

**New Jersey State Legislature
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**Department of Human Services
Division of Medical Assistance and Health Services
Medicaid Provider Networks**

July 1, 2013 to May 31, 2016

**Stephen M. Eells
State Auditor**

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Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Provider Networks for the period of July 1, 2013 to May 31, 2016. If you would like a personal briefing, please call me at (609) 847-3470.

A handwritten signature in black ink, appearing to read "Stephen M. Eells".

Stephen M. Eells
State Auditor
January 23, 2017

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Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Provider Networks for the period July 1, 2013 to May 31, 2016. The division administers the NJ FamilyCare (Medicaid) program which provides medical assistance to needy individuals. The state contracts with five Managed Care Organizations (MCOs) to provide quality health care and needed medical services. The MCO provider networks consist of physicians or groups of physicians, specialists, hospitals, pharmacies, and clinics that are contracted by an MCO to provide its members with all of the health care services they may require. MCOs receive a monthly payment for each Medicaid beneficiary enrolled in their plan. For the year ended December 31, 2015, New Jersey spent \$8.1 billion on managed care for approximately 1.6 million or 93 percent of all Medicaid beneficiaries. The remaining 7 percent of beneficiaries participated in the fee-for-service Medicaid program.

Objectives

The objective of our audit was to determine if the division effectively monitored the adequacy of the MCO provider networks regarding access to care and provider availability. Our review focused on hospitals, primary care physicians, primary care dentists, and specialists.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In preparation for our testing, we studied the administrative code, policies of the division, and the health maintenance organization (MCO) contract. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and testing. We interviewed division personnel as well as individuals employed by the MCOs to obtain an understanding of the contract, the Geo Access Report process, and the provider networks.

A nonstatistical sampling approach was used. Our samples were designed to provide conclusions about our audit objective, as well as compliance with the MCO contract and the accuracy and reliability of the Geo Access reports. Sample populations were sorted and transactions were judgmentally selected for testing.

Conclusions

We found the division does not effectively monitor the adequacy of the Managed Care Organization (MCO) provider networks regarding access to care and provider availability. We found quarterly Geo Access reports submitted to the division by the MCOs were not accurate. We found MCOs misreported facilities in their networks as general acute care hospitals in certain counties, thus giving the appearance Medicaid beneficiaries had access to the general acute care hospital services when they did not. We also found dentists and primary care physicians are not always at the locations stated in the Geo Access reports indicating the actual amount of dental providers and primary care physicians may be considerably less than what is reported by the MCOs. In addition, we noted the MCO online directories, which Medicaid beneficiaries rely on, do not always include accurate provider information. Furthermore, we found the division failed to request contractually required claims inactivity reports from the MCOs. These reports would have further enhanced the division's ability to monitor MCO provider networks. Finally, we found primary care physicians' panel sizes that exceeded contractual limits which can reduce the physicians' availability and the beneficiaries' access to care.

Background

Each MCO is contractually required to submit quarterly provider network files to the division. Section 4.8.1 of the New Jersey managed care contract states that MCOs "shall 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 this contract." MCOs should ensure there are sufficient participating providers, including specialists, geographically accessible to beneficiaries. MCOs are required to submit quarterly, geographical accessibility (Geo Access) reports for each county, using Medicaid/NJ FamilyCare eligibility data files and the provider network files. These reports show the percentage of beneficiaries that have access to all providers at various distances. The MCOs also submit a spreadsheet of providers which supports the data used in creating the quarterly Geo Access reports. The division verifies the information on the Geo Access reports is supported by the data on the spreadsheets. The division also utilizes the MCOs' quarterly certified provider network text file to run various reports which assist in monitoring and evaluating the services provided by the MCOs. The division utilizes and relies solely on MCO generated data to verify the accuracy of the Geo Access report as well as for monitoring and evaluating the services provided by the MCOs.

The Geo Access Report

Access to General Acute Care Hospital Services

Not all hospitals included in the MCO networks are licensed as general acute care hospitals and, in addition, Medicaid beneficiaries do not always have contractually required access to general acute care hospital services.

The MCO contract requires that the MCO shall provide general acute care hospital services that are no farther than 15 miles or 30 minutes driving time, whichever is less, from 90 percent of its members within the county or adjacent counties. The contract also states that the MCOs should utilize the Department of Health's website to verify hospitals in their network are licensed general acute care hospitals. We reviewed each of the five MCO networks as reported to the division in the Geo Access reports for the third quarter of calendar year 2014 through the third quarter of calendar year 2015, and found four of the five MCOs had a total of 41 facilities in 14 counties that were not general acute care hospitals. By including these facilities in their networks, it appeared the MCOs met contract requirements and beneficiaries had appropriate access to hospitals. We found when removed from the networks, 20 of the 41 facilities did impact beneficiaries' required access standards to general acute care hospitals, six facilities may affect beneficiaries' access, and 15 facilities did not affect beneficiaries' access to general acute care hospitals. Examples of the facilities that were improperly included in the Geo Access as general acute care hospitals were a rehabilitation center, a behavioral health center, a psychiatric facility, a heart and lung center, and a special needs child care facility. The division relies solely on the Geo Access reports and the supporting data reported by the MCOs to determine whether access to general acute care hospital services is available to beneficiaries as required by the contract. However, the Geo Access reports as well as the supporting documentation were at times inaccurate. The MCOs are not in compliance with the contract as they are not maintaining a network of general acute care hospital services that is sufficient to provide adequate access to services.

We also noted one MCO could not provide general acute care hospital services in Cumberland County to some of its members in accordance with the contract requirements because the MCO would not accept the only available hospital's proposed rates. In addition, another MCO could not provide services to most of its members in Hunterdon County because the only available hospital in the county refused to contract with the MCO. Furthermore, that same MCO could not provide services to some of its members in Warren County because one of the two hospitals in the county would not contract with the MCO. The MCOs must continually reach out to the hospitals in an attempt to negotiate a contract with them. Each MCO has demonstrated they have attempted to negotiate with the available hospitals. However, some hospitals will not contract with certain MCOs making it difficult for beneficiaries to gain access, while other hospitals have proposed rates the MCOs will not accept.

Access to Dental Services

Dental providers are not always at the locations stated in the Geo Access reports, therefore, the actual number of dental providers may be considerably less than what is reported by the MCOs.

Based on the information provided in the Geo Access reports for the quarter ending December 31, 2015, for the two largest MCOs, we selected 52 individual dental providers from a population of 357 providers who were listed at five or more locations throughout the state. The dentists tested were listed at a total of 795 locations. We attempted to contact every location where the dentists were listed to determine whether they were providing services at those locations. We found the dentists were not providing services at 731 of the 795 listed locations. Furthermore, from the population of the 357 providers who were assigned to five or more locations, we noted 94 (26.3%) dentists were assigned to 10 or more locations throughout the state. One dentist was reported in the Geo Access report as being located at 39 different addresses. Thirty-eight of the locations were long-term care facilities which do not offer dental services to the public. The dentist provided services at only one publicly accessible location. Although we selected the two largest MCOs for our testing, most of the exceptions were noted with one MCO rather than the other.

Our analysis of the Geo Access supporting documentation noted at least 15 dentists were located at 22 practices throughout the state. Many of the practices had the same dentists assigned to each of the locations. Fifteen of the 22 practices reported at least 60 dentists practicing there. However, when the practices were contacted we were told there were only, at most, eight dentists practicing at the locations. We tested to determine if all dentists assigned to the 22 practices were actually performing services at the locations as reported in the quarter ending December 31, 2015 Geo Access report. We found from a total of 1,396 unique combinations of dentists and locations tested, 1,216 (87%) unique combinations were inaccurately reported in the Geo Access report because the dentists were not practicing at the locations. The division relies on the information provided in the MCOs' Geo Access reports to ensure beneficiaries have adequate access to care. However, these inaccuracies in the reports suggest beneficiaries may not have adequate access to dental services.

The contract states that 90 percent of beneficiaries must be within six miles of two primary care physicians and two primary care dentists in an urban setting and 85 percent of beneficiaries must be within 15 miles of two primary care physicians and two primary care dentists in a non-urban setting. We reviewed access to dental services for all five MCOs for the first quarter of 2014 through the third quarter of 2015 and determined four MCOs had beneficiary access below contract standards in Morris and/or Somerset counties, according to the Geo Access reports. There may be considerably more beneficiaries who do not have access to dental services within contract standards as we noted most dentists were not at their assigned locations as reported in the Geo Access reports.

Recommendation

The division should work with the MCOs so all Medicaid beneficiaries enrolled in managed care networks have appropriate access to general acute care hospitals and dental providers. In addition, the division should enhance their review of the Geo Access reports and the supporting documentation to determine the accuracy of the MCOs’ information to ensure they are in compliance with the contract.



MCO Online Provider Directories

MCO online provider directories need to include accurate provider information to ensure members have appropriate access to care.

The MCOs maintain online provider directories for beneficiaries to access and determine their available services and locations. We selected the three largest MCOs and reviewed the online provider directories in Camden, Atlantic, Passaic, Essex, and Monmouth counties to determine the accuracy of the provider information on the directories. We attempted to contact a sample of specialist providers including dermatologists, endocrinologists, ophthalmologist, otolaryngologist (commonly known as ear, nose, and throat specialists, or ENTs), and orthopedic surgeons to verify their service locations and whether they were accepting the MCOs’ insurance. We found a number of listed specialty providers were not available to serve beneficiaries at the addresses listed on the online provider directories. We tested a total of 251 specialist providers at individual locations and found 65 (25.9%) were not at the locations as stated on the online directories. For those providers at the locations, we determined 21 (11.3%) were not accepting the MCOs’ insurance.

Provider*	Provider not at the location listed in directory	Provider not accepting MCOs' insurance
Dermatologists	23 out of 71 (32.4%)	5 out of 48 (10.4%)
Endocrinologists	5 out of 31 (16.1%)	2 out of 26 (7.7%)
Ophthalmologists	18 out of 61 (29.5%)	4 out of 43 (9.3%)
ENTs	10 out of 46 (21.7%)	3 out of 36 (8.3%)
Orthopedic surgeons	9 out of 42 (21.4%)	7 out of 33 (21.2%)

*The term "provider" refers to a provider at a specific location in a specific MCO.

In addition to the specialists above, we also attempted to contact a sample of general dentists, pediatric dentists, orthodontists, and oral surgeons and found 25 (33.8%) of the 74 dental providers tested were not at the locations listed in the directories. We also noted from the 49

providers tested who were at the locations, all but one provider accepted the MCOs' insurance. In addition, we tested primary care physicians (PCPs) to determine the accuracy of the MCO online directories. We selected the three largest MCOs and PCP locations within Camden, Newark, and Trenton and attempted to contact the PCPs to determine the accuracy of the addresses listed on the directories, if they were accepting the MCOs' insurance, and if they were actually acting as PCPs and servicing patients. We tested 171 provider locations based on the online directories and found 77 (45%) of the doctors listed in the directories at the various addresses were not at those locations. We also noted from the 94 practices where the physicians were at those locations, 12 (12.8%) were not accepting the MCOs' insurance, and 10 (10.6%) addresses had PCPs listed that were not practicing as PCPs. Two addresses had a PCP listed who was a physician, but was acting as the chief executive officer at both locations and was not seeing any patients. Another five locations were hospital addresses where the physicians listed on the online directories were "hospitalists" who are dedicated in-patient physicians who work exclusively in a hospital and care only for hospitalized patients, while two other locations listed an endocrinologist and an infectious disease doctor. The division relies on the MCOs reporting accurate information on the online directories so Medicaid beneficiaries have appropriate access to care. In addition, we expanded our testing of the PCPs in our sample to determine the accuracy of the addresses in the Geo Access reports' supporting data, as well as the certified provider network files, for the quarter ending December 31, 2015. We reviewed provider addresses for the three largest MCOs and found 73 (46.8%) of 156 addresses were not accurately stated in the Geo Access supporting spreadsheets. In addition, we found 77 (46.1%) of 167 addresses were not accurately stated in the certified provider network files.

We also tested the accuracy of the online MCO directories using the monthly Provider Network Spot Check reports. As stated in the contract, the MCOs submit to the division monthly Provider Network Spot Check reports to verify the accuracy of the MCOs' provider network files. At a minimum, the MCOs should survey 50 percent of its specialty, PCP, OB/GYN, and dental networks per county, annually; and although it is not clearly stated in the contract, 100 percent of the providers should be included in the spot check review every two years. However, the division is not able to determine if the MCOs are surveying 50 percent of its provider networks annually due to the manner in which the MCOs submit the information.

The contract also states that the MCOs shall verify the accuracy of the provider network files through a survey questionnaire reviewing the provider name, practice type or specialty, address, phone number, MCO participation status, office hours, open or closed panel, and the ability to accommodate special needs members, and determine whether the provider should be removed from the network. Although the spot check reports are used by the MCOs to verify the accuracy of the MCOs' provider network files, we used the reports to determine the accuracy of the MCOs' online provider directories. We tested provider information on the reports for four MCOs for a one-month period. A fifth MCO was tested for a two-month period. We selected reports from the months of August, September, and November of 2015 and tested and traced the information to the MCOs' online provider directories to determine the accuracy of the information on the directories. We tested 429 provider locations to determine that the provider, along with the specific address, was found on the online directories; however, 115 (26.8%) providers at the specific locations could not be found on the directories. In addition, we found

from the 126 physicians' addresses that should have been removed per the Provider Network Spot Check reports, 54 (42.9%) of the addresses remained on the online directories. The division's contract requires MCOs to maintain and update their online provider directories every 30 days.

Recommendation

The division should routinely verify the accuracy of the MCO provider online directories to determine beneficiaries have access to provider information that is accurate and up-to-date. Also, the Provider Network Spot Check reports, used to verify the accuracy of the provider network file, should also be used by the division to verify the accuracy of the MCO directories. In addition, the contract language in the MCO provider network contract should clearly state that 100 percent of the provider networks be reviewed every two years. Furthermore, the division should work with the MCOs to provide the monthly Provider Network Spot Check reports in a format which will allow the division to determine whether 50 percent of the MCO network files are reviewed annually.



Claims Inactivity Report

Primary care physicians' (PCPs') and primary care dentists' (PCDs') claims inactivity should be reported to the division by the MCOs to assist in monitoring the participation status of the providers.

Section 4.7.2 of the New Jersey MCO contract states that the MCO shall monitor, review, and investigate claims inactivity of all PCPs and PCDs for whom there were the lesser of 10 claims or less than \$600 of claims paid to the provider in a year to determine actual participation status. The contract also states that the MCO shall report its findings to the division. Our review noted both the division and the MCOs are not in compliance with the MCO contract because the division has never requested this information from the MCOs nor have the MCOs ever submitted this data to the division. We created the claims inactivity report for three of the five MCOs for calendar year 2014 to determine which PCPs qualified under the claims inactivity criteria. We noted the following.

- One MCO had a total of 3,542 PCP providers in its network for the year with 635 (17.9%) of the providers meeting the claims inactivity criteria. Of those 635 providers, 244 had no claims for the year.
- Another MCO had a total of 3,819 PCP providers in its network for the year with 961 (25.2%) of the providers meeting the claims inactivity criteria. Of those 961 providers, 447 had no claims for the year.

- A third MCO had a total of 3,079 PCP providers in its network for the year with 1,176 (38.2%) of the providers meeting the claims inactivity criteria. Of those 1,176 providers, 644 providers had no claims for the year.

The claims inactivity report is a useful and effective means to monitor and effectively identify providers who may no longer be actively participating in the MCO networks.

Recommendation

We recommend the division enforce the requirement of the contract and require MCOs to submit the annual report to use as a tool to monitor actual provider participation.



MCO Provider Panel Sizes

Twenty-nine primary care physicians' (PCPs') panel sizes at times exceeded limits which can reduce the PCPs' availability as well as the beneficiaries' access to the PCPs.

The MCO contract states that the MCOs shall monitor the capacity of each of its providers and decrease ratio limits as needed to maintain appointment availability standards. According to the contract, a full time equivalent PCP working at least 20 hours per week shall have a maximum panel size of 2,000 beneficiaries. A PCP contracted as a provider with more than one MCO, shall not have a combined panel size of more than 3,000 beneficiaries. Panel sizes of PCPs are reported to the division quarterly by the MCOs. We reviewed PCP panel sizes for six quarters beginning with calendar year 2014 through the second quarter of 2015 and noted there were 29 PCPs who had panel sizes exceeding 3,000 members across all MCOs, with 13 PCPs above the 3,000 limit for all six quarters. Five of the PCPs had panel sizes greater than 4,000 beneficiaries. These panel sizes include only Medicaid beneficiaries and do not include individuals participating in other insurances such as Medicare and commercial insurances, which would only further increase the amount of the panel sizes and likely decrease PCPs' availability as well as the beneficiaries' access to the PCPs.

Recommendation

We recommend the division work with the MCOs to prohibit providers from accepting new beneficiaries when their panel sizes exceed the standards so beneficiaries' access and availability to PCPs is not reduced.





State of New Jersey

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January 19, 2017

John J. Termyna, Assistant State Auditor
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Dear Mr. Termyna:

The Department of Human Services is in receipt of a draft audit issued by your office, "**Department of Human Services' (DHS) Division of Medical Assistance and Health Services (DMAHS) Medicaid Provider Networks.**"

The audit was designed to determine if DMAHS effectively monitored the adequacy of the Managed Care Organization (MCO) provider networks regarding access to care and provider availability.

Audit Conclusions

The auditor concluded that DMAHS should improve the effectiveness of its monitoring of managed care organization networks in a number of areas and that the quarterly Geo Access reports submitted to the division by the MCOs were not accurate. The auditor further indicated that MCOs misreported hospitals in their networks as general acute care hospitals in certain counties, and that dentists and primary care providers were not always at the locations indicated in the report. It also was noted that the MCO online directories, which Medicaid beneficiaries rely upon to choose health providers, do not always include accurate provider information. The auditor suggests that the Division failed to request contractually-required claims inactivity reports from the MCOs.

Finally, the auditor determined that primary care providers' panel sizes exceed contractual limits reducing provider availability and beneficiary access to care.

Division Responses

The Division monitors provider networks of all five MCOs rigorously, managing its available resources and utilizing the tools at its disposal. Based upon obtainable information, including the MCO network files, MCO encounter data, data in the Business Intelligence Warehouse, the Division's Complaint, Grievance and Appeals databases, MCO reports of Complaints, Grievances and Appeals for members and providers (Tables A, B and C), surveys of beneficiary experience and satisfaction (including the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]), and the National Core Indicators for the Aged and Disabled face-to-face survey, DMAHS is confident that the MCO networks meet the prescribed adequacy standards for access set forth in both the New Jersey Managed Care Contract and applicable regulatory and contractual requirements.

MCO provider network files indicate sufficient redundancy such that access to providers to deliver the full Medicaid benefit is assured. Unlike the fee-for-service (FFS) system, the MCOs are accountable to deliver the full Medicaid benefit to their beneficiaries, whether it is through participating provider contract arrangements, documented relationships, or single-case agreements when participating providers are not available or willing to contract with the MCO. Single-case agreements are most often used for certain specialty hospitals and Centers of Excellence such as the Children's Hospital of Pennsylvania, DuPont/Nemours, or St. Barnabas which provide clinically necessary services often not provided by other acute care hospitals, or for specific specialists such as Pediatric Neurologists who decline network participation status to any MCO.

Continued improvement in monitoring MCO provider networks is important to support beneficiary decisions in choosing a health plan and to ensure real choice in access to services. It is not unreasonable, at any singular point in time that provider network files, and the network itself, will have inaccuracies. The MCOs are required to identify and fix any errors in accordance with contract requirements, while continuing to maintain access and availability to members.

The Division takes steps regularly to increase its monitoring of MCO provider networks, assigning additional resources, both staffing and technological in nature, to this function. The Division also has enhanced its review and analysis of MCO provider network reports and expanded contractual requirements. The Division has instituted a weekly All Cause Provider Termination/Non-Renewal Report to crosswalk with the network file. DMAHS' Network Unit has increased the number of provider spot-checks at the state level and has enforced required provider spot-check submissions from the MCOs. The MCOs must complete monthly spot-checks of provider networks to verify the accuracy of their provider network files.

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Each MCO must survey 50% of its provider network (excluding hospital-based specialties), per county, and submit monthly provider network spot-checks. The monthly survey is required to be county-specific, with all counties within the MCO's operating area being surveyed at least annually. MCOs are required to document to the Division any corrective actions taken as a result of this spot-check activity as well as to verify provider participation during Annual Primary Care Provider After-Hours Availability Studies.

Using its allocated resources, the DMAHS conducts its own ad hoc spot-checks to verify provider participation in response to identified trends, complaints and/or special requests. Corrective action is required when deficiencies, negative patterns or trends are identified.

The DMAHS also monitors enrollment capacity. If enrollment capacity exceeds 80%, the MCO is notified and must submit updated provider network files and geographic accessibility reports. DMAHS' Office of Quality Assurance and Office of the Medical Director evaluates the data to determine whether or not the network is robust enough to adequately serve the membership in that county. Once the DMAHS is satisfied, the request with supporting documentation is forwarded to the federal Centers for Medicare and Medicaid Services (CMS) for its approval.

The most significant initiative regarding MCO provider network monitoring the Division has undertaken is the replacement of the current Medicaid Management Information System with a more modern Replacement Medicaid Management Information System (R-MMIS). This began in February 2015 when Molina Medicaid Solutions was awarded the R-MMIS contract. The anticipated launch date of the R-MMIS is July 2018. The R-MMIS solution will include functionality to create the Universal Credentialing Program (UCP) for all NJ FamilyCare (FamilyCare) fee-for-service and managed care network providers.

The UCP project will transfer the responsibility for provider credentialing from the managed care organizations to the state and it will create and maintain a single pool of approved providers from which the MCOs can contract. This will give the Division direct access to information about the availability of providers that serve all 1.7 million FamilyCare beneficiaries. By having a single source of data, the Division will not only be able to monitor individual MCO provider networks, but also monitor provider networks across all MCOs.

Finally, the FamilyCare MCOs are contractually required to provide and cover services, via non-participating providers, if necessary, any time a beneficiary is unable to obtain required services in a timely fashion. This provision acts as a fail-safe to ensure that periodic access issues do not lead to actual gaps in care. The relevant language in the Managed Care Contract, between DMAHS and each plan, is as follows:

4.1.1.I. Non-Participating Providers

1. *The Contractor shall pay for services furnished by non-participating providers to whom an enrollee was referred, even if erroneously referred, by his/her PCP or network specialist. Under no circumstances shall the enrollee bear the cost of such services when referral errors by the Contractor or its providers occur. It is the sole responsibility of the Contractor to provide regular updates on complete network information to all its providers as well as appropriate policies and procedures for provider referrals.*

4.8.1.K. Out of Network Providers

1. *The Contractor shall provide adequate and timely coverage of services out of network, when the medically necessary services covered under the contract, are not available within the Contractor's network for as long as the Contractor is unable to provide the services in-network. See also Articles 4.1.1.I and 4.8.7.G.*
2. *The Contractor shall allow referral to a non-network provider, upon request of a network provider, when medically necessary covered services are not available through network providers, or the network providers are not available within a reasonable period of time in accordance with appointment standards in Article 5.12. See also Articles 4.1.1.G and 4.8.7.G.*

4.8.7.G. Specialty Providers and Centers

1. *If the Contractor determines that it does not have a health care provider with appropriate training and experience in its panel or network to meet the particular health care needs of an enrollee, the Contractor shall make a referral to an appropriate out-of-network provider, pursuant to a treatment plan approved by the Contractor in consultation with the primary care provider, the non-Contractor participating provider and the enrollee or where applicable, authorized person, at no additional cost to the enrollee. The Contractor shall provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the Contractor may deny a referral. If the Contractor does not have an MLTSS network provider with the appropriate training, experience and availability to meet the particular service needs of the Member, or if the Contractor's network provider cannot meet the timeliness standards set forth by the State, the Contractor shall make a referral to an appropriate out-of-network provider.*

Specific Audit Findings

The Geo Access Reports

Access to General Acute Care Hospital Services

Finding: *Not all hospitals included in the MCO networks are licensed as general acute care hospitals and, in addition, Medicaid beneficiaries do not always have contractually required access to general acute care hospital services.*

Response:

The Division's most important responsibility is to maintain member access to services under the Medicaid benefit. Acute care hospitals, of course, are critical to this mission.

The Division regularly reviews the Department of Health (DOH) Licensing website to ensure that data pertaining to general acute care hospitals is accurate, and the Division runs systematic quality reports on the supporting Geo Access data to identify potential inaccuracies. With the resources and tools available, the Division works to analyze and to identify any discrepancies between the supporting Geo Access data, Provider Network File data and updated DOH Licensing data. Additionally the Division periodically generates its own Geo Access reports using a representative beneficiary file against eligible acute care hospitals to provide insight on potential access issues.

Access to Dental Services

Finding: *Dental providers are not always at the locations stated in the Geo Access reports; therefore, the actual number of dental providers may be considerably less than what is reported by the MCOs.*

Response:

The Division is profoundly aware of the importance of access to primary dental care for beneficiaries. The exclusion of the providers questioned in the audit would not reduce any MCO's dental provider network below the minimum contractual requirements. The Division maintains MCO contractual requirements for primary dental provider networks that exceed the State's regulatory specifications. Additionally, the Division performs stringent reviews of the separate MCO certified provider network files to ensure compliance with contract requirements. This review includes identifying providers operating from multiple locations.

MCO Online Provider Directories

Finding: *MCO online provider directories need to include accurate provider information to ensure members have appropriate access to care.*

Response:

The Division has created a workgroup involving relevant stakeholders to identify challenges and to recommend solutions related to assisting the MCOs in keeping timely, accurate online databases of available providers. The workgroup concurred with the State's planned action to undertake universal credentialing of providers. This initiative is expected to improve the quality and accessibility of provider data and provider directories. The planning and design of the Universal Credentialing Program is underway and the State will continue to take under advisement recommendations regarding streamlining and assuring a better consumer experience in the use of MCO online provider directories.

The Division, through its Office of Managed Health Care, does periodic testing of the functionality of on-line directories; however, as indicated, these are not tied to the provider network file. Each plan is responsible for the design and operation of their directories.

Claims Inactivity Report

Finding: *Primary care physicians' (PCPs') and primary care dentists' (PCDs') claim inactivity should be reported to the division by the MCOs to assist in monitoring the participation status of the providers.*

Response:

The Division has begun to expand the Network Unit allowing for regular review of provider claims inactivity reports. It is the Division's intent to modify contract language to require quarterly MCO reporting of this information to the Division. Furthermore, the Division will make more effective use of MCO encounter data reporting to track actual service delivery and will develop utilization profiles cross-walked with the provider network files.

MCO Provider Panel Size

Finding: *Twenty-nine primary care physicians' (PCPs') panel sizes at times exceeded limits which can reduce the PCPs' availability as well as the beneficiaries' access to the PCPs.*

Response:

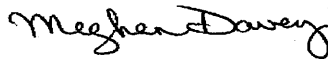
DMAHS monitors and reviews data on a quarterly basis related to panel sizes, both of individual MCOs and across all MCOs. The audit identified 29 PCPs with panel sizes exceeding 3000 across all plans, out of a total population of approximately 8000 distinct reported PCPs.

Mr. John J. Termyna
January 19, 2016
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Strict enforcement of this requirement has its own challenges including potentially burdening smaller MCOs, that are not yet statewide; creating self-induced access issues in some geographic areas; and, reducing member choice of preferred providers. In addition, MCOs only have access to panel sizes in their own network, and have no way to monitor the panel sizes of networks of other MCOs, for providers who are in more than one network.

If you have any questions, please do not hesitate to contact me, or Richard H. Hurd, at 609-588-2550.

Sincerely,



Meghan Davey
Director

MD:jf

c: Elizabeth Connolly, Acting Commissioner
Richard H. Hurd, DMAHS Chief of Staff