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Combating healthcare fraud in New Jersey

an interview with Paul J. Fishman

United States Attorney for the District of New Jersey

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by Michael S. Adelberg

Narrow network health plans: New approaches to regulating adequacy and transparency

» New network adequacy measures are coming across Medicare, Medicaid, and the health insurance Marketplaces.
» Network adequacy measures will be followed by new provider network transparency requirements.
» Soon, researchers and consumer advocates will be continually monitoring and comparing provider networks.
» Compliance departments will need to assure that approved networks do not slip after approval.
» This is part of a larger trend toward data-focused oversight and making real-time plan data publicly available.

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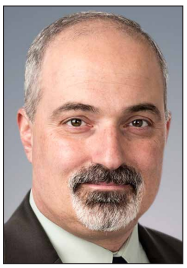
Today, health plans are doing all they can to hold down premiums against a backdrop of aging members and increasingly expensive therapies, particularly biologics and other specialty drugs. A widely used cost containment method is narrowing provider networks to those willing to accept discounted reimbursement. It is hard to precisely quantify the growth of narrow network health plans, because they have no uniform definition and the data is ever-changing and disaggregated. But the Affordable Care Act, by creating public marketplaces that facilitate comparison shopping on plan premiums, pressures insurers to hold down costs through narrow networks. Three studies demonstrate the results: (1) A study of five markets suggests that marketplace plan networks have ⅓ fewer providers than employer plans in the same markets;[1] (2) A study of physician participation in 2015 Marketplace plans concluded that 41% of qualified health plans have "small" or "x-small" networks;[2] (3) A study of hospital participation in 2015 Marketplace plans concluded that 55% of such plans have either "ultra-narrow," "narrow," or "tiered" hospital participation.[3]



Adelberg

It is widely assumed that the trend toward narrowing networks is rippling well beyond the Marketplaces and across health insurance markets. Another recent study suggests this is occurring "in the western United States" in particular.[4]

The consumer trade-off for selecting a narrow network plan should be obvious. In exchange for a lower premium, the consumer has access to fewer providers. This is a fair trade-off when the consumer fully understands which providers are available and can access needed services without exceptional inconvenience. But understandable complaints arise when Ms. Smith, a consumer living in Center City, must drive 30 miles into the exurbs to see the nearest network specialist, or when Mr. Johnson selects Plan A to gain access to Dr. Jones, only to find out that she is not accepting new Plan A members. These situations

aggrieve consumers, anger advocates, and, if more than isolated incidents, force regulator attention. Indeed, the range of concerns and complaints about narrow networks over the last two years has stirred both the Centers for Medicare & Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC) into action.

Today's focus: Provider network adequacy

In their consumer protection roles, CMS and the NAIC are taking a fresh look at the potential downside of the narrow network trade off. Particularly at CMS, the ground is being seeded to make provider network oversight the next major regulatory push—a push that will bridge across all three of the agency's major programs, Medicare (Medicare Advantage), the health insurance Marketplaces, and Medicaid. The current state of affairs between health plans and regulators regarding the oversight of network adequacy is changing, and certain trends are emerging. Regulatory attention is evolving from network *adequacy* to network *transparency.*

Medicare Advantage

Medicare Advantage (MA), Medicare's managed care program, continues to grow. Roughly 16 million Americans are enrolled in MA plans—about 30% of all beneficiaries. New Medicare Advantage plan applicants, including existing MA contractors expanding into new service areas, submit Health Service Delivery (HSD) tables that list their contracted providers across a broad array of provider and facility categories. These tables are geo-mapped against the service area's Medicare population and a default time/distance standard to assure network adequacy. If the plan applicant does not meet the network adequacy standard, it receives a deficiency notice from CMS and is given the opportunity to bolster the network. Alternatively, the plan applicant can seek an exception, explaining why it cannot meet a particular standard (i.e., lack of a provider type in the county). Importantly, once the applicant is approved, it does not have to resubmit HSD tables to CMS. Except in the rare case in which CMS investigates plan performance, the MA plan does not have to re-prove that its network continues to meet the CMS standard.

However, CMS is implementing a system upgrade that could change this. The agency is rolling out a Network Management Module (NMM) that enables it to:

1. Check provider networks for compliance with the CMS standard at any time; and
2. Let MA plans self-check for their continued compliance with MA network adequacy requirements at any time.

CMS also announced that it expects to conduct network adequacy "pilot audits" in 2015, in which it will probe whether provider networks are narrowing after receiving CMS approval. This is within existing agency authority. The NMM will soon expand into Medicare Part D, testing retail pharmacy access standards as well. The establishment of the NMM gives CMS the ability to require MA plans to resubmit HSD tables at any time, whether based on beneficiary complaints, provider directory inconsistencies, or broader performance concerns. The tool gives MA plans the ability to test their networks at any time in the NMM. This is a significant service to health plans, but it also greatly strengthens CMS's hand when it determines a MA plan to be non-compliant. The agency now can argue that the MA plan "should have checked and should have known" that their network was narrowing to the point of non-compliance. Although pilot audits are not generally punitive, CMS still may choose to impose penalties that include monetary penalties and enrollment freezes for significant network problems.[5]

Health insurance Marketplaces and other commercial insurance markets

Provider networks in commercial market insurance products are overseen by state Departments of Insurance to assure they are adequate. The regulatory approaches taken by the states are as diverse as the states themselves. According to a recent study, 27 states conduct some type of quantitative network adequacy review (e.g., a time-and-distance test). However, in 11 of those states the review is confined to HMOs. PPOs and other products that allow members to go outside the network are not subject to quantitative review. The remaining 23 states do not have quantitative review standards, but most conduct other reviews. In rural states where the number of carriers and providers is low, an "eyeball" review from an experienced regulator can be rigorous. States also reserve the right to investigate complaints, administer market conduct exams, and perform ad hoc provider network checks during the year.

Marketplace qualified health plans (QHPs) may be reviewed by the entity operating the state's health insurance Marketplace (the state Marketplace or CMS as the federally facilitated Marketplace). The ACA requires the Marketplace to assure the QHPs provide "reasonable access" to members. Marketplaces can choose more rigorous standards than those used by the Department of Insurance. In the states in which CMS operates a federally facilitated Marketplace, CMS collects the provider network data necessary to conduct rigorous network adequacy reviews and sends deficiency notices to insurers with potential network concerns. It then accepts resubmissions or justifications from the QHP applicant and confers with the State Department of Insurance to see if the concern is adequately addressed. Unlike Medicare Advantage, the submission and review of provider networks is an annual process for all QHPs operating in the federally facilitated Marketplace.

Amid discussion about the need to more effectively regulate narrow networks, the NAIC convened a working group last year to look at their model network adequacy act, which has not been updated since 1996. The new draft model act includes updates related for the ACA (i.e., the inclusion of Essential Community Providers) and healthcare delivery innovations (i.e., telemedicine). Although the working group has not yet completed its work, it appears unlikely that the act will include specific quantitative standards or prescribe methodologies for measuring network adequacy. But spurred by the increased attention, many states have increased their level of network oversight in advance of the NAIC completing its work. At least four state insurance commissioners, in Colorado, New Hampshire, Ohio and Oregon, have received or are currently receiving public comment regarding strengthening their state's provider network oversight.[6]

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Medicaid

Similar to the commercial markets, states are the primary enforcer of Medicaid network adequacy, and similar to commercial markets, they have adopted widely differing approaches to overseeing Medicaid provider

networks. Given the uniqueness of Medicaid beneficiary populations (i.e., high behavioral health needs, large numbers with complex conditions, reliance on public transportation, reliance on safety net providers), it could be reasonably argued that Medicaid provider networks require the most oversight. A recent study by the California State Auditor found significant inaccuracies (more than 23% in one plan) in reported Medicaid provider networks. And a September 2014 HHS Office of Inspector General (OIG) Report was critical of the network adequacy checks performed by state Medicaid agencies. The report concluded, for example, that state-to-state standards for primary care providers varied from 1-per-100 beneficiaries to 1-per-2,500 beneficiaries—a variation too large to be explained by differences in local patterns of care. Noting the growth of Medicaid to 70 million beneficiaries and the emergence of managed care as the dominant delivery system within it, the OIG challenged CMS to "strengthen its oversight of State standards and ensure that states develop standards for key providers" and "ensure that States conduct direct tests of access standards."[7,8]

Informed by the OIG report, which also suggests reluctance in many states to act on network issues, CMS recently issued a proposed regulation that would enhance network adequacy oversight over Medicaid managed care plans and also maintain state flexibility and its role as the primary enforcer of network standards. Per the proposed regulation, "states must establish time and distance standards" for a variety of provider types. But, as proposed, the state maintains the key roles as the setter of the time/distance standards and the enforcer of those standards. CMS is seeking comment on this approach and will likely finalize the regulation before the end of this year.[9]

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Tomorrow's focus: Provider network transparency

The trend toward more empirical approaches to measuring network adequacy is not without critics. Some state officials, for example, have argued that they know their market, and hard numerical tests could be arbitrary. And there is reason to wonder about the stringent regulation of this health plan business area when many plans already address member complaints by bolstering network weak spots or by allowing members go to out of network to providers that accept the plan's base payment (the member picks up any remaining balance). And in an era of increasingly powerful star ratings and publicly-available quality measures, narrow networks are a way for health plans to boost quality by driving traffic toward higher-performing providers. A recent opinion piece in JAMA notes that "by deliberately excluding lower-performing hospitals and shrinking networks (i.e., by contracting selectively), insurance carriers encourage competition based on quality of care while simultaneously lowering the costs of care."[10]

Two other recent studies support these arguments: A California-focused study published in *Health Affairs* in April 2015 found that, at least for hospitals, narrow network plans have not caused more access issues or lower quality scores than wider network plans.[11]

A Michigan-focused study published by a University of Michigan-affiliated think tank found that 88% of consumers consider

premium "very important" when selecting a health plan, but only 41% consider network size comparably important.[12]

And there's one more basic shortcoming to numerical standards: No matter how empirical the approach, time-and-distance tests do not assure that a consumer has access to the particular provider he/she wants, which is usually more important to an individual consumer than access to a broad panel. Although it might not happen very often, new plan members are understandably frustrated when they select a plan based on the presence of a particular provider in the plan's provider directory only to find the provider has left the network or closed his/her practice to new members. This has forced regulators to think about network *transparency*, even as they refine their approaches to ensuring network *adequacy*.

The focus in the future will likely center on transparency—giving consumers the tools they need to find providers more easily and giving researchers the data to compare networks. In the Marketplaces, CMS has regulated that provider directories must be accurate and accessible to the public. In the Medicare Advantage program, CMS recently put out similar rules, including an additional requirement that network providers that are closed to new members must be noted as such. The proposed Medicaid managed care regulation proposes minimum content elements for provider directories as well as standards for keeping them current. At this time, only 10 state Departments of Insurance have specific requirements regarding the frequency of provider directory updates. But a state may still investigate and take action against an insurer that is not keeping its directories current and accurate. The current draft NAIC model act would update the 1996 model act to include a section on provider directory oversight, indicating a likelihood of greater focus on this point.

Current online provider directories give prospective members an accurate view of the provider network, but only one plan at a time, which does not facilitate comparison shopping. The next step in provider network transparency is making networks "machine readable" so that third parties can aggregate and compare network information across plans. Consumers soon will be able to find where their favorite provider is participating and compare the overall breadth of plan networks. This "machine readable revolution" is in its earliest stages—CMS is still finalizing the data specifications for federally facilitated Marketplace plans. The agency is (optimistically) aiming to have version 1.0 of the machine-readable environment operable for this fall's Marketplace open enrollment. But, even if machine-readable functionality is not fully operable this fall, it will happen. CMS has already tipped its hand, in the proposed Medicaid managed care regulation, that it would like to expand machine-readable functionality into Medicaid. Medicare Advantage probably is not far behind.

At first blush, the machine-readable advent is a nightmare for the health plan compliance officer. A few familiar government regulators will soon be flanked by a gaggle of eager researchers and advocates continually comparing providers, and creating tools that will instantly report network soft spots and inconsistencies. The headaches arising from continually updating online provider directories are significant. A recent white paper on this subject lists a string of challenges, including providers opening and closing to new patients, new specialties, changed or multiple-address practice sites, and pulling updates out of rental networks. And the funds that a health plan must invest in improving its provider directory accuracy count against Medicare Loss Ratio.[13] But, these headaches could be balanced by two very positive outcomes. First, better informed consumers will

make better-informed plan selections, leading to fewer grievances, rapid disenrollments, and complaints to regulators. Second, the transparency of the machine-readable revolution could make the hard numerical standards of today's network adequacy programs less relevant. Fully informed and empowered consumers require less protection.

Suggestions for the Compliance department

For Compliance departments that have not fully engaged on provider network issues, the time to engage was yesterday. Expect the rest of this year and 2016 to be a period of unprecedented provider network oversight. Given this need, here are some actions Compliance department leaders should consider taking right now:

1. Use government standards to self-assess your networks where the standards exist, and use defensible in-house standards where they don't. Knowing that providers come in and drop out mid-year, measure your networks at regular intervals based on formal policies and procedures.
2. Anticipate that regulators will be checking to make sure provider directories are accessible to the public and accurate, and develop an internal audit program to catch errors before the regulators do.
3. Consider "secret shopping" your provider offices to make sure that they are telling the public what they are telling your contracting staff. It is the health plan, after all, that will be held accountable if a provider's office staff gives out wrong information.
4. Proactively discuss network complexities —tiered networks, preferred pharmacies, telehealth providers, etc.—that might confound the NMM, machine-readable specifications, and other regulatory tools. Informed by your experience, the tools will improve.

Finally, the move toward more empirical and transparent provider network oversight should not be viewed in isolation. Expect more and more regulatory reviews—benefits, appeals, claims processing, complaints investigation, etc.—to become increasingly driven by numerical standards, outlier tests, and real-time public access to plan performance. If your Compliance department doesn't already have its own "numbers cruncher," consider hiring or contracting for one. Big data is coming into the Compliance department, and it won't be leaving anytime soon.

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