Wisconsin
Department of Health Services

Medicaid Plan for Monitoring Access to Fee-for-Service Health Care

Wisconsin Medicaid Program

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Executive Summary

On October 29, 2015, the Centers for Medicare and Medicaid Services (CMS) issued a new rule (CMS-2328-FC) that requires state Medicaid agencies to measure access to health care for individuals enrolled in the state's fee-for-service Medicaid program. Medicaid agencies are required to develop a plan for monitoring access to fee-for-service Medicaid benefits that includes data-driven access metrics, a review of fee-for-service reimbursement rates, and input from stakeholders on factors that affect access to care.

In compliance with the federal rule, the Department of Health Services (DHS) has completed this plan to evaluate access to health care for individuals who receive health care coverage through Wisconsin's fee-for-service Medicaid program. DHS developed the plan throughout the first half of 2016 and released a draft for public comment on August 15, 2016. Per federal requirements, the final plan is being submitted to CMS and will be updated at least every three years.

DHS's Division of Health Care Access and Accountability (DHCAA) administers Wisconsin's Medicaid program, which provides health care coverage to over one million low-income Wisconsin residents. The Medicaid program covers a wide range of health care services, including hospital, physician, dental, behavioral health, long-term care, and others. Enrolled members receive coverage through one of two delivery systems: fee-for-service or managed care. This access monitoring plan only measures access to care under the fee-for-service delivery system. DHS separately monitors access to care under the managed care delivery system through its contracts with health maintenance organizations (HMOs).

Access to care is influenced by many complex factors, such as availability of health care providers, geography, and social factors. Given this complexity, there are no national standards for measuring access. In 2011, however, the national Medicaid and CHIP Payment and Access Commission (MACPAC) developed a generalized framework to examine major aspects of access to care, with a focus on members and their unique characteristics, availability of health care providers, and service utilization. This access monitoring plan relies on the structure from the MACPAC framework and is organized into five sections:

- **Section 1** presents an overview of Wisconsin's Medicaid program, including a review of major eligibility categories, the fee-for-service and managed care delivery systems, and basic demographic information about the fee-for-service member population.

- **Section 2** describes DHS's methodology for analyzing access to six core services under the fee-for-service delivery system. The core services were identified by CMS and include primary care, dental, physician specialty, behavioral health, obstetrics, and home health services.

This methodology includes data-driven metrics for each core service that measure the following:

- Percent of licensed health care providers enrolled in the Medicaid program
- Level of participation among enrolled providers
- Regional variation in service utilization among members
- Reliance on safety net providers for service delivery

DHS's methodology also analyzes the reimbursement rates paid to health care providers under the fee-for-service Medicaid program, with an additional metric that compares fee-for-service Medicaid reimbursement rates to Medicare reimbursement rates.

- **Section 3** applies the methodology described above to analyze access to the six identified core services under the fee-for-service delivery system.

- **Section 4** summarizes the processes for obtaining stakeholder input on access to care for members who receive health care coverage through the fee-for-service Medicaid program. DHS receives input through many different mechanisms, including Member and Provider Services; advisory committees and councils; tribal consultations; and standing meetings with provider associations, member groups, and advocacy organizations.

- **Section 5** summarizes the main findings of the plan and reviews the DHS initiatives to improve access to care through the fee-for-service Medicaid program. Analysis in this plan shows that members access each of the core services. DHS will, however, continue its ongoing efforts to improve access and quality of care in the Medicaid program in alignment with the results of the analysis from this plan. Comparison among the core services suggests that access to both dental care and behavioral health services is more limited than access to other core services through the fee-for-service Medicaid program. Therefore, we conclude that DHS should prioritize efforts to improve access to these services as part of its ongoing program improvement process.

Section 1: Overview of Wisconsin's Medicaid Program

General Program Information

Medicaid is a public program that provides health care coverage to low-income individuals. The program covers a wide range of health care benefits, including hospital, physician, dental, behavioral health, long-term care, and other health care services. The Medicaid program is also commonly known as Title XIX or T19.

All states operate Medicaid programs, which are jointly administered by the federal and state governments. At the federal level, CMS oversees Medicaid and is responsible for setting general policies and rules. At the state level, DHS administers the Medicaid program and is responsible for policy development, day-to-day operations, and program oversight.

Medicaid programs are funded jointly by the federal and state governments. In Wisconsin, the federal government pays approximately 58% of program costs, while the State of Wisconsin pays the remaining 42% of program costs. The total cost of Wisconsin's Medicaid program in State Fiscal Year 2015 was approximately $8.5 billion.

Major Eligibility Categories

The Medicaid program provides health care coverage to low-income individuals in the following eligibility categories:

- Children
- Pregnant women
- Parents and caretakers
- Adults without dependent children
- Elderly, blind, or disabled individuals

To enroll, an individual must meet both the financial and non-financial eligibility requirements for his or her eligibility category. Financial requirements may include income and/or asset limits, among others; non-financial requirements may include U.S citizenship or residency verification, among others.

The term "BadgerCare Plus" is used to refer to the part of Wisconsin's Medicaid program that provides coverage to children, pregnant women, parents, caretakers, and adults without dependent children. Certain BadgerCare Plus members have their benefits funded through the federal Children's Health Insurance Program (CHIP). The term "EBD Medicaid" is used to refer to the part of Wisconsin's Medicaid program that provides

coverage to elderly, blind, or disabled individuals. Figure 1 shows enrollment by eligibility category as of January 2016.

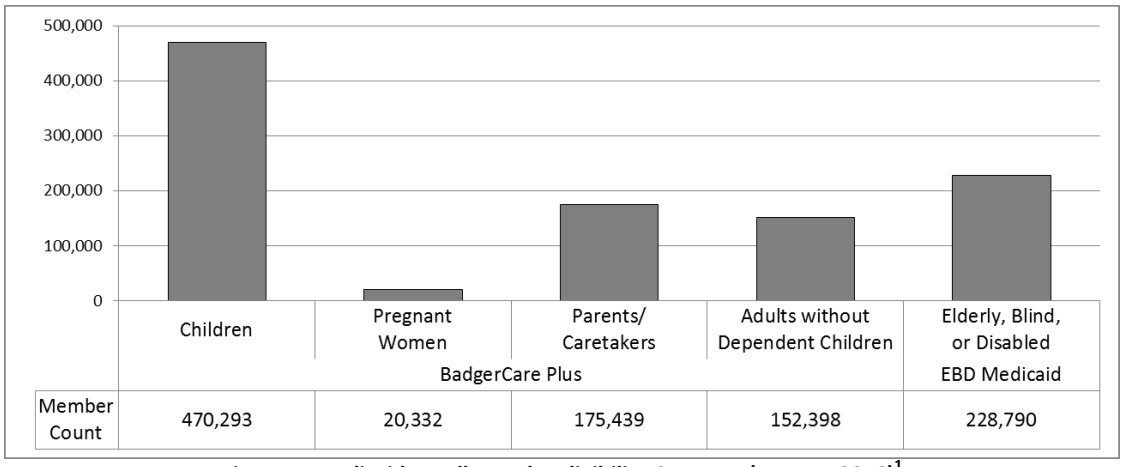


Figure 1: Medicaid Enrollment by Eligibility Category (January 2016)[1]

Individuals who do not qualify for enrollment in the full-benefit Medicaid program may qualify for enrollment in one of several limited-benefit programs administered by DHS. Limited-benefit programs include SeniorCare, the Family Planning Only Services program, and the Medicare Savings Program, among others. Limited-benefit programs are outside the scope of this access monitoring plan.

Delivery Systems

Members enrolled in the Medicaid program receive health care coverage through one of two delivery systems: fee-for-service or managed care.

In the fee-for-service delivery system, a member obtains Medicaid coverage directly from DHS. The member can receive covered health care services from any Medicaid-enrolled provider. The provider then submits the bill, known as a claim, for the services to DHS. DHS processes the claim and pays the health care provider accordingly. Figure 2 summarizes the fee-for-service delivery system.

Figure 2: The Fee-for-Service Delivery System

In the managed care delivery system, a member receives Medicaid coverage through an HMO contracted with DHS. Under managed care, a member chooses among the contracted HMOs that serve his or her area. DHS pays the HMO a fixed monthly amount,

[1] Data does not include individuals enrolled in limited-benefit programs.

called a capitation payment, for providing Medicaid coverage to the member. The member receives covered health care services from any Medicaid-enrolled health care provider who is part of the HMO's provider network. The health care provider submits a claim for the services to the HMO, and the HMO, in turn, processes the claim and pays the health care provider accordingly. Figure 3 summarizes the managed care delivery system.

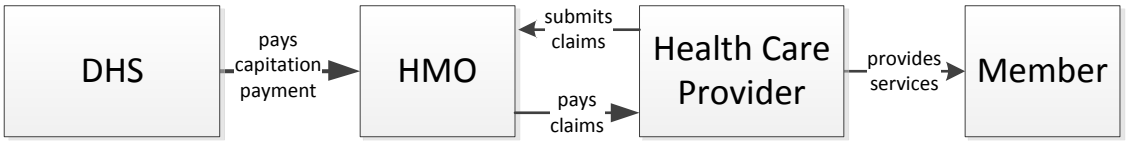


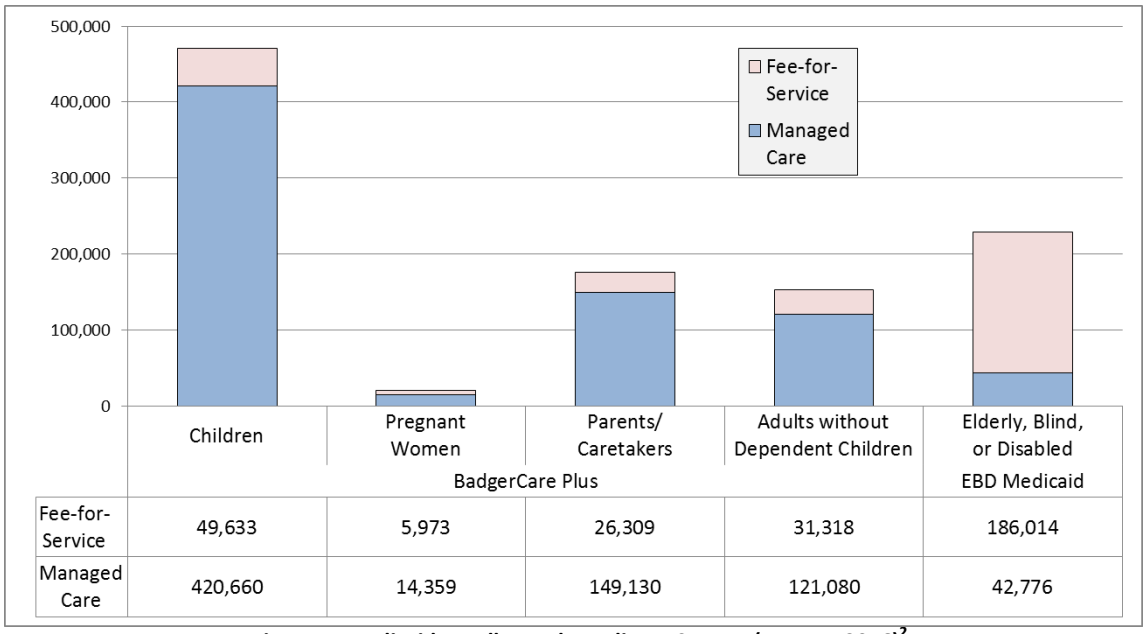
Figure 3: The Managed Care Delivery System

The delivery system does not affect the types of services to which a member is entitled but rather determines the way in which Medicaid coverage is provided. Members receive coverage of the same services through the Medicaid program regardless of whether they receive that coverage through fee-for-service or managed care.

As of January 2016, approximately 30% of members enrolled in the full-benefit Medicaid program received coverage through fee-for-service, and 70% of members received coverage through managed care. The primary factor that determines the delivery system under which a member receives coverage is the member's eligibility category.

Per federal and state rules, most BadgerCare Plus members (children, pregnant women, parents, caretakers, and adults without dependent children) receive coverage through managed care. However, BadgerCare Plus members may initially receive coverage through fee-for-service for several months to allow time for them to select and enroll in an HMO, or under other limited circumstances. Most EBD Medicaid members (elderly, blind, or disabled individuals) can choose to receive coverage through either fee-for-service or managed care. Figure 4 on the following page shows enrollment by delivery system for each eligibility category as of January 2016.

Certain fee-for-service members who are frail elders, adults with developmental or intellectual disabilities, or adults with physical disabilities may also be enrolled in Family Care, a managed long-term care program. Fee-for-service members who are also enrolled in Family Care receive coverage of certain health and long-term care services through a care management organization (CMO) instead of through the fee-for-service delivery system. As of January 2016, approximately 47,000 fee-for-service Medicaid members were also enrolled in Family Care.



	Children	Pregnant Women	Parents/ Caretakers	Adults without Dependent Children	Elderly, Blind, or Disabled
	BadgerCare Plus				EBD Medicaid
Fee-for-Service	49,633	5,973	26,309	31,318	186,014
Managed Care	420,660	14,359	149,130	121,080	42,776

Figure 4: Medicaid Enrollment by Delivery System (January 2016)[2]

DHS has worked to increase the percentage of members who receive coverage through managed care as part of its overall strategy to improve access. The managed care delivery system incentivizes better coordination of care, which can lead to improved health outcomes and member satisfaction. To ensure members receive high quality care, DHS has implemented pay-for-performance initiatives with contracted HMOs; these initiatives provide further incentive to improve access to core services, such as primary and dental care.

Overview of the Fee-for-Service Member Population

This access monitoring plan measures access to care for the approximately 30% of Medicaid members who receive coverage through the fee-for-service delivery system (shaded light red in Figure 4). Through its contracts with HMOs, DHS separately monitors access to care for the approximately 70% of Medicaid members who receive coverage under managed care (shaded light blue in Figure 4).

As shown in Figure 4, most members who receive coverage through the fee-for-service delivery system are in the EBD Medicaid eligibility category (elderly, blind, or disabled individuals), while most members who receive coverage through managed care are in a BadgerCare Plus eligibility category. As of January 2016, there were approximately 186,000 EBD Medicaid members and 113,000 BadgerCare Plus members who received coverage under the fee-for-service delivery system.

[2] Data does not include individuals enrolled in a limited-benefit program, such as SeniorCare or the Family Planning Only Services program.

Figure 5 shows the make-up of the fee-for-service member population by age and gender.

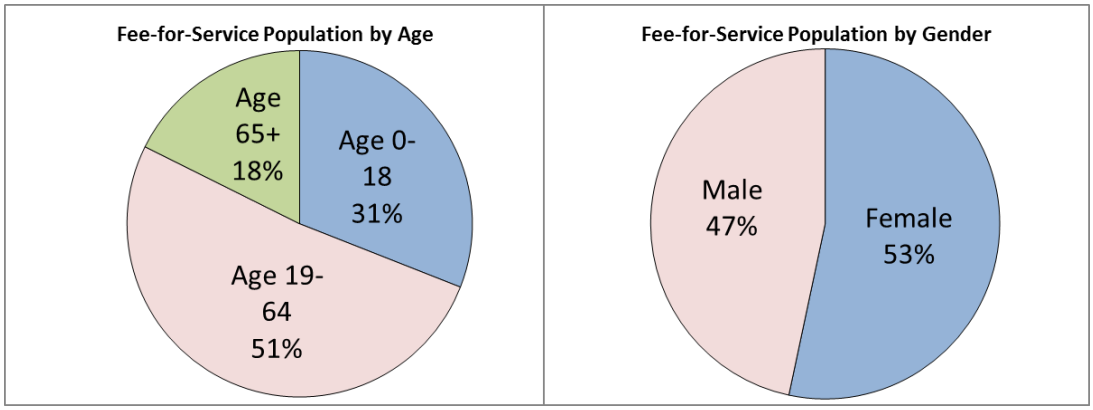


Figure 5: Fee-for-Service Member Population by Age and Gender

Figure 6 shows the distribution of the fee-for-service member population across six geographic regions of Wisconsin: North, Northeast, West Central, Southeast, South Central, and Milwaukee. These regions match the regions used by DHS to set capitation payment rates under the managed care delivery system; however, they differ slightly from regions used by DHS for other purposes and programs, including Family Care regions and Area Administration regions.

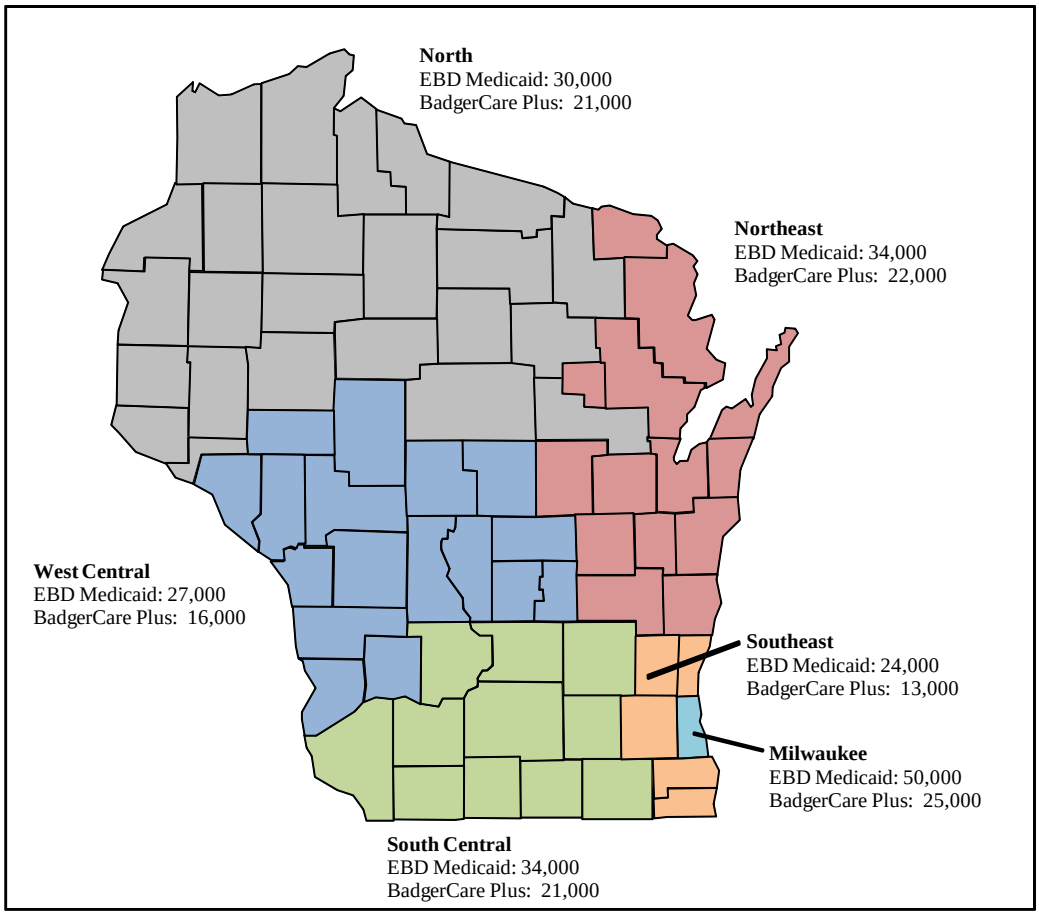


Figure 6: Fee-for-Service Member Population by Geographic Region

Section 2: Methodology for Analyzing Fee-for-Service Access to Core Services

General Framework

This section of the access monitoring plan describes DHS's methodology for analyzing access to certain core services by members who receive health care coverage through Wisconsin's fee-for-service Medicaid program. The core services were defined by CMS and include:

- Primary care
- Dental care
- Physician specialty services
- Behavioral health services
- Obstetric services
- Home health care

For each core service, we include metrics that evaluate the provider network, service utilization, and fee-for-service reimbursement.

Provider Network

Our analysis of the provider network for each core service evaluates the health care providers who are available to serve fee-for-service Medicaid members. All other factors being equal, a larger and more active provider network for a given core service can enable better access to care, while a smaller or less active provider network can impede access to care. For each core service, we calculate one metric to measure the percent of licensed providers who are enrolled in the Medicaid program and another metric to measure the level of participation among enrolled providers.

Metric 1: Percent of Licensed Providers Who Are Medicaid-Enrolled

Metric 1 measures the percent of licensed health care providers for each core service who have enrolled in the Medicaid program. To practice in Wisconsin, most health care providers must be licensed by either the Wisconsin Department of Safety and Professional Services or the DHS Division of Quality Assurance, depending on their provider type. After licensure, health care providers can choose whether to enroll in the Medicaid program. The Medicaid enrollment process includes confirmation of licensure, federally required screenings, and other requirements, based on the provider type. Once enrolled, a health care provider is available to serve Medicaid members. Fundamentally, Metric 1 measures the availability of health care providers able to serve Medicaid members as a relative percentage of the total availability of health care providers and is, therefore, an important measure of the Medicaid provider network.

To calculate Metric 1, we divide the number of Medicaid-enrolled providers by the total number of licensed providers in calendar year 2014 for each core service. We use calendar year 2014 data as it represents the most recent year for which complete data is

available. We exclude out-of-state providers from the calculation because we were unable to obtain licensure data from other states.

All other factors being equal, a high percentage of enrolled providers would mean there are more providers available to possibly serve Medicaid members, which would suggest a more robust Medicaid provider network. However, it would not be reasonable to set a goal that 100% of licensed providers become Medicaid-enrolled because some licensed providers do not actively practice and because licensed providers commonly choose to limit their participation across all types of health care payers, including private insurers and Medicare, in addition to the Medicaid program. Because access to care ultimately depends on many factors, we cannot define a specific percentage of providers who would need to be enrolled to guarantee adequate access to care. Instead, we must interpret the results of Metric 1 in the context of other metrics and analyses.

Metric 2: Level of Participation Among Medicaid-Enrolled Providers

Metric 2 measures the level of participation among Medicaid-enrolled providers. Metric 2 builds upon Metric 1: whereas Metric 1 measures how many licensed providers are Medicaid-enrolled and, therefore, available to possibly serve Medicaid members, Metric 2 measures the levels at which enrolled providers are actually serving Medicaid members. DHS does not require enrolled providers to serve a certain number of members; therefore, the level of participation among enrolled providers varies. In a given year, some enrolled providers may serve few or no members. Other providers may serve a significant number of members.

To calculate Metric 2, we group enrolled providers for a given core service into three categories based on the number of fee-for-service members they served over a calendar year:

- Inactive providers (defined as those serving no members)
- Limited-participation providers (defined as those serving between 1 and 25 members)
- Active providers (defined as those serving 26 or more members).

We exclude both out-of-state providers and providers who were not enrolled for the entire calendar year. The calculation is based on data from calendar year 2014, which represents the most recent year for which complete data is available.

A large number of active providers, relative to the number of inactive and low-participation providers, would mean that most enrolled providers are actively engaged with the Medicaid program. This would suggest a robust Medicaid provider network. However, because we know participation among providers depends on multiple factors, we cannot define a specific level of provider participation that would guarantee adequate access to care. Instead, we must interpret the results of Metric 2 in the context of other metrics and analyses.

DHS established the “members served” thresholds for determining inactive, limited-participation, and active providers for purposes of this access monitoring plan. For

consistency, the same thresholds are used across all core services. Admittedly, the number of members served depends on many factors, such as a provider's practice model or employment status, the average patient panel for a given type of provider, and the specific needs of the local member population. Some provider types, such as radiologists, may see more members based on the nature of their specialty while other provider types may see fewer members, on average, based on their business model. Additionally, some providers may see fewer members simply because there are fewer members who need care. We may adjust the "members served" thresholds for the three levels of provider participation in future analyses based on stakeholder feedback and as we gather additional data.

Service Utilization

Our analysis of service utilization evaluates how fee-for-service Medicaid members have actually accessed each core service, with a focus on patterns and variations in utilization. For each core service, we calculate one metric to measure regional variation in service utilization among members and another metric to measure reliance on safety net providers for service delivery.

Metric 3: Regional Variation in Service Utilization Among Members

Metric 3 measures regional variation in utilization of each core service among members enrolled in the fee-for-service Medicaid program. We would not expect the need for services among members to vary considerably based on geography; thus, any regional variation in service utilization might instead suggest that members in certain parts of the state are less able to access services than members in other parts of the state. Conversely, low regional variation in service utilization might suggest that members have similar access to services in all areas of the state.

To calculate Metric 3, we divide the number of fee-for-service members who received a core service in the calendar year by the total number of fee-for-service members enrolled in the calendar year. We use data from calendar year 2014, which represents the most recent year for which complete data is available. For the calculation, we only include members who were continuously enrolled for the entire year since we believe this provides the most accurate representation of service utilization patterns. We exclude members also enrolled in Family Care, since these members do not receive all services through fee-for-service but rather receive certain services through care management organizations. For calendar year 2014, there were approximately 148,000 continuously enrolled fee-for-service members who were not also enrolled in Family Care.

For each core service, we calculate average statewide utilization and utilization for six geographic regions in Wisconsin: North, Northeast, West Central, Southeast, South Central, and Milwaukee[3]. Members are assigned to the region in which they live. We compare average statewide utilization to utilization in the six geographic regions to

[3] These geographic regions match the regions used by DHS to set capitation payment rates under the managed care delivery system. A map of the regions is included in Section 1 of this access monitoring plan.

determine regional variation. We calculate utilization separately for children (defined as members ages 18 and younger) and adults (defined as members ages 19 and older) to account for differences in the health needs between these populations.

Metric 3 is primarily intended to measure regional variation in utilization of each core service. However, in measuring regional variation, Metric 3 also incidentally shows the overall level of utilization of each core service. The overall level of utilization can be a valuable measure of access to care for those services for which we would expect high overall service utilization, such as primary care and dental care. For these types of services, we would expect that most members would access the service during a given year; thus, a high level of overall utilization might suggest adequate access while a lower level of overall utilization could suggest that members face barriers to accessing care. However, overall service utilization is not a valid measure of access to care for other types of services where we would expect utilization to depend on the population's specific medical needs. For these services, we would only expect members who have a medical need for the service to use the service; thus, a low level of overall utilization might simply reflect the population's lower medical need for the service. Because we are unable to reliably or accurately measure the medical need, we cannot say whether a specific overall level of utilization suggests adequate or inadequate access to care.

Metric 4: Reliance on Safety Net Providers for Service Delivery

Metric 4 measures the reliance on safety net providers for the delivery of each core service through the fee-for-service Medicaid program. For purposes of Metric 4, safety net providers are identified as federally qualified health centers and rural health clinics. By definition, these providers render health care to underserved areas or underserved populations and, thus, represent an access point to care for members who might otherwise have inadequate access. For the Medicaid program, a high reliance on safety net providers would suggest that members are less able to access care through standard providers. Safety net reliance is, therefore, a valuable metric to measure how members are able to access care.

To calculate Metric 4, we divide the number of services delivered by safety net providers in calendar year 2014 by the total number of services delivered by all providers for each core service. We use calendar year 2014 data as it represents the most recent year for which complete data is available. For each core service, we calculate safety net reliance both statewide and for each of the geographic regions used in Metric 3.

Metric 4 results build upon the service utilization data presented in Metric 3 by further describing the options for care available to members. These results must be interpreted in conjunction with the results of other metrics. An optimal outcome would show good access to care represented by the other metrics and a low reliance on safety net providers, suggesting that members are able to access care through standard providers. Alternatively, if other metrics suggest good overall access to care, but Metric 4 shows a high reliance on safety net providers for that care, we might conclude that while members are able to get care, they nevertheless must rely on safety net providers for that care.

Finally, if other metrics suggest poor overall access, we might conclude an outcome where members are not able to access services through either standard or safety net providers.

Fee-for-Service Reimbursement

Our analysis of fee-for-service reimbursement evaluates the reimbursement rates paid to health care providers for each core service provided through the fee-for-service Medicaid program. Federal law gives states flexibility in establishing Medicaid reimbursement rates, subject to four basic requirements. Rates must:

1. Be accepted by enrolled providers as payment in full.
2. Be secondary to most third-party payment sources, including Medicare.
3. Be sufficient to attract enough providers so that Medicaid members have the same health care services available as the general population.
4. Be adequate to safeguard against unnecessary utilization and be consistent with efficiency, economy, and quality of care.

When analyzing the impact of Medicaid reimbursement on access to care, we focus on the third and fourth requirements listed above.

As discussed previously, DHS's primary approach to promote access to care through the Medicaid program is to utilize the managed care delivery system. Under managed care, DHS creates the opportunity for contracted HMOs to develop custom reimbursement arrangements with health care providers that ensure the availability of high quality, efficient services. DHS monitors HMO performance and subsequently pays for high performance.

In the fee-for-service delivery system, health care providers submit bills, known as claims, directly to DHS for provided services. Health care providers use nationally standardized billing codes, known as procedure codes, to identify each distinct service included on a claim. DHS requires that providers indicate their usual and customary charge for services included on claims. This means providers should charge the Medicaid program no more than they would charge for the same service provided to a person who is not a Medicaid member.

If DHS determines that a service on a claim is covered by the Medicaid program and was provided in accordance with program requirements, DHS will reimburse the provider either the usual and customary charge indicated on the claim or DHS's "max fee" for the service, whichever is lower. The max fee is established by DHS and represents the highest amount DHS will pay a provider for a particular service. Max fees are based on various factors, including a review of charges submitted by providers, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Max fees are also adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law. Max fees are published on DHS's Medicaid program website, known as the ForwardHealth Portal; the fees are published as a fee schedule, which is a list of fees grouped by common procedure codes.

For certain services, DHS provides an add-on payment to the max fee when certain conditions are met. For example, DHS provided an add-on payment authorized under the federal Affordable Care Act to primary care providers in calendar years 2013-14 for office visits; the add-on payment equaled the difference between the Medicare and Medicaid max fees. DHS also provides an add-on payment to primary care providers and emergency medicine providers for office visits and preventive medicine services provided in Health Professional Shortage Areas.

Metric 5: Comparison of Fee-for-Service Medicaid Max Fees and Medicare Max Fees

Metric 5 compares fee-for-service Medicaid max fees to Medicare max fees for each core service area. The comparison of Medicaid and Medicare max fees is informative in the context of other measures of access but is not valuable as a stand-alone measure of access. As described in federal requirements, Medicaid reimbursement should be sufficient to ensure that the availability of services to Medicaid members is equivalent to the availability of services to the general population, but it is not intended to directly match the reimbursement made by other health care payers.

By including the direct comparison of max fees, we are able to evaluate the role of reimbursement as a potential incentive or barrier for provider participation in the Medicaid program, as well as the role of reimbursement in influencing service utilization patterns. For the core services that are flagged for potential access concerns based on other metrics, low Medicaid max fees, relative to Medicare max fees, might indicate that adjusting max fees would positively impact access. Relatively high max fees might indicate that other factors are impacting access and that access improvement initiatives should consider what other policies might be more pertinent to the service in question.

To calculate Metric 5, we first identify the procedure codes representative of each core service area. We then identify the Medicaid and Medicare max fees in effect in 2014 for each procedure code. We exclude procedure codes that are not covered or priced by Medicare and procedure codes for which DHS did not receive any claims in 2014. We do not consider Medicaid add-on payments in the comparison. We divide the Medicaid max fees by the Medicare max fees to represent Medicaid reimbursement as a percentage of Medicare reimbursement.

We also explored options to compare Medicaid max fees to max fees paid by commercial health insurance companies. The most comprehensive source of health care claims data in Wisconsin is the Wisconsin Health Information Organization (WHIO), a voluntary statewide all-payers claim database. This database includes over 400 million claims representing health care services for more than 84% of Wisconsin residents. The available data for rates, however, is limited to the amount charged by a provider on a claim. This information is valuable for analysis of variation in health care charges but cannot be used to measure actual reimbursement. The actual fee paid by commercial health insurance companies often differs significantly from the amount charged by the provider. Commercial plan fees are withheld from WHIO as proprietary information.

Assumptions, Trends, and Baselines

For each core service, we calculate the five metrics previously described. While the metrics can individually measure certain aspects of access to care, they must be interpreted together to provide a more complete picture of access. Therefore, we end our analysis of each core service with a summary of the metrics shown together.

All five metrics will become more valuable when trended over time. Since this plan is intended as the first of a regularly updated plan, we expect to be able to include trends for all metrics in future updates to the plan as more recent data becomes available. The results for all metrics in the current access monitoring plan represent baselines that will be used in future updates to measure changes in access to care.

Unless otherwise noted, the data for all metrics represents data from calendar year 2014. While we would like to use more current data, calendar year 2014 represents the most recent year for which complete data is available. More recent data is not available primarily due to a policy that allows health care providers up to one year to bill for rendered services. Thus, complete data for calendar year 2015 will not be available until the end of calendar year 2016. We have calculated all metrics based on data from calendar year 2014, including metrics not based on billing data, to ensure consistency across metrics.

During calendar year 2014, DHS implemented several changes to the Medicaid program that are important to the interpretation of some of the data results included in this plan. We describe the potential impact of 2014 program changes on our analysis where appropriate.

Data Sources

All metrics are based on administrative data obtained from DHS's Medicaid Management Information System (MMIS). The MMIS is an information system used to process claims from health care providers and stores other data needed to administer the Medicaid program, such as provider and member enrollment information.

Limitations

There are no national standards established for measuring access to care. All frameworks, including the one presented in this plan, are subject to important limitations.

First, no single metric is a complete and accurate measure of access to care. Thus, we have not defined artificial or absolute thresholds for individual metrics as a means to make a definitive conclusion about members' ability to access care. Instead, we evaluate access to care by interpreting the full collection of metrics for each core service.

Second, the plan would benefit from additional metrics such as the percent of enrolled providers who are accepting new patients or the average wait time to schedule an appointment with a provider, among others. Unfortunately, existing data available to DHS does not support these metrics.

Finally, the presented metrics are summary metrics and cannot capture the experience of individual members. An individual member's experience might differ from the conclusions included in this plan.

Section 3: Analysis of Fee-for-Service Access to Core Services

Primary Care

The Wisconsin Medicaid program provides comprehensive coverage of primary care services, including annual physicals, office visits, screenings, immunizations, and other medically necessary primary care interventions.

In this part of the access monitoring plan, we present data-driven metrics that measure access to primary care services for members who receive health care coverage through Wisconsin's fee-for-service Medicaid program. We include metrics that measure the provider network, service utilization, and fee-for-service reimbursement.

Provider Network

Our analysis of the provider network for primary care services evaluates the primary care providers who are available to serve fee-for-service Medicaid members. For purposes of our analysis, we define primary care providers as primary care physicians, nurse practitioners, and physician assistants. Primary care physicians are defined as having a specialty of family practice, general practice, geriatrics, internal medicine, pediatrics, or preventive medicine.[4]

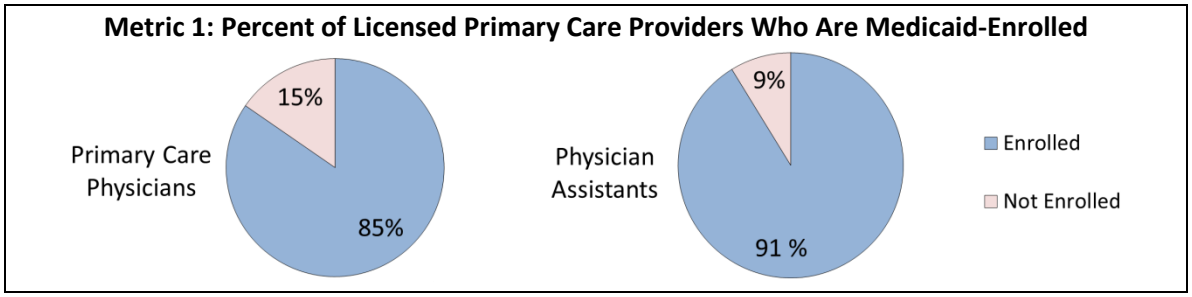
We calculate two metrics to measure the provider network for primary care services:

- The percent of licensed primary care providers who are enrolled in the Medicaid program
- The level of participation among enrolled primary care providers

Metric 1: Percent of Licensed Primary Care Providers Who Are Medicaid-Enrolled
Metric 1 measures the percent of licensed primary care providers who are enrolled in the Medicaid program. To practice in Wisconsin, primary care providers must be licensed by the Wisconsin Department of Safety and Professional Services. After licensure, primary care providers can choose whether to enroll in the Medicaid program, which would make them available to serve fee-for-service Medicaid members. The Medicaid enrollment process includes confirmation of Wisconsin licensure and federally required screenings.

To calculate Metric 1, we divided the number of Medicaid-enrolled primary care providers by the total number of licensed primary care providers for calendar year 2014. We were unable to include nurse practitioners in the calculation for Metric 1 because state licensing data does not differentiate nurse practitioners from other licensed registered nurses.

[4] Other definitions of primary care physicians often include physicians who specialize in obstetrics and gynecology (OB-GYN); however, we have excluded OB-GYN physicians from the definition of primary care physicians because this plan separately measures access to obstetric services.

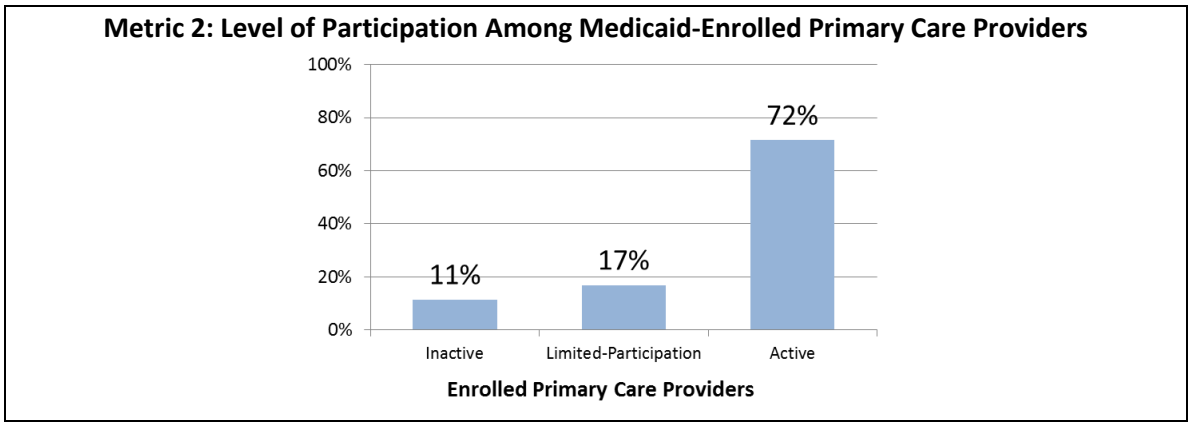


Metric 1 shows that 85% of licensed primary care physicians and 91% of licensed physician assistants were enrolled in the Medicaid program for calendar year 2014. These high percentages of enrolled providers mean there are a large number of primary care providers who are available to serve Medicaid members, relative to the total number of licensed primary care providers.

Metric 2: Level of Participation Among Medicaid-Enrolled Primary Care Providers
Metric 2 measures the level of participation among Medicaid-enrolled primary care providers. DHS does not require enrolled providers to serve a certain number of members; therefore, the level of participation among enrolled primary care providers can vary. Metric 2 builds upon Metric 1: whereas Metric 1 measures how many licensed primary care providers are Medicaid-enrolled and, therefore, available to possibly serve Medicaid members, Metric 2 measures the levels at which enrolled primary care providers are actually serving Medicaid members.

To calculate Metric 2, we grouped enrolled primary care providers into three categories based on the number of members they served in calendar year 2014:

- Inactive providers (defined as those serving no members)
- Limited-participation providers (defined as those serving between 1 and 25 members)
- Active providers (defined as those serving 26 or more members)



Metric 2 shows that, during calendar year 2014, 11% of enrolled primary care providers were inactive, 17% had limited participation, and 72% were active. The high percentage of active providers, relative to the percentages of inactive and low-participation providers, shows that most enrolled primary care providers were actively engaged with the Medicaid program, thus providing access to primary care services.

Service Utilization

Our analysis of service utilization measures how fee-for-service Medicaid members have actually accessed primary care services, with a focus on patterns and variations in utilization. For purposes of our analysis, we define a primary care service as any service provided by a primary care physician, nurse practitioner, or physician assistant[5].

We calculate two metrics to measure utilization of primary care services:

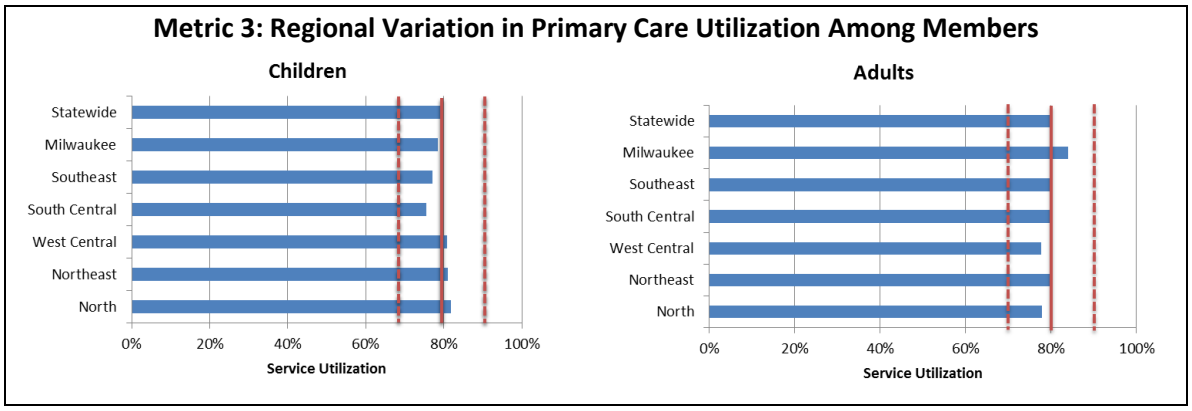
- Regional variation in utilization among members
- Reliance on safety net providers for service delivery.

Metric 3: Regional Variation in Primary Care Utilization Among Members

Metric 3 measures the regional variation in utilization of primary care services among members enrolled in the fee-for-service Medicaid program. The need for primary care among members should not vary based on geography; thus, any regional variation in utilization might instead suggest regional differences in the ability of members to access primary care services.

To calculate Metric 3, we divided the number of fee-for-service members who received a primary care service in calendar year 2014 by the total number of fee-for-service members enrolled in calendar year 2014. We compared average statewide utilization to utilization in each of six geographic regions to determine regional variation. We calculated utilization separately for children (defined as members ages 18 and younger) and adults (defined as members ages 19 and older). On the chart on the next page, the red dotted lines mark 10 percentage points above and below the average statewide utilization and are included as visual reference points.

[5] We acknowledge that primary care providers frequently provide more than what might be considered primary care and, conversely, that other types of providers can frequently provide services that might be considered primary care. However, Medicaid billing data shows that the majority of primary care is delivered by primary care providers; thus, we have decided to use this definition of primary care services for purposes of this plan.



Metric 3 shows that the average statewide utilization of primary care services was 79% and 80% for children and adults, respectively, in calendar year 2014. This high level of utilization suggests that members are able to adequately access primary care.

In terms of regional variation:

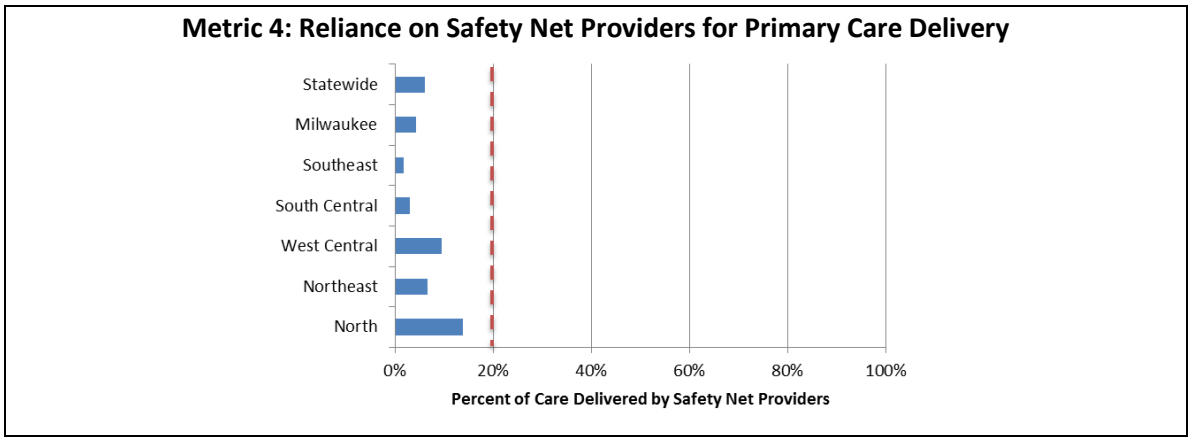
- The South Central region had the lowest utilization of primary care for children, at 75%.
- The highest rate for children was in the North region of the state, at 82%, four percentage points above the statewide average.
- The North and West Central regions had the lowest utilization of primary care among adults, both at 78%.
- The highest rate for adults was in Milwaukee, with 84% of adults receiving primary care services.

While Metric 3 shows some variation in utilization across regions, regional variation overall is minimal, with no region varying from the statewide average by more than 10 percentage points for either children or adults.

Metric 4: Reliance on Safety Net Providers for Primary Care Delivery

Metric 4 measures the reliance on safety net providers for the delivery of primary care through the fee-for-service Medicaid program. Safety net providers represent an access point to care for members who might otherwise have inadequate access. A high reliance on safety net providers would suggest that members are less able to access primary care through standard providers.

To calculate Metric 4, we divided the number of primary care services delivered by safety net providers in calendar year 2014 by the total number of primary care services delivered by all types of providers for each of six geographic regions in Wisconsin. On the chart on the next page, the red dotted line marks 20% and is included as a visual reference point.



Metric 4 shows that 6% of primary care services across the state were delivered by safety net providers, with all regions having less than 20% reliance. There is regional variation of reliance on safety net providers, with the North region relying on safety net providers for 14% of primary care services. We would expect higher reliance on safety net providers in the North due to the rural nature of the region. Alternatively, 2% of primary care in the Southeast region is provided by safety net providers. We would expect less reliance on safety net provides in the Southeast due to the urban nature of the region. The overall low reliance on safety net providers in all regions suggests members are able to adequately access primary care through standard providers without having to rely on safety net providers.

Fee-for-Service Reimbursement

Our analysis of fee-for-service reimbursement evaluates the reimbursement rates paid to health care providers for primary care services provided through the fee-for-service Medicaid program. Health care providers use nationally standardized billing codes, known as procedure codes, to bill for each distinct service that they provide. DHS establishes a reimbursement rate, known as a max fee, for each covered service. The max fee represents the highest amount DHS will pay a provider for the service. Max fees are based on various factors, including a review of charges submitted by providers, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations.

Metric 5: Comparison of Medicaid and Medicare Max Fees for Primary Care Services

Metric 5 compares fee-for-service Medicaid max fees to corresponding Medicare max fees for primary care services. The procedure codes that we identified as representative of primary care services include those categorized nationally as evaluation and management (E&M) services. We identified the Medicaid and Medicare max fees in effect in 2014 for each E&M procedure code. Of note, we did not consider the Medicaid add-on payment authorized under the Affordable Care Act for most E&M procedure codes in effect for calendar years 2013-14. The add-on payment equaled the difference between the Medicaid and Medicare max fees.

We divided the Medicaid max fees by the corresponding Medicare max fees for all E&M procedure codes to represent Medicaid reimbursement as a percentage of Medicare reimbursement. We also divided the Medicaid max fees by the corresponding Medicare max fees for the subset of E&M procedure codes that represent office visits. Office visits represent the most frequently utilized subset of E&M procedure codes.

Metric 5: Comparison of Medicaid and Medicare Max Fees for Primary Care Services		
Representative Procedure Codes	Code Range	Medicaid Rate as % of Medicare Rate
All E&M Codes	All Codes	67.64%
Office Visit Codes	99201-99215	49.72%

Metric 5 shows that the Medicaid max fees for primary care, as represented by E&M procedure codes, are equal to 68% of Medicare reimbursement. Office visit codes are equal to 50% of Medicare reimbursement.

Summary

The analysis in this section presents five metrics that measure access to primary care services for members who receive health care coverage through Wisconsin's fee-for-service Medicaid program.

Metrics 1 and 2 measure the Medicaid provider network for primary care providers. Metric 1 shows that a high percentage of licensed primary care physicians and physician assistants were enrolled in the Medicaid program. Metric 2 shows that, of these enrolled providers, a high percentage were actively serving Medicaid members. Taken together, Metrics 1 and 2 suggest a robust Medicaid provider network for primary care services that should enable adequate access to care.

Metrics 3 and 4 measure utilization of primary care services. Metric 3 shows that overall utilization of primary care was high among both children and adults and that utilization did not vary considerably by region. This suggests that members are able to access primary care and that members have similar access to primary care in all areas of the state. Metric 4 shows a slightly higher reliance on safety net providers to deliver primary care in the North and West Central regions of the state, both of which represent largely rural areas. Nevertheless, reliance on safety net providers was still low even in these areas, which suggests that most members are able to effectively access primary care through standard providers. High service utilization and low reliance on safety net providers support the conclusion from Metrics 1 and 2 that the primary care provider network is relatively strong.

Metric 5 shows that Medicaid max fees for primary care are equal to, on average, 68% of Medicare reimbursement. Metrics 1 through 4 suggest that Medicaid max fees for primary care services have enabled adequate access to care. However, as noted previously, effective during calendar year 2014, DHS implemented an add-on payment authorized under the Affordable Care Act for many primary care services. This add-on

payment may have encouraged more Medicaid participation among primary care providers during this time period. The add-on payment was discontinued in calendar year 2015 in accordance with the Affordable Care Act. DHS will continue to monitor access to primary care to evaluate the effect of the add-on payment.

Dental Care

The Wisconsin Medicaid program provides comprehensive coverage of dental care, including coverage of dental exams, cleanings, diagnostic services, fillings, crowns, periodontics, and other dental services.

In this part of the access monitoring plan, we present data-driven metrics that measure access to dental care for members who receive health care coverage through Wisconsin's fee-for-service Medicaid program. We include metrics that measure the provider network, service utilization, and fee-for-service reimbursement.

Provider Network

Our analysis of the provider network for dental care evaluates the dentists who are available to serve fee-for-service Medicaid members. We do not separately evaluate the availability of registered dental hygienists because most hygienists practice and bill for their services through a supervising dentist. Thus, we do not have separate data for most registered dental hygienists.

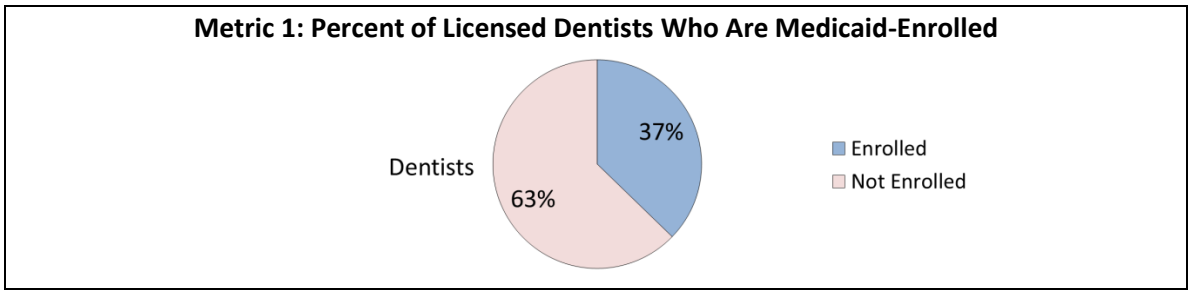
We calculate two metrics to measure the provider network for dental care:

- The percent of licensed dentists who are enrolled in the Medicaid program
- The level of participation among enrolled dentists

Metric 1: Percent of Licensed Dentists Who Are Medicaid-Enrolled

Metric 1 measures the percent of licensed dentists who are enrolled in the Medicaid program. To practice in Wisconsin, dentists must be licensed by the Wisconsin Department of Safety and Professional Services. After licensure, dentists can choose whether to enroll in the Medicaid program, which would make them available to serve fee-for-service Medicaid members. The Medicaid enrollment process includes confirmation of Wisconsin licensure and federally required screenings.

To calculate Metric 1, we divided the number of Medicaid-enrolled dentists by the total number of licensed dentists for calendar year 2014.

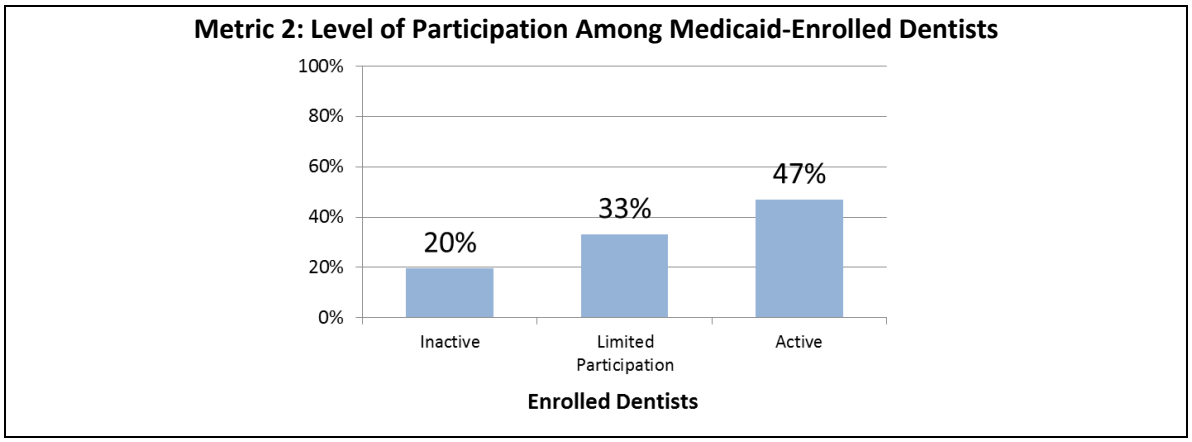


Metric 1 shows that 37% of licensed dentists were enrolled in the Medicaid program for calendar year 2014. This percentage of enrolled dentists is lower than other types of providers and shows that there are fewer dentists who are available to serve Medicaid members, relative to the total number of licensed dentists in Wisconsin.

Metric 2: Level of Participation Among Medicaid-Enrolled Dentists
Metric 2 measures the level of participation among Medicaid-enrolled dentists. DHS does not require enrolled dentists to serve a certain number of members; therefore, the level of participation among enrolled dentists can vary. Metric 2 builds upon Metric 1: whereas Metric 1 measures how many licensed dentists are enrolled and, therefore, available to possibly serve Medicaid members, Metric 2 measures the levels at which enrolled dentists are actually serving Medicaid members.

To calculate Metric 2, we grouped enrolled dentists into three categories based on the number of members they served in calendar year 2014:

- Inactive providers (defined as those serving no members)
- Limited-participation providers (defined as those serving between 1 and 25 members)
- Active providers (defined as those serving 26 or more members)



Metric 2 shows that, during calendar year 2014, 20% of enrolled dentists were inactive, 33% had limited participation, and 47% were active. While the largest category was active dentists at 47%, most enrolled dentists (53%) were nevertheless either inactive or had limited participation. The high combined percentage of inactive and limited-participation dentists, relative to active dentists, suggests that enrolled dentists are less actively engaged with the Medicaid program.

Service Utilization

Our analysis of service utilization measures how fee-for-service Medicaid members have actually accessed dental care, with a focus on patterns and variations in utilization. For purposes of our analysis, we define a dental service as any service provided by either a dentist or a registered dental hygienist.

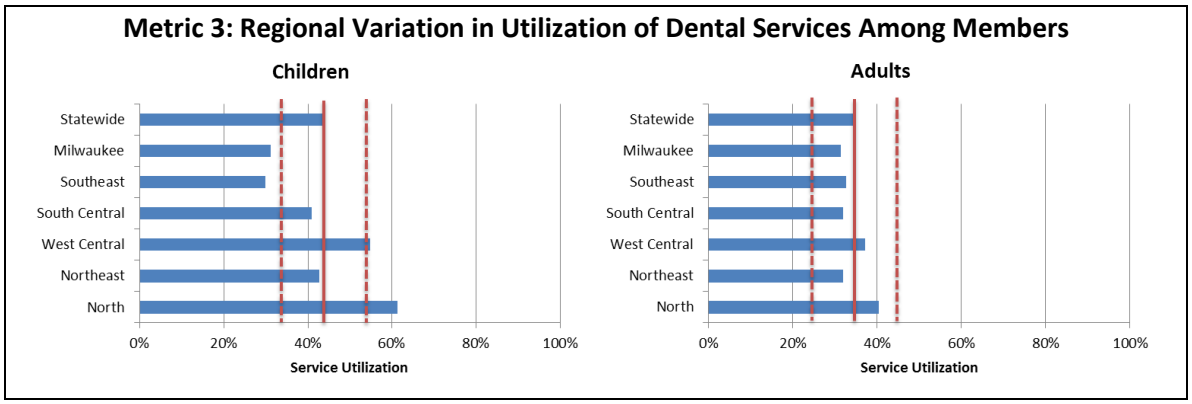
We calculate two metrics to measure utilization of dental care:

- Regional variation in utilization among members
- Reliance on safety net providers for service delivery

Metric 3: Regional Variation in Dental Utilization Among Members

Metric 3 measures the regional variation in utilization of dental care among members enrolled in the fee-for-service Medicaid program. The need for dental services among members should not vary based on geography; thus, any regional variation in service utilization might instead suggest regional differences in the ability of members to access dental care.

To calculate Metric 3, we divided the number of fee-for-service members who received a dental service in calendar year 2014 by the total number of fee-for-service members enrolled in calendar year 2014. We compared average statewide utilization to utilization in each of six geographic regions to determine regional variation. We calculated utilization separately for children (defined as members ages 18 and younger) and adults (defined as members ages 19 and older). On the chart below, the red dotted lines mark 10 percentage points above and below the average statewide utilization and are included as visual reference points.



Metric 3 shows that the average statewide utilization of dental services was 43% and 34% for children and adults, respectively, for calendar year 2014. This level of overall utilization is low given the goal that most members should have routine dental care during the year.

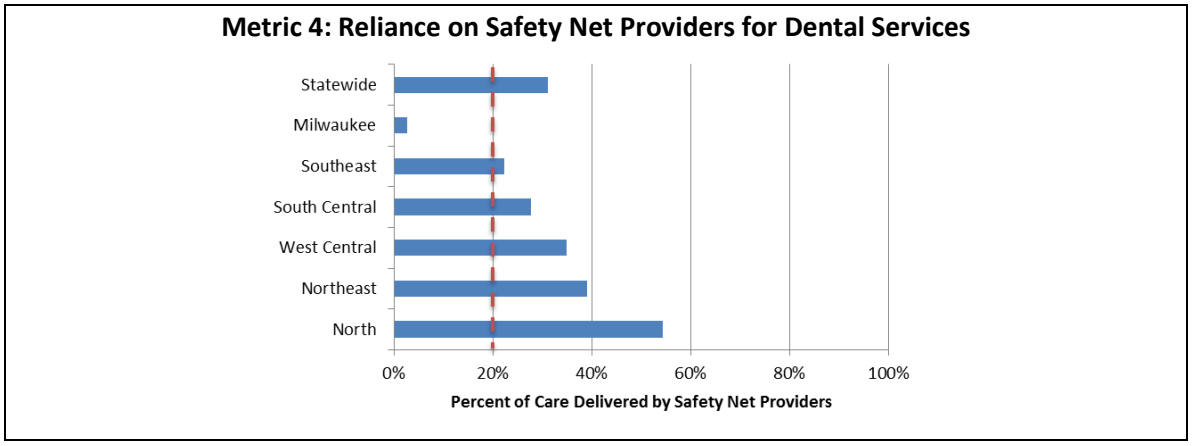
In terms of regional variation:

- The Southeast region had the lowest utilization of dental services for children, at 30%.
- The highest rate for children was in the North region of the state, at 61%, 18 percentage points above the statewide average.
- Milwaukee had the lowest utilization of dental services among adults, at 31%.
- The highest rate for adults was also in the North region, with 41% of adults receiving dental services.

Utilization of dental services varies significantly by region, particularly for children. The urban areas of the state show the lowest utilization of dental services, while more rural regions exceed the statewide average.

Metric 4: Reliance on Safety Net Providers for Dental Care Delivery
Metric 4 measures the reliance on safety net providers for the delivery of dental care through the fee-for-service Medicaid program. Safety net providers represent an access point to care for members who might otherwise have inadequate access; thus, a high reliance on safety net providers would suggest that members are less able to access dental care through standard dental providers.

To calculate Metric 4, we divided the number of dental services delivered by safety net providers in calendar year 2014 by the total number of dental services delivered by all types of providers for each of six geographic regions in Wisconsin. On the chart below, the red dotted line marks 20% and is included as a visual reference point.



Metric 4 shows that 31% of dental services across the state were delivered by safety net providers. There is regional variation in reliance on safety net providers that largely mirrors the regional utilization of dental services. The North region has the highest reliance on safety net providers, at 54% of dental services, while only 3% of dental services in Milwaukee are provided by safety net providers.

Fee-for-Service Reimbursement

Our analysis of fee-for-service reimbursement evaluates the reimbursement rates paid through the fee-for-service Medicaid program to dentists. Dentists use nationally standardized billing codes, known as procedure codes, to bill for each distinct service that they provide. DHS establishes a reimbursement rate, known as a max fee, for each covered service. The max fee represents the highest amount DHS will pay a provider for the service. Max fees are based on various factors, including a review of charges submitted by providers, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations.

Metric 5: Comparison of Medicaid Max Fees for Dental Care
Unlike other core services, we were unable to compare Medicaid max fees to corresponding Medicare max fees for dental care because Medicare does not set rates for dental services. Instead, we compare Wisconsin Medicaid max fees to max fees from neighboring state Medicaid programs, including Illinois, Iowa, Michigan, and Minnesota.

To compare rates across states, we identify a base rate for each dental procedure using the 2016 max fee schedule for adult members but do not account for rate adjustments or other unique reimbursement methodologies designed to improve access to dental care. Many state Medicaid programs, including Wisconsin's, provide an add-on payment for certain dental services provided to children. Due to variations among states in how and when add-on payments are applied, we do not consider add-on payments in our analysis. Although there are differences among neighboring states in coverage of dental services, we were able to analyze max fees for those dental services that are common among the states.

The procedure codes that we identified as representative of dental care include the subset of procedure codes known as Current Dental Terminology (CDT) codes. We identified the max fee for each CDT code for Wisconsin and each neighboring state. In comparing Wisconsin max fees to each other state, we only analyzed CDT codes covered by both Wisconsin and the other state.

We divided the Wisconsin Medicaid max fees by the corresponding max fees from each neighboring state to represent Wisconsin reimbursement as a percentage of each neighboring state's reimbursement. We also divided the Wisconsin Medicaid max fees for the top 10 most frequently billed dental services by the corresponding max fees from neighboring states.

Metric 5: Comparison of Medicaid Max Fees for Dental Care		
State	Wisconsin Medicaid Rate as % of Neighboring State's Rate for All Common CDT Codes	Wisconsin Medicaid Rate as % of Neighboring State's Rate for Top 10 Common CDT Codes
IL	155%	117%
IA	107%	80%
MI	137%	123%
MN	89%	94%

Metric 5 shows that Wisconsin Medicaid max fees for dental care are equal to 89% to 155% of max fees of neighboring states. When selecting only the 10 most frequently billed dental services, Wisconsin Medicaid max fees ranged from 80% to 123% of neighboring state max fees.

Summary

The analysis in this section presents five metrics that measure access to dental care for members who receive health care coverage through Wisconsin's fee-for-service Medicaid program.

Metrics 1 and 2 measure the Medicaid provider network for dentists. Metric 1 shows that fewer than half of licensed dentists were enrolled in the Medicaid program. Metric 2 shows that, of these enrolled dentists, fewer than half were active, while 53% were either

inactive or had limited participation. Taken together, Metrics 1 and 2 suggest a less robust Medicaid provider network for dental care compared to other types of services.

Metrics 3 and 4 measure utilization of dental care. Metric 3 shows that overall utilization of dental services was low among both children and adults and that utilization varied considerably by region. This shows that members experience different challenges accessing dental services in different regions of the state. The pattern of utilization indicates that access to dental services is highest in rural regions of the state. This pattern may seem unexpected, but Metric 4 further shows that higher levels of dental utilization in rural regions were primarily a result of high reliance on safety net providers in those areas. Thus, while members in rural areas of the state are better able to access dental services, they are largely relying on safety net providers instead of standard providers for care. Members in more urban regions of the state have lower levels of utilization overall and are thus less likely to access dental services from either standard or safety net providers.

Metric 5 compares Wisconsin Medicaid max fees for dental services to corresponding Medicaid max fees of neighboring states and shows that Wisconsin Medicaid max fees are largely aligned with regional Medicaid reimbursement. In general, Wisconsin max fees as a percentage of neighboring state max fees are higher when comparing all dental services than when comparing the most frequently utilized dental services. This general trend suggests that Wisconsin max fees are lower for more common preventive dental services but higher for specialized dental services.

Physician Specialty Services

The Wisconsin Medicaid program provides coverage of physician specialty services, including office visits, consultations, diagnostic procedures, surgery services, and other medical interventions.

In this part of the access monitoring plan, we present data-driven metrics that measure access to physician specialty services for members who receive health care coverage through Wisconsin's fee-for-service Medicaid program. We include metrics that measure the provider network, service utilization, and fee-for-service reimbursement.

Provider Network

Our analysis of the provider network for specialty services evaluates the physician specialists who are available to serve fee-for-service Medicaid members. For purposes of our analysis, we define physician specialists as surgeons, radiologists, and medical specialists.

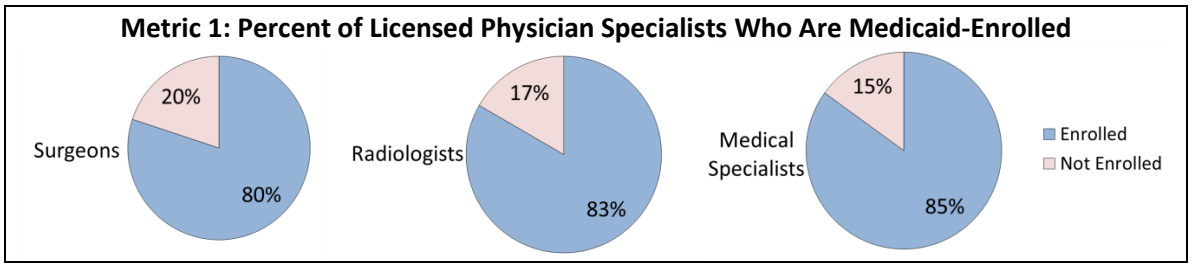
We calculate two metrics to measure the provider network for physician specialty services:

- The percent of licensed physician specialists who are enrolled in the Medicaid program
- The level of participation among enrolled physician specialists

Metric 1: Percent of Licensed Physician Specialists Who Are Medicaid-Enrolled

Metric 1 measures the percent of licensed physician specialists who are enrolled in the Medicaid program. To practice in Wisconsin, physicians must be licensed by the Wisconsin Department of Safety and Professional Services. After licensure, physicians can choose whether to enroll in the Medicaid program, which would make them available to serve fee-for-service Medicaid members. The Medicaid enrollment process includes confirmation of Wisconsin licensure and federally required screenings. Physicians are asked to identify their specialty at the time of enrollment.

To calculate Metric 1, we divided the number of Medicaid-enrolled physician specialists by the total number of licensed physician specialists for calendar year 2014.



Metric 1 shows that 80% of licensed surgeons, 83% of licensed radiologists, and 85% of licensed medical specialists were enrolled in the Medicaid program for calendar year

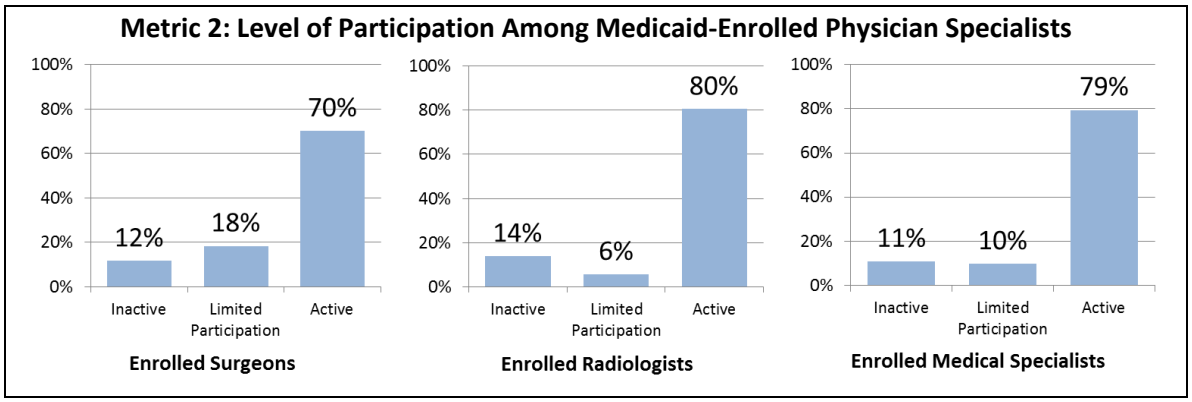
2014. These high percentages of enrolled physician specialists mean there are a large number of physician specialists who are available to possibly serve Medicaid members, relative to the total number of licensed physician specialists.

Metric 2: Level of Participation among Medicaid-Enrolled Physician Specialists
Metric 2 measures the level of participation among Medicaid-enrolled physician specialists. DHS does not require enrolled providers to serve a certain number of members; therefore, the level of participation among enrolled physician specialists can vary.

Metric 2 builds upon Metric 1: whereas Metric 1 measures how many licensed physician specialists are Medicaid-enrolled and, therefore, available to possibly serve Medicaid members, Metric 2 measures the levels at which enrolled physician specialists are actually serving Medicaid members.

To calculate Metric 2, we grouped enrolled physician specialists into three categories based on the number of members they served in calendar year 2014:

- Inactive providers (defined as those serving no members)
- Limited-participation providers (defined as those serving between 1 and 25 members)
- Active providers (defined as those serving 26 or more members)



Metric 2 shows that, during calendar year 2014, 12% of enrolled surgeons, 14% of enrolled radiologists, and 11% of enrolled medical specialists were inactive. Eighteen percent of enrolled surgeons, 6% of enrolled radiologists, and 10% of enrolled medical specialists had limited participation. Finally, 70% of enrolled surgeons, 80% of enrolled radiologists, and 79% of enrolled medical specialists were active. The high percentage of active providers across physician specialties, relative to the percentages of inactive and low-participation providers, shows that most enrolled physician specialists are actively engaged with the Medicaid program, thus providing access to physician specialty services.

Service Utilization

Our analysis of service utilization measures how fee-for-service Medicaid members have actually accessed physician specialty services, with a focus on patterns and variations in utilization. For purposes of our analysis, we define a physician specialty service as any service provided by a surgeon, radiologist, or medical specialist.

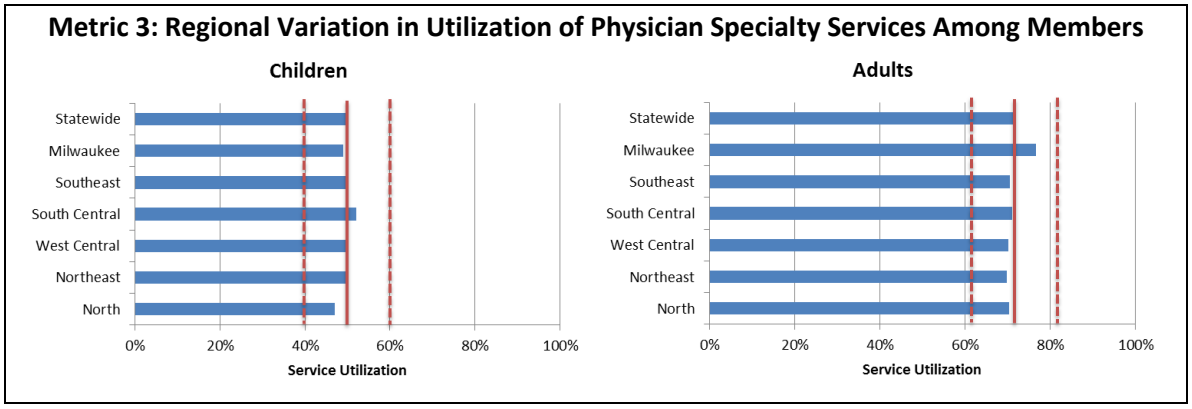
We calculate two metrics to measure utilization of physician specialty services:

- Regional variation in utilization among members
- Reliance on safety net providers for care delivery

Metric 3: Regional Variation in Physician Specialty Utilization Among Members

Metric 3 measures the regional variation in utilization of physician specialty services among members enrolled in the fee-for-service Medicaid program. The need for physician specialty services among members should not vary considerably based on geography; thus, any regional variation in service utilization might instead suggest regional differences in the ability to access physician specialty services.

To calculate Metric 3, we divided the number of fee-for-service members who received a physician specialty service in calendar year 2014 by the total number of fee-for-service members enrolled in calendar year 2014. We compared average statewide utilization to utilization in each of six geographic regions to determine regional variation. We calculated utilization separately for children (defined as members ages 18 and younger) and adults (defined as members ages 19 and older). On the chart below, the red dotted lines mark 10 percentage points above and below the average statewide utilization and are included as visual reference points.



Metric 3 shows that the overall average statewide utilization of physician specialty services was 50% for children and 71% for adults. We cannot say whether this level of utilization of physician specialty services suggests adequate or inadequate access to care because utilization of physician specialty services is primarily dependent on the medical needs of the population. We are unable to reliably measure the medical need for physician specialty services among fee-for-service Medicaid members due to limitations in available data. We therefore limit our interpretation of Metric 3 to an analysis of regional variation.

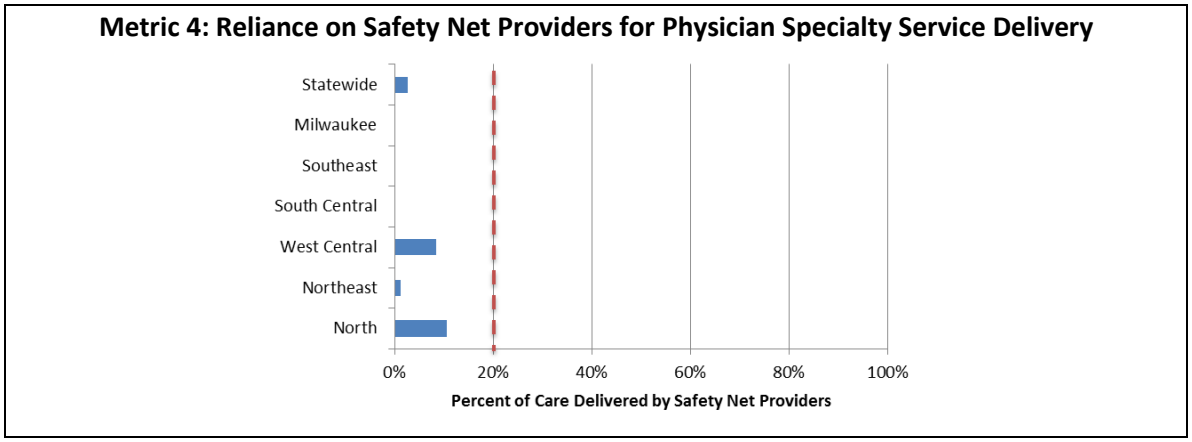
In terms of regional variation:

- Utilization among children was lowest in the North region of the state at 47%, while the highest utilization was 52% in the South Central region.
- For adults, the lowest utilization was at 70% in four regions, while the Milwaukee region was highest at 77%.

We would expect that utilization of physician specialist services would be highest in the South Central and Milwaukee regions, two urban regions with large health care systems. While Metric 3 shows some variation in utilization across regions, regional variation overall is minimal, with no region varying from the statewide average by more than 10 percentage points for either children or adults.

Metric 4: Reliance on Safety Net Providers for Physician Specialty Service Delivery
Metric 4 measures the reliance on safety net providers for the delivery of physician specialty services through the fee-for-service Medicaid program. Safety net providers represent an access point to care for members who might otherwise have inadequate access; thus, a high reliance on safety net providers would suggest that members are less able to access physician specialty services through standard providers.

To calculate Metric 4, we divided the number of physician specialty services delivered by safety net providers in calendar year 2014 by the total number of physician specialty services delivered by all types of providers for each of six geographic regions. On the chart below, the red dotted line marks 20% and is included as a visual reference point.



Metric 4 shows that 3% of physician specialty services across the state were delivered by safety net providers in calendar year 2014. There is regional variation in reliance on safety net providers, with the North and West Central regions relying on safety net providers for 11% and 8%, respectively, of physician specialty services. We would expect higher reliance on safety net providers in these rural regions in comparison to regions with larger health care systems. The overall low reliance on safety net providers suggests members are generally able to access physician specialty services through standard providers without having to rely on safety net providers.

Fee-for-Service Reimbursement

Our analysis of fee-for-service reimbursement evaluates the reimbursement rates paid to health care providers for physician specialty services provided through the fee-for-service Medicaid program. Health care providers use nationally standardized billing codes, known as procedure codes, to bill for each distinct service that they provide. DHS establishes a reimbursement rate, known as a max fee, for each covered service. The max fee represents the highest amount DHS will pay a provider for the service. Max fees are based on various factors, including a review of charges submitted by providers, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations.

Metric 5: Comparison of Medicaid and Medicare Max Fees for Physician Specialty Services

Metric 5 compares fee-for-service Medicaid max fees to corresponding Medicare max fees for physician specialty services. The procedure codes that we identified as representative of physician specialty services include those categorized nationally as surgery services[6]. We identified the Medicaid and Medicare max fees in effect in 2014 for each surgery procedure code.

We divided the Medicaid max fees by the corresponding Medicare max fees for all surgery procedure codes to represent Medicaid reimbursement as a percentage of Medicare reimbursement. We also separately divided the Medicaid max fees by the corresponding Medicare max fees for the top 10 most frequently billed surgery procedure codes.

Metric 5: Comparison of Medicaid and Medicare Max Fees for Physician Specialty Services		
Representative Procedure Codes	Code Range	Medicaid Rate as % of Medicare Rate
Surgery	All Codes	81.03%
Top 10 Billed Surgery Codes	20610	67.97%
	11721	
	17110	
	58300	
	43239	
	64493	
	11981	
	64483	
	62311	
	66984	

[6] The definition of surgery services for the purpose of procedure code classification is broader than the common definition and includes procedures such as colonoscopies, injections, certain diagnostic services, and maternity care and delivery. We excluded procedure codes representing maternity care and delivery since they are separately covered under the section of this plan on obstetric services.

Metric 5 shows that the Medicaid program max fees for physician specialty services, as represented by surgery procedure codes, are equal to 81% of Medicare reimbursement. The top 10 most frequently used procedures are equal to 68% of Medicare reimbursement.

Summary

The analysis in this section presents five metrics that measure access to physician specialty services for members who receive health care coverage through Wisconsin's fee-for-service Medicaid program.

Metrics 1 and 2 measure the Medicaid provider network for physician specialty services. Metric 1 shows that a high percentage of licensed surgeons, radiologists, and medical specialists were enrolled in the Medicaid program. Metric 2 shows that, of these enrolled providers, a high percentage were actively serving Medicaid members. Taken together, Metrics 1 and 2 suggest a robust Medicaid provider network for physician specialty services that should enable access to care.

Metrics 3 and 4 measure utilization of physician specialty services. Metric 3 shows that utilization did not vary considerably by region, indicating that members have similar access to physician specialty services in all areas of the state. Metric 4 shows a higher reliance on safety net providers to deliver physician specialty services in the North and West Central regions of the state, both of which represent largely rural areas. Nevertheless, reliance on safety net providers was still low even in these areas, which suggests that most members are able to effectively access physician specialty services through standard providers. Minimal regional variation in utilization and low reliance on safety net providers support the conclusion from Metrics 1 and 2 that the physician specialty provider network is relatively strong.

Metric 5 shows that fee-for-service Medicaid max fees for physician specialty services are equal to, on average, 81% of Medicare reimbursement. Metrics 1 through 4 suggest that Medicaid max fees for physician specialty services have enabled adequate access to care.

Behavioral Health Services

The Wisconsin Medicaid program provides coverage of behavioral health services for both mental health and substance use disorder diagnoses. Coverage includes assessments and diagnostic evaluations, outpatient counseling and psychotherapy, day treatment services, pharmacologic management, and other behavioral health interventions. Behavioral health services are provided both through private-sector providers and through public psychosocial rehabilitation programs administered locally by Wisconsin counties[7].

In this part of the access monitoring plan, we present data-driven metrics that measure access to behavioral health services for members who receive health care coverage through Wisconsin's fee-for-service Medicaid program. We include metrics that measure the provider network, service utilization, and fee-for-service reimbursement.

Provider Network

Our analysis of the provider network for behavioral health services evaluates the behavioral health providers available to serve fee-for-service Medicaid members. For purposes of our analysis, we define behavioral health providers as psychiatrists, psychologists, psychotherapists, and substance abuse counselors. Psychotherapists include licensed marriage and family therapists, licensed professional counselors, and certain licensed social workers. Substance abuse counselors include certified clinical substance abuse counselors and certified substance abuse counselors.

We calculate two metrics to measure the provider network for behavioral health services:

- The percent of licensed behavioral health providers who are enrolled in the Medicaid program
- The level of participation among enrolled behavioral health providers

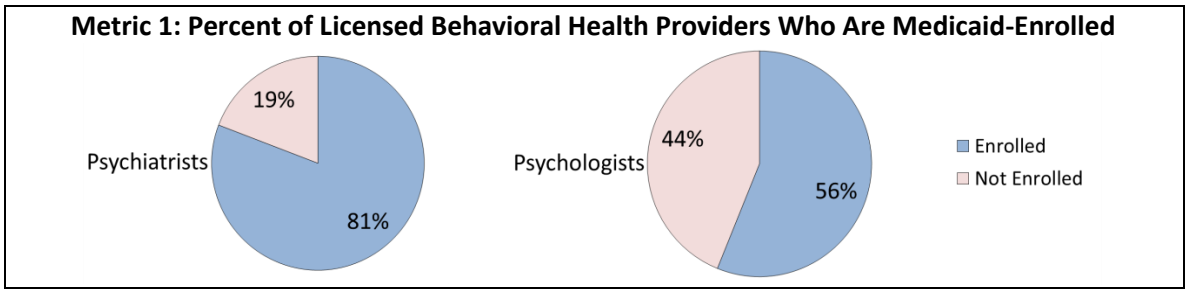
Metric 1: Percent of Licensed Behavioral Health Providers Who Are Medicaid-Enrolled

Metric 1 measures the percent of licensed behavioral health providers who are enrolled in the Medicaid program. To practice in Wisconsin, most behavioral health providers must be licensed by the Wisconsin Department of Safety and Professional Services. After licensure, behavioral health providers can choose whether to enroll in the Medicaid program, which would make them available to serve fee-for-service Medicaid members. The Medicaid enrollment process includes federally required screenings and confirmation of Wisconsin licensure, national certification, or a higher education degree, depending on the provider type.

To calculate Metric 1, we divided the number of Medicaid-enrolled behavioral health providers by the total number of licensed behavioral health providers for calendar year 2014. We were unable to include psychotherapists or substance abuse counselors in the

[7] County-administered psychosocial rehabilitation programs include Crisis Intervention, Community Support Programs, Comprehensive Community Services, and Community Recovery Services.

calculation for Metric 1 because state licensing data for these providers did not crosswalk consistently to the provider type categories used for Medicaid enrollment. We recognize that these providers do enroll in the Medicaid program to provide behavioral health services for Medicaid members and only exclude them from Metric 1 due to data constraints.



Metric 1 shows that 81% of licensed psychiatrists were enrolled in the Medicaid program for calendar year 2014. This high percentage of enrolled psychiatrists means there are a large number of psychiatrists who are available to possibly serve Medicaid members, relative to the total number of licensed psychiatrists.

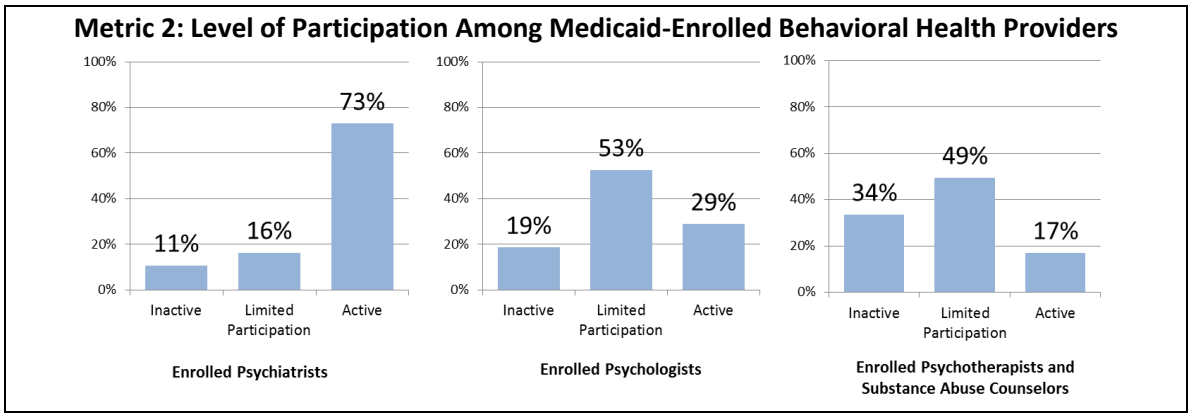
Metric 1 shows that 56% of licensed psychologists were enrolled in the Medicaid program for calendar year 2014. The percentage of enrolled psychologists is lower than other types of providers and shows that there are fewer psychologists who are available to serve Medicaid members, relative to the total number of licensed psychologists. The lower enrollment percentage for psychologists could partially reflect that some licensed psychologists pursue careers other than active practice.

Metric 2: Level of Participation Among Medicaid-Enrolled Behavioral Health Providers

Metric 2 measures the level of participation among Medicaid-enrolled behavioral health providers. DHS does not require enrolled providers to serve a certain number of members; therefore, the level of participation among enrolled behavioral health providers can vary. Metric 2 builds upon Metric 1: whereas Metric 1 measures how many licensed behavioral health providers are Medicaid enrolled and, therefore, available to possibly serve Medicaid members, Metric 2 measures the levels at which enrolled behavioral health providers are actually serving Medicaid members.

To calculate Metric 2, we grouped enrolled behavioral health providers into three categories based on the number of members they served in calendar year 2014:

- Inactive providers (defined as those serving no members)
- Limited-participation providers (defined as those serving between 1 and 25 members)
- Active providers (defined as those serving 26 or more members)



Metric 2 shows that, during calendar year 2014, 11% of enrolled psychiatrists were inactive, 16% had limited participation, and 73% were active. The high percentage of active psychiatrists, relative to the percentages of inactive and limited-participation psychiatrists, shows that most enrolled psychiatrists are actively engaged with the Medicaid program, thus providing access to behavioral health services.

Metric 2 further shows that, during calendar year 2014, 19% of enrolled psychologists were inactive, 53% had limited participation, and 29% were active. For calendar year 2014, 34% of enrolled psychotherapists and substance abuse counselors were inactive, 49% had limited participation, and 17% were active. The level of participation among psychologists, psychotherapists, and substance abuse counselors is considerably lower than that for psychiatrists.

The lower levels of participation among these provider types may be due to several factors. First, psychologists, psychotherapists, and substance abuse counselors typically see fewer patients than psychiatrists overall, based on their practice model. Second, the apparent lower level of participation could partially be due to a Medicaid billing policy that allows these provider types to bill certain behavioral health services through a supervising provider. If a provider bills through his or her supervisor, we would not have complete data on that provider's rendered services, which could cause the provider's level of participation to appear lower than it actually is. However, even after accounting for these factors, the level of participation among psychologists, psychotherapists, and substance abuse counselors appears low compared to other types of providers.

Service Utilization

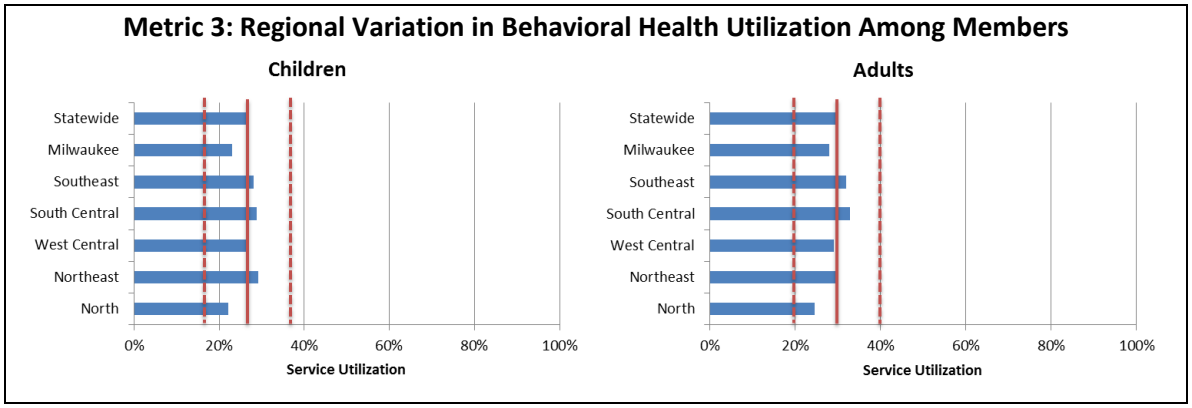
Our analysis of service utilization measures how fee-for-service Medicaid members have actually accessed behavioral health services, with a focus on patterns and variations in utilization. For purposes of our analysis, we include behavioral health services provided through both private-sector providers and public psychosocial rehabilitation programs.

We calculate two metrics to measure utilization of behavioral health services:

- Regional variation in utilization among members
- Reliance on safety net providers for service delivery

Metric 3: Regional Variation in Behavioral Health Utilization Among Members
Metric 3 measures the regional variation in utilization of behavioral health services among members enrolled in the fee-for-service Medicaid program. The need for behavioral health services among members should not vary considerably based on geography; thus, any regional variation in service utilization might instead suggest regional differences in the ability to access behavioral health services.

To calculate Metric 3, we divided the number of fee-for-service members who received a behavioral health service in calendar year 2014 by the total number of fee-for-service members enrolled in calendar year 2014. We compared average statewide utilization to utilization in each of six geographic regions to determine regional variation. We calculated utilization separately for children (defined as members ages 18 and younger) and adults (defined as members ages 19 and older). On the chart below, the red dotted lines mark 10 percentage points above and below the average statewide utilization and are included as visual reference points.

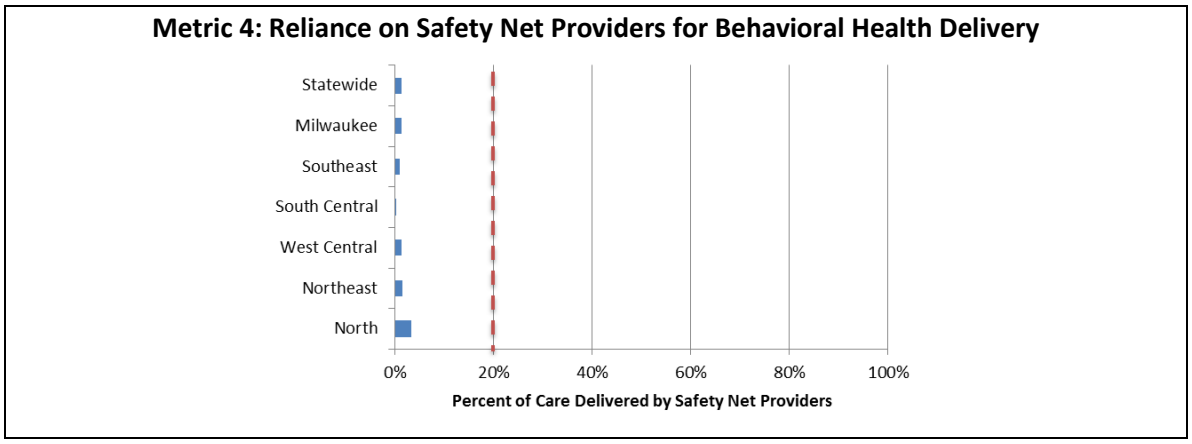


Metric 3 shows that the average statewide utilization of behavioral health services was 26% for children and 29% for adults. We cannot say whether this level of overall utilization of behavioral health services suggests adequate or inadequate access to care because utilization of behavioral health services is primarily dependent on the medical needs of the population. We are unable to reliably measure the medical need for behavioral health services among fee-for-service Medicaid members due to limitations in available data. We therefore limit our interpretation of Metric 3 to an analysis of regional variation.

Utilization among children was lowest in the North region of the state at 22%, while the highest utilization was 29% in the South Central region. The pattern was similar for adults, with the lowest utilization in the North at 25%, and the highest utilization in the South Central region at 33%. Each region is within 5 *percentage points* of the statewide average. However, because the average statewide utilization is a low number for both children (26%) and adults (29%), the *percent* of variation across regions is high. Therefore, we conclude that there is regional variation in the utilization of behavioral health services across the state.

Metric 4: Reliance on Safety Net Providers for Behavioral Health Delivery
Metric 4 measures the reliance on safety net providers for the delivery of behavioral health services through the fee-for-service Medicaid program. Safety net providers represent an access point to care for members who might otherwise have inadequate access; thus, a high reliance on safety net providers would suggest that members are less able to access behavioral health services through standard providers.

To calculate Metric 4, we divided the number of behavioral health services delivered by safety net providers in calendar year 2014 by the total number of behavioral health services delivered by all types of providers for each of six geographic regions in Wisconsin. On the chart below, the red dotted line marks 20% and is included as a visual reference point.



Metric 4 shows that 1% of behavioral health services across the state were delivered by safety net providers. The low overall percentage suggests that safety net providers across the state are less engaged in delivering behavioral health services.

Regional variation is also impacted by the low overall percentage of behavioral health services delivered by safety net providers. Reliance is highest in the North region at 3% of behavioral health services and the lowest in the South Central region at less than 1%. Although these values only differ by 2 percentage points, the reliance on safety net providers in the North region is more than three times greater than that in the South Central region.

Fee-for-Service Reimbursement

Our analysis of fee-for-service reimbursement evaluates the reimbursement rates paid to providers for behavioral health services provided through the fee-for-service Medicaid program. Health care providers use nationally standardized billing codes, known as procedure codes, to bill for each distinct service that they provide. DHS establishes a reimbursement rate, known as a max fee, for each covered service. The max fee represents the highest amount DHS will pay a provider for the service. Max fees are based on various factors, including a review of charges submitted by providers, the

Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations.

Metric 5: Comparison of Medicaid and Medicare Max Fees for Behavioral Health Services

Metric 5 compares fee-for-service Medicaid max fees to corresponding Medicare max fees for behavioral health services. The procedure codes that we identified as representative of behavioral health services include those categorized nationally as psychiatry services. Of note, the definition of psychiatry services for purposes of procedure code classification is broader than the common definition and includes services such as psychotherapy provided by non-psychiatrists. We identified the Medicaid and Medicare max fees in effect in calendar year 2014 for each psychiatry procedure code. We did not consider add-on payments to some public psychosocial rehabilitation programs administered locally by Wisconsin counties, which are paid through a cost-reconciliation process.

We divided the Medicaid max fees by the corresponding Medicare max fees for all psychiatry procedure codes to represent Medicaid reimbursement as a percentage of Medicare reimbursement. We also divided the Medicaid max fees by the corresponding Medicare max fees for the subset of psychiatry procedure codes that represent psychotherapy, which represents the most frequently utilized subset of psychiatry procedure codes.

Metric 5: Comparison of Medicaid and Medicare Max Fees for Behavioral Health Services		
Representative Procedure Codes	Code Range	Medicaid Rate as % of Medicare Rate
All Psychiatry Codes	All Codes	73.03%
Psychotherapy	90832-90853	76.12%

Metric 5 shows that the Medicaid max fees for behavioral health services, as represented by psychiatry procedure codes, are equal to 73% of Medicare reimbursement. The most frequently used subset of behavioral health procedures, psychotherapy, is equal to 76% of Medicare reimbursement.

Summary

The analysis in this section presents five metrics that measure access to behavioral health services for members who receive health care coverage through Wisconsin's fee-for-service Medicaid program.

Metrics 1 and 2 measure the Medicaid provider network for behavioral health services. Metric 1 shows that a high percentage of licensed psychiatrists were enrolled in the Medicaid program. Metric 2 further shows that, of these enrolled psychiatrists, a high percentage were actively serving Medicaid members. Taken together, Metrics 1 and 2 suggest a robust Medicaid provider network for psychiatrists, relative to the total number

of psychiatrists in Wisconsin. This finding must be reconciled with other feedback that suggests individuals frequently have difficulty accessing psychiatrists. Metrics 1 and 2 suggest only that Medicaid members have access to psychiatrists that is comparable to access by the general population. Other feedback suggests that there are broader access concerns regarding psychiatrists that apply to all Wisconsin residents, including fee-for-service Medicaid members.

Metrics 1 and 2 show a less robust Medicaid provider network for psychologists, psychotherapists, and substance abuse counselors. Metric 1 shows that just over half of licensed psychologists were enrolled in the Medicaid program. Metric 2 shows that the level of participation among psychologists, psychotherapists, and substance abuse counselors was lower than other provider types.

Metrics 3 and 4 measure utilization of behavioral health services. Metric 3 shows that utilization varied by region, indicating that members experience different challenges accessing behavioral health services in different parts of the state. Metric 4 shows a low reliance on safety net providers to deliver behavioral health services throughout the state, with some regional variation. Metrics 3 and 4 suggest that further analysis is required to better understand local differences in access to behavioral health services. This conclusion is supported by Metrics 1 and 2, which suggest that variation in the availability of certain provider types may impact access to behavioral health services.

Metric 5 shows that fee-for-service Medicaid max fees for behavioral health services are equal to, on average, 73% of Medicare reimbursement.

Obstetric Services

The Wisconsin Medicaid program covers comprehensive obstetric care services, including prenatal visits, labor and delivery services, post-partum care, laboratory tests, ultrasounds, and other medically necessary pregnancy-related services. The Medicaid program also covers prenatal care coordination. Prenatal care coordination providers identify pregnant women with high social risk factors and help them address any medical or social barriers to care. There is no cost sharing for pregnant members.

The majority of pregnant women enrolled in the Medicaid program receive coverage through the managed care delivery system. Managed care incentivizes better management and coordination of obstetric services, which can lead to better access and improved birth outcomes. Contracted HMOs have the flexibility to use unconventional approaches (e.g., offering diapers) to encourage women to attend obstetric care appointments.

Furthermore, DHS's pay-for-performance initiatives require contracted HMOs to meet certain performance standards for prenatal and post-partum care in order to receive full payment.

DHS has also implemented a medical home model under the managed care framework for pregnant women in communities with lower access to care. Under the medical home model, clinics known as Obstetrics Medical Home providers work with HMOs to provide enhanced care coordination, social support, and other services aimed at identifying and removing barriers to care. There is an enhanced financial incentive for participating providers to coordinate care to help women achieve improved birth outcomes.

As a result of the initiatives described above, very few pregnant women enrolled in the Medicaid program receive coverage through the fee-for-service delivery system.

In this section of the access monitoring plan, we present data-driven metrics that measure access to obstetric services for the small population of pregnant women who receive coverage through the fee-for-service delivery system.

Provider Network

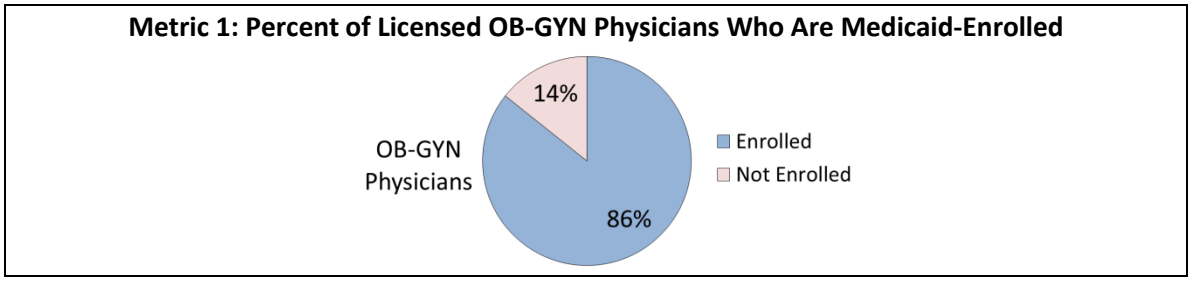
Our analysis of the provider network for obstetric services evaluates physicians with a specialty of obstetrics and gynecology (OB-GYN) who are available to serve fee-for-service Medicaid members. We were unable to include nurse midwives in the provider network analysis because the provider type categories used for state licensing purposes did not crosswalk consistently to the provider type categories used for Medicaid enrollment. Thus, an accurate comparison of licensure and enrollment data could not be completed.

We calculate two metrics to measure the provider network for obstetric services:

- The percent of licensed OB-GYN physicians who are enrolled in the Medicaid program
- The level of participation among enrolled OB-GYN physicians

Metric 1: Percent of Licensed OB-GYN Physicians Who Are Medicaid-Enrolled
Metric 1 measures the percent of licensed OB-GYN physicians who are enrolled in the Medicaid program. To practice in Wisconsin, OB-GYN physicians must be licensed by the Wisconsin Department of Safety and Professional Services. After licensure, OB-GYN physicians can choose whether to enroll in the Medicaid program, which would make them available to serve fee-for-service Medicaid members. The Medicaid enrollment process includes confirmation of Wisconsin licensure and federally required screenings.

To calculate Metric 1, we divided the number of Medicaid-enrolled OB-GYN physicians by the total number of licensed OB-GYN physicians for calendar year 2014.

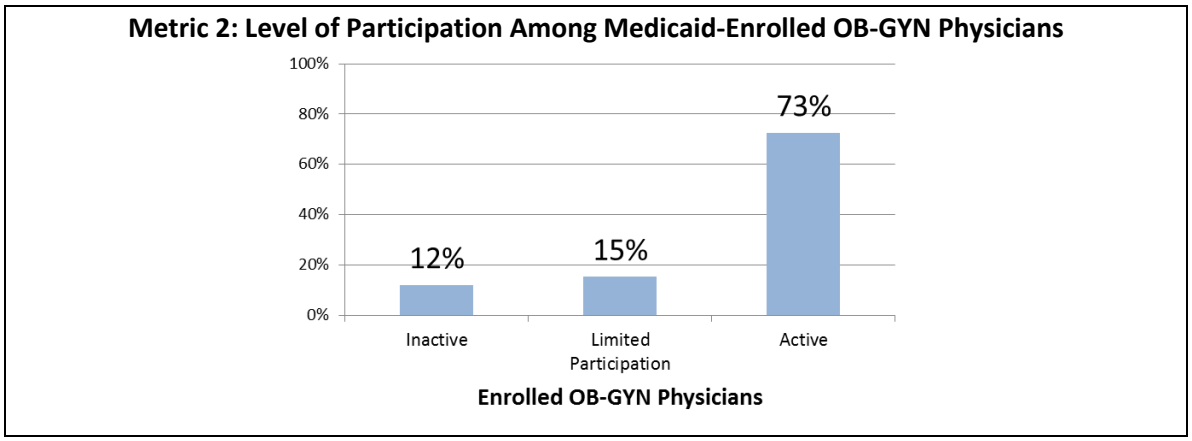


Metric 1 shows that 86% of licensed OB-GYN physicians were enrolled in the Medicaid program for calendar year 2014. This high percentage of enrolled OB-GYN physicians means there are a large number of OB-GYN physicians who are available to possibly serve Medicaid members, relative to the total number of OB-GYN physicians.

Metric 2: Level of Participation Among Medicaid-Enrolled OB-GYN Physicians
Metric 2 measures the level of participation among Medicaid-enrolled OB-GYN physicians. DHS does not require enrolled providers to serve a certain number of members; therefore, the level of participation among enrolled OB-GYN physicians can vary. Metric 2 builds upon Metric 1: whereas Metric 1 measures how many licensed OB-GYN physicians are Medicaid-enrolled and, therefore, available to possibly serve Medicaid members, Metric 2 measures the levels at which enrolled OB-GYN physicians are actually serving Medicaid members.

To calculate Metric 2, we grouped enrolled OB-GYN physicians into three categories based on the number of members they served in calendar year 2014:

- Inactive providers (defined as those serving no members)
- Limited-participation providers (defined as those serving between 1 and 25 members)
- Active providers (defined as those serving 26 or more members)



Metric 2 shows that, during calendar year 2014, 12% of enrolled OB-GYN physicians were inactive, 15% had limited participation, and 73% were active. The high percentage of active providers, relative to the percentages of inactive and low-participation providers, shows that most enrolled OB-GYN physicians are actively engaged with the Medicaid program, thus providing access to obstetric services.

Service Utilization

Our analysis of service utilization is intended to measure how fee-for-service Medicaid members have actually accessed obstetric services, with a focus on patterns and variations in utilization.

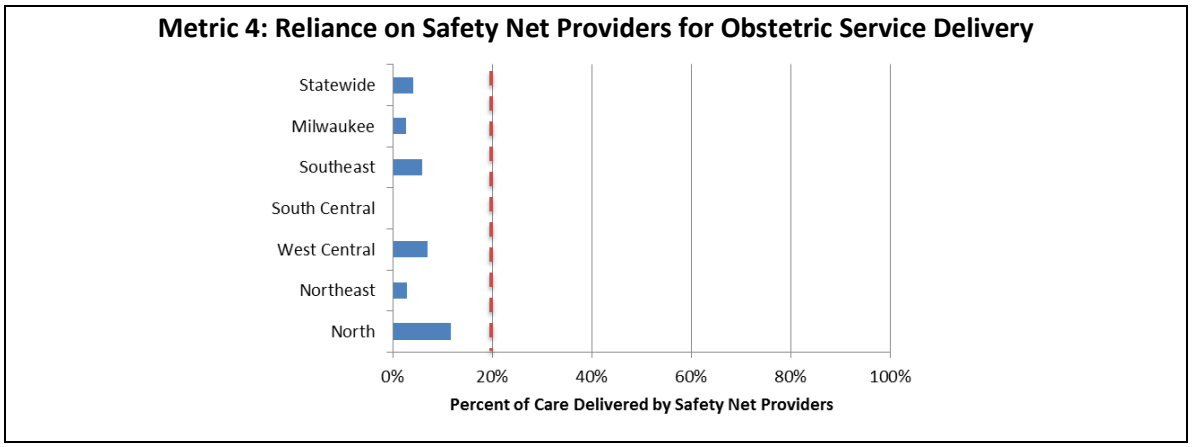
Metric 3: Regional Variation in Obstetric Service Utilization Among Members

We did not calculate Metric 3 for obstetric services. As discussed in Section 2 of this plan (Methodology for Analyzing Fee-for-Service Access to Core Services), our methodology for calculating Metric 3 measures service utilization among the population of Medicaid members who were continuously enrolled in the fee-for-service delivery system throughout 2014. Most women who were pregnant in 2014 were enrolled in the managed care delivery system for all or part of the year due to DHS's access initiatives described previously.

Metric 4: Reliance on Safety Net Providers for Obstetric Service Delivery

Metric 4 measures the reliance on safety net providers for the delivery of obstetric services through the fee-for-service Medicaid program. Safety net providers represent an access point to care for members who might otherwise have inadequate access; thus, a high reliance on safety net providers would suggest that members are less able to access obstetric services through standard providers.

To calculate Metric 4, we divided the number of obstetric services delivered by safety net providers in calendar year 2014 by the total number of obstetric services delivered by all types of providers for each of six geographic regions in Wisconsin. On the chart below, the red dotted line marks 20% and is included as a visual reference point.



Metric 4 shows that 4% of obstetric services across the state were delivered by safety net providers. There is regional variation in reliance on safety net providers, with 12% of obstetric services provided by safety net providers in the North region and less than 1% provided by safety net providers in the South Central region. The overall low reliance on safety net providers suggests that fee-for-service members are adequately able to access obstetric services through standard providers.

Fee-for-Service Reimbursement

Our analysis of fee-for-service reimbursement evaluates the reimbursement rates paid to health care providers for obstetric services provided through the fee-for-service Medicaid program. Health care providers use nationally standardized billing codes, known as procedure codes, to bill for each distinct service that they provide. DHS establishes a reimbursement rate, known as a max fee, for each covered service. The max fee represents the highest amount DHS will pay a provider for the service. Max fees are based on various factors, including a review of charges submitted by providers, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations.

Metric 5: Comparison of Medicaid and Medicare Max Fees for Obstetric Services

Metric 5 compares fee-for-service Medicaid max fees to corresponding Medicare max fees for obstetric services. The procedure codes that we identified as representative of obstetric services include those categorized nationally as maternity care. We identified the Medicaid and Medicare max fees in effect in 2014 for each maternity care procedure code.

We divided the Medicaid max fees by the corresponding Medicare max fees for all maternity care procedure codes to represent Medicaid reimbursement as a percentage of Medicare reimbursement. We also divided the Medicaid max fees by the Medicare max

fees for the subset of maternity care procedure codes that represent vaginal delivery, antepartum care, and postpartum care, which represent the most frequently utilized subset of maternity care procedure codes.

Metric 5: Comparison of Medicaid and Medicare Max Fees for Obstetric Services		
Representative Procedure Codes	Code Range	Medicaid Rate as % of Medicare Rate
All Maternity Care	All Codes	74.31%
Vaginal Delivery, Antepartum and Postpartum Care	59400-59614	64.39%

Metric 5 shows that the Medicaid max fees for obstetric services are equal to 74% of Medicare reimbursement. The procedures most representative of obstetric care (vaginal delivery, antepartum care, and postpartum care) are equal to 64% of Medicare reimbursement.

Summary

The majority of pregnant women enrolled in the Medicaid program receive coverage through the managed care delivery system, with few pregnant women receiving coverage through the fee-for-service delivery system. Therefore, our analysis of fee-for-service access to obstetric services is more limited than our analysis of other core services.

For the small population of pregnant women who receive coverage through the fee-for-service delivery system, Metrics 1 and 2 suggest a robust Medicaid provider network for obstetric services. Metric 1 shows that a high percentage of licensed OB-GYN physicians were enrolled in the Medicaid program. Metric 2 shows that, of these enrolled providers, a high percentage were actively serving Medicaid members.

We did not calculate Metric 3 to measure regional variation in obstetric service utilization among members due to the small population of fee-for-service pregnant women. Metric 4 shows a low reliance on safety net providers for obstetric services, which supports the conclusion of Metrics 1 and 2 that standard obstetric providers are available to serve fee-for-service members.

Metric 5 shows that fee-for-service Medicaid max fees for obstetric services are equal to, on average, 74% of Medicare reimbursement.

Home Health Care

The Wisconsin Medicaid program provides coverage of home health services, including skilled nursing care, home health aide services, and home health therapy services. Many Medicaid members who are frail elders, adults with developmental or intellectual disabilities, or adults with physical disabilities receive coverage of home health services through the Family Care program instead of the fee-for-service delivery system. Family Care is a managed long-term care program that provides coverage of certain Medicaid services, including home health services, through care management organizations. As of January 2016, approximately 47,000 fee-for-service Medicaid members were enrolled in Family Care.

In this part of the access monitoring plan, we present data-driven metrics that measure access to home health care for non-Family Care members who receive coverage of home health services through the fee-for-service delivery system.

Provider Network

Our analysis of the provider network for home health care evaluates the home health agencies that are available to serve fee-for-service Medicaid members.

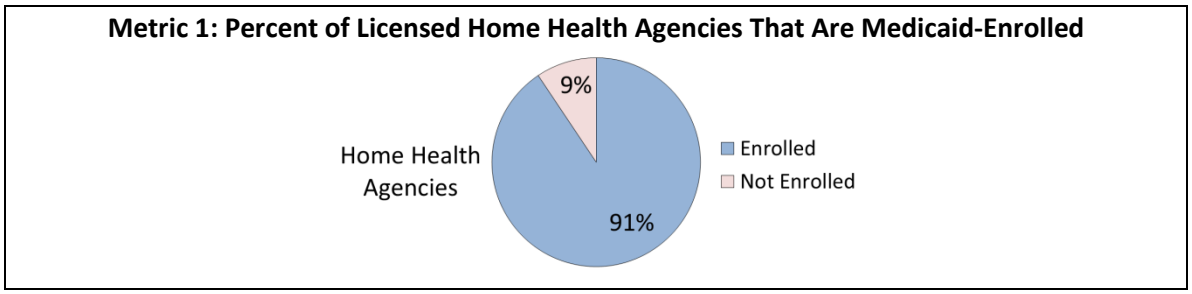
We calculate two metrics to measure the provider network for home health care:

- The percent of licensed home health agencies that are enrolled in the Medicaid program
- The level of participation among enrolled home health agencies

Metric 1: Percent of Licensed Home Health Agencies That Are Medicaid-Enrolled

Metric 1 measures the percent of licensed home health agencies that are enrolled in the Medicaid program. To operate in Wisconsin, home health agencies must be licensed by the DHS Division of Quality Assurance. After licensure, home health agencies can choose whether to enroll in the Medicaid program, which would make them available to serve fee-for-service Medicaid members. The Medicaid enrollment process includes confirmation of licensure and federally required screenings.

To calculate Metric 1, we divided the number of Medicaid-enrolled home health agencies by the total number of licensed home health agencies for calendar year 2014.

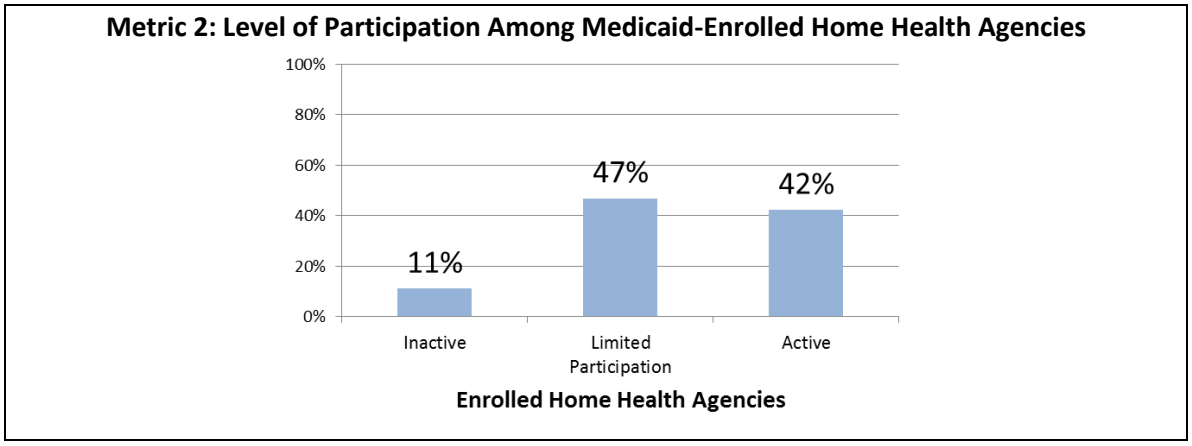


Metric 1 shows that 91% of licensed home health agencies were enrolled in the Medicaid program for calendar year 2014. This high percentage of enrolled home health agencies means there are a large number of home health agencies that are available to possibly serve Medicaid members, relative to the total number of licensed home health agencies.

Metric 2: Level of Participation Among Medicaid-Enrolled Home Health Agencies
Metric 2 measures the level of participation among Medicaid-enrolled home health agencies. DHS does not require enrolled providers to serve a certain number of members; therefore, the level of participation among enrolled home health agencies can vary. Metric 2 builds upon Metric 1: whereas Metric 1 measures how many licensed home health agencies are Medicaid-enrolled and, therefore, available to possibly serve Medicaid members, Metric 2 measures the levels at which enrolled home health agencies are actually serving Medicaid members.

To calculate Metric 2, we grouped enrolled home health agencies into three categories based on the number of members they served in calendar year 2014:

- Inactive providers (defined as those serving no members)
- Limited-participation providers (defined as those serving between 1 and 25 members)
- Active providers (defined as those serving 26 or more members)



Metric 2 shows that, during calendar year 2014, 11% of enrolled home health agencies were inactive, 47% had limited participation, and 42% were active. The low percentage of inactive providers shows that most enrolled home health agencies are engaged with the Medicaid program at some level. However, there are more home health agencies with limited participation than active home health agencies. The high percentage of home health agencies with limited participation may be caused by several factors. First, home health agencies typically provide more time-intensive services than other types of providers and therefore may serve fewer members overall. Second, some home health agencies may see fewer members due to a lower need for services among the local population.

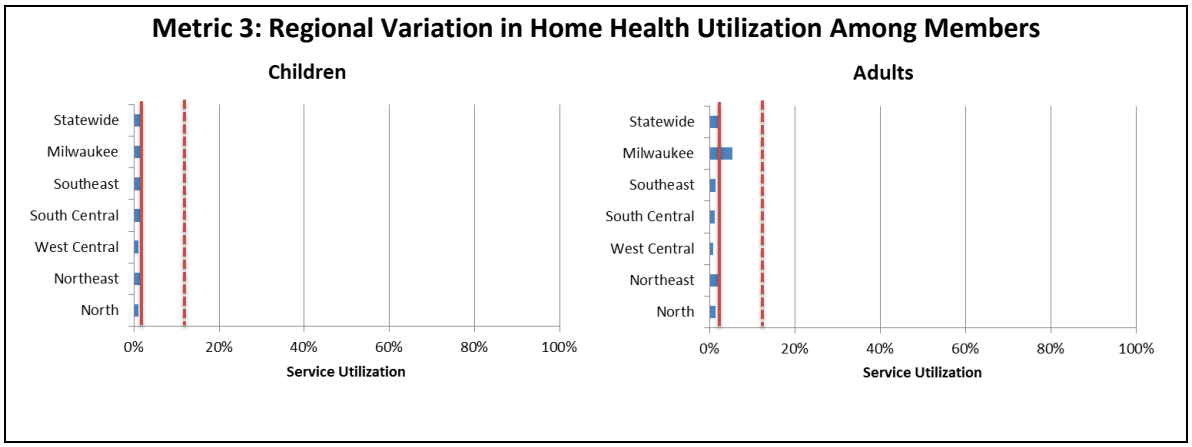
Service Utilization

Our analysis of service utilization is intended to measure how fee-for-service Medicaid members have actually accessed home health care, with a focus on patterns and variations in utilization.

Metric 3: Regional Variation in Home Health Utilization Among Members

Metric 3 measures the regional variation in utilization of home health care among members enrolled in the fee-for-service Medicaid program. As noted previously, many members who are frail elders, adults with developmental or intellectual disabilities, or adults with physical disabilities receive coverage of home health care through the Family Care program instead of the fee-for-service delivery system. Family Care members are more likely to have a medical need for home health care. As discussed in Section 2 of this plan (Methodology for Analyzing Fee-for-Service Access to Core Services), our methodology for Metric 3 excludes members enrolled in Family Care. Thus, the remaining fee-for-service members included in Metric 3 represent populations less likely to have a medical need for home health care.

To calculate Metric 3, we divided the number of non-Family Care fee-for-service members who received a home health service in calendar year 2014 by the total number of non-Family Care fee-for-service members enrolled in calendar year 2014. We compared average statewide utilization to utilization in each of six geographic regions to determine regional variation. We calculated utilization separately for children (defined as members ages 18 and younger) and adults (defined as members ages 19 and older). On the chart below, the red dotted line marks 10 percentage points above the average statewide utilization and is included as a visual reference point.



Metric 3 shows low overall utilization of home health care among non-Family Care fee-for-service members. As noted previously, this result is expected since non-Family Care fee-for-service members represent populations less likely to have a medical need for home health care. Metric 3 also shows little regional variation in the utilization of home health care among children, with percentages at 1% or 2% in each region. There was some regional variation in home health care utilization for adults. Most regions were aligned with the statewide average of 2%, but adult utilization of home health care in

Milwaukee was an outlier at 5%. This suggests that further analysis is needed to better understand local variations in home health utilization.

Metric 4: Reliance on Safety Net Providers for Home Health Service Delivery
We did not calculate Metric 4 for home health care because safety net providers do not provide home health services. Safety net providers are defined for purposes of this report as clinics that have received a federal designation as a federally qualified health center or a rural health clinic.

Fee-for-Service Reimbursement

For our analysis of fee-for-service reimbursement, we evaluated the reimbursement rates paid to providers for home health services provided through the fee-for-service Medicaid program. Health care providers use nationally standardized billing codes, known as procedure codes, to bill for each distinct service that they provide. DHS establishes a reimbursement rate, known as a max fee, for each covered service. The max fee represents the highest amount DHS will pay a provider for the service. Max fees are based on various factors, including a review of charges submitted by providers, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations.

Metric 5: Comparison of Medicaid and Medicare Max Fees
For Metric 5, we tried to compare the fee-for-service Medicaid max fees to corresponding Medicare max fees for home health services. However, Medicare covers home health services under different procedure codes and uses different reimbursement methodologies than the Medicaid program. Therefore, we were unable to compare fee-for-service Medicaid max fees to corresponding Medicare max fees.

As an alternative, we also researched publically available reimbursement rates set by Medicaid programs in neighboring states for home health services. Included in this review were rates from the Illinois, Iowa, Michigan, and Minnesota Medicaid programs. However, we determined that coverage policy differed significantly among states in both the procedure codes used and reimbursement methodologies applied to these services. The variation in coverage policy for home health services among states prevents meaningful comparison of reimbursement among state Medicaid programs.

Included on the next page is a table of current Wisconsin fee-for-service Medicaid max fees for home health services.

Service Category	Procedure Code	Description	Wisconsin Medicaid Max Fee
Home Health Skilled Nursing Services	T1001	Nursing Assessment/Evaluation	$85.54
	99600	Intermittent Skilled Nursing Visit	$85.54
	T1502	Medication Administration Visit	$40.31
Home Health Aide Services	T1021	Home Health Aide, Per Visit	$40.31
Home Health Therapy Services	97799	Home Health Physical Therapy	$81.73
	97139	Home Health Occupational Therapy	$83.91
	92507	Home Health Speech Therapy	$86.63

Summary

Many Medicaid members who are frail elders, adults with developmental or intellectual disabilities, or adults with physical disabilities receive coverage of home health care through the Family Care program instead of the fee-for-service delivery system.

The analysis in this section presents data-driven metrics that measure access to home health care only for non-Family Care members who receive coverage through the fee-for-service delivery system.

Metric 1 shows that nearly all licensed home health agencies were enrolled in the Medicaid program. Metric 2 shows that, of these enrolled providers, nearly all had some level of participation. Metric 3 shows small overall utilization of home health care among non-Family Care fee-for-service members, which was expected since non-Family Care fee-for-service members represent populations less likely to have a medical need for home health care. Metric 3 also shows little regional variation in the utilization of home health services, with the exception of the Milwaukee region.

We did not calculate Metric 4 to measure reliance on safety net providers for the delivery of home health care because safety net providers do not provide home health care services. We also did not calculate Metric 5 to compare Medicaid and Medicare max fees for home health care due to differences in Medicaid and Medicare coverage policies.

Section 4: Stakeholder Input on Fee-for-Service Access to Care

This section of the access monitoring plan summarizes how DHS gathers stakeholder input on access to care for members who receive health care coverage through Wisconsin's fee-for-service Medicaid program. Stakeholders include enrolled members, advocacy organizations, health care providers and associations, counties and other local partners, the Wisconsin State Legislature, state and federal agencies, and other individuals interested in Wisconsin's Medicaid program.

DHS recognizes that stakeholder input is a critical component of monitoring program performance. We receive input through many different mechanisms, including Member and Provider Services; advisory committees and councils; tribal consultations; and standing meetings with provider associations, member groups, and advocacy organizations.

Member Services

Member Services is DHS's primary resource to answer Medicaid member questions and is the main mechanism through which members interact with the Medicaid program. The Member Services Call Center answers calls from members about covered services and cost-share requirements, requests for assistance in locating Medicaid-enrolled providers, and requests to confirm enrollment and coverage, among other topics. The Call Center also responds to written questions from members submitted either by mail or electronically through DHS's Medicaid program website, known as the ForwardHealth Portal. The Call Center is available from 8:00 a.m. to 6:00 p.m., Monday through Friday, and is operated by DHS's fiscal agent, Hewlett Packard Enterprise.

The Call Center documents and tracks all received calls for monitoring purposes. Calls are categorized based on a member's primary question during the call. Table 1 shows the top reasons for member calls in June 2016, the most recent month for which complete data is available[8]. DHS is reviewing how the Call Center classifies calls in order to better identify and track calls that relate specifically to member concerns about access to care.

Call Reason	Call Volume	% of Total Calls
Inquiry about a covered service	4,938	10%
Request to replace a Medicaid ID card	4,931	10%
Inquiry about a health maintenance organization (HMO)	4,171	9%
Inquiry about current eligibility/application status	3,671	8%
Request to add/remove/change private insurance information	3,189	7%

Table 1: Top Calls to Member Services (June 2016)

[8] The table excludes calls that were transferred or referred to other call centers, such as local enrollment agencies.

Member Services includes a fee-for-service ombudsman resource in addition to the Call Center to assist members. The fee-for-service ombudsman works to address escalated concerns from members about access to care, payment for services, and other coverage or policy issues.

The main access concern raised by members through Member Services relates to dental care and the ability to find Medicaid-enrolled dentists who are accepting new patients. In response, Member Services created a dedicated dental ombudsman position to work directly with members to assist them in finding dental care. However, access to dental care continues to be the most common access concern raised by members through Member Services.

Provider Services

Provider Services is DHS's major resource for Medicaid-enrolled health care providers with enrollment, policy, and billing questions. The Provider Services Call Center works with providers to resolve issues related to Medicaid enrollment, billing and claims submission, coordination of benefits, and other policy or coverage questions. The Call Center also responds to written inquiries from providers submitted either by mail or electronically through the ForwardHealth Portal. The Call Center is operated by DHS's fiscal agent, Hewlett Packard Enterprise, and is available to providers from 7:00 a.m. to 6:00 p.m., Monday through Friday.

In addition to the Call Center, Provider Services supports a team of Provider Relations Field Representatives and a separate Dental Unit. The Provider Relations Field Representatives work directly with individual providers on complex billing issues and conduct in-person and virtual trainings. The Dental Unit specializes in working with dental providers to resolve billing and reimbursement issues unique to dental care.

Inquiries Received by DHS

Stakeholders can directly contact DHS with questions or concerns about the Medicaid program. DHS tracks all inquiries to ensure accurate and timely replies. The most common inquiries received by DHS regarding the Medicaid program have historically involved access to dental care and concerns about the ability to locate Medicaid-enrolled dentists.

Committees and Councils

DHS participates on and coordinates with many different standing committees and councils to gather feedback about the performance of the Medicaid program and to coordinate on program improvement initiatives, including initiatives to improve access to

care. Examples of committees and councils include the Wisconsin Council on Mental Health, the Home Care Advisory Council, and the Transportation Advisory Council.

Historically, feedback regarding access to care from these committees and councils has identified access to dental care and access to behavioral health services as primary areas of concern. DHS has also received feedback through several organizations that access to dental care can be especially limited for individuals with disabilities.

Tribal Consultations

DHS consults with Wisconsin's 11 federally recognized tribes on issues related to the Medicaid program. DHS meets with tribes quarterly to review and obtain feedback on proposed changes to the Medicaid program that DHS plans to submit to CMS. DHS also meets at locations around the state with tribal medical directors to review program changes and obtain feedback on access to services.

Public Comment Period

DHS published a draft of this plan on its main public website on August 15, 2016 for a 30-day public comment period. DHS accepted comments by fax, email, and U.S. mail. DHS also held a public forum on August 23, 2016 to obtain feedback on the plan from stakeholders.

We received a total of 24 comments from advocates, providers, professional organizations, and other stakeholders on this plan. We have summarized and responded to those comments below.

Comments regarding primary care add-on payment: Several comments highlighted the add-on payment to primary care reimbursement authorized under the Affordable Care Act that was in effect in 2014 and indicated that this factor likely improved access to primary care during the time period analyzed. The comments indicated that future reports should more fully examine the impact of the add-on payment.

DHS Response: DHS expects to include trends in future reports as data for more recent years is finalized and analyzed. DHS will consider the timing of the add-on payment for primary care when examining these trends to better determine its impact on primary care access.

Comments regarding workforce challenges: Multiple comments addressed workforce challenges in Wisconsin for physicians, personal care workers, and behavioral health providers. Some comments indicated that specific workforce challenges include employee turnover, staffing challenges, and an increasing need for services due to an aging population.

DHS Response: DHS recognizes the workforce challenges that many providers and stakeholders experience. We are committed to working collaboratively with our partners to address statewide concerns. DHS intends to use a wide array of tools to improve access to care for Medicaid members.

Comments/questions regarding DHS setting specific performance goals: Some comments asked whether DHS would establish goals or targets for performance on any of the metrics included in the plan. A few comments recommended goals, such as 100% Medicaid enrollment for providers licensed in Wisconsin.

DHS Response: DHS has not set goals for any of the individual metrics in the plan as no single metric is a complete or accurate measure of access to care. For example, efforts focused solely on enrolling providers in the Medicaid program may improve performance on this metric but would not guarantee that the additional providers were active in treating Medicaid members. Instead, DHS evaluates access to care by monitoring the full collection of metrics for each core service.

Comments/questions regarding how fee-for-service compares to managed care: Several comments asked how access to care for the fee-for-service member population compares to access for members enrolled in managed care. Several of these comments recommended including metrics in the fee-for-service access plan that mirror those reported by managed care organizations, such as HEDIS measures.

DHS Response: DHS completed this access report in accordance with the final rule issued by CMS. Separately, DHS has begun analysis and work to implement a final rule specific to managed care programs and the ways in which DHS monitors managed care. Moving forward, DHS hopes to review both the fee-for-service access plan and efforts to implement the managed care rule to identify common issues and potential efficiencies for monitoring services across delivery systems.

Comments regarding updates to measuring provider participation: Multiple comments recommended updates to the categorization of "Limited Participation" and "Active" providers used in Metric 2. Commenters acknowledge DHS' efforts to standardize metrics across core services but believe the differences among average provider panels for each core service justify a custom approach to quantifying levels of provider participation. As an example, commenters indicated primary care physicians might have panel sizes of 1,500 to 2,000 patients. Commenters believed the 25 member threshold used in Metric 2 to define active participation was too low for these providers and should be raised to at least 100 members. Other recommendations included adjusting the threshold to reflect a percentage of the average provider panel equal to the percentage of Medicaid members among the Wisconsin population.

DHS Response: DHS recognizes that the average provider panel varies significantly by provider specialty and that a single measure of provider participation has limitations. We intend to review the recommendations and determine which adjustments to Metric 2 can be made to more accurately measure provider participation using available data.

Comments regarding additional metrics: Many comments recommended additional metrics that should be considered for future reports. These recommendations include adding measurements of average wait time for appointments, the percent of providers accepting new patients, the volume of churn in Medicaid enrollment, member reported barriers to care, percent of children who receive services in school settings, average travel time and distance to appointments, provider to member ratios, and level of emergency department utilization.

DHS Response: DHS recognizes the value in adding additional metrics to better understand the dynamics of accessing care through the Medicaid program. We will review the recommended metrics to identify which data sources might be available for this analysis or what data collection efforts would be needed to capture this information. Some metrics may be added to future reports, but any expansion will be balanced with efforts to retain current metrics so that DHS can conduct additional analysis on trends using the existing measurements.

Comments/questions regarding interpretation of Metric 4: Several comments questioned DHS' interpretation of Metric 4 that measured reliance on safety net providers. Commenters indicated that service provision by safety net providers is a positive indicator of access and that access initiatives should support and enhance the services available through these providers.

DHS Response: DHS recognizes the importance of safety net providers in providing health care to underserved populations and supports their efforts to bring health care to areas of the state and member populations that might otherwise have less access to care. Metric 4 is intended only to identify where members are less able to access care through standard providers and, thus, where the Medicaid program's policies for standard providers may be creating barriers to participation and can be improved.

Comments regarding initiatives that could improve access to care: Several comments provided additional suggestions for initiatives or policy changes that DHS should implement to improve access to care. These suggestions included expanding the allowable providers of substance abuse treatment, reinstituting the add-on payment for primary care, increased reimbursement for specific services, reducing churn through automatic re-enrollment and extended eligibility, reducing some provider certification requirements, and creating access support measures specific for members with disabilities.

DHS Response: These suggestions address many of the challenges faced by Medicaid members and providers in accessing and delivering health care services. DHS records and maintains stakeholder suggestions for program improvements and works diligently to implement changes that promote delivery of high-quality care for Medicaid members. DHS will continue to collaborate with its partners to identify and implement program improvements.

Question regarding end-of-life care: One question asked if end-of-life care was considered in the plan or would be included in future versions of the plan.

DHS Response: DHS conducted analysis of access to the core services identified by CMS in its final rule. We will continue to solicit feedback on additional services that should be broken out for additional analysis in future versions of the plan.

Section 5: Conclusions

This section of the access monitoring plan summarizes the key findings of the monitoring process. The analysis in the plan shows that members access each of the core services defined by CMS, including primary care, dental care, physician specialty services, behavioral health services, obstetric services, and home health care. DHS will, however, continue its ongoing efforts to improve access and quality of care in the Medicaid program in alignment with the results of the analysis from this plan.

Metric 1 measures the percent of licensed health care providers for each core service who are enrolled in the Medicaid program. Of the core services reviewed, licensed dental providers had the lowest percentage of provider enrollment, with overall enrollment at only 37% for calendar year 2014. Licensed psychologists also had a lower percentage of enrollments than providers for other core services, with 56% enrolled in calendar year 2014. Licensed health care providers for other core services had high Medicaid enrollment, with no provider type falling below 80%.

Metric 2 measures the level of participation among Medicaid-enrolled health care providers. Of the core services reviewed, enrolled behavioral health providers (specifically, psychologists, psychotherapists, and substance abuse counselors) and enrolled dental providers had the lowest levels of participation, suggesting less robust provider networks for these core services. Enrolled providers for other core services had higher levels of participation, suggesting robust provider networks.

Metrics 3 and 4 measure member utilization of each core service, with a focus on patterns and variations in utilization. Of the core services reviewed, utilization of dental care varied most across geographic regions, suggesting that members in certain parts of the state are less able to access dental care. Regions with higher dental utilization appeared to rely largely on safety net providers for care delivery, suggesting that access to standard dental providers is limited even in regions with higher utilization. Utilization also varied across geographic regions for behavioral health services. Regional variation in utilization was minimal for other core services, suggesting equal access to services across the state.

Metric 5 compares max fees paid to health care providers through the fee-for-service Medicaid program to corresponding Medicare max fees for each core service area. Medicaid max fees were lowest in comparison to Medicare max fees for primary care services, at 68%; however, access to primary care services remained high. Medicaid max fees were highest in comparison to Medicare max fees for physician specialty services, at 81%. Medicaid max fees for behavioral health and obstetric services compared to Medicare were roughly equivalent, at 73% and 74%, respectively. We were unable to compare Medicaid max fees to Medicare max fees for dental care and home health services due to differences in Medicaid and Medicare coverage.

Taken together, the key findings of this access monitoring plan suggest DHS should prioritize efforts to improve access to dental care and behavioral health services.

Access Initiatives for Dental Care

Metric 1 shows that the percent of licensed dentists who are enrolled in the Medicaid program is low, which suggests that DHS could improve access to dental care through initiatives that increase provider enrollment. Higher provider enrollment could increase utilization of dental care and decrease reliance on safety net providers for care delivery. Furthermore, Metric 2 shows low levels of participation among currently enrolled dentists, which suggests DHS could also improve access to dental care through initiatives that increase participation among currently enrolled providers.

In response to these findings, to increase both provider enrollment and participation, DHS plans to implement a targeted rate increase for certain types of dental care, as authorized by the Wisconsin State Legislature in the 2015-17 biennial budget. The targeted rate increase will raise Medicaid reimbursement rates for pediatric dental care and adult emergency dental services provided in certain counties. While mainly focused on dental care provided through the fee-for-service delivery system, the targeted rate increase will also apply to dental care provided through the managed care delivery system.

DHS will closely monitor the impact of the targeted rate increase on access to dental care. DHS plans to implement the targeted rate increase by October 2016.

Access Initiatives for Behavioral Health Services

Metrics 1 and 2 show that enrollment and participation in the Medicaid program among psychologists, psychotherapists, and substance abuse counselors is low, which suggests that DHS could improve access to behavioral health services through better engagement of these provider types. Surprisingly, psychiatrists have high Medicaid enrollment and participation, suggesting that access to psychiatry services for Medicaid members is largely equivalent to the general population. Thus, efforts to improve access to psychiatrists need to address the overall shortage of psychiatrists in the state.

In recent years, DHS has prioritized initiatives to improve access to behavioral health services. In 2014, DHS increased reimbursement for Comprehensive Community Services (CCS) as authorized by the Wisconsin State Legislature in the 2013-15 biennial budget (2013 Wisconsin Act 20). CCS is a psychosocial rehabilitation program administered locally by counties for Medicaid members who require more intensive treatment than typical outpatient care. This initiative specifically increased reimbursement for regional CCS programs and, as a result, has improved behavioral health access in rural areas of the state.

In 2016, DHS implemented a change to its managed care policy that requires contracted HMOs to cover medication-assisted treatment for members with opioid addiction. This policy will ensure that Medicaid members who require medication-assisted treatment will continue to benefit from the care coordination available through the managed care delivery system.

In order to continue to improve access to behavioral health services, DHS plans to pursue a variety of initiatives moving forward.

First, DHS plans to work with CMS to add coverage of residential substance abuse treatment through the Medicaid program as authorized by the Wisconsin State Legislature in the 2015-17 biennial budget. This initiative would expand the array of substance abuse services available to Medicaid members.

Second, DHS plans to implement state legislation passed in 2015 to improve access to mental health treatment in schools. Changes to coverage policy include:

- Expanding the types of providers who may receive reimbursement from the Medicaid program for school-based mental health services.
- Reducing the certification requirements for outpatient mental health clinics providing mental health treatment in school settings.

Third, DHS intends to review existing prior authorization (PA) policy for outpatient treatment to assess the impact of PA requirements on providers and determine whether current thresholds for PA are aligned with industry standards and clinical best practices. This initiative will identify the potential for reductions in administrative paperwork, allowing behavioral health providers to spend additional time providing clinical services. By increasing available clinical time, we anticipate both increased participation from currently enrolled providers and an increase in the number of providers who choose to enroll in the Medicaid program.

Fourth, DHS will explore the expanded use of telehealth as a delivery model for behavioral health services. Although the Medicaid program currently reimburses behavioral health services provided via telehealth, adoption of this service delivery model is limited. DHS will work to review its telehealth certification process and identify options to streamline policy in this rapidly evolving environment. We anticipate increased utilization of telehealth, particularly in those regions of the state with low service utilization relative to urban centers.

Finally, we intend to review models for integrated care and identify options to more effectively structure our fee-for-service coverage policy to support integration of behavioral health and primary care services.