MO HealthNet Oversight Committee Meeting
February 17, 2015

Provider Directory Survey

1. The MO HealthNet Managed Care, Contract Compliance Unit conducted a survey of the health plans' provider panels in November and December 2013.

2. The survey focused on verifying:
   a. The provider's address on the health plan's website and
   b. If the provider was accepting new patients

3. The provider types surveyed were:
   a. Primary care providers,
   b. Behavioral health providers (Psychiatrists and Psychologists),
   c. Dentists, and
   d. Vision providers.

4. A total of 621 providers were surveyed and staff identified errors (either incorrect addresses or incorrect open/closed panel status) with the information of 325 (52.3%) providers on the health plans' websites.

5. In January 2014, the MHD sent letters to each of the health plans notifying them of a few instances of the mis-information on their website. A corrective action plan was requested from each health plan outlining the health plan's process for monitoring and correcting the provider directory.

6. Contract Compliance staff reviewed and approved the corrective action plans and notified the health plans.

7. In December 2014, the Contract Compliance staff conducted a follow-up review of each health plan's provider directory. The review results are not finalized but staff have seen an approximate 20% in increased accuracy across all three health plans.

Managed Care provider networks are receiving attention at the national level.

a. The Department of Health and Human Services, Office of Inspector General published a report in December 2014 as a result of a congressional request to evaluate the adequacy of access to care for enrollees in Managed Care nationwide.
b. The OIG sampled 1800 primary care providers and specialists in 32 states providing full-risk Managed Care (active January 2012 through December 2013) to assess the availability and timeliness of appointments for Managed Care enrollees.
   (2 of Missouri's health plans were included in the report. Findings within the report were aggregated, not health plan specific).
c. The report found:
   - Slightly more than half of providers could not offer appointments to enrollees.
   - 35% of providers could not be found at the location listed by the health plans.
   - Another 8% were at the location, but were not participating with the health plan.
   - An additional 8% were not accepting new patients.
   - Among providers who offered appointments, the median wait time was 2 weeks.
     - Over a quarter had wait times more than 1 month,
     - 10% had wait times longer than 2 months, and
     - Specialists had longer wait times than primary care providers.

The OIG called for the Centers of Medicare and Medicaid Services (CMS) to work with states to improve oversight of health plan networks.

a. Assess the number of providers offering appointments and improve the accuracy of health plan information.
b. Ensure health plan networks are adequate and meet the needs of their enrollees.
c. Ensure the health plans are complying with existing State standards and assess whether additional standards are needed. (MO health plans have to meet travel distance standards required by the Department of Insurance, Financial Institutions, and Professional Registration – 20 CSR 400-7.095)

I would expect policy changes from CMS in the future.

Managed Care Contract Effective July 1, 2015

As mentioned previously, the Managed Care contract effective July 1, 2015 includes and administrative performance withhold of one half of one percent (0.50%) tied to provider panel accuracy and completeness.

a. The external quality review organization will be conducting these provider surveys for MHD.
b. After the first 6 months of the contract period, the provider directory for primary care providers and psychiatrists on the health plans' websites must have a 90% accuracy rate and must be accepting new members.
c. After the second 6 months of the contract period, appointment wait times for primary care providers and psychiatrists must be compliant with the contract requirements 70% of the time.
d. The health plans must meet the performance metrics to receive the withhold amount. No partial return of the withhold amount is available for performance by rate cell or by region.
e. The types of providers measured for the provider panel performance metric are subject to change in the second and third years of the contract.