

Recommendations to NCDOT from Summer NAWG Meetings

Provider Group Representatives – July 28, 2016

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

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 measurable, prescriptive guidance which includes travel time and distance standards by geography, wait times for appointments, and considers whether a provider is taking new patients.
- 2) Establish standards specific to tiered-network products that reflect the network type, and establish standards that apply at the lowest cost-sharing tier of the product; make special considerations for providers who traditionally have provided services to underserved populations (such as essential community providers and critical access facilities.) Recognize that mental health provider networks should be held to comparable standards as other medical providers.
- 3) Establish transparency standards for consumers so that consumer plan documents include a better description of how the network works. Provide consumers with notice of network changes in advance and provide a reasonable amount of time to make transition of care.
- 4) Establish standards which give DOI flexibility to adjust standards to better reflect the need of an area or to accommodate special considerations in order to protect and service consumers. Establish standards that recognize and accommodate how care is provided and how that is evolving, such as non-traditional settings for certain types of care.
- 5) Establish a standard which requires a health carrier to permit a provider to participate if the provider meets the participation requirements of the network and agrees to the terms of contracting. The standard should prevent restrictive networks between providers and health carriers which make it difficult for independent providers' to participate in-network due to exclusivity agreements. Health carrier should not be able to exclude a provider from a network without cause, and any declinations should permit a rebuttal from the provider.

Guiding Principle – Establish standards that are transparent to the provider and the consumer, and which are enforceable and feasible.

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) Establish a standard that requires a health carrier to make information about tiered networks transparent to consumers and providers and assure that adequate information is given the consumer about the product and it’s network structure, establish standardized terminology related to tiered networks that health carrier’s must use, and set a time frame for how long an health carrier may use a standard to establish tiered networks (how frequently must it be updated).
- 2) Hold consumers harmless if the consumer makes a choice of a health carrier during open or special enrollment based upon a provider being identified as in-network for a plan year, only to find the provider is not in the network.
- 3) Establish a standard that clearly communicates to consumers and providers how a tiered network is established, and requires active communication between the health carrier, providers and consumers and does not rely upon passive communication. The standards should include timeliness of updates, timeliness of delivery of notices, and the readability of the information/explanation (8th grade reading level).
- 4) Prohibit provisions in contracts which indicate that a provider who agrees to be a participating provider agrees to participate in all products offered by the health carrier. Require the health carrier to provide notice to a provider when the provider is being cut out of a select network; require contracts at issuance and renewal to include a specific listing of all of the networks and products the provider agrees to participate.

Guiding Principle – All key terms should have standardized definitions established.

Suggestions Not Making the Recommendation List

- 1) Establish standards relating to healthcare stewardship that would require providers to identify the extent to which the provider meets healthcare stewardship standards, direct payment models, and evolving health care system provisions.

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 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) Established standards should be stringent enough that a health carrier is unable to set an unreasonably low reimbursement rate, which discourages participation by providers, and yet still meet adequacy and accessibility standards with those few participating providers able to accept the low reimbursement. Establish a uniform and fair manner in which UCR is calculated by all health carriers. Require health carriers to pay a reasonable rate, then network adequacy issues would not exist.
- 2) Require health carriers to be totally transparent to consumers and providers of what the health carrier will pay in out-of-network situations. Include this information in the consumer information and make fee schedules available to the public.
- 3) Require participating facilities to give some type of disclosure to consumers relating to services being provided by non-participating providers.
- 4) Establish standards which protect the consumer and hold them “harmless”.
- 5) Establish a standard which provides that payment for any covered services should go to the provider and that health carriers are required to accept assignment of benefits without limitation.

Guiding Principle – Should not reward bad behavior.

Suggestions Not Making the Recommendation List

- 1) Establish standards which require the health carrier to pay the difference between the allowed charged and the billed amount.
- 2) Do not establish a benchmark or mediation process.
- 3) Consider as we establish standards what may be evolving in terms of how care is funded, such as providers as health carriers, and what issues that evolution may bring about with regard to network adequacy and insurance regulation.

Section 9 – Provider Directories

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

Group’s Recommendations

- 1) Establish standards across all health carriers for content uniformity standards (such as whether a provider is accepting new patients, and the networks and products the provider participates in), frequency of updates to keep information accurate and up-to-date – would prefer it to be real time updates, or if not feasible, establish specific times when the provider directory must be updated such as prior to open enrollment or other enrollment seasons; directory to indicate if the provider or group is accepting new patients. Require a connection between the products and networks that are listed in a directory and the products and networks found in the provider contract.
- 2) Require that directories to be searchable by network type and product type so that the directory accurately reflects which providers participate on a specific product. The information should be very granular in order to properly convey the information about providers’ participation in what products and networks.
- 3) Directories should have a clear differentiation of what is a broad network and what is a narrow network, explain what “in-network” means, and what “participation” means, particularly when multiple networks are identified. Standards should consider how to best accurately reflect a provider’s participation, and how those standards should be flexible to recognize unique challenges of keeping information up-to-date in certain provider setting types.
- 4) Set a standard which would set a civil fine for health carriers who provide inaccurate provider directories; provide NCDOL with authority to audit provider directories through a “secret shopper” type provision.
- 5) Establish directory standards for health carriers which help identify a good network fit for a consumer and help consumers navigate the health care system.