Network Adequacy

Issue Brief

(May 2014)

Background: Network adequacy refers to criteria established to ensure a health plan can provide services to all of the subscribers to whom it sells insurance. In the Medicaid marketplace, network adequacy is governed by the federal Centers for Medicare & Medicaid Services (CMS) regulation.

Specifically, CMS requires at 42 CFR § 438.207(d) that after reviewing documentation provided by a health plan, the state must certify that each managed care plan has complied with the state's requirements for availability of services, as required by federal regulations 42 CFR § 438.206, which includes maintaining and monitoring a network of appropriate providers, supported by written agreements and the ability to provide adequate access to all services covered under the contract. The Managed Care Organizations (MCO) must consider anticipated Medicaid enrollment; expected utilization of services; numbers and types of providers required to furnish the contracted Medicaid services; and geographic location of providers and Medicaid enrollees.

With respect to accessing these services, CMS requires the MCOs to consider the numbers of network providers who are not accepting new Medicaid patients. Additionally, CMS requires the MCO to ensure its provider hours are comparable to the commercial marketplace and, when medically necessary, make certain services available 24 hours a day, 7 days a week.

The state bears a great deal of responsibility for overseeing the particulars of a how a health plan ensures an adequate network. In New Jersey, the health plans that provide services to Medicaid beneficiaries are held to standards established through regulation and provisions in the state's contract with the Medicaid MCOs. New Jersey regulations establish geographic and travel time requirements that apply to both commercial and Medicaid MCOs. The requirements are very specific and include differences based on provider type. For example, with respect to hospital services, the regulation requires that an MCO must contract with (or have another arrangement acceptable to the Department) at least one licensed acute care hospital including at least licensed

medical-surgical, pediatric, obstetrical and critical care services in any county or service area no greater than 20 miles or 30 minutes driving time, whichever is less from 90 percent of members within the county or service area.

Finally, the state's contract with MCOs mandates stricter requirements for Medicaid MCOs with regard to demonstrating adequate hospital access in the network. Specifically, the contract states the MCO shall include in its network at least one licensed acute care hospital including at least licensed medical-surgical, pediatric, obstetrical and critical care services in each county or in adjacent counties no greater than 15 miles or 30 minutes driving time, whichever is less from 90 percent of members within the county or adjacent counties.

Significance: One of the major challenges in the Medicaid market is ensuring that an adequate network exists so that Medicaid beneficiaries can actually obtain services to which they are entitled. This issue was further exacerbated by the influx of approximately 234,000 individuals who were eligible for Medicaid on January 1, 2014, through the Medicaid expansion, according to the Rutgers Center for State Health Policy. Network adequacy takes on particular relevance in the age of health reform, with its focus on improving quality of care and decreasing costs in the system – if an adequate network does not exist, beneficiaries will not receive proper primary and routine care and will continue to rely on the emergency department as the primary method of access.

Potential Solutions: There are a number of potential ways to assist to ensure that MCOs serving the Medicaid population provide a network that enables beneficiaries to properly utilize care.

- Require Medicaid officials to, on a regularly statutorily-specified basis, review each MCO network and re-evaluate its adequacy under existing requirements;
- Limit network adequacy waivers issued by Medicaid officials to a one-year period, for example;
- Mandate that MCOs who do not have an adequate network a) pay out-of-network charges to providers who serve these beneficiaries; and b) cannot deny payment to providers who are unable to transfer beneficiaries to step-down facilities and therefore continue to provide acute-level care; and
- Secure state-level statutory changes that would provide stricter network adequacy requirements based on the number of subscribers in each respective MCO network.