CMS released the Medicaid and CHIP Managed Care Final Rule to “modernize Medicaid managed care regulation to reflect changes in the usage of managed care delivery systems.”2 As a result of the final rule, states will need to update their managed care contracts and supporting documentation to address new regulations regarding provider network adequacy and beneficiary access to services. To truly improve access, however, states must also evaluate their methodologies for developing network adequacy requirements, processes for monitoring provider networks, exceptions, and enforcement tools.

The final rule establishes new requirements formalizing provider network adequacy standards for Medicaid managed care programs, which will become effective July 1, 2018.

According to CAHPS Health Plan Survey data, only 54% of adults and 59% of children enrolled in Medicaid health plans in 2015 reported that it was often easy to access needed care and schedule appointments with specialists as soon as needed.3

We reviewed contracts to determine:

- Compliance with the new CMS regulations relative to network adequacy (42 CFR 438.68 and 438.207) in four key areas:
  - Time and Distance Standards
  - Exceptions to Provider Network Standards
  - Required Elements for Provider Network Establishment
  - Provider Network Documentation
- Monitoring approaches the states rely on to enforce access requirements

While other regulatory sources may include network adequacy requirements (e.g., state Medicaid and insurance regulations, accreditation organization guidelines, policy guidance from CMS and states), Navigant reviewed risk-based contracts because they are the primary Medicaid managed care arrangement used to enforce program requirements and hold contractors accountable.

Overall, states will need to develop or build upon existing network adequacy standards for provider types where there are not already defined standards and develop monitoring approaches and policies for exceptions. Although states have until July 2018 to comply with the regulations, we recommend that states begin to analyze population-specific data and leverage existing network standards (e.g., Medicare Advantage, Qualified Health Plans) to meet the new regulations as soon as possible. States will be challenged by competing internal agency priorities, tightening budgets, and finite resources to analyze and determine the accuracy and appropriateness of set standards.

Key findings from Navigant’s analysis of state Medicaid managed care contracts include:

1. **Most states will need to develop time and distance standards for additional provider types.** Although approximately half (53%) of state contracts include time and distance standards for at least one required provider type, only two state contracts contained time and distance standards for each of the seven provider types specified in the new regulations.

2. **Nearly every state must delineate specific time and distance standards for adults and children related to the following provider types:** primary care providers (PCPs), specialists, and behavioral health. Only four state contracts (13%) currently include breakouts for adult and child time and distance standards for the select provider types.

3. **States should formalize approaches for overseeing exceptions to standards.** Only three states (10%) include contract provisions that meet all of CMS’s requirements for monitoring exceptions. While states may already use these approaches in internal processes and state regulations, states should also specify them in contracts to enhance the ability to enforce exceptions.

4. **Given the elevated focus on network adequacy, states should evaluate their current monitoring and oversight practices.** States will need to improve the rigor of network adequacy analyses, better leverage data analytics, and enhance reporting to determine if there is appropriate access to services. When identifying deficiencies, states will need the tools and the willingness to enforce corrective action plans, sanctions, and penalties.

**TIME AND DISTANCE STANDARDS**

CMS’s new regulations require that states develop time (minutes) and distance (miles) network adequacy standards for the following provider types:

1. PCP (adult and pediatric)
2. Behavioral health (adult and pediatric)
3. Specialist (adult and pediatric)
4. OB/GYN
5. Hospital
6. Pharmacy
7. Pediatric dental
8. Additional provider types that promote state objectives

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3. **Managed Care, 42 C.F.R. § 438.68 (b).**
States retain the flexibility to develop their own unique time and distance standards for various geographic regions rather than follow specified national standards. To date, most states include time and distance standards in their managed care contracts to some extent. Our research indicates that 27 state contracts (90%) include a time or distance standard for at least one of the required provider types. However, only two states (7%) have both time and distance standards for all seven specified provider types. As shown in the chart below, states most frequently include time and distance standards for PCPs, and most frequently fail to include them for OB/GYN providers.

The final rule also requires states to delineate time and distance standards for both adults and children for three provider types: PCPs, behavioral health, and specialists. We found that approximately one in three states (32%) include both adult and child breakouts for any provider type, and only four states (14%) meet the new requirements for all required provider types.5

EXCEPTIONS TO PROVIDER NETWORK STANDARDS

CMS acknowledges that local patterns of care, such as a lack of providers in a given region, may require a contractor to seek an exception to the established provider network standard. Federal regulations require that, to the extent a state permits an exception, states must:6

- Specify in the contract the standard for evaluating the exception;
- Base the standard, at a minimum, on the number of healthcare professionals in that specialty practicing in the service area; and
- Outline how the state will monitor enrollee access to providers in networks that operate under an exception and report to CMS annually.

73% of states grant exceptions to provider network standards.

Only 10% of states included contract provisions meeting all of CMS’s requirements listed above.

While some states may already use these approaches in their internal exceptions and monitoring processes, states should also specify these elements in contracts to enhance their ability to enforce exceptions and hold managed care organizations accountable for meeting requirements.

REQUIRED ELEMENTS FOR ESTABLISHING PROVIDER NETWORK STANDARDS

CMS requires that states consider nine elements when developing network adequacy standards and establishing provider networks. Although CMS does not require inclusion of these elements in contracts (i.e., states can also include these in other documentation outside of the contract), states generally require contractors to consider these elements, and thus should consider including them in their risk-based contracts. No state included all nine of the required elements in its managed care contracts.

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5. Two contracts examined covered population ages 21 and over only; thus would not be required to delineate adult and child breakouts for time and distance standards. Therefore, the total contracts examined for this section of the analysis was 28 instead of 30.

6. Managed Care, 42 C.F.R. § 438.68 (d) 1-2 (2016).
As a result of the growing Limited English Proficiency (LEP) population and to comply with CMS regulations, many states should require that contractors consider the ability of providers to communicate with LEP enrollees in the development of provider networks. In particular, 12 state contracts (40%) do not include provisions requiring network standards to account for a provider’s ability to communicate with LEP enrollees.

Federal Medicaid managed care regulations previously required consideration of LEP in enrollee communication. As a result, most states already have a starting point for compliance. The new regulations now require this consideration when developing network adequacy standards.

<table>
<thead>
<tr>
<th>CMS REQUIRED ELEMENTS FOR ESTABLISHING NETWORK STANDARDS</th>
<th>NUMBER OF STATE CONTRACTS CONTAINING ELEMENTS (30 STATES REVIEWED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anticipated enrollment</td>
<td>24 (80%)</td>
</tr>
<tr>
<td>2. Expected utilization of services</td>
<td>23 (77%)</td>
</tr>
<tr>
<td>3. Characteristics and healthcare needs of specific populations</td>
<td>25 (83%)</td>
</tr>
<tr>
<td>4. Numbers and types of network providers required</td>
<td>24 (80%)</td>
</tr>
<tr>
<td>5. Numbers of network providers not accepting new Medicaid patients</td>
<td>22 (73%)</td>
</tr>
<tr>
<td>6. Geographic location of network providers and enrollees, considering distance, travel time, and transportation</td>
<td>29 (97%)</td>
</tr>
<tr>
<td>7. Ability of network providers to communicate with enrollees in their preferred language</td>
<td>18 (60%)</td>
</tr>
<tr>
<td>8. Ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for enrollees with disabilities</td>
<td>25 (83%)</td>
</tr>
<tr>
<td>9. Availability of triage lines or screening systems, as well as the use of telemmedicine, e-visits, and/or other evolving and innovative technological solutions</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

**Additional State Considerations**

- How does the state assess the impact of provider network standards and provider outreach?
- Do Medicaid contractors classify provider types consistently?
- How does the state assess population healthcare needs?
- How does the state or contractor assess Americans with Disabilities Act and language accessibility at provider offices?
- How does the state monitor provider panel status and size across contractors?
- What are the state’s policies for allowing exceptions, and how will those exceptions be monitored?
- Do the state’s reimbursement guidelines account for telemedicine?

As of 2012, people with LEP made up 12% of the Medicaid population, but as the ACA continues to expand Medicaid coverage, we anticipate that the number of enrollees with LEP will likely grow.

Only one state contract (3%) addressed the consideration of triage lines, telemedicine and other technology solutions in the development of network adequacy requirements. Given the expansion of Medicaid managed care to rural areas in many states, contractors will increasingly rely on technology-related solutions to improve access to care and thus should consider this when developing network adequacy standards.

**PROVIDER NETWORK DOCUMENTATION**

CMS’s new regulations codified practices that states commonly use to verify appropriate enrollee access. A majority of states (83%) require contractors to submit documentation to demonstrate that their networks provide access to an appropriate range of services and are sufficient in terms of mix and geographic distribution.

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7. Fourteen states (47%) encourage MCOs to use telemedicine to improve access to care; however, only one state specifically indicated that these elements are to be considered in the development of network adequacy standards.

In addition, states must also require documentation in special situations such as:

- At the time a contractor enters into the contract with a state;
- Annually; and
- Anytime there is a significant change in the contractor’s operations that would affect the adequacy and capacity of services (e.g., changes in benefits and service area or enrollment of a new population).

States must publish network adequacy standards clearly on their website and make them available at no cost to enrollees with disabilities in alternate formats or through auxiliary aids and services.10

Although most states already follow this practice and may request reports from contractors at any time, 19 states (63%) do not have explicit requirements that contractors must submit documentation in all of the required circumstances. Specific conditions under which states may request this detailed reporting would reduce ambiguity and clarify contractor expectations.

WHAT’S NEXT? ACTIONS SPEAK LOUDER THAN WORDS...

Most states will need to update their managed care contract language and related state requirements (e.g., regulations, policy, and reporting manuals) to fully comply with the new network adequacy requirements, particularly with regard to time and distance standards and the exceptions process. Adding related contract requirements is only a small fraction of the work that is needed. States must also develop and document appropriate methodologies for determining these network adequacy requirements. For example, how will states decide when a 30-minute/30-mile versus a 60-minute/60-mile requirement is appropriate? When and how should requirements differ by physician type and specialty? How will policies and requirements vary for adults and children? Will there be exceptions, and if so, how will they be implemented and monitored?

Network Adequacy Reporting

States routinely require geographic access maps, provider addition/deletion reports, and enrollee surveys to monitor MCO provider networks.

Ready for 2018?

To prepare for the new regulations, states should consider:

1. What information do we need to assess our current service network adequacy and standards?
2. How can we leverage existing data analytics to verify our methodology for developing provider network standards?
3. What does the data say about the need for exceptions?
4. How can we strengthen our processes and tools to more effectively monitor compliance with provider network standards?
   - How do we monitor exceptions?
   - What feedback and support do we provide to contractors?
   - Are internal monitoring processes comprehensive enough to identify potential problems?
   - Have we issued any corrective action plans related to network adequacy?
5. How “compliant” is the program’s overall network with adequacy standards across contractors?
   - Where do we have gaps and how can we address them?
   - How will the External Quality Review Organization validate network adequacy for the Medicaid managed care program?
6. How do our enrollees choose providers?
   - Do contractors require enrollees to select a primary care physician or clinic?
   - Is choice limited due to appointment availability?

9. Managed Care, 42 C.F.R. § 438.207(c) (2016).
10. Managed Care, 42 C.F.R. § 438.68(e) (2016).
For more information about state-specific findings or for further assistance with your Medicaid managed care program, including provider network development, please contact Hanford Lin (hlin@navigant.com) or Randal Whiteman (rwhiteman@navigant.com).

About Navigant Government Healthcare Solutions

Navigant’s Government Healthcare Solutions (GHS) advisors work with healthcare decision makers in key state and federal agencies, supporting government clients with advice on service delivery, financing, and operations. Our consultants collaborate with experts from all areas of our healthcare practice, giving our government clients access to thought leaders in the healthcare industry, and providing valuable insight into the challenges facing payers and providers.