

## SUMMARY OF PUBLIC COMMENTS

### ACCESS MONITORING REVIEW PLAN

The State received public comments from three separate advocacy groups and one individual. Some comments were outside the scope of §447.203 and are not addressed in the State responses here.

#### Comments Regarding the Access Monitoring Review Plan

##### CAHPS Data

**Comment:** Several commenters expressed concern regarding the use of CAHPS data as a measure of access to care. Concern centered on the content and detail level of the access questions used in the AMRP index, and the frequency of the survey (adults and children are surveyed on alternate years).

**Response:** The final rule allows states broad discretion in identifying data sets and other information that may be used to conduct the analysis required in the access monitoring review plans. DMHF does not currently have the resources to create new sources of data so we are relying on existing sources to fulfill the requirements under §447.203. The State is confident CAHPS data provides insight into beneficiaries' perception of access to care. CAHPS surveys follow scientific principles in survey design and development. The surveys are designed to reliably assess the experiences of a large sample of patients. They use standardized questions and data collection protocols to ensure that information can be compared across healthcare settings. CAHPS surveys are developed with broad stakeholder input, including a public solicitation of measures and a technical expert panel, and the opportunity for anyone to comment on the survey through multiple public comments period through the Federal Register. Finally, many CAHPS measures are statistically adjusted to correct for differences in the mix of patients across providers and the use of different survey modes.

CAHPS data represents two components of the analysis incorporated into the access to care index, there are two additional measures including provider data and utilization. Each measure of the index will be looked at independently to identify potential access to care issues.

##### Mechanisms for Collecting Member Feedback

**Comment:** Several commenters indicated apprehension about the State's plan to collect feedback using a call tracking system. They stated that the in-house reporting system may not provide data of sufficient depth and quality for the purposes of tracking access to care.

**Response:** §447.203(b)(7) states that the agency must have mechanisms for ongoing beneficiary and provider input on access to care. DMHF has routed all member calls to HPRs and developed a tracking tool to aggregate member feedback as required in §447.203(b)(7). Once the tracking tool is fully implemented the State will monitor and evaluate the effectiveness of the tracking system and subsequent reports. DMHF is in the process of making contact information more accessible and easily identifiable to members on both the website and the Medicaid Member Card.

### Specific Member Types

**Comment:** Several commenters stated concern about the lack of specific analysis regarding members with disabilities and children. They suggest that the State examine partnerships with local organizations to collect more information.

**Response:** The State agrees with the conclusion and has revised the Access Monitoring Review Plan to add data describing and comparing utilization and provider rates for the above mentioned groups.

### Provider Data

**Comment:** Several commenters were concerned that the provider data included in the access to care index was insufficient. They suggested that the State examine providers with open panels.

**Response:** While we appreciate the commenters concern, §447.203(b)(4) states that the plan must include the specific measures the state uses to analyze access to care, it then gives several suggestions in parenthesis. DMHF chose 4 measures to analyze access to care, providers participating in the Medicaid program, service utilization patterns, and data on beneficiary feedback.

### Thresholds

**Comment:** Several commenters suggested that the 25% threshold set in the Access Monitoring Review Plan was too high and should be lowered to 10-15%.

**Response:** The State believes it has met all the requirements for the analysis, the rule does not stipulate a specific threshold but instead leaves that up to the State. The State has determined that a 25% swing in the differential for separate indices is the appropriate threshold to trigger an investigation into potential access to care issues.

### HCBS Waiver Programs

**Comment:** One commenter stated that the reimbursement for HCBS waiver services are insufficient and that access to these services is an acknowledged issue.

**Response:** While the State understands the concerns expressed by the commenter, §447.203 only applies to benefits inside the State Plan. We would note that all Members currently on waiver programs are also able to access State Plan benefits so therefore any FFS Members on waiver programs were included in the analysis.

### Behavioral Health

**Comment:** One commenter stated that most local mental health agencies do not have the competence to provide psychiatric and therapy services to dually-diagnosed individuals; and that while they understand not including mental health because it's FFS population is less than 5% of the State it does not make sense to exclude the rural and frontier populations.

**Response:** The State appreciates the commenters concern, rural and frontier populations would not be included in the AMRP since all the counties are covered under a Prepaid Mental Health Plan (Managed Care). There is currently only one county in Utah that is not covered under a PMHP, that is Wasatch County, substance abuse services in Cache, Rich, and Box Elder counties

are also FFS. An analysis of the FFS services in these counties have been added to the AMRP final draft.

#### Conversion Factor

**Comment:** One commenter asked for further explanation of the conversion factor used in the physician fee reimbursement methodology. Specifically what is its history and what is the impact to access to starting every fiscal year budget neutral, with no possibility of raising rates.

**Response:** Annually, the Division updates the physician fee schedule using recent Relative Value Unit (RVU) information. Briefly stated, the rate for a particular code is determined by multiplying the RVU and the conversion factor. The conversion factor is set based on a budget neutral approach; however, if additional appropriations are received from the legislature, then the conversion factor will target the updated amount.

In order to raise rates, the Division needs additional monies appropriated from the Utah State Legislature.

#### Health Program Representatives and Constituent Services

**Comment:** One commenter asked for clarification concerning the roles and responsibilities of HPRs and the Constituent Services Representative. They stated that in addition to wanting more clarification, locating contact information for HPRs on the Medicaid website is difficult and confusing.

**Response:** A description of the roles and responsibilities for HPRs was provided on page 16 of the original draft. A description was added of the roles and responsibilities for the Constituent Services Representative in the same section of the final draft.

#### Policy Changes

**Comment:** One commenter stated that although the Division regularly files rules and State Plan Amendments for public comment, many policy changes are made at the Provider Manual level and not subject to the same process.

**Response:** A mechanism is currently in place to notify the public of changes to provider manuals through the quarterly Medicaid Information Bulletin. In addition all provider manuals are available on the Medicaid website with an archive that includes the most recent version prior to revision.

#### Demographics

**Comment:** One commenter states that the AMRP does not examine access concerns by race or ethnicity with the exception of American Indian and Alaska Natives.

**Response:** We appreciate the commenter's concerns, since the American Indian/Alaskan Native designation is a category of aid versus self-reported data it is inherently more reliable. In the future the State will assess the utility of adding the self-reported statistics regarding race to the logistic regression model.

### Complaints about Access

**Comment:** One commenter asked what qualifies as ‘significantly higher than usual’ when it comes to complaints about access?

**Response:** Since the State has yet to collect information regarding complaints it will take some time to determine a baseline. Once a baseline is established the State will look for any statistical variations that would indicate significantly higher, 25% or more, than the normal baseline for complaints.

### Other Department Programs and Activities

Several comments were submitted regarding the section about other department programs and activities to ensure success.

**Comment:** Several commenters noted that Medicaid enrollee utilization of some of these programs and entities could be quantified, and this information could supplement the proposed measures of access.

**Response:** The State appreciates the suggestion, the AMRP was drafted within the scope of requirements found in §447.203. If the State determines in the future that analysis of any of these programs, or others not currently listed, would be beneficial to an investigation of access issues, an analysis will be completed.

**Comment:** One commenter asked for more detail regarding the responsibility and resources of Local Health Departments to help enrollees find and access care, as well as identifying health professional shortages, health workforce issues, and health disparities would be informative.

**Response:** At this time all relevant information regarding contracts with the Local Health Departments has been included in the AMRP.

**Comment:** One commenter noted that while they were thankful to learn Medicaid will consider paying for certain home visits if an enrollee lives a significant distance from his or her provider, they asked what the rationale is for 50 miles and could it be set at something more like 25-30 miles?

**Response:** The current policy is 25 miles one way, 50 miles roundtrip. That clarification has been made in the AMRP.

**Comment:** One commenter stated that transportation is a general problem in many areas off the Wasatch Front.

**Response:** The State appreciates the comment and will be mindful of it as complaints are aggregated in the future.

### Premier Access Terminating/Changing Agreements with Dentists

**Comment:** One commenter stated concern that many dentists along the Wasatch Front received notice from Premier Access terminating their Premier Utah Medicaid Dentist Agreement effective September 30, 2016. Also, that other dentists were contacted by Premier Access about

becoming providers under a capitation program. The commenter stated that this was done over the phone without any formal or transparent process.

**Response:** While the State understands the concern expressed by the commenter, this falls outside the scope of the AMRP, since all counties in the Wasatch Front are managed care counties, not FFS. Also, Premier Access is a managed care entity.

#### FQHCs and RHCs

**Comment:** One commenter noted the absence of several Federally Qualified Health Clinics (FQHCs) and the incorrect listing of some that are closed or no longer receive the FQHC or Rural Health Clinic designations.

**Response:** The clinics that are noted missing, Sacred Circle and the clinics operated by the Paiute Indian Tribe of Utah, are enrolled with Medicaid under the Indian Health Services provider type and not as FQHCs, which is why they do not appear on the list. The two clinics that were listed incorrectly, the Midvale Family Health Clinic, and the Ivan W Kazan clinic, have been removed.