

## **Background Paper on Network Adequacy and Essential Community Providers**

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### **Background**

The Patient Protection and Affordable Care Act (ACA) directs the U.S. Department of Human Services (HHS) to issue certification criteria for Qualified Health Plans (QHPs) sold in American Health Benefit Exchanges. In March 2012, HHS issued final rules governing the Exchanges, including requirements for insurers and QHPs offered through the Exchange. These standards include QHP requirements related to health plan network adequacy and the inclusion of essential community providers.

This background paper has two purposes:

- 1) to describe federal Exchange requirements related to network adequacy and essential community providers and to compare those requirements to existing related state laws and rules. As previously noted in work group discussions, these existing standards will serve as the basis for addressing federal certification requirements for the first year of Exchange certification and operation.
- 2) to outline potential other options for network adequacy and related issues that may be considered for implementation starting in 2015. Adoption of new standards would require modification of existing statutes and/or rules. Insurers would subsequently need adequate lead time to develop and seek certification for new products meeting different standards.

### **Federal Network Adequacy Requirements and Existing State Standards**

On March 12, 2012, HHS issued the final rules governing the establishment of Exchanges and Qualified Health Plans. These rules include network adequacy standards requiring Exchanges to ensure that QHP provider networks are sufficient in number and types of providers, including mental health and substance abuse providers, to assure that all services are accessible without unreasonable delay.<sup>i</sup>

While Minnesota does not currently have market wide requirements for network adequacy, the state does have network adequacy standards for Health Maintenance Organizations (HMOs). Minnesota Statutes 62.D 124 prescribes geographic access standards for HMOs, guaranteeing enrollee access to primary and specialty care within in the service area. Enrollees must be able to access primary care within 30 miles or 30 minutes of travel time while specialty care must be available within 60 miles or 60 minutes. HMOs must also contract with or provide enrollees with sufficient and appropriate resources to meet anticipated need for health services and implement guidelines to assess the capacity of each provider network to provide timely access to care.

The Minnesota Department of Health (MDH) reviews network adequacy standards and is the lead regulatory and licensing agency for HMOs operating in the state. HMOs seeking authorization must file their networks for approval with MDH. Issuer filings contain maps displaying the physical location of providers within the proposed service area. Provider networks which do not reach the 30/60 mile radius

requirement for the entire service area must either contract with additional providers or apply for an exemption from MDH. In practice, exemption applications are generally related to provider shortages in rural parts of the state. Issuers do not currently provide notification when providers stop accepting new patients.

HMOs may request exemption from the network adequacy requirements by providing MDH specific data demonstrating that the requirement is unfeasible in some portion of the service area. Criteria for granting an exemption include utilization and referral patterns and the ability to pay for non-contracted providers.<sup>ii</sup> While there is no similar exemption explicit in the final rule from HHS, the preamble reflects regulators intent that the standard "...should reflect local geography, demographics, patterns of care, and local market conditions..."<sup>iii</sup>

Other potential standards for network adequacy exist and could be considered for Minnesota's QHP certification process. Examples include standards used in other states' commercial markets and those employed in the Medicaid and Medicare Advantage programs.

### **Network Adequacy in Other States**

At least 20 states require private insurers to meet network adequacy requirements for managed care plans such as Health Maintenance Organizations (HMOs). Several states have implemented National Association of Insurance Commissioners' Managed Care Network Adequacy Model Act, requiring managed care plans to maintain a network sufficient to deliver all covered services without unreasonable delay.<sup>iv</sup> Washington State extends network adequacy standards to other products in the commercial health insurance market that rely on provider networks to provide medical care. North Carolina requires all network based plans to develop their own network adequacy standards.<sup>v</sup> Additional options for state network adequacy criteria include the following:

- Urban and rural geographic accessibility
- Provider-covered person ratios by provider type (providers per 1,000 enrollees)
- Appointment wait times
- Availability of primary care physicians and high utilization specialists
- Provider hours of operation
- Volume of technological and specialty and ancillary services to meet projected need
- Hospital access and physician admitting privileges
- Patient referral patterns

### **Network Adequacy in Medical Assistance, MinnesotaCare, and Medicare Advantage**

Federal law requires Medicaid Managed Care Organizations (MCOs) to provide assurances that they have capacity sufficient ensure that covered services are available to enrollees whenever they are medically necessary. Upon contracting with a state Medicaid agency, issuers must provide documentation showing that the organization offers a range of providers sufficient in number, provider mix, and geographic distribution to meet the anticipated needs of enrollees.<sup>vi</sup> Issuers must also provide

notice of any significant changes in the network that would affect access including changes in benefits, service area, and enrollment.<sup>vii</sup>

Minnesota's Medicaid and MinnesotaCare managed care contracts include standards for enrollee access to primary and specialty care with the same time and distance requirements as HMOs operating in the state. State provider contracts in Minnesota build on these standards with additional provisions guaranteeing timely access to covered services including appointment availability and transportation time standards.<sup>viii</sup> Participating MCOs must also offer appropriate services to special needs groups including persons with severe and persistent mental illness, enrollees with language barriers, cultural and racial minorities, and people with physical disabilities.<sup>ix</sup>

The Centers for Medicare and Medicaid Services (CMS) has established provider network criteria for Medicare Advantage as measured by minimum numbers of providers and maximum travel time and travel distance to providers. These criteria vary by facility and specialty type and U.S. Census geographic designation. CMS minimum provider ratios per 1,000 beneficiaries are set by specialist type based on utilization patterns and projected clinical need. Insurers must also include a minimum number of acute hospital beds per 1,000 beneficiaries in each county and must demonstrate a sufficient number of select contracted hospital based providers including anesthesiology, emergency medicine, pathology, and radiology. Maximum time and distance requirements are calculated by mapping a sample of beneficiary locations juxtaposed against provider locations. Each insurer must demonstrate that 90% of its network meets the established time and distance requirements.<sup>x</sup>

#### Other Issues Related to Provider Networks

Work group members also expressed interest in exploring options for how often insurers must update provider network information, what type of notice is required for enrollees when a provider network changes and the degree of change that would trigger such notification requirements.

An HMO is currently required to file a network when it first seeks approval to operate in the State. Networks are filed at the issuer level rather than tied to a specific product. HMOs are then required to report most terminations to networks 120 days in advance of potential provider contract terminations, but few contracts are actually terminated. Under more urgent circumstances (for "cause", such as loss of license or death), [terminations must be reported within ten working days of the date the HMO receives the notice or termination](#). These changes trigger a review by MDH staff to determine whether networks are still adequate.

Managed care organizations (MCOs) serving Medical Assistance and MinnesotaCare enrollees have stricter requirements with respect to network changes and enrollee notification. MCOs must notify the state and enrollees of a material change in provider network. Under limited circumstances, enrollees experiencing provider disruption due to a material change in network may move to different MCO.<sup>xi</sup>

#### Essential Community Providers

The final rules from HHS also require QHPs to include within its network a sufficient number and geographic distribution of essential community providers, where available, that serve predominantly low income, medically underserved individuals. Providers meeting this definition deliver significant care to the uninsured and enrollees in public programs and are eligible for the drug pricing program authorized by section 340(B) of the Public Health Services Act. These would include Federally Qualified Health Centers, Indian Health Centers, rural health clinics, disproportionate share and critical access hospitals, and other traditional safety net providers.<sup>xii</sup> Staff model health plans or integrated delivery system plans that contract with a single medical group must have a sufficient distribution of providers to ensure reasonable and timely access for low-income, medically underserved individuals in its service area.<sup>xiii</sup> In some limited circumstances this may require staff model and integrated delivery systems to provide additional contracted or out of network care.

Minnesota Statutes 62Q.19 also requires all health plans (public or private) to offer contracts to designated essential community providers within its service area.<sup>xiv</sup> The Minnesota Department of Health designates essential community providers pursuant to statutory requirements<sup>xv</sup>. To qualify, providers must have a demonstrated ability to integrate appropriate and stabilizing services such as transportation and child care with medical services for underserved, high-risk, and special needs populations. Providers must also demonstrate a commitment to serve low income, underserved populations and may not restrict access to services because of a client's financial situation.<sup>xvi</sup> Once providers receive this designation, the designation remains in effect for five years.<sup>xvii</sup> In practice, the vast majority of those designated by state authorities also meet the similar federal definition of essential community provider.<sup>xviii</sup>

Minnesota law is stronger than the federal requirement and requires health plans that contract with providers to offer contracts to all state-designated essential community providers in its service area.<sup>xix</sup> Because Minnesota already has a stronger set of standards related to essential community providers than required by federal QHP certification rules, the work group may choose to discuss these provisions or to affirm that existing state policies in this area should remain in place for purposes of QHP certification.

#### **Factors to Consider Related to Network Adequacy Standards**

The goal of network adequacy requirements is to assure that a network can provide enrollees access to covered services. While the federal guidance suggests a quantitative standard for provider network adequacy, the rules stop short of prescribing specific provider to enrollee ratios or proximity requirements. The standard that all services be available without unreasonable delay conveys a clear intent, but provides states with discretion to structure network adequacy standards to account for local conditions. Under the current rules, states must, at a minimum, must ensure the inclusion of essential community providers, mental health and substance abuse providers, and providers that offer essential health benefit services.

The following discussion questions may be helpful in determining whether to recommend additional or different network adequacy standards in the future:

- How well are existing network adequacy standards working from the perspective of various stakeholders?
- What changes will occur as a result of establishing an Exchange that may prompt reconsideration of existing standards?
- What strategies could be used to assure that medically necessary services are being provided without unreasonable delay?
- What are the best approaches to notify regulators and enrollees regarding significant changes to provider networks or changes in existing provider capacity to accept new patients?
- What enforcement mechanisms would be most effective to accommodate changes to existing network adequacy standards?
- Are there differences between the fee for service and managed care marketplace that could necessitate variations in standards between product types?
- Should network adequacy standards for QHPs include criteria for the provision of out of network services under limited circumstances of medical necessity?

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<sup>i</sup> 42 CFR § 156.230

<sup>ii</sup> MN Rules 4685.1010

<sup>iii</sup> United States Department of Health and Human Services, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans”, p. March 12, 2012.

<sup>iv</sup> National Association of Insurance Commissioners, “Plan Management Function: Network Adequacy Function,” May 2012. Accessed at [http://www.naic.org/documents/committees\\_b\\_exchanges\\_120531\\_network\\_adequacy\\_white\\_paper.pdf](http://www.naic.org/documents/committees_b_exchanges_120531_network_adequacy_white_paper.pdf)

<sup>v</sup> Meeting of the North Carolina Health Benefit Exchange Workgroup, October 26, 2011. Accessed at [http://www.ncmedicaljournal.com/wp-content/uploads/2011/07/HBE-summary\\_final\\_2011-10-26.pdf](http://www.ncmedicaljournal.com/wp-content/uploads/2011/07/HBE-summary_final_2011-10-26.pdf)

<sup>vi</sup> 42 CFR § 438.207

<sup>vii</sup> 42 CFR § 438.207.

<sup>viii</sup> Minnesota Department of Human Services Contract for Medical Assistance and MinnesotaCare,” Section 6.15. Available at [http://www.dhs.state.mn.us/main/groups/business\\_partners/documents/pub/dhs16\\_156514.pdf](http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_156514.pdf).

<sup>ix</sup> Minnesota Department of Human Services Contract for Medical Assistance and MinnesotaCare,” Section 6.17. Available at [http://www.dhs.state.mn.us/main/groups/business\\_partners/documents/pub/dhs16\\_156514.pdf](http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_156514.pdf).

<sup>x</sup> Centers for Medicaid and Medicare Services, “2011 CMS Medicare Advantage Network Adequacy Development Overview,” no date of publication. Accessed at [https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/downloads/2011\\_MA\\_Network\\_Adequacy\\_Criteria\\_Overview.pdf](https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/downloads/2011_MA_Network_Adequacy_Criteria_Overview.pdf)

<sup>xi</sup> Minnesota Department of Human Services Contract for Medical Assistance and MinnesotaCare,” Section 3.2.6. Available at [http://www.dhs.state.mn.us/main/groups/business\\_partners/documents/pub/dhs16\\_156514.pdf](http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_156514.pdf).

<sup>xii</sup> 42 CFR § 156.235

<sup>xiii</sup> 42 CFR § 156.235 (b)

<sup>xiv</sup> MN Statutes § 62Q.19 and MN Rules 4688.0050. Note: Public programs serving fewer than 50,000 enrollees are exempt from this requirement.

<sup>xv</sup> MN Statutes § 62Q.19

<sup>xvi</sup> Ibid.

<sup>xvii</sup> A list of approved essential community providers may be found on the MDH website at <http://www.health.state.mn.us/divs/hpsc/mcs/ecp.htm>

<sup>xviii</sup> Interview with staff at the Minnesota Department of Health, June 19, 2012

<sup>xix</sup> MN Statutes § 62Q.19