Network Adequacy & Exchanges

How delivery system reform and technology may change how we evaluate health plan provider networks

Emerging technologies, models of care and changes in provider payments that can enhance access to high quality care may allow rethinking of how to judge whether health plans have robust provider networks. The Affordable Care Act calls for health plans serving Exchanges to meet standards for network adequacy. As states and the federal government implement this requirement, they should support innovations in furnishing care while maintaining focus where it belongs – ensuring consumer access.

Traditional network adequacy standards, which vary among different regulators, are usually tied to the fee-for-service visit-based model of care. For example, 'time and distance' standards – especially common in Medicaid and Medicare managed care programs – that assess how far people must go to receive treatment are based on the premise that care is delivered in a face-to-face office visit.

For many services that model is changing. Conversations are being moved from an in-person discussion to the computer or other technologies. Some care is being transferred from the hospital (or nursing facility) to the home. In addition:

- Medicare and other payers are supporting providers' use of electronic means of communication (such as email and phone calls), and team-based care to improve communication, reduce unnecessary services and improve both access and quality.
- Telemedicine is bringing care (e.g., remote monitoring and video conferencing) to areas where provider networks heretofore have not sufficed.
- Urgent care centers and minute clinics are providing high quality, easy-to-access care.
- Other new initiatives are building high-quality specialty care expertise (or making specialty care accessible) in rural primary care practices.
- Many payers are moving towards value-based purchasing to promote providers who deliver high quality, efficient patient-centered care over low quality, inefficient providers. They are also rewarding team-based approaches to care that could have non-physician providers furnishing services, including care coordination.
- Using peers as care coordinators and as coaches is becoming common in the behavioral health world. Peers are persons with a lived experience (i.e. someone who has been treated for a behavioral health problem). They help patients coordinate their care and keep them on track, which can help reduce unnecessary hospitalizations.

These innovations can improve access to and the quality of care. In particular, they may help address the primary care provider shortage that could be worsened by the influx of new patients in 2014. Yet there is so far no consensus on how to incorporate them into assessments of network adequacy.

We recommend that regulators and other stakeholders explore how to account for new models of care and the growing trend to address beneficiary issues via non-face-to-face encounters. It may be time to move beyond traditional, more prescriptive requirements that freeze in place old models when new models can offer better patient access, better experience and more cost effective care. Instead of

relying on time and distance standards, regulators could focus more on information from patients regarding their expectations about access as well as their experience of care.

Network Adequacy Standards

Many health plans are required to meet network adequacy standards set by applicable regulatory and accrediting bodies. Generally speaking, regulatory standards now focus simply on whether "enough" providers and facilities are included in the network based on prevalent norms.

Commercial – Most commercial health insurance is regulated at the state level and most states have set minimum standards for network adequacy, although their approaches vary.[1] Many have set broad standards, requiring plans to have a "robust" or "sufficient" network but do not get into specifics. States often require plans to provide members with a list of in-network providers to help them find care. However, they typically do not set guidelines for whether the list must indicate whether a provider is taking new patients or how often the list needs to be updated.

Medicaid – States also set network adequacy requirements for Medicaid managed care plans. These tend to be more specific than those for commercial plans due to concerns about more vulnerable populations and weaker access because of low payment to providers.[2] States often require plans to contract with certain providers, like Federally Qualified Health Centers and, if they cover long-term care benefits, certified nursing facilities. Medicaid standards also reflect fears that providers often make Medicaid patients wait longer for care than patients with more generous insurance. To address this, some states have implemented "in-office wait time" standards that require plans to monitor the time that beneficiaries wait to receive care once they arrive at a provider's location.

Medicare Advantage – The Centers for Medicare and Medicaid Services (CMS) sets network adequacy requirements for Medicare Advantage. Medicare Advantage plans are required to have enough providers in their network to ensure that beneficiaries can access care within specific 'time and distance' requirements. These time and distance rules vary substantially by specialty and county based on the number of beneficiaries and type of region (Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations). Medicare Advantage plans cannot serve areas where they do not meet these standards, unless they successfully petition CMS.

Monitoring

Approaches for monitoring plan compliance with network adequacy standards also vary among regulators. Before Medicare Advantage plans can open their doors for business, CMS requires them to submit a list of network providers that is evaluated against CMS' standards. As noted above, Medicare Advantage plans cannot serve areas where they do not meet the standards, unless they successfully petition CMS to create an exception.

Many states require commercial plans to submit access plans when applying for licensure, certification or upon any material change to the network. States also monitor beneficiary complaints about the availability of and access to providers and require plans to notify members if there is a network change that will affect their care.

[1] Self-insured plans are regulated by the Department of Labor.

[2] A recent national study in Health Affairs (31, no.8 (2012):1673-1679) noted that roughly one-third of physicians said they would not accept new Medicaid patients.

For Medicaid plans, some states require Medicaid plans to submit "Geo Mapping" of their in-network providers as part of their annual reports. However, Geo Mapping does not address providers' quality of care, assess whether providers offer electronic access, or tell whether they are accepting new patients from Medicaid or other insurers. States may also conduct secret shopper reviews, where faux-beneficiaries call providers to see if and how quickly they can get an appointment.

Quality Rarely Considered

Current network adequacy standards put a premium on the number of providers in a plan's network. They rarely address whether those in-network providers are high quality or offer expanded access. This can make it difficult for plans to develop products with smaller networks that promote access to high quality low cost providers, but limit access to poor quality high cost providers.

In addition, standards usually do not address whether contracted providers are taking new patients, which can create barriers to access for consumers seeking care. Exchanges have an opportunity to confront this problem, but it will be challenging. Under the Affordable Care Act, QHP Issuers are required to submit a copy of their provider directory to the Exchanges, and to potential enrollees in hard copy upon request. The directory must identify whether those providers are taking new patients.[3] Unfortunately, providers can change their mind on whether to accept new patients and they don't always notify the impacted health plan, which, as a result, can't notify its impacted members. This reality could complicate efforts by QHPs and Exchanges to help consumers find providers that are open for business.

Evolving Trends in Access and Moving Beyond Visit-Based Care

Promising initiatives are showing different ways to expand provider capacity and improve quality while reducing the need for patients to travel long distances and or wait for long periods of time to get care. Given the anticipated shortage of primary care providers once people obtain health coverage through Exchanges, we advocate for more flexible network adequacy standards that support innovation while closely monitoring patient experience – and taking action to work with plans to address access problems when they arise.

- ***New approaches to communication and team-based care:*** Medicare and commercial plans are exploring ways to support care delivered outside of face-to-face visits, including helping providers communicate with patients by phone and email. Many providers have started using electronic medical records with online portals that enable patients to easily look up and share their health information. Payers are also expanding support for coordinating care among providers and facilities so patients don't fall through the cracks when moving between care settings. Most recently, Medicare proposed to pay primary care providers for coordinating a patient's care when they transition out of the hospital.[4]

- ***Spreading specialist expertise:*** Project ECHO (Extension for Community Healthcare Outcomes), a University of New Mexico School of Medicine initiative, connects urban specialists with rural general practitioners using telemedicine to co-manage complex patients. Over time, the general practitioners develop expertise to manage the complex patients on their own. Project ECHO has shown that patient outcomes in the rural primary care practices are similar to those achieved in

[3] 45 CFR § 156.230

[4] Medicare Physician Fee Schedule Proposed Rule (https://www.federalregister.gov/articles/2012/07/30/2012-16814/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-dme-face-to-face)

urban specialists' practices.[5] Molina, a New Mexico Medicaid managed care plan, is now reimbursing providers seeking specialty care consults through Project ECHO.[6] In another vote of confidence, the Department of Veterans Affairs recently launched a major pilot to broaden access to specialty pain care management using the ECHO model.[7]

- ***High quality intensive care via telemedicine***: Innovations have also spread to the hospital space, where many have embraced eICUs. Research indicates that ICU patients managed by specially-trained intensivists do better than patients managed by providers without that training.[8] However, intensivists are in short supply, especially in rural areas. eICUs bring the intensivists' expertise to rural intensive care units via video monitoring technology.

- ***'Skyping' therapists***: Web-based counseling is filling critical gaps in mental health care. Montana and Wyoming recently received a multi-million dollar grant for telepsychiatry services in underserved areas.[9] Kansas requires Medicaid plans to establish a telemedicine program for substance use disorder to improve rural access.[10] Even outside rural areas, therapists are opening up more convenient web-based practices.

- ***Bringing broadband to rural areas:*** Since 2006, the Federal Communications Commission (FCC) has led the Rural Health Care Pilot Program. The program funds projects that spread internet access and use telemedicine to connect rural providers with those in urban areas. In South Carolina, the Palmetto State Providers Network reported that its telepsychiatry program has made psychiatric consults available 24/7 and saved Medicaid $18 million dollars.[11]

Suggestions for Developing Exchange Network Adequacy Requirements

Regulators, plans and other stakeholders should consider the following as they look for ways to evolve network adequacy assessments.

- ***Focus on the beneficiary:*** No matter what network adequacy standards are put in place, it is a problem if beneficiaries cannot access a provider when they need care. That is why monitoring plan performance using CAHPS survey results is an important way to gauge whether plans provide adequate access. Using CAHPS will also allow Exchanges to compare the performance of plans across product lines to understand whether problems are broadly experienced rather than a reflection of a particular plan's network. How do Exchange QHPs compare to commercial (or Medicaid) plans outside the Exchange?

- ***A system in flux***: The delivery system is at various stages of evolution***.*** In some areas, many providers may be adopting new models; in others, providers may be relying on visit-based care. We hope innovations will continue to take hold and flourish. However, in areas where older models prevail, more structural network adequacy requirements may be in order but these should not be baked into regulations that cannot easily be changed over time. For example,

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[5] Arora S, Thornton K, Murata G, et al. Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers. N Engl J Med 2011;364:2199-2207

[6] http://echo.unm.edu/providers-partners/Molina.html

[7] http://telemedicinenews.blogspot.com/2012/07/spotlight-on-vas-scan-echo.html

[8] Pronovost PJ, Angus DC, Dorman T, Robinson KA, Dremsizov TT, Young TL. Physician staffing patterns and clinical outcomes in critically ill patients: a systematic review. JAMA. 2002; 288: 2151-62

[9] http://www.wyomingbusinessreport.com/article.asp?id=63890

[10] KanCare RFP available here: http://da.ks.gov/purch/default.htm

[11] http://transition.fcc.gov/Daily_Releases/Daily_Business/2012/db0813/DA-12-1332A1.pdf

requiring Medicaid Managed care plans to have in-office wait time standards in their provider contracts is still important to address disparities in treatment.

- ***Support delivery system innovation:*** Going forward, network adequacy standards (and other QHP certification criteria) should support, not inhibit, innovations needed to broaden access. Traditional time and distance standards are based on the premise that care is delivered via a face-to-face office visit. In many systems, that model is changing. Embracing team-based care and telemedicine will help improve access, lower costs and improve quality.

- ***Quality, not quantity:*** Tiered networks, narrow networks and other forms of value-based purchasing encourage the use of high value providers and facilities. They also discourage using poor quality providers and services which evidence has shown to be ineffective. Network adequacy standards should account for these arrangements while protecting consumers (via ongoing oversight, assessment and contract enforcement with meaningful sanctions) against crude cost-sharing techniques that limit access to needed care.

- ***Chance to improve CAHPS®:*** Under the Affordable Care Act, the Secretary is tasked with developing an enrollee satisfaction survey for Exchanges.[12] This creates an important opportunity to build on the CAHPS survey to make it more Exchange-focused, and expand the sections on access, availability and culturally-sensitive care. In addition, Exchanges that want to rely more on consumer experience data to gauge network adequacy could require plans to increase the frequency or sample size when CAHPS is administered.

- ***We need more providers, particularly in primary care and child psychiatry:*** The influx of patients in 2014 will put pressure on the already-stressed primary care and adolescent mental health infrastructure. Exchanges can work with QHP Issuers and other stakeholders to address this by exploring scope of practice rules, access to advance practice nurses, telehealth solutions and equity of payment issues. For a long term strategy, states could apply Tennessee's model, which requires Medicaid managed care plans to help the state proactively address provider shortages by working with local colleges and technical schools.[13]

Consumer Assessment of Health Plan Providers and Systems (CAHPS) Survey and Network Adequacy

The CAHPS survey asks consumers themselves about their care. This consumer-reported information is perhaps the most important measure of network adequacy.

AHRQ has designed versions for both children and adults. Health plans typically hire a vendor to administer the surveys and NCQA requires accredited plans and plans submitting HEDIS data to use vendors that have been 'certified' to ensure their process is accurate.

The survey process works like this: health plan enrollees receive the survey via mail and are asked to complete it and mail it back. Some vendors may administer it over the phone and it takes consumers on average less than 20 minutes to complete. Two of the four questions on access to services in the CAHPS 4.0 Adult survey are:

- In the last 12 months, how often was it easy to get the care, tests or treatment you needed? (*Possible answers: Never, Sometimes, Usually, Always*)
- In the last 12 months, when you needed care right away, how often did you get care as soon as you needed? (*Possible answers: Never, Sometimes, Usually, Always*)

[12] PL 111-148, Section 1311(c)(4)
[13] TennCare Contract, Section 2.11.6.7 – Applies to long-term care providers

- ***Essential Community Providers*:** QHP Issuers must include "a sufficient number and geographic distribution" of essential community providers, such as Federally Qualified Health Centers, in their network.[14] Exchanges need to establish a process to verify QHP Issuers are in compliance with, at a minimum, federal requirements. NCQA does not currently review whether plans include essential community providers in their networks, but this may be included in future updates to our Health Plan Accreditation program.

- ***Provider directories:*** QHP Issuers must also make available a directory (list) of network providers to the Exchange and to potential enrollees. These directories have to identify providers that are no longer taking new patients. Since it can be challenging to keep this information up-to-date, Exchanges need to work with stakeholders to consider how frequently this information needs to be updated and how it might be incorporated into evaluating network adequacy. The difficulty keeping directories current also compounds the interest in collecting CAHPS results to monitor consumer satisfaction. NCQA recently added a requirement that accredited plans validate provider information (including contact information and insurance acceptance) annually.

- ***Resource constraints are a reality**:* Over the last several years, states facing budget shortfalls have reduced agency staffing to cut costs. This may impact the ability to effectively monitor plan compliance with network adequacy standards, especially if the state has specific time and distance requirements. Requiring plans to rely on NCQA review may be an option for states with resource constraints.

NCQA Standards

NCQA's Health Plan Accreditation program requires plans to develop reasonable standards for access and availability of services and measure themselves against those standards. More specifically, plans must develop standards for the number and geographic distribution of providers – including primary care, specialty care and behavioral health providers. Plans must also set standards on the ability of members to get care – including regular appointments, urgent care appointments, after hours care and member services by phone. They must collect data and analyze their performance against these standards using a statically valid methodology at least annually. [15]

Plans are also required to assess the cultural, ethnic, racial and linguistic needs of their members and adjust the availability of providers in their network, if necessary. This encourages plans to ensure members have access to providers that fit their preferences, critical for patient-centeredness and good quality.

We take the critical additional step of requiring plans to ask enrollees directly whether they have adequate access to care using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[16] survey. This is perhaps the most salient measure of network adequacy and helps address the question of whether network providers are actually seeing patients and not merely listed in a directory. The CAHPS survey is the most widely used tool to gauge consumer experience with their care.

States can use NCQA's standards as, or to support, state requirements.

[14] 45CFR § 156.230 / 45 CFR § 156.235
[15] NCQA Health Plan Accreditation Program, Standard: Quality Improvement 4 (QI 4), Quality Improvement 5 (QI5)
[16] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). The agency maintains and updates the survey.

Important Opportunity

Exchanges and other plan regulators have a challenging but important opportunity as they explore possible ways to modernize network adequacy requirements. The primary care provider shortage, evolving nature of technology, delivery system reforms and expanded coverage through Exchanges create an important opportunity to rethink these standards in ways that will improve quality and expand access. Policymakers and other stakeholders should consider how network adequacy requirements can be used to further access to providers that are high value (i.e. providing high quality at a lower cost). Promoting these and other innovations is critical to ensuring millions of new patients have somewhere to receive care in 2014.