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Medicaid MCO Network Adequacy Overview
June 2016

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Texas Association of Health Plans

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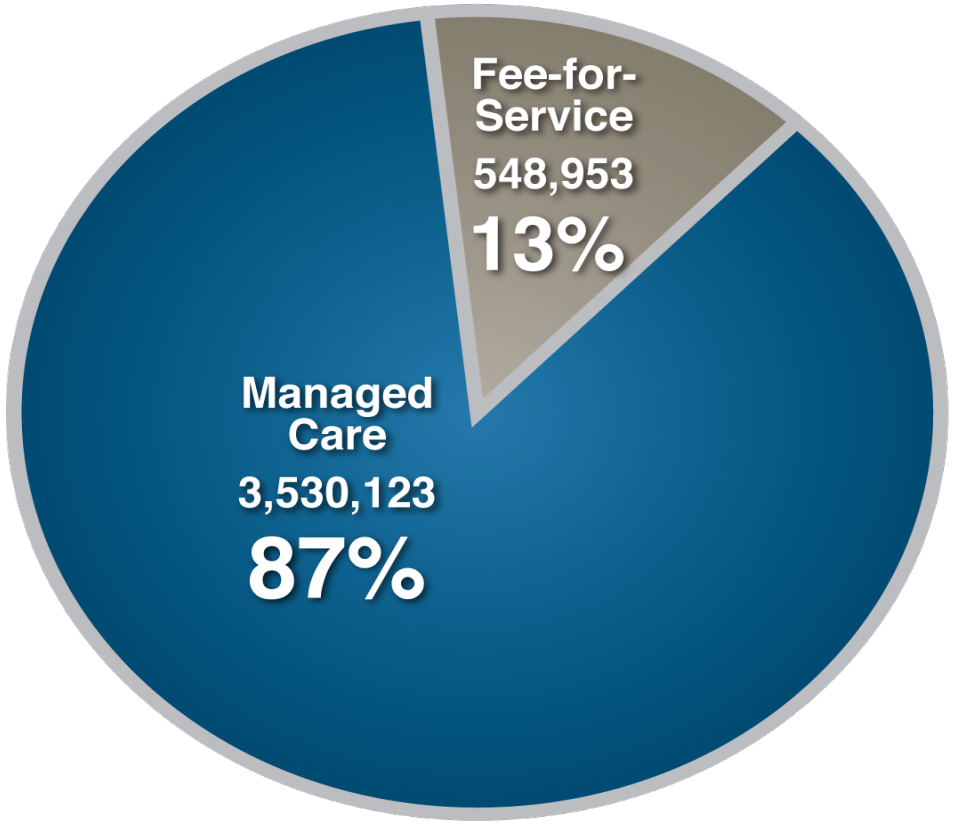
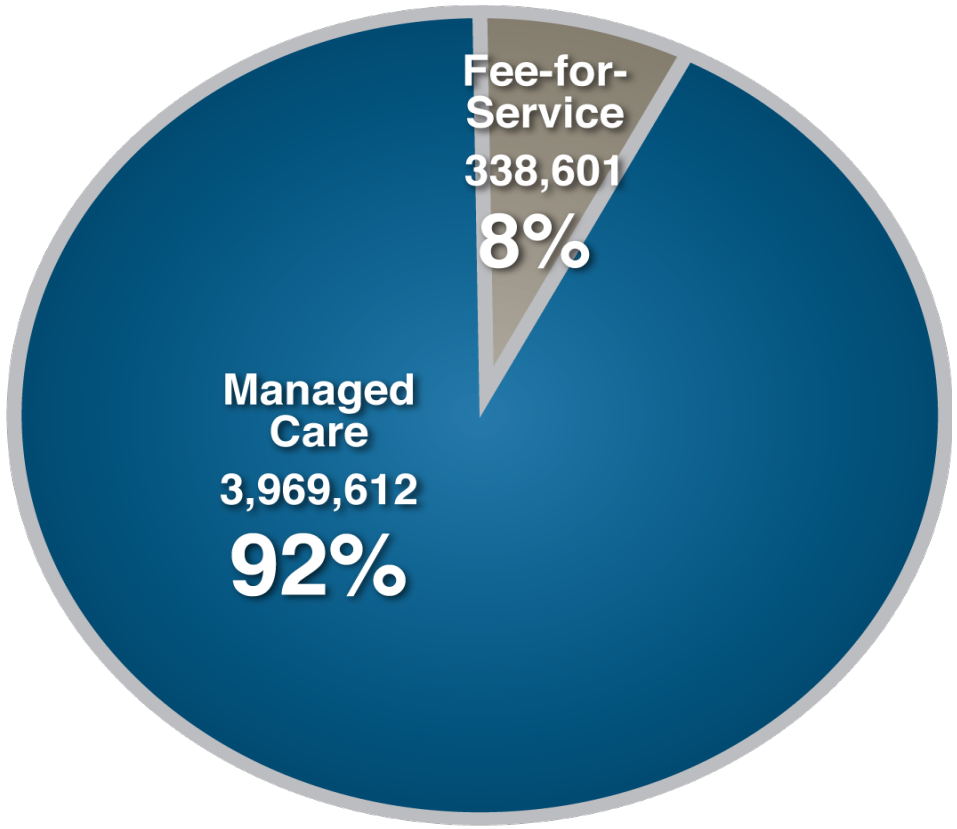
Texas Medicaid MCO Enrollment

FY 2015
Fee-for-Service vs. Managed Care
Total = 4,079,076



FY 2017
Fee-for-Service vs. Managed Care
Total = 4,308,213



Source: Texas Health and Human Services System 2015 Fact Book.

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The Value of Medicaid Managed Care in Texas

Goal of Managed Care: To better manage care to improve access, quality, and outcomes while ensuring appropriate utilization, containing costs, and reducing fraud and abuse.

Budget Certainty and Cost Containment: Premiums set once a year and MCOs assume the full financial risk of care delivery, limiting state exposure to costs

Profit-Sharing With the State

Improved Outcomes and Quality of Care

Increased Access: Contracted network of providers and network adequacy standards

Case Management and Care Coordination

Value-Added Benefits: Medicaid health plans tailor benefits and programs to the specific need of patient populations at no additional cost to the state

Increased Accountability: Rigorous oversight including audits, contractual requirements, performance guarantees and penalties, transparency, and outcomes not found in fee for service (FFS)

Guaranteed Provider Network

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Medicaid Network Adequacy

- **Practice of health plans establishing provider networks to ensure their members have guaranteed access to quality health care providers**
- **In Texas, Medicaid health plans must adhere to a number of stringent network adequacy standards, including**
  - Texas Department of Insurance (TDI)
  - Health and Human Services Commission(HHSC)
  - Centers for Medicare and Medicaid Services (CMS)
- **Texas Medicaid network adequacy standards are in line with or stronger than most other states' requirements**

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Medicaid Network Adequacy

- **Network adequacy in the Texas Medicaid program is evaluated using the combination of the following factors:**
  - Establishment of a medical home
  - How close providers are to patients (distant standards)
  - How quickly Medicaid patients can access care (client wait-time standards)
  - How often a patient has to go out-of-network (OON) to access care (OON utilization)
  - Patient Outcomes (Quality of Care)
  - Consumer Satisfaction
  - Consumer Complaints
- **Not just distance and wait times**
- **Evaluating any of these factors alone does not provide an accurate picture of what is happening in the MCO's network or how a MCO is ensuring access to care**

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Monitoring Network Adequacy

- **HHSC and the external quality review organization (EQRO) also monitor and enforce network adequacy through a number of activities:**
  - Readiness reviews
  - Quarterly provider network reports on primary care provider (PCP) and specialty providers, including (but not limited to): geo-access, provider networks, and the number of active provider types at the program, plan, and service area level (HHSC reviews the data and recommends corrective action plans or liquidated damages for MCOs that have deficiencies)
  - HHSC's Data Analytics Unit monitors network adequacy standards by tracking health care access and utilization trends
  - HHSC tracks member complaints by category, including access to care
  - EQRO tracks timeliness of care through member satisfaction surveys
  - HHSC's EQRO surveys select provider types and collects data on wait times for appointments
  - HHSC's EQRO monitors MCOs' compliance with 24/7 access requirements through member surveys
  - HHSC has quarterly calls and submits quarterly reports to federal CMS regarding MCO network adequacy which include provider network counts, geo-mapping standards, out-of-network utilization, access for members with special health care needs, 24/7 availability of specific services, and member and provider complaints and appeals
  - EQRO conducts "secret shopper" activities to validate provider availability and appointment timeliness in MCO networks

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Network Adequacy Distance Requirements

- **HHSC Geomapping**
  - Process of taking each individual member's residential address and testing their access millage to each provider type
  - Every Medicaid consumer address is mapped
  - Failure to meet standards, results in a corrective action plan being created by the HMO and being monitored by HHSC
  - Quarterly maps

- **TDI Geomapping (HMO License)**
  - Create a sample member for each zip code and test access for each provider type
  - Center of each zip code

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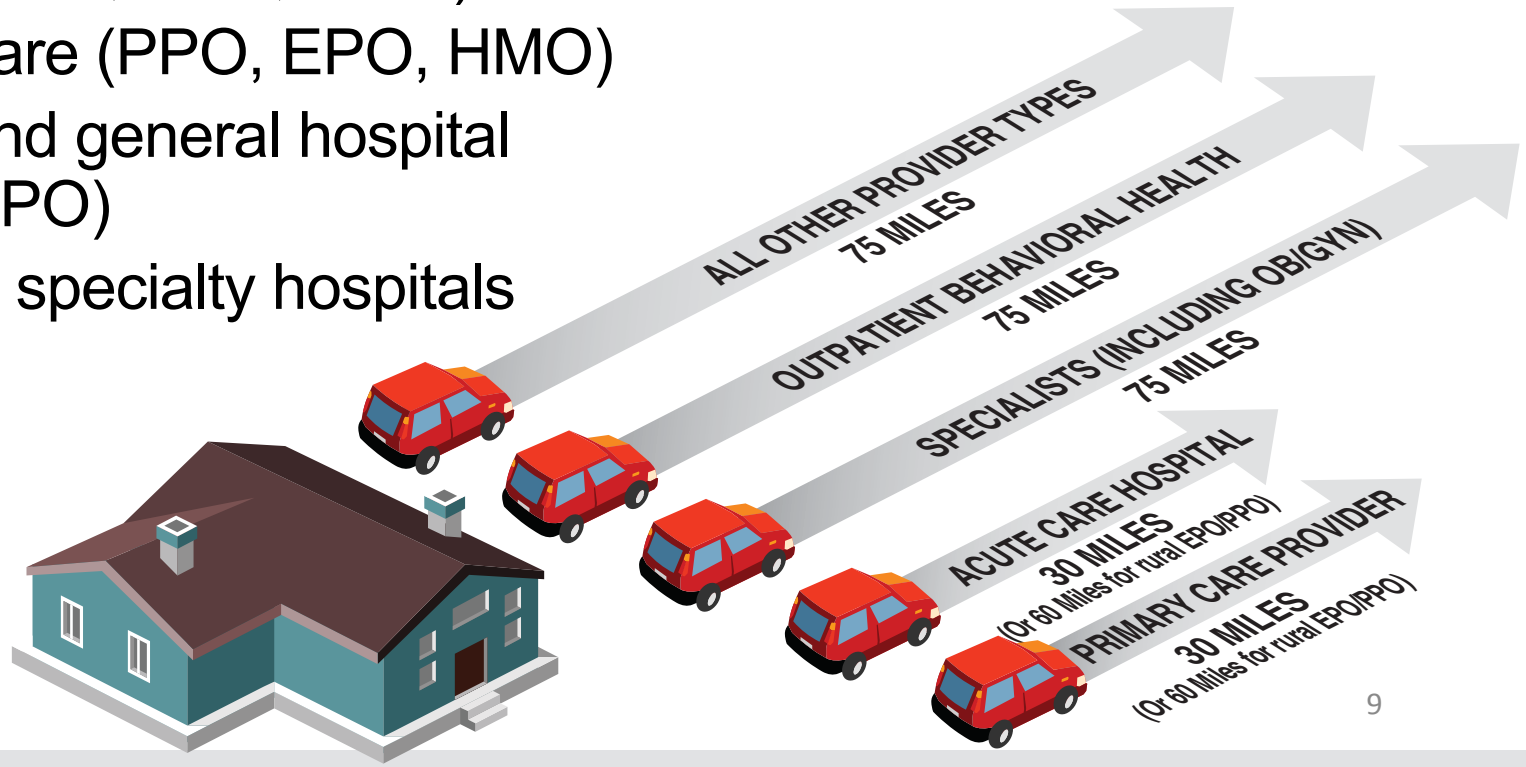
HHSC: Medicaid Distance Requirements

CATEGORY	PROVIDER TYPE	GEOGRAPHY	ACCESS REQUIREMENT	PERCENT OF MEMBERS
Medical Providers	PCP*	Statewide	30 miles	90%
	Acute Care Hospital		30 miles	
	Specialists (including OB/GYN)		75 miles	
	Outpatient Behavioral Health	Urban	30 miles	
		Rural	75 miles	
	All Other Provider Types	Statewide	75 miles	
Pharmacy	Non-MRSA**	Urban	2 miles	80%
		Suburban	5 miles	75%
		Rural	15 miles	90%
	MRSA	Urban	2 miles	75%
		Suburban	5 miles	55%
		Rural	15 miles	90%
	24-Hour Pharmacy	Statewide	75 miles	90%
Dental	Main Dentist	Urban	30 miles	95%
		Rural	75 miles	95%
	Specialists	Statewide	75 miles	75%

HHSC may assess up to $1,000 in liquidated damages per quarter, per program, per service area, and per provider type.

Texas Department of Insurance: Distance Requirements

- **Maximum distance from any point in a health plan's service area:**
  - 30 miles for primary care (PPO, EPO, HMO)
  - 30 miles general hospital care (PPO, EPO, HMO)
  - 60 miles for primary care and general hospital care in rural areas (PPO, EPO)
  - 75 miles for specialists and specialty hospitals (PPO, EPO, HMO)



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HHSC: Medicaid Wait Times

SERVICE TYPE	WAIT TIME
Emergency services	Upon member presentation at service delivery site
Urgent care	Within 24 hours
Routine primary care	Within 14 days
Initial outpatient behavioral health	Within 14 days
PCP referrals to specialty	No later than 30 days
Pre-natal care	Within 14 days
Pre-natal care for high-risk pregnancy	Within 5 days
Preventive health services—adults	Within 90 days
Preventive health services—children	In accordance with periodicity schedule

HHSC may assess up to $1,000 in liquidated damages per quarter, per program, per service area, and per provider type.

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Texas Department of Insurance: Wait Times

- **EPO & PPO Wait Times**
  - ER - 24 hours a day, 7 days a week
  - Non - emergency, urgent care - within 24 hours
  - Preventive care - within 2 months for a child and 3 months for adults
  - Appointment for medical condition - within 3 weeks
  - Appointment or behavioral health conditions - within 2 weeks
- **HMO Wait Times**
  - ER Care - 24 hours a day, 7 days a week
  - Preventive health - within 2 months for a child, 3 months for an adult, and 4 months for dental services
  - Routine care - within 3 weeks for medical services, 8 weeks for dental conditions, and 2 weeks for behavioral health conditions
  - Urgent care - within 24 hours for medical, dental, and behavioral health conditions

HHSC: Out-of-Network Utilization Thresholds

Use Out-of-Network Utilization Thresholds

Inpatient hospital admissions (applies to MCOs only)	No more than **15 percent** of a health care MCO's total hospital admissions, by service area, may occur in out-of-network facilities.
Emergency room visits (applies to MCOs only)	No more than **20 percent** of a health care MCO's total emergency room visits, by service area, may occur in out-of-network facilities.
All other services (applies to both MCOs and DMOs – dental managed care organizations)	No more than **20 percent** of total dollars billed to an MCO or DMO may be billed by out-of-network providers.

HHSC may assess up to $25,000 per quarter, per standard, per Medicaid MCO, per service area for MCOs that do not meet these standards.

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Medicaid Network Adequacy in Other States

When compared to other states, Texas' Medicaid network adequacy standards are in line with (or stronger than) other states' requirements.

DISTANCE REQUIREMENTS

- 32 states limit travel distance or travel time to PCPs; only 14 do so for specialists. **Texas has distance limits for both.**
- For states that have mileage standards for PCPs, standards range from 5 miles (urban areas) to 60 miles (rural areas). **Texas is in line with most states at 30 miles.**
- For the few states that have mileage requirements for specialists, the **Texas standard** for most specialty types (75 miles) **was within the normal range for other states.**
- (30-90 miles). **Texas has even stronger requirements** for behavioral health providers and main dentists in urban areas (30 miles).

CLIENT WAIT TIMES

- **31 states, including Texas,** require appointments to be provided within a prescribed time frame.
- All of these states have standards for PCPs that vary widely (10-45 days). **The Texas standard is 14 days for routine care** (only two states are lower) and **1 day for urgent care.**
- Only 21 states specify wait times for routine specialty care (states range from 10-60 days). **Texas is in line** with most states at **30 days for routine specialty care** and **1 day for urgent specialty care.**

Medicaid Network Adequacy

- MCOs are contractually and financially responsible for meeting HHSC's access standards and also for meeting quality measures through the Pay-for-Quality program
- As a result, MCOs are incentivized to proactively monitor and respond to issues related to access and quality of care that require performance improvement
- MCOs look comprehensively at their performance on network access standards as well as quality outcomes, and the interaction between the two, to identify issues and develop quality improvement plans
- Evaluating any factor in isolation doesn't provide an accurate picture of what is happening in a MCO's network and whether the MCO's members have access to care
- This is why MCOs monitor and analyze a variety of data including:
  - geo-access maps
  - member satisfaction and complaint data
  - provider access surveys (e.g., after-hours care access, linguistic access, appointment availability)
  - health care outcomes, geo-mapping of provider access
  - out-of-network utilization rates
  - other data related to quality and access to care
- Majority of MCOs are NCQA and URAC accredited – another set of very stringent network adequacy rules and monitoring

Medicaid MCOs Outcomes & Access

- **MCOs are required to ensure 100% of consumers have a PCP within 5 business days of MCO enrollment**
- **In FY14, HHSC confirmed that all MCOs assigned members to a PCP and there were at least two age-appropriate PCPs within established mileage standards for all members**
- **PCP Open Panel Rates – FY2014**
  - STAR: Reached 90% in 2015
  - STAR PLUS: Reached 90% in 2015
- **Both dental plans met the state's 90% standard for main dentists with an open panel in every fiscal quarter of 2014**
- **2015 MCO provider participation:**
  - STAR: 18,155 (increased in 2014 and 2015)
  - STAR+PLUS: (increased in 2014 and 2015)

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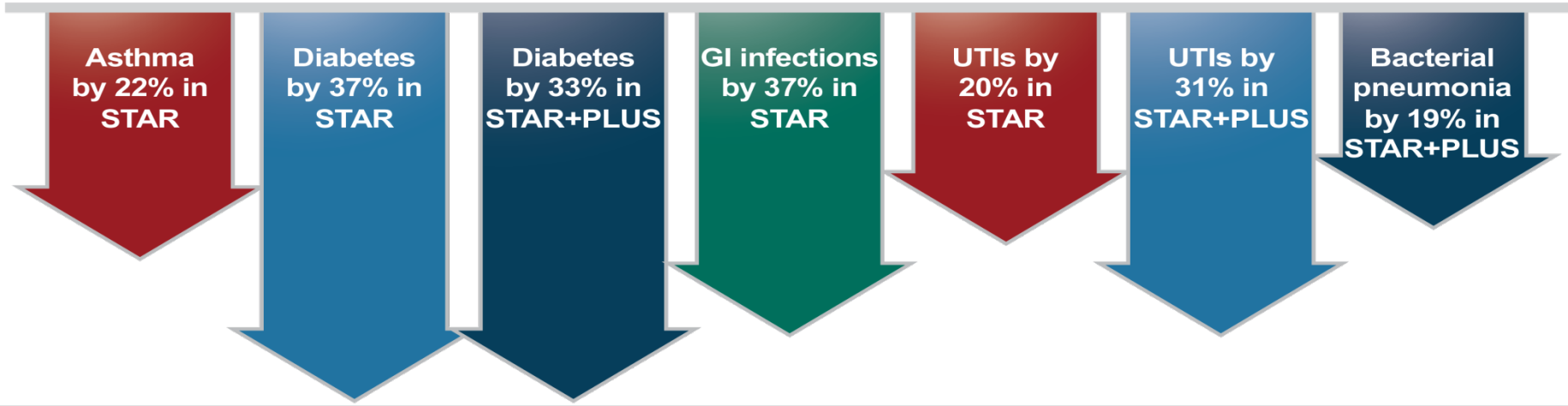
Medicaid MCOs Outcomes & Access

- The most valuable measure of access to care is to monitor quality of care measures, the impact of these measures on a patient's overall health, and the level of satisfaction patients express about their ability to access care and the quality of that care
- Data shows that Texas Medicaid MCOs have made significant strides in improving health outcomes and reducing hospital admissions for some of the most common, preventable conditions
- For example, between 2009 and 2011, hospital admissions related to asthma, diabetes, GI infections, and UTIs were reduced by 20%- 40% under managed care



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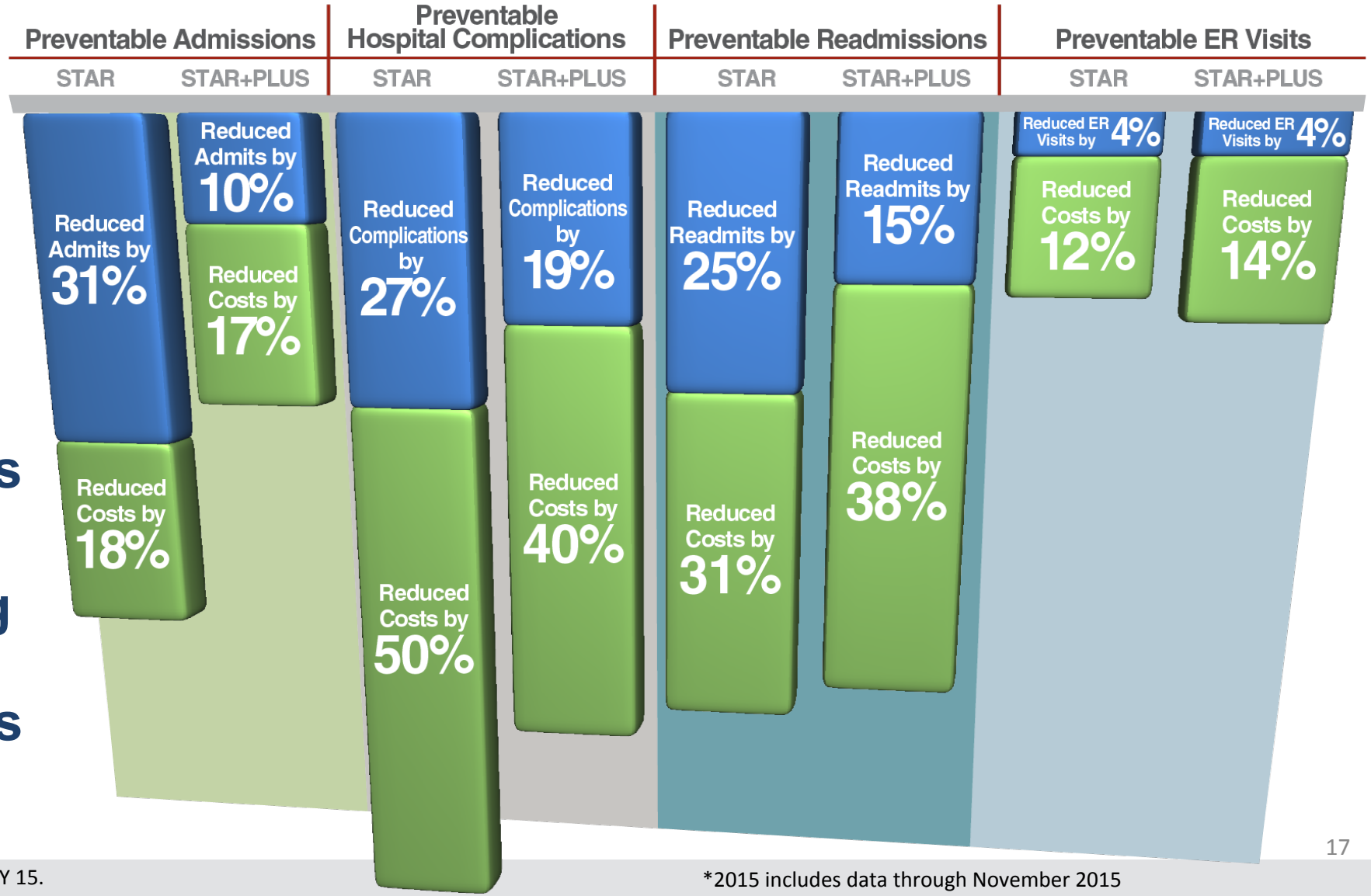
Medicaid MCOs Outcomes & Access

P4Q Program:

- Focuses on outcomes
- 4% of MCO premium payments at risk for quality
- Focus on reducing Potentially Preventable Events (PPEs)

Medicaid Health Plans Reduced Potentially Preventable Events



Source: HHSC Interactive MCO PPE Report CY 12- CY 15.

*2015 includes data through November 2015

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Medicaid MCOs Outcomes & Access

- EQRO conduct surveys related to member satisfaction with timeliness and access to primary and specialist care
- Consumer satisfaction and consumer complaints are a useful tool for assessing access to care

Consumer Satisfaction

The most important way to measure access to care is to ask consumers directly. Medicaid managed care members have a high satisfaction rate with their care:

- Over 70% of adult members in STAR and STAR+PLUS report that they "usually" or "always" had positive experiences with timeliness of care
- 83% of parents report that they are "usually" or "always" satisfied with timeliness of care for their children
- 93% of parents also report that their child has access to their primary care provider (PCP) when needed

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Texas Medicaid Networks: Current Realties

- **Most network adequacy gaps are systemic and not associated with just one health plan**
- **Texas is a large, geographically diverse state**
- **Texas has many provider shortage areas that impact the entire health care system, not just Medicaid**
- **Lower reimbursement rates relative to other payers are associated with lower levels of physicians participation**
  - A 10 percentage point increase in the fee ratio (Medicaid to Medicare) correlated with a 4 percentage point increase in the acceptance of new Medicaid patients
- **Medicaid enrollment and administrative requirements are a barrier**
- **Strained contract negotiations between hospitals and MCOs**
- **Layering on additional network adequacy measures and paperwork will not fix these problems**

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Network Adequacy Recommendations

- **HHSC collects an extraordinary amount of data related to quality and access in its contract monitoring of the MCOs**
  - Lack of a comprehensive report or format looks across access standards and quality of care outcomes to provide a full picture
  - As required by SB 760, HHSC will begin submitting a biennial report to the Legislature, which will also be available to the public, containing information and statistics about member access to providers through the MCO provider networks, MCO compliance with provider access standards, and a description, analysis, and results from HHSC's monitoring of the MCO networks
  - TAHP believes this report is a step in the right direction and that HHSC should ensure that this report provides a comprehensive picture of MCO performance across quality outcomes and access to care.
- **Before layering on additional access standards that may not provide additional information and instead only increase administrative burdens and costs, HHSC should provide a comprehensive analysis of access and quality data the agency is already collecting, including reviewing member complaints**
- **Texas needs a comprehensive assessment on levels of Medicaid provider participation**
  - Most of the current information is anecdotal or based on surveys versus data
- **While distance and wait time standards are common and useful way to assess network adequacy standards, the state should be cautious about over-reliance on these standards alone**
- **More focus on outcome measures: A more reliable method of measuring how well members are able to access medical services are the quality-of-care outcome measures, the impact of these measures on members' health, and the level of satisfaction members express about their ability to access care and the quality of care**

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Network Adequacy Recommendations

- **While distance and wait time standards are common and useful ways to assess network adequacy, the state should be cautious about over-reliance on these standards alone**
  - Distance standards are not always appropriate, especially in a large, geographically diverse state like Texas, and may have the unintended consequence of pushing people to seek care that is closer, but poorer quality, especially when it comes to specialty care or rare health conditions
- **Having a consistent point of contact at the MCOs should help alleviate confusion among members and providers on who to contact when trying to find an available provider**
- **TAHP believes wait times for appointments by service type are a more appropriate standard rather than distance and ratio standards, particularly in a geographically large and diverse state like Texas**
  - Wait time standards should be realistic compared to wait times in other health care markets, which are almost always higher payers than the Medicaid program
  - MCO compliance with any additional wait time standards would need to be monitored by HHSC through "secret shopper" activities, member satisfaction surveys, physician reported information, and complaints
- **Enhanced mileage standards should be by specialty type and should take into consideration rural versus metro:**
  - Texas ranks close to the bottom in physicians per capita; accessibility for certain types of physicians, especially certain specialists, is challenging even with commercial insurance
  - Texas is geographically diverse - the current 75 mile requirement for specialists may be too far in large urban areas, yet too restrictive in our very rural/frontier portions of the state where few residents reside. It's also important to note that distance standards are not appropriate for all services types
- **Regarding ratios, HHSC is already using wait time standards and distance requirements - adding provider to member ratios adds no value to the state in terms of monitoring access to care because ratios do not tell you whether a member is actually accessing care**

Provider Directories

- **Accuracy and completeness of provider directories is a critical issue for health plans, providers and consumers**
- **"Shared Responsibility" – Providers and health plans have a shared responsibility to update and maintain provider directories**
  - The information is only as good and as up-to-date as the information provided by a provider office
- **Today, health plans employ a variety of approaches to maintain and update provider directory data:**
  - scheduled phone calls
  - follow-up faxes
  - emails
  - in-person visits
  - contractual requirements between health plans and providers to ensure information is accurate and up-to-date
- **New CMS Medicaid MCO Rules will impact provider directory requirements**
- **Because paper directories are out-of-date as soon as they are printed, TAHP recommends that all Medicaid members receive a paper directory only upon request**

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Expedited Credentialing

- **Expedited credentialing:**
  - Requires MCOs to pay a non-credentialed provider during the credentialing process (30 days)
  - Does NOT mean a faster credentialing process
- **Credentialing must be completed within 90 days**
- **Credentialing is critical to patient safety and protecting the state from fraud and abuse**
- **Already allowed and required:**
  - All health plans in Texas, including Medicaid MCOs, are required to expedite the credentialing and payment of physicians, podiatrist, and therapeutic optometrists who have joined established medical groups or professional practices already in their contract
  - MCOs already allow non-contracted providers to provide services while the credentialing process is underway on a case-by-case basis
- **Concerns and recommendations:**
  - Broad expansion of expedited credentialing would require health plans to reimburse large number of providers that have not been scrutinized for fraud and abuse, quality of care, or patient safety
  - Should be limited to providers joining an existing group
  - Access standards should be the primary driver for any decision to expand expedited credentialing

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Improving Provider Participation in Medicaid

- TAHP is currently procuring a CVO for use by all Medicaid health plans to reduce administrative burden for providers
- TAHP is designing and implementing a resource web site that would compile helpful information and links for providers participating in Medicaid managed care
- Working with HHSC to improve their Medicaid provider enrollment process

Addressing Systemic Access Concerns

- **TAHP believes there are significant opportunities through a partnership between HHSC, the MCOs, and provider groups/associations working together to improve provider education and outreach**
  - One such opportunity would be for HHSC to work with the MCOs and provider groups/ associations in specific areas of the state where there are identified provider shortages and/or access issues to determine how to serve Medicaid members in that area
- **Work together to reach out to providers not currently accepting Medicaid who may not be aware of all of the improvements that are underway in Medicaid, and managed care more specifically**
- **Another opportunity is to make education/training available to providers for specific Medicaid populations**
  - For example, additional education/training for providers related to serving individuals with IDD could increase the number of providers who understand and are willing to serve the specific needs of this population

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New CMS Medicaid MCO Rules

- On April 25, 2016, the final CMS rule on Medicaid managed care was released
- The 1,500-page rule contains numerous provisions
- Requires states to develop and CMS approve time and distance standards for:
  - Primary care, both adult and pediatric
  - Obstetrical and gynecology services
  - Behavioral health (both adult and pediatric)
  - Adult and pediatric specialty care
  - Hospital care
  - Pharmacy services
  - Dental care
- Rules will require substantial changes in the Texas Medicaid Managed Care program
- TAHP looks forward to working with HHSC on implementation of the new managed care rules
- Texas has been proactive on network adequacy and will not have to make substantial changes to current standards