

# National Analysis of Medicare Network Adequacy Rules and Impact on Primary Care and Behavioral Health Medicaid Managed Care Plans

Nathaniel Bell PhD,<sup>1,2</sup> Ana Lòpez-De Fede PhD<sup>1,2</sup>

<sup>1</sup>Institute for Families in Society;<sup>2</sup>College of Social Work

## Research Question

Does the CMS’ new tiered network adequacy standard, now mandatory for Medicare Advantage (MA) and recommended for Qualified Health Plans (QHP), result in adjusted access to primary and behavioral healthcare services within state Medicaid plans?

## Research Rationale

In light of new rules (§ 422.116) for MAs and recommendations for QHPs (§ 156.230), universal time/distance network adequacy thresholds within Medicaid are now possible and soon may be required given churn within QHPs and historical under-estimation of provider access within state Medicaid plans. Using a reference of 30 minutes/30-miles (**Ad Hoc**), we sought to answer (1) Where do the gaps in provider access emerge following the transition to a dynamic access model? (2) Do these gaps exhibit variation within specific regions or populations? (3) Are there potential areas where inequalities could arise? All analyses were based on CY2021 provider/member data for the contiguous United States, including DC.

## Data Sources

- NPPES/NPI provider address file (active as of 12/2021)
- National Bureau of Economic Research (NBER) Medicaid Licensure File (2021)
- CMS provider taxonomy codes used to define provider/services in § 422.116
- American Comm. Survey (ACS) Census Tract Medicaid enrollment estimates (2021)

CMS Time and Distance Standards for Individual Provider Specialty Types for Medical QHPs for Exchange Plan Year 2023 Certification.

Individual Provider Specialty Types*	Maximum Time and Distance Standards									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Conditions (CEAP)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Primary Care (Adult)	10	5	15	10	30	20	40	30	70	60
Primary Care (Child)	10	5	15	10	30	20	40	30	70	60
Ob/Gyn	10	5	15	10	30	20	40	30	70	60
Behavioral Health	20	10	45	30	60	45	75	60	145	130

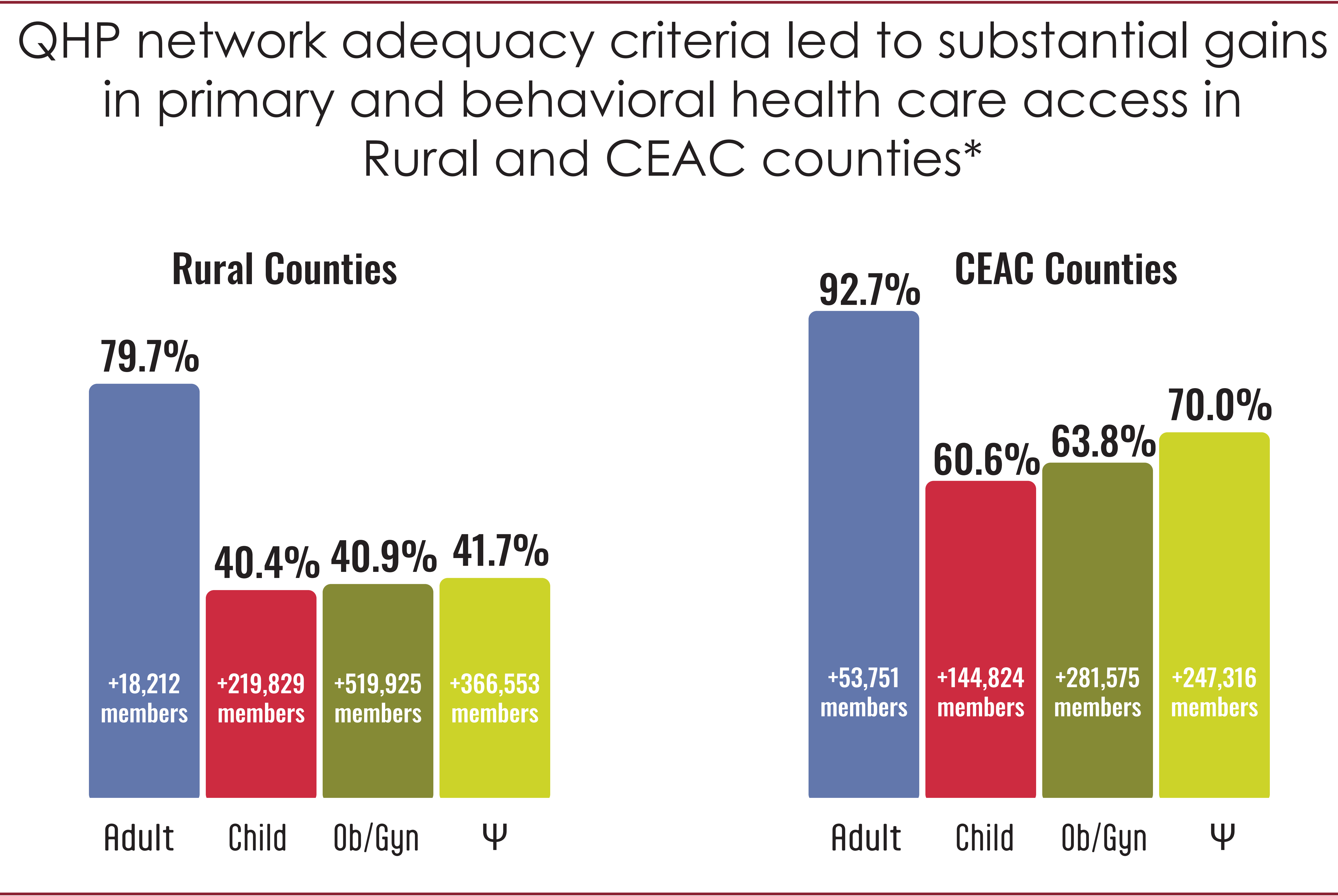
\*Maximum time and distance standards are listed for 42 provider specialty types

## Data Analysis

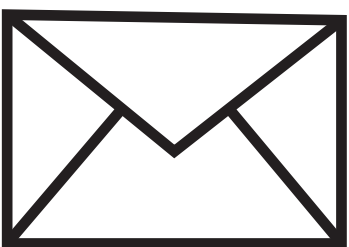
Network Analysis of provider/clinic address and Census Tract population-weighted centroids using ESRI street network file pro. Counties where < 90% of members were within maximum time/distance thresholds were defined as network failures. Exposures and risk factors were assessed using logistic regression, with clustering of standard errors at the state level (Stata v. 18)

## Key Findings

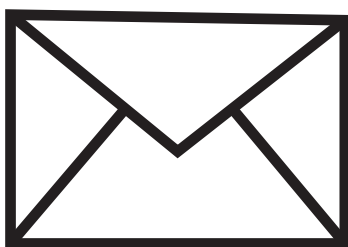
- CMS’ shift toward tiered standards that are tailored to population size and density will benefit rural providers/patients.
- Plans should expect to see a substantial decrease in network failures in Rural and CEAC Counties.
- QHP criteria doubled the number of network failures. 3 of 4 network failures were in Metro and Micro Counties.
- CMS County Designation type (e.g., Micro, Rural) was the most consistent predictor of network failures for all provider/service types, relative to area poverty, demographic, and population-to-provider ratios.



\*reference = “Ad Hoc” 30 mile/minute threshold, by CMS county designation type



nathaniel@sc.edu



adefede@mailbox.sc.edu

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UNIVERSITY OF  
South Carolina



Institute for Families in Society  
at the University of South Carolina



College of Social Work  
UNIVERSITY OF SOUTH CAROLINA

Tables 1 - 4: Number and % of Medicaid members outside of maximum network adequacy thresholds, by criteria type

### Network Failures for Primary Care (Adult)\*

CMS Designation	Member Network Failures (n, %)		
	Ad Hoc	QHP + CMS	Ad Hoc + CMS
Large Metro	143,746 (0.0)	11,986 (0.1)	1,469 (0.0)
Metro		120,578 (0.9)	32,021 (0.2)
Micro		20,159 (0.6)	29,407 (0.9)
Rural		4,636 (0.3)	22,848 (1.2)
CEAC		4,250 (1.2)	58,001 (15.8)
Totals	143,746 (0.0)	161,609 (0.6)	143,746 (0.0)

\*Ages 19 - 64

### Network Failures for Primary Care (Child)\*

CMS Designation	Member Network Failures (n, %)		
	Ad Hoc	QHP + CMS	Ad Hoc + CMS
Large Metro	1,049,326 (3.5)	138,634 (1.5)	889 (0.0)
Metro		913,579 (6.3)	78,705 (0.5)
Micro		289,908 (9.1)	186,545 (5.9)
Rural		324,244 (15.7)	544,073 (26.4)
CEAC		94,290 (23.5)	239,114 (59.6)
Totals	1,049,326 (3.5)	1,760,655 (5.9)	1,049,326 (3.5)

\*Ages 0 - 18

### Network Failures for Ob/Gyns

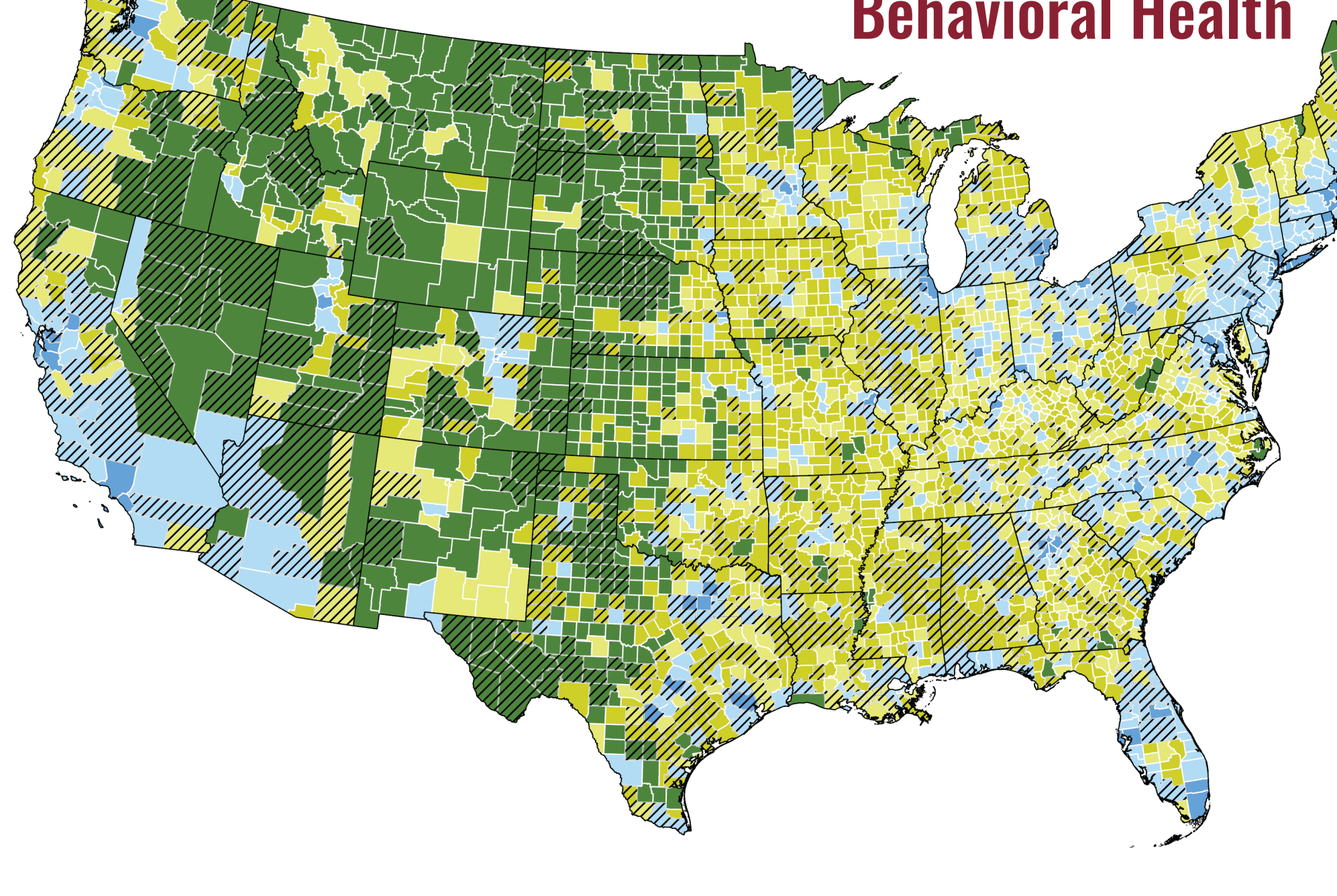
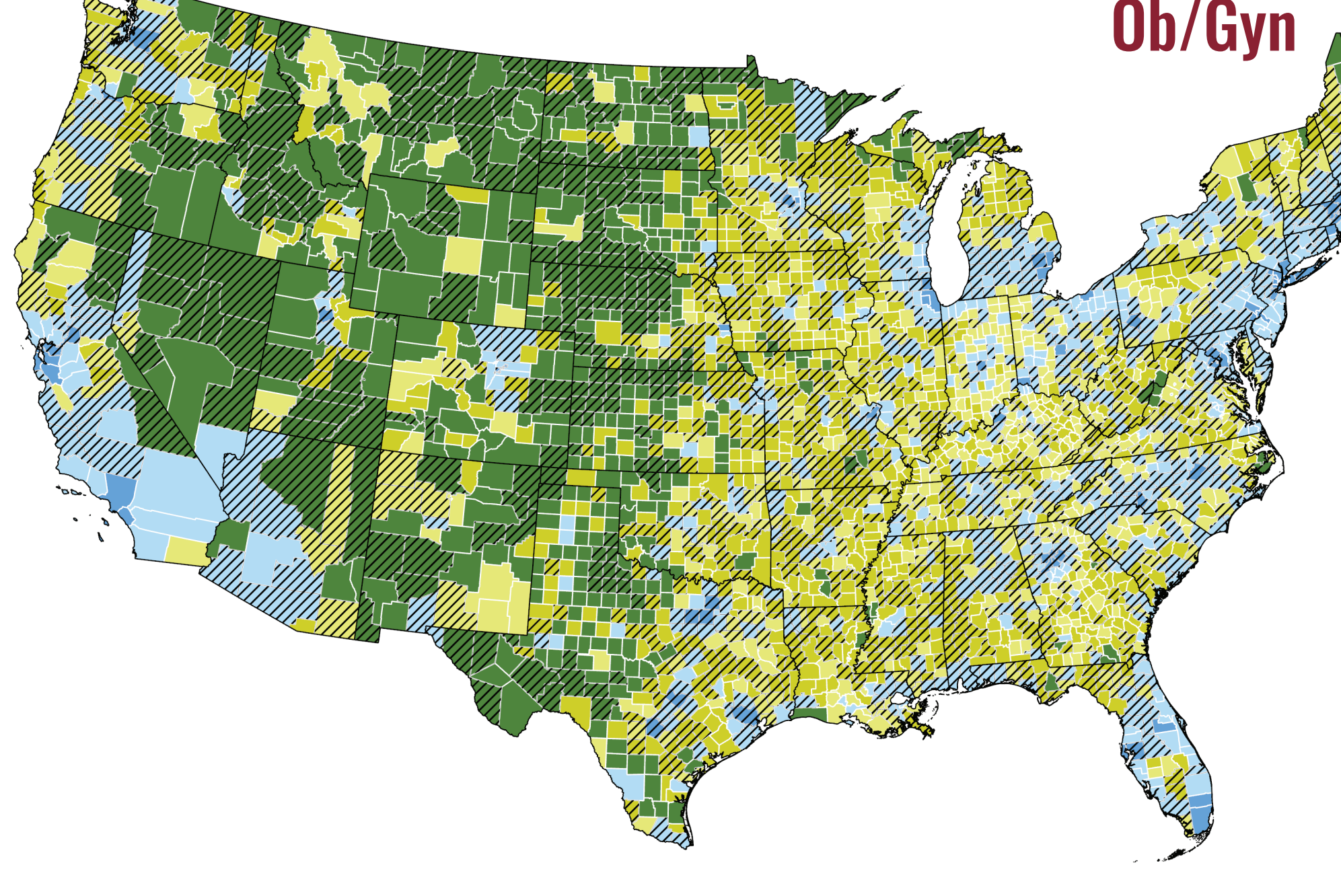
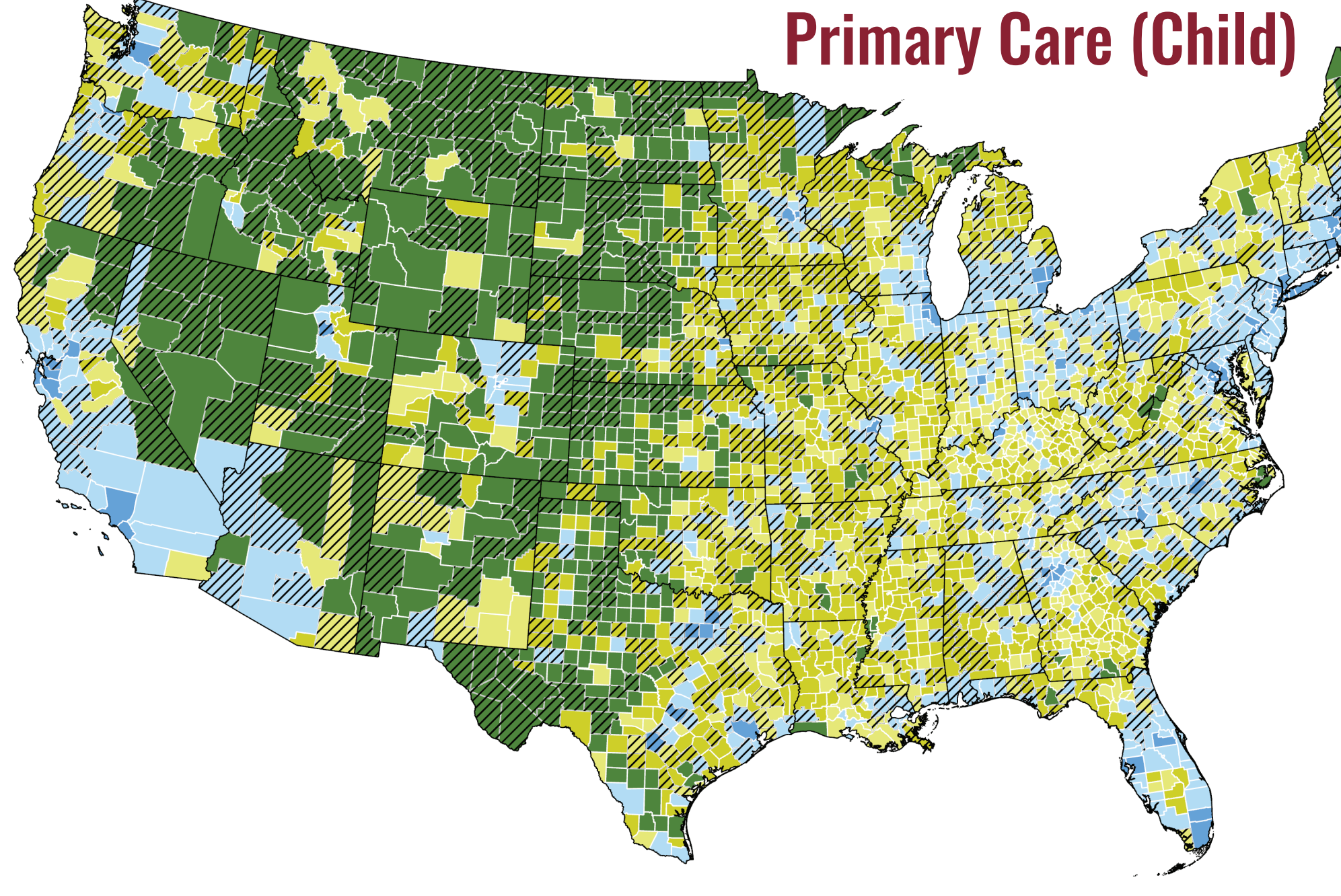
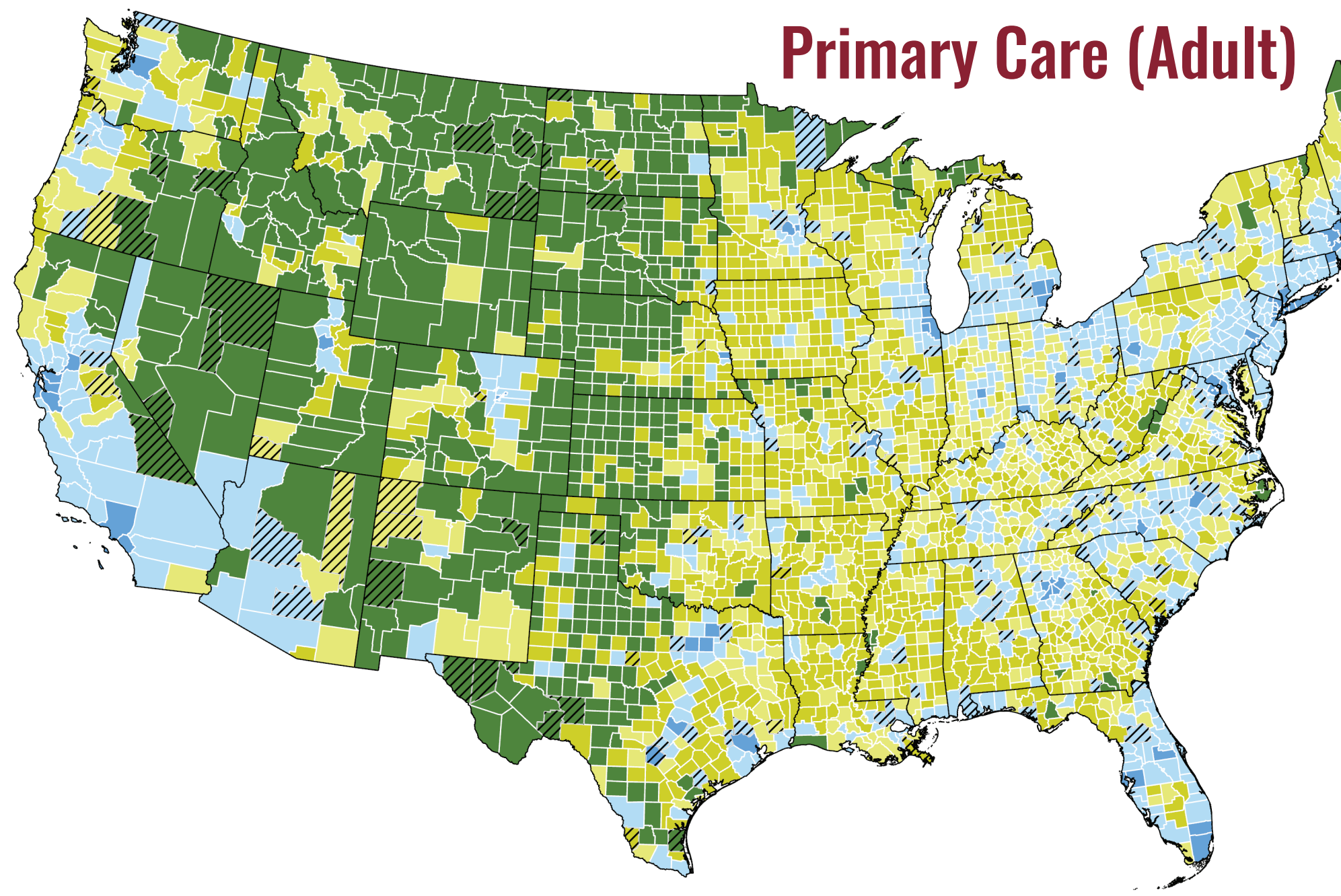
CMS Designation	Member Network Failures (n, %)		
	Ad Hoc	QHP + CMS	Ad Hoc + CMS
Large Metro	2,583,331 (4.4)	1,181,936 (6.1)	7,598(0.0)
Metro		3,050,533 (10.8)	311,113 (1.1)
Micro		888,951 (14.2)	553,155 (8.8)
Rural		749,935 (19.3)	1,269,860 (32.6)
CEAC		160,030 (20.9)	441,605 (57.5)
Totals	2,583,331 (4.4)	6,031,385 (10.3)	2,583,331 (4.4)

### Network Failures for behavioral health providers

CMS Designation	Member Network Failures (n, %)		
	Ad Hoc	QHP + CMS	Ad Hoc + CMS
Large Metro	1,856,218 (3.2)	342,138 (1.8)	2,751 (0.0)
Metro		2,007,876 (7.1)	232,832 (0.8)
Micro		598,714 (9.5)	388,019 (6.2)
Rural		512,907 (13.2)	879,460 (22.6)
CEAC		105,840 (13.8)	353,156 (46.0)
Totals	1,856,218 (3.2)	3,567,475 (6.1)	1,856,218 (3.2)

County Designations (number of counties)

Large Metro	Metro	Micro	Rural	CEAC	< 90% Threshold
78	712	689	1,068	561	



Recommended citation: Bell N. & Lòpez-De Fede A. (2024). National analysis of Medicare network adequacy rules and impact on primary care and behavioral health Medicaid Managed Care plans. In AcademyHealth Annual Research Meeting, Baltimore, MD.