DC Health Benefit Exchange Authority

February 28, 2013

Network Adequacy Working Group Final Draft Recommendations for the District of Columbia Health Benefit Exchange Authority

The Affordable Care Act (ACA) requires that all exchanges develop a process to ensure that carriers' qualified health plans meet the following network adequacy requirements for health plans that become effective on January 1, 2014. For network adequacy, the ACA requires[1] that carriers must:

1. Have a network for each plan with sufficient number and types of providers to ensure that all services are accessible without unreasonable delay.
2. Have a network that must include providers which specialize in mental health and substance abuse services.
3. Have a network with sufficient geographic distribution of providers for each plan.
4. Have sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the service area.
5. Make its provider directory available to the exchange for publication online in accordance with guidance from the exchange, and to potential enrollees in hard copy upon request. This directory must identify providers that are not accepting new patients.

The ACA allows an exchange discretion and flexibility on how to certify that these requirements are met. The operational capacity to develop and implement standards to meet these requirements within a limited timeframe should be considered in determining how an exchange will verify that these requirements are satisfied. States in general have been following three approaches for confirming these requirements:

1. The exchange verifies directly by collecting data that ACA requirements have been met.
2. The exchange accepts verification by a carrier that it has met requirements through attestation.
3. The exchange uses a combination of attestation, reliance on an accreditation entity, and direct collection of data to verify that requirements are met.

[1] Summarized from US Code of Federal Regulations 45 CFR Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans *§ 155.1050 and 156.230*

Given that a state-based exchange has the opportunity to establish standards for what constitutes a sufficient number and types of providers to meet its own market dynamics and ensure consumer protection, the Working Group recommends that the DC HBX use the next two years to collect the data needed to adequately assess network adequacy, and then in year three implement District-specific network adequacy standards as outlined in step 3 below.

Recommendation 1: Phase In Network Adequacy Requirements.

To meet ACA requirements during the initial start-up period, the Working Group recommends that the DC HBX adopt the following hybrid approach for how carriers will meet network adequacy requirements as outlined below in a three step process covering the first two years of exchange operation:

Step 1, Year 1 (For coverage effective starting January 1, 2014)

In the first year, the DC HBX will require carriers to attest that they meet the five ACA requirements as described above through standards that they have developed or that are in current use.

Step 2, Year 1 (2014)

During year 1, the DC HBX works with the Department of Insurance, Securities and Banking (DISB) to collect data to assess the current environment of network adequacy in terms of the following:

- Adequacy of current processes and procedures
- Scope of gaps and challenges with network adequacy as documented through this assessment
- Impact of implementation of the ACA network adequacy standards on key factors such as premiums, carrier participation, provider participation on panels, and enrollment

Carriers will submit an access plan by July 2014 that reports on how they have met network adequacy requirements and their plan to correct any deficiencies. The access plan should consider at least the following dimensions of access:

- Metrics for primary care providers (PCPs), specialty providers, and mental health and substance abuse providers specified in terms of:
  - Time and distance
  - Wait time
  - Provider to patient ratios
- Access to ECPs
- Provider directory accuracy.

In determining other data to include in the access plan, the DC HBX should consider the National Association of Insurance Commissioners (NAIC) *Plan Management Function: Network Adequacy*

White Paper and National Committee for Quality Assurance (NCQA) NCQA accreditation standards on access and availability.

Step 3, Year 2 (2015)

Based upon data provided by carriers in the access plans they submit in July 2014, the DC HBX will issue a request to carriers for additional data on DC specific metrics. It will use these data to develop standards in year 2, with the goal of having DC-specific standards applicable in year 3.

Recommendation 2: Data Collection Process.

The DC HBX will work with participating carriers to specify the process for collecting baseline data to assess the dimensions of network adequacy as outlined in the above three step process. Where possible, given the overlap of markets, the DC HBX will consult with the appropriate Maryland and Virginia agencies to achieve consistency in requests for network adequacy data .

Recommendation 3: DC Specific Standards.

The Network Adequacy Working Group recommends that the following areas be addressed in DC specific standards which would become effective for the January 2016 plan year. It is anticipated that these standards will be verified through prospective regulatory review. The Working Group further recommends that the DC HBX involve DISB, participating carriers, key stakeholder groups, and quality improvement experts in developing needed standards and the mechanisms for ensuring compliance.

1. Metrics for PCPs, specialty providers, and mental health and substance abuse providers
    a. Time and distance
    b. Wait time
    c. Provider to patient ratios
2. Access to ECPs. The Working Group recommends that a provision be adopted to encourage the inclusion of ECPs into a carrier's network while recognizing that ECPs must meet applicable carrier requirements
3. Access to mental health and substance abuse providers.

    Note: Following the conclusion of the Working Group meetings, Dr. Stephen Baron, Director of the DC Department of Mental Health, asked that the DC HBX consider including public sector mental health and substance abuse resources as part of the universe of providers carriers include in their network with the understanding that these public sector resources must meet applicable carrier requirements.
4. Provider directory accuracy
5. Ensure that plan beneficiaries have appropriate access to full range of covered benefits

    Note: While the Working Group agreed that the DC HBX will need to ensure that plan beneficiaries have appropriate access to the full range of covered benefits, there was a divergence of opinion about the extent to which this was a measureable problem and, if so, whether a new enforcement mechanism was needed to ensure compliance. There were members of the Working Group, including representatives from consumer groups,

that supported imposing a remedy such as reduced out-of-network cost sharing when plan members cannot obtain access to in-network providers. Other members of the Working Group object to the imposition of a policy to reduce out-of-network cost sharing when plan members claim they cannot obtain access because some carriers report that they have an adequate process to provide reasonable access. Given this divergence, the Working Group recommends that DC HBX monitor this issue during the two year start-up period and, if needed, develop a policy for the next plan year. In developing this policy, the DC HBX Board should involve representatives from participating carriers and stakeholders.

In summary, the recommended phased approach for assessing and monitoring the network adequacy of the qualified health plans that will participate in the DC HBX should be designed to meet any documented problems that District residents have in obtaining covered services. This assessment should consider how changes in network adequacy requirements would affect the District healthcare market.