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Making Affordable Care Act Coverage a Reality

A National Examination of Provider Network Monitoring Practices by States and Health Plans

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I. Summary of Key Findings and Recommendations

This qualitative study examines the standards and practices that state agencies and health plans use to ensure access to care in the period following the implementation of the Affordable Care Act (ACA). Based on evidence gathered through surveys of and interviews with key informants in state agencies and plans, the study explores the standards applied by commercial insurance regulators and Medicaid agencies and the practices actually employed by Medicaid managed care organizations (MMCOs) and Qualified Health Plans (QHPs) in Marketplaces to form provider networks and monitor performance. While the response sample is small, the information provided paints a picture of the range of standards and practices used and the challenges faced, which provides a basis for identifying gaps in current understanding and strategies and opportunities for developing best practices. The key findings and recommendations are set forth below.

Key Findings

1. **Network standards differ significantly between state insurance regulators and Medicaid agencies.** Consistent with their differing roles, state insurance regulators (referred to also as Departments of Insurance or DOIs) and Medicaid agencies differ significantly in the detail and number of standards for network adequacy. The relationship between Medicaid agencies and MMCOs is contractual – MMCOs are vendors of the Medicaid agency. Therefore, contractual provisions on network adequacy tend to be highly prescriptive. By contrast, DOIs serve as regulators to create the basic floors for market entry, primarily to avoid market disruptions. Their standards overall tend to be more general, with more permissive thresholds, and they are less directed to achieving optimal performance.

2. **Health plans report that they are exceeding state network standards.** Notwithstanding their different regulatory frameworks, both MMCOs and QHPs report that they exceed state standards, although the degree to which state standards are exceeded is reported to be much greater among QHPs. They report that they need to maintain these high levels of performance to be effective in competing for market share. It is unclear what role required accreditation for QHPs by independent quality review organizations plays in network formation, although the requirement does provide external standards and scrutiny beyond that provided by the DOIs.

3. **Primary Care Practitioners (PCPs) are defined broadly by states and health plans.** In defining what types of practitioners can be designated as PCPs, both DOIs and Medicaid agencies include a broad range of providers. Allied professionals such as nurse practitioners and physician assistants tend to be recognized as PCPs. MMCOs and QHPs mirror this inclusiveness.

4. **Provider-to-enrollee ratios and maximum travel time and distance (geo-access) standards vary widely.** Requirements regarding provider-to-enrollee ratios and geo-access standards vary widely, with geo-access standards having the widest variation. Regulators do not appear to have used a consistent methodology or approach to developing standards for measuring network adequacy – either in terms of geo-access or provider-to-enrollee ratios. The standards themselves reflect little consensus regarding optimal provider distribution based on geography or population. No effort appears underway to develop algorithms or formulas that apply local variables in a consistent way

to arrive at standards that reflect a reliable indication of access. Similar variation exists among QHPs and MMCOs in the standards adopted. Most surveyed QHPs report having more providers for their enrolled population than required by DOIs and using geo-access standards. Reporting MMCOs appear on average to have fewer providers to enrollees than the standards reported on average by Medicaid agencies. However, it is not clear that those plans with fewer providers to enrollees deviate from the actual contractual standards in their particular states. Some key informants question the degree to which these metrics provide insight into the "nitty gritty" of the actual availability of care when it is needed.

5. **Few states track provider network overlap across plans.** It is rare for regulators to take into account the multiplicity of plans with which providers contract (plan overlap) to evaluate actual provider capacity. Providers who serve patients in a large number of plans may have less capacity to serve patients in any one plan than is suggested by plan-specific provider to enrollee ratios. Only a small number of Medicaid agencies, MMCOs, and QHPs monitor total provider patient load and its consequent effects on patient wait-time, out-of-network utilization, and access by new patients. Most regulators limit the evaluation of provider capacity to an individual plan's provider network. DOIs universally fail to monitor plan overlap effects on provider networks.
6. **Essential Community Providers (ECPs) are an increasing option.** Some states have integrated into their general commercial market and Medicaid program Marketplace requirements to include ECPs in provider networks.
7. **After-hours appointment availability is still rare.** While 24/7 telephone availability to a provider is almost universally reported by plans and Medicaid agencies as a standard for network performance, after-hours in-person appointment availability remains on the sidelines of network planning for state agencies and plans. No DOIs and few Medicaid agencies require it.
8. **Many plans report covering out-of-network care provided by clinicians working at in-network facilities to protect consumers from having to pay for unintended out-of-network care.** While a majority of MMCOs and QHPs report addressing this issue, most Medicaid agencies and state insurance regulators do not. Some state insurance regulators report emerging legislative activity to protect consumers from out-of-network costs for in-network facility care.
9. **Member complaints are the most frequent but not the most reliable indicator of systemic network deficiencies.** In monitoring network structure and availability, DOIs, Medicaid agencies, QHPs, and MMCOs rely extensively on consumer complaints and surveys to flag problems. State insurance regulators report that while they rely on complaints, they find them to be poor indicators of problems, either because they represent only "the tip of the iceberg" or are distorted by provider efforts to encourage their patients to complain about proposed networks that do not include those providers. While not completely absent, little analysis of claims data such as emergency room, out-of-network, or specialist utilization occurs that might be early-indicators of difficulties in gaining access to in-network care.
10. **Many regulators are hampered by insufficient information technology (IT) to monitor networks.** Many **s**tate insurance regulators and Medicaid agencies report that they do not have the IT

resources necessary to automate monitoring activities and perform data analytics, a situation that impedes timely and accurate evaluation. This presents more of a challenge to state agencies than achieving adequate staffing levels. Some states are moving to increase their IT capabilities and are engaging partners in data collection efforts so as to have an independent source of information on providers and locations against which to compare plan network files.

11. **State insurance regulators report substantially increased oversight activity since the passage of the Affordable Care Act.** Some report the change as "dramatic" with "frenetic" levels of activity around the new plan designs and submissions required under the ACA. This increased activity responds to new levels of regulation regarding network adequacy and increased public scrutiny in an environment where having insurance is mandatory.

Key Recommendations

While the variety of practices and perceptions suggests there are many avenues to achieving more consistency in network standards and ensuring better access to care, the recommendations set forth below reflect the synthesis of experiences that provide evidence for approaches that are both useful and feasible.

1. **Monitor program-wide provider capacity.** Monitoring of provider total patient capacity and plan overlap should be implemented as a way to assess actual provider availability. If the monitoring process is to be effective, it must be based on program-wide standards (e.g., Medicaid managed care in one state) and cross-program standards (e.g., Medicaid managed care, the Marketplace and other insurance programs in one state) on provider capacity and a re-examination of the basis for determining provider-to-enrollee standards. On the other hand, this standard also must account for the benefits to consumers of continuity-of-care when providers participate in multiple networks so that consumers can move between plans while maintaining the same providers.
2. **Invest in network standards.** More investment is needed to develop network standards based on data to ensure that application of the standards will result in care being available when it is needed. This requires consensus on how to develop the data and build algorithms. More forums for collaboration among states and across coverage programs should be convened. This effort will provide useful information to state agencies that are struggling to develop appropriate metrics. It will also promote standardization of measures and practice, which will be useful to plans operating in multiple markets.
3. **Increase after-hours access.** Standards for after-hour appointments in primary care settings need to move from the frontier to the mainstream. This will require close collaboration with providers to develop the infrastructure and staffing organization to make complying with such standards feasible. Approaches used to establish Patient-Centered Medical Homes (PCMH) and access to telemedicine and urgent care centers could be used as models.
4. **Deploy data analytics.**
    a. More data analytics need to be employed to create "early-warning" flags for network availability problems, particularly the analysis of claims data to signal whether enrollees are

resorting to emergency room and out-of-network care to deal with network access problems and to determine if specialty care is occurring in appropriate ratios to overall utilization.

b. Enhanced data analytics need to be employed to determine the accuracy of provider network information and enable mapping of providers to evaluate access. This may entail developing more centralized data bases on providers across a state.

5. **Increase the state insurance regulator's role in network oversight.** Given the large number of newly insured people and the importance of ensuring the integrity of insurance products when people are mandated to purchase insurance, state insurance regulators may need to reevaluate their role to encompass more oversight of ongoing performance by plans.

II. Introduction and Research Objective

In recent years, the role of risk-based managed care in Medicaid has grown substantially, both in absolute terms as Medicaid continues its growth under the Affordable Care Act (ACA) and as a proportion of enrollees with public coverage as states bring more Medicaid sub-populations under the umbrella of managed care.[1,2] As a result, states increasingly rely on MMCO networks and monitoring of network adequacy to ensure access to care.

On a parallel track, over 10 million people have gained coverage in the individual commercial market in QHPs offered through the ACA Marketplaces. Access to care in the individual market in particular, therefore, largely depends on the network adequacy of QHPs. The ACA requires issuers of QHPs to maintain provider networks that are sufficient in number and types of providers to ensure that all services will be accessible to enrollees without unreasonable delay.[3] However, rather than being a primary role of the Marketplaces, monitoring provider networks in QHPs has been delegated largely to the state departments of insurance and their partners, a role historically included in the licensure process in many states. In addition, the Marketplaces require that QHPs have accreditation from independent quality review organizations, and quality rankings for QHPs begin in the Marketplaces in 2016. The extent to which these factors also drive network formation is unclear. These activities will provide an additional level of external standards and scrutiny.[4] Variation in network standards across states—and how states monitor health plans using these standards—has important implications for enrollees, providers, and insurers.

Ensuring provider network adequacy is fundamental to fulfilling the promise that Medicaid expansion and Marketplace coverage under the Affordable Care Act will lead to improved individual and population health. Federal Medicaid rules and the ACA prescribe floors for network adequacy in MMCOs and QHPs. However, previous studies suggest that access to providers varies considerably across states. This variation raises concerns among policymakers, advocates, and other stakeholders about the degree to which access to providers is adequate in the new QHP and MMCO networks serving the Marketplace and Medicaid populations.

In this report, Health Management Associates (HMA) examines the strengths and weaknesses of state and health plan network-monitoring activities in the Marketplace and Medicaid managed care expansion environment by identifying the barriers to effective oversight and efforts underway to

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[1] Howell E., Palmer A., Adams F. *Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future.* Washington, D.C.: The Urban Institute, 2012.
[2] Smith V., Gifford K., Ellis E., Rudowitz R., Snyder L. *Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*. Washington, D.C.: The Henry J. Kaiser Family Foundation, 2014.
[3] 45 C.F.R. 156.230(a)(2).
[4] Centers for Medicare and Medicaid Services. Health Insurance Marketplace Quality Initiatives. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html
Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services. *Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces*. Washington, DC. February 20, 2015. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf

overcome those barriers. This report summarizes project findings and provides recommendations to improve standards and practices that promote dependable network monitoring. Appendix A includes summary tables with current network standards that reflect the variation seen across the industry.

III. Study Design

This project examines health plan provider network monitoring activities by state departments of insurance or similar regulators (DOI), Medicaid agencies, Marketplace plans, and Medicaid plans using a two-step methodology to identify: (1) the barriers to effective oversight and (2) efforts underway to overcome those barriers. In the first phase of the project, the study team reviewed the literature to understand the landscape of measures, standards, and practices. The second phase entailed a survey of key informants from insurance departments, Medicaid programs, and health plans to explore and update current practices, ongoing challenges, and successes. Following the survey, a subset of 12 respondents, evenly distributed among DOIs, Medicaid agencies, QHPs, and MMCOs, were selected for follow-up interviews to probe survey responses. The findings were then synthesized into a set of key findings and recommendations for network adequacy monitoring and compliance measures, standards, and practices.

Literature Review

An in-depth review of recent studies of provider network adequacy measures and standards served as the basis for the state and health plan survey to uncover what standards, measures, and monitoring activities are in place to maximize compliance with the standards. The review also examined:

- barriers to collecting, submitting, and analyzing timely, accurate, and complete provider network data; and
- efforts by states and plans to overcome these barriers.

It included gathering close to 40 existing standards and measures to form the basis for four distinct online survey tools developed to address the unique requirements and experiences of the state agencies responsible for monitoring network adequacy (DOIs and Medicaid agencies) and the health plans (QHPs and MMCOs) that participate in these markets. This research revealed considerable variation in the network adequacy standards and tools currently in use. It also allowed us to identify additional measures and recommendations that have been proposed. This review informed our survey tools, which are attached in *Appendix B.* Further, a complete bibliography of the literature reviewed to develop the survey tools has been provided in *Appendix C.*

Surveys and Interviews

This phase of the project entailed three discreet tasks: (1) selection of respondents for both on-line surveys and telephone interviews, (2) creation of on-line survey content, and (3) creation of the telephone interview guide.

Respondent Selection Process

The study team worked with HMA colleagues with state government and managed care backgrounds, Medicaid Health Plans of America (MHPA), and the Association for Community Affiliated Plans (ACAP) to identify subject matter experts (SMEs) who work on provider network monitoring activities within: a) DOI or Marketplace offices, b) Medicaid agencies, c) QHPs, and d) MMCOs. Some states manage Marketplace operations out of their insurance departments, while others have set up separate organizations. However, in most cases, the insurance departments themselves and their state partners

directly regulate provider networks. HMA did not survey insurance departments in the states with federally facilitated Marketplaces that CMS determined do not meet the network adequacy assessment standards in 45 C.F.R. § 156.230(a).[5]

Selection criteria prioritized MMCOs and QHPs with significant Medicaid or Marketplace market penetration. The study also took into account plan geographic distribution, organizational structure (including provider organizations and CO-OPs), plan participation in both Medicaid and Marketplace markets, and for-profit/nonprofit status.

On the basis of the survey responses, three respondents from each of the project study areas (DOIs, Medicaid agencies, QHPs, and MMCOs) were selected to participate in follow-up telephone interviews to explore responses and further identify best practices. Selection criteria for telephone interviews took into consideration states and plans that demonstrate well defined measures, standards, and monitoring practices or offer additional recommendations for standards and monitoring to adequately manage access to care.

Survey Instrument Content

Based on the literature review, HMA designed a master on-line survey tool with two surveys for departments of insurance staff and Medicaid agency staff, respectively. The surveys identified all measures, standards, and practices currently used to monitor QHPs and MMCOs. It further inquired into states' experiences with the existing measures; standards and monitoring practices; new measures, standards, and monitoring practices; and the processes for gathering and analyzing network information, monitoring challenges, and enforcing standards. Survey questions covered two key domains: a) thresholds for provider access standards and b) provider network monitoring practices.

The study team then developed a second on-line survey tool with two versions, respectively, for QHPs and MMCOs. This tool explored the measures, standards, and monitoring practices they use. It asked about their experience collecting, maintaining, analyzing and submitting the information to the states. It also examined their approaches to assessing network needs. How they address challenges, develop alternative strategies, and resolve chronic compliance issues were also explored. These questions were organized into the same two domains as the master survey for states: a) thresholds for provider access standards and b) provider network monitoring practices. To control for survey bias, HMA peer reviewed the survey structure and questions with staff experts who have experience in survey design and provider access.

HMA conducted the on-line surveys using Survey Monkey, a web-based survey service.

Interview Instrument Content

The telephone survey explored in more detail topics including: a) barriers in network monitoring; b) revisions made to network measures/standards to align with changes taking place in the delivery system; c) best practices to improve the integrity of network data files; d) the extent of collaboration

[5] CMS requires that health plans in these states submit an access plan or current accreditation results to demonstrate network adequacy. Three states do not meet minimum QHP HMO network assessment standards (IN, LA, SC) and seven states do not meet minimum QHP non-HMO network assessment standards (IN, LA, MO, OK, SC, TN, WY).

between state agencies in their monitoring of QHPs and MMCOs; and e) other activities that play a supporting role in the efforts to maximize provider network monitoring activities to make access to care a reality for beneficiaries enrolled in a QHP or MMCO.

Response Rates

HMA surveyed the 39 state Medicaid agencies with known managed care programs,[6] 43 state-based, federally facilitated and partnership states whose state insurance departments monitor provider networks, and a representative mix of 30 MMCOs and 30 QHP carriers.[7] The 30 plans for each target group represent an estimated 9 percent of all MMCOs (332)[8] and 10 percent of all QHP carriers (286)[9]. Follow-up interviews were pursued with 12 respondents or 8 percent of the total respondent pool. Ultimately, 17 (44 percent) Medicaid agencies, 13 (30 percent) DOIs[10], 7 (23 percent) MMCOs, and 8 (27 percent) QHPs responded to the surveys. Eleven follow-up interviews were completed. This project received letters of support from MHPA and ACAP to help facilitate outreach with MMCOs.

Limitations

This study faced a number of limitations. While the response rates generally exceeded the expected response rate for on-line surveys, the sample remains small across all types of respondents. Moreover, it is not clear that the respondents are representative of the sample pool. For example, 76 percent of the DOI responses came from the 28 percent of states that operate state-based exchanges. In addition, most surveys had questions left unanswered. While it is plausible to assume that the failure to answer reflects an absence of standards or activity in that subject area, such a conclusion without confirming information would be speculative. Finally, surveys are necessarily dependent on the specific knowledge of the individual respondent, who may not have expertise on all aspects of the relevant standards and practices. This could affect response accuracy. Validation of survey responses is beyond the scope of this study. Notwithstanding these limitations, the information provided in the surveys and interviews provides a qualitative picture of practices and challenges—information that can be useful in formulating best practices and identifying barriers to ensuring access.

[6] Kaiser Family Foundation, Medicaid MCO Enrollment, September 2014.
[7] QHPs may operate HMOs, PPOs and indemnity plans. For the purposes of this research, we limited the survey to HMO-type QHPs, which generally limit coverage to in-network providers.
[8] CMS Medicaid Managed Care Enrollment Report, 2011.
[9] ACAP report, "Overlap Between Medicaid Health Plans and QHPs in the Marketplaces: An Examination," December 13, 2013.
[10] Of the 13 DOI responses, four respondents reported that they do not regulate network adequacy for Marketplace QHPs.

IV. Principal Findings

The ways in which Medicaid agencies and DOIs regulate network adequacy and attempt to ensure access to care differ substantially from each other. In general, Medicaid agencies contract directly with MMCOs, which operate as vendors to the agencies. These contracts tend to be prescriptive regarding network formation and maintenance. DOIs, on the other hand, serve as external regulators of the market, so they review network adequacy by setting floors that must be met for licensure and for protecting consumers by ensuring product integrity and appropriate response to complaints. More recently, DOIs have intervened in situations where network disputes between health plans and health systems have caused large numbers of consumers to pay higher costs or lose access to longstanding providers of their care.[11]

External factors that affect the practices of plans are more likely to be an issue in the commercial market than the Medicaid market, although some arise in Medicaid as well. For example, starting in 2016, QHPs operating in the Marketplaces will be assigned quality rankings based on the result of consumer satisfaction surveys, as is now done for Medicare Advantage plans.[12] These quality rankings will help consumers make wise plan selections and likely will create additional incentives for plans to improve networks as they compete for market share. In addition, in some states, oversight of network adequacy is delegated to a partner agency, such as the Department of Health. The result is more fragmented processes for oversight, with some DOIs having insufficient knowledge of network performance.

QHPs report that they often exceed specific state standards regarding the structure and sufficiency of the network. They do this in response to market demands, particularly to the demands of larger employers and to accreditation requirements imposed by NCQA, URAQ or others, which must be met to gain QHP certification to participate in Marketplaces. Despite more prescriptive and consistent regulatory requirements for MMCOs, the survey findings show that these plans also report that they exceed state standards in several ways.

The specific findings by topic of inquiry are set forth below.

Scope of Primary Care Provider Definition

In general, where the definition of primary care providers is addressed, both Medicaid agencies and state insurance regulators tend to be inclusive in specifying the types of providers considered to be primary care providers. However, DOIs are less likely to address this issue, with approximately 16 percent of respondents failing to answer the question. The overall pattern of inclusiveness is reflected in the networks developed by plans in Medicaid and the Marketplace. While this inclusiveness is generally considered desirable in promoting access to care, particularly in provider shortage areas, and facilitating

[11] http://www.upmc.com/about/why-upmc/changing-health-insurance-market/Pages/default.aspx

[12] Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services. *Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces*. Washington, DC. February 20, 2015. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf

Centers for Medicare and Medicaid Services. *Overview of 2015 QRS Requirements for QHP Issuers.* October 2014. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Issue-Brief-4-QRS-Requirements-for-Issuers.pdf

shorter wait times to care, the inclusion of ancillary providers may mask a shortage of physician care. The specific breakdown of responses by type of respondent is reflected in Table 1-1 in Appendix A.

Medicaid agency requirements and MCOs. The majority of, and in some cases all, Medicaid agency respondents indicate that their agency recognizes the following types of providers as primary care practitioners:

- general practitioners
- family practitioners
- internists
- pediatricians
- nurse practitioners
- physician assistants
- OB/GYN

It is worth noting that 25 percent of Medicaid agency respondents report that their agency does not recognize physician assistants as primary care providers. Mid-level practitioners are becoming an accepted addition to primary care practice by Medicaid agencies, although states have different scope-of-practice guidelines, which, in those areas that place greater constraints on scope of practice, can limit access to primary care, particularly in underserved areas.[13]

In addition to recognizing the commonly accepted primary care provider types, eight Medicaid agencies responded that they recognize specialty providers as PCPs on a case-by case-basis for enrollees whose care would be more appropriately managed by a specialist. Two Medicaid agencies identified gerontologists as PCPs. One Medicaid agency recognized certified nurse midwives as PCPs. Another Medicaid agency recognized primary care teams consisting of residents and a supervising faculty physician under contracts with teaching facilities or teams that include certified mid-level practitioners.

The majority of responding Medicaid MCOs recognized as primary care practitioners the same types of providers as Medicaid agencies with the exception of physician assistants. Two responding Medicaid MCOs permit specialists who agree to fulfill the obligations of a PCP in that role on a case-by-case basis. It is noteworthy that 75 percent of responding Medicaid agencies accept physician assistants (PAs) in the role of PCP while just half of the Medicaid MCOs do so. This may reflect guidelines that limit scope of practice for MCOs in some states despite the Medicaid agencies' acceptance of this provider type for primary care.

State insurance regulators and QHPs. A clear majority of respondent state insurance regulators recognize all of the identified providers as PCPs. Interestingly, more states recognize nurse practitioners and physician assistants (75 percent) than include internists as PCPs (64 percent). General practitioners, family practitioners, and pediatricians are the most recognized PCPs (83 percent). The generally high rate of inclusion of nurse practitioners and physician assistants and lower rate of internist inclusion suggest that the perception of what constitutes primary and specialty care may drive the definition.

[13] LeBuhn R., Swankin D., *Reforming Scopes of Practice, A White Paper,* Citizen Advocacy Center, Washington, DC, July 2010.

While DOI standards are somewhat less inclusive than Medicaid agencies, QHPs universally regard general practitioners, family practitioners, internists, and pediatricians as PCPs. OB/GYNs are included as PCPs among 63 percent of QHPs. Allied health professionals are also frequently included. Nurse practitioners are included by 88 percent of responding QHPs while PAs are included by 50 percent. The relatively lower inclusion of PAs may relate to state scope-of-practice rules that expanded the scope of practice for nurse practitioners. The relatively new emergence of PAs may not yet be captured by legislation.

Network Sufficiency: Provider-to-Enrollee Ratios, Program-Wide Provider Capacity, Geographic Access, Accepting New Patients, Hospital Admitting Privileges

Network sufficiency standards vary widely across markets and states, and the use of one metric by a state (e.g., provider-to-enrollee ratios) does not necessarily mean that other standards such as geographic access are also used by that state. Because the NAIC is in the process of developing an update to its Managed Care Plan Network Adequacy Model Act, some interview informants indicated that their states are waiting for that process to unfold before revising standards. One informant also indicated that the model legislation will result in more uniformity rather than the current wide variation from state to state.[14] One state insurance regulator expressed concern that network sufficiency metrics do not necessarily provide insight into whether plan members have access to the specific services needed and covered in their benefit packages.

Use of Provider-to-Enrollee Ratios

Provider-to-enrollee ratios have been a common approach to assess a network's capacity to serve a plan's enrollees, or as one Medicaid Director said "to reassure the public that the [Medicaid managed care program] can handle the workload and that enrollees have choices." However, in issuing the recently proposed Medicaid Managed Care rules, CMS invited public comment on the use of provider-to-enrollee ratios as a measure of network adequacy and indicated that CMS believes that "time and distance standards present a more accurate measure of the enrollee's timely access to covered services than provider-to-enrollee ratios." CMS noted wide variation in the standards. This survey found that provider-to-enrollee ratios are most commonly set for PCPs, pediatricians, and OB/GYNs, as well as dentists. In addition, one Medicaid agency includes advanced practice nursing specialists in their provider-to-enrollee ratio measurement requirements. The extent to which established ratios are based on current data regarding the number and geographic distribution of providers and population is unknown. Tables 2-1 and 2-2 in Appendix A show provider-to-enrollee ratios and a breakdown of provider-to-enrollee ratio responses by type of respondent.

Medicaid agencies and MCOs. The majority of Medicaid agencies require that contracting MCOs track provider-to-enrollee ratios to monitor provider network supply. Yet, one-third of Medicaid agency respondents do not require the use of ratios. Given the wide range of responses as to the number of

[14] http://www.naic.org/committees_b_rftf_namr_sg.htm. National Association of Insurance Commissioners, Network Adequacy Model Review (B) Subgroup, Regulatory Framework (B) Task Force

enrollees allowed per provider type, the basis for the ratios may reflect geographic variations in provider availability, but the basis for the variation was not volunteered.

Only half of the Medicaid MCOs respondents use provider-to-enrollee ratios to assess network capacity. One Medicaid MCO reported that it uses ratios to track network capacity for high volume specialties — behavioral health providers, cardiologists and orthopedists — although this was not a specific requirement of the Medicaid agency respondents.

State insurance regulators and QHPs. Only 33 percent of responding state insurance agencies require that plans meet provider-to-enrollee ratios. Only two state respondents specified the ratios, and those applied to PCPs only. For both, the state required that the plan have one PCP per 2000 enrollees. By contrast, 88 percent of responding QHPs report using provider-to-enrollee ratios. Moreover, the ratios used are substantially lower than required by insurance regulators, with a median ratio of one PCP to 600 patients. Health plan respondents interviewed report that network formation is driven by market demands, particularly the demands of large employers, which are reflected in the QHP networks of those carriers. They indicated that competitive pressures required them to ensure greater provider availability.

Program-Wide Provider Capacity

Government agencies and plans rarely take into account the total numbers of patients and providers in an area in determining whether ratio standards are satisfied. Rather, the ratios are evaluated *by plan* without considering the multiplicity of plans in which contracted providers participate. This oversight may result in an over-statement of provider capacity. A provider that serves patients enrolled in multiple plans is not as readily available to the enrollees of a particular plan as one who serves enrollees in only that one plan. This overstatement may account for access barriers, such as practices closed to new patients or long wait-times for routine appointments—barriers that could not be predicted on the basis of plan-specific ratios. On the other hand, overlap of providers among plans may facilitate continuity of care because consumers can often maintain a relationship with providers when they change plans, either during open enrollment periods or when they move between Medicaid and the Marketplace. If regulators are to be effective in setting standards to ensure access, they must take into account the fact that providers participate in multiple plans, which affects their availability. This issue is apparently not being addressed in most states; if it were to be addressed, the process could trigger changes in the metrics used to measure network adequacy.

Medicaid agencies and MMCOs. While Medicaid agencies hold individual MCOs responsible for meeting pre-determined ratios of providers to enrollees, the survey findings show that just 22 percent monitor provider overlap between plans or the total number of enrollees assigned to individual providers program-wide. Among responding Medicaid MCOs, 14 percent monitor the overall capacity of providers in their network. Medicaid agencies should explore ways to track program-wide provider access to close the monitoring gap that exists with respect to provider overlap among plans.

Capacity conundrum, an example.
A Medicaid agency contracts with four MCOs. Each MCO contracts with 100 PCPs. Seventy percent of the PCPs belong to all four of the MCOs' provider networks, and most of the PCPs are at 50 percent of their maximum capacity for each MCO (e.g., where the maximum capacity cannot exceed 1 PCP to 2,000 enrollees). That puts most of these PCPs over the maximum capacity permitted across the program. Yet, their global capacity is not being tracked by the majority of Medicaid agencies. MCOs can track only their own network's capacity and do not have easy access to network data for the other MCOs. However, states have complete network files of all MCOs. States would only become aware that network capacity for a provider type may be problematic after the fact, when enrollees complain about difficulties scheduling appointments.

State insurance regulators and QHPs. No state insurance regulators report having standards to address total provider capacity or the effects of provider overlap among plans. Unlike Medicaid agencies, DOIs may not maintain QHP provider lists and may rely on other tools, such as mapping or attestation by the plans that they have met standards, to indicate provider sufficiency. To determine accurate provider capacity may require state agencies to gather and maintain different types of documentation or delegate the determination of total patient census to the QHP, accompanied by reporting requirements. Among responding QHPs, 29 percent report monitoring the total capacity of providers in networks across plans to accurately evaluate network sufficiency and availability to members.

Maximum Distance and Time Standards to Provider Locations

Maximum distance and time standards, commonly referred to as "geo-access" standards, serve as a primary method for demonstrating that a provider network is sufficient to serve the number of enrollees in a health plan. Maximum distance and time standards are typically used by Medicaid agencies to meet the federal requirement that the "geographic location of providers and Medicaid enrollees, considering distance, time travel" are satisfied by Medicaid MCOs.[15]

As with provider-to-enrollee ratios, the maximum distance and time standards vary from state to state and from market sector to market sector. CMS gives states flexibility in setting the distance and time standards in recognition of the regional variables that can have an impact on this standard. In the proposed Medicaid managed care regulations released on June 1, 2015, CMS asked for public comment as to whether it should define the actual distance/time measures set by states. The wide variation in geo-access standards reflected in the surveys confirms the findings of a previous report from OIG[16] and suggests the importance of local conditions in the development of geo-access standards, although it is not clear how these standards are developed.

Medicaid agencies and MCOs. While 85 percent of Medicaid agencies indicate they use travel distance standards, only 60 percent of surveyed MCOs used travel time standards. Travel distance for primary care ranged from an average of 21 miles for an urban PCP to 30 miles for a rural or frontier pediatrician or OB/GYN. Travel distance standards for specialists were greater, averaging 37 miles in urban settings

[15] 42 CFR 438.206(b)(1)
[16] Suzanne Murrin, *State Standards for Access to Care in Medicaid Managed Care.* Department of Health and Human Services, Office of Inspector General, September 2014.

and 50 miles on the frontier. Maximum travel time standards were similarly variable, averaging 28 minutes to an urban PCP and 60 minutes to a rural or frontier specialist. Fewer MCO respondents completed the travel distance survey question (60 percent) or the travel time question (40 percent). Yet variation in geo-access standards remains evident from this small sample. The significance of the range in responses for maximum distance and time travel cannot be overstated. As discussed above, the basis for the extent of the variation needs further exploration. Refer to Tables 3-1 to 3-2 in Appendix A for a complete review of the survey findings.

State insurance regulators and QHPs. The responses to these questions exhibit wide variation consistent with the overall pattern. For travel distance, only 17 percent of DOIs indicate that they have such a standard. Most failed to answer the question. Travel time elicited more responses, with a majority (58 percent) indicating that they do not have such a standard. Where travel time standards applied, travel time varied depending on the type of provider, from 20 minutes for a pediatrician in an urban area to 60 minutes for a specialist in both rural and urban areas. The basis for specifying the same travel time to a specialist in both urban and rural areas is unclear. One insurance regulator in a Western state noted in an interview that distance standards, in particular, are less meaningful when they do not take into account terrain such as the need to cross mountains or deal with other geographic barriers to care. He recommended developing alternative requirements in areas where significant geographic barriers exist, such as the availability of alternative modes of transportation on a reliable and fully-transparent basis (e.g., urgent or emergency helicopters).

While 75 percent of QHPs respondents appear to use geo-access standards, the standards vary widely depending on the type of provider and locale of the member. For example, the average travel distance used for an urban member to a PCP, pediatrician, or OB/GYN is 24 miles, while the average travel distance to a specialist for a rural member is 55 miles. Interestingly, there is less variation in travel time (compared to travel distance); the average time for travel for both rural and urban members for most types of providers is 50 minutes.

Accepting New Patients

Federal Medicaid managed care regulations require that states and contracting organizations identify providers that are not accepting new patients.[17] This information is typically made available in the provider directory, which is available in print or on plan websites. Medicaid agencies and state insurance regulators differ in their approaches to this issue. Unlike Medicaid agencies, state insurance agencies generally do not impose a standard for notification regarding access by new patients or open practice requirements, and plans again report creating their own standards.

Medicaid agencies and MCOs. Just 23 percent of responding Medicaid agencies require that the minimum percentage of network PCPs accepting new patients be between 80 percent and 99 percent. Similarly, just 25 percent of Medicaid MCO respondents use minimum thresholds of 80 percent to 99 percent or 60 percent to 89 percent to track the PCPs in the network that are accepting new patients. While this measure is not a common requirement according to survey results, federal Medicaid managed care regulations require that health plans provide information to new enrollees on the

[17] CFR §438.10

network providers who are not accepting new patients, information which is typically made available in the provider directory. This would suggest that MCOs are tracking and can identify which providers (PCPs *and* other provider types) are accepting new patients on an ongoing basis. Tracking acceptance of new patients could alert plans when the primary care network is reaching capacity, requiring corrective action.

State insurance regulators and QHPs. None of the DOI respondents provide standards or monitor the percentage of network providers accepting new patients. Insurance regulators have typically not used such a detailed measure of access. By contrast, two-thirds of responding QHPs report having such a standard for their contracted providers. Of the small number of QHPs (4) who provided specific information on their standards, two reported requiring at least 80 percent of their PCPs to accept new patients, while one plan reported requiring all their PCPs to accept new patients. An interview informant noted that these requirements to accept new patients are more likely to apply to HMOs than PPOs.

Hospital Admitting Privileges

Historically, the Medicare managed care program required that primary care providers (PCP) have admitting privileges in at least one hospital in an MCO network so that the PCP could visit patients during an inpatient stay.[18] This requirement was similarly adopted by Medicaid MCOs and has made it possible for MCO enrollees to receive continuous care and remain in-network when they need inpatient care. Yet, this requirement can raise challenges for some health plans during their recruitment of PCPs. If the health plan is unsuccessful in contracting with the only hospital in town, the majority of PCPs in that region will not have admitting privileges at out-of-town hospitals and thus will be unable to serve as the admitting physician for patients who would need to use another hospital to remain in-network. As a result, most PCPs in this situation will not contract with the health plan, which would limit the plan's primary care network in that geographic region. Moreover, in the last ten to 15 years, the majority of hospitals employ or contract with hospitalists who assume the primary responsibility for providing in-patient care and render hospital privileges by the PCP less important.[19] These trends appear to be reflected in survey responses of Medicaid and state insurance agencies.

Medicaid agencies and MCOs. In keeping with the hospitalist trend, close to three-quarters of responding Medicaid agencies do not require that PCPs have hospital admitting privileges, but three-quarters of the Medicaid MCOs do have that requirement. In a follow-up telephone interview with one northeast urban MCO, we learned that despite the hospitalist trend, this requirement has made sense because their MCO is owned by a hospital system anxious for the business, and as a practical matter, many of their enrollees regard the hospital as their source of health care. This MCO believes the hospital admitting requirement may be a legacy of the past now that "low income people [who relied on hospitals] have more choices." Yet in a telephone interview, another MCO does not require that PCPs have hospital admitting privileges because: a) it is not a state requirement, and b) this could cause self-imposed network gaps since a growing number of PCPs do not affiliate with hospitals. The MCO

[18] CMS.gov, Outreach & Education, Physician Regulatory Issues Team, "Hospital Privileges for Physicians Working with Medicare Managed Care."

[19] Knowledge@Wharton, *Hospitals Hiring Physicians: Why the Trend is on the Rise.* Wharton University of Pennsylvania, February 12, 2014.

representative asserted that hospitalists can manage patient care across many specialties, whereas PCPs do not have acute care training.

State insurance regulators and QHPs. The overwhelming majority of state insurance regulator respondents reported that they have no standards regarding PCP hospital admitting privileges**.** This does not appear to be a change from long-standing practice. The declining number of PCPs with hospital privileges suggests that adoption of such a standard is unlikely.[20] Notwithstanding these trends, 86 percent of responding QHPs require their PCPs to have hospital admitting privileges, again suggesting that competitive pressures play a role in network management in the Marketplaces.

Considerations of Circumstances: Appointment Wait Times, After-Hours Access, Continuity of Care, Unplanned Out-of-Network Coverage

While ratio, geo-access, and similar standards provide objective metrics of network structure, they do not necessarily provide evidence that patients can see the clinicians they need when they need them. Standards directed to appointment wait times, after-hours access, continuity of care, and coverage for facility-based care may provide better windows on the patient experience and serve as markers for network sufficiency.

Appointment Wait Times

Medicaid agencies and MCOs. The true test of provider access occurs when an enrollee calls to schedule an appointment. Eighty-one percent of Medicaid agencies respondents require that Medicaid MCOs ensure their providers adhere to standard wait time limits between scheduling an appointment and being seen by a practitioner. Similarly, 87 percent of Medicaid MCO respondents follow an appointment wait time standard. The reported Medicaid agency and MCO maximum appointment wait time measures varied considerably for certain types of appointments. Well care and routine care appointment wait time standards had the most variation, and initial pre-natal care appointments had significant wait time variation, albeit smaller in range. This variation may be attributed in part to differences in each Medicaid program's definitions of the terms "well care" and "routine" and to provider supply and geography. Appointment wait time measures for urgent and emergency care were more consistent for Medicaid agency and MCO respondents. The basis for variations in appointment wait-times based on the patient's condition is unclear; the variations do not appear to be tied to consensus regarding clinical appropriateness.

State insurance regulators and QHPs. Half of the state insurance regulators report having no standard for appointment wait times. Among those with standards, the wait times varied from 7 to 30 days for well care and routine care to 1 to 2 days for urgent care. By contrast, all of the responding QHPs impose limits on providers regarding the wait times for appointments. Typically, well care appointments waiting periods are limited to 30 days while urgent care wait time is limited to 2 days. No wait times are permitted for emergency care. Interestingly, none of the QHPs appear to have standards for wait-times for the first pre-natal care visit. See Tables 4-1 and 4-2 in Appendix A for details on appointment wait time standards.

[20] Ibid.

After-Hours Access

Notwithstanding the public focus on reducing emergency room utilization, the existence of benchmarks for after-hours access to care at provider offices or clinics remains on the frontier of provider adequacy policies in both Medicaid and the private market. Most of the attention focuses on 24/7 telephone access.

Medicaid agencies and MCOs. The majority of Medicaid agency respondents require that MCO PCPs offer 24/7 telephone access and a 24 hour nurse call line for enrollees. The same held true for Medicaid MCO responses. Still, 35 percent of agency respondents require that PCPs offer appointments after-hours, and 18 percent require that specialists do so. Yet, just one MCO respondent requires PCPs to offer appointments after hours, and no MCOs require that their specialists do so. This uncovers a possible discrepancy between state requirements and health plan practice that deserves further inquiry.

State insurance regulators and QHPs. After-hours access has generally not attracted the attention of insurance regulators. Only 10 percent of respondents have standards that address the availability of after-hours appointments, and only 20 percent require 24/7 telephone access either to a PCP or nurse call line. By contrast, all QHPs report requiring PCPs to have 24/7 telephone access. In addition, all QHPs report maintaining a 24-hour nurse call-in line. However, no QHP reports requiring providers to offer after-hours appointments. One interview informant noted that expanded hours were included in the plan's initiative to substantially expand the development of Patient-Centered Primary Care Medical Homes (PCMH). After-hours access is an element assessed by NCQA for provider practices seeking PCMH certification. As providers increasingly seek PCMH certification, health plan enrollees may experience improved access to after-hours primary care services.[21]

Refer to Chart 1 in Appendix A for a comparative review of after-hours provider access standards by survey group.

Continuity of Care for Enrollees in Transition

With the increasing emphasis on management of chronic disease, attention has focused on the need for continuity of care to complete a course of treatment, facilitate patient self-management, and ensure appropriate transitions to new providers.[22] This attention to chronic disease and population health management has been particularly important in Medicaid, although it is an important factor in the commercial market as well.[23]

Medicaid agencies and MCOs. Over eighty percent of Medicaid agencies require their health plans to cover the services of new enrollees who are in active treatment with an out-of-network provider for a minimum period of time to maintain continuity of care in the enrollee's treatment. Similarly, all of the Medicaid MCO respondents provide continuity-of-care coverage for a minimum period of time. This

[21] NCQA Patient-Centered Medical Home 2011, PCMH 1: Enhance Access and Continuity, Element B.
[22] Ladapo J., Chokshi D. *Continuity of Care for Chronic Conditions: Threats, Opportunities, And Policy*, Health Affairs Blog, November 18, 2014. http://healthaffairs.org/blog/2014/11/18/continuity-of-care-for-chronic-conditions-threats-opportunities-and-policy-3/
[23] Arora, R., Boehm J., Chimento L., Moldawer L., Tsien, C., *Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide*. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. March 2008. http://www.ahrq.gov/sites/default/files/publications/files/medicaidmgmt.pdf

access requirement provides important protections for newly enrolled Medicaid beneficiaries who are mandatorily enrolled with a plan, existing Medicaid enrollees who transition from Medicaid fee-for-service into managed care, and health plan enrollees who transfer from one Medicaid MCO to another.

Medicaid agencies and MCOs report variation in the number of days that enrollees can continue using an out-of-network provider. Medicaid agency and MMCO standard timeframes generally range from 60 to 90 days, although one MMCO provides coverage for up to 120 days. In addition, three Medicaid agencies require that the continuity of care period be customized based on the enrollee's care plan. While just a few Medicaid agencies report that they customize the continuity of care standard to enrollee needs, this approach may become more common in states that implement managed long term services and supports (MLTSS). Individuals receiving MLTSS use services frequently, sometimes daily, and could pose greater risk for physical or mental deterioration or injury if there are disruptions to their care.

In pre-survey discussions with Medicaid MCOs leaders, the researchers learned that MCOs will frequently recruit non-participating providers of new enrollees to preserve the patient-provider relationship, maintain continuity of care, and expand network capacity, especially during times of program growth; yet non-participating providers may not have interest in becoming a provider in that plan's network or in accepting that plan's reimbursement rates.

State insurance regulators and QHPs. Illustrating the pattern of less engagement by state insurance regulators in details of plan operations, only about 27 percent of responding states confirm having a standard for continuity of care. Only one specified the standard (60 days). By contrast, all responding QHPs have a standard for allowing new members in active treatment to continue care with existing providers. For most (67 percent), coverage for out-of-network providers to continue active treatment is permitted for 90 days.

See Table 6 in Appendix A for a complete review of continuity of care standards in Medicaid and Marketplace programs.

Unplanned Out-of-Network Coverage

While federal regulations require Medicaid health plans to cover emergency services provided in out-of-network (OON) settings, other use of OON providers is typically limited to services that have been prior authorized by the health plan, such as when an enrollee needs to see a type of specialist that is not in the plan's network or is not available within a reasonable distance from their home.[24] Yet, enrollees may inadvertently receive services from OON providers under circumstances that are beyond their control. This may happen when the enrollee goes to an in-network inpatient or outpatient facility, and providers in that setting are not in the health plan's network. There are many reasons for this fragmented coverage. Emergency room physicians, anesthesiologists, or radiologists may be employed by independent contractors to the hospital who do not contract with the hospital's payers. This enables those providers to operate out-of-network and engage in balance billing to hospital patients. In other

[24] 42 CFR 438.206(4).

words, the hospitals do not require their provider contractors to contract with hospital payers.[25] Other scenarios occur in private medical practices as well. The provider group may be under contract with the health plan, but a new provider who recently joined the practice is not yet credentialed and recognized by the health plan's claims payment system.[26]

Unplanned OON care raises network access concerns since patients may not have adequate information to choose an in-network provider, or an in-network provider may not be available in the in-network facility as a result of facility contracting strategies.

While a small portion of regulators responding to the survey require unplanned OON coverage, most health plans report providing coverage for services in these instances, exceeding regulatory requirements to ensure that enrollees experience appropriate access to care.

Medicaid agencies and MCOs. More than half of the responding Medicaid agencies do not require MCOs to cover unplanned OON services (53 percent), while 35 percent require that unplanned OON care be covered. By comparison 86 percent of Medicaid MCO respondents report that they cover the services of unplanned OON care. One MCO that does not cover unplanned OON services explained in a telephone interview that, while they do not cover these services in order to control costs, their state has new legislation that will now require this type of coverage, depending on the circumstances. Another MCO explained that all in-network inpatient care must be authorized during the hospital admission, which would limit the times when unplanned OON services would occur.

State insurance regulators and QHPs. Less than a quarter of states have policies that address these issues, although respondents interviewed report that the scope of the problem is increasing. One interview respondent reports that this issue is now being considered by the state legislature and would probably have a regulatory/legislative response. Notwithstanding the increased visibility of network access problems occurring at in-network facilities and news reports regarding high out-of-pocket costs for care at in-network facilities, 83 percent of QHP respondents report providing coverage for such care.[27] One QHP interview respondent reports substantially increased efforts to contract with independent contractor provider groups at hospitals and to flag in the provider directory the OON status of some hospital providers (e.g., radiologists). Fully integrated provider-sponsored plans report that this problem does not arise in their QHPs. As with other elements of network adequacy, the visibility of problems and market perceptions appear to drive network formation strategies among QHPs.

[25] Siegel-Bernard, T. *Out of Network, Not by Choice, and Facing Huge Health Bills*. The New York Times. New York, NY, October 2013. <http://www.nytimes.com/2013/10/19/your-money/out-of-network-not-by-choice-and-facing-huge-health-bills.html

[26] Rosenthal, E. *After Surgery, Surprise $117,000 Medical Bill From Doctor He Didn't Know*. The New York Times. New York, NY September 2014. http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?_r=0

[27] Herman, B. *Billing squeeze: Hospitals in middle as insurers and doctors battle over out-of-network charges.* Modern Healthcare. August 2015. http://www.modernhealthcare.com/article/20150829/MAGAZINE/308299987

Provider Directories

Provider directories have been considered unreliable sources of provider availability, as documented in numerous articles in recent years and by OIG in December 2014.[28] Given the challenges health plans have had in providing up-to-date information about provider availability, this survey asked states about how frequently they require updating both printed and online provider directories. It also asked the health plans to report how frequently they update both printed and online provider directories in practice.

Medicaid Agencies and MCOs

Online provider directories. Twenty-nine percent of Medicaid agencies require MCOs to update online networks monthly, and 18 percent require updates whenever changes occur to the network. These requirements reflect recognition of that fact that consumers should be able to expect that online content is up to date. In keeping with this expectation, 71 percent of MCOs report updating the online provider directory whenever changes occur to the network. In achieving such reported promptness, MCOs exceed state requirements, demonstrating their commitment to providing enrollees with the most current information available.

Forty-one percent of state respondents reported a required frequency of "Other" to the question regarding update frequency, which was a surprising finding, since the survey offered a full range of frequencies (annually, semi-annually, quarterly, monthly, whenever changes occur to the provider network, other). The structure of the survey did not make it possible to determine the experience in the states that responded "Other." During one Medicaid agency telephone interview, the Medicaid Director described provider networks as a "moving target," addressing the challenges for Medicaid MCOs in publishing network directories.

Printed provider directories. Medicaid agencies were more varied in their requirements for updating printed provider directories. The responses were equally distributed across three frequencies: annually, semi-annually, and quarterly. As with online directories, the largest number of state respondents cited "Other" (29 percent) as the frequency required to update printed provider directories. MCO respondents were more consistent, with 37 percent indicating that printed provider directories are updated annually, and another 37 percent indicating "Other" to the question about frequency of updates. A smaller percentage print updated directories quarterly (25 percent). Medicaid MCOs generally provide enrollees with printed copies of provider directories on request since the information becomes out of date so quickly.

State insurance regulators and QHPs. About half of the responding states indicate that they have a standard that specifies how often provider directories must be updated. However, the overwhelming majority failed to report the standard. The most commonly specified standard was monthly. Only a handful of the DOI respondents differentiated between online and print standards, with about half of those requiring monthly updates to the online directory compared to 20 percent for print directories. States generally required less frequent updates for print directories, although 40 percent answered

[28] Daniel R. Levinson, Inspector General. *Access to Care: Provider Availability in Medicaid Managed Care.* Department of Health and Human Services, Office of Inspector General, December 2014.

"Other," making the time frames uncertain. One state reports efforts by the DOI to provide consumers with continuously updated information on all providers in the state and on the plans with which they contract. It partners with the state university to collect provider data and maintain a current database on all providers, which is available on its website. Consumers can use this to cross-check the provider information provided in the plan directory. In addition, the DOI cross-checks this data base with the provider files submitted by plans to validate network adequacy and directory accuracy.

All QHPs report updating their provider directories at standard intervals, although the practices differ for print and online directories. One-third of responding QHPs report that they update online directories on a monthly basis, while two-thirds of respondents do not specify the interval. For print directories, where respondents specify the update intervals, about half report semi-annual updates with others reporting annual and monthly updates.

Coverage of services by providers erroneously listed in the provider directory. Failure to cover services obtained as a result of provider network directory errors can lead to substantial unplanned costs for beneficiaries and difficulties in organizing care.

Medicaid agencies and MCOs. The majority of states do not require that Medicaid MCOs cover eligible services rendered to enrollees who saw out-of-network providers erroneously listed in the latest provider (53 percent). Yet, 75 percent of MCO respondents report that they will cover eligible services in this instance. Medicaid MCOs are exceeding state access requirements and affording protections to enrollees through this practice.

State insurance regulators and QHPs. Of the state insurance regulators who responded to this question, only 30 percent indicated they required coverage of services by providers erroneously listed in the directory, while 83 percent of QHPs report covering eligible services under these circumstances.

Innovations: Inclusion of Essential Community Providers and Alignment of MMCO/QHP Networks

Inclusion of Essential Community Providers (ECP)

Continuity of care is an issue for individuals whose coverage arrangements change frequently and, in particular, for individuals whose incomes fluctuate such that their health care coverage alternates repeatedly between Medicaid and the Marketplace. Otherwise known as "churn," this movement on and off coverage and from health plan to health plan can disrupt provider-patient relationships and lead to poor continuity and potential gaps in care. The survey explored whether Medicaid and Marketplace health plan networks were similarly following the Affordable Care Act (ACA) requirement of Marketplace Qualified Health Plans (QHP) to include 30 percent of ECPs[29] in their networks. Essential Community Providers are defined by CMS as providers that serve predominantly low-income, medically underserved individuals. While this is a requirement of QHPs, it is not an explicit requirement of Medicaid MCOs.

[29] CMS, *Frequently Asked Questions on Essential Community Providers*, May 13, 2013.

Medicaid Agencies and MCOs. The survey found that 69 percent of responding Medicaid agencies encourage their plans to replicate the carrier's QHP ECP network in the Medicaid MCO network when the carrier has a QHP. Twenty-four percent of the Medicaid agency respondents do not know whether they encourage ECP replication, and an additional 18 percent do not encourage this. Yet all MCO respondents adopted the Marketplace ECP network standards. The survey findings confirm that even individuals who decide to change from one carrier to another will experience some network overlap and continuity of care if they rely on ECPs. One Medicaid agency reported that an analytics team is looking into how to project and track the movement of Medicaid enrollees into the Marketplace and back to Medicaid.

State insurance regulators and QHPs. One-third of state respondents report that they have adopted a standard for inclusion of ECPs in provider networks that mirrors the Federal standard for QHPs. This is particularly significant for individual and small-group markets in general since 70 percent of surveyed states report that they apply the same network adequacy standards for all plans in the individual and small-group markets, regardless of their status as QHPs in the Marketplace.30 This alignment should operate to improve overall access to ECPs. As discussed above, QHPs are required to conform to the federal standard for ECP inclusion in order to received QHP certification to operate in the Marketplaces. Fully integrated plans report difficulty in meeting the alternative ECP standard that applies to them, particularly in rural areas.

Alignment of MCO/QHP Networks

The rise of the Marketplaces and the subsidized coverage they provide enable lower-income people to sustain coverage as they churn between Medicaid and the individual market. In response to the ability of lower-income people to obtain coverage when they leave Medicaid, many MCOs offer QHPs in the Marketplaces to capture the churn population and ensure their continued enrollment when and if they return to Medicaid.[31] As a result, substantial market incentives exist for MCOs offering QHPs to align the networks of the plans to provide continuity of care for the population that moves between Medicaid and the Marketplace and entice members to remain enrolled with the same parent organization. On the other hand, having the same network in both markets may stress overall provider capacity as discussed above. Most Medicaid and state insurance regulators have not encouraged or set policy for Medicaid MCO/QHP network alignment.

Medicaid and MCOs. Just 17 percent of Medicaid agencies responded that they have encouraged Medicaid MCO and QHP network replication, and they report significant overlap in the contracted Medicaid MCO and QHP provider networks. In contrast, 86 percent of Medicaid MCOs have taken steps to align their complete provider network with that of the QHP. The findings are reassuring and indicate that most enrollees will experience continuity of care when they change health care coverage sources, provided they transfer to a health plan operated by the same carrier. A few Medicaid MCOs and Medicaid agencies explained in telephone interviews their reasons for aligning their Medicaid MCO

[30] Farris, M., McCarty S., *ACA Implications for State Network Adequacy Standards*. Robert Wood Johnson Foundation. August 2013. <http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486

[31] "Overlap Between Medicaid Health Plan and QHPs in the Marketplaces: An Examination", ACAP, December 13, 2013; Medicaid MCO telephone interviews.

networks with their QHP networks. Medicaid agencies assumed Medicaid MCOs would leverage the contractual relationships with providers in pre-existing networks to form a QHP network. Medicaid MCOs pursued alignment: 1) to provide seamless health care to families as their circumstances change so they can stay with one carrier through all stages of life; and 2) because network alignment offered administrative convenience and sustained enrollment to the plans**.**

State insurance regulators and QHPs. Two-thirds of the QHP respondents report that they also operate MCOs. State insurance agencies universally do not require network alignment between MCOs and QHPs and believe that the market incentives are sufficient to sustain alignment. Because the QHPs in this case have the same parent organization as the MCOs, their responses align with the MCO practices on this issue. Accordingly, QHPs universally align plan networks between Medicaid and Marketplace plans.

Monitoring Practices: Data Sources, Common Monitoring Challenges, Enforcement

Because of the contractual nature of the relationship between the Medicaid agency and the MCO, the monitoring of MCO network adequacy universally resides with the Medicaid agency. In the regulatory context of the private market, 63 percent of respondent state insurance regulators monitor network adequacy, while a third report that monitoring functions reside in the Marketplace operating in their states. The remaining respondents report that partner agencies monitor QHP provider networks, most often Departments of Health. None delegates responsibility for monitoring network adequacy to third parties such as accreditation organizations.

Network Adequacy Data Sources

Medicaid agencies and MCOs. All Medicaid agency respondents rely on the CAHPS surveys and on enrollee complaints and grievances to identify potential network deficiencies. Eighty-one percent track the total number of complaints about network access received by the state's call center, and 94 percent review MCO reports on the number of enrollee complaints about network access. Other common data sources and metrics include the use of call center reports (76 percent) and emergency room utilization rates (71 percent). Less than half of the Medicaid agencies track encounters by category of service to assess underutilization, a metric that might indicate that enrollees are experiencing barriers or delays in scheduling appointments. Just 18 percent of Medicaid agencies track the proportion of out-of-network encounters to total encounters as a network deficiency metric. When out-of-network activity is higher in one MCO than other MCOs in the program, or than previous experience, it may serve as an indicator of a network deficiency.

As with the Medicaid agencies, contracting MCOs rely on several sources of information to monitor the adequacy of their provider networks. The most widely used data source comes from enrollees through CAHPS surveys and from enrollee complaints and grievances. All Medicaid MCO respondents report using these resources to identify network problems and also rely on complaints received by both the MCO and state agency. Other reported popular sources of information include tracking emergency room utilization rates (86 percent), call center reports (67 percent), tracking the proportion of out-of-network encounters to total encounters (67 percent) and tracking encounters by category of service to assess

underutilization (57 percent). The survey responses suggest that Medicaid MCOs may rely on a larger set of metrics to monitor their networks than Medicaid agencies do.

In addition to these data sources and metrics, the Medicaid agency respondents offered other sources of information for monitoring network access:

- provider complaints
- changes in enrollee "Level of Care"
- inpatient admission and readmission rates
- prior authorization rates
- provider suspensions and terminations
- review of monthly provider file
- monthly geo-access analysis
- secret shopping
- annual network analysis by the contracted external quality review organization

None of the MCO respondents offered additional metrics for identifying potential network deficiencies.

State insurance regulators and QHPs. The overwhelming majority of responding states (89 percent) report reviewing a QHPs entire network file submission against agency standards. While none of the respondents actually delegates responsibility to accrediting organizations, over half (56 percent) use accreditation by independent organizations in accessing ongoing compliance. By far, member complaints and grievance reports constitute the major data sources for network monitoring; 90 percent of state respondents report tracking this information. Call center reports and CAHPS surveys are relied on to a much lesser extent (22 percent). State insurance regulators rarely or never use encounter or utilization data as a marker for access problems. However, as discussed previously in the section on provider directories, one state has developed its own database of providers and uses it to cross-check the network composition of QHPs.

While QHPs report using claims and utilization data to a much greater extent (60 percent) than DOIs, QHPs also rely heavily on consumer-initiated activity—e.g., complaints/grievances, call center reports, and CAHPS surveys—to flag network adequacy problems. All QHPs report using consumer-initiated metrics to identify network deficiencies. The importance of the CAHPS surveys in QHP quality rankings may also contribute to plan reliance on this data.

Common Challenges in Network Monitoring

Provider networks are challenging to monitor because of the volume of information that must be continuously gathered, documented, maintained and analyzed. State insurance regulators report more major and moderate challenges than Medicaid agencies. Participants in follow-up interviews report that provider networks are "moving targets" whose composition changes on an ongoing basis, further complicating oversight. One state insurance regulator interview informant reports network composition changes, including information about provider location and hours, of 8 percent monthly. They also note that standards by their nature are broad and may not reflect the "nitty gritty" of the challenges faced in ensuring access.

The survey sought to identify the top network monitoring challenges for Medicaid agencies and contracting MCOs. Respondents ranked a list of challenges by level of difficulty. Complete State agency and health plan challenges in network monitoring by order of magnitude are illustrated in Charts 2-1 and 2-2 in Appendix A.

Medicaid agencies and MCOs. Medicaid agencies most commonly considered network monitoring a moderate or minor challenge, with a smaller portion of respondents reporting major challenges. Monitoring and identifying network adequacy problems on an ongoing basis was ranked as a moderate challenge by 41 percent of Medicaid agency respondents, while having an adequate number of qualified staff and good IT infrastructure was a moderate challenge for 35 percent of respondents. Twenty-four percent of Medicaid agency respondents reported that obtaining complete, accurate and timely information on network participation from MCOs was a major challenge. A smaller percentage of states reported a lack of IT infrastructure and inadequate staffing and as a major challenge (18 percent and 6 percent, respectively).

The greatest network monitoring challenge for MCOs is obtaining complete, accurate, and timely information from providers (85 percent). Educating consumers about the use of in-network providers is a major challenge for 33 percent of MCOs. During an interview, one Medicaid agency representative reported that many enrollees do not read the information MCOs distribute to them about provider networks because they believe "I have Medicaid – I can go anywhere." Other major/moderate challenges for MCOs in monitoring their networks are lack of IT infrastructure to automate or facilitate monitoring and reconciling updates to credentialing records, provider directories, and contracts (71 percent).

One Medicaid MCO interviewee explained that IT support is evolving. He said they need to rely on "superb customization to make up for the lack of administrative dollars." This MCO reprocesses a lot of provider network data because the information is received in many ways from providers.

State insurance regulators and QHPs. The most significant challenges for state insurance regulators are monitoring network adequacy on an ongoing basis (56 percent), lacking adequate IT infrastructure to automate monitoring processes (44 percent), and having adequate staffing levels (33 percent). One state reported being in the process of updating its IT capabilities. Somewhat surprisingly, difficulty obtaining network files from QHPs or educating consumers regarding the use of in-network providers did not emerge as significant challenges for most state insurance regulator respondents.

QHPs, on the other hand, tend to cite obtaining accurate information from providers as a major challenge (50 percent). One interview participant reports great difficulty keeping data current. For example, in a spot check conducted by the plan of information on 20 providers, none of the location information for any of the providers was correct. She further noted recent changes in QHP strategies to monitor networks. Pressure from regulators, legislators, and members has spawned much more proactive oversight by plans to ensure data accuracy as opposed to previously passive engagement, waiting for notifications from providers. However, the responding QHPs do not generally engage in direct monitoring activities. For example, one-third make scheduled office visits, and none conducts secret shopper calls.

Reconciling updates to credentialing records, provider directories, and provider contracts represents a moderate challenge for 50 percent of plans, as does having adequate IT infrastructure. Interestingly, consistent with state insurance regulator responses, educating consumers on in-network use is not regarded as a significant challenge by most plans.

Enforcement

Having standards is an essential ingredient in bringing life to general requirements to ensure that networks are sufficient to meet the needs of the enrolled population. However, whether standards are enforced and how deficiencies are addressed may ultimately affect the level of effort by plans in ensuring access to care. Again, the contractual versus regulatory relationship of the state agency and the plan appears to result in relatively more enforcement activity by Medicaid agencies. However, as described below, this activity is not robust in either sector. Both Medicaid agencies and state insurance regulators express a preference for "working with" plans to resolve difficulties. Plans demonstrate a reluctance to be proactive in discerning network performance issues by their providers.

Medicaid and MCOs. Medicaid agency survey respondents use requests for corrective action (59 percent) to enforce provider network regulatory requirements. Less than half of Medicaid agencies reduce the number of new-enrollee auto-assignments to non-complying MCOs; one Medicaid agency reports that it closes enrollment completely to MCOs that are out of compliance with provider network standards. Other enforcement actions are rarely or never used. More than 82 percent of Medicaid agencies rarely or never assess liquidated damages or withhold a portion of the capitation payment from the MCO, although one Medicaid agency reports that it assesses fines, another type of financial penalty. A complete analysis of survey findings on enforcement are in Table 5 in Appendix A. One Medicaid MCO interviewee took a proactive approach with its network and recently introduced value-based provider reimbursements to incentivize providers to improve the accuracy of network information.

State insurance regulators and QHPs. Most state insurance regulators failed to respond to the question on enforcement activities. Of those that provided information, most rarely apply sanctions to non-compliant plans. Only 25 percent of respondents use corrective action plans. Restricting enrollment or imposing financial penalties does not occur. In interviews, respondents indicated that they prefer to work with the plan to resolve difficulties, an approach that they report to be effective.

Similar to state insurance regulator approaches, all QHPs rely on engagement with providers to meet network performance standards, primarily using training and education. They also report employing outreach in those cases where problems with specific providers have been identified. Some plans (40 percent) report offering incentives to providers to meet network performance standards.

V. Discussion

The findings suggest a fundamentally different relationship between Medicaid agencies and MCOs on the one hand and insurance regulators and QHPs on the other. While the structure of the differences (vendor vs. licensed carrier) would seem obvious, it appears to have resulted in very different practices in the Medicaid and Marketplace sectors. Medicaid MCO contracts tend to be much more prescriptive and employ standards across almost all domains of inquiry. As a result, while MCOs report exceeding state standards, the "daylight" between MCO performance and Medicaid agency requirements is less significant than the discrepancy between DOI standards and QHP practices. In addition to the vendor relationship, this level of oversight may also reflect the fact that the Medicaid program serves highly vulnerable populations enrolled in closed network plans who typically have fewer health care choices than individuals enrolled in the commercial market.

By contrast, insurance departments and Marketplaces are providing floors that determine who can participate in the market. Their role is more limited to making sure the market is doing what it is supposed to do. Therefore, network adequacy issues tend to emerge as consumer protection issues around product integrity, premium value, and market disruption. The equation between health insurance and access to care is an emerging phenomenon with which state insurance regulators are starting to grapple. The value of insurance in an environment where having it is mandatory adds another imperative to that equation.

Issues around how to define meaningful access to care still lack consensus, particularly around ratios, geo-access, and provider availability. There do not appear to be fully substantiated bases for the variation. While local conditions appear to dictate some of the variation, algorithms or other approaches that could take local variables into account to achieve more standardized strategies do not appear to be under consideration. This is particularly apparent in the failure to develop standards for total provider capacity or plan overlap among providers. While plan-specific ratios may seem appropriate, the nearly-universal failure to measure and include plan overlap (and determine how much total provider capacity is optimal) in the calculation of ratios may account for long wait-times for appointments, out-of-network utilization, emergency room utilization, closed practices, and other challenges that directly affect the patient experience.

Also apparent is the effect of the Marketplaces and the regulated competitive environment in which QHPs operate. The requirements for quality certification that includes network adequacy standards from entities like the National Committee on Quality Assurance and URAQ impose a level of regulation that operates between state insurance regulators and QHPs. The quality rankings that include consumer satisfaction will begin in 2016 and guide consumer selection of plans, adding another factor to the competition for market share among QHPs in the Marketplaces. Similarly, in the updated Medicaid managed care regulations published in the Federal Register for public comment on June 1, 2015, CMS has proposed to begin using a star rating system to rank Medicaid MCOs. These regulatory incentives combined with the somewhat greater ability of QHP consumers to exercise choice and benefit from the long-standing power of the employer market as the basis for network composition in the individual commercial market also may drive the disparity between state standards and reported performance. The role of these factors merits further exploration.

VI. Key Recommendations

While the variety of practices and perceptions suggests there are many avenues to achieving more consistency in network standards and ensuring better access to care, the recommendations set forth below reflect the synthesis of experiences that provide evidence for approaches that are both useful and feasible.

1. **Monitor program-wide provider capacity.** Monitoring of provider total patient capacity and plan overlap should be implemented as a way to assess actual provider availability. If the monitoring process is to be effective, provider-to-enrollee ratios must be based on program-wide standards (e.g., Medicaid managed care in one state) and cross-market standards (e.g., Medicaid managed care, the Marketplace, and other insurance programs in one state). This will entail a re-examination of the basis for determining provider-to-enrollee standards. On the other hand, this standard also must account for the continuity-of-care benefits of having providers in multiple networks so that consumers can move between plans while maintaining relationships with the same providers.
2. **Invest in network standards.** More investment is needed to develop network standards based on data to ensure that application of the standards will result in care being available when it is needed. This requires consensus on how to develop the data and build algorithms. More forums for collaboration among states and across coverage programs should be convened. This effort will provide useful information to state agencies that are struggling to develop appropriate metrics. It will also promote standardization of measures and practice, which will be useful to plans operating in multiple markets.
3. **Increase after-hours access.** Standards for after-hour appointments in primary care settings need to move from the sidelines to the mainstream. This will require close collaboration with providers to develop the infrastructure and staffing organization to make complying with such standards feasible. Approaches used to establish Patient-Centered Medical Homes (PCMH) and access to telemedicine and urgent care centers could be used as models.
4. **Deploy data analytics.**
    a. More data analytics need to be employed to create "early-warning" flags for network availability problems, particularly the analysis of claims data to signal whether enrollees are resorting to emergency room and OON care to deal with network access problems and to determine if specialty care is occurring in appropriate ratios to overall utilization.
    b. Enhanced data analytics need to be employed to determine the accuracy of provider network information and enable mapping of providers to evaluate access. This may entail developing more centralized databases on providers across a state.
5. **Increase the state insurance regulator's role in network oversight.** Given the large number of newly insured people and the importance of ensuring the integrity of insurance products when people are mandated to purchase insurance, state insurance regulators may need to reevaluate their role to encompass more oversight of ongoing performance by plans.

Appendix A. Summary tables and charts

Table 1-1. Scope of Primary Care Provider definition -- provider types recognized as PCPs by survey respondents

	RESPONSE GROUP			
Common Primary Care Provider Types[32]	**Medicaid Agency**	**Department of Insurance**	**Medicaid MCO**	**Qualified Health Plan**
General Practitioners	x	x	x	x
Family Practitioners	x	x	x	x
Internists	x	x	x	x
Pediatricians	x	x	x	x
Nurse Practitioners	x	x	x	x
Physicians Assistants	x	x	-	x
OB/GYNs	x	x	x	x
Less Common Primary Care Provider Types				
Specialty providers	x	-	x	-
Gerontologists	x	-	-	x
Certified nurse midwives	x	-	-	-
Family medicine with OB		-	-	x
Primary care teams with residents and supervising faculty physician	x	-	-	-

Table 2-1. Provider-to-enrollee ratio usage

Percentage of State and Plan Respondents that use Enrollee To Provider Ratios				
	State Agencies		Health Plans	
	Medicaid Agency	**State Insurance Department**	**Medicaid MCO**	**Qualified Health Plan**
Yes	65%	33%	50%	88%
No	30%	58%	50%	0%
Don't Know	5%	8%	0%	13%

[32] Common primary care provider types are those provider types for which the majority of respondents reported as recognized to serve enrollees as primary care providers. Less common primary care provider types are those recognized to serve as a primary care provider in fifty percent or fewer respondents.

Table 2-2. Median provider-to-enrollee ratio benchmarks

Provider/ Region		Median Member to Provider Ratio Benchmark			
		Medicaid		Marketplace	
		State Medicaid Managed Care Program*	Medicaid Managed Care Organizations	State Insurance Regulators**	Qualified Health Plans
PCP	Urban	1,500	2000	2000	600
	Rural	1,500	2000	2000	600
	Frontier	2,000	2000	None Provided	None
Pediatrician	Urban	1,500	2,000	None Provided	600
	Rural	1,500	2,000	None Provided	600
	Frontier	1,750	2,000	None Provided	None
OB/GYN	Urban	1,500	2,000	None Provided	525
	Rural	1,500	2,000	None Provided	525
	Frontier	1,750	2,000	None Provided	None Provided
Dentist	Urban	1,750	2,000	None Provided	None Provided
	Rural	2,000	2,000	None Provided	None Provided
	Frontier	1,500	None Provided	None Provided	None Provided
Other Provider Types					
Orthopedics	Urban	None Provided	None Provided	None Provided	3,000
	Rural	None Provided	None Provided	None Provided	3,000
	Frontier	None Provided	None Provided	None Provided	None Provided
General Surgery	Urban	None Provided	None Provided	None Provided	3,000
	Rural	None Provided	None Provided	None Provided	3,000
	Frontier	None Provided	None Provided	None Provided	None Provided
Ears, Nose, and Throat specialist	Urban	None Provided	None Provided	None Provided	3,000
	Rural	None Provided	None Provided	None Provided	3,000
	Frontier	None Provided	None Provided	None Provided	None Provided
Cardiology	Urban	None Provided	None Provided	None Provided	5,000
	Rural	None Provided	None Provided	None Provided	5,000
	Frontier	None Provided	None Provided	None Provided	None Provided
Dermatology	Urban	None Provided	None Provided	None Provided	5,000
	Rural	None Provided	None Provided	None Provided	5,000
	Frontier	None Provided	None Provided	None Provided	None Provided
Gastroenterology	Urban	None Provided	None Provided	None Provided	5,000
	Rural	None Provided	None Provided	None Provided	5,000
	Frontier	None Provided	None Provided	None Provided	None Provided

Provider/ Region		Median Member to Provider Ratio Benchmark			
		Medicaid		Marketplace	
		State Medicaid Managed Care Program*	Medicaid Managed Care Organizations	State Insurance Regulators**	Qualified Health Plans
Ophthalmology	Urban	None Provided	None Provided	None Provided	5,000
	Rural	None Provided	None Provided	None Provided	5,000
	Frontier	None Provided	None Provided	None Provided	None Provided
Psychiatrist	Urban	None Provided	None Provided	None Provided	5,000
	Rural	None Provided	None Provided	None Provided	5,000
	Frontier	None Provided	None Provided	None Provided	None Provided
Behavioral Health provider	Urban	None Provided	None Provided	None Provided	3,000
	Rural	None Provided	None Provided	None Provided	3,000
	Frontier	None Provided	None Provided	None Provided	None Provided
High volume specialists	None specified	None Provided	None Provided	None Provided	10,000

Table notes:

1. *Qualified Health Plans do not distinguish between urban and rural settings as evidenced by the same enrollee to provider ratios for both types of geographic areas.*
2. *The Medicaid Managed Care Organization responses were skewed downward by lower than expected provider-to-enrollee ratios of one state in New England.*
3. *The differences in ratios offered in responses were negligible across the four survey groups.*
4. *As evidenced by the table, differences in Medicaid agency responses for ratios between urban and rural areas are relatively small. The maximum urban/rural difference was 500 enrollees per provider.*
5. *For state insurance regulators, at least one respondent noted that the enrollee to provider ratio for all physician types was "at least 1 per 1,200 enrollees"*
6. ** State Medicaid Managed Care program respondents reported that ratios for specialties vary by type of specialty. Advanced practice specialty nursing ratios similarly vary and at least one respondent provided a ratio of 1 to 100.*
7. *** State insurance regulator responses noted that one New England state differs from the provided figures in that it employs Medicare Advantage Network Calculations for its provider networks.*

Table 3-1. Maximum distance benchmark ranges and most frequently used benchmarks by provider type and region

Provider/Region		Maximum Distance Benchmark Range and Most Frequently Used			
		Medicaid		Marketplace	
		Range	Most Frequent	Range	Most Frequent
PCP	Urban	5 – 30	30	5 – 60	5, 15, 20*
	Rural	10 – 120	30	15 – 60	60
	Frontier	10 – 120	10, 30*	None	None
Pediatrician	Urban	5 – 35	30	5 – 60	5
	Rural	10 – 120	30	15 – 75	60
	Frontier	10 – 120	30	None	None
OB/GYN	Urban	5 – 30	30	5 – 60	5
	Rural	15 – 75	30	25 – 75	60
	Frontier	10 – 75	30	None	None
Dentist	Urban	5 – 90	30	10 – 90	None
	Rural	10 – 90	60	35 – 90	None
	Frontier	10 – 90	None	None	None
Specialist	Urban	5 – 75	30	10 – 90	10
	Rural	15 – 75	60	30 – 90	30
	Frontier	60 – 90	60	None	None
Acute care hospital	Urban	10 – 60	30	10 – 60	30
	Rural	15 – 60	30	15 – 60	60
	Frontier	90	None	None	None
Pharmacy	Urban	2 – 60	2	2	None
	Rural	5 – 60	30, 60*	15	None
	Frontier	60 – 75	60	None	None

** Provider and region types with more than one mileage distance benchmark had benchmark distances that were reported with equal frequency.*

Table 3-2. Maximum time benchmark ranges, and most frequently used benchmarks by provider type and region

Maximum Time Benchmark Range and Most Frequently Used Ranges					
Provider/Region		Medicaid		Marketplace	
		Range	Most Frequent	Range	Most Frequent
PCP	Urban	8 – 30	30	20 – 30	20
	Rural	15 – 60	30	30 – 60	None
	Frontier	30	30	None	None
Pediatrician	Urban	8 – 50	30	20 – 50	None
	Rural	15 – 75	30	50 – 60	None
	Frontier	30	30	None	None
OB/GYN	Urban	8 – 50	30	20 – 50	None
	Rural	15 – 75	30	50 – 60	None
	Frontier	30	30	None	None
Dentist	Urban	30 – 60	30	50	None
	Rural	30 – 75	60	None	None
	Frontier	None	None	None	None
Specialist	Urban	30 – 60	30	50 – 60	None
	Rural	30 – 60	60	50 – 60	None
	Frontier	30 – 60	None *	None	None
Acute care hospital	Urban	30 – 60	30	20 – 30	30
	Rural	30 – 60	30	30 – 60	None
	Frontier	30	None*	None	None
Pharmacy	Urban	15 – 60	30	None	None
	Rural	30 – 60	30	None	None
	Frontier	None	None	None	None

**There were too few responses to establish a "Most Frequent" time benchmark.*

Table 4-1. Appointment wait time standard usage

Percentage of State and Plan Respondents that use Appointment Wait Time Standards				
	State Agencies		Health Plans	
	Medicaid Agency	State Insurance Department	Medicaid MCO	Qualified Health Plan
Yes	81%	40%	88%	100%
No	19%	50%	13%	0%
Don't Know	0%	10%	0%	0%

Table 4-2. Appointment wait time standards in minutes by survey group

Appointment Type	Appointment Wait Time Standards in Days by Survey Group							
	Medicaid Agency		Medicaid MCO		State Insurance Department		Qualified Health Plan	
	Range	Most Frequent	Range	Most Frequent	Range	Most Frequent	Range	Most Frequent
Well care	10 – 84	30	10 – 90	10	15	None[33]	7 – 30	30
Routine care	7 – 84	30	10 – 90	10, 14[34]	10 – 120[35]	None	7 – 30	14
Urgent care	0 – 2	2	1 – 2	1	2	2	1 – 2	1
Emergency care	0 – 2	0	0 – 1	0	0	None	0 – 1	0
Initial pre-natal care	10 – 30	10, 14	10 – 42	14	None[36]	None	None	None

[33] None indicates that there were too few responses to establish a "Most Frequent" appointment wait time standard.
[34] Frequencies that include two data points occurred with equal frequency in survey responses.
[35] 120 represents an outlier among responses which otherwise ranged between 10 – 15 days.
[36] None indicates that there were too few responses to establish an appointment wait time standard "Range".

Table 5. Enforcement actions by Medicaid agencies and state insurance regulators

Enforcement Actions	Enforcement Actions by State Regulators							
	Medicaid Agency				State Insurance Department			
	Often	Sometimes	Rarely	Never	Often	Sometimes	Rarely	Never
State agency requests Corrective Action Plan of the MCO or QHP	24%	35%	18%	24%	25%	13%	50%	13%
State agency reduces the number of new enrollees auto-assigned to the MCO or restricts enrollment to the QHP	6%	41%	18%	35%	0%	13%	25%	63%
State agency assesses liquidated damages from the MCO or QHP	12%	6%	41%	41%	0%	0%	13%	88%
State agency withholds a portion of the capitation payment from the MCO*	6%	12%	18%	65%	–	–	–	–
States agency uses other penalties	0%	12%	24%	65%	0%	17%	17%	67%

** This question was only posed to state Medicaid agencies, which contract with MCOs. State insurance regulators do not contract with Marketplace carriers.*

Table 6: Use of continuity of care time standards in Medicaid managed care and Marketplace programs

Continuity of Care Time Standards	Medicaid	Marketplace
60 days	25%	13%
90 days	35%	50%
120 days	5%	13%
Customized to care plan	20%	0%
Other	15%	25%

Chart 1. After-Hours provider access standards

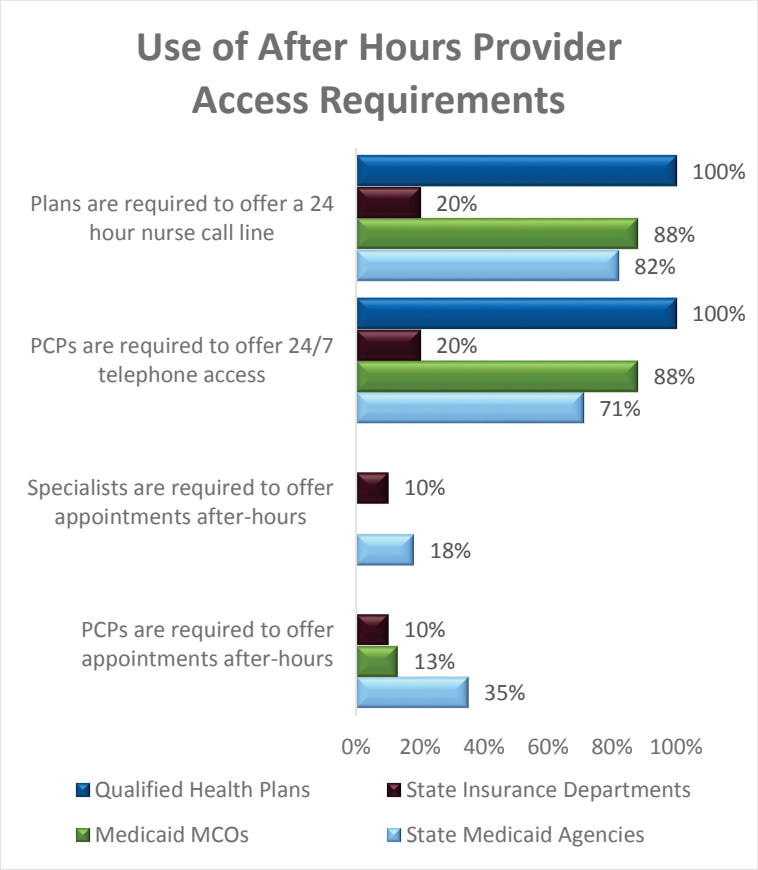


Chart 2-1. Common challenges in network monitoring for Medicaid and Insurance Regulator respondents

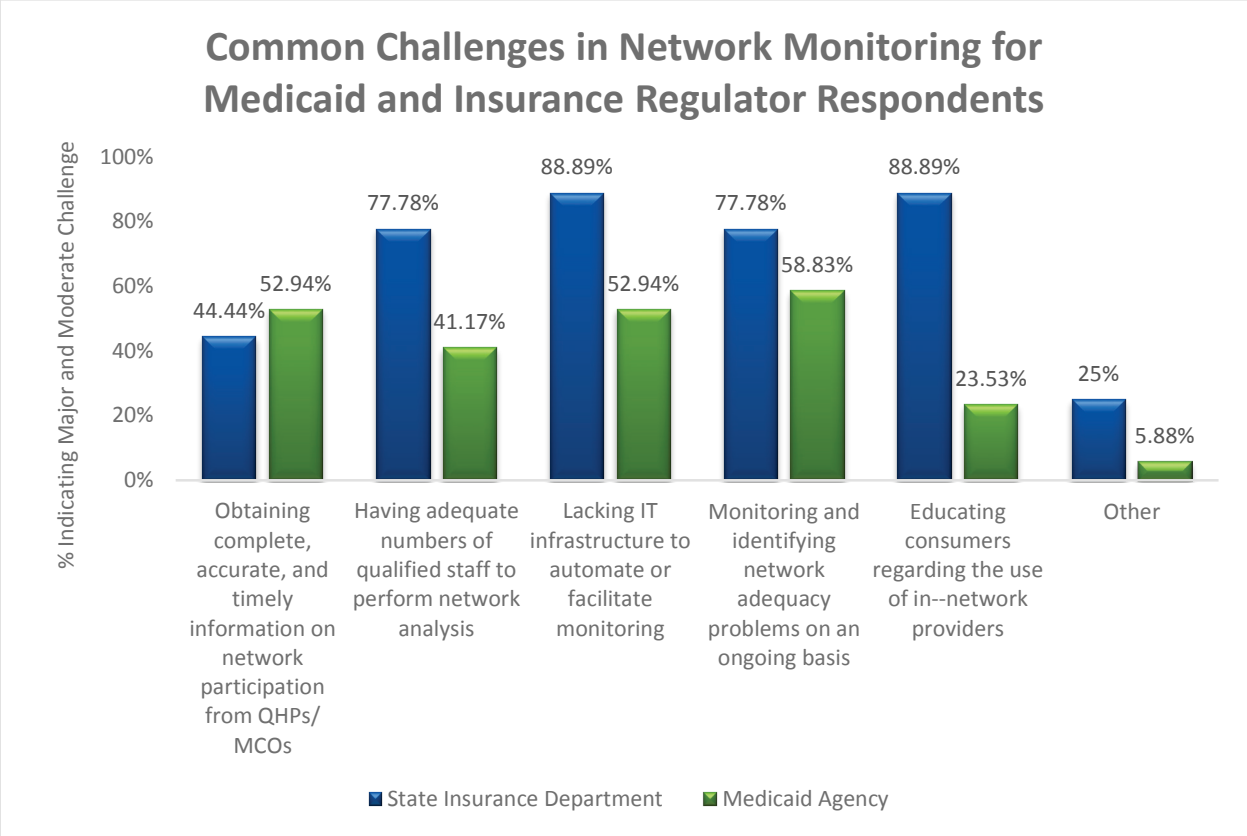
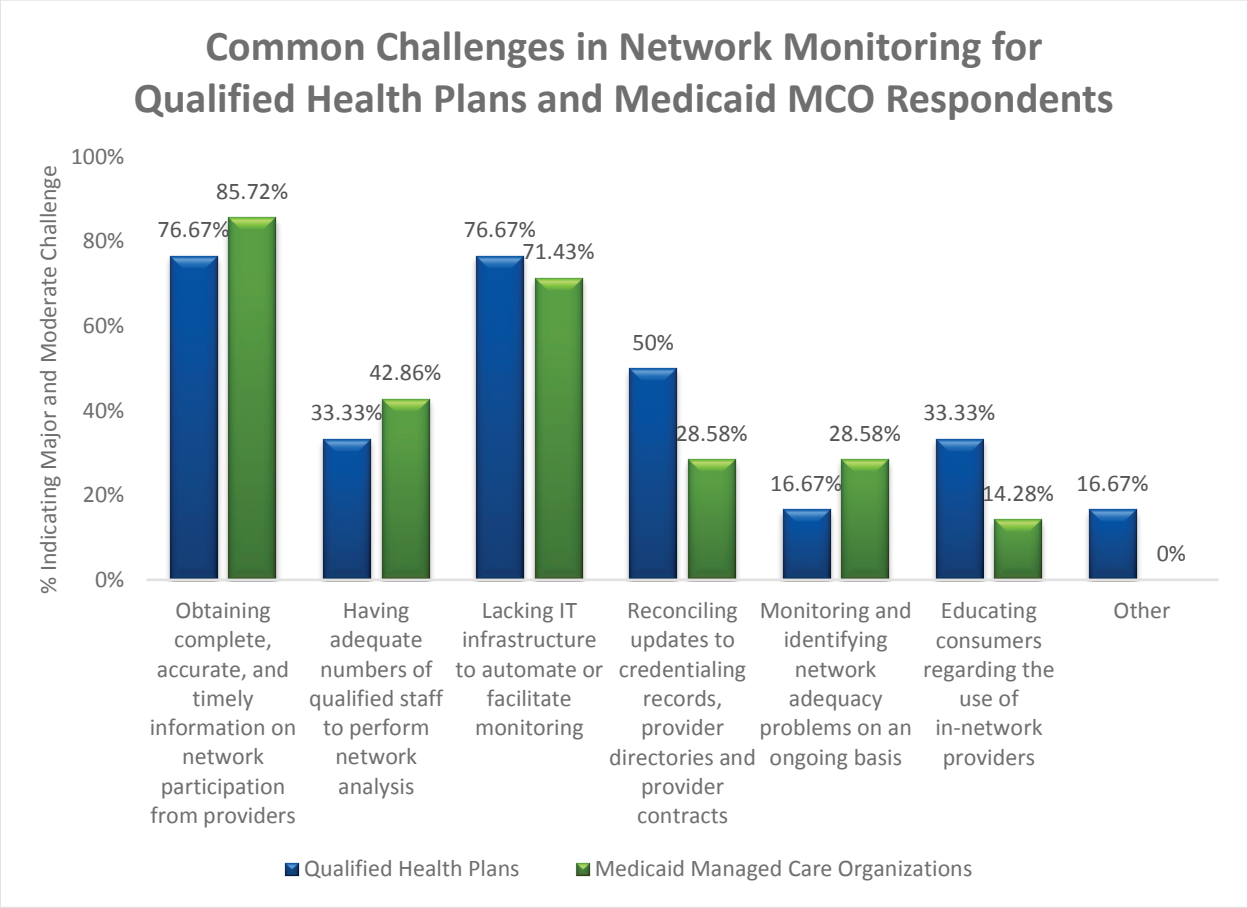


Chart 2-2. Common challenges in network monitoring for Qualified Health Plan and Medicaid Managed Care Organization Respondents



Appendix B. Survey Tools

A National Examination of Provider Network Monitoring Practices

A Robert Wood Johnson Foundation Grant to Health Management Associates

STATE MEDICAID MANAGED CARE PROGRAM SURVEY

This survey is being conducted by Health Management Associates (HMA) under a grant from the Robert Wood Johnson Foundation. This research is being conducted with interest from the Association of Community Affiliated Health Plans (ACAP), Medicaid Health Plans of America (MHPA) and the National Association of Insurance Commissioners (NAIC). The goal of the project is to identify best practices and provide a thorough understanding of the challenges entailed in determining network adequacy.

You are being asked to supply information about your agency's provider network standards and practices for monitoring of Medicaid managed care organizations (MCOs). A related survey will be conducted with a nationwide sample of Medicaid MCOs. In addition, surveys will be conducted with a nationwide sample of qualified health plans and the state departments of insurance that monitor the Marketplace.

This survey will take 30-45 minutes to complete. When you have completed all of the questions, scan and email a copy of the survey to kbrodsky@healthmanagement.com or fax to (646) 861-2746. If you have any questions at any time, please call Karen Brodsky at (646) 584-5827 or contact her by email: kbrodsky@healthmanagement.com. Secondary contact is Barbara Smith at (202) 601-7744 or contact her by email: bsmith@healthmanagement.com.

Please submit the survey by May 1, 2015. *Survey responses will be reported in the aggregate or de-identified and will not be attributed to any individual, state or MCO without express permission.*

Section 1. Thresholds for Access Standards

1. Please indicate whether the following types of providers are considered Primary Care Providers (PCPs). *SKIP #2 IF RESPONSE TO "OTHER" IS NO OR DON'T KNOW.*

Primary Care Provider Type	YES	NO	DON'T KNOW
General practitioners			
Family practitioners			
Internists			
Pediatricians			
Nurse practitioners			
Physician assistants			
OB/GYNs			
Other			

2. If you answered Other to the previous question, please describe:

   _____

3. Does your state agency have provider-to-enrollee ratio requirements? *SKIP #4 IF "NO" OR "DON'T KNOW" IS SELECTED.*
   ___ YES ___ NO ___ DON'T KNOW

4. What is the maximum number of enrollees allowed per provider per contracting MCO for the following provider types in each geographic area?

Provider Type	Urban	Rural	Frontier	Not Applicable
PCP				
Pediatrician				
OB/GYN				
Dentist				

5. If there are other types of providers for which you employ enrollee to provider ratios, please list the type of provider and the ratios applied below.

Provider Type	Urban	Frontier	Rural

6. Given that many providers in a service area participate in more than one Medicaid MCO network, it is possible that the total number of enrollees attributed to a provider across all of the MCOs with which the provider contracts could be more enrollees than the maximum number allowed under the Medicaid managed care contract.

   Does your state agency monitor the total number of enrollees attributed to a provider across all contracting MCOs in a service area to determine compliance with provider-to-enrollee ratios?
   ___ YES ___ NO ___ DON'T KNOW

7. Does your state agency require that contracting PCPs have hospital admitting privileges at network hospitals?
   ___ YES ___ NO ___ DON'T KNOW

The next two questions refer to Geo-access requirements in Medicaid managed care contracts. For each type of provider, please indicate the standard your state agency applies for Urban, Rural, and/or Frontier regions, as applicable.

8. What is the travel distance standard in miles from an MCO enrollee's residence to a:
   You may skip over the provider types for which a distance standard does not exist.

Provider Type	Urban	Rural	Frontier
PCP			
Pediatrician			
OB/GYN			
Dentist			
Specialist			
Acute Care Hospital			
Pharmacy			

9. What is the travel time standard in minutes from an MCO enrollee's residence to a:
   You may skip the provider types for which a time standard does not exist.

Provider Type	Urban	Rural	Frontier
PCP			
Pediatrician			
OB/GYN			
Dentist			
Specialist			
Acute Care Hospital			
Pharmacy			

10. Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers.

    Does your state agency use different provider access thresholds in Health Professional Shortage Areas?
    ___ YES ___ NO ___ DON'T KNOW

11. Does your state agency require MCOs to cover care provided by non-network providers when that care is provided at an in-network facility?
    ___ YES ___ NO ___ DON'T KNOW

12. Does your state agency require MCOs to cover the services of new members in active treatment with an out-of-network provider for a minimum period of time in order to maintain continuity of care in the member's treatment? *SKIP #13 IF "NO" OR "DON'T KNOW" IS SELECTED*.
    ___ YES ___ NO ___ DON'T KNOW

13. What time standard for coverage for continuity of care by non-network providers, is used?

    ___ 60 days

    ___ 90 days

    ___ 120 days

    ___ Other

    ___ Customized based on the member's care plan

14. Does your state agency have a standard that limits the wait time between scheduling an appointment and being seen by a provider? *SKIP #15 IF "NO" OR "DON'T KNOW."*
    ___ YES ___ NO ___ DON'T KNOW

15. For each of the following types of appointments or patient visits, please indicate the maximum wait time in days within which a member must be seen by a provider.

Type of Appointment	Maximum Wait Time in Days
Well care	
Routine care	
Urgent care	
Emergency care	
Initial pre-natal care visit	

16. What is the maximum, in-office wait time, in minutes, members can experience for scheduled appointments? Please indicate "Not applicable" if this standard does not exist.

    _____

17. What are the standards required for MCOs have after-hours access to providers?

After Hours Standard	YES	NO	DON'T KNOW	NOT APPLICABLE
PCPs are required to offer appointments after-hours				
Specialists are required to offer appointments after-hours				

After Hours Standard	YES	NO	DON'T KNOW	NOT APPLICABLE
PCPs are required to offer 24/7 telephone access				
MCOs are required to offer a 24 hour nurse call line				

18. Does your state agency require that a minimum percentage of PCPs in an MCO's network accept new patients? *SKIP #19 IF ANSWER IS "NO" OR "DON'T KNOW."*

    ___ YES ___ NO ___ DON'T KNOW

19. What is the minimum percentage of PCPs in a network that must accept new patients?

    ___ 100%

    ___ 80% - 99%

    ___ 60% - 89%

    ___ 40% - 59%

    ___ Less than 40%

    ___ Don't know

20. The Affordable Care Act (ACA) requires Marketplace QHPs to include 30% of Essential Community Providers (ECP) in their networks. ECPs are providers that serve predominantly low-income, medically underserved individuals. Medicaid enrollees also rely on ECPs for treatment.

    Given the anticipated movement of enrollees between Medicaid MCOs and QHPs as their income fluctuates, if MCOs operate in the Marketplace in your state, has the Medicaid managed care program considered encouraging Medicaid MCOs that operate QHPs to:

    Replicate the QHP's ECP networks in the Medicaid MCO provider network?

    ___ YES ___ NO ___ DON'T KNOW

    Have significant overlap in the contracted Medicaid MCO and QHP provider networks?

    ___ YES ___ NO ___ DON'T KNOW

21. Does your state agency require that Medicaid MCOs cover eligible services rendered to members who saw out-of-network providers erroneously listed in the latest provider directory?

    ___ YES ___ NO ___ DON'T KNOW

22. Please indicate the greatest frequency required for Medicaid MCOs to update the provider directory online. Select one.

    ___ Annually

    ___ Semi-annually

    ___ Quarterly

    ___ Monthly

    ___ Whenever changes occur to the provider network

    ___ Other

    ___ Don't know

23. Please indicate the greatest frequency for Medicaid MCOs to update the provider directory in print. Select one.

    ___ Annually

    ___ Semi-annually

    ___ Quarterly

    ___ Monthly

    ___ Whenever changes occur to the provider network

    ___ Other

    ___ Don't know

24. Children with Special Health Care Needs (CYSHCN) are defined by the Department of Health and Human Services as "*Those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."*

    Does your state agency carve out specialty care for CYSHCN from its standard Medicaid MCO contract to a contractor that specializes in serving this population?

    ___ YES ___ NO ___ DON'T KNOW

25. Does your state agency have different provider access requirements for MCOs that serve only CYSHCN from standard MCO provider access requirements? *SKIP #26 IF ANSWER IS "NO"*

    ___ YES ___ NO ___ DON'T KNOW

26. If you answered Yes to the previous question, please describe:

    _____

27. Does your state agency have the following special MCO contract provisions and/or access standards specifically for CYSHCN in its standard MCO contract?

Policies or Provisions Specifically for CYSHCN	YES	NO	DON'T KNOW
MCOs must give members the ability to bypass "gatekeepers," prior authorization, or other referral requirements for in-network pediatric specialty care			
MCOs must include pediatric centers of care in their provider network (examples include: cardiac, regional genetics, end stage renal disease, perinatal care, transplants, hematology/ oncology, pulmonary, craniofacial, and/or neuromuscular specialists)			
MCOs are required to customize durable medical equipment and home health service provider arrangements for CYSHCN			
MCOs have provider access standards for CYSHCN that differ from standards for other enrollee populations			

28. With respect to CYSHCN, does your state agency:

Policies or Provisions Specifically for CYSHCN	YES	NO	DON'T KNOW
Directly educate families of CYSHCN about the special provider access provisions or options?			
Delegate the education of families of CYSHCN about the special provider access provisions or options to a vendor?			
Require the MCO to educate families of CYSHCN about the special provider access provisions or options?			
Require the MCO to inform network **providers** about the special provider access provisions or options for CYSHCN?			

29. Does your state agency plan to add or change provider access standards for CYSHCN in any of its Medicaid MCO contracts over the next year?

    ___ YES ___ NO ___ DON'T KNOW

30. If you answered Yes to the previous question, please describe:

    _____

    _____

Section 2. Monitoring Practices

31. Who is responsible for monitoring Medicaid MCO network adequacy in your state?

Responsible for Monitoring Network Adequacy	Completely	Partially	Never
Medicaid agency staff members			
A state agency other than Medicaid			
A contracted EQRO			
A contracted consulting firm			
Other			

32. If you answered other to the previous question, please describe:

_____

_____

33. To what degree does your state agency rely on the certifications of third parties, such as NCQA, to determine whether MCOs have provider network adequacy?

___ Complete reliance (only third party certifications are required)

___ Some reliance (third party certifications are required but not sufficient)

___ Minimal reliance (third party certifications are optional and not required)

___ No reliance (third party certifications are not included in determination of network adequacy)

34. Please indicate which of the following ways your state agency monitors MCOs' provider networks:

Ways State Agency Monitors Provider Networks	YES	NO	DON'T KNOW
A review is done of the Medicaid MCO's entire provider network file submission			
A review is done on a sample of the MCO's provider network files			
Our state agency requires that MCOs perform spot checks on network providers to confirm their network status			
Our state agency or a delegated entity performs "secret shopper" surveys with MCO network providers			

Ways State Agency Monitors Provider Networks	YES	NO	DON'T KNOW
Medicaid relies on the accreditation process by independent entities for reviews of network adequacy			
The Medicaid agency and Department of Insurance coordinate network monitoring activities			
The Medicaid agency and Department of Insurance routinely share reports and other information on Medicaid MCO network adequacy			

35. Please provide the greatest frequency with which the reviews of MCO provider file submissions occur. Select one.

___ Annually

___ Semi-annually

___ Quarterly

___ Monthly

___ Other

___ Don't know

36. If you answered other to the previous question, please describe:

_____

_____

37. Please indicate the metrics that your state agency uses to identify potential network deficiencies

Metrics Used to Identify Potential Network Deficiencies	YES	NO	DON'T KNOW
Percentage of out-of-network encounters to total encounters			
Emergency room utilization rates			
CAHPS survey results			
Encounters by category of service to assess underutilization			
Call center reports			
Member complaints and grievances reports			
Other			

38. If you answered Other to the previous question, please describe the other metric(s) in use to identify potential network deficiencies.

    _____

39. Please indicate the provider network monitoring practices your state agency employs to evaluate member complaints and grievances.

Monitoring Practices	YES	NO	DON'T KNOW
Our state agency tracks the total number of complaints received at its call center about network adequacy/access to care			
MCOs must report the number of complaints received related to difficulty obtaining access to care to our state agency			
MCOs must report the number of complaints related to nonpayment for out of network care to our state agency			

40. Does your state agency have network monitoring metrics or practices specifically for Children and Youth with Special Health Care Needs and their providers in MCOs?

    ___ YES___ NO ___ DON'T KNOW

41. Please select the frequency of the following enforcement actions employed when MCOs are out of compliance with provider network access standards. (Often/Sometimes/Rarely/Never)

	OFTEN	SOMETIMES	RARELY	NEVER
State agency requests Corrective Action Plan of the MCO				
State agency reduces the number of new enrollees auto-assigned to the MCO				
State agency withholds a portion of the capitation payment from the MCO				
State agency assesses liquidated damages from the MCO				
States agency uses other penalties				

42. If you use other penalties with MCOs that have a deficient network, please describe:

    _____

43. Please rate the challenges experienced in monitoring MCO provider network information by significance of the challenge:

Type of Challenge	Major challenge	Moderate challenge	Minor challenge	Not a challenge
Obtaining complete, accurate, and timely information on network participation from MCOs				
Having adequate numbers of qualified staff to perform network analysis				
Lacking IT infrastructure to automate or facilitate monitoring				
Monitoring and identifying network adequacy problems on an ongoing basis				
Educating consumers regarding the use of in-network providers				
Other				

44. If you answered Other to the previous question, please describe the other challenges experienced in maintaining MCO provider network information.

_____

Section 3. Background Information

45. How many individuals enrolled in your state's Medicaid program were enrolled in a comprehensive, risk-based Medicaid MCO in December 2014? _____

46. How many comprehensive risk-based Medicaid MCOs were under contract in your state in December 2014? _____

47. Contact Information:

    Respondent Name:

    _____

    Title:

    _____

    Name of Office:

    _____

Phone number:

_____

Email:

_____

48. Do we have your permission to identify your state, though not your name, in the final report?

___ YES ___ NO

Thank you for your participation!

A National Examination of Provider Network Monitoring Practices
A Robert Wood Johnson Foundation Grant to Health Management Associates

STATE INSURANCE REGULATOR SURVEY

This survey is being conducted by Health Management Associates (HMA) under a grant from the Robert Wood Johnson Foundation. This research is being conducted with interest from the National Association of Insurance Commissioners (NAIC), the Association of Community Affiliated Health Plans (ACAP), and Medicaid Health Plans of America (MHPA). The goal of the project is to identify best practices and provide a thorough understanding of the challenges entailed in determining network adequacy.

You are being asked to supply information about your state's provider network standards and your state insurance department/commission/ Marketplace (referred to as "agency") practices for certifying and monitoring Qualified Health Plans (QHPs) that participate in your state's Marketplace. A related survey will be conducted of a nationwide sample of Qualified Health Plans (QHPs). In addition, surveys will be conducted with a nationwide sample of Medicaid managed care organizations and Medicaid agencies that monitor their provider networks.

This survey will take 30-45 minutes to complete. When you have completed all of the questions, scan and email a copy of the survey to kbrodsky@healthmanagement.com or fax to (646) 861-2746. If you have any questions at any time, please call Barbara Smith at (202) 601-7744 or contact her by email: bsmith@healthmanagement.com.

Please submit the survey by May 1, 2015. *Survey responses will be reported in the aggregate or de-identified and will not be attributed to any individual, state or MCO without express permission.*

Section 1. Environmental Information

1. In what type of Marketplace does your state participate?
   ___ Federal ___ State-based

2. If a State-based Marketplace, which entity provides oversight of QHP network adequacy?
   ___ State insurance department/commission
   ___ State-based Marketplace
   ___ Both the insurance department/commission and state-based Marketplace

3. Does your state agency regulate network adequacy or otherwise apply network adequacy standards to Marketplace QHPs? *IF "NO" STOP SURVEY HERE AND SUBMIT.*
   ___ YES ___ NO

4. Does your state agency apply the same network adequacy standards to QHPs as other health plans operated by all licensed health insurance carriers in the individual and small group markets?
   ___ YES ___ NO ___ DON'T KNOW

5. If you answered No to the previous question, please describe areas of difference in standards for QHPs and other health plans.

   _____

Section 2. Thresholds for Access Standards

6. Please indicate whether the following types of providers are considered Primary Care Providers (PCPs). *SKIP #7 IF RESPONSE TO "OTHER" IS NO OR DON'T KNOW.*

Primary Care Provider Type	YES	NO	DON'T KNOW
General practitioners			
Family practitioners			
Internists			
Pediatricians			
Nurse practitioners			
Physician assistants			
OB/GYNs			
Other			

7. If you answered Other to the previous question, please describe:

   _____

8. Does your state agency have provider-to-enrollee ratio requirements? *SKIP #9 IF "NO" OR "DON'T KNOW" IS SELECTED.*
   ___ YES ___ NO ___ DON'T KNOW

9. What is the maximum number of enrollees allowed per provider per QHP for the following provider types in each service area?

Provider Type	Urban	Rural	Not Applicable
PCP			
Pediatrician			
OB/GYN			
Dentist			

10. If there are other types of providers for which you employ enrollee to provider ratios, please list the type of provider and the ratios applied below.

Provider Type	Urban	Rural

11. Given that many providers in a service area participate in more than one QHP network, it is possible that the total number of enrollees attributed to a provider across all of the QHPs with which the provider contracts could be more enrollees than the maximum number allowed.

    Does your state agency monitor the total number of enrollees attributed to a provider across all QHPs in a service area to determine compliance with provider-to-enrollee ratios?
    ___ YES ___ NO ___ DON'T KNOW

12. Does your state agency require that contracting PCPs have hospital admitting privileges at QHP network hospitals?
    ___ YES ___ NO ___ DON'T KNOW

The next two questions refer to Geo-access requirements. For each type of provider, please indicate the standard your state agency applies for Urban and Rural regions, as applicable.

13. Does your state agency have a standard for travel distance in miles from a member's residence to a provider? *SKIP #14 IF "NO" OR "DON'T KNOW" IS SELECTED.*
    ___ YES ___ NO ___ DON'T KNOW

14. What is the maximum travel <u>distance</u> standard in miles from QHP member's residence to a:
    You may skip over the provider types for which a distance standard does not exist.

Provider Type	Urban	Rural
PCP		
Pediatrician		
OB/GYN		
Dentist		
Specialist		
Acute Care Hospital		
Pharmacy		

15. Does your state agency have a standard for travel time in minutes from a member's residence to a provider? *SKIP #16 IF "NO" OR "DON'T KNOW" IS SELECTED.*
    ___ YES ___ NO ___ DON'T KNOW

16. What is the travel time standard in minutes from an member's residence to a:
    You may skip the provider types for which a time standard does not exist.

Provider Type	Urban	Rural
PCP		
Pediatrician		
OB/GYN		
Dentist		
Specialist		
Acute Care Hospital		
Pharmacy		

17. Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers.

    Does your state agency use different provider access thresholds in Health Professional Shortage Areas?
    ___ YES ___ NO ___ DON'T KNOW

18. Does your state agency require QHPs to cover care provided by non-network providers when that care is provided at an in-network facility?
    ___ YES ___ NO ___ DON'T KNOW

19. Does your state agency require QHPs to cover the services of new members in active treatment with an out-of-network provider for a minimum period of time in order to maintain continuity of care in the member's treatment? *SKIP #20 IF "NO" OR "DON'T KNOW" IS SELECTED*.
    ___ YES ___ NO ___ DON'T KNOW

20. What time standard for coverage for continuity of care by non-network providers, is used?

    ___ 60 days

    ___ 90 days

    ___ 120 days

    ___ Other

    ___ Customized based on the member's care plan

21. Does your state agency have a standard that limits the wait time between scheduling an appointment and being seen by a provider? *SKIP #22 IF "NO" OR "DON'T KNOW."*
    ___ YES ___ NO ___ DON'T KNOW

22. For each of the following types of appointments or patient visits for which a standard exists, please indicate the maximum wait time in days within which a member must be seen by a provider.

Type of Appointment	Maximum Wait Time in Days
Well care	
Routine care	
Urgent care	
Emergency care	

23. What are the standards required for QHPs to provide after-hours access to providers?

After Hours Standard	YES	NO	DON'T KNOW	NOT APPLICABLE
PCPs are required to offer appointments after-hours				
Specialists are required to offer appointments after-hours				
PCPs are required to offer 24/7 telephone access				
QHPs are required to offer a 24 hour nurse call line				

24. Does your state agency require that a minimum percentage of PCPs in a QHP's network accept new patients? *SKIP #25 IF ANSWER IS "NO" OR "DON'T KNOW."*
    ___ YES ___ NO ___ DON'T KNOW

25. What is the minimum percentage of PCPs in a network that must accept new patients?

    ___ 100%

    ___ 80% - 99%

    ___ 60% - 89%

    ___ 40% - 59%

    ___ Less than 40%

    ___ Don't know

26. The Affordable Care Act (ACA) requires Marketplace QHPs to include 30% of Essential Community Providers (ECP) in their networks. ECPs are providers that serve predominantly low-income, medically underserved individuals. Medicaid enrollees also rely on ECPs for treatment.

    Given the anticipated movement of enrollees between QHPs and Medicaid MCOs as their income fluctuates, if QHP carriers operate Medicaid MCOs in your state, has your state agency considered encouraging QHP carriers that operate Medicaid MCOs to have significant overlap between the QHP and Medicaid MCO provider networks?

    ___ YES ___ NO ___ DON'T KNOW

27. As the federal Marketplace requires that QHPs have a minimum of 30% of the ECPs in its service area in the provider network, did your state agency adopt a standard to align with the federal minimum ECP requirements for QHPs in the Marketplace?

    ___ YES ___ NO ___ DON'T KNOW

28. Does your state agency specify the types of ECPs that must be in the provider network?

    ___ YES ___ NO ___ DON'T KNOW

29. Does your state agency require that QHPs cover eligible services rendered to members who saw out of network providers erroneously listed in the latest provider directory?

    ___ YES ___ NO ___ DON'T KNOW

30. Does your state agency have a standard for the frequency with which provider directories must be updated? *SKIP #31 AND #32 IF ANSWER IS "NO" OR "DON'T KNOW."*

    ___ YES ___ NO ___ DON'T KNOW

31. Please indicate the greatest frequency required for QHPs to update the provider directory online. Select one.

    ___ Annually

    ___ Semi-annually

    ___ Quarterly

    ___ Monthly

    ___ Whenever changes occur to the provider network

    ___ Other

    ___ Don't know

32. Please indicate the greatest frequency for QHPs to update the provider directory in print. Select one.

    ___ Annually

    ___ Semi-annually

    ___ Quarterly

    ___ Monthly

    ___ Whenever changes occur to the provider network

    ___ Other

    ___ Don't know

Section 3. Monitoring Practices

33. Who is responsible for monitoring QHP network adequacy in your state? *SKIP to #47 IF "THIRD PARTY CERTIFICATION" IS SELECTED AS "COMPLETELY" AND THE REST ARE "NEVER".*

	Completely	Partially	Never
Department of Insurance staff members			
Marketplace office staff members			
Third party certification is provided to the Federal Marketplace			
A contracted consulting firm			
Other			

34. If you answered other to the previous question, please describe:

    _____

    _____

35. Please indicate which of the following ways your state agency monitors QHP provider networks:

	YES	NO	DON'T KNOW
A review is done of the QHP's entire provider network file submission			
A review is done on a sample of the QHP's provider network files			
Our state agency requires that QHPs perform spot checks on network providers to confirm their network status			

Our state agency or a delegated entity performs "secret shopper" surveys with QHP network providers			
Our state agency relies on the accreditation process by independent entities for reviews of network adequacy			

36. To what degree does your state agency rely on the certifications of third parties, such as NCQA, to determine whether MCOs have provider network adequacy?

___ Complete reliance (only third party certifications are required)

___ Some reliance (third party certifications are required but not sufficient)

___ Minimal reliance (third party certifications are optional and not required)

___ No reliance (third party certifications are not included in determination of network adequacy)

37. Please provide the greatest frequency with which the reviews of QHP provider file submissions occur. Select one.

___ Annually

___ Semi-annually

___ Quarterly

___ Monthly

___ Other

___ Don't know

38. If you answered other to the previous question, please describe:

_____

_____

39. Please indicate the metrics that your state agency uses to identify potential network deficiencies

Metrics Used to Identify Potential Network Deficiencies	YES	NO	DON'T KNOW
Percentage of out-of-network encounters to total encounters			
Emergency room utilization rates			
CAHPS survey results			

Metrics Used to Identify Potential Network Deficiencies	YES	NO	DON'T KNOW
Encounters by category of service to assess underutilization			
Call center reports			
Member complaints and grievances reports			
Other			

40. If you answered other to the previous question, please describe the other metric(s) in use to identify potential network deficiencies.

_____

41. Please indicate the provider network monitoring practices your state agency employs to evaluate member complaints and grievances.

Monitoring Practices	YES	NO	DON'T KNOW
Our state agency tracks the total number of complaints received about network adequacy/access to care			
QHP must report the number of complaints it receives related to difficulty obtaining access to care to our state agency			
QHPs must report the number of complaints related to nonpayment for out of network care to our state agency			

42. Please select the frequency of the following enforcement actions employed when QHPs are out of compliance with provider network access standards.

Enforcement Actions	OFTEN	SOMETIMES	RARELY	NEVER
State agency requests Corrective Action Plan of the QHP				
State agency restricts enrollment to the QHP				
State agency assesses liquidated damages from the QHP				
States agency uses other penalties				

43. If you use other penalties with QHPs that have a deficient network, please describe:

_____

44. Please rate the challenges experienced in monitoring QHP provider network information by significance of the challenge:

Type of Challenge	Major challenge	Moderate challenge	Minor challenge	Not a challenge
Obtaining complete, accurate, and timely information on network participation from QHPs				
Having adequate numbers of qualified staff to perform network analysis				
Lacking IT infrastructure to automate or facilitate monitoring				
Monitoring and identifying network adequacy problems on an ongoing basis				
Educating consumers regarding the use of in-network providers				
Other				

45. If you answered other to the previous question, please describe the other challenges experienced in maintaining QHP provider network information.
_____

Section 4. Background Information

46. How many QHP carriers were licensed / certified to operate in the Marketplace in your state in 2014? _____

47. How many QHP carriers are licensed / certified to operate in the Marketplace in your state in 2015? _____

48. How many total QHPs were operating in the Marketplace in your state in December 2014? _____

49. How many total QHPs are operating in the Marketplace in your state in 2015? _____

50. How many individuals were enrolled in QHPs in your state in December 2014? _____

51. How many individuals were enrolled in QHPs in your state as of March 2015 (after the last open enrollment period)? _____

52. Contact Information:

    Respondent Name:

    _____

    Title:

    _____

    Name of Office:

    _____

    Phone number:

    _____

    Email:

    _____

53. Do we have your permission to identify your state, though not your name, in the final report?

___ YES___ NO

Thank you for your participation!

A National Examination of Provider Network Monitoring Practices

A Robert Wood Johnson Foundation Grant to Health Management Associates

MEDICAID MANAGED CARE ORGANIZATION SURVEY

This survey is being conducted by Health Management Associates (HMA) under a grant from the Robert Wood Johnson Foundation. This research is being conducted with interest from the Association of Community Affiliated Health Plans (ACAP), Medicaid Health Plans of America (MHPA) and the National Association of Insurance Commissioners (NAIC). The goal of the project is to identify best practices and provide a thorough understanding of the challenges entailed in determining network adequacy.

You are being asked to supply information about the provider network standards your organization must follow and the practices for complying with them. A related national survey will be conducted of Medicaid agencies. Both are part of a larger study that also will examine provider network oversight of Marketplace qualified health plans, and will be shared with survey respondents.

This survey will take 30-45 minutes to complete. When you have completed all of the questions, scan and email a copy of the survey to kbrodsky@healthmanagement.com or fax to (646) 861-2746. If you have any questions at any time, please call Karen Brodsky at (646) 584-5827 or contact her by email: kbrodsky@healthmanagement.com . The secondary contact is Barbara Smith at (202) 601-7744, or by email: bsmith@healthmanagement.com .

Please submit the survey by May 1, 2015. *Survey responses will be reported in the aggregate or de-identified and will not be attributed to any individual, state or MCO without express permission.*

Section 1. Thresholds for Access Standards

1. Please indicate whether your MCO considers the following types of providers Primary Care Providers (PCPs). *SKIP #2 IF RESPONSE TO "OTHER" IS NO OR DON'T KNOW.*

Primary Care Provider Type	YES	NO	DON'T KNOW
General practitioners			
Family practitioners			
Internists			
Pediatricians			
Nurse practitioners			
Physician assistants			
OB/GYNs			
Other			

2. If you answered Other to the previous question, please describe:

_____

3. Does your MCO use provider to member ratios in forming and maintaining provider networks?
   SKIP #4 IF "NO" OR "DON'T KNOW" IS SELECTED.
   ___ YES ___ NO ___ DON'T KNOW

4. What is the maximum number of members per provider for the following provider types in each geographic area? ***You may skip over the provider types for which member to provider ratios are not in use.***

Provider Type	Urban	Rural	Frontier	Not Applicable
PCP				
Pediatrician				
OB/GYN				
Dentist				

5. If there are other types of providers for which your MCO uses member to provider ratios, please list the type of provider and the ratios applied below.

Provider Type	Urban	Frontier	Rural
PCP			
Pediatrician			
OB/GYN			
Dentist			

6. Given that many providers in a service area participate in more than one MCO network, it is possible that the total number of enrollees attributed to a provider across all of the MCOs with which the provider contracts could be more enrollees than the maximum number allowed under the Medicaid managed care contract.

   Does your MCO request information from providers on their total patient census or otherwise monitor the total number of patients attributed to them across all contracting Medicaid MCOs in a service area?
   ___ YES ___ NO ___ DON'T KNOW

7. Are the PCPs with whom your MCO contracts required to have hospital admitting privileges at network hospitals?
   ___ YES ___ NO ___ DON'T KNOW

The next two questions refer to Geo-access requirements in Medicaid managed care contracts. For each type of provider, please indicate the standard your MCO applies for Urban, Rural, and/or Frontier regions, as applicable.

8. What is the travel distance standard in miles from a member's residence to a:
   You may skip over the provider types for which a distance standard does not exist.

Provider Type	Urban	Rural	Frontier
PCP			
Pediatrician			
OB/GYN			
Dentist			
Specialist			
Acute Care Hospital			
Pharmacy			

9. What is the travel time standard in minutes from a member's residence to a:
   You may skip the provider types for which a time standard does not exist.

Provider Type	Urban	Rural	Frontier
PCP			
Pediatrician			
OB/GYN			
Dentist			
Specialist			
Acute Care Hospital			
Pharmacy			

10. Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers.

    Does your MCO use different provider access thresholds in Health Professional Shortage Areas?
    ___ YES ___ NO ___ DON'T KNOW

11. Does your MCO cover care provided by non-network providers when that care is provided at an in-network facility?
    ___ YES ___ NO ___ DON'T KNOW

12. Does your MCO cover the services of new members in active treatment with an out-of-network provider for a minimum period of time in order to maintain continuity of care in the member's treatment? *SKIP #13 IF "NO" OR "DON'T KNOW" IS SELECTED*.
    ___ YES ___ NO ___ DON'T KNOW

13. What time standard for coverage for continuity of care by non-network providers, is used?

    ___ 60 days

    ___ 90 days

    ___ 120 days

    ___ Other

    ___ Customized based on the member's care plan

14. Does your MCO use a standard that limits the wait time between seeking an appointment and being seen by a provider? *SKIP #15 IF "NO" OR "DON'T KNOW."*
    ___ YES ___ NO ___ DON'T KNOW

15. For each of the following types of appointments or patient visits, please indicate the maximum wait time in days within which a member must be seen by a provider.

Type of Appointment	Maximum Wait Time in Days
Well care	
Routine care	
Urgent care	
Emergency care	
Initial pre-natal care visit	

16. What is the maximum, in-office wait time, in minutes, members can experience for scheduled appointments? Please indicate "Not applicable" if this standard does not exist.

    _____

17. What are the standards that your MCO uses for after-hours access to providers? (Yes/No/Don't know/Not applicable)

After Hours Standard	YES	NO	DON'T KNOW	NOT APPLICABLE
PCPs are required to offer appointments after-hours				
Specialists are required to offer appointments after-hours				
PCPs are required to offer 24/7 telephone access				
Our MCO offers a 24 hour nurse call line				

18. Does your MCO have a minimum threshold against which it tracks the percentage of PCPs in its network that accept new patients? *SKIP #19 IF ANSWER IS "NO" OR "DON'T KNOW."*
    ___ YES ___ NO ___ DON'T KNOW

19. What is the minimum percentage of PCPs in your MCO's network that must accept new patients?

    ___ 100%

    ___ 80% - 99%

    ___ 60% - 89%

    ___ 40% - 59%

    ___ Less than 40%

    ___ Don't know

20. Does your parent organization offer a QHP in the state's Marketplace? (Yes/No/Don't know) *SKIP #21 AND #22 IF ANSWER IS "NO" OR "DON'T KNOW."*

    ___ YES ___ NO ___ DON'T KNOW

21. The Affordable Care Act (ACA) requires Marketplace QHPs to include 30% of Essential Community Providers (ECP) in their networks. ECPs are providers that serve predominantly low-income, medically underserved individuals. Medicaid enrollees also rely on ECPs for treatment.

    Has your MCO adopted the Marketplace standard for including ECPs in the provider network?

    ___ YES ___ NO ___ DON'T KNOW

22. Has your MCO taken steps to align its provider network with that of its QHP?

    ___ YES ___ NO ___ DON'T KNOW

23. Does your MCO cover eligible services rendered to members who saw out-of-network providers erroneously listed in the latest provider directory?

    ___ YES ___ NO ___ DON'T KNOW

24. Please indicate the greatest frequency with which your MCO updates the provider directory online. Select one.

    ___ Annually

    ___ Semi-annually

    ___ Quarterly

    ___ Monthly

    ___ Whenever changes occur to the provider network

    ___ Other

    ___ Don't know

25. Please indicate the greatest frequency with which your MCO updates the provider directory in print. Select one.

    ___ Annually

    ___ Semi-annually

    ___ Quarterly

    ___ Monthly

    ___ Whenever changes occur to the provider network

    ___ Other

    ___ Don't know

26. Children and Youth with Special Health Care Needs (CYSHCN) are defined by the Department of Health and Human Services as *"Those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."*

    Does your MCO enroll CYSHCN? *SKIP #27 THROUGH #30 IF ANSWER IS "NO/DON'T KNOW."*

    ___ YES ___ NO ___ DON'T KNOW

27. If you enroll CYSHCN, does your MCO have the following policies or provisions specifically for CYSHCN? – or that are available to CYSHCN? *SKIP #28 IF ALL ANSWERS ARE "NO."*

Policies or Provisions Specifically for CYSHCN	YES	NO	DON'T KNOW
Members have the ability to bypass "gatekeepers," prior authorization, or other referral requirements for in-network pediatric specialty care			
Our MCO includes pediatric centers of care in its provider network (examples include: cardiac, regional genetics, end stage renal disease, perinatal care, transplants, hematology/ oncology, pulmonary, craniofacial, and/or neuromuscular specialists)			
Our MCO customizes durable medical equipment and home health service provider arrangements for CYSHCN			
Our MCO uses provider access standards for CYSHCN that differ from standards for other enrollee populations			

28. With respect to CYSHCN, does your MCO:

Policies or Provisions Specifically for CYSHCN	YES	NO	DON'T KNOW
Have policies/systems to directly educate families of CYSHCN about the special provider access provisions or options?			
Leave the education of families of CYSHCN about the special provider access provisions or options to the state or the state's vendor?			
Have policies/systems to inform network providers about the special provider access provisions or options for CYSHCN?			

29. Has your MCO recommended Medicaid contract revisions, changed its own practices, or have plans to do so in the near future to monitor network access for CYSHCN?

___ YES ___ NO ___ DON'T KNOW

30. If you answered Yes to the previous question, please describe:

_____

_____

Section 2. Monitoring Practices

31. Please provide the greatest frequency with which your MCO reviews the provider files against state standards. Select one.

    ___ Annually

    ___ Semi-annually

    ___ Quarterly

    ___ Monthly

    ___ Other

    ___ Don't know

32. If you answered other to the previous question, please describe:

    _____

    _____

33. Please indicate the metrics that your MCO uses to identify potential network deficiencies.

Metrics Used to Identify Potential Network Deficiencies	YES	NO	DON'T KNOW
Percentage of out-of-network encounters to total encounters			
Emergency room utilization rates			
CAHPS survey results			
Encounters by category of service to assess underutilization			
Call center reports			
Member complaints and grievances reports			
Other			

34. If you answered Other to the previous question, please describe the other metric(s) in use to identify potential network deficiencies.

    _____

35. Please indicate the provider network monitoring practices your MCO employs to evaluate member complaints and grievances.

Monitoring Practices	YES	NO	DON'T KNOW
Our MCO tracks the number of complaints received through our call center and in writing from members related to difficulty obtaining access to care			
Our MCO tracks the number of complaints it receives related to nonpayment for out-of-network care			
Our MCO tracks the total number of complaints about network adequacy/access to care received by the state agency			

36. Does your MCO have network monitoring metrics or practices specifically for Children and Youth with Special Health Care Needs and their providers?

___ YES___ NO ___ DON'T KNOW

37. Please rate the challenges your MCO experiences in updating and monitoring provider network information by significance of the challenge:

Type of Challenge	Major challenge	Moderate challenge	Minor challenge	Not a challenge
Obtaining complete, accurate, and timely information on network participation from providers				
Having adequate numbers of qualified staff to perform network analysis				
Lacking IT infrastructure to automate or facilitate monitoring				
Reconciling updates to credentialing records, provider directories and provider contracts				
Monitoring and identifying network adequacy problems on an ongoing basis				
Other				

38. If you answered Other to the previous question, please describe the other challenges experienced in maintaining MCO provider network information.

_____

_____

39. What additional strategies has your MCO used to improve its ability to meet the state's provider network standards? Please indicate the strategies that apply and whether the strategies have been useful.

Additional Strategies Used to Improve Ability to Meet Network Standards	Useful	Somewhat Useful	Not Useful
Conduct secret shopper calls			
Conduct scheduled provider office site visits			
Conduct provider training and education			
Offer providers call-in hours for consultations with the MCO medical director			
Conduct outreach to providers named in member complaints			
Contract with consultants to assist in network validation activities			
Partner with MCOs to develop network compliance solutions			
Partner with the Medicaid agency to develop network compliance solutions			
Offer provider incentives to meet provider network performance requirements			

40. If there are any other strategies that were not listed in the previous question, please describe them.

    _____

Section 3. Background Information

41. Does your MCO contract out <u>all</u> of the review and analysis of provider network adequacy to a vendor? *IF RESPONSE IS "YES," SKIP #42.*

    ___ YES ___ NO ___ DON'T KNOW

42. Does your MCO contract out some of the review and analysis of the provider network to a vendor?

    ___ YES ___ NO ___ DON'T KNOW

43. How many individuals were enrolled in your MCO in December 2014?

    _____

44. Contact Information:

    Respondent Name: _____

    Title: _____

    Name of Office: _____

    Phone number: _____

    Email: _____

45. Do we have your permission to identify your MCO, though not your name, in the final report?

___ YES___ NO

Thank you for your participation!

A National Examination of Provider Network Monitoring Practices

A Robert Wood Johnson Foundation Grant to Health Management Associates

QUALIFIED HEALTH PLAN (QHP) SURVEY

This survey is being conducted by Health Management Associates (HMA) under a grant from the Robert Wood Johnson Foundation. This research is being conducted with interest from the Association of Community Affiliated Health Plans (ACAP), Medicaid Health Plans of America (MHPA) and the National Association of Insurance Commissioners (NAIC). The goal of the project is to identify best practices and provide a thorough understanding of the challenges entailed in determining network adequacy.

You are being asked to supply information about the provider network standards your organization must follow and the practices for complying with them. A related national survey will be conducted of Marketplace agencies. Both are part of a larger study that also will examine provider network oversight of Medicaid managed care organizations and Medicaid agencies. We will send you a copy of the final report when it is published in the fall of 2015.

This survey will take 30-45 minutes to complete. When you have completed all of the questions, scan and email a copy of the survey to kbrodsky@healthmanagement.com or fax to (646) 861-2746. If you have any questions at any time, please call Barbara Smith at (202) 601-7744 or contact her by email: bsmith@healthmanagement.com.

Please submit the survey by May 15, 2015. *Survey responses will be reported in the aggregate or de-identified and will not be attributed to any individual, health plan or state without express permission.*

Section 1. Thresholds for Access Standards

1. Please indicate whether your QHP considers the following types of providers Primary Care Providers (PCPs). *SKIP #2 IF RESPONSE TO "OTHER" IS NO OR DON'T KNOW.*

Primary Care Provider Type	YES	NO	DON'T KNOW
General practitioners			
Family practitioners			
Internists			
Pediatricians			
Nurse practitioners			
Physician assistants			
OB/GYNs			

2. If your QHP considers any other types of providers as PCPs please describe.

_____

3. Does your QHP use provider to member ratios in forming and maintaining provider networks?
   SKIP #4-6 IF "NO" OR "DON'T KNOW" IS SELECTED.
   ___ YES ___ NO ___ DON'T KNOW

4. What is the maximum number of members per provider for the following provider types in each geographic area?

Provider Type	Urban	Rural
PCP		
Pediatrician		
OB/GYN		
Dentist		

5. If there are other types of providers for which your QHP uses member to provider ratios, please list the type of provider and the ratios applied below.

Provider Type	Urban	Rural

6. Given that many providers in a service area participate in more than one QHP network, it is possible that the total number of patients attributed to a provider across all of the QHPs with which the provider contracts could be more patients than they are able to serve.

   Does your QHP request information from providers on their total patient census or otherwise monitor the total number of patients attributed to them across all QHPs in a service area?
   ___ YES ___ NO ___ DON'T KNOW

7. Are the PCPs with whom your QHP contracts required to have hospital admitting privileges at network hospitals?
   ___ YES ___ NO ___ DON'T KNOW

The next two questions refer to Geo-access requirements. For each type of provider, please indicate the standard your QHP applies for Urban and Rural, as applicable.

8. If your QHP uses travel distance standards, what is the travel distance standard in miles from a member's residence to a:
   You may skip over the provider types for which a distance standard does not exist.

Provider Type	Urban	Rural
PCP		
Pediatrician		
OB/GYN		
Dentist		
Specialist		
Acute Care Hospital		
Pharmacy		

9. If your QHP uses travel time standards, what is the travel time standard in minutes from a member's residence to a:
   You may skip the provider types for which a time standard does not exist.

Provider Type	Urban	Rural
PCP		
Pediatrician		
OB/GYN		
Dentist		
Specialist		
Acute Care Hospital		
Pharmacy		

10. Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers.

    Does your QHP use different provider access thresholds in Health Professional Shortage Areas?
    ___ YES ___ NO ___ DON'T KNOW

11. Does your QHP cover care provided by non-network providers when that care is provided at an in-network facility?
    ___ YES ___ NO ___ DON'T KNOW

12. Does your QHP cover the services of new members in active treatment with an out of network provider for a minimum period of time in order to maintain continuity of care in the member's treatment? *SKIP #13 IF "NO" OR "DON'T KNOW" IS SELECTED*.
    ___ YES ___ NO ___ DON'T KNOW

13. What time standard for coverage for continuity of care by non-network providers, is used?

    ___ 60 days

    ___ 90 days

    ___ 120 days

    ___ Other

    ___ Customized based on the member's care plan

14. Does your QHP use a standard that limits the wait times for member between scheduling an appointment and being seen by a provider? *SKIP #15 IF "NO" OR "DON'T KNOW."*
    ___ YES ___ NO ___ DON'T KNOW

15. For each of the following types of appointments or patient visits, please indicate the maximum wait time in days within which a member must be seen by a provider.

Type of Appointment	Maximum Wait Time in Days
Well care	
Routine care	
Urgent care	
Emergency care	

16. What are the standards that your QHP uses for after-hours access to providers?

After Hours Standard	YES	NO	DON'T KNOW	NOT APPLICABLE
PCPs are required to offer appointments after-hours				
Specialists are required to offer appointments after-hours				
PCPs are required to offer 24/7 telephone access				
Our QHP offers a 24 hour nurse call line				

17. Does your QHP have a minimum threshold against which it tracks the percentage of PCPs in its network that accept new patients? *SKIP #18 IF ANSWER IS "NO" OR "DON'T KNOW."*
    ___ YES ___ NO ___ DON'T KNOW

18. What is the minimum percentage of PCPs in your QHP's network that must accept new patients?

    ___ 100%

    ___ 80% - 99%

    ___ 60% - 89%

    ___ 40% - 59%

    ___ Less than 40%

    ___ Don't know

19. Does your parent organization offer a Medicaid MCO in the state's Medicaid managed care program? *SKIP #20 IF ANSWER IS "NO" OR "DON'T KNOW."*
    ___ YES ___ NO ___ DON'T KNOW

20. The Affordable Care Act (ACA) requires Marketplace QHPs to include 30% of Essential Community Providers (ECP) in their networks. ECPs are providers that serve predominantly low-income, medically underserved individuals. Medicaid enrollees also rely on ECPs for treatment. Has your QHP taken steps to align its provider network with that of its Medicaid MCO?
    ___ YES ___ NO ___ DON'T KNOW

21. Does your QHP cover eligible services rendered to members who saw out of network providers erroneously listed in the latest provider directory?
    ___ YES ___ NO ___ DON'T KNOW

22. Please indicate the greatest frequency with which your QHP updates the provider directory online. Select one.

    ___ Annually

    ___ Semi-annually

    ___ Quarterly

    ___ Monthly

    ___ Whenever changes occur to the provider network

    ___ Other

    ___ Don't know

23. Please indicate the greatest frequency with which your QHP updates the provider directory in print. Select one.

    ___ Annually

    ___ Semi-annually

    ___ Quarterly

    ___ Monthly

    ___ Whenever changes occur to the provider network

    ___ Other

    ___ Don't know

Section 2. Monitoring Practices

24. Does your QHP periodically review its provider network files against the state's network adequacy standards?
    ___ YES ___ NO ___ DON'T KNOW

25. Please provide the greatest frequency with which your QHP reviews the provider files against state standards. Select one.

    ___ Annually

    ___ Semi-annually

    ___ Quarterly

    ___ Monthly

    ___ Other

    ___ Don't know

26. If you answered other to the previous question, please describe:

    _____

    _____

27. Please indicate the metrics that your QHP uses to identify potential network deficiencies.

Metrics Used to Identify Potential Network Deficiencies	YES	NO	DON'T KNOW
Percentage of out-of-network encounters to total encounters			
Emergency room utilization rates			
CAHPS survey results			
Encounters by category of service to assess underutilization			
Call center reports			
Member complaints and grievances reports			
Other			

28. If you answered Other to the previous question, please describe the other metric(s) in use to identify potential network deficiencies.

_____

29. Please indicate the provider network monitoring practices your QHP uses to evaluate member complaints and grievances.

Monitoring Practices	YES	NO	DON'T KNOW
Our QHP tracks the number of complaints received through the call center and in writing from members related to difficulty obtaining access to care			
Our QHP tracks the number of complaints it receives related to nonpayment for out of network care			
Our QHP tracks the number of complaints about network adequacy/access to care received by the Marketplace and the Department of Insurance.			

30. Please rate the challenges your QHP experiences in updating and monitoring provider network information by significance of the challenge:

Type of Challenge	Major challenge	Moderate challenge	Minor challenge	Not a challenge
Obtaining complete, accurate, and timely information on network participation from providers				
Having adequate numbers of qualified staff to perform network analysis				
Lacking IT infrastructure to automate or facilitate monitoring				
Reconciling updates to credentialing records, provider directories and provider contracts				

Type of Challenge	Major challenge	Moderate challenge	Minor challenge	Not a challenge
Monitoring and identifying network adequacy problems on an ongoing basis				
Educating consumers regarding the use of in-network providers				
Other				

31. If you answered other to the previous question, please describe the other challenges experienced in maintaining QHP provider network information.

    _____

32. What additional strategies has your QHP used to improve its ability to meet the state's provider network standards? Please indicate the strategies that apply and whether the strategies have been useful.

Strategy	Useful	Somewhat useful	Not useful	Not applicable
Conduct secret shopper calls				
Conduct scheduled provider office site visits				
Conduct provider training and education				
Offer providers call-in hours for consultations with the QHP medical director				
Conduct outreach to providers named in member complaints				
Contract with consultants to assist in network validation activities				
Partner with the state agency to develop network compliance solutions				
Offer provider incentives to meet provider network performance requirements				

33. If there are any other strategies that were not listed in the previous question, please describe them.

    _____

Section 3. Background Information

34. Does your QHP contract out <u>all</u> of the review and analysis of provider network adequacy to a vendor? *SKIP #35 IF ANSWER IS "YES".*
    ___ YES ___ NO ___ DON'T KNOW

35. Does your QHP contract out some of the review and analysis of the provider network to a vendor?
    ___ YES ___ NO ___ DON'T KNOW

36. How many individuals were enrolled in your QHP in December 2014? _____

37. Contact Information:

    Respondent Name:

    _____

    Title:

    _____

    Name of Office:

    _____

    Phone number:

    _____

    Email:

    _____

38. Do we have your permission to identify your state, though not your name, in the final report?

    ___ YES___ NO

Thank you for your participation!

Appendix C. Literature Review

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