Report on the Plan Year 2022 Recommendations for Network Adequacy Standards

Presented by:
The Network Adequacy Advisory Council

To: Barbara Richardson
Commissioner of Insurance, Nevada Division of Insurance

Prepared by: Jeremey Gladstone
Division of Insurance

September __, 2020

Table of Contents

NAAC Recommendations for Network Adequacy Standards for Plan Year 2022

Overview of the NAAC Recommendations Process.

This section includes a description of the:

1) Commencement of the Plan Year 2022 meetings of the Network Adequacy Advisory Council (hereinafter referred to as "Council" or "NAAC")
2) Process of Plan Year 2022 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 2022 was held on March 12, 2020 (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 2020, to finalize the recommendations of network adequacy standards for Plan Year 2022. The Council recommends these standards to achieve network adequacy for individual and small employer group health benefit plans.

At the March 12, 2020, meeting, the Council revisited its vision for what it hoped to achieve during the Plan Year 2022 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. Educate 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. Contribute to health literacy: transparent to consumer.
8. Provided care that is culturally and linguistically appropriate.
9. Influenced the other 93% of non-regulated plans.

The data that the Nevada Division of Insurance (Division) 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 Division and other relevant parties. It should be noted that the Council continues to seek data which would provide greater insights into patient access and network adequacy in Nevada.

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

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 or before September 15, 2019.[2]

March 12th – At this meeting, the Division reviewed the network adequacy standards for Plan Year 2021. A presentation on Health Workforce Supply and Demand was made by M. Tabor Griswold, PhD, Director, Health Workforce Research, University of Nevada, Reno School of Medicine. The Council reviewed and confirmed their vision and future considerations from last year's meetings. The Council discussed possible standards for plan year 2022 and brainstormed metrics and data that they would like to review in considering potential standards. The discussion included: telehealth as an option to address provider shortages, geographic criteria and adequacy of other specialties in the network adequacy template, and coordination with the Patient Protection Commission. The Council discussed additional information they would like to see before putting forth any recommendations.

June 11th – At this meeting, the Council reviewed the vision and agreements. Jeremey Gladstone from the Division of Insurance discussed the findings of the time and distance analysis for the additional provider specialties included in the network adequacy template. Further discussion included possible recommendations for plan year 2022 and the data they would like the Division to present for future meetings for consideration prior to making any recommendations. There was discussion by some of the members to maintain the current standards given the current situation with the COVID-19 pandemic and the lack of data to support additional standards.

July 9th –

August 13th –

September 10th –

Council's Recommendation for Plan Year 2022.

From the outset, as with prior years, the Council expressed that any proposed changes to Plan Year 2022 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 changes or reconsideration of existing criteria and standards. Generally, the same number of carriers are offering plans, although there has been a reduction in the health plans and products.

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

[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.

evaluate the impact of any proposed changes to network adequacy standards. As with their discussion and review in past years, 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 maintaining the current network adequacy regulations as adopted by the state in regulation R067-19 and adding additional standards for dental network plans. Specifically, the Council recommends the following:[3]

[3] Council vote was _____ for plan year 2022.

The Plan Year 2022 Recommendations are noted below in the Network Adequacy Time/Distance Standards Chart.

Specialty	Network Adequacy Time/Distance Standards : Plan Year 2022 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
Psychiatrists	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 2022 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								
Offer contracts in good faith to all available ECPs in all counties designated as Counties with Extreme Access Considerations (CEAC)								

The Plan Year 2022 Recommendations are noted below in the Dental Network Adequacy Time/Distance Standards Chart.

Specialty	Network Adequacy Time/Distance Standards : Plan Year 2022 Recommendations					
	Metro/Micro		Rural		CEAC	
	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)
General Dentist	15	10	30	20	40	30
Periodontist	60	40	100	75	110	90
Orthodontist	60	40	100	75	110	90
Adequacy Requirement	90% of the population in a service area must have access to at least one of each of these specialties types with in the specified time or distance					
Plan Year 2022 Standards for ECPs:						
Contract with at least 20% 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						

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

Future Considerations.

Throughout the meetings, the Council discussed numerous issues associated with the assessment of existing standards, including the absence of 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 not deemed sufficiently robust nor accurate to warrant changes in network adequacy standards without the possibility of incurring unintended negative consequences. Division staff clarified that to achieve accuracy along the standards of interest to the council (i.e., wait time; provider ratios), the universe of all possible carriers and insurers in the state needs to be considered.

Considerations for future action were discussed to prepare the Council with a better understanding of what additional standards might be added for Plan Year 2022 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) Identify opportunities for providers and licensing agencies to systematically report on data useful to the Council.
    a. Support efforts to develop a provider database similar to what was proposed in the 2019 Legislation under SB 170 and determine the impact this type of database could have on the Council's charge

2) Improve Workforce data to support the work and decisions of the Network Adequacy Advisory Council (e.g., Provider FTEs for patient care within network). Potential sources of data:
    a. NV Bureau of Health Care and Quality Compliance (Facilities Data)
    b. NV State Board of Medical Examiners, NV State Board of Nursing, and other NV State Boards of licensing for various providers

3) Work on building a communication channel with Governor's Patient Protection Commission ("Commission") and other similar task forces to allow for collaboration and to ensure consistency in data and to minimize duplication of efforts.

4) Review and consider other metrics for the determination of network adequacy e.g. appointments wait times, provider enrollee ratios, etc.

a. Continue reviewing existing network adequacy models used by other state agencies and federal agencies
b. If feasible research the metrics and standards currently required by carriers when contracting with providers

5) Support efforts to expand the development of the health workforce in critical provider categories required for network adequacy.

6) Examine the impact of network adequacy regulations on the insurance market place (i.e., # of carriers, # of products and consumer costs) for Plan Year 2021 and beyond.

7) Improve data on provider availability on open/closed panels.

Appendix:

Minutes from NAAC Meetings:

March 12th, June 11th, July 9th, August 13th and September 10th