Access Monitoring Review Plan for the State of Maryland

Draft for Public Comment—August 5, 2016

Access Monitoring Review Plan

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Access Monitoring Review Plan

Introduction

The Social Security Act requires state Medicaid programs to assure that payments to providers are "sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area."[1] The Centers for Medicare & Medicaid Services (CMS) refers to this standard as the "access requirement." In November 2015, CMS issued a final rule on the *Medicaid Program: Methods for Assuring Access to Covered Medicaid Services*,[2] which requires states to develop an access monitoring review plan for services provided through their Medicaid fee-for-service (FFS) delivery systems to monitor compliance with this access requirement. Originally, the deadline for submitting the first access monitoring review plan was July 1, 2016. However, in April 2016, CMS issued a rule, *Medicaid Program: Deadline for Access Monitoring Review Plan Submissions*, which changed the deadline to October 1, 2016.[3] The regulation requires states to monitor the following service categories:

- Primary care
- Physician specialist services
- Behavioral health services
- Pre- and post-natal obstetric services
- Home health services

The Maryland Department of Health and Mental Hygiene (DHMH) presents this report to CMS as Maryland's first submission of the access monitoring review plan. This report first provides an overview of the Maryland Medicaid program and descriptive characteristics of the FFS population. This overview is followed by a comparative analysis of Maryland's FFS Medicaid payment rates with other states and payers. Finally, the report presents metrics for each of the five required service categories (primary care, specialist, behavioral health, pre- and post-natal, and home health) as appropriate to Maryland. In accordance with the regulation, this report was posted on Maryland's website for public comment following an announcement in the Maryland Register from August 5 to September 5, 2016.[4] See Appendix I for a summary of the comments received.

Overview of Maryland Medicaid

As of June 2016, Maryland Medicaid covered nearly 1.3 million individuals, roughly 21 percent of the state's population. The majority (85 percent) of Maryland Medicaid participants are enrolled in HealthChoice, Maryland's statewide mandatory Medicaid managed care program, which was implemented in 1997 under authority of Section 1115 of the Social Security Act.

[1] 42 USC §1396a(a)(30).
[2] See https://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27697.pdf.
[3] See https://www.gpo.gov/fdsys/pkg/FR-2016-04-12/pdf/2016-08368.pdf.
[4] See https://mmcp.dhmh.maryland.gov/Pages/Fee-For-Service-Access-Monitoring-Review-Plan.aspx.

Participants in the HealthChoice program include children enrolled in the Maryland Children's Health Program (MCHP). HealthChoice participants can choose one of eight managed care organizations (MCOs) and a primary care provider (PCP) from their MCO's network to oversee their medical care. The HealthChoice MCO program includes the following coverage groups:

- Families with low income that have children
- Families that receive Temporary Assistance for Needy Families (TANF)
- Children younger than 19 years who are eligible for MCHP
- Children in foster care and, starting in calendar year (CY) 2014, individuals up to age 26 who were previously enrolled in foster care
- Adults through age 64 years with incomes up to 138 percent of the federal poverty level (FPL), starting in CY 2014
- Women who are pregnant or less than 60 days postpartum with incomes up to 250 percent of the FPL
- Individuals receiving Supplemental Security Income (SSI) who are younger than 65 years and not eligible for Medicare

Each year, DHMH, in partnership with The Hilltop Institute, conducts an annual evaluation of the HealthChoice program for stakeholders and focuses on measures of access and quality of care. The most recent evaluation was completed in April 2016.[5]

Only a small portion of Maryland's Medicaid population is enrolled in FFS coverage. Maryland's FFS-only population is limited to the following coverage groups:

- Individuals who are dually eligible for Medicare and Medicaid
- Individuals in a "spend-down" eligibility group who are only eligible for Medicaid for a limited period of time
- Women in the Breast and Cervical Cancer Health Program[6]
- Individuals who reside in an intermediate care facility for intellectual disabilities
- Individuals enrolled in the Model Waiver or the Employed Individuals with Disabilities Program
- Individuals in long-term care facilities
- Individuals in the Rare and Expensive Case Management (REM) program, which covers individuals with a specified list of rare diseases who would otherwise be eligible for HealthChoice MCO enrollment

[5] Evaluation of the HealthChoice Program CY 2010 to CY 2014. https://mmcp.dhmh.maryland.gov/Documents/HealthChoice%20Evaluation%20CY%202010%20-%20CY%202014%20updated.pdf.

[6] There have been no new participants in this program since December 31, 2013. As of June 2016, 177 women were enrolled in the program.

- Undocumented immigrants who are only eligible for emergency services
- Individuals enrolled in the Family Planning Program who are only eligible for family planning services

Individuals eligible for mandatory MCO enrollment through the HealthChoice Program may have a short FFS eligibility period while they are selecting their MCO. Individuals in this group are excluded from this report. Both MCO and FFS participants in Maryland receive comprehensive health care benefits, including, but not limited to:

- Inpatient and outpatient hospital care
- Physician care
- Federally qualified health center (FQHC) or other clinic services
- Laboratory and x-ray services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children
- Prescription drugs
- Behavioral health services
- Durable medical equipment and disposable medical supplies
- Home health care
- Vision services, including eyeglasses for children under EPSDT
- Dialysis
- Long-term care services
- Dental care for children, pregnant women, and adults in the REM program
- Physical therapy
- Community-based occupational, speech, and audiology for children and adults in the REM program

Certain services are covered on a FFS basis for both MCO and FFS participants, including dental benefits for children, pregnant women, and REM adults , substance use disorder treatment, and specialty mental health services.

Following significant public input over four years, DHMH has implemented an administrative services organization (ASO) model to serve as the hub for the provision of publicly-funded behavioral health services in Maryland. Beacon Health Options (formerly ValueOptions Maryland) was selected as the ASO. On January 1, 2015, the ASO integrated substance use treatment and specialty mental health services into one comprehensive system that includes claims, billing, authorization, and referral services for individuals seeking behavioral health care. Previously, only specialty mental health care services were carved out of the MCO benefit package and managed by an ASO.

DHMH also implemented an ASO for dental benefits for children under the age of 21 years, pregnant women, and REM adults. On January 1, 2016, Scion Dental began administering the Maryland Healthy Smiles Dental Program. The dental ASO is responsible for outreach to providers and participants, expanding the provider network, enrolling providers, claims adjudication, pre-authorizing dental services, referral services for participants seeking dental care, and assigning participants to a dental home.

Participant Population

This access monitoring review plan focuses on the Medicaid participants enrolled in Maryland's FFS delivery system. The following partial benefit FFS populations are excluded from this report: partial Medicare-Medicaid dually eligible participants,[7] individuals enrolled in the Family Planning program that are eligible for family planning services only, and undocumented immigrants who are eligible for emergency services only.

[7] Individuals who are dually eligible for both Medicare and Medicaid fall into two categories: (1) full benefit dual eligibles ("full duals") and (2) partial benefit dual eligibles ("partial duals"). Full duals qualify for full Medicaid benefits, which include services not traditionally covered by Medicare. Maryland's partial duals are not eligible for full Medicaid benefits; instead, they receive assistance with Medicare premiums and cost-sharing through Maryland's Medicare Savings Program (MSP). Examples of partial dual eligibles include Qualified Medicare Beneficiaries (QMBs) and Specified Low Income Medicare Beneficiaries (SLMBs).

Table 1 presents enrollment for full-benefit Medicaid FFS participants for CY 2012 through CY 2015 by the participants' last coverage group in the year. Participants are grouped into the following categories: REM, full Medicare-Medicaid dually eligible participants, and all other FFS groups. The majority of the full-benefit FFS-only population was full duals, accounting for nearly 90 percent in CY 2015. Because duals receive many of their healthcare services with Medicare as the primary payer, they will be excluded from any analyses in this report for services where Medicare is the primary payer. Medicaid participants receiving FFS while waiting to enroll in a MCO were also excluded.

Table 1. Number of Full-Benefit FFS Participants by Coverage Group, CY 2012-CY 2015

	CY 2012		CY 2013		CY 2014		CY 2015	
Coverage Group	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
REM	3,876	4.0%	3,995	4.1%	4,069	4.1%	4,161	4.2%
Full Dual	82,919	85.8%	85,795	87.2%	88,264	88.2%	88,896	88.8%
Other FFS Group	9,866	10.2%	8,654	8.8%	7,719	7.7%	7,050	7.0%
Total	**96,661**	**100%**	**98,444**	**100%**	**100,052**	**100%**	**100,107**	**100%**

Table 2 shows the demographic characteristics of the participants included above in Table 1. The majority of participants are either black or white, over the age of 65 years, female, and live in the Baltimore and Washington, D.C., metro areas.

Table 2. Demographic Characteristics of Full-Benefit FFS Participants, CY 2012-CY 2015

	CY 2012	CY 2013	CY 2014	CY 2015
Race/Ethnicity				
Asian	7.3%	7.6%	7.7%	7.9%
Black	39.2%	39.3%	39.3%	39.2%
White	40.2%	39.3%	38.5%	37.9%
Hispanic	3.9%	4.1%	4.2%	4.3%
Other	9.4%	9.7%	10.3%	10.8%
Total	**100%**	**100%**	**100%**	**100%**
Sex				
Female	60.9%	61.0%	60.6%	60.4%
Male	39.1%	39.0%	39.4%	39.7%
Total	**100%**	**100%**	**100%**	**100%**
Region				
Baltimore City	22.2%	21.8%	21.6%	21.3%
Baltimore Suburban	28.0%	28.1%	27.9%	27.8%
Eastern Shore	9.0%	8.9%	8.9%	8.6%
Southern Maryland	4.3%	4.2%	4.2%	4.3%
Washington Suburban	27.1%	27.5%	28.0%	28.5%
Western Maryland	9.1%	9.1%	9.0%	9.0%
Out-of-State	0.4%	0.4%	0.4%	0.4%
Total	**100%**	**100%**	**100%**	**100%**
Age Group (Years)				
0-18	3.6%	3.5%	3.5%	3.5%
19 -64	43.5%	42.9%	42.8%	41.5%
65+	53.0%	53.6%	53.8%	55.0%
Total	**100%**	**100%**	**100%**	**100%**

Access Concerns Raised by Participants

Maryland Medicaid participants have several options for expressing concerns about access to care. DHMH maintains hotlines to address consumer calls about accessibility, including a dedicated hotline for FFS participants and the HealthChoice hotline for members enrolled in MCOs. Dedicated program staff also respond to calls from FFS providers, such as hospitals, FQHCs, and individual practitioners. Separate hotlines are also maintained for users of dental and behavioral health services. Consumers may also request a fair hearing after a claim for a service has been denied. Additionally, monthly meetings of the Maryland Medicaid Advisory Committee (MMAC) provide another venue for consumers to share their access concerns.

Both the FFS and HealthChoice hotlines identify and track complaints in real time. Both hotlines are accessible by a toll-free number (written on the back of each participant's Medical Assistance cards) and staffed by operators who log complaints regarding access to care. After logging,

complaints are addressed as they are raised and supplemented by a grievance and appeal process to safeguard identification and remediation of access to care issues faced by participants. In cases where a FFS participant errantly contacts the HealthChoice hotline, hotline staff work to resolve the consumer's issue without transferring the call to the FFS line.

During the six month period from January 1, 2016, through June 30, 2016, the FFS hotline answered 18,000 calls: 47 percent of the calls were about billing concerns; 29 percent of the calls pertained to eligibility status; and 14 percent were from participants requesting a duplicate benefits card. Ten percent of the calls were from patients needing assistance in searching for a FFS provider. Since the launch of the behavioral health ASO model, Beacon Health Options has maintained its own hotline to address participant concerns and complaints regarding access to care. In May 2016, the ASO fielded approximately 15,000 calls. Call codes include specific designations for emergency, clinical, and customer service. Clinical calls from providers seeking authorization for services account for the majority (75 percent) of hotline use, while customer service calls account for about 18 percent.

Beacon Health Options also distributes an annual survey to measure satisfaction with care, access, and quality. In 2015, 85 percent of survey respondents reported agreement or strong agreement with the statement, "Overall, I am satisfied with the mental health services I received." Additionally, under its contract with Beacon Health Options, DHMH may request a corrective action plan (CAP) to address vendor performance issues. The CAP must include background information; a problem statement; findings and root cause descriptions; corrective actions and implementation dates; and a chart detailing the correction, level of urgency, timeline, damage assessment, and estimated cost per day. The CAP is delivered within three business days of DHMH's request. DHMH requested a CAP for information technology in March 2015 and for compliance in October 2015.

Scion Dental has a dental hotline that provides support to both providers and participants. Since January 1, 2016, Scion has answered approximately 42,000 calls; participants account for approximately 76 percent of all calls and providers account for approximately 24 percent. The average call duration for providers is 5 minutes and 45 seconds, with an average wait time of approximately 8 seconds. The average call duration for participants is 5 minutes and 30 seconds, with an average wait time of approximately 11 seconds. The majority of the provider calls were related to claims inquires (i.e., pre-authorization status, status of a claim, claim submission process, etc.), while the majority of the participant calls were to request materials (i.e., new Medicaid cards, benefits packets, etc.) and assistance in finding a provider.

Medicaid participants are also able to express access concerns through the request for a fair hearing after a claim for a service has been denied. Medicaid participants are entitled to a fair hearing if the participant asserts that the claim for a service has been erroneously denied or not acted upon with reasonable promptness.[8] Medicaid must provide participants with a notice informing them of their right to request a hearing.[9] A Medicaid participant must request a hearing within 90 days of receipt of the notice.[10] Both the participant and Medicaid will have the

[8] COMAR 10.01.04.02(A)(4).
[9] COMAR 10.01.04.03.
[10] COMAR 10.01.04.04(D)(1).

opportunity to present witnesses, evidence, written and oral arguments, and refute any testimony or evidence.[11] An administrative law judge will preside over the fair hearing and issue a decision within 90 days of receiving a request for a fair hearing.[12] Either party may seek administrative review of the administrative law judge's decision.[13] If the decision is favorable to the Medicaid participant, then Medicaid must correct payments or relief retroactive to the date in which the claim was denied.[14]

Finally, DHMH convenes the MMAC every month. The MMAC consists of 28 members representing consumers and advocates for the Medicaid population, senators and delegates from the Maryland General Assembly, providers who are familiar with the medical needs of low-income population groups, hospital representatives, and representatives of the Maryland Health Care Commission and the Maryland Association of County Health Officers. Among other things, the MMAC serves as a forum for addressing participant concerns through a designated opportunity for public comment at each meeting.

Participant Perceptions of Access to Care

In Maryland, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are only administered to managed care participants. Therefore, CAHPS survey results are unavailable for the FFS-only population for this report.[15] However, CMS recently commissioned a national adult CAHPS survey that includes the FFS and full dually eligible populations. Maryland participated in this survey and the results are forthcoming.[16] A total of 6,563 adult Medicaid participants were sampled from Maryland: 1,629 were fully dually eligible for Medicare and Medicaid; 1,407 were persons with disabilities; 2,022 were enrolled in managed care; and 1,505 were enrolled in FFS Medicaid.

Comparison Analysis of Medicaid Payment Rates

One of the CMS requirements for the access monitoring review plan is to compare Medicaid reimbursement rates with those of other payers. Maryland is the only state in the country with an all-payer hospital rate-setting system. Under this system, the Maryland Health Services Cost Review Commission (HSCRC) has set the hospital rates for all payers—including Medicare and Medicaid—since 1977 through a waiver with CMS. All payers including public programs pay the same rates for hospital services; thus Maryland's Medicaid FFS hospital rates are comparable to other payers.

In addition to this hospital rate regulation, Maryland agencies also perform annual analyses comparing professional service payment rates. Since 2001, the Maryland General Assembly has

[11] COMAR 10.01.04.06)A).
[12] COMAR 10.01.04.08.
[13] COMAR 10.01.04.08(C).
[14] COMAR 10.01.04.08(D).
[15] For information on the managed care CAHPS survey in Maryland, see https://mmcp.dhmh.maryland.gov/healthchoice/Documents/2015%20Adult%20and%20Child%20CAHPS%20Executive%20Summary.pdf.
[16] For more information on this initiative, see http://www.norc.org/Research/Projects/Pages/nationwide-adult-medicaid-cahps.aspx.

required DHMH to submit an annual report that, among other things, compares Maryland's Medicaid professional reimbursement rates with those of Medicare and other states.[17] The findings from this annual report have resulted in several fee increases over the years to make Medicaid more comparable to Medicare. The Maryland Health Care Commission (MHCC), which maintains the Medical Care Database (MCDB), Maryland's all-payer claims database, also performs analyses comparing commercial professional fees in the state with Medicare and Medicaid fees. Their studies have found that commercial payment rates for professional services are approximately 94 percent of what Medicare would have paid for a similar set of services, and the overall commercial insurance to Medicaid payment ratio for 2013 was 1.08.

For purposes of this access monitoring review plan, DHMH built upon its existing physician fee report to include a comparison analysis between Maryland commercial payers and Medicaid. Commercial payer data were obtained from the MCDB.[18] DHMH selected an array of current procedural terminology (CPT) codes from the most frequently used specialists as outlined in the section below titled "Analysis of Physician Specialists." The analysis used claims for services that were completed in CY 2014 by residents of Maryland and included claims reported by payers from the individual market, the large group market, the small group market, private and public employee sponsored plans, and individual and small business options offered through the Maryland Health Benefit Exchange. The analysis excluded claims from payers where payment amounts are imputed. Any payment amounts that were less than zero dollars, or any values that were less than the 5th percentile or greater than the 95th percentile for the average payment amount of a specific CPT code were excluded from the analysis.

Medicaid and Medicare professional fees from Maryland and surrounding states are also available for the comparison analysis and presented in Table 3. These data were derived from the annual Medicaid payment report described above, [19] which includes the Medicaid physician fees from Delaware, Pennsylvania, Virginia, West Virginia, and Washington, D.C., based on the current physician fee schedules from the states' websites.

Table 3 presents the average Maryland commercial professional fees for CY 2014, the Maryland Medicare and Medicaid fee schedule for fiscal year (FY) 2015, as well as the fee schedules from other surrounding states for select CPT codes. The table also presents the percent difference between the average Maryland commercial payment and the Medicaid non-facility charge, as well as the percent difference between the Medicaid and Medicare non-facility charged for Maryland.

The payment and fee schedule for evaluation and management codes were similar between Medicaid and commercial payers, with a percent difference ranging from 1.3 to 5.8 percent, with Medicaid being slightly higher than commercial. A limited number of procedures had larger variation. In general, Maryland Medicaid pays for psychiatric services at a rate comparable to Medicare.

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[17] . See https://mmcp.dhmh.maryland.gov/Documents/physicianfeeJCRfinal1-16.pdf for Maryland's most recent report.

[18] Additional information on the MCDB can be found at http://mhcc.maryland.gov/mhcc/pages/apcd/apcd/apcd.aspx

[19] Maryland Department of Health and Mental Hygiene (2016, January). Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Reimbursement Rates. Retrieved from https://mmcp.dhmh.maryland.gov/Documents/physicianfeeJCRfinal1-16.pdf.

Table 3. Comparison of Maryland Medicaid, Other States, Medicare, and Commercial Payments for Select CPT Codes, 2014[20]

Procedure Code	Description	MD Commercial	MD Medicaid NF	MD Medicaid FA	Medicare NF	Medicare FA	DE	VA NF	WV NF	WV FA	PA	DC
Evaluation and Management												
99203	Office/outpatient visit, new	$104	$107	$75	$117	$82	$110	$73	$75	$55	$54	$98
99204	Office/outpatient visit, new	$153	$162	$127	$177	$139	$166	$112	$115	$93	$90	$149
99212	Office/outpatient visit, established	$41	$43	$25	$47	$27	$44	$30	$29	$18	$26	$40
99213	Office/outpatient visit, established	$69	$71	$49	$78	$54	$73	$49	$50	$36	$35	$66
99214	Office/outpatient visit, established	$105	$106	$76	$116	$83	$109	$73	$74	$56	$54	$97
Radiology												
71010	Chest x-ray	$12	$20	$20	$24	$24	$23	$19	$15	$15	$19	$22
71020	Chest x-ray	$25	$26	$26	$30	$30	$28	$24	$18	$18	$25	$29
Cardiovascular Medicine												
93000	Electrocardiogram complete	$28	$18	$18	$19	$19	$17	$15	$12	$12	$19	$15
93010	Electrocardiogram report	$13	$6	$6	$9	$9	$9	$7	$6	$6	$8	$8
92012	Eye exam, established patient	$59	$53	$32	$92	$56	$86	$74	$57	$37	$29	$80

[20] NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Description	MD Commercial	MD Medicaid NF	MD Medicaid FA	Medicare NF	Medicare FA	DE	VA NF	WV NF	WV FA	PA	DC
92014	Eye exam & treatment	$75	$77	$50	$133	$85	$125	$107	$83	$56	$45	$115
Neurology												
95819	EEG, awake and asleep	$235	$167	$167	$452	$452	$416	$354	$259	$259	$23	$385
95886	Musc test done w/n test comp	$117	$48	$48	$99	$99	$92	$79	$89	$89	$66	$85
Oncology												
96413	Chemo, IV infusion, 1 hr	$200	$126	$126	$149	$149	$137	$117	$85	$85	$125	$127
96415	Chemo, IV infusion, addl hr	$61	$28	$28	$31	$31	$28	$24	$18	$18	$28	$26
Urology												
51798	Ultrasound urine capacity measurement	$22	$16	$16	$21	$21	$19	$16	$12	$12	$14	$0
52000	Cystoscopy	$164	$163	$94	$223	$138	$130	$178	$140	$92	$75	$186
General Surgery												
11042	Debride skin/tissue	$88	$54	$35	$128	$67	$119	$102	$78	$44	$33	$108
10060	Drainage of skin abscess	$128	$74	$66	$128	$106	$119	$102	$79	$67	$24	$107
Podiatry												
11721	Debride nail, 6 or more	$32	$31	$21	$48	$26	$45	$39	$31	$18	$20	$41

Procedure Code	Description	MD Commercial	MD Medicaid NF	MD Medicaid FA	Medicare NF	Medicare FA	DE	VA NF	WV NF	WV FA	PA	DC
17250	Chemical cautery, tissue	$75	$54	$26	$87	$40	$81	$69	$52	$26	$26	$74
90791	Psy dx evaluation (no medical)	N/A	$147	$147	$137	$133	$131	$113	$94	$91	$26	$116
90792	Psy dx evaluation (with medical)	N/A	$147	$147	$154	$149	$147	$126	$104	$101	$75	$125
90832	Psytx, pt &/ family 30 minutes	N/A	$48	$48	$67	$66	$64	$55	$47	$47	$26	$56
90833	Psytx pt &/fam w/ E&M 30 min	N/A	$48	$48	$69	$68	$66	$56	$48	$48	N/A	$57
90834	Psytx, pt &/ family 45 minutes	N/A	$88	$88	$88	$88	$84	$73	$62	$61	$39	$74
90837	Psytx, pt &/ family 60 minutes	N/A	$98	$98	$133	$132	$127	$109	$91	$91	$52	$111
90847	Family psytx w/ patient	N/A	$92	$87	$111	$111	$107	$92	$77	$77	$13	$92

Analysis of Primary Care Services

Data Sources

The primary data source for this and subsequent sections of the report is the Maryland Medicaid Management Information System (MMIS), which contains all of Maryland's FFS claims, MCO encounters, eligibility/enrollment, and provider information. The utilization measures presented in this report were prepared using MMIS data collected through the summer of 2016. Providers have 12 months to submit claims. Therefore, MMIS data are not considered completed until 12 months have passed for submission of FFS claims. To accommodate this claims run-out period, this report only presents utilization data for CY 2012 through CY 2014. Data from CY 2015 are only included in analyses focusing on enrollment and identifying FFS providers.

Availability of Primary Care Providers

PCPs were defined using Maryland's regulatory definition that any of the following can serve as a PCP: general practitioner, family practitioner, internist, pediatrician, OB/GYN, nurse practitioner, physician assistant, or certified midwife.[21] The provider's specialty was identified using the specialty code included in the MMIS provider files. Behavioral health provider specialties included social work, psychiatry, drug counseling, and mental health. In addition to these behavioral health specialty types, behavioral health providers belong to a variety of professional classes including physicians, nurses, and therapists and will provide services within different settings (e.g., mental health clinics, psychiatric rehabilitation service facilities).

Table 4 presents the total number of enrolled providers who had at least one FFS claim with a participant during CY 2012 through CY 2015. The number of providers offering services to FFS participants increased across the measurement period. The general distribution of provider types remained relatively stable; PCPs represented the largest group of providers. The data from CY 2015 should be considered preliminary; not all billing and utilization data from CY 2015 have been received and processed at this time. Additional providers may have submitted at least one FFS claim during CY 2015.

[21] COMAR 10.09.66.05.

Table 4. Percentage of Providers with at Least One FFS Claim by Specialty Type, CY 2012- CY 2015

	CY 2012		CY 2013		CY 2014		CY 2015	
Specialty Type	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Behavioral Health	1,643	6.1%	1,735	6.2%	1,806	6.2%	2,170	6.4%
Primary Care Non-Physician	582	2.1%	705	2.5%	922	3.2%	1,445	4.2%
PCP	8,173	30.1%	8,294	29.9%	8,665	30.0%	10,091	29.5%
Specialist	5,644	20.8%	5,696	20.5%	5,968	20.7%	6,749	19.8%
Other	6,780	25.0%	6,911	24.9%	6,965	24.1%	9,153	26.8%
Unknown	4,310	15.9%	4,426	15.9%	4,573	15.8%	4,562	13.4%
Total	**27,132**	**100%**	**27,767**	**100%**	**28,899**	**100%**	**34,170**	**100%**

Ratio of PCPs to Participants

The ratio of PCPs to FFS participants was estimated using the number of FFS providers who were classified as PCPs based on COMAR guidelines and billed for at least one service during the CY 2015. The FFS Medicaid program in Maryland does not have specific network adequacy requirements, and the selection of a PCP is not mandatory for participants. Maryland Medicaid MCOs, however, are required to have a ratio of 1 PCP to every 200 participants within each local access area in the state. Because some PCPs traditionally serve a high volume of participants at some of their sites, the regulations permit DHMH to approve a ratio of 2,000 adults and 1,500 children per high-volume provider.[22] For purposes of this report, DHMH is using the MCO requirement as the benchmark for the FFS program.

Table 5 presents two capacity estimates: 200 participants per PCP office and 500 participants per PCP office. Based on a standard participant-to-PCP ratio of 200:1, provider networks in the counties are more than adequate. There are limitations to this analysis, however. There may be additional providers who are eligible to offer PCP services, but did not bill for any services during CY 2015. Medicaid participants enrolled in MCOs may also receive services from these same providers, reducing the provider's capacity to serve the FFS population. Lastly, participants residing in Prince George's County may receive care from PCPs located in Washington, D.C., and these out-of-state providers are not included in the analysis.

[22] COMAR 10.09.66.05(B)(7)(d).

Table 5. Primary Care Capacity by County for Full-Benefit FFS Participants with Any Period of Enrollment, CY 2015

	Total PCP Providers			Enrollment	Excess Capacity	
County	**CY 2015**	**Multiplied by 200**	**Multiplied by 500**	**CY 2015**	**Difference 200:1 Ratio**	**Difference 500:1 Ratio**
Allegany	136	27,200	68,000	141	27,059	67,859
Anne Arundel	774	154,800	387,000	642	154,158	386,358
Baltimore City	2,849	569,800	1,424,500	2,543	567,257	1,421,957
Baltimore County	1,412	282,400	706,000	1,517	280,883	704,483
Calvert	121	24,200	60,500	160	24,040	60,340
Caroline	11	2,200	5,500	90	2,110	5,410
Carroll	202	40,400	101,000	168	40,232	100,832
Cecil	122	24,400	61,000	113	24,287	60,887
Charles	126	25,200	63,000	201	24,999	62,799
Dorchester	22	4,400	11,000	74	4,326	10,926
Frederick	291	58,200	145,500	296	57,904	145,204
Garrett	30	6,000	15,000	47	5,953	14,953
Harford	257	51,400	128,500	259	51,141	128,241
Howard	389	77,800	194,500	470	77,330	194,030
Kent	29	5,800	14,500	31	5,769	14,469
Montgomery	1,407	281,400	703,500	1,795	279,605	701,705
Prince George's	824	164,800	412,000	1,807	162,993	410,193
Queen Anne's	34	6,800	17,000	47	6,753	16,953
Somerset	11	2,200	5,500	48	2,152	5,452
St. Mary's	110	22,000	55,000	127	21,873	54,873
Talbot	107	21,400	53,500	67	21,333	53,433
Washington	223	44,600	111,500	242	44,358	111,258
Wicomico	210	42,000	105,000	220	41,780	104,780
Worcester	92	18,400	46,000	70	18,330	45,930
Total (in MD)	**9,789**	**1,957,800**	**4,894,500**	**11,175**	**1,946,625**	**4,883,325**

Utilization Data

Ambulatory Care Visits, Emergency Department Visits, and Inpatient Admissions

The following table presents the number and percentage of full-benefit FFS participants with an ambulatory care visit, an emergency department (ED) visit, and an inpatient admission between CY 2012 and CY 2014. The table excludes full dual eligibles because Medicare is the primary payer for these services. An ambulatory care visit is defined as a contact with a doctor or nurse practitioner in a clinic, physician's office, or hospital outpatient department at any time during the measurement year. This measure includes ambulatory care visits related to mental health[23] and substance use disorders.[24] This definition excludes ED visits, hospital inpatient services, home health, x-ray, and laboratory services.

The ambulatory care visit rate increased from 67.2 percent in CY 2012 to 69.7 percent in CY 2014, and the ED visit rate increased by 2.2 percentage points during the same time period. The rate of participants with at least one inpatient admission, on the other hand, decreased substantially by 10.5 percentage points, from 34.4 percent in CY 2012 to 23.9 percent in CY 2014. This is consistent with downward trends in inpatient utilization observed across the entire Medicaid program.

Table 6. Percentage of Full-Benefit FFS Medicaid Participants with an Ambulatory Care Visit, Outpatient ED Visit, or Inpatient Admission, CY 2012- CY 2014

	CY 2012		CY 2013		CY 2014	
Ambulatory Care Visit	**#**	**%**	**#**	**%**	**#**	**%**
Participants with at least 1 ambulatory care visits	9,233	67.2%	8,655	68.4%	8,219	69.7%
Total	**13,742**	**100%**	**12,649**	**100%**	**11,788**	**100%**
ED Visit						
Participants with at least 1 ED visit	3,811	27.7%	3,595	28.4%	3,472	29.5%
Total	**13,742**	**100%**	**12,649**	**100%**	**11,788**	**100%**
Inpatient Admissions						
Participants with at least 1 Inpatient Admission	4,327	31.5%	3,915	31.0%	2,814	23.9%
Total	**13,742**	**100%**	**12,649**	**100%**	**11,788**	**100%**

Analysis of Physician Specialists

Physician specialists were defined as physicians who had at least one FFS claim submitted during the calendar year and were not identified as primary care or behavioral health providers. The analysis focused on the 10 most common specialist provider types: anesthesiology, radiology, surgery, ophthalmology, podiatry, cardiovascular disease, neurology, oncology,

[23] See page 294 of the Healthcare Effectiveness Data and Information Set (HEDIS) 2015 Technical Specifications for Health Plans for a list of mental health diagnosis and procedure codes.
[24] See page 294 of HEDIS 2015 Technical Specifications for Health Plans for a list of substance use diagnosis and procedure codes.

urology, and all other specialists.[25] This was determined based on the number of specialists who had at least one FFS claim during the calendar year. Table 7 presents the number and percentage of the most common physician specialties with at least one FFS claim during the calendar year. The number of specialists billing FFS increased across all specialties from 5,644 in 2012 to 6,749 in 2015. The data from CY 2015 should be considered preliminary; not all billing and utilization data from CY 2015 have been received and processed at this time. Additional providers may have submitted at least one FFS claim during CY 2015.

Table 7. Percentage of Specialty Physicians with at least One FFS Claim by Specialty Type, CY 2012- CY 2015

	CY 2012		CY 2013		CY 2014		CY 2015	
Provider Type	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Anesthesiology	806	14.3%	824	14.5%	832	14.0%	957	14.2%
Cardiovascular Disease	313	5.5%	319	5.6%	345	5.8%	347	5.1%
Neurology	273	4.8%	282	5.0%	311	5.2%	365	5.4%
Oncology	190	3.4%	182	3.2%	205	3.4%	202	3.0%
Ophthalmology	377	6.7%	373	6.5%	396	6.7%	449	6.7%
Other Specialist	1,243	22.0%	1,279	22.5%	1,306	21.9%	1,508	22.3%
Podiatrist	318	5.6%	327	5.7%	333	5.6%	355	5.3%
Radiology	934	16.5%	906	15.9%	927	15.6%	1,079	16.0%
Surgery	1,015	18.0%	1,029	18.1%	1,106	18.6%	1,267	18.8%
Urology	175	3.1%	175	3.1%	193	3.2%	220	3.3%
Total	**5,644**	**100%**	**5,696**	**100%**	**5,954**	**100%**	**6,749**	**100%**

Utilization Data

Utilization of physician specialists was evaluated based on FFS participants' use of common procedures for the most frequently visited physician specialists. Table 8 presents the sample of procedure codes used to measure utilization of physician specialist services.

Table 8. Procedure Codes Used for Identify Utilization of Physician Specialist Services

Physician Specialty Type	CPT Code
Surgery	11042, 10060
Radiology	70450, 71010, 71020
Anesthesiology	00740, 00810
Ophthalmology	92012, 92014
Podiatry	11721, 17250
Cardiovascular Disease	93000, 93010
Neurology	95886, 95819
Oncology	96413, 96415
Urology	51798, 52000

[25] Other specialist includes gastroenterology, otolaryngology, physical medicine & rehabilitation, nephrology, pulmonary disease, infectious disease, endocrinology & metabolism, neonatal-perinatal medicine, hematology, allergy & immunology, nuclear medicine, pediatric cardiology, rheumatology, audiologist, osteopath, geriatric, maternal & fetal medicine, pediatric hematology-oncology, pediatric gastroenterology, gynecologic oncology, pediatric pulmonology, pediatric endocrinology, pediatric nephrology, and reproductive endocrinology.

Table 9 presents the percentage of full-benefit FFS participants who received at least one of the procedure codes listed in Table 8 by specialist type during the measurement period. The table excludes full dual eligibles because Medicare is the primary payer for these services. The most frequently used specialist service was radiology, followed by cardiovascular disease.

Table 9. Percentage of Full-Benefit FFS Participants with at least One Physician Specialist Service for Select Procedure Codes, by Specialty Type, CY 2012– CY 2014

	CY 2012		CY 2013		CY 2014	
Specialty Type	**#**	**%**	**#**	**%**	**#**	**%**
Cardiovascular Disease	3,473	25.3%	2,990	23.6%	2,457	20.8%
Radiology	4,173	30.4%	3,777	29.9%	3,088	26.2%
Ophthalmology	995	7.2%	935	7.4%	893	7.6%
Neurology	287	2.1%	240	1.9%	200	1.7%
Urology	138	1.0%	145	1.1%	141	1.2%
Oncology	79	0.6%	67	0.5%	37	0.3%
Surgery	365	2.7%	309	2.4%	310	2.6%
Anesthesiology	664	4.8%	621	4.9%	473	4.0%
Podiatry	725	5.3%	714	5.6%	757	6.4%

Analysis of Behavioral Health Services

Unlike the other sections of this report, the analysis of behavioral health services, includes participants who were full Medicare-Medicaid dual eligible participants at any point within the calendar year. Although Medicare is the primary payer for many behavioral health services for those who are dually eligible,[26] it only covers partial hospitalizations and traditional outpatient and inpatient visits to behavioral health professionals and providers.[27] Medicaid covers a broader range of behavioral health services including supports and services to keep participants in the community.[28] Because Medicaid is the primary payer for many of these services, full duals are reported in this section of the report.

Utilization Data

Mental Health Disorders

Table 10 shows the percentage of full-benefit Medicaid FFS participants who were diagnosed with and/or treated for a mental health disorder (MHD) in CY 2012 through CY 2014.[29] It also shows the percentage of participants who were diagnosed with and/or treated for a substance use

[26] Centers for Medicare and Medicaid Services. (February 2016). Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs. Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.
[27] Centers for Medicare and Medicaid Services. (n.d.). Mental health care (outpatient). Retrieved from https://www.medicare.gov/coverage/outpatient-mental-health-care.html.
[28] Centers for Medicare and Medicaid Services. (n.d.). Behavioral Health Services. Retrieved from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html
[29] Individuals were identified as having an MHD if they had any ICD-9 diagnosis codes beginning with 290, 293-302, 306- 316, or an invoice control number (ICN) beginning with "6" denoting a specialty mental health claim.

disorder (SUD) in CY 2012 through CY 2014.[30] The percentage of participants with an MHD increased from 46.0 percent in CY 2012 to 50.1 percent in CY 2014, and the percentage with an SUD increased from 5.9 to 6.5 percent during the same time period.

Table 10. Percentage of Full-Benefit FFS Medicaid Participants with an MHD and an SUD, CY 2012- CY 2014

	CY 2012		CY 2013		CY 2014	
	Number	Percentage	Number	Percentage	Number	Percentage
Participants with an MHD	44,510	46.0%	48,557	49.3%	50,171	50.1%
Participants with an SUD	5,681	5.9%	6,331	6.4%	6,499	6.5%

DHMH is currently preparing a detailed analysis for the Maryland General Assembly, evaluating access, quality and delivery of SUD services. The report will be completed by December 15, 2016.[31]

Analysis of Pre-and Post-Natal Obstetric Services

In Maryland, pre-and post-natal obstetric services are paid under managed care, including the costs associated with labor and delivery. Since these services are not paid through FFS, Maryland is not including an analysis of pre-and post- natal obstetric services as part of this access review monitoring plan submission.

Analysis of Home Health Services

Availability of Home Health Services

Home health in the context of this report is defined as the federally required service described in 42 CFR §440.70. Reimbursable services provided by these agencies include skilled nursing services, home health aide services, physical therapy, occupational therapy, speech and audiology services, medical supplies, equipment, and appliances. Home health services must be ordered by a physician. Services are covered only if they are medically necessary on a part-time, intermittent basis. Usually, home health provides home-based services, such as wound care or assistance with activities of daily living, or a therapy following a hospitalization. This is different from other longer term community services, such as Community First Choice or private duty nursing, which provide personal assistance and nursing services for individuals needing such services on a longer term basis.

[30] Individuals were identified as having an SUD if they had a diagnosis code that met the criteria from the Healthcare Effective Data and Information Set (HEDIS) metric "Identification of Alcohol and Other Drug Services" measure, which includes the following ICD-9 diagnosis codes: 291-292, 303-304, 305.0, 305.2-305.9, 535.2, 571.1; MS-DRG 894-897; and ICD-9-CM Procedure 94.6x with an inpatient code.

[31] Joint Chairmen's Report, 2016, pg 78. Available at http://mgaleg.maryland.gov/Pubs/BudgetFiscal/2016rs-budget-docs-jcr.pdf.

Home Health Providers in Maryland

Home health services are rendered by licensed home health agencies throughout Maryland. Maryland Medicaid requires these agencies to also be enrolled as a home health agency under Medicare (Medicare-certified). Medicare-certified home health agencies are subject to a certificate of need (CON) requirement in Maryland. As a condition of CON approval for proposed new home health aide agencies (HHAs), MHCC's State Health Plan for Home Health Agency Services requires Medicaid participation for qualified entities proposing to acquire an existing HHA, and for the new HHA entity that results from the merger of two existing HHAs. As a condition for approval, all categories of HHAs, regardless of how established, must agree to accept clients whose primary payer source is Medicaid. There are 49 actively enrolled home health agencies in Maryland Medicaid.

Home Health Reimbursement Rates

Maryland Medicaid uses the same reimbursement methodology as the Medicare program for home health services. The fee schedule is adjusted annually by the same factor used by Medicare in updating Medicare's prospective payment system rates.

Utilization Data

Table 11 presents the number and percentage of full-benefit Medicaid FFS participants who had at least one home health visit.[32] The table excludes full dual eligibles because Medicare is the primary payer for these services. The percentage of participants who received at least one home health remained stable across the measurement period at just under 4 percent. Please note that many disabled children and adults are more likely to use long term services such as personal assistance and private duty nursing.

Table 11. Percentage of Full-Benefit FFS Medicaid Participants Receiving a Home Health Visit, CY 2012- CY 2014

	CY 2012		CY 2013		CY 2014	
	#	%	#	%	#	%
Participants with at least 1 Home Health Visit	498	3.6%	473	3.7%	443	3.8%
Total	**13,742**	**100%**	**12,649**	**100%**	**11,788**	**100%**

[32] Home health services in the professional setting were defined as any claims with a service category of UB billed on the CMS 1500 form. Institutional claims in the inpatient and outpatient setting were identified as claims with a facility type of home health and bill class of hospice (hospital –based), outpatient or other (part B) on the UB-92 bill.

Conclusion

In summary, the CMS access monitoring review plan requirements apply to FFS Medicaid participants. In Maryland, the majority (85 percent) of participants are enrolled in HealthChoice, Maryland's statewide mandatory Medicaid managed care program. Of the remaining 15 percent, most are either dually eligible for Medicare and Medicaid (where Medicaid is often not the primary payer) or are only eligible for limited benefits. This report found that both the rate of full-benefit FFS participants with an ambulatory care visit and participants with an ED visit increased slightly from CY 2012 to CY 2014. However, the rate of participants with at least one inpatient admission decreased substantially by 10.5 percentage points, which is consistent with downward trends in inpatient utilization observed across the entire Medicaid program. Participants most frequently used radiology specialists, followed by cardiovascular disease specialists.

Although this report has focused on only a small subset of Maryland Medicaid participants, the state has had a long-standing, robust system for monitoring provider payment rates. Maryland is the only state in the country with an all-payer hospital rate-setting system under which all payers—including Medicare, Medicaid, and commercial—pay the same rate for hospital services. The state has been setting hospital rates for all payers for nearly 40 years. In addition to monitoring and setting payment rates for hospital services, the state also performs annual analyses comparing professional service payment rates. Since 2001, the Maryland General Assembly has required DHMH to submit an annual report that, among other things, compares Maryland's Medicaid professional reimbursement rates with those of Medicare and other states. The findings from this annual report have resulted in several fee increases over the years to make Medicaid more comparable to Medicare. The next annual report will be released in January 2017.

Appendix I. Public Comments