Report on the Plan Year 2019 Recommendations For Network Adequacy Standards

Presented by:
The Network Adequacy Advisory Council

To:
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Network Adequacy Standards for Plan Year 2019

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

1) Commencement of the 2017 meetings of the Network Adequacy Advisory Council (heretofore referred to as Council or NAAC)
2) Process of 2017 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 met first on February 13, 2017 as dictated by regulation RO49-14 and continued to meet through September 11, 2017 to finalize the recommendations for Plan Year 2019. The Council recommends these standards to achieve network adequacy for individual and small employer group health benefit plans.

At the June 20, 2017 meeting the Council revisited and refined its vision for what it hoped to achieve during the 2017 sessions. 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[1] to care
4. Access to 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.

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

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. It should be noted that, as with their meetings in 2016, the DOI was unable to provide some of the data that was requested by the Council. 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 this Report that will be submitted to the Commissioner of Insurance on September 15, 2017.[2]

February 13th- At this meeting, the DOI reviewed the network adequacy standards for plan year 2018 and a schedule of meetings was introduced and approved by the Council. The May 2017 meeting was cancelled based on the fact that no new data was available at that time for the Council to review and formulate initial recommendations for plan year 2019.

June 20th – At this meeting, the Council reviewed the vision and process for subsequent sessions, using a workshop format. The Council received an update of changes at the Federal and State level which impact Nevada's network adequacy standards. The Council requested that specific data be reviewed at the July 21st meeting, including a comparison of the Plan year 2017 and 2018 insurance markets for individual and small group plans, and a review of the changes to the Essential Community Providers given the lowering of the percentage by CMS from 30% to 20% minimums.

July 21st –At this meeting, the Council reviewed the data requested at the June 20th meeting. The Council considered the impact of this information and made the decision to retain the 2018 standards for 2019, with the caveat that it specify that metrics listed in the chart be retained, regardless of any lowering of the standard by CMS. The Council deferred any final recommendations and justifications until additional data was reviewed at the August 17th meeting.

August 17th –At this meeting, the DOI presented the Council with additional findings from data analyses requested at the July 21st meeting. The Council reviewed, confirmed their decision related to the standards, and reviewed and revised the first draft of this Report. The Council also created X recommendations, for inclusion in the final draft of the report.

September 11th – At this meeting, the Council approved the final Report.

[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.

Council's Recommendation for Plan Year 2019.

From the outset, as with plan year 2017, the Council has been aware of the fact that plan year 2018 standards are largely requirements mandated by Centers for Medicare & Medicaid Services (CMS). Any proposed changes to future standards must consider the ability of carriers to meet any changes to existing standards. The Council acknowledged that the current market was unstable, and that making any major changes would potentially have unintended consequences that might significantly reduce the conditions they had committed to create at their June 20th meeting (see above).

Changes to plan year 2018 standards for the proposed 2019 plan year continue to be impacted by the absence of better and more comprehensive data. The Council's ability to make decisions from DOI's analysis and presentation is hampered by the ongoing gaps in what and how data is collected by various entities, which restricts their ability to accurately evaluate the impact of any proposed changes to network adequacy standards. Of particular note during the 2017 meeting series were the gaps in tracking and monitoring. For example, gaps were noted in: # of carriers and categories served by telemedicine; wait time and time to first visit for urgent or primary care requests (currently collected only for Medicaid patients and providers), and other items not included on the Declaration Documents.

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

1. Retain the plan year 2018 standards as originally recommended by the Council with no further modifications in metrics;
2. Return to the standard of 30% (the original CMS minimum standard for 2018) for Essential Community Providers (ECPs) as represented in their 2018 plan year recommendations, for the plan year 2019 in order to maintain consistency with the decision of the Council in September 2017.
3. All metrics noted in the plan year 2019 chart should be followed, regardless of any *reductions* in the minimums that CMS might make once the plan is adopted.

The current NAAC recommendation for 2019 would be equivalent to the requirements outlined in the CMS call letter for 2019, with the exception of retaining the 30% standard for ECPs.

The Plan Year 2019 Recommendations are noted below in the Network Adequacy Time/Distance Standards Chart.

[3] The recommendation was based on a Council vote with nine in favor

Specialty	Network Adequacy Time/Distance Standards : Plan Year 2019 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
Mental Health	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 and distance metrics.							
Plan Year 2019 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
- Expansion of the number of insured

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 and reality 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. Going forward, the Council agrees to maintain service areas as the geographic criteria for establishing network adequacy. (*needs to be verified at 8/17 meeting)*

The rationale for including and retaining pediatric services in the plan year 2019 standards as a stand-alone category was based on state statute that requires insurance policies and plans to provide an option of coverage for screening and treatment of autism and the importance of pediatrics as a stand-alone category as an essential provider of primary care for children. The Council agreed that along with the recommendation to include it as a stand-alone category, it would also adjust the time/distance criteria to the level where networks in all four service areas could meet the requirement. There was no perceived change in the rationale for this standard during the plan year 2019 review.

The Council made a decision to meet the 30% minimum standard for ECPs based on data indicating that all carriers met or exceeded that level for plan year 2018. The data indicated that this was also true for 2019. Therefore, the Council voted to return to and maintain the 30% standard even though CMS had lowered the standard to 20%, in order to be consistent in their recommendations and with the data's indication of capacity of carriers to meet this standard.

Finally, the Council voted to recommend that the specified metrics in the standards chart be met, regardless of whether CMS reduced these standards, since the data they reviewed and that was the basis for their recommendations supported the proposed standards.

Future Considerations. Throughout the meetings, the Council identified numerous data and definitional issues associated with the assessment of existing standards,

not to mention proposed changes to those standards. The primary concern with existing data is that it is inadequate for calculating the true impact of decisions to improve network adequacy and not have unintended negative consequences. Considerations for future action were discussed to prepare the Council with a better understanding of what additional standards might be added in 2020 and beyond. 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 (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.
2) Identify and operationalize opportunities for providers to systematically report on data useful to the Council.
3) 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-Affordable Care Act (ACA) products).
4) Advocate for workforce development in critical provider categories required for network adequacy.
5) Examine the impact of Network Adequacy regulations on the insurance market place for 2018 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 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).
7) Improve data on provider availability on open/closed panels.
8) Further explore network adequacy as it pertains to Essential Community Providers (ECPs).
9) Explore further network adequacy of mental health and the necessity of separating out psychiatrists from other mental health professionals, given that psychiatrists are the only mental health professionals able to prescribe medication.
10) Request that the DOI provide a description of the existing data collected, their definitions, and how they are validated, if at all. Present this information at the first meeting of the 2020 plan year.

Note: Highlighted areas were either discussed in 2017 and identified as decisions, further considerations for plan year 2018, or were tentatively identified during 2018 meetings for plan year 2019. These need to be reviewed and confirmed or excluded in the plan year 2019 report of recommendations.

Appendix:
Draft Minutes from NAAC Meetings:
February 13th, June 20th, July 21st, August 17th and September 11th