



How Adequate is your Provider Network?

Applying and Measuring Managed Care Provider Network Compliance Against the New 2018 Requirements

Presented by:

Jennifer Tryder, Program Director

Mike Walsh, Senior Auditor

Kimberly Hornik, VP of Compliance and Administration

This document is Confidential and Proprietary. Any unauthorized review, use, disclosure or distribution is prohibited.

IntegrityM

2

Integrity Management Services, Inc. (IntegrityM) is a certified women-owned small business, CMMI Level 3 appraised, ISO 9001:2015 certified, and FISMA compliant organization.

Recognized by the Small Business Administration (SBA) Washington Metropolitan Area District Office (WMADO) as the 2017 Small Business Subcontractor of the Year, IntegrityM was created to support the program integrity and compliance efforts of healthcare organizations. Results are achieved through analysis and support services such as, statistical and data analysis, compliance, audit, investigation, medical review, and software solutions.



Presenters

3



Kimberly Hornik, VP of Compliance and Administration



Mike Walsh, Senior Auditor



Jennifer Tryder, Program Director

Agenda

4

1. Major Change Provisions within the 2016 Final Medicaid Rule
2. Revised Requirements for Network Adequacy Standards
3. State and MCO Provisions of Network Adequacy
4. Medicaid and CHIP Access Standards
5. Establishing Proper Time and Distance Standards Across Providers and Networks
6. Monitoring Adequacy of Established Providers & Networks
 - *State Contract Considerations and Recommendations*
 - *Establishing Monitoring Standards & Internal Controls*
 - *External Quality Review Requirements (EQR)*
 - *Determining an Effective Audit Planning Strategy*
 - *The Importance of Data Validation*
 - *Suggested Audit Segments for Overall Program Evaluation*
 - *Oversight Agency Activities & Reports*

Major Change Provisions Within the 2016 Medicaid Rule

5



(published on May 6, 2016 in 81 CFR 27498-27901)

Major Change Provisions Within the 2016 Medicaid Rule (cont'd)

6

On April 21, 2016, the Centers for Medicare & Medicaid Services (CMS) issued final regulations that revise and significantly strengthen existing Medicaid Managed Care rules

- Rule increased Federal expectations of fundamental aspects of State Medicaid Managed Care Programs
- Significant changes include:
 - Further disbursement of program integrity responsibilities across CMS, States, and MCOs
 - **Network Adequacy**
 - Strengthen payment provisions through the assurance of complete, accurate, and timely encounter data
 - Align Medicaid and CHIP Managed Care requirements with other major health coverage programs (MA, Marketplaces)
 - Enhance the beneficiary experience of care and strengthen beneficiary protections
 - Promote quality of care

Cited: <https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/>

Revised Requirements For Network Adequacy Standards

7

- Compliance with the new CMS regulations relative to Network Adequacy (42 CFR 438.68 and 438.207) in four key areas:
 - Time and Distance Standards
 - Exceptions to Provider Network Standards
 - Required Elements for Provider Network Establishment
 - Provider Network Documentation
- As with previous Federal Rules, the 2016 Final Rule continues to require states to ensure that Managed Care plans maintain “sufficient” provider networks to provide adequate access to covered services for all enrollees
- **The final rule establishes new requirements formalizing provider network adequacy standards for Medicaid Managed Care programs, which became effective on July 1, 2018**

LTSS (Long Term Services & Support) Plan Changes

8

- Additional changes for LTSS (Long Term Services & Support) Plans:
 - Supporting an enrollee’s choice of provider
 - Ensuring the health, welfare, and support community integration of enrollees
 - Other considerations in the best interest of enrollees who need LTSS
 - Additional standards for traveling LTSS providers

State and MCO Provisions of Network Adequacy

9

- **Data Collection:** The 2016 final rule requires each state to use data collected from its MCO contract oversight and monitoring activities to improve the performance of its Managed Care program
- **Provider Directory:** Must contain specific types of information about providers, provide this information for all providers of services covered in the plan, and update the directory regularly
- **Establishing Reasonable Time and Distance Standards:** From enrollee homes to provider sites; strengthens requirements for states to monitor enrollees' access to care; and addresses the needs of people with disabilities, or other special needs who increasingly are enrolled in Managed Care plans
- **Network Adequacy and Service Availability Standards:** Incorporating as an integral part of state based quality strategies and initiatives, including metrics, and targets used to measure.
- **Annual state certification of networks:** To CMS demonstrating compliance with the state established standards and the adequacy of health plan networks to provide timely access to care for all Medicaid Managed Care beneficiaries

CMS has allowed flexibility to states with respect to network adequacy, by allowing implementation of state standards specific to time and distance and timely access

Medicaid & CHIP Access Standards

10

- **Developing Access Standards**

To ensure the availability and accessibility of services in a timely manner, states must develop Network Adequacy standards and access requirements for a range of provider types covered under Managed Care contracts

- **Timely Appointments**

In addition to travel time and distance standards, the 2016 Final Rule requires states to ensure that covered MCO contract services are available in a timely manner to enrollees, and any medically necessary services are available 24 hours a day, seven days a week

- **Provider-to-Enrollee Ratios**

States must ensure that that Managed Care plan networks are sufficient to provide adequate access to all services covered under the contract for all enrollees

States must also ensure that their MCO contracts allow for a sufficient amount of network providers to provide care and services under the plan at least to the extent that such care and services are available to the general population in a geographic area

- **CHIP Adopts Nearly All of the Medicaid Standards**, including the Medicaid provisions related to provider networks and Network Adequacy

- States must also consider the differing health care needs and the providers that serve the adult and child populations

Establishing Proper Time and Distance Standards Across a Network

11

- The Final Rule also requires states to take into account a number of factors when setting their time and distance standards for Network Providers, including:
 - Anticipated Medicaid enrollment
 - Expected utilization of services and specific needs of Medicaid populations covered by the plans
 - The number and types (specialization) of network providers
 - The number of network providers who are not accepting new patients
 - Geographic location of network providers
 - Availability of network providers that communicate in non-English languages
 - The ability of network providers to ensure accessible, culturally competent care to people with disabilities
 - Use of telemedicine or similar technologies
- While states are required to establish time and distance standards, plans are required to meet the standards for time *or* distance

Establishing Proper Time and Distance Standards Across Network Providers

12

- CMS' new regulations require that states develop time (minutes) and distance (miles) Network Adequacy standards for the following provider types:
 - PCP (adult and pediatric)
 - Behavioral Health (adult and pediatric)
 - Specialist (adult and pediatric)
 - OB/GYN
 - Hospital
 - Pharmacy
 - Pediatric Dental
 - Additional Provider types that promote state objectives
- States retain the flexibility to develop their own unique time and distance standards for various geographic regions rather than follow specified national standards

Primary Care, Adult, and Pediatric Network Adequacy Elements

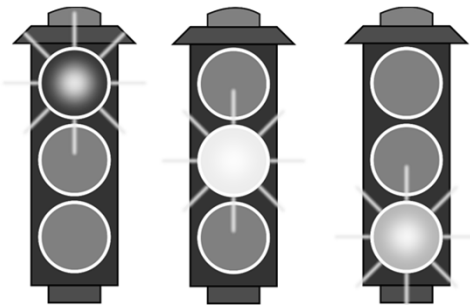
13

- **Anticipated Utilization of Services:**

- The characteristics and health care needs of specific Medicaid populations covered in the contracts
- The number and type of providers supplying services
- The number of providers who are not accepting new patients
- The geographic location of providers and enrollees
- **The Ability of Network Providers to Ensure:**
 - Physical access (including access equipment for the disabled) and reasonable accommodations
 - Culturally competent communications
- **The Use of Evolving and Innovative Technological Solutions:**
 - Telemedicine and E-visits
 - Availability of triage lines or screening systems

Monitoring Adequacy of Established Providers and Networks

14



State/MCO Contract Recommendations

15

- Require submission of documentation to demonstrate that MCO networks provide access to an appropriate range of services, and that these services are sufficient in terms of geographic distribution
- Ensuring, through their contracts with Managed Care plans, that all covered services are available and accessible, and that Medicaid and CHIP enrollees will receive timely access to medically necessary and appropriate care
- Establish goals and incentives to promote timely access to care (appointment availability, wait times, etc.)
- Work closely with Managed Care plans, providers, consumers, and other stakeholders to address any barriers to care

State Agency Contractual Considerations

16

Properly Define the Following:

- Service & encounter types specific to each program
- Audit vs. Assessment
- Defining a sample unit and allowable error rates
- Defining attributes and errors of accuracy, timeliness, and completeness
- How to treat missing records and data (error vs. no finding)
- Reporting requirements
- Impact assessment on State Agency and MCO

**Encounters make good
sample units for MCOs**

**Allowable error rates
and expected error
rates**

State Strategies for Monitoring MCO Contracts

17

- Ensure specific data and reporting requirements are included in MCO contracts in order for states to conduct efficient monitoring and proper controls
- Collect, validate, and analyze MCO reports and data to verify compliance with network standards and evaluate enrollee access to covered services
- Include contractual enforcement tools (sanctions, corrective actions, and penalties), and strategies to immediately address risks/issues upon identification of non-compliance against established access and network standards
- Develop policies for identified exceptions
- Review contracts annually, and, anytime there is a significant change that would affect the adequacy and capacity of services (i.e., new population enrollment, changes to benefits/service area)

Although CMS does not require these contract elements, states should highly consider including them within the contract terms in order to increase monitoring and controls

Collect, Compare, and Analyze

18

- ✓ **States must compare results to standards**
- ✓ **States must collect and analyze reports**
 - ✓ **States must validate the data**
- ✓ **MCOs must demonstrate completeness**
- ✓ **States must collect and analyze reports**

Best Practices: State Examples

19

- **California:** Requires weekly electronic updates to all Managed Care provider directories
Providers who fail to verify directory information can have a percentage of their capitation rates held or denied claims
- **Massachusetts:** Requires Managed Care plans to submit a “Summary Access and Availability Analysis Report,” containing key findings from all access reports and data sources
- **Other State Strategies:**
 - *Geo-mapping software* to map the location of Medicaid and CHIP Managed Care enrollees to Medicaid Managed Care plans’ network providers, and against time and distance standards
 - **Cross comparative analysis** of provider network files vs. provider-to-enrollee standards across plans, allowing states to assess the capacity of individual providers who participate in multiple plans that serve Medicaid enrollees

Monitoring Standards and Reports for Network Adequacy

20

- *The 2016 final rule requires State Medicaid agencies to establish a monitoring system for all state-based Managed Care Programs, including oversight of provider network management, compliance with provider directory requirements, Network Adequacy, and service availability standards [§438.66(b)].*
- **Monitoring standards should include:**
 - Provider network reports on primary care provider (PCP) and specialty providers, including: number of active provider types at the program, plan, and service area level
 - Out-of-Network utilization reports to identify potential deficiencies
 - Data analytics to monitor standards through tracking of access and utilization trends
 - Accurate, complete, and timely Managed Care encounter data, used to detect potential under-use or inappropriate use of services
 - Trending and reporting of member complaints and appeals
 - Use of “secret shopper” or similar activities to validate provider availability and appointment times
 - Member satisfaction surveys to monitor and measure timeliness of care
 - Sharing of data to key stakeholders (CMS, States, etc.)
 - Establishing Corrective Action Plans for any identified deficiencies

Establish and Verify Internal Controls

21

- ✓ Comparing the needs of enrollees to the capacity and availability of providers who can serve them is a critical step in developing Network Adequacy standards
- ✓ Provide an overall framework and suggest metrics for monitoring provider Network Adequacy and service availability
- ✓ Calculate ratios of network providers to anticipated enrollees to determine regions/areas with gaps and shortages that may warrant different time and distance standards, or those that may qualify for exceptions to established standards
- ✓ Testing of internal and external controls to validate effectiveness of policies and procedures put in place to monitor network adequacy standards and detect or prevent adverse conditions
- ✓ Additional compliance reviews to verify that internal controls are functioning as intended

Monitor, Verify, and Measure

22

Have you ever spot checked enrollees to see if everything is working?

Does the state verify and measure the effectiveness of MCO contracts regarding:

- ✓ Specialty Provider Qualifications
- ✓ Travel time
- ✓ Provider Capacity
- ✓ Clinic Qualifications

Does the MCO verify that its network meets the State standards?

Identify, Validate, and Adjust

23

How does the MCO document the factors it takes into account to set standards?

The MCO should have a system of verification to ensure that the elements are in place:

- ✓ Identify variances
- ✓ Validate compliance
- ✓ Make adjustments to the network

Testing, Tracking, and Reporting

24

Are your processes periodically tested to make sure they are functioning as intended?

Do you match enrollee complaints and complaint resolution, to specific compliance requirements?

Innovative solutions change over time. Are they tracked and reported?

Periodic Policy Reviews

25

Have you verified that all of CMS' requirements are included? E.g., pre-existing conditions, discrimination, complaint review, and resolution?

Are your procedures periodically reviewed? Do they include ratios, verify provider types, and specify regional characteristics?

External Quality Review (EQR) Requirements

26

- The Final Rule added a new mandatory requirement for the External Quality Review Organization (ERQO), an independent entity, to review the new Network Adequacy standards and validate the health plan networks on an annual basis
- States must begin conducting the EQR-related activity described in §438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) no later than one year from the issuance of the associated EQR protocol

Determining an Effective Audit Planning Strategy

27

- Each audit should proceed logically and systematically to use audit resources efficiently and effectively
- Audit work should be broken down into seven phases, each of which has a bearing on how and to what extent the audit is conducted
- The phases are defined as follows:
 - **Phase 1 - Selection of Auditee and Scope of Review**
 - **Phase 2 - State Agency Background Information**
 - **Phase 3 - Initial Risk Evaluation**
 - **Phase 4 - MCO Documentation (contracts)**
 - **Phase 5 - Risk Re-evaluation**
 - **Phase 6 - Detailed Audit Procedures/Data Verification Using Applicable Segments**
 - ✦ For each segment, the auditor must first determine contractual requirements and determine if the MCO has developed and implemented written policies to address the elements of each segment
 - **Phase 7 – Reporting**

The Importance of Data Validation

28

- When determining the need for internal or external consulting resources to support agency efforts with network adequacy audit and program evaluation, it is critical that each Managed Care Program within both the State Agency and MCO Entity, take the following into consideration for data evaluation:
 - ✓ Analyzing data output
 - ✓ Standardized audit and investigation protocols
 - ✓ Statistical and quality data analysis
 - ✓ Definition and generation of performance metrics based on the above
 - ✓ Well defined audit objectives
 - ✓ Prior audit results
 - ✓ Specific program experience

Suggested Audit Segments for Overall Medicaid Managed Care Program Evaluation

29

- Financial and Encounter Data Controls*
- Claims Processing*
- Provider Network and Access*
- Quality Assessment and Performance Improvement*
- Contractual Requirements*
- Organization and Structure*
- Language and Cultural Competency*
- Marketing*
- Grievances, Appeals, and Fair Hearings*
- Enrollment, Education, and Outreach*
- Enrollee Services and Medical Coverage*

Thank You!

30

Thank you for attending today's presentation. We'll be happy to answer questions!

For more information, or to reach Jennifer, Kimberly, or Mike please contact info@integritym.com or (703) 683-9600 or visit our website at integritym.com



twitter.com/integritym_inc



linkedin.com/company/integrityminc