

Recommendations to NCDOI from Summer NAWG Meetings Industry Representatives – July 26 and September 1, 2016

Overall Guiding Principles – Many of the provisions discussed have unique implementation and applicability issues when considering application to dental and vision products, therefore consider those issues and develop standards specifically for those products.

NCDOI should use existing North Carolina laws and regulations as the base from which enhancements would be made, rather than using the language of the NAIC Network Adequacy Model Act as the base.

Section 5 – Network Adequacy

Model essentially provides a regulatory structure which requires that a health carrier maintain a network that is sufficient in numbers and appropriate types of providers to assure that all covered services to all consumers will be accessible without unreasonable travel or delay.

Group's Recommendations

- 1) Establish standards that consider the density of population and providers by geography.
- 2) Establish standards that utilize distance, and vary those by the population distribution mentioned in #1.
- 3) Do not establish any standard which relates to wait time for an appointment as the statistic is problematic to establish, difficult for health carriers to measure because that relies upon self-reporting from the provider, and would be difficult for DOI to audit/confirm.
- 4) Do not establish a standard that applies at the county level because medical care referral and access patterns frequently cross county lines. Some counties may not have certain types of providers within the geographical boundaries of the county.
- 5) Do not establish standards that would require a health carrier to accept “any willing provider” on its networks.
- 6) Established standards around which providers to count to measure adequacy and accessibility - consider how physician extenders and telemedicine should be reflected in counts to help establish adequacy and accessibility. Standards should be distinguished by provider type, and primary care would be a very important category.

Guiding Principles

- 1) Utilize a geo-map of all providers to help establish standards that consider distribution of providers by geography.

- 2) Have a goal of creating flexibility in standards to allow for discretion when unforeseen situations beyond the health carriers control arise.
 - 3) State-established standards are preferable to federally-established national standards.
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Section 6 –Requirements for Health Carriers and Participating Providers (i.e. provider contracting)

This section includes standards relating to contracting between health carriers and providers.

Group’s Recommendations

- 1) KEY RECOMMENDATION - Current standards do not need to be changed.
- 2) Establish standards that contain flexibility in providing information on tiering criteria; the discretion and flexibility will facilitate health carriers’ ability to establish new and innovative networks.
- 3) For continuity of care – focus on serious conditions and extend NC’s continuity of care to all relevant managed care products (i.e. PPOs and POS).
- 4) Establish a standard relating to continuity of care notices to consumers that requires the notices only at the practice level rather than for every individual provider, especially in regard to academic center and hospital-based providers.
- 5) Establish a standard which requires for publication of health carriers’ criteria for participation in a network; but continue to provide flexibility in terms of whom with the health carrier actually contracts.

Guiding Principle – See overall guiding principle above.

Section 7&8 – Requirements for Participating Facilities with Non-participating Facility-based Providers (i.e. Surprise Billing) and Disclosure and Notice Requirements

These sections set out suggested requirements for addressing “surprise billing” which includes situations where a consumer receives services at a participating facility from a non-participating facility-based provider and the consumer was not aware of the participation level of the ancillary service provider or had no choice as to that provider. This typically occurs in the situation when a consumer is being treated in the emergency department by a non-participating emergency physician (or other provider) and has no choice of provider, and in situations when the consumer chooses an in-network provider for their primary treatment, but has ancillary providers (such as radiologists, pathologists, anesthesiologists, etc.) which they did not select.

Additionally, this section suggests requirements for health carriers to develop a written disclosure or notice to be provided to consumers at the time of pre-certification. The suggested notice should inform the consumer that there is the possibility that the consumer could be treated at the participating facility by a health care professional who is not in the same network as the consumer's network and should provide the consumer with reasonable alternative choices of in-network providers in the same facility.

Group's Recommendations

- 1) KEY RECOMMENDATION - Standards should balance the providers' and health carriers' interests; establish a benchmark maximum that a provider can charge; if an appropriate and balanced benchmark is established then there is no need for a conflict resolution process.
- 2) Do not eliminate the ability of the health carrier to limit payment to the insured member so as to provide incentives for the parties to negotiate.
- 3) While NCGS §58-3-200(d), along with other Chapter 58 laws, do provide some consumer protections, NCGS §58-3-200(d) should be revisited with regard to health carriers because the current law and interpretation leaves health carriers on unequal footing to providers relating to payment.
- 4) Establish the benchmark standard from #1 to be the lesser of the health carrier's negotiated rate and some of percentage of Medicare to incentivize providers to participate. The benchmark should NOT be based upon billed charges.
- 5) Establish standard that requires a facility to provide notice to member to inform them of obligations and the possibility of out-of-network billing and what that means to the consumer given other standards that may be adopted. For example if a law is passed which prohibits balance billing in certain circumstances or establishes a payment benchmark, then the notice would note those things. Consider how to provide consumers with recourse if a provider does not give the notice in this recommendation and/or a provider balance bills inappropriately.

Guiding Principles – See overall guiding principle above.

Section 9 – Provider Directories

This section establishes requirements for health carriers related to electronic and print provider directories.

Group's Recommendations

- 1) Establish a standard that requires provider directories to be updated no less frequently than monthly. No standard should require real time updates of directories.

- 2) Establish a standard that provides standard timeframes for when a provider must inform a health carrier of changes in the provider's critical information. Suggest using Illinois as an example.
- 3) Establish a standard that requires health carriers to include disclaimers on provider directories which explains to consumers to contact the provider, including at the time of service, to establish the provider's participation level. Include description of the health carrier's process for updating, and how information is evolving, and why checking with the provider is critical to establish participation.
- 4) Establish standards that give health carriers some flexibility in updating directories such as providing adequate time for audits to assure that the information which is published has been verified.

Suggestions Not Making the Recommendation List

- 1) If the provider does not update information in a timely fashion or provides inaccurate information to the health carrier which results in the provider being shown as a network provider and the provider is actually out of network, then the provider will be treated as out of network and the maximum amount the provider may bill the consumer is the lesser of the reimbursement amount set forth in the current or most recent provider contract or the benchmark for non-participating providers.