Network Adequacy and Essential Community Providers Workgroup – Presentation of Report to the MHBE Board of Trustees

September 15, 2015

A service of Maryland Health Benefit Exchange

Agenda

- Workgroup Process
- Policy Options Review
- Next Steps

Workgroup Process

Workgroup Process

- Included stakeholders representing carriers, consumers, and providers
- Met seven times between May and August 2015
- Reviewed federal and state law related to network adequacy; federal and state-level network adequacy data sources; and standards being developed in other states
- Developed policy options for the MHBE's consideration, providing advantages, disadvantages, and other considerations
- Public was given the opportunity to comment on these options

Workgroup Members

Name	Affiliation
Robyn Elliott, Co-Chair	Public Policy Partners
Mark Haraway, Co-Chair	DentaQuest of Maryland and DentaQuest Mid-Atlantic
Salliann Alborn	Community Health Integrated Partnership
Donna Behrens	Maryland Assembly on School-based Health Care
Steve Davis	Fuse Health Strategies LLC
Lori Doyle	Community Behavioral Health Association of Maryland
Adrienne Ellis	The Mental Health Association of Maryland
Renee Ellen Fox	Institute for Healthiest Maryland
Michelle Green Clark	Maryland Rural Health Association
Lena Hershkovitz	HealthCare Access Maryland
Megan Mason	Maryland Insurance Administration
Matthew McClain	Public Health Policy & Planning, McClain and Associates, Inc.
Deborah Rivkin	CareFirst BlueCross BlueShield
Kimberly Robinson	League of Life and Health Insurers of Maryland, Inc.
Tanya Robinson	Kaiser Foundation Health Plan of the Mid-Atlantic States Inc.
Ellen Weber	Drug Policy Clinic at the University of Maryland Carey School of Law

Policy Options Review

Policy Options Overview

- Policy options were divided into five categories:
  - Data Collection and Reporting
  - Provider Directory
  - Essential Community Providers (ECPs)
  - Quantitative Standards
  - Informing Consumers
- In analyzing these policy options, the Workgroup considered:
  - Impact on the overall commercial health insurance market, in the context of the purview of the MHBE's statutory authority
  - Timing of the options report with the revised National Association of Insurance Commissioners (NAIC) Model Act
  - Feasibility for the MHBE, in light of its budget and staff capacity

Policy Options Overview

- Workgroup reached consensus on 7 policy options. These options were also endorsed by the SAC.
- Workgroup did not prioritize these options.
- Workgroup was unable to reach consensus on 9 options.
- Several of the non-consensus options require additional work and time to address, and perhaps even a new workgroup process.

Policy Options With Workgroup Consensus

Policy Options with Consensus

- The MHBE should:

1. **(IA – Data Collection)** Work with MHCC to analyze network adequacy through claims and encounter data.
2. **(IB – Data Collection)** Work with licensure boards, providers, carriers, MHCC, and consumer groups to expand licensure data collection in order to better assess the number of active providers and other data.
3. **(IC – Data Collection)** Work with Medicaid and other divisions of DHMH to assess the number, capacity, and types of providers in the state in order to identify willing providers.
4. **(2A – Provider Directories)** Work with the MIA, carriers, providers, and consumer groups to improve the accuracy of provider directories.
5. **(2C – Provider Directories)** Consider whether there should be portals through which providers and consumers can communicate information about the accuracy of provider directories.
6. **(3B – Essential Community Providers)** Work with state partners to create an ongoing process, using Maryland data sources, to ensure that the CMS list of Maryland ECPs is accurate and complete.
7. **(5A – Informing Consumers)** Work with the MIA, carriers, consumer stakeholders, providers, and the HEAU to develop messaging to inform consumers on how to find a provider and how to obtain relief when they cannot find a provider pursuant to Ins. Art. §15-830(d).

Policy Options Without Workgroup Consensus

Policy Options Without Consensus

The MHBE should:

1. **(1D – Data Collection)** Work with MHCC, providers, payers, carriers, and consumer groups to expand the consumer satisfaction data collected and made accessible, and determine specific ways to make the data more transparent to the public (*e.g.*, consumer report cards).

2. **(2B – Provider Directories)** Expand on the types of providers that are included in provider directories, including mental health and substance use disorder programs, in addition to individual practitioners.

3. **(2D – Provider Directories)** Assess the feasibility of developing a standard taxonomy for provider types.

4. **(3A – Essential Community Providers)** Expand the definition of ECPs beyond the federal definition to include local health departments, mental health and substance use disorder providers licensed by DHMH as programs or facilities, and school-based health centers.

5. **(3C – Essential Community Providers)** Use the FFM threshold for ECP participation and the FFM alternate standard for qualifying carriers

Policy Options Without Consensus

The MHBE should:

6. **(4A – Quantitative Standards)** Collect data regarding network adequacy and consider developing quantitative standards in the future (either wait for the NAIC Model Network Adequacy Act or set a specific deadline – e.g., 2018).

7. **(4B – Quantitative Standards)** Work with the MIA, consumer groups, and carriers to define the current unreasonable delay standard so that consumers will better understand when they can see an out-of-network provider with in-network cost-sharing.

8. **(4C – Quantitative Standards)** Work with the MIA to make the quantitative standards used and reported by carriers in their availability plans submitted to MIA and access plans submitted to the MHBE publicly accessible.

9. **(4D – Quantitative Standards)** Work with the MIA to standardize the format for reporting quantitative standards in availability plans the MIA requires, and with DHMH to standardize the format for reporting quantitative standards in availability plans DHMH requires.

Data Collection and Reporting

The MHBE should work with:

1A. (Consensus) MHCC to help analyze network adequacy using claims and encounter data.

- Information could assist in determining patterns and systemic problems. The database's limitations and the significant amount of interagency collaboration would have to be considered.

1B. (Consensus) The licensure boards, providers, carriers, MHCC, and consumer groups to expand licensure data collection in order to better assess the number of active providers and other data, such as provider specialty.

- Boards have most complete list of providers practicing in the state, but there is a wide range of data capabilities amongst the boards. Therefore, option may be less of a priority in context of the others.

Data Collection and Reporting

The MHBE should work with:

1C. (Consensus) Medicaid and other divisions of DHMH to assess the number, capacity, and types of providers in the state, especially mental health and substance use disorder providers, provider organizations, and programs, in order to identify potential provider shortages and identify willing providers.

- Medicaid may be source of most robust data, capturing information at the program and provider level. Utility of comparison may vary since there are different standards for provider contracting depending on the specialty (*e.g.,* any willing provider for mental health and substance use disorder).

1D. (Without Consensus) Work with MHCC, providers, payers, carriers, and consumer groups to expand the consumer satisfaction data collected and made accessible, and determine specific ways to make the data more transparent to the public (*e.g*., consumer report cards).

- Consumer satisfaction data will enable consumers to make more informed QHP selections, but data may not fully capture network adequacy issues, and should therefore be used along with access and quality metrics.

Provider Directories

The MHBE should:

2A. (Consensus) Work with the MIA, carriers, providers, and consumer groups to improve the accuracy of provider directories.

- More accurate and transparent information would make the directories more useful for consumers. Issues such as providers not being aware of the plans they accept, especially in larger practices, and the limited enforcement to ensure that providers promptly update information would have to be considered.

2B. (Without Consensus) Expand on the types of providers that are included in provider directories, including mental health and substance use disorder programs, in addition to individual practitioners.

- Programs names as opposed to individual practitioners can be important because often substance use disorder treatment is delivered through programs. One concern is that the approach would require carriers and CRISP to change their systems.

Provider Directories

The MHBE should:

2C. (Consensus) Consider whether there should be portals through which providers and consumers can communicate information about the accuracy of provider directories.

- Consumers have the most up-to-date information based on experience trying to reach providers; could reduce burden on carriers to identify inaccurate information. The DC Exchange has a similar system in place. Concerns around overwriting, and inconsistencies with the portals and the CRISP provider directory should be considered.

2D. (Without Consensus) Assess the feasibility of developing a standard taxonomy for provider types.

- A standard taxonomy would improve consistency across all provider directories and more accurately capture all available specialties, but it would be resource-intensive.

Essential Community Providers

The MHBE should:

3A. (Without Consensus) Expand the definition of ECPs beyond the federal definition to include local health departments, mental health and substance use disorder providers licensed by DHMH as programs or facilities, and school-based health centers.

- Broadening the definition would enhance network adequacy for the underserved, and would allow providers treating the underserved to seek payment from carriers. Some potential ECPs may not have experience or be able to contract with carriers, however, and they would need to meet licensure and credentialing requirements.

3B. (Consensus) Work with state partners to create an ongoing process, using Maryland data sources, to ensure that the CMS list of Maryland ECPs is accurate and complete.

- An accurate list will improve transparency regarding which providers are serving the low income, medically needy population. The list could be a starting point before any ECP participation standards are adopted. Members suggested that Maryland could adopt a process the capture all ECPs at the state level, and then provide this information to CMS.

Essential Community Providers

The MHBE should:

3C. (Without Consensus) Use the FFM threshold for ECP participation and the FFM alternate standard for qualifying carriers.

- The FFM threshold would improve transparency and provide a measureable standard for ECP participation, but adopting the federal threshold in combination with expanding the ECP definition could increase contract pressure on carriers.

Quantitative Standards

The MHBE should:

4A. (Without Consensus) Collect data regarding network adequacy and consider developing quantitative standards in the future (either wait for the NAIC Model Network Adequacy Act or set a specific deadline – *e.g.,* 2018).

- Awaiting the NAIC's model act would allow for a more informed decision on quantitative standards, but the Model Act will recommend the use of quantitative standards without specifying how states should implement them.
- Any standards will need to account for demographic, geographic, and other factors for different regions, should distinguish between emergent and non-emergent care, and should consider the impact on the insurance market. They should also include a safe harbor.

Quantitative Standards

The MHBE should:

4B. (Without Consensus) Work with the MIA, consumer groups, and carriers to define the current unreasonable delay standard so that consumers will better understand when they can see an out-of-network provider with in-network cost-sharing.

- Providing guidance will help consumers know when to take action, like contacting the MIA, but determining compliance with the standard must be on a case-by-case basis, so creating a standard definition could be problematic. MHBE also could only apply the standard to QHPs and not the entire market.

4C. (Without Consensus) Work with the MIA to make the quantitative standards used and reported by carriers in their availability plans submitted to MIA and access plans submitted to the MHBE publicly accessible.

- This requirement would improve transparency and reduce the need for uniform quantitative standards, but carrier availability and access plans may contain proprietary information, and making the information public does not directly improve network adequacy and could be overwhelming.
- Could develop compromise by releasing some, non-proprietary information, and goal could be to balance the release of information with equipping regulators with the ability to enforce standards

Quantitative Standards

The MHBE should:

4D. (Without Consensus) Work with the MIA to standardize the format for reporting quantitative standards in availability plans the MIA requires, and with DHMH to standardize the format for reporting quantitative standards in availability plans DHMH requires.

- A uniform format will help carriers understand what they need to submit to state agencies and could help to provide better categories of standards used by carriers, which can be used for future analysis.
- It may be more of an administrative burden for some carriers, and would require a rule-making process with public input.

Informing Consumers

5A. (Consensus) The MHBE should work with the MIA, carriers, consumer stakeholders, providers, and the Health Education and Advocacy Unit (HEAU) to develop messaging and a reasonable process to inform consumers on how to find a provider and obtain relief when they cannot find a provider pursuant to Ins. Art. §15-830(d).

- Considerations around this policy option included that: 1) more advertising is needed to inform consumers about HEAU; 2) the MIA could update its complaint form to allow consumers to indicate difficulty finding a provider; and 3) all materials developed pursuant to this option should be user-friendly.

Public Comments

Public Comments

- Report was posted on the MHBE website from August 27 – September 4th for public comment
- 17 sets of public comments received
- Stakeholders represented included: county health officers, insurance carriers, stand-alone dental plans, provider groups, mental health and substance use disorder treatment advocates, and social workers
- Comments chart is included within the report, at the beginning of Appendix B

Public Comments List

- Nancy Harrington, Greater Washington Society for Clinical Social Work
- Barbara Cowan, Licensed Social Worker
- Ruth Maiorana, Maryland Association of County Health Officers
- Gene Ransom, MedChi
- Michael Such, DaVita
- Duane Taylor, The MidAtlantic Association of Community Health Centers
- Ellen Weber, The Drug Policy Clinic of the University of Maryland Carey School of Law
- Geralyn Trujillo, America's Health Insurance Plans
- Stephanie Berry, Delta Dental of Pennsylvania
- Natasha Mehu, Maryland Association of Counties
- Leni Preston, Maryland Women's Coalition for Health Care Reform
- Michelle Green Clark, Maryland Rural Health Association
- Nancy Rosen-Cohen, National Council on Alcoholism and Drug Dependence – Maryland Chapter
- Judith Gallant, Maryland Clinical Social Work Coalition
- Tanya Robinson, Kaiser Permanente
- Kery Hummel, Maryland Psychiatric Society
- Colette McKie, Maryland Acupuncture Society

Next Steps

Next Steps

- Co-chairs can provide a more detailed presentation on the options if the Board is interested in pursuing after members have had time to review the report
- The Workgroup and the SAC are available to provide additional information on the process and options developed as the Board reviews the report and begins to discuss QHP certification standards for the 2017 benefit year at next month's meeting
- Implementing some of the options may require another workgroup