

Provider Networks: Renewed Scrutiny on Adequacy and Accurate Directories

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Renee Kimm, Assistant Compliance Counsel, Central Health Plan of California
Ryan Morgan, Attorney, Polsinelli PC

Disclaimer

- The thoughts and opinions expressed by Ms. Kimm are her own and do not reflect those of Central Health Plan of California or any affiliated company.

How Did We Get Here?

- Rise of HMOs in 1970s and 1980s
 - Desire to control costs
 - Credentialed network of providers
 - Managed care controls
 - Federal and state health care insurance funding intended to help rural, poor, elderly.
 - Financial incentives to enter market, but difficult requirements.
 - HMO Act of 1973.
- Many forms of HMOs
 - Provider-Sponsored (Marshfield Community Health Plan)
 - Exclusive system (Kaiser)
 - IPA (Bay State Health Care)
 - Capitated Primary Care (US Healthcare)

How Did We Get Here?

- HMO Fall from Grace by mid 1990s
 - Member complaints about managed care
 - Denied services
 - Limited referrals
 - Limited choice of provider
 - Forced into HMO by employer
 - Provider complaints about managed care
 - Preference for choice of treatment
 - Preference for predictability of fee-for-service payment
 - Employers lagging behind
 - General reluctance to change health benefit structure
 - Failure to offer choice of plans
 - Failure to offer employees share of savings

How Did We Get Here?

- The Pendulum Swings
 - Movement towards all-inclusive networks
 - Rise of PPOs → Member incentive to use network providers, but still coverage for OON
 - Reduced control over cost and quality



How Did We Get Here?

- The Pendulum Swings Back
 - Increasing cost of health care
 - Pressure on Plans to innovate new ways to manage care, including narrow networks
 - More engaged employers, demanding custom networks
 - Success of MA, Part D, Medicaid managed care
 - Rise of ACOs, CINs
 - Evolving market incentives
 - Changed perception of managed care
 - Insurer consolidation
 - cross industry mergers
 - New challenges

Current State of Provider Networks

- Narrow networks are back
 - Market demands generally (cost and quality)
 - Opportunity to co-brand
 - Affordable Care Act limited other insurer cost control strategies
 - 1/3 of MA plans have narrow networks
- Narrow networks are effective
- How narrow is too narrow?
 - Patient access concerns
 - Adequacy concerns
 - Quality concerns
 - Provider concerns

Provider Directories in MA

- In accordance with 42 C.F.R. §422.111 and guidance in section 100.2.2 of the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual), organizations are required to provide the number, mix and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services.

Provider Directory Accuracy

- CMS began to examine the accuracy of information contained in online provider directories in 2016
 - CMS intends to conduct a review of all Medicare Advantage Organizations (MAOs) over the course of 3 years
 - Anticipates reviewing approximately 1/3 of all MAOs each year

Directory Review Process

Phase 1:

- Calls to each provider's office to verify information accuracy
 - Does the provider see patients at this location?
 - Does the provider accept the MA-PD plan at this location?
 - Does the provider accept (or not accept) new patients who have this MA-PD plan?
 - Is the provider a [PCP, cardiologist, oncologist, or ophthalmologist]?
 - Is the address correct?
 - Is the telephone number correct?
 - Is the provider's name correct?
 - Is the practice name correct?
- Shared initial deficiencies with the Plan Sponsor
 - 2 weeks to issue Plan response
- CMS reviews and makes final determination
 - Plan has 30 days to make all required corrections

Directory Review Process

Phase 2:

- CMS validates deficiencies have been corrected
- May look at the Plan Sponsor's Health Service Delivery (HSD) tables, if needed

Directory Review – 1st Round Results

- CMS reviewed the online provider directories for 54 parent organizations
 - February through August 2016
 - 108 providers reviewed per MAO
 - 5,832 providers at 11,626 locations
 - Providers:
 - Cardiologists
 - Oncologists
 - Ophthalmologists
 - Primary Care Physicians (PCP)
- Results: 45.1% of provider directory locations inaccurate

Common Directory Inaccuracies

- Providers not at the location listed
- Inaccurate phone number
- Provider was not accepting new patients when directory noted that they were

Compliance Actions

- During first round of reviews, the following compliance actions were issued:
 - 31 Notices of Non-Compliance
 - 18 Warning Letters
 - 3 Warning Letters with a Request for a Business Plan

Contributing Factors Identified By CMS

- Group practices may be providing data at a group level rather than at the provider level
- Lack of internal auditing and monitoring of provider directory accuracy
- Providers who have been retired or deceased for a long period of time are still listed in the provider directories

Best Practices Identified By CMS

- Self-audits, monitoring, and validation of provider directory data
- Work with group practices to ensure providers are only listed at the locations where they accept appointments
- Develop internal processes for members to report provider directory errors
- Machine readable format
- List the provider’s medical group, institutional affiliation, non-English languages spoken by the provider, website address, accessibility information for those with physical disabilities

MA Directory Considerations

- Assess your internal process
 - How accurate is the Plan’s current provider directory?
 - What is the Plan’s process for updating it?
 - Who owns the process internally at the organization?
 - Are there any gaps in your current process that need to be addressed?
 - If working with a vendor, what is the vendor’s process?
- Focus on improving the areas that CMS gives the most weight/priority when scoring

| Final Deficiency | Deficiency Weight |
|---|-------------------|
| Provider should not be listed in the directory at this location | 3 |
| Phone number needs to be updated | 3 |
| Provider is not accepting new patients | 3 |
| Address needs to be updated | 2 |
| Address (suite number) needs to be updated | 1 |
| Provider IS accepting new patients | 1 |
| Specialty needs to be updated | 1 |
| Provider name needs to be updated | 0 |

MA Directory Considerations

- Audit your provider directory on a consistent basis to ensure accuracy
 - Need to consider your resources
- Assess how you will work with your providers in order to obtain accurate information
- Contractual provisions

Provider Directory for Marketplace

- QHP issuers must ensure that the directory:
 - Is available online
 - Is available in hard copy on request
 - Identifies providers that are not accepting new patients
- Is updated on a monthly basis
- 30 days written notice of provider termination to Members seen on a regular basis by provider

Network Adequacy in MA

- Medicare Advantage organizations (MAOs) must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served.
 - Minimum number of provider/facility types
 - Quantitative time and distance requirements
 - 42 CFR 417.414, 417.416, 422.112(a)(1)(i), and 422.114(a)(3)(ii)

Network Adequacy Considerations

- Changes in provider directories may affect beneficiary access
 - Plan Sponsors should also update their Health Service Delivery (HSD) tables accordingly and ensure that the current network still meets standards.

Network Review

- Previous Process
 - Review at the time of application
- Beginning 2019
 - Remove the HSD submission requirement and network review from the application process
 - Review the MA provider & facility networks at a minimum of every 3-years or sooner if there is a “network triggering event”

Triggering Events

- Initial application
- Service Area Expansion applications
- Initial offerings of a provider-specific plan
- Potentially significant provider/facility contract termination
- Change of ownership
- Network access complaints
- Organization-disclosed network deficiencies

Review Process

- HSD upload request letter to all MAOs with contracts that haven't received an entire network review in the previous 12 months
 - 60 days in advance
- MAOs will have 60 days to prepare HSD tables and test networks
- Compliance actions for deficiencies
- 3-year network review anniversary date for the contract is reset

MA Network Adequacy Considerations

- Implement a provider network oversight process
 - Ensure ongoing compliance with new guidance
- Implement policies & procedures:
 - Investigating network issues/complaints
 - Handling provider terminations
 - Reviewing network adequacy subsequent to updates
 - Notification to regulators or members

Network Adequacy for Marketplace

- ACA network adequacy requirements for QHPs
 - Sufficient numbers and types of providers
 - Including mental health and substance abuse providers
 - Services must be accessible without unreasonable delay
 - Essential community providers (min 20%)
- No ACA criteria for:
 - Minimum enrollee/provider ratios
 - Maximum travel distance/time
 - Maximum wait time
- CMS will rely on state reviews for enforcement, provided state review processes are sufficient

Network Adequacy for Part D

- Typically, CMS requires the beneficiaries have “convenient” access to retail pharmacy close to home
- CMS access/adequacy rules do not apply to “preferred pharmacy networks”
 - Lower copays in exchange for lower reimbursement
 - Essentially a preferred provider tier
- Any Willing Pharmacy laws do not apply to preferred pharmacy networks
 - Non-preferred pharmacies can participate in network at lower tier

Network Adequacy for Self-Funded

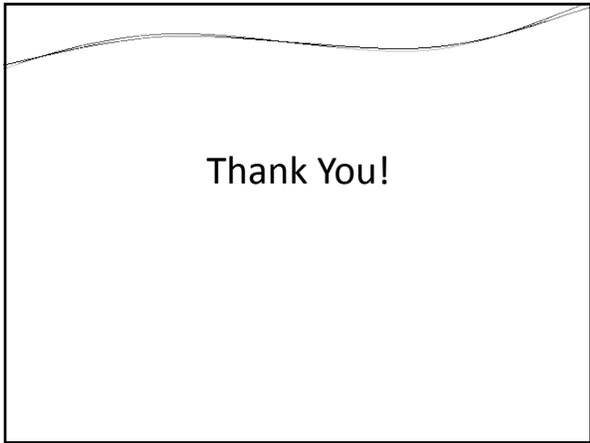
- No specific ERISA regulations on network adequacy
- ACA rule on cost-sharing maximum
 - Amounts balance-billed by OON providers does not count toward out-of-pocket maximums. ACA §§ 2707(b), 1302(c).
- Plans can comply with cost-sharing maximum requirement if the plan “uses a reasonable method to ensure that it provides adequate access to quality providers.”
 - Narrow network must not serve as “subterfuge” to evade cost-sharing maximums.

Network Adequacy Enforcement

- Provider initiated network adequacy suits
 - *In re: Seattle Children’s Hospital’s Appeal of OIC’s Approvals of HBE Plan Filings*, Doc. No. 13-0293 (2014)
- Any Willing Provider laws
- Antitrust
 - *US & North Carolina v. The Charlotte-Mecklenburg Hospital Authority*, No. 3:16-cv-00311 (W.D.N.C. 2016)
 - ASC-initiated suits

Best Practices

- Review compliance with network adequacy and provider directory rules
- Add narrow network and steerage language to provider agreements
- Anticipate balance billing issues
- Anticipate surprise billing issues with hospital based providers
- Anticipate OON reimbursement disputes
- Ensure appeals/grievance systems are compliant
- Ensure system edits in place for OON emergency claims



Thank You!
