



Medicaid Managed Care
Proposed Concept Paper

Prepaid Health Plan
Network Adequacy and
Accessibility Standards

North Carolina Department of
Health and Human Services

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This document is part of a series of concept papers that the Department of Health and Human Services scheduled for release from late 2017 through early 2018 to provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a managed care model. This technical paper is written primarily for providers and health plans that will participate directly in Medicaid managed care, but anyone may respond and provide feedback to the Department, including beneficiaries, advocates or other interested parties. Some topics mentioned in this document may be covered in more detail in other concept papers in the series. For more information on the Department’s proposal, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver Application and previously released concept papers available at ncdhhs.gov/nc-medicaid-transformation.

Input is welcome and appreciated. Send comments to Medicaid.Transformation@dhhs.nc.gov.

I. Introduction

The Department of Health and Human Services (the Department) seeks to ensure provider access for all beneficiaries to Medicaid covered services. Prepaid Health Plans (PHPs) will be subject to strict requirements regarding provider contracting, network adequacy and accessibility to services. According to North Carolina State law, PHPs must include all willing providers in their networks, except when a PHP is unable to negotiate rates or when there are quality concerns. By law, PHPs must contract with all essential providers¹ in their area unless the Department approves another arrangement. PHPs will be expected to regularly submit their contracted provider networks and an access plan to the Department for review. PHPs will also be required to make updated provider directories available in standardized machine-readable formats, so that beneficiaries and other stakeholders have access to comprehensive information on providers available across different PHP offerings.

In 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of the State's Medicaid program from a predominately fee-for-service program to managed care. Since that time, the Department worked with the General Assembly and stakeholders to plan for the implementation of this directive. At the core of these efforts is the goal to improve the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care, which addresses medical and non-medical drivers of health.

In Medicaid managed care, the Department will delegate the direct administration and management of certain health services and financial risks to PHPs. PHPs will receive a monthly capitated payment and will be expected to contract with practitioners and providers to deliver health services to the PHP's members. Consistent with federal regulations,² the Department will ensure that PHPs maintain sufficient provider networks to provide adequate access to covered services for all enrollees. To assess network adequacy, the Department will develop provider network standards based on reasonable travel time and distance to provider offices, will track enrollees' access to or denial of care, and will consider the needs of people with disabilities, special needs or differing health needs (adult versus child populations) in developing those standards.

This concept paper focuses on the Department's recommended provider network and access standards, and its approach for holding PHPs accountable for addressing the access needs of beneficiaries.

II. Background

At the national level, access to care within Medicaid managed care historically was measured by provider network adequacy, or whether managed care plans contract with a sufficient number of providers to serve enrollees. Increasingly, however, "access to care" is thought of in a more multi-faceted way, with multiple provisions in place beyond ensuring a sufficient number of providers. The Department based its approach

¹ As defined in Section 5.(13) of Session Law 2015-245.

² 42 CFR § 438.68, § 438.206, § 457.1218 and § 457.1230.

primarily on the standards reflected in the final federal Medicaid managed care rule,³ which includes the following features⁴:

1. **Availability** addresses whether provider networks are sufficient to meet the needs of enrollees. Availability is a function of the number of providers, their willingness to participate in the program, and their ability to offer timely appointments.
2. **Accessibility**⁵ involves the proximity of providers to enrollees, based on geographic time and distance. At the point of care, accessibility is determined by physical access, such as ramps, and providers' ability to communicate in non-English languages or sign language.
3. **Accommodation** is the extent to which a provider's operating hours, appointment policies, language and cultural competencies, awareness, and communications meet enrollees' constraints and preferences.
4. **Realized access** addresses managed care enrollees' actual use of services.

The Department developed network adequacy and provider accessibility standards consistent with federal and State laws, and developed a monitoring system to ensure compliance by PHPs with all applicable standards. The specific standards are detailed in this paper. In some cases, the Department is requesting feedback from stakeholders on the standards and approach to adequacy and accessibility.

III. State Standards for Access

North Carolina's PHP contracts will include requirements to ensure that PHPs meet and, in some cases, exceed federal standards. These include requirements related to beneficiary access to care such as network adequacy, availability of services, and assurances of adequate capacity and services. These requirements are vital in verifying that member services are adequately provided. The Department will closely monitor these areas and respond as necessary to ensure requirements are successfully met.

A. Network Adequacy Standards

PHPs will be expected to maintain and monitor a network of contracted providers supported by mutually agreed upon PHP/provider contracts. The network should be sufficient to provide adequate access to all services covered under the Medicaid and NC Health Choice programs for all beneficiaries,⁶ based on standards developed by the State. North Carolina's network adequacy standards will vary by geographic area and include time and distance standards for providers who serve adult and pediatric beneficiary needs. To recognize the special needs of accessibility to behavioral health services, the standards will include specific measurements for those services. PHPs will be expected to also meet standards for appointment wait-times for primary care and specialist care. Refer to Appendix A for a full outline of these standards, on which the Department welcomes feedback. Additionally, refer to Appendix B for a list of specialties to which specialty provider standards apply.

³ Published in the Federal Register May 6, 2016 (81 FR 27498).

⁴ "Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability."

⁵ For long-term services and supports (LTSS) provided in a home or community setting, accessibility can be expressed as the time and distance for caregivers to travel to enrollees' residences.

⁶ This includes beneficiaries with limited English proficiency or physical or mental disabilities.

While the network adequacy standards in the final federal Medicaid managed care rule⁷ allow for the use of standards associated with provider-to-enrollee ratios, the Department will not develop those standards at this time due to concerns about the reliability of such measurements and the complexity to develop such standards. The Department may develop these standards in the future based on beneficiary experience in managed care. The Department will use actual beneficiary experience to adjust its approach to monitoring and verifying access to care and, if necessary, will require specific provider-to-enrollee ratios from PHPs in future contract amendments. The Department also welcomes feedback on this recommendation not to include provider-to-enrollee ratios in the standards.

Mandatory Network Providers. Federal and State statutes and regulations require PHPs to contract with certain types of providers. For example, federal regulations require PHP networks to include in their networks at least one federally qualified health center (FQHC), at least one rural health clinic (RHC), and at least one freestanding birth center (FBC), where available, for the PHP's contracted service area. North Carolina statute⁸ requires PHPs to contract with *all* "essential providers"⁹ in their geographic area, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.

Exceptions to Network Adequacy Standards. PHPs that are unable to meet the State's network adequacy standards may request an exception for a specific access to care gap in a specific region. To determine whether an exception is granted, the Department may consider, but is not limited to, such factors as:

- Utilization patterns in the specific service area;
- The number of Medicaid providers in that provider type/specialty practicing in service area;
- The history of beneficiary complaints regarding access;
- Specific geographic considerations;
- The proposed long-term plan by the PHP to address the access to care gap in its network; and
- The comprehensiveness of PHP's plan for addressing beneficiary needs in the short-run, including the PHP's process for assisting in finding services through out-of-network providers, or coordinating the use of telemedicine and other telecommunications technology, as applicable.

Where exception requests are approved, the Department will monitor beneficiary access to the relevant provider types in the relevant regions on an ongoing basis and annually report the findings to CMS, as required.

Out of Network Services. If a PHP's provider network is unable to provide necessary covered services to an enrollee, the PHP must cover these services out-of-network for the enrollee in an adequate and timely manner, for as long as the PHP's network is unable to provide them. PHPs are responsible for communicating administrative requirements (e.g., prior authorization requirements, to the degree prior authorization is not prohibited under federal regulation) and coordinating payment with the out-of-network providers and ensuring the cost to the beneficiary is no greater than it would be if the services were furnished within the

⁷ Published in the Federal Register on May 6, 2016 (81 FR 27498).

⁸ NC S.L. Session Law 2015-245 as amended by Session Law 2016-121.

⁹ "Essential providers" are FQHCs, RHCs, rural health centers overseen by the Department, free/charitable clinics, State veterans' homes and local health departments.

network.¹⁰ In certain cases where there may be a longer-term need, the PHP and out-of-network provider may be encouraged to engage in single case agreements to ensure both parties understand what is administratively and financially expected and to minimize potential disputes which may disrupt the beneficiary care. Additionally, beneficiaries may switch plans under certain conditions during the lock-in period to obtain medically necessary services that are not all available within the PHP's network.

Telemedicine. As discussed previously, when an enrollee requires a medically necessary service that is not available within the State's expected driving distance, the PHP will be expected to ensure that enrollee has access to that service and could utilize either an out-of-network provider *or* could access the service through telemedicine, if applicable and medically appropriate. The enrollee must have a choice between an out-of-network provider and telemedicine and cannot be forced to receive services through telemedicine.

B. Availability of Services

PHPs will be expected to contract with enough providers to ensure that all services covered under the Medicaid managed care contract between the Department and the PHPs are available and accessible to beneficiaries in a timely manner.¹¹ Under State law, PHPs must include all willing providers in their networks, except when a PHP is unable to negotiate rates or where there are provider quality concerns.

Other requirements on PHP networks and the availability of services will include:

- Direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services (note that this in addition to the enrollee's designated source of primary care if that source is not a women's health specialist);
- Direct access to emergency services, children's screening services and Local Health Department services;
- Direct access to behavioral health services, such that PHPs will not require beneficiaries to obtain a referral or prior authorization for at least one mental health assessment and at least one substance dependence assessment from a participating provider in any calendar year;
- Direct access to family planning providers and/or family planning services;
- Direct access to specialists, for adults and children with special health care needs,^{12 13} in a manner that is appropriate for the beneficiaries' health conditions;
- Access to a second opinion from either a network provider or an out-of-network provider (to be arranged by the PHP) at no cost to the enrollee;

¹⁰ The Department will publish the process that enrollees must follow to access services from an out-of-network provider, and PHPs will be expected to adhere to that process. Enrollees will have the right to appeal an adverse decision about accessing out-of-network benefits through the enrollees' appeal and grievances processes.

¹¹ As required under 42 CFR §438.206.

¹² "Adults with special health needs" are those who have or are at risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition. This includes, but is not limited to individuals: with HIV/AIDS; an SMI, SED, I/DD or SUD diagnosis; or receiving 1915(b)(3), Innovations or TBI Waiver services.

¹³ "Children with special health needs" are those who have or are at risk of having a serious or chronic physical, developmental, behavioral or emotional condition, and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children in foster care; receiving Early Intervention; with an SMI, SED, I/DD or SUD diagnosis; and/or receiving 1915(b)(3), Innovations or TBI waiver services.

- Access to necessary covered services from an out-of-network provider if the PHP's network is unable to provide such services;
- Access to covered services 24 hours a day, 7 days a week, when medically necessary; and
- Access to network providers during hours of operation that are no less than the hours of operation offered to commercial enrollees or, if the provider serves only Medicaid beneficiaries, comparable to Medicaid fee-for-service.

PHPs must also ensure the availability and delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and literacy, and diverse cultural and ethnic backgrounds, disabilities, gender, sexual orientation or gender identity.

C. Assurances of Adequate Capacity and Services

The Department will develop and maintain a monitoring and oversight system to ensure that PHPs have adequate capacity to provide care to all beneficiaries in their service areas.¹⁴ Key components of this system include, but are not limited to:

- Requiring PHPs to submit regular documentation, including provider network data and report(s) that summarize findings from PHPs' own network data analysis) to demonstrate network adequacy;
- Requiring PHPs to submit updated machine-readable provider directories in a standardized format;
- Requiring that PHPs be accredited by year three;
- Monitoring beneficiary complaints related to access to care and provider networks;
- Reviewing "Consumer Assessment of Healthcare Providers and Systems" (CAHPS) survey findings related to availability and access to services and acting as needed; and
- When necessary, issuing corrective action plans when PHPs are identified as noncompliant with network adequacy standards and access requirements.

As outlined in Appendix C, the Department intends to contract with a qualified external quality review organization (EQRO) to perform an annual external quality review of each PHP. This review will determine, in part, PHP compliance with network adequacy and access requirements, confirm the adequacy of PHP networks, and validate PHP data. The EQRO must include issue a report on these findings, which will be posted on the Department's website.

The Department will monitor beneficiary access to care issues, including using geographic mapping and other techniques.

¹⁴ In accordance with 42 CFR 438.207.

Demonstrating Adequate Capacity and Services Before and After Managed Care Launch. The Department will evaluate the capacity and capability of PHPs to develop a network that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. The initial evaluation will occur during the competitive bidding process, where the PHPs will be assessed, in part, as to their understanding of North Carolina’s beneficiary and provider needs, and the PHPs capacity to build and maintain a network of contracted providers to serve those needs within the regions in which they are bidding.

PHPs will not be expected to have a full, contracted provider network in place prior to award but, in addition to signed provider contracts or “letters of intent,” the Department may consider such factors as 1) PHP understanding of the general or specific needs of North Carolina Medicaid beneficiaries by eligibility group; 2) available practitioners and providers who may be able to serve those beneficiary needs; 3) potential or predicted gaps in practitioners or providers who may be able to serve those beneficiary needs; or 4) PHP plan and approach to developing a strong provider network given local market conditions and needs.

After award, the Department will work closely with the awarded PHPs to evaluate their progress toward developing adequate networks. The Department will require PHPs to provide supporting evidence that the PHP has developed the capacity to serve the expected enrollment in its service area according to the State’s standards for access and timeliness of care. PHPs will be expected to provide documentation, in a format specified by the Department, to demonstrate that it offers an appropriate range of preventive, primary care and specialty services for the anticipated number of enrollees for the service area. The Department recommends that if it determines that a PHP does not have a sufficient provider network, the Department would take appropriate action including putting the PHP on a specific corrective action plan, issuing monetary penalties, reducing or suspending beneficiary enrollment or, in extreme situations, contract termination.

The Department will review the PHP provider network adequacy after the managed care launch at a frequency to be defined during the procurement process.

The Department will require PHPs to provide machine-readable provider directories in a standardized format. The Department and its contractors will use these standardized files to develop a unified provider directory where a beneficiary can access information about which PHPs include specific providers and facilities within their networks. PHPs will be expected to submit updated files daily, and should expect that the standardized file format will be based on the approach used by the federally facilitated marketplace for qualified health plans.

D. Standards for American Indian/Alaska Native (AI/AN) Populations and Providers¹⁵

By federal law, members of federally recognized tribes, including the Eastern Band of the Cherokee Indians (EBCI),¹⁶ are exempted from participation in managed care and, therefore, may voluntarily enroll in PHPs on an opt-in basis. Additionally, AI/AN enrollees are guaranteed the freedom to use Indian Health Care Providers (IHCPs),¹⁷ regardless of whether those providers participate in managed care or are located within the state. While North Carolina has only one federally recognized tribe located primarily in the western part of the state,

¹⁵ Refer to 45 CFR 438.14 for federal regulation outlining these requirements.

¹⁶ EBCI is North Carolina’s only federally recognized tribe.

¹⁷ “IHCP” means a health care program operated by the HIS or by an Indian Health Service/Tribal Health Services/Urban Indian Health Provider (I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

the provisions relating to AI/AN beneficiaries access to health care apply statewide regardless of a beneficiary's actual tribe affiliation or the location of the beneficiary's residence within the state.

Where AI/AN enrollees are enrolled in a PHP, the PHP must:

- Demonstrate that there is timely access to covered services for AI/AN enrollees eligible to receive services from IHCP;
- Pay IHCPs at a rate negotiated between the PHP and the IHCP, consistent with any applicable agreements made by the Department relating to payment rates to IHCPs;
- Permit any AI/AN enrollee who is enrolled in the PHP¹⁸ to choose a IHCP as the enrollee's primary care provider, if that provider has capacity to provide services;
- Permit an IHCP, regardless of network status, to make a referral to an in-network provider for an AI/AN enrollee needing specialist care;
- Permit AI/AN enrollees to obtain covered services from out-of-network IHCPs and permit such providers to refer AI/AN enrollees to in-network providers.
- When timely access to a participating provider cannot be ensured, provide access to out-of-state and/or out-of-network IHCPs or disenrollment from the PHP will be allowed.¹⁹
- Refer AI/AN enrollees to IHCPs and other sources of culturally competent care.²⁰
- Make a good faith effort to contract with IHCPs.
- Per Departmental policy, use the Indian Managed Care Addendum.²¹

Also, PHPs may include additional special terms and conditions in the managed care addendum, providing that they are approved by the PHP and the IHCP. PHPs will be expected to submit a complete copy of the additional special terms and conditions to the Tribal Liaison at the Department, along with a written statement that both parties have agreed to them.

Tribal Option. The Department is prepared to further consult with the EBCI about the Tribal Option. The Department expects to define or refine these network adequacy and accessibility standards as they pertain to the Tribal Option as part of those discussions.

¹⁸ A PHP that is not an Indian managed care entity (IMCE).

¹⁹ AI/AN enrollees who opt-in to managed care may disenroll from the plan in which they selected or were auto-assigned at any time during the coverage year.

²⁰ And provide training for culturally competent care among contracts providers.

²¹ Indian Managed Care Addendum, December 14, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf>

IV. PHP Access Plan

PHPs will be required to submit an access plan to the Department, which will be reviewed and monitored by Department staff. An access plan must:

- Describe a PHP's policies and procedures for maintaining and ensuring that its network is sufficient and consistent with State and federal requirements.
- Be filed with the Department with the RFP, periodically through readiness reviews, annually after managed care launches, and within 30 business days after a material change occurs.
- Demonstrate that a PHP has:
 - An adequate network that it is actively maintaining (or a plan for establishing such).
 - Procedures to address referrals, disclosures and notices to beneficiaries of the plan's services and features, documented process for coordination, and continuity of care and transition of care that complies with the Department's requirements.
- Demonstrate the PHP's efforts to address the needs of all beneficiaries, including those with limited English proficiency or literacy.
- Demonstrate the PHP's efforts to ensure its network providers make available physical access, reasonable accommodations, culturally competent communications and accessible equipment for beneficiaries with physical or intellectual disabilities.
- Establish that a PHP's network has an adequate number of providers and facilities within a reasonable distance.
- Document a PHP's quantifiable and measurable process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of the Medicaid population enrolled.
- Include the factors used to build a provider network, including a description of the network and the criteria used to select providers.
- Demonstrate a PHP's quality assurance standards, consistent with the Department's quality strategy and requirements, which must be adequate to identify, evaluate and remedy problems relating to access, continuity and quality of care.

The Department will review each PHP's access plan to ensure it meets network adequacy expectations and requirements, and provides a reasonable approach to a PHP's oversight and management of its providers and networks.

Appendix A: Network Adequacy Standards

Network Adequacy Standards: Time and Distance Standards for Standard Plans

The State’s proposed network adequacy standards for time and distance vary by geographic area and ensure that enrollees have access to providers and care.

Table 1. Network Adequacy Standards: Time and Distance Standards for Standard Plans, for Adults and Children

Provider Type	Urban Standard ²²	Rural Standard ²³
Primary Care (adult and pediatric)	≥ 2 providers within 30 minutes or 10 miles for at least 95% of enrollees	≥ 2 providers within 30 minutes or 30 miles for at least 95% of enrollees
Specialty Care (adult and pediatric) – See Appendix B for a list of provider types that are subject to this standard	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of enrollees	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of enrollees
Hospitals	≥ 2 hospitals within 30 minutes or 15 miles for at least 95% of enrollees	≥ 2 hospitals within 30 minutes or 30 miles for at least 95% of enrollees
Pharmacies	≥ 2 pharmacies within 30 minutes or 15 miles for at least 95% of enrollees	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of enrollees
OB/GYN	≥ 2 providers within 30 minutes or 10 miles for at least 95% of enrollees	≥ 2 providers within 30 minutes or 30 miles for at least 95% of enrollees
Outpatient Behavioral Health Services ²⁴	≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of enrollees	≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of enrollees
Location-Based Services	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of enrollees	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of enrollees
Crisis Services ²⁵ (Behavioral Health)	≥ 1 provider of each crisis service within each PHP region ²⁶	

²² For the purposes of the State’s network adequacy standards, “urban” is defined as “non-rural counties,” or counties with average population densities of 250 or more people per square mile. This includes 20 counties categorized by the North Carolina Rural Economic Development Center (the Rural Center) as “regional cities or suburban counties” or “urban counties.” These 20 counties include 59% of the State’s population. See more at http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

²³ For purpose of network adequacy standards, “rural” is defined as counties with population densities below 250 people per square mile. Per the Rural Center, there are 80 counties in North Carolina that meet this definition; these counties are home to 41% of the State’s population. See more at http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

²⁴ “Outpatient behavioral health services” includes outpatient behavioral health services provided by direct-enrolled providers (e.g., psychiatry) for adults and children.

²⁵ A behavioral health crisis is defined as a non-life-threatening situation in which a person experiences an intensive behavioral, emotional, or psychiatric response triggered by a precipitating event. The person may be at risk of harm to self or others, disoriented or out of touch with reality, functionally compromised, or otherwise agitated and unable to be calmed. If this crisis is left untreated, it could result in a behavioral health emergency. For purpose of time and distance standards, “crisis services” does **not** include mobile crisis services. See the Community/Mobile Services Appointment Wait-time Standards in Table 5 below for a standard for mobile services.

²⁶ “PHP region” refers to the six regions identified in the N.C. Legislative Report: “Transformation and Reorganization of North Carolina’s Medicaid and NC Health Choice Programs,” March 1, 2016, <https://files.nc.gov/ncdhs/Medicaid-NCHC-JLOC-Report-2016-03-01.pdf>. (Note that Alamance County is included in Region IV.)

Provider Type	Urban Standard ²²	Rural Standard ²³
Inpatient Behavioral Health Services ²⁷	≥ 1 provider of each inpatient BH service within each PHP region	
Specialized Services ²⁸ (Behavioral Health)	≥ 1 provider of specialized services (partial hospitalization) within 30 minutes or 30 miles for at least 95% of enrollees	≥ 1 provider of specialized services (partial hospitalization) within 60 minutes or 60 miles for at least 95% of enrollees

The Department welcomes feedback on this approach, particularly those relating to Crisis Services and Inpatient Behavioral Health Services.

Network Adequacy Standards: Access Standards for Long-Term Services and Supports

North Carolina does not cover any State Plan LTSS services that would require beneficiaries to travel to a provider and, therefore, time and distance standards do not apply. The Department requires PHPs to meet the requirements in Table 2 to ensure access to LTSS services for which providers travel to beneficiaries.

Table 2. Access Standards for Long Term Services and Supports

Provider Type	Urban Standard ²⁹	Rural Standard ³⁰
All State Plan LTSS (except nursing facilities) ³¹	PHPs must have at least 2 LTSS provider types, identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	PHPs must have at least 2 providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.
Nursing Facilities	PHPs must have at least 1 nursing facility accepting new patients in every county.	PHPs must have at least 1 nursing facility accepting new patients in every county.

The Department welcomes feedback on this approach.

Care Access Standards: Appointment Wait-Time Standards for Standard Plans

PHPs are additionally required to meet appointment wait-time standards for adult and pediatric providers, which vary by the type of service.

²⁷ For adults, “inpatient behavioral health services” includes acute care hospitals with adult inpatient psychiatric beds; other hospitals with adult inpatient psychiatric beds; acute care hospitals with adult inpatient substance use beds; and other hospitals with adult inpatient substance use beds. For children, it includes acute care hospitals with adolescent inpatient psychiatric beds; other hospitals with adolescent inpatient psychiatric beds; acute care hospitals with adolescent inpatient substance use beds; other hospitals with adolescent inpatient substance use beds.

²⁸ “Specialized services” includes partial hospitalization for adults and children.

²⁹ For purpose of State’s network adequacy standards, “urban” is defined as “non-rural counties,” or counties with average population densities of 250 or more people per square mile. This includes 20 counties that are categorized by the North Carolina Rural Economic Development Center (the Rural Center) as “regional cities or suburban counties” or “urban counties.” These 20 counties include 59% of the State’s population. See more at http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

³⁰ For purpose of network adequacy standards, “rural” is defined as counties with population densities below 250 people per square mile. Per the Rural Center, there are 80 counties in North Carolina that meet this definition; these counties are home to 41% of the State’s population. See more at http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

³¹ “State Plan LTSS” is defined as nursing facility, home health, personal care, hospice, home infusion therapy, private duty nursing and durable medical equipment.

Primary Care Access Standards. “Primary care” means basic or general health care provided by a medical professional (such as a general practitioner, pediatrician or nurse) with whom a patient has initial contact and by whom the patient may be referred to a specialist.

Table 3. Access Standards for Primary Care

Visit Type	Definition	Standard
Preventive Care	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears.	Within 30 calendar days
Urgent Care Appointment	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
Routine/Check-up Appointment without Symptoms	Non-symptomatic visits for health check.	Within 30 calendar days
After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately (available 24 hours a day, 7 days a week, 365 days a year)

The Department welcomes feedback on this approach.

Specialty Care Access Standards. “Specialty care” means specialized health care provided by physicians whose training focused primarily in a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics and other specialized fields.

Table 4. Access Standards for Specialty Care

Visit Type	Definition	Standard
Urgent Care appointment	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
Routine/Check-up Appointment without Symptoms	Non-symptomatic visits for health check.	Within 30 Calendar days
After-Hours Access – Emergent and Urgent Instructions	Care requested after normal business office hours.	Immediately (available 24 hours a day, 7 days a week, 365 days a year)

The Department welcomes feedback on this approach.

Behavioral Health Care Access Standards. “Behavioral health care” means health care services provided for treatment and services in the community for behavioral and/or substance use disorders. DHHS has proposed that standard plans would cover certain behavioral health care services for individuals with mild to moderate behavioral health care needs. Individuals with more serious needs (including individuals with I/DD) would be enrolled in tailored plans; more detail on the proposal for tailored plans appears in the [“Behavioral Health and Intellectual/Developmental Disability Tailored Plan”](#) concept paper. The access standards that follow apply to the services standard plans would cover for the mild to moderate population.

Table 5. Access Standards Behavioral Health Care

Visit Type	Definition	Standard
Community/Mobile Services for Behavioral Health Care	For adults and children, direct and periodic services that are available at all times, 24 hours a day, seven days a week, 365 days a year, and primarily delivered face-to-face with the individual and in locations outside the agency’s facility.	Within 30 minutes
Urgent Care appointment for Behavioral Health Care	Urgent behavioral health services include urgent mental health services and urgent SUD services. Urgent mental health services are those services for conditions in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness, or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, will progress to the need for emergency services/care. Urgent SUD services are those services for conditions in which a person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person’s substance use is in need of prompt assistance to avoid further deterioration in the person’s condition which could require emergency assistance.	Within 24 hours
Routine Behavioral Health Care appointment	Routine behavioral health services include Mental health services provided when a person describes signs and symptoms resulting in impaired behavioral, mental, or emotional functioning, which has impacted the person’s ability to participate in daily living or markedly decreased the person’s quality of life; and SUD services provided when a person describes signs and symptoms consequent to substance use resulting in a level of impairment, which can likely be diagnosed as an SUD according to the current version of the Diagnostic and Statistical Manual.	Within 14 calendar days
After-Hours Access through Behavioral Health Practitioners - Emergent and Urgent Instructions	Emergency behavioral health services include emergency mental health services (i.e., services for life-threatening conditions in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations, and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention) and emergency SUD services (i.e. services for life-threatening conditions in which a person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; and includes crisis intervention).	Immediately (available 24 hours a day, 7 days a week, 365 days a year)

The Department welcomes feedback on this approach.

Appendix B: Providers Subject to Specialty Care Access Standards

Adult and pediatric providers who are subject to the State's specialty care standard practice in the following fields:

- Allergy/immunology;
- Anesthesiology;
- Cardiology;
- Dermatology;
- Endocrinology;
- ENT/otolaryngology;
- Gastroenterology;
- General surgery;
- Hematology/oncology;
- Nephrology;
- Neurology;
- Ophthalmology;
- Optometry;
- Orthopedic surgery;
- Pain management (board certified);
- Pulmonology;
- Radiology; and
- Urology.

The State will periodically revisit this list of special care provider practices and revise based on utilization and needs of PHP enrollees.

The Department welcomes feedback on this approach.

Appendix C: External Quality Review Organization Activities

As noted under “Assurances of Adequate Capacity and Services,” the external quality review organization (EQRO) plays a crucial role in reporting PHPs’ performance in several areas identified as mandatory (federal regulations require these activities to be completed by the EQRO) or optional (State has elected to use the EQRO for these activities) under 42 CFR § 438.352 and § 438.364. EQRO responsibilities are listed in Table 6. EQRO activities specifically related to network adequacy are highlighted.

Table 6. EQRO activities

Mandatory EQRO Activities
<ul style="list-style-type: none"> • Validation of performance improvement projects conducted by each PHP • Validation of each PHP’s reported performance measures • Review of each PHP’s compliance with the standards set forth in 42 CFR 438 Subpart D • Validation of PHP network adequacy³² • Annual technical report that summarizes findings on access and quality of care, including the requirements set forth in 42 CFR 438.364
Optional Activities as elected by the Department
<ul style="list-style-type: none"> • Validation of encounter data reported by each PHP • Administration of the CAHPS Plan Survey • Calculation of performance measures in addition to those reported by PHPs, at the direction of the Department or as required for completion of the technical and/or disparity report • Completion of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time (e.g., specific assessment of the interventions described within a quality strategy), at the direction of the Department
Additional Activities
<ul style="list-style-type: none"> • Review, in conjunction with the requirements set forth in 42 CFR 438 Subpart D, of the requirements set forth by the Department in PHP contracts • Technical assistance to PHPs as related to conducting PIPs, quality reporting, and accreditation preparedness, as directed by the Department. • Annual disparity report, assessing PHP and program-wide performance against HEDIS measures based on age, race, ethnicity, sex, primary language, and a breakdown of measures for key population groups (e.g., LTSS) • Tracer audits of each PHP for program integrity

³² Validation of network adequacy is required by 42 CFR 438.358(b)(iv), pending release of EQRO protocols related to this requirement. In the interim, the Department utilizes the EQRO for this function as an additional activity. Additional information can be found in this June 2016 CMCS informational bullet: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib061016.pdf>