TO: Medicaid Managed Care Organizations

FROM: Matthew Hobbs, Deputy Director
Office of Managed Care

DATE: 01/09/2025

SUBJECT: 2025 MCO Process to Request Exception for Network Adequacy

Background

The Medicaid Managed Care Provider Agreement (PA) requires managed care organizations (MCOs) to meet the network adequacy requirements outlined in Appendix F of the agreement. The Ohio Department of Medicaid (ODM) has created reports for network adequacy which are monitored weekly by ODM and received weekly by the MCOs. At the beginning of each calendar quarter (January, April, July, October), ODM utilizes these reports to determine if MCOs meet network adequacy standards in the PA and if compliance action is required.

The PA allows an MCO to request an ODM exception review when the MCO does not meet a Network Adequacy Standard(s). When ODM approves an exception request, it waives any non-refundable sanctions otherwise required by the PA.

Appendix F.5. Exception Process for Provider Network Access Requirements of the Medicaid Managed Care PA, states:

Upon written request of the MCO, ODM may grant an exception to a provider network access requirement:

1. if action taken by ODM adversely impacted the MCO's ability to meet the requirement, or
2. if there is no provider available to meet the requirement.

When the MCO has a network deficiency attributable to one of these reasons, this document outlines the process requirements for MCOs to follow when submitting an exception request to ODM for review. All approved exceptions are limited in 90-day or 180-day increments.

As part of the review process, ODM will take into consideration the time requested (90 or 180 days) and any approvals granted will include the timeframe. Once the time elapses, and the exception request expires, MCOs will need to request a new exception request if the deficiency is still not met.

Each quarter, ODM monitors the different standards and deficiencies across the state. When ODM has identified a standard that may be a common issue for all the MCOs, the department may waive or exempt the standard from compliance action. Any exception requests that is submitted for a standard that is being waived or exempted from compliance due to deficiencies across the state will be returned to the MCO as 'not applicable'.

Please note that exception requests do not need to be submitted for any network standard that is included in an active Corrective Action Plan (CAP). Also, exception requests should not be submitted for failure to meet the provider panel requirement for a given measure because a provider chooses to not contract with the MCO. Any exception request submitted for one of the reasons described in this paragraph will be rejected by ODM without consideration

Appendix F.2.d of the PA includes requirements for MCOs to maintain a network development management plan with strategies to expand capacity within their service areas. As a result, exception requests are not to be used to relieve MCOs from recruiting Medicaid providers or from contracting Medicaid with enrolled providers/facilities in the relevant service area within the time/distance and/or county-based requirements.

Exception requests will be accepted by ODM two weeks prior to and two weeks following the date when quarterly network compliance is conducted by ODM but should be submitted to ODM as early as possible for consideration. (See table below for specific dates.) MCOs have access through the Ohio Medicaid Enterprise System (OMES) Provider Network Management (PNM) module to download their weekly network adequacy reports. MCOs should review and monitor their weekly reports prior to the first week of the reporting month to eliminate possible compliance action.

Exception requests will be accepted during the following timeframes:

Compliance Date (first Monday of month)	Open period to submit exception requests
Quarter 1, 1/6/2025	12/23/2024 - 1/20/2025
Quarter 2, 4/7/2025	3/24/2025 - 4/21/2025
Quarter 3, 7/7/2025	6/23/2025 - 7/21/2025
Quarter 4, 10/6/2025	9/22/2025 - 10/20/2025

When a MCO requests an extension to a network adequacy report due date, it does not change the due date for exception request submission.

Eligible Exception Requests

As of the 1/1/25 Managed Care Provider Agreement, the following are ODM's Network Adequacy Standards that an exception request may be submitted for:

1. **Insufficient Number of Medicaid Enrolled Providers/Facilities in Service Area**

   Minimum Number of Providers/Facilities Standard (ODM refers to this as County-Based)

   - This exception would apply in counties where there are insufficient numbers of providers/facilities enrolled in Ohio Medicaid to meet the standard network adequacy criteria.
     Provider Agreement - Appendix F Table F.3-F.7
     - Minimum Number of Hospital Providers
       - General Hospital
       - Hospital System
       - Inpatient Psych Hospital
     - Minimum Number of Nursing Facility Providers

    - Nursing Facility
- Minimum Number of Medication Assisted Treatment (MAT) Providers
- Minimum Number of Other Behavioral Health (BH) Providers (Not Provider Types 84 or 95)
- Minimum Number of Dental and Vision Providers
    - Dental
    - Vision

2. **No Providers/Facilities that Meet the Specific Time and Distance Standards in Service Area**

Time and Distance Standards

- This exception would apply in counties where there are no providers/facilities enrolled in Ohio Medicaid in the service area within the maximum time and or distance.

Provider Agreement - Appendix F Table F.2

- Adult Primary Care
- Adult Dental
- Allergy
- Behavioral Health
- Cardiology
- Outpatient Dialysis
- ENT/Otolaryngology
- Gastroenterology
- General Surgery
- Gynecology, OB/GYN
- Hospital
- Nephrology
- Neurology
- Oncology
- Oral Surgery
- Orthopedics
- Pediatrics
- Pediatric Dentistry
- Pediatric Behavioral Health
- Podiatry
- Psychiatry
- Radiology
- SUD – Outpatient
- SUD – Residential
- Surgical Services - Outpatient
- Urology

Submission Requirements for Requesting an Exception Review

When submitting an exception request to your contract administrator at ODM, the following should be included:

1. ODM Form 10279 (appendix A), ODM_10279_12025.pdf. One form per each provider category should be submitted for consideration.
2. Narrative providing conclusive, substantial, and credible evidence to support the reason for the exception request. This narrative should also include a description of how the MCO will ensure member access to medically necessary providers/ services. (ODM has provided a few suggestions on what should be submitted as supporting evidence below.)
3. The MCOs strategy to recruit new providers or contract with existing Medicaid enrolled providers/ facilities.
4. Include the timeframe for which you are requesting the exception - 90 days or 180 days.

ODM will consider the exception request when quarterly network compliance reviews are conducted. Any exception request not meeting the requirements outlined in this document will be denied. If no exception requests have been submitted, ODM will review and issue compliance as necessary.

For non-compliance deficiencies which do not meet the exception request requirements outlined in this document, MCOs may submit a reconsideration form once a Notice of Non-Compliance has been issued.

As stated above, MCOs have access through OMES PNM module to download their weekly network adequacy reports. MCOs should review and monitor their weekly reports prior to the first week of the reporting period to eliminate possible compliance action.

Examples of Supporting Evidence

ODM is providing examples of what the supporting documentation/ evidence could be included, depending on the deficiency, for ODM's consideration.

1. For insufficient *Number of Providers/Facilities in Service Area* not being met (ODM refers to this as **County-Based**):
   - List of potential alternatives for member(s) to have access to services not meeting standard.
   - Results of MCO's internal Time and Distance Analysis (see appendix B for suggested standards)
     - If MCO is requesting an exception where there are 2 providers short in the county, they should provide a list of all members in the county and the distance to the nearest 2 providers of that specialty type. An additional nearest provider should be included for each provider that they are short.
   - List of Members in the County and the nearest distance to a provider of that specialty type.
     - Provide data on local patterns of care (e.g., using claims data, referral patterns, local provider interviews, use of telemedicine) indicating where members currently seek this type of care and/or where doctors currently refer members for this type of care.
     - Indicate data sources (e.g., dates for source data, interviews)
     - Provide a detailed description of contracting alternatives (e.g., coverage of transportation costs) that will help to address the insufficient number of providers in the service area, in addition to details on potential contracting alternatives that were explored by the health plan but could not be pursued.

- Include any relevant health plan policies and procedures that address contracting alternatives.
- Describe any special accommodation and/or reimbursement (including transportation arrangements used to meet the needs of members) and any corresponding health plan.

2. For insufficient *Providers/Facilities that meet the Specific Time and Distance Standards in Service Area* not being met:
   - Results of their Time and Distance Analysis
     - Provide distance and travel time points that members would have to travel beyond the required criterion (e.g., 20 minutes and 10 miles for a Primary Care Physician (PCP) in a metropolitan service area) to reach the next closest contracted provider of this type outside of the service area.
       - Provide contact information including names, addresses, and phone numbers for next closest contracted providers/facilities.
         - MCOs should use the appropriate providers for running this Time and Distance analysis (e.g., Dental providers and Vision providers must hold a full-time equivalency at that location).
   - List of Members in the County and the nearest distance to a provider of that specialty type.
     - Provide data on local patterns of care (e.g., using claims data, referral patterns, local provider interviews, use of telemedicine) indicating where members currently seek this type of care and/or where doctors currently refer members for this type of care.
     - Indicate data sources (e.g., dates for source data, interviews)
     - Provide data sources used to confirm that there are no practicing (not contracted) providers in the service area (e.g., Medicare.gov, other health plan networks)
   - List of potential alternatives to meeting standard.
     - Provide a detailed description of contracting alternatives (e.g., coverage of transportation costs) that will help to address the insufficient number of providers in the service area, in addition to details on potential contracting alternatives that were explored by the health plan but could not be pursued.
       - Include any relevant health plan policies and procedures that address contracting alternatives.
       - Describe any special accommodations and/or reimbursement (including transportation arrangements used to meet the needs of members) and any corresponding health plan.

Questions regarding this policy guidance letter may be directed to the Managed Care Network Management and Operations section of ODM: mcprovideroversight@medicaid.ohio.gov

Appendix A – Notice of Provider Exception form

Ohio Department of Medicaid

NOTICE OF PROVIDER EXCEPTION

Name of Managed Care Plan	Program for Which Exception is Requested ☐ Medicaid ☐ MyCare ☐ Both

List County or Region Based Metric (County or Region and Specialty)	For State Use Only Approved	Denied	N/A

List Time and Distance Metric (County and Specialty)	Approved	Denied	N/A

Reason See *Exception Request Guidance Memo* for supporting documents that could be included to support the reason.
Detail how members' need will be satisfied
Time *(Select One)* ☐ 90 days ☐ 180 days

Signature	Date

ODM 10279 (1/2025)

(Form location: Managed Care Policy Forms | Medicaid)

Appendix B – Suggested Time and Distance Standards

Table B.1 : Suggested Time and Distance standard adaptations for the specialties measured for County Based Measures (Tables F.3 through F.7).

Individual Provider Specialty Types	Maximum Time and Distance Standards Time is measured in minutes and distance is measured in miles.							
	Large Metro County		Metro County		Micro County		Rural County	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Community Behavioral Health Providers (CBHP)								
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	10	5	15	10	30	20	40	30
Dental								
Adult Dental	20	10	30	20	50	35	75	60
Hospital								
Hospital	20	10	45	30	80	60	85	70
Inpatient Psychiatric Hospitals and Facilities								
Inpatient or Residential Behavioral Health Facility Services	30	15	70	45	90	75	90	75
Medication Assisted Treatment (MAT)								
SUD – Outpatient	20	10	30	20	50	35	75	60
Nursing Facilities								
Skilled Nursing Facilities	20	10	45	30	80	60	75	60
Vision								
Ophthalmology	20	10	30	20	50	35	75	60