MEDICARE ADVANTAGE PLANS AND MEDICAID MANAGED CARE PLANS: ACCESS TO CARE REQUIREMENTS

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BY:

JEFFREY S. BAIRD, ESQ.
CARA C. BACHENHEIMER, ESQ.
BROWN & FORTUNATO, P.C.
HEALTH CARE GROUP
P.O. BOX 9418
AMARILLO, TX 79105
806-345-6300
JBAIRD@BF-LAW.COM
CBACHENHEIMER@BF-LAW.COM
WWW.BF-LAW.COM

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By: Jeffrey S. Baird, Esq. and Cara C. Bachenheimer, Esq.

This White Paper addresses access to care requirements that federal law imposes on Medicare Advantage Plans and Medicaid Managed Care Plans.

Medicare Advantage Plans ("MAPs")

42 C.F.R. § 422.2 states that a MAP provides health benefits coverage pursuant to a contract with a Medicare Advantage Organization ("MAO"). The coverage includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MAP. 42 C.F.R. § 422.2.

Federal law requires MAPs to provide enrollees with coverage of all services that are covered by Medicare Parts A and B ("traditional Medicare"). Additional benefits may be offered beyond those covered by traditional Medicare. Additional benefits may be (i) a reduction in the premiums, deductibles and coinsurance payments ordinarily required or (ii) health care services not covered by traditional Medicare such as dental and vision care or certain preventative services. Many MAPs also include Part D prescription drug coverage.

An MAO that offers an MAP may be specific as to what network providers enrollees may use, but to do so they must ensure that all covered services are available and covered under the MAP. 42 C.F.R. § 422.112. There are 10 requirements that must met by the MAP in establishing a provider network. First, the MAP must maintain and monitor a network of appropriate providers that is (i) supported by written agreements and (ii) sufficient to provide adequate access to covered services to meet the needs of the population served. 42 C.F.R. § 422.112(a)(1). Methods other than written agreements are allowed to be used but they must be pre-approved by CMS. The network adequacy standards can be found in 42 C.F.R. § 422.116.

Second, the MAP must establish a panel of primary care providers ("PCP") from which an enrollee may select a PCP. 42 C.F.R. § 422.112(a)(2). In the event an enrollee is required to obtain a referral before receiving services from a specialist, the MAP must either assign a PCP for purposes of making the needed referral or make other arrangements to ensure access to medically necessary medical care.

Third, the MAP must provide or arrange for necessary specialty care. As a basic benefit, the MAP must give women enrollees the option of direct access to a women's health specialist (within the network) for women's routine and preventative health care service. 42 C.F.R. § 422.112(a)(3). Basic benefits mean all Medicare-covered benefits. 42 C.F.R. § 422.2. In the event the network providers are unavailable or inadequate to meet an enrollee's medical needs, the MAP must arrange for specialty care outside of the MAP provider network. 42 C.F.R. § 422.112(a)(3).

Fourth, if the MAP seeks to expand the service area of the MAP, it must demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served. 42 C.F.R. § 422.112(a)(4).

Fifth, the MAO must demonstrate to CMS that the providers in the MAP are credentialed through the process set forth at 42 C.F.R. § 422.204(a). 42 C.F.R. § 422.112(a)(5).

Sixth, the MAP must have written standards that (i) establish the timeliness of access to care and (ii) require and member services that meet or exceed the standards established by CMS in 42 C.F.R. §42.116. 42 C.F.R. § 422.112(a)(6). The MAP must continuously monitor the timely access to care within its provider network and take corrective action as necessary. 42 C.F.R. § 422.112(a)(6)(i). The MAP must have policies and procedures that (i) allow for individual medical necessity determinations and (ii) have provider consideration of beneficiary input into the provider's proposed treatment. 42 C.F.R. § 422.112(a)(6)(i)-(ii). According to the Medicare Managed Care Manual, Chapter 4, Section 110.1., a MAP is required to employ written standards for timeliness of access to care and member services that meet or exceed the standards as may be established by CMS. The Manual further states that the MAP must ensure that, when medically necessary, services are available 24 hours a day, 7 days a week. This includes requiring PCPs to have appropriate backup for absences. The standards should consider the member's need and common waiting times for comparable services in the community.

Seventh, the MAP must ensure that (i) its providers have convenient hours of operation for the population served, (ii) it does not discriminate against Medicare enrollees and (iii) the plan services must be available 24 hours a day, 7 days a week, when medically necessary. 42 C.F.R. § 422.112(a)(7).

Eighth, the MAP must ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R. § 422.112(a)(8).

Ninth, the MAP must provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services in accordance with 42 C.F.R. § 422.113. 42 C.F.R. §422.112(a)(9). 42 C.F.R. § 422.113 establishes special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization services. It defines what constitutes an emergency as well as what the MAP is financially responsible for.

Finally, the MAP that meets Medicare access and availability requirements through direct contracting with network providers must do so consistently with the prevailing community pattern of health care delivery in the areas where the network is being offered. The factors that make up the community patterns of health care delivery that CMS will use as a benchmark in evaluating the MAP include but are not limited to: (i) the number and geographic distribution of eligible health care providers available to contract with the MAP to provide plan covered services within the service area of the MAP, (ii) the prevailing market conditions in the service area of the MAP, (iii) whether the service area is made up of rural or urban areas or a combination of the two, (iv) whether the MAP's proposed provider network will meet the Medicare time and distance standards for member access to health care providers, and (v) other

factors that CMS determine are relevant in setting a standard for an acceptable health care delivery network in a particular service area. The Maximum time and distance standards are in 42 C.F.R. § 422.116(d)(2). *See Table 1 to Paragraph (d)(2) attached.*

The network adequacy standards are established in 42 C.F.R. § 422.116. CMS only requires an attestation by the MAP regarding compliance with this provision. The MAP must meet the maximum time and distance standards and contract with a specific minimum number of each provider and facility-specialty type. 42 C.F.R. § 422.116(a)(2). Each contract provider type must be within the maximum time and distance of at least one beneficiary in order to count toward the minimum number, and the minimum number criteria and the time and distance criteria vary by county type. 42 C.F.R. § 422.116(a)(2)(i)-(ii). CMS annually updates and makes a health service delivery reference file that identifies all minimum provider and facility number requirements, all provider and facility time and distance standards and the ratios that are established in paragraph (e) of the section in advance of network reviews of the applicable year. Paragraph (e) of 42 C.F.R. § 422.116 establishes the minimum number standard for each provider and facility specialty type. *See Table 2 to Paragraph (e)(3)(i)(C) attached.*

Medicaid Managed Care Plans ("MMCPs")

An MMCP provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations ("MCOs") that accept a set per member per month payment for the services. Federal law sets forth the requirements for the contract that will be established between the state and the MMCP.

Section 1932 of the Social Security Act establishes the requirements related to the federal oversight of full-risk managed care programs. 42 U.S.C. § 1396u-2. Under 42 U.S.C. § 1396u-2(b)(5), each Medicaid MCO must provide assurances that (i) its plan offers an appropriate range of services and access to both preventative and primary care for the population that is expected to enroll in each service area and (ii) the MAP will maintain a distribution of providers that are of a sufficient number, type, and location. This requirement varies state by state. Under the quality assurance standards in subsection (c), the standards for access to care must be available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity. 42 U.S.C. § 1396u-2(c)(1)(A)(i).

State Medicaid programs use three main types of managed care delivery system: (i) comprehensive risk-based managed care, (ii) primary care case management, and (iii) limited-benefit plans. In a comprehensive risk-based managed care arrangement, states contract with MCOs to cover all or most Medicaid-covered services for their Medicaid enrollees. In a primary care case management program, each enrollee has a designated PCP who is paid a monthly case management fee to be responsible for managing and coordinating the enrollee's basic medical care. In a limited-benefit plan, a state contracts with the plan to manage specific benefits, such as inpatient mental health or substance abuse benefits, nonemergency transport, oral health, or disease management.

The states are required to develop and enforce network adequacy standards on the MMCP according to the standards set forth in 42 C.F.R. § 438.68. The regulation sets forth a provider-

specific network adequacy standard for which the MMCP must develop a quantitative network adequacy standard for providers of primary care (adult and pediatric), OB/GYN, behavioral health, (adult and pediatric), specialists (adult and pediatric), hospitals, pharmacies, and pediatric dental. 42 C.F.R. § 438.68(b)(1)(i)-(vii). The network standards must include all of the geographic areas covered by the MMCP. It is possible for the contract between the state and the MMCP to have varying standards for the same provider type based on the geographic area that is covered. 42 C.F.R. § 438.68(b)(3). Any exceptions granted by the state to the MMCP is required to be specified in the contract and based on the number of providers practicing in that specialty in the MMCP service area. 42 C.F.R. § 438.68(d)(1)-(2).

The relevant provisions that apply to MMCPs are found in 42 C.F.R. § 438.206. The basic rule for availability of service is that the state must ensure that all services covered by the MMCP are available and accessible to enrollees in a timely manner. Each state establishes its own standards. The state must ensure the MMCP maintains and monitors 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 with enrollees. 42 C.F.R. § 438.206(b)(1). The MMCP must 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 preventative health care services. 42 C.F.R. § 438.206(b)(2).

The MMCP must provide for a second opinion from a network provider, or arrange for the enrollee to obtain a second opinion outside the network, at no cost of the enrollee. 42 C.F.R. § 438.206(b)(3). If a provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MMCP must adequately and timely cover these services out of network for the enrollee, for as long as the MMCP's network is unable to provide them. 42 C.F.R. § 438.206(b)(4). CMS declined to define the term "timely" in 42 C.F.R. § 438.206(b) because it is considered at 42 C.F.R. § 438.206(c)(1). Medicaid and Children's Health Insurance Program ("CHIP") Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 FR 27498-01. CMS further explains that the states should be allowed to set appropriate and meaningful quantitative standards for their programs. *Id.* The state must also ensure that the MMCP will coordinate with out-of-network providers for payment and ensure that the cost to the enrollees is no greater than it would be if the services were furnished within the network. 42 C.F.R. § 438.206(b)(5).

The MMCP is required to demonstrate that its network providers are credentialed as required by 42 C.F.R. § 438.214. This section provides that the state must ensure that each MMCP implements written policies and procedures for selection and retention of network providers and that the policies and procedures meet the requirements of the section. 42 C.F.R. § 438.214 *et seq.* Each state must establish uniform credentialing and recredentialing policies that address acute, primary behavioral, substance use disorders and requires that each plan follows those policies. *Id.* It also requires the plans to follow a documented process for credentialing and recredentialing of network providers. *Id.* The MMCP is required to demonstrate that its network includes enough family planning providers to ensure that there is timely access to covered services.

Each MMCP must provide timely access, cultural considerations, and accessibility considerations. 42 C.F.R. § 438.206(c). Timely access requirements under this section include

meeting the state standards for timely access to care and services while considering the urgency of the need for services. 42 C.F.R. § 438.206(c)(1) *et seq*. Additionally, the hours of operation for the network providers can be no less than the hours of operation offered to commercial enrollees or comparable to Medicaid. *Id.* The MMCPs must make services included in the contract available 24 hours a day, 7 days a week when medically necessary. *Id.* The MMCPs need to enact mechanisms to ensure compliance by network providers and monitor them regularly to ensure compliance. *Id.* If the network provider fails to comply with the requirements, then the MMCP is required to take corrective action. 42 C.F.R. 438.206(c)(1)(i)-(vi).

Each MMCP's network providers are required to promote the delivery of services in a culturally competent manner to all enrollees and ensure that they provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. 42 C.F.R. § 438.206(c)(3).

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Table 1 to Paragraph (d)(2)

Provider/Facility type	Large metro		Metro		Micro		Rural		CEAC	
	Max Time (MIN)	Max Distance (MILES)	Max time	Max distance	Max time	Max distance	Max time	Max distance	Max time	Max distance
Primary Care	10	5	15	10	30	20	40	30	70	60
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OB/GYN	30	15	45	30	80	60	90	75	125	110
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Oncology—Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology—Radiation/Radiation Oncology	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry, Rehabilitative Medicine	30	15	45	30	80	60	90	75	125	110
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100

Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Critical Care Services—Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Diagnostic Radiology	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Inpatient Psychiatric Facility Services	30	15	70	45	100	75	90	75	155	140
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100

Table 2 to Paragraph (e)(3)(i)(C)

Minimum ratio	Large metro	Metro	Micro	Rural	CEAC
Primary Care	1.67	1.67	1.42	1.42	1.42
Allergy and Immunology	0.05	0.05	0.04	0.04	0.04
Cardiology	0.27	0.27	0.23	0.23	0.23
Chiropractor	0.10	0.10	0.09	0.09	0.09
Dermatology	0.16	0.16	0.14	0.14	0.14
Endocrinology	0.04	0.04	0.03	0.03	0.03
ENT/Otolaryngology	0.06	0.06	0.05	0.05	0.05
Gastroenterology	0.12	0.12	0.10	0.10	0.10
General Surgery	0.28	0.28	0.24	0.24	0.24
Gynecology, OB/GYN	0.04	0.04	0.03	0.03	0.03
Infectious Diseases	0.03	0.03	0.03	0.03	0.03
Nephrology	0.09	0.09	0.08	0.08	0.08
Neurology	0.12	0.12	0.10	0.10	0.10
Neurosurgery	0.01	0.01	0.01	0.01	0.01
Oncology—Medical, Surgical	0.19	0.19	0.16	0.16	0.16
Oncology—Radiation/Radiation Oncology	0.06	0.06	0.05	0.05	0.05
Ophthalmology	0.24	0.24	0.20	0.20	0.20
Orthopedic Surgery	0.20	0.20	0.17	0.17	0.17
Physiatry, Rehabilitative Medicine	0.04	0.04	0.03	0.03	0.03
Plastic Surgery	0.01	0.01	0.01	0.01	0.01
Podiatry	0.19	0.19	0.16	0.16	0.16
Psychiatry	0.14	0.14	0.12	0.12	0.12
Pulmonology	0.13	0.13	0.11	0.11	0.11
Rheumatology	0.07	0.07	0.06	0.06	0.06
Urology	0.12	0.12	0.10	0.10	0.10
Vascular Surgery	0.02	0.02	0.02	0.02	0.02
Cardiothoracic Surgery	0.01	0.01	0.01	0.01	0.01
Acute Inpatient Hospitals	12.2	12.2	12.2	12.2	12.2