EPSTEIN BECKER GREEN

CMS's Crackdown on Network Adequacy

Network Adequacy in Medicare Advantage and other Programs

National Medicare Advantage Summit
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Agenda

1. Drivers of Network Adequacy Concerns
2. Medicare Advantage Network and Related Requirements
3. Special Needs Plans (SNP)-specific Network Adequacy Requirements
4. Medicaid Managed Care and Exchange Networks and Related Requirements
5. Uncertainty and the New Administration

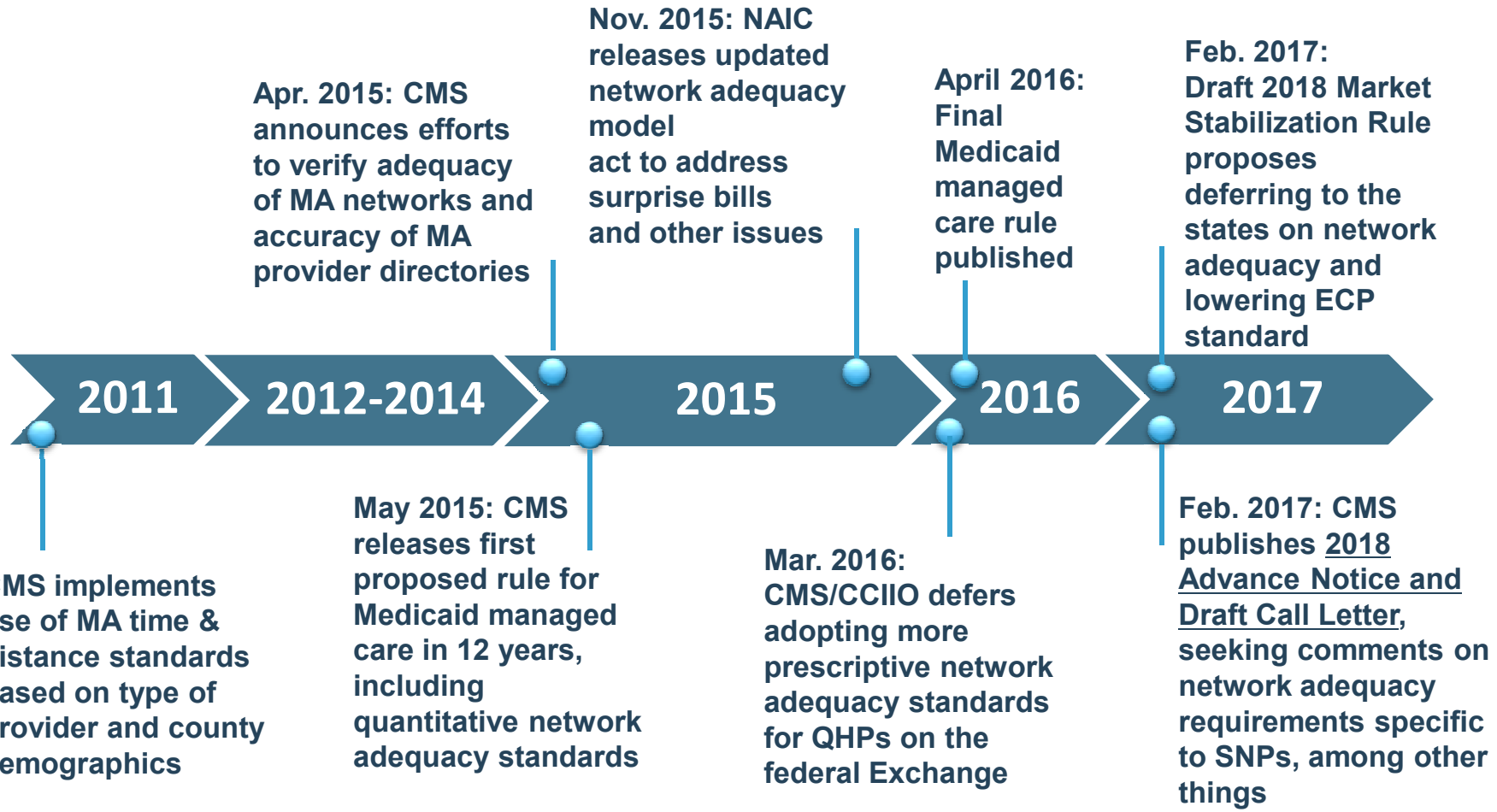
New Actions on Network Adequacy

DRIVERS OF CONCERN

- Federal programs reacting to
  - Narrow networks
  - Surprise bills/Transparency of network information
  - Provider terminations
  - Accuracy of provider directories
  - Pressure from providers and consumers/advocacy groups

New Actions on Network Adequacy

REGULATORY AND OTHER INITIATIVES



Medicare Advantage

NETWORK ADEQUACY STANDARDS

- Vary by
  - Provider/facility type
  - County designation (based on population and density)
    - Large Metropolitan
    - Metropolitan
    - Micropolitan
    - Rural
    - Counties with Extreme Access Considerations (CEAC)
- Providers do not need to be located within physical boundaries of county being assessed, but must be within time and distance requirements of at least one beneficiary within the county
- Specific 2018 Criteria and information on standards for each county are published in the MA Network Adequacy Criteria Guidance Document and the HSD Reference File, both available at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html - main_content

Medicare Advantage

TIME/DISTANCE AND OTHER NETWORK-RELATED REQUIREMENTS

- Minimum of one provider/facility per type, based on 95th percentile of beneficiaries served by Medicare Advantage in the county
  - Minimum provider ratios (#/1000 beneficiaries) based on utilization patterns & clinical needs
- Maximum travel time/distance such that 90% of beneficiaries must be able to access within time & distance constraints for at least 1 provider/facility
- Exceptions process available where lack of providers in county and/or pattern of care supports different network configuration
- Significant changes in network require 90-Days notice to CMS
  - CMS may also require
    - Network adequacy assessment
    - Plan for outreach to enrollees to help them find new providers and/or address continuity of care issues
    - Special enrollment period (SEP) for affected enrollees

Medicare Advantage

TRIGGERS FOR NETWORK ADEQUACY REVIEW

- Initial or Service Area Expansion Application
- Request for Provider-Specific Plan
  - Submitted with bid on the first Monday in June of each calendar year
- Provider/Facility Contract Termination
  - Review at CMS's discretion
- Change of Ownership
  - Acquiring entities not previously approved in the service area of the plan to be acquired may need to undergo a network adequacy review
- Network Access Complaints
  - Review at CMS's discretion
- Organization-Disclosed Network Deficiency
  - Expectation that plan sponsors will conduct ongoing monitoring of compliance with network adequacy standards

Medicare Advantage

PROVIDER DIRECTORY REQUIREMENTS

- Plan sponsors must have a structured process to keep provider directories current
  - Regular (at least quarterly) contact with providers to ascertain availability, acceptance of new patients, current contact information
  - Effective protocol to address denial of access to contracted providers and required changes to provider directories
  - Real time updates to online directories
- Must include:
  - Provider medical group
  - Provider institutional affiliation
  - Non-English languages spoken by provider
  - Provider website address
  - Accessibility for people with physical disabilities
  - Acceptance of new patients
- Machine readable content is a best practice

Medicare Advantage

OVERSIGHT AND ENFORCEMENT

- Provider Directories assessed more for accuracy than network adequacy
  - Directly monitored by contractors to verify accuracy
    - Plans have opportunity to cure prior to compliance and/or enforcement
  - 2016 review of online directories found poor performance
    - 47% of provider info/45% of location info reviewed had at least one deficiency
    - Plan sponsors reviewed had an average per location deficiency rate of 41%
- Compliance Actions taken
    - Aetna fined $1M for inaccuracy of provider directory (April 2015)
    - CMS issued 31 Notices of Non-Compliance, 18 Warning Letters, and 3 Warning Letters with Business Plan for findings from 2016 study
- Intent to issue future rules with additional requirements for MA provider directories consistent with Medicaid and QHPs
    - Potential future standardized electronic submission of network information for inclusion in a nationwide provider database
- Directory monitoring data “could drive additional reviews of network adequacy”

Special Needs Plans (SNPs) Network Adequacy

SNP-SPECIFIC NETWORK ADEQUACY REQUIREMENTS

- CMS released the **2018 Medicare Advantage and Part D Advance Notice and Draft Call Letter** on February 1, 2017
- Requests input on *how* and *whether* SNP-specific provider networks *do* and *should* differ from non-SNP networks to ensure appropriate access for SNP enrollees
- CMS is interested in whether a SNP-specific network adequacy assessment would improve patient health or quality of care
  - Specifically, CMS is asking commenters to consider the following:
    - What do SNP-specific networks currently look like?
    - How are SNP-specific network different from other MA networks?
    - What would be desirable in a SNP-specific network adequacy evaluation?
  - Also, CMS asks for any suggested modifications to the current network adequacy evaluation and oversight relative to SNP-specific networks

Medicaid Managed Care (MMC)

NETWORK ADEQUACY REQUIREMENTS

- For plan years beginning on/after July 1, 2018, states are responsible for setting **time and distance standards** for providers of:

- Pharmacy
- Primary care (adult and pediatric)
- OB/GYN
- Mental health/Substance use disorder (adult and pediatric)
- Pediatric dental

- Specialists (adult and pediatric) (can be further defined by states)
- Hospital
- Other providers if applying such standards "promotes the objectives of the Medicaid program"

- Considerations in developing these standards: expected enrollment, utilization of services, characteristics & health needs of covered population, etc.
- Network adequacy validation/oversight
  - State must publish network adequacy standards for transparency
    - Timeliness would be assessed as routine, urgent, or emergency care
    - MMC Org. must document network adequacy for state review at least yearly and when a significant change to operations would affect capacity/services
    - External Quality Review Organization to validate plans' network adequacy for the 12 prior months
    - MLTSS must have distinct network adequacy standards
  - State must publish network adequacy standards for transparency

Medicaid Managed Care (MMC)

OTHER NETWORK RELATED REQUIREMENTS

- Female enrollees must have direct access to women's health specialists
- Ability to go out-of-network if necessary for medically necessary services without paying more
- Network providers cannot have lesser hours of operation than for commercial/Medicaid FFS enrollees; 24/7 services when medically necessary
- Information Requirements
  - Apply consistently across MMC plan types with respect to enrollee materials
  - Strengthens MMC info dissemination rules to more closely align with MA and commercial
  - Recognizes cultural/linguistic diversity of Medicaid beneficiaries - MMC entities must make available vital documents in each prevalent non-English language in the MMC's service area, to include:
    - Provider directories;
    - Member handbooks;
    - Formulary;
    - Other notices critical to obtaining services

Qualified Health Plans in the Federal Exchanges

PROPOSED CHANGE IN DIRECTION FOR NETWORK ADEQUACY REVIEW

- Proposed market stabilization rule issued Feb. 17, 2017, includes proposed changes to Network Adequacy standards for qualified health plans (QHPs)
  - Three options proposed for Network Adequacy review in Federally-facilitated Exchanges
    - Rely on State review , if the State has a sufficient network adequacy review process that is at least equal to the QHP "reasonable access standard"
    - In States without authority or means to do Network Adequacy reviews, CMS would rely on accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity
    - Unaccredited entities would need to submit an access plan to demonstrate that the maintains an adequate network consistent with the NAIC Network Access and Adequacy Model Act
  - Lowered to 20% the safe harbor standard for Essential Community Providers
    - Entities including 20% of the ECPs in their area will be found to comply with the ECP requirements

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New Strategies for Monitoring Network Adequacy: Focus on Provider Directory Data Management

Challenges, Recent Developments, and Opportunities for Improvement

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Provider Directories Emerging as Policy Issue

- Provider networks nationwide are becoming more narrow, as health plans compete for members on price
- Provider exclusions from the network cause dissatisfaction among both consumers and providers
- News stories about exclusions or inaccurate data drive advocacy efforts and spur regulatory oversight
- No industry-wide gold standard for provider data

Increased Scrutiny of Directory Information

- In addition to the size of networks themselves, there is also increased focus on accuracy of network data, with news stories arising about “surprise out-of-network bills”
- Federal and state regulators are taking steps to mandate greater transparency of provider network information
  - California recently fined two plans $600,000 for faulty data
  - CMS fined a national MA plan $1M for pharmacy directory errors
- Consumers have separately brought suits in response to inaccurate provider directory information
  - At least five lawsuits are pending against health plans for misrepresenting provider access – one recently settled for $15M

Machine Readable Data

- One approach to ensure network data are accurate and transparent is to mandate that insurers publish network data in machine-readable format, allowing users to analyze the data in a structured fashion
- Since 2016, Qualified Health Plans (QHP) operating on federally-facilitated Marketplaces have been required to post machine-readable provider network directories
- The QHP machine-readable data were used by CMS to pilot test a measure of network breadth on HealthCare.gov, allowing some consumers to compare network sizes at the point of sale

The Market Responds

- Discussion about adopting machine-readable files in Medicaid managed care and Medicare Advantage, though possibly on hold for now
- Vendors are emerging to address issues of provider network directory accuracy and completeness
- Solutions include:
  - Using calling or secret shopping to verify contact information
  - Automated tools to track complaints
  - Other tools to allow providers to update data themselves

NORC Evaluation of AHIP Pilot

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NORC Evaluation of AHIP's Provider Directory Pilot

- In 2016, AHIP funded a pilot to test different approaches for validating provider directory data
  - Pilot conducted from April to September 2016
  - Two vendors selected to participate
- AHIP contracted with NORC to evaluate pilot
  - Evaluation consisted of surveys, semi-structured interviews, and reviews of vendors' operational data
  - Final report outlined main findings for AHIP based on defined goals

Pilot Vendors

	Availity	BetterDoctor	
Pilot state	Florida	California	Indiana
# of Plans	5	9	2
Approach	Leverage existing electronic resources used for eligibility inquiries, claims submissions, portal notifications and other provider-related administrative activities.	Develop outreach methods from scratch and test effectiveness of different media and techniques, i.e., phone calls, faxes, emails based on an aggregation all participating health plan data.	

AHIP Provider Directory Pilot - Goals

- Improve the accuracy of provider directories to benefit consumers regardless of whether they are covered by private insurance or public programs such as Medicare and/or Medicaid;
- Reduce burden on providers and develop a more efficient approach for providers to update their information for ALL plans; and
- Test different approaches to identify the most effective path to a potential solution at a national level.

Key Themes from Evaluation

Three Main Themes Emerged

- Provider Engagement
  - Providers are not consistently engaged in the data verification process
- Provider Accountability
  - Providers are not routinely held accountable for unverified or erroneous directory information
- Technical Standards
  - Lack of consistency in the management and formatting of data across the industry

Challenges with Provider Engagement

- Providers expressed a general lack of awareness for need to proactively alert plans of changes
- Did not understand the purpose of, or need for, responding to requests to validate or update data
- Felt overwhelmed with responsibilities and thus, prioritized “mandatory” activities (e.g. credentialing) over directory reconciliation

Challenges with Provider Accountability

- Providers don’t realize that they are accountable through contracts
- Necessary language is in provider contracts, but it is not enforced by plans
- Coordinated effort but uneven accountability for ensuring timely data updates

Challenges with Technical Standards

- Providers generally confused about the process for maintaining directory data
- Inconsistent data file formats and lack of transparency related to updates from one version to another
- Lack of guiding industry standards

Proposed Strategies for Improvement

Proposed Strategies for Improving Provider Engagement

- Balance outreach methods burden with effectiveness
- Use complementary outreach methods
- Pursue flexible and iterative approach
- Seek feedback from stakeholders (i.e., providers)
- Conduct proactive education about how data will be used and protected prior to, and during, vendor outreach
- Make it easy for providers to confirm the vendor's role

Proposed Strategies for Improving Provider Accountability

- Leverage power of contractual agreements
- Consider combination of incentives and penalties that mirror those for plans
- Identify specific contractual provisions that hold providers accountable for non-responsiveness
- Raise provider awareness of existing compliance responsibilities

Proposed Strategies for Improving Technical Standards

- Develop industry-wide standards for data definitions, file format protocols, and other validation standards
- Focus on more efficient sharing of data between plans and providers
- Collaborate with stakeholders and set meaningful, long-term goals
- Ensure that validation files clearly identify which data have been updated for audit trail
- Adopt standard processes and channels to allow providers and other consumers to flag provider directory discrepancies

Thank You!

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Please contact
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with any questions.

insight for informed decisions™

2017: The Year of the Provider Network?

How did we get here?

Here's what we know…

- Networks are narrowing
- The ACA accelerates this trend by pushing health plans to identify and drive patients toward "high value" providers
- Provider terminations aggrieve members and attract national attention
- Providers and consumer advocates are now mobilized and aligned in pushing for action (i.e., specialty societies, NAMI, Families USA)
- Researchers showing unprecedented level of interest in provider networks (RWJ/U.Penn., Urban Inst., Commonwealth, NORC)

From the Regulator's Vantage Point

Taking shots from all sides…

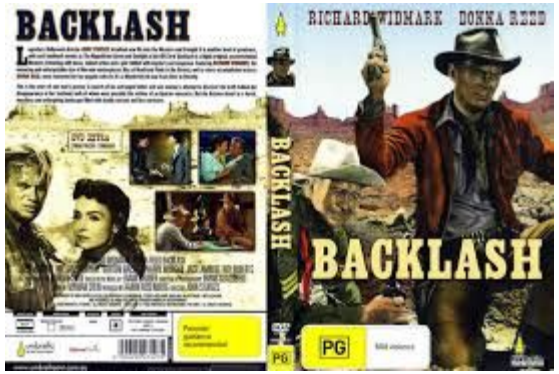
- Unflattering media attention
- Researchers are documenting narrowing
- Advocates are forwarding examples
- Legislators are sponsoring bills

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?

The Regulatory Backlash has Begun

- 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
- GAO and OIG studies on provider networks



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

Machine Readable Directories

- 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
- Not discussed in NAIC model regulation

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.

Examine Operations to Measure Adequacy/Accuracy

Data-mine – Do you consolidate network concerns from all departments (claims, provider relations, member services, etc.) and assure remediation?

Contracting – Do your provider contracts include carrots (financial) and sticks ("claims block") for keeping directories accurate and seeing patients through the full year?

Continuity of Care – Do you let members complete care episodes with departing docs?

Keep Current – Do you survey for new requirements, research, and best practices?

Provider Appeals – Is your process fair to the provider? What does it say about your process if you always win?

Adequacy Year Round – Do you check adequacy at regular intervals and when your network changes? Do you account for closed panel docs when considering adequacy? Do you focus on problem specialties (i.e., mental health, ophthalmology)?

Cultural Competency – Have you examined your network against non-English speaking populations in your service area?

Improving Accuracy – Do you have an ongoing program (mystery shops, checks against address lists) to detect and correct directory inaccuracies & record improvement?

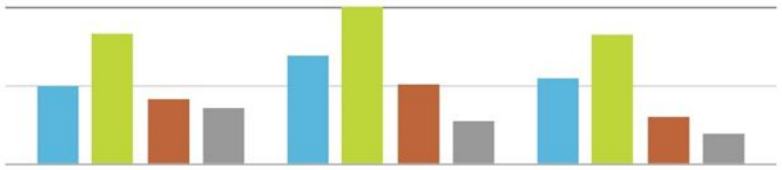
Get in Front of It – Do you have a SOP for notifying regulators and members when your network changes midyear (including courtesy notices for small network changes)?

Establish Network Oversight SOP

- Implement a provider network oversight SOP
  - Assures ongoing compliance with new guidance from CMS and State regulators
  - P&Ps for receiving and investigating network issues
  - P&Ps for provider terminations and network adequacy checks
  - P&Ps notifying CMS or other regulator of significant network changes
  - P&Ps for notifying members of network changes
  - Document actions and rationales for situations not covered in guidance
  - Implement a directory accuracy solution with ongoing data

Self-Assess on Your Provider Directories

- Provider Director Accuracy is the Immediate problem, especially for MA plans…
  - What is our standard for directory accuracy?
  - What is our baseline directory accuracy?
  - Who is tasked with correcting our weaknesses?
  - How do we know we are improving?
  - How do we know our docs are telling patients what they're telling us?
- Provider Directories are on agenda for May CMS conference… for third straight meeting… they're not kidding around



Network Oversight Under the Trump Administration

- New Administration has not yet offered a vision, but it has acted…
- Medicare Advantage
  - CMS did not require machine readable provider directories for 2018
  - However, strict provider network reviews remain; provider directory audits continue; agency opens doors to new SNP network requirements
- Exchanges
  - CMS proposes to defer to state network adequacy reviews or defer to accreditation if state does not review
  - Network breadth pilot continues
- Medicaid
  - Managed care reg which establishes national network adequacy and provider directory rules for 2018 may clash with “state flexibility” vision

Concluding Thoughts…

- While much is still unknown about new Administration, provider networks will be among the hot compliance issues in 2017
- Researchers are looking at your directories and publishing results
- The “Machine Readable Revolution”
  - Regulators can check your networks at any time
- Providers, by and large, are not focused on the need to keep directories accurate – health plans will need to help them focus
- At least in the short-run, the road ahead will remain hard…
  - Provider directory inaccuracies are an easy target for regulators
  - Regulatory actions, lawsuits, fights w/ providers, unflattering reports will likely continue

To continue the discussion…

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Provider Network Oversight Publications:

1. "From Machine Readable Provider Directories: A Preview of a Revolution," *Health Affairs* blog, February 27, 2017 (with Michelle Strollo, Dr.Ph.)
2. "Regulators React to Debate Over Narrow Networks," *Managed Healthcare Executive,* May 2016.
3. "Narrow Network Health Plans: New Approaches to Regulating Adequacy and Transparency," *Healthcare Compliance Today,* October 2015.