MCO Provider Network Management

MCAC Access Subcommittee Meeting

Wednesday, January 13, 2021

9:30 a.m. – 11:30 a.m.

Agenda

I. What is the 21st Century Cures Act?

II. What is Network Adequacy

III. Provider Network

IV. Network Adequacy Requirements

V. MCO Contacts

VI. References

What is the 21st Century Cures Act?

21st Century Cures Act: Screening and Enrollment of Managed Care Network Providers

- States must and enroll and (revalidate) all network providers of managed care plans in accordance with Medicaid FFS screening and enrollment requirements.

- This does not obligate network providers to render services to Medicaid FFS Enrollees.

- Section 5005(b)(2) of the 21st Century Cures Act extends the Medicaid FFS screening and enrollment requirements from section 1902(kk) of the Act of Medicaid Managed Care under Section 1932(d) of the Act **effective January 1, 2018.**

What is Network Adequacy?

Network Adequacy

Network adequacy refers to a health plan's ability to deliver the services promised by providing access to in-network primary care and specialty physicians, and all health care services included under the terms of the MCO contract.

In order to strengthen access to services in a Managed Care network, CMS has required all states to establish network adequacy standards in Medicaid Managed Care for key types of providers, while leaving states the flexibility to set the actual standards.

Network Adequacy

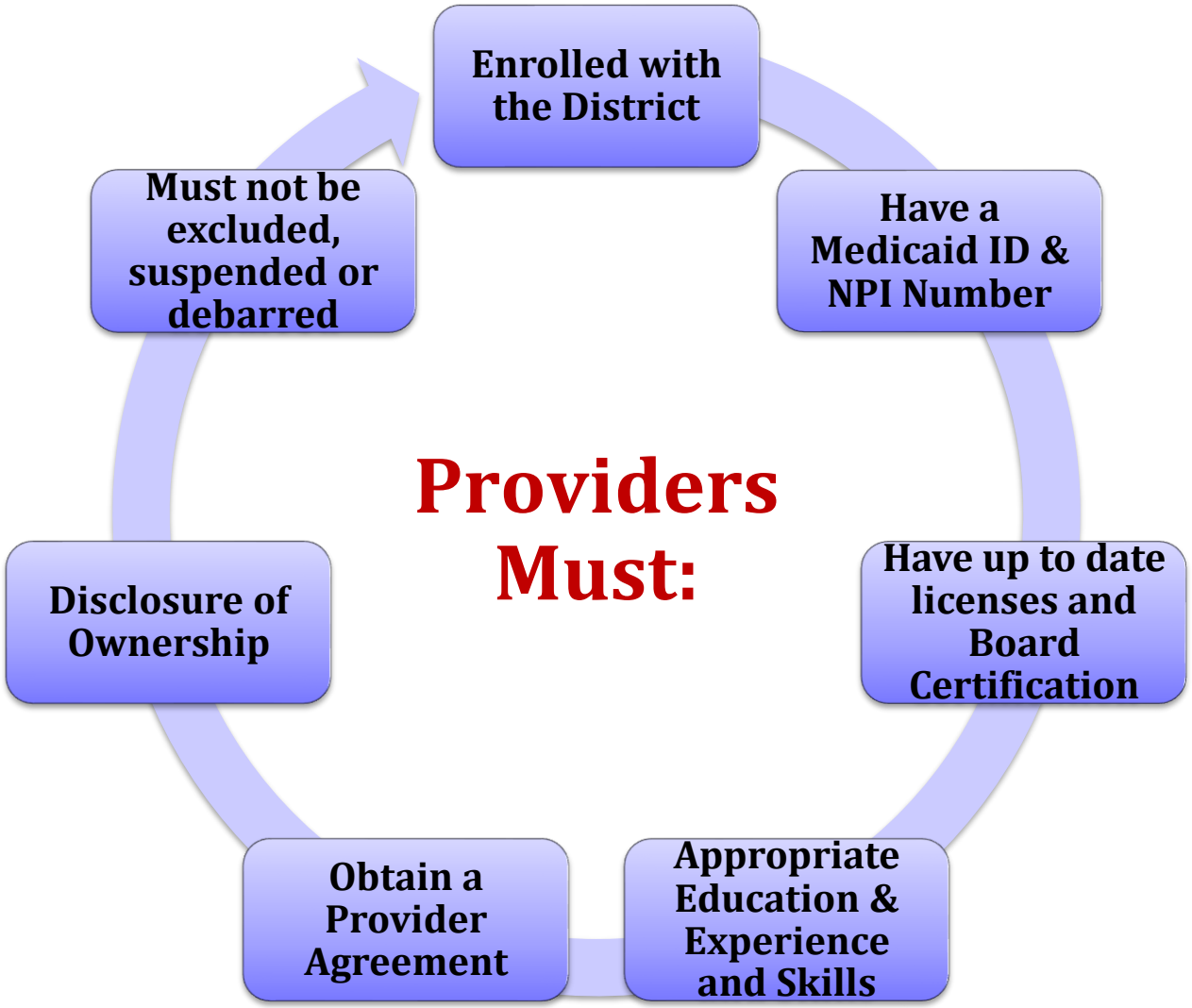
DHCF Division of Managed Care has developed the Network Adequacy Standard for the Managed Care Organizations and is waiting for final approval. Upon approval, the Standards will be posted to the DHCF website.

The Managed Care Contract will also be available on the DHCF website.

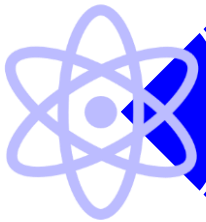
8 Required Provider Types

- Primary Care
- Specialty
- Behavioral Health
- OB/GYN
- Hospital
- Pharmacy
- Pediatric Dental
- Long-Term Services & Support

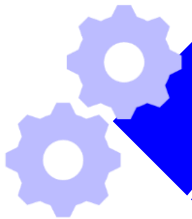
Provider Network


Providers Must:
Enrolled with the District
Have a Medicaid ID & NPI Number
Have up to date licenses and Board Certification
Appropriate Education & Experience and Skills
Obtain a Provider Agreement
Disclosure of Ownership
Must not be excluded, suspended or debarred

MCO Responsibilities



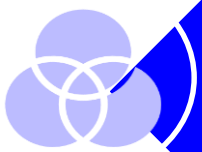
The MCO must have written guidelines and procedures to ensure Enrollees are provided Covered Services without regard to race, color, gender, creed, or religion.



The MCO network of providers must have a sufficient number and variety of provider types to provide covered services to meet the needs of the enrollees.

On a quarterly basis, the MCO will analyze the composition of its network and, based upon the health status and needs of its Enrollees, identify any gaps or areas requiring improvement.

MCO Responsibilities



The MCO considered the cultural practices and beliefs related to the health care of the persons they serve, and whether they effectively serve Enrollees from various cultures.

The ability of Network Providers to communicate with Enrollees who have limited English proficiency in their preferred language.

The MCO submit on quarterly basis the GeoAccess reports which will address each provider type included in (Mileage and Time Standards).

Credentialing Process

Be	Have	Contact	Submit	Be
Provider must **be** enrolled with the District.	Provider must **have** an NPI#, Medicaid ID#, Tax ID# and SS#.	Provider will **contact** the Director of Provider Relations for each health plan and express interest in joining their network.	All Providers must **submit** a signed/dated application and an attestation/ release form.	Applications must **be** filled out correctly, completely and must be legible.

- The MCO will ensure that the Provider credentialing process is completed within one hundred twenty (120) days upon receipt of all required documents.

- The MCO must give a status update notifying the Provider where they are in the credentialing process.

- The Provider must submit an updated Disclosure of Ownership as referenced in **42 C.F.R. § 455.104**.

- A Provider must not be excluded, suspended or debarred from participating in any District, State, or Federal health care benefit program.

Network Adequacy Requirements

4 Access Standards Requirements

- Time & Distance Standards
- Timely Access Standards
  (i.e. Appointment Wait Times)
- Provider to Enrollee Ratio
- Language and Cultural Competency Accessibility

Appointment Wait Time Standards

Provider Type	Appointment Type	Wait Time
Primary Care	New Enrollee Appointment Routine Appointment Well – Health for Adults 21+ Non-Urgent Referrals Diagnosis and Treatment of Health Condition (*not urgent*)	45 days of enrollment 30 days of Enrollee Request 30 days 30 days 30 days
Specialists	Non-Urgent Referral	30 days
Pediatrics (EPSDT)	New Enrollee Appointment EPSDT Examination IDEA IDEA Treatment	60 days 30 days 30 days 25 days with IFSP

Secret Shopper

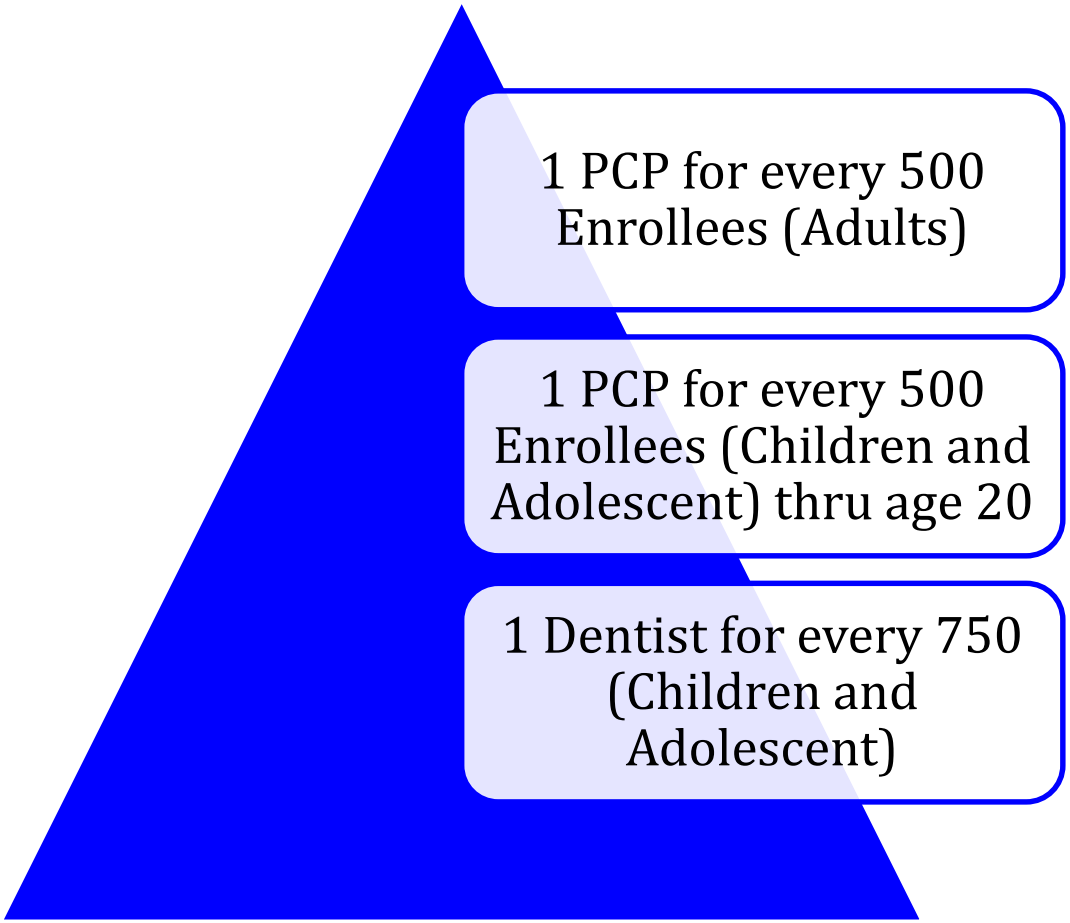
The MCO will conduct Secret Shopper activities, including test-calls and site-visits, to assess the following:

The MCOs has sufficient PCPs, Specialty Care, hospitals, mental health and dental providers in their network in order to adequately serve its Medicaid and Alliance Enrollees.

The MCOs has a sufficient provider network to offer Enrollees choice among providers.

The Enrollees are able to obtain referrals to specialists

Provider to Enrollee Ratio



MCO Contact

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- **MedStar Family Choice**
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DHCF Contact Information

Contact Information

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References

References:
Code of Federal Regulations

- 42 CFR § 438.6 - Special Contract Provisions Related to Payment
- 42 CFR § 438.10 - General Information Requirements
- 42 CFR § 438.12 - Provider discrimination prohibited
- 42 CFR § 438.66 - State Monitoring Requirements
- 42 CFR § 438.68 - Network Adequacy Standards
- 42 CFR § 438.102 - Provider-Enrollee Communications
- 42 CFR § 438.206 - Availability of Services
- 42 CFR § 438.207 - Assurances of Adequate Capacity and Services
- 42 CFR § 438.214 - Provider Selection
- 42 CFR § 438.700 - Basis for Imposition of Sanctions
- 42 CFR § 438.702 - Types of Intermediate Sanctions
- 45 CFR § 156.230 - Network Adequacy Standards

References: MCO Contract Language

- C.5.29.2 Network Composition
- C.5.29.15 Capacity to Serve Enrollees with Diverse Cultures and Languages
- C.5.29.16 Provider Directory
- C.5.29.17 Access to Covered Services
- C.5.29.18 Appointment Time Standards for Services
- C.5.29.21 Network Management
- C.5.29.22 Written Standards for Accessibility of Care
- C.5.29.24 Credentialing
- C.5.29.26 Provider Agreements
- C.5.29.29 Provider Training
- C.5.29.30 Provider Manual
- C. 5.29.32 Provider Relations Department