ACAP
Association for Community Affiliated Plans

## ACAP Fact Sheet

# Ensuring Access Through Strong Provider Networks

**SUMMARY**

One of the most notable benefits of the Affordable Care Act is its expansion of access to health coverage for people and families with low incomes: by 2014, the Act will provide for the extension of Medicaid coverage to all individuals with income up to 133 percent of the federal poverty level (FPL), should states opt to do so. Such an expansion of coverage will dramatically improve the lives of those with low incomes: a study has found that those with access to Medicaid coverage report better health, lower out-of-pocket medical expenditures and less medical debt.[1]

This expansion of health coverage to the previously uninsured is a laudable achievement in its own right. But 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. But the adequacy of provider networks in Medicaid challenges states and health plans around the country, and as Medicaid expands to cover approximately millions of new enrollees in 2014, these challenges will be compounded, requiring commitment and creativity on the part of Medicaid plans and providers alike.

SNHPs employ several innovative approaches to broaden their provider networks; many 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, and provides brief profiles of plans with particularly innovative strategies to maximize their provider networks. A 2013 update of this paper extends the profiles to additional plans

[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.

that have developed innovative approaches to assure that their provider networks will be ready to meet the needs of a fast-growing membership.

## 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.

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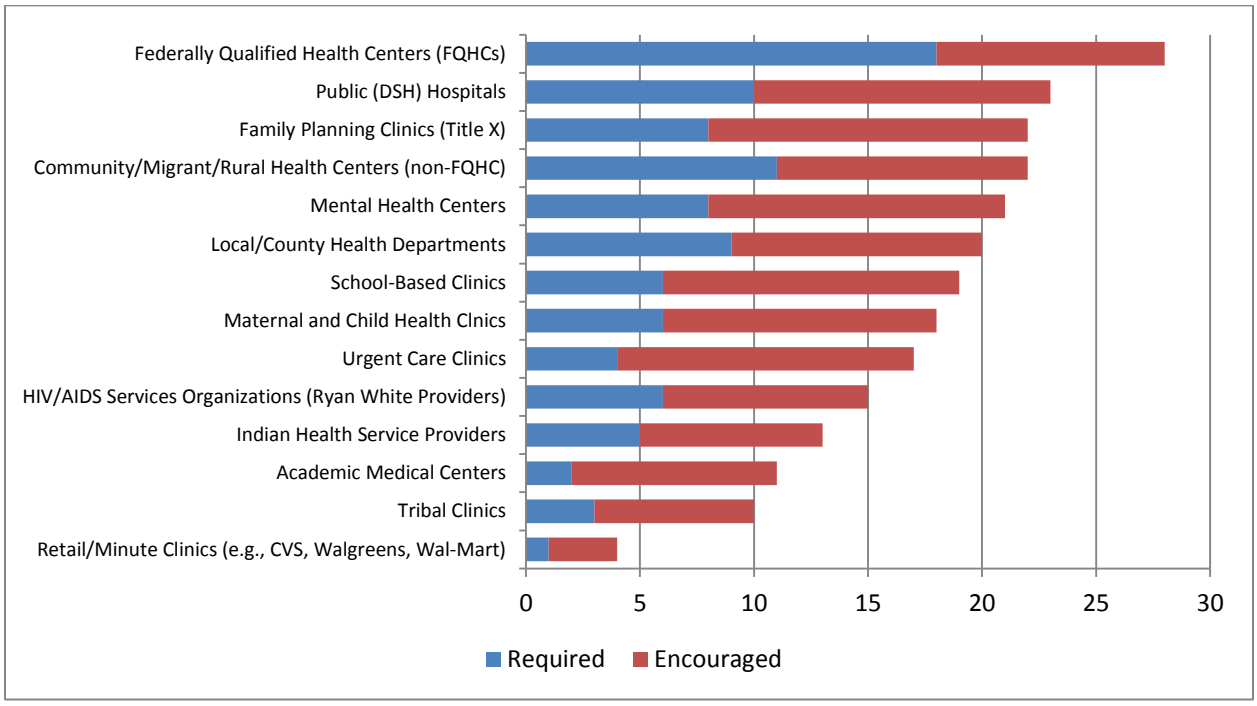
[3] 42 CFR § 438.206(b)
[4] Kaiser Commission on Medicaid and the Uninsured. *A Profile of Medicaid Managed Care Programs in 2010: A 50-State Survey.* Page 26. Online at http://www.kff.org/medicaid/8220.cfm. Accessed September 30, 2011.
[5] PPACA §1311(c)(1)(C)

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 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)

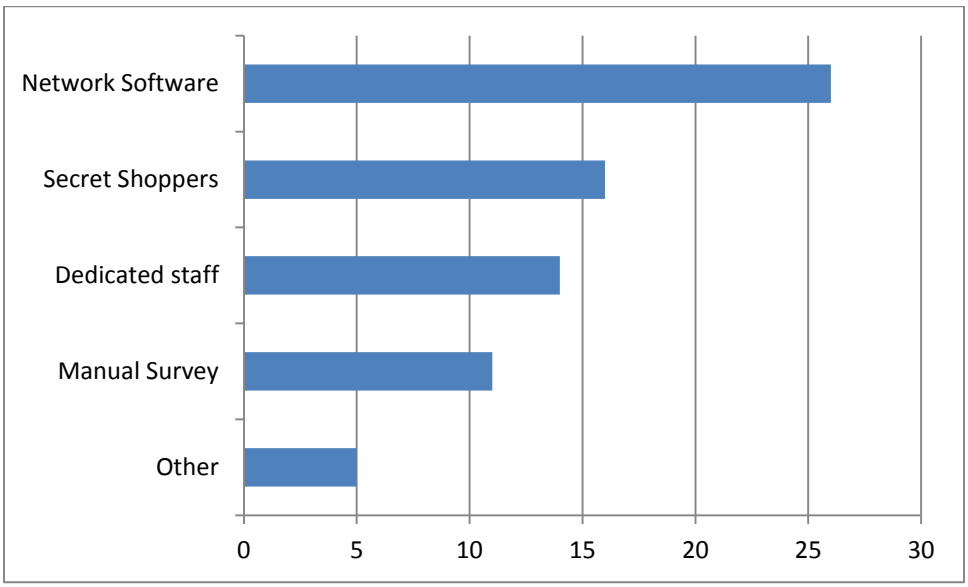



## HOW IS NETWORK ADEQUACY MONITORED?

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.

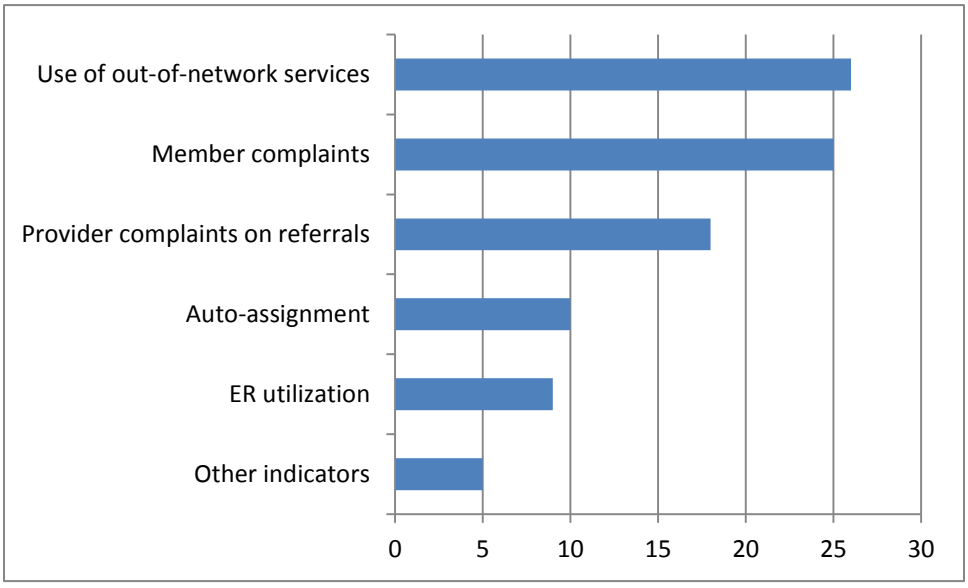
[6] GeoAccess is an Ingenix software product used for analyzing and monitoring networks. More information can be found at http://www.ingenix.com

**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.

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[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.

Between 2009 and 2011, enrollment in the plan grew by nearly 40,000 members. The primary care 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 in the clinics' first year of operation. 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. And in August 2011, 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. "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."

***2013 Update:***

**TEXAS CHILDREN'S HEALTH PLAN: BUILDING A PATIENT-CENTERED MEDICAL HOME TO CALL ITS OWN**

On the north side of Houston in the Greenspoint community, not far from George Bush Intercontinental Airport, Texas Children's Health Plan has built a $13 million state-of-the-art medical facility. The Center for Children and Women, as the facility is known, opened in August 2013 and will employ physicians, nurse practitioners, certified nurse midwives, nurses and other health-care professionals from a wide range of disciplines—including social workers, clinical therapists, health educators, care coordinators, dietitians and more—all dedicated to improving care for the members of Texas Children's Health Plan, with a focus on obstetrics and pediatrics.

More than 100,000 members of the plan live within 15 minutes of the Center's location. "Early on, Texas Children's Health Plan performed an analysis that identified Greenspoint as an area in particular that would benefit from increased access to primary obstetrics and pediatrics care," says Tangula Taylor, Director of the Center at Greenspoint. "What we really wanted to do was create the opportunity of improve the overall health of the community and this drive influenced how we built the Center and the supporting processes to deliver outstanding care and service. The decision from the beginning was to incorporate the principles of the Patient-Centered Medical Home."

While the term "Patient-Centered Medical Home" calls forth the image of a physical structure, it refers to a care delivery model that promotes the opportunity for access to care, patient and family engagement, and coordination of care. The model allows for a whole-patient focus that is more difficult to effect in a fee-for-service environment. "Picture someone who comes in for a cough. Under fee-for-service, their cough is treated, and probably treated very well. But in a medical home like The Center for Children and Women, a patient comes in for a cough. In the course of conducting the history and physical, you might notice that a sibling has poor body language, and through a follow-up conversation with the sibling and the family member you find out that there's no food in the home and make arrangements with the Social Worker to see the family. That's something fee-for-service just doesn't give you the time to catch."

The Center will improve access to care in its community by providing full services seven days a week for pediatrics and six days a week for obstetrics with extended evening hours for both. "It's important to give our members a place where they can visit their primary care provider at non-traditional hours," adds Taylor. "Otherwise, they will go to emergency rooms for care that can be rendered in an office setting." Of course, emergency rooms are a far more costly setting.

Texas Children's Health Plan has partnered with Baylor College of Medicine to staff the Center; its providers are dedicated to primary care and work full-time at the Center. Taylor praised the partnership. "Our providers are as invested as we are in terms of the care delivery model and the collaboration and team concept that we've created for the Center – using best practices and evidence-based guidelines."

The Center will also serve as a resource for physicians who currently serve Texas Children's Health Plan members. "We spent time with them to discuss how the Center is not so much the competition as it is an opportunity for partnership. For instance, not many traditional pediatricians are open at 7 at night. But they also don't want their patient visiting the ER unnecessarily. The patient can visit The Center instead, and we can go back to their PCP and provide them with information about their patient's visit to maintain that continuity of care."

A wide variety of services will be available at the Center, ranging from behavorial health to optometry, radiology and an in-house lab. "It really is designed to be a one-stop shop to address the maximum spectrum of needs in a primary care setting. For example, when you talk with folks in the health care community, you often hear about how tough it is to tap into behavioral health services – there is such a need in both the pediatric and OB community. Embedding those services in the primary care setting will have a huge impact."

The Center's ongoing emphasis will be on improving the quality of care, and performance on relevant indicators of care – such as well-child visits and appropriate prenatal care – will be monitored continuously. Reduction of inappropriate emergency room visits will also be examined.

"We'll also want to know, of course, whether we've been able to bend the cost curve for our Medicaid and CHIP members of Texas Children's Health Plan," adds Taylor. "However, at the end of the day, we want to be able to show that we've turned the dial on the health of the population and the Greenspoint community." The Center for Children and Women will pursue certification as a specialty Patient-Centered Medical Home from the National Committee for Quality Assurance on two fronts: through its pediatrics practice and its obstetrics clinic.

"The NCQA designation represents the gold stamp of quality in the medical community," says Taylor. "We want to demonstrate how we can deliver care and service extremely well, and be successful, from the ground up."

**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."

*2013 Update:* L.A. Care is significantly expanding its eConsult program, which now involves over 1,700 providers at 132 clinics, health centers, and other practice sites. Today, eConsults encompass 26 areas of specialty care, ranging from allergy to urology. More than 29,000 eConsults have been initiated.

***2013 Update:***

**HEALTH PLAN OF SAN JOAQUIN: USING "DIRECT DERM" TO MEET PATIENT NEEDS, EXPAND ACCESS**

While California's San Joaquin Valley is known as the most agriculturally productive area in the United States, the nature of its economy poses challenges for Health Plan of San Joaquin (HPSJ), the ACAP-member Safety Net Health Plan that serves the region. Poverty there is higher than average (15.3 percent, versus 14 percent statewide) and the prevalence rates of a number of conditions – including diabetes, all cancers, and premature childbirth, are among the highest in the state.

Of particular concern to HPSJ was access to dermatologists for its members. "We have a lot of members whose jobs take them outdoors, so we see a lot of sun-induced lesions," says Dr. David Eibling, Chief Medical Officer at HPSJ. "And dermatology services were scarce to Medicaid patients. Few dermatologists are willing to accept Medicaid reimbursement, so we had limited capacity. Waiting times were high. We needed to do something."

As HPSJ was faced with a comparatively high number of members in need of dermatologists and few dermatologists in the area willing to see Medicaid patients, they implemented a teledermatology program in 2012 that would expand access by providing access to board-certified dermatologists through e-mail.

The mechanics of the program are similar in nature to those in L.A. Care's eConsult program: a patient sees his or her primary care physician, who performs a preliminary evaluation, takes photographs and other needed documentation, and sends the information off to a dermatologist through e-mail, who performs an evaluation and sends his recommendations back to the PCP.

The results of HPSJ's teledermatology program are striking: more than 90 percent of patients who are evaluated through the program do not require an in-person follow-up visit with the dermatologist. Most can take a prescription and follow up with their primary care physician. More than 80 percent report improvements in their skin condition on their follow-up visit.

"The difference is night and day," adds Dr. Eibling. "It used to be that patients could wait weeks to get in to the dermatologist. Now they see their PCP and they get an answer in as little as 24 hours. And if they do need a specialist, they can now get in in about a week" thanks to the diversion of patients whose cases can be handled in the PCP's office; dermatologists who serve HPSJ patients remotely from Stanford University come to San Joaquin county periodically to see patients that need further attention from a specialist.

While the program was met with some skepticism from HPSJ's primary care providers, they have found it to be invaluable. It has led to closer contact with the patients in their panel, and has served as a learning experience for the PCPs. "Most of the care takes place in the PCP's office, since most patients don't need a physical visit with a dermatologist," says Dr. Eibling. "In many cases, the PCP is performing the biopsy of the lesion in his office and sending it out. After our PCPs started using the program, they became quite enamored with it." Dr. Eibling also cited lowered liability risks for PCPs that consult with board-certified dermatologists as an attractive feature of the program.

The program has led to significant savings. "For us, psoriasis is a big cost driver," says Eibling. Initial estimates suggest savings of up to 60 percent compared with conventional dermatologists; however, HPSJ has contracted with an actuary to more formally quantify the savings associated with the teledermatology program.

"The quality of care is better—and our members love the program," says Eibling. "Before putting [this program] in place, I visited with PCPs across our entire service area to talk with them about the program and generate some buy-in. Now I have providers calling asking to get in to the program thanks to patient demand."

HPSJ is considering expanding its telemedicine model to include endocrinology and psychiatry.

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*The Association for Community Affiliated Plans (ACAP) is a national trade association representing 59 nonprofit safety net health plans in 25 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 more than 10 million enrollees.*