**Comparison of Existing Managed Care Plan Requirements and Preferred Requirement Standards for Financial Alignment Demonstration Plans Related to Network Adequacy**

The chart below adapts information from the May 16, 2011 Federal Register Notice, Vol. 76, No. 94, which outlined, among other items, key differences between Medicaid and Medicare managed care administration requirements. This chart also describes pre-established parameters articulated in the July 8, 2011 Medicaid Director Letter, as well as MMCO’s position on preferred requirements for States and plans participating in the capitated model, and authority needed to carry out this preferred position.

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| **Federal Medicaid Requirements** | **Medicare Requirements** | **Pre-Established Parameter and/or Preferred Requirement Standard** | **Authority Needed to Implement Requirement** | **State-Specific Negotiated Standard**  **(***To be jointly completed***)** |
| Medicaid managed care contracts must require the plan gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care.  Among other requirements, plans must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. 42 CFR 438.207 | Medicare Advantage requires that plans must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.  Also, plans must provide or arrange for necessary specialty care. The MA organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs. 42 CFR 422.112  **Exceptions to the Criteria**  CMS recognizes that in certain cases, an applicant’s contracted network may not meet the provider network adequacy criteria. In such cases, the applicant may request an exception, from a pre-defined list created by CMS, for a specific provider/facility type in a specific county. These exceptions are detailed in the CMS Health Services Delivery Tables Exceptions Guidance.  Plans must have a contracted pharmacy network that assures convenient access to network pharmacies, including retail, home infusion, long-term care, and I/T/U pharmacies. 42 CFR 423.120 | **Preferred Requirement Standard:** Use State Medicaid standards for long term care networks and use Medicare standards for medical services and prescription drugs.  Demonstration plans will be able to utilize an exceptions process in areas where Medicare network standards may not reflect the number of dual eligible beneficiaries. Plans will be required to use Medicare network adequacy standards and review processes during plan selection process and network adequacy will be subject to confirmation through readiness reviews.  For areas of overlap where services are covered under both Medicaid and Medicare, the appropriate network adequacy standard will be determined via MOU negotiation and memorialized in three-way contracts with health plans, so long as such requirements result in a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.  Note: Part D requirements will continue to be applied; see #3 for details. | MA deadline to have demonstrated network adequacy may need to be extended consistent with the plan selection process in the demonstration. |  |