

Medicaid Health Plan Networks: What You See Isn't Always What You Get

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Overview

- What are the federal MCO Network Adequacy Standards?
- What are the challenges for state administration?
- Connecticut Secret Shopper Experience
- Implications for future Medicaid expansion

Medicaid MCO Regulatory Standards

- All contracts must be reviewed and approved by CMS
- States must insure mechanisms to comply with 42CFR438.206-210, including:
 - 42CFR438.206: Networks accessible by time and distance, access to ob/gyns, access to second opinions, standards for appointments and waiting times, documentation of written provider contracts and member materials, 24/7, etc.

Medicaid Standards (cont.)

- - 42CFR438.207: Contracts with the MCOs must demonstrate capacity, and capacity must be re-measured/certified if there is change or expansion in the enrolled population
- - 42CFR438.208: Contracts must insure the delivery of primary care and coordination of care for dual eligibles and populations with special care needs, including access to specialists

Medicaid Standards (cont.)

- - 42CFR438.210: Contracts with the MCOs must
- provide services in equal amount, scope, and duration as in fee-for-service Medicaid
- Coverage determinations must be based on the state's own definition of medical necessity
- MCOs authorization decisions need to follow federal standards for promptness and notice of action
- Utilization review contracts cannot include any financial incentives to deny care

What could possibly go wrong?

- MCO provider contracts typically require providers to notify them if they close their panels
- Many providers ignore this requirement for Medicaid MCOs
- If the MCO or the state sanctions providers for non-compliance, they may drop out altogether
- For many private providers other than those where Medicaid is almost unavoidable (pediatrics and obstetrics), Medicaid is a line of business that many providers don't want and don't need (low reimbursement, compliance issues, language, etc.)

What is the reimbursement standard in Medicaid?

- 42CFR447.204: Fees must be “sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population”.
- What is the “general population”?
 - Commercially insured?
 - Self-pay/uninsured?
 - Medicare?
 - All of the above?

2006: the Connecticut Context

- Managed Medicaid for children and families (HUSKY) since 1995
- 340,000 members enrolled in HUSKY A (Medicaid) and HUSKY B (CHIP)
- Concerns from legislators, advocates, and consumers about access
- FOI request about provider reimbursement by the MCOs
- No Medicaid across the board rate increase for physicians since 1989

What to do?

- Medicaid commissioned EQRO (Mercer) to do a Secret Shopper provider survey
- State staff issued Medicaid IDs to contact providers and MCO member services as parents of newly enrolled members (children 0-18 years)
- Calls went to primary care providers (pediatricians, family practitioners, etc.), but also to specialists (dermatologists, neurologists, dentists, etc.)
- Calls included follow up calls to MCO member services if appointment could not be scheduled

Results

		<u>Scheduled (%)</u>	<u>Reasonable Not Scheduled (%)</u>
Pediatricians	(676)	33.58%	3.99%
Dentists	(453)	27.15%	2.87%
Dermatologists	(110)	30.00%	28.87%
Neurologists	(284)	15.85%	12.32%
Total	(1,851)	26.20%	12.32%

Not Scheduled Reasons

- Non-Participating Provider 22.62%
- Not Accepting New Patients 9.15%
- Sub-Specialty (reasonable) 8.78%
- Wrong Phone Number 8.78%
- Records Required (reasonable) 8.49%
- PCP referral (reasonable) 7.91%
- Other 34.26%
- (voicemail, not accepting HUSKY, etc.)

Results by MCO

		»	Not Scheduled
		»	Reasonable (%)
		<u>Scheduled (%)</u>	<u>Reasonable (%)</u>
• Anthem	(497)	27.16%	12.07%
• CHN	(566)	25.27%	14.13%
• HealthNet	(384)	23.44%	15.10%
• WellCare	(404)	28.96%	7.43%
• Total	(1,851)	26.20%	12.32%

Consequences in Connecticut

- FOI challenge went forward. Governor Rell ordered MCOs to comply and suspended risk contracting in January, 2007
- Three MCOs withdrew (Anthem, HealthNet, and Wellcare)
- Contracts re-bid in July, 2007 with strict FOI requirements and expansion to include state-funded Charter Oak Plan
- Legislature voted largest one-year Medicaid rate increases in history for physicians and hospitals
- Dental litigation settled with \$20 million rate increase and a carve out to a single statewide ASO (Benecare)

Implications for Reform and the Expansion of Medicaid

- Connecticut may be unique, but it is likely that access in many Medicaid MCO networks may be problematic.
- How will these networks expand to accommodate significant enrollment increases without costly increases in provider reimbursement?
- These Medicaid access issues persist for fee-for-service, as well as for managed care
- Provider lists in Medicaid MCO member handbooks don't mean much unless they are tested periodically