HEALTHY INDIANA PLAN

Provider Payment Report

9/25/2017

The Provider Payment Report evaluates whether the differential in MCE provider payment rates between the HIP 2.0 program and the Hoosier Healthwise (HHW) program has resulted in unequal access to health care services, in accordance with Section IX.8.a of the HIP 2.0 Special Terms and Conditions (STCs).

Background

The enabling Healthy Indiana Plan (HIP) legislation requires that providers are reimbursed at Medicare rates to ensure access under the program. As part of the HIP 2.0 financing agreement, the Indiana hospitals agreed to support costs to increase provider reimbursement in the non-HIP fee for service (FFS) and Medicaid managed care programs, including Hoosier Healthwise (HHW). Historically, the State has reimbursed non-HIP Medicaid providers at approximately 60% of Medicare rates; under the new agreement, provider rates increased to 75%.[1, 2]

All FFS and Medicaid managed care providers must be certified under the Medicaid program by the Indiana Health Coverage Program (IHCP), so all HIP providers are also Medicaid\IHCP Providers.

Description of Report

In accordance with Section IX.8.a of the HIP 2.0 Special Terms and Conditions, the State shall submit an annual report by December 30th in DY 1 and September 30th of each subsequent DY that:

> "i. Evaluates whether the differential in MCO provider payment rates between the HIP 2.0 program and the Hoosier Healthwise (HHW) program has resulted in unequal access to health care services, either in the number of providers available to beneficiaries, the number of providers accepting new beneficiaries, or in the time required to access care. Beneficiary access shall be assessed for routine care and urgent care in the following provider groups: primary care providers, OB\GYNs, and the most commonly used adult specialty providers;
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> ii. Describes corrective actions implemented if evaluation shows access between programs is not equal; and
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> iii. Describes any incremental changes to the provider payment rates in either the HHW and/or HIP 2.0 programs the state will be making for the upcoming rating period."[3]

Data

Primary Medical Providers

The number of primary medical providers (PMPs) in HIP and HHW are presented in Table 1. The State enrolls Medicaid providers through IHCP, and the MCEs contract with these enrolled providers for the HIP program and HHW. During the reporting period, there were three MCEs (Anthem, MDwise, and MHS) serving HIP and HHW members, and the MCEs for the HIP program are the same MCEs for HHW. Providers may contract with one, two or all three MCEs for both HIP and HHW. Two of the MCEs require providers to enroll in both HIP and HHW; within the third MCE, the vast majority of providers are enrolled in both programs.

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[1] Milliman Client Report. Physician Fee Schedule Increase. Estimated Fiscal Impact of Updated Fee Schedule: 75% of Medicare Target. November 14, 2014.

[2] Exceptions include Maternity services, which are reimbursed at Medicare rates; and Behavioral Health services, which are reimbursed at 80% of Medicare rates.

[3] Healthy Indiana Plan 2.0 Special Terms and Conditions. Page 34 of 58.

Members select a PMP upon enrollment into HIP and HHW. If a member doesn't select a PMP at enrollment, then the member is assigned a PMP by his/her MCE.

As Table 1 illustrates, as of September 22, 2017, there were 4,650 PMPs in HIP, with 1,552 accepting new members, and there were 4,646 PMPs in HHW, with 1,551 accepting new members.

TABLE 1.[4] Number of Primary Medical Providers (PMPs) in HIP and Hoosier Healthwise (HHW).

Provider Description	HIP	HHW
Primary Medical Providers	4,650	4,646
Primary Medical Providers who are Accepting New Patients	1,552	1,551

Primary care physicians or advanced nurse practitioners (ANPs) can serve as a member's assigned PMP in HIP and HHW. Physicians can have a panel of up to 2,500 members assigned to them. ANPs can have a panel of up to 500 members. Nurse practitioners are reimbursed at 75% of Medicare rates in Indiana Medicaid.

Specialty Providers

Table 2 presents the ratio of the most commonly used adult specialty providers in HIP and HHW. As Table 2 demonstrates, as of September 22, 2017, there is a 1 to 1 ratio of oncologists, and psychiatrists in HIP compared to HHW; the ratio of OB/GYNs and neurologists in HIP compared to HHW is .91 to 1 and 1.5 to 1 respectively.

TABLE 2. Ratio of Specialty Providers in HIP and Hoosier Healthwise (HHW).

Provider Type	HIP	HHW
OB/GYNs	.91	1
Oncologists	1	1
Psychiatrists	1	1
Neurologists	1.5	1

Time to Access Care

Data reported through the ***Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey are analyzed t***o assess whether there is a difference in the HHW and HIP 2.0 programs for the *perceived time required to access care* for beneficiaries.[5] ***The CAHPS Health Plan Survey, funded and overseen by the*** Agency for Healthcare Research and Quality (AHRQ), asks patients to evaluate and report on their experiences with health plans and their services. The National Quality Forum (NQF)-

[4] PMP counts are lower compared to the previous Provider Payment Report, due to an updated methodology designed to account for providers who are contracted by multiple MCEs (i.e., duplicate providers).

[5] Agency for Healthcare Research and Quality. (2016). *Health Plan Survey*. Retrieved on September 14, 2017 from https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html

endorsed Health Plan Survey is considered the national standard for measuring and reporting on the experiences of consumers with their health plans.

Each of the state's managed care entities (MCEs) selected different National Committee for Quality Assurance (NCQA)-certified HEDIS® (Healthcare Effectiveness Data and Information Set) survey vendors to field the 2017 CAHPS Health Plan Adult Medicaid Survey 5.0H to both HHW and HIP 2.0 Members: MDwise selected SPH Analytics; Managed Health Services (MHS) selected Morpace Market Research & Consulting; and Anthem selected DSS Research. The Survey was administered from January through May of 2017. In September 2017, the MCEs provided the state with the reports on the CAHPS Health Plan Survey for the HHW and HIP 2.0 programs.[6] Each of the MCE's vendors prepared separate CAHPS reports for the HHW and HIP 2.0 programs. For this section, we focus on the *access to care* measures as described in these MCE-provided reports.

Four specific CAHPS survey questions assessing member perceptions related to timely access to care are examined (also known as attributes):

1. Got urgent care as soon as needed
2. Got routine appointment as soon as needed
3. Ease of getting care, tests, or treatment
4. Got specialist appointment as soon as needed

Following the NCQA's HEDIS 2017 CAHPS Health Plan Survey 5.0H specifications,[7] the first two are combined into the composite measure, *Getting Needed Care*. The latter two are combined into the composite measure, *Getting Care Quickly*.

Also in accordance with NCQA's CAHPS 5.0H Survey guidelines, the CAHPS reports provide *summary rates* for the attributes and the composite measures. The summary rate represents the percent of respondents who responded favorably; for example, for the specific question related to timely access to care, the summary rate will include the respondents that answered *always* and *usually* (the other possible responses to these specific questions are *sometimes* and *never*). The summary rate for each composite measure is presented in the CAHPS reports as the simple average of the individual summary rates of the composite measure's individual attributes.

The reports prepared for the MCEs also include comparison or benchmark averages:

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[6] The National Committee for Quality Assurance's (NCQA) HEDIS 2016 Volume 3: Specifications for Survey Measures includes surveys and protocols for the CAHPS Health Plan Survey 5.0H: http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2016. For details on survey methodology specific to the MCE and program, including data collection, questionnaire, and response rates, as well as profile of survey respondents, please see the following documents: (i) 2017 CAHPS® Medicaid Adult 5.0H Final Report MDwise Hoosier Healthwise; Project Number(s): 4122537; SPH Analytics; (ii) 2017 CAHPS® Medicaid Adult 5.0H Final Report MDwise Healthy Indiana Plan; Project Number(s): 4122538; SPH Analytics; (iii) 2017 CAHPS® Adult Medicaid Survey Summary Report Centene – IN (MHS) – HHW; Morpace; (iv) 2017 CAHPS® Adult Medicaid Survey Summary Report Centene – IN (MHS) – HIP; Morpace; (v) 2017 CAHPS® 5.0H Member Survey Adult Medicaid – HMO; Anthem BCBS Indiana Augment; DSS Research; (vi) 2017 CAHPS® 5.0H Member Survey Adult Medicaid – HMO; Healthy Indiana Plan; DSS Research.

[7] The National Committee for Quality Assurance's (NCQA) HEDIS 2017 Volume 3: Specifications for Survey Measures includes surveys and protocols for the CAHPS Health Plan Survey 5.0H: http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2017.

- MDwise's CAHPS report, prepared by SPH Analytics, used the *2017 SPH Analytics Book of Business* as a benchmark comparison, which contains data from 58 plan-specific Medicaid adult samples that contracted with SPH Analytics to administer the CAHPS 5.0H survey.
- Anthem's CAHPS report, prepared by DSS Research, benchmarked their measures to the *2017 DSS Adult Medicaid Book of Business*. This benchmark is made up of 69 adult Medicaid plans with a total of 26,909 respondents.
- MHS' CAHPS report, prepared by Morpace, benchmarked to the *2016 Adult Medicaid Quality Compass®*, which is made up of approximately 191 public and non-public reporting health plan products.[8]

The CAHPS reports for each program identify if the difference between a measure and its benchmark, or its corresponding 2016 measure, is statistically significant or not at the 95% confidence level. [9]

Access measures for the HHW and HIP 2.0 programs are presented separately by MCE in Tables 3, 4, and 5. Each table reports the summary rates for the individual questions and composite measures as noted specified above. The benchmark rates, as available from the CAHPS reports, as well as the number of total responses corresponding to each individual question are also included.

To provide insight into the potential impact of differential provider payment rates, statistical testing examined if the differences in the proportion of survey respondents perceiving access favorably between the HHW and HIP 2.0 programs were statistically significant. Results from the statistical testing between the access measures in HIP 2.0 or HHW and their corresponding benchmarks, as available in the CAHPS reports, are also noted.

Table 3 reports the CAHPS access measures for MDwise members.

Table 3: MDwise: Summary Rates for Key Access Measures in HHW and HIP 2.0 and Benchmark Comparisons[1]

Key Measures	**HHW**		**HIP 2.0**		**Benchmark Rate[3]**
	Summary Rate	Denominator[2]	Summary Rate	Denominator[2]	
Getting Needed Care (% Always or Usually)	83.1%		81.4%		81.3%
Ease of getting needed care, tests or treatment	87.9%	215	82.5%	257	83.6%
Got appointment with specialist as soon as needed	78.4%	74	80.3%	147	79.0%
Getting Care Quickly (% Always or Usually)	81.9%		79.6%		80.6%

[8] NCQA's Quality Compass® includes, among others products, comprehensive adult Medicaid CAHPS benchmark data based on all Medicaid adult samples that submits data to NCQA. The scheduled release date for the 2016 CAHPS Adult Medicaid component of Quality Compass® is September 2017; therefore, the vendor-supplied benchmarks are utilized for this report.

[9] MDwise and Anthem test for statistical significance against the benchmark; MHS reports if the difference between a 2017 measure and its corresponding 2016 measure is statistically significant or not at the 95% confidence level.

Got urgent care as soon as needed	86.7%	105	83.2%	137	83.0%
Got routine appointment as soon as needed	77.1%	188	76.1%	234	78.2%

Notes:

1. Statistical testing for difference in the summary rates/proportions in HIP 2.0 and HHW for each measure is performed at the 95% confidence level.
2. The denominators for the composite measures are not reported in the CAHPS reports.
3. Benchmark rates are from the *2017 SPH Analytics Book of Business*.

None of the differences between HIP 2.0 and HHW in the proportions of individuals responding favorably to the individual questions is statistically significant. The summary rates for the composite measure – the simple average of the corresponding individual summary rates – are not significantly different between the two programs.[10] Additionally, as noted in the CAHPS reports for MDwise, the summary rates for the individual attributes and composite measures for the two programs are not significantly different from the benchmark rates reported in the *2017 SPH Analytics Medicaid Adult Book of Business*.

Table 4 reports on the composite and individual access measures for the MHS plan members.

Table 4: Managed Health Services (MHS) – Summary Rates for Key Access Measures in HHW and HIP 2.0 and Benchmark Comparisons[1]

Key Measures	**HHW**		**HIP 2.0**		**Benchmark Rate[3]**
	Summary Rate	Denominator[2]	Summary Rate	Denominator[2]	
Getting Needed Care (% Always or Usually)	83.2%	163	83.9%	422	80.4%
Ease of getting needed care, tests or treatment	90.3%	154	86.7%	407	82.8%
Got appointment with specialist as soon as needed	76.2%	63	81.0%	221	78.5%
Getting Care Quickly (% Always or Usually)	80.2%	156	82.4%	397	80.1%
Got urgent care as soon as needed	79.7%	69	85.1%	202	83.1%
Got routine appointment as soon as needed	80.6%	134	79.6%	363	77.8%

Notes:

1. Statistical testing for difference in the summary rates/proportions in HIP 2.0 and HHW for each measure is performed at the 95% confidence level.
2. MHS CAHPS report presents the denominators for the composite measures.
3. Benchmark rates are Means from the *2016 Adult Medicaid Quality Compass®.*

The differences in the respective individual and composite access measures between MHS's HIP 2.0 and HHW programs are not statistically significant. Further, there is no significant difference between any of

[10] The statistical testing for the composite measure is conducted with a denominator that is the simple average of the denominators for the individual attributes (to correspond with the summary rate for the composite measure, which is reported as the simple average of the corresponding individual summary rates).

these 2017 summary rates in the two programs and the corresponding 2016 rates. The access measures for Anthem's HIP 2.0 and HHW members are presented in Table 5.

Table 5: Anthem – Summary Rates for Key Access Measures in HHW and HIP 2.0 and Benchmark Comparisons[1]

Key Measures	HHW		HIP 2.0		Benchmark Rate[3]
	Summary Rate	Denominator[2]	Summary Rate	Denominator[2]	
Getting Needed Care (% Always or Usually)	86.2%	160	84.9%	235	82.6%
Ease of getting needed care, tests or treatment	88.1%	218	87.1%	295	84.9%
Got appointment with specialist as soon as needed	84.3%	102	82.8%	174	80.3%
Getting Care Quickly (% Always or Usually)	84.7%	152	83.8%	217	82.3%
Got urgent care as soon as needed	90.0%	100	87.7%	171	84.7%
Got routine appointment as soon as needed	79.3%	203	79.9%	263	79.8%

Notes:

1. Statistical testing for difference in the summary rates/proportions in HIP 2.0 and HHW for each measure is performed at the 95% confidence level.
2. Anthem's CAHPS reports present the denominators for the composite measures.
3. Benchmark rates are from the *2017 DSS Adult Medicaid Book of Business*.

The differences in the respective individual and composite access measures between the Anthem's HIP 2.0 and HHW programs are not statistically significant. Moreover, none of the access to care measures in the two programs is significantly different from the corresponding benchmark rate from the *2017 DSS Adult Medicaid Book of Business*.

Overall, access to care does not differ statistically significantly between the HIP 2.0 and HHW programs. Further, the data available from the CAHPS Health Plan Survey for all three MCEs indicate similar access to care between the HIP 2.0 members and the benchmark as well as between the HHW members and the benchmark.

Conclusion

The available data indicate that the differential in provider payment rates between the HIP program and the HHW program has not resulted in unequal access to health care services. As Table 1 demonstrates, the number of primary medical providers in HIP and HHW (4,650 and 4,646, respectively) are nearly identical, and the ratio of the most commonly used adult specialty care providers in HIP and HHW are comparable.

In addition, the evaluation of CAHPS data for HIP and HHW found no statistically significant differences in access between the programs, while concluding that access to care for both HIP and HHW members are similar to the Medicaid benchmarks.

As the data does not indicate unequal access to care, the State does not propose any corrective actions at this time. In addition, the State does not propose any incremental changes to the provider payment rates in either the HIP program or HHW at this time.