

Georgia Medicaid Access Monitoring Review Plan (AMRP)

Georgia Department of Community Health
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Executive Summary

The following report comprises Georgia Department of Community Health's (DCH) 2016 Access Monitoring Review Plan (AMRP) for fee-for-service (FFS) beneficiaries and providers, as required by CMS's final rule on measuring Medicaid beneficiary access to care (codified at 42 C.F.R. §447.203(b)). The AMRP analyzes whether Georgia Medicaid is meeting its obligation under 42 U.S.C. §1396a(a)(30)(A) to ensure that provider payments allow FFS beneficiaries to access care in a manner equal to that of the general population in their geographic region.

The AMRP Baseline Access Analysis examines Georgia Medicaid's 449,423 2015 FFS beneficiaries' access to providers of primary, physician specialty, behavioral health, obstetric, home health, and dental care providers. Analyses of beneficiary population, need and utilization, access complaints and concerns, provider network, and rate review and comparison inform final conclusions as to level of access. Key findings in each area include:

- I. **Beneficiary Population** – The FFS population is mainly adult (87%), female (58%), and is primarily composed of blind and disabled (55%), Qualified Medicare Beneficiary (17%), Medicare (15%), and Aged (11%) aid categories.
- II. **Beneficiary Need & Utilization** – Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results show that most beneficiaries are able to get care as soon as needed. Performance Measure Reports show that, compared to those in managed care, FFS children have similar rates of access while rates for FFS adults vary by age. Utilization reports identify physician and community mental health services as the most commonly utilized FFS services.
- III. **Access Concerns** – The most prevalent access concerns cited by Medical Care Advisory Committee (MCAC) members were regarding dental care, behavioral health, and Gynecology.
- IV. **Provider Network Adequacy** – Over 90% of Georgia FFS members in all 12 DCH regions have adequate access to providers: in urban areas, two Primary Care Physicians (PCPs) within 8 miles of their home, and one physician specialist, OBGYN, dental, behavioral health, or home health provider, within 30 miles of their home, and in rural areas, two Primary Care Physicians (PCPs) within 15 miles of their home, and one physician specialist, OBGYN, dental, behavioral health, or home health provider, within 45 miles of their home.
- V. **Rate Review** – On average, Medicare reimburses at a higher rate than Georgia Medicaid for the top utilized procedure codes. When compared to South Carolina, Alabama, and North Carolina Medicaid reimbursement rates, Georgia's rates were either lower or higher than one, two, or all three states, depending on procedure code. But for the majority of directly comparable, highly utilized procedure codes, including those for behavioral health and dental care coverage, Georgia Medicaid provides higher reimbursement rates than South Carolina and Alabama. Relative to North Carolina, Georgia provides higher rates for comparable dental and behavioral health procedures.

Although Georgia Medicaid reimburses providers of certain services at lower rates than Medicare or neighboring states, provider network analysis, CAHPS surveys, and Performance Measure Reports show that FFS beneficiaries are able to adequately access care. Where access concerns with certain provider groups (dental, behavioral health, and OB/GYN) or regions (South Georgia) exist, the inadequacies are not particular to FFS or Medicaid, but rather faced by the entire geography. Future AMRPs will build upon the data and procedures used in this AMRP, and will include national and FFS-only CAHPS analyses, expanded call center data, more accurate provider enrollment data, provider credentialing findings, and more detailed provider network analysis.

Introduction

Background

On November 2, 2015, CMS released its highly anticipated final rule on measuring Medicaid beneficiary access to care (codified at 42 C.F.R. §447.203(b)). According to the rule, by October 1, 2016, state Medicaid agencies must develop and submit a medical assistance access monitoring review plan (AMRP) for their fee-for-service (FFS) beneficiaries and providers, which enables the state to determine whether beneficiaries have adequate access to care under current payment rates. The AMRP should analyze beneficiary population characteristics, changes in beneficiary utilization of services, the extent to which beneficiary needs are met, availability of enrolled providers, and comparisons of provider payment data (including other public and/or private payers). The analysis must include the following providers: primary care, physician specialist, behavioral health, obstetric, home health, and any additional types of services selected by the state, or receiving a higher amount of complaints¹. The AMRP must also describe procedures to continue monitoring access going forward.

AMRP Team & Development Process

In order to complete this substantial task, Georgia Department of Community Health (DCH) utilized its partnership with Georgia State University's Georgia Health Policy Center (GHPC). From March through July 2016, DCH (including director and manager level representatives from regulatory services and compliance, medical policy, provider complaint and resolution, member services and policy, provider enrollment, performance, quality and outcomes, managed care and contracts, Medicaid Management Information System (MMIS), long-term care/behavioral health/hospice, waivers, health check, as well as the Director of Medicaid) and its partner (the GHPC's Medicaid Policy & Business Team) identified and gathered the best available data, consistent with the final rule, and conducted a variety of analyses in order to determine the level of access to care for Georgia Medicaid FFS beneficiaries. Bi-weekly meetings between DCH and GHPC provided an opportunity for continuous feedback and development of the AMRP. Data collection and informational interviews were conducted with numerous Medicaid divisions as well as the Medical Care Advisory Committee (MCAC), the Georgia Board for Physician Workforce (GBPW), Hewlett-Packard Enterprises (HPE) beneficiary call center directors, Alliant Georgia Medical Care Foundation (GMCF), the Georgia Department of Auditing and Accounts (DOAA, responsible for inspecting Care Management Organization (CMO) access reports), and Georgia State University geographic information systems mapping experts. Prior to being finalized, the AMRP underwent a 30-day comment period during August, 2016, and then received sign-off from requisite high-level DCH representatives, including its Commissioner.

AMRP Components

In its first year, the Georgia AMRP consists of a baseline access analysis, which has been organized in the following manner: I. Beneficiary Population, II. Beneficiary Need & Utilization, III. Access Concerns, IV. Provider Network Adequacy, and V. Rate Review. Each section of the baseline analysis examines a different component of access, based on requirements outlined in the CMS final rule, and reports individual results in detail. An in-depth discussion of methodology and

¹ Because access to dental care was identified as an area of particular concern among Georgia providers, it has been separated out from primary care providers for analysis.

data can be found within each section. The AMRP Comprehensive Access Findings section contains a combined analysis of the findings from all baseline analysis sections. The final section, Access Monitoring Procedures, outlines the processes that DCH plans to put into place, in order to continue and improve its capacity to monitor access, conduct analyses, and respond to results. **Table 1** below outlines the data informing the various sections of the AMRP, as well as the CMS final rule requirements addressed by each section.

Table 1. Georgia AMRP Components and CMS Requirements

| Georgia AMRP Section | Georgia AMRP Data | CMS Requirement |
|------------------------------------|--|--|
| I. Beneficiary Population | 2015 Medicaid enrollment / beneficiary files | Beneficiary population characteristics |
| II. Beneficiary Need | 2013-2015 CAHPS data; 2011-2014 Georgia Medicaid Performance Measure Report; 2015 utilization reports | Beneficiary utilization patterns |
| III. Access Concerns | Provider / MCAC feedback on access issues; Beneficiary access complaints from call center; Input from DCH management / multi-division AMRP team | Availability of enrolled providers; Provider and beneficiary input |
| IV. Provider Network Adequacy | 2016 Medicaid FFS provider enrollment list; 2014 Medicaid FFS provider data by category of service; 2015 Medicaid enrollment / beneficiary files; DCH CMO GeoAccess distance standards; 2015 GAPP providers v. members, by geography | Availability of enrolled providers; Typical access monitoring standards / methodologies |
| V. Rate Review | Medicaid rates / Medicare rates for most highly utilized services | Provider payment data; Comparative rate review |
| AMRP Comprehensive Access Findings | Includes everything above | Includes everything above |
| Access Monitoring Procedures | Input from DCH management / multi-division AMRP team | Procedures to continue monitoring access and conduct analysis every 3 years or upon payment change |

I. Beneficiary Population

As of December 2015, Georgia's Medicaid program provided health insurance coverage to nearly 1.75 million enrolled beneficiaries [1]. Among these enrollees, the approximate distribution of beneficiaries by enrollment group was: 59% of beneficiaries were children, 16% were low-income adults, 16% were disabled, and 9% were aged [2]. As of July 1, 2015, 39 states were contracting with risk-based managed care organizations, known as CMOs in Georgia, to provide care to their beneficiaries [3]. In Georgia, nearly two-thirds (66%) of Medicaid beneficiaries were enrolled in a CMO; the remaining 34% of beneficiaries had their health care services covered on a FFS basis [4]. The differences in managed care penetration rate among Georgia Medicaid beneficiaries are striking: over 88% of children are enrolled in a CMO (88.3%), nearly 86% of low-income adults are enrolled in a CMO (85.5%), and less than one percent of the aged and disabled are enrolled in a CMO (0.6%) [5]. Because Georgia beneficiaries are either enrolled in a CMO or have care reimbursed via FFS, it can be surmised that those *not* in a CMO are included in Georgia's FFS population. Accordingly, Georgia's FFS population includes a small portion of children and low-income adults, but is primarily composed of aged and disabled individuals: 11.7% of children, 14.5% of low-income adults, and 99.4% of aged and disabled Medicaid beneficiaries have services covered via FFS.

Methods

Using Georgia Medicaid enrollment files from 2015, we calculated basic descriptive statistics on the population of Medicaid beneficiaries who were enrolled in a CMO or FFS for at least 11 months during the 2015 calendar year.

Findings

In 2015, the Georgia Medicaid program served 449,423 individuals who were enrolled in FFS for at least 11 months, equaling nearly one-third of the state's Medicaid population. During 2015, 58% of the FFS population was female, and the majority (53%) was between the ages of 19 and 64 (Figures 1 and 2). Only 13% of the FFS population was comprised of individuals under the age of 19.

Figure 1

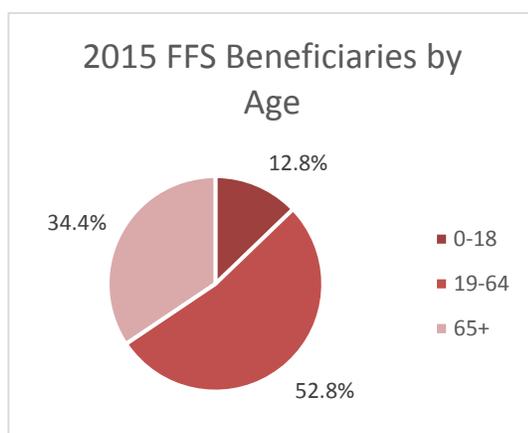
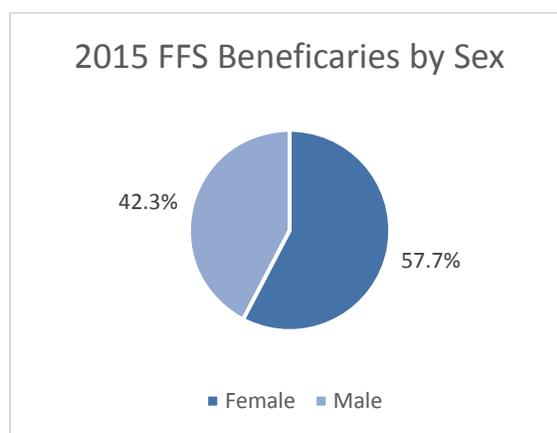


Figure 2



As seen in Figure 3, during 2015, the four largest aid category groups were blind and disabled (55%), Qualified Medicare Beneficiary (QMB, 17%), Medicare (15%), and Aged (11%). The fifth largest aid category group was "Other" and accounted for slightly less than 3% of the FFS

population. “Other” was comprised of aged, breast and cervical cancer, foster care and adoptions, Katie Beckett, low-income Medicaid (LIM) adult, LIM child, medically needy, PeachCare for Kids, Planning for Healthy Babies, Right from the Start (RSM) child, and RSM mother. All five groups were comprised of a larger proportion of women than men (Figure 4). Three of the five groups were comprised of a larger proportion of individuals 65 and older, the “Other” group had a larger proportion of members between 0 and 18 years, and the “Blind and Disabled” group had a larger proportion of members between 19 and 64 years (Figure 5).

Figure 3

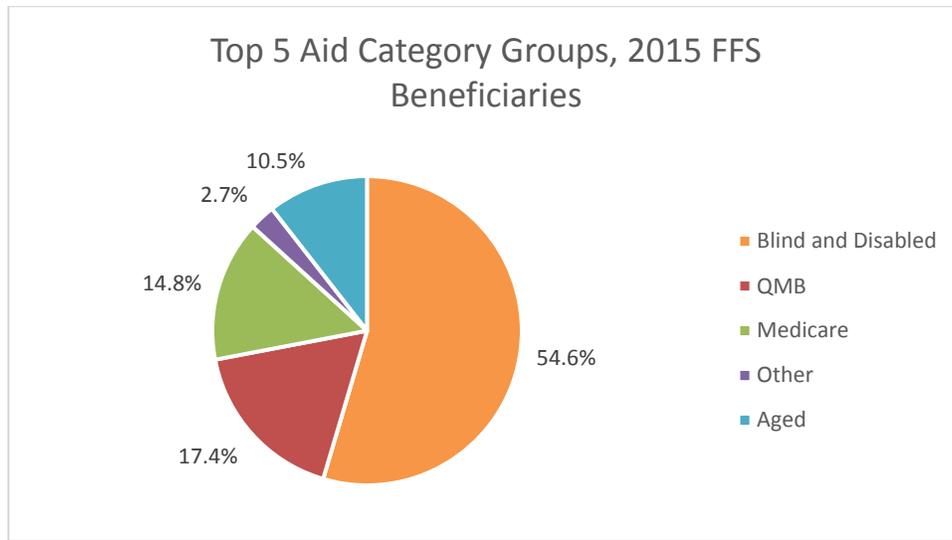


Figure 4

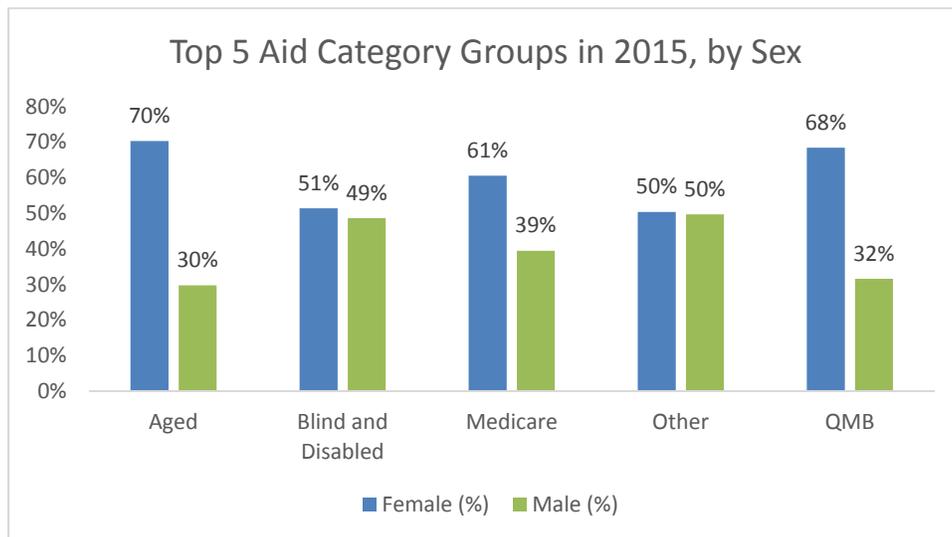
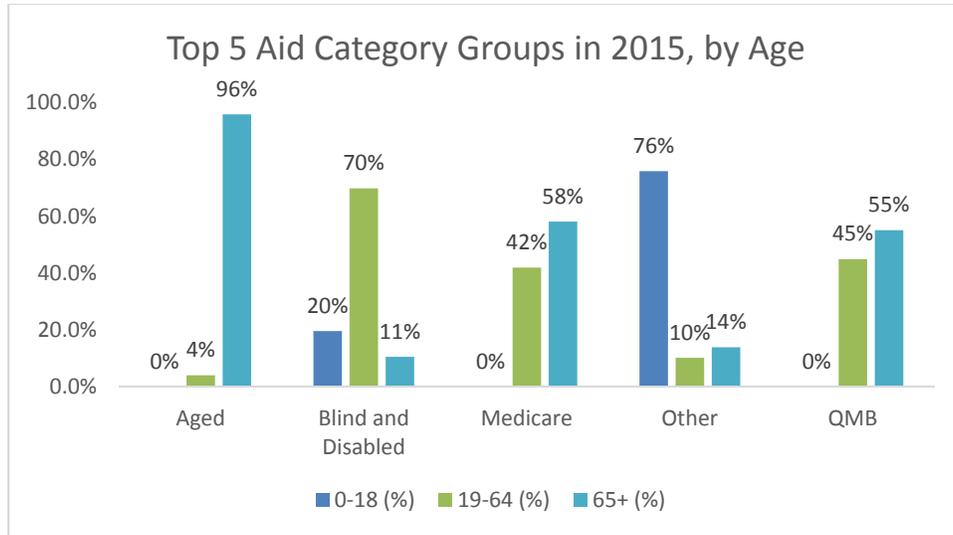


Figure 5



Conclusion

Overall, the Georgia FFS beneficiary population is made up largely of older adults who are primarily female and are either aged, blind or disabled or are some form of dual eligible. Because much of this FFS population is elderly or disabled, they may have high health care needs that require a significant amount of health care services. Thus, it is particularly critical that this population be able to access the care that they need, when they need.

II. Beneficiary Need & Utilization

Access to health care is critical for all individuals. Medicaid creates an avenue for those with limited resources, or those who are otherwise vulnerable, to access care. A Kaiser Family Foundation assessment of access to care among Medicaid beneficiaries found that, generally, Medicaid beneficiaries' access to care is comparable to those with private insurance and exceeds that of the uninsured. Children and adults covered by Medicaid are more likely to have a usual source of care than individuals without insurance. More specifically, compared to those without insurance, children with Medicaid were more likely to see a doctor and a dentist, and adults were more likely to receive preventive care. Across all of these measures, access to care for Medicaid beneficiaries was roughly equivalent to those with private insurance [6-8]. Among adults with chronic conditions, those with Medicaid coverage were more likely to have a usual source of care and a doctor visit in the past year, and were less likely to be delayed in getting medical care or prescriptions compared to those without insurance [6]. Again, across these measures, Medicaid beneficiaries' access to care was nearly identical to those with private insurance [6]. Finally, children and adults with Medicaid coverage were far less likely to report going without needed care due to costs compared to those without insurance [6].

Methods

In order to gauge Georgia Medicaid FFS beneficiary need and perception of access to care, we took a three-pronged approach by reviewing:

1. The most recent set of Consumer Assessment of Healthcare Providers and Systems surveys for Georgia adult Medicaid beneficiaries (2013, 2014, and 2015);
2. Georgia Medicaid Performance Measure Report for calendar year (CY) 2011 through CY2014; and
3. Utilization reports from Alliant GMCF, one of DCH's contractors, for CY2014 and CY2015.

Findings

CAHPS 5.0H Survey Review

In accordance with CMS policies and procedures, Georgia fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS survey assesses patient satisfaction with their experience of care. The data reported here were collected using the CAHPS 5.0H survey for Georgia Medicaid. In order for an adult to be eligible to participate in the CAHPS survey, they must be enrolled in the Medicaid program for at least six (6) months, with no more than one enrollment gap spanning 45 days or less. Here we compare CAHPS data for adult Medicaid beneficiaries in Georgia from the 2013, 2014, and 2015 administration cycles [9]. Important to note is that the CAHPS survey does not distinguish between whether a beneficiary is enrolled in a CMO or whether they receive care on a FFS basis. However, CMS conducted a Nationwide CAHPS Survey of Adult Medicaid Enrollees between January and July 2015, separating responses by FFS versus managed care. Additionally, Georgia is exploring adding a question to the

Georgia CAHPS survey to distinguish between FFS and managed care beneficiaries. While the national CAHPS data could not be acquired in time for inclusion in this Access Monitoring Review Plan (AMRP), Georgia will be able to include the national CAHPS data as well as distinguish FFS beneficiaries from managed care beneficiaries in Georgia CAHPS data in future AMRPs.

The CAHPS 5.0H survey has five composite areas representing different domains of beneficiary experience, two of which are explored here: Getting Care Quickly and Getting Needed Care. Additionally, questions addressing beneficiary rating of the quality of their care, providers, and health plan are included.

I. Getting Care Quickly

Two questions in the CAHPS survey gauge whether beneficiaries were able to get care quickly. As seen in Figures 6 and 7, from 2013 to 2015, an average of 84.2% of CAPHS respondents who needed care right away reported that they were usually or always able to get it as soon as needed, and an average of 80.8% of CAHPS respondents who needed an appointment for a check-up or routine care reported that they were usually or always able to secure an appointment as soon as necessary.

Figure 6

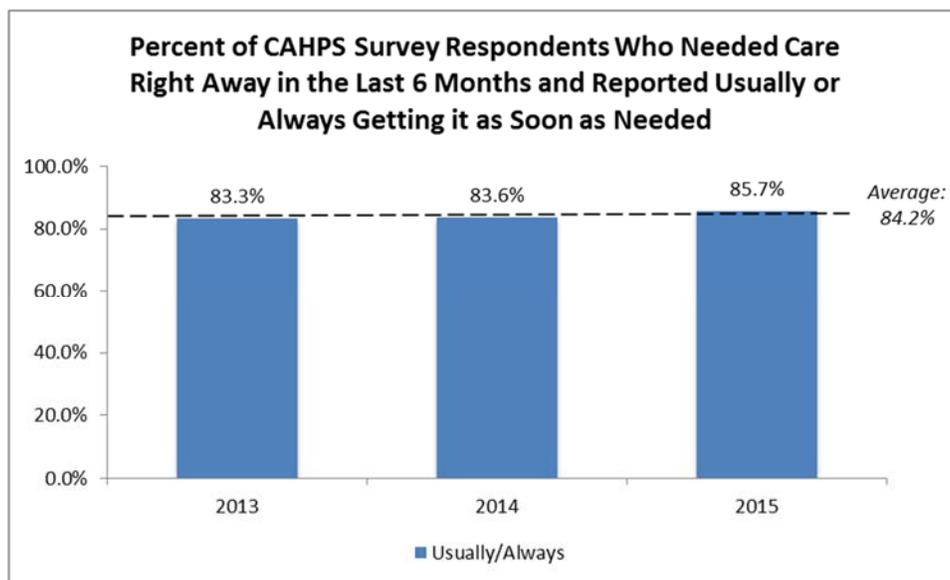
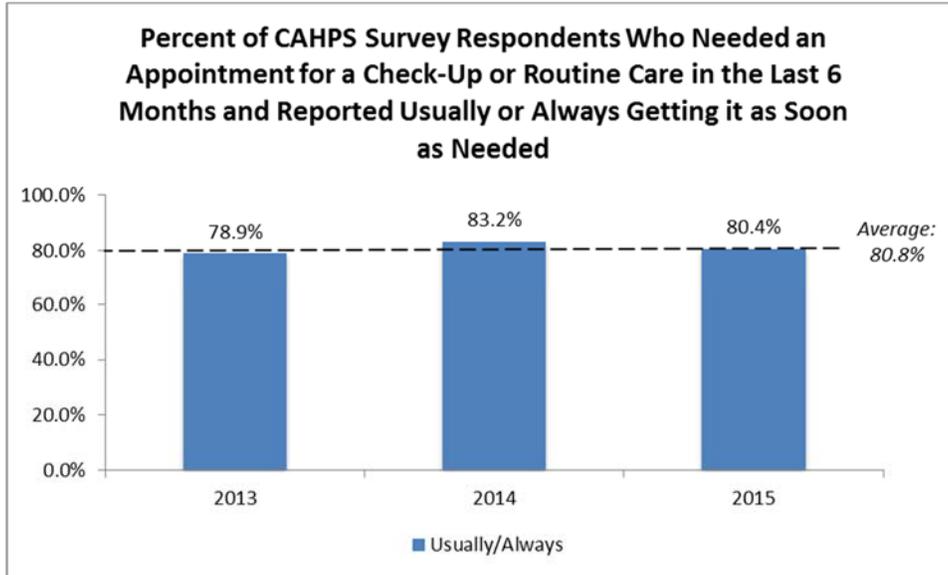


Figure 7



II. Getting Needed Care

Two questions in the CAHPS survey gauge whether beneficiaries were able to get needed care right away. As seen in Figures 8 and 9, from 2013 to 2015, an average of 83.3% of CAPHS respondents reported that it was usually or always easy to get the care, tests, or treatment that they needed, and an average of 78.9% of CAHPS respondents reported that they were usually or always able to secure an appointment with a specialist as soon as necessary.

Figure 8

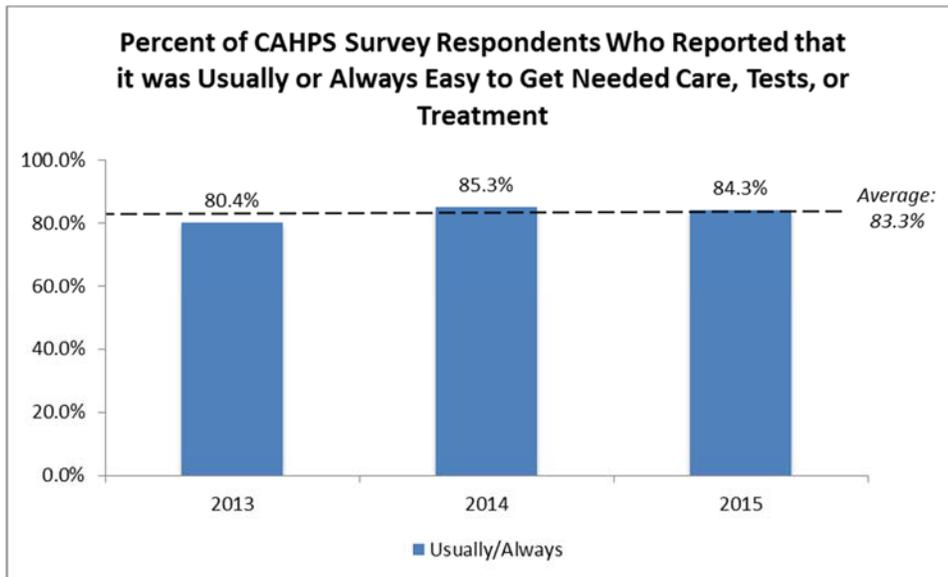
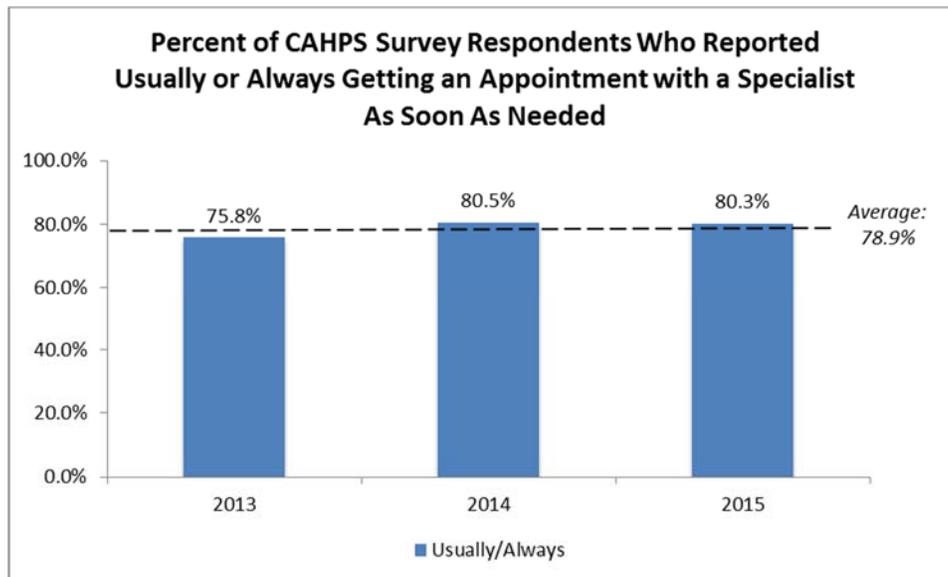


Figure 9



III. Quality of Care

Finally, four questions in the CAHPS survey ask respondents to rate various aspects of their health care on a scale from 0 to 10, with 0 being the worst quality of care and 10 being the best care possible. As seen in Figures 10 through 13, from 2013 to 2015, an average of 70.9% of CAPHS respondents rated their health care as an 8, 9, or 10; 80.0% rated their personal doctor as an 8, 9, or 10; 81.9% rated their most seen specialist as an 8, 9, or 10; and 72.2% rated their health plan as an 8, 9, or 10.

Figure 10

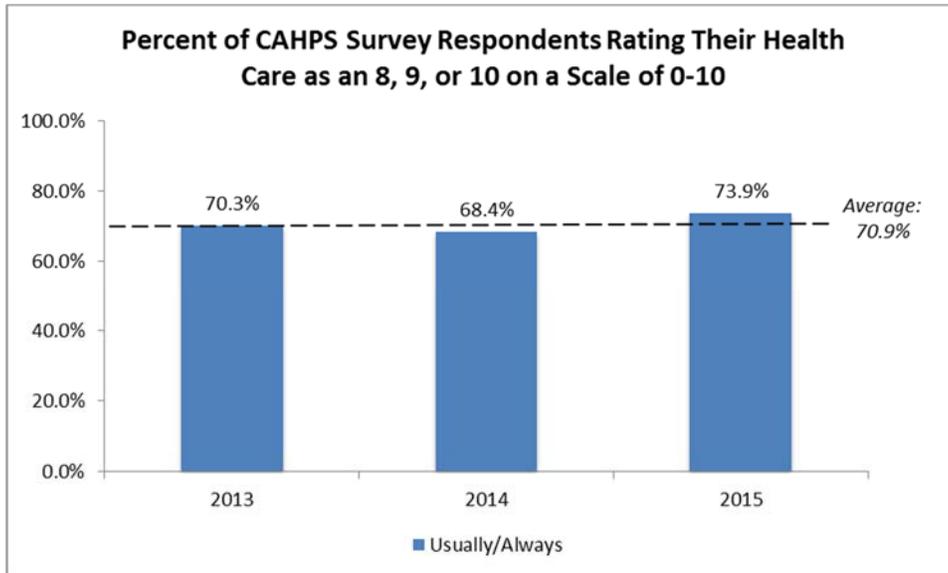


Figure 11

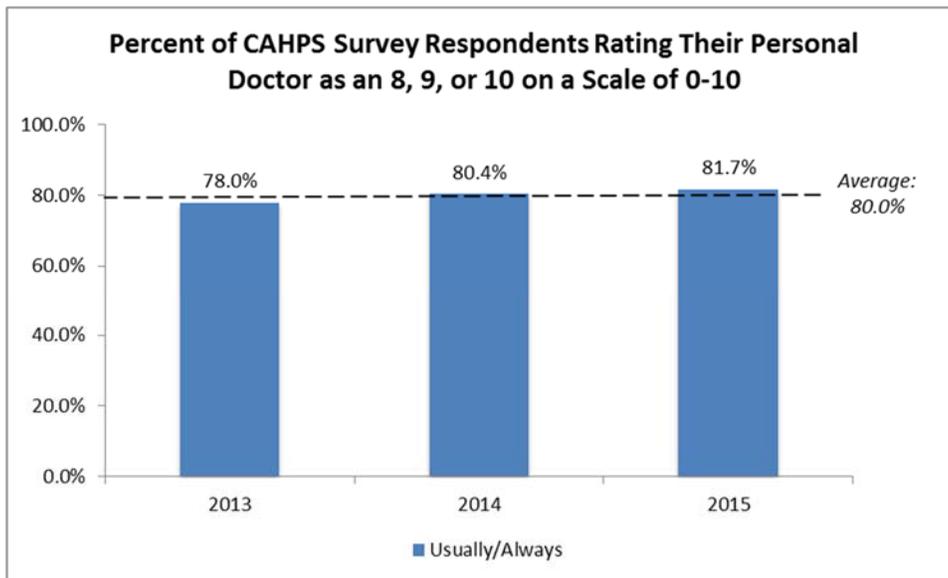


Figure 12

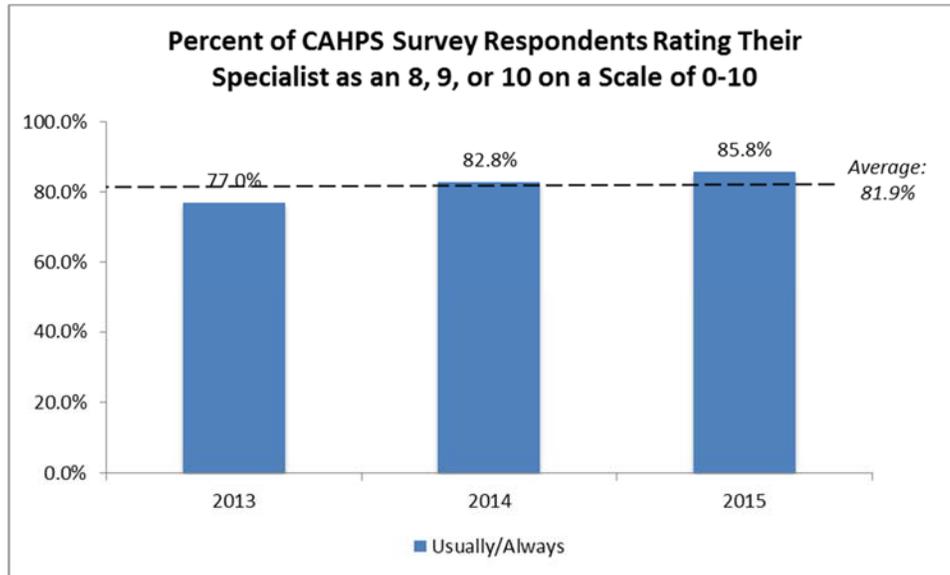
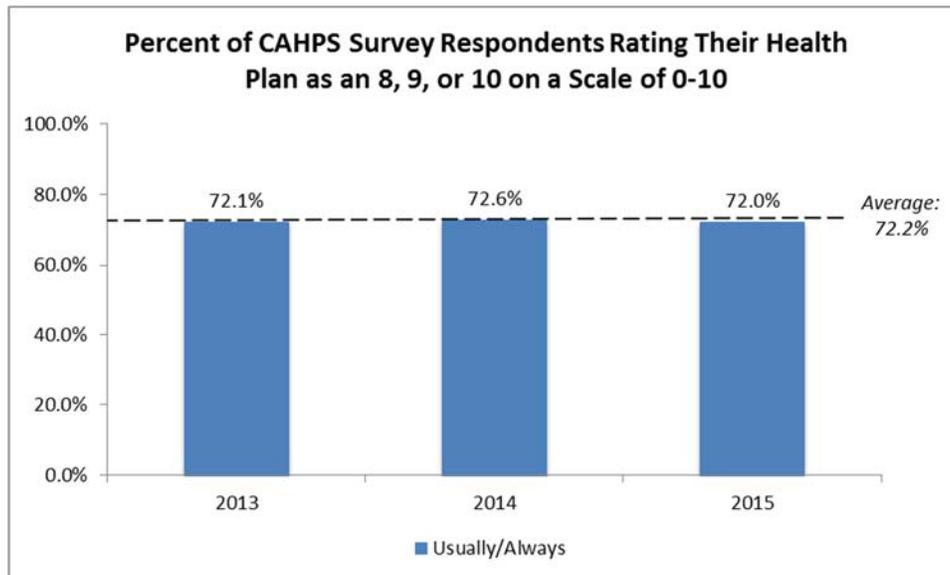


Figure 13



Georgia Medicaid Performance Measure Report Review

As part of the Georgia’s annual reporting requirements, DCH tracks a variety of performance measures for their beneficiaries [10]. Two of the measures monitor access to care: access to primary care providers for children and adolescents ages 12 months through 19 years; and access to preventive or ambulatory health services for adults ages 20 years and older. DCH compares

rates for each measure between the state’s fee-for-service population, the Georgia Families population, the Georgia Families 360° population (i.e. children, adolescents, and young adults in foster care, adoptive assistance or a Department of Juvenile Justice setting), and the entire beneficiary population. Both the Georgia Families population and the Georgia Families 360 population are enrolled in managed care.

I. Child and Adolescent Access to Care

As seen in **Table 2**, children in Georgia’s Medicaid FFS population have similar rates of access to a primary care provider (PCP) as those in the Georgia Families and Georgia Families 360° populations, both of which are served by managed care organizations. The percent of all children and adolescents in Medicaid FFS who have access to a PCP is one percentage point higher than that of all children in the Georgia Families 360° population, and four percentage points lower than the Georgia Families population.

Table 2. Percentage of Children and Adolescents with Access to a Primary Care Provider in 2014, by Age Group

| Age Group | FFS Population | Georgia Families Population | Georgia Families 360° Population | Total Population |
|------------------------------|----------------|-----------------------------|----------------------------------|------------------|
| 12 mos. – 24 mos. | 93.66% | 94.09% | 92.09% | 93.84% |
| 25 mos. – 6 years | 85.13% | 86.07% | 81.71% | 85.06% |
| 7 yrs. – 11 yrs. | 87.20% | 88.97% | 86.30% | 88.54% |
| 12 yrs. – 19 yrs. | 79.98% | 86.21% | 79.96% | 85.16% |
| All (12 mo. and over) | 83.44% | 87.41% | 82.45% | 86.64% |

II. Adult Access to Care

As seen in **Table 3**, adults aged 20 to 44 years in Georgia’s Medicaid FFS population have slightly lower rates of access to preventive or ambulatory health services than those in the Georgia Families population. Adults aged 45 to 64 years in the FFS population have rates of access to preventive or ambulatory health services that are comparable to those in Georgia Families. Interestingly, adults 65 years and older had significantly *higher* rates of access to preventive or ambulatory health services compared to those in Georgia Families. However, this is likely due to the low percentage of adult beneficiaries ages 65 and older covered via the Georgia Families program. There were no Georgia Families 360° beneficiaries in this measure.

Table 3. Percentage of Adults with Access to Preventive / Ambulatory Health Services in 2014, by Age Group

| Age Group | FFS Population | Georgia Families Population | Total Population |
|-------------------|----------------|-----------------------------|------------------|
| 20 yrs. - 44 yrs. | 77.89% | 81.23% | 79.36% |
| 45 yrs. - 64 yrs. | 88.87% | 89.27% | 88.76% |
| 65+ yrs. | 86.37% | 66.67% | 86.37% |

Alliant GMCF Utilization Report Review

Alliant GMCF, a contractor for DCH, provided global utilization reports on a set of category of service codes for calendar year 2015. Claims were included in the analysis if the associated individual was enrolled in FFS Medicaid for at least 11 months in 2015. Recognizing that there is some overlap in these required service categories, the category of service codes included in the data pull were primary care-related services (i.e. Physician Services [COS 430], Physician Assistant Services [COS 431], Dental Services [COS 490], Federally Qualified Health Center/Rural Health Clinic [COS 540], Podiatry Services [COS 550], and Advanced Nurse Practitioner Services [COS 740]), physician specialist services (i.e. Physician Services [COS 430]), behavioral health services (i.e. Physician Services [COS 430], Physician Assistant Services [COS 431], Community Mental Health Services [COS 440] and Psychological Services [COS 570]), pre- and post-natal obstetric services (i.e. Physician Services [COS 430], Physician Assistant Services [COS 431], and Nurse Midwifery [COS 480]) and home health services (i.e. Home Health Services [COS 200]). During 2015, Georgia FFS beneficiaries filed 4.6 million claims for those ten categories of service, for which \$337 million was paid (see **Table 4** below). Physician services were the most commonly utilized services, followed by community mental health services and advanced nurse practitioner services.

Table 4. Claim Counts and Total Paid by COS, CY2015

| COS | COS Name | Claim Counts | Total Paid |
|--------------|--------------------------------------|------------------|-------------------------|
| 430 | Physician Services | 2,725,673 | \$180,618,907.93 |
| 440 | Community Mental Health Services | 1,372,836 | \$121,212,333.81 |
| 740 | Advanced Nurse Practitioner Services | 190,494 | \$10,700,032.42 |
| 431 | Physician Assistant Services | 121,285 | \$7,556,295.61 |
| 540 | FQHCs/Rural Health Clinics | 53,540 | \$6,034,109.99 |
| 200 | Home Health | 92,432 | \$5,110,560.64 |
| 570 | Psychological Services | 27,895 | \$3,172,801.53 |
| 550 | Podiatry Services | 38,002 | \$1,931,562.99 |
| 480 | Nurse Midwifery | 3,017 | \$272,909.12 |
| 490 | Dental Services | 904 | \$146,480.76 |
| Total | - | 4,626,078 | \$336,755,994.80 |

Overall, Georgia Medicaid's FFS beneficiaries generate a large proportion of Georgia Medicaid's total costs, the majority of which are concentrated in physician services, community mental health services, and advanced nurse practitioner services.

Conclusion

Overall, the data indicate that Georgia's FFS Medicaid beneficiaries seem to be able to access care at rates similar to their managed care counterparts. As seen through the CAHPS results, Georgia's Medicaid beneficiaries report being able to access the care they need, when they need, and positively rate their health, providers and plans. Children in Georgia's FFS population tend to have similar rates of access to primary care providers when compared to children in Georgia's managed care plans. Adults in FFS fare similar to and, in some cases, better than adults in managed care when accessing ambulatory and preventive health services. Finally, Georgia's FFS population is utilizing a large number of services, the most common of which are physician services and community mental health services.

III. Access Concerns

According to the federal access rule, states must consider the concerns of providers and beneficiaries when analyzing the sufficiency of access to care in their FFS Medicaid programs; part of this analysis must include input from the state's MCAC (42 C.F.R. § 447.203 (b)(2)).

Methods

In order to meet this portion of the rule's requirements, DCH:

- Sought information from its MMIS and call center vendor, HPE, and
- Conducted a qualitative survey of its MCAC members.

MMIS Data

DCH requested information from HPE about calls they received concerning access to care for FFS members in the Medicaid program. For these calls, HPE only recorded whether or not they were related to non-emergency transportation (NET) services.

MCAC Surveys

In order to obtain feedback from the Georgia MCAC, surveys were emailed to all committee members on March 29, 2016. Out of 14 surveys sent out, seven were received back with responses. These responses were supplemented by comments made during the May 18, 2016 MCAC meeting at which the survey questions were again shared to garner additional feedback. The surveys contained the following questions regarding access to care issues for the FFS Medicaid population in Georgia:

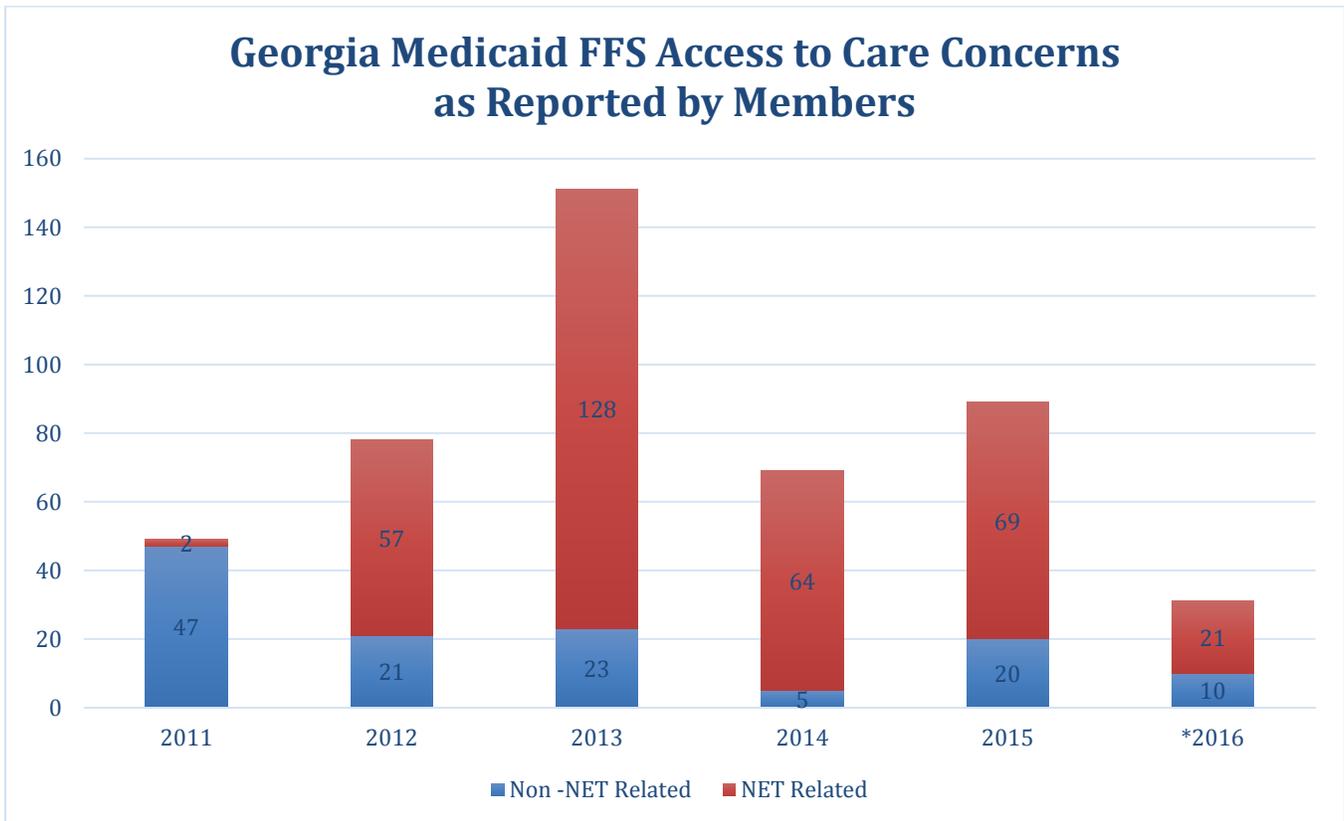
1. What factors do you feel negatively impact access to care for Medicaid FFS patients in Georgia?
2. What factors do you feel positively impact access to care for Medicaid FFS patients in Georgia?
3. Are there any medical services that are particularly difficult for Medicaid FFS patients to access? What are they?
4. Are there any regions of the state that have disproportionately lower access for Medicaid FFS patients than other areas? Why? Is that the same for all insurance, or just for Medicaid FFS?
5. How do payment rates for Medicaid FFS physicians compare with those for other public payers and private insurance? Does this impact access to care?
6. What would be the best measures for DCH to use to monitor access to care in the Medicaid FFS program?
7. Is there anything else that we should know about patient access to care in Georgia's Medicaid FFS program?

Findings

MMIS Data

The Georgia Department of Community Health contracts with HPE to manage the MMIS system for Georgia, which includes a call center. As part of that work, HPE often receives calls from FFS members with questions or concerns about access to services. The number of calls received each year since 2011 are shown in Figure 14 below, broken down by those that were related to NET services and those that were not. In 2011, out of 47 calls received by FFS members, only 2 were related to NET (4%). However, by 2013, 128 out of 151 calls received were NET related (85%). 2013 also saw the highest number of total calls related to access for FFS members. As of February 19, 2016, 31 calls were received, 21 of which were NET related (68%). Except for 2011, the majority of calls received by HPE have been NET related. Therefore, this data suggests that one of the main barriers to access may be a lack of available transportation.

Figure 14



*As of 2/19/2016

MCAC Surveys

Of the seven MCAC members who initially responded, six were practicing physicians and one was a pharmacist. The physicians represented a variety of practices, such as pediatrics, primary care, oncology, and women's health. Most were from Metro Atlanta, but at least two were located in

South Georgia. The other MCAC members, providing feedback during the quarterly meeting, did not specify their profession or location.

Regarding factors that negatively impact access to care, low provider payment rates were mentioned by all respondents. One provider specified:

“Reimbursement is so low that if a provider has more than 17.5% of patients from Medicaid they will lose money. The only way to mitigate the loss is to limit access.”

Three respondents mentioned that many of their Medicaid patients do not show up on time or at all for appointments nor fully comply with physician instructions. More specifically, respondents noted that patients who do not show up to appointments cannot be penalized; thus the physician loses money on no-shows. This may cause providers to avoid Medicaid patients. One provider even suggested making continued Medicaid coverage contingent on showing up for scheduled appointments. However, another respondent mentioned that this was not necessarily the patient’s fault, as access to transportation can be difficult for Medicaid members. Problems with accessing transportation were mentioned by several respondents, particularly non-emergency transportation (NET), which patients often do not understand and thus are unable to take full advantage of that benefit. Finally, several providers mentioned that the administrative burden associated with becoming a Medicaid provider is often so heavy for office staff that they may not want to participate in the program, especially when compared to the procedures utilized by private insurance. One provider even suggested a “top-down approach” to reducing Medicaid’s administrative burden. Finally, inaccurate provider directories were also mentioned as a problem for both providers and members.

Of the specialties mentioned as particularly difficult to access, dental care was the most frequently mentioned. Obstetrics (OB) and Gynecology (GYN), and behavioral health were also mentioned by several respondents, although one specified that OB was not really a problem while Gynecology was. Other specialties mentioned as particularly difficult to access were dermatology, general surgery, neurology, genetics, psychology and psychiatry, endocrinology, wound care, rheumatology, and urgent care. In addition, two respondents mentioned that all services could be difficult to access, especially in rural settings. Finally, one MCAC member mentioned that some of the newest wound care codes were not currently in the Medicaid system; therefore, physicians cannot provide these services because they are unable to bill for them.

In terms of areas with particular access shortages, rural areas and specifically South Georgia were mentioned by all respondents. Moreover, health district 5-1 in Southeast Georgia was specifically mentioned by one respondent. One respondent said that the problem was getting worse in rural areas and added:

“When there are not enough providers to spread the government payer patient load, then access to government payer patients must be limited to preserve sustainability of provider services.”

Finally, all respondents said that Medicaid FFS payment rates were too low, and that this inhibited access by discouraging provider participation. Respondents pointed out that Medicaid FFS rates were lower than both Medicare and private insurance, and that for most providers, seeing

Medicaid patients is really a “charitable decision.” Moreover, one provider opined that the losses sustained by Medicaid providers made it even less likely that they could provide needed care to those without any insurance.

Despite these concerns, some respondents did point to factors that positively influenced access. The oncologist mentioned the positive effects that have been seen in cancer patients because of Medicaid coverage, particularly for breast cancer. Another mentioned that there was good coverage of obstetrics (OB) and pediatrics, and another opined that most providers accepted at least *some* Medicare and Medicaid patients. In addition to these, another respondent mentioned NET services (when available), medical homes, low cost-sharing, and the presence of public health nurses in local health departments as factors which improve access to care. Finally, one pediatrician mentioned that reimbursement rates seemed to be improving, although another clarified during the MCAC meeting that this is primarily for those enrolled in waiver programs.

When asked about ideal measures for gauging access, several respondents suggested an online system that could document and address access issues in real time. Others mentioned annual report cards similar to what private insurance companies use for their network providers. One respondent suggested using the same system that private insurance uses, as creating a new system just for Medicaid would be an added burden for providers. Others recommended using surveys in clinics, as well as secret shoppers. One emphasized that whatever information is gathered, it should be collected at the local level. In terms of specific measures that should be used in data analyses, several providers recommended waiting times, distance travelled, ratios of providers to patients, denied requests for services, outpatient ER visits, and primary care provider (PCP) HEDIS measures for annual wellness exams.

In terms of other matters that respondents felt were important, respondents suggested relaxing scope of practice restrictions on nurse practitioners and other mid-level providers, easing up on NET restrictions (e.g. those using NET cannot bring a child with them and have to arrange for day care), a public relations campaign to inform providers of newly increased reimbursement rates, and a care coordination program for the aged, blind, and disabled (ABD) population. Finally, several MCAC members felt that telemedicine holds promise as a technological means for improving access to care, particularly for members with chronic disease, members who need to see a specialist, or members who otherwise would go to the emergency room for primary care. However, others pointed out challenges, such as cost of equipment, billing issues, and a lack of eligible sites that currently limit the use of telemedicine in the Medicaid program to a handful of services, such as neurology.

Conclusion

Although not captured by the MMIS data, the MCAC survey results indicate that in rural areas of Georgia, FFS members have difficulty accessing care. Moreover, the entire state faces shortages of dental, behavioral health, and OBGYN providers. MCAC members identified several reasons for these shortages, including payment rates, administrative difficulties, and access to transportation. Interestingly, the MMIS data also showed that NET was a particular area of concern for FFS members, as it made up the majority of calls to the HPE call center. Despite these issues, the latest

report from the Georgia Board for Physician Workforce shows that, since 2008, there has been a steady increase in the number of physicians accepting Medicaid [11].

IV. Provider Network Adequacy

A critical part of determining a health plan member's access to care is assessing the adequacy of a plan's provider network or its ability to provide a sufficient number of providers and services for members to access. To measure provider network adequacy generally, one could count the number of providers in the network, by service type and geography, and compare that to the number of beneficiaries located in a particular area. This "per population" method is often utilized by public health or provider organizations, and is best used with larger populations. A more precise method, however, is creating geographical mapping reports that use distance and/or time measures to determine whether beneficiaries are able to access a sufficient number and type of providers within an agreed-upon criteria. We have therefore chosen geographical mapping as our main measure of provider network adequacy for the AMRP. Additionally, supplementary provider counts per beneficiary population and geography were created in order to offer more detail for a sub-set of home health providers: Georgia Pediatric In-home Nursing Providers (GAPP).

Methods

I. Geographic Access: Data & Tools

In the private insurance industry and increasingly in the public sphere, GeoAccess is the standard mapping tool used to measure provider network adequacy. GeoAccess can quickly map time and distance from members to providers, in order to assess network adequacy. Georgia DCH requires that its CMOs, which serve the majority (66%) of its Medicaid population, provide yearly GeoAccess reports for their provider networks.² However, DCH does not currently have GeoAccess or any other mapping software in house. Thus, in order to create similar FFS access mapping reports for this AMRP, the GHPC utilized its in-house ArcGIS geographic mapping tool and experts. The GHPC geocoded the locations of beneficiary and provider addresses and created estimates measuring the *radial distance* (straight line) between each beneficiary and providers by type, noting where the distance measures (detailed below in part II) were and were not met.

Beneficiary addresses for analysis were pulled via Truven from calendar year 2015 beneficiary enrollment files; only those beneficiaries enrolled in FFS for 11 months or longer were included.³ The majority of providers and provider addresses came from a 2016 Medicaid FFS provider enrollment file, pulled by HPE upon request from DCH in April 2016.⁴ Certain provider groups that were not contained in the HPE file were pulled separately by the GHPC via Truven using 2014

² In addition to GeoAccess, CMOs must provide information on their ability to meet wait time, appointment, retention, and validation standards for their provider networks.

³ Within this new geocoding system, roughly 18% of members (82,718 of the original 449,423) were either impossible to code based on errant address data or were not within the state of Georgia. Cleaning and recoding these data was not practicable.

⁴ 5,900 providers outside of Georgia were removed from the HPE file, as well as 9,352 providers with administrative codes or not matching our provider types of interest. While we know that providers in neighboring states are important sources of care for beneficiaries close to the border, we did not have the mapping capacity to stretch outside of Georgia for this AMRP.

data. Providers were pulled using COS codes⁵, cleaned for duplicates, and then added to the HPE file. After combining this data, the provider data included: 41,180 primary care providers, 7,745 dental providers, 61,476 physician specialists, 5,821 obstetric/gynecologists, 2,636 behavioral health providers, and 239 home health providers.⁶

It should be noted that use of the HPE 2016 Medicaid FFS provider enrollment file comes with two important caveats: provider duplications and provider specialty inaccuracies. Provider duplications may appear because the provider enrollment file is not cleaned year to year; therefore, a provider who submits multiple sets of enrollment paperwork with different name spellings, location or address changes, or typos, will show up multiple times. However, because providers do practice in multiple specialty areas and locations, removing all National Provider Identifier (NPI) duplications would drop many legitimate provider records. DCH is aware of this issue, and is currently devising the best way to clean duplicates from the provider enrollment file in the future. Regarding provider specialty inaccuracies, in order to have more accurate provider specialties, specialty designations were assigned using the NPIs in the CMO provider network files.⁷ Where no NPI match existed between a provider in the HPE Medicaid FFS provider enrollment file and the CMO files (about 10% of the FFS providers), we used the specialty designation listed in the HPE file. These inaccuracies will be fixed in the near future as a result of the newly instated provider credentialing process (detailed within the Access Monitoring Procedures section, p.35), and assigning specialties using CMO files will become unnecessary. Due to the aforementioned processes (credentialing and cleaning for duplicates), the overall accuracy of the provider enrollment file and any related analyses will improve in future AMRPs.

II. Geographic Access: Distance Measures / Provider Grouping

States vary tremendously in the distance standards they require of their private insurers and managed care plans [12]. Georgia currently has no law on the matter; thus DCH developed its own CMO network requirements with the assistance of a consultant. DCH requires that its CMOs deliver a rate of 90% access for seven different categories of providers: Primary Care Providers (PCPs), Specialists, General Dental Providers, Dental Subspecialty Providers, Hospitals, Mental Health Providers, and Pharmacies. Accordingly, the following DCH CMO distance standards (see **Table 5** below), relatively strict when compared with other states, were applied to FFS providers for this analysis:

⁵ These providers include CNMs (COS 480), PAs (COS 431), NPs (COS 740), FQHCs (COS 540), and home health (COS 200).

⁶ For this analysis, in order to capture providers with multiple practice locations, we count each provider practice location as one provider (i.e. a provider who practices primary care in four locations around the state has been counted four separate times).

⁷ GA's three CMOs provided files containing provider type, name, address, specialty, NPI, and in some cases Medicaid IDs for the AMRP required provider types. One CMO was mapped in first by NPI; where it did not have the provider match by NPI, a second CMO file was used. Where neither had the provider, the third CMO file was used. Where none of the CMOs had a matching NPI / provider (a little over 10% of the HPE file), the original Medicaid specialty designation from HPE was used.

Table 5. Georgia AMRP Geographic Access Standards

| Provider Type | Urban | Rural |
|---|-------------------|-------------------|
| PCPs (includes FP, GP, Ped, IM, NP, PA, FQHC, and PH) | 2 within 8 miles | 2 within 15 miles |
| Physician specialists (any/all specialists) | 1 within 30 miles | 1 within 45 miles |
| OB/GYN (includes GYN, OB, OB/GYN, and CNM) | 1 within 30 miles | 1 within 45 miles |
| Dental Providers (including dental specialists) | 1 within 30 miles | 1 within 45 miles |
| Behavioral Health Providers (including psychiatrists) | 1 within 30 miles | 1 within 45 miles |
| Home Health Providers | 1 within 30 miles | 1 within 45 miles |

One of the main differences between the CMO and FFS measures is that CMOs use the following *time* and distance measures for all provider categories except PCPs: Urban – 1 within 30 minutes or 30 miles; and Rural – 1 within 45 minutes or 45 miles. Another difference is that CMOs are required to estimate “driving distance”, not radially⁸. Both of these modifications for FFS are the result of computer processing power, software, and personnel limitations. Additionally, CMOs may only count full-time (16 hours / week) providers in a location, and must note where provider locations are part-time or no longer accepting new patients. A lack of FFS provider data collection mechanisms prevents us from applying the same criteria. Other differences between the CMO and FFS measures, due to mapping capacity and time constraints, include grouping all specialists together, instead of by specialty, and grouping all dental providers together, instead of dividing into general dentists and specialists.

Other important caveats to the FFS access estimates are related to provider groupings: the FFS provider access estimates group psychiatrists with behavioral health (BH) providers instead of physician specialists; gynecologists (GYNs), obstetricians (OBs), obstetrician-gynecologists (OB/GYNs), and certified nurse midwives (CNMs) are grouped together;⁹ and family practitioners (FPs), general practitioners (GPs), Internal Medicine (IM) doctors with no subspecialty, pediatricians (Peds) with no subspecialty, physician assistants (PAs), nurse practitioners (NPs) public health (PH) clinics, and Federally Qualified Health Centers (FQHCs) are grouped together. IM doctors and Peds with subspecialties were grouped with Physician specialists.

Last, federal agencies often differ in how they define a rural or urban area. To determine if rural or urban standards should apply to a member’s location, we utilized the U.S. Department of Agriculture (USDA) 2013 Rural-Urban Continuum Codes, which were assigned by county. We further considered all “metro” counties according to the USDA to be urban, and “non-metro” counties to be rural (see **Table 6** below). For the geographic analysis, urban and rural member results were run separately, and then rolled up into the 12 DCH regions (see **Appendix A**) for analysis as a regional group.

⁸ However, please note: GeoAccess “driving distance” estimates do not utilize street map routes, but rather line of sight distance with estimates for the curves in the geography.

⁹ Although the CMS request was for OB only, we felt it was important to group OB/GYN together for the following reasons: 1) it is the typical grouping for insurers, 2) out of the group of 5,821 GYN, OB, OB/GYN, and CNM providers, only 55 were GYN only, and only 10 were OB only; 3) it made more sense to group GYN with OB than with other specialists, and 4) since GYNS, OB/GYNs, and CNMs may all serve as PCPs for female beneficiaries, we wanted to be able to show this group together.

Table 6. GA AMRP Rural-Urban County Designations

| USDA Rural-Urban Continuum Codes for Counties | GA AMRP Designation | # GA Counties |
|--|---------------------|---------------|
| Metro - Counties in metro areas of 1 million population or more | Urban | 29 |
| Metro - Counties in metro areas of 250,000 to 1 million population | Urban | 15 |
| Metro - Counties in metro areas of fewer than 250,000 population | Urban | 30 |
| Non-metro - Completely rural or < 2,500 urban population, adjacent to a metro area | Rural | 14 |
| Non-metro - Completely rural or < 2,500 urban population, not adjacent to a metro area | Rural | 8 |
| Non-metro - Urban population of 2,500 to 19,999, adjacent to a metro area | Rural | 36 |
| Non-metro - Urban population of 2,500 to 19,999, not adjacent to a metro area | Rural | 16 |
| Non-metro - Urban population of 20,000 or more, adjacent to a metro area | Rural | 8 |
| Non-metro - Urban population of 20,000 or more, not adjacent to a metro area | Rural | 3 |

III. Provider Counts by Geography

In addition to the access estimates, we conducted a simple provider count per population and DCH region (see **Appendix A**) for GAPP providers. This specialty was analyzed separately from other home health providers because of their utilization among a particular sub-set of beneficiaries – children requiring home health care. For this analysis, the following Truven data was pulled: all GAPP providers (COS 971) with claims in calendar year 2014; and calendar year 2015 FFS beneficiaries under 19 years with at least 11 months of enrollment, who have utilized GAPP.

Findings

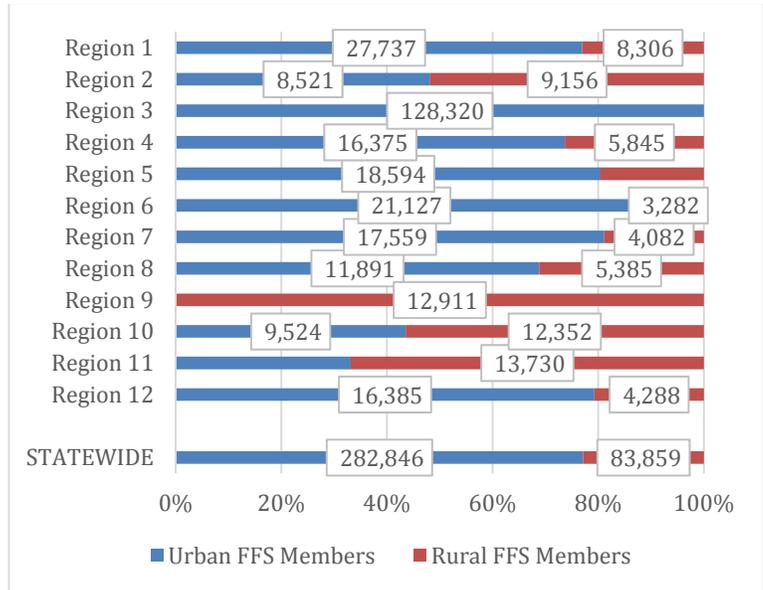
I. Geographic Access

In order to present a more detailed picture of FFS member geographic access in the state, results were stratified by DCH region (see below, or **Appendix A** for a larger version of the map) and urban versus rural status. As shown in **Figure 15** below, DCH regions may contain both urban and rural areas and beneficiaries. However certain regions are predominantly urban or rural. Region 3, which contains metro-Atlanta, has only urban beneficiaries. Regions 1, 4, 5, 6, 7, 8, and 12 have a majority urban beneficiaries, with some rural, and Regions 2, 10, and 11, have a majority rural beneficiaries, with some urban. Region 9 has only rural beneficiaries. Statewide, a little over 75% of FFS beneficiaries were considered to be living in an urban area. For the geographic access analysis, this means that most FFS beneficiaries had a slightly stricter provider access standard applied, because they are considered to be living in urban area (see **Table 5**, p.25).

STATE SERVICE DELIVERY REGIONS
Amended Effective July 1, 2005



Figure 15. Urban v. Rural FFS Beneficiaries, by DCH Region



In summary, for each DCH region, 90% or greater of its urban members have access to 2 PCPs within 8 miles of their home, and access to a physician specialist, OB/GYN, dental, behavioral health, or home health provider, within 30 miles of their home. Additionally, 90% or greater of each region’s rural members have access to 2 PCPs within 15 miles of their home, and access to a physician specialist, OB/GYN, dental, behavioral health, or home health provider, within 45 miles of their home (see **Table 7** below). These overall access levels are relatively similar to the geo-access results of Georgia’s CMO networks. Based on this criteria, the geographic analysis found that Georgia Medicaid FFS beneficiaries are likely have adequate access to primary care, physician specialty, obstetric, dental, behavioral health, and home health providers, should the providers be willing to see them.

Table 7. Provider Network Adequacy per Provider Type by Region

| DCH Region | # FFS Beneficiaries | PCP | Spec | OB/GYN | Behavioral Health | Home Health | Dental |
|------------|---------------------|-----|------|--------|-------------------|-------------|--------|
| 1 | 36,043 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2 | 17,677 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 3 | 128,320 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4 | 22,220 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 5 | 23,116 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 6 | 24,409 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 7 | 21,641 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 8 | 17,276 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 9 | 12,911 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 10 | 21,876 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 11 | 20,543 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 12 | 20673 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

✓ Indicates an adequate beneficiary provider access level: $\geq 90\%$ of beneficiaries are within 8 (urban) or 15 (rural) miles of 2 PCPs, and 30 (urban) or 45 (rural) miles of a physician specialist, OB/GYN, dental, behavioral health, or home health provider.

✓ Indicates slightly lower access for a noteworthy number of beneficiaries in this region, despite provider adequacy being met for the region as a whole ($\geq 90\%$).

Although access was met for each region in each provider category, some interesting variations in access did present. For primary care providers, urban beneficiaries in Regions 4, 5, 7 and 11 had the lowest levels of access (90.8%, 94.8%, 94.4% and 90.3%), respectively, while rural beneficiaries in these regions had extremely high levels of access. Additionally, urban beneficiaries in Region 7 had slightly lower, albeit still very high, levels of access to OB/GYNs (98.9%) and home health providers (98.3%) than rural beneficiaries in their region, and urban and rural beneficiaries in all other regions. These variations between urban and rural beneficiary access within a region are not uncommon in such analyses, and could be due to a number of things: more restrictive access measures for urban areas (see **Table 5** on p. 25), designation methods for urban v. rural areas (see **Table 6** on pp. 26), or inexact provider enrollment data (see Methods, Part I, p. 23). However, despite these potential concerns, CMO geo-access results show some similar variation regionally. Additionally, inexact provider enrollment data (duplicates and questionable specialty designations), and provider grouping methodology (all physician specialists rolled up into one group or all dental providers grouped together) may factor in to the very high FFS access results for all provider types and regions, although it is hard to estimate to what extent.

II. Provider Counts by Geography for the GAPP Population

GAPP providers are home care nurses, both RNs and LPNs, and home care aids employed by a nursing agency for home care services to the GAPP pediatric population. The rate of GAPP providers per 1,000 population of FFS beneficiaries under the age of 19 who utilized GAPP services in 2015, was 45.12 for the state as a whole. This, of course, is a very high rate, as only a small percent of the FFS child population in 2015 (1.2%) was in need of such in home care. However, the GAPP analysis also shows that there is a lack of GAPP providers (only 1 or none) in Regions 4, 5, 9, 10, and 11, where there are still a number of beneficiaries utilizing GAPP services (25-36 per region). This does not mean that the needs of the FFS beneficiaries are not being met / that there is no access, but rather that GAPP providers from other regions are traveling across

regional lines in order to serve these areas. Thus, while there is an extremely high rate of GAPP providers in Georgia per 1,000 of the FFS patient population, there are certain areas of the state that would greatly benefit from additional GAPP providers.

Table 8. GAPP Providers per 1,000 Population (FFS Beneficiaries under 19, Utilizing GAPP), 2015

| DCH Region | # FFS Beneficiaries under 19 Utilizing GAPP Services in 2015 | # GAPP Providers | Rate of Providers per 1,000 Population (FFS GAPP Utilizers under 19) |
|--------------------|--|------------------|--|
| 1 | 47 | 2 | 42.55 |
| 2 | 31 | 2 | 64.52 |
| 3 | 297 | 13 | 43.77 |
| 4 | 36 | 0 | 0.00 |
| 5 | 36 | 1 | 27.78 |
| 6 | 39 | 3 | 76.92 |
| 7 | 45 | 2 | 44.44 |
| 8 | 17 | 3 | 176.47 |
| 9 | 25 | 0 | 0.00 |
| 10 | 31 | 0 | 0.00 |
| 11 | 31 | 1 | 32.26 |
| 12 | 52 | 4 | 76.92 |
| Grand Total | 687 | 31 | 45.12 |

Conclusion

The geographic access results indicate that Medicaid FFS members, in all twelve DCH regions of the state, have adequate access to the FFS provider network for the six services in question: primary care, physician specialty, obstetrics, dental, behavioral health, and home health. This is particularly impressive considering the relatively strict distance access measures, when compared to other states, which Georgia has applied to its FFS provider network for this analysis. Although the overall analysis results are extremely positive, it is also clear that some regions and FFS provider types could benefit from access improvement (PCPs in Regions 4, 5, 7, and 11, and OB/GYNs and home health in Region 7). Additionally, DCH is aware that certain provider shortages (OB/GYN, dentist, PCP, behavioral health) do exist for the entire population of certain areas of the state, such as South Georgia or the more rural counties. For example, the Health Resources and Services Administration (HRSA) has designated 193 areas in Georgia as primary care Health Professional Shortage Areas (HPSAs), 148 areas as dental care HPSAs, and 91 areas as mental health care HPSAs [13-15]. The 2014 GBPW physician workforce report found that Metropolitan Statistical Areas (MSA), or urban areas of the state, had 41.8% more physicians per 100,000 population than Non-MSAs, and that 76 counties had no OB/GYN physician [16]. Therefore, DCH will continue to improve upon the detail (running results by county, splitting out physician specialties and dental providers, and utilizing driving distance mapping) and accuracy (cleaning its provider files) of its geographic access analysis for future AMRPs, while also continuing to develop innovative ways to circumvent the state’s provider shortages.

V. Rate Review

Medicaid reimbursement rates are often discussed as a barrier to providing sufficient access to providers and the services that they render. As part of the AMRP, CMS required that states conduct a comparative rate review potentially including the Medicaid reimbursement rates for the state, Medicare, and private insurance, if possible. We were unable to secure reimbursement rates for private insurers and instead included rate information for comparable Medicaid programs in other states.

Methods

The Georgia Medical Care Foundation (GMCF), a contractor for DCH, compiled the top 20 utilized services for physicians, physician assistants, midwives, nurse practitioners, oral maxillofacial, podiatry, psychological, home health, behavioral health, and dental services for Medicaid members with at least 11 months of FFS enrollment during the 2015 calendar year. We report the top twenty utilized services for the first seven categories of service together in **Appendix B, Table 12** (p.38), but separately report the top 20 utilized services for behavioral health and dental services. Behavioral health services are reported separately because the rate comparisons do not include Medicare. Dental procedures are reported separately because they were mentioned by our stakeholders as a service with poor access. We compared Georgia's Medicaid reimbursement rates for these services to those of Medicare, South Carolina's Medicaid program, Alabama's Medicaid program, and North Carolina's Medicaid program [17-42].

Findings

The top two utilized procedures were for outpatient office visits. Georgia Medicaid reimbursed \$40.70 for procedure code 99213 and \$62.71 for procedure code 99214. These rates are lower than those of Medicare and Medicaid in South Carolina, Alabama, and North Carolina to varying degrees. Procedure code 99213 is reimbursed at \$73.00 by Medicare, 79% higher than the reimbursement rate in Georgia. While not as stark a difference, procedure code 99214 is reimbursed at \$47.12, \$42.00, and \$54.26 in the South Carolina, Alabama, and North Carolina Medicaid programs, respectively. Therefore, Georgia Medicaid reimburses 15.8%, 3.2%, and 33.3% less than comparable programs in South Carolina, Alabama, and North Carolina respectively (see **Appendix B, Table 12**, p.38).

While we find a general trend of lower reimbursements comparing the Georgia Medicaid program to Medicare, we found three instances where Georgia Medicaid reimbursed at a higher rate than Medicare or our comparable Medicaid programs. For example, procedure code 71010 for chest x-ray frontal was reimbursed at \$24.44. The same procedure code was reimbursed at a rate that was 7.7%, 28.2%, 59.4%, and 23.9% less by Medicare, South Carolina Medicaid, Alabama Medicaid, and North Carolina Medicaid, respectively. Other procedure codes were 93010 for an electrocardiogram report and 71020 for a chest x-ray two view frontal and lateral. Georgia Medicaid reimbursed at higher rates than comparable programs in each of these three cases. Among directly comparable services between programs, Georgia Medicaid provided higher reimbursement for 27% of procedure codes offered in Medicare, 65% of procedures in South Carolina Medicaid, 63% of procedures in Alabama Medicaid, and 37% of procedures in North Carolina Medicaid.

Behavioral Health

We compared reimbursement rates for behavioral health services separately due to an apparent lack of coverage by Medicare.¹⁰ As seen in **Appendix B, Table 13** (p.41), the reimbursement rates for similarly covered procedures vary widely by Medicaid programs; not all services are covered for each of the Medicaid programs reviewed.¹¹ For example, procedure code H2017 for psychosocial rehabilitation service at 15 minute increments is a covered service in all four Medicaid programs. However, for this service, Georgia Medicaid pays 50.6%, 84.8%, and 89.8% more than South Carolina Medicaid, Alabama Medicaid, and North Carolina Medicaid respectively. Regarding procedure code 90837 for PSYTX PT and family in 60 minute increments, Georgia Medicaid pays \$155.87 per service, 4.8% less than what South Carolina pays, 48.7% more than what Alabama pays, and 38.1% more than what North Carolina pays. There also appears to be variation in the services that are covered by each Medicaid program. For example, procedure code H0038 for self-help / peer service in 15 minute increments is a covered service in both the Georgia Medicaid and South Carolina Medicaid programs. We were not able to locate a reimbursement amount for this service in the Alabama or North Carolina Medicaid programs, suggesting that the procedure may not be covered. For behavioral health procedure codes in Georgia Medicaid and the comparator programs, Georgia provided greater reimbursement for 73%, 91%, and 91% of covered services relative to South Carolina, Alabama, and North Carolina, respectively.

Dental

Finally, we reviewed reimbursement rates for dental services, which were identified as a service type with poor access by our stakeholders. Similar to behavioral health services, Medicare does not provide dental care comparable to what is covered under Medicaid [43]. The only dental services included under Medicare are those provided in a hospital setting. **Appendix B, Table 14** (p.43) summarizes reimbursement rates for dental procedures covered by Medicaid in Georgia, South Carolina, Alabama, and North Carolina. While reimbursement rates varied by procedure and state, Georgia provided higher reimbursement for the majority of frequently utilized services. For comparable procedures commonly claimed among beneficiaries, Georgia's reimbursement rate was greater for 75%, 95%, and 60% of service codes offered in South Carolina, Alabama, and North Carolina, respectively. Among the top 20 highest utilized dental services for the state, procedure code D1110, for dental prophylaxis adult, was the only claim for which Georgia provided lower reimbursement rates relative to South Carolina (-27.6%), Alabama (-9.1%), and North Carolina (-12.9%).

¹⁰ We were not able to find reimbursement rates for any of the behavioral health services listed in this report. We submitted both procedure codes and descriptions to colleagues in other state Medicaid programs who were also working on their AMRP as well as to colleagues at the Georgia Department of Behavioral Health and Developmental Disabilities in an attempt to determine if these services were covered by Medicare. Our colleagues stated that, to their knowledge, these services were not covered by Medicare. Finally, we reached out to the Medicare program. As of this writing, we are still awaiting a response.

¹¹ We were able to obtain some additional reimbursement rates from colleagues in the South Carolina Medicaid program, but they could not confirm rates for all highly utilized behavioral health procedure codes in this report. There is no evidence that Alabama Medicaid or North Carolina Medicaid covers any of the missing procedure codes in publicly available documents, and we have not been able to confirm the coverage of these procedures with program representatives.

Conclusions

While Georgia Medicaid generally reimburses at a rate lower than that of Medicare, there are variations in the reimbursement rate when compared to other Medicaid programs. Georgia Medicaid reimbursement rates can be lower or higher than one, two, or all three of our comparison states, depending on procedure code. There are also variations in what procedures are covered when comparing Georgia Medicaid to Medicare or to other Medicaid programs. Medicare appears to provide no coverage for the behavioral health services or dental services included in this section. Comparison Medicaid programs varied in both their coverage and reimbursement rates for these same services. As seen in **Table 9**, below, relative to Medicaid programs in South Carolina and Alabama, Georgia Medicaid provided higher reimbursement rates for the majority of directly comparable, highly utilized procedure codes, including those for behavioral health and dental care coverage. Georgia also provided higher reimbursement rates than North Carolina for the majority of directly comparable dental and behavioral health services.

Table 9. Percent of Comparable, Highly Utilized Procedure Codes for which Georgia Medicaid Offers Greater Reimbursement

| Service Type | Medicare | SC | AL | NC |
|-------------------|----------|-------|-------|-------|
| General/Medical | 26.7% | 65.0% | 63.2% | 36.8% |
| Behavioral Health | N/A | 73.3% | 90.9% | 90.9% |
| Dental | N/A | 75.0% | 95.0% | 60.0% |

AMRP Comprehensive Access Findings

Combined analysis of CAHPS survey and Performance Measure Reports results, access concerns from beneficiaries, providers, and the MCAC, provider network geographic access, and comparative rate review indicates that overall, current Georgia Medicaid reimbursement rates for FFS providers allow FFS beneficiaries adequate access to primary, dental, physician specialty, obstetric, behavioral health, and home health care. The Georgia FFS beneficiary population is primarily made up of older adults who are either aged, blind or disabled, or are some form of dual eligible. 2015 utilization reports indicate that the FFS beneficiaries utilize services, especially physician and community mental health services, very frequently. Thus it is important that these beneficiaries be able to access appropriate and timely health services, particularly in these areas.

While MCAC members praised Medicaid FFS access to a number of services (pediatrics, OB, and breast cancer services), they also voiced concerns over access shortages in dental, behavioral health, and GYN care, particularly in rural areas of the state. Suggested explanations for these access issues included beneficiary lack of access to transportation, provider administrative difficulties in dealing with Medicaid, and low provider payment rates. While our rate review found that Georgia Medicaid does tend to reimburse at a lower rate than Medicare, there are variations in how Georgia's reimbursement rates compare to Medicaid programs in neighboring states. In fact, Georgia Medicaid provides higher reimbursement rates for the majority of directly comparable, highly utilized procedure codes (including behavioral health and dental care), than South Carolina and Alabama Medicaid. Thus one cannot accurately conclude that Georgia Medicaid FFS provider payment rates are responsible for perceived FFS provider shortages.

Further, CAHPS and Performance Measure Report data indicate that Georgia FFS Medicaid beneficiaries are able to access care at rates similar to their managed care counterparts. CAHPS data show that Georgia Medicaid beneficiaries (including FFS) are able to access the care they need, when they need. CAHPS data also show that Georgia Medicaid beneficiaries positively rate their health, providers and plans. Performance Measure Report data show that the FFS child population has similar rates of access to primary care providers as children in Georgia's CMOs, and that FFS adults have similar, if not better, access to ambulatory and preventive health services than adults in CMOs.

Finally, the geographic access analysis of the FFS provider network (which utilizes relatively strict access standards) indicates that Medicaid FFS members in all twelve DCH regions of the state have adequate access to the six services in question. While the results did show a slight variation in access between urban and rural FFS beneficiaries in certain regions (Middle and South Georgia) and provider types (PCPs, OB/GYNs, and home health), outside reports indicate that provider shortages in Georgia are in no way unique to Medicaid FFS, but rather affect the entire population in certain geographies [16, 44-47].

In summary, while Georgia Medicaid reimburses some providers and procedures at lower rates than Medicare or neighboring states, geographic access analysis, CAHPS survey, and Performance Measure Report results show that FFS beneficiaries are able to satisfactorily access care. DCH will

continue to actively monitor its FFS beneficiaries' access to health care services (establishing new and more detailed monitoring procedures), and will continue to explore innovative ways to improve their beneficiaries' access to the providers and services they need.

Access Monitoring Procedures

During the course of the AMRP, DCH used a variety of procedures to measure access for the various part of the plan. Some of these were adequate for this purpose, while others could use improvement. Going forward, DCH intends to make changes to certain procedures and additions to others in order to bolster subsequent AMRPs. The changes are outlined in **Table 10** below, according to AMRP section and the current monitoring procedures. The table also notes which DCH departments or partners are responsible for carrying out each monitoring activity. Additionally, DCH will continue to work (internally and with external partners) toward developing comparison provider, access, and rate data to be analyzed and shared in future AMRPs.

Table 10. Access Monitoring Procedures and Responsible Parties

| AMRP section | Current monitoring procedures | Future monitoring procedures | Responsible Parties |
|--------------------------------|---|---|--|
| Part I: Beneficiary Population | DCH beneficiary enrollment data analysis | Same | Fiscal Agent (FA); DCH MMIS / Member Services & Policy |
| Part II: Beneficiary Need | GA CAHPS survey analysis | GA and national CAHPS survey analyses with FFS split out from CMO data | DCH Performance, Quality and Outcomes |
| | GA Medicaid performance measures data analysis | Same | DCH Performance, Quality and Outcomes |
| | Utilization report | Same | Medical Management and Quality Review Vendor (MMURS); DCH Medical Policy |
| Part III: Access Concerns | FA call center data analysis | Expand call center data by categorizing calls by specific access concerns | FA; DCH MMIS / Member Services & Policy |
| | MCAC survey summary | Follow up survey of MCAC | DCH Medical Policy |
| Part IV: Network Adequacy | DCH beneficiary & provider enrollment data collection | Same, but FA provider enrollment data will be cleaned to eliminate duplications and specialty inaccuracies | FA; DCH MMIS; GHPC |
| | Geo-mapping analysis | Same, but with driving distance mapping, more detailed mapping for counties, top utilized physician specialties | GHPC; DCH Regulatory Services & Compliance / Medical Policy / Managed Care and Contracts |
| | Compare number of GAPP providers to members, for 2015 | Compare all provider types of interest to members, trended over time | FA; DCH MMIS, Medical Policy; GHPC |
| | Preliminary new provider credentialing process | Complete implementation of provider credentialing process | DCH Provider Enrollment |
| | | Potential secret shopper testing of network | DCH Member Services & Policy |
| Part V: Payment Rate Review | DCH FFS claims data analysis | Same | GHPC; DCH Regulatory Services & Compliance, Medical Policy |
| | AL & SC Medicaid physician fee schedules | Comparisons to other Medicaid programs stays the same but the exact states might change | |
| | Medicare physician fee schedules | Same | |

New Provider Credentialing Process (as of 8/1/2016)

One procedure that deserves special mention is the work that DCH began in 2015 to have all Medicaid providers, both current providers and newly-applying providers, credentialed by a Centralized Verification Organization (CVO). Managed care companies in Georgia have long had a credentialing process for providers; however, this is the first time that DCH has created a separate credentialing process for *all* Medicaid providers, including FFS-only providers. DCH's new credentialing process will take the place of any credentialing efforts currently conducted by the CMOs. Current providers have three years to be re-credentialed. **Table 11** (below) shows the numbers of applications that have either been approved or are being processed by the new CVO since 2015. Providers are stratified by those who are newly credentialed and those who are re-credentialed. In addition, the provider's status in the separate Medicaid enrollment process is shown. Although not a full picture of provider access in Georgia, these numbers provide a picture of the number of new physicians in the Medicaid program, as well as a portion of those who are already providing Medicaid services. However, these numbers are not broken down by whether the provider is part of a CMO or serves FFS Medicaid.

Of those who have newly applied for credentialing in Georgia, 6,847 providers have had their CVO applications approved. The majority of these providers (6,365) have already been enrolled as a Medicaid provider. Of the new applicants whose applications are in process, none have been enrolled as a Medicaid provider. Of those who have applied for re-credentialing, 2,523 have had their applications approved. Again, the majority of these providers (2,464) have been enrolled as a Medicaid provider. Of those who have applied for re-credentialing and whose CVO applications are in process, none have been enrolled in Medicaid. Nevertheless, out of 16,242 total applications received, 11,450 have either been approved or are being processed. These applicants have also either been accepted as Medicaid providers or their approval is in process or under review. A total of 4,792 applicants have either been denied by the CVO, denied by Medicaid, or both (numbers not shown). The re-credentialing process will take three years to be completed. At that time, DCH should be able to show the total number of credentialed providers in Georgia who are also enrolled as Medicaid providers.

Table 11. CVO Approved and In Process Applications

| CVO Applications | CVO Approved | | | CVO In Process | | | Totals |
|--------------------|-------------------|---------------------|-----------------------|-------------------|---------------------|-----------------------|----------------|
| | Medicaid Enrolled | Medicaid In Process | Medicaid Under Review | Medicaid Enrolled | Medicaid In Process | Medicaid Under Review | |
| As of 8/1/2016 | | | | | | | |
| Credentialed (New) | 6,365 | 265 | 217 | 0 | 512 | 1,336 | 8,695 |
| Re-credentialed | 2,464 | 17 | 42 | 0 | 39 | 193 | 2,755 |
| Total | 8,829 | 282 | 259 | 0 | 551 | 1,529 | 11,450* |

*out of 16,242 total CVO applications submitted (the remainder were CVO denied)

Appendix B – Rate Review Charts

Table 12. Top 20 Highest Utilized Procedure Codes for Fee-for-Service Population, Calendar Year 2015

| PROC CD | PROC Description | Service Type | GA Claim Counts | Max Allowed by GA MEDICAID | Max Non-Facility Price Allowed by MEDICARE | Percent Difference btw GA and MEDICARE | Max Allowed by SC MEDICAID | Percent Difference btw GA and SC | Max Allowed by AL MEDICAID | Percent Difference btw GA and AL | Max Allowed by NC MEDICAID | Percent Difference btw GA and NC |
|---------|--------------------------------|-----------------------|-----------------|----------------------------|--|--|----------------------------|----------------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|
| 99213 | OFFICE/ OUTPATIENT VISIT EST | Office Visit | 286,900 | \$40.70 | \$73.00 | -79.36% | \$47.12 | -15.77% | \$42.00 | -3.19% | \$54.26 | -33.32% |
| 99214 | OFFICE/ OUTPATIENT VISIT EST | Office Visit | 277,247 | \$62.71 | \$108.39 | -72.84% | \$70.99 | -13.20% | \$67.00 | -6.84% | \$81.76 | -30.38% |
| 99232 | SUBSEQUENT HOSPITAL CARE | Hospital Care | 111,165 | \$48.02 | \$72.86 | -51.73% | \$52.25 | -8.81% | \$40.00 | 16.70% | \$59.96 | -24.86% |
| 99233 | SUBSEQUENT HOSPITAL CARE | Hospital Care | 74,577 | \$67.47 | \$104.98 | -55.60% | \$74.83 | -10.91% | \$57.00 | 15.52% | \$85.87 | -27.27% |
| 99285 | EMERGENCY DEPT VISIT | ED Visit | 71,920 | \$132.41 | \$175.63 | -32.64% | \$132.27 | 0.11% | \$104.00 | 21.46% | \$138.64 | -4.71% |
| 71010 | CHEST X-RAY 1 VIEW FRONTAL | Radiology/ Cardiology | 60,083 | \$24.44 | \$22.56 | 7.69% | \$17.56 | 28.15% | \$9.93 | 59.37% | \$18.60 | 23.90% |
| 99284 | EMERGENCY DEPT VISIT | ED Visit | 60,069 | \$84.21 | \$118.67 | -40.92% | \$89.05 | -5.75% | \$66.00 | 21.62% | \$93.26 | -10.75% |
| 93010 | ELECTROCARDIOGRAM REPORT | Radiology/ Cardiology | 55,821 | \$9.45 | \$8.57 | 9.31% | \$6.95 | 26.46% | \$8.00 | 15.34% | \$7.29 | 22.86% |
| 71020 | CHEST X-RAY 2VW FRONTAL & LATL | Radiology/ Cardiology | 51,676 | \$31.11 | \$27.94 | 10.19% | \$23.22 | 25.36% | 13.65 | 56.12% | \$24.68 | 20.67% |

| PROC CD | PROC Description | Service Type | GA Claim Counts | Max Allowed by GA MEDICAID | Max Non-Facility Price Allowed by MEDICARE | Percent Difference btw GA and MEDICARE | Max Allowed by SC MEDICAID | Percent Difference btw GA and SC | Max Allowed by AL MEDICAID | Percent Difference btw GA and AL | Max Allowed by NC MEDICAID | Percent Difference btw GA and NC |
|---------|------------------------------|---------------|-----------------|----------------------------|--|--|----------------------------|----------------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|
| 99283 | EMERGENCY DEPT VISIT | ED Visit | 46,317 | \$54.80 | \$62.38 | -13.83% | \$47.47 | 13.38% | \$42.00 | 23.36% | \$49.81 | 9.11% |
| S9123 | NURSING CARE IN HOME RN | Home Health | 45,189 | \$65.00 | | | \$35.09 | 46.02% | | | | |
| 99215 | OFFICE/ OUTPATIENT VISIT EST | Office Visit | 33,782 | \$93.46 | \$146.24 | -56.47% | \$76.67 | 17.96% | \$98.00 | -4.86% | \$110.58 | -18.32% |
| 99212 | OFFICE/ OUTPATIENT VISIT EST | Office Visit | 29,396 | \$29.67 | \$44.02 | -48.37% | \$17.77 | 40.11% | \$31.00 | -4.48% | \$32.50 | -9.54% |
| 99204 | OFFICE/ OUTPATIENT VISIT NEW | Office Visit | 28,830 | \$110.51 | \$165.81 | -50.04% | \$88.34 | 20.06% | \$111.00 | -0.44% | \$125.39 | -13.46% |
| 99203 | OFFICE/ OUTPATIENT VISIT NEW | Office Visit | 27,842 | \$76.53 | \$109.01 | -42.44% | \$52.50 | 31.40% | \$78.00 | -1.92% | \$80.86 | -5.66% |
| 99223 | INITIAL HOSPITAL CARE | Hospital Care | 27,551 | \$132.67 | | | \$140.97 | -6.26% | \$113.00 | 14.83% | \$161.88 | -22.02% |
| G0431 | DRUG SCREEN MULTIPLE CLASS | Lab Tests | 23,754 | \$76.58 | | | \$82.89 | -8.24% | \$82.89 | -8.24% | \$91.62 | -19.64% |
| 81003 | URINALYSIS AUTO W/O SCOPE | Lab Tests | 23,604 | \$2.83 | | | \$2.56 | 9.54% | \$2.40 | 15.19% | \$2.77 | 2.12% |

| PROC CD | PROC Description | Service Type | GA Claim Counts | Max Allowed by GA MEDICAID | Max Non-Facility Price Allowed by MEDICARE | Percent Difference btw GA and MEDICARE | Max Allowed by SC MEDICAID | Percent Difference btw GA and SC | Max Allowed by AL MEDICAID | Percent Difference btw GA and AL | Max Allowed by NC MEDICAID | Percent Difference btw GA and NC |
|---------|------------------------------|-----------------------|-----------------|----------------------------|--|--|----------------------------|----------------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|
| 85025 | COMPLETE CBC W/AUTO DIFF WBC | Lab Tests | 23,523 | \$9.77 | | | \$8.45 | 13.51% | \$7.93 | 18.83% | \$9.58 | 1.94% |
| 93000 | ELECTROCARDIOGRAM COMPLETE | Radiology/ Cardiology | 22,032 | \$25.09 | \$17.17 | 31.57% | \$15.41 | 38.58% | \$21.00 | 16.30% | \$16.34 | 34.87% |

Table 13. Top 20 Highest Utilized Behavioral Health Procedure Codes for Fee-for-Service Population, Calendar Year 2015

| PROC CD | PROC Description | Service Type | GA Claim Counts | Max Allowed by GA MEDICAID | Max Allowed by SC MEDICAID | Percent Difference btw GA and SC | Max Allowed by AL Medicaid | Percent Difference btw GA and AL | Max Allowed by NC MEDICAID | Percent Difference btw GA and NC |
|---------|------------------------------|---|-----------------|----------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|
| H2017 | PSYSOC REHAB SVC, PER 15 MIN | Psychotherapy | 241,725 | \$26.36 | \$13.02 | 50.61% | \$4.00 | 84.83% | \$2.69 | 89.80% |
| H0038 | SELF-HELP/PEER SVC PER 15MIN | Family and Patient Support / Peer Support | 187,108 | \$24.36 | \$5.98 | 75.45% | | | | |
| 90837 | PSYTX PT&/FAMILY 60 MINUTES | Psychotherapy | 123,835 | \$155.87 | \$163.29 | -4.76% | \$80.00 | 48.68% | \$96.44 | 38.13% |
| H0039 | ASSER COM TX FACE-FACE/15MIN | Family and Patient Support / Peer Support | 113,121 | \$32.46 | | | | | | |
| T1016 | CASE MANAGEMENT | Non-Physician Evaluation and Management | 91,317 | \$24.36 | \$20.00 | 17.90% | | | | |
| H2014 | SKILLS TRAIN AND DEV, 15 MIN | Family and Patient Support / Peer Support | 88,606 | \$24.36 | \$13.02 | 46.55% | | | | |
| H2015 | COMP COMM SUPP SVC, 15 MIN | Family and Patient Support / Peer Support | 85,575 | \$24.36 | | | | | \$14.50 | 40.48% |
| H0004 | ALCOHOL AND/OR DRUG SERVICES | Addiction/ Chemical Dependency Evaluation | 60,327 | \$10.39 | \$19.40 | -86.72% | \$25.00 | -140.62% | | |
| H0036 | COMM PSY FACE-FACE PER 15MIN | Psychotherapy | 41,810 | \$41.26 | | | \$14.00 | 66.07% | | |

| PROC CD | PROC Description | Service Type | GA Claim Counts | Max Allowed by GA MEDICAID | Max Allowed by SC MEDICAID | Percent Difference btw GA and SC | Max Allowed by AL Medicaid | Percent Difference btw GA and AL | Max Allowed by NC MEDICAID | Percent Difference btw GA and NC |
|---------|------------------------------|---|-----------------|----------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|
| 99213 | OFFICE/OUTPATIENT VISIT EST | Outpatient Evaluation and Management | 37,802 | \$74.09 | \$45.37 | 38.76% | \$42.00 | 43.31% | \$54.26 | 26.76% |
| H0031 | MH HEALTH ASSESS BY NON-MD | Non-Physician Evaluation and Management | 33,595 | \$38.97 | \$112.32 | -188.22% | | | \$19.60 | 49.70% |
| H0020 | ALCOHOL AND/OR DRUG SERVICES | Addiction/ Chemical Dependency Evaluation | 33,530 | \$33.40 | | | \$11.31 | 66.14% | \$16.60 | 50.30% |
| H0032 | MH SVC PLAN DEV BY NON-MD | Non-Physician Evaluation and Management | 32,920 | \$38.97 | \$11.73 | 69.90% | \$22.00 | 43.55% | \$81.25 | -108.49% |
| T1001 | NURSING ASSESSMENT/ EVALUATN | Non-Physician Evaluation and Management | 24,339 | \$38.97 | \$176.00 | -351.63% | | | | |
| T1003 | LPN/LVN SERVICES UP TO 15MIN | Non-Physician Evaluation and Management | 20,205 | \$24.36 | \$6.25 | 74.34% | | | | |
| 99214 | OFFICE/OUTPATIENT VISIT EST | Outpatient Evaluation and Management | 19,049 | \$123.48 | \$120.40 | 2.49% | \$67.00 | 45.74% | \$81.76 | 33.79% |
| 90834 | PSYTX PT&/FAMILY 45 MINUTES | Psychotherapy | 19,031 | \$140.28 | \$108.86 | 22.40% | \$60.00 | 57.23% | \$65.81 | 53.09% |
| T1002 | RN SERVICES UP TO 15 MINUTES | Non-Physician Evaluation and Management | 18,198 | \$46.76 | | | | | | |
| 90832 | PSYTX PT&/FAMILY 30 MINUTES | Psychotherapy | 17,099 | \$77.93 | \$54.43 | 30.16% | \$34.00 | 56.37% | \$50.67 | 34.98% |
| 96372 | THER/PROPH/DIAG INJ SC/IM | Non-Physician Evaluation and Management | 16,789 | \$42.51 | \$3.88 | 90.87% | \$12.00 | 71.77% | \$16.53 | 61.12% |

Table 14. Top 20 Highest Utilized Dental Procedure Codes for Fee-for-Service Population, Calendar Year 2015

| PROC CD | PROC Description | Child (<21) or Adult Service | Service Type | GA Claim Counts | Max Allowed by GA MEDICAID | Max Allowed by SC MEDICAID | Percent Difference btw GA and SC | Max Allowed by AL Medicaid | Percent Difference btw GA and AL | Max Allowed by NC MEDICAID | Percent Difference btw GA and NC |
|---------|------------------------------|------------------------------|---|-----------------|----------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|
| D1120 | DENTAL PROPHYLAXIS CHILD | Child | Prophylaxis | 33,048 | \$32.08 | \$28.11 | 12.38% | \$28.00 | 12.72% | \$25.87 | 19.36% |
| D1208 | TOPICAL APP FLUORID EX VRNSH | Child | Prophylaxis | 28,191 | \$17.59 | \$15.89 | 9.66% | \$15.00 | 14.72% | \$15.25 | 13.30% |
| D0120 | PERIODIC ORAL EVALUATION | Child | Problem-Focused Codes (Evaluation and Procedures) | 26,511 | \$22.77 | \$22.00 | 3.38% | \$18.00 | 20.95% | \$24.51 | -7.64% |
| D0150 | COMPREHENSVE ORAL EVALUATION | Child | Problem-Focused Codes (Evaluation and Procedures) | 22,686 | \$39.33 | \$38.48 | 2.16% | \$22.00 | 44.06% | \$42.41 | -7.83% |
| D0140 | LIMIT ORAL EVAL PROBLM FOCUS | Adult | Problem-Focused Codes (Evaluation and Procedures) | 20,966 | \$38.29 | \$36.04 | 5.88% | \$29.00 | 24.26% | \$34.94 | 8.75% |
| D0272 | DENTAL BITEWINGS TWO IMAGES | Child | Dental Radiology / Imaging | 20,169 | \$21.73 | \$18.94 | 12.84% | \$18.00 | 17.17% | \$17.59 | 19.05% |
| D0220 | INTRAORAL PERIAPICAL FIRST | Child | Dental Radiology / Imaging | 17,038 | \$13.45 | \$12.83 | 4.61% | \$11.00 | 18.22% | \$14.18 | -5.43% |

| PROC CD | PROC Description | Child (<21) or Adult Service | Service Type | GA Claim Counts | Max Allowed by GA MEDICAID | Max Allowed by SC MEDICAID | Percent Difference btw GA and SC | Max Allowed by AL Medicaid | Percent Difference btw GA and AL | Max Allowed by NC MEDICAID | Percent Difference btw GA and NC |
|---------|------------------------------|------------------------------|---|-----------------|----------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|
| D0220 | INTRAORAL PERIAPICAL FIRST | Adult | Dental Radiology / Imaging | 14,041 | \$13.45 | \$12.83 | 4.61% | \$11.00 | 18.22% | \$14.18 | -5.43% |
| D0230 | INTRAORAL PERIAPICAL EA ADD | Child | Problem-Focused Codes (Evaluation and Procedures) | 13,837 | \$10.35 | \$10.39 | -0.39% | \$10.00 | 3.38% | 11.44 | -10.53% |
| D0274 | BITEWINGS FOUR IMAGES | Child | Dental Radiology / Imaging | 12,721 | \$33.12 | \$27.51 | 16.94% | \$24.00 | 27.54% | \$30.50 | 7.91% |
| D0330 | PANORAMIC IMAGE | Adult | Dental Radiology / Imaging | 9,637 | \$56.92 | \$50.09 | 12.00% | \$49.00 | 13.91% | 56.32 | 1.05% |
| D7210 | REM IMP TOOTH W MUCOPER FLP | Adult | Problem-Focused Codes (Evaluation and Procedures) | 9,294 | \$128.34 | \$112.41 | 12.42% | \$99.00 | 22.86% | \$103.83 | 19.10% |
| D1110 | DENTAL PROPHYLAXIS ADULT | Adult | Prophylaxis | 8,224 | \$32.08 | \$40.93 | -27.59% | \$35.00 | -9.10% | \$36.21 | -12.87% |
| D0330 | PANORAMIC IMAGE | Child | Dental Radiology / Imaging | 8,190 | \$56.92 | \$50.09 | 12.00% | \$49.00 | 13.91% | \$56.32 | 1.05% |
| D0230 | INTRAORAL PERIAPICAL EA ADD | Adult | Problem-Focused Codes (Evaluation and Procedures) | 7,182 | \$10.35 | \$10.39 | -0.39% | \$10.00 | 3.38% | \$11.44 | -10.53% |
| D7140 | EXTRACTION ERUPTED TOOTH/EXR | Adult | Problem-Focused Codes (Evaluation and Procedures) | 7,178 | \$64.17 | \$69.03 | -7.57% | \$53.00 | 17.41% | \$60.40 | 5.88% |

| PROC CD | PROC Description | Child (<21) or Adult Service | Service Type | GA Claim Counts | Max Allowed by GA MEDICAID | Max Allowed by SC MEDICAID | Percent Difference btw GA and SC | Max Allowed by AL Medicaid | Percent Difference btw GA and AL | Max Allowed by NC MEDICAID | Percent Difference btw GA and NC |
|---------|------------------------------|------------------------------|---|-----------------|----------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|----------------------------|----------------------------------|
| D1351 | DENTAL SEALANT PER TOOTH | Child | Pediatric Services - Prophylaxis | 5,989 | \$27.94 | \$22.61 | 19.08% | \$26.00 | 6.94% | \$27.17 | 2.76% |
| D0140 | LIMIT ORAL EVAL PROBLM FOCUS | Child | Problem-Focused Codes (Evaluation and Procedures) | 5,795 | \$38.29 | \$36.04 | 5.88% | \$29.00 | 24.26% | \$34.94 | 8.75% |
| D2392 | POST 2 SRFC RESINBASED CMPST | Child | Problem-Focused Codes (Evaluation and Procedures) | 5,456 | \$95.22 | \$104.46 | -9.70% | \$77.00 | 19.13% | \$97.81 | -2.72% |
| D2391 | POST 1 SRFC RESINBASED CMPST | Child | Problem-Focused Codes (Evaluation and Procedures) | 4,314 | \$80.72 | \$80.03 | 0.85% | \$59.00 | 26.91% | \$73.72 | 8.67% |

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