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Network Adequacy Standards

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Agenda

- Network Adequacy Developments Overview
- NAIC Network Adequacy Model Act

Network Adequacy Developments Overview

--Growing concern over use of narrow networks, surprise billing and inaccurate provider directories.

--Developing network adequacy standards and enforcement in:

- Medicare/Medicaid managed care programs
- Exchange markets
- State regulated commercial markets

Government Reports Find Network Adequacy Deficiencies

September 29, 2014, HHS OIG Report "State Standards for Access To Care in Medicaid Managed Care," http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf

--found that State standards for access to care vary and that states have different strategies to assess compliance with access standards.

December, 2014, HHS OIG Report "Access to Care: Provider Availability in Medicaid Managed Care," http://oig.hhs.gov/oei/reports/oei-02-12-00670.pdf

--found significant issues with Medicaid managed care plan provider availability.

August 2015 "Medicare Advantage Actions Needed to Enhance CMS Oversight of Provider Network Adequacy.

http://www.gao.gov/products/GAO-15-710

--found that CMS not doing a good job of insuring network adequacy.

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Network Adequacy Evolution

- Litigation
- Regulatory action
- New state regulations
- Changing federal regulations
- Updating the NAIC Model Act

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Medicaid Managed Care Final Rule [Beginning July 1, 2018]

- On April 25, 2016, CMS released Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (1425 pages with preface) https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered
- intent to align Medicaid Managed Care requirements with regulations applying to QHPs and MA plans.

Medicaid Managed Care Final Rule [Beginning July 1, 2018]

- provider directories must be:
  - available electronically and in paper-- same as QHP provider directories-- but must include more data about provider's cultural/linguistic capabilities and disability access.
  - updated monthly and no later than 30 days after receipt of updated provider information.
- states must develop/make publicly available time and distance network adequacy standards for primary care (adult and pediatric), OB/GYN, behavioral health, adult and pediatric specialist, hospital, pharmacy, and pediatric dental providers, and for additional provider types that promote the objectives of the Medicaid program.

Medicaid Managed Care Final Rule PY on or after July 1, 2018

- factors states should consider in establishing delivery network requirements:
  - direct access to women's health specialists,
  - availability of second opinions,
  - access to out-of-network providers,
  - ability of providers to communicate with enrollees who have limited English proficiency and to accommodate disabilities,
  - access to telemedicine, electronic medical records and other innovative technologies in healthcare delivery
- CMS makes determination of network adequacy based upon documentation that supports the assurance of the adequacy of the network for each MCO.

Medicare Advantage

Network Adequacy Determinations

42 CFR § 422.112 requires MAOs to maintain and monitor the network of providers and to provide adequate access to covered services.

- MAOs must establish written standards for timeliness of access to care that meet or exceed standards established by CMS
- The standards established are located in the annual MA HSD Provider and Facility Specialties and Network Adequacy Guidance and annual MA HSD Reference table

Medicare Advantage

- CMS will deem a network adequate if MAO demonstrates:
  - (1) networks have a minimum number of providers/facilities to meet the utilization patterns and clinical needs of the Medicare population as determined by CMS; and
  - (2) MAOs must demonstrate that their networks do not unduly burden beneficiaries in terms of travel time and distance to network providers/facilities.

Medicare Advantage
April 4, 2016 CY 2017 MA Call Letter

Guidance on the Future of Provider Directory Requirements/Best Practices

- CMS emphasizes importance of providing accurate provider directories to MA enrollees.
- CMS supportive of industry efforts/innovation to improve provider directories and encourage MAOs and providers to continue to work collaboratively to develop more effective and efficient methods of maintaining accurate provide directories.
- Preliminary data gathered by CMS, as well as continued stakeholder concerns, has intensified CMS concerns with provider directory accuracy.
- CMS will continue to aggressively identify and pursue instances of non-compliance by using a host of oversight methods.
- CMS will share methodology for provider directory monitoring activities currently underway in an upcoming HPMS memo and provide preliminary data related to the monitoring to MAOs prior to taking any action.
- CMS remains committed to making provider directory requirements across CMS programs consistent.

Guidance on the Future of Provider Directory Requirements and Best Practices

CMS plans to propose revisions to § 422.111 to require MAO to issue provider directories that include the following additional elements and urges MAOs to incorporate them into directories in advance of future rulemaking:

--Machine readable content

--Provider medical group

--Provider institutional affiliation

--Non-English languages spoken by provider

--Provider website address

--Accessibility for people with physical disabilities

CMS urges MAO customer service call centers to adopt a “warm transfer” approach in responding to calls from enrollees who need assistance in locating a provider that is accepting new patients. Under this approach the enrollee would be transferred to the provider’s office to set up an appointment.

Marketplace Plans
CMS 2017 Final Rule and Letter to Issuers

--Under 45 CFR 156.230(a)(2) QHP issuers must maintain network sufficient in number and types of providers (including mental health and substance use disorder) to assure all services are accessible to enrollees without unreasonable delay.

--Did not finalize time and distance standards policies as proposed but continuing to use reasonable access standards to give states time to adopt NAIC Network Adequacy Model Act.

-- Issuers must provide 30 days advance written notice of provider's termination from network to enrollees seen on regular basis or who receive primary care. When enrollee in active treatment, issuer must allow completion of treatment or 90 days continuance of treatment at in-network cost-sharing rates.

--Starting in 2018, issuers must count enrollee cost sharing for EHBs provided by out-of-network provider at in-network facility toward enrollees annual limit on cost sharing.

--Committed to increase transparency and available information to facilitate consumer choice by including rating of each QHP's network coverage on HealthCare.gov.

--Issuers must include sufficient number and geographic distribution of Essential Community Providers (ECPs) that serve primarily low income, medically underserved.

NAIC Model Network Adequacy Act Changes

- "Managed Care Plan Network Adequacy Model Act" renamed "Health Benefit Plan Network Access and Adequacy Model Act"
- Revised "for consistency with the Patient Protection and Affordable Care Act to reflect changes in the way heath care services are delivered since [the model act] was initially adopted in 1996."
- "Managed care plan" replaced with "network plan" – broadened to encompass PPO, HMOs, ACOs and other delivery models.
- Approved by NAIC November 22, 2015

NAIC Model Act: Primary Revisions/Additions

- Significant revisions to existing sections:
  - Network Adequacy (**Section 5**)
  - Health Carrier/Participating Providers (**Section 6**)
- New sections:
  - out of network surprise billing
    - regulation of participating facilities with non-participating facility-based providers (**Section 7**)
    - disclosure and notice requirements related to out-of-network professionals (**Section 8**)
  - provider directories; tiering (**Section 9**)

NAIC Model Act: Other Changes

- accreditation
- continuity of care linked to provider terminations (new)
- intermediaries
- limited scope dental and vision plans (new)
- provider contracting

NAIC Model Act Section 5: New Network Sufficiency Criteria

Commissioner may establish network sufficiency by reference to any reasonable criteria including:

- Geographic variation and population dispersion.
- Ability to meet needs of covered persons including low income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency.
- Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care.

NAIC Model Act Section 5: Out-of-Network Provider Access When Network Gap

Carrier must have process to assure in-network level of benefits, including in-network level of cost sharing from an out-of-network provider or make acceptable arrangements when:

(a) sufficient network but not type of in-network provider to provide covered benefit or to provide covered benefit without unreasonable travel or delay; or

(b) insufficient number or type of in-network providers available to provide covered benefit to covered person without unreasonable travel or delay.

NAIC Model Act Section 5: Access to Out-of-Network Provider For Specialized Care

- Carrier must specify and inform covered persons of process to request access to out-of-network provider when:
- (a) Covered person diagnosed with condition or disease requiring specialized health care or medical services; and
- (b) Health carrier
  - (i) doesn't have in-network provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or
  - (ii) cannot provide reasonable access to an in-network provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.
- Out-of-network specialized services treated as if provider in-network including counting cost sharing toward the maximum out-of-pocket limit applicable to in-network provider services.

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NAIC Model Act Section 5: New Network Access Plan Requirements

- how the use of telemedicine or telehealth or other technology may meet network access standards
- factors used to build network, including criteria to select/tier providers ;
- carrier's efforts to address needs of those with serious, chronic or complex medical conditions.
- carrier's method of informing covered persons of the plan's covered services and features, including:

  (a) grievance and appeals procedures;

  (b) process for choosing and changing providers;

  (c) process for updating its provider directories for each network plan;

  (d) health care services offered, including those services offered through the preventive care benefit, if applicable; and

  (e) procedures for covering/approving emergency, urgent, specialty care.
- process for monitoring access to physician specialist services in ER room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at participating hospitals.

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NAIC Model Act Section 6: Carrier/Provider Agreements

- **Insolvency of Carrier/Intermediary**—provider's obligation to deliver covered services to covered persons without balance billing will continue to the earlier of:
  - (1) The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms, or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled; or
  - (2) The date the contract between the carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the carrier or intermediary had remained in operation.

NAIC Model Act Section 6: Carrier/Provider Agreements

- **Access to Medical Records** – Must be provided for state and federal authorities, where required under state and federal law, and covered persons.
- **No Assignment/Delegation**.—Contract neither assignable nor delegable without mutual assent.
- **Documents Incorporated By Reference**. –Carrier must timely notify participant at time contract is signed.
- **Notice of Material Changes--** During contract, carrier shall timely notify provider of material changes.
- **Notice of Network Participation Status--** Carrier shall timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider.

NAIC Model Act Section 6: Provider Selection/Tiering

- Carrier selection/tiering criteria for participating providers must not:
  - discriminate against high-risk populations by excluding/tiering providers located in geographic areas with populations or providers presenting risk of higher than average claims, losses or health care services utilization;
  - exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization;
  - discriminate with respect to participation under the health benefit plan against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.
- Carrier not required to contract with: (i) any provider willing to abide by participation terms and conditions; (ii) specific providers; or (iii) more providers than necessary to maintain sufficient network.
- Standards for selecting /tiering participating providers must be available for Commissioner's review/approval and in plain language to the public.

NAIC Model Act Section 6: Continuity of Care

- Notice to enrollees upon provider termination
- Continuity of care following provider termination
- Carriers must establish a transition process to a network provider for persons eligible for continuity of care, including a list of relevant participating providers
  - Continuity of care must be approved by the carrier's Medical Director and is subject to medical necessity
  - Providers accepting continuity of care covered persons must accept contracted payments and may not balance bill

NAIC Model Act Section 7: Surprise Billing--What is it?

- Covered persons receive emergency or non-emergency services from an in-network facility but some of the services provided by out-of-network facility-based providers (i.e. pathologists, radiologists or anesthesiologists).
- Covered person receives bill from out-of-network provider asking for out-of-network cost-sharing levels, and where allowed by state law, balance bills for difference between provider's charges and the insurer's allowed amounts for the services.

NAIC Model Act Section 7: Surprise Billing Program Requirements

- Carrier must establish program for payment to out-of-network facility-based providers where difference in billed charge and plan's allowable amount exceeds $500:
  - Insurer may pay submitted facility-based out-of- network provider bill; OR
  - pay in accordance with benchmarks set by state, with benchmark deemed reasonable if higher of contracted rate and % Medicare for same service in same geographic area.
- Provider mediation process for out-of-network providers who object to benchmark rates.

NAIC Model Act Sections 7-8: Surprise Billing Notice Requirements

- Notice that out-of-network provider services may be provided at in-network facility must be provided to covered persons:
  - By participating facility:
    - at time of scheduling or prior authorization, which must be signed by covered person at time of admission for non-ER services and with billing notice for ER services.
    - under its contract with a carrier, within ten (10) days of an appointment for inpatient or outpatient services,
  - By carriers at pre-certification including
    - possibility of higher cost sharing; and
    - options available to access participating providers

  Non-participating facility-based providers may not balance bill unless they notify covered persons of their payment options in a Payment Responsibility Notice.

NAIC Model Act Section 9: Provider Directories; Tiering

- Current/accurate electronic and print directories must be available
- Must be updated monthly
- Carrier should audit periodically
- Must include plain language criteria used to build/tier networks, to designate provider tiers and to place providers in tiers.
- Must indicate if referral or prior authorization is required.
- Must specify which provider directory applies to which network plan
- Customer service number to report inaccuracies
- Communication accommodations required for disabled and those with limited English proficiency.

Trending

- CMS move to make standards consistent across government programs.
- CMS urging the states to adopt the NAIC model Act
- the involvement of, not only the carriers, but of providers and others in the development of the standards
- taking into consideration new ways of delivering healthcare
- making sure carrier can meet the needs of low income persons, those with serious, chronic or complex health conditions or physical or mental disabilities or person with limited English proficiency.
- The importance of accurate provider directories
- increased transparency to enrollees as to which providers are on the network and taking new patients, explanation about tiers, how does a provider get into a tiers, about the possibility of non-network providers providing care in a contracted facility.
- access to specialists and out-of-network providers
- penalties for insufficient access and/or inaccurate directories