# Pennsylvania Access Monitoring Draft Review Plan 2016

pennsylvania
DEPARTMENT OF HUMAN SERVICES

# Contents

# Overview

- The Pennsylvania Medicaid program provides health care coverage for low-income individuals, including children, pregnant women, individuals with disabilities, the elderly, parents, and other adults. The Pennsylvania Department of Human Services (DHS) is the single state agency that administers the Medicaid program within the commonwealth. As of December 2015, the Pennsylvania Medicaid program covered 2,744,031 beneficiaries.[1] In FY 2014, total Pennsylvania Medicaid spending was approximately $23.6 billion.[2]

- Pennsylvania has a population of 12.8 million. With 171 acute care hospitals,[3] affiliated practices, and a large network of rural health clinics and federally qualified health centers throughout the state, there are numerous options for Medicaid beneficiaries to receive health care.

- DHS measures and monitors indicators of health care access to ensure that its Medicaid beneficiaries have access to care that is comparable to the general population. DHS has separate access-related requirements for the Medicaid managed care population, which contracted managed care organizations (MCOs) must meet or exceed.

- In accordance with 42 CFR 447.203, Pennsylvania developed an access review monitoring plan for the following service categories provided under a fee-for-service (FFS) arrangement:

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

- The plan describes data that 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' health care needs are met.

- Individuals in different geographic areas may face different challenges in accessing care. This plan reports on access measures separately for urban and rural areas. According to the Health Resources & Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP), 12 percent of Pennsylvanians resided in a rural area in 2010. To define rural areas, FORHP uses concepts from both the U.S. Census Bureau of Office and Management and Budget (OMB) definitions. OMB defines urban areas according to population, designating areas with a population of greater than 50,000 as metropolitan. FORHP uses this designation, plus an additional analysis of population density and commuting patterns, to determine if additional Census tracts within metropolitan areas should be designated rural.[4] According to this definition, 37 of Pennsylvania's 67 counties are urban, and the remaining 30 counties are designated rural. Stratification by one geographic measure allows for a large enough denominator to calculate the required availability and utilization measures. While this approach is limited in that it does not offer the same granularity that county-level measures would, measures other than utilization will be monitored as part of this plan that will signal access issues in specific areas of Pennsylvania.

| URBAN (37 counties) | | | RURAL (30 counties) | | |
|---|---|---|---|---|---|
| Adams | Columbia | Mercer | Bedford | Greene | Schuylkill |
| Allegheny | Cumberland | Monroe | Bradford | Huntingdon | Snyder |
| Armstrong | Dauphin | Montgomery | Cameron | Indiana | Somerset |
| Beaver | Delaware | Montour | Clarion | Jefferson | Sullivan |
| Berks | Erie | Northampton | Clearfield | Juniata | Susquehanna |
| Blair | Fayette | Perry | Clinton | Lawrence | Tioga |
| Bucks | Franklin | Philadelphia | Crawford | McKean | Union |
| Butler | Lackawanna | Pike | Elk | Mifflin | Venango |
| Cambria | Lancaster | Washington | Forest | Northumberland | Warren |
| Carbon | Lebanon | Westmoreland | Fulton | Potter | Wayne |
| Centre | Lehigh | Wyoming | | | |
| Chester | Luzerne | York | | | |
| | Lycoming | | | | |

- As required under the final rule, the plan includes comparisons of reimbursement rates for each of the six service categories. DHS currently compares its rates to Medicare, which is presented in this document. In the future, DHS may also include comparisons to Medicaid managed care rates and private insurance rates as available.

- The plan was developed during the months of January – June 2016 and posted on the state Medicaid agency's website from June 24, 2016 – July 25, 2016 to allow for public review and feedback. The plan was presented to the Pennsylvania Medical Assistance Advisory Council (MAAC) for feedback on June 23, 2016.

# Beneficiary Population

As of January 2016, approximately 79.4% of Pennsylvania Medicaid beneficiaries were enrolled in HealthChoices, Pennsylvania's Medicaid managed care program for physical health services[5]. Approximately 93% of all Pennsylvania Medicaid beneficiaries receive state plan behavioral health services through behavioral health MCOs.[6] Most of the individuals who are not enrolled in Physical Health HealthChoices are dual eligibles (i.e., individuals who are eligible for both Medicare and Medicaid benefits). Dual eligibles receive their physical health benefits through FFS, but receive their behavioral health services through behavioral health MCOs.

In addition to dual eligibles, another significant portion of the FFS population are beneficiaries who are enrolled in FFS during a transition period of 30 days or less, during which they select a HealthChoices MCO. HealthChoices MCO enrollees who participate in the Pennsylvania Aging waiver for more than 30 days or reside in a nursing facility for more than 30 days, are disenrolled from HealthChoices and receive their Medicaid services through FFS. Other populations which are excluded from HealthChoices in Pennsylvania include individuals in the Health Insurance Premium Payment Program[7], Living Independence for the Elderly (LIFE) enrollees[8], residents of state psychiatric hospitals, residents of juvenile detention centers (unless the individual was previously enrolled in managed care), residents of transitional care homes (which provide temporary medical and personal care to children following hospital discharge), and aliens who are only eligible for emergency services.[9]

Descriptive information on the Pennsylvania Medicaid FFS population is displayed in the FFS enrollment table below. Three groups are presented: Enrollees in FFS physical and behavioral health (180,284), physical health FFS and behavioral health managed care (323,732), and physical health managed care and behavioral health FFS (6,965). The remaining 2.1 million beneficiaries are enrolled in HealthChoices for both their physical and behavioral health services.[6] Many of the individuals enrolled in FFS for less than 30 days are temporarily enrolled before transitioning to mandatory managed care.

*Fee-for-Service Enrollment Table (December 2015)*

| | FFS Enrollees | Physical Health FFS/ Behavioral Health Managed Care Enrollees | Physical Health Managed Care/ Behavioral Health FFS Enrollees |
|---|---|---|---|
| **Total** | **180,284** | **323,732** | **6,965** |
| **Length of Enrollment** | | | |
| **Enrolled > 30 Days** | 150,130 | 301,582 | 6,786 |
| **Enrolled ≤ 30 Days** | 30,154 | 22,150 | 179 |
| **Residency** | | | |
| **Institution** | 56,624 | 2,140 | 421 |
| **Not Institution** | 123,660 | 321,592 | 6,544 |
| **Waiver Status** | | | |
| **Waiver** | 31,391 | 35,347 | 5,207 |
| **Not in a waiver** | 148,893 | 288,385 | 1,758 |
| **Gender** | | | |
| **Female** | 116,251 | 183,861 | 4,676 |
| **Male** | 64,033 | 139,871 | 2,289 |
| **Age** | | | |
| **Age 18 and under** | 30,805 | 17,542 | 962 |
| **Age 19 or 20** | 3,029 | 2,136 | 113 |
| **Age 21-64** | 63,186 | 205,291 | 1,387 |
| **Age 65 and over** | 83,264 | 98,763 | 4,503 |
| **Eligibility** | | | |
| **Dual Eligible** | 88,014 | 260,423 | 4,952 |
| **Non-Dual Eligible** | 92,270 | 63,309 | 2,013 |
| **Disability Status** | | | |
| **Permanently Disabled** | 45,111 | 216,809 | 3,334 |
| **Not Permanently Disabled** | 135,173 | 106,923 | 3,631 |

*Note: All figures are as of 12/31/2015*
*Source: Pennsylvania Department of Human Services*

As adults account for the largest group of FFS enrollees (90.4%)[6], the majority of availability and utilization measures in this plan are designed to address access for adults. Children have been excluded from measures that require continuous enrollment, since only a small minority of children remain in FFS long-term. To address the limited time-period that children are enrolled in FFS, at least one availability and utilization access measure has been included in each service category that includes children in the numerator and denominator. While DHS typically identifies beneficiaries as children up until they are 21 years old (when EPSDT eligibility ends), many measures in this plan use age 18 as the cutoff between children and adults. This is to maintain consistency with the CMS-endorsed Child and Adult Core Set measures' specifications for identifying child and adult beneficiaries.

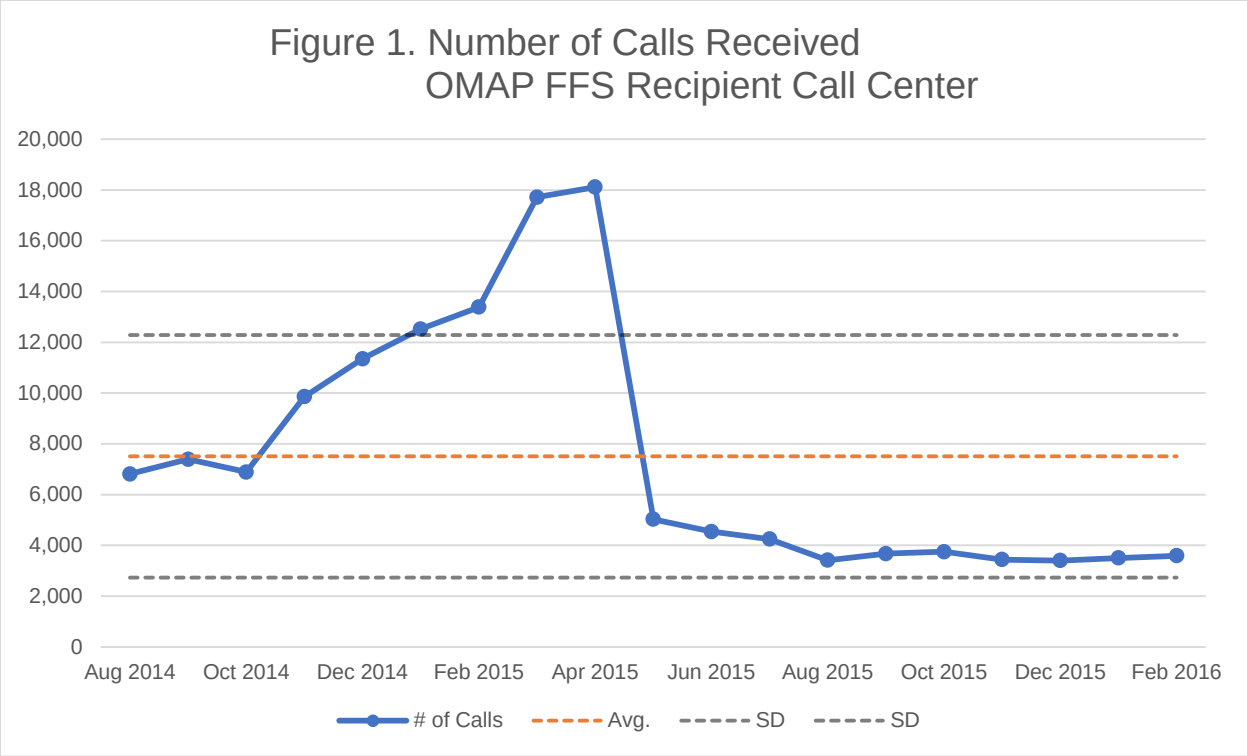
Starting in 2017, DHS will implement a new managed long term services and supports program, Community HealthChoices (CHC). DHS estimates that approximately 420,000 individuals will enroll in CHC, the majority of whom are currently part of the FFS population[10]. CHC will provide beneficiaries with physical health and long term care services, and work with BH-MCOs to coordinate the delivery of behavioral health services. The CHC program will start in the Southwest region of the state in 2017, extend to the Southeast region in 2018, and reach statewide implementation in 2019. CHC will not include LIFE participants or individuals with developmental or intellectual disabilities served by HCBS waivers managed by the Office of Developmental Programs (ODP).

When the CHC program begins, it will have a significant impact on the longitudinal utilization measures proposed in this plan. To ensure an accurate assessment of access for the FFS beneficiary population, the next review plan analysis will only use longitudinal data for those beneficiaries who are not eligible for the new CHC program.

## Access concerns raised by beneficiaries

DHS operates a statewide beneficiary call center as a service to beneficiaries and as a way to engage beneficiaries to assist them with their needs. Each beneficiary is provided with the call center's 800 telephone number in the mailer the beneficiary receives at the time of the eligibility determination or renewal, and the number is also posted on the DHS website. The call center is open Monday through Friday from 8 AM to 4:30 PM. When the beneficiary calls they are given a list of prompts, including one for enrollees in Medicaid managed care. If the recipient chooses that prompt, they are linked to their specific MCO call center. If a beneficiary has difficulty in obtaining access to services, employees at the call-center provide multiple services to assist them. First, the call-center will obtain a list of participating providers near the beneficiary for the given specialty. If the beneficiary exhausts that list and continues to have access issues, the call center expands the geographic scope of the provider search and provides an updated list to the beneficiary. If access issues persist, the call center staff may contact providers on the beneficiary's behalf and provide the information and assistance necessary to enable the provider to bill for services rendered to a Medicaid beneficiary, so that the beneficiary can be seen. The call center also handles general questions about Medicaid coverage, medical bills, finding a dentist, prior authorization requests, third party liability verification, and client reimbursements.

Call volume for the beneficiary call center has been monitored since June 2014. Data for August 2014 to February 2016 are presented in Figure 1. The number of calls includes any call received by the beneficiary call center, but excludes those callers who were redirected through the prompt system to their Medicaid MCO's customer support. Between August 2014 and February 2016, the number of beneficiary calls decreased by 47%. Over this period, the average monthly call volume was 7,506 with a standard deviation of 4,776, and ranged from 18,110 in April 2015, to 3,403 in December 2015.




*Source: OMAP Automated Call Distribution Electronic Reporting System*

By itself, this measure indicates that critical access issues may not be occurring in this population, as FFS recipient calls have declined and stabilized over this period. The increase in call volume in early 2015 can be attributed to the implementation of the HealthyPA program. Calls significantly dropped when Governor Wolf switched to a traditional Medicaid expansion through HealthChoices, which went in to effect on April 27, 2015. If an unexplained increase in calls to the call center occurs, DHS will investigate common topics of concern by categorizing calls by beneficiary reason for calling to determine if access issues have increased and for which beneficiaries and provider types. Following such an investigation, DHS will determine the appropriate course of action to resolve these access issues and monitor any changes in response to those actions.

DHS will also track and report minutes from MAAC meetings related to access concerns for the FFS population. Persistent access concerns discussed by the MAAC in the most recent year will be reported in this plan to supplement and provide contextual information for the monitored access measures.

## Beneficiary perceptions of access to care

Consumer Assessment of Healthcare Providers and Systems (CAHPS) data are patient surveys administered by CMS designed to capture the patient's experience with health care. In 2013, the National Opinion Research Center at the University of Chicago and Thoroughbred Research Group partnered to conduct the first-ever Nationwide Adult Medicaid CAHPS Survey. Populations surveyed were stratified by state as well as by dual-eligibility status, disability status, and Medicaid managed care vs. FFS enrollment. The number of beneficiaries included in this sample and response rates from Pennsylvania are presented in Table 1. DHS will work with CMS to receive and analyze the adult FFS CAHPS data in order to determine the extent to which beneficiary needs are met. DHS will include the most recent access-relevant CAHPS data in this report to supplement other measures presented so that a complete picture of FFS beneficiary access can be assessed. Specifically, DHS will analyze the CAHPS measures on getting needed care, timely care, and access to specialty care for the purposes of this plan. CAHPS survey questions provide information about access to care that is independent of utilization data; such as whether a beneficiary needed care and was not able to receive care in a timely

manner. For this reason, the CAHPS data will provide an additional dimension of access for the FFS populations. CAHPS survey questions that specifically target one of the six service categories in this plan will be reported and analyzed to the extent possible (e.g. In the past six months, how often was it easy to get the mental health or behavioral health services you needed?).

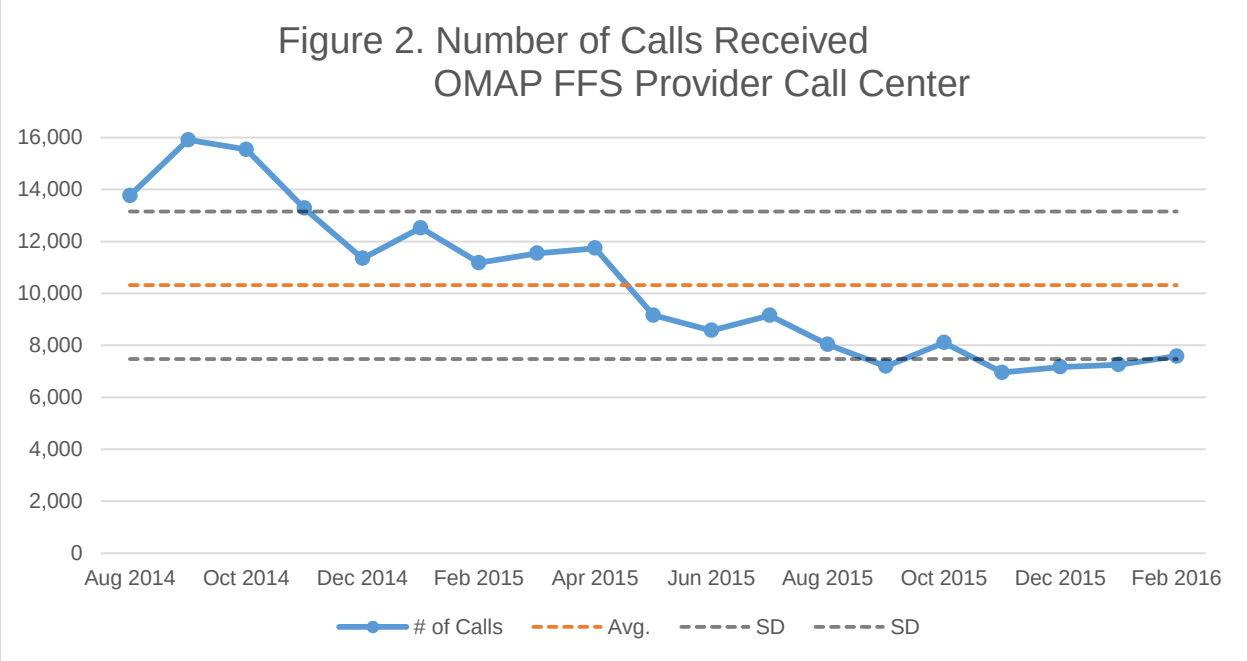
*Table 1. Final Sample Size and Response Rate for the 2014-2015 Pennsylvania Adult Medicaid CAHPS Survey*[11]

| | Dual Eligible | Non-Dual Disabled | Non-Dual Non-Disabled Managed Care | Non-Dual Non-Disabled FFS |
|---|---|---|---|---|
| **Sample Size** | 5,556 | 5,556 | 11,110 | 5,376 |
| **Response Rate** | 41.9% | 32.4% | 15.5% | 19.6% |

## Provider Feedback

DHS operates a statewide Medicaid provider call center to facilitate the provision of services for the FFS beneficiary population. The provider call center is open Monday through Friday from 8 AM to 4:30 PM. The provider call center handles a variety of queries, including billing, remittance advice, eligibility, and Medicaid program policy, and is directed towards questions on the FFS program. Providers with billing questions specific to Medicaid managed care are directed to contact the given MCO.

Call volume for the provider call center has been monitored since August 2014. Between August 2014 and February 2016, the number of provider calls decreased by 45% (Figure 2). Over this period, the average monthly call volume was 10,316 with a standard deviation of 2,839, and ranged from 15,909 in September 2014, to 6,952 in November 2015.




*Source: OMAP Automated Call Distribution Electronic Reporting System*

By itself, this measure may indicate that access issues from the provider perspective are not critical at this time, as FFS provider calls have declined and stabilized over this period. Another factor driving declines in FFS call volume may be that an increasing number of providers participate in and are reimbursed directly by managed care plans. Additionally, provider call volume at a given time may not correspond directly with current access issues. When DHS transitioned to statewide managed care in 2013, provider call volume remained steady for the following year because many FFS claims were still being processed in the PROMISe claims system.

If an unexplained increase in calls to the call center occurs, DHS will investigate common topics of concern by categorizing calls by provider reason for calling to determine if access issues have increased and for which provider types. Following such an investigation, DHS will determine the appropriate course of action to resolve these access issues and monitor changes in response to those actions.
DHS also receives letters and other communications from legislators, providers, provider trade group organizations and professional organizations. These communications are collected and tracked by the DHS Secretary's office. In the future, DHS will report on any recurring provider feedback in the plan to identify potential access issues.

# Review Analysis of Primary Care Services

## Data Sources

- DHS FFS Claims
- DHS FFS Enrollment
- Pennsylvania Aggregated Health Center Data
- Pennsylvania Adult Medicaid CAHPS Survey

## Availability of Primary Care Providers

Current availability of Primary Care Providers (PCPs) will be assessed using the measures presented in Table 2. To be included in these measures, PCPs must have provided a service to a FFS-enrolled beneficiary in the given year or quarter. These measures will be stratified by geography (urban vs. rural counties), site of service (facility vs. non-facility), and PCP type. The PCP types include primary care physicians (family practice, general practice, and pediatricians), nurse practitioners (NPs), dental providers, and FQHCs. In addition, trends of these measures will be presented by annual quarter over the most recent four years, along with the standard deviation and average over the entire four year period.

*Table 2. Availability of Primary Care Provider Measures*

| Title | Description | Numerator | Denominator | Exclusions | Source |
|---|---|---|---|---|---|
| **Availability of Primary Care Providers** | Number of PCPs with at least one FFS Medicaid claim per 1,000 enrollees | Number of family medicine, general practice, and pediatricians with at least one FFS Medicaid claim | Number of thousands of FFS Medicaid enrollees | | DHS FFS Claims Data |
| **Availability of Nurse Practitioners** | Number of NPs with at least one FFS Medicaid claim per 1,000 enrollees | Number of NPs with at least one FFS Medicaid claim | Number of thousands of FFS Medicaid enrollees | | DHS FFS Claims Data |
| **Availability of Dental Providers** | Number of dentists with at least one FFS Medicaid claim per 1,000 enrollees | Number of dentists with at least one FFS Medicaid claim | Number of thousands of FFS Medicaid enrollees | | DHS FFS Claims Data |
| **Availability of FQHCs** | Number of FQHCs with at least one FFS Medicaid claim per 1,000 enrollees | Number of FQHCs with at least one FFS Medicaid claim | Number of thousands of FFS Medicaid enrollees | | DHS FFS Claims Data |

## Utilization Measures

DHS will monitor seven utilization measures that indicate access to primary care services. These measures range from straightforward primary care provider utilization to indicators of poor access, such as acute care admissions for asthma. The title, description, numerator and denominator definitions, exclusions, and any relevant citations are presented for each measure in Table 3. Each utilization measure will be stratified by geography (urban vs. rural counties) and will be calculated for FFS

beneficiaries only. DHS will present both the current utilization for each measure for the most recent year, as well as the quarterly or annual trend over the previous four years (depending on the measure's specifications), including standard deviation and average over the four-year period.

*Table 3. Utilization Measures to Monitor Access to Primary Care Services*

| Title | Description | Numerator | Denominator | Exclusions | Source/ Citation |
|---|---|---|---|---|---|
| **Child primary care utilization** | Number of PCP visits provided to FFS enrolled children per child-month. | Number of unique visits to a PCP among FFS enrolled children age 17 and younger during the measurement period. | Total number of months of FFS Medicaid enrollment for enrollees age 17 and younger during the measurement period. | | DHS FFS Claims Data<br><br>Based on Child Core Set NCQA/HEDIS |
| **Adult primary care utilization*** | Percentage of continuously enrolled adults age 18 years and older who had a visit with a primary care practitioner (PCP). | Number of continuously enrolled FFS adults with one or more visits with a PCP during the measurement year. | Continuously enrolled adults age 18 years and older. | | DHS FFS Claims Data<br><br>Based on Child Core Set NCQA/HEDIS** |
| **Percent of adults who received preventive dental services*** | Percentage of individuals ages 21 and older who are continuously enrolled in Medicaid for at least 90 continuous days, and who received at least one preventive dental service during the reporting period. | The unduplicated number of individuals receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999, based on an unduplicated paid, unpaid, or denied claim. | The total unduplicated number of individuals ages 21 and older who have been continuously enrolled in Medicaid programs for at least 90 continuous days. | Beneficiaries enrolled in limited eligibility (e.g. pregnancy related service) | DHS FFS Claims Data<br><br>Based on Child Core Set NCQA/HEDIS** |
| **Percent of FQHC patients in Medicaid*** | Percent of patients served by FQHCs who are enrolled in Medicaid | Patients served by FQHC enrolled in Medicaid | Total patients served by FQHC<br><br>(e.g., 43.2% average across all sites in 2014) | | HRSA Health Center Program Grantee Profiles: PA "PA Aggregated Health Center Data" |

| Title | Description | Numerator | Denominator | Exclusions | Source/ Citation |
|---|---|---|---|---|---|
| **Asthma in younger adults admission rate** | Number of inpatient hospital admissions for asthma per 100,000 enrollee months for Medicaid enrollees ages 18 to 39. | All non-maternal inpatient hospital admissions for FFS enrollees ages 18 to 39 with an ICD-9- CM principal diagnosis code of asthma. | Total number of months of FFS Medicaid enrollment for enrollees ages 18 to 39 during the measurement period. | Transfers from another health care facility, admissions with missing gender, obstetric admissions, and ICD-9-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system. | DHS FFS Claims Data<br><br>Adult Core Set NCQA/ HEDIS |
| **Diabetes short term complications admission rate** | Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 enrollee months for Medicaid enrollees age 18 and older. | FFS inpatient hospital admissions with ICD-9-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma). | Total number of months of FFS Medicaid enrollment for enrollees age 18 and older during the measurement period. | Transfers from another health care facility, admissions with missing gender, obstetric admissions. | DHS FFS Claims Data<br><br>Adult Core Set NCQA/ HEDIS |
| **COPD or asthma in older adults admission rate** | Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 enrollee months for Medicaid enrollees age 40 and older. | FFS non-maternal inpatient hospital admissions with an ICD-9-CM principal diagnosis code for:<br>• COPD or<br>• Asthma or<br>• Acute bronchitis and any secondary ICD-9-CM diagnosis codes for COPD. | Total number of months of FFS Medicaid enrollment for enrollees age 40 and older during the measurement period. | Transfers from another health care facility, admissions with missing gender, obstetric admissions, and ICD-9-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system. | DHS FFS Claims Data<br><br>Adult Core Set NCQA/ HEDIS |

** = Annual trend only.*
*** = Measure has been adapted from the Child Core Set to specify an adult age range.*

## Data Relevant to Beneficiary Primary Care Needs Being Met

The extent to which beneficiary primary care needs are being met will be measured using the Pennsylvania Sample of the Nationwide Adult Medicaid CAHPS Survey, as discussed on page 7 of this plan. Any CAHPS survey questions that specifically target access to primary care will be reported and analyzed in this plan (e.g. In the last six months, how often was it easy to get the dental services you needed?).

## Comparative Analysis of Primary Care Provider Medicaid and Medicare Payment Rates

DHS compares Medicaid FFS reimbursement rates for primary care services to those of Medicare for Pennsylvania Region 99, "Rest of Pennsylvania." These comparisons are presented in the tables below for select evaluation and management procedure codes. A Medicaid-to-Medicare ratio is used to determine how closely Medicaid rates match those of Medicare. A single Medicaid rate per procedure code is compared to the Medicare non-facility and facility-based rates in Pennsylvania, as DHS reimbursement levels for primary care services are consistent across sites of service.

The CY 2015 Medicaid-to-Medicare ratio for primary care providers (Table 4) ranged from 0.47 to 2.18. Since FQHCs are reimbursed by Pennsylvania Medicaid using encounter/provider specific rates, a median rate calculated from all Pennsylvania FQHC locations was calculated for procedure code T1015 and presented (Table 5); however, a comparable procedure code used by Medicare was not identified. Since Medicare does not reimburse for dental services, a comparison was not possible with Medicare rates (Table 6). In the future, DHS may compare the rates for these dental codes to Medicaid managed care reimbursement levels.

*Table 4. Comparison of Reimbursement Rates - Primary Care Providers*

| Procedure Code | Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|
| **99201** | New patient office or other outpatient visit, typically 10 minutes | $42.37 | $26.34 | $20.00 | 0.47 | 0.76 |
| **99202** | New patient office or other outpatient visit, typically 20 minutes | $72.62 | $49.59 | $35.33 | 0.49 | 0.71 |
| **99203** | New patient office or other outpatient visit, typically 30 minutes | $105.75 | $76.37 | $54.25 | 0.51 | 0.71 |
| **99204** | New patient office or other outpatient visit, typically 45 minutes | $161.55 | $129.17 | $90.37 | 0.56 | 0.70 |
| **99205** | New patient office or other outpatient visit, typically 60 minutes | $203.31 | $167.93 | $117.54 | 0.58 | 0.70 |
| **99211** | Established patient office or other outpatient visit, typically 5 minutes | $19.17 | $9.16 | $20.00 | 1.04 | 2.18 |
| **99212** | Established patient office or other outpatient visit, typically 10 minutes | $42.37 | $25.34 | $26.00 | 0.61 | 1.03 |
| **99213** | Established patient office or other outpatient visit, typically 15 minutes | $70.70 | $50.34 | $35.00 | 0.50 | 0.70 |

| Procedure Code | Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|
| **99214** | Established patient office or other outpatient visit, typically 25 minutes | $105.18 | $77.81 | $54.42 | 0.52 | 0.70 |
| **99215** | Established patient office or other outpatient visit, typically 40 minutes | $142.25 | $110.54 | $78.05 | 0.55 | 0.71 |

*Source: Medicare Physician Fee Schedule; Pennsylvania Medicaid Fee Schedule*

### *Table 5. Reimbursement Rates - FQHCs*

| Procedure Code | Description | FFY 16 Median Medicaid Reimbursement |
|---|---|---|
| **T1015** | Clinic Visit/Encounter, All-Inclusive | $148.53 |

*Source: Pennsylvania Department of Human Services*

### *Table 6. Comparison of Reimbursement Rates - Dentists*

| Procedure Code | Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|
| **D0120** | Periodic oral evaluation | $0.00 | $0.00 | $20.00 | N/A | N/A |
| **D0145** | Oral evaluation for a patient under three years of age and counseling with primary caregiver | $0.00 | $0.00 | $20.00 | N/A | N/A |
| **D0150** | Comprehensive oral evaluation | $0.00 | $0.00 | $20.00 | N/A | N/A |
| **D0210** | Intraoral radiograph – complete series | $0.00 | $0.00 | $45.00 | N/A | N/A |
| **D1110** | Prophylaxis – adult | $0.00 | $0.00 | $36.00 | N/A | N/A |
| **D1120** | Prophylaxis – child | $0.00 | $0.00 | $30.00 | N/A | N/A |
| **D1206** | Topical application of fluoride varnish | $0.00 | $0.00 | $18.00 | N/A | N/A |
| **D1208** | Topical application of fluoride - excluding varnish | $0.00 | $0.00 | $18.72 | N/A | N/A |
| **D1351** | Sealant - per tooth | $0.00 | $0.00 | $25.00 | N/A | N/A |
| **D2330** | Resin-based composite restoration – one tooth, anterior | $0.00 | $0.00 | $50.00 | N/A | N/A |

| Procedure Code | Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|
| **D2391** | Resin-based composite restoration – one tooth, posterior | $0.00 | $0.00 | $50.00 | N/A | N/A |
| **D5110** | Complete upper denture | $0.00 | $0.00 | $525.00 | N/A | N/A |
| **D5120** | Complete lower denture | $0.00 | $0.00 | $525.00 | N/A | N/A |

*Source: Pennsylvania Medicaid Fee Schedule*

## Recommendations

DHS will continually measure trends in all primary care service availability and utilization measures. DHS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DHS will implement changes to improve access and monitor select measures accordingly.

# Review Analysis of Physician Specialists

## Data Sources

- DHS FFS Claims Data
- DHS FFS Enrollment Data
- Pennsylvania Adult Medicaid CAHPS Survey

## Availability of Physician Specialists

Current availability of specialists will be assessed using the measure presented in Table 7. This measure will be calculated for each of 16 specialty groups defined by DHS in Appendix A. To be included in these measures, specialists must have provided a service to a FFS-enrolled beneficiary in the given year or quarter. These measures will be stratified by geography (urban vs. rural counties), and site of service (facility vs. non-facility). In addition, trends of these measures will be presented by annual quarter over the most recent four years, along with the standard deviation and average over the entire four year period.

*Table 7. Availability of Specialists Measures*

| Title | Description | Numerator | Denominator | Exclusions | Source |
|---|---|---|---|---|---|
| **Availability of [specialist grouping]** | Number of [specialists] with at least one FFS Medicaid claim per 1,000 enrollees | Number of [specialists] with at least one FFS Medicaid claim | Number of thousands of FFS Medicaid enrollees | | DHS FFS Claims Data |

## Utilization Measures

DHS will monitor one utilization measure for each of the 16 specialty groups in Appendix A that indicate access to physician specialists. The title, description, numerator and denominator definitions, exclusions, and any relevant citations are presented for this measure in Table 8. This measure will be stratified by geography (urban vs. rural counties) and will be calculated for FFS beneficiaries only. DHS will present both the current utilization for this measure for the most recent year, as well as the quarterly trend, including standard deviation and average over the four year period.

*Table 8. Utilization Measures to Monitor Access to Physician Specialist Services*

| Title | Description | Numerator | Denominator | Exclusions | Source/ Citation |
|---|---|---|---|---|---|
| **[Specialist grouping] Services** | Number of [specialist grouping ]services per 100,000 FFS member months | Number of unique FFS [specialist grouping ] claims | Total number of months of FFS Medicaid enrollment for all enrollees during the measurement period. | | DHS FFS Claims Data |

## Data Relevant to Beneficiary Specialty Care Needs Being Met

The extent to which beneficiary specialty care needs are being met will be measured using the Pennsylvania Sample of the Nationwide Adult Medicaid CAHPS Survey, as discussed on page 7 of this plan. Any CAHPS survey questions that specifically target access to specialty care will be reported and

analyzed in this plan (e.g. In the last six months, how often did you get an appointment to see a specialist as soon as you needed?).

## Comparative Analysis of Physician Specialist Medicaid and Medicare Payment Rates

DHS compares Medicaid FFS reimbursement rates for specialty care services to those of Medicare for Pennsylvania Region 99, "Rest of Pennsylvania." These comparisons are presented in Tables 9a and 9b below. Two types of codes are presented in Table 9a: Telemedicine and Consultation codes. The telemedicine codes are labeled with a "GT" modifier. Because Medicare does not recognize consultation codes, the most comparable Medicare codes have been selected for this comparison. Note that some consultation codes are also used as telemedicine codes.

Surgical procedure code reimbursement rates are compared in Table 9b. Each procedure code for which both Medicare and Medicaid reimburse in the categories listed in Table 9b were compared to both Pennsylvania Medicare non-facility and facility reimbursement rates, and a median Medicaid-to-Medicare ratio was calculated and is presented for each category. A Medicaid-to-Medicare ratio is used to determine how closely Medicaid rates match those of Medicare.

The CY 2015 Medicaid-to-Medicare ratio for specialty care providers ranged from 0.24 to 1.14.

*Table 9a. Comparison of Reimbursement Rates – Specialist Consultation and Telemedicine Codes*

| Medicaid Procedure Code | Comparable Medicare Procedure Code | Medicaid Code Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|---|
| **99213 GT** | 99213 | Established patient office or other outpatient, visit typically 15 minutes, with telemedicine modifier | $70.70 | $50.34 | $35.00 | 0.50 | 0.70 |
| **99213 TH, GT** | 99213 | Established patient office or other outpatient, visit typically 15 minutes, with telemedicine modifier, obstetrical service, prenatal or post-partum | $70.70 | $50.34 | $35.00 | 0.50 | 0.70 |
| **99213 U9, HD-GT** | 99213 | Established patient office or other outpatient, visit typically 15 minutes, with telemedicine modifier | $70.70 | $50.34 | $40.00 | 0.57 | 0.79 |

| Medicaid Procedure Code | Comparable Medicare Procedure Code | Medicaid Code Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|---|
| **99214 GT** | 99214 | Established patient office or other outpatient, visit typically 25 minutes, with telemedicine modifier | $105.18 | $77.81 | $54.42 | 0.52 | 0.70 |
| **99214 TH, GT** | 99214 | Established patient office or other outpatient, visit typically 25 minutes, with telemedicine modifier, obstetrical service, prenatal or post-partum | $105.18 | $77.81 | $54.42 | 0.52 | 0.70 |
| **99214 U9, HD-GT** | 99214 | Established patient office or other outpatient, visit typically 25 minutes, with telemedicine modifier | $105.18 | $77.81 | $54.42 | 0.52 | 0.70 |
| **99215 GT** | 99215 | Established patient office or other outpatient, visit typically 40 minutes, with telemedicine modifier | $142.25 | $110.54 | $78.05 | 0.55 | 0.71 |
| **99215 GT, TH** | 99215 | Established patient office or other outpatient, visit typically 40 minutes, with telemedicine modifier, obstetrical service, prenatal or post-partum | $142.25 | $110.54 | $78.05 | 0.55 | 0.71 |
| **99215 U9, HD-GT** | 99215 | Established patient office or other outpatient, visit typically 40 minutes, with telemedicine modifier | $142.25 | $110.54 | $78.05 | 0.55 | 0.71 |
| **99215 U9, HD-21-GT** | 99215 | Established patient office or other outpatient, visit typically 40 minutes, with telemedicine modifier | $142.25 | $110.54 | $78.05 | 0.55 | 0.71 |

| Medicaid Procedure Code | Comparable Medicare Procedure Code | Medicaid Code Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|---|
| **99241** | 99201 | Patient office consultation, typically 15 minutes | $42.37 | $26.34 | $30.00 | 0.71 | 1.14 |
| **99241 GT** | 99201 | Patient office consultation, typically 15 minutes, with telemedicine modifier | $42.37 | $26.34 | $30.00 | 0.71 | 1.14 |
| **99242** | 99202 | Patient office consultation, typically 30 minutes | $72.62 | $49.59 | $55.15 | 0.76 | 1.11 |
| **99242 GT** | 99202 | Patient office consultation, typically 30 minutes, with telemedicine modifier | $72.62 | $49.59 | $55.15 | 0.76 | 1.11 |
| **99243** | 99203 | Patient office consultation, typically 40 minutes | $105.75 | $76.37 | $76.93 | 0.73 | 1.01 |
| **99243 GT** | 99203 | Patient office consultation, typically 40 minutes, with telemedicine modifier | $105.75 | $76.37 | $76.93 | 0.73 | 1.01 |
| **99244** | 99204 | Patient office consultation, typically 60 minutes | $161.55 | $129.17 | $120.56 | 0.75 | 0.93 |
| **99244 GT** | 99204 | Patient office consultation, typically 60 minutes, with telemedicine modifier | $161.55 | $129.17 | $120.56 | 0.75 | 0.93 |
| **99245** | 99205 | Patient office consultation, typically 80 minutes | $203.31 | $167.93 | $151.44 | 0.74 | 0.90 |
| **99245 GT** | 99205 | Patient office consultation, typically 80 minutes, with telemedicine modifier | $203.31 | $167.93 | $151.44 | 0.74 | 0.90 |
| **99251** | 99231 | Inpatient hospital consultation, typically 20 minutes | $38.76 | $38.76 | $30.00 | 0.77 | 0.77 |

| Medicaid Procedure Code | Comparable Medicare Procedure Code | Medicaid Code Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|---|
| **99252** | 99232 | Inpatient hospital consultation, typically 40 minutes | $71.83 | $71.83 | $30.00 | 0.42 | 0.42 |
| **99253** | 99221 | Inpatient hospital consultation, typically 55 minutes | $101.10 | $101.10 | $30.00 | 0.30 | 0.30 |
| **99254** | 99222 | Inpatient hospital consultation, typically 80 minutes | $136.29 | $136.29 | $49.00 | 0.36 | 0.36 |
| **99255** | 99223 | Inpatient hospital consultation, typically 110 minutes | $201.75 | $201.75 | $49.00 | 0.24 | 0.24 |

*Source: Medicare Physician Fee Schedule; Pennsylvania Medicaid Fee Schedule*

*Table 9b. Comparison of Reimbursement Rates for Surgical Procedures - Specialists*

| Procedure Codes | Description | Median Medicaid-to-Medicare Ratio Nonfac | Median Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|
| **20005-29916** | Surgical procedure codes of the musculoskeletal system | 0.52 | 0.57 |
| **30000-32988** | Surgical procedure codes of the respiratory system | 0.62 | 0.74 |
| **33010-39561** | Surgical procedure codes of the cardiovascular system | 0.60 | 0.72 |
| **40490-49906** | Surgical procedure codes of the digestive system | 0.50 | 0.60 |
| **60000-60650** | Surgical procedure codes of the endocrine system | 0.61 | 0.63 |
| **70010-79445** | Surgical procedure codes for radiology (including radiation oncology) | 0.72 | 0.72 |
| **91030-96922** | Surgical procedure codes for additional invasive and noninvasive medical testing and services | 0.67 | 0.73 |

## Recommendations

DHS will continually measure trends in all specialty care service availability and utilization measures. DHS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DHS will implement changes to improve access and monitor select measures accordingly.

# Review Analysis of Behavioral Health Services

## Data Sources

- DHS FFS Claims Data
- DHS FFS Enrollment Data
- Pennsylvania Adult Medicaid CAHPS Survey

## Availability of Behavioral Health Providers

Current availability of behavioral health services will be assessed using the measures presented in Table 10. To be included in these measures, behavioral health providers must have provided a service to a FFS-enrolled beneficiary in the given year or quarter. These measures will be stratified by geography (urban vs. rural counties), site of service (facility vs. non-facility), and provider type. The provider types include psychiatrists and psychologists. In addition, trends of these measures will be presented by annual quarter over the most recent four years, along with the standard deviation and average over the entire four year period.

*Table 10. Availability of Behavioral Health Provider Measures*

| Title | Description | Numerator | Denominator | Exclusions | Source |
|---|---|---|---|---|---|
| **Availability of Psychologists** | Number of behavioral health providers with at least one FFS Medicaid claim per 1,000 enrollees | Number of psychologists with at least one FFS Medicaid claim | Number of thousands of FFS Medicaid enrollees | | DHS FFS Claims Data |
| **Availability of Psychiatrists** | Number of psychiatrists with at least one FFS Medicaid claim per 1,000 enrollees | Number of psychiatrists with at least one FFS Medicaid claim | Number of thousands of FFS Medicaid enrollees | | DHS FFS Claims Data |
| **Availability of Mental Health Outpatient Clinics** | Number of outpatient clinics for mental health with at least one FFS Medicaid claim per 1,000 enrollees | Number of outpatient clinics for mental health with at least one FFS Medicaid claim | Number of thousands of FFS Medicaid enrollees | | DHS FFS Claims Data |
| **Availability of Department of Drug and Alcohol Program Clinics** | Number of DDAP clinics with at least one FFS Medicaid claim per 1,000 enrollees | Number of DDAP clinics with at least one FFS Medicaid claim | Number of thousands of FFS Medicaid enrollees | | DHS FFS Claims Data |

## Utilization Measures

DHS will monitor six utilization measures that indicate access to behavioral health services. The title, description, numerator and denominator definitions, exclusions, and any relevant citations are presented for each measure in Table 11. Each utilization measure will be stratified by geography (urban vs. rural counties) and will be calculated for FFS beneficiaries only. DHS will present both the current utilization for each measure for the most recent year, as well as the quarterly or annual trend over the previous four years (depending on the measure's specifications), including standard deviation and average over the four-year period.

*Table 11. Utilization Measures to Monitor Access to Behavioral Health Services*

| Title | Description | Numerator | Denominator | Exclusions | Source/ Citation |
|---|---|---|---|---|---|
| **Individual psychotherapy with any psychiatrist in an office setting** | Number of enrollees per 100,000 member months who received psychotherapy from a psychiatrist | FFS enrollees who have at least one visit coded as psychotherapy in an office setting by a psychiatrist | Total number of months of FFS Medicaid enrollment during the measurement period. | | DHS FFS Claims Data |
| **Individual psychotherapy with any psychologist in an office setting** | Number of enrollees per 100,000 member months who received psychotherapy from a psychologist | FFS enrollees who have at least one visit coded as psychotherapy in an office setting by a psychologist | Total number of months of FFS Medicaid enrollment during the measurement period. | | DHS FFS Claims Data |
| **Individual psychotherapy in a clinic setting** | Number of enrollees per 100,000 member months who received psychotherapy from an outpatient mental health clinic | FFS enrollees who have at least one visit coded as psychotherapy in an outpatient mental health clinic setting | Total number of months of FFS Medicaid enrollment during the measurement period. | | DHS FFS Claims Data |
| **New psychiatric visit*** | Percent of continuously enrolled adults who have a new service with a psychiatrist | Continuously enrolled FFS Adults ages 18+ who received a service from a psychiatrist | Continuously enrolled adults 18+ enrolled in FFS Medicaid | Patients with a previous visit with a psychiatrist in the last measurement year | DHS FFS Claims Data |
| **Ongoing psychiatric care*** | Percent of continuously enrolled adults with a visit as an established patient with a psychiatrist | Continuously enrolled FFS Adults ages 18+ who have 3 or more services coded as "established patient" with a psychiatrist in a measurement year | Continuously enrolled adults 18+ enrolled in FFS Medicaid | | DHS FFS Claims Data |
| **Initiation of Alcohol and Other Drug Dependence Treatment*** | Initiation of Alcohol and Other Drug Dependence Treatment for adults | Continuously enrolled FFS Adults ages 18+ initiating alcohol or drug dependence treatment | Continuously enrolled adults 18+ enrolled in FFS Medicaid | Existing diagnosis of alcohol or drug dependence | DHS FFS Claims Data<br>NCQA |

** = Annual trend only.*

## Data Relevant to Beneficiary Behavioral Health Needs Being Met

The extent to which beneficiary behavioral health care needs are being met will be measured using the Pennsylvania Sample of the Nationwide Adult Medicaid CAHPS Survey, as discussed on page 7 of this plan. Any CAHPS survey questions that specifically target access to behavioral health care will be reported and analyzed in this plan (e.g. In the past six months, how often was it easy to get the mental health or behavioral health services you needed?).

## Comparative Analysis of Behavioral Health Provider Medicaid and Medicare Payment Rates

DHS compares Medicaid FFS reimbursement rates for behavioral health care services to those of Medicare for Pennsylvania Region 99, "Rest of Pennsylvania." These comparisons are presented in Table 12 for select diagnostic evaluation and psychotherapy procedure codes. A Medicaid-to-Medicare ratio is used to determine how closely Medicaid rates match those of Medicare. A single Medicaid rate per procedure code is compared to the Medicare non-facility and facility-based rates in Pennsylvania, as DHS reimbursement levels for behavioral health services are consistent across sites of service.

The CY 2015 Medicaid-to-Medicare ratio for psychiatrists and behavioral health providers ranged from 0.12 to 1.01.

*Table 12. Comparison of Reimbursement Rates – Psychiatrists and Behavioral Health Providers*

| Procedure Code | Comparable Medicare Procedure Code | Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|---|
| **90832** | **90832** | Psychotherapy, 30 minutes with patient and/or family member | $63.69 | $63.02 | $26.00 | 0.41 | 0.41 |
| **90834** | **90834** | Psychotherapy, 45 minutes with patient and/or family member | $84.34 | $83.68 | $39.00 | 0.46 | 0.47 |
| **90837** | **90837** | Psychotherapy, 60 minutes with patient and/or family member | $126.70 | $126.04 | $52.00 | 0.41 | 0.41 |
| **90846 UB/ UB, U1** | **90846** | Family Psychotherapy (without the patient present) | $102.42 | $101.75 | $13.00 | 0.13 | 0.13 |
| **90847 UB/ UB, U1** | **90847** | Family Psychotherapy (conjoint psychotherapy) w/ patient present | $106.00 | $105.33 | $13.00 | 0.12 | 0.12 |
| **90853 UB/ UB, U1** | **90853** | Group Psychotherapy (other than of a multiple-family group) | $25.49 | $25.16 | $3.50 | 0.14 | 0.14 |
| **90870*** | **90870** | Electroconvulsive therapy | $173.14 | $110.38 | $45.00 | 0.32 | 0.41 |
| **90875** | **90875** | Individual psychophysiological therapy incorporating biofeedback training with psychotherapy; approximately 20-30 minutes | $0.00 | $0.00 | $44.57 | N/A | N/A |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **96101 TG/ TG, U1** | **96101** | Psychological testing, four or more intellectual or personality evaluations | $79.71 | $79.38 | $80.00 | 1.00 | 1.01 |
| **96116** | **96116** | Comprehensive neuropsychological evaluation with personality assessment) | $92.42 | $86.74 | $52.00 | 0.56 | 0.60 |
| **96118** | **96118** | Neuropsychological testing per hour / generally accepted individual measurements for organicity | $96.68 | $78.72 | $40.00 | 0.41 | 0.51 |
| **96127** | **96127** | Brief emotional/behavioral assessment | $5.01 | $5.01 | $4.00 | 0.80 | 0.80 |

*Source: Medicare Physician Fee Schedule; Pennsylvania Medicaid Fee Schedule*
* = Only psychiatrists may bill for the given code

## Recommendations

DHS will continually measure trends in all behavioral health care service availability and utilization measures. DHS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DHS will implement changes to improve access and monitor select measures accordingly.

# Review Analysis of Pre- and Post-Natal Obstetric Services

## Data Sources

- DHS FFS Claims Data
- DHS FFS Enrollment Data

## Availability of Obstetric Services

Current availability of obstetric services will be assessed using the measure presented in Table 13. To be included in this measure, obstetricians must have provided a service to a FFS-enrolled beneficiary in the given year or quarter. This measure will be stratified by geography (urban vs. rural counties), and site of service (facility vs. non-facility). In addition, trends of this measure will be presented by annual quarter over the most recent four years, along with the standard deviation and average over the entire four year period.

*Table 13. Availability of Obstetric Services Measures*

| Title | Description | Numerator | Denominator | Exclusions | Source |
|---|---|---|---|---|---|
| **Availability of Obstetric Care** | Number of obstetricians with at least one FFS Medicaid claim per 1,000 enrollees | Number of obstetricians with at least one FFS Medicaid claim | Number of thousands of female FFS Medicaid enrollees age 15 to 44 | | DHS FFS Claims Data |

## Utilization Measures

DHS will monitor two utilization measures that indicate access to obstetric services. The title, description, numerator and denominator definitions, exclusions, and any relevant citations are presented for each measure in Table 14. Each utilization measure will be stratified by geography (urban vs. rural counties) and will be calculated for FFS beneficiaries only. DHS will present both the current utilization for each measure for the most recent year, as well as the annual trend over the previous four years, including standard deviation and average over the four year period.

*Table 14. Utilization Measures to Monitor Access to Obstetric Services*

| Title | Description | Numerator | Denominator | Exclusions | Source/ Citation |
|---|---|---|---|---|---|
| **Pre-natal visit*** | Any visit to an OB/GYN, family practitioner or other PCP with either an ultrasound or a principal diagnosis of pregnancy 176-280 days prior to delivery | Any FFS-enrolled woman with a visit to an OB/GYN, family practitioner or other PCP with either an ultrasound or a principal diagnosis of pregnancy 176-280 days prior to delivery | FFS women with live births in the given year | Women who are not enrolled in FFS 43 days prior to delivery through 56 days after delivery. | DHS FFS Claims Data<br><br>NCQA |

| Title | Description | Numerator | Denominator | Exclusions | Source/ Citation |
|---|---|---|---|---|---|
| **Post-partum visit*** | The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. | Any FFS-enrolled woman with a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. | FFS women with live births in the given year | Women who are not enrolled in FFS 43 days prior to delivery through 56 days after delivery. | DHS FFS Claims Data<br><br>NCQA |

** = Annual trend only.*

## Comparative Analysis of Obstetrician Medicaid and Medicare Payment Rates

DHS compares Medicaid FFS reimbursement rates for obstetric services to those of Medicare for Pennsylvania Region 99, "Rest of Pennsylvania." Pennsylvania Medicaid pays for maternity care and delivery via a traditional payment arrangement for each visit and the delivery, or via a trimester-based bundle arrangement called "Healthy Beginnings Plus" (HBP). HBP fees are differentiated between basic and high-risk pregnancies. Comparisons presented in Tables 15a include select traditional maternity care and delivery procedure codes. Table 15b includes HBP maternity care and delivery procedure codes, as well as packages of codes that are comparable to what is included in Medicare's reimbursement. For example, 99384 U8, 99384 UB, and 59400 are packaged together to present the total Pennsylvania Medicaid reimbursement for all antenatal, postnatal and vaginal delivery care. This is compared to Medicare's reimbursement for 59400, which includes all three of those elements. For both tables, a Medicaid-to-Medicare ratio is used to determine how closely Medicaid rates match those of Medicare. A single Medicaid rate per procedure code is compared to the Medicare non-facility and facility-based rates in Pennsylvania, as DHS reimbursement levels for obstetric services are consistent across sites of service.

The CY 2015 Medicaid-to-Medicare ratio for obstetricians ranged from 0.65 to 2.73.

*Table 15a. Comparison of Reimbursement Rates – Obstetric Services, Non-Healthy Beginnings Plus*

| Procedure Code | Comparable Medicare Procedure Code | Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|---|
| **59409** | 59409 | Vaginal delivery only (with or without episiotomy and/or forceps) | $837.10 | $837.10 | $1200.00 | 1.43 | 1.43 |
| **59410** | 59410 | Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care | $1,067.04 | $1,067.04 | $1200.00 | 1.12 | 1.12 |
| **59425 U5** | 59425 | Third trimester OB services with delivery at Birth Center | $458.39 | $366.59 | $1,000.00 | 2.18 | 2.73 |
| **59426 U5 AF** | 59426 | Third trimester OB services with delivery at Birth Center (Physician) | $820.35 | $646.10 | $900.00 | 1.10 | 1.39 |

| Procedure Code | Comparable Medicare Procedure Code | Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|---|
| **59426 U5 SB** | 59426 | Third trimester OB services with delivery at Birth Center (Nurse Midwife) | $820.35 | $646.10 | $900.00 | 1.10 | 1.39 |
| **59514** | 59514 | Cesarean delivery only | $940.44 | $940.44 | $1,200.00 | 1.28 | 1.28 |
| **59515 TH** | 59515 | Cesarean delivery only; including postpartum care | $1,289.91 | $1,289.91 | $1,200.00 | 0.93 | 0.93 |
| **59610 TH** | 59610 | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery | $2,225.17 | $2,225.17 | $1,500.00 | 0.67 | 0.67 |
| **59612** | 59612 | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); | $939.90 | $939.90 | $1,500.00 | 1.60 | 1.60 |
| **59614** | 59614 | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care | $1,168.53 | $1,168.53 | $1,500.00 | 1.28 | 1.28 |
| **59618** | 59618 | Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery | $2,378.87 | $2,378.87 | $1,500.00 | 0.63 | 0.63 |
| **59620** | 59620 | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; | $973.38 | $973.38 | $1,500.00 | 1.54 | 1.54 |
| **59622** | 59622 | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care | $1,324.41 | $1,324.41 | $1,500.00 | 1.13 | 1.13 |

*Source: Medicare Physician Fee Schedule; Pennsylvania Medicaid Fee Schedule*

*Table 15b. Comparison of Reimbursement Rates – Obstetric Services, Healthy Beginnings Plus*

| Procedure Code | Comparable Medicare Procedure Code | Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|---|
| **59400 HD** | 59400 | Third trimester basic maternity package with vaginal delivery | $2,122.87 | $2,122.87 | $1,786.00 | 0.84 | 0.84 |
| **59400 U7 HD** | 59400 | Second trimester maternity care package with vaginal delivery | $2,122.87 | $2,122.87 | $2,025.00 | 0.95 | 0.95 |
| **59400 U8 HD** | 59400 | Third trimester high-risk maternity package with vaginal delivery | $2,122.87 | $2,122.87 | $2,076.00 | 0.98 | 0.98 |
| **59410 U9 HD** | 59410 | Third trimester package with early vaginal delivery | $1,067.04 | $1,067.04 | $2,050.00 | 1.92 | 1.92 |
| **59510 HD** | 59510 | Third trimester basic maternity package with cesarean delivery | $2,345.96 | $2,345.96 | $1,786.00 | 0.76 | 0.76 |
| **59510 U7 HD** | 59510 | Second trimester maternity care package with cesarean delivery | $2,345.96 | $2,345.96 | $2,025.00 | 0.86 | 0.86 |
| **59510 U8 HD** | 59510 | Third trimester high-risk maternity package with cesarean delivery | $2,345.96 | $2,345.96 | $2,076.00 | 0.88 | 0.88 |
| **59515 U9 HD** | 59515 | Third trimester early cesarean delivery | $1,289.91 | $1,289.91 | $2,050.00 | 1.59 | 1.59 |
| **59610 U9 HD** | 59610 | Third trimester basic maternity package with vaginal delivery after previous cesarean delivery | $2,225.17 | $2,225.17 | $1,786.00 | 0.80 | 0.80 |
| **59610 TG HD** | 59160 | Third trimester high-risk maternity package with vaginal delivery after previous cesarean delivery | $2,225.17 | $2,225.17 | $2,076.00 | 0.93 | 0.93 |
| **59610 UB HD** | 59610 | Second trimester maternity care package with delivery with vaginal delivery after previous cesarean delivery | $2,225.17 | $2,225.17 | $2,025.00 | 0.91 | 0.91 |

| Procedure Code | Comparable Medicare Procedure Code | Description | 2015 Medicare Nonfac Rate (PA) | 2015 Medicare Fac Rate (PA) | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio Nonfac | Medicaid-to-Medicare Ratio Fac |
|---|---|---|---|---|---|---|---|
| **99384 U8, 99384 UB, 59400** | 59400 | Basic maternity care vaginal delivery ages 12-17: First trimester basic maternity care package + Second trimester basic maternity care package + Third trimester basic maternity care package | $2,122.87 | $2,122.87 | $2,090.00 | 1.08 | 1.08 |
| **99385 U9, 99385 TG, 59510 U8** | 59510 | High risk maternity care cesarean delivery ages 18-39: First trimester high risk maternity care package + Second trimester high risk maternity care + Third trimester high risk maternity care package | $2,345.96 | $2,345.96 | $2,732.00 | 1.08 | 1.08 |
| **99835 U8, 99835 UB, 59400** | 59400 | Basic maternity care vaginal delivery ages 18-39: First trimester basic maternity care package + Second trimester basic maternity care package + Third trimester basic maternity care package | $2,122.87 | $2,122.87 | $2,090.00 | 0.98 | 0.98 |

## Recommendations

DHS will continually measure trends in all obstetric service availability and utilization measures. DHS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DHS will implement changes to improve access and monitor select measures accordingly.

# Review Analysis of Home Health Services

## Data Sources

- DHS FFS Claims Data
- DHS FFS Enrollment Data
- CMS National Direct Service Workforce Resource Center

## Availability of Home Health Services

Home health services in Pennsylvania Medicaid include the following home-based services: nursing services, home health aide services, physical and occupational therapy, speech pathology and audiology, supplies and equipment suitable for home use, and shift care for children. Current availability of home health services will be assessed using the measures presented in Table 16. To be included in these measures, home health providers must have provided a service to a FFS-enrolled beneficiary in the given year or quarter. These measures will be stratified by geography (urban vs. rural counties), but not site of service as all services should have occurred in the home. In addition, trends of these measures will be presented by annual quarter over the most recent four years, along with the standard deviation and average over the entire four-year period.

*Table 16. Availability of Home Health Measures*

| Title | Description | Numerator | Denominator | Exclusions | Source |
|---|---|---|---|---|---|
| **Availability of Home Health Agencies** | Number of Home Health Agencies with at least one FFS claim per 1,000 enrollees | Number of Home Health Agencies with at least one FFS claim Medicaid | Number of thousands of FFS Medicaid enrollees | Services delivered under 1915(C) waivers | DHS FFS Claims Data |
| **Availability of Direct Service Workers** | Percent of all Direct Service Workers (DSWs) employed full-time, by setting and job title | Number of DSWs employed full-time (35 hours or more per week), by setting and job title | Total number of DSWs currently employed in each setting and in each job title | | CMS National Direct Service Workforce Resource Center |

## Utilization Measures

DHS will monitor one utilization measure that indicates access to home health services. This measure broadly includes the utilization of nursing, home health aide, physical/occupational therapy, speech pathology and audiology, supplies and equipment, and shift care services in the home. The title, description, numerator and denominator definitions, exclusions, and any relevant citations are presented for the measure in Table 17. This utilization measure will be stratified by geography (urban vs. rural counties) and will be calculated for FFS beneficiaries only. DHS will present both the current utilization for the measure for the most recent year, as well as the quarterly trend over the previous four years, including standard deviation and average over the four-year period.

*Table 17: Utilization Measures to Monitor Access to Home Health Services*

| Title | Description | Numerator | Denominator | Exclusions | Source/ Citation |
|---|---|---|---|---|---|
| **Home Health Services** | Number of home health services per 100,000 FFS member months | Number of unique FFS home health claims | Total number of months of FFS Medicaid enrollment for enrollees during the measurement period. | Services delivered under 1915(C) waivers | DHS FFS Claims Data |

## Comparative Analysis of Home Health Medicaid and Medicare Payment Rates

DHS compares Medicaid FFS reimbursement rates for home health services to those of Medicare for Region 99, "Rest of Pennsylvania." These comparisons are presented in the Table 18 below for home health aide, physical therapist, occupational therapist, speech-language pathologist, and direct skilled nursing services. It should be noted that Medicare home health rates are based on either episode or per-visit units[12]. The per-visit unit is used and compared to a similar procedure code reimbursed by DHS. A Medicaid-to-Medicare ratio is used to determine how closely Medicaid rates match those of Medicare. The home was the only site of service used for the comparison.

The CY 2015 Medicaid-to-Medicare ratio for home health providers ranged from 0.58 to 0.84.

*Table 18. Comparison of Reimbursement Rates - Home Health Services*

| Procedure Code | Description | 2015 Medicare Per Service Rate | 2015 PA FFS Medicaid Rate | Medicaid-to-Medicare Ratio |
|---|---|---|---|---|
| **G0151** | Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes | $139.75 | $88.00 | 0.63 |
| **G0152** | Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes | $140.70 | $88.00 | 0.63 |
| **G0153** | Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes | $151.88 | $88.00 | 0.58 |
| **G0154 U8** | Direct skilled nursing services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes | $121.10 | $88.00 | 0.73 |
| **G0156 U8** | Services of home health/hospice aide in home health or hospice settings, per visit | $54.84 | $46.00 | 0.84 |

*Source: Medicare Home Health Per Visit Rates[12]; Pennsylvania Medicaid Fee Schedule*

## Recommendations

DHS will continually measure trends in all home health care service availability and utilization measures. DHS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DHS will implement changes to improve access and monitor select measures accordingly.

# Review Analysis of Nursing Facility Services

## Data Sources

- DHS Nursing Facility Information System
- DHS Nursing Facility Assessment System

## Availability of Nursing Facility Services

Nursing facility services are not one of the five basic service categories that are subject to mandatory review under the Access Monitoring Rule. However, the rule requires an additional access review for any service subject to changes in a state plan amendment (SPA) that reduce or restructure Medicaid payment rates. States submitting SPAs as described in 42 C.F.R. §447.203(b)(6) must update their access monitoring review plan within 12 months prior to submitting a SPA and have ongoing monitoring procedures in place for at least three years after the effective date of the SPA.

Since the implementation of the Budget Adjustment Factor (BAF) in SFY 2005-2006, DHS has submitted a BAF SPA on an annual basis, along with information related to compliance with Section 1902(30)(A) of the Social Security Act. In anticipation of submitting an annual BAF SPA, nursing facility services were added to the Pennsylvania access monitoring plan..

Current availability of nursing facility services will be assessed using the measures presented in Table 19. These measures will be stratified by geography (urban vs. rural counties). Site of service is excluded from these measures as all services should occur in the nursing facility. In addition, annual trends over the most recent five years, along with the standard deviation and average over the entire five-year period will be reported.

*Table 19. Availability of Nursing Facility Services Measures*

| Title | Description | Numerator | Denominator | Exclusions | Source |
|---|---|---|---|---|---|
| **Percent Change in Number of MA Nursing Facilities and Number of MA Beds*** | Percent change in number of MA nursing facilities and number of MA beds for past five years for both Urban and Rural^ | Total number of MA nursing facilities in Year 1 | Total number of MA nursing facilities in Year 2 (e.g., 711/699 *100 = -1.7%) | Data encompasses all active MA certified providers for July 1 of each SFY excluding Veterans homes, state-run homes and charity care-only facilities since they generally are not available to most MA recipients | The DHS Nursing Facility Information System (NIS+) |
| | | Total number of MA nursing facility beds in Year 1 | Total number of MA nursing facility beds in Year 2 (e.g., 82,903/82,850*100= -.06%) | | |
| **MA Nursing Facilities as Percent of All Nursing Facilities*** | Percent of MA certified facilities to all nursing facilities and percent of MA beds to all beds for past five years for | Total number of MA nursing facilities | Total number of all nursing facilities (e.g., 699/712 = 98.17%) | Data encompasses all active licensed providers for July 1 of each SFY excluding | The DHS Nursing Facility Assess-ment System |

| Title | Description | Numerator | Denominator | Exclusions | Source |
|---|---|---|---|---|---|
| | both Urban and Rural. | Total number of MA nursing facility beds | Total number of all nursing facility beds (e.g., 82,850/92,500 = 89.56%) | Veterans homes, state-run homes and charity care-only facilities since they generally are not available to most MA recipients | (NAS) |

** = Annual trend only*
*^ = Urban/Rural designation used by Medicare for FFY2016 for all years.*

## Utilization Measures

DHS will monitor two utilization measures that indicate access to nursing facility services. The title, description, numerator and denominator definitions, exclusions, and any relevant sources and citations are presented for each measure in Table 20. Each utilization measure will be stratified by geography (urban vs. rural counties) and will be calculated for FFS beneficiaries only. DHS will present both the current utilization for each measure for the most recent SFY, as well as the annual trend over the previous five years, including standard deviation and average over the five-year period.

*Table 20. Utilization Measures to Monitor Access to Nursing Facility Services*

| Title | Description | Numerator | Denominator | Exclusions | Source/ Citation |
|---|---|---|---|---|---|
| **MA Nursing Facility Overall Occupancy Rate*** | Average occupancy rate for past five years for both Urban and Rural for MA nursing facilities | Total number of annual resident days | Total number of available bed days for a year<br><br>(e.g., 27,821,030/ (82,850 * 365 days) = 90%) | Data encompasses all active MA certified providers at the beginning of a SFY and their reported days for the entire fiscal year. | The DHS Nursing Facility Assess-ment System (NAS) |
| **MA Nursing Facility Occupancy Rate by Payor*** | Average occupancy rate by payor source for past five years for both Urban and Rural for MA nursing facilities | Total number of MA FFS, MA managed care, Medicare and all other residents days | Total number of annual resident days<br><br>(e.g., MA FFS = 55%; LIFE/HC/CHC = 10%; Medicare = 12%; all other = 23%) | Data encompasses all active MA certified providers at the beginning of a SFY and their reported days for the entire SFY. | The DHS Nursing Facility Assess-ment System (NAS) |

** = Annual trend only.*

## Comparative Analysis of Nursing Facility Medicaid and Medicare Payment Rates

DHS compares Medicaid FFS reimbursement rates for nursing facility services to those of Medicare. These comparisons are presented in Table 21 and are based on daily reimbursement rates and are stratified based on urban and rural location. Since each facility receives a specific Medicaid rate, the median was used for the comparison to the median assumed Medicare rate. An assumed facility Medicare rate was calculated for each nursing facility enrolled in Medicaid using Medicare's final payment rates for FFY 2016 (10/01/15 – 9/30/16) under their prospective payment system for skilled nursing facilities using MDS, or minimum dataset, assessments from Pennsylvania's November 1, 2015 Picture Date which is the underlying acuity information used for the Medicaid rates for April 2016. Medicare rates were calculated for each Medicaid resident on a selected day using the Medicare Resource Utilization

Group (RUG-IV) and the rate assigned to the facility for each RUG category for the appropriate time period and divided by total Medicaid residents to generate a facility Medicare rate. A Medicaid-to-Medicare ratio is used to determine how closely Medicaid rates match those of Medicare.

The Medicaid-to-Medicare ratio for nursing facilities was 0.58 in rural counties in Pennsylvania, and 0.60 in urban counties.

*Table 21. Comparison of Reimbursement Rates - Nursing Facilities*

| Geographic Location | FFS 2016 Medicare Median Per Diem (PA) | April 2016 PA Medicaid Median Per Diem | Medicaid-to-Medicare Ratio |
|---|---|---|---|
| **Urban** | $329.24 | $198.96 | 0.60 |
| **Rural** | $304.20 | $176.71 | 0.58 |

*Source: Pennsylvania Department of Human Services*

## Recommendations

DHS will continually measure trends in all nursing facility service availability and utilization measures. DHS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DHS will implement changes to improve access and monitor select measures accordingly.

# Appendix A – Specialty Categories

| Specialty | Notes |
|---|---|
| **Allergy & Immunology** | |
| **Anesthesiology** | Includes Critical Care Medicine and Pain Management |
| **Dermatology** | |
| **Emergency Medicine** | Includes Sports Medicine |
| **Surgery** | Includes Cardiovascular, Colon and Rectal, General, Neurological, Pediatric, Hand, Critical Care, Thoracic, and Vascular Surgeons |
| **Internal Medicine** | Includes Adolescent Medicine, Cardiovascular Disease, Immunology, Cardiac Electrophysiology, Endocrinology, Gastroenterology, Geriatric Medicine, Hematology/Oncology, Infectious Disease, Interventional Cardiology, Nephrology, Proctology, Pulmonary Disease, and Rheumatology |
| **Ophthalmologist** | |
| **Orthopedic Surgery** | |
| **Otolaryngology** | |
| **Pathology** | |
| **Physical Medicine & Rehabilitation** | |
| **Plastic Surgery** | |
| **Neurology** | |
| **Radiology** | |
| **Preventive Medicine** | |
| **Urology** | |

# References


1. CMS. *Medicaid & CHIP: December 2015 Monthly Applications, Eligibility Determinations and Enrollment Report.* 2016.
2. Kaiser Family Foundation. Total Medicaid Spending. 2016; http://kff.org/medicaid/state-indicator/total-medicaid-spending/. Accessed March 31, 2016.
3. Pennsylvania Health Care Cost Containment Council. *Financial Analysis 2014 - Volume One: General Acute Care Hospitals.* 2015.
4. HRSA. Defining Rural Population. 2016; http://www.hrsa.gov/ruralhealth/aboutus/definition.html. Accessed March 29, 2016.
5. The Pennsylvania Department of Human Services. Monthly Physical Health Managed Care Program Enrollment Report - January 2016. 2016; http://www.dhs.pa.gov/cs/groups/webcontent/documents/presentation/c_222674.pdf. Accessed March 29, 2016.
6. Pennsylvania Department of Human Services. *December 2015 Pennsylvania Medicaid Enrollment Data.* 2016.
7. The Pennsylvania Department of Human Services. Health Insurance Premium Payment (HIPP) Program. 2016; http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm#.VvlibOIrKUk Accessed March 29, 2016.
8. The Pennsylvania Department of Human Services. LIFE (Living Independence for the Elderly). 2016; http://www.dhs.pa.gov/citizens/alternativestonursinghomes/lifelivingindependencefortheelderly/#.Vv1ivfkrKUl. Accessed March 29, 2016.
9. The Pennsylvania Department of Human Services. *Section 1915(b) Waiver Proposal For MCO, PIHP Programs And FFS Selective Contracting Programs.* 2014.
10. The Pennsylvania Department of Human Services. Pennsylvania's Community HealthChoices Program Concept Paper. 2016; http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_209847.pdf. Accessed March 31, 2016.
11. National Opinion Research Center. *Methodology Report: 2014-2015 Nationwide Adult Medicaid CAHPS Survey.* 2016.
12. CMS. *Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2015.* 2015.