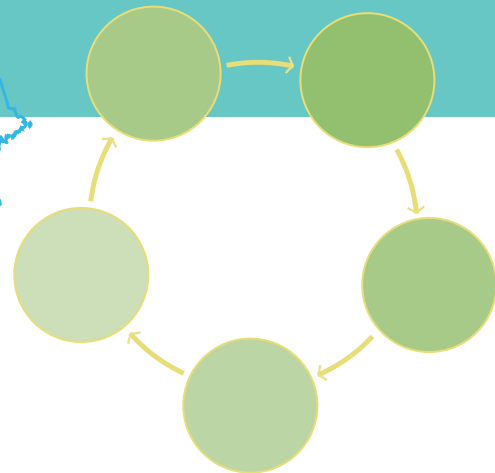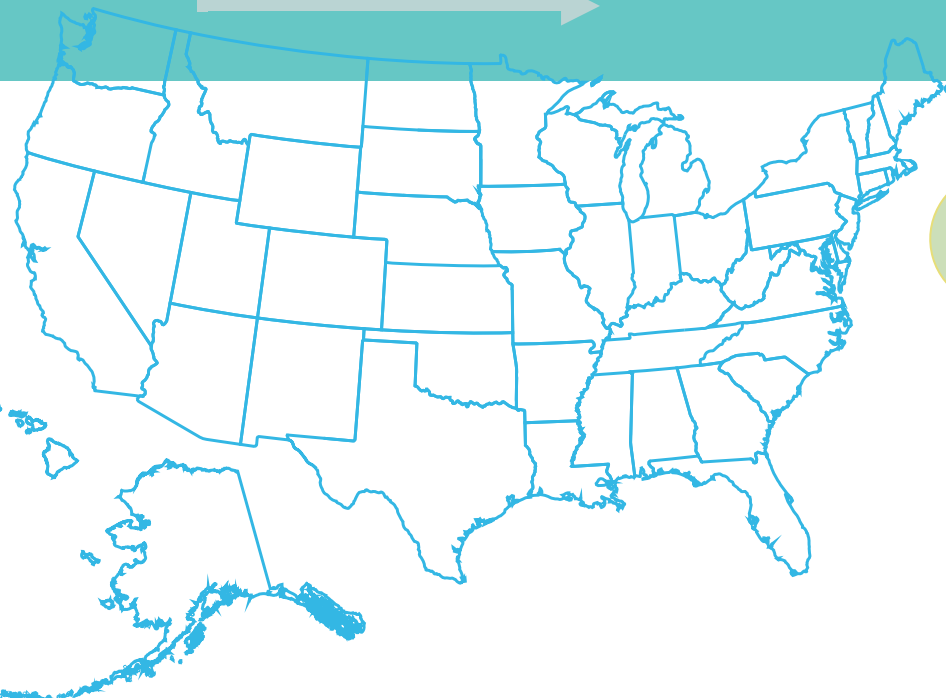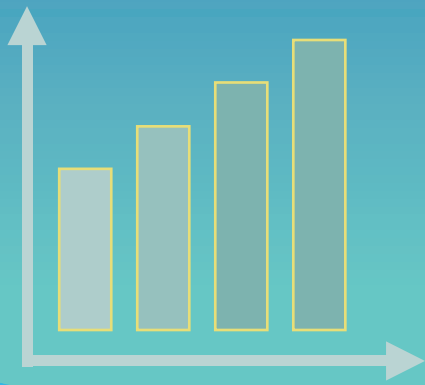April 2017

Promoting Access in Medicaid and CHIP Managed Care:

A Toolkit for Ensuring Provider Network Adequacy and Service Availability

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Chapter I:
Purpose, Background, and Overview

A. Purpose of the toolkit

More than 75 percent of Medicaid beneficiaries, or about 55 million people, received some or most of their care through a managed care plan in 2015 (CMS 2016). In addition, 30 states currently provide coverage under the separate Children's Health Insurance Program (CHIP) through managed care. In May 2016, the federal government issued regulations that clarified state Medicaid and CHIP agency responsibilities for ensuring that people enrolled in Medicaid and CHIP managed care plans have timely access to services covered under the contract.[1,2]

As with previous federal rules dating back to 2002, the regulations issued in 2016 continue to require states to ensure that managed care plans maintain "sufficient" provider networks to provide adequate access to covered services for all enrollees [42 CFR §438.68, §438.206, §457.1218, and §457.1230]. However, the 2016 Medicaid and CHIP managed care final rule goes further. It requires states to develop provider network standards based on reasonable travel time and distance from enrollee homes to provider sites; strengthens requirements for states to monitor enrollees' access to care; and addresses the needs of people with disabilities or other special needs who increasingly are enrolled in managed care plans. In the 2016 final regulations, CHIP adopts nearly all of the Medicaid standards, including the Medicaid provisions related to provider networks and network adequacy. Children enrolled in Medicaid and individuals enrolled in CHIP account for more than 50 percent of the total Medicaid and CHIP enrollment. States, therefore, must also consider the differing health care needs and the providers that serve the adult and child populations [§438.66, §438.68, §438.206, §438.207, §457.1218, and §457.1230].

This toolkit, designed as a resource guide for state Medicaid and CHIP agency staff, is intended to:

- Assist state Medicaid and CHIP agencies with implementing the requirements of the new federal rule related to network adequacy and service availability standards

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[1] The majority of these rules are in 42 Code of Federal Regulations (CFR) 438 for Medicaid, located at http://www.ecfr.gov/cgi-bin/text-idx?SID=e8aa7196f908fa99de16a76d78c6b9f2&mc=true&node=pt42.4.438&rgn=div5, and 42 CFR 457 for CHIP, located at http://www.ecfr.gov/cgi-bin/text-idx?SID=ca3cb9a31f8bd52c18f20b970f3c718d&mc=true&node=pt42.4.457&rgn=div5. The final rule was published in the *Federal Register* on May 6, 2016 (81 FR 27498). The final rule became effective on July 5, 2016, but some provisions do not take effect until later. A list of effective dates for each provision is available at https://www.medicaid.gov/medicaid/managed-care/downloads/webinar-implementation-dates.pdf.

[2] Federal law makes CHIP managed care subject to the same federal regulations that establish standards for Medicaid managed care (§2103 (f)(3) of the Social Security Act).

- Provide an overall framework and suggest metrics for monitoring provider network adequacy and service availability as well as Medicaid and CHIP managed care enrollees' access to care overall

- Highlight effective or promising practices that states currently use to develop and monitor provider network and access standards, and promote access to care

1. Sources and methods

This toolkit drew from multiple data sources and methods, including the following:

- A review of published and grey literature, to understand the range of state approaches to developing and monitoring provider network and access standards, examine evidence on the impact of state standards and monitoring practices on access and service use, and identify standard metrics for monitoring and evaluating access

- An assessment of relevant national and state-level data on Medicaid beneficiary health needs, utilization trends, and provider supply

- A review and analysis of state Medicaid contracts, managed care quality strategies, and external quality review reports to identify model contract language, access goals, and strategies that promote network adequacy and service availability

The toolkit also describes many practices that state representatives discussed when they participated between July and November 2016 in a series of conference calls organized by the Centers for Medicare & Medicaid Services (CMS), the National Association of Medicaid Directors, and Mathematica Policy Research. Though the sources and methods for the toolkit did not specifically examine CHIP practices, many Medicaid practices may apply to CHIP as well.

Box I.1 What is Medicaid and CHIP managed care?

The most common type of managed care provided by states that deliver Medicaid and CHIP is risk-based care. Under this type of arrangement, states pay managed care plans a fixed monthly rate for each enrollee to provide all benefits covered by the contract.[3] Managed care plans assume financial risk for delivering all services in the benefit package, even if the cost exceeds the capitation payment from the state. This arrangement allows states to better predict and control Medicaid spending, compared to fee-for-service (FFS) delivery systems, in which states pay providers directly for services.

Managed care has the potential to provide higher quality, more coordinated care at lower cost than FFS and promote timely access to appropriate care. However, because managed care plans bear financial risk, there can be incentive to restrict access to costly care. Consequently, states are responsible for ensuring, through their contracts with managed care plans, that all covered services are available and accessible, and that Medicaid and CHIP enrollees will receive timely access to medically necessary and appropriate care.

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[3] States may also operate non-risk managed care programs. In non-risk contracts with prepaid inpatient or ambulatory health plans [Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs)], the plans (1) are not at financial risk for changes in utilization or for costs incurred that do not exceed specified upper payment limits, and (2) may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to specified limits. Network adequacy rules apply to risk-based managed care organizations (MCOs), and both risk-and non-risk PIHPs, and PAHPs.

2. Selection of state practices

The toolkit describes numerous effective and promising state practices and approaches to developing network and access standards and monitoring compliance and access to care. Mathematica regarded practices as effective or promising if they met the following criteria: (1) at least one or more states have shown they are feasible to implement and can be integrated into routine business processes, (2) they have potential for wider adoption, and (3) they are consistent with the intent of the managed care final rule. The toolkit is not intended to be an exhaustive list of approaches. CMS may allow and approve other approaches not described in the toolkit. State officials should consult with CMS to determine whether their proposed approaches comply with federal rules.

For a number of reasons, the toolkit does not use the term "best practice" to describe state standards or monitoring approaches. First, the toolkit is not meant to be prescriptive; different standards and approaches may offer reasonable ways to comply with federal rules and promote access to care. Second, few state practices have been rigorously evaluated, so there is little or no evidence to show that they produce measurable improvement in access. Third, because many structures, processes, and state-specific factors influence access, the impact of a single policy or practice on access is difficult to prove.

At the same time, some states and managed care plans perform better than others on key indicators of access and network adequacy. Medicaid managed care plans in certain states usually achieve higher rates of preventive care visits than those in other states (NCQA 2016). These results are due to many factors, including managed care plan efforts; state Medicaid and CHIP policies and oversight; provider practices; and state-specific advantages, such as having a greater supply of providers than other states. Nevertheless, state agencies play a crucial role in setting goals, standards, and incentives to promote timely access, and working with managed care plans, providers, consumers, and other stakeholders to address barriers to care. The toolkit provides guidance and resources to help these agencies fulfill these important responsibilities.

3. Special considerations for children

Because of the large number of children enrolled in Medicaid and CHIP, and their varying needs, the 2016 final rule requires that states set distinct provider network adequacy standards for certain pediatric provider types in managed care. The final rule aligns the CHIP managed care requirements with   Medicaid managed care standards to promote consistency across programs. States should use this document when considering pediatric populations in both Medicaid and CHIP. To address different needs of children in these programs, the toolkit includes suggestions throughout about some additional factors to consider for children; more information pertaining to children is in Sections F and G of Chapter V. However, these examples are not exhaustive, and states should use the toolkit as a starting point when considering the needs of children.

B. Access framework and its link to federal final rule

In the past several years, the federal government's concern about Medicaid and CHIP managed care enrollees' access to care has focused on provider network adequacy—that is, whether managed care plans contract with a sufficient number of providers to serve plan enrollees. In 2014, the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG) released two reports highlighting wide variation in state Medicaid managed care provider network standards and provider availability (OIG 2014a, 2014b). Network adequacy, however, is necessary but not in itself sufficient to ensure access.

Just as the 2016 final rule contains multiple provisions designed to ensure enrollees' access to care, this toolkit sets provider network adequacy and standards within a broader access landscape. It uses a framework—the "5 A's of Access" developed by Penchansky and Thomas (1981)—to highlight five key factors that influence access, and adds a sixth domain, *realized access*, a key outcome often expressed as enrollees' use of appropriate services (Figure I.1).[4]

Figure I.1: Access framework

```
                    Accommodation
                          |
                          v
  Accessibility  -->              <--  Acceptability
                    Realized
                    Access
  Availability   -->              <--  Affordability
```
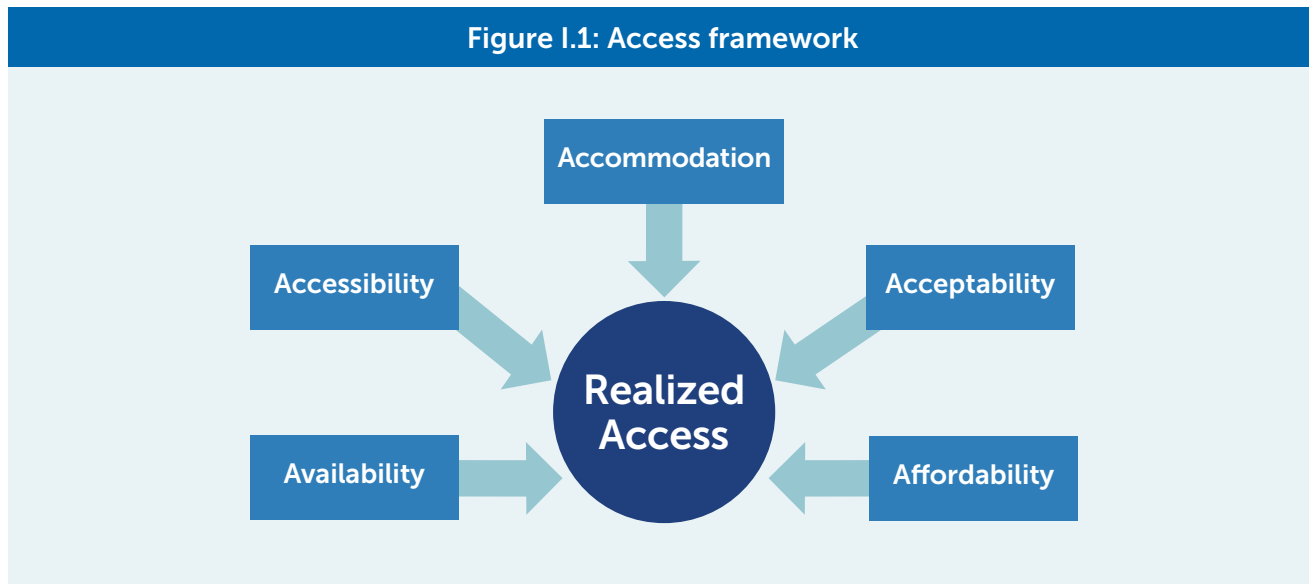
1. **Availability** addresses whether provider networks are sufficient to meet the needs of enrollees. Availability is a function of the number of providers, their willingness to participate in the program, and their ability to offer timely appointments. Provider participation, in turn, is influenced by reimbursement rates, timeliness of payment, and administrative burden.

2. **Accessibility** involves the proximity of providers to enrollees, based on geographic time and distance. For long-term services and supports (LTSS) provided in a home or community setting, accessibility can be expressed as the time and distance for caregivers to travel to enrollees' residences. At the point of care, accessibility is determined by physical access, such as ramps, and providers' ability to communicate in non-English languages or sign language.

3. **Accommodation** is the extent to which a provider's operating hours, appointment policies, language and cultural competencies, and approach to communications meet enrollees' constraints and preferences.

4. **Acceptability** captures whether enrollees and providers are comfortable with and relate well to one another, and the extent to which managed care plans and providers respect and respond to enrollees' concerns and preferences.

5. **Affordability** encompasses the costs that enrollees incur relative to their ability to pay, subject to Medicaid and CHIP rules limiting enrollee cost-sharing amounts.

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[4] This framework is similar to one proposed to CMS to enable it to monitor Medicaid enrollees' access to care across and within states for key services and populations covered by the program, regardless of the delivery system (that is, FFS, managed care, or waivers). The two frameworks are largely consistent. To view the "Proposed Medicaid Access Measurement and Monitoring Plan" visit https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/monitoring-plan.pdf.

6. **Realized access** addresses managed care enrollees' actual use of the services covered under the contract. For monitoring purposes, it is most important to measure the use of clinically recommended care, such as preventive screenings and immunizations, as well as services that could be markers of potential access problems, such as hospital admissions for chronic conditions that can be avoided through regular outpatient care.

Access-related provisions in the final rule. The final rule focuses on four of these six dimensions of access: availability, accessibility, accommodation, and realized access. Table I.1 is a list of the major access-related requirements in the final rule in the order of citation in 42 CFR 438 and the toolkit chapters in which they are discussed. Although the final rule does not explicitly address acceptability of services, patient satisfaction measures and grievances and appeals can inform states as to whether managed care plans are meeting enrollees' needs. The Medicaid and CHIP managed care final rule also does not address affordability, but other federal regulations (for example, 42 CFR 447.56 and 42 CFR 457.540) require state Medicaid and CHIP agencies to limit premiums and cost-sharing to 5 percent of family income, and track beneficiary out-of-pocket spending against this limit.

Table I.1. Access-related provisions of the Medicaid and CHIP managed care final rule

Sections[a]	Topic	Relevant toolkit chapters			
		II	II	IV	V
438.4(b)(3)[c]	Actuarially sound rates that are adequate for managed care plans to meet availability and capacity requirements			✓	
438.10(h)[b], 457.1207[e]	Provider directories		✓	✓	
438.14(b)[b], 457.1209[e]	Requirements involving Indians & Indian Health Care Providers (IHCPs)				✓
438.66[b]	State monitoring requirements			✓	
438.68[c], 457.1218[e]	Network adequacy standards	✓	✓	✓	✓
438.70[b]	Stakeholder involvement	✓			✓
438.110[b]	LTSS member advisory committee				✓
438.206[c], 457.1230(a)[e]	Availability and timeliness of services	✓	✓		✓
438.207[c], 457.1230(b)[e]	Assurances of adequate capacity and services			✓	✓
438.330(b)(3), 457.1240(b)[e])	Mechanisms to detect service utilization for potential over- or under-utilization			✓	
438.340(b)(1), 457.1240(e)[e]	Network adequacy and availability of services standards in the Managed Care Quality Strategy			✓	
438.358(b)(1)(iv)[d], 457.1250(a)[d]	External quality review (EQR)-related activities—mandatory validation of network adequacy			✓	
438.364, 457.1250(a)[d]	EQR results—findings on the quality, timeliness, and access to care in annual technical report			✓	
438.416[b], 457.1260[e]	Managed care plan records of grievances and appeals related to access			✓	
438.602(g)[b], 457.1285[e]	Transparency—posting contracts and data on access/provider networks on state websites			✓	
438.604[b], 457.1285[e]	Data, information, and documentation certifying that plans comply with state requirements for availability and accessibility of services, including provider network adequacy			✓	
438.900-930	Mental health and substance use disorder benefit parity				✓

[a] All sections refer to 42 CFR 438, available at http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8, or 42 CFR 457, available at http://www.ecfr.gov/cgi-bin/text-idx?SID=ca3cb9a31f8bd52c18f20b970f3c718d&mc=true&node=pt42.4.457&rgn=div5.
[b] These provisions are effective for rating periods for contracts starting on or after July 1, 2017.
[c] These provisions become effective for rating periods for contracts starting on or after July 1, 2018.
[d] EQR validation of network adequacy will become effective one year after CMS issues a new protocol.
[e] These provisions become effective no later than the state fiscal year beginning on or after July 1, 2018.

C. Content and organization of toolkit

Three of the chapters that follow this introduction are organized according to the sequence of steps that states commonly use to develop and monitor provider network standards and access require-ments for new managed care programs or new enrollee groups, generally for primary care services (see Figure I.2). Chapter V contains information about issues and considerations for specialized providers and services.

States that already have Medicaid and CHIP managed care programs may use similar steps and resources to develop additional standards to meet the requirements of the managed care final rule. For example, although most states set time and distance standards for primary care services, some might need to set such standards for the service categories specified in §438.68(b) for Medicaid and §457.1218 for CHIP, including obstetricians-gynecologists (OB-GYNS), behavioral health [mental health and substance use disorders (SUDs)] services, specialists, hospitals, pharmacies, pediatric dental, and LTSS, or they might need to set different standards for adults and children.

Some of the steps and resources may also be useful when revising or updating provider network standards due to changes in managed care program design, provider supply, and delivery innova-tions, or in response to patterns indicating inadequate enrollee access to key services and providers.

Figure I.2. Toolkit chapters, by steps in developing and monitoring access

Identify enrollee needs and provider supply

Develop provider network and access standards

Monitor network adequacy and access

Special providers and services

Chapter II

1. Identify enrollee needs, project enrollment, and estimate future demand for covered services
2. Determine provider supply and capacity, by provider types
3. Match enrollee needs to the providers available to serve them currently and in the future

Chapter III

4. Develop provider network, time and distance, and other access standards for 8 service categories, as relevant
5. Consider aligning Medicaid network and access standards with those for health coverage programs serving similar groups
6. Adjust standards to reflect state-specific policies, geography and local markets and assess need for out-of-network service use or other exceptions
7. Revise provider network and access standards to reflect changes in state policies, provider supply and distribution, and delivery models

Chapter IV

8. Define access goals in state quality strategies, and select metrics and targets for monitoring
9. Include provider network and access standards and reporting requirements in state contracts with managed care plans
10. Use multiple data sources and methods to monitor managed care plan compliance with provider network standards, provider directory requirements, and evaluate access to care broadly
11. Enforce contract requirements and use incentives and strategies to improve access

Chapter V

Same steps, taking into account provider and enrollee characteristics related to specialized care and services: LTSS; behavioral health services; essential community providers, such as Federally Qualified Health Centers and Rural Health Centers; Indian health care providers; Family planning providers; pediatric services; and pediatric dental care

Toolkit legend		
	In text	**In boxes**
Data and information resources	*Bold/italic*	*i* Data and information resources
State practices	**Bold**	✔ State practices
Federal Medicaid managed care and CHIP rule provisions		🔍 Federal rules

Links to data and information available online are provided in footnotes.
Publications are cited in the text and listed in the reference section at the end of each chapter.

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Chapter II:
Identifying Enrollee Needs and Provider Supply/Capacity

To set clear expectations about access to care and provider networks, states must identify and quantify the health and long-term services and supports (LTSS)[5] needs of enrollees who they are serving with their managed care programs and calculate the supply—the number and types of providers—each participating plan's network must have to meet those needs. States should also consider the unique needs of child and adult enrollees when evaluating the number and types of providers that serve these two groups of enrollees.

In this chapter, we provide guidance on how states can collect and analyze data on enrollee needs as well as provider supply and capacity, two key steps that states must take to develop access and network standards (to be discussed in Chapters III and V).

SECTIONS

- **Section A** describes data sources and methods to **identify enrollee needs** and estimate future demand for covered services.
- **Section B** describes how to **identify provider supply** in each state, focusing on primary care providers (PCPs).
- **Section C** describes methods and tools to **compare and match enrollee needs to the providers available** to serve them currently and in the future.

A. Identify enrollee needs

The 2016 Medicaid and CHIP managed care final rule requires that when states are developing network adequacy standards they must consider the needs of the population enrolled in managed care. A variety of factors influence need, including the volume of enrollment; expected utilization of services; and health care and LTSS needs, including the need for physical access, reasonable accommodations, culturally competent communications, and accessible equipment [§438.68(c)(1) and §457.1218].

Projecting enrollee needs commonly starts with collecting and analyzing a wide variety of data on enrollment trends, beneficiary characteristics (such as age), and utilization of Medicaid services that

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[5] The Medicaid LTSS provisions do not apply to CHIP.

states typically store in a Medicaid Management Information System (MMIS). To anticipate needs that are not captured in MMIS or other Medicaid and CHIP administrative data sets, or to estimate the needs of individuals who are not currently enrolled in Medicaid and CHIP, states have to obtain data from other sources. Suggested sources of data on enrollment, utilization, and enrollee characteristics and health needs are presented below.

1. Estimate enrollment during contract period

To estimate the expected demand for managed care services, states and plans must develop accurate projections of the total enrollees for the next contract period, stratified by major beneficiary subgroups, and counties or regions. To project the number of Medicaid and CHIP managed care enrollees, states typically start by using Medicaid and CHIP growth trends from previous years, and then adjust for demographic changes, major eligibility policy changes that will increase or decrease enrollment, and any new regions (or changes in the regions) in which programs operate.

More sophisticated models also factor in state and local economic conditions that affect enrollment. For example, in its *2016 Actuarial Report on the Financial Outlook for Medicaid*,[6] the CMS Office of the Actuary accounts for several factors in predicting future trends in Medicaid enrollment, including: (1) the employment rate, which varies by eligibility category (for example, child and adult enrollment in Medicaid is more sensitive to changes in the unemployment rate than that for older adults and people with disabilities); (2) population growth; and (3) eligibility for and enrollment in other forms of health care coverage (such as employer-sponsored insurance and the health insurance marketplaces). Because eligibility for CHIP depends on the child's household, these factors may also be pertinent when evaluating CHIP enrollment during a contract period.

Predicting managed care enrollment for new groups of beneficiaries, such as Medicaid expansion adults, is more difficult. One method is to use a simulation model. The Urban Institute, for example, developed a simulation model to project enrollment growth if states were to expand Medicaid to low-income adults (Holahan et al. 2012; Buettgens et al. 2015).

2. Estimate service utilization

Claims and encounter data. As with enrollment projections, states can estimate demand for specific services based on utilization patterns derived from Medicaid and CHIP claims and encounter data available for previous periods in the state's MMIS. For existing managed care programs, states typically use managed care plan encounter data from the past two or three years.[7] For new managed care programs, FFS claims are the primary source of data for analyzing previous service use. Regional patterns of care among Medicare patients are well documented[8] so states might find it useful to examine them as benchmarks for Medicaid service utilization rates among states in the same region, or states with similar demographics.

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[6] Available at https://www.medicaid.gov/medicaid/financing-and-reimbursement/actuarial-report/index.html.

[7] For tips on data collection, validation, and reporting of encounter data, states can refer to the CMS Encounter Data Toolkit, available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/medicaid-encounter-data-toolkit.pdf.

[8] For more information on patterns of health care use among Medicare beneficiaries, see the *Dartmouth Atlas of Health Care*, available at http://www.dartmouthatlas.org/

Medicaid Statistical Information System (MSIS) data—which contains eligibility, enrollment, program, utilization and expenditure data in a standardized format, are available for most states in the ***MSIS State Summary DataMart.***[9] The DataMart contains tables on enrollment counts by eligibility category, age, dual status, race/ethnicity, gender, and managed care plan type, as well as utilization and spending. For example, in 2012, on average, 21 percent of beneficiaries in the 39 states for which data were available used outpatient hospital services; the percentages ranged from less than 10 percent in Delaware and Tennessee to more than 60 percent in Mississippi.[10] Nonetheless, because the latest data in the DataMart are usually several years old,[11] it might not depict recent trends.

Previous utilization patterns and trends in FFS and managed care programs are not, however, perfect predictors of service use under managed care in the future because (1) they will not reflect changes in care delivery patterns due to managed care and (2) the populations served under FFS or other states' managed care programs may differ in important ways from current enrollees in the program. Previous utilization data for Medicaid and CHIP beneficiaries, delivered through either FFS or managed care, also can be misleading if access to care was inadequate, as indicated by such measures as low immunization rates, poorly controlled chronic conditions, or high incidents of emergency department (ED) visits or avoidable hospitalizations. Therefore, although previous trends in service use are useful as a baseline for estimating future service needs, they should be adjusted to reflect the effects of: (1) benefit changes, such as greater use of mental health services due to the mental health parity requirements; (2) delivery system reforms designed to encourage greater use of appropriate primary and preventive care; and (3) differential risk arising from voluntary versus mandatory enrollment into managed care.

When calculating the number of preventive care visits for children compared to adults, it is important to consider differences in children's use of health care, particularly primary care. Children undergo rapid growth and development, and they require more frequent access to primary care as well as access to a wide variety of specialty services to treat special health care needs. States can use periodicity schedules (for example, ***Bright Futures***[12]) to estimate the minimum number of primary care visits by age that children would be expected to make. In calculating the need for specialty providers, states should consider the most common specialties that children require, which could include pediatric dentists, allergists/immunologists, and neurologists, among others.

Survey data. Data from national and state surveys can supplement state administrative data by providing benchmarks. By comparing state service use trends with national means, states can determine whether state rates are in line with, or diverge substantially from, those for enrollees with similar characteristics. Two of the most comprehensive national data sources are the ***National Health Interview Survey (NHIS)***,[13] and the ***Medical Expenditure Panel Survey-Household Component (MEPS-HC)***,[14] each of which is based on annual surveys of representative

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[9] See https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Tables.html.

[10] MSIS Fiscal Year 2012 Medicaid Beneficiaries by Service Category. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MSIS_Tables/MSIS2012Table10.zip.

[11] As of December 2016, the most recent year for which data were available was 2012.

[12] Available at https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx.

[13] Available at https://www.cdc.gov/nchs/nhis/.

[14] Available at http://meps.ahrq.gov/mepsweb/survey_comp/household.jsp.

i **Data and information resources**

Box II.1 Medical Expenditure Panel Survey (MEPS)

MEPS reports data on the use of specific health services, frequency of use, and costs and payment sources. The Household Component (HC) collects data on representative samples of families and individuals across the nation including, but not limited to:

- Medical provider visits
- Physician specialty (including primary care specialties)
- Other medical professionals [including physicians assistants (PAs) and nurse practitioners (NPs)]
- Type of care received during a visit
- Medical condition

States with sufficient sample sizes to support state-level estimates can order MEPS files from the U.S. Census Research Data Center:

http://meps.ahrq.gov/mepsweb/data_stats/onsite_datacenter.jsp

samples of non-institutionalized people in the U.S. (Box II.1). Both contain state-specific data for the largest states. Two additional surveys that can provide information on health needs and service use for specific age groups include Substance Abuse and Mental Health Services Administration (SAMHSA's) **National Survey on Drug Use and Health (NSDUH)**[15] and the **National Ambulatory Medical Care Survey (NAMCS).**[16] More information on these surveys can be found in Chapter 5, Sections B and F, respectively.

In smaller states, state-level household surveys are likely to provide more useful information. The **State Health Access Data Assistance Center (SHADAC)**[17] maintains a list of state-level data collection and research about health care coverage and access, and the date of the most recent surveys. SHADAC also has online data tools to generate state-level comparisons of selected types of health care utilization, based on NHIS data. For example, Figure II.1 shows state residents' use of general doctor or provider visit in the past year (2012) by state, relative to the U.S. average.

Survey data can also be used to compare state-level to national service use patterns for Medicaid and CHIP enrollees overall, and between those with Medicaid, CHIP, and other sources of insurance. For example, over the 2006–2011 period, full-year Medicaid adult enrollees (excluding Medicare-Medicaid dual enrollees) had an average of 2.33 primary care visits per year, according to MEPS. Adults who had Medicaid at any point in the year had an average of 2.1 primary care visits per year, 0.4 more visits per year than part-year enrollees (Roberts and Gaskin 2015).[18]

Using NHIS data, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that Medicaid-only adults 19 to 64 years old were more likely than dual enrollees of the same age to make three or fewer visits to the doctor or other professionals, and much less likely to make four or more visits (Table II.1). MACPAC (2014) also provides similar figures for children newborn to age 18 and adults age 65 and older. Comparing state to national patterns can help state Medicaid agencies determine if their enrollees have greater needs, or if there are opportunities to improve care delivery.

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[15] Available at https://nsduhwebesn.rti.org/respweb/homepage.cfm.

[16] Information is available through the National Center for Health Statistics website at http://www.cdc.gov/nchs/ahcd/.

[17] State surveys of household health care use and coverage can be found on SHADAC's website: http://shadac.org/resources/State-Survey-Resources-and-Technical-Assistance/State-Survey-Research-Activity.

[18] By comparison, the national average for all Americans was 1.6 visits per year to primary care physicians in 2008.

Figure II.1. Percentage of adults and children, newborn to age 64, who had a general doctor or provider visit in the past year, 2014

State	Percent
Alabama	72.8%
Alaska	59.4%
Arizona	66.4%
Arkansas	71.4%
California	69.4%
Colorado	68.2%
Connecticut	75.7%
Delaware	85.3%
Dist.of Columbia	74.4%
Florida	66.9%
Georgia	66.7%
Hawaii	67.7%
Idaho	66.0%
Illinois	73.4%
Indiana	72.0%
Iowa	75.7%
Kansas	70.3%
Kentucky	73.1%
Louisiana	69.2%
Maine	72.2%
Maryland	76.0%
Massachusetts	76.9%
Michigan	76.7%
Minnesota	71.6%
Mississippi	65.7%
Missouri	71.8%
Montana	59.2%
Nebraska	63.6%
Nevada	60.0%
New Hampshire	76.8%
New Jersey	68.7%
New Mexico	65.2%
New York	72.9%
North Carolina	69.4%
North Dakota	76.8%
Ohio	74.8%
Oklahoma	76.5%
Oregon	71.0%
Pennsylvania	77.7%
Rhode Island	76.5%
South Carolina	64.8%
South Dakota	56.9%
Tennessee	74.8%
Texas	67.5%
United States	71.1%
Utah	66.5%
Vermont	87.2%
Virginia	79.1%
Washington	67.0%
West Virgina	72.0%
Wisconsin	75.8%
Wyoming	64.9%

Source: SHADAC analysis of National Health Interview Survey (NHIS) data, National Center for Health Statistics (NCHS).

Table II.1. Use of care by non-institutionalized individuals ages 19–64, by source of health insurance, 2010–2012

	Adults age 19-64	Selected sources of insurance				Medicaid			
		Medicaid	Private	Medicare	Uninsured	Medicaid adults age 19-64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100 percent)									
None	22.2*	14.1	15.5*	6.4*	48.4*	14.1	5.5*	8.7*	16.4*
1	18.3*	12.9	19.8*	5.8*	17.4*	12.9	5.0*	9.2*	14.8*
2–3	25.9*	20.8	29.6*	15.7*	17.3*	20.8	14.3*	17.8	22.4
4+	33.6*	52.3	35.0*	72.1*	16.9*	52.3	75.2*	64.3*	46.4*
Number of ED visits in past 12 months (categories sum to 100 percent)									
None	80.3*	60.9	84.1*	60.4	79.4*	60.9	54.4*	56.4*	62.7
1	12.4*	18.0	11.5*	18.6	12.0*	18.0	18.0	17.6	18.2
2–3	5.1*	13.0	3.4*	12.2	5.9*	13.0	16.5*	15.3	12.0
4+	2.2*	8.1	1.0*	8.7	2.6*	8.1	11.1*	10.7*	7.1

Source: MACPAC analysis of the 2010–2012 NHIS. Medicaid and CHIP Payment and Access Commission. MACStats: Medicaid and CHIP Program Statistics. June 2014, Table 7. Accessed October 31, 2016. Available at https://www.macpac.gov/wp-content/uploads/2015/01/2014_06_MACStats.pdf.

Note: Use of care by non-institutionalized individuals ages newborn to 18 and 65+ is available in Tables 4 and 10, respectively, of the MACStats report (2014).

* Difference from Medicaid/CHIP enrollees is statistically significant at the 0.05 level.

3. Taking into account special health care needs

Several provisions in the Medicaid and CHIP managed care final rule require states to ensure access to services for enrollees with specific characteristics and health needs. For example, §438.68(c)(1) for Medicaid and §457.1218 for CHIP require that states consider such factors as physical access, reasonable accommodations, culturally competent communications, and accessible equipment when developing their provider network adequacy standards. States also must ensure that services are delivered in "a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity" [§438.206 (c)(2) for Medicaid and §457.1230(a) for CHIP]. Consequently, it is important to consider health disparities and the effects of disability on access to care.

Health disparities. Federal law (42 U.S.C. 3101) identifies a number of data elements, collected at the smallest geographical level statistically possible, that are important to informing trends on health disparities. The data elements include race, ethnicity, sex, primary language, and disability status, as well as information on locations where individuals with disabilities obtain primary, acute, and long-term care; the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities; and the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities.

A number of federal resources present trends in subpopulations that can highlight potential disparities in health and access to care. For example, the annual **National Healthcare Quality and Disparities Report**, published by the Agency for Healthcare Research and Quality (AHRQ), documents disparities in care experienced by different racial, ethnic, and socioeconomic groups (see Box II.2). The **American Community Survey (ACS)**[19] provides state- and county-level population estimates by race and ethnicity, and includes information on nativity/birthplace, ancestry, language, and years in the U.S. Several national surveys contain information on people with different types of disability, such as functional limitations, mental/emotional disorders, and cognitive impairment, which can support state-level estimates and specify respondents' source of health insurance (see Box II.3). Many other data sources related to health disparities are on the **Partners for Information Access for the Public Health Workforce** website.[20]

[19] Available at https://www.census.gov/programs-surveys/acs/
[20] Available at https://phpartners.org/health_stats.html

> ### ℹ Data and information resources
>
> #### Box II.2
>
> The **National Health Quality and Disparities Report** provides a snapshot of trends from 2000–2002 to 2011–2012 (select measures of access to care are tracked through the first half of 2014, and adverse events in hospitals through 2013).
>
> Use this link to generate state-level queries: http://nhqrnet.ahrq.gov/inhqrdr/data/query.
>
> Use this link to view state profiles and dashboards: http://nhqrnet.ahrq.gov/inhqrdr/state/select.

> ### ℹ Data and information resources
>
> #### Box II.3
>
> **Disability Data in National Surveys** contains a comprehensive inventory of 40 national surveys with disability-related information sponsored by the federal government. As of 2011, for example, 9 surveys, including the **American Community Survey**, NHIS, and the **Behavioral Risk Factor Surveillance System** (BRFSS), supported state-level estimates and have information about respondents' source of health insurance See http://www.mathematica-mpr.com/~/media/publications/pdfs/disability/data_national_surveys.pdf

States may also partner with their public health agencies or departments to understand local social determinants of health. For example, **Wisconsin**'s Medicaid agency used public health data on disparities in birth outcomes and infant mortality rates across demographic groups to target a medical home initiative to certain geographic areas of the state. Collecting self-reported health information during enrollment into managed care can also help states determine who has special health care needs. **Wisconsin** requires managed care plans to ensure that all newly enrolled child-less adults and adults who receive Supplemental Security Income (SSI) Medicaid complete health needs assessments. These assessments gather information on chronic physical health issues, mental health needs, and self-reported health status. **Wisconsin** also provides historical claims/encounter and prior authorization data to managed care plans about their newly enrolled members, which can assist in completion of the needs assessment and care plan development. Studies have shown that self-reported health care needs are strongly predictive of future utilization, and significantly improve predictive accuracy relative to models using age and sex alone (Leininger et al. 2014).

By definition, children in Medicaid and CHIP come from low-income families, many of whom are racial and ethnic minorities. Because children depend on their parents and other caregivers to select appropriate care and provide transportation, the needs and preferences of low-income, and racial and ethnic minority parents should be considered when determining how to give children consistent access to quality care as well.

Unique health care needs of children. Although children tend to have low rates of illness or disease, among the roughly one-quarter of children who have special health care needs, rare conditions dominate (Zickafoose et al. 2014a). It is important that states evaluate the access children may need to a wide variety of medical and surgical specialists. In addition, children with identified or suspected developmental delays require timely access to providers who can diagnose or treat these conditions to address delays.

Stakeholder input. To better understand the characteristics and health care needs of the various populations that will enroll in Medicaid, states should consult with local stakeholders and advocates to learn about health care needs and service utilization patterns. State departments of health, mental health, aging and disability, and labor employ individuals with expertise in the needs of special enrollee populations and specific provider types, services, and geographic areas. **Wisconsin**'s Medicaid agency, for example, worked with the state public health department to identify acute access barriers, such as high rates of homelessness, when developing a local pilot program. The state used this information to develop standards reflecting regional health needs, and shared the data with managed care plans so they could develop appropriate provider networks and consider the social determinants of health.

States with large populations of individuals who have specific health needs may want to designate an internal liaison to help identify specific access challenges that these groups face. **New Mexico**, for example, appoints a tribal liaison who works closely with Indian Health Service and other providers who predominantly serve the state's American Indian community. The tribal liaison attends the state's quarterly Native American Technical Advisory Committee work group and is responsible for advocating for American Indians and communicating their health care needs to the Medicaid department (see Chapter V for more information special providers and services).

B. Determine provider supply and capacity

The 2016 final rule also requires that when states develop network adequacy standards, they consider provider supply and capacity. Supply, in this context, refers to the numbers and types of providers needed to deliver the Medicaid benefits covered under each managed care program [§438.68(c)(1)(iv) for Medicaid and §457.1218 for CHIP]. Provider capacity refers to the ability of providers to serve the needs of enrollees, as indicated by the share of network providers who accept new patients; whether such providers place any limits on the total number of Medicaid enrollees they will serve; modes of service they offer, such as availability of triage lines or screening systems, telemedicine, or e-visits; and the location of providers relative to the enrollees they will serve [§438.68(c)(1)(v) through (ix) for Medicaid, and §457.1218 for CHIP].

To determine the number of providers of each type required to serve the expected numbers of Medicaid and CHIP managed care enrollees, and to establish provider network standards, states can examine the supply and composition of the health workforce in the state—overall and in specific regions. The resources below can help states identify existing capacity of providers, using primary care practitioners as an example, and predict future supply. Additional sources of data relating to the supply of specialty provider types—including behavioral health and substance abuse, LTSS, Indian Health Services, essential community providers [such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)], family planning, pediatric health care, and pediatric dental—are available in Chapter V.

1. Define eligible providers for each service category

To establish network standards, the first step is to define the professionals and service settings that qualify under each provider type or category. Primary care professionals, for example, include physicians, nurse practitioners (NPs), and physician assistants (PAs) who trained and practice in such primary care specialties as general and family medicine, general pediatrics, general internal medicine, and geriatrics (Health Resources & Services Administration 2013). Primary care professionals may also distinguish themselves according to particular ages that they serve: pediatric, adult, or geriatrics.

Obstetricians and gynecologists (OB/GYNs) are often a principle source of care for women and as of 2014, Medicaid programs in at least 35 states and the District of Columbia explicitly recognized OB/GYNs as primary care providers (PCPs) in managed care or primary care case management programs (ACOG, 2014). States may also consider including Essential Community Providers in the primary care standards, such as FQHCs, Ryan White providers, family planning providers, Indian Health Services providers, and critical access hospitals.

New Jersey's Medicaid managed care contract, for example, defines PCPs as general/family practice physicians, internal medicine physicians, pediatricians, nurse midwives, and NPs. At the managed care plan's option, PCPs can also include other physician specialists who have agreed to provide primary care to enrollees with special needs and will provide such services in accordance with the requirements and responsibilities of a PCP. They can also include PAs in accordance with their licensure and scope of practice provisions.[21]

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[21] See New Jersey's 2016 contract here: http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf

States may also model their definition of PCPs by 42 CFR §447.440.[22] The definition includes physicians in primary care practice with a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association. Physicians not board certified in primary care can be considered PCPs if they attest that 60 percent of their billed Medicaid claims in the past 12 months were for eligible primary care services. Non-physician practitioners, such as advanced practice nurses and PAs who provide primary care services under the supervision of an eligible provider, are also included under this definition.

2. Estimate provider supply

To determine how many of each provider type are currently practicing within their borders, states must identify and obtain state- and county-level workforce data that provide information on supply and demand, practice locations, Medicaid participation, specialty and demographic information, and sometimes language skills. For example:

- State- and county-level provider supply data are available from the ***Area Health Resource File (AHRF)***,[23] which draws from an extensive county-level database assembled annually from more than 50 sources (see Box II.4). The file can be used to determine the availability of primary care services by county (practitioners as well as FQHCs and community health clinics); medical school graduates in a state; and the availability of specialty care, such as the number of rehabilitation facilities in or near specific counties. PCP information in the AHRF files includes the number of PCPs, advanced practice nurses, NPs, PAs, and other non-federal physicians by specialty category.[24]

National-level data sources on provider supply offer a useful starting point, but they have several limitations, and that means states must obtain other sources of information to calculate the supply of providers available to serve Medicaid and CHIP managed care enrollees. Most health workforce data sources omit information that state Medicaid and CHIP agencies require to calculate provider capacity, such as:

- **Provider participation in Medicaid and CHIP managed care.** Although workforce data sets have information on the number and locations of licensed providers, they

> ### ℹ Data and information resources
>
> ### Box II.4.
>
> The ***Area Health Resource File (AHRF)*** contains information on health facilities, health professions, and measures of resource scarcity, health status, economic activity, and health training programs. AHRF has demographic, workforce, employment, and training data for 50 health care professions at the state and national level.
>
> Products include county and state ASCII files, an MS Access database, and other useful tools. For example:
>
> - Health Resources Comparison Tools enable local health planners, administrators and researchers to compare health status indicators and available health resources for their state and county (or county equivalents) to states or similar counties nationwide. Available at: https://datawarehouse.hrsa.gov/topics/hrsainyour/customcompare.aspx
> - The AHRF Mapping Tool enables users to prepare maps that compare the availability of health care providers as well as environmental factors that impact health at the county and state levels. For example, the tool can show the number of providers of different types, by county, and providers per 100,000 residents, in each state. Available at: https://datawarehouse.hrsa.gov/Tools/MapTool.aspx

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[22] The ACA offered primary care providers covered under this definition a rate increase in 2013 and 2014.

[23] Available at https://datawarehouse.hrsa.gov/topics/ahrf.aspx

[24] State-by-state data on licensed primary care physicians by field of specialty is also available at http://kff.org/other/state-indicator/primary-care-physicians-by-field/#notes

generally do not indicate whether the providers participate in Medicaid and CHIP. Many states can use their **MMIS provider files** to identify providers that currently serve Medicaid and CHIP patients. In addition, states must maintain a centralized list of Medicaid- and CHIP-registered providers (whether they participate in FFS, managed care, or both), as required by §438.600(a)(9) and §457.1285 of the final rule, and Section 1902(a)(80) of the Social Security Act. This information can be used to calculate total numbers of providers who participate in Medicaid or CHIP. **Wisconsin**'s registry, for example, collects information on provider type and specialty, languages spoken, and physical accessibility of clinic locations when a provider enrolls with the state to provide Medicaid services. The state updates the information each week as providers enter or leave Medicaid. In addition, by comparing the list of all participating providers to the list of providers that submit managed care claims in a given year, states can calculate the percentage of providers available to serve managed care enrollees. **Wisconsin**, **Indiana**, and many other states also share the list of Medicaid-certified providers with managed care plans to help them identify and recruit providers that are not yet in their networks.

- **State licensing laws.** States vary with respect to the type of care mid-level practitioners can provide without physician supervision. In states with more permissive licensing rules, provider capacity is likely greater than in states with more restrictive rules.

- **Use of telemedicine, non-physician providers, and other delivery innovations.** These factors, which vary by specialty or type of provider, influence the capacity of PCPs to serve enrollees (Keckley et al. 2013). To improve estimates of current supply, states should explore whether provider surveys or other sources can provide information on the extent to which telemedicine, non-physician providers, and other delivery innovations are used in the state and how this affects productivity.

Expert and stakeholder involvement. Due to the data limitations of national data sets, and state variability in provider supply and practice patterns, Medicaid and CHIP agency staff are encouraged to consult with stakeholders, providers, and other workforce experts in each state to gain a more nuanced understanding of health workforce supply, distribution, and capacity in each state. The following groups can provide information and expertise:

- As described above, **state departments of health, mental health, aging and disability,** and **labor, and state offices of oral health** employ individuals with expertise on specific provider types, services, and geographic areas. These organizations may also collect data on the number of health professions and occupations, specialties, locations of practice, demographics, and other information.

- **State offices of primary care** conduct ongoing analysis of health workforce data and are responsible for designating Health Profession Shortage Areas and Medically Underserved Areas/Populations,[25] and **state offices of rural health** serve as state focal points for coordinating rural health issues and resources.[26] **Minnesota**'s Department of Health, for example, has an Office of Rural Health and Primary Care which collaborates with licensing agencies to collect data on PCPs as required by state statute.[27]

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[25] To find your state's primary care office, visit: http://bhw.hrsa.gov/shortage-designation/hpsa/primary-care-offices.

[26] For a list of grantees, visit http://www.hrsa.gov/ruralhealth/programopportunities/fundingopportunities/?id=bef01f80-cf99-47c7-8a7e-79b88886c35d.

[27] Minnesota's Department of Health publicly reports a variety of workforce data at http://www.health.state.mn.us/divs/orhpc/workforce/data.html.

- *State licensing boards* are responsible for regulating and licensing health professionals, and typically collect and maintain information about the providers they license. State Medicaid and CHIP agencies can use this information to identify provider supply and shortages. Licensing boards include boards of medicine (including physician assistants), nursing, and many others.

- *Health professional associations* often employ staff with expertise in workforce planning who can provide up-to-date data on the number of licensed providers in the state and explain which services different types of professionals provide. They may also have data on the prevalence and use of new delivery models and technologies, including e-health and telehealth. These associations include state medical and nursing associations, as well as specialty associations of family physicians, pediatricians, OB/GYNs, NPs, and PAs. They also include hospital, health system, nursing home, home health agency, and primary care associations, which represent FQHCs, RHCs, and community health centers.

- In some states, *university centers and institutes* conduct research and health workforce planning. Health Resources and Services Administration (HRSA) supports six such centers nationwide that are available to help state agencies.[28] Some universities have dedicated health resource centers that specialize in workforce supply issues in rural areas.

C. Match enrollee needs to provider capacity

1. Assessing current supply and distribution

Comparing the needs of enrollees to the capacity of providers who can serve them is a vital step in developing network adequacy standards. By calculating ratios of current providers to expected enrollees, states can ascertain if certain areas have shortages and identify gaps to fill, areas that warrant different time and distance standards, or provider types and regions that qualify for exceptions to network standards.

For example, the HRSA Bureau of Health Workforce, is responsible for designating health professional shortage areas (HPSAs) and medically underserved areas (MUAs). Areas designated as HPSAs and MUAs are eligible to receive certain federal resources and those with the highest need are given highest priority.[29] State Medicaid agencies can also use HRSA-designated shortage areas to identify areas where managed care plans may need to provide transportation benefits, permit out-of-network service use, or make other arrangements to ensure access. HRSA designates shortage areas by the following categories:

- **Primary care** professional shortage areas are counties with 3,500 or more people per primary care physician, excluding the availability of additional primary care services NPs and PAs provide in an area.

- **Mental health** professional shortage areas are counties with 30,000 or more people per psychiatrist, excluding other core mental health providers such as clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

- **Dental health** professional shortage areas are counties with 5,000 or more people per dentist.

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[28] To For a list of HRSA health workforce centers, visit http://bhpr.hrsa.gov/healthworkforce/researchcenters/index.html.

[29] The **HRSA Data Warehouse** can be used to map HPSAs for primary care, dental, and mental health providers. Available at http://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName =HPSAPC.

More sophisticated tools can account for not only the physical location of enrollees and providers, but also the travel time between the two. Many states use *geo-mapping software* to map the location of Medicaid and CHIP managed care enrollees to Medicaid managed care plans' network providers. For example **Florida**'s geo-mapping software, created by a vendor (Quest Analytics), can calculate distance from enrollees to PCPs in miles and minutes of drive time, enabling the state to set parameters on the number of providers that are accessible to enrollees in various regions of the state. **Ohio** developed its own tool with ArcGIS software, which it uses to compare multiple plan networks to each other to identify whether provider shortages reported by one plan are the result of low provider supply in the area or contracting challenges on the part of the plan.

Pediatric providers. Due to low provider density (in rural areas, for example), low supply (of children's hospitals and many pediatric specialists, for example), or extensive regionalization of specific services (children's hospitals, for example), it is often very challenging to recruit pediatric specialists into Medicaid managed care provider networks. For instance, some providers that are members of a relatively rare subspecialty may demand higher rates than Medicaid plans are willing or able to pay, given the capitation rates paid by the state. Other providers might not want to attract large numbers of Medicaid patients, and they agree to see Medicaid patients only on a case-by-case basis. As a result, these providers might not be listed in provider directories and access to their care might not be well advertised (Zickafoose et al. 2014b).

2. Projecting supply and capacity into the future

Geographical mapping tools can account for supply and demand only at a point in time. Estimating the supply of providers available to meet future demand for services is more complex because it requires assumptions about whether current utilization patterns, size and age of the population, prevalence of chronic conditions, practitioner productivity and delivery innovations, and many other factors will continue into the future. Using national data combined with many assumptions about future trends, HRSA's National Center for Health Workforce Analysis prepares national estimates of future health workforce needs. Its 2013 report projects that demand for primary care physicians will grow more rapidly than the supply of them, creating a shortage of about 20,400 full-time equivalent (FTE) physicians by 2020. However, it projects the supply of NPs and PAs will grow rapidly and could mitigate the projected shortage of physicians "if nurse practitioners and physician assistants continue to be effectively integrated into the primary care delivery system" (HRSA 2013).

To analyze future supply within their borders, states can use the *FutureDocs Forecasting Tool*.[30] Developed by the University of North Carolina at Chapel Hill (UNC) Sheps Center for Health Services Research, the forecasting tool is an interactive, web-based model that estimates the supply of physicians, use of physician services, and capacity of the physician workforce at the sub-state, state, and national levels. Users can test the impact of various assumptions including retirement rates, work effort measured in FTE staffing, Medicaid expansion, use of NPs and PAs, and availability of graduate medical education on supply and demand through 2030. Figure II.2 provides an example of the predicted supply of FTE PCPs, including OB/GYNs, in 2020 using baseline assumptions.

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[30] Available at http://www.shepscenter.unc.edu/programs-projects/workforce/projects/futuredocs-forecasting-tool/.

Figure II.2. Predicted supply of FTE PCPs, including OB/GYNs, in 2020
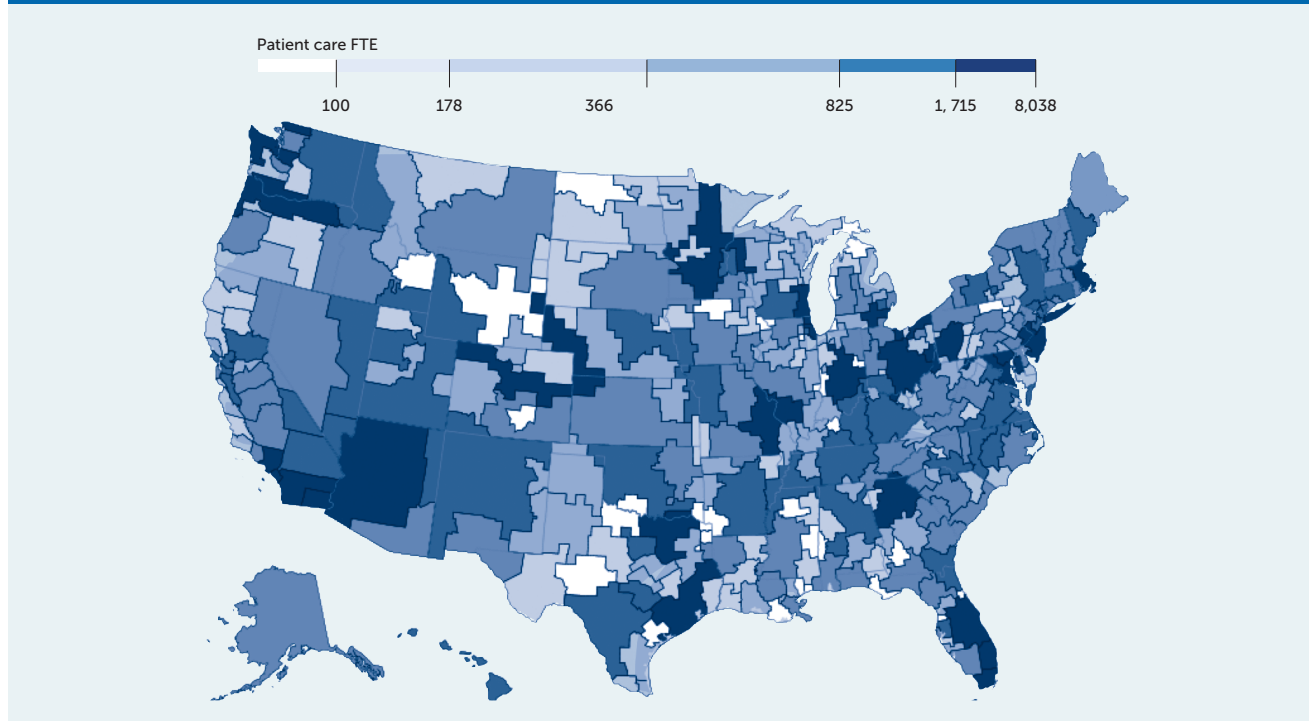
Source: University of North Carolina Sheps Center for Health Services Research, FutureDocs Forecasting Tool.

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Chapter III:

Developing Access Standards

To ensure the availability and accessibility of services in a timely manner [as required by §438.206 for Medicaid and §457.1230(a) for CHIP], states must develop network adequacy standards and access requirements for a range of provider types covered under managed care contracts [§438.68 for Medicaid and §457.1218 for CHIP].

This chapter offers descriptions of approaches and methods for developing or updating provider network adequacy and access standards, tailored to the beneficiaries and services covered by each managed care program, and adapted to each state's geographic and provider context. Building on the information about enrollee needs and provider capacity in Chapter II, this chapter covers the following topics:

SECTIONS

- **Section A** describes different **approaches to setting standards**, including types of network adequacy and access standards (such as time and distance standards, provider-to-enrollee ratios, and other access standards), and provides examples to illustrate state standards.

- **Section B** describes network adequacy and access **standards used in other insurance programs**, which can provide benchmarks for Medicaid and CHIP managed care programs serving similar populations, such as (1) older adults and people with disabilities (Medicare Advantage and Medicare-Medicaid Plans participating in the Financial Alignment Initiative demonstration) and (2) low-income adults and children [Qualified Health Plans (QHPs) and commercial plans subject to state insurance regulations].

- **Section C** discusses how state-specific policies and conditions can influence **adjustments to standards** and circumstances in which exceptions or waivers may be granted.

- **Section D** is a review of some of the circumstances that indicate the need to **revise provider network and access standards.**

A. Developing provider network and access standards

Network standards and access-related requirements can be categorized into four types: (1) time and distance standards; (2) timely access standards, such as appointment wait times; (3) provider-to-enrollee ratios; and (4) other standards, such as those related to physical and cultural accessibility. All four types are important to ensure that Medicaid and CHIP beneficiaries can receive timely and adequate access to services.

1. Maximum time and distance standards

The Medicaid and CHIP managed care final rule requires states to develop time and distance standards for multiple provider and service types if covered by the contract, including the following: (1) primary care, adult and pediatric; (2) obstetrics/gynecology pro-viders (OB/GYN); (3) behavioral health (mental health and substance use disorder), adult and pediatric; (4) specialist, adult and pediatric; (5) hospital; (6) pharmacy; and (7) pediatric dental [§438.68(b)(1) for Medicaid and §457.1218 for CHIP]. The 2016 final rule also requires standards other than time and distance for providers who travel to enrollee homes or community residences, as is often the case for LTSS [§438.68(b)(2) for Medicaid and §457.1218 for CHIP]. (See Chapter V for a discussion of LTSS time and distance standards.)

> **🔍 Federal rules**
>
> ### Box III.1. Public notice requirements related to network and service availability standards
>
> The 2016 Medicaid and CHIP managed care final rule includes many requirements related to the docu-mentation and publication of network adequacy and availability-of-services standards. Per §438.68(e) for Medicaid and §457.1218 for CHIP, states must publish their network adequacy standards on their websites and make them available for managed care enrollees with disabilities in alternative formats. States also must include the network adequacy and availability-of-services standards in their managed care quality strategies [§438.340 for Medicaid and §457.1240(e) for CHIP].

CMS did not develop national time and distance standards, despite suggestions by some com-menters on the proposed Medicaid and CHIP managed care rule that it do so. CMS officials rea-soned that "states are in the best position to understand the unique needs of their populations and can best set criteria and standards that are most meaningful to their respective programs" (*Federal Register* 2016).

When developing time and distance standards for the first time, states often find it helpful to start with standards used by other states or health coverage programs, and then modify them to reflect state-specific geography, transportation patterns, and other circumstances. Most states with long-standing managed care programs already have established time and distance standards; however, generally they apply to primary care practitioners rather than all of the provider types required by the 2016 final rule. Moreover, many states established their standards more than a decade ago, after federal rules issued in 2002 implementing the Balanced Budget Act of 1997 required Medicaid managed care plans to "consider the means of transportation ordinarily used by enrollees when developing their provider networks" (GAO 2004).

As of 2013, 32 of the 33 states with risk-based managed care plans had established standards for the maximum time and distance that enrollees would have to travel to see a provider, most often for primary care services (OIG 2014). The OIG report found that state standards for maximum travel distance to a primary care provider for urban areas ranged from 6 to 30 miles, and for rural areas, from 15 miles to 60 miles (see Table III.1 for select state examples and Box III.2 for information about specialists). In 2010, the most frequent distance required in 20 states for geographic proxim-ity to primary care providers (PCPs) was 30 miles in both urban and rural areas (Howell et al. 2012).

Table III.1. Time and distance standards in select states, 2013

State	Primary care providers	Specialists
Colorado	Within 30 minutes or 30 miles	Within 30 minutes or 30 miles
Georgia	Urban: within 8 miles Rural: within 15 miles	Urban: within 30 minutes or 30 miles Rural: within 45 minutes or 45 miles
Indiana	Within 30 miles	Within 60 miles for selected specialists and within 90 miles for all others
Kentucky	Urban: within 30 minutes or 30 miles Rural: within 45 minutes or 45 miles	No standard
Nebraska	Urban: within 30 miles Rural: within 45 miles Frontier: within 60 miles	Within 90 miles for high-demand specialists
New Jersey	Urban: within 6 miles for 90 percent of enrollees Rural: within 15 miles for 85 percent of enrollees	Within 60 minutes or 45 miles for 90 percent of the enrollees in each county or approved sub-county service area

Source: OIG analysis of 2013 state data. Department of Health and Human Services. "State Standards for Access to Care in Medicaid Managed Care." September 2014, Table A-1. Available at https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf. Accessed November 15, 2016.

✔ **State practices**

Box III.2. Network standards for adult specialists

Because of the large number and diversity of specialists, states face challenges when they establish provider network standards. Depending on the characteristics and health care needs of managed care enrollees, however, the need for certain types of specialists might be more common than often believed. **Washington State**, for example, requires its managed care plans to use encounter data to identify and report on the specialty types that provide the highest volume of services. This includes, but is not limited to: cardiologists, oncologists, ophthalmologists, orthopedic surgeons, general surgery, gastroenterologists, pulmonologists, neurologists, endocrinologists, otolaryngologists, mental health providers, and specialists in physical medicine and rehabilitation. Thus, specialists with the highest volume of care might be candidates for provider-to-enrollee ratios.

In addition, as of 2013, 18 of the 32 states with time and distance standards distinguished between primary care and specialty providers, with the maximum travel distance to specialty care ranging from 15 miles to 100 miles (OIG 2014). About half of the states set different standards for urban and rural areas; maximum travel times in the latter were typically twice those for the former.

The standards other states establish can provide a starting point for states that are creating standards for the first time and those that want to refresh dated time and distance standards. States may wish to consider standards used in neighboring states or in those with similar geography. However, each state should consider whether to adapt such standards based on differences in traffic patterns, car ownership, and public transportation in urban and rural areas within the state to assess the time required to travel to provider offices and facilities. Though states may vary their standards based on population density between urban, rural, and frontier regions, they should also consider the location of those regions in relation to each other. **Florida**, for example, benefits from a narrow geography, in which rural regions are relatively close to urban centers. Thus, Florida's expectations for travel times in rural regions are shorter than they would be in states with widespread, continuous rural areas.

States should also consider adjusting time and distance standards to reflect the populations enrolled in a program and the services covered. A program that primarily enrolls older adults and

people with disabilities, who may have challenges with mobility or transportation, may require shorter travel times and distances than one that primarily enrolls healthy adults and children. Programs that provide non-emergency transportation may also require different standards. **New Jersey**'s contract, for example, contains very detailed time and distance standards (see Box III.3); it specifies the geographic access standards in distance (miles) between beneficiary residence and providers of several types for both adults and children. The contract also makes distinctions based on whether enrollees live in urban versus rural areas, and accounts for roads and the availability of public transportation in different parts of the state.

✔ State practices

Box III.3. New Jersey 2015 Medicaid Managed Care Contract
4.8.8 PROVIDER NETWORK REQUIREMENTS

Geographic Access. The Contractor shall maintain networks that comply with the geographic access standards in accordance with New Jersey Administrative Code (N.J.A.C). 11:24-6 et seq. and with this contract for Primary Care Providers (PCPs), primary care dentists and hospitals. The following lists guidelines for urban geographic access for the Division of Medical Assistance and Health Services population.

1. Beneficiary children who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Pediatrics or 2 Certified Nurse Practitioners (CNPs) or Clinical Nurse Specialists (CNSs); within 2 miles of 1 PCP whose specialty is Family Practice, General Practice or Pediatrics or 1 CNP or 1 CNS

2. Beneficiary adults who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Internal Medicine or 2 CNPs or 2 CNSs; within 2 miles of 1 PCP whose specialty is Family Practice, General Practice or Internal Medicine or 1 CNP or 1 CNS

3. Beneficiaries who reside within 6 miles of 2 providers of general dentistry services; within 2 miles of 1 provider of general dentistry services

4. Beneficiaries who reside within 15 miles of acute care hospital

5. Beneficiaries with desired access and average distance to 1, 2 or more providers

6. Beneficiaries without desired access and average distance to 1, 2 or more providers

Access Standards

1. 90% of the enrollees must be within 6 miles of 2 PCPs and 2 Primary Care Dentists (PCDs) in an urban setting.

2. 85% of the enrollees must be within 15 miles of 2 PCPs and 2 PCDs in a non-urban setting

3. Covering physicians must be within 15 miles in urban areas and 25 miles in non-urban areas.

Travel Time Standards

The Contractor shall adhere to the 30-minute standard, i.e., enrollees will not live more than 30 minutes away from their PCPs, PCDs or CNPs/CNSs. The following guidelines shall be used in determining travel time.

1. Normal conditions/primary roads—20 miles

2. Rural or mountainous areas/secondary routes—20 miles

3. Flat areas or areas connected by interstate highways—25 miles

4. Metropolitan areas such as Newark, Camden, Trenton, Paterson, Jersey City - 30 minutes' travel time by public transportation or no more than 6 miles from PCP

5. Other medical service providers must also be geographically accessible to the enrollees

6. Exception: Social Security Insurance (SSI) or New Jersey Care-Aged, Blind, and Disabled (ABD) enrollees and clients of the Division of Developmental Disabilities (DDD) may choose to see network providers outside of their county of residence

The 2016 final rule requires states to develop separate adult and pediatric PCP network standards, but few states have included such standards in their contracts (OIG 2014; Silow-Carroll et al. 2016), and those that do use minimum provider-to-enrollee ratios. **Massachusetts** and **Virginia** require the same provider-to-enrollee ratios for providers serving both populations; **Maryland** requires more pediatric than adult PCPs (one provider to 1,500 children younger than age 21 compared to one provider to every 2,000 adults). Regardless of the standards a state sets, the state should adjust them to reflect variations in the needs of pediatric enrollees and the supply of providers in a given area. Children with special health care needs may also require specific considerations. A 2016 *MACPAC Report on Contract Provisions for Children with Special Health Care Needs* presents results from a survey of states and managed care plans on contract provisions related to access to care for this population.[31]

2. Timely appointments

In addition to travel time and distance standards, the 2016 final rule requires states to ensure that services covered under managed care contracts are available to enrollees in a timely manner, and any medically necessary services are available 24 hours a day, seven days a week [§438.206(c)(1) and §457.1230(a)]. Because the 2016 final rule does not prescribe which methods states must employ, they can consider a variety of standards to meet this requirement.

Appointment wait times. States can design wait time limitations to ensure that patients can see a provider in a reasonable amount of time based on the urgency of care, the type of appointment, and/or the medical necessity for services. As of 2013, 31 states had these standards in place for PCPs; 15 had specific wait time standards for prenatal appointments (OIG 2014). Twenty-nine states also had wait time standards for urgent care appointments. Table III.2 shows the range in wait times across states for primary care and specialist appointments as of 2013.

Table III.2. Appointment wait time standards, 2013

Provider type	Appointment type	Shortest wait time among states	Longest wait time among states
Primary care	Routine appointments	10 days	45 days
	Urgent appointments	1 day	2 days
Specialists	Routine appointments	10 days	60 days
	Urgent appointments	1 day	4 days

Source: OIG analysis of 2013 data for 29 states with appointment wait time standards. Department of Health and Human Services. "State Standards for Access to Care in Medicaid Managed Care." September 2014, Table 2. Available at https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf. Accessed November 15, 2016.

Most states, including **New Mexico** and **California**, also set appointment wait time standards for provider types other than those that offer primary and specialty care. For behavioral health providers, New Mexico requires that plan members can obtain an appointment within 14 calendar days or 24 hours for non-urgent and urgent outpatient needs, respectively. For dental providers, New

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[31] Available at https://www.macpac.gov/publication/access-to-care-for-children-with-special-health-care-needs-the-role-of-medicaid-managed-care-contracts/.

Mexico requires that plan enrollees can obtain appointments within 60 calendar days for routine, asymptomatic dental needs; within 14 days for routine, symptomatic, non-urgent dental care; and within 24 hours for urgent needs.[32] California also sets many appointment wait time standards for different provider types, which apply to all managed care plans in the state, including those serving Medicaid enrollees (see Box III.4).

For certain populations, such as children, states may want to consider how contracts between plans and providers established on an as-needed basis for specific patients, known as "single-case agreements," can help augment access to care for certain enrollees. The level of effort that managed care plans must expend to arrange for out-of-network services through single-case agreements can be significant. The burden to request such agreements often falls on families, and those with low health literacy likely have particular difficulty navigating these arrangements. Nevertheless, for certain services, including those that relatively rare specialists or subspecialists provide, such agreements are sometimes the only way to provide access to critical care (Zickafoose et al. 2014b).

When specialists are not available in a given region, managed care plans may be able to extend the services available through PCPs by incorporating telemedicine and providing training and direct consultative support to PCPs. For example, PCPs might be able to consult by telephone with a mental health professional, which are in limited supply in many communities, to feel more confident about providing certain mental health services (Zickafoose et al. 2014a). **Arizona** augments its pediatric provider network by including the field clinics and virtual clinics that incorporate the use of telemedicine, teleconferencing among providers, and an integrated medical record for children who need multi-specialty, interdisciplinary care that is not otherwise available near their home (Arizona Health Care Cost Containment System Division of Business and Finance 2014).

✔ State practices

Box III.4. California timely access standards

California's timely access standards* apply to almost all managed care products in the state, as required by the Knox-Keene Health Care Service Plan Act of 1975. The standards require that enrollees can get appointments for urgent problems within 48 hours (for services that do not need prior approval) and 96 hours (for services that do need prior approval). For non-urgent problems, the following time periods apply:

- Within 10 business days of a request for primary care appointments.
- Within 15 business days of a request for specialist appointments.
- Within 10 business days of a request for non-physician mental health care providers.
- Within 15 business days of a request for other diagnostic or treatment ("ancillary") services.
- If appointments cannot be obtained within these time frames because there are not enough providers nearby, the managed care plan must help enrollees get an appointment with an appropriate provider, which may be outside of the health plan's network or at a greater distance.

Each year, the California Department of Managed Health Care releases a report on managed care plans' compliance with timely access standards. To view reports, see http://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings.aspx#.WAefpP4VBD8.

* Source: California Health and Safety Code, Title 28, Rule §1300.67.2.2 Timely Access to Non-Emergency Health Care Services (adopted 2010).

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[32] For the complete list of appointment wait standards in New Mexico, see Section 4.8.7 Access to Services in its Medicaid Managed Care Service Agreement, available at http://www.hsd.state.nm.us/uploads/files/About%20Us/MAD%20Contracts/MCOs/Molina%20Contract.pdf.

In-office wait times. Many states set limits for in-office appointment wait times to ensure that individuals receive services in a timely fashion. As of 2013, 11 states had limited the time that a beneficiary might wait in an office or clinic before seeing the provider (OIG 2014). For example, in **New Jersey**, PCPs are required to see patients within 45 minutes of the appointment start time. Managed care plans that do not meet these standards may be required to complete a corrective action plan and can be subject to sanctions by the state if the issue is not resolved.[33] States may also consider reducing wait times by limiting the number of scheduled appointments per hour per provider.

Hours of operation. Because 60 percent of Medicaid recipients live in a family with at least one full- or part-time worker (Park et al. 2015), and many have jobs with regular working hours, states can also consider establishing standards that require managed care plans to ensure that certain types of providers offer appointments during non-traditional times more convenient to enrollees, such as weekday evenings and weekend days.

Provider service hours. Some states also require providers to meet a service hour standard to be included in managed care plan networks. For example, **Michigan** requires providers to work full time—defined as a minimum of 20 hours per week—per practice location to be included in provider-to-enrollee ratios. **New Jersey** requires that PCPs be available to patients and deliver care at least 20 hours per week.

24/7 availability for medically necessary services. States may set standards requiring around-the-clock availability of phone consultation with specific providers and care for medically necessary, urgent services. Six states require enrollees to have 24-hour telephone access to their PCP or clinical staff (OIG 2014). Access to certain services may also be facilitated by managed care plans' provision of nurse or physician advice lines.

3. Provider-to-enrollee ratios

The 2016 final rule requires states to ensure that managed care plan networks are "sufficient to provide adequate access to all services covered under the contract for all enrollees" [§438.206(b)(1) for Medicaid; and §457.1230(a) for CHIP]. Additionally, the Social Security Act requires these plans to ensure there are "enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area" [§1902(a)(30)(A)].

Although the 2016 final rule and statute do not specify the type of standards states must use to meet these requirements, states often choose to establish provider-to-enrollee ratios to comply with these provisions because such metrics of managed care plan network adequacy can be readily monitored. Using primary care as an example, as of 2013, 20 states had provider-to-enrollee ratio requirements in state Medicaid managed care contracts, although the standards varied widely (see Figure III.1). Of the 20 states with provider-to-enrollee ratios, 8 had different ratios for physician and non-physician PCPs, and some set ratios for specific enrollee populations, such as OB/GYNs to pregnant women and pediatricians to children (OIG 2014). Although many states already include provider-to-enrollee ratios in their network adequacy standards, they may still consider revising and updating standards as access issues arise or access improves overall.

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[33] New Jersey's contract is available at http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf.

Figure III.1. Range of primary care provider-to-enrollee standards used, 2013
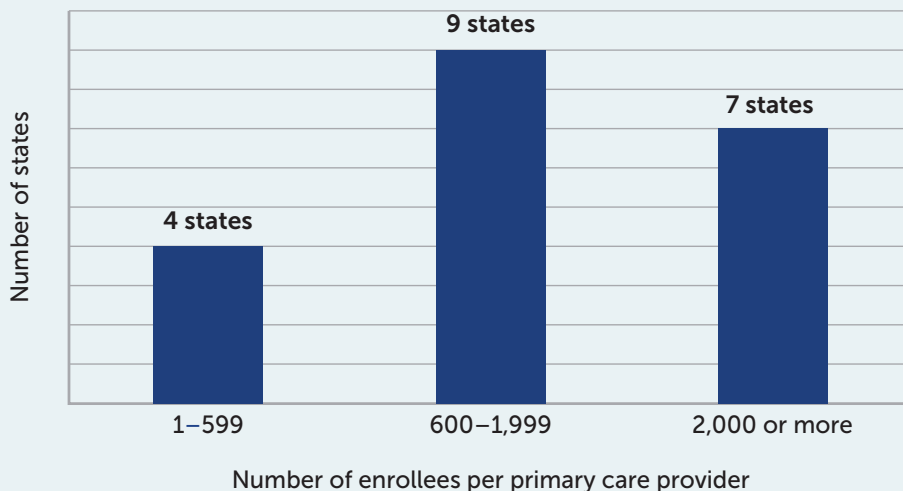
Source: OIG analysis of 2013 state data. Department of Health and Human Services. "State Standards for Access to Care in Medicaid Managed Care." September 2014, Table C-1. Available at https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf. Accessed November 15, 2016.

Note: <u>1–599</u>: Hawaii, Massachusetts, West Virginia, Wisconsin; <u>600–1,999</u>: Florida, Kentucky, Michigan, Nevada, New Mexico, New York, Pennsylvania, Rhode Island, Virginia; <u>2,000 or more</u>: California, Colorado, Delaware, Illinois, Maryland, New Jersey, Tennessee.

To formulate provider-to-enrollee ratios, states typically gather information on enrollee demand for services, as discussed in Chapter II, and determine how many providers are required to meet the demand, considering the provider types that count toward each service category. For example, **Michigan** counts OB/GYNs as PCPs and includes them in PCP-to-enrollee ratios. **Florida** allows advanced registered nurse practitioners (ARNP) and physician assistants (PA) affiliated with network PCPs to be included in plan ratios. For each ARNP and PA affiliated with the network provider, an extender adds 750 enrollees to the ratio.

To determine how many providers states need to deliver services of various types, they should estimate the following: (1) the expected number of visits or encounters for each type of service among program enrollees; (2) provider productivity, such as the mean number of visits or encounters that providers can actually perform each year, given reasonable assumptions about hours or days worked and the average time per visit; and (3) the share of Medicaid managed care enrollees in each provider practice, taking into account those providers' participation in non-Medicaid plans (see Subsection C, Part 2: "Providers Accepting New Medicaid Patients" below for detailed discussion of provider participation). States then can calculate the projected number of providers needed to serve all enrollees by dividing the total possible number of visits by the number of expected provider encounters per year.

For example, if a pediatrician or family physician can see 4 children per hour and works 2,000 hours each year (50 weeks at 40 hours per week), he or she can make 8,000 total appointments with children (well or sick) each year. States must then determine the share of patients who are Medicaid enrollees to calculate provider capacity. For instance, if a state provider association survey indicates that an average of 35 percent of each physician's panel of patients are Medicaid

managed care enrollees, physicians can provide 2,800 visits each year to children in all man-aged care plans with which the provider contracts (35 percent of 8,000 = 2,800). If a periodicity schedule recommends that children between ages 1 and 2 make an average of 4 pediatric visits each year, and the state managed care program expects to enroll 60,000 children of this age, the plan(s) must contract with at least 86 pediatricians or family physicians to ensure that each child of this age has reasonable access to pediatric care. This calculation is as follows:

➜ 60,000 children ages 1–2 at 4 visits/year = 240,000 visits

➜ 240,000 visits / 2,800 available visits per year per physician = 86 physicians

This calculation is illustrated by **New Jersey**, which requires managed care plans to have at least one PCP in its network per 2,000 enrollees (see Box III.5). Although this calcula-tion is relatively straightforward, states might find it time-consuming to repeat it for each type of provider and for enrollees of differ-ent age groups and health risk. In addition, it could produce results that are overly simplistic or inaccurate because they depend on many assumptions. Consequently, states that choose to calculate provider-to-enrollee ratios should be careful to make explicit their assumptions and the data supporting them, and consult with health workforce experts and stakeholder groups to ensure that their ratios are realistic. (See Chapters II and V for data resources.)

> ✔ **State practices**
>
> ### Box III.5. New Jersey's provider-to-enrollee calculation
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> New Jersey assumed that PCPs would see each enrollee four times each year, and that each visit (encounter) must be no shorter than 15 minutes. Thus, each patient would receive at least one hour of care from a PCP each year.
>
> ➜ 4 visits x 15 minutes each = 1 hour of care each year
>
> Assuming a 40-hour work week, PCPs can be expected to work 2,000 hours a year.
>
> ➜ 40 hours/week x 50 weeks/year = 2,000 hours/year
>
> With 2,000 available hours each year, a PCP can provide care to 2,000 patients.
>
> ➜ 1 hour per patient per year/2,000 working hours in a year = 1 PCP: 2,000 patients
>
> The result is then multiplied by the share of the PCP's practice that consists of Medicaid managed care enrollees to derive the provider-to-enrollee ratio.

4. Other standards: language, cultural competence, and physical accessibility

Language and cultural competency. The 2016 final rule requires that states ensure each man-aged care plan "participates in the state's efforts to promote the delivery of services in a culturally competent manner to enrollees, including those with limited English proficiency and diverse cul-tural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity" [§438.206(c)(2) and §457.1230(a)]. The 2016 final rule also requires states to develop standards that consider the ability of providers to communicate with limited English-proficient enrollees in their preferred language or through an interpreter [§438.68(c)(1)(vii) and §457.1218]. To address the language needs of limited English-proficient beneficiaries, Medicaid and CHIP agencies must identify the most prevalent non-English languages (that is, a significant number or percentage) spoken by enrollees [§438.10(d)(1) and §457.1207]. According to one report (HHS 2011), 56 percent of states collect information on Medicaid/CHIP applications about the primary language spoken. Six states also require managed care plans to provide interpreters or multilingual providers (OIG 2014).

For example, **California** requires managed care plans to have language access programs to assess enrollees' language needs and provide free interpreter services at points of contact with these plans, specifically at providers' offices and facilities. In addition, to implement the managed care plan information requirements of §438.10, California issues annual standards—incorporated into contracts with Medi-Cal managed care plans—indicating the languages in which they must translate certain member information. The materials required to be translated include, but are not limited to, welcome packets and service guides, marketing information, and letters acknowledging grievances and explaining resolutions. The standards are based on concentrations of people in each county and zip code who indicate their primary language is other than English. In 2014, for example, among the 30 non-rural counties, managed care plans were required to issue materials in Spanish for all 30 counties, in Vietnamese for 7 counties, in Chinese for 6, in Tagalog for 4, in Russian for 3, and in Hmong for 3 (California Department of Health Care Services, All Plan Letter 14-008, August 2014).

Physical accessibility. As required by the 2016 final rule, states must consider physical accessibility when developing network adequacy standards and ensure that plan networks are sufficient to provide physical access, reasonable accommodations, and accessible equipment for Medicaid and CHIP enrollees with physical or mental disabilities [(§438.68(c)(1)(viii), §438.206(c)(3), §457.1218, and §457.1230(a)]. With the use of Medicaid categorical eligibility aid codes, utilization data, and other information on the proportion of Medicaid enrollees with disabilities, states can set standards governing special accessibility or other accommodations needed to aid these enrollees at provider offices or clinics. Although the final rule and existing laws, such as the Americans with Disabilities Act, already require health care providers to make certain accessibility accommodations, some states have included additional standards. For example, **California** requires all provider sites that serve high numbers of seniors and people with disabilities to be physically accessible. The state created a "physical accessibility review tool" to serve as a checklist of the elements required to fulfill this requirement.[34] In turn, managed care plans must submit annual reports that explain the benchmarks and methods they use to identify high-volume providers subject to this requirement [DHCS Policy Letter 10-016 and W&I Code §14182(b)(9)].

B. Aligning Medicaid and CHIP network and access standards with those for insurance programs that serve similar populations

One of the goals of the 2016 final rule was to promote alignment of standards across public and private health coverage programs and plans to ease the transition for people moving from one plan to another. Indeed, Medicaid and CHIP managed care enrollees often participate in or transition between other insurance coverage programs. These enrollees typically include those who are dually eligible for Medicare and Medicaid, and those who may churn between Medicaid, CHIP, and Qualified Health Plan (QHP) coverage due to changes in family income or household composition. Given the potential overlap across programs and populations, states are encouraged to review standards for other private and public health care coverage programs, and align them when appropriate.

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[34] See Attachment D in the "Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers." California Department of Health Care Services, All Plan Letter 15-023, October 2015. Available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-023.pdf.

1. Medicare Advantage (MA)

Relevance to Medicaid. As of 2015, 16 state Medicaid comprehensive managed care programs had enrolled seniors and people with disabilities who were dually enrolled in Medicare and Medicaid (CMS 2014). That same year, 31 percent of all Medicare beneficiaries were enrolled in MA plans (Jacobson et al. 2015). To the extent that dually eligible and Medicaid-only enrollees in Medicaid managed care plans share similar characteristics (for example, age, disability, and chronic conditions), the network standards that CMS developed for MA may be relevant to Medicaid managed care programs serving the same populations. **Florida**, for example, used MA as the basis for its Medicaid managed care standards because it felt that standards developed for an older and likely higher-needs population would ensure strong service availability and timely access for Medicaid managed care enrollees.

To participate in the MA program, Medicare Advantage organizations (MAOs) must meet CMS-specified standards for a set of providers and facility types in every county in which they wish to operate. The standards fall into three categories: (1) maximum travel time; (2) maximum distance; and (3) minimum number of providers and/or facilities in each county, expressed as provider-to-enrollee ratios.

MA maximum travel time and distance standards. CMS sets time and distance standards for all counties and maximum travel time standards for large metro counties. CMS bases time and distance standards for MA on existing provider locations and beneficiary home addresses, and considers the current market share of a typical MA plan each year. To be approved, MAOs must demonstrate to CMS that at least 90 percent of beneficiaries in each county in which the MAO operates will have access to the appropriate number of providers and facilities within the required distance. In large metro counties, MAOs must also demonstrate 90 percent of enrollees have access to providers within the required time.

To facilitate the MAO application process, each year CMS produces *Health Services Delivery (HSD) reference tables* that include the required time and distance standards for each provider and facility type in every county (see Box III.6). For example, PCPs in metro counties must be within 15 miles or 10 minutes of beneficiaries; in rural counties, they must be within 40 miles or 30 minutes. MAOs that are applying for the first time or expanding their existing service area download the tables and submit documentation of provider and facility locations for CMS approval and validation.

> ### *i* Data and information resources
>
> #### Box III.6.
>
> The MA program publishes **Health Services Delivery (HSD)** reference tables that specify the required time and distance standards and provider-to-enrollee ratios for every provider and facility type for each county in the country. Additional guidance on MAO network adequacy criteria and current HSD tables is available at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/.

MA provider-to-enrollee ratios. CMS sets minimum provider ratios per 1,000 Medicare beneficiaries per county for more than 30 types of medical professionals and 22 types of facilities. The ratios differ based on a county's designation as (1) large metro, (2) metro, (3) micro, (4) rural, or (5) county with extreme access considerations (CEAC). County classifications are based on U.S. Census Bureau and Office of Management and Budget data on population and density. Provider-to-enrollee ratios are based on the total number of Medicare beneficiaries in the county, historical data on the market share of MA plans in similar counties, and historical utilization patterns in FFS Medicare.

CMS calculates the 95th percentile of market penetration rates for each of the five county types to determine the number of beneficiaries a MAO can cover in a given county, thus calculating the number of providers required to serve these beneficiaries. In other words, for every county of a given type, CMS calculates the number of enrollees in each MAO divided by the number of eligible Medicare enrollees in that county. CMS arrays these market shares and identifies the 95th percentile (that is, the share of beneficiaries enrolled in 95 percent of MAOs), which it then uses to determine an estimate of expected enrollment in each MAO. In effect, this method creates an overestimate of likely enrollment in each MAO. CMS recalculates the 95th percentile each calendar year based on the current market share of MAOs. Figure III.2 describes the CMS methodology for developing the standards, which are published annually in the HSD tables, and shows how the agency calculates provider-to-enrollee ratios for a given county. Although not required by the 2016 final rule, states that choose to implement provider-to-enrollee standards may consider using a similar methodology.

Figure III.2. Medicare Advantage methodology for calculating minimum number of PCPs in an MAO in Muscogee, GA, contract year 2017		
Applicable county type and 95th percentile for 2017		

To determine the total number of Medicare beneficiaries expected to enroll in a given MAO in Muscogee, CMS multiplies the applicable 95th percentile market penetration rate for the county type (Muscogee is a metro county with a market penetration rate of 0.121) by the total number of Medicare beneficiaries in the county (31,705 x 0.131) = 4,164.

County type	95th percentile
Large metro	0.072
Metro	0.131
Micro	0.115
Rural	0.121
CEAC	0.129

Calculation for number of PCPs required

CMS then determines the number of providers per 1,000 beneficiaries needed to serve the expected number of MA enrollees, based on utilization data and the clinical characteristics of beneficiaries. For 2017, CMS calculated that 1.67 PCPs are required per 1,000 enrollees. Multiplying this ratio by the expected MA enrollees in Muscogee yields 7 PCPs in each MAO network:

➜ (1.67 / 1,000) * 4,164 = 6.95, rounded up to 7.

County classification based on population size and density. See U.S. Census Bureau https://www.census.gov/geo/reference/ua/urban-rural-2010.html.

2. Medicare-Medicaid plans (MMPs)

Relevance to Medicaid. Special network adequacy standards apply to a subset of MA plans that provide integrated Medicare and Medicaid benefits to dual enrollees participating in CMS and state Financial Alignment Initiative (FAI) demonstrations. Because MMPs focus on providing coordinated care for high-need, high-cost individuals, MMP standards can serve as useful models for states developing network adequacy standards to address the needs of the people who qualify for Medicaid based on advanced age or a disability.

MMP network standards. Unlike standard MA plans, whose networks CMS reviews only at application or when their service areas expand, MMPs participating in the capitated FAI demonstrations must demonstrate annually that they have a contracted provider network "sufficient to provide access to covered services in each demonstration." Although the specific Medicaid benefits covered by each state participating in the demonstration vary, all MMPs must meet federal provider network standards for the Medicare services provided through the demonstrations. CMS developed the standards for MMPs using the same methodology used for MA plans but adapted the MMP standards to reflect the population served under these demonstrations. The major differences between MA and MMP network standards follow (Engelhardt 2014):

- **Utilization patterns and minimum number of providers:** MA network standards are based on an analysis by CMS of service use patterns for all beneficiaries in FFS Medicare. MMP standards are based exclusively on utilization rates for dual enrollees in FFS Medicare.

- **Number of enrollees:** CMS establishes MA network standards for the estimated number of Medicare beneficiaries in each county based on current MA market penetration rates. For its MMP standards, CMS uses full benefit dual eligible and projected enrollment in the FAI demonstration based on specific enrollment policies in each state, which affects the minimum number of providers and acute inpatient hospital beds criteria.

- **Time and distance:** MA and MMP network standards require that 90 percent of beneficiaries be able to reach the minimum number of a certain type of provider within the specified time (for large metro counties) and distance standards. To develop MMP network standards, CMS adjusted the standards for certain provider and facility types in counties where the 90 percent threshold could not be met using different times or distances. To accomplish this aim, CMS hired a contractor to map the demonstration population against available providers and facilities by geography by using many Medicare data sources, including ***Physician Compare***[35] and ***Nursing Home Compare***.[36]

Standards used by two states participating in the demonstration—**Massachusetts** and **New York**—are described in Box III.7, on the next page.

3. Marketplace/QHPs

Relevance to Medicaid and CHIP. QHPs certified to participate in the Federal or State Health Insurance Marketplaces enroll individuals otherwise ineligible for Medicaid, CHIP, or employer-sponsored insurance. As almost half of adults with incomes below 200 percent of the federal poverty level experience income changes that shift their eligibility between Medicaid, CHIP, and

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[35] Available at https://www.medicare.gov/physiciancompare/staticpages/aboutphysiciancompare/about.html.
[36] Available at https://www.medicare.gov/nursinghomecompare/search.html.

✔ **State practices**

Box III.7. Network standards in two FAI demonstrations

Massachusetts requires MMP networks to "include adequate numbers of providers with the training, experience, and skills necessary to furnish quality care to enrollees." Rather than specify the share of enrollees who must be able to travel to providers within a certain time, the state required managed care plans to meet the stricter of the following standards: (1) For Medicare medical providers and facilities, time, distance, and minimum number standards updated annually on the CMS website; (2) for Medicare pharmacy providers, time, distance and minimum number as required in Appendix F, Article II, Section I and 42 C.F.R. §423.120; or (3) within a 15-mile or 30-minute radius from the enrollee's zip code of residence, have at least two PCPs, two hospitals, and two providers in selected categories, such as primary care or nursing facilities, within 20 minutes (urban) or 45 minutes (rural) of an enrollee's residence. In addition, these plans are required to demonstrate annually that they have an adequate network, as approved by CMS and the Medicaid agency, to ensure "adequate access to medical, behavioral health, pharmacy, community-based services, and LTSS providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access."

More information on Massachusetts's FAI demonstration is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlign-mentInitiative/Massachusetts.html.

New York specifies minimum appointment availability standards for physical and behavioral health services in its demonstration. For example, the state requires emergency care to be available immediately upon presenta-tion at a service delivery site; urgent care within 24 hours; non-urgent "sick" visits within 48 to 72 hours; routine non-urgent, preventive appointments within four weeks; and non-urgent specialist appointments within four weeks. The state also specifies minimum access standards for LTSS. New participants must be able to receive community-based LTSS within 30 days of enrollment and have access to eight nursing facilities per county. Cur-rent participants must have a choice of at least two providers for each community-based LTSS within a 15-mile or 30-minute radius.

Additional information on New York's Fully Integrated Duals Advantage Demonstrations is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/New-York.html.

the Marketplaces, states may choose to align network adequacy standards across programs to streamline their oversight and management of networks for both types of products, and to mini-mize delays in care for beneficiaries (Sommers and Rosenbaum 2011).

QHP network standards. The Affordable Care Act (ACA) established broad qualitative standards for QHPs' network adequacy, based on provisions in the Managed Care Network Adequacy Model Act for states developed by the National Association of Insurance Commissioners (NAIC) (U.S. Government Accountability Office 2015). QHP network adequacy standards require plans offered in state-run and Federally-Facilitated Marketplaces to maintain a network that "includes essential community providers (ECPs)" and is "sufficient in number and types of providers, including provid-ers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay" [45 CFR 156.230(a)].[37] State Marketplaces must meet these minimum requirements and often include additional statutory requirements or require QHPs to adhere to existing state network adequacy laws.

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[37] Through the annual rule-making process, CMS makes periodic updates to these QHP standards, which apply both to state-run and Federally-Facilitated Marketplaces. For example, in 2015, CMS added requirements that plans maintain updated paper and electronic provider directories.

For state-run Marketplaces, it is up to the state to add any standards and determine whether the Marketplace meets network standards. CMS evaluates QHP networks for Federally-Facilitated Marketplaces and provides guidance on new requirements each year. For example, in 2014, CMS required that QHPs in Federally-Facilitated Marketplaces contract with at least 20 percent of the ECPs in their service areas; in 2015, the required percentage increased to 30 percent (CMS 2015). Both states that operate their own state-based Marketplaces and those using Federally-Facilitated Marketplaces, may develop additional standards beyond those established by the ACA and federal rules. **Connecticut**'s 2016 QHP standards, for example, go beyond the minimum federal require-ments by requiring that plans operating on the exchange contract with 90 percent of ECPs in the state. Connecticut also requires plans to include at least 85 percent of the unique providers and entities in the insurer's network for its largest plan (representing a similar product) outside of the Marketplace, and to submit quarterly documentation of compliance with the 85 percent standard.[38]

An inventory of state QHP standards for 2014, the first year of Marketplace operations, found wide variation in types of state standards (Giovanelli et al. 2015). Among the 27 states with any quantita-tive standards for network adequacy, time and distance standards were the most common. Stan-dards for appointment wait times, provider-to-enrollee ratios, and extended hours of operation or 24/7 access were less common, but 3 states added these requirements in 2015 (Giovanelli et al. 2015). For example, in 2015, **Delaware** specified PCP-to-enrollee ratios of at least one full-time physician per 1,200 covered persons and one full-time PCP per 2,000 covered persons. The state's QHPs must obtain approval from its insurance commissioner if the ratio exceeds 2,500 enrollees (Delaware Department of Insurance 2015). States may look to other states with quantitative stan-dards for QHPs, listed in Table III.3, when developing standards for Medicaid managed care.

Table III.3. Quantitative network adequacy standards applicable to some Marketplace plans, January 2014

Network standard	States
Maximum travel time or distance	23 states: AL,* AZ,* CA, DE, FL,* IL, KY, MI, MN,* MO,* MT,* NV, NH, NJ, NM, NY, OK,* PA,* SC, TN,* TX, VT, WV*
Provider-to-enrollee ratios	10 states: CA, DE, IL, ME, MT,* NV, NM, NY, SC, WV*
Maximum appointment wait time	11 states: AZ*, CA,* DE, FL,* MO,* MT,* NH, NJ, NM, TX, VT
Extended hours of operation	7 states: CA, IL, MN,* MO,* RI, VA, WI*

Source: Giovanelli, Justin, Kevin W. Lucia, and Sabrina Corlette. "Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks." Pub. 1814. The Commonwealth Fund, May 2015.

Notes: State network adequacy standards may apply broadly to all network plans or more narrowly to specified network designs (HMOs, for example) or plan types (Marketplace plans, for example). Standards identified in this exhibit and in the text are applicable to Marketplace plans in either of two ways: (1) through state action that specifically identifies the requirements for such plans; or (2) to the extent a Marketplace plan uses a network design (HMO, for example) regulated by the state standard.

* Standard applies only to specific types of network plans and does not regulate all Marketplace plans generally.

In 2017, CMS will begin to use a measure of network adequacy and breadth in the Federally-Facil-itated Marketplace called the Provider Participation Rate (described in CMS 2016). The measure will calculate the proportion of providers by specialty group (adult primary care, pediatric primary

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[38] The 2016 Connecticut QHP Solicitation is available at http://www.ct.gov/hix/lib/hix/2016_QHP_Solicitation_04_08_15.pdf.

care, and hospital facilities) in each county in a QHP's network. CMS will compare individual plan performance on these measures to the overall mean in the county to apply a network breadth rating of basic, standard, or broad to each plan. Once publicly released, the ratings will help consumers to evaluate network breadth when choosing a plan. States may consider adopting similar measures to evaluate individual Medicaid and CHIP managed care plan networks.

4. State standards for commercial insurance plans

Relevance to Medicaid and CHIP. Many states regulate network standards for all types of insurance plans licensed to operate in the state, including those in the commercial market, CHIP, and Medicaid, as is the case with **California**'s timely access standards, discussed above. In these states, Medicaid and CHIP officials developing network adequacy and timely access standards must abide by state insurance laws and rules.

NAIC Managed Care Plan Network Adequacy Model Act Standards. Many states adopt insurance regulations based on model laws and rules developed by the NAIC, an organization comprising state insurance regulators. In November 2015, the NAIC revised its decades-old Managed Care Plan Network Adequacy Model (Model #74) to address the trend toward narrow network health plans. Like its predecessor, the revised model, now called the "***Health Benefit Plan Network Access and Adequacy Model Act***,"[39] established qualitative standards for managed care plan provider networks and required that such networks be "sufficient in numbers and appropriate types of providers" to ensure access to services "without unreasonable travel or delay." The Model Act also requires 24-hour access to emergency services and recommends (but does not require) use of standards related to the following: provider-to-enrollee ratios; geographic accessibility of providers; geographic variation and population dispersion; appointment wait times; hours of operation; the ability of the network to meet the needs of covered populations, including children and adults with serious, chronic, or complex health conditions, physical or mental disabilities, or limited English proficiency; other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering care; and the volume of technological and specialty care services available to serve the needs of covered individuals. It also requires that when changes occur in networks, insurers must submit access plans to the state with information on the network and methods for meeting beneficiaries' needs.

C. Adjusting standards to reflect state-specific conditions, out-of-network access, and other exceptions

The 2016 final rule allows states to develop standards that account for variation in local markets and state geography. The most common factor affecting time and distance standards is geography, as people in urban areas generally have greater access to health professionals and facilities than those in rural areas. Other state-specific conditions that can affect the availability and accessibility of health care providers, provider-to-enrollee ratios, and network adequacy or access standards are described below. In adjusting standards, states should also consider situations that allow enrollees to obtain out-of-network care and make exceptions to the standards under certain situations.

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[39] More information and a link to the Model Act is available at http://www.naic.org/cipr_topics/topic_network_adequacy.htm.

1. Scope of practice laws

Scope of practice laws that determine the ability of NPs, PAs, and ancillary providers to provide certain services without physician supervision vary across states.[40] For example, 22 states and the District of Columbia allow NPs to deliver care without physician supervision, 17 states allow NPs to collaborate with another health discipline practitioner for certain activities, and 12 states require physicians to supervise the care that NPs deliver (American Association of Nurse Practitioners 2016). States with broader scope of practice laws should take this variation into account when defining provider types named in network adequacy standards or changing the assumptions about the number of providers available to deliver different services.

2. Providers that accept new Medicaid and CHIP patients

In a survey conducted in 2013, nearly 70 percent of physicians said they accepted new Medicaid patients, but this percentage varied considerably by state and the survey did not distinguish between those that served FFS beneficiaries and managed care plan enrollees. (Hing et al. 2015 and Figure III.3). In early 2015, another national survey found that about 50 percent of PCPs and 66 percent of NPs and PAs said they accepted new Medicaid patients at that time (The Commonwealth Fund 2015).

Figure III.3. Percentage of office-based physicians that accept new Medicaid patients, by state, 2013
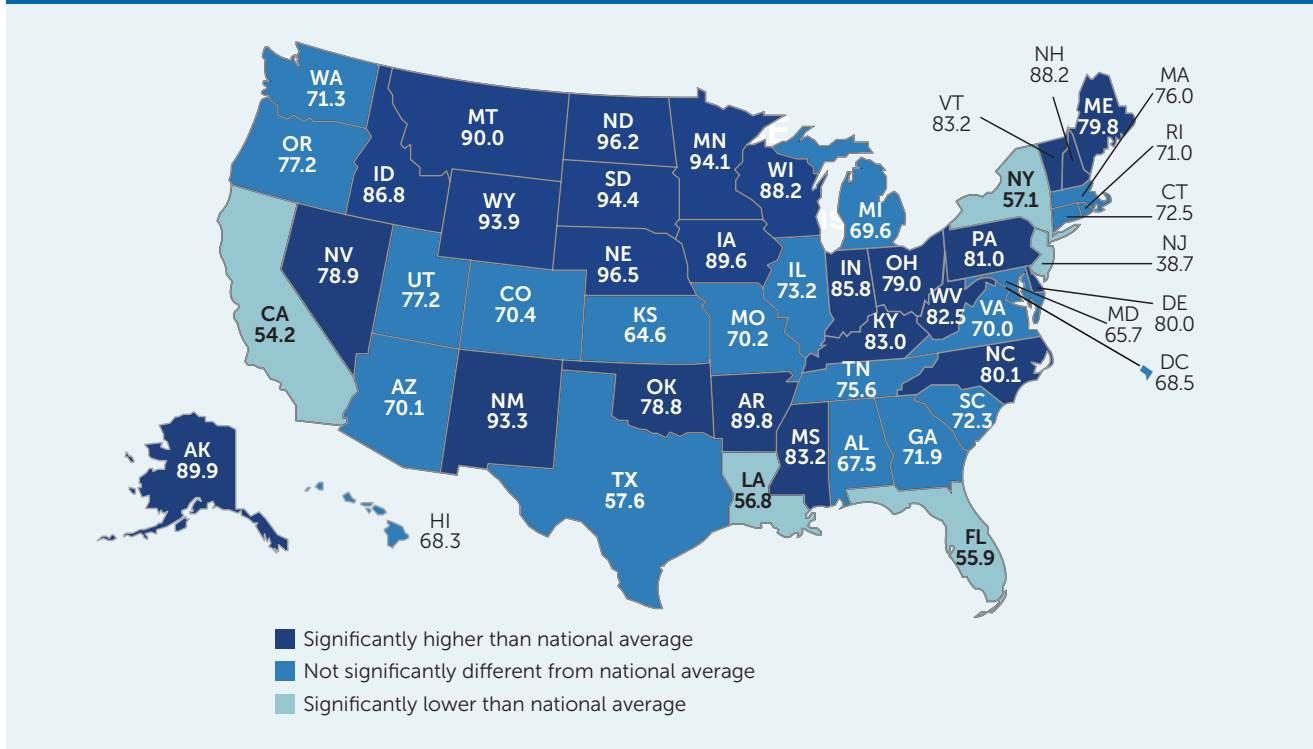
Source: Hing et al. 2015. Available at https://www.cdc.gov/nchs/data/databriefs/db195.pdf. Accessed December 7, 2016.

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[40] For PA scope of practice information, see https://www.bartonassociates.com/locum-tenens-resources/pa-scope-of-practice-laws/. For NP scope of practice law guide, see https://www.bartonassociates.com/locum-tenens-resources/nurse-practitioner-scope-of-practice-laws/.

Some states try to adjust provider network standards to reflect the share of providers that accept Medicaid patients in a given region. Modifying standards in this fashion, however, assumes that the managed care plans have little control over providers' decisions about whether to participate in Medicaid managed care networks; by comparison, MA standards do not permit this kind of exception. In fact, managed care plans have several levers to influence provider participation rates, such as adjusting payment rates, paying clean claims in a timely fashion, simplifying prior authorization procedures, and working in collaboration with providers to improve quality. Studies have shown that acceptance of new Medicaid patients is higher in states with higher Medicaid payment rates to physicians (Decker 2011).

Several factors—including size and capacity of practice, type and location of practice, revenue and payer mix targets, and the mix of current patients—affect clinicians' willingness and ability to accept new Medicaid patients. These factors can change frequently, and finding accurate and timely data is challenging. Nevertheless, states can use the Medicaid provider participation rates listed by state that are available from the 2013 data collected for the **National Center for Health Statistics' National Electronic Health Records Survey**[41] as a starting point.

Some states have developed network standards designed to increase provider participation and ensure that networks include enough providers who are accepting new patients. For example, to ensure network adequacy, **Florida**, depending on the region, requires plans to demonstrate that either 85 or 90 percent of the PCPs and required specialists in the network and reported in the Provider Network Verification system meet the state's minimum standard for accepting new Medicaid patients. Chapter V discusses additional strategies states can use to increase participation by specific types of providers.

If a state uses provider-to-enrollee ratio standards, providers who are not accepting new patients still should be counted as participating in managed care plans' provider networks, but only in such a way as to account for the number of existing patients that they treat when determining whether plans are complying with such standards. As required by §438.10 and §457.1207, plans must identify providers in their networks that are not currently accepting new Medicaid patients.

States may want to consider how contracts between plans and providers established on an as-needed basis for specific patients, known as "single-case agreements," can help augment access to care for certain enrollees. The level of effort that managed care plans must expend to arrange for out-of-network services through single-case agreements can be significant. The burden to request such agreements often falls on families, and those with low health literacy may have particular difficulty navigating these arrangements. Nevertheless, for certain services, including those that relatively rare specialists or subspecialists provide, such agreements are sometimes the only way to provide access to critical care (Zickafoose et al. 2014b).

3. Care delivery models

Some delivery models provide more comprehensive, coordinated, and continuous care than others, and some make greater use of teams, non-physician providers, and technology to deliver care more efficiently, and help to address provider shortages, particularly for primary care (Green et al.

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[41] See http://www.cdc.gov/nchs/data/databriefs/db195.pdf. As of 2016, the latest available data are for 2013, before the full effect of the Medicaid primary care rate bump went into effect.

2013). The development and modification of state access standards should consider the prevalence of these models in each state and the extent to which they extend or expand the availability of various services.

4. Telehealth

When developing network adequacy standards, the final rule requires states to consider "the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions." [§438.68(c)(1)(ix)] The use of telehealth has expanded significantly, even beyond the rural areas where the technologies were first introduced (Daniel and Sulmasy 2015). Other technologies, such as smartphones, electronic health record (EHR) portals, and patient-provider e-visits have also expanded service availability for enrollees. Given their growing presence, states should consider the prevalence and use of such technologies when establishing provider network standards. **New Mexico**, for example, requires plans to expand the use of e-visits by 15 percent each year; managed care plans have successfully met that goal since implementation.

> ### ℹ Data and information resources
>
> #### Box III.8. Telehealth defined
>
> The federal Medicaid statute does not recognize telehealth as a distinct service, but rather as a means or mode of delivering covered services (CMS 2016). Three terms are used to define telehealth technologies:
>
> - *Telehealth* includes arrangements to extend provider networks past their geographic bounds (for example, by connecting rural and urban providers together to deliver dermatology or behavioral health services).
> - *E-health* includes electronic modes of communication that help extend the reach of network providers through electronic chat, triage, and so on.
> - *Telemedicine*, or more broadly telehealth technologies, allows health care services to be delivered when the provider and patient are in different places.

Although the use of telemedicine to extend services to people in rural areas or those with limited access to transportation is growing, there may be restrictions. For example, 48 state Medicaid programs cover telemedicine in some form (Connecticut and Rhode Island are the exceptions, likely due to their size), but about half of state Medicaid programs "require that a patient be in some sort of medical facility during telemedicine encounters, rather than at home." (Ollove 2015) **Hawaii**, **Indiana**, and **Ohio** limit Medicaid coverage of telehealth services to patients who live some minimum distance away from their providers (for example, 20 miles in Indiana). Some states also require that doctors be licensed in every state where they practice medicine, effectively limiting the reach of telemedicine services across borders. The ***Center for Connected Health Policy*** conducts an annual survey of telehealth policy laws and reimbursement policies in each state and publishes the results in an interactive map.[42] The report and map present current and pending laws and regulations related to broadband coverage; demonstrations and pilot projects; professional board regulation; provider-patient relationships; reimbursement for live video, store and forward technologies, and remote patient monitoring; email phone and fax requirements; consent; location; and cross-state licensing, among other topics. State Medicaid agencies should consider these issues when they set maximum time and distances, provider-to-enrollee ratios, and other types of network adequacy standards.

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[42] The full report of survey findings is available at http://www.cchpca.org/telehealth-medicaid-state-policy. An interactive map is available at http://www.cchpca.org/state-laws-and-reimbursement-policies.

5. Exceptions to standards

Permanent or long-term exceptions to standards. In certain areas of a state or for certain types of health care services or providers, states may decide to establish permanent exceptions from network standards. **Michigan**'s contract, for example, requires managed care plans to allow women who are pregnant at the time of managed care plan enrollment to select or remain with the Medicaid maternity care provider of her choice, even if the provider is not a contracted network provider, and to receive all medically necessary obstetrical and prenatal care without preauthorization from the plan. Michigan also requires plans to allow an enrollee's maternity care provider to also be the enrollee's PCP if primary care is within his or her scope of practice. In this case, the state would subtract the average number of enrollees who meet this criterion from the provider-to-enrollee ratio for OB-GYNs (and possibly PCPs) to implement this type of permanent exception. States can also consider the use and availability of telehealth solutions when determining whether to grant a managed care plan an exception. In **Florida**, managed care plans able to demonstrate sufficient telehealth solutions to ensure enrollee access may have some provider-to-enrollee ratio requirements waived.

Long-term exceptions to network standards, on the other hand, might be granted in situations in which certain regions of the state have had chronic provider shortages, such as the lack of specialty providers in the plans' service area(s). States should clearly indicate the circumstances under which managed care plans will be granted such long-term exceptions to the network standards in their contracts, and inform enrollees of their right to use out-of-network providers for these services or providers. Additionally, plans should inform enrollees about their transportation options, such as reimbursement of travel costs, for traveling to providers located beyond normal time and distance standards. Children are reliant on parents and other caregivers for transportation so states should consider different circumstances for transportation to pediatric providers. The 2016 final rule also requires state Medicaid and CHIP agencies or contracted vendors to establish an ongoing process for monitoring enrollee access to services that operate under a permanent exception [§438.68(d)(2)) and §457.1218].

Temporary, short-term exceptions. Even if managed care plans meet state provider network standards at the beginning of the contract period, circumstances may arise during the contract period that they could not have predicted or could not control, resulting in too few providers within the required time and distance travel standards. Such a shortfall can occur if health care facilities or providers go out of business or temporarily lose their license, or many physicians retire or cancel network contracts at the same time.

States should establish a process through which they grant managed care plans temporary, short-term exceptions to standards due to access issues and give the plans a reasonable period to find new providers or develop an alternative strategy for ensuring reasonable access to services covered in the contract. As specified in §438.206(b) and §457.1230(a), during any period in which managed care plans do not meet minimum network standards, plans should ensure that appropriate processes are implemented to adequately cover services in a timely manner out of network, including paying claims to out-of-network providers and ensuring that enrollees incur no additional costs. As with long-term exceptions, during temporary or short-term exception periods, state Medicaid agencies or contracted vendors should monitor enrollee access to services that operate under an exception.

6. Contingency capacity

States can also require or set standards to incentivize managed care plans to develop contingency capacity if some plans reach capacity, leave the service area, or terminate the contract. For example, **Florida** requires plans to demonstrate adequate capacity to serve the Medicaid managed care enrollees in the entire region of operation, even if they service only a subsection, so as to reduce potential disruption to enrollees if another plan leaves a service area. The state also requires plans to build networks that could serve enrollees plus an additional 20 percent in most regions, or by 100 percent in two regions due to the presence of only two operating plans. Similarly, **New Jersey** requires its contractors to be able to serve at least 25 percent of all individuals eligible for managed care in each urban county they serve and 33 percent of individuals in non-urban counties (New Jersey Department of Medical Assistance and Health Services 2016).

D. Revising provider network and access standards

There is no formula or rule for deciding when a comprehensive revision to network standards is warranted. Developments and policy changes that may trigger the need to revise or update provider network standards include the following: (1) expansion of managed care programs to new populations previously exempt; (2) expansion of managed care programs to new areas of the state; (3) significant increases or decreases in provider supply, due, for example, to changes in scope of practice laws that allow mid-level practitioners to deliver certain services; (4) increased adoption of delivery system reforms or use of technology that affect underlying assumptions regarding provider-to-beneficiary ratios; or (5) evidence of inadequate enrollee access to key services and providers. Even when populations and areas of the state enrolled in Medicaid managed care programs remain constant over time, states should consider a comprehensive assessment of network standards every 5 to 10 years. Additionally, the 2016 rule requires states to develop separate adult and pediatric provider network standards, but few states have included such standards in their contracts (OIG 2014; Silow-Carroll et al. 2016), and those that do use minimum provider-to-enrollee ratios.

As the capacity and overall market of the state Medicaid and CHIP managed care program evolves, states may choose to modify or tighten network adequacy standards. For example, **Michigan** recently changed the state provider-to-enrollee ratio maximum of one PCP for every 750 enrollees to a higher ratio—one PCP for every 500 enrollees—because nearly every plan in the state had exceeded the lower standard. The state attributes the improvement to its auto-assignment incentive, in which plans with higher provider-to-enrollee ratios receive more points and therefore more beneficiaries automatically assigned to them. By altering the standard to more closely reflect the capacity of the managed care market, the state aims to encourage health plans to continue improving access.

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Chapter IV:

Monitoring Provider Network Adequacy, Service Availability, and Access

The 2016 final rule requires state Medicaid agencies to operate a monitoring system for all Medicaid managed care programs in the state, including oversight of provider network management, compliance with provider directory requirements, network adequacy, and service availability standards [§438.66(b)]. Although certain provisions addressed in this chapter also apply to CHIP, 42 CFR 438.66 does not apply to separate CHIP programs.

SECTIONS

- **Section A** describes **access goals** commonly found in state Medicaid managed care quality strategies and discusses how to select metrics and targets to monitor progress toward goals and compliance with network adequacy standards.

- **Section B** reviews **contract provisions** relevant to provider networks, provider directories, and access indicators, and illustrates how states can specify managed care plan reporting requirements and metrics in contracts.

- **Section C** describes the **methods** states can use to monitor provider network adequacy, service availability, and access. These methods include using managed care encounter data to calculate utilization rates, "secret shopper" calls to verify network provider availability, and using enrollee and provider hotlines as well as grievances and appeals to identify access issues. This section also describes analyses and tools that may be useful in evaluating system-wide access and identifying access problems in specific regions within the state or for specific enrollee groups.

- **Section D** discusses **enforcement actions**, **incentives**, **and strategies** to remedy provider network inadequacies and improve enrollee access.

A strong system to monitor provider network adequacy and service availability consists of four interlinked elements (Figure IV.1). To build such a system, states should first define goals for access to care and identify the metrics to monitor performance and progress toward them. Ideally, access goals and metrics would apply to all beneficiaries regardless of the delivery system—managed care, FFS, accountable care organization or other—to ensure consistency and facilitate comparisons

Figure IV.1. Elements of a system to monitor provider network adequacy

across delivery systems within the state.[43] Second, states should specify in contracts with managed care plans the data and reports that these plans must provide to the states so they can conduct monitoring. Third, states should collect, validate, and analyze the reports and data submitted by managed care plans to verify compliance with network standards and evaluate enrollee access to covered services. Fourth, if the data indicate lack of compliance with network standards or access problems, states should use enforcement tools and strategies to remedy problems and improve access. The process then starts over by revising access goals in the next contract period, either by setting higher access goals if the plans met previous targets, or focusing on particular regions or groups with greater access problems. This Chapter offers guidance and resources to strengthen these four elements.

A. Defining access goals and selecting metrics for monitoring

The 2016 final rule requires all states operating managed care programs to develop and update their managed care quality strategy (§438.340). This strategy serves as a blueprint for states and contracted health plans on how they will assess and ensure the quality of services delivered to managed care enrollees, and lays out measurable goals and targets for improvement.

1. Access goals

Because access to timely and appropriate care is a prerequisite to quality, the 2016 final rule requires network adequacy and service availability standards to be an integral part of quality strategies [§438.340(b)(1) and §457.1240(e)]. In addition, quality strategies must include the metrics and targets used in measuring the performance and improvement of certain types of managed care plans defined in §438 [managed care organizations (MCOs), prepaid inpatient health plans (PIHPs),

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[43] For example, as part of their access monitoring review plans (AMRPs) required by §42 CFR 447.203 and 447.204, states use a variety of measures to monitor access to care by Medicaid FFS beneficiaries. To promote consistency, such measures would be the same for FFS and managed care enrollees. See the *Proposed Medicaid Access Measurement and Monitoring Plan*, developed by CMS as a technical assistance tool for states to inform the selection of access measures. https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/monitoring-plan.pdf

prepaid ambulatory health plans (PAHPs), and the subset of primary care case management entities (PCCM) entities[44] described at §438.310(c)(2) with which the state contracts [(§438.340(b)(3), §438.340(b)(8), and §457.1240(e)].

To help states craft robust quality strategies, in 2013, CMS developed a **Quality Strategy Toolkit**,[45] which specifies six core elements in a state's managed care quality strategy. In addition to specifying the network and service availability standards now required by the 2016 Medicaid managed care final rule, the toolkit recommended that states describe their provider credentialing and grievance systems, and specify the measures and mechanisms to detect underutilization, overutilization, and the appropriateness of services. However, the toolkit did not provide guidance on how to specify goals related to access.

To help states develop specific and measurable metrics and targets, CMS issued further guidance in 2013.[46] Although it was designed to help states establish quality and outcome metrics for value-based payment programs, its principles can be applied to the steps involved in creating measurable access goals.

- **Data driven.** Identify areas needing improvement by analyzing data on utilization, health needs of target populations, barriers to care, and other indicators of access problems. For example, such analyses can pinpoint areas of the state or population subgroups whose utilization of primary care services are well below the state average.

- **Relevant metrics.** Select measures tied directly to the goals and interventions required to remedy access problems. For example, to measure increased access to primary care, appropriate metrics would be those directly linked, such as primary care visits and hospitalizations for ambulatory care-sensitive conditions.

- **Sequencing.** If access problems are acute, set short-term goals and incremental targets that build capacity and confidence to achieve long-term goals. For example, targets related to an increase in the number of Medicaid-participating PCPs may be appropriate before managed care plans can achieve high rates of primary care visits.

- **Targets.** To encourage continuous improvement, it is useful to establish measures representing a mix of (1) absolute targets, such as 95 percent of children having primary care visits every year; (2) national benchmarks, such as the 75th percentile of Medicaid Healthcare Effectiveness Data and Information Set (HEDIS®) scores; and (3) specific improvements, such as improvement of at least 20 percent from the baseline to motivate those plans with performance rates significantly below the median to achieve progress.

Access metrics in state quality strategies illustrate these principles. As part of developing its quality strategy in 2013, **Tennessee** specified measurable goals for improving access for each of the next

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[44] PCCM entities that contract with states to receive shared savings or other types of financial incentives for improved quality outcomes must comply with provisions in §438.330(b)(2), (b)(3), (c), and (e), §438.340, and §438.350.

[45] In early 2017, an update to the Quality Strategy Toolkit was in process to align with the 2016 final rule. Until the update is completed, it still may be a helpful resource. To download the CMS "Quality Strategy Toolkit for States, 2013," visit: https://www.medicaid.gov/medicaid/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf.

[46] CMS. "Quality Considerations for Medicaid and CHIP Programs." State Health Official/Medicaid Director Letter, #13-007. November 2013. Available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-007.pdf.payers, hospitals, large provider groups, and health systems, which eliminates duplicative data entry for submitting provider profile information for claims administration, credentialing, directory services, and so on. See http://www.caqh.org/solutions/caqh-proview for more information.

three years relative to 2013 performance and specified the data sources to track progress each year (TennCare 2013). Some example goals follow, including the anticipated data source for the metric:

- By 2016, the statewide weighted HEDIS® rate for childrens' and adolescents' access to primary care practitioners will increase to 95.3 percent for enrollees ages 7–11 years (from 93.5 percent in 2013) and 93.09 percent for enrollees ages 12–19 (from 90.4 percent in 2013) [data source: external quality review organization (EQRO)-audited results of TennCare managed care plan HEDIS® scores].

- By 2016, 97 percent of TennCare heads of household and 98 percent or greater of TennCare children will go to a doctor or clinic when they first seek care rather than a hospital emergency room (ER) (data source: TennCare survey of recipients, performed by the University of Tennessee Knoxville).

As an example of targets relative to national benchmarks, **Massachusetts** selected the national HEDIS® Medicaid 90th percentile as a benchmark for high quality performance on certain HEDIS® measures in 2015, and the 75th percentile for acceptable performance, both of which were higher than previous years' benchmarks. (Previously, the 75th percentile was the high-performance benchmark and the national Medicaid mean was deemed acceptable.) As Medicaid agency officials explained, "The decision to aim higher, using the 90th percentile as the goal for MassHealth managed care plan performance, was made as part of MassHealth's broader quality strategy" (MassHealth 2016).

Georgia's new quality strategy, developed to support the value-based payment (VBP) initiative included in its 2015 managed care reprocurement, specifies access metrics tied to VBP performance targets. Starting in calendar year (CY) 2017 (the first full CY of managed care plan operations under the new contracts), the VBP metrics will include well child and adolescent well child visits that meet or exceed the Medicaid 2016 HEDIS® national 50th percentile in CY 2017 and the 75th percentile in CYs 2018 and 2019 (Georgia Department of Community Health 2016).

2. Selecting monitoring metrics for access and service availability

To complement CMS's guidance on how to establish metrics, additional guidelines and criteria discussed by Gold and Kenney (2014) can help states select the right mix of access and service availability metrics and indicators for each managed care program they operate. They include the following:

- *Diverse access domains*. Metrics covering multiple domains provide a comprehensive view of access. States can use the access framework, discussed in Chapter I, as a checklist to ensure that the metrics cover all relevant domains, including availability, accessibility, accommodation, acceptability, affordability, and realized access.

> Table IV.1 contains example measures in each of the access framework domains, many of which are applicable to all Medicaid beneficiaries, whether enrolled in managed care plans or in the FFS system.[47]

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[47] Table IV.1 does not include the affordability domain, which is addressed through federal regulations concerning all Medicaid beneficiaries, including managed care enrollees. States could develop a measure specific to managed care enrollees, such as the number or share of enrollees in each managed care plan charged for out-of-network services when the plan cannot provide needed care. (For this type of metric, a lower number is better.)

Table IV.1. Examples of managed care access metrics, by access domain and enrollee group

Measures shown in bold are included in the
2017 Core Sets of Adult or Children's Health Care Quality Measures for Medicaid and CHIP

	Availability	Accessibility	Accommodation	Acceptability	Realized access
	Provider supply and capacity	Timely access, proximity, and physical accessibility	Operating hours, non-English languages	Communication and customer service	Appropriate use of service
All enrollee groups	Number of participating providers per 1,000 Medicaid enrollees Percentage of network providers who accept new Medicaid enrollees [§438.68(c)(1)(v) and Decker 2012]	Percentage of enrollees living within maximum time and distance to primary care practitioners, hospitals, and other providers Percentage of enrollees able to make appointments within the maximum wait time for urgent and non-urgent care	**Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey measures** (Adult and Child Core Sets): • **Getting needed care** • **Getting care quickly** Percentage of providers who can communicate, directly or through interpreters, in non-English languages or sign language	**CAHPS Health Plan survey measures** (Adult and Child Core Sets): • **How well doctors communicate** • **How often health plan customer service provided needed information or help** Number of appeals, grievances, and complaints per 1,000 enrollees related to service availability Share of managed care enrollees who voluntarily choose to leave their health plan during the year	• Percentage of enrollees reporting a usual source of care • Primary care visits/1,000 enrollees (Child Core Set) • **Avoidable hospitalization: admissions for ambulatory care-sensitive conditions (asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart failure** (Adult Core Set) • **Emergency department visits** (Child Core Set)
Specific enrollee groups					
Children	Number of months each plan meets pediatrician-to-enrollee ratios		Providers making night and weekend appointments for children		• **Well child visits** (Child Core Set) • **Child immunization rates** (Child Core Set) • **Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication** (Child Core Set) • **Receipt of preventive dental services and dental sealants for children at elevated risk** (Child Core Set)
Children with disabilities	Number of months each plan meets pediatric specialist-to-enrollee ratios	Percentage of facilities and offices fully accessible to people with disabilities (for example, with ramps, accessible equipment, and parking spaces)	**CAHPS Children with chronic conditions** (Child Core Set): 1. **Easy to get prescription medicines** 2. **Easy to get special medical equipment, therapy, counseling**	**CAHPS Children with chronic conditions** (Child Core Set): • **Parent experience with care coordination** • **Parent experience of shared decision making**	
Pregnant women	Number of months each plan meets OB/GYN-to-enrollee ratios				• **Prenatal and postpartum care timeliness** (Child Core Set) • **Postpartum care rate** (Adult Core Set)
Adults and seniors using LTSS		• Percentage of enrollees who live within specified time and distance standards to provider sites [§438.68(b)(2)(i)] • Percentage of LTSS enrollees whose caregivers are within specified time and distance standards to enrollee residences • Percentage of facilities and offices fully accessible to people with disabilities (for example, with ramps, accessible equipment, and parking spaces)	• Percentage of eligible enrollees who report that they had a choice of services that matter to them	CAHPS Home and Community-Based Services Survey (HCBS) Experience of Care measures: • Staff are reliable and helpful • Case manager is helpful	• Percentage of new MLTSS enrollees receiving a comprehensive assessment within a specified period after plan enrollment • Percentage of new MLTSS enrollees whose care is initiated within a certain period after enrollment • Percentage of personal care visits that are timely

Table IV.1. Examples of managed care access metrics, by access domain and enrollee group

Measures shown in bold are included in the
2017 Core Sets of Adult or Children's Health Care Quality Measures for Medicaid and CHIP

	Availability	Accessibility	Accommodation	Acceptability	Realized access
	Provider supply and capacity	Timely access, proximity, and physical accessibility	Operating hours, non-English languages	Communication and customer service	Appropriate use of service
Beneficia-ries with behavioral health needs (children and adults)	Number of months each plan meets provider-to-enrollee ratios for behavioral health therapists			CAHPS Experience of Care and Health Outcomes (ECHO) measures • Perceived improvement • Information about treatment options	• 7-day follow-up after hospitalization for mental illness (Adult and Child Core Set) • Initiation and engagement of alcohol and other drug dependence treatment (Adult Core Set)

Source: Mathematica Policy Research 2016.

The 2017 core sets of measure are available at the following links:

- ***2017 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)*** https://www.medicaid.gov/medicaid/quality-of-care/downloads/2017-child-core-set.pdf.
- ***2017 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)*** https://www.medicaid.gov/medicaid/quality-of-care/downloads/2017-adult-core-set.pdf.

- *Appropriate measures for the services and beneficiary groups enrolled in each managed care program*. Measures related to access to acute, primary, and specialty service are appropriate for a comprehensive managed care plan. States should use access metrics specific to mental health and substance use disorder services for behavioral health organizations, and should develop metrics related to long-term services and supports (LTSS) for managed long-term services and supports (MLTSS) programs. When managed care programs cover diverse populations, such as nondisabled children, pregnant women, disabled adults, and seniors, access metrics should address each of these groups, as illustrated by the example metrics in Table IV.1.

- *Ability to disaggregate data to identify "hot spots."* To identify the managed care plans, regions within the state, and population groups with more acute access problems, the data used to construct the measures should be granular enough to sort by plan, region, or county within the state, and by sociodemographic characteristics, such as race or ethnicity.

- *Benchmarking*. Choosing metrics that apply to both managed care enrollee and FFS beneficiaries allows for comparisons across delivery models. Similarly, selecting metrics used to monitor access for people with other types of insurance, whether commercial, Medicare, or QHPs, allows states to compare Medicaid performance against national and state benchmarks for the general population.

- *Data availability*. Selecting metrics that states and plans can construct with existing data will reduce data collection burden and make it possible to monitor performance on a regular basis. The most common Medicaid managed care data sources, HEDIS® and CAHPS, are described in Box IV.1. States may be able to institute additional metrics as new data sets or sources become available—for example, via health information exchanges and from electronic health records.

- *Balance of "real-time" and annual indicators*. Ideally, states and health plans should be able to monitor availability of services in real time to detect and resolve problems that put enrollees at risk of suffering health consequences from lack of timely access. Enrollee and provider complaints to call centers and hotlines can identify problems in real time but do not necessarily indicate whether the problems are systemic or affect a large proportion of enrollees.

> **ⓘ Data and information resources**
>
> ### Box IV.1. Medicaid managed care data sources—HEDIS and CAHPS
>
> HEDIS® and CAHPS® measures comprise the majority of core measures for children's and adult Medicaid programs.
>
> **HEDIS®**. Developed and maintained by the National Committee for Quality Assurance (NCQA), the Healthcare Effectiveness Data and Information Set (HEDIS®) is one of the most widely used sets of health care quality and performance measures in the United States. As of July 2016, 37 state Medicaid programs collected or required Medicaid managed care plans to report HEDIS® data and validate HEDIS® measures as part of annual external quality reviews. More information is available at http://www.ncqa.org/hedis-quality-measurement.
>
> **CAHPS**. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®), developed by the Agency for Healthcare Research and Quality (AHRQ), is composed of a set of surveys that ask consumers and patients to evaluate their experiences with health care. The survey questions cover a variety of topics, such as the communication skills of providers and ease of access to health care services. The **CAHPS Health Plan Survey** collects standardized information on enrollees' experiences with health plans. As with HEDIS, most state Medicaid programs require managed care plans to conduct annual CAHPS surveys using authorized vendors and report the results to the state. More information is available at http://www.ahrq.gov/cahps/index.html.

Consequently, it is preferable that states complement real-time complaints and grievances with annual beneficiary surveys capturing the experience of a representative sample of enrollees as well as annual service utilization trends that reflect patterns across all enrollees.

B. Stipulating managed care plan provider network and access standards and reporting requirements in state conracts with managed care plans

The 2016 final rule requires states, through their contracts with managed care plans, to obtain assurances and supporting documentation that the plans have the capacity to serve all enrollees in each service area and comply with all other state access standards [§438.207 and §457.1230(b)]. This section first describes the importance of specifying network standards and access requirements in contracts and the requirements for provider directories. It then discusses the types of reports, data, and other information that states may want to require managed care plans to submit to verify compliance with these standards and requirements.

1. Contract provisions

To ensure that a state Medicaid and CHIP agency can effectively monitor compliance with provider network standards, and that managed care enrollees receive timely access to care, state contracts with managed care plans should both (1) clearly spell out network standards and access requirements, discussed in detail in Chapter III; and (2) specify the data plans must submit to document compliance with these standards. CMS has developed a **state-managed care contract review guide**[48] to assist states in ensuring their contracts meet federal requirements for approval.

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[48] CMS. "State Guide to CMS Criteria for Managed Care Contract Review and Approval." January 20, 2017. Available at https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf.

The contract language describing all required data and reports should be clear and specific; generic contract language that simply requires plans to submit information to verify compliance with standards is insufficient. States can specify the format and frequency of reports and data files in separate documents but should include contract provisions that require managed care plans to follow these instructions. States must post contracts with all types of managed care plans on their websites (see Box IV.2). Finally, contracts should define the incentives and sanctions the state will use to promote compliance (discussed below in Section D).

Provider directory requirements. Like provider network standards, requirements for provider directories should be incorporated into states' managed care plan contracts. The 2016 Medicaid and CHIP managed care final rule requires provider directories maintained by managed care plans to (1) contain specific types of information about providers, (2) provide this information for all providers of services covered in the plan, and (3) update the directory regularly [§438.10(h) and §457.1207, summarized in Box IV.3. States can exceed these minimum federal requirements if they choose. For example, a **California** law adopted in 2016 now requires weekly online updates to all managed care provider directories, including but not limited to Medi-Cal (Medicaid) plans. If network providers do not respond to the plan's efforts to verify directory information, the California law allows health plans to withhold up to 50 percent of the capitation rate to a provider or provider group; for providers paid on an FFS basis, plans may delay claims payment for up to one month.[49]

2. Data and reporting requirements in state-managed care plan contracts

The 2016 Medicaid and CHIP managed care final rule requires states to specify in contracts with managed care plans the *reports and documentation* that these plans must

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🔍 **Federal rules**

Box IV.2. Posting of managed care plan contracts and compliance information online

Federal Medicaid rules [§438.602(g)] require states to post contracts with all types of managed care plans on their Medicaid websites.

🔍 **Federal rules**

Box IV.3. Medicaid and CHIP managed care provider directory information requirements

Federal rules [§438.10(h)] require that plan directories do the following:

A. Contain the following information about network providers:

- The provider's name and group affiliations
- Street address
- Telephone number(s)
- Website URL, as appropriate
- Specialty, as appropriate
- Whether accepting new enrollees
- Cultural and linguistic capabilities; for example, languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training
- Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment

B. Include the above information for the following provider types (if covered under the contract):

- Physicians, including specialists
- Hospitals
- Pharmacies
- Behavioral health providers
- LTSS providers, as appropriate

C. Be updated regularly:

- At least monthly, for paper versions
- For electronic versions, no later than 30 calendar days after the managed care plan receives updated provider information

D. Be posted/available on managed care plan websites

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[49] SB 137 is available at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB137.

submit to the state to demonstrate network adequacy [§438.207(b) and §457.1230(b)]. The final rule also requires, at a minimum, that such documentation be submitted (1) when the contract first goes into effect; (2) at least annually thereafter; or (3) when significant changes affect the adequacy of capacity and services, such as "changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its pro-vider network," or enrollment of new popula-tions [§438.207(c)(3) and §457.1230(b)]. Box IV.4 explains states' responsibilities for public reporting and assuring CMS that managed care plans have submitted documents verify-ing compliance with network and availability requirements.

States also must specify the **data** to be submit-ted to certify managed care plan compliance with state requirements for availability and accessibility of services, including the adequacy of the provider network, and conduct overall monitoring and oversight [§438.604(a)(5) and §457.1285]. Finally, states should specify the **timing** for managed care plans to submit the required reports and data.

Data and reports that states commonly use to monitor compliance with network standards and access goals include the following:

> ### 🔍 Federal rules
>
> ### Box IV.4. Public reporting and CMS assurances regarding managed care plan compliance with network and availability requirements
>
> *Post online.* States must post documentation (described in [§438.207(b)]) on their Medicaid websites that justifies the state's certification of MCO, PIHP, or PAHP compliance with requirements for availability and accessibility of services, including the adequacy of the provider network in §438.206 [per §438.602(g)(2)].
>
> *CMS reporting.* States must submit an assurance of compliance to CMS that MCOs, PIHPs, and PAHPs meet the state's requirements for availability of ser-vices, and must include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO, PIHP, or PAHP related to its provider network [§438.207(d)].* Such assurances must be provided at these times:
>
> - When first entering into such contracts
> - On an annual basis
> - When significant changes occur in covered benefits, geographic service area, or enrollment of a new popu-lation in managed care
>
> ** This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2018. Until that date, states must to continue to comply with §438.207 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.*

- **Network adequacy reviews**, including geo-mapping and waiting times, stratified by provider type, geographic location, and urban/rural, as well as providers no longer participating or not accepting new patients

- Accurate, complete, and timely managed care **encounter data**, used to detect potential under-use or inappropriate use of services

- **Provider participation reports**, submitted monthly, quarterly, annually, or with another fre-quency, in specified formats, data fields, and file submission standards

- Results of enrollee surveys, provider surveys, secret shopper studies, and audits of appoint-ment requests

- **Member complaints, grievances, and appeals logs** related to problems in obtaining needed services in a timely fashion or finding participating providers, and the dispositions and resolu-tions of such complaints, grievances, and appeals

- **Provider complaints and appeals logs**, and data related to problems such as securing timely approval of referrals to specialists

- **Out-of-network utilization reports**, an indicator of potential deficiencies in provider networks

Deliverables checklists or cross-walks, like the example from **California** in Box IV.5 below, can help to ensure that each contract requirement related to provider networks and access or availability has an associated report.

✔ State practices		
Box IV.5. California network and access requirements and required reports		
Domain	**Contract requirements**	**Compliance documentation, monitoring, and evaluation**
Provider network	Plans are required to provide access to the following services: • Adequate capacity of the primary care network • Board certified or eligible specialists • Non-physician medical practitioners (e.g., midwives, nurse practitioners) • Federally Qualified Health Center services • Traditional and safety-net providers	• Change in Provider Network Quarterly Report • Geographic mapping reports • Medical surveys conducted by the Division of Audits & Investigations and Department of Managed Health Care • Plan Subcontractors Quarterly Report • Provider directory (updated semi-annually) • Subcontractors' agreements/records
Access and availability	Plans communicate, enforce, and monitor provider compliance with the following standards: • Appointments (per contract criteria) • Emergency services facility within service area with at least one physician and one nurse on duty at all times • Urgent care within 24 hours • After-hours calls • Linguistic/interpreter services available 24 hours/7days/week • Access for disabled members • Services with special arrangements (e.g., family planning) • Community advisory committee(s)	• Consumer Satisfaction Survey • Emergency department (ED) protocols • Evidence of coverage member handbook • Inpatient days information • Medical surveys conducted by the Division of Audits & Investigations and Department of Managed Health Care • Policies and procedures • Quality improvement projects

States also might find it useful to issue an annual managed care report guide, as in **Florida**, listing all of the reports and forms required to be filed, along with templates (see Box IV.6). The contract references the guide, and each report is described in the contract "Summary of Reporting Requirements Table."

Annual reports. Although states should develop systems to integrate all data and reports related to network adequacy and availability of services, they also might find it helpful to require managed care plans to prepare an annual report that consolidates this information for each plan, which could be shared with the state's EQRO to avoid duplication of data collection. This approach could help state officials examine multiple access measures and identify overall patterns. For

✔ **State practices**

**Box IV.6. Florida's Statewide Medicaid Managed Care Program
MCO Reporting Requirements**

Florida's annual MCO Report Guide lists all reports and forms required to be filed, along with templates.* The contract references the Guide, and each report is described in the contract "Summary of Reporting Requirements Table." Encounter data and CAHPS and HEDIS data are subject to different reporting requirements.

For each report, the guide specifies (1) which plan types must submit it; (2) its purpose; (3) the frequency and due date; (4) report submission requirements, including file formats, layouts, naming conventions, and others; (5) specific instructions for different types of plans; and (6) the location of report templates. Network and access-related reports and templates include the following:

- Provider Network File—full file refresh due weekly
- Provider Termination and New Provider Notification report—due weekly
- Denial, reduction, suspension, or termination of services for LTSS enrollees—due monthly
- Missed services for LTSS enrollees, with pre-specified codes for reasons: provider cancellation, provider no-show, enrollee cancellation, enrollee no-show, scheduling error due to enrollee, scheduling error due to provider, lack of authorization, other—due monthly
- Additional network adequacy standards (under development, to be submitted monthly)
- Emergency room (ER) visits for enrollees without primary care practitioner appointment—due annually
- Timely access/PCP appointment wait times for a statistically valid sample of enrollees—due annually

* All Florida reports and templates are posted online, available at http://www.fdhc.state.fl.us/medicaid/statewide_mc/report_guide_2016-10-01.shtml.

example, **Massachusetts** requires its contracted managed care plans to submit a "Summary Access and Availability Analysis Report," which contains key findings from all access reports and data sources (for example, grievance system, telephone contacts with access/availability-associated reason codes, provider site visits, use of out-of-network alternatives due to access/availability, care management staff experiences with scheduling appointments, and so on; *MassHealth Managed Care Quality Strategy 2013*).[50]

C. Methods for monitoring provider network and access

The 2016 final rule [§438.66(c)] requires each state to "use data collected from its monitoring activities to improve the performance of its managed care program."[51] To operationalize this rule, states should establish data systems and procedures that can collect, organize, and analyze information and reports submitted by managed care plans; validate the data; and compare the results to state standards and benchmarks. Some of these functions may be carried out by the state Medicaid agency and some by the state's external quality review organization (EQRO); coordination between the state and EQRO is therefore essential.

This section describes (1) the methods to monitor provider network adequacy and directory accuracy for each contracted managed care plan, (2) methods to monitor access to care and availabil-

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[50] "MassHealth Managed Care Quality Strategy 2013, Appendix 1, Managed Care Entity Program Reporting Requirements." Available at http://www.mass.gov/eohhs/docs/masshealth/research/mco-reports/quality-strategy-dec2013.pdf.

[51] Though the requirements at §438.66(c) do not apply to CHIP, other recommendations in this section of the toolkit may be applicable to CHIP managed care programs.

ity of services in each managed care program more broadly, and (3) analyses to assess progress toward statewide access goals. This section also highlights the need for states to publicize the findings of these monitoring efforts in the interest of transparency and accountability, and provide assurances to CMS that the state is faithfully carrying out its oversight responsibilities.

Table IV.2 shows each of the monitoring methods described in this section by the corresponding domain in the access framework shown in Chapter I and indicates how the sample measures listed in the table can be used for monitoring.

Table IV.2. Methods to monitor compliance with network and access standards, by domain

Data sources	Availability and provider capacity	Accessibility	Accommodation	Realized access
Provider network lists and provider directories	Reviewing monthly or quarterly managed care plan network provider files against contract standards Reviewing number of participating providers in each plan by type, geographic location (urban/rural), specialty, acceptance of new patients Validating provider directory accuracy Making secret shopper calls to verify appointment availability	Conducting geo-mapping to calculate average driving distance by plan, region, and enrollee groups, and relative to benchmarks (e.g., Medicare Advantage standards)	Comparing percentage of network providers who can communicate in the non-English languages most common among enrollees to contract standards [§438.68(c)(1)(vii) and (viii), and §438.206(c)(2) and (c)(3)]	
Grievances and appeals	Tracking trends over time in the volume of grievances and appeals related to lack of timely access to care, denial of out-of-network authorizations, etc.; also, comparing across managed care plans and comparing similarities or differences across regions or counties			
Beneficiary call center requests	Comparing number and percentage of calls or complaints concerning provider access—by managed care plan, region or county, and enrollee group			For LTSS, electronic visit verification (EVV) systems to monitor the timeliness and delivery of home care services (see Chapter V for more information)
Beneficiary surveys (CAHPS, Behavioral Risk Factor Surveillance System [BRFSS], other state surveys)	Comparing all enrollee and population-specific survey responses to state averages and across plans			
Provider surveys and call centers	Tracking number and percentage of calls and complaints related to credentialing and prior authorization delays—over time, and across plans, regions, and provider types			
HEDIS® measures and scores				Comparing access-relevant HEDIS® scores across health plans and against national benchmarks
Managed care encounter data and other managed care plan reports	Tracking out-of-network service use and claims			Analyzing service use trends over time and by plan, region, and enrollee group Flagging sentinel events: ED visits, preventive screenings

1. Monitoring managed care plan compliance with network standards and provider directory requirements

As of 2012, about half of state Medicaid agencies required plans to submit monthly or quarterly reports and files concerning their provider networks, whereas the rest required annual or less

frequent reporting. A few, like **Florida**, require weekly file submissions (see Box IV.7). Many states regularly review provider network files, compare them to provider-to-enrollee standards, and conduct geo-mapping to compare each plan's provider locations against time and distance standards. By comparing files across plans, states can also assess the capacity of individual providers who participate in multiple plans that serve Medicaid enrollees.

States have long been required to conduct an annual EQR, in which a state's EQRO conducts an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services furnished by a managed care plan to its Medicaid beneficiaries (§438.320). The EQR uses information generated by the mandatory and optional EQR-related activities. New federal regulations establish a new mandatory EQR-related activity, the validation of MCO, PIHP, and PAHP network adequacy [§438.358(b)(1)(iv) and §457.1250(a)]. Consistent with §438.352, CMS must develop a protocol for this new mandatory EQR-related activity. States will be required to begin conducting an annual validation of network adequacy using methods consistent with the associated EQR protocol [§438.350(e)] no later than one year from its issuance. The information from this activity must be given to the state's EQRO for inclusion in the annual EQR technical report [§438.364 and §457.1250(a)].

> ### ✔ State practices
>
> ## Box IV.7.
>
> **Florida's Provider Network Verification (PNV)** is a database created and maintained by the state Medicaid agency's enrollment broker. It houses information about all providers who contract with each state Medicaid managed care plan. Each week, the plans must send an updated provider network file to the PNV system. The data are cleaned, deduplicated, and checked against provider licensing, Medicare exceptions, and other files to identify ineligible providers.
>
> PNV data are used in several ways: (1) the enrollment broker uses the cleaned files in choice counseling, (2) a data analytics vendor (Quest Analytics) runs geo-mapping software to analyze each plan's compliance with time and distance standards, (3) a unit within the Medicaid agency uses PNV files as the basis for secret shopper calls, and (4) the Medicaid data unit examines all plans' networks in each region to determine whether the aggregate number is sufficient to serve all enrollees in that region. In the future, the state plans to use PNV to create an online provider directory for all participating Medicaid managed plans.

Some states already conduct network adequacy validation activities outside of the context of the forthcoming annual EQR requirement. **Tennessee**, for example, contracts with an EQRO to conduct quarterly provider data validation surveys, using statistically valid samples of providers in each plan to determine the accuracy of provider data files. The state can issue fines (called liquidated damages) "if data for more than 10 percent of providers is incorrect for individual data elements" (TennCare 2016a). Tennessee's EQRO also conducts an annual network adequacy survey to determine the extent to which managed care plans' networks comply with all contractual obligations related to provider networks.

Health plan compliance with network standards may be exempt from EQR review if the state Medicaid and CHIP agencies use the results of NCQA accreditation reviews and reports to verify network adequacy.[52] As of July 2016, 24 states require Medicaid managed care plans to obtain NCQA health plan accreditation and 9 states use NCQA accreditation documents to demonstrate compliance with components of the Medicaid managed care EQR and state-specific requirements. For example, in **Michigan**, plans that receive NCQA accreditation are exempt from certain portions of the state's annual on-site review. The state also factors the results into annual bonus awards to the plans. The NCQA Health Plan Accreditation Standards related to network management and access are listed in Box IV.8.

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[52] To be exempt from EQR review, the Medicaid contract must have "been in effect for at least 2 consecutive years before the effective date of the exemption and during those 2 years the MCO has been subject to EQR under this part, and found to be performing acceptably for the quality, timeliness, and access to health care services it provides to Medicaid beneficiaries" [§42 CFR 438.362(a)(3)]. Note, however, that the two-year period does not begin until CMS issues a new EQR protocol pertaining to network adequacy validation; that protocol had not yet been issued when this report was published.

> ### *i* Data and information resources
>
> ## Box IV.8. 2016 NCQA Health Plan Accreditation Standards—network and access*
> ## NETWORK MANAGEMENT
>
> **Availability of practitioners**
>
> - Are practitioners located throughout the plan's service area?
> - Did the organization consider the cultural needs of its members when it created its practitioner network? For example, are there multilingual practitioners?
> - Does the organization take steps to ensure that there are sufficient numbers of primary care and specialty practitioners available to its members?
> - Does the organization measure its performance and make improvements when needed?
>
> **Accessibility of services**
>
> - Does the organization have standards to ensure access to medical care, including routine primary care, emergency care, and after-hours care?
> - Can members get behavioral health care when they need it?
> - Does the organization measure its performance and make improvements when needed?
>
> **Assessment of network adequacy**
>
> - Does the organization analyze data from complaints and appeals to determine if there are issues concerning geographic distribution or types of practitioners in its network?
> - Does the organization make improvements in its network from information it receives from its analysis of access and availability?
>
> **Continued access to care**
>
> - Does the organization or practitioner notify members affected by the termination of a primary care practitioner's contract?
> - Are there circumstances in which members may continue to see a practitioner whose contract has been terminated?
>
> **Physician and hospital directories**
>
> - Does the organization provide a searchable web-based directory of its physicians and hospitals?
> - Does the physician and hospital directory contain the most current information?
> - Does the plan test the directory for understanding and member ease of use?
> - Is the directory available in other formats (e.g., printed, by telephone)?
>
> **Delegation of network activity**
>
> - If the organization delegates network activity, has it worked with the delegate to develop a mutually agreed-upon document that outlines responsibilities, delegated activities, and evaluation processes?
> - Does the organization provide member experience and clinical performance data to the delegate when requested?
> - Has the organization evaluated whether the delegate can perform the activities?
> - Does the organization review the delegate's quality improvement (QI) program and review its performance annually?
>
> **Medicaid benefits and services**
>
> - Does the Medicaid plan provide direct access to women's health services?
> - Does the Medicaid plan provide for a second opinion from an in-network provider or arrange for the member to obtain a second opinion outside the network?
> - Does the Medicaid plan adequately cover services out of network when it cannot provide them within its network in a timely fashion?
> - Does the Medicaid plan ensure that the cost to members for out-of-network services when it cannot provide them in its network is the same as the cost of in-network services?
> - Does the Medicaid plan require the hours of operation that providers offer to Medicaid members to be no less than those offered to commercial members?
>
> * Available at http://www.ncqa.org/Portals/0/Programs/Accreditation/2016_HPA_SGs.pdf.

Secret shoppers. Many states also perform some type of secret shopper surveys to verify compliance with provider network standards and validate the accuracy of managed care plan provider directories. These calls can be used to (1) verify that the providers actively contract with the managed care plan, (2) determine which providers have open or closed panels (that is, whether they see new patients), and/or (3) check how long it takes new patients to get an appointment for urgent and non-urgent visits. To conduct these calls, state agency staff, EQROs, or other vendors call providers in each plan's network (blocking caller ID) and either announce the purpose of their call or pose as a plan enrollee to inquire about appointment availability. Survey staff are usually trained and coached to deliver the script in a conversational format.

The quantity of calls and method of sampling providers varies by state. Some states, like **New York**, call a sample of providers in each region listed in the plans' most current provider directory at least once every year. **Pennsylvania** and **Indiana** Medicaid agency staff complete about 50 calls each quarter. **Michigan** uses Medicaid agency staff to call 15 to 20 providers from each plan to ask if they are accepting new Medicaid patients. Other states rotate calls among providers of various types, based on services of special concern; for example, **Florida** recently called all adult psychiatric providers in certain regions.

2. Monitoring access and availability of services

To complement the monitoring of managed care plan compliance with network adequacy and provider directory requirements, states typically use a number of different methods and data sources to monitor the extent to which enrollees have timely access to providers and services covered by the managed care contract.

According to a 2015 survey of state Medicaid agencies and Medicaid managed care plans, CAHPS surveys and enrollee complaints and grievances are the most common methods used to monitor access. All respondents to the survey, which included 17 state Medicaid agencies and seven Medicaid managed care plans, indicated they relied on these sources to some degree (Brodsky et al. 2015).[53] Fourteen of the 17 state respondents reported tracking "the total number of complaints about network access received by the state's call center," and nearly all of them reported reviewing the number of enrollee complaints about network access reported by each managed care plan. Twelve of the 17 states and six of the seven Medicaid managed care plans responding to the survey also tracked ER utilization rates, but less than half of the former and just over half of the latter tracked encounters by service type to assess potential underutilization of important types. Three of the 17 responding Medicaid agencies and four of the seven responding Medicaid managed care plans tracked the proportion of out-of-network encounters to total encounters as a potential indicator of inadequate availability of providers in the network.

Member grievances and appeals. The 2016 final rule requires all states to direct health plans to maintain records of and submit reports to the state on member grievances and appeals [§438.416(a) and (b), and §457.1260]. However, the timing and level of detail in these reports vary by state. To be most useful for monitoring provider network adequacy and availability of services,

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[53] Among the 39 states with Medicaid managed care programs asked to participate in the survey, 17 responded; among 30 Medicaid managed care plans contacted, just 7 responded to the survey. Consequently, the results are not representative of all states and Medicaid managed care plans nationally (Brodsky et al. 2015).

Box IV.9. California's grievance logs

Medi-Cal (California's Medicaid program) health plans must submit a Grievance Report every quarter, using a state-issued template that standardizes how plans classify and report grievances, and their resolution. The template has several categories—access, benefit/coverage, referrals, quality of care or service, and other—and specifies six access subcategories to identify major problems within and across plans and regions:

1. Excessively long wait time/appointment schedule time
2. Lack of primary care provider availability
3. Lack of specialist availability
4. Lack of telephone accessibility
5. Lack of language accessibility
6. Lack of facility physical access

California's template is available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsand-PolicyLetters/APL2014/GrievanceReportTemplate.xls.

the reports should develop standardized categories for different types of grievances and appeals, as in **California** (see Box IV.9). **Florida**'s grievance and appeals reports, due monthly, list 13 categories, including access to care, out-of-plan service authorization, and in-plan service authorization.

Enrollee/provider complaints to call centers and enrollee surveys. When enrollees encounter problems with access, quality, benefits, or other rights, they can file formal grievances and appeals that are subject to legal rules and requirements. In contrast, complaints by enrollees and providers to hotlines, call centers, or ombudsman programs offer a more informal means of providing feedback to states on problems with access, benefits, and other issues. These methods can help states monitor access in real time by serving as early warning signals, particularly during initial program roll-out. However, consumer and provider complaints may not be representative of systemic problems with network adequacy and access. Consequently, states should complement this information with annual surveys of enrollees and providers, using statistically valid samples to assess the prevalence of access problems more broadly.

To supplement annual CAHPS surveys, some health plans conduct more frequent enrollee surveys to monitor access. For example, two health plans in **Tennessee** (Blue Cross and TennCare Select) conduct quarterly patient experience surveys to monitor enrollee satisfaction with office wait times and overall experience with care. The plans contact members who recently visited medical and behavioral health providers, and ask about wait times for scheduling appointments, office wait times, and enrollees' experiences and satisfaction with office visits. The plans compare survey responses to the previous five quarters to assess whether there are notable changes (TennCare 2016a).

Validation of plan-reported access measures and performance improvement projects. As part of the annual EQR assessment of managed care plan performance, the 2016 final rule requires a state, a non-MCO agent, or an EQRO contracting with a state to validate the performance measures required by the state as a part of each managed care plan's quality assessment and performance improvement (QAPI) program [§438.358(b)(1)(ii) and §457.1250(a)]. States or EQROs must also validate performance improvement projects (PIPs) [§438.358(b)(1)(i) and §457.1250(a)]; state Medicaid agencies can select the focus of these projects (see Box IV.10 for example).

Use of managed care encounter data to construct access measures and identify potential problems. Because managed care plans are required to submit encounter data on enrollees' individual service use, and states or EQROs usually validate encounter data, states can use these data to regularly monitor access. For example, **Florida** uses encounter data to analyze the proportion of

✔ **State practices**

Box IV.10.

In **Oregon**, the EQRO examined the performance of Medicaid managed care plans (called Coordinated Care Organizations, or CCOs) in 2015. It found that all plans made progress in improving access to behavioral health services by co-locating mental health and SUD treatment practitioners in primary care clinics or embedding physical health practitioners in mental health clinics. It also found that some CCOs increased after-hours availability, deployed mobile units in rural communities, and recruited additional providers. However, the EQRO indicated more work was needed to improve access to care in rural areas and increase access to specialists, especially psychiatrists and mental health practitioners. Moreover, it found that some CCOs did not have systematic mechanisms to monitor capacity and access, and were unprepared to identify gaps or disparities across the CCO network (Acumentra Health 2016).

providers in each plan actually serving Medicaid enrollees in a given time period. **Michigan** uses encounter data to monitor the percentage of new managed care enrollees who have a primary care visit within the first 150 days of enrollment, as well as the use of transportation services and immunizations. If the state detects signs of potential access problems, such as more than half of new enrollees not having primary care appointments, it will ask plans to assess provider availability. In addition to validating aggregate access measures reported by plans, encounter data can be used to track trends in services that may indicate regions of the state where access problems are more acute. **New York** developed a sophisticated system that calculates HEDIS® measures from encounter data every month (see Box IV.11).

3. Evaluating system-wide access

To evaluate access more holistically, states, in collaboration with EQROs, have developed various tools and processes to pool information and data from multiple sources, though this development is not explicitly required by federal rules. Such practices allow state officials to obtain a comprehensive picture of access; view trends over time; and identify whether certain plans, regions, service types, or enrollee groups are facing greater access problems than others. With the increased use and capabilities of data analytics, these practices are becoming more common.

For example, **Arizona** holds quarterly meetings with staff from all divisions to review all performance measures for each plan over time, as well as performance relative to other plans, to identify areas needing improvement.

✔ **State practices**

Box IV.11. New York's use of encounter data

As part of a multifaceted initiative to monitor access, timeliness, and quality of care, New York worked with a contractor to develop automated tools and systems to construct utilization measures from Medicaid claims and encounter records. Each month, the state loads claims and encounter data from each managed care plan into its Clinical Data Mart, which uses a custom-built software program to calculate HEDIS measures, such as well child visits and hospitalizations for ambulatory care-sensitive conditions. The results are compared to aggregate HEDIS measures reported by plans to the state, allowing New York to validate plan-reported measures and monitor utilization more frequently than most other states.

Although state officials say it took many years to develop the system and was quite costly, they expect the total expense to be less than the cost of paying HEDIS-certified software vendors to run the data continually for the millions of Medicaid beneficiaries in the state. In addition, the state can use the system to support several other programs, such as the state's Delivery System Reform Incentive Payment (DSRIP) Program.

New Mexico produces reports that show how many of the state's four managed care plans meet access standards for distance, divided by provider type and by urban-rural-frontier geographic area. For example, Figure IV.2 below depicts trends in 2014 and 2015 by quarter; this provides information at a glance about the provider type with the greatest problems (dermatology). Figure IV.3 shows average appointment waiting times for new patients by managed care plan.

Figure IV.2. Sample New Mexico report: Physical health provider types with limited access																		
	Urban counties						**Rural counties**						**Frontier counties**					
Geo-access standard	**Urban = 30 miles**						**Rural = 60 miles**						**Frontier = 90 miles**					
	2014				**2015**		**2014**				**2015**		**2014**				**2015**	
Provider Type	1st qrt	2nd qrt	3rd qrt	4th qrt	1st qrt	2nd qrt	1st qrt	2nd qrt	3rd qrt	4th qrt	1st qrt	2nd qrt	1st qrt	2nd qrt	3rd qrt	4th qrt	1st qrt	2nd qrt
Certified midwives	4	4	4	4	4	4	2	2	3	3	3	3	4	4	4	4	4	4
Dermatology	0	1	1	1	1	1	0	0	0	0	0	0	3	1	1	1	1	1
Endocrinology	3	4	4	4	4	4	0	0	0	1	1	0	0	0	0	1	1	1
Hematology/oncology	4	4	4	4	4	4	2	2	2	3	3	3	4	3	3	4	4	4
Neurology	4	4	4	4	4	4	2	1	1	1	1	2	1	2	1	1	1	2
Neurosurgeons	3	4	4	4	4	4	0	0	0	0	0	0	0	0	0	0	0	0
Rheumatology	3	3	4	4	4	4	0	0	1	1	1	0	1	1	1	1	1	0

Source: 2014 and 2015 MCO Geo-Access Reports.
Note: 0 = Met by no MCO; 1 = Met by 1 MCO; 2 = Met by 2 MCOs; 3 = Met by 3 MCOs; 4 = Met by all 4 MCOs.

Figure IV.3. Sample New Mexico report: Primary care provider phone survey results: Average wait times for new patient appointment, in days							
	Urban			**Rural**		**Frontier**	
	Bernalillo	**Doña Ana**	**Santa Fe**	**Chaves**	**McKinley***	**San Juan**	**Mora***
BCBSNM	36	12	28	2	n/a	14	28
MHNM	51	35	49	12	21	30	14
PHP	33	9	23	35	17	77	n/a
UHC	66	46	27	18	31	28	n/a
County Average	43	25	32	21	n/a	52	n/a

Source: Legislative finance committee (LFC) survey March 8−22, 2016.
Notes: n/a indicates no surveyed PCP in that county was accepting new clients for that MCO, and thus it was not possible to calculate a county average wait time; blue shading indicates long wait times.

D. Enforcing requirements, incenting change, and improving activities on an ongoing basis

Ensuring and improving the availability of services and access to care requires constant vigilance. When data and monitoring activities reveal problems, states must inform managed care plans that they are falling short. However, if states are to hold managed care plans accountable for network adequacy and ensure that their members have sufficient access to services, they also must have

the authority and the tools to (1) apply penalties and other enforcement actions for violations of network standards and access requirements, (2) give plans positive incentives to improve, and (3) devise and implement strategies to remedy deficiencies and improve the availability of services.

At the end of each contract period, the results of reviews of managed care plans' compliance with network standards and analyses of access metrics may indicate a need to revise or update access goals and network and access standards. Major delivery system reforms that involve managed care may call for a comprehensive revision to managed care network standards. The cycle then will begin again: establishing new goals, revising contract terms, updating or creating new reports, collecting and analyzing additional data, and devising new incentives and improvement strategies.

1. Penalties

The 2016 final rule requires states to both develop network adequacy standards and enforce them [§438.68(a) and §457.1218]. When states, through their contracted EQROs or other vendors, identify violations of contract terms regarding provider networks, they should be prepared to employ a continuum of enforcement actions and sanctions [§438.700 and §457.1270]. These include (1) warnings and official notices of violations of contract terms, (2) requests for corrective action plans to resolve problems and discrepancies, (3) capitation rate withholds or suspension of capitation rate payments, (4) suspension of all new enrollment, (5) financial penalties, or (6) contract termination. Managed care plans should be entitled to appeal these actions and penalties or request an exception under certain circumstances. State-managed care plan contracts should clearly define the consequences and the specific penalty amounts for violation of compliance with access-related contractual requirements for the following:

- **Network and access deficiencies**, including failure to meet network standards, provider directory inaccuracies, or excessive waiting times for appointments

- **Reporting delays and inaccuracies**, such as repeated failure to submit reports on time, submission of files and reports that do not conform to specified layouts, and error rates higher than certain thresholds for each data field

Each state can decide the type of penalty and the amount of financial penalties, and should be reasonable relative to the severity of each violation. **Florida**, for example, sets "liquidated damages" (financial penalties) at a certain amount per recipient or a flat amount resulting from an event or action; plans can challenge these decisions within 21 days. Some states may also consider the plan's history of violations or number of occurrences when assessing financial penalties.

2. Incentives

States use a variety of incentives to encourage plans to meet access standards and metrics, including the following:

- **Public reporting** can include, for example, access indicators for each managed care plan in public report cards to inform beneficiary choice. This method encourages plans to maximize their performance to attract new members.

- **Pay for performance** involves states setting access targets or thresholds for value-based purchasing awards. In **Oregon**, for example, contracted CCOs receive funds from a quality funding

pool based on their annual performance on 17 measures, including those related to access. CCOs' performance is assessed based on whether they meet state or national benchmarks and demonstrate improvement from their own baselines. In **New York**, the Medicaid Managed Care Quality Incentive Program awards financial incentives to managed care plans if their performance on specified quality, satisfaction, and compliance scores exceeds certain benchmarks and shows improvement over time; several of the individual measures reflect access and network adequacy.[54]

- **Bid evaluations** involve scoring by weighting submissions related to network adequacy and access. For example, in its last completed procurement for acute services, **Arizona** awarded a predetermined percentage of total bid points for responses related to access and network development processes, use of data to monitor adequacy, and special efforts to ensure access in medically underserved areas and for special needs populations. For its last procurement of a plan that enrolls children with special health care needs, the state assigned significantly more points to access and network development processes to show the importance of these requirements.

- **Enrollee assignment** covers default and passive assignment (often called auto-assignment) preferences based at least in part on network capacity. In **Michigan**, plans that demonstrate lower primary care provider-to-enrollee ratios are awarded additional performance points in annual reviews and may also receive more enrollees through the automatic enrollment process for those new enrollees who do not choose a plan within a certain period. This method serves as an incentive for plans to build their networks.

3. Strategies to increase provider participation and access

In many parts of the country, particularly but not exclusively rural areas, there simply are not enough providers to serve Medicaid enrollees (Petterson et al. 2012). In contrast to long-standing shortages of primary care providers for adults, the number of primary care providers per child has more than doubled—from 32 per 100,000 children in 1975 to 78 per 100,000 children in 2005 (Freed and Stockman 2009). However, supply is not evenly distributed: an estimated 1 million children live in areas in which there is no local pediatrician or family physician (Shipman et al. 2011). Many pediatric specialties report fewer than 1,000 physicians nationwide, and nearly all pediatric specialists practice in urban, tertiary care centers (Mayer 2006). Inpatient care for children with chronic conditions is also highly concentrated in tertiary care children's hospitals (Berry et al. 2013), and hospital care for common conditions is increasingly provided in larger hospitals (Hasegawa et al. 2013; Lopez et al. 2013).

In areas with provider shortages, states can collaborate with managed care plans to increase the supply of certain provider types through recruitment and retention strategies or use other methods to improve distribution in underserved areas of the state. Ensuring and improving access to care for Medicaid and CHIP managed care enrollees is an ongoing challenge, and there are several strategies that have had some success.

Assess provider payment rates. Provider network inadequacies and too few providers accepting new Medicaid managed care patients may be due to managed care plans offering low provider

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[54] For more information on New York's Medicaid Managed Care Quality Incentive Program, this report is available at http://health.ny.gov/health_care/managed_care/qarrfull/qarr_2015/docs/quality_incentive.pdf.

payment rates. Many studies have shown that physician participation rates in Medicaid are generally correlated with payment levels, and that increased Medicaid rates raise the likelihood that providers will accept new Medicaid patients. Evidence suggests that after the ACA temporarily required states to increase Medicaid primary care reimbursement rates to Medicare levels in 2013–14, PCPs were more willing to see new Medicaid patients; in states with the largest payment increases, primary care appointments for Medicaid patients increased as well (Polsky et al. 2015). However, when a state or a region has critical physician shortages, increased Medicaid payment rates alone are unlikely to solve the problem, and Medicaid enrollees may encounter barriers to access because even if a high percentage of doctors accept Medicaid patients, there still are too few to serve enrollees. Consequently, states should look at several indicators of physician participation to determine whether and to what extent increases in managed care plan payment rates can remedy the problem, and if so, what size increase would induce greater participation (Sommers and Kronick 2016).

As part of setting actuarially sound capitation rates, the 2016 final rule [§438.4(b)(3)] also requires states to ensure that rates are "adequate" to allow managed care plans to meet the availability, capacity, and coordination and continuity of care requirements of §438.206, §438.207, and §438.208. States may need to increase the capitation rates to allow plans to meet their access and network adequacy requirements under these circumstances: (1) if actuaries determine that the capitation rates do not consider prevailing provider reimbursement rates or (2) if they find evidence that the rates paid by managed care plans are substantially lower than those paid by Medicare and thus a major cause of widespread shortages of providers for certain services. As noted in Chapters I and II, however, provider payment rates may be only one of numerous factors affecting the ability of plans to contract with providers, so it is important to consider all of these factors as well as other remedies.

Coordinate and streamline provider recruitment and credentialing. A reduction in paperwork requirements may persuade providers who already serve FFS beneficiaries to join managed care plan networks and serve their enrollees. To encourage them, many states have centralized Medicaid and CHIP provider registration systems for all providers, whether they participate in Medicaid and CHIP FFS or managed care. Using this system, states—or plans if states share these lists with them—can compare managed care network providers against all of those registered and identify providers for network recruitment. In addition, the 2016 final rule now requires each state to establish a uniform credentialing and recredentialing policy for acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate. The final rule also requires each managed care plan to follow those policies. When states use the registration system to credential and recredential providers, it obviates the need for providers to submit multiple applications to various plans.[55]

- **Use telehealth to expand access in provider shortage areas.** States may expand provider capacity in shortage areas by covering telehealth services as a Medicaid and CHIP benefit, and permitting electronic consults with specialists. For example, in January 2015, Medi-Cal,

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[55] Another option is CAQH ProView, an online database that providers use to self-report professional and practice information to payers, hospitals, large provider groups, and health systems, which eliminates duplicative data entry for submitting provider profile information for claims administration, credentialing, directory services, and so on. See http://www.caqh.org/solutions/caqh-proview for more information.

California's Medicaid program, began covering teledentistry services (that is, dental services delivered by hygienists in consultation with dentists connected through the Internet). California law allows dental hygienists to perform certain procedures under remote dentist supervision, although it requires the hygienist to refer a patient to a dentist if more complex procedures are needed (MACPAC 2015, Chapter 2).

- **Ease state scope-of-practice laws.** Allowing mid-level practitioners (for example, physician assistants, nurse practitioners, and dental therapists) to serve Medicaid and CHIP enrollees— either statewide or in targeted geographic areas with provider shortages—can increase capacity as well. For example, in 2009, **Minnesota** became the first state to allow dental therapists (mid-level dental practitioners) to perform a limited number of authorized dental procedures. They are required to practice in settings serving primarily low-income, uninsured, and underserved patients or in Health Professional Shortage Areas for dental care. Similarly, the Alaska Native Tribal Health Consortium allows "dental health aides" to perform routine dental services under the supervision of a dentist to increase the dental workforce serving tribal communities (MACPAC 2015, Chapter 2).

- **Repay loans or fund residency programs for in-demand providers.** Some states have created their own educational incentives to supplement the loan repayment programs offered by the National Health Service Corps (NHSC).[56] For example, **Nebraska** runs a loan repayment program designed to bring dentists and other health care providers to rural areas. The program uses matching local and state funds to repay up to $40,000 per year for a three-year period to dentists who practice for at least three years in a dental shortage area and agree to serve Medicaid patients (MACPAC 2015, Chapter 2). New Mexico funds a residency program for four community and rural psychiatrists, in the belief that people who work in **New Mexico** will "remain where they train" and will continue to practice in the state's high-demand areas following the completion of their residency (see Box IV.12).

> ### ✔ State practices
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> ### Box IV.12. Behavioral health workforce development in New Mexico
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> New Mexico's' Behavioral Health Collaborative Strategic Plan includes a number of innovative examples of ways to develop the state's workforce. For information, see New Mexico Behavioral Health Collaborative. "Positioning Behavioral Health for Health Care Reform: Framework for Action—FY11-FY14." Chapter 9. Available at http://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/7_Behavioral_Health_Strategic_Plan.pdf.

- **Increase funds for services provided in community health centers.** The Health Resources and Service Administration (HRSA) administers capital development grants to support community- and school-based health center efforts to expand their capacity to provide primary and preventive health services to medically underserved populations, including those covered by Medicaid and CHIP, in underserved communities. For example, to increase dental care to children and adolescents covered by Medicaid and CHIP, states can apply for school-based health center capital grants to provide dental services through school-based health centers (MACPAC 2015, Chapter 2).

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[56] NHSC provides up to $50,000 in student loan repayment to dentists and other types of health professionals in exchange for a two-year commitment to work at an approved NHSC site in a high-need, underserved area.

- **Pursue other innovations.** A number of states are devising new incentives for providers to participate in Medicaid and CHIP managed care networks or expanding the types of providers who can deliver services. **Iowa**'s current Section 1115 Medicaid demonstration waiver, which relies on a managed care delivery system, includes three tiers of dental benefits. All waiver enrollees receive basic benefits, whereas those who get an annual dental exam once or twice each year can receive increasingly enhanced dental benefits (MACPAC 2015, Chapter 2). Tying the availability of services to frequency of use may persuade providers to participate in Medicaid and CHIP, particularly if enhanced payment is available. In addition, some states permit or require managed care plans to contract with individual behavioral health providers, rather than just clinics or community mental health centers, and will certify additional providers, such as licensed drug and alcohol counselors, to expand the availability of services.

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Chapter V:

Network and Access Standards and Monitoring for Special Provider and Service Types

The Medicaid and CHIP managed care final rule requires states to establish provider network standards and service availability requirements for a variety of provider types, including (1) primary care, adult and pediatric; (2) obstetrics and gynecology (OB/GYN); (3) behavioral health (mental health and substance use disorder [SUD]), adult and pediatric; (4) specialist, adult and pediatric; (5) hospital; (6) pharmacy; (7) pediatric dental; (8) long-term services and supports (LTSS); and (9) additional provider types, as appropriate [§438.68(b)]. Chapters II–IV of this toolkit use primary care services to illustrate the typical steps involved in identifying enrollee needs and provider capacity, developing network and access standards, and monitoring continued access to care because all or most Medicaid and CHIP managed care enrollees—particularly children—need primary care.

This chapter describes special considerations for a variety of other service and provider types, listed below.[57] For each provider and service type, it presents (1) an overview of the provider and service type and relevant federal rules, (2) special considerations in identifying enrollee needs and provider capacity, (3) special issues for establishing network and timely access standards, and (4) methods for monitoring managed care plan compliance and ensuring access to care. Considerations are discussed separately for each of the following provider types:

SECTIONS

- **Section A** Managed long-term services and supports providers
- **Section B** Behavioral health providers and services
- **Section C** Essential community providers, such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- **Section D** Indian health care providers
- **Section E** Family planning providers
- **Section F** Pediatricians
- **Section G** Pediatric dental providers

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[57] Due to resource constraints, this toolkit does not discuss network standards and access for two of the provider types for which the 2016 final rule requires minimum time and distance standards: hospitals and pharmacies. States needing to develop and set new standards for these provider types may seek advice from Medicaid pharmacy directors and consultants, and/or state associations representing these groups.

A. Managed long-term services and supports (MLTSS) providers

1. Overview of LTSS and relevant federal rules

Medicaid is the single largest payer for LTSS in the country. LTSS encompasses a diverse array of health and non-medical services and supports that help individuals with functional limitations perform activities of daily living (ADLs), such as bathing, dressing, and toileting, as well as instrumental ADLs, such as money management, shopping, and taking medications. Providers of LTSS include a wide range of organizations and individuals: nursing homes, group and supported living facilities, adult day health centers, personal care attendants, home-delivered meal services, case managers, home adaptation accessibility providers, transportation services, therapists, and others. The services and supports may be delivered in provider facilities, institutional settings, individuals' homes, or community settings.

As of 2016, about half of all state Medicaid programs provided LTSS through managed care organizations.[58] To ensure Medicaid beneficiaries will have timely access to all the LTSS they need, managed care plans should demonstrate that they contract with sufficient numbers and types of providers to "provide adequate access to all services covered under the [managed care plan] contract." The 2016 final rule requires states to do the following:

- **Establish time and distance standards** specifically for MLTSS programs [§438.68(b)(2)]. Time and distance standards should be defined for LTSS provider types in which the enrollee must travel to the provider. States must, however, develop standards other than time and distance for LTSS provider types that travel to the enrollee to deliver the service. States could consider, for example, the number of providers and staffing levels, such as staff-to-member ratios or the percentage of time the provider is likely to spend on patient care.

- **Ensure provider availability and accessibility** [§438.206]. To serve LTSS users, network providers must be able to ensure physical access, reasonable accommodations, and accessible equipment for enrollees with physical and mental disabilities. Provider characteristics that affect accessibility include hours of operation, wheelchair access, and geographic proximity to LTSS users to allow the provider to get to individuals or individuals to the provider, depending on the service (Klebonis and Barth 2013).

- **Collect and review documentation from contracted managed care plans** that demonstrates they can offer an appropriate range of preventive, primary care, specialty care, and LTSS services adequate for the anticipated number of enrollees for the service area [§438.207].

- **Establish a uniform credentialing and recredentialing policy** that addresses the LTSS providers who will deliver the benefits covered in their managed care plan [§438.214(b)].

2. Issues in identifying enrollee needs and provider capacity for LTSS

Transitioning to managed care. When states transition from an FFS system to managed care, they often require MLTSS plans to maintain the services, providers, and payment levels under the FFS programs for a set period so that providers, as well as enrollees and plans, can adjust to managed care. During this time, states might require each managed care plan to contract with "any willing

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[58] Source: Mathematica Policy Research analysis of unpublished data from the Medicaid Managed Care Data Collection System.

provider" that participated under FFS so LTSS users can maintain their existing providers to ensure continuity of care. They also might require managed care plans to honor all existing service plans to help maintain continuity in services.

When (or if) these protections expire, states should have robust network adequacy standards in place that reflect the expected volume of providers and services required under managed care. States should consider whether to develop these standards based on utilization patterns that existed under FFS or to change them based on expected shifts from institutional care to home and community-based services (HCBS)—a major "rebalancing" goal that has been a key driver of growth in MLTSS.

Data sources to identify enrollee needs. State and national data sources can help states that already operate MLTSS programs to project LTSS service needs. Functional assessment data collected by states or managed care plans when beneficiaries first enroll in MLTSS plans provide information on health and functional needs by level of care. Care plans developed to meet the needs identified in the assessment provide information on common services and provider types that MLTSS enrollees use most. However, few states collect such information electronically or in a standardized format, making it difficult to use for estimating overall needs and service demand.

National data can supplement state-level data. The Centers for Disease Control and Prevention's (CDC's) National Center for Health Statistics conducts a biennial survey of long-term care providers. The annual **National Study of Long-Term Care Providers (NSLTCP)**[59] report tracks service-use trends in major sectors of paid, regulated long-term care, including adult day services centers, home health agencies, hospices, nursing homes, and assisted living and similar residential care communities. The NSLTCP also provides information on long-term care users, including demographics (age, race, ethnicity, sex, and Medicaid use); medical conditions (Alzheimer's disease or other dementias, developmental disability, severe mental illness, and depression); physical and cognitive functioning (ADL assistance and wheelchair/scooter use); health care use (overnight hospitalizations, re-hospitalizations, and emergency department [ED] use); and other characteristics (move-ins, move-outs and where went, and left because of cost).[60] Sengupta et al. (2016) have also produced **state-specific tables for 2013–2014**.[61]

Estimating future demand for covered services and providers by subgroup. Demand for covered services can vary based on a number of factors, including income, age, gender, race and ethnicity, health status and health utilization, marital status, level of education, and geographic location. For example, national-level data has shown that more than 60 percent of disabled older adults living in the community use some long-term care services, most commonly basic personal care services and help with household chores, averaging about 180 hours per month. African Americans tend to use nursing homes at higher rates than white older adults; they are also more likely to experience preventable adverse events or complications from care received during hospitalization. Married older adults are less likely to report a limitation or disability than those who are widowed, divorced, or never married, and rates of limitations and disabilities decline with years of education. Older adults in rural areas have higher rates of chronic illness, disability, and mortality (IOM 2008).

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[59] For more information, visit the NSLTCP webpage at http://www.cdc.gov/nchs/nsltcp/index.htm.

[60] Information on each of the 50 states plus the District of Columbia can be found in a series of web tables and maps in Appendix B, Detailed Tables 1–4 of this report at http://www.cdc.gov/nchs/data/nsltcp/State_estimates_for_NCHS_Series_3_37.pdf.

[61] Available at http://www.cdc.gov/nchs/data/nsltcp/2014_nsltcp_state_tables.pdf.

To estimate short-term trends, states can use current service patterns by subgroup as a baseline, based on national estimates. The **NSLTCP** provides information on LTSS users, including demographics, selected medical conditions, physical and cognitive functioning, health care use, and other characteristics. Another source is the **Health and Retirement Study**,[62] conducted by the University of Michigan Institute for Social Research, which collects information from a nationally representative sample of adults age 50 and older regarding income, work, assets, pension plans, health insurance, disability, physical health and functioning, cognitive functioning, and health care expenditures.

For long-term trends, states should consider how social and demographic forces might affect disability trends and demand for LTSS among specific subgroups. For example, higher educational levels, which have increased over time with the aging of the baby boom generation, are associated with lower levels of disability. Fertility rates, which have been declining, may decrease the availability of informal care and cause an increase in the use of nursing home care and paid home care (Johnson 2007). Building on these links, the Urban Institute and RTI International developed projections of paid and unpaid long-term care services as a function of disability, financial resources, children's availability, and other factors. Their model estimated, for example, that by 2040, about 25 percent of older adults age 65 and older would use paid home care and about 13 percent would need nursing home care.

Estimating the availability of, and need for, direct care workers. Regardless of the setting in which LTSS is provided, direct care workers provide most of the paid care (though family and friends provide a large amount of unpaid support) (PHI 2013). Direct care workers include nursing assistants, home health aides, and personal care aides. In contrast to other health professionals, the direct care workforce is characterized by several factors that make it challenging to define adequate provider networks (see Box V.1).

Data sources to identify provider supply. As with estimating enrollee needs, states can use in-state or national data sources to estimate provider supply, as indicated by the following examples:

- The **NSLTCP**[63] includes basic operating characteristics (ownership, chain status, capacity, number served, Medicaid participation, part of a continuing care retirement community, years in operation, and dementia special care unit); services offered and how (dental, hospice, social work, case management, medication management, mental health, therapeutic, pharmacy, podiatry, skilled nursing, and transportation); staffing (nursing, social workers, and activities staff); and practices [depression screening, disease management programming, electronic health records (EHRs), and person-centered practices].

- The **U.S. Bureau of Labor Statistics (BLS), Occupational Employment Statistics (OES) program**[64, 65] publishes data on employment, wages, and occupational projections for a variety of LTSS professions, including nursing assistants; home health aides; psychiatric aides; occupa-

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[62] More data and documentation are available at http://hrsonline.isr.umich.edu/.

[63] Study results are available on the NSLTCP webpage at http://www.cdc.gov/nchs/nsltcp/nsltcp_products.htm.

[64] More information is available at http://www.bls.gov/oes/ and http://www.bls.gov/emp/empiols.htm.

[65] BLS data used to produce state-specific information on the direct care workforce, employment projection, wages, training requirements, legislation/regulatory requirements, and other key information are available from the Paraprofessional Healthcare Institute (PHI) State Data Center at http://phinational.org/policy/states.

tional, recreational, and physical therapists and assistants; orthotists and prosthetists; hearing aid specialists; and personal care aides (see Box V.1).

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i Data and information resources

Box V.1. Direct care workers often are characterized by the following:

- **Maintain part-time schedules**. Nearly half of direct care workers (47 percent in 2011) work less than full time, year round. More than half of personal care aides (59 percent in 2011) work part-time or full time for only part of the year (PHI 2013). Consequently, states that use staffing ratios to define an adequate network should consider the impact that part-time or seasonal worker schedules have on access.

- **Have minimal education or training**. Although federal rules specify training requirements for nurse aides in nursing facilities as well as for home health aides, they provide limited guidelines for the training of direct care workers (see below), leaving it to states. For example, just one-quarter of states specify the number of hours of training personal care assistants must have; 40 percent of states require completion of a competency exam (Marquand and Chapman 2014). Consequently, state Medicaid agencies must decide whether to make their MLTSS network standards regarding provider qualifications, credentialing, or certification consistent with their state's requirements for direct care workers or use different rules.

- **May be directly employed by beneficiaries**. In recent years, participant-directed programs that allow LTSS users to employ their own support workers have grown in popularity. In 2011, more than 240 programs operated in every state plus the District of Columbia, up from 139 programs in place in 2001 (NRCPDS 2015). At least 800,000 independent providers nationwide participate in these programs. Because participant direction allows beneficiaries to decide which direct care workers they hire, including family members in many states, and how many hours they need (up to the cash amount allowed), traditional provider-enrollee ratios do not apply to this care delivery model.

Education and training requirements for direct care occupations (IOM 2008)

Nurse aides, orderlies, and attendants	Home health aides	Personal care aides and home care aides
Federal rules require 75 hours of training (for nurse aides); a competency evaluation results in state certification. There is not always a requirement for a high school diploma and previous work experience.	Per federal rules, if an employer receives Medicare/Medicaid reimbursement, workers must pass a competency test (75 hours of classroom and practical training suggested); a high school diploma and previous work experience are not always required.	Dependent on state: Some require no formal training; a high school diploma and previous work experience are not always required.

- In addition to examining whether there are enough providers to serve MLTSS users, states might also consider whether the providers have the right qualifications, training, and experience to serve LTSS enrollees. **Tennessee**, for example, designates preferred contracting standards for providers in its Employment and Community First CHOICES program, which serves people with intellectual and developmental disabilities (see Box V.2). Although the state does not require managed care plans to contract exclusively with providers who meet its standards or contract with every available provider, it requires plans to report the unique capabilities of each provider in its networks and demonstrate that the standards are being considered as part of network development.

✔   **State practices**

Box V.2. Tennessee: preferred providers serving individuals with intellectual and developmental disabilities (I/DD)

In its MLTSS program serving people with I/DD, Tennessee designates preferred providers who can support employment, community living, and person-centered care. Standards that providers must meet to achieve a preferred contracting status include the following:

- Participated in a current 1915(c) waiver serving people with I/DD and received consistently high performance ratings
- Achieved accreditation from a nationally recognized organization
- Documented success in facilitating employment and community integration
- Employed a certified work incentive coordinator (CWIC)
- Built long-standing community relationships with organizations that will employ beneficiaries with I/DD
- Transitioned beneficiaries with I/DD into more independent living arrangements
- Adopted policies and systems that allow beneficiaries to make staffing choices
- Contracted with medical or behavioral health providers who can serve complex needs
- Completed recommended trainings

For a complete list of standards, see Section 2.11.6.4.1 of the 7/1/2016 TennCare CHOICES contract. Available at https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf.

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3. Issues in developing network and access standards for LTSS

Due to the wide range of services and supports that may be provided to LTSS users, federal regulations do not specify which LTSS provider types should have adequacy standards. For time and distance standards, states might consider developing standards for provider types that deliver the most frequently used services (for example, personal care and adult day care), and/or providers that deliver life-sustaining services (Barth and Brodsky 2016).

- The standards for community-based, non-residential services in which an enrollee travels from his or her residence to the site (for example, adult day health centers and therapy) may be maximum time and distance rules similar to those for medical providers. Standards for residential service settings (such as nursing facilities, assisted living centers, or group homes, for example) may count the number of "beds" or units available within a certain distance of the enrollees who likely will use them. Alternatively, standards may be expressed as the maximum time an individual could wait before receiving placement.

- Specifying a maximum wait time could also be appropriate for services provided in an individual's home (for example, personal care and home modifications). In this case, the standard would measure the time between requesting or authorizing a service and receiving it. States might have to modify network requirements, depending on whether the services are provided on a one-time or ongoing basis. At minimum, states should reflect the frequency of certain services in contract language (see the examples of Tennessee in Table V.1).

Case managers spread their time and talent across a panel of clients; communication might not always be in person, nor does it usually occur at a specific location. For these reasons, states might choose to structure provider network standards for case managers using provider-to-enrollee ratios. States should also consider adjusting each of these standards to accommodate the level of need of LTSS users, which might vary by setting. **Florida**, for example, requires that case managers serve no more 60 enrollees in HCBS settings or 100 enrollees in nursing facilities.

Case managers may serve no more than 60 enrollees when the case load mixes both individuals in HCBS settings and nursing facilities (see Table V.1).

Relevance of standards in other programs. Provider network standards that apply to medical care delivered in Medicare and commercial products generally are not relevant to LTSS. Consequently, states must look to their peer MLTSS programs for examples. Three states that recently have transitioned to MLTSS—**Florida**, **New Jersey**, and **Tennessee**—created detailed standards related to the time and distance requirements of the Medicaid managed care regulations (see Table V.1).

Table V.1. LTSS time and network standards in Florida, New Jersey, and Tennessee

Standard and provider type	Standard
Travel time standard (Florida and Tennessee)	
Adult day care, occupational therapy, physical therapy, respiratory therapy, and speech therapy (Florida)	At least two providers must serve each county of the region, with at least one provider within 30 minutes' travel time (urban) or 60 minutes (rural).
Adult day care (Tennessee)	Transport distance to licensed adult day care providers will be the usual and customary, not to exceed 20 miles in urban areas, not to exceed 30 miles for suburban areas, and not to exceed 60 miles in rural areas, except when community standards and documentation apply.
Wait time to receipt of service (Tennessee)	
Assistive technology	No more than 30 calendar days.
Minor home modifications	No more than 90 calendar days.
Pest control	No more than 60 calendar days.
In-home or in-patient respite	Based on the frequency specified in the care plan.
Time to initiation of ongoing service (Tennessee)	
Adult day care, attendant care, home-delivered meals, personal emergency response system, and personal care	No more than 10 business days.
Level II community-based residential alternative	No more than 10 business days for most; immediately for certain enrollees.
Nursing facility care	No more than 10 business days for new enrollees; immediately for existing nursing facility residents.
Facility-based network requirements (Florida)	
Assisted living facility, assistive care services, and nursing facility care	At least two providers serving each county of the region, and one licensed bed for each enrollee in the applicable maximum enrollment.
Time management (Florida and New Jersey)	
Case management (Florida)	The managed care plan ensures that case managers are not assigned duties unrelated to enrollee-specific case management for more than 15% of their time if they carry a full caseload.
Case management (New Jersey)	Contractors must ensure that MLTSS care managers are not assigned duties unrelated to member-specific care management for more than 15% of their time if they carry 90% or more of an MLTSS caseload.
Staffing (Florida and New Jersey)	
Case management (Florida)	Each case manager's caseload may not exceed 60 for enrollees in HCBS settings, 100 for enrollees in nursing facilities, or 60 when the case manager has a mixed caseload.
Case management (New Jersey)	Contractor must maintain staffing ratios of (1) 1:240 for nursing facility members and a non-pediatric special care nursing facility, (2) 1:120 for HCBS members residing in an alternative community setting, (3) 1:60 for members receiving HCBS, and (4) 1:48 for members receiving services in a pediatric special care nursing facility. Each care manager's standard caseload must not exceed a weighted value of 120.

Sources: Florida AHCA model contract, August 15, 2016, Attachment II, Exhibit II-B, Table 1; New Jersey Family Care Contract, 9.5.5, January 2015; Tennessee LTSS Operational Protocol July 1, 2012.

For services in which someone must travel to a provider site, such as an adult day care facility, **Florida** and **Tennessee** use maximum travel time standards, which differ for urban and rural areas. For one-time services, such as acquiring assistive technology, **Tennessee** uses wait time standards that require a service be provided within a certain amount of time of when authorization occurs. Similarly, ongoing services must be initiated shortly after authorization. For case management services, **Florida** and **New Jersey** require that each staff member devote a minimum amount of time to case management duties. They also specify a maximum case load, which varies based on care setting. For facility-based care, such as nursing facilities, **Florida** specifies the minimum number of licensed beds relative to maximum enrollment.

Modifying LTSS network standards to fit state policies, geography, and local market conditions. There are several state and local factors that states should consider when developing LTSS provider network standards. First, Nurse Practice Acts determine whether nurses can delegate certain tasks, such as giving medications, giving tube feedings, or managing bowel and bladder care (for example, giving enemas or changing catheters) to direct care workers or whether they can train family members to perform these tasks. For instance, nine states (Alaska, Colorado, Iowa, Minnesota, Missouri, Nebraska, Oregon, Vermont, and Washington) allow liberal delegation of 16 health maintenance tasks. Four states (Florida, Indiana, Michigan, and Rhode Island) do not allow delegation of any health maintenance tasks (Reinhard et al. 2014). Where delegation is allowed, states should ensure managed care plan networks include an adequate number of direct care workers to carry out health maintenance tasks under nurse supervision. Conversely, where it is not allowed, networks should include enough nurses to support home care.

Second, states should also consider whether there are training or certification programs that could formalize the roles of current voluntary, informal caregivers (for example, "care coaches" similar to those used in behavioral health settings to help individuals working through addiction issues). Such workers may influence the volume and composition of providers in managed care networks (Klebonis and Barth 2013). In addition, states with providers that use alternative delivery models, such as electronic communication, telemedicine, or team-based care/roving care teams, might want to consider the impact that these innovations have on demand for LTSS providers, particularly in rural areas.

Anticipate exceptions by identifying the circumstances that justify use of out-of-network providers. When a state wishes to contract with a plan that cannot meet all provider network requirements, it may use out-of-network providers or waive adequacy requirements for a short time. Allowing out-of-network providers can be particularly helpful for providing LTSS needed on a time-limited or infrequent basis (such as home modifications) (Klebonis and Barth 2013). Out-of-network use or waiving of provider network standards in the short term may also be justified in regions within the state that have acute shortages of home care workers or in rural areas where other types of LTSS providers are scarce.

Some states have contract language that describes the circumstances in which existing provider network requirements do not apply. **Florida**, for example, allows managed care plans to extend travel time requirements to 60 minutes if there are insufficient providers of facility-based services within 30 minutes' travel time from an enrollee's residence (Florida AHCA 2016, Attachment II, Section VI.A.1.d.). The state may also grant plans the ability to include network facilities from neighboring counties to meet network requirements for certain rural counties (Florida AHCA 2016, Attachment II, Section VI.A.1.g.).

Revise or update provider network standards. States new to MLTSS frequently add populations or services over time. Including a new population or service to a program provides an opportunity for states to refine existing provider network standards or develop new ones. Services for individuals with I/DDs are often the last population to be added to managed care. The services can include supportive employment, family training, and residential care that providers with expertise unique to the I/DD population can offer. States will want to carefully think through the demand and supply for such services, the appropriate network standard for the location and frequency of the services, and ways in which to modify requirements so that they reflect the special needs of the population.

Seek input and comments on proposed standards from key stakeholders. As required by §438.70, states developing MLTSS programs must seek input and feedback from a broad set of stakeholders, including: (1) LTSS providers (nursing facilities, home health agencies, case man-agement agencies, and social services); (2) consumer counseling, education and support enti-ties, such as Area Agencies on Aging, centers for independent living, senior health information programs that serve Medicare beneficiaries (including dual eligibles), or Aging and Disability Resources Centers; and (3) long-term care ombudsmen. Consistent with §438.110, managed care plans must also engage LTSS members or their representatives in decision making.

4. Issues in monitoring and ensuring access to care for LTSS

In addition to collecting the data and information described in Chapter IV, states monitoring MLTSS network adequacy should collect information relevant to LTSS provider types and service accessibility. **Arizona**, for example, requires managed care plans to submit information on the tests given to direct care workers. It also requires managed care plan networks to include enough providers "to ensure that critical services are provided without gaps in care." Contractors must resolve gaps in critical services within two hours of one being reported and have backup caregiv-ers available on call to substitute for times when an unforeseeable gap in critical service occurs.[66] **New Jersey** requires contractors to submit information on accessibility and whether providers can serve special populations. It also states in its contracts that it will spot check any provider's ability to accommodate members with special needs.

States should also pay close attention to complaints, grievances, and appeals that indicate pos-sible issues in provider network capacity. Providers who do not arrive at the home on time or cannot accommodate the special needs of LTSS users may signal larger issues related to network composition, care planning, or plan-provider communication. Member satisfaction surveys can also indicate the degree to which plan networks comply with state standards.

Electronic visit verification (EVV) systems use telephone and computer-based processes to electronically verify and document when services provided in another location began and ended. They can be useful technological tools for monitoring whether services provided in the home are delivered based on the plan of care. Section 12006 of a federal law, the 21st Century Cures Act (P.L.114-255) will reduce federal Medicaid matching funds to states that do not require personal care providers and home health care service agencies to use EVV systems starting in 2019.

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[66] Arizona defines critical services as including "attendant care, personal care, homemaking, and respite care, and is inclusive of, but not limited to, tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities. A "gap in critical services" is defined as the difference between the number of hours of home care worker critical services scheduled in each member's HCBS care plan and the hours of the scheduled type of critical services delivered to the member. ALTCS-EPD, Contract YH12-0001, October 2015, p. 76. More information is available at https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ALTCS/ALTCSCYE2015/ALTCSEPD10-1RenewalFinal.pdf.

In the years since implementing CHOICES in 2010, Tennessee has required its MLTSS plans to use an EVV system to track services delivered in the home, including personal care, attendant care, in-home respite, and home-delivered meals (see Box V.3). MLTSS plans may select their own qualified EVV vendor. Each EVV system tracks the services delivered relative to the plan of care. If a provider does not arrive at a beneficiary's home within a specified period following the scheduled time, the system generates immediate alerts to the plan and provider organization. Tennessee monitors gaps in care through reports of missed visits and late visits that MLTSS plans generate.

> ✔ **State practices**
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> ### Box V.3. EVV in Tennessee
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> For a complete list of Tennessee's requirements for its EVV system, see Section 2.9.6.13.5 of the TennCare CHOICES contract beginning 7/1/2016, available at http://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf.

Since initial implementation, Tennessee has modified its EVV system requirements in several ways. For example, it added global positioning technology and backup access via telephone and text message. It also removed participant-directed services from the EVV system because it limited the ability of individuals and staff to adjust service schedules without approval. The state now monitors beneficiary-directed services with a different time management system. Furthermore, Tennessee incorporated value-added enhancements that allow direct care workers to record notes on each service they provide and receive notices on changes in a beneficiary's needs; the enhancements also allow members to provide real-time, point-of-service data regarding their experience of care and access information on health education and self-management of chronic conditions.

Although EVV systems promise to increase worker accountability and care quality, states may face a number of implementation challenges. In planning the rollout of an EVV system for Centennial Care, **New Mexico** reported difficulties in transforming the culture of those providers who were not used to logging the hours they worked in real time. Local provider associations were instrumental in educating providers on the need to adopt EVV technology; in some cases, they were also able to connect early-adopting providers to late adopters to share lessons learned. New Mexico also had difficulties in finding connectivity options for providers who work in rural or frontier areas that lack reliable access to phones, the Internet, or, in some cases, electricity. Over time, New Mexico developed three ways for providers, including those in "no tech zones," to log services in the EVV system: (1) the provider can use his or her own phone or application-enabled smartphone, supported through a small monthly stipend; (2) with permission, the provider can call into the system from a member's landline phone; or (3) the provider can use an app-enabled tablet that stores data offline and upload those data within seven days.

B. Behavioral health providers and services

1. Overview of behavioral health and relevant federal rules

Medicaid is the single largest payer for mental health services in the country, and its role in the reimbursement for SUD services is growing (MACPAC 2015). Behavioral health services encompass both mental health and SUD services, and include a broad range of prevention, intervention, treatment, and recovery support services designed to improve the health of people with mental illnesses and SUDs. States offer mental health and SUD services through multiple Medicaid mandatory and optional service categories; behavioral health benefit packages vary considerably across states.

States are increasingly engaging managed care organizations and behavioral health organizations to manage behavioral health services for Medicaid beneficiaries through a variety of contracting arrangements (Smith et al. 2016). Managed care plans rely on a network of providers across many settings, such as specialty community behavioral health centers, inpatient psychiatric units, and home and community-based settings, to provide care.

In the 2016 final rule, CMS includes regulations and related guidance on states' and managed care plans' obligations related to behavioral health providers. Specifically, states and plans must do the following:

- **Establish time and distance standards for behavioral health providers.** States must develop standards for behavioral health providers [§438.68(b)(1)(iii) and §457.1218] separately for adult and child behavioral health providers. The 2016 final rule also clarifies that behavioral health includes both mental health and SUD treatment and providers.

- **Ensure timely access to services.** Managed care plans must demonstrate that their networks include sufficient behavioral health providers to ensure timely access to covered services [§438.206 and §457.1230(a)]. This access is particularly important after acute behavioral health events, such as inpatient psychiatric hospitalization or detoxification (Pincus 2014).

- **Ensure provider accessibility.** Plans must maintain a network of providers able to offer physical access, reasonable accommodations, and accessible equipment for those with disabilities, including mental disabilities [§438.206(c)(3) and §457.1230(a)]. In the behavioral health context, reasonable accommodations may include flexible scheduling policies and availability of services in alternative settings, such as an individual's home.

- **Allow access to out-of-network providers.** If a plan's network cannot provide all covered services, it must cover services by providers not in the network in an adequately and timely manner [§438.206(b)(4) and §457.1230(a)]. Given the extensive behavioral health provider shortages across the country and the broad range of behavioral health services some states offer, states should consider the need for out-of-network providers.

Parity. States are developing network adequacy standards at the same time they are attempting to implement the 2008 Mental Health Parity and Addictions Equity Act (MHPAEA) as it applies to Medicaid managed care plans (§438 Subpart K and §457.1201(1)). MHPAEA requires parity between mental health or SUD benefits and medical/surgical benefits with respect to financial requirements and treatment limitations.

Importantly, the final rule prohibits managed care plans from imposing "non-quantitative treatment limitations" (NQTLs), which limit the scope or duration of benefits in ways not framed numerically without meeting certain criteria. Plans may apply NQTLs to mental health and SUD benefits if the same limits on the scope or duration of benefits are comparable to, and applied no more stringently than, factors they use to limit medical surgical/benefits [§438.910(d) and §457.496(d)]. The MHPAEA final rule provides examples of factors considered to be NQTLs, such as designing behavioral health network tiers, standards for admission to a provider network, and reimbursement rates that restrict behavioral health benefits in ways that create disparity with medical benefits. Additional guidance and other sources also suggest that, depending on how they are framed, certain network adequacy standards could constitute a prohibited NQTL

(Department of Labor 2016; Mental Health & Substance Use Disorder Parity Task Force 2016). States are encouraged to seek advice from CMS and other federal agencies, and consult MHPAEA resources to ensure network standards comply with federal parity requirements (see Box V.4).[67]

2. Issues in identifying enrollee needs and provider capacity for behavioral health

New service models. The behavioral health service provision landscape is changing rapidly. States and providers are developing new care models that integrate primary and behavioral health services, and increasing the use of care coordination, evidence-based practices, and non-traditional Medicaid services that call for providers with new skills and credentials. In addition, to address the maldistribution of behavioral health providers, many states are permitting plans to use telepsychiatry and other telehealth services. The shortage of behavioral health providers, coupled with the evolution of new service models, suggest that states may have to rethink how they set provider network standards and establish access goals.

Behavioral health workforce diversity and shortages. Estimating provider supply also is complicated by the diversity of the behavioral health workforce, which includes psychiatrists and psychologists as well as such non-degreed workers as community health workers and peer specialists (HHS 2013; IOM 2012). The BLS estimates that there were 24,060 psychiatrists in the U.S. in 2015 (BLS 2016). In 2014, there were about 173,900 psychologists and 168,200 mental health counselors and marriage and family therapists (BLS 2015). Provider categories can be further subdivided by life stage or disorder. For example, psychiatrists might have as their subspecialties child and adolescent, adult, or geriatric psychiatry, and specialize in SUD treatment or treatment of mental health disorders. Behavioral health providers also work in a variety of settings, such as community behavioral health centers, primary care practices, and inpatient settings, or they might practice independently. Yet the nation faces a shortage and maldistribution of behavioral health providers that limits access to care and places stress on existing provider networks. According to HRSA, there are 4,000 mental health professional shortage areas (HPSAs) across the country, defined as those without enough psychiatrists, compared to 6,100 primary care provider HPSAs (HRSA 2016).

These shortages are exacerbated for Medicaid beneficiaries by low rates of Medicaid participation by psychiatrists. Although their participation in health insurance networks is low across all types of insurance, the problem is particularly pronounced in the Medicaid program (Cummings 2015). For example, in 2011, 20 percent of Medicaid beneficiaries had a behavioral health disorder, yet about 8 percent of beneficiaries lived in a county without an outpatient mental health facility that accepts Medicaid payment, and around 35 percent of all U.S. counties had no outpatient mental

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> **ℹ Data and information resources**
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> ### Box V.4. Parity and network adequacy
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> Provider network adequacy standards could constitute non-quantitative treatment limitations. Under MHPAEA, plans are prohibited from applying such limitations if they disproportionately affect the scope or duration of mental health and SUD benefits.
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> For additional information on this and other intersections of MHPAEA with network adequacy standards, refer to https://www.medicaid.gov/medicaid/benefits/bhs/index.html or contact the federal government's mental health parity technical assistance mailbox at parity@cms.hhs.gov.

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[67] For CMS MHPAEA resources, including the Parity Compliance Toolkit and Parity Implementation Road Map, visit https://www.medicaid.gov/medicaid/benefits/bhs/index.html.

health treatment facilities that accepted Medicaid (MACPAC 2015; Cummings et al. 2013). These behavioral health provider shortages are more pervasive in rural areas and those with a larger percentage of minority residents, due to difficulty in recruiting and retaining providers (Cummings et al 2013; National Rural Health Association 2008). Moreover, psychiatrists are less likely to accept Medicaid than are other specialty medical providers (Bishop et al. 2014).

Data sources to identify enrollee needs. State and national data sources can help project the behavioral health service needs of managed care enrollees. As with other services, state Medicaid FFS claims and managed care encounter data, and data from the Medicaid behavioral health child and adult quality measures core sets can provide some indication of trends in mental health and SUD treatment use, although as with creating other estimates of demand, these sources may underestimate demand if existing access is limited. To supplement these sources, states should consult their state's mental health and SUD departments, which have traditionally been responsible for providing mental health and SUD services paid for with non-Medicaid funds. This issue is particularly important for SUD services because the implementation of MHPAEA has expanded Medicaid's role in covering SUD treatment (Buck 2011).

National surveys and other data sources can also be used to supplement information on behavioral health service needs in each state, as in the following examples:

- The *National Survey on Drug Use and Health*[68] provides national, state, and region-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs), and mental health in the United States (see Box V.5).

- The Substance Abuse and Mental Health Services Administration's (SAMHSA's) *Treatment Episode Data Set*[69] contains client-level demographic characteristics and admissions to treatment facilities due to substance abuse problems. Data are available by state and metro region.

- The *Behavioral Risk Factor Surveillance System*[70] collects state data regarding residents' health-related risk behaviors; chronic health conditions, including mental health disorders; and use of preventive services.

> ### ⓘ Data and information resources
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> #### Box V.5
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> The *National Survey on Drug Use and Health* is an annual nationwide survey involving interviews with about 70,000 randomly selected individuals age 12 and older. The survey data are the primary source of statistical information on the use of illegal drugs, alcohol, and tobacco by the civilian, non-institutionalized population 12 years old or older. The survey also covers mental health issues, allowing for a comprehensive look at the behavioral health of the U.S.
>
> Data tables and state and sub-state/metro reports can be found at http://www.samhsa.gov/data/population-data-nsduh.

Data sources to identify provider supply. To estimate provider supply, several state and national sources are available:

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[68] More information is available at http://www.samhsa.gov/data/population-data-nsduh.

[69] More information is available at http://www.samhsa.gov/data/client-level-data-teds.

[70] More information is available at http://www.cdc.gov/brfss/.

- The **National Mental Health Services Survey (N-MHSS)**[71] is an annual survey that gathers statistical information on the numbers and characteristics of all known public and private mental health treatment facilities within the 50 states, the District of Columbia, and the U.S. territories. Every other year, beginning in 2014, the survey also collects statistical information on the numbers and demographic characteristics of people served in these treatment facilities as of a specified survey reference date.

- SAMHSA's **National Substance Survey of Substance Abuse Treatment Services**[72] is an annual census of all known public and private SUD service providers across the country.

- The **BLS OES**[73] publishes data on employment, wages, and occupational projections of a variety of behavioral health professions, including psychiatrists; counselors, social workers, and other community and social service specialists; and psychiatric aides.

In addition to considering whether there are sufficient providers to serve those with behavioral health disorders, states may also consider whether providers have the right qualifications, training, and experience to serve the populations with mental health and SUD.

3. Issues in developing network and access standards for behavioral health

The 2016 final rule requires that, at minimum, states establish separate time and distance standards for adult and child behavioral health providers. However, the 2016 final rule does not specify which provider types must be included [§438.68(b)(1)(iii) and §457.1218]. Therefore, states have latitude to decide which behavioral health provider types warrant specific time and distance or other types of access standards. The choice may be influenced by the most common needs of beneficiaries with behavioral health disorders, the range of services covered in the contract, state licensing rules that restrict service delivery to certain provider types, or other factors.

Because the range of behavioral health services and provider types is so large, some experts in the field recommend developing standards for all providers at each point in the behavioral health service continuum (National Association of State Mental Health Program Directors 2015). These might include, for example, developing separate standards for inpatient, outpatient, and emergency/crisis service providers. Some states may wish to establish additional access standards, such as appointment wait times and provider ratios.

Several states have established detailed standards that relate to time, distance, wait time, and provider ratio for various behavioral health provider types (see Table V.2 on the next page). Tennessee, for example, has maximum travel distance and wait time standards for 12 behavioral health provider types. Texas distinguishes between outpatient behavioral health providers and entities that provide other services, such as those offering supervised services from peer providers, and has established distance standards for both.

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[71] More information is available at http://www.samhsa.gov/data/mental-health-facilities-data-nmhss.

[72] More information is available at http://www.samhsa.gov/data/substance-abuse-facilities-data-nssats.

[73] More information is available at http://www.bls.gov/oes/ and http://www.bls.gov/emp/empiols.htm.

Table V.2. Behavioral health provider network standards in Florida, Georgia, Tennessee, and Texas

Standard and provider type	Standard
Travel time or distance standards (Florida and Georgia)	
Board-certified/eligible adult and child psychiatrists (Florida)	30 minutes or 20 miles (urban); 60 minutes or 45 miles (rural)
Mental health providers (Georgia)	30 minutes or 30 miles (urban); 45 minutes or 45 miles (rural)
Maximum travel distance (Tennessee and Texas)	
Psychiatric inpatient hospital services (Tennessee)	$\leq$ 90 miles for at least 90% of members
24-hour psychiatric residential treatment, children (Tennessee)	$\leq$ 60 miles for at least 75% of child members and $\leq$ 90 miles for at least 90% of child members
Intensive outpatient mental health (Tennessee)	$\leq$ 90 miles for at least 90% of members
Outpatient mental health, non-physician (Tennessee)	$\leq$ 30 miles for all members
Outpatient behavioral health (Texas)	$\leq$ 30 miles of a member's residence (urban); $\leq$ 75 miles of a member's residence (rural)
Entities that provide covered mental health services through qualified mental health professionals for community services [including licensed practitioners of the healing arts (LPHAs) and community services specialists, peer providers, or family partners if acting under the supervision of an LPHA (Texas)	$\leq$ 75 miles of a member's residence
Provider-to-enrollee ratios (Florida)	
Board-certified adult psychiatrists	1:375 adults
Board-certified child psychiatrists	1:3,500 children
Wait time to receipt of service	
Mental health providers (Georgia)	$\leq$ 14 days
Outpatient mental health, non-physician (Tennessee)	$\leq$ 10 business days (non-urgent); $\leq$ 48 hours (urgent)
Intensive outpatient mental health (Tennessee)	$\leq$ 10 business days (non-urgent); $\leq$ 48 hours (urgent)
Inpatient substance abuse facility services (Tennessee)	$\leq$ 4 hours in an emergency; $\leq$ 24 hours for non-emergency; $\leq$ 2 calendar days for detoxification
24-hour residential substance abuse treatment services (Tennessee)	$\leq$ 10 business days
Outpatient substance abuse treatment (Tennessee)	$\leq$ 24 hours for detoxification; $\leq$ 10 business days for other services
Mental health case management (Tennessee)	$\leq$ 7 calendar days
Psychosocial rehabilitation (Tennessee)	$\leq$ 10 business days
Supported housing (Tennessee)	$\leq$ 30 calendar days
Crisis services (Tennessee)	Face-to-face contact within 2 hours for emergency situations and 4 hours for urgent situations
Crisis stabilization (Tennessee)	$\leq$ 4 hours of referral
24-hour psychiatric residential treatment, children (Tennessee)	$\leq$ 30 calendar days
Psychiatric inpatient hospital services (Tennessee)	$\leq$ 4 hours (emergency involuntary); $\leq$ 24 hours (involuntary); $\leq$ 24 hours (voluntary)
Outpatient follow-up or continuing treatment for members receiving inpatient psychiatric services (Texas)	Must be scheduled before discharge and occur within 7 days from discharge. Behavioral health service providers must contact members who have missed appointments within 24 hours to reschedule.

Table V.2. Behavioral health provider network standards in Florida, Georgia, Tennessee, and Texas

Standard and provider type	Standard
Facility-based standards (Florida and Tennessee)	
Inpatient substance abuse detoxification units (Florida)	1 bed/1,000 enrollees
Fully accredited psychiatric community hospital (adult) or crisis stabilization units/freestanding psychiatric specialty hospital (Florida)	1 bed/500 adults
Fully accredited psychiatric community hospital (child) or crisis stabilization units/freestanding psychiatric specialty hospital (Florida)	1 bed/ 2,000 children
24-hour psychiatric residential treatment, adults (Tennessee)	At least 1 provider in each region

Sources: Georgia Department of Community Health Care Management Organization Model Contract;[74] Florida 2016 Statewide Medicaid Managed Care Plan Model Contract Attachment II-C;[75] Tennessee TennCare 2016 Statewide MCO Contract;[76] and Texas Uniform Managed Care Contract Terms and Conditions.[77]

Relevance of network standards in other programs. For Medicaid managed care programs that serve significant numbers of older adults and/or dual enrollees with high rates of mental illness or SUD, Medicare Advantage (MA) standards may be useful models. These standards specify time and distance, and minimum numbers of behavioral health providers, but only for psychiatrists (see Table V.3) and inpatient psychiatric facilities; MA does not include standards for other behavioral health services.

Table V.3. MA network adequacy standards for psychiatrists, 2017

Geographic designation	Time and distance standards		Minimum providers per 1,000 enrollees[a]
	Maximum minutes	**Maximum miles**	
Large metro	20	10	140
Metro	45	30	140
Micro	60	45	120
Rural	75	60	120
Counties with extreme access considerations	110	100	120

Source: Medicare Advantage CY 2017 Reference File. Available at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/.

[a] Minimum number of providers required is based upon the minimum provider-to-beneficiary ratio multiplied by the 95th percentile of the average health plan market share times the total Medicare beneficiaries residing in a county.

Modifying behavioral health network standards to fit state policies, geography, and local market conditions. When developing standards, specific services and models of care employed by a state may require special considerations to ensure network adequacy and access. For example, if implemented as designed, assertive community treatment (ACT), an evidence-based model used

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[74] More information is available at https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/site_page/CMO_DCH%20Contract.pdf.

[75] More information is available at http://www.fdhc.state.fl.us/medicaid/statewide_mc/plans.shtml.

[76] More information is available at https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf.

[77] More information is available at https://hhs.texas.gov/sites/hhs/files//documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf.

in many states to treat people with serious mental illnesses, recommends small caseload size (that is, about 10 to 12 staff to 100 enrollees) and involves team-based care consisting of staff from multiple disciplines (Substance Abuse and Mental Health Services Administration 2008). For these services, states might consider developing standards for the number of teams required to serve the expected number of enrollees who will use ACT. Other non-traditional Medicaid behavioral health services, such as supportive housing and supported employment services, may also warrant specific access standards.

Some states have developed standards for crisis services unique to their behavioral health services and may be offered in a range of settings. **New York**, for example, requires plans that offer an extended range of behavioral health services to "contract with a sufficient network of providers to deliver the crisis intervention service for enrollees in emotional crisis via phone, in person (if the individual presents for emergency care), and mobile response on a 24-hour basis" (New York State 2015).

Seek input and comments on proposed standards from key stakeholders. Although federal rules do not require input and feedback, states developing behavioral health provider network standards are encouraged to seek them from a broad group of stakeholders, including behavioral health providers and their representatives, as well as consumers or such consumer organizations as state chapters of the National Alliance for the Mentally Ill (NAMI). Beneficiary and provider perspectives on met and unmet needs in their communities can provide critical information that may not be reflected in other data sources.

Monitoring services availability and access to care. States can use the same techniques to monitor behavioral health services as they do for other provider types. Given the wide variety of services in this category, if a state has limited resources, its monitoring activities might focus on high-volume and critical need providers, or utilization of services among enrollees with certain behavioral health diagnoses.

C. Essential community providers

1. Overview of essential community providers (ECPs) and relevant federal rules

ECPs include a variety of provider types and settings that serve predominantly low-income and medically underserved populations. In addition to providing specialized medical care, ECPs typically offer patient support services, in-person language services, culturally competent staff, and connections with community resources that make them especially well-suited to serving hard-to-reach populations[78] Examples of ECP services and settings[79] can include the following:

- FQHCs and FQHC "look-alike" clinics
- RHCs

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[78] Some states define ECPs based on the additional services they provide. For example, Minnesota requires ECPs to "provide or coordinate supportive and stabilizing services, such as transportation, child care, linguistic services, and culturally sensitive and competent services to its clients" (Minnesota Department of Health 2014).

[79] As CMS describes in its February 2016 guidance to states on how to use the final updated list of ECPs, its definition of ECPs includes health care providers defined in section 340B(a)(4) of the Public Health Service Act in section 1927(c)(1)(D)(i)(IV) of the Social Security Act. For more information, see "Description and Purpose of Non-Exhaustive HHS List of Essential Community Providers," available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Description-and-Purpose-of-HHS-List-of-ECPs-for-PY-2017.pdf.

- Ryan White HIV/AIDS program providers

- Hospitals, such as disproportionate share hospital (DSHs) and DSH-eligible hospitals, critical access hospitals, children's hospitals, and sole community hospitals

- Clinics, including sexually transmitted disease clinics, tuberculosis clinics, hemophilia treatment centers, and black lung clinics.

- Indian health care providers (IHCPs), including tribal health programs, tribal organization providers, and Indian health service facilities (discussed in Part D)

- Family planning providers (discussed in Section E)

Due to their unique capabilities, ECPs and their providers play an important role in managed care plan networks. The 2016 final rule does not provide specific guidance on the network adequacy requirements for many types of ECPs. However, because Medicaid beneficiaries and low-income individuals covered by Qualified Health Plans (QHPs) use ECPs more than those with Medicare or commercial insurance, states may wish to consider adopting requirements similar to those for QHPs under 45 CFR 156.235 into Medicaid managed care.

In its 2017 final letter to issuers in the federally facilitated Marketplaces, CMS identifies satisfactory networks as those that: (1) contract with at least 30 percent of available ECPs in each plan's service area, (2) offer contracts in good faith to all available IHCPs in the service area, and (3) offer contracts in good faith to at least one ECP in each category listed above in each county in the service area.[80] CMS clarifies that "good faith" denotes contracts comparable in terms to those it offers to similarly situated non-ECP providers.

2. Resources to identify enrollee needs and provider capacity, develop network standards, and monitor access for ECPs

Identify enrollee needs and provider capacity. Certain types of enrollees are more likely to use ECP providers. They include residents of medically underserved areas and primary health care shortage areas, children with special health care needs, patients seeking family planning and reproductive health services, people experiencing homelessness, people with HIV/AIDS, and farm workers and their families (Rosenbaum 2011). In addition to the resources described in Chapters II and III of this toolkit, states may use the following resources to identify these individuals:

- *Data on vulnerable counties.* CMS maintains a database of zip codes listed as HPSAs or low-income areas where 30 percent or more of the population falls below 200 percent of the federal poverty level.[81]

- *AIDSVu*[82] offers a variety of maps and data sets, available at the state and county levels that describe trends in HIV/AIDS diagnoses, prevalence, and mortality.

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[80] Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf.

[81] The database is available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Low_income_and_HPSA_Zip_Code_List.xlsx.

[82] Available at http://aidsvu.org/resources/downloadable-maps-and-resources/.

- CMS created a **database of ECPs** and supporting guidance to help QHPs build their networks.[83] The database contains information on more than 19,000 ECPs, including facility type, location, provider identifiers, and the number of full-time equivalent practitioners available at each facility. Some states also maintain their own list of in-state ECP providers. **Connecticut**, for example, created a list of ECPs because it found that those in the CMS database were not sufficient in number or geographic diversity.

Develop access standards and requirements. Although states are not required to develop contract or access standards specific to ECPs, they may want to consider doing so to ensure access to these important provider types. **Colorado** and **Minnesota**, for example, require all plans to seek proposals from or offer contracts to all ECPs in their service areas. States may also consider requiring managed care plans to contract with at least 30 percent of available ECPs in each plan's service area, as CMS requires of QHPs.

Monitoring services availability and access to care. If a state sets ECP network standards, it may want to focus its monitoring efforts on regions and enrollees within each plan located in medically underserved areas. **New Mexico**, for example, breaks out FQHCs and RHCs in its geo-mapping software reports to monitor their participation in managed care. States can also monitor the number and type of out-of-network requests for ECPs, as well as member grievances and appeals related to provider network issues. More information on these approaches, which may be particularly useful for IHCPs and family planning providers, is available in Sections D and E.

D. Indian health care providers (IHCPs)

1. Overview of Indian health services and relevant federal rules

By law, American Indians and Alaska Natives (both of which are referred to henceforth as Indians) are guaranteed the freedom to use IHCPs,[84] regardless of whether these providers participate in managed care. IHCPs can include health care programs operated by the Indian Health Service (IHS) or by an Indian tribe, tribal organization, or urban Indian organization, otherwise known as IHS/Tribal Health Services/Urban Indian Health Providers (I/T/U).[85] Where Indians are enrolled in Medicaid managed care, managed care plans are required to do the following:

- *Demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to services* available under the contract from such providers for Indian enrollees eligible to receive services [§438.14(b)(1) and §457.1209]. "Sufficient participation" must consider the anticipated enrollment of Indians and the capacity of network IHCPs to meet the needs of that population. States have the flexibility to specify that managed care plans must offer a provider agreement to all IHCPs in the service area or establish other measures of network adequacy similar to those in §438.68 or other appropriate measures (81 FR 27746). In a state where timely access to covered services cannot be ensured due to few or no IHCPs, Indian enrollees

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[83] A non-exhaustive database of ECPs is available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/FINAL-non-exhaustive-HHS-List-of-ECPs-for-PY-2016.xlsx. See http://www.cciio.cms.gov/programs/Files/ecp-listing-cover-sheet-03262013.pdf for a cover sheet that explains the database.

[84] "IHCP" means a health care program operated by the IHS or by an I/T/U as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

[85] I/T/U terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

must be allowed to access out-of-state IHCPs or disenroll if the state deems the circumstance good cause for disenrollment [§438.14(b)(6)].

- *Make timely and sufficient payment* to all IHCPs in the network. Payments must be at a negoti-ated rate or, in the absence of a negotiated rate, at a rate no less than would be paid to non-IHCP providers [§438.14(b)(2) and §457.1209].

- *Facilitate access to IHCP services in and out of network*. Specifically, plans must allow any eligible Indian to choose in-network IHCPs as his or her primary care provider. Plans must also allow Indian enrollees to obtain covered services from out-of-network IHCPs, which, in turn, must also be allowed to refer an Indian enrollee to an in-network provider [§438.14(b)(3), (4), and (6), and §457.1209].

Despite these guarantees, some out-of-network IHCPs encounter difficulties in getting paid and/or referring clients to in-network providers for services. For example, when Indians obtain primary care from both IHCP and non-IHCP network PCPs, but do not designate the IHCP as their in-net-work PCP, the IHCP may encounter difficulties in getting reimbursed for the services they provide (Marquez 2001). In addition, Indians who are enrolled in managed care and require specialty care that an IHCP cannot provide may be required to visit an in-network PCP to obtain a referral, even if he or she has already seen an IHCP provider. These practices can create barriers to access and emphasize the need to include as many IHCPs in-network as possible.

Including IHCPs in-network, however, is often complicated by credentialing and contracting requirements that apply to these providers. For example, IHCP requirements for liability coverage and provider credentialing comply with Indian Health Care Improvement Act, and these require-ments may be different from what managed care plans typically allow (81 FR 27746). To facilitate contracting, CMS has developed an **Indian Health Care Addendum for Contracting with Medic-aid and CHIP Managed Care Entities**[86] analogous to a recent addendum created for QHPs.[87] CMS encourages states and plans to use the addendum, though doing so is voluntary (81 FR 27746). **Washington State** has also developed its own managed care plan Indian addendum, which other states may wish to look at for ideas on how to develop their own model addendum.[88]

2. Resources to identify enrollee needs and provider capacity, develop network standards, and monitor access for IHCPs

Identify provider capacity. The IHS publishes comprehensive lists of its facilities by geography and facility type (hospital, health center, dental clinic, or behavioral health facility).[89] Information is available as an Excel list, map, or searchable database. States can use this information to locate facilities and encourage managed care plans to contract with as many facilities as possible.

Develop access standards and requirements. Because there are a limited number of IHCPs, states should consider standards that encourage managed care plans to contract with as many IHCPs as possible. States may also consider ensuring that as many IHCPs as possible participate in man-aged care networks by offering network provider agreements to all IHCPs in their service area that request one.

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[86] The addendum is available for download at https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf.

[87] For reference, the QHP addendum to facilitate contracting with IHCPs is at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Model_QHP_Addendum_Indian_Health_Care_Providers_04-25-14.pdf.

[88] Available at http://www.hca.wa.gov/assets/program/mco-indian-addendum-20160328.pdf.

[89] IHS facilities are available through the IHS website at https://www.ihs.gov/locations/.

New Mexico has a number of contracting requirements that facilitate inclusion of IHCPs in managed care networks. For example, the state requires managed care plans to make their best efforts to contract with every essential community provider, including IHCPs, FQHCs, and RHCs. Some managed care plans increase the number and role of IHCPs in their networks by contracting with IHCPs to conduct short health risk assessments (HRAs) by telephone to determine whether someone needs a more comprehensive needs assessment. Managed care plans typically reimburse providers for each completed HRA. Some also contract with IHCPs to reimburse for Indian-specific services not covered by Medicaid, such as traditional healers or sweat lodges. Managed care plans also have provided enhanced reimbursement to IHCPs above the rates the Office of Management and Budget (OMB) has established, offered incentives for electronic claims and payment processing to participating IHCP providers, and reimbursed IHCPs that provide community health representatives and translation services.

Monitoring services availability and access to care. States can monitor access to IHCP services with data- and stakeholder-driven approaches. In terms of data, IHCPs can be included as a provider type in regular reviews of provider network adequacy. **California**, for example, reviews the number of IHCPs in managed care plan networks yearly by checking the list of included IHCPs against the monthly provider files managed care plans submit. If an IHCP is not contracted with each plan that operates in its service area, California Medicaid officials contact the provider to ensure the plan has made a good faith effort to enter into a contract.

Stakeholders that represent Indian communities can also provide useful feedback on access issues and strategies for including IHCPs in managed care networks. **New Mexico**, for example, requires contracted managed care plans to have a tribal liaison and a Native American advisory board. Most of the MMC plans in the state have a separate unit dedicated to this population. In addition, the state Medicaid agency has a tribal liaison who works closely with IHS and Tribal 638 providers, and attends the quarterly Native American Technical Advisory Committee work group. **California** also relies on stakeholder feedback to identify access concerns; it meets with tribal entities annually and as needed to discuss concerns and identify solutions.

E. Family planning providers

1. Overview of family planning services and relevant federal rules

Family planning encompasses a broad array of services—from contraception to "family planning-related" services, such as health education and promotion, testing and treatment for sexually transmitted infections, screening and treatment for cervical and breast cancers, interpersonal violence screening and prevention, and sexual health counseling. Beneficiaries can obtain such services from a range of providers, including private physicians, FQHCs, family planning clinics, health departments, and other clinics. Family planning services are a mandatory benefit under Medicaid, but optional under CHIP; however, states have considerable discretion in identifying the specific services and supplies the benefit covers. As a result, there is some variation from state to state in the services available. For example, a 2015 survey[90] demonstrated that most states cover all prescription contraceptive methods approved by the Food and Drug Administration, and sterilization services. Only some, however, cover over-the-counter contraceptives or sexual health services, and few pay for fertility services (Ranji et al. 2016).

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[90] Results were based on self-reported data from 40 states and the District of Columbia.

In 2016, CMS issued regulations and related guidance that reminded states and plans of their obligations related to family planning. Specifically, states and plans must ensure the following:

- *Free choice of provider*. Federal law guarantees Medicaid beneficiaries the free choice of any qualified family planning provider, even if they are enrolled in a managed care plan that otherwise restricts enrollees' coverage to a network of providers. Beneficiaries cannot be required to obtain a referral for family planning regardless of whether the provider is in-network or out of network. States must ensure access to these providers even if they provide the full range of legally permissible gynecological and obstetric care, including abortion services (1902(a)(23)(B), §431.51(b)(1); State Medicaid Director Letter#16-005; State Health Official Letter #16-008).

- *Free choice of method*. Beneficiaries may choose the method of family planning they wish to use and are guaranteed the right to be free from coercion or mental pressure when doing so. States cannot have requirements that would place an undue burden, coercion, or mental pressure on a beneficiary that would impinge on access to family planning services. Although states and managed care plans can apply medical necessity or utilization control criteria to a beneficiary's request for family planning services, such processes cannot interfere with the individual's freedom to choose the method of family planning or the services or counseling associated with choosing the method (§441.20; SMD #16-008).

- *Timely access to services*. Managed care plans must demonstrate that their networks include sufficient family planning providers to ensure timely access to covered services (§438.206, §457.1230(a), and SMD #16-005).

- *An understanding of the right to obtain care from a family planning provider of choice*. Managed care enrollee handbooks must include information that enables enrollees to understand how to effectively use the managed care program, including the extent to which, and how, enrollees may obtain family planning services and supplies from out-of-network providers. This information explains that the managed care plan cannot require enrollees to obtain a referral before choosing a family planning provider [§438.10 (g)(2)(vii)) and §457.1207].

Despite these guarantees, several state policies continue to make access to family planning providers difficult. States can help to remedy this issue by setting explicit managed care access standards.

- Whether a family planning provider is **in-network versus out of network** can affect access to care in two ways. First, when beneficiaries cannot obtain care from in-network providers, they might be unaware of their right to the free choice of family planning providers outside of the network. Second, family planning providers may have difficulty in receiving reimbursement if they are not part of a managed care network (Walls et al. 2016). Consequently, it is better if Medicaid managed care enrollees can select in-network family planning providers. This also helps to integrate family planning providers into the broader managed care network, which facilitates referrals and more timely payment (Coleman 2015).

- **Utilization controls** are commonly used by managed care plans to manage the use of medical services and prescription drugs. In the context of family planning, however, such techniques may be inappropriate if they interfere with enrollees' right to choose a family planning method free of coercion or mental pressure (SHO #16-008). Nevertheless, contraceptive drugs and supplies are often treated as a prescription drug benefit and subject to the same formulary restrictions as other drugs, which could include quantity limits on oral contraceptives and

injectables, requiring prescriptions for emergency contraceptives, requiring prior authorization for long-acting reversible contraception (LARC), or limiting coverage of contraceptives to certain brands (Walls et al. 2016). Contraceptives might also be subject to step therapy, which requires patients to prove that certain methods or generic brands have "failed" so they can obtain coverage for a higher tier or more expensive therapy. In the case of contraception, "failure" could mean an unintended pregnancy. For this reason, CMS has explicitly prohibited step therapy and other policies that restrict a change in method (SHO #16-008).

- **Waiting periods** can serve as another barrier to access, particularly for time-sensitive services. For example, women seeking access to sterilization must meet a 30-day waiting period requirement, which was put in place to protect them from coercion. However, this requirement means that women who have recently given birth and are still in the hospital must obtain sterilization services as part of a separate hospital stay to meet the waiting period requirement, which may discourage them from receiving the services they desire (Ranji et al. 2016).

- **Payment policy** can have a significant effect on access to family planning services. In the case of LARCs, inpatient settings that use a single prospective payment for labor and delivery services may not sufficiently address the cost of LARC devices, placement, or insertion services. The payment rate in outpatient settings may not address the significant up-front costs providers face in obtaining the devices. Furthermore, providers paid to place LARCs but not replace or reinsert them may feel this policy is a disincentive to provide these services to women (CMCS 2016).

These challenges each require different remedies and different methods to ensure access. For example, states might set time and distance standards for the number of in-network family planning providers relative to the number of potential users in each plan. They might monitor those standards through regular geo-mapping software reports of family planning providers that managed care plans submit. States can make the requirements regarding utilization controls and waiting periods explicit in their contracts, and use complaints, grievances, and appeals to ensure that such controls are not being applied more stringently than required by federal rules (see Box V.6). Alternatively, they might use encounter data to analyze utilization patterns for contraceptives, ensuring that step therapies are not used systematically. Finally, they might address payment issues through policy and ensure they are achieving their goals by analyzing encounter data (for example, looking for increases in the number of LARCs after they unbundle payments).

> **ⓘ Data and information resources**
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> ### Box V.6. State approaches to utilization controls and LARC payment
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> In 2016, the Kaiser Family Foundation published results from a state-level survey on state family planning benefits under Medicaid as of July 2015. The report also describes variations in state contract requirements regarding utilization controls and payment policies to facilitate postpartum LARC insertion.
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> For more information, see Medicaid Coverage of Family Planning Benefits: Results from a State Survey. Washington, DC, available at http://kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey/.

2. Resources to identify enrollee needs and provider capacity, develop network standards, and monitor access for family planning

Identify enrollee needs and provider capacity. Federal regulations do not explicitly require provider network standards for family planning providers other than primary care physicians and OB/

GYNs. However, states might consider setting and monitoring in-network access to a range of family planning providers to ensure that the policies or practices are not restricting access. Few states have done so.[91] The following resources could be useful to states looking to understand the supply of family planning providers:

- The **Guttmacher Institute** produces county-level data on the number of women in need of contraceptive services by age, income, race/ethnicity, and payer (publicly funded or not). It also produces data on the number of publicly funded clinics by provider type and the number of clients each type serves.[92] The institute also maintains the names of safety-net family planning providers in each county by type, and will share this information upon request.

- Names of individual clinics that receive Title X family planning funding are available from the HHS **Office of Population Affairs**.[93]

Monitoring services availability and access to care. Grievance and appeals data, as well as stakeholder feedback, are important sources of information for states to use when monitoring the availability of and access to family planning services. Both sources provide information that official data or reports do not document, and can provide the context needed to address access problems quickly. **New Mexico**, for example, has multiple interagency work groups related to family planning service issues to discuss solutions to those issues identified through complaint and grievance reports. After the state received complaints from out-of-network providers about delays in payment from managed care plans and having claims denied, it worked with health plans to reprogram their claims processing systems. With the state's help, managed care plans moved from processing systems that categorized claims from out-of-network providers separately to a streamlined system, so the plans can now process out-of-network provider claims the same way as in-network claims.

F. Pediatric health care providers

1. Overview of pediatric services and relevant federal rules

Children make up an important and sizeable portion of Medicaid managed care enrollment in most states. As of 2016, 34 states covered 75 percent or more of all Medicaid-enrolled children through MCOs (Smith et al. 2016). In addition, at least 30 states used managed care systems for their separate CHIP programs in 2013 (MACPAC 2014). Four unique characteristics of children—developmental change, differential epidemiology, demography, and dependency—distinguish their needs from adults and result in important differences in provider network requirements (Zickafoose et al. 2014a).

- **Development.** Children experience rapid growth and development, so the health services they receive should focus on enhancing this development and detecting and ameliorating conditions that can result in developmental delays or lifelong morbidity (Stille et al. 2010).

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[91] Source: Mathematica analysis of contracts in 20 states with the greatest number of Medicaid managed care enrollees nationwide. Of the 20 contracts reviewed, none included time or distance standards for family planning providers. Only New York's contract included a standard defining timely access to care for family planning services: initial family planning visits must be available within two weeks of request.

[92] Data are available on the institute's website at https://data.guttmacher.org/counties.

[93] More information is available at http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/title-x-grantees-list/#.

Access to primary care for all children at regular intervals—more frequently than what is required for adults—is vital for normal development. Children with identified or suspected developmental delays need timely access to pediatric specialists who can diagnose or treat conditions that contribute to the delays. Providers that specialize in child development (such as speech, occupational, and physical therapists; audiologists; and mental health providers) are particularly important.

- **Differential epidemiology.** Children tend to have low rates of illness or disease, but among the roughly one-quarter of children who have special health care issues, rare conditions (such as neurological impairments or genetic disorders) dominate (Zickafoose et al. 2014a). As a result, certain children can require access to a wide variety of pediatric medical and surgical special-ists, as well as other providers. Their need for such access will vary over time.

- **Demographics and dependency.** The demographics of children and their dependence on adults for care can each have important implications for network design. Because children depend on their parents and other caregivers to select appropriate care and provide transpor-tation, the needs and preferences of parents should be considered when determining how to give children consistent access to quality care, including culturally competent care.

Given the large number of children enrolled in Medicaid and CHIP, and their varying needs, the 2016 final rule requires that states set distinct provider network adequacy standards for certain pediatric provider types in managed care. Federal law makes CHIP managed care subject to the same federal regulations that establish standards for Medicaid managed care [§2103 (f)(3) of the Social Security Act], even if the state CHIP is not a Medicaid expansion.

Regarding provider network adequacy standards, §438.68(b)(1) and §457.1218 require states to set time and distance standards for providers of the following:

- *Primary care*.

- *Behavioral health (mental health and SUD)*. This requirement is consistent with those related to physical health providers and is particularly important for children and youth—especially those with behavioral health conditions who are enrolled in foster care.

- *Specialists*. States can define the pediatric specialist and subspecialist types that they determine deserve separate provider network standards. This could include pediatric specialty pharma-cies, pediatric specialty hospitals, pediatric medical subspecialists, pediatric surgical specialists, and LTSS (see Box V.7).

✔ **State practices**

Box V.7. Network standards for pediatric specialists

Because of the large number and diversity of specialists, states face challenges in establishing provider network standards and adapting adult standards to pediatric populations. As with standards for adult specialists, states may use encounter data to identify and report on the specialty types that provide the highest volume of services, and therefore may be candidates for provider-to-enrollee ratios. Alternatively, states may work with stakeholders to identify the need for standards for pediatric specialists and benchmarks against which they will be measured. **Florida** adapted its standards for Medicare-based specialists for adults to pediatric specialists for children after consulting with children's hospitals. These stakeholders provided guidance on the types of specialists children with special needs used most and would benefit from provider network standards.

- *Pediatric dental providers and specialists*. See Section G of this chapter for more information on pediatric dental providers.

Federal law also ensures access to certain services through out-of-network provisions. Specifically, §438.206(b)(4) and §457.1230(a) require Medicaid and CHIP managed care plans to cover "necessary medical services," such as emergency care, from out-of-network for as long as the managed care provider network is unable to provide them. Also, §438.206(b)(5) and §457.1230(a) require that if managed care plans cannot meet beneficiary needs with in-network providers, Medicaid and CHIP plans must coordinate payment with out-of-network providers and ensure the cost to the enrollee is no greater than it would be if the services were furnished within the network.

The supply and distribution of pediatric providers can make it difficult for children and families to access care. In contrast to long-standing shortages of primary care providers for adults, the number of primary care providers per child has more than doubled—from 32 per 100,000 children in 1975 to 78 per 100,000 children in 2005 (Freed and Stockman 2009). However, the supply is not evenly distributed: an estimated 1 million children live in areas in which there are no local pediatricians or family physicians (Shipman et al. 2011). Many pediatric specialties report fewer than 1,000 physicians nationwide, and nearly all pediatric specialists practice in urban, tertiary care centers (Mayer 2006). Inpatient care for children with chronic conditions is also highly concentrated in tertiary care children's hospitals (Berry et al. 2013), and hospital care for common conditions is increasingly provided in larger hospitals (Hasegawa et al. 2013; Lopez et al. 2013).

Due to low provider density (in rural areas, for example), low supply (of children's hospitals and many pediatric specialists, for example), or extensive regionalization of specific services (children's hospitals, for example), it is often challenging to recruit pediatric specialists into Medicaid managed care provider networks. Nonetheless, states have an obligation, often extended through plan contracts, to make sure that children have access to required screening and necessary services to treat health conditions.[94] Medicaid benefits not provided by the managed care plan remain the responsibility of the state Medicaid agency, so that in combination with benefits delivered through managed care and directly by the agency, eligible individuals will have access to all Medicaid benefits.[95]

2. Resources to identify enrollee needs and provider capacity, develop network standards, and monitor access for pediatric providers

Identify enrollee need and provider capacity. Many of the data sources this toolkit describes for states to use in identifying enrollment and provider trends for adults can be used to identify trends for children and pediatric providers as well. For example, states can use the following:

- *MMIS systems* to generate counts of enrolled children by primary residence or identify the most commonly used pediatric specialties or service types.

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[94] Available at https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf. Accessed February 23, 2017.

[95] For more information, see https://www.medicaid.gov/federal-policy-guidance/downloads/cib010517.pdf.

- National-level data sets to estimate the prevalence of health conditions within pediatric populations. For example, the **National Health Interview Survey (NHIS)** contains information on the prevalence of select health conditions, obesity, and dental caries by age. The **Medical Expenditure Panel Survey (MEPS)** contains data on a family unit's use of specific health services, frequency of use, and costs and payment sources. **Area Health Resource Files (AHRFs)** can be used to calculate state-level estimates of licensed general pediatric and family care providers.

- Data from **SAMHSA's National Survey on Drug Use and Health (NSDUH)** to estimate rates of substance abuse and mental illness, including depression and suicidal ideation, by age group. Information on NHIS, MEPS, and AHRF is available in Chapter II; information on NSDUH is available in Chapter V, Section B.

- The **National Ambulatory Medical Care Survey (NAMCS)**,[96] an annual, nationally representative survey that can be used to produce estimates of the number of physician office visits for children by age, physician specialty (for example, general pediatricians, medical specialists, and surgical specialists), and visit type (well care or a problem-focused visit).

Develop access standards and requirements. The 2016 final rule requires states to develop separate adult and pediatric primary care provider network standards, but few have included such standards in their contracts (OIG 2014; Silow-Carroll et al. 2016), and those that do so use minimum provider-to-enrollee ratios. **Massachusetts** and **Virginia** require the same provider-to-enrollee ratios for providers serving both populations; **Maryland** requires more pediatric than adult primary care providers (one provider to 1,500 children younger than age 21 compared to one provider to every 2,000 adults). Regardless of the standards a state sets, the standards should be adjusted to reflect variations in the needs of pediatric enrollees and the supply of providers in a given area. Children with special health care needs may also require specific considerations. A 2016 **MACPAC Report on Contract Provisions for Children with Special Health Care Needs** presents results from a survey of states and managed care plans on contract provisions related to access to care for this population.[97]

States may want to consider how contracts between plans and providers established on an as-needed basis for specific patients, known as "single-case agreements," can help augment access to care for certain enrollees. The level of effort that managed care plans must expend to arrange for out-of-network services through single-case agreements can be significant. Nevertheless, for certain services, including those that relatively rare specialists or subspecialists provide, such agreements are sometimes the only way to provide access to critical care (Zickafoose et al. 2014b).

When specialists are not available in a given region, managed care plans may be able to extend the services available through primary care providers by incorporating telemedicine and providing training and direct consultative support to them. For example, primary care providers may be able to consult by telephone with a mental health professional, who are in limited supply in many communities, to feel more confident about providing certain mental health services (Zickafoose et al. 2014a). **Arizona** augments its pediatric provider network by including field clinics and virtual

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[96] Information is available through the National Center for Health Statistics website at http://www.cdc.gov/nchs/ahcd/.

[97] Available at https://www.macpac.gov/publication/access-to-care-for-children-with-special-health-care-needs-the-role-of-medicaid-managed-care-contracts/.

clinics that incorporate the use of telemedicine, teleconferencing among providers, and an integrated medical record for children who need multispecialty, interdisciplinary care not otherwise available near their home (Arizona Health Care Cost Containment System Division of Business and Finance 2014).

Monitoring services availability and access to care. As discussed in Chapter IV, monitoring access to care for adult populations involves a number of activities, including validating provider networks, confirming that access requirements are met, and using the quality assessment and improvement strategy process.[98] Medicaid and CHIP managed care programs should use the same processes to monitor access to pediatric provider types, with modifications to account for the unique characteristics of children.

G. Pediatric dental providers

1. Overview of pediatric dental services and relevant federal rules

Comprehensive dental services for children and adolescents are required as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit [Social Security Act, Section 1905(r)]. Dental services required in the EPSDT benefit are provided at no cost to Medicaid-enrolled children. They include, at a minimum (1) dental care needed for relief of pain and infection, restoration of teeth, and maintenance of dental health (provided at as early an age as necessary); (2) emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures; and (3) medically necessary orthodontic services (CMS 2014; CMS 2013). Given the large number of children entitled to receive dental benefits through Medicaid and CHIP, the 2016 final rule added requirements that states develop quantitative time and distance standards for pediatric dental providers [§438.68(b)(1)(vii) and §457.1218].

Slightly fewer than half of the nation's 42 million Medicaid and CHIP children eligible for EPSDT received dental service in a given year, and fewer receive a preventive dental service (CMS 2015). Access to pediatric dental care can be limited by many factors—which vary by state—at both the delivery system and family levels. For example, families can encounter difficulty when attempting to find a dentist who participates in Medicaid and is willing to see their children. It can be a challenge for states to enroll enough oral health providers because of low provider reimbursement rates, numerous administrative requirements, and high appointment no-show rates (Davis and Brown 2009). Accordingly, some dentists who participate in Medicaid limit the number of Medicaid patients in their practice, potentially contributing to access challenges.

2. Resources to identify enrollee needs and provider capacity, develop pediatric dental network standards, and monitor access for pediatric dentists

Identify enrollee needs and provider capacity. To estimate expected demand for pediatric dental services, states can combine information on the number of children covered by Medicaid and CHIP with the number of recommended dental visits. States are allowed to establish their own schedules of periodicity that set standards regarding the recommended timing and frequency of dental services for children younger than age 21 (see §441.58 and CMS State Medicaid Manual

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[98] The requirement for a Quality Assessment and Improvement Strategy can be found at §1932(c)(1)(A) of the Act. Section 2103 applies all of these standards to managed care in CHIP.

Sections 5510 and 5140). States must consult with recognized medical and dental organizations involved in child health care to determine that periodicity schedules meet reasonable standards of medical and dental practice. However, about half of states use the ***periodicity guidelines established by the Academy of Pediatric Dentistry (AAPD)*** or a modified version of these guidelines (see Box V.8). Using the AAPD-recommended schedule, states could expect children ages

0–1 to receive one preventative care exam during the year, and children ages 1–20 to receive two preventative exams (that is, an exam every six months) every year thereafter. Through the EPSDT benefit, children can also access dental and oral health services more frequently than outlined in the state's periodicity schedule if the services are medically necessary (for example, if the child is at high risk for dental caries; CMS 2013).

> **_i_ Data and information resources**
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> ### Box V.8. Pediatric dental periodicity
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> A list of state dental periodicity schedules is available from the AAPD Pediatric Oral Health Research & Policy Center website at http://www.aapd.org/policy_center/state_dental_periodicity_schedules/.
>
> The AAPD periodicity schedule is available at http://www.aapd.org/policies/.

To understand provider capacity, states can check surveys of the dental health workforce conducted by professional organizations and the U.S. Census Bureau, such as the following:

- *The Dentist Locator at **InsureKidsNow.gov**,*[99] a Congressionally mandated provider directory, can be used to identify dentists in each state who participate in Medicaid and CHIP. The directory includes the provider's address, specialty, ability to accommodate special needs, and ability to accept new patients.

- The ***Area Health Resource Files (AHRF)*** can be used to calculate state-level estimates of licensed dentists and dental hygienists.[100]

- The American Dental Association (ADA) Health Policy Institute (HPI) conducts ongoing **surveys of private practice dentists** to learn more about the characteristics of their practices and employees. Two surveys that might be of interest to state Medicaid agencies are Characteristics of Private Dental Practices and Employment of Dental Personnel.[101]

- A report produced by the Oral Health Workforce Research Center (2015) profiles data on dental assistants and provides several helpful sources of information that states could use to conduct similar analyses of dental provider types. Specifically, it suggests using the following data sources to determine dental provider capacity:

  - **BLS, OES**[102] provides annual employment statistics and wages for dental assistants, hygienists, and laboratory technicians. BLS statistics do not, however, include the individuals who are self-employed or owners/partners in unincorporated firms, which may include some dental practices.
  - ***American Community Survey (ACS)***[103] collects self-reported demographic information from households in five-year increments on job titles, including dentist; dentist, public health dentist attendant; dental aide; dental hygienist; and dental surgeon.

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[99] Available at https://www.insurekidsnow.gov/state/find-a-dentist/index.html.
[100] Available at https://datawarehouse.hrsa.gov/topics/ahrf.aspx.
[101] These surveys are available on the HPI Data Center website available at http://www.ada.org/en/science-research/health-policy-institute/data-center/dental-practice.
[102] More information is available at http://www.bls.gov/oes/.
[103] More information is available at https://www.census.gov/programs-surveys/acs/.

MEDICAID MANAGED CARE NETWORK AND ACCESS TOOLKIT

Develop access standards. Self-reported data from members of the ADA shows that average wait time for an appointment with a dentist (for dentists who accept private and public payment and serve adult and pediatric clients) was five days in 2014 (see Table V.4).

Table V.4. Average adult and pediatric patient wait for scheduled appointments with general dental practitioners and wait time after arriving, 2014

Average wait	Wait
Wait for initial appointment (days), patient of record	5.0 days
Wait for initial appointment (days), new patient	6.2 days
Wait after arrival (minutes), patient of record	6.3 minutes
Wait after arrival (minutes), new patient	7.1 minutes

Source: American Dental Association, Health Policy Institute, 2015 Survey of Dental Practice, Table 7. Includes wait time for private pay and Medicaid clients.

Despite these estimates, many states set standards for significantly greater wait times. For example, **New Jersey** requires that Medicaid enrollees be able to obtain routine non-symptomatic appointments within 30 days of referral, and **Maryland** requires a wait of no more than 60 days for follow-up routine and preventive care. **Georgia** requires that scheduled appointment wait time does not exceed 60 minutes—nearly six times longer than the standard appointment wait time the ADA reported.

In regard to time and distance standards, states may look to their peers for example provider network standards related to pediatric dental providers, and adjust the standards to fit their state needs, capacity, and goals. Table V.5 below presents standards from five states with dental managed care programs: **Arizona**, **Georgia**, **Maryland**, **New Jersey**, and **Texas**.

Table V.5. Dental provider network standards in five states

State	Standard
Appointment availability	
Georgia	The contractor shall have in its network the capacity to ensure that waiting times in the provider office do not exceed the following for pediatrics and adults: • Scheduled appointments waiting times shall not exceed 60 minutes. After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment. • Work-in or walk-in appointments waiting times shall not exceed 90 minutes. After 45 minutes, patient must receive an update on waiting time with an option of waiting or rescheduling appointment.
Maryland	Appointments must be scheduled within the following time frames: • 48 hours for urgent care • 90 days of enrollment for an initial comprehensive assessment; 60 days for follow-up routine and preventive care • 60 days of initial authorization from recipient's general dentist/PCD or more expeditiously as deemed necessary by the general dentist/PCD for specialty care
New Jersey	For dental appointments, the contractor shall be able to provide: • Emergency dental treatment no later than 48 hours, or earlier as the condition warrants, of injury to sound natural teeth and surrounding tissue and follow-up treatment by a dental provider • Urgent care appointments within three days of referral • Routine non-symptomatic appointments within 30 days of referral

Table V.5. Dental provider network standards in five states

State	Standard
Time and/or distance	
New Jersey	The contractor shall adhere to the 30-minute standard, i.e., enrollees will not live more than 30 minutes away from their PCPs, PCDs, or CNPs/CNSs. The following guidelines shall be used in determining travel time: • Normal conditions/primary roads—20 miles • Rural or mountainous areas/secondary routes—20 miles • Flat areas or areas connected by interstate highways—25 miles Metropolitan areas such as Newark, Camden, Trenton, Paterson, and Jersey City—30 minutes' travel time by public transportation or no more than 6 miles from PCP.
Arizona	[Contractors must maintain] a network such that 90% of its members residing within Pima and Maricopa counties do not have to travel more than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through a multi-specialty interdisciplinary clinic.
Texas	At least 95 percent of members must have access to two or more main dentists with an open practice within 30 miles of the member's residence in urban counties and 75 miles of the member's residence in rural counties….The dental contractor also must ensure that 90 percent of all members have access to at least one specialty provider within 75 miles of the member's residence.

Sources: Arizona Health Care Cost Containment System 2014, Section D.27; Georgia Department of Community Health Amendment #12, Section 4.8.14.3; Maryland Department of Mental Hygiene 2013, Section 3.2.1.C; New Jersey Department of Human Services 2013, Section 4.8.8.E and Section 5.12.N; Texas Health & Human Services Commission Version 1.7, Section 8.1.4.3.

PCP = primary care provider; PCD = primary care dentist; CNP = certified nurse practitioner; CNS = clinical nurse specialist.

States may also want to consider additional ways in which ancillary dental providers, such as dental hygienists and dental therapists, can help increase access, especially in areas with dentist shortages. For example, school-based sealant programs, mobile programs that use portable equipment, or a dental van staffed by dental hygienists can be effective ways to provide preventive care to hard-to-reach, low-income children (Pew 2015). In **California** and other states, an innovative demonstration program combines telehealth and use of non-dentist providers to provide dental care in community settings such as schools and Women, Infants, and Children centers. Through this program, dental hygienists in the community provide preventive care, education, and case management, and collect medical history and x-rays to send to a collaborating dentist. The dentist then creates a treatment plan that the hygienist carries out. Many states also require or encourage health plans to contract with FQHCs and other community health centers to deliver dental services. States may also require contractors to include non-dentist dental providers, such as dental therapists, in their dental networks. **Minnesota**, for example, requires managed care plans to cover the services dental therapists provide within their scope of practice, as defined in Minnesota law. **Colorado** allows hygienist-owned practices to provide prophylaxis and sealants for children, as well as other routine preventative care (Yalowich and Corso 2015).

Monitoring services availability and access to care. States can use a variety of methods to monitor provider network access. At a minimum, states should report Child Core set measures for oral health so that they can compare state-level performance with performance in each plan. Analyzing actual utilization of dental services through encounter data may be a second helpful method. **Ohio**, for example, uses encounter and FFS data to analyze utilization of dental services in urban regions compared to rural ones. It establishes expected baselines for utilization in urban regions (such as two encounters per patient per year) and looks to see where rural regions fall short of expected utilization. It then uses HEDIS® scores and grievances and complaints data from plans and regions of interest to understand whether utilization patterns result from access problems.

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