Issue Brief

CMS Proposed Regulation on Medicaid Managed Care – 6/1/2015

Background

On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) issued a proposed regulation intended to modernize existing Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems.[1] Specifically, CMS seeks to align the Medicaid managed care requirements with those of other regulatory structures such as those imposed on Qualified Health Plans offered inside and outside of the health insurance marketplace, and those used under the Medicare Advantage program.

Managed care has become an increasingly popular vehicle for states to use in delivering the Medicaid package of benefits. According to the Medicare and CHIP Payment and Access Commission, as of 2014, 48 percent of adults and more than 63 percent of children covered by Medicaid were enrolled in a comprehensive managed care plan.[2] Managed care plans also administered limited portions of the Medicaid benefit for additional enrollees, making it the predominant means through which Medicaid beneficiaries receive their benefit.

Medicaid is the single most important payer for birth in the US. States are required to provide Medicaid coverage to pregnant women with income at or below 138 percent of the federal poverty level (FPL) and many states have more generous income eligibility standards, with the median being 200 percent of the FPL and ranging as high as 380 percent.[3] As of 2013, Medicaid covered 44 percent of all births, although the percentage among states ranges from 24 to 67 percent.[4]

The proposed rule covers a number of issues related to operation of a managed care program, however, a single topic covered in the regulation is of critical interest to certified nurse-midwives (CNMs) and certified midwives (CMs). That topic is a set of new provisions related to the adequacy of plans' provider networks.

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[1] 80 FR 31098. See: http://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf

[2] See: https://www.macpac.gov/publication/percentage-of-medicaid-enrollees-in-managed-care-by-state-and-eligibility-group/

[3] See the Kaiser Family Foundation analysis of CMS data, available at: http://kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/

[4] CDC/NCHS, National Vital Statistics System and Markus, et. al., "Medicaid Covered Births, 2008 to 2010, in the Context of the Implementation of Health Reform," Women's Health Issues, vol. 23, issue 5, e273-e280.

Provider Network Adequacy

In 2014, the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) conducted an analysis of state standards for access to care in Medicaid managed care programs.[5] The OIG concluded that state standards varied widely. For example, standards for access to primary care ranged from 1 primary care provider for 100 enrollees to 1 primary care provider for every 2,500 enrollees. Further, standards are not specific to certain types of providers or areas of the state and different strategies are used to assess compliance with access standards. In its proposed regulation, CMS seeks to respond to specific OIG recommendations for strengthening Medicaid managed care networks.

The specific proposals related to provider network adequacy in this regulation include:

- Each state must ensure that all services covered under the state plan are available and accessible to plan enrollees in a timely manner.
- Provider networks must meet standards established by the state.
- State network adequacy standards must include time and distance standards for:
    - OB/GYNs
    - Behavioral health providers
    - Adult and pediatric specialists
    - Hospitals
    - Pharmacies
    - Pediatric dental providers
    - Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS.

  Note that "time and distance standards" refers to requirements that the plan ensure providers of these types are available within specified times and distances for the expected population of enrollees.
- Network adequacy standards must apply to all plan service area geographies, although states are permitted to have varying standards for the same provider type based on geography.
- In developing network adequacy standards, states must consider:
    - anticipated Medicaid enrollment;
    - expected utilization of services;
    - characteristics and health care needs of specific Medicaid populations covered by the plan;
    - the numbers and types (in terms of training, experience, and specialization) of network health care professionals required to furnish the contracted Medicaid services;
    - the numbers of network health care professionals who are not accepting new Medicaid patients;

[5] See: http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf

    - the geographic location of health care professionals and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees;
    - the ability of health care professionals to communicate with limited English proficient enrollees in their preferred language; and
    - the ability of healthcare professionals to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.
- States may permit exceptions to the provider network adequacy standards. CMS will evaluate potential exceptions based on whether they are:
    - specified in the plan contract; and
    - based, at a minimum, on the number of health care professionals in that specialty practicing in the plan's service area.
- States that grant an exception to network adequacy standards must monitor enrollee access to that provider type on an ongoing basis and report their findings to CMS.
- States must publish the network adequacy standards on their Web sites and make them available upon request in other formats to enrollees with disabilities.
- Each managed care plan must:
    - Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.
    - Provide female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.
    - Provide for a second opinion from a qualified health care professional within the provider network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.
    - If the provider network is unable to provide necessary services, the plan must adequately and timely cover these services out of network.
    - Require out-of-network providers to coordinate with the plan for payment and ensure the cost to the enrollee is no greater than it would be if the services were furnished within the network.
    - Demonstrate that its network providers are properly.
- States must ensure that their contracts with managed care plans:
    - Require plans to meet standards for timely access to care and services, taking into account the urgency of the need for services.
    - Ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
    - Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

- Establish mechanisms to ensure compliance by network providers.
- Monitor network providers regularly to determine compliance.
- Take corrective action if there is a failure to comply by a network provider.
- Plans participate in state efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
- Plans ensure network providers provide physical access, accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

Notably, in its discussion of the proposed provisions, CMS points to network adequacy requirements under the Medicare Advantage (MA) program, as well as those for Qualified Health Plans (QHPs) offered through the health insurance marketplace. Using these programs as models, however, is somewhat problematic from ACNM's perspective. These programs define their benefits as certain types of services, which may be delivered by a range of provider types. The Medicaid statute differs somewhat in that it requires coverage of the services of specified provider types, notably CNMs and birth centers.[6]

Next Steps

Comments are due to CMS on July 27. In its comments, ACNM will note this distinction and request modifications to make it clear that plans must cover the services of both CNMs and birth centers and may not substitute in their stead the services of other provider types. Further, we will offer information to CMS regarding the fact that CNMs/CMs are attending a high proportion of births in several states and thus should be included in the list of providers for whom time and distance standards must be developed.

Unfortunately, CMS made no proposals with regard to regulation of birth center services, which became a required Medicaid benefit in March 2010. Final regulations can only reflect topics addressed in the proposal, so while we cannot expect CMS to include birth center regulations in the final version of these regulations, ACNM will take this opportunity to highlight, again, the need for regulation on this important topic.

[6] See Section 1905(a)(17) and (28), at: http://www.ssa.gov/OP_Home/ssact/title19/1905.htm