Hidden Benefits:

The Value of Medicaid Managed Care Networks

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Hidden Benefits: The Value of Medicaid Managed Care Networks

Introduction

As states increasingly look to risk-based managed care to serve the majority of Medicaid beneficiaries, they are also looking for new and innovative ways to ensure that beneficiaries have access to the full array of services needed to keep them healthy. Traditional measures of "network adequacy" – including physician-to-enrollee ratios and time/distance requirements – are important, but they paint an incomplete picture of how Medicaid managed care plans, working with their provider and state partners, enhance network access and delivery of high quality care for their members through innovative network-enhancing strategies including:

- Using technology, such as tele-health, tele-monitoring and technology-supported PCP-to-specialist consults, to leverage provider access and expertise, and improve convenience for members. In both rural and urban areas, Medicaid MCOs are utilizing tele-health strategies to reduce the need for some face-to-face specialty visits and to expand access to services, such as psychiatry, that have traditionally had an inadequate supply of providers. It is important to note that this solution in part addresses a "root cause" of physician access issues in rural and some urban markets – physician capacity.
- Working with and paying providers to create incentives for team-based, population-focused care. Medicaid MCOs are critical partners in supporting the development and proliferation of medical and health home models, as well as effective care coordination strategies, both through direct support and through value-based reimbursement models. Value-based payment is becoming an increasingly powerful network recruitment and retention tool, as providers look for reimbursement that supports the practice transformation they are undertaking. Value-based payment can also help address one of the underlying reasons why some providers limit their participation in Medicaid – low reimbursement rates.
- Empowering providers to work at the top of their license and supporting the use of non-traditional providers, physician extenders, and patient access models, such as group visits or plan-operated health centers. Medicaid health plans have embraced mid-level and non-traditional providers as key partners in ensuring access for vulnerable populations. At the same time, some health plans have addressed provider shortages by establishing their own plan-operated health centers with care models designed specifically around the needs of their members.

These and other innovative strategies should be a part of an expanded dialogue as Medicaid programs continue to seek ways to ensure that beneficiaries have access to the right services at the right time. Indeed, the timing for such dialogue is now. On June 1, 2015, the Centers for Medicare and Medicaid Services (CMS) published and requested comments on proposed new regulations[1] governing a broad range of requirements under Medicaid managed care programs, including standards for ensuring network adequacy.

State and federal policy makers can also support the expansion of innovative network-enhancing strategies by reducing regulatory barriers that further inhibit network access for a population that already experiences challenges with access. Specifically, state and federal policy makers should address overly restrictive scope-of-practice policies and regulatory barriers that inhibit full implementation of tele-health and tele-outreach programs. State Medicaid programs can facilitate the delivery of highly accessible, high-quality care by finding ways to recognize access-enhancing programs and initiatives by their contracting health plans.

Network Adequacy in Today's Medicaid Program

Medicaid finances the delivery of health care services to nearly 70 million low-income children, families and adults, disabled individuals, and long-term care beneficiaries.[2] As the Medicaid population grows and states continue to face tight fiscal constraints, Medicaid programs are increasingly looking to managed care to reduce their financial risk and ensure high-quality delivery of care. As of September 2014, more than half of all Medicaid beneficiaries nationwide were enrolled in risk-based, capitated managed care organizations (MCOs).[3] This figure is even higher in states that have adopted the Medicaid expansion under the Affordable Care Act (ACA), where more than 70 percent of Medicaid enrollees are in managed care.[4]

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As states shift more beneficiaries to managed care, they are also looking for new and innovative ways to ensure that beneficiaries have access to the full array of services needed to keep them healthy. Traditional measures of "network adequacy"– including physician-to-enrollee ratios and time/distance requirements – can help assess network access and inform network development decisions. However, these measures may paint an incomplete or inaccurate picture by not reflecting other factors key to accessibility such as whether members can make appointments within a reasonable time period. Furthermore, these measures do not reflect how Medicaid managed care plans, working with their provider and state partners, can enhance network access for their members through strategies that minimize access barriers, embrace new technologies, and create incentives for providers to deliver cost-effective, patient-centered care. These strategies should be part of the evolving dialogue as Medicaid programs continue to seek ways to ensure that beneficiaries have access to the right services at the right time.

State Medicaid Programs Look to Managed Care to Provide Value

Beneficiary growth in Medicaid managed care is driven by several factors. Many states have transitioned to managed care from a fee-for-service (FFS) approach as a more efficient way to deliver Medicaid benefits and services. States have expanded managed care by adding new geographic regions (e.g., rural areas), populations (e.g., adults newly eligible under the ACA; seniors and persons with disabilities), and services (e.g., behavioral health, long term services and supports).[5] Between 2000 and 2010, enrollment in Medicaid managed care increased by 13.6 million across 36 states.[6]

Medicaid MCOs have a strong track record of delivering care that meets the highest standards of quality while increasing access for beneficiaries and producing budget savings and predictability for states. The quality advantages of Medicaid managed care are evident in multiple studies that find that Medicaid MCOs outperform Medicaid FFS on key clinical quality metrics. For example, in 2009, Virginia Medicaid MCOs demonstrated rates of women giving birth to low-weight babies were 28.6 percent and 20.6 percent lower than those experienced under FFS Medicaid and primary care case management, respectively.[7] Medicaid MCOs in California reduced the incidence of preventable hospitalizations for children and adults with disabilities by 23 percent.[8] Medicaid MCOs are also driving savings for states by controlling costs. For example, the Louisiana Bayou Health program recently reported managed care savings amounted to $29.55 per-member per-month (PMPM).[9] In Texas, after MCOs assumed risk for inpatient care in 2012, inpatient medical/surgical claims for non-dual Medicaid members receiving long-term services and supports (LTSS) decreased over the seven quarters studied, as compared with the previous FFS model.[10]

Medicaid managed care consistently outperforms commercial insurance on common metrics of member satisfaction, as measured by the Consumer Assessment of Healthcare Providers and Systems (CAHPS),[11] and also has a track record of improving access to services relative to fee-for-service or primary care case management (PCCM) models.[12] Notably, some states are beginning to work with health plans to add questions to their CAHPS survey for specialized populations and assess the results at a more granular level to drive improvement.

Current Medicaid Access Standards

CMS sets broad federal standards for access to care that all MCOs must meet to participate in a state's Medicaid program. Federal regulations are intended to ensure that each participating MCO maintains a provider network that is sufficient to provide adequate access to Medicaid services.[13] Federal guidelines for network adequacy under Medicaid managed care address the following areas:[14]

- √ Demand – anticipated Medicaid enrollment
- √ Mix – expected utilization of services
- √ Supply – numbers and types of providers needed
- √ Availability – numbers of network providers who are not accepting new Medicaid patients
- √ Geo-Access – geographic locations of providers and Medicaid enrollees
- √ Accessibility – timely access to care and services[15]
- √ Out of network coverage – if services cannot be provided in-network, services must be provided using out-of-network providers at no additional cost

Federal regulations also require that CMS review and approve all contracts that states enter into with MCOs, including provisions that incorporate standards for access to care.[16] Each state submits to CMS its quality strategy, which outlines the state's approach to ensuring not only high-quality care but also access to care.[17] Accordingly, states have developed a variety of measures and monitoring practices to translate the above categories into practice, including distance and travel time, appointment wait-time standards, provider-to-enrollee ratios, and in-office wait time standards. Within each measure, the standards vary considerably across states. See Appendix 1 for an overview of access measures that states frequently use.

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Medicaid MCOs are generally held to access-related standards that are more rigorous than those applied to Medicare and commercial markets. A 2004 GAO report found, for example, that, compared to Medicare MCOs and commercial insurers, Medicaid MCOs were held to equal or higher standards in areas such as means of transportation typically used by Medicaid enrollees, cultural competence, and physical access for people with special health care needs. When developing provider networks, Medicaid MCOs are required by federal regulation, for example, to "take into account the means of transportation – such as public transportation – that enrollees use to access health care providers."[18] Federal regulation also places specific requirements around cultural and linguistic competencies of the provider network including language spoken by the health care providers in the enrollees' service area. Medicaid regulations are more specific than Medicare and private accreditation requirements.[19]

CMS also requires states to have a monitoring and enforcement plan for compliance with access standards. In fact, federal regulations require annual program reviews to evaluate the quality, timeliness of, and access to care. States have developed a variety of strategies to assess MCO provider network compliance with access standards. Monitoring practices employed by states and MCOs generally include the following:

- √ Provider network data file reviews
- √ External quality reviews
- √ CAHPS surveys of member satisfaction
- √ State compliance tests
- √ Review of member complaints
- √ Monitoring of enrollment reports against provider capacity

Limitations of Current Access Measures

While traditional network adequacy measures and monitoring practices are an important component of ensuring access to services, Medicaid health plans continue to face unique challenges that hinder their ability to build and maintain networks. They face a complex web of state and federal regulations that govern issues such as provider billing and payment and provider scope of practice. States often develop and pay MCO capitation rates based on the state's low Medicaid FFS provider fee schedules. As a result, health plans are constrained by this underlying assumption of low provider rates when developing their own provider fee schedules, potentially affecting their ability to attract high quality providers to their networks. Indeed, physician survey data prior to ACA implementation indicated that nearly one-third of physicians were not planning to accept new Medicaid patients. Physicians in states with higher Medicaid rates were more likely to be willing to accept new Medicaid patients than states with low Medicaid physician rates.[20] A survey of Medicaid health plans ranked low payment rates as the top challenge in contracting with PCPs and specialists, with 94 percent of plans identifying it as a contracting challenge.[21]

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Provider shortages pose another significant challenge. Over 58 million Americans live in areas or belong to population groups that are classified by the federal government as primary care Health Professional Shortage Areas (HPSAs).[22] Similarly, Medicaid programs frequently experience a shortage of certain specialists and sub-specialists willing to see Medicaid patients, particularly in rural areas.

Traditional network adequacy measures have not adapted to changes in care delivery that are moving more care out of institutional settings and into home and community-based settings. Traditional network adequacy measures are also based largely on a fee-for-service model that links payment (and, therefore, access) to a patient encounter, though some states are beginning to ask health plans to propose value-based reimbursement models and assess their impact.

Medicaid Managed Care Employs Network-Enhancing Strategies

Medicaid plans utilize numerous strategies and tools to both attract and retain providers and enhance the "reach" of their provider networks. These strategies include technologies that can effectively replace some office visits and thus enhance network capacity, new delivery models that support management of the "whole patient," and the incorporation of new types of providers into their networks.

Technology-Based Innovations

One area that holds much promise for enhancing network access is the use of tele-health, which includes tele-monitoring and tele-provider services, as well as tele-outreach strategies. A growing base of evidence points to the potential of tele-health services to improve access to care by addressing some of the geographic and provider shortage issues noted above. For example, a review of two dozen studies comparing tele-psychiatry services with in-person psychiatry services found that tele-psychiatry "increases access to care, enables specialty consultation [and] yields positive outcomes…"[23] Provider shortages in psychiatry and among other types of behavioral health providers have made behavioral health one of the pioneering areas in tele-health. In Georgia, where nearly half of the counties do not have psychiatrists, the Amerigroup Georgia health plan has collaborated with the Georgia Partnership for TeleHealth (GPT) to expand access to behavioral health and other health care services through tele-health. When specialists are unavailable in a member's community, the member's provider or an Amerigroup Care Manager can schedule an appointment at one of GPT's "presentation sites" located throughout the state, often within 30 miles of the member's home. At these sites, members can engage with physicians using real-time video conferencing and other devices that support remote consults. From 2011 to 2014, the number of Amerigroup members receiving behavioral health services through tele-health grew from 167 to 2,105 (approximately 1,260 percent).[24]

Tele-health has also demonstrated its ability to increase access to medical sub-specialties, some of which are in extremely short supply in certain, particularly rural, regions. These programs utilize tele-health technology to bring some specialty services into the primary care setting for specialty consults and provider training. Project ECHO, for example, utilizes tele-health technology to connect primary care providers in rural areas with academic specialists.[25] The Health Plan of San Joaquin (CA) developed a tele-dermatology program to address severe shortages in this specialty (only one dermatologist in the county was taking new Medicaid patients, and appointment wait times were in excess of 90 days).[26]

Under the program, the patient's PCP conducts an exam and takes photos that are e-mailed to the consulting dermatologist. The program is credited with greatly reducing wait times for dermatology services and producing cost savings as well. In Los Angeles County, L.A. Care has significantly improved access to specialists for its members through its web-based "eConsult" program. These models have proven effective both in minimizing access barriers for the patient (who doesn't have to travel to a specialist's office or endure lengthy appointment wait times) and in freeing up specialist access for higher-intensity services.

Tele-monitoring has also shown promise as a mechanism for improving access and reducing barriers to care by supporting patient self-management in the home. Tele-monitoring may include video consultations with a provider, remote measurement of vital signs, or phone-based check-ups of physical and mental well-being. A growing number of states are recognizing the value of tele-monitoring services for the Medicaid population. For example, Illinois includes coverage of tele-monitoring as a value-added service for plans serving seniors and persons with disabilities.[27] The Texas Medicaid program recently revised its standard MCO contract to include a requirement that all plans be able to accept and process claims for tele-monitoring and tele-health services.[28] Health plans are also partnering with providers of home and community-based services (HCBS), to introduce tele-health as a way to support home-based care options for members.

Leveraging Technology to Increase Access to Specialists: The eConsult Model

Faced with a patient population that had complex care needs but a limited supply of specialists who were willing and able to serve their members, L.A. Care, a Medicaid health plan serving the Los Angeles area, turned to a technology-based solution: eConsult. Piloted in 2009, eConsult allows primary care providers (PCPs) to consult with a specialist using a web-based platform, thereby eliminating the need for many specialty referrals. Specialists typically reply to requests from primary care physicians within 24-48 hours. The PCP serves as the intermediary, following up with the patient regarding next steps and treatment or referring if necessary.

Initial results from the pilot were promising and included improved communication between providers and a reduced need for hard-to-schedule specialty visits. The pilot also demonstrated the need for common referral protocols and guidelines to ensure that limited specialty resources were being used as efficiently as possible.[1] In addition, by helping specialists limit office visits to patients who truly need face-to-face communication, the program avoids overwhelming the specialist's time and makes them more willing to participate.[2]

As of 2013, L.A. Care had expanded eConsult to include 1,700 providers at 132 locations across 26 specialty areas.[3] L.A. Care is working with the Los Angeles County Department of Health Services and several local provider organizations to develop a single eConsult platform for Los Angeles clinics.[4] Other health plans and providers are rapidly adopting eConsult or similar programs as part of a strategy to ensure access to specialty care, especially as the implementation of the Medicaid expansion in many states strains already limited specialty care services.

1. Blue Shield Foundation. Mission Possible: Implementing eConsult in the Los Angeles County Health-care System. April 2013.
2. Association for Community Affiliated Health Plans. Ensuring Access Through Strong Provider Networks. 2013.
3. Ibid.
4. http://www.econsultla.com/about/background-and-history (Accessed May 12, 2015).

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While currently focused largely on the commercial population, a recent study found that mobile device technologies hold tremendous potential for the Medicaid population, given access barriers such as lack of paid time off for medical appointments.[29] For example, Molina recently partnered with CHI Franciscan Health in Washington State to provide 24/7 "Virtual Urgent Care" services via phone, webcam, smartphone, tablet or PC to an estimated 16,000 Medicaid members.[30] A similar model – LiveHealth Online – provides 24/7 virtual access to a provider via live two-way video for non-emergent issues.[31] A LiveHealth Online visit costs the same or less than a primary care office visit. Medicaid health plans have also developed member outreach strategies that leverage mobile technology to provide education on chronic conditions, to send preventive screening reminders, and to consult with members who have not filled critical prescriptions in a timely manner.

Despite the growing body of evidence to support the use of tele-health, use varies considerably from state to state, and the practice as a whole has grown at a slower rate than many predicted. One challenge to the expansion of tele-health and tele-monitoring is state regulations and payment methodologies not keeping pace with changes in technology. For example, in Tennessee, a patient must visit a provider in person before the provider can write a prescription via a tele-medicine visit, and in some states, the tele-medicine provider cannot write a prescription unless she or he is licensed in the state under which the member is covered. These rules, designed to ensure quality, are outdated because simple solutions can address basic quality of care concerns. Industry analysts predict that much of the growth in the use of telemedicine will be driven by new payment and delivery system models, such as accountable care organizations (ACOs), which reward providers for quality and value rather than the quantity of face-to-face patient interactions. This creates strong incentives for plans and providers to care for patients in the most efficient way. In many cases, tele-medicine is equally effective and less expensive than in-person care. Regulatory barriers remain a significant obstacle in some states, however, as each state employs its own requirements with respect to allowable provider types, patient and provider settings, distance or geography requirements, state licensure requirements, and other factors. Federal regulation has also, in some cases, limited the ability of plans to leverage mobile technology for member outreach purposes, by requiring these calls to be categorized as "telemarketing" rather than tools for engaging and educating existing members about their health.[32]

Care Delivery and Payment Innovations to Support Provider Collaboration

How care is delivered in the Medicaid program is changing more rapidly than any other time in the program's history. The rapid pace has been driven by multiple factors, including:

- Growing evidence about the components of effective medical homes,[33] health homes, and care coordination models.
- Expanded availability of data and tools to support population health management,[34] care management, and patient care.
- New service delivery models, such as ACOs, that provide integrated, population-focused services for patients.
- Innovative payment models that align with the goals of patient access, quality of care, and outcomes rather than quantity of care.

These and other factors are contributing to new care delivery models that are uniquely structured to meet the needs of the Medicaid population by enhancing access and reducing traditional barriers to care. In fact, these programs are especially effective with providers that treat large numbers of Medicaid patients; many have worked with Medicaid MCOs to develop effective, culturally sensitive systems of care. Medicaid MCOs are leaders and key partners across a range of innovative approaches. For example:

Medical homes, care coordination and practice transformation. Medical homes can enhance provider networks through team-based care, care coordination, and population management. A growing body of evidence demonstrates the potential of high-functioning medical homes to substantially enhance patient access to primary care provider services through effective care management as well as through the provision of non-face-to-face services.[35] "Practice transformation" – the critical change process that underlies the development of an effective medical home – is a time- and resource-intensive activity that encompasses every facet of the practice. Medicaid MCOs are increasingly taking an active role in supporting practice transformation, especially for smaller practices that may lack the resources to achieve transformation on their own.[36] For example, CareOregon has facilitated learning collaboratives to help network providers learn from each other about practice transformation.[37] It also offers "System Innovation Grants" to encourage providers to engage in transformative change and quality improvement.[38] In other instances, MCOs have partnered with their network providers to supplement clinical staff in providing and coordinating care for particularly complex members. HealthPartners of Minnesota places clinical teams at institutional and day facilities with high concentrations of Medicaid members with complex medical, mental health, and social needs. These teams work with clinical and non-clinical staff on the ground to provide and coordinate primary, urgent, and behavioral health care.[39]

Data-driven care. Medicaid MCOs have developed data-driven strategies for ensuring that members receive preventive services as well as recommended routine care for chronic conditions. Gateway Health Plan of Pennsylvania continuously reviews member data and sends specialized alerts to its care management team to arrange preventive care for members who are overdue for a preventive service.[40] Anthem's affiliated health plans' "Clinic Days" program goes even further, working with network providers to block out appointment time for members with identified care gaps and coordinating transportation for members who need it.[41]

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Integrated service delivery models. As evidence mounts about the importance of integrating services across the care continuum, particularly for individuals with multiple, complex conditions, Medicaid MCOs have become catalysts in breaking down silos characteristic of the traditional FFS system. Strategies include integrated behavioral health models that embed behavioral health specialists in the primary care setting and ACOs. ACOs are provider-based organizations that are held accountable for the quality and cost of care provided to a defined population. ACOs are becoming increasingly common in the commercial and Medicare markets and are beginning to make inroads with state Medicaid programs, often supported by Medicaid MCOs.

Recognizing the need to identify behavioral health symptoms early on in order to reduce acute utilization and improve health outcomes, Anthem affiliated health plans initiated a program called the Primary Care Integrated Screening, Identification, Treatment, and Evaluation of depression and substance use disorders (PC-INSITE). The model is based on the evidence-based IMPACT model developed by psychiatrists at the University of Washington. PC-INSITE embeds a behavioral health provider in the PCP's office. Working with typically larger primary care practices, a behavioral health coach (licensed clinical social worker, psychologist, marriage and family therapist) is located in the primary care clinic to carry out universal screenings on members using both the PHQ9 (depression) and a modified Audit C (alcohol and illegal drug use, as well as potential prescription drug abuse). Systematic monitoring and follow-up includes re-administering the PHQ9 to evaluate changes and adjusting the intervention plan based on that response (stepped-care). This integrated care program is currently underway in clinics in Maryland, Tennessee, Texas, and California.[42]

Value-based payment. Payment models that align with and support care delivery innovations are critical to enhancing network access and overall capacity. Pay-for-performance (P4P) models, for example, can reward provider improvements in quality, operational efficiency, and/or reductions in medically unnecessary utilization and costs. Currently, 63 percent of Medicaid members in Anthem's affiliated health plans are served under a provider incentive payment model.[43] Shared savings or capitation models similarly create strong incentives for providers to maximize the value in service utilization and quality of service provided within the provider network. Medicaid programs are increasingly looking to managed care to shift a greater share of payments into value-based methodologies. MCOs participating in New York's Medicaid program, for example, have committed to moving 90 percent of payments to value-based methodologies over the next five years.[44] Similarly, Medicaid MCOs report that providers are increasingly looking for value-based payment options in their contracts as a means to increase Medicaid revenues and align reimbursement incentives with quality improvement activities, making value-based payment an important tool that MCOs

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bring to network development. Anthem plans may reward high-performing, high-quality primary care practices by auto-assigning members to them who do not make a PCP selection, which increases the size of their member panels.[45] Anthem's affiliated health plans are also offering after-hours payment incentives to smaller PCP practices to improve appointment availability and overall network capacity within the existing network.[46] Also, the Amerigroup Tennesee health plan introduced the Cherokee Model in east Tennessee in January 2015 to provide enhanced reimbursement to fully integrated behavioral health tele-health programs.[47] Value-based payment is also becoming increasingly important within Medicaidmanaged long-term care programs. Some states have added specific access standards to managed care contracts for LTSS, and health plans are increasingly offering incentive programs to attract and drive quality improvement among these providers.

Boosting provider network quality and member access. Medicaid MCOs have also adopted other innovative models with potential to enhance access to quality providers and services, such as integrated care teams for LTSS, centers of excellence, and customized networks of high-value providers. About half of all states now offer long-term services and supports under Medicaid managed care contracts,[48] which by federal rule requires the use of integrated care teams to coordinate provider services to render member care. The integrated care team is an interdisciplinary approach to care to maximize provider cross-communications and quality of care, making the most of limited resources for members who require a more intense level of service. The care management departments of Medicaid MCOs manage the work of the integrated care team.

Many Medicaid MCOs locate specialty provider organizations in their network that have developed standards of care for members with rare and expensive medical conditions such as HIV/AIDs, hemophilia, and cystic fibrosis. For example, Hemophilia Treatment Centers (HTCs) offer comprehensive, multi-disciplinary hemophilia services; their providers are trained to manage the care of individuals with hemophilia to prevent complications.[49] The Hemophilia Center of Western Pennsylvania contracts with four Medicaid health plans to provide comprehensive medical, nursing, and psychosocial services to individuals with hemophilia and other bleeding and clotting disorders. It is a designated provider for UPMC for You, a Medicaid managed care plan in the state.[50] In addition to HTCs, Medicaid MCOs contract with hospital-based Centers of Excellence to ensure access for members with special needs such as children with autism, individuals with HIV or AIDs, and individuals with cystic fibrosis. In Tennessee's Medicaid managed care program, known as TennCare, Medicaid plans are required to contract with designated Centers of Excellence for HIV/AIDS to maximize access to comprehensive HIV care and supportive services.[51] Medicaid MCOs may also offer specialized health benefit plans. For example, Simply Healthcare Plans operate a comprehensive Medicaid specialty plan for individuals living with HIV and AIDS in Florida, targeting underserved Latinos and African Americans in urban communities.[52]

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Physician Extenders and Non-Traditional Providers

As noted above, national provider shortages remain a significant concern in the Medicaid program. Yet there are numerous examples around the country of strategies employed by Medicaid plans, working with state, provider, and community partners, to overcome acute shortages of providers. While the strategies vary, they share several key features:

Support for providers working "at the top of their license and training." Physician extenders, including physician assistants (PAs), nurse practitioners (NPs), advanced practice nurses (APNs), and certified nurse midwives (CNMs), can help extend the reach and efficiency of a provider network by increasing the supply of primary care and specialty providers and by optimizing the clinical time of the physician. Studies have found that models that incorporate physician extenders are more productive.[53] Many health plans have embraced the important role that nurse practitioners and physician assistants play in the Medicaid program by credentialing these providers as PCPs in states that allow it. A 2010 survey found that 25 of the 35 states surveyed allow nurse practitioners to be defined as a PCP.[54] A recent survey of 31 safety net health plans found that the vast majority (27 of 31, or 87 percent) of credentialed nurse practitioners are counted as PCPs in their networks.[55]

The CareMore model in Memphis, Tennessee, relies on physician extenders to address the care needs of its more medically complex members. Clinicians referred to as "extensivists" assume responsibility for the most ill and frail members, while physician extenders provide care for members with less complex needs. An array of enabling service providers, including pharmacists, nutritionists, and social service professionals, expand and coordinate care across the full care continuum.[56]

Plan-Operated Clinics: The CareMore Model

As states increasingly rely on Medicaid MCOs to manage the care of more members, and more complex patients, several plans have entered the realm of direct medical services as a strategy to help ensure access to high-quality care.

The CareMore program,[1] rooted in the philosophy of providing coordinated care for the chronically ill and frail, employs a care model built to identify the causes of decline in health and then create programs to manage and even stop health decline, returning patients to a healthy (or healthier) status. Seeking more innovative ways to manage the needs of its Medicaid members, Amerigroup of Tennessee has partnered with CareMore to open three neighborhood care centers in Memphis under its CareMore Essentials program. Using a multi-disciplinary set of clinical and non-clinical providers, these holistic centers offer the full continuum of clinical care including primary care and behavioral health, lab services, self-management courses and group care, and access to social services. The CareMore model emphasizes equal attention to the medical, social, psychological and pharmacological needs of the patient. The model improves members' access to care by incorporating a number of innovative practices:

- Deploys clinicians ("Extensivists") who assume responsibility for the most ill and frail patients and manage the complete medical event from acute to sub-acute to clinic to home utilizing the same multi-disciplinary care team, promoting continuity of care.
- Coordinates care in the hospital, in long-term care facilities, and with other providers.
- Offers support services including transportation, home care, and remote monitoring.
- Employs cultural and lingual competency requirements for clinicians and multi-lingual materials at centers.
- Offers extended hours of facilities (after-hours and weekend) for individuals whose employment or other circumstances make it difficult or impossible to come to appointments during normal working hours.
- Uses physician extenders, pharmacists, nutritionists, and social service professionals.
- Utilizes existing network to build up provider base of care centers, which has created an expanded and coordinated care network for patients.

Early findings from the CareMore Essentials program, which launched in January 2015, indicate high member satisfaction and promising results with respect to patient outcomes and quality. The model has also proven to be an effective provider recruitment tool, as they value the extensive wrap around supports provided for members in the CareMore health centers.

1. The Care More Model. PowerPoint presentation, February 2015, and HMA interview with CareMore subject matter experts, April 27, 2015

Similarly, medication therapy management (MTM) programs utilize the expertise of pharmacists, working in close coordination with other members of the care team, to help patients achieve optimal benefits from their medication therapy, better manage chronic conditions, and avoid medication-related problems. MTM programs have demonstrated impressive results from a cost-perspective (primarily because of reduced hospitalizations and adverse drug events) and from a clinical outcomes perspective (primarily because of better compliance with prescribed therapies).[57] The value of MTM programs can be particularly strong in the Medicaid program, where educational, economic, cultural, and transportation barriers often negatively impact adherence to medication therapies. In 2012, CareSource, Ohio's largest Medicaid MCO, implemented a MTM program that reimburses pharmacists to manage member medication routines. Members who are enrolled in the program receive a medication review by a pharmacist to analyze their complete medication list. The member may also receive targeted interventions, such as education about their condition and medication regimen, medication compliance monitoring, and increased prescriber contact. An analysis of the program found a strongly positive rate of return on investment of 8:1 when unnecessary ER and provider office visits were taken into account.[58]

To address shortages of specialists, particularly in rural areas, programs such as Project ECHO train primary care providers to provide lower-level specialty services – often supported through tele-health consults with a consulting specialist as needed – to reduce the need for some specialty visits. In 2012, Project ECHO was a recipient of an $8.5 million federal Innovation grant from CMS to further enhance and test the model by incorporating "outpatient intensivist teams" funded by multiple Medicaid MCOs. This new type of primary care clinical team cares for patients with complex medical, behavioral, and social needs at provider sites located around New Mexico.[59]

Support for patient care delivered in non-traditional settings. Originally developed as a cash-only, convenient alternative to overcrowded emergency rooms or urgent care centers, retail clinics have grown rapidly to become an important part of the delivery system. Retail clinics initially sought contracts with commercial carriers, which offered higher reimbursement rates and fewer administrative requirements.[60] Medicaid health plans are increasingly contracting with and integrating retail clinics into their provider networks as a relatively low-cost (most retail clinics are staffed by mid-level providers with physician oversight), convenient option (most retail clinics do not require an appointment and are open evenings and weekends) for their members.[61]

Medicaid programs are also looking at ways to redefine the traditional patient visit to improve the patient experience and maximize the value of the time spent in the provider's office. Health plans actively support the CenteringPregnancy model, a model that includes health assessment, patient education, and support for pregnant women in a group setting facilitated by a provider.[62] While CenteringPregnancy has demonstrated positive results with respect to patient outcomes and satisfaction, it also has a direct and positive impact on clinical capacity by making more efficient use of staff and freeing up exam rooms.[63]

If it doesn't exist, build it. As Medicaid managed care enrollment grows and states turn to MCOs to manage the care of increasingly complex populations, some plans have met the network challenges described above head on by building their own clinical capacity. Plans report that they build clinics to address a specific identified provider shortage in a geographic area. For example, CareOregon has opened and operated multiple clinics in areas where geo mapping and other information flagged need. These clinics are often co-located with a mental health clinic.[64] In other instances, the unique, complex needs of the patient population (or a sub-set of the population) called for an intensive, integrated model of care that did not exist in the community. This was one of the driving factors behind the CareMore Essentials program. In other instances, health plans have supported existing providers that needed an infusion of capital to be able to meet the access demands of a growing and changing patient population. In addition to reporting positive results with respect to patient outcomes and satisfaction, health plans have also found that plan-operated health centers – by offering an employed model with extensive patient enabling services – can be an attractive option for providers who previously may have been unwilling to practice in a certain geographic area or serve a predominantly Medicaid population.

Beyond the Numbers–Policy Considerations

As states increasingly look to risk-based managed care to serve Medicaid beneficiaries, including complex populations such as the disabled, traditional measures of "network adequacy" paint an incomplete picture. They do not capture the ways many Medicaid MCOs enhance network access through a variety of innovative strategies. These strategies embrace and support a care delivery model that is built around quality and value rather than volume. They are aimed at addressing core barriers that have historically impeded access to care under Medicaid fee-for-service programs. These strategies include:

- New ways of working with and paying providers to create incentives to promote team-based, population-focused care.
- Support for non-traditional providers, physician extenders, and patient access models, such as group visits or plan-operated health centers.
- Strategies for ensuring that members get maximum value from providers empowered to work at the top of their license and training.
- Use of technology to leverage provider access and expertise and improve convenience for members.

State and federal policy makers can support the expansion of innovative managed care strategies by reducing regulatory barriers that inhibit network access.

State and federal policy makers can support the expansion of these and other strategies by reducing regulatory barriers that inhibit network access. Barriers include overly restrictive scope-of-practice requirements and provider credentialing requirements that limit the ability of mid-level providers to practice at the top of their license and education, as well as reimbursement, provider enrollment, and federal communications requirements that inhibit full implementation of tele-health and tele-outreach programs.

While current network adequacy standards are necessary and provide a common framework for measuring network supply across plans and states, not all networks of equal size are created equal. The recently published Medicaid managed care proposed regulations presented an opportunity for plans, states, and other stakeholders to provide comments on network adequacy standards and metrics. State Medicaid policy makers can also contribute to the development of a broader network adequacy framework by finding ways to recognize access-enhancing programs and initiatives. Terms and conditions for MCO procurements, auto-assignment methodologies that assign beneficiaries to plans, and state payment incentive policies are a few of the ways state Medicaid programs have adapted advances in medical practice to improve provider access under Medicaid managed care.

These actions are a critical first step toward broadening the dialogue around how network adequacy is defined in a time when the delivery system is rapidly moving from volume to value-based care. Regulatory flexibility and policies that recognize health plan innovation will support MCO efforts to expand and enhance provider networks and go a long way toward creating an environment where these innovations can grow to scale.

Appendix: Summary of State Network Adequacy Measures[65]

	Definition	States that have adopted[66]	Example of metric	Notes
Distance and travel time	Limit the distance or time enrollees should have to travel to see a primary care provider (PCP).	32 states (97%)	Maximum distance to a PCP range from 5 miles to (2 states) to 60 miles (3 states).	Slightly more than half of the surveyed states have standards that also apply to specialists, where the requirements again vary widely. Slightly less than half of the states have a different set of standards for urban and rural areas.
Appointment wait-times	Access standards that set the maximum number of days an enrollee should have to wait to see a provider.	31 states (94%)	Nebraska has created access standards for prenatal appointments that include requirements for initial prenatal visits – 14 days in first trimester, 7 days in second trimester, and 3 days for a high-risk pregnancy.	The 31 states have all established standards for PCPs, for both routine-care and urgent-care appointments. Specialist standards are not as restrictive, with only 21 states adopting wait-time maximums.
Provider-enrollee ratios	Standards that set the minimum for the ratio of PCPs to enrollees.	20 states (61%)	In New York, MCOs must ensure 1 PCP for every 1,500 enrollees, and 1 Nurse Practitioner for every 1,000 enrollees. Illinois requires plans to ensure a network of 1 OB per 300 pregnant enrollees and 1 women's health provider per 2,000 female enrollees.	The standards vary across the states, ranging from 1:100 to 1:2,500 enrollees. States also have a variety of sub-measures to establiash appropriate network size.[67] Only four states require plans to have a minimum number of specialists in relation to enrollees.

	Definition	States that have adopted[66]	Example of metric	Notes
In-office wait time	Standard that limits the time that Medicaid beneficiaries can wait in an office before being seen by the provider.	11 states (33%)		Some states accompany this standard by limiting the number of appointments a practice may schedule in an hour.
Access to multi-lingual care	Provide enrollees with access to interpreter services or multilingual providers.	6 states (19%)	D.C. MCOs are required to provide non-English-speaking enrollees with access to free interpreters during appointments.	
Twenty-four hour telephone access	Require enrollees to be connected to providers 24/7.	6 states (19%)		
Access-related performance measures	Evaluate network adequacy through contractual performance metrics.	1 state (3%)	Ohio not only uses HEDIS requirements in its MCO contracts but also to establish standards for pediatric access to PCPs.	State requires 83 percent of enrollees 1 to 19 years old to have a primary care visit in the previous year.

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