Draft Report on the Plan Year 2018 Recommendations For Network Adequacy Standards

Presented by:
The Network Adequacy Advisory Council

To:
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Network Adequacy Standards for Plan Year 2018

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

1) commencement of the Network Adequacy Advisory Council (Council or NAAC);
2) process of 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 insurance carriers. The Council met first on June 15, 2016 as dictated by regulation RO49-14 and continued to meet through September 12, 2016, at which point they it finalized the recommendations for Plan Year 2018. These are standards the Council recommends to achieve network adequacy for individual and small employer group health benefit plans.

At the June 15, 2016 meeting the Council created a vision for what it hoped to achieve during the 2016 sessions. The vision was:

- Standards are pragmatic, achievable and meaningful.

In addition, the Council wanted to ensure that conditions were created that would:

1) maximize access to care and insurance for all consumers;
2) ensure that services were affordable across the state; and
3) costs were contained for providers offering products to consumers.

At the June 15th meeting a number of issues and questions were raised, as they were at subsequent meetings in July, August and September. These questions and requests for data analysis were made of DOI staff, who indicated whether they could be achieved within the timeframe that the Council was meeting, in advance and by each subsequent meeting as they moved forward with their process. The Council consistently received information from the DOI staff as per its requests. Findings from the data analyses requests were presented toward the beginning of public meetings, with a review of the questions that had been asked, and in relation to any recommendations that were currently under consideration at each meeting. As will be seen in the rationale and criteria section, the Council believed that many of its decisions were restricted based on the available data that it was able to get analyzed and presented at their meetings. This was not a reflection on the DOI staff and their willingness to do analyses with the data that was collected through the annual data collection process of network submissions. It did, however, reflect an absence of specific data that would allow the Council to make decisions with confidence. Specifically, the Council felt the available data limited their confidence and ability to: 1) make some recommendations that aligned with its vision and 2) consider what

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the implications of such recommendations might be on the three conditions it had established as requisites for achieving its vision. This will be discussed more fully in the section following the recommended standards.

A total of five public meetings were conducted with the final and fifth meeting being held to review and approve the final report with its recommendations for standards and future considerations for submission and review by the Commissioner of Insurance on September 15, 2016.

June 15th – this initial meeting laid out the vision and process the Council would adhere to in subsequent sessions, using a workshop format. With its facilitator, the Council established agreements for how it would make decisions, communicate, and consider multiple perspectives, both within the Council and from the public.

July 22nd –the second meeting involved the process whereby, after receiving a presentation on the findings from the data requests made during the June 15th meeting, the Council generated a series of nine recommendations and/or considerations and held a discussion regarding the value, feasibility and practicality of each of each of these. A mock vote was taken to consider where Council members were/were not in agreement, and whether there was a clear majority for certain recommendations.

August 1st- during the third meeting the Council was presented with additional findings from data analyses requested at the July 22nd meeting and considered the recommendations it had put forth with this new information. The Council was able to use and reflect on the findings to eliminate some of the recommendations it had made earlier.

August 17th- *to be completed*

September 12th- *to be completed*

Council's Recommendations for Plan Year 2018.

This report reflects the status of the August 1, 2016 NAAC meeting, with additional data requests being analyzed in preparation for the August 17th meeting. The CMS template presented below establishes a floor that cannot be altered. The Council is considering two additional standards as placeholders until it receives additional findings that would suggest that this is not only feasible, but will not have negative impacts on the number of people insured by networks, nor will it affect choices that consumers currently have for insurance products. In addition, the Council is placing a restriction on the reporting definition of hospitals as a facility in the CMS template. Two of three recommendations are starred in the existing template below:

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1. Add pediatrics as a separate provider category with modification to time/distance criteria.
2. Increase the % of ECPs in the network from the current 30% required by CMS.
3. Use the Bureau of Health Care Quality and Compliance (BHCQC) definition for a licensed hospital in Nevada (**NRS 449.012 "Hospital" defined.** "Hospital" means an establishment for the diagnosis, care and treatment of human illness, including care available 24 hours each day from persons licensed to practice professional nursing who are under the direction of a physician, services of a medical laboratory and medical, radiological, dietary and pharmaceutical services) as the network adequacy definition for a hospital facility (codes designated as 040/043 in the CMS Network Adequacy Template must adhere to these guidelines).

Again, the first two are considered as placeholders, only until the information is presented on 8/17/16 about:

a) time and distance thresholds for accessing Pediatric services in each service area;
b) and current information on the baseline levels of the percent of ECPs in each of Nevada's networks is analyzed along with guidance from California and Medicaid regarding their methodology.

The Council will proceed on August 17, 2016 to consider any public input from August 1 and previous meetings, and any posts on the website where this draft is posted. They will also consider feedback from their constituents as they present the discussion and recommendations thus far.

With that additional information on August 17th, insofar as possible, the Council will finalize a set of recommendations and move those forward for final approval on September 12th when this report will be finalized. This may also warrant, with the presentation on September 12th of findings from additional information requests made during their August 17th meeting, some modifications to the final report of recommendations.

It is important to note that as part of the process, NAAC members were the Council is well aware that the plan year 2017 standards, while they reference some Nevada regulations laws, are largely requirements of CMS. These have not yet been implemented nor has data been collected to determine whether this level of network adequacy can be met and what the consequences of delivering services under the plan year 2017 standards will yield. That said, if neither of the Council's two recommendations meet with its approval, the Council discussed retaining the standards as presented for 2017 and to continue to meet over the course of the next year as new data and new methodology are explored to determine what additional standards can be imposed.

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2018 Recommended ECP/Network Adequacy Template

	Specialty		Metro		Micro		Rural		CEAC	
		Specialty Codes	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)
Provider	Primary Care	001,002,003,005, & 006	15	10	30	20	40	30	70	60
	Endocrinology	12	60	40	100	75	110	90	145	130
	Infectious Diseases	17	60	40	100	75	110	90	145	130
	Mental Health	029, 102, & 103	45	30	60	45	75	60	110	100
	Oncology - Medical/Surgical	21	45	30	60	45	75	60	110	100
	Oncology - Radiation/Radiology	22	60	40	100	75	110	90	145	130
	Rheumatology	31	60	40	100	75	110	90	145	130
	Pediatrics*	101								

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	Specialty		Metro		Micro		Rural		CEAC	
		Specialty Codes	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)
Facility	Hospitals**	040 & 043	45	30	80	60	75	60	110	100
Facility	Outpatient Dialysis	44	45	30	80	60	90	75	125	110

*Place Holder for Pediatrics as a separate category (based on findings from analyses on what modifications would be needed to time/distance criteria to insure networks can meet the standard); or as a provider type within Primary Care;
**Follow the BHCQCL definition of hospitals and distinguish urgent care from hospitals

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Rationale and Criteria for Recommended Standards. The recommendations above are based on extensive discussion by the Council related to whether these 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, and wherever possible, expand the number of insured. Going forward, the Council agrees to maintain service areas as the geographic criteria for establishing network adequacy. County level data revealed that in many counties, network adequacy standards could not be met, based on the CMS floor for required provider categories and facilities. Further, the risk of carriers dropping coverage for a particular county, or withdrawing products from consumers was too great at this time to warrant a county level criteria for network adequacy.

The rationale for including pediatric services as either a stand-alone category or a provider type within the Primary Care category is based on the fact that state statute (AB 162) requires insurance policies and plans to provide an option of coverage for screening and treatment of autism; the Council perceived that meeting this law would be challenging without a parallel standard to insure pediatricians are made available to consumers. Current time and distance criteria presented by DOI staff indicated that in two service areas, pediatrics did not meet these requirements. Therefore, the Council agrees that along with this recommendation it will also adjust the time/distance criteria to the level where networks in all four service areas can meet the requirement. Therefore, the recommendation is a placeholder pending presentation of the level required for adjusting these criteria for all four service areas to meet the standard.

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The rationale for including a potential increase in in-network ECPs was based on several points of consideration. Currently a carrier must:

- Contract with at least 30% of available Essential Community Providers (ECP) in each plans' 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.

The data presented by DOI staff indicate that initial ECP contracting rates achieved the 30% level required by CMS in three of four carriers they examined. Currently, all carriers meet the 30% requirement based on the most recent annual data collection/submission, although the data has not been analyzed in a manner that could be presented to validate this claim (*Data analysis request to be presented at 8/17/16 meeting)*. All carriers have offered contracts in good faith to at least one ECP in each category in each county in the service area.

Initial contracting rates for the three carriers that met the 30% rate actually achieved a 73% level for ECPs contracted across plans. Given that the ECP contracting rate is well over the 30% requirement for three of the four carriers, the

Council believes that the level should be raised. Concern was raised over the lack of diversity of ECPs contracted. There are six categories of ECPs—Family Planning; 2) Federally Qualified Health Centers (FQHCs); 3) Hospitals; 4) Indian provider; 5) Ryan White; and 6) Other ECP Providers such as STD clinics, TB clinics, Community Health Centers, Rural Health Clinics, and other entities serving predominantly low-income, medically underserved individuals. However, only one category is represented in the average percent rate for contracted ECPs: FQHCs. ECPs are available in each of the six categories across service areas and plans, but none of those, aside from the FQHCs, have agreed to become in-network providers for any of the carriers. The Council views ECPs as being an important access point for linking consumers to primary care, particularly in the rural areas. In Nevada both exchange and non-exchange carriers must meet this standard, whereas the federal ECP standard is for on-exchange carriers only. Before it agrees to increase the percent above 30%, the Council wants to know the baseline (current vs. initial) for both exchange and non-exchange carriers. It also needs to consult with two sources that have a higher standard to learn about their methodology: California's Network Adequacy Standards and Medicaid/MCO.

Finally, although not a new standard, the Council did recommend that for purposes of establishing network adequacy, hospitals as listed under the facility category in the CMS template should refer to a licensed hospital in Nevada. The Network Adequacy Standards CMS template should utilize the same definition of "Hospital" as the Bureau of Health Care Quality and Compliance (BHCQC), with urgent care being distinguished from hospitals in the standards. Instructions should be added to the template to make it clear that carriers only report hospitals that are licensed in Nevada (040/043 must adhere to these guidelines).

<u>Future Considerations.</u> Throughout the meetings, the Council brought up issues regarding the data that is available to the Division of Insurance staff and other regulatory bodies or departments within the state of Nevada. The primary consideration regarding existing data is that it is inadequate for calculating the true impact of the Council's decisions to improve network adequacy on the key conditions the Council believes must be in place to ensure improvements don't have unintended negative consequences. Specific considerations for future action were recommended to adequately prepare the Council and give it a better understanding of what additional standards might be added in 2019 and beyond. The timeframe for making recommendations for plan year 2018 was significantly restricted, therefore the members, first and foremost, believe that it is critical to establish an ongoing meeting schedule where it is ready to respond to new CMS changes as information becomes available. In addition, the following considerations were put forth:

1) Explore whether data can be collected from other state departments or sources or added as categories of information to existing network submission forms for understanding what access/adequacy issues are at stake:
    a. Wait time

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    b. Provider/enrollee ratios (determining what provider categories in addition to primary care would be a meaningful addition)
2) Identify and operationalize opportunities for providers to systematically report on data useful to the Council.
3) Look to other states: what is and isn't successful?
4) Look at existing network adequacy across the state for all the different requirements imposed by different regulatory bodies (i.e., Medicaid/Medicare/ fully insured non-ACA products, etc.) to determine whether these might be aligned under a unified system of standards and requirements.
5) Work closely with other entities to stay informed about and advocate for workforce development in critical provider categories required for network adequacy.
6) Examine the impacts of different regulations on the insurance marketplace and identify what types of services and products are available in Nevada—and where they aren't available.
7) Work toward a data collection system that more adequately represents provider counts based on the Full-Time Equivalent of employed staff (FTE) or their 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). For example, there are 417 licensed pediatricians in the state but over 1200 count on plans; the same is true for psychiatrists.
8) Work with network carriers to obtain more frequent data on provider availability (open/closed panels) as they are improving their own infrastructure and on-line data collection systems, so that the information upon which the Council bases its decisions is more current.
9) Explore what is contributing to why only one of six categories of ECPs are being included in networks, when these provider types are seen as critical links to primary care for so many consumers, particularly in rural areas.
10) Recommend working with other state departments to:
    a. obtain regular consumer feedback on whether they consider other providers to be part of their safety net (home health; pulmonary; gastro; Cardio-Vascular Disease) as well as to their overall health and wellness, and
    b. provide validation of access/availability data such as that obtained by the secret shopper survey.
11) Include a statement on the Declaration Document that will break out psychiatrists from other mental health providers.

Overall, the spirit of these recommendations for future considerations is given with the expectation that more adequate methods for collecting specific data will allow the Council to make data-driven decisions that align with its vision and conditions for improved network adequacy as well as validate network adequacy standards as they are implemented. For the Council to operate in this manner, the capacity of the Division of Insurance staff to collect, analyze and report on data in a timely manner may need to be examined and adjusted to meet this expectation.

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