ACAP
Association for Community Affiliated Plans

ACAP Fact Sheet

Ensuring Access Through Strong Provider Networks

SUMMARY

One of the most salient features of the Affordable Care Act is its expansion of access to health insurance for low-income individuals: by 2014, the Act will require states to extend eligibility for Medicaid coverage to all individuals with income up to 133 percent of the federal poverty level (FPL). Such an expansion of coverage will dramatically improve the lives of those with low incomes: a recent study has found that those with access to Medicaid coverage report better health, lower out-of-pocket medical expenditures and less medical debt.[1]

But while this expansion of individuals with health insurance is a laudable achievement in its own right, there must be a sufficient supply of primary care physicians and specialists available to deliver needed care. Safety Net Health Plans[2] (SNHPs) have built strong relationships and trust with community providers in a way that facilitates improved access to care for populations served by Medicaid, CHIP and Medicare. Indeed, many SNHPs were established by community health centers, public hospitals, and children's hospitals so that these providers could secure their participation in the Medicaid program. Still, the adequacy of provider networks in Medicaid challenges states and health plans around the country, and as Medicaid expands to cover approximately 16 million new enrollees in 2014, these challenges will be compounded, requiring commitment and creativity on the part of Medicaid plans and providers alike.

Currently, SNHPs employ innovative approaches to broaden their provider networks. Many of these approaches are profiled in this paper. However, these approaches alone are not enough. Medicaid health plans must be assured that the rates paid to plans are appropriate and reflect the growth in services and population to be served.

BACKGROUND

Medicaid managed care plans have consistently served as a critical link to timely, quality health care for low-income children and parents in working families, people with disabilities, and seniors. To prepare for the expansion of Medicaid to all individuals with income below 133 percent of the FPL, Medicaid SNHPs are evaluating their networks to ensure that all enrollees can expect to receive the care they need and deserve in a timely fashion.

In February 2011, ACAP surveyed its nonprofit Safety Net Health Plan members to assess state policies and requirements for measuring, monitoring, and evaluating provider networks, common challenges plans face, and best practices implemented by plans in an effort to meet or exceed state requirements. This fact sheet provides a summary of the responses of the 31 ACAP Safety Net Health Plan members that responded to the survey.

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[1] National Bureau of Economic Research. *The Oregon Health Experiment: Evidence From the First Year.* http://www.nber.org/papers/w17190. Accessed July 7, 2011.

[2] ACAP defines a "Safety Net Health Plan" as a local, community affiliated non-profit health plan that derives 75 percent or more of its gross revenues from government programs that target low-income, elderly or disabled populations. Congress has acknowledged the special nature of many of these plans by exempting them from the health insurance plan excise tax.

HOW IS NETWORK ADEQUACY DEFINED AND MEASURED?

In states' Medicaid managed care programs, a state's guarantee of health care coverage to its beneficiaries is enforced through its contracts with Medicaid health plans. Federal regulations specify that these contracts require plans to maintain a network of appropriate providers "sufficient to provide adequate access to all services covered under the contract."[3] While federal law requires states to ensure that Medicaid plans evaluate their networks on a variety of dimensions, states have some flexibility to develop specific measures and standards of network adequacy based on the needs and characteristics of enrollees. Several common measures of network adequacy follow.

Geography. A simple measure of network adequacy is geography. All states covered in the survey use a geographic measure of network adequacy. While such standards varied from state to state, plans reported the most common state requirement to be **one primary care provider (PCP) within 30 miles of each member**.

Primary care provider-to-member ratio. Another common measure of network adequacy is the ratio of in-network primary care providers to plan enrollees. Plans reported a range of PCP-to-member ratios, which varied based upon plan size, location, and policies governing which health care providers are considered primary care providers.

- 25 health plans reported their PCP-to-member ratio. Their responses varied widely—from 1 PCP for 53 members up to 1 PCP for 2,000 members. The average ratio was 1:584.
- 17 of 31 plans reported that their contracts specified a minimum PCP-to-member ratio. On average, plans were required to have one PCP in their network per 1,385 members. These limits varied significantly: from 1:200 up to 1:2,000. A recent survey of state Medicaid officials has found similar variation in limits across states. [4]

Other measures of network adequacy. In addition to geographic standards, states employ additional methods and oversight policies to ensure access:

- 14 states set minimum standards for networks,
- 12 states monitor member wait times, and
- 7 states monitor patient panel sizes

WHICH PROVIDERS MAKE UP SAFETY NET HEALTH PLAN NETWORKS?

ACAP member plans have a long history of contracting with safety net providers, including community health centers and other essential community providers.[5] States often require or encourage contracting with Federally Qualified Health Centers (FQHCs) and other community health centers. Ninety-three percent of plans are required (19 of 31 plans) or encouraged (10 of 31 plans) to contract with FQHCs. Seventy-seven percent of plans consider FQHCs to be primary care providers in their networks.

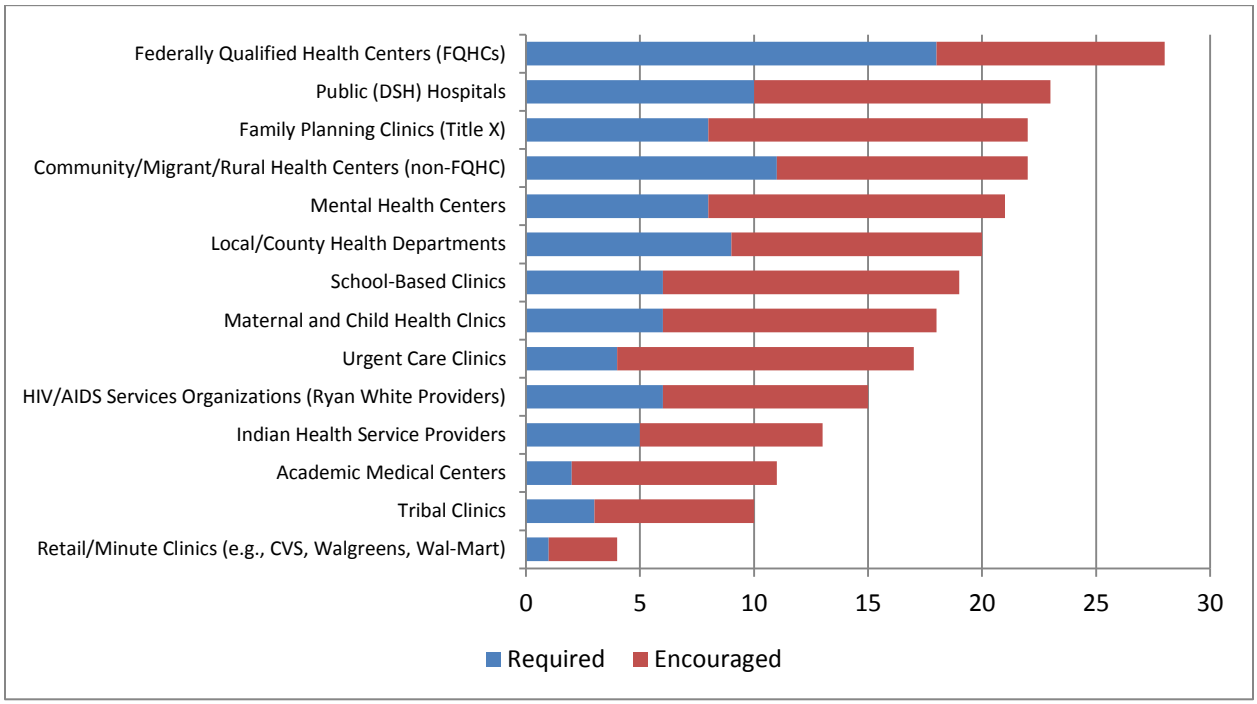
Four plans report that they are encouraged to contract with retail clinics such as those found in CVS or Wal-Mart. In addition, 19 of 30 plans (63 percent) have in-network primary care clinics that operate as

[3] 42 CFR § 438.206(b)
[4] Kaiser Commission on Medicaid and the Uninsured. *A Profile of Medicaid Managed Care Programs in 2010: A 50-State Survey.* Page 26. Online at http://www.kff.org/medicaid/8220.cfm. Accessed September 30, 2011.
[5] PPACA §1311(c)(1)(C)

urgent care centers or offer extended hours after regular office hours.

As many women rely on OB-GYNs as their primary point of contact in the health care system, 71 percent of plans contract with OB-GYNs as primary care providers. 27 of 31 plans (87 percent) credential nurse practitioners as PCPs in their networks.

Figure 1. ACAP Member Plan Primary Care Providers (by practice type)
State Contract Requirements/Encouragements (n=31)

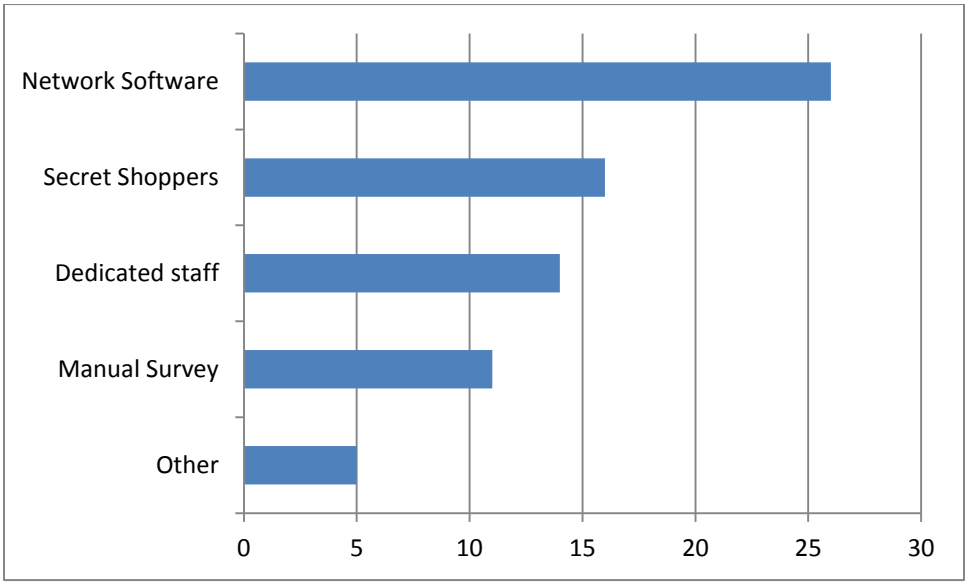


HOW IS NETWORK ADEQUACY MONITORED?

Plans use a wide variety of strategies to monitor their networks. Of the 29 plans responding to survey questions regarding network monitoring, nearly all – 26 – use software such as GeoAccess to monitor their networks.[6] Figure 2 shows other network monitoring techniques employed by plans.

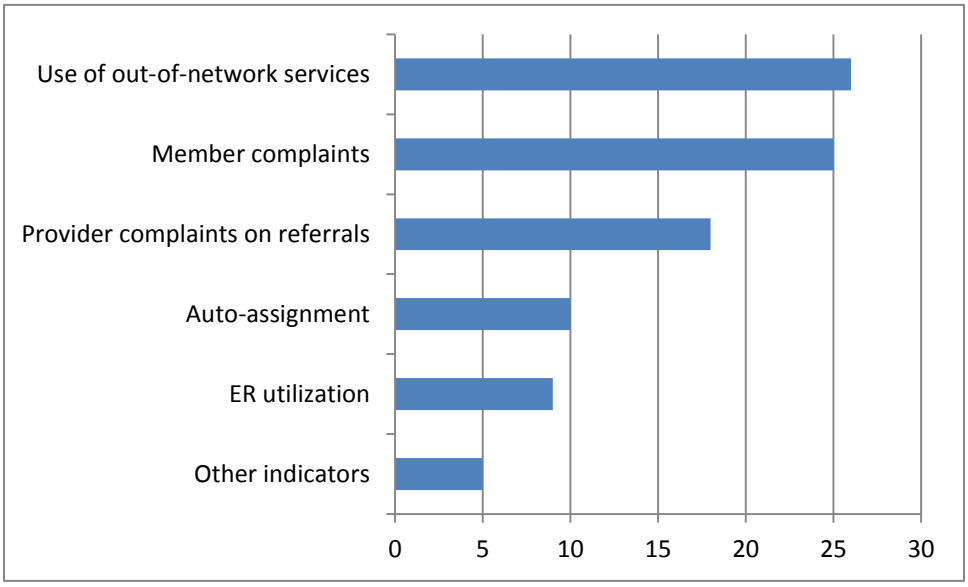
[6] GeoAccess is an Ingenix software product used for analyzing and monitoring networks. More information can be found at http://www.ingenix.com

Figure 2. Methods Used by ACAP Member Plans (n=31) to Actively Monitor Network Adequacy



Plans also monitor other bellwether indicators to detect potential network issues. Figure 3 shows the most frequent bellwethers used by ACAP plans.

Figure 3. Bellwether Indicators Used by ACAP Member Plans to Monitor Network Adequacy (n=31)



Of 31 plans surveyed, 25 regularly share information about network adequacy with their respective states and are able to amend their network numbers with the state throughout the contract year. This information is most commonly shared on a quarterly basis.

Eighty-three percent (24 of 29) of plans are involved in workgroups or committees monitoring network adequacy in their state or plan. Ten plans reported they have groups internally, four plans are part of state-level work groups, and 10 plans are involved in both internal and state level workgroups.

WHAT ARE THE CHALLENGES TO MAINTAINING AN ADEQUATE NETWORK?

Maintaining robust networks is essential to assuring appropriate, timely care for enrollees. But fiscal constraints faced by states have a direct impact on reimbursement rates to health plans and providers. When states reduce capitation payments to plans, some plans report they must pass this on through reduction in the rates they pay their network providers**.** In particular, this is the case in states where plans' provider rates are contractually tied to the state's Medicaid fee-for-service reimbursement schedule, or on a percentage of premium paid.

Some plans—9 out of 29—have absorbed some or all of the state's recent rate cuts and did not pass these on to providers in an effort keep their provider networks intact.

Insufficient reimbursement rates to health plans also threaten the ability of plans to expand their provider networks. Provider payments were reported as a challenge to adding providers to a plan's network for both contracted and non-contracted providers. More than three-quarters of plans (77 percent) reported that provider payment rates were the primary reason providers outside the plan's network chose not to participate. What's more, low reimbursement often limits in-network provider participation: nearly half of plans (48 percent) cite low provider payment rates as the reason in-network providers limit their participation in the plan's network.

The new requirement that Medicaid reimbursement for certain primary care services be temporarily increased to at least the Medicare level for two years is expected to help some plans attract more providers, but not all.

Forty-five percent of plans (13 of 29) believe they will be able to expand their networks because of the more generous reimbursement level required by Federal law, while 6 of 29 plans report that they already pay at or close to the Medicare rates and therefore the increase will have little to no impact. The remaining ten plans are still evaluating the rate increase's potential effect on their networks.

Additional incentive or program changes also could assist Medicaid plans in attracting additional providers. For example, incentive payments to certain Medicaid providers for adopting and using health information technology could encourage new providers to participate in the Medicaid program.

And more than a third of plans (34.5 percent) report "Scope of Practice" policies as a limitation in meeting network adequacy standards. These plans cite the following specific limitations:

- The inability to add nurse practitioners to the network as PCPs; and
- Restrictions on a nurse practitioner's ability to practice independently. Some state laws restrict nurse practitioners to operate under the direct supervision of a physician while others allow them to practice independently[7].

A recent Kaiser Family Foundation survey found that 25 of 35 responding state Medicaid officials allowed a nurse practitioner to be defined as a primary care provider.[8]

HOW ARE SAFETY NET HEALTH PLANS MEETING THE CHALLENGE?

ACAP plans are actively working to expand and adjust their networks to reflect the ongoing needs of enrollees and to prepare for the forthcoming expansion of coverage to all non-elderly, non-disabled individuals with income up to 133 percent of the FPL. To date, more than three-quarters of plans have undertaken or plan to undertake a comprehensive evaluation of their networks; 80 percent of respondents indicated that their plans have already examined the demographics of the federal Medicaid expansion population and will adjust their networks in order to meet anticipated network adequacy standards. Plans have already deployed a variety of tactics to expand their networks in anticipation of the eligibility expansion:

Tactic	Number of Plans
Adding adult providers	16
Adding mental health providers	8
Using telehealth	7
Using e-consults	5
Integration	5
Scope of practice changes	4
Establishing plan-sponsored clinics	2
Adding Urgent Care	2
Using mobile vans	1

Safety Net Health Plans are working today to ensure that the needs of their members are met tomorrow. Following are two examples of innovative approaches plans have taken to ensure access to primary and specialty care, respectively.

EXPANDING NETWORK ACCESS TO PRIMARY CARE AT CAREOREGON

CareOregon, a health plan that connects more than 150,000 Medicaid-eligible enrollees to care, was faced with rapid increases in enrollment as the economy in Oregon, like the rest of the country, sputtered. Between 2009 and 2011, enrollment in the plan grew by nearly 40,000 members. The primary care

[7] Many nurse practitioners must enter into a collaborative agreement with a physician for the purposes of prescribing.

[8] Kaiser Commission on Medicaid and the Uninsured. *A Profile of Medicaid Managed Care Programs in 2010: A 50-State Survey.* Page 27. Online at http://www.kff.org/medicaid/8220.cfm. Accessed September 30, 2011.

providers under contract to CareOregon were having difficulty keeping up with the growing demand, and the plan looked for solutions to ensure that their members had access to primary care.

The plan embarked on a dual-track strategy to keep the number of available primary care physicians in line with the demand posed by swelling enrollment. The use of geomapping software identified "hot spots" that required immediate attention. Once the areas that needed urgent attention were identified, CareOregon provided the upfront capital to ensure that a local clinic would remain in operation: they purchased and refurbished a facility, then leased it back to a local FQHC partner that provided needed care.

The second track of CareOregon's strategy involved opening and operating clinics of their own in areas where the need was most acute. "This was a pressing need more than a year ago, and something we would have done with or without the Affordable Care Act," says Margaret Rowland, MD, CareOregon's chief medical officer. "We faced a growing challenge in matching our members to primary care physicians and needed to develop a creative solution."

CareOregon made the decision to open clinics in areas of need in late 2009 and moved quickly to implement their solution: the first CareOregon-operated clinic opened in East Portland in June of 2010. "We had to move quickly based on need," says James Schroeder, Executive Director of CareOregon Community Health and a former director of a Federally Qualified Health Center. Since opening their first clinic in a facility co-located with a mental health clinic, CareOregon has opened three more clinics in areas where their needs for primary care are most pressing.

An unexpected benefit of these clinics has been the organic development of specialties tailored to the needs of the community: one such clinic housed in the same building as a Head Start program and a behavioral health service has expended its care model beyond medical services to true community-based service through integration with other programs offered by the community.

Another clinic in West Portland has developed an extensive chronic pain treatment program. The clinic has hired nurse practitioners, social workers and physical therapists to treat chronic pain and any underlying addiction issues. "Chronic pain care is hard to find, especially for Medicaid beneficiaries," says Rowland. "We've found that in addition to our own members, we've started to get referrals from traditional Medicaid, commercial plans and Medicare providers." The clinic also treats uninsured patients with chronic pain issues.

By any measure, the clinics have been a boon to access for CareOregon members. PCP assignment rates improved 90 percent since the clinics opened just over a year ago. The plan's newest clinic opened in the Portland suburb of Canby in June, 2011.

Plans are in motion to bring the clinics forward for designation as an FQHC or an FQHC-lookalike; in August, CareOregon announced that its clinic would be transferred to a new not-for-profit organization, Neighborhood Health Center. "Being on the ground gives you a better vantage point on what your members need," adds Schroeder, who will serve as CEO of the new entity. "Our activities around the clinics are a result of what we've learned and experienced—our designs are in response to the needs of our members."

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L.A. CARE: LEVERAGING TECHNOLOGY TO EXPAND ACCESS TO SPECIALISTS

L.A. Care, a Medicaid-focused health plan serving 800,000 MediCal beneficiaries in Los Angeles County, has piloted an innovation that holds promise for enhancing connections to specialty care: the development of an electronic system that allows its primary care providers to consult with specialists quickly and efficiently.

The plan first rolled out its eConsult pilot program in early 2009. The pilot program provided a Web-based platform for about 40 of the plan's primary care physicians in individual and small-group practices to quickly confer electronically with a specialist when a patient presented with symptoms that would have required a referral in the past.

Take, for instance, a patient who visits his family doctor with a suspicious rash. In the past, the family physician may have simply referred him to a dermatologist. This would require scheduling another appointment – and an office visit weeks or even months later. With the eConsult program, the family physician would use a Web-based platform to send a message to a specialist with the relevant clinical information, including photographs and the patient's demographic data. The dermatologist would examine the data and reply – usually, within 24 to 48 hours – with advice and educational information for the primary care physician to follow up directly with the patient. The dermatologist might also request the patient for a face-to-face visit, if warranted.

As many patient visits to specialists do not result in the need for a full workup, the benefits of an electronic peer-to-peer consultation are readily apparent: preliminary results suggest that the pilot program has resulted in a deferment of more than a quarter of specialty visits that would have otherwise occurred. This, in turn, provides greater and more timely access to specialists for patients in need of a face-to-face visit. And for those face-to-face visits, the specialist is already armed with information from the eConsult workup, resulting in increased efficiency and better quality of care.

The program has brought specialists into L.A. Care's network who might not otherwise participate, says Sajid Ahmed, L.A. Care's director of health information technology. "If I'm a dermatologist who can perform consultations electronically, I can keep my office hours open for patients who I already know need procedures. It's a much more efficient way to deliver care."

And the benefits of the program extend to primary care physicians, too. "There's an education piece with primary care doctors – eConsult expands the scope of the primary care practice," says Elaine Batchlor, M.D., M.P.H., Chief Medical Officer, L.A. Care. "It helps the primary care physician address a broader spectrum of issues in their practice, and enhances the physician-patient relationship."

L.A. Care has completed its pilot program and is in the process of extending the eConsult program to safety net providers in the Los Angeles area, focusing on community clinics and the public delivery system.

The Association for Community Affiliated Plans (ACAP) is a national trade association representing 59 nonprofit safety net health plans in 28 states. ACAP's mission is to represent and strengthen not-for-profit, safety net health plans as they work with providers and caregivers in their communities to improve the health and well-being of vulnerable populations in a cost-effective manner. Collectively, ACAP plans serve 8 million enrollees, over one-third of individuals enrolled in fully-capitated Medicaid health plans.