

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**ACCESS TO CARE:  
PROVIDER AVAILABILITY IN  
MEDICAID MANAGED CARE**



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**December 2014  
OEI-02-13-00670**

# **EXECUTIVE SUMMARY: ACCESS TO CARE: PROVIDER AVAILABILITY IN MEDICAID MANAGED CARE OEI-02-13-00670**

## **WHY WE DID THIS STUDY**

Examining access to care takes on heightened importance as enrollment grows in Medicaid managed care programs. Under the Patient Protection and Affordable Care Act, States can opt to expand Medicaid eligibility, and even States that have not expanded eligibility have seen increases in enrollment. Most States provide some of their Medicaid services—if not all of them—through managed care. The Office of Inspector General received a congressional request to evaluate the adequacy of access to care for enrollees in managed care. This report determines the extent to which providers offer appointments to enrollees and the timeliness of these appointments. A companion report issued earlier this year, *State Standards for Access To Care in Medicaid Managed Care*, OEI-02-11-00320, found that State standards for access to care vary, and that they are often not specific to certain provider types or to areas of the State. Additionally, States have different strategies to assess compliance with access standards.

## **HOW WE DID THIS STUDY**

We based this study on an assessment of availability of Medicaid managed care providers. The assessment included calls to a stratified random sample of 1,800 primary care providers and specialists to assess availability and timeliness of appointments for enrollees.

## **WHAT WE FOUND**

We found that slightly more than half of providers could not offer appointments to enrollees. Notably, 35 percent could not be found at the location listed by the plan, and another 8 percent were at the location but said that they were not participating in the plan. An additional 8 percent were not accepting new patients. Among the providers who offered appointments, the median wait time was 2 weeks. However, over a quarter had wait times of more than 1 month, and 10 percent had wait times longer than 2 months. Finally, primary care providers were less likely to offer an appointment than specialists; however, specialists tended to have longer wait times.

## **WHAT WE RECOMMEND**

Together, these findings—along with those from our companion report—call for the Centers for Medicare & Medicaid Services (CMS) to work with States to improve the oversight of managed care plans. We recommend that CMS work with States to (1) assess the number of providers offering appointments and improve the accuracy of plan information, (2) ensure that plans' networks are adequate and meet the needs of their Medicaid managed care enrollees, and (3) ensure that plans are complying with existing State standards and assess whether additional standards are needed. CMS concurred with all three of our recommendations.

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## OBJECTIVES

1. To determine the extent to which providers could offer appointments to Medicaid managed care enrollees.
2. To assess wait times for appointments for Medicaid managed care enrollees.
3. To describe any differences in the availability of primary care providers and specialists.

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## BACKGROUND

Medicaid is a jointly funded Federal and State health insurance program that finances the delivery of medical services to more than 69 million people.<sup>1</sup> In fiscal year (FY) 2013, the Federal Government and the States combined spent almost \$460 billion on the program.<sup>2</sup> Each State designs and administers its own Medicaid program within broad Federal guidelines. Most States provide some or all Medicaid services through Medicaid managed care, which covers nearly three-quarters of Medicaid enrollees.<sup>3</sup>

Examining access to care takes on heightened importance as enrollment grows in Medicaid managed care programs. Under the Patient Protection and Affordable Care Act, States have the option to expand eligibility for their Medicaid programs.<sup>4</sup> As a result, Medicaid is expected to provide coverage for as many as 18 million more people by 2018.<sup>5</sup> In addition,

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<sup>1</sup> Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*. Accessed at <http://www.cbo.gov/publication/45010> on August 26, 2014.

<sup>2</sup> The Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, March 2014. Accessed at <http://www.macpac.gov/reports> on August 26, 2014.

<sup>3</sup> Centers for Medicare & Medicaid Services (CMS), *Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011*. Accessed at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf> on April 1, 2014.

<sup>4</sup> P.L. No. 111-148 § 2001 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010), collectively referred to as “the ACA.”

<sup>5</sup> Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*. Accessed at <http://www.cbo.gov/publication/45010> on August 26, 2014.

many States that have not expanded eligibility have also seen increases in enrollment.<sup>6</sup>

The Office of Inspector General (OIG) received a congressional request to evaluate the adequacy of access to care for enrollees in Medicaid managed care. This report determines the extent to which providers offer appointments to enrollees and the timeliness of these appointments. A companion report found that State standards for access to care vary, and that they are often not specific to certain provider types or to areas of the State.<sup>7</sup> Additionally, States have different strategies to assess compliance with access standards.

### **Medicaid Managed Care**

States have the option to provide either all or some portion of their Medicaid services through Medicaid managed care.<sup>8</sup> The goal of managed care is to decrease Medicaid costs while providing high-quality care to enrollees. Additionally, managed care is intended to reduce the State's financial risk and allow for more predictable Medicaid costs.

States have different types of managed care arrangements, but the most common is full-risk managed care.<sup>9</sup> Under this arrangement, managed care organizations (MCOs) assume the full financial risk for delivering a comprehensive set of services. These services generally include all primary, specialty, and acute medical care. States pay MCOs a fixed monthly fee per enrollee (often referred to as capitation), and the MCO delivers services through a network of participating providers.<sup>10</sup> MCOs maintain listings—typically in the form of a provider directory—of all participating providers in their networks who provide care to enrollees.

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<sup>6</sup> MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2014. Accessed at: <http://www.macpac.gov/reports> on September 8, 2014, and Kaiser Family Foundation, *Medicaid Enrollment: June 2013 Data Snapshot*. Accessed at <http://kff.org/report-section/medicaid-enrollment-june-2013-data-snapshot-appendix-a-table-a-1-total-medicicaid-enrollment-by-state/> on September 8, 2014.

<sup>7</sup> OIG, *State Standards for Access to Care in Medicaid Managed Care* (OEI-02-11-00320).

<sup>8</sup> States may provide Medicaid services through managed care under their State plans for medical assistance in accordance with Social Security Act § 1932(a) or under waivers to their State plans in accordance with Social Security Act §§ 1115, 1915(a), and 1915(b).

<sup>9</sup> Another arrangement is primary care case management, which pays providers a nominal fee for providing case management services to enrollees assigned to them. States may also contract with MCOs to provide a limited set of services under managed care, such as dental services.

<sup>10</sup> 42 CFR § 438.2. The MCO is responsible for paying for services delivered to enrollees by participating providers. In assuming the full financial risk, the MCO must cover the cost of services delivered to enrollees, even if the cost exceeds the amount of capitation payment from the State. The MCO pays providers on a fee-for-service basis.

This report focuses solely on MCOs providing full-risk managed care for a comprehensive set of services.

### **Federal Regulations Governing Medicaid Managed Care Access Standards**

Federal regulations require States to have a written strategy for assessing and improving the quality of health care services offered by all MCOs.<sup>11</sup> That strategy must include standards for access to care that all MCOs must meet. These standards are intended to ensure that each MCO maintains a network of providers that is sufficient to provide adequate access to Medicaid services covered under the contract between the State and the MCO.<sup>12</sup> When establishing and maintaining its provider network, each MCO must consider (1) the anticipated Medicaid enrollment, (2) the expected utilization of services, (3) the numbers and types of providers needed, (4) the numbers of network providers who are not accepting new Medicaid patients, and (5) the locations of providers and Medicaid enrollees. Regulations also require that each MCO provide timely access to care and services.<sup>13</sup>

Additionally, regulations require State contracts to ensure that if the MCO is unable to provide necessary services to a particular enrollee with providers in the managed care network, the MCO must cover these services using out-of-network providers at no additional cost to the enrollee.<sup>14</sup>

### **CMS Oversight**

According to Federal regulations, CMS must review and approve all contracts that States enter into with MCOs, including contract provisions that incorporate standards for access to care.<sup>15</sup> In addition, each State must submit to CMS its quality strategy, which includes these standards, and must certify that its MCOs have complied with its requirements for availability of services.<sup>16</sup> Further, each State must submit to CMS regular reports describing the implementation and effectiveness of its quality strategy.<sup>17</sup>

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<sup>11</sup> 42 CFR § 438.202 (a).

<sup>12</sup> 42 CFR § 438.206(b)(1).

<sup>13</sup> 42 CFR § 438.206(b)(1)(i) – (v). The regulations that we outline in this paragraph of our report are intended to ensure both the adequacy of MCO networks and timely access to care. State standards for access to care ensure that MCOs comply with both of these regulatory requirements.

<sup>14</sup> 42 CFR § 206(b)(4).

<sup>15</sup> 42 CFR § 438.6(a).

<sup>16</sup> 42 CFR §§ 438.202 and 438.207(d).

<sup>17</sup> 42 CFR § 438.202(e)(2).

## Related Work

In a companion report, OIG found that States that contract with MCOs have established at least one of the following three types of standards for access to care: (1) standards that limit the distance or amount of time enrollees should have to travel to see a provider; (2) standards that require appointments be provided within a certain timeframe; and (3) standards that require a minimum number of providers in relation to the number of enrollees.<sup>18</sup> These standards are often not specific to certain types of providers or to areas of the State.

OIG also found that States have different strategies to assess compliance with access standards, but they do not commonly use what are called “direct tests.” Direct tests seek to reliably measure whether plans comply with access standards and commonly include calls to providers. The report recommended that CMS strengthen its oversight of State standards and ensure that States develop standards for key providers. It also recommended that CMS strengthen its oversight of States’ methods to assess plan compliance and that it ensure that States conduct direct tests of access standards.

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## METHODOLOGY

### Scope

We based this study on an assessment of availability of Medicaid managed care providers. The assessment included calls to a stratified random sample of primary care providers and specialists to assess availability and timeliness of appointments for new patients. This study measures the availability of specific providers at specific locations in Medicaid managed care networks. It does not attempt to measure whether an enrollee would have been able to obtain an appointment elsewhere, such as with another provider at the same location. Further, it focuses solely on Medicaid managed care and does not include an assessment of other types of Federal or State health care programs or private insurance. Lastly, this study focuses on the earliest routine, non-urgent appointment available for new patients. We conducted calls from July through October 2013, which preceded States’ expansion of Medicaid under the ACA.

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<sup>18</sup> OIG, *State Standards for Access to Care in Medicaid Managed Care* (OEI-02-11-00320).

## Identification of Medicaid Managed Care Providers

We contacted all States to identify those that contracted with Medicaid MCOs. We included only MCOs providing full-risk managed care for a comprehensive set of services to the general Medicaid population.<sup>19</sup> We identified 32 States with 221 MCOs that were active from January 2012 through July 2013. From each of the 32 States, we requested a list of all providers participating in Medicaid managed care plans.

We requested information about each provider, such as the address and phone number for each location at which the provider was practicing and the name of each Medicaid managed care plan in which the provider was participating in as of January 1, 2012.<sup>20</sup> We also requested information on whether the provider was a primary care provider or specialist, as well as the provider's specialty.

Using this information, we identified all primary care providers and selected specialists participating in Medicaid managed care. For primary care providers, we included pediatricians, obstetricians/gynecologists (OB/GYN), as well as family practitioners and general internists. We also included nonphysician practitioners—such as nurse practitioners and midwives—who were primary care providers. For specialists, we selected nine types of specialists with whom an enrollee would typically make an appointment for a routine consultation in an office setting. These nine specialists were: allergists/immunologists; cardiologists; dermatologists; endocrinologists; gastroenterologists; neurologists; orthopedists; otolaryngologists; and urologists.

Each provider may practice at multiple locations and may participate in multiple plans. A provider may also participate in different plans at different locations. In this report, we use the term “provider” to refer to a provider at a specific location in a specific plan. In total, we identified 1.36 million providers who were participating in Medicaid managed care as of January 1, 2012.

From this population of providers, we selected a stratified random sample of 1,800 providers, which included 450 providers from each of the following four strata: (1) urban primary care providers, (2) rural primary

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<sup>19</sup> We excluded noncomprehensive plans, as these offer a limited range of services under managed care. We also excluded plans that served only specific populations, such as foster children, enrollees with long-term-care needs, or enrollees who are eligible for both Medicaid and Medicare.

<sup>20</sup> We collected all addresses for each provider but included in our analysis only the addresses at which the provider was listed as practicing and offering care to patients. We refer to these addresses as the provider's “location.”



care providers, (3) urban specialists, and (4) rural specialists. We determined whether each provider was in an urban or rural area on the basis of the provider's ZIP Code.<sup>21</sup> We determined our sample size on the basis of the outcome of a pretest.<sup>22</sup>

### **Assessment of Provider Availability**

To assess provider availability, we called all 1,800 providers in our sample and attempted to schedule an appointment. These calls took place from July through October 2013. On each call, we confirmed whether the provider practiced at the location listed, whether the provider participated in the plan, and whether the provider was accepting new patients enrolled in the plan. If the provider's practice had relocated nearby, we considered the provider to be at the location and determined whether the provider was able to offer an appointment. In contrast, if the provider had retired or left the practice, we considered the provider to be not participating at the location listed and to be unable to offer an appointment.

During our calls, we asked for the earliest date available for a routine appointment with the provider. We did not provide details about any enrollee or schedule appointments. If asked, we said that we were calling on behalf of a new enrollee to determine the earliest available appointment. For primary care providers, we asked about an appointment for a new patient visit and/or checkup; for specialists, we asked about an appointment for a consultation.<sup>23</sup>

We used several criteria for excluding providers from our sample that made our estimate of the percentage of providers who could not offer appointments more conservative. For example, when a caller determined that a provider was not practicing at a location or participating in a plan, we followed up with the plan. If the plan had information indicating that the provider was not at the location or not participating in the plan during the time of our calls, we excluded this provider from our analysis. We also excluded a provider if we determined during the call that the provider was a different type than indicated by the State, such as chiropractors

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<sup>21</sup> We used rural-urban commuting area codes (RUCAs), which classify counties using measures of population density, urbanization, and daily commuting distance. Accessed at <http://depts.washington.edu/uwruca/> on January 15, 2013. We defined an area as urban if 30 percent or more of its workers commute to or live within an area with 50,000 people or more. We considered all other areas to be rural.

<sup>22</sup> We selected a stratified random sample of 120 providers to conduct a pretest. From the results of the pretest, we included additional providers in each strata in our study sample to ensure that we could project the results of our analysis at the 95-percent confidence level.

<sup>23</sup> For obstetricians, we asked about an appointment for a first prenatal visit at the eighth week of pregnancy.

incorrectly identified as orthopedists. Finally, we excluded providers if they practiced at a location at which appointments could not be made, such as a hospital where a provider had admitting privileges.

In total, we excluded 692 of the 1,800 providers from our sample. We also excluded 16 additional nonrespondents for a total sample population of 1,092 providers.<sup>24</sup> See Appendix A for the number of providers excluded from our analysis by reason.

### **Analysis**

We first determined the percentage of providers who could not offer appointments. We defined this measure to include providers who could not be found at the location listed by the plan as well as providers at the listed location who said that they were not participating in the plan. In all of these cases, the plans confirmed that these providers were supposed to have been participating in the plan at the location at the time of our calls. We also included providers who were not accepting new patients.

Next, we determined the length of wait times for appointments. For providers who offered appointments, we determined the number of days between the date of the call and the earliest available appointment date. For providers who offered an approximate appointment or a range of possible appointment dates, we chose the earliest appointment date possible (e.g., if the earliest appointment with a provider was “sometime in October,” we considered the earliest appointment date to be October 1). Lastly, we determined whether there were any differences in availability and wait times between primary care providers and specialists.<sup>25</sup> We did the same for urban and rural providers but did not find any differences in availability and wait times that were statistically significant.

We projected the results of our analysis to the population of 778,475 Medicaid managed care providers. See Appendix B for the projected population by strata. See Appendix C for the point estimates and confidence intervals.

### **Standards**

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

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<sup>24</sup> We had a 98-percent response rate overall; we did not adjust our results for nonresponse.

<sup>25</sup> The differences presented in this report are significant at the 95-percent confidence interval unless otherwise specified.

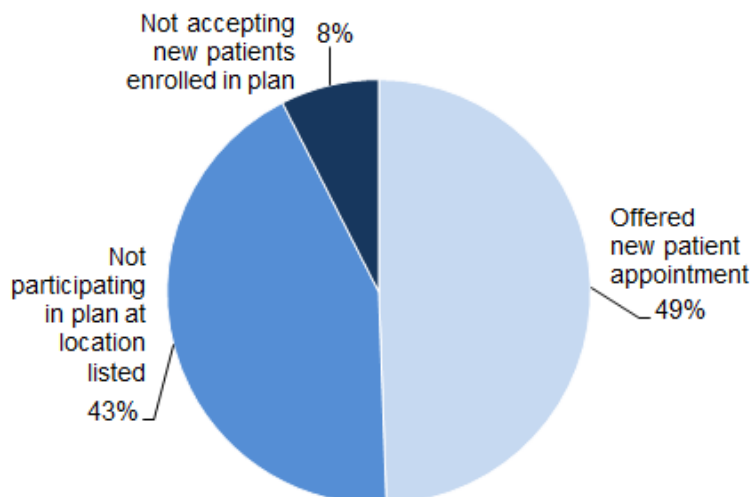
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## FINDINGS

### Half of providers could not offer appointments to enrollees

Fifty-one percent of providers could not offer appointments because they were not participating at the listed location (i.e., not practicing at the location listed or were practicing there but not participating in the plan), or were not accepting new patients enrolled in the plan. This means that Medicaid managed care enrollees may not be able to make appointments with as many as half of the providers listed by their plans. See Figure 1.

**Figure 1: Availability of Providers, 2013**



Source: OIG assessment of provider availability, 2014.

When providers listed as participating in a plan cannot offer appointments, it may create a significant obstacle for an enrollee seeking care. Moreover, it raises questions about the adequacy of provider networks—it suggests that the actual size of provider networks may be considerably smaller than what is presented by Medicaid managed care plans. It also raises questions about whether these plans are complying with their States' standards for access to care.

#### ***Forty-three percent of providers were not participating in the plan at the listed location***

Forty-three percent of providers were not participating in the Medicaid managed care plan at the listed location and could not offer appointments.

Notably, 35 percent of providers could not be found at the location listed and were therefore not participating at the location listed by the plan. In these cases, callers were sometimes told that the practice had never heard of the provider or that the provider had practiced at the location in the past but had retired or left the practice. Some providers had left months or even years before the time of the call.

Another 8 percent of providers were at the location listed but said that they were not participating in the plan. In some cases, these providers had participated in the plan in the past; in other cases, the providers had never participated in the Medicaid managed care plan.

In all of these cases, the plans confirmed that these providers were supposed to have been participating in the plan at the location at the time of our calls. Plans typically provide lists of participating providers and their locations to enrollees in Medicaid managed care plans, and enrollees often refer to these lists when seeking care from primary care providers and specialists. Potential enrollees also refer to these lists when selecting a plan. By continuing to inaccurately list these providers as participating, plans limit an enrollee's ability to find a participating provider at a nearby location.

Additionally, many States rely on information from plans to determine plan compliance with State standards for access to care.<sup>26</sup> For example, all but one of the States we reviewed have standards that establish a maximum distance enrollees should have to travel to see a provider, and these States often use provider location information from plans to determine compliance with their distance standards. If 43 percent of providers are not participating in plans at the locations specified, these States may be incorrectly determining plans' compliance with their access standards.

***Another 8 percent of providers were not accepting new patients***

Additionally, 8 percent of providers were participating in the Medicaid managed care plan but were not accepting new patients enrolled in the plan. As a result, these providers could not offer appointments to enrollees. Providers were often not accepting new patients because they were leaving the practice, or because they already had too many patients. One provider was not accepting new patients with the plan because of frequent no-shows. Having a large number of providers who are not accepting new patients can also affect enrollees' access to care.

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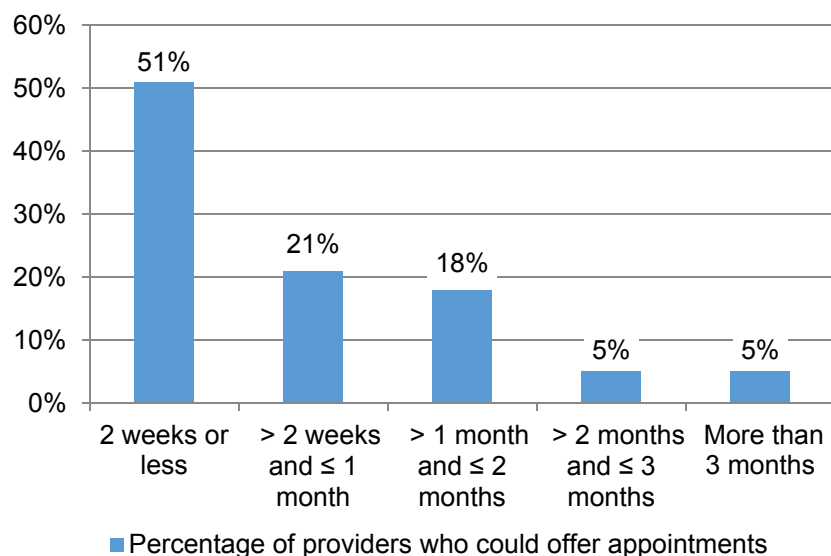
<sup>26</sup> For more detailed information, see OIG, *State Standards for Access to Care in Medicaid Managed Care* (OEI-02-11-00320).

## Among the providers who offered appointments, the median wait time was 2 weeks; however, over a quarter had wait times of more than 1 month

Forty-nine percent of providers offered appointments for new patients enrolled in a Medicaid managed care plan with a median wait time of 2 weeks.<sup>27</sup> Wait times for these appointments varied widely, ranging from same-day appointments to an appointment in 9 months. For 28 percent of providers who offered appointments, enrollees had to wait more than a month for an appointment. Ten percent of providers had wait times longer than 2 months. See Figure 2.

All but two of the States we reviewed have access standards that require appointments be provided within a certain timeframe. For the majority of these States, the required timeframe is 1 month or less.<sup>28</sup> That more than a quarter of providers were unable to offer appointments within a month raises further questions about enrollees' ability to obtain timely access to care.

**Figure 2: Wait Times for Routine Appointments for Enrollees**



Source: OIG assessment of provider availability, 2014.

<sup>27</sup> Five percent of providers were accepting new patients enrolled in the plan, but did not offer a specific appointment date without more information about the enrollee (e.g., Medicaid identification number). Although these providers are counted as offering appointments, they are excluded from the wait-time analysis because we could not obtain an appointment date.

<sup>28</sup> In most cases, these States' standards require the plan to ensure that an enrollee can get an appointment within the given timeframe.

In some circumstances, long wait times can have a significant impact on patient care. For example, a number of obstetricians had wait times of more than 1 month, and one had wait times of more than 2 months for an enrollee who was 8 weeks pregnant. Such lengthy wait times could result in a pregnant enrollee receiving no prenatal care in the first trimester of pregnancy.<sup>29</sup>

***A small number of providers required patients to submit medical records prior to scheduling an appointment or would not accept patients with certain medical conditions***

Enrollees' ability to obtain timely access to care may also be affected by providers who offer appointments only under certain circumstances. A small number of primary care providers required medical records prior to scheduling appointments. These providers first review the medical records and then accept patients on a case-by-case basis. A few providers would not accept patients with certain medical conditions, such as chronic pain. In one example, a specialist would offer an appointment only if the patient had a body mass index (BMI) under 40. By requiring enrollees to submit medical records or meet certain criteria, providers may be further limiting enrollees' ability to access care.

**Primary care providers were less likely to offer an appointment than specialists; however, specialists tended to have longer wait times**

Primary care providers were less likely to offer appointments than specialists. Only 44 percent of primary care providers offered appointments, compared to 57 percent of specialists. See Figure 3.

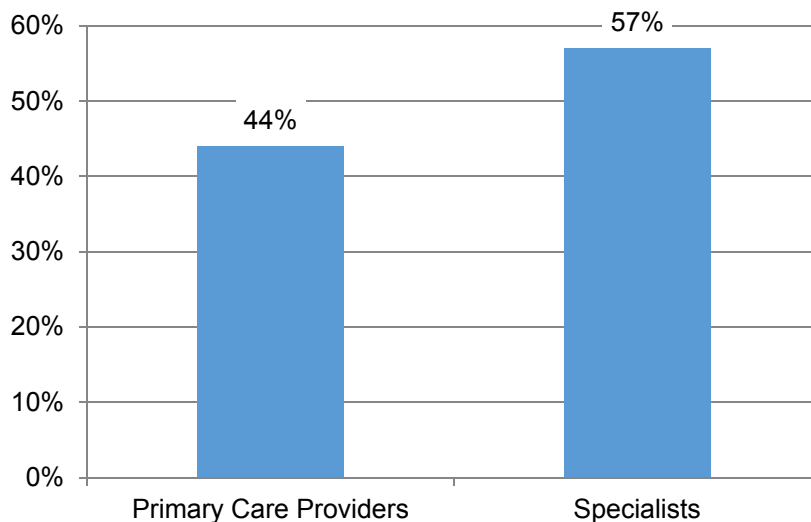
Among primary care providers, family practitioners and general internists were less likely to offer appointments than pediatricians: 40 percent of family practitioners and general internists offered appointments compared to 53 percent of pediatricians. Among the different types of specialists, the ability to offer appointments ranged from 68 percent of gastroenterologists to 54 percent of cardiologists; however, the differences among specialists were not statistically significant.<sup>30</sup>

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<sup>29</sup> The Agency for Healthcare Research and Quality recommends at least one prenatal visit in the first trimester. Accessed at <http://www.guideline.gov/content.aspx?id=38256> on September 18, 2014.

<sup>30</sup> Except for cardiologists, the 95-percent confidence intervals for these estimates exceed plus or minus 10 percent because of small sample sizes.

**Figure 3: Percentage of Providers Who Could Offer a New Patient Appointment, by Provider Type**



Source: OIG assessment of provider availability, 2014.

***The median wait time for specialists was twice as long as that for primary care providers***

Although primary care providers were less likely to offer appointments, specialists had longer wait times. Specialists offered appointments with wait times that were twice as long as those offered by primary care providers. The median wait time for an appointment with a specialist was 20 days, compared to just 10 days for a primary care provider.

Moreover, 34 percent of specialists who offered appointments had wait times longer than 1 month, and 11 percent had wait times longer than 2 months. Specialists gave a variety of reasons for long wait times. For example, in some cases callers were told that the providers practiced only one day a week or once a month at their offices. One provider practiced even less often, and his first opening was almost 3 months away; another provider closed his office entirely during the winter. In other cases, providers were highly sought after for their specialization, which could explain the longer wait times. For example, one neurologist who specialized in Tourette's and tic disorders had a wait time of 9 months.

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## CONCLUSION AND RECOMMENDATIONS

Our findings demonstrate significant vulnerabilities in provider availability, which is a key indicator for access to care. These findings also raise serious questions about the abilities of plans, States, and CMS to ensure that access-to-care standards are met. Without adequate access, enrollees cannot receive the preventive care and treatment necessary to achieve positive health outcomes and improved quality of life.

Notably, 51 percent of providers were either not participating in the plan at the location listed or not accepting new patients enrolled in the plan. When providers listed as participating in a plan cannot offer appointments, it creates a significant obstacle for an enrollee seeking care. Moreover, it suggests that the actual size of provider networks may be considerably smaller than what is presented by Medicaid managed care plans.

Among the providers who offered appointments, the median wait time was 2 weeks. However, over a quarter had wait times of more than 1 month, and 10 percent had wait times longer than 2 months. Long wait times can have a significant impact on patient care. It also raises questions about whether these plans are complying with their States' standards for access to care, as most States have access standards that require appointments be provided within 1 month or less. That so many providers could not offer appointments within a month raises concerns about enrollees' ability to obtain timely access to care.

Together, these findings—along with those from our companion report—call for CMS to work with States to improve the oversight of managed care plans. In our companion report, we recommended that CMS strengthen its oversight of State standards and States' methods to assess plan compliance. This report expands on these recommendations and provides additional recommendations about how CMS should further ensure access to care for Medicaid managed care enrollees.

We recommend that CMS:

**Work with States to assess the number of network providers who can offer timely appointments and to improve the accuracy of plan information**

CMS should work with States to ensure that they routinely test the availability of network providers. These tests could include calls to providers or other methods to determine whether providers are able to offer care in a timely manner. In addition, tracking the availability of network providers over time will help ensure that enrollees have access to care as coverage expansions under the ACA take effect.



CMS should also work with States to develop strategies for improving the accuracy of plan data. These strategies should ensure that plans are effectively identifying providers who are no longer actively participating. CMS should work with States to ensure that plans have detailed steps for how they verify providers' participation. This could be achieved through such means as using claims data to identify those who have not submitted claims for enrollees for a significant amount of time or by contacting providers directly by phone or by mail. As part of its approval of MCO contracts with States, CMS should ensure that plans have controls to ensure that provider information is accurate and up to date.

### **Work with States to ensure that plans' networks are adequate and meet the needs of their Medicaid managed care enrollees**

CMS should work with States to use the data from their testing to assess the robustness of their networks. CMS should ensure that States and plans continually monitor their networks to identify any barriers that are impeding access to care. For example, States should monitor whether there are shortages of specific provider types, such as obstetricians. Similarly, States should monitor whether there are shortages in specific geographic areas. States should also monitor their networks for other barriers to care, such as providers who require patients to submit medical records prior to scheduling appointments or providers who do not accept patients with certain medical conditions. If such barriers are identified, CMS should work with States to address them and increase plans' networks as needed to ensure timely access to care for enrollees.

### **Work with States to ensure that plans are complying with existing State standards and to assess whether additional standards are needed**

CMS should work with States to use the data from their testing to reassess whether plans are—in fact—complying with State standards for access to care. If plans are found to not be in compliance, CMS should work with States to take actions to ensure that any instances of noncompliance are addressed.

CMS should also work with States to determine whether each State needs to modify its existing standards or develop additional standards to address gaps in provider availability. For example, if a State discovers that specialists have particularly long wait times for appointments, and the State does not have any wait-time standards that are specific to specialists, the State should consider revising its standards. Similarly, if States are uncovering access issues among key provider types, such as obstetricians,

the State should consider developing additional standards that apply specifically to those providers.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all three of our recommendations.

CMS concurred with our first recommendation to work with States to assess the number of network providers who can offer timely appointments and improve the accuracy of plan information. CMS stated that it will continue to work with States to reinforce their regulatory obligations to provide timely care and to identify proven best practices. CMS is considering how best to strengthen its and States' oversight of provider networks and ensure that enrollees have access to up-to-date information on the network. It is also considering establishing expectations of States regarding assessing network access under managed care, the frequency with which an MCO's provider directory should be updated, and the increased use of electronic communication methods to improve data timeliness and accuracy. Finally, CMS will collaborate with States and MCOs to consider best practices for the various mechanisms designed to connect enrollees with providers in a timely fashion.

CMS noted that although the provider directory is one resource used by enrollees, there are many other supports that plans provide, such as managed care call centers, care coordinators, ombudsman offices, and community health centers. Additionally, CMS noted that managed care enrollees would not need to make a "cold call" to set up an appointment. Although we recognize that many enrollees may receive additional support from plans in finding a provider, the vast majority of States reported to OIG that they provide a plan directory to enrollees upon enrollment so that they may select a primary care provider. As a result, we continue to stress the importance of accurate provider information.

CMS concurred with our second recommendation to work with States to ensure that plans' networks are adequate and meet the needs of their Medicaid managed care enrollees. CMS added that it would engage collaboratively with States and MCOs to identify and share best practices for ongoing, effective network analysis as well as support services that States and MCOs can provide. Further, CMS will remind States of the availability of technical assistance that can support States' efforts. Finally, CMS will identify issues associated with network adequacy during its waiver implementation, monitoring efforts, and renewals reviews, and bring them to each State's attention when warranted.

CMS concurred with our third recommendation to work with States to ensure that plans are complying with existing State standards and to assess whether additional standards are needed. Finally, CMS will encourage

States to use its technical assistance resources when researching or developing standards.

We support CMS's efforts to provide increased oversight of Medicaid managed care, and encourage it to continue to work with States to ensure access to care for managed care enrollees.

For the full text of CMS's comments, see Appendix D.

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## APPENDIX A

### Providers Excluded from Analysis

**Table A-1: Providers Excluded from Analysis, by Reason**

<b>Reason</b>	<b>Number of Providers</b>
Plan had information indicating that the provider was not at the location or not participating in the plan during the time of our calls.	348
Provider practiced at a location at which appointments could not be made, such as a hospital where the provider had admitting privileges.	166
Provider was associated with a plan that was not providing Medicaid managed care during the time of our calls. <sup>1</sup>	75
Provider was not one of our provider types	75
Provider did not have a valid address	28
<b>Total</b>	<b>692</b>

<sup>1</sup> One plan became inactive, and another plan was mistakenly identified as serving Medicaid enrollees.

Source: OIG analysis of State Medicaid data, 2014.

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## APPENDIX B

### Projected Population

**Table B: Projected Population**

<b>Area</b>	<b>Primary Care Providers</b>	<b>Specialists</b>	<b>Total</b>
Urban	398,392	283,079	681,471
Rural	68,154	28,850	97,004
<b>Total</b>	<b>466,546</b>	<b>311,929</b>	<b>778,475</b>

Source: OIG analysis of State Medicaid data, 2014.

## APPENDIX C

### Point Estimates and Confidence Intervals

**Table C-1: Providers Who Could Not Offer Appointments, by Type, 2013**

Data Element	Sample Size	Point Estimate (Percentage)	95-percent confidence limit (%)	
			Lower	Upper
<b>Could Not Offer Appointment</b>				
All Providers	1,092	50.6%	46.7%	54.5%
<b>Not Participating in Plan</b>				
All Providers	1,092	43.0%	39.2%	47.0%
Providers not at location	1,092	35.4%	31.8%	39.3%
At location, but not participating	1,092	7.6%	5.7%	10.1%
<i>All Providers by Provider Type</i>				
Primary care providers	506	45.5%	40.0%	51.1%
Specialists	586	39.4%	34.4%	44.6%
<i>All Providers by Area</i>				
Urban providers	522	43.0%	38.7%	47.5%
Rural providers	570	43.2%	38.8%	47.7%
<b>Not Accepting New Patients Enrolled in Plan</b>				
All Providers	1,092	7.5%	5.6%	10.0%
<i>All Providers by Provider Type</i>				
Primary care providers	506	10.2%*	7.3%	14.1%
Specialists	586	3.5%*	2.0%	6.0%
<i>All Providers by Area</i>				
Urban providers	522	7.4%	5.3%	10.3%
Rural providers	570	8.1%	5.8%	11.0%

\*Indicates that differences are statistically significant at the 95-percent confidence level.

Source: OIG assessment of provider availability, 2014.

## APPENDIX C (CONTINUED)

**Table C-2: Providers Who Offered Appointments, by Type, 2013**

Data Element	Sample Size	Point Estimate (Percentage)	95-percent confidence limit (%)	
			Lower	Upper
All Providers	1,092	49.4%	45.5%	53.3%
<i>All Providers by Provider Type</i>				
Primary care providers	506	44.3%*	38.9%	49.9%
Specialists	586	57.1%*	51.8%	62.2%
<i>Primary Care Providers</i>				
Pediatricians	122	53.4%*	42.9%	63.7%
OB/GYNs	94	41.9%	30.5%	54.2%
Family practitioners/general internists	290	40.0%*	32.8%	47.7%
<i>Specialists</i>				
Gastroenterologists	55	68.4%	52.4%	81.0%
Urologists	63	62.7%	47.0%	76.1%
Orthopedists	94	56.9%	42.6%	70.2%
Neurologists	62	56.0%	40.3%	70.6%
Cardiologists	188	53.7%	44.1%	63.0%
<i>All Providers by Area</i>				
Urban providers	522	49.5%	45.1%	54.0%
Rural providers	570	48.8%	44.3%	53.2%

\*Indicates that differences are statistically significant at the 95-percent confidence level.

Source: OIG assessment of provider availability, 2014.



## APPENDIX C (CONTINUED)

**Table C-3: Provider Wait Times, 2013**

Data Element	Sample Size	Percentage	95 percent confidence limit (%)	
			Lower	Upper
<b>Provider Wait Times</b>				
<i>All Providers by Timeframe</i>				
2 weeks or less	502	51.2%	45.4%	56.9%
> 2 weeks and ≤ 1 month	502	20.5%	16.2%	25.5%
> 1 month and ≤ 2 months	502	18.4%	14.4%	23.2%
> 2 months and ≤ 3 months	502	5.3%	3.3%	8.5%
More than 3 months	502	4.6%	2.6%	7.9%
<b>Providers With Wait Times Greater Than 1 month</b>				
All providers greater than 1 month	502	28.4%	23.5%	33.8%
Primary care providers	199	23.6%	16.9%	32.0%
Specialists	303	33.7%	27.2%	40.9%
<i>Primary Care Providers</i>				
Pediatricians	64	21.8%	11.9%	36.4%
Family practitioners/general internists	108	26.2%	16.6%	38.7%
<i>All Providers by Area</i>				
Urban providers	246	29.2%	23.8%	35.4%
Rural providers	256	21.8%	17.0%	27.6%
<b>Providers with Wait Times Greater Than 2 months</b>				
All providers greater than 2 months	502	10.0%	7.0%	14.0%
Primary care providers	199	9.0%	5.0%	15.7%
Specialists	303	11.1%	7.3%	16.5%
<i>All Providers by Area</i>				
Urban Providers	246	10.4%	7.1%	15.0%
Rural Providers	256	6.8%	4.3%	10.7%

Because of small sample size, point estimates were not calculated for certain provider types.  
Source: OIG assessment of provider availability, 2014.

## APPENDIX C (CONTINUED)

**Table C-4: Median Wait Times, 2013**


Data Element	Sample Size	Days	95-percent confidence limit (Days)	
			Lower	Upper
<b>Median Wait Times</b>				
All Providers	502	13.6	11.3	16.0
<i>All Providers by Provider Type</i>				
Primary care providers	199	9.9*	6.4	13.3
Specialists	303	19.5*	15.3	23.7
<i>All Providers by Area</i>				
Urban providers	246	13.9	10.5	17.3
Rural providers	256	11.8	9.5	14.1

\*Indicates that differences are statistically significant at the 95-percent confidence level.

Source: OIG assessment of provider availability, 2014.

## APPENDIX D

### Agency Comments

	DEPARTMENT OF HEALTH & HUMAN SERVICES	Centers for Medicare & Medicaid Services
		<i>Administrator</i> Washington, DC 20201

**DATE:** Oct 28 2014

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Marilyn Tavenner */S/*  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Access to Care: Provider Availability in Medicaid Managed Care" (OEI-02-13-00670)

Thank you for the opportunity to review and comment on the above-referenced OIG draft report. The Centers for Medicare & Medicaid Services (CMS) appreciates the OIG's interest in Medicaid beneficiaries' access to care under state managed care arrangements.

CMS is strongly committed to assuring access to care and is implementing a number of initiatives to ensure all Medicaid beneficiaries, including those in managed care, have timely access to high-quality, low-cost care.

Recent CMS efforts to ensure access to care in Medicaid managed care include:

- Benchmarking wait times for Medicaid beneficiaries against other data, including data for privately insured populations whenever possible. For example, data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) from the Agency for Healthcare Research and Quality shows that Medicaid enrollees' experiences are generally close to those of other insured populations. These additional efforts will provide a more comprehensive assessment of access than could be determined through the use of "cold calls" that was used in this report.
- Working with states to implement best practices for updating provider directories, using electronic communication methods for sharing provider information, and analyzing managed care organization provider's capacity to offer timely appointments.
- Strengthening our internal processes for reviewing state oversight of network adequacy as part of reviewing State Plan amendments, reviewing and approving Managed Care Organization contracts, implementing and renewing waivers, and reviewing quarterly waiver status reports.
- Ensuring that states monitor managed care organizations' compliance with state-established access and network adequacy standards, and develop additional guidance where it is needed to establish and assess network adequacy under Medicaid managed care.

**OIG Recommendation**

OIG recommends that CMS work with States to assess the number of network providers who can offer timely appointments and improve the accuracy of plan information.

**CMS Response**

CMS concurs that we should continue to work with states to assess network adequacy and improve the accuracy of managed care organizations' information. States must ensure that managed care organizations report accurate provider information to the state and make such information available to Medicaid enrollees. The information is critical for States' oversight of managed care organizations' networks. Medicaid enrollees also need accurate provider directories to aid them in finding providers. Inaccurate provider directory data may unnecessarily delay an enrollee from selecting a provider; States and managed care organizations should utilize every tool available to obtain and publish accurate provider data and to maintain accurate data over time.

While the provider directory is one resource used by enrollees, there are many other supports under managed care already available to enrollees who are looking for a provider, such as managed care call centers, care coordinators, ombudsman offices, and community health centers. Most Medicaid managed care beneficiaries have assigned primary care physicians and are able to use this relationship to obtain an appointment. Most beneficiaries would not need to make a "cold call" to set an appointment. Further, beneficiaries commonly access specialists through a referral from a primary care physician.

Federal regulations require managed care organizations to meet State standards for timely access to services, ensure compliance, monitor network providers, and take corrective actions if necessary. CMS will continue to work with states to reinforce these regulatory obligations and identify proven best practices. In addition, CMS has promoted innovative care delivery models such as health home and other arrangements that assure beneficiaries are linked to providers or teams of providers that focus on health outcomes. For example, in a health home, if the specific primary care provider did not have an available appointment, another member of the care team probably could have accommodated the enrollee's request.

We are currently considering how best to strengthen CMS and state oversight of provider networks and ensure enrollees have access to up-to-date information on the network. We are also considering options to set forth CMS' expectations of States for assessing network access under managed care arrangements, the frequency with which a managed care organization's provider directory should be updated, and the increased use of electronic communication methods to improve data timeliness and accuracy. We expect to address these issues through the development of additional guidance. We will also work with States to consider the value of establishing requirements on managed care organizations for the publication and update of provider directory information.

Beyond working to improve the accuracy of provider directories, CMS will collaborate with States and managed care organizations to consider best practices for the various mechanisms

designed to connect Medicaid enrollees with providers in a timely fashion. As noted, provider directories are just one means to help beneficiaries' access providers. In collaboration with States, CMS will use its technical assistance contractor to develop resources for States to improve state oversight of network adequacy. The resources are anticipated to focus on data analysis and evaluation methods for assessing the ability of managed care organizations' network providers to offer timely appointments.

**OIG Recommendation**

The OIG recommends that CMS work with States to ensure that plans' networks are adequate and meet the needs of their Medicaid managed care enrollees.

**CMS Response**

CMS concurs that it is important for States to perform regular, ongoing oversight of managed care organizations' efforts to ensure that their provider networks are meeting the needs of their enrollees. This can be done through analysis of provider network and enrollee data as well as call center and grievance data. CMS will engage collaboratively with States and managed care organizations to identify and share best practices for ongoing, effective network analysis as well as support services (ombudsman/call center/outreach) that States and managed care organizations can provide to assist enrollees encountering difficulties accessing care. This effort may include approaches to testing provider availability, improving the quality of plan data, and developing approaches to verifying provider participation, as OIG suggests. CMS will remind States of the availability of technical assistance for data analytics that can support States' efforts. Lastly, as part of waiver implementation, monitoring efforts, and renewals reviews, CMS will identify issues associated with network adequacy to the State's attention when warranted.

**OIG Recommendation**

OIG recommends that CMS work with States to ensure that plans are complying with existing State standards and to assess whether additional standards are needed.

**CMS Response**

CMS concurs that States must use data analysis both to ensure compliance with existing standards and to determine if their current standards are sufficient or need revision. In addition, as noted previously, CMS is considering additional guidance to set forth CMS' expectations of States when assessing network access under Medicaid managed care arrangements. CMS will encourage States to utilize CMS resources should they need assistance in researching or developing standards.

CMS thanks OIG for the work done on this issue and looks forward to working with OIG in the future.

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## ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Vincent Greiber served as team leader for this study. Other staff from the New York regional office who conducted the study include Marissa Baron, Judy Bartlett, and Hailey Davis. New York regional office staff who provided support include Miriam Anderson, Marisa Beatley, Rachel Bryan, Lucia Fort, Jen Karr, Judy Kellis, Jason Kwong, and Michael Rubin. Additional Office of Evaluation and Inspections staff who provided support include Deborah Cosimo from the Dallas regional office and Janna Sayer from the Atlanta regional office. Central office staff who provided support include Kevin Farber, Kevin Manley, Christine Moritz, and Julie Taitsman.

# Office of Inspector General

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