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## Provider Networks for State Health Insurance Exchange and Medicaid Plans after the ACA

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# Provider Networks for State Health Insurance Exchange and Medicaid Plans after the ACA

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## Executive Summary

The Patient Protection and Affordable Care Act (ACA) will greatly expand eligibility for coverage, and the bulk of those newly covered will be enrolled in Medicaid/NJ FamilyCare or Qualified Health Plans (QHPs) through the State Health Insurance Exchange (exchange). The ability of health plans in both Medicaid and the exchange to provide those enrolled with access to quality care is central to the success of the ACA and will require provider networks which meet the needs of both existing and new enrollees. The challenge is increased by the expectation that many of the adults newly eligible for Medicaid are likely to have complex health care needs and pent-up demand for care (Somers et al. 2010) and that a substantial number of people are likely to move between Medicaid and the exchange with a year (Sommers and Rosenbaum 2011). For individuals whose eligibility changes over time, continuity of care during transitions between plans is vital. The purpose of this Issue Brief is to review provisions of the ACA and other existing law regarding provider network requirements, current provider network rules for HMOs codified in New Jersey law and the current Medicaid HMO contract, and issues pertinent to assuring access for New Jersey residents.

The ACA encourages alignment of provider networks across public and exchange markets by establishing a minimum network adequacy requirement for QHPs and including behavioral health, substance abuse, and essential community providers. It has been suggested that ensuring continuity of care would be facilitated by a more integrated market between managed care plans which enroll individuals who receive affordability subsidies through the exchange and Medicaid managed care (Bachrach, Boozang, and Garcimonde 2011; Rosenbaum and Riley 2012). However, federal regulatory standards applicable to both the Medicaid and exchange markets are complex and do not yet address the issue of product alignment across programs which provide affordable coverage (Rosenbaum and Riley 2012). Nonetheless, states can take an active approach to developing strategies to insure that individuals moving between different types of coverage will have continuity of care from their customary providers to the greatest extent possible. States can consider several options, including 1) providing incentives or requirements for plans or providers within a plan to participate in both Medicaid and exchange products, 2) increasing provider incentives to participate in Medicaid, 3) requiring

QHPs to contract with any willing essential community provider, and/or 4) encouraging consultation between Medicaid and the exchange in developing provider network adequacy standards. In addition to suggesting approaches to ensuring network adequacy for those with complex health needs, state Medicaid policies provide models of contracting requirements designed to ensure provider continuity of care as eligibility status changes, particularly for those individuals undergoing active treatment for an acute or chronic medical condition (Ingram, McMahon, and Guerra 2012).

# Provider Networks for State Health Insurance Exchange and Medicaid Plans after the ACA

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## Introduction

The Patient Protection and Affordable Care Act (ACA) will greatly expand eligibility for coverage; approximately 444,000 additional non-elderly individuals are likely to be enrolled in New Jersey after implementation of the ACA (Cantor et al. 2011). The bulk of those newly covered will be enrolled in Medicaid/NJ FamilyCare or Qualified Health Plans (QHPs) through the State Health Insurance Exchange (exchange). The ACA established the exchange as the marketplace in which individuals and small employers can compare and select among affordable quality health insurance options. The ability of health plans to provide those enrolled with access to quality care is central to the success of the ACA and will require provider networks which meet the needs of both existing and new enrollees. In Massachusetts, Commonwealth Care increased access to services for previously uninsured individuals, but concerns were also raised about difficulties in accessing care, resulting in a review of the adequacy of provider networks for Commonwealth Care plans. Among other concerns, Massachusetts stakeholders reported that serving individuals who did not formerly have insurance took longer and put a strain on waiting times during the implementation of Commonwealth Care (Bailit Health Purchasing 2009). Many of the adults newly eligible for Medicaid will be childless adults, who are likely to have complex health care needs and pent-up demand for care (Somers et al. 2010).

The purpose of this Issue Brief is to review provisions of the ACA and other existing law regarding provider network requirements, current provider network rules for HMOs codified in New Jersey law and the current Medicaid HMO contract, and issues pertinent to assuring access for New Jersey residents. The ability to access needed care is vital for individuals who already have health coverage, as well as those newly covered by a health plan and those who may move from enrollment between exchange plans and Medicaid due to changes in life and/or economic circumstances. Changes in eligibility for health coverage in Medicaid or exchange plans may occur because of job loss, reduction in work hours, divorce, widowhood, relocation, and aging off of parental health insurance (Jacobs et al. 2011). With the implementation of ACA, the number of people likely to move in and out of Medicaid within a year is substantial (Sommers and Rosenbaum 2011). Switching between health plans can delay needed care (Lavarreda et al. 2008), particularly if an individual needs to change health care providers.

## Policy and Legal Context

### *Applicable ACA Law and Rules*

Section 1311 of the ACA, which is codified at 42 U.S.C. § 18031, provides that the Secretary of Health and Human Services is charged with promulgating regulations which “establish criteria for the certification of health plans as qualified health plans”<sup>1</sup> for the exchange. On March 12, 2012, the U.S. Department of Health and Human Services (HHS) published a final rule on the ACA exchanges, setting forth the minimum standards exchanges must meet, including the minimum requirements for issuers to offer QHPs through the exchange.<sup>2</sup>

- Exchanges must ensure that QHPs, at a minimum, ensure a sufficient choice of providers.<sup>3</sup> The final rule establishes a minimum network adequacy requirement, consistent with the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act, that a QHP “must maintain a sufficient number and type of providers including those specializing in mental health and substance abuse to assure availability of all services without unreasonable delay.”<sup>4</sup> The preamble to the rule notes HHS’s intent to ensure sufficient numbers and variety of providers in QHP networks, while maintaining the flexibility of an exchange to align with network adequacy standards outside the exchange. The preamble also recognizes that inclusion of mental health and substance abuse services will create new demand for services which have traditionally been difficult to access for low income and underserved populations.
- A QHP is required to have a provider directory that notes whether or not the provider is accepting new patients.<sup>5</sup> The final rule permits exchanges to determine the best way to give potential enrollees access to the provider directory for each QHP, including through a link from the Exchange’s website to the issuer’s website, or by establishing a consolidated provider directory through which a consumer may search for a provider across QHPs.<sup>6</sup>
- Plans are required to “include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.”<sup>7</sup> Essential community providers include as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers

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<sup>1</sup> 42 U.S.C. § 18031(c)(1).

<sup>2</sup> CMS-9989-F, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers.” The regulations are effective 60 days after publication in the Federal register.

<sup>3</sup> 42 U.S.C. § 18031(c)(1)(B).

<sup>4</sup> §155.1050.

<sup>5</sup> §156.230.

<sup>6</sup> §155.205.

<sup>7</sup> ACA Section 1311(c)(1).



described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8. The preamble to the final rule notes that the list of essential community providers is not exhaustive and not intended to exclude any providers that are not specifically listed.

- The final rule requires each QHP network to have a sufficient number and geographic distribution of essential community providers to ensure reasonable and timely access to a broad range of such providers for low income, medically underserved individuals in the service area.<sup>8</sup> Exchanges can go further than this minimum requirement, including requiring QHPs to contract with any willing essential community provider.
- The final rule addresses potential conflict between the ACA Section 1311(c)(2) provision that QHPs are not required to contract with an essential community provider if the provider refuses to accept the generally applicable payment rates of the plan and ACA Section 1302(g) requiring QHPs to reimburse Federally Qualified Health Centers (FQHCs) at each facility’s Medicaid prospective payment system (PPS) rate. The final rule specifies that a QHP issuer must pay an FQHC either the relevant PPS rate or, alternatively, a mutually agreed upon rate that is at least equal to the QHP’s generally applicable rate. The preamble to the final rule clarifies that “generally applicable payment rates” mean, at a minimum, the rates offered by QHPs to similarly situated providers who are not essential community providers (Manatt Health Solutions 2012).
- The ACA requires that all QHPs provide an Essential Health Benefit (EHB) with minimum standard coverage benefits and cost-sharing that varies by subsidy level and plan tier<sup>9</sup>, thus necessitating provider networks sufficient to provide these benefits to all enrollees. While individuals already eligible for Medicaid are entitled to benefits in accordance with existing state plans, the population newly covered by Medicaid will receive a benchmark benefit package which is at least as generous as the EHB, with nominal levels of cost-sharing.<sup>10</sup> Recent guidance suggests that states will have considerable discretion in defining the EHB for QHPs, although it is not clear whether states will have similar flexibility in the Medicaid context.<sup>11</sup> An important purpose of applying the EHB provisions to Medicaid’s benchmark plan requirements was to promote greater seamlessness across the Medicaid and exchange markets, hopefully encouraging cross-

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<sup>8</sup> §156.235.

<sup>9</sup> §1302, 1401, 1402, 1411, 1412.

<sup>10</sup> §2001(c).

<sup>11</sup> HHS, Center for Consumer Information and Insurance Oversight, “Essential Health Benefits Bulletin,” December 16, 2011, available at [http://cciio.cms.gov/resources/files/Files2/12162001/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162001/essential_health_benefits_bulletin.pdf).

market participation by health plans and provider networks (Rosenbaum and Riley 2012).

### ***Access to Care in Medicaid Managed Care Plans***

Access to health care has been a focus of the Medicaid program since its enactment with the aim of integrating Medicaid beneficiaries into the general health care system, enabling them to receive care from the participating provider of their choice (Rosenbaum 2011). However, Medicaid beneficiaries nationally continue to receive a disproportionate amount of health care from “safety net” providers such as community health centers, public hospitals, and free clinics, while private physicians are more limited in their Medicaid participation. The 19% of primary care physicians who accept most or all new Medicaid patients are more likely to be located in lower income communities and to work at community health centers and public hospitals (Sommers and Paradise 2011). Specialty care is a particularly serious challenge for Medicaid patients (Rosenbaum 2011). States with Medicaid populations served by managed care organizations (MCOs) cite problems with access to dental care, pediatric specialists, psychiatrists and other behavioral health providers, as well as other specialists such as dermatologists, ear-nose-throat doctors, neurologists, and orthopedists (Gifford et al. 2011). Some states indicated that where an access problem existed, it paralleled a similar problem encountered by those with other types of insurance.

Since the 1980’s, states have increasingly used various forms of managed care to establish a network of providers through contracts with health plans and/or providers who agree to accept Medicaid patients and meet certain requirements to ensure timely access to care (Gifford et al. 2011). States have built on federal statutory and regulatory requirements to develop robust criteria and systems for managed care plan certification, procurement, and oversight of key requirements for quality and network adequacy (Bachrach, Boozang, and Garcimonde 2011). While Medicaid managed care differs from commercial health insurance with respect to the population served, consumer cost-sharing, benefit designs, and provider networks, many Medicaid enrollees are in plans that also serve the commercial market (McCue and Bailit 2011).

Federal regulations require states to ensure that covered services are available and accessible to all Medicaid MCO enrollees through a requirement that each plan “maintains and monitors a network of appropriate providers that is ... sufficient to provide adequate access to all services covered under the contract.”<sup>12</sup> MCOs are required to consider a number of factors in establishing networks, including anticipated enrollment, expected utilization, the geographic location of providers relative to enrollees, and physical accessibility for enrollees with disabilities. Females must have direct in-network access to a women’s health specialist. The

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<sup>12</sup> 42 CFR §438.206.

federal regulations also require plans to meet state standards for timely access to care and services and make services available 24/7 when medically necessary (Gifford et al. 2011).

States typically use provider-to-population ratios and distance and travel-time maximums as standards to ensure that MCO networks are adequate (Gifford et al. 2011). They generally apply different standards for primary and specialty care. Most states require or encourage MCOs to contract with health centers, public health departments, and school-based clinics to help ensure adequate access for Medicaid beneficiaries. In most states, in addition to primary care physicians, providers such as women's health care specialists, nurse practitioners, FQHCs, and physician groups/clinics are recognized as primary care providers for MCO enrollees.

### ***Experience from Massachusetts Commonwealth Care***

A report on Massachusetts Commonwealth Care indicated that contract standards for the plan incorporate features of both MassHealth MCO contracts and commercial plans, a hybrid approach to covering the previously uninsured population (Bailit Health Purchasing 2009). Bailit found relatively few statewide problems with provider access in Commonwealth Care, attributed to the program contracting with MCOs who were already providing services to MassHealth populations and utilization of network adequacy standards and monitoring requirements that are highly similar to MassHealth's requirements. Commonwealth Care network adequacy standards generally focus more on behavioral health and elements such as cultural and linguistic access than standard commercial contracts. In December 2008, Commonwealth Care strengthened its behavioral health requirements beyond the provisions of the original MCO contract, since known behavioral health care needs required providers more akin to MassHealth than the commercial market. It also added new requirements to provide more choice of PCPs, rehabilitation hospital services, and urgent care services.

There were issues related to open and closed panels of PCPs when the program started. Originally, information about panels was updated weekly by download to a CD, but the process was upgraded to a weekly file transfer to keep information more current. In addition, definitions of open, partially closed, and closed panels was updated to provide that partially closed panels means that "current" patients and certain family members of current patients, can be added to a PCP's panel. Commonwealth Care clarified to plans that the standard is to include only open panels in determining network adequacy of a plan (Bailit Health Purchasing 2009).

In its report, Bailit recommended that the state collaborate with MCOs and providers to develop better strategies for collecting information from members about their ability to access care and insure that plans continue to meet contracted network adequacy requirements.

## ***New Jersey Context***

Several New Jersey statutes address access to providers directly or indirectly. N.J.A.C. §§ 11:24-6.1, 6.2, and 6.3 address provider network adequacy for commercial HMOs.<sup>13</sup> A separate network adequacy provision, N.J.A.C. § 11:24A-4.10, covers “carriers offering one or more health benefits plans that are managed care plans.”<sup>14</sup>

N.J.A.C. § 11:4-37.3 sets forth standards for selective contracting arrangements. This regulation requires that “[a] selective contracting arrangement that involves direct contracting between the carrier and network providers or that involves a contract between the carrier and a PPO shall contain an adequate number of network providers by specialty to render the particular covered services in the geographic service area where it operates.”<sup>15</sup> Section 11:4-37.3 goes on to provide that “[a] selective contracting arrangement that involves direct contracting between the carrier and a licensed or certified [organized delivery system], or under which an HMO makes its network available to a carrier, shall be presumed to have an adequate provider network.”<sup>16</sup>

Several other statutory provisions relate to provider networks. Both § 17B:27A-4.7 relating to individual health benefits plans and § 17B:27A-19.11 relating to small employer health benefits plans permit carriers to “offer one or more of the plans through the carrier’s network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care.” Under these provisions, “[a] carrier’s

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<sup>13</sup> Of potentially indirect effect on provider networks, N.J.A.C. § 11:22-5.8 sets forth the following requirements: “POS contracts issued by health maintenance organizations and health service corporations, and [selective contracting arrangement] policies issued by insurance companies, shall provide coverage for covered services and supplies regardless of whether rendered by a network or an out-of-network provider, with the following exceptions: 1. The following services and supplies may be covered only when provided by a network provider, and are not required to be covered when provided by an out-of-network provider: i. Health club membership; ii. Prescription drugs, other than insulin and oral agents for controlling blood sugar as mandated by N.J.S.A. 17:48-6n, 17:48A-7l, 17:48E-35.11, 17B:26-2.1l, 17B:27-46.1m and 26:2J-4.11, and medications to treat infertility as mandated by N.J.S.A. 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x and 26:2J-4.23; iii. Dental services and supplies, other than services and supplies for injury to sound natural teeth, bony impacted teeth and as required by P.L. 1999, c. 49; iv. Routine eye care and appliances; v. Routine foot care; vi. Routine hearing care and appliances; vii. Smoking cessation programs; and viii. Travel companion benefits.” In addition, “[a]ll contracts issued by health maintenance organizations and health service corporations, and all SCA policies issued by insurance companies, shall provide the following: 1. That a covered person’s liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is a network provider and the covered person and/or provider has complied with all required preauthorization or notice requirements, shall be limited to the copayment, deductible and/or coinsurance applicable to network services; and 2. That a covered person’s liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is an out-of-network provider, shall be limited to the copayment, deductible and/or coinsurance applicable to network services.” Finally, “[c]arriers shall not calculate benefits for services provided by out-of-network providers by using negotiated fees agreed to by network providers.”

<sup>14</sup> N.J.A.C. § 11:24A-4.10.

<sup>15</sup> N.J.A.C. § 11:4-37.3(a).

<sup>16</sup> *Id.*

network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier.”

Also of relevance to provider networks is §17B:27A-26, which provides that “[n]o health maintenance organization shall be required to offer coverage or accept applications pursuant to section 3 of this act to a small employer if the small employer does not have eligible individuals who live, work, or reside in the service area for such plan, or if the health maintenance organization reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of such groups because of its obligations to existing group contract holders and enrollees.”<sup>17</sup>

New Jersey's provider network rules for HMOs as codified in N.J.A.C. 11:24-6 et seq. currently do not mention essential community providers. The state's Medicaid HMO contract, however, requires contracting with "at least one federally qualified health center (FQHC) within each enrollment area based on the availability and capacity of the FQHCs in that area.”<sup>18</sup> FQHC providers are required to meet the contractor's credentialing and program requirements.<sup>19</sup> Both commercial issuers offering managed care plans and Medicaid HMOs must comply with detailed provider directory requirements, including maintenance of a web-based directory.<sup>20,21</sup> In focus groups conducted by the Rutgers Center for State Health Policy, stakeholders noted the importance of ascertaining the accuracy of advertised provider networks, alleging that plans have engaged in a variety of strategies to artificially inflate the number of providers they offer (Michael et al. 2011).

The number of HMOs offered in New Jersey Medicaid has decreased from six in 2009 to four in 2010 (NJ DHS, DMAHS 2010). Two carriers covering 84 percent of the Medicaid managed care population currently offer both commercial and Medicaid plans in the state; the others are Medicaid only (Gifford et al. 2011). Two HMOs do not offer coverage in all NJ counties. The Medicaid HMO contract requires that contractors “establish, maintain, and monitor at all times a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access...to all services covered” under the contract and sets detailed

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<sup>17</sup> Section 17B:27A-26 goes on to provide that “[u]pon denying health insurance coverage in any service area as a result of insufficient network capacity in accordance with this subsection, the health maintenance organization shall not offer coverage in the small employer market within such service area for a period of at least 180 days after the date the coverage is denied.”

<sup>18</sup> NJ Medicaid HMO contract, see <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-vol1.pdf>, accessed August 2, 2011.

<sup>19</sup> NJ Medicaid HMO contract, section 4.8.1.

<sup>20</sup> NJ Medicaid HMO contract, section 4.8.4.

<sup>21</sup> N.J.A.C. 11:24A-4.2 and 4.3.

minimum standards for provider networks.<sup>22</sup> Provider networks must include primary care and specialist providers who are trained and experienced in treating individuals with special needs. The contract specifies standards for ratios of primary care providers per enrollee and geographic access standards by county.<sup>23</sup> There are separate requirements for dental provider networks.<sup>24</sup>

A recent survey of Medicaid directors provided some information about network adequacy requirements in 34 states across the US. States report a range of network adequacy standards for primary care, specialty care, and obstetric care. Eleven states had lower patient to primary caregiver ratios than New Jersey (CT, HI, FL, IL, MA, MD, MI, NM, NV, RI, VA). California and Colorado were equivalent, two states (SC and TN) had higher patient to primary caregiver ratios, and the remaining 19 states did not specify a ratio (Gifford et al. 2011).<sup>25</sup> The survey did not assess whether states with stricter network adequacy requirements had better access for consumers.

During 2011, three groups of NJ FamilyCare/Medicaid clients formerly covered by fee for service arrangements were enrolled in managed care, including a large number of individuals with complex medical needs, as part of delivery system innovations meant to improve the quality of care and health outcomes. Home health agencies and other community providers experienced in caring for these vulnerable patients needed to contract with HMOs and set up billing systems to link with carriers so that individuals could maintain relationships with their longtime providers (Stainton 2011), expanding provider networks to meet the needs of these new enrollees. In addition, the NJ Division of Medical Assistance and Health Services (DMAHS) is undertaking a variety of managed care improvements and pilot programs, including a three-year Medicaid Medical Home demonstration project and an Accountable Care Organization demonstration project. These initiatives are designed to deliver coordinated care to Medicaid recipients who are at risk for fewer choices of physicians, longer wait times, and greater disparities in health outcomes compared to their counterparts in commercial coverage (NJ DHS, DMAHS 2011). Such initiatives are an example of the experience which DMAHS, like other state Medicaid agencies, has in procuring and establishing contracting criteria for health plans, including individuals with special health care needs and/or needs for behavioral health care.

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<sup>22</sup> NJ Medicaid HMO contract, section 4.8.1.

<sup>23</sup> NJ Medicaid HMO contract, section 4.8.8.

<sup>24</sup> NJ Medicaid HMO contract, section 4.8.9.

<sup>25</sup> New Jersey's ratio is 1 primary care provider (PCP) for every 2000 enrollees. South Carolina and Tennessee require 1 PCP for every 2500 enrollees. The number of enrollees for PCPs in states that were lower than New Jersey are: 200 (MD), 301 (CT), 600 (HI), 750 (MI), 1200 (IL and MA), 1500 (FL, NM, RI and VA) and 1800 (NV) (Gifford et al. 2011, Appendix 7, pp. 65–67).

## Policy Options

There is little information about possible approaches by states to developing consistency of provider networks across public and commercial insurance markets, although New York has recognized the need for more evaluation and modeling of strategies to incentivize plans which participate in public and QHP products to align provider networks (Boozang and Lam 2012). To date, there are no comparative studies of New Jersey's commercial HMO networks to provide guidance on gaps in access, although some information about the adequacy of provider networks and consumer-reported access is gathered if a plan is accredited by NCQA.<sup>26</sup> A full analysis of the implications of strategies for aligning provider networks is beyond the scope of this paper; however, some options are suggested below.

- **Dual certification of plans and/or providers**

States could provide incentives or mandate plans to participate in both Medicaid and the exchange, allowing consumers to keep the same plan and provider network when switching from Medicaid to the exchange (or vice versa), which would be less disruptive (Short et al. 2011; Sommers and Rosenbaum 2011). The National Governor's Association held two meetings in September 2010 in which mandatory participation in Medicaid and the exchange was discussed among state representatives who were concerned about churning issues. A spokesperson from Minnesota Department of Human Services noted that HMOs are currently required to participate in Medicaid as a condition of being licensed in Minnesota, but could not say what requirements the state would make of plans under health reform. A Delaware representative also said that it was considering the issue of mandatory participation (Trompeter and Davis 2011). Medicaid Health Plans of America supports voluntary participation in both arenas, but notes that some Medicaid plans have specialized in serving low income populations and may not be able to offer a competitive exchange product, and also that many providers specialize as well (Johnson 2010). National research shows that Medicaid managed care plans have become more specialized, with the percentage of plans dominated by publicly insured individuals increasing from 43 percent of managed care plans in 2003 to 56 percent in 2008 (Kaiser Commission on Medicaid and the Uninsured 2010). A national survey of state Medicaid directors showed that while most states are planning to increase the use of managed care in Medicaid, they are uncertain about the landscape of managed care under health care reform--most did not know if dual participation in Medicaid and the commercial market, or any participation in the exchange, would be required. Thirteen of thirty states reported managed care interest in the exchange (Gifford et al. 2011).

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<sup>26</sup> NCQA, *Consumer Protections in NCQA Health Plan Accreditation*. Accessed April 23, 2012 at <http://www.ncqa.org/Portals/0/Public%20Policy/Strong%20consumer%20protection%20is%20a%20cornerstone%20of%20NCQA.pdf>.

States may take an alternative approach by requiring providers in plans which participate in both the exchange and Medicaid to contract with both the commercial and Medicaid products. This might increase the networks of both primary care providers and specialists to improve network adequacy, as well as continuity of care.

- **Increased provider incentives to participate in Medicaid**

Low reimbursement rates in Medicaid are widely blamed for low provider participation (e.g., Legal Services of New Jersey Poverty Research Institute 2011). Research shows that reimbursement is the most important factor in providers' decisions to participate, but also important are the administrative burdens of billing and documentation and delays in receiving payment (Cunningham and May 2006). New Jersey has recently raised reimbursement rates for some providers, and the ACA requires a temporary increase in rates for primary care providers. There is little evidence to suggest successful approaches to reducing administrative burdens.

- **Require Qualified Health Plans under the Exchange to contract with any willing essential community provider**

After health reform in Massachusetts significantly improved levels of coverage, previously uninsured safety net users did not switch their site of care when they gained coverage (Ku et al. 2011). Safety net patients reported that these facilities are convenient and affordable. Nearly 18% of individuals projected to be covered under a New Jersey exchange will have family incomes below 139% of poverty (Cantor et al. 2011), and many may be familiar with safety net providers and continue to use them. One study indicates that non-elderly New Jersey adults who use clinics as their usual source of care are more likely to be covered by public insurance or uninsured compared to those who use physician practices (Lloyd and Gaboda 2011), and may continue to use clinics if they move into an exchange plan.

- **Encourage consultation between Medicaid and the exchange in developing provider network adequacy standards**

As part of building a relationship between Medicaid and the exchange, it has been suggested that a more integrated market for plans which enroll individuals who receive affordability subsidies could benefit from joint development of a common framework for managed care plan certification in such areas as consumer information, clinical quality measures, provider network composition and capabilities, and access (Bachrach, Boozang, and Garcimonde 2011; Rosenbaum and Riley 2012). State Medicaid staff have developed a wealth of expertise and experience in MCO purchasing strategies, which can inform QHP certification. However, the federal regulatory standards applicable to both the Medicaid and exchange markets are complex and do not yet address the issue of product alignment across programs which provide affordable coverage (Rosenbaum



and Riley 2012). However, consultation between Medicaid and the exchange would allow the state to consider network standards which could promote continuity of care for individuals who are likely to move between coverage mechanisms. More generally, state Medicaid policies provide models of contracting requirements designed to ensure provider continuity of care as eligibility status changes, particularly for those individuals undergoing active treatment for an acute or chronic medical condition (Ingram, McMahon, and Guerra 2012).

## Conclusions

The ACA encourages alignment of provider networks across public and exchange markets by establishing a minimum network adequacy requirement for QHPs and including behavioral health, substance abuse, and essential community providers. The availability of a consistent set of providers across Medicaid and QHPs will also depend upon exchange policy and price sensitivity of providers evaluating participation in various MCO networks. States can take an active approach to developing strategies to insure that individuals moving between types of coverage will have consistent access to their customary providers to the greatest extent possible.

One analysis suggests that QHP qualifications promulgated in the regulations appear to be based on the view that competition in QHP markets will produce more capacity for business than necessary to serve the exchange population (Hirsh Health Law and Policy Program 2011). If capacity falls short of what is needed, exchanges may need to monitor access to coverage and care for populations at risk of medical underservice and disparities in health care. HHS has indicated that it intends to monitor effectiveness of the provisions regarding essential community providers and may modify its approach (Manatt Health Solutions 2012). States may wish to actively monitor access to care for people covered by exchange QHPs, especially those who experience changes in eligibility, in order to adjust their network adequacy requirements to reflect changing health care needs and characteristics of the health care provider community.

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