Rules based, data driven

Network Adequacy

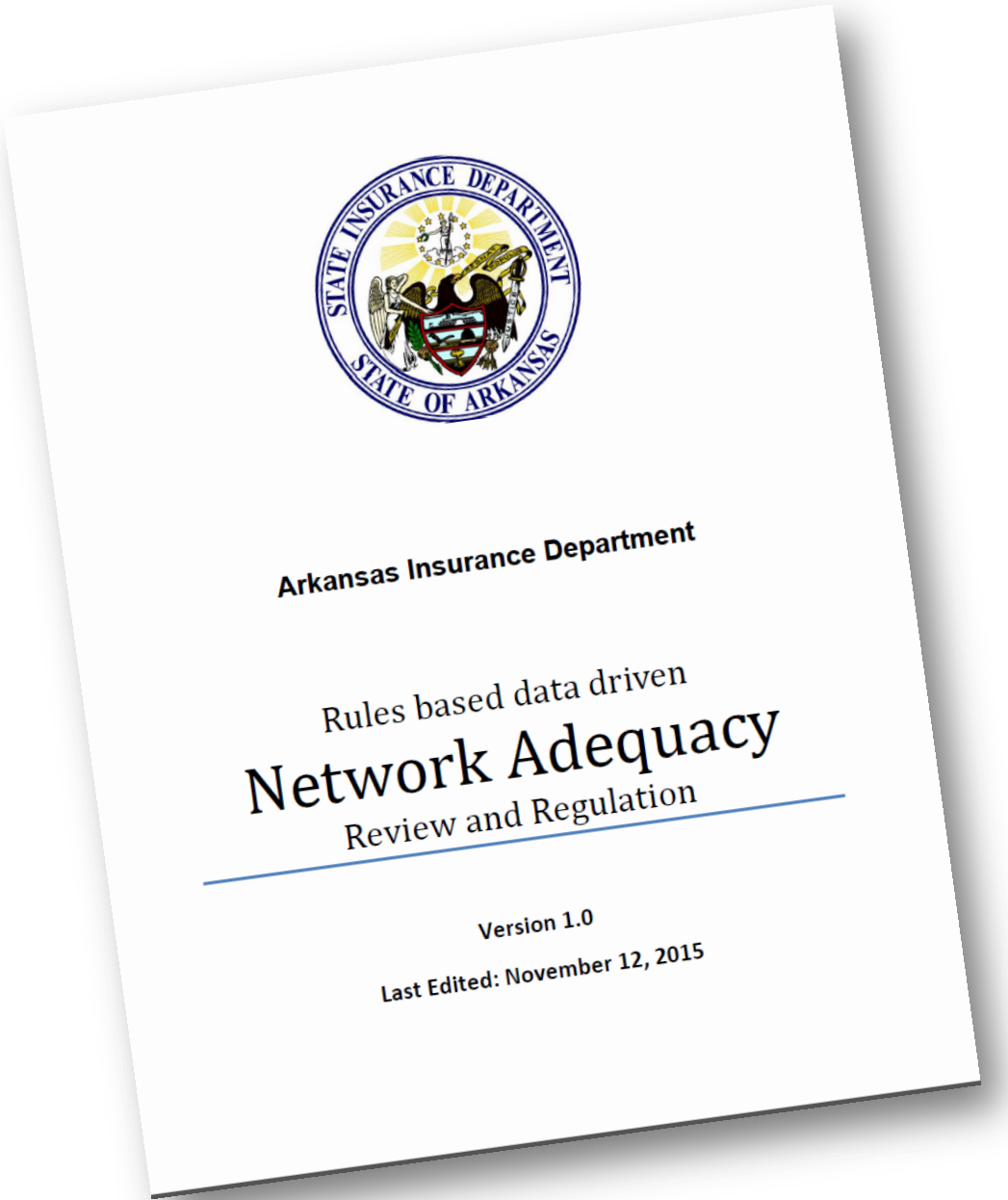
Review and Regulation

10:00 am-12:00 pm
November 16, 2015
Regulatory Health Link Division,
Arkansas Insurance Department

REGULATORY HEALTH LINK Division
Arkansas Insurance Department

STATE INSURANCE DEPARTMENT STATE OF ARKANSAS

Proposal document



Arkansas Insurance Department

Rules based data driven

Network Adequacy

Review and Regulation

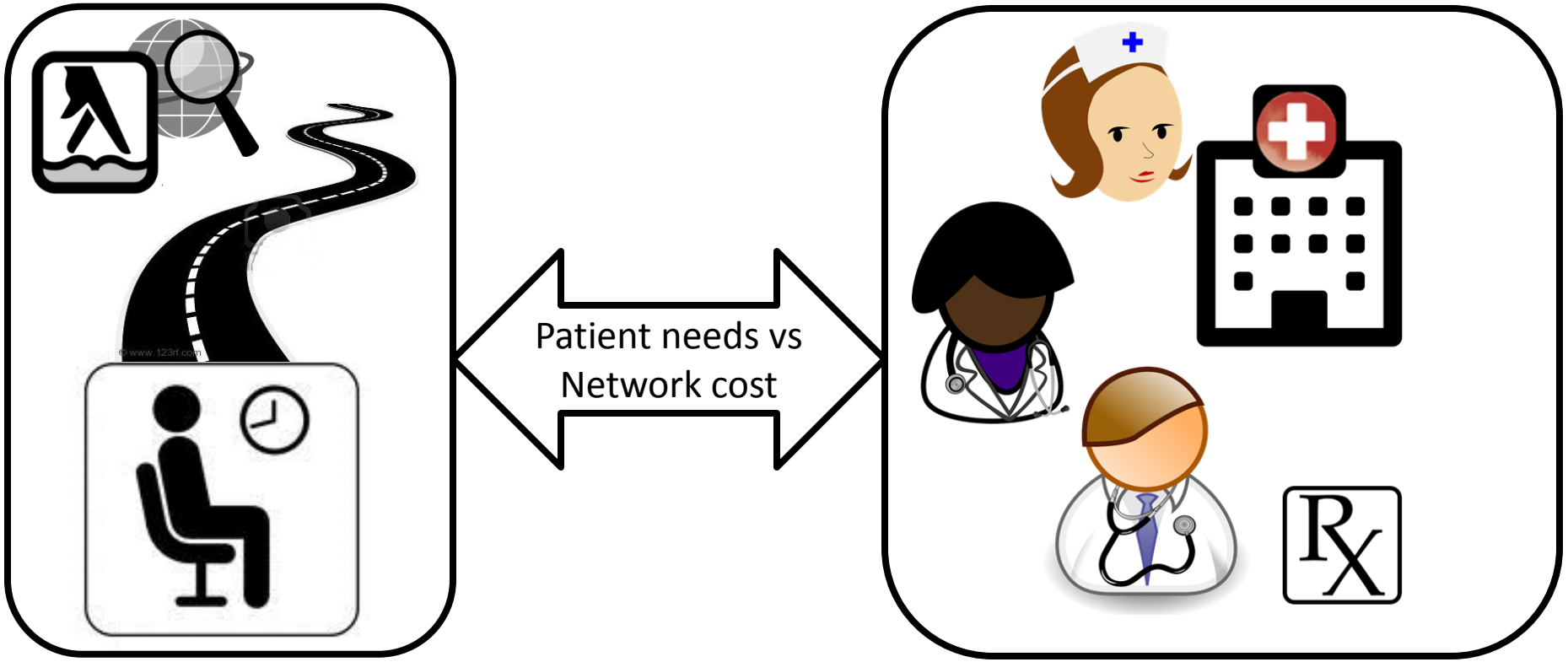
Version 1.0

Last Edited: November 12, 2015

Objectives of meeting

- Propose *uniform* understanding on
  - Description of Provider Groups and
  - Description of a Provider
- Propose a governance structure for continuous improvement of Network Adequacy regulation
- Provide opportunity to industry to counter, improve or accept AID's proposal on achieving uniform "Description of a Provider"

Network Adequacy



- Is Network adequate for the patient to get the right care, at the right time without having to travel unreasonably far?
- Network information presented usefully?

Network Adequacy

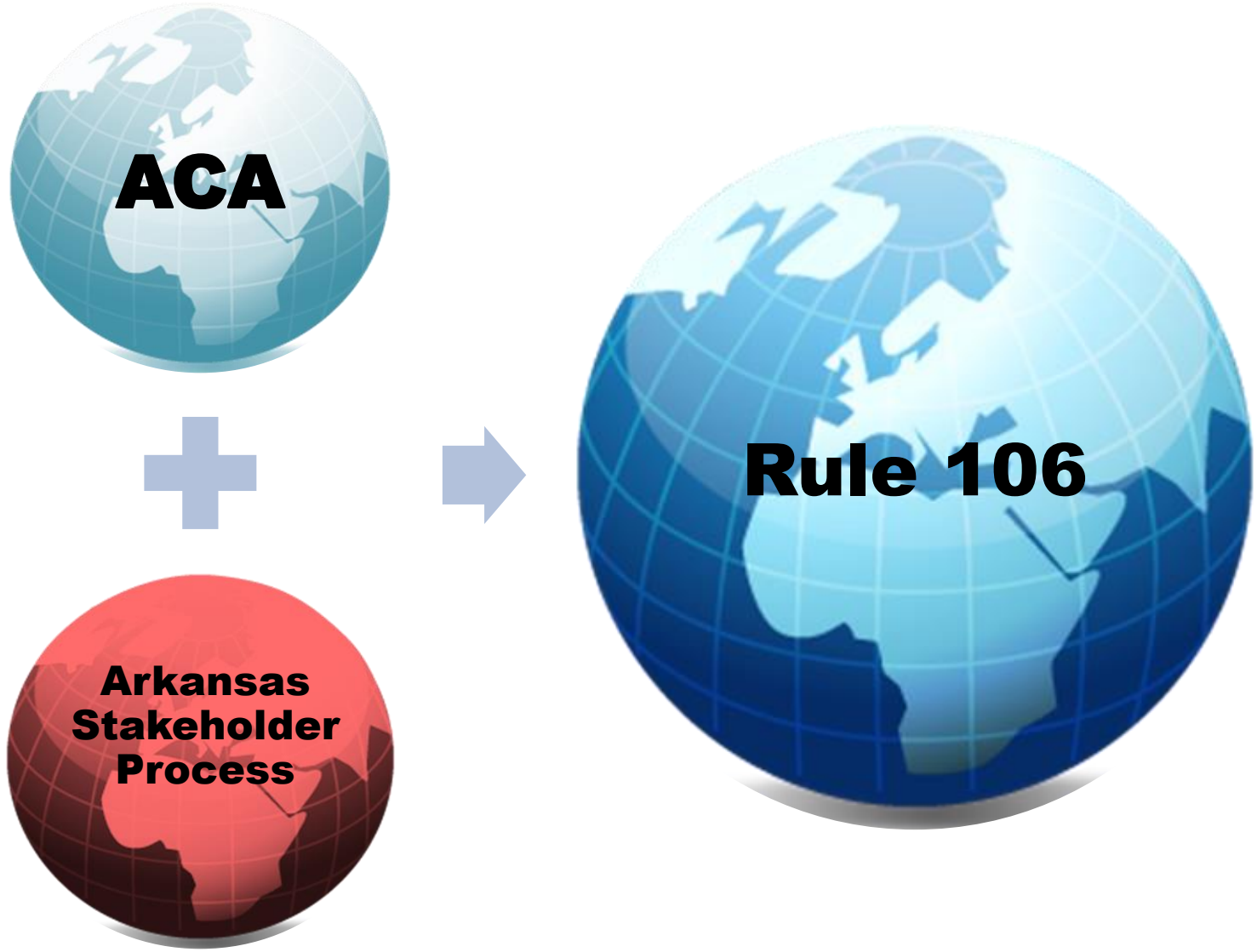
- Does the network have the right mix and number of providers for consumer base size and needs?
- Is an insurer gaining unfair advantage by reducing providers catering to riskier pools?

What the data revealed in PY2016

- **How may times does the same provider appear in different networks?**
- **Study of 4 networks**

Number Of Issuers in Common	Provider Count	Percentage of Total
1	14093	(41%)
2	11668	(34%)
3	3186	(9%)
4	5290	(15%)

Network Adequacy Rule 106 Origins



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Geographical Analysis

How far is the Doctor or Specialist? (Miles)

Specialty/Facility coverage

Have you included enough Specialists or Facilities? (Percent)

Consumer information

Is the Provider Directory useful? Accurate?

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PY2015 Regulatory Efforts

Manual review using Geo-access maps and detailed county reports

Geo-access maps

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Mental Health/Substance Abuse Providers 20

Psychiatrists and Psychologists

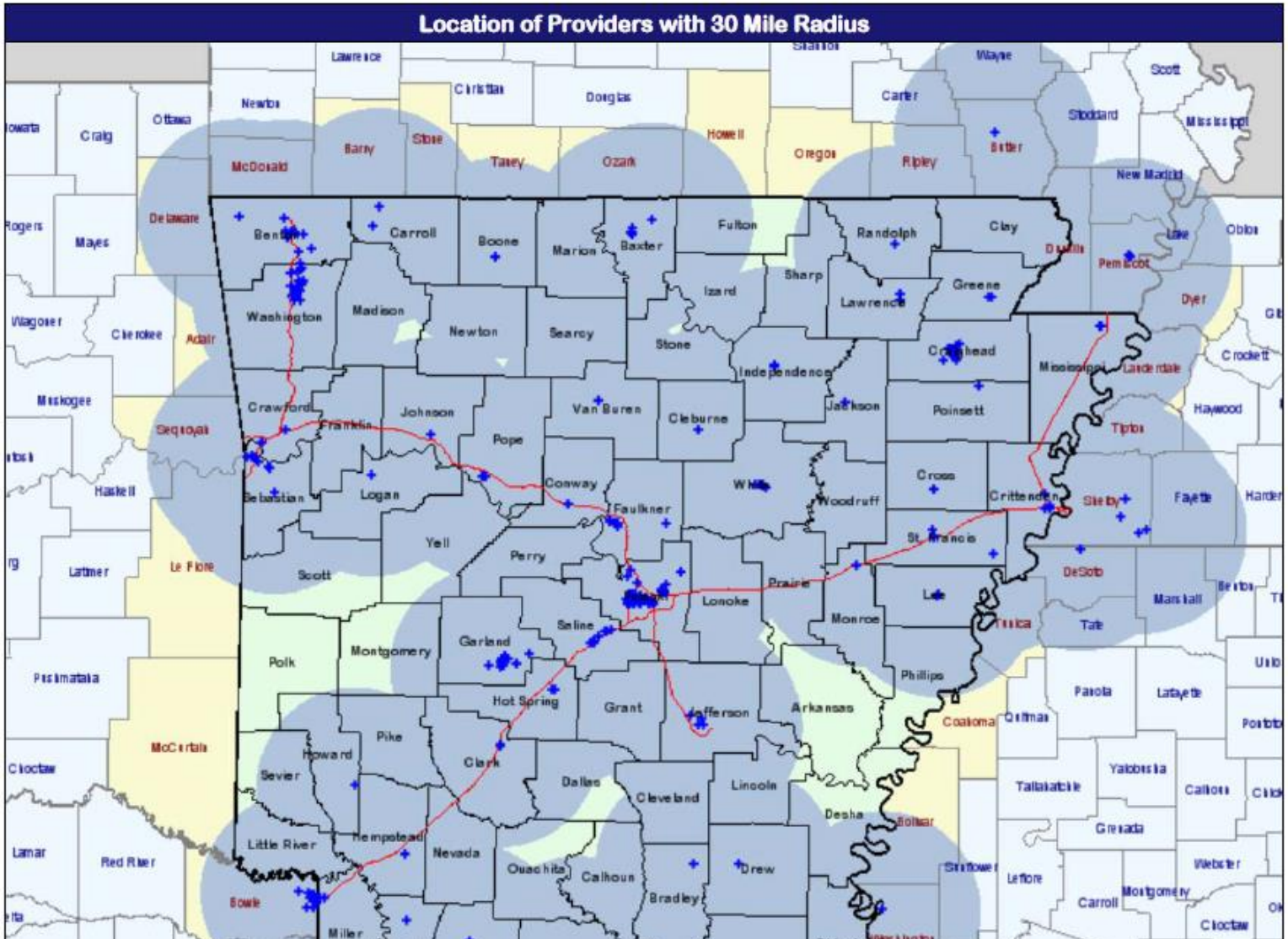
June 12, 2014

Created by...
Arkansas Blue Cross And Blue Shield

Psychiatrists and Psychologists

446 providers at 267 locations
All Providers
30 mile radius

1 in = 46.44 miles



Detailed County Reports

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Arkansas Insurance Department

Access to Other Mental Health/Substance Abuse Providers 54

Access Detail Within 45 Miles

June 13, 2014

Created by...
Arkansas Blue Cross And Blue Shield

3B Access to 1 MA/SA Prov within 45 Miles - Other MA/SA Providers

[1] (Arkansas Blue Cross Members) accessing...
(Mental Health/Substance Abuse - Other) Providers
1 within 45 miles

Members With and Without Access										
State	County	Member	Provider	With Access[1]		Without Access[1]		Average Distance		
		#	#	#	%	#	%	1	2	3
Arkansas	Little River	1,684	2	1,684	100.0	0	0.0	6.5	7.1	15.8
	Logan	3,763	1	3,763	100.0	0	0.0	11.6	20.0	21.8
	Lonoke	9,294	9	9,294	100.0	0	0.0	6.0	8.8	9.2
	Madison	2,201	4	2,201	100.0	0	0.0	10.1	10.2	10.2
	Marion	2,381	0	2,381	100.0	0	0.0	13.7	14.5	14.7
	Miller	5,494	17	5,494	100.0	0	0.0	4.7	4.8	5.0
	Mississippi	6,946	5	6,946	100.0	0	0.0	6.8	16.4	16.4
	Monroe	1,563	0	1,563	100.0	0	0.0	28.1	28.4	33.0
	Montgomery	1,528	2	1,528	100.0	0	0.0	8.5	10.4	19.2
	Nevada	1,258	2	1,258	100.0	0	0.0	6.4	6.4	6.5

Members With and Without Access

County	Member	Provider	With Access[1]		Without Access[1]		Average Distance		
	#	#	#	%	#	%	1	2	3
Little River	1,684	2	1,684	100.0	0	0.0	6.5	7.1	15.
Logan	3,763	1	3,763	100.0	0	0.0	11.6	20.0	21.
Lonoke	9,294	9	9,294	100.0	0	0.0	6.0	8.8	9.
Madison	2,201	4	2,201	100.0	0	0.0	10.1	10.2	1
Marion	2,381	0	2,381	100.0	0	0.0	13.7	14.5	1
Miller	5,494	17	5,494	100.0	0	0.0	4.7	4.8	
Mississippi	6,946	5	6,946	100.0	0	0.0	6.8	16.4	16.
Monroe	1,563	0	1,563	100.0	0	0.0	28.1	28.4	33
Montgomery	1,528	2	1,528	100.0	0	0.0			

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This is too much information!

But even so …
How can I tie together all my regulatory communications to the data and validate actual improvement over time ?!

Compliance Officers

W. Edwards Deming
1900 - 1993

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PY2016 Regulatory Efforts

First attempt at rules based data driven review & regulation

Arkansas Vision

Arkansas shall strive towards a data driven evidence based Network Adequacy implementation in order to

- ***Provide Arkansas Health and Dental Plan consumers the best possible protection of their rights***
- ***Ensure fairness to all Carriers***
- ***Ensure transparency for all***
- ***Track improvements over time***
- ***Use appropriate technology to minimize long term expenses and manual review***

Architectural Principles

- *Align with available Federal/National standards or efforts if feasible*
- *Build collaboratively – across organizations, disciplines*
- *Perfection should not be the enemy of the good*
- *Build incrementally - Over years and scope*
- *Apply Pareto's 80-20 principle for every phase*
- *Seek lessons learned – from others and within.*

Rules based, Data Driven?

1. Compare networks against statutory requirements
2. Compare networks against one another
3. Compare networks against provider count data if possible (such as Medicare county data).

Major lessons from PY2016 efforts

Uniform interpretation needed on two entities

1. Description of Provider &
2. Description of Provider Groups

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PY2017 Description of Provider Groups

In terms of NUCC Taxonomy

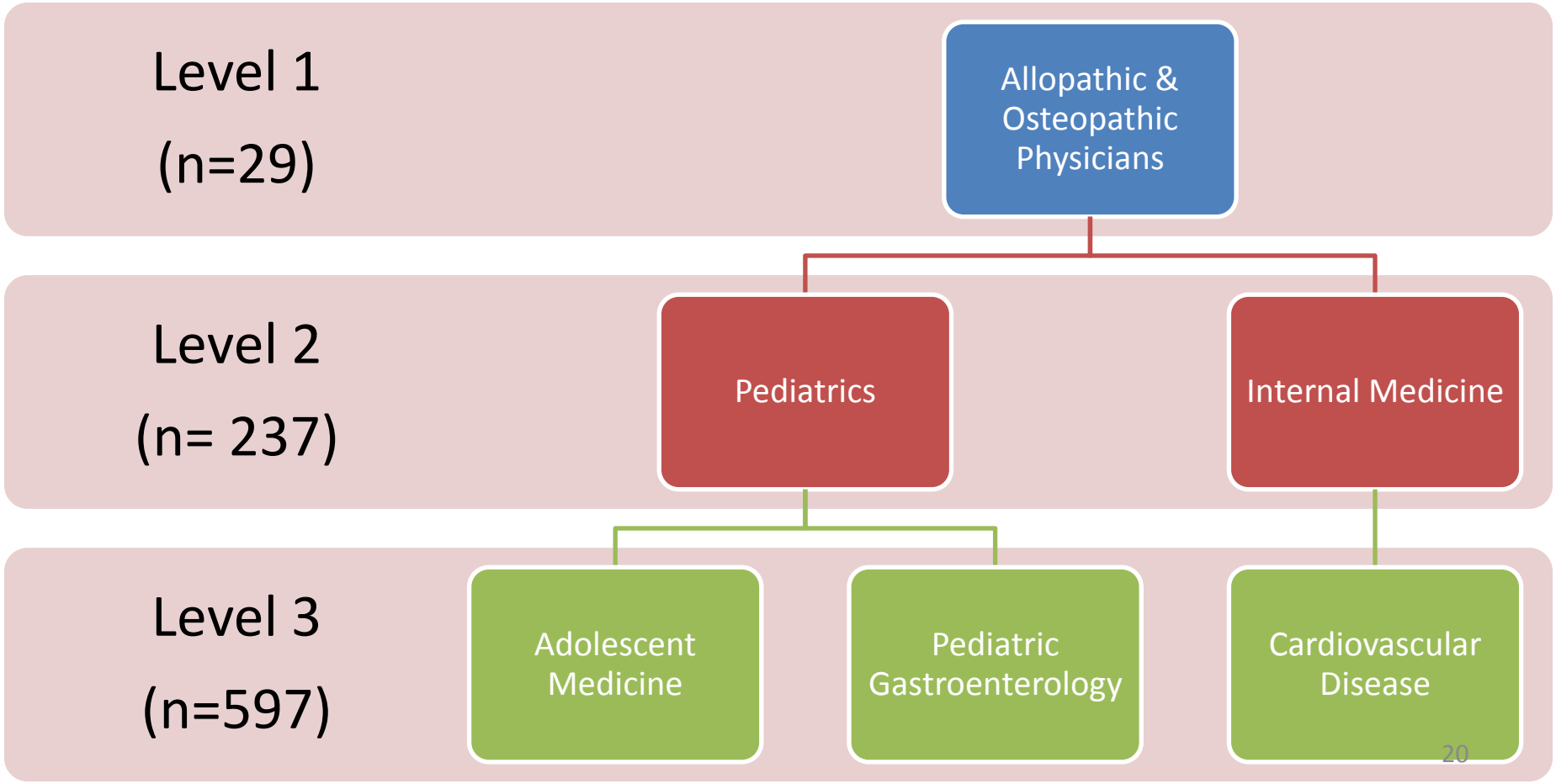
Consumer Centric Provider Groups

- Defined using NUCC Provider Taxonomy
- Defined in collaboration with
  - Department of Health &
  - Arkansas Center for Health Improvement
- Not from Medical training view.
- Finalized list will be located at http://rhld.insurance.arkansas.gov/Info/Public/Templates

NUCC Provider Taxonomy

Excerpt shown below

1) Three levels
2) Each node has its own unique Taxonomic code



Provider Groups for PY2017

1) Access to Adult/Geriatric Primary Care Providers
2) Access to Pediatric Primary Care Providers
3) Access to Mental Health/Behavioral Health/Substance Use Disorder Facility
4) Access to Mental Health/Behavioral Health Providers
5) Access to Substance Use Disorder Providers
6) Access to Oncologists
7) Access to Skilled Nursing Facilities
8) Access to Cardiologists
9) Access to Obstetrics
10) Access to Pulmonologists
11) Access to Endocrinologists
12) Access to All Hospitals
13) Access to Hospital by Licensure Type-Acute Care
14) Access to Hospital by Licensure Type-Mental
15) Access to Hospital by Licensure Type-Rehabilitation
16) Access to Rheumatologists
17) Access to Ophthalmologists
18) Access to Urologists

APPLIES TO ALL PLANS ON & OFF-MARKET

Additional ECP criteria apply to ACA Marketplace Plans

1) Access to FQHC
2) Access to Ryan White
3) Access to Family Planning
4) Access to Indian Provider
5) Access to School-Based Providers

Limitations

- Limited set
- Nurses and Physician Assistants serving Specialists may be interpreted as Primary Care Providers
- Insurers may be in various stages of NUCC Taxonomy adoption

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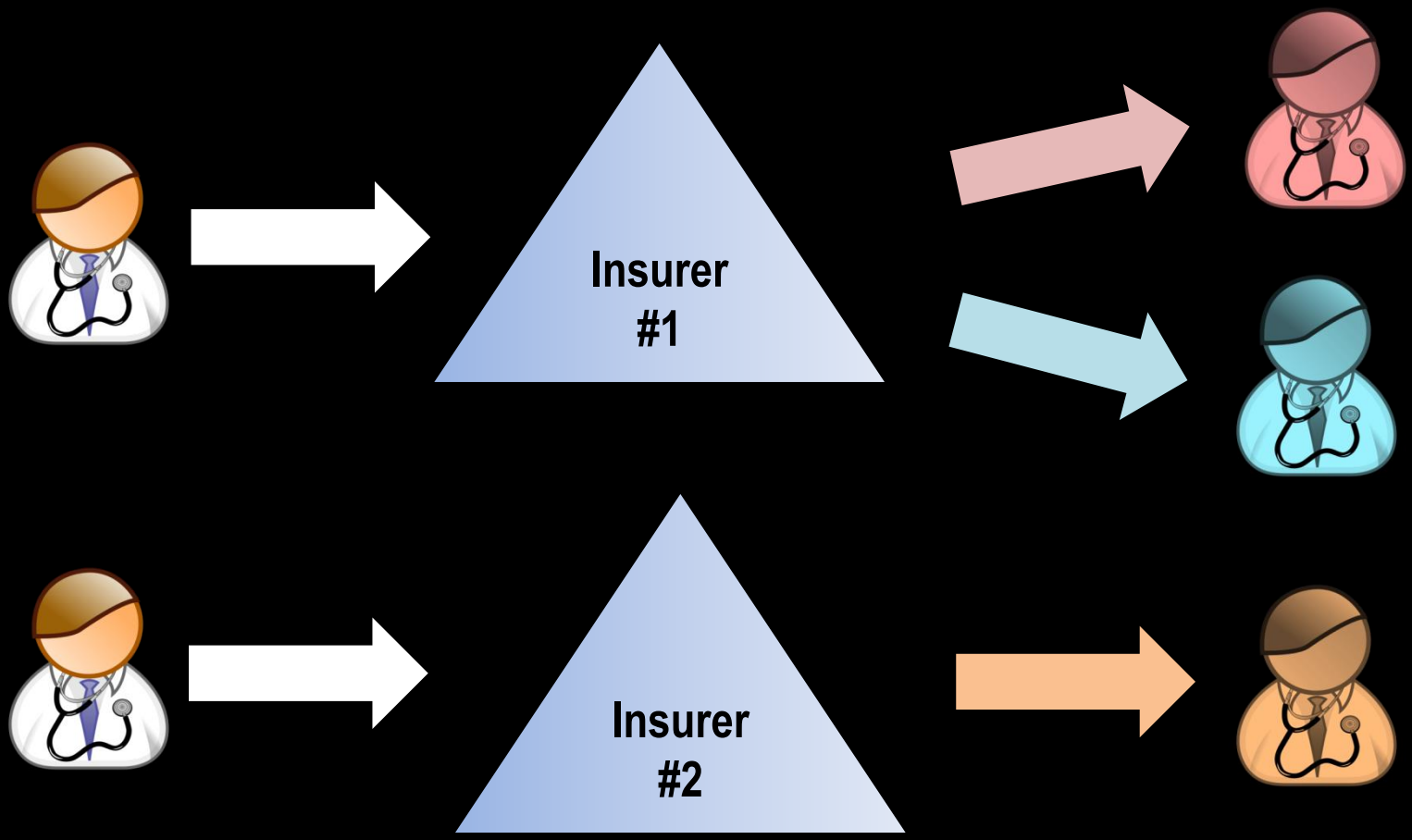
Description of a Provider

Issues and feedback details

The (Problem) Prism of Credentialing



Uniformly classification choices

Options Discussed along with pros & cons

a) NPI Registry hosted by CMS/NPPES

b) CCVS data maintained by Arkansas State Medical Board

c) NPI-taxonomic associative data culled from the All Payers Claims Database

- NPI Registry chosen as the best choice under the given circumstances (Industry can counter with an alternative proposal)

Feedback details

- Industry feedback on AID proposal on “Provider Description” needed no later than COB 11/20/2015 as
  - Agree (With or without comments)
  - Disagree. Will work within industry on an alternate proposal.
    - Industry to work within themselves and agree to one alternate draft by December 18, 2015. AID will not coordinate meetings but will attempt to provide industry contact list at the earliest.
    - AID reserves the right to decide on final proposal.

Provider Network SME Contact needed

Each insurer needs to provide a primary and optionally a secondary email contact by COB.

Please email RHLD.DataOversight@arkansas.gov with the subject line as “Provider Network SME”.

AID will share the consolidated contact list with insurers should industry want to confer offline.

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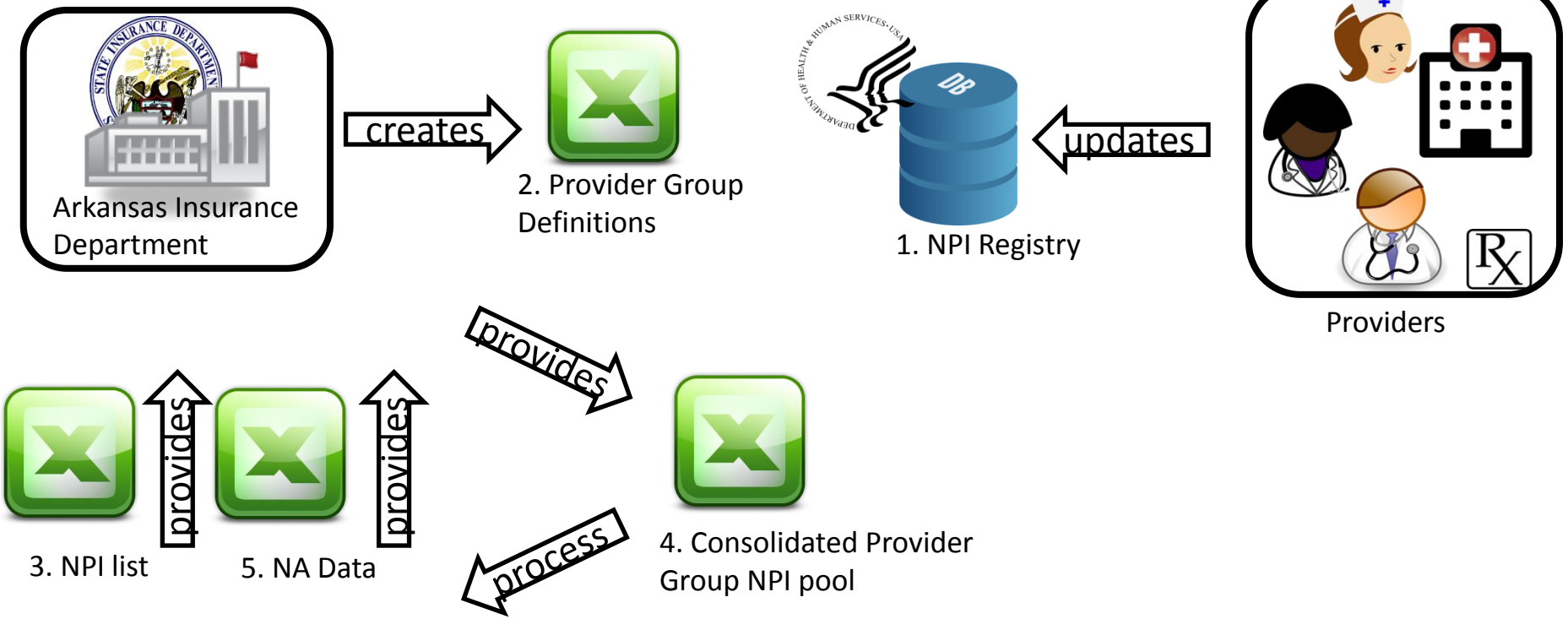
Arkansas Insurance Department

Details on AID's "Description of a Provider"

In terms of NPI-NUCC Taxonomy

How the NPI Registry would be used



- No automated extrapolation will be attempted if appropriate taxonomy in NPI Registry does not exist reflecting the Provider.
- Issuers will be encouraged to get their providers to correctly update the NPI Registry as needed.

Pros and Cons of NPI Registry

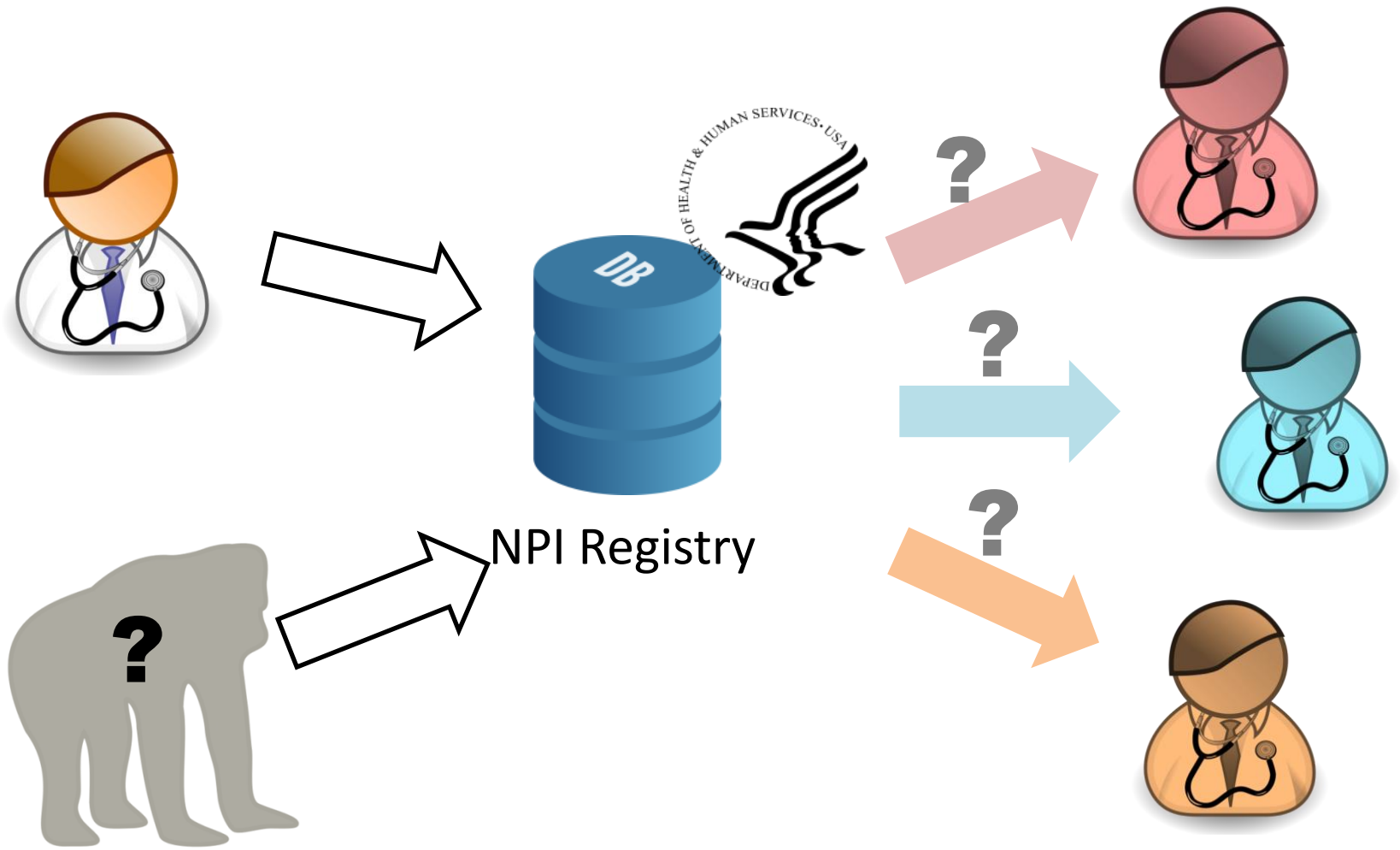
Pros:

- Self reported data. The provider owns the information of what they practice. They may choose to provide taxonomies that they would like to practice in or conversely, withdraw taxonomies for areas they wish to avoid.
- Data readily available for implementation for Plan Year 2017. Involvement of legislature, executive and coordination with external organizations not required.
- Used in Medicare.
- Despite its shortcomings, the NPI-Registry is considered by some carriers and industry experts as the best source of publically available NPI-Taxonomic associative data
- Nationwide repository. Doctors in bordering states serving Arkansans are covered.

Cons:

- Self reported data. There is no oversight on whether the provider intentionally or un-intentionally entered inapplicable taxonomic codes.
- Carriers report that it is difficult to force the provider to update the NPI Registry.
- It takes time and learning for the providers to identify applicable taxonomies and this work may be relegated to billing or back-office staff.
- All carriers do not trust the data in the NPI registry.

advantages of the NPI Registry



2 Stage NPI Data Quality improvement

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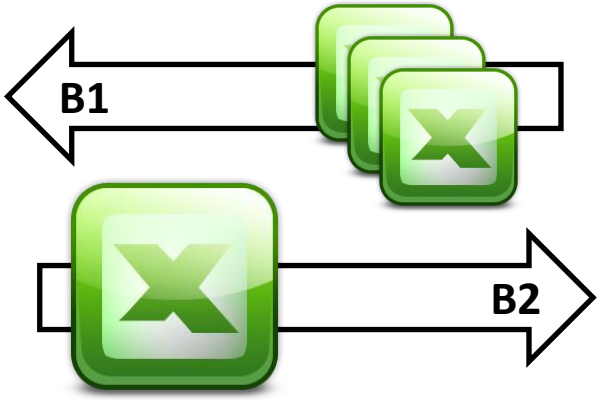
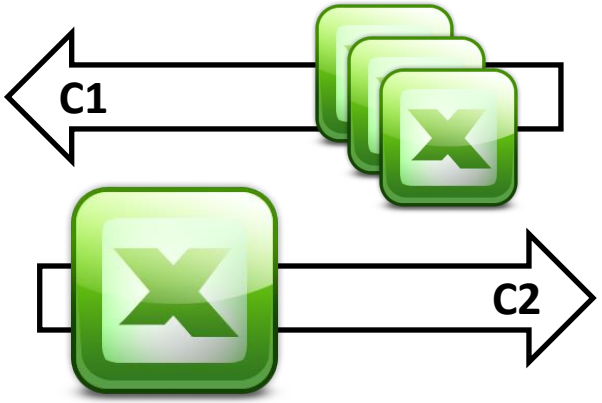


Health Insurers

Stage 1: Consolidation of feedback



Stage 2: Consolidation of decisions

	Data Description
B1	Objections/Suggestions on underlying NPI-Taxonomy associations with reason(s)
B2	Consolidated Objections/ Suggestions with reason(s). Carrier de-identified.
C1	Carrier vote on B2
C2	Final consolidated NPI pool per criteria

Rules based decisions

Rules based association data refinement

Response from Carriers	AID action
Unanimous agreement	Change accepted
Majority in agreement	Change accepted
Majority in disagreement	Change denied
Split	AID decides

All insurers are required to participate. Non-participation may default to agreeing with insurer proposing the changes.

Governance Structure proposed

- Meeting on a quarterly basis after initial rounds of implementation meetings
- Balanced multi-disciplinary group appointed by Insurance Commissioner
- Proceedings transparent to public

Next steps for industry

- Provide feedback on
  1. Description of Provider (Friday 11/20/2015) &
  2. Description of Provider Groups
     1. Agree or Disagree (Friday 11/20/2015)
     2. Alternate industry-wide proposal if any (Friday 12/18/2015)
  3. Provide designated Network Adequacy SME contact details (Monday 11/16/2015)

Contact

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501-773-0420