Network Adequacy in the Commonwealth Care Program

Submitted to the Blue Cross Blue Shield of Massachusetts Foundation
Bailit Health Purchasing
April 3, 2009

Executive Summary

On behalf of the Blue Cross Blue Shield of Massachusetts Foundation ("the Foundation"), Bailit Health Purchasing, LLC ("Bailit") conducted a study to examine whether or not access is adequate for enrollees served by the publicly funded Commonwealth Care program, which is administered by the Commonwealth Health Insurance Connector Authority ("the Connector"). Specifically, the study sought to review network adequacy, including geographic, temporal, cultural linguistic and appointment access, provided by managed care organizations (MCOs) with which the Connector contracts. Bailit conducted a multi-faceted review including a:

- literature review of national standards and geo-access data from Commonwealth Care MCOs;
- in-depth comparison of Commonwealth Care network adequacy standards with both MassHealth and a commercial benchmark plan; and,
- stakeholder interviews including Connector staff, Commonwealth Care MCO staff, provider association, community health center staff and consumer advocates.

Based on a review of the network adequacy requirements within the current Commonwealth Care MCO contracts and the requirements included in the Connector's 2009 procurement, effective July 1, 2009, Bailit determined that the Connector's contract includes appropriate requirements to support sufficient network adequacy for the Commonwealth Care population. Most importantly, the Connector and MCO contracts support a process whereby all Commonwealth Care members either select or are assigned a primary care physician.

Bailit found that like the Commonwealth Care program itself, contract standards incorporate aspects of both MassHealth MCO contracts and commercial plans, representing a hybrid approach to covering this previously uninsured population. With the implementation of new contract provisions beginning July 1, 2009, Commonwealth Care plans will be required to better support the needs of enrollees regarding cultural and linguistic access and behavioral health needs.

Interviews with Connector and Commonwealth Care MCO staff and targeted stakeholders revealed few statewide problems with network adequacy. While all stakeholders acknowledged program start-up issues, the general perception was that Commonwealth Care is providing adequate access to its membership overall. In general, stakeholders indicated that Commonwealth Care enrollees share similar barriers to access in both MassHealth and commercial plans, indicating that access issues are not specific to Commonwealth Care. For example, where members are experiencing delays in obtaining appointments or are facing longer wait times at physician's offices, those delays do not appear to be any greater than delays experienced by consumers in Massachusetts as a whole.

Neither the Connector nor the Commonwealth Care MCOs staff reported member complaints to Bailit that indicated issues regarding network adequacy. As complaints or other issues arise within the plans, they are solved on an ad-hoc basis. However, community health center staff noted that they often receive member complaints either about the members' ability to continue with their current primary care provider under a Commonwealth Care plan or about their ability to obtain access to specialists.

Bailit's stakeholder interviews did reveal some access issues in targeted areas of the state, despite the fact that plans are in compliance with contractual network adequacy requirements. In some cases, issues mirror statewide problems across all managed care products; however a number of the issues arise from the Connector's current policy of requiring members to bear the difference in cost for enrolling in a plan other than the low-cost plan in the service area. Based on a new reimbursement methodology that will be included in the Connector's MCO contracts effective July 1, 2009, however, the differences in cost will be minimal, reducing this as an on-going issue.

Even without the pressure of paying additional premium dollars in exchange for choice, members will still face limits on access and choice as a result of narrow networks and an inability to obtain covered services based on traditional referral relationships. Bailit notes, however, that the principles of managed care intentionally seek to promote use of specific MCO networks and referral patterns and the Connector appropriately maintains an arms-length relationship with its MCOs while balancing the access needs of its members.

As part of this report, Bailit offers a number of recommendations to the Connector Board and staff to further improve access going forward.

- Conduct a planned analysis of provider overlap across MCOs to understand the impact of limited provider networks within Commonwealth Care.
- Require MCOs to report on out of network referrals as potential way to target access issues.
- Collaborate with contracted MCOs and providers to develop better methods and strategies through which to collect information from members about their ability to access care.
- Work closely with contracted MCOs to ensure that the plans continue to meet the network adequacy requirements within their contract, particularly given the expected entrance of CeltiCare, a new Commonwealth Care plan as of July 1, 2009 and the ongoing state budget crisis.

I. Introduction

Bailit Health Purchasing, LLC ("Bailit") is pleased to submit this report to the Blue Cross Blue Shield of Massachusetts Foundation ("Foundation") regarding provider network adequacy for publicly funded Commonwealth Care managed care organizations in Massachusetts.

A recent Urban Institute report on Massachusetts Health Reform found that Commonwealth Care has increased access to services for the previously uninsured. However, anecdotal reports of Commonwealth Care members' difficulty in accessing care persist. The Foundation commissioned this report to gain a better understanding of the network adequacy of the Commonwealth Care plans. Our review of network adequacy focuses on whether there are sufficient providers within a plan's network to provide timely care to its membership. We also touch on the cultural competency of the provider network, credentialing of providers, and the impact of inclusion or exclusion of safety net providers on network adequacy and continuity of care.

In order to complete this study, Bailit:

1. **Reviewed current Commonwealth Care MCO Contracts**
As a first step, Bailit obtained and reviewed the current Commonwealth Care MCO contracts. Bailit's goal was to understand the current network adequacy requirements within the contract. In addition, Bailit looked at the contract to determine the current remedies available to the Connector should an MCO not be in compliance with network adequacy or access standards. Bailit also reviewed the Connector's 2009 Procurement (released in December 2008) to understand the requirements that will be in place for Commonwealth Care plans as of July 1, 2009.

2. **Studied current access issues related to network adequacy**
Next, Bailit staff developed an understanding of current access issues that affect a Commonwealth Care members' ability to obtain care including but not limited to structural, policy, and contracting barriers. To develop this understanding Bailit staff:
   - interviewed Connector staff and staff at Commonwealth Care MCOs,
   - conducted targeted interviews with key provider and advocacy groups, community health centers (CHCs), and commercial MCOs,
   - reviewed GeoAccess reports to determine compliance with network adequacy requirements and,
   - reviewed additional issues as documented that are relevant to Commonwealth Care network adequacy.

3. **Reviewed Best Practices**
To identify and document best practices regarding network adequacy and access standards, Bailit set out to review relevant literature regarding strategies to enhance access for low-income populations, including a web search targeted to leading organizations in the area of access to care for publicly funded coverage. However, our

research found limited applicable information on network adequacy as related to access for low-income populations, particularly given the uniqueness of the Commonwealth Care program. Bailit staff reviewed the limited information available and also compared Commonwealth Care's network adequacy standards to the recent MassHealth MCO reprocurement as well as to a commercial plan in the Commonwealth.

4. Analyzed Adequacy of Current Network Access Standards
Based on the results of our interviews and research described above, Bailit evaluated current Commonwealth Care network adequacy standards against standards for MassHealth and the commercial market to identify where Commonwealth Care standards differ and any potential issues. Bailit staff also considered other barriers to access and how such barriers within the system can be addressed through access standards.

II. Overview of Commonwealth Care

The Commonwealth Care program is administered by the Commonwealth Health Insurance Connector Authority (the "Connector"). The Connector is a quasi-independent state agency that is overseen by a 10-member board, chaired by the Secretary of Administration and Finance. Launched in October 2006, Commonwealth Care is one piece of the Commonwealth's historic health care reform enacted in April 2006. The Commonwealth Care program provides health care coverage to individuals in the Commonwealth 19 and older with incomes at or below 300% of the federal poverty level (FPL) who are ineligible for MassHealth and who do not have access to health insurance through an employer. The program currently serves 162,726 members.

The table below shows membership by FPL and describes the premium responsibility of a member.[1]

Plan Type	Enrollment	Monthly Premium Responsibility
Type 1 (0-100% FPL)	84,697	No premium
Type 2A (100-150% FPL)	33,084	Premium if enrollee does not select lowest price plan in service area; premium is equal to half of the difference in cost between the lowest price plan and selected plan[2]
Type 2B (150-200% FPL)	24,514	Base premium: $39, premiums increase by full difference in cost if enrollee does not select lowest price plan
Type 3 (200-300% FPL)	20,431	Base premium: $77 (if 200-250% FPL); $116 (if 250-300% FPL); premiums increase by full difference in cost if enrollee does not select lowest price plan

The majority of Commonwealth Care members – 110,854 – pay no premium towards the cost of their care. This includes all 84,697 members with incomes at or below 100% of the FPL and most of the 33,084 members with incomes between 100 and 150% of the FPL.

The benefit packages provided to Commonwealth Care members are set by the Connector Board. The plans offer comprehensive medical coverage that is at least as generous as plans offered by employers in Massachusetts.[3] Services must include:

- inpatient services;
- outpatient services,
- preventive care services;
- inpatient mental health and substance abuse services;
- outpatient mental health and substance abuse services, and
- prescription drugs.

By design, Commonwealth Care is a hybrid model that incorporates concepts and policies from both the commercial and Medicaid markets. As described above, no individual with income at or below 100% of the FPL is required to pay a premium.

[1] Source: Commonwealth Health Insurance Connector Authority; December 11 Board Materials (enrollment numbers by plan type); see also Health Connector Facts and Figures; accessed December 30, 2008 at www.mahealthconnector.org.
[2] This will be changing to the full cost of the difference effective July 1, 2009.
[3] See Health Care Reform Status Report to Legislature; October 2008 (p. 11), available at www.mahealthconnector.org.

Premiums increase as an individual moves up the income scale.[4] Co-payment responsibilities also increase as an individual moves up the income scale. Those at or below 100% of the FPL are only responsible for minimal prescription drug co-pays that mirror those paid by the MassHealth population.[5] As mandated by Chapter 58, the plans also provide dental coverage to members with incomes at or below 100% of the FPL.

Currently, coverage is provided by one of the four Managed Care Organizations (MCOs) that participate in the MassHealth program[6]; these are the only plans eligible to provide coverage to Commonwealth Care members.[7] Through June 2009, the four MCOs participating in Commonwealth Care will include:

- Fallon Community Health Plan
- Boston Medical Center (BMC) HealthNet
- Neighborhood Health Plan (NHP)
- Cambridge Health Alliance's Network Health

The Connector recently completed its re-procurement for plans to offer coverage effective July 1, 2009. This procurement was open to any qualified bidder, not just MassHealth MCOs, and the Connector received a bid from a new entrant – a partnership between Caritas Christi Health Care ("Caritas") and Centene, a national Medicaid health plan. The new partnership is officially CeltiCare Health Plan of Massachusetts, Inc. and will market itself under the name CeltiCare.

While the plans that currently participate in Commonwealth Care are able to do so because of their participation in MassHealth, the program is operated independently from MassHealth. The Connector maintains separate contracts for Commonwealth Care. Plans are not required to use the same provider networks or provider reimbursement levels for Commonwealth Care as they do for MassHealth. Like MassHealth, the Connector maintains an arms-length relationship with MCOs regarding participation in their network. The Connector must balance the principles of managed care that intentionally seek to promote use of specific MCO networks and referral patterns with appropriate access to providers for its Commonwealth Care members.

---

[4] Individuals with incomes between 100% and 150% of the FPL are only responsible for a monthly premium payment if they do not select the lowest cost price in their service area.
[5] For detailed information on co-payment requirements, see Ibid, p. 12. The Connector eliminated emergency room co-payments for this population in July 2008.
[6] Unlike MassHealth, Commonwealth Care members do not have access to the state's Primary Care Clinician (PCC) Plan.
[7] See Chapter 58 of the Acts and Resolves of 2006. The Medicaid MCOs exclusivity expires in FY09.

To enroll in Commonwealth Care, an individual must first complete an application for public health coverage, known as a Medical Benefit Request form or "MBR."[8] The MBR is used for MassHealth, Commonwealth Care and the Health Safety Net. Once an individual is determined eligible for Commonwealth Care, he or she will receive a notice of eligibility and subsequently an enrollment packet that provides information on how to enroll in a managed care plan. For individuals with incomes at or below 100% of the FPL, the Connector follows the MassHealth managed care enrollment process and provides an individual 14 days within which to select a managed care plan. As of August 2008, 55% of enrollees selected a plan on their own.[9]

If the individual does not select an MCO within that time period, the individual is automatically assigned to an MCO based on an auto assignment protocol constructed by the Connector. As a first step, if an individual has a known previous relationship with an MCO in his or her service area, the individual will be auto-assigned to that MCO. Otherwise, the individual will be auto-assigned via a protocol that gives preference to the lowest cost plan in a service area.[10] As of August 2008, of the remaining 45% of enrollees who did not select their own plan, 18% were assigned to an MCO with whom the individual had had a previous relationship and 27% were automatically assigned to an MCO.[11]

Where a member is required to pay a premium, or may pay a premium based on his or her health plan selection, the enrollment process is different by necessity, since premium paying members must agree to, and pay, such fees. Premium paying members must first select an MCO and pay the first month's premium prospectively in order to become enrolled in Commonwealth Care. No individual with income above 100% of the FPL is auto-assigned to a plan; these individuals must affirmatively select a plan for coverage to begin.

As of August 2008, the majority of Commonwealth Care members were enrolled in either HealthNet (43% of all Commonwealth Care members) or Network Health (35% of all Commonwealth Care members). NHP enrolled 15% of all Commonwealth Care members and the remaining 5% were enrolled with Fallon. Network Health and BMC HealthNet garnered the highest enrollment as the two plans were available in the most regions of the state and, because they were the lowest cost plans in various regions, providing them with auto-assignment from those with incomes at or below 100% of FPL.

---

[8] As with MassHealth, Commonwealth Care members are required to have an eligibility re-determination on an annual basis. In addition, Commonwealth Care utilizes similar program integrity tools as MassHealth to ensure a member's eligibility, such as use of matches with the Massachusetts Department of Revenue and matches to determine whether employer-sponsored insurance is available.

[9] HCR Report to the Legislature, p. 13.

[10] Ibid.

[11] Ibid. Our stakeholder interviews revealed a number of issues around the enrollment and auto-assignment process, as described below on page 20.

Under the current Commonwealth Care contracts, MCOs bid a premium rate for a service area, and where they are the lowest price plan in the area, the MCO receives preference for auto-assignment. In addition, premium-paying members are only required to pay the base premium without a supplement if they enroll in the lowest cost plan. In the first year of the Commonwealth Care program, Network Health and HealthNet were the lowest cost plans across the state. In July 2008, Fallon became the lowest cost plan in Central Massachusetts. That change had no cost impact for the vast majority of Commonwealth Care's members that do not pay any premium at all. However, for those in premium categories, individuals faced major increases in their premium for remaining with the previous lowest cost plan – Network Health. While many members changed plans, network adequacy issues were raised because Fallon utilizes its limited direct care network, consisting mainly of Fallon Clinics. [12] Because Fallon utilizes its direct care network it has not contracted with area community health centers (CHCs) which many members utilized when Network Health was their plan.[13] The Fallon plan, however, meets all Connector network adequacy requirements.

The Connector is set to modify its payment methodology effective July 1, 2009. In its recently completed procurement, the Connector published target premiums, which will be risk adjusted. Bidders were encouraged to bid below the target premiums by two percent and will receive auto-assigned members as a result. Having a maximum premium for participating plans and a relatively small difference between that maximum premium and the lower cost plans should prevent large differences in premiums among plans and, therefore, decrease the possible out-of-pocket exposure for members who wish to join or remain in a "higher cost plan." The Connector will publish a new affordability schedule in 2009 that is based on the new target premiums.

Commonwealth Care members may change their health plan selection once within the first 60-days of coverage with a plan. After that, the member may only change a health plan during open enrollment or by requesting a waiver from the Connector. Since June 2007, the Connector has tracked the numbers of requests and appeals. Between June 2007 and August 2008, the Connector received approximately 500 appeals, based on a request to change health plans. The majority of these appeals have been approved. In most cases, an individual requested a change after having been subject to the auto assignment process.[14]

Similar to commercial insurance, the Connector holds an annual open enrollment period when a member may change plans. Previously, Commonwealth Care has engaged in a passive open enrollment process; that is, if a member does not select a new plan he or she has remained in his or her current plan. Going forward, however, members must

[12] Plan changes that require individuals to change their primary care provider may have an impact on an individual's continuity of care.
[13] As described below, in our interview with stakeholders, there has been disruption in continuity of care and/or large increases in premiums for a number of members in Central Massachusetts.
[14] HCR Report, p. 21; the Connector also received 800 appeals requesting a waiver of co-pay or premium. The majority of those have also been approved.

affirmatively choose an MCO or they will be auto-assigned to the lowest cost plan, if their income is at or below 100% of the FPL. [15] For those with incomes above 100% of the FPL, the open enrollment period will remain passive.

During the late summer/fall of 2008, the Connector engaged Navigant Consulting to conduct an operational audit of the Commonwealth Care MCOs. As part of their work, Navigant was charged with assessing the adequacy and competitiveness of the MCOs' provider networks. The Navigant report has not yet been finalized and has not been made public by the Connector to date. However, at its December 11th Board meeting, the Connector briefly discussed the Navigant assessment and provided the following information regarding their recommendations relevant to network adequacy[16]:

- work with MCOs to conduct a survey to determine actual availability of appointments for enrollees;
- require MCOs to provide policies and procedures related to services from closed panels[17] and ensure promotion of continuity of care, and
- add behavioral health access standards and monitoring policies to RFP and contract requirements.

[15] Effective July 1, 2009, Commonwealth Care enrollees with incomes at or below 100% of the FPL have increased protection to limit movement among plans based on the low cost MCOs. Enrollees whose current MCO did not bid 1% below the target rate are subject to being transferred to a different MCO if that enrollee does not actively affirm their current MCO during the open enrollment period. When transferring the enrollee to a lower cost MCO, the Connector will look to assign the enrollee to another plan where he or she may remain with his or her current PCP. No enrollee that has a Serious or Very Serious risk score will be transferred. All enrollees have 60 days to transfer plans from the date of assignment.

[16] See Commonwealth Care FY 2010 MCO Procurement Update, Presentation to the Connector Board by Patrick Holland, December 11, 2008.

[17] A provider that is not currently accepting new patients has a closed panel.

III. Analysis of Network Adequacy within Commonwealth Care

To understand what, if any, network adequacy issues existed with the Commonwealth Care program, Bailit staff began the project by requesting a number of documents from the Connector, including:

- current Commonwealth Care Contracts;
- 2009 procurement;
- Commonwealth Care GeoAccess reports;
- Commonwealth Care Grievances and Complaints Log;
- report on out of network referrals; and
- Navigant Consulting MCO Operational Audit Report.

The Connector shared copies of the current Commonwealth Care contracts, the RFP released in December 2008, and GeoAccess reports received from the plans. The Connector declined to share its grievances and complaints log as well as the results of the 2008 MCO operational audit conducted by Navigant since it was not finalized. While Bailit hoped to review out-of-network referrals as a proxy for adequate access, the Connector does not currently require MCOs to provide a report on out of network referrals.

In addition to reviewing the available information, Bailit spoke in detail with Connector staff responsible for managing the Commonwealth Care MCO Contracts. To obtain a balanced understanding of access based on the opinions of various stakeholders groups, Bailit also conducted a number of interviews with a broad range of stakeholders.

Our findings from these activities are described below.

Commonwealth Care Network Adequacy Standards

To assess the adequacy of requirements in the Connector's MCO contract, Bailit gathered information regarding access standards from the National Committee on Quality Assurance (NCQA), the Massachusetts Division of Insurance (DOI), MassHealth MCO contracts, a commercial health plan in Massachusetts, the Connector's original Commonwealth Care contract, and its 2009 procurement. Bailit also conducted a literature review regarding referral patterns for specialty and acute care services generally and, for cultural and linguistic competence specifically. Bailit's review of the Commonwealth Care contract included attention to key elements of access such as geographic, temporal, cultural linguistic and physical access.

Both NCQA and DOI language offer health plans a significant degree of latitude to develop access standards that are unique to their plan. In some states (i.e. New York and Maryland) the state incorporates specific access standards into statute or regulation rather than offering health plans such discretion; however, this is not the case in Massachusetts. Instead, plans that are NCQA accredited and/or DOI licensed are free to establish access standards of their own.

Because there are few comparable programs to Commonwealth Care, there is limited research on network adequacy that is applicable.[18] In addition, there is not much recent research on the topic. In 2001, the Center for Health Care Strategies (CHCS) developed a toolkit focused on ensuring access to providers in managed care networks.[19] While the CHCS toolkit focused on special needs populations, much of the work is applicable to all publicly sponsored programs. The CHCS report recommends that states' consider a number of issues in determining what type of priority to place on monitoring of network adequacy and select areas to monitor based on the state's specific program features and policy issues and the population's needs. The report suggests that network adequacy provisions include:

- numbers and types of providers required in the network;
- time and distance standards for availability of services, and
- appointment availability standards.

The report also suggests that states should require routine monitoring of provider networks, including reports from MCOs, provider and member surveys related to access to providers, and corrective action plans. Additionally, the state should provide clear information on how to complain about provider access at a plan, program and statewide level. For out-of- network providers, the report suggests that states require MCOs to ensure out-of-network or out-of-area providers as necessary to provide reasonable access to services. The Commonwealth Care MCO contracts provide many of these provisions and others, as described below, are being considered by Connector staff.

Bailit reviewed standards from Commonwealth Care plans by looking at a current Commonwealth Care MCO contract as well as the Connector's RFP which was released in December 2008, during the term of this project. Bailit also reviewed the network adequacy standards contained in the pending MassHealth procurement and obtained network adequacy standards from a commercial plan in Massachusetts that does not offer coverage through Commonwealth Care. The commercial plan's standards were developed as part of their NCQA accreditation process. A table providing our complete comparative analysis is included as Appendix A to this report.

Among other requirements, the Connector's initial Commonwealth Care contract included a delineation of health plan requirements for necessary and valuable elements of access including: wait times for services (i.e. non-symptomatic care, symptomatic care, urgent care and emergent care); network contracting practices to ensure a sufficient provider network; and, standards to support cultural and linguistic competence.

[18] The Connector is working with NCQA to develop accreditation standards for Commonwealth Care plans that will address both network adequacy requirements and other NCQA standards, such as quality and utilization management standards.

[19] Suzanne Felt-Lisk, Jessica Mittler, and Amanda Cassidy, Mathematica Policy Research, Inc., *Ensuring Special Needs Populations' Access to Providers in Managed Care Networks, A Technical Assessment Tool for State Medicaid Agencies*, Center for Health Care Strategies, Informed Purchasing Series, January 2001.

In general, Bailit believes that the Connector's contractual access standards in its 2008 MCO contracts were reasonable and sound; however, the standards were not always as specific or detailed as those utilized in the MassHealth MCO contracts. While the Connector's requirements are a hybrid of what is found in commercial and Medicaid contracts, the known behavioral health needs of the Commonwealth Care population may call for requirements that are more akin to MassHealth than the commercial market. In its original contracts, Commonwealth Care plans did not have specific behavioral health requirements. These requirements have been updated in the 2009 procurement as discussed below.

Bailit's review shows that Commonwealth Care contract standards are generally less stringent than network adequacy standards established by commercial insurers. For example, the commercial standards reviewed require that enrollees have a choice of at least 2 PCPs with open panels in urban areas within a distance of 8 miles while the Connector requires that enrollees have a choice of at least 2 PCPs with open panels within 15 miles or 30 minutes travel time. The commercial standard also distinguishes between urban and rural areas while Commonwealth Care contracts do not.

Like the commercially available standards, the Commonwealth Care contract includes a requirement for the ratio of providers to enrollees – a 1:200 ratio per service area for PCPs and a 1:500 ratio for OB/GYNs to female enrollees in a service area.[20] Unlike the commercial requirements, however, the Commonwealth Care contracts do not include a requirement for the percentage of PCPs with open panels. However, the Connector measures network adequacy for Commonwealth Care based only on open panels, as described below in the analysis of the GeoAccess reports. At the same time, Commonwealth Care contracts include more of a focus on behavioral health[21] and elements such as cultural and linguistic access than commercial contracts.
With the release of its most recent MCO procurement in December 2008, the Connector significantly strengthened its behavioral health requirement, as well as other access requirements beyond those in its original MCO contract. Highlights of changes from the original contract to the contract that was released as part of the current procurement include additional and/or new requirements for the MCOs to:

- Provide Physician Services where the MCO must make commercially reasonable efforts to provide a PCP Network located within each Service Area sufficient enough to offer each Enrollee within the Service Area a choice of at least two different PCP sites with an open PCP panel located within 15 miles or 30 minutes travel time from the Enrollee residence.
- Provide Rehabilitation Hospital Services – within 15 miles or 30 minutes travel time from an Enrollee's residence.

[20] See Section 2.5.C.4 and Section 2.5.G.2 of the Commonwealth Care contracts.
[21] As noted below, Commonwealth Care in its current contracts has significantly less of a focus on behavioral health, however, than MassHealth. There is a greater behavioral health focus in its 2009 procurement.

- Provide Urgent Care Services – within 15 miles or 30 minutes travel time from an Enrollee's residence.

Specifically for behavioral health:

- Ensure that Enrollees have access to a choice of at least two Network Providers who provide Behavioral Health Services to the extent that qualified willing Providers are available. Contractor must develop and implement policies to monitor access and availability of their behavioral health Provider Network.
- Offer access to Behavioral Health Services – within 60 miles or 60 minutes travel time from the Enrollee's residence.[22]
- Provide Emergency Services – immediately, on a 24-hour basis, 7 days a week, with unrestricted access to Enrollees who present at any qualified Provider, whether a Network Provider or a non-Network Provider.
- Provide Emergency Service Provider (ESP) Services – immediately, on a 24-hour basis, 7 days a week, with unrestricted access to Enrollee who present for such behavioral health crisis services.
- Provide Urgent Care - within 48 hours for services that are non-Emergency Services or routine services.
- Provide All Other Behavioral Health Services – within 14 calendar days.
- Develop policies and procedures for the Connector's prior review and approval that outline how behavioral health providers shall integrate and coordinate Inpatient Services admissions, discharge planning, and other utilization management activities.

The new Commonwealth Care standards are more similar to MassHealth standards than in the previous contract but are still somewhat less detailed than the MassHealth standards.

[22] It is important to note that these standards are more lenient than for access to medical services. Likely, this is driven by availability of behavioral health providers in the state. The Foundation, as part of a separate project, is beginning to look at behavioral health capacity issues on a statewide basis. As a first effort, the Foundation will be focusing their work on behavioral health capacity for children.

GeoAccess Report Analysis

The geographic access standard included in the MCO contract with the Connector is as follows:

> "The PCP network shall include a sufficient number of PCPs to offer each Enrollee a choice of at least two appropriate and culturally sensitive PCPs with open panels at separate locations by Service Area or at least two appropriate and culturally sensitive PCPs with open panels located within 15 miles or 30 minutes travel time from the Enrollee's residence. (Section 2.5 (C)(1))."

Each MCO submits a geographic access report semi-annually to the Connector. Our analysis is based on the reports submitted to the Connector in July 2008 for the January through June 2008 time period. The GeoAccess reports show that, overall, the plans are meeting the network adequacy requirements of the contract.[23]

HealthNet and Neighborhood Health Plan both offer coverage statewide. HealthNet's reports show that its network meets the contractual standards for PCPs in all service areas. Neighborhood Health Plan reports access that meets the contractual standards in all service areas. However, access in Falmouth (16.6 miles) and Wareham (16.9 miles) slightly exceed the 15-mile standard. For those areas, NHP uses a standard of 2 PCPs within 30 minutes because the areas are rural. Travel times meet the 30-minute standard (Falmouth is 24.8 minutes, Wareham is 25.3 minutes).

Network Health reports that its network meets the contractual access standards in all service areas in which they are licensed to do business for Commonwealth Care. Network Health is not licensed to do business on the Cape, and in Central and Western Massachusetts is licensed only in Holyoke, Springfield, and Westfield. It is not licensed in Adams, Greenfield, Northampton or Pittsfield.

Fallon reports that its network meets the contractual access standards in all service areas it serves except in the following West Central Massachusetts locations:

a. Orange, MA: 14 members must travel an average of 30.2 minutes;
b. New Salem, MA: 1 member must travel an average of 33.1 minutes, and
c. Warwick, MA: 2 members must travel an average of 38.2 minutes to have access to 2 open PCP panels.

[23] It is important to note that GeoAccess reports are based on computer-simulated models; a GeoAccess report does not tell whether or not members could actually get into care, or whether plans were meeting contractual network adequacy standards. In order to determine whether or not plans are actually meeting standards, "secret shopper" calls or provider surveys would be required.

Fallon's service area is Central and Western Massachusetts, but excludes the far western counties.

While the GeoAccess reports show that the plans are meeting their network adequacy requirements, they also show that there are limited plans available in some areas of the state and wide differences in the proximity of available providers within distances depending on the plan, as shown in the table below.

Access Statistics in Cape Code & the Islands; Central and Western Massachusetts

	HealthNet	Fallon	Network Health	NHP
SOUTH				
Falmouth	1.6 miles	Not Served	Not Served	16.6 miles
Nantucket	3.4 miles	Not Served	Not Served	Limited service
Oak Bluffs	2.6 miles	Not Served	Not Served	Limited service
Orleans	1.8 miles	Not Served	Not Served	7.2 miles
Wareham	2.0 miles	Not Served	Not Served	16.9 miles
CENRAL/WEST				
Greenfield	2.9 miles	Access issues in Warwick, New Salem, and Orange	Not Served	8.0 miles
Adams	2.3 miles	Not Served	Not Served	Not Served
Holyoke	1.4 miles	Not Served	1 mile	3.2 miles
Pittsfield	2.9 miles	Not Served	Not Served	Limited service
Westfield	2.2 miles	Not Served	2 miles	6.0 miles

Monitoring Network Adequacy

As described above, the Connector engaged Navigant Consulting to perform an independent audit of Commonwealth Care, including a review of the program's network adequacy. While the audit findings are not yet finalized and the individual plans have not received feedback, in its 2009 procurement the Connector made changes to reflect at least one of Navigant's recommendations for plans to serve Commonwealth Care beginning July 2009, by including additional behavioral health access standards and monitoring policies.[24]

[24] The Navigant report does not contain a finding about poor behavioral health access, but makes the recommendation as Navigant was unable to assess behavioral health access due to lack of requirements.

The Connector is considering additional changes to its monitoring, including working with the Commonwealth Care MCOs to conduct a survey to determine actual availability of appointments for enrollees and requiring MCOs to provide policies and procedures to the Connector related to services from closed panels and strategies to promote continuity of care.

From its inception, the Connector's monitoring of network adequacy has been appropriately informed by the fact that all MCOs participating in Commonwealth Care also serve the MassHealth population and that within MassHealth, except for specific providers (e.g., dental) access to providers has not been a particularly evident problem.[25] The Connector monitors the network adequacy of its plans in a number of ways, including review of GeoAccess reports of the plans networks, and review of the plans complaints logs. The Connector also looks at calls and complaints received through its customer service vendor. Where the Connector receives reports regarding an issue with network adequacy, Connector staff investigate each complaint as it is received. In many instances, reports of network adequacy complaints, upon investigation, have been found to be made by or on behalf of members of MassHealth or those with coverage through the Health Safety Net. Where issues do involve Commonwealth Care members, the Connector appropriately brings issues to the attention of the particular MCO. Connector staff report that each MCO has been responsive to members and has satisfactorily dealt with issues raised on a case-by-case basis.

During the first six to twelve months of operations, Commonwealth Care experienced numerous start-up issues as MCOs built up their networks and worked to distinguish their MassHealth and Commonwealth Care plans. At the same time, Commonwealth Care members, in many cases, required education regarding managed care and how to use the health care system, resulting in a steep learning curve. Connector staff reported that currently there are few known instances of plans not meeting the contract network adequacy standards. To the extent that non-compliance exists, it occurs in areas of the state with the most acute provider shortages – Western and Central Massachusetts, the Cape and Islands, and the Cape Ann area. These are also the areas that are not currently served by all four Commonwealth Care MCOs.

The Connector receives information semi-annually from MCOs on inquiries, appeals and grievances. While Bailit was unable to access the reports directly, staff note that there are not many reported grievances related to network adequacy. In addition, because the reports are only submitted once every six months, the reports themselves are outdated by the time they are received by the Connector.

In the start-up of Commonwealth Care, the Connector received concerns related to access for dental and vision services. There were issues both in terms of finding

[25] While there is undoubtedly a primary care shortage in the state, typically MassHealth rarely hears from physicians regarding their problems with the program or its rates; and rarely hears complaints from members who cannot find a physician.

participating providers and in members' understanding that they only could use in-network providers. The Connector dealt with these issues on an ad-hoc basis. There were also a number of issues early on regarding auto-assignment and alleged exclusivity arrangements. To deal with this issue, the Connector amended Commonwealth Care contracts to prohibit MCOs from including exclusivity language within their agreements with providers. Lastly, there were a number of issues at the beginning of the program related to open and closed panels of PCPs. Originally, the panels were updated on a weekly basis by a download to a CD. The process has been upgraded to utilize a weekly file transfer instead. In addition, the Connector and its MCOs have clarified with providers its definition of open, partially closed, and closed panels. Partially closed panels mean that "current" patients and sometimes, family members of current patients, can be added to a PCP's panel.[26]

To gain a better understanding of the overlap among Commonwealth Care providers across MCOs, the Connector intends to undertake an "affiliation analysis", using provider NPI numbers to identify overlap and lack thereof. For example, there are a handful of areas where there is a known lack of cross-over today: Fallon Clinics contract only with Fallon; and Atrius Health, which includes Harvard Vanguard and Dedham Medical Associates, only contracts with Neighborhood Health Plan.

Both the current contract and the 2009 procurement include requirements that mandate the provision of out-of-network services where appropriate and further allow for continuity of care around certain transitions in care delivery. Commonwealth Care MCOs are required to report to the Connector on continuous monitoring activities, including updates to the network which often occur based on the demand for out-of-network services. One area where the Connector does not currently receive any reports from the MCOs regards the amount or type of out-of-network referrals requested by members, or approved or denied by the plans. Nor does the Connector receive information regarding whether or not enrollees are allowed to continue pre-existing relationships with providers and for what period of time. Such provisions would serve to better ensure continuity of care.

The most recent RFP follows the Division of Insurance's Office of Patient Protection (OPP) continuity of care guidelines. Under the OPP guidelines, health plans are required to offer enrollees a description of the procedure for choosing a new primary care physician (PCP) if a physician is disenrolled from a plan. The general laws of Massachusetts further state where continuity of care must be provided (e.g. women in their second or third trimester of pregnancy, individuals who are terminally ill, individuals who have an established relationship with a PCP who is not in a new plans' network must have the ability to receive covered services from such a PCP for at least 30

[26] As part of its report, Navigant recommends that the Connector be more prescriptive in defining a panel as open, partially open or closed, or closed. The Connector is considering this but has made no definitive change yet. The Connector is clarifying that the standard is to include only opened panels in determining the network adequacy of a plan.

days after their initial effective date of enrollment). The regulations regarding continuity of care appear in M.G.L Chapter 176o Section 15.

The Connector has not heard many specific complaints regarding cultural/linguistic issues and the impact on network adequacy. There are some issues regarding immediate access to interpreters, and because of that, some wait times are longer for persons speaking a language other than English or Spanish.

Stakeholder Interviews

As part of our research, the Bailit Team interviewed stakeholders with various levels of experience and interaction with Commonwealth Care. Stakeholders included consumer advocacy organizations, provider associations, health plans participating in Commonwealth Care, and directors of CHCs.[27] A full list of organizations interviewed as part of this report is included as Appendix B.

Except as described below, most stakeholders did not believe a member's ability to access care through Commonwealth Care was any different than access issues generally occurring in the state due to provider shortages. A number of stakeholders did note however, that the Health Care Reform legislation and the introduction of Commonwealth Care exacerbated provider access issues as more individuals were looking for a primary care physician or trying to get specialty care, including behavioral health, dental and vision services. As with MassHealth, access to dental services for members with incomes at or below 100% of the FPL continues to be problematic as there are limited numbers of dentists willing to accept insurance from Doral, the dental vendor for both MassHealth and three of the four Commonwealth Care plans.[28] In addition, a number of stakeholders indicated that there was confusion at the start of the program as to which providers were participating in which plans' networks, differentiating Commonwealth Care from MassHealth, and confusion around the initial auto-enrollment of individuals who had previously been determined eligible for services through the Uncompensated Care Pool.[29]

Under Commonwealth Care's design every member must be assigned to a PCP. The Connector and the participating MCOs report that all members successfully choose or are assigned to an open panel and have a designated PCP through which they may receive care.[30] In addition, the Health Care for All consumer help-line reports receiving only a small number of calls from individuals needing assistance with obtaining a PCP.

---

[27] In addition to individual interviews with directors of CHCs, Bailit attended the Mass League of Community Health Center's Governmental Affairs Committee meeting on January 15, 2009 to hear from the CHCs as a group.

[28] Fallon Community Health Plan contracts with Dental Benefit Providers to provide dental care to its Commonwealth Care enrollees.

[29] currently known as the Health Safety Net.

[30] As part of this report, Bailit did not analyze whether Commonwealth Care members were actually accessing services through their plan.

In each case, the helpline has been able to assist a Commonwealth Care member in being placed with an appropriate PCP.

Stakeholders report that many Commonwealth Care members are new to having health care coverage. As a result, it takes additional time for providers to explain the health care system and rules to some members. Often, it requires multiple visits to bring pre-existing patient health issues under control. While this is a positive development, it increases wait times to schedule an appointment and also affects temporal access for those in waiting rooms as providers spend more time with Commonwealth Care members, particularly when they first enroll. As Commonwealth Care members continue to utilize coverage, this problem is likely to diminish.

Bailit received mixed feedback regarding a member's ability to access specialists.[31] To the extent stakeholders raised issues about specialists, the issues were limited to certain types (e.g., dermatology in Central Massachusetts), or long wait times for non-urgent appointments and barriers such as lack of interpreters. In particular, CHCs raised the issue of being able to refer to specialists within their physicians regular practice patterns. Because not all specialists provide care through the same Commonwealth Care plans as for MassHealth, it has complicated the referral process and put additional burden on the staff at the CHCs to assist their patients in scheduling follow-up visits with specialists.

When asked about adequacy of providers' understanding cultural and/or linguistic issues of the Commonwealth Care population, stakeholders generally felt that because the Commonwealth Care MCOs were familiar with the cultural and linguistic needs of the MassHealth population[32], they were able to appropriately develop networks that provide suitable services from a cultural and linguistic basis to Commonwealth Care members.[33] However, some stakeholders did express concerns regarding the diversity of cultural and linguistic needs making it difficult to cover the entire population. CHCs noted that in some cases health center staff accompanies individuals to specialty appointments to ensure that they receive interpreter services. Some provider groups did note that providers often had difficulty recruiting and keeping staff with multi-lingual skills and, that providers do not receive reimbursement for interpreter services.[34]

---

[31] Providers also noted difficulties in the credentialing process with the different Commonwealth Care plans and discussed the negative impact of that on access to providers. Each Commonwealth Care plan has its own credentialing requirements; the Connector requires that the MCOs follow NCQA credentialing requirements.

[32] This suggests an area to watch if there are new entrants into Commonwealth Care in July 2009.

[33] CHCs also raised an issue regarding their efforts to assist in providing interpreter assistance for clients needing to contact the customer service center and having the vendor decline their assistance. They note that this makes it difficult for consumers who need to schedule time or call back to speak with someone in their native language.

[34] Although outside of the scope of this report, we heard from many stakeholders that the process of applying for Commonwealth Care and enrolling in a plan is difficult because of limited number of customer service representatives speaking other languages and difficulty in using the AT&T language line to assist in the process.

All stakeholders agreed that access issues and the adequacy of provider networks were most acute in Cape Cod, the Islands, and Western and Central Massachusetts. In part, these issues may arise from the fact that only BMC's HealthNet had a presence in those areas of the state prior to the implementation of Commonwealth Care and it takes time for new MCOs to build networks and develop strong relationships with providers in a geographic market. This is particularly true where many of the providers in these areas of the state are not part of large provider groups but are small or individual practices that may be less familiar with public programs. In addition, in some areas there is limited access to care through CHCs. Stakeholders in the areas of the state detailed above speak eloquently about the difficulty they face in assisting members with receiving care. They note that network adequacy is particularly an issue for members with incomes between 100 and 300% of the FPL due to their potential to be required to pay a supplemental premium, above their base premium, in order to enroll in a plan that includes their regular provider of care or to be able to more easily get to appointments. The ease of getting to appointments is a significant issue – particularly because non-emergency transportation is not covered in Commonwealth Care.

Some stakeholders noted that some access issues arise because, unlike in the Commercial market, not all Commonwealth Care plans contract with all providers. Examples include, but are not limited to:

- Fallon's network is limited to PCPs within the Fallon Clinic and does not include CHCs;
- BMC's HealthNet plan's network does not include hospitals or health centers associated either with Partners Health Care or Cambridge Health Alliance.

In these situations, members may not be able to access care using historical providers or referral patterns, depending on the plan that is available and affordable in their service area.

An oft-sited issue from stakeholders interviewed involved the switch in July 2008 of the low-cost plan in central Massachusetts from Network Health to Fallon. As described above, Fallon's Commonwealth Care plan is limited to coverage through the Fallon Clinic, and while it meets the network adequacy standards of the Connector, it does not include CHCs.[35] Network Health's plan does include CHCs and the switch of low-cost plans left many members with a dilemma: either switch their primary care provider and regular source of care to a provider that was 30 miles away to remain in the lowest cost plan or face a large increase in their monthly premium (at least one individual faced an increase of $120 per month) in order to remain in their current plan where they could

[35] Fallon's network for its MassHealth MCO is more open and does include CHCs.

continue to see their current PCP.[36] In addition to the premium and distance issues raised, one stakeholder also questioned whether the Fallon Clinic had the necessary linguistic ability to appropriately provide services to patients whose primary languages are other than English or Spanish, such as Vietnamese, Albanian, or Portuguese. It is important to note that Fallon reported that it has not received direct complaints regarding adequacy of their network. It appears that patients may be complaining to their historical providers, such as CHCs, regarding their difficulty in accessing care; however, such complaints do not appear to have made their way to either the MCOs or the Connector.[37]

Stakeholders noted that while members are able to obtain a primary care physician and referrals to see specialists, non-emergent or urgent needs might require long wait periods in order to get an appointment. This is true across primary care, specialty care, behavioral health and dental care. Stakeholders did not believe that longer wait times were a greater issue in Commonwealth Care than they are for MassHealth or Commercial members. A number of stakeholders noted that the participating MCOs have strict credentialing standards that seem overly restrictive and prevent providers from being able to expand capacity which would in turn reduce some of the long wait times.

Stakeholders also commented on the confusion and issues that arise from having one program-wide annual open enrollment for Commonwealth Care members.[38] While each stakeholder we spoke to was in favor of choice, many were concerned about the auto-assignment process whereby a member with income at or below 100% of the FPL would be enrolled in a lower cost plan instead of his or her last plan if he or she did not respond to the open enrollment mailing. Stakeholders noted that, depending on the overlap of provider networks between plans, such changes are not only confusing but have a large impact on continuity of care for members. CHCs[39] also noted that both the re-determination and the annual open enrollment processes placed a burden on the CHCs as many Commonwealth Care members, whether or not patients of the CHC, come to the CHC for support in the re-determination process.[40]

---

[36] Commonwealth Care members do have the ability to appeal the affordability of their premium. Bailit did not analyze whether in this particular case an individual would have been likely to receive a premium waiver or reduction from the Connector.

[37] In some cases, CHCs may be continuing to see patients who are part of a Commonwealth Care plan that does not include the CHC, without pay, to provide continuity of care.

[38] In respect to use of an open enrollment process, Commonwealth Care mirrors the commercial market. Unlike MassHealth, enrollees are given one opportunity per year to select a new health plan. In MassHealth, an enrollee can choose a new plan at any time during the year, including during the redetermination process.

[39] According to a just released report, Commonwealth Care enrollees accounted for 5% of the patient base at CHCs in 2007, or roughly 24,000 patients. Ku, Leighton et al.; *How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform*, Kaiser Commission on Medicaid and the Uninsured, March 2009, Figure 3, page 10.

[40] Of interest, CHCs also noted that they often provide initial enrollment assistance and that somewhere between 40-50 percent of individuals that they assist enroll with a different entity as

IV. Findings

Bailit's research and analysis indicates that overall, the Connector and its Commonwealth Care plans have processes in place to ensure sufficient access for the vast majority of its members. Bailit found relatively few statewide problems with network adequacy in Commonwealth Care, including limited issues regarding cultural or linguistic needs of the population due to:

- Commonwealth Care's contracting with MCO's that provide services to the MassHealth population; and,
- Utilization of network adequacy standards and monitoring requirements that are highly similar to MassHealth's requirements enabling MCOs to be able to meet network adequacy requirements.

All Commonwealth Care members have a primary care physician. While members may have delays in accessing non-emergent or urgent care, delays experienced by Commonwealth Care patients are no greater than for the general population, whether publicly or privately insured. The Connector's reprocurement will further strengthen network adequacy requirements for the program, particularly in the area of measuring behavioral health access. Given the state's 9C budget cuts and additional cuts expected for FY10, it will continue to be important to closely monitor the timely access to care and to consider methods to bolster provider capacity. Budget cuts may also affect the availability of interpreters that are critical to serving the Commonwealth Care population. Bailit is aware that some safety net hospitals have made cuts in this area as a direct result of cuts in funding from the State (for MassHealth patients) that may also affect Commonwealth Care enrollees.

At the same time, Bailit's research and analysis indicates that for targeted areas of the state, there are potentially significant barriers to accessing care through Commonwealth Care, even when MCOs are in compliance with the Connector's network adequacy standards. One stakeholder told of an individual who resided in Central Massachusetts that did not have a car or access to public transportation. The individual was initially enrolled in one plan that had a CHC located in her town; the individual changed plans when the original plan was no longer the least expensive and remaining in it would have resulted in a $120 monthly premium increase. In the new plan, however, the closest primary care provider was 30 miles away and difficult for the individual to visit.

---

its primary care provider. They also noted that as more individuals seek public coverage due to unemployment, there are new challenges for consumers, the State and providers in familiarizing these individuals with process for obtaining and maintaining public coverage. The burden on CHCs of providing this enrollment assistance will be greatly increased given the proposed discontinuation of outreach and enrollment grants in state fiscal year 2010 due to the state budget crisis.

The barriers encountered in the story above impact members of Commonwealth Care despite the similarity between Commonwealth Care and MassHealth network adequacy standards due to the following significant policy differences in the two programs:

- MassHealth provides non-emergency transportation coverage for the majority of its members while Commonwealth Care does not;
- MassHealth provides members with the option of enrolling in either a capitated managed care plan or in the state's Primary Care Clinician (PCC) Plan while Commonwealth Care only offers coverage through capitated managed care plans and, in some instances, networks are more restricted in Commonwealth Care than in MassHealth;
- MassHealth members have limited premium and/or co-payment responsibility; where MassHealth members pay premiums, the cost to the member is not impacted by the total cost to the state of a particular plan. In contrast, Commonwealth Care members have more significant cost-sharing responsibility and are required to pay the difference in cost of lower to higher cost plans.

All of these differences represent intentional policies set by the state – whether legislatively or by the Connector Board and staff – to develop Commonwealth Care as a step on the continuum away from traditional Medicaid coverage and towards commercial coverage. In practice, however, the populations of the two programs are not dramatically different – as described above, the vast majority of Commonwealth Care members have incomes at or below 150% of the FPL.

Bailit believes that the Connector's reimbursement strategy within the 2009 procurement will limit the magnitude of differences in premiums between plans in service areas, thereby alleviating access issues related to cost. However, the issue of narrow networks will remain and, in some areas of the state, may impact a member's ability to obtain services through regular sources of care. Given that plans are able to develop limited networks that meet the state's network adequacy requirements, a question for consideration is whether plans should be required to include certain safety net providers within their networks.

There is an inherent tension between consumer choice of providers and managed care contracting practices. Historically, a major goal of managed care has been to channel members to contracted providers and facilities to promote the delivery of quality, cost-effective care. As a result, networks may not always include the full range of providers that a consumer wishes to utilize. However, as stakeholders pointed out during our interviews, commercial plans in Massachusetts typically contract with "any willing provider" and do not operate limited provider networks. Likewise, in MassHealth, the MCOs generally operate with more open networks and a member has more flexibility to change plans within MassHealth than within Commonwealth Care. The instances where Bailit heard of limitations in provider networks involved CHCs; these instances included the ability of members to utilize these sites or the ability of CHCs to refer members to

specialists with whom a center has established referral relationships in place. The Connector is aware of such concerns and acknowledges their importance; however, as described earlier in this report, the Connector must balance this with its arms-length relationship with its MCOs and the MCOs individual business strategies.

V. Conclusion and Recommendations

Based on the findings described above in Section IV, we offer the following recommendations to the Connector Board and staff:

1. that the Connector staff conduct its planned analysis of provider overlap across MCOs; in addition, the Connector should work with MCOs – as recommended by Navigant – to survey both enrollees and providers to understand the impact of limits on provider networks within Commonwealth Care. Depending on the results of that analysis, the Connector may want to consider requiring plans to include a certain amount of traditional safety net capacity within their network, assuming the ability of the plans to negotiate reasonable rates with safety net providers. Alternatively, the Connector may want to consider allowing enrollees to remain in alternative plans at the lower premium payment where there is not sufficient safety net capacity within a service area.
2. that the MCOs be required to report on out of network referrals as potential way to target access issues.
3. the Connector, its Commonwealth Care plans and providers work together with consumer advocates to develop a better method to collect information from members regarding their ability to access care and their actual experience of care once they gain access to a provider's office.
4. that the Connector staff should monitor impact of 9C budget cuts and expected cuts for FY10 on the Commonwealth Care program; the Connector should closely monitor the impact of budget cuts on enrollment and retention in the program and particularly on availability of interpreters. The Connector and its plans should work closely to develop strategies to bolster capacity for services.
5. that the Connector should work closely with CeltiCare as it prepares to enter the Commonwealth Care market on July 1, 2009, to ensure both network adequacy at the start of the contract and a strong understanding of the needs of the Commonwealth Care population.

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards

2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
Proximity Requirements			
The Contractor shall execute and maintain, and require that its Material Subcontractor(s) execute and maintain, written contracts with Providers to ensure that Enrollees have access to Covered Services substantially in accordance with the following access standards.	The Contractor shall provide adequate access to Covered Services for all Enrollees. Adequate access shall include physical, telephone and geographic access, as well as access to all forms of communication.	The Contractor shall execute and maintain, and ensure that its Material Subcontractor(s) execute and maintain written contracts with Providers to ensure that Enrollees have access to MCO Covered Services within a reasonable travel time from the Enrollee's residence, as provided below. The Contractor shall take into account both walking and public transportation.	
Acute inpatient services – at least 1 hospital within each County;	*Acute inpatient services* – at least 1 full service, including women's health services, hospital within each County;	*Acute inpatient services* - within 15 miles or 30 minutes travel time from an Enrollee's residence;	Within 30 miles

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards

2006 CommCare Contract Reference	2010 CommCare Contract Reference (Procurement – Model Contract)	MassHealth Contract Requirements (2008 Procurement – Model Contract)	Commercial Requirements *(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan*
Physician Services – at least two PCP sites with open panels in different locations within each Service Area or located within 15 miles or 30 minutes travel time from the Enrollee's residence.	*Physician Services* – at least two PCP sites with open panels in different locations within each Service Area or at least two PCPs with open panels located within 15 miles or 30 minutes travel time from the Enrollee's residence. The Contractor shall make commercially reasonable efforts to provide a PCP Network located within each Service Area sufficient enough to offer each Enrollee within the Service Area a choice of at least two different PCP sites with an open PCP panel located within 15 miles or 30 minutes travel time from the Enrollee residence. Plans must have 1:200 enrollees in a service area.	*Physician Services* The Contractor shall develop and maintain a network of Primary Care Practitioners (PCP network) that ensures PCP coverage and availability throughout the Region 24 hours a day, seven days a week. The Contractor shall maintain a sufficient number of PCPs, defined as one adult PCP for every 200 adult Enrollees and one pediatric PCP for every 200 pediatric Enrollees throughout the Region, provided that, EOHHS may approve a waiver of the above ratios in designated rural areas. The PCP network shall include a sufficient number of PCPs to offer each Enrollee a choice of at least two appropriate PCPs with open panels. An appropriate PCP is defined as a PCP who: • Is located within 15 miles or 30	Distance to Provider Office: measured using GeoAccess twice a year • Distance to PCPs' Offices: o Urban: 2 PCPs within 8 miles o Rural: 1 PCP within 15 miles • Distance to Specialists' Offices (top 7 high volume specialists: cardiologist, dermatologist, gastroenterologist, general surgery, OBGyn, ophthalmologist, orthopedic surgeon) o 1 provider within 15 miles o measured separately for each specialty

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
		minutes travel time from the Enrollee's residence; • Has qualifications and expertise commensurate with the health care needs of the Enrollee; and • Has the ability to communicate with the Enrollee in a linguistically appropriate and culturally sensitive manner. If the Contractor does not meet this standard in any part of a Region, the Contractor shall demonstrate to EOHHS that it meets this standard when factoring in PCPs in a contiguous Region that are within 15 miles or 30 minutes travel time from the Enrollee's residence.	

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements *(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
Not Provided	*Rehabilitation Hospital Services* – within 15 miles or 30 minutes travel time from an Enrollee's residence	*Rehabilitation hospital services* - within 30 miles or 60 minutes travel time from an Enrollee's residence;	None
Not provided	*Urgent Care Services* – within 15 miles or 30 minutes travel time from an Enrollee's residence.	*Urgent Care services* - within 15 miles or 30 minutes travel time.	None
	OB/GYN and Women's Health: The Contractor shall maintain an Obstetrician/Gynecologist-to-female Enrollee ratio of one to 500.	*OB/GYN and Women's Health:* The Contractor shall maintain an Obstetrician/Gynecologist-to-female Enrollee ratio of one to 500, throughout the Region, provided that, EOHHS may approve a waiver of the above ratio in designated rural areas. Such ratio should include female Enrollees age 10 and older. For any part of the Region(s) where the Contractor does not meet this standard, the Contractor must demonstrate to EOHHS that it meets this standard when factoring in Obstetricians/Gynecologists in a contiguous Region or Regions that are within 15 miles or 30 minutes travel time from the Enrollee's residence.	

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
Exceptions to Standards			
The Contractor shall document and submit to the Authority, in writing, a justification for any exceptions to the standards specified in Section 2.6.A.1. above. Such justification shall be based on the usual and customary community standards for accessing care.	The Contractor shall document and submit to the Authority, in writing, a justification for any exceptions to the standards specified in Section 2.6.A.1. above. Such justification shall be based on the community standards for accessing care.	The Contractor shall document and submit to EOHHS, in writing, a justification for any exceptions to the standards specified in Section 2.9.C. Such justification shall be based on the usual and customary community standards for accessing care. Usual and customary community standards shall be equal to or better than such access in the Primary Care Clinician Plan.	

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards

2006 CommCare Contract Reference	2010 CommCare Contract Reference (Procurement – Model Contract)	MassHealth Contract Requirements (2008 Procurement – Model Contract)	Commercial Requirements *(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan*
Waiting Times			
Emergency Services - immediately upon Enrollee presentation at the service delivery site, including non-Network and out-of-area facilities. The Contractor shall provide coverage for Emergency Services to Enrollees 24 hours a day and 7 days a week without regard to prior authorization or the Emergency Service provider's contractual relationship with the Contractor;	*Emergency Services* - immediately upon Enrollee presentation at the service delivery site, including non-Network and out-of-area facilities. The Contractor shall provide coverage for Emergency Services to Enrollees 24 hours a day and 7 days a week without regard to prior authorization or the Emergency Service provider's contractual relationship with the Contractor;	*Emergency Services* • Immediately upon Enrollee presentation at the service delivery site, including non-network and out-of-area facilities. • The Contractor shall, in accordance with 42 U.S.C. §1396u-2(b)(2) and 42 CFR 434.30, provide coverage for Emergency Services to Enrollees 24 hours a day and seven days a week without regard to prior authorization or the Emergency Service Provider's contractual relationship with the Contractor.	• Appointment wait times for PCPs: measured during site visit to PCP offices for NCQA-related chart reviews (represents a sampling of PCP offices) o Preventive Care: w/in 30 days o Symptomatic Care: w/in 48 hours o Urgent care: w/in 24 hours o Emergency care: immediately

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards

2006 CommCare Contract Reference	2010 CommCare Contract Reference (Procurement – Model Contract)	MassHealth Contract Requirements (2008 Procurement – Model Contract)	Commercial Requirements *(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan*
Primary Care- within 48 hours of the Enrollee's request for Urgent Care, within 10 days of the Enrollee's request for Non-urgent, Symptomatic Care; and within 45 calendar days of the Enrollee's request for Non-Symptomatic Care;	*Primary Care*- within 48 hours of the Enrollee's request for Urgent Care, within 10 days of the Enrollee's request for Non-urgent, Symptomatic Care; and within 45 calendar days of the Enrollee's request for Non-Symptomatic Care;	*Primary Care* • Within 48 hours of the Enrollee's request for Urgent Care; • Within 10 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and • Within 45 calendar days of the Enrollee's request for Non-Symptomatic Care, unless an appointment is required more quickly to assure the provision of screenings in accordance with the schedule established by the EPSDT Periodicity Schedule in Appendix W of all MassHealth provider manuals, per 130 CMR 450.141.	• Appointment wait times for PCPs: measured during site visit to PCP offices for NCQA-related chart reviews (represents a sampling of PCP offices) o Preventive Care: w/in 30 days o Symptomatic Care: w/in 48 hours o Urgent care: w/in 24 hours o Emergency care: immediately
Specialty Care - within 48 hours of the Enrollee's request for Urgent Care, within 30 calendar days of the Enrollee's request for Non-urgent, Symptomatic Care; and within 60 calendar days for Non-Symptomatic Care;	*Specialty Care* - within 48 hours of the Enrollee's request for Urgent Care, within 30 calendar days of the Enrollee's request for Non-urgent, Symptomatic Care; and within 60 calendar days for Non-Symptomatic Care;	*Specialty Care* • Within 48 hours of the Enrollee's request for Urgent Care; • Within 30 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and • Within 60 calendar days for Non-Symptomatic Care.	None

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
All Other Services - in accordance with the usual and customary community standards	All Other Services - in accordance with the community standards	All Other Services - in accordance with usual and customary community standards.	
Behavioral Health Services			
	Behavioral Health Services The Contractor shall ensure that Enrollees have access to a choice of at least two Network Providers who provide Behavioral Health Services to the extent that qualified willing Providers are available. Contractor must develop and implement policies to monitor access and availability of their behavioral health Provider Network. miles or 60 minutes travel time from the Enrollee's residence; and ESP Services – in accordance with the geographic distribution set forth in Appendix E, Exhibit 2.	*Behavioral Health Services* Inpatient Services - within 60 miles or 60 minutes travel time from the Enrollee's residence, whichever requires less travel time; ESP Services – in accordance with the geographic distribution set forth in Appendix H, Exhibit 4. All other services - within 30 miles or 30 minutes travel time from the Enrollee's residence, whichever requires less travel time The Contractor shall ensure that Enrollees have access to a choice of at least two Network Providers who provide Behavioral Health Services to the extent that qualified, willing Providers are available.	*Behavioral Health Services* Distance to BH facility: 1 facility within 50 miles or 60 minutes. Distance to BH providers' offices (measured separately for social workers, psychologists, child psychiatrists and adult psychiatrists) • 1 provider within 20 miles or 30 minutes

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
		• Behavioral Health Inpatient Services - within 60 miles or 60 minutes travel time from the Enrollee's residence; • ESP Services – in accordance with the geographic distribution set forth in Appendix H, Exhibit 2; • As directed by EOHHS, Community Service Agencies (Intensive Care Coordination providers) – in accordance with the geographic distribution provided by EOHHS; and • Behavioral Health Outpatient Services, Behavioral Health Diversionary Services, Behavioral Health Intensive Community Treatment Services - within 30 miles or 30 minutes travel time from the Enrollee's residence**.**	
ESP Services - immediately on a 24-hour basis, 7 days a week, with unrestricted access, to Enrollees who present.	ESP Services – immediately, on a 24-hour basis, 7 days a week, with unrestricted access to Enrollee who present for such services;	ESP Services - Immediately, on a 24-hour basis, seven days a week, with unrestricted access to Enrollees who present for such services	None

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
	Emergency Services – immediately, on a 24-hour basis, 7 days a week, with unrestricted access to Enrollees who present at any qualified Provider, whether a Network Provider or a non-Network Provider; Urgent Care - within 48 hours for services that are non-Emergency Services or routine services; and	Emergency Services – immediately, on a 24-hour basis, 7 days a week, with unrestricted access to Enrollees who present at any qualified Provider, whether a Network Provider or a non-Network Provider; Urgent Care Within 48 hours for services that are not Emergency Services or routine services.	
	All Other Behavioral Health Services within 14 calendar days.	All Other Behavioral Health Services within 14 calendar days.	
Hours of Operation			
The Contractor shall require that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial insurance enrollees.	The Contractor shall require that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial insurance enrollees.	The Contractor shall ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or MassHealth Fee-For-Service if the Provider serves only Enrollees or other Members.	None. Contractually required to have after-hours coverage.

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
Diversionary Services			
Specific standards are not noted, however the Connector requires reporting on diversionary behavioral health services as described below.	Specific standards are not noted, however the Connector requires reporting on diversionary behavioral health services as described below.	For services described in the Inpatient or 24-Hour Diversionary Services Discharge Plan: • Non-24-Hour Diversionary Services – within two calendar days of discharge • Medication Management – within 14 calendar days of discharge; • Other Outpatient Services – within seven calendar days of discharge; • Intensive Care Coordination Services – within the time frame directed by EOHHS.	None

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
Monitoring of Access Standards			
The Contractor shall have a system in place to monitor and document waiting times and appointment scheduling standards. The Contractor shall use statistically valid sampling methods for monitoring compliance with the appointment/waiting times standards specified above in Section 2.6.B.1. and shall promptly address any access deficiencies. Annually, in accordance with Appendix A, the Contractor shall evaluate and report to the Authority network-wide compliance with the standards specified in Section 2.6.B.1.	The Contractor shall have a system in place to monitor and document waiting times and appointment scheduling standards for both physical and Behavioral Health Services. The Contractor shall use statistically valid sampling methods for monitoring compliance with the appointment/waiting times standards specified above in Section 2.6.B.1.and shall promptly address any access deficiencies. Annually, in accordance with Appendix A, the Contractor shall evaluate and report to the Authority network-wide compliance with the standards specified in Section 2.6.B.1.	The Contractor shall have a system in place to monitor and document access and appointment scheduling standards. The Contractor shall use statistically valid sampling methods for monitoring compliance with the appointment/access standards specified above in Section 2.9.B.1.and 2. and shall promptly address any access deficiencies. Annually, in accordance with Appendix A, the Contractor shall evaluate and report to EOHHS Network-wide compliance with the access standards specified in Section 2.9.B.1. and 2.	Annually, semi-annually or quarterly, depending on measure.

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
Access for Non-English Speaking Enrollees			
The Contractor shall require that multi-lingual Providers and skilled medical interpreters are available for the most commonly used languages in a particular geographic area in the Contractor's Service Area. In said area, the Contractor shall require that non-English speaking Enrollees have a choice of at least two PCPs who can provide services to, and speak to the Enrollee in his or her primary language provided that such PCP capacity exists within the Service Area. To the extent such PCP capacity does not exist, the Contractor shall develop alternative arrangements acceptable to the Authority.	The Contractor shall ensure that multi-lingual Providers and skilled medical interpreters are available for the most commonly used languages in a particular geographic area in the Contractor's Service Area. In determining the most commonly used languages in a particular geographic area, Contractor may rely on the information provided by the Authority as described in Section 3.2.B.4. In said area, the Contractor shall provide non-English speaking Enrollees with a choice of at least two PCPs who can provide services to, and speak to the Enrollee in his or her primary language provided that such PCP capacity exists within the Service Area. To the extent such PCP capacity does not exist, the Contractor shall develop alternative arrangements acceptable to the Authority.	The Contractor shall ensure that non-English speaking Enrollees have a choice of at least two PCPs, and at least two Behavioral Health Providers within each behavioral health covered service category, in the Prevalent Language in the Region provided that such provider capacity exists within the Region.	Measures ratios of PCPs who speak a foreign language to members. Must be 1:1000 members.

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards

2006 CommCare Contract Reference	2010 CommCare Contract Reference (Procurement – Model Contract)	MassHealth Contract Requirements (2008 Procurement – Model Contract)	Commercial Requirements *(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan*
Access for Enrollees with Disabilities			
The Contractor shall require access to Covered Services for Enrollees with disabilities by ensuring that physical and communication barriers do not inhibit Enrollees with disabilities from obtaining services from the Contractor's Plan.	*Access for Enrollees with Disabilities* The Contractor shall require its Network Providers to afford access to Covered Services for Enrollees with disabilities by ensuring that physical and communication barriers do not inhibit Enrollees with disabilities from obtaining services from the Contractor's Plan.	Not explicitly spelled out in the contract; information re: access appears throughout.	All PCPs must have accessible offices.
Direct Access to Specialists			
The Contractor shall have a mechanism in place to allow Enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) in accordance with 105 CMR 128.505.	The Contractor shall have a mechanism in place to allow Enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) in accordance with 105 CMR 128.505.	For Enrollees including, but not limited to, those with Special Health Care Needs, determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to allow Enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs.	None

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
			Additional Requirements: • Percent of PCP practices with open panel o On average, 80% of the plan must be open to new members o Monitored by group; quarterly o BCBSMA relies on providers to tell them when the practice is closed. No serious issues regarding accuracy of information. • Ratios of providers to members o PCP ratio: 1 per 1000 members o Child psychiatry: 0.2 per 1000 members o Adult psychiatry: 0.2 per 1000 members o Non-MD provider: 0.8

Appendix A: Comparison of Network Adequacy Standard for Commonwealth Care (2006 and 2010), MassHealth, and Commercial Standards			
2006 CommCare Contract Reference	**2010 CommCare Contract Reference (Procurement – Model Contract)**	**MassHealth Contract Requirements (2008 Procurement – Model Contract)**	**Commercial Requirements** ***(Very Limited review of standards only (e.g. full contract language was not reviewed) based on one commercial plan***
			per 1000 members o For each of top 7 high volume specialists: 0.3 per 1000 members

Appendix B: Stakeholder Interviews

Organization Type	Organization
Program Administrator	Commonwealth Health Insurance Connector Authority
Commonwealth Care/Medicaid MCOs	Boston Medical Center Health Net
	Network Health
	Fallon
	Neighborhood Health Plan
Provider Associations	Mass League of Community Health Centers
	Mass Hospital Association
	Mental Health and Substance Abuse Corporations of Mass
Community Health Centers	Brockton Community Health Center
	Family Health Center
	Great Brook Valley
	Lynn Community Health Center
	Uphams Corner
Advocacy Groups	Health Care for All
	Community Partners
	Greater Boston Interfaith Organization