Report on the Plan Year 2020 Recommendations For Network Adequacy Standards

Presented by:
The Network Adequacy Advisory Council

To: Barbara Richardson
Commissioner of Insurance Nevada Division of Insurance

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NAAC Recommendations for Network Adequacy Standards for Plan Year 2020

Overview of the NAAC Recommendations Process. This section includes a description of the:

1) Commencement of the Plan Year 2020 meetings of the Network Adequacy Advisory Council (hereinafter referred to as "Council" or "NAAC")
2) Process of Plan Year 2020 NAAC meetings
3) Timeline and significant discussions made at each of the five meetings.

The NAAC is comprised of nine individuals representing consumers across Nevada, providers of health care services, and health insurance carriers. The Council's first meeting for Plan Year 2020 was held on February 27, 2018 (NAC 687B.770 subsection 4 requires that the first meeting of the NAAC must be held no later than June 15th). They continued to meet through September, 2018, to finalize the recommendations of network adequacy standards for Plan Year 2020. The Council recommends these standards to achieve network adequacy for individual and small employer group health benefit plans.

At the June 26, 2018, meeting, the Council revisited and approved its vision for what it hoped to achieve during the Plan Year 2020 NAAC meetings. The vision is:

- Standards are pragmatic, achievable and meaningful.

In addition, the Council continues to be committed to creating conditions that ensure Nevada has:

1. Maximized access for consumers with adequate workforce and providers cost containment.
2. Validated data about whether providers are available.
3. Access to care[1].
4. Access to health insurance.
5. Maximized health and wellness.
6. Educated consumers so that, whether their health needs are emergent or non- emergent:
    a. Consumers know how to use their network care;
    b. Are informed; and
    c. Access care appropriately.
7. Contributed to health literacy: transparent to consumer.
8. Provided care that is culturally and linguistically appropriate.
9. Influenced the other 80% of non-regulated plans.

The data that the Nevada Division of Insurance (DOI) was able to provide the Council assisted the Council to: 1) make some recommendations that aligned with its vision and 2) consider what the implications of such recommendations might be on the conditions it had established as requisites for achieving its vision. This year the presentations included participation and data from both DOI and other NAAC member agencies. It should be noted that, as with their meetings in 2017, the DOI was able to provide only some of the data that was requested by the Council. Other groups represented by NAAC members were able to

[1] Access to care—consumer can utilize their health plan benefits; Access refers to clinical best practice.

provide additional information. However, there remains a gap in the types of data requested and what is currently being collected and tracked by DOI or other partner agencies. The primary gap identified by NAAC members remains "wait times." This will be discussed more fully in the section following the recommended standards.

A total of five public meetings were conducted. The result of these meetings is contained in the Report that will be submitted to the Commissioner of Insurance on September 15, 2018.[2]

February 27th- At this meeting, the DOI reviewed the network adequacy standards for Plan Year 2019 and the ten recommendations for future consideration. They also reviewed the schedule of meetings that was introduced and approved by the Council. The May 2018 meeting was cancelled based on the fact that no new data would be available at that time for the Council to review and formulate initial recommendations for Plan Year 2020. The council did not see the need and did not want to prioritize or change any of the recommendations, stating that they would like to carry them forward and that there was no need for change since no changes have taken place in the marketplace. They felt the standards are still relevant and until they had more data that these would suffice.

June 26th – At this meeting, the Council reviewed the vision and agreements for subsequent sessions and no changes were made to either. The Council received an update of changes at the Federal and State level that could potentially impact Nevada's health insurance market. The Council requested that specific data be reviewed at the July 24th meeting, including a comparison of the Plan Year 2018 and 2019 insurance markets for individual and small group plans. They also requested a breakout of Mental Health Provider types, to look individually at psychiatrists, Licensed Clinical Social Workers, and psychologists as well as receive a brief orientation to a comparison between mental and behavioral health providers. Additional information was also requested on Medicaid methodologies and health plans and products that do not cover trauma services.

July 24th –At this meeting, the Council reviewed the data requested at the June 26th meeting. The Council considered the impact of this information and made the decision to retain the Plan Year 2019 standards for Plan Year 2020, with the exception that they make a final decision on whether to break out Licensed Clinical Social Workers from psychiatrists under Mental Health Provider types to determine if recommendations for Plan Year 2020 network adequacy criteria should be specified for individual Mental Health Provider types. The Council deferred any final recommendations and justifications until different methodologies data was reviewed at the August 21st meeting.

August 21st – To be determined.

September 13th – To be determined: At this meeting, the Council approved the final Report.

Council's Recommendation for Plan Year 2020.

From the outset, as with Plan Year 2019, the Council expressed that any proposed changes to Plan Year 2020 standards must consider the ability of carriers to meet any changes to existing standards. The Council acknowledged that few if any changes had occurred in the market place to warrant significant

[2] The video recordings of the meetings and supporting materials are available on the Division website at http://doi.nv.gov/Insurers/Life_and_Health/Network_Adequacy_Advisory_Council/. Included in the Appendix of this Report are the minutes of each meeting.

changes or reconsideration of existing criteria and standards (see attached minutes for the February 2018 meeting). Generally, the same number of carriers are offering plans, although there have been a reduction in the health plans and products. They reaffirmed their decision from Plan Year 2019 to keep the Essential Community Provider (ECP) standard of 30% in place for Plan Year 2020.

Changes to Plan Year 2019 standards for the proposed Plan Year 2020 continue to be impacted by the absence of data, although some new data was considered for Mental Health provider types. The Council's ability to make decisions is hampered by the ongoing gaps in what and how data is collected by various outside entities, which restricts the Council's ability to accurately evaluate the impact of any proposed changes to network adequacy standards. As with their discussion and review during Plan Year 2019, the gaps in the data for wait time and time to first visit for urgent or primary care requests continue to be areas of interest and urgency.

With these caveats, the Council recommends the following:[3]

1. Retain the Plan Year 2019 Standards as originally recommended by the Council which included pediatrics, with the following modifications in metrics:
   - Breakout Mental Health criteria for psychiatrists, psychologists and LCSWs, leaving the Time/Distance criteria the same for each *(clarify whether the option is for either type to be available to meet the standard, or for all types to be available)*
2. All metrics noted in the Plan Year 2020 chart should be followed, regardless of any *reductions* in the minimums that CMS might make once the Plan Year 2020 Standards are adopted.

Commented [DL1]: Ask NAAC members if they meant for all three to be required standards 1 and 2 and 3 or 1 and/or 2 and/or 3?

[3] The recommendation was based on a Council vote with # present/# votes in favor

The Plan Year 2020 Recommendations are noted below in the Network Adequacy Time/Distance Standards Chart.

Specialty	Network Adequacy Time/Distance Standards : Plan Year 2020 Recommendations							
	Metro		Micro		Rural		CEAC	
	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)
Primary Care	15	10	30	20	40	30	70	60
Endocrinology	60	40	100	75	110	90	145	130
Infectious Diseases	60	40	100	75	110	90	145	130
Psychiatrist	45	30	60	45	75	60	110	100
Psychologist	45	30	60	45	75	60	110	100
Licensed Clinical Social Workers (LCSW)	45	30	60	45	75	60	110	100
Oncology - Medical/Surgical	45	30	60	45	75	60	110	100
Oncology - Radiation/Radiology	60	40	100	75	110	90	145	130
Pediatrics	25	15	30	20	40	30	105	90
Rheumatology	60	40	100	75	110	90	145	130
Hospitals	45	30	80	60	75	60	110	100
Outpatient Dialysis	45	30	80	60	90	75	125	110
Adequacy Requirement	90% of the population in a service area must have access to these specialties types with in the specified time or distance metrics.							
Plan Year 2020 Standards for ECPs:								
Contract with at least 30% of available Essential Community Providers (ECP) in each plan's service area								
Offer contracts in good faith to all available Indian health care providers in the service area								
Offer contracts in good faith to at least one ECP in each category in each county in the service area								

Rationale and Criteria for Recommended Standards. The recommendation above, based on extensive discussion by the Council, related to whether additional standards would have a positive impact on:

- Network adequacy
- Consumer access to high quality health services
- Affordability and the capacity of carriers to offer products to both individuals and small groups

A review of the current Plan Year 2018 data revealed that the 30% minimum standard for Essential Community Providers was able to be met or exceeded by all of the carriers, therefore it was decided to retain that level. The data indicated that this was also true for the carrier data submitted for Plan Year 2019.

DOI clarified that CMS will no longer review the adequacy of networks and has put this process back on states, leaving the decisions for standards for network adequacy to state councils, commissioners and legislatures.[3] In PY 2018 the Council voted to recommend that the specified metrics in the standards chart be listed in regulation, which has been accomplished.

The recommendation to break out the Mental Health providers was based on the concurrence among most Council members that it didn't make sense to combine psychiatrists, psychologists and Licensed Clinical Social Workers (LCSWs) into one category given their services differed significantly and that some Mental Health provider types (like LCSWs) might be easier to recruit to rural/underserved areas. Therefore, it was warranted that they be listed individually, as provider types that can meet the Mental Health standard.

Future Considerations. Throughout the meetings, the Council discussed numerous issues associated with the assessment of existing standards, including the absence of significant data, the sources of data collection, the manner in which data was collected, and the burden of requiring additional data collection by carriers. The primary concern with existing data remains: it does not provide support for the Council to look at standards beyond time and distance for network adequacy. Currently the data gathered and presented to the Council, per its requests, was deemed not sufficiently robust nor accurate to warrant changes in network adequacy standards without the possibility of incurring unintended negative consequences.

Considerations for future action were discussed to prepare the Council with a better understanding of what additional standards might be added for Plan Year 2021 and beyond. The Council maintains the stance that data collection and standards should not impose burdens that might compromise the adequacy of current networks. The following considerations were put forth:

1) Come up with a fiscal note for presentation to the legislature for further exploration of "wait time", without transferring the costs for DOI reviews of data to carriers, as is currently required by Nevada law: first determine whether providers already collect this data and whether it is accurate—or what methodology would provide the most accurate data (e.g., Secret Shopper Survey).
2) Explore and incorporate other network adequacy methodologies currently used by other state

[3] For those states that are not doing network adequacy review the carriers are required to have their networks accredited through an organization approved by CMS. See CMS Letter to Issuers PY 2019 pg 13.

agencies, such as Medicaid/Medicare/fully insured non- Affordable Care Act products, that might be possibilities for :

   a. Wait time (to first appointment and in office time)
   b. Provider/enrollee ratios (determining what provider categories in addition to primary care would be a meaningful addition)
   c. Utilization of telehealth/telemedicine for delivery of urgent, primary care, and specialized services, particularly in rural areas.

3) Identify and operationalize opportunities for providers to systematically report on data useful to the Council.
4) Advocate for workforce development in critical provider categories and recruitment incentives/encouragement to recruit providers to rural/underserved areas required for network adequacy.
5) Examine the impact of network adequacy regulations on the insurance market place for Plan Year 2019 and beyond.
6) Work toward a data collection system that better represents provider counts based on the Full-Time Equivalent (FTE) of employed staff or providers' actual availability at a given site; currently the count is one provider per site regardless of how available they are to that site and its consumer base (FTE or days/week). Possible options for *exploration* in collecting this data were noted: a state-developed, separate template for carriers to report on provider FTEs; a request to state licensing boards to share annual data on new and current health professionals.
7) Improve data on provider availability on open/closed panels.
8) Further explore network adequacy as it pertains to ECPs.
9) Conduct a feasibility study as to whether FCI is possible.

Appendix:

Draft Minutes from NAAC Meetings:
February 27th, June 26th, July 24th, August 21st and September 13th
TO BE INSERTED AFTER SEPTEMBER 13th MEETING