



Medicaid Expansion: Access to Services

Study questions

- What standards are Virginia's MCOs required to meet to ensure Medicaid members can access services?
- Are the provider network adequacy standards for Virginia's MCOs comparable to other states?
- How does DMAS ensure that MCOs meet network adequacy standards?
- Are actions needed at this time to improve access to Medicaid services?

Research activities

- Comparison of the network adequacy standards for Virginia's MCOs and standards in other states
- Analysis of MCO compliance with network adequacy standards
- Interviews with DMAS staff, MCO leadership, and health-care advocacy groups

MCO = managed care organization.

In brief

DMAS's network adequacy standards are generally comparable to other states and no changes are needed at this time.

Available data from MCOs indicates that appointment availability may be a challenge for some services, and DMAS does not measure whether members can get appointments in a timely manner.

The most frequently used providers are generally located close enough to where members live, but some specialists are too far away from members in certain regions.

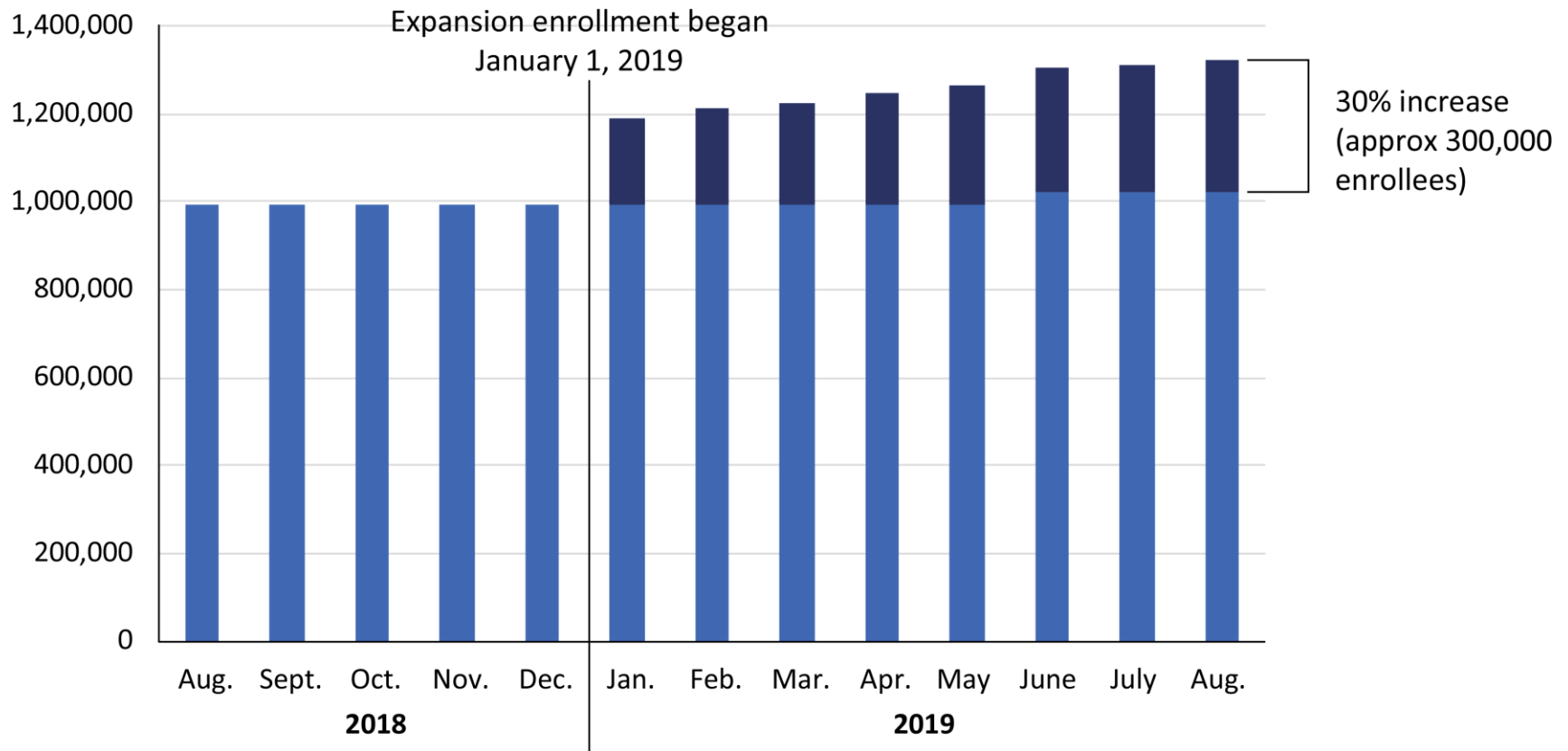
In this presentation

Background

Availability of appointments

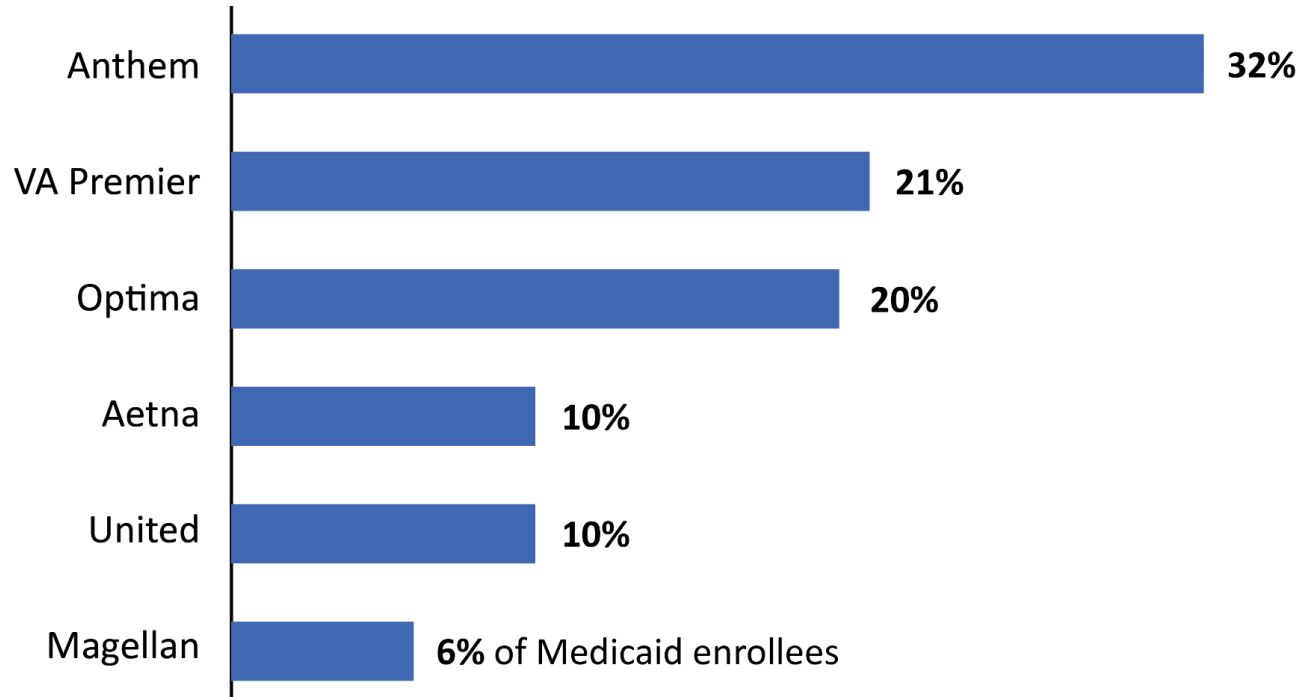
Travel time and distance to providers

Expansion has increased the number of Medicaid enrollees by 30% so far



NOTE: Member data includes only full benefit members.

Virginia contracts with six MCOs to provide most Medicaid services



NOTE: Enrollment data as of January 1, 2019, which included about two-thirds of current expansion enrollees.

Increased enrollment creates risk that Medicaid members will have difficulty accessing services

- DMAS worked with MCOs, major health systems, and other providers to enhance networks before expansion
- Initial data indicates that many expansion members are accessing services, but data is not currently sufficient to fully assess access
- Assessing the adequacy of current MCO provider networks can help identify and manage actual or potential access challenges

MCOs are required to ensure that Medicaid members can access needed services

- Must comply with appointment standards for how quickly members can be seen by providers
- Must comply with travel standards for how long it takes members to travel to specific providers
- Standards complement each other by ensuring providers are located close to members and have appointments available
- Standards apply to all Medicaid members, including the expansion population

In this presentation

Background

Availability of appointments

Travel time and distance to providers

Appointment standards are set based on the type of service and urgency of medical need

Example of appointment standards

	First offered appointment	
Primary care	Routine	30 calendar days
	Urgent	24 hours
OB/GYN	1 st and 2 nd Trimester	7 calendar days
	3 rd Trimester and High Risk	3 business days

NOTE: Example standards are from the Medallion 4.0 contract.

Finding

DMAS appointment standards are comparable to or more stringent than other states' standards.

Most DMAS appointment standards are comparable to other states

- Five of six appointment standards are comparable to or more stringent than standards in other states
- Routine primary care appointment standard is slightly less stringent than most other states
 - Virginia members must be able to schedule appointments within 30 days
 - Other states require appointments between 14 and 30 days, median is 28 days

Finding

Available MCO data shows that some Medicaid members may be unable to get timely appointments, but DMAS does not collect data to measure the extent of challenges.

Data from two MCOs indicate that appointments with certain providers could be difficult to obtain

- Two MCOs were able to report results of provider surveys that measured appointment timeliness
- The percentage of surveyed providers meeting contract standards ranged from 39 to 97 percent for the most commonly used providers
 - Primary care
 - OB/GYN
 - Behavioral health
- Data is inadequate to determine extent of potential challenges with securing appointments

DMAS does not proactively monitor MCO compliance with appointment standards

- DMAS does not collect data to measure whether members can get appointments in required timeframes
- DMAS instead relies on member complaints, which are ad hoc and are not analyzed to identify systemic problems
- DMAS also relies on MCO national accreditation, which requires MCOs to monitor appointment timeliness but does not ensure compliance with specific standards

Other states proactively monitor MCO compliance with appointment standards

- “Secret shopper” surveys of providers
- Member and provider surveys
- Non-emergency ED utilization reports
- Out-of-network utilization reports

ED = Emergency Department

Recommendations

DMAS should develop and implement a reliable methodology for measuring MCOs' compliance with contract appointment standards.

Until a methodology is developed, DMAS should use available information from MCOs to identify and address challenges members have getting timely appointments.

In this presentation

Background

Availability of appointments

Travel time and distance to providers

Travel standards are set for urban and rural localities

Example of travel standards

		Time (minutes)	Distance (miles)
Primary care	Urban	30	15
	Rural	45	30
OB/GYN	Urban	45	30
	Rural	75	60

NOTE: Example standards are from the Medallion 4.0 contract.

DMAS measures provider availability by how far members have to travel to see providers

- DMAS requires each MCO to have a certain number of providers located within a certain distance to Medicaid member residences
- Goal is that 75 percent to 80 percent of each MCO's members live within a specified travel time and distance
- Standards are measured at the zip code level

Finding

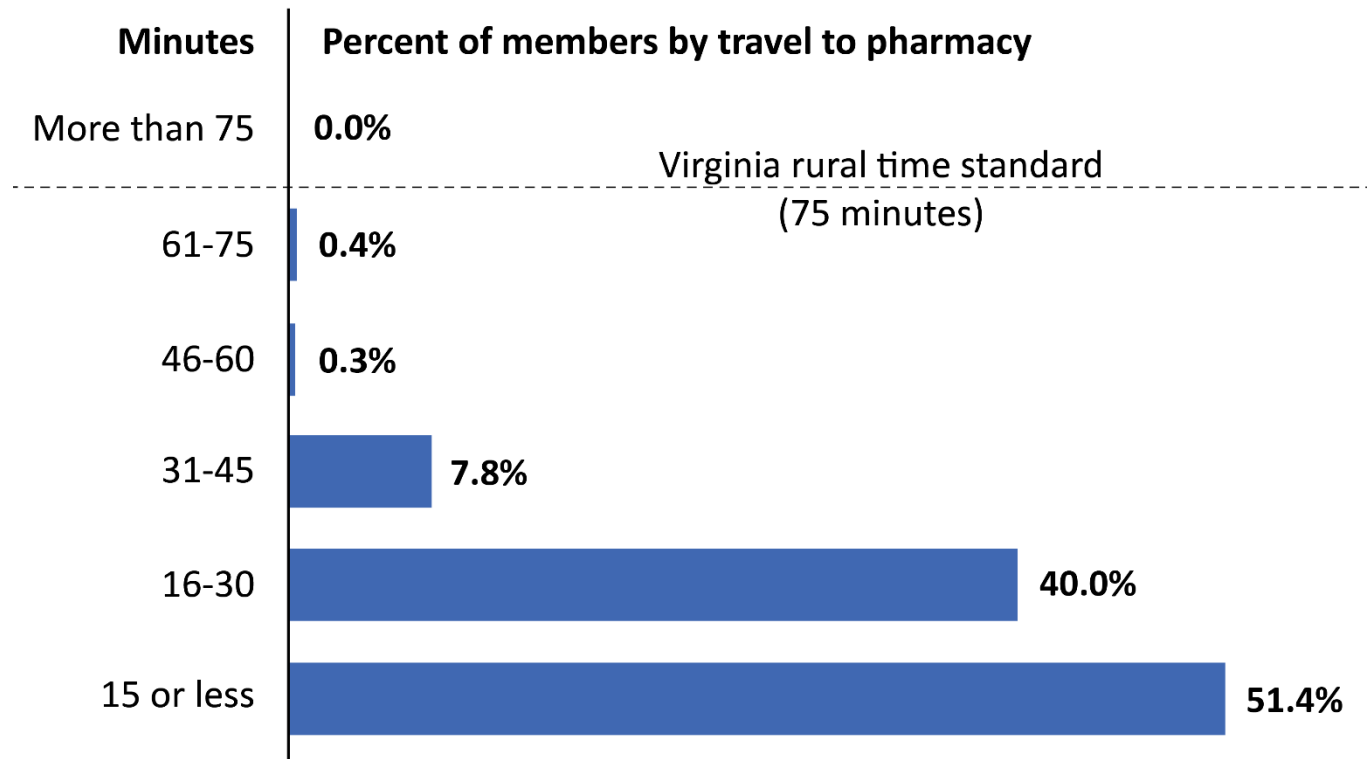
DMAS travel time and distance standards for most frequently used providers are comparable to other states, with the exception of rural pharmacies.

Establishing more stringent travel standards for rural pharmacies is not necessary at this time, but DMAS should evaluate the need to do so in the future.

Majority of DMAS travel standards are comparable to other states

- 14 (70%) travel standards are comparable to or more stringent than standards in other states
- 6 (30%) are less stringent than the typical standard in other states
 - Four of six within the range of other states' standards
- Virginia travel standards for rural pharmacies are the least stringent of all states used in the comparison
 - MCOs currently outperform these standards, so more stringent standards would have no immediate effect

MCOs outperform the required travel time standard for rural pharmacies



NOTE: Member data as of September 2019. Travel time for each zip code was averaged across the six MCOs. The median standard for other states is 30 minutes.

More stringent rural pharmacy standards need to be considered as networks change

- MCO provider networks will change over time with provider availability and provider participation
- Under the current standards, networks for rural pharmacies could become substantially more limited but still meet DMAS standards

Recommendation

DMAS should evaluate the feasibility and need to establish more stringent travel standards for rural pharmacies in the Medallion 4.0 and CCC+ contracts when these contracts are eligible for renewal.

Finding

MCOs meet travel time and distance standards for the most frequently used providers, but not for some specialists in Southwest Virginia.





All MCOs meet travel standards statewide for the most frequently used providers

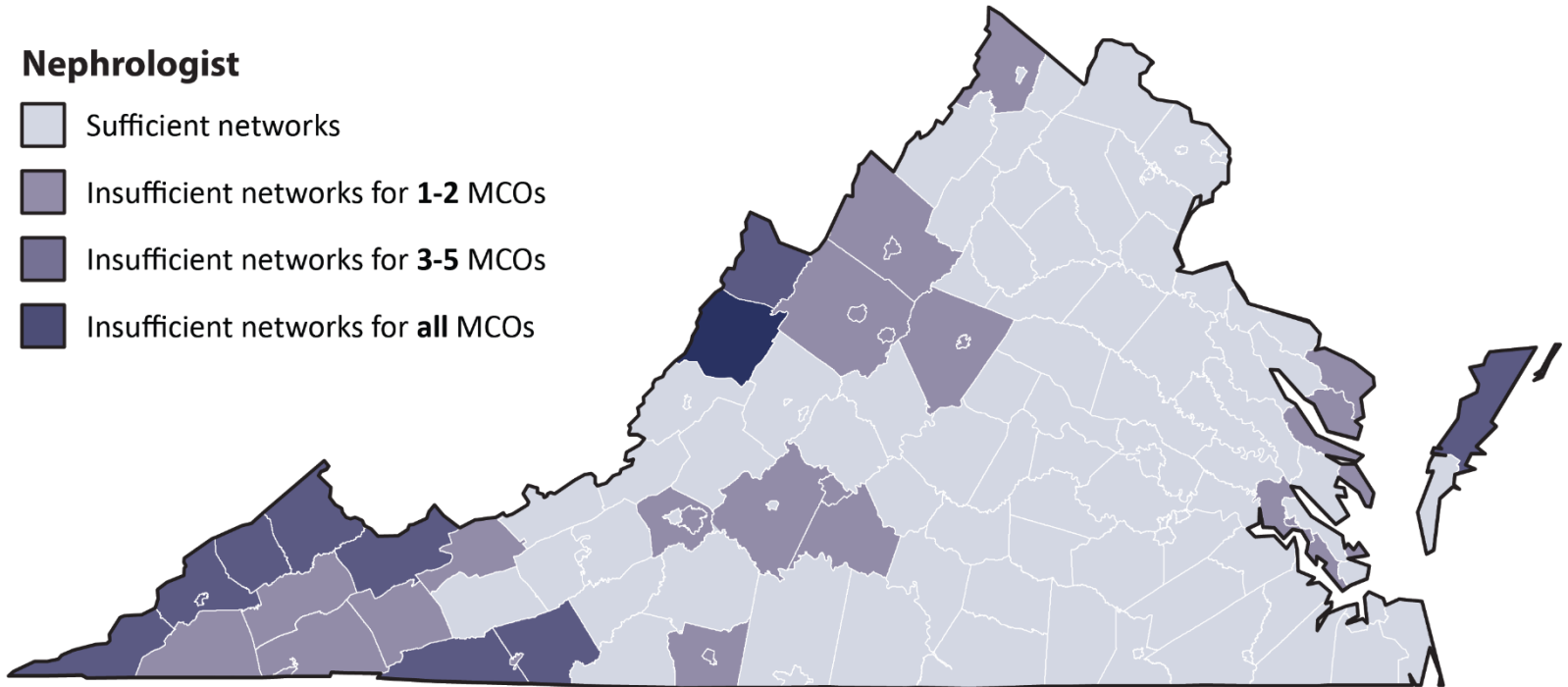
- All six MCOs have a sufficient number of routinely used providers in their network in almost every locality in Virginia
- MCOs generally have a sufficient number of specialists statewide with the exception of localities in Southwest Virginia
 - Endocrinology and nephrology are the most limited and do not meet travel standards in some localities

NOTE: Most frequently used providers include hospitals, primary care, pharmacies, pediatricians, OB/GYN, and behavioral health.

Access to nephrologists is most limited in Southwest Virginia

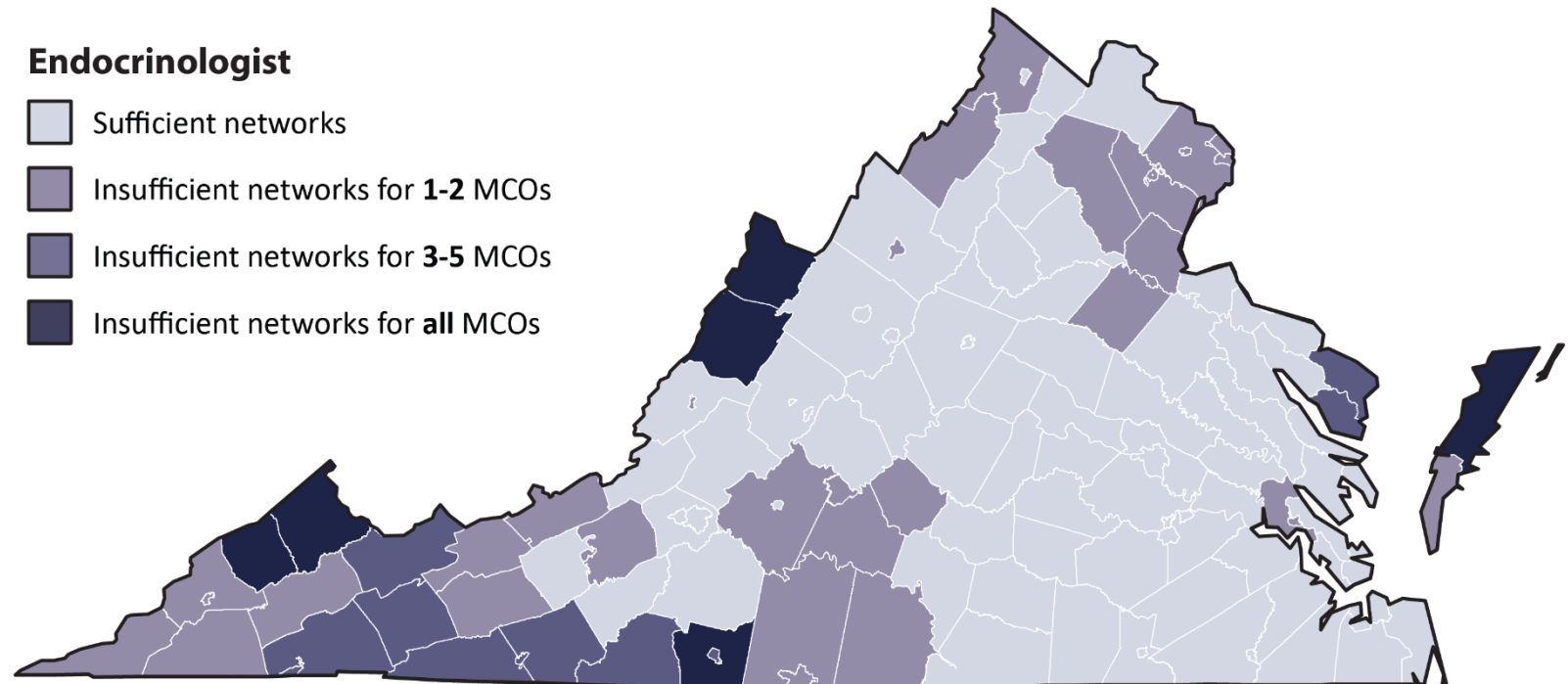
Nephrologist

-  Sufficient networks
-  Insufficient networks for 1-2 MCOs
-  Insufficient networks for 3-5 MCOs
-  Insufficient networks for all MCOs



NOTE: Specialists must be located no further than 60 miles and 75 minutes from where members live in rural areas. Nephrologists specialize in kidney treatment.

Access to endocrinologists is most limited in Southwest Virginia



NOTE: Specialists must be located no further than 60 miles and 75 minutes from where members live in rural areas. Endocrinologists treat diabetes, one of the most common chronic diseases.

A minority of members live in areas with potentially insufficient networks of specialists

- **Nephrology**: 19.1 percent of members live in an area where at least one MCO has an insufficient network
 - Less than one percent of members live in an area where no MCOs have sufficient networks
- **Endocrinology**: 37.4 percent of members live in an area where at least one MCO has an insufficient network
 - One percent of members live in an area where no MCOs have sufficient networks

DMAS policies help address insufficient MCO networks

- Members are provided information on MCO networks and can select their MCO upon enrollment
 - Members can switch MCOs if necessary providers are not in-network
 - Members can switch MCOs annually
- MCOs are required to facilitate access to services when they don't have any providers in network
 - Pay for out-of-network providers
 - Provide transportation
 - Provide telehealth

Limited networks are primarily due to providers not participating in all MCO networks

- At least one MCO has a sufficient network in nearly all localities, indicating there is at least one provider that's accessible from nearly all localities
- MCOs report that providers choose not to participate in their networks for a variety of reasons
 - Limited capacity to accept more Medicaid patients
 - Lower reimbursement rates compared to other payers
 - Higher no-show rates among Medicaid members
 - Administrative burden of contracting with all six MCOs

Recommendation

DMAS should work with providers and MCOs to identify reasons for lack of provider participation in MCO networks and develop solutions to improve provider participation.

Upcoming JLARC work on Medicaid expansion

Topic	Scheduled briefing
Eligibility Determination	October 7 th
Enrollment and Spending	December 16 th
COMPASS Waiver	December 16 th

JLARC staff for this review

Tracey Smith, Associate Director

Jeff Lunardi, HHR Unit Director

Tess Hinteregger, Assistant Legislative Analyst

*Recommendations and agency response attached

Recommendations:

Medicaid Expansion - Access to Services

RECOMMENDATION 1

The Department of Medical Assistance Services should develop and implement a reliable methodology for measuring managed care organizations' compliance with contract standards about how quickly members need to be able to schedule appointments with providers.

RECOMMENDATION 2

The Department of Medical Assistance Services should use currently available information from all six managed care organizations to identify and address challenges members have getting timely appointments until the agency can develop and implement its own methodology for measuring compliance with contract appointment standards.

RECOMMENDATION 3

The Department of Medical Assistance Services should evaluate the feasibility and need to establish more stringent travel standards for rural pharmacies in the Medallion 4.0 and CCC+ contracts when these contracts are eligible for renewal.

RECOMMENDATION 4

The Department of Medical Assistance Services should work with providers and managed care organizations (MCOs) to identify reasons why specialists are not participating in MCO networks in areas with limited specialist networks and develop solutions to improve participation.

Agency Response

As part of an extensive validation process, the state agencies and other entities that are subject to a JLARC assessment are given the opportunity to comment on an exposure draft of the review. JLARC staff sent an exposure draft of this review to the Department of Medical Assistance Services and the Secretary of Health and Human Resources.

Appropriate corrections resulting from technical and substantive comments are incorporated in this version of the report.

This appendix includes response letters from

- the Department of Medical Assistance Services and the
- Secretary of Health and Human Resources.



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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DIRECTOR

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September 10, 2019

Mr. Hal Greer, Director
Joint Legislative Audit and Review Commission
919 East Main Street
Richmond, Virginia 23219

Dear Mr. Greer:

Thank you for the opportunity to review and comment on the exposure draft of the JLARC briefing on *Medicaid Expansion: Access to Services*. The Department of Medical Assistance Services (DMAS) appreciates having had the opportunity to meet with JLARC staff to discuss and clarify issues and to submit written comments prior to the report being finalized. We are committed to working with you and members of the General Assembly to continue to improve access to care for all Medicaid individuals.

We are most appreciative of the Commission's attention on access to care. DMAS agrees that access to health care impacts a person's overall physical, social, and mental health status and also leads to an enhanced quality of life. DMAS was able to significantly improve access this year as a result of the Medicaid Expansion initiative.¹ On June 7, 2018, Governor Northam signed the state budget to expand eligibility under Medicaid for up to 400,000 adult Virginians who had not been eligible for Medicaid in the past. Eligible individuals include adults ages 19 to 64, who are not Medicare eligible, and who have income at or below 138% of the federal poverty limit (FPL). The vast majority of individuals covered through Medicaid expansion are served through managed care organizations (MCOs).

DMAS worked collaboratively with the Virginia Department of Social Services, MCOs, providers, other state agencies, and key stakeholders to implement the expansion initiative effectively and expeditiously, within 6 months of the Governor's approval. Prior to the program launch, DMAS initiated multiple activities to assess, improve, and monitor network adequacy. DMAS proactively worked with the MCOs and major health systems to host a series of Provider Town Hall Meetings across the Commonwealth to recruit new providers and to promote increased provider participation from existing Medicaid providers. DMAS also worked with the thirteen major health systems in Virginia to ensure their participation with the MCOs. DMAS also worked in collaboration with the MCOs to provide support to free clinics interested in enrolling as network providers. Additionally, DMAS and the MCOs worked closely with the Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) to support their

¹ [http://dmas.virginia.gov/files/links/2283/Medicaid%20Expansion%20Memo_FINAL%20\(12.05.2018\).pdf](http://dmas.virginia.gov/files/links/2283/Medicaid%20Expansion%20Memo_FINAL%20(12.05.2018).pdf)

efforts to increase capacity for serving Medicaid expansion members. DMAS also conducted rigorous readiness reviews with each MCO. These reviews included an evaluation of MCO network adequacy, especially with respect to travel time and distance standards as reflected in the JLARC exposure draft.

We are pleased to share that in the first nine months of operation, over 300,000 Virginians have enrolled in the Medicaid expansion group and more than 229,100 of these individuals received some type of health service, including going to the doctor, filling a prescription, or receipt of another medical service. The claims data for these individuals also reflects that they have received treatment for a wide range of health conditions, such as hypertension, diabetes, substance use disorder, behavioral health and cancer. Prior to Medicaid expansion, many of these individuals went without health care.²

We are also pleased that JLARC's findings support that DMAS's network adequacy standards are generally comparable to other states and that the MCOs meet travel standards statewide for the most frequently used providers. JLARC's findings also recognize that DMAS has policies in place that help address insufficient MCO networks. For example, MCOs are required to facilitate access to services when they do not have providers in the network (i.e., pay out of network, provide transportation, provide telehealth). In addition, members have the option to change from one MCO to another outside of their annual open enrollment period if their assigned MCO lacks access to the type of provider needed to meet their health needs.

While we have many best practices in place, we recognize the need for continued improvement. DMAS agrees with all of JLARC's recommendations in this area. Several are consistent with DMAS's planned improvements. For example, DMAS monitors MCO compliance with appointment standards indirectly, i.e., through contract standards, national accreditation standards, and member complaints. However, DMAS recognizes the value of using more proactive methods such as those noted in the JLARC exposure draft. DMAS plans to work with its external quality review organization (EQRO) to develop and implement additional methods for proactively monitoring and measuring MCO compliance with contract appointment standards and toward improving access, including in rural areas.

Thank you for the opportunity to comment on this briefing. We look forward to continuing this discussion and working with the members of the General Assembly to ensure access to important health services to Virginians.

Sincerely,



Karen Kimsey, MSW

c: The Honorable Daniel Carey, M.D - Secretary of Health and Human Resources
Marvin B. Figueroa - Deputy Secretary of Health and Human Resources

² http://dmas.virginia.gov/files/links/4341/07_31_19%20Medicaid%20Expansion%20Milestone%20Announced.pdf



COMMONWEALTH of VIRGINIA

Office of the Governor

Daniel Carey, MD
Secretary of Health and Human Resources

September 10, 2019

Mr. Hal Greer, Director
Joint Legislative Audit and Review Commission
919 East Main Street
Richmond, Virginia 23219

Re: JLARC briefing on *Medicaid Expansion: Access to Services*

Dear Mr. Greer,

Thank you for the opportunity to review and comment on the exposure draft of the JLARC briefing on *Medicaid Expansion: Access to Services*. This letter will confirm that I have reviewed the relevant draft. I discussed my feedback with the Department of Medical Assistance Services (DMAS) and my feedback is reflected in their response.

Please let me know if my office may be of further assistance.

Sincerely,

A handwritten signature in black ink, appearing to read "Daniel Carey", with a long, sweeping horizontal line extending to the right.

Daniel Carey