Report on the Plan Year 2018 Recommendations For Network Adequacy Standards

Presented by:
The Network Adequacy Advisory Council

To:
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Nevada Division of Insurance

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August 24, 2016

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

1) Commencement of the Network Adequacy Advisory Council (heretofore referred to as 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 health insurance carriers. The Council met first on June 15, 2016 as dictated by regulation RO49-14 and continued to meet through September 12, 2016 to finalize the recommendations for Plan Year 2018. The Council recommends these standards to achieve network adequacy for individual and small employer group health benefit plans.

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

- 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 are affordable across the state.
3) Costs are contained for insurance carriers offering products to consumers.

The data that the 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 three conditions it had established as requisites for achieving its vision. It should be noted that 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 standard.

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, 2016.[1]

> June 15th – At this meeting the Council laid out the vision and process for subsequent sessions, using a workshop format. The Council established agreements for decision-making, communication, and consideration of multiple perspectives, from both within the Council and from the public.

[1] 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.

July 22nd –At this meeting the Council reviewed the data requested. The Council generated a series of nine recommendations and/or considerations and discussed the value, feasibility and practicality of each.

August 1st –At this meeting, the DOI presented the Council with additional findings from data analyses requested at the July 22nd meeting. The Council considered the impact of this information on its nine recommendations. Based on new information the Council eliminated some of the earlier recommendations.

August 17th –At this meeting the DOE presented the Council with additional findings from data analyses requested at the August 1st meeting and the Council reconsidered the recommendations given this new information. The Council reviewed and revised the draft of this Report.

September 12th – At this meeting, the Council created and approved the final Report.

Council's Recommendation for Plan Year 2018.

From the outset, the Council has been aware of the fact that plan year 2017 standards are largely requirements mandated by CMS. Any proposed changes to future standards must consider the ability of carriers to meet any changes to existing standards. At a minimum, a complete assessment of the impact of existing standards and proposed changes to plan year 2018 standards will require better data and a more comprehensive methodological approach to evaluating the impact of all network adequacy standards.

With these caveats, the Council recommends the following:[2]

1. Add pediatrics as a separate provider category with modification to time/distance criteria: changing METRO to 25 minutes/15 miles and CEAC to 105 minutes/90 miles.

The current NAAC recommendation for 2018 would be in addition to the requirements outlined in the CMS call letter for 2018.

[2] The recommendation was based on a majority vote

2017 Network Adequacy Template based on CMS 2016 Call Letter

	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 (recommended to be added in 2018)	*101*	*25*	*15*	*30*	*20*	*40*	*30*	*105*	*90*
Facility	Hospitals	040 & 043	45	30	80	60	75	60	110	100
	Outpatient Dialysis	44	45	30	80	60	90	75	125	110

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

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 a stand-alone category is 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 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 the recommendation to include it as a stand-alone category, it will also adjust the time/distance criteria to the level where networks in all four service areas can meet the requirement.

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 2019 and beyond. The timeframe for making recommendations for plan year 2018 was shortened, therefore the members believe it is critical to establish an ongoing meeting schedule to respond to 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

   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 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.).
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 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).
7) Improve data on provider availability on open/closed panels.
8) Further explore network adequacy as it pertains to ECP's.
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 2019 plan year.