

District of Columbia Health Benefit Exchange Authority: Network Adequacy Working Group Meeting 1 Summary

February 14, 2013

The following is a summary of the network adequacy working group meeting one discussion on the issues related to the network adequacy requirements as outlined in the Affordable Care Act (ACA) and the District of Columbia's Health Benefit Exchange Authority's charge to the working group.

Provider Directory Issues

ACA Requirement: Provider directories are required to be listed on the exchange but the accuracy and utility to all residents of the directories were questioned.

It was stated that the directories often list providers who are longer taking new patients, inaccurate contact information, deceased providers, and multiple listings of the same provider to give a false impression of an actual robust network of providers in the District. A suggestion was made to include a "Is this information wrong?" form that a consumer could fill out through the exchange to update provider directory. It was also noted that because of the influx of new enrollees seeking care for the first time, assistance would be necessary to assist enrollees in understanding provider directories. Providers then stated that credentialing agencies (such as CAQH) could be better utilized to update provider directories and they informed the group of the challenges they face in keeping accurate information up to date. There were also concerns about "inexperienced or low quality providers" being the only ones listed in the directories that will accept new patients when the exchange begins operations. Maryland intends to update its centralized provider directory every two weeks, which is in line with how carriers update their information. It was asserted that if provider directories were accurate, Medicaid managed care networks shouldn't have any problems with accessing specialists if provider directories are accurate but in reality many Medicaid managed care patients have difficulty finding primary care and specialists east of the Anacostia. A cause of this could be administrative, billing, and or timely payment issues which in turn is driving providers away.

Essential Community Providers

ACA Requirements: Essential community providers (ECP) are a requirement of the Affordable Care Act which garnered a discussion related to access for low-income, medically underserved residents within the District.

ECPs in the District are struggling with closed network plans both from a reimbursement perspective and access to care. There were suggestions to expand the DC Alliance contract language to the exchange which states that plans must *offer* a contract to any willing provider to increase the amount of essential community providers available. This included also offering medical homes to be included into networks. Contracting with hospitals was also discussed with relations to access to care. There is a concern that closed networks would create desert of hospital care in the District; it was noted that California ECP regulations specially address this issue to prevent deserts of care.

General Access to Care and Network Issues

Mental health and substance providers often do not take insurance in the District. Some of this is the result of mental health providers not being able to get into networks or others choosing not to participate in networks. Psychologists and psychiatrists are not in networks or only contracting with one network creating significant issues for those seeking care with mental health disabilities. Further, many individuals do not have insurance or have inadequate insurance, creating barriers to care.

Problems beyond capacity issues were discussed in great detail and the concern for how well network adequacy standards would be able to address historical and entrenched access issues within the district. The role of the exchange in addressing these issues is to ensure an adequate supply of providers was noted by many. However, it was also noted that the feasibility of health plans to meet aggressive network adequacy standards needs to be carefully considered to ensure that existing plans remain and the District is able to attract new carriers. The expected carriers to participate in the exchange are Kaiser Permanente, Carefirst, United, Aetna, and the DC Medicaid managed care plans.

Consistency of regulations in and out of the exchange was discussed to both ensure access while retaining a dynamic health insurance market. It was also noted that the ACA does not require insurance regulations to be consistent, but some states have made this a requirement. A separate suggestion was to provide provisions for out of network access to care with equivalent cost sharing if enrollees can't get care or timely care in network.

A possible option is to deem plans that have received accreditation as meeting network adequacy requirements. It was noted that the majority of carriers are accredited but access is still a serious problem in the District. Accreditation was not believed to be sufficient due to the large number of access to care issues discussed.

As noted above, locating physicians east of the Anacostia was discussed several times. Public transportation and a general lack a primary and specialty care arising from either capacity or network standpoint was a topic of concern. It was stated that provider rates are less east of the river, but it is difficult to know without comparable data. In the District as a whole, sustainability of physicians was noted to be something that the working group and Board need to consider in making their network adequacy recommendations.

There was a discussion on the possibility of increasing or incentivizing evening and weekend hours to increase access to care. Also, a possible strategy of having mobile health access by either bringing the patients to the providers or the providers to the patients was mentioned.

The District of Columbia has a unique political and urban environment. In addition, the fact that many of its workers live in adjacent states may warrant special consideration when creating network adequacy requirements.

Medicaid, low income residents, and those with chronic conditions

Parts of the District have large populations of Medicaid enrollees and that Medicaid managed care plans should be encouraged to participate on the exchange because this population may move from Medicaid to subsidized private care and having carriers sell both types of plans may ease administrative issues and ensure continuity of care. Another group of citizens that may warrant extra considerations was those with chronic conditions who are ages 55-65. Often these patients utilize large amounts of care but have traditionally had difficulty in obtaining insurance and receiving adequate access to care. It was highlighted that patients with bleeding disorders often have to seek care outside of the District. Oncology was also seen as a difficult specialty to access in the District and that timely access to care following a diagnosis is a problem. There was also a discussion that a lack of data on specialty providers made it difficult to know the totality of the access to care issues. For many patients with chronic conditions they face barriers to access because precipitous cost of medications that do not have a generic available.

Scope of practice

There was a discussion on the scope of practice regulations in the district and how they relate to the ACA and access to care. How providers are defined by the law and the relationship between credentialing versus network adequacy was discussed. It was the viewpoint of one member that nurse practitioners refer and depend more on specialists and that increasing their scope of practice may not increase the supply of primary care providers as they also tend to refer more resources to hospitals. Naturopathic physicians are out of network and are generally not reimbursed by carriers and may be a solution to easing the provider capacity issues. However it was noted that the non-discrimination clause in the ACA only states that carriers who contract with providers cannot limit their scope of practice but the option to contract still remains with the carrier.

Questioner Responses not otherwise discussed above

Several questions were posed to workgroup members that elicited other comments. Many of the comments are discussed above and more general comments are presented below.

1. Most critical access to healthcare issues in DC:
 - a. having navigators to assist;
 - b. having local screening and medical monitoring sites;

- c. expanding scope of access for nurse practitioners, physician assistant, and alternative providers (e.g. naturopathic) to shore up primary care access;
 - d. increasing role of providers to include prevention and wellness guidance;
 - e. increasing access to mental health;
 - f. improving health literacy;
 - g. affordability of specialty care including access to specialty therapeutics;
 - h. increasing communication and coordination between Medicaid, DC Alliance, and Qualified Medicare Beneficiary programs to simplify enrollment and retain enrollees;
 - i. ensuring that reimbursement among specialists who provide for the medically underserved is adequate; and
 - j. reducing chronic conditions to reduce costs.
2. The role health plans can play:
 - a. coverage for services that provide health education;
 - b. providing reimbursement for providers practicing within their scope of practice;
 - c. surveying members regularly to understand their needs;
 - d. maintaining up to date treatment guidelines;
 - e. improving the credentialing process with insurance companies;
 - f. providing better reporting and measurement of network adequacy data;
 - g. increasing education in realigning the diversity of population in DC; and
 - h. making it easier to obtain out of network coverage due to the tri-state reality of the District.
 3. The role the exchange could play in addressing concerns about network adequacy.
 - a. Responses included: ensuring an adequate supply of providers;
 - b. ensuring that provider reimbursement accurately reflects quality of care and time spent with patients;
 - c. having a robust appeals grievance and appeals process,
 - d. a regularly scheduled survey of consumers which includes a rating system based on feedback and an accreditation system;
 - e. ensuring a seamless transition between public and private coverage;
 - f. clear guidance on reducing cancer rate disparities;
 - g. recognizing that choice and cost need to be considered;
 - h. recognizing that changes need to be cautious, thoughtful, and incremental as to not disrupt current care and offer opportunities to innovate.

Data needs

Because of the complexity of network adequacy, work group members identified many areas where more data could inform the future policy making of the DC Health Benefit Exchange Authority. The data needs identified by work group members included:

- Better data on the Scope of the access to care problems in DC
- Building or updating existing studies such the 2008 RAND study, the Urban and Mercer studies, recent RAND cancer study, physician survey study, Jackie Watson study

- Wait times in DC by specialty
- Provider director accuracy over time including data on new patient acceptance rates
- Visual data showing access and healthcare need
- License providers/what specialty/what network or panel, especially behavioral health and adequacy of reimbursement rates in DC
- From carriers:
 - Provider/patient ratios by specialty by ward
 - Wait times
- Access to providers who speak other languages
- Plan to improve access from carriers using data (look to other states)
- Software to monitor data from Maryland
- Medicaid managed care contractor's compliance with the District's network adequacy standards