# Provider Networks: Renewed Scrutiny on Adequacy and Accurate Directories

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**Renee Kimm**, Assistant Compliance Counsel, Central Health Plan of California
**Ryan Morgan**, Attorney, Polsinelli PC

## Disclaimer

- The thoughts and opinions expressed by Ms. Kimm are her own and do not reflect those of Central Health Plan of California or any affiliated company.

# How Did We Get Here?

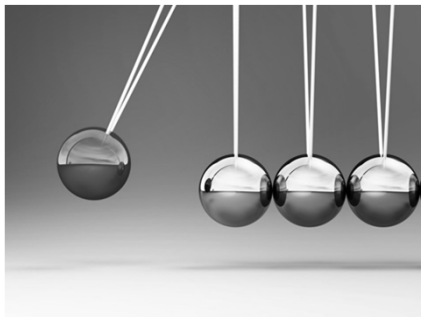
- Rise of HMOs in 1970s and 1980s
  - Desire to control costs
    - Credentialed network of providers
    - Managed care controls
  - Federal and state health care insurance funding intended to help rural, poor, elderly.
    - Financial incentives to enter market, but difficult requirements.
    - HMO Act of 1973.
  - Many forms of HMOs
    - Provider-Sponsored (Marshfield Community Health Plan)
    - Exclusive system (Kaiser)
    - IPA (Bay State Health Care)
    - Capitated Primary Care (US Healthcare)

# How Did We Get Here?

- HMO Fall from Grace by mid 1990s
  - Member complaints about managed care
    - Denied services
    - Limited referrals
    - Limited choice of provider
    - Forced into HMO by employer
  - Provider complaints about managed care
    - Preference for choice of treatment
    - Preference for predictability of fee-for-service payment
  - Employers lagging behind
    - General reluctance to change health benefit structure
    - Failure to offer choice of plans
    - Failure to offer employees share of savings

# How Did We Get Here?

- The Pendulum Swings
  - Movement towards all-inclusive networks
  - Rise of PPOs → Member incentive to use network providers, but still coverage for OON
  - Reduced control over cost and quality



# How Did We Get Here?

- The Pendulum Swings Back
  - Increasing cost of health care
    - Pressure on Plans to innovate new ways to manage care, including narrow networks
    - More engaged employers, demanding custom networks
  - Success of MA, Part D, Medicaid managed care
  - Rise of ACOs, CINs
  - Evolving market incentives
    - Changed perception of managed care
    - Insurer consolidation
    - cross industry mergers
  - New challenges

# Current State of Provider Networks

- Narrow networks are back
  - Market demands generally (cost and quality)
  - Opportunity to co-brand
  - Affordable Care Act limited other insurer cost control strategies
  - 1/3 of MA plans have narrow networks
- Narrow networks are effective
- How narrow is too narrow?
  - Patient access concerns
  - Adequacy concerns
  - Quality concerns
  - Provider concerns

# Provider Directories in MA

- In accordance with 42 C.F.R. §422.111 and guidance in section 100.2.2 of the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual), organizations are required to provide the number, mix and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services.

# Provider Directory Accuracy

- CMS began to examine the accuracy of information contained in online provider directories in 2016
  - CMS intends to conduct a review of all Medicare Advantage Organizations (MAOs) over the course of 3 years
  - Anticipates reviewing approximately 1/3 of all MAOs each year

# Directory Review Process

**Phase 1:**

- Calls to each provider's office to verify information accuracy
  - Does the provider see patients at this location?
  - Does the provider accept the MA-PD plan at this location?
  - Does the provider accept (or not accept) new patients who have this MA-PD plan?
  - Is the provider a [PCP, cardiologist, oncologist, or ophthalmologist]?
  - Is the address correct?
  - Is the telephone number correct?
  - Is the provider's name correct?
  - Is the practice name correct?
- Shared initial deficiencies with the Plan Sponsor
  - 2 weeks to issue Plan response
- CMS reviews and makes final determination
  - Plan has 30 days to make all required corrections

# Directory Review Process

**Phase 2:**

- CMS validates deficiencies have been corrected
- May look at the Plan Sponsor's Health Service Delivery (HSD) tables, if needed

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# Directory Review – 1st Round Results

- CMS reviewed the online provider directories for 54 parent organizations
  - February through August 2016
  - 108 providers reviewed per MAO
    - 5,832 providers at 11,626 locations
  - Providers:
    - Cardiologists
    - Oncologists
    - Ophthalmologists
    - Primary Care Physicians (PCP)
- Results: 45.1% of provider directory locations inaccurate

# Common Directory Inaccuracies

- Providers not at the location listed
- Inaccurate phone number
- Provider was not accepting new patients when directory noted that they were

# Compliance Actions

- During first round of reviews, the following compliance actions were issued:
  - 31 Notices of Non-Compliance
  - 18 Warning Letters
  - 3 Warning Letters with a Request for a Business Plan

## Contributing Factors Identified By CMS

- Group practices may be providing data at a group level rather than at the provider level
- Lack of internal auditing and monitoring of provider directory accuracy
- Providers who have been retired or deceased for a long period of time are still listed in the provider directories

## Best Practices Identified By CMS

- Self-audits, monitoring, and validation of provider directory data
- Work with group practices to ensure providers are only listed at the locations where they accept appointments
- Develop internal processes for members to report provider directory errors
- Machine readable format
- List the provider's medical group, institutional affiliation, non-English languages spoken by the provider, website address, accessibility information for those with physical disabilities

# MA Directory Considerations

- Assess your internal process
  - How accurate is the Plan's current provider directory?
  - What is the Plan's process for updating it?
  - Who owns the process internally at the organization?
  - Are there any gaps in your current process that need to be addressed?
  - If working with a vendor, what is the vendor's process?
- Focus on improving the areas that CMS gives the most weight/priority when scoring

| Final Deficiency | Deficiency Weight |
|---|---|
| **Provider should not be listed in the directory at this location** | 3 |
| **Phone number needs to be updated** | 3 |
| **Provider is not accepting new patients** | 3 |
| **Address needs to be updated** | 2 |
| **Address (suite number) needs to be updated** | 1 |
| **Provider IS accepting new patients** | 1 |
| **Specialty needs to be updated** | 1 |
| **Provider name needs to be updated** | 0 |

# MA Directory Considerations

- Audit your provider directory on a consistent basis to ensure accuracy
  - Need to consider your resources
- Assess how you will work with your providers in order to obtain accurate information
- Contractual provisions

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# Provider Directory for Marketplace

- QHP issuers must ensure that the directory:
  - Is available online
  - Is available in hard copy on request
  - Identifies providers that are not accepting new patients
  - Is updated on a monthly basis
- 30 days written notice of provider termination to Members seen on a regular basis by provider

# Network Adequacy in MA

- Medicare Advantage organizations (MAOs) must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served.
  - Minimum number of provider/facility types
  - Quantitative time and distance requirements
  - 42 CFR 417.414, 417.416, 422.112(a)(1)(i), and 422.114(a)(3)(ii)

# Network Adequacy Considerations

- Changes in provider directories may affect beneficiary access
  - Plan Sponsors should also update their Health Service Delivery (HSD) tables accordingly and ensure that the current network still meets standards.

# Network Review

- Previous Process
  - Review at the time of application
- Beginning 2019
  - Remove the HSD submission requirement and network review from the application process
  - Review the MA provider & facility networks at a minimum of every 3-years or sooner if there is a "network triggering event"

# Triggering Events

- Initial application
- Service Area Expansion applications
- Initial offerings of a provider-specific plan
- Potentially significant provider/facility contract termination
- Change of ownership
- Network access complaints
- Organization-disclosed network deficiencies

# Review Process

- HSD upload request letter to all MAOs with contracts that haven't received an entire network review in the previous 12 months
  - 60 days in advance
- MAOs will have 60 days to prepare HSD tables and test networks
- Compliance actions for deficiencies
- 3-year network review anniversary date for the contract is reset

# MA Network Adequacy Considerations

- Implement a provider network oversight process
  - Ensure ongoing compliance with new guidance
  - Implement policies & procedures:
    - Investigating network issues/complaints
    - Handling provider terminations
    - Reviewing network adequacy subsequent to updates
    - Notification to regulators or members

# Network Adequacy for Marketplace

- ACA network adequacy requirements for QHPs
  - Sufficient numbers and types of providers
    - Including mental health and substance abuse providers
    - Services must be accessible without unreasonable delay
  - Essential community providers (min 20%)
- No ACA criteria for:
  - Minimum enrollee/provider ratios
  - Maximum travel distance/time
  - Maximum wait time
- CMS will rely on state reviews for enforcement, provided state review processes are sufficient

# Network Adequacy for Part D

- Typically, CMS requires the beneficiaries have "convenient" access to retail pharmacy close to home
- CMS access/adequacy rules do not apply to "preferred pharmacy networks"
  - Lower copays in exchange for lower reimbursement
  - Essentially a preferred provider tier
- Any Willing Pharmacy laws do not apply to preferred pharmacy networks
  - Non-preferred pharmacies can participate in network at lower tier

# Network Adequacy for Self-Funded

- No specific ERISA regulations on network adequacy
- ACA rule on cost-sharing maximum
  - Amounts balance-billed by OON providers does not count toward out-of-pocket maximums. ACA §§ 2707(b), 1302(c).
- Plans can comply with cost-sharing maximum requirement if the plan "uses a reasonable method to ensure that it provides adequate access to quality providers."
  - Narrow network must not serve as "subterfuge" to evade cost-sharing maximums.

# Network Adequacy Enforcement

- Provider initiated network adequacy suits
  - *In re: Seattle Children's Hospital's Appeal of OIC's Approvals of HBE Plan Filings*, Doc. No. 13-0293 *(2014)*
- Any Willing Provider laws
- Antitrust
  - *US & North Carolina v. The Charlotte-Mecklenburg Hospital Authority*, No. 3:16-cv-00311 (W.D.N.C. 2016)
  - ASC-initiated suits

# Best Practices

- Review compliance with network adequacy and provider directory rules
- Add narrow network and steerage language to provider agreements
- Anticipate balance billing issues
- Anticipate surprise billing issues with hospital based providers
- Anticipate OON reimbursement disputes
- Ensure appeals/grievance systems are compliant
- Ensure system edits in place for OON emergency claims

Thank You!