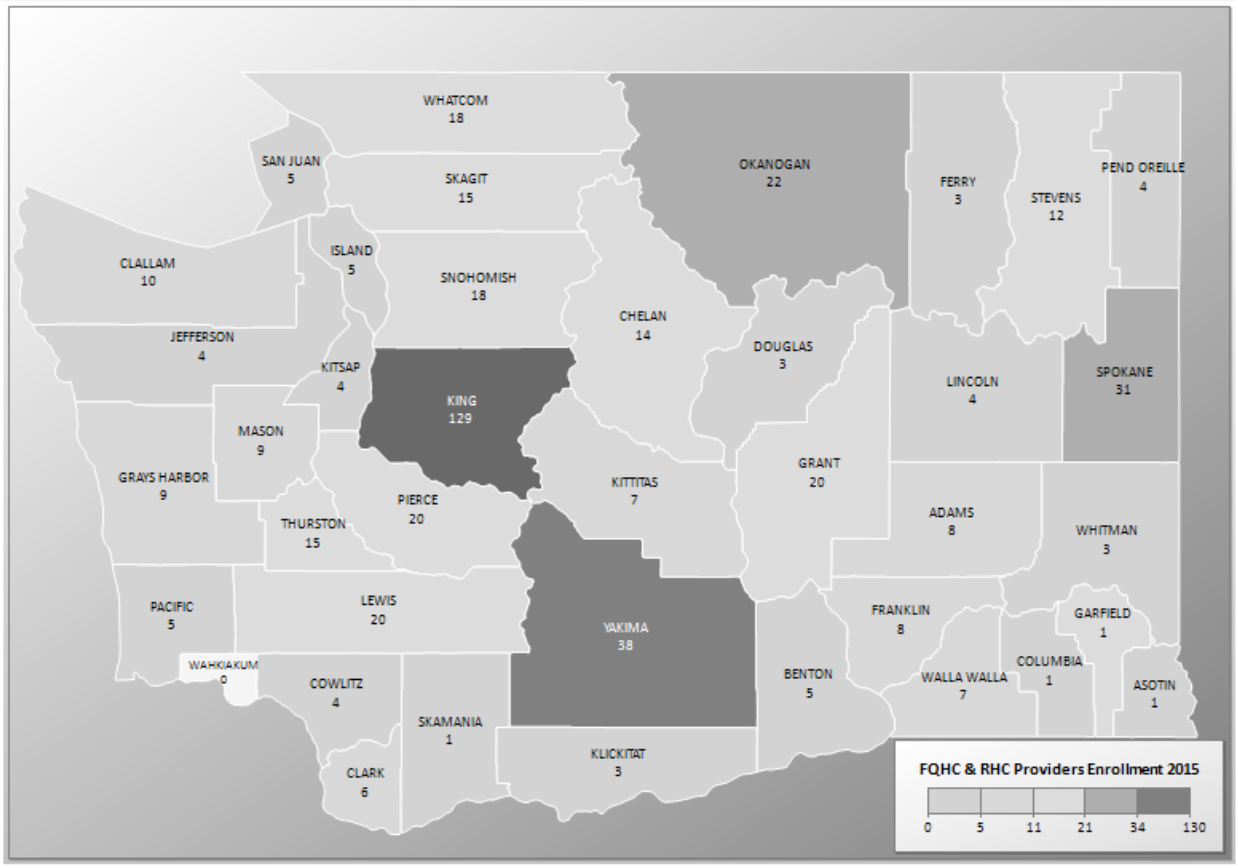


Figure 1 above shows the geographic distribution of FQHCs and RHCs across Washington State.

Overview of the Plan

- HCA worked to develop an access review monitoring plan for the following service categories provided under a FFS arrangement:
    - Primary care services
    - Physician specialist services
    - Behavioral health services
    - Pre- and post-natal obstetric services, including labor and delivery
    - Home health services

- The plan will be used to measure access to care for beneficiaries in FFS. The plan considers the availability of Medicaid providers, utilization of Medicaid services, and the extent to which Medicaid beneficiaries' healthcare needs are met.

- The plan was developed during August 2016 and is available for public inspection and feedback on the state Medicaid agency's website from September 1, 2016 – October 1, 2016.

- The plan is preliminary in nature and we anticipate developing a more robust data set over time with the assistance of an outside consultant.

Beneficiary Population

In 2015, the Apple Health (AH) program provided coverage to approximately 1,876,642 enrolled beneficiaries. Approximately 1,537,985 or 82% of these beneficiaries are enrolled in managed care as shown in Figure 2, with approximately 338,657 enrolled in FFS.

Approximately 45.06% of AH enrollees are children under 19 years of age (Figure 3) and over 53% of the enrolled population are female (Figure 4).

The 338,657 receiving care through FFS primarily include dual eligibles, American Indians and Alaska Natives (AI/AN), and individuals with third party coverage (Figure 6).

Of the total FFS population, only about 76,773 (Figure 5) or just 4% of total Medicaid enrollment (Figure 6) meet the CMS definition of FFS for the purposes of this report.

It is also important to note that changes in the composition of the FFS population have taken place since 2015; further reducing enrollment as more are moved to managed care. For instance, on April 1, 2016 earlier enrollment was implemented. Newly eligible Medicaid clients and renewing clients now choose, or are auto-assigned into a managed care organization (MCO) the day they become eligible. Their managed care enrollment is backdated to the beginning of the current month.

The intent of this change was to close the gap between eligibility and enrollment, decreasing the time on FFS, and allowing for quicker care coordination. Instead of having to wait another month or possibly two months before being enrolled, the client now can enter a plan immediately.

Additionally, as a result of Senate Bill 6312, the Health Care Authority began enrolling children and youth in foster care, into a managed health care plan, named Apple Health Core Connections, effective April 1, 2016. Moving this population to managed care provides a more collaborative approach to care, allowing for smoother health care transitions, as children and youth move from home to foster care, between placements, hospitals, or other institutional settings.

Figure 2 – AH Enrollment as of 12/2015

FEE FOR SERVICE (FFS) AND MANAGED CARE (MC)

MC VS FFS	Exemption/MC Plan	#of Clients	%
⊞ Fee For Service		338,657	18.05 %
⊞ Managed Care		1,537,985	81.95 %
Total		**1,876,642**	**100.00%**

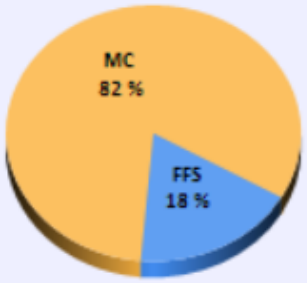


Figure 3 - AH Enrollment by Age as of 12/2015

CLIENT BY AGE

Age Group	# Clients	%
<19	845,611	45.1%
19-25	182,650	9.7%
26-34	249,536	13.3%
35-44	180,869	9.6%
45-54	164,742	8.8%
55-64	148,917	7.9%
>65	104,317	5.6%
Total	**1,876,642**	**100%**

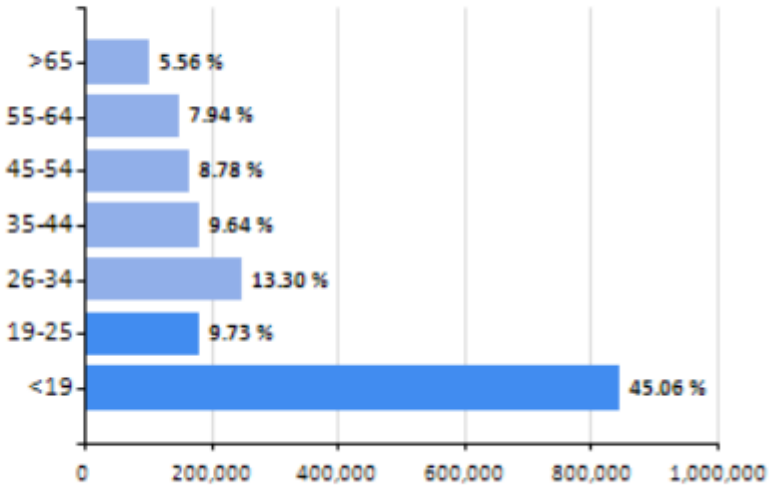
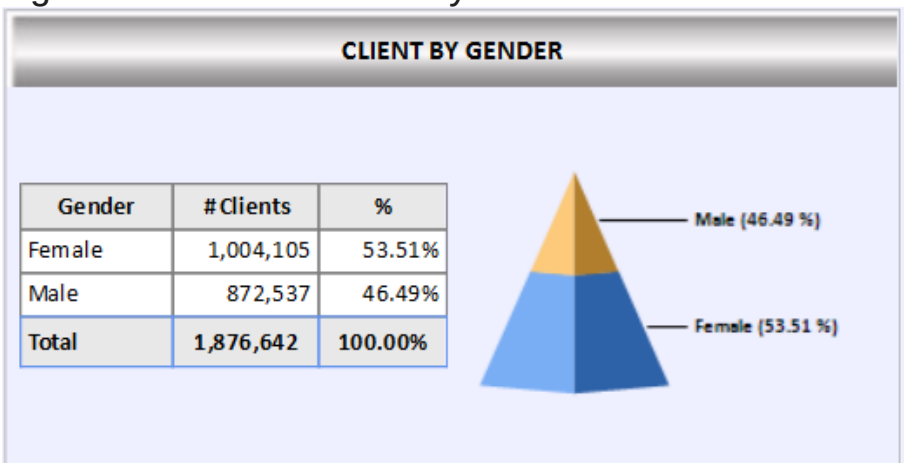


Figure 4 – AH Enrollment by Gender as of 12/2015



Gender	# Clients	%
Female	1,004,105	53.51%
Male	872,537	46.49%
Total	**1,876,642**	**100.00%**

Figure 5 – AH FFS Composition per CMS Reporting Criteria as of 12/2015

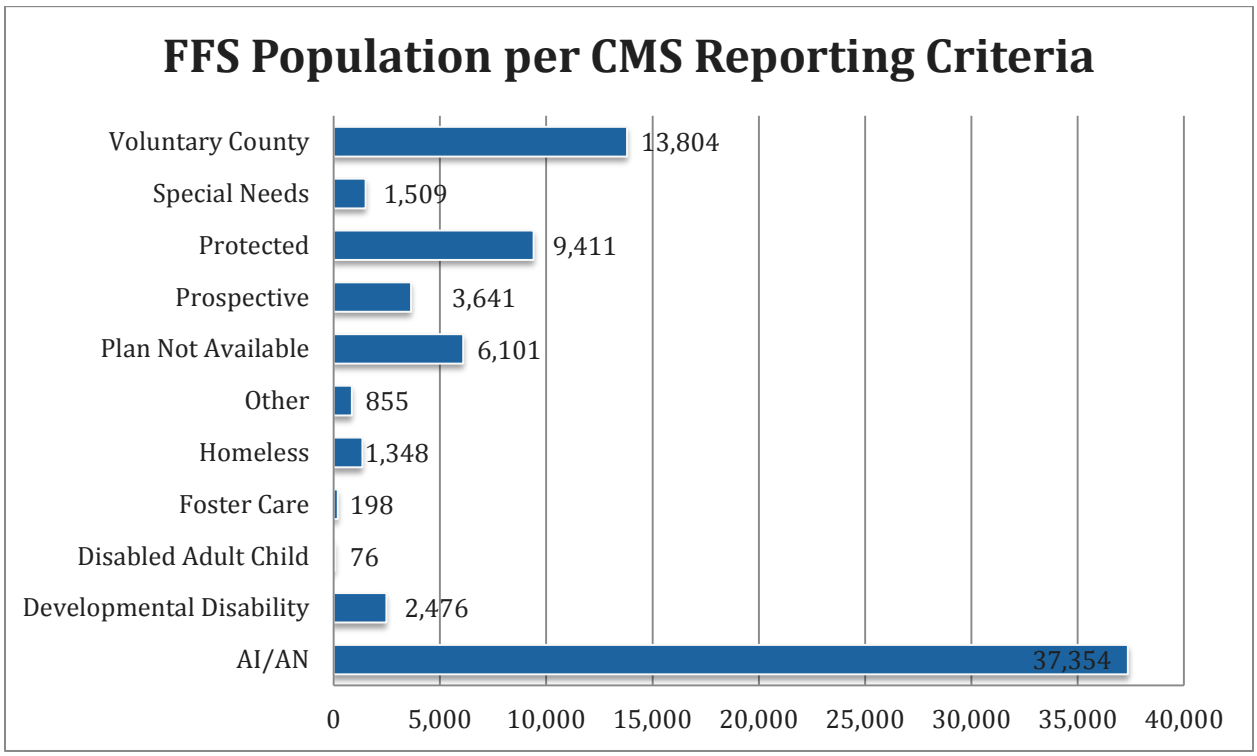
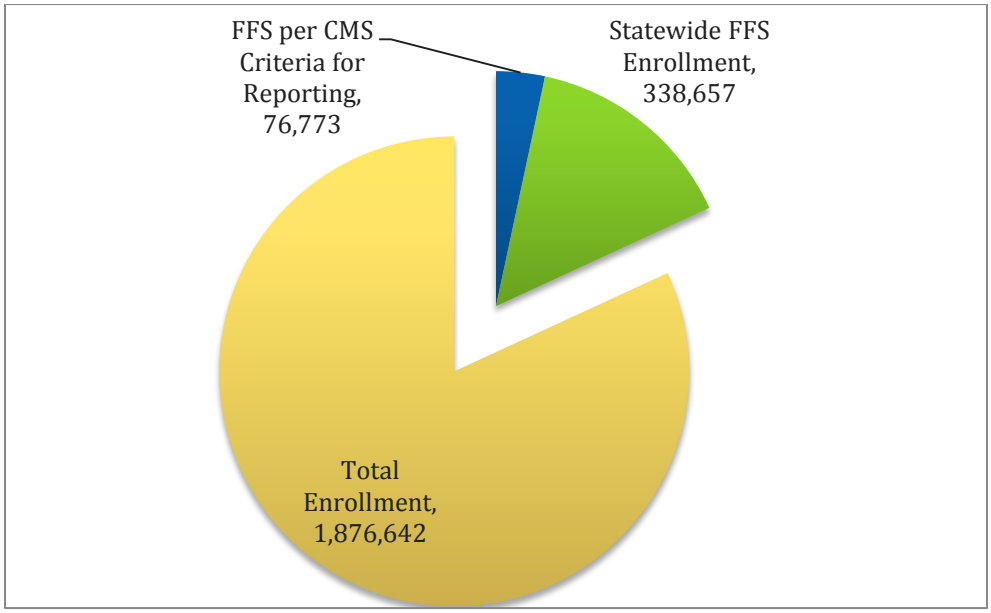


Figure 6 – AH FFS Composition & Eligibility Definitions as of 12/2015

#of clients	FFS Eligibility Group	Brief Description
37,354	AI/AN	A client who identifies as an American Indian or Alaskan Native. Identified by a client profile with a Race Code of "4" or "5".
4,202	Alien	A client who is a lawfully present immigrant who meets criteria outlined in WAC 388-424-0001 (Citizen and Alien Status). Identified in the data by a client profile with a Citizenship Status Code of "3".
2,476	Developmental Disability	A Client determined by the Developmental Disabilities Administration to have met established criteria for an intellectual disability or related condition. Identified in the data by a client profile with a Developmental Disability flag of "Y"
76	Disabled Adult Child	A client who meets Supplemental Security Income (SSI) and resource limits and is considered disabled as defined by the Social Security Administration. Identified in the data by a client profile with a Disabled Adult Child Flag of "1".
4,236	Family Planning	A client who is receiving family planning services only through the Family Planning Extension program (family planning services for women for 10 months following the end of a pregnancy) or the Take Charge program (pre-pregnancy family planning services for men and women). Identified in the data by specific RAC Codes.
123,672	Full Duals	A client who is eligible for the full scope of Medicare and Medicaid covered benefits. Identified in the data by a client profile with any one of the following Dual Indicators: 02, 04, or 08
198	Foster Care	A client with a relative care placement program code in the client profile. The code for either foster care placement, adoption support, relative placement, unaccompanied minor,
4,466	Health Home	A client receiving Categorically Needy coverage who is dually eligible with one or more chronic conditions and who agrees to participate in the Health Home Program. Identified in the data by a client profile with a Health Home indicator of "Y".
1,348	Homeless	A client who is without a home or who is in temporary housing. Identified in the data by a client profile with a Living Arrangement code of "HO" or "HH"
28,903	Undocumented	A client who is a noncitizen without a lawful immigration status as outlined in WAC 388-424-0001. Identified in the data by a client profile with a Citizenship Status Code of "4".
855	Other	Includes clients whose eligibility is ending during the month of reporting; newborns that have not yet received client ID's; Involuntary Treatment Act (ITA) clients; and pregnant clients on SSI.
59,396	Partial Duals	A client who is a Specified Low-Income Medicare Beneficiary who also is eligible for Medicaid coverage.
6,101	Plan Not Available	An exemption for a pregnant with an estimated delivery date in less than 60 days whose plan is not available in her residential zip code.
3,641	Prospective	A client enrolled in a managed care plan prospectively for the upcoming month or month after.
9,411	Protected	A client or any other client in the address confidentiality program. Identified in the data by an Address Confidentiality indicator of "y".
1,509	Special Needs	A child who has medical, developmental, or behavioral needs that require individualized care, treatment, or intervention. Identified in the data by a client profile with a Special Needs Flag of "y".
37,009	TPL-PHIPP	A client with primary insurance coverage.
13,804	Voluntary County	A client with a residential zip code in Skamania, Clallam, or Klickitat counties.

Figure 7 – AH FFS Enrollment and Total Enrollment as of 12/2015



Divisions Programs and Resources Supporting Beneficiary Access

Medical Assistance Customer Service Center (MACSC)

The Apple Health Medical Assistance Customer Service Center (MACSC) is the front-line support available to over 1.8 million clients and 40,000 providers. MACSC helps customers with a wide range of program issues, including managed care enrollment, ProviderOne client services card questions, benefit coverage, and billing/claims.

Provider Relations Unit (PRU)

The Apple Health Provider Relations Unit (PRU) provides information, training, and consultation to providers to help them more efficiently deliver services and support to Apple Health clients.

Medical Eligibility Determination Section (MEDS)

The Apple Health Medical Eligibility Determination Services (MEDS) offers eligibility support for programs covering a wide range of Apple Health clients, including children, pregnant women, families, and adults.

Community-based Eligibility Specialists

HCA has eligibility specialists located in each county across the state to help applicants, enrollees, and community partners answer questions related to eligibility rules for Apple Health programs.

Interpreter Services

HCA provides spoken and sign language Interpreter Services to HCA-contracted health care providers. This program assists health care providers to meet their federal requirement to offer and provide interpreter services to individuals with limited English proficiency (LEP) or who are deaf, deaf-blind, or hard of hearing.

Transportation Services (non-emergency)

HCA covers non-emergency medical transportation for eligible clients to and from covered services through contracted brokers. Brokers arrange and pay for trips for qualifying beneficiaries who have no other means to access medical care.

Telemedicine

Washington has reimbursed FFS providers for telemedicine services since 2014 for FFS clients. The telemedicine program assists in addressing health care access issues, and is used to substitute for a face-to-face, "hands on" encounter for the following services:

- Consultations
- Office or other outpatient visits
- Psychiatric intake and assessment
- Individual psychotherapy
- Visit for drug monitoring

Statewide 2-1-1 Program

On April 15, 2003, the Washington state legislature passed ESHB 1787 in support of the creation of a 2-1-1 system statewide. This system provides an easy to remember phone number for people to call for health and human service information and referrals by utilizing a statewide database of community resources.

J-1 Visa Waiver Program

The J-1 Physician Visa Waiver program is administered by the Washington State Department of Health, and supports efforts to increase the number of physicians in rural and underserved areas of the state. Washington State will sponsor up to 30 waivers per federal fiscal year, with a minimum of 20 waivers granted to primary care physicians and up to 10 waivers granted to specialists with practices located in designated Health Professional Shortage areas.

Access Concerns Raised by Beneficiaries

The Health Care Authority operates a beneficiary call center as a service to beneficiaries and as a way to engage beneficiaries and assist them with their needs. Each beneficiary's Medicaid card includes the toll-free number for the call center along with information about how to seek assistance if they have difficulty finding a provider or scheduling an appointment. The call center operates daily from 7am – 5pm and utilizes an email box https://fortress.wa.gov/hca/p1contactus/ as well as an updated website at www.hca.wa.gov that is available to clients 24/7.

At this time, call center staff can log the number of callers who need assistance with "finding a provider." However, the system does not currently track whether the caller is FFS or managed care. We will be working to establish a more robust set of metrics in the future and hope that by the end of 2016 we will be able to add additional elements to our tracking.

Provider Enrollment Data

HCA tracks provider enrollment volume, location, and provider type. Figure 7 details the number of provider enrollments approved for Calendar Year (CY) 2015.

Figure 8 - Provider Enrollment Statistics CY 2013 - 2015

Enrollment Status	CY 2013	CY 2014	CY 2015
Enrollments Received	9991	7284	7968
Returned to Provider for Missing information	316	359	463
Enrollments Rejected	26	29	16
Percentage of Applications Processed in 30 days	92%	76%	87%

Figure 8 shows the number of active providers in each of the categories of services for CY 2015. The provider count is by taxonomy and unique National Provider Identifier (NPI) as shown in figure 9; however, providers may be listed under more than one taxonomy. In order to avoid duplication, the following methodology was used:

1. If a provider record had the home health agency taxonomy, then they were considered a "Home Health Agency", regardless of another taxonomy;
2. If a provider did not have a home health agency taxonomy, and they had at least one taxonomy in the "behavioral health" category, then we classified the provider as "Behavioral Health";
3. If a provider did not have the home health agency taxonomy or behavioral health taxonomy, but they had a primary care taxonomy, then we classified the provider as "Primary Care"; and
4. If a provider with physician specialist taxonomy did not have a primary care, behavioral health, or home health agency taxonomy, then we classified the provider as a "Physician Specialist".

Figure 9 - Number of Enrolled Providers by Category CY 2015

Provider Type	Summary
Primary Care	23,225
Physician Specialist	10,990
Behavioral Health	7,417
Home Health Agency	76
Dental	3,847
Total	**41,708**

Figure 10 - Related Specialties for Categories of Practitioners

Provider Category	Included Specialty Codes
Primary Care	(provider type 20) 7Q – Family Practice, 7V – Obstetrics & Gynecology, 80 – Pediatrics, 8D – General Practice, 7R – Internal Medicine; and ARNP's - 363L00000X, PA's - 363A00000X, Naturopath s- 175F00000X
Physician Specialists	(provider type 20) 4E – Oral & Maxillofacial Surgery, 7K – Allergy & Immunology, 7L – Anesthesiology, 7P – Emergency Medicine, 7T – Neurological Surgery, 7U – Nuclear Medicine, 7W – Ophthalmology, 7X – Orthopedic Surgery, 7Y – Otolaryngology, 7Z – Pathology, 81 – Physical Medicine & Rehabilitation, 82 – Plastic Surgery, 83 – Preventive Medicine, 85 – Radiology, 86 – Surgery, 88 – Urology, 8C – Colon & Rectal Surgery, 8G – Thoracic Surgery (Cardiothoracic Vascular)
Behavioral health	Psychiatrist - provider type 20, specialty 84 – Psychiatry & Neurology, Psychiatric ARNP 363LP0808X, 104100000X – Social Worker, 101YM0800X – Mental Health Counselor, 1041C0700X – Social Worker Clinical, 106H00000X – Marriage & Family Therapist, Psychologist – provider type 10, specialty 3T
Home Health	Home Health Agency: 251E00000

Comparison of Medicaid Payment Rates to Medicare

We currently do not have the ability to compare our rates to rates in the private sector unilaterally. We have included some rates where available from other states. In addition, rates for some services are too complex to display as the rate may vary depending upon the service facility, who provided the service, or the length of the service. HCA plans to use this initial data as a baseline to the development of a more robust data set in the future.

The data in Figure 11 is a sampling of Primary Care Services by CPT code for the most recent period (2015). The facility rate was used if different rates exist for facility versus non-facility services. [1]

Figure 11 – Primary Care Services Sampling of Medicaid FFS Rates, Private Plan Rates, and Medicare Rates

Procedure Code	Brief Descriptor	WA Medicaid	CA Medicaid	ID Medicaid	OR Medicaid	Regence	Medicare
99201	Level 1 New Patient	$20.52	$22.90	$34.15	$18.66	$37.50	$26.32
99202	Level 2 New Patient	$39.30	$34.30	$59.02	$35.13	$70.50	$49.57
99203	Level 3 New Patient	$59.81	$57.20	$86.54	$53.78	$108.50	$75.47
99204	Level 4 New Patient	$102.29	$68.90	$133.19	$91.20	$183.50	$128.28
99205	Level 5 New Patient	$132.05	$82.70	$167.67	$118.51	$238.50	$166.64
99211	Level 1 Existing Patient	$7.22	$12.00	$18.25	$6.50	$13.00	$9.19
99212	Level 2 Existing Patient	$19.65	$18.10	$35.18	$17.92	$36.00	$25.23
99213	Level 3 Existing Patient	$40.17	$24.00	$57.45	$35.72	$71.50	$50.47
99214	Level 4 Existing Patient	$61.55	$37.50	$86.45	$55.16	$110.50	$77.86
99215	Level 5 Existing Patient	$86.69	$57.20	$117.01	$78.24	$157.00	$110.28

[1] Facility Rate used if different rates for Facility vs. Non-Facility, Paid claims for client population when the line From Date of Services is within CY 2015, state only codes were excluded, when rates differ, rates for children were used, WA rates from Jan 2015, if not started Jan 2015 then those in effect at that time, CA rates only available for dates as of 08/15/2016, when different Primary Care and Child rates are used

The data in Figure 12 is a sampling of Primary Care Services by CPT code for the most recent period (2015). [2]

Figure 12 – Physician Specialist Services Sampling of Medicaid FFS Rates and Medicare Rates

Procedure Code	Brief Descriptor	WA Medicaid	CA Medicaid	ID Medicaid	OR Medicaid	Regence	Medicare
99284	Emergency Dept Visit	$68.99	$68.35	$101.61	$82.71	$166.50	$115.42
99285	Emergency Dept Visit	$101.59	$108.08	$149.67	$122.29	$246.50	$170.39
99283	Emergency Dept Visit	$36.18	$44.60	$53.37	$82.71	$87.50	$60.78
71010	Chest X-Ray, 1 View	$14.51	$17.30	$19.74	$15.62	$28.35	$22.49
71020	Chest X-Ray, 2 View	$18.93	$25.98	$25.65	$19.37	$39.00	$27.94
70450	CT Scan Head/Brain	$76.14	$165.86	$103.12	$80.88	$162.50	$117.11
93010	Electrocardiogram Report	$5.05	$12.30	$7.39	$6.00	$12.00	$8.47
74177	CT Scan Abdmn/Pelvis	$200.23	$311.37	$268.93	$217.30	$437.00	$315.46
88305	Tissue Exam	$42.91	$46.34	$59.20	$50.99	$102.00	$73.61
74000	Abdomen X-Ray	$15.14	$17.30	$20.61	$16.36	$33.00	$23.59
G0431	Drug Screen Multi Class	$79.56	$46.65	$89.28	$69.27	N/A	N/A
76705	Echo Exam Abdomen	$67.31	$60.74	$90.23	$64.40	$129.50	$93.37
92015	Refractive State Test	$11.78	$8.01	$17.80	$13.77	$19.94	N/A

2 Facility Rate used if different rates for Facility vs. Non-Facility, Paid claims for client population when the line From Date of Services is within calendar year 2015, state only codes were excluded, when rates differ, rates for children were used, WA rates from Jan 2015, if not started Jan 2015 then those in effect at that time, CA rates only available for dates as of 08/15/2016, when different Primary Care and Child rates are used, For Radiology and Laboratory Services, global rate used

The data in Figure 13 is a sampling of Behavioral Health Services by CPT code for the most recent period (2015). [3]

Figure 13 – Behavioral Health Services Sampling of Medicaid FFS Rates and Medicare Rates

Procedure Code	Brief Descriptor	WA Medicaid	CA Medicaid	ID Medicaid	OR Medicaid	Regence	Medicare
H0020	Alcohol/Drug Services	$12.79	N/A	N/A	$4.54	N/A	N/A
99232	Subsequent Hospital Care	$42.91	$37.80	$62.14	$50.94	$64.26	$71.91
99233	Subsequent Hospital Care	$61.63	$45.80	$89.56	$73.34	$92.61	$103.43
99231	Subsequent Hospital Care	$23.35	$27.50	$33.78	$27.46	$34.65	$38.74
96153	Health/Behavior Intervention	$2.73	$5.81	$3.98	$4.03	$3.78	$4.13
96101	Psychological Testing	$47.32	$41.79	$70.76	$91.19	$69.93	$78.80
99239	Hospital Discharge	$63.73	$53.40	$91.83	$75.64	$95.45	$107.16
99223	Initial Hospital Care	$115.47	$80.10	$174.53	$142.73	$180.50	$201.09
90837	Psychotherapy, Family	$67.77	$51.00	$112.56	$144.11	$82.49	$125.56
96150	Health/Behavior Assessment	$12.62	$18.03	$18.90	$18.55	$18.90	$21.23
90834	Psychotherapy, Family	$45.43	$67.16	$75.16	$98.11	$74.03	$83.47
90832	Psychotherapy, Family	$34.07	$52.87	$56.66	$66.53	$55.76	$62.78
90853	Psychotherapy, Group	$13.63	$14.48	$23.02	$35.13	$22.37	$25.19
99238	Hospital Discharge	$43.12	$37.60	$62.16	$51.36	$64.89	$72.70
90791	Psychiatric Dx Eval	$68.90	$128.08	$116.89	$95.43	$112.14	$126.28
90792	Psychiatric Dx Eval	$82.66	$103.25	$126.11	$140.94	$126.00	$141.42

3 Facility Rate used if different rates for Facility vs. Non-Facility, Paid claims for client population when the line From Date of Services is within calendar year 2015, state only codes were excluded, when rates differ, rates for children were used, WA rates from Jan 2015, if not started Jan 2015 then those in effect at that time, CA rates only available for dates as of 08/15/2016, when different Primary Care and Child rates are used, For BH procedures, used MH rates if available, otherwise physician

The data in Figure 14 is a sampling of Home Health Services by CPT code for the most recent period (2015). [4]

Figure 14 – Home Health Services Sampling of Medicaid FFS Rates and Medicare Rates

Procedure Code	Brief Descriptor	WA Medicaid	CA Medicaid	ID Medicaid	OR Medicaid	Regence	Medicare
G0154	Home Health Services	$88.66	$7.36	$102.92	N/A	N/A	N/A
G0151	Home Health Services	$20.61	N/A	$123.22	N/A	N/A	N/A
T1000	Private Duty Nursing, RN	$8.83	N/A	N/A	$7.00	N/A	N/A
90847	Psychotherapy, Family	$62.89	$51.00	$94.06	$115.49	$126.23	$105.23
G0152	Home Health Services	$22.24	N/A	$101.17	N/A	N/A	N/A
G0157	Home Health Services	$20.61	N/A	$123.22	N/A	N/A	N/A
Q5001	Home Health Services	$20.61	N/A	$123.22	N/A	N/A	N/A
G0163	Home Health Services	$88.66	N/A	$102.92	N/A	N/A	N/A
90785	Interactive Complexity	$8.41	$3.88	$12.56	$10.00	$17.00	$14.22
G0156	Home Health Services	$44.15	$4.73	$40.00	N/A	N/A	N/A

4 Facility Rate used if different rates for Facility vs. Non-Facility, Paid claims for client population when the line From Date of Services is within calendar year 2015, state only codes were excluded, when rates differ, rates for children were used, WA rates from Jan 2015, if not started Jan 2015 then those in effect at that time, CA rates only available for dates as of 08/15/2016, when different Primary Care and Child rates are used, WA pays Home Health claims using Revenue codes, rates listed are, G0151/G0157/Q5001 using 0421, G0152 using 0431, G0154/G0163 using 0551 and G0156 using 0571, WA Home Health Revenue pricing is by client county of residence, an average of all county rates was used above.

The data in Figure 15 is a sampling of Pre/Post Natal Obstetric Services by CPT code for the most recent period (2015). [5]

Figure 15 – Pre/Post Natal Obstetric Services Medicaid FFS Rates and Medicare Rates

Procedure Code	Brief Descriptor	WA Medicaid	CA Medicaid	ID Medicaid	OR Medicaid	Regence	Medicare
59400	Obstetrical care	$2,101.29	$1,390.14	$1,774.87	$2,352.99	$3,031.00	$2,033.55
59409	Obstetrical care	$817.01	$544.28	$698.56	$919.21	$1,187.50	$787.65
59410	Obstetrical care	$1,041.82	$1,390.97	$889.46	$1,172.88	$1,515.00	$1,005.96
59514	Cesarean delivery only	$769.22	$544.72	$784.70	$1,032.06	$133.50	$883.87
59515	Cesarean delivery	$1,041.82	N/A	$1,075.29	$1,418.09	N/A	$1,216.48

5 Facility Rate used if different rates for Facility vs. Non-Facility, Paid claims for client population when the line From Date of Services is within calendar year 2015, state only codes were excluded, when rates differ, rates for children were used, WA rates from Jan 2015, if not started Jan 2015 then those in effect at that time, CA rates only available for dates as of 08/15/2016, when different Primary Care and Child rates are used, for Radiology and Laboratory Services, global rate used.

Analysis of Dental Services

Washington covers dental and dental-related services for eligible children, age 20 and younger and currently covers some dental and dental-related services for adults. These services are paid via FFS; however, data includes the entire statewide Medicaid population eligible for services.

In fiscal year 2015, dental expenditures totaled $347,717,079 for both children and adults (Figure 16) with approximately 67% of this amount spent on children ages 20 and under. Over time expenditures on dental services have steadily increased as shown in Figure 17. The data in figure 18 shows the utilization of dental care services by county for children statewide.

Figure 16 – Apple Health Dental Services Expenditures FY 2015

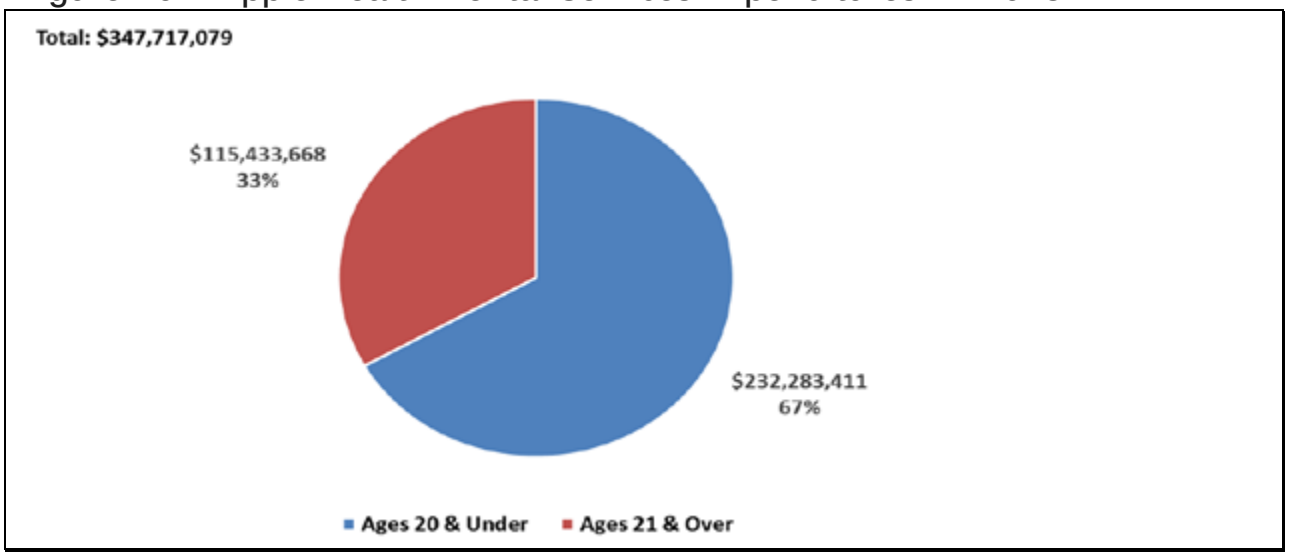


Figure 17 – Historical Apple Health Dental Services Expenditures

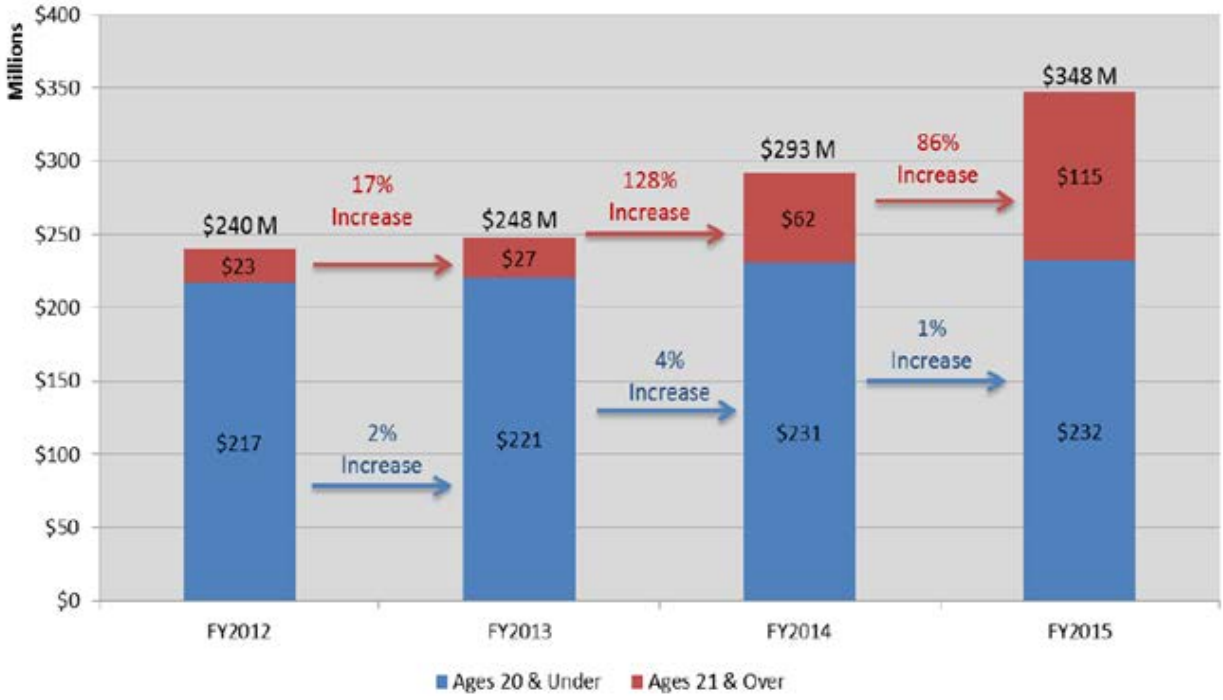
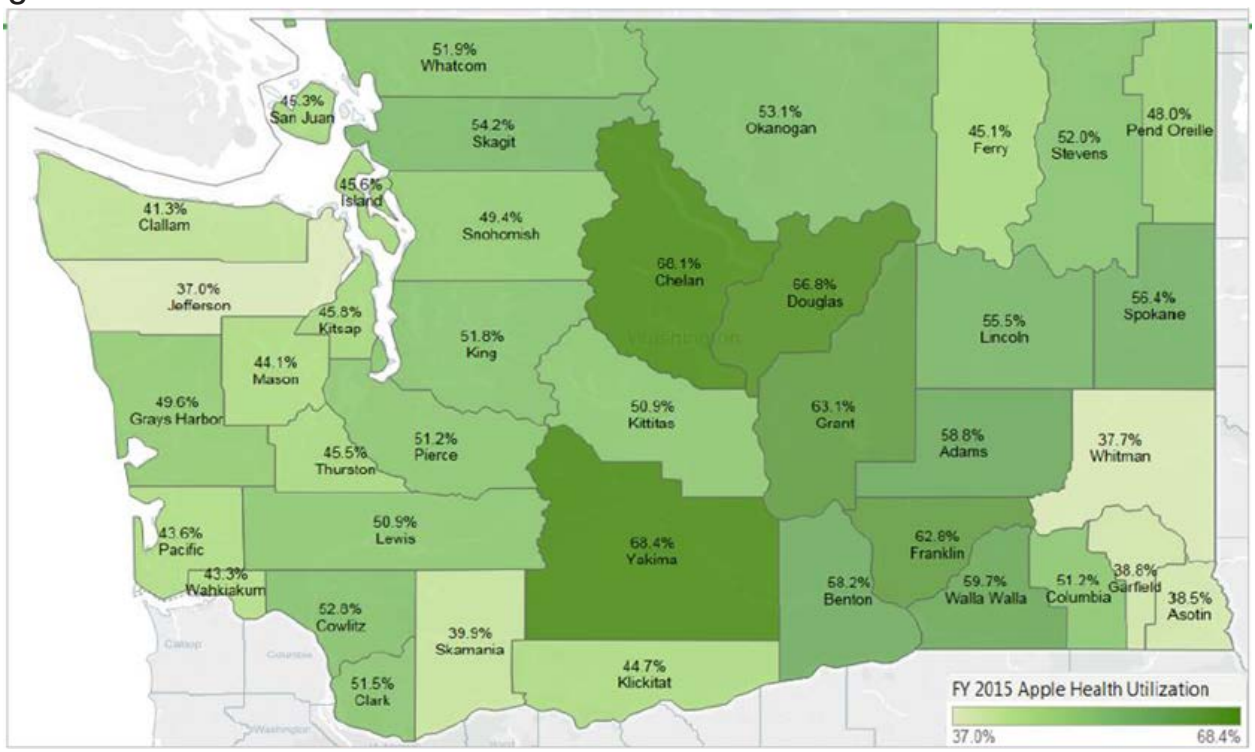


Figure 18 – FY 2015 Apple Health Dental Utilization by County Children Ages 20 and Under



The data in Figure 19 is a sampling of Home Health Services by CPT code for the most recent period (2015). [6]

Figure 19– Dental Services Sampling of Medicaid FFS Rates and Medicare Rates

Procedure Code	Brief Descriptor	WA Medicaid	CA Medicaid	ID Medicaid	OR Medicaid	Regence	Medicare
D0120	Periodic Oral Evaluation	$21.73	N/A	N/A	$23.66	N/A	N/A
D1120	Dental Prophylaxis, child	$22.98	N/A	N/A	$28.59	N/A	N/A
D0230	Intraoral Periapical, addl	$2.37	N/A	N/A	$5.45	N/A	N/A
D0220	Intraoral Periapical, first	$7.92	N/A	N/A	$9.44	N/A	N/A
D1208	Topical Fouride Varnish	$13.25	N/A	N/A	$12.97	N/A	N/A
D1351	Dental Sealant, per tooth	$21.98	N/A	N/A	$19.31	N/A	N/A
D1206	Topical Fouride Varnish	$13.25	N/A	N/A	$12.97	N/A	N/A
D0272	Dental Bitewings, 2 films	$10.29	N/A	N/A	$10.92	N/A	N/A
D2392	Resin Based Comp, 2 sur	$61.97	N/A	N/A	$46.60	N/A	N/A
D0140	Limit Oral Eval	$19.79	N/A	N/A	$31.54	N/A	N/A
D0150	Comprehensive Oral Eval	$33.64	N/A	N/A	$36.81	N/A	N/A
D2391	Resin Based Comp, 1 sur	$49.97	N/A	N/A	$37.05	N/A	N/A

6 Facility Rate used if different rates for Facility vs. Non-Facility, Paid claims for client population when the line From Date of Services is within calendar year 2015, state only codes were excluded, when rates differ, rates for children were used, WA rates from Jan 2015, if not started Jan 2015 then those in effect at that time, CA rates only available for dates as of 08/15/2016, when different Primary Care and Child rates are used, for Radiology and Laboratory Services, global rate used

Summary of Findings

The FFS population targeted in this report represents approximately 4% of the overall Medicaid population in Washington. Teasing out data specific to this population in the formats specified by CMS is challenging; however, we have attempted to provide a sampling that complies with the spirit of the regulation. Initial comments received during the public comment period indicated a need to include dental data and more robust comparative data. Based on these comments, which are attached to this report, HCA has added a dental section and additional rate information where available from neighboring states, Regence, and Medicare.

Next Steps

The Washington Health Care Authority is committed to ensuring access to care for the Medicaid program and as such we have incorporated it as one of our agency key goals incorporated on the agency strategic plan. This data is essential to achieving the overarching goal of a Healthier Washington and the Triple Aim: better health, better care and lower costs. Currently, as part of a larger Healthier Washington project, the agency has launched and new initiative- Analytics, Interoperability and Measurement (AIM).

The AIM initiative seeks to:

- Develop business intelligence and shared analytics (BI/SA) tools for analysis of health data—beginning with Medicaid claims data, Behavioral Risk Factor Surveillance System data, and Department of Health Immunization Information System data;
- Build capacity to support the BI/SA tools, including data infrastructure, personnel, processes, and procedures.

As the AIM initiative evolves, we will leverage this work to provide more in depth reporting in future years. We will actively engage our partners through our Accountable Communities of Health, and Tribes and others to identify community needs; plan for smart data driven responses; and evaluate results.

We are committed to enhancing our analytical aptitude and further developing our data management systems in order to further support meaningful policy discussions surrounding Washington Apple Health. As we build capacity and further refine our data, we will incorporate updates into future versions of this plan. In addition, in compliance with 42 CFR 447.203, we will submit to CMS an updated version of the Access Monitoring Review Plan every three years.

Tribal collaboration:

On September 30, 2016, we received letters from (a) the American Indian Health Commission for Washington State and the Northwest Portland Area Indian Health Board, (b) the Port Gamble S'Klallam Tribe, and (c) the Lummi Nation (attached hereto). While the deadline for submission of this report precluded us from addressing the concerns raised in these letters prior to submission, we will work the tribal governments and Indian health care providers in the next few months to schedule one or more workgroups and a consultation to develop a plan going forward. The

Washington Health Care Authority is committed to collaborating with the tribes and Indian health care providers – up to and including tribal consultation and government-to-government engagement – in the development of our data management systems as part of the AIM initiative and in identifying opportunities to improve the Medicaid Fee-for-Service program for American Indians/Alaska Natives and their tribal governments and Indian health care providers.

American Indian Health Commission for Washington State

Northwest Portland Area Indian Health Board

September 30, 2016

Preston W. Cody, Division Director
Medicaid Program Operations and Integrity
Health Care Authority

SUBJECT: Solicitation of Comments on Medicaid Fee-for-Service Access Monitoring Review Plan.

Dear Mr. Cody:

The American Indian Health Commission for Washington State (AIHC) and the Northwest Portland Area Indian Health Board, serving as an advocate for twenty-nine tribes and two urban Indian health organizations in Washington, is providing comments in response to the Health Care Authority's (HCA) draft "Fee for Service Access Monitoring Review Plan," dated September 1, 2016. The purpose of this letter is to (1) identify information and analysis lacking within the plan regarding American Indian/Alaska Natives; (2) identify the need to preserve and enhance the Fee-for-Service (FFS) system; and (3) provide important recommendations to improve the plan and its implementation in the coming year.

1. Insufficient Data and Analysis Addressing the American Indian/Alaska Native Population

42 C.F.R. §447.203(b)(1) requires the State to provide an access monitoring analysis that includes various data sources that "analyze and inform determinations of the sufficiency of access to care." The plan does not adequately address access issues of AI/AN beneficiaries who comprise 93% of the FFS population in Washington state per CMS reporting criteria. Many of the data sets used by the State for policy and program planning lack complete or accurate information on AI/AN. In many of these available data sources, race coding has only allowed for choice of one race. This categorization often results in misclassification of mixed race AI/AN, and most often produces inaccurately low numbers. Also, the plan does not address recent significant developments in the FFS system including the end of auto-enrollment into managed care for Medicaid mental health services for AI/ANs by July 2017. In addition, the plan must include "an analysis of the percentage comparison of Medicaid payment rates to other public (including, as practical, Medicaid manage care rates)..." 42 C.F.R. §447.203(b)(3). The State's plan lacks any meaningful payment rate comparisons (FFS to Managed Care) in order to assess AI/AN (or all populations) access to care.

2. Preservation and Enhancement of the Fee-for-Service System

The State must take steps to ensure that the ongoing expansion of managed care within the Medicaid system will not adversely impact the fee-for-service (FFS) system accessed by AI/AN. The preservation and enhancement of the FFS for AI/AN remains crucial. As we have seen with the Regional Support Networks

(RSN), expansion of managed care has caused further degradation of the FFS reimbursement system that the Indian health care delivery system utilizes. Value based payments for providers contracted with managed care entities will further degrade the FFS specialty network in the coming years. The State currently has no process or plan to implement value-based payment to non-Indian Health Care FFS providers.

Managed care entities have often been a hindrance for AI/AN to access the care they need. Some of the issues have been assignment to the wrong plan and provider, plan requests to see an unknown provider before being able to access needed specialty care, lack of reimbursement for provided care, unwillingness to contract with Indian health care providers, and geographical boundaries to managed care networks that are not conducive to AI/AN health needs for both primary and specialty care services. Because the Medicaid managed care entities can pay more to specialty providers than the FFS system, the FFS specialty network is not adequate. When referred outside the Indian health care system, Medicaid eligible AI/AN travel further and wait longer for specialty appointments than other AI/AN and non-Native Medicaid clients. The transition to managed care has also resulted in decreased staff and administrative resources for the FFS system and has created difficulty for Indian health care providers accessing care for their patients while increasing the administrative burden to the I/T/U to handle FFS encounters. While these issues may also occur in the general population, they are amplified in the complex and heavily regulated Indian health delivery system. Also, the impacts of delays in access to care are more profound in the AI/AN population which has the largest health disparities of any other population in Washington state. For these reasons, the State and tribes must continue their collaborative efforts to maintain the FFS system.

3. <u>Recommendations</u>

The AIHC and NPAIHB have the following recommendations:

1. schedule a consultation under the HCA Consultation Policy on the Medicaid Fee-for-Service Access Monitoring Review Plan;
2. initiate Tribal-State collaboration to develop a plan for resolving ongoing data quality deficiencies and improving access to quality AI/AN data (through a workgroup);
3. provide support and funding for Tribes to strengthen their capacity to collect, manage, analyze, report and share their data;
4. include Tribal and urban Indian program and Epidemiology representation on efforts to analyze and report AI/AN data- these effort directly influence policy and program design;
5. provide meaningful Medicaid FFS rate comparisons to managed care rates;
6. implement FFS fee schedule rates that are competitive to the rates paid by Medicaid Managed Care Plans;
7. utilize Administrative Services Organization (ASO) to help with contracting for Tribal FFS;
8. allocate savings achieved by value-based payments to raise the FFS fee schedule rates;
9. allocate reimbursement by the federal government for 100% FMAP payments exclusively into the FFS system for Tribes. Those savings should be used to pay for services and/or benefits as directed by the Tribes and fund the ASO;

10. utilize current Purchased and Referred Care (PRC formerly CHS) provider contracts asking those providers to accept Tribal FFS with care coordination plans; and
11. utilize the state savings on 100% FMAP to help fund ASO

As the State has moved to using Medicaid managed care entities to provide benefits to Washington State Medicaid recipients, the FFS provider network has nearly disappeared. This transition is resulting in significant changes to the delivery of Medicaid services for AI/AN. When such drastic changes to the Medicaid system occur, they severely impact tribal clinics and tribal community members. It seems by being asked to simply provide comments on an already developed plan we have a long way to go before true collaboration and consultation takes place.

Should you need any additional information, please do not hesitate to contact Vicki Lowe, Executive Director for AIHC at vicki.lowe.aihc@outlook.com or 360-477-4522.

Thank you for your prompt response to our request for consultation.

Sincerely,

Stephen Kutz, Chair
American Indian Health Commission for Washington State

Andy Joseph, Chairman
Northwest Portland Area Indian Health Board

cc:
Kitty Marx, Director CMS Division of Tribal Affairs
Cecile Greenway, CMS Medicaid Region 10 Program Branch Manager
Alice Lind, Section Manager, HCS, HCA
Alison Robbins, Program Manager, HCS, HCA
Kathy Pickens-Rucker, Project Manager, MCS, HCA
Alonah (Loni) Greninger, DBHR Tribal Administrator, BHSIA, DSHS
Ann Myers, State Plan Coordinator, LAS, HCA
Tribal Leaders
Tribal Health Directors
Urban Indian Health Organization Directors
AIHC Delegates
Indian Policy Advisory Committee Delegates
Nathan Johnson, HCA Policy Director
MaryAnn Lindeblad, HCA Medicaid Director
Jessie Dean, HCA Tribal Liaison
Joe Finkbonner, NPAIHB Executive Director
Laura Platero, NPAIHB Policy Analyst
Vicki Lowe, AIHC Executive Director
Heather Erb, AIHC Legal Consultant

LUMMI INDIAN BUSINESS COUNCIL
2665 KWINA ROAD BELLINGHAM, WASHINGTON 98226 (360) 312-2000
DEPARTMENT_____DIRECT NO._____

September 27, 2016

Preston W. Cody, Division Director
Medicaid Program Operations and Integrity
Washington Health Care Authority

SUBJECT: Medicaid Fee-for-Service Access Monitoring Review Plan

Dear Mr. Cody,

Many drastic changes are happening within healthcare for Washington State. The Lummi Nation, a federally recognized Indian Tribe with over 5000 members located in Whatcom County, would like to start this letter by reminding the State of Washington about the Government-to-Government relationships that exists between the state and each Indian Tribe. In meeting its legal and ethical requirements to consult with Tribes, the State must include Tribal technical assistance to assure that HCA and DSHS adequately address the needs of AI/AN and the Indian health care delivery system in Washington. The State must also seek such technical expertise from the Tribes, the urban Indian health organizations, Indian Advisory Policy Committee, and the American Indian Health Commission for Washington State when developing any plans such as this. This consultation requirement is a sovereignty issue. Indian Tribes own health data about their members and must be consulted about how and when it is used.

Many of the data sets being used by the State for planning lack complete or accurate information on AI/ANs. Race coding has only allowed for choice of one race. This has often resulted in misclassification of mixed race AI/ANs. Because of this, the Accountable Communities of Health (ACHs) have been unable to include Tribal Data in their Regional Health Need Assessments (RHNA), as quality data is simply not available. There is currently no funding or consensus to determine the best way to gather Tribal data.

The Lummi Nation makes the following recommendations:

- Tribal-State collaboration to develop a plan for improving access to AI/AN data and address accuracy issues and gaps (workgroup).
- Funding for technical assistance to tribes to understanding the role of data in tribal sovereignty and self-determination.
- Support/funding to tribes to build capacity to collect and analyze their own data.

The Lummi Nation's health care programs have not had a positive experience with the Medicaid Managed Care (MMC) Plans. These plans have often been a hindrance for Tribal members to access the care they need. Some of the issues have been assignment to the wrong plan and provider, requests to go see an unknown provider before being able to access needed specialty care, lack of reimbursement for provided care, unwillingness to contract with Tribal clinics. The Lummi Nation has never contracted with RSN's or BHO's for these very reasons.

The State must take steps to ensure that the ongoing expansion of managed care within the Medicaid system will not adversely impact the fee-for-service (FFS) system accessed by AI/AN's. These steps should include:

i. FFS rates that are competitive with rates paid by MMC's; and
ii. Allocate savings achieved by value-based payments to raise the FFS fee schedule rates.

Because the MMC's can pay more to specialty providers than the FFS payments, the FFS specialty network is not adequate. When referred outside the tribal healthcare system, Medicaid eligible AI/ANs travel further and wait longer for specialty appointments than other AI/ANs and non-Native Medicaid clients.

It is the Lummi Nation's understanding that value based payments for providers contracted with MMC's will be implemented in the next few years. The State currently has no process or plan to implement value-based payment to non-Indian Health Care FFS providers. This will further degrade the FFS specialty network. The Lummi Nation recommends that savings made from reimbursement by the federal government for 100% FMAP payments should be put solely back into the FFS system for tribes. Those savings should be used to pay for services and/or benefits as directed by the tribes.

Changes to the State Plan on FFS payments are needed. For example the utilization of an Administrative Services Organization (ASO) to help with contracting for Tribal FFS, utilize current Purchased and Referred Care (formerly CHS) provider contracts asking those provider to accept Tribal FFS with care coordination plans and utilize the state savings on 100% FMAP to help fund ASO's are all possible solutions.

As the State has moved to using MMC's to provide benefits to Washington State Medicaid recipients, the FFS provider network has nearly disappeared. This is resulting in significant changes to the delivery of Medicaid services for tribal members. When such drastic changes to the Medicaid system occur, these changes severely impact tribal clinics and tribal community members. Simply being asked to provide comments on an already developed plan is far from true consultation.

Thank you,

Cheryl Andrews VC

Timothy Ballew II, Tribal Chairman
Lummi Nation

Port Gamble S'Klallam Tribe
Health Services
32020 Little Boston Road NE • Kingston, Washington 98346

September 26, 2016

Preston W. Cody, Division Director
Medicaid Program Operations and Integrity
Health Care Authority

SUBJECT: Solicitation of Comments on Medicaid Fee-for-Service Access Monitoring Review Plan.

Dear Mr. Cody:

Many changes are happening within healthcare for Washington State. The Port Gamble S'Klallam Tribe would like to start this letter by reminding the State of Washington about the Government-to-Government Relationships that exists between the state and each tribe. In meeting its requirement to consult and coordinate with tribes, the State needs to include Tribal technical assistance to assure that HCA and DSHS adequately address the needs of AI/AN and the Indian health care delivery system in Washington. The State needs to seek such technical expertise from the tribes, the urban Indian health organizations, Indian Advisory Policy Committee, and the American Indian Health Commission for Washington State when developing any plans such as this. This is a sovereignty issue. Tribes own their data and should be determining how and when it is used.

Many of the data sets being used by the state for policy and program planning lack complete or accurate information on AI/AN. Race coding has only allowed for choice of one race. This has often resulted in misclassification of mixed race AI/ANs. Because of this, the Accountable Communities of Health (ACHs) were unable to include Tribal Data in their Regional Health Need Assessments (RHNA) as quality data is not available. There is currently no funding to determine the best way to gather Tribal data.

The Port Gamble S'Klallam Tribe has the following recommendations:

- Tribal-State collaboration to develop a plan for improving access to AI/AN data and address accuracy issues and gaps (workgroup).
- Funding for technical assistance to Tribes to understanding the role of data in Tribal sovereignty and self-determination.
- Support/funding to Tribes to build capacity to collect their own data.

The Port Gamble S'Klallam Tribe's health care programs have not had a positive experience with the Medicaid Managed Care Plans. These plans have often been a hindrance for tribal members to access the care they need. Some of the issues have been assignment to the wrong plan and provider, requests to go see an unknown provider before being able to access needed specialty care, lack of reimbursement for provided care, unwillingness to contract with tribal clinics. These are important reasons why the State needs to take steps to ensure that the ongoing expansion of managed care within the Medicaid system will not

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adversely impact the fee-for-service (FFS) system accessed by AI/AN. These steps should include:

i. FFS fee schedule rates that are competitive to the rates paid by Medicaid Managed Care Plans; and
ii. Allocate savings achieved by value-based payments to raise the FFS fee schedule rates.

Because the Medicaid Managed Care Plans can pay more to specialty providers than the FFS payments, the FFS specialty network is not adequate. When referred outside the tribal healthcare system, Medicaid eligible AI/ANs travel further and wait longer for specialty appointments than other AI/ANs and non-Native Medicaid clients.

It is the Port Gamble S'Klallam Tribe's understanding that value based payments for providers contracted with Medicaid Managed Care Plans will be implemented in the next few years. The State currently has no process or plan to implement value-based payment to non-Indian Health Care FFS providers. This will further degrade the FFS specialty network. The Port Gamble S'Klallam Tribe recommends that savings made from reimbursement by the Federal Government for 100% FMAP payments should be put solely back into the FFS system for Tribes. Those savings should be used to pay for services and/or benefits as directed by the Tribes.

Changes to the State Plan section on FFS payments are needed. For example the utilization of an Administrative Services Organization (ASO) to help with contracting for Tribal FFS, utilize current Purchased and Referred Care (PRC formerly CHS) provider contracts asking those provider to accept Tribal FFS with care coordination plans and utilize the state savings on 100% FMAP to help fund ASO are all possible solutions.

As the State has moved to using Medicaid Managed Care Plans, to provide benefits to Washington State Medicaid recipients, the FFS provider network has nearly disappeared. This is resulting in significant changes to the delivery of Medicaid services for tribal members. When such drastic changes to the Medicaid system occur, these changes severely impact tribal clinics and tribal community members. It seems by being asked to simply provide comments on an already developed plan we have a long ways to go before true collaboration and consultation takes place.

Thank you,

Jeromy Sullivan
Tribal Chairman
Port Gamble S'Klallam Tribe

NoHLA
Northwest Health Law Advocates

September 30, 2030

Memo to:
Taylor Linke
Deputy Director, Medicaid Program Operations and Integrity Division
via email at taylor.linke@hca.wa.gov

Re: Comments on Medicaid Fee-for-Service Access Monitoring Review Plan

Thank you for the opportunity to comment on the state's first Medicaid Fee-for Service Access Monitoring Review Plan. These comments are submitted on behalf of Northwest Health Law Advocates (NoHLA). NoHLA is a nonprofit organization that focuses its work on improving access to quality care for low and moderate income individuals and securing the health rights of all persons.

We appreciate that states were given only a short period to produce these initial plans, and that they are a work in progress. We recognize the difficulty of the task. We anticipate HCA will add pieces to the plan as they are developed.

This new task for states, however, is vital for Medicaid clients. The Supreme Court of the United States has ruled providers may not enforce the statutory Medicaid requirements concerning rates and access in 42 USC 1396a(a)(30)(A). This CMS program is a way for CMS to acquire the information needed to assure the federal statutory requirements concerning access and rates are met.

In that light, this report is disappointing, providing insufficient information to analyze the access questions. We hope that some of the missing pieces can be put into place sooner rather than later. We also report here specific services for which we have information indicating access is a problem.

1. **Population limits for the analysis**

We are confused about why HCA thinks that CMS requires this access analysis for only about 4% of the Medicaid population. A larger percentage, about 18%, of the Medicaid population (in 2015) is not included in the Apple Health managed care programs, and the other 82% of the population receives some state plan services through fee-for-service payment arrangements.

We don't understand why the fee-for-service clients who receive Medicare or the other categories identified in Figure 4 of the report were simply excluded from the analysis. We see nothing that prohibits states from including these clients. Particularly useful information may be gleaned from reviewing access for dual eligibles, for whom the rates paid for services tend to be higher than Medicaid rates but lower than the full Medicare allowed rate. This information may help in assessing the extent to which Medicaid rates

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affect an identified access problem.

We also do not understand why no analysis was attempted for services such as dental that are provided fee-for-service to all Medicaid clients. The access rule addresses state plan fee-for-service *services*.[1] Washington's delivery system includes carve-out of services from managed care. We see no basis to avoid analyzing access for these services for individuals just because they may get *other* health services through a managed care payment arrangement.

We also see no directive to states to omit consideration of access for fee-for-service services provided to clients who are eligible for waiver programs. We think the guidance is better read as meaning the access analysis need not consider waiver program *services*, as those are addressed in the structures for monitoring waiver programs. But the state plan services that waiver clients receive – are not part of that monitoring structure. And Washington's current delivery system for waiver programs means that many clients get few services as waiver services, now that personal care services are provided under the state plan. Thus reviewing access for all the state plan fee-for-service services these waiver clients receive is important and is addressed in no other way.

2. Specific services not addressed

The new rule and policy require states to review access to care for at least the following services[2]:

- Primary care services (including those provided by a physician, FQHC, clinic, or dental care);
- Physician specialist services (for example, cardiology, urology, radiology);
- Behavioral health services (including mental health and substance use disorder);
- Pre- and post-natal obstetric services including labor and delivery; and
- Home health services; and
- Additional types of services for which the state or CMS has received a significantly higher than usual volume of beneficiary, provider or other stakeholder access complaints for a geographic area, including complaints

[1] See discussions in the preamble to the publication of the final rule with comment period for 42 C.F.R. 477.203. 80 FR 67576 (November 2, 2015). Relevant excerpts: "This final rule with comment period applies to all covered services under the state plan for which payment is made on a FFS basis." 80 FR 67576, 67583. "As stated in the May 6, 2011 proposed rule, section 1902(a)(30)(A) of the Act specifically applies to payment for care and services available under the state plan, *which we interpret to refer to payments to providers and not to capitated payments to managed care entities*. While Medicaid access to services under managed care arrangements is an important issue, that issue is addressed through reviews of network sufficiency and managed care quality review processes. As a result, *we are not addressing access to care under managed care arrangements* in this rulemaking effort. Similarly, methods to assure access to care, including payment methodologies, are reviewed in the approval process for Medicaid waiver and demonstration programs (and, when appropriate, may be monitored in the evaluation of a demonstration program). As a result, we did not specifically address those programs within the context of this rulemaking process." 80 FR 67576, 67582 (*emphasis added*).

[2] 42 CFR 447.203(b)(5), (b)(7).

received through mechanisms for beneficiary input (through hotlines, surveys, ombudsman, review of grievance and appeals data, or other mechanisms).

Nothing in the report addresses data or analysis of access for any of these specific services. Yet we know that HCA has detailed data regarding dental services, at least, and indeed is producing a report to the legislature that addresses access issues for dental services. That information should have been included and analyzed.

3. Data element identification

Under the rules and policy, this access monitoring review plan must identify data elements that will support the state's analysis of whether beneficiaries have sufficient access to care. 42 CFR 477.203(b)(1).

The CMS FAQ on access plans, issued March 16, 2016, identified a number of potential resources for states to use in doing this. These include MMIS data sets, data from service utilization review activities, provider rosters, available federal data sets (such as data available from: CMS, US Census Bureau, HRSA, SAMSHA, AHRQ, ASPE and other pertinent data sets available at: www.healthdata.gov), beneficiary call center logs, provider call center logs, Medicare fee schedules, and recommendations from the state medical care advisory committees.

The data mentioned in the state's report is inadequate to analyze access issues. Data about provider enrollment was limited to gross number of enrolled providers by year, with no information about the numbers of each kind of provider (primary care, specialty care, dental care, etc.) or whether the providers are actively serving clients, or whether they are open to new Medicaid patients. Call center data about clients needing help finding a provider does not include whether the service is provided through fee-for-service, the part of the state where a provider is sought, the provider type sought, or whether access was achieved.

HCA's understanding that data about a very limited set of clients (4%) must be "teased out" from existing datasets may be related to this problem of identifying appropriate data sources. But encounter data for services HCA pays as fee-for-service should be readily available. As discussed above, we don't believe HCA must complicate the analysis by excluding categories of people who actually receive the relevant services on a fee-for-service basis.

The report should at least identify additional datasets from which sufficient data could be pulled in order to perform a proper analysis of access. We recommend that feedback be sought from stakeholders as HCA designs better metrics for call centers and considers other data options.

4. Rates analysis

The rules requires the state's plan and monitoring analysis to consider, among other things, "Actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service." 42 CFR 447.203(b)(1)(v).

The report does include at least a sampling of rates comparing Medicaid fee-for-service rates and Medicare rates. It would be helpful to include rates for other services in the list the rule requires, such as rates for durable medical equipment (which are within the category of home health services).

The report does not have any comparison to rates from payers other than Medicare. We understand it may be difficult and take time to develop information about purely private sector payments. But CMS requires the plan to show aggregate comparisons between Medicaid rates and rates paid by *other public* payers as well as private payers. Why couldn't HCA compare Medicaid rates to those paid to providers by other public payers such as PEBB and Labor and Industries?

5. Access problems

Because the report was unable to assess adequacy of access, it also does not address corrective actions that may be needed to improve access. This is important to develop. Health advocates hear many stories about access problems, and there are indications that some of these are related to rates. Dental access concerns are documented in HCA's report to the legislature on the "Dental Proviso." Advocates who assist clients seeking dental providers repeatedly hear from dental providers who are listed as contracted with Medicaid that they are not accepting new Medicaid patients – due to the low rates. Advocates also hear of Medicaid client problems accessing psychiatrists, psychologists, private duty nursing, and pain specialists.

Conclusion

Given the data deficiencies and the resulting lack of ability to analyze access issues, the state's report is unable to show that beneficiary needs are being met. We expect the state to continue to work to address the data and analysis deficiencies, and to comply with the CMS directive to consider real-time information from providers and beneficiaries gathered through ongoing feedback mechanisms.

We appreciate your consideration of these comments. If you have questions, concerns, or responses, please do not hesitate to contact me by email.

Respectfully submitted,
Ann Vining
Staff Attorney, Northwest Health Law Advocates

September 29, 2016

Taylor Linke
Deputy Director, Medicaid Program Operations and Integrity
Washington State Health Care Authority
P.O. Box 45502
Olympia, WA 98504

Submitted via Electronic Mail

Re: Medicaid Fee-for-Service Access Monitoring Review Plan

Dear Ms. Linke:

The Washington Association of Community & Migrant Health Centers (WACMHC) welcomes this opportunity to comment on the Health Care Authority's (HCA) Draft Fee-for-Service Access Monitoring Review Plan, an assessment of Medicaid client access to certain services required by 42 CFR 447.203. As Washington State's federally-recognized primary care association, WACMHC represents the state's 28 community health centers and the 971,000 patients they serve. We acknowledge the difficulty in consolidating and analyzing data on Apple Health beneficiaries that receive health care services in a fee-for-service arrangement, and appreciate HCA's efforts in measuring these clients' access to care. We are concerned, however, that the draft plan does not include any review of dental access.

Although the vast majority of Medicaid patients that receive medical services at community health centers have their care reimbursed through Apple Health managed care plans, the Medicaid dental program remains in a fee-for-service reimbursement structure. Under 42 USC 1396a(a)(30)(A), State Plans for medical assistance must:

> [P]rovide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in Section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area[…]

The process mandated by 42 CFR 447.203 is intended to establish a data set to assess whether Medicaid beneficiaries have a level of access to the services outlined in the State Plan that is on par with the access enjoyed by the general population. Dental services are a core element of Apple Health, and covered dental services are extensively detailed in Washington's Title XIX State Plan (Attachment 3, pp. 27-28B). Indeed, 42 CFR 447.203(b)(5)(ii)(A) requires that the State Medicaid agency must include in its Access Monitoring Review Plan an analysis of

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data on "Primary care services (including those provided by a physician, FQHC, clinic, or dental care)."

Recent HCA data show that Apple Health dental coverage is severely underutilized, particularly among adults. According to 2015 claims data analyzed by the Washington Dental Service Foundation, only 22 percent of Apple Health-enrolled adults received dental care last year. We strongly suspect that this lack of access can be traced to the relatively low reimbursement private providers receive for serving adults under the current fee-for-service payment structure. The robust data analysis conducted under the Access Monitoring Review Plan should include this vital service. Washington's community health centers have significantly expanded their dental service capacity to care for more adult patients, increasing their Medicaid-enrolled patient load by 55 percent from 2014-2015, but this population needs significantly more assistance from other dental providers.

Lastly, we wish to suggest a correction to the section of the draft plan entitled "Overview of Apple Health." On page 3, HCA writes "Washington also has a large network of 116 Rural Health Clinics (RHCs) and 142 Federally Qualified Health Centers (FQHCs) throughout the state." In fact, there are only 28 Federally Qualified Health Centers, but they operated 267 service delivery sites in 2015.

We appreciate your attention to the comments. If you have questions or concerns, please do not hesitate to contact me by email at ckaasa@wacmhc.org or by phone at 360.786.9722 ext. 226.

Sincerely,

Chris Kaasa
Government Relations Associate
Washington Association of Community & Migrant Health Centers