Managed Care Organization (MCO) Provider Network Adequacy

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services

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MCO Provider Network Adequacy

I. Acronyms and Definitions

A. AODA: Alcohol and drug abuse
B. CMS: Centers for Medicare & Medicaid Services
C. DHS: Department of Health Services
D. LTSS: Long-term services and supports
E. MCO: Managed care organization
F. Service Area: The geographic service area within which potential members must reside in order to enroll in and remain enrolled in an MCO. To be eligible to enroll in an MCO, a potential member must be a resident of the county (or one of the counties) in the MCO's assigned service area
G. Member: A person who is currently enrolled in an MCO
H. General Equipment or Supplies: In-stock and available through a medical equipment supplier. Does not require prior authorization or specialty fitting.
I. Highly Specialized Equipment: Durable medical equipment requiring prior authorization and specialized fitting for the individual

II. Purpose

This document describes the standards for MCO provider network adequacy.

III. Programs Affected

X	Family Care
X	Family Care Partnership
X	PACE (Program of All-Inclusive Care for the Elderly)
	IRIS (Include, Respect, I Self-Direct)
	Long-Term Care Functional Screen
	Tribes

IV. Policy

This policy is created to comply with 42 CFR §438.68, §438.206 and §438.207. This policyis also in compliance with DHS 10.43 and 10.44 (applicable to Family Care only) and the DHS-MCO Family Care/Partnership contract. This policy is posted at www.dhs.wisconsin.gov/familycare/mcos/contract.htm.

V. Provider Network Adequacy

A. Development of the Standards

In accordance with 42 CFR 438.68, the following factors were considered in developing the provider network adequacystandards:

a. The MCO's enrollment per county and service area.
b. The member demographics, including age and disability per county and per servicearea.
c. The characteristics and health care needs of the covered populations.
d. The total demographics (all residents) of each county and service area in order to project potential future program enrollment.
e. The MCO's expected service utilization based on the previous three months' utilization by current members.
f. The numbers and types of contracted providers for each MCO, in terms of training,experience, and specialization.
g. The number of contracted providers who are not accepting new Medicaid patients.
h. The ability of contracted providers to communicate with limited English-proficientmembers in their preferred language.
i. The ability of contracted providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipmentfor members with physical or mental disabilities.
j. The geographic location of contracted providers and members, considering distance,travel time, and the means of transportation ordinarily used by members.
k. The number of available providers in the region contracted or not contracted with theMCO.
l. The MCO's projected increase or decrease in enrollment.
m. The rural or metro counties in the service areas served by the MCO.
n. The availability of triage lines or screening systems, the use of telemedicine, e-visits, and/or other technological solutions.
o. Elements that support a member's choice of provider.
p. Strategies that ensure the health and welfare of the member and support their community integration.
q. Other considerations that are in the best interest of members that need LTSS.

B. Standards for 1915(c) HCBS Waiver Services and Supports

In accordance with 42 CFR §438.68(b), providers of 1915(c) waiver services and supports shall meet the standards for wait time or provider to member ratios outlined below.

Service Type	Provider to Member Ratios	Wait Time to Receive Service
Adaptive aids	N/A	For general equipment or supplies, no more than 30 business days from the time of service order. For highly specialized equipment and supplies, no more than 120 business days from the time of service order.

Service Type	Provider to Member Ratios	Wait Time to Receive Service
Adult day care services	350 members per 1 provider	N/A
Adult residential care – 1- 2 bed adult family homes	75 members per 1 provider	N/A
Adult residential care – 3- 4 bed adult family homes		
Adult residential care – community-based residential facility	200 members per 1 provider	N/A
Adult residential care – residential care apartment complex	300 members per 1 provider	N/A
Assistive technology and communication aids	N/A	For general equipment or supplies, no more than 30 business days from the time of service order. For highly specialized equipment and supplies, no more than 120 business days from the time of service order.
Care management	N/A	N/A
Consultive clinical and therapeutic services for caregivers	N/A	No more than 60 business days from the time of service approval.
Consumer-directed supports (self-directed supports) broker	900 members per 1 provider	N/A

Service Type	Provider to Member Ratios	Wait Time to Receive Service
Consumer education and training	N/A	No more than 60 business days from the time of service approval.
Counseling and therapeutic resources	300 members per 1 provider	N/A
Daily living skills training	200 members per 1 provider	N/A
Day habilitation services	300 members per 1 provider	N/A
Environmental accessibility adaptations (home modifications)	N/A	No more than 60 business days from time of service approval.
Financial management services	900 members per 1 provider	N/A
Home-delivered meals	1200 members per 1 provider	N/A
Housing counseling	N/A	No more than 60 business days from the time of service approval.
Personal emergency response systems services	N/A	No more than 30 business days from time of service order.
Prevocational services	250 members per 1 provider	N/A
Relocation services	N/A	No more than 60 business days from the time of service approval.

Service Type	Provider to Member Ratios	Wait Time to Receive Service
Respite	400 members per 1 provider	N/A
Self-directed personal care	775 members per 1 provider	N/A
Skilled nursing services registered nurse/licensed practical nurse	775 members per 1 provider	N/A
Specialized medical equipment and supplies	N/A	For general equipment or supplies, no more than 30 business days from the time of service order. For highly specialized equipment and supplies, no more than 120 business days from the time of service order.
Supported employment – individual employment support	250 members per 1 provider	N/A
Supported employment – small group employment support		
Supportive home care	300 members per 1 provider	N/A
Training services for unpaid caregivers	N/A	No more than 60 business days from the time of service approval.

Service Type	Provider to Member Ratios	Wait Time to Receive Service
Transportation (specialized transportation) – other transportation	150 members per 1 provider	N/A
Transportation (specialized transportation) – community transportation		N/A
Vocational futures planning and support	N/A	No more than 30 business days from time of service approval.

C. Standards for Family Care Long Term State Plan Services and Supports

In accordance with 42 CFR §438.68(b), providers shall meet the standards for wait time or provider to member ratios outlined below.

Service Type	Provider to Member Ratios	Wait Time to Receive Service
AODA services (excluding inpatient or physician- provided)	200 members per 1 provider	N/A
AODA day treatment	200 members per 1 provider	N/A
Case Management	N/A	N/A
Community support program	350 members per 1 provider	N/A
Durable medical equipment (excluding hearing aids, prosthetics, and family planning supplies)	N/A	For general equipment or supplies, no more than 30 business days from the time of service order. For highly specialized equipment and

Service Type	Provider to Member Ratios	Wait Time to Receive Service
Disposable medical supplies		supplies, no more than 120 business days from the time of service order.
Home health services	250 members per 1 provider	N/A
Mental health services (excluding inpatient, physician-provided, or comprehensive community services)	150 members per 1 provider	N/A
Mental health day treatment		N/A
Nursing (including intermittent and private duty)	775 members per 1 provider	N/A
Nursing home stays (nursing home, institute for mental disease, and intermediate care facility for individuals with intellectual disabilities	350 members per 1 provider	N/A
Occupational therapy	200 members per 1 provider	N/A
Personal care	775 members per 1 provider	N/A
Physical therapy	200 members per 1 provider	N/A
Respiratory care	200 members per 1 provider	N/A
Speech and language pathology services (except in inpatient and hospital settings)	200 members per 1 provider	N/A
Transportation (excluding ambulance)	150 members per 1 provider	N/A

Family Care Partnership program acute and primary provider standards are set and monitored by CMS as part of the Medicare advantage plan CMS oversight process. Thesestandards can be found on the CMS website.

D. DHS Oversight

DHS reviews each individual MCO's provider network and determines adequacy compliance. Due to the varying service needs and demographics of members in each county and the availability of out-of-county providers, DHS reviews each MCO's servicearea in detail to determine adequacy. This review is conducted at the following times:

1. When an MCO first enters into a contract with DHS.
2. Annually.
3. When there has been a significant change in the MCO's operations that would affectthe adequacy of capacity and services, including, but not limited to:
    a. An increase or reduction of 25 percent or more in the number of members in the MCO's service area as compared to the number of members reported in the mostrecent documentation provided to DHS.
    b. A reduction of five percent or more in the number of providers in the servicearea as compared to the number of providers reported in the most recent documentation provided to DHS.
    c. Enrollment of a new population in the MCO.
    d. Changes in MCO services, benefits, geographic service area, and composition ofor payments to its provider network.

If DHS determines the network is inadequate, the MCO shall, within a timeframe determined by DHS, contract with additional providers or cover these services throughout-of-network providers.

DHS may grant an exception to these standards if the MCO requests an exception and provides all of the following to the Department:

a. The number of and availability of provider types in the service area
b. The MCO's ability to contract with available providers
c. The impact to members in the proposed county and the surrounding areas
d. The MCO plan for how the MCO will serve its members despite network adequacy deficiencies

DHS will require the MCO to submit documentation to address the factors listed above. If DHS grants an exception, DHS will monitor member access to affected provider type(s). Further, if DHS grants an exception, the MCO will be required to provide updates on its efforts to meet network adequacy requirements every 90 days or upon DHS request.