

Medicaid Managed Care: Ensuring Access to Quality Care



Texas is a national leader in the use of managed care to increase access to care, manage costs, and improve health quality in its Medicaid and CHIP programs. The managed care private market approach drives innovation through flexibility and

competition reduces health care costs and holds managed care organizations (MCOs), also referred to as Texas Medicaid health plans, accountable for providing access to quality care.

Access to care is an essential part of any health care delivery system, and the Texas Medicaid program is no exception. Ensuring that Medicaid consumers have access to the right kind of care for their needs at the right time leads to improved health outcomes for Medicaid patients and lower costs for Texas taxpayers.

For the past several years, Texas Medicaid has moved from the traditional fee-for-service model (FFS) to the managed care approach, in which the state contracts with MCOs, also called Medicaid health plans, to provide and administer benefits to Medicaid clients. Unlike the FFS model, which pays for services based on volume, Texas Medicaid health plans are risk-

based, which means the state pays each plan a fixed per-person, per-month fee (known as capitation or premium) for all of the Medicaid clients enrolled in that plan. In return for this premium, the Medicaid health plan provides its enrollees with comprehensive health benefits and assumes the full financial risk of costs related to providing and administering those benefits.

Texas MCOs establish provider networks to ensure their members have guaranteed access to quality health care providers. Many states, including Texas, have enacted network adequacy standards to ensure that Medicaid health plans are providing access to the right kind of care for their members at the right time and the right location. “Network adequacy” refers to a health plan’s ability to deliver plan benefits by providing reasonable access to a sufficient number of contracted providers. To meet Texas’ network adequacy standards, Texas Medicaid health plans are incentivized to proactively monitor and respond to issues related to access and quality of care that require improvements.

Texas’ 20 Medicaid/CHIP MCOs have effectively improved access to and quality of care for Texas Medicaid beneficiaries while containing costs for the state. Additionally, Texas MCOs have implemented innovative solutions not possible under the traditional FFS model to improve access to care beyond network adequacy requirements.

Texas Medicaid Health Plans: Successfully Ensuring Access to Care

Over the past several years, Texas MCOs have:

- **Significantly reduced hospital admissions** for common, preventable conditions: Admissions are **down anywhere from 20 to nearly 40 percent** for asthma, diabetes, GI infections and more
- **Increased network access to primary care doctors and specialists**
- **Met and exceeded** a number of **national and state standards** for improving access to timely and quality care
- **Surpassed national performance** expectations on access to child well visits and childhood immunizations
- Ensured all Medicaid adults and children **have access to a primary care doctor** who is willing to see new patients and is within 30 miles of their homes
- Ensured a **high level of consumer satisfaction**: 83% of families with children in managed care report an overall positive experience with their MCO
- **Improved access to primary care**: 93% of parents report having access to their child’s PCP when needed
- **Improved access to timely prenatal care**

What is Network Adequacy?

When discussing access to care, the primary term used by the health care industry and policy makers is “**network adequacy**.” This is the practice of health care plans establishing provider networks to ensure their members have guaranteed access to quality health care providers. In Texas, the health plans that manage Medicaid, MCOs, must comply with a number of stringent network adequacy standards, including those issued by the Texas Department of Insurance (TDI) and the Health and Human Services Commission (HHSC), as well as federal standards enforced by the Centers for Medicare and Medicaid Services (CMS).

The result is a robust set of network adequacy requirements and monitoring activities that ensure Medicaid managed care enrollees have access to timely and quality care.

Network adequacy is evaluated using the combination of the following factors:

- Establishment of a medical home
- How close providers are to patients (distance 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

Evaluating any of these factors alone does not provide an accurate picture of what’s happening in the MCOs’ networks and whether clients have access to care. It is also important to look at underlying provider trends and shortages across the state. With diverse populations and wide rural areas, Texas has a systemic, underlying provider shortage crisis in both rural areas and specialty care that goes beyond network adequacy standards and requires a more comprehensive solution. This solution would include greater efforts to recruit and graduate physicians who practice in Texas. More simply stated, MCOs can only do so much to meet adequacy standards when an underlying statewide provider shortage exists.

Provider shortages impacting other payers (commercial, Medicare, etc.) will impact the Medicaid MCOs as well, and usually to a greater degree, since Medicaid tends to be the lowest payer in the health care system.

Providers Included in an MCO’s Network

The **provider network** established by an MCO includes physicians, hospitals, pharmacies and other health care providers who have:

- Agreed to see patients covered by that MCO
- Agreed to accept the MCOs contracted rates, which helps contain costs for the State and taxpayers
- Been selected to meet that MCO’s requirements, which ensures the MCO is meeting state and federal adequacy standards and that patients receive quality, safe care at the right place and the right time

Access To The Right Care, At The Right Time, In The Right Place

The managed care model provides greater accountability for network adequacy and access to care than the traditional fee-for-service model that it replaced. Unlike FFS, MCOs are legally, contractually and financially accountable for ensuring that their members get the right care, at the right time, and in the right location. MCOs must meet all TDI licensure standards, including access to care standards. Additionally, MCOs must meet all of HHSC’s contractual standards, which include numerous network access standards and reporting requirements related to access to care. MCOs who fail to meet these standards risk contractual remedies and financial losses.

As a result, MCOs proactively monitor and respond to issues related to access to care that require performance improvement. MCOs identify these issues by looking comprehensively at consumer 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, and other data related to access to care. When

consumers have trouble locating a provider, they can contact their MCO for assistance, a benefit that was not available under the FFS model.

To ensure access to the right kind of providers, every patient covered by an MCO is guaranteed a “**medical home**,” which is a care delivery model in which patient treatment is coordinated through a centralized setting—the patient’s **primary care physician (PCP)**. Through the PCP, care is facilitated by partnerships with any other providers seen by the patient, and in some cases, the patient’s family members; by registries; information technology; health information exchange; and other means to ensure the patient is receiving necessary and timely care, delivered in a manner they can easily understand.

Through the medical home and its network of providers, MCOs provide a number of services to patients including **preventive care access, service coordination, access to long-term services and supports** and a number of additional **value-added services**.

What Are Value Added Services?

Value-added services are services that are not covered by Traditional FFS Medicaid and are provided by MCOs at no cost to the state. MCOs provide these services because they are cost-effective and improve patient outcomes. Many of the value-added services provided by MCOs enhance members' access to care in ways not available under FFS Medicaid:

- 24-hour nurse line
- Additional dental, vision, transportation services
- Health and wellness programs
- Meals and nutrition
- Respite services
- Other cost-effective services not covered by the traditional FFS model

Texas Provider Access Standards

To monitor whether Medicaid MCOs are providing their members' with access to care, the state has established several specific standards related to access, including client wait times, limits on how far a patient has to travel to get care, and limits on the use of out-of-network providers by MCOs.

Under state and federal network adequacy standards, Texas MCOs must ensure patients are seen by a provider in a timely manner. As detailed below, HHSC has established client wait times standards – wait times must not exceed specific periods of times, based on the type of care the patient is seeking.

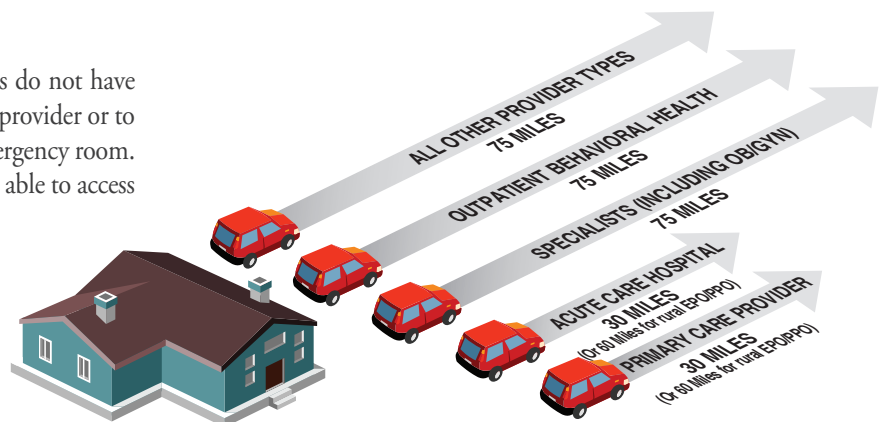
Client Wait Times Standards

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.

TDI Travel Distance Requirements

Under TDI standards, MCOs must ensure that patients do not have to travel farther than 30 miles to visit their primary care provider or to seek acute medical care, such as visiting a hospital or emergency room. For visits to specialists and other providers, they must be able to access a provider within a 75-mile radius from their residence.



Medicaid Distance Requirements

HHSC contractually holds the Medicaid MCOs to even more stringent distance standards depending on the type of provider and geography (urban, rural, suburban).

CATEGORY	PROVIDER TYPE	GEOGRAPHY	PERCENT OF MEMBERS	ACCESS REQUIREMENT	
Medical Providers	PCP	Statewide	90%	30 miles	
	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	80%	2 miles	
		Suburban	75%	5 miles	
		Rural	90%	15 miles	
	MRSA	Urban	75%	2 miles	
		Suburban	55%	5 miles	
		Rural	90%	15 miles	
24-Hour Pharmacy	Statewide	90%	75 miles		
Dental	Main Dentist	Urban	95%	30 miles	
		Rural	95%	75 miles	
	Specialists	Statewide	75%	75 miles	

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

HHSC does allow special exceptions to the Medicaid distance standards under certain limited circumstances:

- A lack of Medicaid enrolled providers of type and specialty in the area;
- A lack of providers of type and specialty in the area;
- Contracting issues (provider refuses to contract)

Medicaid Network Adequacy in Other States

When compared to other states, Texas' Medicaid network adequacy standards are in line (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.**

Monitoring Out-of-Network Use to Identify Needs

One important way to gauge if a Medicaid health plan's provider network is appropriately providing access to care is to monitor the how often beneficiaries seek services through the health plan's network versus how often they are having to seek care outside the network. If

HHSC determines that consumers are having to seek more out-of-network care, the agency may penalize the health plan. HHSC sets limits for the amount of out-of-network care (OON), and it should not exceed the following thresholds in each quarter.

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 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.

HHSC allows special consideration for MCOs who exceed the OON threshold if the MCO can demonstrate substantial efforts to contract with an OON provider. If the state grants the special consideration, the non-contracted provider is removed from the plan's OON calculation.

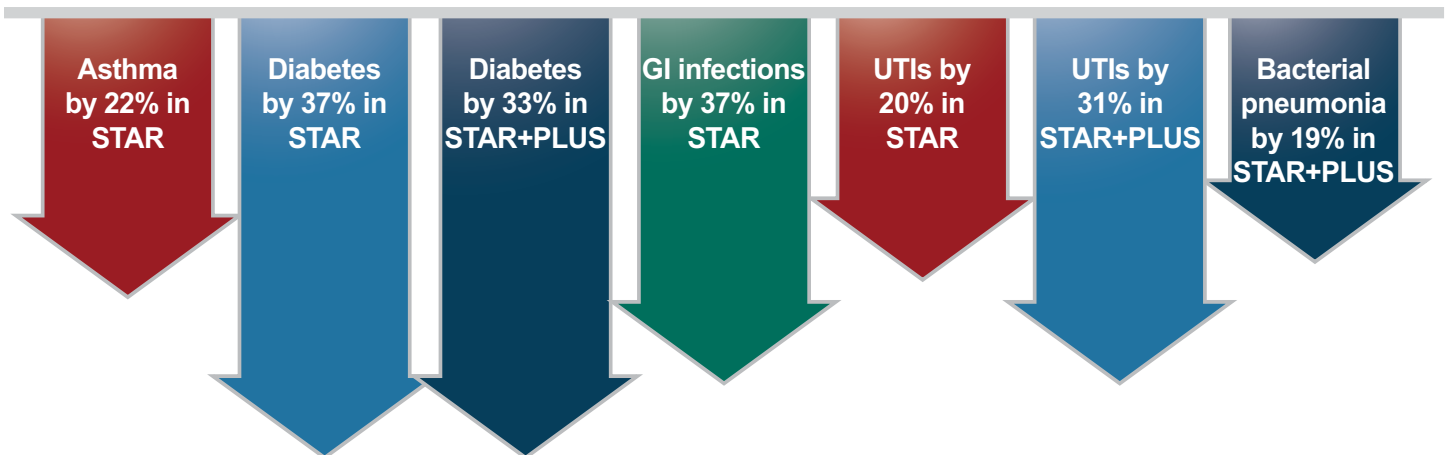
Patient Outcomes

While distance and wait time standards are common and useful ways to assess network adequacy, perhaps a more important method to measure how well patients are able to access medical services 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. Research shows that Texas MCOs have made significant strides in improving patient health and reducing unnecessary hospital admissions.

For example, diabetes and asthma are two very common conditions in the Medicaid program that should not result in hospitalizations if enrollees have access to appropriate care and care management. Between 2009 and 2011, Medicaid MCOs dramatically reduced hospitalizations—down anywhere from 20 to nearly 40 percent—related to these common conditions: a clear indication that patients had timely access to the care they needed.

MCOs Improved Quality of Care

Between 2009 and 2011,
MCOs reduced hospital admissions for:



Patients Are Satisfied With Their Care

Just as important, Medicaid patients in Texas are expressing satisfaction with their ability to access health care services and the quality of those services.

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**

Additional MCO Access to Care Requirements

In addition to network adequacy standards, there are a number of other requirements on MCOs that ensure access to care and continuity of care for consumers in Medicaid managed care:

- **Significant Traditional Providers:** For the first three years post-implementation of managed care, MCOs are required to offer a network contract to providers who traditionally provided services under the FFS model.
- **Authorizations:** During transitions to managed care, MCOs must honor service authorizations the member received under FFS for acute care services (for 90 days or until a new authorization is in place, whichever is shorter) and long-term services and supports (for up to 120 days or until a new authorization is put in place).
- **Single Case Agreements:** If a member’s provider does not wish to be in a MCO’s network, the provider can still treat the member on a case-by-case basis through a single case agreement with the member’s MCO.
- **24/7 Access Requirements:** MCOs are required to make certain services (emergency services, toll-free emergency and crisis behavioral health services hotlines, PCPs and PCP after-hours availability) available 24/7.

Maintaining Current, Helpful Provider Directories

To promote access to care, Texas Medicaid health plans must update their provider directories on a quarterly basis. They are required to update their online provider directories at least twice a month. Plans must also mail member handbooks to new members no later than five

days after receiving the state’s enrollment file, and to all members at least once annually and upon request. The handbooks must provide an easily understandable description of how to access primary and specialty care.

Through these handbooks and other efforts, Texas Medicaid health plans must provide helpful tips on these topics:

- How managed care operates and the role of primary care providers
- How to obtain covered services
- The value of screenings and preventive care
- How to obtain transportation to medical appointments



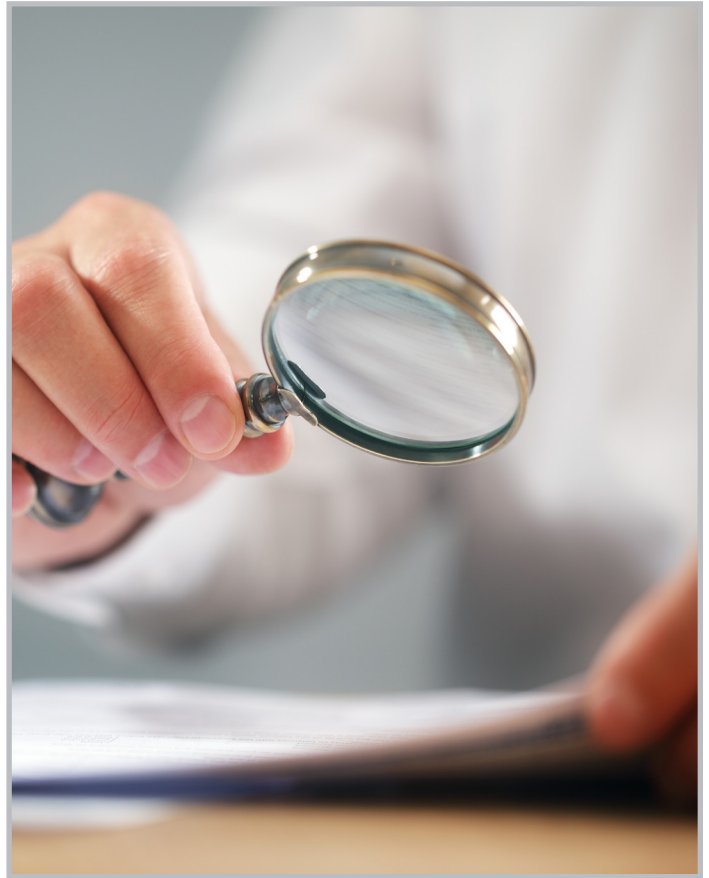
How Texas Monitors and Enforces Network Adequacy

As a national leader in the use of managed care to improve access to care and health care outcomes and reduce costs, Texas serves as a model for other states in its oversight and accountability of MCOs. The specific network adequacy requirements for Texas Medicaid MCOs are spelled out in HHSC's contracts with the MCOs. If an MCO fails to meet these standards, HHSC can take punitive action such as liquidated damages or corrective action plans. In addition, MCO contracts can be terminated for not meeting contractual standards, including network access standards. In the same vein, TDI can take action against a Medicaid MCO's license for failing to meet its access standards. It's important to note that whenever there are multiple federal/state requirements that address the same access standard, the MCOs are subject to the most stringent standard.

HHSC is federally required to contract with an independent, external quality review organization (EQRO) that helps the agency monitor whether the MCOs are meeting contractual requirements related to quality and access to care. HHSC and its EQRO monitor and enforce network adequacy among Texas MCOs through a number of activities:

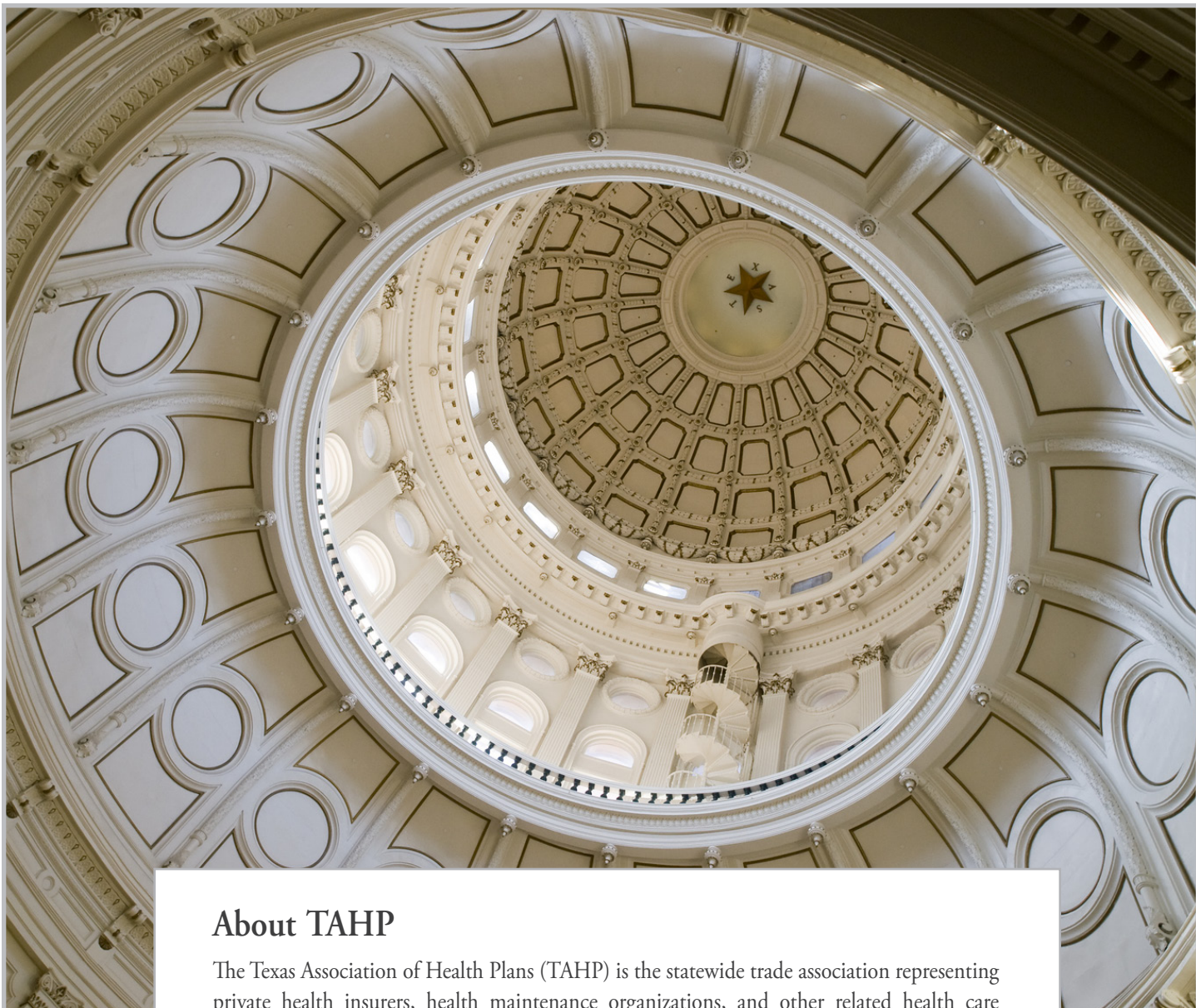
- HHSC conducts **readiness reviews** to determine an MCO's ability, preparedness, and availability to fulfill its obligations, including provider access, prior to ever allowing the MCO to enroll members
- HHSC requires MCOs to submit **quarterly provider network reports** on primary care provider (PCP) and specialty providers, including (but not limited to) geoaccess, 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
- HHSC's EQRO tracks timeliness of care through **consumer 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 consumer surveys
- HHSC 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

- HHSC has **quarterly calls with CMS** and has not received any concerns from CMS related to MCO network adequacy on these calls



In addition to the threat of liquidated damages and other contractual remedies, HHSC's Pay-for-Quality (P4Q) program also holds the MCOs financially accountable through sizeable penalties, up to 4% of the premium paid by the state, if the MCO does not meet the state's quality of care outcome measures. These measures include: reducing preventable hospital admissions, hospital readmissions, and emergency room visits. An MCO's performance on these measures is indicative of the accessibility and quality of care received by members in the MCO's network. Ultimately, an MCO will not be able to meet these thresholds if it is not providing appropriate access to care and care management.

As required by SB 760 (84R, Senator Schwertner), HHSC will also begin submitting a biennial report to the Legislature, which will also be available to the public, containing information and statistics about recipient 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.



About TAHP

The Texas Association of Health Plans (TAHP) is the statewide trade association representing private health insurers, health maintenance organizations, and other related health care entities operating in Texas. As the voice for health plans in Texas, TAHP strives to increase public awareness about our members' services, health care delivery benefits and contributions to communities throughout the state.

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