ACCESS TO CARE MONITORING REVIEW PLAN 2016

GUAM MEDICAID

August 2016

Overview

Guam Medicaid program provides healthcare coverage for low-income individuals, including children, pregnant women, individuals with disabilities, elderly, parents and other adults. The Guam Department of Public Health and Social Services (DPHSS) is the single state agency that administers the Medicaid program.

Guam is a United States Territory, with a total population of approximately 169,885. It is highly unique in terms of geographic location, size, and population. The island has three (3) acute hospitals, and two (2) Federally Qualified Health Centers (FQHC). In addition, Guam has numerous options for Medicaid beneficiaries to receive healthcare.

Guam measures and monitors indicators of healthcare access to ensure that its Medicaid beneficiaries have access to care that is comparable to the general population.

Guam Medicaid program operates 5 days a week, Monday to Friday from 8:00am – 5:00pm. Beneficiaries may call, or visit our offices for assistance with their needs or requests. Should the beneficiary be confined to a hospital, our Social Worker coordinates the required services. The issues are resolved immediately utilizing a hierarchical process.

In accordance with 42 CFR 447.203, Guam developed an access review monitoring plan for the following services categories provided under a fee-for- service (FFS) arrangement.

- Primary care services
- Physician specialist services
- Behavioral health services
- Pre- and post-natal obstetric services, including labor and delivery
- Home health services

The plan describes data that will be used to measure access to care for beneficiaries in FFS. The plan considers: the availability of Medicaid providers, utilization of Medicaid services and the extent to which Medicaid beneficiaries' healthcare needs are fully met. It was developed during the months of July – August 2016 and posted on the DPHSS website from September 1, 2016 – September 30, 2016 to allow for public inspection and feedback.
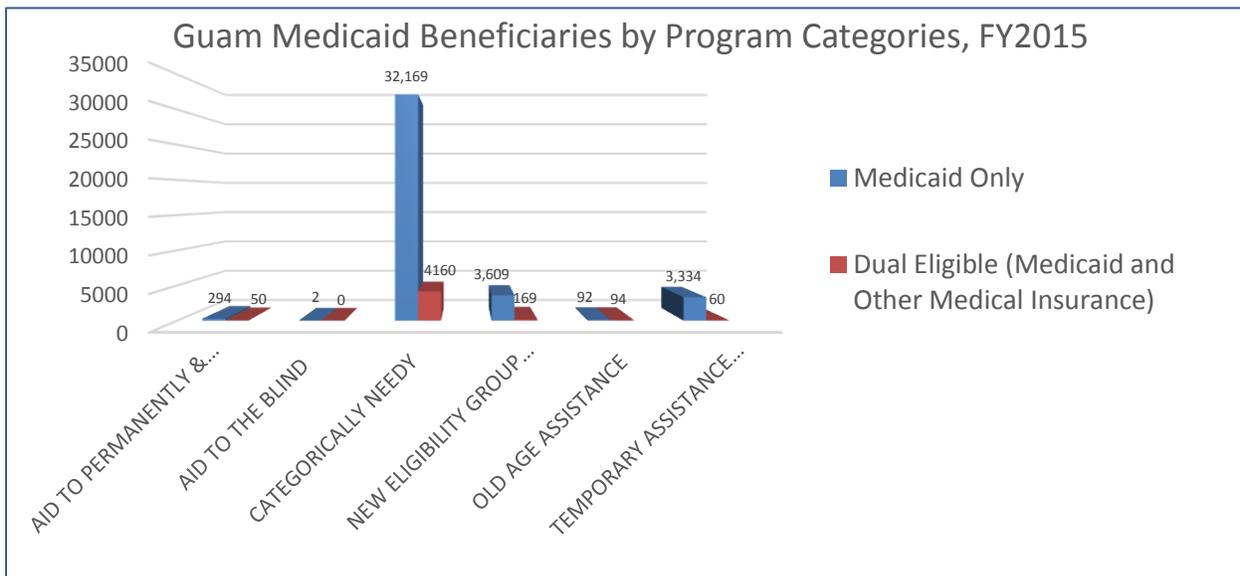
Although Guam has insufficient number of specialists to provide needed services to beneficiaries, the Guam Medicaid Program makes every effort to arrange for off-island care to ensure adequate access to quality care. Beneficiaries may avail of needed services in either the US Mainland, or in the Philippines, as authorized by the Centers for Medicaid and Medicare Services (CMS).

Analysis of the data and information contained in this report show that Guam Medicaid beneficiaries have access to healthcare that is similar to that of the general population in Guam.
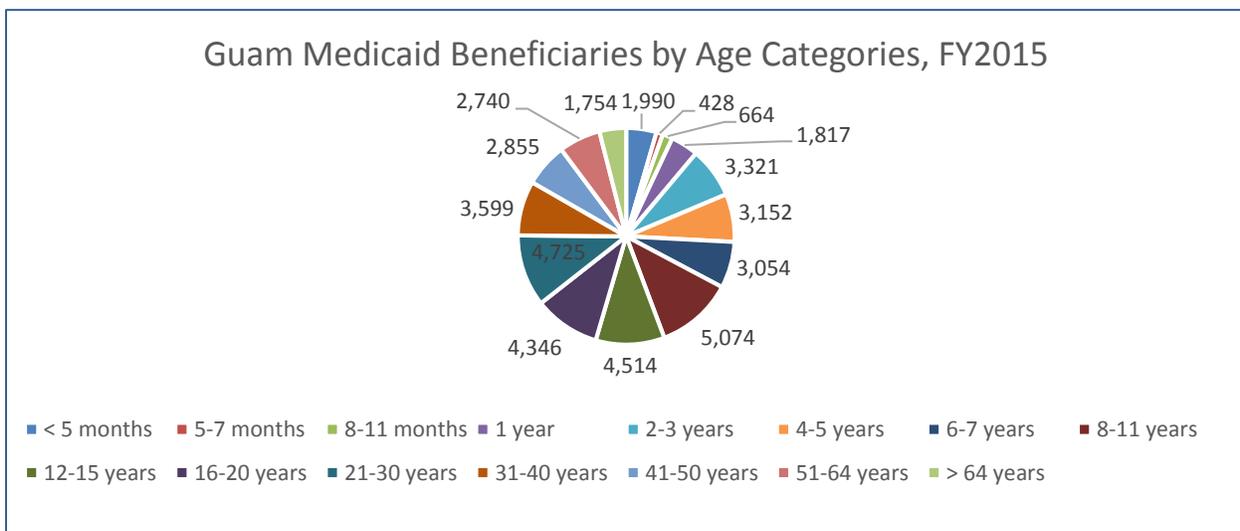
Beneficiary Population

The Guam Medicaid program has six eligibility categories: Aid to the Permanently & Totally Disabled, Aid to the Blind, Categorically Needy, New Eligibility Group, Old Age Assistance, Temporary Assistance to the Needy Families and the Medicaid Childless Adults.

In 2015, the Guam Medicaid program provided coverage to approximately over 44,000 enrolled beneficiaries with total expenditures of over $80 million. Approximately 26% of the territory's population were enrolled in the Guam Medicaid program.

Guam Medicaid Beneficiaries by Program Categories, FY2015

Category	Medicaid Only	Dual Eligible (Medicaid and Other Medical Insurance)
AID TO PERMANENTLY &...	294	50
AID TO THE BLIND	2	0
CATEGORICALLY NEEDY	32,169	4160
NEW ELIGIBILITY GROUP...	3,609	169
OLD AGE ASSISTANCE	92	94
TEMPORARY ASSISTANCE...	3,334	60

Source: Guam Medicaid FY2015 Annual Report

Guam Medicaid Beneficiaries by Age Categories, FY2015

Age Category	Beneficiaries
< 5 months	1,990
5-7 months	428
8-11 months	664
1 year	1,817
2-3 years	3,321
4-5 years	3,152
6-7 years	3,054
8-11 years	5,074
12-15 years	4,514
16-20 years	4,346
21-30 years	4,725
31-40 years	3,599
41-50 years	2,855
51-64 years	2,740
> 64 years	1,754

Source: Guam Medicaid FY2015 Annual Report

Access concerns raised by beneficiaries

The Division of Public Welfare (DPW) operates a KEHA Hotline (KEHA means to "tell" in the native language called Chamorro) for beneficiaries to report fraud, abuse, and relay complaints. The hotline number is 735-7353 and operates Monday to Friday from 8:00am – 5:00pm. The division also provides for a Fair Hearing Process to assist with clients and providers appeals.

A survey/comment box is provided within the Guam Medicaid program office, to allow for beneficiaries and providers to submit complaints or concerns, however we have noticed that there is a preference to call in, email, or visit. Every attempt is made to resolve these issues immediately. Should a resolution not be met, or should beneficiaries/providers not be satisfied with the initial findings, the Guam Medicaid office utilizes a hierarchical process to rectify the problem. In addition, the office receives letters of complaint or requests for information, which are answered within 10 to 30 days, and filed accordingly.

Based on KEHA hotline calls, Fair Hearing Processes, and comment box retrievals, there is very minimum complaints/issues.

As part of the monitoring plan, Guam intends to have one call center that will be dedicated only for Medicaid beneficiaries and providers to report access concerns and complaints. Calls into the call center will be logged detailing the issues raised and the resolution. It will be operated daily from Monday to Friday, 8:00 am – 5:00 pm. During weekends and holidays, a voice mail will be available to take messages. On a weekly basis, a report will be produced detailing the number of calls, the issues raised and the resolution of the issue, including the timeliness. The majority of calls in which the beneficiary requests assistance with locating a provider will be resolved immediately by call center staff. These calls are tracked and repeat callers seeking assistance in locating the same type of provider will be flagged as this might indicate a potential access issue.

Additionally, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) used by Centers for Medicare and Medicaid Services will be adapted to develop the new Guam Patient Experience of Care Survey (GPECS). It will be conducted every 3 years. The data will be collected on a monthly basis and aggregated for one full year. The survey will have standardized questions on how patients experienced or perceived key aspects of their care such as the communication skills of providers and ease of access to health care services. It is not a customer satisfaction survey on how satisfied the patient is with their care. Beneficiaries who avail of the services from the Prior Authorization office and Certification Section will be given a survey to fill out.

Guam also plans to develop a web-based mechanism for beneficiaries to report access concerns (to be called "Guam Medicaid Access to Care"). Guam will develop a tracking system to categorize and monitor complaints that are submitted through the online portal, as well as to track the resolution of reported issues as needed. Guam will summarize the complaints for the public and post information on the DPHSS website to improve the ease of finding participating providers. In addition, a Frequently-Asked Questions (FAQ) will be developed that addresses

common complaints or questions that were received through the online portal and clarify misconceptions about covered benefits.

Moreover, DPHSS Bureau of Economic Security under DPW is currently seeking a Request for Information to develop a Service Call Center (SCC) to answer program and case specific inquiries, make minor changes, provide certification, reschedule appointments, provide Fair Hearing information and accepts report of potential program violators and abusers. Also, the SCC will provide Medicaid beneficiaries with location and contact numbers of authorized providers.

Beneficiary perceptions of access to care

Guam will summarize and report the complaints and concerns submitted through the call center and the online portal. The report will be available on the Guam Medicaid Access to Care website that will be developed.

The data results from the GPECS will be aggregated and analyzed in order to determine the extent to which beneficiary needs are met. Since the data is retrospective, it may not demonstrate current access, but it is an indicator for whether or not beneficiaries are able to access medical services when they are needed.

Medicaid payment rates

Guam Medicaid's FFS reimbursement rates are sufficient to assure access for all service areas at least to the extent that they are available to the general population. The availability of care, as well as providers, and the utilization of Medicaid services are comparable to the Medicare Fee Schedule, versus those rates paid by other payers in the market. The fee schedules are updated regularly based on the Medicare Fee Schedule updates.

Review Analysis of Primary Care Services

Data sources

- DPHSS Medicaid Claims Data
- DPHSS Medicaid Enrollment Data
- Results of Patient Experience of Care Survey (GPECS) (access-related questions)
- Summary results of complaints through call center and online portal

Availability of primary care providers

Current availability of Primary Care Providers (PCPs) will be assessed using the measures presented in Table 1. To be included in these measures, PCPs must have provided a service to a FFS-enrolled beneficiary in the given year or quarter. These measures will be stratified by PCP type. The PCP types include primary care physicians (family practice, general practice, and pediatricians), nurse practitioners (NPs), dental providers and Federally Qualified Health Centers (FQHC).

Table 1. Availability of Primary Care Provider Measures

Title	Description	Numerator	Denominator	Exclusions	Source
Availability of Primary Care Providers	Number of PCPs with at least one FFS Medicaid claim per 100 enrollees	Number of family medicine, general practice, and pediatrics with at least one FFS Medicaid claim	Number of hundreds of FFS Medicaid enrollees		DPHSS Medicaid Claims data
Availability of Nurse Practitioners	Number of NPs with at least one FFS Medicaid claim per 100 enrollees	Number of NPs with at least one FFS Medicaid claim	Number of hundreds of FFS Medicaid enrollees		DPHSS Medicaid Claims data
Availability of Dental Providers	Number of dentists with at least one FFS Medicaid claim per 100 enrollees	Number of dentists with at least one FFS Medicaid claim	Number of hundreds of FFS Medicaid enrollees		DPHSS Medicaid Claims data
Availability of FQHCs	Number of FQHCs with at least one FFS Medicaid claim per 100 enrollees	Number of FQHCs with at least one FFS Medicaid claim	Number of hundreds of FFS Medicaid enrollees		DPHSS Medicaid Claims data

Utilization Measures

DPHSS will monitor seven (7) utilization measures that indicate access to primary care services. These measures range from straightforward primary care provider utilization to indicators of poor access, such as acute care admissions for asthma. The title, description, numerator and denominator definitions, exclusions, and any relevant citations are presented for each measure in Table 2. Each utilization measure will be calculated for FFS beneficiaries only. DPHSS will present both the current utilization for each measure for the most recent year, as well as the quarterly or annual trend over the previous four (4) years (depending on the measure's specifications), including standard deviation and average over the four-year-period.

Table 2. Utilization Measures to Monitor Access to Primary Care Services

Title	Description	Numerator	Denominator	Exclusions	Source
Child primary care utilization	Number of PCP visits provided to FFS enrolled children per child-month	Number of unique visits to a PCP among FFS enrolled children age 17 and younger during the measurement period	Total number of months of FFS Medicaid enrollment for enrollees age 17 and younger during the measurement period		DPHSS Medicaid Claims data
Adult primary care utilization*	Percentage of continuously enrolled adults age 18 years and older who had a visit with a PCP	Number of continuously enrolled FFS adults with one or more visits with a PCP during the measurement year	Continuously enrolled adults age 18 years and older		DPHSS Medicaid Claims data
Percent of adults who received preventive dental services	Percentage of individuals ages 21 and older who are continuously enrolled in Medicaid for at least 90 continuous days, and who received at least one preventive dental service during the reporting period	The unduplicated number of individuals receiving at least one preventive dental service by or under the supervision of a dentist is defined by HCPCS codes D1000 – D1999, based on an unduplicated paid, unpaid, or denied claim.	The total unduplicated number of individuals ages 21 and older who have been continuously enrolled in Medicaid programs for at least 90 continuous days	Beneficiaries enrolled in limited eligibility (e.g., pregnancy related service)	DPHSS Medicaid Claims data
Percent of FQHC patients in Medicaid	Percent of patients served by FQHCs who	Patients served by FQHC enrolled in Medicaid	Total patients served by FQHC (e.g. 43.2%		DPHSS Medicaid Claims data

	are enrolled in Medicaid		average across all sites in 2014)		
Asthma in younger adults admission rate	Number of inpatient hospital admissions for asthma per 100 enrollee months for Medicaid enrollees ages 18 to 39	All non-maternal inpatient hospital admissions for FFS enrollees ages 18 to 39 with an ICD-9-CM principal diagnosis code of asthma	Total number of months of FFS Medicaid enrollment for enrollees ages 18 to 39 during the measurement period	Transfers from another health care facility, admissions with missing gender, obstetric admissions, and ICD-9-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system	DPHSS Medicaid Claims data
Diabetes short term complications admission rate	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100 enrollee months for Medicaid enrollees age 18 and older	FFS inpatient hospital admissions with ICD-9-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, or coma)	Total number of months of FFS Medicaid enrollment for enrollees age 18 and older during the measurement period	Transfers from another health care facility, admissions with missing gender, obstetric admissions	DPHSS Medicaid Claims data
COPD or asthma in older adults admission rate	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100 enrollee months for Medicaid enrollees age 18 and older	FFS non-maternal inpatient hospital admissions with an ICD-9-CM principal diagnosis code for: • COPD or • Asthma or • Acute bronchitis and any secondary ICD-9-CM diagnosis codes for COPD	Total number of months of FFS Medicaid enrollment for enrollees age 40 and older during the measurement period	Transfers from another health care facility, admissions with missing gender, obstetric admissions, and ICD-9-CM diagnosis codes for cystic	DPHSS Medicaid Claims data

	fibrosis and anomalies of the respiratory system

* =Annual trend only.

Monitoring and Recommendations

DPHSS will continually measure trends in all primary care service availability and utilization measures. DPHSS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DPHSS will implement changes to improve access and monitor select measures accordingly.

Review Analysis of Physician Specialists

Data sources

- DPHSS Medicaid Claims Data
- DPHSS Medicaid Enrollment Data
- Results of Patient Experience of Care Survey (GPECS) (access-related questions)
- Summary results of complaints through call center and online portal

Availability of Physician Specialists

Current availability of specialists will be assessed using the measure presented in Table 3. This measure will be calculated for each specialty groups defined by DPHSS. These measures will be stratified by physician specialist type. To be included in these measures, specialist must have provided a service to a FFS-enrolled beneficiary in the given year or quarter. In addition, trends of these measures will be presented by annual quarter over the most recent four years, along with the standard deviation and average over the entire four year period.

Table 3. Availability of Physician Specialists

Title	Description	Numerator	Denominator	Exclusions	Source
Availability of [specialist grouping]	Number of [specialists] with at least one FFS Medicaid claim per 100 enrollees	Number of [specialists] with at least one FFS Medicaid claim	Number of thousands of FFS Medicaid enrollees		DPHSS Medicaid Claims data

Utilization Measures

DPHSS will monitor one (1) utilization measure for each of the specialty groups defined by DPHSS. The title, description, numerator, and denominator definitions, exclusions, and any relevant citations are presented for this measure in Table 4. This measure will be calculated for FFS beneficiaries only. DPHSS will present both the current utilization for this measure for the most recent year, as well as the quarterly trend, including standard deviation and average over the four year period.

Table 4. Utilization Measures to Monitor Access to Physician Specialist Services

Title	Description	Numerator	Denominator	Exclusions	Source
[Specialist grouping] Services	Number of [specialist grouping] services per 1,000 member months	Number of unique FFS[specialist grouping] claims	Total number of months of FFS Medicaid enrollment for all enrollees during the measurement period		DPHSS Medicaid Claims data

Data Relevant to Beneficiary Specialty Care Needs Being Met

The extent to which beneficiary specialty care needs are being met will be measured using the Guam PECS Survey. Any PECS survey questions that specifically target access to specialty care will be reported and analyzed in this plan (e.g., In the last six months, how often did you get an appointment to see a specialist as soon as you needed?).

Monitoring and Recommendations

DPHSS will continually measure trends in all specialty care service availability and utilization measures. DPHSS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DPHSS will implement changes to improve access and monitor select measures accordingly.

Review Analysis of Behavioral Health Services

Data sources

- DPHSS Medicaid Claims Data
- DPHSS Medicaid Enrollment Data
- Results of Patient Experience of Care Survey (GPECS) (access-related questions)
- Summary results of complaints through call center and online portal

Availability of Behavioral Health Provider Measures

Current availability of behavioral health services will be assessed using the measure presented in Table 5. To be included in these measures, behavioral health providers must have provided a service to FFS-enrolled beneficiary in the given year or quarter. These measures will be stratified by provider type. The provider types include psychiatrists and psychologists. In addition, trends of these measures will be presented by annual quarter over the most recent four years, along with the standard deviation and average over the entire four year period.

Table 5. Availability of Behavioral Health Provider Measures

Title	Description	Numerator	Denominator	Exclusions	Source
Availability of Psychologists	Number of behavioral health providers with at least one FFS Medicaid claim per 100 enrollees	Number of psychologists with at least one FFS Medicaid claim	Number of hundreds of FFS Medicaid enrollees		DPHSS Medicaid Claims data
Availability of Psychiatrists	Number of psychiatrists with at least one FFS Medicaid claim per 100 enrollees	Number of psychiatrists with at least one FFS Medicaid claim	Number of hundreds of FFS Medicaid enrollees		DPHSS Medicaid Claims data
Availability of Mental Health Outpatient Clinics	Number of outpatient clinics for mental health with at least one FFS Medicaid claim per 100 enrollees	Number of outpatient clinics for mental health with at least one FFS Medicaid claim	Number of hundreds of FFS Medicaid enrollees		DPHSS Medicaid Claims data
Availability of Department of Drug and Alcohol	Number of DDAP clinics with at least one FFS	Number of DDAP clinics with at least one FFS Medicaid claim	Number of hundreds of FFS Medicaid enrollees		DPHSS Medicaid Claims data

Program Clinics	Medicaid claim per 100 enrollees				

Utilization Measures

DPHSS will monitor six (6) utilization measures that indicate access to behavioral health services. The title, description, numerator and denominator definitions, exclusions, and any relevant citations are presented for each measure in Table 6. Each utilization measure will be stratified by type of service and calculated for FFS beneficiaries only. DPHSS will present both the current utilization for this measure for the most recent year, as well as the quarterly or annual trend over the previous four years (depending on the measure's specifications), including standard deviation and average over the four-year period.

Table 6. Utilization Measures to Monitor Access to Behavioral Health Services

Title	Description	Numerator	Denominator	Exclusions	Source
Individual psychotherapy with any psychiatrist in an office setting	Number of enrollees per 100 member months who received psychotherapy from a psychiatrist	FFS enrollees who have at least one visit coded as psychotherapy in an office setting by a psychiatrist	Total number of months of FFS Medicaid enrollment during the measurement period		DPHSS Medicaid Claims data
Individual psychotherapy with any psychologist in an office setting	Number of enrollees per 100 member months who received psychotherapy from a psychologist	FFS enrollees who have at least one visit coded as psychotherapy in an office setting by a psychologist	Total number of months of FFS Medicaid enrollment during the measurement period		DPHSS Medicaid Claims data
Individual psychotherapy in a clinic setting	Number of enrollees per 100 member months who received psychotherapy from an outpatient mental health clinic	FFS enrollees who have at least one visit coded as psychotherapy in an outpatient mental health clinic setting	Total number of months of FFS Medicaid enrollment during the measurement period		DPHSS Medicaid Claims data
New psychiatric visit*	Percent of continuously enrolled adults who have a new service with a psychiatrist	Continuously enrolled FFS adults ages 18+ who received a service from a psychiatrist	Continuously enrolled adults 18+ enrolled in FFS Medicaid	Patients with a previous visit with a psychiatrist in the last	DPHSS Medicaid Claims data

					measurement year
Ongoing psychiatric care*	Percent of continuously enrolled adults with a visit as an established patient with a psychiatrist	Continuously enrolled FFS adults ages 18+ who have 3 or more services coded as "established patient" with a psychiatrist in a measurement year	Continuously enrolled adults 18+ enrolled in FFS Medicaid		DPHSS Medicaid Claims data
Initiation of Alcohol and Other Drug Dependence Treatment*	Initiation of Alcohol and Other Drug Dependence Treatment for adults	Continuously enrolled FFS adults ages 18+ initiating alcohol or drug dependence treatment	Continuously enrolled adults 18+ enrolled in FFS Medicaid	Existing diagnosis of alcohol or drug dependence	DPHSS Medicaid Claims data

*=Annual trend only

Data Relevant to Beneficiary Specialty Care Needs Being Met

The extent to which beneficiary behavioral health care needs are being met will be measured using the Guam PECS Survey. Any PECS survey questions that specifically target access to behavioral health care will be reported and analyzed in this plan (e.g., In the last six months, how often was it easy to get the medial health or behavioral health services you needed?).

Monitoring and Recommendations

DPHSS will continually measure trends in all behavioral health care service availability and utilization measures. DPHSS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DPHSS will implement changes to improve access and monitor select measures accordingly.

Review Analysis of Pre- and Post-Natal Obstetric Services

Data sources

- DPHSS Medicaid Claims Data
- DPHSS Medicaid Enrollment Data
- Results of Patient Experience of Care Survey (GPECS) (access-related questions)
- Summary results of complaints through call center and online portal

Availability of Obstetric Services

Current availability of obstetric services will be assessed using the measure presented in Table 7. To be included in this measure, obstetricians must have provided a service to FFS-enrolled beneficiary in the given year or quarter. This measure will be stratified type of service. In addition, trends of these measures will be presented by annual quarter over the most recent four years, along with the standard deviation and average over the entire four year period.

Table 7. Availability of Obstetric Services Measures

Title	Description	Numerator	Denominator	Exclusions	Source
Availability of Obstetric Care	Number of obstetricians with at least one FFS Medicaid claim per 100 enrollees	Number of obstetricians with at least one FFS Medicaid claim	Number of hundreds of female FFS Medicaid enrollees age 15 to 44		DPHSS Medicaid Claims data

Utilization Measures

DPHSS will monitor two (2) utilization measures that indicate access to obstetric services. The title, description, numerator and denominator definitions, exclusions, and any relevant citations are presented for each measure in Table 8. Each utilization measure will be stratified by type of service and calculated for FFS beneficiaries only. DPHSS will present both the current utilization for each measure for the most recent year, as well as the annual trend over the previous four years, including standard deviation and average over the four-year period.

Table 8. Utilization Measures to Monitor Access to Obstetric Services

Title	Description	Numerator	Denominator	Exclusions	Source
Pre-natal visit*	Any visit to an OB/GYN, family practitioner or other PCP with either an	Any FFS-enrolled woman with a visit to an OB/GYN, family practitioner or other PCP with	FFS women with live births in the given year	Women who are not enrolled in FFS 43 days prior to	DPHSS Medicaid Claims data NCQA??

| ultrasound or a principal diagnosis of pregnancy 176-280 days prior to delivery | either an ultrasound or a principal diagnosis of pregnancy 176-280 days prior to delivery | | delivery through 56 days after delivery |

Monitoring and Recommendations

DPHSS will continually measure trends in all obstetric service availability and utilization measures. DPHSS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DPHSS will implement changes to improve access and monitor select measures accordingly.

Review Analysis of Home Health Services

Data sources

- DPHSS Medicaid Claims Data
- DPHSS Medicaid Enrollment Data
- Results of Patient Experience of Care Survey (GPECS) (access-related questions)
- Summary results of complaints through call center and online portal

Availability of Home Health Services

Home health services in Guam Medicaid include the following services: nursing services, supplies and equipment suitable for home use, and hospice care.

Current availability of home health services will be assessed using the measure presented in Table 9. To be included in these measures, home health providers must have provided a service to a FFS-enrolled beneficiary in the given year or quarter. These measures will be stratified by type of service. In addition, trends of these measures will be presented by annual quarter over the most recent four years, along with the standard deviation and average over the entire four year period.

Table 9. Availability of Home Health Measures

Title	Description	Numerator	Denominator	Exclusions	Source
Availability of Home Health Agencies	Number of Home Health Agencies with at least one FFS claim per 100 enrollees	Number of Home Health Agencies with at least one FFS claim Medicaid	Number of hundreds of FFS Medicaid enrollees	Services delivered under 1915(C) waivers	DPHSS Medicaid Claims data

Utilization Measures

DPHSS will monitor one (1) utilization measures that indicate access to obstetric services. This measure broadly includes the utilization of nursing, supplies and equipment, and hospice care. The title, description, numerator and denominator definitions, exclusions, and any relevant citations are presented for each measure in Table 9. Each utilization measure will be stratified by type of service and calculated for FFS beneficiaries only. DPHSS will present both the current utilization for each measure for the most recent year, as well as the quarterly trend over the previous four years, including standard deviation and average over the four-year period.

Table 9. Utilization Measures to Monitor Access to Home Health Services

Title	Description	Numerator	Denominator	Exclusions	Source

Home Health Services	Number of home health services per 20 FFS member months	Number of unique FFS home health claims	Total number of months of FFS Medicaid enrollment for enrollees during the measurement period	Services delivered under 1915(C) waivers	DPHSS Medicaid Claims data

Monitoring and Recommendations

DPHSS will continually measure trends in all home health care service availability and utilization measures. DPHSS will conduct an investigation in the event of a significant negative trend in any of these measures of access that cannot be explained by systematic changes in the eligible FFS population. Based on the findings of this investigation, DPHSS will implement changes to improve access and monitor select measures accordingly.