August 6, 2012

Qualified Health Plan Policies and Considerations – Section 4 & Section 5

The following summary is in response to the California Health Benefit Exchange's recommendations around qualifying health plans for Network Adequacy for initial participation as well as ongoing monitoring and review.

The California Health Benefit Exchange has an obligation to provide appropriate consumer protections to ensure that the QHP's provider networks participating in the Exchange include all the essential providers needed for an adequate network as well as being accessible to the potential membership they can service. As such, this feedback is in response to the recommendation to maintain the status quo for plan self-reporting for Network Adequacy.

The Evolution of Network Adequacy

In the early days of measuring plan compliance for network access with State-based programs, health plans were typically required to self-report the adequacy of their network using maps of their provider network or simple access requirements, such as of 1 provider within 30 minutes/30 miles. Because of the simplistic nature of both of these reporting requirements plan inconsistencies were discovered and challenges that included:

- Concerns of self-reporting
- Inability to address geographic disparities within States
- Didn't cover essential specialties across the network service area to prevent **Adverse Selection**

As the stakes get higher for health plans to diversify their participation across various programs, the ***Concerns of self-reporting*** are heightened. In order to provide a consistent measurement, a model needs to be developed that provides tighter controls and needs to shift from self-reporting to an automated adequacy review that assures consistency across all plans.

[1] Centers for Medicare & Medicaid Services. *Medicare Advantage Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance*. http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf.

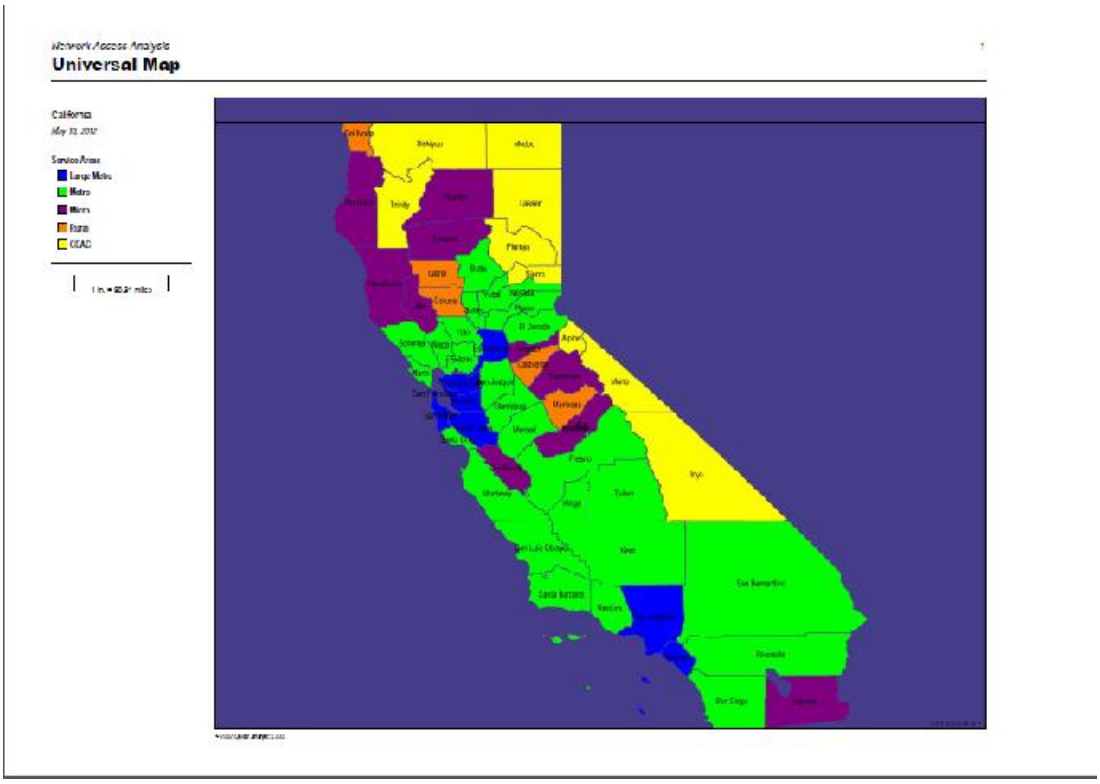
Several years ago, the Medicare program was faced with the same challenge as the California Health Benefit Exchange; continue with the simple process of plan self-reporting or to redesign the process to provide appropriate consumer protections. To provide the appropriate consumer protections and to prevent against adverse selection, a model was created with the realization that adequacy standards needed to be more sophisticated and designed around the patterns of care specific to each State to a***ddress geographic disparities within each State.*** As such, this model moved beyond basic access standards that applied to every geographic area of a State and instead create a variable standard based on the patterns of care in each State.
And finally the model was created around the premise that a health plan needed to cover a broad range of specialties and services to provide the consumer protections to ensure that the same ***Essential specialties*** are available within any plan participating in the program.

In developing their model, they realized that the process needed to achieve four specific goals:

1. Address geographic disparities across every State
2. Prevention of adverse selection
3. Transparency of requirements
4. Scalable & flexible to be leveraged across various programs

Addressing Geographic Disparities
Understanding the demographics of every State was a critical underlying component in the model to allow for fair comparisons across the geography. To improve upon the previous methods of either designating; a single standard that is measured across every area in the State; or designating areas as either Urban or Rural, a comprehensive model was created that designates every county within a State into classifications based on the population density patterns within each county. This process has already been designed for California (See table 1). [1]

[1] Centers for Medicare & Medicaid Services. *Medicare Advantage Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance*. http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf.



County	State	Population	County Designation	County	State	Population	County Designation
Alameda	CA	1,515,717	Large Metro	Orange	CA	3,016,237	Large Metro
Alpine	CA	957	CEAC	Placer	CA	351,411	Metro
Amador	CA	38,369	Micro	Plumas	CA	22,007	CEAC
Butte	CA	220,287	Metro	Riverside	CA	2,193,070	Metro
Calaveras	CA	46,221	Rural	Sacramento	CA	1,420,705	Large Metro
Colusa	CA	21,078	Rural	San Benito	CA	53,857	Micro
Contra Costa	CA	1,043,451	Large Metro	San Bernardino	CA	2,034,446	Metro
Del Norte	CA	28,596	Rural	San Diego	CA	3,091,958	Metro
El Dorado	CA	181,009	Metro	San Francisco	CA	805,232	Large Metro
Fresno	CA	935,125	Metro	San Joaquin	CA	684,089	Metro
Glenn	CA	29,460	Rural	San Luis Obispo	CA	270,086	Metro
Humboldt	CA	134,955	Micro	San Mateo	CA	690,399	Large Metro
Imperial	CA	169,046	Micro	Santa Barbara	CA	424,106	Metro

[1] Centers for Medicare & Medicaid Services. *Medicare Advantage Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance*. http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf.

Inyo	CA	19,497	CEAC	Santa Clara	CA	1,814,584	Large Metro
Kern	CA	845,968	Metro	Santa Cruz	CA	270,853	Metro
Kings	CA	151,702	Metro	Shasta	CA	186,561	Micro
Lake	CA	64,687	Micro	Sierra	CA	3,597	CEAC
Lassen	CA	32,205	CEAC	Siskiyou	CA	43,543	CEAC
Los Angeles	CA	9,811,939	Large Metro	Solano	CA	412,119	Metro
Madera	CA	150,446	Micro	Sonoma	CA	484,679	Metro
Marin	CA	251,685	Metro	Stanislaus	CA	516,314	Metro
Mariposa	CA	19,360	Rural	Sutter	CA	96,255	Metro
Mendocino	CA	87,738	Micro	Tehama	CA	53,951	Micro
Merced	CA	254,483	Metro	Trinity	CA	13,427	CEAC
Modoc	CA	11,018	CEAC	Tulare	CA	438,327	Metro
Mono	CA	12,975	CEAC	Tuolumne	CA	54,242	Micro
Monterey	CA	402,842	Metro	Ventura	CA	827,963	Metro
Napa	CA	137,050	Metro	Yolo	CA	200,716	Metro
Nevada	CA	93,496	Metro	Yuba	CA	73,115	Metro

Prevention of Adverse Selection

In order to understand which provider specialties and facility services needed to be measured, a comprehensive review of the actual patterns of care was completed for the given population. This process is essential to drive the specialty types that will ultimately be measured to determine plan participation in each particular program. Using this as the guideline, a specialty requirements table was created to build in the appropriate consumer protections to assure that every plan included in the program had adequate coverage across all essential specialties to service the population.

Once the specialty designations were identified to support the patterns of care requirements for the program, appropriate adequacy requirements (time & distance criteria) were applied for each specialty across the five county designations. This provided the flexibility to drive tighter standards in more populated areas while relaxing the standards for rural areas. Figure 3 is an illustration of the corresponding standards per specialty across each county classification.

Figure 3 CMS Published Standards for 2013….Time and Distance [1]

[1] Centers for Medicare & Medicaid Services. *Medicare Advantage Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance*. http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf.

	Geographic Type									
	Large Metro		Metro		Micro		Rural		CEAC	
Specialty	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Primary Care	10	5	15	10	30	20	40	30	70	60
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Cardiac Surgery	30	15	60	40	100	75	110	90	145	130
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OB/GYN	30	15	45	30	80	60	90	75	125	110
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Oncology - Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology - Radiation/Radiation Oncology	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Oral and Maxillofacial Surgery	30	15	60	40	100	75	110	90	145	130
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry, Rehabilitative Medicine	30	15	45	30	80	60	90	75	125	110
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Thoracic Surgery	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130

Transparency of Standards

Publishing the standards along with any updates to the criteria, allows all stakeholders to monitor Network Adequacy throughout the coverage period.

Scalable and Leveraged Across Other State-based Programs

The foundation of this model provides the ***blue-print*** for any State-based program to obtain a fast track approach to solving their Network Adequacy requirements across their various programs. This model has been successfully vetted in the Medicare Advantage program over the last several years in qualifying health plans for participation in the program. Some of the benefits that States can achieve with this model include:

1. Benefit from the process that is actively in place.
2. Allows more choice of Health plan options for beneficiaries and consumer protections to protect against adverse selection.

[1] Centers for Medicare & Medicaid Services. *Medicare Advantage Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance*. http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf.

3. Allows the opportunity for the state to spread the **cost** of Network Adequacy technology across several departments (Medicaid, Dual Eligible's, CHIP, State Based Exchanges and Managed Care Oversight) are just a few examples of state based insurance programs that all have a Network Adequacy requirement.
4. Consistency across programs. Integrating these proven Network Adequacy methodologies across many different entities helps streamline the process for the State.

Vetted and Utilized in California

Currently this model is utilized by every health plan in California who participates in the Medicare Advantage program and can be easily adopted by the California Health Benefit Exchange for the qualification and ongoing monitoring for health plans participation in the California Exchange. In addition to providing a consistent process that provides appropriate consumer protections, studies have shown that this drives better access to care and fewer cost related issues as illustrated in The Commonwealth Fund July 18, 2012 summary (attached).

With a model that has been developed to provide both an appropriate level of consumer protections as well as ensures fair and accurate comparisons across plans, we strongly encourage the California Health Benefit Exchange to adopt the same model. To help demonstrate the capabilities of the model, we have included a sample for several counties in California.

I'd welcome the opportunity to meet directly with the California Health Benefit Exchange to discuss how to incorporate this model.

Thank you for your consideration.

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[1] Centers for Medicare & Medicaid Services. *Medicare Advantage Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance*. http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf.