Health Care Compliance Association
Managed Care Compliance Conference
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- Reasons for network narrowing trends
- Why regulators and others are concerned by these trends
- How regulators are responding with new requirements and oversight
- What can be learned from machine readable provider directory data
  - Trends in network size and composition
  - Health plans compared to each other
  - Health plans measured against new requirements
- Strategies for compliance oversight of health plan network adequacy

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How did we get here?
Here's what we know…

- Networks are narrowing
- The ACA accelerates this trend
- Narrow networks trend used by GOP during election as evidence of Obamacare failures
- Provider terminations aggrieve members and attract national attention
- Providers and advocates are mobilized and pushing for action
- Researchers showing unprecedented interest in provider networks

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Savings? Yes. But Narrow Health Networks Also Show Troubling Signs, *New York Times*, 10/17/16
Using a "secret shopper" approach, the study found that only about 30 percent of attempts for appointments with specific primary care doctors were successful. In about 15 percent of cases, the doctor did not accept the caller's plan, despite being listed in its directory. In nearly 20 percent of cases, the directory included the wrong phone number

Insurers Race to Avoid New Fines, *Wall Street Journal*, 12/28/15 New regulations allow the Centers for Medicare and Medicaid Services to *fine insurers* up to $25,000 per beneficiary for errors in Medicare Advantage plan directories and up to $100 per beneficiary for errors in plans sold on the federally run *insurance* exchanges in 37 states. States are imposing their own rules and sanctions.

As Provider Directory Fines near, Insurers Look for Ways to Improve, Update Them, *Healthcare Finance*, April 4, 2016 While healthcare provider directories have always been hard to maintain, new regulations can mean costly fines if insurers fail to keep accurate, up-to-date information on the physicians who are in their health plans… Payers found in violation of the CMS rules can also be banned from new enrollment and marketing.

Feds Find Doctor Listings Often Wrong In Medicare Advantage Directories, *Kaiser Health News,* 10/24/16
Regulators Urge Broader Health Networks, *New York Times*, 11/8/15
75% of ACA Plans in 18 States Will have Narrow Networks Next Year, *Becker's Hospital Review*, 9/1/16
Federal Officials to Warn Obamacare Customers of Narrow Networks, *The Hill*, 3/16/16
Narrow Networks are Here to Stay, *Huffington Post*, 3/25/16
How Narrow Is It? Gov't Begins Test Of Comparison Tool For Health Plan Networks, *Kaiser Health News*, 10/14/16
Half Of Obamacare Choices Are HMOs Or Narrow Network Plans, *Forbes*, 1/13/16
Regulation of Provider Networks, *Health Affairs*, 7/28/16

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- Five market study suggests that exchange plan networks have 1/3 fewer providers than employer plans in the same markets. (Avalere)
- A study of physician participation in 2015 exchange plans concluded that 41 percent of qualified health plans have "small" or "x-small" networks. (University of Pennsylvania)
- A study of hospital participation in 2015 exchange plans concluded that 55 percent of such plans have either "ultra-narrow," "narrow," or "tiered" hospital participation. (McKinsey)
- String of reports and opinion pieces in *JAMA* and *Health Affairs*

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Taking shots from all sides…

- Unflattering media attention
- Researchers are documenting narrowing
- Advocates are forwarding examples
- Legislators are sponsoring bills

The result is predictable… Provider network oversight will be hot in 2017 and types of inquiries will expand…

- Now: Adequacy – are there enough providers?
- Now: Accuracy – are consumer correctly informed of their providers?
- Coming: Competitor Breadth – how do networks look vs. each other?
- Coming: Stability – are networks fluctuating unusually?

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- "Slightly more than half of providers could not offer appointments to enrollees ."
- "35 percent could not be found at the location listed by the plan, and another 8 percent were at the location but said that they were not participating in the plan."
- "Over a quarter [of providers] had wait times of more than 1 month, and 10 percent had wait times longer than 2 months."
- "We recommend that CMS work with States to (1) assess the number of providers offering appointments and improve the accuracy of plan information, (2) ensure that plans' networks are adequate and meet the needs of their Medicaid managed care enrollees, and (3) ensure that plans are complying with existing State standards and assess whether additional standards are needed.
- "CMS concurred with all three of our recommendations."

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- GAO concludes: "The Administrator of CMS should augment oversight of MA networks to address provider availability, verify provider information submitted by MAOs, conduct more periodic reviews of MAO network information, and set minimum information requirements for MAO enrollee notification letters."
- "MA criteria do not reflect aspects of provider availability… MA provider networks may appear more robust than they actually are."
- "CMS does not require MAOs to routinely submit updated network information for review… CMS does not measure ongoing MAO networks against its current MA criteria."
- CMS given a chance to rebut the GAO's findings: "HHS concurred with the recommendations."

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- CA: Fines up to $600,000 for provider directory inaccuracies
- CMS fines national MA plan $1M for pharmacy directory errors
- Other States have issued smaller fines for not verifying providers are still in network and accepting new patients
- CMS is actively auditing provider directories in Medicare Advantage and Exchanges
  - Medicare Advantage provider directory error rate based on pilot - 45%

At least five lawsuits are pending against health plans for mis-representing provider access – one recently settled for $15M

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"CMS also remains committed to making provider directory requirements across CMS programs consistent. As such, the MA program is taking steps to harmonize the requirements and provide organizations that operate across multiple CMS programs consistency in the application of provider directory requirements. Currently among MA, QHPs and the Medicaid managed care programs, MA provides the least prescriptive provider directory requirements… The MA program also has the fewest data elements required for its provider directory." *–2017 Medicare Advantage and Part D Call Letter*

"We believe that provider directories are an extension of provider network management. We believe this clarification to the regulatory text is important since the provider directory requirements at §438.10(h) are new, and we want to ensure that states include these new requirements in the state's monitoring system… We note that the content and accuracy of provider directories have long been an issue of contention between states, managed care plans and stakeholders and that the move to electronic provision of this document should improve the accuracy of the information." *– Medicaid Managed Care Regulation (June 2016)*

CMS.gov
Centers for Medicare & Medicaid Services

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- Already in use in most Health Insurance exchanges
- Medicaid requirement for 2018
- Not required in Medicare Advantage, but…
  - In previous Call Letters CMS discussed a "national provider database"
  - In 2017 Call Letter, CMS spoke of machine readable directories as a good practice
  - Good chance of being required for 2018

Trend toward "Harmonization": new Medicare Advantage and Medicaid guidance discusses CMS desire to "harmonize" provider network standards and oversight across Medicare, Medicaid and the Exchanges. Generally, moving requirements to the strictest standard of the three.

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Network Adequacy:

- How to apply regulatory standards for provider networks based on product type -- HMO vs. EPO vs. PPO
- How to "count" non-preferred providers in tiered networks
- How to count telehealth providers
- How to account for growing scopes of practice – i.e, NPs and PAs providing primary care

Network Transparency:

- How to distinguish significant from de minimus directory errors
- How to set a "benchmark" error rate

Macro-Level Question:

- If satisfaction, value, and quality are high, can we live with narrowing networks and imperfect directories? What is an acceptable trade-off?

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- Provider networks will be among the hot compliance issues in 2017
  - Continued bad press around narrow networks
  - Cross market harmonization
- Researchers are looking at your directories and publishing results
- The Coming "Machine Readable Revolution"
  - Regulators can check your networks at any time
- CMS PRA package sets stage for regular MA network audits
- Providers, by and large, are not focused on the need to keep directories accurate – health plans will need to help them focus
- In short-run, the road ahead will be hard…
  - New rules, enforcement actions, fights w/ providers, unflattering reports
- In the long-run, more integrated ops and better market intelligence

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Examining Exchange Network Transparency Data

Implications for Measuring Network Breadth

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What do Exchange Provider Networks look like in 2016 and 2017?

Assessing Network Breadth on the Exchanges Using the Provider Participation Rate

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- CMS began requiring Qualified Health Plans (QHPs) in the Federally Facilitated Marketplace (FFM) to publish JSON machine-readable provider network files for the 2016 plan year.
  - Machine-readable ≠ usable
  - Machine-readable ≠ clean or complete
- NORC downloaded, aggregated, cleaned, and linked these JSON files with other QHP and provider files.
- NORC recently updated the dataset with the 2017 provider network data

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- The Provider Participation Rate (PPR) is the proportion of all providers in a given county in a given specialty that are participating in an issuer's network.
- A network with a PPR:
  - More than one standard deviation above the mean in the county is classified as broad;
  - More than one standard deviation below the mean is basic;
  - Everything in between classified as standard
- PPR is a relative, not absolute benchmark, allowing for even comparisons *within* counties but uneven ones *across* counties.
- CMS is piloting network classifications for plans on healthcare.gov for three specialties in 2017 (adult primary care, pediatric primary care, and hospital facilities) in four states (Maine, Ohio, Texas, and Tennessee).

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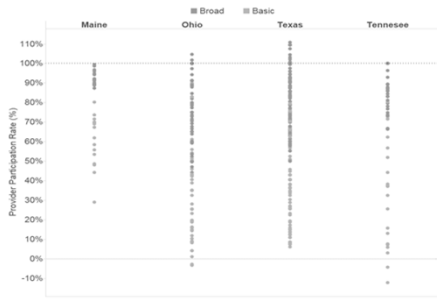
Average Provider Participation Rate Needed to Achieve a Broad or Basic Network in Adult Primary Care, by County in Selected States, 2017



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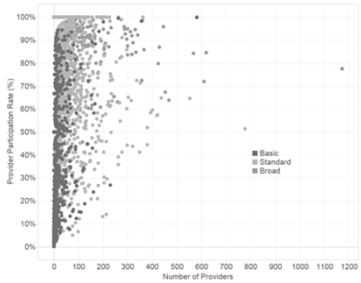
Network Classification by Provider Participation Rate and Raw Provider Counts in Network for Adult Primary Care, by County, 2017



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Unique counts	2016	2017
Plans	3,858	2,787
Providers	989,865	855,965
Networks	439	274
Issuers	222	155
Unique Counties	2,578	2,565
Unique Primary Care Providers	72,044	63,832

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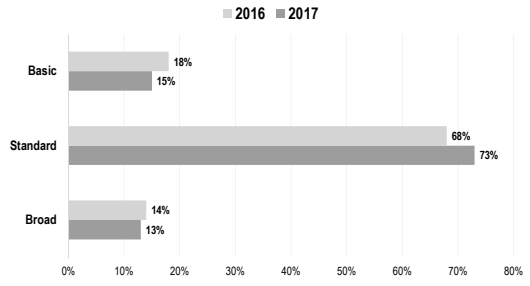

NOTE: Figures above reflect unique combinations of a network and a specialty within a given county.

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Proportions of Basic, Standard, and Broad Networks in Adult Primary Care, By Issuer Ownership Group, 2016-2017

Network Classification	BCBS		Integrated Health Plan		National Commercial Carrier		Co-Op		Medicaid Managed Care	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Basic	9.5%	6.4%	33.1%	33.5%	25.0%	24.9%	17.6%	12.3%	23.2%	21.8%
Standard	80.9%	79.5%	53.7%	48.3%	49.9%	54.9%	72.1%	71.1%	66.4%	67.1%
Broad	9.7%	14.1%	13.3%	18.2%	25.1%	20.2%	10.2%	16.7%	10.4%	11.1%

Average Network Size of Basic, Standard, and Broad Networks in Adult Primary Care, By Issuer Ownership Group, 2016-2017

Network Classification	BCBS		Integrated Health Plan		National Commercial Carrier		Co-Op		Medicaid Managed Care	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Basic	18	29	12	10	19	20	15	5	17	14
Standard	26	26	27	11	29	34	45	17	26	25
Broad	58	61	30	20	34	31	43	10	32	33

NOTE: BCBS refers to plans offered by the local BCBS affiliate plan. Integrated health plans refer to health systems that offer their own health plan. National commercial issuers include those owned by Aetna, Humana, Cigna, or United. Medicaid managed care refers to plans in the Marketplace whose primary or original line of business was Medicaid managed care. Figures above reflect unique combinations of a network and a specialty within a given county.

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Average Provider Participation Rate and Network Proportions for Basic, Standard, and Broad Networks in Adult Primary Care, in Large Metro Areas Compared to Rural Frontier Counties, 2016-2017

Network Classification	Average PPR (Proportion of Networks)			
	Large Metro		Rural Frontier	
	2016	2017	2016	2017
Basic	24.6% (19.9%)	26.8% (13.4%)	57.3% (10.2%)	62.4% (7.1%)
Standard	51.4% (66.3%)	48.3% (66.8%)	88.7% (80.6%)	90.7% (80.4%)
Broad	73.6% (13.8%)	80.4% (19.8%)	96.2% (9.3%)	96.2% (12.5%)

NOTE: Figures above reflect unique combinations of a network and a specialty within a given county.

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Average Network Size for Basic, Standard, and Broad Networks in Adult Primary Care, by Population Density in Counties, 2016-2017

Network Classification	Large Metro		Metro		Micro		Rural		Frontier	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Basic	81	101	28	29	9	10	5	5	4	4
Standard	178	153	53	53	14	13	6	6	3	3
Broad	299	271	68	71	18	19	8	9	5	6

NOTE: Figures above reflect unique combinations of a network and a specialty within a given county.

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Implications for the Market

What impact does network size have in practice?

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- Expect scrutiny of provider networks to continue at the state and federal level, especially as more markets begin to mandate the release of machine-readable network data
- Narrow networks can receive negative publicity if providers are dropped from networks or if consumers are restricted on their choices
- However, are narrow networks necessarily bad for consumers? **It's uncertain!**

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- Narrow network plans on the Marketplaces are cheaper than broad-network plans (McKinsey), and consumers prefer narrow networks with lower premiums to broader networks with higher premiums (Kaiser Health Tracking Poll)
- A study of California hospital networks found that narrow networks do not substantially reduce geographic access to care or quality (Haeder)
- However, narrow networks may impose a burden on vulnerable populations in Medicaid managed care, especially for children with special health care needs (OIG)

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What comes next?

- Medicaid managed care plans will soon be required (by summer 2018) to make available provider network information in a machine-readable format.
- The data will include provider names, contact information, languages spoken, and information about whether the provider is accepting new patients.
- Data must be updated monthly (for paper) or within 30 days of receiving updated provider information (electronic)
- Key challenge is to address errors and inaccuracies in the network data
  - Many pilots currently underway to address poor data quality

- The nature of the Provider Participation Rate means that what constitutes a broad or basic network can vary widely across geographies, and we also find that the distribution of network sizes on the Exchanges varies by issuer group
- Challenge in coming years will be to improve upon metrics of *network size* (like the PPR) to better reflect network *quality*
  - Narrow networks not necessarily bad for consumers, but network data needs to be accurate and up-to-date
  - Consider integrating measures of provider quality, time and distance standards, cost of care, or performance on certain health conditions
- Network transparency is expanding into Medicare Advantage and Medicaid managed care, which will lead to specific new metrics for consumers and other stakeholders to assess networks.

Comprehensive Checklist Handout

- Considerations and strategies that can be implemented for oversight of your organizations network accuracy and adequacy
- Reminder: each managed care organization is different…
- Your organization's unique products, risks and resources should be considered when deciding which strategies will be most effective for your needs

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The Basics

- How many providers are in your network?
- How far do members need to travel to access your network providers?
- Start with the minimum regulatory requirements for your products…

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Beyond the basics. Other considerations

- How many providers are accepting new patients?
- How long are members waiting for appointments?
- Are all covered benefits available in your network?
  - Think beyond provider specialty…
    - Do you have enough Ophthalmologists?
  - Think about availability of services…
    - Do you have sufficient availability of cataract surgery / treatment services for your Medicare members?

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Beyond the basics. Other considerations

- Does your member population have other unique needs?
  - Are providers located along public transportation routes for low-income members?
  - Are providers / office staff able to meet the cultural and language needs of your members?

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Impact of Provider Data Accuracy on Network Adequacy

- Is this physician actually practicing at this location?
- Is this physician actually practicing this specialty?
- Is this physician still associated with a contracted group?
- What services are available at this facility location?
- If you don't know the answers to these questions, then how do you know your network is adequate?

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Impact of Provider Terminations on Network Adequacy

- What if…
  - …you lost multiple providers in same specialty in same area at same time?
  - …a major health system in a rural area closes?
  - …a large primary care provider group in a rural area terminates their contract?
- What is the impact of a *potential* provider termination on your network adequacy?
- Move from reactive to *proactive* contingency planning for potential terminations

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Prevention and Risk Assessment Considerations

- Do your internal business process owners understand the regulatory and compliance requirements?
- Do you have a structure / process for assessing and implementing new requirements?
- Do you have clear accountability, roles and responsibilities across internal departments and teams?

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Prevention and Risk Assessment Considerations

- Do you have clear policy and procedure documents to guide employees and decision makers?
  - P&Ps for monitoring and maintaining your network?
  - P&Ps for intake / investigating network concerns?
  - P&Ps for the provider termination process including
    - early assessment of network adequacy impact?
    - ensuring affected members are notified and transitioned effectively?
    - considering whether to notify regulators or other stakeholders?

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Prevention and Risk Assessment Considerations

- Do you have internal standards for directory accuracy and network adequacy?
- Do you have a structure / process for monitoring and reporting outcomes?
- If you are not meeting your goals, can you demonstrate improving performance trend?

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Prevention and Risk Assessment Considerations

- Do your providers understand the requirements?
- Do provider contracts require advance notice to plan of changes impacting a provider's availability?
- Do you publish administrative guidelines that clearly explain HOW providers can report changes?
- Do you require your contracted providers to respond to periodic requests for review and validation of data (e.g., CMS requires quarterly validation contacts)?

Prevention and Risk Assessment Considerations

- Do you make it easy for providers to review and update their information?
  - Participation in industry collaboration effort?
  - Easy to use online tools to review / update data?
- Do you have provider incentives to update data?
- Do you have a way to enforce requirements when providers don't comply with your update policies?

Detection and Monitoring Considerations

- Are you routinely monitoring the basics?
  - Minimum numbers of providers by specialty by area?
  - Travel time / distance standards?
- Is the frequency of monitoring appropriate?
  - If your network is robust, well integrated and generally stable, less frequent monitoring may be appropriate…
  - If your network is narrow, complicated and/or volatile, more frequent monitoring may be appropriate…
- Are you monitoring your delegates if you delegate any network functions?

Detection and Monitoring Considerations

- Are there additional measures you should be monitoring (appointment availability, etc.)?
- Are you monitoring member / provider calls, complaints, and appeals to identify areas of potential concern / network trends?
  - Member difficulty locating PCPs accepting new patients
  - PCP difficulty locating specialty providers for referrals
  - High volumes of out of network coverage requests
- If your performance is not meeting your goals, do you have interim goals for improvement?

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Detection and Monitoring Considerations

- How are you validating the accuracy of provider directory data?
  - Are you validating in a way that is consistent with how your regulator will audit and monitor your plan?
    - Example: CMS tests online provider directory data by calling providers directly to validate their data
  - Are you validating in other ways that may be even more effective?
    - Use data analytics to identify and target potential defects for research and validation or correction

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Detection and Monitoring Considerations

- How are you validating provider data accuracy?
  - Using claims data to identify potential defects
    - physician no longer billing under group Tax ID number
    - provider no longer billing at place of service
  - Comparing address data to USPS address files
  - Comparing specialty data to state licensing data
  - Comparing your data to other sources (e.g., Medicare)
  - Look for physicians with unusual number of addresses or unusual combination of specialties

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Correction Considerations

- Do you have a rapid response / SWAT team ready to jump into action for urgent issues?
- Do you have feedback loops from the areas that handle concerns back to your network and provider data management teams?
- Do you have a link on your online directory to report inaccurate data?
- Do you have a way to escalate open corrective action plans or other issues that are not getting the attention they need?

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Additional Recommendations for Provider Network Changes

- Compassion, Communication, Coordination
  - Doctor choice is very "personal" for your members
    - Make your communications clear and compassionate
  - Timing is everything - consider how much time passes between provider and member notifications
    - Don't lose control of the message, your members should hear it from you first
  - Comprehensive Communication Plan
    - Beyond provider / member communications…
    - Who else needs to hear it from you first?
    - Be ready with a media / regulator response plan

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Additional Recommendations for Provider Network Changes

- Document! Document! Document!
  - Document decisions when terminating providers
  - Document network adequacy was reviewed, outcomes
  - Document provider appeals received, decisions, rationales
  - Document continuity of care and transition of care policies
  - Document all communications (who, when, how notifications handled)

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