Background of this document: *Three carriers provided joint feedback to AID based on the communications of the first PY2018 NA Planning meeting on 8/25/2016. This feedback was received by AID on 9/20/2016. AID's responses are noted as Microsoft Word "Comments". This is being shared with the industry as it communicates potential industry thoughts and AID's stand.*

2018 AID PROPOSAL FOR NETWORK ADEQUACY FEEDBACK

The industry partners propose the following steps regarding the NPI List maintenance and validation.

1. NPI List from PY2017 with final justification additions and deletions will be provided to the issuers.
2. Changes to both taxonomy groupings and limitations to contiguous counties will be proposed and sent to AID. This would include suggestions for any new taxonomy groupings that will be reflected in later Geo-maps.
3. Final AID NPI Listing will be sent back to the Issuers.
4. Issuers will review listing.
5. Issuers respond back with final changes to NPI Listing.

The industry feels that Cycle 1; 2.00, 2.10, 2.20, 2.30, and 2.40 to create the final PY2018 Provider type NPI list are valid, but question the taxonomy requirement (which is not required for submission to CMS) and creates an additional potential level of error in the reporting data. Aren't "C bucket" groupings enough?

The industry feels that 2.45 and other steps related to creating an Employer NPI to Provider NPI list are not especially valuable and require considerable additional effort that is not necessarily justified.

Comment [TD1]: AID assumes that these steps are no different than that proposed by AID in "PY2018 NA Review Process " at the location http://rhld.insurance.arkansas.gov/Default/Network Adequacy other than the idea of limiting providers to Arkansas counties and counties bordering Arkansas. AID agrees with this idea of limiting providers.

Comment [TD2]: AID assumes that this relates to NPI addition/ deletion and not change in the definition of the provider type grouping. Industry would provide these addition/deletion suggestions.

Comment [TD3]: The "C buckets" are defined taxonomically. The taxonomic association with the NPI is key to placement of a NPI within a "C bucket". Providing the taxonomic code will in fact reduce error. The utility of this taxonomic reporting is going to be limited to categorization in the "C buckets" and nothing beyond that. AID however realizes the hesitation a carrier may have in suggesting a taxonomy on behalf of a provider and therefore would make the supply of a taxonomy recommended, but optional. The "PY2018 NA Review Process" document would be updated accordingly.

Comment [TD4]: This is an industry initiated need. If industry does not see the return on effort justified, AID will not press for this. . The "PY2018 NA Review Process" document would be updated accordingly.

The industry agrees with the proposals in Cycle 2; 2.60, 2.70, 2.80, 2.90, and other "mid-year" activities and believes they are an excellent opportunity to validate the data's accuracy.

The industry feels that while new entrants should use the suggested 0.5% of the non-elderly population, existing QHPs should only have to use exact membership and not the US Census Bureau information. Being required to submit additional Geos would require significant additional effort on the part of the QHPs. It would also create a second set of standards the QHPs would have to meet when filing justifications.

The industry supports the use of **CMS** time and distance standards wherever possible. If AID is suggesting the use of Rural and Non-rural, the industry would like to clarify that this is only for the provider enrollee ratio calculations, and not any other time/distance testing. The industry is unsure of the value provided by the acute care bed ratio, as it seems that access issues would already be covered under the time/distance testing. Should the bed ratio be required, a standard source of the data (CMS?) would be necessary to ensure reporting accuracy. The industry would also support increasing the hospital radius to 60 miles/minutes to be more in line with what would be a more realistic service area for a hospital, according to the hospitals themselves.

The industry tentatively agrees with the new mapping of ECP Providers and ECP Facilities collectively, however it requests additional definitions of precisely which providers are to be included in each category. ECP Dental, School Based Providers, and ECP Hospital facilities were not mentioned and would also need taxonomic

Comment [TD5]: AID will hold off on this need for PY2018. The Department will investigate other means of arriving at a standard distance calculation that is not based on an enrollee base.

Comment [TD6]: Alignment with available CMS standards has been AID's preference since the start of this program as a key architectural principle.

Comment [TD7]: Not limited to ratio reporting. An allowance of 20% is provided for Rural counties in the time/distance reporting.

Comment [TD8]: AID does not agree because you could extend that argument to all provider types. Why limited it to acute care bed ratio?

Comment [TD9]: AID intends to base ratios on CMS Medicare data as it has done in the past.

Comment [TD10]: Noted for future consideration and amendment to Rule 106

Comment [TD11]: AID will defer to the ECP provider classification (individuals and facilities) efforts by CMS/CCIIO, the data of which is available in the Federal Network Adequacy template. AID does not want to engage in a duplicative effort on this classification.

categorization if they were to need mapping, since they were not mentioned on page 26 of the presentation.

The industry still needs further clarification on the definition of what would fall into a pharmacy categorization. IE, Drug stores, PBM, Medical Supply, DME, Pharmacists for immunization purposes.

The industry requests additional detail regarding the types of providers included in Dental-General and Dental-Specialist. In Arkansas, a dental provider is required to declare to the Arkansas Dental Board if they are a general dentist or specialist. They would then further declare a particular specialty. It is requested that any requirements also align with Dental Board policy. The industry would also like clarification on whether the new dental requirements are for add-on dental business sold in conjunction with a medical plan, or if they are for stand-alone dental, or both.

The industry would like further clarification on the provider directory review. Files are already being submitted to regulators, would this not simply be a duplication of effort? Will AID be taking responsibility for ACA provider directory requirements by all regulators? We do not believe a master directory is necessary and would prefer AID supply the name of a provider to the QHPs for verification in cases where there is a discrepancy backed by two or more carriers. Should a master directory be deemed necessary, the industry would strongly recommend that the directory be for private use only, and not open to the public. Information on the directories is unlikely to be current after the date of submission to AID and will rapidly become less reliable as time goes on. This means that any information supplied to a company to assist in updating their consumer facing directory would

Comment [TD12]: This definition has been published on 9/16/2016 as "PY2018 Provider Type Taxonomic Descriptions" within http://rhld.insurance.arkansas.gov/Default/NetworkAdequacy . The definitions have been developed in consultation with Pharmacy Association.

Comment [TD13]: Definitions has been published at the location cited in a prior comment. On Dental providers, AID has attempted to align definitions with CMS/CCIIO reporting requirements on dental specialties and general through the Federal Network Adequacy template.

Comment [TD14]: The dental requirements are applicable to both. It is pointed out that NA standards requirement was applicable in the previous years. What is different this year is the creation of Provider Type-NPI pools for uniform interpretation.

Comment [TD15]: AID is not sure what "provider directory review" means here. From the initial narrative within this paragraph it appears to be referring to the AID suggestion of sharing specialty locations by issuer geocoded on a map. This was more intended as a data aid for issuers when non-compliance objections are issued with language similar to "Your company is far from compliance in County XYZ for Provider Type ABC". Such objections are usually issued when the competition is compliant or has much better access statistics. The upfront sharing of location information can address the subsequent request of competition's providers in the vicinity. AID will not make this locational information public because industry is not comfortable even with the issuer name being masked. AID will find some other means to make an information dump available rather than reacting case by case basis.

Comment [TD16]: AID finds this inefficient for a case by case basis data extraction because of the volume of non-compliance in counties where competitors are compliant. AID would prefer to share this information as a periodic dump.

Comment [TD17]: AID will accommodate industry desire on this and will provide an periodic information dump.

be welcomed, but as an updated and accurate directory is desirable to everyone, these changes should be considered helpful and not associated with anything punitive in nature.

Since numerous hospitals have a single NPI (i.e. UAMS), they only have a single taxonomy code for the entire hospital. By using a single taxonomy code, hospital services are under reported (i.e. rehab units, psychiatric units, skilled nursing). There needs to be a better way to accurately report all the hospital units without having to submit numerous validations on the justification template.

Comment [TD18]: This language appears to refer to AID's intention of reviewing the machine readable online provider directories. AID would review these directories for compliance with Rule 106.

Comment [TD19]: There is nothing preventing industry suggesting additional provider type classification with *suggestive* underlying taxonomy. AID may verify justification of such classifications from other sources or the facility itself, over time.