Presentation Questions & Responses

Questions	Responses
1. 5 of 6 networks analyzed fail for pediatrics with current time/distance, how do we know actual issue?	Outlying areas of Washoe + rural is where the challenge lies: may want to loosen time/distance standard – most weren't far off (low 80's)
2. Did we agree to stick with service area?	Not yet. Recommendation only.
3. We can take pediatrics as a separate standard?	Pediatrics was originally in then take out of CMS Yes. It doesn't have to be included in Primary Care.
4. Where you able to estimate mileage adjustment?	Not yet.
5. Time/Distance can point to maldistribution or shortage? Can enrollee count be an alternative?	Yes it could be. There are 417 licensed pediatricians in state; over 1200 count on plans (duplicate address; same with psychiatrists)
6. Duplicity implies more: is there a way to look at it more accurately?	Availability to patients at each location is the criteria; council can look at adjustments to full count. CMS/DOI will likely look at this in future. Hospitals are a great example of the count being high – not reflective of actual acute care facilities. Urgent care is also classified as hospital. Counts for 040/043 are actual contract vs hospital
7. Did other states include other criteria besides time and distance?	Some
8. Counts would affect time factor	We'll have to operationalize it. Types of duplications will need to be looked at. Some metrics we don't have the ability to operationalize at this time. We are always locked into CMS;
9. Based on # of providers we have, how many can actually get insurance? It will look like carriers are pulling out.	That is the balancing of this Council.
10. We think additional data is important Re: provider/patient ratio to understand What access/adequacy issues are at stake?	We were rushed; next year will give an opportunity to look more deeply at these requests
11. Whatever we decide may give other licensing boards the impetus to get in gear. 2018 seems a long way away.	It does but realistically it is not.
12. ECP: What about Carrier 1 at 22%?	All carriers have now met ECP requirement but current data not organized for reporting.
13. Are you counting individual types as multiple sites (FQHC's) b. With % of time of site will this count as a full provider?	13. You'll see an entity listed several times with multiple sites. b. When listed individual locations are listed but believe the adequacy % would be taken into account.
14. Why (p.7) are there 0's in so many types?	Were offered in "good faith"

Presentation Questions & Responses

15. Does offer mean some are no contracts? →Can you pull final #'s for next meeting?	Need time to put a chart together for # of ECP's |# of contracted |current #'s
16. Can you be counted as both if you meet multiple criteria? (e.g. HOPE)	Yes; not an either/or
17. Isn't it Council's charge to improve conditions for consumers vs status quo? Primary care ≠ specialties. We don't have enough providers. Carriers access plan	No it is to make recommendations for standards for Nevada; Adequacy model is more than adequacy standards. There is a lot of controversy in provider ratios, even in primary care. Provider: patient access to primary care is backbone of system.
18. On exchange 18.4 individual Off exchange – 6	
19. Area carriers able to get waivers if adequacy can't	Waiver – there are specific questions we address; it is part of certification process; not a specific NV document; provide the topics

Review of Recommendations

Recommendation 2: Pediatrics under separate category with modification to time/distance. OR: with in pediatrics if we don't have data. [Table voting until we have stats]	Can we? We can make whatever standard we want – ideally might want to adopt metro/micro/metro/rural/CEAC Would like more info on actual/distance standards would need to be. Despite waiver process, size of carrier can impact whether they'll put effort in or pull out.

All we don't move forward (7-9) should move to future consideration with suggestions for data collection. There are short comings in data (like wait time in other states) & impedes our decisions

Recommendation 6: Distinguish a licensed hospital BHCQ&L and urgent care – come up with criteria. Ask how they come up w/ hospital definition. Reminder: Burden falls on carrier.

Recommendation 2: Pediatrics separately as holding place pending data; all else in future considerations

Recommendation 6: Distinction between hospital & urgent care

Recommendation 5: The standard of 30% is exceeded for 3 of 4: all meet it currently. How onerous is 40-50%? Will see if an increase is warranted after data; this might be an area where wait time would be helpful - is the federal standard adequate for linking patients to primary care. Do we recommend it for 2019 – data collection. Ask CA how they came up with it. A lot more is delegated to providers.
Medicaid/MCO have these requirements – look at methodology
Are the other non-exchange products meeting 30%; yes but exact numbers are not available.
Need to know baseline, before we make an increase.
Insure an env. is created in rural areas to get med coverage. Reasonable standards.
ECP standard on federal level only for on-exchange; for NV its both.
Is it possible to poll ECP's to see their data/wait times.

Final Review

- Recommendations 2 & 5 from the July 22, 2016 meeting transfer as placeholders pending data on 8/17; 8/17 is final approval pending public & constituents comments. Posting 9/12/2015 for final approval with revisions.
  All other recommendations move to future considerations

Review of Recommendations

- Recommendations 6 from the July 22, 2016 meeting – Get definition of Bureau of Health Care Quality Compliance & Licensure for hospital licensure + recommend (Future Considerations?) Hospitals be distinguished from urgent care (or standard?) – discuss

- Report/Recommendations to Commissioner:
    - Background/Context of Council Development & Process 6/15-9/15/16
    - Formal proposed recommendations for Standards
    - Overview of Rationale + Criteria for 2018 standards
    - Future considerations for 2019 beyond for Council to consider additional/enhanced standards

Additional Recommendations

- Are there additional recommendations you want to make that weren't brought forward last time or from constituent's feedback?
- Is there a threshold (like baseline data is in place 2+5) for recommendations to be transferred?

Additional Recommendations	Rationale

Recommendation 4, Home Health; Pulmonary; Gastroenterology; Cardiovascular Disease.
• What is the advantage?
• Why pediatrics?
  o Value of kids
  o It is part of primary care and was overlooked
• The issue is to not make rules just to make rules – what is downside of not adding them?
• Negative consequence of pulling out of exchanges is critical
• Are we unique to consider these providers or one of only a few states who don't
• Nevada is unique that standards are extended to plans off-exchange also
	• These providers are becoming more important to clients (no data);
	• seems geographically it wouldn't be a barrier;
	• seems CMS is trying to provide a basic safety net so that's why we might include these
	• We do follow CMS guidelines/add them? When we meet need/standards already
	• Have carriers made attempt to contract with providers out there, if not, naming a provider is appropriate

Recommendation 3, verified
• Does declaration form fit into this conversation?
• Network Adequacy: the mental health parity issue
• Declaration document has 6 pieces not grabbed under template
  o 5 codes captured by NV not part of CMS template (Done in prior years)
  o Urgent Care, Emergency Care, Autism Providers + 2
	• Mental Health Parity falls under a requirement already
	• Statement on declaration form breaking out psychiatrists from other mental health providers

Recommendation 2, Pediatrics as stand – alone pending data	Is there and incentive to providers out of state if we include

- Recommendation 4 was voted on and the decision was to not include
- Section 12-18 in Binders (R049-14) outlines when significant change in network
- NV Statute requires 90 days to certify network adequacy
  - Run analysis and identify deficiencies
  - Notify/respond – annual process

Additional Recommendations

- Recommendation 6; Hospital as licensed in Nevada should be what we use for adequacy of Network (040/043 must adhere to these guidelines – include in narrative; distinguish from Urgent Care → when carriers complete template the instructions should be clear as to what to report)
  Could many of the overestimations in providers or facilities be handled internally by DOI clarifying instructions and definitions? Make recommendations; Commissioner can say this is DOI's internal operationalization →improve process: Have the discussion with carrier
- Credible data source for estimating actual #'s by FIT; future consideration
  - More adequate methods for collecting accurate date to make data-driven decisions + validate standards (Including DOI Staffing).
  - Narrative/Rationale: Critical Data Issues. Narrative should reflect: Data: Workforce Issue: Safety net issues. New process setting stage for future discussions. Focus on staffing.
- Data Request: Pull Psychiatry out independently and look at network adequacy
  a. Mental Health: Clinical Social Worker
  b. Run psychiatry using mental health standards as well as run using specialty (Endocrinology) standard
- Recommend: Improve collection of data for DOI to be able to estimate of specialty/provider what % have open panels (open/closed)
  - Wait time →to be used for future recommendations; Not part of annual data call/submission → would be a DOI request for stand-alone report
  - Request that the open/closed panel data being provided to consumer also be provided to DOI

Future Considerations

- Wait time
- Provider/Enrollee ratios (What would be meaningful in addition to provider count for network adequacy)
- Responding to new CMS changes as information is available
- Identify opportunities for providers to systematically report on data useful to Nevada Network Adequacy Advisory Council
- Looking to other state as we go forward: What is/isn't successful?
- Look at existing network adequacy across state – all the different requirements: Medicaid, Medicare, Fully insured non-ACA /ACA products
- Workforce
- Impact on Insurance marketplace: availability in some part of Nevada; types of services/products

Summary of Data Requests

1. Pediatrics – What are the minimum time and distance metrics which can be set which would allow the majority of carriers to meet network adequacy standards?
2. ECP – Provide the final on and off exchange data for contracted providers.
3. Contact California and Medicaid to determine the methodology which they use to determine provider wait times.
4. Contact the Bureau of Health Care Quality & Compliance Licensure to determine definition of a hospital.
5. Using mental health standards run the adequacy for each of the three mental health specialty codes. In addition run psychiatry, 029, using the Endocrinology standard.