Medicaid Managed Care Model Provisions:

Network Adequacy

Issue No. 3

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Introduction

The National Health Law Program has focused on the legal provisions governing Medicaid managed care for nearly three decades. The Medicaid program has changed significantly and now requires millions of older people, people with disabilities, and those with Limited English Proficiency to enroll in managed care. Yet, the regulations have not been updated for more than a decade and no longer reflect the needs of the covered populations, or current clinical practices and technological capabilities. To help address these deficiencies, NHeLP has developed a complete set of modernized model federal regulations.[1]

To focus advocates on areas that were significantly updated, NHeLP has prepared a series of issue briefs featuring selected model provisions governing five aspects of Medicaid managed care: beneficiary grievances and appeals, enrollment and disenrollment, network adequacy, accessibility, and quality and transparency.[2] We encourage policy makers and advocates to use these model provisions to update existing regulations, policies, and managed care contracts.

TOPIC #3: NETWORK ADEQUACY

Background on Managed Care Network Adequacy:

Most Medicaid beneficiaries who are enrolled in managed care receive their services through managed care organizations (MCOs) or prepaid health plans (PHPs) (collectively "prepaid Medicaid managed care plans" or "plans"). These plans are capitated, meaning that they receive a set payment per Medicaid enrollee in exchange for providing services.[1] Moreover, MCOs contract with the state on a "comprehensive risk" basis, such that

[1] We used the current federal Medicaid managed care regulations at 42 C.F.R. part 438 as the starting point for developing our comprehensive model provisions. The regulations address state obligations, enrollee rights and responsibilities, quality assessment and improvement, external quality review, grievance systems, certification and program integrity, sanctions, and conditions for federal funding.

[2] Our issue brief on Quality and Transparency will be issued later in the fall of 2014.

plans incur a loss if they spend more on services than they receive through the capitated payments, but make a profit if providing services costs less than the payments.[2] These arrangements give plans a clear incentive to limit coverage of services for their enrollees in order to maximize profits. One way that service coverage can be limited – intentionally or not- is by failing to have sufficient providers in the network.

Accordingly, some of the most important federal requirements are those requiring that Medicaid managed care plans have adequate provider networks.[3] The Medicaid Act requires that each prepaid Medicaid managed care plan ensure that all services covered under the State plan are available and accessible to managed care enrollees.[4] The regulations currently require Medicaid prepaid managed care plans to assure and document to the state their capacity to serve the health care needs of their enrollees.[5] Documentation must demonstrate that the participating plans offer a range of primary, preventive and specialty services.[6] In addition, in determining whether its provider network is accessible to enrollees, plans must account for the physical accessibility of participating facilities for enrollees with disabilities.[7]

The Medicaid Act requires that each prepaid Medicaid managed care plan ensure that all services covered under the State plan are available and accessible to managed care enrollees.

Prepaid Medicaid managed care plans must 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.[8] 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."[9] Plans must ensure that their networks are adequate in terms of reasonable distance/travel time, considering the geographic location of providers and enrollees.[10] In calculating the appropriate distance and travel time requirements, plans must account for the means of transportation used by Medicaid enrollees.[11] Plans must also demonstrate to the state that their provider networks offer sufficient "geographic distribution" to provide access to covered services.[12]

Plans must ensure that their networks are adequate in terms of reasonable distance/travel time, considering the geographic location of providers and enrollees. In calculating the appropriate distance and travel time requirements, plans must account for the means of transportation used by Medicaid enrollees.

States' contracts with plans must ensure that plans meet the following requirements: comply with state standards for timely access to care and services, including 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.[13] 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.[14]

Recurring problems: Managed care enrollees have faced barriers when attempting to access health care providers in their plans. These include plans:

- Failing to contract with sufficient numbers and types of providers to ensure that all covered services are accessible, including the full range of covered reproductive health services and covered home and community-based services;
- Failing to account for whether its providers are accepting new patients.
- Failing to make appointments available with network providers within a reasonable amount of time;
- Failing to contract with providers and facilities located within reasonable times or distances;
- Refusing to authorize enrollees to seek care out-of-network, even when no in-network providers are available;
- Failing to provide full access to people with disabilities by ensuring that contracted facilities are accessible;
- Failing to monitor plan networks or take corrective action when the network is inadequate;
- Failing to report regularly to the state on network capacity;
- Neglecting to monitor plans' networks and enforce existing requirements.

These model provisions address these problems by:

- Explicitly requiring plans to cover providers of all covered services in their networks, and to account for the range of reproductive health and home and community-based services its network providers will offer;
- Requiring plans to ensure that access to needed reproductive health and home- and community-based services are readily available to enrollees out-of-network, when the plan lacks network providers who offer those services;
- Specifically requiring plans to account for whether its providers are accepting new patients;
- Delineating clear timely access standards to ensure that enrollees have timely access to care;
- Specifying clear geographic access standards to ensure that enrollees can access providers within a reasonable distance of their homes or workplaces, and requiring plans to document the locations of their providers to the state;
- Obligating plans to ensure that their contracted facilities are fully accessible to enrollees with disabilities and have been certified as compliant with the ADA and any other applicable laws;
- Mandating plans to provide and pay for any services needed to provide access to enrollees with disabilities;
- Requiring plans to provide and pay for any services needed to provide language access to people with Limited English Proficiency;
- Imposing clear requirements on plans to monitor access to care and take corrective action if they fall out of compliance;
- Charging plans to provide the state with documentation of their compliance with applicable network adequacy standards at least annually.

- Directing plans to provide the state with specific information about their contracted providers, including maps showing where the providers are located.

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Medicaid Managed Care Network Adequacy Protections

Note: These model provisions are based on NHeLP's comprehensive set of modernized Medicaid managed care regulations.

Definitions:

Prepaid Managed Care Plan (PMCP): A Medicaid managed care organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP), as defined by 42 C.F.R. § 438.2.

Primary Care Case Manager (PCCM): A physician, entity employing physicians, or (at state option) another health care practitioner that contracts with a State to provide case management services, as defined by 42 C.F.R. § 438.2.

LEP means Limited English Proficiency, as defined by the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (Aug. 8, 2003).

Section One: Availability of Services

(a) Basic rule. Each State must ensure that all services covered under the State plan are available and accessible to enrollees of PMCPs.

(b) A PMCP may specify the networks of providers from whom enrollees may obtain services if the State and the PMCP ensure that all covered services are available and accessible under the plan. To accomplish this, the State shall ensure that each contracting PMCPs meets the following requirements:

(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. These providers shall include (i) providers of all categories of services covered by the State plan and the PMCP contract, (ii) qualified providers of long term services and supports who meet state licensing, credentialing, or certification requirements, particularly providers of home and community-based long term services and supports; and (iii) a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers in the plan's service area. ECPs are providers that serve predominantly low-income, medically underserved individuals, including providers defined in section 340B(a)(4) of the Public Health Services Act and § 1927(c)(1)(D)(i)(IV) of the Social Security Act.

(2) In establishing and maintaining the network, each PMCP must account for the following:

(i) The anticipated Medicaid enrollment.

(ii) The expected utilization of services, taking into consideration the characteristics and health care needs, including accessibility needs, of specific Medicaid populations represented in the particular PMCP.

(iii) The numbers of network providers who are not accepting new Medicaid patients.

(iv) The numbers of network providers who provide a full range of covered reproductive health services including high risk pregnancy care, family planning services and supplies, and abortion.

(v) The needs of enrollees for home and community-based long term services and supports, mental health, and substance use services.

(3) Provides or arranges for necessary specialty care, including home and community-based long term services and supports, including by offering access to such care out-of-network when required by subsection (8) below.

(4) If a PMCP contracts with institutions or individual providers who refuse to provide a full range of reproductive health services, the PMCP must also:

(i) Contract with at least one institutional provider and one professional provider within the same geographic area that provides covered services in-network providers refuse to provide;

(ii) If there is no provider in the geographic area that offers the covered services, contract with additional providers in nearby regions and provide transportation services; and

(iii) Ensure a protocol is in place to allow enrollees to obtain covered services when a primary care provider refuses or is unable to make a referral to needed services.

(5) Establish written standards for the following:

(i) Timeliness of access to care and enrollee services. Each PMCP must demonstrate that its written standards ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments as follows:

(A) Urgent care appointments for medical or dental services shall be available within 48 hours of the request for appointment, except as provided in (F);

(B) Non-urgent appointments for primary and specialty care shall be available within 15 business days of the request for appointment, except as provided in (F) and (G);

(C) Non-urgent appointments with a non-physician mental health care provider shall be available within 10 business days of the request for appointment, except as provided in (F) and (G);

(D) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition shall be available within 15 business days of the request for appointment, except as provided in (F) and (G);

(E) Non-urgent dental appointments shall be offered within 30 business days of the request for appointment, except as provided in (F); and

(F) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;

(G) The applicable waiting time for a particular appointment must be shortened if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined that it is medically necessary for the enrollee to receive care more quickly; and

(H) The network providers shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

(I) Services included in the contract shall be available 24 hours a day, 7 days a week, when medically necessary.

(J) The PMCP shall establish mechanisms to ensure compliance by providers.

(K The PMCP shall monitor providers regularly to determine compliance.

(L) The PMCP shall take corrective action if there is a failure to comply.

(ii) Policies and procedures (coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations.

(iii) Provider consideration of beneficiary input into the provider's proposed treatment plan.

(iv) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services that meet or exceed standards established by CMS.

(v) The geographic location of providers and Medicaid enrollees considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities. Except as provide in subsection (E) below, the PMCP shall ensure that:

(A) 90% of enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.

(B) 90% enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.

(C) 90% enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated laboratory, pharmacy and similar ancillary facilities that dispense services and goods by order or prescription on the primary care provider.

(D) All contracting providers certify that their facilities and services are accessible to all enrollees, and fully compliant with the Americans with Disabilities Act (ADA) and any other applicable State and federal disability and civil rights laws.

(E) The State will establish alternative primary, specialty, and ancillary access standards for PMCPs operating in rural areas, service areas within a State with a population of

500,000 or fewer, other areas within a State that are sparsely populated, or in other circumstances in which the standards are unreasonably restrictive.

(6) Provides female enrollees including adolescents with direct access to a women's health specialist within the network for covered women's health services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

(7) Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

(8) If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the PMCP must adequately and timely cover these services out of network for the enrollee, for as long as the PMCP is unable to provide them.

(9) Requires out-of-network providers to coordinate with the PMCP with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

(10) Demonstrates that its providers are credentialed as required by 42 C.F.R. § 438.214.

(c) *Furnishing of services.* The State must ensure that each PMCP contract complies with the requirements of this paragraph.

(1) *Ambulance services, emergency and urgently needed services, and post-stabilization care services coverage*. Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services.

(2) *Preventive dental services.* Each PMCP must provide coverage for dental sealants and fluoride varnish for enrollees under age 21, to the extent the PAHP covers the services of practitioners authorized to provide such services.

(3) *Cultural considerations.* Each PMCP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with LEP and diverse cultural and ethnic backgrounds. Each PMCP must ensure that services related to language access and disability access are provided to all potential enrollees and enrollees who have LEP or have disabilities, as otherwise required by these provisions. Each PMCP must pay for the costs of the language access and disability access and not require its network providers to pay for these costs.

(4) Plans shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined at subsection (b)(5).

(i) Plans shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.

(ii) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services; telephone medical advice services; the plan's contracted primary care and mental health care provider network; or other method that provides triage or screening services consistent with the requirements of this subsection.

(5) Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative who is knowledgeable about and competent to respond to an enrollee's questions and concerns shall not exceed 10 minutes.

Section Two: Assurances of Adequate Capacity and Services

(a) *Basic rule.* The State must monitor and ensure that each PMCP gives assurances to the State and provides—at least annually—supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this subpart and the standards governing services for people with Limited English Proficiency and with disabilities.[15]

(b) *Nature of supporting documentation.* Each PMCP must submit documentation to the State certifying that it complies with the requirements of Section One, as follows:

(1) Each PMCP shall submit a narrative description of its service area and the geographic area in which its enrollees (actual and/or projected) live and work and list all U.S. Postal ZIP Code numbers included in the service areas. To the extent possible, service areas should be delineated by political or natural boundaries

(2) Each PMCP shall submit a map or maps upon which the information specified below is indicated by the specified system of symbols. The map(s) employed should be of convenient size and of the largest scale sufficient to include the applicant's entire service area and the surrounding area in which the actual or projected enrollees live or work. The use of good-quality city street maps or the street and highway maps available for various metropolitan areas, and regions of the State, such as are commonly available from automobile associations or retail service stations or from an internet or computer based program is preferred. The map or maps should show the following information:

(i) Such geographic detail, including highways and major streets, as is generally portrayed on the kinds of maps referred to above.

(ii) The boundaries of applicant's service area.

(iii) The location of any contracting or plan-operated hospital and, if separate, each contracting or plan operated emergency health care facility. Hospitals are to be designated by an "H" and emergency care facilities by an "E."

(iv) The location of primary care providers, designated by a "P." For convenience, the primary care providers within any mile-square area may be considered as being at one location within that area.

(v) The location of all other contracting or plan-operated health care providers including the following: Dental, designated by a "D." Pharmacy, designated by an "Rx." Laboratory, designated by an "L." Eye Care, designated by an "O." Specialists and ancillary health care providers, designated by an "S." Providers of home and community-based long term services and supports, designated by "HCB."

(vi) The location of all subscriber groups which have submitted letters of intent or interest to join the applicant's plan designated by a "G." (See Item CC-3.)

(3) Each PMCP shall attach an index to the map or maps described in subsection (2) which shows, for each symbol placed on the map for a hospital, emergency care facility, primary care provider or ancillary provider, the following information:

(i) For each hospital, its total beds and the number of beds available to enrollees of the plan.

(ii) For each symbol for primary care providers, the number of full-time equivalent primary care providers represented by that symbol.

(iii) For each interested subscriber group, the name of the group and the projected number of enrollees from that group.

(4) Has policies in place to ensure required disability access and language access.[16]

(c) *Timing of documentation.* Each PMCP must submit the documentation described in paragraph (b) of this Section as specified by the State, but no less frequently than the following:

(1) At the time it enters into a contract with the State.

(2) At any time there has been a significant change (as defined by the State) in the PMCP's operations that would affect adequate capacity and services, including—

(i) Changes in PMCP services, benefits, geographic service area or payments; or

(ii) Enrollment of a new population in the PMCP.

(d) *State review and certification to CMS.* After the State reviews the documentation submitted by the PMCP, the State must certify to CMS that the PMCP has complied with the CMS and the State's requirements for availability of services, as set forth in Section One.

(e) *CMS' right to inspect documentation.* The State must make available to CMS, upon request, all documentation collected by the State from the PMCP.

ENDNOTES

[1] 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.
[2] *See* 42 C.F.R. § 438.2 (defining "comprehensive risk contract" and "capitation payment").
[3] Throughout this issue brief, when we refer to prepaid Medicaid managed care plans, or plans in general, we are referring to MCOs and PHPs. While Primary Care Case Management entities (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.
[4] 42 U.S.C. § 1396u-2(b)(5); 42 C.F.R. § 438.206(a) (requiring states to ensure that services are available to Medicaid managed care enrollees); *id.* § 438.207(b) (requiring State to ensure adequate network adequacy in Medicaid managed care plan contracts).
[5] 42 C.F.R. § 438.207(a).
[6] *Id.* § 438.207(b)(1).
[7] *Id.* § 438.206(b)(1)(v).
[8] *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).
[9] 42 C.F.R. § 438.207(b)(1).
[10] *Id.* § 438.206(b)(1)(v).
[11] *Id.*
[12] *Id.* § 438.207(b)(2).
[13] *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).
[14] 42 C.F.R. § 438.206(b)(4).
[15] *See* NHELP, MEDICAID MANAGED CARE MODEL PROVISIONS TOPIC #4: ACCESSIBILITY & LANGUAGE ACCESS (Sept. 8, 2014), available at www.healthlaw.org.
[16] *See id*.