NATIONAL HEALTH LAW PROGRAM

# Network Adequacy in Medicaid Managed Care: Recommendations for Advocates

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## Introduction

Approximately three quarters of Medicaid beneficiaries receive services through some type of managed care arrangement.[1] Medicaid managed care entities can deliver care through managed care organizations (MCOs), primary care case managers (PCCMs) or Prepaid Health Plans (PHPs).[2] Most Medicaid beneficiaries who are enrolled in managed care receive their services through MCOs or PHPs. These plans are capitated, meaning that they receive a set payment per Medicaid enrollee in exchange for providing services.[3] Moreover, MCOs contract with the state on a "comprehensive risk" basis, such that the plan incurs a loss if it spends more on services than it receives through the capitated payments, but make a profit if providing services costs less than the payments.[4] These arrangements give plans a clear incentive to limit coverage of services for their enrollees in order to maximize profits.

In the last several years, an increasing number of states have required Medicaid beneficiaries to enroll in managed care.[5] Medicaid managed care has expanded to

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[1] CENTERS FOR MEDICARE & MEDICAID SERVS., MEDICAID MANAGED CARE ENROLLMENT REPORT: SUMMARY STATISTICS AS OF JULY 1 2011 at 1 (2013),*available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

[2] 42 U.S.C. §§ 1396u-2(a)(1)(B), 1396b(m)(1)(A) (regarding managed care organizations, 1396d(a)(25), 1396d(t) (regarding primary care case managers). For more on how these arrangements work, see NATIONAL HEALTH LAW PROGRAM ("NHELP"), THE ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM (May 2011, revised Sept. 2011), available at www.healthlaw.org; Sarah Somers, *Medicaid Managed Care*, 5 HEALTH ADVOCATE 1 (Sept. 2012), available at www.healthlaw.org/images/stories/2012_09_Vol_5_Health_Advocate.pdf.

[3] KAISER COMM'N ON MEDICAID AND THE UNINSURED, A PROFILE OF MEDICAID MANAGED CARE PROGRAMS IN 2012: FINDINGS FROM A 50-STATE SURVEY 30 (Sept. 2011), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8220.pdf.

[4] *See* 42 C.F.R. § 438.2 (defining "comprehensive risk contract" and "capitation payment").

[5] *See* CENTERS FOR MEDICARE & MEDICAID SERVS., *supra* note 1 at 1 (Medicaid managed care enrollment increased from 58% to 74% between 2002 and 2011); *see also, e.g.,* Leo Cuello, *Section 1115 Waivers: More Than Meets the Eye,* 7 HEALTH ADVOCATE 1, 2-3 (2012) (discussing the expansion of Medicaid managed care to new populations), *available at* http://healthlaw.org/images/stories/2012_11_Vol_7_Health_Advocate.pdf.

include hundreds of thousands of Medicaid beneficiaries with disabilities and thousands of beneficiaries enrolled in Medicare and Medicaid (dual eligibles).[6] These new managed care enrollees' need for medical services—particularly specialty services—is likely to be high. Moreover, in many cases, states are including long-term services and supports in capitated managed care contracts for the first time.[7] And in 2014, at least 28 states are expected expand Medicaid to cover most low-income adults, primarily using managed care plans to deliver services to the new enrollees.[8] These new enrollees are estimated to have a significant incidence of chronic conditions and diseases, meaning that they will be expensive to serve.[9] This provides a further incentive to capitated plans to deny coverage of services. Thus, strong legal protections are needed to ensure that enrollees have access to high quality, medically necessary services.

Some of the most important federal requirements are those requiring that MCOs and PHPs ("Medicaid managed care plans") have adequate provider networks.[10] While existing federal law sets a floor of network adequacy standards, additional rules at the state level may be needed to help provide enrollees with real access to care. This issue brief will describe the federal laws that govern network adequacy for Medicaid managed care plans; recommend additional protections that state advocates should seek, with examples from various states; and suggest ways in which state advocates can work with their state policymakers, regulators, and Medicaid agencies to enforce network adequacy protections.

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[6] *See, e.g.,* KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 3 at 5-6; David Machledt, *Major Changes for Individuals Who Are Dually Eligible*, 6 HEALTH ADVOCATE 1 (2012), *available at* http://healthlaw.org/images/stories/2012_10_Vol_6_Health_Advocate.pdf.

[7] *See* Sarah Somers, *Beyond the HMO: Managing Care through Integrated Care Models in Medicaid,* 10 HEALTH ADVOCATE 1 (2013), *available at* http://healthlaw.org/images/stories/2013_02_Vol_10_Health_Advocate.pdf.

[8] *See, e.g.,* Advisory Board Co., Beyond the pledges: Where the states stand on Medicaid, Jul. 28 2013, http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap#lightbox/2/.

[9] *See, e.g.,* Sandra Decker *et al., Health Status, Risk Factors, and Medical Conditions Among Persons Enrolled in Medicaid vs Uninsured Low-Income Adults Potentially Eligible for Medicaid Under the Affordable Care Act,* 309 J. AM. MED. ASS'N 2579, 2583 (2013) (finding that approximately 30% of the population likely eligible for Medicaid Expansion had hyperlipidemia, hypercholesterolemia, or diabetes, and that those chronic conditions were often untreated or uncontrolled); *cf.* KAISER COMM'N ON MEDICAID AND THE UNINSURED, HEALTH CARE USE AND CHRONIC CONDITIONS AMONG CHILDLESS ADULT MEDICAID ENROLLEES IN ARIZONA (2012) (finding that Arizona's early expansion population used services at a lower rate than the Medicaid population overall, but a significant minority with one or more chronic conditions used services frequently), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8310.pdf.

[10] Throughout this issue brief, I will use the term "managed care plan" to refer to MCOs and PHPs. While PCCMs are also a kind of managed care plan, they do not contract with the state on a risk basis, and their networks are designed quite differently. As such, the federal Medicaid rules on network adequacy do not apply to PCCMs.

**Requirements for Network Adequacy in Medicaid**

Federal Medicaid law requires that each Medicaid managed care plan ensure that all services covered under the State plan are available and accessible to managed care enrollees.[11] Federal Medicaid regulations require Medicaid managed care plans to assure and document to the state their capacity to serve the health care needs of their enrollees.[12] Documentation must demonstrate that the participating plans offer a range of primary, preventive and specialty services.[13] In addition, plans must maintain a provider network sufficient in number, type and geographic distribution.[14]

- **Medicaid managed care plans must provide access to covered services by including applicable provider specialty types as needed.**

Federal Medicaid rules require plans to provide access to all covered services considering the expected utilization of services, given the specific health needs of Medicaid enrollees, and the number and types of providers, in terms of training, experience and specialization.[15] In addition, the plan must demonstrate, to the state's satisfaction, that it provides an "appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area."[16] Unlike federal Medicare rules, however, which require Medicare Advantage plans to meet specific provider ratios in several specified specialty areas, the Medicaid rules generally decline to specify any particular number of providers per patient that plans must meet. [17] But plans must provide female enrollees with direct access to women's health specialists for routine and preventative services.[18]

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[11] 42 U.S.C. § 1396u-2(b)(5); 42 C.F.R. § 438.206(a) (requiring states to ensure that services are available to enrollees in Medicaid managed care organizations ("MCOs"), Prepaid Inpatient Health Plans ("PIHPs") and Prepaid Ambulatory Health Plans ("PAHPs")); *id.* § 438.207(b) (requiring State to ensure adequate network adequacy in Medicaid managed care plan contracts).

[12] 42 C.F.R. § 438.207(a).

[13] *Id.* § 438.207(b)(1).

[14] *Id.* § 438.207(b)(2).

[15] *Id.* § 438.206(b)(1)(ii)-(iii). States may "carve out" certain services and provide them outside of the managed care context, but must clearly specify which entity is responsible for which services. 42 U.S.C. § 1396u-2(b)(1); 42 C.F.R. § 438.10(e)(2)(ii(A).

[16] 42 C.F.R. § 438.207(b)(1).

[17] CMS, MA HEALTH SERVICES DELIVERY PROVIDER & FACILITY SPECIALTIES AND NETWORK ADEQUACY CRITERIA GUIDANCE 7 (2012), *available at* https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf.

[18] 42 C.F.R. § 438.206(b)(2); *see also* Jina Dhillon, *Medicaid Managed Care and Women's Health,* 16 HEALTH ADVOCATE 1 (2013), *available at* http://healthlaw.org/images/stories/2013_08_Vol_16_Health_Advocate.pdf; JINA DHILLON, MEDICAID MANAGED CARE AND WOMEN'S HEALTH (2013), *available at* http://www.healthlaw.org/images/stories/2013_08_09_Medicaid_Mng_Care_Women_Health.pdf .

- **Medicaid managed care plans must account for the geographic location of enrollees and providers, and means of transportation.**

Federal Medicaid regulations require plans to ensure that their networks are adequate in terms of reasonable distance/travel time, considering the geographic location of providers and enrollees.[19] In calculating the appropriate distance and travel time requirements, plans must account for the means of transportation used by Medicaid enrollees.[20] Plans must also demonstrate to the state that their provider networks offer sufficient "geographic distribution" to provide access to covered services.[21] States have discretion to require plans to ensure that certain provider types are available within a certain geographic area.

- **Medicaid managed care plans must provide timely access to services.**

Federal Medicaid rules require plans to provide enrollees with timely access to services.[22] States' contracts with plans must ensure that plans meet the following requirements: comply with state standards for timely access to care and services, considering urgency of care; provide hours of operation no less than that offered to commercial enrollees or comparable to Medicaid fee-for-service; when medically necessary, make services available 24 hours a day, 7 days a week; and, monitor provider compliance and take corrective action if needed.[23]

- **Medicaid managed care plans must provide access to services out-of-network if no in-network providers are available.**

Under federal Medicaid rules, plans must provide access to all covered services in a timely and adequate manner, including by providing access to out-of-network providers if no providers are available within a plan's network.[24] Plans must attempt to ensure that in-network providers are available by monitoring the number of network providers not accepting new Medicaid patients.[25] When a service is not available in-network, however, the plan must provide for the enrollee to obtain it out-of-network.[26] States must ensure that plans provide access to emergency care out-of-network without requiring

[19] 42 C.F.R. § 438.206(b)(1)(v).
[20] *Id.*
[21] *Id.* § 438.207(b)(2).
[22] *Id.* § 438.206(c)(1).
[23] *Id.* § 438.206(c)(1)(i) (urgency of care); *id.* § 438.206(c)(1)(ii) (hours of operation); *id.* § 438.206(c)(1)(iii) (care available 24/7 when needed); *id.* § 438.206(c)(1)(v)-(vi) (obligation to monitor compliance).
[24] 42 C.F.R. § 438.206(b)(4).
[25] *Id.* § 438.206(b)(1)(iv).
[26] *Id.* § 438.206(b)(4).

prior authorization.[27] States must also guarantee that plans provide or arrange for enrollees to seek second opinions, including by arranging for enrollees to see an out-of-network provider, if necessary.[28] In all cases where enrollees are authorized to see an out-of-network provider, the plan must also coordinate payment with that out-of-network provider to ensure that the enrollees do not incur greater costs than if they had received care in-network.[29]

- **Medicaid managed care plans must provide access to services for enrollees with disabilities.**

Federal Medicaid rules dictate that, in determining whether its provider network is accessible to enrollees, plans must account for the physical accessibility of participating facilities for enrollees with disabilities.[30] Federal Medicaid regulations do not specify how physical accessibility is to be determined. While the regulations do not explicitly require plans to ensure programmatic access to people with cognitive impairments or developmental disabilities, plans must provide all notices and materials in a format that will be easily understood by enrollees.[31] Plans must also comply with any applicable provisions of federal and state law with respect to disability access, such as the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

**Recommendations for Strong State Network Adequacy Requirements**

Medicaid rules do not define with a great deal of specificity how plans are to ensure that their networks are adequate. Rather, the federal regulations leave the plans and states a good deal of discretion to define network adequacy.[32] In some states, state laws impose network adequacy standards on health care plans in general, which include Medicaid managed care plans. Other states have Medicaid-specific laws or regulations on network adequacy. Network adequacy may also be governed by Medicaid managed care contracts. Advocates should work with their state Medicaid Agency and state policymakers to ensure that network adequacy standards in their state Medicaid programs are strong and will ensure that enrollees have real access to the services they need.

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[27] 42 U.S.C. § 1396u-2(b)(2); 42 C.F.R. §§ 438.114(b)-(c). Plans must also cover post-stabilization care in certain circumstances. *See* 42 U.S.C. § 1395w–22 (d)(2); 42 C.F.R. §§ 438.114(b), (e).
[28] 42 C.F.R. § 438.206(b)(3).
[29] *Id.* § 438.206(b)(5). Providers of emergency services to Medicaid managed care enrollees must accept the state's fee-for-service rate for services to Medicaid enrollees. 42 U.S.C. § 1396u-2(b)(2)(D).
[30] 42 C.F.R. § 438.206(b)(1)(v).
[31] 42 U.S.C. § 1396u-2(a)(5)(A); 42 C.F.R. §§ 438.10(b)-(d); HCFA, *Dear State Medicaid Director* (Feb. 20, 1998).
[32] 42 C.F.R. §§ 438.206-207.

- **Require Medicaid managed care plans to ensure access to specific provider types who provide covered services.**

Advocates should encourage their states to go beyond the federal minimums and require plans to ensure participation of particular provider types. For example, Virginia requires plans to include certain specialty types, like adolescent medicine and periodontics.[33] Wisconsin's contracts for its BadgerCare program require participating plans to meet specific provider ratios, including a 1:1000 ratio for cardiologists, a 1:4200 ratio for dematologists, a 1:900 ratio for psychiatrists, and a 1:3500 ratio for urologists.[34] Moreover, advocates must make sure that their states do more than merely count the numbers and types of providers, but that they also ensure that there are enough providers, including specialists, who actually provide all covered services. Ensuring the actual provision of services is especially important for women who need covered reproductive health services, if some or all of the providers in the area do not provide those services.[35]

- **Ensure that Medicaid managed care plans meet specific time and distance standards.**

Advocates should ensure that their states establish specific geographic standards that are appropriate for their communities. For example, Pennsylvania requires Medicaid plans to ensure that at least two primary care providers, and that at least one or two specialists in designated specialty areas are available within 30 minutes of members' homes in urban areas, and within 60 minutes in rural areas; travel time is to be calculated accounting for use of public transit to the extent it is available.[36] Similarly, Michigan requires plans to make primary care, hospital services, and pharmacy services available within 30 minutes or 30 miles.[37]

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[33] COMMONWEALTH OF VIRGINIA, MEDALLION II MANAGED CARE CONTRACT, Jul. 12, 2012, 112-13, *available at* http://www.dmas.virginia.gov/Content_atchs/mc/mc-mdl2_cntrct710.pdf. Virginia does require plans to provide one primary care provider per 1500 members, and one pediatric primary care provider per 2500 members under age 18. *Id.* at 112.

[34] WISCONSIN MEDICAID STANDARDS, CONTRACT FOR BADGERCARE PLUS § III(H)(7), Aug. 1, 2010 – Dec. 31, 2013, 54-55, *available at* http://www.dhs.wisconsin.gov/rfp/DHCF/pdf/Appendix%20A%20-%20Contract%20for%20BadgerCare%20Plus%20HMO%20Services%202010-2013.pdf.

[35] DHILLON, *supra* note 18 at 8.

[36] COMMONWEALTH OF PENNSYLVANIA, HEALTHCHOICES PHYSICAL HEALTH AGREEMENT, Apr. 1, 2012, Ex. AAA, AAA(1)1-2 (on file with author).

[37] MICH. DEP'T OF MGMT. & BUDGET PURCHASING OPERATIONS, CONTRACT NO. 071B02000, COMPREHENSIVE HEALTH CARE PROGRAM FOR THE MICH. DEP'T OF CMTY. HEALTH, OCT. 1, 2009, § 1.022(R)(2)(k), *available at* http://www.michigan.gov/documents/contract_7696_7.pdf.

- **Obligate Medicaid managed care plans to provide appointments within specified time frames.**

Advocates should work with their states to establish specific timely access standards, to ensure that Medicaid managed care enrollees have access to care when they need it. For example, Minnesota requires plans to provide appointments within 45 days for routine and preventative care, within 24 hours for urgent care, and immediately for emergency care.[38] Similarly, California requires plans to provide non-urgent primary care appointments within 10 business days of request, and non-urgent specialty or ancillary service appointments within 15 business days of request.[39]

- **Mandate Medicaid managed care plans to provide access to services out-of-network if no in-network providers are available.**

Advocates should make sure that their states require plans to provide out-of-network care when needed. For example, Maryland provides by regulation that plans ensure that children with special health care needs have access to appropriate specialty care. The regulation requires that plans permit such children access to out-of-network specialists for medically necessary specialty care when the plan does not contract with an appropriate specialist in-network, and the child was not diagnosed at enrollment.[40]

- **Make sure that Medicaid managed care plans provide access for enrollees with disabilities.**

Advocates should counsel their states to require plans to take additional steps to ensure accessibility for people with disabilities. For example, California requires plans to implement special procedures to identify and provide appropriate services to enrollees with developmental disabilities, including coordination with Regional Centers.[41] Maryland requires plans to make additional efforts to outreach to enrollees with cognitive impairments or psychosocial disabilities to ensure that these enrollees make and attend appointments according to their plan of treatment.[42]

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[38] MINNESOTA DEP'T OF HUMAN SERVS., [MODEL] CONTRACT FOR MEDICAID ASSISTANCE AND MINNESOTACARE MEDICAL CARE SERVICES §§ 6.16.1-3 (2012), *available at* http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_166537.

[39] CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR TWO-PLAN COUNTIES, Ex. A, Att. 10 § 4(b) (2011), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/MMCD_TwoPlanBoilerplate-Web.6-1-11.pdf.

[40] MD. CODE REGS. § 10.09.65.05(K).

[41] CAL. DEP'T OF HEALTH CARE SERVS., *supra* note 40 at Ex. A, Att. 10 § 10.

[42] MD. CODE REGS. § 10.09.66.03.

**Recommendations on Working with States to Monitory and Enforce Network Adequacy Requirements**

Advocates must also work with their state Medicaid agency and state regulators to ensure that plans are appropriately monitored for compliance with federal and state network adequacy standards.[43] Federal regulations require managed care plans that participate in Medicaid to assure and document to the state their capacity to serve the health care needs of their enrollees in each service area in accordance with state access-to-care standards.[44] States must certify to the Centers for Medicare and Medicaid Services ("CMS") that the plans comply with state standards for service availability, after the state's review of each plan's documents.[45] Advocates should work with their state policymakers, regulators and Medicaid Agencies to ensure that state standards are vigorously monitored and enforced, so that enrollees have true access to services.

- **Plans must monitor their networks regularly and quickly correct inadequacies**

Advocates should ensure that their states require plans to monitor compliance with applicable standards on a regular basis, at least quarterly. States could require plans to perform "secret shopper" calls to providers to ensure that networked providers are accepting new patients. States must mandate that plans take swift corrective action if their networks have fallen out of compliance, and report any corrective actions to the state promptly.

- **Plans should regularly report on their provider networks**

Advocates should also work with their states to require plans to provide quarterly reports to the state Medicaid agency and to the public. These reports should include the number, location, type, and current capacity of providers who are contracting with plans. This data must be accessible online and in written form so that consumers can be made aware of any problems, as well as compare and contrast plan performance.[46] And, like all information provided in connection with Medicaid, this information should be conveyed in a manner that is easily understood and accessible to people with low literacy, limited English proficiency, and disabilities. This level of transparency is critical

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[43] *See, e.g.,* JANE PERKINS, Q&A: ASSURING ACCOUNTABILITY AND STEWARDSHIP IN MEDICAID MANAGED CARE: PUBLIC REPORTING REQUIREMENTS FOR STATES AND MCOS (2007), *available at* http://www.healthlaw.org/images/stories/QA/QA-Accountability-MCOs_6-07.pdf.

[44] 42 C.F.R. § 438.207(a).

[45] *Id.* § 438.207(d).

[46] *Cf.* David Machledt, *Quality and Accountability: An Introduction for Advocates*, 15 HEALTH ADVOCATE 1 (2013) (discussing the importance of transparency in Medicaid managed care oversight), *available at* http://healthlaw.org/images/stories/2013_07_Vol_15_Health_Advocate.pdf.

to ensuring that Medicaid plans are held accountable for providing access to all covered services.

- **States must independently monitory plan's networks**

Advocates must also make sure that the applicable state regulating entities independently assess plans' compliance with network adequacy standards. States should regularly obtain plans' geo-access data that plots their networks. Using that data and other sources, the state regulators should verify the number and location of providers, the scope of services they provide, the timeliness of appointments, and the accessibility of contracted facilities. And as described above, any monitoring of Medicaid plan networks must be transparent, publicly available, and easy for consumers to understand.[47] States should broadly disseminate all non-confidential information derived through the monitoring process. Finally, states must assess appropriate penalties—which might include lower ranking for assignment of new enrollees, fines, or even contract termination—when plan networks fall out of compliance with the applicable standards.

## Conclusion

As more low-income individuals, especially those with disabilities and chronic care needs are enrolled in Medicaid managed care plans, consumer advocates must ensure that their states plans' networks are adequate to provide all covered services to Medicaid enrollees. Consumer advocates should work with their state regulators, Medicaid agencies and/or policymakers to enact specific network adequacy standards into state law, and to ensure that those standards are monitored and enforced.[48]

[47] *See id.*

[48] NHeLP has developed model contract language focused on the particular network adequacy needs of seniors and people with disabilities. LEO CUELLO & DAVID MACHLEDT, FIVE KEY STANDARDS FOR DUAL ELIGIBLE MOUS 3-7 (2012), *available at* http://www.healthlaw.org/images/stories/NHeLP_5_Key_Contract_Terms_for_Duals_MOUs.pdf. This language could be adapted into statutory language.