Medicaid Managed Care Final Regulations: Network Adequacy & Access

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Prepared By: Abbi Coursolle

This issue brief will review selected provisions in the final rule, *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability* implementing the requirements governing network adequacy and access to services in Medicaid managed care.[1] We also include recommendations to help state advocates ensure robust implementation of these provisions in their states. These recommendations are highlighted throughout and also listed at the end of this brief.

Definitions & effective dates (§ 438.2)

The final regulations made two definitional changes that impact the regulatory provisions related to network adequacy and access to services. First, the final regulations no longer use the term "health care professional," and instead use the term, "provider."[2] In the preamble to the rule, CMS clarified that it intended the word provider to have a broad scope, to include the full range of providers who deliver services to Medicaid Managed Care enrollees, including those services that are sometimes delivered by providers who are not licensed by the state, such as certain long-term services and supports (LTSS) and behavioral health providers.[3]

Second, CMS also added a new definition of "network provider" to this section.[4] This term extends to any provider who enters a network provider agreement or a subcontract with managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs), and who receives

[1] *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, 81 Fed. Reg. 27,498-27,901 (May 6, 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] 42 C.F.R. § 438.2; *see* 81 Fed. Reg. at 27,753-54 (noting that this change brings the terminology in the managed care provisions of the Medicaid regulations in line with terminology used elsewhere in the regulations, and that the definition is intended to align with the definition of the word "provider" at 42 C.F.R. § 400.203).
[3] 81 Fed. Reg. at 27,753.
[4] 42 C.F.R. § 438.2; *see* 81 Fed. Reg. at 27,753, 27,755.

Medicaid funds, directly or indirectly, to provide Medicaid covered services to plan enrollees.[5] This definition is particularly important to the concept of network adequacy, since it defines the universe of providers who are considered "in network" for the purposes of assessing whether a plan's network is adequate.

Network adequacy-related provisions have different effective dates. The provisions of this rule related to provider directories of the regulatory provisions governing state and plan policies and procedures for ensuring network adequacy become effective for the rating period for contracts with capitated plans beginning on or after July 1, 2018. The rating period is "the twelve month period for which capitation rates are developed under a managed care contract, to address States that have multi-year managed care contracts."[6]

The provisions governing state monitoring of network adequacy are phased in over time: States must also include certain performance targets related to network adequacy and timely access to services in their state quality strategy starting July 1, 2018; then, states must begin conducting external quality review (EQR) activities to validate plans' performance with respect to network adequacy "no later than one year from the issuance of the associated EQR protocol."[7]

Provider Directories (§ 438.10(h))

To determine whether a plan's network is adequate, enrollees must first know which providers are included in the plan's network. For the first time, these regulations explicitly require capitated plans and primary care case management (PCCM) entities to provide enrollees and potential enrollees an electronic directory of its network providers; directories must also be available in hard copy upon request.[8] Online directories must be available on the plan's website in a machine-readable file and format. Directories must be updated regularly; plans must update online directories within 30 days of receiving notice of a change, and monthly for hard copy directories. CMS had originally proposed to require plans to update directory listings within three business days, but extended the time for updates after receiving comments indicating that many plans lacked the capacity to update listings in that period.[9] Nevertheless, states may require plans to update their provider directories more frequently than monthly. Advocates should encourage their states to require plans to update their directories more regularly to ensure that enrollees have up-to-date information about which providers are included in their plans' networks.

Where an enrollee relies on an erroneous directory listing (by, for example, receiving services from a provider who is no longer in her plan's network), CMS encourages, but does not require, states and plans to hold the

[5] These terms are defined at 42 C.F.R. § 438.2. This paper will refer to MCOs, PIHPs, and PAHPs collectively as "capitated plans."
[6] CMS, Medicaid and CHIP Final Rule (CMS 2390-F) Implementation Dates (Apr. 25, 2016), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/implementation-dates.pdf (last visited May 9, 2016). A PCCM entity is an organization that provides certain functions in addition to primary care case management. 42 C.F.R. § 438.1.
[7] 81 Fed. Reg. 27,499.
[8] 42 C.F.R. §§ 438.10(c)(3), (h).
[9] 81 Fed. Reg. 27,725-26.

enrollee harmless, and to treat the visit as if the provider were in network.[10] Such protections are needed to ensure that managed care enrollees are not penalized with unaffordable bills if they rely on a directory listing to receive services from a listed provider who is actually out-of-network. Moreover, this protection will provide an extra incentive to plans to ensure that their listings are accurate and up-to-date.

State Advocacy Tip

Encourage states to require plans to treat providers as network providers if they are listed as such in plan's provider directory, and to hold enrollees harmless if they relied on such listing.

The regulation provides significant detail about the content that capitated plans and PCCM entities must require in their directories. Directories must include listings for physicians, hospitals, behavioral health providers, and LTSS providers, as appropriate. Each listing must include the following information, as applicable to individual providers:

- Name and group affiliation;
- Street address;
- Telephone number;
- Web site;
- Specialty;
- Whether the provider is accepting new enrollees;
- Cultural and linguistic capabilities; and
- Ability to offer accommodations for individuals with physical disabilities.[11]

  States may require plans to include other information in provider directory listings, such as the providers' institutional affiliations, admitting privileges information, or hours of operation.[12]

In the preamble to the rule, CMS clarified that the requirement that provider directories identify whether a provider's office or facility has accommodations for people with physical disabilities is not meant to supplant providers' duty to comply with the Americans with Disabilities Act, Rehabilitation Act, or other disability laws.[13] NHeLP suggested additional requirements for provider directories to include whether an office or facility

[10] *Id.* at 27,730.
[11] 42 C.F.R. § 438.10(h)(1).
[12] For more information about the requirements to include providers' linguistic and cultural capacity in the directory, see MARA YOUDELMAN, NAT'L HEALTH LAW PROG., MEDICAID MANAGED CARE FINAL REGULATIONS AND HEALTH EQUITY 4-5 (2016), http://www.healthlaw.org/publications/Brief-1-MMC-Final-Reg.
[13] 81 Fed. Reg. 27669-70, 27729.

exceeded minimum physical accessibility requirements, had auxiliary aids and services available, or had expertise serving people with disabilities. These recommendations were not adopted and could be an opportunity for state advocacy. Where more than one accommodation could be offered under the law to provide access to enrollees with disabilities, having information about which accommodation a particular office or facility provides may assist enrollees in choosing a provider who suits their needs and preferences.

Where a capitated plan or PCCM entity subcontracts a portion of its network to a subcontractor, it may link to a directory on the subcontractor's website.[14] For example, a plan that contracts with a pharmacy benefits manager to deliver outpatient prescription drugs to enrollees may link to the pharmacy benefits manager's website for a listing of contracted pharmacies. State advocates may wish to work with their states to require plans to provide all listings in one place, rather than simply linking to subcontractor's websites.

Time and distance standards for access to care (§ 438.68)

One of the most significant changes from the previous version of the Medicaid Managed Care regulations in the area of network adequacy is the addition of a requirement that states establish time and distance standards for capitated plans. Time and distance standards are a common metric to evaluate the potential accessibility of a plan's network. The Medicare Advantage program, for example, requires plans in large metro areas to demonstrate that they contract with at least one primary care provider who is available within 5 minutes or 10 miles of 90% of beneficiaries in large metro counties. The previous version of the Medicaid Managed Care regulations requires plans to ensure that their networks are adequate in terms of reasonable distance and travel time, considering the geographic location of providers and enrollees, but does not require states to set specific quantitative measures to evaluate whether the distance and travel time required is reasonable.

The new rule requires states to set specific time and distance standards for capitated Medicaid Managed Care plans for the first time. The state's standards must be published on the state's website. States must develop standards in eight different areas:

- Primary care;
- Behavioral health, including mental health and substance use disorder services;
- Specialist;
- OB/GYN;
- Hospital;
- Pharmacy;
- Pediatric dental; and
- LTSS services that require the enrollee to travel to the provider.

For primary care, behavioral health, and specialist services, states must develop standards for both adult and pediatric services. CMS may also identify additional provider types that states must subject to time and distance standards when doing so promotes the objectives of the Medicaid program.

[14] *Id.* at 27,729.

States must develop standards for all geographic areas of the state covered by the managed care program, but may allow capitated plans to meet different standards in different parts of the state. Thus, a state could require plans to provide primary care within 10 miles or 15 minutes in urban areas of the state, but within 30 miles or 45 minutes in rural areas, for example. States may allow plans to obtain an exception to its time distance standards, as long as the exceptions process is set forth in the plan contract, and is based on the number of providers in the relevant specialty area who are practicing in the plan's service area. State time and distance standards must be published on the state's website and available in hard copy and accessible formats upon request.

State Advocacy Tip

States must develop time and distance standards for all capitated plans. Thus, in states where certain services are provided by a PIHP or PAHP—for example, behavioral health or dental services—the state must nevertheless develop time and distance standards under the regulation. Advocates should ensure that states subject all capitated plans to time and distance standards.

In developing time and distance standards, the state must account for a wide variety of factors, including:

- anticipated plan enrollment and expected service utilization;
- population characteristics; numbers of network providers not accepting new patients;
- the means of transportation ordinarily used by Medicaid enrollees; network providers' linguistic capacity;
- network providers' ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities;
- availability of triage lines or screening systems; and
- use of telemedicine or similar technologies.[15]

Currently, most states do use time and distance standards to measure network adequacy for at least some services delivered through Medicaid managed care.[16] But existing standards may not account for all provider types specified in the new rule. NHeLP and other commenters urged CMS to adopt national time and distance standards that would apply to all Medicaid managed care plans. Since CMS instead permitted states to develop

[15] *Id.* § 438.68(c)(1).

[16] *See, e.g.*, SUZANNE MURRIN, DEP'T HEALTH & HUM. SERVS., OFFICE INSPECTOR GEN., STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE 8 (2014), http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf (finding that 32 out of 33 states with capitated managed care in 2013 used distsance and time standards to monitor access to care).

standards at their discretion, state advocates should work closely with their states to ensure that they adopt robust standards that truly reflect the needs of Medicaid managed care enrollees and provider availability, for all of the provider types listed in the rule.

Acknowledgement of telemedicine (§ 438.68(c)(1)(ix))

For the first time, CMS recognized that capitated plans may use "telemedine, e-visits, . . . or other evolving and innovative technological solutions" to meet network adequacy requirements.[17] CMS provides little guidance, however, on how these technologies should be used, and when telemedicine is a reasonable alternative to an in-person visit. Instead, CMS "encourage[s] states to consider how current and future technological solutions could impact their network adequacy standards."[18] Advocacy and monitoring will be needed to ensure that plans do not rely on telemedicine inappropriately in an effort to inflate the size of their network, and to develop appropriate standards to regulate plans' use of telemedicine in their networks.

Measuring network adequacy for LTSS (§ 438.68(b)(2))

In recent years, more states have been using managed care delivery systems to deliver services to people with disabilities and chronic conditions in Medicaid. In many states, MCOs, PIHPs, and PAHPs provide LTSS to these enrollees. But existing metrics for assessing the adequacy of plan networks are often not a very good match for LTSS, particularly for services that are delivered in home and community settings to support Medicaid enrollees with disabilities.[19]

For LTSS that require enrollees to travel to a fixed provider location (such as adult day services, and most speech and occupational therapy services), states must develop time and distance standards as described above. For other types of LTSS, where the provider generally travels to the enrollee's home or meets the enrollee in a community-based setting like the enrollee's school or workplace (such as personal care or home health services), CMS will require states to develop network adequacy standards, but has provided states with discretion to determine the most appropriate standards for those services.[20] Further, if pediatric LTSS providers offer necessary services that an adult LTSS provider cannot appropriately provide, states should consider how to address pediatric LTSS providers in the network adequacy standards.[21]

States must consider many factors in developing network adequacy standards for LTSS whether time and distance, or some other standard), including all of the factors that must be considered for time and distance standards for other types of services, as well as (1) the plan's ability to support the enrollee's choice of provider;

[17] 42 C.F.R. § 438.68(c)(1)(ix).
[18] 81 Fed. Reg. 27,653.
[19] *See* 81 Fed. Reg. 27,653, 27,658, 27,664-65.
[20] 42 C.F.R. § 438.68(b)(2)(ii).
[21] 81 Fed. Reg. 27,666.

(2) strategies to support enrollees' integration into the community; and (3) any other considerations that promote the best interest of enrollee's who use LTSS.[22]

State Advocacy Tip

Advocates should work closely with their states to evaluate the kinds of standards that will best help their state to evaluate the adequacy of its LTSS network, recognizing that that states may need to employ different metrics to fit different types of services.

Timely access to care (§ 438.206(c)(1))

Medicaid MCOs, PIHPs, and PAHPs must provide enrollees with timely access to services. States' contracts with MCOs, PIHPs, and PAHPs must require those entities to: 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 FFS; when medically necessary, make services available 24 hours a day, 7 days a week; and, monitor the network regularly to ensure compliance with these rules and take corrective action if needed.[23]

While NHeLP and other advocates encouraged CMS to set national quantitative access standards for timely appointments, CMS declined to do so. CMS also failed to mandate that states set any particular quantitative standard to measure and monitor timely access to care. Instead, CMS declared that its regulatory regime provides states "flexibility to tailor their program to the populations served and the benefits provided."[24] Currently, a majority of states do use quantitative standards to ensure enrollees receive timely access to care, such as requiring that contracted plans make primary care appointments available within 10 days of request.[25] Often, however, state standards often only require Medicaid plans to ensure that they provide access to primary care and urgent care within a specified number of days, and fewer states use quantitative standards for specialty or other services.

[22] 42 C.F.R. § 438.68(c)(2).
[23] *Id.* § 438.206(c)(1).
[24] 81 Fed. Reg. 27,665.
[25] MURRIN, *supra* note __ at 9-10.

State Advocacy Tip

Encourage states, which will already be in the process of revising and developing network adequacy standards, to adopt new or improved quantitative timely access to care standards.

Requirements for service accessibility in terms of language, culture and disability (§§ 438.14, 438.68(c)(vii)-(viii), 438.206(c)(2)-(3))

States must account for language and disability access in designing time and distance standards and standards for LTSS access under § 438.68(b).[26] In addition, States must ensure that capitated plans participate in the state's efforts to deliver culturally competent services; the new regulations clarify that cultural competency extends to limited English proficient enrollees; those with "diverse cultural and ethnic backgrounds;" enrollees with disabilities; and enrollees of all genders, gender identities, and sexual orientations.[27] With respect to enrollees with disabilities, capitated plans are responsible for ensuring that their network providers are accessible to enrollees with physical or mental disabilities. Such access includes reasonable accommodations, physical access, and accessible equipment.

Finally, the new rule clarifies the network adequacy requirements for capitated plans and PCCM entities that enroll certain Native American enrollees. In addition to ensuring these plans meet any other applicable network adequacy requirements, State contracts with these plans must require the capitated plan or PCCM entity to demonstrate that it contracts with a sufficient number of Indian Health Care Providers to ensure timely access to care for all eligible Native American enrollees.[28] Capitated plans, PCCMs, and PCCM entities must also permit eligible Native American enrollees to select an Indian Health Care Provider as a primary care provider.

Access to out-of-network providers, including during transitions (§§ 438.10(g)(2)(vi), 438.62, 438.114, 438.206(b))

Capitated 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.[29] Thus, when

[26] 42 C.F.R. § 438.68(c)(vii)-(viii).
[27] *Id.* § 438.206(c)(2).
[28] *Id.* § 438.14(b)(1).
[29] *Id.* § 438.206(b)(4).

a service is not available from a network provider, the plan must provide for the enrollee to obtain it out-of-network. In addition, states must ensure that capitated plans provide access to emergency care out-of-network without requiring prior authorization.[30] 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. Capitated plans and PCCM entities must also pay out-of-network Indian Health Care Providers when they deliver care to eligible Native American enrollees.[31] Finally, under "freedom of choice" rules, capitated plans must allow enrollees to see the out-of-network family planning provider of their choice without first requiring a referral from the plan.[32] 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.

The new rules add protections that require states to ensure that enrollees can continue seeing their existing providers during certain times of transition. Specifically, they require states to develop transition of care policies to permit enrollees to continue seeing existing providers who are out-of-network with their new plans when: (1) they move into a capitated plan, PCCM, or PCCM entity from FFS Medicaid, or when they change plans; and (2) without continuity of care, the enrollee is at risk of hospitalization or institutionalization.[33] States have discretion to set the length of time that enrollees can continue to see their current providers who are out-of-network with their new plan.

State Advocacy Tips

- **Encourage states to include other times of transition (e.g., Marketplace to Medicaid) in their transition of care policies, to ensure new Medicaid Managed Care enrollees have the benefit of those policies during all transition periods.**
- **Ensure that transition of care policies include protections for pregnant and postpartum women, people with procedures scheduled post-transition, people with terminal illnesses, and those in an ongoing course of treatment.**
- **Advocate for states to allow enrollees to continue seeing their existing providers for at least the amount of time needed to complete any scheduled procedures or ongoing treatment, including necessary follow-up appointments.**

[30] 42 U.S.C. § 1396u-2(b)(2); 42 C.F.R. §§ 438.114(b)-(c). Capitated 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).
[31] 42 C.F.R. § 438.14(b)(2), (4).
[32] 42 U.S.C. § 1396a(a)(23); *see also* 42 C.F.R. 438.10(g)(2)(vi) (new requirement that plans explain freedom of choice in the enrollee handbook); *id.* § 438.206(b)(7) (new requirement that plans demonstrate adequate capacity to deliver timely access to family planning services from network providers, notwithstanding enrollees' right to seek such services out-of-network).
[33] 42 C.F.R. § 438.62(b).

Monitoring and enforcement (§§ 438.66(b), 438.66(d), 438.68(a), 438.206(b)-(c), 438.207)

The new rules considerably strengthen states' responsibilities to monitor and enforce network adequacy rules. State must have system for monitoring standards for capitated plans and PCCM entity provider directories. States must also enforce time and distance standards for capitated plans developed pursuant to § 438.68(b). In addition, states must have systems in place for monitoring timely access, availability, and accessibility of services delivered by capitated plans. States must monitor the networks of capitated plans to ensure that those networks are supported by written agreements and are able to provide adequate access to all covered services, including for enrollees with limited English proficiency or physical or mental disabilities.

States must conduct specific monitoring activities at certain times. States must conduct a readiness review for new capitated plans or PCCM entities and those that expand (in terms of service area or population served) that evaluates the plan's capacity to manage its provider network. In addition, states must account for network adequacy in the process of certifying the actuarial soundness of rates. Then, states must require capitated plans to provide documentation of their network capacity when they enter into a contract, and annually thereafter, or whenever there is a significant change that could affect network capacity. The state must review each plan's documentation and certify compliance with state standards to CMS; CMS may review the underlying documentation collected by the state.

Moreover, in their annual program assessment report to CMS, states must include an assessment of the availability and accessibility of services within capitated plans, including an evaluation of their plans' compliance with state network adequacy standards. In addition, whenever a state grants an exception to state time and distance standards, it must monitor access to the provider type for which they have granted an exception, and report their findings in their annual program assessment report. Finally, states must ensure that the network adequacy of each capitated plan is validated annually by the State, its agent, or an External Quality Review Organization (EQRO).

Conclusion

These regulations seek to modernize the Medicaid managed care procedures and protect beneficiary rights to a network adequate to provide access to all covered services. A number of opportunities exist for state advocates to strengthen or clarify the final regulations.[34] NHeLP recommends that state advocates monitor development of policies, contracts, practices, and implementation to ensure that:

[34] For more detailed recommendations, including NHeLP's recommendations for specific quantitative standards, see ABBI COURSOLLE, NAT'L HEALTH LAW PROG., MEDICAID MANAGED CARE MODEL PROVISIONS: NETWORK ADEQUACY (2014), http://www.healthlaw.org/publications/medicaid-managed-Care-model-provisions-issue-3, and ABBI COURSOLLE, NAT'L HEALTH LAW PROG., NETWORK ADEQUACY IN MEDICAID MANAGED CARE: RECOMMENDATIONS FOR ADVOCATES (2013), http://www.healthlaw.org/publications/network-adequacy-in-medicaid-managed-care.

- States require plans to regularly monitor and quickly update provider directory listings;
- States ensure that enrollees are held harmless if they rely on erroneous directory listings;
- Plan provider directories are designed to facilitate enrollees with disabilities' selection of providers who offer appropriate accommodations;
- Plan provider directories include all network providers, including those of their subcontractors;
- States adopt robust quantitative time and distance standards;
- States develop appropriate standards to measure plans' capacity to deliver covered LTSS;
- States implement strong quantitative timely appointment waiting time standards;
- States account for the use of telemedicine and other technological delivery models in developing network adequacy standards in a manner that ensures access to appropriate services, not merely those that are convenient for the state;
- State network adequacy standards account for plans that cover particular services;
- When designing network adequacy standards, states account for providers' linguistic capacity, accessibility to enrollees with disabilities, and cultural competency;
- Plans allow enrollees to seek out-of-network care at no additional cost when needed;
- State transition of care policies are designed to protect enrollees' right to continue care with their existing providers for an appropriate period of time.
- States engage in a searching review of contracted plans' networks to ensure that they are adequate to provide enrollees with access to covered services.
- States establish robust mechanisms for correcting any access or network deficiencies that their network adequacy reviews uncover.