Managed Care Organization (MCO) Provider Network Adequacy

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services

P-02542 (01/2020)

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I. 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 services 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. Metro Classification: A county with a population greater than 10,000 residents
I. Rural Classification: A county with a population less than 10,000 residents
J. General Equipment or Supplies: In-stock and available through a medical equipment supplier. Does not require prior authorization or specialty fitting.
K. 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
	IRIS (Include, Respect, I Self-Direct)
	Money Follows the Person
	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 policy is 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: https://www.dhs.wisconsin.gov/familycare/index.htm

V. Provider Network Adequacy

A. Development of the Standards

The following factors were considered in developing the provider network adequacy standards:

a. The MCO's enrollment per county and service area.

b. The member demographics, including age and disability per county and per service area.
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-proficient members in their preferred language.
i. The ability of contracted providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for 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 the MCO.
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 CMS Time and Distance Standards for providers of similar services to those included in the CMS Health Service Delivery Table.
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 Providers a Member Must Travel to in Order to Receive Services 42 CFR §438.68(b)(1)&(2)(i)

Providers for the following services shall meet the standards for both time and distance and provider to member ratios.

Service Type	Time and Distance		Provider to Member Ratios	
	Rural	Metro	Rural	Metro
AODA services (excluding inpatient or physician-provided)	110 minutes/90 miles	60 minutes/40 miles	200 members per 1 provider	150 members per 1 provider
AODA day treatment				
Mental health services (excluding inpatient, physician-	110 minutes/90 miles	60 minutes/40 miles	150 members per 1 provider	100 members per 1 provider

Service Type	Time and Distance		Provider to Member Ratios	
	Rural	Metro	Rural	Metro
provided, or comprehensive community services)				
Mental health day treatment				
Adult day care services	110 minutes/90 miles	60 minutes/40 miles	350 members per 1 provider	225 members per 1 provider
Day habilitation services	110 minutes/90 miles	60 minutes/40 miles	300 members per 1 provider	275 members per 1 provider
Supported employment – small group employment support	110 minutes/90 miles	60 minutes/40 miles	250 members per 1 provider	200 members per 1 provider
Prevocational services				

C. Standards for Providers that Must Travel to a Member in Order to Provide Services 42 CFR §438.68(b)(2)(ii)

Providers for the following services shall meet the standards for provider to member ratios or the wait time to recipient, or both, as indicated.

Service Type	Provider to Member Ratios		Wait Time to Recipient of Service
	Rural	Metro	
Community support program	350 members per 1 provider	1,500 members per 1 provider	
Counseling and therapeutic resources	300 members per 1 provider	300 members per 1 provider	
Home health services	250 members per 1 provider	150 members per 1 provider	
Supportive home care	300 members per 1 provider	100 members per 1 provider	
Personal care	400 members per 1 provider	775 members per 1 provider	
Self-directed personal care			
Respite	400 members per 1 provider	400 members per 1 provider	
Occupational therapy	100 members per 1 provider	200 members per 1 provider	

Service Type	Provider to Member Ratios		Wait Time to Recipient of Service
	Rural	Metro	
Physical therapy			
Skilled nursing services registered nurse/licensed practical nurse	400 members per 1 provider	775 members per 1 provider	
Nursing (including intermittent and private duty)			
Supported employment – individual employment support	250 members per 1 provider	200 members per 1 provider	
Transportation (specialized transportation) – other transportation	100 members per 1 provider	150 members per 1 provider	
Transportation (excluding ambulance)			
Transportation (specialized transportation) – community transportation			
Home-delivered meals	200 members per 1 provider	1200 members per 1 provider	
Financial management services	300 members per 1 provider	900 members per 1 provider	
Consumer-directed supports (self-directed supports) broker	900 members per 1 provider	900 members per 1 provider	
Adult residential care – 1-2 bed adult family homes	75 members per 1 provider	50 members per 1 provider	
Adult residential care – 3-4 bed adult family homes	75 members per 1 provider	50 members per 1 provider	
Adult residential care – community-based residential facility	100 members per 1 provider	200 members per 1 provider	
Adult residential care – residential care apartment complex	200 members per 1 provider	300 members per 1 provider	
Nursing home stays (nursing home, institute	125 members per 1 provider	350 members per 1 provider	

Service Type	Provider to Member Ratios		Wait Time to Recipient of Service
	Rural	Metro	
for mental disease, and immediate care facility for individuals with intellectual disabilities)			
Durable medical equipment (excluding hearing aids, prosthetics, and family planning supplies)			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.
Disposable medical supplies			
Specialized medical equipment and supplies			
Adaptive aids			
Assistive technology and communication aids			
Personal emergency response systems services			No more than 30 business days from time of service order.
Environmental accessibility adaptations (home modifications)			No more than 60-90 business days from time of service approval.
Daily living skills training	100 members per 1 provider	200 members per 1 provider	
Consultative clinical and therapeutic services for caregivers			No more than 60 business days from time of service approval if the service is not provided internally by the MCO.
Consumer education and training			
Housing counseling			
Training services for unpaid caregivers			
Relocation services			
Vocational futures planning and support			No more than 30 business days from time of service approval.
Speech and language pathology services (except in inpatient and hospital settings)	100 members per 1 provider	200 members per 1 provider	
Respiratory care	100 members per 1 provider	200 members per 1 provider	
Case management			

Service Type	Provider to Member Ratios		Wait Time to Recipient of Service
	Rural	Metro	
Care management	No greater than 1 case manager per 50 members, if service is not provided internally by the MCO.		

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. These standards 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 service area 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 affect the 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 most recent documentation provided to DHS.
    b. A reduction of five percent or more in the number of providers in the service area 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 of or 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 through out-of-network providers.

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

1. Conclusive evidence that there are an insufficient number of providers to contract with for a service in a given county.
2. An explanation of the factors beyond the MCO's control contributing to the inadequate supply.
3. The MCO's strategy to provide a similar service to support member outcomes or other alternatives.

VI. Revision History

Date	Rev. No.	Change	
01.24.20		Original Draft	DM, AL